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

IN THE COURT OF COMMON PLEAS

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

Plaintiffs,

vs. CASE NO. 307715

Chandrakant Patel, M.D.,
et al,

Defendants.

* * *

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

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APPEARANCES:

On behalf of the Plaintiffs:

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On behalf of Defendant University Hospitals of Cleveland:

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Also Present: Lee Ann Lyzen

P R O C E E D I N G S

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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.

A. Sorry you couldn't hear me.
Q. Doctor, have you had your deposition taken before?
A. That's correct, yes.
Q. Okay. I just want to review the ground rules for you before we get underway.

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

A. Yes.
Q. Also it's very important that you answer verbally because it's difficult for our Court Reporter to take down head nods or uh-huh, and so we don't have to figure out what you meant by that. So if you answer affirmatively we'd ask you to use the word yes and of course negatively no. Okay?
A. Okay.
Q. However, unless you indicate otherwise to us today, I'm going to assume that you have fully understood the question that has been posed and you are giving your best and most complete answer today. Fair enough?

A. Fair enough.
Q. Okay. Doctor, would you tell me each and every thing you have reviewed in preparation for this deposition?
A. I have reviewed the hospital records of the first admission, slides dated July, July 15th through August the 5th; depositions of Dr. Vanhare, Dr. Zahka and Dr. Patel; glanced over the records from the second admission.
Q. Anything else?
A. That's everything.
Q. Do you have any personal notes or are there any personal notes that you generated as a result of your care on this particular child?
A. No.
Q. And that question applies whether in the chart or outside of the chart. So the answer also would be no?
A. Correct.
Q. Okay. Can you explain to me why there is no entry by you in the chart?
A. Can you specify?
Q. I'm sorry, we didn't hear that.
A. Are you referring to a specific period?
Q. Right. Maybe I should precede that question by

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

My first question to you, is that representation accurate?

A. I believe that could be inaccurate.

Q. Okay.

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

Q. We didn't hear that.

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

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

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

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

A. That is our recollection, yes.

Q. What is the basis for that recollection?

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

that I had some of my old schedules in.
Q. Are those documents still in existence?
A. No, not documents, electronic Wizard. As far as I know the original schedules are not in existence. I certainly don't have any of them.
Q. Well, whose Wizard was this that you reviewed?
A. My own.
Q. So based on your Wizard you were taking care of Tom Lyzen or at least were the pediatric cardiologist on service for approximately seven days of his first hospitalization?
A. That's including both periods. It was originally four days, yeah, and another four days towards the end.
Q. Okay.
A. I was on service. I was not taking care of him directly.
Q. Okay. Well, who would have been on service from the 15th through the 18th based on your knowledge?
A. I have no knowledge of that.
Q. And who would have been on service between the 21st and August 1st?
A. Again, I have no knowledge of who was on. I just have, I have my records the days I would have

been rendering the service.

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

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

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

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

A. How many echoes were done?

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

A. Correct.

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

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

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

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

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

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

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

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

A. 21st of August?

Q. Of July.

A. Excuse me, of July.

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

Q. Well, I'm interested in the interplay between Dr. Patel, you, while you're on service and neonatology. How did it work, what input did you give to neonatology?
A. Are you asking what specifically in this instance, in this case?
Q. Yes.
A. I have no recollection of directly caring for this patient.
Q. Then I'm assuming that you did not care for this patient during his second hospitalization?
A. According to my review of the chart I was not directly involved in Thomas' care during his second hospitalization.
Q. Okay. Were you involved in any conferences regarding Thomas, that these conferences occurred during the second hospitalization?
MS. CARULAS: Note my objection to any conferences. This is Anna Carulas.
A. I have no direct recollection of specifically being involved in conferences. We had weekly conferences. I noted in some of the depositions that was already explained to you. Physically I would have been at those conferences, but at this time I don't recall specific conversations.

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

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

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

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

A. Correct.

Q. And you were at MCO for ten years?

A. Correct.

Q. And you came to UH in 1991?

A. Correct.

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

A. Correct.

Q. What month in '96 did you leave?

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

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

A. Other opportunities.

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

A. Other opportunities.

Q. Did you leave voluntarily from UH?
A. Yes.
Q. I see that you are an echocardiographer, is that correct?
A. Echocardiography is one of my skills, that is correct.
Q. From whom and when did you learn that skill?
A. I initially learned echocardiography when I was a fellow from various attendings in the program. I've continued to learn it over the next 16 years of my career. I really can't say I learned it from any single --
Q. Source.
A. Excuse me, I didn't hear your last statement, sir.
Q. I was just finishing your sentence. You hadn't -- there's not a single source that you learned it from?
A. That's correct.
Q. Okay. You didn't mention the echo films as material you reviewed in preparation for this deposition. Is it fair for me to conclude that you have not recently looked at those, these echo films?
A. Referring to the videotapes?

Q. Yes.
A. Then I have not reviewed the videotapes, that is correct.
Q. Okay. Based on the information you have at hand and the material you've reviewed, did you actually interpret the echoes while you were on service for Tom Lyzen?
A. During the first admission?
Q. Yes.
A. I have no recollection or I have no, I have no record that I ever interpreted formally any of the echoes that --
Q. That Dr. Patel read?
MS. CARULAS: Is that a question, Mike? I'm sorry.
MR. BECKER: It sounded like he didn't finish his answer or we did not hear the end of his answer.
A. I'll repeat it for you.
I have no recollection or record that I formally interpreted any of Thomas Lyzen's echoes.
Q. Okay.
MS. CARULAS: During the first hospitalization.

A. During the first hospitalization.
Q. All right. You're licensed in, you're still licensed in Ohio to practice medicine?
A. I believe my license is still current in Ohio, that is correct.
Q. You're licensed in New Jersey, correct?
A. That's correct.
Q. Any other states?
A. Pennysylvania.
Q. Have you ever had your license suspended, revoked or called into question by any state board?
A. No, sir.
Q. Have you ever had any hospital privileges suspended, revoked or called into question?
A. No, sir.
Q. How would you describe your current clinical practice?
A. They have a clinical cardiology program at the hospital that involves outpatient echoes, emanations. We bring our patients to St. Christopher's Hospital in Philadlephia for inservice catheterization and surgery.
Q. Have you come into contact with Dr. Elvin Shin?
A. Personally, no.
Q. Have you deferred interpretations of

echocardiography, echocardiograms to him?
A. Referred interpretations?
Q. Yes.
A. No, sir.
Q. Have you or someone from your division consulted with him?
A. I have not consulted with him. I can't tell you specifically that someone from my division has.
Q. Okay. What's the reason that you contact the Philadelphia Childrens Hospital; for intervention?
A. No, no. I said I didn't contact the Philadelphia Childrens Hospital. I said that I have privileges at St. Chritopher's Hospital and will bring patients there when I will do inpatient cardiac catheterizations or surgery, we'll transfer the patients to St. Christopher's Hospital.
Q. I thought you said something about Philadlephia?
A. St. Christopher's Hospital is in Philadelphia. There is a second Childrens Hospital in Philadelphia known as Childrens Hospital of Philadelphia, CHOP.
Q. Okay. I'm sorry. I misunderstood you.
A. A separate institution.

Q. Okay. So you do the intervention at St. Christopher's in Philadelphia?
A. I will do invasive cardiology. I do cardiac cahterizations. I generally have steered clear of doing interventional cardiology in the last few years.
Q. Why?
A. Because it's a philosophical decision in some ways in that there are people who subspecialize in interventional cardiology and they're available. It's to everybody's benefit to give them the interventional cases. They can get the most experience with them.
Q. All right. So currently what is the reason that you see people at St. Christopher's in Philadelphia?
A. I don't see people at St. Christopher's. I will bring patients there because we do not have the facilities at Cooper Hospital yet to perform cardiac catheterization or surgery. We will bring some of our patients there to perform those services.
Q. All right, Doctor, I want to talk a little bit about your medical/legal experience.

Have you ever acted yourself as an expert in

a medical/legal matter?
A. Yeah, I have.
Q. All right. Would you tell me a little bit about how many cases?
A. Over the years probably 15 or 20.
Q. And do you keep an index or a log of the cases that you participated in?
A. No.
Q. What records are available that could tell you the names of the cases and the attorneys that hired you on the respective cases?
A. I really haven't kept records over the years of those. I mean, it would be very difficult to give you any kind of a comprehensive list.
Q. Have you ever, do you do work for both the plaintiff patient as well as the defendant medical provider?
A. I have mainly done work for plaintiffs, but probably one or two for defendants.
Q. Can you think of some names of some plaintiffs' attorneys that have consulted with you in the last ten years?
A. No. I really don't keep the names, a record of those.
Q. Do you have any active cases?

A. There is one case that I'm working on currently, but I don't think I'm really at liberty to give you any details of that at this point.
Q. Have you been identified as an expert in that case?
A. I've actually been reviewing the records and I don't, I haven't submitted a full report on that yet, so I can't really say. I think I was asked to review it as an expert witness.
Q. But to your knowledge you can't say whether or not you've been identified yet?
A. I don't believe I have since I haven't submitted the report yet.
Q. All right. Have you reviewed any cases as an expert relative to, from the perspective of whether there was a delay in diagnosis of aortic or subaortic stenosis which had a negative impact on the patient?
A. Not that I recall at the time.
Q. Okay. Have you ever gone and testified in the Courtroom in a medical/legal case?
A. I have been -- I have not gone to full testimony. I think the most cases I have been involved in have been through deposition.
Q. Okay. You've given depositions, but when the

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

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

Q. Well, do you recall --

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

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

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

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

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

Q. Yes, sir.

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

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

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

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

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

A. A service?

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

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

Q. And to your knowledge where are they located?

A. Somewhere in the Philadelphia region.

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

A. Maybe ten years.

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

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

Q. Okay. Soponaro in Akron?

A. Say that again.
Q. Soponaro in Akron?
A. That, that could be it.
Q. Okay.
A. That could be it as a matter of fact.
Q. Doctor, let's talk a little bit about --
A. Guy was the first name.
Q. I don't remember his first name.
A. Guy Soponaro, I think that's actually the one that he had contacted me once or twice.
Q. Doctor, let's talk a little bit about your experience as a defendant in a case.

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

MS. CARULAS: Note my objection.

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

Q. How many times, Doctor?
A. Just once.
Q. Just one time.

Is that case still pending?

A. No.
Q. Okay. Where did that case, was that filed in

Cleveland?
A. Filed in Toledo.
Q. Toledo?
A. Right.
Q. And what was the allegation against you at that time?
A. It was a case where a technician hooked up an IV line wrong, causing the patient to have a reaction. I was the physician in charge of the pediatric intensive care unit. The case was settled out of Court. They determined there was no admission of liability.
Q. Okay. That's the only time, just one case other than this case?
A. The only time.
Q. Okay. Doctor, would you define a couple terms for me?

What does aortic stenosis mean?

A. Aortic stenosis refers to narrowing between the left ventricle and the aorta.
Q. What does a hypoplastic left heart mean?
A. That's such a generally used term, it's really hard for me to define it. It refers to, in general, smallness of the left heart, left side of the heart.

Q. Did you say smallness?
A. Smallness or decrease in size, that's correct.
Q. What about the term cardiomyopathy, what does that mean?
A. Cardiomyopathy is a very generic or generally used term meaning disease of the heart muscle.
Q. Would a congenital malformation fall under your definition of cardiomyopathy?
A. Would you repeat that question, please.
Q. Would a congenital physical malformation of the heart fall within your definition of cardiomyopathy?
A. No.
Q. Do you have an opinion, Doctor, as to what the, what the reason was that Tom Lyzen's physical condition worsened between his first and second hospitalization?
MS. CARULAS: Objection.
A. That's the whole question? I don't think we heard it at this end, sir.
Q. Do you have an opinion today as to why Tom Lyzen's heart condition worsened between his first and second hospitalization?
A. No.
Q. Have you talked to Dr. Zahka or Dr. Vanhare or

Dr. Patel regarding this case?

A. No.

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

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

A. No.

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

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

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

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

Q. Similiar question. Do you have any recollection

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

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

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

A. No.

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

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

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

service during that particular day?

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

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

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

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

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

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

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

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

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

Let me know when you're ready, Doctor.

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

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

A. Sometimes we would cosign the notes and sometimes we wouldn't.
Q. Okay. Do you see a cosignature over Dr. Fink's on those two dates that might have been one of your colleagues?
A. I think that the signature over Dr. Fink's name is Dr. Fink's signature. To the best of my recollection he printed it and then signed over it.
Q. I'm sorry. We didn't hear that.
A. If you'd look specifically on the note of the 18th, Dr. Fink's name is printed and I believe that is his signature over the printing.
Q. Okay. Well, is it your responsibility to oversee all of Dr. Fink's work and interpretation and management of a pediatric cardiology patient?
A. At the time it would have been my responsibility to oversee Dr. Fink's activity. Here again, we were not managing this patient if he was being managed by neonatology.
Q. So if Dr. Fink concludes there's no left ventricle obstructive tract -- what does LVOT mean?
A. Left ventricular outflow track.
Q. Okay. If Dr. Fink concludes that there is no

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

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

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

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

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

* * *

Thereupon, a short recess was had.

Thereupon, the deposition was continued pursuant to recess.

* * *

MR. BECKER: Back on the record.

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

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

A. That was a yes.
Q. Okay. And you were on vacation according to your Wizard between the 21st or between the 22nd and, well, the last, from the 22nd through the end of July, correct?
A. Correct.
Q. Can you tell us based on the information you have at hand as to which pediatric cardiologist was in charge of Tom Lyzen's care between July 16th and July 17th and also between July 22nd and July 25th?
A. I have no records of that.
Q. Who, if anyone, would be in the best position to know that data?
A. I have no information to help you with that, sir.
Q. Doctor, there's a nurse's note on July 21st regarding the ventilation settings on Tom Lyzen and the nurse's notes reflect on the 21st that they're going to discuss a decrease in oxygen setting with a Dr. Patel.

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

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

or --

MR. BECKER: No, no.

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

A. I don't know.

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

MS. CARULAS: Objection.

MR. MOSCARINO: I also object to the form.

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

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

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

A. No.

Q. Why?

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

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

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

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

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

MR. MOSCARINO: Objection to the form.

MS. CARULAS: I object as well.

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

Q. Well, do they have --

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

Q. Well --

A. It such a general --

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

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

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

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

A. Yes.

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

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

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

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

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

Q. And how do you determine the gradient?

A. You determine multiple ways.

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

A. Probably the simplest way of determining a gradient is with the echocardiogram.
Q. Okay. And does that take, does something called the angle of interrogation of the jet come into play?
A. In most echocardiograms done today we do not quantify the angle of interrogation, because in this situation we're able to line up close enough so it doesn't become a factor.
Q. Well, ideally what do you want the angle of interrogation to be?
A. We determine, we're trying to line up for a gradient high by, we generally try to keep the angle as close to parallel to the echo beam as we can. That generally does not become a consideration to most of the patients, particularly in this scenario, it is not an important issue.
Q. Why wouldn't it be an important issue in this case?
A. Because we're able to line up typically for the aorta and the outflow track without problems. When you're within 10 or 20 degrees the actual calculated change is insignificant.
Q. If you are outside of 20 degrees what is the

impact on the end product of pressure gradient?
A. What do you mean outside?
Q. When you're graded in 20 degrees.
A. Twenty-five degrees there's no impact. Usually I said within 20, 30 degrees. At 90 degrees you can't measure the gradient at all. But as I said to you, in this particular scenario looking for these types of deficits, it generally has very little effect whatsoever.
Q. We didn't hear that, Doctor. Looking for these type of defects -- what did you say after that?
A. The setting looking for left ventricular output tract gradients, my experience is it has little or no impact at all in order to measure the gradients accurately.
Q. Okay. Would you agree that if the angle of interrogation is not close to parallel that could lead you to a falsely low pressure gradient?
A. Anything is possible.
Q. Well, isn't it likely that if you measure the flow at anything greater than 20 or 25 degrees, the end product pressure gradient is likely to be falsely low?
A. I said it is possible. I would have to look at, you know, a specific echo to give you a specific

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

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

A. Yes.

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

MR. MOSCARINO: Object to the form.

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

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

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

MR. BECKER: Would you repeat that question.

(Notary read back last question.)

MR. MOSCARINO: Same objection.

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

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

MR. MOSCARINO: Objection.

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

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

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

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

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

Q. Okay.
A. Could you repeat the question again, please?
(Notary read back last question.)
A. I think we ruled it out both when his ductus was open and when his ductus had closed.
Q. Tell us, Doctor, how did you rule it out?
A. No, we felt there was no significant heart problem at that admission.
Q. And how did you make that determination?
A. In terms of as a cause of his respiratory distress.
Q. How did you make that determination that --
MR. BECKER: What did he say about significant? Hold on, Doctor. I'm going to -- what did he say about significant.
(Notary read back last answer.)
Q. Doctor, you just said that you felt there was no significant heart problem during that admission, and I'm asking you how were you able to make that conclusion; what tests did you run to make that conclusion? What was the bases for that conclusion?
A. I believe I, you know, as I told you earlier, I have very little direct recollection of this patient. What I am offering you is based on my

review of the records as I see them today.

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

Q. Does or does not?

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

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

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

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

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

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

A. Tachypnea is rapid heart or rapid breathing.

Q. Right.

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

MS. CARULAS: Mike, did we lose you?

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

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

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

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

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

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

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

(Notary read back last answer.)

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

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

A. Yes.

Q. Okay.

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

Q. Right.

A. The answer to your question is yes.

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

A. No.

Q. Why not?

A. Has nothing to do with the gradient.

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

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

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

A. Sixteen years of experience.

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

A. Define relying, please.

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

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

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

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

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

MS. CARULAS: Are you done?

MR. BECKER: I'm done.

A. No.

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

A. Please repeat the question.

(Notary read back last question.)

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

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

MS. CARULAS: Note my objection to the question.

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

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

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

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

A. Endocardial fibroelastosis.

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

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

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

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

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

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

A. No, sir.

Are you still there?

Q. Yes. Bear with me, Doctor.

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

A. Yes.

Q. And what did you conclude?

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

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

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

children whose annulus --

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

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

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

A. Repeat the question, please.

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

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

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

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

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

related to his heart.

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

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

Q. No. I can't answer that off the top of my head.

Doctor, can you agree with me that -- I think that is the discharge summary -- Doctor, can you agree with me that before your service would be insistent on a condition they'd better well be certain that there is no lesion of any significance in Tom Lyzen's heart, correct.

MR. MOSCARINO: Object to the form.

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

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

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

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

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

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

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

(Notary read back last question.)

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

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

MS. CARULAS: Note my objection to that.

Why don't you be a little more specific as

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

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

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

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

* * *

Thereupon, a short recess was had.

Thereupon, the depostion was continued pursuant to recess.

* * *

MS. CARULAS: Okay. We're back.

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

available for intervention with those conditions?
A. Critical valvular stenosis or subarotic stenosis? I'd like you to be a little more specific.
Q. Let's talk about, let's break down each one.
How do you address valvular and subvalvular?
A. The modalities for valvular aortic stenosis include balloon angioplasty and surgery.
Q. Okay. Is one likely more successful than the other?
A. That's really so dependent on the case.
Q. Okay.
A. There's a number of factors that will mitigate whether an angioplasty, whether a valvularplasty, balloon valvularplasty, or surgical valvularplasty has a success rate.
Q. And what are the --
A. I can't answer the question more specifically than that.
Q. What are the most important factors as to success?
A. Of a balloon valvularplasty?
Q. Or surgery, yes.
A. A lot of them are very specific things that involve the, either the valve, the thickness of the leaflet, size of the aortic annulus, whether

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

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

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

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

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

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

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

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

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

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

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

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

Q. What are the available intervention options with subvalvar?

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

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

A. I did not perform the autopsy --

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

A. -- to answer your question.

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

side of the heart based on the pathology?
A. I, again, I reviewed a report, report as well as I did and they felt that there was a most moderate narrowing in the report. I did not specifically review that autopsy specimen, so I can't give you any more of a specific answer than that.
Q. You acknowledge, Doctor, that that pathology took place after balloon valvularplasty was done on Tom's heart, correct?
A. I really wasn't involved in Tom's care at that time, so I don't know how I can give you any more specific opinion than I have already from the record.
Q. Doctor, other than balloon valvularplasty what would cause an increase in the size of the aortic annulus?
A. As far as I know balloon valvularplasty does not cause an increase in the size of the annulus.
Q. Okay.
A. The only thing that I know that causes the annulus to increase in size is growth and time.
MR. BECKER: Okay. I'm wrapping this down. We're going to go off the record for a moment. So we'll be back to you

folks in just a few minutes.

* * *

Thereupon, a discussion was had off the record.

* * *

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

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

Q. Okay.

A. Thank you.

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

Q. It looks like 8-31-94.

A. Yes.

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

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

Q. 8-31.

A. Right.

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

A. Those five echoes?

Q. Yeah.

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

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

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

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

A. The patient had a number of problems.

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

A. The fourth day.

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

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

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

Q. Any kind.

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

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

echo that you interpreted.

Do you have it at hand, Doctor?

A. I have a study dated 8-31.

Q. Okay. You talk about --

A. 1520.

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

A. No.

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

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

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

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

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

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

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

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

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

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

A. Mild.

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

A. Mild.

Q. What's the basis for that opinion?

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

Q. The echocardiogram interpretation by Dr. Patel?

A. Correct.

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

A. Could you reread the question, please?

(Notary read back last question.)

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

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

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

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

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

A. I can't answer your question.

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

A. I'd say so.

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

attorneys may have questions.

MS. O'BRIEN: No questions from me.

* * *

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

BY MR. MOSCARINO:

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

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

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

A. That is correct.

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

A. Correct.

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

A. Yes.

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

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

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

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

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

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

A. Correct.

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

A. Correct.

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

A. The attending cardiologists, yes, sir.
Q. The what?
A. The attending cardiologist.
Q. Okay. Who was the attending cardiologist in this case?
A. There were several.
Q. Can you name them for me?
A. Dr. Vanhare initially saw the patient. I was the attending cardiologist for the dates that I mentioned previously. It would be Dr. Patel, was the attending cardiologist on service part of the time. And I also believe Dr. Zahka was the attending cardiologist part of the time.
Q. Okay. And just so I'm clear, and keep in mind that I represent Dr. Fink in the case, that he was not an attending cardiologist, that being Dr. Fink, right?
A. That is correct.
Q. And all those people you mentioned Dr. Zahka, Vanhare, yourself and Patel, supervise the fellows and the residents who work in training in cardiology, true?
A. Yes.

MR. MOSCARINO: That's all I 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

in that assessment, correct?
A. It would not be typical that I would not be there, so I really can't answer that question. We made it our business to see these patients together.
Q. Well, Doctor --
A. We would not have the fellows working independently.
Q. Well, Doctor, if the fellows were working independently then that would be inappropriate, correct?
A. Not necessarily. They may have seen the patient at one point independently, but we would generally review and discuss with them.
Q. If the parents had close observation of their child and they did not see you have hands-on care of their child, do you have an explanation for that?

MR. MOSCARINO: I object to that question.

MS. CARULAS: I object as well.

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

been there before or after the parents visiting hours.

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

* * *

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

BY MR. MOSCARINO:

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

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

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

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

A. Correct.

MR. MOSCARINO: That's all I have.

MS. CARULAS: All done?

MR. BECKER: Yes.

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

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

MR. BECKER: Sure.

MS. CARULAS: Thank you very much.

C E R T I F I C A T E

The State of Ohio,)
) SS:
County of Lorain.)

I, Kathleen A. Hopkins Durrant, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within-named witness, MARC R. LEVINE, M.D., was by me first duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by him was reduced by me to stenotype in the presence of said witness, subsequently transcribed into typewriting under my direction, and that the foregoing is a true and correct transcript of the testimony so given by him as aforesaid.

I do further certify that this deposition was taken at the time and place as specified in the foregoing caption, and was completed without adjournment.

I do further certify that I am not a relative, counsel or attorney of either party, or otherwise interested in the outcome of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Elyria, Ohio, this 4th day of November, 1997.

Kathleen A. Durrant

Kathleen A. Durrant, Notary Public
My commission expires 1-10-00
Recorded in Lorain County, Ohio

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-V-

-W-

-X-

-Y-

-Z-