

4-436: Marla Spreadbury

Deposition Outline
Laura Cawthon, M.D. – radiologist
Monday, April 12, 1999

Exhibits: **Dr. Cawthon's vitae – page 7**
 Photo of CT scan image – page 53

<u>PAGE / LINE</u>	<u>DESCRIPTION</u>
5 / 23-25	Business address: Mercy Medical Center, 1320 Mercy Drive, Canton
7 / 14	Marking of deponent's CV – exhibit 1
7 / 11 – 8 / 14	Description of educational background
8 / 17	Board certified in Canton, Ohio
8 / 22	Employed by Radiology Services of Canton
9 / 3	Since 1993
9 / 8	Instructor of radiology residents at the hospital
10 / 4	Assistant Prof of Radiology at NEOUCOM since 1993
10 / 9-11	Lectures on OB ultrasounds, conducts filmreading sessions of plain films, US's, CT's
11 / 10-12	Teaches 2 nd year students who are part of a 6-year accelerated program
11 / 20	Medical school provides/recommends radiology text book
12 / 16-10	Curriculum is a set course done at all various hospitals to keep it standard
12 / 25	Teaching includes plain films, CTs & US's
13 / 6	Taught anatomy at Columbus Mercy School of Radiologic Technology
13 / 13	Gave presentation in April of 1997 Evaluation Of The Mediastinum On Chest Radiographs On Patients With Esophageal Cancer
14 / 4	Has not researched in the area of mediastinal disease
14 / 12	Has employment contract with Radiology Services
14 / 15	Has always had an annual contract
14 / 23	Doesn't if it contains a job description
15 / 16	As far as she knows, groups services to hospital are exclusive

15/ 10-11 Some people are semi-specialized, certain things all are able to read

15/ 22 Primarily read ultrasounds and plain films; secondarily reads CTs and MRIs

16/ 5 Spends more time reading US's in terms of volume; less people in group that do US's as in depth

16/ 15-25 On any given day, reads US's; would secondarily read plain films and CTs

17/ 6 No one person in group better able to read CTs

17/ 13 Group consists of 11 radiologists

17/ 19 Was on a stated salary in 1997 – not by how many films read

17/ 22 Daily schedules are kept

18/ 4 Schedules are discarded yearly

18/ 11 Most films are read on an emergent basis

18/ 21 Number of films read are kept in the records

18/ 24 Tracked by billing service

19/ 8-11 Number of films read are based on a monthly volume, then a yearly volume

20/ 2 In 1997, read 50 – 100 films on the average; sometimes only would read 2 films

20/ 14 No average amount of time spent on reading plain films to give approp diagnostic reading

20/ 20 Amount of films read per day depends on complexity of each film

21/ 6 CT reading in this case was electronically signed by Dr. Cawthon

21/ 25 – 22/ 5 Stat readings are hand written, faxed to doctor's office/nurses' station as to what's normal/abnormal, then dictates a formal report when time allows

22/ 14 Used to use the DECRAD system; now uses an electronic signature system

22/ 19 Meaning report is signed on the computer

23/ 14 What is dictated for electronic signature is what goes into the phone system report

23/ 23 Rereads her reports at a later time

24/ 6 (Electronically) signed WET report

241 19 WET Reports are sent to the ED in cases of emergencies

24/ 24 Then filed with the films

25 113-24 Has served as an expert in approx 5 or 6 cases medical negligence case within the last 5 years; mainly for physicians; did give an opinion for a plaintiff, but not used as an expert

26 13-12 Has given depositions as an expert on behalf of doctors; has worked for a number of law firms including Buckingham and 2 other groups but cannot recall who

261 19 Might have some records of such information

27111 Has never been sued before

28 / 3 Individually contacts insurance carrier when claims are made

28 / 8 Didn't male an incident report

28 113-25 Misreading of film was brought to her attention by Dr. Murphy on the morning of the 24th, but did not review it with him

2912 In re-reviewing of the films, they recognized a possible tear in the aorta

29 / 5 Re-read film for herself later that day

29 / 16 Re-read the films with Dr. Tawil (Tawil)

30 / 4 When re-reviewing the film on the 24th (the next day), saw a line that was suspicious for a tear

30 / 15 Doesn't recall discussing film with anyone else.

31 / 4 Does not agree that CT film was misread on 23rd as to the existence of a disruption in the aorta

3 1/19-3213 Defendant's affirmative three read into the record as to plaintiff assuming the risk

321 10 When asked if whether she offered Plaintiff patient alternative procedures, Dr. Cawthon responded that Mrs. Spreadbury was not conscious when seen she was seen

32 / 22 -25 When teaching at a medical school, she is introducing the students to radiology that involves some basic film reading

33 / 5 Doesn't usually discuss diagnostic errors with students

33 117 Doesn't agree that films can be misread, feels films can be interpreted differently

34 / 8 Agrees that some things are not as clear on films because of the patient's improper positioning

34 / 15 Improper positioning may result in poor diagnostic quality

35 14-8 As to why one person might see something on a film and another person doesn't depends on the quality of the film, position of the patient...

35 / 23 To determine what 'level of training a person needs to distinguish the disruption of an aorta depends on how a disruption of the aorta is defined

36 16 One should be board certified to be able to diagnose a transection of the descending thoracic aorta, to see the evidence on a CT

37 19 Some of the policies and procedures are promulgated by the radiology group

37 / 12 Some are by the hospital

37 / 16-21 There is no policy for reading; there is a procedure to allow for the performing of a traumatic CT promulgated by Dr. Rockenstein

38 / 23 Doesn't recall looking at Mrs. Spreadbury's chest x-ray that was done before the CT

39 13 Doesn't think there is a procedure to read plain film before interpreting CTs

39 18 Only recently looked at the chest x-rays

39 / 11-20 Plain films are usually read by the ED physician by the time the patient is sent for any CT scans

40 14 Only gets requisition for CT, no other information

40 19 Requisitions are not kept

40 16 Only knew Mrs. Spreadbury was hit by a semi-truck when she arrived in the department

40 123 Knew she had rib fractures because the doctor told her, plus there were chest tubes in place

41 / 3 Saw pneumothoraces on the film

41 / 14 Saw some of the rib fractures on the CT

41 / 25 Does read chest films in trauma cases

42 / 5 Findings on a film that are suggestive of a mediastinal hematoma are distorted aorta, massive protrusion, usually left-sided

42 / 12 - 15 Placement of an NG tube, deviation of to the right of T-4 may be an indication that there is blood in the mediastinum as well as depression of the left margin of the bronchus

42 122 Not told to include or exclude the existence of mediastinal hematoma

43 / 11 Only reviewed radiology reports

43 / 22 Reviewed the CT films of her head, chest, abdomen and pelvis and chest films

44! 10 To day a CT is not generally diagnostic for a tear would depend on the tear

44 / 13 CT is diagnostic for a complete tear

44 !21 May also be diagnostic of something that is less than a complete tear and disruption in the aorta

44/24 – 45/1 An indirect sign that there may be a disruption could be **an** abnormal contour of the aorta, false aneurysm, delayed contrast opacification of the lumen, extravasation of contrast, pleural effusion, large pleural effusionlarge pleural effusion, large hemothorax

45 / 8 The appearance of hematoma in the mediastinum probably suggests disruption of the mediastinal vein

45 113-15 . . . as well as the disruption of the aorta which is a more indirect sign

45 / 21 Has seen in past patients an aortic pseudoaneurysm

4615 Has seen about half a dozen Pas

46 / 10 – 15 Asked Dr. Murphy for assistance in interpreting Mrs. Spreadbury's films, but he did not sign

46 / 18-22 Asked for help when seeing evidence of mediastinal trauma

47 / 5 Reads more scans than Cawthon

47! 13 Asked for the second opinion because she saw mediastinal air that couldn't be explained by the rib fracture and subcutaneous air

47 122 Reviewed films Saturday before the depo

48! 13 Dr. Murphy is the same who told her on the 24th of the misread

48 116 Doesn't know if he now saw it; he just told her

49 / 2 Murphy told Cawthon that the trauma patient from day before did have disruption of her aorta or an aortic tear

49 / 10 Doesn't know how he knew

49 !23 When looking at a PA on a CT film, one sees an outpouching of the aorta, a distortion of the contour

50 / 2 Outpouching can occur anywhere in the aorta

5019 Outpouching, abnormal contour, delayed contrast opacification are signs of a PA

50 / 23 Believes photograph of a CT image is from this case (but it's not)

51 / 12 Interprets a line that looks like a disruption of the aorta

52 / 3 Can't point to the line, but can see it's suspicious

53 / 2 Exhibit 2 marked

53 / 5 Request made for shadow box

53 / 19 The chief of diagnostic radiology in 1997 was Robert Raven

54 / 14 No policy that the chief perform a second overread of trauma patients' films

54 / 112 No such requirement that an overread be done

54 / 120 Films groups are plain films mammograms, then the rest are overflow

55 / 2 No special names/titles in place

55 / 18 Read Marla's CT because that was her assignment for that week in addition to head scans and MRIs of the brain and spine

55 / 13 Because that's what was on the schedule

55 / 117-20 One person gets assigned to read body CTs & MRIs, one person is assigned to read head and spine MRIs and CTs

56 / 1 Dr. Murphy was assigned to read the body CTs that week

56 / 14-16 Looked at copies of the chest x-rays; originals have been missing

56 / 18 No record of them being checked out

58 / 12 Identifies multiple rib fractures on film taken at 11:30

58 / 15-19 Identifies bilateral pulmonary infiltrates peripheral in location and a widened mediastinum on the supine chest

58 / 21 Says it looks a little full but it's a supine chest

59 / 8 Saw fullness of the whole mediastinum

59 / 11 Defines a wide mediastinum as anything that looks fuller than it would on the normal PIA and lateral chest

59 / 17 As to measuring, if it doesn't measure and still looks full, says it looks full

- 6012 The rib fractures are abnormalities
- 6015-7 May have a pneumo as there are black areas on the film in the left costophrenic angle
- 60 / 12 Fuller than normal mediastinum – not necessarily an abnormality, but is a finding
- 60 / 19 Doesn't think trachea is deviated abnormally due to the position of the patient
- 60 / 24 Sees extensive subcutaneous air on left side
- 61 / 2 Relates it to the rib fractures

Review of 11:45 film

- 61110-12 When Mrs. Spreadbury was brought down for the CT, the films were not brought down nor did Cawthon ask to see them
- 61 / 17-20 It depends on the situation as to whether or not she asks to see films
- 61 / 25 Didn't feel the need to see the films in this case
- 6217-10 The film demonstrates a less rotated mediastinum not as wide; the aorta is not real distinct; there is still subcutaneous air, bilateral rib fractures, right rib fractures are better seen
- 62 / 20-25 Rib fractures indicate enough force to break bones; this kind of chest injury could mean contusion to any of the organs – lungs, pleural effusions, or trauma to the vessels or tracheobronchial tree; risk of pneumothorax
- 63 / 3 Said mediastinum appears a little less widened
- 63 / 8 Says it's not well defined on this study
- 63 / 13 Could mean there is a risk of a great vessel injury

Review of 12:30 film

- 63 / 20 Doesn't remember what time CT performed – remembers it was in the morning
- 63 / 24 CT times are recorded by when the tech took the image
- 64 / 5 Difference between 11:45 & 12:30 films is on 12:30 film, patient has bilateral chest tubes inserted
- 6417-10 She's again rotated so it's difficult to assess trachea position & mediastinum
- 64113 Mediastinum doesn't appear fuller

REVIEW OF CT SCAN

- 64 / 20 Identifies images 24 through 13
 65 / 5 These are some of the images Cawthon was concerned about
 65 / 10 Her report comments on images 16, 17, 18
 65 / 20 Showed Dr. Murphy the whole mediastinum
 65 / 21 Took from the highest level to the lowest level that include the mediastinum
 66 / 3 Was concerned about the pattern of mediastinal air on images
 67 / 1-3 Cawthon outlines area of air that appears to be tracking from the trachea, coming anterior
 67 / 12 Agrees that air is leaking to the sternal wall from the trachea
 67 / 18 Would recommend a bronchoscopy or esophagram
 67 123 Image 17 is the descending aorta
 68 12 Doesn't recognize the aortic pseudoaneurysm
 - 68 16 Doesn't based on that image
 68 / 9 In retrospect, doesn't look normal-
 68 / 14 – 18 Didn't see it when she read the x-ray; doesn't know why
 68 120 Sees the line
 68 / 24 States it's the descending aorta with a line
 69 12 Not sure which side
 69 / 5 Restates that it is the descending aorta with a line through it
 69 / 8 When asked if it represents a PIA, responds could represent a partial tear of the aorta
 69 / 13 Agrees that was not what was reported
 69 120 Doesn't agree as to a hemorrhage in the ascending aorta
 70 12 Appears to be normal to Cawthon
 - 70 / 11 On image 17, between the ascending & descending aorta, does not call the blurry area a hematoma
 70 / 13 Calls it a normal mediastinum

70 / 15 Sees possible hematoma around the esophagus

70 / 17 Or soft tissue fullness; thought it was abnormal

71 / 4 There is soft tissue fullness and the hematoma or esophageal leak

71 / 16 Doesn't agree that the area around the esophagus is similar in appearance to the area between the ascending and descending aorta

71 / 18-21 The esophagus' contour is convex when it should be concave; the contour between the ascending & descending aorta is based on normal contour

72 / 12 Disrupted blood flow could move structures; however, these aren't displaced

72 / 5 Can cause abnormalities in their shapes

72 / 12-21 Found most abnormalities to be in the chest; the mediastinal pattern bothered her, especially the air indicating significant trauma; asked tech to perform additional thin image of mediastinum

73 / 13 It's not indicated on her report that thinner images were taken

74 / 1 Something she added as part of her exam; did not communicate to the physician

74 / 14-9 Didn't see extravasation of contrast or any change in contrast enhancement that would indicate pseudoaneurysm; didn't see difference in contrast of opacification often seen with a P/A

74 / 13 Was looking for a contrast outside of the aorta rather than inside the aorta

74 / 19 One of the things seen with disruption of the aorta is extravasation of the contrast material

74 / 25 Doesn't know the likelihood of seeing extravasation of contrast material in a disrupted aorta

75 / 9 Films were done at 1350

75 / 13 Numbered 13 through 24

75 / 120 Numbering is based on where tech is told to scan; it's random numbering the tech puts on the film

75 / 24 Believes Dr. Murphy looked at these films also

76 / 14 Had him look at the mediastinal images

76 / 10 Was not reassured by images 1 – 24 that no great vessel injury existed

76 115-19 Felt the trachea area was bothersome in images 8, 9, 10, 11 12; Images 1, 2, 3, 4, 5 shows tracking from the distal trachea and carina area

7716 Image 12 delineates descending aorta

77/ 12-25 Doesn't see a mediastinal hematoma; only sees esophageal fullness, not between the ascending and descending aorta

78/ 6 In looking for a hematoma, one would see widening of the mediastinum, soft tissue fullness in the mediastinum and possible attenuation change in the mediastinum

78/ 10 Defines attenuation as difference in contrast

78 112 Between mediastinal fat and normal mediastinum

79/ 19 Like a shade of gray

79121 A hematoma would be a whiter shade of gray if it's acute

7916 To differentiate attenuation from fat depends on how well one sees shades of gray; depends how old or acute the hematoma is or the settings on the scanning machine

81/ 21 When viewing plain films, recommendations would depend on the clinical situation

82 12-11 When recommending an aortogram vs a CT scan would depend if the patient had significant chest trauma or if you had no idea of where the injury is at and if the patient is hemodynamically stable, would recommend a chest CT to screen out the injuries

82/ 12-16 If someone is not hemodynamically stable with significant chest trauma, the worst scenario is aortic disruption, they go to the angiography suite or operation room

83/ 2 Doesn't agree that if a CT doesn't rule out the existence of disruption in the aorta to send that patient for an aortogram

83 113-16 An aortogram only tells you about the aorta, won't tell you about the trachea or esophagus or pneumothoraces or soft tissue injury or fractures

8417 If Cawthon was suspicious of disruption of the aorta, she would have suggested an aortogram

84/ 14 A mediastinal hematoma in the area of the aorta is a possible finding for the recommendation

84 116-21 Mediastinal hematoma indicates a disruption of the mediastinal vessels ...most likely from trauma; one doesn't know how affected the mediastinal organs might be; if suspicious of an aortic tear, an aortogram would better delineate the aorta

8511 A P/A would definitely be cause to send someone for an aortogram

85/ 6 A mediastinal hematoma is not

Cross-exam by Ron Mingus for Drs Telesz & Packer

861 19 Cawthon and Dr. Telesz talked about the aorta and the line that was on the films

87 / 1 Never talked to Dr. Packer [about this case]

Cross-exam by Thomas Treadon for Dr. Tawil

87 115-19 CT scan is best for a hemodynamically stable patient to determine great vessel injury, and if suspicion of aortic injury arises, aortogram is next step

87 / 25 Did not have suspicion of an aortic disruption at the time of reading the films

88 / 10 Dr. Murphy said to Cawthon, "By the way, that trauma patient did have an aortic tear, they were taking her to OR, she was in OR.

88 / 22 Looked at the CT a second time after there had been a surgery

Re-direct by DTK

90 18-13 Saw Dr. Telesz late in the day (24th or 25th) to see the films

91 116 Only remembers Telesz & Murphy being there; Dr. Murphy read the films with her

91 / 21 CTs usually stay in the department unless someone requests them

91 / 24 Left work that day around 6pm or 7pm

9214 Wouldn't know if someone looked at films after she left the hospital

Laura A. Cawthon, M.D.

4
1428 Danbury Road N.E.
N. Canton, OH 44720

(330)499-3576

Columbia Mercy Medical Center
Department of Radiology
1320 Columbia Mercy Drive N.W.
Canton, OH 44708
(330)4891067

Current Position

Staff Radiologist, Columbia Mercy Medical Center
Undergraduate Program Director
Northeastern Ohio Universities College of Medicine
1992 - Present
Assistant Professor of Radiology
Northeastern Ohio Universities College of Medicine
1993 - Present
Instructor
Columbia Mercy School of Radiologic Technology
1992-1993
Instructor
Radiology Residency Core Lecture Series
1992 - Present

Certification and Licensure

Certified by the American Board of Radiology
November 1992
Diplomate, National Board of Medical Examiners, 1988
Licensed in Michigan, Massachusetts, and Ohio

Post Graduate Training

Residency in Diagnostic Radiology
Chief Resident 1991
Oakwood Hospital
Dearborn, MI
July 1987 to June 1991

Fellowship in CT/MRI/US
Tufts University New England Medical Center
Boston, Massachusetts
July 1991 to June 1992

Education

Wayne State University School of Medicine - Detroit, MI	M.D.	June 1987
University of Michigan School of Public Health - Ann Arbor, MI	M.P.H.	Aug. 1983
Wayne State Univ. College of Pharmacy and Allied Health - Detroit, MI	B.S.	June 1978

PLAINTIFF'S
EXHIBIT

4-12-99

Laura A. Cawthon, M. D.

Research and Publications

The Radiolucent Foreign Body, Cawthon, Meza, Eggleston, Journal of Pediatric Emergency Care, August 1991.

Why Not to "Pocket Shoot": Radiology of Intravenous Drug Abuse, McCarroll, Fisher, Cawthon, et al. Presented at the Radiological Society of North America, Nov. 1987

Evaluation of the Mediastinum on Chest Radiographs in Patients with Esophageal Cancer, McCarroll, Cawthon, et al, Presented at the Am Roentgen Ray Society meeting April 1987

Maximizing Cell Loading in Immobilized Cell Systems, Wang, Lee, Takach, Cawthon, Presented at the 3rd Ann. Symposium on Biotech. and Energy Prod. May 1992

Professional Memberships

American Medical Association

Ohio State Medical Society

Stark County Medical Society

American College of Radiology

American Roentgen Ray Society

Radiological Society of North America

American Association of Academic Radiologists

1 THE STATE of OHIO,
2 : SS:
3 COUNTY of STARK.

4 -----

5 IN THE COURT OF COMMON PLEAS

6 -----

7 MARLA J. SPREADBURY, et al., :
8 plaintiffs, :

9 vs. : case No. 1998CV1681
10 1998CV00589

11 MERCY MEDICAL CENTER, et al., :
12 defendants.

13 -----

14 Deposition of LAURA CAWTHON, M.D. a
15 defendant herein, called by the plaintiffs for the
16 purpose of cross-examination pursuant to the Ohio Rules
17 of Civil Procedure, taken before Constance Campbell, a
18 Notary Public within and for the State of Ohio, at the
19 offices of Buckingham, Doolittle & Burroughs, 4518
20 Fulton Drive, NW, Canton, Ohio, on MONDAY, APRIL 12TH,
21 1999, commencing at 9:10 a.m. pursuant to agreement of
22 counsel.
23
24
25

1 APPEARANCES:

2 ON BEHALF OF THE PLAINTIFFS:

3 Donna Taylor Kolis, Esq.
4 Donna Taylor Kolis Co., LPA
5 330 Standard Building
6 Cleveland, Ohio 44113
7 (216) 861-4300.

8 and

9 George Emershaw, Esq.
10 Melissa D. Berry, Esq.
11 Emershaw, Mushkat & Schneier
12 437 Quaker Square
13 Akron, Ohio 44308
14 (330) 376-5756.
15 -----

16 ON BEHALF OF THE DEFENDANT LAURA CAWTHON, M.D. and
17 RADIOLOGY SERVICES OF CANTON:

18 Michael Ockerman, Esq.
19 Buckingham, Doolittle & Burroughs
20 4518 Fulton Drive, NW
21 Canton, Ohio 44735
22 (330) 492-8717.
23 -----

24 ON BEHALF OF THE DEFENDANTS WALTER TELESZ, M.D. and
25 STARK COUNTY SURGEONS, INC. and ROBERT PACKER, M.D.:

Ronald Mingus, Esq.
Reminger & Reminger
The 113 Saint Clair Building
Cleveland, Ohio 44114
(216) 687-1311.

26 ON BEHALF OF THE DEFENDANTS ALEJANDRO SOS, M.D.
27 and ALEJANDRO SOS M.D., INC.:

28 Edward E. Taber, Esq.
29 Bonezzi, Switzer, Murphy & Polito
30 1400 Leader Building
31 Cleveland, Ohio 44114
32 (216) 875-2767.
33 -----

APPEARANCES:

ON BEHALF OF THE DEFENDANTS MARK TAWIL, M.D.
and THORACIC SURGICAL ASSOCIATES, INC.:

Thomas A. Treadon, Esq.

Roetzel & Andress

222 South Main Street

Akron, Ohio 44308

(330) 376-2700.

ON BEHALF OF THE DEFENDANT MERCY MEDICAL CENTER:

Alicia M. Wyler, Esq.

Day, Ketterer, Raley, Wright & Rybolt

800 William R. Day Building

Canton, Ohio 44701

(330) 455-0173.

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I N D E X

WITNESS: LAURA CAWTHON, M.D.

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PLAINTIFFS' EXHIBITS MARKED

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(FOR COMPLETE INDEX, SEE APPENDIX)

(IF ASCII DISK ORDERED, SEE BACK COVER)

1

LAURA CAWTHON, M.D.

2 of lawful age, a defendant herein, called by the
3 plaintiffs for the purpose of cross-examination pursuant
4 to the Ohio Rules of Civil Procedure, being first duly
5 sworn, as hereinafter certified, was examined and
6 testified as follows:

7

8

MISS KOLIS: Dr. cawthon, am ■

9

pronouncing it correctly?

10

THE WITNESS: cawthon.

11

MISS KOLIS: I'm probably going

12

to call you Doctor the rest of the time. Allow me to

13

introduce myself, my name is Donna Kolis, I'm one of the

14

attorneys who has been retained to represent Marla and

15

Mark spreadbury in an action, as you're well aware

16

you've been named as a defendant.

17

18

CROSS-EXAMINATION

19

BY MISS KOLIS:

20

Q. Before we begin the question portion of the

21

deposition, for the record would you state your name and

22

professional address?

23

A. My name is Laura, L-a-u-r-a, cawthon,

24

C-a-w-t-h-o-n. My address is at Mercy Medical Center,

25

1320 Mercy Drive, Canton.

1 Q. Fair enough. Before today have you ever had the
2 opportunity to give a deposition?

3 A. Yes.

4 Q. I'll remind you of some of the ground rules. Each
5 attorney probably states them differently. I assume you
6 are aware you are required to answer each question
7 verbally?

8 A. Yes.

9 Q. So that the court reporter doesn't end up
10 interpreting what you and ■ say. Do try to keep that in
11 mind.

12 Do you understand if ■ ask a question,
13 you submit an answer to it, I will presume you
14 understood the question?

15 A. yes.

16 Q. If at any time I ask a question that you do not
17 understand, indicate that you don't know what
18 information I'm seeking; can ■ extract that promise from
19 you?

20 A. Yes.

21 Q. I've been handed this morning what is apparently
22 your current CV. If you could examine the document and
23 confirm for me it is an accurate statement of your
24 educational and work history.

25 A. Yes.

1 MISS KOLIS: I'm going to have
2 the court reporter mark my copy as a Plaintiffs' 1.

3 -----

4 (Plaintiffs' Exhibit 1 marked for identification.)

5 -----

6 Q. obviously I've just been handed this document,
7 regrettably I didn't have a chance to digest your
8 education. For the record briefly tell me about your
9 education beginning with undergraduate school that led
10 you to become degreed as a physician.

11 A. I obtained a Bachelor's degree in science and
12 medical technology at Wayne State University. I worked
13 for about five years at which time I went to graduate
14 school full time, completed a Master's of public health
15 degree. I have to look at the year.

16 Q. Since 1983; is that accurate'?

17 A. Yes. Then I went to medical school at Wayne State
18 University, graduated four years later in 1987 with my
19 M.D. I did a residency at Oakwood Hospital for four
20 years, completed in 1991. Then did a one year
21 Fellowship in Boston at Tufts University which was
22 completed in 1992.

23 Q. Doctor, let me ask you a couple of questions just
24 about that training you received at the postgraduate
25 level.

1 You indicated of course clearly on your
2 CV you were a resident in diagnostic radiology, that was
3 a four year program?

4 A. Four year.

5 Q. Following that you did a Fellowship, it's got CT,
6 MRI and US for ultrasound I'm assuming?

7 A. Yes.

8 Q. That was yet another one year specialty training
9 specific to those kinds of examinations, right?

10 A. Yes.

11 Q. Prior to beginning, actually looks like after you
12 finished your Fellowship training up, then became
13 certified; is that right, in radiology?

14 A. Yes.

15 Q. what did you do after you obtained your Board
16 certification, where did you go to work?

17 A. Here in Canton, Ohio.

18 Q. who did you work for?

19 A. who I work for presently.

20 Q. That is?

21 A. Radiology Services of Canton.

22 Q. Radiology Services of Canton, their office is
23 located in the hospital itself?

24 A. Yes.

25 Q. Do they have an office anyplace else?

1 A. No.

2 Q. That is who you went to work for when you came
3 here in 1992, you continue through the present?

4 A. Yes.

5 Q. It seems that, or at least I'm reading this, you
6 are an instructor of radiology resident core lecture
7 series; where is that program taught?

8 A. At the hospital.

9 Q. At Mercy Medical Center?

10 A. Correct.

11 Q. what residents are you teaching?

12 A. Residents that are part of a residency program to
13 share with Aultman Hospital.

14 Q. Do your residents come from one medical school or
15 is it an AMA certified program you recruit from a number
16 of medical schools?

17 A. It's an AMA certified program.

18 Q. How many radiology residents do you have at
19 present?

20 A. I believe 14.

21 Q. Pretty lot of residents. Are you their supervisor
22 at this point?

23 A. Not the direct supervisor.

24 Q. You have always done lectures for the radiology
25 residents since you started here, correct?

1 A. Correct.

2 Q. It also indicates that you are an assistant
3 professor of radiology at NEOUCOM?

4 A. Correct,

5 Q. Since 1993?

6 A. Correct.

7 Q. what do you specifically teach or have you taught
8 beginning with 1993 through the present?

9 A. I gave lectures in OB ultrasound, I do some of the
10 film reading sessions on Friday afternoons, which
11 include plain films, chest, abdomen, ultrasound.

12 Q. CT?

13 A. Yes.

14 Q. This plain film reading, is that part of the
15 training that is given to the students at the medical
16 school before they go into say their postgraduate years?

17 A. Correct.

18 Q. How long have you taught that class?

19 A. Since I started at the hospital.

20 Q. In conjunction with teaching that course, have you
21 prepared any written materials that would instruct or
22 illustrate for your radiology -- I don't want to call
23 them students --

24 MR. OCKERMAN: Excuse me.

25 -----

1 (Interruption in proceedings.)

2 -----

3 Q. I'm sorry, I believe when we were interrupted you
4 had told me the sections that you teach.

5 -----

6 (Answer read.)

7 -----

8 Q. when you are teaching at the medical school, what
9 year student are you teaching radiology to?

10 A. ■ think they are second year. They have this
11 accelerated six year program, ■ think equivalent to the
12 second year student at a four year school.

13 Q. I'll accept that answer because I'm familiar with
14 what that program looks like.

1.5 They are not residents, they are
16 students who happen to be taking a radiology course?

17 A. Correct.

18 Q. Do you recommend a textbook for that course or is
19 there one that is prescribed for the course?

20 A. There is, **it** comes from the medical school. I'm
21 not sure what **it** is right now.

22 Q. would you be able to provide the name of the
23 textbook that was in use in 1997 at the medical school
24 for the radiology course?

2.5 A. ■ could.

1 Q. Thank you.

2 The next question that I had was do you
3 yourself in conjunction with teaching that course
4 provide the students with citations to medical
5 literature or use some form of writing to instruct them?

6 A. I usually don't personally. Most of that
7 information comes from the medical school because it's a
8 set course done at all the various hospitals, to keep it
9 standard they send the same material to all the
10 hospitals.

11 Q. Do you have a copy of the curriculum, not on your
12 person, do you have a copy of the curriculum?

13 A. Yes, I do.

14 Q. would you provide that to your attorney?

15 A. Yes.

16 Q. Can I assume when you are indicating these
17 sections that you teach, you do plain films, correct?

18 A. Yes.

19 Q. Do you do CAT scans?

20 A. Sometimes.

21 Q. MRIs?

22 A. I haven't personally. This course is shared by a
23 radiologist, I haven't shown MRs at this course.

24 Q. You confined your teaching to the plain films, CT?

25 A. And ultrasound. I don't confine, that is just the

1 way the schedule worked out.

2 Q. Fair enough.

3 On your CV it says you were an
4 instructor at the Columbus Mercy School of Radiologic
5 Technology?

6 A. I no longer do that. I used to teach an anatomy
7 course for the radiology technologists.

8 Q. Doctor, I also notice while you were out of the
9 room that you had given a presentation in April of 1997,
10 evaluation of the mediastinum on chest radiographs on
11 patients with esophageal cancer; I stated that
12 accurately I'm assuming, correct?

13 A. Yes.

14 Q. In conjunction with this presentation did you
15 prepare written materials to be submitted at the
16 conference?

17 A. Yes.

18 Q. Do you still have a copy of the material which you
19 submitted?

20 A. I might, I might not, I'm not sure.

21 Q. could I have your word in earnest you will search
22 your file for a copy of the material that you prepared
23 for that particular conference, if you do in fact locate
24 it, give a copy to your attorney?

25 A. Yes.

1 Q. Have you done any research in the area of
2 mediastinal disease that didn't end up being published,
3 you did preliminary studies on?

4 A. No.

5 Q. Are you currently in the process of any research
6 article or publication that doesn't appear on this CV?

7 A. No.

8 Q. I want to ask you a few questions about your
9 relationship with Radiology services of Canton.

10 First of all, do you have an employment
11 contract with Radiology Services?

12 A. Yes.

13 Q. Have you always had an annual employment contract
14 with that particular business?

15 A. Yes.

16 Q. ■ would ask that you provide your attorney with a
17 copy of the contract that was in effect in 1997; can you
18 do that?

19 A. I can try.

20 Q. Does the contract include a job description, what
21 you were personally responsible for?

22 MR. OCKERMAN: Do you know?

23 A. I don't know. It's pretty loose. ■ read films.

24 Q. I'm just asking if you know if they had a job
25 description in it?

1 You're indicating you've been a member
2 of the group since you came here in 1992. Did your
3 group, to your knowledge, at the time in 1997, have an
4 exclusive contract to provide services for Mercy Medical
5 Center, or did you read at other places?

6 A. As far as I know it's exclusive.

7 Q. As far as you know is that still true today?

8 A. As far as I know, yes.

9 Q. Is your group divided by specialties?

10 A. We have semi specialized, certain people that read
11 certain areas, certain things all of us read.

12 Q. Obviously you knew what I meant. You have
13 diagnostic radiologists, correct?

14 A. Yes.

15 Q. Do you have vascular radiologists?

16 A. We have an angiographer.

17 Q. I call that vascular radiologist, as long as we're
18 speaking the same language. Therapeutic radiologist?

19 A. No.

20 Q. You fall into what category of specialists in your
21 group?

22 A. I primarily read ultrasounds and plain films and
23 secondarily I do CT and MR.

24 Q. I try to listen and sometimes I'm in the middle of
25 writing, I don't get it.

1 You primarily do plain films,
2 ultrasound, when you say you secondarily do CAT scan,
3 explain to me in English what you mean when you say
4 that?

5 A. I spend more physical time in ultrasound because
6 of need, in terms of volume. There are less people in
7 the group that do ultrasound in the depth that I do.

8 Q. Your nomination — I'm sure there is a much better
9 word — your assignment to do ultrasound is based on A,
10 your technical skill?

11 A. Correct.

12 Q. And B, the sheer volume of the ultrasounds that
13 must be read for Mercy Medical Center?

14 A. Correct.

15 Q. understand I've never been in your radiology
16 department, so I don't know how assignments come in.

17 On any given day are you the person that
18 is up on the board if an ultrasound comes in, Dr. Laura
19 cawthon — I'm mispronouncing your last name — is going
20 to read them?

21 A. Correct.

22 Q. Secondarily you would be doing plain films?

23 A. Correct.

24 Q. But you have the ability to read CAT scans?

25 A. Correct.

1 Q. Who is the primary CAT scan reader for your group?

2 A. we have a number of readers.

3 Q. In 1997 was there one person who the group itself
4 deemed to be more expert in reading CAT scans than any
5 other?

6 A. No.

7 Q. who in your group was reading CAT scans in 1997?

8 A. As far as I know, Dr. Rockenstein, Dr. Murphy,
9 Dr. Degallon, Dr. McNalty, he's a newer member of the
10 group, I think he was in the group at that time,
11 Dr. Bong.

12 Q. How many people are in your group?

13 A. 11.

14 Q. Doctor, are you individually -- let's frame it
15 this way: In 1997 which is the time frame that is the
16 subject matter of this lawsuit of course, was your
17 salary determined by the number of films you read or
18 were you a stated salary person?

19 A. Stated salary.

20 Q. Do you keep in the radiology department schedules,
21 daily schedules?

22 A. Yes.

23 Q. would you be aware as to whether or not your
24 schedule for September 23, 1997 would still be located
25 in the department in paper form?

1 A. Probably not.

2 Q. why would you say that?

3

4

5

6

7

8

9

10

11

12 Q. would you happen to have an assessment of how many

13 films a day you were reading in 1997?

14 A. I don't know.

15 Q. was it -- I don't mean to be impertinent -- it's

16 more than one a day I'm assuming?

17 A. Likely.

18 Q. Does your practice or group practice not keep any

19 numbers on individual doctors as to how many films you

20 read on an annual basis?

21 A. They keep numbers.

22 Q. That is sort of in the form of a report that you

23 submit to perhaps another body, JCOH or someone?

24 A. Our billing service keeps track of how many cases.

25 Q. what I would ask you to do through your attorney,

1 is to deal with whatever paperwork you find to be
2 appropriate or informative that would allow me to
3 determine how many films you read on September 23, 1997.
4 A. I don't think we would have information on a daily
5 basis.
6 Q. on what basis do you believe that your group
7 provides that kind of information?
8 A. They have reports on numbers of films from the
9 billing services, the numbers are based on monthly
10 volumes and then yearly volume, based on what the
11 billing service bills for.
12 Q. so you don't specifically know whether or not your
13 billing service has the ability to go back in, put the
14 date and actually indicate to me by patient, and doctor
15 provider code, the number of films you did that day?
16 A. No, I don't know.
17 Q. I'll draft a request to your attorney, we will see
18 how it goes with your billings service; you aren't aware
19 of how they do that?
20 A. Excuse me?
21 Q. You wouldn't be aware of how they do that?
22 A. NO.
23 Q. Even though you stated you didn't have any idea,
24 do you have some idea of the volume of films you were
25 reading on a daily basis in 1997?

1 A. Based on how many reports I sign, somewhere
2 between 50 and 100, depending on plain films or
3 specialty films. If I'm doing a lot of biopsies I read
4 very little cases. Sometimes I may read only two cases
5 a day.

6 Q. The number of films in actuality you read in a day
7 would be driven by what kind of films you were required
8 to read?

9 A. correct.

10 Q. As to a plain film, is there an average to the
11 amount of time that you need to spend on a plain film to
12 give an appropriate diagnostic reading?

13 MR. OCKERMAN: Objection.

14 A. NO.

15 Q. How variable is that?

16 A. It depends how complicated the film is.

17 Q. when you say you're in the range of 50 to 100 a
18 day, it depends on A, what kind of film you have to read
19 and the complexity of those films?

20 A. correct.

21 Q. There isn't a curve you say five minutes for a
22 plain film, 10 minutes for a single sheet of CT; it
23 doesn't work that way, does it?

24 A. No.

25 Q. Let me ask you some questions about dictation in

1 your group, how it's communicated to the hospital.

2 I've had an opportunity obviously to
3 read your CT reading of Mrs. Spreadbury. At the bottom
4 it says Dr. Cawthon, electronic signature; is that
5 right?

6 A. Yes.

7 Q. Does that refresh your memory how it's signed?

8 A. um-hum.

9 MR. OCKERMAN: Say yes.

10 A. Yes.

11 Q. At that time in 1997, we can do it hypothetically,
12 a request would come to you to read a film, okay; are
13 you with me so far?

14 A. Yes.

15 Q. The examination, whether it was a plain film or CT
16 or an MR got performed, then you looked at the film,
17 tell me how you then communicated the film findings to
18 the physicians that requested the study?

19 MR. OCKERMAN: Hypothetical
20 situation?

21 Q. Yes, what was your standard routine, how did you
22 do this?

23 A. In any case?

24 Q. Yes.

25 A. A number of cases come through this stat readings,

1 in which case I hand write a written report that is just
2 a brief statement of what is normal, what is abnormal.
3 It's faxed to the doctor's office or called to the
4 nurse's station. when I have time I dictate a formal
5 report.

6 Q. You're handwritten report, in the trade -- you're
7 not a trade, a profession -- is that what you call your
8 wet read, the handwritten note you would fax?

9 A. Yes, otherwise there is a delay in the
10 transcription having a formal report generated.

11 Q. At the time of Mrs. Spreadbury's admission in
12 September of 1997 did Mercy Hospital make use of a
13 DECRAD system?

14 A. I believe so. we've changed over, I think we were
15 using DECRAD then. We were using an electronic
16 signature system.

17 Q. when you say using electronic signature system,
18 can you explain to me what you mean by that?

19 A. Instead of hand signing the report you sign it on
20 the computer.

21 Q. That's not what I meant when I said DECRAD. I'll
22 give you a generic explanation.

23 In September of 1997 did Mercy Hospital
24 have in place a telephone report system so that a
25 physician could dial in the patients's number, call

1 radiology, hear the report orally?

2 A. Yes.

3 Q. That is what I'm using as DECRAD, at UH that is
4 what they have.

5 A. Yes.

6 Q. To lay this out so I don't get lost, on any given
7 case that comes in, not Mrs. spreadbury, let's say you
8 were scheduled to read a plain film chest x-ray, it
9 wasn't stat, would you both put the report in the phone
10 system and dictate it for electronic signature?

11 A. It's all done at the same time.

12 Q. So what you dictate for your electronic signature
13 is precisely what goes into your phone system report?

14 A. Yes.

15 Q. The only difference is -- let me back up.

16 The actual transcription of your report
17 appears sometime after it's already logged into the
18 phone system?

19 A. Yes.

20 Q. under the electronic signature program, you don't
21 actually come back and reread the report after it's
22 transcribed, or do you?

23 A. I reread it.

24 Q. You simply don't have to affix your written
25 signature to it, is that what you are telling me?

1 A. You sign **it** on the computer, is that what you are
2 asking?

3 Q. You sign **it** on the computer?

4 A. You reread **it** and sign **it**.

5 Q. Did you write a wet report?

6 A. Yes.

7 MR. OCKERMAN: In this case?

8 Q. In this case?

9 A. Yes.

10 Q. That wet report is not part of the hospital chart,
11 correct?

12 MR. OCKERMAN: Do you know?

13 A. I don't know.

14 Q. If I represent to you I've never seen **it** in the
15 hospital chart, do you have a copy of the wet report
16 that you wrote?

17 A. No.

18 Q. where do you keep wet reports?

19 A. They are sent to the emergency room if it is an
20 emergency room case, they are sent to the emergency
21 room.

22 Q. You do not keep a copy in the radiology
23 department?

24 A. They are supposed to get the films and report back
25 to the emergency room and then when the films come back

1 to the file room they are supposed to be filed with the
2 films.

3 Q. You file the wet report actually in the film
4 jacket?

5 A. That is where they go, yes. I should add a number
6 of ER reports don't end up in the jacket, they go to the
7 emergency room, then we don't see them.

8 Q. They are replaced with the final read anyway,
9 correct?

10 A. Yes.

11 Q. Have you ever served as an expert in a medical
12 negligence case?

13 A. Yes.

14 Q. On how many occasions?

15 A. Five or six.

16 Q. During what time span were those five or six
17 reviews done?

18 A. In the last five years.

19 Q. Have they been for the physician or the patient?

20 A. Most for the physician.

21 Q. Do you actually recall serving as an expert for a
22 plaintiff?

23 A. I gave an opinion for a plaintiff once. I wasn't
24 used as an expert.

25 Q. Then the other four or five where you have worked

1 on behalf of the doctors, have you given a deposition in
2 any of those cases?

3 A. Yes.

4 Q. Have you worked for one law firm or a number of
5 law firms?

6 A. A number of law firms.

7 Q. Can you, sitting here today, tell me who you've
8 done work for?

9 A. I've done work for them.

10 Q. That would be a good guess. Anyone else?

11 A. I've done work for two groups up in Akron, I don't
12 know them offhand.

13 Q. Do you remember the name of the cases that you
14 testified in?

15 A. No.

16 Q. Do you keep reports of sufficient organized basis
17 that you can go back and redact the names of the cases
18 you've worked on?

19 A. I might. There is a lot of paperwork six months
20 ago, I might have some of them.

21 Q. Doctor, I would ask that you provide to your
22 attorney the case names, of the cases that you worked
23 on, if you still can reconstruct that.

24 Are you currently working as an expert
25 on any case?

1 A. No.

2 MR. OCKERMAN: case name she is
3 working on or case name she has given deposition?

4 MISS KOLIS: only ones she's
5 given deposition. I'm sure there are cases you looked
6 at the case for people, gave advice, not appeared in
7 court. I don't want to concern myself with those. Case
8 number, county and number would be appreciated.

9 Q. other than the lawsuit you are now involved with
10 myself, have you been sued previously?

11 A. No.

12 Q. ■ gather, Doctor, that as part of being a
13 physician and a professional you carry liability
14 insurance?

15 MR. OCKERMAN: objection.

16 A. Yes.

17 MISS KOLIS: You can have a
18 continuing objection. I'm not going to ask you any more
19 on that, I do have a written set of interrogatories your
20 attorney is going to answer for me.

21 Q. Is it part of your responsibility under your
22 insurance policy to notify your carrier of a potential
23 claim when you are aware of a potential claim?

24 A. Yes.

25 Q. In your group are you individually responsible for

1 reporting those losses or is there someone in your group
2 that contacts the carrier?

3 A. usually we contact them individually.

4 Q. Doctor, do you acknowledge that you actually made
5 an incident report to the insurance company before I
6 filed this lawsuit?

7 MR. OCKERMAN: objection.

8 A. I don't believe I did.

9 Q. At any time after you read Mrs. Spreadbury's CAT
10 scan, but before I initiated a lawsuit, did any
11 radiologist in your group bring to your attention that
12 the film was misread?

13 A. Yes.

14 Q. Can you tell me what doctor brought this to your
15 attention?

16 A. Dr. Murphy.

17 Q. Can you, Doctor, to the best of your ability, tell
18 me approximately when Dr. Murphy brought this to your
19 attention?

20 A. The next morning.

21 Q. The morning of the 24th?

22 A. Correct.

23 Q. Did you at that time review the CAT scan with
24 Dr. Murphy?

25 A. No.

1 Q. what do you recall Dr. Murphy telling you?

2 A. That re-reviewing the films they thought there was
3 a tear in the aorta.

4 Q. So that day you didn't look at the film?

5 A. I think later that day I did. The films were
6 missing at that time when I found out.

7 Q. Did you think they were with the cardiothoracic
8 surgeon?

9 A. I don't know where they were.

10 Q. Later that day you think you went down and looked?

11 A. I had the films that day or the next afternoon, I
12 reviewed them.

13 Q. Did you review them by yourself?

14 A. No.

15 Q. who reviewed them with you?

16 A. I believe I was with a physician, Dr. Tawil.

17 Q. Dr. Tawil?

18 A. Came and reviewed them.

19 Q. upon your second look at the films, did you see --

20 MR. OCKERMAN: Wait a second, when
21 you are saying second look, the next day?

22 Q. Yes, you didn't only look at it one time
23 originally?

24 A. I did not.

25 Q. The next day on the 24th, to the best of your

1 memory that day you looked at the films, did you then
2 see what on the film seemed to demonstrate there had
3 been an aortic disruption?

4 A. I saw a line that was suspicious for a tear.

5 Q. At that point -- this doesn't have a lot to do
6 with your reading -- at the point you read the film,
7 were you aware that Mrs. spreadbury had been taken, the
8 morning of the 24th, for repair of a dissected aorta?

9 A. I was aware she went to surgery.

10 Q. Were you aware what it was for?

11 A. No.

12 Q. Did you discuss that particular film any further
13 with any other physicians after the 24th, before I filed
14 a lawsuit?

15 A. Not that I remember.

16 Q. So no one else discussed it with you to the best
17 of your knowledge?

18 A. No.

19 Q. Doctor, do you concede at this point that your
20 reading of September 23, 1997 was in error as it relates
21 to a disruption in the aorta?

22 MR. OCKERMAN: objection. Go
23 ahead.

24 A. I don't understand your question, your word
25 concede.

1 Q. Do you agree you misread the CT on the 23rd as to
2 the existence of a disruption in the aorta?

3 MR. OCKERMAN: objection.

4 A. No.

5 Q. You don't agree with that?

6 A. No.

7 Q. okay, I need to know that.

8 Before we get into actual additional
9 medical questions, I received an answer to the complaint
10 which I filed against you which was obviously drafted by
11 your attorney, I want to ask you about one of the
12 affirmative defenses in the answer.

13 Have you ever reviewed the answer filed
14 on your behalf?

15 A. No.

16 Q. First I'm going to read the answer or the
17 allegation into the record, ask you a couple questions
18 about it.

19 In response to the lawsuit which I filed
20 against you there was an affirmative defense that was
21 pled that states as follows, three: The plaintiff was
22 advised of alternative available treatment for the
23 plaintiff's medical conditions, and the risk or
24 potential complications associated therein; thereafter
25 authority was received for the medical and surgical

1 procedure employed in treating the plaintiff and in so
2 doing assumed the risks explained to them as being
3 inherent in said surgical or medical procedure; do you
4 know what that means?

5 A. No.

6 Q. Just was checking.

7 Did you personally offer the patient,
8 Mrs. Spreadbury, some alternative medical procedure
9 other than the CAT scan that she declined?

10 A. she was not conscious when I saw her.

11 Q. That assertion doesn't apply to anything you
12 recommended to the patient I gather?

13 A. I can't understand that assertion based on a one
14 time reading of it.

15 Q. I was just curious, when I read it I thought I
16 would ask you about it.

17 Let's talk generally about some issues
18 in radiology. You related to me this morning based on
19 your CV you do some teaching at a medical school, you do
20 that by way of helping the students learn to read films;
21 is that correct?

22 A. Introducing them to radiology.

23 Q. Do they actual try to read films as part of that
24 course?

25 A. some basic film reading.

1 Q. I would assume as a person who is involved in the
2 process of educating students in general radiology, that
3 you probably teach them something about how diagnostic
4 errors in radiology occur; is that a fair statement?

5 A. I don't usually get into that.

6 Q. Let's see if you and I can agree, we're not going
7 to agree on a lot of things, we will see what we can
8 agree on, okay?

9 As a general principle you understand
10 that some films are misread, correct, that is an easy
11 way to say that films get misread?

12 MR. OCKERMAN: objection.

13 A. I don't know what you mean by misread.

14 Q. Sometimes information is contained on a film that
15 is not picked up by a radiologist, that is an easier way
16 to say it for you?

17 A. Films can be interpreted differently. You are
18 making black and white decisions based on shades of
19 gray.

20 Q. In radiology there is such a thing as a subtle
21 miss?

22 A. A subtle finding.

23 Q. some findings are obvious?

24 A. Some findings are more obvious than others.

25 Q. I use the phrase perceptual miss, do you know

1 what I'm referring to?

2 A. No.

3 Q. Fair enough.

4 Do you believe and/or agree with the
5 following statement: Sometimes things are not as clear
6 as they should be on the film because of improper
7 positioning of a patient?

8 A. That's true.

9 Q. That is one thing that will cause an error in
10 reading?

11 MR. OCKERMAN: objection.

12 A. It's one error in reading.

13 Q. If a person is not in a proper position, a film is
14 taken, you can't properly interpret the film?

15 A. It may not be of diagnostic quality.

16 Q. what are other reasons that misses occur that you
17 are aware of?

18 MR. OCKERMAN: Objection.

19 A. Reasons that -- ■ think you need to rephrase that.

20 Q. I guess we will try to delineate it a couple of
21 ways.

22 If something is obvious on a film, we're
23 doing this very generally, okay, if there is an obvious
24 lesion on a film, how could two radiologists looking at
25 it, one of them sees it, one of them doesn't; what are

1 the reasons that happens?

2 MR. OCKERMAN: Objection.

3 Q. If you know?

4 A. Sometimes it depends on the quality of the film.
5 A second film may be of higher diagnostic quality,
6 patient positioning, technique, may mimic a normal
7 structure, may mimic something external to the patient
8 that projects on the film.

9 Q. What about level of knowledge of the particular
10 kind of defect that a person is being asked to assess,
11 how does that come into play with whether or not they
12 may miss a finding?

13 MR. OCKERMAN: objection.

14 A. I'm not sure what you are asking.

15 Q. Let me ask you this as a global question: Any
16 person who received their Board in radiology from the
17 person who you took them from, should they be able to
18 see a disruption of an aorta on a CAT scan?

19 MR. OCKERMAN: objection.

20 A. That's too broad of a question to answer.

21 Q. What level of training would you presume a person
22 needs to be able to see that?

23 A. It depends on what you are saying is a disruption
24 of the aorta.

25 Q. In this case the eventual diagnosis of a

1 transection of the descending thoracic aorta, to see
2 evidence on a CAT scan for that diagnosis, what level of
3 experience, training would a person have to have?

4 A. To see a transection of the aorta?

5 Q. Yes, to be qualified to read the film you had.

6 A. They should probably be Board certified.

7 Q. You are saying a Board certified person should be
8 able to see a transection or disruption by looking at
9 the CAT scan film once they have their Boards?

10 A. No.

11 Q. How much additional training do they need to be
12 able to see that?

13 MR. OCKERMAN: . objection.

14 A. To see what?

15 Q. we will go back to that question when we look at
16 the films, that might make it easier.

17 In the department of radiology at Mercy
18 Hospital, do you have protocol and procedures for
19 reading of CAT scans?

20 A. Yes.

21 Q. Who promulgated the policies and procedures that
22 are in place in the radiology department?

23 A. All the policies and procedures? which policies
24 and procedures?

25 Q. You acknowledge you do have policies and

1 procedures?

2 A. Correct.

3 Q. By your answer, I gather that more than one group
4 has promulgated policies and procedures that are a part
5 of your manual in the radiology department?

6 A. Correct.

7 Q. Are some of them promulgated or put in the book by
8 your radiology group?

9 A. Yes.

10 Q. Are some promulgated and published by the
11 hospital?

12 A. I believe so.

13 Q. Do you have protocols and procedures -- were they
14 in existence as to the reading of a CAT scan to
15 determine whether or not there is mediastinal hematoma?

16 A. There is not policy for reading. There is a
17 procedure to allow for performing a traumatic CAT scan
18 or performing a CAT scan on a patient who has sustained
19 trauma.

20 Q. Who promulgated that?

21 A. I think Dr. Rockenstein.

22 Q. I ask that you provide your attorney with a copy
23 of that procedure, hopefully we will be able to
24 determine if that was the one, because do you know **if**
25 that has changed, the policy and procedure for treating

1 or reading in a trauma situation since September of
2 1997?

3 MR. TREADON: I'm going to object,
4 that is a different question than you asked before.

5 A. You asked about a reading and performance, you are
6 interchanging both words.

7 MR. TREADON: You got it, Doctor.

8 MISS KOLIS: Can you read the
9 question.

10 -----

11 (Question read.)

12 -----

13 Q. That I gather was for the performance of a CAT
14 scan?

15 A. Correct.

16 Q. Do you know whether or not there is the same one
17 that was in existence in September of 1997?

18 A. I believe it is.

19 Q. That is the one I would like to see a copy of.

20 when you interpreted Mrs. Spreadbury's
21 CAT scan study, did you look at the chest x-ray which
22 were performed before the CAT scan?

23 A. Not that I remember.

24 Q. Do you know whether or not there is a protocol in
25 the radiology department requiring a CAT scan reader to

1 look at the plain films before they interpret the CAT
2 scan?

3 A. Not that I know of.

4 Q. Did you end up looking at the plain films after
5 the CAT scan at any time?

6 A. Not until --

7 Q. Recently?

8 A. -- recently.

9 Q. In reading CAT scans on trauma patients, is it
10 just not your procedure to look at those plain films?

11 A. usually the plain films are read by a radiologist
12 in the department, part of the department, the plain
13 films are done first on a trauma patient. To insure
14 things are performed as quickly as possible, those are
15 generally read by the emergency room physician who wants
16 the film back at the emergency room with the reports.
17 So usually the trauma films are over in the emergency
18 room by the time we have the patient for CAT scan.
19 usually they have been read, the handwritten report with
20 films goes back to the emergency room.

21 Q. Do you have a copy of the handwritten report?

22 A. NO.

23 Q. what information do you have about the patient if
24 you don't have the handwritten report or the film?

25 A. I don't have any information except what the

1 emergency room tells me.

2 Q. when you say you don't have any information, other
3 than a requisition for the CAT scan?

4 A. Correct.

5 Q. where do you keep the requisition for CAT scans,
6 are those kept in the department?

7 A. Permanently?

8 Q. Um-hum.

9 A. No.

10 Q. In the case of Mrs. spreadbury, before you read
11 her CAT scan, what information did you have about her
12 trauma?

13 MR. OCKERMAN: That she recalls
14 now?

15 Q. That you recall now?

16 A. That she was hit by a semi truck.

17 Q. You were unaware or aware of what the findings
18 were on the plain chest films?

19 A. At the time she arrived at the department ■ was
20 unaware.

21 Q. By the time she left the department did you know
22 what the findings were on the plain films?

23 A. I know she had rib fractures, because the
24 physician told me, plus there were chest tubes in.

25 Q. what does that mean, the chest tube?

1 A. Pneumothoraces.

2 Q. Did you see pneumothoraces on the film?

3 A. Yes.

4 Q. when you say the information the physician told
5 you there was rib fractures, are you talking about one
6 of the radiologists or one of the attending doctors?

7 A. I don't know. It was a physician, a physician
8 with her, somebody telling me she has rib fractures,
9 pneumothoraces, she had bilateral chest tubes, there was
10 a whole trauma team that came with her to the CAT scan,
11 I don't remember every individual that was there.

12 Q. You saw the rib fractures on the CAT scan, didn't
13 you?

14 A. Some of them.

15 Q. Generally, let's talk about radiographic evidence
16 of aortic disruption. Let's talk about x-rays first.

17 I understand your testimony today you
18 did not look at the films, right?

19 A. which films?

20 MR. OCKERMAN: Plain films.

21 Q. Her chest films?

22 A. Correct.

23 Q. However, you do read chest films in cases of
24 'trauma?

25 A. Yes.

1 Q. what findings on a chest film do you believe
2 suggest the presence of mediastinal hematoma, if any?

3 MR. TABER: continuing objection
4 with respect to the fact she didn't review the films.

5 A. Distorted aorta, massive protrusion, usually
6 left-sided.

7 Q. Deviation of the trachea?

8 A. If it's severe.

9 Q. If an NG tube is in place, deviation to the right
10 of T-4, is that an indication there may be blood in the
11 mediastinum?

12 A. Can be.

13 Q. Depression of the left margin of the bronchus,
14 does that suggest that to you?

15 A. Can be.

16 Q. Those are things that would suggest.

17 when you began to perform the CAT scan
18 or when the requisition was received by you, do you
19 recall being told by one of the radiologists that they
20 recommended the chest CT to include or exclude the
21 existence of mediastinal hematoma?

22 A. NO.

23 Q. Prior to today have you ever looked at radiology
24 readings in cases other than your own?

25 A. Yes.

1 Q. would you agree with me that in fact, in terms of
2 chronology, if someone else in the x-ray department had
3 a suspicion there might be some mediastinal hematoma
4 they ask for a chest CT to be included?

5 MR. OCKERMAN: objection.

6 A. It says it on the reports.

7 Q. Did you review a 12:30 x-ray report?

8 A. I don't know.

9 Q. Did you review any other medical records in this
10 case?

11 A. Just radiology reports.

12 Q. You have not read the surgery report, any of her
13 postoperative notes?

14 A. No.

15 Q. Did you read the clinical notes from the emergency
16 room?

17 A. NO.

18 Q. So then I'm perfectly clear all you read in this
19 case are the radiology findings?

20 A. Correct.

21 Q. what films have you looked at?

22 A. The CT films that I originally read of her head,
23 chest, abdomen and pelvis and her chest films.

24 Q. The chest films prior to coming down for CT, not
25 the later ones?

1 A. I saw some of the later ones, I didn't really
2 review them.

3 Q. As a general statement I suppose, CAT scan itself
4 is not diagnostic for a tear in the aorta in any
5 location, generally speaking?

6 MR. MINGUS: objection.

7 MR. TABER: objection,

8 Q. would you agree or disagree?

9 MR. MINGUS: objection.

10 A. It depends on the tear.

11 Q. what tears do you think you can actually visualize
12 in the CAT scan of an aorta?

13 A. If there is a complete tear.

14 Q. You could generally see that?

15 A. Yes.

16 Q. Minus a complete tear, a CAT scan is capable of
17 providing you with information that is suggestive of the
18 fact that there may be something less than a complete
19 tear and disruption in the aorta; do you agree with
20 that?

21 A. Yes.

22 Q. what are the indirect signs there is a disruption
23 in the aorta on the CAT scan?

24 A. Abnormal contour.

25 Q. of?

1 A. The aorta, false aneurysm, delayed contrast
2 opacification of the lumen, extravasation of contrast,
3 pleural effusion, large pleural effusion.

4 MR. TREADON: what was that?

5 A. Large pleural effusion, large hemothorax.

6 Q. what about the appearance of hematoma in the
7 mediastinum itself, what does that suggest?

8 A. The appearance of hematoma in the mediastinum
9 probably suggests disruption of the mediastinal vein.

10 Q. Does the appearance of hematoma in and around the
11 area of the aortic arch suggest there is disruption to
12 the aorta?

13 A. There could be.

14 Q. That is a more indirect sign?

15 A. Indirect sign.

16 Q. Prior to reading Mrs. Spreadbury's CAT scan, do
17 you ever recall seeing a pseudoaneurysm, aortic
18 pseudoaneurysm on a CAT scan?

19 MR. OCKERMAN: on past patients?

20 Q. on past patients?

21 A. Yes.

22 Q. Those are since you came to the hospital, not
23 during your Fellowship?

24 A. Yes.

25 Q. Just asking to get a frame of reference.

1 How frequently have you seen aortic
2 pseudoaneurysm?

3 MR. OCKERMAN: Do you know?

4 Q. If you know.

5 A. I would say a half dozen to a dozen occasions.

6 Q. On the particular day that you are interpreting
7 Mrs. Spreadbury's CAT scan, did you ask anyone in the
8 radiology department for any aid or assistance in
9 interpreting what was on the film?

10 A. Yes.

11 Q. who did you talk to?

12 A. Dr. Murphy.

13 Q. Dr. Murphy didn't sign off on the electronic
14 report; is that correct?

15 A. correct.

16 Q. At what point in the examination did you ask
17 Dr. Murphy for aid and assistance?

18 A. she had evidence of mediastinal trauma,
19 particularly the mediastinal area which concerned me. I
20 did the image of the mediastinum, I asked him to look at
21 the image to re-evaluate it, to see what he thought of
22 the mediastinum and the vessels.

23 Q. Let me slow down and go backwards I guess.

24 Explain to me what Dr. Murphy's
25 relationship is to you.

1 A. He's one of my partners.

2 Q. Does he have more experience in reading CAT scans
3 than you do, less experience, or just happened to be
4 around for you to ask?

5 A. By volume currently he probably reads more CAT
6 scans than I do.

7 Q. Then the sequence of events is that the films are
8 taken, you are reading them, you see something you're
9 not sure what it means?

10 A. No, I wanted a second opinion.

11 Q. Specifically tell me what you saw that you wanted
12 a second opinion on?

13 A. I saw that she had mediastinal air, that I
14 couldn't explain solely by her rib fractures and her
15 subcutaneous air. The pattern bothered me because the
16 air looked at first to be tracking from the trachea.

17 with that amount of trauma I was also
18 concerned there could be a trauma to the great vessels,
19 so I asked him to specifically look at the chest images
20 to see if he saw anything else that bothered him.

21 Q. How recently have you reviewed the films?

22 A. I looked at them Saturday.

23 Q. So that when we get to that point it might make it
24 a little faster.

25 Do you remember what frame we're

1 discussing? I call them frames, you might call them
2 impression numbers?

3 A. NO.

4 Q. Is it impressions 16 through 18 you listed in your
5 report?

6 A. I don't know right now.

7 Q. I guess we will have to find them then.

8 Is Dr. Murphy the same person -- I'm
9 asking questions, not taking great notes -- the same
10 person that came to you on the 24th, told you there was
11 a misread?

12 MR. OCKERMAN: objection.

13 A. Yes.

14 Q. On the 24th could Dr. Murphy now see the evidence
15 for the disruption to the aorta on the CAT scan?

16 A. I don't know, I suppose he did.

17 MR. OCKERMAN: Don't guess.

18 A. He told me, I don't know.

19 Q. Obviously you can't read what is in his mind,
20 let's explore a little better the conversation you had
21 with Dr. Murphy.

22 Did Dr. Murphy come to you, say I've
23 looked at the films again, there is a mistake?

24 MR. OCKERMAN: objection.

25 A. NO.

1 Q. what did he come to you and say?

2 A. From what I remember he said the trauma patient
3 from yesterday did have disruption of her aorta or an
4 aortic tear.

5 Q. Did he say that was his opinion based on the
6 films?

7 A. No.

8 Q. where did he tell you he got that information
9 from?

10 A. He didn't tell me where he got it from.

11 Q. Is Dr. Murphy still your partner?

12 A. Yes.

13 Q. Have you never subsequently discussed the sequence
14 of events that led to him discussing that with you?

15 A. NO.

16 Q. Did you discuss it with him after I sued you?

17 A. No.

18 Q. Tell me, Doctor, in a descriptive term,
19 radiologists are used to describing so I'm hoping you
20 can do this, what does a pseudoaneurysm look like on a
21 CAT scan film?

22 A. You generally will see an outpouching of the
23 aorta, a distortion of the contour.

24 Q. when you say the outpouching, is it generally
25 located in the area of the isthmus, that arching, one

1 side or the other; how does that pouching occur?

2 A. It depends where the tear is. It can occur
3 anywhere in the aorta.

4 Q. what else tells you what you are looking for, or
5 is that basically it?

6 A. For?

7 MR. OCKERMAN: Pseudoaneurysm.

8 Q. To see pseudoaneurysm?

9 A. outpouching, abnormal contour, delayed contrast
10 opacification.

11 Q. Are those separate things that might be indicative
12 or that's the constellation you have to see altogether?

13 A. They are separate things. It's better if you see
14 them together.

15 Q. Sometimes you don't always see them together,
16 right?

17 A. Correct.

18 Q. I'm going to hand you a photograph, we will make a
19 copy so everyone can have it. It is a photograph of a
20 CAT scan image. can you tell me what you see in this
21 photograph on this CAT scan image?

22 MR. OCKERMAN: objection.

23 A. I believe this is from the case.

24 Q. I will represent to you that truthfully it is not.

25 A. There is a line through the descending part of the

1 aorta, partial line which could represent a partial
2 tear.

3 MR. OCKERMAN: what else do you
4 see?

5 A. No extravasation of the contrast, no widening of
6 the mediastinum, NG tube in the esophagus. There is
7 also a left effusion.

8 Q. Are you indicating that you can see in that an
9 aortic pseudoaneurysm?

10 A. ■ see a line. I see a line through the --
11 actually you need to see the image above and below this
12 point. There is a line that looks like disruption of
13 the aorta.

14 MR. TABER: I'll state an
15 objection.

16 MR. OCKERMAN: I'm going to object
17 to this. This is something else that she has never seen
18 before, she doesn't have any other image other than this
19 one.

20 Q. Is it impossible for you without having seen other
21 images? You already testified what you thought you saw,
22 can you demonstrate for me with a simple arrow where you
23 think you see a disruption?

24 A. I see a line that is suspicious for a partial
25 tear.

1 Q. Can you tell me without seeing other films where
2 the line is?

3 A. I can see it's suspicious. I can't point to a
4 line.

5 Q. That's what I'm asking you, you can't tell me, you
6 would have to circle or show me the area you believe is
7 disrupted?

8 MR. OCKERMAN: I'm going to object.
9 I'm not going to let her do that. You take it up with
10 the judge.

11 MISS KOLIS: That's fine. We
12 will state on the record, not to disrupt today's
13 deposition, ■ asked the doctor to indicate an area of
14 suspicion for disruption on the photograph, her attorney
15 asked her not to perform the same.

16 MR. TABER: would you mind
17 telling us where that came from?

18 MISS KOLIS: ■ can provide that,
19 the case if they think it's necessary. I'll represent
20 it's not a photograph from this case. The photographs
21 from this case do not look precisely like this.

22 MR. OCKERMAN: That is why ■
23 objected.

24 MISS KOLIS: why don't you mark
25 this. You hold onto this.

1

2

(Plaintiffs' Exhibit 2 marked for identification.)

3

4

MISS KOLIS: what I would like to

5

do is get your attorney to get the shadow box so we can

6

look at the actual films. Mr. Emershaw and I are going

7

to take a short break.

8

9

(Recess had.)

10

11

BY MISS KOLIS:

12

Q. Doctor, before we look at films I had a couple

13

other clarifying questions I want to ask you.

14

Back in September of 1997 you've

15

indicated that different people in your group did

16

different things, or provided different specialty

17

services. was there a person who was considered to be

18

the chief of the diagnostic radiologists?

19

A. The chief of diagnostic radiology I believe is

20

Robert Raven.

21

Q. was he at that time?

22

A. I believe so.

23

Q. Did you, within your group or anywhere within the

24

policies and procedures manual, have a requirement that

25

the chief himself review trauma patient's CAT scans in

1 addition to the radiologist looking at them?

2 MR. OCKERMAN: A second overread?

3 Q. Yes, a second overread?

4 A. No.

5 Q. Did you have any sort of requirement that there
6 was an overread on a traumatic CAT scan?

7 A. Do we have?

8 Q. what I'm saying is you read the CAT scan, was
9 there in place in September of 1997 a protocol that
10 required that CT to be at least looked at by another
11 person in the group?

12 A. No.

13 Q. That was solely your decision to involve another
14 person to look at it; is that right?

15 A. Right.

16 Q. Is a CT considered by your group a special film?
17 I don't mean special, let me ask a better question.

18 when you broke it down into divisions,
19 the diagnostic radiologists read what kind of films?

20 A. Plain films, mammograms, then they take care of
21 overflow from other areas.

22 Q. what do you call within your group the group that
23 reads CAT scans?

24 A. what do we call?

25 Q. what kind of radiologists do you call it when you

divide out responsibilities?

A. we don't have a special name for them.

Q. On this particular day, as best you can recall it now, you've already indicated that you primarily read ultrasounds, how was it you came to read her CAT scan?

6 MR. OCKERMAN: objection. Go
7 ahead.

8 A. My assignment for that week was to read the head
9 CAT scans and MRI's of the brain and spine.

10 Q. why was that your assignment for that week?

11 A. Because it was.

12 Q. Because that is what they told you to do?

13 A. That is what was on the schedule.

14 Q. ■ there a reason they would have assigned you
15 head CAT scans and MRI versus CAT scans of the head,
16 chest, pelvis, separated out that way?

17 A. The way the department is divided, because of
18 space, we have one person that is assigned to read the
19 body CT and MR ■ cases, one person assigned to read the
20 head and spine MRI and CT cases.

21 Q. why is it divided that way?

22 A. Because of volume and space. It's the way we have
23 the films on alternators.

24 Q. who was assigned to read the body CT that week if
25 you know?

1 A. Dr. Murphy.

2 Q. Is that why you asked Dr. Murphy to have a look at
3 this finding?

4 A. Correct.

5 Q. What we would like to do, this is probably going
6 to be difficult given the size of the shadow box, room
7 and location, we're going to put this up and look at the
8 films and show us where you found a problem. we will be
9 like residents in a viewing room, we will all have to
10 hang on that side.

11 Doctor, what I would first like to have
12 you do is look at -- you've indicated that you have been
13 able to look at the chest x-ray?

14 A. I looked at a copy of the chest x-ray, the
15 original films have been missing from the jacket, I
16 haven't spent hours looking for those.

17 Q. I have the folder that shows they are checked out.

18 A. There is no record of them being checked out.

19 Q. When I answered your questions, I went back, they
20 were inside my envelope. It does say these obviously
21 are the originals. I'm going to represent to you ■
22 think the copies are pretty good.

23 A. They aren't good.

24 Q. This is the first x-ray, if you can see it's
25 identified Mercy Medical center at 11:30; you agree with

1 that?

2 A. Yes.

3 Q. If you want to mark on it, you can. If you don't
4 want to mark on it, ■ don't know what we will do about
5 that.

6 MR. OCKERMAN: Wait a second. ■
7 would strongly, ■ think Alicia would agree with me, not
8 want her to mark on these originals.

9 MISS WYLER: ■ agree. ■ object
10 on behalf of the hospital. so we'll take that up with
11 the court since there are copies available. She can
12 view the originals and mark a copy.

13 MISS KOLIS: we can work that out
14 I'm sure.

15 MR. TABER: ■ would like to
16 object to her reviewing films she didn't review
17 contemporaneous on the 23rd. ■ think we establish that
18 already, ■ don't need to keep interrupting.

19 MISS KOLIS: Mr. Taber, that is
20 okay.

21 MR. MINGUS: I'll join the
22 objection.

23 Q. You've seen a copy of the chest x-ray film; is
24 that right?

25 A. Yes.

1 Q. This is obviously the original since it has the
2 hospital sticker on it. This is better quality than the
3 copy you were provided with?

4 A. Yes.

5 Q. Are you able to see things in this film that you
6 couldn't see in the copy?

7 A. I don't remember.

8 Q. Doctor, why don't you tell me what you see in that
9 x-ray.

10 MR. OCKERMAN: Objection. Go
11 ahead, Doctor.

12 A. I see multiple rib fractures, it looks from here
13 like the 1st, 2nd, 3rd, 4th, 5th, 6th, maybe 7th ribs.

14 Q. On the right-hand side of the patient's body?

15 A. On the left-hand side. Bilateral pulmonary
16 infiltrates peripheral in location. The heart looks
17 normal in size, I don't see significant pleural fluid in
18 the supine chest. Her mediastinum does look whited on
19 the supine chest.

20 MR. TABER: Does or doesn't?

21 A. Does, looks a little full, but it's a supine
22 chest, they often look full on supine chest.

23 Q. This particular chest film taken, was that
24 sufficient for diagnostic information purposes, you
25 don't have a problem with the quality of that film?

1 A. Just the part of the right chest is missing from
2 the film.

3 Q. Right chest is missing, left is there. You
4 indicated for the record that you do see, I wasn't
5 paying attention because I was holding this film and
6 looking at it, you see a widening of the superior
7 mediastinum; that's what you said?

8 A. ■ said fullness, the whole mediastinum.

9 Q. Can I have your definition of a widened
10 mediastinum?

11 A. A wide mediastinum is anything that looks fuller
12 than it would on the normal P/A and lateral chest.

13 Q. Do you have, I guess I have seen it written a
14 couple of ways, do you go with if it is fuller or wider
15 than .025 of the entire diameter of the chest or greater
16 than 8 centimeters or either?

17 A. I usually more look. If it doesn't measure, still
18 looks full, I'm going to say it looks full.

19 Q. Do you see anything else that does not appear
20 normal on that particular chest film?

21 MR. TABER: Objection to the
22 extent she didn't say it was abnormal before.

23 MR. OCKERMAN: objection, I agree.
24 Go ahead.

25 Q. well, I take it rib fractures of the left 1

1 through 6 are abnormalities; would you agree with that?

2 A. Those are abnormalities.

3 Q. The pneumo, I think you said she has pneumos,
4 right?

5 A. ■ can't see pneumo very well on this film. she
6 may have one because there are black areas in the left
7 costophrenic angle.

8 Q. That would be an abnormality?

9 A. Right.

10 Q. The fuller mediastinum, that would be an
11 abnormality?

12 A. Correct. Not necessarily an abnormality, it's a
13 finding.

14 Q. It's a finding. This isn't exactly a normal chest
15 film, is it?

16 A. No.

17 Q. Do you see the deviation or a deviation of the
18 trachea on that film?

19 A. It's deviated a little but the patient is rotated,
20 I don't think it's abnormally deviated considering the
21 position.

22 Q. Do you see any other findings on there that would
23 suggest traumatic injury?

24 A. she has extensive subcutaneous air on the left
25 side.

1 Q. what do you think that would represent?

2 A. Probably related to her rib fractures.

3 Q. I'm going to put up the film that was done at
4 11:45. Doctor, as I'm putting this up, you indicated
5 that Mrs. spreadbury came down to have that CAT scan
6 with a trauma team; is that correct?

7 A. Correct.

8 Q. They didn't bring down her x-rays when they came
9 down with her?

10 A. Not that I know of.

11 Q. Did you ask to see them?

12 A. No.

13 Q. Do you generally not look at the plain films
14 before you do a chest CAT scan?

15 MR. TREADON: I'm going to object,
16 you've been through all this before.

17 A. It depends if I need them.

18 Q. Do you determine your need for the plain film
19 before or after the examination?

20 A. It depends on the situation.

21 Q. In this instance, did you think that you needed to
22 see the plain film at any time during your evaluation
23 either after the film was done or after you interpreted
24 it?

25 A. No.

1 Q. This is the film that was produced at apparently
2 11:45. what changes do you see from the one you just
3 looked at?

4 MR. TABER: Same objection.

5 MR. MINGUS: objection.

6 MR. OCKERMAN: objection.

7 A. A less rotated mediastinum, doesn't look as wide
8 on this study. The aorta is not real distinct on this
9 study, there is still subcutaneous air, bilateral rib
10 fractures, right rib fractures are better seen.

11 Q. Now you can see the right-hand side a little
12 better on the one that you have; that's an accurate
13 statement?

14 A. You can now see it.

15 Q. what is the significance of the fractures in terms
16 of determining what underlying chest injuries the person
17 may have sustained, if any?

18 MR. OCKERMAN: Objection. Go
19 ahead.

20 A. If she has rib fractures she had enough force to
21 break her bones. That means there is injury to the
22 chest, which could be contusion of any of the organs,
23 contusion of the lungs, pleural effusions, contusions or
24 trauma to the vessels or any of the tracheobronchial
25 tree. There is the risk of pneumothorax.

1 Q. Did I hear you correctly, on this particular film
2 the mediastinum appears a little less widened?

3 A. Correct.

4 Q. would you say diagnostically that would be a key
5 finding, a widened mediastinum?

6 A. ■ wouldn't call it widened in this case.

7 Q. what would you call it, full?

8 A. Well, not well defined.

9 Q. If the mediastinum is not well defined, does that
10 indicate perhaps that there is a risk that there has
11 been great vessel injury?

12 MR. OCKERMAN: objection.

13 A. It could.

14 Q. Then another film is done at about 12:30.

15 MR. TREADON: what is the time on
16 this one?

17 MISS KOLIS: 11:45.

18 Q. This one is 12:30. what time did you start to
19 perform the CAT scan; if you remember?

20 A. I don't remember, it was in the morning.

21 Q. How are the times for these films recorded?

22 MR. OCKERMAN: which films?

23 Q. CT's?

24 A. The CT films it's the time that the technologist
25 took the image.

1 Q. You'll be able to show me where the times are on
2 these, I cannot make that out. That is the 12:30 plain
3 film portable chest x-ray. what is now different about
4 this film versus the one you just looked at?

5 A. she has bilateral chest tubes inserted.

6 MR. TABER: Same objection.

7 A. The rib fractures are still present, subcutaneous
8 air is present, the heart looks normal in size,
9 bilateral infiltrates. she is again rotated so it's
10 difficult to assess trachea position and mediastinum.

11 Q. In that one does the mediastinum appear fuller
12 than it did at the 11:45 film?

13 A. I don't think so.

14 Q. You don't think-so, okay. Those are I believe the
15 three chest films that were done before the CAT scan.
16 You might have to get a little closer for this. This is
17 a sheet from the CAT scan, obviously not the complete
18 CAT scan, correct? Can you identify what images are
19 shown on this particular sheet?

20 A. Images 24, 23, 22, 21, 20, 19, 18, 17, 16, 15, 14,
21 and 13.

22 Q. Is this the group of images that are contained
23 within the group of images that gave rise to a concern
24 on your part?

25 MR. OCKERMAN: objection.

1 A. Concern about what?

2 Q. You just testified that you asked Dr. Murphy to
3 step in, take a second look based on what you thought
4 was some mediastinal air is what ■ think you said?

5 A. These are some of the images ■ was concerned
6 about.

7 Q. Your report, ■'■■hand you this copy right here,
8 that is my highlighted copy, you end up commenting on
9 image 16 through 18; is that an accurate statement?

10 A. Yes.

11 Q. ■ do have the right sheet, correct?

12 A. I believe so.

13 Q. There is 18, 17, 16?

14 A. Yes.

15 Q. we're in the same place, right? I'm going to ask
16 you a couple of questions.

17 Do you believe as you sit here today
18 that it is those films, images 16, 17, 18 are the ones
19 that you showed Dr. Murphy?

20 A. I showed him the whole mediastinum.

21 Q. You took from the highest level to the lowest
22 level that would include the mediastinum, you went
23 through each and every image?

24 A. As far as I remember.

25 Q. I'm asking you specifically, if you can recognize

1 that it's one of these three images where you had some
2 concern about the mediastinal air?

3 A. I was concerned about the pattern of mediastinal
4 air in these images.

5 MR. OCKERMAN: Excuse me one
6 minute.

7 -----

8 (Recess had.)

9 -----

10 BY MISS KOLIS:

11 Q. Doctor, the last question that I asked you I think
12 you fairly answered that you were concerned about the
13 pattern of mediastinal air that you saw; is that an
14 accurate statement?

15 A. Yes.

16 Q. Ultimately on your CT report the area of concern
17 which you made recommendations for were images 16
18 through 18; am I also stating that accurately?

19 A. Yes.

20 Q. So just for the last time -- first of all, not for
21 the last time, in any of those three images, 16, 17 or
22 18, can you indicate for me -- this is a grease
23 pencil, if anybody is going to cry about it, this is
24 what she looked at before -- point out to me what areas
25 of mediastinal air you were concerned about?

1 A. I'm concerned about this air right here which
2 appears to be tracking from the trachea, coming
3 anterior.

4 Q. For you and me we're not going to mark these up
5 right here, for this little black arch, this is the
6 trachea coming down from here?

7 A. Right.

8 Q. what you are concerned about is you see air
9 leaking, would it appear to be leaking, that's the best
10 way to say it if I was a radiologist, to the sternal
11 wall from the trachea?

12 A. Correct.

13 Q. obviously doesn't belong there?

14 A. Correct.

15 Q. Based upon this interpretation, we both agree that
16 is the trachea and air toward the sternum, you recommend
17 the bronchoscopy or esophagarn, right?

18 A. Right.

19 Q. Doctor, I would like for you to tell me what this
20 structure right here is on image 17?

21 A. what structure?

22 Q. Right here, tell me what I'm pointing to?

23 A. That is the descending aorta.

24 Q. Can you recognize that?

25 A. As a descending aorta?

1 Q. No, as an aortic pseudoaneurysm?

2 A. NO.

3 Q. why would you say that area of luminescence with
4 that line through it here is not a traumatic
5 pseudoaneurysm?

6 A. I don't know that it is based on this image.

7 Q. Does this look normal to you for the descending
8 aorta?

9 A. In retrospect, no.

10 Q. At the time you looked at it were you not
11 concerned about this luminescence that appears with the
12 line through the middle in the area where the descending
13 aorta goes in?

14 A. I probably didn't see it at the time I read the
15 x-ray.

16 Q. Why didn't you see it at the time you read the
17 x-ray?

18 A. I don't know.

19 Q. would you agree with me that is what that is?

20 A. That's a line.

21 Q. on either side of it or one of these two sides is
22 the pouch we talked about earlier that represents the
23 aortic pseudoaneurysm?

24 A. That is the descending aorta with a line.

25 Q. which side are you indicating there is a line

1 there?

2 A. I'm not sure which side.

3 Q. It is not a normal appearing descending aorta; you
4 agree with that?

5 A. There is a line through the descending aorta.

6 Q. which in all probability could represent a
7 pseudoaneurysm?

8 A. It could represent a partial tear.

9 Q. A partial tear of the aorta, correct?

10 A. Correct.

11 Q. That you and I can agree was not reported in your
12 CAT scan evaluation?

13 A. Correct.

14 Q. Just above this area that we just described, up
15 here, this is the ascending aorta; do I have this
16 correct?

17 A. That is the ascending aorta.

18 Q. Right in this area here, between those two
19 structures, would you agree with me that is hemorrhage?

20 A. NO.

21 Q. what do you believe that represents?

22 A. I can't tell that is hemorrhage based on that.

23 Q. If you can't tell it's hemorrhage, does that have
24 a normal appearance to you?

25 A. of the mediastinum?

1 Q. Yes.

2 A. Yes.

3 Q. I want to be perfectly clear because we're going
4 to ask someone to look at this testimony, the area we're
5 referring to is the area of material on this CAT scan,
6 image number 17, between the ascending and descending
7 aorta, the blurry area between it you are indicating you
8 don't think represents hematoma?

9 A. This area here?

10 Q. Yes.

11 A. I don't call that hematoma.

12 Q. What do you call that?

13 A. Normal mediastinum.

14 Q. Have you seen any evidence of hematoma?

15 A. Possibly around the esophagus.

16 Q. You thought this area was hematoma, not this area?

17 A. Or soft tissue fullness. I thought it was
18 abnormal.

19 Q. You can't distinguish whether it is soft tissue
20 fullness or hematoma; is that what you are telling me?

21 A. Correct.

22 Q. So I don't put words in your mouth, the area you
23 thought looked abnormal was not the area between the
24 ascending and descending but the area near the
25 esophagus?

1 MR. OCKERMAN: I think it is more
2 consistent to say hematoma than area between the
3 ascending and descending aorta.
4 A. There is soft tissue fullness and the hematoma or
5 esophageal leak, I can't tell what that is.
6 Q. Not the normal appearance?
7 A. Correct.
8 Q. Does the mediastinum usually look blurry like
9 that?
10 A. what do you mean look blurry?
11 Q. Did you agree with me the area around the
12 esophagus which you are saying could be soft tissue
13 fullness, a leak or edema has the same or very similar
14 appearance to that area between the ascending and
15 descending aorta?
16 A. No.
17 Q. How would you describe those differently?
18 A. There is a contour abnormality around the
19 esophagus, it's convex where it ought to be concave, the
20 contour between the ascending and descending aorta, that
21 is based on normal contour.
22 Q. The contour abnormality of the esophagus, can that
23 be caused by an aorta that has been -- I don't want to
24 use transected -- disrupted blood flow, will that also
25 move structures within the mediastinum, the esophagus,

1 the trachea?

2 A. It could move structures, these aren't displaced
3 though.

4 Q. Can it cause abnormalities in their shapes?

5 A. Yes.

6 Q. Did you consider that when you were looking at
7 these impressions?

8 A. Yes.

9 Q. How did you rule out that there was a potential
10 disruption to the descending aorta based upon your
11 examination?

12 A. I looked at the mediastinum, I looked at the whole
13 CT to the whole body, most abnormalities were in the
14 chest. The mediastinal pattern bothered me, especially
15 mediastinal air indicating there is significant trauma
16 to this area.

17 while the patient was still on the table
18 they wanted to get her up and move her, I told the
19 technologist to do an additional thin image of the
20 mediastinum so we could get a second look at them with
21 thinner images.

22 Q. where are the thinner images, are these them?

23 A. These are not them, these are the original images.

24 Q. Have you recently looked at the thinner images?

25 A. Yes.

1 Q. There is a folder. Doctor, do you happen to
2 remember what numbers were on those slices?

3 A. NO.

4 MR. OCKERMAN: why don't you hand
5 it to her.

6 Q. You can find it for me?

7 MR. OCKERMAN: we want to look for
8 additional images taken of the mediastinum?

9 Q. Exactly. Let me ask you a couple of questions.
10 There is no indication in your CT report
11 that you had additional you are saying thinner section
12 slides, right?

13 A. Um-hum.

14 MR. OCKERMAN: You need to say yes.

15 A. Yes.

16 Q. These are thinner sections, that is not contained
17 in your report that you would have dictated that you
18 decided to do additional scanning to better define this
19 area?

20 A. I did it as part of the original exam, there is
21 not an extra chart or extra interpretation, it was
22 something I added.

23 Q. Something you didn't think you needed to
24 communicate to the physician you had done an extra look
25 at to evaluate that area of the mediastinum?

1 A. Correct,

2 Q. what if anything do you see on these films that
3 assured you that there was no great vessel injury?

4 A. I didn't see extravasation of contrast, I didn't
5 see a change in contrast enhancement that would indicate
6 a pseudoaneurysm. I didn't see difference in contrast
7 of opacification which you often see with
8 pseudoaneurysm. On delayed image the arch will be
9 bright, the rest will have contrast that is more normal.

10 Q. This is probably the third time you mentioned
11 extravasation, what is it that you think that you are
12 looking for on the CT?

13 A. You are looking for the contrast outside of the
14 aorta rather than inside the aorta.

15 Q. was that your training in medical school and then
16 postgraduate, that with a disruption -- we'll start with
17 disruption of the aorta -- you would see extravasation
18 of the contrast material?

19 A. One of the things you might see.

20 Q. How highly likely is it that you would see
21 extravasation of the contrast material in a disrupted
22 aorta?

23 A. I can't answer that.

24 Q. You just don't know, do you?

25 A. No.

1 Q. So that was one thing you based **it** on, the other
2 thing was, I'm sorry, I was trying to listen,
3 Mr. Emershaw wrote **it** down -- difference in the
4 technique on this is what?

5 A. These are delayed from the initial images, they
6 are thinner images.

7 Q. on these particular films, these started at what
8 time?

9 A. 1350.

10 Q. These are numbered **1** through 12 and 13 through --
11 I can't read that far way?

12 MR. OCKERMAN: 24.

13 A. 13 through 24.

14 Q. Did **it** start numbering at **1** through 24 because you
15 started a new series, is that the right way to phrase
16 **it**?

17 A. when I was looking at the original **CT** I said let's
18 do some images through the mediastinum. He said from
19 where to where. I said here to here, I pointed on the
20 initial chest image. They are numbered based on where I
21 tell them to go. That is random numbering the
22 technologist puts on the film.

23 Q. Did Dr. Murphy also look at these films?

24 A. I believe so.

25 Q. You're not positive?

1 A. I'm not positive.

2 Q. You are fairly positive you had him look at the
3 regular cuts?

4 A. ■ had him look at the mediastinal images, I'm not
5 sure if he saw one set or both sets, but I know he
6 looked at the mediastinal images. ■ don't remember
7 exactly what area he looked at.

8 Q. It's your testimony that these image 1 through 24
9 reassured you there was no great vessel injury?

10 A. It didn't reassure me, ■ didn't see any finding to
11 indicate such when I read this.

12 Q. Did you see any findings on 1 through 24 that
13 indicated to you that there was a problem with the
14 trachea or the esophagus?

15 A. The trachea area showed up more bothersome, the
16 mediastinal air anterior from the trachea in the images
17 8, 9, 10, 11, 12, you have the 1, 2, 3, 4, 5 image,
18 there appears to be tracking from the distal trachea and
19 carina area.

20 Q. Let's use number — ■ don't know if you like that
21 one, did you like number 12?

22 MR. OCKERMAN: In terms of?

23 Q. The trachea tracking?

24 A. This is right here, it's tracking there, there
25 it's very clear.

1 MR. OCKERMAN: To image 8, 9, 10,
2 11.

3 Q. Did you see anything abnormal -- first of all tell
4 me which of these additional images delineate or define
5 for you the descending aorta?

6 A. Probably image 12.

7 Q. In image 12, for my purposes, tell me what this
8 area in here is, is that the aorta; am I reading this
9 right?

10 A. Yes.

11 Q. Back here with the trachea and esophagus, is there
12 any abnormality that you can see on the aorta right
13 there?

14 A. I don't see abnormality there.

15 Q. Do you see any evidence of mediastinal hematoma?

16 A. I don't, not by the aorta. I see the esophageal
17 fullness.

18 Q. You see the esophageal fullness, you do not see it
19 on 12 in the area of the aorta; is that right?

20 A. Don't see what?

21 Q. Hematoma?

22 A. I see the esophageal fullness on image 12, I don't
23 see it between the ascending and descending aorta. You
24 see partial volume image of the image above. You are
25 partially seeing part of the aortic arch coming over.

1 Q. what would you expect hematoma to look like in the

2

3

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12 A. Between what you would expect to be mediastinal

13 fat and normal mediastinum.

14 Q. How does a person know what mediastinal fat looks

15 like?

16 A. You look at fat in the mediastinum. It's got fat

17 attenuation.

18 Q. Does it have to do with shade?

19 A. Like a shade of gray.

20 Q. Isn't hematoma also a shade of gray?

21 A. It has a little whiter characteristic if it's

22 acute.

23 Q. How skilled do you have to be to differentiate

24 between the white attenuation caused by fat and white

25 attenuation caused by hematoma?

1 MR. OCKERMAN: objection.

2 MR. TREADON: How skilled do you
3 have to be, medium, very, low?

4 MISS KOLIS: I don't know how to
5 ask that question.

6 A. It depends how well you see shades of gray. It
7 depends how old or acute the hematoma is, it depends on
8 your setting on your scanning machine. How many shades
9 of graduated gray you are filming this at. what your
10 window settings are.

11 Q. It's based on the skill of the reader being able
12 to call what grayish white shade is a hematoma versus
13 what is fat?

14 A. That's based on how well you see shades of gray.
15 I don't know what you are asking in terms of skill.

16 Q. I just don't know how much experience you have to
17 have to differentiate between that shade of gray and
18 that shade of gray, call one fat, call one hematoma, I'm
19 asking if you have any idea?

20 MR. OCKERMAN: You answered that
21 question.

22 MISS KOLIS: she answered it.

23 MR. OCKERMAN: Then go on.

24 Q. when you were in school, subsequent to that
25 time -- I guess we will start with when you were in

1 school?

2 MR. OCKERMAN: Medical school?

3 Q. when you were in medical school, before you went
4 into PGY-I through seems like a lot of years, VI ■
5 think, what did you know or what was your perception of
6 what was the best diagnostic tool to use to look for
7 injury to the great vessels?

8 MR. MINGUS: Objection.

9 MR. OCKERMAN: objection. Go
10 ahead.

11 A. I don't know. I can't remember what knowledge
12 base ■ had back then.

13 Q. If you don't remember that is fine, it may have
14 changed over time.

15 After you got out of medical school, as
16 you received your specialty training up to and including
17 through your Fellowship year, were you trained as a
18 radiologist in this: Pretend you saw the plain chest
19 film we already looked at today, those three, would you
20 have recommended a CAT scan, or would you have
21 recommended a visit to the arteriogram suite?

22 MR. TABER: objection. well
23 beyond her field *of* expertise.

24 MR. MINGUS: objection.

25 MR. OCKERMAN: objection.

1 Q. I'm asking you what -- you as a radiologist make
2 recommendations based on the chest films; do you agree
3 with that?

4 MR. OCKERMAN: You want her to
5 pretend all she saw was a chest x-ray, then say what
6 would she recommend based on the chest x-ray?

7 Q. Let me make **it** so nobody gets upset.

8 MR. OCKERMAN: ■ don't think you
9 can do **it**.

10 Q. Ignore the chest x-rays you saw today. Those are
11 not the ones I'm referring to. I'm trying to ask **if** you
12 had a chest film, with findings suggestive of a possible
13 disruption of the great vessels, **i.e.**, descending
14 thoracic aorta or other vessels, you are the
15 radiologist, what recommendation would you have made at
16 that time you completed your graduate program, would you
17 have referred the person to CT or sent them to have the
18 aortogram?

19 MR. MINGUS: objection.

20 MR. OCKERMAN: objection.

21 A. Depends on the clinical situation.

22 Q. what clinical situation do you believe requires a
23 radiologist, **if** any, to refer a person for the aortogram
24 versus CAT scan?

25 MR. MINGUS: objection.

1 MR. OCKERMAN: objection.

2 A. ■ If a patient had significant chest trauma, you
3 can't tell from the chest x-ray whether it's injury to
4 the great vessels or esophagus or trachea or lungs, you
5 have no idea where the injury is at, you know the
6 patient has experienced significant chest trauma, the
7 exam of choice is, if the patient is hemodynamically
8 stable, is a chest CT to screen out the injuries and
9 evaluate what is the most important injury at that time.
10 That is why you do the chest CT, you get a better look
11 at all the vessels in the chest.

12 If someone is not hemodynamically
13 stable, there is a reason for it, you couldn't tell what
14 it is, if they had significant chest trauma, the worst
15 scenario is aortic disruption, they go to the
16 angiography suite or to the operating room.

17 Q. If you are not able to exclude by CAT scan the
18 existence of disruption in the aorta, the next thing you
19 do based upon a film with a serious amount of chest
20 trauma is to send them for the aortogram; do you agree
21 with that?

22 MR. TABER: objection.

23 MR. MINGUS: objection.

24 MR. TREADON: I think that is a
25 totally different question.

1 MR. OCKERMAN: Objection.

2 A. No.

3 Q. At what point then, you just said if you can't
4 exclude damage to the great vessels by a CAT scan --

5 A. That's not what ■ said. ■ said you can't tell
6 from the plain film chest what is going on in the body,
7 you can tell maybe there is a rib fracture,
8 pneumothorax, you have the idea with soft tissue, if the
9 patient is hemodynamically stable to undergo a CAT scan,
10 that is usually the examination of choice because it
11 better screens out injury, shows you a bigger area of
12 the body than an aortogram would to look for other
13 injuries. Aortogram will only tell you about the aorta,
14 won't tell you about the trachea, will not tell you
15 about the esophagus, will not tell you about
16 pneumothoraces or soft tissue injury or fractures.
17 Q. You are right, ■ did ask the question incorrectly
18 based upon your answer.

19 If you have a suspicion based upon the
20 things that we previously discussed that you might see
21 on CAT scan, mediastinal hematoma, a pseudoaneurysm, did
22 you say attenuation of the flap around the aorta, did
23 you say that?

24 A. No.

25 Q. If you didn't say that let me ask you a different

1 way.

2 what things would you need to see on a
3 CAT scan in the area of the aorta that would have caused
4 you as a radiologist to refer the person for the
5 aortogram?

6 MR. MINGUS: objection.

7 A. If I was suspicious of disruption of the aorta I
8 would have referred, suggested an aortogram be done.

9 Q. Once again, let me ask you the specific findings.
10 If you had found mediastinal hematoma in the area of the
11 aorta, is that something included in your list that
12 would have required you to refer for the aortogram?

13 MR. MINGUS: Objection.

14 A. Possibly.

15 Q. Possibly being maybe --

16 A. Mediastinal hematoma tells you there is disruption
17 of the mediastinal vessels, most likely those are veins
18 which happen from trauma to the mediastinum. How much
19 that trauma affects the mediastinal organs, you don't
20 know. If you are suspicious there is an aortic tear,
21 you do an aortogram to better delineate the aorta.

22 Q. If I understand, what you are saying is what would
23 definitely cause you to send someone for an aortogram is
24 if you recognized the pseudoaneurysm, that's a definite;
25 is that right?

1 A. Yes.

2 Q. Maybe if you recognized mediastinal hematoma, but
3 that is not --

4 A. Okay.

5 Q. -- it's not a definite, am I fairly phrasing that?

6 A. Yes.

7 MISS KOLIS: I need about two
8 minutes with Mr. Emershaw to see if there is anything he
9 really wants me to ask. Anybody else want to ask
10 questions?

11 -----

12 (Recess had.)

13 -----

14 MISS KOLIS: Doctor, I don't
15 personally have any further questions for you at this
16 time. There are other attorneys representing other
17 parties.

18 MR. TABER: No questions.

19 MR. OCKERMAN: You represent?

20 MR. TABER: Dr. Sos.

21 MR. MINGUS: Doctor, my name is
22 Ron Mingus, I represent Dr. Telesz and Packer, I have a
23 couple of questions for you.

24 -----

25 CROSS-EXAMINATION

1 BY MR. MINGUS:

2 Q. To your knowledge, other than yourself and
3 Dr. Murphy, did any other physician look at the CT scans
4 on September 23rd or September 24th?

5 A. Not that I know of.

6 Q. Can you recall the specifics of any conversation
7 with Dr. Telesz?

8 A. I believe it was after she, Mrs. spreadbury, had
9 been taken to the operating room, he wanted to review
10 the CAT scan again. Meanwhile I had been trying to
11 locate the films to review them for my own knowledge.
12 He came down and said do you have time to review the
13 films, I said let's see if they are available. we
14 looked at them, went through the whole films again, it
15 seems to me that was after her surgery, I don't know,
16 the 24th or 25th, sometime after.

17 Q. Do you recall what you and Dr. Telesz talked
18 about?

19 A. we talked about the aorta and the line that was on
20 the films. Then I asked him about the other, I believe
21 I asked him about the other injuries, what else she had

22

23 Q. Do you recall anything else?

24 A. NO.

25 Q. Did you ever talk to Dr. Packer?

1 A. No.

2 MR. OCKERMAN: About this case.

3 A. Not about this case. ■ talk to him all the time.

4 MR. MINGUS: I don't have
5 anything else.

6 MR. TREADON: Dr. cawthon, I
7 represent Dr. Tawil and his group.

8 -----

9 CROSS-EXAMINATION

10 BY MR. TREADON:

11 Q. It's my understanding you believe the best method
12 for determining traumatic injury to the great vessels if
13 the patient is hemodynamically stable is to do a CT
14 scan?

15 A. Correct.

16 Q. If there is some suspicion of an aortic injury,
17 based upon the CT scan, then you move ahead and
18 recommend an aortogram?

19 A. Correct.

20 Q. In this case, not retrospectively, in this case at
21 the time you looked at these CT scans did you have a
22 suspicion of aortic disruption?

23 A. Back at that time?

24 Q. Yes.

25 A. No, ■ didn't.

1 Q. You talked to Dr. Murphy apparently the day after
2 the day of the surgery?

3 A. Yes.

4 Q. The 24th?

5 A. Yes.

6 Q. Then you and Dr. Murphy went back and looked at
7 these?

8 A. I didn't go back and look at them with him. I was
9 coming in to work, I saw him in the hallway, he passed
10 me. He said by the way, that trauma patient did have an
11 aortic tear, they were taking her to OR, she was in OR.
12 That was the extent of the conversation, we were
13 passing, I got called away.

14 Q. when Dr. Murphy saw you that day he knew that the
15 patient already had been taken to surgery?

16 A. Yes.

17 Q. Then went and looked at the CT scan?

18 A. I don't know. I don't know if he saw it ahead, I
19 don't know.

20 Q. The second time you looked at the CT scan results
21 you knew that there had been surgery?

22 A. Yes.

23 Q. on the aorta, to repair the aorta?

24 A. Yes.

2s Q. So you knew the end of the story when you looked

1 at the CT scans the second time?

2 A. Yes.

3 MR. OCKERMAN: The next day?

4 Q. The next day on the 24th?

5 A. Yes.

6 MR. TREADON: That's all I have.

7 MISS WYLER: No questions.

8 MR. OCKERMAN: Follow-Up?

9 MISS KOLIS: Just briefly so ■

10 didn't miss hear.

11 -----

12 RECROSS-EXAMINATION

13 BY MISS KOLIS:

14 Q. Initially ■ asked you if you discussed the CAT
15 scan with anyone else after the 23rd, you told me no,
16 apparently could be the way I asked the question.

17 A. ■ went over it with --

18 Q. Dr. Murphy?

19 A. Not afterwards, just at the time.

20 Q. so you are indicating today you've spoken also
21 with Dr. Telesz that day?

22 A. Let me go through the whole thing. The next day I
23 had a couple of hours off so I came in later in the
24 morning. when ■ came in, ■ was unlocking my office,
25 putting my coat in, Dr. Murphy went by, that lady with

1 the bad car accident had an aortic tear, they are doing
2 an aortogram, taking her to OR. I was called away, had
3 to do something else. I tried to get a hold of the
4 films and couldn't because I didn't know where they
5 were. Meanwhile I have a job to do.

6 Either late the following day, I believe
7 it was the following day, 24th or 25th, I believe after
8 her surgery, Dr. Telesz wanted to see the films, he
9 happened to come down and he caught me somewhere in the
10 radiology department, can I look at those films with
11 you. I say sure, let's see if we can find them. I
12 haven't been able to find them. That was the first time
13 I saw the films after I initially read them.

14 Q. You saw the films with him?

15 A. Yes, after the event.

16 Q. Had you reviewed CAT scans previously in the past
17 with Dr. Telesz?

18 A. I don't remember.

19 MR. OCKERMAN: on other cases?

20 Q. On other cases?

21 A. probably.

22 Q. You were also asked by one of the counsel as to
23 whether or not anybody else came down on the 23rd to
24 look at the CAT scans. would you know whether any other
25 doctors were down there reviewing the films after you

1 had done the reading on them?

2 A. The time the films were taken, the times they were
3 officially dictated was a couple hours. I know there
4 were people in and out, ■ was calling ER physicians with
5 findings as I saw them. I not only sent a written
6 report, I called and said the chest tube needs to be
7 pulled back, there is air. ■ don't think I went over
8 the films with anyone else though.

9 MR. OCKERMAN: Her question is do
10 you know whether any physician other than yourself came
11 and looked at these films when you were there or not
12 there; do you know that?

13 A. Meaning right after she had been scanned, while
14 still in the department?

15 Q. Right.

16 A. The only people I remember being there with me was
17 Dr. Telesz and Dr. Murphy. Dr. Murphy looked at the
18 images with me.

19 Q. when you were done scanning where would the films
20 have gone, upstairs or stayed in the department?

21 A. The CT generally stays in the department unless
22 someone asks for them.

23 Q. Do you remember what time you left work that day?

24 A. Probably 6:00 or seven o'clock at night.

25 Q. If someone came downstairs to look at the film, a

1 physician attending Mr. Spreadbury after 6:00 or 7:00,
2 you would have no knowledge of that, would you?

3 MR. TABER: Objection.

4 A. NO.

5 MISS KOLIS: No further
6 questions. Anybody else?

7 MR. TREADON: NO.

8 MR. OCKERMAN: We will read.

9 MISS KOLIS: I'll waive the seven
10 days.

11 -----

12 (Deposition concluded; signature not waived.)

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ERRATA SHEET

NOTATION

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I have read the foregoing transcript and
the same is true and accurate.

LAURA CAWTHON, M.D.

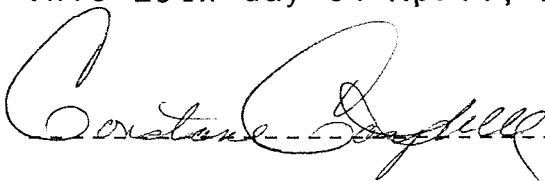
1 The state of Ohio,

2 County of Cuyahoga. : CERTIFICATE:

3 ■ Constance Campbell, Notary public within and for
4 the State of Ohio, do hereby certify that the within
5 named witness, LAURA CAWTHON, M.D. was by me first duly
6 sworn to testify the truth in the cause aforesaid; that
7 the testimony then given was reduced by me to stenotypy
8 in the presence of said witness, subsequently
9 transcribed onto a computer under my direction, and that
10 the foregoing is a true and correct transcript of the
11 testimony so given as aforesaid.

12 I do further certify that this deposition was taken
13 at the time and place as specified in the foregoing
14 caption, and that ■ am not a relative, counsel or
15 attorney of either party, or otherwise interested in the
16 outcome of this action.

17 IN WITNESS WHEREOF, I have hereunto set my hand and
18 affixed my seal of office at Cleveland, Ohio,
19 this 19th day of April, 1999.

20 -----
21

22 Constance Campbell, stenographic Reporter,

23 Notary Public/State of Ohio.

24 Commission expiration: January 14, 2003.

25

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NOTATION

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2	<u>NOTATION</u>	<u>PAGE/LINE</u>
3	Science in	7/11
4	program we	9/12
5	shared by the radiologists.	12/21 + 23
6	Rauchenstein	17/8
7	Degalen, McNulty	17/9
8	Bang	17/11
9	JCHO	18/23
10	twenty	20/4
11	from the emergens	24/25
12	I threw out a lot	26/19.
13	No, Dr Murphy told me the patient	28/13
14	had a transection of her aorta	
15	Yes, we have protocol for performing catem	36, 20
16	Dr Rauchenstein	37, 21
17	In another part of the department	39, 12
18	read by the radiologist assigned to ER films ^{who sends}	39, 15
19	film back to the	39, 16
20	usually, after	39, 19

a have read the foregoing transcript and
the same is true and accurate.

Laura Cawthon

LAURA CAWTHON. M.D.

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42	5	effusion
45	9	of mediastinal veins.
46	20	images
46	21	images to re evaluate them
48	13	No, he told me the patient had a disruption of her aorta or aortic tear.
53	20	Dr Pearson
56	16	I & personell have
58	18	it does look widened.
59	17	I look at the mediastinum Even if the it measures normal and still looks full
71	4	fullness. Could be hematoma
72	13	CT of the whole body
72	19	additional <u>thin</u> images
74	8	images, the pseudocapsule will be
77	24	volume imaging
82	11	any organs.
83	9	Stable enough
91	20	Between the times taken and the time they were

I have read the foregoing transcript and the same is true & accurate.

Jaura Cantor

FLOWERS, VERSAGI & CAMPBELL

16-771-5133
FAX

COURT REPORTERS
113 SAINT CLAIR AVENUE NE * SUITE 505
CLEVELAND, OHIO 44114-1214
04 JUNE 1999

216-771-8018
1-800-837-DEPO

E-mail: fvc.reporters@worldnet.att.net

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NOTATION

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3	Science in	7/ 11
4	program we	9/12
5	shared by the radiologists.	12/21 + 23
6	Rauchenstein	17/8
7	DeGalen, McNulty	17/9
8	Bang	17/11
9	JCHO	18/23
10	twenty	20/4
11	from the emergens	24/25
12	I threw out a lot	26/19.
13	No, Dr. Murphy told me the patient	28/13
14	had a transection of her aorta	
15	Yes, we have protocol for performing catem	36, 20
16	Dr. Rauchenstein	37, 21
17	In another part of the department	39, 12
18	read by the radiologist assigned to ER films ^{who sends}	39, 15
19	film back to the	39, 16
20	Usually, after	39, 19

I have read the foregoing transcript and
the same is true and accurate.

Laura Cawthon

LAURA CAWTHON, M.D.

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42	5	effusion
45	9	of mediastinal veins.
46	20	images
46	21	images to re evaluate them
48	13	No, he told me the patient had a disruption of her aorta or aortic tear.
53	20	Dr Resnick
56	16	I + personell have
58	18	it does look widened.
59	11	I look at the mediastinum Even if the it measures normal and still looks full
71	4	fullness. Could be hematoma
72	13	CT of the whole body
72	19	additional <u>then</u> images
74	8	images, the pseudocapsule will be
77	24	volume imaging
82	11	any organs.
83	9	Stable enough
91	20	Between the times taken and the time they were

I have read the foregoing transcript and the same is true & accurate.

Jaura Cantor

FLOWERS, VERSAGI & CAMPBELL

216-771-5133
FAX

COURT REPORTERS
113 SAINT CLAIR AVENUE NE * SUITE 505
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- - - - -
IN THE ~ O OH COMMON PLEAS
- - - - -

MARIA J. SPREADBURY, et al.,

plaintiffs,

vs.

MERCY MEDICAL CENTER, et al., : Case No. 1998 CV 1681
: 1998 CV 00589
: NOTARY'S REPORT TO TEE
: COURT, ERRATA RETURN
: RESPONSE, DR. CAWTHON

- - - - -
Now comes Constance Campbell, Notary Public within and for the State of Ohio, duly commissioned and qualified, and advises this Honorable Court that at the request of plaintiffs' counsel a verification of the transcribed testimony of Dr. Cawthon's deposition was undertaken on this date, including stenographic notes, computer disks, and final transcribed work product. Attached please find results of same.

Constance Campbell
Notary Public, State of Ohio,
Commission expiration: 01-14-02.

cc: all counsel of record
files: fv&c

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ERRATA SHEET RESPONSE

RE: Marla J. Spreadbury, et al., vs. Mercy Medical
Center, et al.

04-12-99 deposition of Laura Cawthon, M.D.

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