STATE OF ILLINOIS)
) SS:
COUNTY OF ADAMS)

IN THE CIRCUIT COURT FOR THE EIGHTH JUDICIAL CIRCUIT, ADAMS COUNTY, ILLINOIS

MICHELLE LONG, Special Administrator of the Estate of KYLEE BIVENS, Deceased,

Plaintiff,

vs.) No. 01 L 68

DR. A.O. MATHEW, DR. MATHEW, M.D., P.C., BLESSING HOSPITAL, DR. RICHARD SAALBORN, DR. GREGORY A. FRANCKEN,

Defendants.

The discovery deposition of RICHARD MICHAEL GORE, M.D., taken under oath on the 30th day of June 2005, at Evanston Hospital, 2650 Ridge Avenue, Evanston, Illinois, pursuant to the Rules of the Supreme Court of Illinois and the Code of Civil Procedure, before Jacqueline Pietrzyk, a notary public in and for the County of Will and State of Illinois, pursuant to notice.

APPEARANCES:

COSTELLO, McMAHON & BURKE, LTD., by MR. WILLIAM J. BURKE
(150 North Wacker Drive, Suite 3050
Chicago, Illinois 60606-4202)
appeared on behalf of the plaintiff;

APPEARANCES: (Cont'd)

DRAKE, NARUP & MEAD, P.C., by
MR. RICHARD H. NARUP
(107 East Allen Street
Springfield, Illinois 62704)
appeared on behalf of the defendants
Dr. A.O. Mathew and Dr. Mathew, M.D.,
P.C.;

HINSHAW & CULBERTSON, LLP, by
MR. PAUL C. ESTES
(456 Fulton Street, Suite 298
Peoria, Illinois 61602)
appeared on behalf of the defendant
Dr. Gregory A. Francken;

APPEARED TELEPHONICALLY:

SCHMIEDESKAMP, ROBERTSON, NEU &
MITCHELL, by
MR. JAMES A. HANSEN
(525 Jersey Street
P.O. Box 1069
Quincy, Illinois 62306)
appeared on behalf of the defendants
Blessing Hospital and Dr. Richard
Saalborn.

* * * * * * *

I N D E X

E X H I B I T S

(X-ray Exhibits 4, 5, and 6 retained by counsel.)

(Deposition Exhibits Nos. 1 - 3, Witness Gore, were marked for identification 6/30/05.)

(Witness sworn.)

RICHARD MICHAEL GORE, M.D.

called as a witness herein, having been first duly sworn, was examined and testified as follows:

EXAMINATION

BY MR. BURKE:

Q. Doctor, my name is Bill Burke, and I represent the plaintiff in this case.

Can you please state your full name and spell it for us.

A. Okay. My name is Richard Michael Gore, G-o-r-e.

MR. BURKE: Let the record show this is the discovery deposition of Dr. Gore.

BY MR. BURKE:

Q. Sir, I'm assuming that you have given a deposition before.

A. Yes, sir.

Q. My only concern is that you understand my question before you give us an answer that the court reporter will take down and later transcribe.

Okay?

A. I understand.

Q. What is your present occupation?

A. I'm currently a radiologist at Evanston Northwestern Healthcare.

Q. Let me show you what has been marked as Exhibit No. 1. And is that a copy of your curriculum vitae?

A. Yes, it is, but it's about a year and a half out of date.

Q. Okay. And in that year and a half, how much additional material would have to be added?

A. Well, in terms of presentations, probably quite a few. I also won the Teacher of the Year Award for a residency in 2004, and I've had some more publications.

Q. Anything in particular dealing with the issues in this case?

A. Well, a lot of my discussions and my lectures are about bowel obstruction, but not that specifically pertained to this case.

Q. And how about the publications themselves as opposed to presentations, any of the new ones particularly dealing with --

A. No, sir.

Q. The publications, I believe, that are listed in your c.v. now, do any of those deal in particular with the issues that you feel need to be addressed in this case?

A. Well, there are many that address bowel obstruction. About communication?

Q. Yes, sir.

A. I don't believe so, no.

Q. With regard to the issue of bowel obstruction, do any of your publications deal with the issue of bowel obstruction in terms of its urgency or significance in terms of radiological findings?

A. Let's see. In terms of urgency, I'm not sure, but in terms of the radiological findings, yes, it addresses those.

And I've edited a textbook called Textbook of Gastrointestinal Radiology, and the first edition was published in 1994, the second edition was in 2000, and I'm working feverishly on the third edition now, and we certainly do discuss bowel obstruction in that.

Q. And in dealing with bowel obstruction

there, do you know if you cover any issues of communication with bowel obstruction?

A. In terms of communicating to the managing physicians?

Q. Yes.

A. No, I don't believe so.

Q. What about the emergent or urgent nature of such findings?

A. Yes, I may have, yes.

Q. You're going to have to lower the price of that book because both editions were ripped off at the UIC library.

Okay. Exhibit No. 2 is your disclosure in this case; is that --

MR. ESTES: It's my disclosure for him.

BY MR. BURKE:

Q. Okay.

A. Yes, sir.

Q. Have you seen this document before?

A. Yes, I have.

Q. Did you draft the language in it, help edit it? How did you --

A. I believe Mr. Estes drafted it, and I edited it.

Q. And do you have any of the prior versions of the 213 disclosure?

A. I don't know if there were any prior versions, but no, I don't.

Q. Okay. So your communication with Mr. Estes in regard to this 213 disclosure, was it by mail, e-mail?

A. It was by telephone.

Q. Did you receive a copy of a proposed disclosure, which you then discussed with him?

A. I'm not entirely sure, but I probably did.

Q. Do you have that proposed disclosure with you as opposed to the final version?

A. No, I don't.

Q. Do you know if you made changes or suggestions with regard to the proposed disclosure?

A. I don't believe I did.

Q. So as far as you're aware, what we have here, which are nine opinions, that would have been the nine opinions that were initially submitted to you by Mr. Estes and you approved those?

A. That is correct.

Q. When is the first time that you were

contacted in this case?

A. I believe it was in spring of last year, 2004.

Q. I've got here marked as Exhibit 3 a letter from -- well, actually this is from you to Mr. Estes, outlining 17 categories of items that you have evaluated, received and evaluated in this case. (Tendering document.)

A. Yes, I see the letter, and it's dated May 27th, 2004.

Q. So I take it you were contacted sometime prior to that.

A. Yes, sir.

Q. And since that time, attached to Exhibit 2, the disclosures there, is a summary, or an outline, I guess, more correctly, of the items that you have reviewed, and is that inclusive?

A. To the best of my recollection, yes.

Q. There's nothing else that you can recall or think of at this time that you reviewed in addition to what's listed here; is that correct?

A. That's correct.

Q. By the way, do you know Kate Feinstein?

A. Oh, yes. She's a very dear personal

friend.

Q. Have you ever spoken to her about this case?

A. No, I have not.

Q. And your friendship, does it precede medical school, or is it brought about as a result of your medical employment?

A. Via medical employment, and my wife and Dr. Feinstein are very close friends as well. I've known Kate probably 15 years.

Q. Is your wife a physician?

A. Yes, she is.

Q. What type of physician?

A. A pediatric radiologist.

Q. Where at?

A. Evanston Northwestern Healthcare.

Q. By the way, what name does she go by?

A. Margaret Dembo Gore.

Q. Have you ever discussed this case with your wife?

A. Yes, I have.

Q. And has your wife rendered any opinions in this case?

A. Yes, she has.

Q. And are you relying at all upon the opinions rendered by your wife?

A. No, I'm not.

Q. Have you discussed the case with any other physicians?

A. Yes, I have.

Q. And who?

A. Probably about six or seven physicians in our department, general radiologists, and also I showed it to another one of our pediatric radiologists.

Q. And are you relying upon the opinions of any of those other physicians and radiologists?

A. No.

Q. Have you ever prepared a written report?

A. No.

Q. Have you ever reduced your opinions to writing in any form?

A. No.

Q. Have you made any notes?

A. No.

Q. I see on the materials that you have received there are medical records from OSF Saint Francis Medical Center. Do you have those

here?

A. Yes, I do.

Q. Are you relying on those in any way as a basis for your opinions?

A. Well, in the medical records, we do see doctor -- the various doctors' report and also Dr. Francken's report, so I am depending upon that, yes.

MR. ESTES: He's talking about Saint Francis, not Blessing.

THE WITNESS: Oh.

MR. ESTES: Do you have Saint Francis here?

THE WITNESS: I have OSF Saint Francis Medical Center, and this is Kylee's medical history from '92 to '93.

And then I have another group of records from OSF Saint Francis Medical Center that's from '92 to '94. I don't recall these influencing my opinion.

BY MR. BURKE:

Q. Okay. So there's nothing in there that you can point to on which you are relying as a basis for your opinion.

A. That's correct.

Q. Now, also noted here is a Blessing Hospital Emergency Department Patient Care Policy for Follow-Up of X-rays and Laboratory Tests. Do you have that here with you?

A. Let's see.

(Reviewing documents.) Oh, here's another letter from Mr. Estes. Here's another letter, and here's another letter.

MR. ESTES: Do you have that, Doctor?

THE WITNESS: Oh, yes, I do. Blessing Hospital Quincy, Patient Care Policies Emergency Center?

BY MR. BURKE:

Q. Yes, sir.

A. Yeah, I have it.

Q. Anything in that policy in particular that you are relying on to support your opinions in this case?

A. Not that occur to me now, no.

Q. All right. And other correspondence, April 13th, 2005, sending deposition transcripts, all of which are included in the disclosure form; May 5th correspondence trying to contact you; and a June 7th, 2005, correspondence scheduling a pre-

deposition meeting for June 9th and then the deposition today.

(Tendering documents.) Thanks.

Did you meet with Mr. Estes on June 9th?

A. Yes, I did.

Q. Here at the hospital?

A. Yes, I did.

Q. For approximately how long?

A. About an hour.

Q. Had you ever met with him prior to June 9th?

A. Yes, one time before.

Q. And when was that relative to the review that you performed?

A. That was performed after my initial review, and, as I recall, it was downtown in the Lyric Opera Building. Is that Hinshaw --

MR. ESTES: No, 222 North LaSalle.

THE WITNESS: 222 North LaSalle, yeah. I met with him down there because I was downtown that day for another meeting.

BY MR. BURKE:

Q. That would have been in 2004?

A. That's correct.

Q. For another hour approximately?

A. Yes.

Q. Do you know how Mr. Estes got your name?

A. I believe I've reviewed cases for Hinshaw & Culbertson before.

Q. Have you ever reviewed a case before for Mr. Estes?

A. No, I have not.

Q. How about for his firm or his branch in Peoria? Is it Peoria?

MR. ESTES: (Nodding.)

THE WITNESS: I don't believe so.

BY MR. BURKE:

Q. Do you have any other cases that you are currently working on in which the defense firm is Hinshaw & Culbertson?

A. Yes. This is the Chicago firm, and the attorney is William Yu, Y-u. Can I give you the name of the case --

Q. Sure.

A. -- or is that going to violate HIPAA?

Q. No, you can give me the name of the case.

A. Okay. The name of the case is Watters, W-a-t-t-e-r-s, vs. Medtronic, M-e-d-t-r-o-n-i-c.

Q. Is that a medical malpractice case?

A. A medical malpractice case and also an appliance failure case.

Q. Have you ever given a deposition in that case?

A. No, I have not.

Q. Are you currently working on any other cases in which the counsel that retained you was Hinshaw & Culbertson?

A. I recently finished the case in which they were on the opposing side, and the attorney for that was George Lindner, L-i-n-d-n-e-r, and Terry Heady, H-e-a-d-y. And I believe they're in the western suburbs.

Q. But you don't have any currently pending in which you were retained by Hinshaw & Culbertson other than this Watters case.

A. That's correct.

Q. Have you ever been sued?

A. Oh, yes.

Q. Have you ever been defended by the law firm of Hinshaw & Culbertson?

A. No.

Q. Have you ever acted as an expert before in a case involving issues of communication of radiological results to the ordering or attending physician?

A. Well, yes. Actually the case, the Watters case, W-a-t-t-e-r-s, that's a communication case.

Q. And without going into great detail, what is the issues in that case as far as you're concerned?

A. The issue is, again, very similar to this case, was it a standard of care for the radiologist to have contacted the neurosurgeon about the finding that she found on the X-ray.

Q. And is this a postsurgical X-ray?

A. It is a postsurgical X-ray, right.

Q. And the communication suggested there being direct communication, as opposed to by written report?

A. That is correct.

Q. And do you know who the plaintiff's attorney is in that case?

A. No, I haven't been deposed yet, but I

could find that information out for you.

Q. Any others in which you were involved where the issue was communication of radiological results?

A. You mean timeliness of or the type of communication?

Q. Either one, yes.

A. Not that I can recall, no.

Q. And those were as expert witnesses. Have you ever been involved as a defendant in cases involving issues of communication?

A. Yes, I am.

Q. You are currently?

A. Currently, yes.

Q. And what's the name of that case?

A. The case is Magurshak, M-a-g-u-r-s-h-a-k, vs. ENH and Northwestern University. And it's the Clifford Law Firm. And not to get into that much of the specifics, a chest X-ray was obtained, which I read correctly and promptly communicated to the physician, but I received the X-ray five days after it was taken.

Q. And by communicating it promptly to the physician, was that by direct communication?

A. That was actually by fax.

Q. To the ordering physician's office?

A. Correct.

Q. Was there any issue of receipt?

A. No.

Q. And the delay in that case in your obtaining the X-ray film was due to what?

A. The films were not -- well, again, I guess this is still in discovery. The films were not brought over from Northwestern Student Health to our department to read. This was over the New Year weekend, I believe.

Q. So a student went to the Northwestern Student Health Department, somehow an order for an X-ray was given, and the X-ray was obtained.

A. Yes. And the X-ray was read by the physician over there.

Q. And then sent -- I guess the typical protocol would be once it's taken and read by the physician in that whatever outpatient-type setting it is, it is then sent for a formal reading to Northwestern Hospital?

A. That's correct, but they always -- no, Evanston Northwestern Healthcare. But they always

have the opportunity, and they frequently do, if they have a question, you know, they will send a special messenger over so we can look at it immediately.

Q. And that wasn't done in this case.

A. That's correct.

Q. So somebody was relying on normal channels to get the X-ray from where it was taken to some formal reading center at Evanston North-western Healthcare.

A. That's correct.

Q. And I take it the normal channels would be less than five days.

A. Yes.

Q. So somehow it fell through the cracks for a couple of days.

A. Sadly, yes.

Q. And that's known to happen. Regular procedures with regard to handling of any type of test in a hospital can go awry, and the report or the specimen itself can be misplaced or even lost.

A. That's correct.

Q. And that's true, I take it, with radiologic results, the actual reports. I take it

that when a radiology report is transcribed, there is some type of process or procedure wherever you've worked whereby it gets from the transcriptionist's typewriter or whatever they -- computer to the patient's chart.

A. That is correct.

Q. And yet I take it there have been occasions where you've come to realize that that never happened.

A. That's correct. Happily, now we have electronic medical record and everything is digitized, and the reports go instantly to the patient's chart, to the doctor's hospital e-mail address. So happily, or hopefully, this is going to diminish that likelihood.

Q. Are they still generating paper reports?

A. For Northwestern Student Health, we are still generating paper reports, yes.

Q. What about for patients admitted to Evanston Northwestern Healthcare, Evanston Hospital, I guess?

A. There may be some physicians who don't have e-mail or fax who insist on a written report, but none come to mind. Evanston Northwestern

Healthcare is fairly technologically savvy.

Q. Okay. Do you know, back in 1999, have you been able to determine from your review of materials in this case whether or not paper reports were generated at Blessing Hospital and sent to the patient's chart?

A. From my understanding from reviewing the materials is that paper reports were generated and then sent to each patient floor.

Q. And I believe that Dr. Francken testified that usual practice, as far as his experience was, was that the report would make it to the chart within two to four hours of its being transcribed, I guess.

A. That's what he stated was in his hospital. And I'm just trying to think in 1999. We would generally tube reports from the transcriptionist to the patient floor, so two hours or less seems like an appropriate time.

Q. Did you say the word tube, t-u-b-e?

A. T-u-b-e.

Q. I think someone testified to that the other day, that there was a tube system at Blessing Hospital in 1999 for sending reports to the floor.

A. We also had other means of bringing reports. We had hospital employees, you know, go by radiology and then pathology and then go up and distribute the reports, but we primarily relied on the tube system then, I believe.

Q. Was there any policy, to your knowledge, in effect at Evanston Northwestern Healthcare with regard to nursing responsibilities in terms of notifying the attending physician of the results?

A. I'm not aware of any, but I'm sure there were.

Q. And have you read Dr. Feinstein's deposition?

A. Yes, I did.

Q. And I think you both agree that Dr. Francken read or interpreted the abdominal series appropriately.

A. Yes.

Q. By the way, you have copies of the films here I saw somewhere?

A. Yes, I do.

Q. And are all the films that you have of diagnostic quality?

A. (Reviewing films.)

I have what looks like a copy of a copy. That is a lateral film of the abdomen dated 10/18/99. This copy is not of diagnostic quality.

Q. Is there any indication on that film of the time it was taken?

A. Other than 10/18/99, no, sir.

MR. ESTES: Just for the record, he's also seen copies of my films, which are over there, so he's looked at those the last time we met. So if you need those for any reason, feel free.

MR. BURKE: I want to get, you know, the best available copy that he has.

THE WITNESS: Okay. And then I think I have two copies of the same film, and the copies are too dark.

MR. ESTES: He wants you to get out the ones that are --

THE WITNESS: Oh, that are --

MR. ESTES: -- representative of what was used from 10/18, I think.

MR. BURKE: No, what I want --

MR. ESTES: I'm sorry, I thought that was --

BY MR. BURKE:

Q. I want to know which films are

diagnostic quality that you can read and which aren't.

A. Okay. I have films performed at -- on 10/18/99, and the time is 12:47 a.m., and these are supine and erect films of the abdomen, and the upright film also includes the chest.

Q. And would that be known as an acute abdominal series?

A. Yes, sir.

Q. Does it consist of two films, or are there more?

A. Well, it depends from institution to institution. Some also get decubitus films; some might also get a lateral film of the chest.

Q. But as far as you're aware, this study consisted of two views.

A. I have a cross-table lateral radiograph here that says 10/18. It might have been obtained at the same time, but I'm not sure.

Q. And is that of diagnostic quality?

A. It's a very dark quality film, but it corroborates what we see on the frontal films.

Q. From looking at the films, can you tell if they were taken at about the same time or not?

A. Probably not, because the one done on 10/18/1999 has a nasogastric tube in, and the ones performed at 12:47 a.m. on 10/18 do not have a nasogastric tube in.

Q. Any others from that abdominal study?

A. Okay. Then in the copies I have, this is 10/18/1999, and looking at -- the patient's name and the date are handwritten, and this is probably, I'm just speculating, performed at the same time because they were stamped at the same time with the same marker. So I suspect this abdominal film, which looks like it's frontal, and the cross-table lateral radiograph were done at the same time. Unfortunately, both of these are very, very dark.

Q. Okay. Is it fair to say then that the only abdominal films which -- other than the one cross-table, the only abdominal films which are of diagnostic quality are the two taken at approximately 12:47 a.m. on the 18th?

A. The films, in terms of their copying being of diagnostic quality, that's correct. The original films may well have been of diagnostic quality, but not the copies that I have. But Paul, I think, may have some better versions.

MR. ESTES: I'll let you take a look. These are the 10/18s.

THE WITNESS: There is a supine radiograph that is a little bit less dark, which is of marginal diagnostic value. But, again, the original film may have been perfect, but the copies are very dark.

BY MR. BURKE:

Q. And the one you're talking about now also has a handwritten patient name?

A. That's correct.

Q. Which, again, you would, looking at the others, would think it was taken approximately at the same time as the cross-table?

A. I would think so, but I'm not sure I see a nasogastric tube on this film (indicating).

Q. Okay.

MR. ESTES: Do you have this one, Doctor? This has got a time of 0047 on it.

BY MR. BURKE:

Q. By the way, before you take that down.

A. Yeah.

Q. Is that a copy, or is that --

A. Oh, it's a copy. It's a copy of a copy.

I also have a chest X-ray done on

10/18/99 at 12:47 a.m., and this is a very nice original, a digital reproduction of an image that usually -- that probably came from PACS, p-a-c-s.

Q. So that's printed from the original digital data?

A. Well, I see a notch here. It's a copy of it, but it's quite good.

MR. ESTES: You can see this one. I can't read the time on that one.

THE WITNESS: And I have yet another film of the chest and upper abdomen. It shows a nasogastric tube in place, and it was done at 1:30 a.m. on 10/19/1999.

MR. ESTES: You don't need that one.

BY MR. BURKE:

Q. Does that show a white-out in one of the lungs?

A. Yes, sir.

Q. Which lung?

A. Right lung.

Q. All right. So, again, getting back to the abdominal study that was done approximately 12:47 a.m., there are only two sheets of film that are of diagnostic quality that you can see pertaining

to that study, correct?

A. I believe these are the films that Dr. Francken had to read the morning of the 18th.

Q. Right. But in terms of how many films he had showing the abdomen, there were two.

A. May I look at his report?

Q. Sure. Yeah, sure.

MR. ESTES: It says multiple. That's all it says.

THE WITNESS: AP. This is a report by Dr. Gregory Francken, F-r-a-n-c-k-e-n, and it was dictated on 10/18/1999: Upright frontal chest demonstrates normal heart size. And this is my upright chest film (indicating). Should we mark these or ...

BY MR. BURKE:

Q. Sure.

MR. ESTES: Are they different?

THE WITNESS: Actually, they are different. But according to this, the handwritings on these were obtained or processed at the same time. And that is -- I have three films here, and I believe Dr. Francken alludes to three films.

First of all, in his first paragraph,

he says: Upright frontal chest demonstrates normal heart size and mediastinal contour. And can we mark this?

MR. BURKE: Yes. I think it's 4.

(Deposition Exhibit No. 4, Witness Gore, was marked for identification 6/30/05.)

THE WITNESS: Okay. And then Dr. Francken goes on to say: AP and upright views of the abdomen. AP supine and upright views of the abdomen. The AP supine done on 10/18 at 12:47 a.m. can we call the No. 5?

MR. BURKE: Yes, please.

(Deposition Exhibit No. 5, Witness Gore, was marked for identification 6/30/05.)

THE WITNESS: And then the upright view of the abdomen that Dr. Francken describes is this furthest film on the right, which we'll call Exhibit No. 6?

MR. BURKE: Okay.

(Deposition Exhibit No. 6, Witness Gore, was marked for identification 6/30/05.)

MR. HANSEN: What's Exhibit 4?

MR. NARUP: Exhibit 4 is the chest film.

MR. HANSEN: Okay. Thanks.

THE WITNESS: And I'm just checking to see if Dr. Francken had any other films.

He had a film from 12/2/95 to compare, but I've never seen that radiograph.

These are the only three films I have at this time, and I believe these are the only three films that Dr. Francken discusses.

BY MR. BURKE:

Q. Okay. The 2.5 centimeter rounded well demarcated soft tissue structure is visible to you in which of those three films?

A. Okay. I see this 2.5 rounded well demarcated soft tissue structure in the --

Q. Go by exhibit number.

A. In Exhibit No. 5 and on Exhibit No. 6.

Q. 5 is the --

A. 5 is the supine film of the abdomen, and No. 6 is the upright film that includes the abdomen and the chest.

Q. And both 5 and 6 reveal multiple dilated small bowel loops?

A. Yes, sir.

Q. With multiple air fluid levels?

A. Yes, they do.

Q. By the way, he indicates the air fluid levels are on the upright view. Is that 6?

A. Yes, the air fluid levels are on Exhibit No. 6, yes.

Q. And multiple dilated small bowel loops with multiple air fluid levels, is that consistent with a small bowel obstruction?

A. Indeed it is.

Q. Okay. Then you go on in your disclosure to indicate that Dr. Francken's method of communication by providing a timely written accurate interpretation of the October 1999 abdominal series was reasonable and within the standard of care.

THE WITNESS: Can I take a small break now?

MR. BURKE: Oh, sure.

(Short break.)

MR. ESTES: We're back on.

BY MR. BURKE:

Q. Okay. And then opinion No. 6: Based upon the information provided to Gregory Francken,

the abnormalities identified on the October 18, 1999, X-rays, and the fact that Kylee Bivens was an inpatient, admitted through the ER, the standard of care did not require direct phone or personal communication of Dr. Gregory Francken's interpretation.

Now, in reaching those opinions, were you relying at all upon the American College of Radiology's Standards for communication in diagnostic radiology?

A. Yes, I am familiar with them, and I actually have the 2000 version here.

Q. And that's in a book that's called what?

A. It's called Standards 2000-2001 published by the American College of Radiology.

Q. The 2000 version was effective January 1st of 2000?

A. It was effective 1/1/01.

Q. '01?

A. '01.

Q. And do you know if it's materially different than the ACR's Standards for communication in diagnostic radiology that was in effect in

October of 1999?

A. I don't know, but I'd be happy to compare.

Q. (Tendering documents.)

A. (Reviewing documents.)

There is a little bit of a difference, yes.

Q. And is it a difference that will be applicable to the issues in this case?

A. Is it a --

MR. ESTES: Applicable to his opinions in this case?

MR. BURKE: Right.

THE WITNESS: No.

BY MR. BURKE:

Q. What are the differences?

A. I'd like to read from the 2000-2001 standard, on page No. 2, subparagraph 4, called Direct Communication. Okay. It states that direct communication can be accomplished in person or by telephone to the referring physician or an appropriate representative.

Okay. B: In those situations in which the interpreting physician feels that

immediate patient treatment is indicated; for example, tension pneumothorax, the interpreting physician should communicate directly with the referring physician, other healthcare provider, or an appropriate representative. If the individual cannot be reached, the interpreting physician should directly communicate the need for emergent care to the patient or a responsible guardian if possible.

And then there's C, which I don't see on the older standards: In those situations in which the interpreting physician feels that less urgent findings compared to B above or significant unexpected findings are present, the interpreting physician or designee should directly communicate the findings to the referring physician, other healthcare provider, or an appropriate representative.

So the wording is not the same. I think the emphasis is pretty much the same, though.

Q. Now, in terms of the physician's responsibility under the 2000 version B and C, am I correct that they both require the radiologist to have direct communication with the referring physician or his representative?

MR. ESTES: Well, under what circumstances? Show an objection to lack of foundation.

THE WITNESS: Well, having actually served on the ACR for designing the standards for GI radiology, there's a lot of latitude in these standards, and they only give one specific example, for example, tension pneumothorax, so a lot is left to the physician's discretion.

BY MR. BURKE:

Q. But in terms of the requirements of B, which is the requirements of C, they both require the radiologist to make direct communication under certain circumstances, correct?

A. Under circumstances, yes, which they leave to the discretion of the radiologist.

Q. And B is where the radiologist feels that immediate patient treatment is indicated, correct?

A. That's correct.

Q. Okay. C is less urgent findings, but both still require direct communication.

A. That's correct.

Q. And by direct communication, it means what?

A. Direct communication can be a call. Nowadays, it might be electronic mail for ENH, but in 1999, it might have been a fax, a call. And a written report would be another way of communicating.

Q. That's what I'm trying to get at.

Does a written report in 1999, sent through ordinary channels to the patient's chart, satisfy the direct communication requirement?

A. No.

Q. So it requires something more than sending a written report through normal channels.

A. That's correct.

Q. And both B and C require that.

A. Correct. But, again, these are standards, but actually we're -- they're going to be changing the name to guidelines, and, again, a lot of discretion is left to the radiologist, because they only cite one specific example that is tension pneumothorax.

Q. Can I get that --

A. Should we -- should we make a copy?

MR. BURKE: Sure. It's attached to Feinstein's dep, if you have it.

MR. ESTES: He wants this back.

THE WITNESS: Oh, you want this back?

MR. BURKE: Yeah.

MR. ESTES: You don't want to lose that.

BY MR. BURKE:

Q. Would you agree with me that a small bowel obstruction on an abdominal film is a significant finding?

A. Yes, I do.

Q. Would you agree with me that a small bowel obstruction on an abdominal film is an urgent finding?

A. It depends whether it's closed loop or not. It also depends on the degree of the obstruction and whether it's high grade or low grade, chronic, intermittent, or acute.

Q. Anything else?

A. Not that comes to mind now, no.

Q. In our case, is it closed loop or something else?

A. It doesn't look closed loop to me, no.

Q. What is closed loop?

A. Closed loop is when a portion of bowel twists upon itself or a portion of bowel is trapped by an adhesion, and so fluid can get into this

trapped bowel, but it can't get out, and that segment of bowel gets progressively larger and larger and larger, and that's a closed loop obstruction.

Q. And that is an urgent finding, I take it.

A. That's correct.

Q. But if it's -- the fact that it's -- something is not closed loop doesn't necessarily mean the findings are not urgent.

A. I'm sorry, I don't understand the question.

Q. Okay. You could have an urgent finding even without a bowel obstruction, even without a closed loop finding.

A. Oh, yes. There could be perforation associated with your bowel obstruction, yes.

Q. Okay. Now, you also mentioned urgency could depend on degree of the small bowel obstruction.

A. That's correct.

Q. And I don't know if these are the degrees you were talking about, but you mentioned high or low grade.

A. Or intermediate grade.

Q. And what is a high, intermediate, and

low grade small bowel obstruction?

A. Okay. A high grade obstruction is when you see massive dilation of the small bowel or colon above the level of the obstruction. An intermediate grade is when you see mild dilatation. And a low grade, you see mild dilatation and you see gas beyond that segment of obstruction.

Q. And the gas -- first of all, in our situation here, in Exhibits 4, 5, and 6, do you -- how would you describe those in terms of grading?

A. I would say this is intermediate.

Q. In that there is at least mild dilatation of the bowel?

A. That is correct. And well, actually, I do see some colonic gas, so I guess low to intermediate grade.

Q. I take it the absence of gas beyond the point of obstruction would indicate that the obstruction is complete.

A. More often than not, yes.

Q. And the presence of gas beyond the obstruction would tend to make the obstruction possibly less than complete.

A. Yes, sir.

Q. But the presence of gas here in the colon does not rule out the complete obstruction in this case, does it?

A. Is your question can you have somebody who has complete obstruction and still have colonic gas?

Q. Yes.

A. That is possible, though more often than not, when you see colonic gas, the obstruction is not complete.

Q. What would account for colonic gas when there is a complete bowel obstruction?

A. Oh, there still might be some gas left over from before the patient became obstructed.

Q. Can there be the production of any gas in the segment distal to the obstruction following complete obstruction?

A. Yes, but the majority of gas that we have in our small bowel or colon is actually air that we swallow. The organisms in our gut do make some amount of gas, but not an appreciable amount unless there's some problem distally.

Q. And would you agree with Dr. Francken's description in his report that there is only a

small amount of colonic gas noted?

A. If that -- I would agree with that assessment, yes.

Q. Now, is a finding, radiologic finding, of an intermediate grade small bowel obstruction an urgent finding?

A. I guess people have different definitions of urgent. When I'm -- and I was just looking at the hospital -- what I -- my cases I was reading this morning. I saw many urgent findings. I had patients with congestive heart failure. I had patients with pneumonia. I had patients with pericardial effusion, big pleural effusions. On CT, I saw some patients with some very dense calcified coronary arteries. These are all urgent findings. And I think probably about half my cases do have urgent findings such as that.

Q. Is -- I don't know if that's a yes or a no to my question, but is a high grade -- or an intermediate grade small bowel obstruction an urgent finding?

A. In the same sense that a hospitalized patient with congestive heart failure or pulmonary edema or pericardial effusion or pleural effusion,

yes.

Q. And we've already agreed that it is a significant finding.

A. Correct.

Q. So that with regard to the ACR standard, the issue would be in terms of the duty for direct communication whether or not those findings are unexpected. Would you agree with that?

A. If they were unexpected and how acute and how quickly the patient needed treatment of this finding, yes.

Q. Say you were looking at Exhibits 4, 5, and 6 within 15 minutes of the time they were taken.

A. Uh-huh.

Q. And you had no patient contact; you had no more information available to you than Dr. Francken had. In your opinion, is this an urgent situation?

A. I think it's a significant situation. It does not require immediate, immediate attention because I don't think this is absolutely life-threatening at this point, but I think it's an important finding, yes.

Q. Can this situation, as you see it, develop into a life-threatening situation?

A. Oh, yes.

Q. And what would cause that to develop?

A. What would cause that to develop is if the obstruction became worse, if the patient ultimately developed ischemia or some vascular compromise. But the majority of small bowel obstructions that we see in our practice, general radiologists see in our practice, do resolve by themselves.

Q. The fact that the majority of small bowel obstructions resolve by themselves, does that ipso facto make the finding of a small bowel obstruction not urgent?

A. No.

Q. The fact that they can lead to further dilatation, ischemia, and death, does that risk factor make all small bowel obstruction findings urgent?

A. It makes them very important, but, again, urgent meaning you have to -- for example, like a tension pneumothorax, you have to address this issue within five minutes or the patient may

die. Not with that ultimate, ultimate urgency, no.

Q. How long can you delay in communicating results such as we see in 4, 5, and 6, to the attending physician? How long is it acceptable to delay a report like that?

A. I don't know.

Q. Should the findings that are apparent in these studies, in these films, be made known to the attending physician as soon as possible?

A. In the same sense that my patient with congestive heart failure and my patient with pericardial effusion and pleural effusion and coronary artery calcification. These are things we see very commonly on a daily basis, and this morning I saw about five of each. And so in these cases, the standard practice is to dictate a report, correct.

Is there something here that screams out to me I have to get on the telephone and call this -- the attending physician? And you're saying this film was taken 15 minutes ago.

Q. Right.

A. Is it outpatient or inpatient?

Q. Emergency room patient.

A. No.

Q. And why not?

A. Can I share the situation in which I would call?

Q. Yes.

A. Okay. This is an outpatient, who is having some belly pain. He was sent over from the doctor's office, and usually the doc will ask could you give us a call with it. The reason I would call is because otherwise the patient is going to be sent home, and, you know, I don't want to send a small bowel obstruction home.

Q. So I guess I misunderstood your answer before then. This is something that you would have a direct communication on.

A. Again, if this were an outpatient --

Q. Right.

A. -- yes, but it actually depends on the situation. And, again, also with a patient with congestive heart failure, if the patient came in as an outpatient, he was short of breath, I would certainly call the doctor, because this was an outpatient, and, rather than him sending home, you might want to admit him.

If the patient was an inpatient or an emergency room personnel -- emergency room patient, and which this patient is actually being seen actively by a physician at this time, I would not, no.

Q. And if the patient were an emergency room patient, is part of the reason you would not be having direct communication with the emergency room physician is because you would expect that the emergency room physician is going to look at these films himself?

A. Yes. And also equally important to actually have a clinical assessment of the patient.

Q. Would you agree with me that a clinical assessment of a patient cannot always diagnose a small bowel obstruction?

A. That is correct. That's why we need radiology.

Q. All right. And oftentimes symptoms of gastroenteritis, when a patient exhibits symptoms of gastroenteritis, they can, in fact, have a small bowel obstruction.

A. Yes, indeed.

Q. Which would not be apparent clinically.

A. That's correct.

Q. If you were, in this hypothetical situation, aware that the emergency room physician could not read abdominal films, would you then have a direct communication with the emergency room physician?

MR. ESTES: Show my objection unless you define the phrase "could not read" meaning films weren't there or he didn't have the skill or --

MR. BURKE: Didn't have the skill.

THE WITNESS: That physician should not be practicing emergency medicine if he does not have the skills to read this film. This is a very obvious finding.

BY MR. BURKE:

Q. All right. What about a pediatrician, should a pediatrician be able to read those films?

A. A fourth-year medical student should be able to read these films, yes.

Q. A fourth-year medical student should be able to look at those films and see that there is a possible small bowel obstruction.

A. Should see this and say there's something wrong. They may not know exactly where

it is or the cause of it, but they should appreciate that this bowel is too wide.

Q. Now, in the situation where you've read the films 15 minutes after they were taken, the patient is in the emergency room, you're assuming, I guess, that the films are going to be sent to the emergency room.

A. Well, are we talking about 1999 --

Q. Yes, sir.

A. -- or now?

MR. HANSEN: I'll object to form. I'm confused. Are you talking about his hospital or Blessing Hospital?

MR. ESTES: Go ahead and answer. Do you understand the question?

THE WITNESS: I don't understand the question.

MR. BURKE: I don't remember the question.

(Record read.)

THE WITNESS: Yes. And -- yes.

BY MR. BURKE:

Q. And I take it that one of the reasons you feel that direct communication is not necessary is because the ordering physician is either going to have the benefit of the films themselves or your

report in short order.

A. That is correct.

Q. If, for whatever reason, you were made aware that the films and/or the report was not going to make it to the ordering physician, would then the standard of care require you to make direct communication with him?

A. Was the hospital -- was the patient discharged, or was he admitted?

Q. The patient is still in the emergency room.

A. And could you repeat the hypothetical again?

Q. All right. If, for some reason, you were made aware that the films and the report are not going to be able to be given to the ordering physician in a short time period, would then the standard of care require you to make direct communication?

A. That is -- I -- I -- I don't know. That's such a hypothetical situation. One expects the films and/or report to be there in a prompt manner.

Q. The condition shown in the films is of

sufficient urgency that one would hope that whoever is treating the patient would be made aware of those findings in a short amount of time, correct?

A. Could you repeat the question?

(Record read.)

THE WITNESS: I hope that all physicians who treat patients will get the information for all their patients in a timely manner, yes.

BY MR. BURKE:

Q. But would you agree with me that it's particularly important in a situation like this, where there's a small bowel obstruction that's shown on the film?

A. Also in a small bowel obstruction, a person with congestive heart failure, pericardial effusion, pleural effusion, coronary artery calcification, yes. Again, these are things we see commonly, commonly every day, and they're not extraordinary findings or terribly unusual findings, no.

Q. Does the fact that this is an eight-year-old add anything to the equation in terms of the urgency of the communication to the ordering physician?

A. Not that I'm aware of.

Q. Is there any difference in the progression of small bowel obstruction in a pediatric patient versus an adult?

A. In an adult, a small bowel obstruction is more likely to resolve spontaneously. In a pediatric patient, that's less likely to occur.

Q. Is the reserve in a pediatric patient any less than in an adult?

A. Well, if you've got a strapping 16-year-old, the reserve is better. In a little baby, the reserve is far less.

Q. And what about in Kylee Bivens?

A. Kyle was eight years old, I believe.

Q. Yes.

A. And how much did she weigh?

Q. 50.

A. 50 pounds? And how tall approximately?

Q. (Reviewing documents.)

A. To save you some time, I'm not entirely sure. I think a pediatrician would be better able to answer that question.

Q. I can't see her height in here anyway. But you're not sure.

A. I'm not sure for an eight-year-old, no.

Q. Would you agree that, in a child such as Kylee Bivens, that they can deteriorate very quickly due to a small bowel obstruction?

A. Any patient can deteriorate quickly with a small bowel obstruction, sure.

Q. And based on that fact, is it important that someone responsible for the patient's care be made aware of the small bowel obstruction as soon as possible?

A. I believe with any significant finding it's important that the person managing the patient is aware of these findings.

Q. Now, would you agree with me that a radiologist should not assume that a written report will automatically reach its destination?

A. No, I disagree. Otherwise, you know, radiologists read between 50 and 100 cases a day, and we dictate them, and in an ideal world, we should call every physician about it, we should discuss the results with the patient, and this, unfortunately, is not the real world.

We dictate a report in the hopes and in the assumption and the knowledge that this will

get to the appropriate hands.

As I said, significant findings like this (indicating) I see in about half my cases, and this would mean 50 phone calls a day. And I wish we had the resources to do that. And I think that is coming. With the electronic medical record and with voice transcription, I think that is coming maybe in the next five years, but it's not standard of care now, and it certainly wasn't standard of care in 1999.

Q. Move to strike what is coming in the next five years.

MR. ESTES: What good is that going to do?

MR. BURKE: It's a reminder to me later on, when I do my motion in limine, I don't want to hear that again.

BY MR. BURKE:

Q. Would you agree with me that a physician is less likely to expect an abnormality in a routine study?

MR. ESTES: Show the doctor with a puzzled look on his face.

THE WITNESS: What is a routine study?

BY MR. BURKE:

Q. Like a chest film or an abdominal series.

A. Well, where -- because of fears of radiation and because of efficacy studies, fewer and fewer screening studies are done in terms of plain chest X-rays, and so we seldom get chest X-rays just for the hell of it, just on a searching expedition. There's usually an indication for it.

In terms of an abdominal series, you order it because you're suspecting something, not because, you know, this is just a checkup.

Q. In your experience, did you work a general call here?

A. Oh, yes.

Q. So you would be looking at films that come in through the emergency room?

A. Oh, yes.

Q. Do you get a lot of cases of gastro-enteritis coming in through the emergency room?

A. Yes, but more often than not they don't get abdominal films.

Q. When you do get the films or studies done on patients, is there ever a diagnosis of gastroenteritis that accompanies the requisition?

A. On the requisition, I may get a good history, no history, a misleading history, or, you know, for an abdominal series, I may get a history of headache, so it's very variable.

Q. Would you agree with me that in a eight-year-old who is vomiting, that a small bowel obstruction is a relatively uncommon finding?

A. I don't know.

Q. You don't know if the majority of children who have repeated vomiting have a small bowel obstruction?

A. I guess it would depend what age group they are and what the circumstances are. No, I would defer to a pediatrician or a pediatric surgeon in that regard.

Q. You have an opinion here that it was reasonable for Dr. Gregory Francken to expect that his transcribed report would be reviewed in a timely fashion. What do you mean by that?

A. Well, we don't dictate reports not to be read. We dictate them to impart information to patients. And it's not in our job description to ensure that each report gets to each physician. And, again, with the electronic medical record,

this won't be an issue in the future.

Q. Same objection.

And when you say reviewed in a timely fashion, what do you mean by that?

MR. ESTES: I'll just stipulate he's not going to testify to standards of care for any other practitioner other than Francken, so -- but you can answer that, Doctor, with that reminder.

THE WITNESS: Could you repeat the question?

(Record read.)

THE WITNESS: That the report would be evaluated by the managing physician or nurse, resident, intern, or fellow. You know, we don't generate reports, we don't collect data, we don't order tests just for, you know, the sake of ordering them. These results have to be evaluated by the managing physicians.

BY MR. BURKE:

Q. And when you say in a timely fashion, what is a timely fashion?

A. As soon as they're available preferably. But, again, as I said, in the future, it's going to be instantaneous. In 1999, things were different.

Q. You say in opinion 9 the opinions of

Kate Feinstein will be rebutted. Anything in particular?

A. Can we go to her deposition?

Q. Sure. Yes.

A. Okay.

MR. ESTES: Other than what he's already testified to?

MR. BURKE: Right.

MR. ESTES: Which is --

MR. BURKE: Right.

MR. ESTES: -- different than her testimony.

THE WITNESS: Oh.

MR. ESTES: While you're looking at that, I'm going to take a break.

(Brief pause.)

MR. ESTES: Go ahead on the record.

THE WITNESS: On the record, Kate indicated that she felt the interpretation was within the standard of care, and I believe that she felt that Dr. Francken deviated from standard of care by not directly getting on the phone and talking to somebody. So I guess that would be my disagreement.

BY MR. BURKE:

Q. On the transcript itself, did you make

any notes, highlights, dog-ear any pages trying to --

A. I -- no. I don't do that. It was the smallest one. That's why I can't find it.

MR. ESTES: Here it is. Read for a few minutes. I'm going to go to the rest room.

THE WITNESS: Okay.

MR. ESTES: And then we'll talk on the record.

(Short break.)

MR. ESTES: I think the pending question is is there anything else, after looking at that deposition, that you want to rebut other than the disagreement on the communication issue?

THE WITNESS: Okay. Not in my cursory re-review.

BY MR. BURKE:

Q. Now, in this case, Dr. Francken came in somewhere 7:00 or 8:00 a.m.?

A. The -- Kylee had her films at about 1:00 o'clock a.m., and Dr. Francken came in at about 8:00 o'clock in the morning.

Q. Okay. So that's about seven hours later.

A. That's correct.

Q. And his testimony -- in his testimony, he indicated that he phoned the emergency room asking about Kylee Bivens, correct?

A. Yes, to see if she was admitted.

Q. And he was informed that she was admitted.

A. That's correct.

Q. He did not talk to anyone about the findings that he had from his interpretation of abdominal films, correct?

A. As I recall, he didn't recall talking to anybody about the specific findings, no.

Q. And I take it you find that acceptable, correct?

A. If I were in Dr. Francken's situation, I would say, Oh, there's a small bowel obstruction, the patient came in through the emergency room, and I want to see if the patient is admitted.

Now I can simply go to the computer and bring that up, but in 1999, we had a list of admissions through the emergency room, and that is sufficient, and that would certainly have satisfied my curiosity and my duty.

MR. BURKE: Okay. That's all I have. Thanks.

MR. NARUP: No questions.

MR. BURKE: Wait.

BY MR. BURKE:

Q. I guess I -- I just want to -- do you have any other opinions that are not in your 213s and that we haven't discussed today?

A. Not that come to mind now, no.

MR. BURKE: That's all. Thanks.

MR. ESTES: You don't have any questions, do you, Jim?

MR. NARUP: Jim?

MR. ESTES: Maybe he's taking his own bathroom break and he didn't get back yet.

MR. NARUP: Jim?

MR. ESTES: Oh, well, we'll order him a copy. Thank you for your speed in this one.

MR. BURKE: You're welcome.

FURTHER DEPONENT SAITH NOT ...

STATE OF ILLINOIS)
) SS:
COUNTY OF ADAMS)

IN THE CIRCUIT COURT FOR THE EIGHTH JUDICIAL CIRCUIT, ADAMS COUNTY, ILLINOIS

MICHELLE LONG, Special Administrator of the Estate of KYLEE BIVENS, Deceased,

Plaintiff,

vs.) No. 01 L 68

DR. A.O. MATHEW, DR. MATHEW, M.D., P.C., BLESSING HOSPITAL, DR. RICHARD SAALBORN, DR. GREGORY A. FRANCKEN,

Defendants.

This is to certify that I have read my deposition taken on the 30th day of June 2005 in the foregoing cause, and that the foregoing transcript accurately states the questions asked and the answers given by me, with the changes or corrections, if any, made on the Errata Sheet attached hereto.

RICHARD MICHAEL GORE, M.D.

No errata sheets submitted (Please initial)
Number of errata sheets submitted (pgs.)

Subscribed and sworn to before me this day of 2005.

Notary Public

STATE OF ILLINOIS)
) SS:
COUNTY OF WILL)

I, Jacqueline Pietrzyk, a notary public in and for the County of Will and State of Illinois, do hereby certify that RICHARD MICHAEL GORE, M.D., was duly sworn to testify the whole truth, and that the foregoing deposition was recorded stenographically by me and was reduced to computerized transcript under my direction, and that the said deposition constitutes a true record of the testimony given by said witness.

I further certify that the reading and signing of the deposition was not waived, and the deposition was submitted to the deponent's counsel for signature. Pursuant to Rule 207(a) of the Illinois Supreme Court, if deponent does not appear or read and sign the deposition within 28 days, or make other arrangements for reading and signing, the deposition may be used as fully as though signed, and this certificate will then evidence such failure to appear as the reason for signature not being obtained.

I further certify that I am not a relative or employee or attorney or counsel of any of the parties, or a relative or employee of such attorney or counsel, or financially interested directly or indirectly in this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Chicago, Illinois, this 19th day of July, A.D. 2005.

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