

COPY

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24

IN THE COURT OF COMMON PLEAS
STATE OF SOUTH CAROLINA
COUNTY OF HORRY



SUE PRICE MCGEE : Civil Action No.
: 91-CP-26-1651
vs. :
: James C. Madix, M.D., :
CONWAY RADIOLOGY, P.A., :
and PETER W. ROSSI :



Wynnewood Pennsylvania
Tuesday, October 20, 1992

Videotape De Bene Esse Deposition of
ROBERT G. PEYSTER, M.D., held at the residence of
Robert G. Peyster, M.D., 922 Bowman Avenue, at
8:56 p.m. on the above date before Lynne B. Coale,
a Registered Professional Reporter and Notary
Public.

THOMPSON and RANDALL
Registered Professional Reporters
250 West Lancaster Avenue, Suite 235
Paoli, Pennsylvania 19301
(215) 993-0666

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24

APPEARANCES:

RICHARD W. FROELICH, ESQUIRE
Furr and Henshaw
1900 Oak Street
Myrtle Beach, SC 29578

Counsel for Plaintiff

WILLIAM W. DOAR, JR., ESQUIRE
The McNair Law Firm
121 Screven Street
Georgetown, SC 29442

Counsel for Defendant
James C. Madix, M.D.

(VIA TELEPHONE:)

JOHN K. BLINCOW, JR., ESQUIRE
Law Firm of Robert H. Hood, Esqu
172 Meeting Street
Charleston, SC 29402

Counsel for Defendant Peter W. R

ALSO PRESENT: EDWARD LUCIC
Videotape Specialist

1 MR. FROELICH: As far as
2 stipulations are concerned on this, the attorneys
3 have agreed that all objections are to be made
4 here tonight on the record as though this witness
5 were live in court.

6 Right, Bill?

7 MR. DOAR: That's correct.

8 MR. BLINCOW: That's correct.

9

10 (Discussion off the record.)

11 THE VIDEOTAPE SPECIALIST: This is
12 the videotape deposition of Robert G. Peyster
13 M.D., taken by the plaintiff in the matter of
14 McGee versus Madix, et al, in the Court of Common
15 Pleas, County of Horry, State of South Carolina,
16 No. 91-CP-26-1651, held in the offices of Robert
17 G. Peyster, M.D., 922 Bowman Avenue, Wynnewood,
18 Pennsylvania, on Tuesday, October 20, 1992,
19 scheduled for 8 o'clock and starting at the time
20 indicated on the videotape.

21 My name is Edward Lucic. I'm the
22 videotape technician in association with Thompson
23 and Randall Court Reporting, Paoli, Pennsylvania.
24 The court reporter is Lynne Coale of Thompson and

1 Randall Court Reporting.

2 Counsel will now introduce
3 themselves.

4 MR. FROELICH: My name is Richard
5 Froelich. I'm attorney for plaintiff in this
6 matter.

7 MR. DOAR: My name is William W.
8 Doar, Jr., and I represent the defendant, Dr.
9 James Madix.

10 MR. BLINCOW: Miss court reporter,
11 my name is John Blincow, Jr., of the Hood law firm
12 of Charleston, South Carolina. I represent the
13 defendant Dr. Rossi and am participating over the
14 telephone tonight.

15 ...ROBERT G. PEYSTER, M.D., 922
16 Bowman Avenue, Wynnewood PA, having been duly
17 sworn, was examined and testified as follows:

18 DIRECT EXAMINATION ON VOIR DIRE

19 BY MR. FROELICH:

20 Q. Please tell the jury your name.

21 A. Robert G. Peyster, M.D.

22 Q. Dr. Peyster, where are we tonight?

23 A. We're at my home in Wynnewood,

24 Pennsylvania.

Peyster - direct

1 Q. And we're doing a deposition in the case
2 of Sue McGee?

3 A. Yes.

4 Q. All right, sir. Let's talk to the jury
5 a little bit about your background so they
6 understand a bit about you.

7 If you would tell us when you went
8 to medical school and when you graduated and what
9 you did professionally after medical school.

10 A. I went to medical school in New York
11 City at Downstate Medical School, State University
12 of New York. I graduated in 1973. I then went to
13 Harvard University for the rest of my training in
14 Boston, starting off with a year of surgical
15 training at Beth Israel Hospital, finished in
16 1974; and then did a three-year diagnostic
17 radiology residency at Massachusetts General
18 Hospital, finished that in 1977. That was
19 followed by two years of subspecialty training in
20 neuroradiology, also at Massachusetts General
21 Hospital, finished that on June 30, 1979; at which
22 point I moved to Philadelphia and took on the post
23 of director of neuroradiology at Hahnemann
24 University Hospital -- at that time it was

Peyster - direct

1 Hahnemann Medical School and College -- in
2 Philadelphia. That's where I am currently still.

3 Q. And what is your position at Hahnemann
4 today?

5 A. I am director of neuroradiology and
6 professor of radiology and neurology.

7 Q. Would you explain for the jury, so that
8 they understand a little better, what a
9 radiologist is and what a neuroradiologist is.

10 A. Well, radiologist, or diagnostic
11 radiologist to be even more specific, because
12 radiologist often includes radiation therapy. In
13 the old days, radiation therapy and diagnostic
14 radiology was one group and they had the same
15 boards. They have since split apart and -- so my
16 specialty is diagnostic radiology.

17 And diagnostic radiology deals with
18 the diagnosis of disease by utilizing imaging
19 procedures. Imaging procedures would include
20 plain x-rays, ultrasound, CAT scan, MRI,
21 myelography, arteriography, venography,
22 specialized studies of the kidneys, such as IVPs,
23 hysterosalpingography of the uterus. For every
24 body part, we have some specialized studies.

Peyster - direct

1 And, of course, there is also a
2 therapeutic arm within diagnostic radiology, where
3 treatment of some conditions, like drainage of
4 abscesses, biopsy procedures, and dilatation of
5 blood vessels are performed. All of those things
6 are in the field of diagnostic radiology.

7 Now, I limit my practice to
8 neuroradiology, which is that segment of
9 diagnostic radiology that deals with problems of
10 the brain, spine, and head and neck regions. That
11 would include CAT scans, MRIs, arteriograms,
12 myelograms, plain films, and ultrasounds of the
13 brain and intraspinal ultrasounds. That's
14 basically what I do.

15 Q. All right. Now, are you Boarded in
16 radiology?

17 A. Yes.

18 Q. All right. What does it mean to be
19 Boarded in radiology?

20 A. To become Boarded in diagnostic
21 radiology requires completion of an approved
22 residency, followed by satisfactory completion of
23 both a written and an oral examination.

24 Q. And are there Boards in neuroradiology

Peyster - direct

1 as well?

2 A. Not yet. There will be, I think,
3 starting in a year or two.

4 Q. Are you eligible for those Boards?

5 A. Yes, I am.

6 Q. As the chief of neuroradiology, tell the
7 jury a little bit about what your job is, what you
8 do for a living.

9 A. Basically I practice neuroradiology, but
10 I have two associates whom report to me, but we
11 share the work equally. And in addition to
12 practicing neuroradiology, I teach neuroradiology
13 to residents and to a neuroradiology fellow and
14 have some contact with the medical students, but
15 that's on an elective. That's kind of a small
16 portion of the teaching. The teaching is
17 primarily on a working-together basis rather than
18 classroom teaching. There is a limited amount of
19 classroom teaching involved.

20 Q. Do you teach residents in radiology that
21 then go out and practice in community hospitals?

22 A. Yes.

23 Q. Do they leave your teaching and go
24 around the country?

Peyster - direct

1 A. Yes.

2 Q. Do you yourself -- have you ever
3 practiced radiology in a community-type hospital
4 setting?

5 A. During my neuroradiology fellowship, I
6 worked on the weekends in three community
7 hospitals in Massachusetts practicing general
8 radiology.

9 Q. Have you published any literature in
10 radiology?

11 A. Yes, I have.

12 Q. Can you tell us, is it an extensive
13 list? Is it one publication?

14 A. There's 53 recorded publications, I
15 believe, on my CV. I think it's 53.

16 Q. How about presentations to other
17 radiology groups or other health care groups; do
18 you do that as well?

19 A. Yes, I do.

20 Q. Can you give us an idea of what you've
21 done in terms of presentations.

22 A. Well, I think I have recorded something
23 in excess of 70 on my curriculum vitae, but that
24 doesn't include a lot of the local presentations.

Peyster - direct

1 The majority of them I don't bother recording.
2 The majority of those are national level
3 presentations and/or visiting professorships at
4 other universities.

5 MR. FROELICH: At this time I'd like
6 to offer Dr. Peyster as an expert in radiology in
7 this matter.

8 Does counsel wish to cross-examine
9 him?

10 MR. DOAR: We have no questions at
11 this time.

12 MR. FROELICH: All right.

13 MR. BLINCOW: No questions.

14 MR. FROELICH: All right.

15 DIRECT EXAMINATION

16 BY MR. FROELICH:

17 Q. Dr. Peyster, at my request have you
18 reviewed some matters regarding a patient by the
19 name of Sue Price McGee?

20 A. Yes, I have.

21 Q. All right. And did I contact you and
22 ask you to do that?

23 A. Yes.

24 Q. All right. Sir, can you tell the jury

Peyster - direct

1 what materials you have reviewed in this matter.

2 A. I'm going to refer to my report, just so
3 I can be more specific.

4 I reviewed CT scan studies of the
5 head of June 1985 and September 1988 and an MRI of
6 the brain from September 1988. And then I
7 reviewed medical records of Dr. Robert Clayton,
8 Dr. Paul Brazzia, Dr. Frank Harper, records from
9 Conway Hospital, deposition of Dr. James C. Madix,
10 and copies of Pages 152 and 153 from Susan McGee's
11 deposition.

12 Q. Any other materials you reviewed?

13 A. Not to the best of my recollection.

14 Q. Now, tell us, sir, can you tell the
15 jury, are you aware of the standard of care of a
16 radiologist in 1985 in reading CT scans on
17 patients, in particular CT scans of the head?

18 A. Yes.

19 Q. Would you tell the jury how you're aware
20 of that standard of care.

21 A. Well, I'm aware of that standard of care
22 because I was practicing the reading of CT scans
23 in 1985 myself. I was practicing it with a number
24 of other physicians with which I worked. And I

Peyster - direct

1 was also teaching it to physicians in community
2 hospitals in the Philadelphia area.

3 So that's -- I guess that's how I
4 would be aware of the standard of care.

5 Q. Were you practicing at Hahnemann Medical
6 School in 1985?

7 A. Yes.

8 Q. All right. And were you reading CT
9 scans at that institution in 1985?

10 A. Yes.

11 Q. Now, is there any difference between the
12 way you would read a CT scan at Hahnemann in 1985
13 and the way in which a physician would read it in
14 a community hospital?

15 A. That's a difficult question to answer.

16 Q. All right.

17 A. If you want me to -- I think that
18 they're all -- just like there are all kinds of,
19 you know, baseball players with, you know,
20 averages from the 180s up to the 300 and some
21 odds, there are all kinds of radiologists. Not
22 all of the really good radiologists are in the
23 university hospitals, either. Many of them are in
24 the community hospitals. Just because you're in a

Peyster - direct

1 community hospital doesn't make you a bad
2 radiologist.

3 I think that -- so that I could say
4 that there shouldn't be any difference between the
5 way they're read in the two different places, and
6 that, however, mistakes are made in both
7 university hospitals and in community hospitals.

8 I don't know if that answers your
9 question, but I think that's the best I can do
10 with it.

11 Q. That's fine.

12 Now, please, can you tell the jury,
13 after your review of these materials, do you have
14 an understanding as to the radiological care that
15 was given to Sue Price McGee from 1985 to 1990?

16 A. Yes.

17 Q. Can you just tell us, in a capsulized
18 version, what happened to her radiologically in
19 that interval of time?

20 A. Yes.

21 Now, I have reviewed the CT scan --
22 I'm just going to take that down for a moment --
23 from June 28, 1985, that was performed at Conway
24 Hospital, which, to my eye, shows a large brain

Peyster - direct

1 tumor which was not diagnosed at that time.

2 Q. Have you seen the report of that study,
3 the June 28, '85?

4 A. I have.

5 Q. Was that report read as normal or
6 abnormal?

7 A. That report was -- did not mention the
8 tumor.

9 I don't have that immediately in
10 front of me. I would like to refer to it directly
11 before I....

12 THE VIDEOTAPE SPECIALIST: We are
13 now going off the record at 9:11 p.m.

14 (Discussion off the record.)

15 THE VIDEOTAPE SPECIALIST: We are
16 now back on the record at 9:11 p.m.

17 BY MR. FROELICH:

18 Q. Dr. Peyster, do you currently have in
19 front of you the radiology report dictated for the
20 June 28, 1985, CT scan?

21 A. I do.

22 Q. Have you reviewed that report? Is that
23 correct? Have you reviewed that, sir?

24 A. Yes, I have.

Peyster - direct

1 Q. Does that -- tell me, is that report
2 read by the radiologist, Dr. Madix?

3 A. J.C. Madix, M.D.

4 Q. Is it read as normal or abnormal in any
5 way?

6 A. It's read as "unremarkable study without
7 contrast."

8 Q. Tell me in radiology language, what does
9 "unremarkable study without contrast" mean?

10 A. Normal.

11 Q. All right, sir. Now, after that 1985
12 x-ray, what happened to her subsequent to that?

13 A. The next study that I have is in
14 September, September 13 of 1988, I guess, to be
15 precise.

16 Q. And where was that study, sir?

17 A. And that study was obtained at Moore
18 Regional Hospital.

19 Q. All right. And what does that study
20 show you?

21 A. That study again shows a large brain
22 tumor which appears larger than it did on the
23 first study, but not -- it hasn't doubled in size.
24 It's just larger.

Peyster - direct

1 In addition, I don't have the films
2 in front of me, but there was hydrocephalus shown
3 on the first study -- I'll go over this when I
4 show the films -- which got worse by the time of
5 the second study.

6 Q. Sir, let's go back to the June 1985
7 study, that interval of time, and let's talk a
8 little bit and tell the jury a little bit about
9 what a CT scan is of the brain, if they don't
10 understand that.

11 A. A CT scan, CT stands for computerized
12 tomography. So I think everybody has an idea of
13 what computer means or computerized. Tomography
14 is the obtaining of slices of tissue or slices of
15 anatomy radiographically.

16 Before we had computerized
17 tomography, we had regular tomography. We
18 actually had two types of film tomography: one
19 which we call linear tomography and one which was
20 called hypocycloidal tomography. And that enabled
21 you to look at -- that was primarily used for,
22 well, bones, we also used it for kidneys, and it
23 would allow you to see more detailed -- because
24 instead of looking at an entire slab of tissue of

Peyster - direct

1 the body, like a chest x-ray, it looks all the way
2 from the nipples in the front to the skin on the
3 back in one package; as opposed to slicing that up
4 in increments of varying thickness that we can
5 control. And that's what a tomogram does.

6 So, now, to make computerized
7 tomography, we use an x-ray beam, just like we
8 take plain x-rays, same kind of beam. We pass it
9 through tissue -- namely the patient -- whatever
10 area we're interested in, either the head or the
11 spine or whatever. But instead of seeing the
12 entire thing on a film like we do with plain
13 films, we divide that area up into little boxes,
14 and the computer then assigns a number to each one
15 of those boxes by a series of detecting mechanisms
16 and is able to create a picture of great detail,
17 showing a thin slab of tissue through that area.

18 Since this case is dealing with the
19 brain, you can think of it in terms of just taking
20 a saw and slicing through the head in this
21 direction -- this would be the axial plane -- and
22 making a series of slices of equal thickness. And
23 just as if you would look at those on an autopsy
24 table like the pathologist does, we get to see

Peyster - direct

1 this same slab of tissue. So there's a bone on
2 the outside, just as if you would cut it that way,
3 and then the brain on the inside.

4 And because of the sophistication of
5 the computer, we're able to see the differences
6 between soft tissue structures. On plain x-rays,
7 we see mainly the bone. We see bone and we see
8 air, but nothing else is different enough for us
9 to see it. So we can't tell brain from muscle or
10 anything else.

11 With computerized techniques, we can
12 see the gray matter of the brain, the white matter
13 of the brain, the fluid-containing structures
14 normal within the brain, and any abnormal tissue
15 that gets into the head in or around the brain.
16 And that's why it's been totally revolutionized
17 neuroradiology.

18 Before computerized tomography, we
19 were limited to arteriography and
20 pneumoencephalography, which are no longer
21 important tests in the area of brain tumors in
22 terms of the diagnosis of finding a brain tumor.

23 Q. Doctor, having reviewed the records,
24 have you reached some opinions in this matter?

Peyster - direct

1 A. Yes.

2 Q. And, sir, do you have an opinion to a
3 reasonable degree of medical certainty as to
4 whether or not Dr. Madix complied with or fell
5 below the standard of care of a radiologist with
6 respect to reading the June 28, 1985, CT scan of
7 Sue McGee?

8 A. I have an opinion.

9 Q. Would you please tell the jury your
10 opinion.

11 A. I find his care to be below the
12 acceptable levels.

13 Q. When you say "below acceptable levels,"
14 do you mean below the standard of care?

15 A. Below the standard of care.

16 Q. All right, sir. And in what way or ways
17 do you find his care to be below the standard of
18 care?

19 A. All right. I'm going to answer this in
20 a medical fashion. I know that this is a legal
21 procedure and this is -- but in medicine, like in
22 many things in life, I mean, there is right and
23 wrong.

24 I have difficulty recognizing --

Peyster - direct

1 what happened here is what, to me, is an obvious
2 abnormality on an imaging study, that's an
3 important abnormality. This is a large brain
4 tumor. It's not a little teeny thing. And I
5 can't see how missing such a large and, to me,
6 obvious finding is within any acceptable level of
7 care. So I don't have -- you know, it's hard for
8 a doctor to, you know, have a -- to accept some
9 standard that says it's okay to miss, you know.

10 To me, this is equivalent to taking
11 off the left leg when the right leg is sick. And,
12 to me, that's always below the level of care,
13 wherever it happens.

14 So I think that in this particular
15 case, I understand that the radiologist that read
16 this is working in a community hospital. Granted,
17 he may not have had the benefits of extra training
18 in neuroradiology. But, however, I would expect
19 any of the residents that trained with me but
20 didn't have any extra training in radiology to
21 have no trouble finding this abnormality. And I
22 can't imagine -- I mean, I've trained -- well, we
23 have 16, 17 residents I've trained probably over
24 13 years. We do about four to five residents a

Peyster - direct

1 year, so I've had a lot of residents come through.
2 And I can't imagine any one of them ever missing
3 something like this.

4 So I just think, therefore, that
5 this is an unacceptable mistake and hope that that
6 meets the falling below standards of care
7 definition, because that's the best that I can do.

8 I mean, if there is a standard
9 somewhere else that's much worse than anything
10 I've ever seen, then I can't really deal with it.
11 I mean, maybe in a third-world country, this could
12 possibly not fall below some standard. But I
13 still would have a problem even there, because
14 it's just frankly wrong. I just don't know how to
15 find that acceptable.

16 Q. All right, sir. Now, do we have the CT
17 scan with us here with us tonight?

18 A. Yes, we do.

19 Q. And can we go to that, and can you show
20 the jury what you mean by the presence of a tumor
21 on the scan.

22 MR. FROELICH: And let's go off the
23 record for just one second so we can get him
24 juggled over here.

Peyster - direct

1 THE VIDEOTAPE SPECIALIST: We are
2 now going off the record at 9:21 p.m.

3 (Discussion off the record.)

4 THE VIDEOTAPE SPECIALIST: We are
5 now back on the record at 9:24 p.m.

6 Q. Dr. Peyster, we're looking at a view box
7 at an x-ray.

8 Can you identify the x-ray for us
9 that we're looking at.

10 A. Yes. It's a CT scan on Sue Price from
11 Conway Hospital dated June 28, 1985.

12 Q. And, sir, in looking at this x-ray, this
13 CT scan, can you tell whether this is an original
14 or a copy?

15 A. This is an original film.

16 Q. All right. Can you explain to the jury
17 why it's an original film.

18 A. Well, there's two reasons.

19 When it's a copy film, there's a
20 little mark or a little copy mark that appears on
21 the film that isn't present on this film. And the
22 other reason is that copy film is shiny on both
23 sides, and this film is dull on one side and shiny
24 on the other side. So this is an original film.

Peyster - direct

1 Q. All right, sir. Now, is this a CT scan
2 that we're looking at, a --

3 A. Yes. This is a CT scan study of the
4 head.

5 Q. All right. And can you just explain to
6 the jury what we're looking at here now.

7 A. All right. Well, you know what, if it
8 wouldn't be too disruptive, can you go up here for
9 just one second. I'd like to just show the jury
10 how this is obtained.

11 Q. Okay.

12 A. I was trying to explain the concept of
13 axial slicing of the head by slicing my own head,
14 but it's a little easier to show you how it's
15 actually done.

16 What we're looking at here is an
17 x-ray of the skull and neck and face that was
18 obtained on the CT scan equipment itself. And
19 then we choose the location for our -- and
20 thickness for our slices, and they get posted on
21 what we now call the lateral scout film. So slice
22 No. 1 is right where this bottom slice, slice No.
23 2 and slice No. 3, and we go right through the
24 head until we get to the top; we get to the top,

Peyster - direct

1 we say we're done. So here there were 12 slices
2 obtained, there are 11 that are photographed.

3 And that's what an axial study
4 consists of, is slices obtained in this direction.
5 Each one of these slices is ten millimeters thick,
6 and this study was performed without intravenous
7 contrast material.

8 Q. What's that mean, "without intravenous
9 contrast material"?

10 A. Well, we often give radiographic dye
11 intravenously to bring out certain pathologies and
12 make them show better or tell us more information
13 about certain pathologies; that there are some
14 things that are invisible without intravenous
15 contrast material. And then there's some things
16 that go from visible but dark to visible but
17 white; and then there are certain things that
18 are, you know, enhanced -- when I say "enhanced,"
19 I mean light up or turn white -- in a certain
20 pattern that helps us make a diagnosis.

21 So it's helpful in brain tumors;
22 it's helpful sometimes with vascular
23 abnormalities, such as vascular malformations and
24 aneurysms. It has a definite role in CT scanning.

Peyster - direct

1 We're using it less and less these days,
2 especially since we have MRI available.

3 I believe that the request --
4 somebody recorded that there was a question of an
5 allergy to IVP dye in this patient. I don't know
6 what that was based on, but that's presumably why
7 contrast wasn't given in this instance.

8 And the other comment technically
9 that I'd like to make is that one-centimeter-thick
10 slices as were used here is somewhat excessive for
11 the posterior fossa or lower area of the skull.

12 The way we perform these studies is,
13 we do five-millimeter thick slices through the
14 posterior fossa, and then we do ten --
15 one-centimeter thick slices above that. That's
16 because there's less artifact in the posterior
17 fossa when you use thinner slices and, also, some
18 of the pathology in the posterior fossa could be
19 small and better seen if you use thinner slices.

20 I don't think in this particular
21 case that it made a whole lot of difference,
22 however.

23 Q. All right, sir. Let's go to the
24 technical aspects of this particular CT scan.

Peyster - direct

1 Tell the jury what this scan shows
2 to you as a radiologist."

3 A. Right. Well, what I'm seeing is a large
4 tumor in an area that I'm going to call the
5 tentorial notch. It would be -- I won't be able
6 to tell the jury about the tentorium very easily
7 until later in the discussion when I show the MRI,
8 where you can actually see the tentorium much
9 better.

10 Q. All right.

11 A. But let's just say for now that the
12 entire brain is lined by membranes. The outer
13 membrane is the dura, inside of the dura is the
14 arachnoid, and then the most inner lining is the
15 pia, which lines the immediate surface of the
16 brain.

17 Now, while the dura goes all the way
18 around the brain, it also goes down the middle,
19 dividing the upper brain into right and left
20 hemispheres. That dural structure is called the
21 falx, F A L X.

22 Now, there is another dividing dural
23 structure called the tentorium. The tentorium
24 covers the hindbrain or lower brain; namely, the

Peyster - direct

1 cerebellum and the brain stem, which lie into the
2 posterior fossa or the infra, I N F R A, tentorial
3 space.

4 So you can think of the head divided
5 into the supratentorial space, meaning above the
6 tentorium, and infratentorial space, or below the
7 tentorium. And it's called the tentorium because
8 if you see it in the right projection, it looks
9 like a tent. I has a V coming up in the middle.

10 And you can't appreciate that
11 looking at the axial plane. You have to look at
12 sagittal or coronal planes which are available to
13 us on the MRI.

14 Q. All right, sir.

15 A. Now, with that in mind, as the tentorium
16 comes up towards its peak, if you think of the
17 peak of a tent, it closes around the lower
18 structures. And there is a notch at the top just
19 before it closes, and that's called the tentorial
20 hiatus or tentorial notch. That is one of the
21 famous locations for the tumor called meningioma,
22 although not the first or second or even third
23 choice for that tumor, but it's a common location.
24 It's one of the ones that's always recorded, and

Peyster - direct

1 it's one of the only tumors that actually occurs
2 in that location.

3 Now, what I'm trying to say is that
4 we don't -- you have to know the normal anatomy.
5 And since we don't have a normal scan in front of
6 us, I can't really teach the jury in a very little
7 bit of time what normal looks like. And what
8 we're discussing here is a distortion from normal
9 that should be recognized by anybody that is
10 familiar with the normal brain.

11 Now, I'm going to outline a
12 structure here, which I think is visible, should
13 be visible even on the TV monitor. And it goes
14 like this.

15 Now, to describe this structure I'm
16 outlining, it has got sharp edges and it is a
17 slightly whiter shade of gray than all of the
18 tissue around it. These dark structures here,
19 almost black, represent the lateral -- the frontal
20 horns of the lateral ventricles and the third
21 ventricle. I am going to mention in a moment that
22 these are dilated. These are not normal in size.

23 This tissue all around here is brain
24 tissue: gray matter on the outside, white matter

Peyster - direct

1 on the inside.

2 This structure that I outlined here
3 is denser or whiter than the white matter for sure
4 and denser than almost all of the tissue around
5 it, so I can see an edge all the way around it.

6 Now, the position that this tissue
7 is lying in is the tentorial incisura. That
8 should be filled with the cerebellar vermis or
9 upper portion of the cerebellum and fluid, which
10 should be black. All of this is missing. All of
11 the black that should be in there is gone, and
12 it's replaced by this slightly whitish shade of
13 gray structure that has this funny outline.

14 This structure, to me, knowing the
15 normal anatomy, stands out grotesquely as a tumor,
16 and, for me, this is a less than five-second
17 diagnosis of tentorial notch meningioma. I mean,
18 I would make this before the film hit the board.

19 Now, I think that this is not the
20 only abnormal slice, either. I want to go to this
21 slice here for a moment.

22 Q. Which slice are you pointing out, sir?

23 A. That's No. 4. We started on No. 5.

24 This is No. 4. Okay.

Peyster - direct

1 On slice No. 4, again we see the
2 third ventricle is dilated. The temporal horns of
3 the lateral ventricles are mildly dilated. The
4 pattern of dilatation of the ventricles is
5 consistent with mild obstructive hydrocephalus.
6 That means there's a blockage to the ventricular
7 system causing ventricles to dilate. And that's
8 abnormal in and of itself. And if you don't see
9 an excuse for that, you need to investigate for a
10 tumor or suspected tumor, even if you didn't see
11 one.

12 Now, in this area right here, this
13 tissue here is again the meningioma. And I see it
14 quite discreetly as a slightly whiter shade of
15 gray than the rest of this brain tissue that we
16 see all around here.

17 It's also deforming the posterior
18 aspect of the brain stem. You can see this is
19 kind of a square straight line. That's not
20 supposed to be that way. It's supposed to come
21 back and kind of make a W.

22 So there is a total distortion of
23 the normal architecture, plus the presence of this
24 tumor, plus the presence of the obstructive

Peyster - direct

1 hydrocephalus. So we're not really just
2 discussing one sign. We're not just discussing
3 the conspicuity of the tumor, which I think is
4 conspicuous. But even if this were totally the
5 same density as all the rest of the tissue around
6 it, I'd have to say it's there because of what it
7 is doing to the other structures in the area.

8 Of course, that would require a
9 somewhat better radiologist than somebody that
10 could just see this. But that's the problem, is
11 that I see this big tumor on this slice and on
12 this slice, and I see a portion of it even on
13 slice No. 6 over here, where there's actually a
14 difference in density between the two sides. The
15 tissue on this side here is of higher density than
16 the normal tissue on this side. And if you see,
17 this is the trigone of the lateral ventricle or
18 the atrium of the lateral ventricle sitting next
19 to the normal brain tissue on this side; and on
20 this side we have the higher density tumor, and
21 then we have distortion of the trigone on this
22 side.

23 Now, if this were the only slice,
24 what should be recognized is the ventricles are

Peyster - direct

1 abnormally dilated, and a good radiologist would
2 see this difference by putting it -- you know, we
3 have it on one slice, we have it on this slice, we
4 have it on the other slice. And we have on top of
5 that, if we continue to look below on the lower
6 slices, there is a structure called the fourth
7 ventricle, which is supposed to contain cerebral
8 spinal fluid and be black like the other
9 ventricles we have been looking at. And it
10 happens to be missing.

11 Now, a missing fourth ventricle is
12 not an acceptable finding. I mean, everybody's
13 got one. And if it's not there, you're missing
14 something. So that should be recognized as well.
15 And that's why this patient has obstructive
16 hydrocephalus, because the fourth ventricle and
17 above the fourth ventricle, the aqueduct of
18 Sylvius, which connects the fourth ventricle to
19 the third ventricle, are both compressed by this
20 tumor.

21 So as I said, even if the tumor
22 wasn't visible because of its density, which it
23 is, I'd still know that there's a tumor there
24 because there's no fourth ventricle and there's

Peyster - direct

1 obstructive hydrocephalus. So there has to be a
2 mass. At that point, if it were invisible, I
3 would be forced to give contrast even with an
4 anesthesiologist present to treat any complication
5 that might occur from this alleged dye allergy.
6 And, of course, I would go the next step of
7 further investigating the dye allergy.

8 But that's not even necessary here,
9 because of the fact that the tumor is visible, and
10 that's, of course, the rule. Meningiomas --
11 probably 80% of meningiomas is probably a good
12 figure -- are denser than normal brain without
13 contrast. And that's one of the reasons we're
14 able to make a specific diagnosis of meningioma,
15 is because they tend to occur in typical
16 locations, where they are based on a dural
17 surface, and because they have a base line density
18 higher than brain. Those are their two most
19 characteristic features.

20 Q. Dr. Peyster, does this June 25 -- June
21 28, 1985, CT scan show you any additional
22 information relative to this patient?

23 A. I think I've covered what I want to say.

24 Q. All right, sir. Now, which of the

Peyster - direct

1 slices on the CT scan shows the dilated
2 ventricles?

3 A. Lots of them: specifically 3, 4, 5, 6,
4 7 and 8.

5 Q. Is there any mention in the report of
6 any dilated ventricles?

7 A. No, there isn't.

8 Q. Is that in keeping with the standard of
9 care, in reviewing this particular CT scan, not to
10 mention dilated ventricles in the report?

11 A. No, it isn't.

12 Q. Is it below the standard of care?

13 A. Yes, it is.

14 Q. Why is it below the standard of care?

15 A. Because it's not a difficult observation
16 to make. I mean, it's -- you know, comment on the
17 ventricles is part of the standard of care. I
18 mean, I have never dictated a CT scan of the head
19 in my life where I didn't say that the ventricles
20 were either normal, large, or small, small meaning
21 that they might be compressed by, you know,
22 outside forces, or because that's the way that
23 patient was built. Just because they're large
24 doesn't mean that it's obstructive hydrocephalus.

Peyster - direct

1 They could be large based on atrophy. But there
2 is no cortical atrophy present here, and the
3 pattern of ventricular dilatation is typical of
4 obstructive hydrocephalus.

5 So there should have been comment
6 not only on the size, but an additional comment on
7 the appearance of them together. In other words,
8 you know, the findings here should be that the
9 lateral and third ventricles are dilated and the
10 fourth ventricle is invisible, indicating some
11 structure compressing the fourth ventricle causing
12 obstructive hydrocephalus.

13 Q. Now, what kind of CT scanner was this
14 particular film done, the June 28, 1985, film?

15 A. It was done on a General Electric 8800
16 CT scanner.

17 Q. And can you tell the jury whether or not
18 this film is of diagnostic quality?

19 A. Oh, absolutely. It's the same scanner
20 that I had at the time.

21 Q. All right.

22 A. In fact, it was the best scanner in
23 existence at the time.

24 Q. And when using that particular machine,

Peyster - direct

1 that particular scanner, and doing a CT scan of
2 the head, are there times when the fourth
3 ventricle is not seen?

4 A. No, not in a normal patient.

5 Did I miss your question?

6 Q. Does it always show the fourth
7 ventricle, the G.E. 8800?

8 A. Yes.

9 Q. Are there any reasons why it would not?

10 A. Yeah. There's a tumor compressing it or
11 an infarct compressing it. Some mass in the
12 posterior fossa compressing the fourth ventricle
13 is the only reason why you wouldn't see the fourth
14 ventricle.

15 Q. Is the tumor sometimes hidden just
16 because of the technology of the machine? Not the
17 tumor.

18 Is the fourth ventricle sometimes
19 missing just because of the technology of the
20 machine?

21 A. Not unless the patient is completely
22 uncooperative and moves all over the place. You
23 would not miss the fourth ventricle just because
24 of the machine.

Peyster - direct

1 The very old, very, very old CT
2 scanners, that's another story. They did thicker
3 sections than these and they were much less
4 quality. But the 8800 scanner was and, if it's
5 still around, is an excellent scanner.

6 Q. Now, were subsequent films done on this
7 particular patient?

8 A. Yes.

9 Q. Have you reviewed those films?

10 A. I have.

11 Q. Do those films help you to explain to
12 the jury what is happening in this patient?

13 A. Yes.

14 Q. Can you put the next film up for the
15 jury and explain to them what's happening, please.

16 A. I'd be happy to.

17 MR. FROELICH: Go off the record for
18 just one second.

19 THE VIDEOTAPE SPECIALIST: We are
20 going off the record at 9:44 p.m.

21 (Discussion off the record.)

22 THE VIDEOTAPE SPECIALIST: We are
23 now back on the record at 9:45 p.m.

24 MR. BLINCOW: Richard, I hate to

Peyster - direct

1 interrupt, but I'm really having trouble hearing.

2 MR. FROELICH: He was just putting
3 it back on the record John.

4 BY MR. FROELICH:

5 Q. Dr. Peyster, have you put a new -- an
6 additional x-ray up on the shadow box?

7 A. I have.

8 Q. Would you tell the jury what film you've
9 put up. Would you identify it, please.

10 A. Yes. This is a CT scan, Susan Price,
11 September 13, 1988, Moore Regional Hospital.

12 Q. Is this done with or without or both in
13 terms of contrast?

14 A. All right. The film that I've put up is
15 without.

16 Q. All right.

17 A. I will subsequently show a film with.

18 Q. Would you please tell the jury, explain
19 to them what this film shows to you as a
20 radiologist.

21 A. All right. I've chosen an image, image
22 No. 10. This particular image, the white circle
23 and the No. 1 were placed there by the radiologist
24 to measure the density within the circle and could

Peyster - direct

1 be ignored.

2 What I'm going to point out again is
3 a whitish gray structure, namely the tumor, the
4 meningioma, and the tentorial notch, the same
5 tumor that I pointed out on the last study. And
6 again, its shape is about the same. It measures a
7 little bit larger, I believe. But the conspicuity
8 may be slightly better than on the previous study,
9 but it looks otherwise the same to me. It's
10 causing the same distortion of adjacent
11 structures.

12 Here it's pressing on the third
13 ventricle to forming it. And if we looked around,
14 we'd find mass effect on other structures as well.

15 Now, ventricles are again dilated.
16 These are the frontal horns of the lateral
17 ventricles. There's the more anterior portion of
18 the third ventricle, and they're too large.
19 They're actually larger than they were on the last
20 study, indicating that the obstruction has gotten
21 worse, which indicates that the mass again is a
22 little bit bigger or somewhat bigger, without
23 having them side by side at this point. So we see
24 increased obstructive hydrocephalus. Again we see

Peyster - direct

1 the large tentorial notch meningioma.

2 And I'd like to now show the study
3 with contrast.

4 Q. If you would, please.

5 A. I don't have the study with contrast, do
6 I? It's probably back on the table.

7 MR. FROELICH: Let's go off the
8 record for just one second.

9 THE VIDEOTAPE SPECIALIST: We are
10 now going off the record at 9:48 p.m.

11 (Discussion off the record.)

12 THE VIDEOTAPE SPECIALIST: We are
13 now back on the record at 9:50 p.m.

14 BY MR. FROELICH:

15 Q. Dr. Peyster, would you identify the film
16 that you have up there currently on the view box.

17 A. Okay. We have decided to skip to the
18 MRI study that was done on September 13, 1988, the
19 same day as the last CT scan. And, in fact, I
20 don't actually recall that there was a contrast
21 study. They may not have given intravenous
22 contrast, because I think they went and did the
23 MRI instead. As I said, I haven't had a chance to
24 review all the films inside. But they may have

Peyster - direct

1 decided not to give the intravenous contrast,
2 again based on the possible dye allergy. Again, I
3 don't know.

4 Q. Doctor, look at the report for the 13th
5 and see if the CT scan was done with and without
6 contrast.

7 A. CT scan, 9/4, says -- no, it was done
8 only without contrast.

9 Q. Okay.

10 A. Okay. So they did go ahead and give
11 contrast for this MRI study which was done on the
12 same day at Moore Regional Hospital. They gave
13 intravenous gadolinium. But that's a different
14 contrast than the dye that we give for CT scans.

15 Q. Now, is this still Sue Price McGee?

16 A. Still Sue Price. It says "N. Sue
17 Price."

18 Q. Okay, fair enough, sir.

19 Now, tell us what that study shows
20 you.

21 A. Okay. We have the first slice here that
22 we're showing -- this is an MRI now -- in the
23 axial plane, so it's the same plane that we've
24 been looking at in the CT. And this white, very

Peyster - direct

1 white thing is the tumor here. This is with the
2 benefit of the contrast material for the MRI, and
3 it stands out here definitely more obviously than
4 it did on the -- than the CT scan. I mean, I
5 won't quibble with that. I think it's very well
6 demarcated, enhances homogeneously.

7 Now, again, we see dilated temporal
8 horns due to the obstructive hydrocephalus, and
9 the tumor here is pushing into the brain stem and
10 compressing the aqueduct of Sylvius.

11 We're going to now go down to the
12 bottom where we have a coronal image.

13 Q. All right. What's a coronal image?

14 A. A coronal is the plane as if you were to
15 slice the head from ear to ear. And, in fact,
16 that's what was done.

17 Here's one of the ears. They're
18 slightly off on the other side, so we didn't get
19 the other ear.

20 Q. Okay.

21 A. So this is looking at the patient like
22 from nose, you know, face on, but we've sliced him
23 somewhere, you know, in the back part of his
24 brain.

Peyster - direct

1 Now, this allows me to demonstrate
2 the tumor, which is very large and bright white
3 here because of the contrast. The tentorium runs
4 like this. It's the membrane that runs -- it runs
5 up, the tumor is pushing it up, comes down on this
6 side, and it divides the cerebral hemispheres.

7 Here is the left cerebral hemisphere
8 with the left lateral ventricle; here is the right
9 cerebral hemisphere with the right lateral
10 ventricle; and here is the cerebellum and brain
11 stem down in the posterior fossa; so that the
12 infratentorial space is the posterior fossa, and
13 the tumor lies in the superior aspect of the
14 posterior fossa up in the tentorial hiatus, in the
15 central or highest portion of the tent. As I
16 said, it's called the tent because it goes like
17 this. It tents up in the middle.

18 Now, I'm going to show you that
19 anatomy again on the sagittal view, and I'll
20 define sagittal.

21 Sagittal view is as if you split the
22 patient straight through the nose, cutting between
23 the eyes, straight through the nose.

24 Near the mid line, you will find the

Peyster - direct

1 brain stem and the spinal cord. Here's the spinal
2 cord and the neck. We come up to the brain stem.
3 This is the upper brain stem, the pons, and the
4 mid brain.

5 This structure here, which is not
6 bright white because the contrast wasn't given, is
7 the tumor. The tentorium sits on top, is pushed
8 up and sits on top. So this is just in the
9 highest portion of the tentorium centrally.

10 And this actually shows what's
11 happened to the fourth ventricle. It's pushed way
12 down and compressed, and the upper fourth
13 ventricle is obliterated by the tumor. There
14 should be a channel going from there into the
15 third ventricle.

16 Here's the dilated third ventricle.
17 This large structure here is the tumor without
18 contrast, and the upper fourth ventricle and
19 aqueduct of Sylvius are missing completely.

20 So that's the anatomy of where the
21 tumor is. You can see how large the tumor is.
22 It's almost as big as the whole cerebellum. It's
23 almost as big as the posterior fossa. It's almost
24 filling the posterior fossa. So, I mean, from the

Peyster - direct

1 standpoint of tumors, this is a very large tumor.

2 And I think that basically shows the
3 radiology of this case, I hope.

4 MR. FROELICH: All right. Let's go
5 off the record again.

6 THE VIDEOTAPE SPECIALIST: We are
7 going off the record at 9:55 p.m.

8 (Discussion off the record.)

9 THE VIDEOTAPE SPECIALIST: We are
10 now back on the record at 9:56 p.m.

11 BY MR. FROELICH:

12 Q. Dr. Peyster, we've been talking about CT
13 scans of Sue Price and how they were interpreted
14 in June '85 and in September of 1988.

15 Would you please tell the jury, sir,
16 what would Dr. Madix -- what should he have done
17 in June of 1985 to comply with the standard of
18 care for a radiologist in reading that particular
19 CT scan?

20 A. Yes. Dr. Madix should have, to comply
21 with the standard of care in reading that CT scan,
22 recognized the tumor specifically because of its
23 abnormal density in that particular location. He
24 should have recognized the developing obstructive

Peyster - direct

1 hydrocephalus. He should have recognized the fact
2 that the fourth ventricle was not visible. And
3 he, therefore, should have made a diagnosis of
4 posterior fossa tumor with mild obstructive
5 hydrocephalus.

6 I would say that the majority of
7 people reading CT scans, including those that are
8 not neuroradiologists, should have gone one step
9 further and called it a tentorial notch
10 meningioma. It would have been -- that particular
11 point may or may not fall below some level of --
12 some standard of care. In other words, if he had
13 recognized the hydrocephalus and recognized that
14 there was a tumor there, but didn't know what to
15 call the tumor, I wouldn't be here testifying
16 against him today.

17 Q. All right, sir. Now, this x-ray of June
18 28, 1985, was done without contrast only.

19 Was that -- should contrast have
20 been used on this patient?

21 A. That question could only be answered by
22 further investigation of the questionable IVP dye
23 allergy.

24 Now, there's more than one way to

Peyster - direct

1 answer that question.

2 First of all, I'd like to point out
3 that the majority of people in which you see
4 things like question of IVP dye allergy are not
5 really allergies. Patient says they threw up when
6 they had it; that's not an allergic reaction.

7 Allergic reactions extend from hives
8 at the most minor to bronchial spasm to
9 respiratory or cardiac arrest. There's no
10 question in people's minds when they've had the
11 latter couple, because they've wound up
12 hospitalized.

13 I think that too often IVP allergy
14 question mark is used as an excuse not to give
15 contrast. But I don't know what the case is
16 here. I don't know what her situation was, so I
17 can't tell you whether that was below the standard
18 of care, because if she had a true allergy in and
19 of itself, in a patient with headaches, which is
20 what she complained of, occipital headaches, a
21 truly negative non-contrast study would probably
22 suffice in that patient.

23 However, here we are faced with a
24 definitely and obviously abnormal non-contrast

Peyster - direct

1 study that was misread. So once that is
2 established, now we have the situation that we
3 have a brain tumor that might be more fully
4 evaluated with contrast material. But if she had
5 a serious dye allergy, that would have been given
6 some thought.

7 In 1985, MRI was not as readily
8 available as it is now. It was present, of
9 course, at Duke. I don't know about in South --
10 you know, it probably was somewhere in South
11 Carolina, but I can't say that for sure. I know
12 there were several machines in North Carolina in
13 1985. Duke had two or three.

14 So if the abnormality were
15 recognized and there was a serious reason not to
16 give IVP dye, that could have been an alternative
17 if it were available somewhere.

18 Otherwise, what we did is, when we
19 had a situation where we really felt we had to
20 give contrast, we gave the patient steroids,
21 antihistamines; and if they had had a serious
22 previous reaction, we'd have an anesthesiologist
23 present and we'd go ahead and give the contrast,
24 if we had an important reason to give it.

Peyster - direct

1 As I said here, if the only thing I
2 saw here was obstructive hydrocephalus, and I
3 didn't see the tumor, then I'd be forced to give
4 contrast.

5 So it's kind of a difficult question
6 to answer, because he should have seen the tumor
7 without the contrast, and then he would have to
8 say, "Well, gee, I already see the tumor, so is it
9 worth taking the risk and giving the contrast."
10 That's a harder question to answer.

11 Q. I understand what you're saying. All
12 right, sir.

13 Do you have an opinion to a
14 reasonable degree of medical certainty as to what
15 the violation -- what harm the violations of the
16 standard of care most probably caused for Sue
17 McGee?

18 A. I really don't think I can answer that.

19 Q. All right. And why is that, sir?

20 A. Well, I can say that the ventricles, the
21 obstructive hydrocephalus increased and the tumor
22 got somewhat larger. But I think that in this
23 case, it's more in the province of the
24 neurosurgeon that took care of her or some

Peyster - direct

1 neurosurgeon to evaluate the clinical side, to say
2 whether that had an important effect on her
3 outcome. I don't think I can speak to that.

4 Q. All right. In the normal course of
5 events, had this been recognized June 28, 1985,
6 what would have happened subsequent to that?

7 A. Oh, the patient would have been operated
8 on promptly.

9 You're talking about in normal
10 circumstances that I'm familiar with?

11 Q. Yes.

12 MR. BLINCOW: I'm sorry to
13 interrupt, but I can't hear again.

14 MR. FROELICH: I'm sorry, John.

15 Q. (Continued) The question is, had this
16 tumor been seen in 1985, June 28, in the normal
17 course of events, what would have occurred?

18 A. And my answer is that --

19 MR. DOAR: I'm going to object to
20 that. He indicated that he didn't feel he was
21 qualified to get into that, Richard, and I'm going
22 to object to that question on the basis that he is
23 a radiologist and not a treating physician.

24 BY MR. FROELICH:

Peyster - direct

1 Q. In your experience, what has occurred
2 when you have diagnosed tumors of this nature sir?

3 Have you done that?

4 MR. DOAR: Same objection.

5 Q. (Continued) Have you diagnosed tumors
6 of this nature, Dr. Peyster?

7 A. Yes.

8 Q. And in that, do you still have contact
9 with what's happening with the patient after the
10 diagnosis of the tumor is made?

11 A. Yes.

12 Q. All right. And what happens in the
13 normal course of events?

14 MR. DOAR: Same objection.

15 MR. FROELICH: All right.

16 A. The patient would be operated on
17 promptly. It would not be acceptable to allow
18 such a tumor of that magnitude, that was causing
19 obstructive hydrocephalus, to sit untreated.

20 Now, that's not to say that that's a
21 general statement about all tumors. That's not
22 true. I mean, I've seen many meningiomas in less
23 vital locations, that were not causing obstructive
24 hydrocephalus, watched. That involves how old is

Peyster - direct

1 the patient? How is the patient's general health?
2 What's the size of the tumor? What's it doing?
3 What dysfunction is it causing her?

4 This particular tumor was causing
5 her headaches. I mean, there's no question about
6 that. And obstructive hydrocephalus is not an
7 acceptable condition in the presence of headaches.
8 Even if there weren't a tumor and the patient had
9 obstructive hydrocephalus of a communicating
10 nature, which means that there's not a direct
11 block to the ventricular system but there is a
12 failure to absorb cerebral spinal fluid over the
13 surface of the brain, that would be treated with a
14 shunt, also. So at the very least, even if there
15 weren't a tumor and a patient with headaches with
16 ventricles that are dilated because of obstructive
17 hydrocephalus, a shunt would have been placed, and
18 that would have been done promptly.

19 In this particular case, a shunt
20 alone was not the answer, because you have a
21 benign tumor. When I say "benign," I mean, it's
22 not the type of tumor that metastasizes all over
23 the body like lung cancer, for example. It's a
24 tumor that you can sometimes remove completely and

Peyster - direct

1 cause a cure.

2 So, you know, I've been --
3 participated in the care, although I didn't do the
4 actual surgery, in many of these cases, and that
5 was done in all of them. And my statement about
6 Susan McGee is that I was not in the same position
7 with her and I didn't interact with her
8 clinicians, and, therefore, I don't know -- I'm
9 not that familiar with her medical condition at
10 these times, so I can't really, you know, render
11 an opinion on that aspect of care in her.

12 Q. Fair enough, Doctor.

13 Doctor, do you have any opinions
14 about the care given by the defendant Dr. Rossi in
15 this case?

16 A. I don't have any opinions.

17 MR. FROELICH: All right, sir.

18 Would you please answer any
19 questions Mr. Doar has for you.

20 THE WITNESS: Absolutely.

21 THE VIDEOTAPE SPECIALIST: We are
22 going off the record at 10:07 p.m.

23 (Discussion off the record.)

24 THE VIDEOTAPE SPECIALIST: We are

Peyster - direct

1 now back on the record at 10:13 p.m.

2 CROSS-EXAMINATION

3 BY MR. DOAR:

4 Q. Dr. Peyster, I would like to start off
5 by asking you couple of questions about the fact
6 that the 1985 study, the CT study, that was
7 performed at Conway was done without contrast.

8 Now, isn't it a matter of fact, sir,
9 that an allergic reaction reported by a patient, a
10 prior allergic reaction to contrast material, is a
11 legitimate reason for not administering a
12 contrasted study?

13 A. All right. Let me answer that it is not
14 an absolute contraindication, but it is a warning
15 or a caution, which means that you would not give
16 contrast indiscriminately in somebody that claimed
17 a prior reaction.

18 What I mean by that is, you
19 unquestionably would do a non-contrast study first
20 in any patient that claimed a contrast allergy and
21 then evaluated what you saw, and then you would
22 make further decision based on that; as opposed
23 to, there are many times where we would just
24 inject the patient first and the first -- the only

Dr. Peyster - cross

1 study they would have would be a contrast study.
2 You would not do that in somebody that had a
3 previous -- that reported a previous reaction.

4 So I'm not -- as I said, I don't
5 have information in this case to the nature of the
6 alleged reaction, and I don't have -- I don't
7 really have a problem with them not giving
8 contrast in this case.

9 Q. All right, sir. Well, I just wanted to
10 make that clear, because, of course, an allergic
11 reaction can be fatal; isn't that right?

12 A. Yeah. One in 30,000.

13 Q. Okay. But it's still, if you happen to
14 get that one, then you'd be sued for killing the
15 patient by giving the patient contrasted material
16 when that patient had reported to you that he or
17 she had had a prior allergic reaction to the
18 contrast material; isn't that right?

19 A. As I said, you must take all precautions
20 and really have a severe need for, contrast at
21 which point -- and that might include having an
22 anesthesiologist standing by.

23 Q. All right, sir. And isn't it true that
24 if you had had a prior allergic reaction to

Dr. Peyster - cross

1 contrast material, that the chances or the
2 propensity for having another reaction, allergic
3 reaction, to that material, is enhanced or is
4 increased?

5 A. That's true.

6 Q. All right. Now, let's go back, and I
7 wanted to just make certain that I understood or
8 you understood or we understood together, the 1985
9 Conway study that was done at Conway, that was
10 done on a G.E. 8800 scanner; is that your
11 understanding?

12 A. That's correct.

13 Q. All right, sir. And it was done without
14 contrast for the reasons that we've just
15 discussed; isn't that correct?

16 A. That's correct.

17 Q. All right. It was reported by Mrs.
18 McGee to her treating physician, Dr. Clayton, that
19 there had been a prior allergic reaction to IVP
20 dye and to sulfa; isn't that's reported on the
21 order slip there?

22 MR. FROELICH: Objection. That's
23 not contained in the testimony.

24 A. Yes. The slip says "any pertinent

Dr. Peyster - cross

1 allergy history" and the answer is "sulfa plus"
2 question mark "IVP dye."

3 Q. All right, sir. Now, isn't it not true,
4 sir, that the 1988 study that you alluded to that
5 was done at Moore Regional Hospital in North
6 Carolina was done on a G.E. 9800 scanner, and it,
7 likewise, was done without contrast; isn't that
8 correct?

9 A. Those statements are correct.

10 Q. All right. And it was not until the CT
11 scan in 1988 without contrast was performed that
12 they then later did an MRI study; isn't that your
13 understanding?

14 A. Yes.

15 Q. All right, sir. Now, Doctor, let me go
16 back.

17 As I understand it, you got involved
18 in this case through a contact with Mr. Froelich
19 here, who is representing Mrs. McGee, her
20 attorney; is that correct?

21 A. Yes.

22 Q. And I believe that as a matter of fact,
23 you have reviewed one other case for Mr. Froehlich
24 as well as the McGee case; isn't that correct?

Dr. Peyster - cross

1 A. That's correct.

2 Q. All right, sir. Do you know what the
3 status of the other case is?

4 A. I'm not certain.

5 Q. All right. Have you given a deposition
6 in that case?

7 A. I think Mr. Froelich would have to help
8 me with that. I'm not sure.

9 Q. All right, sir. Did you give a written
10 report to Mr. Froelich in that case after your
11 review?

12 A. I know we discussed my findings actually
13 in person. I think he was here.

14 Q. All right, sir.

15 A. And I don't know -- I know I definitely
16 didn't initially do a report. I don't know if he
17 subsequently requested a report.

18 Frankly, I don't think I did do a
19 deposition in that case, but I can't specifically
20 recollect.

21 Q. All right, sir. But the fact is, your
22 recollection is that Mr. Froelich came to
23 Philadelphia, came to your house where we are
24 tonight, and reviewed the McGee films as well as

Dr. Peyster - cross

1 the other films involving the other case with you
2 and asked you to review the matters; is that
3 right?

4 A. To the best of my recollection.

5 Q. All right, sir. Now, Doctor, as a
6 radiologist, I assume that you spend a good bit of
7 your time reading, looking at, reviewing films, CT
8 film, x-ray film, all sorts of film; isn't that
9 correct?

10 A. That's correct.

11 Q. And wouldn't it be fair to say -- and I
12 know you want to be fair -- that once you as a
13 radiologist know or are aware of a condition, then
14 it becomes quite obvious, doesn't it?

15 A. That's not necessarily so. I mean, I
16 have -- I think it can work both ways. I think
17 that -- I know what you're getting at. If you
18 know the diagnosis, it's easy to make the finding.

19 Well, it certainly doesn't hurt.
20 But in cases where the diagnosis is otherwise
21 obvious, it doesn't help. And there are other
22 cases where the findings may be so subtle, you may
23 not see them knowing the diagnosis or not knowing
24 the diagnosis.

Dr. Peyster - cross

1 So the answer is sometimes.

2 Q. All right, sir. Well, in the cover
3 letter that Mr. Froelich, when he sent you -- and
4 this letter is dated October 22, 1991, and I got
5 it out of your file. Mr. Froelich indicates that,
6 "Please review the June 1985 CT scan and see if
7 it was read appropriately or not." And then the
8 third paragraph says, "In 1988, a posterior fossa
9 meningioma was found. Please review those films
10 to see that was done appropriately."

11 So as a matter of fact, when you got
12 the films, when you got the case, of course, you
13 were aware that Mrs. McGee had been diagnosed at
14 Moore's with a meningioma, a posterior fossa mass,
15 and that it had been ultimately removed at Duke
16 University; isn't that correct?

17 A. That's true.

18 Q. All right. Now, Doctor, I think you
19 have also testified in some other cases as a
20 medical expert witness; isn't that correct?

21 A. That's correct.

22 Q. I believe you have indicated that you
23 had testified in court at least on three
24 occasions.

Dr. Peyster - cross

1 A. Yes.

2 Q. And I believe you told us that you had
3 given a video deposition as you are giving here
4 tonight on at least five occasions; isn't that
5 right?

6 A. I said five would be a best guess
7 number. It should be within one or two in either
8 direction.

9 Q. All right, sir. As a matter of fact,
10 when we arrived here about 8 o'clock p.m. tonight
11 at your residence, you were in the process of
12 giving a video deposition in another case; isn't
13 that right?

14 A. That's true.

15 Q. All right. But I believe you indicated
16 that that case was not a medical malpractice case,
17 but involved other issues other than medical
18 malpractice; is that correct?

19 A. Car accident, personal injury case, yes.

20 Q. All right. But you have given, as you
21 say, your best guesstimate, of video depositions
22 as expert witness in a medical malpractice case,
23 that equals five?

24 A. Approximate number.

Dr. Peyster - cross

1 Q. All right. And I believe you said you
2 had given approximately five depositions,
3 discovery-type depositions, also, in medical
4 malpractice cases; is that right?

5 A. I don't know if I answered that question
6 before. If I did, I didn't hear it right, because
7 I didn't think about that answer.

8 Q. All right, sir. Well, I wrote that
9 down. If I'm wrong, I believe you told us you
10 testified in court three times.

11 A. True.

12 Q. You had given approximately five video
13 depositions.

14 A. Right.

15 Q. And approximately five depositions in
16 malpractice cases.

17 A. I'm not sure if I've given that many
18 discovery depositions.

19 It seems to me the malpractice cases
20 I've been involved in have gone right to videotape
21 deposition. I'm not sure I've given -- I'm not
22 sure I've given as many as five non-videotape
23 depositions. In fact, the only ones I definitely
24 recall is yours before we started this one.

Dr. Peyster - cross

1 Q. That is was about a 15-minute
2 deposition.

3 A. Right. I don't remember doing -- I'm
4 not sure I remember doing one before.

5 Q. All right, sir.

6 A. A discovery deposition.

7 Q. All right, sir. Now, I believe you've
8 indicated, also, that you have been involved in
9 medical malpractice cases as an expert witness in
10 cases involved here, of course, in the State of
11 Pennsylvania.

12 A. Yes.

13 Q. And I believe you indicated in the State
14 of Michigan.

15 A. Michigan.

16 Q. The State of West Virginia.

17 A. Yes.

18 Q. The State of Florida.

19 A. Yes.

20 Q. The State of Texas.

21 A. Yes.

22 Q. And now in the State of South Carolina.

23 A. State of South Carolina. And I forgot
24 New Jersey.

Dr. Peyster - cross

1 Q. And New Jersey. All right, sir.

2 Can you recall any other states that
3 your testimony has been involved in medical
4 malpractice cases as an expert witness?

5 A. No.

6 Q. All right, sir. Now, I believe you've
7 also indicated that your fee for your expert
8 involvement in a medical malpractice case is what?

9 A. It's \$400 an hour, \$125 for each study
10 that I review. And depositions are billed at \$500
11 an hour, with a thousand dollar minimum, meaning
12 the first two hours are covered by that.

13 Q. All right, sir. So the first two hours
14 would be a thousand dollars plus \$500 for each
15 hour thereafter?

16 A. Or any part thereof.

17 Q. All right. And I assume you said you
18 charge for review, you charge \$400 plus \$125 for
19 each study. And I would assume you've had three
20 studies in this case or four studies?

21 A. MRI and two CTs. I think it's just
22 three studies.

23 Q. All right, three studies. So that would
24 be three times 150 plus \$400 is what you've been

Dr. Peyster - cross

1 paid for your review in the McGee case; is that --

2 A. Three times 125, plus \$400 per hour, so
3 that would include review of records, discussions
4 with Mr. Froelich, if we had any, or if there was
5 a report, which I don't think there was in this --
6 no, there was a report in this case, so
7 preparation of the report.

8 Anything other than the specific
9 review of the films is billed on a time basis.

10 Q. All right, sir. Now, Doctor, as a
11 radiologist, as I understand it, you do not
12 consider yourself to be a treating physician.

13 A. I think in the sense that you're asking
14 that, that's correct, yes.

15 Q. All right, sir. And I believe you've
16 also indicated, either to Mr. Froelich or in the
17 previous deposition, that you have not had any
18 direct communication, either by telephone or by
19 letter, with Mrs. McGee concerning this case; is
20 that right?

21 A. That's correct.

22 Q. All right, sir. Now, Doctor, let's
23 look, if we might, for the moment -- and I believe
24 it's a part of the information that you were

Dr. Peyster - cross

1 provided -- the order for the 1985 CT scan, if you
2 don't mind, if you would look at that. And I
3 believe you've got it right before you.

4 At the top of that is typed in, and
5 it says in bold type, it has the date 6/28/85, and
6 then it says "CT scan of the head without
7 contrast," and then it gives the dictated opinion
8 of Dr. Madix; is that correct?

9 A. Correct.

10 Q. Doctor, wouldn't it be fair to say that
11 any physician who read that report would
12 understand that the CT scan of the head had been
13 performed by Dr. Madix without contrast?

14 A. Yes.

15 Q. And wouldn't you believe, sir, that a
16 practicing physician would be aware of the
17 consequences or the differences in a CT scan of
18 the head with as opposed to without contrast?

19 A. Now, are we talking about any referring
20 physician, or like a neurologist or a neurosurgeon
21 or -- can we be specific? I mean, I would have to
22 say that, unfortunately, not all physicians are
23 equally enlightened.

24 I would suspect that any neurologist

Dr. Peyster - cross

1 or any neurosurgeon would certainly be aware of
2 that.

3 A family practitioner, the majority
4 would, but I wouldn't be able to state that all of
5 them understand or know enough about CT scanning,
6 at least maybe not in 1985.

7 Q. In your testimony, in your direct
8 testimony -- and I listened very carefully. And
9 if I missed it, you correct me. I never heard you
10 say anything about whether or not it was important
11 for the radiologist who had read the study to
12 discuss it and review it with the treating
13 physician.

14 Do you believe that's important?

15 A. Not if he felt that it was normal. I
16 mean, if you have a brain tumor, if you make the
17 diagnosis of a brain tumor, you must contact the
18 physician by phone. I mean, that goes without
19 saying. In fact, had I performed this study, once
20 I diagnosed the brain tumor, I wouldn't have let
21 the patient leave. She would have stayed there
22 until I contacted her physician, or I would have
23 sent her to the emergency room.

24 Q. All right, sir. Well, do you know

Dr. Peyster - cross

1 whether or not from any of the materials that you
2 have reviewed -- and I believe you have reviewed
3 the deposition of Dr. Madix.

4 A. Yes.

5 Q. Do you know whether or not Dr. Madix
6 reviewed this film, the 1985 study at Conway, with
7 the treating physician?

8 A. I can't answer that without reading the
9 whole deposition over. I don't know at this
10 point.

11 Q. All right, sir. Now, Doctor, in looking
12 at your report, the report that you provided to
13 Mr. Froelich, concerning your review of the case,
14 I was interested in a couple of things.

15 No. 1, you refer on Page 2, you
16 refer to the tumor in the tentorial notch and
17 posterior fossa in density and then you say
18 "relatively isodense with gray matter."

19 What does the term "isodense" or the
20 word "isodense" mean to you as a radiologist?

21 A. It means of approximately the same
22 density.

23 Q. And what significance does that have? I
24 mean, does that mean that the lesion that you saw

Dr. Peyster - cross

1 or the mass that you saw there was the same color
2 as the surrounding brain tissue?

3 A. No. It means it was similar to gray
4 matter.

5 Q. Does that make it easier to detect or
6 more difficult to detect?

7 A. Well, if it were completely surrounded
8 by gray matter, it would be more challenging. But
9 since it wasn't completely surrounded by gray
10 matter, and, therefore, interfaced with other
11 tissue, it was significantly denser than white
12 matter and much, much denser than cerebral spinal
13 fluid. Since, therefore -- so if this were -- if
14 there were any area where such a large tumor could
15 be completely surrounded by gray matter, it would
16 be more challenging in such a location.

17 Q. All right, sir. You have made the
18 statement, sir, that you do not believe that
19 anyone could have missed the tumor on the '89 --
20 on the '85 study. Isn't that basically what
21 you've said?

22 A. Well, I didn't say that no one could
23 miss it. I said no one should miss it.
24 Obviously, someone did miss it.

Dr. Peyster - cross

1 Q. Right. Were you provided with a report
2 from a Dr. John A. Janes at the Department --

3 MR. FROELICH: Objection. This is
4 hearsay material.

5 MR. DOAR: Okay. You object? Go
6 ahead, object. All right. The objection is on
7 the record.

8 Q. (Continued) Were you provided with a
9 report dated January 10, 1990, from Dr. John A.
10 Janes, the David D. Weaver professor of
11 neurosurgery and chairman, Department of
12 Neurosurgery, I assume, at the University of
13 Virginia Medical Center, Health Science Center, in
14 Charlottesville, Virginia? Did Mr. Froelich give
15 you that?

16 A. Not that I know of.

17 Q. All right, sir. I'd like to have you
18 take a look at that, if you would, that letter.

19 MR. FROELICH: For the record, let
20 me object to that again as being hearsay and
21 request that all questions relating to or arising
22 out of that report be stricken.

23 MR. DOAR: All right.

24 A. All right, I have read it.

Dr. Peyster - cross

1 Q. So, Doctor, you've read the letter.

2 Does it come as a surprise to you
3 that Dr. Janes reports that he showed the 1985
4 film, CT film, to his CT conference, and he says
5 "Quite honestly, half of the people didn't see
6 it"?

7 A. Well, you see, he's showing it to a
8 bunch of neurosurgeons. So it doesn't come as any
9 surprise, because all of the neurosurgeons that
10 I've come across are totally incompetent in
11 reading these studies. That's why we're able to
12 make a living.

13 Now, that doesn't mean -- I think
14 that's about the figure I would expect. I mean, I
15 would say that about half of neurosurgeons I would
16 expect to see this tumor. But I would expect 100%
17 of my radiologists to see it.

18 Q. I see.

19 A. So that's the difference. I mean, we
20 really can't compare the standard of neurosurgery
21 practicing neuroradiology or radiology versus
22 radiology practicing radiology. It would be like
23 trying to evaluate me performing a neurosurgical
24 procedure, which would be a disaster. So I can't

Dr. Peyster - cross

1 do what they do and they can't do what I do.

2 Q. Don't neurosurgeons read CT scans and
3 x-rays of the head daily?

4 A. No.

5 Q. And you're saying that a neurosurgeon is
6 not competent to read a CT scan?

7 A. That's correct. They are not competent
8 to read a CT scan.

9 MR. DOAR: All right. We'd like to
10 mark this as an exhibit to the deposition.

11 (Exhibit 1 marked for
12 identification.)

13 BY MR. DOAR:

14 Q. Doctor, I also wanted to ask you about
15 your comments about the hydrocephalus.

16 In looking at the 1985 film -- and,
17 of course, you understand, and I think we've
18 agreed, that the standard of care that you are
19 involved with in this case involves the standard
20 and effect in 1985 as opposed to the standard in
21 1992. You would agree with that?

22 A. Yes.

23 Q. That's seven years ago as opposed to the
24 current -- the current standard of care; isn't

Dr. Peyster - cross

1 that right?

2 A. Right.

3 Q. And you would also, I assume, agree with
4 me that imaging scanners, imaging-type machinery,
5 has become more sophisticated and is better today
6 than it was in 1985; isn't that correct?

7 A. Somewhat. I mean the MRI, of course,
8 has come along tremendously since 1985. CT has
9 made only recently some large strides.

10 The difference between the 8800 and
11 the 9800 CT scanner was real, but not huge. It
12 was -- the 9800 was what I'd call 15% better. The
13 newest CT scanners are dramatically different, but
14 they've added some entirely new technology in the
15 last year.

16 Q. What generation scanner do you all use
17 at Hahnemann today?

18 A. 9800.

19 Q. The 9800.

20 A. It's no longer state of the art, but
21 that's all the money we have.

22 Q. All right, sir. Doctor, would it be
23 fair to say that in terms of the size of the
24 ventricles, that at worst they appear -- in the

Dr. Peyster - cross

1 1985 film would be best described as the upper
2 limits of normal?

3 A. That's incorrect.

4 Q. You would not agree with that?

5 A. No. It's clearly obstructive
6 hydrocephalus.

7 Q. All right, sir. And couldn't it be or
8 isn't it possible that the ventricles could be the
9 size as they appear in the 1985 study and Mrs.
10 McGee not have a tumor?

11 A. If you're asking me if you can have
12 obstructive hydrocephalus without having a tumor,
13 the answer is yes.

14 Q. All right, sir.

15 A. You would, of course, have to exclude a
16 tumor under those circumstances before you knew
17 you didn't have one.

18 Q. Now, Doctor, I believe we've also
19 discussed briefly about the frequency of a
20 posterior fossa meningioma, and I believe you've
21 indicated that it would be approximately 1% of all
22 brain tumors.

23 Isn't that what we talked about
24 earlier?

Dr. Peyster - cross

1 A. Well, as I said earlier, meningiomas are
2 something like 15 to 20 percent of primary brain
3 tumors, and posterior fossa is maybe fourth or
4 fifth on the list of favored locations of
5 meningiomas.

6 So that figure sounds approximately
7 right. I think that that's not unreasonable.

8 Q. All right, sir. And I believe, Doctor,
9 you, too, have been sued for medical malpractice
10 some few years in the past; isn't that correct?

11 A. That's correct.

12 Q. Doctor, if the treating physician
13 reviewed the film and decided to send the patient
14 for a neurological consult, would that change your
15 opinions in this case?

16 A. I don't think so, no. I wouldn't see
17 how.

18 I mean, my opinion is strictly
19 related to the reading of the CT scan, and,
20 frankly, my opinion wouldn't be different even if
21 there was no history provided or the patient never
22 saw a doctor and just showed up in the scanner.
23 So nothing else that happened would affect my
24 opinion regarding the interpretation of that scan.

Dr. Peyster - cross

1 Q. All right, sir. And I believe we've
2 also asked you about your involvement in the
3 community hospital setting, which, of course,
4 Conway Hospital is. And I believe you indicated
5 that you had not practiced in a community hospital
6 setting since your fellowship in Massachusetts
7 back when? When was that?

8 A. Between 1977 and 1979.

9 MR. DOAR: All right, sir. I
10 believe that's all the questions I have. Thank
11 you.

12 MR. BLINCOW: No questions.

13 MR. FROELICH: Doctor, just a few
14 questions to follow up if I might, please.

15 REDIRECT EXAMINATION

16 BY MR. FROELICH:

17 Q. The difference between an 8800 and a
18 9800 machine, does it play any difference at all,
19 the fact that those are two different pieces of
20 x-ray equipment in these particular films or your
21 interpretation of these films?

22 MR. DOAR: I think he's already
23 answered that.

24 MR. FROELICH: You can answer it,

Dr. Peyster - redirect

1 Doctor.

2 MR. DOAR: "All right. I'm going to
3 object. It's not reply. He's already answered
4 it.

5 A. No. It really makes no difference in
6 this particular case.

7 Q. Why not?

8 MR. DOAR: Same objection.

9 A. All right. First of all, we're dealing
10 with a very large abnormality. Both the 8800 and
11 9800 were excellent CT scanners or are excellent
12 CT scanners.

13 The 9800 scanner was faster than the
14 8800 scanner, offered a smaller matrix, which was
15 only important in diagnosing tiny --
16 discriminating tiny structures. So for something
17 like a pituitary microadenoma, like a
18 three-millimeter tumor in the pituitary gland, the
19 9800 did a better job.

20 But here, we're talking about
21 something that's, I think, over five centimeters
22 in size, which is over two inches in size.
23 That's, therefore -- I don't know. I suppose
24 that's bigger than a golf ball, isn't it? So

Dr. Peyster - redirect

1 that's really not something that required any
2 difference there is between those two scanners. I
3 mean, basically we're here because this tumor
4 happened to be obvious on both studies.

5 Now, the difference between the two
6 studies is not enough. I mean, the tumor got a
7 little bit larger and the obstructive
8 hydrocephalus increased somewhat. All those
9 things happened. And the 9800, on that study, the
10 tumor was a little bit better discriminated from
11 the other tissue. But all in all, the difference
12 was not substantial enough.

13 And, frankly, I diagnosed many
14 meningiomas on an 8800 CT scanner, which I had for
15 many years, from 1980, oh, probably until about
16 1987. I'm sure -- I'm sure I've seen several
17 hundred meningiomas done on 8800 CT scanners. And
18 I would say the extremely vast majority of them
19 were all diagnosable on non-contrast CT scans.

20 Q. All right, sir. Now, when I first
21 contacted you about this case, you became aware
22 that there was a posterior fossa meningioma.

23 Did having that knowledge, that this
24 lady was ultimately diagnosed as having a

Dr. Peyster - redirect

1 posterior fossa meningioma, affect your opinions
2 or your interpretation -- did it affect your
3 opinions of the June 28, 1985, CT scan?

4 A. No, it didn't.

5 Q. Did it affect any of your opinions as to
6 any violations of the standard of care by Dr.
7 Madix?

8 A. No, it didn't.

9 Q. Did it affect your opinions about your
10 particular -- your interpretation of that CT scan?

11 A. No, it didn't.

12 Q. Now, Mr. Doar has asked you about your
13 testifying in other malpractice cases.

14 THE VIDEOTAPE SPECIALIST: We are
15 going off the record at 10:47 p.m.

16 (Discussion off the record.)

17 THE VIDEOTAPE SPECIALIST: We are
18 now back on the record at 10:47 p.m.

19 Q. (Continued) Doctor, Mr. Doar has asked
20 you about testifying in other malpractice cases or
21 other lawsuits.

22 Have you testified both for and
23 against physicians in the past?

24 MR. DOAR: That's a leading

Dr. Peyster - redirect

1 question.

2 MR. FROELICH: I'll change the
3 question.

4 Q. (Continued) Tell us, sir, have you
5 testified as you have for patients before?

6 A. Are we talking about plaintiff's side?

7 Q. Yes, sir.

8 A. Yes.

9 Q. Have you testified for defense side?

10 A. More often than for plaintiff.

11 Q. All right, sir. Now, in terms of this
12 particular tumor being seen as isodense on the
13 June 25 -- June 28, 1985, study, does the fact
14 that you have described it as an isodense tumor
15 affect your opinions about whether or not Dr.
16 Madix should have seen the tumor?

17 A. No, not in the least.

18 Q. Why is that, sir?

19 A. Because the tumor is visible as I
20 believe I outlined it on the films.

21 I mean, I think that the jury will
22 have to decide if they can see what I was pointing
23 out. And if they see it, then I would think that
24 they would suspect that a radiologist, who is paid

Dr. Peyster - redirect

1 and trained to see it, should see it.

2 MR. FROELICH: Thank you sir. No
3 more questions.

4 MR. DOAR: I have no questions.

5 MR. BLINCOW: No questions.

6 THE VIDEOTAPE SPECIALIST: This
7 concludes the videotape deposition of Robert G.
8 Peyster, M.D., at 10:49 p.m. on October 20, 1992.

9 (Witness excused.)

10 (The deposition concluded at 10:49
11 p.m.)

12

13

14

15

16

17

18

19

20

21

22

23

24

1 I HEREBY CERTIFY that the
2 proceedings and evidence are contained fully and
3 accurately in the stenographic notes taken by me
4 upon the foregoing matter on Tuesday, October 20,
5 1992, and that this is a correct transcript of
6 same.

7

8

9

Lynne B. Coale

10

11

Lynne B. Coale
Registered Professional Reporter
Notary Public

12

13

14

15

16

17

18

19

(The foregoing certification of this
transcript does not apply to any reproduction of
the same by any means, unless under the direct
control and/or supervision of the certifying
reporter)

20

21

22

23

24