1 THE STATE of OHIO, -SS: 2 COUNTY of STARK. 3 4 IN THE COURT OF COMMON PLEAS 5 ----6 MARLA J. SPREADBURY, et al., : plaintiffs, 2 7 vs. : Case No. 1998CV1681 1998cv00589 8 MERCY MEDICAL CENTER, et al.,: 9 defendants. 10 -----11 Deposition of MICHAEL KRALIK, M.D., a 12 witness herein, called by the plaintiffs for the purpose 13 of cross-examination pursuant to the Ohio Rules of Civil 14 Procedure, taken before Constance Campbell, a Notary 15 public within and for the State of Ohio, at the offices 16 of Thoracic Surgical Associates, 1320 Timken Mercy Road, 17 NW, Canton, Ohio, on WEDNESDAY, APRIL 14TH, 1999. 18 commencing at 2:12 p.m. pursuant to agreement of 19 counsel. 20 21 22 23 24 25

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1 APPEARANCE§: 2 ON BEHALF OF THE PLAINTIFFS: 3 Donna Taylor Kolis, Esq. Donna Taylor Kolis Co., LPA 4 330 standard Building Cleveland, Ohio 44113 5 (216) 861-4300. 6 and 7 George Emershaw, Esq. Melissa D. Berry, Esq. Emershaw, Mushkat & Schneier 8 437 Quaker Square 9 Akron, Ohio 44308 (330) 376-5756. 10 11 ON BEHALF OF THE DEFENDANT LAURA CAWTHON, M.D. and RADIOLOGY SERVICES OF CANTON: 12 Michael Ockerman, Esq. Buckingham, Doolittle & Burroughs 13 4518 Fulton Drive, NW Canton, Ohio 44735 14 (330) 492-8717. 15 16 ON BEHALF OF THE DEFENDANTS WALTER TELESZ, M.D. and STARK COUNTY SURGEONS, LNC. and ROBERT PACKER, M.D.: 17 William A. Meadows, Esq. 18 Reminger & Reminger The 113 Saint Clair Building Cleveland, Ohio 44114 19 (216) 687-1311. 20 2 1 ON BEHALF OF THE DEFENDANTS ALEJANDRO SOS, M.D. and ALEJANDRO SOS M.D., INC.: 22 Edward E. Taber, Esq. 23 Bonezzi, Switzer, Murphy & Polito 1400 Leader Building Cleveland, Ohio 44114 24 (216) 875-2767. 25 

2

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1	MICHAEL KRALIK, M.D.
2	of lawful age, a witness herein, called by the
3	plaintiffs for the purpose of cross-examination pursuant
4	to the Ohio Rules of civil Procedure, being first duly
5	sworn, as hereinafter certified, was examined and
6	testified as follows:
7	
8	MISS KOLIS: Dr. Kralik, just for
9	purposes on the record, my name is Donna Kolis, of
10	course you know, we just met. I'm quite certain at this
11	point in time you understand that ∎have been retained
12	to represent Marla Spreadbury. I'm trying to think of
13	how I would like to make this transaction.
14	
15	<u>CROSS-EXAMINATION</u>
16	<u>BY MISS KOLIS:</u>
17	Q. For the record, could you state your name and
18	professional address?
19	A. My name is Michael Kralik, my profession address
20	is 1320 Mercy Drive, Northwest, Canton, Ohio 44708.
21	Q. Doctor, undoubtedly you are aware I've not named
22	you as a defendant in this lawsuit. For that reason 🔳
23	would like to acknowledge that Mr. Treadon did arrange
24	for this deposition to take place, I do appreciate it.
25	A. Thank you.

1	Q. I'm going to ask you a series of questions today
2	that have to do with your care and treatment of the
3	patient. Alicia Wyler graciously today brought the
4	original chart, which is more readable than the copies
5	most of us have. If you need to refer to those or do
6	you have a personal office chart on Mrs. Spreadbury, or
7	is <b>it</b> a joint office chart?
8	A. We have a joint office chart.
9	Q. whatever you want to refer to in being able to
10	answer my questions, those that you can from memory is
11	certainly acceptable.
12	<b>I'm</b> going to try to ask you intelligible
13	questions. That is not always a possibility since I'm a
14	lawyer, you are a doctor. If ∎ask something you don't
15	understand, will you please let me know that, okay?
16	A. Yes, ma'am.
17	Q. Answer all the questions verbally.
18	A. Yes, ma'am.
19	Q. Let's briefly go through your background, we were
20	all handed your CV, ∎think that you've indicated that
2 1	this is perhaps not complete; did I misunderstand what
22	you were saying?
23	A. ■ have two of what I believe are three pag <sup>es, you</sup>
24	may have all three.
25	Q ■ have four pages.

	<b></b>	7
1	A.	should be complete.
2	Q.	This <b>is</b> a complete one?
3	Α.	Yes.
4	Q٠	Evidently you obtained your undergraduate degree
5	at Ha	arvard; is that correct?
6	Α.	Yes, ma'am.
7	Q.	what is your degree in?
8	Α.	Chemistry and physics.
9	Q.	You received a BA degree?
10	Α.	Yes.
11	Q.	You went on to Case Western Reserve School of
12	Medic	ine, graduated in 1986?
13	Α.	Yes, ma'am.
14	Q.	Thereafter it looks like you began your specialty
15	train	ing?
16	Α.	Yes.
17	Q.	Tell me about that, you were trained at Parkland
18	as a	surgical intern, correct, for a year?
19	Α.	Yes, ma'am.
20	Q.	Did you continue the rest of your residency at
2 1	Parkl	and in surgery?
22	Α.	Yes.
23	Q.	You finished that particular surgical residency in
24	1991?	
2 5	Α.	Yes, ma'am.

1	Q.	During the time you were at Parkland were you
2	train	ed in cardiothoracic surgery?
3	Α.	It was an elective as part of general surgery
4	traini	ng.
5	Q.	That was your exposure, evidently you must have
6	liked	it enough to apply for a Fellowship?
7	Α.	Yes.
8	Q.	I see you had a two year Fellowship at the New
9	York	University
10	Α.	Yes, ma'am.
11	Q.	After that I assume that you obtained your Boards
12	in ca	rdiothoracic surgery, it's thoracic surgery,
13	corre	ct?
14	Α.	Yes, ma'am.
15	Q.	That was 1994?
16	A.	Yes, ma'am.
17	Q.	If we go through your employment, which obviously
18	we ha	ven't seen this before, you obtained that Board <b>in</b>
19	1994,	but you finished your program in 1993. Who did
20	you w	ork for in calendar year 1993?
21	Α.	The end of 1993 through the beginning of 1995 ${f I}$
22	worked	d at Saint Luke's Medical Center with a group of
23	cardio	othoracic surgeons.
24	Q.	Saint Luke's in Cleveland?
2 5	Α.	Yes.

	9
1	Q. Who did you work with?
2	A. I worked with three other surgeons, James Thorton
3	was my closest associate. Also with Dr. James Engle and
4	for a brief period of time with one of them who I can't
5	remember now.
6	Q. I guess let me ask you this way I suppose: It
7	says you were working for Cleveland Thoracic and
8	cardiovascular Surgeons from 1993 to <b>1995</b> ?
9	A. Correct.
10	Q. That's the group you just discussed with me?
11	A. Yes.
12	Q. That group had surgical privileges at a number of
13	Cleveland hospitals?
14	A. You are correct.
15	Q. Sometimes these are not that hard to piece
16	together for me I don't suppose.
17	That was Meridia, Saint Alexis,
18	Marymount, Saint Luke's?
19	A. Yes, ma'am.
20	Q. Then in 1995 did you leave the Cleveland Thoracic
2 1	and cardiovascular surgery group, work for one year at
22	the clinic?
23	A. Yes. The group dissolved through various
24	Dr. Thornton moved to Michigan, Dr. Engle took
2 5	disabi1ity
1	

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		10
1		MR. TREADON: You don't have to go
2	throu	gh the details why.
3	Q.	They dissolved, you went on for other employment?
4	Α.	They dissolved.
5	Q.	You worked for one year at the Cleveland clinic?
6	Α.	Yes, ma'am.
7	Q.	I just guessed. That is only because the CV says
8	1995,	it looks like through present, it isn't?
9	Α.	Correct.
10	Q.	You worked on the cardiothoracic service at the
11	clinio	c ?
12	Α.	Yes.
13	Q.	■hate to ask it, who was your supervisor if you
14	had o	ne?
15	Α.	I was an associate staff member. As an associate
16	staff	I worked with a number of staff physicians, most
17	frequ	ently ∎worked with Dr. Bruce Lytle, Dr. Floyd
18	Loop,	Dr. Delos Cosgrove.
19	Q.	You stayed there give me an idea when to when?
20	L L	July 1, 1995 to July 1, 1996.
2 1	Q.	In your experience subsequent to finishing your
22	cardi	othoracic Fellowship, at any time in 1993, '94, '95
23	throu	gh the time that you left the Cleveland clinic were
24	you -	- ∎don't know how to ask it, were you serving as a
25	traum	a surgeon for these institutions?

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1	11
1	A. At Saint Luke's.
2	Q. So at Saint Luke's that was your responsibility,
3	you were on call as a trauma surgeon?
4	A. Yes, ma'am.
5	Q. when you went to the clinic, what kind of
6	cardiothoracic work did you do?
7	A. Primarily elective, occasionally emergent.
8	Q. when you say occasionally emergent, can you define
9	for me what quantity of your work was done in emergency
10	cardiothoracic surgery, <b>if</b> it's possible?
11	A. I would guess 5 to 10 percent at most.
12	Q. How would that come about that you would be called
13	upon to do emergency cardiothoracic work?
14	A. Quite a few of the patients who develop injuries
15	to their aorta, not necessarily traumatic injuries,
16	acquired injuries, aortic dissection, are transferred to
17	the Cleveland clinic from outlying institutions for
18	their care.
19	Q. Facilities that may not have the capability of
20	performing that surgical procedure, is that what you are
21	∎ndicating?
22	A. Yes, ma'am.
23	Q. We will focus on your year at the clinic since
24	that was your last one before coming here.
2 5	when you were doing elective

,	
1	cardiothoracic procedures, can you break down for me
2	what kind of procedure and what percentage of your time
3	you spent to the best of your ability?
4	A, About 90 percent of the cases were elective, that
5	means scheduled, probably before the day of the
6	operation, cases for acquired heart disease. Acquired
7	heart disease would consist of in this country primarily
8	coronary artery disease and acquired valvular disorder.
9	Q. You were doing a lot of bypass surgery?
10	A. Yes, ma'am.
11	Q. I'm trying to find out what you were doing in
12	addition to bypass and valve surgery I take it?
13	A. Yes, ma'am.
14	Q. Were you the person who the clinic I doubt
15	it were you the person the clinic would have doing
16	bronchoscopies, esophagrams, things of that nature?
17	A. Not primarily. occasionally for patients that
18	required it we would do those things.
19	Q. Fair enough.
20	Why did you leave the Cleveland clinic?
21	A. I obtained employment at this institution.
22	Q. Explain that to me, what position you took with
23	them.
24	A. I took a position here as a staff cardiac and
2 5	thoracic surgeon to work with Dr. chrysos and Dr. Tawil.

	1.7 
1	Q. I'm a little confused by your answer probably
2	because 🛚 didn't ask a good question.
3	when you said you came to take a
4	position here, who did you interview with, the hospital
5	for a position at the cardiothoracic surgeons or with
6	Drs. Chrysos and Tawil?
7	A. I don't remember all of the meetings that I had on
8	my interview day here. I know that I met Dr. Tawil and
9	chrysos, I believe that I met a number of the
10	administration, the administrators at this hospital
11	also. I don't recall their names and the times of my
12	meetings.
13	Q. The employment opportunity that you were made
14	aware of, was it advertised as an associate surgeon for
15	this surgical group or was it advertised as the need for
16	a cardiothoracic surgeon to be a staff surgeon for the
17	hospital; <b>if</b> you recall?
18	A. ■don't recall.
19	Q. You interviewed for and obtained a position as an
20	employee of what entity?
2 1	A. Regional Heart Center, Thoracic Surgical
22	Associates.
23	Q. That is this group here?
24	A. This group of physicians, yes.
2 5	Q. Do you have an employment contract?

1	A. Yes, I do.
2	Q. Are you a partner of the group?
3	A. No, I'm not.
4	Q. I would ask that you provide to Mr. Treadon a copy
5	of your employment contract.
6	MR. TREADON: I'm not sure I'm
7	going to provide that. what do you need that for?
8	MISS KOLIS: We will talk about
9	it.
10	A. I don't think I'm at liberty to do that.
11	Q. We will discuss that.
12	when were you first employed here, was
13	that 1996?
14	A. Yes, ma'am.
15	Q. The Summer of 1996 if I'm following our
16	conversation.
17	what was your job description, what were
18	you hired to do?
19	A. surgical therapy for patients requiring operations
20	that I'm specialized and Board certified to do.
21	Q. Were you hired for any particular area of
22	expertise?
23	MR. TREADON: He just said what
24	his area of expertise was.
25	Q. I'm asking <b>if</b> there was a special need you were

	16
1	Q. Yes.
2	A. I'm not sure how the call schedule is distributed.
3	There are certain areas of my field which overlap with
4	other surgeons that do not work with our group, so the
5	responsibilities in those areas are shared.
6	For instance, there are other physicians
7	at this institution who are thoracic surgeons who will
8	deal with chest trauma that is admitted from the
9	emergency room outside of our group.
10	Q. So ∎guess let me see if I interpret your answer.
11	We can discuss it a little bit.
12	In terms of being the on-call doctor,
13	you're not sure how the schedule is selected but you
14	were available to the hospital to be an on-call doctor
15	for thoracic emergencies, i.e., blunt chest trauma?
16	A. Yes, ma'am.
17	Q. Cardiothoracic, cardiothoracic emergencies?
18	A. Yes.
19	Q. Generally speaking in 1997 how frequently were you
20	the on-call thoracic surgeon?
2 1	A. ■don't recall.
22	Q. Was it once a week?
23	A. I don't pay any attention to the call schedule.
24	MR. TREADON: Give her your best
2 5	guess.

-

	15
1	filling within this group?
2	A. As time has evolved I think I did fill a special
3	need of the group. I do not know the intentions of the
4	people that hired me when I came to the institution.
5	Q. wasn't trying to determine if you guessed their
6	intentions. what I want to know is when you came to
7	work, was an agreement reached or was there discussion
8	that they had a need for someone to do their bypass
9	surgery or their valve surgeries, or were you just hired
10	in general to cover all bases?
11	A" To do everything that a Board certified
12	cardiothoracic surgeon does.
13	Q. The practice you entered, I gather you had
14	in-office patients you saw on a regular basis; that is a
15	fair statement?
16	A. Yes, ma'am.
17	Q. Referred to you probably from other physicians?
18	A. Yes, ma'am.
19	Q. In addition to that, did you serve as an attending
20	on an on-call basis in the hospital for the
2 1	cardiothoracic service, cardiothoracic surgery?
22	A. Yes, ma'am.
23	Q. How did that work?
24	MR. TREADON: You mean the on-call
25	schedule?
	-

1	A. My best guess is that for periods of a month at a
2	time our group is the primary group responsible for
3	thoracic emergencies. During that month I would be
4	taking call on average every third day.
5	Q. That is all I want to know, if you knew how it was
6	divided up?
7	A. I believe the call is distributed among three
8	different people so I believe our group is responsible
9	for the thoracic call at least four months of the year.
10	Q. what other two groups would those on-call thoracic
11	persons represent?
1 2	A. I don't know the corporate names.
13	Q. Is it two other groups of thoracic surgeons?
14	A. Thoracic surgeons.
15	Q. There isn't another cardiothoracic surgery group
16	providing services at this hospital, are there?
17	A. Not cardiac surgery.
18	Q. Have you had an opportunity to look at your notes
19	before this deposition today?
20	A. Yes, ma'am.
2 1	Q. To the best of your recollection, or based upon
22	what is contained in the notes, when was the first time
23	that you saw Marla Spreadbury?
24	A. The morning following her admission.
25	Q. Do you have a reference in your chart?

	18
1	MR. TREADON: You want to use that
2	notebook I gave you?
3	Q. We asked for the original records because we
4	wanted to see them.
5	A. I believe it was in the intensive care unit, it's
6	documented in the nurses' notes from the intensive care
7	unit the morning following her admission.
8	Q. You are looking at the nursing notes, right, what
9	time do the nurses' notes reflect you were in the
10	intensive care unit?
11	A. Sometime after 9:20 in the morning.
12	Q. You know that because you are looking in the
13	nursing note?
14	A. Yes, ma'am.
15	Q. what does that note read, the one you are
16	referring to?
17	A. Dr. Kralik notified of condition and here.
18	Q. what is your memory of what you were told and when
19	you found out that Mrs. spreadbury was in need of
20	cardiothoracic care, I guess that is the easy way to ask
21	it?
22	A. Several minutes before I went to see her I was
23	notified that her blood pressure was low.
24	Q. Were you in the hospital or were you in your
25	office?

	19
1	A. In the hospital.
2	Q. Were you in the hospital doing rounds on patients?
3	A. I was assisting with surgery on the third floor of
4	the hospital. Miss spreadbury was a patient on the
5	first floor of the hospital.
6	Q. She was down in the ■ CU, you were up in surgery?
7	A. Yes, ma'am.
8	Q. Who were in surgery with, if you know?
9	MR. TREADON: You mean the
10	patient?
11	Q. No, I don't want the patient's name. were you
1 2	assisting a surgery?
13	A. I don't recall exactly which physician I was
14	assisting but to my recollection, Dr. Tawil and
15	Dr. Chrysos was both performing surgery that morning.
16	Q. Because you wouldn't be assisting anybody else
17	other than those two doctors?
18	A. Correct.
19	Q. So they paged you in the OR, is that your
20	recollection?
2 1	MR. TREADON: Don't guess. If you
22	remember, fine, <b>if</b> you don't.
23	Q. I'm just trying to get events?
24	A. ■don't remember exactly the way <b>P</b> was notified,
25	but I believe I was notified just a few minutes earlier

**\*** 

	20
1	that her blood pressure was very low.
2	Q. You left the surgery, came down to the first floor
3	to see the patient?
4	A. Yes, ma'am.
5	Q. Did you at that time write an examination note?
6	A. I do not believe so.
7	Q. The reason I ask, I'm just asking, what I have, I
8	may not have all the notes, the note I have the first
9	time I see your name in the chart with your signature I
10	believe is the pre-op note. Have you reviewed your
11	pre-op note in this matter?
12	A. Yes, ma'am.
13	Q. The way I read it, you have fairly nice
14	an w t ng, 43 year old with an aortic transection
15	emergent repair, family aware of risks including
16	paraplegia; is that your first note in the chart
17	regarding Mrs. Spreadbury?
18	A. Yes, ma'am.
19	Q. Tell me, since there is not a writing you are
20	going to have to reconstruct for me, the sequence of
21	events that occurred following you coming downstairs, up
22	to the point where she is taken to the surgery, I would
23	1ike that sequence first.
24	A. when I saw the patient in the intensive eare unit
25	she still was hypotensive, I.V. pressor agents,

1 specifically Levophed. I felt that although there were 2 many possibilities for the etiology of her hypotension, that aortic transection was one. I arranged for an 3 immediate and urgent arteriogram and aortogram. 4 h was 5 transferred as soon as possible to the aortography 6 suite, which is in the radiology area on the same floor 7 of the hospital. 8 I was present with her during that exam. 9 For the period of time that she was in radiology her 10 blood pressure seemed to be adequate. I was very 11 impressed by the findings during aortography. 12 One thing that stands out in my memory 13 is the size of the hematoma that was appearing on her 14 delayed films during her aortography. As soon 5 Ξ 15 were able to diagnose that injury, we contacted the 16 operating room to get the patient to the operating room 17 for emergent surgery. I do not recall whether I spoke 18 to the husband at that time. My note would seem to 19 indicate that I did. That does not stand out in my 20 memory, 21 On arrival to the operating room we 22 placed the usual monitoring lines. 23 Q. I would like to stop you. I would sort of like to 24 separate out this sequence of events then from the 25 surgery.

21

1	Do you normally, Doctor, go to the
2	aortogram with your patients <b>if</b> you order one?
3	A. Ilike to be there, yes.
4	Q. Because you can watch along with the person who is
5	performing the examination, correct, to see or be told
6	what do you have the ability to interpret what is
7	being seen at the time of examination on your own?
8	MR. TREADON: You asked a couple
9	questions. Do you want to know why he goes?
10	MISS KOLIS: Yes.
11	MR. TREADON: Why do you go?
12	Q. Some doctors do, some don't, why do you go with
13	your patients?
14	A. When I order aortography it's because I suspect a
15	transection of the aorta. when a patient has a
16	transection of the aorta they can at any time have a
17	cardiac arrest, so I would like to be present <b>if</b> they do
18	have an arrest so that I could resuscitate the patient.
19	Q. You stated I believe that when you got down to ■CU
20	a couple minutes after you were notified she had low
2 1	pressure there were in your mind several possibilities
22	of things that could cause low pressure; am I stating
23	this accurately?
24	A. Yes, ma'am.
25	Q. Doctor, what <b>if</b> anything did you know about the

,	23
1	patient's course of treatment in the hospital from the
2	time she was admitted up to the time that you went down
3	to see her in ICU?
4	MR. OCKERMAN: Asking what he knew
5	at that time?
6	Q. when you got downstairs, what if anything did you
7	know about the patient's course of treatment in the
8	hospital before your arrival in 📭
9	MR. TREADON: If you remember,
10	don't try to guess.
11	A. I don't remember everything that ∎heard. when I
12	was in the operating room assisting the message was
13	given to me the patient had a motor vehicle accident
14	with severe injuries. I do not remember exactly which
15	injuries were mentioned to me before I went downstairs.
16	I do recall that ∎was told that the patient did have a
17	CT scan done.
18	Q. I'm wondering when you got down there who was
19	giving you information about the patient?
20	A. when ∎arrived the nurses at the bedside.
21	Q. Did a doctor, Dr. Telesz come in and talk to you?
22	A. I don't recall speaking to Dr. Telesz.
23	Q. How were you able to or why was it within your
24	differential to suspect a dissection of the aorta <b>if</b> you
25	didn't even know she had been in an auto accident?

1	A. I believe that I was told that she was in an auto
2	accident.
3	Q. You had the basic information when you got down to
4	ICU?
5	A. Yes, ∎believe that may I explain where I was
6	in a little more depth?
7	Q. Absolutely.
8	A. when we do open heart surgery, which is what I was
9	doing at the time, we generally have one primary
10	physician and one assistant physician. The assistant is
11	there to facilitate the operation, but his presence
12	isn't absolutely essential. when the patient had her
13	hypotension I believe the nurses called upstairs
14	directly, the message was given to me by a nurse who was
15	circulating in the room ∎ was in.
16	At that time the surgeon who was across
17	from me, I cannot remember if it was Dr. Tawil or
18	Dr. Chrysos gave me a little bit of information about
19	the patient. Then ∎immediately went downstairs. So I
20	had the information from that person, and also from the
2 1	nurses downstairs.
22	Q. I would ask you do you keep a copy in your office
23	for record keeping purposes of your surgery schedules?
24	A. I don't know <b>if</b> they keep copies here. It is
25	scheduled with the main scheduling desk of the OR, you

1	can find those records.
2	Q. Fair enough. It would tell us who the attending
3	was, you would be listed as the assistant in all
4	probabi1ity?
5	A. Yes.
6	Q. It's a pretty good guess.
7	A. ∎think so.
8	Q. So someone gave you some information, whether it
9	was the nurse or otherwise, you at least at a minimum
10	knew she had been in an automobile accident?
11	A. Correct.
12	Q. Other than the transection of the aorta, what was
13	within your potential differential that would have
14	caused the pressure to drop?
15	A. Hypotension from cardiac contusion from a
16	pneumothorax, a tension pneumothorax, intra-abdominal
17	blood loss. Those are the three most likely things that
18	I thought of.
19	Q. At that point, since there isn't a note that you
20	dictated later, that is why I have to ask the questions,
21	did you eliminate these other possibilities for a
22	reason?
23	A. That was the purpose of my going downstairs, the
24	patient had chest tubes, they seemed to be functional.
2 5	Q. That would rule out a tension pneumothorax?

1 Α. Generally and along with auscultory exam. The 2 other ones are more difficult to eliminate urgently. 3 Generally cardiac contusions are accompanied by 4 arrythmia, gross arrhythmias. ∎did not believe it was 5 those at the time. Intra-abdominal blood loss usually 6 results in a firm, distended abdomen. 7 Q. That wasn't present? 8 Not to my recollection was not present. Α. 9 Q. Before we get to the surgery issue --10 MR. TREADON: That is lawyer 11 speak, the surgery issue. 12 0. It is lawyer speak. ■wish I could do doctor 13 speak, ■ haven't been to medical school. 14 On occasion since coming to this 15 particular cardiothoracic group, I gather you've been 16 called to the emergency room to evaluate blunt trauma 17 patients; would I be fair in that guess? Yes. Parkland is a center for trauma care. 18 Α Pretty good one, parenthetically. 19 Q. 20 Α. I also spent time at Bellevue during my time in 21 New York. 22 Q. Tell me how you as a cardiothoracic surgeon work up a blunt chest trauma patient? 23 24 I object to the MR. TABER: extent he's a fact witness, not an expert, so anything 25

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1 beyond the scope of his treatment is technically off 2 limits. That is my objection. 3 MISS KOLIS: Thank you. 4 Mr. Taber. 5 MR. TREADON: You may answer. In 6 a general sense you are asking. 7 Α. Immediately we're concerned with what we call the 8 airway, breathing and circulation problems, A, B, C's for these patients. We want to establish an airway, 9 10 make sure it's secure, make sure they can breathe and 11 that they have some preservation of their circulatory 12 system. 13 **If** we feel that the patient is stable we 14 will order some tests following our initial exam and s ry y. Our initial exam and survey are chest trauma 15 16 usually just includes palpation to check for 17 subcutaneous hematoma, or unstable ribs, 18 for S A sutet n to 19 simple observation for hematomas, breath sounds. 20 disfigurement. 21 when you say simple observation, you are talking Q. 22 external hematoma? m. Following that we would generally 23 А , m 24 andan a chact v wav 25 Let me ask you at this point, although I'm going Q.

27

1	to let you go on with your explanation, in the emergency
2	room of Mercy Hospital, <b>is</b> the scenario you are
3	outlining for me what you do to evaluate a chest trauma,
4	is that contained within a procedures, policy or
5	protocol manual for evaluation of blunt chest trauma?
6	A. when you say procedures manual, you mean a manual
7	from Mercy Medical Center?
8	Q. Yes.
9	MR. TREADON: You mean that tells
10	the doctors how to be doctors or for nursing, what do
11	you mean?
12	Q. what I mean is, first of all, is there a document
13	in the emergency room that lists the procedures of how
14	to triage for a blunt chest trauma?
15	A. I do not know.
16	Q. You haven't read one, or if you have you don't
17	recall?
18	A. I don't recall seeing one in the emergency room at
19	Mercy Medical Center.
20	Q. Going on, so then you are looking for external
21	hematomas, et cetera, you order a chest film?
22	A. Generally that is the first test for patients.
23	Q. chest films is ordered, what are you looking for
24	on the chest film in a blunt chest trauma?
25	A. You check the bony anatomy to see if there are any

	29
1	rib fractures. You check for pneumothoraces, you check
2	for the size of the mediastinum silhouette, for any
3	pleural fluid that the patient might have, the size of
4	the cardiac silhouette, any possible infiltrates or
5	contusion in the lung tissue.
6	Q. At the time that Mrs. spreadbury was admitted
7	September 23, 1997 you had been with this group about a
8	year and three months.
9	During that time had you and Dr. Chrysos
10	if I'm pronouncing that correctly and Dr. Tawil
11	discussed and established how you as a group would
12	triage blunt chest trauma?
13	A. During the course of our day at the medical center
14	the majority of our time is spent discussing patients
15	and how we feel they should be treated.
16	with that said, I do not recall exactly
17	whether we had established any particular guideline for
18	this particular injury.
19	Q. You don't have anything in writing in your office
20	that reflects what procedures you would follow in what
2 1	order regarding blunt chest trauma?
22	A. Notin my office.
23	Q. when you first came to work here, were you
24	supervised by either <b>Dr. Tawil</b> or chrysos or were <b>you</b>
25	pretty much because of your training and background left

1	to manage trauma cases as they came in on call on your
2	own?
3	A. Pretty much to work on my own.
4	Q. You, yourself, Doctor, have you had occasions when
5	your chest x-ray reveals a widening of the mediastinum?
6	A. Yes.
7	Q. Do you personally send the patients for a CAT scan
8	to evaluate that widening or do you prefer they go
9	immediately for an aortogram?
10	MR. TABER: objection. Same
11	objection as before. I can presume it will be
1 2	continuing to this line of questioning.
13	MR. TREADON: You are trying to
14	use him an now. He
15	care
16	MISS KOLIS: I'm trying to find
17	out what this group thinks was as a preference to one
18	exam over another.
19	MR. TREADON: There is group
20	thinking? These are the doctors that are <b>Board</b>
21	certified in thoracic surgery. I think there is some
22	latitude. Are we going to get into using him as an
23	expert witness against one of his partners, I'm not
24	going to permit <b>it</b> .
25	MR. MEADOWS: I object for the

1	record. I don't know <b>if</b> there is a question.
2	Q. I asked if he had a diagnostic preference when he
3	sees the widening mediastinum as to whether he would
4	prefer to do a CT or proceed immediately to an
5	aortogram?
6	A. There are circumstances in which you might prefer
7	one or the other.
8	For example, as <b>in</b> this case, a patient
9	with multiple injuries to the head, injuries suspected
10	to the abdomen, injuries to the chest, it's a
11	possibility to take the patient to the CT scan suite, do
12	all three examinations at that same time, assess a
13	patient who is unstable, therefore it would be
14	preferred.
15	MR. TREADON: "It" meaning CT
16	scans.
17	A. There are other situations when maybe there is no
18	of other to the head or to the
19	
20	tissue to the chest as
21	
22	The problem with the aortogram is that
23	it will not give you any information about rib
24	fractures, pulmonary contusions, pericardial effusion
25	which could represent cardiac contusion, possible

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1	tamponade. So a CT scan has definite benefits when you
2	are worried about more than one problem.
3	In addition, <b>CT</b> scans have been refined
4	through the period that $lacksquare$ have been a physician. when $lacksquare$
5	was in medical school we were using first generation CT
6	scanners. The images of the aorta were not ideal. They
7	were good, but they weren't ideal. Now we have spiral
8	CT scanners with I.V. boluses, we can get a tremendous
9	amount of information without requiring the patient to
10	wait 30 minutes for a specialized radiologist to come,
11	without waiting for radiology techs, specialized
12	radiology tech to come to the hospital, without the risk
13	of arterial puncture.
14	Arterial puncture could result in many
15	sorts of complications. You can have a stroke, you can
16	dissect the aorta from the arterial puncture, you can
17	get thrombus with occlusion of the vessel. That can be
18	a horrible problem. There are definite complications to
19	aortography.
20	Q. I just wanted to know how you viewed that.
21	when you decided that Mrs. Spreadbury
22	needed an aortogram, were the special radiologists
23	already here in the hospital?
24	A. Yes, ma'am.
2 5	Q. At this facility are they here for a prescribed

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1	number of hours or are they, <b>if</b> you know?
2	A. I don't know. ■ know they were here that day. I
3	do not believe the suite was immediately available. In
4	other words, I think there was a patient that was having
5	a study done, there was a small wait for the procedure.
6	Q. How long do you think the wait was <b>if</b> you can
7	recall?
8	A* ■can't remember.
9	Q. My question was: Are you aware whether there is
10	on premises, 24 hours a day, a person who can do an
11	aortogram?
12	A. There is not.
13	Q. Do you know what time that suite ■call it a
14	suite it closes; do you know what time?
15	A. No, ma'am.
16	Q. That's okay. You go with her to the aortogram,
17	you know there is a dissection, correct, based upon the
18	examination?
19	A. Yes, ma'am.
20	Q. You are I'm assuming frantically calling for an
21	operating room at that point?
22	MR. TREADON: I object to frantic.
23	Q. I'll withdraw the word.
24	You arranged for the operative suite
25	based upon that examination?

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1	A. Yes, ma'am.
2	Q. Do you recall whether or not you spoke with
3	Mrs. spreadbury' husband before the surgery?
4	A. My notes indicate that I did. However, that does
5	not stand out in my memory.
6	Q. what does that mean?
7	A' There are many things about this case that I can
8	recall, even though it was a year and a half ago.
9	Basically it was because they were associated with the
10	possibility something bad was going to happen to the
11	patient.
12	I remembered distinctly the picture on
13	the aortogram and the fact that the hematoma was rapidly
14	ar i I remember many details vividly from the
15	operation because they were very dramatic.
16	Q. Let me ask you a couple of questions once again
17	back to the aortogram.
18	I get that you are telling me you can
19	vividly remember seeing the hematoma. while the
20	examination was going on was the hematoma increasing in
21	size from your perception during that exam?
22	A. what happens is that after dye is injected into
23	the artery, <b>if</b> there is an injury to the aorta <b>it</b> will
24	leave the lumen of the aorta and mix with and opacify a
25	hematoma around the aorta. It does not necessarily mean

	33
1	that the hematoma was enlarging as we were watching it,
2	it means the dye that has been in the aorta was
3	gradually filling a space around the aorta.
4	Q. The visual you have of the dye is
5	A. Dissipating out <i>of</i> the area.
6	Q. Giving you the full picture of what the hematoma
7	looked like, correct?
8	A. Yes, ma'am.
9	Q. In lawyerly, probably not too doctorly, let's see
10	if I can do this.
11	At the time, based upon what you were
1 2	be o ee was the hematoma still contained at that
13	point?
14	A. Yes, ma'am.
15	Q. The rupture occurred later, the rupture of the
16	hematoma; would you agree
17	· · · · · · · · · · · · · · · · · · ·
18	Q. Back to wherever we were before I backtracked and
19	questioned you, you just don't vividly remember speaking
20	to Mr. spreadbury prior to surgery?
2 1	A. Yes, ma'am.
22	Q. Was Marla Spreadbury paraplegic before you
23	performed your
24	A. I don't know.
25	Q. Explain your answer to me.

	36
1	MR. TREADON: As opposed to
2	something he doesn't know, how do you explain that?
3	MISS KOLIS: I'll ask it another
4	way, Mr. Treadon, if you don't like the phraseology.
5	MR. TREADON: I'm not giving
6	testimony, <b>if</b> you understand that question, go ahead and
7	answer it.
8	A. when ∎ was assessing the patient, prior to her
9	surgery, I noticed that she could not move her legs;
10	however, at that time the patient had a very low blood
11	pressure, was very lethargic, intubated, it was very
12	difficult to communicate with her. It was still more
13	difficult to do an ideal neurologic exam.
14	Q. You couldn't do an ideal neurologic examination at
15	that time because of the medications that were required
16	to have her intubated?
17	A. Because of the activity required to keep her blood
18	pressure at a decent level.
19	Q. I'm sorry, that is what I get for looking at
20	Mr. Emershaw's note when are you answering.
21	when you say the activity required to
22	keep at a decent blood pressure, what are you referring
23	to?
24	A. When the patient was in the intensive care unit
25	her blood pressure was low, we were trying to increase

-90
1	pressure.	
2	Q. Did he assist in this surgery?	
3	A. Yes, ma'am.	
4	Q. If there are documents that made it look like you	
5	were the assistant, he was the primary surgeon, that	
6	would be inaccurate?	
7	A. Yes, ma'am.	
8	MR. TREADON: what documents are	
9	you referring to.	
10	Q. I'm asking because my brain is telling me the	
11	anesthesia record might have been recorded that way.	
12	It's not a big event. It's your memory you were the	
13	primary surgeon?	
14	A. Yes, ma'am.	
15	Q. Just out of curiosity, in your group if you have a	
16	rule, who dictates the operative summary?	
17	A. usually it's the surgeon of record.	
18	Q. Have you reviewed the surgery report from the	
19	repair of the rupture?	
20	A. Yes, ma'am.	
21	MR. TREADON: Talking about the op	
22	note?	
23	MISS KOLIS: Yes, his op note.	
24	l'm calling it his op note but	
25	Q. Did you dictate this operative summary or did	

1 it with certain medications.

2 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.

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

14 Q. Limited in nature?

15 A. Limited.

16 Q. sure. Let's see if I can piece this together.
17 You've been to the aortogram, you've
18 made a call to arrange for a surgical suite, did
19 Dr. Chrysos then enter the picture because you called
20 him or he came downstairs, what happened?
21 A. I do not recall my communication with Dr. chrysos

22 before going to the operating room. I do know that he 23 came to the operating room after the procedure had 24 already been started. After I had clamped the aorta, 25 stopped the bleeding and re-established a blood

1	Dr. chrysos?	
2	A. I dictated the operative summary.	
3	Q. His signature appears in the typewritten version	
4	for what reason, <b>if</b> you know?	
5	A. Idon't know. Iassume	
6	MR. TREADON: Don't assume.	
7	Q. You don't know why that it is. In any event, you	
8	crossed it out, you ended up signing the report?	
9	A. Yes, ma'am.	
10	Q. I think I just asked this, did you dictate the	
11	operative report?	
12	A. Yes, ma'am.	
13	Q. when this was received back from the transcription	
14	which looks like a day later, is that right, or is that	
15	it was transcribed the following day?	
16	A. Yes, ma'am.	
17	Q. There are some additions to the transcription	
18	which were in your handwriting, that are dated 9-30-97;	
19	do you see them?	
20	A. Yes, ma'am.	
2 1	$Q_{m{\cdot}}$ would that be the date when you saw the operative	
22	transcription?	
23	A. That would be the day I made the corrections. I	
24	believe this was the day that I first saw the dictation.	
25	Q. Is that pretty normal who does your	
1		

	17	
1	transcription, operative?	
2	A. Hospital system.	
3	Q. Hospital system does the operative transcription,	
4	what is the normal ∎should never use that word in a	
5	medical deposition what is the average turn around	
6	time you can anticipate on an operative dictation?	
7	A. usually we see the dictation three to four	
8	business days after the procedure.	
9	Q. The first thing you added was that patient was	
10	unable to move her lower extremities pre-op. You signed	
11	that with your signature, dated it. Why did you feel	
1 2	that that was important to add to the operative summary?	
13	A. It was an observation that ∎ had made.	
14	Q. Prior to reviewing this operative note, between	
15	the 24th and 30th, did you have any discussions with	
16	your partners do you consider Dr. Tawil and	
17	Dr. Chrysos associates?	
18	A. NO.	
19	Q. ■asked you early on if you were a partner in this	
20	business entity. Who issues the paycheck to you?	
21	A. Do you mean who signs the paycheck?	
22	Q. Right, who signs your paycheck?	
23	MR. TREADON: Do you know who	
24	signs your paycheck?	
25	THE WITNESS: Yes.	

	±1	
1	MR. TREADON: Is that really	
2	important, who signs the paycheck? The corporation paid	
3	you?	
4	Q. The corporation pays you?	
5	A. The corporation pays me.	
6	Q. In any event, prior to the time you read this	
7	operative transcription, had you discussed with	
8	Dr. Tawil and Dr. chrysos the events leading up to the	
9	surgery that you performed on Mrs. Spreadbury?	
10	A. I do not recall the discussions but I felt we must	
11	have had discussions because we are a group of	
1 2	physicians that takes care of our patients together. We	
13	confer about our patients, especially when they have	
14	problems to try to determine how best we can help them.	
15	In addition, our call is shared. For	
16	instance, there might be a patient that I am the primary	
17	surgeon on who after six o'clock Dr. Tawil may be	
18	answering some questions about from the intensive care	
19	unit nurses. Therefore, we all try to familiarize	
20	ourselves with every patient that we take care of.	
2 1	Q. Let me just go backward now, I'11 ask a better	
22	specific question.	
23	On the 23rd when Mrs. spreadbury was	
24	admitted did you and Dr. Tawil and Dr. Chrysos discuss	
25	this blunt chest trauma patient that <b>Dr.</b> Tawil was <b>goin</b> g	

<u>41</u>

	42		
1	over to examine?		
2	A. No. The reason is that it was in the evening.		
3	Q. So is your recollection that Dr. Tawil's first		
4	exam was in the early evening, therefore you wouldn't		
5	have discussed the patient that night?		
6	MR. TREADON: He wasn't there the		
7	day before.		
8	Q. September 23, I gather?		
9	A. I do not recall any knowledge of the patient prior		
10	to my seeing her 9:20 on the next morning, on the 24th.		
11	Q. I asked you about discussions afterwards,		
12	afterwards, after the surgery, did you look at the CAT		
13	scans that had been performed on Mrs. spreadbury on the		
14	23rd?		
15	A. I do not believe I did.		
16	Q. Did you discuss the CAT scans with Dr. Tawil, did		
17	he tell you he had looked at all of them or seen them?		
18	MR. TREADON: what time frame are		
19	you talking about?		
20	A. On my way down to the operating room I heard that		
21	the CT scan was negative, did not show an injury.		
22	Q. My question was did you talk with Dr. Tawil		
23	during you couldn't talk to him during the surgery		
24	obviously, did you talk to him after surgery about		
25	whether or not he had looked at the CT scan before this		

	ты		
1	event on September 24th?		
2	A. I do not recall that specific piece of		
3	information.		
4	Q. You indicated in your testimony that your group		
5	shares call, therefore you discuss patients and patient		
6	care as a group?		
7	A. Yes, ma'am.		
8	Q. After you performed this surgery on		
9	Mrs. spreadbury, did this group have a conversation		
10	regarding Mrs. spreadbury and whether or not this		
11	dissection should have been detected prior to the time		
12	it was?		
13	MR. OCKERMAN: objection.		
14	A. I do not recall the specifics of our discussion.		
15	I know that we were disappointed in her outcome. We		
16	were even happy she was alive. At times during her		
17	course we did not think she would live. I don't recall		
18	the details of our discussion.		
19	Q. You are indicating to me you don't recall the		
20	details of the discussion that would be responsive to my		
2 1	question as to whether or not your group discussed there		
22	was a missed opportunity to have dealt with this before		
23	the surgical emergency, I guess that is the way I would		
24	like to phrase it?		
25	MR. TABER: objection.		

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1	MR. OCKERMAN: objection.
2	MISS KOLIS: Read it back and we
3	will deal with my phraseology.
4	
5	(Question read.)
6	= =
7	MR. TREADON: Do you understand
8	the question now after she read it back?
9	A. I think so. I believe that there was some
10	discussion as to why the CT was negative, aortogram was
11	positive. I believe we talked about some of the
12	possibilities that could possibly be responsible for
13	that. I don't remember any thoughts about missed
14	opportunity. We were happy she was alive.
15	MR. TREADON: That's fine.
16	Q. At any time did Dr. Tawil or Dr. Chyrsos after the
17	surgery tell you that they had looked at the CAT scans
18	and a pseudoaneurysm was on that CAT scan?
19	A I do recall Dr. Tawil telling me an initial
20	reading on the CAT scans was revised by the radiologist.
2 1	Q. Do you know <b>if it</b> related to the issue of a
22	pseudoaneurysm?
23	A. I don't know if they used the word pseudoaneurysm.
24	I'm not sure as to the details. I think what they said
25	was hematoma or possible injury. I don't recall the

	43		
1	exact details of how they changed their reading but I do		
2	remember that thei <b>r i</b> nitial reading was not suspicious.		
3	Their second reading not being totally diagnostic, would		
4	lead to more suspicion.		
5	Q. Does your recollection allow you to recall if you		
6	know when this alleged revision occurred, the revision		
7	of the reading?		
8	MR. OCKERMAN: objection.		
9	MR. TREADON: Alleged revision?		
10	Q. The revision.		
11	A. ■heard this		
1 2	MR. TREADON: You asked him if he		
13	knows anything, he told you what he knew, you call it		
14	alleged.		
15	MISS KOLIS: I've been driving		
16	for two days.		
17	A. I believe it was after our surgery took place.		
18	Q. Doctor, do you have an opinion as to why		
19	Mrs. Spreadbury became paraplegic?		
20	A. I think that there are a number of possibilities.		
21	I think that they can all be considered.		
2 2	About 6 percent of people with		
23	transection of the aorta arrive in the emergency <b>room</b>		
24	with paraplegia. It can be a presenting finding. This		
2 5	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.

7 I think it's possible that the patient 8 became paraplegic when she had a prolonged period of 9 hypotension. This is another recognized cause of 10 paraplegia. Nice example of this is actually in 11 patients who we repair aortic dissections on, they can 12 after successful repair of the aortic dissection become 13 paraplegic three days later. Even though the artery is 14 intact, there is no more bleeding, they can sit up, 15 abruptly, pool blood in the legs, lower blood pressure, 16 decrease perfusion of the anterior spinal artery and 17 become a paraplegic three days after the surgery. 18 A prolonged period of hypotension can cause paraplegia. The patient did have prolonged 19 20 hypotension prior to surgery. 2 1 Q. when you say she had a prolonged period of 22 hypotension, can you define for me the period when her 23 prolonged period of hypotension began? 24 objection. MR. TABER: 25 MR. TREADON: You can answer.

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1	A. At 9:10 in the morning following that the patient	
2	was resuscitated with a low blood pressure for her	
3	journey to the angiogram suite as as ert	
4	i e Then only intermittently was she normal	
5	tensive. In the operating room she was again extremely	
6	hypotensive. One might say she was dead because she	
7	really didn't have a measurable blood pressure for a	
8	time.	
9	Q. when it is 28 over 10?	
10	A. when a patient dies you look at the blood	
11	pressure, that is usually what it is.	
1 2	MR. TREADON: what?	
13	A. It will equilibrate something between 20 and 30 on	
14	the monitor even though there is no life in a patient.	
15	That is a column of fluid, it's the fluid pressure	
16	inside of our blood vessels, blood pressure 30 to 40 is	
17	not very high.	
18	Q. I'm sorry. ■interrupted you. You were	
19	discussing with me how you were defining	
20	A. It's a possibility the patient was paraplegic in	
21	the field. ■didn't really examine her the night before	
22	or the morning of in detail enough to render an opinion	
23	on that.	
24	It's a possibi <b>li</b> ty the patient became	
25	paraplegic in that period of hypotension initiated at	

	48		
1	nine o'clock the following morning. It's possible that		
2	the patient was paraplegic because of the hematoma		
3	shearing off the artery of Adamkiewicz, that could occur		
4	at any time, that can occur any time during		
5	presentation. Those are the main things.		
6	Q. You just haven't you didn't in your course of		
7	continuing care of Mrs. spreadbury after the surgery,		
8	before she left the hospital, sit down and try to make		
9	that determination; is that a fair statement?		
10	A. I think it was discussed but I don't think any of		
11	us know with certainty,		
12	Q. In those discussions do you recall being told by		
13	Dr. Tawil that Mrs. spreadbury in fact could move her		
14	lower extremities when she presented in the emergency		
15	room?		
16	A. I don't recall that.		
17	Q. I'm just asking <b>if</b> you remember.		
18	You continued to care for her following		
19	this surgery?		
20	A. Yes.		
21	Q. How did your office do it, a rotation basis or did		
22	you sort of take her on primarily?		
23	A. We all rounded on her on a daily basis as ∎		
24	recall. I believe that all of us at some time wrote		
25	some notes, did some procedures on her while she was in		

1	the hospital. I believe that I did the m	najority of the	
2	communicating with the family because I established a		
3	good rapport with them.		
4	Q. I was going to ask <b>if</b> you remember	discussing with	
5	the family, being asked questions about h	er prognosis,	
6	sharing with them what happened in surger	у?	
7	A. Yes.		
8	Q. You remember Nark pretty well, Mr.	spreadbury?	
9	A. Yes.		
10	Q. Do you remember her son and daughte	r?	
11	A. And daughter, yes, ma'am.		
12	Q. Dr. Tawil prepared the discharge su	mmary; is that	
13	right?		
14	A. Yes, ma'am.		
15	Q. How do you decide which person in y	our group when	
16	you've got joint care going on prepares t	you've got joint care going on prepares the discharge	
17	summary?		
18	A. Generally whoever discharges the pa	tient.	
19	Q. whoever is there on the day of disc	narge?	
20	A. whoever writes the discharge order.		
2 1	Q. Have you read Dr. Tawil's discharge	summary?	
22	A. Yes.		
23	Q. You guys consult with one another w	hat to put on	
24	the discharge summaries or one person wri	tes them?	
25	A. Generally the important things abou	t discharge the	

1	summary is communicating are the diagnoses and	
2	medications so that physicians following the patient	
3	will be aware of those things.	
4	Q. So part of it is to confirm diagnosis, Dr. Tawil's	
5	second diagnosis in his discharge summary is paraplegia	
6	post and pre-operative; do you see that?	
7	A. Yes, ma'am.	
8	Q. Do you have a dispute with the diagnosis as he	
9	listed it?	
10	A. No, ma'am.	
11	Q. In the history, and I could not find this in the	
12	notes, this is where I would like you to help me with	
13	the history portion, <b>if</b> you could see where <b>it</b> says	
14	history of illness, present illness?	
15	A. Yes, ma'am.	
16	Q. Go to the last sentence of the first paragraph?	
17	A. Yes, ma'am.	
18	Q. Actually you have to go to the two sentences, I'11	
19	begin it for you, she had dropped her blood pressure to	
20	basically nothing for several minutes intraoperatively.	
2 1	In the ICU she was fine, woke up but was paraplegic. Of	
22	interest, before she was taken to the angiogram suite	
23	for angiogram, she was not moving her lower extremities	
24	but was moving the upper ones very easily.	
25	what does that sentence summarize, is	

#### <u>w</u>

	5 1
1	this before the surgery or after the surgery?
2	A. Before surgery.
3	Q. The angiogram suite for angiogram, that means
4	aortogram?
5	A. In this case it does.
6	Q. I wanted to be certain.
7	First of all, who observed this movement
8	of her arms, her upper extremities?
9	A. I guess he is basing this on my observation of the
10	patient, because I do not believe that he saw the
11	patient immediately after this period of hypotension. I
12	believe he was busy in surgery.
13	So can I fairly interpret this as an accurate
14	conclusion of medical information, she was moving her
15	upper extremities
16	A. I think so, yes.
17	Q. That is information he got from you?
18	A. Yes, I believe he's basing it on
19	MR. TREADON: Maybe you can better
20	direct that question to Dr. Tawil.
2 1	Q. I wanted to confirm it was accurate, insure myself
22	this was presurgery and you are saying this is what this
23	represents?
24	A. Yes, this is Dr. Tawil's dictation.
25	Q. I understand that.

As I understand he's speaking about angiogram 1 Α. 2 meaning aortogram, this exam being prior to the time when we took her to surgery. 3 I would like to have 4 MISS KOLIS: 5 five minutes with Mr. Emershaw. We will be back. 6 \_ \_ \_ \_ \_ 7 (Recess had.) 8 \_ \_ \_ \_ \_ For the record, I 9 MR. TABER: 10 would like to withdraw -- Ed Taber for Dr. Sos, I 11 withdraw my objection as previously noted to the expert 12 testimony. Anyone else have 13 MR. TREADON: 14 anything? 15 MISS WYLER: Νo. MISS KOLIS: Thank you. 16 - - - - -17 18 (Deposition concluded; signature not waived.) 19 \_\_\_\_\_ 20 2 1 22 23 24 25

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2	the same is true and accurate.	er un sorr pt	unu
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5	MICHAEL KRALIK, M.D.		

	54
1	The State of Ohio, :
2	County of Cuyahoga. : <u>CERTIFICATE:</u>
3	I, Constance Campbell, Notary Public within and for
4	the State of Ohio, do hereby certify that the within
5	named witness, M∎CHAEL KRAL∎K, M.D. was by me first duly
6	sworn to testify the truth in the cause aforesaid; that
7	the testimony then given was reduced by me to stenotypy
8	in the presence of said witness, subsequently
9	transcribed onto a computer under my direction, and that
10	the foregoing is a true and correct transcript of the
11	testimony so given as aforesaid.
12	I do further certify that this deposition was taken
13	at the time and place as specified in the foregoing
14	caption, and that I am not a relative, counsel or
15	attorney of either party, or otherwise interested in the
16	outcome of this action.
17	IN WITNESS WHEREOF, $\blacksquare$ have hereunto set my hand and
18	affixed my seal of office at Cleveland, Ohio,
19	this 21st day of April, 1999.
20	
21	Ondesee Duffle
22	Constance Campbell, stenographic Reporter,
23	Notary Public/State of Ohio.
24	Commission expiration: January 14, 2003.
25	

	MICHAEL KRALIK, M.D.			
11       10:22       24th       [1] 23       Action         11       10:22       28       9       Activity         12       11:47:9       9-30-97       [1] 48:3         12       11:11:8       9       Activity         12:11:11:47:9       3       (1):24       11:48:3         12:11:11:47:9       3       (1):24       11:48:3         12:11:11:47:9       30       (1):47:13       Adatkiewicr         12:11:11:47:9       30       (1):48:3       Add         12:11:11:47:9       30       (1):49:12       Additions         12:11:11:47:9       30       (1):49:12       Additions         12:11:11:47:9       30       (1):49:12       Additions         12:11:12:3       376-2700       553653758       S31553165314       Additess         11:11:17       11:38       53155315314       Additess       [1]:49:17         11:11:17       11:38:3535453758       53155315314       Additess       [1]:41:16         11:11:17       11:13:18       531553165317       Additions       [1]:13:10         11:11:17       11:13:18       531553165317       Additions       [1]:11:12:10         11:11:17       11:13:12	1	24	[1] 317	Acquired
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# 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 Cu	rriculum Vitae
716	Undergraduate from Harvard
7 18-10	Received a BA in chemistry & physics
a i 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 En	nployment 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
- 151 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 3<sup>rd</sup> 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 Ber 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  $3^{rd}$  floor; Marla was patient on  $1^{st}$  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
- 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 aortogram
- 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 1 8 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;  $2^{nd}$  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 24<sup>th</sup> 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 24<sup>th</sup> 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 summary 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