IN THE COURT OF COMMON PLEAS

COUNTY OF SUMMIT

RUBY J. NANCE, Executrix, et al.,	)	CASE NO. CV 99 02 0596
Plaintiffs,	)	EXCERPT OF TRANSCRIPT OF PROCEEDINGS
vs.	)	
SYED ALI, M.D., et al.,	)	EXAMINATION OF LAWRENCE COOPERSTEIN, M.D.
Defendants.	)	

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APPEARANCES:

TIMOTHY F. SCANLON, Attorney at Law,
KEVIN P. HARDMAN, Attorney at Law,
On Behalf of the Plaintiffs.

GARY A. BANAS, Attorney at Law,
On Behalf of the Defendants.

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BE IT REMEMBERED that upon the hearing of the above-entitled matter in the Court of Common Pleas, Summit County, Ohio, before the Honorable John R. Adams, Presiding, and commencing on January 10, 2000, the following proceedings were had, being an Excerpt of Transcript of Proceedings:

TRACY L. ROWLAND, RPR
Official Court Reporter
Summit County Courthouse
Akron, Ohio 44308

January 12, 2000

* * * * * (Beginning of Excerpt) * * * * *

THE COURT: Ladies and gentlemen of the jury, to accommodate the schedule of this particular witness, he's going to be taken out of order. He's going to be called on behalf of the Defendant at this time.

Sir, before you're seated, please stand while I administer the oath, please. Raise your right hand.

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LAWRENCE COOPERSTEIN

a witness herein, called on behalf of the Defendant, having been first duly sworn as provided by law, was examined and testified as follows:

THE COURT: Please be seated in the witness stand. Keep your voice up and use the microphone so the jury can hear your testimony, please.

Mr. Banas.

DIRECT EXAMINATION

BY MR. BANAS:

Q. Doctor, give us your full name.

A. Lawrence Cooperstein.

Q. Your business address?
A. My business address is Department of Diagnostic Imaging, UPMC, Shadyside Hospital, Pittsburgh, Pennsylvania. The street address is 5230 Center Avenue, 15232.
Q. Doctor, so the jury will understand your qualifications, will you start at undergraduate school and take us to the time that you started practicing diagnostic radiology, if that's your specialty?
A. Yes, it is. I graduated from Princeton University, Princeton, New Jersey, in --
MR. BANAS: Is that a little loud?
THE COURT: Just a little bit.
THE WITNESS: I'll sit back.
MR. BANAS: Most people don't speak up.
THE WITNESS: I graduated with a bachelor's degree in 1975, then went to the University of Rochester Medical School and graduated with the M.D. degree in 1979. Following that I came to Pittsburgh, did an internship at the University Hospital, followed by a residency in

diagnostic radiology, which I completed in 1983.

I then did a fellowship which lasted four months in musculoskeletal imaging. Two months of that was spent at the Florida -- University of Gainesville, two months at University of California, San Diego.

Following that I took a position on the staff, University Hospital Pittsburgh.

BY MR. BANAS:

Q. What's the difference between a residency and a fellowship?

A. A residency is the basic training in diagnostic radiology. It covers all areas of diagnostic radiology. The fellowship was further training in a more specialized part of that.

Q. Are you board certified?

A. Yes, I am.

Q. Briefly, how does one become board certified?

A. One has to take a written examination which is taken over two days which covers all different areas of diagnostic imaging. That written test also includes a section on

radiographic physics.

Then six to nine months later one can take the oral examination, which is given over one day in which one has to sit with individual examiners, eight or nine different sections, one-on-one, looking at different sorts of X-ray cases and discussing those.

One has to pass the written and pass the oral in order to be board certified.

Q. You did that?

A. Yes.

Q. On the first time?

A. Yes.

Q. Do you teach?

A. Yes, I do.

Q. Do you teach residents?

A. Yes.

Q. Have you written for the literature?

A. Yes, I have.

Q. Explain to the jury "written for the literature," what that means, by way of publication, articles, chapters, whatever it is.

A. I've written several book chapters, different

books that have been published in the last ten years or so in different areas of radiology. In terms of papers, I've been author or coauthor on probably 20 to 25 different articles in what are called peer review journals.

Q. What are peer review journals?

A. Peer review journals, one has to submit the article to the journal. The article is sent out to reviewers who are experts in the field who have to agree that the paper is reasonable, deserves to be published, and then the paper, if it gets through peer review, gets published in the journal.

Q. Doctor, is more than 50 percent of your time spent in the active practice of diagnostic radiology?

A. Yes, it is.

Q. And so the jury understands, tell me essentially what you do on a day-to-day basis.

A. On a daily basis I may interpret 100 to 150, sometimes even more, different radiographic studies. That may be a mix of routine X-rays, as well as more specialized things

such as CAT scans, ultrasounds, MRI particularly. I may be involved with some procedural things, different sorts of injections, biopsies, things such as that.

Q. Are you an interventional radiologist?

A. Not specifically. I do take part in some procedures that would probably be called interventional, but I don't bill myself as an interventional radiologist.

Q. Doctor, some time ago Sue Ellen Salsbury came to your office and asked to you look at a series of CT films, did she not?

A. Yes, she did.

Q. I'm going to hand this packet of films to you which is marked as Defendant's Exhibit A. You don't have to look at them unless you want to. Do you know what's in there?

A. Yes, I do.

Q. And tell the jury what is in there and how this all happened.

A. Ms. Salsbury came to my office and really had not told me why she was coming. She produced these CT images and just asked me to interpret them. What she was trying to do

was simulate the normal working environment.

She gave me one case after another, asked me my interpretation. We did this in my office. I put each case up individually on the view box and gave her my interpretation of each case in sequence.

Q. Now I'm going to hand you Defendant's Exhibit C. Can you tell me what that is?

A. That looks like my interpretations of the five CT -- I'm sorry, it's more than five -- six CT scans that she brought that day.

Q. I'm going to show you Defendant's Exhibit D. Can you tell me what that is?

A. That's the same thing with the names blocked out.

Q. Right. Because of confidentiality for the patients, we have blocked out the names of the people whose CT's you read, correct?

A. Correct.

Q. Now, Doctor, you've indicated that this was a way to simulate how you would actually do it in practice. Is this, from your standpoint, a reliable way of looking at a set of CT films to determine exactly how they should be read?

A. Yes. I think it's important to do this. The problem, of course, is when you receive a case from an attorney to look at, you know there's something there, and therefore you're prejudiced.

By looking at them in this way, I believe we're trying to get rid of that prejudice. I didn't know which case when I first looked at this was the case in question. I just looked at them one right after the other.

Q. Now, let's stop there for a moment and change our focus and we'll come back. I understand that you and I have never dealt before this particular case. Is that true?

A. That's correct.

Q. But I understand that you have done two or three matters for people in my firm?

A. Yes, that's correct.

Q. Do you do plaintiff's work also?

A. I have done some, yes.

Q. All right. Now, let's go back -- let's assume that you're a plaintiff's expert and a plaintiff's lawyer sends you a set of films. Is there any sort of bias built into that

when a plaintiff's lawyer would send you a set of films?

MR. SCANLON: I object, Your Honor.

THE COURT: Sustained.

BY MR. BANAS:

Q. Well, Doctor, when you receive a set of films from either a defendant or a plaintiff's lawyer, is there anything built into that by way of the fact that you know a known plaintiff's or a known defense lawyer sends you something to look at?

A. Well, sure, there's always a bias.

Q. All right.

A. Lawyers don't send me cases to look at unless there's either something that was felt to be missed or a missed diagnosis, there's a lawsuit already in place or one being contemplated. Sure, there's definitely a bias.

Q. When you went through these six -- and I think you indicated you didn't know which was the case that we're here in this courtroom about?

A. That's correct, I did not.

Q. I think because of the pieces of paper we

have it was number 3, correct?
A. Correct.
Q. Tell the jury how you read number 3. Do you need the papers?
A. No, I believe I remember.
Q. All right. Do you need the films?
A. No, I remember the case also. When I first looked at that case, I interpreted the images as showing evidence of bullous emphysema. That is a form of chronic obstructive pulmonary disease. I believe that's all I saw on those particular images.
Q. All right. Now, we know also since we've been in this courtroom -- and I believe at the deposition were lawyers from Summa, Akron City, perhaps on the phone, but there was also a lawyer from Kaiser present at the deposition, and as well as Mr. Scanlon, who is sitting here, correct?
A. Correct.
Q. Now, did you have any information other than the CT scans, which is Exhibit A?
A. My recollection is I had no other clinical information.
Q. For instance, let's assume you have something

that shows bladder cancer, and I'm not sure whether you had that or not. Does bladder cancer, is that something that you would expect to see metastasize in the lungs?

A. That would be very uncommon.

Q. Doctor, tell the jury as you looked at that set of films what you saw by way of -- well, how would you read it, particularly with regard to anything in the lungs?

A. I would have read the scan as showing evidence of emphysema. There were some bullous changes, there were large air spaces in the upper lungs, particularly on the right, if I remember correctly. And I would have reported out no other abnormality.

Q. Did you see anything that would indicate there was a lesion somewhere in the lungs?

A. I did not.

Q. What did you see, if you saw anything, in that area?

A. I saw what I interpreted to be normal pulmonary vessels. The lung is highly vascular. There are normal structures which one can see in the lungs, and that's how I interpreted those images.

Q. We've been told by another radiologist that it is impossible for that to be pulmonary vessels. Is that true? In other words, what this expert said is that you cannot read that area as pulmonary vessels. Do you agree with that?

A. I completely disagree.

Q. Now, at the conclusion of what you did, were you ultimately shown a film from 1995?

A. Yes, I was.

Q. All right. What was different in the '95 film, the CT scan of June of '95 as opposed to the June of '94 CT scan?

A. The second scan showed a mass in the lower part of the left lung.

Q. Now, when you go back and look at the '94 film, what happens?

A. After I had seen the mass on the second scan, I went back to the first scan and at that point I could detect a small abnormality on the same area.

Q. Based upon reasonable medical certainty, Doctor, did Dr. Ali fall below the standard of care when he read the CT scan of June of 1994 as he did, without seeing this

particular lesion? First of all, do you have an opinion?

A. Yes, I do.

Q. What is your opinion?

A. My opinion is that he did not fall below the expected standard of care, that indeed his interpretation was reason within the expected standard of care.

Q. Let's assume, let's assume that somebody gives him a copy of a chest film of October of 1993 that shows either a summation shadow in the same area or a possible lesion. Would that be helpful to somebody like Dr. Ali in reading these films?

A. It certainly could have been, yes.

Q. What does that do to a radiologist such as yourself when you're looking at that set of films?

A. It directs your attention to that particular area and probably makes you look at it just a little bit harder.

Q. Now, Doctor, I'm going to tell you, the size of the slices are what size, roughly?

A. Do you mean the actual sheet of film?

Q. On the film, what are they, about 4 by 5?

A. You're upside down.
Q. I'm always upside down. What is it?
A. Well, they're probably 3 or 4 inches, by the same.
Q. And when you're looking for the lesion such as you're looking for, now that you know the 1995 CT scan, looking back at the 1994 CT scan, what are you looking at? What is the rough size of this as you look at it, which you determine to be pulmonary vessels?
A. Oh, it's a centimeter, just a centimeter or maybe just slightly larger.
Q. All right. Now, let's assume that we blow that up. Let's assume that we blow up slice 21 and put it on the screen. Are we going to see a difference?
A. Oh, I suspect everybody will see it, and it will look enormous.
Q. Is this the way radiologists like Dr. Ali look at things, or do you look at the slices here?
A. We look at them just as they are here. We don't blow up individual images on screens.
MR. BANAS: May I have a moment, Your Honor?

THE COURT: Yes, sir, you may.

MR. BANAS: You may cross-examine.

THE COURT: Counsel.

CROSS-EXAMINATION

BY MR. SCANLON:

Q. Dr. Cooperstein, part of the work that you do involves serving as an expert witness or consulting in what I believe you would call medical legal cases; am I right?

A. That is correct.

Q. Now, in that work that you do, you are basically a spokesperson for the physicians in these cases, aren't you?

A. On the cases that I've reviewed for the defense, yes.

Q. Well, you told this jury that you've done some work for patients who have been misdiagnosed. Do you recall that testimony?

A. Yes.

Q. In fact, in all the years that you have been serving as an expert witness or a consultant, you've been contacted twice on behalf of patients, haven't you?

A. It's actually three.

Q. Yesterday afternoon in Pittsburgh you gave testimony under oath, didn't you, Doctor, that there were two such cases?

A. I did, and after it was over -- actually on my drive home I remember that there have actually been three.

Q. Three. Out of what, Doctor, 100?

A. I doubt it's 100, but I'd say probably somewhere in the 50 to 100 range.

Q. And in fact, you have a rather close working relationship with the law firm who represents Dr. Ali in this case, don't you?

A. Only in the sense that they've asked me to look at a few cases over the years. I'm not sure I would characterize it as a close relationship, but yes, I've done some expert review for them.

Q. They've asked you to look at a lot of cases, haven't they, Doctor?

A. Again, I'm not sure how many is a lot, but yes, I've looked at cases for them. That is true.

Q. More than 15?

A. Oh, I don't think that's true. I'm sure it's less than 15.

Q. What did you testify to on that exact point yesterday afternoon, Dr. Cooperstein?
A. I don't recall a number that I testified to, but I can tell that you I can almost certain -- I'm almost certain that I've not reviewed 15 cases for that particular firm.
Q. It's a number, isn't it?
A. Pardon?
Q. It's a lot, isn't it?
MR. BANAS: I object. He's already testified.
THE COURT: Answer the question, Doctor. I'll allow it, go ahead.
THE WITNESS: Again, I don't think I'd characterize it as a large number. I think you're trying to portray it as something more than it is.
BY MR. SCANLON:
Q. How about 10 to 12?
A. I'll go with that.
Q. In addition to that, Doctor, you have been a spokesperson for the very company that is a defendant in this case, Akron Radiology, Incorporated; isn't that true?
A. I believe that a couple of the cases that

I've looked at have involved Akron Radiology. But again, I don't consider myself a spokesperson.

Q. All right. Then I'll withdraw that word. Yesterday afternoon under oath you indicated that you had testified or appeared as an expert witness consultant for five or six cases for this same company, didn't you?

A. No, I don't believe I said that. I believe I was asked how many times I had been asked to defend or look at cases which Akron Radiology was involved, and I believe I answered I wasn't sure of the number but I didn't think it was very many.

Q. Five or six sound about right?

A. I think probably less than five, but not very many.

Q. We are here because of the interpretation of a CT scan of the chest of Vernon Nance on June 6th, 1994, correct?

A. Yes.

Q. And that CT scan was in fact misinterpreted, wasn't it?

A. A small abnormality was overlooked on that scan, yes.

Q. This patient was misdiagnosed, wasn't he?
A. Yes. The scan was interpreted as normal and I've already stated in retrospect I can see a small abnormality.
Q. But the wrong interpretation of that CT scan resulted in a misdiagnosis of a man who in fact had a malignant tumor in his lung at that time; isn't that true?
A. Did you say "misdiagnosis" or "missed diagnosis"?
Q. "Mis."
A. M-i-s?
Q. Yes.
A. He was interpreted as having bullous emphysema. That's correct. I believe the diagnosis of malignancy might be a missed diagnosis. I don't believe he had a misdiagnosis.
Q. The diagnosis was missed on June 6, 1994, wasn't it?
A. Correct.
Q. Now, Doctor, and in asking you this next question I'm not attempting to test your memory. You are welcome to look at this CT scan. On how many pictures of that CT scan

of June 6th, 1994 does that tumor appear?
A. My recollection is it is on one and partially seen on a second.
Q. And how many pictures are we talking about altogether, or slices, whichever, I should say?
A. That I don't know without actually counting them. A standard scan would probably have at least one more sheet of film than this, maybe even two. There's 12 on a sheet, so we're probably talking somewhere between 24, 36 images.
Q. And on how many of those images or slices or pictures do the pulmonary veins appear?
A. I'm not sure I can specifically answer that question, but probably on every single slice there were pulmonary vessels.
Q. Thank you. Now, there's no question, is there, Doctor, that the mass that was found in June of 1995 is the same growth in the same place that was missed by Dr. Ali in June of 1994, is there?
A. That is correct.
Q. Now, the fact -- and this is a general question, Doctor; I recognize your field is

radiology. The fact that a growth or enlargement of a tumor in a lung has occurred between June of 1994 and June of 1995 is not a good thing for the patient, is it?

A. In general, no.

Q. Now, you mentioned the emphysema, and -- which was a diagnosis that was correctly made, correct?

A. Yes.

Q. And as I recall, Dr. Cooperstein, you referred to emphysema in the lungs, plural, correct?

A. I may have.

Q. In fact, it's only in one of the lungs, isn't it?

A. I'd have to review the scan to be certain, but I remember there being bullous disease, I think in the right upper lobe. Whether or not there were changes on the left I don't remember with certainty. I suspect that anybody with those sorts of changes in one lung probably has changes in the other, whether they're apparent on the films or not.

Q. But this patient did not have it in the left lung, did he?

A. Oh, I don't know for certain. As I said, I'd have to review the scan to see what the evidence on the scan showed. But I can tell you that somebody with emphysema to that degree in one lung, if one were to pathologically analyze the other lung, you'd probably find evidence of it in the other lung.

Q. Let me refer you -- to refresh your recollection, Doctor, we were together in your office in Pittsburgh last July 21 -- excuse me, July 21st, 1998.

A. Yes. It's "Cooperstein," by the way, not "Cooperstein."

Q. I'm sorry.

A. Thank you.

Q. You've had a chance to review this in preparation for today?

A. Yes, I have.

Q. Let me refer you to page 15 of your deposition, and if you want to get this in context, do you recall me asking you in general terms about how emphysema appeared on the lungs?

A. At the top of page 13 you asked me, "In

layman's terms, what would you see on the CT scan that would lead you to the interpretation of bullous emphysema?" Is that what you're referring to?

Q. Yes, sir. That's the background. So we had a discussion of how it would appear on the CT scan; am I correct?

A. Correct.

Q. Then on page 15, Doctor, do you remember this question being asked by me and this answer?

Question, "So that this will mean something to me when I read the transcript, the darkened area on the right of image number 9 is what you described as healthy, a normal appearance?"

Did I read that correctly?

A. Yes.

Q. And your answer, Doctor, "On the right side is really his left lung, since the image is reversed. His left is to your right. So, yes, I would say the upper part of the left lung is normal. The upper part of the right lung, which is on your left, is not, in that it contains these multiple large air spaces."

Did I read that correctly, Doctor?

A. Absolutely.

Q. All right. The films that you were given to look at and included, as I understand it, six CT scans -- correct?

A. Correct.

Q. Were they all of the chest?

A. I believe that five were of the chest. I think one was of the abdomen.

Q. And incidentally, Doctor, you've told the jury that this was the best way to do it, because when an attorney representing a family or a doctor gives you an X-ray or an image to look at, you have a heightened sense of suspicion, correct?

A. There is a heightened sense of suspicion, yes.

Q. And these were given to you by a woman by the name of Sue Ellen Salsbury?

A. Correct.

Q. Well, who was Sue Ellen Salsbury?

A. She is an attorney.

Q. So when you looked at these you knew there was something wrong with one or more of those, didn't you?

A. I suspected that was the case, the difference being of course that I didn't know which one it was, nor did I know what the abnormality in question was. Oftentimes an attorney will call and say, "I have this case I'd like you to look at, involves a missed case of lung cancer. Such and such was missed on this particular case. See what you think."

The case comes, you know what to look for. You can find it in an instant. It does not, in my estimation, simulate the real world. It would be nice if every case came with the answer provided, but that isn't the way it happens.

Q. But that's your job, isn't it?

A. My job is to accurately to the best of my ability interpret images, including CT scans. But unfortunately nothing is 100 percent.

Q. And that was Dr. Ali's job, wasn't it?

A. He does the same job that I do.

Q. Patients rely on your interpretations?

A. Certainly.

Q. And referring physicians rely on it?

A. Certainly.

Q. Now, you and Mr. Banas have used the word "standard of care" in this case. We've all used the word "standard of care" in this case, Doctor.

What did the standard of care require Dr. Ali to do in reading this patient's CT scan in June of 1994?

A. I believe the standard of care requires him to give as accurate and as correct a reading as humanly possible.

Q. Well, Doctor, let me say it my way and see if you agree.

The standard of care required him to do basically two things. First of all, it required him to do a complete examination of the CT scan, correct?

A. I would agree with that.

Q. Secondly, it required him to make an accurate interpretation of that CT scan. Isn't that true?

A. I would agree with that.

Q. You have not been shown the -- any of this man's previous chest films, correct?

A. Correct.

Q. You have not been shown any of the subsequent

scans or films?
A. I did see the second CT scan.
Q. You did not see the test of his head in September of 1995?
A. No.
Q. Or the test of his head -- or brain. It's the same thing, right?
A. Sure.
Q. In April of 1996?
A. I did not.
Q. Or in May of 1996?
A. No.
Q. Now, Doctor, you said that in looking at these CT scans -- and incidentally, Doctor, before I go there let me ask you this. We've talked about centimeters and millimeters in this case. A centimeter is about 4/10 of one inch, isn't it?
A. Yes, that's correct.
Q. .3937 inches?
A. I'll accept that.
Q. And a millimeter is an awful lot smaller than that, isn't it?
A. Sure.
Q. A centimeter is -- correct me if I'm wrong,

Doctor, but it's 1/100 of a meter. Am I right or wrong on that?

A. 10 millimeters to a centimeter, 100 centimeters in a meter.

Q. So if a centimeter is .4 inches, 1 millimeter is .004 inches, correct?

A. No. If a centimeter is 0.4 inches, a millimeter is .04 inches. I think you added an extra zero.

Q. All right. I won't quarrel with you. Pretty small?

A. It's small.

Q. And, Doctor, I noticed that in one of these readings right here that you put in front of the jury, case number 5 -- do you have the original? Mr. Banas, do you have the small version of that exhibit?

MR. BANAS: Here they are. Which one do you want? Take the one with the names out.

BY MR. SCANLON:

Q. I'll show you Exhibit D, Doctor. In case number 5 you found a growth in the kidney as small as 5 millimeters, right?

A. That's correct.

Q. And that same case, you found a 1 centimeter nodule or growth in that patient's left lung, didn't you?
A. Correct.
Q. Now, Doctor, I want you to assume, if you will, please, that the tumor in Vern Nance's left lung that was missed by Dr. Ali was 2 centimeters by 1.8 centimeters. I'm asking you to assume that. Can you do that?
A. Sure.
Q. I put a little white cutout on Exhibit 146, Doctor. Does that look like about 2 centimeters by 1.8 centimeters.
A. If you say it is, I'll accept it. I don't have a ruler with me.
Q. Here's a ruler, Doctor. That has both inches and centimeters, Doctor. I believe the centimeters are on the top of the ruler. If you'd like to check those measurements.
A. Your measurements are correct. That little white cutout measures 2 by 1.8 centimeters.
Q. So that if Dr. Vogel is correct in his testimony that the lesion or growth or tumor that was missed by Dr. Ali measures 2 centimeters by 1.8 centimeters, this white

cutout on Exhibit 146 represents the size of the tumor that was missed, correct, Doctor?

A. If you accept those numbers.

Q. Now, I started to ask you about these studies. You said that you thought it was right to do it that way because it simulated the normal working environment?

A. As close as one can get to that, yes.

Q. Is that really true, Doctor?

A. Yes.

Q. You read CT scans daily with no clinical information about the patient?

A. Usually we have a little bit of clinical information, but there are plenty of times when I would read with very limited or no clinical information, yes.

Q. And the reason that you do that, Doctor, is that without regard to whether you're provided with a lot, a little or no clinical information, you recognize that your obligation in interpreting that CT scan is to look at it completely and carefully, correct?

A. Sure.

Q. All right. And you felt comfortable for your role in the case in looking at six CT scans

with no clinical information at all?
A. I felt comfortable looking at those scans and giving interpretation.
Q. With no clinical information, Doctor?
A. I believe that -- I didn't have much in the way of clinical information. I believe in a couple of the scans, and I'd have to look at it again, I think there are little bits of writing which may give a very little hint of clinical information, but I would characterize that as minimal, at best.
Q. Now, every man or woman who does what you do for a living knows that when a referring physician asks for a CT of the chest, in all probability that referring physician is asking you to look in the lungs to see whether there is a growth or mass or lesion in the lung; isn't that true, Doctor?
A. I would not say that's true all the time. I think there are lots of indications for CT scanning of the chest. That is certainly one of them, and it's a common one, but there are plenty of scans that we do, not specifically looking at the lungs.
Q. I know that. I think I said CT's of the

chest, Doctor. Let me try to turn it around.

A. Well, you say CT's of the chest. There's more in the chest than just the lungs.

Q. When you interpret a CT of the chest of a patient, Doctor, do you look for growths or masses or lesions or nodules in the lungs?

A. Yes.

Q. Every time?

A. Sure.

Q. With or without clinical information?

A. Yes.

Q. And therefore, that means, doesn't it, Doctor, that one of your functions in looking at and interpreting a CT of the chest is to rule in or rule out a possible mass in the lung? Isn't that true?

A. That is one of the things we do, yes.

Q. That's what Dr. Ali was expected to do?

A. Sure.

Q. With or without clinical information?

A. Yes.

Q. Doctor, the jury knows that two chest films were taken of this patient at Kaiser Permanente in May of 1994 and that on the

basis of findings made in those chest X-rays this patient was sent to Dr. Ali's company for a CT of the chest. Do you understand that also?

A. Yes.

Q. And do you understand that it was the radiologist who looked at those chest films of May 4th and May 12th, 1994, that made the recommendation for a CT scan? Do you understand that?

A. Yes.

Q. Now, Doctor, in general terms, would you tell me why a radiologist, having made suspicious findings or potentially suspicious findings on chest X-ray would suggest or want a CT to be done of that patient's chest?

MR. BANAS: I'm going to object. There's no such evidence before this jury.

THE COURT: Approach for a second, counsel, one second.

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(Whereupon, a conversation was held at side bar off the record.)

- - -

THE COURT: I'm sorry, ladies

and gentlemen. Objection is overruled.

Mr. Scanlon, you can proceed, sir.

BY MR. SCANLON:

Q. Doctor, I'm going to show you an enlargement of a Kaiser Permanente X-ray report of May 12th, 1994. Do you see that date?

A. Yes, May 12th of 1994, yes.

Q. Now, have you ever been permitted to -- have you seen this report?

A. I have seen the report. I have not seen the films.

Q. All right. Now, tell the jury whether or not in that report the radiologist at Kaiser Permanente, after reporting what she was seeing in the lung, recommended CT scan.

A. She suspected, according to that report, not actually an abnormality in the left lung. What she was suspicious of in that report was what she has described as a subtle density in the left posterior mediastinum. That's not actually in the lung.

Nonetheless, she suspected an abnormality and suggested a CT scan for further evaluation.

Q. So she recommended a CT scan?

A. Correct.
Q. Now, in general terms, Doctor, why would a radiologist such as Dr. Urso at Kaiser Permanente suggest a CT scan under those circumstances?
A. CT scan would be another way of evaluating the lungs -- or the chest. It would be a way of either confirming that an abnormality was present or proving that an abnormality was not present. It's a more sophisticated, perhaps, test of the chest.

By the very nature of the exam it probably shows more detail in particular areas, and therefore it's quite common if one suspects an abnormality in a chest X-ray to go ahead and get a CT scan to clarify it.
Q. Doctor, it's pretty tough to explain to this jury, isn't it, how Dr. Urso at Kaiser Permanente could see an abnormality in the left lung on that plain old chest X-ray and Dr. Ali could not see it on the sophisticated CT scan, isn't it?
A. I've not seen the films, so I can't give you an explanation. I think when you refer to the "plain old chest X-ray," it's not quite

that unsophisticated an examination. But I don't have a great explanation as to why an abnormality was seen on the chest X-ray and not on the CT scan.

Q. Well, when you say you don't have a great explanation, you don't have any explanation, do you?

A. Without seeing the previous films, I don't have an explanation, no.

Q. Well, page 30, Doctor, of your deposition, do you remember this question being asked by me and this answer being given by you?

Question, "Now, how is it that Dr. Urso, who interpreted these plane films of the chest, was able to see a density, a possible lesion in the left lower lung in these plane chest films, and Dr. Ali was not in the CT of the chest?"

Did I read that correctly?

A. Yes.

Q. And your answer, "I'm not sure I have a good answer. I don't know."

A. You've read it correctly. I think that's what I've just said.

MR. SCANLON: I have nothing

further, Your Honor.

THE COURT: Thank you, Mr. Scanlon.

Mr. Banas, any redirect, sir?

REDIRECT EXAMINATION

BY MR. BANAS:

Q. In reference to that, not having seen the chest film, would that have helped you, if you had ever seen the chest films, which you know Dr. Ali did not see?

A. I think it might have helped, yes.

Q. Does everybody who looks at films like you read them 100 percent every time?

A. I wish that were true, but I don't know anybody who reads them 100 percent, all of the time, no.

Q. What did you see at this point where it is now called a lesion in the 1995 film? What did you see it as?

A. I'm sorry?

Q. What did you notice in this area that in 1995 became bigger?

A. Oh, looking back -- once I had the second scan and saw a mass, I went back to the first scan and I could see what I then realized was

a small nodule that subsequently grew.

Q. And what did you think it was when you first read it?

A. I thought it was normal.

Q. All right. And is that within the standard of care?

A. I believe it is.

Q. Well, now, obviously Mr. Scanlon wants everybody to read every film 100 percent and not ever make a mistake. Is that within the standard of care?

A. I wish it were, but reality is it is not.

Q. Doctor, you've talked about -- or you were asked about a 5 millimeter nodule on the right kidney. Is there something special about seeing something that small with the right kidney?

A. Sure. It's not just size that allows you to see things. It's size, but it's also what does the structure around it look like. And a kidney cyst on a CT scan is a very low density, it's very black, and it's highlighted against the rest of the kidney which is a different density.

It's not only size; it's contrast

resolution between two structures. For instance, if there is a little calcification on the lung, which is not uncommon to see, you can probably perceive that calcification smaller than a millimeter simply because it's so different than the structures around it.

Q. In this instance I think what you indicated what you were seeing were pulmonary vessels in the area that ultimately became this lesion?

A. I believe it is.

Q. That's the standard of care?

A. I believe it is.

Q. One last question. You were asked a series of questions about a deposition yesterday.

A. Yes.

Q. I think you were asked questions about a Mr. Lawrence Scanlon.

A. That's correct.

Q. Do you understand Lawrence Scanlon to be the brother of Tim Scanlon?

A. Yes.

MR. BANAS: That's all I have.

THE COURT: All right. Anything further, counsel?

RECROSS-EXAMINATION

BY MR. SCANLON:

Q. That deposition, that testimony yesterday, Doctor, was taken in another case involving Akron Radiology?

A. Now I'm trying to remember who the radiology group involved was. It may indeed have been Akron Radiology.

Q. Doctor, CT is a pretty sensitive device, isn't it?

A. That's correct.

Q. It can -- depending upon what the structure is, where it is, it can see structures as small as 1 to 2 millimeters, can't it?

A. Again, depends not only on size but on contrast differences.

Q. But otherwise the answer is yes?

A. Under the right circumstances, with the right contrast differences, yes.

Q. Was it Dr. Ali's obligation to this patient -- did the standard of care require him to see what was there to be seen, Doctor?

A. Well, as I've testified here, the standard of care in my opinion is to give as accurate and as complete a reading as possible. I don't

think anybody sees 100 percent.

I don't think anybody reads every single scan throughout his or her entire career 100 percent correctly, and to hold people to that sort of standard and to make that the standard of care makes the practice of medicine and radiology impossible.

So my concept of the standard of care is as I've said. It seems to differ from yours somewhat, but that's my opinion on what it entails.

Q. A tumor that big ought to be seen?

MR. BANAS: Well, I object.

THE COURT: Overruled.

THE WITNESS: I disagree.

MR. SCANLON: I have nothing further. Thank you, Doctor.

THE COURT: Mr. Banas, quickly.

FURTHER REDIRECT EXAMINATION

BY MR. BANAS:

Q. This size that we're seeing, are these the areas that you have interpreted being pulmonary vessels, as opposed to a lesion?

A. I'm not sure I totally understand your question.

Q. Well, apparently -- I have it upside down. Mr. Scanlon has made a big deal out of size, and what I'm suggesting is, is this the area or the size or whatever where, when you looked at Dr. Ali's CT scan, you determined those were pulmonary vessels as opposed to a lesion?

A. Oh, correct.

MR. BANAS: I have nothing further.

THE COURT: Thank you, Doctor, you may step down, sir.

MR. SCANLON: Thank you, Doctor.

* * * * * (End of Excerpt) * * * * *

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