

1 THE STATE of OHIO,  
 2 : SS:  
 3 COUNTY of STARK.

4 IN THE COURT OF COMMON PLEAS

5  
 6 MARLA J. SPREADBURY, et al , :  
 7 plaintiffs :  
 8 vs. : Case No. 1998CV1681  
 9 : 1998CV0589  
 10 MERCY MEDICAL CENTER, et al ., :  
 11 defendants :

12 Deposition of MICHAEL ODDI, M.D., a  
 13 witness herein, called by the plaintiffs for the purpose  
 14 of cross-examination pursuant to the Ohio Rules of Civil  
 15 Procedure, taken before Constance Campbell, a Notary  
 16 Public within and for the State of Ohio, at the offices  
 17 of Michael Oddi, M.D., 224 West Exchange Street, Akron,  
 18 Ohio, on MONDAY, OCTOBER 18TH, 1999, commencing at  
 19 1:00 p.m. pursuant to agreement of counsel.  
 20  
 21  
 22  
 23  
 24  
 25

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I N D E X

WITNESS: MICHAEL ODDI, M.D.

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(FOR COMPLETE INDEX, SEE APPENDIX)

(IF ASCII DISK ORDERED, SEE BACK COVER)

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1                   MISS KOLIS:                   Doctor, for  
2     identification purposes on the record, as you know we've  
3     been introduced, my name is Donna Kolis, I've been  
4     retained to represent Marla spreadbury in the action  
5     currently pending against Dr. Cawthon and Dr. Tawil  
6     only.

7                   My purpose today is to discover what  
8     facts you know, what opinions you hold.

9                   Have you had the opportunity 'to give a  
10    deposition in the past as an expert witness?

11                  THE WITNESS:               Yes, I have.

12                  MISS KOLIS:                This is Melissa  
13    Berry who is a couple minutes late, she is also on this  
14    case.

15                  I gather if you have given a deposition  
16    before you would probably be familiar with the  
17    deposition rules, I like to go over them.

18                  I gather you are acquainted with a  
19    concept that you must answer every question verbally?

20                  THE WITNESS:               Yes, I am.

21                  MISS KOLIS:                I gather you  
22    understand the testimony you are giving under oath today  
23    is just as if you were in a courtroom?

24                  THE WITNESS:               Yes.

25                  MISS KOLIS:                If ■ ask questions

1 which you do not understand, please be advised ■ prefer  
2 you tell me you don't understand the question. Can ■  
3 secure that agreement from you?

4 THE WITNESS: Yes.

5 MISS KOLIS: Do you understand  
6 I'll rely upon the answers that you give me today to  
7 represent that which you will testify to at trial?

8 THE WITNESS: Yes.

9 -----

10 CROSS-EXAMINATION

11 BY MISS KOLIS:

12 Q. Having said that, ■ would like to know what you  
13 brought with you this afternoon to the conference room  
14 in anticipation of whatever questions I might ask.

15 A. This is my copy of the inpatient record from  
16 Mrs. Spreadbury dated from the 23rd of September, '97 to  
17 3 November, encompassing the radiology report, pathology  
18 report and operative reports, progress notes, and  
19 nursing notes from that hospitalization.

20 Q. In addition to the Mercy Medical Center records  
21 have you seen any of Mrs. Spreadbury's subsequent  
22 records, either from rehabilitation or medical records  
23 of her current condition, any other medical records  
24 relating to this patient?

25 A. No.

1 Q. Will you be offering an opinion at trial in this  
2 matter based on your review of the hospital records  
3 which you already mentioned as to whether or not there  
4 is a reduction in the life expectancy of this patient  
5 due to her outcome?

6 A. Realizing that is really impossible to speculate  
7 very objectively on, there is some decrease in life  
8 expectancy in a paraplegic patient because they tend to  
9 develop repeated urinary tract infections and sometimes  
10 other systemic infections. Over and above that it  
11 depends on what kind of daily care they get. I have  
12 seen paraplegics with family care live for a normal life  
13 expectancy. I've seen others put in institutions that  
14 don't live long at all. Theoretically there will  
15 probably be some decrease, It is pure conjecture what  
16 that might be in terms of years.

17 Q. Do you know Dr. Began?

18 A. Doctor?

19 Q. Began?

20 A. No.

21 Q. Are you familiar with the physiatrists that work  
22 at the Crystal clinic?

23 A. No,

24 Q. Do you yourself work with physiatrists to work  
25 with patients postparaplegia?

1 A. Not really work with them as such in terms of

3 patients to at the Edwin Shaw Rehabilitation Hospital  
4 when I have a case that involves physical rehab, yes.

5 Q. In addition to the medical records which you  
6 brought to the deposition this afternoon, Doctor, do you  
7 have a correspondence file between yourself and  
8 Mr. Treadon?

9 A. No.

10 Q. So there isn't one in existence?

11 A. That is correct.

12 Q. First of all, do you know since there is no  
13 correspondence file, when were you initially contacted  
14 to review this matter?

15 A. I can't recall the exact date. Mr. Treadon may  
16 have some more information regarding that. It had to be  
17 some time before the 1st of January. The reason I say  
18 that is because I had pneumonia in January, I know I  
19 didn't have a chance to review the records I really  
20 wanted to at that time until everything got better. It  
21 was sometime before the 1st of the year.

22 Q. I just want to know if you recalled it.

23 Not in any particular order here let me  
24 ask you this: In addition to those medical records,  
25 have you reviewed the deposition testimony of anyone

1 involved in this case?

2 A. Yes.

3 Q. Whose deposition have you reviewed?

4 A. Drs. Telesz, Cawthon, Tawi1, Chryssos, Kralik, and  
5 Donahue.

6 Q. I gather you would have been given Dr. Donahue's  
7 deposition testimony today or Friday?

8 MR. TREADON: I can tell you it  
9 was delivered to his office on Friday.

10 A. I picked it up on Saturday. I was out of town  
11 Friday, yes.

12 Q. You were able to review this this past weekend?

13 A. Yes.

14 Q. Have you reviewed the testimony that was given by  
15 Mr. or Mrs. Spreadbury?

16 A. No, I have not.

17 Q. Have you read the testimony of the neurosurgeon,  
18 Dr. Sos?

19 A. No.

20 Q. Have you reviewed the chest films for  
21 September 23rd and September 24th of Mrs. Spreadbury?

22 A. Yes.

23 Q. when I say chest films, first of all I gather you  
24 looked at the x-rays?

25 A. The plain chest, yes.



1 Q. Have you also reviewed the CAT scan for  
2 September 23, 1997?

3 A. Yes, I did.

4 Q. When did you review that?

5 A. I would say probably sometime in June or July,  
6 then again within the past three weeks.

7 Q. Fair enough. Let's go back to some logical order.

8 Prior to meeting you today I had asked  
9 Mr. Treadon for a copy of your CV, it was duly delivered  
10 today. I believe you are once again providing me a copy  
11 of the same; is that right?

12 A. That's correct.

13 MISS KOLIS: We will mark that.

14 -----

15 (Plaintiff's Exhibit A marked for identification.)

16 -----

17 Q. So I don't forget the question, I always forget  
18 what I really want to ask, as the court reporter was  
19 marking the Exhibit conversation ensued whether or not  
20 you reviewed Mrs. Spreadbury's subsequent treatment  
21 records at Edwin Shaw.

22 Doctor, today as you sit here can you  
23 tell me whether you have yet reviewed those?

24 A. I have not.

25 Q. Therefore any opinion you render to me today

1 regarding the issues in this case would not include  
2 information that was contained in those records; that's  
3 a fair statement?

4 A. That is correct.

5 Q. Briefly, if we could go through your background  
6 and training.

7 First of all, Doctor, you can identify  
8 your CV. Is it accurate for me to state that contained  
9 in your CV are no publications?

10 A. That's correct.

11 Q. Have you published, I just don't know about it?

12 A. Yes.

13 Q. Do you have a CV that contains your publications?

14 A. I need to update the CV. There are only a few,  
15 it's not an extensive number at all.

16 Q. would you extend me the courtesy, please, through  
17 Mr. Treadon, of providing me with what I would consider  
18 to be a complete CV with all the publications,  
19 abstracts, articles, things of that nature?

20 A. Yes.

21 Q. Have you authored any book chapters in any surgery  
22 textbooks?

23 A. There was a fairly thick textbook, was not a  
24 surgery textbook, basically a general medicine textbook  
25 called The Five Minute Consultant, I was asked to author

1 a chapter on thoracic outlet syndrome years ago. That  
2 is the only even brief book chapter ■ authored.

3 Q. You indicated the title of the book is The Five  
4 Minute Consultant, did I hear that correct?

5 A. Yes.

6 Q. What is the nature of the material contained in  
7 that book, general subject matter?

8 A. Basically a compendium of every medical subject  
9 imaginable. It's got a two page blurb on each thing,  
10 there are two pages on chronic lymphocytic leukemia and  
11 on aortic insufficiency, thoracic outlet syndrome.

12 Q. Was it written to be of use to the emergency room  
13 physician or just general medical?

14 A. General medical book. It is available both in  
15 hard copy as well as CD rom.

16 Q. Publication year on that book, if you recall it?

17 A. They do another one every year.

18 Q. Have you continued to author the section?

19 A. It's been unchanged for the last six or seven  
20 years, they continue to publish it every year.

21 Q. Knowing you are going to be submitting to me your  
22 complete CV I need to ask the question up front: Are  
23 there any articles that you authored that have to do  
24 with the treatment of traumatic transected descending  
25 aorta?

1 A. No, ma'am.

2 Q. Are there any articles, abstracts, listed on your  
3 CV that deal with the issues that present themselves in  
4 this case?

5 A. No.

6 Q. That's fair enough. Thank you very much.

7 You have testified on previous occasions  
8 as an expert witness, fair statement?

9 A. Yes, ma'am.

10 Q. Whom have you worked for previously in terms of  
11 expert testimony?

12 A. I can't really recall the specifics of the case.  
13 It was just a single case about three years ago in Stark  
14 County, the attorneys worked for Buckingham, Doolittle  
15 in their Canton office. I honestly can't remember the  
16 name.

17 Q. Do you know who you worked for in that office?

18 A. No.

19 Q. Do you know which doctor you were testifying on  
20 behalf of?

21 A. No, I can't remember.

22 Q. Do you recall the facts of the case?

23 A. I really can't.

24 Q. Is that the only time that you have done any  
25 medical/legal expert work?

1 A. No, I was asked to render an opinion about a case  
2 involving a wrongful death suit in a patient who had an  
3 esophagectomy for esophageal carcinoma years ago, at  
4 that time I worked for an attorney who was with  
5 Jacobson, Tuschman, Maynard and Kalur in Cleveland, the  
6 case did come to trial, but summary judgment was given  
7 by the judge before I ever had a chance to testify.

8 Q. So in that case you were also retained to testify  
9 on behalf of the thoracic surgeon but your testimony  
10 never became necessary?

11 A. Yes.

12 Q. Other than these two instances that we're  
13 discussing where you've given testimony, have you  
14 periodically provided medical consulting services to  
15 attorneys that represent the doctor, i.e. have they  
16 called you to run facts by you, get your opinion on a  
17 situation?

18 A. only a couple of times.

19 Q. Have you worked with Mr. Treadon in the past?

20 A. No, ma'am.

21 Q. Have you worked with Mr. Ockerman or Mr. Schobert  
22 from Buckingham?

23 A. I've not worked with Mr. Ockerman, I know  
24 Mr. Schobert. I don't think I've worked with him.

25 Q. I think we've gone through what is in your file.

1                   Having had the opportunity to do a  
2   Common Pleas index in Summit County I find you are  
3   currently involved in one malpractice case; is that a  
4   fair statement, Doctor?

5                   MR. TREADON:               As a defendant?

6   Q.       As a defendant. I'm sorry.

7   A.       Yes.

8   Q.       That was recently filed, June of 1999?

9   A.       Yes.

10   Q.       Burgess versus Dr. Oddi and this group.

11                   Have you had an opportunity to give a  
12   deposition in that case yet?

13   A.       No.

14   Q.       I never can rely upon bureaucratically generated  
15   court reports. My search of the docket reveals you were  
16   not involved in any other cases; is that a fair  
17   statement?

18   A.       Yes.

19   Q.       Doctor, how much time have you spent reviewing the  
20   medical records, the films and anything else you might  
21   feel is pertinent in this case to arrive at the opinion  
22   you are going to tell me about today?

23   A.       Somewhere between nine and 10 hours.

24   Q.       what is your hourly charge for medical/legal  
25   records review?

1 A. \$250.

2 Q. That's what you will be charging me today for  
3 deposition time?

4 A. Deposition time is \$350.

5 Q. Do you know any of the doctors involved in this  
6 case?

7 A. As I was telling Mr. Treadon earlier in this case  
8 the only ones I know are Dr. Menia, who is the emergency  
9 medicine physician involved in Mrs. spreadbury's care,  
10 specifically because he was a resident at Akron General  
11 years ago. I know Dr. Chryssos by reputation, that's  
12 all.

13 Q. You have not had any professional interaction with  
14 Dr. Chryssos, you just know his reputation, that's it?

15 A. That's correct.

16 Q. Have you had the chance to speak with Dr. Menia?

17 A. No.

18 Q. Do you know where he is now?

19 A. No.

20 Q. I don't have any documents to help me but I'm  
21 going to rely upon your memory. when you were initially  
22 contacted by Mr. Treadon what were you told to evaluate  
23 in this case?

24 A. Whether or not there was a departure from the  
25 standard of care relating to the case in a patient who

1 turned out to have a traumatic rupture of the aorta.

2 Q. Have you evaluated this case from the point of  
3 view of standard of care as to the cardiothoracic  
4 surgeons only?

5 A. That is where my expertise lies, that's my focus,  
6 yes.

7 Q. Do you plan to offer opinion testimony only as to  
8 the cardiothoracic surgeons, whether or not they met the  
9 standard of care?

10 A. Yes.

11 Q. Will you be offering any opinions as to whether or  
12 not the radiologist met the standard of care?

13 A. No.

14 Q. Other than the gentleman who you've been retained  
15 to represent and the radiologist, as you reviewed this  
16 set of medical records did you make a determination that  
17 anyone other than these two groups of doctors deviated  
18 from the accepted standard of medical care?

19 A. Can you repeat the question, please?

20 Q. As you had the opportunity to read these records,  
21 aside from your assignment to determine whether or not  
22 the thoracic surgeons were within the standard, did you  
23 determine that any other doctors had deviated from the  
24 standard of care, or was that not anything you analyzed?

25 A. Do I read in your question there is a presumption



1     that the thoracic surgeon deviated from the standard of  
2     care?

3     Q.     No. That may be my contention, all I want to know  
4     is are you going to offer opinions as to any of the  
5     doctors, Dr. Telesz, Dr. Menia, Dr. Sos, Dr. Packer, as  
6     to whether or not they met the standards of care?

7                     MR. TREADON:             ■ can represent to  
8     you I don't intend to ask him that question.

9     Q.     ■ appreciate that. As you went through the record  
10    did you as a surgeon determine that anyone had deviated  
11    from the standard of care in the failure to discover  
12    this transection prior to the time of surgery?

13    A.     No.

14    Q.     That's what the question was. Sometimes I don't  
15    ask questions very straightforward.

16                     In contemplation of today's deposition,  
17    have you completed any literature review?

18    A.     I did search for a few papers concerning the  
19    treatment of traumatic rupture of the aorta, sure, I  
20    mean anybody would.

21    Q.     How did you search that, MEDLINE or what did you  
22    use?

23    A.     I just went to the medical library, asked them to  
24    do that.     ■ presume they used MEDLINE or Grateful Med or  
25    one of those services.

1 Q. As a result of the request you made did the  
2 library return to your attention a list of articles  
3 dealing with the subject matter?

4 A. Yes.

5 Q. I request that Mr. Treadon provide me with the  
6 printout of the MEDLINE search and the articles  
7 contained therein.

8 A. okay.

9 Q. Subsequent to the time the library gave you the  
10 MEDLINE search and articles, did you pull the articles  
11 to read them?

12 A. The ones that I thought were pertinent, yes.

13 Q. Are you relying upon those articles in terms of  
14 rendering opinion testimony in this case?

15 A. Not entirely. They are additional information.

16 Q. Have you shared with Mr. Treadon those articles  
17 which you will be in part relying upon?

18 A. No.

19 Q. Let's go through your background and training that  
20 led you to your current profession.

21 I see that you went to Ohio state  
22 University, correct?

23 A. Yes.

24 Q. Got your degree in medicine in 1972?

25 A. Yes.

1 Q. You then did an internship for one year at Walter  
2 Reed?

3 A. Yes.

4 Q. In general surgery ■ take it?

5 A. Yes.

6 Q. '73 to '77 you completed a four year program in  
7 general surgery at Walter Reed also?

8 A. Yes.

9 Q. Then you do a two year residency at Brooke Army  
10 Medical Center?

11 A. Yes.

12 Q. cardiothoracic?

13 A. Yes.

14 Q. I always hate to sound uninformed, this time ■ am,  
15 where is Brooke Army Medical center?

16 A. Fort Sam Houston, San Antonio, Texas.

17 Q. Is it affiliated with another medical entity or is  
18 this the name of the entity?

19 A. That is the name, There is actually an E on it,  
20 B-r-o-o-k-e.

21 Q. Misspelled on your CV?

22 A. Yes.

23 Q. Subsequent to that I take it you did not  
24 participate in a cardiothoracic Fellowship?

25 A. Residency and Fellowship in cardiothoracic is

1 pretty much the same thing regardless of what people  
2 call it. For an actual Fellowship I'm told you are not  
3 supposed to be involved in daily care of patients, it's  
4 mostly a consultative program. In cardiothoracic  
5 residency we are involved basically 24 hours a day for  
6 two years.

7 Q. Subsequent to completing that residency, you then  
8 became certified in thoracic surgery?

9 A. Yes.

10 Q. I'm going to guess you passed your Boards the  
11 first time you took them?

12 A. Yes, ma'am.

13 Q. That was in 1980 when you became certified in  
14 thoracic?

15 A. Yes.

16 Q. You had actually become certified in general  
17 surgery in 1978?

18 A. Yes.


19 Q. As part of your thoracic surgery training, were  
20 you taught how to read CAT scans to look for injuries in  
21 the chest?

22 A. Everyone who goes through residency learns how to  
23 approach radiology interpretation of specific x-ray  
24 studies that are germane to that particular specialty.  
25 I don't consider myself an expert in radiographic

1 interpretation but I have some experience in knowing  
2 what to look for in particular studies.

3 Q. Does that include CAT scans?

4 A. Yes, although I will say that the CAT scans that  
5 we used to read in the 1970's are a poor distant cousin  
6 to the ones we have available now.

7 Q. Since the time you learned to read them, have you  
8 taken it upon yourself to become conversant with the  
9 newer  technology so you as a thoracic surgeon could  
10 look at the CAT scan and potentially discern injuries in  
11 the chest?

12 A. with the understanding I always look at one with a  
13 radiologist because I miss things sometimes he'll point  
14 out, say this is such and such. You need to consider  
15 the three dimensional structure, what this is going to  
16 look like even though we have a two dimensional x-ray to  
17 look at. I would never base any kind of clinical  
18 decision on my interpretation alone.

19 Q. Have you had an occasion in the time that you've  
20 been a thoracic surgeon to look at the CAT scan,  
21 disagree with what the radiologist found in that?

22 A. No, I can't say that I have.

23 Q. when you completed your training at Brooke Army  
24 Medical Center, was your first place of employment here  
25 in Akron, Ohio?

1 A. No, ■ was in the military for four years beyond  
2 that, I spent three years in West Germany, at Landstuhl,  
3 L-a-n-d-s-t-u-h-1, West Germany, initially as assistant  
4 chief of thoracic surgery, then the chief for two years.

5 From there I was at Letterman Army  
6 Medical Center at the Presidio in San Francisco for one  
7 year. During that year I decided to leave active duty,  
8 search for a clinical practice.

9 Since I'm from Columbus initially I was  
10 looking for some place in Ohio. At the time the two  
11 surgeons in this group were looking for another to join  
12 them. We hooked up at a surgery meeting in January,  
13 '83. Then ■ ended up coming to Akron.

14 Q. You didn't put your military experience in there,  
15 I'm sorry, it didn't have a year, I made a presumption.

16 In 1983 you came here to Akron and  
17 joined -- was it at that time cardiothoracic and  
18 Vascular Surgery of Akron, Inc.?

19 A. Yes.

20 Q. It remained the same from 1983 through present?

21 A. Yes.

22 Q. Dr. Oddi, have you been insured with Mutual  
23 Assurance of Alabama at any time?

24 A. No.

25 Q. Subsequent to the demise of ■■■ who I know was

1 your carrier at least through 1996, who did you become  
2 insured with?

3 A. I have to check with the office manager to find  
4 out. I really don't know.

5 Q. Are you fairly certain it's not Medical Assurance  
6 of Alabama?

7 A. Am I absolutely certain, no.

8 Q. I ask you to extend the courtesy to me to advise  
9 Mr. Treadon who your carrier has been since the  
10 liquidation of PIE.

11 You came here in the 1983, tell me what  
12 you do.

13 A. I do cardiothoracic, peripheral vascular surgery  
14 that involves doing coronary bypass surgery, valve  
15 repair and replacement surgery. We used to do a fair  
16 number of pacemakers, the cardiologists do that now. We  
17 do a lot of pulmonary surgery for lung cancers, do  
18 esophageal surgery for esophageal carcinoma. A lot of  
19 the perivascular surgery for arterial plaque involving  
20 the carotid artery, abdominal aorta and its branches and  
21 lower extremity arteries, as well as I have a part to  
22 play in the residency program, general surgery in terms  
23 of teaching the residents both peri-operative management  
24 of cases as well as hands-on instruction in the  
25 operating room, and we also have students from the

1 Northeastern Ohio Universities College of Medicine  
2 rotate through the service on a regular basis. So, we  
3 have teaching responsibilities as well as our own  
4 clinical practice.

5 Q. Let me clarify this: Based upon my understanding  
6 from the past there is no thoracic residency program at  
7 Akron General; is that a fair statement?

8 A. That's correct.

9 Q. It's a general surgery residency?

10 A. Yes.

11 Q. You don't teach didactically in the classroom, you  
12 teach clinically; am I correct in that statement?

13 A. Yes.

14 Q. You are instructing students in general surgery?

15 A. We instruct general surgery residents in thoracic  
16 surgical problems, yes.

17 Q. At no time has there been an AMA certified  
18 thoracic surgery program at Akron General; am I stating  
19 that correctly?

20 A. Yes.

21 Q. Did you know Dr. Cawthon from NEOUCOM?

22 A. No.

23 Q. Do you teach on site in the classroom at NEOUCOM?

24 A. No.

25 Q. Are you a participant with the NEOUCOM students as



1     they are rotating through the hospital?

2     A.     Yes, ma'am.

3     Q.     Doctor, do you have an ATLS certification?

4     A.     Yes, ■ do.

5     Q.     When did you obtain that certification?

6     A.     November, 1998.

7     Q.     Prior to that time you had not endeavored to  
8     obtain that certification?

9     A.     That's correct.

10    Q.     what made you decide to get the ATLS  
11    certification? I'm asking if you know.

12    A.     I just thought it would be wise to do that since  
13    we deal with a fair number of trauma patients. As of  
14    right now I'm trying to convince my partners it would be  
15    a good idea also.

16                     The surgeon who runs the program at  
17    Akron General suggested to me about a year or so ago it  
18    would be wise to think about that. ■ had a good time  
19    taking the course, did well, plan to do it again in a  
20    couple of years,

21    Q.     That certification and recertification for the  
22    same is available approximately every two years after  
23    you obtain it; is that fair?

24    A.     Two or three years, I think it's three years  
25    actually.

1 Q. Did you save your materials from the ATLS  
2 certification course?

3 A. Did I save them?

4 Q. Yes.

5 A. You mean the manual? Absolutely.

6 Q. Have you had an opportunity to review that manual?

7 A. Since last November, no, I have not.

8 Q. would you consider that the information which is  
9 contained in the ATLS manual is -- first we will use the  
10 word authoritative in terms of its references on how a  
11 person should be treated for a blunt chest trauma?

12 A. The ATLS course has been devised and developed by  
13 the American College of Surgeons committee on trauma  
14 since sometime in the 1980's, I think most people, most  
15 surgeons would recognize that these are fairly good  
16 guidelines to work with, although really just like  
17 anything else it depends on your experience, the  
18 ancillary services you have available at your particular  
19 hospital or trauma center, They serve as good  
20 guidelines, yes.

21 Q. Fair enough, thank you for that answer.

22 Do you have an ACLS certification also?

23 A. Not current.

24 Q. when was the last time you were current with your  
25 ACLS?

1 A. 1982.

2 Q. As I understood what you told me, clearly I didn't  
3 give you a lot of time to describe your practice, what  
4 is your practice's relationship to the hospital in terms  
5 of being called in to evaluate trauma cases?

6 A. We have a rotating call schedule my four partners  
7 and ■, whoever is on call for our service on a  
8 particular evening is also available for trauma cases  
9 related to our specialty.

10 Q. That specialty of course being traumatic injury to  
11 the heart or chest, correct?

12 A. Or peripheral arteries, yes.

13 Q. This question has been asked already a few times  
14 of different people involved in this case, about how  
15 many times in the past, for you I guess about 16 years,  
16 have you had the opportunity to be involved in a case  
17 where a person has presented to this facility with a  
18 transection of the descending thoracic aorta?

19 A. I think I have had four cases personally, probably  
20 assisted on one or two others.

21 Q. Now I'm going to ask you hopefully some short  
22 medical questions.

23 Let's start with the following: Doctor,  
24 I gather you've been asked to testify as to the standard  
25 of care regarding Dr. Tawil; that's a fair statement,

1 correct?

2 A. Yes.

3 Q. Can you state for me as concisely as possible  
4 whether or not you feel that Dr. Tawil complied with the  
5 accepted standard of medical care required of a thoracic  
6 surgeon in his evaluation of the chest trauma that  
7 occurred in Mrs. spreadbury?

8 A. Yes, I think he did.

9 Q. what is the basis of that opinion?

10 A. His initial evaluation of the patient as the case  
11 was presented to him by the emergency medicine physician  
12 and his review of the initial radiographic study, as  
13 well as his proceeding with a very timely bronchoscopy  
14 to rule out tracheal injury, obtaining an esophagogram  
15 to rule out esophageal injury. Providing for fairly  
16 close daily follow-up while the patient was in the  
17 intensive care unit.

18 Q. Do you have reason to believe that I on behalf of  
19 my client am critical of anything that occurred after  
20 September 24, 1997?

21 Let me ask you the question a different  
22 way: Did you understand what the nature of my  
23 allegation of medical negligence was against Dr. Tawil  
24 before you began your endeavor to look through the  
25 chart?

1 MR. TREADON: I'm going to object  
2 as to what **is** in your mind, or your expert's minds. Go  
3 ahead, Doctor, answer that **if** you can.

4 A. Before ■ began to look through the medical  
5 records?

6 Q. Let me ask **it** a simpler way so there is no  
7 confusion about the fact I'm not asking you to know what  
8 ■ was thinking. Were you told prior to the time you  
9 read the records what the basic allegation of 'negligence  
10 was against Dr. Tawil?

11 A. You know, I don't recall any specific  
12 conversation, I would suppose that Mr. Treadon had asked  
13 me to review the medical record with the idea that  
14 Dr. Tawil had departed from the standard of care since  
15 that was the allegation, and give an opinion about that.

16 Q. You just had a generalized question put to you,  
17 you weren't told specifically what **my** allegation of  
18 negligence was?

19 A. That's correct.

20 Q. Let's go through this. I gather that since you've  
21 just testified to the same, that you've had an  
22 opportunity at least four times in your career to be  
23 involved in a surgery to a transected descending  
24 thoracic aorta?

25 A. Yes, ma'am.

1 Q. Of those four cases to the best of your  
2 recollection were you called to evaluate the person in  
3 an emergency room setting or did they become your  
4 patient only after the diagnosis was already known?

5 A. No, I was called in an emergency room, emergency  
6 medicine situation, that is the usual way things are  
7 done.

8 Q. Can you outline for me, to a reasonable degree of  
9 medical probability, what you believe constitutes the  
10 standard of care in evaluating a blunt chest trauma to  
11 exclude the existence of aortic injury step by step?

12 A. The first is to try to get some idea of mechanism  
13 of injury at the accident because that has a lot to do  
14 with what you can -- what you project the injuries might  
15 be. You usually obtain that either from the paramedics  
16 written record or from the paramedic personally if you  
17 happen to arrive when he is still there.

18                   Cursory physical examination involving  
19 the so called ABCs of ATLS management. By the time we  
20 get to the emergency room the emergency medicine  
21 residents have already done that.

22 Q. So that there is no mistake, when you say cursory  
23 exam, ABCs meaning airway, breathing, circulation, by  
24 the time you get there A and B are taken care of,  
25 usually the airway and breathing hopefully?

1 A. By the time we get there everything is taken care  
2 of pretty much.

3 Q. The C of ACLS is circulation, you are doing the  
4 physical examination to test or determine whether the  
5 circulation is intact, or explain it a different way?

6 A. To try to determine whether the patient's  
7 circulation is adequate.

8 In other words, you obviously depend on  
9 blood flow for brain function, kidney function, liver  
10 function, everything else, so unless there is adequate  
11 blood pressure, unless you can demonstrate there is some  
12 satisfactory measure of internal perfusion, usually on  
13 the basis of adequate urine output, you presume if the  
14 kidneys are getting perfused all the other internal  
15 organs are, and until you determine that you can't  
16 determine adequate circulation.

17 You palpate for the peripheral pulses in  
18 terms of strength and the pulse rate, how the  
19 extremities look. In terms of whether or not they are  
20 pink or cool or warm, kind of a general physical. This  
21 entire thing of the ABCS shouldn't take more than a  
22 couple minutes initially. By the time we get there it  
23 is pretty much done, at least some initial observation  
24 recorded in the chart.

25 Q. The question was, I wanted you to state for me as

1 comprehensively as possible what the standard of care  
2 requires to test for the existence of an injury to the  
3 aorta in a blunt chest trauma, I've got a feeling it  
4 goes beyond this.

5 A. Yes. The next thing obviously is to do -- once  
6 you determine that the patient has an adequate blood  
7 pressure, is fairly stable, you want to do a kind of  
8 secondary assessment in which you palpate the chest wall  
9 itself to look for any rib fractures, any evidence of  
10 ecchymosis or bruising in the skin and subcutaneous  
11 tissues.

12 If the patient is awake you want to know  
13 whether or not they grimace with pain when you touch  
14 certain areas, you push on ribs or the sternum. Want to  
15 look for any evidence of break in the skin that might be  
16 of concern in terms of possible penetrating injury.  
17 Then you get a kind of expeditious chest x-ray to look  
18 for any evidence of rib fractures, pneumothorax with a  
19 collapsed lung, what they call soft tissue masses which  
20 may be evidence of severe bruising within the muscles,  
21 underneath the skin. Look at the cardiac shadows, look  
22 at the lung fields, then go from there.

23 Q. Let me stop you where we are. My question related  
24 to how do you test to determine that there has not been  
25 or is the existence of an injury to the aorta, what



1 relationship do rib fractures have in making the  
2 preliminary assessment that would allow you to have a  
3 degree of suspicion about an aortic injury, or are they  
4 not relevant in your opinion?

5 A. They certainly are relevant. Basically in  
6 somebody who is fairly young, otherwise healthy, it  
7 takes a fair impact to break a number of ribs. older  
8 people have brittle ribs, they break easily. I've had a  
9 patients who fell off of a two step ladder, have  
10 multiple rib fractures in their 70's and 80's. You  
11 can't match much about the degree of impact, but in  
12 someone who is young and healthy it takes a fair amount  
13 of impact. If somebody has multiple fractured ribs,  
14 they have taken a pretty good shot in the chest wall.

15 Q. In your set of records you don't have any prior  
16 medical records from Miss spreadbury, do you?

17 A. No, ma'am.

18 Q. Based upon your complete and thorough evaluation  
19 of this chart would you characterize Marla spreadbury as  
20 a person who presented to the hospital as young and  
21 otherwise healthy, except for the accident she had just  
22 been involved in?

23 A. That was my impression. she had two or three back  
24 operations in the past by the record, I didn't see any  
25 evidence of any overwhelming medical problems, no.

1 Q. Do you have a recollection of the number of ribs  
2 that were fractured in this patient?

3 a. After the dust settled there was more than the  
4 initial x-rays, there were eight ribs on the left, three  
5 or four on the right.

6 Q. Based upon your review of the literature, your  
7 training, your experience and your recent completion of  
8 the ATLS course and certification, what particular  
9 significance is there to rib number 1 and 2 being  
10 fractured in this kind of setting?

11 A. Any time you have the first rib, especially the  
12 first rib fractured, that requires a pretty powerful  
13 injury, you have to think about the possibility of a  
14 major vascular injury, whether that involves the aorta  
15 or one of the other large vessels in the chest.

16 Q. What other large vessels would you be looking to  
17 be injured other than the aorta in this kind of impact?

18 A. You would look for the left common, left  
19 subclavian artery, any intercostal arteries that are in  
20 proximity to those ribs that are fractured.

21 Q. As a matter of academic curiosity, not to be  
22 surprised at trial, based on your review of the records,  
23 did you find evidence there was injury to any of the  
24 other major arteries in addition to the aorta?

25 a. No.

1 Q. So we're back to -- we've established you get a  
2 chest x-ray, then what on a chest x-ray would you be  
3 looking for that would cause you to do further  
4 exploration as to whether or not there is an injury to  
5 the great vessels?

6 A. significant pleural fluid accumulation, more  
7 commonly on the left than right, can be bilateral.

8 Q. why is it more common on the left?

9 A. Because that is where the descending aorta is.  
10 I'm not sure why it is, statistically it is.

11 Q. If you -- I'm sorry. Go ahead.

12 A. That's okay.

13 Again rib fractures, that is a prominent  
14 sign, especially the first and second ribs as you point  
15 out.

16 What is called a widened mediastinum is  
17 also significant.

18 In terms of major vascular injury inside  
19 the chest from blunt trauma we can talk about right  
20 deviation of the trachea, simply because when the aorta  
21 gets injured, the associated hematoma will commonly make  
22 the trachea deviate to the right.

23 It can also lower the left main stem  
24 bronchus so the angle between the trachea and bronchus  
25 is increased.

1                   If you have an NG tube or nasogastric  
2 tube down the patient to decompress the stomach, that  
3 very commonly will be deviated toward the right for the  
4 same reason the trachea is.

5                   There is also talk about pleural or  
6 apical capping in the pleural space, that relates to  
7 blood accumulation or hematoma in the apex of the  
8 pleural space that is thought to be associated with  
9 major vascular injury. I can't think of any others  
10 right now.

11 Q.       In terms of having your level of suspicion  
12 increased based upon these findings, did you need to  
13 have any or all of the associated findings for that  
14 suspicion to be established?

15 A.       I think any time you have one of them in the  
16 appropriate setting you have to think about it.  
17 Basically if you've had much experience with chest  
18 trauma at all, there is a little light bulb that goes  
19 off inside your brain when you see something like that.

20 Q.       That bulb meaning possible injury to the aorta,  
21 that's the light bulb?

22 A.       Possible major vascular injury inside the chest.

23 Q.       How many of these factors from review of the  
24 records did Mrs. spreadbury have?

25 A.       She had bilateral pleural fluid, she had the

1 obvious rib fractures, she had what was thought to be  
2 widening of the mediastinum. I don't recall whether she  
3 had a nasogastric tube in when she had the initial chest  
4 x-ray or not, I can't remember.

5 Q. Have you recently reviewed the chest films?

6 A. No, not recently.

7 Q. Do you have a recollection, I know you didn't keep  
8 any notes, from initially looking at them in June or  
9 July did you make notes what the findings were on the  
10 chest films?

11 A. No, because I knew I would take a look at them  
12 again sometime.

13 Q. Do you know if you detected a deviation after the  
14 NG tube was placed?

15 A. No.

16 Q. So at this point we have a chest x-ray, it has the  
17 pleural effusion and rib fractures, a widened  
18 mediastinum; do you agree with that?

19 Thought to be widened in at least one  
20 chest film, or the CT there was a distinct margin of the  
21 mediastinum in the superior aspect?

22 A. Yes. while the quality of the portable chest  
23 x-rays are notoriously inadequate in terms of defining  
24 anything, the purpose for getting an emergency portable  
25 film is to look at the lung fields, make sure that the

1     lungs aren't collapsed, that you don't have the very  
2     gross displacement of the mediastinum, that is the only  
3     thing I can tell from the portable chest x-ray. The  
4     standard A/P portable chest film, especially in large  
5     patients, will almost always show a widened mediastinum,  
6     that in itself is pretty unreliable.

7     Q.     So would you agree with this statement, since you  
8     are advocating the position it's necessary to take the  
9     portable A/P in trauma situations, that the mediastinum  
10    widened is not the be all, end all, if that is not  
11    there, there could still be a traumatic injury to the  
12    aorta?

13    A.     Sure.

14    Q.     So you obtained the chest work, then what is the  
15    next step in the situation like this to exclude the  
16    existence of an injury to the aorta after you have these  
17    findings on chest film?

18    A.     Presuming the patient is stable enough to be  
19    transported we go to the CT scanner in the radiology  
20    department.

21    Q.     The purpose of CT scanning is to screen for the  
22    existence of findings that are suggestive of injury to  
23    the aorta; am I stating that correctly?

24    A.     There are a lot of people at this point in time  
25    who because of the fairly good definition you get on CT

1 scan will make a diagnosis on the basis of the scan  
2 alone. I'm not sure that is generally accepted, that is  
3 certainly written in the literature.

4 Q. Let me ask you the question and I will infuse a  
5 few things: In this case as you are aware, Dr. Tawil  
6 was advised by Dr. Cawthon there were not findings  
7 suggestive of an aortic injury on the CAT scan; do you  
8 know that from reading the testimony?

9 A. Yes.

10 Q. The fact there was an injury to the aorta,  
11 obviously you can concede that?

12 A. Yes.

13 Q. In this instance, when you have a situation where  
14 the chest film reveals pleural effusions, bilateral rib  
15 fractures, especially left 1 and 2, potentially  
16 indistinct margins or widened mediastinal findings, is  
17 it acceptable to rely upon the radiologist telling you  
18 that the CAT scan is negative, doing nothing further?

19 A. Depends on the radiologist. If it is a  
20 radiologist I've worked with for the last 10, 15 years  
21 like there are at Akron General, I have implicit faith  
22 in their interpretation, yes.

23 Q. Let me see if I understand your answer. Did you  
24 just qualify your answer to say if you as the thoracic  
25 surgeon had absolute faith in the radiologist you could

1 then rely upon their interpretation of the CT?

2 A. Yes.

3 Q. If you didn't have absolute faith, but you had the  
4 previous chest film findings we discussed, given the  
5 high potential for injury do you proceed to another form  
6 of testing?

7 A. If you presume that someone is a Board certified  
8 radiologist, knows what he or she is talking about,  
9 given the fact that there is no invasive test that I  
10 know of that is without the potential for complications,  
11 the radiologist tells me there is no evidence of a great  
12 vessel injury, I'm not sure exactly whether I would rush  
13 the patient over to the aortography suite at that point  
14 or not, probably would not.

15 Q. why?

16 A. Because of the potential for complications of  
17 arteriogram.

18 Q. Where is the potential for injury greater, the  
19 injury potentially from the aortogram in terms of the  
20 percentage, or dying from an undiagnosed transected  
21 descending thoracic aorta if it is in existence?

22 MR. TREADON: objection. You may  
23 answer.

24 A. The answer to that is the obvious. We're looking  
25 at things retrospectively.



1 Q. Yes, we are.

2 A. Let me ask you this.

3 Q. ■■■ see if ■ can answer the question for you.

4 A. It's an honest question. ■ I'm a trauma surgeon,  
5 patients are involved in blunt chest injury with motor  
6 vehicle accident, does every patient that comes in the  
7 hospital who has a suggestion of widened mediastinum  
8 whose been involved in an automobile accident get an  
9 aortogram? The answer to that is no, simply because  
10 there overkill there, you are going to be doing a lot of  
11 unnecessary aortograms,

12 Q. When you said the answer is obvious, there is a  
13 greater risk in terms of mortality to the patient in not  
14 discovering the transection than there is a risk of  
15 aortography?

16 A. Yes.

17 Q. what do you believe that ATLS says you should do  
18 in a situation where you have a person whose got  
19 documented pleural effusion, rib fracture of 1 and 2 on  
20 the left, potentially a widened mediastinum, if you get  
21 a negative CAT scan?

22 A. Again, I haven't reviewed that recently, ■ think  
23 that given the clinical situation, from what you tell  
24 me, the CAT scan has no evidence of any great vessel  
25 injury, at least according to the interpretation of the

1 experienced radiologist, I would probably watch that  
2 patient overnight, see what happens in the next six to  
3 eight hours.

4 Q. You as the trauma surgeon -- I mean the thoracic  
5 surgeon --

6 A. As the thoracic consultant.

7 Q. -- you would be watching them.

8 In this case, do you have an opinion --  
9 you looked at the CAT scan; is that right?

10 A. Yes, ma'am.

11 Q. Are you, Doctor, competent -- I got in trouble  
12 with Mr. Treadon for using that word -- are you able as  
13 the thoracic surgeon, based upon your training, to look  
14 at the thoracic CAT scan and discover those signs and  
15 symptoms which may suggest a tear in the aorta?

16 A. I think I am. I'm not a radiologist, there are  
17 certainly subtle things I miss. Anyone who claims that  
18 he is able to interpret x-ray studies better than a  
19 radiologist, I would have to question his own voracity.

20 Q. ■ it apparent to you, can you concede there are  
21 some people who are involved in the teaching and  
22 training of residents in a thoracic program who might  
23 have an opportunity to look at CAT scans on a daily  
24 basis such that they could increase their expertise as a  
25 thoracic surgeon and the ability to see those findings?

1 A. Sure.

2 Q. Were you able to see any finding on the CAT scans  
3 that were suspicious for injury to the aorta?

4 A. Yes.

5 Q. I'll ask a question for someone else that might  
6 ask it.

7 Were you able to find those because they  
8 were pointed out to you?

9 A. Yes.

10 Q. Independent of them being -- what happened first,  
11 did you look at it and didn't see it and then someone  
12 pointed it out, said how about that?

13 A. I had a question.

14 Q. what question did you have, Doctor?

15 A. There was slight irregularity of the aortic  
16 contour on one of the slices, there was a kind of a  
17 radiolucent line on one of the other slices that  
18 suggested perhaps an intimal tear.

19 Q. You saw something that perhaps suggested intimal  
20 tear, I'm working backwards, you also saw something  
21 where the contour was slightly -- did you use the word  
22 distorted?

23 A. Distorted or irregular.

24 Q. The aortic arch area?

25 A. Or perhaps just beyond the aortic arch.

1 Q. You would call that technically what, that change  
2 or that finding?

3 A. It could be suggestive of an aortic injury, could  
4 be remanent of a vascular ring that I have seen pictures  
5 of in the past. Again, depending on the position,  
6 degree of rotation of the patient, it may or may not be  
7 significant.

8 Q. Doctor, if a radiologist who you are relying upon  
9 to include or exclude -- I'm not sure which is the best  
10 way to phrase it -- an injury to the aortic area, the  
11 descending aorta, decides there were troubling findings,  
12 did additional thin cuts, would you expect to be told  
13 that as a thoracic surgeon?

14 A. No.

15 Q. You wait and see what their interpretation was?

16 A. They do that all the time, the radiologist will  
17 say I'm not sure about this one area, we will get a few  
18 additional cuts, they don't call me, ask my opinion  
19 about that, that is their area of expertise. If they  
20 feel additional views are necessary, I would certainly  
21 never argue with that at all.

22 Q. I didn't ask the question very well.

23 The question I asked you is you are the  
24 thoracic surgeon, you're awaiting diagnostic information  
25 that will help you to determine whether or not a person

1 has an injury to their descending thoracic aorta, would  
2 you want to know personally to make future diagnostic  
3 decisions or treatment decisions that the radiologist  
4 was having difficulty interpreting the results in a  
5 certain area of the mediastinum?

6 A. I think I would.

7 Q. Knowing that, how would that factor into your  
8 decision to do something, if anything, further?

9 A. I would want to have a personal conversation with  
10 a radiologist, maybe have another opinion.

11 Q. Another opinion from another radiologist?

12 A. Yes.

13 Q. Mr. Treadon gets mad at me when I ask something  
14 that as been answered, I like to make sure I heard it.

15 To be perfectly clear, when you looked  
16 at the CAT scan for the first time without someone  
17 pointing it out to you, you had questions?

18 A. Yes. Can I add something there?

19 Q. Absolutely you can.

20 -----

21 (Discussion had off the record.)

22 -----

23 A. I don't whisper very well.

24 Q. At least you are trying to be straight forward,  
25 that's okay.

1 A. Let me say after having looked at the x-rays --

2 Q. The chest x-rays?

3 A. No, the CT scan.

4 Q. I don't want to be confused.

5 A. I took that entire study, put it up on the large  
6 viewbox in the radiology department at Akron General,  
7 had one of our what I think is very experienced  
8 radiologists who reads a lot of CT scans take a look at  
9 it. Basically what that radiologist said is oh, there  
10 is a lot of subcutaneous air I would be worried about.

11 I told the radiologist this was a case  
12 from a couple of years ago, the patient had been in an  
13 auto accident, she said there is a lot of subcu air, I  
14 would be concerned about possible tracheal injury.  
15 There is a lot of fluid in both pleural spaces, I wonder  
16 what that means.

17 I said do you see anything else. The  
18 radiologist said no. I pointed out those two slices on  
19 this study, the radiologist said you know, I was  
20 focusing on this other stuff, that totally slipped by  
21 me.

22 We do that clinically all the time, we  
23 focus on a particular problem, may miss some other  
24 things. clinicians do that, radiologists do that,  
25 dermatologists do that. You focus in on one area that

1 is very obviously abnormal, you may miss something. It  
2 happens.

3 Q. I appreciate it, I really do, you relating to me  
4 candidly what you did in an endeavor to understand this  
5 case, to reach conclusions.

6 I want to go back to my first question.  
7 You found something on the films on your own without the  
8 assistance of a radiologist first?

9 A. Yes.

10 Q. That's what I needed, Doctor.

11 A. Can I do that again if somebody gave me a study,  
12 maybe, maybe not.

13 Q. I think it's clear from your testimony today  
14 customarily you attempt to work with a radiologist whose  
15 experience level you know, you can rely upon their CT  
16 results; am I restating that fairly?

17 A. Yes.

18 Q. Do you think that Dr. Tawil should have seen the  
19 same suspicious areas that you saw?

20 A. That's pure speculation on my part.

21 Q. Did you understand from his deposition testimony  
22 where he was trained?

23 A. Yes.

24 Q. Are you familiar with Dr. Gahauss' cardiothoracic  
25 program at University Hospitals?

1 A. Not specifically. I know that he came from Yale  
2 University with an excellent reputation, basically  
3 international reputation. ■ can't imagine he doesn't  
4 run a top notch program.

5 Q. Dr. Gahaus?

6 A. Dr. Gahaus.

7 Q. Can you tell me, do you know what Dr. Gahaus'  
8 approach is in training in CAT scan in the  
9 cardiothoracic program?

10 A. No, ■ don't.

11 Q. When you took your recertification and for the  
12 Boards in 1990, do you have a recollection of having  
13 your mettle tested as it were, your ability to look at a  
14 CAT scan and interpret it; do you recall questions in  
15 that area?

16 A. I don't recall specific questions. This is  
17 basically you submit an application, including 100  
18 consecutive cases, surgical cases you've done, the Board  
19 sends you what amounts to being an open book test. I'm  
20 certain there were some radiologic studies on some of  
21 these questions, I don't recall specifics about that.

22 Q. Fair enough answer.

23 I don't usually do this, I really need  
24 the glass of water, I'm on antihistamines, can we take a  
25 one minute break for me to find a glass of water.



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(Recess had.)

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BY MISS KOLIS:

Q. Doctor, we've gone through what you think the standard of care requires, to recapitulate. Essentially we were at the phase where you get a CAT scan, if the CAT scan has any questionable inference that you then need to make a decision to go to surgery or aortography; that's a fair statement?

A. About whether to go to the aortograph or observe the patient for the next several hours.

Q. Sorry, I did misstate that.

Can you outline for me so I don't miss this, what findings in a CAT scan you would find to be suspicious for or suggestive or consistent with an aortic injury?

A. Any irregularity of the aortic contour that I couldn't ascribe to obvious atheromatous disease in older patients, an extravasation or escape of the contrast from the aorta to surrounding tissues. Any what is called a wedge-shaped defect in the aortic wall. Basically anything that didn't look completely smooth, unless it could be ascribe to atheromatous disease, would be reason for suspicion.

1 Q. what about a mediastinal hematoma?

2 A. You see mediastinal hematoma in chest trauma all  
3 the time. If the aortic contour is completely smooth I  
4 would say probably due to ruptured mediastinal veins or  
5 one or two little intercostal arteries. The mediastinum  
6 is filled with blood vessels. If the aorta looks  
7 otherwise good, I'm not sure ■ would make too much of  
8 the mediastinal hematoma in and of itself.

9 Q. Let's skip to your options. One of your options  
10 when you find things from the screening CAT scan that  
11 aren't exactly regular, or they are suspicious, is to do  
12 an aortogram or watch the patient, correct, that is what  
13 you just testified to?

14 A. Right, depending on the clinical situation,  
15 although I think if there were any suspicious findings  
16 on CT scan I would probably recommend an aortogram to be  
17 on the safe side.

18 Q. What would you be watching the patient for?

19 A. Any kind of clinical instability, drops in blood  
20 pressure, drops in hematocrit or blood count, anything  
21 suggesting hypovolemia, which basically is a decrease in  
22 blood pressure, increase in heart rate. Any increasing  
23 respiratory difficulty that the patient might have,  
24 although this patient is paralyzed, on the ventilator,  
25 you couldn't really --

1 Q. You can't judge that because of her being  
2 mechanically assisted and supposedly maintained at a  
3 certain level?

4 A. Yes.

5 Q. Did you from the chart notice any changes in the  
6 evening in Mrs. Spreadbury's respiratory status that  
7 would have concerned you as a thoracic surgeon?

8 A. I can't recall any changes in respiratory status.

9 Q. Is that something you would have made note of in  
10 terms of reviewing this chart?

11 A. I certainly should have, I don't recall anything  
12 specific.

13 MR. TREADON: You don't have to do  
14 this by memory if you want to look.

15 Q. If you want to look if there is anything in that  
16 evening that bothers you.

17 A. The only note in the physician's progress notes is  
18 from Dr. Telesz at 6:00 p.m. that relates to very  
19 transient decrease in blood pressure that responded  
20 fairly adequately as far as I can tell to some increase  
21 in I.V. fluid administration.

22 Let me take a quick look at the nursing  
23 notes.

24 Q. That's fine, Dr. Oddi, we are doing good, we're  
25 only at the one hour mark.

1 A. It's a sad thing to say, very commonly the nurse's  
2 are --

3 Q. Better than doctors' notes?

4 A. More informative and much more legible than the  
5 doctors' notes, that's true. The nurses' notes state  
6 that right around 5:15 p.m. the patient was fairly  
7 combative to Dr. Tawil's attempt to do the bronchoscopy  
8 at that time.

9 Q. what significance does that have to you; if any,  
10 in context of ongoing watchfulness for potential aortic  
11 injury?

12 A. Theoretically anybody who exhibits increased  
13 anxiety or respiratory difficulty could be having some  
14 bleeding inside the chest. If you are trying to put a  
15 bronchoscopy in somebody's mouth, it's hard to sort all  
16 that stuff out, it depends on what else is going on.  
17 I'm not sure I make too much of that of itself. I don't  
18 really see anything else.

19 Q. I just wanted to ask that question. Let's skip to  
20 a different issue.

21 Doctor, I suspect highly the answer to  
22 the following question is yes: Are you going to be  
23 rendering an opinion at trial as to the cause of the  
24 paraplegia in this patient?

25 A. Yes.

1 Q. why don't you briefly in the initial phase tell me  
2 what your opinion is?

3 A. It's a terrible thing to admit, but if you read  
4 the medical literature, there are a certain percentage  
5 of patients who have successful thoracic aortic rupture  
6 repair operations, the surgeon is pleased with the  
7 result after the operation being able to repair or  
8 replace that part of the aorta that is injured, then you  
9 have the patient wake up not being able to move his or  
10 her legs. That is about as depressing as anything.

11 The fact of the matter is because of the  
12 variability in blood supply to the spinal cord and the  
13 fact that it's necessary to clamp off a fairly good  
14 portion of the thoracic aorta to do this operation,  
15 anyw e f . . . depending on the study that you read, 3  
16 to 20 percent of patients will be paraplegic after these  
17 operations.

18 Q. Anything else you would like to add to that?

19 A. In terms of?

20 Q. Probably didn't ask the question the best way, let  
21 me put words in your mouth, we will digress from there.

22 MR. TREADON: she asked you the  
23 cause of paraplegia.

24 Q. I'm asking you your opinion as to the cause of the  
25 paraplegia in this patient.

1 A. I think it had to do with clamping of the aorta,  
2 the spinal cord ischemia, when that happened.

3 Q. You've read Dr. Donahue's deposition as well as  
4 Kralik, Chryssos and Tawil?

5 A. Yes.

6 Q. Have you been made aware of the content of the  
7 testimony of Dr. John Anastasi taken last Friday?

8 A. Yes.

9 Q. Did anything that was related to you about  
10 Dr. Anastasi's testimony change your opinions in this  
11 case?

12 A. No.

13 Q. So it's your opinion that the surgery itself is  
14 what caused the paraplegia?

15 A. Yes, ma'am.

16 Q. Let me ask you some foundational questions, we  
17 will go backwards to some testimony questions.

18 You've had the opportunity to do four  
19 repairs, what is your preferred method if you have one  
20 for repairing a transection of an aorta?

21 A. classically and I'm sure you know this from  
22 reviewing the literature, there are a few different ways  
23 to approach these cases.

24 Classically the way to do this was to  
25 use what some people call a clamp and sew technique.

1 You clamp the aorta, both above and proximal and distal  
2 to the injury, open the hematoma, see exactly what the  
3 situation is, primarily repair the aorta or replace that  
4 part with a prosthetic tube graft. Statistically or  
5 theoretically if this aorta clamp time is in the range  
6 of 30 minutes or less, then that is supposed to  
7 decrease, not eliminate the possibility of paraplegia in  
8 those patients. (If it goes much beyond 30 minutes the  
9 probability of paraplegia increases with time.)

10 The other ways to do this provide some  
11 type of shunting of blood flow to the lower extremities  
12 around the area that you are working on. There are a  
13 couple of different ways to do that.

14 One is Heparinized shunt to go around,  
15 the other is called a partial bypass with a Heparinized  
16 circuit so you don't have to give systemic Heparin,  
17 which you don't want to do in acute trauma cases.

18 My way of doing this in the past was to  
19 clamp and sew. If I had a case come in tonight in a  
20 patient in whom I had the time to set it up, I would do  
21 what is called a left arterial to femoral bypass  
22 realizing that doesn't eliminate the possibility of  
23 paraplegia, it decreases it.

24 The reason I say that is because the  
25 contribution from the anterior spinal artery may be very

1 significant, from those intercostal branches of the  
2 aorta and part of the aorta that is being clamped off.  
3 In that case you may provide a good blood flow to the  
4 legs and kidneys, you may not provide a good blood flow  
5 to the spinal cord. In those patients they still may  
6 wake up paraplegic. ~~It's~~ theoretically a more  
7 reasonable thing to do to try to do whatever you can to  
8 try to minimize the chance of post-op paraplegia.

9 Q. Let me ask you a couple of questions about what  
10 you said.

11 When you say theoretically, I gather you  
12 don't make the transformation in your own practice from  
13 you call a cut and clamp, I've heard clamp and sew, we  
14 all understand what that means, your transformation to  
15 using a method of bypass, was it based on a theoretical  
16 lick and promise, or you felt there was an actual based  
i7 on scientific principle of having a better chance of not  
18 becoming paraplegic to your patients; do you understand  
19 the question?

20 A. It's scientific principle.

21 Q. when you said it decreases the risk of paraplegia  
22 when you have the time to set it up, do you agree in  
23 this case based upon the presentation of the patient to  
24 the OR there was no possibility of using a bypass method  
25 on this patient?



1       .       Absolutely.

2       Q.       Do you agree that if the transection had been  
3       discovered the day before, that more likely than not a  
4       bypass method could have been used to protect this  
5       person's spinal cord function?

6                       MR. OCKERMAN:               objection.

7       A.       It depends on the particular surgeon. I don't  
8       know what Dr. chryssos and Kralik prefer to do. I have  
9       a personal friend do every one of these cases'with clamp  
10      and sew technique.

11      Q.       They do it in less than 30 minutes?

12      A.       Not always.

13      Q.       My question was, which I would like an answer to,  
14      if the transection had been discovered on the 23rd, you  
15      would have to agree with me it was impossible to have  
16      done on this patient a bypass procedure at that time?

17      A.       Yes, but the corollary to that is you are asking  
18      me whether or not that would have eliminated the  
19      paraplegia Mrs. Spreadbury suffered, that is pure  
20      speculation.

21      Q.       I understand that may be your answer, we will work  
22      with that in a second.

23                       Do you believe that Mrs. Spreadbury  
24      because of her hypotension -- first of all, when was her  
25      first serious episode of hypotension in this case?

1 A. From the medical record it was about 6:00 p.m. on  
2 the 23rd.

3 Q. That rebounded very quickly, didn't it?

4 A. To increase in I.V. fluids, yes.

5 Q. Her next episode -- do you remember what her  
6 pressure was at the episode you are talking about?

7 A. Dr. Telez recorded the pressure was 70 to 80  
8 systolic.

9 Q. The next episode of hypotension that you can  
10 determine occurred when?

11 A. On the 24th at about 9:00 a.m.

12 Q. Am I correct in my memory that was 35 over -- I  
13 don't want to say 20, is it 20?

14 A. I don't recall the number.

15 Q. You want to look in the nursing notes to be sure?

16 A. Yes.

17 The recorded pressure at 9:10 a.m. on  
18 the 24th was 35 over 21 as recorded by arterial line,  
19 yes.

2 Q. What do you suppose caused Marla Spreadbury's  
1 pressure to record at 35 over 21 at 9:10 a.m. on the  
2 24th of September?

3 A. You would have to presume there was acute volume  
24 loss, blood loss that occurred right at that time.

25 Q. What are the possible sources for the acute blood

1 loss at that time?

2 A. The most likely source is an acute expansion of  
3 the hematoma that she turned out to have secondary to  
4 the aortic injury.

5 Q. Let's talk about that concept.

6 Doctor, since you know I don't get to  
7 see you again until trial, I like to bug you now. Is  
8 there any medical evidence contained in the record or  
9 any other explanation for the blood pressure other than  
10 acute expansion of that hematoma?

11 A. If it's a reliable blood pressure reading, I don't  
12 see any obvious explanation for that

13 Q. When we say acute expansion, let's I guess work on  
14 that concept.

15 What do you think the progression of  
16 transection was from the time she was transected until  
17 the time she ruptured?

18 A. Typically a portion of the aortic wall will be  
19 torn by the blood flow, will be contained by surrounding  
20 tissue, typically the adventitia, which is the internal  
21 lining of the aorta and at least part of the media which  
22 is the muscle layer or middle layer is torn. The media  
23 and adventitia comprises about 60 percent of the  
24 archit ct l str t As long as the adventitia is  
25 intact, theoretically the patient will be stable ce

1 that develops a tear in the adventitia such as the one  
2 containing the hematoma or what are called the  
3 mediastinal soft tissues and mediastinal pleura, that  
4 begins to expand very quickly, depending on the blood  
5 pressure.

6 Q. Let me ask you a surgery question.

7 would you agree that it would be  
8 preferable in a person who has a transection of their  
9 descending thoracic aorta to perform the surgery prior  
10 to the time that the collection of blood breaks through  
11 the adventitia?

12 A. Yes.

13 Q. This period of time where the blood pressure as I  
14 think you and I have now established at 9:10 is dropping  
15 due to acute expansion of hematoma, at that time is it a  
16 fair and accurate medical statement that if the hematoma  
17 is expanding outside the adventitia, now for sure less  
18 blood is going to the spinal cord?

19 A. No.

20 Q. You don't think that is an accurate statement?

21 A. I'm not sure why that would be the case.

22 Q. what causes spinal cord ischemia?

23 A. Decrease in blood flow through  
24 that supply or arterial branches that contribute to the  
25 anterior spinal artery.

1 Q. The descending thoracic aorta supplies what  
2 arterial branches?

3 A. Again it's variable from one person to the next.  
4 Some of the intercostal arteries that originate under  
5 each rib can provide a contribution and the anterior  
6 spinal artery.

7 Q. As the hematoma is expanding outside the  
8 adventitia, starting to carrying and supply less of a  
9 blood supply to the branches, the blood is being  
10 rerouted outside of this area; do you agree with that?

11 A. It depends how much blood is getting lost.

12 Q. Do you believe that in this case her paraplegia  
13 was caused by a hematoma compressing upon the artery of  
14 Adamkiewicz?

15 A. No,

16 Q. Are you aware that was testified to as a potential  
17 cause by Dr. Kralik, I use the word potential, he said  
18 possible, he didn't say that was the cause.

19 A. I don't believe that.

20 Q. Do you recall that Dr. Chryssos testified that the  
21 surgery was not the cause of the paraplegia?

22 MR. TREADON: I'm not certain he  
23 did.

24 Q. We will make it easy, 1'71 go through this.

25 Mr. Treadon is very good at following up statements that

1 I make.

2 First of all, you are aware that  
3 Dr. Tawil testified -- you read his deposition,  
4 correct?

5 A. Yes.

6 Q. -- he would be unable to determine the cause of  
7 the paraplegia; do you recall that?

8 A. No, but I can understand why you would say that.

9 Q. Actually let me restate, I don't want to be on the  
10 record with inaccurate statements.

11 Page 62, line 4 of Dr. Tawil's  
12 deposition he testified that there is no way he can tell  
13 when she was paraplegic, had you read that statement?

14 A. Yes.

15 Q. Given that you read that statement, you're  
16 indicating that you believe that the surgery is the  
17 cause of the paraplegia, correct?

18 A. Yes.

19 Q. So therefore she wouldn't have been paraplegic  
20 before the surgery?

21 A. Repeat that please.

22 Q. Therefore if it's your belief the surgery itself  
23 caused the paraplegia, she could not have been  
24 paraplegic prior to the surgery?

25 A. Yes.

1 Q. Have you read Dr. Tawil's admission and discharge  
2 summary in this case?

3 A. Yes.

4 Q. Are you aware that he listed in his discharge  
5 summary that Mrs. spreadbury suffered from pre and  
6 post-op paraplegia?

7 A. Yes, that was qualified in Dr. Kralik's deposition  
8 when he mentioned because she was at least partially  
9 sedated **it** was really impossible to do an adequate  
10 neurological exam on her pre-operatively. I'm not sure  
11 you can say somebody is paraplegic because they don't  
12 seem to move their toes to either command or painful  
13 stimuli **if** they are under sedation.

14 Q. **If** the person was under sedation to the extent  
15 sufficient enough to prevent them from moving their  
16 lower extremities, wouldn't that necessarily indicate  
17 they wouldn't be able to move the upper extremities?

18 A. Probably.

19 Q. Are you aware she was in fact moving her upper  
20 extremities on the morning prior to the surgery, not  
21 moving the lower extremities?

22 A. **As I** recall she was moving her toes but the degree  
23 of moment was not thought to be what would be expected  
24 on the basis of how well she was moving her upper  
25 extremities.

1 Q. Can you point to me a place in the record where  
2 you see an indication at any time after 9:10 in the  
3 morning of September 24<sup>th</sup>, testimony or records that she  
4 was moving her toes? I have time, I'm not worried about  
5 having to pay you.

6 MR. TREADON: You want him to look  
7 at all the depositions too?

8 MISS KOLIS: I want him to make  
9 sure that as part of forming his opinion is there  
10 testimony or any records that she was moving her toes at  
11 any time after 9:10.

12 MR. TREADON: That isn't what he  
13 said. I don't think what you said is what he said. You  
14 said after 9:10?

15 MISS KOLIS: Yes, after 9:10,  
16 that is what I'm looking for.

17 MR. TREADON: She was or was not?

18 MISS KOLIS: I thought if you  
19 want to run this back to save 15, 20 minutes, I thought  
20 that what the doctor said was, I asked the question  
21 about if a person was in a paralytic state due to  
22 medication, that was the reason for not moving their  
23 feet or toes, that you would expect they didn't have  
24 upper arm movement, he agreed with that. I asked if he  
25 was aware in the morning she had the ability to move her



1 upper extremities, the ability to move the lower  
2 extremities, he seem to have recalled there was some  
3 piece of information she was moving her toes in the  
4 morning.

5 MR. TREADON: In the morning,  
6 before 9 10 or after 9:10?

7 Q. Any time in the morning, once the doctor started  
8 writing narratives, I'm not talking --

9 MR. TREADON: Twelve o'clock  
10 midnight on the -- the morning is a long period of time.

11 Q. I want to know if at 9:10 she was moving her toes?

12 MR. TREADON: That's a different  
13 question.

14 A. There is nothing in the physicians' or nurses'  
15 notes about that. My recollection was that Dr. Kralik  
16 mentioned he had been in to see the patient that morning  
17 when he was called after she dropped her blood pressure,  
18 I thought he mentioned that she was moving her toes, ■  
19 may be mistaken. ■ would have to go through his  
20 deposition again.

21 Q. ■'■ accept that. ■ assume you probably will go  
22 through his deposition again.

23 A. Yes, ma'am.

24 Q. From reading Dr. Kralik's deposition do you have a  
25 recollection of the fact that ■ asked him for his

1 opinion as to when Mrs. Spreadbury became paraplegic?

2 A. I'm sure you asked that question, I can't remember  
3 his exact response.

4 Q. Do you recall, Doctor, that in sum total after  
5 pages of his deposition, that he did not at all indicate  
6 the possibility of surgery being the cause of the  
7 paraplegia in this case?

8 A. No, I don't remember that.

9 Q. Dr. Chryssos, do you remember what he thought the  
10 cause of the paraplegia was?

11 A. I think he mentioned that because the patient was  
12 severely hypotensive in the early part of the operation,  
13 also there was some increased difficulty of the  
14 procedure because of the mild anomaly she had in her  
15 aortic arch, it made the operation a bit more difficult  
16 than otherwise, he thought that contributed to it,  
17 because basically the patient was without a blood  
18 pressure I guess for several minutes,

19 You know, to be honest with you, as I  
20 review the record and operative note, a few journal  
21 articles, Mrs. Spreadbury had a very significant  
22 likelihood of not surviving the operation. I think it's  
23 kind of a testimonial to the surgical expertise of  
24 Dr. Kralik and Dr. Chryssos she is even alive at this  
25 point.

1 Q. You do understand I've not personally sued them or  
2 accused them of medical negligence?

3 A. Yes.

4 Q. Do you recall when ■ specifically asked  
5 Dr. Chryssos if he felt the surgery was the cause of  
6 paraplegia, he said no?

7 A. Again, ■ would have to go back and take a look at  
8 his deposition. If you say that is what he said, I'm  
9 sure that is what he said.

10 Q. Let me ask you something else, ■ don't know how  
11 much it has to do with any of the issues in this case, ■  
12 become more curious as the days go by.

13 Marla spreadbury apparently had a two  
14 vessel aortic arch, that was a finding on aortography;  
15 did you see the aortogram?

16 A. No.

17 Q. I gather what I heard you say, ■ restudied the  
18 literature because of something Dr. chryssos said, how  
19 does a two vessel arch such as described in the  
20 aortogram -- if you would like to see it I highlighted  
21 it to make it easier -- effect the surgery in this case?

22 A. I'm just kind of trying to read his mind. As far  
23 as ■ can tell it makes the decision where you can safely  
24 put the clamp proximal to the subclavian artery a bit  
25 problematic.

1 Q. I wasn't asking you to read his mind. I'm asking  
2 you a medical question based on your training and  
3 experience as a thoracic surgeon, how would this effect  
4 the surgery. You are telling me it comes into play  
5 where you are going to place the clamp, correct?

6 a. Yes.

7 Q. Did you discern from reading the deposition or  
8 reading the operative summary that the clamp was placed  
9 in the wrong position because of this anomalous anatomy?

10 a. It was described by Dr. chryssos, yes.

11 Q. What do you think lengthened this surgery to  
12 45 minutes, the extent of the double vessel arch or the  
13 fact when Dr. Kralik opened her chest, it was full of  
14 blood?

15 A. Both.

16 MISS KOLIS: I'm going to step  
17 out in the hallway with Melissa.

18 -----

19 (Recess had.)

20 -----

21 MISS KOLIS: I'm not going to ask  
22 you any further questions unless Mr. Ockerman has  
23 something that causes me to think of another question.

24

25

-----

CROSS-EXAMINATION

BY MR. OCKERMAN:

Q. Doctor, so ■ can get the sequence correct, you had the records prior to reviewing any x-rays; is that correct?

A. Yes.

Q. So you had a chance to review the records?

A. I had the medical records before the x-rays.

MR. OCKERMAN: No further questions. Thank you.

MISS KOLIS: ■ don't have any questions. Are you going to have your doctor read?

MR. TREADON: He's not my doctor. You have the right to read the transcript to make sure what was taken down accurately reflects what you said here today. I recommend that do you that.

MISS KOLIS: I'll waive the seven day reading requirement with the standard promise within 30 days.

MR. TREADON: You can send it directly to the doctor.

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(Deposition concluded; signature not waived.)

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ERRATA SHEETNOTATIONPAGE/LINE

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

\_\_\_\_\_  
MICHAEL ODDI, M.D.

1 The State of Ohio,  
2 County of Cuyahoga. : CERTIFICATE:  
3 I, Constance campbell, Notary Public within and  
4 for the State of Ohio, do hereby certify that the within  
5 named witness, MICHAEL ODDI, 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  
13 taken at the time and place as specified in the  
14 foregoing caption, and that ■ am not a relative, counsel  
15 or attorney of either party, or otherwise interested in  
16 the outcome of this action.

17 IN WITNESS WHEREOF, ■ have hereunto set my hand  
18 and affixed my seal of office at Cleveland, Ohio, this  
19 22nd day of October, 1999.

20   
21 -----

22 Constance Campbell, stenographic Reporter,  
23 Notary Public/State of Ohio.

24 Commission expiration: January 14, 2003.

25

**MICHAEL ODDI, M.D.**

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CROSS-EXAMINATION

BY MR. OCKERMAN:

Q. Doctor, so I can get the sequence correct, you had the records prior to reviewing any ::-rays; is that correct?

A. Yes.

Q. So you had a chance to review the records?

A. I had the medical records before the ::-rays.

MR. OCKERMAN: No further questions. Thank you.

MISS KOLIS: I don't have any questions. Are you going to have your doctor read?

MR. TREADON: He's not my doctor.

You have the right to read the transcript to make sure what was taken down accurately reflects what you said here today, I recommend that you do that.

MISS KOLIS: I'll waive the seven day reading requirement with the standard promise within 30 days.

MR. TREADON: You can send it directly to the doctor.

-----  
(Deposition concluded; signature not waived,)  
-----

25

1 The State of Ohio, :

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2 County of Cuyahoga. : CERTIFICATE:

3 I, Constance Campbell, Notary Public within and  
4 for the State of Ohio, do hereby certify that the within  
5 named witness, MICHAEL ODDI, 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  
13 taken at the time and place as specified in the  
14 foregoing caption, and that I am not a relative, counsel  
15 or attorney of either party, or otherwise interested in  
16 the outcome of this action.

17 IN WITNESS WHEREOF, I have hereunto set my hand  
18 and affixed my seal of office at Cleveland, Ohio, this  
19 22nd day of October, 1999.

0

1 .....

2 Constance Campbell, Stenographic Reporter,

3 Notary Public/State of Ohio.

4 Commission expiration: January 14, 2003.

5

ERRATA SHEET

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NOTATIONPAGE/LINE

3	<u>DONAHOO</u>	<u>8/5,6</u>
4	<u>blush → blurb</u>	<u>11/9</u>
5	<u>perivascular → peripheral vascular</u>	<u>23/19</u>
6	<u>the innominate common carotid, @</u> <u>Subclavian</u>	<u>34/18</u>
8	<u>distinct → indistinct</u>	<u>37/20</u>
9	<u>"chest work"?</u>	<u>38/14</u>
10	<u>whose → who's</u>	<u>41/8 &amp; 18</u>
11	<u>voracity → veracity</u>	<u>42/19</u>
12	<u>Dr. Gehaus' → Dr. Geha's</u>	<u>47/24</u>
13	<u>Dr. Gehaus → Dr. Geha</u>	<u>48/5 &amp; 6</u>
14	<u>to go to zortography</u>	<u>49/11</u>
15	<u>bronchoscopy → bronchoscope</u>	<u>52/15</u>
16	<u>"lick and promise"?</u>	<u>56/16</u>
17	<u>impossible → possible</u>	<u>57/15</u>
18	<u>internal → external</u>	<u>59/20</u>
19	<u>thymic adenitis → thymic adenitis</u>	<u>59/22-3</u>
20	<u>moment → movement</u>	<u>63/23</u>

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

23   
24

25 MICHAEL ODDI, M.D.

FLOW

*Curriculum Vitae*

**MICHAEL A. ODDI, M.D**

**ADDRESS:**

4448 Westview Drive  
Copley, Ohio 44321  
(330) 665-5008

**PERSONAL DATA:**

Born: 10-16-47  
Wife: Rebecca

**EDUCATION:**

Ohio State University College of Medicine  
BA 1968

Ohio State University College of Medicine  
MD 1972

Internship 1972-1973  
Walter Reed Army Medical Center  
Surgery

Residency 1973-1977  
Walter Reed Army Medical Center  
General Surgery

Residency 1977-1979  
Brook Army Medical Center  
Cardiothoracic Surgery

**BUSINESS LOCATION:**

Cardiothoracic & Vascular Surgery of Akron, Inc  
224 W. Exchange St., Suite #300  
Akron, Ohio 44302  
(330) 762-9163

**CURRENT APPOINTMENTS:**

Clinical Assistant Professor  
Northeastern Ohio College of Medicine

**LICENSE:**

35029 Ohio

**PROFESSIONAL  
ORGANIZATIONS:**

American Board of Surgery  
Board certified 1978

American Board of Thoracic Surgery  
Board Certified 1980 Recertified 1990

**PLAINTIFF'S  
EXHIBIT**

A 10-18-99

*Curriculum Vitae*

**MICHAEL A. ODDI, M.D.**

**PRINCIPAL HOSPITAL:**

Akron General Medical Center  
400 Wabash Avenue  
Akron, Ohio 44307

**MEMBERSHIPS:**

American College of Cardiology  
American College of Chest Physicians  
American College of Surgeons  
American Heart Association  
American Board of Thoracic Surgeons  
American Medical Association  
Assoc. of Military Surgeons of the United States  
Cleveland Vascular Society  
International College of Surgeons  
International Society for Endovascular Surgery  
Ohio Chapter of American College of Surgeons  
Ohio State Medical Association  
Society of Thoracic Surgeons  
Summit County Medical Society

DEPOSITION INDEX of  
MICHAEL ODDI, MD

Page 4/11	Has given deposition before
Page 5/15	Has copy of patient record dated September 23, 1997 to November 3, 1997 encompassing the radiology report pathology report and operative report progress notes and nursing notes
Page 6/7	There is some decrease in life expectancy in a paraplegic patient because they tend to develop repeat urinary tract infections & sometimes other systemic infections
Page 6/20	Does not know Dr. Began
Page 6/23	Not familiar with the physiatrists that work at the Crystal Clinic
Page 7/1 Hospital	I have a physiatrist who I refer patient to at the Edwin Shaw Rehabilitation Hospital
Page 7/9	Has no correspondence file between himself and Mr. Treadon
Page 7/11	No file even in existence
Page 7/15	Doesn't recall the exact date it was probably in January I had pneumonia then
Page 8/4	Dr.'s Telesz, Cawthon, Tawil, Chryssos, Kralik and Donahue
Page 8/10	I picked it up on a Saturday I was out of town on Friday
Page 8/16	Has not reviewed the testimony that the Spreadbury's gave
Page 8/19	Has not read the testimony of Dr. Sos
Page 8/22	Has reviewed the chest films of Mrs. Spreadbury
Page 8/25	I reviewed plain chest x-ray
Page 9/3	Has reviewed the CAT scan
Page 9/5	Probably in June or July then again in the past three weeks
Page 9/24	Has not reviewed the Edwin Shaw records
Page 10/10	Has not had any publications

Page 10/14 Needs to up date CV as he has a few publications

Page 10/23 There was a fairly thick textbook not a surgical book basically general medicine called a five minute consult I was asked to author a chapter on thoracic outlet syndrome years ago

Page 11/8 A compendium of every medical subject imaginable it's got a two page blurb on each thing two pages on chronic lymphocytic leukemia & on aortic insufficiency thoracic outlet syndrome

Page 11/14 General Medical book

Page 11/17 They do another every year

Page 11/19 It has been unchanged for the past 6 or 7 years

Page 12/12 Can't really recall the specifics of the case, it was in Stark Cty., and the attorneys worked for Buckingham, Doolittle

Page 13/1 I was asked to render an opinion about a case involving wrongful death suit in a patient who had an esophagectomy for esophageal carcinoma years ago

Page 13/5 At the time I worked for an attorney at Jacobson, Maynard & Kalur in Cleveland

Page 13/18 Only a couple of times

Page 13/23 I worked for Mr. Ockerman I know Mr. Schobert

Page 14/23 Somewhere between 9 and 10 hours

Page 15/1 Charges hourly for medical legal records review is \$250

Page 15/4 Deposition time is \$350

Page 15/7 The only one I know is Dr.'s Menia and Dr. Chryssos I only know by reputation

Page 15/16 Has not had the chance to talk to Dr. Menia

Page 15/24 Whether or not there was a departure from the standard of care relating to the care in a patient who turned out to have a traumatic rupture of a aorta

Page 16/5 That is where my expertise lies

Page 16/13	Will not be offering any opinions as to whether or not the radiologist met the standard of care
Page 17/18	I did search for a few papers concerning the treatment of traumatic rupture of the aorta
Page 17/23	I went to the medical library asked them to do it I presume they used medline or grateful med
Page 18/4	The library did return article on it
Page 18/12	The ones that I thought were pertinent
Page 18/15	They are additional information
Page 18/23	Attended Ohio State University
Page 18/25	Received degree in 1972
Page 19/3	Did internship at Walter Reed for one year in general surgery
Page 19/6	Between '73 and '77 complete 4 year program in general surgery At Walter Reed
Page 19/11	Did two years of residency at Brooke Army Medical Center
Page 19/12	Cardiothoracic
Page 19/16	Fort Sam Houston, San Antonio, Tx
Page 19/25	Residency & fellowship in cardiothoracic is pretty much the same thing regardless of what people call it
Page 20/15	Was 1980 when I became certified in thoracic
Page 20/18	Became certified in general surgery in 1978
Page 20/22	Everyone who goes through residency learns how to approach radiology interpretation of specific x-ray studies
Page 21/4	Although I will say the CAT scans that we used to read in 1970 are a poor distant cousin to the ones we have today
Page 21/12	I always look at one with a radiologist because if I miss something he'll point it out

Page 2211 I was in the military for 4 years beyond that I spent 3 in West Germany at Landstuhl as assistant chief of thoracic surgery then chief for 2 years

Page 2215 I was at Letterman Army Medical Center at the presidio in San Francisco for one year

Page 22/9 I am from Columbus I was looking for something in Ohio and the two surgeons were looking for someone to join them

Page 22113 I ended up in Akron

Page 22/20 It remained the same from '83 through the present

Page 22/24 Has never been insured by Mutual Assurance of Alabama

Page 2314 Doesn't really know

Page 231 7 Is certain it is not Medical Mutual

Page 23113 I do cardiothoracic peripheral vascular surgery that involves doing coronary bypass surgery valve repair and replacement surgery

Page 23116 We do a fair amount of pacemakers

Page 23/17 We do a lot of pulmonary surgeries for lung cancer, esophageal surgery for arterial plaque involving the carotid artery, abdominal aorta & its branches & lower extremity arteries

Page 2418 There is no thoracic residency program at Akron General

Page 2419 It's general surgery residency

Page 24115 We instruct general surgery residents in thoracic surgical problems

Page 24/20 There has never been an AMA certified thoracic surgery at Akron General

Page 2514 Is certified is ATLS

Page 2516 Obtained certification in November of 1998

Page 25/12 Thought it would be wise to do that since we deal with a fair number of trauma patients I'm trying to convince my partners it would be a good idea

Page 25/16 The surgeon who runs the program at Akron General suggested to me about 1 ½ years ago it would be wise to think about it



Page 25/24 2 or 3 years I think it's 3 years

Page 26/3 I did save the materials from the ATLS

Page 26/7 Since last November

Page 26/12 The ATLS course has been devised & developed by American College of Surgeon committee on trauma sometime in 1980

Page 26/23 Doesn't hold any certifications in ACLS

Page 27/1 The last holding for that was 1982

Page 27/6 We have a rotating call schedule whoever is on call for our service on a particular evening is also available for trauma

Page 27/12 Peripheral arteries

Page 27/19 I think I have 4 cases personally, probably assisted on one or two others

Page 28/10 His initial evaluation of this patient as the case was presented to him by the emergency medicine physician & his review of the initial radiographic study

Page 28/15 Providing for fairly close daily follow-up while the patient was in intensive care

Page 29/4 Before I began to look through the medical records

Page 29/11 I don't recall any specific conversation I would suppose that Mr. Treadon would have asked me to review the medical records with the idea that Dr. Tawil had departed from the standard of care since that was the allegation

Page 30/5 I was called in an emergency room emergency medicine situation

Page 30/12 First you try to get some idea of mechanism of the injury at the accident, you project the injuries might be

Page 30/15 You obtain that either from the paramedics written report or from the paramedic personally if you arrive while they are still there

Page 30/18 cursory physical examination involving the so called ABCs of ATLS management by the time you get to the emergency room the emergency medicine residents have already done that

Page 31/1 By the time we get there everything is taken care of pretty much

Page 31/6 Try to determine whether the patient's circulation is adequate

Page 31/8 You obviously depend on blood flow for brain function, kidney function, liver function unless there is adequate blood pressure

Page 31/17 You palpate for the peripheral pulses in terms of strength and pulse rate, how the extremities look

Page 32/5 The next thing obviously once you determine that the patient has an adequate blood pressure is fairly stable

Page 32/8 Secondary assessment in which you palpate the chest wall itself to look for any rib fractures, evidence of ecchymosis or bruising in the skin and subcutaneous tissue

Page 32/12 If the patient is awake you want to know whether or not they grimace with pain when you touch certain areas

Page 32/14 You push on the ribs or the sternum look for evidence of break in the skin that might be of concern in terms of possible penetrating injury

Page 32/17 You get a kind of expeditious chest x-ray to look for any evidence of rib fractures, pneumothorax with a collapsed lung

Page 33/5 They certainly are relevant if someone who is fairly young, otherwise healthy, it takes a fair impact to break a number of ribs

Page 33/23 That was my impression she had 2 or 3 back operations in the past by the record

Page 33/25 Didn't see any evidence of overwhelming medical problems

Page 34/3 After the dust settled there was more than the initial x-rays there were 8 ribs on the left 3 or 4 on the right

Page 34/11 Any time you have the first rib especially the first rib fracture that requires a pretty powerful injury

Page 34/18 You would look for the left common, left subclavian artery, any intercostal arteries that are in proximity to those ribs that are fractured

Page 35/6 Significant pleural fluid accumulation, more commonly on the left than the right

Page 35/9 Because that is where the descending aorta is but I'm not sure why

Page 35/13 Again rib fractures that is a prominent sign, especially the first and second ribs as you point out

Page 35/16 What is called a widened mediastinum is also significant

Page 35/18 In terms of major vascular injury inside the chest from blunt trauma we can talk about right deviation of the trachea when the aorta gets injured

Page 35/23 It can also lower the left main stem bronchus so the angle between the trachea & bronchus is increased

Page 36/1 If you have an NG tube or nasogastric tube down the patient to decompress the stomach that very common will be deviated toward the right for the same reason the trachea is

Page 36/5 There is also talk about pleural or apical capping in the pleural space that relates to blood accumulation or hematoma in the apex

Page 36/15 Anytime you have one of them in the appropriate setting you have to think about it

Page 35/22 Possible major vascular injury inside the chest

Page 36/25 She had bilateral pleural fluid, she had obvious rib fractures she had what was thought to be widening of the mediastinum

Page 37/3 Doesn't recall whether she had a nasogastric tube when she had the initial chest x-ray or not

Page 37/11 Because I knew I would take a look at them again sometime

Page 37/22 While the quality of the portable chest x-rays are notoriously inadequate in terms of defining anything

Page 37/25 To look at the lung fields make sure that the lungs aren't collapsed

Page 38/4 The standard A/P portable chest film especially in large patients will almost show a widened mediastinum

Page 38/18 Presuming the patient is stable enough to be transported we go to the CT scanner in the radiology department

Page 38/24 There are a lot of people at this point in time who because of the fairly good definition you get on Ct scan will make a diagnosis on the basis of the scan

Page 39119 Depends on the radiologist if it is some one that I have worked with for years like at Akron General I have implicit faith in their interpretation

Page 40/7 If you presume that someone is a board certified radiologist

Page 40112 I'm not sure I exactly whether I would rush the patient over to the aortograph suite at that point or not, probably would not

Page 40116 Because of the potential for complications of arteriogram

Page 40124 We're looking at things retrospectively

Page 41124 I haven't reviewed that recently, I think that given the clinical situation the CAT scan has no evidence of any great vessel injury according to the interpretation of the experienced radiologist

Page 42/6 As the thoracic consultant

Page 42116 I'm not the radiologist there are certain subtle things I miss

Page 4314 I was able to see the finding on the CAT scan that were suspicious for injury to the aorta

Page 4319 I found them as they were pointed out to me

✓ Page 43/15 There was slight irregularity of the aortic contour on one of the slices

✓ Page 43/17 There was a kind of a radiolucent line on one of the other slides that suggested perhaps an intimal tear

Page 43123 Distorted or irregular

Page 43/25 Perhaps just beyond the aortic arch

Page 4413 It could be suggestive of an aortic injury could be remnant of vascular ring that I have seen picture of in the past

Page 44/16 They do that all the time the radiologist will say I'm not sure about this one area

Page 44118 We get additional cuts that is their area of expertise

Page 44120 If they feel additional views are necessary I would certainly never argue that at all

Page 45/6 I think I would

Page 45/9	I want to have a personal conversation with a radiologist maybe have another opinion
Page 46/13	Not the x-ray the CT scan
Page 46/5	I took that entire study put it on the large view box in the radiology department at Akron General
Page 46/11	I told the radiologist this was a case from a couple years ago she said there was a lot of subcu air I would be concerned about possible tracheal injury
Page 46/22	We do that clinically all the time we focus on a particular problem
Page 46/24	Clinicians do that, radiologists do that dermatologists do that
Page 47/1	You focus on an area that is very obviously abnormal you miss something it happens
Page 47/11	Can I do that again if somebody gave me a study maybe may be not
Page 47/20	That pure speculation from his deposition testimony where he was trained
Page 48/1	I know that he came from Yale University with an excellent reputation basically international reputation
Page 48/6	Dr. Gahaus
Page 48/16	I don't recall specific questions basically you submit an application, including 100 consecutive cases
Page 48/18	The board sends you what amounts to being an open book test
Page 49/11	About whether to go the aortograph or observe the patient for the next several hours
Page 49/18	Any irregularity of the aortic contour that I couldn't ascribe to obvious atheromatous disease in older patients
Page 49/22	What is called a wedge-shaped defect in the aortic wall basically anything that doesn't look smooth
Page 50/2	You see mediastinal hematoma in chest trauma all the time
Page 50/14	Depending on the clinical situation although I think if there were any suspicious findings on the CT scan I would probably recommend an aortogram to be on the safe side

- Page 50/19 Any kind of clinical instability drops in blood pressure, drops in hematocrit or blood count anything suggesting hypovolemia which is decreasing in blood pressure
- Page 51/8 Doesn't recall any changes in respiratory status
- Page 51/11 I certainly should have, but I don't recall anything specific
- Page 51/17 The only note in the physician's progress notes is from Dr. Telesz at 6:00 pm which relates to very transient decrease in blood pressure that responded fairly adequately as far as I can tell to some increase in I.V. fluid administration
- Page 52/4 The nurse's note are much more legible than the doctors' notes, they state that right around 5:15 pm the patient was fairly combative to Dr. Tawil's attempt to do the bronchoscope at that time
- Page 52/13 Anybody who exhibits increased anxiety or respiratory difficulty could have some bleeding inside the chest
- Page 53/3 It is a terrible thing to admit but if you read the medical literature there are a certain percentage of patients who have successful thoracic aortic rupture repair operations
- Page 53/11 Variability in blood supply to the spinal cord and the fact that it's necessary to clamp off a fairly good portion of the thoracic aorta to do this operation
- Page 53/16 Three to twenty percent will be paraplegic after these operations
- Page 54/1 I think it had to do with clamping of the aorta the spinal cord ischemia when that happened
- Page 54/15 Believes it was the surgery that caused her to become a paraplegic
- Page 54/24 Classically the way to do this was to use what some people call a clamp and sew technique
- Page 55/1 Clamp the aorta both above and proximal and distal to the injury open the hematoma see exactly what the situation is repair the aorta or replace that part with a prosthetic tube graft
- Page 55/10 The other way to do this provide some type of shunting of blood flow to the lower extremities around the area that you are working on
- Page 55/14 One is heparinized shunt to go around the other is called a partial bypass with a heparinized circuit then you don't have to give systemic heparin

Page 55/18 My way is clamp and sew

Page 55/24 I believe the contribution from the anterior spinal artery may be very significant from those intercostal branches of the aorta and part of the aorta that is being clamped off

Page 56/20 It's scientific principle

Page 57/7 It depends on the particular surgeon I don't know what Dr. Chryssos and Dr. Kralik prefer to do

Page 57/12 Doesn't always take less than 30 minutes

Page 58/1 From the medical records it was about 6:00 pm on the 23<sup>rd</sup>

Page 58/4 To increase in I.V. fluids

Page 58/7 Dr. Telesz recorded the pressure was 70 to 80 systolic

Page 58/11 On the 24<sup>th</sup> at about 9:00 am

Page 58/14 Doesn't recall the number

Page 58/17 The recorded pressure at 9:10 am on the 24<sup>th</sup> was 35 over 21 as recorded by arterial line

Page 58/23 You would have to presume there was acute volume loss blood loss that occurred right at that time

Page 59/2 The most likely source is an acute expansion of the hematoma that she turned out to have secondary to the aorta injury

Page 59/11 If it's reliable blood pressure reading I don't see any obvious explanation for that

Page 59/18 Typically a portion of the aorta wall will be torn by blood flow will be contained by surrounding tissue typically the adventitia, which is the internal lining of the aorta and at least part of the media which is the muscle layer of the middle layer is torn

Page 60/23 Decrease in blood flow through the artery branches that supply or arterial branches that contribute to the anterior spinal artery

Page 61/3 Again it's variable from one person to the next, some of the intercostal arteries that originate under each rib can provide a contribution and the anterior spinal artery

Page 61/11 It depends how much blood is getting lost

Page 62/5 Has read Dr. Tawil's deposition

Page 62/18 Believes that the surgery is cause of her being a paraplegic

Page 62/25 She may not have been paraplegic prior to the surgery

Page 63/3 Has read Dr. Tawil's admission and discharge summary

Page 63/17 Dr/ Kralik mentioiicd she was partially sedated it was really impossible to do an adequate neurological exam on her pre-operatively

Page 63/22 As I recall she was moving her toes but the degree of movement was not thought to be what would be expected on the basis of how well she moving her upper extremities

Page 65/14 There is nothing in the physicians' or nurses' not about her moving her toes my recollection is that Dr. Kralik mentioned he had been to see the patient that morning when he was called after she dropped her blood pressure

Page 65/18 I thought he mentioned she moved her toes I could be mistaken

Page 65/23 Will go through Dr. Kraliks' deposition again

Page 66/12 Can't remember his exact response

Page 66/8 Doesn't recall him indicating the possibility of surgery being the cause of the paraplegia

Page 66/11 I think he mentioned that because the patient was hypotensive in the early part of the operation

Page 66/13 There was also some increased difficulty of the procedure because of the mild anomaly she had in her aorta arch

Page 66/15 It made the operation a bit more difficult he thought the patient contributed to it because basically the patient was without a blood pressure I guess for several minutes

Page 66/22 I think it's kind of a testimonial to the surgical expertise at this point that she is even alive at this point

Page 67/7 Will have to go back and review his deposition



Page 67/16 Did not see that the findings on the aortogram

Page 67/22 I'm trying to read his mind as far as I can tell it makes the decision where you can safely put the clamp proximal to the subclavian artery a bit problematic

Page 68/6 It is determined as to where you place the clamp

Page 68/10 It was described by Dr. Chryssos

Page 69/6 Had the records prior to receiving the x-rays