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| <p style="text-align: right;">Page 1</p> <p>1 IN THE COURT OF COMMON PLEAS</p> <p>2</p> <p>3 OF CUYAHOGA COUNTY, OHIO</p> <p>4</p> <p>5 *****</p> <p>6</p> <p>7 LESLIE WALTER, ADMIN, etc.,</p> <p>8</p> <p>9 Plaintiff,</p> <p>10</p> <p>11 vs Case No. 393899</p> <p>12</p> <p>13 METROHEALTH MEDICAL CENTER,</p> <p>14 et al,</p> <p>15</p> <p>16 Defendants.</p> <p>17</p> <p>18</p> <p>19 *****</p> <p>20 DEPOSITION OF RICHARD FRIRES, M.D.</p> <p>21 THURSDAY, JUNE 28, 2001</p> <p>22</p> <p>23 *****</p> <p>24 Deposition of RICHARD FRIRES, M.D., a</p> <p>25 Witness herein, called by counsel on behalf of</p> | <p style="text-align: right;">Page 3</p> <p>1 APPEARANCES:</p> <p>2 On behalf of the Plaintiff</p> <p>3 Becker & Mishkind Co., L.P.A.</p> <p>4 JEANNE M. TOSTI, ESQ.</p> <p>5 1660 West Second Street</p> <p>6 660 Skylight Office Tower</p> <p>7 Cleveland, Ohio 44113</p> <p>8 216-241-2600</p> <p>9</p> <p>10</p> <p>11 On behalf of the Defendant</p> <p>12 Reminger & Reminger Co., L.P.A.</p> <p>13 THOMAS A. KILBANE, ESQ.</p> <p>14 The 113 St. Clair Building</p> <p>15 Cleveland, Ohio 44114</p> <p>16 216-687-1311</p> <p>17</p> <p>18</p> <p>19</p> <p>20 *****</p> <p>21</p> <p>22</p> <p>23</p> <p>24</p> <p>25</p> |
| <p style="text-align: right;">Page 2</p> <p>1 the Plaintiff for examination under the statute,</p> <p>2 taken before me, Vivian L. Gordon, a Registered</p> <p>3 Diplomate Reporter and Notary Public in and for</p> <p>4 the State of Ohio, pursuant to agreement of</p> <p>5 counsel, at the offices of Huron Hospital, 13951</p> <p>6 Terrace Road, Cleveland, Ohio, commencing at</p> <p>7 7:00 o'clock p.m. on the day and date above set</p> <p>8 forth.</p> <p>9</p> <p>10</p> <p>11</p> <p>12</p> <p>13</p> <p>14</p> <p>15</p> <p>16</p> <p>17</p> <p>18</p> <p>19</p> <p>20</p> <p>21</p> <p>22</p> <p>23</p> <p>24</p> <p>25</p> | <p style="text-align: right;">Page 4</p> <p>1 RICHARD FRIRES, M.D., a witness herein,</p> <p>2 called for examination, as provided by the Ohio</p> <p>3 Rules of Civil Procedure, being by me first duly</p> <p>4 sworn, as hereinafter certified, was deposed and</p> <p>5 said as follows:</p> <p>6 EXAMINATION OF RICHARD FRIRES, M.D.</p> <p>7 BY MS. TOSTI:</p> <p>8 Q. Doctor, would you please state your</p> <p>9 full name for us.</p> <p>10 A. Dr. Richard Frres.</p> <p>11 Q. What is your business address?</p> <p>12 A. Emergency department, Huron Hospital,</p> <p>13 13951 Terrace Road, East Cleveland, Ohio, 44112.</p> <p>14 Q. Have you ever had your deposition</p> <p>15 taken before?</p> <p>16 A. Yes.</p> <p>17 Q. How many times?</p> <p>18 A. I do not track that precisely. I</p> <p>19 could give you a ballpark estimate.</p> <p>20 Q. If you would, please.</p> <p>21 A. I would say ten to 15 times. Ten to</p> <p>22 20, perhaps.</p> <p>23 Q. I'm going to go over some of the</p> <p>24 ground rules. I am sure you have had a chance</p> <p>25 to talk w/lt defense counsel.</p> |

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| <p style="text-align: right;">Page 5</p> <p>1 This is a question and answer 2 session. It's under oath and it's Important 3 that you understand the questions that I ask 4 you. 5 If you don't understand the 6 questions, just let me know and I'll be happy to 7 repeat the question or to rephrase it; 8 otherwise, I'm going to assume that you 9 understood my question and that you are able to 10 answer it. 11 it's important that you give all of 12 your answers verbally because our court reporter 13 can't take down head nods or hand motions, and 14 if at any point in time you would like to refer 15 to the medical records, please feel free to do 16 so. 17 At some point defense counsel also 18 may chose to enter an objection. You are still 19 required to answer my question unless for some 20 reason he instructs you not to do so. 21 Do you understand those instructions? 22 A. Yes. 23 Q. Doctor, the materials that you have 24 before you on the table, is that your complete 25 file on this case?</p> | <p style="text-align: right;">Page 7</p> <p>1 medical/legal matters. 2 MR. KILBANE: Just from a 3 housekeeping standpoint, if you could send me a 4 letter on that. By the time I walk out of this 5 deposition, I will have forgotten you requested 6 it. 7 Q. Have you offered your services as a 8 medical/legal expert prior to this case? 9 A. Yes. 10 Q. How many times have you offered your 11 services in a medical/legal matter? 12 A. I really don't track the precise 13 number. I could give you an estimate. 14 Q. Okay. 15 A. I have been doing medical expert 16 witness work for at least ten years, and I have 17 been asked to review cases during that time 18 period. I would estimate roughly that it has 19 varied between five and 15 cases per year. 20 Q. How many files do you currently have 21 that you are reviewing? 22 A. I am really not tracking that. I 23 would say roughly between five and eight cases. 24 Q. What proportion of the medical/legal 25 matters on which you have been consulted have</p> |
| <p style="text-align: right;">Page 6</p> <p>1 A. Yes. 2 Q. Has anything been removed from your 3 file? 4 A. No. 5 Q. Is there anything that you've 6 reviewed that you didn't bring with you today? 7 A. No. 8 Q. Have you been provided any fact 9 summaries or depo summaries or anything like 10 that? 11 A. No. 12 Q. Have you provided Mr. Kilbane or his 13 law firm with any bills for your services to 14 date? 15 A. Yes. 16 Q. Are those contained in your materials 17 in front of you? 18 A. No. 19 Q. Where are those? 20 A. I believe I have a copy in my file at 21 home. 22 MS. TOSTI: I would make a request 23 for those. 24 Q. Doctor, I would like to talk to you a 25 little bit about your experience in</p> | <p style="text-align: right;">Page 8</p> <p>1 been for plaintiff and approximately what 2 proportion for defendant? 3 A. Approximately, it's about a 50-50 4 mix. 5 Q. And of the cases in which you were 6 consulted by plaintiff, how many times have you 7 found substandard care? 8 A. I have not tracked that result. I 9 can't answer that. 10 Q. Now, doctor, you said you had your 11 deposition taken anywhere from about ten to 20 12 times. Were all of those as an expert? 13 A. Yes. 14 Q. Have you ever testified at trial as 15 an expert? 16 A. Yes. 17 Q. Approximately how many times have you 18 done that? 19 A. I have testified at trial before a 20 jury twice in the past, and had one videotaped 21 deposition, testimony, that was utilized at the 22 trial. 23 Q. The two times that you testified live 24 at trial, was that for plaintiff or for 25 defendant?</p> |

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| <p style="text-align: right;">Page 9</p> <p>1 A. One of each.</p> <p>2 Q. What is your charge for consultation</p> <p>3 on legal matters?</p> <p>4 A. My fee is \$350 per hour for reviewing</p> <p>5 cases and reading depositions.</p> <p>6 Q. And what is your charge for</p> <p>7 deposition testimony?</p> <p>8 A. The same.</p> <p>9 Q. And how about for trial?</p> <p>10 A. For trial I charge the same hourly</p> <p>11 rate, but for a minimum of a four hour day.</p> <p>12 Q. Have you ever provided your name to a</p> <p>13 professional service or medical/legal consulting</p> <p>14 firm indicating that you were available to do</p> <p>15 medical/legal consultations?</p> <p>16 A. No.</p> <p>17 Q. Other than this case, have you ever</p> <p>18 consulted on a medical/legal matter for</p> <p>19 Mr. Kilbane's law firm?</p> <p>20 A. Yes.</p> <p>21 Q. How many times have you done that?</p> <p>22 A. I cannot even give you an estimate.</p> <p>23 I would say six to 12 times over the years.</p> <p>24 Q. Have you ever worked with Mr. Klibane</p> <p>25 before?</p> | <p style="text-align: right;">Page 11</p> <p>1 A. I believe so.</p> <p>2 Q. You have to answer verbally so that</p> <p>3 she can take it down.</p> <p>4 I take it none of those cases are</p> <p>5 currently pending; is that correct?</p> <p>6 A. Correct. I was dismissed in each of</p> <p>7 those cases prior to any depositions.</p> <p>8 Q. Could you tell me what the allegation</p> <p>9 of negligence was in those cases?</p> <p>10 A. I don't remember a single one of</p> <p>11 them, I'm sorry. They were the type of cases</p> <p>12 that involved blanket naming of a series of</p> <p>13 physicians that at some point in time of care</p> <p>14 was involved with these patients and I really</p> <p>15 don't remember the details.</p> <p>16 Q. Doctor, have you been asked by</p> <p>17 Mr. Kilbane to arrange your schedule to testify</p> <p>18 in the trial of this matter?</p> <p>19 A. Yes.</p> <p>20 Q. Do you have a copy of your curriculum</p> <p>21 vitae with you?</p> <p>22 A. No, I do not.</p> <p>23 Q. Doctor, what is your date of birth?</p> <p>24 A. July 7th, 1949.</p> <p>25 Q. Where did you go to medical school?</p> |
| <p style="text-align: right;">Page 10</p> <p>1 A. I believe so, yes, on a peripheral</p> <p>2 basis. He was a co-attorney on one case that I</p> <p>3 was involved with.</p> <p>4 Q. Do you know how it is that he or his</p> <p>5 law firm came to consult you in regard to this</p> <p>6 case?</p> <p>7 A. No.</p> <p>8 Q. When were you first contacted?</p> <p>9 A. I believe I was originally contacted</p> <p>10 about this case in June of the year 2000, about</p> <p>11 a year ago.</p> <p>12 Q. Have you ever been named as a</p> <p>13 defendant in a medical negligence case?</p> <p>14 A. Yes.</p> <p>15 Q. How many times?</p> <p>16 A. I believe three times in the past.</p> <p>17 Q. When were those cases filed,</p> <p>18 approximately?</p> <p>19 A. I would say the first two cases were</p> <p>20 filed ten to 13 years ago, and the most recent</p> <p>21 case was in 1995.</p> <p>22 Q. Were those cases filed here in</p> <p>23 Cleveland?</p> <p>24 A. I believe so.</p> <p>25 Q. Cuyahoga County?</p> | <p style="text-align: right;">Page 12</p> <p>1 A. I graduated from Rush Medical</p> <p>2 College.</p> <p>3 Q. And what year was that?</p> <p>4 A. 1977.</p> <p>5 Q. What was your undergraduate degree</p> <p>6 in?</p> <p>7 A. I had a BA in psychology from the</p> <p>8 University of Wisconsin, Madison.</p> <p>9 Q. Did you do a residency after you</p> <p>10 completed medical school?</p> <p>11 A. Yes.</p> <p>12 Q. Where did you do a residency?</p> <p>13 A. At Cook County Hospital, Chicago,</p> <p>14 Illinois.</p> <p>15 Q. And what area of medicine was your</p> <p>16 residency in?</p> <p>17 A. Specialty of family practice.</p> <p>18 Q. How long was that residency?</p> <p>19 A. Three years.</p> <p>20 Q. And would that be from 1977 until</p> <p>21 1980?</p> <p>22 A. Correct.</p> <p>23 Q. And you completed the full residency</p> <p>24 period?</p> <p>25 A. Yes.</p> |

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| <p style="text-align: right;">Page 13</p> <p>1 Q. Following that residency, did you do 2 any other residencies or fellowships? 3 A. No. 4 Q. Do you have any particular training 5 in emergency medicine? 6 A. Via clinical practice and experience, 7 yes, but no formalized residency program. 8 Q. You are licensed in the State of Ohio 9 to practice medicine; is that correct? 10 A. Yes. 11 Q. When did you become licensed in Ohio? 12 A. In 1983. 13 Q. Do you currently hold a license in 14 any other state? 15 A. Yes. 16 Q. What other states? 17 A. The state of Oregon. 18 Q. Have you ever held a license in any 19 other states? 20 A. Just in Illinois, during my time 21 there. 22 Q. Has your license in Ohio or any other 23 state ever been suspended, revoked or called 24 into question? 25 A. No.</p> | <p style="text-align: right;">Page 15</p> <p>1 exam, it required 5,000 clinical hours in the 2 emergency department, or seven years of 3 experience. 4 Q. And did you pass board certifications 5 on your first attempt? 6 A. Yes. 7 Q. Now, doctor, could you just give me 8 an overview of your work history after 9 completing your family practice residency? 10 A. Yes. After completing residency, I 11 began to work as an emergency physician 12 immediately within the Chicago area. 13 For the following three years I 14 worked as an emergency department physician at 15 several hospitals within the Chicago land area. 16 In 1983, I moved back to Cleveland, 17 Ohio, which was my original home, and began to 18 practice here at Huron Hospital, and I have been 19 here since. 20 Q. Since you came back to Cleveland, has 21 all of your clinical work been in the field of 22 emergency medicine? 23 A. Yes. 24 Q. Do you do any family practice 2s medicine now?</p> |
| <p style="text-align: right;">Page 14</p> <p>1 Q. Now, doctor, you are not board 2 certified in any area of medicine; is that 3 correct? 4 A. No, that's not correct. 5 Q. Let me reask it. Are you board 6 certified in any area of medicine? 7 A. Yes. 8 Q. What area? 9 A. I'm double boarded. I have board 10 certification in the specialty of family 11 practice, and I also have board certification in 12 emergency medicine. 13 Q. When did you obtain your board 14 certification in family practice? 15 A. The family practice board 16 certification was obtained in 1980. 17 Q. And in emergency medicine? 18 A. In 1986. 19 Q. And I take it the board certification 20 for emergency medicine doesn't require any type 21 of residency requirement in emergency medicine? 22 A. No. 23 Q. What type of requirement does it 24 require as far as clinical practice? 25 A. At the time that I qualified for that</p> | <p style="text-align: right;">Page 16</p> <p>1 A. No. 2 Q. Do you hold any administrative 3 positions currently? 4 A. Yes. 5 Q. What are your administrative 6 positions? 7 A. I'm the chairman of the department of 8 emergency medicine here at Huron Hospital. I 9 also have some administrative responsibility in 10 terms of medical staff affairs. 11 Q. Any particular titles that you hold 12 in regard to that? 13 A. I'm the treasurer for the medical 14 staff, and past chief of staff at this 15 institution. I also am chairman of the 16 continuing medical education program here. 17 Q. Doctor, I do not have a copy of your 18 curriculum vitae. Do you have any type of 19 professional publications that you have authored 20 or co-authored? 21 A. No. 22 Q. Who is your present employer? 23 A. Lakeland Emergency Associates. 24 Q. Do you provide professional services 25 for any other entity besides Lakeland Emergency</p> |

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| <p style="text-align: right;">Page 17</p> <p>1 Associates?</p> <p>2 A. No.</p> <p>3 Q. How long have you been an employee of</p> <p>4 Lakeland Emergency Associates?</p> <p>5 A. Since 1988.</p> <p>6 Q. Are all of your emergency services</p> <p>7 provided here at Huron Hospital's main campus?</p> <p>8 A. No.</p> <p>9 Q. Where else do you provide emergency</p> <p>10 services?</p> <p>11 A. I have staff privileges for emergency</p> <p>12 medicine at Hillcrest Hospital and at South</p> <p>13 Pointe Hospital. I periodically provide</p> <p>14 emergency services at those institutions, as</p> <p>15 well.</p> <p>16 Q. How often are you going to Hillcrest</p> <p>17 and South Pointe, just on average?</p> <p>18 A. In the past, it was with minor</p> <p>19 frequency. Lately, in the last year or two, or</p> <p>20 three, I don't believe I have even pulled a</p> <p>21 shift there, so it's very rarely.</p> <p>22 Q. Now, I would like you to describe for</p> <p>23 me your professional responsibilities and how</p> <p>24 you divide your professional time. What</p> <p>25 percentage of your professional time is spent in</p> | <p style="text-align: right;">Page 19</p> <p>1 Q. Are there any particular textbooks</p> <p>2 that you consider to be the best or the leading</p> <p>3 textbook in emergency medicine?</p> <p>4 A. No.</p> <p>5 Q. Is there any that you refer to on a</p> <p>6 regular basis in your own practice?</p> <p>7 A. No.</p> <p>8 Q. Doctor, I have what's been marked</p> <p>9 here as Plaintiff's Exhibit I. I would ask if</p> <p>10 you would Just identify that for us, please.</p> <p>11 A. This is a medical report,</p> <p>12 consultative report that I wrote addressed to</p> <p>13 Mr. Thomas Kilbane dated March 27th, 2001.</p> <p>14 Q. And that is in reference to your</p> <p>15 opinions in this case; is that correct?</p> <p>16 A. Correct.</p> <p>17 Q. Did you provide counsel with any</p> <p>18 drafts of this report prior to its final</p> <p>19 preparation?</p> <p>20 A. No.</p> <p>21 Q. Is this the only report that you have</p> <p>22 authored on this case?</p> <p>23 A. Yes.</p> <p>24 Q. Did you meet with anyone to discuss</p> <p>25 the content of your report before it was</p> |
| <p style="text-align: right;">Page 18</p> <p>1 the clinical practice of emergency medicine?</p> <p>2 A. I'm in the clinical practice of</p> <p>3 emergency medicine about 85 percent of my time.</p> <p>4 The rest of the time is spent with various</p> <p>5 administrative functions.</p> <p>6 Q. Have you ever been involved in any</p> <p>7 research dealing with the subject matter of</p> <p>8 bacterial endocarditis, prosthetic heart valves,</p> <p>9 echocardiography?</p> <p>10 A. No.</p> <p>11 Q. Doctor, you do not hold yourself out</p> <p>12 as an expert in the area of cardiology, do you?</p> <p>13 A. No.</p> <p>14 Q. Vascular surgery or vascular</p> <p>15 medicine?</p> <p>16 A. No.</p> <p>17 Q. Or neurology?</p> <p>18 A. No.</p> <p>19 Q. Has your medical license ever been</p> <p>20 suspended, revoked or called into question?</p> <p>21 A. No.</p> <p>22 Q. Have you ever lectured or taught on</p> <p>23 the subject matter of bacterial endocarditis or</p> <p>24 prosthetic valve endocarditis?</p> <p>25 A. I don't recall.</p> | <p style="text-align: right;">Page 20</p> <p>1 finalized?</p> <p>2 A. No.</p> <p>3 Q. Does your March 27th report summarize</p> <p>4 all of the opinions that you currently hold in</p> <p>5 this case?</p> <p>6 A. To the best of my knowledge, yes.</p> <p>7 Q. And the opinions that you have stated</p> <p>8 in your March 27th report, do you still maintain</p> <p>9 all of those opinions?</p> <p>10 A. Yes.</p> <p>11 Q. Do you at this time intend to do any</p> <p>12 additional work or review any additional</p> <p>13 materials in this case before trial?</p> <p>14 A. I do not intend to do so. If I'm</p> <p>15 asked by counsel to review something else prior</p> <p>16 to trial, I would do as he requests.</p> <p>17 Q. Now, doctor, you have referenced in</p> <p>18 your report a number of materials that you</p> <p>19 reviewed prior to offering your report; correct?</p> <p>20 A. Correct.</p> <p>21 Q. I'm not going to go through those,</p> <p>22 but I note that there are a couple things that</p> <p>23 are available in this case that I don't see</p> <p>24 here.</p> <p>25 I don't see a reference to the</p> |

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| <p>Page 21</p> <p>1 Southwest General Hospital March 10th, '98 2 records, and I'm wondering if you reviewed those 3 and that they just aren't mentioned here in your 4 report? 5 A. Southwest General Hospital emergency 6 room visit report is listed as the fifth item. 7 Q. For March 10th of '98, I don't see 8 that. 9 MR. KILBANE: To clear up some 10 confusion, there is a copy of that chart as part 11 of the outpatient chart from Metro. I know he 12 has seen it. 13 MS. TOSTI: So obviously, it's in 14 his Metro records then. 15 THE WITNESS: Right. 16 Q. And I don't see a deposition of 17 Dr. Alexander, who is the vascular surgeon in 18 this case. Did you review that deposition? 19 A. I have not received that deposition 20 to review. 21 Q. And I also do not see Cleveland 22 Clinic records or records from Broadview 23 Multicare, which is the nursing home. Have you 24 reviewed any records from those? 25 A. This volume contains some records</p> | <p>Page 23</p> <p>1 any textbooks? 2 A. Repeat that, please. 3 Q. in formulating your opinions, did you 4 refer to any medical literature, journal 5 articles, textbooks, that type of thing? 6 A. I believe a year ago, some time after 7 I initially received the records to review, I 8 did review a few case reports regarding 9 endocarditis and reviewed some of the topics in 10 some general medical textbooks. 11 Q. Can you tell me what those materials 12 were that you reviewed? 13 A. I really can't. I did not maintain 14 those or I don't even recall which sources they 15 were. 16 Q. As you sit here today, are there any 17 particular publications that you believe have 18 particular significance to the issues in this 19 case? 20 A. No. 21 Q. in the preparation of your report, 22 did you consult with any physicians at any time? 23 A. No. 24 Q. Doctor, prior to accepting this case 25 for review, did you have any contact with any of</p> |
| <p>Page 22</p> <p>1 from the Broadview Multicare facility, as well 2 as some Cleveland Clinic records. 3 Q. Did you have those before you 4 authored your report? 5 A. No. 6 Q. So you have seen those since the time 7 of your report? 8 A. Yes. 9 Q. Have you reviewed the reports of 10 defense experts, Dr. Armitage and Dr. Lesnfsky? 11 A. No. 12 Q. Have you since the time of your 13 report reviewed the depositions of Dr. Rozman, 14 Dr. Brachfeld, or Dr. Baird? 15 A. Yes, all three. 16 Q. Now, at any time when you are 17 reviewing the materials in this case, did you 18 ask defense counsel to provide you with anything 19 additional? 20 A. No. 21 Q. Have you read all the depositions 22 that you have been provided? 23 A. Yes. 24 Q. In formulating your opinions on this 25 case, did you refer to any medical literature,</p> | <p>Page 24</p> <p>1 the medical providers named in Earline Miwy's 2 records? 3 A. No. 4 Q. Have you ever had any contact with 5 any of the experts that have been identified in 6 this case? And those would include Dr. Claude 7 Brachfeld, Dr. Ian Baird, Dr. Raymond Rozman, 8 Dr. Edward Lefnesky and Dr. Keith Armitage. 9 A. Yes. 10 Q. And which of those have you had some 11 contact with? 12 A. I have had minimal contact with 13 Dr. Keith Armitage. 14 Q. Any of the others? 15 A. No. 16 Q. And can you just tell me in what 17 manner you had contact with Dr. Armitage? 18 A. Yes. I am currently a member of the 19 Northeast Ohio Society for Emergency Medicine, 20 which is a society of emergency physicians in 21 the area, and, periodically, we recruit 22 prominent physicians in the area to give talk, 23 to our group on various subjects. 24 And I believe that on at least one, 25 perhaps two, occasions he was one of the</p> |

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| <p style="text-align: right;">Page 25</p> <p>1 featured speakers at our meetings. 2 Q. Was the person that recruited him to 3 speak at your meeting? 4 A. No. 5 Q. Have you ever had a professional 6 affiliation with MetroHealth Medical Center? 7 A. Perhaps. 8 Q. Well, would you please define that a 9 little more thoroughly for me, please. 10 A. Sure. I am a certified instructor of 11 advanced trauma life support. And in this area 12 of Northeast Ohio, MetroHealth Medical Center is 13 the only medical center that puts on a formal 14 training in trauma care as part of the ACLS 15 course. 16 I'm a faculty member and from time to 17 time I'm requested by Metro to help participate 18 in Instruction of that course. 19 Q. When is the last time that you 20 provided those types of services at Metro? 21 A. I would say maybe six months ago. 22 Q. Are you actually providing 23 instructional services then where you actually 24 teach a class? 25 A. Yes.</p> | <p style="text-align: right;">Page 27</p> <p>1 you are going to be rendering opinions on that 2 met the standard of care, are you referring to 3 the emergency room physicians that provided care 4 on those dates that I have just referenced? 5 A. Yes. 6 Q. And those, from what I understand, 7 would be Dr. Pennington, Dr. Poponick, and 8 Dr. Maxine Gilles? 9 A. Yes. 10 Q. Are you going to be offering opinions 11 on any other physicians in regard to the care 12 that they rendered to Earline Mizsey? 13 A. No. 14 Q. Now, doctor, your report does not 15 reference any opinions as to the cause of her 16 multiple strokes or the cause of death. Are you 17 going to be offering any opinions on those 18 subject matters? 19 A. No. 20 Q. I believe your report does have some 21 opinions in reference to her right leg 22 symptomatology, and I take it you will be 23 offering some opinions on her right leg symptoms 24 and cause of that? 25 A. Yes.</p> |
| <p style="text-align: right;">Page 26</p> <p>1 Q. How much time is involved when you do 2 that? Is this a one day or several days? 3 A. It's typically a one to two-day 4 course. 5 Q. Doctor, when you were reviewing this 6 case, did you prepare any personal notes on the 7 case? 8 A. No. 9 Q. Have you ever generated any notes in 10 regard to this case? 11 A. No. 12 Q. Now, doctor, in regard to your report 13 in the first paragraph of it, you state that you 14 were writing an answer to your -- meaning 15 Mr. Kilbane's -- request that you provide him 16 with an expert opinion on the care rendered to 17 Ms. Earline Mizsey by the emergency room 18 physicians in the emergency department at 19 MetroHealth Medical Center, Cleveland, Ohio, on 20 April 21st, '98, April 26th, of '98 and May 6th 21 of '98. 22 Was that the assignment that you were 23 given in this case? 24 A. Yes. 25 Q. And in regard to the physicians that</p> | <p style="text-align: right;">Page 28</p> <p>1 Q. How often in your practice do you see 2 patients with bacterial endocarditis? 3 A. I have been practicing emergency 4 medicine for 21 years, and in that time period, 5 I've seen probably six cases or so. 6 Q. Of those six cases, how many of them 7 have been prosthetic valve endocarditis? 8 A. One or two that I recall. 9 Q. Have you personally diagnosed a 10 patient with bacterial endocarditis? 11 A. Yes. 12 Q. How many times have you done that? 13 A. Twice. 14 Q. Have either of those cases been 15 prosthetic valve endocarditis? 16 A. I believe so. 17 Q. One of them, two of them? 18 A. Yes, one of them. 19 Q. Doctor, in the cases that you 20 diagnosed endocarditis, was that on the basis of 21 blood cultures or echocardiogram? 22 A. No, it wasn't. 23 Q. Could you tell me the basis for your 24 diagnosis then in the cases that you personally 25 diagnosed?</p> |

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| <p style="text-align: right;">Page 29</p> <p>1 A. Yes. One case was a drug addicted 2 patient who utilized intravenous drugs on a 3 recreational basis, and this particular patient 4 had a history of bacterial endocarditis in the 5 past for which he had had a prosthetic valve 6 replacement. After being fully treated and 7 cured of that illness, he went back out into the 8 community and once again abused intravenous 9 drugs on a recreational basis and returned to 10 our emergency department in a very ill state. 11 And I don't recall the details, but I 12 do know that there was a strong suspicion that 13 the endocarditis had recurred in the exact same 14 place. He had some stigmata bacterial 15 endocarditis and had a very high fever, and that 16 prompted us to eventually order an echo, which 17 later proved to be a recurrence of the bacterial 18 endocarditis in the tricuspid valve. 19 Q. Any other case that you recall the 20 circumstances? 21 A. I don't recall the details. 22 Q. Would you agree that the presence of 23 a bioprosthetic valve would place a patient at 24 increased risk for developing bacterial 25 endocarditis as compared to a patient that has a</p> | <p style="text-align: right;">Page 31</p> <p>1 overlooking the diagnosis of infectious 2 endocarditis? 3 A. I believe for a patient with a 4 prosthetic heart valve that one would need to be 5 concerned about the possibility of that clinical 6 entity occurring, depending upon the 7 presentation and circumstances that revolve 8 around the patient's condition. 9 Q. Doctor, isn't it true that when 10 endocarditis has been present for a period of 11 time, it's not unusual to see weight loss and 12 anemia and increased white blood cell count? 13 A. An increased white blood cell count, 14 weight loss -- did you mention anemia? 15 Q. Yes, I did. 16 A. It would be considered part of the 17 symptom complex that can occur in endocarditis. 18 Q. Isn't it also true that the type of 19 fever that is usually seen with subacute 20 endocarditis is usually a low grade fever that 21 can be intermittent at times? 22 A. I believe the fever can be 23 intermittent or it can be continuous. 24 Endocarditis, depending on what type it is, and 25 what type of virulent bacterium is involved,</p> |
| <p style="text-align: right;">Page 30</p> <p>1 native valve? 2 A. Yes. I would say that there would be 3 a slight increase in risk over someone with a 4 normal native heart valve. 5 Q. Would you agree that diabetes in 6 advanced age would also increase the risk for 7 infection in a patient with a bioprosthetic 8 heart valve? 9 A. I believe that diabetes mellitus 10 would give one an increased risk of infection in 11 any part of the body. Typically, it's not a 12 specifically mentioned risk factor for 13 endocarditis, but for any type of infection. 14 And in terms of older age, I think 15 that would depend on the definition of the age 16 of the person and also the type of condition 17 that person was in for their particular age. 18 Q. Okay. Well, if we confine it to the 19 seventh decade of life, does that make any 20 difference? 21 A. It could be a risk factor for 22 endocarditis. 23 Q. Would you agree that in patients that 24 have prosthetic heart valves, there has to be a 25 high degree of vigilance utilized to avoid</p> | <p style="text-align: right;">Page 32</p> <p>1 could present either a higher degree or a lower 2 degree of temperature. 3 Q. Would you agree that because patients 4 with prosthetic heart valve are at increased 5 risk for endocarditis, that the presence of 6 fever at any time warrants considering the 7 diagnosis of prosthetic valve endocarditis? 8 A. I would think that that would be 9 dependent upon the situation involved and the 10 symptom complex involved. 11 Q. Doctor, if you are the emergency room 12 physician and a patient presents with prosthetic 13 heart valve and fever, doesn't that have to be 14 one of the things that you consider when you see 15 a patient in the emergency room situation? 16 A. The priority of that consideration 17 would be fully dependent upon the symptom 18 complex. 19 Q. If the symptom complex includes fever 20 in conjunction with stroke in the presence of 21 prosthetic heart valve, would prosthetic valve 22 endocarditis be within a differential diagnosis 23 for the patient? 24 A. I would say yes. 25 Q. Now, doctor, in your report, I</p> |

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| <p>Page 33</p> <p>1 believe that you reference a number of skin 2 manifestations that are sometimes seen in 3 endocarditis; correct? 4 A. Yes. 5 Q. Isn't it true that skin 6 manifestations that you referenced are seen only 7 in a minority of patients with endocarditis? 8 A. I know that they are seen with some 9 frequency. When you define the term minority as 10 being less than 50 percent, that statement 11 probably is true. 12 Q. Isn't it true that systemic emboli 13 are among the most common clinical sequelae of 14 infectious endocarditis? 15 A. They are among some of the more 16 common sequelae, yes. 17 Q. Isn't it also true that systemic 18 emboli are seen more often in endocarditis 19 patients than skin manifestations that you 20 mention in your report? 21 A. I'm not really sure about that fact. 22 Q. Doctor, what diagnostic studies do 23 you consider to be helpful in diagnosing 24 bacterial endocarditis? 25 A. Well, the laboratory tests that would</p> | <p>Page 35</p> <p>1 endocarditis cannot be ruled out on the basis of 2 a single blood culture? 3 A. Not completely, no. 4 Q. Does a patient have to have a 5 positive blood culture before a presumptive 6 diagnosis of bacterial endocarditis can be made? 7 A. Could you please define what you mean 8 by presumptive diagnosis? 9 Q. A point when the physician feels that 10 that's the likely diagnosis but does not have 11 the diagnostic tests in hand to confirm it. 12 A. Okay. Now, repeat the original 13 question. 14 Q. Does a patient have to have a 15 positive blood culture before a presumptive 16 diagnosis of bacterial endocarditis can be made? 17 A. Not necessarily. If there are enough 18 symptom complex manifestations of the illness to 19 make you suspicious or believe that that entity 20 is going on -- because there is an entity known 21 as culture negative endocarditis -- positive 22 blood cultures don't necessarily have to always 23 be present. 24 Q. You had recently referenced a case in 25 which you had diagnosed prosthetic valve</p> |
| <p>Page 34</p> <p>1 be utilized that would be helpful in making the 2 diagnosis would be a clinical blood count or CBC 3 that would include a white blood cell count, a 4 red blood cell count, a sed rate. In addition, 5 renal function tests would be useful, blood 6 cultures, and echocardiogram. Chest x-ray, EKG 7 would also be useful. 8 Q. Doctor, you would agree that when you 9 are arriving at a diagnosis, even if some of 10 these tests are not what would be considered 11 diagnostic, they still may be helpful in you 12 coming to a final conclusion for a diagnosis, 13 adding weight or support to a diagnosis; 14 correct? 15 A. Yes. 16 Q. For example, a complete blood count 17 isn't diagnostic of endocarditis, but it may be 18 helpful to a physician in arriving at a final 19 diagnosis; correct? 20 A. It could be one piece of the puzzle. 21 Q. And it's important to look at the 22 whole picture when you are attempting to arrive 23 at a diagnosis; correct? 24 A. Yes. 25 Q. Would you agree that bacterial</p> | <p>Page 36</p> <p>1 endocarditis in an IV drug user. Was that an 2 instance where you had arrived at a presumptive 3 diagnosis before you had confirming tests of 4 either a blood culture or an echocardiogram? 5 A. Yes, it was a clinical suspicion. I 6 didn't realize that the diagnosis had been made 7 until the results were confirmed by the blood 8 culture at a later date. 9 Q. Doctor, would you agree that with 10 endocarditis infecting a bioprosthetic valve, 11 one of the pathological changes that usually 12 occurs is destruction of the valve leaflets? 13 A. That can be one of the manifestations 14 of the illness. 15 Q. What are vegetations? 16 A. Vegetations are a tissue complex, if 17 you will, or a conglomerate of substances 18 primarily composed of fibrin and platelets and 19 the infecting organism that would be occurring 20 on the surface of an aspect of the inner lining 21 of the heart or valve leaflets. 22 Q. You would agree that when infective 23 vegetations grow on a heart valve, they can in 24 some instances break off, travel through the 25 bloodstream, and can result in a stroke, in some</p> |

9 (Pages 33 to 36)

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| <p>Page 37</p> <p>1 instances; correct? 2 A. Yes. 3 Q. They can also in some instances 4 travel through the bloodstream and lodge in a 5 leg artery and disrupt the blood flow to the 6 leg; correct? 7 A. Yes. 8 Q. Doctor, as an emergency room 9 physician, have you ever ordered serial blood 10 cultures for a patient where there is more than 11 one blood culture taken in order to evaluate a 12 patient for endocarditis? 13 A. Routinely, in our emergency 14 department, our protocol is to order two sets of 15 blood cultures, 30 minutes apart, in different 16 sites. We do that for any infection that we may 17 be suspecting in the bloodstream. 18 Q. In order to determine what patients 19 you are going to do a blood culture on and which 20 ones you are not, would one of the indicators be 21 doing a complete blood count, and if you see 22 elevations of the white blood cells that are 23 suggestive of infection, that might be a patient 24 you may move to do the blood cultures on? 25 A. That could possibly be one of the</p> | <p>Page 39</p> <p>1 that would be a valid explanation for the 2 leukocytosis. It really would depend on the 3 clinical situation. 4 Q. If a patient has a bioprosthetic 5 valve, elevated white blood count with a 6 differential suggestive of an infectious 7 process, is that a patient that would normally 8 have blood cultures? 9 A. When you say the term normally have, 10 I probably would order a set of blood cultures 11 on that patient. 12 Q. Would most emergency room physicians 13 do that? 14 A. Possibly. 15 Q. Would the standard of care require 16 that emergency physicians do that? 17 A. Again, possibly it would. 18 Q. Well, doctor, you are here as an 19 expert to speak to the standard of care for 20 patients, and this patient had endocarditis, so 21 I'm trying to elicit what your opinions are. I 22 need you to tell me whether or not that would be 23 the standard of care. 24 A. If the symptom complex required 25 ruling out bacterial endocarditis, then</p> |
| <p>Page 38</p> <p>1 Indications. I mean, we see many, many patients 2 with elevated blood counts that we do not do 3 blood cultures on all the time every day, so it 4 would depend on the symptom complex. 5 Q. In a patient with a bioprosthetic 6 valve, if you had a CBC that showed an elevation 7 of white blood cells with a differential that 8 also was suggestive of an infectious process, 9 would that be a patient that might fall into the 10 category of having these sets of blood cultures 11 drawn? 12 A. Perhaps. 13 Q. Would there be other things that you 14 would be looking for that would tell you that 15 you should or shouldn't do blood cultures in 16 that type of situation? 17 A. Well, we don't routinely do blood 18 cultures on everyone that comes in that has a 19 high white count. 20 Q. I restricted it to bioprosthetic 21 valve. 22 A. It would depend on the clinical 23 presentation and what we suspect was causing the 24 elevation of white blood cells. For example, if 25 the patient was leukemic or something like that,</p> | <p>Page 40</p> <p>1 definitely those two sets of blood cultures 2 would be performed. 3 Q. Just tell me if this is something 4 that you would do as an emergency room physician 5 or not. 6 Once blood cultures are drawn, 7 because of the time involved for the cultures to 8 grow out, as a physician in the emergency, in 9 the field of emergency medicine, do you ever 10 deal with the administration of empiric 11 antibiotics for patients where there is a 12 presumptive diagnosis for endocarditis? 13 A. That usually occurs as a decision 14 that's made in conjunction with the other 15 providers that will be taking care of the 16 patient. 17 Q. Do you know how prosthetic valve 18 endocarditis is usually treated? 19 A. I believe it's treated primarily with 20 intravenous antibiotic therapy, and/or surgery. 21 Q. And by surgery, you are referring to 22 usually the replacement of the infected valve? 23 A. Correct. 24 Q. Would you agree that one of the main 25 goals of treatment in prosthetic endocarditis is</p> |

10 (Pages 37 to 40)

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| <p>Page 41</p> <p>1 to eradicate the infecting organism as soon as 2 possible? 3 A. Yes. 4 Q. Would you agree that the sooner 5 prosthetic valve endocarditis is treated with 6 antibiotics, if it's a bacterial infection, the 7 more likely the outcome will be positive? 8 A. Yes. 9 Q. Doctor, do you know if the incident 10 of embolic events as a result of bacterial 11 endocarditis decreases promptly during the 12 administration of appropriate antibiotics? 13 A. I'm familiar with the concept that 14 overall the embolic phenomenon can decrease. 15 I'm not sure how promptly that really takes 16 place. 17 Q. Would you agree that when a patient 18 with a bioprosthetic valve presents with fever, 19 elevated white blood cell count, suggestive of 20 infection, and symptoms of transient ischemic 21 attack or stroke, that endocarditis should be 22 included in the differential diagnosis? 23 A. Yes. 24 Q. Have you ordered echocardiograms for 25 patients that you have suspected of having</p> | <p>Page 43</p> <p>1 Q. Do you know whether a transthoracic 2 or a transesophageal echo is more sensitive for 3 picking up evidence of vegetations? 4 A. It's my understanding that a 5 transesophageal echo is more sensitive. 6 Q. Do valvular vegetations have to be 7 present before the diagnosis of prosthetic valve 8 endocarditis can be made? 9 A. I don't believe so. 10 Q. Would you agree that prosthetic valve 11 endocarditis can cause life-threatening 12 complications? 13 A. Yes. 14 Q. Doctor, what is capillary refill? 15 A. Capillary refill is a phenomena 16 observed on clinical exam that is used to 17 estimate blood flow into an area that's 18 examined. 19 Q. How is it assessed? 20 A. It's a clinical exam that's assessed 21 by applying a pressure of some sort to the area 22 in question, and observing for color change to 23 the area caused by pressure and observing the 24 area in terms of color response to the pressure. 25 Q. Generally, when capillary refill is</p> |
| <p>Page 42</p> <p>1 endocarditis? 2 A. In consultation with the primary care 3 physicians or consulting specialists, yes. 4 Q. Have you in conjunction with those 5 other consultants ordered both transesophageal 6 as well as transthoracic echoes? 7 A. I have not had the opportunity to do 8 that. 9 Q. Mostly just transthoracic echoes? 10 A. Correct. 11 Q. So, doctor, in most cases, if you 12 were considering ordering an echo, you would 13 probably have a consultant that would be 14 assisting with that decision? 15 A. Yes. That's the protocol at our 16 institution. 17 Q. If you know, is that typical of most 18 emergency rooms? 19 A. I think it varies from institution to 20 institution. 21 Q. Doctor, if there is a reasonable 22 suspicion for endocarditis, do you have an 23 opinion within what time frame an echo should be 24 done on a patient? 25 A. I really can't comment on that.</p> | <p>Page 44</p> <p>1 assessed in the emergency room on the 2 extremities, how is it done? 3 A. Typically, the examiner would place 4 his own, his or her own digit on the area, apply 5 pressure enough to cause a blanching to the 6 epidermis and dermal area, observing for the 7 blanching color to be in existence, and then 8 with release of the pressure to the area 9 observing for the occurrence of a redness, if 10 you will, indicating perfusion to that area to 11 recur after the pressure stimulus has been 12 removed. 13 Q. Typically, isn't that done by 14 compressing one of the nail beds, like on the 15 toes, to check circulation in the feet? You 16 would compress the nail bed of the toe and then 17 watch for the return of the color after it 18 blanches? 19 A. It can be. 20 Q. And when you are checking the nail 21 beds on the feet, what is considered to be a 22 normal capillary refill time? 23 A. Traditionally, over the years, two 24 seconds or less has been considered as somewhat 25 of a normal capillary refill, but there has been</p> |

11 (Pages 41 to 44)

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| <p>Page 45</p> <p>1 a lot of controversy about the inadequacy of the 2 estimation of a peripheral flow from capillary 3 refill. It's a very gross technique that has 4 not been really scientifically proven to be 5 accurate. 6 Q. Is checking capillary refill and 7 checking peripheral pulses a skill that an 8 emergency physician should be able to 9 competently perform? 10 A. Yes. 11 Q. Is that something that's done 12 frequently, that's an everyday occurrence for 13 most emergency room physicians, something that 14 they do on a regular basis when they assess 15 patients? 16 A. I would say more palpating for pulses 17 than capillary refill. 18 Q. But it's a skill that all emergency 19 room physicians will utilize at some point; 20 correct? 21 A. Yes. 22 Q. Doctor, in your review of the 23 records, did you find that Earline Mlzsey's 24 diabetes was under reasonably good control? 25 A. Yes.</p> | <p>Page 47</p> <p>1 You don't think that those set of 2 facts would cause an emergency room physician to 3 include prosthetic valve endocarditis within the 4 differential? 5 A. It could have been included in the 6 differential. I'm not sure how much priority. 7 She did have an explanation for a 8 fever in that her history Included upper 9 respiratory symptoms, cold symptoms In the 10 previous days prior to the admission, and also 11 included the imaging evidence on CAT scan for 12 sinusitis, which could explain her symptoms. 13 Q. Now, when a patient with a prosthetic 14 heart valve presents with a febrile illness to 15 the emergency room, and symptoms or history of 16 what is considered to be possibly a transient 17 ischemic attack, shouldn't endocarditis always 18 be suspected until proven otherwise? 19 A. I would say that would be fully 20 dependent upon the symptom complex. 21 Q. Would you agree that after that 22 emergency room visit, Earline Mlzsey should have 23 been followed up by her cardiologist at Metro, 24 specifically to determine if her symptoms were 25 due to endocarditis?</p> |
| <p>Page 46</p> <p>1 Q. Now, you did have an opportunity to 2 see the Southwest General Hospital emergency 3 room records from March 10th, which is the visit 4 when she had her first stroke; correct? 5 A. Yes. I wouldn't say that was her 6 first stroke, but it was a stroke that was 7 described in the course of the case that we are 8 reviewing. 9 Q. When she presented to the emergency 10 room on March 10th, she had a history of 11 bioprosthetic heart valve, and the emergency 12 room physician felt that she had a possible 13 transient ischemic attack. She had a white 14 blood cell count of 15.4, with an elevation of 15 her segs, and her temperature was 100.9. They 16 also noted that she had labored respirations and 17 that she had complained of a fever for several 18 days. 19 In that scenario, should prosthetic 20 valve endocarditis have been included in the 21 differential diagnosis? 22 A. It could have possibly been 23 considered at that point. 24 Q. Now, you have a lot of qualifiers 25 there, "could have possibly".</p> | <p>Page 48</p> <p>1 A. I believe that that attempt was made; 2 that adequate follow-up was arranged by 3 Dr. Craber at Southwest. 4 Q. Now, the emergency room physician at 5 Southwest did contact Metro and spoke with 6 Dr. Vrobel, the cardiologist, who was covering 7 for Dr. Rakita. Dr. Rakita was Earline Miwy's 8 cardiologist at Metro. 9 In the record that you had an 10 opportunity to review, Dr. Craber indicated that 11 he discussed his findings from the emergency 12 room visit in detail. Was that an appropriate 13 course of action on the part of the Southwest 14 General Hospital emergency room physician to 15 contact the cardiology people at Metro to 16 discuss his findings from the emergency room 17 visit? 18 A. Yes. 19 Q. Why do you think that's appropriate? 20 A. Well, that's the usual practice. if 21 there is any question regarding symptomatology, 22 and follow-up needs to be arranged, one possible 23 way of assuring that the patient will be seen 24 would be to contact a physician and arrange 25 follow-up.</p> |

12 (Pages 45 to 48)

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1 Q. Is that something that emergency room
2 physicians do fairly regularly, is contact
3 either a primary care or a treating cardiologist
4 to make sure that there is some follow-up and
5 care after an emergency room visit?
6 A. It's done on an as-needed basis.
7 It's certainly not done on every patient that
8 presents to the department. There is a clinical
9 judgment made, and depending upon the presenting
10 symptom complex, we may or may not arrange
11 follow-up.
12 But in general, the majority of the
13 cases that we do see, we do not contact any
14 physician for follow-up, but we refer the
15 patients for follow-up with adequate
16 instructions in their going home sheets.
17 Q. In this case, as you reviewed this
18 particular emergency room visit, anything that
19 you felt warranted the call that was made to
20 Metro? Anything particular that as an emergency
21 room physician would key you into, this is the
22 type of a situation where arrangements should be
23 made with the primary care or cardiologist to
24 continue follow-up care?
25 A. This type of case is kind of like a

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1 opinions on. And you are not going to be
2 rendering opinions on whether Dr. Vrobel or
3 Dr. Rakita or Dr. Einstadter met the standard of
4 care; is that correct?
5 A. I would prefer to focus my opinions
6 on the emergency department visits.
7 Q. I won't go into those if that's your
8 intentions.
9 Now, did you have an opportunity to
10 see the echocardiogram report of the April 9th,
11 '98 transthoracic echo that was done on Earline
12 Mizsey?
13 A. Yes.
14 Q. Did you also see the carotid
15 ultrasound report that was done on that same
16 date for her?
17 A. Yes.
18 Q. Now, do you have it?
19 A. Yes.
20 Q. Do you have the carotid ultrasound
21 report there?
22 A. Yes.
23 Q. Did you find anything of concern on
24 that report for the carotid ultrasounds?
25 A. The impression of the carotid

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1 borderline presentation in that the patient
2 presented with some symptomatology, but really
3 it was found to have been a completely normal
4 neurological exam, so it was appropriate to go
5 ahead and contact someone in that if, indeed,
6 the symptom complex proved to be a transient
7 ischemic attack -- and I don't believe it was
8 absolutely clear, but it was a very vague
9 possibility. There is controversy in terms of
10 whether a patient with TIAs require admission or
11 not -- and therefore, he would seek the advice
12 of a follow-up physician as to what they wanted
13 to do with this patient.
14 Q. And once Dr. Craber, who was the
15 emergency room physician, spoke to the
16 cardiologist, Dr. Vrobel, at Metro and explained
17 his findings, would it be proper then for Dr.
18 Graber to feel that follow-up would then be
19 arranged by Metro Hospital for Mr. Mizsey?
20 A. It depends on the circumstances that
21 he left with regarding discharging the patient
22 and how the arrangements were made for the
23 follow-up.
24 Q. Now, doctor, I don't want to get into
25 areas that you are not going to be expressing

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1 ultrasound, that there was arterial plaque which
2 did not appear to be hemodynamically
3 significant, so although there was evidence of
4 atherosclerosis, it did not at that point seem
5 to be causing any significant stenosis of the
6 carotid artery.
7 Q. The finding was she had a mild
8 arterial plaque?
9 A. That's what is described in the
10 report.
11 Q. That type of finding would not be at
12 all unusual in a 73-year-old patient; correct?
13 A. Correct.
14 Q. Now, you also had a chance to see the
15 report of the transthoracic echo that was done
16 on April 9th of '98; correct?
17 A. Yes.
18 Q. Did you find anything of concern in
19 that report?
20 A. This report describes some aortic
21 regurgitation present, and apparently there was
22 some difficulty in assessing that adequately,
23 and the echocardiologist suggested that the
24 bioprosthetic valve could be deteriorating and
25 also offered that it could be a potential

13 (Pages 49 to 52)

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| <p style="text-align: right;">Page 53</p> <p>1 embolic source.</p> <p>2 Q. Did you find any of those particular</p> <p>3 results of concern in this patient?</p> <p>4 A. Well, to me it indicates that it's</p> <p>5 not a totally normal study and that follow-up to</p> <p>6 this would probably be warranted to better</p> <p>7 adequately assess the area.</p> <p>8 Whether or not the aortic</p> <p>9 regurgitation was present for years or was a</p> <p>10 recent event is not suggested, and this report</p> <p>11 could be consistent with some deterioration of</p> <p>12 the valve over time.</p> <p>13 Q. Aortic regurgitation is the type of</p> <p>14 damage that is seen in a heart valve from</p> <p>15 endocarditis, isn't it, doctor?</p> <p>16 A. It can be.</p> <p>17 Q. Isn't that typically the type of when</p> <p>18 you hear a murmur, it's a regurgitation murmur?</p> <p>19 A. It can be.</p> <p>20 Q. That's seen with endocarditis?</p> <p>21 A. It can be.</p> <p>22 Q. Doctor, would you agree that given</p> <p>23 Earline Mizsey's bioprosthetic heart valve, and</p> <p>24 the recent stroke that she had -- and I believe</p> <p>25 if you ever reviewed the records, you know that</p> | <p style="text-align: right;">Page 55</p> <p>1 clarify.</p> <p>2 Do you have an opinion as to whether</p> <p>3 it was appropriate to do a follow-up TEE, in</p> <p>4 this instance?</p> <p>5 A. This is the type of ongoing</p> <p>6 outpatient care that emergency physicians don't</p> <p>7 typically get involved with, so again, I would</p> <p>8 prefer to reserve judgment to the expertise of</p> <p>9 the cardiologist.</p> <p>10 Q. Earline Mizsey was then seen in the</p> <p>11 emergency department at Metro, I believe, on</p> <p>12 April 21st of '98 and at that time, I believe,</p> <p>13 she was complaining of right hand tremors.</p> <p>14 Doctor, can hand tremors be a</p> <p>15 neurological result of a stroke?</p> <p>16 A. Tremors have a multitude of</p> <p>17 etiologies that can include anything from</p> <p>18 electrolyte imbalance, to hypoglycemia, to</p> <p>19 seizure activity, to muscle weakness, and</p> <p>20 hangover. And as one of the myriad of</p> <p>21 possibilities that hand tremor could represent,</p> <p>22 including anxiety and nervousness, could include</p> <p>23 also the possibility of a stroke.</p> <p>24 Q. And in this instance, do you have an</p> <p>25 opinion as to what was causing her hand tremors?</p> |
| <p style="text-align: right;">Page 54</p> <p>1 Dr. Einstadter confirmed that her symptoms were</p> <p>2 consistent with stroke when he saw her on the</p> <p>3 13th -- given her recent stroke, and this echo</p> <p>4 result, that it should have raised a concern</p> <p>5 that her stroke may have been caused by emboli</p> <p>6 from her heart?</p> <p>7 A. I believe that Dr. Einstadter's</p> <p>8 initial impression was because of the risk</p> <p>9 factors for stroke in this patient who is a</p> <p>10 diabetic, high cholesterol, anemic,</p> <p>11 hypertensive, has atherosclerosis, coronary</p> <p>12 artery disease and peripheral valvular disease.</p> <p>13 From his impression from the initial visits that</p> <p>14 the stroke was more likely caused by a small</p> <p>15 cortical infarct due to atherosclerosis and</p> <p>16 valvular disease and the cerebral vasculature</p> <p>17 than it would be embolus.</p> <p>18 Q. Do you know if most patients with</p> <p>19 porcine heart valves have deterioration of the</p> <p>20 valve only four years after placement?</p> <p>21 A. That's somewhat out of my expertise.</p> <p>22 I would prefer to defer to the cardiologist in</p> <p>23 that regard.</p> <p>24 Q. Now, this particular report suggests</p> <p>25 a TEE or transesophageal echo to further</p> | <p style="text-align: right;">Page 56</p> <p>1 A. I would tend to agree with the</p> <p>2 assessment by the emergency physicians in that</p> <p>3 department. The clinical exam did not find any</p> <p>4 acute neurological deficits other than the more</p> <p>5 chronic neuro deficits that occurred on the left</p> <p>6 side as a result to the prior incident.</p> <p>7 Q. Was there anything in the emergency</p> <p>8 room visit records that would allow you to rule</p> <p>9 out stroke as a cause for her tremors in her</p> <p>10 hand?</p> <p>11 A. I would say that the fact that the</p> <p>12 neuro exam on the right side that included the</p> <p>13 upper extremities and lower extremities were all</p> <p>14 within normal limits, and, therefore, there is</p> <p>15 no evidence there is an acute neurological event</p> <p>16 going on.</p> <p>17 Q. Did you find anything or any evidence</p> <p>18 in this April 21st ER visit to support a finding</p> <p>19 that she was complaining of any pain in her</p> <p>20 lower extremities or was having any type of</p> <p>21 symptomatology that was of concern in her lower</p> <p>22 extremities?</p> <p>23 A. Not on this particular visit, that I</p> <p>24 can glean from reviewing the chart.</p> <p>25 Q. Doctor, I would like to move to the</p> |

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1 emergency room visit then on April 26th.
 2 A. Okay.
 3 Q. She was seen in Metro's ER on April
 4 26th for pain in her right leg and thigh that
 5 was sudden in onset, that was aching from her
 6 foot all the way to her hip, and it occurred
 7 suddenly after stepping out of the shower.
 8 She had a temperature of 37.6
 9 Centigrade, which is a little over 99.6
 10 Fahrenheit. Do you consider that to be a low
 11 grade fever in Earline Mizsey's case?
 12 A. No, I do not.
 13 Q. At what level would you consider it
 14 to be a low grade fever?
 15 A. Fever is a symptom and sign that you
 16 will see quoted in a variety of sources at very
 17 different levels. From my experience of working
 18 in the emergency department and assessing what I
 19 would consider a fever, I would say it would be
 20 100 degrees Fahrenheit or above. It's well
 21 known there is diurnal variation in the
 22 temperature, in everyone, and you would think
 23 that a temp of 37.6, which is 99.6 or a little
 24 greater, would be within that normal diurnal
 25 variation that would be observed in the human.

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1 A. Before I answer that hypothetical
 2 question, I would just like to say that in
 3 Dr. Einstadter's note of March 13th, his plan
 4 included increasing aspirin, and I believe it
 5 says to 650 milligrams QD, not BID.
 6 And then on the visit subsequent to
 7 April 26th, it notes in the medical record that
 8 the patient should be taking aspirin, but is
 9 not, because she was on another prescription.
 10 And she wasn't taking the aspirin, therefore,
 11 because of that. She did not list aspirin as
 12 her medication on her visit on April 26th. So it
 13 is not clear to me at all that she is taking
 14 aspirin at that point in time during her visit
 15 on the 26th.
 16 Now, if she was, and if she was
 17 taking aspirin at 650 milligrams twice a day,
 18 depending upon when she took the aspirin in
 19 relation to when the temperature was taken, it
 20 may or may not affect the result of the temp.
 21 Q. And I believe the last order was 650
 22 milligrams QD, and I believe you are correct
 23 when you stated that.
 24 A. I don't know if she took that at
 25 night or took it at noon or took it at 4:00

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1 Q. Doctor, Earline Mizsey was on aspirin
 2 twice a day. Would that, as an emergency room
 3 physician, affect your opinion in this case
 4 knowing she has a prosthetic heart valve and is
 5 coming in with a temperature of 37.6 with this
 6 symptomatology?
 7 MR. KILBANE: Objection. You are
 8 asking him to assume that the patient was on
 9 aspirin twice a day?
 10 MS. TOSTI: I believe it's in the
 11 record that this lady is on aspirin.
 12 MR. KILBANE: I know at some point
 13 there is aspirin twice a day, but you are asking
 14 him to assume that she was at this time?
 15 Q. Dr. Einstadter put her on aspirin 650
 16 milligrams twice a day at, I believe, it was the
 17 March 13th of '98 visit. She had been taking
 18 aspirin once a day. And I won't ask you to find
 19 that particular reference. I'll just ask you to
 20 assume that that's correct, doctor.
 21 If she was taking aspirin twice a day
 22 and is presenting to the emergency room with a
 23 temperature of 37.6, would that have an impact
 24 on your opinion that this was not an elevation
 25 or low grade fever in her case?

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1 o'clock in the morning. So it really would
 2 depend on the timing. The aspirin is a short
 3 acting drug, as you know, and may or may not
 4 affect the temperature, depending on the dosage
 5 and frequency.
 6 Q. And depending on whether she took
 7 aspirin on this particular date would impact
 8 whether or not that 37.6 was or was not
 9 significant and also as to when she took it in
 10 relationship to this particular temperature
 11 reading; correct?
 12 A. That is possible.
 13 Q. Doctor, in a patient with a
 14 prosthetic heart valve that has a history of
 15 recent stroke, has evidence of valve
 16 deterioration on the echo, who presents to the
 17 emergency room with the sudden onset of pain in
 18 her leg, has a temperature of 37.6, shouldn't
 19 that have raised a level of concern for emboli
 20 from the prosthetic heart valve for
 21 endocarditis? Shouldn't there have been at
 22 least a concern that endocarditis may be the
 23 cause?
 24 A. In my opinion, I do not think so. I
 25 don't consider a temp of 37.6 as a fever, and as

15 (Pages 57 to 60)

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| <p>Page 61</p> <p>1 we know, fever is the most prominent symptom and 2 sign for a patient presenting with endocarditis. 3 Her pain was quite classic and 4 typical of a radicular type pain, and that it 5 came on with movement of the leg as she was 6 coming out of the shower. It kind of radiated 7 up and down the leg, and it occurred in a woman 8 who was known to have osteoarthritic changes. 9 To me, by gleaming the records and reading some 10 of the depositions, it really seems like this was very 11 compatible with a radicular type pain. 12 Q. Well, doctor, wouldn't you agree that 13 when there is a sudden onset of pain in one leg 14 and pulses are not palpable or audible with 15 doppler, that arterial occlusions should be 16 within the differential diagnosis? 17 A. I would say perhaps if that was the 18 ultimate finding, but there were no other 19 findings described here in this record that 20 would lead me to indicate that there was an 21 acute embolus to that extremity. 22 For example, there was no description 23 that the extremity was pale, which is often the 24 case if there is a large embolus, large enough 25 to occlude flow to the entire length of the</p> | <p>Page 63</p> <p>1 some later point there is documentation that the 2 circulation is now improved? 3 A. I don't think that's unusual at all. 4 I can tell you from my own experience that 5 examinations are very variable and practitioner 6 dependent, and it can go either way. But one 7 physician will go in and find one particular 8 finding and three minutes later another doctor 9 will go in and repeat the exam and find entirely 10 different findings. It's not unusual; it's a 11 common occurrence. 12 And in most cases, the emergency 13 physician, master of many illnesses, but expert 14 of none, so to speak, would defer to the service 15 with the more expertise and feel confident that 16 their exam will guide them in the right 17 direction. 18 Q. Now, in this particular instance the 19 consultant from the vascular service was Dr. 20 Storoe. Are you aware Dr. Storoe was a general 21 surgery resident and not a vascular surgery 22 resident? 23 A. I'm fully aware of that. I also 24 understand that Dr. Limsrichamrem was also 25 involved in the evaluation of this case, and I</p> |
| <p>Page 62</p> <p>1 extremity. 2 In addition, it was not described 3 that the extremity was mottled in any way. And 4 I believe the emergency physicians did the right 5 thing in suspecting that, okay, we need to be 6 sure that there is no vascular deficit going on 7 here, let's get the vascular service team 8 involved in this and get the experts to take a 9 look and see what they consider is going on 10 here. 11 The fact that there was a dorsalis 12 pedis pulse, palpable by the vascular service to 13 me indicates there was no large embolus going 14 on. And indeed, several days later, when the 15 patient reappeared to the primary care 16 physician, according to Dr. Elstadter's note, 17 there are good pulses bilaterally, there is no 18 mottling, no pallor to the extremity and no 19 suspicion at that point in time that there was 20 an embolus or clot going on. 21 Q. Don't you find that unusual that the 22 emergency room physician on the 26th is 23 indicating that the pulses were not palpable and 24 that the capillary refill was delayed 25 approximately three to five seconds, and then at</p> | <p>Page 64</p> <p>1 also believe that there was contact with the 2 attending physicians that were covering the 3 service, as well, so that a group decision was 4 made on how to proceed and what advice to give 5 regarding this patient's condition. 6 Q. What is your understanding of 7 Dr. Limsrichamrem's background and experience? 8 A. I don't know the full details, but I 9 believe that he was a more senior resident with 10 a lot of experience in the area. 11 Q. Do you know what his area of 12 specialty was? 13 A. Not at this point, no. 14 Q. And why is it that you believe that 15 they were in consultation with the overseeing 16 attending vascular surgery person? 17 A. Well, it's my belief that in a 18 teaching institution -- and I am part of a 19 teaching institution here, as well -- that it's 20 protocol and routine to consult and discuss the 21 findings with the attending physician. 22 Q. So you have made an assumption here 23 that the appropriate procedure was followed; 24 correct? You are assuming that 25 Dr. Limsrichamrem or Dr. Storoe contacted the</p> |

16 (Pages 61 to 64)

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| <p>Page 65</p> <p>1 attending vascular surgeon? 2 A. That's usually how it's done in 3 teaching facilities. 4 Q. Well, doctor, I'm asking, is that an 5 assumption on your part or are you basing it on 6 some facts that you have reviewed? 7 A. We can put it this way. I don't see 8 that fact described in the chart, but charts 9 often don't fully reflect what goes on in a 10 patient encounter. 11 Q. Doctor, would you agree that the pain 12 from diabetic neuropathy in most cases is not 13 sudden in onset? 14 A. Well, let's investigate that for a 15 minute. If you are without pain for a period of 16 time and now you do have pain, okay, one moment 17 you didn't, and another moment you start to 18 experience pain, so that by definition is a 19 sudden onset of pain. So it's very difficult to 20 dissect that out exactly. 21 Q. All right. Let me clarify my 22 question then. Would you agree that the pain 23 from diabetic neuropathy in most cases is not 24 sudden onset of severe pain? 25 A. I can't agree with that either,</p> | <p>Page 67</p> <p>1 Q. Now, doctor, you had an opportunity 2 to read Dr. Pennington's deposition testimony; 3 correct? 4 A. Yes. 5 Q. Do you recall him in his deposition 6 testimony indicating that both he, as well as 7 his resident, checked pulses and also attempted 8 doppler and was unable to palpate or to find 9 pulses with the doppler. Do you recall reading 10 that? 11 A. I believe so, yes. 12 Q. From the perspective of an emergency 13 physician, would those findings raise a high 14 level of concern for vascular compromise? 15 A. Yes. 16 Q. Is the assessment of pulse with a 17 doppler something that emergency room physicians 18 are familiar with and utilize in their practice? 19 A. Yes. 20 Q. Do you have any reason to believe 21 that Dr. Pennington was unskilled in the use or 22 the technique of assessing pulses using a 23 doppler? 24 A. No. But as I stated earlier, these 25 types of exams are extremely practitioner</p> |
| <p>Page 66</p> <p>1 because I think pain is a subjective phenomena 2 and to someone could be very severe and to 3 others very mild, so -- 4 Q. in your experience of patients that 5 you have seen with diabetic neuropathy, have the 6 majority of the patients come in complaining of 7 the sudden onset of severe pain? 8 A. I would have to say yes, because 9 that's what makes them present to an emergency 10 department rather than seeing their own private 11 physician at an appointment two weeks later or 12 something like that. 13 Q. Now, doctor, you had a chance to 14 review Dr. Pennington's emergency room note in 15 which he mentions that she had right leg pain, 16 which she described as sudden onset. Was there 17 anything in Dr. Pennington's initial exam of 18 Earline M I w y that would raise a concern for 19 vascular compromise in her right leg that you 20 saw? 21 A. Well, in his exam, he said the pulses 22 were not palpable on initial exam. The patient 23 was able to ambulate with a limp, so that one 24 statement would indicate that some pulses were 25 not palpable.</p> | <p>Page 68</p> <p>1 dependent and finding a doppler pulse is not so 2 easy. 3 If you are off by a millimeter or two 4 from where the strong sensation of the pulse is, 5 it would be very easy to miss, and depending on 6 how much time was spent, meticulously going 7 millimeter by millimeter across the dorsum or 8 the unilateral of the foot, it is very easy to 9 miss a doppler of a pulse. 10 Q. Based on what you reviewed as 11 Dr. Pennington's assessment, was it reasonable 12 for him to call for a vascular service consult 13 to rule out an acute vaso-occlusive event? 14 A. I think it was reasonable. 15 Q. And Dr. Pennington described it as 16 acute vaso-occlusive event. That would be 17 consistent with emboli or thrombus; correct? 18 A. Yes. 19 Q. When an emergency room physician 20 calls a specialist for consultation on a 21 patient, is it reasonable for the emergency room 22 physician to rely on the consultant's 23 conclusions? 24 A. Yes. 25 Q. We discussed that the assessment was</p> |

17 (Pages 65 to 68)

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| <p>Page 69</p> <p>1 done by Dr. Stroe, a general surgery resident. 2 In your opinion, would a general surgery 3 resident be more skilled in assessing peripheral 4 circulation than an experienced emergency room 5 physician? 6 A. That could be practitioner dependent, 7 but in general, surgical residents deal with 8 vascular surgery. It's part of their training, 9 and I would say, yes, in general. 10 Q. What is radiculopathy? 11 A. Radiculopathy is a term that 12 describes a pathological process which involves 13 the nerve root as it comes out of the spinal 14 cord and travels down the extremity. 15 Q. Is it characterized by pain, pain 16 syndrome? 17 A. It can be. 18 Q. From what we previously discussed, 19 you agree with the diagnosis of radiculopathy 20 that was made at this April 26, 1998 emergency 21 room visit, correct? 22 A. Yes. 23 Q. Earline Mizsey described to 24 Dr. Pennington that the pain was most prominent 25 over the lateral aspect of her thigh.</p> | <p>Page 71</p> <p>1 Q. Now, would that be indicative of a 2 problem with her arterial circulation? 3 A. I suppose there is a possibility that 4 there could be. Capillary refills are very 5 subjective, somewhat inaccurate, and there is no 6 study that adequately correlates capillary 7 refill with what is actually going on in an 8 extremity in terms of blood flow. 9 Q. So do you have any explanation as to 10 why Dr. Pennington's assessment of capillary 11 refill is different than what Dr. Stroe found? 12 A. You know, actually both practitioners 13 had overlap of the capillary refill time count 14 in that Dr. Pennington found that it varied 15 between three to five seconds and Dr. Stroe 16 said that it was two to three seconds in part of 17 the area, so that both practitioners were 18 roughly around the same time period in terms of 19 the refill. 20 Again, it would depend on whether 21 this was a rough ballpark estimate, did they 22 actually look at a watch while they were 23 compressing and time it scientifically, or, you 24 know, was it just a rough ballpark estimate. So 25 it would be very dependent, very practitioner</p> |
| <p>Page 70</p> <p>1 Is this area of described pain of any 2 significance in arriving at the diagnosis of 3 radiculopathy? 4 A. Yes, I think the pain typically in a 5 radiculopathy can radiate from the back and 6 around the hip area and then either down the 7 lateral aspect of the thigh, which is very 8 typical, I believe for the L4-L5 dermatome or 9 anterior aspect or posterior aspect. It would 10 depend on which nerve root was irritated, but it 11 would be quite typical to experience that type 12 of pain on the lateral aspect. 13 Q. In your review of the records, did 14 you find any place that Earline Mizsey had an 15 arthritic condition in her back, or had suffered 16 any type of injury to her back or at any time 17 prior to this had complaints related to her back 18 in anything that you reviewed? 19 A. No. 20 Q. Now, she also described tenderness to 21 palpation -- I'm sorry. 22 Dr. Pennington also found that she 23 had a capillary refill of three to five seconds 24 in her right foot. Do you recall seeing that? 25 A. Yes.</p> | <p>Page 72</p> <p>1 dependent. 2 Q. Doctor, isn't it true that with 3 peripheral embolisms, the embolism can break up 4 after a period of time and the blood flow 5 through the vessel can reestablish itself? 6 A. I suppose that's possible. I don't 7 think it happens too commonly. Usually if there 8 is a clot large enough to involve the entire 9 leg, that would be a sufficient size clot that 10 would then promulgate more clot and thrombosis 11 distal to the initial destruction. It would be 12 somewhat unusual, but it can occur. 13 Q. Well, doctor, you can have emboli 14 that lodge in various arteries in the leg. It 15 doesn't have to be in the main artery feeding 16 the leg, correct? 17 A. Correct. But if the pain was 18 prominent in the proximal area of the extremity, 19 I would think that the clot therefore would be 20 near the bifurcation of the femoral artery if it 21 was going to cause pain down the lateral side of 22 the thigh, not down in the popliteal area or 23 ankle or plantar arch. 24 Q. Would you agree that the pain that 25 she described on the lateral aspect of her right</p> |

18 (Pages 69 to 72)

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| <p style="text-align: right;">Page 73</p> <p>1 thigh could be consistent with an ischemic 2 problem in the vasculature of her right leg? 3 A. The answer to that would be yes. I 4 mean, any kind of pain could represent any 5 condition. 6 Q. Okay. Could an occlusion in the 7 popliteal trifurcation cause that type of pain? 8 A. I doubt that. Usually the pain would 9 be distal. 10 MS. TOSTI: Give me a minute. 11 (Recess had.) 12 Q. In the records you reviewed, there 13 was a call where Earline Mizsey's daughter 14 called Dr. Einstadter, I believe, on May 6th. 15 And according to his progress note, in the 16 chart, she told him that Earline Mizsey was 17 having so much pain in her leg that she was 18 crying and unable to get out of bed. 19 Dr. Einstadter's note says the pain 20 could be due to vascular compromise and that 21 given the presence of the porcine valve in the 22 aortic position and the history of recent CVA, 23 arterial embolism is certainly a possibility. 24 Now, doctor, when a patient is in 25 extreme pain and there is a question about the</p> | <p style="text-align: right;">Page 75</p> <p>1 was bilateral at that point -- were cold to the 2 touch, and that once again the vascular service 3 was appropriately consulted to evaluate the 4 patient. 5 They were able at this time to 6 extract from this patient a history that seemed 7 to indicate that the patient's symptomatology 8 was really a chronic problem that seemed to be 9 getting worse. 10 The patient admitted that this foot 11 pain had been there for a significant length of 12 time. I believe that it was written in the 13 chart twice, both on the emergency department's 14 history that this leg pain had been there for 15 four months, and per the vascular surgeons, the 16 pain was in the area of the calf and seemed to 17 improve after the walking, which exacerbated the 18 pain, stopped. These symptoms are entirely 19 compatible with the history of peripheral 20 vascular disease and claudication. 21 Q. Doctor, did you notice that there was 22 a difference in the history that the emergency 23 room physician took as opposed to what the 24 vascular surgery consultant had in regard to the 25 length of time that Earline Mizsey was having</p> |
| <p style="text-align: right;">Page 74</p> <p>1 disruption of the blood supply to a limb by an 2 emboli, doesn't that call for immediate medical 3 evaluation? 4 A. If there is any doubt, yes. And I 5 think Dr. Einstadter appropriately advised them 6 that if there was any doubt at all whatsoever 7 about the possibility of this being from a 8 serious cause, to go directly to the emergency 9 room. 10 Q. In fact, Earline Mizsey was taken by 11 her daughter to Metro's ER on, I believe, May 12 6th because of her severe leg pain. The 13 diagnosis of claudication was made, I believe. 14 A. Yes. 15 Q. I would like to ask if you would 16 agree with that diagnosis on that visit? 17 A. Yes. 18 Q. Tell me why you believe that that was 19 an appropriate diagnosis. 20 A. At this point in time, the 21 presentation was somewhat different. It seemed 22 like the symptoms were more consistent with a 23 peripheral vascular disease process. 24 At this point in time, there was 25 comment made that the patient's feet -- and it</p> | <p style="text-align: right;">Page 76</p> <p>1 symptoms? Did you think there was an error? 2 Dr. Gilles says that she was having a 3 bilateral foot pain over the last four weeks, 4 and in the vascular surgery notes it says four 5 months. Do you think maybe an error was made 6 there? 7 A. I see in the chart where it's written 8 four months twice, both in the personal 9 handwriting of the physician that filled out the 10 emergency department history. 11 Q. Do you see the typewritten note of 12 Dr. Gilles? 13 A. Yes, I see that. 14 Q. In her history? 15 A. Yes. There may be a typographical 16 error, I don't know. And I can't explain the 17 discrepancy exactly. But I do know that, you 18 know, the chronic symptomatology was worse on 19 walking, better with rest, is quite classic of 20 peripheral vascular disease secondary to 21 thrombosis and claudication. 22 Q. Doctor, the description of the pain 23 that she had being so severe, that she was 24 unable to get out of bed, is not a typical 25 description of claudication pain, is it, doctor?</p> |

19 (Pages 73 to 76)

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1 A. Well, it seemed like the claudication
2 was progressing. And although pulses were
3 dopplerable all the way down, there was concern
4 that this might be approaching a stage where an
5 intervention may have to be done. I think it
6 was appropriate to order a more definitive
7 imaging study to be done the very next day. I
8 don't think that it was absolutely necessary to
9 do that on an emergency stat basis, because
10 there was pulsation all the way through to the
11 foot.

12 Q. And her complaints that brought her
13 to the emergency room were her right leg
14 symptoms; correct?

15 A. Right. She did also state that she
16 had pain in the left leg as well, but that the
17 pain was worse on the right than the left.

18 Q. In her leg or her foot?

19 A. Probably foot.

20 Q. Doctor, you would agree that with
21 underlying peripheral vascular disease in the
22 legs, you can still have an embolic event that
23 cuts off the arterial blood supply and causes
24 acute ischemia in the leg; correct?

25 A. Yes.

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1 than claudication; correct? That would still
2 have to be a possibility; correct?

3 A. I guess it's a remote possibility.

4 Putting the whole history together, in the fact
5 that this pain upon presentation on the 6th per
6 Ms. Mlzeys herself is of a chronic long
7 duration, and whether it was four weeks or four
8 months, which we haven't determined, that does
9 not go along with an acute embolic process that
10 occurred on that day or the day before.

11 In addition, just, you know, a short
12 period of time before, the patient, looking at
13 it globally, was seen in Dr. Einstadter's office
14 and was found to have a condition that did not
15 indicate that there was a continuous embolus
16 going on or recurrence.

17 Q. Well, in the vascular surgeon's note
18 it says complaining of worsening right foot pain
19 and burning sensation since this morning.

20 That's an indication that there was a change in
21 the pain; correct?

22 A. Correct.

23 Q. And so would there --

24 A. But this is a continuum of a process
25 going on for four months.

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1 Q. Was it reasonable for Dr. Gilles to
2 call for a vascular consult at this visit?

3 A. I believe so.

4 Q. And is it your understanding that
5 that vascular consultant was Dr. Alexander?

6 A. I believe that the official
7 consultation went to him, and I believe the
8 resident ~~am~~ examined the patient on
9 Dr. Alexander's behalf.

10 Q. Do you have an opinion as to whether
11 it was appropriate to discharge Earline Mlzeys
12 from this emergency room visit on May 6th?

13 A. I believe I answered that question
14 before and said that because pulses were
15 dopplerable all the way into the foot area that
16 there was no indication that there was an abrupt
17 obstruction.

18 And although it seemed like this was
19 claudication with questionable pain, worsening
20 at rest, that it was appropriate to order the
21 imaging study for the very next day.

22 Q. Doctor, from the assessment that was
23 done in the emergency room, it would not be
24 possible to rule out that her compromise of the
25 arterial circulation was due to emboli rather

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1 Q. Earline Mlzeys underwent a vascular
2 study on May 7th of '98 and she was found to
3 have a right popliteal trifurcation occlusion
4 with severe distal ischemia, just a day after
5 this emergency room visit.

6 Do you have an opinion as to whether
7 the arterial occlusion in her right leg was
8 caused by emboli originating from her heart?

9 A. No, I don't. That's an ultrasound
10 study, that's not an angiogram or an imaging
11 study. That point of view I can't really
12 comment on whether it was an embolus or
13 thrombosis.

14 Q. Would you be able to tell the
15 difference even on an angiogram if it was an
16 embolism or thrombosis?

17 A. I think that would be a question you
18 best ask the vascular surgical experts.

19 Q. Do you have an opinion based on that
20 arterial study whether it should have raised a
21 concern for emboli from the heart caused by
22 bacterial endocarditis?

23 A. I think we are getting out of my area
24 of expertise here and I don't have an opinion in
25 that regard.

20 (Pages 77 to 80)

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| <p style="text-align: right;">Page 81</p> <p>1 Q. If you don't have an opinion, tell me 2 that, doctor, and we will go on to something 3 else. 4 Doctor, in retrospect, on the basis 5 of that ultrasound, do you have an opinion as to 6 whether the pain that she was having in the 7 emergency room on April 26th was due to arterial 8 occlusion in her popliteal trifurcation? 9 A. The ultrasound doesn't help me decide 10 what happened four days before. 11 Q. I have just a couple questions in 12 regard to your report, if you would like to look 13 at that for just a second. 14 On page two of your report, at the 15 beginning part of the paragraph on that page, 16 you refer to her carotid artery disease as part 17 of her past medical history. And we had looked 18 at her carotid ultrasound that showed very mild 19 plaque. 20 Is that the carotid artery disease 21 that you are referring to? 22 A. Yes. 23 Q. Now, you have also mentioned in your 24 report on page, I think it's three, at the top 25 paragraph, when you are talking about</p> | <p style="text-align: right;">Page 83</p> <p>1 opinions that you intend to offer in the trial 2 of this matter? 3 A. I believe so. 4 Ms. TOSTI: Then I don't believe that 5 I have any further questions for you and I thank 6 you for your time this evening. 7 8 (Deposition concluded at 9:10 p.m.) 9 (Signature not waived.) 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25</p> |
| <p style="text-align: right;">Page 82</p> <p>1 Dr. Elstadter's visit, and you mention he notes 2 on an exam that her extremities were warm with 3 good capillary refill, and both popliteal -- I'm 4 sorry, both posterior tibial and dorsalis pedis 5 pulses were intact. 6 Would you expect that type of finding 7 in a patient that had peripheral vascular 8 disease and claudication to the extent that it 9 was seen at that emergency room visit on May 10 6th? 11 A. This exam, I believe, was on April 12 30th, which is roughly a week before. So there 13 comes a point in the continuum of the disease 14 process where there is good peripheral flow on 15 rest, pulses can be palpable, and claudication, 16 meaning that once there is an exercise stress 17 test, if you will, to the muscles of the 18 extremities that is what causes the pain. 19 Now the pain has progressed to a 20 point where there seems to be interference and 21 with the blood flow and worsening of the 22 condition at that point, so I think this is 23 entirely consistent with continuum of the 24 disease process. 25 Q. Doctor, have we covered all of your</p> | <p style="text-align: right;">Page 84</p> <p>1 AFFIDAVIT 2 I have read the foregoing transcript from 3 page 1 through 83 and note the following 4 corrections: 5 PAGE LINE REQUESTED CHANGE 6 7 8 9 10 11 12 13 14 15 16 17 18 Richard Frires, M.D. 19 Subscribed and sworn to before me this 20 day of , 2001. 21 Notary Public 22 23 My commission expires 24 25</p> |

21 (Pages 81 to 84)

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1 CERTIFICATE

2
3 State of Ohio,
4 SS:
5 County of Cuyahoga.

6
7
8 I, Vivian L. Gordon, a Notary Public within
and for the State of Ohio, duly commissioned and
9 qualified, do hereby certify that the within
named RICHARD FRIRES, M.D. was by me first duly
10 sworn to testify to the truth, the whole truth
and nothing but the truth in the cause
11 aforesaid; that the testimony as above set forth
was by me reduced to stenotypy, afterwards
12 transcribed, and that the foregoing is a true
and correct transcription of the testimony.

13
14 I do further certify that this deposition
was taken at the time and place specified and
was completed without adjournment; that I am not
15 a relative or attorney for either party or
otherwise interested in the event of this
16 action.

17 IN WITNESS WHEREOF, I have hereunto set my
hand and affixed my seal of office at Cleveland,
18 Ohio, on the 3rd day of July, 2001.

19
20 *Vivian L. Gordon*
21

22 Vivian L. Gordon, Notary Public
23 Within and for the State of Ohio
24 My commission expires June 8, 2004.
25

WORD - INDEX

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H U R O N
H O S P I T A L
CLEVELAND CLINIC HEALTH SYSTEM

PLAINTIFF'S
EXHIBIT

Department of Emergency Medicine

Richard F. Frires, M.D.
Chairman, FACEP, PAAFP

March 27, 2001

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Reminger and Reminger
Attorneys at Law
113 St. Clair Avenue, NE
Cleveland, Ohio 44114-1273

RE: E/O Earline Mizsey vs. MetroHealth Medical Center, et al
File No.: 393899

Dear Mr. Kilbane:

I am writing to you in answer to your request that I provide you with an expert opinion on the care rendered to Ms. Earline Mizsey, by the emergency physicians in the Emergency Department at MetroHealth Medical Center, Cleveland, Ohio on April 21, 1998, April 26, 1998, and May 6, 1998.

I have had the opportunity to review the following materials sent to me regarding the above captioned matter:

- 1) MetroHealth Medical Center: Out-Patient Care 1/9/95 to 8/5/98
- 2) MetroHealth Medical Center: Emergency Room Visit 4/21/98
- 3) MetroHealth Medical Center: Emergency Room Visit 4/26/98
- 4) MetroHealth Medical Center: Emergency Room Visit 5/6/98
- 5) Southwest General Hospital: Emergency Room Visit 5/8/98
- 6) MetroHealth Medical Center: Admission 5/8/98 to 5/15/98
- 7) Deposition: Douglas Einstadter, MD
- 8) Deposition: Jeffrey Pennington, MD
- 9) Deposition: Elizabeth Dorr McKinley, MD
- 10) Deposition: Thomas W. Graber, MD
- 11) Deposition: Louis Rakita, MD
- 12) Deposition: Raymond Vrobel, MD

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- 13) Deposition: Leslie Walter
- 14) Deposition: Catherine Visnic
- 15) Expert Report: Raymond W. Rozman, Jr, MD
- 16) Expert **Report: Ian Baird, MD**
- 17) Expert Report **Claude Brachfeld, MDs**

Ms. Mizsey **was** a 73 year old female with a **past** medical *history* of osteoarthritis, hypertension, hyperlipidemia, diabetes mellitus, coronary **artery disease**, carotid **artery** disease, *status* post coronary artery **bypass graft**, and **was status** post aortic valve replacement in 1994 for severe aortic stenosis. On March 10, 1998 she **was** seen at the Southwest General Hospital for malaise, low-grade fever **and** dropping **things**. Her neurological **exam was** within normal **limits** and after a work up she was diagnosed with probable **TIA and** sinusitis. She **was** seen by Dr. Einstadter on March 13, 1998 and complained of some clumsiness in **the** left **hand**. Dr. Einstadter noted **a** left pronator drift in Ms. **Mizsey** and slight decrease **strength** in the left leg. **His** diagnosis was acute CVA now **three** days old **and** he ordered a carotid **ultrasound** and echo to rule out embolic source.

Dr. Einstadter **again** saw her in the **outpatient** clinic on March 18, 1998. At that visit Ms. Mizsey presented with **sensory** and proprioceptive deficits of the **left** upper extremity. **The** carotid ultrasound **and** echo **were** pending. **On April 9, 1998, an** echocardiogram was performed which suggested bioprosthetic deterioration, **which** could be a potential embolic source. **A** transesophageal echocardiogram **was** suggested to further clarify the status of the aortic **valve**. **Also on April 9,** a carotid ultrasound **was** performed which **showed** mild calcified plaque bilaterally.

On April 21, 1998, Ms. **Mizsey** presented to **the** MetroHealth Emergency Department and **was** evaluated by Dr. Janet Poponik for the complaint of **right** hand tremor. Her neurological **exam** revealed old **sensory deficits in** the **left upper** extremity and old **left** facial droop. There were no new neurological deficits. Her symptoms **were** attributed to **anxiety state** and she was encouraged to follow up with Dr. Einstadter as scheduled.

On April 26, 1998, Ms. Mizsey presented to the MetroHealth Emergency Department again. Ms. Mizsey complained of **pain** throughout **her right leg since** the previous night. **This** pain **came** on suddenly after stepping **out** of the shower. The **pain** radiated from the foot to the **hip**. Dr. Jeffrey Pennington evaluated Ms. **Mizsey** and **noted** that he **suspected** delayed **capillary** refill **and that the** pedal pulses **were** difficult to palpate. The **vascular** surgery service **was** consulted and it was determined that she had adequate pulses in both **legs**. The **diagnosis of** radiculopathy **was made** and Ms. **Mizsey** was discharged on Motrin for **pain** and advised follow up with Dr. Einstadter within **48** hours. **She was** sent home with careful **warnings** to return to **the** ED if her leg pain worsened or she developed numbness, weakness, or **any other problems**.

On April 30, 1998, she **saw** Dr. Einstadter for follow up in **the** Outpatient Department. It **was** noted that Ms. **Mizsey** appeared to be depressed, **noting that** her daughter recently

died after a long bout with pancreatic cancer. Ms. Mizsey complained of a burning type pain in the right leg and foot, which she admitted, had been there over the past one to two months. On exam the extremities were noted to be warm with good capillary refill and both PT and DP pulses were intact. Because of the duration and nature of the pain, Dr. Einstadter's impression was that Ms. Mizsey's pain was consistent with a peripheral neuropathy secondary to her diabetes.

On May 6, 1998, Ms. Mizsey returned to the MetroHealth Medical Center Emergency Department. Ms. Mizsey saw Dr. Maxime Gilles with the complaint of persistent right leg and foot pain as well as pain in the left foot. The pain again was described as burning pain. Her vital signs were Temperature 36.1, Pulse 100, RR 20 and Blood Pressure 144/77. Dr. Gilles consulted vascular surgery to see Ms. Mizsey because she had difficulty palpating the pulses in her lower extremities and her feet were cool. Ms. Mizsey was evaluated by the vascular surgery service in the emergency department. Ms. Mizsey admitted to having calf pain with walking for four months. She complained of right foot pain and burning sensation since the morning. Her history also included bilateral foot surgery for bunions in 1991. On exam her feet were cold. Right toes appeared cyanotic and capillary refill was greater than two seconds. Ail pulses were either palpable or dopplerable. Vascular surgery diagnosed peripheral vascular disease with history of claudication and questionable pain on rest. They scheduled an angiogram for the next day to determine the vascular status of her legs.

On May 8th, 1998 Ms. Mizsey was transported by ambulance to the Southwest General Health Center with difficulty speaking and right-sided weakness. She was diagnosed as having a stroke and was transferred to MetroHealth Medical Center. Ms. Mizsey was admitted to MetroHealth from May 8 to May 15, 1998. Her evaluation eventually revealed the presence of bioprosthetic valve endocarditis with blood cultures positive for the presence of peptostreptococcus bacteremia. On May 13, 1998 Ms. Mizsey suffered a further deterioration in her neurological status and was transferred to the Cleveland Clinic Foundation for possible aortic valve surgery. The decision was made to not proceed with surgery, as there was general agreement that they were able to control her infection well with antibiotics. She was eventually transferred to the Broadview Multicare Center for home IV antibiotics. Eventually, Ms. Mizsey expired while in the nursing home.

After review of the above records and depositions, it is my opinion that the medical care provided to Ms. Mizsey in the emergency department on all visits was reasonable and met the standard of care for emergency medicine. It is widely recognized that bacterial endocarditis is a challenging and elusive diagnosis to make. A definitive diagnosis is only made on autopsy or on direct visualization of the heart valve involved at the time of surgery. Fever is the most prevalent clinical finding in prosthetic valve endocarditis. Evidence of a new or changing heart murmur, signs of valvular dysfunction such as congestive heart failure, conduction abnormalities and chest pain are further signs and symptoms suggestive of endocarditis. This patient did not exhibit any of these signs or symptoms upon presentation to the emergency department at Metrohealth.

On the latter two MetroHealth emergency department visits, Ms. Mizsey's **pain was** very consistent with neuropathic **pain** either from diabetic peripheral neuropathy or **radiculopathy**. The emergency physicians involved prudently sought **consultation** with the **vascular surgery service** on both these visits and because of the chronic **nature** of Ms. Mizsey's symptoms, **the most** likely cause of her persistent **pain** was peripheral **vascular disease** as was suggested by the **vascular service** on May 6, 1998.

Ms. Mizsey **did not have** any **stigmata** often seen in bacterial **endocarditis** **such as** Osler nodes, **Janeway** lesions, petechiae, clubbing, splenomegaly, or splinter hemorrhages. With no signs of fever, heart failure, or **new** or **changing** **murmur** there **would** be no reason to suspect endocarditis on **any of** these emergency department visits. There **was** not **sufficient** clinical evidence to **make** the diagnosis of **endocarditis** **on** any of these emergency department **visits** and I **believe** MetroHealth's emergency department physicians appropriately evaluated Ms. Mizsey, treated **her** **immediate** needs, and appropriately referred her for further **vascular studies** in a timely **fashion**. Ms. Mizsey **was** well managed in the emergency department on **all** visits.

MetroHealth's emergency physician **staff** displayed the skill and **diligence** **expected** of emergency physicians and clearly met **the** standard of **care** in their evaluation of Ms. **Mizsey**. I hold these opinions **Within** a reasonable **degree** of **medical** certainty. Please do **not hesitate to contact me if there is any additional information or input that I can provide**.

Sincerely yours,


Richard F. Frires, MD FACEP