IN THE COURT OF COMMON PLEAS

TURNBULL COUNTY, OHIO

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THOMAS W. MONROE,

Plaintiff,

vs. CASE NO. 00CV2380

JOHN MAXFIELD, M.D.,

et al.,

Defendants.

* * *

Deposition of PHYLLIS T. DOERGER, M.D., Witness herein, called by the Plaintiff for cross-examination pursuant to the Rules of Civil Procedure, taken before me, Mindy R. Huffman, a Notary Public in and for the State of Ohio, at the offices of Mike Mobley Reporting, 334 South Main Street, Dayton, Ohio, on Thursday, February 20, 2003, at 5:01 o'clock p.m.

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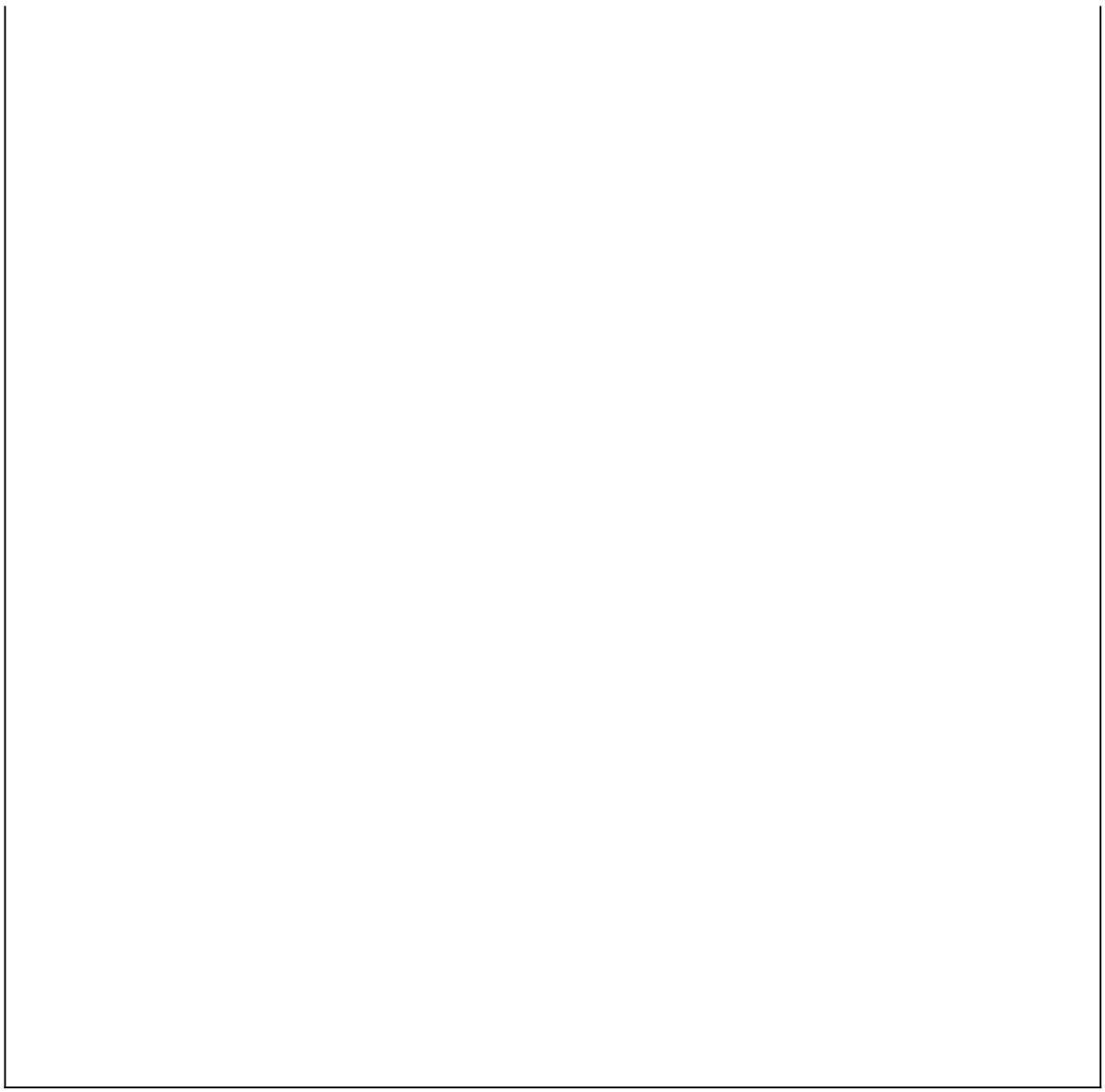

APPEARANCES:

On behalf of the Plaintiff:

Friedman, Domiano & Smith Co., L.P.A.

By: Donna Taylor-Kolis
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Cleveland, Ohio 44113

On behalf of the Defendants:

Hanna, Campbell & Powell

By: Michael Ockerman
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PHYLLIS E. ROGERS, M.D.

of lawful age, witness herein, having been first duly cautioned and sworn, as hereinafter certified, was examined and said as follows:

CROSS-EXAMINATION

BY MS. KOLIS:

Q. Doctor, for identification purposes on the record, can you state your name and professional address?

A. Yes. My name is Phyllis T. -- I use the middle initial T. -- Doerger, D O E R G E R. That's M.D. My address is 9870 Kittywood Drive, all one word, K I T T Y W O O D. That's Cincinnati, Ohio, 45252. My professional address is Miami Valley Hospital in Dayton, if you need that.

Q. Thank you very much, doctor, as I know, my name is Donna Kolis. I represent the estate of Deborah Monroe. It is my understanding from Mr. Ockerman that you have been retained as one of his emergency room physician experts and that you are planning on giving testimony in this matter. Is my understanding correct?

A. Yes, it is.

Q. Okay. Before we get started with

the important questions, we always have to do the background. I noticed today that I never inquired what your hourly fee is going to be. Can you tell me on the record what you charge for deposition testimony per hour?

A. Yes. I charge $350 for an hour of deposition.

Q. Okay. Prior to today's deposition, I received from Michael two documents relative to yourself. One is your curriculum vitae, and one is your expert report. What I would like to do is briefly go through your vitae and talk a little bit about your background and what you do.

I understand that you are, in fact, board certified as an emergency room physician, correct?

A. Correct, and I just got my recertification about a month ago.

Q. Okay. So you were a diplomate of the American Board of Emergency Medicine in July of 1993, and the American college certified you in 1995; is that right?

A. That's right.

Q. And you don't hold any other board certifications; is that correct?

A. Correct.

Q. I think all of your education, et cetera, is just self-explanatory, so I won't go through all of that. I notice that you do involve yourself in some writing in emergency medicine. Have you written anything that would be relevant to the issues in this case?

A. No.

Q. Okay. Therefore, I would assume that you don't have anything in press relative to this case either?

A. No.

Q. Fair assumption, okay. Doctor, can you tell me what you do on a daily basis? Please describe the nature of your practice and where you practice.

A. I practice at Miami Valley Hospital in Dayton, which is the referral tertiary center for the surrounding environment. It is a very busy level-one trauma center. We see 95,000 patients a year, primarily all adults. We have about three to four percent pediatric patients. I am a full-time physician with Miami Valley. In the past, I was working half-time clinically and half-time

administratively I changed that ratio now so that I'm working three quarters of the time clinically and a quarter administratively so that I have a little more free time

Q Okay I think we're speaking the same language. Isn't when you say three quarters of your time is clinical, you mean you're in the emergency room three quarters of the time tending to patients, making diagnoses?

A. Correct.

Q. And --

A. Correct. I was there this morning

Q Okay You know I'm going to ask you this question: How did you meet Mr. Ockerman?

A. Actually this is the first time we physically have met I talked with him on the phone I believe I spoke with him initially from Jeff Schlobert, who is one of his partners I met Jeff through my senior partner at Miami Valley and mentor, Mr. Schneiderman.

Q Okay I'm going to not pronounce your last name correctly, I know, the first time It it Doerger?

A. Doerger, it rhymes with Burger

Q. Is that close enough?

A Yes.

Q Okay Whe did you begin doing medical/legal reviews?

A. Well, I've actually been doing reviews of cases at my place of employment for complaint management, which is a little bit different official reviews for medical issue, probably two years ago

Q. All right. How is it that you started doing medical reviews?

A. My mentor basically thought I would be good at doing it and that I would be a valuable asset to the practice of emergency medicine as being a reviewer and gave my name to Mr Schobert, and he asked me to participate in a case that he couldn't do, that Norm couldn't do

Q That was -- it's a little hard not being with you, but I'm trying to follow That was Dr Schneiderman?

A Norman Schneiderman, yeah He's been -- he was the director at Miami Valley before I took that position, and he has been my mentor for most of my career

MR OCKERMAN: Could, let me pull this speaker closer to her

MS. KOLIS: I appreciate tnat, Michael. That would probably be helpful.

THE WITNESS: Is that better?

BY MS. KOLIS:

Q. That's much better. Thank you. I should have said something earlier. About two years ago, you got involved in a case with Jeffrey Schobert; is that correct?

A. Correct.

Q. And if you're working for Jeffrey or Mike, you're testifying on behalf of a physician, correct?

A. Yes.

Q. How many reviews have you done?

A. Reviews of records or depositions?

Q. Just reviews of records, period, in the medical/legal context, not in the hospital compliance sense, for attorneys.

A. For attorneys, probably in the neighborhood of 10 to 12. I would have to go back and go through my files and count.

Q. Okay. You don't have to do that. I'll accept your word that that's close enough. Have they all been for the law firm of Hanna, Campbell & Powell, or have you made contact with

other offense lawyers?

A Well, actually a couple of other firms have contacted me, so I have worked now with three different law firms

Q And can you tell me who those three firms are?

A The one is -- I think it's Kirkatras I just started working with him.

Q. All right.

A The other one is Mr Brazeau, and I forget the name of that firm. I don't keep the names of the law firms all in my mind

Q These are all law firms that represent physicians; is that correct?

A Correct

Q So you have not provided any cases or testified on behalf of any patients; is that right?

A I had one case where I looked at a record for an attorney for a patient and didn't feel that I was able to provide testimony for that one.

Q In other words, it was a negative review Your review didn't -- you probably indicated to the attorney that you didn't feel

there were merits to the claim?

A. Correct.

Q. Okay. Fair enough. I'm going to guess I know the answer to this, but I have to do my job. You're not listed with any professional expert witness service, are you?

A. No.

Q. Okay. So all the work that you've done has been a virtue of just getting to know some attorneys; is that right?

A. Correct. Actually them getting to know me.

Q. Okay. In that context, you said you've reviewed 10 to 12 cases. Have you, before today, had the opportunity to give a deposition?

A. I have given one previous deposition.

Q. Okay. And have you ever had the ultimate privilege of showing up in a courtroom?

A. Once.

Q. And where was that?

A. I think it was in, I think, if I recall, Cleveland.

Q. Do you recall the case name?

A. No, I don't. I can tell you what it

was about briefly It was about a distal foot fracture.

Q Okay, interesting material You were testifying for an emergency room physician at that time?

A. Yes, I was.

Q. Do you remember what emergency room physician you were testifying for?

A. No The name of the physician escapes me now.

Q. Do you remember the plaintiff's name?

A. No. I can remember her age and weight, but I can't remember her name.

Q. Okay. Can you recall what attorney you were working for?

A. Yeah That was with Jeff Schobert

Q. Okay. And that oad to have been within the last two years, right?

A. I believe so.

Q. Okay. Do you have a recollection of whose courtroom you were in?

A. No.

Q. Okay The judge didn't impress you that much? You don't remember, right?

I find that I don't like to keep needles [illegible] up.

I appreciate that, Doctor.

MR. OCKERMAN: She will remember you, Donna.

MS. KOLIS: Michael, everybody does. We'll just [illegible]

BY MS. K[illegible]

All right. Moving on, I assume, Doctor, you're licensed to practice medicine in the Stat[illegible]

Correct.

Okay. Doctor, have you had the misfortur[illegible] ?

A Yes, I have.

Q Okay. Can you tell me how many times?

A Yes. I have been named in four suits, two of which were -- I was dropped from within a month and two others that were dropped eventually but [illegible] revolve.

Q. What you're telling me is you were involved in four cases named as a defendant, and for whatever reasons, all were dismissed --

A. That's correct.

Q. -- and no payments have been made on your behalf?

A. That's correct.

Q. Okay.

MR. OCKERMAN: Wait for her to get her question out.

THE WITNESS: Okay.

BY MS. KOLIS:

Q. Okay. Did any of those four cases involve your failure to diagnose a dissecting aorta?

A. No.

Q. Okay. Doctor, how many -- you've practiced emergency medicine for about 13 years

A. Correct.

Q. Okay. In your 13-year career, have you always been at Miami Valley Hospital?

A. Yes.

Q. Okay. During that tenure, in 13 years, have you ever had the occasion to make a diagnosis or have a suspicion that someone was having a dissection of their aorta?

MR. OCKERMAN: Objection. Go ahead.

THE WITNESS: Yes.

BY MS. KOLIS:

Q. On how many occasions? Just generally, it doesn't have to be a specific number.

A. Not that commonly, maybe 20 times. That's really a rough estimate.

Q. That's all right. We won't make you go through your patient files and count them. Rough estimates are usually good in those questions.

I understand that you have prepared a report, and I have received a report. The report that I have is dated February 11, 2003. Doctor do you have a copy of that report?

A. Yes, I do.

MS. KOLIS: Okay. I'm going to ask the court reporter to mark that Plaintiff's Exhibit A. She can make a copy and give you back your original if you don't have an extra one.

BY MS. KOLIS:

Q. Is that the only report that you authored in this case?

A. Yes.

Q. All right. Do you have a file relative to this case with you?

I have the medical records and the depositions that I looked at plus one deposition I received just yesterday.

Q. Okay. Do you have correspondence from Michael in any of those files?

A. No, actually I don't.

Q. Okay. Is there a reason you didn't bring that with you?

A. I usually keep that in a separate file at home, just correspondence with attorneys.

Q. Okay. When did Michael originally contact you relative to this case?

A. I believe it was in September in probably -- September of 2001, if I recall correctly.

Q. Okay. But that's just from your recollection because you didn't bring that file with you?

A. Correct. The only time I use those files is when I'm reviewing for billing purposes or I need an address or something like that. They get mixed in with the records, so I don't use them.

Q. Okay. I would ask -- you may not have seen the subpoena that I issued or the

notice of deposition, but as part of my process, I insist on seeing people's correspondence files, so I would ask that you photocopy those documents that you have, prior to the time I send Michael and I trust that he will give them to me Can I secure that agreement from you?

A. Yes.

Q. Okay Let me ask you a few questions about materials that you have reviewed before we get into the substance of your opinions

The report that I have indicates that you reviewed the following medical records: The visit to St. Joseph's Medical Center Howland of July 15th, 1999 You did review that, correct?

A. Right.

Q. The St. Joseph's emergency department records for 7/16/99, correct?

A. Correct.

Q. Autopsy?

A. Correct.

Q. Doctor, have you seen the emergency room report that was generated when Deborah was transferred from the Family Medical Center to the

hospital?

A Yes. It's attached to the St Joseph Emergency Department record, so I was at on there

Q All right So you don't specifically list it out That's in part of the record that you looked at, correct?

A Correct.

Q All right And prior to -- at the time you wrote this report, you had seen the depositions of Dr Maxfield, or Shaw, or Ogawa and or Janiak, correct?

A. Correct.

Q. Having said that, would this refresh your recollection -- if you had already seen or Janiak's deposition, he wasn't deposed until September 13, 2001 Do you think you were ever contacted by Michael in September of 2002, not 2001?

A I really -- it's possible I get dates mixed up a little bit

Q. Okay.

A. It will be clear when I get the letters from Michael.

Q Okay Have you seen the testimony

of Dr. Charles Emmerman?

A. Yes, I did. I just got that yesterday.

Q. Okay. And you recognize that Dr. Emmerman is also an emergency room physician retained by Mr. Ockerman in this matter?

A. Correct.

Q. Okay. Did you have an opportunity to read Dr. Emmerman's testimony?

A. I read it briefly last night.

Q. Okay. I was going to ask you if you differ substantially from anything he said, but that would be too broad of a question. When I get to that section, I'll go through things that I've tabbed, but you did have an opportunity to read it?

A. Correct.

Q. Have you, since the time you authored the report, seen a radiology report written by someone other than Dr. Crawford, the radiologist in this matter?

A. I saw the reports that were attached to the medical record of the radiologist that did the reading at the time of the patient's visit. That's the only radiology reports that I've seen.

Q. Have you, yourself, reviewed any of the films?

A. No.

Q. Okay. Do you read films, as an emergency room doctor?

A. Yes. We have 24-hour radiology coverage, but the plain films are read by the emergency room physicians and reread or overread, however you want to phrase it, usually the following day by the radiologist. All of the more advanced studies, the CTs, are read primarily by the radiologist.

Q. Do you -- as an emergency room physician, do you feel comfortable reading plain chest films?

A. I feel fairly comfortable. We have a discrepancy procedure in place so that should one of the emergency room physicians at my hospital overlook something, there's a mechanism in place that the radiologist will contact the emergency room and make sure that that patient is followed up.

Q. As part of your residency training in emergency room medicine, you were taught the essentials, were you not, of reading a plain

chest film?

A. I believe that's part of medical school training for every specialty, but yes.

Q. Okay. Just checking how good your training was at Wright State. All right. And you have seen no other material, no other reports, no other depositions other than the ones we've just gone through?

A. That's correct.

Q. Okay. Fair enough. Do you know who Dr. Janiak is?

A. Yes, I do.

Q. And in what context?

A. He's actually been to Miami Valley a couple times to visit with Dr. Schneiderman, and I probably was introduced to him at one of those visits. He probably would not know who I was, being the junior partner. I know him by his reputation and the fact that he's a colleague of my mentor. I've heard a lot about him.

Q. To the extent that you're able to address his reputation, what is Dr. Janiak's reputation in emergency medicine?

MR. OCKERMAN: Objection.

THE WITNESS: I think he has an

excellent reputation in emergency medicine

BY MS KOLIS:

Q Okay You know, I forgot to ask you something just because I'm tired, but I'll stay awake long enough to do this deal doctor, do you currently teach emergency room medicine?

A. I do instruct residents and medical students in clinical care while we're seeing patients in the emergency department It's basically bedside, hands-on teaching I have occasionally given lectures, but I'm not currently li ed u to do any lectures right or just a stroke lecture for the courses

Q Can I assume that the Miami Valley Hospital does not have a residency in emergency room medicine, or do you?

A We participate in the integrated residency program. The residency at Wright State does not have its own hospital, so the residents get their rotations spread through all the clinical facilities in this city that are qual f ed

Miami Valley is one of the teaching hospitals for that residency program, and I am a clinical faculty member for the program and a

graduate of the program, so I am pretty familiar with it

Q All right Let's talk about medicine a little bit before we talk about facts In reading Dr Janiak's deposition, you may or may not have noticed that he cited some textbooks that he felt were authoritative or reliable in the area of emergency medicine, and one of them was Rosen & Barkin do you agree with him that that is a reasonably reliable textbook in the area of emergency medicine?

A. I would say it's one of the standards of emergency medicine in terms of being the textbook that is relied on in most programs as being one of their basic texts, yes

Q did they rely on that text in your program when you were training?

A They recommended that we read it, but we used a variety of sources

Q. Okay

A There's no one specific text It's a variety of texts

Q Okay Let's talk about aortic dissection From your training, what would you say the signs and symptoms of aortic dissection

are?

A. From the signs and symptoms, most patients are complaining of a sharp pain of a ripping or a tearing quality that is of maximum intensity at outset and is not changed in the quality of the intensity during the time that they have it, usually not very responsive to pain medication

Q Okay Let's talk about the use of the word usually Would you agree with me that it is well documented in medical literature that although the initial presentation in a large number of cases in most cases is severe pain of a ripping or tearing quality, not all people with dissection of their aorta present with that level of pain?

A. I would say it's true in any case that not all patients present typically for any disease process.

Q Okay Additionally, is it not well documented in the medical literature for emergency room physicians that the administration of a narcotic pain medication which results in some improvement in the person's experience of the level of pain doesn't mean there isn't a

dissection?

MR OCKERMAN: Objection

THE WITNESS: I would say you can't use the response to narcotics to any condition as a sole diagnostic parameter, but it certainly can enter into the decision-making process at some point

BY MS KOLIS:

Q Okay Would you agree with me as a matter of medicine that interscapular pain can indicate a dissection of the descending thoracic aorta?

A. It would be in the differential along with a myriad of other things

Q And that's not the only thing it means, but I'm asking if something is in your constellatio -- if a person has a sudden onset of severe interscapular pain, it could indicate that there's a dissection of the descending thoracic aorta?

A. If it went with a variety of other symptoms that lent itself towards that

Q I gather that you're not critical of Dr Shah in this matter since you don't mention him in your report; is that correct?

A. No, I'm not.

Q. Okay. Were you asked to evaluate the conduct of Dr. Shah?

A. When I spoke with Mr. Ockerman initially, he indicated that Dr. Shah was a defendant in this particular matter. I had Looked at the records at that time for that, but subsequently, apparently Dr. Shah was discontinued from the case, so I did not write my report in that regard.

Q. Okay. Continuing on with my medical points of agreement, would you agree with the following: Pain is by far the most common presenting complaint and is present in 90 percent of the cases of people who go on to have a diagnosis of aortic dissection?

A. I agree with the first part of that. I'm not sure about the 90 percent percentage since those numbers -- I would have to check the recent literature to see what those are. I agree that with the majority of patients, that the pain is an issue.

Q. If you read Rosen & Barkin, page 1821, the 1998 edition says it's about 90 percent with a footnote. That's just a place to look.

MR. OCKERMAN: Objection.

BY MS. KOLI

Q. What is propagation of a dissection?

A. Propagation of a dissection?

Q. Yes

A. Propagation is when the path physiology of a dis[illegible] layer of the aorta - there are three layers -- gets a tear in it and the blood moves beyond the inner layer downward with the area of the blood flow. They can go retrograde or against the area that the blood flow would normally be going in. You get blood spreading out beyond the inner wall of the aorta. When it propagates, that means the blood is spreading beyond that wall

Q. And propagation also means that it's migrating, c[illegible]

A. Right, by spreading out.

Q. Okay. Would you agree with the following medical statement: A history of migration of pain in a pattern consistent with propagation of a dissection of an aorta has a very high diagnostic accuracy for aortic dissection?

MR. OCKERMAN: Objection.

THE WITNESS: Can you repeat that again? I'm not certain what you were saying there.

BY MS. KOLIS:

Q Sure I'll read it verbatim. A history of migration of pain in a pattern consistent with propagation of the dissection of an aorta has a very high diagnostic accuracy for aortic dissection?

MR OKEEFMAN: Objection

THE WITNESS: What might be a true statement if you're looking again at all of those other features that have already led you to consider aortic dissection as one of the main things in your differential

BY MS KOLIS:

Q Doctor, you've carefully read the medical records in Dr Shah's deposition; is that correct?

A. The medical records of the two visits?

Q Right

A. Yes

Q Okay And more specifically, you've read Dr Shah's deposition, correct?

A. Yes, I did.

Q. Okay. Do you agree with the testimony that was proffered by Dr. Maxfield that under the circumstances of the presentation as Dr. Shah understood it to be in his clinical findings, that it was reasonable to suspect that the person might be having an -- he called it an aneurysm of the aorta?

MR. OCKERMAN: Objection.

THE WITNESS: I'm sorry. Are we talking about Dr. Maxfield's deposition right now?

BY MS. KOLIS:

Q. Right.

A. Okay. And your question about the deposition was?

Q. I asked if you agreed with his testimony that under the circumstances that were presented to Dr. Shah, that it was reasonable for him to have within his differential an aneurysm of the aorta?

A. Yes.

Q. Okay. Would you agree with the following medical statement: More than 75 percent of patients with aortic dissection have a

history of chronic hypertension?

MR. OCKERMAN: Objection.

THE WITNESS: I would agree that that's probably in the ballpark. Again, the exact percentage, I wouldn't put my reputation on.

BY MS. KOLIS:

Q. Okay. That's all right. Close enough. Would you agree with the following statement: CAT scan is a reliable tool for evaluating aortic dissection, false positives and false negatives are around five percent?

MR. OCKERMAN: Objection.

THE WITNESS: Again, I would not know how many false positives and false negatives there are, percentage-wise. I know those things exist. In terms of whether it's a reliable test in terms of diagnosing aortic dissection or not, I would say it would be one of several possible choices.

BY MS. KOLIS:

Q. Those choices being CT, TEE, MRI and one other one that I can't remember?

A. Generally ultrasound, you know, and that may depend on the institution that you work

in as to which is the quickest, safest, most reliable, et cetera.

Q. Chest CT is not a tool that diagnoses aortic dissection, per se, is it?

A Are you saying chest CT does not diagnose --

I meant to say chest X ray

A. Okay Chest X ray can sometimes pick up abnormalities related to dissection

Q And those abnormalities would be what?

A. Widening on other associated conditions with it, you can have a widening of the mediastinum

Okay What else?

A. You can see sometimes, depending on whether there's any leakage of blood around the aorta some effusions in the chest which are fluid collections at the bases You can see sometimes, if the dissection is moving backwards into the pericardial sac, a change in the outline of the heart itself or something that looks like a pericarditis There can be a variety of things

Q Okay Let's see if you can agree

with the following statement: A widening of the descending thoracic aorta may be difficult to differentiate from aortic tortuosity?

MR OCKEDMAN: Objection

THE WITNESS: On a radiograph?

BY MS KOLIS:

Q. On a plain chest film.

A. Yes. I agree with that

Q Okay I want to go through your report. and I'm probably going to flip back and forth I have medical records and depositions. But I'm at least somewhat organized today. hopefully did you make notes in any of the depositions that you read? You know, sometimes people write in the margins

A. I don't generally do that My handwriting when I'm in a hurry is very hard to read.

Q. You haven't seen mine

A ine is illegible

Q. So you don't have notes within the depositions?

A. No.

Q. How is it that you formulate a report? Do you dictate as

you go along? What's your methodology?

A. I generally have a fairly good memory for immediate recall, and so I tend to sit down and read them and write my first draft and correct it on the computer at home. Then if I find things that I want to check back in the records, I'll flip back to them again.

Q. Okay. I'm going to ask a random question. These are always fun. If you were an emergency room physician and you were assessing a woman who was 36 years old and her urinalysis comes back to show a large amount of blood in the urine, do you ask that person if they are menstruating?

A. First, I am an emergency room physician.

Q. Sorry. If I was an emergency room physician --

A. You're asking me if I had a woman that was 36 years old and had blood in her urine, would I ask her if she was menstruating?

Q. Yes.

A. The nurses ask the question of the last menstrual period on the nursing paperwork at the top of the page, so it should appear on

there, on my paperwork at my hospital. If it hasn't appeared there and I feel that it is important for me to know that, I would ask the patient.

Q. Okay. Do you see any indication in the emergency room record of St. Joseph's whether or not they ever inquired as to the menstruation cycle of Ms. Monroe?

A. I did not see that.

Q. Okay. Is that a question that should be asked?

A. It depends what you're looking for and what your concerns are. It may have been something that someone knew and simply didn't write down or document.

Q. Okay. All right. I would like to go through several things. Let's -- first of all, let's look at the EMS run report first. Can you access that quickly?

A. Yes.

Q. Okay.

Care records, but it probably should have been stapled t

Q. Okay. Doctor, you don't mention the

Trumbull County EMS incident report and their findings in your report; is that correct?

A. I don't believe so, no.

Q. Okay. Do you agree with me that there's some significant information contained in that EMS incident report relative to what pain Ms. Monroe was experiencing on July 16th, 1999?

A. I see what they've written. I'm not sure what you're asking me. There's information here, yes. I agree that there's information in the EMS report.

Q. Let's establish for purposes of the further questioning in this case, you agree with me that the chief complaint recorded by the ambulance driver who is transporting Ms. Monroe to the emergency room is that her complaint is upper back pain?

A. I see that listed under chief complaint, but I don't know if that was independently obtained by the EMS personnel or obtained verbally from the nursing staff at the Urgent Care there. I'm not sure where that information originated, but I see that that's written that

Q. Wouldn't you -- you have patients

who arrive via ambulance, obviously, to the emergency room, don't you?

A. Correct.

Q. Okay. And if there's a section on the form that says physical assessment and observation, you're going to assume that the EMT techs actually did a physical examination and observed the patient, correct?

A. I would expect that they would have on the physical assessment section their own physical assessment. That's what they should be doing.

Sometimes the chief complaint is not obtained from the patient themselves. For instance, you can have a nursing home patient who is alert, but they take the complaint from the nursing personnel at the nursing home. There's a variety of reasons where the chief complaint may come from the people that are transferring the patient rather than the patient themselves.

Q. Doctor, in this instance, the EMT techs did, in fact, perform a physical assessment and observation. Do you agree with that?

A. I believe so.

Q. I'll read from it: Found this

3x-year-old female standing in doctor's office, complaints of upper back pain. The if she go over, it says exam shows all -- I can't make that word out -- something intact, which was evaluation of upper back. Do you see that?

A. Yes, I do.

Q. Would you expect that an MRI would know the difference between the upper and lower back?

A. I think upper and lower back terms can cover the middle back area, so they're not, to me, as anatomically correct and as helpful as if someone would have said a specific area like within at the T2 level or down at the T7 level when you're talking about the thoracic vertebrae so you know what they're talking about.

Upper back covers a wide area of growth. When you say upper back evaluation, I don't know if that's medical, if that's musculer, if it's one side or the other. It's very nonspecific.

Q. Doctor, doesn't that physical assessment and observation lend support to the fact that Ms. Monroe's complaints were in her upper or mid to upper back?

A I see that the EMS felt that that was what her complaint was, that it was her upper back I'm not sure what you mean by leaning support That's what they got on their assessment, you know, so that's what they reported.

Q Does it also support the information that was given to Dr. Shah at the Family Medical Center in Howland?

A Yes His history is a little more specific It states that the pain is in the mid scapular region, so I have a better idea of where Dr. Shah had the pain reported to him by the patient

Q And when you're reading his testimony and looking at his record and he says mid scapular, where is mid scapular to you?

A In between the scapulae, which are the shoulder blades in the back.

Q Okay And that complaint is consistent with what Ms Monroe died from. Would you agree with that?

A. I would agree that that is -- the complaint of upper back pain or the mid scapular back pain?

Q. Yes.

A. Yes, that would be consistent with it.

Q. Based upon Dr. Shah's testimony and his medical record, do you agree with me that it is clear that Dr. Shah thought that she needed -- she being Ms. Monroe -- needed to have her aorta evaluated?

A. I believe he did, but the flavor that I got from his report and the front sheet indicated that the concern seemed to be more of an aneurysm than of a dissection.

Q. Okay. Do some people -- do some doctors -- I'm sorry, we don't care about any other people. Doctors use that term aneurysm and dissection sometimes interchangeably, do they not?'

A. Not correctly.

Q. I don't disagree with that.

A. I worked at a pathology department. That was before I was a physician. They do tend to use aortic dissection and aneurysm kind of in the same breath because the underlying physiology can be the same, although on pathology you don't always see the aneurysm with a dissection.

They are really quite different in some ways, in the way they present, in the way they are treated, in the way they are discovered. It's a little confusing for people when you lump them all together.

Q. Okay. We wouldn't expect a cardiothoracic surgeon to interchange those, but other practitioners and emergency room personnel, when they say aneurysm, they mean dissection. Would you agree with that?

MR. OCKERMAN: Objection.

THE WITNESS: Not at all. I would say most of the time when they say aneurysm, anybody other than a cardiac physician would be talking about an aneurysm usually in the aorta in the lower area in the abdomen.

BY MS. KOLIS:

Q. In the abdomen?

A. Correct.

Q. Based upon Dr. Shah's testimony and his documentation, he was not concerned about an aneurysm of the abdominal aorta, correct?

A. I don't believe I would say that. Even the front sheet seemed to be more of an aneurysm issue rather than anything else. I

mean, he never mentioned anything about a dissection. I would think his concern was with an aneurysm, and the most common location for that would be in the abdomen.

Doctor, you don't even know whose handwrit[illegible]?

A. No, I don't.

Q. You do know, however, that the handwriting at the bottom of the first page after the observat[illegible] and physical assessment is that of Dr. Sh[illegible]?

A. I would assume so because that's his record an[illegible] the rest of his handwriting here.

Q. Right. It says rule out aneurysm of aorta, co[illegible]?

A. Correct.

Q. Okay. As a matter of fact, Dr. Maxfield has testified that he had a conversat[illegible]

A. That's correct.

Q. And he did testify, did he not, that he knew that the aneurysm that Dr. Shah was concerned with was in the chest. Do you recall that testimony?

MR. OCKERMAN: Objection. Go ahead.

THE WITNESS: I think he said something more to the effect of if he had thought that it was in the chest, that he would not have thought that Dr. Shah's suggestion was unreasonable.

BY MS. KOLIS:

Q. Okay. We'll go through the deposition. Either I asked the question poorly or you didn't understand it.

A. Okay.

Q. The question that I had -- if I can rephrase it, we'll see if that helps at all. Dr. Maxfield's testimony under oath is that he understood that what Dr. Shah was concerned about was an aneurysm in the chest; is that correct?

MR. OCKERMAN: Do you have the page?

MS. KOLIS: Yeah. Let me find it for you. It may take a few. I have a lot of paperclipped pages here.

MR. OCKERMAN: It wasn't that long of a depo.

MS. KOLIS: With good reason, which I'm not permitted to say.

THE WITNESS: I think she's

referring to page 12.

BY MS. KOLIS:

Q. Let me see. It's on page 12, yeah.

A. Correct.

Q. The question was, did he tell you what tests he thought the patients should undergo. I think he said CAT scan, I mean, because from what he considered, that would have been the logical thing to do. Do you agree with what Dr. Shah considered, that a CAT scan was the logical thing to do?

A. He's saying based on what Dr. Shah considered.

Q. Correct, correct.

A. I agree with you on that.

Q. And then I asked him, I said, a CAT scan of what area of the body, and his answer was chest, correct?

A. That's what Dr. Maxfield says, yes.

Q. Okay. So that's clear that Dr. Maxfield understood and knew that Dr. Shah's concern was pathology in the aorta of the chest, not the abdomen, correct?

A. I think he was talking about an aneurysm in the chest.

Q I understand that, but the pathology that he was looking for was in the aorta of the chest, not the abdomen, correct?

A Correct But an aneurysm in the chest, you probably would have seen on a chest X ray, which was done, so I'm not sure that insisting on saying just pathology -- the aorta -- there are a lot of other diseases of the aorta as well I think we need to keep clear with there we're talking about aneurysm or dissection

I don't disagree with that The good or axfield indicates in his discharge summary that caused upon what he saw, he didn't think there was what, do you remember?

MR O'KERMAN: Hold on

THE WITNESS: I think he thread it problem with the aorta Let me look and see what his exact torminology was

BY MS. KOLIS:

Q. I can read it to you It says aortic problem unlikely Is that what it says?

A Aortic problem unlikely, correct

Q Okay And he didn't say whether it was -- whether it was a dissection or an

aneurysm. He's covering the universe that there's no problem with the aorta. Would you agree with that?

A. That's what his wording is, correct.

Q. Fair enough. Why did Dr. Maxfield order a chest X ray on Deborah Monroe?

A. Did he address that in his deposition?

Q. No, because I didn't ask him.

A. Okay. I can't speak exactly why he did it, but I can tell you why I might have in a patient similar to this.

Q. That's not my question.

A. Okay.

Q. You don't know why he ordered the chest X ray, correct?

A. I can tell you some reasons why I think he might have or a reasonable physician might have, but I would think that would be a question that you need to ask Dr. Maxfield.

Q. His clinical indication on the report says chest pain, doesn't it?

A. It does, yes.

Q. Okay. So is that some evidence to you that Deborah Monroe must have told

Dr. Maxfield that she had chest pa

A. He specifically stated in his dictation and the nurses did as well that she denied chest pain.

Q. But nonetheless, he put chest pain as the indication for the chest X ray, didn't he?

A. I'm not sure where that information came from. That might be another question to ask him.

Q. The ordering physician is the one that gives the indication so the radiologist has an indication why the exam is being performed; isn't that true?

A. Not necessarily. In our facility, up to a month ago, the complaint that was given on presentation at the door to the registration personnel, who are not clinical people, was the one that was transferred by computer with the X ray request, and so they sometimes were not correlated at all.

Q. Well, the admitting diagnosis from the hospital itself, the emergency room, says chest pain, doesn't it?

A. The one where he came in -- she came in initially?

MR. OCKERMAN: To the ER, to St. Joseph's ER.

BY MS. KOLIS

Q. Dr. John Maxfield -- it says admitting diagnosis, chest pain. Did you see that, Doctor when you reviewed this case?

A. Which page are you looking at?

Q. We don't have them paginated, but at the top, it says St. Joseph's Health Center.

THE WITNESS: Is she talking about the registration sheet?

MR. OCKERMAN: Is it an all-typed sheet?

BY MS. KOLIS

Q. It's a registration sheet.

A. It's a registration sheet, right. That's probably where -- if their place worked similar to ours where that went onto the X ray report, sometimes that's just the registration person's interpretation, and they are not clinical people. I would have to ask them where that admitting diagnosis c

Q. So, Doctor, you're saying that somebody just, you know -- that they are interpreting -- that when somebody says I have

chest pain, there's an interpretation to that?

A. The people who do the registration who enter their name into the computer sometimes put an admitting complaint on presentation which they may get from a variety of sources, but those are not clinical people, so I would not rely on that information if I were evaluating this patient.

Q. All right. I would like you to look at the emergency department nurse's notes.

A. Qkay.

Q. Okay?

A. Uh-huh.

Q. And this is the triage nurse, apparently, filling this out. It says patient states sudden onset mid back pain. Do you see that?

A. Yes, I do.

Q. Okay. Mid back pain, once again, is not low back pain. Would you agree with that?

A. No. It's mid back pain. Whether that's middle at the waist -- that would be my interpretation of that, but it's not a specific anatomic area of where the pain is.

Q. Okay. And at that point in time,

Ms. Monroe denies chest pain. Would you agree with that?

A. Correct.

Q. That's what the note says. Let me ask you a question: You have the benefit of some hindsight because you've seen the autopsy. Based upon the testimony that you rendered earlier this evening that you understand the process of propagation, isn't it more likely than not, based upon the scenario that we are presented with, that what happened to Deborah Monroe is that her dissection was propagating even as Dr. Maxfield was treating her?

A. That's very possible. The final autopsy report, I think, only indicated a total distance of the dissection of about seven centimeters.

Q. Which would account for the pain starting in one place and moving to another place. Would you agree with that?

A. That's possible. Again, seven centimeters is not very far if you look at how long that really is. I mean, you can get different pain centers or nerves involved when you have different areas involved, and the pain

can be referred to different areas.

Q. I think I can agree with that. Simplistically, would you agree with me that nowhere in this ED discharge note of Dr. Maxfield's does it say that Dr. Maxfield originally was apprised that the patient had chest and mid scapular pain and that he said she never told anyone that. That's not clear in this record at all, is it?

A. It's not stated in that way.

Q. But we do know at the time she presented at the ED, at that point she was denying chest pain.

A. Correct.

Q. That's as much as we know, correct?

A. Correct.

Q. Okay. For what purpose do you believe, based upon the record, did Dr. Maxfield order an abdominal CT?

A. Based on the record, my opinion about what he -- why he ordered that test was to evaluate the patient for kidney stones.

Q. Okay. And why would he think she had kidney stones?

A. He believed she had low back pain.

He believed she had blood in her urine. Those are some of the indications that you would see if you were suspecting a kidney stone.

Q. Okay. Once again on the ordering of the CT, it says ordering diagnosis, abdominal pain. Do you see that?

A. For the CT of the abdomen?

Q. Right.

A. Correct.

Q. Okay. Radiology didn't somehow magically get that off the registration form, did they?

A. I don't know where that came from. I don't know what their procedure is at this facility for how those indications are made on that form.

Q. All right. So that alters your initial answer a little bit because you're speculating. It's clear that on the registration sheet, it says chest pain. That's how you thought that may have got on the chest X ray?

A. Correct. That's happened at my facility before. We just recently changed it.

Q. Okay. So you have no idea how abdominal pain got on the abdominal CT?

A. I would have to ask someone at that facility how those go on the record, if it is dictated by the CT tech, which is what is done at our facility, or by some other personnel

Q The CT tech doesn't order the exam. The exam is ordered by the physician requesting it, correct?

A. That's correct Oftentimes the techs, to assist the radiologist with their billing procedures, will get additional information from the patient They may have some input into that I don't know that for sure, but that sometimes happens.

Q Does'nt Mr Maxfield's discharge from ED -- there are no handwritten notes from Dr. Maxfield anywhere, that you're aware of; is that right?

A. There is some handwriting on the order sheet which is orders, and he has a diagnosis written down there at the bottom of the progress sheet, but I don't see -- you mean any notes like a historical note?

Q Correct.

A. I haven't seen any other than the record

Q. I didn't either. In his discharge summary -- that's what I'm going to call it -- he says patient denies any abdominal pain. Would you agree with that?

A. Are we talking about review of symptoms?

Q. In the history of present illness, he does state there's been no abdominal pain. Do you agree with that?

A. I'm looking here. I believe that to be the case, but I'll recheck it to be sure.

Q. That's fine.

A. Yes, that's what it says.

Q. And it says -- down where it says physical examination, abdomen soft, nontender, good bowel sounds -- would you agree that's what it says?

A. Correct.

Q. Okay. And you're stating that you believe that the CT may have been ordered, I'm assuming, for suspicion *of* kidney stones.

A. That would seem logical based on his report.

Q. Well, if he had obtained a history from her that she was menstruating, would you

exclude or include kidney stones based upon your analysis?

A. You wouldn't be able to do that. These percentages are rough, and I don't want to be held to them strictly, but maybe 10 to 15 percent of patients with kidney stones don't have blood in their urine. If your history and physical is consistent with kidney stones and you want to rule it out, you would rule that out whether or not you have hematuria. The relevance of having a period as the source of the blood really wouldn't enter into it, although it may raise or lower the weight that you give to your pretest probability.

Q. Okay. Should, in your opinion, Dr. Maxfield have called Dr. Shah back after Ms. Monroe presented?

A. No, I don't believe so.

Q. Tell me, Doctor, why you don't believe that.

A. First, he's not the family physician, so you would not be consulting him for ongoing care, and I believe he spoke with him once, and at that time he had obtained the information that he felt necessary to obtain.

Q Ultimately, doctor, the suggestion of Dr Shah that the aorta be CAT-scanned would have saved this young woman's life to a reasonable degree of medical probability Do you agree with that?

A. Whose statement was that, ma'am?

Q Ultimately has Dr Shah's assessment of the situation there and his recommendation for an aorta -- a CAT scan of the aorta have been performed, to a reasonable degree of medical certainty, this young woman's life would have been saved

MR ECKERMANN: Objection

THE WITNESS: I don't know that to be true

BY MS KOLIS:

Q Because you don't have enough information or that's not your area of specialty?

A Primarily not my area of specialty Even if the dissection had been diagnosed at the time of her visit, the likelihood of her surviving or not surviving and having her life or not having her life, I don't have enough information because that's not my area of expertise I would have to defer to the vascular

surgeons on that one

Q And that would be ar gaadi, and you read his testimony, correct?

A. Yes.

Q So you have now got basad upo the autopsy that if an <AT scan had been performed, that the dissection would have been seen?

A If the correct <AT scan had been performed, I would think that it was reasonable that if she was having the pain from that at that time, that it would have been seen.

Q When you say the correct <AT scan, how mean one with contrast? I don't know which one you're saying is the correct one

A. Yeah You have to do the correct amount of contrast If you do a noncontrast CT, you may not have seen it even on that

Q In this instance, she had already undergone a contrast <T of her abdomen Is that a fair statement?

A I don't believe so If he did it for kidney stones, it should have been n noncontrast study.

Q Do you agree with the testimony of ar Emmerman that it would have taken another 15

minutes to do that c rast and CAT-scan the thoracic aorta?

A If they were giving the through there, I believe -- those are fairly quick I would assume that it wouldn't have taken much longer What's institution-wide protocol

Q Okay Let me see if I understand this correctly In this case, your defense of Dr Maxfield is based upon your believing his testimony that she claimed that she never had chest pain or mid scapular pain; is that right?

A. I believe that he firmly believed that the patient's complaint to him was of low back pain, and I think this particular woman was reluctant to even seek initial care and emergency crews and may have been one of the people who tend to minimize their symptoms

I think that based upon what history he got from a patient sitting right in front of him, that he did an appropriate workup That's my defense of Dr Maxfield I think it was a reasonable approach to the history that he obtained from this particular patient

Q All other medical professionals in this case, the ones who assessed that she had mi

scapular pain and then back pain, where they fold this woman? How did that happen?

MR. ECKERMAN: Objection

THE WITNESS: I don't think it's a matter of being fold I think each practitioner is dependent upon relying on an alert patient giving them their own history, and I would put the most weight in my evaluation of the history I'm getting at the time from the patient

If they are telling me they have pain in a certain area and they're not having it anywhere else, it's not radiating anywhere, they're not having any chest pain, I certainly would do a reasonable workup in that regard

Again, that changes the weight of all of the symptoms and signs that you look for and what you're going to evaluate You can't do every test on every patient You have to pick and choose what's reasonable to do, and I think that's what Dr Maxfield did

Q And as a result of his reasonable choices, Deborah Monroe did would you agree with that?

MR. ECKERMAN: Objection

THE WITNESS: No. I would agree that she died of a dissection, which is a disease process, not of anything that Dr. Maxfield did or didn't do.

BY MS. KOLIS:

Q. Well, he failed to diagnose it, didn't he?

A. It wasn't seen at that time.

MS. KOLIS: I don't have any more questions. We're done. Thank you.

Michael, are you going to give me a waiver? What are you guys going to do?

MR. OCKERMAN: Doctor, you have a right to review the transcript, or you can waive that right. We are under some time constraints with starting the trial on March 3rd.

THE WITNESS: Do you wish to guide me in that decision in terms of the time constraints?

MR. OCKERMAN: Do you feel comfortable waiving your signature? You would have seven days from the time it was typed up to review it and make any changes that you feel the court reporter took down inaccurately.

THE WITNESS: Okay. I don't

really -- I mean, it's reasonable to look at it if I can look at it in seven days and that's not going to run into any time problems.

MS. KOLIS: It would have to be read and signed within seven days. I will have the court reporter expedite it. She needs to get it done within 24 hours.

MR. OCKERMAN: Okay. Thank you, Donna.

(Thereupon, Plaintiff's Exhibit A was marked for purposes of identification.)

(Thereupon, the deposition concluded at 6:02 o'clock p.m.)

STATE OF OHIO )
COUNTY OF MONTGOMERY ) SS: CERTIFICATE

I, Mindy R. Huffman, a Notary Public within and for the State of Ohio, duly commissioned and qualified,

DO HEREBY CERTIFY that the above-named PHYLLIS T. DOERGER, M.D., was by me first duly sworn to testify the truth, the whole truth and nothing but the truth; that said testimony was reduced to writing by me stenographically in the presence of the witness and thereafter reduced to typewriting.

I FURTHER CERTIFY that I am not a relative or Attorney of either party nor in any manner interested in the event of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office at Dayton, Ohio, on this 21st day of February, 2003.

Mindy R. Huffman /TMM

MINDY R. HUFFMAN
NOTARY PUBLIC, STATE OF OHIO
My commission expires 3-21-2004

**Look-See Concordance Report**

- - -

UNIQUE WORDS: **1,233**
TOTAL OCCURRENCES: **3,383**
NOISE WORDS: **384**
TOTAL WORDS IN FILE: **9,511**

- - -

SINGLE FILE CONCORDANCE

- - -

CASE SENSITIVE

- - -

INCLUDES **ALL** TEXT OCCURRENCES

- - -

DATES ON

- - -

INCLUDES PURE NUMBERS

- - -

POSSESSIVE **FORMS ON**

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**awake** [1]
*22:5*
**aware** [1]
*52:16*

## – B –

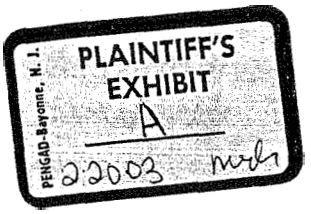
**background** [2]
*5:2, 13*
**backwards** [1]
*31:20*
**ballpark** [1]
*30:4*
**Barkin** [2]
*23:9; 2623*
**Based** [4]
*39:4; 40:20; 49:6; 50:20*
**based** [9]
*43:12; 44:14; 49:9; 50:18; 53:22; 54:1;*

## - W -



## - Y -

PHYLLIS T. DOERGER, M.D.




February 11,2003

Mr. Michael Ockerman
Hanna, Campbell, & Powell, LLP
3737 Embassy Parkway
P.O. Box 5521
Akron, OH 44334

Re: Thomas W. Monroe, etc. v. John Maxfield, M.D., et al.
Trumbull County Common Pleas Court, Case # 00CV2380

Dear Mr. Ockerman:

As you requested, I have reviewed the following in reference to the above mentioned case: the medical records of Mrs. Deborah Monroe's visit to St. Joseph Family Medical Center (Howland) 7/16/99 at 1312 hours, to St. Joseph Health Center Emergency Department 7/16/99 at 1442 hours, her autopsy report, and the depositions of Drs. Maxfield, Shah, Oddi, and Janiak. Based on my review I believe the defendant met the standard of care for the emergency care of Mrs. Monroe.

Briefly, she was a 32 year old woman who developed back pain while at work. Paramedics were called; however, the patient refused transport and arrived on her own for evaluation at St. Joseph-Howland. She had an EKG, was evaluated by Dr. Shah and transferred by ambulance to St. Joseph Health Center ED for further evaluation. There she had an evaluation by Dr. Maxfield which included a history and physical examination, CXR, blood work, urinalysis, and CT scan of the abdomen and pelvis. She received medication to help alleviate her pain and was discharged. Unfortunately, she died the following day of a ruptured dissection of the proximal aorta.

The patient had reported initial chest pain to Dr. Shah but denied this to both the nurse and Dr. Maxfield at the ED. The location of the patient's back pain was also variably reported. The terms "upper" and "lower" back pain axe not clearly defined anatomically. It is clear that Dr. Maxfield believed the patient's pain to be in the lumbar area. Relying on the report of the patient who is there in front of him, he did an appropriate work-up for lower back pain. Finding hematuria, a CT of the abdomen was ordered to look for hydronephrosis (swelling) of the kidneys caused by a kidney stone that would explain pain in the mid to lower back. This CT would also show an enlargement, such as an aneurysm, of the aorta in the abdominal region. An aneurysm in the chest area would be highly unlikely in the face of a normal chest x-ray. Dissection of the aorta, as distinct from an aneurysm, is a difficult diagnosis to make, especially in a patient as young as Mrs. Monroe.

On Dr. Maxfield's examination, she had diffuse tenderness in the lumbar area and his history indicates worsening with movement which pointed to a muscular etiology for her

pain. She got improvement with pain medication, her BP normalized and she "denies any problems at discharge". She was advised to return if worse.

I appreciate the opportunity to review this case. If I can be of any further assistance, please do not hesitate to contact me.

Sincerely,

Phyllis T. Doerger, MD

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