IN THE COURT OF COMMON PLEAS
OF CUYAHOGA COUNTY, OHIO

LESLIE WALTER,
ADMINISTRATOR, ETC.,

Plaintiff,

vs Case No. 393899

METROHEALTH MEDICAL
CENTER, et ai.,
Defendants.

DEPOSITION OF ELIZABETH DORR McKINLEY, M.D.
WEDNESDAY, DECEMBER 20,2000

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Deposition of ELIZABETH DORR McKINLEY, M.D., a Witness herein, called by counsel on behalf of the Plaintiff for examination under the statute, taken before me, Vivian L. Gordon, a Registered Diplomate Reporter and Notary Public in and for the State of Ohio, pursuant to agreement of counsel, at the offices of MetroHealth Medical Center, 2500 MetroHealth Drive, Cleveland, Ohio, commencing at 10:30 o'clock a.m. on the day and date above set forth.

APPEARANCES:

On behalf of the Plaintiff
Becker & Mishkind, by
JEANNE M. TOSTI, ESQ.
Skylight Office Tower Suite 660
Cleveland, Ohio 44113
216-241-2600

On behalf of the Defendant MetroHealth Medical Center
Reminger & Reminger, by
THOMAS KILBANE, ESQ.
The 113 St. Clair Building
Cleveland, Ohio 44114
216-687-1311

On behalf of the Defendant Emergency Professional Services and Thomas W. Graber, M.D.
Mazanec. Raskin & Ryder, by
BEVERLY HARRIS, ESQ.
100 Franklin's Row
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Solon, Ohio 44139
440-248-7906

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ELIZABETH DORR McKINLEY, M.D., a witness herein, called for examination, as provided by the Ohio Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, was deposed and said as follows:

EXAMINATION OF ELIZABETH DORR McKINLEY, M.D.

BY MS. TOSTI:

Q. Doctor, would you please state your name for us.
A. Elizabeth Dorr McKinley.
Q. And that's D-O-R-R?
A. Yes.
Q. And your home address?
A. 2436 Coventry Road, Cleveland Heights, Ohio.
Q. And your zip code?
A. 44118.
Q. Is that a single-family home?
A. Yes.
Q. Is your current business address here at MetroHealth Medical Center?
A. Yes.
Q. And is your current employer MetroHealth Medical Center?
A. Yes.

Q. And in March of '98, was that your business address and your employer also?
A. Yes.
Q. Do you currently render professional services for anyone other than MetroHealth Medical Center?
A. No.
Q. Was that also true in March of '98?
A. Yes.
Q. Have you ever had your deposition taken before?
A. No.
Q. I want to go through some of the ground rules for a deposition. I am sure counsel has had a chance to talk with you.

This is a question and answer session. It's under oath. It's important that you understand my questions. If you don't understand my questions, let me know and I'll be happy to repeat the question or to rephrase it, if I have stated it inartfully.

If at any point you would like to refer to the medical records, feel free to do so.

You should give all of your answers

5

verbally, because our court reporter cannot take down head nods or hand motions. And at some point defense counsel may chose to enter an objection for the record. You are still required to answer my question unless counsel instructs you not to do so.

Do you understand those instructions?

A. Yes.

Q. Have you ever been named as a defendant in a medical negligence suit?

A. No.

Q. Have you ever acted as an expert in a medical/legal proceeding?

A. No.

Q. Have you ever given testimony in any case involving issues dealing with bacterial endocarditis?

A. No.

Q. Now, I have been provided with a copy of your curriculum vitae, I believe.

MS. TOSTI: Would you mark this as Plaintiff's Exhibit 1.

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(Thereupon, McKinley Deposition Exhibit 1 was marked for

6

purposes of identification.)

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Q. I would ask if you would just identify this document for me.

A. That's my CV.

Q. Is it current and up to date?

A. Yes.

Q. Are there any corrections or additions that you would like to make to it?

A. No.

Q. Doctor, you are board certified in internal medicine; is that correct?

A. Yes.

Q. Did you pass that board certification on your first attempt?

A. Yes.

MR. KILBANE: Objection. Go ahead.

Q. You are licensed to practice medicine in the State of Ohio; correct?

A. Yes.

Q. And were you also so licensed in March of '98?

A. Yes.

Q. When did you first become employed with MetroHealth Medical Center?

7

A. Well, I was an intern and resident here and then went to North Carolina and came back in 1992 -- no, that's not right -- 1994.

Q. So from 1994 to the present, you have been a staff physician with MetroHealth Medical Center: is that correct?

A. Yes.

Q. In March of 1998, what was your position and title at MetroHealth?

A. I was a staff physician. A senior instructor in medicine and bioethics.

Q. Did you hold any other administrative positions with Metro at that time?

A. No.

Q. And your current title and position? Is it the same?

A. Assistant professor of medicine and bioethics.

Q. Aside from MetroHealth Medical Center, do you have privileges at any other hospital in Cleveland?

A. No.

Q. And the privileges that you have here at Metro, those are admitting privileges?

A. Yes.

8

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

A. Never.

Q. Have you ever had your medical license called into question, suspended or revoked?

A. No.

Q. Have you been licensed in any other state other than the State of Ohio?

A. In North Carolina.

Q. Now, doctor, you have several publications listed on your curriculum vitae. Do any of these deal with the subject matter of bacterial endocarditis?

A. No.

Q. Do any deal with the subject matter of prosthetic heart valves?

A. No.

Q. Have you ever taught or given a formal lecture on either of those subjects?

A. I have probably done some medical school teaching on endocarditis during my attending rounds when I am on service.

Q. Have any of those presentations been reduced to a written form, videotape or audio

9

tape?
A. No.
Q. Any syllabus or handouts from those presentations?
A. Not that I'm aware of.
Q. Tell me what you have reviewed in preparation for this deposition.
A. I have reviewed all the outpatient records, just to make sure that I was not involved in the care of this lady, and I spent more time on the inpatient admission.
Q. The inpatient admission that you are referring to is the MetroHealth Medical Center admission of May 8th of '98; is that correct?
A. Yes.
Q. You have not reviewed any records from Southwest General Hospital emergency room?
A. I have seen the emergency room records.
Q. How about The Cleveland Clinic records after her discharge from MetroHealth Medical Center?
A. I have looked at them briefly, but they are very sketchy.
MR. KILBANE: Can we go off the

10

record?
(Discussion off the record.)
Q. Have you looked at any from Broadview Multicare, which is the extended care facility that she went to?
A. I have seen some things from there, but again, they are very sketchy.
Q. Have you reviewed any deposition testimony?
A. I have reviewed the deposition of Douglas Einstadter.
Q. Since the filing of this case, have you discussed it with any physicians?
A. No.
Q. And other than with counsel, have you discussed this case with anyone else?
A. No.
Q. Aside from what may be in the actual MetroHealth Medical Center records, do you have any personal notes or personal file on this case?
A. No.
Q. Have you ever generated any such notes?
A. No.
Q. Now, doctor, you indicated that you

11

have a teaching position: is that correct?
A. Yes.
Q. Is there a particular text that you utilize with your students, with the medical students or the interns and residents in internal medicine?
A. No, there is no specific text.
Q. Are you on faculty at Case Western Reserve?
A. Yes.
Q. What is the textbook that they use at Case Western Reserve for internal medicine?
A. I don't think there is a specific textbook. There are several of them.
Q. Do you have a textbook that you consider to be the best or the most reliable in internal medicine?
A. Not really. I mean, some of these texts I think are better than others.
Q. Are there any publications, as you sit here today, that you believe have particular relevance to the issues in this case?
A. No.
Q. Have you participated in any research dealing with the subject matter of bacterial

12

endocarditis?
A. No.
Q. Now, you said that you had an opportunity to review Dr. Einstadter's deposition. He mentioned a research study involving referral of patients for echocardiograms. Have you had any participation in that particular study?
A. No, I have never heard of it until I saw it there.
Q. Your practice of internal medicine, is it limited in any way? By that I mean to any particular population of patients or to inpatient or outpatient.
A. No. I do a little of both inpatient and outpatient.
Q. Is it limited to adult patients?
A. Yes.
Q. Would you describe for me in general terms your professional practice as it is today.
A. Today? I do about 70 percent teaching and research and about 30 percent clinical practice.
Q. And in March of 1998, what was the breakdown?

13

A. It was about 50-50; 50 research, 50 clinical practice.
Q. In March of 1998, were you seeing patients both in the clinic setting as well as patients in the hospital setting?
A. Yes. The way that worked is I would have clinic sessions in the outpatient department, and then maybe two to four weeks of the year I would be on patient service.
Q. I said March. I believe most of the care that you may have provided was during that inpatient admission, so that was actually May of '98.
A. Right.
Q. So during that time period, I'm sorry, most of what you said you saw were inpatients then?
A. During that time period?
Q. Yes.
A. Yes, inpatients. I was attending on one of the medical floors.
Q. Now, tell me again the rotation that you would normally go through between inpatient and outpatient.
A. What I would do is, I believe at that

14

point I had three days, three half days of outpatient practice where I saw my own patients, and then within the year, I would have two, two week blocks of inpatient attending time, at which point I would drop all my other responsibilities and care only for those patients admitted to my team.
Q. And during the time when you weren't having the two, two week blocks, did you continue with the three half day sessions in the outpatient department?
A. Yes.
Q. Then was the rest of your time then devoted to teaching and research?
A. Yes.
Q. When you were teaching, were you doing classroom instruction, as well as clinical instruction?
A. Yes.
Q. What courses were you teaching in the classroom at that time during that time period?
A. What I remember is that I think I had taught a section of the core physician development program for medical students at Case and that was a once a week course.

15

Q. Just generally, what was the subject matter of that course?
A. It was mostly problem solving, thinking about a case and figuring out how to develop a differential diagnosis.
Q. How do you develop a differential diagnosis, doctor?
A. Well, I am not sure there is an exact methodology, but you begin to know what's most common and what's less common with a series of symptoms.
Q. And do you build a hierarchy of most likely to least likely diagnosis when you do a differential diagnosis?
A. I think that's what you try to do, yes.
Q. Now, in May of '98, were you responsible for the supervision of any medical staff at Metro Hospital? And by medical staff, I'm referring to interns, residents, medical students.
A. While I was on the inpatient service, I was supervising, let's see, a senior resident, probably two senior residents and approximately five interns.

16

Q. And were these all in the internal medicine area?
A. Yes.
Q. In regard to the residents and the interns that you were supervising, were they required to discuss their patient care, their plan of care, their assessment of patients with you?
A. Yes. The way that worked was the interns answered directly to the senior resident and then we had teaching sessions where I interacted with the interns to understand their understanding of the cases.
Q. Was the senior resident required to discuss his or her findings with you in regard to a patient?
A. Yes.
Q. Was that done on a regular basis, like each day?
A. Everyday.
Q. And was there any requirement that you sign off on their notes? In other words, review them and indicate that you either agreed with their findings or make additional notations that you find are necessary?

17

A. Actually, the attending physician has to sign off on the intern note, but I always read the senior resident's notes, but I did nor nave to sign off on it.
Q. In some instances, you were an attending physician for a particular patient. Were there other instances where the interns and residents were caring for patients that you were not designated as an attending on? In other words, where you were supervising residents and interns, but there may be another attending involved in the case?
A. Very rarely. I don't remember during that time. There are some physicians who care for their own patients.
Q. How often in your practice do you see patients with bacterial endocarditis? Just approximately.
A. I have probably seen seven or eight cases of endocarditis.
Q. And that would be over the course of your practice to date?
A. Yes. Including residency.
Q. And how many times in your practice have you seen patients with prosthetic valve

18

endocarditis?
A. Two or three times of those.
Q. And prior to Earline Mizsey's case, have you ever diagnosed a patient with prosthetic valve endocarditis?
A. I believe I have, yes.
Q. Do you know how many times prior to her?
A. I think all the cases that I have seen are prior to hers, but again, I would estimate about two or three.
Q. Now, a patient with a prosthetic heart valve will always be at higher risk for endocarditis than a patient with their own native valve; correct?
A. Yes. People with prosthetic valves are at increased risk, yes
Q Would you agree that in a prosthetic heart valve patient, a high index of suspicion must be maintained to avoid overlooking the diagnosis of infectious endocarditis7
MR KILBANE Objection But go ahead
A I would agree that somebody with prosthetic valve endocarditis, the physician has

19

to keep endocarditis on the differential diagnosis.
Q. How is prosthetic valve endocarditis diagnosed?
A. It's diagnosed very similar to native valve endocarditis. The best diagnostic test we have is the transesophageal cardiogram and blood cultures.
Q. What are the signs and symptoms of prosthetic valve endocarditis?
A. Signs and symptoms are very variable. They are very protean.
Q. Well, tell me what you would look for in a patient.
A. Some of the signs and symptoms that you can see are congestive heart failure, conduction abnormalities on electrocardiogram. Peripheral signs and symptoms that suggest endocarditis are things like splinter hemorrhages and Osler nodes and Roth spots in the eyes. You can see nephritis and a number of other findings.
Q. Would you look for fever in a patient?
A. Generally, patients have fever, yes.
Q. What about vascular phenomena like TIAs, like peripheral embolization?

20

A. Those are things that can certainly go along with endocarditis, yes.
Q. Would you look for anemia in the patient?
A. Yeah, I think most patients do develop a low grade anemia.
Q. How about elevated white blood cell count?
A. Yeah, I think patients can.
Q. Increased sedimentation rate?
A. Often.
Q. Would you agree that when a prosthetic valve patient presents with fever and a suspected embolic event that the diagnosis of infectious endocarditis should be investigated?
MR. KILBANE: Objection.
MS. HARRIS: Objection.
A. I agree that a patient who has all that constellation of symptoms, endocarditis has to be considered on the differential for sure.
Q. Does a patient have to have positive blood culture before a presumptive diagnosis of bacterial endocarditis can be made?
A. I guess I am not an expert in endocarditis, but most patients have positive

21

blood cultures.
Q. Have you ever heard of patients having culture negative endocarditis?
A. Yes.
Q. If bacterial endocarditis is suspected, does a patient always have to have positive blood cultures before antibiotic treatment is initiated?
MR. KILBANE: Objection. Go ahead.
A. I think that depends on the case. I think -- I think I'll leave it there.
Q. Can bacterial endocarditis be ruled out on the basis of a single blood cutture?
MS. HARRIS: Objection.
A. No.
Q. Why not?
A. Well, again, endocarditis requires a constellation of signs and symptoms and can often be a difficult diagnosis to make. One blood culture probably isn't enough.
Q. How is prosthetic valve endocarditis treated?
A. Generally, similar to native valve endocarditis, with antibiotic therapy, and possibly surgical replacement of the prosthetic

22

valve.
Q. Would you agree that one of the main goals of treatment in prosthetic valve endocarditis is to eradicate the infecting organism as soon as possible?
A. Yes.
Q. And would you agree that the sooner prosthetic valve endocarditis is treated with antibiotics, the more likely the outcome is going to be positive?
MS. HARRIS: Objection.
MR. KILBANE: Objection. You can answer.
A. I think it's important to be vigilant and to begin treatment as soon as the diagnosis has been made, yes.
Q. Would you agree that the earlier the treatment, the better the chance of a cure is?
MS. HARRIS: Objection.
MR. KILBANE: Objection. Go ahead.
A. You know, I guess I can't say that 100 percent of the time, but I think it's important to begin treatment as soon as possible. Hopefully the outcome would be better.
Q. What type of complications are

23

associated with prosthetic valve endocarditis?
A. Again, they are similar to the native valve endocarditis, and it would be dysfunction of the valve, abscess formation around the valve, embolic events resulting from vegetations on the valve. I am sure there are others, but those are the big ones I think about.
Q. Is abscess formation more common with prosthetic valve endocarditis as compared to native valve endocarditis?
A. I don't know the answer to that.
Q. Do valvular vegetations have to be present before the diagnosis of prosthetic valve endocarditis can be made?
A. No.
Q. Do you have an independent recollection of Earline Mizsey? Do you remember her as you sit here today?
A. Yes.
Q. Now, when is the first time that Earline Mizsey came under your care from your review or your recollection?
A. She was admitted to my service on 5-8-98, and the first time I would have seen her was 5-9.

24

Q. And you did not have any contact with her during any outpatient -- by contact, I mean you didn't provide her with any care when she was seen in the outpatient department prior to her admission to the hospital; correct?
A. Correct.
Q. And how is it that you became involved in her care during that 5-8-98 admission?
A. She was admitted to our medical service.
Q. Now, you were her attending physician. How did you come to be the attending on her particular case?
A. Because for those two weeks when I am the inpatient attending, I was covering -- I can't remember what floor to tell you the truth, but she was admitted under my care on that date.
Q. So that was the two week rotation that we spoke of earlier?
A. Yes.
Q. And because her admission came during those two weeks, she was assigned to you, you being her attending physician?
A. Yes.
Q. Now, at the time of her admission,

25

which was on May 8th of '98, did you receive any information about her from Dr. Einstadter at the time of the admission?
A. Well, again, I didn't see her until the 9th, but standard practice is that we would send for old records. And I did speak with Dr. Einstadter. I can't remember exactly what day it was. It was early in her admission.
Q. When a patient is admitted, would you be notified, even if you didn't see her that day, would they call you and say an admission is coming in, you are going to be her attending on the date that she is actually admitted?
A. The way that works, the senior resident would be called, and then they would, depending on what time it was, see the patient or the senior resident on call would see the patient. I might not have had anything to do with her that day.
Q. So it might be when you first saw her on the 9th, it may have been when you first received information about her also?
A. Yes.
Q. And would it be normal procedure when a MetroHealth Medical Center patient was admitted

26

to the hospital, that the old records would be brought up to the floor?
A. Yes.
Q. And be made available?
A. Yes. It usually takes some time, but that is the procedure, yes.
Q. How much time does it usually take?
A. It varies. I mean, if the records are not in an outpatient clinic, they are generally sent up that same day. If they are at an outpatient clinic, it may be another day or two before we see them.
Q. Do you know when you saw her on the 9th whether the records from her care in the clinics were on the floor?
A. I don't remember.
Q. Now, the first day that you saw her was on May 9th of '98; correct?
A. Yes.
Q. When you saw her, were any of Earline Mizsey's family present at that time?
A. Boy. I don't believe so.
Q. Now, if you would like to open the records to the beginning point of your care, it might be easier, because we are going to be

27

discussing some of your notes.
A. Okay.
Q. Now, I believe that when you first saw her, were there any other physicians present?
I noticed there was a note by a Dr. Kudman. Was he present when you saw the patient?
A. I don't believe so. He is the intern.
Q. Now, I believe her history and physical were initially done by Dr. Kudman?
A. I think it's Kudmari. I thought it was Kudmari. Kudmani.
Q. When you saw her on May 9th, did you review the history and physical findings of Dr. Kudmani?
A. Yes, and the senior resident's note.
Q. Dr. Kudmani was an intern?
A. Yes.
Q. Who was the senior resident?
A. You know, I can't read that name.
Q. You don't recall who it was?
A. I can't read the name and I don't recall who the senior resident was.
Q. You reviewed the history and physical. Did you also, when you saw the patient, do your own physical on the patient?

28

A. Yes.
Q. Take a history?
A. Yes, both.
Q. Was there anything in reviewing Dr. Kudmani's notes that you were critical of or that you didn't agree with or that you felt was incomplete?
A. No.
Q. Now, you wrote a note on this patient, I believe, on 5-9; is that correct?
A. Yes.
Q. Now, it says under the note that you wrote on 5-9, there is a printed section that says I discussed the case and plans with the resident, with the following comments.
Was that a discussion -- did you have a discussion with the resident in this case?
A. Yes.
Q. And was the resident you are referring to the senior resident that we have been unable to identify at this point?
A. It was probably both the senior resident and the intern, but actually that refers specifically to the intern.
Q. Well, it says resident, so -- does

29

that mean intern?
A. Yes.
Q. Did you disagree at all with what the senior resident's note had to say in this case?
A. No.
Q. What was your understanding as to the reason why Earline Mizsey was admitted to Metro on May 8th of '98?
A. I believe she was admitted for stroke.
Q. And was it also to rule out embolic origin to that stroke?
A. Yes.
Q. And in your evaluation of this patient, what evidence of stroke did you find?
A. She had signs of right-sided weakness and an expressive aphasia.
Q. Was there any improvement in her condition from the time of admission that you could discern?
A. From the time of admission?
Q. Yes.
A. I don't remember. She certainly didn't get worse.
Q. Was there any improvement that you could discern from the time of the documentation

30

of her stroke? And I am just asking if there is anything additional that you had knowledge of prior to her admission to Metro.
A. No.
Q. Now, doctor, in your note of 5-9-98, I believe in the first paragraph you have that she was taken to Southwest General Hospital initially and had a head CT and transferred here. Has had significant improvement in speech and weakness since yesterday.
Was that reported by the patient or where did you get that information from?
A. You are right. It does say that. I don't remember exactly where I got that information from. It may well have been reviewing the emergency room note, since I had not seen her previously.
Q. Just in general terms, what was her overall condition, your impression of her when you saw her, initially?
A. She was an older woman with multiple medical problems who appeared to have suffered a small stroke.
Q. Was she able to answer your questions when you talked with her'?

31

A. She was able to follow commands and shake her head yes and no. It was difficult to understand her speech sometimes, which she had trouble expressing herself.
Q. Was she able to stand or to walk at all?
A. You know, I don't remember. I think she could stand, but I don't write it down in my note.
Q. You noted that she had weakness on her right side. Was she able to move her right arm?
A. Yes.
Q. When you saw her on the 9th, did you find anything in her history or signs and symptoms that you observed that would be consistent with the diagnosis of endocarditis?
A. Well, again, I think these are, again, protean symptoms. She was initially febrile at Southwest General, but on the floor was not febrile, at least initially, and she had had a recent history of possible TIA.
Q. Did she have anemia when you saw her?
A. Let me just double-check. On 5-9 she had a hematocrit of 33, so she had a mild anemia, yes.

32

Q. Do you know whether she had had any weight loss?
A. She had had a history of weight loss, yes.
Q. And you are aware at the time of admission that she had a prosthetic aortic valve; correct?
A. Yes.
Q. What was within your differential diagnosis when you saw her on May 9th?
A. Well, certainly she had had a stroke, and it's important to consider sources of that stroke. It could have been from multiple different causes.
She clearly had from Southwest General fever and a urinary tract infection. And clearly in the intern note and senior resident note, they both comment on the possibility of endocarditis, so it was clearly on our differential, as well.
Q. Was that within your differential also?
A. Yes.
Q. Was it identified on your list?
MR. KILBANE: Objection. Go ahead.
A. Well, I think it was on our list, and

33

we needed to do some things to rule it in or out.
Q. So you had a lady with a prosthetic heart valve that had had a possible embolic event, mild anemia, some history of weight loss, fever off and on, and endocarditis wasn't high on that differential diagnosis?
MR. KILBANE: Objection.
A. Endocarditis was definitely on our differential.
Q. What was number one?
A. Stroke and urinary tract infection.
Q. Where was endocarditis on that list?
A. It's in that list. Probably in the -- I don't know. I couldn't give you a number, but it was definitely on our list.
Q. I want to know what was the differential diagnosis, what were the diagnoses and the order of importance in that list.
MS. HARRIS: Objection.
MR. KILBANE: Objection. You have asked and she has answered.
MS. TOSTI: She has not given me the list of differential diagnoses and that's what I am asking for.
MR. KILBANE: Your question presumes

34

that she had a list.
Q. Doctor, did you have a list of differential diagnoses for this patient?
A. We certainly had a group of diagnoses we were considering.
Q. Okay. And we talked about it before, that those are in order of importance. You mentioned that to me when I asked you about differential diagnoses. So I am asking you what the order of importance for this patient was in regard to differential diagnoses.
MS. HARRIS: At the time she saw him?
MR. KILBANE: You asked her in general whether there was an order and now you have switched it and you are implying that automatically, because in general there are orders, that there is in this case.
MS. TOSTI: Well, I haven't heard her answer yet.
MR. KILBANE: I heard her answer three times.
MS. HARRIS: Are you saying at this time or when she came in, the differential?
MS. TOSTI: On the 9th when she saw this patient, she referred to our differential

35

diagnoses and that's what I am asking her for.
Q. When you saw her on May 9th, what was within your differential diagnoses? And I want to know what was first, second, third, whatever diagnoses you had, I want to know what they are and in what order they were in.
MR. KILBANE: Same objection.
MS. HARRIS: Yes.
A. You remember that I have already seen the TEE when I am seeing her. So clearly on the top of our diagnosis was stroke -- possibly embolic in origin -- urinary tract infection, endocarditis. Now, again, I had not put them in numerical order. They are all probable, possible.
Q. So at the time that you saw her on the 9th, you already had the results of a transesophageal echo; is that correct?
A. I believe that's true, because it was done the day before.
Q. You were aware then of the prior echocardiogram that she had had done in April?
A. Yes.
Q. Did you have those results also?
A. Yes.

36

Q. So you were aware when you saw her that the April echo suggested bioprosthetic valve deterioration: correct?
A. I was aware that it suggested that it was possible that she had a dysfunctional valve, yes.
Q. That it was bioprosthetic valve deterioration?
A. That it was possibly valve deterioration, yes.
Q. Can endocarditis cause valve leaflets to deteriorate?
A. Yes.
Q. Now, at the time of her admission, you had an opportunity to talk with Dr. Kudmani as well as the senior resident. Were both of them present at the time of her admission on the 8th, from your knowledge?
A. Yes.
Q. Based on your discussions with them, was it their impression that endocarditis was within the differential diagnosis at the time of her admission?
A. Yes.
Q. Now, there were blood cultures

37

ordered. Were those ordered by the senior resident?
A. Probably, yes. I am not positive of that.
Q. Would that be within the realm *of* his duties? He would be allowed to independently order such tests for a patient?
A. Certainly.
Q. And he would not necessarily have to clear that type of an order with you, the attending physician, before they are ordered?
A. True. The attending neurologist had also suggested that that be done, who had seen the patient on the 8th.
Q. And who is that that you are referring to?
A. Dr. Hanna.
Q. And were those blood cultures ordered in order to rule out or rule in endocarditis in this patient?
A. They were ordered, because the diagnosis of endocarditis was on our differential diagnoses, yes.
Q. Do you know how many were done?
A. Two.

38

Q. Now, in your impressions, you indicate that TEE done last night, no obvious lesions, negative clot, I believe. That does not rule out that her strokes may have been caused by vegetative embolism from her prosthetic valve; correct?
A. Again, I am not an expert here, but it certainly makes the diagnosis not obvious, but you are right, it doesn't rule it out.
Q. And the reason is because the vegetation could have broken off, traveled as an embolism, and there may not necessarily be evidence on the transesophageal echo; correct?
A. From an internist's perspective, I believe that's so. You probably need an echocardiographer to tell you for sure.
Q. You are also aware that this particular echo, the echocardiologist indicated that the aortic valve could not be fully evaluated on this particular study; correct?
A. I know that they said there were no gross lesions and they were unable to fully evaluate the aortic valve, but again, no gross malfunctions were appreciated, yes.
Q. Now, after you had an opportunity to

39

see Earline Mizsey, what was your plan of care for her?
A. Well, we were working in conjunction with our neurologist colleagues who are the stroke experts, and she was treated with Heparin to prevent further embolic events while we awaited the blood cultures. And she was treated for urinary tract infection, which we thought might be the origin of her fever and white count and urinary symptoms.
Q. And why did you feel that the anticoagulation was indicated in her case?
A. Again, it was ordered, indicated by the neurologists for the possibility *of* atheroembolic or nonseptic emboli causing her stroke.
Q. Now, was the next time that you saw Earline Mizsey on May 10th?
A. Yes.
Q. Now, on May 10th, it was your opinion that she had had an embolic stroke; correct?
A. Yes. My note says embolic stroke, stable, continue anticoagulation. At that point, yes, we felt this most likely was embolic in origin.

40

Q. Did you have an opinion as to the source of the embolism?
A. At this point it wasn't clear.
Q. Was it likely it was cardiac in origin?
A. That was probably high on our list, yes, cardiac in origin, although she certainly had other disease that would make thrombotic stroke a possibility.
Q. Did you think it was likely a vegetative embolism from endocarditis?
A. I can't tell you that. I think it was on our list. We had not made a definitive diagnosis yet.
Q. Now, when you saw her on May 10th, she continued to have aphasia problems; correct?
A. Yes.
Q. And she also continued to have the weakness on the right side of her body that you previously described; correct?
A. Yes.
Q. And she continued also to have some confusion, or she wasn't real clear mentally; is that correct?
A. You know, since I didn't write that

41

down in my note, I am not sure I can tell you that exactly. From the intern's note below, awake, alert, oriented, slurred speech.
Q. Was she able to converse with you at all, that you recall?
A. She could converse in short sentences sometimes and then other times it was difficult to understand her.
Q. Was she able to respond to verbal commands?
A. Mostly, yes.
Q. Now, you next saw her on the 11th; is that correct?
A. Yes.
Q. Was it your impression that she had some improvement at this point?
A. Yes.
Q. What did you see as an improvement in her condition?
A. I write embolic stroke resolving deficits, and the above line suggests that her hand strength was normal; slight right facial droop, although I don't comment on it, I think I meant that it was improving, but I did not write that clear.

42

Q. Now, your note of the 11th indicates will talk with Dr. Alexander, vascular, about angiogram of the right foot, right foot without doppler pulses; correct?
A. Correct.
Q. Why did you think consultation with a vascular specialist was indicated?
A. Well, we had learned over the course of a couple of days that she was supposed to have an arteriogram done for evidence of ischemia in that leg, but she was admitted before the test was done, so we called Dr. Alexander again to tell him that she was here and that she could have the procedure.
Q. Did you speak to Dr. Alexander?
A. I don't remember. I probably did, but I don't remember.
Q. Did you have concerns about the arterial circulation to her right foot?
A. Yes. I mean, she had a long history of peripheral vascular disease.
Q. Did you think in this particular instance it was due to her peripheral vascular disease?
A. I don't think it was clear what the

43

etiology of this was.
Q. Did you read back in the outpatient department notes that she complained of sudden onset of leg pain after stepping out of the shower? Do you recall seeing that?
A. Yes. And also saw the vascular surgeon's note, who felt it was not quite as urgent as that.
Q. But that type of a description of sudden onset of severe pain isn't the typical description for a patient that has peripheral vascular disease, is it?
A. You know, I am not an expert there.
Q. Did you have any heightened concerns that she may have had embolization to the arteries of her right leg?
MS. HARRIS: Objection.
MR. KILBANE: Objection, as well.
A. Again, at the time that we were seeing her, I think that it was unclear whether or not she had embolization there or continuing of her already ongoing peripheral vascular disease.
Q. She could have had both, though; correct?
A. She could have had both.

44

Q. Do you know whether it was Dr. Alexander's impression from any conversations that you had with him that she had a probable thromboembolic event?
A. He did write a note -- let me see if I can find it here -- on the 11th. Is that the date that we are talking about?
Q. Yes.
A. He does comment that patient most likely to have an embolic event, but she needs, the angiogram. It's hard to read this. Then he talks about how to do the angiogram while on Heparin.
Q. From your evaluation of her, what did you see that would indicate to you that there was ischemic problems in that right leg?
A. She certainly had some changes in that right leg. It was hard to feel pulses on that side. She had, I believe, a right toe lesion pulse.
Again, we are not aware of her complaining of significant pain in that leg.
Q. You don't have any recollection in regard to skin color, temperature or anything like that?

45

A. I am trying to find it. I don't remember exactly, but there were clear indications that the leg was cool, and we knew she had arterial studies done, suggesting that she had ischemia of that leg.
Q. Now, would you agree that between the time of her admission and the 11th that prosthetic valve endocarditis had not been ruled out on Earline Mizsey?
A. Yes, I would agree with that.
Q. And that it was within the differential diagnosis for this patient?
A. Yes.
Q. Now, between May 8th and May 11th, was Earline Mizsey given any antibiotic therapy that would be appropriate for the treatment of prosthetic valve endocarditis?
A. No, because at this point, we had not made the diagnosis.
Q. And what would you consider to be necessary in order to make the diagnosis?
A. I think in this case, with a lady with multiple medical problems, a complicated history, that we needed one of the definitive tests to be positive, a TEE and/or blood cultures, before we

46

really moved that diagnosis up on our differential.
Q. Now, you saw her on the 12th then again; correct?
A. Correct.
Q. What was her condition when you saw her on the 12th?
A. She had worsened.
Q. In what way?
A. Again, her right-sided findings had worsened, more facial droop, more trouble with speech, less strength on the right side.
Q How did you come to learn that her condition had changed7
A I saw her.
Q So you just came in on your usual rounds and discovered that she had deteriorated somewhat7
A I am sure I was told, as well, but it was my usual routine to see patients early in the morning and then discuss them with the team, so I don't know exactly which happened first, but I definitely knew about the change.
Q. Approximately what time did you see her on the 12th? What would be your usual7

47

A. My usual routine would be to go in early, you know, say, 7:30.
Q. So it's likely in this case you saw her approximately that time in the morning?
A. I would think so. I'm not positive, because I didn't date the note -- I mean time the note.
Q. Now, would you read to us what you have written under the portion of your note that begins AP.
A. Yes. I am having a little trouble with that word. I think it says recurrent. Do you have the actual --
MR. KILBANE: Look at my chart and see if it's any better.
Q. Repeated?
A. Repeated, that's what it says, embolic events, several CNS events, and treated three week old acute popliteal occlusion. TEE showed no large intrachamber clot, but was not able to image prosthetic valve well. White count remains 21,000, and now one blood culture is positive. Again, all events suggest repeated embolic source and possible endocarditis.
Q. Now, doctor, when you wrote this note,

48

did you think it was likely that she had endocarditis?
A. I thought it was likely when I wrote this note. Again, I am not sure when I wrote this note, but it was clearly after we received some other information.
Q. Did you think it was likely that the vascular events that you described and the neurological events that you described were the result of the endocarditis?
MR. KILBANE: Objection. Go ahead.
A. Again, I can't be sure, but --
Q. You think it was likely?
A. I think it's possible.
Q. Now, in this instance, did you think it was likely, though?
MR KILBANE: Objection. Asked and answered. She told you it was possible. You keep asking her the same question. You can answer it again.
Q. So even at this point, you didn't think endocarditis was likely, doctor: correct?
A. That's not what I said. I actually think endocarditis at this point was likely, but whether or not the initial CVA that happened

49

outside the hospital or the popliteal occlusion were the result from the endocarditis, I can't be sure.
Q. After you saw her on the 12th, did you have a conversation with the Mizsey family or any members of the family?
A. I had talked to the family quite a lot, yes.
Q. Well, can you tell me up to this point when you had talked with them?
A. No, I can't, to tell you the truth. I don't document it and I don't remember.
Q. Can you tell me up to that point what you were discussing with them, up to the point of the 12th?
If you can't recall the time, at least tell me what the content of those conversations were, if you can recall.
A. Well, that we were treating her for stroke and that she had improved somewhat and we were preparing her for rehabilitation while the workup went on.
Q. Now, after she had this deterioration on the 12th, did you then talk with the family again?

50

A. Probably later in the afternoon after we had received some other information, like the blood culture.
Q. Do you recall who you talked to?
A. I always talked to two daughters. I don't remember their names.
Q. Were you the one that informed them that Earline Mizsey's condition had deteriorated? Did you provide them with that information?
A. I can't be certain I was the one that did that initially. It may have been the senior resident.
Q. In regard to whatever conversations you recall with the family, can you tell me what you told them?
A. No, I don't remember.
Q. Do you recall whether you told them that endocarditis was likely at this point?
A. I don't remember telling them that.
Q. Now, on the 12th, was there a decision made to treat her for endocarditis?
A. Yes.
Q. Was that a decision that you were involved in?

51

A. Yes.
Q. Why was there a decision to treat her far endocarditis at this point in time?
A. Well, I think at this point, we had begun to collect enough information that this diagnosis became probable.
Q. And what information are you basing that on?
A. Well, the blood culture. Actually, there were two blood cultures positive with an organism that although unusual can cause endocarditis, and we had the input of both our cardiology and infectious disease consults.
Q. And what is the organism that you are referring to that's unusual?
A. Anaerobic peptostreptococcus.
MR. KILBANE: Can you spell that for the court reporter?
THE WITNESS: It's P-E-P-T-O-S-T-R-E-P-T-O-C-O-C-C-U-S.
Q. And what was the therapy that was decided upon to treat her suspected or presumptive endocarditis?
A. Antibiotics.
Q. What antibiotics?

52

A. She was initially begun on Vancomycin and Gentamicin, I believe.
I will double-check that. Yes.
Q. Now, doctor, she had had an initial transesophageal echo done after admission to the hospital, and within the differential diagnosis was prosthetic valve endocarditis.
Is there a reason why if that was within the differential diagnosis, a follow-up TEE was not ordered for this patient to see whether there was any indications of endocarditis, particularly since the study that was done didn't fully evaluate the aortic valve?
A. I mean, she did have a repeat TEE four days later.
Q. Four days later, but after her condition had already deteriorated; correct?
A. That's true, but this is the definitive test. It was abnormal. I mean, it was not grossly abnormal, although you are right, they said they couldn't image it well. We debated about this, but felt that we weren't sure how much more information we would have on the same patient one day later, so we waited a few days, which is what the cardiologists actually

53

suggested should be done weekly if it's on the differential diagnosis.
Q. Did you agree with that decision to wait a week before doing another TEE?
MR. KILBANE: Objection. Go ahead.
A. I think we weren't necessarily just waiting a week for the TEE. We were also building the case by doing the other things that you have to do, looking for stigmata, which she never developed, looking for CHF, which she never developed, but doing blood cultures, which is the other definitive thing, and it should be positive, and when it was, that changed what we did.
Q. Well, what I asked you, though, doctor, did you agree with the decision not to do a follow-up TEE within a day or two of admission to reevaluate that aortic valve?
MR. KILBANE: Objection. Asked and answered. Go ahead.
A. I agreed that repeat TEE needed to be done and we did do it four days later.
Q. And you agreed with that time span?
A. Yes.
Q. If a patient has a TEE done and there

54

is mobile vegetations visualized on it, are any particular precautions taken with the patient regarding restrictions of activity?
A. Not that I'm aware *of.*
Q. Would the patient continue in physical therapy? For example, this patient, if she was seen to have mobile vegetations, would she continue to have activities such as physical therapy, transport to the physical therapy department and exercising, etcetera?
A. I don't know the answer to that. You might want to restrict her activities some.
Q. Now, you also saw her on May 13th; is that correct?
A. Yes.
Q. And did you see her before her arteriogram? I believe it was done on that day.
A. I don't know.
Q. When you saw her on the 13th, what were your findings regarding her condition?
A. They were similar to what we had seen yesterday -- I mean, sorry, the 12th. She had had no change in her murmur.
Q. It was your opinion that her two prior CVA's and right lower leg embolization and

55

positive blood cultures and elevated white blood count were all consistent with endocarditis; correct?
A. That they could be, yes, all consistent with endocarditis.
Q. And your note also mentions that you asked cardiothoracic surgery to become involved in the case; is that correct?
A. Yes.
Q. Why did you want cardiothoracic surgery involved?
A. Because a lady with a prosthetic valve endocarditis may need surgical correction of that valve, but we also needed the TEE to help us with that.
Q. And your note of the 13th further indicates that you had a long discussion with the daughter. Do you have any recollection of which daughter it was that you spoke to?
A. I don't remember which daughter it was, no.
Q. Do you know, was there anyone else present at that discussion besides you and one of the daughters?
A. Probably the senior resident with me.

56

Q. You don't have a specific recollection of that?
A. No, I don't.
Q. Was this a discussion in person with the daughter or on the phone?
A. Oh, in person.
Q. And where did it take place?
A. I don't remember if this was at the bedside or in the conference room, but it was in the hospital.
Q. Is there a conference room on the floor where she was?
A. Yes.
Q. How long did you talk with her?
A. I don't remember. Probably a half hour.
Q. And what did you tell the daughter at this point in time?
A. I think I was discussing with her, although I don't remember exactly what I said to her, discussing with her, her condition, the fact that we now thought she had probable endocarditis and might need a valve replacement, and the risks and benefits of those things in a sick lady.
Q. And what did you tell the daughter

57

were the risks in this case for this patient?
A. The risks of surgery?
Q. Yes. Well, whatever risks you discussed with the daughter is what I am asking you about.
A. I really don't remember the conversation well. I can only read you what's in my note. She was, you know, quite ill at this point, with multiple other problems complicating her cardiovascular risk, so there were certainly risks to potential surgery should she need it. For the benefits there are potential benefits as well, stopping her embolic event.
Q. Did you discuss any specific risks with the daughter, that you recall?
A. Well, we certainly talked about the risk of death without surgery and the risk of death with surgery, which in her case were not minimal. I think most of this discussion was really them trying to think about what her wishes would be should she continue to do poorly.
Q. Was Earline Mizsey able at this point in time to provide any input into that decision-ma king?
A. Again, I can't remember exactly, but

58

you couldn't communicate with her verbally.
Q. So she wasn't answering questions or responding in any way that anyone could understand her desires?
A. She could intermittently follow commands and shake her head yes or no, but I couldn't understand her verbally with words.
Q. In regard to the conversation with the daughter, do you recall any questions that the daughter asked you specifically7
A. I don't really remember, no.
Q. Was Earline Mizsey at greater risk for valve replacement surgery because of the several strokes that she had?
A. Yes.
Q. Now, although you were discussing the possibility of surgery at that point, no one had told the family whether or not Earline Mizsey actually would be accepted for surgical valve replacement; correct?
A. That's probably correct.
Q. Now, there is a note that's also written on the 13th by radiology. I believe it's on the opposite page from where your note is.
It indicates that she apparently went

59

down for arteriograms and became more aphasic after the arteriograms, and then I believe there is a note written by Dr. Kudmani indicating that her mental status was deteriorating rapidly.
Were you made aware of any change in her condition after those arteriograms?
A. I remember this event, and again, it wasn't -- her mental status did fluctuate somewhat, and certainly our neurology colleagues felt that her symptoms hadn't changed dramatically.
Q. So you would disagree then with Dr. Kudmani's note indicating that she was deteriorating rapidly, her condition?
A. I mean, I don't remember when this was written exactly in relation to the neurology note, so it's possible that she did wax and wane a little bit.
Q. If she had mobile vegetations on the transesophageal echo, would it be wise to transport her to x-ray to undergo an arteriogram on her lower extremity?
MR. KILBANE: Objection.
Q. Would that be activity that would be restricted to her?

60

A. I don't believe so.
Q. Now, the increase in aphasia described after the arteriogram, do you have know whether that was caused by any additional embolization?
MR. KILBANE: Objection. Go ahead.
A. You know, I don't know.
Q. Now, Dr. Kudmani writes his note that I have just referred to previously, and in item number seven, in his note of 5-13-98, he indicates he met with the daughters to discuss the condition and the family was aware of the mother's serious condition and they were debating regarding, I believe, do not resuscitate status and how far this should go.
Were you present for that discussion with the family?
A. I don't remember. I probably was. But it is possible that he spoke with them, as well.
Q. Now, in Dr. Kudmani's note, item number two, he indicates that Earline Mizsey's right side is flaccid. Prior to this, you had indicated, at least at the point of admission and for a day or so after, that she had weakness on the side and at one point her hand grasps

61

actually were equal, I believe, you told me.
At what point did she develop flaccidity on that right side? Was it after the arteriogram?
MR. KILBANE: Objection. Go ahead.
A. I think I mentioned flaccidity on the 13th. Let me look at the note. In the neurology note of the 12th, it would suggest flaccidity, and that precedes. I think I cannot say that from these notes.
Q. But her condition definitely deteriorated from the time of admission?
A. Yes.
Q. Correct?
A. Yes.
Q. Do you have an opinion whether it was due to additional stroke that caused her to go from being able to move that right side to flaccid paralysis on the right side?
MR. KILBANE: Objection. Go ahead.
A. Clearly something changed, She did get somewhat worse. On the head CT done on the 12th and 14th, there was no new evidence of stroke, so whether or not she had extended the initial stroke or not is unclear.

62

Q. Now, you saw her again then on the 14th; correct?
A. Yes.
Q. And you noted that she did have a flaccid paralysis on the 14th; correct?
A. Yes.
Q. On the right side?
A. Yes.
Q. Now, she had on the 14th another transesophageal echo.
A. Yes.
Q. What was your understanding as to what was found on that May 14th, '98 transesophageal echo?
A. I write down possible valvular abscess and vegetation. There is a report in here of the exact findings. Perivalvular aortic valve abscess is present, two millimeter by four millimeter vegetation on aortic valve, mild aortic insufficiency.
Q. In your note, you indicate about halfway through it, repeat CT head today shows small infarct on the left and old right infarct present. The small infarct on the left, was that something that was new?

63

A. I think we thought that was the infarct related to her admission and the one done the next day showed there was no change.
Q. You have underlined the word small, a small infarct. Just tell me whether you do or you don't, but do you know whether or not that was something new or whether that was the infarct that was done on admission?
A. I don't know for sure, because we don't have the CAT scan from Southwest General, and even if we did, it probably wouldn't have shown up because she had just had the symptoms, so I guess I can't really tell you if that's new or old.
Q. Now, you also indicate in your note that that patient is extremely high risk for surgery but will most likely not survive if the valve is not replaced; correct?
A. Yes.
Q. So was it your feeling at that point that her chances of survival were best if she did undergo surgery?
A. Yes.
Q. Now, your note indicates that the family was trying to assess the patient's

64

wishes, Would it be fair to say that they wanted her to make the decision in regard to surgery? Was that your impression?
A. Yes.
Q. That they were hoping that the patient would be able to make the determination?
A. Yes.
Q. Now, were you able at some point to discern Earline Mizsey's wishes regarding heart valve replacement surgery?
A. Yes.
Q. What is it that you were able to discern from the patient?
A. Just after the second TEE down in the coronary care unit where it was done, both the cardiologist and I, and I believe the daughters were there, and clearly Ms. Mizsey expressed her wishes for surgery by nodding vigorously when we suggested, when we asked her whether or not she wanted surgery.
Q. Were you the one that actually put the question to her?
A. Yes.
Q. And do you recall who else was present?

65

A. Yes. I think Dr. Vrobel was there, as well as the daughters. It might have been Dr. Rakita, not Dr. Vrobel. I am not positive of that. One of the cardiologists was there.
Q. When the TEE was done on May 14th, were you present when it was done?
A. I think we came down when we heard that there were abnormalities noted. I think actually Dr. Vrobel called me.
Q. So you actually received a verbal report on the transesophageal echo from the echocardiographer that did the test?
A. Yes.
Q. Now, the last note that I see with your signature was written on May 14th. Is that the last date that you were involved in Earline Mizsey's care?
A. Yes.
Q. Did you have any participation in the decision to transfer her to Cleveland Clinic?
A. No, I didn't.
Q. Did you speak to anyone at Cleveland Clinic regarding possible surgery for Earline Mizsey?
A. No, I did not.

66

Q. Do you know who made those arrangements or who was making those calls?
A. Dr. Vrobel.
Q. Now, during the course of time that she was in Metro, did you have any conversations with Dr. Einstadter about her prior history leading up to her admission?
A. Yes.
Q. What was the content of those conversations? What did he tell you?
A. I am probably not going to remember everything, but he certainly was concerned about her and came up several times -- the first time was probably around the 9th -- and did tell us of her previous events. What he was concerned about was the potential for embolic sources, but also that she had multiple medical problems; that some of these might be able to be explained on the basis of her long-standing vascular disease and atherosclerotic disease.
Q. Doctor, if you have a concern about embolic events in a patient with other criteria for endocarditis, such as fluctuating temperature, elevated white blood cell count, mild anemia, weight loss, wouldn't this be a

67

patient that you would want to do a follow up TEE on soon after the initial one to determine if there was an embolic source coming from the heart?
MS. HARRIS: Objection.
MR. KILBANE: Objection. The question is confusing, but go ahead and answer, doctor, if you can.
A. In answer to the question, I think she had a multitude of symptoms that were very nonspecific. I agree, and we did repeat the TEE in four days and awaited her blood cultures and treated her immediately once the diagnosis was made.
Q. Now, you mentioned that Dr. Vrobel was present at the time. You think he may have been present at the time that the TEE was done. Did you talk with Dr. Vrobel at any point between the time of her admission -- I guess the 9th when you first saw her -- and the point when she actually had the repeat TEE?
A. The cardiologists were involved from the 12th. He was attending in the coronary care unit and did not get involved in her care until the TEE.

68

Q. So you didn't discuss her actual case with Dr. Vrobel until then?
A. No. The case had been discussed with Dr. Rakita, who was the consulting cardiologist who certainly did talk to Dr. Vrobel.
Q. Well, I am asking in regard to conversations you had.
A. No, I did not.
Q. With either. Let me clarify.
Did you have any conversations with Dr. Rakita or Dr. Vrobel between the 9th when you saw her and the 14th when she had her transesophageal echo done?
A. Yes, we had the cardiology service involved.
Q. And what became involved on the 12th?
A. On the 12th?
Q. What information did they provide you with in regard to her condition? What were they saying in regard to her condition?
A. Well, on the 12th, we had a blood culture positive, and again, they were certainly in agreement that she had possible endocarditis.
Q. And what was the reason that they

69

became involved on the 12th in this case? Was it because of the positive blood cultures?
A. I would say yes. I mean, we had enough pieces to put the puzzle together.
Q. Were you the ones that called in the cardiologists to become involved in the case?
A. Yes.
Q. And you did that on or about the 12th?
A. Yes.
Q. As a result of the positive blood cultures?
A. I believe, yes.
Q. Any other reason why you were calling them in besides the blood cultures?
A. Well, we were concerned about endocarditis in a lady with a prosthetic valve. That's why we called the cardiologists.
Q, Well, she had been there for four days, though.
A. But we hadn't been able, using the best tests that we had, we hadn't been able to make the diagnosis, and even our infectious disease colleagues note on the 12th with two positive blood cultures they still said this was possible or probable, not definite.

70

Q. Do you have an opinion as to when Earline Mizsey developed prosthetic valve endocarditis?
A. Boy, I don't know.
Q. After Earline Mizsey was transferred to Cleveland Clinic, were you ever informed that they had declined to take her to surgery for valve replacement?
A. I did receive a letter from Dr. Tomford, the infectious disease consultant at the Clinic, saying they had chosen to treat her medically with antibiotics.
Q. Do you know why they made that decision?
A. No, I don't know all of what went into that decision.
Q. Did you speak to any of Earline Mizsey's family after she was transferred out of Metro?
A. No.
Q. Did you speak to any of the physicians that were treating her at Cleveland Clinic? Aside from the correspondence you just mentioned, did you have any conversations with anybody over there that was treating her?

71

A. No. And I don't know whether or not the cardiologists did.
Q. When did you learn that Earline Mizsey had died?
A. I don't think I knew that until this case was presented to me.
Q. If Earline Mizsey had had a transesophageal echo done before her stroke on May 8th, when she entered Metro Hospital, do you think it would have likely showed indications of vegetations?
MR. KILBANE: Objection. Go ahead.
MS. HARRIS: Objection.
A. I have no way of knowing. I mean, the one on the 8th didn't show obvious vegetations.
Q. After stroke?
A. After her stroke, right.
Q. Do you have an opinion as to what point in time she became, as you put it, extremely high risk for surgery?
A. I think she was always at risk because of her diabetes and hypertension and coronary artery disease and her vascular disease, but she became somewhat higher risk after her coronary events.

72

Q. After?
A. After her stroke.
Q. At which point? Which stroke? She had several.
MR. KILBANE: Objection.
MS. HARRIS: Objection. That's a conclusion.
A. I am still not sure that we know that she had several. She may have had an extension. I forgot the question.
Q. Well, you indicated that she was extremely high risk for surgery in one of your notes, and my question is, at what point do you think she became extremely high risk for surgery?
MR. KILBANE: Objection. Asked and answered. Go ahead.
A. Again, I think she was always at risk, probably at higher risk when her symptoms deteriorated.
Q. And at what point in time do you consider her symptoms to have deteriorated?
A. Probably around the 12th. But I think anyone with a stroke is at risk for cardiac bypass.

73

Q. Doctor, your note of 5-13, if you could turn to that.
A. Yes.
Q. Under the AP section of your note, you refer to two CVA's.
A. Yes.
Q. What --
A. Which two am I referring to?
Q. Correct.
A. The first being the one out of the hospital in March, the second one being the one on the 8th.
Q. Do you have an opinion as to what caused Earline Mizsey's death?
A. No. I wasn't involved in her care when she died, so I don't know exactly. It certainly could have been related to her endocarditis.
Q. Do you think that Earline Mizsey had endocarditis at the time of her admission on 5-8-98?
A. I think it's possible, yes, and it took us -- I mean, we did the appropriate workup and found the diagnosis, but it wasn't simple.
Q. If she had been diagnosed and cured of

74

her endocarditis prior to the stroke on 5-8, do you have an opinion as to what her reasonable life expectancy would have been, given her medical conditions?
MS. HARRIS: Objection.
MR. KILBANE: Objection. Go ahead.
MS. HARRIS: It's a lot of assumptions.
A. Again, I can't predict the future. She had a number of medical problems. I don't think she would have had a normal life expectancy.
Q. Do you have any opinion as to how many years she likely would have lived had she been diagnosed, treated and cured prior to that stroke on May 8th?
MR. KILBANE: Objection.
A. No.
Q. Do you have any criticisms of anyone that rendered care to Earline Mizsey?
A. No, I don't.
Q. Any criticisms of the family?
A. No. They were very responsive.
MS. TOSTI: I don't have any further questions for you.

75

MS. HARRIS: No questions.
MR. KILBANE: We will read.
- - - - -
(Deposition concluded at 12:25 a.m.)
(Signature not waived.)
- - - - -

76

AFFIDAVIT

I have read the foregoing transcript from page 1 through 74 and note the following corrections:

PAGE	LINE	REQUESTED CHANGE

Elizabeth Dorr McKinley, M.D.

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

Notary Public

My commission expires

CERTIFICATE

State of Ohio,
SS:
County of Cuyahoga.

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

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

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this 27th day of December, 2000.

Vivian L. Gordon, Notary Public
Within and for the State of Ohio

My commission expires June 8, 2004.

WORD INDEX

ELIZABETH DORR MCKINLEY, M.D., M.P.H.

curriculum vitae

Current Position: Assistant Professor, Case Western Reserve University School of Medicine

Address: Center for Health Care Research and Policy
MetroHealth Medical Center
Rammelkamp Research and Education Bldg.
2500 MetroHealth Drive
Cleveland, Ohio 44109-1998
Office: (216) 778-3902
email: exm20@po.cwru.edu

BIOGRAPHICAL

Date of Birth: September 30, 1960
Place of Birth: Rochester. N.Y.
Family: Husband: Robert Chapman Gilkeson Jr., M.D.
Children: William Rowland Gilkeson (8/17/91)
Katherine Merrick Gilkeson (8/2/94)

EDUCATION & TRAINING

1999-00 Faculty Fellow, Improvement in Health Care Program
MetroHealth Medical Center

1994-96 Fellow, Cancer Control Education Program
UNC Lineberger Comprehensive Cancer Center, Chapel Hill, N.C.

1993-95 M.P.H in Epidemiology
University **of** North Carolina at Chapel Hill, N.C.

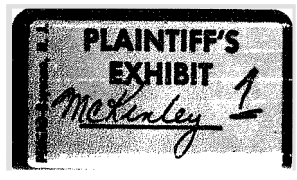
1992-94 Robert Wood Johnson Clinical Scholar
University of North Carolina at Chapel Hill, Chapel Hill, N.C.

1991-92 Fellow, General Internal Medicine
Cleveland Metropolitan General Hospital, Cleveland, Ohio

1987-91 Intern, Resident, and Chief Resident in Internal Medicine
Cleveland Metropolitai General Hospital, Cleveland, Ohio

1987 M.D., Case Western Reserve University School of Medicine, Cleveland, Ohio.

1982 B.A., Middlebury College, Middlebury, Vermont



CERTIFICATION & LICENSURE

Medical License:	Ohio (# 57859) and North Carolina (# 35705)
1990	Diplomat, American Board of Internal Medicine
1988	FLEX examination, State of Ohio

ACADEMIC APPOINTMENTS

1999--	Assistant Professor of Medicine, CWRU School of Medicine
1996-99	Senior Instructor, CWRU Department of Medicine and Biomedical Ethics
1992-96	Clinical Instructor, Department of Medicine. University of North Carolina School of Medicine, Chapel Hill, NC
1992-94	Research Associate, Cecil G. Sheps Center for Health Services Research. University of North Carolina at Chapel Hill
1990-92	Clinical Instructor, Department of Medicine. Case Western Reserve University School of Medicine, Cleveland, OH

ACADEMIC ACTIVITIES

2000--	Member, Central Institutional Review Board Project, National Cancer Institute
	Leader, Osteoporosis Improvement Team, CATALYST project, MetroHealth Medical Center
	Member, Carolina Mammography Registry Advisory Committee
1999--	Reviewer, Population Specific Grant Program, Susan G. Komen Breast Cancer Foundation
	Member, CATALYST Improvement project, MetroHealth Medical Center
1998--	Co-Director, Women's Health Track, Primary Care Residency Program, MetroHealth Medical Center
	Director, Primary Care of Women elective for 4th year medical students
	Committee member, Women's Health in the Millennium Curriculum, CWRU School of Medicine
	Manuscript Reviewer, *Journal of Women'sHealth*
1997	Instructor, Clinical Rotation, Biomedical Ethics Masters Students
1996--	Member, Primary Care Track Oversight Committee, CWRU School **of** Medicine
	Instructor, Core Physician Development Program, CWRU School of Medicine
1995--	Member, National Breast Cancer Surveillance Consortium
1992--	Manuscript reviewer, *Journal of General Internal Medicine*

PUBLICATIONS

McKinley ED, Saleh-Jones **S,** Stange KC. Transition Points: Changing Needs for Information and Support During Breast Cancer Diagnosis, Treatment, and Survivorship. Under review, CANCER 12/00.

McKinley ED, Thompson JW, Briefer-French J. Performance Indicators in Women's Health: Incorporating Women's Health in the Health Plan Employer Data and Information Set (HEDIS). Under review, Women's Health Issues, 11/00.

McKinley, ED. Under Toad Days: Surviving the Uncertainty of Cancer Recurrence. Ann Intern Med 2000;133:479-480.

McKinley ED. Clinical Breast Examination. In: Wigton RS, Tape TG eds. Mosby's Primary Care Procedures Series: Gynecologic Procedures and Women's Health. Mosby, 1999.

O'Malley MS, Klabunde CN, McKinley ED, Newman, E. Community-based primary care physicians' attitudes regarding testing for inherited susceptibility to breast cancer. NC J Med 1997; May/June.

McKinley ED, Garrett JM, Evans AT, Danis M. Differences in End-of-Life Decision-Making among Black and White Ambulatory Cancer Patients.. J Gen Intern Med 1996;11:651-656.

RECENT PRESENTATIONS/ABSTRACTS

McKinley ED, Stange KC, Saleh-Jones **S.** Using Process Diagrams with Patients to Understand and Improve the Process of Breast Cancer Care. Presented at the Institute for Healthcare Improvement 12th Annual National Forum on Quality Improvement in Health Care, San Francisco, Ca., 12/00

McKinley ED, Stange KC. Transition Points: Changing needs for Information and Support During Breast Cancer Diagnosis, Treatment, and Survivorship. Presented at the National Society of General Internal Medicine Meeting, Boston 5/2000.

McKinley ED. The Impact of Health System Reform on Medical Education." 25th Anniversary Celebration of the Robert Wood Johnson Clinical Scholars Program, University of North Carolina at Chapel Hill, 10/99.

McKinley ED, Singh M, McCracken G. Wrist fractures in postmenopausal women: who gets evaluated or treated for osteoporosis? Presented at the Midwest Society for General Internal Medicine Meeting, 9/99

INVITED PRESENTATIONS

"Update in Breast Cancer Prevention", MHMC Department of Clinical Nutrition Conference on Women's Health Issues, 9/29/00.

"Selecting, Tracking, and Evaluating Outcomes for Cancer Treatment Trials", panelist, Seattle Symposium on Cancer Outcomes Research, 9/22/00-9/23/00.

"Healing the Healers: Doctors and Nurses with Cancer" The Gathering Place, Cleveland, Ohio 6/4/00

"Skills for Communicating with Health-Care Professionals", Cancer: Keys to Survivorship, National Coalition for Cancer Survivorship educational program, Cleveland, Ohio, 5/22/2000

"Update in Women's Health", MHMC/YMCA Women's Health and Wellness Day, Cleveland, Ohio 5/13/2000

"Beating Bone Loss", ***Living Well*** Series, MetroHealth Medical Center, 3/2000.

"Women's Health Issues in the 21st Century" Woman2000: Forging a Vision. Case Western Reserve University, 4/8/2000. Panelist with Dr. Susan Blumenthal, U.S. Assistant Surgeon General.

"Breast Cancer Update", YMCA Women's Health and Wellness Day, Cleveland, Ohio 4/99

"The Balancing Act with Chronic Disease". Balancing the Personal and Professional: Challenges for 21st Century Physicians Workshop, Women Faculty of CWRU School of Medicine, 11/98.

ACTIVE GRANTS

Principal Investigator
Communication and Psychosocial Needs of Breast Cancer Patients Receiving Adjuvant Chemotherapy
American Cancer Society Cancer Control Career Development Award for Primary Care Physicians, $165,000, 7/98-7/01