

1 The State of Ohio,)
2) SS:
County of Cuyahoga.)

3 IN THE COURT OF COMMON PLEAS

4 Thomas J. Lyzen,
5 Administrator of the
Estate of Thomas J. Lyzen, II,
6 et al,

Plaintiffs,

7 vs.

CASE NO. 307715

8 Chandrakant Patel, M.D.,
9 et al,

10 Defendants.

11 * * *

12 Deposition of a Defendant,

13
14 MARC R. LEVINE, M.D., by telephonic means, called
15 by the Plaintiffs as upon cross-examination,
16 taken before Kathleen A. Hopkins Durrant, a
17 Notary Public within and for the State of Ohio,
18 at the Offices of Becker & Mishkind Co., LPA, 134
19 Middle Avenue, Elyria, Ohio, on Tuesday, the 21st
20 day of October, 1997, at 10:30 a.m., pursuant to
21 agreement of counsel.

22 * * *

1 APPEARANCES:

2 On behalf of the Plaintiffs:

3 Michael F. Becker, Esq.
4 Suzanne Veverka, R.N.
5 Becker & Mishkind Co., LPA
134 Middle Avenue
Elyria, Ohio 44035

6 On behalf of Defendant Dr. Levine:

7 Anna Moore Carulas, Esq.
8 Jacobson, Maynard, Tuschman & Kalur Co., LPA
1001 Lakeside Avenue
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9 Cleveland, Ohio 44114-1192

10 On behalf of Defendant Dr. Patel & Dr. Zahka:

11 Cheryl O'Brien, Esq.
12 Jacobson, Maynard, Tuschman & Kalur Co., LPA
1001 Lakeside Avenue
Suite 1600
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14 On behalf of Defendant Dr. Vanhare:

15 Linda Epstein, Esq.
16 Jacobson, Maynard, Tuschman & Kalur Co., LPA
1001 Lakeside Avenue
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Hospitals of Cleveland:19 George M. Moscarino, Esq.
20 Arter & Hadden, Esqs.
Suite 1100
21 925 Euclid Avenue
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23
24
25 Also Present: Lee Ann Lyzen

P R O C E E D I N G S

* * *

CURRICULUM VITAE MARKED PLAINTIFF'S EXHIBIT
1 FOR IDENTIFICATION.

* * *

MR. BECKER: Let the record
reflect this is the discovery deposition of Dr.
Marc Levine being taken by telephonic means. And
can we have a waiver of any defects in the manner
that we're taking this deposition?

MS. CARULAS: Yes.

MR. BECKER: And can we also
have an agreement that the Doctor can be sworn by
an Ohio Notary?

MS. CARULAS: Yes.

MR. BECKER: Okay. If you
would proceed, Kath, to swear the Doctor we'll
get underway.

* * *

MARC R. LEVINE, M.D.,
of lawful age, a Defendant herein, called
by the Plaintiffs for the purpose of
cross-examination as provided by the Ohio
Rules of Civil Procedure, being by me
first duly sworn as hereinafter certified,

deposed and said as follows:

CROSS-EXAMINATION OF MARC R. LEVINE, M.D.

BY MR. BECKER:

Q. Doctor, would you tell us your full name, please?

A. Marc R. Levine.

Q. And what is your business address?

A. The Childrens Regional Hospital at Cooper Hospital, University Medical Center, Plaza 509 or 309, excuse me, Camden, New Jersey.

Q. Okay. Doctor, your counsel has been kind enough to recently provide me with a copy of your vitae, which we have marked for purposes of this record as Levine Exhibit 1.

And at the very end of the vitae it's noted as revised October of 1997, so would it be safe for me to assume that this vitae is in fact current?

Q. Hello.

A. We're here. Can you hear us?

Q. Yes.

Did you hear my question, Doctor?

A. You asked if my curriculum vitae was current?

Q. Yes.

A. I answered yes.

Q. Okay.

1 A. Sorry you couldn't hear me.

2 Q. Doctor, have you had your deposition taken
3 before?

4 A. That's correct, yes.

5 Q. Okay. I just want to review the ground rules for
6 you before we get underway.

7 This is a question and answer session under
8 oath. It's important you understand the question
9 that has been asked. If the question doesn't
10 make sense or is inartfully phrased, I'd ask you
11 to tell me so and I'll attempt to rephrase or
12 restate the question. Okay?

13 A. Yes.

14 Q. Also it's very important that you answer verbally
15 because it's difficult for our Court Reporter to
16 take down head nods or uh-huh, and so we don't
17 have to figure out what you meant by that. So if
18 you answer affirmatively we'd ask you to use the
19 word yes and of course negatively no. Okay?

20 A. Okay.

21 Q. However, unless you indicate otherwise to us
22 today, I'm going to assume that you have fully
23 understood the question that has been posed and
24 you are giving your best and most complete answer
25 today. Fair enough?

1 A. Fair enough.

2 Q. Okay. Doctor, would you tell me each and every
3 thing you have reviewed in preparation for this
4 deposition?

5 A. I have reviewed the hospital records of the first
6 admission, slides dated July, July 15th through
7 August the 5th; depositions of Dr. Vanhare, Dr.
8 Zahka and Dr. Patel; glanced over the records
9 from the second admission.

10 Q. Anything else?

11 A. That's everything.

12 Q. Do you have any personal notes or are there any
13 personal notes that you generated as a result of
14 your care on this particular child?

15 A. No.

16 Q. And that question applies whether in the chart or
17 outside of the chart. So the answer also would
18 be no?

19 A. Correct.

20 Q. Okay. Can you explain to me why there is no
21 entry by you in the chart?

22 A. Can you specify?

23 Q. I'm sorry, we didn't hear that.

24 A. Are you referring to a specific period?

25 Q. Right. Maybe I should precede that question by

1 telling you to be fair with you, Doctor, that it
2 has been represented to us, Plaintiff's counsel,
3 that you were the, you were the pediatric
4 cardiologist on service from approximately the
5 17th of July, 16th of July until August 5th.

6 My first question to you, is that
7 representation accurate?

8 A. I believe that could be inaccurate.

9 Q. Okay.

10 A. I was on service according to my recollection
11 between July 18th and July 22nd. Following that
12 I went on vacation. On those four days, that was
13 a Monday through a Thursday, that I was on
14 service. Initially I was on service through
15 August 1st.

16 Q. We didn't hear that.

17 A. August 1st, August 5th I was also on service.

18 Q. So you were on service from the 18th to the 22nd
19 and then from the 1st to the 5th?

20 A. That's the 18th through the 21st.

21 Q. Okay. And then August 1st through August 5th,
22 correct?

23 A. That is our recollection, yes.

24 Q. What is the basis for that recollection?

25 A. I reviewed that with, I have a personal scheduler

1 that I had some of my old schedules in.

2 Q. Are those documents still in existence?

3 A. No, not documents, electronic Wizard. As far as
4 I know the original schedules are not in
5 existence. I certainly don't have any of them.

6 Q. Well, whose Wizard was this that you reviewed?

7 A. My own.

8 Q. So based on your Wizard you were taking care of
9 Tom Lyzen or at least were the pediatric
10 cardiologist on service for approximately seven
11 days of his first hospitalization?

12 A. That's including both periods. It was originally
13 four days, yeah, and another four days towards
14 the end.

15 Q. Okay.

16 A. I was on service. I was not taking care of him
17 directly.

18 Q. Okay. Well, who would have been on service from
19 the 15th through the 18th based on your
20 knowledge?

21 A. I have no knowledge of that.

22 Q. And who would have been on service between the
23 21st and August 1st?

24 A. Again, I have no knowledge of who was on. I just
25 have, I have my records the days I would have

1 been rendering the service.

2 Q. All right. Well, then how many echoes were done
3 and/or interpreted during those approximate eight
4 days that you were in charge of Tom's cardiology
5 care during Tom's first hospitalization?

6 A. I think I have to object to the phrase in charge
7 of Tom's cardiology care. We were consulted, and
8 initially in reviewing the records we'd have done
9 a consult on him. I hadn't done it, but one of
10 my colleagues had.

11 The echoes that I can see from my review of
12 the record over that -- actually there was an
13 echo done -- would you rephrase the question
14 again so that --

15 Q. I sure can, Doctor. In fact, I might be able to
16 answer it myself.

17 A. How many echoes were done?

18 Q. Well, I see an echo done on the, on the 17th.

19 A. Correct.

20 Q. And did you have any input on that echo; did you
21 intrepret it or relay the interpretation?

22 A. My recollection is of it being interpreted by Dr.
23 Patel.

24 Q. Maybe we should start with your independent
25 recollection of this particular case.

1 What is your recollection of this case
2 relative to who was requesting input from you and
3 who were you getting back to and what kind of
4 input Dr. Patel was giving you, what is your
5 recollection of that?

6 A. I have very little recollection of this case. It
7 was over three years ago. Really recall very
8 little about it.

9 Q. Well, the first echo was done on the 15th of
10 July, the second, July 17th. Are you saying that
11 you probably were involved in relaying the
12 interpretation of the 17th echo to neonatology
13 and providing them some advice?

14 A. I again have very little recollection of my
15 involvement in the case.

16 Q. Okay. Well, the next, the third echo was done
17 apparently on the 21st of July. What likely
18 would you have done vis-a-vis receiving input
19 from Patel as well as giving input to neonatology
20 on the 21st?

21 A. 21st of August?

22 Q. Of July.

23 A. Excuse me, of July.

24 I guess, could you rephrase the question?
25 I'm not quite sure what you're asking, sir.

1 Q. Well, I'm interested in the interplay between Dr.
2 Patel, you, while you're on service and
3 neonatology. How did it work, what input did you
4 give to neonatology?

5 A. Are you asking what specifically in this
6 instance, in this case?

7 Q. Yes.

8 A. I have no recollection of directly caring for
9 this patient.

10 Q. Then I'm assuming that you did not care for this
11 patient during his second hospitalization?

12 A. According to my review of the chart I was not
13 directly involved in Thomas' care during his
14 second hospitalization.

15 Q. Okay. Were you involved in any conferences
16 regarding Thomas, that these conferences occurred
17 during the second hospitalization?

18 MS. CARULAS: Note my objection
19 to any conferences. This is Anna Carulas.

20 A. I have no direct recollection of specifically
21 being involved in conferences. We had weekly
22 conferences. I noted in some of the depositions
23 that was already explained to you. Physically I
24 would have been at those conferences, but at this
25 time I don't recall specific conversations.

1 Q. All right, Doctor. Let me ask you a few
2 questions regarding your vitae.

3 You did a fellowship in pediatric cardiology
4 in the New York City region, is that correct,
5 Long Island?

6 A. It was Long Island Jewish-Hillside Medical Center
7 in New Hyde Park.

8 Q. Okay. And then you left your fellowship and then
9 you went to MCO in Toledo?

10 A. Correct.

11 Q. And you were at MCO for ten years?

12 A. Correct.

13 Q. And you came to UH in 1991?

14 A. Correct.

15 Q. And you stayed from 1991 until 1996 and then you
16 left to take your current position?

17 A. Correct.

18 Q. What month in '96 did you leave?

19 A. That would have been July when I finished or the
20 end of June.

21 Q. What was the reason you left UH to go to New
22 Jersey?

23 A. Other opportunities.

24 Q. I'm sorry, I didn't hear that.

25 A. Other opportunities.

1 Q. Did you leave voluntarily from UH?

2 A. Yes.

3 Q. I see that you are an echocardiographer, is that
4 correct?

5 A. Echocardiography is one of my skills, that is
6 correct.

7 Q. From whom and when did you learn that skill?

8 A. I initially learned echocardiography when I was a
9 fellow from various attendings in the program.
10 I've continued to learn it over the next 16 years
11 of my career. I really can't say I learned it
12 from any single --

13 Q. Source.

14 A. Excuse me, I didn't hear your last statement,
15 sir.

16 Q. I was just finishing your sentence. You
17 hadn't -- there's not a single source that you
18 learned it from?

19 A. That's correct.

20 Q. Okay. You didn't mention the echo films as
21 material you reviewed in preparation for this
22 deposition. Is it fair for me to conclude that
23 you have not recently looked at those, these echo
24 films?

25 A. Referring to the videotapes?

1 Q. Yes.

2 A. Then I have not reviewed the videotapes, that is
3 correct.

4 Q. Okay. Based on the information you have at hand
5 and the material you've reviewed, did you
6 actually interpret the echoes while you were on
7 service for Tom Lyzen?

8 A. During the first admission?

9 Q. Yes.

10 A. I have no recollection or I have no, I have no
11 record that I ever interpreted formally any of
12 the echoes that --

13 Q. That Dr. Patel read?

14 MS. CARULAS: Is that a
15 question, Mike? I'm sorry.

16 MR. BECKER: It sounded like he
17 didn't finish his answer or we did not hear the
18 end of his answer.

19 A. I'll repeat it for you.

20 I have no recollection or record that I
21 formally interpreted any of Thomas Lyzen's
22 echoes.

23 Q. Okay.

24 MS. CARULAS: During the first
25 hospitalization.

1 A. During the first hospitalization.

2 Q. All right. You're licensed in, you're still
3 licensed in Ohio to practice medicine?

4 A. I believe my license is still current in Ohio,
5 that is correct.

6 Q. You're licensed in New Jersey, correct?

7 A. That's correct.

8 Q. Any other states?

9 A. Pennysylvania.

10 Q. Have you ever had your license suspended, revoked
11 or called into question by any state board?

12 A. No, sir.

13 Q. Have you ever had any hospital privileges
14 suspended, revoked or called into question?

15 A. No, sir.

16 Q. How would you describe your current clinical
17 practice?

18 A. They have a clinical cardiology program at the
19 hospital that involves outpatient echoes,
20 emanations. We bring our patients to St.
21 Christopher's Hospital in Philadlephia for
22 inservice catheterization and surgery.

23 Q. Have you come into contact with Dr. Elvin Shin?

24 A. Personally, no.

25 Q. Have you deferred interpretations of

1 echocardiography, echocardiograms to him?

2 A. Referred interpretations?

3 Q. Yes.

4 A. No, sir.

5 Q. Have you or someone from your division consulted
6 with him?

7 A. I have not consulted with him. I can't tell you
8 specifically that someone from my division has.

9 Q. Okay. What's the reason that you contact the
10 Philadelphia Childrens Hospital; for
11 intervention?

12 A. No, no. I said I didn't contact the Philadelphia
13 Childrens Hospital. I said that I have
14 privileges at St. Chritopher's Hospital and will
15 bring patients there when I will do inpatient
16 cardiac catheterizations or surgery, we'll
17 transfer the patients to St. Christopher's
18 Hospital.

19 Q. I thought you said something about Philadlephia?

20 A. St. Christopher's Hospital is in Philadelphia.
21 There is a second Childrens Hospital in
22 Philadelphia known as Childrens Hospital of
23 Philadelphia, CHOP.

24 Q. Okay. I'm sorry. I misunderstood you.

25 A. A separate institution.

1 Q. Okay. So you do the intervention at St.
2 Christopher's in Philadelphia?

3 A. I will do invasive cardiology. I do cardiac
4 catheterizations. I generally have steered clear
5 of doing interventional cardiology in the last
6 few years.

7 Q. Why?

8 A. Because it's a philosophical decision in some
9 ways in that there are people who subspecialize
10 in interventional cardiology and they're
11 available. It's to everybody's benefit to give
12 them the interventional cases. They can get the
13 most experience with them.

14 Q. All right. So currently what is the reason that
15 you see people at St. Christopher's in
16 Philadelphia?

17 A. I don't see people at St. Christopher's. I will
18 bring patients there because we do not have the
19 facilities at Cooper Hospital yet to perform
20 cardiac catheterization or surgery. We will
21 bring some of our patients there to perform those
22 services.

23 Q. All right, Doctor, I want to talk a little bit
24 about your medical/legal experience.

25 Have you ever acted yourself as an expert in

1 a medical/legal matter?

2 A. Yeah, I have.

3 Q. All right. Would you tell me a little bit about
4 how many cases?

5 A. Over the years probably 15 or 20.

6 Q. And do you keep an index or a log of the cases
7 that you participated in?

8 A. No.

9 Q. What records are available that could tell you
10 the names of the cases and the attorneys that
11 hired you on the respective cases?

12 A. I really haven't kept records over the years of
13 those. I mean, it would be very difficult to
14 give you any kind of a comprehensive list.

15 Q. Have you ever, do you do work for both the
16 plaintiff patient as well as the defendant
17 medical provider?

18 A. I have mainly done work for plaintiffs, but
19 probably one or two for defendants.

20 Q. Can you think of some names of some plaintiffs'
21 attorneys that have consulted with you in the
22 last ten years?

23 A. No. I really don't keep the names, a record of
24 those.

25 Q. Do you have any active cases?

1 A. There is one case that I'm working on currently,
2 but I don't think I'm really at liberty to give
3 you any details of that at this point.

4 Q. Have you been identified as an expert in that
5 case?

6 A. I've actually been reviewing the records and I
7 don't, I haven't submitted a full report on that
8 yet, so I can't really say. I think I was asked
9 to review it as an expert witness.

10 Q. But to your knowledge you can't say whether or
11 not you've been identified yet?

12 A. I don't believe I have since I haven't submitted
13 the report yet.

14 Q. All right. Have you reviewed any cases as an
15 expert relative to, from the perspective of
16 whether there was a delay in diagnosis of aortic
17 or subaortic stenosis which had a negative impact
18 on the patient?

19 A. Not that I recall at the time.

20 Q. Okay. Have you ever gone and testified in the
21 Courtroom in a medical/legal case?

22 A. I have been -- I have not gone to full
23 testimony. I think the most cases I have been
24 involved in have been through deposition.

25 Q. Okay. You've given depositions, but when the

1 depositions occurred they would be at your office
2 either in New Jersey or in Ohio?

3 A. I can't recall where I -- I gave the depositions
4 at various places.

5 Q. Well, do you recall --

6 A. I don't recall ever having to go to Court for a
7 case.

8 Q. Do you recall the name of the city where the case
9 was pending, city and state?

10 A. Sorry, when you say the case was pending, I don't
11 know what you mean by that.

12 Q. Well, for example, if you look at a case for me
13 it's probable that the case is pending in
14 Cleveland, State of Ohio, whereas, if you were
15 contacted by an attorney from Miami, it's
16 probable that the case was pending somewhere in
17 some city in Florida, State of Florida?

18 A. Where the case originated from, is what you're
19 asking?

20 Q. Yes, sir.

21 A. I have looked at cases, I believe, from, from
22 Pennsylvania. There were probably several in
23 Ohio. I actually don't recall most of the
24 states. Again I don't --

25 Q. What's the medical subject matter of cases, the

1 ones that you recall, what was the medical
2 subject matter?

3 A. The subject matter has generally been pediatric
4 cardiac problems. They have ranged from
5 postoperative problems to problems, questions of
6 diagnosis, et cetera.

7 Q. Okay. Do you belong to any type of a service,
8 Doctor, that promulgates your name to either a
9 plaintiffs' bar or defendants' bar?

10 A. A service?

11 Q. Yeah, a professional expert service, do you
12 belong to any of those?

13 A. Yes. I work with a group called Medical
14 Advisors.

15 Q. And to your knowledge where are they located?

16 A. Somewhere in the Philadelphia region.

17 Q. All right. And how long have you been associated
18 with Medical Advisors?

19 A. Maybe ten years.

20 Q. All right. Have you been associated with any
21 other medical expert service other than Medical
22 Advisors?

23 A. There's another in the Cleveland area, but I
24 honestly can't recall his name at the moment.

25 Q. Okay. Soponaro in Akron?

1 A. Say that again.

2 Q. Soponaro in Akron?

3 A. That, that could be it.

4 Q. Okay.

5 A. That could be it as a matter of fact.

6 Q. Doctor, let's talk a little bit about --

7 A. Guy was the first name.

8 Q. I don't remember his first name.

9 A. Guy Soponaro, I think that's actually the one
10 that he had contacted me once or twice..

11 Q. Doctor, let's talk a little bit about your
12 experience as a defendant in a case.

13 How many times have you been a party
14 defendant in a case?

15 MS. CARULAS: Note my
16 objection.

17 MR. BECKER: Okay. You can
18 have a continuing objection, Anna, to this line
19 of inquiry.

20 Q. How many times, Doctor?

21 A. Just once.

22 Q. Just one time.

23 Is that case still pending?

24 A. No.

25 Q. Okay. Where did that case, was that filed in

1 Cleveland?

2 A. Filed in Toledo.

3 Q. Toledo?

4 A. Right.

5 Q. And what was the allegation against you at that
6 time?

7 A. It was a case where a technician hooked up an IV
8 line wrong, causing the patient to have a
9 reaction. I was the physician in charge of the
10 pediatric intensive care unit. The case was
11 settled out of Court. They determined there was
12 no admission of liability.

13 Q. Okay. That's the only time, just one case other
14 than this case?

15 A. The only time.

16 Q. Okay. Doctor, would you define a couple terms
17 for me?

18 What does aortic stenosis mean?

19 A. Aortic stenosis refers to narrowing between the
20 left ventricle and the aorta.

21 Q. What does a hypoplastic left heart mean?

22 A. That's such a generally used term, it's really
23 hard for me to define it. It refers to, in
24 general, smallness of the left heart, left side
25 of the heart.

1 Q. Did you say smallness?

2 A. Smallness or decrease in size, that's correct.

3 Q. What about the term cardiomyopathy, what does
4 that mean?

5 A. Cardiomyopathy is a very generic or generally
6 used term meaning disease of the heart muscle.

7 Q. Would a congenital malformation fall under your
8 definition of cardiomyopathy?

9 A. Would you repeat that question, please.

10 Q. Would a congenital physical malformation of the
11 heart fall within your definition of
12 cardiomyopathy?

13 A. No.

14 Q. Do you have an opinion, Doctor, as to what the,
15 what the reason was that Tom Lyzen's physical
16 condition worsened between his first and second
17 hospitalization?

18 MS. CARULAS: Objection.

19 A. That's the whole question? I don't think we
20 heard it at this end, sir.

21 Q. Do you have an opinion today as to why Tom
22 Lyzen's heart condition worsened between his
23 first and second hospitalization?

24 A. No.

25 Q. Have you talked to Dr. Zahka or Dr. Vanhare or

1 Dr. Patel regarding this case?

2 A. No.

3 Let me rephrase that. I did speak with Dr.
4 Patel at some point and learned that the case was
5 being investigated, but I have not spoken with
6 any of them regarding the details of the case. I
7 haven't spoken with any of them.

8 Q. Do you recall, I'm assuming, Doctor, you don't
9 recall any specific conversations you've had with
10 Dr. Bailey, the neonatologist, that was
11 attending?

12 A. No.

13 Q. Would your Wizard reflect whether or not you ever
14 had any hands-on care of Tom?

15 A. The only information stored in the Wizard were
16 dates, dates I have, days that I was on service,
17 the days that I was reading echoes. It's simply
18 reflections of my personal schedule.

19 Q. Okay. If I were to ask you if you ever had any
20 actual hands-on care on Tom Lyzen, would you say
21 then that you don't know?

22 A. I have no recollection, nor have I seen any
23 records that reflect that I had any hands-on
24 care.

25 Q. Similiar question. Do you have any recollection

1 having any direct contact with Tom and Lee Ann
2 Lyzen, that's the parents of Tom Lyzen?

3 A. I have no recollection of ever meeting Mr. and
4 Mrs. Lyzen.

5 Q. Do you have any criticism of the care rendered to
6 Tom Lyzen by any medical provider?

7 A. No.

8 Q. All right. Since you don't have a specific
9 recollection, tell me generally how it would work
10 if you were the pediatric cardiologist on service
11 and there would be a consult or request from
12 neonatology, explain to me generally how the
13 interplay would take place and specifically if
14 neonatology asks for another echo?

15 A. Can you be more specific with the question,
16 because you asked first about a consult, then you
17 asked about an echo. Break that question up so I
18 can answer each part specifically for you.

19 Q. I want you to assume it's true that there's
20 already been one consultation between your
21 service and neonatology, and then for whatever
22 reason you come on service and then there is a
23 new request by neonatology for another echo.
24 What likely would take place between neonatology,
25 you and the person that was in charge of the echo

1 service during that particular day?

2 MS. CARULAS: Note my objection
3 to that. I think it's awfully broad as far as
4 what would happen, but if the Doctor can answer
5 it.

6 A. Well, you know, it might vary depending on what
7 the interplay of the attendings were at that
8 point. It's certainly not unusual that if a
9 specific, if an echo were ordered directly by the
10 neonatology service, it could have been read by
11 the person reading echoes and the person on
12 service may not have been involved at all.

13 If, on the other hand, they asked us to
14 reconsult or spoke with us, curbside consult is
15 the word, just without asking to formally
16 consult, I may have reviewed the echo with Dr.
17 Patel and may have also discussed it with Dr.
18 Bailey.

19 Q. Would it be your routine to generate any notes as
20 the result of your contact with Dr. Patel and/or
21 with Dr. Bailey?

22 A. Certainly I would not have, not have generated
23 any notes as a result of my discussions with a
24 person reading echos. It might have been Dr.
25 Patel during that period.

1 If we were asked to formally consult on the
2 patient, I might have written a note or the
3 fellow on service with me might have written a
4 note, which often but not always I would have
5 cosigned.

6 Q. All right. As far as you can tell there is not
7 even a cosignature by you within Tom Lyzen's
8 chart, correct?

9 A. That is correct. There are echoes that were read
10 during the second admission by me that are signed
11 by me. There are no progress notes that I was
12 able to identify.

13 Q. There's some notes by Dr. Fink on July 18th and
14 July 21st in the chart. Apparently, for whatever
15 reason, you didn't cosign them? Take the time to
16 look at it, Doctor.

17 Let me know when you're ready, Doctor.

18 MS. CARULAS: What was the
19 question again, Mike?

20 MR. BECKER: Well, first of
21 all, I wanted him to refresh his memory about Dr.
22 Fink's notes on the 18th and on the 21st. And
23 then I want to know if he was on service during
24 that period of time why doesn't his signature
25 appear as cosigning Dr. Fink's?

1 A. Sometimes we would cosign the notes and sometimes
2 we wouldn't.

3 Q. Okay. Do you see a cosignature over Dr. Fink's
4 on those two dates that might have been one of
5 your colleagues?

6 A. I think that the signature over Dr. Fink's name
7 is Dr. Fink's signature. To the best of my
8 recollection he printed it and then signed over
9 it.

10 Q. I'm sorry. We didn't hear that.

11 A. If you'd look specifically on the note of the
12 18th, Dr. Fink's name is printed and I believe
13 that is his signature over the printing.

14 Q. Okay. Well, is it your responsibility to oversee
15 all of Dr. Fink's work and interpretation and
16 management of a pediatric cardiology patient?

17 A. At the time it would have been my responsibility
18 to oversee Dr. Fink's activity. Here again, we
19 were not managing this patient if he was being
20 managed by neonatology.

21 Q. So if Dr. Fink concludes there's no left
22 ventricle obstructive tract -- what does LVOT
23 mean?

24 A. Left ventricular outflow track.

25 Q. Okay. If Dr. Fink concludes that there is no

1 left ventricular outflow tract obstruction and
2 your signature doesn't appear on it as a
3 cosignature, would it be safe for me to assume
4 that you agreed with his interpretation?

5 MR. MOSCARINO: Objection to
6 the form. That's George Moscarino.

7 A. We would, we would have routinely discussed that
8 and most likely thought over it before Dr. Fink
9 had written the note. And my answer to your
10 question is, yes, it would be reasonable to
11 assume that I agreed with that.

12 THE WITNESS: I'm going to have
13 to take a quick break here for just a minute.

14 MR. BECKER: Okay. Let us know
15 when your back.

16 * * *

17 Thereupon, a short recess was had.

18 Thereupon, the deposition was continued
19 pursuant to recess.

20 * * *

21 MR. BECKER: Back on the
22 record.

23 Q. Doctor, do you currently have privileges at St.
24 Christopher's in Philadelphia?

25 Was that a yes? Was that a yes or a no?

1 A. That was a yes.

2 Q. Okay. And you were on vacation according to your
3 Wizard between the 21st or between the 22nd and,
4 well, the last, from the 22nd through the end of
5 July, correct?

6 A. Correct.

7 Q. Can you tell us based on the information you have
8 at hand as to which pediatric cardiologist was in
9 charge of Tom Lyzen's care between July 16th and
10 July 17th and also between July 22nd and July
11 25th?

12 A. I have no records of that.

13 Q. Who, if anyone, would be in the best position to
14 know that data?

15 A. I have no information to help you with that, sir.

16 Q. Doctor, there's a nurse's note on July 21st
17 regarding the ventilation settings on Tom Lyzen
18 and the nurse's notes reflect on the 21st that
19 they're going to discuss a decrease in oxygen
20 setting with a Dr. Patel.

21 If Dr. Patel on the 21st was merely on echo
22 service, why would the nurses be contacting him
23 on that date?

24 MS. CARULAS: Mike, we don't
25 have that in front of us. You want us to find it

1 or --

2 MR. BECKER: No, no.

3 Q. I just want you, Doctor, I want you to assume
4 it's true that there is a note under the nurse's
5 -- under the ventilation setting on the 21st,
6 and it reflects that oxygen concentration on the
7 ventilation system was decreased after
8 discussion, after discussion with Dr. Patel.

9 A. I don't know.

10 Q. Can we agree, Doctor, that if a pediatric
11 cardiologist is purely on the echo service,
12 theoretically he should not be having any direct
13 contact with the parents and/or with the nurses?

14 MS. CARULAS: Objection.

15 MR. MOSCARINO: I also object
16 to the form.

17 A. I guess I'm not sure what you're asking. I don't
18 know how to answer that question.

19 Q. Well, let's put it in another, in another
20 phrase.

21 If someone was purely on echo service, would
22 you be surprised if the nurses were consulting
23 with that physician regarding the patient's care?

24 A. No.

25 Q. Why?

1 A. You know, if an echo were ordered I'd have
2 reported the echo directly to the people.
3 Generally nurses don't consult directly with, you
4 know, regarding the care. It's physicians who
5 consult, but aside from that, you originally
6 asked the question would he be in contact with
7 the parents.

8 Q. Yeah, I was going to follow-up with that
9 question, but go ahead and answer it.

10 A. Let me kind of cut to the chase. A lot of times
11 if the physician is involved previously with the
12 care or involved with the parents, he may be
13 speaking with the parents. If not, why they're
14 not exclusively locked into just reading echoes
15 and you can't talk with anybody. So, you know,
16 the answer is, no, that would not surprise me
17 that someone who was reading echoes that month
18 might also have some input or might have spoken
19 with the nurses or might have even spoken with
20 the parents, that would not be unusual in our
21 practice.

22 Q. Doctor, can we agree that if, that if aortic
23 stenosis is suspected by a pediatric cardiologist
24 that particular pediatric cardiologist and/or his
25 colleagues and group have a responsibility to

1 define exactly where the aortic stenosis is and
2 to also quantify the severity of the aortic
3 stenosis?

4 MR. MOSCARINO: Objection to
5 the form.

6 MS. CARULAS: I object as
7 well.

8 A. Will you explain what you mean by a
9 responsibility?

10 Q. Well, do they have --

11 A. I'm not sure exactly how you want me to answer
12 that question either.

13 Q. Well --

14 A. It such a general --

15 Q. Well, if you're seeing a patient as a pediatric
16 cardiologist and if there's a suspicion that
17 there might be aortic stenosis, do you then have
18 a further duty to attempt to delineate exactly
19 where the aortic stenosis is and to quantify the
20 seriousness of the aortic stenosis?

21 A. Well, we generally do our best to assess and
22 define the lesion with the knowledge and the
23 tools that we have at hand.

24 Q. Okay. Not only do you have a responsibility to
25 find the lesion, but you have to also attempt to

1 quantify the lesion as something, whether it's
2 mild, moderate, severe or critical, correct?

3 A. Yes.

4 Q. And what are the tools at hand that will enable
5 you to, number one, isolate the lesion, and,
6 number two, to determine its severity?

7 A. First examine the patient and use the
8 stethoscope, and your hands and feel the heart,
9 listen to the heart, feel the pulses.

10 One would secondly obtain an echocardiogram,
11 a chest x-ray. I suppose that I would use an
12 echocardiogram, but if I couldn't, didn't feel
13 that I was defining it well enough, you know, one
14 might resort to a cardiac catheterization.

15 Q. One of the things you would look for in
16 determining the severity of the lesion and the
17 impact of that lesion on the left side of the
18 heart is something called pressure gradient, is
19 that correct?

20 A. A gradient is one way of defining the severity of
21 the aortic stenosis.

22 Q. And how do you determine the gradient?

23 A. You determine multiple ways.

24 Q. Well, please educate me. What are the multiple
25 ways you can choose to determine the gradient?

1 A. Probably the simplest way of determining a
2 gradient is with the echocardiogram.

3 Q. Okay. And does that take, does something called
4 the angle of interrogation of the jet come into
5 play?

6 A. In most echocardiograms done today we do not
7 quantify the angle of interrogation, because in
8 this situation we're able to line up close enough
9 so it doesn't become a factor.

10 Q. Well, ideally what do you want the angle of
11 interrogation to be?

12 A. We determine, we're trying to line up for a
13 gradient high by, we generally try to keep the
14 angle as close to parallel to the echo beam as we
15 can. That generally does not become a
16 consideration to most of the patients,
17 particularly in this scenario, it is not an
18 important issue.

19 Q. Why wouldn't it be an important issue in this
20 case?

21 A. Because we're able to line up typically for the
22 aorta and the outflow track without problems.
23 When you're within 10 or 20 degrees the actual
24 calculated change is insignificant.

25 Q. If you are outside of 20 degrees what is the

1 impact on the end product of pressure gradient?

2 A. What do you mean outside?

3 Q. When you're graded in 20 degrees.

4 A. Twenty-five degrees there's no impact. Usually I
5 said within 20, 30 degrees. At 90 degrees you
6 can't measure the gradient at all. But as I said
7 to you, in this particular scenario looking for
8 these types of deficits, it generally has very
9 little effect whatsoever.

10 Q. We didn't hear that, Doctor. Looking for these
11 type of defects -- what did you say after that?

12 A. The setting looking for left ventricular output
13 tract gradients, my experience is it has little
14 or no impact at all in order to measure the
15 gradients accurately.

16 Q. Okay. Would you agree that if the angle of
17 interrogation is not close to parallel that could
18 lead you to a falsely low pressure gradient?

19 A. Anything is possible.

20 Q. Well, isn't it likely that if you measure the
21 flow at anything greater than 20 or 25 degrees,
22 the end product pressure gradient is likely to be
23 falsely low?

24 A. I said it is possible. I would have to look at,
25 you know, a specific echo to give you a specific

1 answer. You're asking in generalities. I can
2 only answer in generalities.

3 Q. Doctor, around the 21st or -- I don't know if I
4 asked you this question. I think you were about
5 to take a bathroom break. Same question I asked
6 earlier about the note on the 18th, I'm going to
7 ask you this on the note on the 21st. Because
8 your name does not appear to be cosigned on the
9 21st, would it be safe for me to assume that you,
10 not withstanding your cosignature, agree with Dr.
11 Fink's assessment?

12 A. Yes.

13 Q. Doctor, were you and Dr. Fink able to
14 categorically rule out significant aortic
15 stenosis as a cause of Tom Lyzen's signs and
16 symptoms between the 15th of July and the 22nd of
17 July?

18 MR. MOSCARINO: Object to the
19 form.

20 MS. CARULAS: I object as well,
21 but go ahead.

22 A. Could you rephrase the question a little bit for
23 me, please.

24 Q. We'll first try to repeat and then if you still
25 have a problem I'll rephrase it.

1 MR. BECKER: Would you repeat
2 that question.

3 (Notary read back last question.)

4 MR. MOSCARINO: Same objection.

5 A. I, again it's such a general question, signs and
6 symptoms, specify which signs and symptoms, kind
7 of verify for me when you say categorically what
8 you mean and then I'll try to answer the question
9 for you.

10 Q. Well, were you able to, were you and Dr. Fink
11 able to rule out aortic stenosis as a cause of
12 the signs and symptoms that Tom Lyzen was
13 demonstrating between the 15th and the 21st?

14 MR. MOSCARINO: Objection.

15 A. Could you specify which symptoms and which signs
16 you are referring to, please?

17 Q. Well, what about, how about respiratory distress?

18 A. I believe that we were able to rule out aortic
19 stenosis as a cause of Thomas' respiratory
20 distress.

21 Q. And was that before or after Thomas' ductus
22 closed?

23 A. I would have to review the records, if you give
24 me one minute, as to when his ductus closed. I
25 don't have any -- hold on one minute.

1 Q. Okay.

2 A. Could you repeat the question again, please?

3 (Notary read back last question.)

4 A. I think we ruled it out both when his ductus was
5 open and when his ductus had closed.

6 Q. Tell us, Doctor, how did you rule it out?

7 A. No, we felt there was no significant heart
8 problem at that admission.

9 Q. And how did you make that determination?

10 A. In terms of as a cause of his respiratory
11 distress.

12 Q. How did you make that determination that --

13 MR. BECKER: What did he say
14 about significant? Hold on, Doctor. I'm going
15 to -- what did he say about significant.

16 (Notary read back last answer.)

17 Q. Doctor, you just said that you felt there was no
18 significant heart problem during that admission,
19 and I'm asking you how were you able to make that
20 conclusion; what tests did you run to make that
21 conclusion? What was the bases for that
22 conclusion?

23 A. I believe I, you know, as I told you earlier, I
24 have very little direct recollection of this
25 patient. What I am offering you is based on my

1 review of the records as I see them today.

2 Being tested, I would have to tell you at
3 this time for me to make that conclusion is the
4 fact that the echocardiogram shows no significant
5 aortic stenosis.

6 Q. Does or does not?

7 A. Significant by my definition of severe or enough
8 to be causing the respiratory distress. I'm
9 defining significant for purposes of this
10 discussion.

11 Q. Well, how do you make that determination if the
12 aortic stenosis is severe enough to cause
13 respiratory distress?

14 A. It's just based on my experience of taking care
15 of, you know, hundreds and probably thousands of
16 children like this.

17 Q. What did you feel was responsible for Tom Lyzen's
18 murmur?

19 A. I don't know that I had any feeling about it at
20 the time. I have no recollection that I examined
21 him for his murmur at the time.

22 Q. What did you feel was responsible for Tom Lyzen's
23 tachypnea, tachypnea?

24 A. Tachypnea is rapid heart or rapid breathing.

25 Q. Right.

1 A. I, again I have no recollection that I examined
2 him or record that I examined him to tell you
3 what I felt was due to tachypnea.

4 MS. CARULAS: Mike, did we lose
5 you?

6 MR. BECKER: I'm here. I was
7 waiting for a response.

8 A. We're here. I guess I didn't hear the question.
9 I'm sorry.

10 MS. CARULAS: Neither did I. I
11 didn't know there was a question pending.

12 Q. Well, the Doctor said I'll tell you what is
13 responsible for his rapid breathing and then we
14 heard some pages turn and we were waiting for an
15 answer.

16 A. No, I believe -- can we have the record be
17 reread. I don't believe I said that.

18 MS. CARULAS: He did answer
19 that question. At least that's what I heard, but
20 if you want her to reread it, go ahead.

21 MR. BECKER: Did anybody else
22 hear that? Did you, Susie?

23 (Notary read back last answer.)

24 Q. Okay. I'm sorry, Doctor. I misunderstood you.
25 Doctor, based on the chart is it likely you

1 concluded that the reason that there was a
2 finding, a new finding of increased gradient
3 pressure was because Tom was on inotropic drugs?

4 A. Yes.

5 Q. Okay.

6 A. If you are referring to the note on or around the
7 21st, I believe is what you are, is that it?

8 Q. Right.

9 A. The answer to your question is yes.

10 Q. Did you consider as a possible cause of the
11 increase in pressure gradient ductal closure?

12 A. No.

13 Q. Why not?

14 A. Has nothing to do with the gradient.

15 Q. Is it your opinion, Doctor, that pressure
16 gradient won't be impacted closure of the ductus?

17 A. It's my opinion that the pressure gradient in
18 this case will not be impacted by the closure of
19 a small ductus.

20 Q. And what's the basis of that opinion?

21 A. Sixteen years of experience.

22 Q. Doctor, were you relying on Dr. Patel's
23 interpretation of the echoes during the first
24 hospitalization?

25 A. Define relying, please.

1 Q. Well, as part of your opinion that there was no
2 significant aortic stenosis, is one of the bases
3 for that opinion Dr. Patel's interpretation of
4 the echoes?

5 A. As I review the chart today, not having reviewed
6 the echos recently, I would have to rely on the
7 written record of Dr. Patel's interpretation of
8 the echoes.

9 Q. All right. So that is one of the bases?

10 A. What I base my opinion on, on the 21st in 1994, I
11 have to tell you I don't recall.

12 Q. Doctor, if cardiology service in '94 was
13 contacted on several occasions to evaluate an
14 infant's heart during his newborn admission, did
15 the cardiology service have a routine practice to
16 see the patient prior to his discharge from the
17 NICU?

18 MS. CARULAS: Are you done?

19 MR. BECKER: I'm done.

20 A. No.

21 Q. Under what circumstances or would it solely be at
22 the discretion of the cardiologist on service as
23 to when a pediatric patient is seen prior to
24 discharge?

25 A. Please repeat the question.

(Notary read back last question.)

1
2 A. Generally my understanding is that it would
3 generally be the responsibility of the managing
4 service as to when we would see the patient prior
5 to, or who would see the patient prior to
6 discharge.

7 Q. Doctor, if you have stenosis of some
8 significance, severe to critical, and it is not
9 addressed, in other words, no intervention, and
10 that is permitted to continue, isn't it likely
11 that will have a negative impact on LV function?

12 MS. CARULAS: Note my objection
13 to the question.

14 A. Can you ask a more specific question? That's
15 such a general question again. I have difficulty
16 giving you any kind of a reasonable answer.

17 Q. Isn't one of the risks of untreated, severe
18 aortic stenosis a compromise of LV function?

19 A. Yes, I think that that's a fair statement.

20 Q. Okay. What does the term or the phrase EFE mean
21 to you, Doctor?

22 A. Endocardial fibroelastosis.

23 Q. Okay. Do you believe, Doctor, that that
24 condition can be acquired as well as congenital?

25 A. I think it's very difficult to answer that

1 question since we don't fully understand all the
2 causes of the physiology surrounding patients
3 with endocardial fibroelastosis.

4 Q. Isn't there an evolving trend in pediatric
5 cardiology in the last five years to believe that
6 EFE is more likely acquired than congenital?

7 A. It's a -- I'm sorry, I can't answer that question
8 for you. I don't know.

9 Q. Have you seen any literature, are you aware of
10 any literature to that effect?

11 A. No, sir.

12 Are you still there?

13 Q. Yes. Bear with me, Doctor.

14 Doctor, were you able to discern, given your
15 close workings with Dr. Patel in 1994, as to his
16 competency in reading echoes in that year?

17 A. Yes.

18 Q. And what did you conclude?

19 A. I concluded then and I conclude now that Dr.
20 Patel was an excellent pediatric cardiologist and
21 has excellent skills in interpreting pediatric
22 echocardiograms.

23 Q. Can the size of the aortic annulus decrease in
24 size in the early neonatal life?

25 A. I'm not aware of any documented evidence of

1 children whose annulus --

2 Q. We didn't hear the end of that. One more time.

3 A. I'm not aware of any documented evidence to show
4 that the aortic annulus had decreased in size in
5 the neonatal period. Anything is possible.

6 Q. Did you feel that Thomas Lyzen's problems in his
7 first hospitalization were related to RDS?

8 A. Repeat the question, please.

9 Q. I'm assuming that you concluded that Thomas'
10 respiratory problems were related to his RDS
11 during Tom's first hospitalization?

12 A. From my review of the record at this time I think
13 that the answer to that question is, yes, I think
14 that is what his respiratory problems were due
15 to.

16 Q. And it's not unusual, is it, Doctor, to have
17 neonatology feel that he's got a problem with the
18 heart and cardiology feel that it's more RDS, is
19 that an unusual scenario where there is that kind
20 of a disagreement?

21 A. It is not unusual for specialists of different
22 backgrounds to have different opinions.

23 Q. Okay. Dr. Bailey charts that the cardiology
24 service in the first hospitalization was
25 insistent that this child's problem was not

1 related to his heart.

2 MR. MOSCARINO: What's the date
3 of that entry?

4 MS. CARULAS: You are talking
5 about the discharge summary, right?

6 Q. No. I can't answer that off the top of my head.
7 Doctor, can you agree with me that -- I
8 think that is the discharge summary -- Doctor,
9 can you agree with me that before your service
10 would be insistent on a condition they'd better
11 well be certain that there is no lesion of any
12 significance in Tom Lyzen's heart, correct.

13 MR. MOSCARINO: Object to the
14 form.

15 MS. CARULAS: I don't
16 understand the question.

17 A. I don't understand the question either, if you'll
18 excuse me.

19 Q. Before you as a pediatric cardiologist would
20 become insistent to neonatology that the problem
21 is not the heart, you have a duty and
22 responsibility to be absolutely certain by
23 whatever means available to insure that Thomas
24 Lyzen did not have any significant lesion in the
25 left side of his heart?

1 MS. CARULAS: Note my objection
2 to the question, because we all know in life
3 nothing is absolutely certain.

4 MS. O'BRIAN: And that nobody
5 is clairvoyant, I might add.

6 MR. BECKER: That's great. I'm
7 going to repeat my question. You guys have all
8 the objections you want.

9 Q. Doctor, you listen to my question and answer it
10 if you can.

11 (Notary read back last question.)

12 A. After hearing your question I'm not really sure
13 what you mean by insistent. I previously
14 answered the question when you said, when you
15 asked it in a similar form that we would use all
16 the means available to come up with the best
17 diagnosis and quantification of the patient's
18 lesion.

19 Q. And you have a duty to utilize all the means
20 available to quantify that lesion before you
21 might, so as you can avoid giving neonatology the
22 wrong information, correct?

23 MS. CARULAS: Note my objection
24 to that.

25 Why don't you be a little more specific as

1 to what you feel could have been done or what
2 you're saying could be done under the
3 circumstance. Insistent, I don't -- why don't
4 you ask specific questions whether or not
5 something should have been done.

6 Q. How do you rule out a lesion of some significance
7 without doing a catheterization, Doctor?

8 A. Again it's a very general question you're
9 asking. I think I answered you earlier how we
10 would normally evaluate children with aortic
11 stenosis. I don't know what other questions you
12 have, but, I mean, that's a very general question
13 you're asking me.

14 THE WITNESS: Let's go off the
15 record for a second. I'd like to take another
16 quick break. Excuse me.

17 * * *

18 Thereupon, a short recess was had.

19 Thereupon, the deposition was continued
20 pursuant to recess.

21 * * *

22 MS. CARULAS: Okay. We're
23 back.

24 Q. Doctor, talking about aortic stenosis and severe
25 to critical aortic stenosis, what are the means.

1 available for intervention with those conditions?

2 A. Critical valvular stenosis or subarotic stenosis?

3 I'd like you to be a little more specific.

4 Q. Let's talk about, let's break down each one.

5 How do you address valvular and subvalvular?

6 A. The modalities for valvular aortic stenosis
7 include balloon angioplasty and surgery.

8 Q. Okay. Is one likely more successful than the
9 other?

10 A. That's really so dependent on the case.

11 Q. Okay.

12 A. There's a number of factors that will mitigate
13 whether an angioplasty, whether a valvularplasty,
14 balloon valvularplasty, or surgical
15 valvularplasty has a success rate.

16 Q. And what are the --

17 A. I can't answer the question more specifically
18 than that.

19 Q. What are the most important factors as to
20 success?

21 A. Of a balloon valvularplasty?

22 Q. Or surgery, yes.

23 A. A lot of them are very specific things that
24 involve the, either the valve, the thickness of
25 the leaflet, size of the aortic annulus, whether

1 or not it's a bicuspid or tricuspid or a
2 unicuspid valve.

3 Q. This valve was tricuspid but one of the leaflets
4 was foreshortened. Given that setting how would
5 that impact which direction you would go via
6 balloon valvularplasty or surgery and how would
7 that impact the likely success?

8 A. Well, when I saw the patient there really was no
9 indication, well, after to consider a
10 catheterization so I really couldn't answer that
11 question for you.

12 Q. Right. But let's go back to speak in terms of
13 generalities.

14 If you had a patient that had aortic
15 stenosis and had a tricuspid valve with a
16 foreshortened leaflet, would that cause you to
17 lean towards a balloon valvularplasty more than
18 surgery?

19 MS. CARULAS: Note my objection
20 to this because he's here to talk about his care
21 and treatment clearly. Go ahead, Doctor.

22 A. I would have to evaluate each case on an
23 individual basis. I think it's silly to try to
24 make generalities in this area.

25 Q. Well, what is your success rate, Doctor, whether

1 you intervene or you refer the patient for
2 intervention with balloon valvularplasty for
3 aortic stenosis?

4 A. I don't have a specific data base or group of
5 patients that I've evaluated where I could tell
6 you success or failure.

7 Q. Okay. Let's talk about subvalvular stenosis.
8 How did you intervene or manage that condition;
9 same options? Was that a yes?

10 MS. CARULAS: What's the last
11 part of your question? What did you say, Mike?

12 Q. What are the available intervention options with
13 subvalvar?

14 A. I would have to say that the available
15 interventions are both the same. There is the
16 option of balloon valvularplasty, also a surgical
17 option. There are a variety of surgical
18 options.

19 Q. Doctor, did you note any left-sided lesions at
20 autopsy or pathology of Tom's exploded heart?

21 A. I did not perform the autopsy --

22 Q. Yeah, but as a result of your review of --

23 A. -- to answer your question.

24 Q. But as a result of your review, sir, did you
25 discern any lesions or narrowing in Tom's left

1 side of the heart based on the pathology?

2 A. I, again, I reviewed a report, report as well as
3 I did and they felt that there was a most
4 moderate narrowing in the report. I did not
5 specifically review that autopsy specimen, so I
6 can't give you any more of a specific answer than
7 that.

8 Q. You acknowledge, Doctor, that that pathology took
9 place after balloon valvularplasty was done on
10 Tom's heart, correct?

11 A. I really wasn't involved in Tom's care at that
12 time, so I don't know how I can give you any more
13 specific opinion than I have already from the
14 record.

15 Q. Doctor, other than balloon valvularplasty what
16 would cause an increase in the size of the aortic
17 annulus?

18 A. As far as I know balloon valvularplasty does not
19 cause an increase in the size of the annulus.

20 Q. Okay.

21 A. The only thing that I know that causes the
22 annulus to increase in size is growth and time.

23 MR. BECKER: Okay. I'm
24 wrapping this down. We're going to go off the
25 record for a moment. So we'll be back to you

1 folks in just a few minutes.

2 * * *

3 Thereupon, a discussion was had off the record.

4 * * *

5 Q. Let's take a look at your interpretation of the
6 8-31-94 echo.

7 A. Anna has stepped into the bathroom for just a
8 minute. Could we wait until she gets back,
9 please.

10 Q. Okay.

11 A. Thank you.

12 You can give me the dates. I'll start to
13 look at that until she gets back.

14 Q. It looks like 8-31-94.

15 A. Yes.

16 Q. 9-5-94, 9-8-94.

17 A. Excuse me. Let me write the dates down again.
18 Give me them again.

19 Q. 8-31.

20 A. Right.

21 Q. 9-5, 9-8, 9-10, 9-11.

22 A. Those five echoes?

23 Q. Yeah.

24 Doctor, before I go to those echoes, during
25 the first hospitalization Tom Lyzen had blood

1 pressure problems, maintaining an adequate blood
2 pressure. What do you attribute that problem to?

3 A. Would you -- on specifically which part of Tom's
4 care are you referring to and I'll look it up.

5 Q. During the first hospitalization. You mean which
6 day within the first hospitalization?

7 A. The patient had a number of problems.

8 Q. All right. Let's say the fourth day of the
9 hospitalization.

10 A. The fourth day.

11 Generally it's happening on different days
12 for different reasons, I can't put a general
13 answer to that.

14 Q. Okay. Can aorta stenosis and subaortic stenosis
15 cause the child to have a decrease in blood
16 pressure?

17 A. It depends upon what degree of aortic stenosis.
18 Specify.

19 Q. Any kind.

20 A. Mild and moderate aortic stenosis cannot be
21 expected to cause any problems with blood
22 pressure. The patient who had serious or
23 critical aortic stenosis who became shocky would
24 not unreasonably be expected to have it.

25 Q. Okay. All right. Let's go to the, to the first

1 echo that you interpreted.

2 Do you have it at hand, Doctor?

3 A. I have a study dated 8-31.

4 Q. Okay. You talk about --

5 A. 1520.

6 Q. Doctor, this severe subaortic and aortic valve
7 stenosis that you describe on 8-31-94, is that
8 something that likely was present during the
9 first hospitalization?

10 A. No.

11 Q. And what can bring that condition about then
12 between the first and second hospitalization?

13 A. I really can't say. I wasn't caring for the
14 child in between then. Those are questions I
15 don't know.

16 Q. Well, speaking generally then and just medically,
17 what can cause severe subaortic and aortic valve
18 stenosis occurring at approximately the child's
19 fifth week of life?

20 A. Repeat the question and kind of maybe be a little
21 more specific.

22 Q. What are the potential etiologies for aortic and
23 subaortic stenosis found at the fifth week of
24 life?

25 A. You're asking such a general question. Generally

1 these, the thing that's congenital aortic
2 stenosis, the cause of it is that the patient was
3 born with it.

4 Q. That's right. And that's why I asked you,
5 Doctor, isn't it likely that this child had that
6 condition in the first hospitalization?

7 A. And I answered that he did have congenital aortic
8 stenosis. I don't think we're arguing about
9 that. You're asking me about the degree.

10 Q. Well, what was the degree of Tom's congenital
11 aortic stenosis in his first hospitalization?

12 A. Mild.

13 Q. What was the degree of Tom's subaortic stenosis
14 in the first hospitalization?

15 A. Mild.

16 Q. What's the basis for that opinion?

17 A. The basis is my review of the records and the
18 echocardiograms at the time.

19 Q. The echocardiogram interpretation by Dr. Patel?

20 A. Correct.

21 Q. Okay. Now, so I appreciate that one of the
22 causes of finding subaortic, severe subaortic and
23 aortic stenosis at five weeks of life is that the
24 child was born that way. Taking that out of the
25 picture, what are the other causes?

1 A. Could you reread the question, please?

2 (Notary read back last question.)

3 A. I guess, you know, the answer to your question
4 is, I don't know, because it's so rare to see it
5 go from a mild initially to severe by a month of
6 age that I don't have anything to base causes
7 on.

8 Q. One or two more questions. Just bear with me.

9 Doctor, if you see in an echo interpretation
10 a size estimate of the aortic annulus and also
11 within that same interpretation of the size of
12 the aorta, would you expect them to be the same
13 or would you expect the aorta to be slightly
14 larger?

15 A. Typically -- what portion of the aorta are we
16 talking about, are you referring to?

17 Q. Well, it's difficult to tell from this reading,
18 so I can't answer that.

19 A. I can't answer your question.

20 Q. So some parts of the aorta might be larger than
21 the aortic annulus by as much as two to three
22 millimeters in a neonate?

23 A. I'd say so.

24 MR. BECKER: Okay, Doctor,
25 that's all the questions I have. The other

1 attorneys may have questions.

2 MS. O'BRIEN: No questions from
3 me.

4 * * *

5 CROSS-EXAMINATION OF MARC R. LEVINE, M.D.

6 BY MR. MOSCARINO:

7 Q. Doctor, I have a couple questions. Can you hear
8 me?

9 Doctor, my name is George Moscarino. I'm
10 the attorney for University Hospitals of
11 Cleveland.

12 You told Plaintiffs' counsel you don't have
13 any criticisms of the other care givers in this
14 case, am I right?

15 A. That is correct.

16 Q. I take it obviously that applies to Dr. Fink who
17 was a fellow at the time?

18 A. Correct.

19 Q. Dr. Fink as a fellow was working under the
20 direction or the control of the guidance of you
21 and the other members of the Cardiology
22 Department, am I right?

23 A. Yes.

24 Q. And just so I'm clear on the roles of the various
25 doctors here, the attending physician of record

1 was a Dr. Bailey, is that right, in the first
2 admission?

3 A. I believe that is correct. The patient was on
4 the neonatology service and Dr. Bailey is one of
5 the neonatologists or was at the time.

6 Q. And then as far as the cardiologists getting
7 involved, they would have been consulted then by
8 Dr. Bailey, is that the way it goes?

9 A. That is the way it goes, yes, sir.

10 Q. Then Dr. Fink was working as a fellow on the
11 cardiology service which was consulted by the
12 neonatologist then, right?

13 A. Correct.

14 Q. Decisions ultimately on the diagnosis and the
15 reading of echocardiograms, those are made by the
16 cardiologists and not ultimately by the resident
17 staff like Dr. Fink or other physicians in
18 training, am I right?

19 A. Correct.

20 Q. And ultimate decisions regarding diagnosis and
21 whether intervention should take place, keeping
22 in mind some of the questions that Mr. Becker
23 gave you, those are decisions that would
24 ultimately be made by the cardiologists and not
25 the physicians in training, am I right?

1 A. The attending cardiologists, yes, sir.

2 Q. The what?

3 A. The attending cardiologist.

4 Q. Okay. Who was the attending cardiologist in this
5 case?

6 A. There were several.

7 Q. Can you name them for me?

8 A. Dr. Vanhare initially saw the patient. I was the
9 attending cardiologist for the dates that I
10 mentioned previously. It would be Dr. Patel, was
11 the attending cardiologist on service part of the
12 time. And I also believe Dr. Zahka was the
13 attending cardiologist part of the time.

14 Q. Okay. And just so I'm clear, and keep in mind
15 that I represent Dr. Fink in the case, that he
16 was not an attending cardiologist, that being Dr.
17 Fink, right?

18 A. That is correct.

19 Q. And all those people you mentioned Dr. Zahka,
20 Vanhare, yourself and Patel, supervise the
21 fellows and the residents who work in training in
22 cardiology, true?

23 A. Yes.

24 MR. MOSCARINO: That's all I
25 have. Thank you.

* * *

RECROSS-EXAMINATION OF MARC R. LEVINE, M.D.

BY MR. BECKER:

Q. I have one or two questions relative to Dr. Fink. Dr. Levine --

A. Is this Mr. Becker talking again?

Q. Yes.

A. Yes.

Q. Yes.

A. Okay.

Q. You ready?

A. Go ahead.

Q. You in the course when you were back at University Hospital a year or two ago, you relied upon the clinical assessment of Dr. Fink for your advice to him as well as to neonatology, correct?

A. I guess I would object to your term relied upon. I'm not sure what you mean by that. Generally we worked in a team approach. I would review what Dr. Fink had said and we would reach a final conclusion.

Q. Right.

And if you weren't there to make a physical assessment of the patient you relied upon Dr. Fink to do that, and you relied upon his accuracy

1 in that assessment, correct?

2 A. It would not be typical that I would not be
3 there, so I really can't answer that question.
4 We made it our business to see these patients
5 together.

6 Q. Well, Doctor --

7 A. We would not have the fellows working
8 independently.

9 Q. Well, Doctor, if the fellows were working
10 independently then that would be inappropriate,
11 correct?

12 A. Not necessarily. They may have seen the patient
13 at one point independently, but we would
14 generally review and discuss with them.

15 Q. If the parents had close observation of their
16 child and they did not see you have hands-on care
17 of their child, do you have an explanation for
18 that?

19 MR. MOSCARINO: I object to
20 that question.

21 MS. CARULAS: I object as
22 well.

23 A. I really can't say what the parents did and did
24 not see. I was at the hospital various hours of
25 the day and at various times and I might have

1 been there before or after the parents visiting
2 hours.

3 MR. BECKER: Okay. That's all
4 I have.

5 * * *

6 RECROSS-EXAMINATION OF MARC R. LEVINE, M.D.

7 BY MR. MOSCARINO:

8 Q. Doctor, it's George Moscarino again. Just
9 briefly.

10 Correct me if I'm wrong, the typical routine
11 at Rainbow Babies and Childrens Hospital would be
12 that the attending cardiologist, whoever it was,
13 Dr. Zahka, you or Patel or whomever, would round
14 with the physicians in training, discuss these
15 cases and then ultimately come up with a plan or
16 a diagnosis, am I right?

17 A. Sometimes yes and sometimes no. We would
18 typically round with them, but certainly not at
19 the same time every day.

20 Q. Okay. But the physicians in training were not
21 left out there on their own to care for these
22 pediatric patients; you yourself and the other
23 cardiologists would see these patients and make
24 the ultimate decisions on what was to happen with
25 these patients?

1 A. Correct.

2 MR. MOSCARINO: That's all I
3 have.

4 MS. CARULAS: All done?

5 MR. BECKER: Yes.

6 MS. CARULAS: Okay. Kathy, he
7 will not waive. If you would be kind enough, if
8 Mike orders this be written up I will order a
9 copy, send it to me. And then I'll make sure
10 that it gets to the Doctor for signature.

11 And obviously we will waive the specific,
12 whatever it is, seven days or whatever it is,
13 Mike, since he's out of town?

14 MR. BECKER: Sure.

15 MS. CARULAS: Thank you very
16 much.

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