IN THE COURT OF COMMON PLEAS
OF CUYAHOGA COUNTY, OHIO
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LESLIE WALTER, Admin.,
etc.,
Plaintiffs,
vs. Case No.
METROHEALTH MEDICAL
CENTER, et al., 393899
Defendants.
- - - - -
DEPOSITION OF DOUGLAS EINSTADTER, M.D.
Monday, October 30,2000
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Deposition of DOUGLAS EINSTADTER, M.D., a witness herein, called by the Plaintiffs for examination under the statute, taken before me, Karen M. Patterson, a Registered Merit Reporter and Notary Public in and for the State of Ohio, pursuant to notice and stipulations of counsel, at the offices of MetroHealth Medical Center, 2500 MetroHealth Drive, Cleveland, Ohio, on the day and date set forth above, at 9:30 o'clock a.m.
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APPEARANCES:
On behalf of the Plaintiffs:
Becker & Mishkind Co., L.P.A., by
JEANNE M. TOSTI, ESQ.
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On behalf of the Defendant Emergency Professional Services and Thomas W. Graber, M.D.:
Mazanec, Raskin & Ryder Co., L.P.A..
by
COLLEEN PETRELLO. ESQ.
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On behalf of the Defendant MetroHealth Medical Center:
Reminger & Reminger Co., L.P.A., by
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(Thereupon, PLAINTIFFS Deposition Exhibit 1 was mark'd for purposes of identification.)
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DOUGLAS EINSTADTER, M.D., of lawful age, called for examination, as provided by the Ohio Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

E~MINATION OF DOUGLAS EINSTADTER, M.D.

BY MS. TOSTI:

Q. Doctor, would you please state your name for us and spell your last name, please.
A. Douglas Einstadter, E-I-N-S-T-A-D-T-E-R.
Q. What is your home address?
A. 19000 Lake Road, Number 504, Rocky River, Ohio, 44116.
Q. Is that an apartment?
A. Condominium.
Q. Condo. And your current business address, is it here at Metro Medical Center?
A. MetroHealth.
Q. 2500 MetroHealth Drive?
A. That's correct.
Q. Who is your current employer?

A. The MetroHealth System.
Q. And in March of 1998, was your business address and your employer the same as it is now?
A. That's correct.
Q. Do you currently render professional services for any other entity besides the MetroHealth Medical System?
A. Professional services meaning --
Q. Professional medical services.
A. No.
Q. And in 1998, did you render professional medical services for any other entity besides MetroHealth System?
A. No.
Q. Have you ever had your deposition taken before?
A. Yes.
Q. How many times?
A. One time.
Q. And why was your deposition being taken? And by that, my inquiry is, first, was it a medical negligence case?
A. I think so.
Q. And were you having your deposition

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taken as a Defendant in that case?
A. I'm not sure I was named specifically, but I was involved in the care of the patient.
Q. Was the care *of* the patient in question?
A. As far as I know, yes.
Q. I want to review some of the general instructions for deposition. I'm sure counsel has had a chance to speak with you, but this is a question-and-answer session; it's under oath. It's important that you understand my questions. If you don't understand my questions, just let me know and Ill be happy to rephrase them or repeat the question if you'd like. Otherwise, I'm going to assume that you understood my question and that you're able to answer it. It's also important that you give all of your answers verbally because our court reporter can't take down head nods or hand motions.
If at any point during the deposition, you would like to refer to the medical records, please feel free *to* do so. And, also, at some point during the deposition, counsel may choose to enter an objection for the

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record. You are still required to answer my question unless counsel instructs you not to do so. Do you understand those instructions?
A. Yes, I do.
Q. Have you ever been named as a Defendant in a medical negligence case?
A. No.
Q. Have you ever acted as an expert in a medical negligence case?
A. No.
Q. In regard to the case where you had given a deposition, can you tell me what the Plaintiffs name or the patient's name was in that case?
A. I don't recall.
Q. Was that a case that was filed in the Cleveland area?
A. Yes.
Q. How long ago was your deposition taken?
A. I think about two years ago.
Q. Do you recall the allegation of negligence in that case?
A. Would you like me to explain the -- or to outline the case real briefly?

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Q. Yes. I would like to know what was alleged to have occurred.
A. It was a woman who had been hospitalized and then discharged to a nursing home where she developed infection requiring rehospitalization. It was alleged that we – the diagnosis of infection should have been made prior to discharge.
Q. What type of an infection?
A. It was sepsis which was felt to have spread from her intestine.
Q. How was that case resolved?
A. As far as I know, it never went to trial.
Q. Do you know whether it was settled or dismissed?
A. I never heard anything after my deposition.
Q. Doctor, counsel has provided me with a copy *of* your curriculum vitae that we have marked as Plaintiffs' Exhibit 1. I would like you to just take a look at it and tell me if it's current and up to date and if there's any changes or corrections you would like to make to it.
A. It's current and was printed this

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morning.
Q. You are currently licensed in the State of Ohio; correct?
A. That's correct.
Q. And in 1998, did you have a medical license in the State of Ohio?
A. Yes.
Q. You also hold a board certification; correct?
A. That's correct.
Q. That is in internal medicine?
A. Yes.
Q. As well as the National Board of Medical Examiners: is that correct?
A. That's correct. That's the test you take through medical school, three parts.
Q. Where do you currently have hospital privileges?
A. At MetroHealth.
Q. Was that also true in 1998?
A. Yes.
Q. Have your hospital privileges ever been revoked or called into question?
A. No.
Q. Has your medical license in Ohio ever

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been revoked or called into question?
A. No.
Q. Have you ever been licensed in any other state besides Ohio?
A. Yes.
Q. And what other states?
A. Washington State.
Q. And in regard to Washington State, have you ever had a revocation or other investigation in regard to your medical license?
A. No.
Q. Doctor, in regard to your current title and position at MetroHealth, what is it?
A. I'm staff physician at MetroHealth and also assistant professor of medicine, epidemiology and biostatistics at Case Western Reserve.
Q. In 1998, what was your title and position?
A. It would be the same.
Q. When did you first begin working as a staff physician at MetroHealth Medical Center?
A. 1992.
Q. And did you work continuously here as a staff physician since 1992?

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A. Yes.
Q. Now, under your educational activities with Case Western Reserve, I see at one point in 1994 and 95 you were coordinator of fundamentals of medical decision making. What was that position?
A. Fundamentals of medical decision making is a course we teach at the medical school which involves biostatistics, epidemiology, critical evaluation literature.
Q. Does it involve clinical decision making for the physicians?
A. It's something which is used as a basis for clinical decision making, but we're teaching it to first year medical students who aren't really involved in patient care at that point in their training.
Q. In 1993 I see a teaching responsibility, instructor case-oriented problem solving. What is that in regard to?
A. Right. That was specific cases which were presented, generally, at the end of the second year used as sort of a way to reinforce concepts which had been learned throughout the first two years of medical school.

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Q. Doctor, you have a number of publications listed on your curriculum vitae. Do any of these deal with the subject matter of bacterial endocarditis or prosthetic valves?
A. No, they don't.
Q. Have you ever taught or given a formal presentation on the subject matter of endocarditis?
A. I may have given sort *of* presentations on the inpatient ward, but nothing official and not in any sort of a formal situation.
Q. You wouldn't have any type of handouts or outlines or syllabus from any of those presentations?
A. No.
Q. Can you tell me what you have reviewed in preparation for this deposition.
A. I've reviewed the patient's medical record.
Q. Now I'm going to ask you about several other records.
When you say the patient's medical record, are you speaking of the MetroHealth medical records?

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A. The MetroHealth medical records, and I've also seen at least what I had in my record from Southwest General.
Q. Earlene Mizsey had both inpatient as well as outpatient visits at Metro. Did you review both of those?
A. Yes.
Q. In regard to Southwest General, she had at least two visits to the emergency room. Did you see visits related to March 10th of 98 as well as May 5th *of* 98?
A. I saw two records from emergency visits. I think the second one was May 8th.
Q. Did you review any Cleveland Clinic records?
A. I have correspondence from several physicians there about her care, but, otherwise, I have not reviewed any records.
Q. What about records from Broadview Multi Care, which was the nursing facility that she went to?
A. No.
Q. Have you reviewed any tapes or echocardiogram of Earlene Mizsey?
A. No.

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Q. Since this case was filed, have you discussed it with any physicians?
A. No.
Q. And other than with counsel, have you discussed it with anyone else?
A. No.
Q. Now, aside from whatever notes are in the MetroHealth Medical Center hospital chart of Earlene Mizsey, do you have any personal notes or personal file on this case?
A. No.
Q. Have you ever generated any such notes?
A. No.
Q. Doctor, your field of practice is internal medicine; is that correct?
A. That's correct.
Q. Is there a particular textbook in your field that you consider to be the best or the most reliable?
A. No.
Q. Is there any in your teaching responsibilities that you utilize with your students?
A. I utilize a textbook called Studying

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a Study, Testing a Test by Reigelman.
Q. Any in the field of internal medicine specifically?
A. No. No.
Q. Does Case Western Reserve have a particular textbook that they utilize with the medical students for internal medicine that you're aware of?
A. Not that I'm aware of.
Q. Are there any publications, as you sit here today, that you believe have particular relevance to the issues in this case?
A. There might be many publications that would be relevant, but none in particular.
Q. I'm asking if you have knowledge of any particular one right now.
A. No.
Q. Doctor, have you participated in any research dealing with the subject matter of bacterial endocarditis?
A. Yes.
Q. Can you tell me the title of that particular research project and when it was being conducted?
A. I'm not aware of a title. I'm

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involved in a project which *is* currently ongoing.
Q. What is the research question or hypothetical that you're dealing with in that research project?
A. Looking at ways to improve referral of patients for echocardiography to evaluate for endocarditis.
Q. Where is that research being conducted?
A. Here at MetroHealth.
Q. Do you have a research protocol on that case?
A. I'm involved as a statistical consultant, so I'm aware there is a research protocol, but I don't have one in my possession.
Q. When was that particular study begun?
A. I believe about a year ago.
Q. And when is it planned to be completed?
A. I don't know exactly. My guess would be about a year or so.
Q. Have any of the findings from that study been published?
A. No.
Q. Has there been any summarization of

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data collected to this point in time?
A. No. As far as I'm aware, there has been no data collected as of this time.
Q. Who is the Cleveland investigator on that research study?
A. Michelle Hecker.
Q. Would you spell her last name for us, please.
A. H-E-C-K-E-R.
Q. Now, you mentioned that that study involves looking at ways to refer patients for echocardiograms in patients that have been diagnosed with endocarditis.
A. Who are suspected of having endocarditis.
Q. What specifically does that study took at in regard to the referral system?
A. Looking at ways to improve the yield rate of those patients referred for echocardiography.
Q. What do you mean by yield rate?
A. In other words, to try to decrease the number of false -- patients referred inappropriately.
Q. So looking at referral for

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transthoracic or transesophageal echo?
A. Both.
Q. Is your practice of internal medicine limited in any way?
A. In what sense do you mean limited?
Q. Some people are internal medicine physicians and they limit their practice to a certain segment of internal medicine. Do you limit yours or is yours a general practice of internal medicine?
A. General practice of internal medicine.
Q. Do you see adults as well as children in your practice?
A. I would not see anybody under age 18.
Q. Would you describe for me, in general terms, your professional practice schedule as it was in 1998?
A. It would consist of two to three half days per week of patient care.
Q. Now, were you seeing patients in a clinic setting during that time?
A. Yes.
Q. How much time were you spending in the clinic setting seeing patients?

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A. Each half session would be four hours.
Q. So you'd spend two to three --
A. Two to three half days, so two to three four-hour sessions per week.
Q. Were you in the clinic area any particular hours?
A. As I recall, I would have one morning session, which would be from 8:00 until noon, and generally one afternoon session which runs from 1:00 until 5:00.
Q. Did you have any hospital responsibilities during that same time period?
A. I attend on the inpatient service six to eight weeks per year.
Q. And when you were not attending on the inpatient service and you were doing your clinic or outpatient responsibilities the two to three half days a week, what did you do the rest of the time during the week?
A. I supervised residents in their continuity clinics. I'm also involved in teaching activities at the medical school and in research activities.
Q. What is a continuity clinic for the

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residents?
A. That's their general practice clinic, so where they see patients on an ongoing basis.
Q. Where is that continuity clinic conducted?
A. It would have been in the same location where I saw patients in my own practice.
Q. So at MetroHealth Medical Center?
A. Yes, at MetroHealth.
Q. How many hours a week were you supervising residents in the continuity clinic?
A. Also two to three half days per week.
Q. This was in addition to the two to three half days that you were seeing patients?
A. That's correct.
Q. The research that you were involved in, how many hours a week were you doing that?
A. It varies from week-to-week, but it would generally be from 40 to 50 percent of my time.
Q. And did you have responsibilities for regular class instruction at Case Western Reserve?
A. Yes, as part of the fundamentals of medical decision making.

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Q. Was that on a weekly basis?
A. I don't recall if in 1998 there were sessions of that course which run on a weekly basis. I don't recall if I was involved in that at that time, or whether I was just involved in the didactic teaching portion which runs for about a two-week period all day.
Q. Now, in 1998 when you were supervising residents in the continuity clinic, how many residents would you be supervising?
A. It varies from session-to-session, but we keep -- we try to keep a four resident per one attending ratio.
Q. Would all of these be residents in internal medicine?
A. All the residents in internal medicine.
Q. Were you supervising any other level of personnel besides the residents during that period of time?
A. Occasionally there are medical students present also, and on the inpatient service there are medical students.
Q. Doctor, what is bacterial endocarditis?

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A. In general, or a specific type?
Q. In general.
A. In general, it's an infection of the endocardium, or the lining of the heart and heart valves.
Q. How often in your practice have you seen patients with bacterial endocarditis?
A. I don't recall exactly, but it's been maybe five to ten times.
Q. What is prosthetic valve endocarditis?
A. It would be infection of -- involving an artificial valve.
Q. Would that include a bioprosthetic valve?
A. Yeah, both bioprosthetic or mechanical valves.
Q. Have you ever diagnosed a patient with bacterial endocarditis?
A. I don't recall whether I actually diagnosed it, but I've been involved in the diagnosis of several patients with bacterial endocarditis.
Q. Have you ever referred a patient to another physician with a diagnosis of possible

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infectious endocarditis?
A. I don't recall exactly.
Q. Are there any risk factors that would place a patient at increased risk for developing bacterial endocarditis?
A. There are many risk factors which can place patients at increased risk.
Q. Would you tell me about those you have knowledge of.
A. Among the more common risk factors would be older age, IV drug abuse, recent dental or other sorts of procedures which might release bacteria into the bloodstream. Certainly patients with prosthetic valves are at increased risk. There are others also, which I don't necessarily have right *off* the top of my head.
Q. Would diabetes increase the risk for developing bacterial endocarditis?
A. In the sense that patients with diabetes are at somewhat increased risk of all types of infections, it could increase the risk of endocarditis.
Q. What about the presence of another infection?
A. I don't know exactly. I guess it's

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possible.
Q. Have you ever heard the terms early and late prosthetic valve endocarditis?
A. Yes.
Q. Can you tell me what your knowledge is in regard to the difference between those two things.
A. Early prosthetic valve endocarditis would generally refer to disease occurring soon after placement of the valve. So it might be related to problems with the operative procedure. Late endocarditis would be that which occurs generally, I believe, about a year or so after the valve has been placed.
Q. What are the signs and symptoms of prosthetic valve bacterial endocarditis?
A. Well, there can be many signs and symptoms of prosthetic valve endocarditis, and they're generally the same as those of nonprosthetic valve endocarditis. Most commonly the signs or symptoms would be those of a chronic infection.
Q. And would you tell me what signs and symptoms you're referring to?
A. It might be persistent fever not

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explained by other causes, malaise, generalized aches, weight loss, those types of things, you know, which would also be associated with other sorts of chronic infections.
Q. Is anorexia associated with signs and symptoms of prosthetic valve endocarditis?
A. It might be in that it's associated often with chronic infection.
Q. Is anemia?
A. I believe anemia has been reported, again, in most chronic infections.
Q. How about elevated white blood cell count?
A. I'm not sure exactly whether that's always present or just goes along with chronic infection.
Q. Increased erythrocyte sedimentation rate?
A. That can be associated with endocarditis or other chronic infections.
Q. Doctor, are there any diagnostic studies that are helpful in the diagnosis of bacterial endocarditis?
A. There are many which might be helpful in the -- along with the general picture. I'm

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not aware that any one in particular is diagnostic.
Q. Well, my question was: Are there any diagnostic studies that are helpful in the diagnosis?
A. That are helpful. Echocardiogram is helpful in the diagnosis. Blood cultures are helpful in the diagnosis. I think those would probably be the most helpful.
Q. Can bacterial endocarditis be ruled out on the basis of a single blood culture?
A. No.
Q. Why not?
A. It would depend upon your index of suspicion prior to taking the blood culture. As in any test, there are false-positives and false-negatives. So it would depend on the situation. But in all situations, it may not rule out endocarditis with one negative blood culture.
Q. Does a patient have to have a positive blood culture before a presumptive diagnosis of bacterial endocarditis can be made?
A. Not necessarily, no.
Q. Have you heard the term culture

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negative endocarditis?
A. Yes.
Q. What is that?
A. That's when endocarditis has been shown to be present in the absence of a positive blood culture.
Q. Doctor, is there a higher rate of negative blood cultures in patients with prosthetic valve endocarditis as compared to endocarditis patients without a prosthetic valve?
A. I don't know.
Q. Is there a higher rate of negative cultures in subacute bacterial endocarditis as compared to acute bacterial endocarditis?
A. I don't know.
Q. What are vegetations?
A. Vegetations generally describe fibrin clots on the valves.
Q. And in regard to bacterial endocarditis, are these vegetations usually septic?
A. In endocarditis, the vegetations are generally composed of fibrin plus bacteria, so they would be part of the source of the

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infection.
Q. Are there any complications associated with valvular vegetations in endocarditis?
A. There may be. If they break off, they may cause problems elsewhere.
Q. What type of problems?
A. Well, the same type of problems you would see with emboli or when blood clots break off, so they may cause blockage at other sites, arterial sites, elsewhere in the body.
Q. Would one of those complications be stroke?
A. One complication could possibly be stroke.
Q. Would another complication be arterial occlusion in an extremity?
A. That's a possibility, yes.
Q. And how is prosthetic valve endocarditis treated?
A. I'm not an expert in treatment of endocarditis, but generally it would be treated the same way as nonprosthetic valve, which would be antibiotics as a first-line treatment.
Q. In a patient that has prosthetic

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valve endocarditis, is it frequently necessary to replace the infected valve?
A. I don't know if I would say frequently. It is sometimes necessary to replace the valve.
Q. In a patient that has prosthetic valve endocarditis, would you agree that the sooner the endocarditis is treated with antibiotics, the more likely the outcome is going to be positive?
A. I don't know if that's true in prosthetic valve endocarditis.
Q. Is it true with endocarditis, bacterial endocarditis, when a prosthetic valve is not involved?
A. I also don't know.
Q. Would you agree that one of the main goals of treatment in prosthetic valve endocarditis is to eradicate the infected organism as soon as possible?
A. The goal is certainly to eradicate the infecting organism, yes.
Q. Now, we discussed some of the complications associated with endocarditis. Would those same complications be true for a

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patient that has prosthetic valve endocarditis?
A. Yes.
Q. Would you agree that there has to be a high degree of vigilence for bacterial endocarditis in a patient with a bioprosthetic heart valve?
A. I think it needs to be considered.
Q. Would you agree that, in a patient with a bioprosthetic valve that presents with fever and elevated white blood cell count and reports of symptoms suggestive of transient ischemic attack or stroke, that endocarditis should be included in the differential diagnosis?
MS. PETRELLO: Objection.
A. I think it should be included in the differential diagnosis.
Q. What type of echo is more sensitive for picking up signs of prosthetic valve endocarditis?
A. Transesophageal echo is generally more sensitive for that, for picking up endocarditis.
Q. Is there a reason why the transesophageal is better?

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A. I'm not an echocardiographer. I can speculate, but I don't know exactly.
Q. What's your understanding as to why a transesophageal would be --
A. I think the power used is a little bit higher with the echo. It's also less tissue to look through. It also anatomically gets a closer to the area of interest.
Q. In a patient with a prosthetic valve, what would be the clinical indicators that would warrant proceeding with an echocardiogram to assist in evaluating the patient?
A. I'm sorry, can you repeat the question?
(Record read.)
A. It would be the same symptoms which would be -- you know, indicate further workup in a patient without a prosthetic valve, so I think the signs and symptoms which suggest the diagnosis of endocarditis.
Q. Do valvular vegetations have to be present before the diagnosis of prosthetic valve endocarditis can be made?
A. I believe valvular vegetations would be required, but, again, I'm not an expert.

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Q. Doctor, what causes a heart murmur?
A. Heart murmur is due to turbulent blood flow.
Q. Are heart murmurs associated with prosthetic valve endocarditis?
A. Patients with prosthetic valves will have a heart murmur whether or not they have endocarditis.
Q. Would you agree that infectious endocarditis is one of the few infectious diseases that is almost always fatal if it is untreated?
A. I would say endocarditis is an infectious disease which might be fatal if untreated. I don't know whether all infectious diseases would be fatal if untreated also.
Q. Now, if one of your patients is diagnosed with prosthetic valve endocarditis, would you as an internist be the physician that would normally manage the care and treatment of. that patient?
A. It would depend on the situation, but I would probably not be the sole person managing the care of that patient.
Q. Would it be your usual procedure to

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refer the patient for consultation with a cardiologist?
A. Yes.
Q. Do you have an independent recollection of Earlene Mizsey as you sit here today?
A. I remember Ms. Mizsey, yes.
Q. And from your recollection or the review of the records, when is the first time that Earlene Mizsey came under your care? And you may refer to the records if that's helpful to you.
A. I believe it was March 18th, or March 13th I saw her for the first time. March 13th, 1998.
Q. How is it that she came under your care on March 13th of 1998?
A. I was in the urgent care clinic here at MetroHealth, and she presented as a patient to our urgent care.
Q. Now, doctor, was the urgent care clinic something that was part of your regular responsibilities at that time?
A. Yes. Yes.
Q. How often were you in the urgent care

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clinic?
A. Usually one session per week. So the three sessions which I had mentioned before would have included generally one urgent care session.
Q. So that you would have been there individually, not in supervision of resident physicians?
A. Right. That's correct.
Q. Now, when you saw her, did she have a primary care physician at Metro?
A. She saw -- had seen an endocrinologist and a cardiologist, but at that time did not have a primary care physician.
Q. And did you assume care as her primary care physician at the point that she was seen on March 13th, 98?
A. Yes.
Q. I'msorry.
A. Yes.
Q. Was that a typical procedure where, if you were covering the urgent care and a person didn't have a primary care physician, he may pick up that patient as a primary care physician at Metro?
A. Yes. That happened quite

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frequently. She also had an appointment with me already scheduled at that time to see me as a primary care patient.
Q. When you saw her on the March 13th visit, was anybody accompanying her?
A. I believe she was there with her daughter.
Q. She had several daughters. Do you know which daughter accompanied her?
A. I don't remember which daughter, no.
Q. And what did you understand to be the reason she came to Metro on March 13th?
A. She had recently been seen at the Southwest ER for evaluation of a neurologic episode, and she had continued to have some symptoms which were bothersome, and that was what brought her into urgent care.
Q. Now, generally, when a patient was seen in the outpatient clinic or the urgent care in this instance, would the patient be seen by a registered nurse or some type of nursing personnel before you would see the patient?
A. Yes.
Q. Would they usually record vital signs and some basic information from the patient?

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A. Yes.
Q. Would that information then be provided to you prior to the time that you saw the patient?
A. Yes.
Q. Now, you have your notes opened for the March 13th visit?
A. Yes.
Q. The faculty visit note dated March 13th, 98 at 1:05 p.m., is that note in your handwriting?
A. Yes.
Q. Does that continue on to the next page also?
A. Yes.
Q. Now, why is this entitled at the top "Faculty visit note"? What does that mean?
A. We have two separate clinics. One is a faculty clinic where the faculty sees private patients or their own patients. We also have a resident or teaching clinic for the residency patients.
Q. Now, when you saw Earlene Mizsey at this March 13th visit, did you obtain a history from her?

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A. Yes.
Q. And the source of that history, was that from the patient?
A. Yes.
Q. Can you just go through what information you were provided?
A. From the patient or prior -- you know, from the nurse?
Q. Well, let's differentiate. Let's start with what information the nurse provided you with, and then tell me what you received from the patient.
A. Okay. So the nurse's note is what's written at the top of the page, the four lines written in darker ink and signed, it looks like L. Munoz. So that would be the note from the nurse which gives sort of a chief complaint and the vital signs and also the allergies.
What I've written in the note below would be the history I obtained from the patient, which would include both the history of the present illness or the current problem which brought her in to see me, and also some of the past medical history, which is kind of written in the margin on the left side of the page.

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Q. The information that's written in the margin on the left side of the page came from the patient; is that correct?
A. I don't recall exactly. It probably came from a combination of the patient and also the prior medical record from MetroHealth.
Q. Well, I'd like you to go through what information you received from the patient in your note.
A. I don't recall exactly what I received from the patient. The chief complaint would come from the patient. So awoke on 3-10 with weakness and clumsiness of the ieft arm and some trouble eating and talking, that would come from the patient.
I mean, I guess --would you like me to go through this?
Q. Yes. Yes.
A. So she told me she had been seen at Southwest and had had a CT scan which was reported by her as negative for any problem. Hemorrhage is what I've written. She also had upper respiratory infection type symptoms and was treated with Zithromax, an antibiotic, for that. She was discharged and told to follow up here.

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Her symptoms over the next three days continued, and she had weakness and clumsiness of the left hand, and also some numbness. She denied any headache, visual symptoms, fever, chills or other complaints. She hadn't had any chest pain or shortness of breath and denied any palpitations.
Q. In regard to the numbness, was that numbness in her left hand that you're referring to?
A. Yes.
Q. Did you have any communications with the emergency room physician that saw Earlene Mizsey on March 10th, 98 at Southwest General Hospital's emergency room?
A. No, I did not.
Q. Did you, either before or after this 3-13 visit with Earlene Mizsey, have any communications with Dr. Vrobel or Dr. Rakita regarding Earlene Mizsey's emergency room visit of March 10th?
A. No, I did not.
Q. Now, the information regarding the CT scan there, you believe that likely came from the patient?

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A. From the patient, correct.
Q. Now, you refer to upper respiratory infection symptoms, I believe, about halfway down through the note that you just read to us.
A. Yes.
Q. When you were informed that she had the upper respiratory symptoms, what symptoms were you informed that she had?
A. Well, also the nurse's note indicates sinusitis, so that was probably what I'm referring to. I don't recall exactly what I asked. Generally, I would ask about congestion or nasal discharge, cough, sore throat, those types of things, when referring to upper respiratory symptoms.
Q. Do you recall whether she reported she had a fever?
A. I've written she denied fever and chills.
Q. Now, when you saw her on this date, March 13th, you were aware that she had had an aortic valve replacement; correct?
A. That's correct. That's indicated in the margin where it says AV replacement.
Q. Now, did you do a physical exam on

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Earlene Mizsey on this visit?
A. Yes, I did.
Q. Did you find any deviations from normal that you felt were significant on your physical exam?
A. Yes, I did.
Q. Would you tell me just those that you felt were significant deviations from normal.
A. She had bilateral carotid bruits on her neck exam, so murmurs in the neck. She had a cardiac murmur present, and she had some neurologic findings, including a little bit of weakness on the left arm, some decrease in sensation on the left side, a mild facial droop, and some decrease in her deep tendon reflexes.
Q. Now, in regard to the carotid bruits, those were bilateral that you heard?
A. Yes.
Q. What would be causes, or possible causes, for those bilateral bruits?
A. This could be disease of the carotid arteries, narrowing, which would give you bruits. It could also be sound referred from her cardiac murmur.
Q. Now, you heard a cardiac murmur that

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was a grade 3 over 6 murmur; is that correct?
A. That's correct.
Q. You heard it best over the aortic arch; is that correct?
A. Over the aortic area, yes.
Q. Was this a new finding or an old finding for her?
A. It was, as far as I know, an old finding, and, given her aortic valve replacement, not completely an unexpected finding.
Q. Now, when you were doing your physical exam, you conducted a neurological examination; correct?
A. Yes.
Q. And did you specifically check her legs for any signs of weakness or numbness on the side that she was experiencing the weakness and numbness in her upper extremity?
A. I tested her gait and also tandem walk, which would involve some strength in lower extremities, along with sort of balance testing.
Q. And did you notice any deficits in her lower extremeties?
A. Her gate was slightly unsteady, and she couldn't sort of do heel-to-toe walking, you

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know, sort of walking a tightrope line. And she couldn't walk on her heels or on her toes, which would indicate some weakness of the lower extremities.
Q. Was it more on one side or the other or was it about equal, from your assessment?
A. I don't recall exactly, but I didn't note that it was any better or worse on one side compared to the other.
Q. What was your conclusion regarding her condition after your evaluation?
A. My conclusion was that the symptoms were consistent with an acute event, neurologic event, or a stroke of some type.
Q. Was there anything else within your differential diagnosis when you saw her on March 13th?
A. Well, there are many other things which one might consider. I didn't write anything else down there other than her other medical problems. I don't recall at this time exactly what other things I might have been thinking.
Q. Did you consider at any point the possibility of prosthetic valve endocarditis as a

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possible cause for her stroke?
A. I don't recall exactly what I was thinking, but that would certainly be something to consider.
Q. And what was your plan of care at this visit for Earlene Mizsey?
A. The plan of care was to schedule her for a carotid ultrasound to evaluate the arteries in her neck, to get an echo of the heart to look for problems on the valve or a source of emboli or reason for this stroke. She was already on aspirin, which I increased her aspirin, which is a treatment to prevent, or try to prevent, embolic phenomenon.
Her blood pressure was a little bit elevated, and I increased one of her blood pressure medicines. I referred her for an evaluation from our physical therapy and occupational therapy department, and I also requested the records from Southwest, and then scheduled her for a followup about four days later, five days later.
Q. Now, you ordered a carotid ultrasound and an echo to look for an embolic source; is that correct?

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A. That's correct.
Q. Doctor, would you agree that an embolism to the brain can in some instances cause devastating disability and even death?
MS. PETRELLO: Objection.
A. Embolism to the brain can cause problems, yes.
Q. If there was any question in Earlene Mizsey's case that her stroke was a result of a condition that caused embolisms to travel to her brain, shouldn't those diagnostic tests have been done on a high priority basis?
MR. KILBANE: Objection.
MS. PETRELLO: Objection.
A. There was no evidence on my exam at the time that there was something going on which required acute evaluation.
Q. But you would agree that you were considering the possibility that this stroke that she experienced may have been caused by an embolic source; correct?
A. That's correct.
Q. Now, when you saw her on March 13th, 98, did you give orders to schedule the echocardiogram and carotid ultrasound?

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A. I wrote that in my note, so I would have given orders, yes.
Q. Do you speak with the nurses and have them schedule it, or how is that done once you see the patient and you have recorded it in your note?
A. At that time, we would have filled out a form or request for the ultrasound and for the echo, which then the patient would have brought to the front desk where it would have been scheduled from there.
Q. Did you take any action to have these tests scheduled as a high priorty test?
A. I don't recall.
Q. Is that something, as a physician, you can do if you feel that there's a critical need for a particular patient to have a test scheduled as a high priorty?
A. You can call and discuss that with the person doing the test, yes.
Q. When you ordered the echocardiogram, were you considering prosthetic valve endocarditis as one possible source of embolism?
A. I don't recall exactly. It may have been on my differential at that time.

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Q. Well, what would be the reasons for ordering an echocardiogram in a patient with a prosthetic heart valve to rule out embolic sources?
A. There's other reasons for -- patients with prosthetic heart valves may form blood clots on the surface of the valve, and that can also serve as a source of emboli.
Q. Is that true with a porcine heart valve?
A. It's true with any type of heart valve.
Q. Now, your note indicates that you requested the patient follow up with you, I believe, on March 18th, 98; is that correct?
A. That's correct.
Q. Why did you want to see her back within the five days?
A. That was the date of her original appointment with me, so I just said to keep that appointment, and at that time I would do a more complete -- get a more complete history and do the full exam.
Q. What additional things did you plan on doing on the 18th that you didn't do on the

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13th?
A. An urgent care visit is a 20-minute visit, so you don't have time in those visits to address sort of ongoing health needs, preventive measures, primary care health needs and that kind of thing.
The first visit with me on the 18th would have been a 45-minute time slot and would allow me to assess some other problems other than just this one which had brought her into the urgent care.
Q. When she was to come back on the 18th, did you think that you would have the results of the echocardiogram and the ultrasound by the 18th?
A. I don't recall. I mean, it's possible that there may have been some results, but it would depend on the schedule.
Q. Now, there is a physical therapy evaluation note dated, I believe, March 17th, 1998.
A. Yes.
Q. Do you have that? On page 2 of that of that note, it indicates phone contact made with Dr. Einstadter regarding recommendations.

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A. Yes.
Q. Do you recall speaking to the physical therapist in regard to Earlene Mizsey?
A. I don't recall exactly, no.
Q. Now, that note indicates further down, I believe, that the patient was being discharged from physical therapy.
A. Yes.
Q. Can you tell me, either from your recollection or review of the records, as to why she was being discharged from physical therapy?
A. Reading the physical therapy note, it appears that they didn't feel she had the deficits or limitations which would benefit from physical therapy, but I don't recall exactly, other than what's written in the note, why that was.
Q. Now, you then saw her again in the outpatient clinic on March 18th; is that correct?
A. That's correct.
Q. And this was the regular medical outpatient clinic; is that correct?
A. That's correct.
Q. Is there a specific term? I want to

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refer to it appropriately. What do they call that clinic that she was seen in for the 18th visit? The internal medicine?
A. Internal medicine clinic, yes.
Q. Now, did you do an assessment on her when you saw her on the 18th of March?
A. Yes, I did.
Q. Did your assessment of her condition change in any way from your previous assessment of March 13th?
A. No, it did not.
Q. Did you again examine her upper and lower extremities for signs of weakness, numbness, other neurological findings?
A. Yes, I did.
Q. And was your neurological assessment essentially the same as it had been from the 13th?
A. Comparing the two notes, it appears that I've noted that her strength is five of five, or normal in all extremities, although I still note some pronator drift which would indicate a little bit of weakness on the left upper extremity. Otherwise, it appears to be fairly unchanged.

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Q. So she had a slight improvement in her upper extremity?
A. Yes.
Q. Now, doctor, under the part of your note entitled "Assessment" from that March 18th visit, would you read for us what you wrote under item number 1?
A. Recent cerebral event, suspect small cortical infarct. Unclear if this was embolic or thrombotic, though I favor the latter. No evidence of progression of deficit.
Q. What made you suspect a small cortical infarct?
A. The symptoms she described, which consisted of clumsy hand and some difficulty speaking when this first occurred, would go along with what's called a lacunar infarct, or a blockage of one of the small vessels in the brain. That's generally not an embolic event, but more thrombotic, meaning platelet formation to block the blood vessel right at that site as opposed to traveling from another site. Given her symptoms, that seemed to be the best explanation for what had happened.
Q. Were you able to rule out an embolic

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cause to her neurological deficits?
A. At that time, no.
Q. Now, would you read for us what you wrote under item number 2 in your assessment.
A. Coronary artery disease with aortic valve replacement. Suspect bruits in neck is transmitted from the aorta but can't be sure without Doppler exam.
Q. Would the bruits that you heard in her neck be typical of a patient that has had aortic valve replacement?
A. I can't say for sure.
Q. Now, doctor, under the area marked "Plan" for the 3-18 internal medicine clinic visit, would you read to us what you have written under item number 2.
A. To have carotid Doppler and cardiac echo in next two weeks.
Q. Why did you write that particular note?
A. That would -- the test had been scheduled, and I may have looked up when they were scheduled for, and that would be just to remind me that that's, you know, when to expect the results.

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Q. Had the test actually been ordered at the previous visit when she was there on 3-13?
A. That would imply that that is correct.
Q. In this instance, is there a reason that the -- was the two-week time interval the scheduling dictated by the echocardiogram clinic and the ultrasound clinic, or was that something that you requested, that it be done within two weeks?
A. That probably would have been when the schedule allowed those to be fit in.
Q. Did Earlene Mizsey have the two tests done within the two weeks that you ordered them?
A. I don't recall exactly. I can look. She had them on 4-9, which would be in about 3 weeks.
Q. Do you know why there was a delay to three weeks?
MR. KILBANE: Objection.
A. I don't recall. I mean, I don't know why.
Q. When patients are sent for a diagnostic study, is there a system in place at MetroHealth whereby the results of the study are

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reviewed by a physician soon after it becomes available?
A. Yes. I think so.
Q. What is the system? Once a diagnostic study is done and the results become available, what happens to those results? Who are they forwarded to?
A. After they're interpreted, or --
Q. Yes. Once the --
A. The final report is done.
Q. Yes.
A. Once the final report is done, they generally – a copy would be sent back to the requesting physician.
Q. So in this case, the ultrasound study and the echocardiogram study would have been directed to you once it was completed?
A. That's correct. They would also be available on-line.
Q. Now, do you come in and check the results of studies on a regular basis, even if you don't have an appointment scheduled with the patient?
A. I receive the reports, you know, in my mail, so I would review them as they come in.

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Q. Now, the next time that you saw Earlene Mizsey was on April 30th of 98; is that correct?
A. That's correct.
Q. Now, she was, I believe, in MetroHealth Medical Center's emergency department on April 21st prior to the time that you saw her.
A. Yes.
Q. When a patient comes into the emergency room at MetroHealth Medical Center, does the emergency room contact the primary care physician and notify them that the patient is in the emergency room?
A. It depends on the situation, but, in general, the primary care function, or if it's a night or weekend, the person covering for that individual will be contacted, yes.
Q. She was seen, I believe, on April 21st. Were you contacted in regard to that visit?
A. I don't recall exactly.
Q. I believe she had a complaint about right hand tremors that occurred. Do you have any recollection of that?

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A. Reviewing the note, yes. I mean, I don't recall the exact situation.
Q. She was also seen on April 26th in Metro's emergency room department. Do you recall being notified about that visit?
A. I don't recall exactly. I was looking to see if I had received a phone call from her prior to that, but I don't recall exactly, no.
Q. You don't recall speaking with Dr. Pennington or a Dr. Storoe regarding the April 26th, 98 evaluation of Earlene Mizsey?
A. No, I do not.
Q. I'd like you to take a look at that emergency room visit. I'm going to give you a minute just to look it over for a second.
MS. PETRELLO: 4-26?
MS. TOSTI: Yes.
Q. The temperature that's recorded at that visit is 37.6 Centigrade, which is a little over 99.6 Fahrenheit. Do you consider that to be an elevation in temperature?
A. It's above that which would be considered normal, but it depends often on the situation.

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Q. Well, in Earlene Mizsey's situation, would that be considered a temperature elevation?
A. It's elevated.
Q. When you saw Earlene Mizsey on April 30th, did you have the notes from the emergency room visit of April 26th, 98 available to you?
A. I don't recall.
Q. Well, under normal circumstances, if a patient was seen four days previous in the emergency room, would you have at least the handwritten notes from that visit in the MetroHealth Medical Center chart?
A. That may vary. Not in every situation.
Q. Would they normally send a copy of the emergency room visit to the primary care physicians when a patient was seen in MetroHealth's emergency room?
A. I would get a copy of the dictation, yes.
Q. What about the handwritten materials, would those appear on the patient's chart?
A. They would appear in the patient's hospital chart, yes.

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Q. Now, in the emergency room visit notes, I believe it states in the typewritten note that she stepped out of the shower and had a sudden onset of aching pain radiating from her foot all the way up to her hip. Do you see that?
A. Yes.
Q. When you saw her on the 30th, was she still having severe right foot and leg pain?
A. Yes.
Q. What did you attribute her severe foot and leg pain to?
A. I felt that the pain and description was consistent with peripheral neuropathy. So neuropathic pain.
Q. Would neuropathic pain typically be sudden onset?
A. It can be.
Q. Did you note that she had some changes in her legs which were evidence of venous insufficiency?
A. Yes, I did.
Q. What changes did you note?
A. I don't recall exactly in her situation. Generally, that would refer to discoloration of the lower extremities,

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prominence of veins, sometimes some scaling of the skin in the lower extremities.
Q. Now, you found that the dorsum of her right foot in the pretibial area was tender to touch; correct?
A. Yes.
Q. Was that due to what you thought was neuropathy also?
A. That could be due to neuropathy.
Q. Is that a typical thing that you see with neuropathy, where there is tenderness to the touch?
A. It varies, but that is often found with neuropathy.
Q. How long had she had that right foot and pretibial area tenderness?
A. 1 don't know that area exactly, but she had reported pain in the right foot and leg for the past one to two months.
Q. Now, doctor, your notes from March 13th and March 18th don't note anything in regard to pain, does it?
A. It's not in that note, I agree.
Q. And if she had been complaining of it at the time that you saw her, particularly when

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you did a more thorough assessment on the 18th, isn't it something that you would usually put into your note?
A. I would generally ask the question. The note does not always reflect a hundred percent of what went on in the visit, but that would generally be a question I would ask as part of the assessment.
Q. Now, doctor, in the physical therapy evaluation done on Earlene Mizsey on the 17th, it states that she denies any pain. Do you have any reason to disagree with the physical therapy assessment?
A. I was not there. I don't know what pain that refers to.
Q. And you don't have any recollection of discussing the physical therapist's assessment as indicated in the physical therapist's note; correct?
A. That's correct.
Q. Now, in your note of April 30th, you indicate that she had a ten-pound weight loss since her last visit on March 18th, 98; correct?
A. That's correct.
Q. What did you attribute the cause of

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her weight loss to?
A. She indicated that she had been depressed with a decreased appetite and sort of loss of -- anhedonia, kind of loss of joy in everyday things due to the recent death of a daughter.
Q. Isn't lethargy and loss of appetite, weight loss, also associated with subacute bacterial endocarditis?
A. Lethargy and weight loss may be associated with many things. It's certainly been described as being associated with endocarditis.
Q. Now, your note says that it was related to depression or other etiology. What other etiologies were you referring to?
A. I don't recall at this time, but weight loss and loss of appetite can be due to many different things, but I don't recall exactly what other etiology I meant.
Q. Now, Earlene Mizsey's transthoracic echo was done on April 9th of 1998. When did you receive the report from that test?
A. I don't recall exactly the dictation of that. I believe it said the 15th, so it would have been after that date.

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Q. Now, you first suggested that an echo be done on March 13th, 98.
A. That's correct.
Q. The test was actually done on April 9th, 27 days later.
Did you expect that it would take 27 days to complete an echo on someone to rule out an embolic source for stroke?
A. That's not an unusual time frame for that to occur.
Q. Now, you saw her three weeks after the echo was completed; correct, on April 30th?
A. On the 30th, that's correct.
Q. I'd like you to take a look at the transthoracic echocardiogram report of April 9th --
A. Okay.
Q. -- and tell me what your impressions were after you reviewed that report.
A. I can't tell you my exact impression at that time, because I don't remember, but, you know, looking at it now, it would be that she had some disease of the valve, but that that was about it.
Q. At the bottom of the first page on

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the April 9th, 98 echo report, it indicates the above suggests bioprosthetic deterioration which could be a potential embolic source. TEE may be helpful in further clarifying. Do you see that?
A. Yes.
Q. What would cause her valve to deteriorate after being in place for just four years?
A. Not being a cardiologist or a cardiothoracic surgeon, I don't know exactly. I know it's not unusual for valves to deteriorate overtime.
Q. Would you expect a porcine valve to start deteriorating in four years?
A. I don't know.
Q. Would you agree that prosthetic valve endocarditis would be high on the list of things that could cause a porcine valve to deteriorate?
MR. KILBANE: Objection. You can answer.
A. I believe that would be one thing to consider.
Q. Doctor, did you order any blood cultures when you received this report of the echo which was suggestive of bioprosthetic valve

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deterioration?
A. I did not, no.
Q. Should you have?
A. I'm not quite sure how to answer that. At this point in her care, I don't believe so, no.
Q. When you saw the results of this transthoracic echo, did it raise any concerns in your mind that Earlene Mizsey may have prosthetic valve endocarditis?
A. As I said, it likely could have been on the differential. I was more concerned that the valve was a source of emboli.
Q. And as a source of emboli, it could very well result in another stroke; correct?
A. That's correct.
Q. Now, you are not a cardiologist; correct?
A. That's correct.
Q. When you received the results of this April 9th echocardiogram and saw that it was suggestive of bioprosthetic aortic valve deterioration, did you refer her to a cardiologist for further evaluation?
A. I don't believe so.

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Q. Is there a reason why you did not?
A. I don't recall.
Q. Did you take any action in regard to the results of this echocardiogram?
A. I did order the transesophageal echo.
Q. And why did you do that?
A. Well, I still didn't have a source for potential embolic events, and I thought that that might help to clarify the situation.
Q. So a transesophageal echo may be more sensitive for evaluating the aortic valve?
A. Yes.
Q. Did you make any attempts to have the transesophageal echo done on a high priorty basis?
A. I don't recall.
Q. Wouldn't this be a situation where you would want to have this echocardiogram, the transesophageal echo, done on a high priorty basis considering that there was already suggestion of bioprosthetic valve deterioration which may be a potential source of emboli?
A. At that time, I did not have the feeling that this required an urgent referral for a TEE.

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Q. Now, doctor, in the records, and I'm not sure where they would be in your set, there is a referral to MetroHealth Center's heart and vascular lab. It's a requisition for the transesophageal echo. Do you have a copy of that?
A. Yes.
Q. Did you fill out that form?
A. Yes.
Q. And the date that's --
A. I filled out the upper portion, up to the point where it says date scheduled.
Q. And the date that is scheduled there is May 6th; is that correct?
A. That's correct.
Q. That is not in your handwriting?
A. That's correct.
Q. Who would be responsible for obtaining that date for the scheduling of this test?
A. It would have been the clerk at checkout.
Q. I'msorry.
A. When the patient checks out, they make the appointment at that time.

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Q. Would the clerk report back to you when that particular test was scheduled?
A. They might.
Q. Have you ever said to the clerk, I want this test done as soon as possible, as a high priorty?
A. Yes.
Q. In Earlene Mizsey's case, did you do that with the clerk?
A. I don't recall.
Q. Do you think it's appropriate in Earlene Mizsey's case that she is scheduled for a transesophageal echo for May 6th after you saw her on the 30th and knew that her prosthetic valve was deteriorating?
A. Again, I had no reason to suspect that there was an urgent need for the followup test.
Q. When you saw that transesophageal echo and saw that she had deterioration of her --
A. The transthoracic echo.
Q. The transthoracic echo, and saw that she had results suggestive of bioprosthetic valve deterioration, did you think that her previous stroke was caused by emboli from the valve?

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A. I thought that that might be a source.
MR. KILBANE: We've been going about an hour and-a-half.
(Recess had.)
(Record read.)
Q. Doctor, when you saw her on April 30th of 98, would there be any concern for her health or safety with her waiting until May 6th of 98 for a transesophageal echo considering what you knew on her transthoracic echo?
A. No.
Q. Doctor, if she was having emboli from her aortic valve, that would place her at high risk for stroke; correct?
MS. PETRELLO: Objection.
A. If she were having emboli, that would place her at high risk, yes.
Q. And if she was having emboli from endocarditis on that valve, that would place her at risk for stroke also; correct?
MR. KILBANE: Objection.
MS. PETRELLO: Same here.
A. Emboli from a heart valve can cause a stroke, that's correct.

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Q. Now, you saw her on the 30th and you scheduled her for a return visit for one month; correct?
A. Correct.
Q. Considering that she was going in for a transesophageal echo to determine whether she was having an embolic source for her strokes, why would you wait a month to resee this patient?
A. It would be a reasonable followup for her, given the absence of anything really acute going on.
Q. Now, you received a call from Earlene Mizsey's daughter on May 6th regarding her mother; correct?
A. I believe so, yes.
Q. What time did you receive that call?
A. I don't recall exactly. The note itself is timed 12:40 in the afternoon. I don't have the actual phone call record right in front of me to know exactly what time she called.
Q. Is there a handwritten phone record that you keep in regard to telephone calls such as this?
A. There generally is a handwritten phone call record, yes.

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Q. And in this case --
A. I don't see it in this case.
Q. Where would that normally be kept?
A. Normally that -- if the patient calls, the secretary would take the message, it would be forwarded on to me. Depending upon what the nature of the message is, it would generally then, once that's taken care of, be placed in the chart. So normally that's what would happen.
MS. TOSTI: I'm going to make a request for any written phone, telephone, message in relation to this particular call that hasn't previously been produced.
Q. What did her daughter tell you when she called regarding her mother?
A. What I've written here is she indicated her mother continued to have pain in her legs, severe pain in the legs.
Q. Did she tell you that it was so severe that her mother was unable to get out of the bed?
A. Yes.
Q. What was your assessment of the situation?
A. I had seen her the week before where

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her description was more that of a neuropathy. I thought that the current symptoms were related to that, although it could be, you know, possible that there were some other reasons. She had also been seen in the emergency room for similar pain, whereas she had been assessed by the vascular service, and they felt there was no problem there. But I was concerned about that, you know, about the continued pain.
Q. Now, you mentioned it could be due to other reasons besides neuropathy. What other reasons were you considering?
A. Well, in my note, I mention the fact that she could be having, you know, arterial vascular disease there, so a decrease in blood flow to the legs.
Q. Doctor, would you tell us what you have written in the last three sentences of your note from May 6th *of* 98 beginning "The presence of a porcine valve." Would you read that?
A. Given the presence of a porcine valve in the aortic position and the history of recent CVA, arterial embolism is certainly a possibility. She is scheduled for transesophageal echo on 5-7-98. In the meantime,

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I advised her daughter to visit and watch for evidence of decreased blood supply to the legs or toes. If there's any doubt, I advised her to bring her mother to the emergency department for evaluation and possible initiation of heparin.
Q. Doctor, if there was any question of emboli causing Earlene Mizsey's leg pain, shouldn't you have told Leslie Walter to take her mother to the emergency room immediately?
A. Well, I wasn't there to evaluate her directly at that time, and I was getting this secondhand, so it was a little difficult for me to decide.
I think what I did say was that if she was concerned, if she felt that her mother -- that this was significantly different than what her mother had presented with several days earlier which had been evaluated and not felt to be due to vascular disease, that she should bring her mother in for additional evaluation.
Q. Now, your note says I advised her daughter to visit and watch for any evidence of decreased blood supply to the legs or the toes. Do you know whether Leslie Walter had any medical training to be able to assess whether there was

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decreased blood supply to the legs or the toes?
A. I don't know. Generally in that situation, I will tell people to, you know, to watch for -- to feel the legs to see if they're cold, to look at the color, to see if they're discolored, to see if the pain is decreasing. So I would explain what she should look for, and it really wouldn't require any medical knowledge on her part to do that.
Q. If a patient has a leg pain that continues at rest, does that argue against claudication as the cause of pain?
A. Claudication refers to pain which occurs on exertion, so if it's at rest, it's still -- generally claudication would be due to decreased circulation there. I don't know if claudication – if there is such a thing as claudication at rest.
Q. With a deteriorating heart valve, wasn't Earlene Mizsey at risk for another embolic event?
MR. KILBANE: Objection. I mean, to be fair to the record, it doesn't say she has deterioration. It was a study that's --
A. I was going to say. Suggestive. Can

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you repeat the question?
Q. Considering the fact that her transthoracic echo of April 9th showed results suggestive of a deteriorating heart valve, did you consider Earlene Mizsey to be at risk for another embolic event?
A. She was at risk of either an embolic event, or I think she had generalized atherosclerotic disease of the lower extremities, and that could also have been what was going on.
Q. And based on the phone call, you weren't able to make a determination as to the precise cause of her symptoms, were you?
A. I could not make a diagnosis over the phone, no. However, she had had similar complaints going on for several days, and that would tend to make this -- make an acute embolic event less likely.
Q. Had she had so great of pain that she was unable to get out of bed for the last several days?
A. I don't know.
Q. When you saw her in the office on April 30th, was she complaining of excruciating pain in her legs?

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A. She complained of pain in her legs which she described, as I recall, like a rug burn.
Q. Now, doctor, your note says that she is scheduled for a transesophageal echo on May 7th; correct?
A. That's correct.
Q. We just recently looked at the requisition which actually says that she was scheduled for May 6th. Where did you get the date of May 7th?
A. I don't recall exactly. I don't know.
Q. Now, on the 6th, Mrs. Mizsey's daughter, Leslie, did take her mother to the emergency room, and I believe the records indicate she was seen around 11:30 in the morning complaining of pain that was particularly in her right foot, tibia and calf. Were you notified that she was in the emergency room at Metro?
A. I don't recall. I don't believe so.
Q. Now, if you look at that emergency room note, the note says that the patient was seen by the attending physician. Did you see her in the emergency room?

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A. I did not. That would refer to the emergency room attending physician.
Q. Do you recall having any contact at any point in time with the emergency room regarding Earlene Mizsey's visit there on the 6th of May?
A. No, I do not recall any.
Q. Wouldn't it be typical for them to call the primary care physician and notify them when a patient arrived in the emergency room with a problem such as Earlene Mizsey had?
MR. KILBANE: Objection. If you know what the emergency room does typically.
A. I don't know the emergency room procedures. I know that I'm not always called when a patient goes to the emergency room.
Q. Now, Earlene Mizsey underwent vascular studies on her legs on May 7th of 98, and I believe it was found that she had a blockage in the arteries in the right leg with severe distal ischemia. Were you notified of the May 7th, 98 results of that study?
A. I believe I was notified, but I don't recall exactly when, whether it was that day or the next day.

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Q. Would they normally notify you if they found -- it says right popliteal trifurcation occlusion with severe distal ischemia. When those types of results occur on a vascular study, would you normally be notified as soon as the study was completed?
A. If the physician interpreting the study felt that this was something requiring urgent attention, generally the primary care doc, or myself in this situation, would be notified, yes.
Q. In Earlene Mizsey's case, did this require urgent attention?
A. Not being a vascular surgeon, I don't know, but I believe I was notified of the results.
Q. Did you ever have any contact with the vascular lab to tell them it was possible that she may be having arterial emboli?
A. I don't recall.
Q. Did you order the vascular studies for this patient?
A. I did not order these vascular studies, no.
Q. Who ordered them?

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A. I believe they were ordered from the emergency department where she was seen by a vascular surgery -- by the vascular surgery service.
Q. Did you have any conversations with Dr. Alexander regarding the results of this study?
A. Not that I recall, no.
Q. Earlene Mizsey was taken to Southwest General Hospital, I believe, on May 8th of 98. Were you contacted by the hospital when she went to the emergency room?
A. I was contacted by the emergency room, yes.
Q. And what were you told regarding her condition?
A. I received a call and was told that Ms. Mizsey had been brought there with right sided hemiparesis and some dysphagia, and aphasia, and what appeared to be a stroke. I was asked if we would approve her transfer here for treatment, and I approved the transfer.
Q. Were you notified that she had a fever when she was seen in the emergency room at Southwest General Hospital?

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A. I don't recall exactly, but it is not in my note, which would make me think I was not notified.
Q. Doctor, in your progress note of May 8th referencing the phone call, would you read us the last sentence that you wrote.
A. Sure. Given her course, the possibility of embolization from the aortic valve seems much more likely. She will probably require long term anti-coagulation.
Q. So, doctor, was it your assessment at that point in time that it was likely her stroke was from embolization?
A. My assessment at that time was that she had now had a second neurologic event, which I felt was consistent with recurrent emboli from the aortic valve.
Q. Did you think that the ischemia that she had on the vascular study was also related to emboli?
A. The vascular study indicated that she had long-standing atherosclerotic disease of the lower extremities, and there was no evidence from that study of an acute embolic event.
Q. But, doctor, knowing that she now had

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a secondary stroke, even if you have atherosclerosis, you can still have an embolic event that causes ischemia to a lower extremity; correct?
A. That's correct. However, in her situation, given the pain had been ongoing for some time and she had no signs of an embolic event on her physical exam, I felt that that was a less likely possibility than just chronic atherosclerotic disease.
Q. But even with chronic atherosclerotic disease you can have an embolic event that occludes the arterial circulation that causes acute ischemia to a limb; correct?
A. That's correct. However, in this situation, I felt that was a less likely possibility.
Q. Did you consider vegetative emboli from the prosthetic valve as a possible source of the emboli?
A. I don't recall exactly whether that was --whether I had considered that. I felt that, given her situation and her vascular disease elsewhere, that it was likely that any emboli that might have occurred would more likely

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have been due to atherosclerotic disease.
Q. Was endocarditis within your differential diagnosis?
A. I think it was probably something I was considering, but not at the top of my differential diagnosis.
Q. Now, did you request that Southwest General Hospital arrange for transfer and admission of Earlene Mizsey to Metro on May 8th?
A. I don't recall the exact sequence. Generally in this situation, I would approve transfer, I would call our admitting department to let them know the patient was being admitted, to find a bed for her, and then they would arrange for the transfer from the emergency department.
Q. After you were called by the ER at Southwest General Hospital on May 8th, did you have any further conversations with Earlene Mizsey or her family regarding her care?
A. When she arrived here, I went up to visit her and her family. At that point, I was not involved directly in her care.
Q. Do you remember the content of your conversations with the family when you met with

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them?
A. I do not remember exactly, no.
Q. Did you follow her at all as an attending physician after she was admitted to Metro Hospital?
A. No, I did not.
Q. Since you were her primary care provider, is there a reason why you didn't continue to follow her in the hospital?
A. That's our standard sort of operating mode here. We have dedicated inpatient attendings who supervise the residents and are responsible for the care on the inpatient service. And that's just sort of the way we distribute the work.
Certainly the primary care physician is available for providing additional information or for making suggestions, but most of us tend to remain more in the background and let the inpatient service take care *of* the patient once they're hospitalized.
Q. And aside from the visit that you made right after admission, did you visit her at any other time while she was a patient at Metro?
A. I believe I stopped by several times

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during her stay here. I don't recall the exact circumstances of any of those visits.
Q. Was that more of a courtesy visit?
A. Yes.
Q. Rather than clinical involvement with her care?
A. Yes. Yes. It would be more of a social visit and just to see how things were going.
Q. Did you have any conversations with the physicians that were caring for her during the course of that hospitalization?
A. I don't recall exactly, but it would be normal for me to ask them what was going on, or what they thought or what they had found.
Q. Do you recall specifically speaking to any particular physicians regarding her care?
A. I don't recall.
Q. Did you have any conversations with any of the physicians that treated Earlene Mizsey at Cleveland Clinic after she was discharged from MetroHealth?
A. I received letters from some *of* her physicians there, but I never spoke with them directly, no.

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Q. Do you have copies of those letters?
A. Yes.
Q. How many letters are there?
A. It looks like about four.
Q. Could you tell me who wrote the letters and the dates of those letters.
A. I have a letter from J. Walton Tomford dated June 19th, 1998; another one from Tomford dated May 28th, 1998.
Q. I'm sorry, May 28th?
A. May 28th, 1998.
I have a letter from Donald Underwood dated July 13, 1998, and then this other one is the same one dated May 28th, so maybe there were only three letters. I believe that's it. Those are the only letters I see.
MS. TOSTI: I'm going to make a request for a copy of each of those letters.
MR. KILBANE: Sure. Jeanne, so it doesn't get lost in the shuffle, if you could do me a favor and follow up with a letter, otherwise I'll walk out of here and forget about it.
Q. Did you have any contact with any *of* the physicians that treated Earlene Mizsey while she was a patient at Broadview Multi Care nursing

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home?
A. I'm sorry, with the physicians there?
Q. Yes.
A. No.
Q. Did you have any contact with any of the other medical personnel at Broadview Multi Care?
A. I received a phone call from them about an abnormal lab value, and they had requested some assistance, and that was the only contact I had.
Q. Doctor, if a transesophageal echo had been done before Earlene Mizsey had suffered her second stroke on May 8th of 98, do you have an opinion as to whether it would have likely showed results consistent with valve vegetations from endocarditis?
MR. KILBANE: Objection.
MS. PETRELLO: Objection.
MR. KILBANE: Do you have an opinion, doctor?
A. Seeing as an echo was not done on that day, I don't really know what it would have shown.

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Q. If serial blood cultures off antibiotics had been done after her first stroke on March 10th of 1998, do you have an opinion as to whether they would have likely been positive?
MR. KILBANE: Objection.
MS. PETRELLO: Objection.
A. I have no opinion. They weren't done. Idon't know.
Q. Doctor, if Earlene Mizsey had undergone a transesophageal echo that you ordered and it showed multiple echo densities consistent with valvular vegetations, what course of action would you take?
MR. KILBANE: Objection.
MS. PETRELLO: Objection.
A. Would you like me to hypothesize?
Q. Yes.
A. In that situation, she would have been admitted.
Q. And what would her care have consisted of after admission?
MR. KILBANE: If you can say.
A. I think in general, in that situation, at that point it would be necessary to determine whether this was an infectious cause or

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whether this was just due to thrombin or blood clot formation on the valve. The treatment would be different depending upon what was causing the vegetations.
Q. Would serial blood cultures have been in order?
A. If one wanted to rule out endocarditis at that point, serial blood cultures would be done, yes.
Q. Would referral to a cardiologist have been likely?
A. Yes.
Q. Do you have an opinion as to when Earlene Mizsey developed prosthetic valve endocarditis?
MR. KILBANE: Objection.
MS. PETRELLO: Objection.
MR. KILBANE: You can answer.
A. I don't have an opinion, no.
Q. Do you have an opinion as to whether her first stroke on March 10th of 98 was likely caused by embolization as a result of prosthetic valve endocarditis?
MS. PETRELLO: Objection.
MR. KILBANE: Objection. You can

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answer.
A. I don't believe her first stroke was caused by endocarditis.
Q. What's the basis for that opinion?
A. It's an opinion. I feel there are other things that can explain that without invoking endocarditis.
Q. Well, doctor, I'm asking the basis for your opinion that this was not caused by embolization from endocarditis. So I would like you to enumerate whatever the basis is.
A. We have no evidence that she had an ongoing infection at that point. She potentially had some disease or other explanation such as chronic atherosclerotic disease, hypertension, ongoing hypertension, which might explain the prior stroke. I think that the likelihood that those were causes are greater than that of endocarditis and, therefore, I believe they were the more likely reason to explain that initial stroke.
Q. Do you have an opinion as to whether her acute leg pain on April 26th of 98 and May 6th of 98 when she was seen in Metro's ER was likely caused by embolization from prosthetic

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valve endocarditis?
MR. KILBANE: Objection. If you have an opinion, doctor.
A. Again, I don't think that endocarditis is necessarily the best explanation for that either. Chronic atherosclerotic disease is a much more common cause of lower extremity vascular compromise, and, in fact, also peripheral neuropathy in a diabetic patient is also a good explanation for that, which I think is more common and more likely of an embolic event than endocarditis.
Q. Do you have an opinion as to whether her second stroke on May 8th of 98 was likely caused by embolization from prosthetic valve endocarditis?
MR. KILBANE: Objection.
A. Again, I think that endocarditis is a possibility, but it was --would not be what I would consider the most likely source or most likely cause.
Q. What was the most likely cause?
A. Again, I know the underlying atherosclerotic disease -- I don't think we need to invoke necessarily an endocarditis or

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infectious etiologies for this. There are other causes of embolization which can occur from a prosthetic valve.
Q. And in her case you think the most likely cause was something other than prosthetic valve endocarditis?
A. That's correct.
Q. You are aware she was diagnosed with prosthetic valve endocarditis shortly after her admission to Metro; correct?
A. That's correct. I'm giving an opinion as to what I thought at that time, and not in retrospect.
Q. Doctor, were you notified when Earlene Mizsey died?
A. I was not notified, no.
Q. Did you speak to any of Earlene Mizsey's family after her transfer from MetroHealth Medical Center, which I believe took place on May 15th of 98?
A. I don't believe I did. I know I had one phone conversation about, you know, the abnormal lab value at the nursing home, but I don't recall whether I spoke with the daughter or with the nursing home directly.

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MR. KILBANE: You answered the question, doctor.
Q. And do you have an opinion as to what point in time her condition was irreversible?
MR. KILBANE: Objection.
MS. PETRELLO: Objection.
A. I have no opinion.
Q. Do you have an opinion as to what caused her death?
MR. KILBANE: Objection.
A. I have no opinion.
Q. If her prosthetic valve endocarditis had been treated and cured, do you have an opinion as to what her reasonable life expectancy would have been?
MS. PETRELLO: Objection.
A. I think Ms. Mizsey had several serious conditions which would have limited her life expectancy, so I can't give you an exact estimate, but I think it would have been less than what one would expect for an otherwise healthy woman of the same age.
Q. Do you have any criticism of anyone that rendered care to Earlene Mizsey?
MR. KILBANE: Objection. You can

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answer.
A. I have no criticism of anyone who rendered care.
Q. Do you blame Earlene Mizsey in any way for the complications she suffered?
MR. KILBANE: Objection. You can answer.
A. I never blame a patient for any medical condition.
MS. TOSTI: I don't have any further questions for you.
MS. PETRELLO: Doctor, I just have oneortwo.
EXAMINATION OF DOUGLAS EINSTADTER, M.D.
BY MS. PETRELLO:
Q. You testified earlier, I think it was perhaps in your second visit, that you had requested the emergency room visit from Southwest General Hospital.
A. Actually, that was requested on the first.
Q. I'm sorry, on the first.
A. The urgent care visit, yes.
Q. Do you recall whether or not you ever received those records?

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A. I did receive those records. I don't recall the exact date, but I did receive them.
Q. You may have answered this question.
A. Actually, I received them March 31st.
Q. Do you recall having any conversations with Dr. Graber who was the emergency room physician who evaluated Mrs. Mizsey on, I believe it was, March 10th?
A. I do not recall any conversations.
MS. PETRELLO: I don't have any other questions.
MS. TOSTI: No further questions.
MR. KILBANE: We'll read it.
(Deposition concluded at 11:40 o'clock a.m.)
(Signature not waived.)
- - - - -

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AFFIDAVIT

I have read the foregoing transcript from page 1 through 92 and note the following corrections:

PAGE LINE REQUESTED CHANGE

_____
DOUGLAS EINSTADTER, M.D.

Subscribed and sworn to before me this _____ day of _____, 2000.

_____
Notary Public
My commission expires _____.

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CERTIFICATE

State of Ohio,
SS:
County of Cuyahoga.

I, Karen M. Patterson, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named DOUGLAS EINSTADTER, M.D. was by me first duly sworn to testify to the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony as above set forth was by me reduced to stenotypy, afterwards transcribed, and that the foregoing is a true and correct transcription of the testimony.

I do further certify that this deposition was taken at the time and place specified and was completed without adjournment; that I am not a relative or attorney for either party or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this 8th day of November 2000.

Karen M. Patterson, Notary Public
Within and for the State of Ohio
My commission expires October 7, 2004.

WORD INDEX

CURRICULUM VITAE

Douglas Einstadter, MD, MPH

PERSONAL INFORMATION:

SOCIAL SECURITY # : 368-62-7580
BIRTH DATE: November 27, 1957
PLACE OF BIRTH: San Francisco, California
CITIZENSHIP: USA

HOME ADDRESS: 19000 Lake Road #504
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WORK ADDRESS: MetroHealth Medical Center
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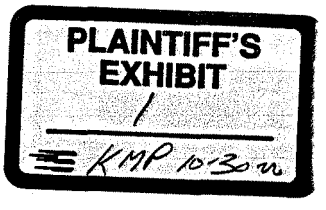
PRESENT ACADEMIC RANK AND POSITION:
Assistant Professor of Medicine, Epidemiology and Biostatistics
Division of General Medicine MetroHealth Medical Center
Center for Health Care Research and Policy
Case Western Reserve University

EDUCATION:

University of Michigan, Ann Arbor, MI		1979 BS Chem. (Honors)
University of Illinois, Chicago, IL		1986 MD (Honors)
University of Washington, Seattle, WA		1992 MPH
Residency:	Internal Medicine Cleveland Metro-General Hospital	1986 - 1989
Chief Resident:	Internal Medicine Cleveland Metro-General Hospital	1989 - 1990
Fellowship:	General Internal Medicine University of Washington, Seattle	1990 - 1992

BOARD CERTIFICATION:

Diplomate American Board of Internal Medicine, # 124057	1989
Diplomate National Board of Medical Examiners,	1987



MEDICAL LICENSURE:
Ohio State Medical License # 35-05-5897

HONORS AND AWARDS:

MD with Honors, University of Illinois	1986
Alpha Omega Alpha	1985
Top 10% of Class Honors University of Illinois	1983
Honors in Chemistry, University of Michigan	1979
Honors in Cellular and Molecular Biology, U. of M.	1979
U of M Club of Ann Arbor Academic Scholarship	1975 - 79

PREVIOUS PROFESSIONAL POSITIONS AND APPOINTMENTS:

Research Analytical Chemist Velsicol Chemical Corporation Ann Arbor, MI	1979-1980
Research Assistant Department of Biological Chemistry University of Michigan	1980-1982
Intern/Resident, Internal Medicine Cleveland Metro-General Hospital	1986-1989
Chief Resident, Internal Medicine Cleveland Metro-General Hospital	1989-1990
Senior Fellow / Acting Instructor University of Washington, Department of Medicine Veterans Administration Hospital, Seattle, WA	1990-1992

EDUCATIONAL ACTIVITIES:
Teaching -- CWRU Medical School:

1995 -	Coordinator, Fundamentals of Medical Decision Making
1997 -	Director, Primary Care Track Research Design Elective
1994 - 95	Co-Coordinator, Fundamentals of Medical Decision Making
1993 - 96	Facilitator, Core Physician Development Program
1993 - 94	Instructor, Fundamentals of Medical Decision Making
1993	Instructor, Case Oriented Problem Solving
1989 - 90	Instructor, Physical Diagnosis

Dissertation Committees

1998 - 2000	Leo Russo -- Epidemiology
1997 - 1999	Zhong Yuan, MD -- Epidemiology
1996 - 97	Reshmi M. Siddique -- Epidemiology

MS Committees

1998	Feng-Hwa Lu, MD -- Epidemiology
1997 - 98	Catherine Curley, MD -- Health Services Research

Faculty Advisor
Research Consultant to Primary Care Track Residents, MHMC

Teaching -- CME:

May 13,2000, Cleveland, OH
Prevention of Venous Thromboembolism in the Surgical Patient. Medical Consultation Seminar.

February 27, 1998 , Cleveland, OH
The Language of Diagnostic Information. Controversies in Preventive Services,

November 15,1995, Cleveland, OH
Community-Based Preventive Medicine: You Can Make a Difference. Medicine Fall 1995

October, 1993, Cleveland, OH
Introduction to the International Normalized Ratio. MHMC Medical Update.

Scientific Reviews:

Journal of General Internal Medicine	1992 - 2000
Medical Care	1993 - 94
Archives of Internal Medicine	1993
International Journal for Quality Improvement	1998
American Journal of Managed Care	1998

INSTITUTIONAL, DEPARTMENTAL, AND DIVISIONAL ADMINISTRATIVE RESPONSIBILITIES, COMMITTEE MEMBERSHIPS, AND OTHER ACTIVITIES:

Academic Activities:

1998	NLM Medical Informatics Fellowship
1996	Co-Chairman, Clinical Epidemiology Abstract Review Committee, Society of General Internal Medicine, National Meeting
1996	Co-Chairman, Abstract Review Committee, Society of General Internal Medicine, Midwest Chapter

1995	Chairman, Abstract Review Committee, Society of General Internal Medicine, Midwest Chapter
1994 - 95	Abstract Review Committee, Society of General Internal Medicine, Midwest Chapter
1993 - 94	Health Services Research Abstract Review Committee, Society of General Internal Medicine, National Meeting
1994	External Reviewer, RAND Corporation

Committees:

1999 -	Curriculum Review Steering Committee, CWRU
1998 -	CATALYST Primary Care Initiative Task Force
1997 -	Year One Comprehensive Exam Committee, CWRU
1995- 98	Clinical Utilization Management Process Team Steering Committee
1995-96	Department of Medicine Quality Assurance Committee
1995-96	Chairman, Stepdown Bed Utilization Process Team
1994-	Intern Selection Committee, MHMC
1992-	Medicine Research Committee, MHMC
1992-	Medical Records Subcommittee, MHMC
1989-90	Ethics Committee, MHMC
1987-90	Residency Review committee, MHMC
1989-90	Quality Assurance committee, MHMC
1989-90	Pharmacy and Therapeutics Committee, MHMC
1987-88	President, House Staff Association, MHMC
1987-88	House Staff Subcommittee, MHMC
1987-88	Medical House Staff Environment Committee, MHMC

Other Activities

1997 -	Clinical Quality Improvement Committee, Medical Mutual of Ohio
1997 -	Statistical Consultant, Medical Mutual of Ohio
1997 -	Research Review Committee, Diabetes Association of Greater Cleveland

PROFESSIONAL AND SOCIETY MEMBERSHIPS:

Fellow American College of Physicians
Member Society of General Internal Medicine
Alpha Omega Alpha Honor Society
Phi Delta Alpha German Honor Society

PRESENTATIONS AT NATIONAL MEETINGS:

Finding Treasure in the Safety-Net: Outcomes for Medicaid and Other Patients Hospitalized in Cleveland 1992 - 1995. SGIM National Meeting. San Francisco, CA. May, 1999

Source and Outcomes of Care for Adult Medicaid and Other Patients Hospitalized in Cleveland: 1993 - 1995. Society of General Internal Medicine, Poster Session, National Meeting, Chicago, IL April, 1998.

From Hospital to Where? American Public Health Association, National Meeting. Indianapolis, IN, November 12,1997.

Discharge Destination after Joint Replacement Surgery: Who Goes Home? Society of General Internal Medicine, Poster Session, National Meeting, Washington, DC May, 1997.

Outcomes of Hospitalization: Trends in an era of Change. Society of General Internal Medicine / American Federation for Clinical Research Combined Session, Washington, DC, May, 1996.

Thromboembolic Complications of Lower Extremity Fracture Repair: A Regional Analysis. Society of General Internal Medicine, National Meeting, San Diego, CA May, 1995

Effect of a Nurse Case Manager on Post-Discharge Follow-up -- A Controlled Trial. Society of General Internal Medicine, National Meeting, Washington, DC May, 1994.

Variation in Cervical Spine Surgery Rates in Washington State: Will Experience in the Lower Back Become a Pain in the Neck? Society of General Internal Medicine, National Meeting, Washington, DC May, 1992.

INTRAMURAL PRESENTATIONS:

Critical Evaluation of the Literature. MHMC Resident Presentation.	October 17, 2000
Sensitivity and Specificity: The Language of diagnostic Information. MHMC Resident Presentation.	October 17,2000
Critical Appraisal of the Literature. Cardiology Resident Seminar.	Sept. 4, 1998
How to Read and Interpret the Literature. MHMC Resident Presentation.	Sept. 5, 1997
Thromboembolism in Pregnancy. OB/GYN Grand rounds. MHMC	Jan 17, 1996

RESEARCH GRANTS AWARDED:

Comparison of Outcomes for Medicaid and Others Hospitalized in Greater Cleveland
Ohio Department of Human Services (Einstadter, D) 8/1/96 to 7/31/99

Rates of Readmission Among Medicare Beneficiaries
AG-10418-04 (Einstadter, D) 12/1/95 to 11/30/96
Pepper Pilot Project

BIBLIOGRAPHY:

Publications - Journal Articles:

Einstadter D, Kent DL, Fihn SD, and Deyo RA. Variation in the Rate of Cervical Spine Surgery in Washington State. Medical Care 1993;31:711-718.

Einstadter D, Cebul RD, and Franta PR. Effect of a Nurse Case-Manager on Post-Discharge Follow-up. J Gen Intern Med 1996;11:684-688.

Hoffman RM, Einstadter D, and Kroenke K. A Rational Approach to the Dizzy Patient. J. Clin. Outcomes Med 1997;4:33-41.

Yuan 2, Bowlin S, Einstadter D, et. al. Atrial Fibrillation as a Risk Factor for Embolic and Non-Embolic Stroke: A Population-based Cohort Study in the Elderly. Am J Public Health 1998;88:395-400.

Hoffman RM, Einstadter D, Kroenke K. Evaluating Dizziness. Am J. Med. 1999;107:468-478.

Kroenke K, Hoffman RM, Einstadter D. How common are the various causes of dizziness: a critical review of the literature. South Med J. 2000;93:160-167.

Yuan 2, Cooper GS, Einstadter D, Cebul RD, Rimm AA. The Association Between Hospital Type and Mortality and Length of Stay. Medical Care 2000;38:231-245

Yuan Z, Dawson N, Cooper GS, Einstadter D, Cebul R, Rimm AA. Effect of Alcohol-related Disease on Hip Fracture and Mortality: A Retrospective Cohort Study of 876,337 Hospitalized Medicare Beneficiaries. Am J Epidemiology (In Press).

Publications - Abstracts, Editorials, Book Chapters

Einstadter D, Fihn SD, Kent DL, and Deyo RA. Variation in Cervical Spine Surgery Rates in Washington State: Will Experience in the Lower Back Become a Pain in the Neck? Clin Research 1992;40(2):580A. (Abstract)

Einstadter D. "Cholesterol Screening" in McGee SR, and Fihn SD (eds): Outpatient Medicine. W.B. Saunders Company, Philadelphia, 1992. (Book Chapter)

Einstadter D, Cebul RD, and Franta P. Effect of a Nurse Case Manager on Post-Discharge Follow-up -- A Controlled Trial. J Gen Intern Med 1994;9(supp 2):51A. (Abstract)

Yuan Z, Bowlin S, Einstadter D, et. al. Atrial Fibrillation as a Risk Factor for Embolic and Non-Embolic Stroke: A Population-based Cohort Study in the Elderly. Medical Decision Making 1994;14:444. (Abstract)

Einstadter D, Cebul RD, Rosenthal GE, and Harper DL. Thromboembolic Complications of Lower Extremity Fracture Repair: A Regional Analysis. J Gen Intern Med 1995; 10(Supp):65A. (Abstract)

Einstadter D, Cebul RD, and Rimm AA. Outcomes of Hospitalization: Trends in an Era of Change. Journal of Investigative Medicine 1995;43:10. (Abstract)

Einstadter D., Kwoh CK, and Snow R. Discharge Destination after Joint Replacement Surgery: Who Goes Home? Journal of Investigative Medicine 1996;44:363A (Abstract)

Einstadter D., Kwoh CK, and Snow R. Discharge Destination after Joint Replacement Surgery: Who Goes Home? J. Gen Int Med. 1997;12(suppl):69A. (Abstract)

Einstadter D, Cebul RD. Source and Outcomes of Care for Adult Medicaid and Other Patients Hospitalized in Cleveland: 1993 - 1995. J. Gen Int Med. 1998;13(suppl 1):44A (Abstract)

Einstadter D, and Cebul RD. Source and Outcomes of Care for Adult Medicaid and Other Patients Hospitalized in Cleveland: 1993 - 1995. J. Gen Int Med. 1998;13(suppl 1):44A (Abstract)

Wolfe SA, Dawson NV, Thomas CL, Einstadter D, Cebul RD, Parran TV. A Novel Method of Screening for Alcohol Use Disorders in a Primary Care Clinic. J. Gen Int Med. 2000;15(suppl 1).

Eiserman JM, Dawson NV, Thomas C, McCormick R, Parren T, Einstadter D, Cebul RD. Better Methods Are Needed for Screening and Management of Alcohol Problems in Primary Care. J. Gen Int Med. 2000;15(suppl 1):64.

Cebul RD, Sudano J, Jean-Baptiste R, Einstadter D. Impact of Medicaid Managed Care in a Community: Focus on Safety Net Physicians. J. Gen Int Med. 2000;15(suppl 1):105.