THE STATE of OHIO,
: SS:
COUNTY of STARK. .

IN THE COURT OF COMMON PLEAS

MARLA J. SPREADBURY, et al., :
plaintiffs, :

vs. : Case No. 1998CV1681
: 1998CV00589
MERCY MEDICAL CENTER, et al.,:
defendants.

Deposition of MICHAEL KRALIK, M.D., a witness herein, called by the plaintiffs for the purpose of cross-examination pursuant to the Ohio Rules of Civil Procedure, taken before Constance Campbell, a Notary public within and for the State of Ohio, at the offices of Thoracic Surgical Associates, 1320 Timken Mercy Road, NW, Canton, Ohio, on WEDNESDAY, APRIL 14TH, 1999, commencing at 2:12 p.m. pursuant to agreement of counsel.

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I N D E X

WITNESS: MICHAEL KRALIK, M.D.

(NO EXHIBITS MARKED)

(FOR COMPLETE INDEX, SEE APPENDIX)

(IF ASCII DISK ORDERED, SEE BACK COVER)

MICHAEL KRALIK, M.D.

of lawful age, a witness herein, called by the plaintiffs for the purpose of cross-examination pursuant to the Ohio Rules of civil Procedure, being first duly sworn, as hereinafter certified, was examined and testified as follows:

MISS KOLIS: Dr. Kralik, just for purposes on the record, my name is Donna Kolis, of course you know, we just met. I'm quite certain at this point in time you understand that I have been retained to represent Marla Spreadbury. I'm trying to think of how I would like to make this transaction.

CROSS-EXAMINATION

BY MISS KOLIS:

Q. For the record, could you state your name and professional address?

A. My name is Michael Kralik, my profession address is 1320 Mercy Drive, Northwest, Canton, Ohio 44708.

Q. Doctor, undoubtedly you are aware I've not named you as a defendant in this lawsuit. For that reason I would like to acknowledge that Mr. Treadon did arrange for this deposition to take place, I do appreciate it.

A. Thank you.

Q. I'm going to ask you a series of questions today that have to do with your care and treatment of the patient. Alicia Wyler graciously today brought the original chart, which is more readable than the copies most of us have. If you need to refer to those or do you have a personal office chart on Mrs. Spreadbury, or is it a joint office chart?

A. We have a joint office chart.

Q. whatever you want to refer to in being able to answer my questions, those that you can from memory is certainly acceptable.

I'm going to try to ask you intelligible questions. That is not always a possibility since I'm a lawyer, you are a doctor. If ■ ask something you don't understand, will you please let me know that, okay?

A. Yes, ma'am.

Q. Answer all the questions verbally.

A. Yes, ma'am.

Q. Let's briefly go through your background, we were all handed your CV, ■ think that you've indicated that this is perhaps not complete; did I misunderstand what you were saying?

A. ■ have two of what I believe are three pages, you may have all three.

Q ■ have four pages.

A. should be complete.
Q. This is a complete one?
A. Yes.
Q. Evidently you obtained your undergraduate degree at Harvard; is that correct?
A. Yes, ma'am.
Q. what is your degree in?
A. Chemistry and physics.
Q. You received a BA degree?
A. Yes.
Q. You went on to Case Western Reserve School of Medicine, graduated in 1986?
A. Yes, ma'am.
Q. Thereafter it looks like you began your specialty training?
A. Yes.
Q. Tell me about that, you were trained at Parkland as a surgical intern, correct, for a year?
A. Yes, ma'am.
Q. Did you continue the rest of your residency at Parkland in surgery?
A. Yes.
Q. You finished that particular surgical residency in 1991?
A. Yes, ma'am.

Q. During the time you were at Parkland were you trained in cardiothoracic surgery?

A. It was an elective as part of general surgery training.

Q. That was your exposure, evidently you must have liked it enough to apply for a Fellowship?

A. Yes.

Q. I see you had a two year Fellowship at the New York University

A. Yes, ma'am.

Q. After that I assume that you obtained your Boards in cardiothoracic surgery, it's thoracic surgery, correct?

A. Yes, ma'am.

Q. That was 1994?

A. Yes, ma'am.

Q. If we go through your employment, which obviously we haven't seen this before, you obtained that Board in 1994, but you finished your program in 1993. Who did you work for in calendar year 1993?

A. The end of 1993 through the beginning of 1995 I worked at Saint Luke's Medical Center with a group of cardiothoracic surgeons.

Q. Saint Luke's in Cleveland?

A. Yes.

Q. Who did you work with?

A. I worked with three other surgeons, James Thorton was my closest associate. Also with Dr. James Engle and for a brief period of time with one of them who I can't remember now.

Q. I guess let me ask you this way I suppose: It says you were working for Cleveland Thoracic and cardiovascular Surgeons from 1993 to 1995?

A. Correct.

Q. That's the group you just discussed with me?

A. Yes.

Q. That group had surgical privileges at a number of Cleveland hospitals?

A. You are correct.

Q. Sometimes these are not that hard to piece together for me I don't suppose.

That was Meridia, Saint Alexis, Marymount, Saint Luke's?

A. Yes, ma'am.

Q. Then in 1995 did you leave the Cleveland Thoracic and cardiovascular surgery group, work for one year at the clinic?

A. Yes. The group dissolved through various -- Dr. Thornton moved to Michigan, Dr. Engle took disability --

MR. TREADON: You don't have to go through the details why.

Q. They dissolved, you went on for other employment?

A. They dissolved.

Q. You worked for one year at the Cleveland clinic?

A. Yes, ma'am.

Q. I just guessed. That is only because the CV says 1995, it looks like through present, it isn't?

A. Correct.

Q. You worked on the cardiothoracic service at the clinic?

A. Yes.

Q. I hate to ask it, who was your supervisor if you had one?

A. I was an associate staff member. As an associate staff I worked with a number of staff physicians, most frequently I worked with Dr. Bruce Lytle, Dr. Floyd Loop, Dr. Delos Cosgrove.

Q. You stayed there give me an idea when to when?

A. July 1, 1995 to July 1, 1996.

Q. In your experience subsequent to finishing your cardiothoracic Fellowship, at any time in 1993, '94, '95 through the time that you left the Cleveland clinic were you -- I don't know how to ask it, were you serving as a trauma surgeon for these institutions?

A. At Saint Luke's.

Q. So at Saint Luke's that was your responsibility, you were on call as a trauma surgeon?

A. Yes, ma'am.

Q. when you went to the clinic, what kind of cardiothoracic work did you do?

A. Primarily elective, occasionally emergent.

Q. when you say occasionally emergent, can you define for me what quantity of your work was done in emergency cardiothoracic surgery, if it's possible?

A. I would guess 5 to 10 percent at most.

Q. How would that come about that you would be called upon to do emergency cardiothoracic work?

A. Quite a few of the patients who develop injuries to their aorta, not necessarily traumatic injuries, acquired injuries, aortic dissection, are transferred to the Cleveland clinic from outlying institutions for their care.

Q. Facilities that may not have the capability of performing that surgical procedure, is that what you are indicating?

A. Yes, ma'am.

Q. We will focus on your year at the clinic since that was your last one before coming here.

when you were doing elective

cardiothoracic procedures, can you break down for me what kind of procedure and what percentage of your time you spent to the best of your ability?

A. About 90 percent of the cases were elective, that means scheduled, probably before the day of the operation, cases for acquired heart disease. Acquired heart disease would consist of in this country primarily coronary artery disease and acquired valvular disorder.

Q. You were doing a lot of bypass surgery?

A. Yes, ma'am.

Q. I'm trying to find out what you were doing in addition to bypass and valve surgery I take it?

A. Yes, ma'am.

Q. Were you the person who the clinic -- I doubt it -- were you the person the clinic would have doing bronchoscopies, esophagrams, things of that nature?

A. Not primarily. occasionally for patients that required it we would do those things.

Q. Fair enough.

Why did you leave the Cleveland clinic?

A. I obtained employment at this institution.

Q. Explain that to me, what position you took with them.

A. I took a position here as a staff cardiac and thoracic surgeon to work with Dr. chrysos and Dr. Tawil.

Q. I'm a little confused by your answer probably because I didn't ask a good question.

when you said you came to take a position here, who did you interview with, the hospital for a position at the cardiothoracic surgeons or with Drs. Chrysos and Tawil?

A. I don't remember all of the meetings that I had on my interview day here. I know that I met Dr. Tawil and chrysos, I believe that I met a number of the administration, the administrators at this hospital also. I don't recall their names and the times of my meetings.

Q. The employment opportunity that you were made aware of, was it advertised as an associate surgeon for this surgical group or was it advertised as the need for a cardiothoracic surgeon to be a staff surgeon for the hospital; if you recall?

A. I don't recall.

Q. You interviewed for and obtained a position as an employee of what entity?

A. Regional Heart Center, Thoracic Surgical Associates.

Q. That is this group here?

A. This group of physicians, yes.

Q. Do you have an employment contract?

A. Yes, I do.

Q. Are you a partner of the group?

A. No, I'm not.

Q. I would ask that you provide to Mr. Treadon a copy of your employment contract.

MR. TREADON: I'm not sure I'm going to provide that. what do you need that for?

MISS KOLIS: We will talk about it.

A. I don't think I'm at liberty to do that.

Q. We will discuss that.

when were you first employed here, was that 1996?

A. Yes, ma'am.

Q. The Summer of 1996 if I'm following our conversation.

what was your job description, what were you hired to do?

A. surgical therapy for patients requiring operations that I'm specialized and Board certified to do.

Q. Were you hired for any particular area of expertise?

MR. TREADON: He just said what his area of expertise was.

Q. I'm asking if there was a special need you were

Q. Yes.

A. I'm not sure how the call schedule is distributed. There are certain areas of my field which overlap with other surgeons that do not work with our group, so the responsibilities in those areas are shared.

For instance, there are other physicians at this institution who are thoracic surgeons who will deal with chest trauma that is admitted from the emergency room outside of our group.

Q. So I guess let me see if I interpret your answer. We can discuss it a little bit.

In terms of being the on-call doctor, you're not sure how the schedule is selected but you were available to the hospital to be an on-call doctor for thoracic emergencies, i.e., blunt chest trauma?

A. Yes, ma'am.

Q. Cardiothoracic, cardiothoracic emergencies?

A. Yes.

Q. Generally speaking in 1997 how frequently were you the on-call thoracic surgeon?

A. I don't recall.

Q. Was it once a week?

A. I don't pay any attention to the call schedule.

MR. TREADON: Give her your best guess.

filling within this group?

A. As time has evolved I think I did fill a special need of the group. I do not know the intentions of the people that hired me when I came to the institution.

Q. I wasn't trying to determine if you guessed their intentions. what I want to know is when you came to work, was an agreement reached or was there discussion that they had a need for someone to do their bypass surgery or their valve surgeries, or were you just hired in general to cover all bases?

A" To do everything that a Board certified cardiothoracic surgeon does.

Q. The practice you entered, I gather you had in-office patients you saw on a regular basis; that is a fair statement?

A. Yes, ma'am.

Q. Referred to you probably from other physicians?

A. Yes, ma'am.

Q. In addition to that, did you serve as an attending on an on-call basis in the hospital for the cardiothoracic service, cardiothoracic surgery?

A. Yes, ma'am.

Q. How did that work?

MR. TREADON: You mean the on-call schedule?

A. My best guess is that for periods of a month at a time our group is the primary group responsible for thoracic emergencies. During that month I would be taking call on average every third day.

Q. That is all I want to know, if you knew how it was divided up?

A. I believe the call is distributed among three different people so I believe our group is responsible for the thoracic call at least four months of the year.

Q. what other two groups would those on-call thoracic persons represent?

A. I don't know the corporate names.

Q. Is it two other groups of thoracic surgeons?

A. Thoracic surgeons.

Q. There isn't another cardiothoracic surgery group providing services at this hospital, are there?

A. Not cardiac surgery.

Q. Have you had an opportunity to look at your notes before this deposition today?

A. Yes, ma'am.

Q. To the best of your recollection, or based upon what is contained in the notes, when was the first time that you saw Marla Spreadbury?

A. The morning following her admission.

Q. Do you have a reference in your chart?

MR. TREADON: You want to use that notebook I gave you?

Q. We asked for the original records because we wanted to see them.

A. I believe it was in the intensive care unit, it's documented in the nurses' notes from the intensive care unit the morning following her admission.

Q. You are looking at the nursing notes, right, what time do the nurses' notes reflect you were in the intensive care unit?

A. Sometime after 9:20 in the morning.

Q. You know that because you are looking in the nursing note?

A. Yes, ma'am.

Q. what does that note read, the one you are referring to?

A. Dr. Kralik notified of condition and here.

Q. what is your memory of what you were told and when you found out that Mrs. spreadbury was in need of cardiothoracic care, I guess that is the easy way to ask it?

A. Several minutes before I went to see her I was notified that her blood pressure was low.

Q. Were you in the hospital or were you in your office?

A. In the hospital.
Q. Were you in the hospital doing rounds on patients?
A. I was assisting with surgery on the third floor of the hospital. Miss spreadbury was a patient on the first floor of the hospital.
Q. She was down in the ICU, you were up in surgery?
A. Yes, ma'am.
Q. Who were in surgery with, if you know?
MR. TREADON: You mean the patient?
Q. No, I don't want the patient's name. were you assisting a surgery?
A. I don't recall exactly which physician I was assisting but to my recollection, Dr. Tawil and Dr. Chrysos was both performing surgery that morning.
Q. Because you wouldn't be assisting anybody else other than those two doctors?
A. Correct.
Q. So they paged you in the OR, is that your recollection?
MR. TREADON: Don't guess. If you remember, fine, if you don't.
Q. I'm just trying to get events?
A. I don't remember exactly the way P was notified, but I believe I was notified just a few minutes earlier

that her blood pressure was very low.

Q. You left the surgery, came down to the first floor to see the patient?

A. Yes, ma'am.

Q. Did you at that time write an examination note?

A. I do not believe so.

Q. The reason I ask, I'm just asking, what I have, I may not have all the notes, the note I have the first time I see your name in the chart with your signature I believe is the pre-op note. Have you reviewed your pre-op note in this matter?

A. Yes, ma'am.

Q. The way I read it, you have fairly nice an w t ng, 43 year old with an aortic transection emergent repair, family aware of risks including paraplegia; is that your first note in the chart regarding Mrs. Spreadbury?

A. Yes, ma'am.

Q. Tell me, since there is not a writing you are going to have to reconstruct for me, the sequence of events that occurred following you coming downstairs, up to the point where she is taken to the surgery, I would 1ike that sequence first.

A. when I saw the patient in the intensive eare unit she still was hypotensive, I.V. pressor agents,

specifically Levophed. I felt that although there were many possibilities for the etiology of her hypotension, that aortic transection was one. I arranged for an immediate and urgent arteriogram and aortogram. She was transferred as soon as possible to the aortography suite, which is in the radiology area on the same floor of the hospital.

I was present with her during that exam. For the period of time that she was in radiology her blood pressure seemed to be adequate. I was very impressed by the findings during aortography.

One thing that stands out in my memory is the size of the hematoma that was appearing on her delayed films during her aortography. As soon as we were able to diagnose that injury, we contacted the operating room to get the patient to the operating room for emergent surgery. I do not recall whether I spoke to the husband at that time. My note would seem to indicate that I did. That does not stand out in my memory.

On arrival to the operating room we placed the usual monitoring lines.

Q. I would like to stop you. I would sort of like to separate out this sequence of events then from the surgery.

Do you normally, Doctor, go to the aortogram with your patients if you order one?

A. I like to be there, yes.

Q. Because you can watch along with the person who is performing the examination, correct, to see or be told what -- do you have the ability to interpret what is being seen at the time of examination on your own?

MR. TREADON: You asked a couple questions. Do you want to know why he goes?

MISS KOLIS: Yes.

MR. TREADON: Why do you go?

Q. Some doctors do, some don't, why do you go with your patients?

A. when I order aortography it's because I suspect a transection of the aorta. when a patient has a transection of the aorta they can at any time have a cardiac arrest, so I would like to be present if they do have an arrest so that I could resuscitate the patient.

Q. You stated I believe that when you got down to [redacted]CU a couple minutes after you were notified she had low pressure there were in your mind several possibilities of things that could cause low pressure; am I stating this accurately?

A. Yes, ma'am.

Q. Doctor, what if anything did you know about the

patient's course of treatment in the hospital from the time she was admitted up to the time that you went down to see her in ICU?

MR. OCKERMAN: Asking what he knew at that time?

Q. when you got downstairs, what if anything did you know about the patient's course of treatment in the hospital before your arrival in ICU?

MR. TREADON: If you remember, don't try to guess.

A. I don't remember everything that I heard. when I was in the operating room assisting the message was given to me the patient had a motor vehicle accident with severe injuries. I do not remember exactly which injuries were mentioned to me before I went downstairs. I do recall that I was told that the patient did have a CT scan done.

Q. I'm wondering when you got down there who was giving you information about the patient?

A. when I arrived the nurses at the bedside.

Q. Did a doctor, Dr. Telesz come in and talk to you?

A. I don't recall speaking to Dr. Telesz.

Q. How were you able to or why was it within your differential to suspect a dissection of the aorta if you didn't even know she had been in an auto accident?

A. I believe that I was told that she was in an auto accident.

Q. You had the basic information when you got down to ICU?

A. Yes, I believe that -- may I explain where I was in a little more depth?

Q. Absolutely.

A. when we do open heart surgery, which is what I was doing at the time, we generally have one primary physician and one assistant physician. The assistant is there to facilitate the operation, but his presence isn't absolutely essential. when the patient had her hypotension I believe the nurses called upstairs directly, the message was given to me by a nurse who was circulating in the room I was in.

At that time the surgeon who was across from me, I cannot remember if it was Dr. Tawil or Dr. Chrysos gave me a little bit of information about the patient. Then I immediately went downstairs. So I had the information from that person, and also from the nurses downstairs.

Q. I would ask you do you keep a copy in your office for record keeping purposes of your surgery schedules?

A. I don't know if they keep copies here. It is scheduled with the main scheduling desk of the OR, you

can find those records.

Q. Fair enough. It would tell us who the attending was, you would be listed as the assistant in all probability?

A. Yes.

Q. It's a pretty good guess.

A. I think so.

Q. So someone gave you some information, whether it was the nurse or otherwise, you at least at a minimum knew she had been in an automobile accident?

A. Correct.

Q. Other than the transection of the aorta, what was within your potential differential that would have caused the pressure to drop?

A. Hypotension from cardiac contusion from a pneumothorax, a tension pneumothorax, intra-abdominal blood loss. Those are the three most likely things that I thought of.

Q. At that point, since there isn't a note that you dictated later, that is why I have to ask the questions, did you eliminate these other possibilities for a reason?

A. That was the purpose of my going downstairs, the patient had chest tubes, they seemed to be functional.

Q. That would rule out a tension pneumothorax?

A. Generally and along with auscultory exam. The other ones are more difficult to eliminate urgently. Generally cardiac contusions are accompanied by arrythmia, gross arrhythmias. I did not believe it was those at the time. Intra-abdominal blood loss usually results in a firm, distended abdomen.

Q. That wasn't present?

A. Not to my recollection was not present.

Q. Before we get to the surgery issue --

MR. TREADON: That is lawyer speak, the surgery issue.

Q. It is lawyer speak. I wish I could do doctor speak, I haven't been to medical school.

On occasion since coming to this particular cardiothoracic group, I gather you've been called to the emergency room to evaluate blunt trauma patients; would I be fair in that guess?

A. Yes. Parkland is a center for trauma care.

Q. Pretty good one, parenthetically.

A. I also spent time at Bellevue during my time in New York.

Q. Tell me how you as a cardiothoracic surgeon work up a blunt chest trauma patient?

MR. TABER: I object to the extent he's a fact witness, not an expert, so anything

beyond the scope of his treatment is technically off limits. That is my objection.

MISS **KOLIS:** Thank you, Mr. Taber.

MR. TREADON: You may answer. In a general sense you are asking.

A. Immediately we're concerned with what we call the airway, breathing and circulation problems, A, **B, C's** for these patients. We want to establish an airway, make sure it's secure, make sure they can breathe and that they have some preservation of their circulatory system.

If we feel that the patient is stable we will order some tests following our initial exam and s r'). Our initial exam and survey are chest trauma usually just includes palpation to check for subcutaneous hematoma, or unstable ribs, s A s·u t:t n to for breath sounds. simple observation for hematomas, disfigurement.

Q. when you say simple observation, you are talking external hematoma?

A , m m. Following that we would generally order a chest x-ray.

Q. Let me ask you at this point, although **I'm** going

to let you go on with your explanation, in the emergency room of Mercy Hospital, is the scenario you are outlining for me what you do to evaluate a chest trauma, is that contained within a procedures, policy or protocol manual for evaluation of blunt chest trauma?

A. when you say procedures manual, you mean a manual from Mercy Medical Center?

Q. Yes.

MR. TREADON: You mean that tells the doctors how to be doctors or for nursing, what do you mean?

Q. what I mean is, first of all, is there a document in the emergency room that lists the procedures of how to triage for a blunt chest trauma?

A. I do not know.

Q. You haven't read one, or if you have you don't recall?

A. I don't recall seeing one in the emergency room at Mercy Medical Center.

Q. Going on, so then you are looking for external hematomas, et cetera, you order a chest film?

A. Generally that is the first test for patients.

Q. chest films is ordered, what are you looking for on the chest film in a blunt chest trauma?

A. You check the bony anatomy to see if there are any

rib fractures. You check for pneumothoraces, you check for the size of the mediastinum silhouette, for any pleural fluid that the patient might have, the size of the cardiac silhouette, any possible infiltrates or contusion in the lung tissue.

Q. At the time that Mrs. spreadbury was admitted September 23, 1997 you had been with this group about a year and three months.

During that time had you and Dr. Chrysos if I'm pronouncing that correctly and Dr. Tawil discussed and established how you as a group would triage blunt chest trauma?

A. During the course of our day at the medical center the majority of our time is spent discussing patients and how we feel they should be treated.

with that said, I do not recall exactly whether we had established any particular guideline for this particular injury.

Q. You don't have anything in writing in your office that reflects what procedures you would follow in what order regarding blunt chest trauma?

A. Not in my office.

Q. when you first came to work here, were you supervised by either Dr. Tawil or chrysos or were you pretty much because of your training and background left

to manage trauma cases as they came in on call on your own?

A. Pretty much to work on my own.

Q. You, yourself, Doctor, have you had occasions when your chest x-ray reveals a widening of the mediastinum?

A. Yes.

Q. Do you personally send the patients for a CAT scan to evaluate that widening or do you prefer they go immediately for an aortogram?

MR. TABER: objection. Same objection as before. I can presume it will be continuing to this line of questioning.

MR. TREADON: You are trying to use him an now. He care

MISS KOLIS: I'm trying to find out what this group thinks was as a preference to one exam over another.

MR. TREADON: There is group thinking? These are the doctors that are Board certified in thoracic surgery. I think there is some latitude. Are we going to get into using him as an expert witness against one of his partners, I'm not going to permit it.

MR. MEADOWS: I object for the

record. I don't know if there is a question.

Q. I asked if he had a diagnostic preference when he sees the widening mediastinum as to whether he would prefer to do a CT or proceed immediately to an aortogram?

A. There are circumstances in which you might prefer one or the other.

For example, as in this case, a patient with multiple injuries to the head, injuries suspected to the abdomen, injuries to the chest, it's a possibility to take the patient to the CT scan suite, do all three examinations at that same time, assess a patient who is unstable, therefore it would be preferred.

MR. TREADON: "It" meaning CT scans.

A. There are other situations when maybe there is no [redacted] of other [redacted] to the head or to the [redacted] tissue [redacted] to the chest as [redacted]

The problem with the aortogram is that it will not give you any information about rib fractures, pulmonary contusions, pericardial effusion which could represent cardiac contusion, possible

tamponade. So a CT scan has definite benefits when you are worried about more than one problem.

In addition, CT scans have been refined through the period that I have been a physician. When I was in medical school we were using first generation CT scanners. The images of the aorta were not ideal. They were good, but they weren't ideal. Now we have spiral CT scanners with I.V. boluses, we can get a tremendous amount of information without requiring the patient to wait 30 minutes for a specialized radiologist to come, without waiting for radiology techs, specialized radiology tech to come to the hospital, without the risk of arterial puncture.

Arterial puncture could result in many sorts of complications. You can have a stroke, you can dissect the aorta from the arterial puncture, you can get thrombus with occlusion of the vessel. That can be a horrible problem. There are definite complications to aortography.

Q. I just wanted to know how you viewed that.

When you decided that Mrs. Spreadbury needed an aortogram, were the special radiologists already here in the hospital?

A. Yes, ma'am.

Q. At this facility are they here for a prescribed

number of hours or are they, if you know?

A. I don't know. I know they were here that day. I do not believe the suite was immediately available. In other words, I think there was a patient that was having a study done, there was a small wait for the procedure.

Q. How long do you think the wait was if you can recall?

A. I can't remember.

Q. My question was: Are you aware whether there is on premises, 24 hours a day, a person who can do an aortogram?

A. There is not.

Q. Do you know what time that suite -- I call it a suite -- it closes; do you know what time?

A. No, ma'am.

Q. That's okay. You go with her to the aortogram, you know there is a dissection, correct, based upon the examination?

A. Yes, ma'am.

Q. You are I'm assuming frantically calling for an operating room at that point?

MR. TREADON: I object to frantic.

Q. I'll withdraw the word.

You arranged for the operative suite based upon that examination?

A. Yes, ma'am.

Q. Do you recall whether or not you spoke with Mrs. spreadbury' husband before the surgery?

A. My notes indicate that I did. However, that does not stand out in my memory.

Q. what does that mean?

A' There are many things about this case that I can recall, even though it was a year and a half ago. Basically it was because they were associated with the possibility something bad was going to happen to the patient.

I remembered distinctly the picture on the aortogram and the fact that the hematoma was rapidly ar i I remember many details vividly from the operation because they were very dramatic.

Q. Let me ask you a couple of questions once again back to the aortogram.

I get that you are telling me you can vividly remember seeing the hematoma. while the examination was going on was the hematoma increasing in size from your perception during that exam?

A. what happens is that after dye is injected into the artery, if there is an injury to the aorta it will leave the lumen of the aorta and mix with and opacify a hematoma around the aorta. It does not necessarily mean

that the hematoma was enlarging as we were watching it, it means the dye that has been in the aorta was gradually filling a space around the aorta.

Q. The visual you have of the dye is --

A. Dissipating out of the area.

Q. Giving you the full picture of what the hematoma looked like, correct?

A. Yes, ma'am.

Q. In lawyerly, probably not too doctorly, let's see if I can do this.

At the time, based upon what you were b e o ɛɛ was the hematoma still contained at that point?

A. Yes, ma'am.

Q. The rupture occurred later, the rupture of the hematoma; would you agree

Q. Back to wherever we were before I backtracked and questioned you, you just don't vividly remember speaking to Mr. spreadbury prior to surgery?

A. Yes, ma'am.

Q. Was Marla Spreadbury paraplegic before you performed your

A. I don't know.

Q. Explain your answer to me.

MR. TREADON: As opposed to something he doesn't know, how do you explain that?

MISS KOLIS: I'll ask it another way, Mr. Treadon, if you don't like the phraseology.

MR. TREADON: I'm not giving testimony, if you understand that question, go ahead and answer it.

A. when I was assessing the patient, prior to her surgery, I noticed that she could not move her legs; however, at that time the patient had a very low blood pressure, was very lethargic, intubated, it was very difficult to communicate with her. It was still more difficult to do an ideal neurologic exam.

Q. You couldn't do an ideal neurologic examination at that time because of the medications that were required to have her intubated?

A. Because of the activity required to keep her blood pressure at a decent level.

Q. I'm sorry, that is what I get for looking at Mr. Emershaw's note when are you answering.

when you say the activity required to keep at a decent blood pressure, what are you referring to?

A. When the patient was in the intensive care unit her blood pressure was low, we were trying to increase

pressure.

Q. Did he assist in this surgery?

A. Yes, ma'am.

Q. If there are documents that made it look like you were the assistant, he was the primary surgeon, that would be inaccurate?

A. Yes, ma'am.

MR. TREADON: what documents are you referring to.

Q. I'm asking because my brain is telling me the anesthesia record might have been recorded that way. It's not a big event. It's your memory you were the primary surgeon?

A. Yes, ma'am.

Q. Just out of curiosity, in your group if you have a rule, who dictates the operative summary?

A. usually it's the surgeon of record.

Q. Have you reviewed the surgery report from the repair of the rupture?

A. Yes, ma'am.

MR. TREADON: Talking about the op note?

MISS KOLIS: Yes, his op note. I'm calling it his op note but --

Q. Did you dictate this operative summary or did

it with certain medications.

Q. Those medications --

A. Levophed. Transfer her from the aortogram suite to the operating room, an ideal neurologic exam takes many minutes to perform. The minimal time would be approximately six or seven minutes.

something that is done not in a situation where you were worried about a patient dying at any minute because the six or seven minutes you spend doing a neurologic exam could be the six or seven minutes that cost a patient their life. Generally our exams when we are faced with a crisis situation are very -- we feel they are accurate.

Q. Limited in nature?

A. Limited.

Q. sure. Let's see if I can piece this together.

You've been to the aortogram, you've made a call to arrange for a surgical suite, did Dr. Chrysos then enter the picture because you called him or he came downstairs, what happened?

A. I do not recall my communication with Dr. chrysos before going to the operating room. I do know that he came to the operating room after the procedure had already been started. After I had clamped the aorta, stopped the bleeding and re-established a blood

Dr. chrysos?

A. I dictated the operative summary.

Q. His signature appears in the typewritten version for what reason, if you know?

A. I don't know. I assume --

MR. TREADON: Don't assume.

Q. You don't know why that it is. In any event, you crossed it out, you ended up signing the report?

A. Yes, ma'am.

Q. I think I just asked this, did you dictate the operative report?

A. Yes, ma'am.

Q. when this was received back from the transcription which looks like a day later, is that right, or is that it was transcribed the following day?

A. Yes, ma'am.

Q. There are some additions to the transcription which were in your handwriting, that are dated 9-30-97; do you see them?

A. Yes, ma'am.

Q. would that be the date when you saw the operative transcription?

A. That would be the day I made the corrections. I believe this was the day that I first saw the dictation.

Q. Is that pretty normal -- who does your

transcription, operative?

A. Hospital system.

Q. Hospital system does the operative transcription, what is the normal -- [redacted] should never use that word in a medical deposition -- what is the average turn around time you can anticipate on an operative dictation?

A. usually we see the dictation three to four business days after the procedure.

Q. The first thing you added was that patient was unable to move her lower extremities pre-op. You signed that with your signature, dated it. Why did you feel that that was important to add to the operative summary?

A. It was an observation that [redacted] had made.

Q. Prior to reviewing this operative note, between the 24th and 30th, did you have any discussions with your partners -- do you consider Dr. Tawil and Dr. Chrysos associates?

A. No.

Q. [redacted] asked you early on if you were a partner in this business entity. Who issues the paycheck to you?

A. Do you mean who signs the paycheck?

Q. Right, who signs your paycheck?

MR. TREADON: Do you know who signs your paycheck?

THE WITNESS: Yes.

MR. TREADON: Is that really important, who signs the paycheck? The corporation paid you?

Q. The corporation pays you?

A. The corporation pays me.

Q. In any event, prior to the time you read this operative transcription, had you discussed with Dr. Tawil and Dr. chrysos the events leading up to the surgery that you performed on Mrs. Spreadbury?

A. I do not recall the discussions but I felt we must have had discussions because we are a group of physicians that takes care of our patients together. We confer about our patients, especially when they have problems to try to determine how best we can help them.

In addition, our call is shared. For instance, there might be a patient that I am the primary surgeon on who after six o'clock Dr. Tawil may be answering some questions about from the intensive care unit nurses. Therefore, we all try to familiarize ourselves with every patient that we take care of.

Q. Let me just go backward now, I'll ask a better specific question.

On the 23rd when Mrs. spreadbury was admitted did you and Dr. Tawil and Dr. Chrysos discuss this blunt chest trauma patient that Dr. Tawil was going

over to examine?

A. No. The reason is that it was in the evening.

Q. So is your recollection that Dr. Tawil's first exam was in the early evening, therefore you wouldn't have discussed the patient that night?

MR. TREADON: He wasn't there the day before.

Q. September 23, I gather?

A. I do not recall any knowledge of the patient prior to my seeing her 9:20 on the next morning, on the 24th.

Q. I asked you about discussions afterwards, afterwards, after the surgery, did you look at the CAT scans that had been performed on Mrs. spreadbury on the 23rd?

A. I do not believe I did.

Q. Did you discuss the CAT scans with Dr. Tawil, did he tell you he had looked at all of them or seen them?

MR. TREADON: what time frame are you talking about?

A. On my way down to the operating room I heard that the CT scan was negative, did not show an injury.

Q. My question was did you talk with Dr. Tawil during -- you couldn't talk to him during the surgery obviously, did you talk to him after surgery about whether or not he had looked at the CT scan before this

event on September 24th?

A. I do not recall that specific piece of information.

Q. You indicated in your testimony that your group shares call, therefore you discuss patients and patient care as a group?

A. Yes, ma'am.

Q. After you performed this surgery on Mrs. spreadbury, did this group have a conversation regarding Mrs. spreadbury and whether or not this dissection should have been detected prior to the time it was?

MR. OCKERMAN: objection.

A. I do not recall the specifics of our discussion. I know that we were disappointed in her outcome. We were even happy she was alive. At times during her course we did not think she would live. I don't recall the details of our discussion.

Q. You are indicating to me you don't recall the details of the discussion that would be responsive to my question as to whether or not your group discussed there was a missed opportunity to have dealt with this before the surgical emergency, I guess that is the way I would like to phrase it?

MR. TABER: objection.

MR. OCKERMAN: objection.

MISS KOLIS: Read it back and we will deal with my phraseology.

(Question read.)

MR. TREADON: Do you understand the question now after she read it back?

A. I think so. I believe that there was some discussion as to why the CT was negative, aortogram was positive. I believe we talked about some of the possibilities that could possibly be responsible for that. I don't remember any thoughts about missed opportunity. We were happy she was alive.

MR. TREADON: That's fine.

Q. At any time did Dr. Tawil or Dr. Chyrsos after the surgery tell you that they had looked at the CAT scans and a pseudoaneurysm was on that CAT scan?

A I do recall Dr. Tawil telling me an initial reading on the CAT scans was revised by the radiologist.

Q. Do you know if it related to the issue of a pseudoaneurysm?

A. I don't know if they used the word pseudoaneurysm. I'm not sure as to the details. I think what they said was hematoma or possible injury. I don't recall the

exact details of how they changed their reading but I do remember that their initial reading was not suspicious. Their second reading not being totally diagnostic, would lead to more suspicion.

Q. Does your recollection allow you to recall if you know when this alleged revision occurred, the revision of the reading?

MR. OCKERMAN: objection.

MR. TREADON: Alleged revision?

Q. The revision.

A. I heard this --

MR. TREADON: You asked him if he knows anything, he told you what he knew, you call it alleged.

MISS KOLIS: I've been driving for two days.

A. I believe it was after our surgery took place.

Q. Doctor, do you have an opinion as to why Mrs. Spreadbury became paraplegic?

A. I think that there are a number of possibilities. I think that they can all be considered.

About 6 percent of people with transection of the aorta arrive in the emergency room with paraplegia. It can be a presenting finding. This is a patient that for a time was paralyzed with

medications, intubated, severely sick, it's very difficult to do a good neurologic exam on the patient when they come in. So it is possible that the patient was paraplegic in the field, in the car in which she was involved in the accident. I don't know, but I think it's a distinct possibility.

I think it's possible that the patient became paraplegic when she had a prolonged period of hypotension. This is another recognized cause of paraplegia. Nice example of this is actually in patients who we repair aortic dissections on, they can after successful repair of the aortic dissection become paraplegic three days later. Even though the artery is intact, there is no more bleeding, they can sit up, abruptly, pool blood in the legs, lower blood pressure, decrease perfusion of the anterior spinal artery and become a paraplegic three days after the surgery.

A prolonged period of hypotension can cause paraplegia. The patient did have prolonged hypotension prior to surgery.

Q. when you say she had a prolonged period of hypotension, can you define for me the period when her prolonged period of hypotension began?

MR. TABER: objection.

MR. TREADON: You can answer.

A. At 9:10 in the morning following that the patient was resuscitated with a low blood pressure for her journey to the angiogram suite [illegible] Then only intermittently was she normal tensive. In the operating room she was again extremely hypotensive. One might say she was dead because she really didn't have a measurable blood pressure for a time.

Q. when it is 28 over 10?

A. when a patient dies you look at the blood pressure, that is usually what it is.

MR. TREADON: what?

A. It will equilibrate something between 20 and 30 on the monitor even though there is no life in a patient. That is a column of fluid, it's the fluid pressure inside of our blood vessels, blood pressure 30 to 40 is not very high.

Q. I'm sorry. I interrupted you. You were discussing with me how you were defining --

A. It's a possibility the patient was paraplegic in the field. I didn't really examine her the night before or the morning of in detail enough to render an opinion on that.

It's a possibility the patient became paraplegic in that period of hypotension initiated at

nine o'clock the following morning. It's possible that the patient was paraplegic because of the hematoma shearing off the artery of Adamkiewicz, that could occur at any time, that can occur any time during presentation. Those are the main things.

Q. You just haven't -- you didn't in your course of continuing care of Mrs. spreadbury after the surgery, before she left the hospital, sit down and try to make that determination; is that a fair statement?

A. I think it was discussed but I don't think any of us know with certainty,

Q. In those discussions do you recall being told by Dr. Tawil that Mrs. spreadbury in fact could move her lower extremities when she presented in the emergency room?

A. I don't recall that.

Q. I'm just asking if you remember.

You continued to care for her following this surgery?

A. Yes.

Q. How did your office do it, a rotation basis or did you sort of take her on primarily?

A. We all rounded on her on a daily basis as I recall. I believe that all of us at some time wrote some notes, did some procedures on her while she was in

the hospital. I believe that I did the majority of the communicating with the family because I established a good rapport with them.

Q. I was going to ask if you remember discussing with the family, being asked questions about her prognosis, sharing with them what happened in surgery?

A. Yes.

Q. You remember Nark pretty well, Mr. spreadbury?

A. Yes.

Q. Do you remember her son and daughter?

A. And daughter, yes, ma'am.

Q. Dr. Tawil prepared the discharge summary; is that right?

A. Yes, ma'am.

Q. How do you decide which person in your group when you've got joint care going on prepares the discharge summary?

A. Generally whoever discharges the patient.

Q. whoever is there on the day of discharge?

A. whoever writes the discharge order.

Q. Have you read Dr. Tawil's discharge summary?

A. Yes.

Q. You guys consult with one another what to put on the discharge summaries or one person writes them?

A. Generally the important things about discharge the

summary is communicating are the diagnoses and medications so that physicians following the patient will be aware of those things.

Q. So part of it is to confirm diagnosis, Dr. Tawil's second diagnosis in his discharge summary is paraplegia post and pre-operative; do you see that?

A. Yes, ma'am.

Q. Do you have a dispute with the diagnosis as he listed it?

A. No, ma'am.

Q. In the history, and I could not find this in the notes, this is where I would like you to help me with the history portion, if you could see where it says history of illness, present illness?

A. Yes, ma'am.

Q. Go to the last sentence of the first paragraph?

A. Yes, ma'am.

Q. Actually you have to go to the two sentences, I'll begin it for you, she had dropped her blood pressure to basically nothing for several minutes intraoperatively. In the ICU she was fine, woke up but was paraplegic. Of interest, before she was taken to the angiogram suite for angiogram, she was not moving her lower extremities but was moving the upper ones very easily.

what does that sentence summarize, is

this before the surgery or after the surgery?

A. Before surgery.

Q. The angiogram suite for angiogram, that means aortogram?

A. In this case it does.

Q. I wanted to be certain.

First of all, who observed this movement of her arms, her upper extremities?

A. I guess he is basing this on my observation of the patient, because I do not believe that he saw the patient immediately after this period of hypotension. I believe he was busy in surgery.

. So can I fairly interpret this as an accurate conclusion of medical information, she was moving her upper extremities

A. I think so, yes.

Q. That is information he got from you?

A. Yes, I believe he's basing it on --

MR. TREADON: Maybe you can better direct that question to Dr. Tawil.

Q. I wanted to confirm it was accurate, insure myself this was presurgery and you are saying this is what this represents?

A. Yes, this is Dr. Tawil's dictation.

Q I understand that.

A. As I understand he's speaking about angiogram meaning aortogram, this exam being prior to the time when we took her to surgery.

MISS KOLIS: I would like to have five minutes with Mr. Emershaw. We will be back.

(Recess had.)

MR. TABER: For the record, I would like to withdraw -- Ed Taber for Dr. Sos, I withdraw my objection as previously noted to the expert testimony.

MR. TREADON: Anyone else have anything?

MISS WYLER: No.

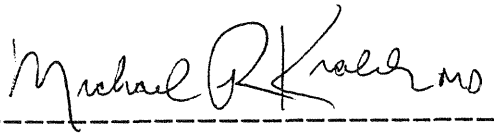
MISS KOLIS: Thank you.

(Deposition concluded; signature not waived.)

ERRATA SHEET

NOTATION	PAGE/LINE

I have read the foregoing transcript and the same is true and accurate.



MICHAEL KRALIK, M.D.

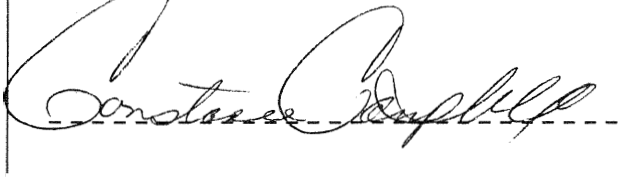
The State of Ohio, :

County of Cuyahoga. : CERTIFICATE:

I, Constance Campbell, Notary Public within and for the State of Ohio, do hereby certify that the within named witness, MICHAEL KRALIK, M.D. was by me first duly sworn to testify the truth in the cause aforesaid; that the testimony then given was reduced by me to stenotypy in the presence of said witness, subsequently transcribed onto a computer under my direction, and that the foregoing is a true and correct transcript of the testimony so given as aforesaid.

I do further certify that this deposition was taken at the time and place as specified in the foregoing caption, and that I am not a relative, counsel or attorney of either party, or otherwise interested in the outcome of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, this 21st day of April, 1999.



Constance Campbell, stenographic Reporter,
Notary Public/State of Ohio.
Commission expiration: January 14, 2003.

T

4-436: Spreadbury

Deposition of
Michael Kralik, M.D.

Wednesday, April 14, 1999

No exhibits marked

Page/Line	Description
5/19	Name: Michael Kralik Professional Address: 1320 Mercy Drive, NW, Canton, OH 44708
6/8	He brought a joint office chart

Review of Curriculum Vitae

716	Undergraduate from Harvard
7 18-10	Received a BA in chemistry & physics
ai 13	Attended CWRU, graduated in 1986
7/19	Received specialty training at Parltland as a surgical intern
7/22-25	Continued residency at Parkland; finished in 1991
8/7	Trained in cardiothoracic surgery and applied for a fellowship
8/10	2 year fellowsnip at NY Univ Med Center
8 14-16	Obtained boards in cardiothoracic surgery (thoracic surgery) in 1994

Review of Employment History

8/21-23	1993 – 1995, worked at St. Luke's Med Center with a group of cardiothoracic surgeons
919	Worked for Cleveland Thoracic & Cardiovascular Surgeons from 93 – 95
9/14	Group had privileges at several area hospitals
9/23	Worked at the Clinic in 1995
10/12	On the cardiothoracic service

10 / 15	Was an associate staff member; frequently worked with Dr. Bruce Lytile, Dr. Floyd Loop, Dr. Delos Cosgrove
10 / 20	Employed 7/1/95 – 7/1/96
11 / 1	Served as a trauma surgeon at St. Luke's
11 / 7	Primarily an elective surgeon at the Clinic; occasionally emergent
11/ 11	Approximately 5% - 10% of cases were emergencies
12/ 4-8	While at Clinic, 90% of cases were elective; heart disease cases, coronary artery disease & acquired valvular disorder
12121	Left the Clinic for Mercy
12/ 24	Initially took a position as a staff cardiac & thoracic surgeon; worked with Dr. Chrysos and Dr. Tawil
13 17-18	Doesn't recall all who interviewed him or what position was advertised
13/ 21	Interviewed for and obtained a position at Regional Heart Center, Thoracic Surgical Associates
1411	Does have an employment contract
14114	First employed in 1996
14119	Job description at time of being hired was surgical therapy for patients requiring operations in which he is specialized & Board certified
1512	Over time, he filled a special need of the group
1511	Hired to do everything that a board cert'd C/T surgeon does
15 / 16	Saw in-office patients regularly
15/22	Served on an on-call basis – cardiothoracic service/surgery
16/ 2-9	On-call duty overlapped with other physicians (ie thoracic surgeons)
17/ 1-4	Was the on-call thoracic surgeon approximately every 3rd day during the month
1717	His group is responsible 4 months of the year for the thoracic call
17112	Doesn't lmow the names of the other Thoracic groups who share on-call duty
17 / 17	No other cardiac group providing surgery

14/24	First saw Mrs. Spreadbury morning after her admission
18 / 5	Believes it was in ICU per the nurses' notes
18 / 11	Saw her sometime after 9:20 am
18 / 17	Note reads, "Dr. Kralik notified of condition and here."
18 / 22	Was notified of Mrs. Spreadbury's low blood pressure
19 / 1	Notified while at the hospital.
19/ 3-5	Was assisting with surgery on 3rd floor; Marla was patient on 1st floor
19/ 13-15	Doesn't recall exactly who he was assisting, but remembers Dr. Tawil and Dr. Chrysos were also performing surgeries that morning
19 / 18	Wouldn't be assisting anyone else except Tawil and/or Chrysos
19/24 – 20 /1	Doesn't remember how he was notified, just remembers it was a few minutes earlier of the low blood pressure
20 / 4	Left surgery to see Marla
20 / 6	Believes he didn't write a note
201 12	First note in chart with signature on it is the pre-op note
20 / 13-18	Notes reads: "43 year old with an aortic transection emergent repair, family aware of risks including paraplegia"

Sequence of Events

20124 –21/7	Patient was hypotensive, IV pressor agents, specifically Levophed when he first saw her; felt aortic transection was only one etiology of hygtension; arranged for immediate arteriogram & aortogram; transferred to aortography suite (same as radiology)
21 / 10	Blood pressure was adequate while in suite
21 113	Size of hematoma stands out in his memory
21 117-18	Doesn't recall speaking to husband; note suggests he did
22 / 3	Likes to accompany patients for the aortograrn
22 114-18	Likes to go because he suspects a transection of the aorta; patient could go into cardiac arrest at anytime; he's there to resuscitate the patient if necessary

23 / 11-17 Doesn't remember what he was told as to the injuries Marla had; does remember being told she had undergone a CT scan

23 / 20 Bedside nurses gave him information when he arrived in ICU

23 / 22 Doesn't recall speaking to Telesz

24 / 8 – 21 Describes what goes on during open heart surgery; received the message from a nurse in the OR with him of Marla's hypotension; attending surgeon gave him a little more info on Marla; immediately went downstairs to see Marla; received more info from nurses downstairs

24 / 24 Doesn't lmow if copies of the surgery schedules are kept

25 / 5 If so, he would be listed as assisting surgeon

25/11 Knew she had been in a car accident

25 / 15 Hypotension could be from cardiac contusion from a pneumothorax, a tension pneumothorax, intra-abdominal blood loss

26 11-6 Tension pneurnothroax ruled out because chest tubes were functional along with auscultory exam; cardiac contusions are accompanied by (gross) arrythimias; intra-abdominal blood loss results in a firm, distended abdomen

26 18 Doesn't recall distended abdomen

26118 Was called to the emergency room to evaluate blunt trauma victims while at Parkland

27 17-12 When working up a blunt chest trauma patient, the doctor is concerned with the A, B, Cs; first, establish an AIRWAY, then make sure they can BREATHE, then preserve their CIRCULATORY SYSTEM

27 / 13-20 If patient is stable, then tests are ordered following initial exam, which includes chest trauma, palpation to check for subcutaneous hematoma or unstable ribs, possible paradoxically moving ribs; ausculatation to check for breath sounds; simple observation for hematomas, disfigurement

27 123 Simple hematomas are external followed by a chest x-ray

28 / 15 Doesn't lmow if there is a document on how to triage a blunt chest trauma

28 122 Chest films is generally the first test ordered

28-25/29-5 The bony anatomy is checked for rib fractures; pneumothoraces are checked for; the size of the mediastinum silhouette for any pleural fluid; size of the cardiac silhouette for possible infiltrates or contusion in the lung tissue

29 / 13-18 Kralik, Tawil & Chrysos would often discuss how patients should be treated; doesn't recall establishing any particular guidelines for this particular injury

30 / 3 Pretty much left on his own to treat patients because of background

31 16-14 When asked if he has a preference of CT or aortogram when diagnosing a widened mediastinum, responded with it depends on the circumstances; if the patient has multiple injuries, it's possible to have a CT, do all 3 exams at once; CT preferred if patient is unstable

31-17132-2 If no other injuries are suspected, then one might do an aortogram; however, it will not give you information about rib fractures, pulmonary contusions, pericardial effusion (cardiac contusion), possible tamponade – that's when a CT is more beneficial

32 13-13 Spiral CT scanners with IV boluses are now used giving tremendous amounts of information without the patient having to wait 30 minutes for techs and have no risk of arterial puncture

32 114-19 Arterial puncture could result in many complications: stroke, dissection of the aorta from the arterial puncture, development of thrombus with occlusion of the vessel

32 / 24 There are specialized radiologists on premises

33 / 2-8 Aortography suite was not readily available; doesn't recall exact length of waiting time

33 112 Special techs not on premise 24 hours

33 / 19 Attended patient to suite; knew there was a dissection

341 1 Made arrangements for operative suite during study

34 17-15 Doesn't recall all the details from this case, but does remember the picture of the aortogram, the rapidly enlarging hematoma and details from the operation as it was very dramatic

34-22/35-3 As to the rapidly enlarging hematoma, after dye is injected, it will leave the lumen of the aorta, mix with and opacify a hematoma around the aorta. It doesn't necessarily mean the hematoma was enlarging as it was watched, just means the dye in the aorta was gradually filling the space around the aorta

3518 The dye dissipating out of the area gives a fuller picture of what the hematoma looks like

35 114 At that point, the hematoma was still contained

35 117 Believes the rupture occurred later

35 / 24 Doesn't know if Marla was a paraplegic prior to surgery

44 19-14	Believes there was some discussion as to why the CT was negative, and the aortogram was positive
441 19	Recalls Tawil saying CT scans were revised by the radiologist
44 / 23-25	Doesn't recall pseudoaneurysm being used; remembers hematoma or possible injury
4%/ 1-4	Remembers initial reading was not suspicious; 2nd reading led to be more suspicious
45 / 17	Believes revision took place after the surgery
45 / 25	Cause of paraplegia could arise for several reasons: 6% of people with Transection of the aorta arrive that way
46 / 7-17	Paraplegia can be caused by prolonged hypotension; this actually occurs in patients where aortic dissections are repaired and become paralyzed 3 days later by sitting up abruptly, pooling blood in their legs, lowering the BP, decrease perfusion of the anterior spinal artery
47 / 1-8	First episode of hypotension began at 9:10 a.m. on the 24th when patient was resuscitated with low BP; then intermittently she was normal tensive; again in the OR, she was extremely hypotensive
47 / 10	BP as low as 28 over 10 is usually when a patient dies
48 11-5	The patient could have become paraplegic at 9:00 a.m. on the 24th when the hypotension began; the hematoma shearing off the artery of Adamltiewicz, which can occur at anytime during presentation
48 / 10	The cause of Marla's paraplegia was discussed but no one knew with certainty
48 / 16	Doesn't recall Tawil saying of Marla could move her lower extremities at first presentation
48 123-25	Each doctor rounded daily; each wrote some notes, did some procedures
491 1-3	Kralik did majority of communicating with the family
491 14	Dr. Tawil prepared discharge summary
49/ 18	Discharge summary is prepared by whoever discharges the patient
49-25 / 50-3	It is important to communicate in the sumrnary the diagnoses and medications for physicians doing follow up care
501 10	Agrees with Tawil's diagnose of post-op & pre-op paraplegia
51 / 2	History comments that Marla could move her upper extremities before going to the angiogram suite, but not her lower extremities is before the surgery
51 19-12	Tawil based this on Kralik's observations