IN THE COURT OF COMMON PLEAS

TRUMBULL COUNTY, OHIO

THOMAS W. MONROE, Administrator :
Of the Estate of Deborah Monroe,:
Deceased,

Plaintiff,

CASE NO. 00-CV-2380

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

- - -

Video Deposition of SUSAN WEINBERG, M.D., taken by the defendants as upon cross-examination, pursuant to the Ohio Rules of Civil Procedure and pursuant to agreement by counsel as to the time and place and stipulations hereinafter set forth, at the offices of Litigation Support Services, 817 Main Street, Suite 400, Cincinnati, Ohio, at 2:15 p.m. on Saturday the 8th day of February, 2003, before Margaret M. Lynch, Registered Professional Reporter, a Notary Public within and for the State of Ohio.

APPEARANCES:

On Behalf of the plaintiff,
DONNA TAYLOR-KOLIS
Friedman, Domiano & Smith
6th Floor Standard Building
1370 Ontario Suite 600
Cleveland, Ohio 44113

On behalf of the defendant,
MICHAEL OCKERMAN
Hanna, Campbell & Powell
3737 Embassy Parkway
Akron, Ohio 44334

S T I P U L A T I O N S

IT IS stipulated by counsel for the respective parties that the deposition of SUSAN WEINBERG, M.D., may be taken at this time by the defendant as upon cross-examination and pursuant to the Federal Rules of Civil Procedure, all other legal formalities being waived by agreement; that the deposition may be taken in stenotype by the Notary Public-Court Reporter and transcribed by her out of the presence of said parties; that the transcribed deposition was submitted to the deponent for examination and signature and that signature may be affixed out of the presence of the Notary Public-Court Reporter.

- - -

I N D E X

Defendant's Exhibits A-0 ere ma ked previously to the deposition by Mr. Ockerman.

(Exhibits marked to the deposition were retained by Mr. Ockerman, Counsel for Defendant.)

(Video deposition began at 2:27 p.m.
On Saturday, February 8, 2003.)

SUSAN WEINBERG, M. D.,
being duly sworn, was examined and
testified as follows:

EXAMINATION

BY MR. OCKERMAN:

Q. Good afternoon. Would you please introduce yourself to the jury?

A. I'm Dr. Susan Weinberg.

Q. Dr. Weinberg, what is your occupation?

A. I'm a diagnostic radiologist.

Q. How long have you been a diagnostic radiologist?

A. For twenty-two years.

Q. Doctor, could you briefly explain to the jury what a general diagnostic radiologist does?

A. A general diagnostic radiologist is responsible for interpreting the following studies: We do barium studies; plane x-rays. We interpret and monitor ultrasounds, CAT scans, magnetic resonance

imaging scans, and perform many routine interventional studies.

Q. Doctor, could you tell the jury the type of practice that you have?

A. We have a general diagnostic practice, probably the busiest in the Tri-State Cincinnati area. We do 200,000 exams. We limit ourselves primarily to adult radiology, and we offer all imaging modalities.

Q. And where is it that you practice your field of radiology?

A. My primary practice is at Bethesda North Hospital. We also run an imaging center immediately adjacent to the hospital called Medi Center North Diagnostics. That imaging center has three MRI scanners, and also provides ultrasound and mammography. All other modalities are performed at the hospital.

Q. Doctor, in your typical day, what type of different exams would you be presented with to interpret?

A. I interpret all general diagnostic exams. In the course of a day, I probably

interpret general diagnostic radiologic exams about seventy, seventy-five percent of the time. And by general diagnostic exams I mean general plane films, barium studies, ultrasound, CAT scans, and MRI's. I probably spend another twenty-five percent of the time limited to specialized MRI and mammographic examinations.

Q. And, Doctor, when I was asking you questions you were referring to "we," who is "we"?

A. My group, Northeast Radiology.

Q. And how many radiologists are in your group?

A. We have eleven.

Q. Are you a full-time radiologist?

A. I am.

Q. Are you licensed to practice radiology in any states within the United States of America?

A. Yes.

Q. What states?

A. In the state of Ohio as well as California.

Q. Doctor, what percentage of time do you spend in the active clinical practice of radiology?

A. One hundred percent.

Q. Doctor, at some point in time I asked you to review radiology films on a Deborah Monroe; do you recall when that was?

A. That was in November of 2001.

Q. And, Doctor, can you briefly tell the jury how it is 'that I presented these x-rays to you?

A. You called me on the phone. I believe it was several weeks before we came up with that date that would work for both of us. And you came to the office. And, basically, you told me you wanted me to look at a number of different cases. You came to the office. You brought lots of chest x-rays for me to look at, probably five or six different chest x-rays on different patients, and you asked me to interpret each without any clinical history. Hers was included within that five or six cases. I blindly

interpreted them all without the clinical history, and I also believe on that date you showed me two or three other cases.

Q. And, Doctor, when I asked you to interpret the cases, did you know which case I was coming for you to look at?

A. I did not.

Q. Did I then ask you then to take another look at -- a closer look at any specific case?

A. You did not.

Q. Did I ask you to look at -- then go back and look at Deborah Monroe's case, the chest x-rays specifically?

A. You did not ask me to look at it again. You asked me to create a report on it.

Q. Okay. Did 1 also then give you the reports that were generated by the radiologist, Dr. Crawford, in this matter?

A. You did.

Q. You issued a report in this case?

A. To you, I did.

Q. And do you know approximately when

met in November of 2001?

A. I would say, I do not have a date on that particular letter, which is unfortunate, but I'm certain that I dictated it when I still had a recollection of what I said, so I would say it was probably within thirty days after we -- our meeting.

Q. And, Doctor, do you feel qualified to give opinions in regard to the radiology films presented in this case?

A. I do.

Q. And why is that? Why do you feel qualified?

A. I feel as though I'm an expert in my field. I practice diagnostic radiology, and I have done it for a very long time, and I feel I'm very competent in that regard.

Q. And, Doctor, did you after reviewing the chest x-rays and the report generated by the radiologist in this matter, did you arrive at an opinion based upon reasonable medical probability based upon your training and experience whether

the radiologist who interpreted these films, interpreted the chest x-ray films of Deborah Monroe on July 16th, 1999 met the appropriate standard of care, did you arrive at an opinion?

A. I did arrive at that opinion.

Q. What is that opinion?

A. That he fell below the standard.

Q. And why are you staying that?

A. Because I believe that there were additional findings on the film that were not mentioned in the report.

Q. Doctor, I would like to take a few minutes and look at the chest x-rays specifically in this case.

Doctor, I'm going to hand you what we have previously marked as Defendant's Exhibit A and B. Can you put those up on the view box behind you?

A. (Witness complied.) I have them up.

Q. And, Doctor, could you explain to the jury what your findings are on that x-ray, those x-rays?

A. Negative as well as positive?

Q. Yes.

A. I think that most radiologists, myself included, have a specific search pattern when we look at x-rays. I, personally, have the following search pattern: I begin by looking at the heart and determining whether or not the cardiac pericardiac silhouette is normal and in this case it is.

Q. Let me stop you there. When you're saying cardiac pericardiac silhouette, in layman's terms what are you talking about?

A. I'm talking about the shadow on the x-ray that represents the heart as well as the pericardium. Unfortunately on the x-ray, you can have changes in the heart and/or the pericardium and you just have an enlargement of the cardiac pericardiac silhouette. You don't -- you're unable to specifically say whether or not the enlargement is coming from the heart or process within the heart per say or within the lining of the heart. So, we tend to generalize when we say cardiac pericardiac silhouette because we can't tell exactly

where our process might be coming from, which of those two structures, that would result in an enlargement of that shadow.

Q. And when we talk about the pericardium, what are we speaking about?

A. The pericardium is the lining, the outside surface lining of the heart.

Q. All right. That was your first step. What is your next step as a radiologist in interpreting chest x-rays?

A. Since the heart is in the middle part of the chest, I continue evaluating the mid structures of the chest and those are the mediastinal structures within the chest. Now, when I look at the mediastinum I try to be specific as to where the abnormalities are within the mediastinum. If in fact there are changes in the upper mediastinum and widening of the upper mediastinum, I try to say whether or not that area is widened or abnormal. In this case, the upper mediastinum is normal.

Then I direct my attention to the mid to low mediastinum. In this

particular case, the structures that course in that area include the aorta. So I'm looking at the aortic shadow, and this particular patient the ascending aorta or the upper part of -- or the ascending aorta or the first part of aortic shadow I don't see any definite abnormalities. That looks normal to me.

Q. And would that part of the aorta be called?

A. The ascending aorta. That looks normal to me in this particular patient.

But once I direct my attention to the first part of the descending aorta, that shadow is too prominent to me for a patient who is thirty years of age.

Q. And how do you know how old -- by looking at this x-ray, how do you know how old the patient is?

A. Well, it's standard practice to put the patient's birth date on the films and I always look at that. Similarly, we always have a date of birth for patients on her requisitions and I always look at that because it's part of the

radiologist's responsibility to have a fund of knowledge for normal versus abnormal and different age ranges.

Q. *Go* ahead. You were completing your review.

A. In this particular patient, when I looked at the films.that I was given to look at, I always **look** at the birth date so I knew the patient was thirty. And so, in my mind I had to refer to my internal frame of reference; what's normal or abnormal in a thirty year old?

Q. And I believe Deborah Monroe is thirty-two at this time?

A. Thirty-two. In this particular case, the first part of the descending thoracic aorta is too prominent for a thirty-two year old patient. And when you showed me the cases initially I think I pointed out to you that this proximal or first part of the descending thoracic aorta was too prominent for a patient of that age range. And you can see that as you progress from the proximal descending thoracic aorta to the distal or the lower

part of the descending thoracic aorta that there is a change in the contour; that the distal descending thoracic aorta is much more tightly pulled into the mediastinum as opposed to the upper aspect of the descending thoracic aorta.

Q. Go ahead with your -- how you would continue on in your overall review of the chest x-rays.

A. Next I turn my attention to the lungs. Actually, before I do that, I look at the rest of the mediastinal structures and I certainly take a good long look at the hilar region and the lower mediastinum. In this case, those structures are all normal. What's particularly nice about having a frontal as well as a lateral view of the chest as we have the opportunity to assess the structures in two different planes.

Then I turn my attention to the lungs. The lungs in this particular case are normal on both the frontal as well as the lateral projections of the chest.

chest you're going to look at the hemidiaphragms to see if those are in fact normal in position on the frontal as well as the lateral view of the chest and in this case they are. We need to direct our attention then as I do in my search pattern to the pleural surfaces that surround the lungs 'to make sure that there are no abnormalities, masses, areas of abnormal thickening or fluid collections in those particular structures. We look at the frontal as well as the lateral view of the chest. And in this particular case, all of those structures are normal as well. We then, or I do at least, in this -- in my search pattern, direct my attention to the bony structures. I look at the ribs. I look at the clavicle, sternum, the scapula as well as the vertebral bodies and I take advantage of the two views that we have available to us and assess the bony. structures.

Finally, I look at the soft tissues surrounding the chest and determine

in those areas. That's my particular search pattern, my way of approaching chest x-rays.

Q. And based upon your review of this chest x-ray, what was your understanding as to the clinical indications of it being taken?

A. I didn't -- when I was first presented with this chest film, I wasn't given any history.

Q. Okay. You subsequently learned of history?

A. Yes.

Q. And I'm handing you what's been marked as Defendant's Exhibit D. What is the clinical information given to the radiologist at that time?

A. Chest pain.

Q. And, Doctor, based upon your interpretation or your review of this chest x-ray, tell the jury what your interpretation of the chest x-ray would be and how you would relate that back to the radiologist -- or, I'm sorry, back to the emergency room physician?

A. My interpretation of this particular chest film is that the proximal and mid descending thoracic aorta are too prominent for a thirty-two year old patient. Now, that's a nonspecific finding. But I would say, I would certainly record that in my interpretation be it wet or permanent, and I would also give a differential diagnosis for the changes. Most commonly you're going to see a prominent aorta in this age range from a process of hypertension, but certainly other differential considerations would include an aneurism and/or a dissection in the appropriate clinical context.

Q. And, Doctor, just briefly read as you would to the jury what your interpretation would say?

A. My interpretation would say: Mild to moderate prominence of the proximal and mid descending thoracic aorta. Differential considerations include: Underlying hypertension. Other differential considerations should be

excluded depending on clinical circumstances, aneurism, or dissection.

Q. Would you comment upon any other -- anything else in your report to the ER physician?

A. Well, I always comment in a hard copy on all the other structures in the chest whether or not they are normal or abnormal, but there is nothing else abnormal in this chest film.

Q. And what do you see on the lateral film?

A. The lateral film is normal.

Q. Okay. Can you on the lateral film show the jury where the aorta would be?

A. The aorta is not well seen on the lateral film of this particular patient, but I can show you the basic region. This is the area of the ascending aorta right here (indicating.) This would be the area of the arch or transverse portion or horizontal portion of the aorta. This is probably where some of the major vessels come off, although they're not well defined on this particular study, and this

is the proximal descending going to the mid descending thoracic aorta.

Q. Now, Doctor, I handed you Defendant's Exhibit D. Can you identify for the jury what Defendant's Exhibit D is?

A. It is a reading on a PA and lateral chest performed on 7-16-99.

Q. And that is the interpretation which you disagree with; is that correct?

A. It is.

Q. Okay. Doctor, the next exhibit underneath that is what?

A. This is a wet reading on a chest film performed at 4:20 p.m., 7-16-99, on Deborah Monroe.

Q. And do "C" and "D", do they go together or can you explain why we have two separate interpretations of the same film?

A. I can't give you an exact time that "D" was interpreted. But "C" is a wet reading for a chest x-ray performed at 4:30 p.m.. It's a preliminary interpretation.

Q. And what is the purpose of a wet reading?

A. To give direction to the emergency room physician or to give them a preliminary reading so that they can make -- interprelate the interpretation into their care *of* the patient.

Q. And do you disagree or agree with the interpretation on the wet reading marked as Defendant's Exhibit "C"?

A. I disagree.

Q. Now, Doctor, based upon your experience, based upon your training as a radiologist, can you tell the jury the percentage of time that a chest -- that you would expect a chest x-ray in a patient to be abnormal if they have a dissection?

A. I would say probably a good percentage is seventy, seventy-five percent *of* the time.

Q. Other x-rays were taken at that time, Doctor, and those are marked as Defendant's Exhibits --

A. May I take these down?

Q. Yes.

Just for a completeness sake, Doctor, other x-rays are marked and if you go to the ones clear to your right?

A. These are marked "E" and "F."

Q. Okay. And then what are those x-rays marked "E" and "F"?

A. This is a KUB or a plane film of the abdomen performed 7-16-99.

Q. Doctor, I also in the middle, right in front of you have x-rays marked "G" through "L." Can you tell the jury what those are?

A. Can I take these down?

Q. Yes, ma'am.

A. This is a CAT scan performed 7-16-99. I'm not going to put these up because they're not in the appropriate order. If you would like me to, I would be happy to.

Q. And, Doctor, what were the CAT scan -- what was the CAT scan taken of?

A. It's a CT scan of the abdomen, pelvis without IV or oral contrast material.

Q. And, Doctor, with the KUB and the CAT scan together, what organs or structures can be seen by the radiologist?

A. We see the liver, spleen, pancreas, adrenal glands, kidneys, the areas of the ureters, bladder, vertebral bodies, musculature about those vertebral bodies, and the aorta.

Q. And in the KUB and the CAT scan, did you find any abnormalities that could be reported in that area?

A. I did not.

Q. Doctor, handing you what's been marked as Defendant's Exhibit M and N, can you tell the jury what that is?

A. "M" is a wet reading on a CT helical kidney performed 7-16-99. And "N" is a formal hard co'py interpretation of that same CT of the abdomen and pelvis without contrast performed 7-16-99.

Q. And, Doctor, do you agree or disagree with those interpretations by the radiologist in this case?

A. I agree. I'm sorry. They also -- the 7-16-99 wet reading is for the CT

helical kidney and the KUB.

Q. Now, Doctor, can you explain to the jury how it is that a patient goes through the process of having a chest x-ray done if it comes from the emergency -- if the chest -- if the patient is from the emergency room, in your experience?

A. I think I need you to be more specific. Do you want me to give you the process of what happens once the patient comes into the registration process and an order is placed for a chest x-ray? How we handle it from that point?

Q. Yes.

A. What happens is is that the patient comes into the emergency room, an order for a specific exam is determined by the nurse and/or the physician, placed in our system, and specifically a requisition is generated with the history and the specific exam that is requested. The examination is then performed. We have a special room where we do all of our emergency room patients. The examination is performed in that room, and brought

immediately to the radiologist for a wet interpretation. We have a special film -- a special sheet of paper to write that interpretation down on. Coming along with the film, the form 'for the wet reading is also the requisition with the history and the examination that was ordered.

Q. And, Doctor, would you expect the -- would you expect the emergency room physician to be able to rely upon your interpretations?

A. I do.

Q. And, Doctor, in this case you indicate that there is a prominency of the mid and distal thoracic aorta?

A. Actually I said proximal.

Q. I'm sorry.

A. And mid descending thoracic aorta.

Q. You found an.abnormality in the mid and --

A. Proximal.

Q. Proximal.

A. The upper and the mid descending thoracic aorta, that's correct.

Q. Would you expect an emergency room

physician to be able to appreciate that finding?

A. I do not. I would not.

Q. Why?

A. Because emergency room physicians do not read lots and lots of plane films in normal patients and specific age ranges, so I do not believe that they have the fund of knowledge to be able to comment on relatively subtle abnormalities such as the range of normal for the dimensions of descending thoracic aorta in different age decades.

Q. In your practice, how many times in a day may you read or interpret a chest x-ray?

A. We do 200,000 examinations a year. General radiography is the line share of our work. Probably seventy percent of our cases are plane x-rays, and chest x-rays are the most common plane x-rays performed in our practice.

Q. Do you have any numbers that you could give to the jury in a typical day how many chest x-rays you may read?

A. I don't have those numbers at hand, but I could generate those for you if you would like them.

Q. Any estimation?

A. I don't want to give you incorrect information. I can just tell you that it makes up the majority of plane film radiography, and most of our practice, about seventy percent of our practice is general radiography.

Q. Doctor, you indicated that you would have as a board certified -- or as a radiologist you would have included a differential diagnosis?

A. I would.

Q. Do you believe that that is the standard of care for a radiologist if he sees an abnormality on a chest x-ray?

A. I believe it is when there is a differential diagnosis available.

Q. Doctor, in this case -- and if we could put the chest x-rays back up?

A. (Witness complied.)

Q. In this case, let me hand you what's been marked as Defendant's Exhibit

0 or Θ. I'm sorry. Defendant's Exhibit Θ, can you tell the jury what that is?

A. This is a report of autopsy. I'm looking for the date, July 18th, 1999.

Q. And, Doctor, can you go to the section that would review Ms. Monroe's cardiovascular system? I believe it's on page four.

A. I have it.

Q. And, Doctor, can you go down to where they're looking at the aorta and read that to the jury, please?

A. It's the second paragraph on the page and it reads as follows: "The aorta and its main branches. An irregular shaped rupture is present three centimeters below the arch of the thoracic aorta. The rupture dissects the aorta for a distance of seven centimeters distally. The intima of the aorta reveals mild arteriosclerosis. The rupture was the source of the right hemothorax."

Q. And, Doctor, looking at the chest x-rays, can you generally give the jury some idea where three centimeters below

the arch of the thoracic aorta would be?

A. Referring back to the frontal view of the chest, the arch of the aorta is the horizontal or transverse portion of the aorta. My red marker is at the upper aspect of the arch of the aorta. Three centimeters distal or inferior to the arch of the aorta is as follows: This part of my finger is about an inch. An inch is 2.54 centimeters. If you put my finger at the top of the arch of the aorta, that rupture would have begun right about this level here (indicating), and continued seven centimeters inferiorly according to the pathology report. And I will progress seven centimeters inferior to this point which would be about -- that's about two and a half, five, right about to here (indicating.)

Q. Okay, Doctor, thank you.

Doctor, can you tell us a little bit about yourself? Where were you born and raised?

A. I was born in Cleveland, Ohio. I was raised in Cleveland, Ohio.

Q. Where did you attend college at?
A. I went to Ohio University for my undergraduate. Case Western Reserve for medical school.
Q. And what year did you graduate from medical school?
A. 1976.
Q. Did you then go on for specialized training?
A. I did. I did an internship in medicine, internal medicine at Hennepin County Medical Center in Minneapolis. And I then went on to do a diagnostic radiology residency at the University of Cincinnati. At that time, the hospital was called Cincinnati General Hospital. I did serve as chief resident in that program.
Q. What year did you finish your residency?
A. 1980.
Q. And have you been steadily employed in the field of diagnostic radiology since 1980?
A. Yes, I have been.

Q. Doctor, are you board certified?
A. I am.
Q. And what is board certification?
A. Board certification diagnostic radiology requires that you take initially a written board examination with emphasis on physics and a lot of general diagnostic questions. That's .taken -- or at that particular point in time when I took my test was taken after the first two years of training. And then after your third year of training we had to undergo oral board examination which was an entire day of testing in eight different disciplines with oral examination.
Q. And did you pass that on your first attempt?
A. I did.
Q. Do all radiologist become board certified?
A. No.
Q. Doctor, do you have any teaching positions?
A. I do.
Q. And where are they?

A. I teach at the Hospital, because we are a teaching hospital. We teach OBGYN, general surgical, and family practice residents. In addition, I do teaching at the University. I did a lot more before, now I just generally do review sessions prior to boards at the University of Cincinnati.

Q. When you say that you teach OBGYN, family practice and internal medicine residents, when does that occur?

A. That occurs in the course of our day. We generally have -- we always have a family practice resident assigned to our department. And we have general surgery, OBGYN residents that come down and review films with us all the time.

Q. Do you hold any position in regard to the University of Cincinnati Medical School?

A. I'm a clinical assistant professor at the University. I used to teach at the University. I used to be on staff.

Q. And, Doctor, do you hold any leadership roles at your hospital that you

work at?

A. I do.

Q. And what are they?

A. I am on the executive committee, and I'm also on the board of our foundation.

Q. Have you in the past had any leadership roles in the Cincinnati area related to medicine'?

A. I have in the past been president of the Greater Cincinnati Radiologic Society. And I have in the past been president of the Academy of Medicine.

Q. Doctor, have you done prior reviews for myself?

A. I have.

Q. And, Doctor, in those prior reviews have you found that radiologists have fallen below the standard of care?

A. Yes, there have been some cases.

Q. And have I asked you to review cases in which you felt the radiologist met the standard of. care?

A. Yes, there has been.

for your time here today?

A. I am.

Q. And can you -- We're approximately two and a half weeks before trial, can you tell us why it is that you cannot appear live?

A. I cannot appear live because I do not have the flexibility to appear live for depositions. I am part of an extremely busy practice. Unfortunately, court cases don't always go as anticipated, and we certainly understand that and appreciate that, but my practice doesn't understand or appreciate that. So, I don't have the flexibility to accommodate the schedule of a case that's not progressing as 'initially intended. So, if I ever do look at films I always make it perfectly clear that I am not necessarily willing to participate in any depositions or trials because my practice does not really lend itself to that.

Q. And, Doctor, are you qualified to give opinions in regard to emergency room medicine?

A. I am not.
Q. And why do you say that?
A. I'm not an emergency department physician.
Q. Are you qualified to give opinions in regard to had a diagnosis been made on Ms. Monroe what the treatment modalities would have occurred?
A. Absolutely not.
Q. And are you qualified to give opinions in regard to had Ms. Monroe had treatment whether that treatment would have been successful or what her prognosis would be?
A. It would not be possible for me to render an opinion about that. I'm not trained in those areas.
Q. And how long have you restricted your practice to the field of radiology?
A. Twenty-two years.
Q. Okay.
MR. OCKERMAN: Doctor, that's all the questions I have. Thank you.
MS. TAYLOR-ROLIS: Can we take a two minute break and I'll be right back?

MR. OCKERMAN: Yes.

(Off-the-record.)

(Back on the video record at 3:06 p.m., February 8, 2003.)

EXAMINATION

BY MS. TAYLOR-KOLIS:

Q. Good afternoon, Doctor.

A. Good afternoon.

Q. Once again for identification purposes since the jury can't see me, my name is Donna Kolis and I represent the estate of Deborah Monroe. I have a couple of questions to ask you on cross-examination, and I anticipate being brief.

Doctor, as I was listening to you I was recording the information hopefully accurately as to what your testimony was. We are both in agreement that the findings that you find are nonspecific findings; is that correct?

A. That is correct.

Q. Okay. Now, when somebody says it's a nonspecific finding sometimes with radiologist I hear the term subtle. Would

you say that it is a subtle nonspecific finding?

A. I think that these findings are not that subtle.

Q. You did describe however today in your direct testimony that these changes that you find were mild to moderate; is that correct?

A. But I said was mild to moderate prominence of the aorta. There's difference between prominence and degree of prominence and whether or not a finding is subtle.

Q. Okay. And one of the things that could have accounted for that appearance as you interpreted is hypertension; is that correct?

A. That is correct.

Q. Doctor, could you advise the jury what radiologist read all of the films that you discussed today?

A. Let me just check very quickly.

Q. Sure.

A. They were interpreted by a Dr. William Crawford.

Q. So, that --

A. I don't have the reading, the formal reading on the KUB. That's the CT and the chest x-ray.

Q. You have the wet reading for the CT and the KUB indicating they were negative, correct?

A. Correct.

Q. All right. And you would agree with Dr. Crawford's interpretation of those diagnostic tests, correct?

A. I do. I do.

Q. Doctor, have you reported Dr. Crawford to the Ohio State Medical Board for this alleged deviation?

MR. OCKERMAN: Objection.

A. I will -- Why would I report him for an alleged deviation?

Q. I ask the questions and you get to answer them. And my question is: Have you reported this alleged deviation to any authorities?

A. No, because it would not be appropriate.

advise him that you feel that he misinterpreted a film on 7-16-99?

A. It would not be appropriate for me to do that.

Q. Have you let anyone, other than myself and Mr. Ockerman, know that you believe that there's a radiologist who misread a film?

A. It would not be appropriate for me to do that.

Q. Doctor, as you indicated in your direct examination you've reviewed limited material, correct?

A. Correct.

Q. You do not know the clinical circumstances surrounding Ms. Monroe's hospitalization; is that correct?

A. That is correct.

Q. Do you know anything other than the fact that she had chest pain?

A. To be honest, I want to be very honest with you, the only information that I have on this patient and the only materials that I reviewed are the interpretations of the x-rays and the

autopsy report.

Q. Okay. Doctor, you are not a cardiothoracic and vascular surgeon, are you?

A. I am not.

Q. As such, you do not and would not know at this point in time what the clinical diagnosis process is regarding a dissection; is that a fair statement?

A. That is fair.

Q. Doctor, would you be aware of the fact that cardiothoracic and vascular surgeons frequently, if not always, look at their own plane films?

A. Am I aware of the fact that they do or they do not?

Q. Yes.

A. I can't speak to that.

Q. Okay. In this instance, Doctor, you have no information which you could share with the jury that would indicate how the outcome of this case would have been different had the interpretation that you claim been given to Dr. Maxfield; is that a fair statement?

A. I do not have that information. She --

Q. You have never read Doctor -- I'm sorry for interrupting you.

You have not read Dr. Maxfield's --

THE WITNESS: She's fading in and out for me.

MR. OCKERMAN: Let's go off the record for a minute.

(Off-the-record.)

(Back on the video record at 3:12 p.m..)

Q. (BY MS. TAYLOR-KOLIS) Dr. Weinberg, are you aware that another emergency room physician named Dr. Shaw transferred Deborah to St. Joseph's with instruction that he believed that she needed a CT of her aorta?

A. I don't have the details of that. I have not reviewed that particular record.

Q. So, you were unaware of that, of course.

Let me ask this question: Based upon the autopsy which you've seen, do you

believe to a reasonable degree of medical probability that had a CT scan of the aorta been performed an July 16th, that it would have revealed a dissection?

A. I think that's a true statement. I believe that's true..

Q. Thank you, Doctor. Doctor, I really, truly only have a couple of more questions. Just let me go through this material.

Relative to your participation in this case today, is it a fair statement that you initially asked me to write a check payable to your daughter, Deborah?

A. I did.

Q. And is it a true statement that your daughter, Deborah, performed no services in interpreting the radiology films in this case?

A. That is correct.

Q. Is it also a fair statement that this is not the first occasion that you have had to work for Mr. Ockerman?

A. Worked for him on one other occasion.

Q. Okay. And in this particular instance as you related to me a little bit earlier today, at the time that you reviewed Deborah Monroe's case Mr. Ockerman brought several cases to you for review; is that a fair statement?

A. That is correct.

BY MS. TAYLOR-KOLIS: Doctor, I don't have any further questions for you.

THE WITNESS: Thank you.

FURTHER EXAMINATION

BY MR. OCKERMAN:

Q. Just in follow up, Doctor. In regard to the reimbursement going to your daughter, can you explain to the jury why you requested that?

A. Any time I have reviewed cases for -- and first I need to preface this. I get a fair number of calls to review cases, and there are very few people that I will review cases for anymore. And I think that Mr. Ockerman will tell you as well, there's one other individual I will review cases for from time to time who happens to be a personal friend as well.

I don't charge anybody to review cases. I've never charged anybody to review cases. I believe if somebody wants to bring me a number of cases to look at and for me to render an opinion as to how I would interpret a case, if I have time to do that I don't really have a problem with that. Any time I have given expert witness, and I do it frankly under duress most often, I have up until the last year donated all of those moneys to the Bethesda Foundation. I have no desire to enhance my income with expert witness dollars. I have no need for additional income. I asked Attorney Ockerman to have that check made out for my daughter because I just don't need extra income, and this is not something that I relish doing.

Q. And, Doctor, you indicated that you have reviewed other cases for another attorney who is a good friend. I am not a good friend?

A. No.

Q. We have --

A. And the othe'r person is not an attorney.

MR. OCKERMAN: And, Doctor, I have no further questions.

THE WITNESS: Thank you.

FURTHER EXAMINATION

BY MS. TAYLOR-KOLIS:

Q. Doctor, just to clarify what you said with all due respect.

The letter that came gave your daughter's name and your daughter's social security number, which for privacy sake I'm not going to read her social into the record.

A. Thank you.

Q. Had I written that check and issued a W-2 it would be reported as her income; is that correct?

A. You chose not to do that, so I don't believe it's an issue. I mean, all you needed to do was point out that you didn't want to do that. That's fine with me.

MS. TAYLOR-KOLIS: Doctor, I have no further questions of you.

THE WITNESS: Thank you.

MR. OCKERMAN: Thank you.

THE VIDEOGRAPHER: Doctor, you have the right to review this video tape to verify its accuracy.

THE WITNESS: Oh, I would like to do that.

(Off-the-record.)

MR. OCKERMAN: We are going back onto the written record. The purpose of going back on the written record is to correct what the Doctor said about reviewing the video transcript. She just wants to review the written transcript. Ms. Taylor had hung up by the time we realized that mistake. Thank you.

(Deposition concluded at 3:12 p.m.)

C E R T I F I C A T E

STATE OF OHIO

: SS

COUNTY OF WARREN

I, Margaret M. Lynch, the undersigned, a duly qualified notary public within and for the State of Ohio, do hereby certify that SUSAN WEINBERG, M.D., was by me first duly sworn to depose the truth and nothing but the truth; foregoing is the deposition given at said time and place by said witness; deposition was taken pursuant to stipulations hereinbefore set forth; deposition was taken by me in stenotype and transcribed by me by means of computer; deposition was submitted to the witness for examination and signature; I am neither a relative of any of the parties or any of their counsel; I am not, nor is the court reporting firm with which I am affiliated, under a contract as defined in Civil Rule 28 (D) and have no financial interest in the result of this action.

In WITNESS WHEROF, I have

hereunto set my hand and official seal of office at Cincinnati, Ohio, this _____ day of _____, 2003.

My commission expires, Margaret M. Lynch, October 29, 2007, Notary Public - State of Ohio.