Doc. 233

The State of Ohio,)
) SS:
COUNTY OF CUYAHOGA.)

IN THE COURT OF COMMON PLEAS

DOROTHY REISIG, et al.,)
Plaintiffs,) Case No.
-vs-) 137,367
JOHN J. KRALIK, M.D., et al.,)
Defendants.)

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Deposition of DR. TERRY A. KING, a witness herein, called by the plaintiffs as if on cross-examination under the statute, and taken before Ronald Stahl, a Notary Public within and for the State of Ohio, pursuant to the agreement of counsel and pursuant to the further stipulations of counsel herein contained, on Wednesday, the 26th day of July, 1989, at 9:00 o'clock a.m., at Mt. Sinai Medical Center, One Mt. Sinai Drive, City of Cleveland, County of Cuywhoga and the State of Ohio.

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APPEARANCES:

On behalf of the Plaintiffs:

Friedman, Domiano & Smith, by:

Joseph Domiano, Esq.

On behalf of the Defendants:

Weston, Hurd, Fallon, Paisley & Howley, by:

Donald Switzer, Esq.

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COMPUTER-AIDED TRANSCRIPTION

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P-R-O-C-E-E-D-I-N-G-S

DR. TERRY A. KING, of lawful age, a witness herein, called by the plaintiffs as if on cross-examination under the statute, having been first duly sworn, as hereinafter certified, deposes and says as f011ows:

CROSS-EXAMINATION OF DR. TERRY A. KING

BY MR. DOMIANO:

Q For the record, would you state your name and address, please?

A My name is 'Terry Alan King, M.D., and my address is Department of Surgery, Mt. Sinai Medical Center, One Mt. Sinai Drive, Cleveland, Ohio.

MR. DOMIANO: All right, sir, we are going to ask you a series of questions related to a pending case in the Court of Common Pleas of Cuyahoga County, Case No. 137,367, Dorothy Reisig, et al., versus John J. Kralik. Are you familiar, generally, with the pendency of the

case?

THE WITNESS: Yes.

MR. DOMIANO: Now, again, for the record, my name is Joseph C. Domiano. I am the attorney for the plaintiff, and I am going to ask you a series of questions about the case and about Dr. Kralik's treatment of the patient, the plaintiff, Dorothy Reisig.

If I ask you any questions you don't understand, please ask for clarification so that I can rephrase it, so that we can be certain that your answers are intelligent, reasoned answers, okay?

THE WITNESS: Yes.

MR. DOMIANO: Mr. Switzer, are there any objections of any kind to the taking of the deposition in terms of notice or service?

MR. SWITZER: No.

MR. DOMIANO: Okay,

(At this time a discussion was had off the record.)

Q Now, doctor, you had submitted a curriculum vitae to Mr. Switzer who, in turn, forwarded it on to me, and I would like to ask you to take a look at this first document. We will have it marked in a minute.

Is that the report that you submitted to Mr.Switzer?

A Yes, it is.

(At this rime Plaintiffs' Exhibits 1 and 2, King, were marked by the reporter.)

Q Doctor, I am handing you what has been marked Deposition Exhibit No. 2, and that is your C.V. or curriculum vitae.

A Yes, it is.

Q Is it factual and accurate and complete?

A There are a few additions, for instance, my address is changed, my home address is changed.

Q All right.

A But nothing of significance has changed,

Q As far as your credentials?

A In terms of credentials.

Q And background and training?

A That is correct.

Q I am going to ask you some questions about the curriculum vitae.

Do you have another copy for your perusal, doctor? For the record, we would like you to tell us what your professional education and training has been despite the fact that I have a copy of your C.V. in my hands.

A Of course. My undergraduate collegiate work was done at the University of Pittsburgh, and I graduated in 1973 and proceeded directly to medical school at the University of Pittsburgh, also, and completed that degree in 1977.

At that time I took an internship and residency in general surgery at Case-Western Reserve University. I completed that five year training program in 1982 and proceeded to Chicago where I completed a one year fellowship in peripheral vascular surgery in June of 1983.

Q All right, does that round out or complete, then, your professional training?

A Yes, it does.

Q In your medical practice?

A The medical practice started, then, in July of 1983 at George Washington University where I worked at the University Hospital as well as the VA Medical Center in Washington, D.C..

In January of 1985 I switched my practice to Cleveland, Ohio where I now work at the Cleveland VA Medical Center as well as the Mt. Sinai Medical Center here.

Q All right, sir, you are on the staff, then, at both of those medical facilities?

A That is correct.

Q Wave you ever sought staff privileges and been denied in any medical facility since you have been admitted to the practice of medicine?

A No, I have not.

Q And are you board certified, doctor?

A Yes, I am. I have board

certification in general surgery as well as a certificate of special qualifications in general vascular surgery.

Q Is there anything you have to do to qualify for a certificate of special qualifications in general vascular surgery, such as training or --

A The qualifications or the eligibility includes e one year postgraduate fellowship, now termed a residency, as well as a certain case volume in vascular surgery, after completion of that training, to qualify to take the examination. They also look at some of the softer indications in terms of publications and academic interests as well.

Q Did you leave your position at George Washington University voluntarily or under other circumstances?

A Voluntarily.

Q Now, I noticed, doctor, that you are an assistant clinical professor of surgery at Case Western Reserve University.

A That is correct.

Q And is there a distinction between being an assistant clinical professor of surgery versus an assistant non-clinical professor of surgery?

A The difference between clinical and non-clinical professors varies from one university to the next. At the Case Western Reserve University it has more to do with your academic interests and research than it does other criteria,

Q Well, as a clinical professor of surgery are you or do you enjoy the same status as a classroom teacher on the faculty of the university?

A No, I do not. My teaching responsibilities in terms of my appointment including the medical students that rotate through Mt. Sinai and also, for that matter, at the VA on the surgery service.

Q All right.

A And I also teach the general surgery residents from Case Western Reserve University over at the VA Hospital.

Q That is as opposed to the classroom

teaching of medical students?

A We do have didactic classroom sessions for those students, for instance, in this room, during their rotation.

Q Tell us for the record what you mean by the term "didactic"?

A Basic science lectures, clinical lectures.

Q So, some students do attend your presentations, but you don't regularly teach, as a member of the faculty of the university, in a classroom?

A That is correct.

Q Sir, do *you* know if there is an affiliation agreement between Case Western Reserve University and Mt. Sinai?

A There is.

Q And does that affiliation agreement require that before *you* are able to be an assistant clinical professor of surgery, you must be on the staff at Mt. Sinai?

A That is not a mutual exclusive arrangement. There are other assistant clinical professors at other institutions in the City *of* Cleveland.

Q Oh, sure, but isn't that the substance of what the affiliation agreement is, you have to one position in order to have the other?

A I am not aware of that. I don't know.

Q What do you understand is the substance of the affiliation agreement between the school and Mt. Sinai?

A I am unaware of the --

Q Substance of it?

A The substance, that is, beyond the medical students' rotations.

Q I em sorry.

A I am unaware of any substance beyond the medical students' rotations through the institution as a training center or teaching center.

Q All right, sir, and you were admitted as such to active medical practice in July of '83?

A Yes.

Q Sir, do you know what I mean by the term tenure track in connection with an appointment to a school, such as Case

Western Reserve University?

A Yes, I do.

Q Are you on tenure track?

A No, I am not.

Q Is the publishing of works or treatises a requirement for your continued academic appointment?

A No, it is not.

Q Now, doctor, you gave us a list in your G.V. of some of your publications, and I noticed that you are the principal author in five of the 10 publications listed.

Do you agree?

A Yes.

Q And your participation in the other five was in what connection or capacity?

A The other publications are co-authorships, for instance, on publication No. 8 I was the senior author, so I oversaw what the other physician wrote, edited it and made it publication ready.

The other manuscripts, for instance, are such where you may write a portion of it or collate the data, and

someone else writes the prose. There are a variety of relationships to being a co-author.

Q Now, you are aware, are you not, doctor, that the defendant in this case, Dr. Kralik, performed a subclavian to subclavian bypass procedure on the patient- plaintiff, Dorothy Reisig, are you not?

A Yes, I am.

Q And during the course of that operative procedure he resected portions of both clavicles.

A That is correct.

Q You are aware of that?

A Yes.

Q You learned that by studying some of the records and charts?

A Correct.

Q Tell us, in connection with any of the publications you have listsd, have you treated or dealt with in any way, in any of those publications, the resection of portions of the clavicle in the psrformance of a subclavian to subclavian

bypass operation, such as Dottie Reisig had?

A No, I have not.

Q None of those publications deal with that?

A None of those publications relate to that procedure.

Q And not only do they not relate to the procedure, they don't relate to the removal of clavicles, do they, or the performance of such a procedure, true?

A True,

Q The subject matter covered by those publications deals with something else?

A That is correct,

Q And that is true, too, in connection with your manuscripts in progress?

A The first manuscript in progress is associated with clavicular and cervical rib programs, the management of arterial complications of thoracic outlet syndrome.

Q Do any of your manuscripts in process deal or treat with the subject of partial removal of the two clavicles in a patient that had the conditions that Dorothy

Reisig did, and where a subclavian to subclavian bypass was performed?

A No.

Q And that is true, too, in connection with the subjsct matter of your guest lectureships, isn't it?

A Correct.

Q And tell me the difference, if you would, doctor, between guest lectureships and presentations?

A Lectureships are where you are invited to speak at a group assembly of a certain element of specialists in different fields.

A presentation is a paper presented in front of a national organization, either by invitation or by competitive presentation. That is where you write a paper and based on its merits are invited to speak in front of a national audience,

Q And, again, during any or in connection with any presentations that you have listed here, the subject matter of partial clavicular resections during the

course of an elective subclavian to subclavian bypass was not treated or addressed, correct?

A That is correct.

Q Doctor, do you have a file on this case since you first became associated with it?

A Yes, I do. The records are right here.

Q We will take a look at those in a minute, but what I am interested in is what it was that you examined to form the basis of your opinion as set forth in your report marked Plaintiffs' Exhibit 1.

Would you characterize those for me?

A My initial correspondence was a letter from Mr. Switzer, and I examined a significant portion of the original hospital records.

Q Well, for clarification, there were two admissions by Dottie Reisig, the plaintiff in this case, to Marymount. One was December 3rd and the other was December 5th.

MR. DOMIANO: Off the record for a minute.

(At this time a discussion was had off the record.)

MR. DOMIANO: Back on the record.

Q When you say you looked at the significant parts of it, could you be a little more specific as to which charts you examined, if any?

A Dr. Medina's office records.

Q Okay, anything else?

A I am looking. Portions of the records from Marymount Hospital from the admission of -- I am looking for the date.

MR. SWITZER: That is December 8th.

A And the hospital records from Marymount with the admission date of 12/2/85 and discharged 12/5/85.

Q Anything else?

A That was it with regard to the hospital admissions.

Q Okay. Are there any other documents that you examined to form the basis of

your opinion in this case?

A I read the depositions of Dr. Kralik, Dr. Leonard Krajewski, K-R-A-J-E-W-S-K-I, Augusto Juguilon, J-U-G-U-I-L-O-N, and Dr. Kenneth Barron.

Q Anything else, doctor?

A I have Dr. Barron's original letter to you, and a letter from Dr. John Brems, B-R-E-M-S, to you.

Q What is the date of that letter?

A August 5, 1987.

Q Okay, anything else, doctor?

A And several office notes from Dr. Brems as well, and that is it.

MR. SWITZER: I think there are some additional records that you have, that I sent you.

THE WITNESS: Where is that?

MR. DOMIANO: Don, I would appreciate your not coaching the witness. Whatever he has got --

MR. SWITZER: I am not coaching him. I am just going to tell you when I asked him questions,

there was more detail, but that is fine, if they are not all here,

Q Is there anything else at the moment?

A Not to my recollection.

Q May I see the documents you have just been referring to as your file in this case?

A (Witness complied.)

MR. DOMIANO: I would like to have the letter from Mr. Switzer to Dr. King marked as an exhibit.

(At this time Plaintiffs' Exhibit 3, King, was marked by the reporter.)

Q Now, Dr. King, other than what has been marked as Exhibit 1, have you submitted any other reports to Mr. Switzer or anybody else in connection with this case?

A No, I have not.

Q How did you first become familiar with this case? How did it come to your attemtion?

A Mr. Switzer called me and asked me to review the chart.

Q And what was the substance of the call? I know the substance of the letter, but what was the substance of the call?

A I don't recall exactly the substance of the call. It was several months ago. Basically most calls are regarding my evailablility and time constraints personally.

Q Can you recall anything else about the first conversation you had with Mr. Switzer?

A Not at all.

Q Well, your letter to Mr. Switzer -- I am sorry, Mr. Switzer's letter to you is dated April 24th of '89.

Can you give me a time frame of the call with respect to April 24th of '89?

A No, I can't.

Q Certainly, it was prior.

A Yes.

MR. SWITZER: Do you have the whole file?

THE WITNESS: As much as I can locate.

MR. SWITZER: Because there are other letters in there.

THE WITNESS: I don't have them here.

MR. SWITZER: I have got copies of them. Do you want to see them, Joe?

MR. DOMIANO: Okay. Off the record for a minute.

(At this time a discussion was had off the record.)

MR. DOMIANO: Back on the record.

At least at this point, Dr. King, you either don't recollect any other documents, or you can't locate them at this point, which make up your file in this matter?

A Correct.

Q Okay, doctor, I am interested in your past experience in connection with reviewing, consulting, making reports, deposing and trial testimony.

Do you have such a past experience?

A Yes, I do.

Q And say in the year 1989 have you participated in any depositions as a witness either for a plaintiff or for a defendant?

A Not in 1989.

Q How about 1988?

A Yes.

Q Now, we are talking about depositions?

A Yes.

Q And how many depositions did you attend in 1988?

A I believe it was two.

Q Were *you* testifying on behalf of a doctor?

A Yes, for the defense.

Q The two depositions, did they involve a medical malpractice *claim?*

A Yes, they did.

Q And can you recall the style of the case. Jones versus Smith, or whoever the parties were?

A Are you interested in cases of plaintiff and defendant?

Q Well, I am interested in the two where you were deposed or you testified on behalf of a defendant doctor in a medical malpractice case.

A What do you wish to know?

Q I wish to know the names of the parties, if you recall.

A I don't remember the plaintiff in one of them, but the defendant was Fumich, F-U-M-I-C-H.

Q Dr. Fumich?

A Yes.

Q And do you remember the defense lawyer?

A Defense lawyer?

Q Yes, for Dr. Furnich.

A Patrick Murphy from Jacobson, Maynard, Tuschman and Kalur. Plaintiff's attorney was Mr. Heller from Nurenberg, Plevin, Heller & McCarthy.

Q And is Dr. Fumich a doctor who practices in the Cleveland or Cuyahoga County area?

A Yes.

Q In 1989, doctor, did *you* testify in

court for or against any doctor?

A No, I did not.

Q Did you testify in court under any circumstances in '89?

A No, I don't believe so.

Q Did you have occasion in '89 to review any medical reports?

A Yes.

Q In connection with litigation?

A Correct.

Q How many, do you recall?

A I generally review one to two cases per year.

Q Was the review of medical report5 done on behalf of the defendant in those case5 in '89?

A '89, yes.

Q Those two that you removed -- Strike that.

Those two that you reviewed, they were or were not medical malpractice cases?

A They were.

Q Are they the same two cases that you were deposed in, or were they something on

top of that?

A Yes, I believe they were the same two cases. I can't recall whether in '88 the one case actually came to deposition. It was a lengthy review and multiple discussions with an attorney, but I can't remember if they settled before deposition or not, but it was --

Q I didn't ask about the settlement. I am just asking --

A I am referring to whether or not I was actually deposed twice or once in '88.

Q Oh, you are not sure?

A I em not sure about the second.

Q That is a fair answer.

A So, it was two cases in '88, both for the defense, one deposition for sure, and one probable, but significant involvement nonetheless.

Q And the second case, perhaps the first one, for sure, that you were deposed on in 1988 was Dr. Fumich's case?

A Yes.

Q The other one was doctor who?

A I don't recall the physician's name.

Q Do you recall the defense lawyer?

A I never met the defense lawyer. As I recall, I was not deposed. I am sorry, the plaintiff's lawyer. The defense lawyer was John Jackson from Jacobson, Maynard, Tuschman & Kalur, and Joan Tomusko, T-O-M-U-S-K-O.

Q Now, let's stay, for the moment, with the year 1988. As I understand it, you had one for sure, and maybe two depositions, Fumich was the one involved with the depo, and the second one was an extensive review, and the defense attorney was John Jackson, and those cases were medical malpractice cases?

A Yes.

Q Did you do any consulting in 1988 for any defendants, whether it was medical malpractice or not?

A I don't recall.

THE WITNESS: Can we go off the record for a minute?

MR. DOMIANO: Sure.

(At this time a discussion was had off the record.)

MR. DOMIANO: Let's go back on the record.

The record should show we had a discussion as to Dr. King's recollection with certainty as to the number of depositions and which year, and he was trying to clarify that, and I appreciate what you are saying- I will try to accomodate you, doctor.

Q Let's stay with 1988. We have had at least one deposition, and we have had how many reports in 1988 for defendants in litigation?

A I believe, just one more.

Q And consults not connected with the depositions and the reports;, are there any consultations for the defense in litigation in '883

A Not to my recollect.

Q And was there trial testimony in '88?

A On that same case, yes.

Q What was the claimed malpractice in the trial testimony case, which is the Fumich matter?

A That claim regarded the decision to

perform a total knee replacement on an elderly patient.

Q So far, doctor, has any of the activity you have described on behalf of defendant doctors or defendant's litigation involved the removal of partial clavicles in connection with a subclavian to subclavian bypass procedure?

A No, they have not.

Q And I appreciate that when I ask you these questions, if I ask you about '88 or '89 or '87, it might be one year or the other.

A That is correct. The cases spanned as many months, it might have started one year and ended in the next.

Q I understand. Is there any other activity in connection with medical-legal activity, that you have engaged in, in '88, that I haven't asked you about?

A Not to my recollection.

Q Let's go back once more to 1989.

Was there any, other medical-legal activity, and understand what I mean by medical-legal in the

context of depositions.

A Yes.

Q Consultations, trial testimony,

about?

A I have recently received a chart that I have not looked at, but I don't recall anything else besides this case in '89.

Q The chart that you just received and really haven't looked at yet, does it involve a medical malpractice claim?

A Yes, it does.

Q On behalf of the defendant doctor?

A I honestly don't know.

Q Do you know who the attorney was, that gave you the chart?

A No, I don't. It was a name that was unfamiliar to me, and I don't recall.

Q Do you know how it was that: the attorney became aware of your availability to look at his chart?

A Through a medical colleague.

Q Again, doctor, as best you can, then,

let's go to 1987. Again, I am interested in your medical-legal activity having to do with litigation either on behalf of plaintiffs or defendants in any kind of a case.

Did you engage in any such activity, medical-legal, in '87?

A Yes.

Q And can you tell us how many?

A I believe, two or three.

Q Were they all medical malpractice cases?

A Yes, they were.

Q Were they all on behalf *of* the defendant doctors?

A I can't remember '86 versus '87.

Q Somewhere in there there was one for a plaintiff?

A Yes.

Q But the other two or three --

A Were for the defense.

Q Were for the defense?

A One was my own case.

Q We will get to that in a minute.

Can you recall the names,

whether it was '86 or '87, can you recall the names of the defendant doctors on whose behalf you testified?

A No, I can't.

Q Can you recall the defense lawyers?

A Most of the work that I have done has been with Jacobson, Maynard, Tuschman & Kalur, but I cannot state that for certain.

Q There may have been others, but you can't recall?

A Yes.

Q Can you tell us with certainty, doctor, that at least one of the cases involved in your medical-legal activity in '86 or '87 was on behalf of a plaintiff?

A Yes.

Q Can you recall the plaintiff doctor's name or the party's; name rather?

A No, I can't. The plaintiff's attorneys were the Elk & Elk Company.

Q Elk & Elk Company?

A Arthur Elk and David Elk.

Q Are they Cleveland lawyers, as far as you know?

A They are Cleveland and also Akron lawyers.

Q Was that case a medical malpractice case?

A Yes, it was.

Q In '87 can you recall any other activity, medical-legal? Again I am asking about, first of all, depositions, secondly trial testimony, reports, consultations?

A Not to my recollection. Beyond that, I don't believe I was actually deposed in '87, but I did write a report or two for the defense, as I mentioned.

Q As far as you reccall, no deposition testimony, no trial testimony in '86-'87?

A Except for my own case.

Q Yes. We will get to that.

A The case for the plaintiff actually went to arbitration, and I testified at the arbitration hearing as well as a deposition.

Q So far, then, doctor, is it correct that none of these cases that you have bsen describing, that you have medical-

legal activity in, involve partial resections of the clavicle in connection with a subclavian to subclavian bypass?

A That is correct.

Q Or any other kind of bypass procedure, is that a fair statement? None of them involved bypass procedure?

A No, that is incorrect.

Q That is --

A Most or all of my testimony is with respect to vascular surgery, and several of those cases have involved questions concerning bypasses.

Q Tell us which one involved a procedure where a shunt was performed, if any, subclavian to subclavian or carotid to subclavian and/or any other?

A You mean a bypass?

Q Yes.

A The shunt implies a temporary intra-operative situation.

Q But just for the record. the term shunt, isn't it used interchangeably, although incorrectly, by many of the doctors, including Kralik? He calls it a

shunt or a bypass, is that a fair statement?

A Incorrectly is correct, yes.

Q Thank you. You were going to tell me, then, which of these cases that you have been describing involved bypass procedure,

A The patient in the Fumich case underwent several bypasses in the lower extremity. None of these cases have involved upper or carotid or subclavian bypasses.

Q That is what I was after.

A Again, my own case involved carotid surgery, but did not involve a bypass.

Q Just for my own clarification, then, doctor, none involved an upper extremity bypass where clavicles were removed?

A Correct.

Q Now, you have been talking about your own case. Have you been the subject of a medical malpractice case?

A Yes.

Q Some plaintiff has brought an action against you?

A Yes.

Q When did that occur?

A Again, the dates become hazey.

Q Sure.

A And I believe the case was filed in '86 and was settled in '87.

Q And what was the name of the plaintiff, if you recall?

A Zoberman, Z-O-B-E-R-M-A-N.

Q And the plaintiff's lawyer, do you recall that?

A Charles Kampinski.

Q And in connection with that case -- I am sorry. Strike that.

You were the defendant?

A Yes.

Q Anyone else?

A The Mt. Sinai Medical Center,

Q And did you give deposition testimony in that case?

A Yes.

Q Do you know if the deposition testimony was transcribed?

A Yes.

Q Did the case to go trial?

A Yes.

Q Do you recall if this was in the Common Pleas Court of Cuyahoga County?

A Yes.

Q Do you recall the judge?

A James McMonagle.

(At this time a discussion was had off the record,)

MR. DOMIANO: Okay, we are back on.

Q Did the complaint against you involve -- Strike that.

What did the complaint against you involve?

A The complaint involved the advisability of carotid artery surgery in an elderly patient with blockage of the carotid artery.

Q Was a bypass contemplated in that procedure?

A No. The stated procedure in carotid surgery is called endarterectomy, E-N-D-A-R-T-E-R-E-C-T-O-M-Y.

Q What was the procedure that you did perform in that case?

A I performed a carotid endarterectomy.
Q Did that procedure involve the removal of any portion of the clavicles?
A It did not.
Q Was there an occlusion present in that patient?
A Yes.
Q Where was the occulsion located?
A In the bifurcation of the carotid artery, the middle zone of the neck.
Q Who was the plaintiff's doctor in that case, do you recall?
A I was one of the plaintiff's physicians.
Q In the trial of the medical malpractice case?
A The plaintiff's expert?
Q Yes, the plaintiff's expert.
A I don't recall his name. He was a neurosurgeon from San Diego.
Q In the case that *you* testified in on behalf of the plaintiff, that one did not go to trial?
A That case went to arbitration and was settled after that.

Q And the defendant doctor in that case -- That was the medical malpractice case?

A Correct.

Q Was the defendant doctor a Cuyahoga County doctor?

A One of them worked in Cuyahoga County, and the other one was in Medina. I am not sure which county that falls in. The arbitration panel was actually held in Summity County in Akron, so I would assume, then, it would be in Summit County.

Q And in your own case the plaintiff's doctor testified against you, the plaintiff's expert testified against you?

A (No response.)

MR. DOMIANO: I will rephrase it. That question isn't clear.

A Well, the question is clear. The answer is difficult, Actually the plaintiff's testimony weighed more against the hospital than it did me, in fact, the decision was split, and I was dismissed from the case while the medical center was

held liable.

MR. DOMIANO: I move the last part be stricken as not responsive.

Q Did the doctor who testified on behalf of the plaintiff in your own medical malpractice case testify that you did something that was improper or incorrect?

A No.

Q Now, doctor, is it your opinion that the selection of the subclavian procedure used by Kralik in this case was within the acceptable standards of medical care?

A Yes, it is.

Q Wouldn't you agree that the selection of any surgical procedure involving a bypass depends in some part on the condition of the patient?

A Yes, it does.

Q What was the condition of this patient prior to the bypass procedure performed by Dr. Kralik?

A Can you be more specific?

Q Sure. What condition was present,

which would indicate subclavian to subclavian versus some other acceptable procedure?

A The patient's pathologic condition and symptoms were related to a stenosis or a partial blockage of the subclavian artery on the left side.

Q Would that condition exclude or rule out any other available procedures to the surgeon to perform the bypass?

A There are other choices that could have been made on the basis of that particular blockage, for instance, a carotid to subclavian or an axillary to axillary bypass, but a subclavian to subclavian is also in the armamentarium for treatment of that disorder.

Q Is in the what, please?

A Armamentarium.

Q And what does that mean, for the record?

A It is within the realm of acceptability to consider that bypass for this condition.

Q Now, your opinion, of course, is

based on your own experience, I would assume?

A And my education.

Q Doctor, you regularly attend seminars where the subject matter includes these bypass procedures, do you not?

A Yes.

Q Can *you* tell me of any that you attended, that you attended in 1989, for example, and I appreciate it might have been '88, but do the best you can, where the surgical procedures available to a surgeon involving a bypass operation where removal of clavicles in elective surgery was recommended?

A I don't recall any.

Q There aren't any, are there, that you attended, where it is recommended?

A No.

Q That is not a fair statement?

A That is a correct statement.

Q That is a correct statement, so in presentation of the subject of these various bypass procedures, where the procedure is elective versus traumatic,

emergency or some other, removal of a portion of the entire clavicle is not recommended, do you agree?

A Mot necessarily. I think that depends on the individual circumstances and the body habitus of the patient.

Q Then you would agree that the following statement is not valid, that it is always preferable to remove the clavicles in a subclavian to subclavian bypass procedure?

Would you say that is a valid or invalid statement?

A Say it once more.

MR. DOMIANO: Sure. Read it back.

THE REPORTER: Question: "Then you would agree that the following statement is not valid, that it is always preferable to remove the clavicles in a subclavian to subclavian bypass procedure? Would you say that is a yalid or invalid statement?"

A That is invalid. Again, it depends

on the body habitus of the patient.

Q Doctor, you are aware of the role that medical literature plays and the impact it has in medical-legal activity, such as we are engaged in, are you not?

A Yes.

Q And when I refer to the literature, you appreciate that what I am talking about are articles that have been written on the subject of the lawsuit.

A Yes.

Q Can you refer us to any literature where clavicular resection during elective subclavian to subclavian bypass procedure is recommended?

A No.

Q What do you recall of the location of Dottie Reisig's occlusion?

A Mrs. Reisig's occlusion was at the very first portion of the left subclavian artery.

Q And --

A It was a stenosis, not a complete and total occlusion.

Q I am sorry.

A It was a partial blockage. It was stenosis, not a complete occlusion.
Q Dr. Kralik used both terms, though, didn't he?
A I don't recall offhand in reading his testimony.
Q And tests were performed, which led Dr. Kralik to believe that a stenosis or a steal was occurring, is that right?
A Yes.
Q Have you read the reports of the doctors that performed those tests, the angiograms and the others?
A Yes.
Q And you will agree with me, will you not, doctor, that Dr. Kralik came to the conclusion that a bypass procedure was warranted, correct?
A Yes.
Q What procedures were available to Dr. Kralik at that point? We know the subclavian to subclavian was available.
A Yes.
Q What other procedures were available?
A Axillary to axillary bypass, carotid

to subclavian bypass and a direct approach with endarterectomy is also an option.

Q Any others?

A Those would be the most likely procedures.

Q With a patient that had the conditions such as Dorothy Reisig did in this case, what would be the shortost bypass that the surgeon could perform?

A A carotid to subclavian bypass would be physically the shortest bypass available.

Q 00 you agree with the statement that the shorter the bypass, the better?

A Yes.

Q Was there any physical condition, that *you* are aware of, that would have prevented Kralik from employing the carotid to subclavian procedure versus the subclavian to subclavian?

A The angiograms that I reviewed, which was only a portion of the complete study, revealed a suggestion of a subclavian artery having anomolus, A-N-O-M-O-L-U-S, origin off the carotid artery instead of

the aortic arch.

Q For the record, anomolus means what?

A Abnormal or unusual.

Q That would have prevented the carotid --

A Depending on the location of the subclavian blockage, that in theory could make you change your choice from carotid to subclavian to another procedure, subclavian to subclavian or perhaps an axillary to axillary.

Q Is it your opinion here that the location of the subclavian blockage was such as to prevent a carotid to subclavian bypass versus subclavian to subclavian?

A Not necessarily. I would have to review those films to make a complete statement.

Q Where would the blockage or the partial blockage have to be in order to rule out carotid to subclavian bypass?

A The location of a carotid plaque Just near the orifice or the opening of the subclavian artery on the carotid might concern the surgeon that the flow is

restricted in the carotid artery also, and if you are performing a carotid to subclavian bypass to improve the circulation of the arm, you must do it with a normal what we call inflow or a normal pressure. Yau should do it with normal inflow so that you are not compromising circulation again.

Q Okay, but I am concerned with whether or not you say that the condition this patient had was the type that would rule out or prevent a carotid to subclavian, and I thought your answer was you are not sure where the occlusion was located, or partial blockage?

A I would have to review the films to make that determination. Again, I only reviewed five films in a series of an angiogram that most probably includes 20 to 30 films.

Q So, depending on what those films would show, your opinion might change as to whether or not carotid to subclavian would be the shorter and more preferable procedure versus a subclavian to

subclavian?

A That is right.

Q Would not any of the charts *you* have with you disclose to you the location of the subclavian blockage that was causing the problem here?

A A surgeon would not make a decision based on a report without seeing the film. I reviewed the films several months ago, so I have no recall.

Q Well, you told us in the report, though, doctor, dated May 31st, '89, Plaintiffs' Exhibit 1, that you feel that not only was the indication of the surgery appropriate, but the selection of the procedure was appropriate.

What I am troubled with is how *you* formed that opinion without knowing where the location of the blockage was with respect to gatting the shorter bypass procedure.

A I must have had the films available to me at that time or near that time.

Q Who would have sent you the films?

A Mr. Switzer.

Q And wouldn't you normally keep those films?

A Mr. Switzer has the films back. I don't have them in my possession.

Q Do you recall returning them to him?

A Yes.

Q Doctor, I am going to refer you to a report from Dr. Woo, W-O-O, which is attached to the deposition of Dr. Kralik.

MR. DOMIANO: Perhaps we can avoid, Mr. Switzer, remarking the same documents over and over again,

MR. SWITZER: Sure.

Q What I am going to refer you to, doctor, is a report dated 12/3/85 written by Dr. Woo, which I am going to show *you,* and since it is already in the record --

MR. SWITZER: He has got a copy in front of him.

MR. DOMIANO: Fine.

Q I draw your attention to Dr. Woo's report, the fourth paragraph, where he says "There is atheromatous plaque with stenosis of approximately 60 to 70 percent involving the left subclavian

artery just proximal to the origin of the left vertebral artery."

Do you see that?

A Yes.

Q Is that sufficient to indicate to you the location of the plaque or blockage?

A No, it is not.

Q What else do you need, films?

A Yes. He doesn't mention the origin. He does not mention the anatomic variation or the anomaly that Dr. Kralik recites, and I see what Dr. Kralik refers to, but I am not sure that I agree with Dr. Kralik in terms of anatomic structure of the takeoff of these vessels.

Again, I only saw five films out of a series of films and was unable with those films to say that tha anatomic variation was present or was not present.

Q You are not sur0 if you agree with him, then, or not?

A Correct. If the anatomic --

MR. DOMIANO: Wait until I put a question to you, doctor,

please.

Q Of the four surgical procedures, doctor, that you have described to us, you have told us that the carotid to subclavian is the shortest?

A Yes.

Q What is the next shortest?

A The subclavian tu subclavian.

Q What is a carotid to subclavian transposition? Is that medical term familiar to you?

A Yes.

Q What doe5 it mean?

A A subclavian to carotid transposition is where the subclavian artery is disconnected from its origin on the arch of the aorta and at the level of the blockage, and is then sewn and connected to the carotid artery very near by. This does not involve a bypass at all.

Q In your experience, doctor, of those four surgical procedures are any more commonly used than the other in an elective surgery where the patient has the same or similar conditions as the

plaintiff here?
A The carotid to subclavian bypass is the most common procedure for this condition.
Q Doctor, have you performed a procedure like Kralik performed, subclavian to subclavian bypass?
A Yes, and axillary bypass.
Q And carotid?
A And carotid to subclavian bypass.
Q And you have also performed an endarteroctomy?
A I believe so.
Q And where the condition of the patient is such it is an elective surgery, in the subclavian to subclavian procedures that you have performed, have you removed a portion or all of the clavicles?
A I have not had the need to remove clavicles for subclavian to subclavian bypass.
Q What are the conditions that support the need to remove the clavicles?
A The condition that would require the removal of a portion of the clavicle would

most commonly be the patient's habitus, that is, the location of the subclavian artery with respect to the clavicle. A very deep artery behind the clavicle would mandate or require resection for exposure,

Q Was that condition present hare in Dottie Reisig?

A I would not know without having seen

of the subclavian artery, are required to be present in order to warrant clavicular resection in an elective surgical situation?

A In an elective situation, the only reason that I would see for removal of the clavicle is the troublesome bleeding that is limited -- That is not surgically

accessible without immediate resection. That is a problem of the elective operation that warrants more urgent action.

Q As far as you know, that condition wasn't present here?

A That is correct.

Q At the time Dr. Kralik performed his bypass?

A That *is* correct.

Q What conditions do you find were present, that would render the removal of Dottie Reisig's clavicles appropriate in this case?

A Again, I can make no comment with regard to her body habitus.

Q And body habitus, would you tell us a little more clearly what you mean *by* that?

A The size of her shoulder girdle, location of her collarbones or clavicles, the stature of the patient, the heavy set nature. Was she thin? Was she fat? Did she have a narrow chest? Did she have a broad chest? Things like that.

Q As far as you are concerned, the

charts don't indicate her body habitus to you?

A They would not indicate anything that would allow me to make a surgical judgment on a technical aspect of a procedure like that.

Q You have had no occasion to physically examine Dottie Reisig, have you?

A I have not, Apparently that would be somewhat difficult postoperative based on what is described in the report.

Q Well, you have been able to determine, though, the breadth and length of her shoulders and shoulder girdle and normal body weight, heavy, light?

A But if the clavicles had been removed even with one or two procedures now, it would be difficult to say now where the artery was located with respect to the previously in place clavicles.

Q Is there any other conditions under which you say removing a portion or all of the clavicles is acceptable and appropriate in an elective surgical

situation, such as here, other than what you have told us?

A I can think of no other situations in an elective procedure.

Q This was an elective procedure, wasn't it?

A Yes, it was.

Q Would you agree, doctor, that the following is a fair statement, although it may be couched in layman's terms, that the surgeon removes and disturbs as little of the physical structures as possible in the course of any surgical procedure he engages in?

A That is correct.

Q In the subclavian to subclavian procedure you have performed -- Which number how many, doctor?

A I believe, one or two. I can't recall for certain.

Q And you have been practicing six years?

A That would include my training program as well, which would be another six years.

Q It is a relatively rare procedure, isn't it?

A Yes. it is.

Q It is even more rare to have the clavicles removed during the course of it, true?

A Yes.

Q You have not removed clavicles in any elective procedures involving subclavian to subclavian bypass, have you?

A That is correct.

Q Have you been involved in removal of clavicles in any procedure that you have performed?

A I believe there was a traumatic situation where I removed a portion of a clavicle.

Q What was the nature of that trauma, a blow or --

A That was -- I believe it was a knife wound.

Q Trauma means blow, doesn't it?

A Yes.

Q And you performed a subclavian tu subclavian?

A We performed a direct repair of the artery that was injured.

Q And that involved removal of the clavicle or a portion?

A Yes.

Q Doctor, you have also told us now of two conditions, the deep location of the artery and the general body habitat or habitus of the patient, which would justify removal of a clavicle in a subclavian to subclavian elective procedure.

A The other indication that we mentioned was problems with bleeding at the time of the surgery.

Q There was no problem of bleeding with Mrs. Reisig?

A There was no problem of bleeding.

Q As far as you know, then, if the two conditions that would make appropriate partial resection of the clavicles were not present, would it make it easier to get at the subclavian artery to perform the bypass by taking the bones out?

A Can you read the first portion of

that statement?

THE REPORTER: Question:

"As far as you know, then, if the two conditions that would make appropriate partial resection of the clavicles were not present, would it make it easier to get at the subclavian artery to perform the bypass by taking the bones out?"

A Yes, somewhat.

Q And in the situation that you were describing where you did remove a portion of the clavicles, that was because there was injury and damage to the subclavian artery in a traumatic situation?

A Yes.

Q Again, unlike what we had here with Dottie Reisig?

A Hers was elective.

Q Where the surgeon decides, as Dr. Kralik did here, to remove a portion of the clavicles, are there hazards to which the patient becomes subject more than had he removed the entire clavicles?

MR. SWITZER: I am going

to object as to the use of the word hazards.

MR. DOMXANO: You may answer.

A The resection of portions of the clavicle still allows significant support of the remaining portion of the clavicle to contribute to the shoulder girdle itself and its structure, so it is preferable in those circumstances to resect less than -- As little of the clavicle as possible,

Q All right, but is the patient subject to any hazards with a partial resection, that he wouldn't be subject to with a complete removal?

A My experience in clavicular resections is so limited, that I would have to say that I would defer to an orthopedic surgeon for that opinion.

Q I am interested, doctor, in your opinion, and I appreciate you may be required to defer that. Once the cardiovascular surgeon, like Kralik, makes a decision to remove bone, what are the

factors that go into how much should be removed in a patient that had conditions such as Mrs. Reisig had?

A The decisions on how much to remove are based on the exposure needed of the structures behind it, so he removed a section based on how much he needed to work with of the -- How much of the subclavian artery he needed to work with.

Q At least as far as he was concerned?

A To the best of his professional judgment, *yes.*

Q But as far as you were concerned, the conditions which require bone removal in the first place weren't present, true?

MR. **SWITZER:** Objection.

A I cannot state that without knowing her body habitus before surgery.

Q You have told us there is no way to know that now postoperatively.

A That is correct.

Q Well, in the two or three subclavian to subclavian bypass procedures, elective, that you have performed, there were no conditions present, which would warrant

removal of bone and, therefore, you didn't remove the bone?

A That is correct.

Q You would agree with me, wouldn't you, doctor, from a reading of material that you described earlier as to that on which you based your opinion, that Mrs. Weisig had disabling symptoms after Kra1ik's procedure?

A Yes.

Q Pain in the knees?

A Yes.

Q Are you aware that Dr. Brems removed the fragment?

A Yes.

Q Are you aware that after the fragment was removed, the patient, Dottie Reisig, said that that sharp, stabbing pain, at least, disappeared or had been reduced?

A Had improved.

Q There is no question in your mind that the removal of the fragment eased the pain that she was complaining of, is there?

A I believe that is correct.

Q There is no question in your mind?

A The removal alleviated the pain?

Q Are *you* able to tell us, from your medical experience or the charts in front of us here, what physiological structure that the fragment was impinging on, that caused the pain?

A The clavicle protects -- Besides providing support to the shoulder girdle, mechanically it also protects the subclavian artery and vein as well as the neurological plexus, called the brachial plexus, from repetitive blunt injury on a daily basis, you know, any blow to the upper chest or a shoulder region could potentially cause great harm, without the protection of the clavicle, to the nerve structure near by, which is the brachial plexus.

Q So, the physiological or a physical structure behind the fragment would be the brachial plexus, which was causing the pain that the fragment impinged on?

A Without doing an exam or looking at her specifically, I don't recall the

location of the pain. The brachial plexus is at risk there. I don't know if it is from a smaller branch of the plexus or what, but there are potential problems there.

Q That is one of the hazards, then, of a partial removal of a clavicle?

A Yes, it is, but you also limit the resection as much as possible to provide the remaining support from the residua7 clavicle,

Q Now, as to the reasons that a surgeon would remove clavicles in an elective procedure, you have already told us there would be two conditions.

A Uh-huh.

Q Would the removal of the clavicle limit the durability of the bypass?

A I think it only allows one to perform it. I don't think it would change the durabi1ity.

Q As to the safety of the bypass, does removal of the clavicles have anything to do with the safety of the bypass?

A You 'mean the performance of the

bypass?

Q Yes.

A Or the long term?

Q The performance,

A It would make it somewhat more safe,. If the artery was deep behind the clavicle, resection of a portion of the clavicle would make it a safer resection with less problems in terms of injury to the artery or, for that matter, more problematic would be an injury to the subclavian.

Q You are talking about a total removal, though, aren't you?

A No.

Q A partial?

A Yes.

Q Would a total removal change the condition you are describing in terms of safety, durability?

A It would not change durability. It would make it physically very easy to do a subclavian to subclavian bypass, but it is unnecessary extensive exposure for this procedure.

Q Absent the traumatic condition?

A Correct.

Q Doctor, assume a patient, such as Dorothy Reisig -- From the charts you have, assume that she had a subclavian to subclavian procedure with partial removal of her clavicles, and the patient complains of chest pain, as she complained, and you have read Dr. Brems' notes and his report, what would be the proper test, as far as you are concerned, to determine the cause of the pain or the etiology of the condition, if that is the proper term?

A The problems could be tested by intensive neurologic physical examination, looking for problems with the brachial plexus, nerve conduction velocity test, if there was significant changes there, or electromyography, EMG, which is a test of the nerve bundles beyond -- That are innervated by the nerves that potentially cause problems.

Q You are aware that Dr. Brems eventuall'y concluded that the fragment

remaining from the partial removal was causing the pain?

A Yes.

Q And you did have access or do have access to Dr. Kralik's office notes, did you not?

A Yes.

Q He didn't perform any of those tests, did he?

A Not to my knowledge.

Q That you have just described?

A Not to my recollection.

Q In fact, he diagnosed her condition at that time as bursitis, didn't he?

A Yes, I believe he did.

Q We all know, of course, she didn't have bursitis, true?

MR. SWITZER: Objection, Who is "we"?

Q Do you agree that she didn't have bursitis, doctor?

A It is difficult to say that without having seen her at that point in time, She might have had two things wrong.

Q Sure, but nonetheless, the tests

that you have just described, to determine the source and cause of the pain, weren't performed by Kralik, as far as you know?

A That is correct.

Q Tell me in medical terms, again, doctor, the condition that she had concerning the plaque, the blockage, the occlusion.

A She had arthrosclerotic blockage of her subclavian artery near its origin, which limited the circulation to her left arm.

Q In such condition does it always follow the steal or stenosis occurs?

A The stenosis is present. It is the factor that causes the steal. Not all patients with subclavian artery blockages, whether complete or partial, actually steal.

Q That was my question. So, does it not follow that the presence of a blockage doesn't result in a steal?

A That is correct.

Q And the presence of bruits, B-R-U-I-T-S, does that indicate a blockage or

narrowing?

A Not necessarily.

Q And would you describe for us what happens to the blood flow when a blockage is there which does, in fact, cause a steal?

A A subclavian steal syndrome is a situation where the subclavian blockage limits the flow to the left arm, and in situations of demand, that is, for instance, exercise of the arm or motion of the arm or even position of the arm in an unusual spot will cause a steal situation where the circulation comes up the carotid artery in the Circle of Willis at the base of the break, and then it goes backward down the vertebral artery to supply the arm which is -- Because a vertebral artery is a branch of the subclavian artery beyond the blockages, and blood flow follows pressure gradients, and when there are situations of demand, like exercise or a funny motion or exaggerated positions, the pressure gradients will dictate that the flow will go down the vertebral

instead of its normal upward fashion.

Q That is where the steal occurs?

A That is what the steal is.

Q There was nothing in any of the charts that you read, was there, doctor, where the patient complained of dizzy spells upon demand, such as moving her left arm or getting into activity with her 1eft arm?

A She complained of dizzy spells and some lightheadedness, but I have no recollection or recall any mention of activity associated with that.

Q Typically if there is a steal, the complaints relate to demand or activity, isn't that true?

A Most of the time, yes, but it can also be position and funny positions that cause a more complete blockage of that area, stenosis or unusual situations, falling asleep in a funny spot.

Q She didn't have any complaints about that, that every time I sit a certain way or every time I move a certain way I get dizzy? She didn't say anything like that,

that you saw or heard?

A Not to my recollection,

Q Those things would be consistent with a steal, would you agree?

A Yes.

Q And the absence would be inconsistent with a steal?

A Not necessarily. You could still have steal situations without exercise if the blockage is severe enough.

Q And no symptom at all of dizziness?

A You can have them with symptoms or without symptoms, You can demonstrate the steal on angiography in a patient with no symptoms, and you can have patients without exercise, that still have dizziness and lightheadedness.

Q Was there anything that you say was uncommon about the size or location of the blockage that Dottie Reisig had according to the charts that are available to you?

A According to the charts, no. That is a fairly typical location for a subclavian artery disease.

Q One 'would expect, typically, the

demand situation to be triggered if she began to move her arm or get into a position which would trigger the dizziness, which would be consistent with the steal presence, would you agree with that?

A That would be the most common manifestation, yes.

Q When the blood comes down the vertebral artery, the retro-flow that you described, does anything happen to the size of that vertebral artery commonly and typically because of the extra demand on it to supply blood?

A It depends on the chronicity of the problem. In longstanding situations the vertebral artery can enlarge somewhat as a collateral vessel to supply circulatisn to the arm.

The vertebral artery is somewhat limited in its growth potential on the basis of its location in the boney structure of the spinal cord or spinal column, and other collaterals will also develop in the chest wall in the region of

the supraclavicular fossa, that will also supply circulation.

Q Just tell us for a moment what the supraclavicular fossa is?

A It is above the clavicle on top of the shoulder.

Q And typically and commonly doesn't the vertebral artery that has the extra demand on it become somewhat larger than the other unaffected vertebral artery?

A Yes.

Q And you will agree with me that Dr. Woo found that both vertebral arteries were small?

A That is correct.

Q He doesn't indicate on his report dated 12/3/85, which is part of the attachments and exhibits to Dr. Kralik's deposition.

Do you appreciate, doctor, this is for purposes of the record?

A Yes.

Q I think it is Exhibit 3. He says, and I quote "Both vertebral arteries are opacified and are small in size and

caliber, but there is no area of stenosis in the vertebral arteries in the neck."

Isn't it consistent, then, with a condition of no steal when the vertebral arteries are both small in size rather than one being larger than the other?

A Again, it would relate to the chronicity of the problem. If it was a new found, newly developing problem, the artery might not yet be enlarged. It take5 quite some time to enlarge a collateral to be significantly larger than its symmetrical pair.

Q How long had the patient been complaining of her dizzy spells?

A I don't recall.

Q In your view what length of time would there have to be complaints in order for the vertebral artery to show a difference?

A Probably in the range of eight to 12 months. Again, the steal situation when it starts occurs only on an intermittent basis, so it is not as if it is

continuously stealing 24 hours a day and, therefore, subject to conditions that would make it hypertrophied in a short period of time.

Q But typically and commonly where both vertebral arteries are either the same sire or small in size, that is consistent with absence of steal, wouldn't you say?

A It is cornpatable.

Q Compatable with absence of steal, not presence?

A Yes.

Q So, you would agree with me, wouldn't you, doctor, that the presence of dizziness doesn't necessarily mean that a steal is occurring, true?

A That is true.

Q And if there is no steal, there is no subclavian to subclavian bypass warranted, true?

A That is true.

Q And isn't it typical, doctor, where a steal is present because of the narrowing in the vertebral artery the blood pressure readings in two arms would be different,

not close and the same?

A Say that again.

MR. DOMIANO: Repeat it.

THE REPORTER: Question: "And isn't it typical, doctor, where a steal it present because of the narrowing in the vertebral artery the blood pressure readings in the two arms would be different, not close and the same?"

A In the steal situation that would be true if they are measured at rest. Where there is no steal, it is not necessarily true.

Q But here it was determined that the steal was present, do you agree with that?

A Yes.

Q And the blood pressure readings in both arms were almost identical, maybe a point or two off, true?

A True.

Q That is inconsistent with a steal, isn't it?

A Not necessarily.

Q Well, is it incompatable with a

steal?

No.

Tell me the difference, because you (used the word incampatable as distinguished from inconsistent.

In your mind, medically, what is the difference?

A It is compatable that you can have normal pressure or equal pressures in both arms and still have a steal situation.

Q Even though the --

A Pressures are equal.

Q The pressures are equal even though ane artery is narrowed more than the other?

A Yes. What that tells us is that the collateral circulation *is* functional and delivering normal blood pressure to the arm at rest, It does not necessarily mean that the patient has symptoms at that time. The subclavian steal can exist without significant clinical symptoms of dizziness;, lightheadedness.

Q And, again, just the presence of the dizziness doesn't mean the steal is there

A Correct.

Q What artery is narrowed, which would cause different blood pressure readings where a steal is present?

A The subclavian artery on the left side.

Q So, if there was a narrowing of the subclavian artery, would it not follow that blood pressure readings would be different significantly?

A That depends on the extent of the collateral circulation.

Q How does one measure the extent of the collateral circulation?

A Indirectly it is measured by the fact that the blood pressures are equal or what the relative blood pressures are comparing arm to arm.

Q Dr. King, Dottie Raisig claims that the pain that she suffered and has been suffering in her general deformed or debilitated condition, by her own claim, is all a result of the removal of the two bones, the two clavicles.

Do you disagree with that?

A Not necessarily, no.

Q It could be a cause of her condition?

A It could be.

Q Are you aware of what her condition is, at least as of the time of Dr. Brems' notes, which are from February, I think, to August of '87 or to '883

A She was complaining of chest wall pain and shoulder area pain on both sides.

Q Have you read her deposition?

A No, I have not.

Q You have discussed her claimed condition with Mr. Switzer?

A Yes.

Q And do you recall that she claims that she is unable to perform day-to-day activities as a result of the removal of these bones?

A Yes.

Q And you don't necessarily disagree with that?

A Not necessarily, no.

Q Removal of the bones could cause those problems?

A It could contribute to those problems.

Q Is there anything else that you have seen, that would supply the reason for her complaints, other than the removal of the bones?

A Not without a medical ex

Q Nothing in the charts or records?

A No, not to my recollecti

Q A patient with complaints such as she has, following the surgical procedure performed by Dr. Kralik, is the treatment of such a patient within your field of expertise, or would *you* refer her to somebody else?

A I would expect to refer her to someone else.

Q What field?

A Probably an orthopedic surgeon.

Q Like Dr. Brems?

A Yes.

Q You are aware of the different things he tried to relieve her pain and to get her to be functional again, by reading his

notes?

A Yes.

Q He wasn't successful, was he?

A NO.

Q Do you know Dr. Brems?

A No, I do not.

Q Do you know Dr. Krajewski?

A Yes.

Q He also has a certificate of special qualifications in vascular surgery, does he not?

A I believe he does.

Q You testified to that, too.

Is Dr. Krajewski a man that you admire and respect?

A Yes.

Q He practices at the Cleveland Clinic, does he not?

A He does.

Q Is your relationship with him anything other than professional?

A No, it is not.

Q You have read his deposition as well as his reports?

A Not completely, but I have looked at

them, yes.

Q We will get into details in a moment.

Do you disagre

he testified to?

MR. SWITZER:

A Not particularly, no.

Q Prior to Mr. Switzer coni

did you have any contact with Dr. Kralik

at all?

A No. I don't know Dr. Kralik.

Q You don't know him at all?

A No.

Q Doctor, do you think it is

appropriate, within the proper degree of

care, to adopt a surgical plan to remove

clavicles when you are attempting to

perform a subclavian to subclavian before

you actually open the patient up and see

what you have got?

A I think that would depend on what the

patient looks like, I mean in some

patients their body habitus can allow you

to say that you think clavicular resection

will be necessary.

Q Isn't it preferable to wait, not

adopt a plan to remove until you have actually made an incision and see what is there?

A The placement of the incision would be approximately the same for either route, so it could be done and then resection could be done through the same incision if it was deemed necessary at the time.

Q But the point I am making is that the adoption of a surgical plan to remove the clavicles even before the first incision is made, is that within the standard of care that doctors subscribe to in this area, or is it preferable to wait until you actually get into the body?

A It would depend on the patient's body habitus. I would be unable to make that decision. It might be very obvious, based on her appearance, that it would be very necessary comparing angiograms and things like that.

(At this time a discussion was had off the record.)

Q Doctor, you used the term in

Plaintiffs' Exhibit 1, your report, it is well within the accepted standards of medical care.

What do you mean by that?

A That is an accepted procedure in this medical community for this condition involved.

Q Doctor, in any of your medical-legal activity, as we defined what that was a few moments ago, have you had occasion to travel outside the state?

A No.

Q Have you been involved in any of your medical-legal activity involving medical malpractice claims where the plaintiffs' expert is a local doctor?

A Yes.

Q Which one was that, do you recall, other than your own, of course, where you have testified on behalf of the plaintiff?

A I can't recall. I think the Fumich case had a local expert. I don't recall.

Q None of the others, though?

A Not to my knowledge. I don't recall.

Q Doctor, you say that you do not feel

that the description of the disability of slumped shoulders is due to the resection of the medial portions of the clavicles,

A Right.

Q On your Exhibit 1. Does it have any -- Strike that.

Did the resection have any affect resulting in slumped shoulders, in your opinion?

A No, in my opinion.

Q None at all?

A No.

Q And is that opinion based on treatment you have given to patients with similar conditions and similar operative procedures?

A It is based on my education. Again, my experience with clavicle resections is very limited.

Q So, you are arcking back, then, to things you learned in medical school or during your residency?

A Or continued education and reading now.

Q Doctor, you will agree that Dr.

Haimovici, H-A-I-M-O-V-I-C-I, is a recognized expert in the field?

A Yes, he is.

Q Doctor, if Kralik had performed an axillary to axillary procedure -- Is it axillo-axillary?

A Axillo-axillary.

Q Axillo-axillary procedure, there would have been no need to remove the clavicles at all, would there?

A That is correct.

Q Do you say that an axillo-axillary procedure here would have been inappropriate and off the standard of care?

A It would have been in the realm of acceptable standards of medical care, but it is not preferable in the sense that it is a longer bypass than the other two mentioned.

Q Even though no bone removal would have been required, wouldn't that have offset its desirability?

A No. The long term function of an axillo-axilliary graft is a lot less than

either the carotid to subclavian or the subclavian to subclavian bypass, again, based on length.

MR. DOMIANO: One more moment and I think we are finished, Off the record for a moment.

(At this time a discussion was had off the record.)

MR. DOMIANO: Let the record show that the discussion off the record had to do with adjourning this deposition so that the doctor could examine some films he needs to examine based on his testimony during the deposition, which Mr. Switzer has disclosed such films have not been made available to him, and Mr. Switzer want5 the doctor to be able to examine those films, too.

That being the case!, we will adjourn Dr. King's deposition for the limited purpose of testimony, after the doctor reviews those films, with respect to choice of procedure and 'with respect to the exact

location of the plaque causing the blockage, okay?

Agreed, Mr. Switser?

MR. SWITZER: Yes.

MR. DOMIANO: We will do that at a time convenient to the doctor's schedule as well as the lawyers, and within the time frame the judge has put down.

You may have some questions, Mr. Switzer.

MR. SWITZER: I just want to clear some things up because, Joe, you marked one exhibit, one of my letters.

EXAMINATION OF DR. TERRY A. KING

BY MR. SWITZER:

Q Doctor, you may not have your whole file here in this classroom today, correct?

A Correct.

Q What I want to clear up is when I originally contacted you in May of 1988, did I sen'd you some information then? Do

you recall that?

A I can't recall specifically but --

MR. SWITZER: Well, maybe the thing to do would be to mark my other letters.

(At this time Defendants' Exhibits A through E, King, were marked by the reporter.)

Q Doctor, let me hand you Defendants' Exhibits A through E.

Would you just take a look at those, doctor, and see if that refreshes your recollection with respect to whether you received copies of those letters before, including enclosures?

A Yes, I did.

Q Doctor, according to these exhibits, at least starting in May of 1988 I sent you records from Msrymount Hospital for both of her admissions as well as the outpatient admission?

A Yes.

Q I sent you Cleveland Clinic records?

A Yes.

Q I sent you a Xerox copy of the left

clavicle fragment removed by Dr. Brems at the Clinic?

A Yes.

Q You received Dr. Laderman's report to Dr. Aldana?

A Yes.

Q I sent you a copy of the office chart of Dr. Aldana?

A Yes.

Q You received a copy of the plaintiff's handwritten versian of her symptoms?

A Yes.

Q A report of Dr. Brems?

A Yes.

Q You have received the report of Dr. Barron?

A Yes.

Q And you have had some X-ray films from Msrymount?

A Yes.

Q Then on September 2, 1988 I sent you a complete copy of the Cleveland Clinic chart, which I had received?

A Yes.

Q On December 6, 1988 I sent you a copy of the plaintiff's deposition transcript?

A Yes.

Q On December 29, 1988 I sent you the office records of Dr. Juguilon and Dr. Heyl?

A Yes.

Q And on January 23rd, '89, I sent you Dr. Kralik's first deposition transcript?

A Correct.

MR. SWITZER: And Joe already identified the other letter. Doctor, maybe what we will do when this deposition is rescheduled -- If you could locate the rest of your file, because apparently your file consists of more than what is here today.

THE WITNESS: Yes.

MR. SWITZER: Thank you.

MR. DOMXANO: I have nothing further. Why don't you instruct him about waiving signature, or let the reporter do that, because he is really not your client.

MR. SWITZER: I don't want to waive it.

CERTIFICATE

The State of Ohio,)
) SS:
COUNTY OF CUYAHOGA.)

I, Ronald Stahl, a Notary Public within and for tho State of Ohio, duly commissioned and qualified, do hereby certify that the within-named witness, DR. TERRY A. KING, was by me first duly sworn to testify to the truth, the whale 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 stenotype 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.

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

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, this 10th day of August, A.D., 1989.

Ronald Stahl

Ronald Stahl, Notary Public
Within and for the State of Ohio
My commission expires 7/26/91

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Terry A. King, M.D.
Hesd, Section of
Peripheral Vascular Surgery
Department of Surgery

May 31, 1989

Donald H. Switzer
Weston, Hurd, Fallon, Paisley & Howley
25th Floor Terminal Tower
CLeveland, Ohio 44113-2241

RE: REISIG VS. KRALIK

Dear Mr. Switzer,

I have had the opportunity to review the records of the above mentioned case that you have provided me. I feel that the indication for surgery as well as the selection of procedure are well within the acceptable standards of medical care. I agree that a subclavean to subclavean bypass is more appropriate than an axillary to axillary artery bypass. I also agree that sometimes clavicular resection is necessary for adequate exposure of the subclavean artery. I do not feel that the description of the disability of slumped shoulders is due to the resection of the medial portions of the clavicles.

I would be happy to discuss this at length if you should feel it necessary. If I can provide other information, please let me know.

Sincerely yours,

Terry A. King

Terry A. King, M.D.

TAK :nlp

PLAINTIFF'S EXHIBIT
KING

Affiliated with Case Western Reserve University School of Medicine and The Jewish Community Federation

CURRICULUM VITAE

TERRY A. KING, M.D.

DATE OF BIRTH:	January 23, 1952 Pittsburgh, Pennsylvania
HOME ADDRESS:	3199 Somerset Road Shaker Heights, Ohio 44122 (216) 283-1053
MARITAL STATUS:-	Married
CITIZENSHIP:	USA

EDUCATION:

1973	University of Pittsburgh **B.S.,** Cum Laude Biophysics, Microbiology, and Economics
1977	University of Pittsburgh School of Medicine M.D.

PROFESSIONAL **, TRAINING:**

1977-78	Intern, Surgery Case Western Reserve University School of Medicine University **Hospitals** of Cleveland
1978-82	Resident, Surgery **Case** Western Reserve University School of Medicine University Hospitals of Cleveland
1982-83	Fellow in Peripheral Vascular Surgery Northwestern University Medical School Chicago, Illinois

PREVIOUS POSITION: 7/83 - 12/84	Assistant Professor of Surgery George Washington University Staff Surgeon, Veterans Administration Medical Center Washington, D.C.
CURRENT POSITION: 1/85 - Present	Staff Surgeon and Head, Section of Peripheral Vascular Surgery, The Mt. Sinai Medical Center Cleveland, Ohio Staff Surgeon, Veterans Administration medical Center Cleveland, **Ohio**
ACADEMIC APPOINTMENT: 1985 - Present	Assistant Clinical Professor of Surgery Case Western Reserve University

PROFESSIONAL SOCIETIES:

Cleveland Vascular Society
Cleveland Surgical Society
Southeastern Surgical Congress
Candidate Group Participant, American College of Surgeons
Cleveland Academy of Medicine
Ohio State Medical Association
American Medical Association

LICENSURE:

Ohio
District of Columbia

BOARD CERTIFICATION:

Diplomate, American Board of Surgery, 1984
Certificate of Special Qualifications in General Vascular Surgery, American Board of Surgery, 1986

PUBLICATIONS:

1. King, Terry A., Rhodes, Robert S., DePalma, Ralph G.: Use of the profunda femoris artery for secondary revascularization, in Bergan, J.J. and Yao, James S.T. (Ed.): Operative Techniques in Vascular Surgery. New York, Grune & Stratton, Inc., 1980.

2. Adul-Karim, Faid W., King, Terry A., Dahms, Beverly B., Gauderer, Michael W. L., Boat, Thomas F.: Carcinoma of the extrahepatic biliary tract in an adult with cystic fibrosis. Gastroenterology 82:758, 1982.

3. King, Terry A., McDaniel, Martha D., Bergan, John J., and Yao, James S. T.: Visceral artery aneurysms, in Moore, W.S. (Ed.): Review of Vascular Surgery. New York, Grune & Stratton, Inc., 1983.

4. King, Terry A., Flinn, William R., *Yao*, James S. T., and Bergan, John J.: Pre-bypass arteriography, in Bergan, J.J. and *Yao*, J.S.T. (Ed.): Evaluation and Treatment of Upper and Lower Extremity Circulatory Disorders. New York, Grune & Stratton, Inc., 1984.

5. Flinn, William R., Ricco, Jean-Baptiste, Yao, James S.T., McDaniel, Martha D., King, Terry A., and Bergan, John J.: Composite sequential grafts in severe limb ischemia: A comparative study. Journal of Vascular Surgery 1:499, 1984.

6. Yao, James S.T., McDaniel, Martha D., King, Terry A.: Arterial surgery of the upper extremity. Clinical Surgery International, Volume 8, Arterial Surgery, London, Churchill Livingstone, 1984.

7. King, Terry A., DePalma, Ralph G., Rhodes, Robert S. Diabetes mellitus and atherosclerotic involvement of the profunda femoris artery. Surgery, Gynecology and Obstetrics 159:553, 1984.

8. Blebea, Jobn, and King, Terry A.: Intraperitoneal infusion as a complication of needle catheter feeding jejunostomy. Journal of Parenteral & Enteral Nutrition 9:758-59, 1985.

9. Rhodes, G.R., King, T.A.: Delayed skin oxygenation following distal tibial revascularization (DTR): Implications for wound healing and late amputations. Journal of Surgical Research. (In press)

10. King, T.A.: Hemodynamics of arterial blood flow, in Giordano, J.M., DePalma, R.G. (eds): The Basic Science of Vascular Disease, Futura Publishing. (In press)

MANUSCRIPTS IN PROGRESS:

Management of Arterial Complications of Thoracic Outlet Syndrome.

Mesoatrial Shunt in the Management of the Budd-Chiari Syndrome.

Pulmonary Embolism from Thrombus Above a Greenfield Filter.

Management of the Occluded **Axillofemoral** Bypass,

GUEST LECTURESHIPS:

"Vascular Surgery **and** its Relation to Prosthetics and Orthotics", Continuing Education Seminar of **Midwest** Chapter **of** Prosthetists **and** Orthotists, Rehabilitation Institute of Chicago, September 25, 1982.

"Cerebrovascular Evaluation in the Stroke Patient", Department **of** Physical Medicine **and** Rehabilitation Grand Rounds, Northwestern University Medical School, Chicago, Illinois, March **25,** 1983.

"The Ischemic Lower Extremity", Department of Medicine Grand Rounds, The Mt. Sinai Medical Center, Cleveland, Ohio, April 10, 1985.

"Lower Extremity Ischemia", Department of Medicine Grand **Rounds,** Ohio College of Podiatric Medicine, March **12,** 1986.

PRESENTATIONS:

"Extending Operability by Pre-Bypass Intraoperative Angiography" at Symposium **on** Evaluation and Treatment of Upper **and** Lower Extremity Circulatory Disorders, John J. Bergan and James S. T. Yao, Chairmen, Northwestern University Medical School, Chicago; December, 1983.

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April 24, 1989

Terry King, M.D.
Mt. Sinai Medical Center
Department of Surgery
1 Mt. Sinai Drive
Cleveland, OH 44106-4198

Re: Reisig vs. Kralik

Dear Dr. King:

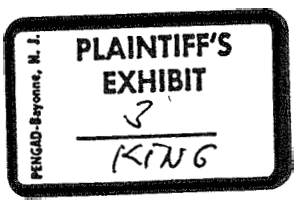
I have received a Court Order requiring me to produce copies of expert witness reports no later than May 31, 1989. Accordingly, it is imperative that I receive your report before that date. If possible, I would like to schedule a meeting with you to review this case and discuss your opinions.

I have scheduled depositions of a number of other physicians who provided treatment to Mrs. Reisig. In May, I will depose Drs. Aldana, Juguillon and Ledernan. I have also scheduled the deposition of Dr. Barron, Plaintiffs' surgical expert witness, for June 8 in Pittsburgh. Plaintiffs' counsel has indicated that he would like to schedule your deposition for June 20 or June 22. Would you please advise me as quickly as possible whether either of these two dates is convenient for you and, if so, the time when you would be available for a deposition.

I am enclosing some additional materials for your review. Enclosed are the following documents:

1.) Transcript of the deposition of Dr. Kralik which was completed on March 1, 1989. (I had previously forwarded the first part of his deposition transcript).

2.) Records of Dr. Jorge Medina.



You will note that the last pages of the Exhibits to Dr. Kralik's deposition contain recent Cleveland Clinic records.

Mrs. Reisig is still complaining of pain throughout her chest and shoulder area and was prescribed Voltaren. Dr. Kralik testified in his deposition that he believed the pain of which Mrs. Reisig was complaining was either caused by bursitis or the osteoporosis which he had.

Following is a brief summary of Dr. Kralik's deposition testimony. After completion of his military service in the 1940's, Dr. Kralik received his medical degree from The University of Pennsylvania in 1949. His internship and residency was at University Hospitals and Wilmington Medical Center in Delaware. Following his residency, he served two years in the Army as Chief of Vascular Surgery at Brook Army Hospital in Texis. He was board certified in general surgery in 1965. Since completing his residency and service, he has been engaged in the private practice of medicine specializing in general and cardiovascular surgery. He is on the staff of Hillcrest, Marymount and Geauga Community Hospitals.

His two most frequent procedures are pacemakers and reconstructive vascular surgery of the head and neck. He generally performs three or four subclavian to subclavian by-pass procedures per year. Depending upon the patient's condition, he does resect the clavicles as he believes that lends safety and durability to the procedure and is a way to avoid the greatest number of complications. With respect to Dorothy Reisig, he believed that resection of the mid-portions of her clavicles was indicated as it would avoid major complications and lend durability to her shunt. This is because the size of the subclavian would be maximum, the length of the graft would be the shortest and the lay of the graft would be the best for this procedure. He was able to achieve a better anastomosis.

He did not perform an axillary to axillary graft because he believed that that would have been less durable for Mrs. Reisig. He believed that with that by-pass there was a greater chance of disturbing the graft and traumatizing his work. Dr. Kralik referred to Haimovici's text on Vascular Surgery, Principles and Techniques, which he finds authoritative. (In Dr. Haimovici's text, Second Edition at pages 204-206, he discusses resection of portions of clavicle for subclavian axillary procedures).

Dr. Kralik also felt that this procedure was indicated because Mrs. Reisig had a number of other problems including an anomalous aortic arch, she had advanced vascular disease, advanced lung disease, high cholesterol and she had

been a smoker for many years which left "less room for error in this regard". If Mrs. Reisig had been in a better condition, then he may have considered a different procedure other than re-secting portions of her clavicles,

In the second deposition transcript, Plaintiffs' counsel extensively questioned Dr. Kralik on the diagnosis made in the post-operative office visits. In the first visit on 12/31/85, he diagnosed "bursitis right shoulder". To do this, he observed movement of her right shoulder and right arm and noticed difficulty that she had in abducting her right arm and raising it over her head. He palpated her shoulder and found an area of point tenderness in the subdeltoid bursa. The area of his operation was free of any inflammation. Blood pressure was equal in both arms and the by-pass was patent. He found no evidence that the "clavicular remnants" were causing any pain or exerting any pressure on any nerves. He prescribed three medications - one injection of Depo-Medrol, Tylenol-3 and Feldene.

In the second post-operative visit (1/8/86), Mrs. Reisig was complaining of tightness in her chest, a poor appetite, pain in her right shoulder and pain in her neck. He prescribed liniment for her bursitis. Her blood pressure reading in the left arm was 162/90. He did not take any reading of her right arm.

Plaintiffs' counsel also extensively questioned Dr. Kralik with respect to whether there was a partial or complete occlusion of the subclavian artery. Dr. Kralik used the term "complete occlusion" in his discharge summary. He testified that from a physiological point of view, it was a complete occlusion, but from an anatomical point of view, there was a partial occlusion. He believes that the occlusion developed very slowly as she had collateral circulation. This explains the reason why there was not a great divergency between the blood pressure readings of the right arm versus the left arm prior to surgery. At the time of his surgery on 12/9/85 he removed the clamp and observed no blood coming out. Therefore, he diagnosed complete occlusion. He testified that just because Mrs. Reisig had blood pressure readings of 140/80 in her left arm and 136/78 in her right arm prior to surgery does not mean that she did not have a significant subclavian stenosis. He testified that collateral circulation would have equalized the blood pressure in the arms.

In the 2/14/86 office visit, Mrs. Reisig was complaining of pain in both shoulders. Dr. Kralik believed

that Mrs. Reisig had generalized arthritis and that that was the cause as well as the acute bursitis she had on her right side. He did not take an x-ray as one had been taken in her prior hospitalization.

The last office visit was 11/5/86 where she was complaining of pain in her left and right shoulders. He prescribed Feldene, Maxide and Persantin. The right blood pressure was 198/98. He could feel blood coursing through the graft. He did not refer her to any other physician as she had been referred to him from Dr. Juguillon, a neurologist. Dr. Kralik denied that the absence of a complaint or a test that the use of her left arm made her dizzy is evidence that there was not a subclavian steal. He also disagrees that where a patient has a subclavian steal that the vertebral artery on the affected side enlarges because it has an extra function of bringing the blood down to the arm. He disagrees with Plaintiffs' counsel's statement that the blood to the affected arm must go up the Circle of Willis and then go down the vertebral. Dr. Kralik indicated that there are several multiple collateral blood vessels and other branches of the subclavian artery which act as detours.

In describing the relation of the graft to the clavicular remnants, Dr. Kralik testified that the graft was a distance of less than an inch from the remnants. Dr. Kralik removed the normal size bone that he usually removes in this type of procedure. He chose the area of anastomosis in order to reduce the possibility of kinking and to avoid the thoracic duct and the recurrent laryngeal nerve. He does not believe that an axillo-axillary graft would have been comparable to the subclavian to subclavian by-pass in terms of results.

With respect to Dr. Brem's report, Dr. Kralik disagreed that a "medial clavicular remnant had tilted posteriorly into the mediastinum and presumably caused some compression of her neurovascular structures". He believes that for that to have occurred, then there would have had to have been pressure on the subclavian artery which would have reduced or turned off the blood in her graft first. There was no evidence of that.

Dr. Kralik believes that Mrs. Reisig experienced a relief in pain fallowing Dr. Brem's surgery at The Clinic in April, 1987 because "a diseased bone was removed, not because compression was relieved". This is because of the diagnosis of osteoporosis, osteoarthritis and costochondritis". The x-rays confirm that Mrs. Reisig did have diseased osteo-

arthritis though that was not present in the portion of the bone that he removed. He believes that the onset of that disease would have been more than ten years. (Plaintiffs' attorney then impliedly criticized Dr. Kralik for failing to remove all of her diseased bone in his surgery). Dr. Kralik stated that he did the prudent thing; he removed the portion that was needed to be removed.

Dr. Kralik testified that he did obtain informed consent from Mrs. Reisig **before** his surgery. He had two conversations with her pertaining to the surgery. He showed her the arteriogram and a drawing of her anatomy and the proposed operation (these are included in the Marymount Hospital records). (Mrs. Reisig testified in her deposition that Dr. Kralik did discuss with her the possibility that he would have cut a hole through her collarbone. This was confirmed by her daughter's deposition also).

Attached as Exhibits to Dr. Kralik's second deposition transcript are copies of the excerpts from Dr. Haimovici's text used by Plaintiffs' counsel, copies of Dr. Kralik's office records, the Marymount Hospital chart for the admissions of **12/2/85-12/5/85,** diagrams used by Plaintiffs' counsel in the deposition, Dr. Brem's report and excerpts from The Cleveland Clinic records.

Would you please provide me with opinions on the following issues:

1.) Whether the subclavian-subclavian by-pass procedure with clavicular resection performed by Dr. Kralik complied with the accepted standards of medical care;

2.) Whether the indications for that surgery including the diagnosis made by Dr. Kralik and the other physicians was appropriate and complied with the acceptable standards of medical care.

3.) Whether Dr. Kralik should have performed an axillary - axillary rather than a subclavian - subclavian by-pass procedure or whether that was a matter of judgment.

4.) Whether Dr. Kralik properly performed the clavicular resection.

5.) Whether the removal of a portion of the clavicles could have caused the disability and pain described by Mrs. Reisig.

Please feel free to comment on any other issues which you deem pertinent to this case.

Thank you for your assistance in this case. I look forward to receiving your report and your statement. Please call me after you have had an opportunity to formulate your opinions.

Very truly yours,

Donald H. Switzer

DHS/kj
Enc.

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May 26, 1988

BY MESSENGER

Terry King, M.D.
Mt. Sinai Medical Center
Department of Surgery
1 Mt. Sinai Drive
Cleveland, OH 44106-4198

RE: Dorothy Reisig, et al. vs. John Kralik, M.D., et al.
Case No. 137367

Dear Dr. King:

Thank you for agreeing to review this case and provide an independent evaluation of the medical care and treatment provided by Dr. John Kralik to Dorothy Reisig. As we discussed, I represent John J. Kralik, M.D., one of the Defendants in this medical malpractice case. The Co-Defendants are Marymount Hospital and Alejandro Aldana, M.D. It is my understanding that Dr. Aldana and perhaps Marymount Hospital will be dismissed in the near future.

The claims in this lawsuit arise out of a subclavian to subclavian bypass procedure performed by Dr. Kralik on December 8, 1985 at Marymount Hospital. In that procedure, Dr. Kralik resected the middle third section of each clavicle. The reason for the surgery was the diagnosis of left subclavian artery occlusion and subclavian steal syndrome and other diagnosis set forth in the enclosed medical records. The patient had been experiencing dizzy spells for a number of months and other symptoms which are more clearly set forth in the enclosed records.

Though their claims are a little unclear at this point, it appears that the Plaintiffs, through their attorney and experts, are claiming that the diagnosis of subclavian steal syndrome was premature or improper and they may be claiming that the surgery performed by Dr. Kralik was

unnecessary or premature. However, the Plaintiff also appears to agree with the diagnosis and the performance of the surgery by Dr. Kralik inasmuch as that surgery was successful to relieve the Plaintiff's symptoms. Regardless of the confused nature of these claims, Plaintiffs, through their attorneys and experts, are claiming that it was improper for Dr. Kralik to resect the middle third portions of the clavicles in order to perform the surgery. Following the surgery, the Plaintiffs' claim that Mrs. Reisig experienced severe gain and disability as a result of the resection of her clavicles and this necessitated further surgery at the Cleveland Clinic.

I would appreciate your reviewing the enclosed materials and providing your opinions with respect to whether the medical care and treatment provided by Dr. Kralik to Dorothy Reisig complied with the acceptable standards of medical care including his diagnosis of her condition, the surgery that he performed on December 8, 1985 and his post operative care. Rather than providing you with an outline of the pertinent information, I would like to have you review all of the available medical records and base your opinions on those records and the other enclosed materials. Accordingly, I am enclosing copies of the following materials for your review:

1.) Marymount Hospital records for Dorothy Reisig's outpatient care on 11/14/85 and two admissions on 12/2/85-12/5/85 and 12/8/85-12/15/85.

2.) Cleveland Clinic records for Dorothy Reisig's emergency room visit of 6/28/86, vascular laboratory reports of 6/20/86, Dr. Richard J. Lederman's history and physical of 6/24/86, tomograms of the clavicles of 1/15/87 and records for the March, 1987 surgery performed by Dr. Brems wherein a partial resection of the proximal fragment of the left clavicle was performed (I am in the process of obtaining the complete Cleveland Clinic chart).

3.) Xerox copy of the left clavicle fragment removed by Dr. Brems in his surgery at the Cleveland Clinic.

4.) Dr. Richard Lederman's report

to Dr. Aldana.

5.) Office chart of Dr. Aldana, including a typed version of his chart.

6.) Plaintiff's handwritten version of the course of her symptoms.

7.) Report of Dr. John J. Brems (Plaintiff's expert witness).

8.) Report of Dr. Kenneth G. Barron (Plaintiff's expert witness).

9.) Marymount Hospital x-ray films.

I will depose Dorothy Reisig on July 21. The Plaintiffs' attorney will depose Dr. Kralik on July 27.

Dr. Kralik resected the middle sections of both clavicles in order to reduce the possibility of kinking, obstruction, etc., which he felt was a risk of this procedure. He believed that Mrs. Reisig had extensive vascular disease and one of his goals was to prevent a major stroke. At the time of the surgery, Mrs. Reisig was smoking one pack of cigarettes per day, which was reduced from two packs per day four months earlier, and she had smoked for 62 pack years. Please advise me if there is any other information which you would like me to obtain from Dr. Kralik. I will forward a copy of his deposition transcript and the Plaintiffs' deposition transcripts after their depositions are completed in July.

I look forward to discussing your initial opinions after you have had the opportunity to review these materials,

Thank you for your assistance. Would you please forward a copy of your curriculum vitae.

truly yours,

Donald H. Switzer

DHS/kj
Enc.

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September 2, 1988

Terry King, M.D.
Mt. Sinai Medical Center
Department of Surgery
1 Mt. Sinai Drive
Cleveland, OH 44106-4198

RE: Dorothy Reisig, et al. vs. John Kralik, M.D., et al.
Case No. 137367

Dear Dr. Xing:

As a follow-up to my May 26 correspondence, I am enclosing a copy of the complete chart which I received from the Cleveland Clinic Foundation. The depositions of the Plaintiff and Dr. Kralik have not yet occurred. Those depositions were cancelled pending receipt of all the Plaintiff's medical records.

I will advise you as I receive additional information. When you have the opportunity to do so, I would appreciate your calling me to discuss your initial opinions.

Thank you for your assistance in this case.

Very truly yours,

Donald H. Switzer

DHS/kj
Enc.

COUNSELLORS AT LAW
'WESTON, HURD, FALLON, PAISLEY & HOWLEY
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December 6, 1988

Terry King, M.D.
Mt. Sinai Medical Center
Department of Surgery
1 Mt. Sinai Drive
Cleveland, OH 44106-4198

RE: Dorothy Reisig, et al. vs. John Kralik, M.D., et al.
Case No. 137367

Dear Dr. King:

Enclosed is a copy of the transcript of Mrs. Reisig's deposition for your review. Dr. Kralik's deposition has been scheduled for January 12.

After you have had an opportunity to review the materials in this case, would you please call me with respect to your initial opinions.

Very truly yours,

Donald H. Switzer

DHS/kj
Enc.

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December 29, 1988

Terry King, M.D.
Mt. Sinai Medical Center
Department of Surgery
1 Mt. Sinai Drive
Cleveland, OH 44106-4198

Re: Reisig vs. Kralik

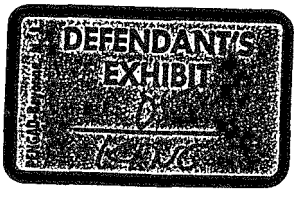
Dear Dr. King:

Enclosed are copies of the office records of Dr. Juguilon and Dr. Heyl for your review.

Very truly yours,

Donald H. Switzer

DHS/kj
Enc.



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January 23, 1989

Terry King, M.D.
Mt. Sinai Medical Center
Department of Surgery
1 Mt. Sinai Drive
Cleveland, OH 44106-4198

Re: Reisig vs. Kralik

Dear Dr. King:

Enclosed is a copy of the transcript of the partially completed deposition of Dr. Kralik for your review.

Very truly yours,

Donald H. Switzer

DHS/kj
Enc.