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

IN THE COURT OF COMMON PLEAS

MARLA I. SPREADBURY, et al., :
plaintiffs, :
:
vs. : case NO. 1998CV1681
1998CV00589
MERCY MEDICAL CENTER, et al.,:
defendants.

Deposition Of ALEJANDRO SOS, M.D., a defendant herein, called by the plaintiffs for the purpose of cross-examination pursuant to the Ohio Rules of civil Procedure, taken before Constance Campbell, a Notary Public within and for the state of Ohio, at the Timken Mercy Medical Center, 1320 Timken Mercy Drive, Canton, Ohio, on WEDNESDAY, MAY 5TH, 1999, commencing at 11:20 a.m. pursuant to agreement of counsel.

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I N D E X

ALEJANDRO SOS, M.D.

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

MISS KOLIS: Dr. So~, good morning again. For identification purposes on the record of course, my name is Donna Kolis. I am one of the attorneys whose been retained to represent Marla spreadbury and her husband in the action in which you were also named as a defendant.

My purpose this morning is hopefully to be brief and concise, but to ask you about your care and treatment of this patient, and observations you might have made.

CROSS-EXAMINATION

BY MISS KOLIS:

Q. Doctor, I suspect that you've at least had an opportunity prior to today to give a deposition?

A. Sure.

Q. I would remind you of the basic rules of deposition taking. we need for you to answer each and

every question verbally; do you understand that requirement?

A. Yes, I do.

Q. If I ask a question that you do not understand, please inform me that you do not understand the question. Can I secure your agreement on that?

A. I do.

Q. Additionally if at any time during the deposition you need to confer with Mr. Taber, just state so for the record, that will be permitted.

A. May I say off the record?

Q. You can say I would like to speak with Mr. Taber, that would be fine.

Lastly it would not be surprising to me there might be some objections during this deposition. If any attorney in this room objects to a question, please do not answer the question until we have resolved our differences and you are instructed by the court reporter or your attorney to answer the question, okay?

A. Very good. I understand very well.

Q. For identification purposes you have handed to us this morning the document that I assume is your current curriculum vitae, that is a two page document?

A. Yes.

Q. we'll have it at the end of the deposition marked

as Plaintiffs' Exhibit 1.

Additionally you handed to me Just before the commencement of the deposition a single sheet of notes that you had prepared; is that an accurate statement?

A. could you repeat?

Q. sure. You handed to me a single sheet of notes that you had prepared, is that an accurate statement?

A. It's a correct statement.

Q. when did you prepare these notes, Dr. Sos?

A. Last night.

Q. You prepared them in anticipation of questions I might ask today?

A. Yes, I prepared to avoid also the bulky chart, to have the most important points here.

Q. Fair enough. This will be marked Plaintiffs' Exhibit 2.

Doctor, for the record can you state your name and your professional address?

A. Yes. My name is Alejandro, A-l-e-j-a-n-d-r-o, last name sos, S-o-s. My office is located at 1445 Harrison Avenue, Northwest, in canton, Ohio.

Q. Doctor, I would like to just briefly go through your medical background.

Looking at your CV, it appears that you

received your medical training in Spain, is that an accurate statement?

A. That is in Akron.

Q. Let's go through it. YOU graduated from what medical school?

A. Madrid Medical School, 1962.

Q. Following that you served in the Medical Corps for the Spanish Army?

A. It was compulsory, yes.

Q. '62 to '63?

A. Yes.

Q. You did a neurosurgery residency also in Madrid?

A. Yes.

Q. '64 to '67, then you took your ECFMG in 1967?

A. Correct.

Q. You came to this country?

A. For training, correct.

Q. Then you essentially -- I say essentially, you then began medical training in this country in 1968?

A. I began from scratch internship in '68, then I did six months of neurology at Georgetown University in Washington D.C. from January to June 30, 1969. Then I did general surgery because these are requirements before doing neurosurgery. we get to do one year of neurosurgery.

University of Louisville Medical school, Louisville, Kentucky one year, finished in June, 1970. Then from '70 to June, '74, four years I spent in Cincinnati doing medical training. After I finished this training they asked me to stay a couple months to help with the new chief resident. Also they gave me a teaching and research Fellowship. I was there until the end of '74, then I returned to Spain.

I was in Spain from '74 to '78 working there in one of the university hospitals. There are three medical schools in Madrid. since we were under the dictator Franciso Franco, this is what it was called, Francisco Franco Hospital. I was there '74 to '78. Then I returned to the States.

Q. Then you took your FLEX examination, obtained a license to practice medicine in 1979?

A. '79 I got the ohio license. I came to Kentucky -- no, I came here in 1980.

Q. You originally were in Kentucky for a year?

A. In Kentucky I took my examination. My wife is from Kentucky, I took it there because she -- that's how we worked it. As soon as I got the examination I had already inquired about Canton, ohio. I went to canton, ohio in 1980, the same building where I am now, same hospital.

Q. Let me ask you a couple of questions about your neurosurgical practice.

Your CV indicates that you have been in Canton as a neurosurgeon since 1980?

A. That's correct.

Q. Your neurosurgical practice, do you have a partner in that practice?

A. only the first year. ■ came with a neurosurgeon, he left at the end of the year. He brought me here, Dr. Gonzalez. ■ have been in solo practice since January, 1981.

Q. To the present ■ assume?

A. To the present, yes.

Q. The CV indicates that you are on active staff at Mercy Medical Center, have been so since 1980?

A. That's correct.

Q. You have courtesy privileges at Massillon?

A. Yes.

Q. Do you hold any positions within the hospital?

A. well, I belong to several committees, ICU committee. ■ belong to the surgical department committee for quality care, some other committees.

Q. In this hospital who is the chief of neurosurgery, if is there is such a position?

A. There is no. Every specialty is in the Department

of Surgery. There is a chief of the Department of Surgery. There are ENT doctors, obstetricians, there are neurosurgeons, currently is me, we all are under the chairmanship of Dr. Grayson.

Q. At any time since 1980 have you been appointed as the chief of surgery?

A. No, because you have to run for it. I didn't run because its meetings are every two weeks, it's too much.

Q. If I'm reading your CV correctly, is it fair to state that you do not hold a Board certification in neurosurgery?

A. No, I don't.

Q. You are currently Board eligible?

A. I'm Board eligible. I had the first part.

Q. You took that in 1994?

A. Yes.

Q. You have obviously privileges to do neurosurgery at this hospital?

A. That's correct.

Q. undoubtedly. Tell me what your neurosurgical practice consists of?

A. I do neurosurgery, everything but stereotactic neurosurgery because we don't have the number of patients, we don't have the equipment. otherwise I do brain aneurysms, I do spinal cord tumors, I do

peripheral nerves. I do laminectomies for lumbar disks, the lumbar spine. I do everything but stereotactic.

Q. Other than this instant lawsuit, have you been a defendant in a medical negligence case before, Doctor?

MR. TABER: objection. You can answer.

A. Yes.

Q. Do you know how many other times you've been sued?

MR. TABER: objection.

MISS KOLIS: You can have a continuing objection to any and all questions about litigation.

A. I think 11 times. I never lost any one.

Q. Those were all obviously here in stark County, the cases that were filed against you?

A. Yes. This is the only place I practice.

I think I have 11 lawsuits, all of them have been dismissed in the discovery period. But one that we went to court I was so upset about that I talked to my counsel, two days later the judge dismissed me.

Q. Have you in the past approximately 19 years of being in this part of Ohio served as a medical expert on behalf of any doctor?

A. No, I refuse. I had several approaches, people approach me, I always refuse.

Q. Have you served as a medical expert witness on behalf of a patient?

A. No. ■ refuse too.

Q. You just have not done any medical/legal testifying?

A. It's too complicated, takes too much time. Somebody will be mad at me anyway.

Q. Doctor, obviously the answer to the question, I don't even have to ask it, you had an opportunity to review the chart in preparation for today's deposition?

A. Yes, I did.

Q. You reviewed it as recently as last night?

A. As recently as last night, correct.

Q. when you did your chart review did you confine yourself solely to notes you prepared or did you look at further information?

A. I looked at further information in general, mainly my concern was -- try to remember this case is two years old, almost two years old -- tried to remember the chronology of the events, the timing when I was involved, when I returned the call for consultation, my clinical impression at the time.

Q. Fair enough.

As part of the informal discovery process in this case I provided to your attorney a set

of films that were performed on my client, Mrs. Spreadbury. Those were x-rays, head CAT scans, chest CAT scans and abdominal CAT scans. Doctor, have you had an opportunity to review those films?

A. No, I didn't.

Q. Although I have some prepared questions I guess what I would like to do is start with the notes you took. Let's see if we can just carefully, slowly, read into the record these pieces of information. I may interrupt you, ask you some questions.

Before I ask the questions, the information that you recorded, you recorded why? Do you understand my question?

A. Yes. I recorded to answer promptly, accurately to your questions about the vital signs, condition of the patient, timing when the patient was rescued by the emergency squad, time when she arrived at the hospital, timing when I saw her.

Q. Did you put on this particular sheet information you felt was medically important? I know that is probably a silly way to ask the question. I'm trying to figure out why you selected certain pieces of information to include on these thoughts?

MR. TABER: objection. I think he just answered that.

A. I think I -- again, to answer your questions promptly and efficiently. I feel we have here much of the information involving the very first two or three days of the stay in the hospital of Mrs. Spreadbury.

Q. The first line looks like you're indicating vitals 133 over 86, correct?

A. Yes.

Q. Then I can't make out what is immediately following that?

A. 130 over 86, that says good. That means that pressure was good. Then blood pressure, good blood pressure, okay. Pulse 107, they were very fast, that was in the emergency department, ED. According to the the emergency physician, Dr. Menia. The patient probably, I say probably question mark or quotations was moving all four limbs. That means all four.

Q. All four extremities at the time of presentation to the emergency department?

A. Yes. To me it's not absolutely clear. The abdomen was soft, the patient has been involved in MVA, the past medical history, PMH, back surgery times three, back three. That Dr. Telez was there when the patient was intubated, that the patient was paralyzed for the intubation.

Q. Stop right there, I want to ask you a couple short

questions at this juncture.

According to the best that I'm able to time this, you would have been contacted to do a consultation at about 11:26; do you agree with that?

A. Let me look at the notes here.

Q. Absolutely.

A. I might look in the chart. Yes, I have 11:26.

Q. Did you draw that information from looking at this particular piece of paper, the sheet?

A. No, probably but let me look -- probably from my consultation.

Q. From your consultation note?

A. Yes. I refer to 11:26 because on my typed consultation, initial consultation on the last paragraph I dictate, while I'm dictating this at 4:25. I said before I follow this patient for several hours. Now while dictating at 4:25 corroborates with the transcriptionist wrote dictation 1629, it's recorded at the time we dictate. I thought that I was there for about four or five hours. I looked at the nurse's note, I had to agree when I arrived there it was 11:26, 11:30 in the morning.

Q. You think that is when you first saw her?

A. Yes, because I was immediately when I was called, sure. Also it's on the nurse's emergency room notes

they recorded time of physician arrival.

Q. You actually examined the patient physically before you went down to CAT scan?

A. Yes. Let me see my note to be correct. Is mentioned on the second paragraph, first line.

Q. You're discussing your transcribed consultation report?

A. Yes, on the second paragraph. I dictated when I arrived in the intensive care unit the patient is just back from having computerized axial tomography of the head.

Q. First of all, since you are now referring to your consult report, this will eventually be marked Exhibit 3.

My question is in the second paragraph, when I arrived in the intensive care unit, that's a mistake, it wasn't the intensive care unit where you first saw her, was it, Doctor?

A. As it's been two years, if I dictate the intensive care unit, I arrived at the intensive care unit.

Q. when you arrived you think she was already in ICU, not the emergency department?

A. I don't recall that.

Q. It may not be important, I'm just asking.

A. I tried to be maybe -- this is transcribed

intensive care unit. I know I was -- the first doctor was Dr. Telesz, the second doctor was me.

Q. How do you know the first doctor was Dr. Telesz, the second doctor was yourself?

A. The patient was intubated and paralyzed when Dr. Telesz was there.

Q. How is it you would come to be called in on a consultation in this kind of case?

A. At the time they called me because they suspected a head injury.

Q. I didn't ask that question very well. were you the on-call neurosurgeon for that day for the hospital's emergency department?

A. yes.

Q. How many days a week are you the on-call doctor?

A. I'm continuously on call, there is no other neurosurgeon here.

Q. Are you the neurosurgeon who would be called in a head trauma case?

A. Yes.

Q. That's all I wanted to establish, thank you.

we've gotten up to the part you are doing some background history. Dr. Telesz intubated the patient and paralyzed her; is that right?

A. Yes.

Q. Did you talk with Dr. Telesz before you initially examined this patient?

A. I don't recall. I know I saw Dr. Telesz, I don't recall if I saw him before I examined the patient or after I saw the patient.

Q. At the time that you initially saw her, she had been given paralytics so she could be intubated; do you agree with that?

A. Yes.

Q. Because she had been given those paralytics was it possible for you to perform a complete and full neurological examination?

A. No, it was not possible. This is why I mentioned that when I dictated I had several hours with the patient, I was waiting until she comes back from that.

Q. Eventually you make a note at the bottom of the consultation report, the typed report on the first page when you are dictating this at 4:25, she does not follow commands, briefly moves the toes with very, very weak movement; would you agree with that statement?

A. Yes.

Q. 4:25, which is several hours after the admit time are you indicating there were positive neurological signs that she was able to move her extremities?

A. Move the toes. She moved the toes for me.

Q. Did you perform a full neurological examination on her before you dictated this note close to the end of the day?

A. Yes, this is why I don't want *to* be repetitive.

Q. It's all right.

A. I stay four or five hours with her in and out *to* make possibly a better neurological evaluation. when the patients are paralyzed, the evaluation is disappointing.

when the patient is paralyzed, they call me from the emergency, I cannot evaluate the patient for several hours.

This is why I stated when I saw she moved the toes a little bit, so upper extremities was almost no moving. when I arrived there the pharmacological process has been taken care of. She was moving very weak but she was moving her toes.

Q. Fair enough.

I guess let's move on to some notes that you took. The line after where Dr. Telesz has her intubated and paralyzed, you have a 12:39 note, you see that? Can you read across that line?

A. 12:39 blood pressure 140 over 100, pulse was 80. The pupil on the left was 3 millimeters, the right side was 5. Ecchymosis, that means bruise on the chest. Has

chest tubes, they were not producing any blood. According to the records pneumothorax, rib fractures, there is four or six ribs on the right side were fractured.

Q. In that line of information that you just read to me, the examination of the pupils, the right is 5 and left is 3, was that your physical observation or is that someone else's?

A. No, my physical observation.

Q. That was your observation?

A. Yes.

Q. At that point what concerns did you have regarding her general health from the accident?

MR. TABER: Are you asking him about what his memory at that time was or --

Q. At that point at 12:39 you just answered you did the pupil examination, you noted that ecchymosis, et cetera?

A. Sure.

Q. Did you have an impression as to whether or not she had a neurological injury at that point?

MR. TABER: she is asking if you remember what you were thinking back a year and a half ago.

A. I think that the patient -- what I was very likely

thinking at the time is I need to see the patient for longer once she is out of the effects of the paralyzing drugs to see if she has any manifestations of immediate injuries. I need to see a CAT scan of the head to see if she had an intracranial injury.

Most of the times when the pupils are as unequal as they are here, it's a result of a direct impact due to the accident. could be a fist fight on the street, they hit on the eye, the pupil becomes dilated and paralyzed. I was not too concerned about the pupillary unequality.

Q. Eventually, to move to what I believe is in your consult note, closer to the time that you completed your exam for that day there was some improvement, correct, in the pupillary response?

A. Let me see. Yes, it was down to 3 millimeters. It was still larger, it was going down.

Q. It had actually reduced in size?

A. Yes, going more toward normal.

Q. Based upon the notes you have, not just these notes, based upon your review of the chart, give me the chronology of what you did for this patient on the 23rd.

A. well, first thing I did, I examined the patient, then I checked, we always go the same way, we inspect the patient, we look if there is any marks, any

abrasions, hematomas, lacerations and so on. That is what I did.

I point out she's got a small laceration on mid of the forehead. She had the abrasion on the -- ecchymosis on the chest due to the impact again, the steering wheel or other reason.

Then we looked if there is a deformity on the long bones, the arm, forearm, the femur and legs, there was no deformity. we looked at rotation since the patient's level of consciousness, it's not always done. Sometimes we take the leg, the leg is rotated outward, we look at it.

we check for the entirety of the neck, any hematomas, any shift in the trachea, she didn't have any.

As I mentioned we look at the head, the head has the abrasion, unequal pupils, didn't have any blood in the auditory canal, which probably told me no skull fracture.

Q. Because there was no blood in the ears?

A. No blood in the ears.

we looked at the chest. On the chest I recall my colleage appreciated the subcutaneous emphysema. That means some free air, some crackling when you push on the skin with your fingers, you feel

like the wrapping plastic with bubbles, you can crack the bubbles of air. she has subcutaneous emphysema.

She has fractures from the -- we know from the x-rays she has fractures. The abdomen is soft, not distended at that time, at least not intra-abdominal bleeding or major intra-abdominal trauma like is seen with a liver or spleen with injury.

We get almost in front of the patient, we push on the iliac crest to see if there is a rocking sign, a fracture of the pelvis when you push, this is moving, this was not present in this patient.

I took into account how the vital signs were. I looked into -- I was anticipating, this is why I waited so much more to see if she was moving an arm, see if she was responsive, able to move the lower extremities.

Q. Let's look at your written consultation report so I can ask you some questions about that.

Doctor, this is the transcribed consultation report 9-23?

A. Correct.

Q. Did you not handwrite a consultation note that day?

A. This day I only wrote the note in the chart, consultation dictated.

Q. That is the one I saw. You don't have a recollection that you hand wrote out all the information?

A. No, I just dictate.

Q. You dictated it?

A. I dictated. when there is trauma sometimes I only write a written note, when there is trauma I dictate this since we are involved today, may develop. I was trying to be very accurate on the timing I dictate.

Q. Given that you just indicated that you dictated this, it was transcribed the following morning; am I reading this accurately 6:56 on --

A. No, same day, 9-23, 4:29 on the 23rd, transcription.

Q. Maybe I misstated it.

A. Dictated on the 23rd.

Q. Transcribed on the morning of the 24th?

A. Yes.

Q. How would you have communicated your impressions and your advice on this patient to other physicians in the case at the close of the day?

A. I recall very well that I talked personally with Dr. Telesz when he was in the intensive care unit. I talked to Dr. Tawil I believe -- no, excuse me, Kralik, I think I talked to Dr. Kralik, one time to Dr. Tawil.

Q. You have a specific recollection of talking with Dr. Telesz?

A. Yes.

Q. Dr. Kralik?

A. And Dr. Tawil.

Q. This would all have been on the 23rd, before you left the hospital?

A. Yes, has to be. Absolutely with Telesz has to be on the 23rd, no question about that. I believe that you know the time is almost two years now.

I know that I believe I talked to Dr. Tawil the same day because we all came to the emergency room to the ICU, to the CAT scan, we crossed paths there, you know.

Q. Do you believe that you independently reported your assessment to Dr. Tawil as well as Dr. Telesz?

A. To Dr. Telesz, 100 percent sure. To Dr. Tawil, I may be misled by timing, I think I talked to Tawil, I think I saw him there because Tawil was the very first one that was called.

Q. Fair enough. Let's go back to your consult note. I have to ask a silly question.

A. Yes.

Q. I'm working on a case in a hospital I haven't worked with before; transcription in this hospital, you

dictate, who does the transcription?

A. Well, now I believe it's done in the hospital.

Q. Do you believe it was done in the hospital in 1997?

A. No, in 1997 I think we had a contract with a company, we had a lot of trouble with them because sometimes it was too many delays. Now I think it's done in the hospital for us, but I think for the emergency room it's done by a company that always times central time. when they said at 6:00 p.m. central time, they fax those.

Q. You didn't have an office employee who you would give this to, it goes through an electronic service done off site, returned to you?

A. This is dictated from the hospital, the hospital takes care of these, yeah.

Q. The first paragraph of your consultation report indicates that you were, if I'm getting this wrong you tell me, at that time that Mrs. Spreadbury was where she was, ICU or ED, that there were actually photographs of the accident which you were able to examine?

A. That's correct. I believe those photographs, I could be wrong, were shown to me by somebody in the emergency room or somebody in the intensive care unit. I saw the photographs.

Q. Were those Polaroid photographs?
A. Polaroid photographs, yes.
Q. Have you seen those photographs since the date of this accident?
A. NO.
Q. Do you know where the hospital keeps these photographs?
A. When the photographs are made in the emergency room. These photographs were at the scene. when they are in the emergency room they are part of the records, they are kept in the records.
Q. So you are unaware as to whether or not if the emergency fire department actually gave those photographs, if the photographs would remain part of the hospital chart?
A. I don't think they would be part of the hospital chart. They wouldn't be taken here.
Q. I'm just asking.
A. But I saw the photographs.
Q. Did the photographs in any way help you in the assessment that you made of this patient?
A. Yes, the photographs I remember very well because the air bag was completely flaccid, deployed, the left front part of the car was destroyed, there was no door, the seat was also broken, the windshield, all the frame

of the windshield was destroyed. My opinion was that I don't know how the patient survived.

Also, probably the front wheel was destroyed because the car was laying on the ground, the car was not standing, the front of the car seemed to me like that, was lying like that, lying on the ground. The front tire was destroyed I believe. very dramatic.

Q. YOU have pretty much gone through your second paragraph I believe, but I want to ask to make sure I haven't missed any information.

It's indicated you are saying you saw her, you did an exam?

A. An exam. I didn't do a neurological examination because we needed the responses from the patient. Then I inspected her, listened to the chest, listened to the abdomen, felt the abdomen, felt the limbs, then I went in and out until she was more awake to see if I could get reflex responses and voluntary responses to pain or voluntary responses responding to verbal commands. She never responded to verbal commands. she did respond to pain eventually, four hours later.

Q. Do you believe that you did some of this examination before she went to CT? I'm asking based on the way your report is written.

A. NO, I say she returned to have a CT scan of the

head, then I know, not surprised these patients are sent to CT scan immediately when they arrive to admission. The timing of CT scan is in your record.

Q. There is why I'm asking if you knew. Your next paragraph indicates I examined the x-rays, you see where that paragraph begins?

A. Yes.

Q. Dr. Sos, did you personally look at the x-ray films, the chest x-ray films taken on this patient?

A. Yes. Routine procedures, yes.

Q. Then you indicate and there was bilateral hemothoraxes with maybe some free air in the mediastinum and rib fractures?

A. Yes.

Q. This sentence, is that recording your impression of what you believe you saw on the x-ray?

A. That is what I saw.

Q. Did you confer with the radiologist about any of those chest findings?

MR. TABER: which ones?

Q. The bilateral hemothoraxes, the free air in the mediastinum?

MR. TABER: I mean which radiologist?

Q. Did you confer with a radiologist at that time on

the 23rd regarding the chest films?

A. I don't recall. I don't think so.

Q. Do you regularly read chest films in the trauma department?

A. No, I look by myself every time I have a trauma patient. I always look. I don't discuss with a radiologist because it's out of my field, you know. I look out of curiosity. I look at the abdomen, I look at bone x-rays, I look at the chest x-ray. The chest x-ray I usually always look. If the patient has to be on a ventilator could be important to know if she has fractures.

Q. So you had a neurological purpose in examining the x-rays, correct?

A. Yes, mainly respiratory support of the patient.

Q. what kind of support were you contemplating?

A. Respiratory support in general, not just Mrs. Spreadbury. Patients with injury as I thought this patient was going to have diminished level of consciousness, many times they need to be intubated, as she was.

Q. she was already intubated before you looked at the x-rays, correct?

A. Sure.

Q. Did you have an opinion, first of all from your

recollection in reviewing the chart, and what you believe that you saw, would you agree that in the chest films that were taken on the morning of the 23rd there was a widened appearance of the mediastinum?

A. No, I don't have that recollection. Also happened, all other patients, not only this patient. Myself, if I lay on the table, they do a chest x-ray of me, my mediastinum is going to be wide because I am recumbant. Widening of the mediastinum is not a very important landmark.

Q. Not very important?

A. The widening of the mediastinum when the chest x-ray has been done with a patient recumbant, means laying down, is not an important landmark. Is not a very important landmark because everybody has a wide mediastinum when we lay down for an x-ray. It's to be thinking about, it's not important.

Q. Did you have an opinion as to the cause of you called it maybe free air in the mediastinum? see how you wrote that?

A. Yes.

Q. Did you discuss with anyone that you thought there might be free air in the mediastinum?

A. Yes.

Q. who did you discuss it with?

A. Kralik.

Q. I have to ask, how do you recall it was Dr. Kralik you discussed it with?

A. I may be wrong, it's the face I remember.

Q. Why would you have discussed it with Dr. Kralik?

A. Because he's the thoracic surgeon. He was in the case.

Q. Did you at that point have a concern as to what might be causing that free air in the mediastinum?

A. I thought that probably was because of the broken ribs.

Q. Your next paragraph deals with the CT of the head; is that right?

A. Yes.

Q. Did you talk with the radiologist who performed the head CAT scan about the results?

A. I don't recall. In general, I not always talk to them because I think I read better than they do. That's true.

Q. Is it your testimony or do you believe or certainly did you read this head CAT scan on your own?

A. Yes, absolutely, I will see it.

Q. what is contained in this particular paragraph is your interpretation of the head CT that was performed on 9-23?

A. Yes, my interpretation. Taken as my own interpretation.

Q. Did you look at any other CAT scans of that day other than the head CT's?

A. I don't believe so.

Q. Your interpretation of this particular head CT revealed what in terms of damage from the accident, if any?

A. Number one there was not any fracture on the skull. only a little bit what I read here a subgaleal swelling, the little bump we get when as little children we fell. It's a small amount of blood under the scalp, between the skin and head, the bone. This is of no importance. There is no masses, no hematomas in the brain, no hematomas outside the brain, no extra-axial. The brain was in the midline. She had a little bit of brain atrophy not related to the accident. She was maybe too young to have brain atrophy being 43, there are variations. Maybe the brain was not as full as should be, the convolutions, convexity, no major importance. I thought that the head was in excellent shape, the brain.

Q. You looked at the head CT, this was your interpretation, you communicated this information about what you thought the CT of the head revealed, correct?

A. Yes. It's transcribed on the -- they are supposed to read it.

Q. That day? Because this was not transcribed this day.

A. when I talked to Telesz, he was -- I told him all my impressions, I am 100 percent sure I tell him everything. There is no question.

Q. Then back to the paragraph we already discussed to make certain.

A. Excuse me, going back to your first question why I remember it was Tawil. I say Kralik, probably was wrong, because I meant Tawil. That Tawil was going to do a bronchoscopy. Then maybe I talk to Tawil. I don't know, I thought it was Kralik when I told him she has free air. Maybe it was Tawil. As a matter of fact, since they are a group sometimes one takes the work of the other guys. Anyway, I interrupted you, I'm sorry.

Q. That's okay. Are you amending your answer that you previously gave?

A. I say only that again I think so I talked to Tawil. Later on in my dictation -- correction.

Again, I think that I talked to Dr. Kralik about the free air on the mediastinum. could be Tawil because I see later on in my dictation I say Tawil is going to do the bronchoscopy. Sorry about the

confusion.

Q. That's all right. You dictated the note at 4:25 in the afternoon, clearly at that point she was in the intensive care unit?

A. Yes.

Q. The lacerations that she had have been sutured, she is now nodding her head to certain questions and commands; is that what you wrote?

A. Yes.

Q. At that point, unlike your preliminary impression, if you spoke to her, you would get a response?

A. A weak response.

Q. I understand that. This was a change, correct?

A. Yes.

Q. She was not responding to commands by nodding?

A. Yes.

Q. Was she opening her eyes?

A. I don't recall.

Q. we've already covered this, you gave her commands, you said she briefly moved her toes with very, very weak movement, correct?

A. yes.

Q. At the point in time which you were, she has been at the hospital about ballparking it five hours, she now has this brief response in moving the toes, you are

calling it very, very weak, did you have any concerns about her neurological condition in the extremities based upon that examination?

A. No, because you know she was not completely out of the medication. Moved the toes, she nods yes, appears to be recovering, appears to be recovering, I didn't say is recovered from sedation. she was still under the affects of the sedation.

Q. At the point you felt sedation was wearing off you had nerve improvement over five hours, this was a reassuring sign to you?

A. I think all these patients many times for two days or so we don't know what is going on. At that point she was waking up, seems to be waking up from the affects of trauma and affects of sedation, affects of the anemia. she was so anemic. She was moving the toes even weakly, probably the next morning we had to assume would be moving better with less pharmacological agents on board.

Q. Then you indicate she was going to have a brochoscopy by Dr. Tawil?

A. Yes.

Q. Did you talk to Dr. Tawil, did he tell you he was going to do a bronchoscopy, is that how that ended up in your notes?

A. That is very likely what happens.

Q. Do you know what the purpose for the bronchoscopy was at that time?

A. They wanted to rule out a laceration to the trachea, injury to the trachea or the primary bronchi that could displace free air in the mediastinum.

Q. Is that what Dr. Tawil told you?

A. I don't know, that is what I tend to believe is why they were doing the thing. I don't recall what he told me, it's a year and a half, two years. I stated here that as a bronchoscopy with thoracic surgeon, I assume the only abnormal thing we found at time was free air on the mediastinum, was to rule out tracheal injury, bronchial injury. This is common sometimes the bronchia can be ruptured, the patient leak air into the mediastinum.

Q. Then you indicate from the neurological standpoint the only thing we have to do is continue support. I fully agree with Dr. Telesz' order to support this patient.

MR. TABER: From the neurosurgical standpoint?

Q. From a neurosurgical standpoint?

A. Yes.

Q. That's what you indicated. You completed your review of the head trauma, you felt confident that was

all right?

A. Yes.

Q. Is that a fair way to state it?

A. I think I stopped at the neck.

Q. You were the neurosurgical consult, correct?

A. Yes, sure. I was satisfied with the patient's situation. I was satisfied that we had gotten it from the patient, me and the other physicians. These patients are going to be sometimes in a coma for two, three or five days.

The fact that six hours, five hours later she started nodding, even poorly nodding to command, wiggling a little bit of toes, I assume I mentioned the -- I didn't mention the upper extremeties, she was probably weakly moving the upper extremities. Let's see how she is tomorrow, or later on.

Q. when you say the only thing we have to do is continue support, what did you mean?

MR. TABER: It says -- don't forget first part *of* the sentence, from the neurosurgical standpoint the only thing --

Q. From a neurological standpoint what support were you going to continue to offer the patient?

MR. OCKERMAN: objection. Go ahead, Doctor.

A. Number one, to maintain the patient stable. This is part that could be I.V.'s, blood she needs, et cetera.

Number two, respiratory management. Part of the support means she has been intubated, needs to be on the vent, needs to be controlled on that.

Three, urine, follow catheter, she is urinating the right amount. Kidneys in trauma sometimes shut down. To see she continues to progress to gain consciousness or remains unconscious.

All these patients they could have injury, could be paralyzed like Mrs. spreadbury was. Sometimes they have an injury to the spinal cord. They have an injury in evolution of the brachial plexus, they are moving the right arm, left is weak, has pain. Many things we can't know until the patient is awake, wiggling toes, flexing knees, flexing arms, moving to command. She couldn't move to commands, she was still out.

Q. I'm going to finish out this in a second. I want to go back to your first page, I see something I want to ask you I don't see in your notes, I want to ask you.

You are indicating a blood pressure of 163 over 90 in your consult report; do you see that?

A. Yes.

Q. second paragraph?

A. 163 over 90, respirations 90 on vent.

Q. Did that seem to be an elevated blood pressure at that time?

A. she was getting vasopressors.

Q. That would account for it?

A. what we do with the patient in the field, that is why the big discrepancy between the EMS report and the arrival to the hospital, at the scene Mrs. Spreadbury's blood pressure when she was still being extricated from the car has a systolic pressure of 60. That we had to assume she has to be completely unconscious with 60, even with brain ischemia. At the scene was 60. First blood pressure was 90, then dropped to 60.

MR. TABER: Doctor, if you need to take a page.

THE WITNESS: No, I don't need to, let them wait.

A. she arrived to the hospital, the blood pressure is 133 over 86. what happened is not that she is better. What happened, she has been, quotation, resuscitated, close quotation. Means that the paramedics, the emergency physician and nurses give this patient a large amount of normal saline. No dextrose water, normal saline. with normal saline most of the time we get very

good response in the patient, that is why the new blood pressure was 163 over 90, because she has been resuscitated, has vasopressors, the I.V. I assume, things like that. I wouldn't say for a normal patient, for a normal individual it is hypertensive systolic, 163. 90 is borderline normal. For this patient, it's to be preferred to have a high pressure, not only the brain and spinal cord, the kidneys and liver.

MISS KOLIS: Hang on one second.

(Discussion had off the record.)

BY MISS KOLIS:

Q. while they are looking at that timed run report, Doctor, where did you get the blood pressure number of 163 over 90 that you dictated into your report?

A. I don't know. probably from the nurses at bedside clinical record.

Q. The clinical record I have, can you point out to me where you got that one from, this is on the ED nursing process form?

A. Must be on the ICU maybe.

Q. At 12:15 the pressure is 163 over 121 --

MR. TABER: Show us what you are talking about.

Q. I'm just curious if at that time you were referring to the bottom number is wrong or this is a second pressure that happens to be 163 over 90 that I didn't see somewhere before.

A. Did I say 163 over 90?

Q. Right.

A. Let me look for the -- we need ICU.

MR. TABER: ICU nurses' notes.

A. I don't know where I got it.

Q. what would a pressure of 163 over 121 indicate to you, if anything, about the person's condition?

MR. TABER: 163 over what?

MISS KOLIS: 121.

A. This is what we call shortening between systolic and diastolic.

Q. Right.

A. That -- well, the diastolic would be very elevated you know. I don't think -- I think 121 could be the wrong transcription. The 121 on diastolic, how was it immediately before, normal, right? How can it go from normal diastolic to 121 diastolic, I think maybe a 121 in the note, 121 for the copy, I don't see -- I didn't see in the last few years anyone's diastolic of 121.

Q. If someone did have a diastolic of 121, what would it indicate physiologically was going on in the body?

MR. TABER: Can we see that again so we're sure?

MISS KOLIS: Sure.

A. 121, you know the pulse is 90. I don't think I have any opinion about this 121 because I think it's wrong. The pulse is 90, the pulse is not even grossly tachycardic. Before the 100, 87 and 9:02 blood pressure of 125 over 82, 10 minutes before, 163 over 121, I think it's probably a mistake. Maybe it's not a mistake.

Q. what would lead you to believe that is a mistake?

A. Because 10 minutes before is normal. with hemodynamic factors that are going to cause such a change in blood pressure, we expect to have some changes in pulse. Before the pulse was 87, then is 90.

Q. Right.

A. But anyway, if that was the blood pressure, abnormal diastolic, very elevated.

Q. what would you consider an abnormally elevated diastolic pressure?

MR. TABKER: For the record I'm going to object. First of all, he wasn't the one that took the reading, we're not sure he was there at that time. It's someone else's note and speculative as to what you are asking him. If you can answer that.

A. No, have no opinion.

Q. Let me ask you this question, Doctor: Do you take blood pressures on these patients?

A. No.

Q. You rely upon the blood pressures that are recorded in the chart by the nursing staff?

A. Most of the time.

Q. As a neurologist --

A. I'm sorry.

Q. I'm sorry, I take that back. As a neurosurgeon variations in blood pressure can tell you something about the patient's condition neurologically?

A. when we are dealing with the brain, head, yes.

Q. In that context, assuming that you were there since you testified earlier today that you believe that you were there at 11:26, this pressure that I've shown you was recorded.

A. I know I was there because it's my record.

Q. You testified that you knew you were there at 11:26, this occurred at 12:15, what could be causing that elevation in diastolic pressure at that time?

A. They didn't called me, I don't want to answer the question. That's it, I was not the final -- the blood pressure, I don't know the other factors. You have not only the blood pressure, you need to examine the patient. I'm the neurosurgeon, I don't want to make any

assumptions.

Q. what you are indicating is no one called you to advise you of this blood pressure and ask your opinion about what it might mean?

A. They are supposed *to* call me, I'm the neurosurgeon, I'm on call, for the benefit of the jury, I've been called there for head injury in the patient with trauma, I examined the patient, the general management of the patient is for the general surgeon. Why I'm going to make an assumption that can be erroneous because I'm the neurosurgeon about the blood pressure, when this is not my primary role. My primary role is to take care of the patient from the neurological standpoint,

Q. Did you talk with Dr. Menia in the emergency department?

A. I don't recall. I know Dr. Menia but I don't know if I talked to him or not, I had to assume this is an assumption that I had talked to him because I came to the hospital to the emergency room, I went to the ICU, he has to be around. I don't recall.

Q. So the information sharing that you were doing was primarily with Dr. Telesz, is that what I'm understanding you?

A. The emergency room would call me in this case or

in other cases following the request by the attending physician, in this case Dr. Telesz, many, many times we exchange information. Most every time the secretary may call me, said the emergency room or emergency department physician wants to talk to you. Dr. Menia may call me, may talk to me. I don't have any recollection.

Q. YOU don't have a recollection of speaking with Mr. Menia?

A. No. Maybe he did, I don't remember.

Q. Back to where we were. After you fully agreed with Dr. Telesz' order to support the patient, you then have in your consultation note a recitation of the laboratory data, if you could look at that part of your report.

A. Yes.

Q. Patient's CK is elevated to 344; do you see that?

A. Yes.

Q. Did you from a neurological standpoint have any concern about an elevated CK?

A. Not neurological. Most of the time soft tissue injury it indicates, especially muscle injury.

Q. In and around the heart?

A. They can make differential diagnosis by checking different segments, you know. could be any muscle. Now they distinguish, they can distinguish now very well if

it's heart muscle or other muscle, I don't know the details, the different proteins that are the components of the muscles. The proteins in the heart has some peculiar chemical characteristics that indicate from the peripheral muscles, the biceps or the quadriceps.

If you are in a crash or building collapse injury, the femur is broken, the muscles on the femur are going to be contused, they increase CK. Also as you mentioned, the same patient has also a contusion on the heart, he's going to have a chemical elevation. They can be a difference in the lab between one and the other. CK was elevated.

Q. Did that concern you enough you would have discussed that with Dr. Telesz?

A. No, I don't think so because he knew already anyway, he was there, it was elevated.

Q. close to the end of that paragraph you are going through the white blood count 24,000, red count 3.18, hemoglobin, 97 gram percent, hematocrit, 27.9 percent.

A. Yes.

Q. Then you indicate this will need to be observed because further doppler in red cells and hematocrit are to be expected. Is the word doppler incorrect in the transcription?

A. I didn't correct it, it was wrong.

Q. what word would you or did you want to use?

A. Drop.

Q. That's what I thought it was.

Why were you expecting a further drop in red cells and hematocrit?

A. I say could be, could be expected. I don't know they are able to, we should watch. If continues dropping we have to be on the alert for something, could be internal bleeding.

Q. From the neurological standpoint were you wanting this to be watched, the drops in the numbers?

A. From a general surgical standpoint.

Q. Were you making general surgical observations in this portion?

A. Regarding the support of the patient, hemoglobin continues dropping we know there is internal bleeding, could be liver, could be heart in this patient, could be kidneys, usually the liver or spleen, or maybe a big fracture in a big limb. That was not the case here. she didn't have a fracture in the femur. we have a patient with a fracture of the femur, they may have lost two or three pints of blood in the thigh very easily.

Q. In any event, let me go back so I'm not confused, we corrected the word drop, I read you said red cells and hematocrit are to be expected; were you expecting

drops in the red cells and hematocrit?
A. I don't know why it's to be expected there, I couldn't say. The paragraph should say this is well noted to observe because further drops in red cells and hematocrit has to be watched. Has to be watched for the drop.
Q. From your point of view as the neurosurgeon who had been called in on this case?
A. Yes.
Q. There was a possibility at this time there was an internal blood loss that had not yet been detected; am I phrasing that correctly?
A. Yes, you phrase correctly. This patient like any other patient in the situation could be having internal blood loss undetected, most common is subcapsular splenic hematoma. The spleen tears, starts leaking for several hours, the blood is under the capsule of the spleen, the spleen gets distended, this is why we watch in all these patients, she could have that.
Q. Can you palpate a spleen?
A. In this patient the abdomen was soft.
Q. There wasn't increase in size of the spleen?
A. I don't mean she has a lesion on the spleen. I say in general in these patients we have to watch, the most common cause of bleeding is the spleen.

Q. By the time that you finished your dictation had you excluded she was having bleeding from her spleen, her kidneys?

MR. TABER: I'll object to the point he's a doctor examining the patient, I think you are really getting into general surgical questions to him. He's not going to ignore something.

Q. Obviously, Doctor, you took enough time with this patient to examine the patient?

A. Yes, ma'am.

Q. To include in your consult report some observations about these lowered hematocrit numbers; am I stating that fairly?

A. Yes. Also in making diagnosis number four I point with arrows, anemia likely secondary to blood loss, this is to be followed.

Q. That was the next question I was going to ask you. Did you have an opinion as to if there was a bleed?

A. At the time?

Q. um-hum.

A. Has to be followed, it's not black and white, may need four, five, six more hours in every patient, this woman too.

Q. You communicated that to Dr. Telesz?

A. I told you I talked to him personally, not on the phone, I talked to him personally. I think I saw him two or three times on that day in CU, I believe in x-ray, I'm not sure.

Q. Is it your testimony, so I don't have to beat a dead horse, that every admitting diagnosis which you list, one, two, three and four, you would have specifically discussed with Dr. Telesz?

A. Yes. Number one verbally and number two because he is supposed to read the transcription. He is supposed to know.

Q. can we both agree he couldn't have read a transcription on that day?

A. I talked to him. There is no question my recollection is very good about talking to him. I'm a little more confused if I talked to Kralik or Tawil.

Q. You're 100 percent certain that you discussed all these things with Dr. Telesz, the secondary issue you're not certain -- let me back that up.

If you talked with Dr. Tawil or Dr. Kralik, which of the four admitting diagnoses that you recorded would you have discussed with them because they were cardiothoracic surgeons?

A. I recall that I discussed with a thoracic surgeon, I don't recall it was Tawil or Telesz, about the free

air in the mediastinum. A cardiothoracic surgeon told me we are going to do a bronchoscopy. It's the group of three who does the bronchoscopy, I don't know.

Then I am pretty sure, 100 percent sure I mentioned the free air in the mediastinum, I don't recall exactly, I think I was talking to Kralik, maybe was Tawil. with Telesz personally I recall very well. I talked to him two or three times about this patient the same day.

Q. would you have discussed with whichever cardiothoracic surgeon who was there your concern that there was -- and Menia perhaps -- secondary to the blood loss that needed to be followed?

MR. TABER: So we're clear, you kind of can be interpretted two ways. You are asking him one, if he remembers a specific conversation with a specific person about a specific finding. secondly, because I think he's answering your question, whether he spoke with these people at all. I know your question was pretty good, if you could make it clearer I appreciate it.

Q. Let me concede for the purposes of the question I accept that you are testify that you spoke with someone in the cardiothoracic group, we don't know which one?

A. Yes.

Q. when I asked you what you would have communicated to them out of the admitting diagnosis, you are certain you would have communicated your concern there might be free air in the mediastinum?

A. um-hum.

Q. Right?

A. Yes.

Q. Do you believe that you would have also discussed or did you also discuss the fact that you felt that the blood loss should be followed, the falling hematocrit should be followed with the cardiothoracic surgeon?

A. Probably I told them in a general way, yes. I know very well I mentioned about the free air. probably I mentioned the anemia too.

Q. Is it possible that with a mediastinal injury would you have been aware at that time -- let me reask the question.

would you have been aware that an injury, mediastinal injury could be accounting for the blood loss that shows up in the hematocrit?

A. we're not aware of any mediastinal injury at that time. The injury she had in retrospect, we know she had, I wasn't aware at the time.

Q. I didn't ask that question very well. I wasn't asking if you were aware of the precise injury.

In your list of things that could possibly be causing a drop in hematocrit due to blood loss in light of the chest injury she sustained and the mediastinal free air that you believed you saw, did you consider a possible explanation for the blood loss was a mediastinal injury?

A. A very remote consideration because they are rare, should be kept in mind.

Q. Let's go back to the notes you took. We left those a while go, the notes you took, these. We were going back through notes that you had taken out of the chart.

By the way, before I do that, there are no other notes from you that evening in the chart; would you agree with that?

A. There is no --

Q. The evening of the 23rd?

A. The chart is available to you, These were the records from the hospital.

Q. were you for any reason contacted by any physicians or nurses from the time you left the hospital on the 23rd but before 6:00 or 7:00 a.m. on the 24th regarding this patient?

A. I don't think so.

Q. If you had received a telephone contact regarding

this patient, would that be reflected in your office chart or some place else?

A. No, it would be reflected on the medical records, this.

Q. Those medical records you would have come whatever time you came into the hospital later, you would have reflected that you were contacted?

A. Yes. Not in my office. My office is a skeleton chart. If I came here for any reason, it should be recorded on the chart.

Q. Going back to the notes that you took, in the center section closer to the top where we last left off reading, you went through the EMS run report?

A. Yes.

Q. You made note of the BP being 90; is that right?

A. Yes. Then the patient was diaphoretic, that means perspiration profusely, cyanotic, means lack of oxygen, the blood pressure dropped to 60. The pulse was very fast, 130. At the scene the paramedics noticed subcutaneous emphyzema on the left side of the chest, abdomen was soft. The blood pressure was 90 at 10:42.

At 11:13, almost 30 minutes later they are still on the scene, the blood pressure is 60 according to my notes as you have there.

Q. Those you took off the EMS report contained in the

hospital chart?

A. Yes.

Q. Right next to it you have the HG 9, you see that?

A. Hemoglobin was 9. The white count was 22,000.

Q. Is this information you reviewed for yourself at the time you examined her on the 23rd?

A. This paper is what I did last night, reviewing the chart.

Q. I understand that. what I'm saying is the information you read to me, that information was available to you in the emergency department?

A. Yes.

Q. where you first saw her, correct?

A. Yes.

Q. The little notes underneath says C spine and pelvis?

A. It means normal.

Q. per?

A. Per radiologist.

Q. That is the word chest, you crossed that out under C spine?

A. C spine and pelvis.

Q. C spine and pelvis.

A. chest was in the following line. when I was writing the C spine, chest, pelvis normal, I realized

the chest was abnormal, I crossed chest out, immediately underneath I wrote chest right pneumothorax, rib fractures several. That is why I crossed chest out there, it was not normal.

Q. chest tube placement?

A. Yes.

Q. That is because chest tubes had been placed prior to the time you arrived or after you arrived?

A. I don't know, I have to review. Two chest tubes inserted were properly draining. They were inserted before I arrived.

Q. I think you mentioned some time much earlier that those tubes were draining very little blood?

A. zero blood, yes.

Q. Then next review CT head okay?

A. Yes.

Q. That's your assessment or is that the assessment of what the radiologist said on the scan?

A. That is my assessment. I believe I write per radiologist CT of head okay. CT of chest no air, pneumothorax,' PND done, pneumothorax. CT of chest PN.

Q. I see that.

A. Pneumothorax, mediastinal air.

Q. In this particular one you didn't write per radiology, Someone is going to ask you, did you look at

the chest CT?

A. I probably looked at it, I probably looked at the CT, probably.

MR. TABER: When are you talking about? she asked you that earlier about the chest.

A. I don't believe I looked. Maybe on the screen when I went. Most of the time we have to go to radiology to collect the films. If we don't go to radiology, the films don't come to us.

Q. Let me go back, you are now saying you probably looked at the chest CT on the 23rd?

A. I'm not trying to avoid answering your question, I don't remember. I want you to believe me, I don't remember. I assume we have all the films there. Out of curiosity I may look at that.

Q. Let me ask a different question. Based on your training, experience as a neurosurgeon, the function you perform at this hospital, being called in in emergency trauma situations and running your own practice, are you capable of reading and interpreting chest CT's?

A. No. Chest CT's are supposed to be read by the radiologist, by thoracic surgeons. I don't know even by the general surgeons, probably not.

Q. If you aren't capable of reading them, I know this is going to sound crazy, why would you look at them?

A. Why would I look at them?

MR. TABER: He didn't say he looked at them. Are you asking him to speculate?

MISS KOLIS: He is saying he probably did, unless I misstated that testimony.

MR. TREADON: He also said out of curiosity he may have looked at them. You are going on assuming in your questions he did look at them.

A. To clarify, it's not my obligation to read any chest x-ray. It's not my obligation to interpret any chest x-ray. It's not my obligation to read CT of the chest, not my responsibility to interpret any CT of the chest. Not here, not in Connecticut, not in Washington, D.C. not in Arkansas. I say Arkansas because Clinton is from Arkansas.

Q. Mr. Emershaw wanted to know if that includes Spain?

A. Includes Spain.

MR. TREADON: Includes canton.

Q. So that there is no mistake about the question that I was asking you, Doctor --

A. I don't know if I looked at the CT of the chest. Can I tell you for sure I didn't read, because I'm not qualified to read that, it's complicated. If in the realm of the central nervous system I think I can read.

Q. You said you can read head CT's, you feel you do that better than the radiologists?

A. Yes.

Q. You have intubated by Menia?

A. Yes, that is the emergency room physician. on the right I put some of the products, one of them he used, the Norcuron 9 milligrams I.V.,that produced sedation and paralysis. Then I wrote under that Telesz in, Sos in, Tawil in. That means they are all there, chronological appearance by the physicians in the emergency room in the hospital, I will say in the hospital to see this patient. The first was Telesz -- the first was Menia, then Telesz, then Sos and Tawil.

Q. underneath of that you then have some dates, you see them?

A. Yes.

Q. Can you read what notes you wrote down for me?

A. I say 9-23-1997 consult Sos, I had a blood pressure here that we discussed before, 163 over 90. The pulse is 90. 3:2, underneath RL means right pupil is 3 millimeters, left pupil was 2 millimeters.

Then 9-25, 11:26 -- no excuse me. 9-23, 9-25. 9-25 and 9-27 are dates that I stopped by to see the patient. Consult Sos and 11:26 is the time that I believe I was there. Then in parenthesis 16:25 D

means dictation, is the time I dictated. Then at the extreme right is 10-30-97 because they called me on consult a second time, I make a drawing on the chart with a level of injury and I say TH5 level, was the level of transection of the spinal cord, was thoracic fifth. I have a drawing on the chart on the progress notes, then consultation at this time I wrote by hand.

Q. underneath the dates you put 9-23, 9-25, 9-27, those are three times you saw the patient, correct?

A. Yes.

Q. underneath that can you tell me what you have written?

A. I say -- on the left?

Q. OR?

A. Operating room, 9-24-97. After drop in blood pressure I underlined she got angiogram, surgery, repair of transected aorta, coded. she arrested I think two or three times in the operating room. She was given Depo-Medrol, that probably as you know is a cortical steroid used to prevent decrease in the degree of injury to the spinal cord.

Q. when you are making the note of Depo-Medrol are you referring to the initiation of that therapy subsequent to surgery, or are you indicating that was used during surgery?

A. I don't recall when they did it. I think they did it, I think I may be wrong, I think they started surgery. Still it can be started really up to 9 or 10 hours after the injury. Still statistically is significant.

Q. As you were reading, you said that you had underlined after drop in BP, why did you underline it?

A. The OR 9-24-97?

Q. Right.

A. After there is OR, drop in BP, I underline with two.

Q. I know that. I'm asking if there is a reason you specifically underlined "after drop in BP"?

A. she dropped her blood pressure, she became shocky I assume. Drop pressure, blood pressure drop, she will be shocky, drop in blood pressure, they did angiogram, that is when they found a tear in the aorta.

Q. . 9-25 says I think Dr. Rosenberg?

A. Correct.

Q. Neurology. Right under says what?

A. Fladen, F-l-a-d-e-n. Dr. Fladen is an ophthalmologist.

Q. Let's talk about 9-25 for a minute. You were in to see the patient on 9-25 according to your notes and chart notes and everything else I guess?

A. I think I saw her twice on 9-25, I may be wrong. 9-25 two notes, one at the top of the page, the other on the bottom, I saw her in the morning, I don't know the time, I didn't write the time. I saw her again the same day, Dr. Telesz, two other doctors saw her after me. 9-25 one I can't read the handwriting, very short note. Then Dr. Telesz with a fine line, six line note. Then the five line. 9-25, 7:45 I saw the patient again.

Q. That is what I want to talk to you about. Dr. Rosenberg is a neurologist you indicate; is that correct?

A. Yes.

Q. Did you ask Rosenberg to see the patient?

A. No, I don't think so. probably was Dr. Telesz.

Q. At the time that Dr. Rosenberg came in to do his consultation, his consult note indicates that you were -- it says the patient was seen along with Dr. Sos at bedside?

A. I was in the room. I walked in the room when he was there. I was in the room when he walked in, I don't remember. We shared the room for a few minutes.

Q. You were both in the room with the patient for a few minutes is what you are telling me?

A. Yes. I guess I left to let him examine the patient. we do that, if somebody arrives I leave while

the other examines.

Q. Did you on that day or any day subsequent to the 25th have a conversation with Dr. Rosenberg about the cause of Mrs. Spreadbury's paraplegia?

A. I assume probably did. For him or for me, was obvious.

Q. what was the obvious cause of her paraplegia?

A. Obvious cause of paraplegia was an injury to the aorta, descending aorta. From the aorta they come very small branches that they again became smaller to the spinal cord. To the neurosurgeon and neurologist this is a well known catastrophy.

Q. Let me ask the question a different way.

On the second page of Dr. Rosenberg's consult report -- you've had an opportunity to read that I gather?

A. Let me read it.

MR. TABER: I'm sorry.

MISS KOLIS: second page, Dr. Rosenberg's consult note, September 25, 1997.

A. He had one written, dictated.

Q. I'm looking at the dictated one which is easier to read, you don't have to interpret his handwriting.

A. That is right.

Q. under his impression it says the patient most

likely has cord ischemia secondary to aortic transection; do you see that?

A. Yes.

Q. Is that what you are trying to explain to me in your answer, Mrs. spreadbury had a cord ischemia from the transection of her aorta?

A. Yes.

Q. MR■ was performed to exclude there had been a separate spinal cord trauma; would you agree with that?

A. what?

Q. Goes on to says I have recommended a head CT as well as MR■. I'm abbreviating, he has spelled that out, MRI of the entire spinal axis in order to rule out spinal cord injury as the contemplated problem; you see that?

A. I follow you.

Q. what you are saying is when I asked what was perfectly obvious, it was perfectly obvious she became paraplegic because of cord ischemia because of an aortic transection; am I stating that simply enough?

A. Yes, at least to me that is what I believe, it's obvious.

Q. You did not see Mrs. spreadbury on the 24th, did you? Maybe I missed that. Did you see Mrs. Spreadbury on the 24th?

A. I will need to look at my -- could I have the records?

Q. sure, this?

A. Yes. I saw her on 9-24, 9-25, 9-26, 9-27, 9-28. 9-28 I'm off the case. The fact I don't have the note doesn't mean I didn't see her.

Q. Did you write a progress note on the 24th?

A. No, not always we write a progress note.

Q. I didn't see one. I was thinking perhaps I missed it.

A. No, this is why I asked for the red card. when I see the patient I put it on the red card.

Q. You did see her on the 24th?

A. Yes.

Q. Do you have a specific recollection of the circumstances under which you saw her on the 24th?

A. No, I don't recall.

Q. Do you know if she was already out of surgery when you saw her?

A. I don't remember.

Q. You have no memory of the 24th?

A. You know it's 18 months.

Q. I know, a couple years.

A. I don't remember it.

Q. You wouldn't remember it. I probably don't

remember what I was doing 18 months ago.

MR. TREADON: How about 18 days ago?

MISS KOLIS: It's probably on my office calendar what I was doing 18 days ago.

Q. Your pink card, you keep this, your practice or procedure is to record each and every date of a visit?

A. Every time I walk in the patient's room I write in the date.

Q. Because you carry around your own folder?

A. Right.

Q. You may put a note in the chart?

A. I have the card with me in the pocket.

Q. Pink pocket cards?

A. It's faster. we all do, we keep cards with patient's name.

Q. You came in, examined her on the 25th?

A. Yes.

Q. Your note says, I think I can read it, the top says the patient is paraplegic, correct?

A. Yes.

Q. At that point you don't determine at what level the ischemia occurred?

A. Let me see. I think I put a note there, I don't recall where. I say patient is paraplegic, no sensation

from L-1 down. Level questionable because of patient's poor level of consciousness. This is the same date Rosenberg saw her in consult.

on the 25th, the very first time I saw her there was no -- was not moving the legs, she didn't have sensation. we didn't determine yet the level. The level could be L-1.

Q. You couldn't be certain because the patient had just been through surgery, she was not awake enough?

A. she wasn't awake enough yet.

Q. Your later note on that day seems like you came back and saw her, I'm getting -- first of all I'm guessing you saw her in the morning, your later note is in the evening, 7:45, does that say discussed with Dr. Kralik?

A. Yes, because Dr. Kralik -- I tried to recall, I may be wrong, Dr. Kralik or Telesz, somebody thought let's do another CT scan. Dr. Rosenberg wanted a CT of the head, then a CT of the head was done.

For peace of mind I wrote my opinion the CT today, means on 9-25, small amount of blood left occipital with mass effect. compatible with hemorrhagic contusion, so far of no clinical or surgical significance.

Then they did the CT scan at the request

of Dr. Rosenberg, they asked me to see the scan or maybe I went on my own. Really nothing justifies the situation.

Q. It was confirmatory of what your initial impression had been essentially on September 23rd?

A. Yes, that the head was clear.

Q. Doctor, did you and Dr. Kralik discuss on the 24th or 25th as to whether or not there had been a misread of the chest CAT scan?

MR. OCKERMAN: objection.

MR. TREADON: objection.

A. I only know as I asked him what was going on with the patient, he told me we operated, he told me the 25th or 26th she's paraplegic. He told me he told the husband before surgery that the patient could be paraplegic. I remember that not like it was yesterday, I remember fair. The CT scan of the chest I didn't discuss with him.

Q. At any time before this lawsuit was filed naming you as a party, did anyone express an opinion to you that the chest CAT scan on the 23rd had been misread?

A. well --

MR. OCKERMAN: objection.

A. You may not believe, nobody told me anything. Nothing whatsoever.

Q. Back on your --
A. why are they going to discuss the CT with me of the chest?
Q. wouldn't it have been a natural question for you, you examined the woman neurologically on the 23rd?
A. Yes. The natural theory is to know a transection of the aorta, is paraplegic, you know. The details of the CT scan was misread, they wouldn't tell me if misread, they wouldn't like for me to know. They wouldn't like for me to know they misread. They don't discuss with me what is misread. I know there are some questions after I review the records, so on, they didn't discuss with me was misread, no.
Q. YOU took some notes underneath the 9-25 notes, I think PEG evaluation?
A. No. This is PEG tube. Tube they put through the nasopharynx into the esophagus to the stomach, they make a hole, PEG tube, P-E-G.
Q. That is what I said.
A. Tube for feeding.
Q. were you involved in this situation?
A. No. I say PEG endoscope on 10-8-1997 by gastroenterologist. It did not occur to me on 10-9-97. I think it was by Kralik. Endoscope 10-8-97, and gastroenterotomy 10-9-97, Tawil. Tawil did it.

Q. The last section a word, the R, with before the word?

A. Rockenstein.

Q. who is that?

A. Radiologist.

Q. Can you tell me 9-23, can you tell me --

A. 9-23 read superior mediastinal hemorrhage. Must be the report of an x-ray from 9-23. Must be a report of the x-ray procedure, whatever it is that was read by Dr. Rockenstein.

Then 9-23 underneath CT I think said chest. CT chest no extravasation of contrast. Again 9-23 arteriogram, parenthesis transection.

9-25, CT head, probably the name of Rockenstein is there because maybe the 9-23 reads superior mediastinal hemorrhage was read by him. The other I assume may or may not have been read by him, maybe we can see the x-rays.

Q. once again that was sort of your summarization of things contained in the x-ray reports, not the readings that you made on those films?

A. Yes. Report very likely read by Rockenstein.

Q. Doctor, are you on the quality assurance committee of the hospital?

A. Yes, surgical.

Q. In the surgical?
A. Yes. Meeting every Wednesday at 5:15.
Q. You were -- I don't see it on your pink card, or maybe I do see it on your pink card, you did another consult?
A. On 10-30.
Q. Right, on 10-30-97?
A. Second card.
Q. You switched cards every month?
A. No, because I signed off the patient.
Q. You originally signed off the patient on 9-28-97, you were called back in on consult?
A. They called me back, yes.
Q. This time I didn't see a typed report, I saw a written report.
A. It's a written record, correct.
Q. I will apologize for the fact I cannot read this handwriting, unfortunately have to --
A. Don't apologize, it's my fault. I read it for you.
Q. what was the purpose of this consult?
A. The purpose was that they did CT of the head in this patient, the radiologist, I don't know which one, we can find in the records, read that the patient may have quotation, subdural hygroma, h-y-g-r-o-m-a, then

they called me.

Q. Now can you tell us?

A. I saw the patient 10-30-1997. I say chart was reviewed. I will read back I said later CT of brain indicated, quotation, possible subdural hygroma. Patient's chief complaint, cc, chief complaint, diplopia, homomymous gaze, sees double when she looks to the right. Right pupil larger than the left, paretic, p-a-r-e-t-i-cfrom the date of original injury 9-23-97. High brain function satisfactory. understands and follows commands well, full range of motion on the upper limbs. Paraplegia --

---

(Interruption in proceedings.)

BY MISS KOLIS:

Q. we got through the line --

A. we were in my consult, second consult.

Q. Right.

A. we are on the reading in my consultation from the second time I saw the patient on October 30, 1997, it says paraplegia at level T-5, thoracic five. There is an area of profound analgia from T-5 to L-2 or 3 on the left, T-5 to L-1 on the right. Patient feels suppositories when inserted in the rectum. Is not aware

of need to move bowels or urinate, has Foley catheter. Able to detect pinprick on distal lower limb areas. Most of the time is wrong regarding toe position. what happened is there is sensation or pinprick of the toes for the different pathway, for the position of the toes and vibration, this is the way I differentiate. Moderate brain atrophy post injury as well as somewhat age related with increase on subarachnoid space. The patient had CT supine. I explain this is hard to read when the patient is supine. The brain is down, the frontal area gets more space, there is no mass effect, in capital letters. Convolutions are not deformed, believe there are no subdural hygromas. No neurological plans, thank you.

what happened, they called me because the radiologist read subdural hygroma. The space may be a little bit increased because of the patient's age, maybe the blood to the head has something to do with it, I doubt it, and I thought the CT didn't reflect any changes we had to be concerned about, the CT of the head. she already established paraplegia, she is alert, awake, she can tell me what she feels and what she doesn't at the level of T-5.

Q. The question that I have for you, I appreciate you very much reading the consult note into the record,

between the first exam that I mentioned of the head CT and then this one, has there been a change in CT findings or not in your opinion?

A. Practically no change.

Q. what did you think was accounting for her blurred or blurred is wrong, double vision to the right?

A. You were right when you said blurred.

Q. It was really blurred, not double vision?

A. No, the patients describe double vision as blurred because they see the object like that. They say I see blur. when it is diplopia, the double picture is very close, only a touch off, the patient sees blur. when the diplopia is at its best the patient sees double. When the images are almost fused completely they say blurred. when the images are well separated they say double.

I think the post-traumatic, one of the reasons could be because the pupils are still different sizes. Anyone that knows a little bit of photography knows you open the diaphragm too much, the profundity, the deeper depth of the field is different. with one she can pinpoint, contract, focus well. when the eye is larger, this image is projected different, then she could have blurred vision, she could have diplopia. The reason for double vision likely was trauma to the right

pupil,

Q. Are you talking about the original trauma from the collision, not post trauma from the surgery?

A. No, no, trauma from the collision.

Q. I want to be sure, there was a suggestion that there was some increased intracranial pressure?

A. somebody, yes. There is no increase of pressure. This is why I said the convolutions are not deformed. It means the convolutions came like that.

Q. It isn't flattened convolutions?

A. NO.

Q. That mitigates against an increased intracranial pressure, what you just said?

A. Yes. I think the CT scan was normal, CT scan they were concerned because maybe she has subdural hygroma .

Q. In this particular instance you ended up being called in on consult regarding a CT, finding that suggestion -- I can't pronounce the word, hygroma?

A. subdural hygroma.

Q. You ended up disagreeing with the read of the CAT scan?

A. Yes.

Q. That's why subspecialists read CAT scans after the radiologist interprets them?

A. NO, the CAT scan really should be read by the

neuroradiologist. we have one here.

Q. who is -- I'm sorry?

A. Dr. McNulty. He didn't read it, they called me. I don't think he read subdural hygroma .

Q. Going back to the question I was asking about whether you are on the quality assurance committee, you said you are on the surgery quality assurance committee?

A. Yes.

Q. If I understood, I might not have understood it correctly --

A. wait a minute. I told you surgical, yes, surgical quality assurance.

Q. At this facility in 1997 were you on the quality assurance committee?

MR. TABER: Hold on, objection. we're coming real close to what is privileged under Ohio law. It's quite clear from statute, I don't want to nip you off in the bud, if you are getting anywhere into the substance of any quality assurance or anything like that, I have no idea if that took place in this case, if it did, it would be completely off limits. He would not be permitted to answer any questions along that line.

MISS KOLIS: I promise you I will not blurt out a question, try to draw out an answer. Let me establish if there was one, then I'll give on the

record what my position is.

MR. TABER: The position is statutory, it's not mine, it's the law of Ohio.

MISS KOLIS: I'm not going to ask about peer review.

MR. TABER: You know the statute was broadened with tort reform.

Q. In 1997 were you on the quality assurance committee for the department of surgery?

A. I think so.

Q. The way you explained it to me, the chief of surgery, that encompasses all surgical subspecialties, neurosurgery, cardiothoracic surgery?

A. Yes, going back to when we were in the other room, there are no independent surgical departments. The chief of surgery is the chief of surgery. In a department as powerful in the hospital as orthopedics there is no department of orthopedics. There is a very powerful orthopedic group, they are integrated in the department of general surgery. They don't have a chairman of the department. There is no department of neurosurgery, there is no department of so and so.

Q. Did that QA committee perform morbidity/mortality reviews on a monthly basis?

MR. TABER: You don't need to

answer. You know that is off limits, you can ask any question, have her certify it, he'll not be answering.

MISS KOLIS: For the record, so Mr. Taber and I don't have to fight with each other, we will state our respective positions.

My interpretation of current Ohio law is that clearly I cannot obtain information regarding a specific peer review. It's likewise my interpretation, however incorrect it might ultimately be determined, that I am able to ask in any particular situation whether a particular case was included in a morbidity and mortality review and if a report was made of the same.

Mr. Taber has respectfully disagreed with that, has instructed his client not to answer the questions. I do not want to keep us here and try to get a judge on the phone. I'm perfectly willing to certify that particular question to the court for resolution at a later time.

I need to talk with Mr. Emershaw in the hallway.

(Recess had.)

MISS KOLIS: I'm going to try to

make this one more question.

BY MISS KOLIS:

Q. Since September of 1997, at the time that Mrs. spreadbury was admitted, were there written guidelines as to how a consultant was to report the findings of the consultation?

A. I think we understand that we talk to the person who calls us. we talk to them. That has been for many years, then the consult is written, or there is information on the chart.

Q. That is pretty much --

A. we don't need to go behind the consultant chasing him. They call me to the hospital, I do my consult, I write, dictate, I write my order. If I see him I talk to him, if I don't see him, I don't have to talk to him but I talked to Telesz.

Q. My question is were you aware or were there in existence on September 23, 1997 if you know, a policy, procedure or protocol that was in writing that outlined how you were to communicate the information?

A. I'm not aware. 'we communicated. we did communicate. we have to amplify the answer. we see the patient in consult, we had to answer the consult promptly, especially in emergency, we had to write a note or dictate.

Q. You are unaware whether this was spelled out in written form?

A. I'm not aware just now this minute. I don't know if this is spelled out in the rules or regulations of the hospital. I don't know, maybe it's written down, I don't know.

Q. The chart indicated that you did talk with Dr. Kralik on the 25th, remember we went through that little note?

A. Yes.

Q. Do you have a recollection of Dr. Kralik discussing with you or inquiring as to whether or not you as a neurosurgeon had an opinion as to at what point in time during the course of this patient's care she became paraplegic?

A. I know he told me she was paraplegic, I asked him what he thought he told the family. He thought he told the family she could be paraplegic. when reviewing the chart I saw the note before surgery risk of paraplegia discussed with husband. Your question was if he asked?

Q. Did he ask you if you had an opinion since you are a neurosurgeon who deals with paraplegics?

A. I certainly -- I don't know if he asked me. Probably we talked because this is a transection of the aorta, ischemia to the cord, there is no other thing.

He will ask me, I will tell them that. He did ask me, probably I told him that. He knew too.

Q. with a transection of the aorta you do not always get the result of cord ischemia that results in paraplegia; would you agree with that statement?

A. Transection of the aorta even in cases with paraplegia, sometimes they evolve over several hours. It depends where is the transection, it depends whether there are clots or other causes.

It's not usual to have a transection, immediately paraplegic, or it develops for six hours or three days. It's a fact. We know because of the vascular supply, there is only one artery going to the spinal cord from the T-11 down on the left side. Always on the left side. There is no other supply to the cord. Sometimes patients, I have here in this hospital patients like that when they have a cardiorespiratory arrest, we resuscitated the patient, they are hypotensive, they wake up, they are paraplegic. There are critical arteries, she had arteries on the spinal cord that supplied the cord. The other supply there is no man's land in the middle. That is where a patient gets ischemic paraplegia.

MISS **KOLIS:** I don't have any further questions.

MR. TREADON: Nothing.

MR. TABER: we will read. waive the seven days?

MISS KOLIS: Absolutely, with the usual promise you will read it in 30 days.

MR. TABER: Yes.

(Plaintiffs' Exhibits 1 through 3 marked for identification.)

(Deposition concluded; signature not waived.)

ERRATA SHEET

NOTATION	PAGE/LINE
A. That is correct	8 3
general surgery	8 25
I came to Canton	9 23
same office building	9 "4
Dr. Chrysos	11 4
delete "I had the first part"	11 14
I followed	16 16
until she recovered somewhat from the medications	19 15
basal skull fracture	23 19
A. Yes	39 4
Foley catheter	40 7
~~drainage~~ catastrophe	~~44 23~~
Catastrophe.	65 12
Ranchestein	72 3/15
arteries in the spine	83 20
that supply the cord. No other supply	83 21

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

Alejandro Sos MD

ALEJANDRO SOS, M.D.

Notary

EDWARD E. TABER, ATTY.
NOTARY PUBLIC • STATE OF OHIO
My Commission Has No Expiration Date
Section 147.03 O.R.C.

ERRATA SHEET

NOTATION	PAGE/LINE

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

_____

ALEJANDRO SOS, M.D.

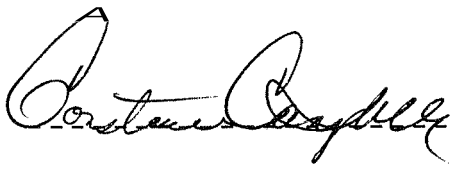
The State of Ohio, :

county of Cuyahoga. : CERTIFICATE:

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

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

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, ohio, this 13th day of May, 1999.



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

P

U

V

W

4-436: Marla J. Spreadbury

Deposition of
Alejandro Sos, M.D.

Wednesday, May 5,1999

Plaintiff's Exhibits: 1 – Dr. Sos' curriculum vitae
2 – Typed consultation report
3 – Dr. Sos' handwritten notes

Page / Line	**Description**
7 / 11	Prepared some notes night before deposition
7/20	Office is located at 1445 Harrison Avenue, NW, Canton, Ohio
REVIEW OF BACKGROUND	
8 / 6	Graduated from Madrid Medical School in 1962
8/13	Did neurosurgery residency in Madrid
8 / 20-25	Began medical training in the U.S. in 1968; 6 months of neurology at Georgetown from Jan to June 1969
9 / 1-8	Attended one year at Univ of Louisville – 1970; 4 years at Cinn for medical training; received teaching and fellowship till the end of '74; returned to Spain
9/9-14	Worked at a university hospital '74 to '78; returned the States in 1978
91 17	Obtain license in Ohio on 1979
9/20	Had taken exam in Kentucky
10 / 5	Began neurosurgical practice in Ohio in 1980
10/ 8	Had a partner during the first year – Dr. Gonzalez; solo since 1981
10 / 16	Is on active staff at Mercy
10 / 17	Has courtesy privileges at Massillon
10 *122*	Belongs tot he surgical committee for quality care and others
10/25 – 11/4	No chief of neurosurgery; all departments are headed by Dr. Grayson; he is the department of neurosurgeons

11/12 Is not board certified

11/16 Took part I in 1994

11122-1212 Does all neurosurgery except stereotactic neurosurgery due to the number of patients, lack of equipment; does brain aneurysms, spinal cord tumors, peripheral nerves, laminectomies for lumbar discs, the lumbar spine

1217 Has been a defendant before

12/13 Has been sued 11 times – never lost any

12/24 Has never served as an expert witness

REVIEW OF SPREADBURY CHART

13/17-22 Reviewed all of chart to refresh memory as to chronology of events, timing of his involvement; his return call for consultation; his clinical impression

1415 Did not review films provided to counsel

14/14-18 Made notes to answer deposition questions promptly and accurately

15/10 Note of blood pressure being 130 over 86 is good; pulse of 107 while in ED is very fast; patient was probably able to move all four limbs while in ED

15/19-24 It is not absolutely clear to him; Dr. Telesz was there when the patient was intubated – patient was paralyzed for intubation

1617 Was contacted at 11:26

16/13 Knows from his typed consultation note

16124-25 It's also recorded on the nurse's ER notes

17/4 Examined the patient prior to the CT scan

17119 Dictated he arrived in ICU

1811 The first doctor was Telesz, the second doctor was Sos

1819 He was called in because of a suspected head injury

18/14 Was the on-call neurosurgeon that day for the ER

18/16 Continuously on-call – no other neurosurgeons

1913-5 Doesn't recall speaking with Telesz before or after his exam of Marla

1919 Prior to his seeing her, Marla had been given paralytics so she could be intubated

19 / 13 As a result, it was not possible for him to examine her – he had to wait for her to recover

19 / 25 Dictated at 4:25, Marla moved the toes for him

20 115-17 When he arrived, she was weak, but was moving her toes

20/23-21/4 Reading of note made at 12:39: BP 1401100, pulse 80; L pupil 3mm; R pupil 5mm; ecchymosis; chest tubes, no blood produced; pneumothorax, rib fractures

22/1-11 Needed to see the patient for longer as effects of paralytic was wearing off; needed to see a CT scan of the head to determine any intracranial injury

CHRONOLOGY OF HIS CARE

22/23-23/19 Examined patient for marks (abrasions, hematoma, etc.); noted a forehead laceration, ecchymosis on the chest; checked for deformities on the long bones, none found; checked patient's level of consciousness; checked neck, if there was a shift in trachea, none found; no blood in auditory canal means no skull fracture

23/21-24/16 Noted subcutaneous emphysema – free air; fractures; soft abdomen, no distention at the time – no intra-abdominal bleeding; checked iliac crest, and pelvis for fracture – none found; checked vital signs; was waiting to see if she could move her arms and lower extremities

24 / 24 On dictated on this day

25 / 18 Dictated on the 23rd, transcribed on the 24th

25 122-25 Personally spoke with Dr. Telesz while in ICU; spoke with Kralik and then Tawil

26 *18-10* Would have had to be on the 23rd before he left the hospital – no question as to speaking with Telesz on the 23rd

26 / 11-14 Believes he spoke with Tawil on the 23rd because they all came to the emergency room, the ICU, the CT scan; they crossed paths there

26 / 17-20 100% sure he reported his findings to Telesz and then later thinks he talked with Tawil because Tawil was first one that was called

27 / 5-11 As to dictation and transcription, had a contract with a company back in '97 the doctors had a lot of trouble with due to many delays

27 / 22-25 Did see photographs of the accident; not sure if in ICU or the ED

28 / 2 Polaroid photos

28 / 5	Has not seen them since that day
28 / 8-11	If photographs are made at the hospital, they are kept as part of the record
28/22-2917	Photographs did help him in his assessment; air bag had been deployed, left front part of car was destroyed; no door; seat was broken; windshield was destroyed; believes front tire had been destroyed
29 113-21	Did not perform a neurological exam because he needed her to respond; he inspected by feeling her limbs, listening to her chest; he would come in and out to until she was more awake so he could perform a neurological exam; she did respond to pain *4* hours later
29 / 25	Performed exam after she had a head CT scan
301 10	Reviewed chest x-rays as part of his routine
301 14	Had notes free air in the mediastinum and rib fractures
31 / 2	Doesn't recall conferring with radiologist
31 15-12	Looks at films out of curiosity; not an expert at reading films
31 / 15	Neurological purpose for looking at chest films was respiratory support
32 / 5-10	Doesn't recall seeing a widening of the mediastinum; if a patient lays on the table to be x-rayed, the mediastinum will be wide because he is recumbent; widening is not a very important landmark
32 112-17	Not a landmark because everyone has a widened mediastinum when laying down
33 / 1	Discussed free air in the mediastinum with Kralik
33 / 4	May be wrong, but that's whose face he remembers
33 / 10	Thought free air was because of rib fractures
33 122	He read the CT of the head

REVIEW OF HEAD CT SCAN

34 19-22	CT reveals to fractures on the skull; minimal subgaleal swelling; no masses or hematoinas in the brain or outside the brain; brain was in the midline; minimal brain atrophy;
35 15-7	100% sure he told Telesz
35 / 10-17	Meant it was Tawil, not Kralik; Tawil was to do the bronchoscopy
3619	Marla nodded head to certain questions

361 12	Got a weak response when he spoke to her
361 18	Doesn't recall if she was opening her eyes
36 122	She moved her toes very weakly
37 14-8	Did not have concerns about condition of extremities as she was still recovering from the sedation
37 / 12-18	Some patients, you don't know for *2* days; she was waking from the effects of the sedation, trauma and anemia; she was moving her toes weakly, assumed would be better the next day
37 / 25	Likely that he spoke to Tawil, that's how he know Tawil was to do a bronchoscopy
38 13-5	Bronchoscopy was to rule out laceration of the trachea or primary bronchi that could displace free air in the mediastinum
38 17-15	Doesn't recall Tawil specifically saying why he was going to do a bronchoscopy; assumed it was because of the abnormal finding of free air in the mediastinum due to injury of the trachea
38 / 23	From a neurological standpoint, agreed with Telesz's order to support the patient as the only thing to do
39 / 11-16	Due to the fact that after 5 – *6* hours, she was poorly nodding and weakly wiggling her toes, all they could do was to wait until the next day
40 / 1-19	In terms of supporting of the patient, he meant, maintain patient's stability ie IV's, blood, etc.; respiratory management; monitor urine output watch for level of consciousness; patient's such as Marla could have a spinal cord injury, injury in evolution of the brachial plexus; can't know until the patient is awake; she couldn't move to commands – she was still out
41 17-25	His explanation as to why Marla's BP was *163190*
421 17	Doesn't know where he got it from, maybe the nurses at bedside
43 / 14	BP of *163 /* 121 is what is called shortening between systolic and diastolic
43 / 17-23	Diastolic would be very elevated; must be wrong transcription
44 14-9	Thinks *121* is wrong because the pulse at *90* isn't even grossly tachycardic
44 / 11	Believes it's a mistake because *10* minutes earlier, BP was normal; with such a change in the BP, one would expect changes in the pulse
44 / 25	Has no opinion was to abnormal elevated diastolic pressure

45 / 12	Variations in a patient's BP can say something about the brain, head
451 17	Was there at 11:26 - when pressure was recorded
45/21-4611	Doesn't want to answer what would cause elevation in diastolic pressure at 12:15
46 15-14	For the benefit of the jury, his only duty was from a neurological standpoint
46 / 17-21	Doesn't recall speaking with Dr. Menia; can only assume he did because he came to the ED
47 120	Did not have a concern neurologically at the CK being elevated
48 / 15	Didn't concern him enough to speak with Telesz as Telesz already knew
48 / 25	The word "doppler" was wrong
4912	Should have been "drop" as to "further drop in red cells"
49 16-9	**A** further drop in red blood cells could mean internal bleeding
491 12	Was watching for drops in numbers from a general surgical standpoint
50 12-6	Doesn't know why drops should be "expected"; this is well noted that drops should be watched for
50 113-19	From a neurological standpoint, felt that there was some internal bleeding that had not yet been determined; most common, subcapsular splenic hematoma
50121	Her abdomen was soft
50 / 23	In general in these patients most common cause of bleeding is the spleen
51 / 22	Patient needed to be watched for bleeding; may take 4, 5,6 or more hours
52 / 9-11	Would have specifically all of his diagnoses with Telesz, number one, verbally, and number two, he is supposed to read the dictation – he is supposed to know
52 114-16	Remembers clearly talking with Telesz; confuse if he talked with Kralik or Tawil
52/24-53/3	Spoke with a thoracic surgeon about the air in the mediastinum; cardiothoracic surgeon advised of the bronchoscopy
53 / 25	Did speak with someone in the cardiothoracic group, but doesn't recall who
5415	Did communicate the free air in the mediastinum to the C/T surgeon
54 / 12	Probably would have generally told them to follow the blood loss and falling hematocrit

54 / 21 Wasn't aware of the mediastinal injury at that time

55 / 7 Would have been a remote suspicion as they are very rare

55 / 24 Doesn't think he was contacted after leaving the hospital on the 23rd

5613 If so, it would be reflected in the hospital chart

REVIEW OF NOTES MADE NIGHT BEFORE

58 / 19 It is his assessment CT head ok

58 / 23 Pneumothorax, mediastinal air as the chest CT

5912 Probably looked at CT

591 12 Doesn't remember

59/21 Is not capable of reading chest CTs; are to be read by the radiologist, thoracic surgeon

60 19-15 It is not his obligation to read or interpret chest x-rays, or CTs of the chest

61 15-13 Noted products used by Menia to sedate and paralyze Marla; also noted that Telesz and Tawil were there during intubation in the ED; order of appearance – Telesz, Menia, Telesz, Sos, Tawil

61/18-62/7 Explanation of pre-depo notes

63 / 1-5 Doesn't know when depo-medrol therapy was used

SEPTEMBER 25th

641 14 Rosenberg may have been called in by Telesz

64 120 He was in the room with Rosenberg for a few minutes

65 18-12 Obvious cause of paraplegia was the injury to the aorta; very well know catastropliy to the neurologist and neurosurgeon

ROSENBERG'S CONSULT NOTE – 9/25/97

661 1 Patient has cord ischemia secondary to aortic transection

67 / 4 Saw Marla on 9/24, 9/25, 9/26, 9/27, 9/28; may have seen her even though there's no note

67 / 14 Did see Marla on the 24th

67 / 17 Doesn't remember if it was before or after surgery

68 / 8 Writes down every time he walks into a patient's room

68/24-6913 Noted patient was paraplegic from E-1 down; level questionable due to patient's consciousness;

69 / 4-7 On the 25th, noted no movement in her legs, no sensation; had not yet determined level – could be L-1

69 / 10 She wasn't awake enough yet (because of just being through surgery)

69 / 16-19 Spoke with either Kralik or Telesz; somebody wanted another CT; Rosenberg wanted a head CT

7016 CT revealed the head was clear

70 1 12-18 Didn't discuss the chest CT

70 / 24 Nobody told him anything whatsoever

71 16-13 It would have been natural to have discussed chest CT with him on the 23rd; they wouldn't tell him or like for him to know the CT had been misread

71 / 22 Was not involved for PEG

72 15 Rocltenstein is a radiologist

72 17-10 9/23 read of superior mediastinal hemorrhage must be the report of 9/23 by Rocltenstein

72 122 It was a summarization of the x-ray reports

CONSULT OF OCTOBER 30TH

73 / 13 Was called back (10-30-97)

73 / 16 Made a "written" record

73 121-25 Thought patient. may have a subdural hygroma

74 13-12 Patient's chief Complaints – diplopia, homomymous gaze, sees double when looking to the right; right pupil larger then left, paretic from 9/23/97; high brain function. satisfactory; follows commands well; full ROM on upper limbs; paraplegia

74 120- Paraplegia from T-5; profound analgia from T-5 to L-1 on the right; patient feels suppositories when inserted in the rectum;

75 / 1-23 Further read of second consult note into the record

7614	There was no change in the CT findings between his consults
76 / 17-25	The cause of the blurred vision may have been because the pupils were still different sizes; most likely due to trauma to the right eye
7714	Trauma from the collision
77 17-9	There was no increased cranial pressure
77 / 14	The CT was because there was a concern of subdural hygroma
77 122	He disagreed with that read
77125-7811	The CT should really be read by a neuroradiologist; Mercy has one
7813	Dr. McNulty is the neuroradiologist; he didn't read – Sos was called
78115-7917	Objection and discussion of DTKs line of questioning as to the surgical quality assurance committee
79 / 14-22	There are no specialty departments under surgery; all categories fall under the Department of Surgery
79125-80121	Taber's objection to: *"Didthat QA committee perform morbidity/mortality reviews on a monthly basis?"*

PROCEDURE OF PREPARING CONSULT REPORTS

81 17-10	The consult talks with the person who calls them and then a report is written
81 *121-25*	Not aware of the existence of any written policy, protocol or procedure of how a consult was to communicate findings
82 / 16-20	When speaking with Kralik, Sos was told Marla was paraplegic; recalls from the chart a note stating risk of paraplegia discussed with husband
82/23-83/2	If Kralik asked for Sos' opinion as to the paraplegia, then Sos would have given him an answer: Kralik knew too
83 16-23	Transection of the aorta, even with cases of paraplegia, sometimes evolve over several hours depending on clots or other causes; it's not usual to have a transection immediately paraplegic or it develops *6* hrs or *3* days; sometimes patients with cardiorespiratory arrest wake up paraplegic

CURRICULUM VITAE

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Born in Castellon de la Plana, Spain, April 18, 1937

Graduated High School with Honors, Spain, 1954

Universidad de Madrid Medical School. Graduated MD m 1962

RESIDENCY:

Medical Corps, Spanish Army, 1962-1963

Resident, Neurosurgery, Institute for Neurological Sciences, Madrid, 1964-1967

ECFMG Examination, 1967

US EDUCATION:

1/1/68 – 12/31/68	Internship, Unity Hospital, Brooklyn, New York
1/1/69 – 06/30/69	Neurology Residency, Georgetown University, VA Hospital, Washington, DC
07/01/69 – 06/30/70	General Surgery Residency, University of Louisville Medical School, Louisville, KY
07/01/70 – 06/30/74	Neurosurgery, Good Samaritan Hospital, Christ Hospital, Cincinnati General Hospital and Children's Hospital, Cincinnati OH Chief Resident, 7/1/73 to 6/30/74
07/01/74 – 09/30/74	Teaching and Research Fellowship, Mayfield Neurological Institute, Cincinnati OH
11/01/74 – 12/78	Attending Neurosurgeon, Neurosurgical Service, "Francisco Franco" University Hospital, Madrid, Spain
1979	FLEX Examination, Louisville, KY; License to practice medicine in KY, #20362

PLAINTIFF'S EXHIBIT
5-5-99

1980	Licensed to practice medicine in OH, # 35-044414
1980	Established Neurosurgical Practice in Canton, OH
09/94	Passed 1st part of European Neurosurgery Boards

AFFILIATIONS

Mercy Medical Center, Canton, OH	Active Staff since 1980
Massillon Community Hospital	courtesy Staff

MEMBERSHIPS

LifeBanc, Board of Trustees, Cleveland, OH.
Ohio State Medical Association
Stark County Medical Society
Ohio Neurosurgical Society
Mayfield Society

Honorary Member – Sociedad Luso Espanola de Neurocircugia (Miembro Correspondiente)

PUBLICATIONS

"Melanotic Schwannoma of the Acoutic Nerve" Archive Pathology and Laboratory Medicine, February 1996.

"Bone Dysplasia with Involvement of the Skull", Journal, Institute of Neurological Science, Madrid, Spain, 1965.

"Organo-Phosphate Insecticides" Tropical Medical, Spain, 1964

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