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IN THE COURT OF COMMON PLEAS
CUYAHOGA COUNTY, OHIO
CASE NO. 281605

KAYLA L. BURKETT, etc., et al.,
Plaintiffs,
versus
CLEVELAND CLINIC, et al.,
Defendants.

DEPOSITION OF
LAURA A. CAWTHON, M.D.

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Deposition of LAURA A. CAWTHON, M.D., a Witness herein, called by the Plaintiffs for Cross-Examination pursuant to the Ohio Rules of Civil Procedure, taken by the undersigned, Linda McAnallen, a Stenographic Reporter and Notary Public in and for the State of Ohio, at the offices of Buckingham, Doolittle & Burroughs, 3721 Whipple Avenue, N.W., Canton, Ohio, on October 7, 1994, at 2:00 p.m.

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APPEARANCES:

On Behalf of the Plaintiffs;

James J. Gutbrod, Attorney at Law
Perantinides & Nolan
80 South Summit Street
Akron, Ohio 44308

On Behalf of the Defendants Dr. Hammel and Dr. Vijayvargiya:

Michael Ockerman, Attorney at Law
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Canton, Ohio 44718

On Behalf af the Defendant Dr. Weiner:

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On Behalf of the Defendant Dr. Kulasekaran:

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Jacobson, Maynard, Tuschman & Kalur
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On Behalf of the Defendant Robinson Memorial Hospital:

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APPEARANCES (continued):

On Behalf of the Defendants Dr. Lang, Dr. Weldy, Dr. Foote, Dr. Allman, and Children's Hospital Medical Center of Akron:

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WHEREUPON,

LAURA A. CAWTHON, M.D.,

after being first duly sworn, as hereinafter certified, testified as follows:

CROSS-EXAMINATION

BY MR. GUTBROD:

Q. Dr. Cawthon, my name is Jim Gutbrod. Paul Perantinides and I represent the plaintiffs in this case, Mr. and Mrs, Burkett and their daughter Kayla. I'm going to ask *you* a series of questions. If I ask you a question that you don't understand or that you want me to clarify, I will expect that *you* will tell me that,

A. Okay.

Q. If *you* don't so tell me, I will presume that you understood my question and are answering my question,

A. Okay.

Q. Your responses need to be verbal words as opposed to nods or gestures.

A. Okay.

Q. Please state your full name for the record.

A. Laura Ann Cawthon,

Q. Now, Dr. Cawthon, what have you reviewed for this deposition?

A. *I* reviewed the films of the case.

Q. What films were those?
A. The chest x-rays. I believe there were three or four.
Q. Anything else? Any other films, documents, depositions, reports?
A. I saw the depositions of the other radiologists.
Q. Who?
A. Dr, Harnmel, I believe, and Dr. Vijay.
Q. Anybody else?
A, No.
Q. So you have reviewed three chest x-rays and the depositions of Dr. Harnmel and Dr. Vijay?
A. Yes.
Q. Rid you actually read those?
A. Very briefly, I skimmed through them.
Q. When did you read those?
A. Sometime last week,
Q. Is there anything else that you've read or reviewed for this case?
A. No.

MR. OCXERMAN: The interpretations.

A. Yes, the x-ray reports, that's right. I did read the x-ray reports at the time of the films.
a. I'm sorry?
A. I read the x-ray reports at the time I reviewed the

films with Michael Ockerman.

Q. When was that?

A. I think it was last week sometime, last week or the week before.

Q. Well, I presume you read them and reviewed the chest x-rays at the time you authored your report as well?

A. Right. Even a couple months before I reviewed the chest x-rays at that time, and I believe I saw the reports at that time, I don't remember but I think I did, and then last week we went over them again. Does that answer your question?

Q. Well, let me just get it clear. When was it that you were first contacted by Mr. Ockerman?

A. I don't really remember. I think it's been a couple months, at least a couple months.

Q. Well, if I tell you that your report is dated April 22, 1996, does that refresh your recollection?

A. That's probably right. I wrote the letter I think the week after I talked to him.

Q. So you were contacted by Mr. Ockerman sometime in the middle of April; is that fair?

A. I believe so, yes.

Q. And what did Mr. Ockerman provide to you at that time?

A. He showed me the chest x-ray films and had me review

them, seeing what I saw, and then he had me review the reports.

Q. So you were provided with the three chest x-ray films that are a part of this case?

A. Correct.

Q. The chest x-rays that were done for Kayla Burkett from April lst, April 2nd, and April 4th of 1988; true?

A, Yes.

Q. And you also reviewed the reports that were authored by either Dr. Vijay os Dr. Hammel?

A. That's correct.

Q. And those are the things that you had when *you* authored yaur repart?

A, Correct. When you're talking about my repart, I wrote a brief letter stating my opinion in the case.

Q. Your letter of April 22, 1996?

A. Correct.

Q. Since that time you have reviewed the depositions of Dr. Hammel and Dr. Vijay?

a. That:'s correct.

Q. And you've once again looked at the x-ray films and the reports?

A. Correct.

Q. And nothing *else?*

A. {shakes head}
Q. You have to answer yes or no.
A. No.
Q. The court reporter has to take down your responses.
A. Okay.
Q. So you can't shake your head or nod.
A. Okay.
Q. Mow, have you had any other cases with either Mr. Banas or Mr. Ockerman os anybody else from this firm?
A. Not a personal case. I had to present films on another case.
Q. You had to present films in another case?
A. Right. It was a surgeon who was involved in a lawsuit, and his action at the time of the case was based on my radiology findings, so I had to present my x-rays. There wasn't a controversy in x-ray readings. It was merely that they wanted my interpretation of my x-rays and why I read them as such and why I told the surgeon what I did.
Q. So I taka it Mr. Ockerman or Mr. Banas --
A. It wasn't either. It was another lawyer in this law firm.
Q. Who was that?
A. I think it was Mr. Frasure.

Q. Mark Frasure was representing a surgeon?
A. Right.
Q. Defending a surgeon?
A. Correct.
Q. And he asked you to become involved in that case?
A. Actually the surgeon approached me because I had done a number of radiology studies on the patient, and my interpretation of the radiology studies was what he based his decision on in this patient. It was a very complicated case, and a lot of his decision on what to do was based on my interpretation. So that's why I became involved.
Q. What kind of case was it? What was the pathology or what was the illness involved?
A. It was a postsurgical complication
Q. So did you actually testify in that case?
A. Yes, I did.
Q. At trial?
A. Yes.
Q. And that's how you became familiar with this firm?
A. Yes.
Q. Apart from that instance, have you had any other occasion of contact with this firm of any kind?
A. I don't believe so.
Q. Now, have you ever reviewed a case as an expert in a

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malpractice case?
A. NO.
Q. And who is your insurance carrier?
MR. OCKERMAN: Objection. Go ahead.
A. I think it's PICO right now. We were talking about changing. I'm not sure if we've changed yet.
Q. And when you say we, who is we?
A. Our corporation.
Q. What corporation are you part of?
A. Radiology Services of Canton.
Q. Are those radiologists out of Timken Mercy?
A. We practice primarily -- it's Columbia Mercy now.
Q. Columbia Mercy?
A. Right. That's where we practice, correct.
Q. So radiologists from Aultman Hospital, would that be a different group?
A. Correct.
Q. Are you charging for your review of this case?
A. Yes.
Q. What are you charging?
A. I think it's two fifty an hour. I'm not really sure. Our business people take care of that.
Q. Does the money go tu the corporation or does it go to you?
A. It goes to the corporation.

Q. Is your €ea any different for testifying at trial?
A. No.
Q. As opposed to review?
A. It's the same.
Q. Describe for me your day-to-day practice at Columbia Mercy.
A. In terms of?
Q. What do you do?
A. I'm a radiologist there. I do general radiology. I do cross-sectional imaging, including MR and ultrasound, a little bit of computed tomography. I do biopsies when they're needed, mostly under ultrasound. And plain film radiography would include upper GIs, IVPs, mammograms, and general x-rays.
Q. Do you from time to time encounter spinal column anomalies?
A. well, there's common anomalies.
Q. Such as?
A. There's scoliosis that I see quite commonly. There are other anomalies that we don't see a lot of, not in our current practice.
Q. Have you ever seen spinal column anomalies in an infant?
A. Yes, I have.
Q. What kind of spinal column anomalies?

A. I've seen hemivertebrae, diastematomyelias, myelomemingoceles. That's probably the majority of them that I've seen.

Q. Have *you* ever seen a cervical spinal anomaly in an infant?

A. Yes, in my training, in my residency training.

Q. How many times?

A. Maybe half a dozen, less than half a dozen.

Q. Less than half a dozen?

A. Probably half a dozen.

Q. I take it then from what you've said that you've never seen that at Timken Mercy or at Columbia Mercy?

A. I don't believe so,

Q. Can you recall what cervical spinal anomalies you've seen?

A. I've seen a basilar invagination case and I've seen blocked vertebrae. I've seen *a* couple blocked vertebrae.

Q. What does that mean?

A. There's no disc space. It's a fusion. It's a congenital fusion.

Q. Okay.

A. And then hemivertebrae involving the cervical spine.

Q. Now, you've read the depositions of Dr. Vijay and

Dr. Hammel?

A. Yes.

Q. They seemed to both agree that when a radiologist receives a film, the standard of care requires them to look at the entire film, the four corners of the film,

MR. OCKERMAN: Objection. Go ahead.

A. Yes. Are you asking me --

a. I'm asking you to accept that;, to accept that that's what their testimony has been so far in this case, both Dr. Vijay and Dr. Harnmel, I'm asking you to assume that.

A. Okay. I didn't read them that carefully, but okay.

Q. Do you agree with Dr. Vijay and Dr. Hammel, who have both testified that the standard of care requires the radiologist, when ha or she receives the film, to examine the entire film, the four corners of the film, to determine whether there's any abnormalities?

A. Yes.

Q. So if a radiolcgist docs not examine the four corners of the film, the entire film, and misses an abnormality, then he or she has fallen below the standard of care?

A. Yes.

Q. And in doing that, examining the four corners of the film, the entire film, in noting any kind of abnormality the standard of care requires the radiologist to describe in detail what he or she sees; is that fair?

A. That's not necessarily correct.

Q. Tell me why that's not fair.

A. Not every abnormality or -- I guess abnormality is not the correct word. Not every finding is necessarily described in detail. It depends on what the finding is and how pertinent it is to the diagnosis. It's important to make the clinician aware of such an abnormality if it possibly could be clinically significant, but not every abnormality is necessarily described in detail.

Q. So if that's the case, if the abnormality is clinically significant or in your view potentially clinically significant, would you agree that the radiologist needs to describe it in detail so that the clinician who has ordered the film can have the benefit of what you see?

A. No, not necessarily in detail. I think it needs to be made mention of.

Q. So all that the radiologist needs to do is mention it. The radiologist doesn't have an obligation to

describe it in detail. Is that what you're saying?

A. Depending on the abnormality, that's correct.

Q. Are there abnormalities that come to mind as we sit here now that you would think need to be described in detail?

A. Something that's life-threatening and needs action at that time. A pneumothorax, *you* probably would describe what percentage of the lung has collapsed. Free air in the abdomen, you would describe probably the amount of free air. More free air might mean a more significant abnormality. They both can be acted on clinically rather emergent. *So* something like that I would think would need to be described in more detail.

a. would *you* agree with me then that an anomaly or an abnormality that is life-threatening and emergent is one that the radiologist ought to describe in detail?

A. If it's life-threatening at that time, *yes.*

Q. And can we agree that the standard of care would require a radiologist, when observing an abnormality that is life-threatening and emergent, to describe that abnormality in detail?

A. Right.

a. Now, would it be fair to say that the radiologist

doesn't always know if a particular abnormality is life threatening and/or emergent?

A. I think I reed your definition of life-threatening and emergent. To me life-threatening and emergent means to be treated at that time within that hour or two hours, and in that case that needs -- and I think a radiologist can make the appropriate judgment of that. For instance, someone could have colon cancer that's described in a report. You're not going to take out that colon cancer in the operating room in the next hour. Could that be life-threatening five years up the road? Certainly. So that's why I think you have to watch your definition of life-threatening and emergent.

Q. So if something is life-threatening but you don't necessarily deem it to be emergent, do you have an obligation to describe that in detail, that abnormality?

A. I don't know if I can answer that question, because I don't know what you mean by life-threatening.

Q. Threatening a person's life.

A. I mean I can't predict what is life-threatening. I mean anything in your body is life-threatening, because sooner or later everything fails. So I don't think it's fair to say -- There are some

abnormalities you don't know are going to be life-threatening at that point in time. They're something that may need to be treated by the clinician. Could they be life-threatening at same point in time? They could be to your demise in terms of loss of life, if that's life-threatening. what I'm talking about as life-threatening is something that's involving that patient at that point in time. A lung that's collapsing and acutely within the next few hours that patient could lose their life, something that needs to be acted on emergently, that definitely needs to be communicated to the clinician.

Q. Absolutely, And you said that there are instances where you don't know whether something is life-threatening either in the immediate future or farther down the road; true?

MR. OCKERMAN: Objection.

A. That's true, yes.

(Discussion was had off the record.)

BY MR. GUTBROD:

Q. So there are some findings, radiological findings, that axe potentially life-threatening and you as the radiologist, given your limited scope and your limited information, may not know whether it is in

fact potentially life-threatening; is that fair?
A. Yes.
MR. OCKERMAN: And that's by her definition of two hours or within the day?
MR. GUTBROD: No.
A. You didn't say --
Q. Any life-threatening condition?
A. Sure.
Q. Potentially life-threatening?
A. Sure.
Q. Under those circumstances, if something may be life-threatening and you don't know whether it is or not, do you have an obligation -- let's back off from obligation. Is it a good idea for *you* to *do* more than simply mention it?
MR. OCKERMAN: Objection.
A. That depends on the case. The important thing is that you make the clinician aware that it exists. And if it's a confusing issue, you might want to explain it more. But there are certain abnormalities that may or may not be potentially life-threatening that another physician is aware of, and *you* mention them *so* they know about them,
Q. How do you mention something like that, something that is potentially life-threatening?

MR. OCKERMAN: Objection.

Q. How do you specifically in your practice?

MR. OCKERMAN: Objection.

A. I try -- I mention it in the body of the report. Also if I feel it's something that I want to make sure the clinician is aware of, I'll try to also mention it in the impression, because there are instances when I think clinicians are busy and they read the impression and the body of the report is skimmed through unless you have something in the impression that makes you want to go up and read the body of the report. So I make sure it's mentioned twice, so it's emphasized.

Q. Are there ever instances where you contact the physician by phone or speak to him personally about a particular matter?

A. Sometimes.

Q. Under what circumstances?

A. Most such cases are done, more so with outpatients, because I want to make sure the patients are going to get follow-up. For instance, if there's a mammogram that comes through that's abnormal and it may have been ordered just as a routine checkup, the patient came in after being ordered three months previously, I want to make sure the physician gets the report,

and rather than relying on the mail, I'll call that. If it's a pre-operative chest, someone is coming in for surgery and they have a chest x-ray done and they're already scheduled for surgery and I find a tumor or an abnormality in their lung, I'm going to call the doctor and say listen, so and so has something in his lung, so in case there's a delay in the report they're not going to get scheduled for surgery. So it's just a matter of courtesy.

Q. When there's a problem with time in terms of when the report is going to be received by the clinician, you would call him instead of waiting for him to receive the report?

A. More so with outpatients, because I don't know if the physician is going to see them and I want to make sure the paperwork is not lost.

Q. Are these instances where it's not a matter of time, that the finding in your view is of a nature that this deserves a phone call to the clinician?

A. In many cases I call because the physician wants to be called. We get a lot of STAT reports, and so I call them or I have the office staff call them. So a lot of those are called mainly because the physician wants them at a certain point, someone has come in bleeding and they want to know if they're aborting,

they have a patient that wants a result, and so those are called. I'd say the most often time I call the reports are it's either something life-threatening and I just don't want to wait for it to go through the general system, like a pneumothorax in the hospital, because most hospital reports are on the floor within 24 hours if they're in the hospital.

I call less reports now because we have a fax system. Almost every report that at Least gets faxed gets a handwritten report that's faxed right up to the floor, So it saves phone calls and it saves time, because if you call the floor, you have to wait for someone tc answer the phone, you have to wait fox someone to get a nurse, and it's very time-consuming. So over the past year we've faxed many reports to doctors' offices and to the floor, to the wards.

Q. Dr. Cawthon, have you been sued?

MR. OCKERMAN: Objection.

A. No.

Q. You have never been sued?

A. No.

Q. Have you ever received a 180-day letter?

MR. OCKERMAN: Objection.

A. No.
Q. There's another matter that Dr. Vijay and Dr. Hammel agree on. That is that when a radiologist observes one anomaly of the bony structure of the spine, that good radiologic care requires them to look elsewhere in the spinal column, because the presence of one anomaly increases the likelihood of the existence of other spinal column anomalies. So I'm asking you to assume that those two doctors, Dr. Vijay and Dr. Hammel, agree on that point,
A. Okay.
Q. Would you agree with that point?
A. Yes.
Q. So say you receive a chest x-ray, and in reviewing and interpreting that chest x-ray, you observe an anomaly of the spine. Good radiologic care requires you to look elsewhere, to look throughout the entire film at least, in order to determine if there are other abnormalities of the spine; fair enough?
A. Correct.
Q. And, in fact, we could agree, could we not, that the radiologic standard of care requires you to do that; isn't that true?
A. That's correct.
Q. And the radiologic standard of care may require you,

in the event that you note an abnormality of the cervical spine, to suggest that other views of the spine be taken in order to rule out whether there are other abnormalities in the spinal column,

MR. OCKERMAN: Objection.

Q. True enough?

A. It depends on the anomaly.

Q. Why do you qualify it that way?

A. If there was an obvious subluxation and malalignment, you know, from trauma or something where there's an obvious malalignment of vertebral bodies, then yes, I would recommend additional views. There are many spinal anomalies and you see them and it means the whale spine should be looked at and worked up at some point in time.

Q. It should or shouldn't?

A. Should at some point in time usually. But you can have an abnormal spine with perfectly normal soft tissues and spinal column. You can also have a perfectly normal-appearing spine and have abnormal soft tissues that you can't appreciate radiographically,

Q. 3 don't want to talk about trauma, for example, You mentioned trauma. Setting that aside for a minute --

A. Okay. Even congenital, if there's an obvious

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malalignrnent, then it would probably be worth getting other films.

Q If you observed that, an obvious malalignment, given the principles that we just talked about, you would suggest in the body of your report or in your impression that there be additional views taken in order to determine whether there are other abnormalities of the structural spinal column?

A. I would probably want to talk to the clinician first. It would depend what's going on with the patient, because spinal anomalies are associated with congenital heart disease and renal anomalies. And if this child is in a life-threatening condition that's worse with some organ system, you've got no business taking further spine films at that point in time.

Q. Let's pursue that then. If you notice a spinal column anomaly such *as* we've described --

A. With an obvious malalignment.

Q. Okay, let's say with an obvious malalignment. Your *next* step would be to contact the physician?

A. Probably, yes.

Q. For the purpose of determining what's going on clinically with that patient; is that true?

A. Yes.

Q. And presuming that it's nothing that would stand in the way of additional studies, you would then suggest that additional studies be done?

A. Probably.

Q. And the reason you would do that is because where these is one significant spinal column anomaly, it increases the likelihood that there may be others; true?

A. The reason I would do it is because subluxation can indicate there is narrowing of the spinal canal, which can affect the cord,

Q. So your concern would be to protect the spinal cord?

A. As well as to search for other anomalies, but the reason I would call would be because of the canal or the cord.

Q. Well, let's make sure I understand. I want to understand what you're saying.

A. Okay.

Q. Setting aside for just a minute that you would have a concern about the spinal canal -- and maybe we need to talk about another kind of anomaly.

A. Okay.

Q. I want to get at in general the principle of if there is a structural spinal column anomaly that you note on say a chest x-ray, good radiologic practice would

require you to pursue looking elsewhere in the spine in order to rule out other spinal anomalies; is that fair?

A. Correct.

Q. And that would involve *not* only examining the four corners of that particular film but also suggesting follow-up studies?

A. I didn't say that.

Q. Well, I'm asking.

A. Not necessarily.

Q. Under what circumstances would you not do that?

A. In the case in point, the case we're discussing today. From what I know about this case, the chest x-ray came down with *a* history of respiratory distress. The child has spinal anomalies. They're there. The clinician *is* made aware *of* it. It's general medical knowledge that you've got a spinal -- The clinician is made aware *of* it, *so* further workup can be *done* if it's indicated. *You don't* know if this child has a syndrome that's even compatible with Life. You don't know if there's a brain. You don't know if the heart is okay. You can presume it's okay by the size on the films and the lungs are fairly clear. You don't know if the kidneys are working. There could be other things going on. And when you

don't know what's going on with that child, to start recommending further studies prematurely I don't think is appropriate. And the clinician is made aware of these abnormalities and knows that one spinal abnormality means there can be others, meaning this kid needs to be referred to a specialist. I think that's in the report, that these are congenital anomalies.

Q. Which report is that?

A. The report of the case we're talking about. If it's in the report that there are congenital anomalies of the spine, the clinician is made aware of it. Not only is it general radiology knowledge that one anomaly of the spine can be associated with other anomalies of the spine, but it is general medical knowledge. This report is going to a physician and a physician has gone to medical school and that's clear, So 1 don't think it's necessary to indicate follow-up studies. It depends on each individual case. I don't think you can say in every case that you have to recommend additional studies,

Q. But you would agree that if you see a spinal anomaly like that, it's goad practice to contact the physician to find out what's going on with the patient?

A. It's a good -- I don't think it's required by the standard of care. It's nice out of curiosity to find out what's going on with the patient.

Q. Well, not just out of curiosity but out of concern for the patient?

A. Out of concern for the patient, but also this is an inpatient that's in the hospital, so this is not a case that's home and in the office, This is a patient that's in the hospital, So the clinician is doing rounds on that patient every day.

I don't always contact those clinicians. It depends on whc the clinician is, There are many clinicians that I see daily, and so I mention the case to them or ask how is he or she doing, you know. So in that case I don't always pick up the phone, There is prioritizing, You've got to prioritize your emergent cases with your non-emergent cases.

Q. Dr. Cawthon, haw many radiology studies do you look at in a day?

A. It depends what I'm doing. If I'm on call on the weekend, I can read a hundred cases in a day. If it's a specialized study, I may read twenty cases, if I'm doing MR or ultrasound. If I'm doing procedures, I'm doing less.

Q. How about just basic x-ray films in a typical day?

A. It all varies on the day, because I usually read a mixture of special studies. I usually do special studies, so I chip in and help with the general x-ray films. So, you know, fifty to a hundred.

Q. Before we move on, you had mentioned also in the instance that you talked about, the obvious malalignment, your concern would be protecting the spinal cord?

A. Right.

Q. Why is that important?

A. Well, the spinal cord carries your nerves. You need your spinal cord to breathe and to move. You need your spinal cord for life. Sa you don't want something impinging on the cord for very long, if you can help it.

Q. If something is impinging on the card for very long, what can happen?

A. You can have damage to the card.

Q. And what kind of result can that bring about in the patiant?

A. It depends on the level of the impingement. It can cause paralysis, bladder dysfunction, breathing dysfunction.

Q. So if you have a concern about the spinal canal and potential damage to the spinal cord, what do you do?

A. You'd probably do an MRI preferrably.
Q. Now, would you do an MRI without an order of the physician?
A. No.
Q. So if you see something on an x-ray that would lead you to be concerned about the spinal canal and the spinal cord, what would you do?
A. I would probably call the physicfan and tell him.
Q. And tell him what?
A. I would tell him what I saw and recommend whatever study I thought would be good, would be the best to evaluate it, which is generally MR or CT. Usually you try to do MR if it's available.
Q. That's what you would do in your practice?
A. Yes.
Q. And you would think that that would be good radiologic care on the part of any radiologist; fair enough?
A. Correct.
Q. And, in fact, in your view the standard of care would require that if a radiologist has reason to believe that the spinal cord could be potentially harmed by what you see on an x-ray, standard of care would require you to pick up the phone and contact a physician; fair enough?

A, Not could be potentially harmed but it looks obviously harmed. I guess your wording, potentially harmed, is rather confusing.

Q. Well, you're not talking about a situation where the spinal card is already harmed, are you?

A. No, but I mean sometimes you can have a perfectly aligned spine and you've got no reason to do an MR, but there could be soft tissue damage to the spine that you don't know about. So that is potentially harmful. You don't know.

a. Right. No, I'm talking about --

A. A bony abnormality that is obviously impinging on the cord, that's obviously impinging on the space where the cord would be, than I think it would be the standard of care to call.

Q. Well, wouldn't it be fair to say that in an x-ray film you're not going to be able to tell particularly whether the bony abnormality is in fact impinging on the spinal canal?

A. You can judge the distance of the spinal canal based on the bony alignment.

Q. And that should lead you to make a call to the physician; right?

A. Correct.

Q. And the standard of care would require you to do

that?

A. Correct.

Q. Doctor, I'm going to ask you to look at these chest x-rays and give me your interpretation.

A. Okay.

(Discussion was had off the record.)

(Plaintiff's Deposition Exhibits 1 through 6, x-rays, were marked for identification.)

BY MR. GUTBROD:

Q. Doctor, I'm going to show you what we've marked as Plaintiff's Exhibits 1 through 6. And what I'm asking you to do is put yourself in the position of Dr. Vijay or Dr. Hammel receiving this chest x-ray into the radiology department, just as you do every day at Columbia Mercy Hospital, or not every day but most days. Okay?

A. Okay.

Q. And I take it you have your dictaphone and you're dictating your report. Okay. I'd Like you to do that with each of these.

I'm going to show you what we've marked as Plaintiff's Deposition Exhibit 1, and I'll represent to you that this is a film that was taken on April 1, 1988.

A. You've got it backwards here, Okay. I would say

that the cardiothymic shadow is in the upper limits of normal. There are a few markings at the left base that probably represents a subsegmental atelectasis. Vascularity is not congested and otherwise lungs are well aerated. And there is -- I'll have tu count these. There's a hemivertebra at the -- it looks like it's at the T9-T10 level and there's extra ribs on the right side than on the left including a hypoplastic right rib. And I know there's anomalies in tne cervical spine from this case. I think they're hard to identify on this AP view. There's a cleft in one of the vertebral bodies on the cervical level which could be developmental.

Q. which could be what?

A. Developmental. It hasn't completely ossified. That's about all I see.

Q. That's all you see?

A. Yes.

Q. Okay.

MR. OCKERMAN: I think to be fair, Jim, as a radiologist interpreting, she should have both of those films up there at the same time.

Q. Absolutely. Whatever you need.

A. Usually you read them together. You need both really.

Q. You're now looking at Plaintiff's Exhibit 2, again a lateral view from April 1st, 1988.

MR. MORIARTY; I don't mean to be presumptuous, but we have a second view box in the room, if you'd like to put them both up at the same time,

A. Oh, that's okay. The cervical spine is difficult to visualize, but I think there are some.

MR. OCXERMAN: He's asking you to look at them as yau would that day.

A. I don't know at that point in time. I know they're there, There are some of the posterior elements that don't appear normal. The alignment of the vertebral bodies is normal.

Q. You are testifying that you see in these Exhibits 1 and 2 cervical spine anomalies; fair enough?

A. I think so. The problem is I know they're there, so in retrospect it's easier, I mean I don't know if I would catch them reading them in a busy reading room. They're there, but they're not obvious.

Q. Dr. Cawthon, these are Exhibits 3 and 4 taken, I represent to you, on April 2, 1988.

A. Okay. Just turn that one around. Okay. The cardiothymic shadow is in the upper limits of normal. Lungs are well aerated. Trachea is midline. And

there are vertebral anomalies again involving the lower thoracic spine with hypoplasia of one of the lower ribs, which is T9. And I can't really see the cervical. anomalies on this film. The cervical vertebral bodies look in normal alignment, These are copies and the cervical level is a little bit washed aut. I can't really comment on it.

Q. So is it your testimony that you can't see cervical spins anomalies on either Exhibit 3 or Exhibit 4?

A. No, I can't.

Q. Then finally showing you what we've marked as Plaintiff's Exhibits 5 and 6 -- Is that the sight way?

A. That's right.

Q. I would represent to you that these are films taken on April 4, 1988.

A. Okay. Again the cardiothymic shadow in this film appears I would say within the upper limits of normal. Lungs are clear. Trachea is midline. Thoracic abnormalities are again seen with the hypoplastic right rib. There is absence of some of the posterior elements of the cervical spine. And cervical vertebral bodies appear in normal alignment.

MR. OCKERMAN: I'm sorry, Absence of

what in the cervical --

THE WITNESS; Sane of the posterior elements.

MR. GROEDEL: Could you identify what level of the cervical spine you're making reference to?

A. To me it looks like C4. Let me count these, It looks like C4, possibly C3. And one of the cervical vertebral bodies isn't completely formed. It might be a hemivertebra, but I can't really tell. It's not as clear. There is an obvious hemivertebra in the thoracic spine. I can't really tell in the cervical spine. And there's more ribs on the right side than on the left. That would be it.

Q. Have you given us both what you would observe and what your impressions would have been?

A. My impressions would be cardiothymic shadow is within normal limits, upper limits of normal. Lungs are clear. And I would say vertebral anomalies of the cervical and thoracic spine. I might mention including a hypoplastic right rib. I would probably just mention the vertebral anomalies.

Q. That's for April 4th?

A. Correct.

Q. Let me go back then. I don't know if you had given

us your impressions from April 1st and April 2nd.

A. I think those two I would have stated the vertebral anomalies. The cervicals are harder to see on those films.

Q. So your impressions for April 1st for Exhibits 1 and 2 are what now?

A. Heart, upper limits of normal in size. Lungs, subsegmental atelectasis in the left lower lobe. Hemivertebra of the lower thoracic spine. And I might mention that there are --

MR. OCKERMAN: Just tell him what you --

A. But from a radiologist's point of view, whether there are thoracic or cervical anomalies, the kid needs to be worked up.

Q. Why do you say that?

A. Because there could be anomalies somewhere else in the spine. The lumbar spine is not visualized on this level. You've already got an obvious thoracic hemivertebra. So you've got one spinal anomaly of the bone, So the whole spine needs to be worked up at some point in time. I mean just based on the thoracic finding, that needs to be done.

Q. And if these came into the Columbia Mercy radiology department, how would you have ensured that the whole spine gets worked up?

MR. OCKERMAN: Objection. Go ahead.

A. I don't really follow up on each individual patient, because I can't.

Q. Why?

A. It's impossible. How am I going to follow up on a hundred patients a day and read a hundred x-rays a day? Clinicians order studies because they feel something is wrong. I give the impression in the report and I give them my findings. And based on my findings, they act on those.

In this case this would go to *the* nursery as vertebral anomalies. We have neonatologists and pediatricians as well as general doctors that I would feel confident would pick up on this and know to work up the spine. This *to* me is not a confusing issue for another physician, *a* nonradiologist,

Q. What is it that the nonradiologist physician should do, given the *way* that you would have reported out these x-rays?

A. I would think the child would be referred to *a* pediatric orthopaedic surgeon or a pediatric neurologist or both, depending on the clinical situation.

Q. And is that something that standard *of* care would

require them to do?

MR. OCKERMAN: Objection.

A. I can't speak for a pediatrician or a general doctor. I would think that that's how it would be worked up.

Q. That would be your expectation as a radiologist?

A. Correct.

Q. And in your mind as you're looking at these, you're saying this child's whole spine needs to be worked up; true enough?

A. True, if everything else is okay and that's indicated, yes.

Q. Well, it's indicated based on the radiology that you have in front of you; correct?

A. Based on that there's nothing else that's of more importance.

Q. Well, whether there is or there isn't, the child's spine at some point needs to get worked up; true enough?

MR. OCKERMAN: Objection.

A. Depending on the situation, yes.

Q. So your expectation would be that whoever the --

A. Assuming that this kid is going to go home from the hospital and the heart and everything else is working fine, the only problem is the spinal anomaly, then it needs to be worked up, yes.

Q. And that would be your expectation of whoever the ordering physician is?
A. Correct.
Q. So is it your testimony that you would not call the doctor or indicate in your report what your expectation is, that the child be worked up?
A. Probably not.
Q. Would it be helpful for there to be dedicated cervical spine x-ray studies?
MR. OCKERMAN: Objection.
A. It's hard to know at this point in time. If this child is referred out tu a pediatric specialist and imaged at a pediatric hospital, I would prefer an MR or CT be done. And I think it might be helpful to have films of the entire spine, AP and lateral. But besides that, your main imaging workup would probably be an MR or CT.
Q. Why?
A. To look at the spinal canal or to look for any other anomalies corresponding with this. And that would all depend on how the kid is doing in terms of clinically, if there's any indication that there's any nerve problems.
Q. So it would be appropriate in your view chat additional radiology studies be done, whether they be

additional x-rays studies or MR or CT studies?
A. Right, at same point in time, yes.
Q. It is impossible for you to tell what the severity of the pathology is that's going on in the cervical spine from these films; is that fair?
A. I'm not sure I understand your question.
Q. Wall, are you able to tell from any of these films what specifically is going on in the cervical spine and what the potential consequences of that would be?
A. Do you mean as far as -- I can see the bony structures. I can't see the soft tissues, if that's what you're asking,
Q. You can't see all the bony structures, can you?
A. No.
Q. So you don't really know what's going on in terms of the bony structures in the cervical spine altogether, do you?
A. No.
Q. And you don't know, given these films, what the potential consequences are of what you see only in parr; on these x-ray films; is that right?
A. That's right.
Q. And as you said before, given the nature of the bony abnormality, there could be an impingement of the

spinal canal; true enough?
A. Not based on these films.
Q. Is it your testimony that based on these films you would be able to rule out any impingement of the spinal canal?
A. No, I didn't say that, but the alignment of vertebral bodies as shown on the lateral views looks normal. There's no obvious subluxation to indicate there's impingement.
Q. I'm asking you, can you rule out impingement of the spinal canal or the spinal cord based on these films?
A. I can't on any plain films, even dedicated cervical spine films.
Q. Especially films where there's portions of the cervical spine itself missing?
A. Correct. Even if I saw the whole cervical spine, I couldn't rule that out. Even if I saw dedicated cervical spine films, I couldn't rule that out.
Q. But if you had films like this, that should prompt one to take the next step tu rule out the possibility of damage to the spinal cord; true enough?
MR. OCKERMAN: Objection,
A. At some point in time the whole entire spine needs to be looked at.

Q. Because of possible damage to the spinal cord?
A. Correct.
Q. And that potential damage to the spinal cord could lead to, as you pointed out earlier, paralysis, lass of breathing, depending on the level; fair enough?
A. Right.
Q. Have you ever seen a cervical spine with these kinds of abnormalities?
A. Not exactly like this, no,
Q. Now, you may or may not be aware from your Preview of Dr. Hammel's deposition that it is Dr. Hammel's view that Dr. Vijay fell below the standard of care in her initial reading of the April 1st, 1988, film.
A. Yes, I'm aware of that.
Q. And what I want to know is do you agree or disagree with Dr. Hammel in his view that Dr. Vijay fell below the standard of care in her interpretation, her initial reading cf the April lst, 1988, film?
A. Based on what I'm seeing here or --
Q I'm asking you what your view is. As you sit here today --
A. Well, I'm having a problem, because these are copies and I don't think they're as good a quality as the original films I saw, so I'm not seeing the cervical spine very well,

MR. OCKERMAN: You saw copies, too.

A. Rid I see copies? The cervical spine that I saw on the film I saw seemed to be a little better delineated on the first film.

MR. OCKERMAN: What he's asking you is based upon --

THE WITNESS: I€ she missed the cervical spine on --

FIR. OCKERMAN: Look at hex report that she dictated on --

Q. Let me stop you.

A. Okay.

MR. GUTBROD: We'll mark this report as Exhibit 7.

(Plaintiff's Deposition Exhibit 7, Radiology Report of 4-1-88, was marked for identification.)

MR. OCKERMAN: Let's take a short break.

(A short break was taken,)

(Plaintiff's Deposition Exhibit 3, Radiology Report of 4-1-88 Redictation, Plaintiff's Deposition Exhibit 9, Radiology Report of 4-2-88, and Plaintiff's Deposition Exhibit 10, Radiology Report of 4-4-88, were marked for identification.)

BY MR. GUTBROD:

Q. Dr. Cawthon, you have reviewed here in the course of this deposition some x-rays that apparently are copies of the originals?

A. Yes.

Q. And at a previous time you reviewed x-rays that were also copies of the originals; true enough?

A. I don't remember if they were copies or originals.

Q. The originals would, in fact, be clearer and would more clearly delineate, for example, cervical spina anomalies; fair enough?

A. It depends on the quality of the copies, The copies are not going to be any better than the originals, They might be fairly equal to or they might be of less quality.

Q. But they're not going to be any better than the originals?

A. No.

Q. So at best if you had the originals, you would have either as good a view or a better view than the copies; true?

A. Yes.

Q. Now, going back to my question, I'm showing you what we've marked as Plaintiff's Exhibit 7, and I'm representing to you that that is the first report

authored by Dr. Vijay upon her initial review of the April 1st, 1988, films, copies of which we have marked as Plaintiff's Exhibits 1 and 2, Fair enough?

A. Yes.

Q. Dr. Harnmel in his deposition testified that that report, that reading of these two x-rays, was below the standard of care for a practicing radiologist, Do you agree with that?

MR. OCXERMAN: Objection. Go ahead.

A. Yes.

Q. And so you would say that with reasonable medical probability, Dr. Vijay fell below the standard of care in that interpretation that she wrote that we've marked a5 Plaintiff's Exhibit 7?

A. Correct.

Q. Now, why is it that Dr. Vijay fell below the standard of care in that interpretation?

A. She didn't mention the vertebral anomalies,

Q. She didn't mention any of the vertebral anomalies?

A. Correct.

Q. She didn't mention the thoracic vertebral anomalies or the cervical spine anomalies?

MR. OCKERMAN: Objection. Go ahead.

A. Uh-huh.

MR. OCKERMAN: Yes or no?

A. Yes.

MR. OCKERMAN: Wait. Can you repeat that question?

(The court reporter read the preceding question as follows: She didn't mention the thoracic vertebral anomalies or the cervical spine anomalies?)

A. She did not mention any anomalies in her report,

Q. So your answer is yes?

A. Yes.

Q. And you can see those anomalies on these films, they're there, and she should have noticed them?

MR. OCKERMAN: Objection. I just want to be clear which anomalies you're speaking of.

Q. Which anomalies are you speaking of, Doctor?

MR. OCKERMAN: That you can see there.

A. I can see the thoracic vertebral anomalies clearly. The cervical are difficult to see.

Q. But you can see them?

A. I can see them because I know they're there, but they're difficult to see.

Q. Now, in Plaintiff's Deposition Exhibit 8, Dr. Vijay has authored another report that is called a

redictation radiology report. I'm showing you what we've marked as Plaintiff's Exhibit 8. This apparently is a re-review of Plaintiff's Exhibits 1 and 2 and a redictation of her initial report, this time dictating it on April 2, 1988. Is that fair enough?

A. Yes.

Q. Now, Dr. Hammel in his deposition testified that in his view Dr. Vijay fell below the standard of care in this redictation interpretation of the April 1st, 1988, chest x-rays. Do you agree with him?

MR. OCKERMAN: Objection. Go ahead.

A. I'm not sure. She mentions the anomalies at the thoracic level, She mentions everything but the cervical anomalies. The cervical anomalies aren't mentioned. And since they're there, it is below the standard of care. It's hard for me to comment because I can't see them very well on the films that we have today.

Q. Doctor, do you have an opinion as to whether or not Dr. Vijay fell below the standard of care in her report of April 2nd, the redictation, as Dr. Harnmel believes that she did?

MR. OCKERMAN: Objection. Go ahead,

A. I'll say yes, she probably did.

Q. I'm going to show you what we've marked as Plaintiff's Exhibit 9, and I will represent to you that this is the report of Dr. Vijay of April 2, 1988, interpreting the April 2, 1988, chest x-rays, the AP and lateral views. And copies of those are Exhibits 3 and 4 that you have just reviewed earlier.

Now, I will represent to you that Dr. Hammel testified once again in his deposition that in his view the cervical spine anomalies are present and visible on the April 2, 1988, x-rays, chest x-rays, and that as such Dr. Vijay fell below the standard of care in not including them in her report, Plaintiff's Exhibit 9.

Now assuming that, do you agree with Dr. Hammel that Dr. Vijay fell below the standard of care in her interpretation of Plaintiff's Exhibit 9 with reasonable medical probability?

MR. OCKERMAN: Objection. Ga ahead.

A. Yes.

Q. Now, it's a fairly common Occurrence for you as a radiologist to review x-rays in a series; is that true?

A. Yes.

Q. That is to say that x-rays will be taken of the same

anatomical part, anatomical place in somebody's body, days in a row or in some kind of serial fashion; true enough?

A. Yes.

Q. And the practice of your radiology department, as with radiology departments across the country, is to keep a jacket or a folder that contains those serial radiographs; fair enough?

A. Correct.

Q. And when a new radiograph is made of that same anatomical part or place in a person's body, you as the radiologist in order to interpret that correctly will look not only at the radiograph. that: was just done but at previous serial radiographs; fair enough?

A. That's correct,

Q. when *you* dictate your report, in that circumstance where *you* are dictating the latest in a series of radiographs, do you in fact describe anomalies that were previously reported?

A. Not necessarily.

Q. Do *you* then, instead of describing them, simply make reference to previous reports?

A. To previous films.

Q. Previous films. Okay. Relying on the fact that they were reported previously?

A. Sometimes I do. Sometimes I don't. Often I don't have reports in the jacket from previous films, so I look at the old films. And if it's these, I'll just say again seen or note is made of this as seen previously.

Q. Let me see if I've got that straight. You're saying that from time to time you will have a jacket that has the films in it but not the reports?

A. Correct.

Q. You don't have the reports at hand?

A. Correct.

Q. And you are dictating a report on the most recent in the series of radiographs; is chat right?

A. Correct.

Q. And instead of describing the abnormality that you see not only in the most recent radiograph but in previous radiographs, you will look at the most recent one and also the earlier films; true enough?

A. True.

Q. And you will dictate something like "as seen again", is that what you're saying?

A. Correct.

Q. Is it fair to say that if you don't have the reports in front of you, you will not know as to whether or not that particular abnormality has been reported

before? Fair enough?

A. That's true.

Q. If in fact you have the reports and you know that it has not been reported before, you will as a rule describe it in greater detail; true enough?

MR. OCKERMAN: Objection.

A. Might or might not. It would depend on what it was.

Q. Well, if you don't have the reports and don't know if in fact it was reported before, it's not really accurate to say "as seen again" or "as reported previously" if you don't know if in fact it was reported previously?

A. I don't use the words "as reported previously". I use "as seen on the previous film", because I saw it on the previous film, meaning it's there now and it was there before.

Q. That you've seen it on the previous film?

A. Yes.

Q. Do you ever use the phrase "as again noted"?

A. Sometimes, yes.

Q. And do you use that when you don't know if in fact it was noted previously?

A. I use the term "as again noted" meaning it was there previously and it's there now. So I rely on visually what I'm seeing.

Q. So noted to yau doesn't imply that somebody actually made a notation about it?
A. Correct.
Q. Have you reviewed the report of Dr. Robert Zimmerman in this case?
A. No.
Q. Do you know who Dr. Zimmerman is?
A. I know of him, I don't really know him,
Q. What do you know of him?
A. He's a pediatric radiologist. I believe he's in Philadelphia. That's about all I know.
Q. You haven't read his report?
A. I think I previously saw it the first time Michael Ockerman brought me the films, and I skimmed part of it but I didn't really read through the whole thing in detail.
Q. You're not a pediatric radiologist; true enough?
A, No, I'm not.
Q. You don't have particular specialized training in the reading of pediatric radiographs?
A. That's true.
Q. And in fact your practice at Columbia Mercy Hospital, the vast majority of that is related to adults; true enough?
A. Yes.

Q. What percentage of your radiological practice is pediatric?
A. Five to ten percent.
Q. And in terms of neuroradiology, your practice is a mixture, is it not, of radiology and neuroradiology?
A. Correct.
Q. Is there a difference between those two?
A. Neuroradiology is a subspecialty of radiology.
Q. What is the difference between the two?
A. Neuroradiology refers to radiology of the brain and spinal column.
Q. And how much of that do you do, neuroradiology?
A. Oh, twenty to thirty percent.
Q. Of your practice?
A. Yes.
Q. So if somebody like Dr. Zimmerman, who is a pediatric neuroradiologist and has been in practice for thirty some years, expresses an opinion, you would have a certain amount of respect for that opinion if it's related to radiology of a child and paxticularly pathology related to the brain or the spinal cord?
MR. OCKERMAN: Objection.
A. Yes, I would have respect for it.
Q. And you would be prepared to say that in those particular areas Dr. Zimmerman has more expertise

than *you?*

MR. OCKERMAN: **Objection.** In **what particular areas?**

MR. GUTBROD: In the areas **of pediatric** and **neuroradiology.**

MR. **OCKERMAN:** Versus a general **radiologist?**

MR. GUTBROD: **Right.**

MR. **OCKERMAN:** Objection. ***Go* ahead.**

A. **He** certainly has more **training** in general pediatric **radiology.** I'm not sure if **he's a pediatric** neuroradiologist. If he is, then he has more training in pediatric neuroradiology, **yes.**

Q. And **so** in **light** of the fact **that he** has more training **and** more practice, you **would** agree that he **has** more **expertise** than *you* in that particular area?

MR. OCKERMAN: **Objection.**

A. In pediatric radiology?

Q. Pediatric **neuroradiology.**

A, **Is** he **a pediatric** neuroradiologist?

Q. ***Yes.***

a. **Yes, I would agree** with **that.**

Q. And if he **expresses** an **opinion** related to that particular **specialty, would you be willing to** defer to him *in* **regard to that opinion** *in* light **of** his

experience and his expertise?

MR. OCKERMAN: Objection. That's not a fair question.

MR. MORIARTY: Objection.

A. What do you mean by defer to him?

MR. GUTBROD: What's the basis of your objection, Mike?

MR. OCKERMAN: The basis of my objection is you're not giving her the opinion that he's expressing.

MR. GUTBROD: I don't have to give her the opinion. I'm asking in general terms.

A. I don't know what you mean by defer to him, so I can't --

Q. If you express an opinion that is in some respects different than his opinion, would you be prepared to defer to his opinion in light of his experience and expertise?

MR. MORIARTY: Objection,

MR. OCXERMAN; Objection.

A. Not necessarily.

MR. MORIARTY; Objection to form.

A. Not necessarily.

Q. So I take it then that: when it comes to a case involving pediatric neuroradiology, in your view

your opinion may be as good as or better than Dr. Zimmerman's?

MR. OCKERMAN: Objection,

A. It may be different. I can't say whether it's as good or better.

Q. You are board certified as of 1992; is that right?

A. Correct.

Q. So you have been a practicing board certified radiologist for a total of four years?

A. Correct.

Q. So if Dr. Zimmerman writes that Dr. Vijay fell below the standard of care in her report of the initial imaging studies on Kayla Burkett in failing to note and describe the cervical spine anomalies on April 1st and 2nd, 1988, do you agree with that?

MR. OCKERMAN: Objection.

A. Yes.

Q. Do you agree that Dr. Vijay fell below the standard of care, in addition to those points, in failing to recommend follow-up studies?

MR. OCKERMAN: Objection.

A, I disagree.

Q. And do you agree when Dr. Zimmerman expresses the opinion that Dr. Hammel fell below the standard of care in mentioning the anomalies in passing and not

specifically describing them in his report of April 4, 1988, and in not recommending follow-up studies?

A. I disagree,

Q. And I take it you disagree with all of those points, that is, that Dr. Hammel fell below the standard of care, first of all, in mentioning the anomalies in passing?

A. I disagree, yes.

Q. You believe that he met the standard of care in simply mentioning the anomalies in passing?

MR. OCKERMAN: Objection.

A. Correct.

Q. And you also believe that he met the standard of care in failing to describe them in his report of April 4, 1988; true enough?

MR. OCKERMAN: Objection. Go ahead.

A. Correct.

Q. And that he also met the standard of care even though he did not recommend follow-up studies?

MR. OCKERMAN: Objection.

A. Correct.

Q. You mentioned earlier that part of your practice involves the interpretation of ultrasound films; true enough?

A. Yes.
Q. And do those involve in utero ultrasound films?
A. Yes.
Q. That's a small part of your practice but you do do that?
A. That's a fairly significant part.
Q. Is it?

MR. OCKERMAN: She's not here to review ultrasound films. She's here to give standard of care opinions in regard to those radiology films. We're not offering her for anything else, and I think it's unfair for *you* to put something up here that she's never seen and I've never seen, nor *is* she here to give opinions on that. I don't think it's fair. I'm not going to let her answer those questions.

MR. GUTBROD: Based on what, Mike?

MR. OCKERMAN: That's not what she's -- we are not going to offer her to look at any other films other than those from Robinson Memorial Hospital involving Doctors Vijay and Hammel.

MR. GUTBROD: Well, Mike --

MR. OCKERMAN: And we're not going to

have her give testimony at trial. unless it involves Dr. Vijay and Dr. Hammel.

MR. GUTBROD: First of all, I don't know what questions are going to be asked of Dr. Cawthon by any of the other lawyers here. Second of all, the only basis that I know of that you can instruct your witness not to answer is privilege. There's no privilege involved here. It may or may not be admissible at trial. I think I'm perfectly within my rights to ask her questions related. to other films.

MR. OCKERMAN: I think it's unfair and I'm not going to let her do it, You can take it up with the judge.

WR. GUTBROD: Well, I will.

MR. MORIARTY: What are the films? I want to know what they are, so they're identified on the record, so we know what the dispute is.

MR. GUTBROD: First of all, we have films related to ultrasound, in utero ultrasound of March 5, 1988, of this child that I think is very relevant to Chis case and should be admitted. Plus I think we have

films that axe pertinent tu follow-up care that I would like to ask Dr. Cawthon about.

MX. OCKERMAN: That's not what she's here for. Her opinions will go strictly to the films that Dr. Vijay and Dr. Hammel read and interpreted. We're not offering her for anything else.

MR. GUTBROD: Can you insure for me that the other lawyers here are going to ask questions strictly along the lines of what you confine your direct examination to?

MR. OCKERMAN: When are they going to do it, if they're not going to do it here? Are they going to do it when she's on the stand?

MR. GUTBROD: Absolutely.

MR. OCKERMAN: I don't think that's fair either, That's not what she's here for. That's not what we're offering her for,

MR. GUTBROD: I don't care. I mean unless you can guarantee for me that these lawyers aren't going to ask her questions related to other matters in this case pertinent to her specialty, I don't see how you can prohibit her from answering the questions here.

MR. OCKERMAN: I can't guarantee you anything.

MR. GUTBROD: That's right.

MR. OCKERMAN: Ask those gentlemen.

MR. GUTBROD: I'm not going ask them, There is no basis for your refusal to let her do it. All right. Well, we'll take it up with the court.

MR. MORIARTY: Who read these films? Was it one of the defendants or an agent of one of the defendants?

MR. GUTBROD: Absolutely.

MR. OCKERMAN: Who? Tell us on the 3-5-88 ultrasound, who is --

MR. GUTBROD: Kayla Burkett read by Robinson Memorial Hospital --

MI. OCKERMAN: Well, who?

MR. GUTBROD: -- who is a defendant in the case.

MS. FRANKLIN: I object. I haven't seen these films.

MR. GUTBROD: They were taken at Robinson Memorial Hospital. They were interpreted by a radiologist there.

MR. OCKERMAN: Who? Is it by Harnmel or

Vijay?

MR. GUTBROD: No, but it's by Robinson Memorial Hospital, a defendant in this case.

MS. FRANKLIN: They weren't read by Robinson Memorial Hospital.

MR. GUTBROD: They were taken at Robinson Memorial Hospital; right?

MS. FRANKLIN; Right. I think that if you're going to have her interpret them, they have to be identified beyond the fact that they were taken at Robinson Memorial Hospital. Do you have a report with them?

MR. GUTBROD: We have a report. There's a report in the file of the 3-5-88 ultrasound that was done,

MR. MORIARTY: Look, you guys can argue about it. Either Mike is going to let her answer the questions or not. And you're either going to not pursue it or you're going to call the judge or we're just going *to go* on to something else.

MR. OCKERMAN: Call the judge.

MR. MORIARTY: If Mike isn't going to let her answer, you're not going to talk him into it, so --

MR. GUTBBOD: Okay. Let's call the judge.

(Discussion was had off the record.)

MR. GUTBROD: We'll file a motion with the court and bring Dr. Cawthon back.

MR. OCKERMAN: That's fine, if that's what the court says.

MR. MCRIABTY: Let the record note I personally do not want to be dragged back down here to redepose this witness on this issue.

MR. OCKERMAN: Are you going to ask her questions at trial in regards to any interpretations that your client may have seen?

MR. MORIARTY: I have no idea what I might ask her. It depends what she says in response to Jim's questions. I can't control how he resolves this issue with you and it is his deposition.

BY MR. GUTBROD:

Q. Doctor, do you have a copy of your report, your letter?

A. I don't have it with me.

MR. GUTBROD: Do you have a copy of it, Mike?

MR. OCKERMAN: Yes.

Q. Would you mind reading for me the third paragraph into the record so we can talk about it?

A. With the limited clinical history given at the time of interpretation of the radiographs, the radiologists were not in a position to recommend further imaging studies without knowing the full clinical spectrum of the patient. Furthermore, the ordering physician was aware of his request for a chest radiograph which is generally performed to evaluate the heart and lungs. The skeletal abnormalities were an incidental finding identified and reported to the requesting physician. The osseous structures are obviously not optimally evaluated on a study performed with a technique and positioning to optimize evaluation of the lungs and soft tissues.

Q. You're trying to make a case for the point in this paragraph that in your view it's not the radiologist's job to recommend further imaging studies in general?

A. In this case.

Q. And I think based upon your previous testimony, in any other instances it's not the radiologist's job?

A. It depends an each individual case.

Q. How often do you recommend follow-up studies?

A, It depends on the case. Soma days I recommend quite a few. Some days I don't recommend any,

Q. So is it possible that you could review a hundred radiographs in a day and not recommend a follow-up stwdy?

A. Probably not.

Q. Do you have any idea what the average would be, five, ten, twenty, thirty, fifty?

A, I don't know. It depends on what I'm doing. Some days I'm doing much more complicated imaging studies than others.

Q. In any event, in your view in this case the responsibility for follow-up studies and follow-up care rested with the clinician?

A. Correct.

Q. Is that your opinion?

A. Correct.

Q. Given the report that the clinician received in this case, the report of -- let's say Dr. Hammel's report of April 4, 1988, what would have been your expectation in terms of the follow-up studies or follow-up care that the clinician, Dr. Lang, undertook upon receiving this report?

MR. GROEDEL: Objection, asked and answered I believe.

MR. OCKERMAN: Objection,

Q. Go ahead.

A. I need you to state the question again.

(The court reporter read the preceding question as follows; Given the report that the clinician received in this case, the report of -- let's say Dr. Hammel's report of April 4, 1988, what would have been your expectation in terms of the follow-up studies or follow-up care that the clinician, Dr. Lang, undertook upon receiving this report?)

A. I would have expected a referral to a pediatric subspecialist or pediatric specialist.

Q. Such as?

A. A pediatric orthopaedic surgeon or a pediatric neurologist or both.

Q. And why?

A. To further evaluate the spine far possible anomalies or for possible complications of the anomalies that are present, which may or may not be clinically significant.

Q. And you don't know?

A. No.

Q. Given the presentation that you have on these radiographs, you don't know the clinical significance

of what you see here?
A. Correct.
Q. And somebody whose specialty or whcse training is more directed in that area is the person who ought to be undertaking the care here?
A. Correct.
Q. Now, what would have been your expectation of the pediatric orthopaedist or the pediatric neurologist? What in general would you have expected him to do?
MR. MORIARTY: Objection.
MR. OCKERMAN: Objection.
A. I can't comment an that, because I don't know what; they saw in the patient. I wasn't there when they examined the patient. I'm not a pediatric orthopaedic surgeon nor am I a pediatric neurologist, so I really can't comment on that.
Q I understand. You would have liked to have seen follow-up studies?
A I would think they'd be helpful.
Q. And again you've told us about MRI particularly or CT particularly?
A. Correct.
Q. I take it you have contact with orthopaedic surgeons?
A, Yes.
Q. Regularly?

A. Fairly regularly.
Q. And in what way does that contact come about?
MR. OCKERMAN: Objection.
A. Usually they're coming through to review some films, want to review a case with me. Sometimes they see me in the hall and give me the results of a case that I read and they remember I read it.
Q. To give you the results of a case?
A. Right. If I read a case and I described something in the knee or shoulder and they've done surgery on it, they'll tell me what they found and how it agrees with my report-
Q. Do orthopaedic surgeons in general read their own radiology studies?
MR. OCKERMAN: Objection.
A. I don't know.
Q. Do orthopaedic surgeons send x-rays to you?
A. Correct.
Q. And you review them?
A. Usually the x-rays are done at the hospital and they come in and review the hospital films with us.
Q. So the orthopaedic surgeons come into the hospital and review the films with you?
A. Sometimes,
Q. Is that typical for other specialties?

MR. OCKERMAN: Objection.

A. Sometimes.

MR. GUTBROD: I think that's all I have.

* * * * * * *

CROSS-EXAMINATION

BY MR. MORIARTY:

Q. When you reviewed these films in this case for the very first time, had you already had some discussions with Mr. Banas or Mr. Ockerman?

A. No.

Q. You didn't know word one about this case?

A. No.

Q. So they just asked you, "We want you to look at some films"?

A. Correct.

Q. And then they showed you some films?

A. Correct.

Q. Did they ask you to interpret the films?

A. Yes.

Q. You didn't know one thing about this case?

A. NO.

Q. You saw the films, you interpreted the films, and then later you saw the reports?

A. Yes.

Q. And later you found out the more general scenario of

what happened in this case?

A. Yes.

Q. Do you remember if the very first time you saw the films from April 1st and before you had seen the reports, before you knew anything more about the case, do you remember whether or not you identified cervical spinal anomalies?

MR. OCKERMAN: From the April 1st, 1988, film?

MR. MOBIARTY: Yes.

A. I don't really remember. I think I did, but it took me awhile to see them.

Q. Do you remember whether you saw them on the April 2nd films in this initial review?

A. I can't remember.

a. Do you remember whether or not you saw them in the April 4th, 1988, film?

A. I think I saw them on that film. I can't really remember which film I saw them on. I know I saw them on one film that was more obvious than the others.

Q. How often do you Look at neonatal chest x-rays in your own practice?

A. Oh, once a week.

Q. How often do you look at spine films, adult or pediatric?

A. Almost every day.
Q. You were talking before about your own practice, and you said that sometimes if you're concerned about a finding you will put it in the body of the report and in the impression section; correct;?
A. correct.
Q. Does the standard of care require that?
A. I don't know.
Q. I assume that you do that because you want to make sure that a busy ordering physician sees it if that busy ordering physician only reads the impression?
A. Correct.
Q. When you are dictating, do you assume that the ordering physicians all only read the impression section?
MR. OCKERMAN: Objection.
A. Not necessarily.
Q. well, just tell me in your own experience when you put it in the impression section and when you only leave a finding in the body of the report,
A. In the body of the report I try to describe anything I see. It may be something that's obviously insignificant, but than no one could fault me for not seeing it because I mentioned it,
So in the impression I put things that I

feel are pertinent that I want to make sure the clinician knows. Sometimes they may not be pertinent and I don't know. For instance, I may have a normal study, normal chest x-ray, and note is also made of a stable appearing lung mass, because I've seen it before and it's obviously benign, so I'll just note it. And I'll put that in the impression, so when he reads it, he knows okay, it's a normal study, she did note this and compared it, so he knows that I evaluated what he sent the patient in for. It's like a time-saving device, I guess I do it for convenience for the clinician. So I try to put anything that I think might be pertinent to that patient, a pertinent negative or pertinent positive, partially, too, to make sure it gets read, but it also makes it more convenient for them, That's just my own way- of reporting.

Q. Do you think in general a cervical spinal anomaly is pertinent?

A. Yes.

Q. In this case, based on the films from the 1st, 2nd, and 4th, do you think that the cervical, spinal finding was pertinent?

A. Yes, it is, except there's already a thoracic abnormality, so you have to just assume that there

could be anomalies elsewhere. So as long as there's anomalies mentioned in the spine, it needs to be further worked up. Even if there was no cervical anomaly present in this case, it was perfectly normal, I would still want this kid worked up.

Q. If you had personally been the radiologist to read all three of these, would you have mentioned the cervical spinal anomalies in the impression section on one or all of the three reports?

A. It's hard to look back in retrospect. Probably I would have mentioned cervical, thoracic, and rib anomalies. I would have put it in one sentence.

Q. Do you think the standard of care required that?

A. No.

Q. I'm not a radiologist, so I don't know how you work or what the standard of care is, but in your answers to Mr. Gutbrod's questions you were expressing some question about these cervical spinal anomalies. They're difficult to see, I think that's the phraseology you used.

A. Correct.

Q. If you look and something is difficult to see, maybe it's a problem, maybe it isn't, does the standard of care require you to err on the side of caution and

include it as a possible finding?
A. Probably.
Q. Mr. Gutbrod was asking you some questions about the language in radiology reports, using the terns -- and these are in quotation marks -- "seen" and then a separate term "noted". Do you remember those questions?
A. Yes.
Q. Would you agree with me that the ordering physician would only know what was seen or noted an a film based upon whae the radiologist dictated in his ox her report?
A. That's true.
Q. Assuming they didn't have an oral conversation about the findings?
A. True.
Q. So in this particular case, for example, the physicians to whom these reports were going, be they Dr. Lang or someone in the neonatal care unit, they would only know that cervical spinal anomalies were seen or noted if that was reported on the radiology reports; correct?
A. Correct.
Q. And assuming they didn't read the films themselves. In paragraph three of your report you used the

phrase, "The skeletal abnormalities were an incidental finding." What do you mean by that?

A. They were a finding not expected, Pediatric chests are generally performed to evaluate the heart and lungs, Often newborns are having trouble breathing, so you're evaluating the lungs to make sure they're well aerated, they're not collapsed. And the bones are visualized and there's something seen but a finding really not associated with the reason far the exam being performed.

Q. Just a couple more things. Just so I understand the obligations of a radiologist, when that radiologist is reporting the third in a series of films, as I understand it the radiologist has several options. One of those options is to fully report and describe all the findings that the radiologist sees on the film they're looking at, Is that one of the options?

A. Yes.

Q. Another option is to give an abbreviated or a partial description with reference back to what has been described in the prior reports. Correct?

A. Yes.

Q. Are there any other options in reporting than those two?

A. You can compare with the previous films, you were saying compare with previous reports.

Q. Well, what I'm talking about is not just when you as a radiologist are looking at the films. I'm talking about the reports, what the radiologist is going to convey via the written report to the ordering physician. So you can either describe everything or make an abbreviated description referring back to the prior reports; correct?

A. True.

Q. And again, getting back to what I asked you a few minutes ago, if you jus-, refer back to the prior film, unless you have the reports, you don't know what was already communicated to the ordering physician?

A. Ccrrect.

Q. Now, if the radiologist chooses our second option, which is the partial or abbreviated description with reference back to the reports, that radiologist would have to read the prior reports to know what additional material to add or subtract or compare; correct?

a. If he's referring back to the reports, yes.

Q. Well, *if* the radiologist chooses that option, doesn't he or she have to look at the reports?

A. If he's referring back to the reports. It depends if you refer back to the reports or the films.
Q. If ycu take the option where you're giving the abbreviated description, if you only refer back to the prior film, you are making an assumption about what has been reported on the second film or the first film in the series, are you not?
A. That's true.
Q. In your opinion, does the standard of care require the radiologist to look at the report and not make assumptions about what has already been reported?
A. No.
Q. So in your practice, you assume as the third reader in a series that the prior two radiologists have seen everything arid reported everything appropriately?
A. Usually we make a notation on the jacket that's very abbreviated. So it would have a brief handwritten notation, not detailed at all, of what the previous radiologist saw, their final impression, normal, abnormal, whatever, because we don't -- we often have a delay in the written reports getting in the jacket because the clinical reports take priority.
Q. I understand that. Maybe I'm not being clear in my

question.

MR. OCKERMAN: Maybe.

Q. You're there and you're reading. You've got these films in front of you that you've been asked to read. There are two sets of films in the jacket already and this third sat is now before you. Correct? Your practice and the standard of care is going to be to compare the films.

A. Correct.

Q. Now, in deciding how to report on the third set of films, do you assume that the prior two radiologists, number cne, saw everything, and, number two, reported ail the pertinent findings? Do you make those two assumptions?

A. It depends on what the abnormality is.

Q. Is it within the standard of care to make those two assumptions, that the prior radiologists, number one, saw all the pertinent findings and, number two, reported all the pertinent findings?

A. I don't know if I can answer that, because how do you know?

Q. How do you know unless you read the reports; correct?

A. Well, how do you know what's going to end up being pertinent sometime in the future?

Q. Well, to you as the radiologist looking at the films

at the time.

A. Ccrrect, if it's something you feel that is pertinent, you would look at their old reports.

Q. Now, for example, in this specific case you have already told me that the cervical spinal anomalies would have been a pertinent finding; is that correct?

A. Correct.

Q. Dr. Hammel had a decision to make about how he reported the films that he saw on April the 4th, 1988; correct?

A. Correct,

Q. He apparently assumed that the cervical spinal anomalies had already been seen and reported by Dr. Vijay in the prior two studies; correct?

MR. OCKERMAN: Objection.

A. I don't know what he assumed, I don't know --

Q. Let's assume that he --

A. Wait a minute. I don't know what you're getting at, because he says right hers that there's congenital skeletal changes right in the impression of his report. You know, whether he went into detail describing them or not doesn't matter. The point is he's described a dorsal anomaly, a cervical anomaly, and his impression is congenital skeletal changes

are again seen. That means that kid needs to be further worked up. End of story. We can talk all we want about assumptions and previous reports. The point is the abnormalities are here, they're in black and white, and this kid needs to be further worked up. So what's the sense in trying to talk about what he assumed in terms of prior reports?

Q. Well, for example, let's assume that the pediatrician feels that he was not adequately informed about these findings because they were so incidentally included in the report. Okay? So it might be important to somebody.

A. If;he doesn't understand them, he should talk to the radiologist. This is not a normal finding. This is a general medical problem that may or may not be significant,

Q. So what you're telling me is that because he made -- Let me ask you this way. Let's assume that Dr. Hammel had in his hands on the 4th not only the films but the reports that had been dictated by Dr. Vijay. Okay?

A. Okay.

Q. And let's assume that he looked at the films and he looked at the reports and he realized that Dr. Vijay had not reported at all the cervical spinal

anomalies. All right?

A. Okay.

Q. Under that set of circumstances and had you been in Dr. Hammel's shoes, would you have personally made a more derailed description of the cervical spinal anomalies?

A. I might not have.

Q. But you might have?

A. I might have. I don't know at the time.

Q. Would you have personally made some reference to the fact that these were a new finding that had not been seen or reported in the previous films?

A. I don't know.

Q. Would you have somehow in some way flagged the cervical spinal anomalies more than Dr. Hammel did?

A. Not necessarily.

Q. Would the standard of care require that those cervical spinal anomalies be more carefully flagged than Dr. Hammel did, assuming he knew that they had not been previously reported at all?

A. No.

Q. If Dr. Hammel knew that they had not been previously reported in writing, would the standard of care have required him to pick up the telephone and call the pediatrician?

A. I don't think so.

MR. OCKERMAN: Let's take a short break.

(Discussion was had off the record.)

BY MR. MORIARTY:

Q. You already told us before it is your opinion that Dr. Hammel complied with the standard of care?

A. Yes.

Q. What's the basis for that opinion?

A. He read the chest x-ray appropriately, described the heart and lungs appropriately. The skeletal anomalies were stated in his report in the impression. And once there is a vertebral anomaly at one level, the whole spine needs to be looked at at some point in time.

Q. Do you know from your own experience as a physician whether or not the standard of case requires the physician who ordered the study to read the entire report?

A. I don't know.

Q. Do you have any sense from your own personal experience how often ordering physicians read the entire report as opposed to just reading the impression?

MR. OCKERMAN: Objection,

A. I don't know, except first of all you're ordering a

study for reasons, so it seems that you're asking questions and waiting for an answer. The same with an x-ray report. If the impression comes out normal -- clinicians want to know is it normal or abnormal. If it's normal, it's normal. I don't think they really care about reading the descriptive content of the report in terms of heart and lungs. When there's an abnormality mentioned, I think that means you go up and read the report, because there is an impression saying something is abnormal. So from being with clinicians, most clinicians read the reports unless they're normal. If the impression says normal, they may not read the entire report.

Q. And just so I specifically understand ycur opinion with respect to this exact report written by Dr. Hammel, impression number two says, "Congenital skeletal changes are again seen." Do you see that?

A. Yes.

Q. You don't believe that the standard of care required him tc flag the fact that this was the first written report of certain different skeletal anomalies?

A. No.

MR. MORIARTY: That's all I have.

Thank you.

MS. FRANKLIN: I have nothing.

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CROSS-EXAMINATION

BY MR. GRCEDEL;

Q. I just have one question for you. You mentioned that Dr. Hammel's diagnosis in your opinion would lead to an expectation on your part of a workup by either a pediatric neurologist, pediatric orthopaedist, or both.

A. Yes.

Q I take it as a radiologist you don't have an opinion as to the speed in which that workup would be necessary, because that would be something that would be based upon clinical signs and symptoms?

A. Correct.

Q So even though you would expect some sort of workup to be undertaken, you're not expressing an opinion as to how quickly that workup would need to be done. It would depend upon the clinical situation that the clinician was being faced with. Is that correct?

A. That's correct.

MR. GROEDEL: That's all I have.

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FURTHER CROSS-EXAMINATION

BY MR. GUTBROD:

Q. I want to get clear on something, and hopefully this will be it. Ycur testimony, I take it, Dr. Cawthon, is that no matter what Dr. Hammel assumed or didn't assume, his care was appropriate?

A. Correct.

Q. And I take it you understand that Dr. Hammel himself has testified, quote, "If I'd had the previous report, I would have dealt with the situation much differently than I did. I had the films, but I don't believe the report was in the jacket." Question, "So the reason you didn't describe the cervical spine abnormalities in greater detail is because you assumed that these films were accurately and appropriately read within the standard of care on April the 1st and April the 2nd?" Answer, "I expected that was the case, yes."

Do *you* recall reading that in the deposition of Dr. Hammel?

A. Yes.

Q. Just *so* I'm *clear,* even though Dr. Hammel himself testified that he was assuming that it had been reported accurately and that if it hadn't been reported accurately in more detail, he would have

acted much differently than he did, even though we have that testimony from Dr. Hammel, you still believe that Dr. Hammel, given what he wrote here, met the standard of care. Fair enough?

A. Yes.

Q. The only other thing I have is -- I'm not clear and I guess you've answered this question already. when is it that you, include something in the impression that's not included in the body of the report?

Let me put the question this way. What is the criteria you use for what gets included in the impression?

A. Any abnormality I include in the impression or reference tc an abnormality I include in the impression or I include pertinent negatives.

Q. Any abnormality, any reference to an abnormality, and any negative impressions?

A. pertinent negatives.

Q. And is it your impression in general that the ordering physician, when he receives a radiology report, if it's normal, there's no expectation on your part that he's going to read the body of the report?

MR. OCKERMAN: Objection.

A. I don't always know if he's going to read the body.

Q. I'm asking what is your expectation. I mean obviously you have some expectation in what you're dictating of what the physician is going to read, True enough?

A. True.

Q. So what is your expectation in terms of what part of your report the doctor is going to read?

A. I expect the doctor to read the whole report, To protect myself legally, I put pertinent things in the impression.

Q. Do you think the standard of care requires the ordering doctor to read the whole report?

MR. OCKERMAN: Objection. Go ahead.

A. I don't know. I expect they should read the whole report.

Q. Can you comment on what the standard of cave is for the ordering doctor in terms of the report 'chat he receives from the radiology department?

A. I don't know. I'm not a -- I don't know, I would expect the report would be read,

Q. In its entirety?

A. Right.

MR. GUTBROD: That's all I have.

MR. OCKERMAN: Doctor, you have the right to review this transcript if it is

ordered. And if it is ordered, I would say that you should review it, but I would ask that we have fourteen days for her to review it rather than seven. You can't change anything that you said, only if you feel that Linda took it down inaccurately.

THE WITNESS; Okay.

MR. OCKERMAN: Can we have that agreement, Jim?

MR. GUTBROD: Yes.

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(The deposition was concluded at 4:25 p.m.)

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(Plaintiff's Deposition Exhibit 11, Dr. Cawthon's report and C.V., was marked for identification.)

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S I G N A T U R E

I, LAURA A. CAWTHON, M.D., do hereby certify that I have read my deposition taken on October 7, 1996, in the case of Kayla L. Burkett, etc., et al., versus Cleveland Clinic, et al., consisting of ninety-two pages, and that said deposition is a true and correct transcription of my testimony.

Laura A. Cawthon, M.D.

Dated this _____ day of _____, 13____

Sworn to and subscribed before me this _____ day of _____, 19____

Notary Public

My commission expires _____

- - - - - - -

C E R T I F I C A T E

STATE OF OHIO,)
) SS:
SUMMIT COUNTY,)

I, Linda McAnallen, a Stenographic Reporter and Notary Public in and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within-named Witness, LAURA A, CAWTHON, M.D., was first duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony sc given by her was by me reduced to Stenotype in the presence of the witness, and that the foregoing is a true and correct transcription of the testimony so given by her as aforesaid.

I do further certify that this deposition was taken at the time and place in the foregoing caption specified.

I do further certify that I am not a relative, counsel or attorney of either party nor otherwise interested in the event of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cuyahoga Falls, *Ohio,* this 10th day of October, 1996.

Linda McAnallen, Notary Public
My commission expires July 24, 2000.