The State of Ohio,)
) SS:
County of Lorain.)

IN THE COURT OF COMMON PLEAS

Henrietta K. Spremulli,

Plaintiff,

vs. No. 93CV111121

Bassel Safi, M.D., et **al,**

Defendants.

* * *

Deposition of, WILLIAM B. BAUMAN, M.D., called as a witness by the Plaintiffs, taken before Kathleen A. Hopkins Durrant, a Notary Public within and for the State of Ohio, at the Offices of William B. Bauman, M.D., 55 Arch Street, Suite 1-A, Professional Center South, Akron, Ohio, on Wednesday, the 4th day of October, 1995, at 3:30 p.m., pursuant to notice.

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APPEARANCES:

On behalf of the Plaintiff:

Michael F. Becker, Esq.
Joanne Sysack, R.N.
Becker & Mishkind Co., LPA
134 Middle Avenue
Elyria, Ohio 44035

On behalf of Defendant Drs. Zahra & Bolla:

Leslie J. Spisak, Esq.
Reminger & Reminger Co., LPA
113 St. Clair Building
Cleveland, Ohio 44114

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WILLIAM B. BAUMAN, M.D.,

of lawful age, called as a witness by the Plaintiff~,being by me first duly sworn as hereinafter certified, deposed and said as follows:

CROSS-EXAMINATION OF WILLIAM B. BAUMAN, M.D.:

BY MR. BECKER:

Q. Hi, Doctor. I'm Michael Becker, and we have just been introduced.

Would you tell us your full name, please?

A. I'm Dr. William Bauman.

Q. Do you have a vitae, Doctor?

MR. BECKER: Do you know what, I think I do have one.

MR. SPISAK: I think you do too. I have a copy of one here, but I think we sent it to you. Yeah.

* * *

CURRICULUM VITAE MARKED PLAINTIFF'S EXHIBIT 1 FOR IDENTIFICATION.

* * *

Q. What is your business address?

A. 55 Arch Street, Akron, Ohia.

Q. You have had your deposition taken before, correct?

A. Yes.

Q. Okay. Just to review things, Doctor, this is a question and answer session under oath. It is important that you understand the question that I pose to you. If the question is inartfully phrased or doesn't make any sense, I would just ask you tu bear with me and tell me that it doesn't make any sense. I will be glad to rephrase or restate the question. Fair enough?

A. Sure,

Q. but unless you indicate otherwise to me, I'm going to assume that you fully understnad the question that's been posed. Okay?

A. Yes.

MR. BECKER: Les, there are a couple things in here that I'd like copies of that look different from what I have.

MR. SPISAK: Okay. Tell me what.

MR. BECKER: Okay. So before we leave, we'll get that accomplished.

Q. Doctar, I want to talk a little bit about your medical/legal experience, acting as an expert.

I know that you have acted as an expert before, In fact, I think you testified on behalf

of Mr. Spisak's partner, Mr. Goldwasser in a Cleveland Clinic case.

A. That is correct.

Q. And that was in the last six months or so, roughly?

A. Yes, roughly six months;.

Q. I think I have that depo here.

Have you ever worked with Mr. Spisak before?

A. No, I haven't.

Q. Other than the one case for Mr. Goldwasser, any other cases on behalf of the law firm of Reminger and Reminger?

A. Marc Groedel sent me a case tu review, but I don't think it came to deposition or to Court.

Q. Are you going to act as an expert on behalf of Marc if called upon?

A. I think the case in question has been settled. It's been some time ago.

Q. Okay. Did you give an opinion on that case?

A. Yes, I did.

Q. Did you write a report on that case?

A. I wrote him a letter, yes.

Q. Do you remember the name of the case?

A. No, I don't. It's been a few years ago.

Q. Did you conclude that that case was defensible?

A Actually in that particular case, as I recall I did not think it was a defensible case.

Q Okay. Handing you what's teen marked as Plaintiff's Exhibit 1, would you identify that for us, please?

A. Yes. This is my curriculum vitae.

Q. Is it current?

A. Yes, it looks to be current.

Q. Any other publications or abstract3 that you have authored or coauthored that are not noted on that vitae?

A. There is an abstract that was submitted recently to *the* American Heart -- American College of Cardiology.

Q. What is the medical subject matter?

A. Coronarv stenting.

Q. Boy, do I know a lot about stenting.

A. Has to do with angioplasty.

Q. What type of stent?

A. It has to do with coronary stent.

Q. What brand of stent or is it a general, generic?

A. It's a general, generic.

Q. Is this your only vitae? Some physicians have vitaes for professionals, some for medical/legal and some just: have a routine vitae they use all

the time.

A. That's it, one and the same.

Q. And I think I noted you are Board certified? —

A. That's correct,

Q. And in internal medicine as well as cardiovascular disease?

A. That's correct.

Q. I assume, Doctar, you passed those Boards on your first attempt?

A. Yea.

Q. And you've written one report on this case, is that accurate?

A. Yes.

Q. Any other letters or report3 to Mr. Spisak that are not within the file that I have just looked at?

A. No.

Q. Okay. Any rough draft3 of your report?

A. No.

Q. Have you had an opportunity to review the report prior to today's deposition?

A. I just read the letter that I wrote to Mr. fpisak dated April '95.

Q. You still want to stand on that report; do you want to make any corrections, additions?

A. No, that'a fine.
Q. Since you drafted that report, Doctor, I'm gathering, have you looked at any additional — information, any depositions?
A. I received an additional deposition of Dr. Feit, 1' believe is hi3 name. And I just looked at that within the last couple of weeks.
Q. Okay. Do you have any personal nates, Doctor, that were generated a3 a result of your review of this case?
A. Mu.
Q. I'm assuming then that you have not looked at Henrietta Spremulli's deposition nor her daughter's, Kathleen White?
A. No, I have not looked at that deposition.
Q. Have you been given a verbal summary of Henrietta and/or her daughter's deposition by Mr. Spisak?
4. We discussed a few minutes ago before you tame in a few points regarding that deposition.
d. May I ask what was related tu you then, Doctor?

THE WITNESS: What did *we* discuss?

MR. SPISAK: Mrs. Spremulli'a position relative *to* what took place on the 18th and 21st, as far as the examination and so forth.

THE WITNESS: Okay.

MR. SPISAK: I sort of gave Dr. Bauman a verbal summary of what the Plaintiff— testified to in that respect.

Q. Okay, Doctor, you have not had any problem with your license ever being called into -- I have to ask these questions, bear with me -- ever being called inta question or suapended or revoked?

A. No.

Q. The aame question a3 to any hospital privileges, any of them ever called into question, suspended or revoked?

A. No.

Q. Have *you* ever given a lecture or spoken to attorneys who defend medical providers?

A. Yes.

Q. Okay. When was that?

A. I reviewed a case regarding a patient that had a particular problem for a plaintiff's attorney; if that's what you're asking.

Q. I didn't follow you.

A. I reviewed a case for a plaintiff's attorney.

Q. Right.

A. Regarding a damage question regarding a particular patient.

Q. Okay.
A In answer to your question regarding did I give lectures, no, I did not give lectures.
Q That's what I meant. Some experts go aut and even make presentation3 to either the defense bar or the plaintiff's bar. That's what I was asking.
A No. I misunderstood the question. I have not done that.
Q It might be me that's not making it clear.

We talked a little bit about your medical/legal experience. We talked about your involvement with the Reminger firm. What about other firms; how many cases in total have you reviewed?

A. I have reviewed cases for P.I.E. Exact number, I'm not sure, but it's certainly less than a half a dozen.
Q. Okay.
A. Over probably the last eight to ten years.
Q. All right. And when you say P.I.E., you mean Jacobson, Maynard?
A. That's correct.
Q. Anybody else?
A. Not that I can recall, no.
Q. So maybe three or four on behalf of Reminger's

office and half a dozen on behalf of Jacobson, Maynard, would that be the extent of it, nine or ken cases?

A Yes. Certainly less than a dozen cases.

Q In total reviewed?

A Total.

Q Now, have you reviewed any cases on behalf of the patient? I think maybe you're giving me an indication of that,

A. Yes, right.

Q. One case, sir?

A. Yes, I did *review* a case.

Q. And who was the plaintiff's attorney?

A. The plaintiff's attorney was an attorney in Akron. And I'm trying to remember his name. I don't recall his name. He's a plaintiff's attorney.

Q. Okay. Did you find that there was substandard care in that review?

A. This was a, this was a damage case involving an auto accident where there was --

Q. So it wasn't a malpractice case?

A. It was not malpractice, no.

Q. It wasn't a lawsuit against the medical provider?

A. That's correct.

Q. So you helped the plaintiff's attorney tie in some damages that flowed from the automobile accident?
A. That is correct.
Q. You've never acted as an expert an behalf of the patient in a medical malpractice case, is that fair?
A. I've never testified in deposition or trial in that manner, but I have reviewed cases and felt that there was malpractice, and I have told the attorney so.
Q. Okay. And how many times has that been?
A. Less than a half a dozen.
Q. What plaintiff's attorneys would those be? You say leas than a dozen or --
A. Less than a half a dozen.
You're asking me to recall the plaintiff's attorney?
Q. If you can't recall, that's fine,
A. Yeah, there was a plaintiff's attorney here in town that asked me to review.
Q. A couple cases for him?
A. Yeah.
Q. Scanlon & Gearinger's office; Tom Henretta, Larry Scanlon?
A. Marty Rosen's firm, which I think is now changed,

split.

Q. All right. Let's go on, Doctor.

Have you ever reviewed a case, whether on behalf of the medical provider ur the patient, where one of the issues involved i3 a hematoma or infected hematoma that developed at or about a groin site post catheterization?

A No. I have never given deposition.

Q Have you ever reviewed a case?

A No, I haven't.

Q That had that similar subject matter?

A No.

Q Are you a P.I.E. insured?

A Yes, I am.

Q Any textbooks that you consider the most reliable in the field of cardiology?

A There's many textbooks.

Q Any that you feel are authoritative?

A. The major ones that are cited are usually Braunwald or Hurst.

Q. Saxe question as to journal articles.

A. Journal articles?

Q. Yeah. Journal publications. I didn't mean to say articles. Journal publications.

A. I read the journal Circulation. And I read the

journal the American College of Cardiology. And I read Cardiovascular Catheterization and Diagnosis, Journal of Invasive Cardiology, New England — Journal of Medicine, Annals of Internal Medicine. Those are the major ones I feel like.

Q. E learned recently, Doctor, that there's a difference between an invasive cardiologist and an interventional cardiologist. What do you consider yourself?

A. An invasive cardiologist would be a cardiologist that performs a diagnostic cardiac catheterization. An interventional cardiologist performs diagnostic cardiac catheterizatiun and also performs procedures under the generic term angioplasty.

Q. And do you?

A. I am an invasive interventional cardiologist.

Q. Okay. You do both?

A. Both, right.

Q. Do you know any of the physicians involved in this case; Dr. Zahra, Bulla?

A. No, I don't know them.

Q. Have you had any contact with any of the physicians involved in this case?

A. I have not.

Q. Was everything you needed to review this case sent to you or did you need to know certain other things and request that of Mr. Spisak?

A. The material I reviewed was sent to me. And I didn't request anything further.

Q. Can we agree, Doctor, that the formation of a hematoma or the formation of a false aneurysm post catheterization is a fairly common complication from heart catheterization?

A. Formation of a hematoma is fairly common. A false aneurysm is much less common following catheterization.

Q Is the formation of a false aneurysm still recognized as a potential complicatinn from a catheterization in the grcin site?

A. That's true.

Q. Has that ever happened to you?

A. Yes.

Q Haw many times?

A I can't give you a precise number.

Q Are we talking fifty to a hundred?

A Well, if I perform 500 procedures plus per year, perhaps one a month.

Q. Okay,

A. Something like that. Again, that's not a firm

number, but it's more of an estimate,

Q. How do you diagnose a hematoma or a false aneurysm combined with a hematoma in a patient?

A. Hematoma is diagnosed primarily by physical examination.

Q. And what about false aneurysm?

A. A false aneurysm is often diagnosed by physical examination and then may be confirmed with either invasive angiography or commonly ultrasound.

Q. In people that are obese or overweight, is it more difficult to make the assessment as to whether the patient truly has a false aneurysm and/or a hematoma?

A. Usually you can make the assessment in an obese patient. It may be more difficult than in a very thin patient, but, nonetheless, on physical exam usually you can, you can make that diagnosis.

Q. As you know in this circumstance, at the time of Henrietta's --

You have the St. Joseph's Hospital records, don't you? Did I see those in there?

MR. SPISAK: I believe he does.

A Yes.

Q At the time of her surgery in October, a hematoma and a false aneurysm was discovered by the

attending surgeons, you are aware of that?

A. Yes.

Q. Given that fact, Doctor, would you agree with me that it's more likely than not that on the 21st of September Mrs. Spremulli had a false aneurysm and hematoma?

A. Would you review the dates, just so I understand what we're talking about here?

Q Okay. I think that she was discharged from -- this may help you to work it forward.

She was discharged from the hospital around the 7th of September.

A. Uh-huh.

Q. After her angioplasty.

A. Okay.

Q. And then I know that she saw Dr. Zahra on the 18th of September, saw Bolla on the 21st of September, saw Dr. Wilder on the 21st of September, and then she was admitted to St. Joseph Hospital on --

MR. SPISAK: The 23rd.

Q. The 23rd of September. Help you?

A. Right.

Q Can you answer my question?

A Okay. Can you repeat the question?

Q. Sure.

Do you think it's more likely than not that there was a false aneurysm and hematoma combined back on September 21st?

A. That's difficult to say. And the reason I say that is, because this is an infected hematoma. It is not infected pseudo aneurysm. It is not a straight forward hematoma or a straight forward pseudo aneurysm.

Q. Are you suggesting that maybe the false aneurysm came about secondary to an infected hematoma?

A. One of the causes for a false aneurysm can be infection. And so the question is, did the infection cause the false aneurysm or did they both coexist.

Q. Right. I appreciate that. In fact, if you recall, that's what Dr. Feit outlined in his deposition.

Do you have an opinion though as to which, which scenario is more likely?

A. I can't tell from the records which is more likely or not.

Q. Do you have an opinion, Doctor, whether there was at least a hematoma present when Dr. Bolla saw Mrs. Spremulli on the 21st of September?

A. Okay. Dr. Bolla was the physician that examined

her at Lutheran Hospital?

MR. SPISAK: I think not. That was Dr. Zahra on the 18th.

Q. Zahra.

MR. SPISAR: Dr. Bolla saw her in his office on the 21st.

THE WITNESS: Okay.

A. Okay. Dr. Bolla's note of 3-21-92, does not suggest that there was a pseudo aneurysm or a hematoma present.

Q. Doesn't answer my question, Doctor.

My question to you, sir, is, do you think it's more likely than not that given the fact that she came into St. Joseph Hospital on the 23rd of September with an infected hematoma, do you think it's more likely than not that she had a hematoma present on the 21st of September?

MR. SPISAK: Okay. Before you answer that, you want him to use the hindsight of what happened on the 23rd to tell you if he thinks something was present on the 21st?

Q. You also can couple that with foresight, the fact that Dr. Wilder made a diagnosis on the same day as Bolla, those two combined factors, do you think it's more likely than not, Doctor, that a hematonia

was present on the 21st of September?

A. You asked me about Dr. gilder, you said Dr. Wilder made a diagnosis of a hematoma?

Q. You are not aware of that, sir?

A. I am aware that Dr. Wilder -- that there was some question of a hematoma in Dr. Wilder's mind, but I never saw his records, is what I'm asking, is what I'm referring to.

Q. Okay. I thought we had sent those to you.

MR. SPISAK: Do you have a copy of Wilder's notes handy? I do not, if it's not in here. You are aware of that?

A. I'm aware of it, but I did not review his office records as I have reviewed Dr. Bolla's records.

Q. Let's back up, Doctor.

Taking Dr. Wilder's opinions and findings aside, putting those aside for a moment, do you think it's more likely than not that because she presented with an infected hematoma on the 23rd of September that she likely had a hematoma on the 21st?

MR. SPISAK: Okay. Now, I'm just going to note my objection, because I'm not sure that that's an accurate statement, but go ahead and answer the question if you can.

A. In reviewing Dr. Bolla's note there is nothing in hi3 note or physical exam that would support the fact that a hematoma was present on the 21st.—

The fact that she was found to have an infected hematoma on the 23rd, obviously means it must have begun at some point prior to the 23rd. And I can't tell you when that began.

Q. Hell, do you have any sense as to how long it would take a hematoma to get infected to the point as preaented on the 23rd, I mean?

A. The question I have is whether the infection led to the hematoma or whether the hematoma was complicated by infection.

Q All right. Well, can you explain to me how an infection can cause a hematoma?

A. If you *have* an infection of the wall of the artery, it will weaken the wall of the artery. It may lead to bleeding, which can lead to hematoma, It may lead to false aneurysm as a complicatinn,

Q And that may lead to a hema-kcma, the false aneurysm?

A And that obviously has blood within it and has a hematoma.

So the question I have in this particular case is, was there a smoldering infection that

then secondarily developed hematoma and pseudo aneurysm or was a pseudo aneurysm/hematoma already present that then became secondarily infected,

Q. Okay. When a patient, when a physician sees a patient two weeks post discharge from catheterization and the patient complains of groin pain --

A. Yes.

Q. -- you'd agree with me, Doctor, that within the doctor's differential he's got to be considering either a hematoma and/or a false aneurysm, is that true?

A. Absolutely.

Q. He's got a duty and responsibility to check those out, correct?

A. Right.

Q And to meet that duty and responsibility, he has to make a physical exam to find what's wrong with the patient, correct?

A As I mentioned, that's one of the major ways we diagnose the problem.

Q And, in fact, Doctor, if it was a patient that came to see you and the patient was mobile prior to the catheterization, but came to see you two weeks later in a wheelchair, that would cause you,

and complained of groin pain, that would cause you to have heightened concern about a hematoma or false aneurysm, correct?

A Sure.

Q And the standard of care of a physician who is presented with a patient that has groin pain, particularly if the patient is in a wheelchair because of the groin pain, is first to get the patient on the table, undress her and make an examination, correct?

A Make an examination, yes.

Q And if Dr. Bolla failed to do that, that would be negligence, correct?

MR. SPISAK: I'm going to object to the word negligence.

Q. That would be negligent?

MR. SPISAK: That's not a conclusion, that's not a conclusion that this witness should make.

MR. BECKER: Oh, all right.

Q. That would be substandard care?

A. That would not be the standard of care.

Q. And if on the 18th of September, and on the 18th of September if she appeared in Dr. Zahra's office with the same complaints of pain in the grain and

also in a wheelchair, Dr. Zahra would have a responsibility again to put her on a table, undress her and make an examination, fair enough?

A Dr. Zahra?

Q Zahra.

A Zahra and Bolla.

Zahra, right. Zahra.

Q Is that fair, Doctor, the sole responsibility would be on Zahra?

A **Yes.**

Q **Okay.** And if Dr. Zahra failed to do that, that would be substandard care?

A. Uh-huh.

Q. Yes?

A. Yes.

Q. You are going to have to answer verbally, because it's difficult for her to pick up a head nod.

Do you think there's anything unusual about Dr. Zahra's office note?

You've got it right in front of you. I just saw it there a few minutes ago,

A Dr. Bolla's is typed. Dr. Zahra's is handwritten.

Q Take a look at the handwritten note, Doctor, a minute, because this occurred in 1992. Take a look at that entry and tell me if **you** see anything

unusual about that Entry?

A. I don't see anything unusual about it.

Q. Let me make sure we're looking at the same note.

A. I think it's this one on the 18th.

Q. Yes. You notice the year that he wrote that note in?

A. '92 it says, I believe. Or is it '94? I can't see it.

MR. SPISAK: It's right here.

A. '92, 9-18-92.

Q. Do you see '93 here? You see that date? You didn't note that?

A. I didn't note that, no.

MR. SPISAK: What he's talking about, the PTCA at Fairview General, 9-4 of 93, is that what you're referring to?

MR. BECKER: Right.

A. I didn't note that. I assumed he was talking about the cath and PTCA.

Q. Okay.

MR. BECKER: This is the page I want photocopied, Les.

Q. Now, what is prudent management if you diagnose a hematoma and/or false aneurysm?

A. Well, the management of hematoma and the

management of **false** aneurysm are different.

Q. Okay. If you are examining a patient and you, and they're both within your differential, then the standard of care is for you to rule out a false aneurysm?

A. Not necessarily rule it out. It depends how symptomatic the patient is.

Q. What if the patient is in pain and presents in a wheelchair because of the pain, difficulty walking?

A. I guess what I'm implying, there are methods to treat a false aneurysm that could be conservative measures and there would be less conservative measures, like calling a vascular surgeon and having this pseudo aneurysm corrected surgically.

Q. What are the methods, what are the conservative methods to treat a false aneurysm?

A Sometimes false aneurysms will spontaneously resolve on their own and every surgical -- every false aneurysm does not require surgical treatment.

Q I was under the impression, Doctor, that false aneurysms are treated one of two ways; either surgical intervention and/or putting the patient on bed rest in the hospital, observing her, doing

blood counts, and applying pressure?
A. No, E don't think that's necessarily required. As I said, if you have a small pseudo aneurysm you may send the patient home to bed rest and plan to follow the patient up in a few day3 or a week depending on the progress of the problem.
Q. But you want bed rest, because you don't want the patient walking around because that could make the problem worse, correct?
A. Usually patients want to stay in bed or stay relatively sedentary, because whether it be a pseudo aneurysm or a hematoma, there's some discomfort associated with having a swelling in that area.
Q. Even the act of standing up on a false aneurysm or hematoma would increase the risk of it getting worse?
A. I'm not sure, having done --
Q. Would you refer that to a vascular surgeon?
A. I see patients that have hematomas in the office, and I don't necessarily send them home to strict bed seat. So it depends on the size of the aneurysm and the amount of problem the patient is having.
Q. All right. Let's -- I'm jumping around here. I

don't mean to do that to you,

But let's talk about management of the hematoma. What is the appropriate management?

A. Sure. Hell, let's talk about what is a hematoma first off.

When you have a hematoma there is blood in the tissues around the artery. The blood may have come from blood seeping out of the artery around the catheter that had been placed in the artery.

Q. Okay.

A. If the artery is sealed and there is simply a collection of blood, the body's own mechanisms are able to recover or to resolve that problem in time. But it may take two or three weeks for that to happen, sometimes longer, but average two or three weeks. Small hematomas are pretty common. They may only take a couple of days to resolve.

Now, if you have a small pseudo aneurysm, sometimes a small pseudo aneurysm will clot off on its own. A pseudo aneurysm implies a connection between the inner portion of the artery and the, the false sac or the false aneurysm. If the neck is very narrow where the blood is going into the false sac, sometimes the blood will clot and the false aneurysm will heal on its own. Those are

the ones you can treat conservatively.

If you have a larger opening, or if conservative therapy hasn't been successful, they may require ultrasound compression or sometimes surgical repair of the neck of that false aneurysm.

Q. Isn't there a risk, particularly in an obese diabetic patient who has a hematoma, of infection if no action is taken?

A. Infection of an aneurysm -- of a hematoma is exceedingly rare. Infection is more common in diabetics.

There is no reason to do anything about a hematoma in a diabetic or nondiabetic in terms of an infection unless you suspect an infection is already present. But the hematoma in itself does not lead to an infection.

Q. Hell, doesn't the hematoma increase the likelihood of an infection?

A. The manner in which one would get an infection if one has a hematoma would involve some break in the integrity of the skin, for instance, where the sheath may go through the skin. So you can get a hematoma and an infection where a catheter went through the skin. That can happen.

But if the catheter is out and the hematoma is in there and the skin is sealed over, I don't see that the hematama should be a major problem for infection.

Q. Would you defer that opinion to an infectious disease specialist?

A. An infectious disease specialist certainly would have an opinion regarding this situation.

I feel comfortable giving an opinion in the sense that I have a lot of experience with catheterization and complications related to that. So, no, I feel comfortable giving an opinion in that isolated area.

Q. Well, have you ever had patients whose hematomas go on to become infected?

A. I have never had an infected hematoma, but I have certainly had an infection around the catheter site in patients that have had a sheath or a catheter in the artery.

Q In place?

A Either in place or after it's been removed, yes.

Q Well, do you have an opinion whether or not there was -- that she presented at St. Joseph's Hospital with an infected hematoma?

A She obviously had an infected hematoma, because

the subsequent hospital records disclose that's what it was, yes.

Q. And my question was, has that ever happened to you, to any of your patients, where the hematoma became infected?

A. No, I have never had an infected hematoma. I have had an infection around the catheter site and I have had hematoma, hut I have never had the two together.

Q. Okay. So since you have never had a patient that's developed an infected hematoma, then it would he safe to say you have never had a patient that's gone on to develop necrotizing fascitis as the result of a mismanagement or a3 a result of progression of the infected hematoma?

A. I have never seen a case personally, and in fact I haven't, I haven't read about a case, but it certainly makes sense when you understand the pathogenesis of the problem.

Q. Hell, do you have any criticism of any of the other medical providers that rendered care to Mrs. Spremulli?

A. Do I have any criticism of the other medical -- can you be more specific?

Q. I can't be any more specific than to say, are you

critical of anyone -- apparently it is your opinion that Drs. Bolla and Zahra rendered the appropriate standard of care?

A. That's what I'm testifying, yes.

Q. And you're basing that opinion solely on your interpretation of their chart, correct?

A. I have reviewed their chart and I have reviewed the medical records which are before me in relation to this case.

Q. Okay. Do you have any criticism of any of the physicians that rendered care to Mrs. Spremulli once she entered St. Joseph Hospital?

MR. SPISAK: Mike, I'll make it easier. I don't intend to ask Dr. Bauman --

MR. BECKER: That's fine.

ME, SPISAK: -- any questions as it relates to his opinions regarding anyone other than Drs. Bolla and Zahra.

Q Well, Doctor, given what Mr. Spisak has told you prior to the deposition, does that change any of your opinions relative to the quality of care these two doctors rendered to Mrs. Spremulli?

A No.

Q Okay. Can I assume then that you are discounting what the patient have and her daughter have stated

under oath?

A. As I said, I have not read the specific deposition of the Plaintiff, but the gist of what was in that testimony was discussed. And I see no reason to change what my opinion is.

Q Do you think that baaed on the summary you've been verbally given, do you think that is inconsistent with the doctors' records?

A No, I don't think it's inconsistent.

Q Okay. Have you ever lectured or given any type of written presentation on the subject matter of managing hematomas and false aneurysms post catheterization?

A. No.

Q. When do you consult with a vascular surgeon when you have a suspected hematoma in a patient's leg?

A It depends upon the severity of the problem. Early on in my career I would consult very frequently. And now, frankly, the cardiologists manage a lot of these patients ourselves without consultation from a vascular surgeon.

If I feel the patient needs a surgical procedure, fur instance, unsuccessful closure with ultrasound of a pseudo aneurysm, then I would call a vascular surgeon and say, I have a patient that

has a pseudo aneurysm and i think the patient will need to have your services.

Q. Hell, hypothetically, Doctor, you diagnose at least a hematoma in a patient that is complaining of severe pain in the groin, who has to present herself in a wheelchair, and has already seen your partner two or three days earlier with the same complaints, with the same presentation, would you be concerned about what's going on in that patient's leg?

A. Sure.

Q. And would you probably hospitalize that patient?

A. IE the patient is in a lot of distress and I'm not sure what the problem is, yes, I would.

Q. And during that hospitalization would you likely a CBC an ultrasound?

A. I likely would do a number of tests, but certainly a CBC and ultrasound would be commonly done.

Q. Any others beside those two?

A. You may proceed to do a CAT scan to make sure there is no retroperitoneal hematoma.

Q. Anything else?

A. If the patient i3 toxic and you're concerned about infection, you would certainly do blood cultures.

Q. Anything else?

A. Those are the major things that I can think of.
And have you done that in the past, Doctor, in managing patients where you've been concerned about a hematoma to the point of hospitalizing the patient and doing those tests?
A. I have hospitalized patients that have come back to the office with hematoma or pseudo aneurysm to further define the problem, yes, I have,
Q You have done it here at this institution?
A Yes.
Q Do you have privileges at any another hospital beside Akron City?
A. Yes.
Q. What other hospitals?
A. Akron General.

MR. BECKER: Off the record.

* * *

Thereupon, a discussion was had off the record.

* * *

Q And back on the record, Doctor.
Can we agree that, although you didn't earlier mention it, aa an additional adjunct to the therapy of a patient you hospitalize when you're concerned about a potential hematoma would be reversal of anticoagulation therapy?

MR. SPISAK: Excuse me. before ycu answer that, I think you just changed the facta. You said if you're going to hospitalize a patient when you're concerned about a potential hematoma. I think his answer was as to what he wauld do if the patient had a hematoma that he was concerned about. And I think those are two different scenarios or at least two different premises.

MR. BECKER: Okay. I didn't mean to be tricky.

MR. SPISAK: I didn't know whether you realized.

A. What is your question now?

Q. In addition to CBC and ultrasound, if the patient is on anticoagulation therapy, don't you generally cut it back or to try to reverse the anticoagulation thsrapy as well?

A. Anticoagulation meaning Caumadin?

Q. Yes.

A. Yes.

Q. And what's the reason or logic behind that?

A. Well, if a patient is anticoagulated, and we're discussing how pseudo aneurysms are treated, we want the false channel to clot. So if the false

channel has blood that is anticoagulated or thinned, as it would be called in common terms, it makes it more difficult for the pseudo aneurysm to clot.

Q. Doctor, do you have -- have you had an opportunity to look at Dr. Feit's deposition?

A. I did read Dr. Feit's deposition, yes.

Q. And do you take strong issue with some of the things that he broached at the deposition?

A. For instance?

Q. Well, let's first talk about Dr. Feit's opinion that in obese patients who may present with a hematoma, he hospitalizes them and does a CBC and ultrasound.

A. I didn't specifically recall that, that focus question.

MR. SPISAK: I'm not sure he said hospitalize. I think his opinion was CBC and ultrasound. But that's my recollection.

Q. Okay.

A. I think you're going to be cautious taking care of diabetics, because you know in general their diabetic status can be thrown off by various features.

But it doesn't mean you have to hospitalize

every diabetic that ha3 a hematoma. i would say you don't have to do that. If you think it's a complicated problem, then you may want to do — that.

Q. Dr. Feit was critical of the placement of the catheterization through the groin site, do you recall that?

A. Yes, I do.

Q. Do you agree with that?

A. No, I don't agree with that.

Q. Do you feel that it's appropriate to place the catheterization through a reddened area on a patient's groin that's likely infected with fungus?

A. Meninlio infection or skin fungus infection is a common problem in the areas of the body that overlap, skin folds in the groin. And it is not uncommon tu go through an area that has reddened, reddened area. And it does nut place the patient at any major risk fer additional infection.

It's a pure superficial infection of the skin with a fungus that'a commonly seen in diabetes. If: does not mean that the patient is going to develop a deep infection. And that's what I would take issue with him.

Q. Does it increase the risk of a deep infection?
A No, I don't think it does. I don't think there is any basis for that statement.
Q. Can we agree, Doctor, that the earlier a false aneurysm or hematoma is addressed and treated, the less likely it is to become infected?
A Again, I have a problem with having the hematoma or the false aneurysm a3 a predisposing factor to infection, and I'm not aware that that is so.
Q. You're not aware, Doctor, that if you are a diabetic and if you have a hematoma, that that person is at increased risk to develop an increased hematoma?
A. That's correct, provided that there is no catheter going into the hematoma to act as a tract for the infection. In other words, if the catheter is out, there ia no way for the infection to enter into the hematoma area, then I don't think that that should be a predisposing factor.
Q. Do you know whether or nut there is bacteria running through everyone's bloodatream all the time, are you aware of that?
A. There, depends whose bloodstream we're talking about. But in general, the only time we worry about infection running through the bloodstream --

Q. No, I'm not talking infection. I'm just saying bacteria, noncolonized, not just infection, noncolonized bacteria.

A. There are not bacteria running through our bloodstream all the time.

Q. Okay. Would you defer that discussion to an infection disease specialist?

A. In cardiology we commonly give antibiotics to patient3 that are at risk of developing a vascular infection. And those situations are related to procedures where infection may enter the bloodstream, for instance, dental procedures.

But normally the bloodstream is sterile. And when we do blood cultures on patient3 we don't come up with bacteria in the bloodstream unless the patient has an infection.

I would defer further discussion of this to an infectious disease expert.

Q. Okay. So can we agree, Doctor, that when Henrietta presented herself with complaints of groin pain and in a wheelchair, Dr. **Zahra** and **Bolla** minimally had a responsibility to rule in or rule out what the, to make a diagnosis of what the problem was?

A Yes.

Q. Particularly given the time sequence of when she's presenting in relation to her discharge from the hospital?

A Sure.

Q And you feel that those doctors met the standard of care based on the charts that you have reviewed?

A. Yes.

MR. SPISAR: Hell, no, and based on, you said earlier, everything that you reviewed, because you reviewed their depositions and so forth.

THE WITNESS: Right.

Q. And, Doctor, if Mrs. Spremulli, although it is not in the chart, it is not in the doctor's depositions, presented with groin pain that was causing her difficulty walking to the point that she had to be in a wheelchair, you've indicated earlier to me that under those circumstances you likely would hospitalize that patient to assess

A patient's in the wheelchair. She had to be

evaluated tu find aut why she's in the wheelchair,
Q. All right. And the only way you can completely evaluate a patient that'a having difficulty -- walking, in a wheelchair, is through the tests that you have juat outlined to us?
A. I believe it was Dr. Bolla who examined her on the 21st, who felt that her problem was related to a former back disorder, degenerative joint disease, €or which she used a TENS unit. And the gist of this note is that he felt her problem was probably orthopedic and not a vascular pseudo aneurysm/hematoma problem.
Q. But retrospectively, Doctor, is it fair to state that Dr. **Bolla** missed this hematoma because of what she presented with two days later?

MR. SPISAK: I'm going **to object** to that, because we don't evaluate these things retrospectively.

A. **As** I discussed earlier, I'm not sure that a hematoma was present on the 21st.

When she was in 5t. Joseph Hospital it was obvious **she** had an infected hematoma. Now, when that developed, I can't tell you, but it doesn't appear in review of these record3 that on the 21st she had evidence of a hematoma or pseudo

aneurysm.

Q. I want you to assume it's true, Doctor, that Dr. Wilder palpated, did an examination of Mrs. Spremulli on the 21st of September, and documented a hematoma with bruising in the right groin. I want you to assume it's true that Dr. Wilder has now given sworn testimony that within -- later that day she was to be seen by Dr. Bolla.

Assuming that to be true, Doctor, and assuming also the clinical condition that she presented with on the 23rd, of September, would you agree with me that it is more likely than not that Dr. Bolla misdiagnosed this leg condition on the 21st.

MR. SPISAK: I'm going to object to that question, because it calls for a retrospective view and because of the choice of the words in the question.

Q. He doesn't like the question.

MR. SPISAK: You can put that on, I don't like the question. I think it's a bad question.

Q. You want the question again?

A. I think I got the question,

The question in my mind is did Dr. Wilder

find a hematoma or did he find bruising. What did you tell me about hi3 --

Q. He's given =warn testimony that he diagnosed a hematoma.

A. The reason I raise this issue is because commonly after catheterization/angioplasty procedure3 there's bruising or ecchymosis. It is not common to have a mass, a bulging, a swelling, a hematoma.

Q. Two weeks post discharge?

A. So that is why I'm saying I would like to get further documentation of that from in the records.

Q. I understand that.

But I want you to assume it is supported in the records and by sworn testimony.

A. Okay. If you are telling me --

MR. SPISAK: Excuse me. I think what you ought to du if you're going tu, you know, try to cross-examine on this, this is, I think, is improper to do in the first place, but I think you aught to let the doctor see what you are referring to and see the actual notes, because I think you're mischaracterizing. He talk3 about bruising, Mike. And I think that'a exactly what Dr. Eiauman is referring to.

Q. I want to quote the note from Dr. Wilder. Quote, on exam there i3 a hematoma with small amount of bruising in the right groin.

A. Uh-huh.

Q. Assume that to be true. Assume, as we know, that's the clinical condition she presented with on the 23rd.

Would you agree with me that it is mare likely than not that Dr. Bolla on the 21st misdiagnosed this hematoma?

MR. SPISAK: Note my objection.

A. If one has a hematoma you should characterize the size of the hematoma. One, it's one centimeter, two centimeters, three centimeters.

If you tell me there was a significant hematoma, four, five centimeter hematoma present on the same clay that Dr. Bolla examined the patient, then it would seem logical that it did not happen between Time A and Time B, that one of them missed the diagnosis, based on those assumption.

Q. Okay. Doctor, do you have an opinion and will you be rendering any opinion to your knowledge a3 to whether or not had a hematoma been diagnosed and treated on the 21st of September, whether the

femoral nerve injury and extensive plastic surgeries would have been avoided?

If you have an opinion I want to explore— that. Wow, this is what a deposition is, it gives me an opportunity so I am not surprised at trial what your opinions are.

So you, if you don't have an opinion, that's fine. But I have to explore it if you do have an opinion.

A. No, I don't have a specific opinion.

Q. Okay. Just trying to be thorough. This guy taught me to be thorough, so I'm just trying to.

* * *

DR. BAUMAN'S REPORT MARKED PLAINTIFF'S EXHIBIT 2 FOR IDENTIFICATION.

* * *

Q. Doctor, just for the record, handing you what's been marked as Plaintiff's Exhibit 2, is that the report that you wrote to Mr. Spisak on this case?

A. Yes, it is.

Q. Is that the only report?

A. Yes.

Q. Doctor, are you of the belief thst the timing of the catheterization and the act of the catheterization was for life saving measures, or,

stated another way, Doctor, could, could this catheterization and angioplasty have been postponed a couple days to treat the groin infection? If you recall from the chart.

A. I would not postpone her particular angioplasty procedure for a meninlio groin infection, I would not do that.

Q. Do yau have any recollection whether or not she was symptomatic of any ischemic problems after she was treated with, began treatment with, with the anticoagulation therapy?

A. She had not had recurrent ischemic changes. However, there is a risk of reinfarction if something isn't done, so that would be reason I would say you should proceed.

Q. But was the risk an immediate one?

A. Yes.

Q. Okay. And what do you base that on?

A. Based upon the severity of the stenosis in the left anterior descending artery and her clinical presentation.

Q. So if a physician managing her after her heart attack treated her with, was it Streptokinase or TPA?

A. It was TPA.

Q. TPA, and then saw the infected groin site, chose to postpone the catheterization and angioplasty for a couple days pending clearing up of that-- infection, would that be substandard care in your opinion?

A I don't think it's a matter of substandard care. but if you told me she had a reinfarction that evening because you postponed the catheterization, then I would say the judgment should have been to try to do it earlier.

Q. What's your definition of -- it's your opinion that these dsctors met the standard of care. What is your definition of standard of care?

A The standard of care is the care given patients by the majority physicians in a specialty in, a majority of physicians in a specialty. So most cardiologists would proceed and do this.

Q. Could the angioplasty have been done through the arm?

A. About the only time angioplasty is done through the arm is when there is a blockage or an occlusion of the aorta and it's impossible to do it through the groin.

Q. Well, certainly the catheterization could have been done through the arm?

A. That's correct.

Q. Is angioplasty through the arm, is it more technically challenging than through the groin-?

A It's technically more challenging and the complication rate i3 higher, related to a number of factors, including the larger catheters required to do an angioplasty and the fact that most physician3 don't have a lot of experience doing angioplaaty through the arm. It i3 not done as frequently.

MR. BECKER: We'll take a short break, I think we're about done.

* * *

Thereupon, a short recess was had.

Thereupon, the deposition was continued pursuant to recess.

* * *

BY MR. BECKER:

Q Doctor, if you were to hospitalize a patient because of, they had problems with their groin enough to require them to utilize a wheelchair, and assuming this patient was overweight or obese, would yau also engage in the practice of measuring their thighs, comparing one to the other an a daily basis?

A. Not necessarily.
Q. Okay.
A. It is very difficult to measure somebody's thigh, especially if they're very large. A half inch, is that really going to make a difference if you measure it two days in a row on patient, is it going to be the same, so it's tough to do that on an obese patient.
Q. Isn't there a risk by not taking any action on a false aneurysm of the false aneurysm rupturing and the patient bleeding?
A. If a false aneurysm keeps getting larger, that would be an indication to surgically take care of the problem, sure.
Q. And how do you know if a false aneurysm is getting larger; through repeat or serial ultrasound?
A. Repeat serial ultrasound and repeat physical exam. You may want to mark the skin area with a pen to give you an idea whether it's enlarging, and clinically you can often tell if the patient is having more discomfort.
Q. I think you indicated earlier that even though you have had this complication of a hematoma and/or a false aneurysm and you have in fact hospitalized patients for that, you have never had one to go on

to develop an infected hematoma?

A. I have never had or never seen an infected hematoma. We do a lot of catheterizations and a lot of intervention, and as Director of the cath lab, I would be aware of other physicians in thiz hospital that would have that as a complication. Re have a conference where we review these things, and I have never seen that combination together.

Q. You have not been given a verbal summary of what Dr. Segarra, the infectious disease expert at Metro, had to say on the issue of frequency of encountering infected hematomas, have you?

MR. SPISAK: That's Dr. Blinkhorn, and the answer is no.

Q. Dr. Blinkhorn.

A. No.

MR. BECKER: Thanks, Doctor.

CERTIFICATE

The State of Ohio,)
) SS:
County of Lorain.)

E, Kathleen A. Hopkins Durrant, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within-named witness, **WILLIAM B. BAUMAN, M.D.,** was By me first duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by him was reduced by me to stenotype in the presenile of said witness, subsequently transcribed into typewriting under my direction, and that the foregoing is a true and correct transcript of the testimony so given by him a3 aforesaid.

I do further certify that this deposition wa3 taken at the time and place as specified in the foregoing caption, and was completed without adjournment.

I do further certify that I am not a relative, counsel or attorney of either party, or otherwise interested in the outcome of thiz action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Elyria, Ohio, this 9th day of October, 1995.

Kathleen A. Durrant

Kathleen A. Durrant, Notary Public
My commission expires 1-10-00
Recorded in Lorain County, Ohio