

IN THE COURT OF COMMON PLEAS
OF GEAUGA COUNTY, OHIO

PATRICIA M. FLETCHER,
Administratrix of the
Estate of VIRGIL G. SLUSHER,
Deceased,

Plaintiff,

vs.

Case No.

GEAUGA HOSPITAL ASSOC, INC.,
et al.,

97PT0126

Defendants.

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Deposition of DAVID GRISCHKAN, M.D.,
called for examination under the statute, taken
before me, Barbara J. Watowicz, a Registered
Professional Reporter and Notary Public in and
for the State of Ohio, pursuant to notice and
stipulations of counsel, at the offices of David
Girschkan, M.D, 24025 Commerce Park, Beachwood,
Ohio, on Thursday, June 1, 2000 at 11:00 a.m.

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1 APPEARANCES:

2
3 On behalf of the Plaintiff:

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10
11 On behalf of the Defendant

12 Joseph A. DiBlasio, M.D.:

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1 APPEARANCES, Continued:

2
3 On behalf of the Defendant

4 Howard Darvin, M.D.:

5 Weston, Hurd, Fallon,

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21
22 ~ ~ ~ ~ ~

1 DAVID GRISCHKAN, M.D., of lawful age,
2 called for examination, as provided by the Ohio
3 Rules of Civil Procedure, being by me first
4 duly sworn, as hereinafter certified, deposed
5 and said as follows:

6 EXAMINATION OF DAVID GRISCHKAN, M.D.

7 BY MR. MARGOLIS:

8 Q. Doctor, my name is Ron Margolis.
9 Myself and my partner Dan Finelli represent the
10 estate of Mr. Slusher. Have you had an
11 opportunity, sir, to review the most recent
12 report that was authored by Dr. Goldstone?

11:02:24

13 A. No, I have not.

14 Q. All right. Do you know who
15 Dr. Goldstone is, Gerry Goldstone, the chief of
16 vascular surgery at UH?

11:02:36

17 A. I don't know him.

18 Q. All right. Dr. Goldstone in his
19 report indicates that when -- Dr. Goldstone
20 indicates in his report that when Mr. Slusher
21 was readmitted to Geauga Community emergency
22 room on September 9th, 1998 that he was in the
23 early stages of acute mesenteric ischemia. Do
24 you agree or disagree with that statement, sir?

11:03:02

25 A. I have no way of making a comment

11:03:20

1 on that.

11:03:22

2 Q. Okay. So based upon your review of
3 the records, you are unable to comment about
4 whether when Mr. Slusher was readmitted to
5 Geauga Community on 9-9-95 if he was suffering
6 from acute mesenteric ischemia?

11:03:34

7 A. You are asking two different
8 questions I'm afraid. You first asked me if he
9 was in the early stages of ischemia. Now you
10 are asking me if he had ischemia. Those are
11 two very different questions.

11:03:50

12 Q. You are right, they are. Thank you
13 for pointing that out to me. When he was
14 readmitted on 9/9/95 to Geauga was he
15 experiencing any form of bowel ischemia?

11:04:00

16 A. Yes, he was.

17 Q. Was he in acute mesenteric
18 ischemia?

19 A. To some degree he had mesenteric
20 ischemia. What level, I don't know.

11:04:12

21 Q. I want to chat with you a little
22 bit about just some general medical concepts.
23 Would you define for me chronic mesenteric
24 ischemia?

25 A. Let me flashback to my medical

11:04:26

1 school days. I am sure I can get you an
2 answer. It's a reduction of blood flow to
3 various portions of the bowel.

11:04:28

4 Q. And how does chronic mesenteric
5 ischemia differ from acute mesenteric ischemia?

11:04:36

6 A. Time frame.

7 Q. Are the symptoms any different?

8 A. It can be.

9 Q. What are the symptoms of acute
10 mesenteric ischemia?

11:04:44

11 A. It can be anything from sudden
12 abdominal pain to just sudden infarction of
13 bowel without the common pain.

14 Q. Diarrhea?

15 A. It can have any number of symptoms.

11:04:56

16 Q. Is that one of them?

17 A. It can be.

18 Q. Blood from the rectum?

19 A. Can be.

20 Q. Nausea?

11:05:02

21 A. Can be. Again, it should be
22 pointed out that none of these symptoms
23 necessarily need to be included.

24 Q. Is chronic mesenteric ischemia
25 characterized by postprandial pain and weight

11:05:14

1 loss in the patient?

11:05:18

2 A. Some cases, yes.

3 Q. Would you define ileus?

4 A. It's a general term for
5 nonfunctioning of the bowel.

11:05:26

6 Q. Is there a difference between a
7 vascular ileus? Is that a term, vascular
8 ileus?

9 A. I have not heard of it.

10 Q. All right. What is a bowel
11 perforation?

11:05:38

12 A. A hole in the bowel.

13 Q. What is a bowel infarction?

14 A. A loss of blood supply with
15 subsequent necrosis of the bowel.

11:05:46

16 Q. If Mr. Slusher would not have
17 undergone the surgery that he did on September
18 5, 1995, do you believe that his bowel would
19 have become necrotic and he would have died on
20 September 19th, 1995 as he did?

11:06:02

21 MR. TORGERSON: Objection.

22 You may answer.

23 A. I have no opinion.

24 Q. You would agree that Mr. Slusher
25 prior to surgery suffered from significant

11:06:14

1 atherosclerotic disease?

11:06:18

2 MR. TORGERSON: Objection.

3 A. I don't know what you mean prior to
4 surgery.

5 Q. Before surgery of September 5,
6 1995, he suffered from severe atherosclerotic
7 disease?

11:06:24

8 MR. TORGERSON: Objection.

9 A. I am not sure to what degree. He
10 certainly had atherosclerotic disease.

11:06:34

11 Q. Would you agree that before surgery
12 of September 5, 1995 Mr. Slusher had extensive
13 vascular disease?

14 MR. TORGERSON: Objection.

15 Q. With some involvement of the
16 mesenteric vessels?

11:06:48

17 MR. TORGERSON: Same objection.

18 A. I can't comment on the degree or
19 extent.

20 Q. Would you look at your report, sir,
21 of July 2, 1999?

11:06:56

22 A. The answer is the same. I don't
23 know to what extent so I can't comment.

24 Q. What do you mean in your report
25 when you say it's a fact that this young man

11:07:04

1 had extensive vascular disease and would have
2 been expected to have some involvement of the
3 mesenteric vessels?

11:07:08

4 A. Usually the vessels that are
5 involved in atherosclerotic disease include the
6 mesenteric vessels as well as aortic vessels.

11:07:16

7 Q. Would some of the vessels that you
8 are referring to be the SMA and IMA?

9 A. Usually the SMA and IMA can be
10 involved.

11:07:38

11 Q. All right. Do the SMA and IMA,
12 between the two of them, pretty much supply 90
13 percent of the blood flow of the bowel?

14 MR. TORGERSON: Objection.

15 Go ahead.

11:07:50

16 A. Yes.

17 Q. Your training is that of a general
18 surgeon, is that accurate?

19 A. Yes.

20 Q. And other doctors refer patients to
21 you for general surgical care, is that
22 accurate?

11:08:00

23 A. Yes.

24 Q. And so when a patient comes to you
25 for a general surgical consultation, do you

11:08:12

1 take a full history regarding that patient's
2 health condition?

11:08:14

3 MR. TORGERSON: Objection.

4 Go ahead.

5 A. Yes.

11:08:22

6 Q. Why do you do that, sir?

7 A. To get a better feel for the
8 diagnosis that I'm about to make.

9 Q. Is it the responsibility of the
10 surgeon who is performing an elective surgical
11 procedure on a patient to do a thorough preop
12 evaluation of that patient?

11:08:34

13 MR. TORGERSON: Objection.

14 A. It's too broad a question to
15 answer. I don't know the answer to that.

11:08:46

16 Q. What is it about the question that
17 makes it so that you can't answer it?

18 A. The manner in which you asked it.

19 Q. What specifically did I ask?

20 THE WITNESS: Could you read back
21 the question, please?

11:08:56

22 (Record read.)

23 A. Each case would be different
24 depending on the age group, condition, nature
25 of the referral. I mean the variables are

11:09:22

1 endless. 11:09:28

2 Q. Would one of the issues be what the
3 patient's known health history is, i.e., if the
4 patient has vascular disease?

5 MR. TORGERSON: Objection. 11:09:34

6 Go ahead.

7 A. With all due respect, if you could
8 just rephrase the question or reask it.

9 Q. Okay. Fair enough.

10 In this case do you have an opinion
11 if chronic mesenteric ischemia would have been
12 diagnosed before surgery if Dr. Darvin would
13 still -- strike that. Let me ask it this way.

14 Do you have an opinion one way or
15 the other as to whether Mr. Slusher suffered
16 from chronic mesenteric ischemia prior to the
17 surgery of 9-9-95? 11:09:45

18 A. I have no evidence for that.

19 Q. What is evidence of chronic
20 mesenteric ischemia? 11:10:0

21 A. I guess you would have to have an
22 angiogram to demonstrate evidence for that.

23 Q. Is there any clinical evidence of
24 chronic mesenteric ischemia?

25 A. Not really. 11:10:14

1 Q. Okay. Postprandial pain, weight 11:10:34
2 loss, would those be symptoms of chronic
3 mesenteric ischemia?

4 A. You and I could have that most days
5 after eating a Happy Meal at McDonald's. 11:10:36

6 Q. Well, could you answer my question?
7 Is postprandial pain and weight loss a symptom
8 of chronic mesenteric ischemia?

9 A. It's a nonspecific symptom.

10 Q. Is it one symptom of chronic 11:10:48
11 mesenteric ischemia?

12 A. It could even be associated with
13 pregnancy, but that does not mean that we're
14 talking about pregnancy.

15 Q. I'm talking about chronic 11:10:56
16 mesenteric ischemia.

17 A. It can fit any variety of symptoms
18 you want.

19 Q. Do you have any criticisms of the
20 care provided to Mr. Slusher by Dr. Darwin, the 11:11:04
21 vascular surgeon in this case?

22 MR. TORGERSON: Objection.

23 A. I'm not a vascular surgeon so I
24 can't really make any specific comments dealing
25 with issues of the vascular condition 11:11:16

1 indicative to the bowel. I think certainly a 11:11:18
2 vascular surgeon is the person involved in
3 managing that.

4 Q. Do you believe that a vascular
5 surgeon by virtue of their training and 11:11:26
6 experience are in a better position to make a
7 diagnosis of a vascular condition effecting a
8 bowel than a general surgeon?

9 A. Generally, yes.

10 Q. Do you have any criticisms of the 11:11:38
11 postoperative care that Dr. Darvin provided to
12 Mr. Slusher?

13 MR. TORGERSON: Objection.

14 A. Not specifically.

15 Q. Do you have any questions about the 11:11:48
16 operative technique demonstrated in the
17 operative note of Dr. Darvin pertaining to the
18 surgery of 9/9/95?

19 MR. TORGERSON: Objection.

20 A. I'm not a vascular surgeon, so I 11:12:00
21 really can't make a comment on that.

22 Q. Have you done any abdominal surgery
23 that involves vascular surgery as well?

24 A. Have I put any holes in the vessels
25 while I'm doing my surgery, is that what you 11:12:12

1 are asking me?

11:12:14

2 Q. Have you ever performed abdominal
3 surgery which also involved components of
4 vascular surgery?

5 A. Not directly. I was very involved
6 in trauma care in the initial years of my
7 practice and in those cases we had many
8 patients who had contaminant vascular injuries,
9 but generally we called in the vascular surgeon
10 to handle that.

11:12:22

11:12:36

11 Q. In this case do you attach any
12 significance preoperatively to the enlargement
13 of Mr. Slusher's IMA?

14 A. Not particularly.

15 Q. Would you agree that two out of
16 three vessels -- would you agree that two out
17 of three arteries must be occluded or stenosed
18 before a patient will become symptomatic for
19 mesenteric ischemia?

11:12:48

20 A. I can just state for the record
21 that I'm a general surgeon. I'm not a trained
22 vascular surgeon. You are asking me questions
23 that are more related to vascular issues.

11:13:04

24 Q. Okay. So you have no opinion as to
25 that question?

11:13:16

1 A. You are asking me a vascular
2 question. That's not my area of expertise.

11:13:14

3 Q. Okay. Do you have any opinion,
4 doctor, as to when the last point in time was
5 that Mr. Slusher would have been salvageable
6 had his mesenteric ischemia been diagnosed and
7 treated?

11:13:26

8 A. Frankly, I'm not sure that we have
9 a firm diagnosis of mesenteric ischemia. He
10 had acute mesenteric insult at the time he came
11 in for the second admission on the 9th. In my
12 mind there is a difference between ischemia and
13 a sudden mesenteric insult.

11:13:47

14 Q. Please tell me what you mean by
15 acute mesenteric insult.

11:13:5

16 A. The patient had documented
17 hypertension on the 8th while he was under
18 Dr. Darwin's care. Additionally, he had an
19 episode of atrial fibrillation. Putting the
20 records together, this means he had some kind
21 of emboli at that time and he may have had a
22 second episode that prompted the stroke. And
23 the abdominal crisis developed in the second
24 admission. And those were the acute mesenteric
25 insults. We're not talking about ischemia.

11:14:10

11:14:26

1 Q. Were echocardiograms done after his 11:14:32
2 episode of atrial fibulation when he was in the
3 hospital from 9/5 to 9/9?

4 A. I don't recall.

5 Q. Based upon his presentation to the 11:14:50
6 emergency room on 9/9/95, do you have an
7 opinion as to what period of time he would have
8 been salvageable from his mesenteric insult
9 that he was suffering from?

10 A. I think this was sudden and massive 11:15:12
11 and it prompted the stroke and the mesenteric
12 occlusion. And I think at the point that he
13 presented in the emergency room he was
14 unsalvageable.

15 Q. From the moment that he was 11:15:22
16 admitted on 9/9/95?

17 A. Yes. Correct.

18 Q. Did you indicate that in your
19 report?

20 A. Not specifically. 11:15:32

21 Q. All right. Are you aware -- you
22 are not offering any opinions in this case in
23 the field of neurology, are you?

24 A. No.

25 Q. Has it been documented anywhere in 11:15:42

1 the chart from 9/9 through 9/12 at Geauga that 11:15:44
2 he had a stroke?

3 A. Yes.

4 Q. Where?

5 A. May I look through the records? 11:15:52

6 Q. Sure. Can you tell me what you are
7 referring to, please?

8 A. Discharge summary dictated by
9 Dr. DiBlasio. In the second line it says I was
10 called by Dr. Crosby and he's the emergency 11:16:24
11 room physician who informed me that the patient
12 was in the emergency room and that he is
13 apparently having or had had a stroke with
14 paralysis on the right side.

15 Q. All right. And do you see in 11:16:38
16 Dr. Crosby's report at the last paragraph at
17 about this time Dr. DiBlasio then arrived and
18 also about this time the patient had an
19 essentially complete recovery from his stroke
20 with his only ongoing problem being abdominal. 11:16:52
21 That's also in the emergency room section.

22 A. Show me where that is.

23 Q. That's in doctor -- as a matter of
24 fact, let me do this. I made a copy for you.
25 We're sort of jumping a little bit ahead. Right 11:17:08

1 here, at about this time.

11:17:24

2 A. Okay.

3 Q. And doesn't that record further
4 indicate that it was the opinion of

5 Dr. DiBlasio that the patient had a transient
6 cerebral vascular insufficiency due to
7 hypovolemia?

11:17:46

8 A. Yes.

9 Q. Is that different than a stroke,
10 sir, a transient cerebral vascular
11 insufficiency due to hypovolemia?

11:17:58

12 A. It would be like a prestroke
13 situation.

14 Q. Is it different from a stroke?

15 A. Just a milder from.

11:18:08

16 Q. Okay. This man's CAT scan was
17 negative, was it not?

18 A. Yes, it was.

19 Q. Do you have an opinion in this case
20 when Mr. Slusher's intestines infarcted?

11:18:16

21 A. Yes.

22 Q. When?

23 A. At the time that he presented to
24 the emergency room on the 9th.

25 Q. Do you have an opinion in this case

11:18:26

1 as to when his intestines perforated?

11:18:26

2 A. It looks like it was probably only
3 the 14th when he noticed free air in the
4 abdomen at University Hospitals.

5 Q. Wasn't there an x-ray, sir, of
6 9/8/95 demonstrating free air in the abdomen?

11:18:36

7 A. That's surgical gas.

8 Q. Okay. Let's look at, if you want
9 to, look at these records, sir. It's actually
10 at 9/9. I think it's -- if you keep turning --

11:18:50

11 A. What are you specifically looking
12 at, an x-ray?

13 Q. Yeah.

14 A. It would be easier for me to --

15 Q. It's the x-ray, sir, of 9/9/95 of
16 his abdomen. Here it is.

11:19:00

17 A. Go ahead.

18 Q. Doesn't this x-ray of 9/9/95 of his
19 abdomen also have a finding of nondifferential
20 air fluid levels on cross-table lateral view
21 suggesting a dynamic ileus?

11:19:36

22 A. Yes.

23 Q. How does this finding differ from
24 the finding of the 9/14 film at UH so that you
25 are concluding that the UH film air level was

11:19:50

1 due to a perforation?

11:19:54

2 A. There are a series of films that
3 they had performed monitoring the patient.
4 There was a change in the status on the 14th
5 that there was actually free air underneath the
6 diaphragm that suggested that there was
7 perforation.

11:20:02

8 Q. Have you reviewed any of the x-ray
9 films themselves?

10 A. No.

11:20:10

11 Q. So your opinions are predicated
12 upon the interpretation of the radiologist?

13 A. Yes.

14 Q. And the reports that you reviewed?

15 A. Correct.

11:20:18

16 Q. All right. How long did it take
17 for his intestines to liquefy?

18 A. I don't know.

19 Q. And I apologize if I asked this
20 before, but is the diagnosis of acute
21 mesenteric ischemia a diagnosis that you would
22 expect a general surgeon to be able to make?

11:20:32

23 A. Again, it depends on the
24 conditions, status, past history. There are
25 many variables.

11:20:50

1 Q. Based upon those variables, what 11:20:56
2 the patient's past history is, the exam, is
3 acute mesenteric ischemia something you would
4 expect a general surgeon to recognize or would
5 that be something more so that you think a 11:21:08
6 vascular surgeon would recognize and treat?

7 A. I think both types of surgeons can
8 make the diagnosis with the appropriate
9 conditions or possibly miss the diagnosis if
10 the symptoms are not there. 11:21:22

11 Q. What would the symptoms be?

12 A. Anything from frank evidence of
13 ischemia, necrosis, to subtle findings such as
14 nausea and vomiting.

15 Q. What would the frank evidence be? 11:21:34

16 A. Evidence on x-ray of air in the
17 bowel. Loss of vascular supply. So on.
18 Isolated loops with a leaking effect.

19 Q. If a specialist performs a consult
20 of a patient in the hospital at the request of 11:21:50
21 another physician, is it the consulting
22 physician's responsibility to review the
23 medical records in the chart?

24 A. With the limitations that are
25 placed on the referral. In other words, if you 11:22:02

1 are asked to check for an ingrown toenail 11:22:06
2 that's specifically what you are going to look
3 for.

4 Q. I want to switch a little bit to
5 your background and your practice. 11:22:22

6 We're presently at the Center for
7 Hernia Surgery?

8 A. Presently at my office at the
9 Hernia Center, yes.

10 Q. Do you own the Hernia Center? 11:22:32

11 A. As of today I still do.

12 Q. Okay. Is that in some type of
13 financial litigation?

14 A. No.

15 Q. Okay. You said as of today. 11:22:42
16 That's why I asked.

17 A. Surgeons today never know what
18 tomorrow brings.

19 Q. What hospitals do you have
20 admitting privileges at? 11:22:50

21 A. Meridia Hillcrest and I used to
22 have them at Mt. Sinai.

23 Q. Tell me the nature of your present
24 practice.

25 A. It probably involves about 70 11:23:02

1 percent hernia surgery and that's inguinal
2 hernias, hiatal hernias, intestinal hernias
3 with bowel resections for infarction of bowel.
4 The other 30 percent is your gamut of general
5 surgery. It's gallbladders, appendix, breasts.
6 Lumps and bumps. Hemorrhoids. You name it.
7 For the last eight or nine years it's been
8 pretty well around the 70/30 percent mark.
9 Prior to that it used to be 70 percent was
10 general surgery and 30 percent was hernias.

11 Q. Of the 70 percent of hernia work
12 that you do, what amount of that involves any
13 bowel resection?

14 A. Oh, maybe one percent. At the
15 most.

16 Q. Would it be the minority of surgery
17 that you perform that involves bowel resection?

18 A. Fortunately, yes.

19 Q. All right. Would you tell me your
20 Social Security number, please?

21 A. 550-96-0258.

22 Q. And your date of birth?

23 A. Do I have to? 7-31-48.

24 Q. Have you ever given testimony in a
25 medical malpractice case on behalf of a

1 plaintiff who is bringing the claim? 11:24:16

2 A. Yes.

3 Q. Where and when?

4 A. It goes back a number of years.

5 Q. When was the last time you served 11:24:26

6 in the capacity of an expert witness on behalf

7 of a plaintiff in a medical malpractice case?

8 A. Probably within the last eight

9 months or so.

10 Q. Approximately how much expert 11:24:44

11 witness work do you do in the medical

12 malpractice area?

13 A. I'm not sure how to answer that.

14 Q. How many cases do you presently

15 have going where you have been retained as an 11:24:54

16 expert in a medical malpractice case?

17 A. Maybe three or four.

18 Q. Okay. And how many cases do you

19 review on a yearly basis?

20 A. Probably about five or six. 11:25:08

21 Q. Do you testify more on behalf of

22 the plaintiff or the defendant?

23 A. Defendant.

24 Q. Can you give me any idea? Is it

25 like 70/30, 90/10? 11:25:18

1 A. Probably 80 percent defendant, 20
2 percent plaintiff.

11:25:20

3 Q. Have you ever had a judgment
4 rendered against you personally for medical
5 malpractice?

11:25:28

6 A. Yes.

7 Q. When was that?

8 A. Probably 1995 or 1996.

9 Q. And was that the only one?

10 A. Yes.

11:25:36

11 Q. Did that go to court, sir?

12 A. No. That was settled by PIE at
13 their insistence.

14 Q. Do you know Dr. Howard Darwin?

15 A. Yes.

11:25:44

16 Q. How do you know him?

17 A. Very peripherally. He comes to
18 Hillcrest once in a while.

19 Q. So he's just a colleague that you
20 sometimes would run into at the hospital?

11:25:54

21 A. Yes.

22 Q. What about Dr. DiBlasio?

23 A. I may have said hello once or twice
24 at some meetings.

25 Q. All right. But you never saw him

11:26:00

1 at the hospital? You don't work at the same
2 facilities?

11:26:02

3 A. No.

4 Q. Have you spoken to Dr. DiBlasio at
5 all about this case?

11:26:08

6 A. No.

7 Q. Have you ever worked previously for
8 Mr. Van Wagner in the capacity of an expert
9 witness?

10 A. I don't think so.

11:26:14

11 Q. Have you worked previously for
12 Mr. Van Wagner's law firm Ulmer & Berne in the
13 capacity of an expert witness?

14 A. Yes.

15 Q. Approximately how many times?

11:26:22

16 A. Maybe once or twice in the last
17 two, three years.

18 Q. I would like to refer you to your
19 report that you wrote, sir, of July 28th, 1999.
20 Did you discuss the conclusions and opinions
21 that you arrived at in that report with Mr. Van
22 Wagner prior to writing the report?

11:27:00

23 A. I don't recall. It's possible.

24 Q. Is this the first draft of the
25 report?

11:27:14

1 A. Yes.

11:27:14

2 Q. You indicated -- let me ask you the
3 question this way. Have you reviewed any
4 materials since you authored the report of July
5 28th, 1999?

11:27:24

6 A. I don't believe so.

7 MR. VAN WAGNER: Well, Dr.
8 DiBlasio's deposition.

9 A. I'm sorry. Dr. DiBlasio's
10 deposition.

11:27:32

11 Q. All right.

12 A. That's why I invited him along.

13 Q. Okay. Nothing else?

14 A. No.

15 Q. You indicate in the second
16 paragraph of your report that Mr. Slusher was a
17 47 year old man with a one-year history of
18 stomach pain. Where did you obtain that
19 information from?

11:27:41

20 A. The records.

11:27:52

21 Q. What records, sir?

22 A. I think the initial consultation by
23 Dr. Darwin was a request for consultation for
24 chronic abdominal pain. And Dr. DiBlasio's
25 history elicited a one-year history of

11:28:04

1 abdominal pain. 11:28:06

2 Q. Did he --

3 MR. TORGERSON: I'll move that go
4 out.

5 But go ahead. 11:28:10

6 Q. Did he also have a history of
7 weight loss at the same point in time that he
8 had the stomach pain?

9 A. Yes.

10 Q. Now, you indicate in the second 11:28:26
11 paragraph Dr. DiBlasio was asked to see him for
12 chronic abdominal pain in view of the lack of
13 acute abdominal signs. What are you referring
14 to?

15 A. Basically guarding and rebound 11:28:42
16 which is an immediate process and emergent
17 process.

18 Q. What does guarding mean?

19 A. Guarding is a physical sign in
20 which you palpate the abdomen and it's rigid 11:28:54
21 and it suggests that there is a perforation or
22 some kind of an acute process going on inside
23 the abdomen.

24 Q. As a general surgeon evaluating the
25 patient for abdominal issues, what is the 11:29:06

1 significance of that positive guarding
2 response?

11:29:08

3 A. Again, it suggests that there may
4 be some acute process going on in the abdomen
5 like a perforation or some kind of acute
6 inflammation, infection, so on.

11:29:14

7 Q. All right. Would diarrhea be an
8 acute abdominal sign?

9 A. No.

10 Q. Nausea?

11:29:26

11 A. No.

12 Q. Absence of bowel sounds?

13 A. No.

14 Q. Was the patient able to eat prior
15 to his discharge on 9/9/95?

11:29:41

16 A. I don't know the specific answer to
17 that, but I will tell you that four days, five
18 days after aortic surgery I'm not sure many of
19 us would have much appetite.

20 Q. Maybe I didn't make myself as clear
21 as I needed to. Was the patient able to keep
22 food down prior to his discharge of 9/9/95?

11:29:56

23 A. I don't know.

24 Q. Is that an important issue to be
25 evaluated in the context of this patient prior

11:30:12

1 to discharge?

11:30:14

2 A. Not in relation to the patient who
3 has had aortic surgery.

4 Q. So you would have no problem
5 discharging a patient who had the type of
6 surgery that Mr. Slusher had even if they were
7 not able to keep food down prior to discharge?

11:30:20

8 A. That's correct.

9 Q. What significance if any do you
10 attach to the rectal bleeding that Mr. Slusher
11 demonstrated when he returned on 9/9/95?

11:30:34

12 A. Again, that needed to be worked up.

13 Q. Okay. For what purpose, sir?

14 A. It could be anything from
15 hemorrhoids to something more severe. If a
16 patient presented to my office with those
17 symptoms I would take the time to work them up
18 and establish a diagnosis.

11:30:54

19 Q. Are you familiar with the concept
20 that usually the diagnosis of mesenteric
21 ischemia is made if the clinician has a
22 suspicion for the disease, a high index of
23 suspicion?

11:31:04

24 A. I have no comment on that.

25 Q. Okay.

11:31:16

1 MR. TORGERSON: Read back the
2 question.

11:31:44

3 (Record read.)

4 MR. TORGERSON: Stick an objection
5 in there.

11:31:48

6 Q. Are you familiar with that concept
7 to qualify it as a question?

8 A. I don't know.

9 Q. You have never heard it?

10 A. I don't know how to give you an
11 answer on that. I have not come across that.

11:31:56

12 Q. What are the general surgical
13 textbooks that you think may not necessarily be
14 authoritative but are a reasonable discussion
15 of general surgery?

11:32:11

16 A. You have Schwartz and Sandstone
17 which are the standard texts.

18 Q. What would have been the findings
19 of 9/9/95 which would have needed to be present
20 for you to conclude that there were findings
21 subjective of a surgical abdomen on his
22 readmission to Geauga?

11:32:34

23 A. Evidence for guarding or rebound.

24 Q. I want to ask you these questions,
25 doctor, now given the health history of

11:32:52

1 Mr. Slusher, not just general questions.

11:32:56

2 Given the health history of
3 Mr. Slusher, specifically his atherosclerotic
4 disease and his readmit to the emergency room
5 on 9/9/95 with diarrhea and blood, isn't that,
6 diarrhea and blood, given his health
7 background, a symptom of mesenteric ischemia?

11:33:10

8 A. Not necessarily.

9 Q. Could it be?

10 A. I don't know.

11:33:28

11 Q. Would mesenteric ischemia be one of
12 the elements you would include in the
13 differential in this patient on 9/9/95 with his
14 health history and presenting symptoms?

15 A. Probably not.

11:33:40

16 Q. Is a distended abdomen a surgical
17 finding or a finding that would cause you to be
18 concerned about a perforation?

19 A. Not by itself.

20 Q. What else would have to be present
21 with it?

11:34:06

22 A. Guarding. Rebound.

23 Q. What do you mean when you say
24 ischemia of the bowel is a diagnose of
25 exclusion?

11:34:18

1 A. We're able to make a diagnosis of 11:34:22
2 gallbladder disease by showing stones in the
3 gallbladder. When you are talking about
4 mesenteric ischemia, the symptoms really have
5 to be ruled out in relation to other entities, 11:34:34
6 ulcers, pancreatitis, colitis, intestinal
7 hernia, adhesions. I mean the list is endless.

8 Q. And what tests would you order if
9 you wanted to rule out ischemia of the bowel?

10 A. Again, taking in reference what I 11:34:57
11 just said, I would have to do all of the other
12 studies or all of the other diagnostics. You
13 know, if it's GI, possibly an endoscopy. CAT
14 scans. Just about every lab test you can think
15 of. If all of those came back normal, then I 11:35:07
16 would have to start looking for the odd
17 entities and the unusual diagnostic things you
18 start considering.

19 Q. Even if a patient has severe
20 vascular disease? 11:35:22

21 A. Yes.

22 Q. How many cases of ischemic bowel
23 have you treated in your career?

24 A. I've probably had one.

25 Q. And is that because you just don't 11:35:34

1 deal much with bowel disease per se, your
2 practice is not related to treating bowel
3 disease?

11:35:36

4 A. I don't think that's a fair
5 assessment. I think this is a very rare
6 entity. You don't see very many of these
7 patients.

11:35:46

8 Q. Okay. So you are saying that the
9 disease of ischemic bowel is a rare disease?

10 A. Very unusual, yes.

11:35:58

11 Q. Am I incorrect in saying that the
12 majority of your medical practice does not
13 involved surgical treatment of the intestines?

14 A. Well, as I said, up to eight years
15 ago I was doing 70 to 80 percent general
16 surgery which involved the intestines. Even
17 today with the hernia practice we do hiatal
18 hernias, intestinal hernias. I do gastric
19 stapling for morbid obesity. It's still quite
20 heavily in the bowels.

11:36:16

11:36:32

21 Q. When was the last time you did a
22 bowel resection?

23 A. I just about did one a couple of
24 days ago with ischemic bowel.

25 Q. So you didn't actually do it?

11:36:42

1 A. No.

11:36:44

2 Q. When is the last time you did a
3 bowel resection?

4 A. I'd say probably about six, eight
5 months ago.

11:36:50

6 Q. What is the basis for your
7 statement unfortunately in most cases the
8 diagnosis is made far too late at surgical
9 exploration or autopsy?

10 A. Because it's an exclusionary
11 diagnosis. When the patient presents with
12 symptoms it's an ongoing entity so that you
13 already have the necrosis and very often you'll
14 make the diagnosis only at autopsy or at actual
15 surgical exploration when you have ruled out
16 the other entities.

11:37:06

11:37:18

17 Q. Is that by virtue of your
18 experience? Is that what you're using to make
19 that statement?

20 A. No.

11:37:26

21 Q. Is there some text that you are
22 relying on, some article?

23 A. Just general medical knowledge.

24 Q. Is it also your general medical
25 knowledge that ischemic bowel is a very rare

11:37:36

1 disease?

11:37:42

2 A. It's a very unusual disease, yes.

3 Q. Now, the extensive vascular disease
4 that Mr. Slusher had started where and stopped
5 where?

11:38:00

6 A. I'm not sure I understand your
7 question.

8 Q. Okay. In your report you wrote
9 this young man had extensive vascular disease.
10 Where?

11:38:12

11 A. We know that there is evidence that
12 there was 90 percent of occlusion of his left
13 carotid. He had very extensive disease in the
14 aorta. I don't doubt that he had extensive
15 disease elsewhere, too.

11:38:24

16 Q. And he would have been expected to
17 have some vascular disease involving his
18 mesenteric vessels, that is your opinion, is it
19 not?

20 MR. TORGERSON: Objection.

11:38:34

21 A. It would be most likely, yes.

22 Q. All right. When we say mesenteric
23 vessels, we're talking about the superior and
24 inferior mesentery arteries?

25 A. Right.

11:38:44

1 Q. Prior to the time, you may not want 11:38:50
2 to answer this because it may be a question
3 that you believe is in vascular medicine, but
4 prior to the time of doing an ABF surgical
5 procedure would you want to workup and see the 11:39:02
6 condition of his superior mesenteric artery?

7 MR. TORGERSON: Objection.

8 A. That's not my area of expertise.

9 Q. Is a distended abdomen considered
10 an abnormal finding? 11:39:40

11 A. Under what circumstances?

12 Q. Under the circumstances of
13 Mr. Slusher's readmission to Geauga on 9/9/95.

14 A. No.

15 Q. What is tympanic, T Y M P A N I C? 11:39:50

16 A. Tympanic.

17 Q. What does that mean, sir?

18 A. When you percuss the abdomen you
19 get kind of a drum sound. It's called a
20 tomomatic sound. 11:40:14

21 Q. What does that tell you as a
22 general surgeon?

23 A. Virtually nothing.

24 Q. Is a tender abdomen an abnormal
25 finding? 11:40:26

1 A. Under what circumstances? 11:40:26

2 Q. All of these questions are under
3 the circumstances of Mr. Slusher's readmission
4 on 9/9/95 to Geauga.

5 A. Well, if we're dealing with a 11:40:34
6 patient four days after having a large incision
7 in the abdomen for aortic surgery it's not an
8 unusual finding, no.

9 Q. If you suspect mesenteric ischemia,
10 is the gold standard test to diagnose it by 11:41:28
11 angiogram study?

12 A. Yes.

13 Q. Do you have any opinion as to what
14 the treatment is for acute mesenteric ischemia?

15 A. No. 11:41:42

16 Q. Is treating acute mesenteric
17 ischemia in the scope of what a general surgeon
18 does?

19 A. No. That's generally within the
20 vascular surgeon's purview. 11:41:54

21 Q. In performing elective major
22 surgery do you try to eliminate as many risks
23 as are possible?

24 A. I guess that's a fair statement.

25 Q. And part of the way to do that is 11:42:10

1 to screen patients for health conditions before 11:42:12
2 elective surgery?

3 A. We're being very general. I also
4 have a problem trying to figure out what you're
5 asking in terms of generalities. I can't 11:42:22
6 answer that.

7 Q. You can't or won't?

8 A. I can't. I mean, are we talking
9 about a 90 year old, a 20 year old? Are we
10 talking about male, female? I mean, there are 11:42:36
11 so many variables there it's hard to give you a
12 blanket answer.

13 Q. Is there ever a time, whether it's
14 any of the people that you have mentioned, that
15 you would want to perform elective surgery 11:42:46
16 without trying to screen the patient for their
17 health history?

18 A. You know, if I'm removing a cyst or
19 doing a lymph node, I'm not sure it's so
20 critical. 11:42:58

21 Q. How about if it's a major abdominal
22 surgery that is being done?

23 A. Sure. You are going to want to
24 know what the background history is. Are they
25 bleeders? Any medication problems? So on. I 11:43:06

1 don't think that's really what you are asking. 11:43:08

2 Q. That's exactly what I'm asking and
3 so that there is no misunderstanding I'll ask
4 it again on the record.

5 If you were performing a major 11:43:16
6 abdominal elective surgery would you want to
7 screen the patient and obtain what their health
8 history is?

9 MR. TORGERSON: Note an objection.
10 Go ahead. 11:43:28

11 A. I mean it's part and parcel of
12 obtaining a history and physical on a patient
13 when you see them.

14 Q. So that would be something that you
15 would do in the course of your practice? 11:43:34

16 A. Yes.

17 MR. TORGERSON: Objection.

18 Q. Can ileus be a sign of bowel
19 ischemia?

20 A. It can be. 11:43:56

21 Q. Do you agree that intestinal
22 ischemia requires its own diagnosis and plan of
23 treatment?

24 A. I'm sorry. Could you repeat that?

25 Q. Certainly. 11:44:10

1 MR. MARGOLIS: Read it back.

11:44:10

2 (Record read.)

3 A. I'm really not sure I understand
4 the question.

5 Q. In treating intestinal ischemia, is
6 there a specific type of treatment that should
7 be utilized or do you diagnose it and just slow
8 it up to a point and see what happens with the
9 patient?

11:44:28

10 MR. TORGERSON: Note an objection.

11:44:42

11 Go ahead.

12 A. It depends on the degree of
13 ischemia you have, the symptomatology
14 associated with it. There are medical
15 treatments. There are surgical treatments.
16 It's just not an area that I'm an expert in or
17 necessarily practice in.

11:44:56

18 Q. Intestinal ischemia?

19 A. Correct.

20 Q. Do you agree with the statement
21 that the diagnosis of acute mesenteric ischemia
22 before the bowel becomes perforated is the most
23 important factor in improving a patient's
24 survivability suffering from that disease?

11:45:22

25 A. That's correct.

11:45:38

1 Q. Is there any Plaintiff's attorney 11:45:48
2 whose name you could provide me that you have
3 reviewed a case for and given an opinion that
4 there was malpractice?

5 A. Paul Kaufman. And I think Howard 11:46:00
6 Mishkind is another name that comes to mind.

7 Q. Do you agree that if the doctor's
8 negligence in the treatment of a patient causes
9 the patient harm that the doctor should be held
10 responsible for that harm? 11:46:28

11 A. Definitely.

12 Q. Sir, I'm going to ask you some
13 questions about these records. If you want to
14 try to locate them in your records, you are
15 certainly welcome to. But in an attempt to try 11:46:46
16 to expedite things I did put them in the record
17 that I'm going to be reading off of.

18 A. That's perfect.

19 Q. Okay. 8/2/95 Mr. Slusher underwent
20 an angiogram and in his history and physical 11:46:58
21 for that angiogram indicated under past history
22 paragraph two that he had poor appetite and
23 lost 15 pounds in one year.

24 Are those symptoms in and of
25 themselves representative of mesenteric 11:47:16

1 ischemia of the bowel?

11:47:26

2 A. Absolutely not.

3 Q. Are they representative of any
4 mesenteric issues involving the bowel?

5 A. No.

11:47:32

6 Q. And then on the third page which
7 appears to be the nurse's evaluation of him
8 admitted on 9/5/95 when he went in for surgery
9 it indicates diminished appetite?

10 MR. TORGERSON: Wait a minute.

11:47:54

11 When he actually went in on 9/5?

12 MR. MARGOLIS: Yeah.

13 Q. Patient's admission history and
14 assessment, Geauga, 9/5/95. It says diminished
15 appetite. Develops burning pain after eating.
16 Weight loss, 15 pounds in one year.

11:48:06

17 Is that symptoms of any type of
18 mesenteric ischemia?

19 A. No.

20 Q. What was the cause of the diarrhea
21 that Mr. Slusher was suffering from in the
22 hospital from 9/5 through his discharge 9/9?

11:48:28

23 A. Probably nonspecific.

24 Q. Is diarrhea in and of itself a
25 symptom of mesenteric ischemia in its early

11:48:46

1	stage?	11:48:50
2	A. No.	
3	Q. If you would look at -- if you	
4	could look at this page. It says critical flow	
5	sheet.	11:49:00
6	A. I've got it.	
7	Q. If you would turn one more page	
8	over. CK stands for creatine kinase?	
9	A. Kinase.	
10	MS. ATWELL: What date?	11:49:16
11	MR. MARGOLIS: That is 9/6/95.	
12	Q. And creatine kinase, as I	
13	understand it, is an enzyme secreted by a	
14	muscle, is that accurate?	
15	A. Yes.	
16	Q. With mesenteric ischemia will the	
17	CK level be elevated?	
18	A. I don't know.	
19	Q. If you would look, sir, at this one	
20	page in the packet, sir, that starts off with	11:50:00
21	Geauga Hospital admission note 9/9/95. Do you	
22	see that? It probably would be the second	
23	packet in.	
24	A. I've got it.	
25	Q. Okay. If we could please turn in	11:50:12

1 to the lab of 9/9/95 which would have been
2 taken when he was admitted to the emergency
3 room. Do you see that?

4 A. I've got it.

5 Q. Okay.

6 MR. TORGERSON: Is this just a
7 group of stuff that you put together taking
8 them out from each admission?

9 MR. MARGOLIS: Yes.

10 MR. TORGERSON: All right.

11 Q. The CK level at that point is 383.
12 Is that a significant finding based upon his
13 overall health picture that he presented to the
14 E.R. on 9/9/95?

15 A. Frankly, it's an isolated increase.
16 I'm not sure what to make of that.

17 Q. Is that an increase that would be
18 consistent with mesenteric ischemia?

19 A. I'm not sure of the answer to that.

20 Q. Is there any significance to that
21 increase from 9/6/95 of 231 to 9/9/95 of 383?

22 A. Well, it does show an increase, but
23 the upper limits of normal are 228. So the 231
24 at the initial level is just about in the realm
25 of normal.

1 Q. What about the 383?

11:51:38

2 A. This is certainly elevated, but it
3 looks like an isolated elevation. I would
4 expect with mesenteric ischemia to see a marked
5 elevation of LDH and other enzymes.

11:51:46

6 Q. Lastly, doctor, if would you turn
7 to page -- go to the CK level of 9/11 which is
8 1,972. Would that be a finding that would be
9 consistent with mesenteric ischemia?

10 A. Again, I'm not sure of the relation
11 of an isolated CK increase to mesenteric
12 ischemia.

11:52:04

13 Q. Do you have any opinion, sir, as to
14 why it increased on 9/9 from 383 to 9/11 to
15 1,972?

11:52:20

16 A. If he's getting intramuscular shots
17 of medication it can cause that. Muscle
18 necrosis or ischemia just from nonuse.

19 Q. Wouldn't there --

20 A. Bumping your muscles into
21 everything from your guardrails to whatever
22 else can cause an increase in your CK.

11:52:32

23 Q. Wouldn't there be an elevation of
24 CK once the bowel starts to be deprived of
25 blood?

11:52:48

1 A. I really would anticipate finding a
2 much greater level of other enzymes.

11:52:50

3 Q. Okay. But my question is
4 pertaining to CK.

5 A. I can't comment on an isolated
6 increase of CK. I don't know.

11:53:00

7 Q. Okay. And then, sir, if you could
8 please go to this packet that starts 9/9/95
9 with it looks like Dr. DiBlasio's admit note.

10 What is the significance -- and,
11 doctor, all of the questions that I'm asking
12 you now are in the context of Mr. Slusher.

11:53:24

13 A. Okay.

14 Q. Okay. What is the significance of
15 the high output from the NG tube that occurred
16 when he was brought into the emergency room on
17 9/9/95?

11:53:34

18 A. Let me see. He has nonfunctioning
19 bowel. It's backing up.

20 Q. Are three liters of fluid, is that
21 a lot of fluid?

11:53:48

22 A. It can be.

23 Q. What is -- can you tell me, and I
24 apologize for my ignorance, what a liter is in
25 ounces?

11:53:58

1 A. I was afraid you were going to ask
2 that. There is 30 ml's to an ounce. So that's
3 roughly about 33 ounces.

11:54:00

4 Q. Okay. Doesn't Dr. DiBlasio
5 conclude that there was guarding in his abdomen
6 when he indicates his abdomen is slightly
7 distended and somewhat firm although he is
8 guarding?

11:54:18

9 A. The guarding that I'm familiar with
10 is where a physician feels the abdomen and
11 calling it frank guarding is not talking
12 distension. If I poke your belly hard enough,
13 as I'm pressing it, you will guard a little bit
14 too. But that's not guarding they're talking
15 about.

11:54:32

11:54:46

16 Q. The guarding that you are referring
17 to that is noted in the chart is frank guarding
18 or is it just guarding?

19 A. This does not give me the
20 perception of true guarding.

11:54:58

21 Q. And my question is, you know, as a
22 general surgeon when you see that there is an
23 abdomen that you would characterize as
24 guarding, how do you indicate that in your
25 chart?

11:55:12

1 A. Diffusely guarding. Rigid. This 11:55:14
2 sounds more like in the area that he's pressing
3 there is some localized guarding. You'll also
4 note that there is active bowel sounds.

5 Q. That are reduced. 11:55:28

6 A. Yes. But nonetheless still bowel
7 sounds. That means it's an active, viable
8 bowel.

9 Q. Do you know whether in
10 Dr. DiBlasio's deposition it indicated if there 11:55:37
11 was any guarding of the bowel in the 9/9/95
12 evaluation he did in the ER?

13 A. I don't recall specifically.

14 Q. What would have been the
15 appropriate window of time for Dr. DiBlasio to 11:56:00
16 wait to do an upper endoscopy under these
17 circumstances?

18 A. An upper endoscopy?

19 Q. I believe that's what he says or
20 maybe I'm wrong. I apologize. It says at some 11:56:16
21 point we may need to evaluate the upper GI
22 tract with endoscope. I'm interpreting that to
23 mean an upper GI endoscopy. Maybe I'm wrong.

24 A. He also goes on to note -- in fact,
25 the flavor of his deposition seemed to indicate 11:56:30

1 somewhat different, but it also says, following
2 what you said, the possibility of a small bowel
3 follow through contrast study of the GI tract
4 will also need to be done. He's thinking
5 globally of just investigating the bowel.

11:56:34

11:56:44

6 Q. What period of time do you believe
7 is appropriate to wait under these
8 circumstances until these tests are done?

9 A. Given the patient who comes in with
10 these kinds of signs and symptoms, you have to
11 recognize that you are dealing with potentially
12 a dangerous neurologic problem. That's not the
13 patient you want down in x-ray waiting for some
14 barium to be put in or left in a corridor
15 somewhere which is pretty standard waiting for
16 some further testing. So this is the kind of
17 patient you kind of have to sit on for a while.

11:56:56

11:57:08

18 Q. But, doctor, Dr. Crosby the
19 emergency room doctor indicated that by the
20 time Dr. DiBlasio arrived that the patient had
21 essentially completely recovered from his
22 stroke and his only ongoing problem was his
23 abdomen. So where is this neurological problem
24 that you have described?

11:57:24

25 A. That's what he came in with, with

11:57:42

1 paresis of the right side.

11:57:4

2 Q. But you'll with agree me, won't
3 you, that when Dr. DiBlasio arrived, that his
4 stroke had resolved and the only remaining
5 problem was his abdomen, that's what the doctor
6 noted in his chart?

11:57:54

7 A. But that does not preclude the next
8 bout being a permanent episode.

9 Q. So do you wait to work up the
10 abdomen issue out of concern that there may be
11 a next bout of neurological issues?

11:58:0

12 A. Yes.

13 Q. Okay. How long do you wait?

14 A. Get a neurologist and have him
15 determine what the underlying process is. Once
16 you feel comfortable that you are not
17 jeopardizing the patient you can proceed with a
18 work up.

11:58:1

19 Q. And --

20 A. Recognizing again that we don't
21 have an acute abdomen.

11:58:22

22 Q. Okay. Any significance to his
23 white count being elevated on admission of
24 9/9/95?

25 A. I think it was barely elevated, if

11:58:48

1 I recall. I think it was 12,800. The realm
2 of normal is somewhere around 12,000. That's
3 not anything to get excited about.

4 Q. But despite that fact
5 Dr. DiBlasio assumed care of this patient after
6 his 9/9/95 readmission to Geauga?

7 A. It sounds like by process of
8 elimination he was there.

9 Q. Does it cause you concern as a
10 general surgeon when there is such a large
11 amount of fluid that comes out of an NG tube
12 such as three liters?

13 A. Not really. I have had had
14 substantially more than that in some patients.

15 Q. And I guess the reason for that is
16 that whatever the contents are that are in the
17 stomach, they are not moving their way through
18 the bowels, is that correct?

19 A. Correct.

20 Q. What is hypovolemia?

21 A. It's low volume fluid in the
22 vasculature.

23 Q. Is there any significance to you as
24 a general surgeon as to what the color is of
25 the fluid that comes back out of the NG tube?

1 And, you know, I'm not trying to dance with you 12:00:18
2 here. If you want to look at page four it
3 looks like it says 2100 c.c.'s dark slash green
4 liquid.

5 A. It's bile that you are describing. 12:00:34

6 Q. Okay. Is bile normally a substance
7 that is in the stomach?

8 A. Yes.

9 Q. And the fact that that would be
10 coming out of an NG tube, why would that occur? 12:00:46

11 A. The patient probably has an ileus.
12 Fluid is just not being propagated. You still
13 have a lot of gastric juice being put out,
14 bile. Pancreatic fluid is all backed up in the
15 NG tube. 12:01:02

16 Q. Because the bowels are not working?

17 A. Right.

18 Q. Is it any significance to you if
19 during his time in the emergency room that
20 there were no bowel sounds heard in his left 12:01:14
21 lower quadrant, left upper quadrant?

22 A. I think in retrospect that goes
23 along with the fact that that patient most
24 likely had an acute mesenteric insult and
25 that's the repercussion. 12:01:28

1 Q. If the patient has an acute 12:01:30
2 mesenteric insult, what is indicated medically
3 in following up on that acute mesenteric
4 insult?

5 A. You know, in honesty, in most cases 12:01:40
6 you are not going to make that diagnosis at the
7 appropriate time. In most of those situations
8 It becomes a diagnosis of exclusion. So I
9 think your questioning is somewhat unfair
10 unless you know ahead of time that that patient 12:01:54
11 specifically has that particular problem.

12 Q. What about if you know ahead of
13 time that the patient had postprandial pain,
14 the patient had weight loss for a year, that
15 the patient underwent a major abdominal surgery 12:02:08
16 and that the patient has, to quote your report,
17 extensive vascular disease that would have been
18 expected to have some involvement of his
19 mesenteric vessels?

20 A. The symptoms you have described fit 12:02:34
21 very much for a patient with a chronic ulcer
22 disease. Reflux esophagitis. Biliary
23 dysfunction. Adhesions. Intestinal
24 herniations. I could go on probably for
25 another 20 minutes rattling off diagnostics. 12:02:46

1 Q. Would any of those diagnostics 12:02:52
2 include mesenteric ischemia?

3 A. Probably way down on the list at
4 the very bottom.

5 Q. Even with the information that I 12:02:58
6 asked you to assume in my question?

7 A. Absolutely.

8 Q. Even knowing that he has extensive
9 vascular disease which you would have expected
10 to effect the mesenteric vessels? 12:03:01

11 A. Correct. Because we know also at
12 University Hospitals when the patient came in
13 they had the same information that was
14 available at Geauga Community.

15 Q. Well, when the patient came into UH 12:03:2
16 he was having more neuro problems, was he not?

17 A. Correct. But at the time there was
18 still the history of the weight loss,
19 postprandial pain, recent femoral surgery. It
20 still was very much a diagnosis of exclusion. 12:03:36

21 Q. Is a tense abdomen an abnormal
22 finding?

23 A. Again, I apologize. Are we
24 referencing just this admission on the 9th?

25 Q. Yes, sir. If you would look please 12:03:56

1 to this physical examination of doctor, it 12:03:58
2 looks like Audi. He indicates the abdomen is
3 tense. There is mild tenderness in the right
4 upper quadrant. Bowel sounds are present but
5 hypoactive. 12:04:10

6 A. What that suggests is an ileus.

7 Q. Couldn't one of the causes of ileus
8 be ischemia?

9 A. It can.

10 Q. Could you please be kind enough, 12:04:30
11 sir, to locate the 9/14 x-ray report in your
12 records from UH?

13 A. Okay.

14 Q. Can I see it, please? Thank you.

15 And the distinction that you are drawing 12:05:48
16 between the 9/14/95 x-ray report and this
17 9/9/95 x-ray report pertaining to the free air
18 is what?

19 A. I think if I may read directly from
20 the report of 9/14/95. 12:06:48

21 Q. Yes, sir.

22 A. In the area under recumbent
23 portable chest it says there is a lucency that
24 suggests air in the peritoneal cavity.

25 Following paragraph, there is evidence of 12:07:04

1 significant distension of a loop of small bowel 12:07:10
2 in the left upper quadrant. Under impression
3 it says free air. I'm told this has been
4 communicated to Dr. May. The floor was also
5 called. Radiologists do not do that unless 12:07:24
6 there is an acute emergency.

7 Q. How does that differ from the
8 9/9/95 film that indicates severe to moderate
9 dilation of multiple loops of small bowel, lack
10 of chronic extension, suggests bowel 12:07:42
11 obstruction but the nondifferential air fluid
12 levels in the small bowel seen on cross-table
13 lateral suggests postop ileus. I guess is the
14 air in a different place in the abdominal
15 cavity? 12:07:58

16 A. It is, because now we're quite a
17 bit further out from the surgery time. The
18 surgery on the fifth. Now we're about ten days
19 past the day of surgery. But the real
20 difference here is that they are talking about 12:08:08
21 a significant distension of a loop of small
22 bowel. We're not talking about a diffuse
23 process anymore. If you'll read the previous
24 KUBs that were done throughout the stay at
25 University Hospitals there is a marked 12:08:22

1 difference from this last report to the
2 interpretation of the previous report.

12:08:22

3 Q. Okay. Is the air though in a
4 different part of the abdominal cavity?

5 A. I think it's more localized at this
6 point which suggests that there is a localized
7 perforation.

12:08:30

8 Q. Okay. Doctor, are you one of the
9 general surgeons that are on call to
10 emergencies?

12:08:42

11 A. Yes.

12 Q. And approximately how often do you
13 get called in as a general surgeon on call?

14 A. Too often.

15 Q. Are we talking a couple of times a
16 month?

12:08:50

17 A. Usually we'll take about a week a
18 month.

19 Q. Do you have any patients that are
20 presently in the hospital now under your care?

12:08:56

21 A. No.

22 Q. When was the last time that you
23 operated at Hillcrest Hospital?

24 A. What's today? Friday.

25 Q. Do you still perform surgery out of

12:09:06

1 your location here?

12:09:1

2 A. No.

3 Q. Did you at one time?

4 A. No just minor stuff.

5 MR. MARGOLIS: Okay. If either
6 counsel want to ask questions, I know that we
7 are under a 1:00 deadline here. Please feel
8 free to do so as I'm reviewing the notes.

12:09:16

9 MR. TORGERSON: I have no
10 questions.

12:09:3

11 MS. ATWELL: I have no questions.

12 Q. How long would it have been in your
13 opinion appropriate for Dr. DiBlasio after
14 9/9/95 to have waited for return of bowel
15 function?

12:10:1

16 A. Generally as long as it takes to
17 attain that. It could be one day. It could be
18 a week or more.

19 Q. Is there a point in time where
20 bowel function does not return that you deem it
21 appropriate to do something other than wait
22 under the circumstances of Mr. Slusher?

12:10:26

23 A. Thank you for qualifying that. I
24 think the real issue again is are there other
25 signs being demonstrate that alter your

12:10:40

1 diagnostic plan. If the patient develops
2 guarding or rebounding or evidence of acute
3 abdomen, obviously you no longer wait.
4 Otherwise, if the patient is stable,
5 demonstrating good vital signs, so on, we just
6 monitor the patient and wait for the bowel
7 function to return. It can take weeks.

12:10:44

12:10:52

8 Q. How does one differentiate between
9 a diagnosis of bowel obstruction or ileus?

10 A. It's a very difficult diagnosis to
11 make. You go by clinical patterns. If there
12 is air in the colon, for example, beyond that
13 point in the small bowel, it suggests there is
14 a mechanical obstruction. If it's just
15 diffused involvement then it's suggestive more
16 of ileus, but very often it's a clinical
17 differentiation.

12:11:16

12:11:28

18 Q. And how is the clinical
19 differentiation made?

20 A. Partly by the history of the
21 previous surgery. Partly of the patient having
22 recent surgery. If you had surgery five years
23 ago and you come in with evidence of dilated
24 bowel, it would be more likely to be
25 obstruction. If you recently had surgery the

12:11:40

12:11:52

1 most likely diagnosis would be ileus.

12:11:54

2 Q. As you reviewed these, as you have
3 reviewed these records, do you have any -- does
4 anything pop out to you as it pertains to the
5 care Dr. Darvin provided this patient?

12:12:18

6 MR. TORGERSON: Note an objection.

7 A. In terms of the quality of his
8 care?

9 Q. Yes.

10 A. Again, I'm not a vascular surgeon,
11 so I can't put a comment on his performance.

12:12:28

12 MR. TORGERSON: Objection.

13 Q. What about his -- you have
14 performed intestinal surgery on patients and
15 followed them up postop, have you not?

12:12:38

16 A. Yes.

17 Q. Do you have any comments about
18 Dr. Darvin's follow-up postsurgical care of
19 this patient.

20 MR. TORGERSON: Objection.

12:12:46

21 A. In terms of?

22 Q. Of the care that he provided the
23 patient?

24 MR. TORGERSON: Objection.

25 A. I don't have any specific

12:12:56

1 complaints. The only obvious issues would be 12:12:56
2 diagnosing this patient after surgery with any
3 ongoing problems.

4 Q. Doctor, do you have any comments
5 about the preoperative workup that Dr. Darvin 12:13:08
6 performed on this patient?

7 MR. TORGERSON: Objection.

8 A. Again, I'm not a vascular surgeon,
9 so I can't comment on that.

10 Q. Thank you very much for your time. 12:13:18

11 A. Thank you.

12 MR. TORGERSON: Once again, I have
13 no questions.

14 MR. VAN WAGNER: We'll read it.

15

16 (Deposition concluded.)

17

- - - - -

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CERTIFICATE

The State of Ohio,)

SS:

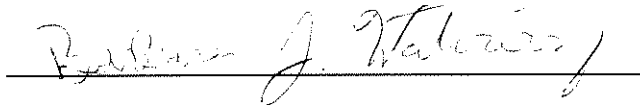
County of Cuyahoga.)

I, Barbara J. Watowicz, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named witness, DAVID GRISCHKAN, 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 the above-referenced witness was by me reduced to stenotypy in the presence of said witness; afterwards transcribed, and that the foregoing is a true and correct transcription of the testimony so given by the above-referenced witness.

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

1 I do further certify that I am not
2 a relative, counsel or attorney for either
3 party, or otherwise interested in the event of
4 this action.

5 IN WITNESS WHEREOF, I have hereunto
6 set my hand and affixed my seal of office at
7 Cleveland, Ohio, on this 5 day of
8 June, 2000.

9
10
11
12
13 

14 Barbara J. Watowicz, Notary Public
15 within and for the State of Ohio
16

17 My commission expires March 20, 2002.
18
19
20
21
22
23
24
25

I N D E X

EXAMINATION OF DAVID GRISCHKAN, M.D.

BY MR. MARGOLIS..... 4:6

SIGNATURE OF WITNESS

The deposition of DAVID GRISCHKAN,
MD, taken in the matter, on the date, and at
the time and place set out on the title page
hereof.

It was requested that the
deposition be taken by the reporter and that
same be reduced to typewritten form.

It was agreed by and between
counsel and the parties that the Deponent will
read and sign the transcript of said
deposition.

AFFIDAVIT

The State of Ohio,)

) SS:

County of Cuyahoga)

Before me, a Notary Public in and for
said County and State, personally appeared
DAVID GRISCHKAN, MD, who acknowledged that
he/she did read his/her transcript in the
above-captioned matter, listed any necessary
corrections on the accompanying errata sheet,
and did sign the foregoing sworn statement and
that the same is his/her free act and deed.

In the TESTIMONY WHEREOF, I have hereunto
affixed my name and official seal at this _____
day of _____ A.D 2000.

Notary Public

My Commission Expires:

DEPOSITION ERRATA SHEET

RE: PATRICIA M. FLETCHER, ETC. VS.
GEAUGA HOSPITAL ASSOC., INC., ET AL

RRS File No.: 1037

Deponent: DAVID GRISCHKAN, MD

Deposition Date: JUNE 1, 2000

To the Reporter:

I have read the entire transcript of my
Deposition taken in the captioned matter or the
same has been read to me. I request that the
following changes be entered upon the record
for the reasons indicated. I have signed my
name to the Errata Sheet and the appropriate
Certificate and authorize you to attach both to
the original transcript.

<p>A</p> <p>abdomen 19:4,6 19:16,19 28:20 28:23 29:4 31:21 32:16 37:9,18,24 38:7 48:5,6,10 48:23 50:23 51:5 51:10,21 55:21 56:2 60:3</p> <p>abdominal 6:12 13:22 14:2 15:23 17:20 27:24 28:1 28:12,13,25 29:8 39:21 40:6 54:15 57:14 58:4</p> <p>ABF 37:4</p> <p>able 20:22 29:14 29:21 30:7 33:1</p> <p>abnormal 37:10 37:24 55:21</p> <p>about 5:3,22 10:8 10:16 12:14,15 13:15 15:25 17:17,18 18:1 22:25 24:20 25:22 26:5 32:18 33:3,14 34:23 35:4 36:23 39:9 39:10,21 42:13 45:24 46:1 48:3 48:15 52:3 54:12 57:18,20,22 58:17 61:13,17 62:5</p> <p>above-captioned 67:12</p> <p>above-referenced 63:13,18</p> <p>Absence 29:12</p> <p>Absolutely 43:2 55:7</p> <p>accompanying 67:13</p> <p>accurate 9:18,22 44:14</p> <p>acknowledged 67:10</p> <p>across 31:11</p> <p>act 67:15</p> <p>action 64:4</p> <p>active 49:4,7</p> <p>actual 35:14</p> <p>actually 19:9 20:5 34:25 43:11</p> <p>acute 4:23 5:6,17 6:5,9 15:10,15</p>	<p>15:24 20:20 21:3 28:13,22 29:4,5 29:8 38:14,16 41:21 51:21 53:24 54:1,3 57:6 60:2</p> <p>Additionally 15:18</p> <p>adhesions 33:7 54:23</p> <p>adjournment 63:22</p> <p>Administratrix 1:6</p> <p>admission 15:11 15:24 43:13 44:21 45:8 51:23 55:24</p> <p>admit 47:9</p> <p>admitted 16:16 43:8 45:2</p> <p>admitting 22:20</p> <p>AFFIDAVIT 67:1</p> <p>affixed 64:6 67:17</p> <p>aforesaid 63:12</p> <p>afraid 5:8 48:1</p> <p>after 12:5 16:1 29:18 38:6 43:15 52:5 59:13 62:2</p> <p>afterwards 63:15</p> <p>again 6:21 20:23 29:3 30:12 33:10 40:4 46:10 51:20 55:23 59:24 61:10 62:8,12</p> <p>against 25:4</p> <p>age 4:1 10:24</p> <p>ago 34:15,24 35:5 60:23</p> <p>agree 4:24 7:24 8:11 14:15,16 40:21 41:20 42:7 51:2</p> <p>agreed 66:13</p> <p>ahead 9:15 10:4 11:6 17:25 19:17 28:5 40:10 41:11 54:10,12</p> <p>air 19:3,6,20,25 20:5 21:16 56:17 56:24 57:3,11,14 58:3 60:12</p> <p>al 1:12 68:4</p> <p>along 27:12 53:23</p> <p>already 35:13</p> <p>alter 59:25</p> <p>although 48:7</p> <p>amount 23:12</p>	<p>52:11</p> <p>angiogram 11:22 38:11 42:20,21</p> <p>another 21:21 42:6 54:25</p> <p>answer 6:2 7:22 8:22 10:15,15,17 12:6 24:13 29:16 31:11 37:2 39:6 39:12 45:19</p> <p>anticipate 47:1</p> <p>anymore 57:23</p> <p>anything 6:11 21:12 30:14 52:3 61:4</p> <p>anywhere 16:25</p> <p>aorta 36:14</p> <p>aortic 9:6 29:18 30:3 38:7</p> <p>apologize 20:19 47:24 49:20 55:23</p> <p>apparently 17:13</p> <p>APPEARANCES 2:1 3:1</p> <p>appeared 67:9</p> <p>appears 43:7</p> <p>appendix 23:5</p> <p>appetite 29:19 42:22 43:9,15</p> <p>appropriate 21:8 49:15 50:7 54:7 59:13,21 68:15</p> <p>approximately 24:10 26:15 58:12</p> <p>area 15:2 24:12 37:8 41:16 49:2 56:22</p> <p>around 23:8 52:2</p> <p>arrived 17:17 26:21 50:20 51:3</p> <p>arteries 14:17 36:24</p> <p>artery 37:6</p> <p>article 35:22</p> <p>asked 5:8 10:18 20:19 22:1,16 28:11 55:6</p> <p>asking 5:7,10 14:1 14:22 15:1 39:5 40:1,2 47:11</p> <p>assessment 34:5 43:14</p> <p>ASSOC 1:11 68:4</p> <p>associated 12:12</p>	<p>41:14</p> <p>assume 55:6</p> <p>assumed 52:5</p> <p>atherosclerotic 8:1,6,10 9:5 32:3</p> <p>atrial 15:19 16:2</p> <p>attach 14:11 30:10 68:16</p> <p>attain 59:17</p> <p>attempt 42:15</p> <p>attorney 42:1 64:2</p> <p>ATWELL 3:16 44:10 59:11</p> <p>Audi 56:2</p> <p>authored 4:12 27:4</p> <p>authoritative 31:14</p> <p>authorize 68:16</p> <p>autopsy 35:9,14</p> <p>available 55:14</p> <p>Avenue 2:7</p> <p>aware 16:21</p> <p>A.D 67:18</p> <p>a.m 1:23</p> <p>B</p> <p>back 10:20 24:4 31:1 33:15 41:1 52:25</p> <p>backed 53:14</p> <p>background 22:5 32:7 39:24</p> <p>backing 47:19</p> <p>Barbara 1:18 63:6 64:14</p> <p>barely 51:25</p> <p>barium 50:14</p> <p>based 5:2 16:5 21:1 45:12</p> <p>Basically 28:15</p> <p>basis 24:19 35:6</p> <p>Beachwood 1:22</p> <p>become 7:19 14:18</p> <p>becomes 41:22 54:8</p> <p>before 1:18 8:5,11 11:12 14:18 20:20 39:1 41:22 67:8</p> <p>behalf 2:3,11 3:3 3:13 23:25 24:6 24:21</p> <p>being 4:3 17:20 39:3,22 51:8,23</p>	<p>53:12,13 59:25</p> <p>believe 7:18 13:4 27:6 37:3 49:19 50:6</p> <p>belly 48:12</p> <p>Berne 2:13 26:12</p> <p>better 10:7 13:6</p> <p>between 7:6 9:12 15:12 56:16 60:8 66:13</p> <p>beyond 60:12</p> <p>bile 53:5,6,14</p> <p>Biliary 54:22</p> <p>birth 23:22</p> <p>bit 5:22 17:25 22:4 48:13 57:17</p> <p>Blackburn 3:14</p> <p>blanket 39:12</p> <p>bleeders 39:25</p> <p>bleeding 30:10</p> <p>blood 6:2,18 7:14 9:13 32:5,6 46:25</p> <p>both 21:7 68:16</p> <p>bottom 55:4</p> <p>bout 51:8,11</p> <p>bowel 5:15 6:3,13 7:5,10,12,13,15 7:18 9:13 13:1,8 21:17 23:3,3,13 23:17 29:12 32:24 33:9,22 34:1,2,9,22,24 35:3,25 40:18 41:22 43:1,4 46:24 47:19 49:4 49:6,8,11 50:2,5 53:20 56:4 57:1 57:9,10,12,22 59:14,20 60:6,9 60:13,24</p> <p>bowels 34:20 52:18 53:16</p> <p>Bradley 3:14</p> <p>breasts 23:5</p> <p>bringing 24:1</p> <p>brings 22:18</p> <p>broad 10:14</p> <p>brought 47:16</p> <p>Building 2:6</p> <p>Bumping 46:20</p> <p>bumps 23:6</p> <p>burning 43:15</p> <p>C</p> <p>C 37:15</p>
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