

IN THE COURT OF COMMON PLEAS

TRUMBULL COUNTY, OHIO

THOMAS W. MONROE,

Plaintiff,

-vs-

JUDGE KONTOS

CASE NO. 00CV2380

JOHN MAXFIELD, M.D.,
et al.,

Defendants.

- - - - -

Deposition of CHARLES L. EMERMAN, M.D.,
taken as if upon cross-examination before
Katherine A. Koczan, a Notary Public within and
for the State of Ohio, at the Cleveland Clinic
Foundation, 9500 Euclid Avenue, Cleveland, Ohio,
at 1:50 p.m. on Thursday, January 16, 2003,
pursuant to notice and/or stipulations of
counsel, on behalf of the Plaintiff in this
cause.

- - - - -

MEHLER & HAGESTROM
Court Reporters

CLEVELAND
1750 Midland Building
Cleveland, Ohio 44115
216.621.4984
FAX 621.0050
800.822.0650

AKRON
1015 Key Building
Akron, Ohio 44308
330.535.7300
FAX 535.0050
800.562.7100

APPEARANCES:

Thomas E. Conway, Esq.
Friedman, Domiano & Smith
600 Standard Building
Cleveland, Ohio 44113
(216) 621-0070,

On behalf of the Plaintiff;

Michael Ockerman, Esq.
Hanna, Campbell & Powell
3737 Embassy Parkway
Akron, Ohio 44333
(330) 670-7300,

On behalf of the Defendants.

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E X H I B I T I N D E X

EXHIBIT

MARKED

Plaintiff's Exhibits 1 and 2..... 11
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1 CHARLES L. EMERMAN, M.D., of lawful age,
2 called by the Plaintiff for the purpose of
3 cross-examination, as provided by the Rules of
4 Civil Procedure, being by me first duly sworn, as
5 hereinafter certified, deposed and said as
6 follows:

7 CROSS-EXAMINATION OF CHARLES L. EMERMAN, M.D.

8 BY MR. CONWAY:

9 Q. Doctor, would you please state your full name for
10 the record, spelling your last name for the court
11 reporter?

12 A. Charles Louis, L-o-u-i-s, Emerman, E-m-e-r-m-a-n.

13 Q. Doctor, myself and Donna Kolis represent the
14 family of Deborah Monroe, and I'm here to take
15 your deposition today. You've had your
16 deposition taken before, correct?

17 A. That's correct.

18 Q. Mr. Ockerman is the attorney that's retained you
19 for expert witness consultation in this case,
20 correct?

21 A. That's correct.

22 Q. And he's seated here as well. I'd like to go
23 over just some ground rules for the record.
24 Obviously answer out loud any of your answers
25 with a yes or no and not a shake of the hand or

1 head so that the court reporter can get that
2 down.

3 If at any time you don't understand a
4 question that I ask you, make sure that you ask
5 me to repeat it or rephrase it or in some way let
6 me know that you don't understand the question.
7 If you do answer a question, I'm going to assume
8 and rely upon the fact that you understood it, is
9 that fair?

10 A. That's fine.

11 Q. All right. At any time you want to go back and
12 amend, delete, supplement, add something to any
13 testimony that you've previously given at any
14 time during the deposition, feel free to do so,
15 we will let you go on the record, you can explain
16 any previous answer, is that fair?

17 A. That's fine.

18 Q. Any time you want to take a break and speak with
19 Mr. Ockerman, that's fine. And finally, you
20 realize you're under oath and everything you say
21 today is being taken down by the court reporter,
22 and it has the same significance as if you were
23 in front of a judge and jury, you understand
24 that?

25 A. That's fine.

1 Q. Approximately how many times have you been
2 deposed?

3 A. I don't keep a running count, so I'll have to
4 guess.

5 Q. All right.

6 A. Approximately three dozen.

7 Q. Okay. Doctor, how did you first become involved
8 in reviewing this case on behalf of Dr. Maxfield?

9 A. I was --- I can't remember whether I was contacted
10 by telephone first or not, but I received a
11 letter from Mr. Ockerman.

12 Q. Okay. Did you bring with you your complete file
13 on this case?

14 A. Yes, I did.

15 Q. Oh, could I take a look at it for a second?

16 A. That would be fine.

17 Q. Okay. I assume there was only one draft of your
18 expert report in this particular case?

19 A. Yes, that would be correct.

20 Q. Okay. At the time you undertook the review of
21 this case, it was your understanding that you
22 were reviewing this case on behalf of both
23 Dr. Maxfield as well as Dr. Shah, correct?

24 A. That's correct.

25 Q. Okay. And in going through the different medical

1 records you've been provided with as well as the
2 deposition, I notice that there's no notes or
3 highlighting or anything like that, correct?

4 A. That is correct.

5 Q. All right. Are there any other notes that you
6 kept independent of the chart that I'm looking at
7 right now?

8 A. No, you have my entire file.

9 Q. Did you have the opportunity as part of your
10 review prior to today to look at any of the x-ray
11 or CAT scan films that were taken back on July
12 16th?

13 A. No, I've not reviewed those.

14 Q. Okay. At any point did you ask Mr. Ockerman to
15 provide you with either the x-rays or the CAT
16 scan from July 16th, 1999?

17 A. No, I did not.

18 Q. What's your understanding of the condition from,
19 from which Deborah Monroe died?

20 A. I'm not sure what you're asking me.

21 Q. Okay.

22 A. Are you asking me the cause of death?

23 Q. Yeah.

24 A. She had an aortic dissection.

25 Q. Okay. Is that a condition of medical emergency?

1 A. Yes, it is.

2 Q. All right. If untreated, will that condition
3 cause a person's death?

4 A. Most of the time, yes.

5 Q. Okay. So to a reasonable degree of medical
6 probability, that type of condition will cause a
7 patient's death if left untreated, correct?

8 A. That's correct.

9 Q. Doctor, do you review chest x-rays in the
10 practice, in your practice of emergency clinical
11 medicine?

12 A. Do I ever review chest x-rays?

13 Q. Yeah.

14 A. Is that your question?

15 Q. Yeah.

16 A. Yes, sometimes I look at chest x-rays.

17 Q. How often would it be that you looked at a chest
18 x-ray that you yourself had ordered?

19 A. I do frequently but not always.

20 Q. Okay.

21 A. In my practice there's a radiologist who's
22 reading the x-rays contemporaneously with my
23 seeing the patient, so I might not look at the
24 x-ray and rely on their reading instead.

25 Q. Okay. Have you had occasions where you wanted to

1 look at the x-ray yourself?

2 A. Certainly.

3 Q. Okay. Even with a radiologist present, you would
4 find it useful for yourself to personally look at
5 a patient's chest x-ray, you've had those
6 situations?

7 A. Sometimes.

8 Q. Would it be the standard of care for an emergency
9 room physician to know how to read and interpret
10 a patient's chest x-ray?

11 A. They would be expected to be able to appreciate
12 some conditions but not necessarily everything.
13 Not to the degree of sophistication of a
14 radiologist.

15 Q. All right. The particular condition for which,
16 from which Ms. Monroe died in this case, do you
17 have an opinion as to whether or not an emergency
18 room physician should be able to appreciate that
19 condition from reading a chest x-ray?

20 A. If the patient had a markedly abnormal
21 mediastinum, I would expect them to be able to
22 appreciate that. If there were subtle
23 abnormalities, they might not be able to detect
24 that.

25 Q. Okay. Doctor, I have brought some chest films

1 from July 16th, 1999. And we have a view box
2 here. If you would care to look at, I think
3 there's a total of four plain x-ray films.

4

5 (Thereupon, a discussion was had off
6 the record.)

7

8 Q. Now, maybe we should just do it film by film.
9 The first film you looked at depicted what,
10 doctor?

11 A. This film?

12 Q. The --

13 A. The first film?

14 Q. Yeah, the first film you viewed.

15 A. That's a KUB.

16 Q. All right. And do you see any abnormalities in
17 that film?

18 A. There's maybe a little bit of scoliosis to the
19 right. Otherwise it appears to be normal.

20 Q. Okay. The film right below it that you're
21 looking at, what is --

22 A. That's the remainder of the KUB. Doesn't --

23 Q. The lower film you're looking at right now?

24 A. Is the other half of the KUB, and it again shows
25 a little bit of scoliosis --

1 Q. Any other abnormalities?

2 A. -- to the right.

3 Doesn't show anything else abnormal.

4 MR. CONWAY: Okay. If you can,
5 while he's looking at those, why don't we
6 mark these as exhibits.

7

8 (Thereupon, Plaintiff's Exhibits 1
9 and 2 were marked for purposes of
10 identification.)

11

12 Q. Directing your attention to Plaintiff's Exhibit
13 Number 1?

14 A. Um-hum.

15 Q. That's an x-ray film of what part of the anatomy?

16 A. That would be a PA chest x-ray, and I don't see
17 any particular abnormality that would jump out at
18 me as an emergency physician looking at this.

19 Q. So looking, directing your attention now to
20 Plaintiff's Exhibit Number 2, that's an x-ray of
21 what body part or body area?

22 A. That's a lateral chest x-ray.

23 Q. All right. Do you see any abnormalities in that
24 chest film?

25 A. I would not appreciate any abnormalities of this

1 chest x-ray looking at it as an emergency
2 physician.

3 Q. Okay. As any type of physician do you see any
4 abnormalities in either one of these films?

5 A. They, I would read these x-rays as being normal
6 if I was looking at these x-rays by myself.

7 Q. Okay. To your knowledge, did Dr. Maxfield ever
8 review either one of these chest x-rays on July
9 16th, 1999?

10 A. Not that I'm aware of.

11 Q. Would it have been reasonable for him to do so?

12 A. He had the contemporaneous reading of a
13 radiologist, it would be reasonable for him to
14 rely on that radiologist's reading.

15 Q. Have you ever had a case similar to this present
16 to you where even though you had a radiologist
17 looking at chest films, you wanted to look at the
18 chest films yourself?

19 MR. OCKERMAN: Objection.

20 A. Have I ever looked at the chest x-ray even though
21 a radiologist has read the chest x-rays?

22 Q. Yes.

23 A. Is that your question?

24 Q. Yes.

25 A. Sometimes I do.

1 Q. And have you done so in a case where there's been
2 a presentation similar to Deborah Monroe's
3 emergency room presentation in this case?

4 A. I might have, I don't have any specific
5 recollection of having done so.

6 Q. Have you had an opportunity to review a report
7 from Dr. Weinberg, Susan Weinberg?

8 A. No, I've not.

9 Q. Okay. Have you had an opportunity to discuss
10 Dr. Weinberg's report with Mr. Ockerman or any
11 other attorney representing Dr. Maxfield?

12 A. Mr. Ockerman is, has told me in general terms
13 that Dr. Weinberg sees something abnormal on the
14 abdominal CT, but he's not given me the details
15 of a report.

16 Q. According to Dr. Weinberg's report, she reads
17 these films as showing a moderate dilation of the
18 proximal and mid descending thoracic aorta. Do
19 you see that?

20 A. I've not seen her report, no.

21 Q. Okay. But you don't see that particular
22 condition when you looked at the films, do you?

23 A. I think I'd like to read her report and then I
24 could look at the x-rays and see whether I see
25 what she's talking about.

1 Q. Okay. Well, you didn't see, you didn't see this
2 condition that she just -- excuse me. You didn't
3 see the condition I just read to you when you
4 looked at the films a moment ago, did you?

5 A. Did you just read to me her description in the
6 entirety?

7 Q. Yes, yes.

8 A. You read me the whole sentence?

9 Q. I read you the mediastinum, she saw moderate
10 dilation of the proximal and mid descending
11 thoracic aorta. That's what part of her report
12 indicates her findings, and you did not find
13 those findings when you looked at the x-rays a
14 moment ago, correct?

15 A. If somebody had minimal dilation, I might not be
16 able to see that.

17 Q. Okay. Have you had an opportunity to review
18 Dr. Bruce Janiak's expert witness report?

19 A. I have his deposition, but I don't think I have
20 his report.

21 Q. Okay. Did you have an opportunity to review his
22 deposition?

23 A. Yes.

24 Q. Were you ever provided with Dr. Janiak's expert
25 witness report?

1 A. Not that I know of.

2 Q. Do you know Dr. Janiak?

3 A. Yes, I do.

4 Q. And what do you know his reputation to be?

5 A. He has a good reputation.

6 Q. All right. He's an emergency room physician,
7 emergency medicine physician himself, correct?

8 A. That's correct.

9 Q. And I'll just go by what he indicated in his
10 report and based upon your recollection of his
11 deposition of the subject area we are covering,
12 and my question to you, if you can answer the
13 question, fine, if not -- Dr. Janiak indicates
14 that he felt that the overall evaluation in the
15 emergency department conducted by Dr. Maxfield
16 was not adequate. You're aware of that
17 criticism?

18 A. Are you telling me that's his criticism? I've
19 not seen his report if you are.

20 Q. Well, I'm saying are you familiar with his
21 deposition?

22 A. Yes.

23 Q. Okay. I guess --

24 A. But I've not memorized it.

25 Q. That's exactly why I'm asking it in a shorthand

1 way, the way I'm asking the question. Obviously
2 Dr. Janiak is critical of Dr. Maxfield for the
3 evaluation he did at the emergency room back on
4 July 16th of 1999, you would agree with me,
5 correct?

6 A. I agree that he's critical, yes.

7 Q. All right. Do you agree that a more persistent
8 effort to evaluate Deborah Monroe for thoracic
9 dissecting aneurism needed to be done?

10 A. No, I do not.

11 Q. Okay. Why not?

12 A. This is an atypical presentation of an unusual
13 disease. And I think given the history that
14 Dr. Maxfield obtained, given the chest x-ray
15 reading by the radiologist, given the age of this
16 patient, all those things made an aortic
17 dissection unlikely, and that having gone through
18 the steps that he did, it was not necessary for
19 him to go further.

20 Q. Would the gold standard for diagnosing the
21 thoracic dissecting aneurism be a CT scan of the
22 chest or a transesophageal echogram?

23 MR. OCKERMAN: Objection. Go
24 ahead.

25 A. Those two things that you just read to me do not

1 encompass the list of things that would be done
2 to further image the aorta if you had additional
3 suspicion.

4 Q. Okay.

5 A. So his answer or his criticism there would be
6 incomplete.

7 Q. Okay. What if someone had a suspicion, if an
8 emergency medicine physician had a suspicion that
9 some patient of his was suffering from a thoracic
10 dissecting aneurism, what other diagnostic tests
11 besides a CT scan of the chest or a
12 transesophageal echogram would be indicated?

13 MR. OCKERMAN: Objection.

14 A. You mean if based on the history, the physical
15 examination and the chest x-ray I still had a
16 significant suspicion that there was a thoracic
17 dissection?

18 Q. Yes.

19 A. What would be the tests that I could do to
20 further evaluate that situation?

21 Q. Sure, what tests would you do?

22 A. It would be a chest CT, a transesophageal
23 echocardiogram, an MRI or an aortogram.

24 Q. What order would you perform those tests or
25 imaging?

1 A. You would not perform them in order, you would
2 pick one of those four tests to do.

3 Q. Okay.

4 A. And which test you performed would be dependent
5 on what sort of tests were available to you at
6 the time.

7 Q. What are the signs and symptoms that someone
8 would present with if they were suffering from a
9 thoracic dissecting aneurism?

10 A. Well, the typical signs of a thoracic dissection
11 is sudden onset of exceedingly severe pain, which
12 is usually described as a catastrophic pain.
13 It's of a ripping or tearing nature with chest
14 pain that may or may not radiate to the back, but
15 they almost all have chest pain.

16 Q. All right. Did Deborah Monroe present on July
17 16th, 1999 with that particular complaint?

18 MR. OCKERMAN: Which one?

19 MR. CONWAY: What he just said.

20 We can read it back.

21 MR. OCKERMAN: Sudden onset,
22 severe pain, ripping, tearing with chest
23 pain?

24 MR. CONWAY: Right.

25 A. No.

1 Q. She didn't? Which one of those signs or symptoms
2 or complaints did she present with on July 16th,
3 1999 at the Urgicare Center?

4 A. She had sudden onset of pain, the pain was
5 described as severe, although I note that it
6 apparently wasn't so severe that she had to go to
7 the Urgicare Center by ambulance. The pain is
8 not described as tearing or ripping. She didn't
9 have chest pain, according to the note at the
10 Urgicare Center.

11 Q. What other signs and symptoms would someone have
12 who was suffering from a thoracic dissecting
13 aneurism?

14 A. You want to know all the possible signs of aortic
15 dissection?

16 Q. Sure.

17 A. I'm not sure I can give you an exhaustive list.
18 Occasionally the pain will radiate to the back,
19 they may have signs of a stroke, they may have
20 signs of, of a heart attack. They may have signs
21 of aortic insufficiency. They can have loss of
22 pulses in the extremities, they can have
23 discrepant in blood pressure between, discrepant
24 in, discrepant blood pressure in the different
25 extremities. They can have signs of vascular

1 occlusion. That's all that comes to mind right
2 off the top of my head.

3 Q. Okay. Out of that --

4 A. That was in addition to the things I said before,
5 of course.

6 Q. Sure, sure. These additional complaints or signs
7 and symptoms that you just listed, on July 16th,
8 at either her presentation to the Urgicare Center
9 or the emergency room, did Deborah Monroe have
10 any of those complaints or symptoms?

11 A. She complained of back pain, she did not have any
12 of those other signs or symptoms as best I can
13 remember the list I just gave you.

14 Q. Okay. Where in her back, what area of her back
15 was she complaining of pain?

16 A. To Dr. Shah she complained of mid scapular pain
17 and to Dr. Maxfield she complained of low back
18 pain.

19 Q. Okay. The nurses at the Urgicare Center, what
20 was, where was the location of the pain that she
21 complained of?

22 A. They didn't specify where in her back she was
23 having the pain.

24 Q. And just so we have the same page, if I can see
25 your, what you've got.

1 Okay. We do. Nursing assessment, in that
2 box there, while at work today she developed
3 sudden onset of back pain and chest. Okay. So
4 that was what a nursing history and assessment
5 showed, correct?

6 A. Yes, I agree that's what that says.

7 Q. And then further in that nursing assessment, it
8 says severe back pain between the shoulders.

9 A. Yes, I agree with that.

10 Q. Okay. So the nurses do get a history from
11 Deborah Monroe that it's, the pain is between her
12 shoulders, correct?

13 A. Yes.

14 Q. Okay. And that would be the same history that
15 Dr. Shah got, correct?

16 A. Yes.

17 Q. Now, Dr. Shah, who you were asked to evaluate the
18 case on his behalf, appropriately referred
19 Deborah Monroe from this Urgicare Center to the
20 St. Joseph's emergency room, correct?

21 A. That's correct.

22 Q. All right. And you would agree that Dr. Shah
23 acted reasonably and appropriate and prudently in
24 doing so, correct?

25 A. Yes.

1 Q. And in fact, she was taken by ambulance from the
2 Urgicare Center to the St. Joe's emergency room,
3 correct?

4 A. That's correct.

5 Q. And you would agree that that was prudent and
6 appropriate that she was taken by means of
7 ambulance, correct?

8 A. Yes.

9 Q. Now, Dr. Shah did raise the issue of whether or
10 not Deborah Monroe was suffering from an
11 aneurism, correct?

12 A. That's correct.

13 Q. All right. And I believe he indicated that she
14 was suffering from severe back pain, had
15 hypertension and that he felt that it was
16 necessary to rule out an aneurism of the abdomen,
17 or does it say aorta?

18 A. On his diagnosis it says rule out aneurism of
19 aorta. On the front sheet of the diagnosis it
20 says rule out aneurism of the abdomen.

21 Q. Okay. The aorta travels through the thoracic
22 area down to the abdomen area, correct?

23 A. That's correct.

24 Q. Is hypertension or high blood pressure a risk
25 factor for developing a dissecting thoracic

1 aneurism?

2 A. Hypertension is a risk factor for developing a
3 dissection and it is a risk factor for developing
4 an aneurism.

5 Q. Okay. For the record, she was hypertensive on
6 July 16th, 1999, correct?

7 A. That's correct.

8 Q. All right. How would you characterize her blood
9 pressure of 180 over 90 upon her presentation at
10 the Urgicare Center?

11 A. The systolic blood pressure is elevated, the
12 diastolic blood pressure is at the upper limit of
13 normal.

14 Q. All right. She would have been considered
15 hypertensive, correct, suffering from
16 hypertension based upon that blood pressure?

17 A. Are you asking me whether I would diagnose her
18 with hypertension based upon a single blood
19 pressure or whether that blood pressure is an
20 elevated blood pressure?

21 Q. Well, she was hypertensive or had an elevated
22 blood pressure at the time she presented,
23 correct? I'm not trying to confuse you, I
24 promise. She had a high blood pressure of, which
25 was 180 over 90 when she presented to the

1 Urgicare Center, correct?

2 A. That's correct.

3 Q. All right. And she had a history of having high
4 blood pressure to the point where she was on
5 blood pressure medication, correct?

6 A. That's correct.

7 Q. Okay. So I'm just asking, at the time she
8 presented, she had a history of being
9 hypertensive, correct?

10 A. That's correct.

11 Q. Okay. That can be a risk factor for either an
12 aneurism or a dissection, correct?

13 A. That's correct.

14 Q. At the Urgicare Center it appears that an EKG was
15 done?

16 A. I believe that's correct.

17 Q. All right. Based upon the symptoms of chest
18 pain, was that an appropriate diagnostic decision
19 made by Dr. Shah to have that done?

20 A. Yes, that's correct.

21 Q. After Deborah Monroe left the Urgicare Center and
22 went by ambulance to St. Joe's Hospital, she was
23 seen at that time by nurses at St. Joe's Hospital
24 prior to being seen by Dr. Maxfield, correct?

25 A. That's correct.

1 Q. All right. If you could, you have the St. Joe's
2 medical records in front of you, right?

3 A. Yes, that's correct.

4 Q. Okay. At the time she presented to the emergency
5 department at St. Joe's, she indicated to the
6 nurses that she was still suffering from a pain,
7 rating it, despite having pain medication, of an
8 8 on a scale up to 10, correct?

9 A. You're not talking about the triage note now?

10 Q. No, I'm looking down at the nurse's notes.

11 A. You're looking at the nurse's progress notes?

12 Q. Correct.

13 A. At 4:42 p.m. she states that the pain was, states
14 pain still better but rates it 8 out of 10.

15 Q. Okay. Which means her perception of the pain is
16 that it is still relatively severe, correct?

17 A. Yes.

18 Q. The location in which she indicated to the triage
19 nurses at St. Joe's where her pain was was the
20 mid back, correct?

21 A. That's correct.

22 Q. All right. In fact, patient states sudden onset,
23 mid back pain.

24 A. That's correct.

25 Q. Okay. The fact that she describes that pain as a

1 throbbing pain, does that have or relate to --
2 strike that.

3 In retrospect, we know what she was suffering
4 from at the time she presented to the emergency
5 department on July 16th, correct?

6 A. In retrospect?

7 Q. Yes.

8 A. Do we know what she had?

9 Q. Yes.

10 A. Yes, in retrospect we can review the autopsy and
11 see what she had.

12 Q. And you would agree that at the time she did
13 present to both the Urgicare Center as well as
14 St. Joe's emergency room, she was suffering from
15 a thoracic dissecting aneurism, correct?

16 A. She was suffering from a, from a thoracic
17 dissection.

18 Q. And so at the time Dr. Maxfield saw and treated
19 her, she was suffering from that condition,
20 correct?

21 MR. OCKERMAN: Retrospectively?

22 Q. Sure, retrospectively.

23 A. That's correct.

24 Q. We know that, retrospectively we know that she
25 had that condition at the time that Dr. Maxfield

1 saw her, correct?

2 A. That's correct.

3 Q. All right. Now, in retrospect, doctor, the
4 description of the pain as a throbbing pain,
5 would that be consistent with someone who's
6 suffering from a thoracic aneurism?

7 A. The description of the pain as throbbing would be
8 atypical, not typical of a patient with a
9 dissection.

10 Q. Okay.

11 A. The vast majority of patients with an aortic
12 dissection describe their pain as ripping or
13 tearing.

14 Q. Okay. Are there patients that you've come across
15 in your experience as an emergency medicine
16 physician who have complained of throbbing pain
17 and were later found to have had a dissecting
18 thoracic aneurism?

19 A. I've never seen anybody that I can recall who
20 described their pain as throbbing when they had
21 an aortic dissection.

22 Q. On the way over to St. Joe's Hospital after she
23 left the Urgicare Center, she was evaluated by
24 the EMS technicians, correct?

25 MR. OCKERMAN: Objection.

1 Q. And I believe you have those records?

2 A. Yes, I have those records.

3 Q. Okay. And once again, where did she complain
4 that the pain was located?

5 A. Their chief complaint is listed as upper back
6 pain.

7 Q. All right. And later, down under the section
8 physical assessment and observations, it
9 indicates that she was complaining of upper back
10 pain, correct?

11 A. Yes, I see that.

12 Q. And then later on it says pain upon palpation of
13 upper back?

14 A. That's correct.

15 Q. All right. Doctor, anywhere in the medical
16 records from the Urgicare Center, the EMS run
17 sheet or the nursing notes and triage from
18 St. Joe's, is there any reference to lower back
19 pain made by Deborah Monroe?

20 A. You mean specifically have they documented that
21 she has lower back pain as opposed to back pain
22 without specifying the location or back pain
23 where they have specified upper back pain, is
24 that your question?

25 Q. No. My question is, did any of the medical

1 providers at the Urgicare Center characterize Ms.
2 Monroe's back pain as being lower back pain?

3 A. Not that I see, no.

4 Q. All right. Did any of the EMS technicians
5 characterize Ms. Monroe's back pain as lower back
6 pain?

7 A. Not that I see here, no.

8 Q. Did any of the other medical providers at
9 St. Joseph's emergency room or emergency
10 department, with the exception of Dr. Maxfield,
11 characterize Deborah Monroe's back pain as being
12 lower back pain?

13 A. Not that I see, no.

14 Q. Do you have any criticism, doctor, of any of the
15 medical personnel who were involved in the care
16 and treatment of Deborah Monroe while she was at
17 the Urgicare Center?

18 A. No.

19 Q. Okay. Do you have any criticism of any of the
20 medical care rendered by any of the EMS
21 technicians who transported Deborah Monroe to
22 St. Joe's Hospital?

23 A. No.

24 Q. Okay. Do you have any criticism of any of the
25 medical providers or medical personnel who were

1 involved in Deborah Monroe's care and treatment
2 while she was at St. Joseph's Hospital?

3 A. Well, I'm not in a position to comment on the
4 standards for a radiologist reading a chest x-ray
5 and, or an abdominal CT. If there is something
6 on the chest x-ray or the abdominal CT that a
7 radiologist would be expected to discover, then I
8 would be critical of them, but I'm not in a
9 position to establish what those standards are.

10 Q. So your answer would be you're not critical of
11 the radiologist in this case, correct?

12 A. That's not at all what I said.

13 Q. Okay. I don't understand how you can have a
14 separate opinion of being critical of someone
15 where you don't know what the standard of care
16 for it, I guess that's what -- maybe we are on
17 two different levels here.

18 MR. OCKERMAN: I think so.

19 Q. You're not offering an opinion regarding the
20 standard of care for a radiologist reviewing the
21 chest films, are you?

22 A. No, I'm not.

23 Q. Okay. Do you, as we sit here, have an opinion to
24 a reasonable degree of medical probability that
25 any of the medical providers at St. Joe's

1 Hospital fell below the standard of care in their
2 care and treatment of Deborah Monroe?

3 MR. OCKERMAN: Objection. My
4 objection is based upon his, what he just
5 said. You're trying to lump them all
6 together.

7 Q. No, I'm not. I want to know whether he's going
8 to -- I, we all know what I want to know. I want
9 to know whether you're going to go into court,
10 doctor, and offer an opinion criticizing someone
11 from your position as an emergency physician.
12 That's all I want to know. If you're going to
13 criticize the nurses, if you have a criticism
14 that you feel is competent to a reasonable degree
15 of medical probability regarding radiology or CAT
16 scan technicians or whatever, I just want to know
17 that right now.

18 MR. OCKERMAN: Talking --

19 Q. Or are you limiting your criticism or are you
20 limiting your review of this case to the
21 emergency medicine aspect? That's what I really
22 want to know.

23 MR. OCKERMAN: If I can clear it
24 up for you?

25 MR. CONWAY: Sure.

1 MR. OCKERMAN: He's not going to
2 have any criticisms of anyone -- he cannot
3 speak to the radiologist. You're not going
4 to ask him to criticize the radiologist?

5 MR. CONWAY: That's fine, then he
6 doesn't have a criticism, he doesn't have
7 a, or an opinion?

8 MR. OCKERMAN: Of the radiologist?

9 MR. CONWAY: Right.

10 Q. Would it make it easier if I asked it that way?
11 You're not going to be offering an opinion
12 regarding the radiologist in this case, correct?

13 A. That's correct.

14 Q. All right. And you don't have a criticism of any
15 of the other medical providers who were involved
16 in the emergency department care and treatment of
17 Deborah Monroe, correct?

18 A. That's correct.

19 Q. Okay. In light of the fact that apparently
20 Dr. Maxfield's information regarding the location
21 of the pain in this case conflicted with other
22 medical providers' description of where the pain
23 was located, would it have been reasonable on
24 Dr. Maxfield's part to pick up a phone and call
25 Dr. Shah and discuss this patient with Dr. Shah?

1 A. I believe the testimony is that they did discuss
2 this patient by telephone.

3 Q. Okay. So it would have been, I mean, and I'm
4 asking you, is that reasonable?

5 A. For Dr. Shah to call Dr. Maxfield and tell him
6 that he was sending a patient in and tell him
7 why?

8 Q. Yeah.

9 A. Yes, that's reasonable.

10 Q. Okay. Is that prudent medical care?

11 A. Yeah, it's perfectly fine to do that, yes.

12 Q. When in the chronology of events did that
13 telephone call take place, did it take place
14 before Deborah Monroe arrived or did that phone
15 call take place after Deborah Monroe arrived at
16 the St. Joe's emergency room?

17 A. Well, Dr. Shah called Dr. Maxfield before he sent
18 the patient from the Urgicare Center to the
19 emergency department.

20 Q. Okay. Were there any telephone calls that took
21 place or conversations between Dr. Maxfield and
22 anyone at the Urgicare Center after Deborah
23 Monroe arrived at the emergency room?

24 A. No.

25 Q. Okay. Would it have been reasonable after

1 Dr. Maxfield did his examination and took his
2 history from this patient, that in light of the
3 apparent contradictions as to the location of the
4 pain, would it have been reasonable for him to
5 pick up the phone and just call and discuss this
6 patient again with Dr. Shah?

7 A. There would have been no particular point to
8 doing that.

9 Q. Why not?

10 A. Well, Dr. Shah got the history that he got and
11 Dr. Maxfield got the history that he, that he
12 got. What would Dr. Shah say if Dr. Maxfield
13 called him? There would be nothing for him to
14 say. He would say, this is the history I got,
15 and Dr. Maxfield would say, well, the patient
16 denies that now. The conversation would not have
17 produced any additional results.

18 Q. Is there any indication anywhere in
19 Dr. Maxfield's notes that the patient was even
20 asked by Dr. Maxfield whether she had upper back
21 pain or mid back pain?

22 A. She told him that she had lower back pain.

23 Q. My question, though, is did Dr. Maxfield ever ask
24 Deborah Monroe whether or not she was suffering
25 from upper back pain or mid back pain?

1 A. No, he's stated that there's no radiation of the
2 pain. So if she had low back pain and upper back
3 pain, then I would expect him to have said that
4 there was radiation of the pain instead of saying
5 that there's no radiation of the pain.

6 Q. So I guess my answer is at no point does
7 Dr. Maxfield explicitly ask Deborah Monroe
8 whether she's suffering from upper back pain or
9 mid back pain, correct?

10 A. No, I don't agree with that interpretation of
11 what I just said. He specifically documented
12 that she complains of diffuse lower back pain,
13 and then his next sentence is that there is no
14 radiation of the pain.

15 Q. Okay. What's your interpretation of, based upon
16 that charting, what's your interpretation of the
17 conversation that would have taken place between
18 Dr. Maxfield and Deborah Monroe regarding the
19 location of her back pain?

20 A. That it was limited to the lower back.

21 Q. What would be involved -- strike that.

22 Are you familiar with how CT scans are done?

23 A. Generally, yes.

24 Q. Okay. How much more involved would it have been
25 in this particular case when Deborah Monroe was

1 already having an abdominal CT scan done to
2 continue up and do a chest CT scan?

3 A. It would have required an additional bolus of
4 dye.

5 Q. How much longer would the procedure have taken?

6 A. About another ten minutes.

7 Q. Okay. Would there be any possible risk in giving
8 the patient another bolus of dye to have the CT
9 scan done immediately following the abdominal
10 scan?

11 A. The risk is the risk of the dye itself, which is
12 the risk of an allergic reaction or the risk of
13 impairing the renal function.

14 Q. Okay. At the time that Deborah Monroe was at
15 St. Joe's emergency department, she was suffering
16 from chest pain, correct?

17 A. No.

18 Q. She was not?

19 A. That's correct.

20 Q. Okay. Was she suffering from chest pain at all
21 when she was in the emergency room at St. Joe's
22 Hospital?

23 A. She denied it twice.

24 Q. Okay. Do you know why an EKG was ordered then at
25 St. Joe's Hospital if she was denying chest pain

1 at that time?

2 A. In a hypertensive patient with back pain,
3 sometimes physicians will get an EKG. I don't
4 recall that you asked that of Dr. Maxfield what
5 his thinking was there.

6 Q. I didn't take Dr. Maxfield's depo, so is it --

7 A. Actually, this is a copy, the one that I have in
8 here is a copy of the Howland, not a separate
9 one.

10 Q. Okay. Was there, do you recall whether or not
11 there was an EKG done at St. Joe's emergency
12 department?

13 A. Well, now I've got myself confused, so let me
14 just --

15 Q. I don't want to confuse you.

16 A. Let me just look.

17 Q. We will stop for a second and let you go through
18 whatever records you want to go through.

19

20 (Thereupon, a discussion was had off
21 the record.)

22

23 A. Okay. I do not see that a separate EKG was
24 ordered at the St. Joe's emergency department.

25 Q. What were the indications for the chest film

1 being ordered, do you know? And I'm talking
2 about the chest films that were ordered at
3 St. Joe's in the emergency department.

4 A. Oh, he may have ordered it -- let me just look at
5 his order sheet.

6 Q. Sure.

7 A. He may have ordered an abdominal series which
8 would have included a chest x-ray. Chest,
9 portable. No, he ordered a portable chest x-ray.
10 No, I can't specifically tell you that.

11 Although, if you were considering the diagnosis
12 of an aortic dissection, then doing a chest CT
13 would be doing an appropriate -- sorry. A chest
14 x-ray would have been an appropriate first step.

15 Q. Okay. Why would that be an appropriate first
16 step?

17 A. Because it's highly unlikely for you to have an
18 aortic dissection with a normal chest x-ray.

19 Q. Would that be true even if it was an abdominal
20 aortic dissection?

21 A. Well, you generally do not get abdominal aortic
22 dissections. You generally get abdominal
23 aneurisms.

24 Q. All right. I guess I just, I didn't follow your
25 last answer that the chest film would be a good

1 first start if you're looking for what?

2 A. For an aortic dissection.

3 Q. All right. Where does the aorta usually dissect?

4 A. In the thorax.

5 Q. So it's more common for an aorta to dissect in
6 the thorax than the abdominal area, correct?

7 A. That's correct.

8 Q. It indicates for clinical indication as to why
9 the chest x-rays, the PA and lateral chest x-rays
10 are being ordered, clinical indication is listed
11 as chest pain. Does that have any significance?

12 A. I see that it says that twice in the medical
13 record they stated that she denies chest pain.

14 Q. What physician's responsible for providing the
15 information to the radiologist as to the clinical
16 indication for a certain type of radiology film?

17 A. Dr. Maxfield.

18 Q. Okay. Why don't -- do you have a copy of your
19 report with you?

20 A. Yes, I do.

21 Q. Okay.

22 A. Or maybe you took it from me.

23 Q. I've got your other -- you know what, before we
24 get to your report, let me ask you a question
25 about it.

1 A. Yes, I have it.

2 Q. All right. Going back to this September 13th,
3 2001 letter from Mr. Ockerman to you, where he
4 says, would you please review these materials and
5 give me a call upon completion of your review, I
6 do not need a written report at this time, rather
7 I would prefer to discuss your opinions via
8 telephone. You received this letter from
9 Mr. Ockerman, correct?

10 A. Yes.

11 Q. And I assume that after you reviewed these
12 matters, you gave him a call and discussed what
13 your opinions based upon your review of the
14 materials was?

15 A. I would presume so, although I have no specific
16 recollection of a conversation 15 months ago.

17 Q. And no notes to document the conversation,
18 correct?

19 A. That's correct.

20 Q. All right. Going to your report, and you have a
21 copy in front of you, right, doctor?

22 A. Yes, I do.

23 Q. Okay. First paragraph, last sentence, "On
24 arrival she complained of severe back pains
25 between the shoulders, which felt like muscle

1 cramps." Where are you, where, what arrival are
2 you referring to, the arrival at St. Joseph's
3 Hospital?

4 A. Yes, that's -- no, the arrival at the Urgicare
5 Center.

6 Q. Then you indicate, "Dr. Shah obtained a history
7 that the patient had severe midscapular back
8 pain, which had developed suddenly." That was
9 your determination from a review of the medical
10 records, correct?

11 A. Yes.

12 Q. Okay. Let's just go paragraph by paragraph.
13 What you've stated in your first paragraph
14 beginning, "My review indicates," remains your
15 understanding of what the facts are today,
16 correct?

17 A. Well, there's a discrepancy in the age between
18 the autopsy report and the Howland.

19 Q. Right.

20 A. And the, and the St. Joseph's records.

21 Q. Correct. Other than that, you're satisfied with
22 your first paragraph here, correct?

23 A. Yes.

24 Q. All right. Second paragraph, anything you want
25 to change starting with, "Dr. Shah obtained a

1 history that the patient had severe midscapular
2 back pain, which had developed suddenly"? As we
3 sit here today, are you satisfied with that
4 paragraph?

5 A. Yes.

6 Q. Third paragraph ending with, "The triage nurse
7 noted a history of sudden onset of mid back pain
8 described as throbbing." Okay. As we sit here
9 today, you're satisfied with that third
10 paragraph?

11 A. Yes. I guess I would add to that that the
12 patient also denied to the triage nurse at
13 St. Joseph's that she had chest pain.

14 Q. Can chest pain associated with a dissecting
15 thoracic aneurism wax and wane?

16 A. Is it possible or --

17 Q. Yes.

18 A. -- does it generally?

19 Q. Is it possible?

20 A. I suppose anything's possible.

21 Q. All right. The next paragraph starting with,
22 "Dr. Maxfield," are you satisfied with that
23 paragraph as we sit here today?

24 A. Yes.

25 Q. Okay. Is cigarette smoking a risk factor for

1 dissecting thoracic aneurisms?

2 A. Not that I recall reading about, no.

3 Q. Going to the --

4 A. Sorry?

5 Q. Going to the last paragraph on the first page
6 starting with, "Laboratory evaluation," and then
7 continuing on to the next page, satisfied with
8 that paragraph as we sit here today?

9 A. Yes.

10 Q. What would tests which measure amylase and lipase
11 be used to diagnose?

12 A. They're generally used to diagnose pancreatitis,
13 which occasionally can present as back pain.

14 Q. Are they useful, those levels, in diagnosing any
15 other type of conditions?

16 A. Rarely they can be elevated in a small bowel
17 obstruction.

18 Q. Going to the next paragraph on the second page,
19 "The patient was given additional pain
20 medication," are you satisfied with that
21 paragraph?

22 A. Yes.

23 Q. After reviewing the depositions and the medical
24 records, were you able to determine what
25 Dr. Maxfield attributed the back pain to?

1 A. Well, his, what I have as his diagnosis, which is
2 back pain.

3 Q. Right. Did Dr. Maxfield, to your knowledge, from
4 your review of these medical records or the
5 deposition, ever determine what the cause of the
6 back pain was or offer any type of differential
7 diagnosis as to what the cause of the back pain
8 was?

9 A. Well, he has evaluated her for the differential
10 diagnosis but he's not written that down.

11 Q. What's your interpretation of the differential
12 diagnosis that Dr. Maxfield had at the time that
13 he saw Deborah Monroe?

14 A. Well, I think he was evaluating her to determine
15 whether she had signs or symptoms of aortic
16 dissection. He did a workup for kidney stones,
17 he did a workup for abdominal problems, urinary
18 tract infection, those are the things that were
19 evaluated.

20 Q. If he was going to do a workup regarding an
21 aortic dissection, why wouldn't he have ordered a
22 chest CT?

23 A. Because the patient's history, her age are not
24 typical of aortic dissection and -- I think I
25 gave you all this before at the beginning. Did

1 you want me to go back through it again?

2 Q. No, I'm just wondering why, if your
3 interpretation is that on his differential
4 diagnosis, which by the way, is set no where in
5 writing, correct, Dr. Maxfield never sets down a
6 written differential diagnosis, does he?

7 A. Well, I think he said in his differential
8 diagnosis that kidney stones are unlikely on the
9 basis of history, physical and tests, an aortic
10 problem is unlikely on the basis of history,
11 physical, tests and he details that, so he
12 actually has --

13 Q. Okay.

14 A. -- put down some of his differential diagnosis.
15 I don't know if that's the entirety of his
16 differential diagnosis.

17 Q. Getting back to it's your interpretation that he
18 was considering an aortic aneurism, is that
19 correct, or a dissecting aortic aneurism? I
20 don't mean to misstate.

21 A. I think he has considered the possibility of
22 aortic dissection.

23 Q. All right.

24 A. And has determined, based on the information that
25 he had, that it did not warrant further testing.

1 Q. Okay. Now, he did do an abdominal CT, correct?

2 A. That's correct.

3 Q. Now, the aorta runs, as we have indicated before,
4 through the thoracic area and the abdominal area,
5 correct?

6 A. That's correct.

7 Q. Now, a useful diagnostic tool in diagnosing an
8 abdominal aortic dissection is an abdominal CT,
9 correct?

10 A. Yes, that's correct.

11 Q. All right. Now, you say based upon the patient's
12 history and her age, that Dr. Maxfield was
13 justified in not doing a chest CT to look for the
14 aortic dissection occurring in the thoracic area,
15 correct?

16 A. Well, you've restated my testimony in a way that
17 did not --

18 Q. I didn't mean to do that.

19 A. You've restated my testimony in a way that did
20 not encompass the entirety of what I said.

21 Q. Okay. I want to be clear on this. So I'll reask
22 it. We have got two parts of the aorta here,
23 correct, we have got the thoracic part and the
24 abdominal part, correct?

25 A. Yes, that's correct.

1 Q. All right. I'm not a doctor and I'm not the most
2 articulate person, so bear with me, all right?

3 MR. OCKERMAN: That's your
4 opinion.

5 Q. I know I'm not articulate. Dr. Maxfield,
6 according to you, is considering that this
7 patient may have an aortic dissection, correct?

8 A. Well, he's aware that that was the concern of the
9 doctor in Howland.

10 Q. Okay.

11 A. And so he has taken a history, done a physical
12 examination and done a chest x-ray. The history,
13 the physical and the chest x-ray do not point
14 toward an aortic dissection.

15 Q. He does, however, do an abdominal CT, correct?

16 A. That's correct.

17 Q. All right. Which would pick up a dissection if
18 it was occurring in the abdominal area, correct?

19 A. Well, you generally do not get dissections in the
20 abdominal area. The dissection from the thoracic
21 area may traverse into the abdomen, but
22 generally, if you're doing an abdominal CT
23 because you're concerned about a problem with
24 aorta, you're generally looking for an aneurism,
25 not a dissection. There's, of course, other

1 things that you do an abdominal CT for, which is,
2 appears to be the case here, you incidentally
3 also see the aorta.

4 Q. And what else do you think he was using that CT
5 scan to look for in this particular case other
6 than the aorta?

7 A. Well, with an abdominal CT scan, you would see
8 the entire contents of the abdomen, so you would
9 see the liver, you would see the spleen, you
10 would see the bowel, you would see whether
11 there's any fat stranding around the appendix,
12 and in this particular case, because she has
13 blood in her urine, it appears he was looking for
14 kidney stones.

15 Q. And after doing that abdominal CT, he was able to
16 rule out any of those organs or areas as being
17 the cause of her pain, correct?

18 A. Well, if you have an abdominal CT, that doesn't
19 always show kidney stones, but it usually does.

20 Q. So more likely than not, he was able to rule out
21 the areas in the, that would be encompassed by
22 the abdominal CT as being the cause of her back
23 pain, correct?

24 A. I'm sorry, say that one more time.

25 Q. Okay. More likely than not, to a reasonable

1 degree of probability, Dr. Maxfield was able to
2 rule out any of the areas that were able to be
3 viewed on the abdominal CT scan as being the
4 cause of Deborah Monroe's back pain --

5 A. That's correct.

6 Q. -- right?

7 Okay. I think we were at the second
8 paragraph, and you're happy with the way that's
9 written, "The patient was given additional pain
10 medication"?

11 A. Yes.

12 Q. All right. And then we have the next paragraph,
13 it is your medical opinion that Dr. Shah met the
14 standard of care in this instance, correct?

15 A. Yes.

16 Q. Then going to the last two sentences, "In this
17 instance it was reasonable to obtain and rely
18 upon the radiologist's interpretation of the
19 abdominal and pelvic CT," correct?

20 A. Yes.

21 Q. Okay. And then it says, "A chest CT was not
22 required under the standard of care based on the
23 complaints given to Dr. Maxfield," correct?

24 A. Yes.

25 Q. All right. Are you happy with the way this

1 paragraph is written?

2 A. Yes.

3 Q. All right. And obviously, the final paragraph,
4 you're satisfied with that, correct?

5 A. Yes.

6 Q. Is there anything else you want to add to this,
7 to your opinions here as set forth in your
8 report, or do these encompass your opinions in
9 this case?

10 A. Including the issues we have talked about in
11 deposition?

12 Q. Including the issues we have talked about in
13 deposition.

14 A. Yes, I'm happy with that.

15 Q. All right. So between your report and all of the
16 issues we have comprehensively covered here, you
17 have no further opinions to offer, is that
18 correct?

19 A. That's correct.

20 Q. All right. Do you know a Dr. Oddi?

21 A. No, I do not. I see that he's provided a
22 deposition here, but I don't know him.

23 Q. Okay. Did you have an opportunity to read his
24 deposition?

25 A. Yes, I did.

1 Q. Did you read Dr. Shah -- was Dr. Shah deposed?

2 Did you read Dr. Shah's deposition?

3 A. Yes, I did.

4 Q. Have you done work before for Mr. Ockerman or
5 Mr. Schobert or anyone else at their law firm of
6 Hanna, Campbell & Powell?

7 A. I've reviewed one other case for them which I
8 received about the same time as this case.

9 Q. All right. Which attorney asked you to review
10 that one?

11 A. Jeff Schobert.

12 Q. How much an hour were you charging Mr. Ockerman
13 and Mr. Schobert to review?

14 A. \$300 an hour.

15 Q. How much an hour for the deposition?

16 A. \$300 an hour.

17 Q. And how much will your trial testimony be?

18 A. The same.

19 Q. You plan to testify live at trial?

20 A. Yes, I do.

21 Q. Did you do any type of medical literature
22 research in preparation for this deposition or in
23 connection with the review of this case?

24 A. No, I'm generally familiar with the issues
25 relevant to this case.

1 Q. Have you ever written on anything that would
2 relate to the issues that we are dealing with
3 here today?

4 A. No, I don't believe I have.

5 Q. Okay. Have you ever testified in a case which
6 involved the same or similar medical conditions
7 as are at issue in this case?

8 A. One time.

9 Q. Okay. And do you recall that case, who the
10 attorneys were?

11 A. It was an attorney in Chicago, I don't recall
12 their name. It was about six years ago.

13 Q. Okay. And what was the issue in that case?

14 A. It was a gentleman who had a typical presentation
15 of aortic dissection with a marked abnormal chest
16 x-ray where there was a delay in, there was a
17 delay in the institution of care and a delay in
18 the reporting of the chest x-ray to the emergency
19 physician.

20 Q. And I don't want to be presumptuous, but since it
21 was in Chicago, did you happen to be on the
22 plaintiff's side of that one?

23 A. In that one, yes.

24 Q. Okay. Defense versus plaintiff, what's the
25 relative --

1
2 (Thereupon, a discussion was had off
3 the record.)
4

5 Q. What's the, what's your breakdown as far as the
6 percentage of cases you review on behalf of
7 doctor versus patients?

8 A. Sometimes I review cases in support of hospitals.

9 Q. Okay. Let's put the hospitals and the doctors on
10 one side and the patient on the other side.

11 What's your overall breakdown as far as
12 percentage of what you review?

13 A. It's about two-thirds defense, one-third
14 plaintiffs.

15 Q. Okay. And in cases that involve local cases,
16 that are in the local area of Cleveland here, it
17 would be almost all defense, correct?

18 A. Generally it's mostly defense in the Cleveland
19 area, yes.

20 Q. Do you still have that deposition from that case?

21 A. No.

22 Q. Do you know what the case's name was or anything
23 like that?

24 A. No, I don't.

25 Q. What area of medicine -- strike that.

1 Would you have done anything different in
2 this case than Dr. Maxfield if you were the
3 emergency room physician at St. Joe's Hospital
4 when Deborah Monroe presented?

5 A. No, I think given this presentation, I would have
6 proceeded as he has.

7 Q. What would your differential diagnosis have been
8 based upon the history, her history as given to
9 medical providers on July 16th, 1999?

10 A. I don't understand what you're asking me.

11 Q. Okay. You're the emergency medicine physician
12 seeing Deborah Monroe at St. Joseph's Hospital,
13 okay? First of all, does the standard of care
14 require you, as a physician, to obtain the EMS
15 record and review that?

16 A. The EMS records are frequently not available to
17 us when we see the patient.

18 Q. If they are available, would the standard of care
19 dictate that you at least look at that if it's
20 available?

21 A. If they are available to me, then I would look at
22 them.

23 Q. Okay. If the medical record from the Urgicare
24 Center was available, would that be something
25 that you, as a reasonable emergency room

1 physician, would like to look at as well?

2 A. Yes, I would.

3 Q. What was my question, would you have done
4 anything different?

5 A. I answered that one.

6 Q. Okay. Have you ever treated a patient who's had
7 a dissecting thoracic aneurism?

8 A. I have once or twice, although I have no specific
9 recollection of the cases.

10 Q. Okay. Did those patients survive your treatment?

11 A. I don't remember the cases.

12 Q. Do you know the physician who authored the
13 radiology report for Dr. Maxfield?

14 MR. OCKERMAN: Dr. Crawford?

15 MR. CONWAY: No, the expert
16 report.

17 MR. OCKERMAN: Oh, Dr. Weinberg.

18 Dr. Weinberg, Susan Weinberg.

19 Q. Do you know her?

20 A. No, I do not.

21 Q. Do you know Dr. Crawford?

22 A. No.

23 Q. Did you know Dr. Maxfield?

24 A. No.

25 Q. Okay. Socially, professionally?

1 A. I have no idea who he is.

2 Q. What emergency medicine textbook is authoritative
3 in this area?

4 A. There would not be any textbooks that would be
5 authoritative in the legal sense of the word.

6 Q. Do you own any textbooks that have as a subject
7 matter emergency medicine?

8 A. Yes.

9 Q. Which ones do you own?

10 A. Oh, let's see. I have a copy of the Tintinalli,
11 I have an outdated copy of Rosen, I think I have
12 a copy of Schwartz.

13 Q. Those are pretty expensive books, aren't they?

14 A. I suppose so, yes.

15 Q. All right. So I assume you find them helpful and
16 reliable?

17 A. I can't tell you that I find them reliable. I
18 sometimes look at them.

19 Q. Why do you sometimes look at them?

20 A. Sometimes they will have lists in there that I
21 want to look at, they may have references that I
22 want to look at.

23 Q. So sometimes they may have some information in
24 there that you find to be reliable?

25 A. Sometimes they have information in there that I

1 find useful.

2 Q. Are you a member of any professional
3 organizations?

4 A. Yes, I am.

5 Q. What?

6 A. The American Medical Association, the American
7 College of Emergency Physicians and the Society
8 for Academic Emergency Medicine.

9 Q. Okay. The American College of Emergency
10 Physicians, are you on any internal board in that
11 organization?

12 A. Not currently, no.

13 Q. Okay. Have you ever been?

14 A. Yes.

15 Q. Have you ever -- okay. What boards?

16 A. Well, I was on committees, not boards. They
17 don't have boards.

18 Q. Okay. What committees were they?

19 A. I was on the scientific review committee, I was
20 on the research committee and also on the
21 academic affairs committee. I was also on the
22 awards committee.

23 Q. Do you find this to be a reputable organization?

24 A. Yes.

25 Q. Have you ever been an officer in that

1 organization?

2 A. No.

3 Q. How long have you been a member of the American
4 College of Emergency Physicians?

5 A. 25 years.

6 Q. Okay. Do you read any --

7 A. Not quite that long.

8 Q. Do you read any of the literature or guidelines
9 that they put out?

10 A. Sometimes.

11 Q. Are there any competing organizations for
12 emergency physicians in this country?

13 A. Yes.

14 Q. What other organizations would compete with or be
15 in the same class as American College of
16 Emergency Physicians?

17 A. Well, I wouldn't classify them as competing
18 organizations, but there are alternative
19 organizations.

20 Q. Okay. Such as?

21 A. The American Osteopathic College of Emergency
22 Physicians or the American Academy of Emergency
23 Medicine.

24 Q. Okay. Which one's the largest?

25 A. The American College of Emergency Physicians.

1 Q. Okay. And the osteopathic, is that confined to
2 physicians who are osteopathic physicians?

3 A. I don't know what their membership requirements
4 are.

5 Q. You're not a member in that, right?

6 A. That's correct.

7 Q. Are you a member of the other one you mentioned?

8 A. No, I'm not.

9 Q. Are you going to be offering an opinion as to
10 whether or not -- well, I take it from your
11 report you're not offering an opinion as to
12 whether or not mister, or excuse me, strike that.

13 Would you agree that had Deborah Monroe been
14 diagnosed by Dr. Maxfield with a thoracic
15 dissecting aneurism during her emergency
16 department visit of July 16th, 1999, she more
17 likely than not would have been able to have been
18 treated and would have survived?

19 A. I think that's probably true, although aortic
20 dissections is not -- the survival from aortic
21 dissections is not something I've researched.

22 Q. But you'd agree that more likely than not she
23 would have survived had she been diagnosed and
24 treated?

25 A. You mean survive the immediate post-operative

1 period if she was going to undergo that?

2 Q. Yes.

3 A. I'm not going to be offering opinions about that.

4 Q. Would you agree more likely than not she would
5 have survived?

6 A. I think I just said I wasn't going to be offering
7 opinions about that.

8 Q. Okay. Do you have an opinion on that?

9 A. No, I do not.

10 Q. Sometimes people have opinions but they just say
11 they are not going to offer them, but it's still
12 fair game to ask them what their opinions are,
13 all right?

14 So I take it you're not going to be offering
15 any type of opinion on survivability or life
16 expectancy, is that correct?

17 A. That's correct.

18 Q. Had she been diagnosed and treated, correct?

19 A. That's correct.

20 Q. What's an expert review form, did they ask you to
21 fill out --

22 A. They sent me a form asking for my hourly rate and
23 my address and my Social Security number.

24 Q. Any other, anything else on that form that you
25 recall?

1 A. Not that I can recall, no.

2 Q. I've never heard of one. Just wondering.

3 MR. OCKERMAN: HCP form.

4 MR. CONWAY: What's that?

5 MR. OCKERMAN: Hanna, Campbell &
6 Powell.

7 MR. CONWAY: It's good that
8 private enterprise is capable of generating
9 bureaucratic paperwork as well, right?

10 If I can have one second, I think
11 we are about done.

12 - - - - -
13 (Off the record.)

14 - - - - -
15 Q. Have you ever been sued, doctor?

16 A. Yes, I have.

17 Q. Okay. Has money ever been paid out on behalf of
18 the care and treatment you rendered to a patient?

19 MR. OCKERMAN: Objection.

20 A. No money's ever been paid out on my behalf.

21 Q. Okay. Would it be correct that -- well, let me
22 ask this. What area of medicine do you consider
23 yourself to be an expert in?

24 A. Emergency medicine.

25 MR. CONWAY: Okay. I guess all we

1 need to do is if we could mark his report,
2 and this will be Exhibit Number 3.

3

4 (Thereupon, Plaintiff's Exhibit 3
5 was marked for purposes of identification.)

6

7 THE WITNESS: I'll read.

8 MR. CONWAY: All right.

9 THE WITNESS: Is this mine or is
10 this one yours?

11 MR. OCKERMAN: Doctor, you have
12 the right to review this transcript or you
13 can waive that right. You told her you'll
14 review it, and Tom, can we have 14 days to
15 review it?

16 MR. CONWAY: Yes.

17 MR. OCKERMAN: And doctor, where
18 do you want it sent to?

19

20

CHARLES L. EMERMAN, M.D.

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C E R T I F I C A T E

The State of Ohio,) SS:
County of Cuyahoga.)

I, Katherine A. Koczan, a Notary Public within and for the State of Ohio, authorized to administer oaths and to take and certify depositions, do hereby certify that the above-named witness was by me, before the giving of their deposition, first duly sworn to testify the truth, the whole truth, and nothing but the truth; that the deposition as above-set forth was reduced to writing by me by means of stenotypy, and was later transcribed into typewriting under my direction; that this is a true record of the testimony given by the witness; that said deposition was taken at the aforementioned time, date and place, pursuant to notice or stipulation of counsel; and that I am not a relative or employee or attorney of any of the parties, or a relative or employee of such attorney, or financially interested in this action; that I am not, nor is the court reporting firm with which I am affiliated, under a contract as defined in Civil Rule 28(D).

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office, at Cleveland, Ohio, this 27th day of January A.D. 20 03.

Katherine A. Koczan
Katherine A. Koczan, Notary Public, State of Ohio
1750 Midland Building, Cleveland, Ohio 44115
My commission expires August 27, 2006

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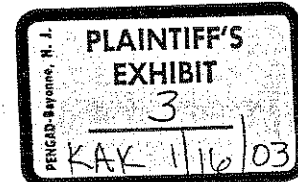
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2500 MetroHealth Drive
Cleveland, Ohio 44124
Department of Emergency Medicine
October 24, 2001



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

Re: Thomas W. Monroe, etc. v. John Maxfield, M.D. et al.

Dear Mr. Ockerman,

At your request, I have reviewed various materials for the purpose of rendering an expert medical opinion as to the care provided by John Maxfield, M.D. and Vijay Shah, M.D. in the above captioned case. I have been given the following documents to review:

- 1) Medical records of the St. Joseph Health Center Emergency Department
- 2) Medical records of the St. Joseph Family Medical Center
- 3) Complaint filed in Trumbull County, Ohio
- 4) Autopsy report
- 5) Deposition of John Maxfield, M.D.

My review indicates that Deborah Monroe, 32 years of age at the time of this incident, presented to the St. Joseph Family Medical Center on 7/16/99 with complaints of chest and back pain. The initial vital signs showed a temperature of 97 degrees with a respiratory rate of 12, pulse of 84, and blood pressure of 180/90. The triage nurse obtained a history that the patient had developed sudden onset of back and chest pain. She had refused transportation by EMS. On arrival she complained of severe back pains between the shoulders, which felt like muscle cramps.

Dr. Shah obtained a history that the patient had severe midscapular back pain, which had developed suddenly. The pain might have started in the chest but there was no radiation to the pain. On examination the lungs were clear and the heart sounds were normal. The capillary refill was normal and the circulation was good. The electrocardiogram showed no acute ischemic changes. The case was discussed with the St. Joseph's Emergency Department. The patient was transferred for further evaluation and possible CT.

The patient arrived at the St. Joseph Emergency Department with complaints of back pain. The initial vital signs showed a temperature of 97.9 degrees with a pulse of 76, respiratory rate of 20, and blood pressure of 154/100. The triage nurse noted a history of sudden onset of mid back pain described as throbbing.

Dr. Maxfield evaluated the patient and obtained a history of sudden onset of diffuse lower back pain with onset 3 hours prior to arrival. There was no radiation. The patient denied numbness or weakness. There was no abdominal pain, chest pain, nausea, or vomiting. The patient had a past history of hypertension and was a cigarette smoker. On examination the patient had a normal heart and lung examination. There was diffuse lumbar tenderness.

Laboratory evaluation showed a normal amylase and lipase. The white blood count was mildly elevated. The urinalysis showed a small amount of hematuria. The patient was given Demerol with improvement in her pain. A

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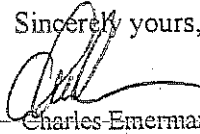
chest radiograph was interpreted by the radiologist with a negative preliminary report. A spiral CT of the abdomen and pelvis was obtained which was interpreted as showing no evidence of obstruction or calculus.

The patient was given additional pain medication during her emergency department stay. The repeat blood pressure was 140/82. Mrs. Monroe was discharged with instructions with a diagnosis of back pain. The patient expired on 7/16/99 and the autopsy revealed a ruptured dissecting thoracic aneurysm with a rupture that began 3 cm below the arch and dissected down 7 cm.

It is my medical opinion that Dr. Shah met the standard of care in this instance. It was reasonable for him to refer the patient to the emergency department for further evaluation. It is further my opinion that Dr. Maxfield met the standard of care in this instance. The deposition testimony and Dr. Maxfield's documentation indicates that the patient complained of low back pain and had lumbar tenderness. The chest radiograph as interpreted by the radiologist did not show signs of an aneurysm. In this instance it was reasonable to obtain and rely upon the radiologist's interpretation of the abdominal and pelvic CT. A chest CT was not required under the standard of care based on the complaints given to Dr. Maxfield.

My opinions are based on my medical experience and review of the above materials. I would be happy to review additional information, as it becomes available.

Sincerely yours,



Charles Emerman, MD