Radiology Expert - per SDW - only fair witness) Has since been used by TT

STATE OF O H I O)
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COUNTY OF CUYAHOGA)

IN THE COURT OF COMMON PLEAS

D. JOHN TRAVIS, Executor of the Estate of THORVALD HENRIKSEN, JR.,

Plaintiff,

vs.

No. 233034

LAKEWOOD HOSPITAL ASSOCIATION, et al.,

Defendants.

The evidence videotaped deposition of RICHARD MICHAEL GORE, M.D., taken in the above-entitled cause, before WILMA A. WEINREICH, a notary public of DuPage County, Illinois, on the 18th day of August, 1994, at the hour of 9:07 o'clock a.m., Evanston Hospital, 2650 Ridge Avenue, Evanston, Illinois, pursuant to notice.

Reported by: Wilma A. Weinreich, CSR
License No.: 84-002566

APPEARANCES:

WEISMAN, GOLDBERG & WEISMAN, by
MR. RICHARD J. BERRIS
1600 Midland Building
Cleveland, Ohio 44115,
Representing the Plaintiff;

WESTON, HURD, FALLON, PAISLEY & HOWLEY, by
MR. STEPHEN D. WALTERS
15th Floor Terminal Tower
Cleveland, Ohio 44113-2241
Representing Defendant Lakewood
Hospital Association;

JACOBSON, MAYNARD, TUSCHMAN & KALIN, by
MR. WILLIAM D. BONEZZI
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North Point Tower Suite 1600
Cleveland, Ohio 44114,
Representing Defendant Michael
Schmitt, M.D.

I N D E X

E X H I B I T S

(Whereupon, Defendant Deposition Exhibit Letters A and B were marked for identification.)

MR. WALTERS: Before the reporter swears in the witness, I believe that we can stipulate that we all waive the filing of this or any other deposition in this case; is that correct?

MR. BERRIS: That's agreed.

MR. BONEZZI: That is agreed.

(Whereupon, the witness was duly sworn.)

MR. WALTERS: Now, you may swear in the witness.

RICHARD MICHAEL GORE, M.D.,

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

DIRECT EXAMINATION

BY MR. WALTERS:

Q. Would you state your full name, please.

A. My name is Richard Michael Gore.

Q. And Dr. Gore, you are a physician, correct?

A. That is correct.

Q. Doctor, we are sitting here in one of the

offices at Evanston Hospital in Evanston, Illinois, correct?

A. Yes.

Q. Right adjoining the campus of Northwestern University, correct?

A. Very close.

Q. Doctor, would you state for the record your professional address?

A. Department of Radiology, Evanston Hospital, 2650 Ridge Avenue, Evanston, Illinois 60201.

Q. As indicated a moment ago, doctor, you are a physician. Is your area of practice focused in any particular speciality?

A. Yes. I am a diagnostic radiologist.

Q. What is a radiologist?

A. A radiologist is a physician who after medical school and internship does a four-year residency and often a fellowship looking at imaging.

The imaging technique can be either plain radiographs, CT, magnetic resonance imaging, ultrasound, nuclear medicine. So it's primarily medical imaging.

Q. And when you use the term plain radiographs, are you talking about what we laymen generally refer to as x-rays?

A. That is correct.

Q. Doctor, if you would for the Jury indicate, please, what your educational background is.

A. I received a bachelor's degree from Northwestern University in 1975. In 1977 I received my medical degree also from Northwestern.

I was in the six year program in honors medical education in which I received my bachelor's degree and M.D. in six years.

I then went to Northwestern University Medical School for my residency, and I did a four-year residency which included in part internship and the remaining years in residency.

After I completed my residency in 1981, I spent a year of fellowship out at the University of California in San Francisco at Moffitt Hospital doing a fellowship in abdominal imaging, and that's the extent of my formal training in radiology.

Q. If I understand then, doctor, you became a physician -- became an M.D. when?

A. In 1977.

Q. And then you embarked upon the residency program you have referred to?

A. In 1977, yes.

Q. As part of your residency program, you or any other radiologist, what is the focus of study? What do you do?

A. The focus of study is the practical aspects of all forms of abdominal imaging. We spend rotations looking at plain films, barium enemas, looking at the kidneys.

We also spend time doing mammography angiography, interventional procedures. We also spend time doing ultrasound and computer tomography and nuclear medicine.

Back then magnetic resonance imaging was in its infancy so there wasn't much exposure to that.

But all facets of abdominal and body and head imaging are included in the residency.

Q. Doctor, are you board certified in your speciality?

A. Yes, I am.

Q. Would you explain for the Jury what that

means, being board certified in a medical speciality?

A. Board certification means that you have met certain accepted standards given by a certain board.

In my case, it happened to be the American Board of Radiology where you fulfilled a residency program, the approved program, and then also you have to take a number of tests.

In radiology, there's both a written and an oral test, and this is a standard that you have to achieve and then you are board certified.

Q. Now, doctor, the exams that you take, are they upon completion of your residency in radiology?

A. In radiology during the fourth year, there is a written portion of the examination; and if you pass the written part of the examination, then in June -- final June of your residency, then you undertake your oral examination.

Q. You became board certified in radiology when?

A. In June of 1981.

Q. Did you pass the exams first time around?

A. Yes, I did.

Q. Doctor, you are based here at Evanston Hospital, correct?

A. That's correct.

Q. And this is the sole hospital right now that you work out of, correct?

A. Evanston Hospital also has an affiliated hospital called Glenbrook Hospital; and on the weekends, sometimes I cross-cover over there as well.

Q. Have you during the course of the practice that you have been engaged in since completion of your residency in 1981 been on staff at any hospitals other than Evanston?

A. Yes. From 1982 to 1991, I was at Northwestern Memorial Hospital which is our sister institution in downtown Chicago. We are both a part of the Northwestern University medical system.

Q. Is Evanston a teaching hospital?

A. Yes, it is.

Q. And is part of your time spent teaching?

A. Yes, it is.

Q. Do you have a faculty appointment of any sort?

A. Yes, I do.

Q. And what is your appointment?

A. I am a professor of diagnostic radiology at Northwestern University Medical School.

Q. I know in the academic world there are levels of faculty appointment I guess beginning with instructor --

A. Right.

Q. -- and ranging up from there. Are you a full professor?

A. Yes, I am.

Q. How long have you been at Evanston Hospital?

A. Since January of 1992.

Q. And here at Evanston Hospital, do you have any particular focus or appointment?

A. Yes. I am chief of the section of gastrointestinal radiology and abdominal imaging.

Q. In a few minutes, we are going to be looking at some films that were taken at Lakewood Hospital.

What portion of the body are they of?

A. These are lumbar spine films, would also include portions of the abdomen as well.

Q. Doctor, in addition to your appointment and service as a member of faculty of the medical school of Northwestern University, have you published in the medical literature?

A. Yes, I have.

Q. And do you have any idea how many publications you have?

A. Approximately about 140, and also just came out with a book as well.

Q. What's the name of the book?

A. Textbook of Gastrointestinal Radiology.

Q. Doctor, what portion of your professional time is spent in the practice or teaching of medicine?

A. Virtually all.

Q. And I assume, although I didn't ask you, that you are licensed to practice medicine in the State of Illinois?

A. Yes, I am.

Q. Dr. Gore, in the course of your practice experience, have you had occasion to interact with emergency departments or emergency rooms at the various hospitals that you have worked at?

A. Yes, I have.

Q. And have you had occasion to engage in what is sometimes called over-reading or rereading of films, mainly x-ray films I am talking about, that have been initially read by an emergency room physician?

A. Indeed I have, yes.

Q. Doctor, were you asked to review certain materials in this particular case involving a patient by the name of Henriksen?

A. Yes, I was.

Q. And I believe my partner Deirdre Henry sent you some materials and asked you to took a look at them, correct?

A. Yes, she did.

Q. What was it that you reviewed?

A. I reviewed the emergency room records of the patient both on the initial presentation and then when he returned the following morning.

I also evaluated his lumbar spine films as well as the radiology report interpreting the lumbar spine films.

Q. Doctor, you read the interpretation of the films as well?

A. That is correct.

Q. Dr. Gore, you are aware that Mr. Henriksen first came to the emergency room of Lakewood Hospital shortly after two a.m. on October 3, 1990, correct?

A. Yes.

Q. And you have reviewed the records from Lakewood Hospital for that emergency room visit?

A. Yes, I have.

Q. And the x-rays -- the x-ray films that you reviewed were taken at that visit?

A. Yes, they were.

Q. And you are aware also that Mr. Henriksen was returned to the emergency department of Lakewood Hospital shortly after 11:30 a.m. that same morning?

A. That's correct.

Q. And you have reviewed the records of that emergency room visit?

A. Yes, I have.

MR. WALTERS: Doctor, prior to starting this video tape deposition, we marked a couple of the x-ray films, and I am going to ask you to put them up on the shadow box, and I am going to ask you some questions.

I understand, however, that our video tape operator will need to move his camera around so we are going to go off the record for just a moment so that we can reverse the position of that camera.

(Whereupon, a discussion was had off the record.)

BY MR. WALTERS:

Q. Dr. Gore, we got a chance to readjust the camera angle. Of the films sent to you, have you selected two that you find particularly instructive in this particular case?

A. Yes, I do.

Q. And have you placed them on the view box or shadow box?

A. Yes, I have.

Q. Doctor, directing your attention and perhaps the camera's attention as well to the x-ray films, these have been marked Exhibits A and B, Defendants' Exhibits A and B.

For the record, let's identify those. Exhibit A is what?

A. Exhibit A is a lateral radiograph of the lumbar spine; and by the markings that we see over here, it was obtained on 10-3-1990 at 3:18 in the

morning.

Q. And Exhibit B, doctor, would you identify that for the record?

A. Exhibit B is an AP radiograph of the abdomen, and this was obtained on the same day and approximately the same time.

Q. When you refer to a lateral view, which is what Exhibit A is, you are talking about a view taken from the patient's side?

A. That is correct.

Q. And when you say AP, which is the view depicted in Exhibit B, you are talking a view taken from front to back, anterior to posterior?

A. That is correct.

Q. Doctor, looking at those x-ray films, do you see any significant abnormality displayed on those films?

MR. BONEZZI: Objection. The question goes beyond the scope of Dr. Gore's opinion letter that was dated in June of 1994. Go ahead, doctor.

THE WITNESS: Yes, I do.

BY MR. WALTERS:

Q. And what do you see on those films?

MR. BONEZZI: Objection. Same basis.

MR. WALTERS: We will start with Exhibit A.

THE WITNESS: Exhibit A, which is the lateral radiograph of the lumbar spine, demonstrates a curvilinear calcification anterior or in front of the L-4 and L-5 vertebral bodies which can be seen here (indicating) and here (indicating), and this indicates calcified abdominal aortic aneurysm.

MR. BONEZZI: Objection. Move to strike for the reason I have already given.

BY MR. WALTERS:

Q. Doctor, with regard to Exhibit A, I am going to ask you to identify for the Jury -- and I think some of these things they will know already or certainly by the time you testify in this case.

But running down the center of that film, there are a series of square-shaped figures. What are those?

A. These are the --

MR. BONEZZI: Objection.

MR. WALTERS: And perhaps -- do you want a continuing objection on this line --

MR. BONEZZI: That would be fine.

MR. WALTERS: -- so we don't have to jump in?

MR. BONEZZI: Yes.

MR. WALTERS: Let me come back.

BY MR. WALTERS:

Q. Doctor, for the benefit of the Jury, down the center -- running down the center of Exhibit A, there are a series of square or block-like structures. What are those?

A. These are the vertebral bodies of the lumbar spine, and we can see L-5, L indicating lumbar, L-5, L-4, L-3, L-2, and L-1.

Q. And so that the Jury can get oriented and understand your testimony all the better, Exhibit A, the lateral view, would you point to what would be the back of Mr. Henriksen?

It's on the left, is it not?

A. This would be the patient's back, correct.

Q. And to the right then would be the abdomen?

A. That's correct. This would be the anterior abdominal wall here. This is the front of the patient (indicating).

Q. Now, you indicated and pointed to areas that you referred to as indicating an abdominal aortic aneurysm.

What is an abdominal aortic aneurysm?

MR. BONEZZI: Objection.

THE WITNESS: An abdominal aortic aneurysm is an expansion of the abdominal aortic wall to greater than three to four centimeters in size.

BY MR. WALTERS:

Q. Now, the aorta is the largest blood vessel in the body, correct?

A. It is the largest artery in the body, correct.

Q. And it is situated where in the body?

A. It is situated anterior or in front of the lumbar spine, and it sits next to the inferior vena cava, which is the largest vein of the body, and it's located deeply posterior in the patient's abdomen.

Q. Typically in an adult male, what is the size of the abdominal aorta in terms of external diameter?

A. In most males, the aorta usually measures 2 to 2.5 centimeters in size.

Q. And that is about an inch?

A. That's correct. An inch.

Q. Slightly over an inch?

A. Uh-huh.

Q. On the lateral view that you have been talking about, the side x-ray view of Mr. Henriksen marked Exhibit A, how wide is the abdominal aorta?

A. The aorta measures 8.2 centimeters, and it corresponds to a width of approximately three and a half inches.

MR. BONEZZI: Objection. Move to strike.

BY MR. WALTERS:

Q. Are you indicating, doctor, then that the aorta on Mr. Henriksen is approximately three times or better the normal size?

MR. BONEZZI: Objection.

THE WITNESS: That is correct.

BY MR. WALTERS:

Q. Now, other than that abnormality, is there anything else with regard to the abdominal aorta of Mr. Henriksen that shows abnormality?

MR. BONEZZI: Objection. And I will take a continuing objection if you don't mind.

MR. WALTERS: Sure.

THE WITNESS: No.

BY MR. WALTERS:

Q. Now you mentioned something -- I think you used the word calcification?

A. That is correct.

Q. Would you point again so that the Jury can see where the calcifications are?

A. Here we see the calcifications along the back wall of the aneurysm (indicating).

Q. Yeah. I was just going to say you can go ahead and circle those.

A. Here and again here and here we see calcifications along the front or anterior wall of the patient's aneurysm (indicating).

Q. Mr. Henriksen has those calcifications per that film, Exhibit A. Through what process? How does that come about?

A. This is part of the atherosclerotic process in which weakness develops in the wall of the aorta, and over time it slowly expands and becomes larger and larger and larger.

And during this process there is often depose -- deposition of calcium within the intima, and that's part of the lining of the aorta.

Q. The aorta is, if I may use the word, sort of like a pipe?

A. That's correct.

Q. And am I understanding correctly that when

you refer to the intima, you are indicating that the wall of that pipe has itself an inner part?

A. That is correct.

Q. Now you have used the term atherosclerosis. I think everyone on the Jury is familiar with that.

But just so the record is complete, what is atherosclerosis?

A. Atherosclerosis is part of the degenerative process that affects the arteries. This is where you get deposition of calcium and also fat in the wall of major blood vessels.

Q. Now, doctor, we have been talking largely about Exhibit A; but referring your attention to Exhibit B, does it also -- that's the anterior/posterior view on the left as we are looking at it -- does it also depict an abdominal aortic aneurysm?

A. Yes, it does, but it depicts it somewhat less well. We see this is the patient's right, patient's left towards his head, towards his feet.

And again we see some calcification on the left side of the aneurysm, and here we see some on the right side.

Q. Doctor, based upon the size of the aneurysm as depicted in Exhibits A and B up on the screen and your indication that the size would appear to be about 8.1 or 8.2 centimeters, do you have an opinion based upon a reasonable medical probability as to how long Mr. Henriksen had an abdominal aortic aneurysm?

MR. BONEZZI: Objection.

THE WITNESS: This has been going on for years because the medical literature indicates that aneurisms grows about two to four millimeters a year. So they grow about a quarter inch to a third of an inch a year.

Q. Just doing some quick artithmetic in my head, doctor, are you indicating that the length of time Mr. Henriksen had an abdominal aortic aneurysm approaches a figure of nearly ten years?

A. I would imagine at least somewhere between five and ten years.

Q. With regard to the period of a month before Mr. Henriksen was first brought to the Lakewood Hospital emergency room, would the size of the abdominal aortic aneurysm at that time have been approximately what we see on Exhibit A?

A. Yes. It wouldn't have grown or changed significantly in a period of a month.

Q. What about the calcifications? Would those calcifications have been present a month earlier?

A. Yes, they would.

Q. Doctor, I think by the time you testify in this case, there will be testimony from more than one source which will explain to the Jury the process of what happens or can happen with an abdominal aortic aneurysm.

But if the Jury will bear with us, I want to ask you a couple questions about that. What is the danger if any to a patient of having am abdominal aortic aneurysm?

A. The danger -- there are two major dangers. The first is rupture and bleeding of the aorta, and the second is infection of the aneurysm.

Q. With regard to an aneurysm of the size of Mr. Henriksen's as it was in early October of 1990, is there any likelihood in your opinion of an imminent rupture or leaking of that aneurysm?

A. Any aneurysm that's eight centimeters in size is a great risk and peril for rupture and

bleeding.

Q. Doctor -- were we getting anything after that? Your microphone came down, which happens a lot.

Doctor, with regard to the radiographic findings that display an eight centimeter abdominal aortic aneurysm in Exhibits A and B, are those subtle findings?

A. What do you mean by subtle?

Q. Well, are those findings that are difficult for you to pick up?

A. Not for me as a radiologist, no.

Q. Doctor, is there any question in your mind that this man as per Exhibits A and B had an abdominal aortic aneurysm?

A. Within reasonable certainty, no.

Q. Doctor, based upon the records that you have reviewed and, if I understand correctly, those are the two emergency room records for Mr. Henriksen from October 3 of 1990 and the x-ray films which include Exhibits A and B above and also the interpretation -- radiographic interpretation by Dr. Mendoza, first of all, do you have an opinion as to whether or not the interpretation by

Dr. Mendoza was correct?

A. It was correct.

Q. And that interpretation relates essentially what you have now told us about the presence of an eight centimeter abdominal aortic aneurysm, correct?

A. Yes, it does.

Q. Secondly, doctor, with regard to the opinions that you have reviewed, I want you to assume that the x-rays, Exhibits A and B, were taken of Mr. Henriksen at or about 3:18 in the morning of October 3rd, 1990 and that they were read and interpreted initially by the emergency room physician, Dr. Michael Schmitt, and his diagnosis is as indicated on the emergency room record that you have reviewed for that first visit of October 3rd, 1990.

I want you to assume further that the records were then read by a radiologist, Dr. Mendoza, at approximately 4 or 4:20 p.m. that same day and that the interpretation was as indicated in Dr. Mendoza's interpretation.

Based upon that, doctor, do you have an opinion based upon a reasonable medical probability

as to whether or not that time between the initial reading by the emergency room physician, Dr. Schmitt, and the subsequent reading of the x-ray by Dr. Mendoza is a time period that is within the standard of care for rereading of x-rays taken in energy rooms?

First of all, do you have an opinion?

A. Yes, I do.

Q. And what is that opinion?

A. My opinion that this falls well within the standard of care and the norms, at least in all my experience in the handling and disposition of emergency room films.

Q. Doctor, if you would, can you tell us what typically takes place when an emergency room visit is made in the middle of the night as in this case and an x-ray is taken for whatever purpose or ordered by the emergency room physician?

Can you track it through for us for the Jury so that they understand what the process is of interrelation between radiology and emergency room?

A. Well, let me just explain our experience at Evanston Hospital. If a patient has an x-ray performed at 3:00 o'clock in the morning, the next

morning, sometime around 6:30 or 7:00 o'clock, one of our filing staff will go over to the emergency room department, pick up the films and then bring them back to the file room.

At that point, one of the file room crew will sit down at the computer and see if this patient has old films.

If old films were present, then these films will be obtained, and they will be put together with the patient's emergency room films.

Also at that time the patient is charged, and also at that time the file room technologist will create a requisition for which the radiologist will make the final interpretation.

If the patient has not had old films, then a new jacket will have to be created, and then this new jacket and the emergency room films will be put together in a cellophane jacket and then presented eventually to the radiologist for interpretation.

Q. Now, doctor, are there some hospitals that have radiologists on site around the clock?

A. Yes, there are.

Q. Is Evanston Hospital here one of those hospitals?

A. No, it is not.

Q. Is it typical that most hospitals do not have a radiologist on site 24 hours?

A. Not on site, but they do have one on call 24 hours a day.

Q. And if an emergency room physician is unsure of what he or she is seeing in an x-ray film or has some level of insecurity about what the radiographic diagnosis is, typically is there a mechanism by which they can either place a phone call to a radiologist or in some fashion flag the x-ray for early reading?

A. What they always, or at least in all the institutions I have been associated with, they will have the phone number of the radiologist who is on call. Then of course they can call the radiologist in to help them out.

If their level of suspicion isn't quite large enough, they don't want to bring the radiologist in, then they can flag it for the radiologist to read first thing in the morning or they can walk the films over themselves and show them to the radiologist.

Q. Absent that sort of flagging of film for

early reading, is the process by which x-rays are re-read by radiologists along the lines that you have testified to a few minutes ago?

A. At the institutions that I am familiar with.

Q. And have you made any determination or testing of, for example, how that works here at Evanston in terms of time, how long the time period is from the initial reading in the emergency room until the final reading by the radiologist after the jacket has been made all up?

A. Yes, I have. I was consulted about this case in late June of this year; and when I have had the opportunity to be officer on day -- and our job as officer on day is to read emergency room films as they come in directly from the emergency room.

That's when we are on duty and a film is taken. Then we read the film immediately. And by reading the film, we give a provisional interpretation.

We don't give a final interpretation until we can compare it with old films. And so for example if the patient comes in at 8:00 o'clock in the morning and has for example a film of the ankle

and I see there is an ankle fracture, I will make my provisional note. The films will go back to the emergency room.

And then on a number of these patients, I have said how long does it take for the films to eventually come back to me to interpret or another radiologist to interpret.

And I was quite struck by the variation in time. The best was about six hour turn around. That is, a patients comes to the emergency room at 8:00 o'clock in the morning, gets his x-ray at 8:15.

I give my provisional interpretation at 8:20. The patient and film go back to the emergency room.

And then the best turn-around time where I get the patient's films and the jacket and the requisition for an official interpretation, that was about six hours.

But I must say some took two or three days, but those are usually patients who had old films.

Q. Now, doctor, in this case I want you to assume that once the radiologist, Dr. Mendoza, did

read the films of Mr. Henriksen, he immediately contacted the emergency room to orally indicate that the man had an aneurysm and needed to be called back.

But that by the time that occurred, which was sometime after 4:00 o'clock in the afternoon, Mr. Henriksen was already in surgery, having returned to Lakewood Hospital about 11:36 that morning.

Were the actions of Dr. Henriksen in immediately calling the emergency department to alert them that this was a man with an abdominal aortic aneurysm within the standard of care in your opinion?

A. It was Dr. Mendoza. And yes, those were within the standard of care.

Q. Do you find any deviation from the standard of care at Lakewood Hospital with regard to the department of radiology, whether it be the radiologist or radiologic staff, in terms of the time period in which the radiographic interpretation was done and communicated back to the emergency room?

A. No, I don't.

MR. WALTERS: That's all I have. Doctor, I think there will be some other people asking you questions. If we can go off the record, we will let you go back to your desk.

(Whereupon, a discussion was had off the record.)

CROSS-EXAMINATION

BY MR. BERRIS:

Q. Doctor, my name is Richard Berris, and I represent the plaintiff in this matter. Would you agree that hospitals have the responsibility and the duty to establish policies and procedures relating to patient safety?

A. Yes.

Q. One of their responsibilities -- a hospital's responsibility in that regard is to establish quality assurance procedures?

A. Yes, they do.

Q. And quality assurance is what?

A. Quality assurance is to make sure that the hospital is functioning to the best interest of the patient.

Q. In terms of rereading of x-rays, how does that relate to quality assurance?

A. I don't understand the question.

Q. Do you know -- do you know what I mean by term rereading x-rays?

A. Yes.

Q. What is meant by that?

A. Rereading x-rays is when the patient comes in off hours in the emergency room. A provisional interpretation is provided by the emergency room physician.

Then when the radiologist comes back the next day will reread routine films and give an official interpretation.

Q. And that is a quality assurance mechanism, correct?

A. That is correct.

Q. It's designed to improve patient care?

A. That is correct.

Q. Would you agree that those working in a hospital setting, doctors, nurses, technicians and all hospital personnel, have a responsibility to comply with the policies and procedures established by the hospital?

A. Yes, if they are good procedures.

Q. If they are good procedures?

A. Right.

Q. The hospital obviously has a responsibility to establish good procedures --

A. That's correct.

Q. -- correct? I want you to assume that Lakewood Hospital established a rereading procedure.

A. All right.

Q. A protocol for rereading of x-rays taken in the emergency room during nighttime hours when there isn't a radiologist within the hospital.

A. Uh-huh.

Q. Do you know what that procedure was?

A. Yesterday I was supplied with the written procedure for the reinterpretation of x-rays, and it's listed here on Exhibit No. 1 from yesterday's deposition.

Q. I want you to assume that there was an established and understood protocol at Lakewood Hospital that x-rays interpreted by the emergency room physician during nighttime hours at Lakewood Hospital were to be read first thing in the morning by the radiologist. All right?

MR. WALTERS: Is there a question?

MR. BERRIS: Yes. I want him to assume that.

THE WITNESS: I don't believe it states that here, though.

BY MR. BERRIS:

Q. I want you to assume that that's the understood protocol and agreement between the emergency room department and the radiology department.

MR. WALTERS: Show my objection.

BY MR. BERRIS:

Q. First of all, is the rereading of x-rays under those circumstances first thing in the morning a reasonable procedure?

MR. WALTERS: Again, objection.

THE WITNESS: What do you mean reasonable? In terms of being --

MR. BERRIS: A good procedure.

THE WITNESS: It's a good procedure.

BY MR. BERRIS:

Q. And assuming that is the procedure, then the hospital personnel have a responsibility to comply with that procedure, correct?

A. That's correct.

MR. WALTERS: Objection. May I have a

continuing objection on this one?

BY MR. BERRIS:

Q. I want you to also assume that the x-rays that are taken in the emergency room during the evening hours, again when a radiologist is not on duty, are picked up by x-ray technicians in the emergency department and delivered over to the radiology department first thing in the morning, and the technicians hang the x-rays on the shadow box. All right?

A. This assumption I have a little bit of difficulty with because usually they don't take the films directly from the x-ray department -- the emergency room department and then deliver them directly to the radiologist to read.

Usually it goes through the catacombs of the file room before they are presented to the radiologist, unless the film has been flagged for special interpretation or --

Q. That's the way you do it at your hospital?

A. Right.

Q. Correct?

A. Correct.

Q. Do you know how it's done over at Lakewood

Hospital?

MR. WALTERS: Let him finish, please.

THE WITNESS: And again all the hospitals I have been affiliated with.

BY MR. BERRIS:

Q. Do you know how it's done over at Lakewood Hospital?

A. Not specifically, no.

Q. Different hospitals establish different protocols, correct?

A. That's correct.

Q. Have the protocols at the various hospitals that you have worked at always been the same?

A. Again, I haven't seen written protocols either here or at my prior institution, but generally the unwritten protocol, the procedures are the same.

Q. What's the protocol here at Evanston Hospital in terms of when an x-ray rereading is to be accomplished?

A. There is no written rule about when it should be reread. They are not given any special priority unless the examination has been flagged.

The people who read the emergency room films also read outpatient films. And so they are put in a big bin together, they are not segregated, and it's primarily on a first-come-first-serve basis. The first films we get are the first ones we interpret.

Q. So the emergency films at your hospital are given no special priority?

A. They are given priority ahead of in-patient films; but with the outpatient films, they are intermingled.

Q. You indicated that after you became involved in this lawsuit, you did a little investigation at your hospital to try to determine how long this rereading procedure was accomplished here at Evanston Hospital, correct?

A. Correct.

Q. And I think you indicated you were quite struck -- I think that's the word you used --

A. Yes.

Q. -- by the discrepancy in time here at your hospital as to how long it may take to get a reread.

A. Uh-huh.

Q. Correct?

A. Correct.

Q. And you indicated that it could take as long as three days at your hospital --

A. That's correct.

Q. -- to get a reread of an emergency film --

A. That's correct.

Q. -- correct? Do you think that's a safe procedure?

A. That's the way the real world is. It's not the ideal procedure, but that's how things work in practicality.

Q. Has there been any consideration here at your hospital of formulating a policy so that emergency films that are re-read aren't sitting around for three days without a reread?

A. By not sitting around, that means films may have been taken -- for example, an orthopaedic surgeon may have pocketed the films for a few days and sent them back to radiology for a final interpretation.

That usually is the case in the films that are missing two or three days. The films have been somehow removed from the system, walked out and

escaped.

Q. The purpose of the reread procedure by the radiologist is to pick up an abnormality seen on the x-ray that for whatever reason was missed by the emergency physician, correct?

A. The purpose is to officially generate a report so it can be part of the patient's permanent medical record, and hopefully the radiologist will have more experience in looking at x-rays and may find abnormalities that are missed by the emergency room physician.

Q. Some of those abnormalities that may be missed by an emergency physician may be life-threatening emergencies, correct?

A. That is correct.

Q. Such as Mr. Henriksen's eight centimeter aneurysm, correct?

A. That's correct.

Q. That was a life-threatening emergency?

A. Yes, it was.

MR. BERRIS: Doctor, I think that's all I have. Thank you.

CROSS-EXAMINATION

BY MR. BONEZZI:

Q. Dr. Gore, my name is Bill Bonezzi. I represent Dr. Schmitt and his emergency group. Yesterday your deposition was taken, and a number of questions were asked not only by myself but also by Mr. Berris relative to your opinions and information that you understood relating to this case.

A. That is correct.

Q. Do you recall that?

A. Yes.

Q. Have you had a chance to review the deposition transcript that would have been generated as a result of those questions asked of you yesterday?

A. No, I did not have a chance to review it.

Q. Did you prior to yesterday and prior to authoring the report that we have talked about very briefly have an opportunity to read Dr. Mendoza's deposition?

A. No, I have not.

Q. And you are aware that Dr. Mendoza was the radiologist at Lakewood Hospital who provided the

interpretation following a reread at approximately 4:20 in the afternoon of October 3rd, 1990?

A. That's my understanding, yes.

Q. And as a result of not reading his deposition, then you are unaware of the protocols and the procedures that Dr. Mendoza discussed during that deposition relative to when films that are generated as a result of a physician's order in the emergency room are over-read by a certified radiologist at Lakewood Hospital; is that correct?

A. I am not familiar with what he said the procedures are.

Q. Doctor, you would agree with me that a radiologist based upon his or her training, experience and background is in a much better position to provide radiologic interpretation as compared to or as opposed to an emergency room physician who has not been trained to the extent that a radiologist has. Do you agree with that?

A. A better physician in determining abnormalities?

Q. Yes.

A. Yes.

Q. I am speaking specifically of

abnormalities that may be seen that may arise on a film, you providing an interpretation as opposed to an emergency room physician.

You would expect to be able to understand and/or pick up abnormalities sooner than an emergency room physician. Would you agree with that?

A. Yes, that's the way it should go, but occasionally they find things that we miss when reading films on line and we might miss a subtle fracture, but the emergency room physician, because he can actually feel where the patient is injured, he can actually see the fracture and pick it up before we do.

Q. So, in other words, what you are saying is that the clinical picture, the clinical presentation of a patient in the scenario that you have just outlined, provides information to the emergency room physician that you don't have as a radiologist?

A. That's correct.

Q. And vice-versa, you as a radiologist can pick up things on a film when you are directly looking at something or looking for something that

an emergency room physician may not appreciate?

A. That's correct.

Q. Doctor, what is reader bias?

A. Reader bias is based on the fact that if you are forewarned that there is an abnormality on a film, and specifically what abnormality there is, you are going to be on special attention to look for that abnormality and really focus in on that area.

Q. At the time that you were first contacted to provide information in this particular case and before you had an opportunity to either review records or to review the films, were you told that Mr. Henriksen had an abdominal aortic aneurysm that had ruptured and that caused him to be taken to surgery on or about October 3, 1990?

A. Yes, I was.

Q. So, in other words, you had prior information that was provided to you before you had the opportunity to review the films that you have spoken about here this morning; is that right?

A. That's right.

Q. Can you tell me whether an LS spine film or an AP, which I believe is Exhibits A and B, are

the best type of diagnostic studies to provide information to a physician, be it an emergency room physician or a radiologist, when attempting to determine if an abnormality exists such as an abdominal aortic aneurysm?

A. The plain films of the lumbar spine and the plain film of the abdomen are not very good tests for diagnosing abdominal aortic aneurysms.

Q. And I believe that you indicated in your previous direct examination in your testimony that Exhibit B, which I believe is the AP view --

A. Correct.

Q. -- was not as good in providing information relative to the abdominal aortic aneurysm that Mr. Henriksen had as Exhibit A or the LS spine?

A. In this patient, correct.

Q. In the past in your practice in the 17 years that you have been a practicing radiologist, you have reviewed diagnostic studies ordered by emergency room physicians in your attempt to provide over-reads or interpretations; is that right?

A. Yes, I have.

Q. And in that period of time, you have picked up abnormalities that had not been appreciated or seen by the emergency room physician; is that right?

A. That's right.

Q. And is it your opinion that the failure of an emergency room physician to pick up an abnormality to miss something that you ultimately see, that by itself is not a deviation from acceptable standards of practice in providing an interpretation by an emergency room physician of an x-ray?

A. That is not a deviation to the best of my knowledge, yes.

Q. You will bear with me for just one second, sir. I think you also testified that the emergency room physician provides what you have characterized as a provisional reading or a reading that would not be considered an official reading of an x-ray; is that right?

A. That's correct.

Q. And is it your understanding that in every hospital or institution that you have been affiliated with that regardless of the stature or

the standing of the emergency room physician who orders an x-ray, regardless of how good he or she may be in interpreting x-rays, there is still a protocol of procedure and a dictate that a radiologist will provide an over-read or a second interpretation, an official interpretation, of any and all diagnostic studies ordered by emergency room physicians?

A. At all the hospitals in which I have worked, yes.

Q. And the purpose of that is to provide the quality assurance that is mandated for patient care; is that right?

A. I don't know if there are specific guidelines for that at every hospital, but that's how things work in practice.

Q. Because things can be missed?

A. Yes.

Q. Which is why you want somebody trained in that speciality, radiologic specialties, to provide the official interpretation so that if something is missed so that help can be provided to the patient that takes place?

A. That is correct.

MR. BONEZZI: I have nothing further. Thank you, sir.

REDIRECT EXAMINATION

BY MR. WALTERS:

Q. Doctor, just a couple things to tie up perhaps some loose ends. And this is Steve Walters again so the Jury understands who is asking the questions.

Dr. Gore, so that it is clear, when x-ray films are brought to the department of radiology, whether it be from the emergency room or from outpatient clinics -- we will stop a minute here. Do you want to go off the record while he's --

THE WITNESS: That's fine.

MR. WALTERS: Is that all right? Let me back up.

BY MR. WALTERS:

Q. Dr. Gore, when x-ray films are brought to the department of radiology from either the emergency room or from the various outpatient clinics, are they immediately put up and hung in front of a shadow box and read or are there things that need to be done?

A. If a film comes in from the emergency room

on line while the radiologist is sitting there, he will look at the film immediately and give a provisional report.

He will then bring it back -- give it back to the emergency room. Then it will go through channels and eventually be officially interpreted.

Q. Okay. Now let me ask you this. Let us suppose that we are talking about films that have been taken during off hours. In other words, the patient is no longer in the emergency room.

A. Right.

Q. Are there things that need to be done?

A. Yes. Again, it has to go through the maze of the file room to eventually come back to be officially interpreted by the radiologist.

Q. And with regard to the time involved in this case, which was a reading occurring sometime after 4:00 o'clock p.m., again, is it your opinion that the standard of care was satisfied by a reading done within that time frame?

A. Yes. It seems very customary.

Q. Some questions have been asked by both Mr. Berris and Mr. Bonezzi about the way things are done here.

So that it is clear to everyone, how many beds are here at Evanston Hospital?

A. We have 625 beds.

Q. So it's a fairly large hospital?

A. Yes, it is.

Q. And with regard to the teaching hospitals of the medical school of Northwestern University, what are the teaching hospitals?

A. The teaching hospitals are Northwestern Memorial Hospital, Children's Memorial Hospital, the Veterans Administration Hospital Lakeside, the Rehabilitation Institute the Chicago, and Evanston Hospital and Glenbrook Hospital.

Q. So this is a teaching hospital?

A. Yes, it is.

Q. And you teach residents and medical students?

A. Yes. The same residents and medical students rotate through all the hospitals.

Q. Mr. Bonezzi asked you about reader bias, and you gave a definition of that. Is the depiction of an abdominal aortic aneurysm in Exhibits A and B, the films that you were good enough to look at for us a few minutes ago, is the

depiction of the aneurysm in those x-rays so subtle that it would be missed without some foreknowledge that it existed in your opinion?

MR. BONEZZI: Objection to the form of the question.

THE WITNESS: For a radiologist it is not subtle, no.

BY MR. WALTERS:

Q. Doctor, there was also some question about the views indicated in Exhibits A and B in terms of their likelihood of picking up an abdominal aortic aneurysm.

During the off hours in an emergency room, who makes the decision as to what type of x-ray or radiographic study if any will be done on a patient?

A. It's initially the emergency room physician.

Q. And if the emergency room physician feels that he is picking up clinically symptoms of something that may not be shown on a flat plate x-ray film --

A. Uh-huh.

Q. -- and wants to consider another study,

does he have certain options available to him in terms of what to do with the patient?

A. Yes. He can order a CT scan, an ultrasound, a magnetic resonance imaging scan. That he would do in conjunction with calling the radiologist to get approval to order these tests.

Q. Was that done in this case?

A. Not that I am aware of.

MR. WALTERS: I have nothing further.

MR. BERRIS: Richard Berris again, doctor. Just a couple questions.

Are you holding yourself out as knowledgeable with regard to the standards of acceptable practice for emergency physicians?

THE WITNESS: No. As a radiologist and the protocols of radiology departments.

MR. BERRIS: You are not rendering any opinions in this case regarding the quality of the care provided by Dr. Schmitt, are you?

THE WITNESS: No.

MR. BERRIS: That's all I have.

MR. BONEZZI: Dr. Gore, Bill Bonezzi again. Are you aware of the clinical presentation of Mr. Henriksen and the information that Dr. Schmitt

gained from asking Mr. Henriksen questions that ultimately caused Dr. Schmitt to order an x-ray in this case?

THE WITNESS: The clinical information is listed on the emergency room sheet.

MR. BONEZZI: And are you aware of the ultimate reason why Dr. Schmitt ordered an LS spine?

THE WITNESS: The reason was the patient had low back pain that was also radiating into one of his legs.

MR. BONEZZI: And are you aware of Dr. Schmitt's thinking process that ultimately caused him to get the x-ray?

MR. WALTERS: Objection.

THE WITNESS: I can't go into his mind.

MR. BONEZZI: You didn't read his deposition, did you?

THE WITNESS: No, I didn't.

MR. BONEZZI: So that's information that was available prior to today that you did not receive as it relates specifically to why Dr. Schmitt ordered that particular diagnostic study. Is that right?

MR. WALTERS: Show my objection. What

information are you talking about?

MR. BONEZZI: All of the information that was contained in Dr. Schmitt's deposition transcript that you were a party to at the time his deposition was taken.

You didn't have that available, did you, sir?

MR. WALTERS: Shows my objection. That's not his thought process. That's what he said on a deposition.

MR. BONEZZI: Did you have that available to you?

THE WITNESS: No, I didn't.

MR. BONEZZI: Thank you. I have nothing further.

MR. WALTERS: Doctor, we thank you and we will be showing this deposition, and I am going to recommend that you waive your signature to the deposition because we do have it on tape.

Will you waive your signature?

THE WITNESS: Yes, I do.

MR. BONEZZI: I will also accept that waiver.

MR. WALTERS: Do we all waive?

MR. BERRIS: Yes.

MR. BONEZZI: Yes.

MR. WALTERS: As I indicated, a waiver of viewing of the video, you will waive that, doctor, actually seeing the video?

THE WITNESS: Yes.

(FURTHER DEPONENT SAITH NOT.)

STATE OF ILLINOIS)
) SS:
COUNTY OF DUPAGE)

I, WILMA A. WEINREICH, a notary public within and for the County of DuPage County and State of Illinois, do hereby certify that heretofore, to-wit, on the 18th day of August 1994, personally appeared before me, at Evanston Hospital, 2650 Ridge Avenue, Evanston, Illinois, Dr. Richard Michael Gore, in a cause now pending and undetermined in the Court of Common Pleas, County of Cuyahoga, Ohio wherein D. John Travis is the Plaintiff, and Lakewood Hospital Association, et al., are the Defendants.

I further certify that the said witness was first duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by said witness was reported stenographically by me in the presence of the said witness, and afterwards reduced to typewriting by Computer-Aided Transcription, and the foregoing is a true and correct transcript of the testimony so given by said witness as aforesaid.

I further certify that the signature to the foregoing deposition was waived by counsel for the respective parties.

I further certify that the taking of this deposition was pursuant to Notice, and that there were present at the deposition the attorneys hereinbefore mentioned.

I further certify that I am not counsel for nor in any way related to the parties to this suit, nor am I in any way interested in the outcome thereof.

IN TESTIMONY WHEREOF: Have hereunto set my hand and affixed my notarial seal this 19th day of August, 1994.

Wilma A Weinreich

NOTARY PUBLIC, DUPAGE COUNTY, ILLINOIS

" OFFICIAL SEAL "
WILMA A. WEINREICH
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES 12/11/94