CAUSE NO. 01-C-753

EDDIE CAFFEY, et al. ) IN THE DISTRICT COURT OF
Plaintiffs ) CASS COUNTY, TEXAS
)
VS. )
)
FOSTER WHEELER )
CORPORATION et al., ) 5th JUDICIAL DISTRICT

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ORAL DEPOSITION OF

RICHARD B. LEVINE, M.D.

APRIL 21, 2003

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ORAL DEPOSITION of RICHARD B. LEVINE, M.D., produced as a witness, and duly sworn, was taken in the above-styled and numbered cause on the 21st of April, 2003 from 5:10 p.m. to 9:25 p.m., before NANCY R. TONER, RPR, reported by machine shorthand at the Elkins Park Hospital, 60 East Township Line Road, Elkins Park, Pennsylvania, pursuant to the Texas Rules of Civil Procedure and the provisions stated on the record or attached hereto.

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ALSO PRESENT:
RICHARD B. LEVINE, M.D.,
The Witness;

MS. NANCY R. TONER,
The Court Reporter.



INDEX



EXHIBITS

Page 6

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RICHARD B. LEVINE, M.D. was called as a witness after having been first duly sworn according to law, was examined, and testified as follows:

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-- EXAMINATION --

BY MR. MORALES:

Q. Good afternoon, Dr. Levine. My name is Carlos Morales. I will be taking your deposition today.

We've never met before, have we?

A. Not to my knowledge.

Q. It's nice meeting you.

A. It's my pleasure.

Q. You've given depositions before so you understand the formalities involved with a deposition and the procedures?

A. Yes. I believe I do.

MR. MORALES: And just for the record, can we have a stipulation that this deposition is conducted under the Texas rules of civil procedure?

MS. BOONE: That's correct.

DEFENSE COUNSEL: And can we have

Page 7

the stipulation that an objection by one is good for all?

MS. BOONE: That's also fine with me.

BY MR. MORALES:

Q. Sir, in 1985 you became a B reader. Is that correct?

A. Let me just to ensure absolute accuracy use my curriculum vitae. But I believe that's correct. I was originally certified in 1986.

Q. And, sir, did you bring me a copy of that updated curriculum vitae?

A. I thought you had one but --

Q. I'm not sure it's the most current one. Thank you.

And how was it that you came to learn about this new field in 1985 or '86?

A. In the 1980s, I was an academic radiologist at Thomas Jefferson University Medical School which is downtown here in Philadelphia.

And as a relatively young radiologist -- still had all my hair and a lot smaller bald spot -- one of my assignments in addition to

Page 8

running the residency training program was to back up one particular field and that was chest radiology.

I have been a subspecialist in bone radiology and have been a general radiologist doing gastrointestinal work, chest and all manner of radiology.

But a Dr. Robert Steiner who was involved with running the chest radiology program -- and in the field of academic radiology it is quite common to travel a lot of do visiting professorships.

In his absense, someone was needed to run the chest radiology program. In that context, I got to see an extraordinary amount of chest radiology.

And I was really enjoying it more and more. And the referrals that went to him because he was a B reader, I had to kind of defer.

And I started to look into this in the early 80s and as a non-NIOSH certified B reader was doing board certified radiologic interpretations but not as a B reader for the physicians that were in the pulmonary

Page 9

department at Jefferson.

And then recognized that the NIOSH certification was very important to these physicians for whatever reasons that they needed it.

For the most part it was epidemiological.

So I went and attended the NIOSH course. I presumed it was in '85 or '86 and stood for the examination and passed the exam and have successfully recertified four times.

Q. Did you pass the exam the first time?

A. I passed the exam every time. And, in fact, the last time I got a call from them because I got one of the highest grades they had on the exam in 2001.

Q. Do you recall what your mean score was the first time you took the exam?

A. I'm sorry?

Q. Do you recall what your mean score was the first time you took the exam?

A . I have no idea.

Q. Now, your certification was up for renewal June 30th, 2002. Did you get recertified at that time?

Page 10

A. Yes. My certification now is through June 30th, 2006. That's the exam that I'm referring to where I did so well this past year.

MR. MORALES: Object to non-responsive.

THE WITNESS: That exam was given in Washington, Tyson's Corner in Washington.

BY MR. MORALES:

Q. Do you recall the first plaintiffs firm you began working with after you became a B reader?

A. I have no idea. I'm not sure I was in any way sophisticated that I would have realized that it was a plaintiffs firm or defense firm.

But a neighbor -- and this may not be the first -- but early on a neighbor in my area at a picnic in my backyard asked me if I did any occupational dust disease interpretations.

And he was with Blank, Rome, Comiskey & McCauley. I believe that law firm still exists in Philadelphia.

Q. And you don't know whether they are a plaintiffs firm or defense firm?

Page 11

A. At the time -- afterwards I subsequently realized they were a plaintiffs firm. And I guess I was involved with Mr. Perlberger for several years when he would on occasion send referrals to me either directly because he was a neighbor and he would drop them off and I would take them to Jefferson or he would just because the firm was downtown have the patients come right to Jefferson for x-rays marked to my attention.

And also just outside films were sent to my attention at Thomas Jefferson University.

That's in the early to mid 80s. But Mr. Perlberger left that firm. He had other areas of expertise besides occupational dust disease. He was also a divorce attorney and one other area that eludes me.

So I haven't -- I'm not sure he's even doing it because I don't think I've seen any referrals from him in maybe 12 or 13 years.

That may be the first. If not, it was certainly one of the earliest.

Q. You said that there were certain other reasons that people used to work with before you became a B reader, there were reasons they

Page 12

became B readers. Was one of those reasons litigation?

A. It could have been. For other people? It's possible. It certainly was very clear to me that the pulmonary physicians at Jefferson wanted someone with additional credentials besides the American Board of Radiology.

And in discussing with this Dr. Steiner, who was a B reader, he suggested I become a B reader so that I could -- I think he had an ulterior motive. I used to leave all the work for him.

So when he would come back, he would have to do all of these B readings. That way I began to do all the B readings.

Q. Was he also doing medical legal work at that time?

A. I have no idea.

Q. Was that some of the work that he needed you to help him out with?

A. Boy, you're going back 20 years. I don't know when the medical legal work really started as opposed to just doing the work for Jefferson.

It was relatively early on. But I

Page 13

couldn't tell you a day, week, month, or year. We're talking about the early 80s. This is 2002 and I'm not sure what I had for dinner yesterday.

I'm not trying to give you a hard time. I mean, it was very early on. I don't know what year it started or anything like that. I don't keep records like that.

Q. Well, nowadays, though, you get x-rays from all over the country now, don't you?

A. I have referrals that I get from the government. I get referrals from attorneys. I get referrals from health and welfare groups. I get referrals from the railroad workers. I get referrals from the amalgamated construction trades in Philadelphia.

I get all the referrals from the pulmonary physicians in the metropolitan area including from my own hospital.

DEFENSE COUNSEL: Objection. Non-responsive.

BY MR. MORALES:

Q. Well, since you've listed all those different places you're getting referrals from, my next question is going to be can you give me

a percentage of the amount of referrals you're getting from each?

And if you want, we can start with the government. And let's --

A. That's on a very episodic basis and that comes from multiple different sources. In other words, an imaging company may have to go --

Q. Before we get started, let's see if we can do it from 2002. It might be a little easier.

A. It's a guess. I don't keep records along those lines. There's no way that I can organize it that way.

Various companies that do imaging may have contracts with the government for, for example, black lung disease because -- coal workers pneumoconiosis because we're here in Pennsylvania and still doing a lot of coal mining in the area.

So the imaging companies will be under contract to do this type of work. And those are reports that are sent right to -- I send them back to the imaging company but they are sent right to the United States Government as



part of the programs of surveillance that the government is doing on the various companies, mines, if you will.

Boy, the percentage? I don't know how I can do this because it's so episodic and there's just no order to it.

I mean, there might be nothing from the government for months, and then for one month most of the work would be from the government.

I don't want to pigeonhole myself to a percentage because I really have no idea. But it's a small percentage because they come from so many different sources that no one source represents the majority.

It's not like 60 percent are from any one source. All the sources are small fractions, if you will, of a hundred. In total they come up to 100 percent.

Q. Okay. Is it a smaller percentage than you would receive from attorney referrals?

A. Probably on a par with attorney referrals. Probably that's on a par with attorney referrals.

Then there's a group of cases that I



receive which is a relatively large percentage and I have no idea whether they are coming from attorneys or not because they are sent to me directly by the unions.

Like, for example, health and welfare groups, I've done all the firefighters in Philadelphia. All the Philadelphia -- we have a -- let me just stop for a second.

We have a real problem with all the school buildings in Philadelphia filled with asbestos. So all the school teachers in Philadelphia have been screened. That's been sent to me.

The firefighters have been sent to me. That's been sent to me by the firefighters union.

Railroad workers are sent to me from around the country. That's sent to me by various unions.

Imaging companies send to me industrial work from anything from -- I presume I am allowed to say this -- Walt Disney World.

Walt Disney World has an asbestos problem underneath some of their facilities, you know, because they have to fireproof it,



obviously, for the safety of the people going through.

So they have miles and miles of corridors underneath that were fireproofed. Things like that.

MR. MORALES: Objection to the non-responsive portion.

BY MR. MORALES:

Q. Do you happen to know what plaintiff firms represent the unions in this area, the fire department and teachers union?

A. No idea.

Q. Are all these cases you're receiving as a result of litigation that's beginning?

A. I have no idea.

Q. Do you ever follow up on any of those cases?

A. I don't. But sometimes they do. If a case comes to litigation like this, then I would realize, for example, that in this case -- that these two cases relate to this particular law firm because I've had to deal with, obviously, with an attorney that I just met for the first time.

Q. Let's talk about that. How did you

Page 18

receive these two cases that remain the basis of this lawsuit?
A. I have no file. I was just called by this attorney.
No. I was called by another attorney in the firm and told that there were some cases that I had been involved in that they are the attorney for and that they were going to require a deposition.
Fine. And then the issue became setting a date. You know, the logistics of it.
As it turned out. That attorney wasn't involved in covering the deposition. I didn't realize initially that it was a discovery deposition that you had called as much as a deposition that they had called until I got the notice which I think I got about ten days ago or something.
Actually. I think it arrived while I was out of the country.
And this attorney had been the one that I had really set up the date and the time with and I think she had then confirmed it with your company because I don't think I ever spoke to your law firm.

Page 19

Q. So you didn't receive any correspondence or anything from any of these firms until after you had already done the ILO and done the read on these two plants? Is that what you're telling me?
A. True. I apparently interpreted these cases a couple years ago.
Q. How did you receive the x-rays?
A. I have no record. I have no file on them. So they must have been sent to me, but I don't know who sent them because I don't have any file on them.
It's impossible for me to keep a file on all the films that come to me because they come to me from so many different courses. I have no way of filing them.
I've tried filing it alphabetically by name, but I have so many with the same name. And fathers, sons, grandfathers, and all that.
So I don't keep a file room on any of this. All the materials I get go back to the referral source. I don't keep a file room. I figured if it's good for the Mayo Clinic, it's good enough for me.
MR. MORALES: Object to the

Page 20

non-responsive.
BY MR. MORALES:
Q. Who is the referral service you keep referring to?
A. Whoever referred them to me.
Q. Well, if it's not the union in the area, if it's not the government, if it comes from some other source, who generally is that?
A. The company that took the films, for example. An imaging company it could be.
Q. What are the names of some of those imaging companies that you're referring to?
A. Most Health Services would be one. Another one would be -- I believe it's called N and M.
And then there's another one. I could tell you the name of the individual but I don't know the name of the company. But it's run by a gentleman by the name of Lloyd Chriss, C-H-R-I-S-S.
He would just call and say that he's sending me cases.
Q. Is it American Medical Testing?
A. Honestly, I don't know.
Q. What about Health Screen? Is that one

Page 21

of them?
A. Health Screen does send me work. That's true.
Q. And how long have you been receiving referrals from these entities?
A. Years.
Q. Do you recall when you first began receiving referrals?
A. No idea. I mean, I've been a B reader since '86. So I have no idea. I mean, Health Screen is relatively recent the last couple years, just the last couple years.
What was the name of the other companies?
Q. Most Health.
A. Most has been probably about eight, nine years.
Q. What about the N and M?
A. Probably about three or four years. But there was only about a year or two that they were sending work to me. And then for whatever reason they stopped.
Q. You are no longer receiving referrals from them?
A. No. But they just contacted me that

Page 22

they wanted to send work to me again.
Q. Are you -- what would your, I guess, classification be in regards to Most Health and these entities? Would you be considered an employee or contractor?
A. I presume an independent contractor. I just charge a fee for service.
Q. What is that fee?
A. It depends on what period you're talking about. Obviously, my fees have gone up over the years.
Q. Let's start at the beginning then. When you first recall doing B reads for these services --
A. Back in the early 80s, it was $10 for reading the study and $1 to get the report typed.
Q. And what is it today?
A. I think now, 2003, the reading including completing the narrative report, the ILO and for the transcription, it's $35 per case.
But I suspect that in these two cases since it was done in '01, it was probably $25.
Q. But you have no records to that, to

Page 23

prove that?
A. I have nothing. The price change is a function of my malpractice insurance going up because we're having a tort reform crisis here in Pennsylvania.
Q. Have you been sued for malpractice?
A. Have I --
Q. Been sued for malpractice?
A. Have I been sued for malpractice? Yes.
Q. When was the first time you were sued for malpractice?
A. I've been dropped from all the -- first of all, my role here at the hospital is chairman of the department of diagnostic imaging. So I've often been named in lawsuits -- when I say often, three or four times that I was named in lawsuits because of the fact that I'm chairman of the department.
In all of those lawsuits, I've been totally dropped before the suits ever went anyplace. It may have taken a year or two or three to finally get me out of the lawsuits, but they got me out.
I've only had one lawsuit that

Page 24

actually involved me over the last -- since I've been a doctor, which has been -- I'm 58 and that was when I became an M.D. when I was 23.
MR. MORALES: Object to the non-responsive portion.
BY MR. MORALES:
Q. Do you recall when you were 23 when you were sued for malpractice --
A. No, no, no, no. I first became a doctor when I was 23 years of age.
Q. Okay.
A. I'm now 58.
Q. Right.
A. And in that period of time, I actually have just one lawsuit that's against me. That's really against me.
Q. Before you became chairman there was only one lawsuit?
A. No, no. That's since I'm chairman. I've been chairman for 17 years here. But I have one lawsuit that I was named in that is irrelevant to my chairmanship. It actually does involve me. It's really a lawsuit against me.

Page 25

A. And this is while you were chairman?
A. I'm still chairman.
Q. And that lawsuit occurred while you were chairman? And it was against you?
A. Yeah. It just occurred in the last two years.
Q. And what did that have to do with?
A. There's an allegation of a missed finding on the mediastinum on an obstruction series on a patient that came in with abdominal pain and had gall stones from the emergency room. It's an emergency room case from here in the hospital.
Q. What was the result of that lawsuit?
A. It's still pending. They haven't even taken --
Q. Depositions?
A. You know, we're eight years behind here. It'll probably be long since after I'm retired before it gets done.
Q. When was that suit filed? Do you know?
A. I said within the last two years.
Q. And that's here in this county?
A. I don't know. I think it's

Page 26

Philadelphia. But that also is being changed because of our tort reform.

It used to be where they would file it in the county where the juries were the best. Now they changed that and said no, you have to file it where the actual incident occurred.

You're going through a tort reform crisis I think in Texas too. So we've got the same sort of thing here and New York, New Jersey. But here it's really a crisis.

Q. Have you given a deposition in that lawsuit?

A. Yes. That lawsuit I gave a deposition.

Q. And when did you give that deposition?

A. Maybe three, four months ago.

Q. And do you know the style or name of the suit?

A. I have no idea.

Q. You don't know the name of the patient that's bringing the suit against you?

A. I believe the last name is [redacted]

[redacted]

Q. Who was your carrier?

A. CIR. They are not currently my

Page 27

carrier because they've pulled out of -- every malpractice carrier has pulled out of the State of Pennsylvania for radiology. There is no radiology carrier left in the state.

Q. How are you going to get insurance?

A. We go through what's called assigned risk. The state set up a joint underwriter that is giving us insurance.

Q. Do you know what that premium is going to be?

A. Yeah. It's not good.

Q. How much?

A. Probably about -- for me alone, about 30 thousand.

Q. Is that a year?

A. Yeah. My insurance five years ago before this crisis hit used to be about 2000.

The neurosurgeon here just walked into my office and told me that his premium was $279,000 for him alone because the carriers for the orthopedists and neurosurgeons and for one other -- OB-GYN also pulled out of the state.

Q. Now, let's talk about what else you do other than these B reads for now. What other facets are there to your practice?

Page 28

A. Well, I'm a general diagnostic radiologist. I'm chairman of the department. I run all the aspects of a clinical department, a full service acute care department.

We have here MRI, CT ultrasound, special procedures, angiography, general diagnosis.

We do everything. We are a full 24-hour, 365, 7 day a week department of radiology.

My own areas of expertise are -- primarily what I do is chest and mammography. But I do general radiography.

Q. Do you have any other special privileges at any other hospitals in the area?

A. None that are active. I have previously been asked and have served as the acting chairman at the medical school when they fired the chairman at the medical school.

But I don't believe any of those privileges are active because I've really been here now -- I guess I've been here now four or five years since I've been both acting chairman there and chairman here.

And I've been chairman here since --

Page 29

the CV will reflect either '85 or '86.

Q. What percentage of your overall income comes from these referrals that you receive?

A. God, I have no idea. I have no idea. I just -- I have no idea.

Q. Let me ask you this: You get a 1099 from these services?

A. Do I get a 1099 from these services? No. I have a corporation. Everything comes from -- the hospital is run -- my department, it's my corporation.

Q. So the funds that are received from these readings go to the hospital?

A. The funds that are received -- no, no, no. Let's back up.

I have a franchise here at the hospital. Radiologists -- I don't know how it works in Texas -- but here I have a contract with the hospital. And the contract is for Richard B. Levine, M.D., President, Cross-County Imaging.

So that gives me the right to be the sole radiology group here at the hospital. It is my corporation. It is my practice. People that work for me are employees.

Page 30

And I have no partners and there are no other shareholders other than myself.
Q. Are there any other B readers that are your employees?
A. (Witness shakes head.)
Q. You're the only one?
A. Right. So all the income that comes in from all the work that we do is all commingled and I just pay salaries to people.
Q. Well, who would know where the income is coming from?
A. I would presume my accountant. At some level my accountant must, I presume. Although I'm not sure that he would recognize what -- he has no medical sophistication. But I deposit checks.
Q. Sure. You got to pay taxes. We all do. We just got through that.
A. Of course. But, I mean, the question you're asking is never a question he's asked.
So after all, I get reimbursed from private insurance, from various other insurance like Blue Cross Blue Shield, the various HMOs that I am capitated with, various other insurance plans.

Page 31

I have people that pay cash and I have --
Q. Now, you're not getting any insurance funds for any of these reads, are you?
A. No, no. This is not compensated by insurance. Absolutely not.
Q. It's all cash?
A. I'm not sure what you mean by cash. I mean, I bill an invoice and I receive a check. You don't normally see cash. I mean, I haven't seen cash except occasionally patients pay us cash.
The hospital doesn't even know what to do with the cash.
Q. So your department is responsible for billing the invoices?
A. Yeah. Well, not my department. My corporation is me.
Q. You have employees, though, right?
A. Right.
Q. So you --
A. But I have a billing company.
Q. Okay. And the billing company is you?
A. No. I have a billing company under contract.

Page 32

Q. And they don't have records of your billings from the previous year?
A. Sure they do. I presume they do. Sure. I have never sat down with them and asked them, you know.
Q. Well, who are they?
A. What do you mean?
Q. Who is the billing company that you use?
A. It's called Radiology Billing and Management.
Q. And where are they located?
A. Here in Pennsylvania. Here in Philadelphia.
Q. Now, your fees, do you charge different for just a reading? Or do you do readings and ILOs and reports for each one?
A. Basically just about everybody is charged approximately the same, $35 a case.
But in some situations, I do have people that because of prices that I've represented to them or amounts that I've raised to them they are paying either a little more and some are paying less.
Some are paying $40 and some are

Page 33

paying $30. And that has to do with the fact that some have gone through a raise with the first of the year. Some haven't because they weren't raised at the time of the first of the year.
And some 30 bucks that I have, it's really a question of competition from the -- what they perceive they could get it for.
So that, frankly, if I raise them I suspect I would lose that market share. That's my looking at it.
But, basically, on average it's probably 85 percent of the people that I'm with now are paying $35 a case. And that includes the narrative report and if they want an ILO completed.
Q. With the insurance situation the way it is, it's probably more beneficial for you to do more B reads now?
MS. BOONE: Objection, form.
THE WITNESS: I'm not sure I understood the question.
BY MR. MORALES:
Q. Well, we were talking about the insurance, the premiums, the increase.

Page 34

A. What does that have to do with anything? It's always better for me to do more work. I mean, when I'm in my hospital, it's better for me to be busier. It's also better for me to have a more successful active practice.

The fact is that I do have a problem with expenses going up in terms of malpractice. But I also have expenses going up in terms of my own medical insurance.

I have expenses going up in terms of, you know, the accountant or whoever else is involved. And also my employees because of these situations and because of inflation they are putting pressure on me for more income.

So the answer to the question is it's also better for me to do more business. I'm not sure it's relevant that it's particularly better because of the malpractice issue. That's just another business pressure that drives me nuts.

Q. It's more efficient, though, isn't it? I mean, how long does it take you to do one of these reads?

A. That purely depends on the complexity

Page 35

of the case. And, obviously, it's also a function of how many are sent.

If somebody sends me 4 as opposed to somebody that sends me 30 and how it's set up, I could waste more time doing the 4 because I wind up having to package it, having to separate that out as opposed to having 30 where I may have a master list and I can go through them a lot faster.

There's no continuum which says that this particular case from this particular group is going to be the same as that case from that group.

It also depends on whether I'm looking at one view, two view, or four views. It depends on whether I'm looking at comparisons.

There are so many variables.

Q. Do you charge a different fee when you receive in bulk rather than individual?

A. No, I don't. I probably should but I don't.

Q. These here, I believe there are two views. How long would it take you on average to view those?

A. If it was standard operating procedure

Page 36

to review a film, I would think the whole process realistically is three to five minutes from beginning to end between opening the package, putting them up per case.

So maybe ten minutes for doing two cases. But then they are dictated. And then I have to handwrite out the report. Then I get the report back, proofread it, and package it and mail it.

Q. Any idea how many B reads you've done this year?

A. No. Definitely as a function of tort reform it's dramatically decreased by a significant percentage. It's a small fraction of what it has been because of what's going on all around the country.

DEFENSE COUNSEL: Objection, non-responsive.

BY MR. MORALES:

Q. Any idea how many you've done this month?

A. You know, like today, for example, I had 16 from one group and 6 from another.

But I don't know. Tomorrow I could get 100 or tomorrow I could get nothing. It's

Page 37

variable.

I could just say that quantitatively it's markedly diminished. It's a fraction of what it had been, small fraction. It's much less than 40 percent of what it had been as a guess.

Q. Since when?

A. Since the first of the year. I'm not sure what was going on, but there must have been something going on as far as statutes of time or something, because it was very busy around October, November to get work done. And then after the first of the year, I could have taken three months off. In fact I did. I went on three vacations.

Q. What's been your most active year doing reads?

A. I couldn't tell you. I just don't keep records like that. Don't forget, this is only part of what I do. I run a department of radiology. I'm doing fluoroscopy in the mornings and I read mammography. I do 85 percent of the mammograms here at the hospital.

MR. MORALES: Objection, non-responsive.

Page 38

BY MR. MORALES:
Q. When you receive these, you have no idea what firm they come from?
A. No. Sometimes they are sent from a firm. If there's a covering letter, then I will know.
But that's not necessarily the case. If the imaging companies send them to me, I won't have any idea. And I send them back to the imaging company.
And there are occasions where the imaging company will then tell me to forward them to a particular either health and welfare group or union or law firm related to the union, that sort of thing.
Q. What are some of the firms you recall working with?
A. In Philadelphia? Greitzer and Locks. As I said, Blank, Rome, Comiskey & McCauley. In the past I've worked with the George Howard firm, but that's not the name. Howard is in the name, but he's out of it now and there are other partners.
In New York, Weitz and Luxenberg. The Nix law firm. Let's see. Brown Torrell in the

Page 39

northern part of Florida.
I'm sure if I think about it I could give you some more.
Q. Other than firm names, do you recall any other states that you've received these images from?
A. I've received images from New York, certainly from Pennsylvania, from Florida, Texas, Mississippi.
I mean, over the years I've probably received them from 40 states. But I couldn't cite specifically. I mean, the ones stand out because there was kind of a rush near the end of last year from Mississippi and Texas.
Certainly New York. And years ago, a lot of stuff from New England. A lot of the shipyards in New England.
I remember there was a period of time that I was receiving a lot of stuff from around the Great Lakes, maritime stuff from the Great Lakes. But that's not been for years.
I couldn't even tell you the name of the law firm. The head of the firm died I know because I read it in the paper. For some reason it made the national news. Nothing

Page 40

negative. Just made the national news as a benefactor or something.
Q. Pretty much all over the country?
A. I said 40 states.
Q. Right. What states are you licensed in?
A. Well, I am licensed in Pennsylvania, New Jersey, and New York. My active license is in New Jersey and New York because my home is here in Pennsylvania. We're only a couple miles from the border.
But I never go out of the state to practice. I practice here in the state. So any work that I'm doing is sent to me here.
Q. To back up I guess, and maybe you can tell me this: Is there a different amount that you charge depending on the result of the read? In other words, if it's a positive read?
A. Not in terms of my time. I mean, it's some equivalent to what it takes me in time. As best I can figure out in some equivalence to what I would charge here for my time. That's how I came up with the fee that I did.
Q. So the fee is set before or after you do your work?

Page 41

A. The fee is just the question of my fee is $35 a case and multiply by 6 cases. You would owe me 6 times $35. It's irrelevant whether it's positive or negative.
Q. That's what I'm getting at. The fee is the same regardless of the result?
A. Oh, of course. It's just like for this particular proceedings my fee is for my time.
Q. What are you charging today?
A. $500 an hour and a four-hour minimum. A half day basically because that's what the equivalent of. I presume we will probably be fours hours by the time we're finished.
Q. How many depositions have you done this year other than your own?
A. I don't understand what you meant. I thought I understood you --
Q. That's fine.
A. You totally confused me at the end of the question.
Q. Right. Okay. Excluding the one lawsuit that you're involved in --
A. Oh, that wasn't this year. That might have been November or December.

Page 42

Q. Okay.
A. I believe one.
Q. And when was that deposition taken?
A. Sometime in January or February.
Q. Was it taken here?
A. Yeah. I don't have the time to travel. I can't travel. And that was a trial deposition.
Q. Have you ever testified at trial?
A. Yes.
Q. When was the last time you testified at trial?
A. I am guessing probably the late 80s.
Q. Do you recall the plaintiffs firm you testified for?
A. I believe it was Weitz and Luxenberg in New York. And that might have even been as late as 1990. But I suspect it was the late 80s.
And I can't remember -- it was in the south -- Florence, North Carolina. I testified in Florence, North Carolina in a medical malpractice case that had been sent to me.
Q. Have you ever testified in any asbestos-related disease cases at trial?

Page 43

A. That was the [redacted] case that I said to you up in New York in about 1990. That was one case that I can remember. If there was another one, I'm just not -- it's been so long ago.
Q. Do you recall how many depositions you gave last year?
A. I would bet -- you know, they come in clusters. Might do nothing for seven or eight months and then do three or four over three or four months; something like that, that order of magnitude.
The number of depositions has really gone down dramatically so that the right order of magnitude might be four last year.
But, again, if you're holding me to four and it was five, I would take exception to that. Like I said, I'm not sure what I had for dinner last night. I'm thrilled that I remember that the Flyers won on Saturday.
Q. On average is four depositions a year, is that an average for you?
A. No. That's been the average for the last many years. There was a period of time where there were more depositions back in the

Page 44

early 90s. They just were more -- probably 10 or 12 over a period of two or three years and that was it.
Q. Do you also do readings for silicosis?
A. Yes. I mean, I have no idea what the film is going to demonstrate.
When I'm sent the film, my primary responsibility is as a physician and a radiologist to review the film. I read for TB. I read for cancer. I read for whatever is on the film.
If it turns out that I'm looking at a regular small -- at an appropriate location and the usual and customary findings that is diagnostic of asbestos type disease, that's what the diagnosis is.
If it turns out that it's primarily an upper lobe modular density and it's a silica type lesion, that's what it is.
If I'm working with coal workers, and they have coal workers pneumoconiosis, that's what I read.
I mean, I don't gear it to the patient. I gear it to the film. Whatever the film tells me. The language of the film is

Page 45

what I interpret.
MR. MORALES: Objection, non-responsive.
DEFENSE COUNSEL: Objection, non-responsive.
BY MR. MORALES:
Q. You've given deposition testimony in silica cases, then?
A. I don't believe so.
Q. Have you ever given trial testimony in silica cases?
A. I don't believe so.
Q. Do you ever need additional information in addition to the x-ray to make your conclusion?
A. On occasion, sure. And on occasion I will call whoever I think has sent me the films and get right on the horn to communicate to them because I will have either picked up a mass in the chest that could be cancer or an upper lobe infiltrate that I think is tuberculosis or metastatic disease.
You know, my primary responsibility as a physician is take care of the patient.
Q. That didn't happen in these cases, did

Page 46

it?
A. No. These cases had asbestosis.
Q. You didn't need to request additional information for these cases?
A. No, not to my knowledge. Because if I did, I would have indicated it in the report.
Q. Do you recall when the last time was that you needed to request additional information from one of these readings that you received?
A. It could be as late as last week. It happens on a potentially everyday basis. There's no way that I could predict when it's going to occur and when it doesn't occur.
I'm a physician. It gets commingled with the activity that I do here at the hospital.
In fact, forget last week. As it turns out, I just had a conversation with a paralegal at a law firm today because on the basis of the report where previous information had been sent to me, the paralegal was requested to call me to discuss the fact that nodules in the lungs were probably from old TB.
And I was confirming an outside

Page 47

treating physician's diagnosis as opposed to the nodules being metastatic or something else.
This was on a potential occupational dust disease case. That particular law firm is from New York.
Q. Do you recall the name of that firm?
A. Colleran, O'Hara and Mills. And the first name of the paralegal is Chris -- I might even have his name. There's only one Chris there. You could get it.
Q. What sort of information -- if you have to make a request, what sort of information do you want?
A. Old films. That would be great for comparison. Or I would request that they get follow up with the private physician and suggest that the patient have a CT, for example, because of a lesion that I've picked up or find out historically whether or not the patient has had a particular type of surgery.
Could be any of a host of things. The variables in the art and science of medicine lead to the potential for a thousand different types of inquiries.
But the most important thing is to try

Page 48

to recognize precisely what is appropriate for that particular patient. But I'm requesting follow up studies on patients every day in this environment.
Q. Regarding the images that you receive?
A. Yeah. And I am in my regular practice also. I mean, I don't practice differently because these patients aren't physically in front of me. The practice of medicine is the practice of medicine. If you start changing the way you practice, things fall through the cracks and people get hurt.
MR. MORALES: Objection, non-responsive.
DEFENSE COUNSEL: Objection, non-responsive
BY MR. MORALES:
Q. I want to stick mostly with the images we're receiving here whenever I'm asking questions in the future. But since you brought it up, is there any difference between the way you treat a patient that's here in the hospital versus these screens that you receive? I mean procedurally.
A. No, other than that these are

Page 49

interpreted in the context in which I am using the specific scheme of the international labor organization, NIOSH criteria.
Now, if I am looking at the hospital because I have hospital referrals for the same thing, then it's precisely the same.
But, for example, God forbid you came to me because you had a chest cold, I wouldn't be considering you for a NIOSH interpretation.
I certainly look for everything. If you had what I thought was occupational dust disease, then I would.
But, you know, by and large, if you had no occupational exposure, I would be reading you as I would any patient that came through.
In this particular case, there is a certain standard that I read to because it's kind of required in terms of my credentials. I think that's one of the reasons why it's sent to me. Because if I didn't read to the NIOSH standard, then you would be all over me for not doing it.
Q. First of all, what's the standard of care for a radiologist?

Page 50

A. What is the standard of care?
Q. Right.
A. To, one, have excellent films of good quality, which it could be even in one projection and to interpret those bringing all the educational experience to bear that you have; all the knowledge that you have; all your previous experience.
And detecting that which is normal and that which is abnormal in terms of anatomy and potentially that which is normal or abnormal physiologically.
If there is something abnormal or normal, both anatomically or physiologically, on the films and articulating that clearly in a report and making sure that that report gets back to whoever requested it.
Q. When the patient is in the hospital, you know the x-rays are taken here; is that correct?
A. For the most part. Some people come in with their own x-rays. But clearly if they were inpatients, then subsequently we will do x-rays here.
Q. What about these images that you

Page 51

received? Do you have any idea where those are taken?
A. I will only because of the demographic shield up in the corner. I can see who took the films because they usually have an indication who has taken the x-rays.
It's on the little demographic shield where they have the name, social security, some other medical record number. It often has the address and that sort of thing.
But quite frankly, it's not relevant to me whether they were taken in one particular town or another particular town as long as they were taken and are good technique.
Q. Well, is it relevant whether or not they were taken in a hospital or in a trailer?
A. If they are a good technique, I have no concern as long as the equipment resulted in a good frontal projection or frontal and lateral with the right exposures and with the right film screen combination and right grids.
Q. I just want to make it clear, though, you're not there whenever these images are being taken, though, correct?
A. True.

Page 52

Q. So you really don't know whether or not they're using the right technique?
A. No. But the fail safe is that if they are not of good technique, then, one, I indicate it in the report; or, two, they are unreadable and I tell them they are technically unsatisfactory.
Not only am I not there, but I don't even know that they are being taken.
Q. And you also don't know whether or not they were taken by a competent technician?
A. To that extent that the companies that I've told you and listed, all the companies that I've told you about where initially when I have been approached by them about the interpretation of x-rays, I reviewed with them their standards and they sent me credentials and that sort of thing.
But I have not met or interrogated or interviewed them. The real issue for me is the quality of the film that's sent to me.
Q. Do you have files that have the names and who these people are that you receive from imaging services that conduct these?
A. I don't keep any of that. It all gets

Page 53

returned back.
As I say, I don't keep any sort of filing system. I have no way of doing that without contaminating my file room here with the inpatients and outpatients here from the hospital.
Q. Does NIOSH have any requirements that you keep records on file?
A. Not to my knowledge.
Q. Do you know if there are any state or federal regulations that require that?
A. Not to my knowledge. The only rules that I am aware of are seven years -- actually, we keep mammographies lifetime -- that's breast x-rays -- for comparison purposes.
We have many a hospital here in Pennsylvania that do not keep a file room. The Mayo Clinic doesn't have a file room. They send everything back with the patient.
MR. MORALES: Objection, non-responsive.
BY MR. MORALES:
Q. Do you agree with me, Doctor, that the amount of money paid to an expert, depending on how great that amount is, could increase the

Page 54

likelihood of bias?
MS. BOONE: Objection, form.
THE WITNESS: Do I think that there could be a financial incentive for bias?
BY MR. MORALES:
Q. Well, the greater money that someone is paid to get an opinion, the more likelihood there would be for bias? Is that a fair statement?
A. If you were paid the money for your opinion. I'm not paid for my opinion. And I can't speak for anybody else. I'm paid for my time.
My time, frankly, is probably more productively used reading films than spending it here with you. This is an obligation I have because I allegedly read these films.
I've looked at this and that is my signature and that is my report so I have an obligation to do this.
Q. And when you're reading these x-rays, you're not giving a diagnosis, are you?
A. I give a diagnosis when I read the films, sure.
Q. You give a diagnosis just from the

Page 55

x-ray?
A. Of course. That's what a radiologist does. That's the usual and customary thing that I do every day.
If your wife comes in and I do a mammogram, you don't want me to make a diagnosis of cancer? You don't want me to make a diagnosis of Class 1, Class 2, Class 3, Class 4, Class 5 mammogram to see whether or not she needs a biopsy?
Do you have any idea, apart from the negligent omission of not making that type of a report and giving that type of an indication, I could be responsible for killing her if I don't pick that up.
Of course I make a diagnosis. And of course I make a diagnosis with this. That's the whole purpose of what I do is to take and use all my experience, all of my education to make a logical, rational, objective conclusion to come to a diagnosis.
Q. Based on the x-ray alone?
A. That's what radiologists do. If I did it based on something other than the radiology, they'd say what the hell are you doing, you're

Page 56

a radiologist. That's what I do.
When I take the NIOSH exam, they don't give me histories. They don't give me latency periods. They don't give me the patient's occupational background. They don't tell me the ambient situation with respect to asbestos or silica.
They give me x-rays and they say interpret them. And then they grade me on the accuracy, the sensitivity and accuracy of that interpretation. That's what I have to do.
Q. Well, from that alone you can't establish that the lung changes are due to dust disease and not something else?
A. Yes, I can. When you take a look at the NIOSH and you look at my standard NIOSH interpretations and you look at the ability of a NIOSH reader to take and review films and then re-review those films at a separate sitting, mix the films up and have them read them again, the inter-observer error is only 3.9 percent. That's phenomenal.
I'd ask you to repeat this same deposition and ask me those same questions, you won't be 3.9 percent accurate. You won't be

Page 57

even 20 or 25 percent accurate and you've got the paperwork right in front of you and the questions will be different.
The incredible consistency within the observer rereading the same films on two separate occasions of 3.9 percent which has stood the test of time is incredible. It's sensational.
And if you take two B readers who bring different experiences, different levels of education, both certified, they have better than 80 percent cross correlation in terms of the grading on a NIOSH examination, meaning a chest x-ray.
MR. MORALES: Object to the non-responsive portion.
BY MR. MORALES:
Q. But you would agree with me, though, that two B readers can look at the same x-ray and have different conclusions?
A. I just said that. It can happen up to 19 percent of the time.
Q. What are you basing that on? Is that a study that's been conducted?
A. Sure. It's a standard study. It's

Page 58

come out of NIOSH.
Q. Do you know the name of that study?
A. I could give it to you. It'll take me a little time. But before the end I will give the reference to you. I will be glad to.
Q. Okay.
A. That's standard historical data.
Q. Wouldn't it be helpful to have epidemiology or industrial hygiene information before a diagnosis is made that someone has an asbestos-related disease?
A. Certainly the predicate is for me that there have been exposures. But apart from the fact that there's been exposures, if I asked you what the ambient concentration of asbestos or silica dust was in that individual environment and for how long a period of time, and if you had given me the physical examination, and if I understood the pulmonary function test and I read that report, you would sit down there and you would contaminate everything and say well, how can you be objective, you have all this clinical information.
It's the very pristine, objective,

Page 59

rational analysis of the films without that that allows me to have the sensitivity and accuracy because I'm not pre-prejudiced either financially or by clinical data.
I bring to bear that experience which allows me to make a judgment. And that judgment is based on the findings on the film.
Now, if that's not good enough for you, then go back to the defense and look at the Manville review of the 20 active radiologists that were put out some 20 years ago.
Sorry. I don't mean 20 years ago. Probably 5 to 7 years ago.
I had nothing to do with it. I wasn't involved with it. I didn't see it. I didn't find out about it until afterwards.
And when Mansville reported their findings, they looked at active B readers. And on the basis of the review of the active B readers, they wanted to know the sensitivity and accuracy of these B readers, recognizing that some would be perhaps plaintiff oriented and some would be defense oriented.
Somebody had to come out on top. And

Page 60

it happened to turn out that the defense found a plaintiff-oriented B reader was the most sensitive and the most accurate among the 20 most active B readers in the United States.
That's an objective analysis.
The result was Dr. Levine. I didn't make it up. I had nothing to do with it. That was just what they told me.
As a result of that, they then started to use me and I read for Mansville and did their second evaluations recognizing from their point of view they perceived that I was, quote, a plaintiffs', if you will, interpreter because the work that came to me came from plaintiffs' sources, health and welfare groups, law firms, and imaging companies.
DEFENSE COUNSEL: Object, non-responsive.
MR. MORALES: Objection, non-responsive portion
MS. BOONE: Are you at a point where we can take a break?
MR. MORALES: Sure.
(A brief recess was taken.)
BY MR. MORALES:

Page 61

Q. Doctor, do you charge a different fee for trial testimony?
A. No.
Q. Is your fee the same as it would be here today?
A. Sure. It's based on time.
Q. And that's $500 an hour?
A. Right, with a four-hour minimum.
Q. And who is paying the bill today?
A. Who called the deposition? I presume your firm called for the deposition.
Q. Right. Who is paying for your time here today?
A. I presume your firm. I might be under a misunderstanding, but I presume that's the case.
Q. Can you tell me the difference between a 1/0 and a 1/1?
A. Can I tell you the difference? I would have to have a NIOSH film to demonstrate the difference.
But what you're talking about is a concentration of densities that are present within a field within the lung and that a 1/0 is definitely an abnormal concentration of

Page 62

density that's considered by all the NIOSH B readers as consistent with occupational dust disease.

Now, a 1/0 would be a low level of profusion or concentration of abnormal densities. 1/1 being the next level of concentration of densities.

Now, they may be irregular densities. They may be rounded densities. They may be a combination of those types of densities.

But to try to give you a narrative definition, it's a situation where a picture is worth a thousand words, which is precisely why when we read these films we read them in the context of the B reader films, the NIOSH standard films.

Q. In a 1/0, what does the zero stand for?

A. That you consider a 1 to be abnormal and zero was a normal film. But it is definitely abnormal.

Q. So the zero stands for normal; is that correct?

A. I think I just said that.

Q. And would you agree with me, Doctor,

Page 63

that there are virtually hundreds of reasons why an x-ray looks a certain way?

A. Forgive me, but I'm not sure I understand the question.

Q. Well, there might be abnormalities in an x-ray which might be consistent with things other than asbestos-related disease?

A. Of course. There could be problems with the bone structure, with the soft tissue structure. There could be changes within the lung substance itself, which we refer to as the interstitium, that are not particularly related to occupational dust disease.

There could be problems with the blood vessels. There could be problems with the compartment outside the interstitium referred to as the pleural compartment. There could be lots of different problems.

Q. And some common x-ray errors may be due to the obesity of the plaintiff?

A. That could lead to fat in the pleura and what some people who are not familiar with that would call pleural thickening. But it's really pleural fat deposition for example.

Q. And that could also -- there could

Page 64

also be an error in the x-ray caused by the age of the individual?

A. It's not an error. The error is in the interpretation. There are no errors on x-rays. X-rays are x-rays.

The error would be in someone who is inexperienced in interpreting something which is artifactual, if you will, as pathology.

Q. And an error in interpretation could also occur because of the poor quality of the film?

A. That could be a variable that could result in interpretative error.

Q. And an error could also occur because of the incomplete inspiration of the plaintiff or patient?

A. Well, that's a technical factor. That would be -- a poor inspiration would be a technical problem. Just as processing artifact could be a technical problem. Poor filming, screen contact, a grid that's not moving right.

Just one of the many types of variables, none of which were relevant in these two patients. But they are variables that can be present.

Page 65

MR. MORALES: Objection, non-responsive.

BY MR. MORALES:

Q. Before you read these x-rays, you didn't know the weight of either one of these individuals, did you?

A. No. But I can tell whether or not the weight would be a potential problem in terms of the interpretation of the films once I observed the soft tissues on the x-ray, because the medical record is the x-ray. And the x-ray delineates the muscular skeletal frame, including the subcutaneous fat.

Q. What about the age? You didn't know the age of the individuals that you reviewed their x-rays of before you did your read, did you?

A. I'm not sure if I did or didn't.

Q. Well, if you did, where did you get that information from?

A. It may well be on the demographic shield. And right now I just don't remember in this particular case whether these two individuals had their age on the demographic shield.

Page 66

But I might add that the date of birth is -- when I am sent films, one of the things that as a requirement for me is that I get a spreadsheet. And that spreadsheet would have the name, social security number, date of the x-ray, and typically has the date of birth which gives me the age of the patient.

So I would have that, if not on the film, on the spreadsheet.

Q. So what all do you receive in one of these packages then?

A. Typically, it would be a note from whoever sent them to me indicating the number of x-rays. And that tells me who sent them so I know where to return them. And also what I would call a master list which should match the x-rays.

That master list is in alphabetical order and the x-rays are in the same alphabetical order. So I can make sure that nothing falls through the cracks.

And on that master list would be antecedent issues like I just said: name, social security number, the date of birth, date of the x-ray.

Page 67

And if there is any relevant known history that they believe I should know -- for example, the patient had a pneumonectomy, had a lung removal; or if the patient had a known carcinoma. If they knew it, they tell me.

Q. What about smoking history? Is that included on there?

A. It depends on where I receive the x-rays from. In some, but only a small minority of cases do I get the smoking history.

Q. Do you recall if the smoking history was included on these?

A. I believe that I do not get smoking history with the films that came from this group because these films came from Nix. So I believe that I did not have any smoking history.

Q. What do you do with the negative reads?

A. Exact same thing I do with the positive reads. They are interpreted and everything is sent back to the referral source.

Q. Okay.

A. What did you think I did with them?

Q. That's why I asked.

Page 68

A. I mean, I'm a physician. I have a responsibility. Just as my patients here.

The vast majority of the cases I read are negative. I interpret them and the report goes to whoever referred them to me, just as I would in the hospital. They are handled exactly the same way as hospital patients.

Q. That was my next question, and I guess you sort of addressed it there.

But are we talking about the films that you received from the imaging services, the vast majority of those are negative? Is that what you're telling me?

A. The vast majority of all the films that I'm sent are negative.

Q. Can you give me a percentage?

A. Overall, probably in the order of magnitude of a minimum of 80, maybe a little more than 80 percent maybe.

But that takes all comers. I have unfortunately run into devastating situations where I've seen 50, 55, 60 percent of the films positive, catastrophically positive with advanced disease, with cancers, with mesotheliomas in certain populations that are

Page 69

really abused.

But those are exceptions.

MR. MORALES: Objection, non-responsive portion.

BY MR. MORALES:

Q. Have you ever attended any asbestos-related screenings?

A. Have I attended asbestos-related screenings? Do you mean when these films were obtained?

Q. Yes.

A. No. Not to my knowledge.

Q. Not these specifically. But ever in your practice, have you ever attended one of those screenings?

A. To my knowledge, no.

Q. What about for silicosis?

A. Not to my knowledge, no.

Q. Now, Doctor, you're not offering an opinion today about any of the products that either Mr. [redacted] or Mr. [redacted], the plaintiffs in this case, that they worked with or around, are you?

A. I'm offering an opinion as to the presence or absense of occupational dust

Page 70

disease.
And in these two cases there was occupational dust disease. And the interstitial fibrosis was characterized at a certain NIOSH level.
And that's what I'm here to do. That's what I presume you called the deposition for.
Q. Yes. But you're not going to offer an opinion as to certain products they may have used in their work history?
A. True.
Q. And you're also not going to offer any testimony about the conditions of their work environment?
A. Well, this is a discovery deposition. If you ask me about it as a hypothetical, I will be more than happy to offer an opinion.
But I presume you're not going to ask me about it.
Q. Well, you're not an industrial hygienist, are you?
A. No. I'm not an epidemiologist. I'm not an oncologist. And I'm not a pulmonary physician.

Page 71

I'm a board certified radiologist with a very large experience and expertise in occupational dust disease. And I'm very cognizant of the literature in all of these areas.
I do not hold myself out as board certified in any of these areas. But I am very knowledgeable in the mineralogy, the pathology, the oncology, and the epidemiology of these diseases.
But I do not hold myself out as a board certified expert in any of them other than radiology.
MR. MORALES: Object, non-responsive.
BY MR. MORALES:
Q. Are you a certified A reader?
A. Excuse me?
Q. Are you a certified A reader?
A. I think anybody that's a B reader is a certified A reader. An A reader is someone who has attended the course.
Q. There's not a different certification for an A reader?
A. Well, let's see if I can give you the

Page 72

logic on this. If you take the NIOSH course and fail the exam, congratulations, you're an A reader.
Since I took the course and passed the exam, I guess I'm an A reader. But it's irrelevant. It's a certification of having attended the course.
It's like when I got out of the Navy and I received the National Defense ribbon because I was in the Navy during the Vietnam war. I mean, it's as meaningful as that.
Thank God I wasn't in Vietnam, through no fault of my own either way. But it doesn't -- it's very nice that I got the National Defense ribbon when I didn't deserve it for anything. I just happened to be in the Navy at the time of the war because they drafted me.
You go to a course and you get an A certification, it's meaningless. You've just taken a course.
MR. MORALES: Object to the non-responsive portion.
BY MR. MORALES:
Q. Did you meet with your lawyers before this deposition?

Page 73

A. The first time I met the attorney was about 30 minutes before the deposition to show her the x-rays that were sent to me and to review the reports and to show her the room that we were going to have.
Q. And what else did you bring with you today?
A. I have black films too in case the light here was a problem, because I didn't know if you were going to do this as a video deposition. And about -- a mini-reference library of about 4 to 6 thousand references in case I need them.
I carry about 300 to a thousand in my head, but have the extra 2 to 3 thousand here as a reference resource.
Q. Have you ever testified for a defense firm in deposition or in trial?
A. Yes.
Q. And who was that?
A. White and Williams.
Q. That's the firm?
A. Yeah.
Q. Do you remember who the defendant was?
A. No.

Page 74

Q. Do you remember when it was that you testified?
A. Years ago.
Q. Was it by deposition?
A. Yes.
Q. And do you remember what the case was about?
A. No. Sorry.
Q. Was it an asbestos-related case?
A. No.
Q. Was it an occupational disease case?
A. I do not believe so.
MR. MORALES: Sir, I believe that's all the questions I have for you at this time.
I pass the witness.
-- EXAMINATION --
BY MR. ROSSICK:
Q. Doctor, my name is Bill Rossick and I have some questions for you. I apologize that as a function of me going next, I will bounce around a little bit.
One of the things I wanted to do was go ahead and talk specifically about your report. Do you have that available to you here

Page 75

today?
A. I do.
Q. One of the things -- it's a two-page report, correct?
A. True.
Q. Okay. The first page is a narrative and the second page is -- how would you describe that?
A. The second page is a completed NIOSH -- National Institute of Occupational Safety and Health standard form.
Q. And with respect to that second page, the NIOSH form, essentially you are looking at -- and correct me if I'm wrong -- two parts of the lung: one is the interstitium and the other part is the pleura, correct?
A. Wrong. You're looking at the two parts on the Section 2 and Section 3. Section 4 allows you to look at the rest of the -- it doesn't allow. It allows you to articulate any changes in the rest of the lung.
So you're really looking at the whole lung. Actually, the whole chest.
Q. Okay. All right.
So let me talk about Section 3 for a

Page 76

second. That's the part that talks about the pleura, correct?
A. True.
Q. Okay. And the pleura is the thin lining of the outside of the lung itself, correct? Or if you can describe that better, feel free.
A. That's wrong. There's actually two layers of pleura. There's a thin, virtually microscopically thin glistening membrane on the outside of the lung referred to as the visceral pleura that invests the whole lung -- top, bottom, sides, fissures as it goes around.
And that is also opposed by a second layer of pleura which is on the inside of the ribcage.
Now, typically you -- because of the physiology of the lung, the ribcage expands and contracts to allow the inhalation and exhalation of air, the exchange of oxygen and carbon dioxide.
I don't want to go into a long song and dance. But that double membrane has a very, very minimal coefficient of friction because there's a very minimal amount of

Page 77

moisture. So that you can breathe in and out and we all do as we all have for the last hour, hour and a half, and feel hopefully no pain, no distress.
That's in the normal function. So you have both a visceral and a parietal pleura that's covering the lung on the inside of the ribcage.
So there's really two layers of pleura.
And normally because they are so thin and you have the potential space, we don't see it on any x-ray because it's typically so thin.
Q. And that was one of the questions I was going to ask. This pleura is probably -- if you want to describe it so that somebody might be able to relate to it that doesn't understand that might be a layperson, a good description might be able to describe it as like a piece of cellophane that's so thin that you wouldn't be able to actually normally see it under x-ray conditions, correct?
A. I typically refer to it as a good, old-fashioned box of Chiclets with cellophane around it; the cellophane being the pleura.

Page 78

But it's really two layers of cellophane around the box of Chiclets, with the box of Chiclets being the lung.

Q. And with respect to the significance perhaps in the NIOSH reading is that when you do see the pleura indicated on an x-ray that that would be an abnormal finding, correct?

A. True. And in the more than 50 percent of the time you do happen to see in association with interstitial disease associated pleural changes, pleural areas of swelling or thickening.

In these two cases, you just happen not to see it. That occurs in a large significant minority of times when you have interstitial disease.

But the majority of time you do have pleural thickening with -- and it could be localized and referred to as plaque with interstitial disease.

It just wasn't present here and I wasn't going to make it up because it's not present.

Q. Okay. There are studies that exist that associate a greater exposure to asbestos

Page 79

with pleural thickening, correct?

A. Well, not necessarily, because the presence of pleural disease is really a function of the term latency.

Now, I really have to digress for a second so that the ladies and gentlemen of the jury understand what I'm talking about.

Let's go back to Chernobyl for a second. Chernobyl has absolutely nothing to do with these two clients other than to make a point about latency.

Unfortunately, at the time the reactor blew up in Russia, they did have a couple of people who went in and tried to close down the reactor and contain as best they can that awful radiation from the explosion.

The day those people went into that reactor, they were exposed to very high doses of radiation, lethal doses of radiation.

They went in on a Tuesday. On Wednesday, they were fine. On Thursday, they were fine. On Friday, they started to get sick. And by the following Tuesday, they were dead.

The latency is that period, that

Page 80

interval disease-free period from the exposure to their onset of symptoms or signs of disease.

Now, it's very dramatic when you have a catastrophic event like the explosion and the exposure to all that radiation.

The point is that there is a disease-free interval. And over a period of time, with time being the important factor, in the case of radiation it caused the disease which unfortunately ultimately killed the majority of people, if not all of them I think.

Let's go back to asbestos. And it has nothing to do with the Chernobyl except this concept of latency.

With Chernobyl you're talking about a very short latency. Radiation, couple of days, don't feel bad. By the third day, they're sick. And by the seventh day, they are dead.

With the concept of pleural disease when you're dealing with asbestos, the correlate is to the initial exposure and time, not necessarily a correlation to the amount of asbestos that you're exposed to.

So time is the issue. Yes, you have to be exposed. Yes, you have to have a certain

Page 81

finite exposure to asbestos dust particles and fibers.

But time is the critical, not the amount of exposure. There's a loose correlation, of course, to the amount of exposure. But it's time.

That's for that lining outside the lung that we talked about, this cellophane wrapper.

That's to be distinguished from interstitial fibrosis or scarring in the lung itself, the actual substance of the lung where gaseous exchange occurs. The fibrosis within the lung is, in fact, a function of the exposure to asbestos and the asbestos dust burden that occurs within that body.

So you have a relationship related to concentration of dust on the one hand related to interstitial fibrosis. On the other hand, you have a relationship related to duration or time.

The latency or time duration for asbestos could be as long as 57 years and as short as 3 years. It averages about 33 years according to Hilledale in 1980.

Page 82

When you're looking at interstitial fibrosis, the latency is about 15 years. But it's really very variable and is very much dose dependent whereas pleura is not dose dependent.

So if you have two variables that run by their own sets of variables, the fact that sometimes you have interstitial disease without pleural disease -- now that's less often than having pleural disease without interstitial disease -- it's explained by these types of variabilities.

And, of course, idiosyncratically it's explained by one's own individual reaction to these toxic contaminants.

Q. So with regard to your -- I just want to clear one thing up with respect to pleural thickening. I think you said, but then it sounded like you may have said something different. So I just want to clear it up.

With regard to the amount of exposure to asbestos, that that's a somewhat smaller factor than the latency period or no factor at all?

A. No. Smaller factor. It's a smaller factor. The latency period seems to be more

Page 83

directly related whereas concentration of exposure is much more of a larger factor with interstitial fibrosis.

Q. So with regard to Mr. [redacted] NIOSH report that the -- with the information that you were just talking about with respect to the latency period, the fact that Mr. -- you didn't identify any pleural thickening for Mr. [redacted] the indication that we can draw from that is that his exposure period would tend to be a little bit more recent than it would earlier time frame, correct?

A. I cannot make that. All I can say is that with him it's not sufficient at this time for him to have developed pleural disease.

He may never develop pleural disease. Not everybody does with interstitial disease. But I would not be surprised because it is a progressive disease for him to go on to develop disease.

And I see that all the time as I do comparative follow ups on patients.

Q. It would be consistent with the literature to the extent you understand the average duration time for latency from time of

Page 84

exposure to indication of the disease to actually see pleural thickening that Mr. [redacted] would tend to have a more recent exposure than it would be if you saw a pleural thickening, correct?

A. That would be correct. But you can't make a specific conclusion. It's a statistical conclusion based on the literature.

You now have other variables that Mr. [redacted] may or may not be responding idiosyncratically in his pleura the way he is with the interstitial.

Q. Understand. But it would be consistent with the literature?

A. Sure.

Q. With regard to the interstitial findings, there we're talking about the actual tissue of the lung -- and what I mean with tissue, I'm talking about where the gas is exchanged, the actual --

A. Parenchyma.

Q. Parenchyma. I guess you can describe it as a spongy part of the lung inside that lining, correct?

A. We refer to it as the lung parenchyma,

Page 85

P-A-R-E-N-C-H-Y-M-A.

Q. Okay. And when you see a -- I'm talking about Section No. 2, the abnormalities of the parenchyma, when you identify a 1/0, that would be an abnormality based upon your testimony before, correct?

A. I don't understand the question. You confused me.

Q. 1/0 is an abnormal finding in terms of NIOSH, correct?

A. True.

Q. And how many different -- when you say 1/0, there's 1/0 I think on the Section 2B sub-part C profusion, there's 1/0, 1/1, 1/2. How many different possibilities?

A. 12. And it's No. 4 of the 12.

Q. What would be the next highest from 1/0?

A. 1/1.

Q. And Mr. [redacted] was 1/0, correct?

A. True.

Q. What would be the next grade below 1/0?

A. 0/1.

Q. And what is the next grade below that?

Page 86

A. 0/0.
Q. And 0/0 would be a normal finding, correct?
A. True.
Q. So the very minimum beyond 0/0 would be a 0/1, and then we have 1/0 which is Mr. [redacted], correct?
A. Right.
Q. Okay.
A. We by convention consider that mild disease.
Q. Okay. You do mammographies, correct?
A. I had indicated I do about 85 percent of the mammograms here at the hospital.
Q. Is there any verification that the radiology department does at the Elkins Park Hospital to have a second radiologist periodically review a mammogram reading and do some verification of whether those mammograms is correct or they would agree with a particular type of diagnosis that was rendered on a mammogram?
A. We don't do double readings. What happens is we do analyze our case for when those that we send for skinny needle biopsies

Page 87

or core biopsies and look at our yield as to true positive, false positive, true negative, false negative and compare that to national averages for the individual radiologists.
Q. So that's done in order to -- well, let me back up.
Is that done as part of some accreditation process? Does the Joint Commission on Hospital Accreditation require some type of validation of the mammograms being read in terms of the diagnosis matching up in terms of what should be expected?
A. We do that because we live and die on our credibility to the surgeons. If I start sending people in for biopsies and the biopsy came back negative, could you imagine how many referrals I would get?
So basically we do that because we want to establish our credibility so that our true positive and true negative rate are appropriate to national standards.
With respect to the Joint Commission standards or state standards, we do do second reviews in all areas whether it be CT, MRI, ultrasound, nuclear medicine, general

Page 88

radiography including chest radiographs and mammography.
We have a periodic calendar and we review cases that are reviewed not only among the radiologists here. But to make sure that it's truly objective, we will send films out to another institution and they'll send films to us so we can cross read each other's looking for what we call anecdotal experiences of error. It's an educational process.
Q. Right. Other than other litigants in cases that might involve B readings, whether the state might be a party or another defendant might be a party, outside the context of litigation, is there anybody that ever looks at your B readings to do that second type of reading that you're describing with respect to the other type of practice you do at the hospital?
A. I don't want to be redundant but Mansville did. The defense trust did. They reviewed my B readings.
MR. ROSSICK: Objection, non-responsive.
BY MR. ROSSICK:

Page 89

Q. With regard -- let's talk about that for just a second. When did Johns Manville do a verification process or anything of that sort of your NIOSH B readings?
A. Within the last five years.
Q. And was that a random selection of cases? Or was that just Johns Manville cases? Or what did that involve?
A. Don't know. They took a total of 20 of the active B readers and reviewed their work and had independent people review them for sensitivity and accuracy.
That's the way it was written.
Q. Doctor, outside the context of litigation, do you agree with me that there's no chance at all that any doctor was going to take a look at your NIOSH report you did on [redacted] to confirm that it was, you know -- at least to say that we agree with this on a second reading?
A. I would take the opposite point of view. From the perspective of this potentially going to litigation, almost certainly I would assume somebody would be looking at this and rendering an opinion.

Page 90

Q. I am talking about outside the context of litigation, whether it's another defendant in this case might have an expert they might retain to look at it.

I'm talking about whether there might be somebody at this hospital or some other doctor that's not involved in this litigation that --

A. You can't have somebody at the hospital look at it because the films didn't generate at the hospital. There are health care financial administration rules and regulations of privacy.

I can't have somebody who doesn't know these patients look at these films. Not allowed to.

MR. ROSSICK: Objection, non-responsive.

BY MR. ROSSICK:

Q. Outside the context of litigation, there's no process in place that you know of to do any validation of your NIOSH reports, correct?

A. Wrong. My NIOSH reports are validated by the government on the government work. They

Page 91

review them.

Q. When does the government validate your NIOSH reports?

A. I don't know but they are all reviewed. Not only for me, but for other people.

Q. What is the name of the agency that you understand that reviews your --

A. NIOSH. NIOSH does.

Q. It's your understanding that there is a possibility that you understand that NIOSH could get a copy of [redacted] report that you did in this case to have another physician --

A. No, no, no. You misunderstood. I said the work that I do for the government. This wasn't done for the government.

But to me, there's no dichotomy between the cases that might be occupational dust disease that come from a mine or from here. I don't know where this guy worked.

But ones that are done under certain circumstances that go to the government that they review them, certainly.

DEFENSE COUNSEL: Objection,

Page 92

non-responsive.

BY MR. ROSSICK:

Q. Doctor, what's a P reading?

A. A who?

Q. P reading?

A. Panel reading. It's usually done for epidemiological purposes or to establish an examination or set up a group of, let's say, a hundred known 1/0s or 1/1s or 2/2s for teaching purposes.

Q. When was the last time you had a panel reading done on any of the NIOSH readings that you did?

A. That I have had a panel -- I don't know that I have ever had a panel reading done other than by the Mansville trust. That's essentially what they did. They had a panel of NIOSH B readers review the work.

MR. ROSSICK: Objection, non-responsive.

BY MR. ROSSICK:

Q. Doctor, to the extent that you see the Johns Mansville trust process that we described before as a panel reading, there's no other

Page 93

panel reading that you know of that was ever done to review your NIOSH reports, correct?

A. To my understanding, that's true.

Q. When I was asking you questions earlier when we were talking about latency versus extent of asbestos exposure, I think when you were talking about extent of asbestos exposure, that was the findings under Section 2 of your report when you were talking about the amount of profusion, in this case 1/0, correct?

A. I can't tell you because I don't remember the context in which you had said it. I told you I don't remember what I had for dinner last night. And I certainly don't remember seven questions ago the context of what you said.

I stand by my answer whatever it was, but I just don't know that I can relate now to that answer in the context of some new question.

Q. Understand. Well, let me go ahead and lay a predicate and we'll come from there.

With regard to the amount of a profusion, that is in this case a 1/0 that you identified Mr. [redacted] as having, that is --

Page 94

and to the extent we go up on profusion to a 1/1 or down to 1/0, as you go up or down that scale, that's an indication of the amount of asbestos exposure, correct?

A. No. It's an indication of the response of his lung to the exposure and the development of interstitial fibrosis.

Why do I say that? Because that same exposure could produce a 1/0 in you or a 1/1 in her or a 1/2 in the woman in the third row.

There is an idiosyncratic variable with respect to the toxic effect of the salycic (phonetic) acid within the fibrules fibrules. Perhaps the auto-immune response. Perhaps the direct physical nature of the irritability of the fibers within the patient.

And your response won't necessarily be her response or her response.

So I can't in any way equate an interstitial fibrosis profusion level necessarily to a person's antecedent occupational exposure. Otherwise, you would have a direct one-to-one correlation for everyone. Absolutely you don't.

Q. Fair enough. And with respect to Mr.

Page 95

[redacted] you have no idea in terms of what his symptoms are, do you?

A. True.

Q. But it wouldn't surprise you that a patient with a 1/0 profusion and neural pleural thickening may be asymptomatic; that is, not exhibiting any symptoms of asbestos exposure?

A. I wouldn't be surprised either way whether he was symptomatic or asymptomatic.

Q. Fair enough.

A. Which is, again, the reason why I wouldn't want to know his symptomatology when I'm interpreting the x-rays. I want to do it purely on the basis of my criteria in my area of expertise.

MR. ROSSICK: Objection, non-responsive.

BY MR. ROSSICK:

Q. Doctor, you would agree with me that there are hundreds of different causes for interstitial disease?

A. There are probably a couple of hundred maybe. When you say hundreds, I presume -- you're talking an order of magniture of two, maybe two-fifty.

Page 96

I would certainly go along with that as a potential. But many of them are totally irrelevant to this process. The vast majority are.

Q. Doctor, in this particular case, Mr. [redacted], you diagnosed him based upon your NIOSH report with asbestosis, correct?

A. True.

Q. How did you go about ruling out the other hundreds or however many figured to narrow it down to asbestosis in this particular case?

A. First of all, you do it primarily by looking at the specific radiographic features.

Mr. [redacted] demonstrated the irregular type of modular densities in the distribution in the mid and lower lung zones that were the usual and customary features for asbestos.

With respect to by category, for example, if you will, collagen vascular diseases, other than scleroderma which causes a different type of pattern of basal lower lobe disease, you're often dealing with upper lobe disease, for example, with the granulomatous

Page 97

processes, both infectious and non-infectious, with vascular as a category.

And please assume when I say vascular as a category, I'm encompassing 30 diseases and am throwing them right out. And the reason for that is the distribution is different, just as silica has different distribution than asbestos.

So on the basis of certain inflammatory diseases, the granulomatous diseases, both infection and non-infectious, whether it be the histiocytoses or the -- you go through this -- and I know on the basis of my experience and having seen all the other diagnoses and having had them confirmed for me over a period of many years and having seen many of them, that they are not relevant to the diagnosis in this particular patient who has bilateral irregular interstitial nodular densities in his mid and lower lung zones.

Now I would be the first to tell you I didn't do a pathologic biopsy. But I made a radiologic diagnosis to a reasonable degree of medical certainty.

Q. I just want to make sure I understand

Page 98

what you saw that you went through to identify asbestosis.
You said bilateral interstitial irregularities --
A. Irregular nodular densities.
Q. Is that how you would describe what you got -- essentially checked off in this NIOSH report, which I guess is the second page of your report?
A. Yes. If you take a look at 2B, S densities are -- the primary densities are 0 to 1.5 irregular nodular densities is the primary density. And the second S or the secondary densities were also irregular nodular densities in the range of 0 to 1.5 millimeters.
And that's precisely what I saw in the mid and lower lung zones. And they were at a profusion concentration of about 1/0 and that there were no pleural abnormalities.
With respect to the rest of the chest, I did not see any other abnormalities which is why in 4A I said no.
Q. Okay. So the abnormalities that we have with regard to Mr. [redacted], we've got -- again, looking at your second page of your

Page 99

report under small opacities, the 2S box checked, correct?
A. Yes.
Q. And what does that indicate?
A. That the primary abnormalities are 0 to 1.5 millimeter irregular nodular densities, mid and lower lung zones.
Q. And, again, the zones where that part B box or the mid and lower lung zones, correct?
A. True.
Q. And we have the profusion which we talked about, correct, the 1/0?
A. True.
Q. And all the rest of the -- when you examined Mr. [redacted]s x-ray film that everything else was normal that you saw?
A. True.
Q. So in your opinion that someone has bilateral interstitial irregular nodule --
A. S type densities.
Q. Yeah. In the mid and lower lung zones, that the only thing they could potentially have is asbestosis?
A. With the particular radiographic features that he has looking at the x-ray, yes.

Page 100

To a reasonable degree of medical certainty, absolutely.
Q. And that's what I'm trying to -- so is there other information that in your mind limits Mr. [redacted]'s diagnosis to asbestosis beyond the raw data that we have on Page 2 of your NIOSH report?
A. I have no idea what you just said.
Q. Looking at Page 2 of your NIOSH report knowing nothing else about this patient, if you looked at this report, in your opinion that the only diagnosis that could be made is asbestosis? Or is there other information on that x-ray --
A. I'm sorry. I don't mean to cut you off.
That report adequately reflects his radiographic features that are diagnostic of asbestosis.
Q. Okay.
A. The reason why you do a narrative and a NIOSH report is because I don't write diagnosis asbestosis on the NIOSH report because by convention it's not done.
I know there are radiologists that do

Page 101

it. I don't.
That's why I provide the narrative report so that I treat this patient like I would like anyone else that I'm doing a clinical report.
Q. Right. The NIOSH report is very fixed criteria in terms of whether something can be a 1/0 or 1/1? It's purely objective data, correct?
A. True.
Q. Okay. Now, are you saying that there's some subjective -- there's a subjective component in terms of making the asbestosis diagnosis as well as besides purely the objective criteria from the NIOSH reading?
A. No. I am just saying that if there was a place on the NIOSH form -- like, for example, let's say 5, not film readers initials but if it wrote diagnosis, I would have written in asbestosis.
But they don't have it so I don't superimpose that on the form. That's all I'm saying.
That's why I did a narrative report. I treated the patient like any other patient I

Page 102

would have here at the hospital.
DEFENSE COUNSEL: Object to non-responsive.
BY MR. ROSSICK:
Q. Maybe I'm a little confused. Maybe it's because it's starting to get late in the day for me too.
Other than the data that's reflected on Page 2, the NIOSH B reading, is there other information that you gleaned from the x-ray report that was helpful to your diagnosis of asbestosis in Mr. [redacted]s case?
A. The data on Page 2 accurately reflects the findings on his report that are diagnostic of asbestosis.
DEFENSE COUNSEL: Objection, non-responsive.
THE WITNESS: I don't know how else to put it.
BY MR. ROSSICK:
Q. Doctor, if I just handed you, for example, the Page 2 which is Mr. [redacted], and not having read the x-ray, can you make a asbestosis diagnosis just based upon the X's in the boxes on this form? Or is there other

Page 103

information on the x-rays that you have to see to verify that?
A. It is consistent with asbestosis.
MR. ROSSICK: Objection, non-responsive.
BY MR. ROSSICK:
Q. I recognize that the data would be consistent with asbestosis on the NIOSH B reading. Would it be consistent -- just the data, just the boxes that were checked -- would that be consistent with anything other than asbestosis?
A. Not if I filled it out. That would be asbestosis. I would not -- if you're suggesting the generic SS 1/0 in the bottom two boxes, would I accept that as asbestosis from anybody else? No. I would look at the films. The patient deserves that.
Q. Okay.
MR. ROSSICK: Objection, non-responsive.
BY MR. ROSSICK:
Q. In your mind any time you, Dr. Levine, checks SS and the mid and lower lung zones and a 1/0 that that would be asbestosis and nothing

Page 104

else, correct?
A. True. If I thought it was something else, I would indicate it under other comments which is precisely why I gave the diagnosis of asbestosis on the correlating narrative report on the same x-ray.
MR. ROSSICK: Objection, non-responsive.
BY MR. ROSSICK:
Q. Doctor, is there no subjective component to making an asbestos diagnosis in Mr. [redacted]s case for you? Or is it purely objective?
A. I'm not sure how to answer that because I bring to bear all of my experience and education in the interpretation and am very comfortable with the diagnosis.
To me, it's asbestosis to a reasonable degree of medical certainty.
MR. ROSSICK: Objection to non-responsive.
BY MR. ROSSICK:
Q. You do use some of your -- I mean, there's an interpretative component to making an asbestosis diagnosis with a NIOSH B reading?

Page 105

It's not just I see a spot on the x-ray, therefore, you know, I check a box, that's the data and it's asbestosis?
There is your education and experience that you use in order to make that diagnosis, correct?
A. To that extent that this process doesn't yield a biopsy and you want to consider that subjective as opposed to objective, I have no problem indicating to you that this was not generated on the basis of a biopsy. It was generated precisely on the process that I used.
MR. ROSSICK: Objection, non-responsive.
I pass the witness.
Thank you, Doctor.
THE WITNESS: Thank you.
---
EXHIBIT:
(Whereupon, LEVINE 1 and 2 were marked for identification by counsel.)
-- EXAMINATION --
BY MR. BURNS:
Q. Hi, Doctor. My name is Randy Burns. I think we met briefly before the deposition.

Page 106

Need a break or anything?
A. No. Now I am warmed up.
Q. All right. I have a little bit of a cold and it's affecting my hearing a little bit. So --
A. As long as you don't give it to me, all is forgiven.
Q. Great.
Would you just take a look at what I've marked as Exhibits 1 and 2. I think they are identical copies of the reports that you have in front of you, but I want to include them for the record.
A. (Witness complies with request.)
I have no idea who this patient is.
Q. Could I see the --
A. [redacted].
MR. BURNS: Off the record for a second.
(Discussion off the record.)
MR. BURNS: Back on the record.
BY MR. BURNS:
Q. Dr. Levine, let me hand you what I've marked as Exhibit No. 1. I think it's a copy of your expert report for [redacted].

Page 107

I just want to make sure that's a true and correct copy insofar as it reflects or similar to the ones that you have in front of you?
A. The only thing I would take exception on for the record is these were not offered as expert reports. They were just offered as clinical reports on these patients.
Q. No problem. We will just use them for identification purposes so we keep track of what we're talking about.
Next I want to hand you what I've marked as Exhibit 2 which is a copy of your CV that we got off the table here. And I just want you to flip through it and make sure that it contains all the pages, at least as you understand it.
A. (Witness complies with request.)
Did you count and make sure everything is here?
Q. I don't know. I just looked through.
Does it look like it's complete?
A. That's an accurate photocopy as is the report.
Q. Thank you. I just want to run over a few things. Again, I'm going to bounce around a little bit, but I will try to not go in between topics.

Page 108

As I looked through your CV, I didn't notice that you published any articles on asbestos-related disease; is that correct?
A. True. I hold no particular editorial bias because I have not published in any one particular area on asbestos; although, I teach on it constantly here at the hospital.
Q. That was my next question. I didn't see in your CV any entries of courses or presentations that you've made on the topic of asbestos. And it sounds like you might have something to add in that regard?
A. It's done on a weekly basis here so I just never updated it. We have residents and students that come through from Medical College of Pennsylvania and Hahnemann Medical School, both of which are part of this system.
Q. Outside of the presentations that you give to the students and folks rotating through the hospital system here, have you ever given any other presentations on asbestos to any other groups of people?

Page 109

A. Yes, down at the medical school. But only within the context of the Tenet and previously the Allegheny system. I don't have time to travel.
Q. And I'm not from the area here, Dr. Levine. When you say "the medical school," which medical school are you referring to?
A. There were two. It's Hahnemann College of Medicine or Hahnemann University. I'm not sure of the exact title actually because it's undergone a change. And the Medical College of Pennsylvania.
They are both now really run by Drexel University. And I think the formal name now is the Drexel University School of Medicine, Hahnemann University Division and the Medical College of Pennsylvania.
To make it worse, it was originally Women's Medical College.
Q. Okay. The presentations that you've given at the medical school, is that a one-time event or have you done it more than once?
A. No. They were done on numerous occasions over many years.
Q. And what's generally the content of

Page 110

that presentation?
A. Occupational dust diseases. Sometimes it's focused on silica. Sometimes coal workers pneumoconiosis. Sometimes asbestos. Sometimes all of them. Sometimes chest and nose are thrown in.
Q. Okay. I may have asked you too broad of a question. What do you, Dr. Levine, teach?
A. Radiology.
Q. With respect to asbestos at those instances when you give a presentation to the medical school?
A. The recognition of asbestos, specifically asbestos, the recognition of asbestos on chest x-rays.
Q. Anything else outside of that category when you're teaching to the students either at the medical school there or as they rotate through?
A. With respect to asbestos?
Q. Yes.
A. Well, often because it's very interesting, we will show cases that have associated other diseases on the chest x-rays because we never want them to forget the fact

Page 111

that they have a primary responsibility if they are a physician.
So we might show TB or a case of rheumatoid arthritis or a case with heart disease associated that -- and two separate diseases, not necessarily related, not necessarily one caused by the other.
They are academic teaching lectures.
Q. And I am just focused on asbestos right now. And I'm sorry if I asked you a broad question again.
Is it accurate to say that the teaching presentations that you make to the students that rotate through here and the ones you make at the medical school involve radiographic recognition of asbestos-related conditions?
A. Yes. And other allied conditions on those films.
Q. Thank you. I think you said earlier, but I'm not sure, that you're not licensed to practice medicine in Texas?
A. No.
Q. And I heard you say --
A. Nor do I practice medicine in Texas.

Page 112

Q. I wasn't sure I heard you earlier when you were talking about which of your licenses are active, because it looks like you've got three of them.
A. Yes.
Q. Was it just New York and Pennsylvania?
A. No. My licenses that are active are New Jersey and Pennsylvania. My New York license dates back to where my training occurred because I went to medical school in New York and did my residency in New York and have a medical license from New York which is just on inactive status because I don't practice in New York.
Q. Does the State of Pennsylvania require a prescription before somebody is able to go get a chest x-ray someplace?
A. Does the State of Pennsylvania require a prescription? Yes. Here at the hospital, yes.
Q. Do you know if the State of Texas requires somebody to have a prescription before they get a chest x-ray?
A. I don't practice in Texas.
Q. All right. So you wouldn't have any

Page 113

way to tell us whether or not the film you read here was taken pursuant to a prescription in the State of Texas, would you?
A. I don't even know if the films were done in Texas.
Q. Assuming that they were done in Texas, you would have no way to know whether or not they were taken pursuant to a prescription, would you?
A. I'm involved in the process way after x-rays are taken. I'm not involved in the organization of taking the x-ray, the taking of the x-ray. I am involved as a consultant in the interpretation of the x-rays after the fact.
Q. So what that sounds like to me is whatever happens up until the time you receive the film in terms of how the x-ray is produced where it's taken, under what circumstances, et cetera, there's nothing you can offer the jury about that process?
A. No, other than if the film is inadequate I won't read it and I will indicate that the film is technically unsatisfactory as I do on a case-by-case basis.

Page 114

Q. Again, in terms of what happened prior to the x-ray reaching your desk, other than if it's overexposed or bad quality, there's nothing that you know about that process?
A. True.
Q. And that would be true for this particular case of [redacted]?
A. That's true for all the cases that are sent to me for consultation from around the country.
Q. We've talked about --
A. Or for that matter in the State of Pennsylvania if they're not done here at the hospital.
Q. We've talked a lot about your B reader certification and NIOSH. And I want to explore that again for just a couple minutes.
There's a set of guidelines that you have to follow as a NIOSH certified B reader in order to fill out these forms and, indeed, to pass the exam; isn't that right?
A. There's a test you have to follow. Sorry. There's a test you have to pass in which you use the scheme and criteria that's established by NIOSH.

Page 115

Q. NIOSH establishes that scheme by promulgating a set of guidelines that you use to interpret chest films in addition to a set of standard chest films that you use to compare x-rays, right?
A. Absolutely, right.
Q. I take it given how you've, it appears to me, taken pride at how well you do on these exams -- follow the guidelines that the ILO promulgates fairly strictly?
A. I believe so.
Q. And are the guidelines that you follow the 1980 guidelines that you were promulgated?
A. Yes. And my most recent recertification was in accordance with the 1980 guidelines because that's the only test that was offered.
Q. I've got a copy of the 1980 guidelines here and I'm going to mark it as -- not yet because it's kind of thick.
Let me just ask you a couple questions about these. On Page 3 of the guidelines -- and I'm happy to share them with you if you need to take a look at them -- under a section called general instructions for the use of

Page 116

classification, the first sentence says there are no features to be seen in a chest radiograph which are pathognomonic of dust exposure.
And what I want to know is what does pathognomonic mean?
A. Equivalent to would be to me a pretty good correlate. Pathognomonic being equivalent.
Q. And as I understand that sentence, it is saying that whatever you see on a chest x-ray is not pathognomonic, diagnostic of, or equivalent with, as you just said, dust exposure?
A. That's not true. I know it's in there but it's not true, because --
Q. Well, whether it's true --
A. Let me finish. Excuse me and let me finish.
Q. Excuse me. I didn't mean to interrupt.
A. Because the very fact that that was written in 1980 is also the Achilles heel of the document, because even the document -- that's why the standards are being changed.

Page 117

And there are new standards that are coming out.
When someone has calcified pleural plaque that is, for example, pathognomonic of previous occupational exposure to asbestos dust.
Now, that's not to say that every case of calcified pleural plaque is due to asbestos. But in the context of interstitial fibrosis and in the absence of, for example, hyperparathyroidism, renal osteodystrophy and other two or three rare causes of calcified plaque that only produce certain things but in the constellation of features of asbestos with calcified plaque, that is pathognomonic.
And that's one of the things that are being changed in the new guidelines.
Q. Whether they are being changed or not, just in terms of the guidelines that are applicable right now that you just said you used, the first sentence of this just does say there are no features to be seen in chest radiograph which are pathognomonic to dust exposure.
Whether or not you agree with it or

Page 118

not --
A. No. I am being intellectually absolutely correct.
Now, having said that, I agree and use those guidelines, which is precisely why -- did you see the word "asbestosis" written anywhere on the report that you entered in as evidence?
No, because I don't make the diagnosis because by convention that's exactly what the guidelines indicate, which is precisely why I use a narrative clinical report which is in the guidelines of the American Board of Radiology and American College of Radiology, because it's a diagnostic clinical report allowing me to make a diagnosis.
But I don't make that diagnosis here. When you ask me or someone else -- your predecessor asked me what does this report mean, it means asbestosis.
But I don't write it in precisely because of the guidelines.
MR. BURNS: Object to the non-responsive portions of the answer.
BY MR. BURNS:
Q. The little boxes down there on what's

Page 119

going to be Page 2 of Exhibit 1, under 4B, those boxes are boxes as a B reader you have to check if you observe any of those conditions on the chest x-ray? Those are obligatory things that you have to check off. Isn't that right?
A. Sure. Such as bullae, coalescence, fractures, pleural effusions, cardiac disturbances -- whatever --
Q. Right.
A. There's like 20 of them if I remember.
Q. And these guidelines say, on Page 9, that it's obligatory that you check one of those boxes off if you see one of those conditions on the radiograph, right?
A. Yes.
Q. And that's something that you follow and practice in accordance with these guidelines?
A. If I observed it, I would have done it.
Q. Right. And my point here is that because we don't see any lines through, for example, any of the emphysema or the bullae or the cancer or any of the other ones, you didn't see any of those features on this chest x-ray?

Page 120

A. True. And I didn't report it in the narrative report either.
Q. There's another statement in the ILO guidelines I want to ask you about. It appears on Page 20 under the larger section called using the classification in the subsection that's called number of readers.
And it says it is strongly recommended -- this is the second sentence and I'm going to read the whole thing -- it is strongly recommended that at least two and preferably three independent readings are made for each radiographs.
And as it explains earlier, it's because of intra-reader variability.
Did you have anybody else read Mr. [redacted]'s chest x-ray as recommended by the ILO guidelines?
A. As a practical matter, it's not done by anybody.
Q. Irrespective of whether it's a practical matter --
A. Not irrespective. As a practical matter it's not done by anybody.
DEFENSE COUNSEL: Objection,

Page 121

non-responsive.
THE WITNESS: And not done by me.
BY MR. BURNS:
Q. You didn't do it in this case?
A. No, that's true.
Q. And you acknowledge that it says it right here in the ILO guidelines on Page 19?
A. Yes.
Q. Okay. In Mr. [redacted]'s case, do you know how old of a gentleman he was when he had this chest x-ray taken?
A. It's not reflected on my report and it might be reflected on the x-ray. But it was reflected on the spreadsheet that was sent to me with the demographic information but I can't cite it now.
Q. Do you know what he did for a living?
A. No. As I indicated to you, I remain purposefully objective so that I don't know his previous antecedent exposures or clinical histories that could jeopardize my ability to be objective in my report.
Q. So just simply stated, you don't know what he did for a living, correct?
A. True.

Page 122

Q. And you don't know where he would have done it for a living, what location or even what state?
A. True.
Q. You don't know how long he did whatever occupation he did for most of his life? If he did one, you don't know how long he did that?
A. All of which is totally consistent with the most objective analysis of the x-rays. And it's purposeful.
Q. That's fine. And you don't know whether he had one or two careers over the course of his life?
A. True. I'm not reading his careers. I'm reading the x-ray.
Q. You don't know anything about his prior medical history?
A. That's not true. I often do know something because it's on the films. In his particular case, there was nothing on the films that gave me any credence as to what was his previous medical history.
But sometimes I do, depending upon what the film shows.

Page 123

Q. Understood. You didn't review any of Mr. [redacted]s medical records?
A. True.
Q. You didn't speak with any of his physicians?
A. Absolutely true.
Q. Other than what's recorded on this radiograph, you don't know anything additional about his prior medical or even current medical condition?
A. No. I was not a treating physician.
Q. And that was my next question. You're not his treating physician?
A. True. That's the whole purpose of my doing this is to be objective and in the absence of being a treating physician render a report for the presence or absence of occupational dust disease.
Q. Do you claim to have a doctor/patient relationship with Mr. [redacted]?
A. No.
Q. Do you know how Mr. [redacted]s individual chest x-ray got to you either from a union screening, some other screening, or any other means?

Page 124

A. Well, it was either mailed to me through the -- the only way I get it is one of four ways -- either through the regular mail, UPS, Fed-Ex, or Airborne.
Q. And in addition to not knowing anything about his work or medical history, you don't know a lick about his exposure to asbestos or under what conditions he would have been exposed?
A. True.
Q. Now, Mr. [redacted]s -- on the B reading form, Page 2 of Exhibit 1, you've indicated in Box 1B the film quality of 1. What does film quality 1 mean?
A. Good.
Q. All right. What does film quality 2 mean?
A. Acceptable.
Q. Is film quality 2 -- well, let me ask it another way.
Could you have a film quality of 1 and it be a copy?
A. Film quality of 1 today can be a copy, because what happens is in many centers you're being sent a reissued digital film. And

Page 125

there's a real controversy as to whether or not those are considered originals or copies.
So you can. But that's because in 1980 when they set the standards they didn't have digital imaging.
That's also being readdressed. That's why we have new standards. Technology has surpassed the standards that are there.
Q. All right.
A. Now, you could have copies that are bad. Then you don't read them.
Q. Do you know whether or not the film you read in this instance was a copy or an original?
A. I could look right now and tell you.
Q. If you would, I would appreciate that.
A. (Witness complies with request.)
Excellent quality original.
Q. And that little box that happens to appear up on my right hand corner and your left hand corner, what does that indicate on the film?
A. That the film was taken with a date, his name, his sex, and by a company called Health Screen.

Page 126

Q. Are you familiar with the company called Health Screen?
A. I've never met them. But they are a very capable, good imaging company that sends work to me.
Q. Do you have a contractual relationship with them?
A. I don't have a contractual relationship with anybody.
Well, that's not true. Let me change that.
I have a contractual relationship here at the hospital with my hospital administration. I have no contractual relationship with any imaging company. And I have no contractual relationship with any referrer that sends work to me.
Q. Do you have any informal understanding with Health Screen about under what circumstances they send you films?
A. Yes, absolutely.
Q. And what is that?
A. That the films come alphabetical, if they do films by date, that a master list be set up, and that I have the demographic

Page 127

information that I've requested, including what I've told you before and that they separate them, you know, like, Monday, Tuesday, Wednesday, whatever.
How they should send them to me, what address, and that they tell me where to send the results back to.
Q. Do you know if they send films to be read by anybody else other than you for the purposes of B readings?
A. Do you mean do they use other B readers besides me?
Q. Yes, sir.
A. I presume they do. They don't send me that much. They could never survive just on what they send me.
Q. How much do they send you?
A. Over the course of a year Health Screen might send me 500 films.
Q. And that's a small number compared to some of the other ones that you get on a yearly basis?
A. There are a number of companies on a yearly basis I could see a couple thousand films. Maybe perhaps even on the biggest years

Page 128

thousands of films. But right now, it's -- and I say --
Q. Who are the other companies that are sending you the thousands of films?
A. Now, nobody. But I already mentioned that. Not to be redundant, but I gave somebody else the names of those companies.
Q. I understood and when you were going through it it didn't register to me or I wasn't clear on which ones, if any, were the ones that predominantly sent you --
A. Well, now nobody predominantly because there's no --
Q. Okay. Let me --
When you were receiving -- taking out Health Screen's 500 per year, when you were receiving more in years past -- the past two years, for example, or whatever is easiest for you to articulate -- what company comes to your mind as the one that sent you the most amount of chest films in a one-year period?
A. Probably Most.
Q. And do you know how many films Most would have sent you over the course of a year?
A. I have no way of tracking it.

Page 129

Q. We know it's over 500 by probably a multiple since --
A. I would assume. I have no way of knowing.
Q. Okay. I'm just basing it -- 500 is a small amount to you. I would assume that it has to be a multiple of 500.
A. I would assume.
Q. And do you know or can you tell me what behind Most who would have sent you the next?
A. Well, as I mentioned, N and M sent me work. And then this fellow Lloyd Chriss sent me work and Health Screen has sent me work.
Q. Do you know whether or not Most is in the business of screening for litigation purposes people for pneumoconiosis?
A. The vast majority of what they do is industrial work, not for litigation. They go and they offer occupational services to industries all across the country.
Q. Do you have a contractual relationship with them in any way? Or have you had one in the past?
A. No.

Page 130

Q. And would they have ever had permission by you to hold you out as being their radiologist, for example?
A. No, because they use other radiologists too.
Q. All right. If they had done that in the past, would you consider that to be a misrepresentation of your relationship?
A. One, I wouldn't have known it. Two, I would have loved it because normally they would have sent me more work. It doesn't work that way.
Q. All right. When you were receiving chest films from Most, do you operate under the assumption that they are being sent to you for medical legal purposes?
A. I can't because an awful lot of the work now -- in fact, the vast majority of the work is not for medical legal work. I mean, 99 percent of it is not medical legal.
Q. When you said earlier at the end of last year there was a flood of work coming in from Texas and Mississippi --
A. That was my sense.
Q. -- who was sending that to you?

Page 131

A. There were some individual files that came in. Cancer and mesothelioma cases I believe. There were screens that came in.
And I can't -- that's six months ago. I couldn't begin to tell you the names of the law firms or the imaging companies or the health and welfare groups.
Q. There was just so much of it come in that you can't --
A. No. See, it's important to you. It's irrelevant to me. You know, it's like asking me which doctor sends me work here. I know all the doctors that are on the staff. I don't know who sends me what. It's irrelevant.
Q. Back to Mr. [redacted]'s report here for a minute. I apologize for that digression.
You said earlier that you selected the 1/0 profusion rating in there. My question is according to the ILO guidelines what that means is you considered it to be an abnormal film but you seriously considered it to be normal?
A. Yes. It's a mild amount of disease where I considered both normal and abnormal and came down that it was abnormal.
Q. Let me focus my question a little bit.

Page 132

ILO guidelines say that that's a serious consideration, not just a passing consideration; that the zero was a potential profusion rating in this case.
A. I can't tell you exactly what my consideration was at the time. I can only tell you my conclusion because it was read back in over two years ago.
Q. I am just -- and, again, I can flip to it here in the ILO guidelines. I'm only going by what I read. I'm not a radiologist so I'm just going by what I read here in the guidelines.
And on Page 5 under parenchymal abnormalities, when it's describing the different profusion levels, it says, for example, thus category 0/1 is profusion category of zero but category 1 was, quote, seriously, unquote, considered and that nomenclature is used throughout the readings.
And my question to you is under the ILO guidelines, the 0 had to be a serious consideration under your interpretation?
A. If I didn't consider it, I wouldn't have considered it a 1/0. I would have

Page 133

considered it a 1/1.
Q. Needless to say, you followed the ILO guidelines and filled out the form according to the dictates in the guidelines when creating this report?
A. Absolutely not. You don't do that, because the first thing it tells you in there is you must compare to the standard films. And in the standard films this was most close to a 1/0.
That's the overriding feature. And this is worthless and trash. Every definition in here is surpassed by the NIOSH films.
So go on and find that paragraph and put that into the record. This is superseded 100 percent by the NIOSH films. Not partially, but 100 percent by the standard films. The standard films dictate what the level of profusion is.
Now, if you are to try to define what 1/0 is, 1/0 typically is a situation where you came down on the side of it being abnormal but you considered it also seriously as a normal.
However, it's irrelevant. Which standard did the film most closely match? And

Page 134

in this case it matched the 1/0. In the case of Mr. [redacted] it matched a 1/2.
MR. BURNS: Object to the non-responsive portion.
BY MR. BURNS:
Q. These ILO guidelines are drafted and they are accompanied by a standard set of x-rays?
A. True.
Q. And you are to use them in conjunction with one another?
A. The standard films supersede anything else.
Q. But the guidelines instruct you how to fill out the form -- for example, making it obligatory for you to check off boxes in 4B if you see those features, correct?
A. They give you procedure. They don't give you interpretation. They give you procedure.
Q. But procedures that are set forth in these guidelines that you --
A. Procedure.
Q. -- as a B reader must follow when filling out this form?

Page 135

A. Yes.
Q. And part of that procedure says when you are comparing the x-ray with the 1/0 film and the 0/1 film that accompanies the guidelines, that when you select 1/0 you considered it to be more closely related to the 1 film but you seriously considered it to be closely related to the zero film?
A. And 1 supersedes. Not the definition. The film. The standard film.
Q. Okay. Would the answer to that question be correct?
A. The 1/0 film. The real question you have to ask is in the 1/0 film what is the consideration. And the consideration in the 1/0 standard film is that it's abnormal but you did consider that it could be normal.
Q. You've mentioned a couple times that these guidelines are being rewritten. Do you know whether or not that's taken place?
A. No, because as of three months ago when I called and checked, I wasn't -- I couldn't get an answer from them because the issue was going to be at what point they were going to re-examine on the new guidelines

Page 136

because they're changing the whole way they evaluate the pleura.
Q. All right. So just for clarity sake, you don't know sitting here today whether or not they've actually issued revised ILO guidelines?
A. True. But regardless, operating under those guidelines, the standard films, that's the law. That's the gold standard are the films.
Q. And if the ILO guidelines had been revised and are available, that's just something you haven't read or come in contact with yet?
A. Nor am I necessarily supposed to read by them because we haven't gotten direction from NIOSH. Since I haven't passed an exam based on the new guidelines, what do I do as a physician accredited by the old guidelines if new guidelines come out.
Where do I have -- excuse me please.
Where do I have the credibility to read on the basis of the new guidelines if I am only accredited by the old guidelines.
Q. Understood.

Page 137

A. And I'm not due to be re-accredited, as I said to you, until 2006.
Q. So the bottom line is the old guidelines govern everything that you're saying here today?
A. And the old guidelines absolutely indicated that 100 percent the films are the standard.
MR. BURNS: Object to the non-responsive portion.
BY MR. BURNS:
Q. So even if these guidelines had been revised, even if they are sitting out there available for public view and comment, this is the gold standard for today, the 1980 ILO guidelines?
A. They are certainly what I was certified on. And also what's relevant is that was the only thing that was available when these films were read.
And that's really the standard by which we have -- that's what was used at that time and that's when these films were interpreted.
Q. Do you know whether Health Screen,

Page 138

Incorporated followed the prescribed procedures mandated by the Texas Department of Health when it conducted the screening of Mr. [redacted]?

A. I've already answered that with respect to all the imaging companies. I don't get involved.

Q. If Health Screen -- I'm not suggesting that they haven't; but if they hadn't, for example, complied with the Texas Department of Health regulations for setting up their screening, would that influence your judgment of the chest x-ray in your opinion in this case at all?

A. It's impossible for me to answer that. First you asked me whether or not I knew and I said I didn't. And now you ask me if they didn't, would that affect me.

First of all, I read the films. Second of all, I don't have any idea whether they did or didn't.

But I will tell you this: That film is a technically excellent film. And by reputation Health Screen does a superb job and they have a wonderful reputation across the country.

Page 139

Having said all that, I can only tell you that I interpret the x-ray and am involved after the fact.

Q. Do you know whether or not Mr. [redacted] is asymptomatic in terms of respiratory impairment or not?

A. Again, that was asked and answered previously. I don't know because I'm not his treating physician.

Q. And in your diagnosis of asbestosis, does it make any difference to you whether or not he's impaired?

A. My diagnosis is not a clinical diagnosis. It's a radiologic diagnosis. Therefore, it's irrelevant.

Now, that doesn't mean it's not important to this patient. It's critically important from the patient's point of view.

But what's critically important for the radiologist is that they give an objective, logical, rational analysis of the films. And taking that information into account can jeopardize that process.

Once that process results in a diagnosis, then, of course, the treating

Page 140

physicians or anybody else involved should take care of the patient.

That's not what I would do in any case because I'm a radiologist. I don't treat the patient.

Q. You mentioned earlier there's a tort reform crisis here in Pennsylvania. Could you explain that a little bit?

A. Unfortunately, the malpractice carriers for malpractice insurance have been leaving the state because of controls over the amount that they can charge.

And that versus the risks that they feel that they face in the large metropolitan areas such as Pittsburgh and Philadelphia, they have -- as soon as their contracts run out have all left and have left many of the subspecialty areas such as neurosurgery, radiology, orthopedics, and obstetrics and gynecology without any source of malpractice coverage.

And, therefore, the joint underwriters which is basically a state agency is the only available insurance source for this state.

We have a similar crisis now occurring in New Jersey and also in New York. I think

Page 141

it's not dissimilar to the crisis you have in Texas.

Q. Do you attribute that to in any part large jury verdicts in medical malpractice cases?

A. That is a question that is debated now for about a year in the legislature in which the insurance companies are taking the position that it's jury verdicts.

The plaintiff and defense attorneys each have their own set of criteria as to what the cause is.

I wouldn't venture a guess as to what the cause is. I'm not sure what the cause is. I don't know. It's a very complicated issue that they haven't been able to settle.

Q. Why does your report on Page 1 of Exhibit 1 say practice limited to radiology at the top?

A. Because that's what I am. I'm a radiologist. That's my specialty. I'm board certified in radiology and occupational dust diseases as a radiologist.

Q. Just so we are crystal clear, I think you testified earlier that all you basically

Page 142

need is to look at these chest films and you can diagnose asbestosis?
A. If I tried to diagnose it on anything else, I couldn't practice radiology. That would be malpractice on the part of what I do in my discipline.
My discipline and responsibility is to make the diagnosis or not make the diagnosis based on the x-rays. Or any other modality that I'm dealing with.
For example, if I'm dealing in a certain oncologic issue with positron emission tomography or ultrasound or magnetic resonance imaging. In this particular case, radiology is the modality.
Q. If you observe a carcinoma on a chest x-ray with nothing else other than the chest x-ray itself, can you diagnose what the cause of that carcinoma was?
A. When I observe a carcinoma on the chest x-ray --
Q. Correct.
A. I can't tell you whether the patient was exposed to radium. I can't tell you if the patient -- and has no other changes at all.

Page 143

I can't tell you if the patient was a smoker or not a smoker. I can't tell you if -- and also it would depend on whether or not it was a large cell/small cell carcinoma.
There are many other variables that I would need to go into before I would attempt to do an attribution as to causation.
Q. Is that principally because what the chest x-ray is showing you in terms of carcinoma is merely the picture of something that appears to be a mass that's not a normal feature of the chest?
A. If that's all there is. But if I saw pleural thickening or plaque or calcified plaque or basular interstitial fibrosis like this in a carcinoma, I would call it an asbestos-related cancinoma. And I see those all the time.
Q. Okay. Would you do that without knowing a lick about the plaintiff's smoking history?
A. Yes. Because I would call it a asbestos-related cancinoma. If, in fact, there was an additional substantial contributing factor and that the patient smoked, then there

Page 144

is a multiplicative risk associated with the fact that the asbestos is a carcinogen that we all recognize as a carcinogen, proven to be a carcinogen by the Environmental Protection Agency; and that the asbestos is -- risk factor for cancer is multiplied by the risk associated with the cigarette smoking which is also carcinogen.
Q. Are you aware of any medical or scientific articles available in the published literature that suggests that smoking can cause changes on an x-ray that mimic a 1/0 or a 1/1 profusion rating?
A. Weiss's offered article and they've been totally discredited by Kilburn among many other authors.
Q. And I just --
A. They are not relevant in these particular cases either in the -- let me finish -- [redacted] or [redacted] since there are no other secondary changes of cigarette smoking.
Specifically, there's no evidence of emphysema, bullae, or any other lung -- or any hyper-eration (phonetic).
Q. I think my question is a little bit

Page 145

more narrow than that, Doctor. I am just wondering if you're aware that -- whether there's a debate or not is not the question.
A. There's no debate in my mind.
Q. All right. There are medical and scientific articles available to the public in the scientific literature that say -- whether you agree with them or not -- that smoking can cause changes that look like or mimic a 1/0 and a 1/1 profusion rate.
A. There has been publications. As I say, those publications are totally discredited, especially in this particular case where there's no secondary changes associated with smoking at all.
MR. BURNS: Object to the non-responsive portion.
BY MR. BURNS:
Q. How much exposure to asbestos do you think somebody needs to have before they are at risk to develop an asbestos-related disease?
Let me withdraw that question.
How much exposure to asbestos does a person need to have before you can diagnose them as having asbestosis?

Page 146

A. I can't answer that. What I can do is tell you the obverse -- with a patient like Mr. [redacted] you're dealing with interstitial fibrosis so he has a minimum of 3 million asbestosis fibers per gram of lung tissue. Upwards of 10 million fibers per gram of lung tissue.

And that's true of Mr. Roy [redacted] So you're talking about an average lung of 150 to 200 grams times 3 to 10 million. So you're talking about anywheres from 200 to maybe 400 million fibers in his lung

That's his asbestos dust burden. And this is all classic information out of the literature from Whitwell in the Journal of Thorax of 1977 substantiated multiple follow up articles.

That is literary documentation of the underlying asbestos dust burden associated with interstitial fibrosis.

Can I tell how much exposure he's had to get that interstitial fibrosis in the ambient atmosphere? No, because of obvious variables.

How concentrated was the exposure?

Page 147

Over how long a period of time? What was his idiosyncratic reaction to that exposure?

All the variables we talked about before are still relevant.

DEFENSE COUNSEL: Objection to the non-responsive portion of the answer.

BY MR. BURNS:

Q. Over what period of time does somebody need to be exposed to asbestos for you to attribute interstitial fibrotic changes on a chest x-ray to asbestos exposure?

A. That's been asked and answered already twice. I indicated to you that the latency period for interstitial fibrosis averages about 15 years, 20 years. But as little as three years, depending upon the exposure in the ambient atmosphere and the idiosyncratic reaction of that person to that exposure.

Q. I didn't mean to ask you a confusing question.

A. I wasn't confused.

Q. I wasn't asking you about latency. I was asking --

A. No, no. I'm not talking about latency. You asked me how long does somebody

Page 148

have to be exposed.

Q. Your answer contained the word latency. And so --

A. For somebody --

Q. Let me just re-ask --

A. No, no. Let me finish.

When you're talking about interstitial fibrosis, for me to see that interstitial fibrosis, for me as a radiologist -- not for someone to make a clinical diagnosis. For me to see that interstitial fibrosis, for me to diagnose it as I did in this patient because he has interstitial fibrosis, radiologic interstitial fibrosis may take 15 years, 20 years.

Q. If somebody claimed exposure to asbestos for a year in an occupation that didn't involve hands-on work with asbestos-containing products, would that be sufficient for you to diagnose that person with an asbestos-related condition if they had interstitial fibrosis on a chest x-ray?

A. The typical lower level of exposure that is associated with interstitial fibrosis but undocumented in the literature is about

Page 149

three years. Again, depending upon concentration and idiosyncratic reaction.

Q. And what do you consider to be the minimum latency period for somebody between exposure and onset of disease for asbestosis?

A. It's not my consideration. It's the literary would be three years.

Q. So you can be exposed for three years, have three years of latency. And that would be sufficient in your mind to diagnose asbestosis if you saw interstitial fibrosis --

A. No, what I'm saying is that someone exposed for three years developing interstitial fibrosis would be consistent with that exposure.

That's different from what you said.

Q. What was your annual income last year?

A. God, I have no idea. I have no idea.

Q. Did you file an extension on your tax return or just not pay attention to it when you filed it on April 15?

A. No. But I file so many different taxes because of the state. But I have no idea.

Q. Ballpark?

Page 150

A. I'm also not sure that it's any of your business. But I have no idea.
Q. You don't have a ballpark figure?
A. I don't want to be inaccurate because there's really -- gross? Collections? My expenses to run the corporation? Just from malpractice for the group and everybody? I wouldn't even want to venture a guess.
Q. Do you think it's more or less than half a million dollars?
A. I have no idea. I wouldn't even want to venture a guess.
Q. And so if I was to ask you questions about what percentage of your annual income you attribute to medical legal film reading, would you be able to answer that question?
A. That's been asked and answered. I have no idea. I just don't keep those type of records.
Q. Are you familiar with the resolution recently passed by the American Bar Association regarding the filing of non-malignant asbestos cases?
A. I have no idea what you're talking about.

Page 151

Q. Have you had the opportunity to review the medical criteria contained in the resolution recently put out by the American Bar Association about what it considers to be the minimums for diagnosing asbestosis?
MS. BOONE: Objection, form.
THE WITNESS: Forgive me, but I'm a radiologist, not a lawyer. That's for you to read.
BY MR. BURNS:
Q. Are you familiar with any rulings that Judge Winger right here in Philadelphia has made within the past year about the status of unimpaired, non-malignant asbestos cases in the multi-district litigation?
A. I am a radiologist. I don't get involved with that.
I know this is very important to you and I don't mean to belittle what you do. But I got to tell you something: It is absolutely irrelevant. The only thing that matters is my accurate interpretation of these x-rays.
Q. I want to hand you what I'm going to mark as Exhibit No. 4.
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Page 152

EXHIBIT:
(Whereupon, LEVINE 4 was marked for identification by counsel.)
BY MR. BURNS:
Q. Let me represent to you that this is a letter that Most Health Services sends to lawyers to have lawyers avail themselves of Most Services.
And I am wondering if you've ever seen that document or if you've ever seen a document like this before?
A. Do you want me to look at it while --
Q. No. The pending question is have you ever seen a document like this from Most or this particular document.
A. No. I think it's a great business model. No, I haven't. You will also note that it's seven years old.
Q. Correct. In 1996, Most Health Services was representing that they've tested over 175,000 union members for asbestos-related disease. Do you have any reason to disagree with that?
A. I have no idea. I think you should also recognize that on the list of the law

Page 153

firms, many of these I have nothing to do with and never even heard of.
Q. I will ask you about that in a second. In the fourth paragraph of this document, it says, quote, our radiologist Richard Levine M.D. is a NIOSH B reader at the Medical College of Pennsylvania.
Did you have any knowledge in 1996 that Most Health Services was calling you their radiologist?
A. Nope.
Q. Out of the 175,000 union members they tested for asbestos-related disease up to that point, do you have any estimate in 1996 how many of those you might have reviewed?
A. No idea.
Q. Would it be in the thousands?
A. I have no idea. You're taking me back seven years.
Q. And it describes a process in here where they bring mobile x-ray equipment to the union hall so that people can be screened for asbestos-related diseases at the union hall.
As a physician, do you have any reservations about mobile x-ray equipment being

Page 154

trucked around for purposes of screening of this nature?
A. Most does absolutely superb x-rays. As good as in the hospital. Their equipment is fabulous. I have no problem about doing a screening.
We do it from the medical school. We go out and we screen locally in Philadelphia to bring that type of health service into our community from MCP and Hahnemann.
We do it with mammography. I do mammography on -- you know, they talk about scan in a van. We do that as part of our commitment to the community.
That's not the issue. The thing that concerns me is that somebody represented my name without my knowing about it back in '96. That's number one.
Number two, as I told you and certainly made it perfectly clear, I did read for Most. But to indicate from that that my relationship was anything other than an independent contractor for whom they sent work for me.
Now, what that does do is absolutely

Page 155

confirm what I said: that I did do work for them, number one. I am an independent contractor for them and have been. And at the time in '96 was charging them $11 a case, $10 and a dollar for the transcription.
But I wasn't the only B reader that they had. Why they selected me probably is because of my excellent reputation.
MR. BURNS: Object to non-responsive portion.
BY MR. BURNS:
Q. What efforts do you use in going out to the community to assemble people to come into mobile screening equipment to look for any diseases?
A. Oh, I don't personally get involved with that. We have a whole group of people that do that. I just do the, again, the interpretations. We have a public relations crew that do that. I presume very similar to what he does.
Q. But --
A. With advertisements and the whole thing.
Q. As a physician, does it give you -- do

Page 156

you have any reservation about people soliciting asymptomatic folks to have chest x-rays for the purpose of looking to determine whether or not they have asbestos-related disease independent of whether or not it causes them any impairment or symptoms whatsoever?
A. Are you kidding? Do you have any idea how many cancers I've picked up that people have gone on to be treated?
Now, unfortunately, I picked up mesotheliomas. They are totally lethal diseases. The fact that I pick up an early mesothelioma doesn't particularly do the patient any good.
But picking up an early asbestos-related carcinoma gives them a chance for life. And if I can save one life, you're damned right I'm happy they are out there doing it.
And if I can pick up people with interstitial disease and get them under medical care, you're damned right.
One-third of the morbidity associated with asbestosis is due to intercurrent infection. If you can get these people under

Page 157

medical care, certainly. I think that's a fabulous thing to do.
Again, your premise is the legal aspects of that. That's irrelevant to me. I am only interested in finding the disease and detecting it and getting the patients under care.
MR. BURNS: Object to everything other than you're damned right I'm happy as non-responsive.
BY MR. BURNS:
Q. After they leave the legal or other societal effects one might have as a result of going through a screening like this is of no concern to you after you read the chest x-ray?
A. I don't follow what you just said at all.
Q. Whether or not somebody going through an x-ray truck like this maybe affects their legal rights or their ability to seek compensation in the future, as a physician a process that would affect something like that doesn't make any difference to you so long as you are reading your chest x-rays and that's all you're concerned with?

Page 158

A. How can I take and weigh in any humane way bringing any humanity to this, taking some theoretical risk to their legal rights that you're concerned about when I'm only concerned about the health of the patient?

Frankly, I think that's a totally obnoxious point of view that you have.

Q. Okay. I take it --

A. This is not the place to debate that. But as a physician, to that extent that I could get patients to come and have screening mammograms and save lives, that's what I do.

To that extent that I could even save one life, you want to put a price on it? Do it. I can't. That's not what I get myself intellectually involved with.

I just want to help the people. The fact that I get paid for that process, that's what I do.

Q. So your view is that these -- for lack of a better descriptive term -- prophylactic screenings done for the purposes of generating litigation for the most part, you don't have any problem as a physician with this type of process because, in your words, it helps detect

Page 159

other diseases?

Is that what I hear you saying to me?

MS. BOONE: Objection, form.

THE WITNESS: Let me give you the long answer because the short answer isn't going to work.

The National Institute of Occupational Safety and Health has a tremendous investment in time and effort to train people to do this type of interpretation for the NIOSH.

The Environmental Protection Agency has made it perfectly clear as has the United States government about the fact that you're dealing with toxic agents that are carcinogens.

You have an antecedent precedent history of abuses where people have been exposed, whether they have been knowledgeable or not, to these types of agents.

And I have the opportunity of detecting that and getting them in care? Of course that's what I want to do. It's a pity that the hospitals in the whole health care profession isn't involved.

Page 160

Now, the very fact that there are lawyers involved, I have nothing to do with that.

And you know what? If it didn't happen, you wouldn't be here and you wouldn't have a job. But that's irrelevant. That's not why you're here. You're not here because you want to see this done.

You're here because you're doing what you have to do that you perceive as a job. As a health care professional, I have the opportunity to take care of patients and get more patients into care.

And the vast, vast majority of these patients also get the knowledge that they are negative.

MR. BURNS: Object to the non-responsive portions.

BY MR. BURNS:

Q. Do you ever do work or consult with a law firm called Shapiro and Shapiro?

A. Yes.

Q. I want to hand you what I'm going to mark as Exhibit No. 5.

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Page 161

EXHIBIT:

(Whereupon, LEVINE 5 was marked for identification by counsel.)

BY MR. BURNS:

Q. It's an advertisement entitled, "A Picture of your Lungs Could Be Worth Millions," and it's a solicitation for an asbestos screening.

As a health professional, do you have any reservations about a law firm putting out an advertisement like that to encourage people to come get chest x-rays in a mobile x-ray screening perhaps?

MS. BOONE: Objection, form.

THE WITNESS: Who did you say this was from?

BY MR. BURNS:

Q. Shapiro and Shapiro.

A. Where does it say that in here?

Q. In the fine print.

A. Where? Your eyes are better than mine.

Q. I will mark it for you if you would like.

A. I have read referrals from Shapiro and

Page 162

Shapiro. And, again, after the fact I have absolutely nothing to do with that.
From my own point of view, my sensitivities are bothered that they would use that type of language to generate the business.
Having said that, again, I feel it's incredibly important to screen these people. But I'm not sure I would use this type of a process to generate, meaning that type of marketing tool.
Q. So I take it from what you said you do have some type of reservation about people using this type of advertising to bring in asbestos cases for purposes of litigation?
A. Or any type of imaging modality, whether it be for this or any other type of litigation.
But I have absolutely no reservations to do the studies on behalf of the patient. The issue is I'm not an advocate for plaintiff or defense. I am an advocate for the patient. That which gives the patient the best opportunity for the best health is the thing that's most important.
MR. BURNS: Object to the

Page 163

non-responsive portion.
I've just got a couple more questions, Doctor, and I will be done.
BY MR. BURNS:
Q. Let me run through some law firm names to see if you've worked for these folks.
Have you ever done any work for Foster & Sear in Texas?
A. Yes.
Q. Silber-Perlman in Texas?
A. Yes.
Q. Barron & Budd in Texas?
A. Yes.
Q. Hissey, Kientz & Herron in Texas?
A. Yes.
Q. Williams-Bailey in Texas?
A. Never heard of them.
Q. Provost-Umphrey in Texas?
A. Humphrey?
Q. U-M-P-H-R-E-Y.
A. If I did I'm not -- maybe. But I think Humphrey -- the name Humphrey. But I don't think Provost-Umphrey rings a bell.
Q. Parker Parks?
A. Never heard of them.

Page 164

Q. John O'Quinn?
A. Never heard of him.
Q. We've obviously got Nix, Patterson & Roach here. We know you've done that.
Let's go outside of Texas a little bit. What about the Jaques Admiralty firm?
A. Remember when I talked about a maritime firm years ago? That's who I was referring to.
Q. What about Goldberg, Jennings, Persky & White, West Virginia?
A. Yes.
Q. I think --
A. In the remote past. I haven't seen anything with them for years. Same with Jaques. I haven't seen anything from them in 10, 12 years.
Q. What about Robles & Gonzales in Miami?
A. I haven't seen anything from them in years. But years ago, yes.
Q. Ferraro, a lawyer named Ferraro? Do you ever remember doing work for a lawyer named Ferraro?
A. Ferraro and Ferraro. But I don't know if that's the same people.

Page 165

Q. That's the reason I used the name Ferraro as opposed to the firm name. Have you ever worked with a lawyer with the last name of Ferraro?
A. I wouldn't necessarily know the lawyer. I would deal with the paralegal or, again, an imaging company. But whether it's Ferraro -- it's certainly possible.
Q. And one last question so I get the time frame right. You started doing readings in the medical legal context at or around about the time you got your B reader certification in 1986?
A. Well, it must have been sometime afterwards. So I would say mid to late 80s. But I don't know when.
Q. And you haven't -- you've been doing that, obviously, with different intervals of business, but continually from that period of time until the present day?
A. Well, I've maintained my B reader certification throughout.
Q. I'm speaking more specifically just about the medical legal work.
A. Yeah. And which the implication is

Page 166

that if I didn't have the B reader certification I would not be able to do this because I wouldn't be certified and I wouldn't be considered an expert.
Q. And to ask you directly: You've been doing that roughly for the past 16 years continuously thereabouts?
A. That's probably not inappropriate.
MR. BURNS: Thank you very much, sir.
THE WITNESS: And also for the government. And when I say for the government, also for the Federal Bureau of Investigation.
MR. BURNS: Object to the non-responsive portion.
Thanks, Doctor. I appreciate it.
-- EXAMINATION --
BY MR. BEVEL:
Q. Dr. Levine, my name is Greg Bevel. I represent one of the defendants in the case. I am going to ask you a few more questions.
You understand from the nature of the deposition at this point I'm going to bounce from topic to topic. I'll try to let you know where I'm headed.

Page 167

A. I think I got the gist of it.
Q. When you're doing x-rays for a screening service, did I hear you correctly earlier in the deposition say that you assume there's an occupational dust exposure history in that person's background?
A. Because when the imaging company first calls me I make sure that anybody that I'm dealing with has at least 15 years exposure before I let them know that I'm not going to look at any films that don't have at least the 15 years exposure.
Q. So in the two cases that we're here to discuss today, would it be fair to say, then, you've assumed through your relationship with the imaging company that these individuals had a 15 year -- a history of occupational dust exposure of at least 15 years?
A. If, in fact, they were sent to me by an imaging company. They were taken by an imaging company, but I don't know whether or not -- see, you used the term "screen."
If a screen is sent to me by an imaging company -- I don't know -- as a function of some advertisement like that they

Page 168

went to a site, went to a factory and did three or four days, then the antecedent that I would expect is that the people that are screening have at least 15 years exposure.
But if films are sent to me individually from wherever they're sent, I don't necessarily have control over who is sending them to me and under what circumstances.
So I can't tell you that that's true in all circumstances. I mean, most of the law firms understand that. But I can't tell you that that's absolutely the case in these two because I don't know how they were sent to me.
Q. The question is in your mind you would have expected from the relationship you have with the lawyers and with the screening companies you would have expected that they understood that you would be assuming there's a 15-year exposure history of occupational dust exposure history to the individuals whose x-rays you're reading?
A. That would not be an unreasonable assumption. Given that, as I said, the latency for pleural disease may be as little as three

Page 169

years and for interstitial disease as little as three years.
Q. Do you keep statistics on different occupations? For instance, if you've --
A. No.
Q. -- read school teachers?
A. The answer is no. And the reason why is I often don't know. Sometimes I do.
Like, for example, when I was asked by the Philadelphia firefighters to screen all the firefighters, I knew the profession.
If I was asked by the Philadelphia school teachers, I knew. It turned out it wasn't only the school teachers. It was all the maintenance employees and anybody else that was involved in the schools.
But very often I do not know the occupations.
Q. My question, though, was do you ever keep statistics of your B readings to determine that X percentage of the fire workers, for example, or the firefighters, for example, had positive radiographic findings?
A. No.
Q. Have you ever participated in a study

Page 170

or an epidemiological study of that nature where they are setting out to determine what percentage of certain trades have positive radiological findings for us?
A. That material may well have been used by the firefighters and the school district, but not by me. By the epidemiologists at the City of Philadelphia, but not by me.
Q. What would you say is the total number of individual x-rays that you've read as a NIOSH B reader?
A. Probably over the last close to 20 years, here at the hospital? Could be in the hundreds of thousands. X-rays. But that doesn't necessarily mean patients, because I often look at two, three and -- two and four views.
Q. You mention that your corporation has a contractual relationship to operate the radiological diagnostic unit here at this hospital?
A. True.
Q. Does that contract demand that you give them 100 percent of your professional time?

Page 171

A. No.
Q. Does it specifically address at all the fact that you also do this consulting work on your B reading?
A. I do it at the private office.
Q. You don't do the B reading here at the hospital itself?
A. True. That's why I'm not doing this deposition during the day. During the day I'm 100 percent of my time here.
Q. That was my question. Does your contract with the hospital require that you give them 100 percent of your professional services in exchange for whatever compensation they give your corporation?
A. No. But I still don't do them here. You have no idea how hassled I am here running the department. It just would be impossible to get anything done.
Q. If I took your work week and asked you to break it down in percentages between being the chairman of the diagnostic radiology here at the hospital and then the consulting work, how would that break out percentage-wise?
A. Probably 80/20, 80 percent at the

Page 172

hospital.
Q. You've never lost your hospital privileges anywhere, have you?
A. Lost my hospital privileges? I've never had a disciplinary action. I've never had any sort of --
Q. Have you ever been rejected or not --
A. Yes. I have been rejected, but mostly by women.
Q. Have you ever been rejected --
A. Actually, I get rejected by my kids a lot too.
Q. Have you ever been rejected or not approved as a provider by any insurance company?
A. Never.
DEFENSE COUNSEL: I will just go ahead and response to the non-responsive portion.
THE WITNESS: I'm sure you've been rejected in your day too.
BY MR. BEVEL:
Q. What would the charges be of your corporation to the hospital for standard review of x-rays -- chest x-rays or a series of chest

Page 173

x-rays?
A. Nothing. I don't charge them anything.
Q. It's just all encompassed within the contract?
A. Sure.
Q. The hospital --
A. Wait, wait. Let me stop you.
I have a contract to provide the service of being the chairman. And for that I do administration, teaching, and supervision. They in turn supply me with access to all the patients, all the equipment, all the employees.
My role is to provide 24/7, 365 service. They don't care that I take ten weeks of vacation a year as long as I provide the service.
Now, I'm saying that from the point of view of being facetious. In other words, I just have to provide the service of having coverage. I have associates that are here.
Q. Here is my -- the gist of my question.
A patient checks into the hospital and has a four view set of x-rays taken of their chest. One of you or one of your associates

Page 174

reads those x-rays here at the hospital. A bill is generated and that patient's insurance company pays for that service.
A. Maybe. Sometimes they -- rarely they will pay cash.
Q. Most of the time a bill is generated and the patient pays --
A. Maybe. That's not true. Come through and they have a HMO and a capitated plan, there's no bill generated. It's part of the capitation.
I have 16 different plans that I'm capitated with where I get a fee for service per day on the number of patients that are within the panel for each one of the physicians.
And those are write offs. We don't charge them. That's part of the contract. I mean, this is a very complicated system.
Now, if you're talking about Personal Choice like Blue Cross Blue Shield or you're talking about other -- Keystone -- other insurance, private insurance groups, then a bill is generated for the professional component and we get compensated for the

Page 175

professional component. And the technical component is billed to the hospital.
Q. Okay. In the instances in which you generate a bill for the professional component of reading chest x-rays, what is the standard or what is the range of fees that you would bill for reading a four-view series of chest x-rays?
A. You would have to talk to my billing company. I have no idea. My fee book is like 280 pages long. It's all the 7000 codes in radiology.
Q. In reading a four-view set of x-rays here at the hospital for a patient for any purpose, would it take you three to five minutes to read that series of x-rays?
A. I presume. Again, it's a question of reading it and then, of course, dictating it; when the report comes through, signing it and getting it out. And any one particular case, if it's positive, I can lose 20 minutes because if it's positive, I got to call the doctor and send the report.
Q. When you do a NIOSH B reading, do you actually put up the NIOSH standard films and

Page 176

put up the patient's film?
A. They are up. I don't put them up. They are up.
Q. And maybe they have changed it. Last time I talked --
A. You can't have all of them up at one time. But there are certain diagnoses that are so unusual I don't have to have them up.
Q. Last time I talked to a B reader, my understanding was for asbestosis there was a 0, a 1 and a 2. Has that changed now?
A. There's 0s, 1s, 2s. But there's also field films where they have 1 -- quarterly films where they show quarters that show mixtures of different types of -- I am trying to remember what they call that. Border films.
Now, what they want to do in the new group is have border films, full 11 by 14 border films for everything.
Q. So there are border films --
A. For most. Not all.
Q. For 1/0 and 0/1?
A. Yes. And those are available because those are part of the teaching set that are used with the NIOSH course for taking the test.

Page 177

That's not part of the original 12 standards. Some are but not all.
Q. Do you use the border films for direct comparison in your practice?
A. No. I use them for teaching purposes.
Q. So you use the 12 standards films?
A. Yeah. And other things they have. They also have other additional films besides the standard.
What happens is besides the standard films, there are films for pleural disease and also masses. And as it turns out, the pleural disease and masses do have interstitial disease.
And if you look at the back of the book, the back of the book on those films also gives you the characterization of what the ILO classification is.
So it's a cheater's way to actually get 15 or 16 films to give you examples of the others. But the primary films are the films that are the standard P, Q, R, S, T, and U major categories.
Q. Okay. And when you say major categories --

Page 178

A. 1/1, 2/2, 3/3.
Q. Okay. So there's -- of the 12 standard films of the NIOSH series, there is a 0, a 1/1, a 2/2 and a 3/3?
A. True.
Q. And you put up an x-ray, any individual's x-ray, and compare it with those films and determine where along the entire grading system of the ILO scale the film falls?
A. You have to. That's what I have to do. It's become second nature to me, more than second nature. I can't do it any other way. I am very uncomfortable without doing it.
Q. And in a case like this, both of these cases I believe where the grading in your opinion is a 1/0 --
A. No. One is a 1/2 and one is a 1/0.
Q. Sorry. I guess I just have the 1/0. Okay. Starting with the --
DEFENSE COUNSEL: Object to non-responsive.
BY MR. BEVEL:
Q. In your opinion that film falls somewhere between the 0 and between the 1/1 standard ILO film, correct?

Page 179

A. I'm sorry. Three people were talking.
Q. Okay. In Mr. Doelitsch's case --
A. Excuse me for a second. Which is the second case we're doing today?
MS. BOONE: Drosche. Those are both 1/0 as far as I can tell.
THE WITNESS: I have a 1/2.
MR. BEVEL: Off the record.
(Discussion off the record.)
---
EXHIBIT:
(Whereupon, LEVINE 6 and 7 were marked for identification by counsel.)
BY MR. BEVEL:
Q. I'm going to hand you Levine Exhibits 6 and 7. I ask you if you can identify them for me.
A. They are two different patients. One is Roy Drosche and one is Larry Drosche.
MS. BOONE: That's a problem.
MR. BEVEL: We're here for Larry, though, right?
MS. BOONE: That's right. We are here for Larry.
DEFENSE COUNSEL: Here we thought

Page 180

that was an uncommon name.
THE WITNESS: Sorry. I call it like I see it.
BY MR. BEVEL:
Q. Let me just ask, the x-ray you brought with you and the report you brought with you today --
A. That's what was sent to me.
Q. By whom?
A. Whoever sent me the films.
Q. No. But the report. Where did you get this copy of this report?
A. I believe it was from your firm.
MS. BOONE: I'm sure we sent it. Must have sent the wrong film. There was probably another Drosche too.
MR. BEVEL: Okay. I will withdraw the exhibits.
BY MR. BEVEL:
Q. If a film is a 1/0 -- and let's take our one remaining case of Mr. Doelitsch. You put that film up to compare it with the standard 0, 1/1, and 2/2 ILO films. And in your judgment as a B reader and with your experience you determined that it comes

Page 181

somewhere in between the 0 and the 1/1. Is that correct?
A. Right. And that it was a 1/0.
Q. And the 1/0 as opposed to a 0/1, in laymen's terms is it fair to say that in your opinion this was a x-ray closer to a 1/1 than it was to a 0/0 on the standard films?
A. You should teach the course.
Q. And that's -- I appreciate the answer, but I need an answer to the question.
In your -- when you give a 1/0 rating, you believe that that is closer to a 1/1 than it is to a 0/0?
A. Yes, because what I'm finding is that there is a film that I'm faced with which is abnormal but is not profused as great as a 1/1.
Q. Now, on the NIOSH form you do not add a specific diagnosis of asbestosis as you've described earlier?
A. True.
Q. And specifically I believe, if I understand your testimony correct, it's because the NIOSH guidelines don't actually require you or allow you to make a radiographic diagnosis on their form?

Page 182

A. Right. They ask are there any parenchymal abnormalities consistent with pneumoconiosis. Yes. And I fill it out.

Are there any pleural abnormalities consistent with pneumoconiosis. Yes or no. And then in this case I didn't fill it out.

They talk about any other abnormalities. Then I do make a diagnosis where they say other comments, because that's what's appropriate to do. That's what I'm trained to do, as are all B readers.

Q. And as you have indicated, the language that NIOSH uses is whether or not there's changes consistent with a diagnosis of pneumoconiosis?

A. Right. Which is precisely why I do a regular clinical narrative report.

Q. And if I heard you correctly, you said that under a different authority -- not when you're acting under NIOSH, but when you're acting as a board certified radiologist -- you feel like there's a different authority that allows you to go forward and make a radiographic or a radiological diagnosis of asbestosis just based upon x-ray alone.

Page 183

Is that fair to say?

A. You're 98 percent of the way there. The issue is that I know there are B readers because I see when I'm doing second readings that people put diagnoses down here all the time. Mixed disease.

I don't do that because that's not the way I was trained and it's not the 80s standard to write the diagnosis in.

But I am trained to do that if the diagnosis is reachable on the basis of a logical, rational, objective analysis of the films and I have criteria to make the diagnosis to do it in a clinical report. Not to do it is a negligent omission of my responsibility. Therefore, I do it when it's appropriate.

Q. And what I want to know is earlier you had given testimony and I thought you had said that it was as a result of a proclamation of a board, whether or not it's the American Board of Radiology or some other authority upon which you rely in saying it's okay to make a radiological or radiographic diagnosis of asbestosis?

A. Yes. Under the guidelines of the

Page 184

American Board of Radiology that's what we do.

Q. Okay. And is that in a published journal somewhere?

A. That's the standard of practice of radiologists.

Q. Okay. I know. But is there someplace you could send me and I could see in a journal that's been published by the American Board of Radiology here is the criteria for making a diagnosis of asbestosis based upon the x-ray appearance of the disease?

A. No, I am not suggesting that. I am suggesting that in general the American Board of Radiology doesn't want analysis. It also wants a diagnosis, for all diseases. Not just asbestos.

That's the way you take your written and oral boards.

If a radiologist approached his oral boards giving anatomic depictions and descriptions of what's abnormal and went on to the next case, he wouldn't pass.

It's required to give a diagnostic conclusion and a differential diagnosis if one is appropriate.

Page 185

Q. For purposes of the jury, when they hear the term diagnosis coming from a doctor, they think that's kind of the final diagnosis.

It's true that a radiologist makes a radiographic diagnosis and is expecting and relying upon a clinician to correlate that radiographic diagnosis with all of the other information that can be gathered and make a final diagnosis for the patient?

A. I have no expectations at all other than my diagnosis. And the reason for that is that very often I'm dealing with situations where nothing else is or can be done or should be done.

Q. And when you say that, you're referring to the screening or the consulting side of your business?

A. I'm talking about whatever I do here at the hospital or any place. When I make a diagnosis -- if I make a diagnosis of a pneumonia, the diagnosis of pneumonia is made and they will treat it with antibiotics. They won't biopsy it. They won't do a CAT Scan on it.

Q. Well, they will go and do other tests

Page 186

to determine the nature -- they will do cultures to determine the nature of the pneumonia, won't they, to determine how to treat it?
A. They may. You would hope that they would have done that before they started treatment. If, as is typical, they come in and they've already had an antibiotic, then the cultures are irrelevant.
Q. Let's use the example of cancer. You wouldn't expect the clinicians here at this hospital to take your radiographic diagnosis of lung cancer and simply go tell the patient we're sorry, you have lung cancer?
A. Absolutely not.
Q. You would expect them to do follow up --
A. And why?
Q. -- diagnostic criteria?
A. And why?
Q. To confirm or dispute this diagnosis.
A. And why? Because on the basis of the diagnosis, therapeutic interventions can be done which can change and alter the course of the disease and quality of the life of the

Page 187

patient.
Q. Right. Because the patient is going to be treated?
A. Yes. In this case there's no treatment that's available.
Q. Let's talk about false positives. If you had a lot of false positives as a practicing radiologist, that wouldn't bode well for the hospital?
A. I think that, one, when your contract was up they would not be considering renewing it. I think you would also have a tough time getting referrals from your physicians which is why you do reviews, have people second review your films, and why you take a look at your biopsy results.
I think in a situation like this where you're dealing on a close, if not a family, certainly an intimate relationship where you have interaction on a daily basis with hundreds of cases, very shortly you know who the good surgeons are and they know who the good radiologists are.
Q. As a treating radiologist where you're in a hospital setting, if you consistently were

Page 188

diagnosing people with false positives for cancer or for other injuries of the chest that would require further work up and perhaps even invasive work up of a patient, the doctors would stop using you?
A. So would the administration.
Q. Yes.
A. Which is precisely, I think, a credibility issue, which in my situation has resulted in my remaining here as chairman for 17 years.
Q. However, in our consulting work when we're reading x-rays for the presence or absence of an asbestos-related disease in a litigation scenario, there isn't the same disincentive for false positives?
You're not going to stop being used by a screening service or by a particular law firm if you are having a higher than normal ratio of false positives?
A. My response to that is -- and I can only give you my response. Do with it what you will. I am considered a very conservative radiologist. End of story.
Q. Yeah. All I am saying is that for

Page 189

somebody -- when you're the radiologist in a consulting scenario as opposed to in the hospital setting, the disincentive for false positives isn't the same; would you agree?
A. True. But I would also tell you that an objective analysis of the work that I did by a defense group indicated that my sensitivity and accuracy was better than any of the other, quote, plaintiff or defense radiologists in the United States at the time.
MR. BEVEL: Object to everything after true as non-responsive.
THE WITNESS: Gee, it seemed responsive to me.
BY MR. BEVEL:
Q. Well, no, because really my question was --
A. That's okay. I am just giving you a hard time. The hour is late and I'm dying to know how the Flyers did.
Q. I know that you don't keep files on any of these consulting x-rays that you read?
A. No. Everything is sent back to the referral source.
Q. What about in the situation where you

Page 190

do see something on the x-ray that allows you to fill in Section 4B such as there's a prominent hilum or something that suggests further work up needs to be done. It could be a cancer here.
A. The master list is highlighted. The report goes out. And the firm is called and told so that there's three opportunities not to fall through the cracks.
Q. But did you keep a copy of those cases?
A. No. They act as the repository for it, because I don't do the work up. I don't do the follow up work up.
If there was somebody local -- not in the hospital, but it just happened to be local and I had the opportunity to do the follow up, sure, treat them as a patient here.
But I don't make any dichotomy between any of these patients. They are all treated the same.
Q. So you're relying upon the screening service and the law firm to get that information back to the patient?
A. Yes. And they do notify the patient

Page 191

with certified mail to get additional -- I get follow ups from the treating physicians.
Q. But you don't have any kind of tickler system in your files to call in six months and make sure somebody has not dropped the ball on the other end?
A. No. But the law firms do or the imaging companies or the health and welfare groups or the government.
Q. So you rely completely upon them to do any of that kind of follow up work?
A. Yes.
Q. You've said before you don't treat patients, you don't treat people. You don't diagnosis patients. You diagnose the x-ray, the radiographic image, correct?
A. Well, no, no, no. I am not the treating physician in this situation. I am a treating physician here at the hospital.
Q. Well, let me ask you this: Do patients ever come into your office and say I need to know whether or not I have asbestosis and I want you to read my x-rays and tell me, Dr. Levine, do I have asbestosis or not?
A. I have had patients come in here who

Page 192

have been sent to me by the referral physicians here in the community of Philadelphia who I have seen and have waited and wanted to talk to me that I've talked to about their x-rays and results, yes.
Q. Okay. That doesn't typically happen, though; isn't that fair to say?
A. True.
Q. Typically, the pulmonary physician would send you the x-ray to review. You give your opinion. Goes back to the pulmonary physician. The pulmonary physician talks with the patient?
A. Absolutely true, unless they ask me to speak to the patient. And that happens also, especially if additional studies need to be done.
Q. And you are aware, are you not, that pulmonary physicians especially in trying to evaluate somebody that might have asbestosis, they might -- well, they are probably going to listen to their chest with a stethoscope; they are probably going to give them a pulmonary function study.
They may do blood gas analysis. They

Page 193

may do exercise testing. They may do a range and series of other clinical tests in addition to obtaining a radiographic review of the chest x-ray?
A. They may.
Q. And they may, even though the x-ray has a 1/0 and has a radiographic diagnosis of asbestosis, based upon all of those other findings they may inform the patient that they don't have asbestosis? That happens?
A. They may.
Q. You mentioned the JM story a couple of times. Did that story get related to you by somebody from Johns Manville?
A. Yep. Not originally. But then when they called me, I asked them about it.
Q. Was it ever published? The story that you tell that Johns Manville --
A. Contact them. They will I'm sure make it available to you.
Q. No. I'm asking you have you ever seen it published in the peer review medical literature any where?
A. I haven't.
Q. And it's basically just -- I hate to

Page 194

use legal terms -- but it's just a hearsay story that they've told you about?
A. No. It started out that I was told by both a plaintiff attorney and then a defense attorney and then it came out by another attorney at a deposition.
And then I didn't think that much of it until they called me. And then when they called me, I asked them about it and they said yes.
Q. Okay. But as far as I'm concerned, it's still people outside this room have told you these things? In other words, it's not written, it's not published, it's not somewhere where I can go and --
A. I believe it is. But I do not have a copy of it. But I would ask you to contact them and I'm sure you can get a copy of it.
Q. They've never provided you with a copy of it?
A. No. But I understand it was presented at a national meeting according to Mansville.
Q. At some point earlier in the deposition you indicated that perhaps NIOSH has done the same thing, that they've reviewed your

Page 195

work?
A. No. They review everybody's work. The government does.
Q. Have they ever reviewed your work or everybody's work in a manner in which it's been published where you can go and point to a publication saying here is where NIOSH specifically reviewed my work?
A. I don't think that when they do that they do it and you know who is who. I think from a privacy point of view they don't do that.
Now, the government does, I believe, admonish particular individuals if there's a problem.
Q. When you were recertified last time by NIOSH, how many x-rays did you have to read as part of that recertification test?
A. I believe the recertification test is 60.
Q. And how long do you have -- how long are you allowed -- what period of time are you allowed to do that?
A. I believe it's three hours.
Q. And are you permitted to use the

Page 196

standard films, the standard 12 films that we've described?
A. If you walk in there without the NIOSH films, they will escort you right out.
Q. So you are mandated to use those films?
A. Must. And they check your films before you sit down and they go through them to make sure that you have every one of the films.
Q. So you have three hours to review 60 films and you do it at their setting? It's a controlled setting?
A. Well, what they do is they set up tables like this in a large room and there are view boxes. It's usually a double view box so that you don't have the opportunity of putting up numerous NIOSH films but you can put up one NIOSH film at a time to compare to the quiz films.
Actually, if I remember correctly, it's two three-hours. I believe it's two three-hour settings. No. Maybe it's two one-hour-and-a-half settings.
It's not something you like to think about. It's a very, very tough exam. In many

Page 197

years they've flunked 50 to 80 percent of the people that take it.
Q. Do you get a score back?
A. Sure.
Q. Do you know out of the 60 films last time --
A. It's such a complicated scoring mechanism. It's done on a percentile basis where 50th, you need to achieve 50 something. It's very, very complicated mathematic analysis.
Q. You have to get 50 out of the 60 films right?
A. No, no.
Q. You have to achieve the 50th percentile?
A. Something like that, yeah. And as I say, you know, over the years with all the years they've been giving it, there's only about 400 B readers in the country.
Q. I don't want to confuse the jury -- and maybe I just did -- but 50th percentile, when I think 50th percentile, I think 50 out of 100 which is --
A. That's totally wrong.

Page 198

Q. And that's what I was going to ask. What's --
A. I'm not a statistician. But it's not the 50th percentile. I can only tell you that I believe on the last one I was in the 79th percentile, I believe. But I'm confused because I did well on the one before that too.
Q. Do you testify or do you accept cases to testify in medical malpractice cases?
A. Yes, but on rare occasions. I am just very busy. I don't have the time. But I do occasionally.
Q. On behalf of the plaintiffs -- in other words, you will confer with lawyers who are suing other doctors or other radiologists particularly for the failure to make a proper radiological --
A. It's turned out to be the plaintiffs or defense. If something I think is egregious, somebody should be really controlled, then I get involved.
Q. Have you done that before?
A. Probably over 20 years less than five times. Probably four times.
Q. Have you ever testified on behalf of

Page 199

other doctors being -- defending themselves in medical malpractice cases?
A. Wasn't that -- isn't that saying for the defense?
Q. Yeah, for the defense on medical malpractice cases.
A. Yeah.
Q. And how many occasions?
A. I'm saying between plaintiff and defense total might have been five.
Q. Okay.
A. Maybe four, maybe five.
MR. BEVEL: I think those are all the questions I have for you. Thank you.
-- EXAMINATION --
BY MS. BOONE:
Q. Dr. Levine, I have a very few questions for you.
But I would like to start by going through your educational background. You mentioned that you're a board certified radiologist; is that correct?
A. Yes.
Q. Could you describe the steps you've taken to get to that point and starting

Page 200

post-high school.
A. I'm going to refer to my curriculum vitae to ensure absolute accuracy with respect to the dates.
I went to college in New York and graduated college in three years having completed a four-year degree with honors between the period 1962 through 1965, as I say, having graduated cum laude.
Then went on to medical school at Albert Einstein in New York achieving an M.D. degree in 1969. I did an internship in medicine between the period 1969 through 1970 at the university of Colorado returning to New York for a residency in radiology with a subspecialization in nuclear medicine between the period 1970 through 1973.
At that time before you could stand for the boards you needed one year of clinical practice. The first time I was eligible to take the boards was 1974. And that's the only time I stood for the boards and successfully passed the examination.
The boards are precisely what the ladies and gentlemen of the jury would have

Page 201

heard about for boards, for example, in internal medicine or surgery or pulmonary medicine.
It's a convocation of specialists who have the right and authority to set up a credentialing examination which test the expertise of individuals.
As I indicated a few hours ago, I did get involved with occupational dust disease in my tenure while at the Thomas Jefferson University Medical School and first became certified by the National Institute of Occupational Safety and Health in 1986 having recertified in 1989, 1993, 1997, and 2001.
The implication is that every four years you have to recertify as a B reader. And I have successfully recertified each and every time I stood before the exam. I am certified through June 30th, 2006.
I have served as a consultant to health and welfare groups throughout the country. Certainly I have received referrals from law firms. I have done work for the United States government. And I have been an expert for the Federal Bureau of Investigation.

Page 202

I am licensed in the three states that we previously mentioned but only actively practice in the State of Pennsylvania.

I am currently chairman of the department of radiology here at Elkins Park Hospital. It's a 270-bed hospital, a suburban affiliate to the Hahnemann University Medical College of Pennsylvania medical schools that are currently now under the administration of Drexel University.

Q. Are your licenses on file with all of the appropriate entities that they are required to be on file with?

A. Absolutely.

Q. You've been referring to your curriculum vitae, which I believe it was attached as Exhibit No. 2. Does that accurately reflect all your professional education, training, and experience?

A. Yes, other than an occasional possible typographical error it is accurate. I might add that in addition to my chairmanship here, I have served in the past as the interim acting chair at the medical school a few years back for a period of about eight months.

Page 203

And I have also been chairman of the department of diagnostic imaging at Vencor, Philadelphia. Vencor is not part of a hospital system and that is a, shall we say, a respiratory care facility in which all of the patients are on ventilators.

That's a facility which requires physicians that are primarily interested in chest diseases.

And so I still act as a consultant for them and read all of their x-rays on daily basis that are sent here by telemetry.

Q. We've talked a good deal tonight about how you split your time between your chairmanship and your work here at the hospital and your work reading films that are referred to you from various areas.

I believe you said you spent about 80 percent of your time doing work related to the hospital; is that correct?

A. Yes. But that's clinical radiologic work as a working radiologist -- film reading. And that's primarily in the areas of chest and in the area of mammography, although as a general radiologist I do do all manner of

Page 204

radiology including fluoroscopy and whatever.

Q. I believe I got this accurate. If I did not, please let me know. Did you state that you don't always know when you're reading an x-ray whether that referral is related to litigation or not?

A. It's rare that I know it's related to litigation. A very small subsegment of the cases I do each year, probably maybe 40 files are sent to me that represent written requests for an expert report in which I am analyzing a series of films on one patient over a long period of time and I have been requested to provide that x-ray report and I have been requested to do that on the part of a law firm in which I know that a patient who is in litigation and they are asking me to evaluate for the presence or absence of occupational dust disease or any other correlate of complicating disease that the patient may have such as cancer, mesothelioma, et cetera.

The vast majority of all the other films that are sent to me, as I very clearly indicated, they come to me from a host of difference sources, some of which are law firms

Page 205

from the paralegals at law firms.

To be sure, I would assume since I have not read the films there's no way I can know whether they are going to be in litigation and clearly I presume since the vast majority -- perhaps 80 percent of the cases are negative at least -- they are not going to be in litigation.

I have no real way of knowing which cases are in litigation or going to be in litigation except for this subsegment where I'm really asked to evaluate for the presence or absence of these diseases as an expert.

Q. Regardless of whether you receive x-rays from a law firm, from a screening company, from whatever source, does that in any way affect the way that you read the x-ray?

A. My opinion is based on my experience and based on my credentials, based on my education. I bring that all to bear in order to do a logical analysis of the films and render a diagnostic conclusion.

Q. Again, regardless of whether the x-rays come to you from a law firm or elsewhere, do you specifically read that x-ray

Page 206

looking for asbestosis or silicosis or specifically anything?
A. I look at the x-ray specifically to determine whether it is positive or negative. And by positive, whether there is an abnormality of anatomic distortion; and then to identify that anatomic distortion, to characterize it, and diagnose it.
And if it's negative, to indicate that it's negative. It has nothing to do necessarily with the history of occupational disease. It may have to do with finding heart disease or TB or cancer unrelated to any occupational dust disease.
Q. And you report those findings as you read them regardless of the source of the x-ray?
DEFENSE COUNSEL: Objection form.
THE WITNESS: I have to. That's my job.
BY MS. BOONE:
Q. If I understand you correctly, it's true your pay is not affected regardless of your findings? If you find asbestosis, if you find silicosis, if you find nothing at all, you

Page 207

receive the same compensation?
DEFENSE COUNSEL: Objection, form.
THE WITNESS: I am paid a fee for service for the service of interpreting the x-ray. It's irrelevant whether the film is positive or negative.
By reputation -- and this may sound very gratuitous -- I'm a very conservative radiologist in the particular endeavor where the question of litigation comes up.
And that has not served me in good stead because as a conservative radiologist I obviously find more negative cases than other people do. But that's what's right.
BY MS. BOONE:
Q. Earlier there was some discussion specifically with regard to I believe Mr. Doelitsch's x-rays and there was a discussion about how you were not aware of his work history, his medical history, those types of facts.
Do you remember that discussion?

Page 208

A. Absolutely.
Q. Is that information needed for you to accurately read an x-ray?
A. No. In fact, as I've indicated previously, that could violate and contaminate my ability to be objective in my analysis.
That's not to say in any way, shape, or form that a physician wouldn't want that information after the fact if he could have it. But the problem is given that information before the fact you could easily be contaminated in your ability to give an objective appraisal.
In these particular cases I was able to reach a conclusion of interstitial fibrosis purely on the criteria of the film. And that's my area of expertise.
Q. As far as work history, occupational exposures, medical history, is that information that you need to generate the report I believe that's contained in Exhibit 1?
A. There is nothing that is of particular relevance that by its absence precludes me from offering this report.
Q. Earlier you were shown what's been

Page 209

marked as Exhibit No. 4. Would you take a look at that. I believe it's three pages.
A. Right.
Q. Had you ever seen that document before today?
A. Never.
Q. There was some implication that perhaps there's something wrong with a law firm or anyone else doing screenings of people who have been occupationally exposed to toxins.
Do you agree with that?
DEFENSE COUNSEL: Objection, form.
THE WITNESS: The issue for me as a physician is to get as many people evaluated as possible.
I certainly want to do that, for example, on mammography. I don't want to divest for a second. But to that extent that I can screen people by doing breast exams and pick up early breast lesions, I could really impact on survivability for those patients.
And that's starting to happen in the field of mammography because we are getting more people coming into and being screened.

Page 210

To that extent that I could bring people into the process of getting a diagnosis and having them then get into possible therapeutic intervention, that's in that patient's best interest.

Picking up an early asbestos-related cancinoma where intervention could save his life is absolutely what this whole thing is about for a physician.

Making the diagnosis. That's what I do. I mean, that's how I get my jollies. I read films.

You guys are lawyers. I'm a radiologist. I read films. To that extent that my reading films results in a patient having a diagnosis so that therapeutic intervention can be made, that's good.

I am appalled if the particular advertising that's used inappropriately is alarmist in nature to bring people into that.

On the other hand, I got to tell you, the end product of having people come into the process of being screened is good. But I certainly don't want to do that through fear tactics.

Page 211

And clearly what was shown to me with respect to advertisements, one, I didn't know about, and, two, it appalls my sensitivity.

BY MS. BOONE:

Q. I believe you're referring to Exhibit No. 5 which was shown to you earlier. Was that the first time that you had seen that document?

A. Yes.

Q. Did you have any part in drafting what's depicted in Exhibit No. 5?

A. No. The first time it was shown to me today and it's rather obnoxious.

Q. Is it your understanding that this document was involved at all in the screening of Mr. Drosche or Mr. Doelitsch?

A. It's clearly not involved in either one of these because in the patients that were screened they were screened by a different imaging company, Health Screen, that is not related to either one of these documents.

Q. Earlier you mentioned a term that I don't know that the jury would be familiar with: dust burden. Can you define what you meant earlier when you talked about dust

Page 212

burden?

A. The dust burden is the amount of asbestos dust particles and fiber that are within the patient.

Now, to that extent that we're talking about asbestos, we're talking about that burden within the lungs.

In patients such as these that have interstitial fibrosis, the literature as I indicated through, for example, classic articles by Whitwell in the Journal of Thorax in 1977, document at minimum of 3 million fibers of dust, asbestos fibers per gram of lung tissue.

How small is a gram of lung tissue? It takes 454 grams to make up a pound. So you're talking about a very tiny piece of lung containing 3 million fibers at least of asbestos.

That's the asbestos dust burden that's recognized in the literature as being associated with interstitial fibrosis. I can't see that dust, but scientifically it's proven to be there. I just see what it has caused, the scarring of the lungs and the fibrosis.

Page 213

Q. Earlier in your testimony you talked about the consistency among reading and you were going to look for an article that talked about the consistency among different readings.

A. Yes.

Q. Have you found that information?

A. Yes.

Q. Just to clarify the record.

A. I had indicated off the top of my head that when a radiologist is asked to read a group of films and grade those films and then asked to go back and mix them up and reread that group of films, remarkably he's 96 percent reliable consistent and accurate. There's only a 3.9 percent inter-observer error. That means the radiologist reading the same material twice on separate days so there's no memory involved is 3.9 percent.

When two radiologists look at the same material, they are 82 percent accurate in delineating the exact same level of interstitial fibrosis when doing an ILO classification.

That was off the top of my head.

And I would like to quote from a

Page 214

classic article by Warren Gefter, professor of radiology at the Hospital of University of Pennsylvania, Issues and Controversies in the Plain Film Diagnosis of Asbestos-related Disorders in the Chest, Journal of Thoracic Imaging, Volume 3, Issue 4, 1988.

He says, quote, using the ILO classification for profusion of small irregular opacities showed an intra-observer variation of 3.9 percent -- precisely the number that I indicated -- and an inter-observer variation of 18 percent -- precisely the number that I indicated.

That's a remarkable consistency in the evaluation of these films talking about people that have similar training and background bringing to bear that expertise coming up with incredibly reliable and consistent methodology.

DEFENSE COUNSEL: Objection to the non-responsive portion of that answer.

MS. BOONE: Thank you, Doctor. That's all I have.

MR. ROSSICK: Doctor, I've got two really quick questions.

Page 215

BY MR. ROSSICK:

Q. Do you recall when you were talking earlier about the standard films, standard NIOSH films superseding the ILO guidelines, do you recall seeing that?

A. Yes. The films always supersede the guidelines.

Q. Is that published anywhere, that statement?

A. In your guidelines.

Q. In the guidelines?

A. Sure. Give me the guidelines and I will show it to you.

A. I don't have a copy.

Q. You had a copy before. But anyway, take my word for it. Not take my word for it. I'm telling you the truth.

Q. It's stated in the guidelines?

A. There's no way that rhetoric would ever take and be superimposed upon, from a credentialing point of view, radiologists interpreting films as compared to the standard films.

Nothing supersedes the standard films.

Q. Next question: Earlier you stated you

Page 216

have -- when you received -- when you do these NIOSH B readings particularly from the medical legal consultations, that there's no doctor/patient relationship formed, correct?

A. No treating physician relationship.

Q. In your mind do you owe the patients a medical duty of care that you see when you do consultations that you receive in the context when litigation is involved?

A. I think I would need two years of legal training to be able to make a answer to that question and to have any understanding of any validity to my answer.

You're way beyond my ability to answer that. Let me try to simplistically indicate to you that when I am interpreting this, I am doing attorney work product. And put it in that context.

Q. Doctor, when you receive -- I am talking about when you receive cases from a law firm like in this case from the Nix Patterson firm, when you see a anomaly that's not an asbestos-related disease -- for instance, say, you see a potential for congestive heart failure -- do you notify the patient's treating

Page 217

physician or do you notify the law firm?

A. I don't know who the patient's treating physician is. I don't even know the patient's address. It's often not given to me. So I only notify the people that I can.

And I do that by three different methodologies because that's the only information that I have available to me.

Q. Do you believe that you have a medical ethical duty to follow up, make sure that that patient gets appropriate medical care? Or in your mind your -- in your mind -- your only duty is owed to make sure that the law firm that you receive a case from is notified about some other type of medical anomaly such as that?

A. As you can well imagine, because of the situation of not having the patient's name, address, phone number, that sort of thing -- because it's not provided to me -- and also the fact that films that I'm asked to review are often two years old, it obfuscates and complicates my ability to find out, one, whether or not they are going to get this follow up, whether or not in some cases they

Page 218

are even alive.
I can only go to the contact people that I have and make sure that they do it and have been assured by them that when possible through certified letters the patients are contacted.
Now, anecdotally, I have received lesions of letters thanking me for picking up acute TB or picking up an early tumor or picking up a pneumothorax. That's just the nature of the beast.
MR. ROSSICK: Objection to the non-responsive portion of the answer.
BY MR. ROSSICK:
Q. Doctor, the only relationship you have when you get cases from a law firm is a contractual relationship with that law firm, correct?
A. Again, I think two years of legal training would help me answer that. I don't know what you mean by a contractual relationship.
I am asked to do a report and I offer a report on a fee-for-service basis. I have no idea whether or not you consider that a

Page 219

contract and I have no idea whether or not that's considered a treating doctor physician relationship. It's a, for lack of a better term, an expert report.
Q. The only relationship in your mind that you have is with the law firm, correct?
A. Very often a law firm is not even involved. I'm involved with the union or I'm involved with the Health and Welfare Council or I'm involved with the United States government or I'm involved with an imaging company.
Q. Last question: When you receive a case from a law firm, the only relationship that you have in your mind is with that law firm, correct?
A. When I receive a case from a law firm?
Q. To do a B reading.
A. My response -- what my response has been has been to bring to bear my education and training to do an accurate diagnosis of the material that's presented to me; and if there's anything that requires immediate management, to make sure that the people who have contacted me know it so that they go ahead and contact the individual involved.

Page 220

Q. And that relationship is limited to that law firm, correct?
A. I have no way of getting past that. I don't have the information.
MR. ROSSICK: I think you answered the question. Thank you very much, sir.
MR. BURNS: I have one question, Doctor.
BY MR. BURNS:
Q. Do you have copies of the thank you letters that you've received, the lesion of thank you letters you've received?
A. I'm sure I do someplace in my records.
Q. Who would know that, if you don't know it sitting here, in your corporation?
A. I would have to go back into my files.
Q. Is that something you would do yourself or ask somebody else to do?
A. No. That would be something I would do myself.
Q. Are those files stored in your office currently?
A. Not here, not at the hospital. I don't do any of this --

Page 221

Q. I'm not suggesting that. In your corporate office?
A. Whether or not they are actively in an active file or in a basement file or even in a storage in Pennsauken, New Jersey? I have no idea. I have never had occasion to go back into those files.
Q. If you don't keep any records of what patients come in and of their records when you diagnose them, how do you keep track of the letters that come in in an organized manner?
A. It's not organized. It's purely an ego thing.
DEFENSE COUNSEL: Thank you very much, Doctor.
(Whereupon, the examination was concluded at 9:30 p.m.)

Page 222

CAUSE NO. 01-C-753
EDDIE CAFFEY, et al. ) IN THE DISTRICT COURT OF
Plaintiffs ) CASS COUNTY, TEXAS
)
VS. )
)
FOSTER WHEELER )
CORPORATION et al., ) 5th JUDICIAL DISTRICT

REPORTER'S CERTIFICATION
DEPOSITION OF RICHARD B. LEVINE, M.D.
APRIL 21, 2003

I, NANCY TONER, Registered Professional Reporter, hereby certify to the following:
That the witness, RICHARD B. LEVINE, M.D., was duly sworn by the officer and that the transcript of the oral deposition is a true record of the testimony given by the witness;
That examination and signature of the witness to the deposition transcript was waived by the witness and agreement of the parties at the time of the deposition;
That the original deposition was delivered by certified mail/hand-delivery to for safekeeping on
That the amount of time used by each party at the deposition is as follows:
MR. CARLOS MORALES - (01:15)
MR. WILLIAM G. ROSSICK - (00:50)
MR. RANDOLPH L. BURNS - (01:10)
MR. GREGORY H. BEVEL - (00:35)
MS. ALEXANDRA BOONE - (00:15)
That $ is the deposition officer's charges for preparing the original deposition transcript and any copies of exhibits, charged to Plaintiffs;
That pursuant to information given to the deposition officer at the time said testimony was taken, the following includes all parties of record:

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That a copy of this certificate was served on all parties shown herein.
I further certify that I am neither counsel for, related to, nor employed by any of the parties in the action in which this proceeding was taken, and further that I am not financially or otherwise interested in the outcome of the action.
Sworn to by me this day of , 2003.

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