SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF WARREN:

----------X

KEVIN ORR,

Plaintiff,

-against-

JAMES E. BELL, MD and ADIRONDACK RADIOLOGY ASSOCIATES, P.C.

Defendants.

----------X

INDEX # 58820

EXCERPT TESTIMONY of DR. JORDAN HABER

HELD AT: Supreme Court, Warren County
Lake George, New York
February 2, 2016

B E F O R E:

HONORABLE THOMAS D. BUCHANAN, J.S.C.

A P P E A R A N C E S:

POWERS & SANTOLA
Attorney for Plaintiff
BY: MARGIE SOEHL, ESQ.
& LAURA JORDAN, ESQ.

BURKE, SCOLAMIERO & MORTATI
Attorney for Defendants
BY: KEVIN BURKE, ESQ.

JOSEPH J. MONDELLA
SUPREME COURT REPORTER

(At this time the jury entered the courtroom.)

THE COURT: Please be seated. Miss Soehl.

MS. SOEHL: At this time I would like to move some records into evidence.

THE COURT: Okay.

MS. SOEHL: Plaintiff's exhibit number 1 for identification purposes has been marked as the Glens Falls Hospital medical imaging belonging to Mr. Kevin Orr.

THE COURT: Without objection?

MR. BURKE: Can I see it, Your Honor?

THE COURT: Go ahead.

MR. BURKE: This is the complete set?

MS. SOEHL: Yes.

MR. BURKE: No objection, Your Honor.

THE COURT: Received.

MS. SOEHL: Plaintiff's exhibit number 2, which is the Glens Falls Hospital medical records for the January 25, 2012 visit.

MR. BURKE: My only objection is the certification is for all the records. They have come under one certification. I just

move all the Glens Falls Hospital records in.

THE COURT: Do you want to move them all in as one?

MR. BURKE: Yes.

MS. SOEHL: Yes.

THE COURT: What was previously marked exhibits 1, 2, 3 and 4 are now marked exhibit 1 and they are all received.

MS. SOEHL: Thank you.

At this time, plaintiff will call Jordan Haber as our first witness.

J-O-R-D-A-N H-A-B-E-R, MD, having been called as a witness by and on behalf of the Plaintiff, having first been duly sworn by the Clerk of the Court, was examined and testified as follows:

THE COURT: Go ahead.

MS. SOEHL: Thank you.

DIRECT EXAMINATION

BY MS. SOEHL:

Q. Good morning, Doctor?

A. Good morning.

Q. How are you doing today?

A. Fine.

Q. Are you a licensed physician in New York State?

A. Yes.

Q. How long have you had your license in New York?

A. Since 1976.

Q. Tell us where you attended medical school?

A. I attended medical school at Saint Louis University School of Medicine.

Q. When did you graduate?

A. 1972.

Q. Did you do a residency program?

A. I did an internship. Then a residency at State University of New York at Downstate Medical Center.

Q. Please tell the jury what did you do next in terms of your education?

A. In terms of residency?

Q. Yes.

A. In the residency I was to be trained as a diagnostic radiologist and we did ER rotations looking at ER x-rays, in-patient out-patient x-rays,

CAT scans. There weren't CAT scans at the time. We did fluoroscopy, angioscopy. We did everything that was state of the art at that time.

Q. Did there come a time that CT scans became state of the art?

A. Yes. In around 1977 there was only one or two CAT scans in the entire City of New York. But by 1980-85 there were a number of CAT scans in the community. About '85 to now. About 30 years ago I started learning and taking courses in CAT scanning. Since 1980 on it's been a very significant part of my practice.

Q. To date, if you could tell us how many CAT scans have you read?

A. Numbering in the tens of thousands. Tens of thousands.

Q. Doctor, are you Board certified?

A. I am Board certified. Yes.

Q. When were you Board certified?

A. I was Board certified in 1976.

Q. Are you currently Board certified?

A. Yes.

Q. Briefly, if you can explain to the jury what does that mean to be Board certified?

A. To be Board certified you have to have gone through a residency in an academic center. You have to have passed written examinations and at the time, you had to pass oral examinations. The oral examinations were performed by the leaders in the field throughout the country. They would have one place in the country once a year that they would have all the nervous residents come in there and we would be literally one on one with the leaders in the field in the country. They would give us unknowns and we would have to review the x-rays in front of the teacher, the professor. A major professor of the country would be sitting next to me and I would be seated here and I would be nervous obviously, but he would throw up unknowns and I would have to read them in front of him. Each sub-speciality had their own professor. That is the way it was. Now, everything is computerized.

Q. As a radiologist do you have to follow standards of care?

A. Absolutely.

Q. Are these standards national standards for all Board certified radiologist?

A. Oh yes. National.

Q. Are you currently a practicing radiologist?

A. In 2006 I left my practice with a medical problem. I had surgery in 2007. And I have been teaching as of 2014.

Q. Please tell the jury what do radiologists do?

A. Radiologist look at imaging. It used to be x-rays when x-rays were all the imaging. Now there is ultrasound, CAT scan, there are MRI. Though you called radiology standing for looking at radiological work, the field has expanded. It includes anything that has to do with imaging.

Q. What is your role as a radiologist in terms of the care of a patient?

A. As a radiologist we are given piles-- it used to be piles of film. Now everything is computerized. We used to be given piles of film. I would come to work at 8 in the morning and I could have a pile of x-rays 18 inches to 2 feet high. You read the x-rays, dictate the report and when there were important findings you communicate them.

Q. Why is it that it's important to communicate important finding, Doctor?

A. Well, the vast majority of findings frankly aren't critical, but the standard of the American College of Radiology, which is the body that gave me my licensure, realized it does not serve the patient well to have an important finding and let it get lost in the confusion of paperwork. At that time everything was paper.

It's my job basically to find the pathology and if it is a critical entity that is going to change the course of the care, it is my job to communicate it with the referring doctor. It just makes sense.

Q. Doctor, in 2012 did my office ask you to review certain medical records belonging to Mr. Kevin Orr?

A. Yes.

Q. Do you have your file here with you today?

A. Yes.

Q. Is that comprised of the white medical binder I see in front of you, along with those medical records in front of you?

A. Yes.

Q. You have all the available information

in front of you, correct?

A. Correct.

Q. From Kevin Orr?

A. Right.

Q. Doctor, tell the jury what did you review in this case?

A. I reviewed the CAT scan performed at Glens Falls Hospital of January 25, 2012 and the report and the CAT scan of 3/17/12 and the report.

Q. Doctor, once my office contacted you please explain to the jury how did you go about in reviewing this case?

A. Well, what I do-- my custom and practice when I review images is I look at the images before I see anything else. I took a look at the January 25, 2012 imaging and I made to myself a report as to my findings. I looked at the dictated report by a Doctor Bell and I wrote some notes where I agreed and where I disagreed. I subsequently looked at the 3/17/12 CAT scan of the brain and similarly, I looked at the imaging and then I looked at the report.

Q. You are familiar with a blind review?

A. A blind review, yes.

Q. What is that? Explain to the jury what a blind review is?

A. A blind review is an attempt to put yourself, that is the interpreter, not the interpreting but the expert radiologist reviewing the case. It's the attempt to be as honest and open and non-committed to any of the reporting that was done previously. So I looked at the films as if they were on my desk. If I were reading them in my office or in the hospital. Sometimes I will try to look to see if the patient had a history. The history on January 25, 2012 was headache. I will just look at that history. The same history that the radiologist had when he read it. I will look at the films and then I will look at the report. Where I agree, I will write down where I agree. And if I differ, I will write myself a note where I differ. That is a blind review. The term to be blind is to be objective.

Q. Doctor, eventually you did review the reports of the CT scan of January 25, 2012 and March 17, 2012, is that correct?

A. Yes.

Q. Can you explain to the jury what is a CT

scan?

A. A CT scan or a CAT is Computerized Axial Tomography. In the past we had nothing like this-- in the '70s and the '60s, but with the advent of computerized technology we are able to take x-ray images, which are-- I don't know how many of you have had a CAT scan. I assume some of you have had. You go into the machine and it takes slices basically of your head or your neck or your entire body. The images they get, the information is axial. The axial refers to cutting the head from top to bottom. Axial. The computer with it's more sophisticated software will take these images and now we can do all these new slices and coronal views front top, back and side to side. A CAT scan is basically a computerized axial-- CA tomogram slices. That's what a CAT scan is.

Q. What can CT scans identify?

A. CT scans can identify-- a part of a much larger matrix, which includes MRI-- CT scans are very important in the evaluation of strokes. Whether they be hemorrhagic. Hemorrhage means blood. CAT scan does it's best job. CAT scan can evaluate brain tumors. Cat scan can evaluate

congenital abnormalities. Abnormalities that you are born with. It's a wonderful tool and it's the first line we have in evaluating the brain. At one point it was the only tool. Now it's the first tool.

Q. Specifically with CT scans of the brain, what is the role of the radiologist in reviewing the CT scan?

A. The role of the radiologist in reviewing the CT scan is what the role of the radiologist is in doing anything else. You look at it. You make an assessment. If the assessment is emergent enough or warranting the doctor to know, you are obligated to call the doctor up and not only call him, but now writing things down and confirming print. You have to have a written report that you spoke to the doctor and or his secretary. So everything right now has to be corroborated and in print. How you communicated? Who you speak with? When did you speak with that doctor? These are the things that we have to do in terms of authenticating our responses to the doctor.

Q. How does that role of the radiologist impact patient care?

A. Well, it's critical. Years ago we were an auxiliary service. In other words, it's nice to have radiologists there, but you don't need him because as a neurologist, I can make an assessment of a stroke. I don't need a radiologist. As a general surgeon I can make an assessment of appendicitis in the belly. I don't need a radiologist. But now radiology, in particular CAT scans, are so important that many hospitals, even local hospitals, have CAT scans literally in the emergency room.

MR. BURKE: I am going to object to this as not responsive. He is talking about in general hospitals and CAT scan machines.

THE COURT: Overruled.

A. When I started radiologists were peripheral. Now we are a fundamental part of the care of the patient. Particularly vis-a-vis the emergency room. At 5 o'clock or 6 o'clock when I left work, for many years I was done. Now, at 5 o'clock when I leave work I am reading emergency cases from the emergency room all evening. All night. I am up all evening and all night reading emergency work because the hospital and the doctors

realize how critical radiology and CAT scans and MRI is to active patient care.

MS. SOEHL: Judge, at this point I would like to take a few minutes so I can set up the tv.

THE COURT: Okay. Very brief recess.

(At this time, the court stood in recess.)

THE COURT: Let's go back on the record.

MR. BURKE: Judge, it has come to my attention during the break that plaintiff's counsel is planning not only to blow up the images on the big screen tv, but they also have printed copies of these. We object to these printed copies being displayed. That is not what the doctor looked at. These were digital images. They're not printed on poster boards. It's as if you took pictures of an accident scene and blew it up. It's not what he saw. I will object to the blow up pictures being used. They don't appear to be the same as they looked on the computer screen.

THE COURT: It's demonstrative.

MR. BURKE: I think it's prejudicial. When we are talking about the key issue of the case, do these films show what a radiologist can see? Blowing these up, they are not going to interpret the films. They already have a big screen tv.

THE COURT: This is clearer than the tv.

MR. BURKE: That is right. Because that is not what the Doctor sees.

MS. SOEHL: This is an exact replication of the image on the screen.

THE COURT: I will overrule it. It's demonstrative. It's not going into evidence.

All right. Let's bring in the jury.

(At this time, the jury entered the courtroom.)

THE COURT: Please be seated.

MS. SOEHL: Thank you, Your Honor.

Q. At this point Doctor, with the court's permission, I am going to display what has been marked in evidence as exhibit number 1, which is the imaging of the CT scan of January 25, 2012. Also, with the court's permission, I am going to ask the

witness to step down.

THE COURT: Sure.

MS. SOEHL: Thank you.

Q. Doctor, first let me address-- do you have the benefit of having this big tv monitor when reviewing imaging?

A. No.

Q. What type of monitor do you have as a radiologist as you are reviewing imaging?

A. I have a high resolution monitor. It's about 21 inches diagonally.

Q. When you say high resolution, does that mean-- what does that mean?

A. High resolution just means that it's an accurate monitor. It's not a monitor like this that is meant to show a large group of people findings. It's meant for me to look at 18 inches away and I would read off of the screen in a dark room.

Q. How far away are you from that monitor when you are reviewing imaging?

A. 12, 18 inches.

Q. Would it help you if we dim the lights to help display to the jury what is on the screen?

A. Yes.

Q. Doctor, can you explain to the jury what is shown on the monitor?

A. On the monitor-- this is a transaxial image. Once again I will draw it on myself. It's a slice from front to back of my brain, or this case Mr. Orr's brain. The CAT scan is instead of just taking a frontal picture, it takes cross sections. You look at each cross section and you comment and you look at the normal anatomy. You compare it to the abnormal anatomy and you make a diagnosis in the context of the history you were given.

Q. Showing here and displayed on the monitor we have an R and an L. What does that mean?

MR. BURKE: Your Honor, if we can have the doctor identify what slide we are looking at?

THE WITNESS: I would be happy to. This is image number 1 of 57 slices. Series number 2 and it's Kevin Orr's January 25, 2012 scan.

Q. Now Doctor, can you explain to us there is an L and there is an R in image 1. Can you explain on the monitor in image 1--

A. Right means the right side of his brain

and left is the left side of his brain. Glens Falls Hospital. Date of birth 8/12/69.

Q. On top of that image there are the initial A.S., is that correct?

A. Yes. That may have been the technician that did this. I am not sure what A.S. stands for.

Q. So can you please explain to the jury in terms of anatomy, what are we looking at on image 1 of 57?

A. Right eyeball with the lens, left eyeball, nose, maxillary sinus, upper cervical spine. Muscles. Parietal gland. Next muscles. Here is the spinal cord right in the middle. That gray area right in the middle.

Q. So at this point on image 1 what is the location?

A. It's right at the base of the brain. At the upper cervical spine. Here it is. (witness demonstrating.) Does everybody see this?

Q. Now Doctor, if you can please go up one level. You are now at image 2 of 57. Is there any change from the image number 1 that was displayed on the monitor?

A. Not really. These are 3 millimeters

thick. You can have 3 millimeters, 5 millimeters, 25 millimeters up to an inch. So this is just incremental up. Going north to the top of the head. You are cutting from here and going up to here.

Q. Let's go to the next level.

A. Similarly, nothing of note.

Q. And we're going up you said north?

A. We're going north.

Q. So image 4, what does that show?

A. Nothing new.

Q. Doctor, is there a bone showing in this CT scan?

A. These are the maxillary bones which you can feel right here. Maxillary bone right behind the orbit. These are bones. We are just beginning to see the base of the skull. The white. The white is bone. Muscles here are gray and black is fat.

Q. Let's go up one more level.

A. All right. We are at level 6. I went up two levels.

Q. We keep going north?

A. We're going north.

Q. Any changes in the anatomy at this point?

A. No. We are just 3 millimeters closer to the top, which is called the vertex. Nothing of any consequence.

Q. On image 6 can you actually see the front part of the brain?

A. No, not yet.

Q. Can you see the back part of the brain?

A. No.

Q. Can you get us to an image that you can actually see the brain?

A. Yes.

Q. Okay Doctor, can you explain to the jury--

MR. BURKE: Can you identify what image you are on?

THE WITNESS: Yes.

Q. It's image 21 out of 57.

A. Thank you.

MR. BURKE: Your Honor, I am going to object to the Doctor lightening and darkening the film. He just changed the resolution of the image.

THE COURT: Maybe Miss Soehl can ask the Doctor what he is doing.

Q. Thank you, Your Honor. Doctor, why were you changing--

A. To clarify the image. In my office and the radiologist that read this report-- it's all digital data. There is no smoke and mirrors. It's set up for you to adjust the windows to maximize the findings. Every radiologist will play with it. Play with the windows to make sure he sees the pathology. These windows that are set up here are arbitrary. Where is says CAT of the brain, CAT of the abdomen. It doesn't change anything. It helps me look at the image and that is what a radiologist does. I can bring it back to where it was, but frankly it doesn't show the findings nearly as well as the radiologist who read this had he--

MR. BURKE: Objection to what the radiologist did.

THE COURT: Sustained. Let's ask another question.

Q. Doctor, is changing the lighting in the imaging is that something only available to you as a radiologist?

A. No. It's done all the time. And it doesn't change the resolution at all. It just

changes the pixel count. The pixel appearance. The resolution stays the same.

Q. Is there any significance as to changing the lighting and imaging for purposes of patient care?

A. Absolutely. What you want to do is extract as much information at your reading station from the images that you were sent. It's what is done.

Q. Can we actually go to image 18 first and then we'll go up.

A. All right. Image 18.

Q. This is image 18 of 57. Doctor, can you please explain to the jury what are we looking at now at this point?

A. You are looking at a transaxial slice moving up from the cervical spine to the level of the mid cerebellum. The cerebellum is that part of the brain in the back of the skull and it controls motor, it controls coordination and equilibrium. This is the front of the brain where the arrow is near A.S.. This is the back of the brain. These are the frontal lobes. These are the temporal lobes on the sides and this area of the back here is the

cerebellum.

Q. Is there symmetry between the upper part of the brain and the lower part of the brain?

MR. BURKE: Objection, leading.

THE COURT: Sustained.

Q. Doctor, what is the appearance of a normal brain?

A. The normal brain-- it should be symmetrical from the right to the left and the brain, the gray matter which is around the entire brain and the white matter on either side should be similar in the frontal lobes through the cerebellum. It should be left to right and front to back.

Q. To a lay-person such as me it looks like different shades of gray?

MR. BURKE: Objection, Your Honor.

THE COURT: Sustained.

Q. To you as a radiologist is there any significance to the different shades of gray shown in a CT scan?

A. Our job as the radiologist is to comment on different shades of gray. If it reaches a threshold where it appears abnormal, you have to ask yourself why it is abnormal and what entities can

make it abnormal and how do I pursue the findings and reflect that in my report.

Q. Doctor, can you go up one level, please?

A. 19.

Q. We are on image 19. Now Doctor, at this point we have actually marked as exhibit 2 for demonstrative purposes, an exact replica of image 19. Can we turn on the lights please?

MR. BURKE: Your Honor, if counsel is planning to display this to the jury I have an objection as set forth on the record previously with regard to this exhibit being displayed to the jury. It's not a digital image. It's a hard copy image.

THE COURT: I have already ruled on that. Go ahead.

MS. SOEHL: Thank you, Your Honor.

Q. Doctor, Plaintiff's exhibit number 2, which is that poster board, is that an exact replica of image 19? My question is, is Plaintiff's exhibit 2 the exact replica of what is being displayed on the monitor?

A. It's the same exact slice. But frankly, I think the monitor shows it a little bit better.

19 of 57. It's the same. I think for the purposes of illustration, the monitor does it better.

MR. BURKE: I am going to object to this colloquy about what is better.

THE COURT: Overruled. Go ahead. Continue.

THE WITNESS: This shows it. That shows it better.

Q. Will this aid you and assist you to explain to the jury the pathology you see on image 19?

A. Yes.

Q. Can you explain to the jury what we are seeing on image 19?

A. I want the jury to know these are exactly the same slices. Anything I refer to here, has a precise exacting correlation on the screen. With that understanding once again these are the frontal lobes and these are the Sylvian fissures on the side. Everything up to this point from front to back is normal. This is the third ventricle. This is the trigeminal cistern. It gets a little technical. This is the beginning of the cerebellum.

What we have here are disturbing findings in

the cerebellum.

MS. SOEHL: Juror number 1, can you see this?

THE COURT: Does everybody want to move down?

Q. Doctor, for the benefit of the jurors that were not able to see, can you repeat what you see on image 19, please?

A. The front of the brain. The back of the brain. Frontal lobes where the brain sits. The back of the brain is the cerebellum. If you put your hand behind your head, right in front of your hand will be your cerebellum. I put my hand back here on my head. This is the back of Mr. Orr's brain. This is Mr. Orr's cerebellum. Located over here on my brain. Normal anatomy. Normal anatomy. I would just ask you look back and forth between here and that screen. Normal water collection. It's call a cistern. It's all normal up to this point. Proceeding to the back is the cerebellum. When I looked at this examination I saw a difference in the inside of the cerebellum, which is darker compared to the outside of the cerebellum, which is lighter. Now these may look like subtle differences

to you, but to the trained radiologist there is enough to cause concern. And if I may, could I go back to--

THE COURT: I think he is saying it would be clearer from the tv.

THE WITNESS: Yes.

MR. BURKE: Can we take down exhibit 2?

THE COURT: What do you say?

THE WITNESS: I would like them both to be up. We'll go back and forth, Judge. Just for the purpose of illustration.

MR. BURKE: I am going to object. If the witness is testifying these are two different images I don't know why we have them both.

THE COURT: He just testified they are the same.

MR. BURKE: Why do we need two?

THE COURT: Overruled.

Q. Just as a follow up question, what does image 18 demonstrate to you as a radiologist?

A. Image 18 on the screen here shows the gray area, which is darker than the lighter area here. This area is darker than this area. This

area at the left cerebellum hemisphere-- this is the left cerebellum here. This is the right. This decrease density is a major concern on my part looking at the imaging from January 25.

Q. Now Doctor, why is that a major concern to you?

A. There are two possibilities. This could be-- this is either going to be a large tumor-- an infiltrating tumor of the cerebellum, or a major collection of infarct or stroke. This area which is the lateral part of the right cerebellum hemisphere is lighter than this area. And I saw it on multiple slices.

Q. Doctor Haber, the areas that you pointed to us, the darker areas, are those considered abnormalities of the brain?

MR. BURKE: Objection, Your Honor. Leading.

THE COURT: Sustained.

Q. Doctor, as a radiologist, when you see these darker areas are they of any significance to you?

A. They are significant. This is what I am looking for. This is without contrast. This was

done as an emergency room evaluation. If I see this in and of itself it means either a stoke or a tumor. This is either dead brain and this is normal brain, or this is tumor. Cancer or benign tumor in the cerebellum. Tumor, or benign entity, or an infarct in the cerebellum.

Q. How does the finding of a bilateral infarct impact Kevin Orr's care and treatment?

MR. BURKE: Objection, Your Honor. Foundation. It's a radiologist. He is not talking about subsequent treatment. He hasn't seen any of the subsequent records.

THE COURT: Overruled. If he can answer.

A. Streaks can be bilateral. You can have unilateral stroke. More often then not they are unilateral. On occasion you will have bilateral and there are medical entities. You have to think of carotid arteries where you are getting mycotic aneurism going to the brain. Where you have continuing feeding of clots going to the brain and they will present with bilateral stroke. If this were a tumor, this could be a large invasive tumor of the cerebellum. The fact it's bilateral means

whatever is going on is affecting both sides. It doesn't give you pause to say well, I see this here on the right and if I can see something on the left I am going to ignore it. Because if you had metastatic disease to the brain very frequently you are going to have bilateral tumor. Cancer to the brain. It presents on multiple areas of the brain. The fact it's on both sides doesn't mean anything. It means you have to comment on both sides.

Q. Doctor, can the dark areas that are showing on image 19 and you commented on, can that be some other process happening in Kevin Orr's brain on January 25, 2012?

A. I have been around for 35 years. This is either going to be an infarction that is already advancing, or a tumor. There are no other possibilities.

Q. Can this be fluid, Doctor?

A. This is fluid. This is fluid in the cells. Otherwise a dead brain cell. This black is fluid. This is normal brain. This is fluid. When this fluid in the right Sylvian fissure goes into the brain it becomes darker. It just makes sense that the fluid that is outside the brain, when it

goes into the cells will cause edema. And that is edema from either tumor edema or vascular blood insult, or a blood vessel has been cut-off and you have a stroke. That is water in the cell.

Q. Doctor, can the dark area shown on the cerebellum, can that be fat?

A. There is no fat in the brain.

Q. Doctor, are you aware of what a critical finding is?

A. Yes.

Q. Can you please explain to the jury what a critical finding is?

A. A critical finding is terminology used throughout the country by the American College of Radiology where a finding that is going to be emergent, sudden, or surprising enough to change the course of care has to be called in to the Doctor and you have to write it down in your report I spoke with doctor so and so at a certain time. And you have to put down exactly who you spoke with. Because the last thing you want is to have possibly a tumor or a stroke fall between the cracks.

Q. Doctor, what you observed here on image 19 of Kevin Orr's CT scan of the brain on January

25, 2012, is that considered a critical finding?

A. Yes.

Q. Why is that, Doctor?

A. The doctor who ordered this-- be it the emergency room doctor, or private medical doctor-- he has to know that this patient is a patient who has a significant serious problem. If I were to call to the doctor-- if I was the ER radiologist I would call up the doctor and not the PA. I speak to the doctor in charge and I say doctor so and so, he either has a massive bilateral stroke or he's got a massive tumor in his cerebellum and he needs number 1, a repeat CAT scan with contrast or an MRI emergently.

Q. Doctor, how would you characterize what we see here on image 19 of the CT scan of Kevin's brain?

A. This is either going to be a subacute infarction or it's going to be a tumor. Most likely subacute infarction. But certainly could be a tumor.

Q. Doctor, in your opinion as a radiologist with a reasonable degree of medical certainty, does Kevin Orr's CT scan of the brain of January 25, 2012

show a bilateral infarct?

MR. BURKE: Objection, leading.

THE COURT: Overruled.

A. The most likely diagnosis what we have here is a subacute infarction bilaterally of the right and left cerebellum hemisphere which needs the immediate calling to the doctor and immediate MRI to substantiate this.

Q. Doctor, you used the term subacute infarct. Can you explain to the jury what that means?

A. Subacute infarction-- you can have 10 radiologists and the 10 radiologist will have different definitions of what constitutes subacute. There is acute and subacute. Acute is within-- under 6 hours, under 8 hours. Anything longer than 8 hours and within 2 to 3 weeks is going to be sub, of lower emergent nature then acute. Subacute. So anything that is going to be more than 6 hours, 8 hours I characterize as subacute.

Q. Doctor, please take the stand again. Thank you.

THE COURT: Do you want to turn the tv off?

MS. SOEHL: I will.

THE COURT: And remove the picture?

Q. Doctor, can you please explain to the jury what is infarction?

A. Whether it's the brain or it's the heart, it has to be supplied by blood. Myocardial infarction is infarction of your heart. A cerebral infarction is an infarction to your brain. Infarct is when the blood to the brain is interrupted. Like your heart will have an insult, your brain will have an insult. What I have attempted to show in that black area in both cerebellum hemispheres is the result of a diminished vascular supply and or tumor. Because as of January 25 I wasn't sure. But you have decrease blood causing the cells in the brain to die. The cells need blood. No blood, death. What you have in the black here is the water that is around the brain and in the brain going into the cells. Healthy cells keep the water out. Dead cells can't keep the water out. Water inside the cells of the brain becomes gray and eventually black.

Q. Doctor, once the radiologist reviews the imaging what is the next step the radiologist takes?

A. Well, I dictate the report and I get on the phone and I find out who is in charge of the ER and I would say listen; Orr either had a stroke or he has a big tumor. He needs an MRI emergently.

Q. Doctor, do you recall seeing the report of the CT scan of January 25, 2012 by Doctor James. Bell?

A. Yes.

Q. Do you have it in front of you?

A. Yes.

MR. BURKE: Your Honor, can he please identify what exhibit he is looking at?

MS. SOEHL: It's exhibit 1, Your Honor. May I approach the witness?

THE COURT: Sure.

MR. BURKE: Your Honor, I ask he read from the exhibit that is in evidence rather than pulling something else out from his chart.

THE COURT: Okay.

Q. Doctor, you have in front of you the report of January 25, 2012?

A. Yes, I do.

Q. Who is the ordering physician for this

CT scan?

A. McKenna, RPA. Robert McKenna.

Q. What is the history provided for this CT scan?

A. Headache.

Q. Doctor, is the clinical history of any medical significance to a radiologist?

A. It is when we get it.

Q. Are there occasions that you don't get clinical history?

A. Far more often than not I do not get good history. It's rather the rule than exception that I get good history.

MR. BURKE: I am going to object with what his experience is as oppose to Doctor Bell and where Doctor Bell was working.

THE COURT: Overruled.

Q. Were you finished with your answer?

A. No. No matter how fragmentary the history we get is, we read it and try to focus on it, but we are trained to look at the imaging in the absence of history.

Q. And as a radiologist, does your findings of a CT scan have to be consistent with the clinical

history that you are provided?

MR. BURKE: Objection. Leading.

THE COURT: Overruled.

THE WITNESS: Could you repeat that, please?

Q. As a radiologist, when you are given a clinical history does your findings have to be consistent with that clinical history?

A. Not at all. Not at all. More often than not it has nothing to do with the history. So you would like to find out what the doctor was worried about or the patient is complaining about, but your findings are your findings. And that is why the doctor is sending you the patient. To comment on the findings.

Q. Doctor, are you familiar with what are expected findings?

A. No.

Q. Are you familiar with what are unexpected findings?

A. Yes.

Q. Explain to the jury what are unexpected findings?

A. If the doctor is following up a patient

with a stroke and the patient is stable and nothing is happening, he is just doing a routine follow up, he would expect that the CAT scan of the brain that he ordered 3 months ago is virtually identical to the CAT scan that was just performed.

MR. BURKE: Objection. Foundation. What the subsequent treating doctor said.

THE COURT: Overruled.

A. If in fact a subsequent CAT scan shows a change that the radiologist feels is important, it's an unanticipated finding and the radiologist will use his judgment whether or not to reach that threshold to call up the ordering doctor. Because that is why he did the study.

Q. As a radiologist are you required to report all findings regardless of the clinical history that you are provided?

A. All findings have to be in the report. It's up to the radiologist to make an assessment, a provisional assessment as to any of these findings reaching the threshold of having to call them in. We don't call up every finding. Otherwise I wouldn't get any work done. Everyone has findings.

Q. Doctor, the finding that you have

explained to us on image 19 as bilateral infarct or the possibility of a tumor, is that a finding that you would report for this patient?

A. I would report it and I would call it in immediately.

Q. Doctor, what happens to a patient when findings such as this critical finding is not reported?

MR. BURKE: Objection, Your Honor. Foundation.

THE COURT: Sustained.

Q. Doctor, in your experience do findings such as what we see on image 19 need to be reported?

MR. BURKE: Objection. Asked and answered.

THE COURT: Sustained.

Q. Doctor, let's go back to the report. What is the technique listed on the CT scan report?

A. I had read from the record axial images of the head obtained from the skull base through the vertex without IV contrast.

Q. Can you explain in layman terms what does that mean to the jury?

A. It means that they didn't inject

contrast which is sometimes injected. Depending upon the indication. And frankly, a headache is one of those indications that contrast is reasonable to be injected. So this study was performed without intravenous contrast for headache, which in and of itself is a concern.

MR. BURKE: Objection. Move to strike. There is no claim for that.

THE COURT: Overruled.

A. Very frequently in the context of evaluating a headache we'll inject contrast to see if we can find a tumor.

Q. Doctor, under findings, what do you include under findings as a radiologist?

A. Well, I would frankly include all the findings that Doctor Bell included. It's just that he missed the single most important finding, which is the finding in the cerebellum. Everything he wrote here I would comment on. You want to comment is there an acute intercranial hemorrhage? He said no. Is there a midline shift? He said no. Is there a hydrocephalus? Meaning too much water to the brain. He said no. Gray-white cortical matter differentiation is within normal limits. That is

wrong. It is not within normal limits. It's abnormal. No foci, which means area. No foci site of decreased attenuation to indicate subacute infarction.

I have gone through great length to express to the Court that this I disagree with. That finding of no abnormal intra or extra-axial fluid collection. Then he says mucosal thickening and opacification of the bilateral sphenoid sinuses. Noted maxillary sinuses are largely off the field of view. Which is an incidental finding.

Impression. Should I read the impression?

Q. Not yet. Just to be clear. Could you just let the jury know what portions of the CT report as interpreted by Doctor Bell you disagree with?

A. The gray-white cortical matter differentiation is within normal limits. On slide 19 on the screen and on the blow up, in my opinion it's decidedly abnormal number 1.

No foci or focus of decreased attenuation to indicate subacute infarct. I don't agree with that. I see two areas or more areas in both cerebral hemispheres which is very suspicious.

Suspicious enough to warrant further studies. If not absolutely convinced, then Doctor Bell certainly in my opinion, should have been concerned enough to say is it real, is it not real, but it definitely needs to be pursued.

Q. Doctor, what is the medical significance to report the bilateral infarct in a patient such as Kevin Orr?

MR. BURKE: Objection. Asked and answered.

THE COURT: Sustained.

Q. Doctor, what was the standard of care in January of 2012 with respect to the manner in which radiologists are to report findings on a CT scan such as this?

MR. BURKE: Objection. Asked and answered.

THE COURT: Sustained.

Q. Doctor, do you have an opinion within a reasonable degree of medical certainty, whether or not Doctor Bell's failure to mention bilateral infarct on a report such as this is a departure from good standard medical practice?

A. In my opinion it's a departure.

Q. Why Doctor?

A. It's a departure because Doctor Bell read the study incorrectly. Had he read it correctly he would have commented on the area of the bilateral cerebral hemispheres. He would have said-- at the very least he could have said is it projection? Is it imaging? But it doesn't. If he had done an MRI with the sequences we have available as of 2012, this would have lit up like a light bulb. It would have stared across the room from him and he would have said thank God I did it.

Q. Doctor, do you have an opinion with a reasonable degree of medical certainty whether the failure of Doctor Bell to report bilateral infarct on this CT report of January 25, 2012 had any affect on Kevin Orr's care and treatment?

MR. BURKE: Objection.

THE COURT: Overruled.

A. Well, I am not a neurologist.

MR. BURKE: I move to strike any other testimony.

THE COURT: Any neurological testimony is stricken and precluded.

Q. Doctor, as a radiologist, if you would

have seen the bilateral infarct what would you have recommended for Mr. Orr?

MR. BURKE: Objection, Your Honor.

THE COURT: Sustained.

Q. Doctor, did you review a neurological consult by Doctor Lenihan at Glens Falls Hospital in March of 2012?

MR. BURKE: Objection. I move to strike any testimony about a neurological consult when he just said he is not trained.

THE COURT: What was the question?

(At this time, the above question was read back by the court reporter.)

THE COURT: I think I need more questions in terms of foundation and how it's relevant to his testimony.

MS. SOEHL: Sure, Your Honor.

Q. Doctor, in preparation of your review of this case did you review the Glens Falls Hospital medical chart of March 17, 2012?

A. Yes, I did.

Q. Within that review, did you also review the neurology consult by Doctor Lenihan at Glens Falls Hospital on March 17, 2012?

A. Yes, I did.

Q. Doctor, that neurology consult note--did that include any comments by Doctor Lenihan as to the CT scan of January 25, 2012?

MR. BURKE: Objection.

THE COURT: Sustained.

Q. Doctor, I am just going to go back to the testimony you gave in front of this jury about if they had done a subsequent MRI, it would have lit up like a light bulb.

MR. BURKE: Objection, Your Honor.

THE COURT: Overruled.

Q. Do you recall giving that testimony?

A. Yes.

Q. Can you explain to the jury why it would have lit up on the MRI?

MR. BURKE: Objection, Your Honor.

THE COURT: Overruled.

A. A CAT scan is a very important tool that we have. Cat scans were developed around 1980. In the last 20 years we have new and better protocols for evaluating intracranial pathology. Pathology in the brain. CAT scans with the newer imaging sequences we have will detect an infarction within

hours, if not minutes.

MR. BURKE: I am going to object to what the technology is now.

THE COURT: Overruled.

A. MRI has the technology right now. It's called diffusion weighted imaging. Not to get too technical, but we can at virtually every local hospital evaluate for the presence of a stroke within-- certainly within hours. If not minutes. It would have made the findings that we see here, which are real, stand out so that a fourth year medical student would have made the diagnosis.

Q. What is the diagnosis in Mr. Orr's case?

MR. BURKE: Objection.

THE COURT: Sustained.

Q. When you refer to the diagnosis, what did you mean by that?

MR. BURKE: Objection.

THE COURT: Sustained. Asked and answered.

Q. Lastly, Doctor, did you prepare for this trial a poster board that contains image 19 with some arrows?

A. I didn't prepare it myself, but a

medical illustrator prepared it.

Q. We have marked this Plaintiff's exhibit 3 just for demonstrative purposes.

MR. BURKE: I object to it being shown to the jury.

THE COURT: Will that assist you in explaining your testimony, Doctor?

THE WITNESS: Yes, it will.

THE COURT: Go ahead.

THE WITNESS: And if we could have the screen back on too, or is it too late?

MS. SOEHL: No, we can do that.

THE WITNESS: Can I approach, counselor?

MS. SOEHL: Yes. Come down.

Q. Let me ask you a question, Doctor. Plaintiff's exhibit number 3, what does it show?

A. This is image 19 of 57, series 2. That is image 19 on the screen. 19 of 57, series 2. There are four arrows which depict the difference in density between this area, which is posterior in the cerebellum which was disturbing to me from the normal area on the side of it. Abnormal - die. Normal. Abnormal - die. Normal. For purposes of illustration, these arrows were put here to show the

difference between a normal brain, which is in front and in the back and a dead brain. Once again, this disease isn't necessarily an infarction. It could also have been cancer or a benign tumor. The one thing that it isn't, is normal.

Now, if I put an arrow over here and I put another arrow over here and I put two arrows on the other side, it would be an exact replication. I took this and sent it to the medical illustrator. We discussed the position of the arrows. This on the screen is an exact replica of this. I frankly feel this does a better job of displaying it. If there was a red arrow here and red arrow there it would be identical. This is abnormal or dying, or dead brain. This is normal brain. When I see this after playing with the windows, which is the job of the radiologist to get the most information you can. No smoking mirrors. It's done 24/7 in any radiology work station.

Q. Doctor, is this only observable to you, a radiologist of more than 30 years experience?

MR. BURKE: Objection.

THE COURT: Sustained.

MS. SOEHL: No further questions. Thank

you.

THE COURT: All right. Okay. I think now would be a good time to take a lunch break for one hour. We'll see everyone back here at 1:15.

(At this time, the court stood in recess for lunch.)

THE COURT: Good afternoon. Ready for the jury?

MR. BURKE: Yes.

MS. SOEHL: Yes, Your Honor.

THE COURT: Doctor, you can take the stand. You are still under oath.

(At this time, the jury entered the courtroom.)

THE COURT: Mr. Burke.

MR. BURKE: Thank you, Your Honor.

CROSS EXAMINATION

BY MR. BURKE:

Q. Doctor Haber, my name is Kevin Burke. I represent Doctor Bell. You and I have never met, correct?

A. That is correct.

Q. I had an opportunity to look through

your file that you have up there.

A. Yes.

Q. You brought that file pursuant to a subpoena served by my office?

A. Yes.

Q. That is everything you have in this case?

A. Yes.

Q. Everything you thought was relevant you brought to the courtroom pursuant to that subpoena?

A. That is correct.

Q. I didn't see any bills in there from you to the plaintiff's firm?

A. I don't think I submitted any bills.

Q. You were retained in 2012, 4 years ago and you never submitted a bill?

A. Other than the original bill.

Q. I didn't find that in there. Do you have the original bill with you today?

A. No.

Q. Why not?

A. Frankly, I forgot to bring it.

Q. Did you forget to bring anything else?

A. No.

Q. That original bill, how much was it for? Do you know?

A. I am not sure.

Q. I didn't see any correspondence at all from you to the plaintiff's firm or from the plaintiff's firm to you. Do you have any?

A. No.

Q. You never received any correspondence?

A. No.

Q. Did they call you on the phone?

A. Yes, they called me.

Q. Did you keep any records about your contact with plaintiff's firm?

A. No.

Q. How many bills have you issued on this? We know one. Have you forgotten any other bills you issued on this?

A. I don't think I have.

Q. Any other-- how many hours do you have into this case from start to finish?

A. I haven't a precise number, but I have a rough idea.

Q. What is your rough idea? How many hours do you have into this case?

A. 20 to 30 hours.

Q. Do you know how much of that you already billed for?

A. Yes.

Q. How much?

A. I think the original bill was under $2,000.

Q. And your rate for reviewing medical records for law firms is $400 to $500 an hour? Somewhere in that range?

A. $400 an hour.

Q. In this case you are charging $400 an hour?

A. For review.

Q. You do charge other law firms $500 on occasion, don't you?

A. Rarely, but yes.

Q. So you have got 30 hours. That is about 12 grand you have got into this case already, correct?

A. Yes.

Q. That 20 or 30 hours would be for you to review a CAT scan film, correct?

A. Correct.

Q. How much of that 30 hours did it take you to review that CAT scan film?

A. I didn't review the film entirely without the context of all the additional information I brought here.

Q. How many times have you looked at this film?

A. I would say at least 5 to 10 times.

Q. In your 30 hours that you have billed plaintiff's firm for, how much time have you spent looking at this film in those 4 or 5 times?

A. I'm sorry, I can't quantify that.

Q. More than an hour?

A. Much more than an hour.

Q. More than 10 hours?

A. I would say 5 to 10 hours. I can't be very precise.

Q. You have 5 to 10 hours reviewing that CAT scan film. Then you have got 20 hours or so doing other things, correct?

A. That is correct.

Q. Can you locate for me your written report you wrote to plaintiff's counsel?

A. I don't have a written report.

Q. You never gave them a written report about your findings?

A. I don't think I did. No.

Q. Well, did you or you didn't? You said you don't think. Is it something else you might have left at your office?

A. I think it was a verbal communication. It was a verbal communication.

Q. But this isn't the first time you have testified, is it Doctor?

A. No.

Q. You testified about 25 different times, is that about right?

A. You know, I don't think the number is that high, but I would appreciate that list after the trial.

Q. Okay. Sure. How many times do you think you testified doctor in any kind of proceeding where you have been under oath in regards to radiology?

A. I think it's around 10 times, but I would certainly appreciate a more inclusive list.

Q. How many times have you testified for the plaintiff's firm before today?

A. Once.

Q. Where was that?

A. I am not sure of the county. It was in New York State.

Q. And you have also testified in other states?

A. I have testified-- yes, in other states.

Q. Would you agree with me 90% of the testimony you do is for plaintiff's?

A. For the testimony. Yes.

Q. At times you have testified in New York, sounds right? You know, Texas?

A. I don't think I have testified in Texas.

Q. New Mexico?

A. No.

Q. On those other times you have testified, you have charged-- let's keep it to this case. You got your 30 hours in. All right. Then you are charging for your trial testimony?

A. No, that is not right. I included that in. I haven't done a precise tabulation of the exact number of hours. When I gave you the 30 hours I included today in there as well.

Q. But you bill a flat fee for coming to

trial, don't you?

A. You asked me how many hours. I included today's hours. I didn't figure out the precise bill precisely.

Q. Do you bill a flat fee for coming to trial?

A. Yes.

Q. You bill $4,000 for half a day and $8,000 for a whole day?

A. Plus travel.

Q. Where did you travel from, sir?

A. New York.

Q. How long did it take you to get up here?

A. It took me from leaving the house, Long Island Railroad-- it took me about 5 hours each way. 5, 6 hours.

Q. Did you come up this morning?

A. I came up last night.

Q. Did they put you up in a hotel?

A. A very nice hotel.

Q. Where abouts?

A. The Hilton in Albany.

Q. Did they meet with you last night to go over your testimony?

A. We had dinner we discussed the testimony.

Q. Were you billing for all that time as well?

A. I haven't billed them yet.

Q. Are you going to bill them for that time?

A. Yes.

Q. And when you leave here today and drive back home you will bill them another 4, 5 hours for your travel time?

A. Yes.

Q. Doctor, you earned-- at least in 2014 you were earning about 200 grand a year doing medical legal work? Does that sound about right?

A. Yes.

Q. The last time you practiced in a hospital setting in the field of radiology was in 2006?

A. Yes.

Q. Since that time you had a bit of time you were out for some medical issues, correct?

A. That is correct.

Q. Since that time you have been involved

in the medical legal field?

A. I have been doing additional things aside from that.

Q. The medical legal field. You testified earlier-- I will get back to that.

You gave up your clinical practice in 2006, correct?

A. That is correct.

Q. You began your medical legal work in 2011, roughly?

A. That is correct.

Q. You never published in the field of radiology, right?

A. That is correct.

Q. You advertise for your services, don't you sir?

A. Yes, I do.

Q. In fact, you have a website that advertises for firms that you are an expert radiologist?

A. That is correct.

Q. It's called consultingradiologist.com, is that correct?

A. That is correct.

Q. You also advertise on something called Expert Page, a leading online directory for expert witnesses?

A. That is correct.

Q. And on that page you tell people that you testify not only in diagnostic radiology, but child abuse radiology, battered baby syndrome, shaken baby syndrome, is that correct?

A. That is correct.

Q. In addition to that site, you advertise on ALM Experts, is that correct?

A. That is correct.

Q. You advertise on Jurist Pro Expert a witness directory, correct?

A. That is correct.

Q. You advertise on HG.dot an organization for expert witnesses?

A. I think I dropped them.

Q. Were you on them? When did you drop them?

A. I never got any patients from them so I dropped them.

Q. Patients?

A. I am speaking as a doctor/client.

Q. You don't have any patients anymore, do you?

A. No.

Q. Not since 2006?

A. Right.

Q. You also advertised on LexViso.com, expert witnesses?

A. I think I am ready to drop them too.

Q. Not getting anyone to hire you from there?

A. No.

Q. You also advertise on LawyerFind.com?

A. Another one.

Q. Lawyer Find Online you state you can testify in all 50 states is that correct?

A. If that was put in there. I am not frankly sure where I can testify. If it was put in there it was put in by the people that put the copy together. I am not sure that I can.

Q. All your communications with plaintiff's firm has been on the phone, other than when you met with them for dinner?

A. Right.

Q. Did you ever meet with them before last

night?

A. On this case?

Q. Let's start there.

A. I met with them last week.

Q. For how long?

A. Must have been about 4 hours.

Q. Any time before that?

A. No.

Q. You have worked with their firm on at least one other occasion?

A. Yes.

Q. You're confident it was just one time?

A. Yes.

Q. How much did you charge them on that case?

A. You know, I can't recall. I think it was a total of around $15,000. I can't recall.

Q. When was that?

A. Must have been about 3 years ago. 2 or 3 years ago.

Q. March 2013 sound about right?

A. It could be right.

Q. You testified for Ms. Soehl's partner, Mr. Santola?

A. Yeah. That is fine.

Q. Do you have in your file that you have in front of you all the emergency room records from January 25?

A. I don't know if I do.

Q. Did you ask for them?

A. No.

Q. Do you have the testimony of the emergency room physician who ordered the CAT scan?

A. I may.

Q. Can you locate it for me?

A. I don't think I have that here.

Q. Do you know the name of the attending doctor for the emergency room or the physician assistant?

A. I mentioned his name earlier. I will have to review this for his name.

Q. Mr. McKenna sound correct?

A. Yes.

Q. Did you ever ask Miss Soehl or her firm for the transcript that Mr. McKenna gave in this case?

A. No.

Q. Did you ever request any documents from

plaintiff's counsel?

A. They sent me a whole slew of documents.

Q. My question is did you request any documents of plaintiff's counsel?

A. No.

Q. So you relied-- you knew you were coming to this courtroom to give an expert opinion today, that is your job correct?

A. That is correct.

Q. You relied on plaintiff's attorney to determine what was relevant for you to review, correct?

A. No.

Q. You did a blind review-- did you call it a blind review?

A. I don't use that term often, but it is in fact a blind review.

Q. That was the term I think Ms. Soehl used, a blind review. And you told the jury what that was?

A. Yes.

Q. This blind review for this case came after the Powers & Santola Law Firm hired you in 2013 and paid you eighteen grand? Then they send

you records and said is there anything wrong with this? That is how you started your blind review is that correct?

A. That is not correct.

Q. The records-- you have got those records you have there. Did they all come together?

A. They came together.

Q. Who put that binder together, was that plaintiff's firm?

A. No. That is my binder.

Q. You got those documents loose with no cover letter, right?

A. Yes.

Q. And you got you have a CD in there of CAT scans?

A. There is a CD somewhere. Yes.

Q. At the time you did your review you didn't take any notes, right?

A. That is right.

Q. Your original review was back in 2012 I think you said?

A. Yes.

Q. No notes from that, right?

A. That is right.

Q. No report about what you saw, right?

A. Did you say a written report?

Q. No written report of what you saw?

A. That is right.

Q. You called them on the phone and told them?

A. Yes.

Q. Did you speak to Miss Soehl about that?

A. Yes.

Q. Now the films and we have the films up here today. These are some of the ones you reviewed, is that correct?

A. Those are the films I reviewed.

Q. You reviewed the film from January 25 and you have given opinions about Doctor Bell, right?

A. That is correct.

Q. You spent 5 or 10 hours reviewing these films, right?

A. That is correct.

Q. I think you told us earlier that-- I wanted to clarify something from earlier. You said to the jury earlier, in reading emergency cases I am up all night reading reports. You didn't mean

yourself, right?

A. Could you repeat that?

Q. Earlier, when you were on direct examination and Miss Soehl was asking you about CAT scans and radiologists reviewing them-- I wrote this down. Because of the value I am reading emergency cases and I am up reading emergency cases all night.

A. Yes.

Q. Is that what you were doing?

A. I was referring to when I was working in 2006.

Q. You were not referring to now?

A. That was not my intention to refer to now.

Q. Because you don't do that anymore other than for lawyers?

A. Lawyers and insurance companies.

Q. So you were Board certified in 1997, right?

A. No. 1976.

Q. 1976. That's when you were Board certified?

A. Yes.

Q. Are you re-certified?

A. It can't be answered like that.

Q. Were you grandfather in so it's your position you don't need to be re-certified?

A. It can't be answered like that.

Q. If I ask you a question that you can't answer yes or no, just let me know.

A. That is what I am doing.

Q. In 1976 there were no CAT scans, were there?

A. At the Neurological Institute of Columbia there was one CAT scan.

Q. I think you told the jury in the mid '80s is when they started coming in vogue?

A. Yes.

Q. That is 10 years after you became Board certified?

A. No, that is not correct.

Q. Now Doctor, you would agree with me a radiologist could miss something and still not commit malpractice?

A. No, that is not correct.

Q. Doctor, do you recall testifying for Mr. Santola back in March 2013 in a case named Boyer and you were asked these questions and you gave these

answers? "Question: In fact, a radiologist may miss something and still not commit malpractice, correct? Answer: That is correct. Question: Doctor, a radiologist reading imaging studies may miss something and still be within the standard of care, correct? Answer: Correct."

Do you recall that testimony Doctor, yes or no?

A. Yes.

Q. Doctor, are you familiar with something called hindsight bias?

A. Yes.

Q. And a hindsight reading would be taking the data and now going backwards and looking at other imaging studies retrospectively to see what they show, is that correct?

A. That's correct.

Q. And that is a term of art in the industry?

A. I don't use that term of art in the industry.

Q. It's cited in the ACR Guidelines, hindsight bias?

A. I would assume it could be.

Q. What are the ACR Guidelines?

A. They are guidelines by the American College of Radiology.

Q. Are you a member of that college?

A. Yes.

Q. That is something every American College of Radiology recognizes, correct?

A. That is correct.

Q. The information that Doctor Bell was given about Mr. Orr on January 25 was a headache, correct?

A. That is correct.

Q. Have you read-- you haven't read. Did anyone tell you what Mr. McKenna said about that? Why he put that down?

A. No. We haven't discussed that.

Q. To the best of your knowledge Mr. McKenna never told Doctor Bell that this man was suffering from dizziness, correct?

A. I couldn't comment on that.

Q. Mr. McKenna never told Doctor Bell he was suffering from nausea?

A. I couldn't comment on that either.

Q. Okay. Are you familiar with Glens Falls

Hospital?

A. No.

Q. Ever been up there?

A. No.

Q. Do you know what kind of technology they have in the emergency room?

A. No.

Q. Do they have an MRI machine there?

A. I don't know.

Q. Did you ask Miss Soehl to find that stuff out for you?

A. No. I didn't see the need.

Q. And Doctor, if you could just limit your answer to my question that would great. Because Miss Soehl is going to get a chance to talk to you again. And you can clarify things if you want to.

You would agree with me sir, wouldn't you, that in January of 2012 a physician's assistant at Glens Falls Hospital when ordering a CAT scan can identify to the radiologist what problems they are seeking him to look for? Would you agree with that, Doctor?

A. I am not sure I understand that question.

Q. Okay. Fair enough. Is there a way in January of 2012 for a physician's assistant at Glens Falls Hospital, when ordering a CAT scan, that he can identify for the radiologist what he is asking him to look for?

A. Yes.

Q. Did they do that in this case?

A. Yes.

Q. What did they say?

A. Headache.

Q. Sir, back in January of 2012 did Mr. McKenna have the wherewithal to provide more information than just headache on that report?

A. You will have to ask Mr. McKenna. I don't know.

Q. You don't know that. You haven't seen his testimony. Okay. Are you aware of whether Mr. McKenna had the ability to free text information in when ordering that CAT scan?

A. I only know what is written on this report here.

Q. It's not relevant to you why someone sends someone for a CAT scan?

A. No, that is wrong.

Q. It is important, right?

A. It is important.

Q. To the radiologist a health care provider is asking the radiologist a question, right? They are looking for an answer to a clinical question?

A. That is correct.

Q. In this case according to you-- Is Mr. McKenna's order in front of you?

A. I have the report here.

Q. Do you have his order?

A. No, I don't.

Q. What clinical question was Mr. McKenna asking Doctor Bell, do you know?

A. I do know what was written here. History was headache.

Q. The clinical question Mr. McKenna was asking Doctor Bell was why does this man have a headache, correct?

A. Correct.

Q. He wasn't asking him why he was dizzy? He wasn't asking him why he was vomiting? Why he had vertigo? Why he had nausea for 12 hours, is that right?

A. That is right.

Q. You are aware Mr. McKenna has given testimony in this case that the history he provided to Doctor Bell about Mr. Orr and the CAT scan was incomplete?

A. Am I aware of that?

Q. Yes.

A. No.

Q. Fair to say you are not aware of what Mr. McKenna his diagnosis was after the CAT scan?

A. Fair enough.

Q. The films that you looked at and we had some up here on the screen earlier, the January 25, when they were up there you changed the resolution, correct?

A. No, that is incorrect.

Q. When they were up there you changed how they looked, correct?

A. I didn't change the resolution.

Q. Did you change how they looked?

A. That was the second question you asked me.

Q. That is what I am looking for an answer on.

A. Yes.

Q. You did that by-- it's a digital image, right?

A. That is right.

Q. You did that by somehow changing that digital imaging?

A. I don't know what somehow means.

Q. Me either. Let's walk through it. There was a digital image on this screen. As I sat in this chair it changed, right?

A. That is correct.

Q. How did you do that?

A. Radiologists have windows and levels that they constantly use at their work console. I am answering your question.

Q. I am waiting.

A. They change the window and level to optimize the information that is readily available under the right imaging parameters.

Q. My question to you is how did you do it in here-- in this courtroom?

A. Right on that software.

Q. There was an area to do that?

A. Sure.

Q. When you originally put it up was it on the default window?

A. I think so.

Q. The default image would be the image that comes over to Doctor Bell originally?

A. No, that is incorrect.

MR. BURKE: Let me get this back on if I may, Your Honor. I am going to turn back on the television.

THE COURT: Okay. You want to turn the lights down?

MR. BURKE: Could we?

Q. Doctor, this is image number 19, correct?

A. I can't see it from here.

Q. You care to come down and look at it?

A. Sure. It's image 19.

Q. That is the default image for slide number 19, correct?

A. No, that is incorrect.

Q. So when I clink up here default, that is in the image that comes up?

A. That is correct.

Q. I just did it. You want to check it

yourself?

A. No, I don't want to check it.

MS. SOEHL: Objection, Your Honor.

MR. BURKE: I will withdraw the question, Your Honor.

Q. Sir, up here there is a little button I can click with the mouse. It says adjust window. It says default image. That is what I clicked is that correct?

A. That is a global. There are different defaults.

Q. If you could answer my question. Did I just do what I said I did?

A. You will have to rephrase the question for me, please.

Q. I clicked the button on top of the tv that said default image, correct?

A. Yes.

Q. And the image that is on the tv now is the image that appears when I clink default image, correct?

A. Correct.

Q. Is it your testimony Doctor that anywhere there is a discoloration on a CAT scan

image, it's either a tumor or an infarct yes or no?

A. No.

Q. In fact, that happens a lot on CAT scan images because the brain is different, correct?

A. What do you mean? What happens a lot?

Q. You can have different shades when you are looking at a CAT scan image, correct?

A. It's my job to know abnormal to normal.

Q. You have different colors, different shades on CAT scan images?

A. Within the range of normal.

Q. I want to know if you have different shades?

A. I can't answer that question.

Q. Are there 256 shades of gray on a CAT scan image?

A. Yes.

Q. Sure.

A. With higher resolution studies they have done more than 256.

Q. A standard CAT scan imaging in January of 2012 had 256 shades of gray, correct?

A. Correct.

Q. Doctor, is it your testimony that

anywhere the shades are gray there is an infarct or tumor, is that your testimony?

A. No.

Q. Doctor, you can have areas in a CAT scan that have discoloration of shades of gray and it can not be a tumor on infarct, correct?

A. No, that is incorrect.

Q. Doctor, would you agree with me a radiologist as he looks at a film has to make a judgment call on what they are seeing?

A. Yes.

Q. And that is when you said earlier, when I read your other testimony, a radiologist can read something wrong and still not have made-- let me get the exact language because I know you like exact language. A radiologist can read a film and miss something and still not commit malpractice, correct?

A. In the--

Q. Yes or no, Doctor?

A. Yes.

Q. And that is why a radiologist has to use his judgment, correct?

A. No, that is incorrect.

Q. Doctor, looking at image 19 there is an

area of discoloration here. Is that a tumor or infarct?

A. I cannot look at that image.

Q. You want to come down here and look at it?

A. No because it's set on the wrong window.

Q. This image you can't tell anything?

A. I would choose not to read that image.

Q. Is it your testimony it's a deviation from the standard of care to read that image?

A. I can't comment whether it's a deviation of the standard of care. I would like to answer the question, if I can.

Q. I think you did.

MS. SOEHL: Objection.

THE COURT: Answer the question.

A. You set that on the default window, but it's not the general default window of brain. I would like to put it on the brain default window and then I could comment on it.

Q. I am sure the attorney that brought you in here will let you do that. Can you interpret that window as it is as a radiologist?

A. No.

Q. Can we have the lights back on? Now, Doctor, I am holding up exhibit 2 which is the blow up of image number 19, correct?

A. That is correct.

Q. By the way, that is not the size Doctor Bell would have looked at?

A. No. He would have looked at something far smaller and much better resolution.

Q. How big was your screen, 21 inches?

A. About 21 inches.

Q. When we show this to the jury this is not the size Doctor Bell was looking at?

A. He would have looked at a better image than that.

Q. My question is this the size he would have looked at? It's a simple question.

A. I understand.

Q. Is it the same size as that on the tv screen?

A. No.

Q. As we look at exhibit 19 Doctor, up here there is a dark area, yes or no?

A. Yes.

Q. Up here is a dark area, yes or no?

A. Yes.

Q. Over here there is a dark area, correct?

A. Yes.

Q. Here there is a dark area, correct?

A. Yes.

Q. Here there is a dark area, correct?

A. Yes.

Q. Here there is a dark area, correct?

A. Correct.

Q. Here there is a dark area, correct?

A. Yes.

Q. Here there is a dark area, correct?

A. That is correct.

Q. Are all those tumors or infarcts?

A. They are all normal.

Q. Are they tumors or infarcts?

A. No, they are normal.

Q. Doctor, what is an artifact in CAT scan imaging?

A. An artifact is a technical abnormality which has nothing to do with any patient pathology. When I use the word pathology, I mean an abnormality within the patient. An artifact is not pathology. It could be a technical-- because we are dealing

with a lot of technology, it's something I have been trained to address and ignore.

Q. Okay. So an artifact is not pathology. So what is it?

A. It's a glitch in the system.

Q. A CAT scan film can have an artifact in it, correct?

A. That is correct.

Q. Part of that is because the x-ray image that is creating the CAT scan has to go through different tissue?

A. That is correct.

Q. The skull is thicker down here than it is up top, correct?

A. That is correct.

Q. So when an x-ray beam is shot through the skull you can have an artifact when it come out the other side, correct?

A. In older machines yes.

Q. How old? Tell me what kind of machine that happens in, Doctor? You clearly have a recollection of one.

A. I would say a machine that was generated in the early '80s when the slices were thicker.

Q. A machine in January 2012, is it your testimony to this jury it cannot have an artifact because of bone?

A. You specifically asked me counselor a different question. If you want to refer to that question--

Q. If you can't answer my question let me know.

A. I can't.

Q. The CAT scan machine used in January 2012 is it possible to have an artifact?

A. Yes.

Q. Is it possible because the x-ray is being shot through bone?

A. Yes.

Q. And the cerebellum is located in an area that has the thickest bone around it, correct?

A. Yes.

Q. The slides that were done for Mr. Orr were 3 millimeters thick?

A. Yes.

Q. The x-ray shot freezes 3 millimeters and converts the information to an image the computer makes?

A. Yes.

Q. If it goes through water it's one color? If it is bone it's another color? If it's tissue it's another color?

A. That's correct.

Q. Did you say there is no fat in the brain?

A. Yes.

Q. The brain is not 60% fat?

A. On a microscopic level.

Q. Okay. As the beam shoots through someone's head and it makes this 3 millimeter slices, at times you can have different types of tissue in that 3 millimeter slice?

A. That is correct.

Q. And that would affect the color they are?

A. Yes.

Q. You gave some testimony about infarction earlier and I think I wrote it down. You were asked in your expert opinion what the definition of a subacute infarct was and I think your answer was you ask 10 different radiologists and you will get 10 different definitions. Do you remember that?

A. I do remember that.

Q. It's a fact Doctor, there is literature that says infarcts don't show up for 48 hours subacute?

A. There is that literature.

Q. That means according to that literature when someone has a stroke you will not be able to see it on a CAT scan for 48 hours according to that literature?

A. That is correct.

Q. And in this incident, the incident that happened to Mr. Orr, it happened 11 hours before the CAT scan?

A. That is correct.

Q. And the reason according to that literature that you can see it 48 hours later is because that dead tissue is now filling with fluid?

A. That is correct.

Q. When the beam shoots there it picks up the fluid and converts that to a darker color, is that right?

A. That is correct.

Q. You mentioned carotid artery disease with this jury. Do you remember that?

A. Yes.

Q. Carotid artery supplies the blood to the front of the head?

A. The front two-thirds of the head.

Q. The vestibular artery in the back are the ones that feed the cerebellum?

A. That is right.

Q. Carotid artery had nothing to do with this case at all?

A. It was asked. That's incorrect. That is incorrect.

Q. All right. Thank you. The areas where you identified there was an infarct was in the cerebellum, correct?

A. That is correct.

Q. That is fed by the vestibular artery?

A. No. That is not vestibular.

Q. One last thing about exhibit 2. I wrote down your testimony earlier. Dark areas are dead tissue you said, right?

A. Dark areas in the cerebellum are dead tissue I said.

Q. Not in other parts of the brain?

A. No. I pointed out before the Sylvian

fissures, which are on the side. The ventricle which are in the middle. There are a lot of areas that are black.

Q. Just because it's black doesn't mean it's dead tissue?

A. No, that is incorrect.

MR. BURKE: No further questions, Your Honor.

THE COURT: Okay. Redirect, Miss Soehl.

MS. SOEHL: Thank you, Your Honor.

REDIRECT EXAMINATION

BY MS. SOEHL:

Q. Doctor Haber, you mentioned that you do work for plaintiffs and insurance companies, defendants, is that correct?

A. Among other people, yes.

Q. Let me give you an opportunity to explain. What type of defense work do you do?

MR. BURKE: Objection. He didn't say he's done any defense work.

THE COURT: Overruled. Go ahead.

A. About 50% of the work is defense work.

Q. Are there occasions when either plaintiffs or defendants send you a case for review

that you don't find any departure?

A. It happens all the time.

Q. When that happens, what do you do with that case?

A. Well, I bill for my time and I call up the attorney and I say you will have to find another expert because I can't find fault in the case.

Q. Now Mr. Burke had mentioned that you drove to this court today, is that true?

A. No.

Q. Explain to the jury how did you get here?

A. I live on Long Island. I took the Long Island Railroad into Penn Station and I took Amtrack up to Albany.

Q. Doctor, Mr. Burke asked you why you didn't ask for the complete records from Glens Falls Hospital. Tell me why?

A. I wanted to focus on the imaging. I had the request that Doctor Bell had. I had the indication that Doctor Bell referred to as headache and as a radiologist, very rarely do I look at the emergency room record to make an assessment on a clinical nature. I rely on the history and if I get

a history, fine. If I don't get a history, frankly that is also fine. But I don't have the opportunity in the normal day to sit and review in detail the emergency room records. How they communicate, what their thoughts were, what their response to my findings are. It's not how hospitals work.

Q. Doctor, did you want to be in the same position that Doctor Bell was on January 25, 2012 when he read Mr. Orr's CT scan?

MR. BURKE: Objection.

THE COURT: Overruled.

A. Did I want-- I don't understand the question.

THE COURT: I understand it.

Q. I will rephrase it. When you were reviewing the CT scan of January 25, 2012 did you want to be in the same position as Doctor Bell was at the time that he was reviewing that CT scan?

MR. BURKE: Objection, Your Honor.

THE COURT: I will sustain it. Rephrase it.

Q. Tell me when you did your initial review how did you perform this for this CT scan of Mr. Orr's brain?

A. What I do is try to recreate with the 35 years of experience that I have in reading CT scans from emergency rooms. More often then not I either get no history or I get a very marginal history with one word, headache. So that is the way I interpreted this. I do not ask for the emergency room records in my normal course of 35 years. I never get it and I couldn't proceed with the volume of work that I customarily do in a hospital if I am going to be reviewing the details of the emergency room record. It's not how it's done.

Q. Doctor, the deposition of PA McKenna was that relevant to your interpretation of the CT images and what they showed on the January 25, 2012 scan of the brain?

A. Would you re-ask that question, please for me?

Q. You were ask if you reviewed the deposition of PA McKenna in this case. Do you recall that?

A. Yes, I do.

Q. Why didn't you ask for that deposition?

A. I thought it was irrelevant.

Q. Why is it irrelevant in this case?

A. It's irrelevant in my opinion because I am the expert witness replicating what Doctor Bell had done when he reviewed the CT. I would assume if Doctor Bell's practice was similar to all the practice that I have seen over 35 years, Doctor Bell does not have the opportunity to sit down with Mr. McKenna and review the details of his clinical presentations. For that reason I asked for a limited amount of information. The information I generally get in the real world when reading CTs.

Q. Thank you, Doctor. Now please explain to the jury why you don't have any notes in your binder in front of you?

A. Well, frankly much of the work I do is what I remember and an affidavit was generated for the purposes of this trial which included my feelings.

Q. Doctor, under what circumstances can a radiologist miss something and not commit malpractice?

MR. BURKE: Objection, Your Honor. No. I will withdraw that. I apologize.

A. It happens all the time that radiologists miss things. When I was asked this

question and I answered Mr. Santola, you can miss things and they have only marginal clinical significance. A stroke, a tumor in the cerebellum is not an incidental finding. It's a critical finding. You can miss something that is of marginal clinical significance and you say, oh yeah I will put it in there. I have done addendum reports all the time. You add things. Missing things are not necessarily a departure. A departure is when you miss something that is of a critical nature. And a missed stroke is significant. A missed tumor is of major consequence. When I answered Mr. Santola's question; is every miss malpractice? Of course they are not. Radiologists are human. But when you make a mistake that has the potential of causing severe adversity to patient care, then that enters the field in my opinion of a departure from the standards of malpractice. That is why we have standards.

Q. When a radiologist misses a critical finding in a report is he exercising medical judgment?

MR. BURKE: Objection, Your Honor.

THE COURT: Sustained.

Q. Doctor, at the time of your initial review did you have any information beyond headache, which is the clinical history given to Doctor Bell on January 25, 2012?

A. No.

Q. Did that lack of further information change what was visible to you on the CT scan of January 25, 2012?

A. Not at all.

Q. Why is that?

A. The radiologist is responsible to use whatever information he has, no matter how marginal, to look at the images and to make a diagnosis and help the patient. It's no excuse in my opinion in coming up with an incorrect report and blaming it on the history. If that were the case, 99% of misses would be exonerated by saying I didn't have the history. The real world is if it's on the film you are responsible to call it. It's my job no matter what history I get. This was a miss. This was not excusable by the absence of history. It's just a miss.

Q. Doctor, you recall Mr. Burke asking you questions about the default on the software of this

CT imaging? Do you recall that?

A. Yes, I do.

Q. Let me give you an opportunity to explain. Is there a default for CT scans?

A. There is a general default. But there are specific defaults for the chest, the abdomen, the knees, the bones. There are at least five defaults. I would never read that CAT scan based upon what was submitted. That is why when the counselor asked me about commenting on it, I couldn't comment on it.

MR. BURKE: I object. The CD is from Glens Falls Hospital that plaintiff has put into evidence. It's the actual software used for this review. That is what was represented to this jury.

THE COURT: Overruled.

THE WITNESS: There are many defaults there.

Q. I just wanted to show you-- you were referring to the different default windows for different CT scans?

MR. BURKE: It doesn't say it's different default windows.

THE COURT: Hold on. That was his testimony.

Q. Doctor, is the infarct of the cerebellum on the CT scan of January 25, 2012 shown on a different image other than the image 19 of the CT scan?

A. It's shown on many images.

MR. BURKE: Objection. Outside the scope of cross.

THE WITNESS: It's on many images.

THE COURT: Overruled.

Q. Doctor, can you show us on how many images it shows?

A. If you are prepared to turn off the lights and let me come to the screen?

MR. BURKE: Objection.

THE COURT: Overruled. Go ahead.

MR. BURKE: Your Honor, just for the record, if the Doctor can identify what he is doing? I can see the light changing on there, for the record.

THE COURT: Doctor, can you do that?

THE WITNESS: For the record, I went to brain window and I changed-- as I told you

it is the course of what I do on a standard basis every day that I interpret. That all radiologists do when they interpret. No smoking guns or mirrors. It's standard.

MS. SOEHL: Can everybody see?

MR. BURKE: Doctor, for the record he was just--

THE COURT: Can you explain what you are doing? Why it's changing?

THE WITNESS: I am using this back here. There is a white and a gray. These are windows and levels. It's standard in the software and you adjust the windows and the levels when you interpret these films.

Q. Doctor, is that software only available to my office?

MR. BURKE: Objection. That is the software that came from Glens Falls Hospital.

THE COURT: I will sustain it.

A. Shall I continue?

Q. Sure.

MR. BURKE: I don't know if there is a question pending.

Q. Doctor, I will ask you a new question. Show me the first image that you can see the bilateral infarct?

A. This is number 13 of 57.

Q. Can you explain to the jury what are you observing on image 13?

A. On 13 there is an area of black or gray. Better termed gray at the right cerebral hemisphere. There is an area wedge shape in nature-- in the left hemisphere. Once again, these are 3 millimeter cuts.

Q. The next slide is number 14. What is shown on that slide, Doctor?

A. There is an area of wedge shape decreased attenuation or decreased density, dead gray. Dead cerebellum in the left hemisphere. Area of dead cerebellum right hemisphere. That is on 14.

On 15 the same thing. No change. It's wedge shape. It's on more than one level. Both cerebral hemispheres.

Q. Image 16?

A. Image 16 has no change. Same thing. You see it on multiple levels.

Q. Can you show to the jury what are you

observing?

A. I am seeing an area of decreased density here compared to here. This area more centrally is darker than here. This area on that side is darker than here centrally. This area of the cerebellum is the same density as the frontal lobes. That is the way it should be. The area that is darker here is the area of dead or dying cerebellum. 17 the same. Wedge shape area on the left. Wedge shape area on the right. This area is darker than this area. The cerebellum should be entirely the same density and it should be the same density as the frontal lobe.

18 a little more dynamic. This area left cerebellum to the right cerebellum laterally. These are the areas that a radiologist looks for. These are not incidental findings. This is not artifact. It has nothing to do with the bone back there. It's my job to see it. The bone doesn't cause this. Maybe the bone causes it in machines that were 5 millimeters of thickness. This was thinner, more resolute. Maybe it was in a study 20 years ago. You could think--

MR. BURKE: I am going to object to the speeches.

THE COURT: Sustained.

Q. Doctor, why is it this cannot be bone?

A. It can't be artifact.

Q. Artifact.

MR. BURKE: Objection. He answered the question.

THE COURT: Sustained.

Q. Why it can't be artifact?

A. Artifact would be stroke density and they look nothing like this. A trained radiologist would know. Artifact is stroke density. I don't know if I have any examples. This is a good study. It's a first rate study.

MR. BURKE: Objection.

THE COURT: Sustained.

Q. Doctor, let's go up one more level.

A. Another good example. I think this is the example you chose. A big black area here compared to a gray area here. A big black area here. Black area here. Artifact wouldn't look like that. This is number 20.

Q. Okay. Explain to the jury what we are observing?

A. You are higher up now in the cerebellum.

This stroke affected a major part of the right cerebellum and a major part of the left cerebellum. On slice number 20 of 57 there is a readily visible area of decreased brain tissue compared to the adjacent area elsewhere. There is nothing like this in any of the cerebral hemispheres. This is an infarction or a tumor. Most likely infarction. It has nothing to do with artifact. And here--

MR. BURKE: Objection. Not a question pending.

THE COURT: Sustained.

Q. Doctor, can you go up one more level?

A. 21 shows it very well. This area of gray is different from this area. This is not artifact. Has nothing to do with the bone. This is dead cerebellum.

Q. Doctor, what is the significance of the different shades of gray in the cerebellum?

MR. BURKE: Objection, Your Honor.

THE COURT: Overruled.

A. The cerebellum should be the same density throughout this area of the cerebellum, which is anterior and central. Should be the same as this area, which it is. This area, this is a

perfect example. This is normal cerebellum. This is normal cerebellum. This is abnormal cerebellum and this is normal cerebellum. What you have here in term of gray is not present at all at that left cerebellum. This isn't mirrored. This is abnormal. Even if it was mirrored it would still be abnormal.

MR. BURKE: Objection.

THE COURT: Sustained. Strike the last portion.

Q. Doctor, should there be dark areas in the cerebellum in this CT scan January 25, 2012?

MR. BURKE: Objection, to dark area. There are 256 shades of gray.

THE COURT: Overruled.

A. This is a wage shape area of cerebellum infarction. This is abnormal. Nothing to do with the bone. It's not an artifact. It's pathology. It's patient's dead or dying cerebellum. That is all it is.

Q. Doctor, as a radiologist are you trained to distinguish the 256 shades of gray?

A. Yes.

Q. Explain to me why?

A. It's my job to know what is artifact,

what is normal, what is abnormal. And there is no radiologist who will call this an artifact.

MR. BURKE: Objection, Your Honor.

THE COURT: Sustained.

MR. BURKE: Move to strike.

THE COURT: Strike the portion about the artifact.

Q. Doctor, can an infarct show on a CT scan less than 48 hours after a stroke?

A. Happens all the time.

Q. Can you explain to the jury how is that possible?

MR. BURKE: Objection, Your Honor.

THE COURT: Overruled.

A. When there is an interruption of the vascular supply, for the first 6 hours it's called acute or subacute infarction. And even within the first 6 hours we see it. We don't always see it, but we can see it. Medicine is not an exact science. There are areas that the technology isn't all that great. For the first 6 hours it is not as resolute as we would like. There are secondary signs that will show up. After 6 hours, between 6 hours and 10 hours and between 6 hours and 2 weeks

you run into the area of subacute. This is a classic example of a subacute infarction. Yes, we can see things. We do it frequently and you don't always see it, but you have to look for it. The fact it doesn't show up on occasion doesn't mean we don't have to look for it when it's there. When it's there we have to comment on it. This study was done around 11 hours after the patient was symptomatic. There is definitely abnormalities here. I see it prospectively. Not looking back at a study in March. I saw it when I first looked at it and I saw the history and I felt the history and the findings are such that this should have been reported immediately as very suspicious. You can say, are you absolutely sure Doctor Haber this is an infarction? And I would have to say no. I say it's abnormal brain. Could be an infarction, it could be a brain tumor, but one thing it is, it's abnormal. What the doctor should have done is he should have called up and documented his call to the ER.

MR. BURKE: Objection.

THE COURT: Sustained. Strike the last portion. Not responsive to the last question.

MS. SOEHL: No further questions.

THE COURT: Okay. Mr. Burke.

MR. BURKE: Briefly, Your Honor.

RECROSS EXAMINATION

BY MR. BURKE:

Q. I think you said as a radiologist you rarely look at ER records, correct?

A. When I am making the initial diagnosis.

Q. When you were practicing back before 2006, if you got an order in for a head CAT scan did you even look at the history?

A. Yes.

Q. Why?

A. Because sometimes there might be valuable information I want to extract.

Q. Do you rely on the health care provider that gives you that history?

A. I am like--

Q. Do you rely on him to give you accurate history, yes or no?

A. No.

Q. That history section is on every single order of every CAT scan for head, correct?

A. When you put things in yes or no I can't

answer that.

Q. That is fine. Just tell me.

A. I cannot answer that question.

Q. Do you have an opinion sir, within a reasonable degree of radiologic certainty as to whether the history is relevant at all?

A. Yes.

Q. But in your practice you didn't rely on it when you practiced, correct? Yes or no.

A. That is incorrect.

Q. Doctor, the imaging we were looking at here, that CD came from Glens Falls Hospital the subpoenaed records. That is the software from Glens Falls?

A. I am not sure which software they used.

Q. You don't know what software the CAT scan machine that is subject to this lawsuit used?

A. No.

Q. Would you agree with me at the time there was a button that said default window, yes or no?

A. No.

MR. BURKE: All right. Nothing further, Your Honor.

THE COURT: Miss Soehl?

MS. SOEHL: Nothing further, Your Honor.

THE COURT: Okay Doctor. You are excused.

THE WITNESS: Thank you.

(Witness excused.)

* * * *

I, Joseph J. Mondella, Supreme Court Reporter of the State of New York, do hereby certify that the foregoing pages comprise a true and accurate transcript of the proceedings reported by me in the above captioned matter.

JOSEPH J. MONDELLA
SUPREME COURT REPORTER