

<p>1 IN THE COURT OF COMMON PLEAS 2 OF CUYAHOGA COUNTY, OHIO 3 4 LESLIE WALTER, ADMINISTRATOR, ETC., 5 6 Plaintiff, 7 8 vs Case No. 393899 9 10 METROHEALTH MEDICAL CENTER, et al., 11 Defendants. 12 13 DEPOSITION OF ELIZABETH DORR MCKINLEY, M.D. 14 WEDNESDAY, DECEMBER 20,2000 15 16 Deposition of ELIZABETH DORR MCKINLEY, M.D., 17 a Witness herein, called by counsel on behalf of 18 the Plaintiff for examination under the statute, 19 taken before me, Vivian L. Gordon, a Registered 20 Diplomat Reporter and Notary Public in and for 21 the State of Ohio, pursuant to agreement of 22 counsel, at the offices of MetroHealth Medical 23 Center, 2500 MetroHealth Drive, Cleveland, Ohio, 24 commencing at 10:30 o'clock a.m. on the day and 25 date above set forth.</p>	<p>1 ELIZABETH DORR MCKINLEY, M.D., a witness 2 herein, called for examination, as provided by 3 the Ohio Rules of Civil Procedure, being by me 4 first duly sworn, as hereinafter certified, was 5 deposed and said as follows: 6 EXAMINATION OF ELIZABETH DORR MCKINLEY, M.D. 7 BY MS. TOSTI: 8 Q. Doctor, would you please state your 9 name for us. 10 A. Elizabeth Dorr McKinley. 11 Q. And that's D-O-R-R? 12 A. Yes. 13 Q. And your home address? 14 A. 2436 Coventry Road, Cleveland Heights, 15 Ohio. 16 Q. And your zip code? 17 A. 44118. 18 Q. Is that a single-family home? 19 A. Yes. 20 Q. Is your current business address here 21 at MetroHealth Medical Center? 22 A. Yes. 23 Q. And is your current employer 24 MetroHealth Medical Center? 25 A. Yes.</p>
<p>1 APPEARANCES: 2 On behalf of the Plaintiff 3 Becker &amp; Mishkind, by 4 JEANNE M. TOSTI, ESQ. 5 Skylight Office Tower Suite 660 6 Cleveland, Ohio 441 13 7 216-241-2600 8 9 On behalf of the Defendant MetroHealth Medical 10 Center 11 Reminger &amp; Reminger, by 12 THOMAS KILBANE, ESQ. 13 The 113 St. Clair Building 14 Cleveland, Ohio 441 14 15 216-687-1311 16 17 On behalf of the Defendant Emergency Professional 18 Services and Thomas W. Graber, M.D. 19 Mazanec. Raskin &amp; Ryder, by 20 BEVERLY HARRIS, ESQ. 21 100 Franklin's Row 22 34305 Solon Road 23 Solon, Ohio 44139 24 440-248-7906 25</p>	<p>1 Q. And in March of '98, was that your 2 business address and your employer also? 3 A. Yes. 4 Q. Do you currently render professional 5 services for anyone other than MetroHealth 6 Medical Center? 7 A. No. 8 Q. Was that also true in March of '98? 9 A. Yes. 10 Q. Have you ever had your deposition 11 taken before? 12 A. No. 13 Q. I want to go through some of the 14 ground rules for a deposition. I am sure counsel 15 has had a chance to talk with you. 16 This is a question and answer 17 session. It's under oath. It's important that 18 you understand my questions. If you don't 19 understand my questions, let me know and I'll be 20 happy to repeat the question or to rephrase it, 21 if I have stated it inartfully. 22 If at any point you would like to 23 refer to the medical records, feel free to do 24 so. 25 You should give all of your answers</p>

<p>5</p> <p>1 verbally, because our court reporter cannot take 2 down head nods or hand motions. And at some 3 point defense counsel may chose to enter an 4 objection for the record. You are still required 5 to answer my question unless counsel instructs 6 you not to do so. 7 Do you understand those instructions? 8 A. Yes. 9 Q. Have you ever been named as a 10 defendant in a medical negligence suit? 11 A. No. 12 Q. Have you ever acted as an expert in a 13 medical/legal proceeding? 14 A. No. 15 Q. Have you ever given testimony in any 16 case involving issues dealing with bacterial 17 endocarditis? 18 A. No. 19 Q. Now, I have been provided with a copy 20 of your curriculum vitae, I believe. 21 MS. TOSTI: Would you mark this as 22 Plaintiff's Exhibit 1. 23 ----- 24 (Thereupon, McKinley Deposition 25 Exhibit 1 was marked for</p>	<p>7</p> <p>1 A. Well, I was an intern and resident 2 here and then went to North Carolina and came 3 back in 1992 -- no, that's not right -- 1994. 4 Q. So from 1994 to the present, you have 5 been a staff physician with MetroHealth Medical 6 Center: is that correct? 7 A. Yes. 8 Q. In March of 1998, what was your 9 position and title at MetroHealth? 10 A. I was a staff physician. A senior 11 instructor in medicine and bioethics. 12 Q. Did you hold any other administrative 13 positions with Metro at that time? 14 A. No. 15 Q. And your current title and position? 16 Is it the same? 17 A. Assistant professor of medicine and 18 bioethics. 19 Q. Aside from MetroHealth Medical Center, 20 do you have privileges at any other hospital in 21 Cleveland? 22 A. No. 23 Q. And the privileges that you have here 24 at Metro, those are admitting privileges? 25 A. Yes.</p>
<p>6</p> <p>1 purposes of identification.) 2 ----- 3 Q. I would ask if you would just identify 4 this document for me. 5 A. That's my CV. 6 Q. Is it current and up to date? 7 A. Yes. 8 Q. Are there any corrections or additions 9 that you would like to make to it? 10 A. No. 11 Q. Doctor, you are board certified in 12 internal medicine; is that correct? 13 A. Yes. 14 Q. Did you pass that board certification 15 on your first attempt? 16 A. Yes. 17 MR. KILBANE: Objection. Go ahead. 18 Q. You are licensed to practice medicine 19 in the State of Ohio; correct? 20 A. Yes. 21 Q. And were you also so licensed in March 22 of '98? 23 A. Yes. 24 Q. When did you first become employed 25 with MetroHealth Medical Center?</p>	<p>8</p> <p>1 Q. Have you ever had your hospital 2 privileges called into question, suspended or 3 revoked? 4 A. Never. 5 Q. Have you ever had your medical license 6 called into question, suspended or revoked? 7 A. No. 8 Q. Have you been licensed in any other 9 state other than the State of Ohio? 10 A. In North Carolina. 11 Q. Now, doctor, you have several 12 publications listed on your curriculum vitae. Do 13 any of these deal with the subject matter of 14 bacterial endocarditis? 15 A. No. 16 Q. Do any deal with the subject matter of 17 prosthetic heart valves? 18 A. No. 19 Q. Have you ever taught or given a formal 20 lecture on either of those subjects? 21 A. I have probably done some medical 22 school teaching on endocarditis during my 23 attending rounds when I am on service. 24 Q. Have any of those presentations been 25 reduced to a written form, videotape or audio</p>

<p style="text-align: right;">9</p> <p>1 tape?</p> <p>2 A. No.</p> <p>3 Q. Any syllabus or handouts from those</p> <p>4 presentations?</p> <p>5 A. Not that I'm aware of.</p> <p>6 Q. Tell me what you have reviewed in</p> <p>7 preparation for this deposition.</p> <p>8 A. I have reviewed all the outpatient</p> <p>9 records, just to make sure that I was not</p> <p>10 involved in the care of this lady, and I spent</p> <p>11 more time on the inpatient admission.</p> <p>12 Q. The inpatient admission that you are</p> <p>13 referring to is the MetroHealth Medical Center</p> <p>14 admission of May 8th of '98; is that correct?</p> <p>15 A. Yes.</p> <p>16 Q. You have not reviewed any records from</p> <p>17 Southwest General Hospital emergency room?</p> <p>18 A. I have seen the emergency room</p> <p>19 records.</p> <p>20 Q. How about The Cleveland Clinic records</p> <p>21 after her discharge from MetroHealth Medical</p> <p>22 Center?</p> <p>23 A. I have looked at them briefly, but</p> <p>24 they are very sketchy.</p> <p>25 MR. KILBANE: Can we go off the</p>	<p style="text-align: right;">11</p> <p>1 have a teaching position: is that correct?</p> <p>2 A. Yes.</p> <p>3 Q. Is there a particular text that you</p> <p>4 utilize with your students, with the medical</p> <p>5 students or the interns and residents in internal</p> <p>6 medicine?</p> <p>7 A. No, there is no specific text.</p> <p>8 Q. Are you on faculty at Case Western</p> <p>9 Reserve?</p> <p>10 A. Yes.</p> <p>11 Q. What is the textbook that they use at</p> <p>12 Case Western Reserve for internal medicine?</p> <p>13 A. I don't think there is a specific</p> <p>14 textbook. There are several of them.</p> <p>15 Q. Do you have a textbook that you</p> <p>16 consider to be the best or the most reliable in</p> <p>17 internal medicine?</p> <p>18 A. Not really. I mean, some of these</p> <p>19 texts I think are better than others.</p> <p>20 Q. Are there any publications, as you sit</p> <p>21 here today, that you believe have particular</p> <p>22 relevance to the issues in this case?</p> <p>23 A. No.</p> <p>24 Q. Have you participated in any research</p> <p>25 dealing with the subject matter of bacterial</p>
<p style="text-align: right;">10</p> <p>1 record?</p> <p>2 (Discussion off the record.)</p> <p>3 Q. Have you looked at any from Broadview</p> <p>4 Multicare, which is the extended care facility</p> <p>5 that she went to?</p> <p>6 A. I have seen some things from there,</p> <p>7 but again, they are very sketchy.</p> <p>8 Q. Have you reviewed any deposition</p> <p>9 testimony?</p> <p>10 A. I have reviewed the deposition of</p> <p>11 Douglas Einstadter.</p> <p>12 Q. Since the filing of this case, have</p> <p>13 you discussed it with any physicians?</p> <p>14 A. No.</p> <p>15 Q. And other than with counsel, have you</p> <p>16 discussed this case with anyone else?</p> <p>17 A. No.</p> <p>18 Q. Aside from what may be in the actual</p> <p>19 MetroHealth Medical Center records, do you have</p> <p>20 any personal notes or personal file on this case?</p> <p>21 A. No.</p> <p>22 Q. Have you ever generated any such</p> <p>23 notes?</p> <p>24 A. No.</p> <p>25 Q. Now, doctor, you indicated that you</p>	<p style="text-align: right;">12</p> <p>1 endocarditis?</p> <p>2 A. No.</p> <p>3 Q. Now, you said that you had an</p> <p>4 opportunity to review Dr. Einstadter's</p> <p>5 deposition. He mentioned a research study</p> <p>6 involving referral of patients for</p> <p>7 echocardiograms. Have you had any</p> <p>8 participation in that particular study?</p> <p>9 A. No, I have never heard of it until I</p> <p>10 saw it there.</p> <p>11 Q. Your practice of internal medicine, is</p> <p>12 it limited in any way? By that I mean to any</p> <p>13 particular population of patients or to inpatient</p> <p>14 or outpatient.</p> <p>15 A. No. I do a little of both inpatient</p> <p>16 and outpatient.</p> <p>17 Q. Is it limited to adult patients?</p> <p>18 A. Yes.</p> <p>19 Q. Would you describe for me in general</p> <p>20 terms your professional practice as it is today.</p> <p>21 A. Today? I do about 70 percent teaching</p> <p>22 and research and about 30 percent clinical</p> <p>23 practice.</p> <p>24 Q. And in March of 1998, what was the</p> <p>25 breakdown?</p>

<p style="text-align: right;">13</p> <p>1 A. It was about 50-50; 50 research, 50 2 clinical practice. 3 Q. In March of 1998, were you seeing 4 patients both in the clinic setting as well as 5 patients in the hospital setting? 6 A. Yes. The way that worked is I would 7 have clinic sessions in the outpatient 8 department, and then maybe two to four weeks of 9 the year I would be on patient service. 10 Q. I said March. I believe most of the 11 care that you may have provided was during that 12 inpatient admission, so that was actually May of 13 '98. 14 A. Right. 15 Q. So during that time period, I'm sorry, 16 most of what you said you saw were inpatients 17 then? 18 A. During that time period? 19 Q. Yes. 20 A. Yes, inpatients. I was attending on 21 one of the medical floors. 22 Q. Now, tell me again the rotation that 23 you would normally go through between inpatient 24 and outpatient. 25 A. What I would do is, I believe at that</p>	<p style="text-align: right;">15</p> <p>1 Q. Just generally, what was the subject 2 matter of that course? 3 A. It was mostly problem solving, 4 thinking about a case and figuring out how to 5 develop a differential diagnosis. 6 Q. How do you develop a differential 7 diagnosis, doctor? 8 A. Well, I am not sure there is an exact 9 methodology, but you begin to know what's most 10 common and what's less common with a series of 11 symptoms. 12 Q. And do you build a hierarchy of most 13 likely to least likely diagnosis when you do a 14 differential diagnosis? 15 A. I think that's what you try to do, 16 yes. 17 Q. Now, in May of '98, were you 18 responsible for the supervision of any medical 19 staff at Metro Hospital? And by medical staff, 20 I'm referring to interns, residents, medical 21 students. 22 A. While I was on the inpatient service, 23 I was supervising, let's see, a senior resident, 24 probably two senior residents and approximately 25 five interns.</p>
<p style="text-align: right;">14</p> <p>1 point I had three days, three half days of 2 outpatient practice where I saw my own patients, 3 and then within the year, I would have two, two 4 week blocks of inpatient attending time, at which 5 point I would drop all my other responsibilities 6 and care only for those patients admitted to my 7 team. 8 Q. And during the time when you weren't 9 having the two, two week blocks, did you continue 10 with the three half day sessions in the 11 outpatient department? 12 A. Yes. 13 Q. Then was the rest of your time then 14 devoted to teaching and research? 15 A. Yes. 16 Q. When you were teaching, were you doing 17 classroom instruction, as well as clinical 18 instruction? 19 A. Yes. 20 Q. What courses were you teaching in the 21 classroom at that time during that time period? 22 A. What I remember is that I think I had 23 taught a section of the core physician 24 development program for medical students at Case 25 and that was a once a week course.</p>	<p style="text-align: right;">16</p> <p>1 Q. And were these all in the internal 2 medicine area? 3 A. Yes. 4 Q. In regard to the residents and the 5 interns that you were supervising, were they 6 required to discuss their patient care, their 7 plan of care, their assessment of patients with 8 you? 9 A. Yes. The way that worked was the 10 interns answered directly to the senior resident 11 and then we had teaching sessions where I 12 interacted with the interns to understand their 13 understanding of the cases. 14 Q. Was the senior resident required to 15 discuss his or her findings with you in regard to 16 a patient? 17 A. Yes. 18 Q. Was that done on a regular basis, like 19 each day? 20 A. Everyday. 21 Q. And was there any requirement that you 22 sign off on their notes? In other words, review 23 them and indicate that you either agreed with 24 their findings or make additional notations that 25 you find are necessary?</p>

<p style="text-align: right;">17</p> <p>1 A. Actually, the attending physician has 2 to sign off on the intern note, but I always read 3 the senior resident's notes, but I did not have 4 to sign off on it. 5 Q. In some instances, you were an 6 attending physician for a particular patient. 7 Were there other instances where the interns and 8 residents were caring for patients that you were 9 not designated as an attending on? In other 10 words, where you were supervising residents and 11 interns, but there may be another attending 12 involved in the case? 13 A. Very rarely. I don't remember during 14 that time. There are some physicians who care 15 for their own patients. 16 Q. How often in your practice do you see 17 patients with bacterial endocarditis? Just 18 approximately. 19 A. I have probably seen seven or eight 20 cases of endocarditis. 21 Q. And that would be over the course of 22 your practice to date? 23 A. Yes. Including residency. 24 Q. And how many times in your practice 25 have you seen patients with prosthetic valve</p>	<p style="text-align: right;">19</p> <p>1 to keep endocarditis on the differential 2 diagnosis. 3 Q. How is prosthetic valve endocarditis 4 diagnosed? 5 A. It's diagnosed very similar to native 6 valve endocarditis. The best diagnostic test we 7 have is the transesophageal cardiogram and blood 8 cultures. 9 Q. What are the signs and symptoms of 10 prosthetic valve endocarditis? 11 A. Signs and symptoms are very variable. 12 They are very protean. 13 Q. Well, tell me what you would look for 14 in a patient. 15 A. Some of the signs and symptoms that 16 you can see are congestive heart failure, 17 conduction abnormalities on electrocardiogram. 18 Peripheral signs and symptoms that suggest 19 endocarditis are things like splinter hemorrhages 20 and Osler nodes and Roth spots in the eyes. You 21 can see nephritis and a number of other findings. 22 Q. Would you look for fever in a patient? 23 A. Generally, patients have fever, yes. 24 Q. What about vascular phenomena like 25 TIAs, like peripheral embolization?</p>
<p style="text-align: right;">18</p> <p>1 endocarditis? 2 A. Two or three times of those. 3 Q. And prior to Earline Mizsey's case, 4 have you ever diagnosed a patient with prosthetic 5 valve endocarditis? 6 A. I believe I have, yes. 7 Q. Do you know how many times prior to 8 her? 9 A. I think all the cases that I have seen 10 are prior to hers, but again, I would estimate 11 about two or three. 12 Q. Now, a patient with a prosthetic heart 13 valve will always be at higher risk for 14 endocarditis than a patient with their own native 15 valve; correct? 16 A. Yes. People with prosthetic valves 17 are at increased risk, yes. 18 Q. Would you agree that in a prosthetic 19 heart valve patient, a high index of suspicion 20 must be maintained to avoid overlooking the 21 diagnosis of infectious endocarditis? 22 MR. KILBANE: Objection. But go 23 ahead. 24 A. I would agree that somebody with 25 prosthetic valve endocarditis, the physician has</p>	<p style="text-align: right;">20</p> <p>1 A. Those are things that can certainly go 2 along with endocarditis, yes. 3 Q. Would you look for anemia in the 4 patient? 5 A. Yeah, I think most patients do develop 6 a low grade anemia. 7 Q. How about elevated white blood cell 8 count? 9 A. Yeah, I think patients can. 10 Q. Increased sedimentation rate? 11 A. Often. 12 Q. Would you agree that when a prosthetic 13 valve patient presents with fever and a suspected 14 embolic event that the diagnosis of infectious 15 endocarditis should be investigated? 16 MR. KILBANE: Objection. 17 MS. HARRIS: Objection. 18 A. I agree that a patient who has all 19 that constellation of symptoms, endocarditis has 20 to be considered on the differential for sure. 21 Q. Does a patient have to have positive 22 blood culture before a presumptive diagnosis of 23 bacterial endocarditis can be made? 24 A. I guess I am not an expert in 25 endocarditis, but most patients have positive</p>

<p style="text-align: right;">21</p> <p>1 blood cultures.</p> <p>2 Q. Have you ever heard of patients having</p> <p>3 culture negative endocarditis?</p> <p>4 A. Yes.</p> <p>5 Q. If bacterial endocarditis is</p> <p>6 suspected, does a patient always have to have</p> <p>7 positive blood cultures before antibiotic</p> <p>8 treatment is initiated?</p> <p>9 MR. KILBANE: Objection. Go ahead.</p> <p>10 A. I think that depends on the case. I</p> <p>11 think -- I think I'll leave it there.</p> <p>12 Q. Can bacterial endocarditis be ruled</p> <p>13 out on the basis of a single blood culture?</p> <p>14 MS. HARRIS: Objection.</p> <p>15 A. No.</p> <p>16 Q. Why not?</p> <p>17 A. Well, again, endocarditis requires a</p> <p>18 constellation of signs and symptoms and can often</p> <p>19 be a difficult diagnosis to make. One blood</p> <p>20 culture probably isn't enough.</p> <p>21 Q. How is prosthetic valve endocarditis</p> <p>22 treated?</p> <p>23 A. Generally, similar to native valve</p> <p>24 endocarditis, with antibiotic therapy, and</p> <p>25 possibly surgical replacement of the prosthetic</p>	<p style="text-align: right;">23</p> <p>1 associated with prosthetic valve endocarditis?</p> <p>2 A. Again, they are similar to the native</p> <p>3 valve endocarditis, and it would be dysfunction</p> <p>4 of the valve, abscess formation around the valve,</p> <p>5 embolic events resulting from vegetations on the</p> <p>6 valve. I am sure there are others, but those are</p> <p>7 the big ones I think about.</p> <p>8 Q. Is abscess formation more common with</p> <p>9 prosthetic valve endocarditis as compared to</p> <p>10 native valve endocarditis?</p> <p>11 A. I don't know the answer to that.</p> <p>12 Q. Do valvular vegetations have to be</p> <p>13 present before the diagnosis of prosthetic valve</p> <p>14 endocarditis can be made?</p> <p>15 A. No.</p> <p>16 Q. Do you have an independent</p> <p>17 recollection of Earline Mizsey? Do you remember</p> <p>18 her as you sit here today?</p> <p>19 A. Yes.</p> <p>20 Q. Now, when is the first time that</p> <p>21 Earline Mizsey came under your care from your</p> <p>22 review or your recollection?</p> <p>23 A. She was admitted to my service on</p> <p>24 5-8-98, and the first time I would have seen her</p> <p>25 was 5-9.</p>
<p style="text-align: right;">22</p> <p>1 valve.</p> <p>2 Q. Would you agree that one of the main</p> <p>3 goals of treatment in prosthetic valve</p> <p>4 endocarditis is to eradicate the infecting</p> <p>5 organism as soon as possible?</p> <p>6 A. Yes.</p> <p>7 Q. And would you agree that the sooner</p> <p>8 prosthetic valve endocarditis is treated with</p> <p>9 antibiotics, the more likely the outcome is going</p> <p>10 to be positive?</p> <p>11 MS. HARRIS: Objection.</p> <p>12 MR. KILBANE: Objection. You can</p> <p>13 answer.</p> <p>14 A. I think it's important to be vigilant</p> <p>15 and to begin treatment as soon as the diagnosis</p> <p>16 has been made, yes.</p> <p>17 Q. Would you agree that the earlier the</p> <p>18 treatment, the better the chance of a cure is?</p> <p>19 MS. HARRIS: Objection.</p> <p>20 MR. KILBANE: Objection. Go ahead.</p> <p>21 A. You know, I guess I can't say that 100</p> <p>22 percent of the time, but I think it's important</p> <p>23 to begin treatment as soon as possible.</p> <p>24 Hopefully the outcome would be better.</p> <p>25 Q. What type of complications are</p>	<p style="text-align: right;">24</p> <p>1 Q. And you did not have any contact with</p> <p>2 her during any outpatient -- by contact, I mean</p> <p>3 you didn't provide her with any care when she was</p> <p>4 seen in the outpatient department prior to her</p> <p>5 admission to the hospital; correct?</p> <p>6 A. Correct.</p> <p>7 Q. And how is it that you became involved</p> <p>8 in her care during that 5-8-98 admission?</p> <p>9 A. She was admitted to our medical</p> <p>10 service.</p> <p>11 Q. Now, you were her attending</p> <p>12 physician. How did you come to be the attending</p> <p>13 on her particular case?</p> <p>14 A. Because for those two weeks when I am</p> <p>15 the inpatient attending, I was covering -- I</p> <p>16 can't remember what floor to tell you the truth,</p> <p>17 but she was admitted under my care on that date.</p> <p>18 Q. So that was the two week rotation that</p> <p>19 we spoke of earlier?</p> <p>20 A. Yes.</p> <p>21 Q. And because her admission came during</p> <p>22 those two weeks, she was assigned to you, you</p> <p>23 being her attending physician?</p> <p>24 A. Yes.</p> <p>25 Q. Now, at the time of her admission,</p>

<p style="text-align: right;">25</p> <p>1 which was on May 8th of '98, did you receive any 2 information about her from Dr. Einstadter at the 3 time of the admission? 4 A. Well, again, I didn't see her until 5 the 9th, but standard practice is that we would 6 send for old records. And I did speak with Dr. 7 Einstadter. I can't remember exactly what day it 8 was. It was early in her admission. 9 Q. When a patient is admitted, would you 10 be notified, even if you didn't see her that day, 11 would they call you and say an admission is 12 coming in, you are going to be her attending on 13 the date that she is actually admitted? 14 A. The way that works, the senior 15 resident would be called, and then they would, 16 depending on what time it was, see the patient or 17 the senior resident on call would see the 18 patient. I might not have had anything to do 19 with her that day. 20 Q. So it might be when you first saw her 21 on the 9th, it may have been when you first 22 received information about her also? 23 A. Yes. 24 Q. And would it be normal procedure when 25 a MetroHealth Medical Center patient was admitted</p>	<p style="text-align: right;">27</p> <p>1 discussing some of your notes. 2 A. Okay. 3 Q. Now, I believe that when you first saw 4 her, were there any other physicians present? 5 I noticed there was a note by a Dr. 6 Kudman. Was he present when you saw the patient? 7 A. I don't believe so. He is the intern. 8 Q. Now, I believe her history and 9 physical were initially done by Dr. Kudman? 10 A. I think it's Kudmari. I thought it 11 was Kudmari. Kudmani. 12 Q. When you saw her on May 9th, did you 13 review the history and physical findings of 14 Dr. Kudmani? 15 A. Yes, and the senior resident's note. 16 Q. Dr. Kudmani was an intern? 17 A. Yes. 18 Q. Who was the senior resident? 19 A. You know, I can't read that name. 20 Q. You don't recall who it was? 21 A. I can't read the name and I don't 22 recall who the senior resident was. 23 Q. You reviewed the history and 24 physical. Did you also, when you saw the 25 patient, do your own physical on the patient?</p>
<p style="text-align: right;">26</p> <p>1 to the hospital, that the old records would be 2 brought up to the floor? 3 A. Yes. 4 Q. And be made available? 5 A. Yes. It usually takes some time, but 6 that is the procedure, yes. 7 Q. How much time does it usually take? 8 A. It varies. I mean, if the records are 9 not in an outpatient clinic, they are generally 10 sent up that same day. If they are at an 11 outpatient clinic, it may be another day or two 12 before we see them. 13 Q. Do you know when you saw her on the 14 9th whether the records from her care in the 15 clinics were on the floor? 16 A. I don't remember. 17 Q. Now, the first day that you saw her 18 was on May 9th of '98; correct? 19 A. Yes. 20 Q. When you saw her, were any of Earline 21 Mizsey's family present at that time? 22 A. Boy. I don't believe so. 23 Q. Now, if you would like to open the 24 records to the beginning point of your care, it 25 might be easier, because we are going to be</p>	<p style="text-align: right;">28</p> <p>1 A. Yes. 2 Q. Take a history? 3 A. Yes, both. 4 Q. Was there anything in reviewing Dr. 5 Kudmani's notes that you were critical of or that 6 you didn't agree with or that you felt was 7 incomplete? 8 A. No. 9 Q. Now, you wrote a note on this patient, 10 I believe, on 5-9; is that correct? 11 A. Yes. 12 Q. Now, it says under the note that you 13 wrote on 5-9, there is a printed section that 14 says I discussed the case and plans with the 15 resident, with the following comments. 16 Was that a discussion -- did you have 17 a discussion with the resident in this case? 18 A. Yes. 19 Q. And was the resident you are referring 20 to the senior resident that we have been unable 21 to identify at this point? 22 A. It was probably both the senior 23 resident and the intern, but actually that refers 24 specifically to the intern. 25 Q. Well, it says resident, so -- does</p>

<p style="text-align: right;">29</p> <p>1 that mean intern?</p> <p>2 A. Yes.</p> <p>3 Q. Did you disagree at all with what the</p> <p>4 senior resident's note had to say in this case?</p> <p>5 A. No.</p> <p>6 Q. What was your understanding as to the</p> <p>7 reason why Earline Mizsey was admitted to Metro</p> <p>8 on May 8th of '98?</p> <p>9 A. I believe she was admitted for stroke.</p> <p>10 Q. And was it also to rule out embolic</p> <p>11 origin to that stroke?</p> <p>12 A. Yes.</p> <p>13 Q. And in your evaluation of this</p> <p>14 patient, what evidence of stroke did you find?</p> <p>15 A. She had signs of right-sided weakness</p> <p>16 and an expressive aphasia.</p> <p>17 Q. Was there any improvement in her</p> <p>18 condition from the time of admission that you</p> <p>19 could discern?</p> <p>20 A. From the time of admission?</p> <p>21 Q. Yes.</p> <p>22 A. I don't remember. She certainly</p> <p>23 didn't get worse.</p> <p>24 Q. Was there any improvement that you</p> <p>25 could discern from the time of the documentation</p>	<p style="text-align: right;">31</p> <p>1 A. She was able to follow commands and</p> <p>2 shake her head yes and no. It was difficult to</p> <p>3 understand her speech sometimes, which she had</p> <p>4 trouble expressing herself.</p> <p>5 Q. Was she able to stand or to walk at</p> <p>6 all?</p> <p>7 A. You know, I don't remember. I think</p> <p>8 she could stand, but I don't write it down in my</p> <p>9 note.</p> <p>10 Q. You noted that she had weakness on her</p> <p>11 right side. Was she able to move her right arm?</p> <p>12 A. Yes.</p> <p>13 Q. When you saw her on the 9th, did you</p> <p>14 find anything in her history or signs and</p> <p>15 symptoms that you observed that would be</p> <p>16 consistent with the diagnosis of endocarditis?</p> <p>17 A. Well, again, I think these are, again,</p> <p>18 protean symptoms. She was initially febrile at</p> <p>19 Southwest General, but on the floor was not</p> <p>20 febrile, at least initially, and she had had a</p> <p>21 recent history of possible TIA.</p> <p>22 Q. Did she have anemia when you saw her?</p> <p>23 A. Let me just double-check. On 5-9 she</p> <p>24 had a hematocrit of 33, so she had a mild anemia,</p> <p>25 yes.</p>
<p style="text-align: right;">30</p> <p>1 of her stroke? And I am just asking if there is</p> <p>2 anything additional that you had knowledge of</p> <p>3 prior to her admission to Metro.</p> <p>4 A. No.</p> <p>5 Q. Now, doctor, in your note of 5-9-98, I</p> <p>6 believe in the first paragraph you have that she</p> <p>7 was taken to Southwest General Hospital initially</p> <p>8 and had a head CT and transferred here. Has had</p> <p>9 significant improvement in speech and weakness</p> <p>10 since yesterday.</p> <p>11 Was that reported by the patient or</p> <p>12 where did you get that information from?</p> <p>13 A. You are right. It does say that. I</p> <p>14 don't remember exactly where I got that</p> <p>15 information from. It may well have been</p> <p>16 reviewing the emergency room note, since I had</p> <p>17 not seen her previously.</p> <p>18 Q. Just in general terms, what was her</p> <p>19 overall condition, your impression of her when</p> <p>20 you saw her, initially?</p> <p>21 A. She was an older woman with multiple</p> <p>22 medical problems who appeared to have suffered a</p> <p>23 small stroke.</p> <p>24 Q. Was she able to answer your questions</p> <p>25 when you talked with her?</p>	<p style="text-align: right;">32</p> <p>1 Q. Do you know whether she had had any</p> <p>2 weight loss?</p> <p>3 A. She had had a history of weight loss,</p> <p>4 yes.</p> <p>5 Q. And you are aware at the time of</p> <p>6 admission that she had a prosthetic aortic valve;</p> <p>7 correct?</p> <p>8 A. Yes.</p> <p>9 Q. What was within your differential</p> <p>10 diagnosis when you saw her on May 9th?</p> <p>11 A. Well, certainly she had had a stroke,</p> <p>12 and it's important to consider sources of that</p> <p>13 stroke. It could have been from multiple</p> <p>14 different causes.</p> <p>15 She clearly had from Southwest General</p> <p>16 fever and a urinary tract infection. And clearly</p> <p>17 in the intern note and senior resident note, they</p> <p>18 both comment on the possibility of endocarditis,</p> <p>19 so it was clearly on our differential, as well.</p> <p>20 Q. Was that within your differential</p> <p>21 also?</p> <p>22 A. Yes.</p> <p>23 Q. Was it identified on your list?</p> <p>24 MR. KILBANE: Objection. Go ahead.</p> <p>25 A. Well, I think it was on our list, and</p>



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1 we needed to do some things to rule it in or out.  
 2 Q. So you had a lady with a prosthetic  
 3 heart valve that had had a possible embolic  
 4 event, mild anemia, some history of weight loss,  
 5 fever off and on, and endocarditis wasn't high on  
 6 that differential diagnosis?

7 MR. KILBANE: Objection.

8 A. Endocarditis was definitely on our  
 9 differential.

10 Q. What was number one?

11 A. Stroke and urinary tract infection.

12 Q. Where was endocarditis on that list?

13 A. It's in that list. Probably in the --

14 I don't know. I couldn't give you a number, but  
 15 it was definitely on our list.

16 Q. I want to know what was the  
 17 differential diagnosis, what were the diagnoses  
 18 and the order of importance in that list.

19 MS. HARRIS: Objection.

20 MR. KILBANE: Objection. You have  
 21 asked and she has answered.

22 MS. TOSTI: She has not given me the  
 23 list of differential diagnoses and that's what I  
 24 am asking for.

25 MR. KILBANE: Your question presumes

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1 diagnoses and that's what I am asking her for.

2 Q. When you saw her on May 9th, what was  
 3 within your differential diagnoses? And I want  
 4 to know what was first, second, third, whatever  
 5 diagnoses you had, I want to know what they are  
 6 and in what order they were in.

7 MR. KILBANE: Same objection.

8 MS. HARRIS: Yes.

9 A. You remember that I have already seen  
 10 the TEE when I am seeing her. So clearly on the  
 11 top of our diagnosis was stroke -- possibly  
 12 embolic in origin -- urinary tract infection,  
 13 endocarditis. Now, again, I had not put them in  
 14 numerical order. They are all probable,  
 15 possible.

16 Q. So at the time that you saw her on the  
 17 9th, you already had the results of a  
 18 transesophageal echo; is that correct?

19 A. I believe that's true, because it was  
 20 done the day before.

21 Q. You were aware then of the prior  
 22 echocardiogram that she had had done in April?

23 A. Yes.

24 Q. Did you have those results also?

25 A. Yes.

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1 that she had a list.

2 Q. Doctor, did you have a list of  
 3 differential diagnoses for this patient?

4 A. We certainly had a group of  
 5 diagnoses we were considering.

6 Q. Okay. And we talked about it before,  
 7 that those are in order of importance. You  
 8 mentioned that to me when I asked you about  
 9 differential diagnoses. So I am asking you what  
 10 the order of importance for this patient was in  
 11 regard to differential diagnoses.

12 MS. HARRIS: At the time she saw him?

13 MR. KILBANE: You asked her in general  
 14 whether there was an order and now you have  
 15 switched it and you are implying that  
 16 automatically, because in general there are  
 17 orders, that there is in this case.

18 MS. TOSTI: Well, I haven't heard her  
 19 answer yet.

20 MR. KILBANE: I heard her answer three  
 21 times.

22 MS. HARRIS: Are you saying at this  
 23 time or when she came in, the differential?

24 MS. TOSTI: On the 9th when she saw  
 25 this patient, she referred to our differential

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1 Q. So you were aware when you saw her  
 2 that the April echo suggested bioprosthetic valve  
 3 deterioration: correct?

4 A. I was aware that it suggested that it  
 5 was possible that she had a dysfunctional valve,  
 6 yes.

7 Q. That it was bioprosthetic valve  
 8 deterioration?

9 A. That it was possibly valve  
 10 deterioration, yes.

11 Q. Can endocarditis cause valve leaflets  
 12 to deteriorate?

13 A. Yes.

14 Q. Now, at the time of her admission, you  
 15 had an opportunity to talk with Dr. Kudmani as  
 16 well as the senior resident. Were both of them  
 17 present at the time of her admission on the 8th,  
 18 from your knowledge?

19 A. Yes.

20 Q. Based on your discussions with them,  
 21 was it their impression that endocarditis was  
 22 within the differential diagnosis at the time of  
 23 her admission?

24 A. Yes.

25 Q. Now, there were blood cultures

<p style="text-align: right;">37</p> <p>1 ordered. Were those ordered by the senior 2 resident? 3 A. Probably, yes. I am not positive of 4 that. 5 Q. Would that be within the realm of his 6 duties? He would be allowed to independently 7 order such tests for a patient? 8 A. Certainly. 9 Q. And he would not necessarily have to 10 clear that type of an order with you, the 11 attending physician, before they are ordered? 12 A. True. The attending neurologist had 13 also suggested that that be done, who had seen 14 the patient on the 8th. 15 Q. And who is that that you are referring 16 to? 17 A. Dr. Hanna. 18 Q. And were those blood cultures ordered 19 in order to rule out or rule in endocarditis in 20 this patient? 21 A. They were ordered, because the 22 diagnosis of endocarditis was on our differential 23 diagnoses, yes. 24 Q. Do you know how many were done? 25 A. Two.</p>	<p style="text-align: right;">39</p> <p>1 see Earline Mizsey, what was your plan of care 2 for her? 3 A. Well, we were working in conjunction 4 with our neurologist colleagues who are the 5 stroke experts, and she was treated with Heparin 6 to prevent further embolic events while we 7 awaited the blood cultures. And she was treated 8 for urinary tract infection, which we thought 9 might be the origin of her fever and white count 10 and urinary symptoms. 11 Q. And why did you feel that the 12 anticoagulation was indicated in her case? 13 A. Again, it was ordered, indicated by 14 the neurologists for the possibility of 15 atheroembolic or nonseptic emboli causing her 16 stroke. 17 Q. Now, was the next time that you saw 18 Earline Mizsey on May 10th? 19 A. Yes. 20 Q. Now, on May 10th, it was your opinion 21 that she had had an embolic stroke; correct? 22 A. Yes. My note says embolic stroke, 23 stable, continue anticoagulation. At that point, 24 yes, we felt this most likely was embolic in 25 origin.</p>
<p style="text-align: right;">38</p> <p>1 Q. Now, in your impressions, you indicate 2 that TEE done last night, no obvious lesions, 3 negative clot, I believe. That does not rule out 4 that her strokes may have been caused by 5 vegetative embolism from her prosthetic valve; 6 correct? 7 A. Again, I am not an expert here, but it 8 certainly makes the diagnosis not obvious, but 9 you are right, it doesn't rule it out. 10 Q. And the reason is because the 11 vegetation could have broken off, traveled as an 12 embolism, and there may not necessarily be 13 evidence on the transesophageal echo; correct? 14 A. From an internist's perspective, I 15 believe that's so. You probably need an 16 echocardiographer to tell you for sure. 17 Q. You are also aware that this 18 particular echo, the echocardiologist indicated 19 that the aortic valve could not be fully 20 evaluated on this particular study; correct? 21 A. I know that they said there were no 22 gross lesions and they were unable to fully 23 evaluate the aortic valve, but again, no gross 24 malfunctions were appreciated, yes. 25 Q. Now, after you had an opportunity to</p>	<p style="text-align: right;">40</p> <p>1 Q. Did you have an opinion as to the 2 source of the embolism? 3 A. At this point it wasn't clear. 4 Q. Was it likely it was cardiac in 5 origin? 6 A. That was probably high on our list, 7 yes, cardiac in origin, although she certainly 8 had other disease that would make thrombotic 9 stroke a possibility. 10 Q. Did you think it was likely a 11 vegetative embolism from endocarditis? 12 A. I can't tell you that. I think it was 13 on our list. We had not made a definitive 14 diagnosis yet. 15 Q. Now, when you saw her on May 10th, she 16 continued to have aphasia problems; correct? 17 A. Yes. 18 Q. And she also continued to have the 19 weakness on the right side of her body that you 20 previously described; correct? 21 A. Yes. 22 Q. And she continued also to have some 23 confusion, or she wasn't real clear mentally; is 24 that correct? 25 A. You know, since I didn't write that</p>

<p style="text-align: right;">41</p> <p>1 down in my note, I am not sure I can tell you 2 that exactly. From the intern's note below, 3 awake, alert, oriented, slurred speech. 4 Q. Was she able to converse with you at 5 all, that you recall? 6 A. She could converse in short sentences 7 sometimes and then other times it was difficult 8 to understand her. 9 Q. Was she able to respond to verbal 10 commands? 11 A. Mostly, yes. 12 Q. Now, you next saw her on the 11th; is 13 that correct? 14 A. Yes. 15 Q. Was it your impression that she had 16 some improvement at this point? 17 A. Yes. 18 Q. What did you see as an improvement in 19 her condition? 20 A. I write embolic stroke resolving 21 deficits, and the above line suggests that her 22 hand strength was normal; slight right facial 23 droop, although I don't comment on it, I think I 24 meant that it was improving, but I did not write 25 that clear.</p>	<p style="text-align: right;">43</p> <p>1 etiology of this was. 2 Q. Did you read back in the outpatient 3 department notes that she complained of sudden 4 onset of leg pain after stepping out of the 5 shower? Do you recall seeing that? 6 A. Yes. And also saw the vascular 7 surgeon's note, who felt it was not quite as 8 urgent as that. 9 Q. But that type of a description of 10 sudden onset of severe pain isn't the typical 11 description for a patient that has peripheral 12 vascular disease, is it? 13 A. You know, I am not an expert there. 14 Q. Did you have any heightened concerns 15 that she may have had embolization to the 16 arteries of her right leg? 17 MS. HARRIS: Objection. 18 MR. KILBANE: Objection, as well. 19 A. Again, at the time that we were seeing 20 her, I think that it was unclear whether or not 21 she had embolization there or continuing of her 22 already ongoing peripheral vascular disease. 23 Q. She could have had both, though; 24 correct? 25 A. She could have had both.</p>
<p style="text-align: right;">42</p> <p>1 Q. Now, your note of the 11th indicates 2 will talk with Dr. Alexander, vascular, about 3 angiogram of the right foot, right foot without 4 doppler pulses; correct? 5 A. Correct. 6 Q. Why did you think consultation with a 7 vascular specialist was indicated? 8 A. Well, we had learned over the course 9 of a couple of days that she was supposed to have 10 an arteriogram done for evidence of ischemia in 11 that leg, but she was admitted before the test 12 was done, so we called Dr. Alexander again to 13 tell him that she was here and that she could 14 have the procedure. 15 Q. Did you speak to Dr. Alexander? 16 A. I don't remember. I probably did, but 17 I don't remember. 18 Q. Did you have concerns about the 19 arterial circulation to her right foot? 20 A. Yes. I mean, she had a long history 21 of peripheral vascular disease. 22 Q. Did you think in this particular 23 instance it was due to her peripheral vascular 24 disease? 25 A. I don't think it was clear what the</p>	<p style="text-align: right;">44</p> <p>1 Q. Do you know whether it was Dr. 2 Alexander's impression from any conversations 3 that you had with him that she had a probable 4 thromboembolic event? 5 A. He did write a note -- let me see if I 6 can find it here -- on the 11th. Is that the 7 date that we are talking about? 8 Q. Yes. 9 A. He does comment that patient most 10 likely to have an embolic event, but she needs, 11 the angiogram. It's hard to read this. Then he 12 talks about how to do the angiogram while on 13 Heparin. 14 Q. From your evaluation of her, what did 15 you see that would indicate to you that there was 16 ischemic problems in that right leg? 17 A. She certainly had some changes in that 18 right leg. It was hard to feel pulses on that 19 side. She had, I believe, a right toe lesion 20 pulse. 21 Again, we are not aware of her 22 complaining of significant pain in that leg. 23 Q. You don't have any recollection in 24 regard to skin color, temperature or anything 25 like that?</p>

<p style="text-align: right;">45</p> <p>1 A. I am trying to find it. I don't 2 remember exactly, but there were clear 3 indications that the leg was cool, and we knew 4 she had arterial studies done, suggesting that 5 she had ischemia of that leg. 6 Q. Now, would you agree that between the 7 time of her admission and the 11th that 8 prosthetic valve endocarditis had not been ruled 9 out on Earline Mizsey? 10 A. Yes, I would agree with that. 11 Q. And that it was within the 12 differential diagnosis for this patient? 13 A. Yes. 14 Q. Now, between May 8th and May 11th, was 15 Earline Mizsey given any antibiotic therapy that 16 would be appropriate for the treatment of 17 prosthetic valve endocarditis? 18 A. No, because at this point, we had not 19 made the diagnosis. 20 Q. And what would you consider to be 21 necessary in order to make the diagnosis? 22 A. I think in this case, with a lady with 23 multiple medical problems, a complicated history, 24 that we needed one of the definitive tests to be 25 positive, a TEE and/or blood cultures, before we</p>	<p style="text-align: right;">47</p> <p>1 A. My usual routine would be to go in 2 early, you know, say, 7:30. 3 Q. So it's likely in this case you saw 4 her approximately that time in the morning? 5 A. I would think so. I'm not positive, 6 because I didn't date the note -- I mean time the 7 note. 8 Q. Now, would you read to us what you 9 have written under the portion of your note that 10 begins AP. 11 A. Yes. I am having a little trouble 12 with that word. I think it says recurrent. Do 13 you have the actual -- 14 MR. KILBANE: Look at my chart and see 15 if it's any better. 16 Q. Repeated? 17 A. Repeated, that's what it says, embolic 18 events, several CNS events, and treated three 19 week old acute popliteal occlusion. TEE showed 20 no large intrachamber clot, but was not able to 21 image prosthetic valve well. White count remains 22 21,000, and now one blood culture is positive. 23 Again, all events suggest repeated embolic source 24 and possible endocarditis. 25 Q. Now, doctor, when you wrote this note,</p>
<p style="text-align: right;">46</p> <p>1 really moved that diagnosis up on our 2 differential. 3 Q. Now, you saw her on the 12th then 4 again; correct? 5 A. Correct. 6 Q. What was her condition when you saw 7 her on the 12th? 8 A. She had worsened. 9 Q. In what way? 10 A. Again, her right-sided findings had 11 worsened, more facial droop, more trouble with 12 speech, less strength on the right side. 13 Q. How did you come to learn that her 14 condition had changed? 15 A. I saw her. 16 Q. So you just came in on your usual 17 rounds and discovered that she had deteriorated 18 somewhat? 19 A. I am sure I was told, as well, but it 20 was my usual routine to see patients early in the 21 morning and then discuss them with the team, so I 22 don't know exactly which happened first, but I 23 definitely knew about the change. 24 Q. Approximately what time did you see 25 her on the 12th? What would be your usual?</p>	<p style="text-align: right;">48</p> <p>1 did you think it was likely that she had 2 endocarditis? 3 A. I thought it was likely when I wrote 4 this note. Again, I am not sure when I wrote 5 this note, but it was clearly after we received 6 some other information. 7 Q. Did you think it was likely that the 8 vascular events that you described and the 9 neurological events that you described were the 10 result of the endocarditis? 11 MR. KILBANE: Objection. Go ahead. 12 A. Again, I can't be sure, but -- 13 Q. You think it was likely? 14 A. I think it's possible. 15 Q. Now, in this instance, did you think 16 it was likely, though? 17 MR. KILBANE: Objection. Asked and 18 answered. She told you it was possible. You 19 keep asking her the same question. You can 20 answer it again. 21 Q. So even at this point, you didn't 22 think endocarditis was likely, doctor: correct? 23 A. That's not what I said. I actually 24 think endocarditis at this point was likely, but 25 whether or not the initial CVA that happened</p>

<p style="text-align: right;">49</p> <p>1 outside the hospital or the popliteal occlusion 2 were the result from the endocarditis, I can't be 3 sure. 4 Q. After you saw her on the 12th, did you 5 have a conversation with the Mizsey family or any 6 members of the family? 7 A. I had talked to the family quite a 8 lot, yes. 9 Q. Well, can you tell me up to this point 10 when you had talked with them? 11 A. No, I can't, to tell you the truth. I 12 don't document it and I don't remember. 13 Q. Can you tell me up to that point what 14 you were discussing with them, up to the point of 15 the 12th? 16 If you can't recall the time, at least 17 tell me what the content of those conversations 18 were, if you can recall. 19 A. Well, that we were treating her for 20 stroke and that she had improved somewhat and we 21 were preparing her for rehabilitation while the 22 workup went on. 23 Q. Now, after she had this deterioration 24 on the 12th, did you then talk with the family 25 again?</p>	<p style="text-align: right;">51</p> <p>1 A. Yes. 2 Q. Why was there a decision to treat her 3 far endocarditis at this point in time? 4 A. Well, I think at this point, we had 5 begun to collect enough information that this 6 diagnosis became probable. 7 Q. And what information are you basing 8 that on? 9 A. Well, the blood culture. Actually, 10 there were two blood cultures positive with an 11 organism that although unusual can cause 12 endocarditis, and we had the input of both our 13 cardiology and infectious disease consults. 14 Q. And what is the organism that you are 15 referring to that's unusual? 16 A. Anaerobic peptostreptococcus. 17 MR. KILBANE: Can you spell that for 18 the court reporter? 19 THE WITNESS: It's 20 P-E-P-T-O-S-T-R-E-P-T-O-C-O-C-U-S. 21 Q. And what was the therapy that was 22 decided upon to treat her suspected or 23 presumptive endocarditis? 24 A. Antibiotics. 25 Q. What antibiotics?</p>
<p style="text-align: right;">50</p> <p>1 A. Probably later in the afternoon after 2 we had received some other information, like the 3 blood culture. 4 Q. Do you recall who you talked to? 5 A. I always talked to two daughters. I 6 don't remember their names. 7 Q. Were you the one that informed them 8 that Earline Mizsey's condition had 9 deteriorated? Did you provide them with that 10 information? 11 A. I can't be certain I was the one that 12 did that initially. It may have been the senior 13 resident. 14 Q. In regard to whatever conversations 15 you recall with the family, can you tell me what 16 you told them? 17 A. No, I don't remember. 18 Q. Do you recall whether you told them 19 that endocarditis was likely at this point? 20 A. I don't remember telling them that. 21 Q. Now, on the 12th, was there a decision 22 made to treat her for endocarditis? 23 A. Yes. 24 Q. Was that a decision that you were 25 involved in?</p>	<p style="text-align: right;">52</p> <p>1 A. She was initially begun on Vancomycin 2 and Gentamicin, I believe. 3 I will double-check that. Yes. 4 Q. Now, doctor, she had had an initial 5 transesophageal echo done after admission to the 6 hospital, and within the differential diagnosis 7 was prosthetic valve endocarditis. 8 Is there a reason why if that was 9 within the differential diagnosis, a follow-up 10 TEE was not ordered for this patient to see 11 whether there was any indications of 12 endocarditis, particularly since the study that 13 was done didn't fully evaluate the aortic valve? 14 A. I mean, she did have a repeat TEE four 15 days later. 16 Q. Four days later, but after her 17 condition had already deteriorated; correct? 18 A. That's true, but this is the 19 definitive test. It was abnormal. I mean, it 20 was not grossly abnormal, although you are right, 21 they said they couldn't image it well. We 22 debated about this, but felt that we weren't sure 23 how much more information we would have on the 24 same patient one day later, so we waited a few 25 days, which is what the cardiologists actually</p>

<p style="text-align: right;">53</p> <p>1 suggested should be done weekly if it's on the</p> <p>2 differential diagnosis.</p> <p>3 Q. Did you agree with that decision to</p> <p>4 wait a week before doing another TEE?</p> <p>5 MR. KILBANE: Objection. Go ahead.</p> <p>6 A. I think we weren't necessarily just</p> <p>7 waiting a week for the TEE. We were also</p> <p>8 building the case by doing the other things that</p> <p>9 you have to do, looking for stigmata, which she</p> <p>10 never developed, looking for CHF, which she never</p> <p>11 developed, but doing blood cultures, which is the</p> <p>12 other definitive thing, and it should be</p> <p>13 positive, and when it was, that changed what we</p> <p>14 did.</p> <p>15 Q. Well, what I asked you, though,</p> <p>16 doctor, did you agree with the decision not to do</p> <p>17 a follow-up TEE within a day or two of admission</p> <p>18 to reevaluate that aortic valve?</p> <p>19 MR. KILBANE: Objection. Asked and</p> <p>20 answered. Go ahead.</p> <p>21 A. I agreed that repeat TEE needed to be</p> <p>22 done and we did do it four days later.</p> <p>23 Q. And you agreed with that time span?</p> <p>24 A. Yes.</p> <p>25 Q. If a patient has a TEE done and there</p>	<p style="text-align: right;">55</p> <p>1 positive blood cultures and elevated white blood</p> <p>2 count were all consistent with endocarditis;</p> <p>3 correct?</p> <p>4 A. That they could be, yes, all</p> <p>5 consistent with endocarditis.</p> <p>6 Q. And your note also mentions that you</p> <p>7 asked cardiothoracic surgery to become involved</p> <p>8 in the case; is that correct?</p> <p>9 A. Yes.</p> <p>10 Q. Why did you want cardiothoracic</p> <p>11 surgery involved?</p> <p>12 A. Because a lady with a prosthetic valve</p> <p>13 endocarditis may need surgical correction of that</p> <p>14 valve, but we also needed the TEE to help us with</p> <p>15 that.</p> <p>16 Q. And your note of the 13th further</p> <p>17 indicates that you had a long discussion with the</p> <p>18 daughter. Do you have any recollection of which</p> <p>19 daughter it was that you spoke to?</p> <p>20 A. I don't remember which daughter it</p> <p>21 was, no.</p> <p>22 Q. Do you know, was there anyone else</p> <p>23 present at that discussion besides you and one of</p> <p>24 the daughters?</p> <p>25 A. Probably the senior resident with me.</p>
<p style="text-align: right;">54</p> <p>1 is mobile vegetations visualized on it, are any</p> <p>2 particular precautions taken with the patient</p> <p>3 regarding restrictions of activity?</p> <p>4 A. Not that I'm aware of.</p> <p>5 Q. Would the patient continue in physical</p> <p>6 therapy? For example, this patient, if she was</p> <p>7 seen to have mobile vegetations, would she</p> <p>8 continue to have activities such as physical</p> <p>9 therapy, transport to the physical therapy</p> <p>10 department and exercising, etcetera?</p> <p>11 A. I don't know the answer to that. You</p> <p>12 might want to restrict her activities some.</p> <p>13 Q. Now, you also saw her on May 13th; is</p> <p>14 that correct?</p> <p>15 A. Yes.</p> <p>16 Q. And did you see her before her</p> <p>17 arteriogram? I believe it was done on that day.</p> <p>18 A. I don't know.</p> <p>19 Q. When you saw her on the 13th, what</p> <p>20 were your findings regarding her condition?</p> <p>21 A. They were similar to what we had seen</p> <p>22 yesterday -- I mean, sorry, the 12th. She had</p> <p>23 had no change in her murmur.</p> <p>24 Q. It was your opinion that her two prior</p> <p>25 CVA's and right lower leg embolization and</p>	<p style="text-align: right;">56</p> <p>1 Q. You don't have a specific recollection</p> <p>2 of that?</p> <p>3 A. No, I don't.</p> <p>4 Q. Was this a discussion in person with</p> <p>5 the daughter or on the phone?</p> <p>6 A. Oh, in person.</p> <p>7 Q. And where did it take place?</p> <p>8 A. I don't remember if this was at the</p> <p>9 bedside or in the conference room, but it was in</p> <p>10 the hospital.</p> <p>11 Q. Is there a conference room on the</p> <p>12 floor where she was?</p> <p>13 A. Yes.</p> <p>14 Q. How long did you talk with her?</p> <p>15 A. I don't remember. Probably a half</p> <p>16 hour.</p> <p>17 Q. And what did you tell the daughter at</p> <p>18 this point in time?</p> <p>19 A. I think I was discussing with her,</p> <p>20 although I don't remember exactly what I said to</p> <p>21 her, discussing with her, her condition, the fact</p> <p>22 that we now thought she had probable endocarditis</p> <p>23 and might need a valve replacement, and the risks</p> <p>24 and benefits of those things in a sick lady.</p> <p>25 Q. And what did you tell the daughter</p>

<p style="text-align: right;">57</p> <p>1 were the risks in this case for this patient?</p> <p>2 A. The risks of surgery?</p> <p>3 Q. Yes. Well, whatever risks you</p> <p>4 discussed with the daughter is what I am asking</p> <p>5 you about.</p> <p>6 A. I really don't remember the</p> <p>7 conversation well. I can only read you what's in</p> <p>8 my note. She was, you know, quite ill at this</p> <p>9 point, with multiple other problems complicating</p> <p>10 her cardiovascular risk, so there were certainly</p> <p>11 risks to potential surgery should she need it.</p> <p>12 For the benefits there are potential benefits as</p> <p>13 well, stopping her embolic event.</p> <p>14 Q. Did you discuss any specific risks</p> <p>15 with the daughter, that you recall?</p> <p>16 A. Well, we certainly talked about the</p> <p>17 risk of death without surgery and the risk of</p> <p>18 death with surgery, which in her case were not</p> <p>19 minimal. I think most of this discussion was</p> <p>20 really them trying to think about what her wishes</p> <p>21 would be should she continue to do poorly.</p> <p>22 Q. Was Earline Mizsey able at this point</p> <p>23 in time to provide any input into that</p> <p>24 decision-making?</p> <p>25 A. Again, I can't remember exactly, but</p>	<p style="text-align: right;">59</p> <p>1 down for arteriograms and became more aphasic</p> <p>2 after the arteriograms, and then I believe there</p> <p>3 is a note written by Dr. Kudmani indicating that</p> <p>4 her mental status was deteriorating rapidly.</p> <p>5 Were you made aware of any change in</p> <p>6 her condition after those arteriograms?</p> <p>7 A. I remember this event, and again, it</p> <p>8 wasn't -- her mental status did fluctuate</p> <p>9 somewhat, and certainly our neurology colleagues</p> <p>10 felt that her symptoms hadn't changed</p> <p>11 dramatically.</p> <p>12 Q. So you would disagree then with Dr.</p> <p>13 Kudmani's note indicating that she was</p> <p>14 deteriorating rapidly, her condition?</p> <p>15 A. I mean, I don't remember when this was</p> <p>16 written exactly in relation to the neurology</p> <p>17 note, so it's possible that she did wax and wane</p> <p>18 a little bit.</p> <p>19 Q. If she had mobile vegetations on the</p> <p>20 transesophageal echo, would it be wise to</p> <p>21 transport her to x-ray to undergo an arteriogram</p> <p>22 on her lower extremity?</p> <p>23 MR. KILBANE: Objection.</p> <p>24 Q. Would that be activity that would be</p> <p>25 restricted to her?</p>
<p style="text-align: right;">58</p> <p>1 you couldn't communicate with her verbally.</p> <p>2 Q. So she wasn't answering questions or</p> <p>3 responding in any way that anyone could</p> <p>4 understand her desires?</p> <p>5 A. She could intermittently follow</p> <p>6 commands and shake her head yes or no, but I</p> <p>7 couldn't understand her verbally with words.</p> <p>8 Q. In regard to the conversation with the</p> <p>9 daughter, do you recall any questions that the</p> <p>10 daughter asked you specifically?</p> <p>11 A. I don't really remember, no.</p> <p>12 Q. Was Earline Mizsey at greater risk for</p> <p>13 valve replacement surgery because of the several</p> <p>14 strokes that she had?</p> <p>15 A. Yes.</p> <p>16 Q. Now, although you were discussing the</p> <p>17 possibility of surgery at that point, no one had</p> <p>18 told the family whether or not Earline Mizsey</p> <p>19 actually would be accepted for surgical valve</p> <p>20 replacement; correct?</p> <p>21 A. That's probably correct.</p> <p>22 Q. Now, there is a note that's also</p> <p>23 written on the 13th by radiology. I believe it's</p> <p>24 on the opposite page from where your note is.</p> <p>25 It indicates that she apparently went</p>	<p style="text-align: right;">60</p> <p>1 A. I don't believe so.</p> <p>2 Q. Now, the increase in aphasia described</p> <p>3 after the arteriogram, do you have know whether</p> <p>4 that was caused by any additional embolization?</p> <p>5 MR. KILBANE: Objection. Go ahead.</p> <p>6 A. You know, I don't know.</p> <p>7 Q. Now, Dr. Kudmani writes his note that</p> <p>8 I have just referred to previously, and in item</p> <p>9 number seven, in his note of 5-13-98, he</p> <p>10 indicates he met with the daughters to discuss</p> <p>11 the condition and the family was aware of the</p> <p>12 mother's serious condition and they were debating</p> <p>13 regarding, I believe, do not resuscitate status</p> <p>14 and how far this should go.</p> <p>15 Were you present for that discussion</p> <p>16 with the family?</p> <p>17 A. I don't remember. I probably was.</p> <p>18 But it is possible that he spoke with them, as</p> <p>19 well.</p> <p>20 Q. Now, in Dr. Kudmani's note, item</p> <p>21 number two, he indicates that Earline Mizsey's</p> <p>22 right side is flaccid. Prior to this, you had</p> <p>23 indicated, at least at the point of admission and</p> <p>24 for a day or so after, that she had weakness on</p> <p>25 the side and at one point her hand grasps</p>

<p style="text-align: right;">61</p> <p>1 actually were equal, I believe, you told me. 2 At what point did she develop 3 flaccidity on that right side? Was it after the 4 arteriogram? 5 MR. KILBANE: Objection. Go ahead. 6 A. I think I mentioned flaccidity on the 7 13th. Let me look at the note. In the neurology 8 note of the 12th, it would suggest flaccidity, 9 and that precedes. I think I cannot say that 10 from these notes. 11 Q. But her condition definitely 12 deteriorated from the time of admission? 13 A. Yes. 14 Q. Correct? 15 A. Yes. 16 Q. Do you have an opinion whether it was 17 due to additional stroke that caused her to go 18 from being able to move that right side to 19 flaccid paralysis on the right side? 20 MR. KILBANE: Objection. Go ahead. 21 A. Clearly something changed. She did 22 get somewhat worse. On the head CT done on the 23 12th and 14th, there was no new evidence of 24 stroke, so whether or not she had extended the 25 initial stroke or not is unclear.</p>	<p style="text-align: right;">63</p> <p>1 A. I think we thought that was the 2 infarct related to her admission and the one done 3 the next day showed there was no change. 4 Q. You have underlined the word small, a 5 small infarct. Just tell me whether you do or 6 you don't, but do you know whether or not that 7 was something new or whether that was the infarct 8 that was done on admission? 9 A. I don't know for sure, because we 10 don't have the CAT scan from Southwest General, 11 and even if we did, it probably wouldn't have 12 shown up because she had just had the symptoms, 13 so I guess I can't really tell you if that's new 14 or old. 15 Q. Now, you also indicate in your note 16 that that patient is extremely high risk for 17 surgery but will most likely not survive if the 18 valve is not replaced; correct? 19 A. Yes. 20 Q. So was it your feeling at that point 21 that her chances of survival were best if she did 22 undergo surgery? 23 A. Yes. 24 Q. Now, your note indicates that the 25 family was trying to assess the patient's</p>
<p style="text-align: right;">62</p> <p>1 Q. Now, you saw her again then on the 2 14th; correct? 3 A. Yes. 4 Q. And you noted that she did have a 5 flaccid paralysis on the 14th; correct? 6 A. Yes. 7 Q. On the right side? 8 A. Yes. 9 Q. Now, she had on the 14th another 10 transesophageal echo. 11 A. Yes. 12 Q. What was your understanding as to what 13 was found on that May 14th, '98 transesophageal 14 echo? 15 A. I write down possible valvular abscess 16 and vegetation. There is a report in here of the 17 exact findings. Perivalvular aortic valve 18 abscess is present, two millimeter by four 19 millimeter vegetation on aortic valve, mild 20 aortic insufficiency. 21 Q. In your note, you indicate about 22 halfway through it, repeat CT head today shows 23 small infarct on the left and old right infarct 24 present. The small infarct on the left, was that 25 something that was new?</p>	<p style="text-align: right;">64</p> <p>1 wishes. Would it be fair to say that they wanted 2 her to make the decision in regard to surgery? 3 Was that your impression? 4 A. Yes. 5 Q. That they were hoping that the patient 6 would be able to make the determination? 7 A. Yes. 8 Q. Now, were you able at some point to 9 discern Earline Mizsey's wishes regarding heart 10 valve replacement surgery? 11 A. Yes. 12 Q. What is it that you were able to 13 discern from the patient? 14 A. Just after the second TEE down in the 15 coronary care unit where it was done, both the 16 cardiologist and I, and I believe the daughters 17 were there, and clearly Ms. Mizsey expressed her 18 wishes for surgery by nodding vigorously when we 19 suggested, when we asked her whether or not she 20 wanted surgery. 21 Q. Were you the one that actually put the 22 question to her? 23 A. Yes. 24 Q. And do you recall who else was 25 present?</p>



<p style="text-align: right;">65</p> <p>1 A. Yes. I think Dr. Vrobel was there, as 2 well as the daughters. It might have been Dr. 3 Rakita, not Dr. Vrobel. I am not positive of 4 that. One of the cardiologists was there. 5 Q. When the TEE was done on May 14th, 6 were you present when it was done? 7 A. I think we came down when we heard 8 that there were abnormalities noted. I think 9 actually Dr. Vrobel called me. 10 Q. So you actually received a verbal 11 report on the transesophageal echo from the 12 echocardiographer that did the test? 13 A. Yes. 14 Q. Now, the last note that I see with 15 your signature was written on May 14th. Is that 16 the last date that you were involved in Earline 17 Mizsey's care? 18 A. Yes. 19 Q. Did you have any participation in the 20 decision to transfer her to Cleveland Clinic? 21 A. No, I didn't. 22 Q. Did you speak to anyone at Cleveland 23 Clinic regarding possible surgery for Earline 24 Mizsey? 25 A. No, I did not.</p>	<p style="text-align: right;">67</p> <p>1 patient that you would want to do a follow up TEE 2 on soon after the initial one to determine if 3 there was an embolic source coming from the 4 heart? 5 MS. HARRIS: Objection. 6 MR. KILBANE: Objection. The question 7 is confusing, but go ahead and answer, doctor, if 8 you can. 9 A. In answer to the question, I think she 10 had a multitude of symptoms that were very 11 nonspecific. I agree, and we did repeat the TEE 12 in four days and awaited her blood cultures and 13 treated her immediately once the diagnosis was 14 made. 15 Q. Now, you mentioned that Dr. Vrobel was 16 present at the time. You think he may have been 17 present at the time that the TEE was done. Did 18 you talk with Dr. Vrobel at any point between the 19 time of her admission -- I guess the 9th when you 20 first saw her -- and the point when she actually 21 had the repeat TEE? 22 A. The cardiologists were involved from 23 the 12th. He was attending in the coronary care 24 unit and did not get involved in her care until 25 the TEE.</p>
<p style="text-align: right;">66</p> <p>1 Q. Do you know who made those 2 arrangements or who was making those calls? 3 A. Dr. Vrobel. 4 Q. Now, during the course of time that 5 she was in Metro, did you have any conversations 6 with Dr. Einstadter about her prior history 7 leading up to her admission? 8 A. Yes. 9 Q. What was the content of those 10 conversations? What did he tell you? 11 A. I am probably not going to remember 12 everything, but he certainly was concerned about 13 her and came up several times -- the first time 14 was probably around the 9th -- and did tell us of 15 her previous events. What he was concerned about 16 was the potential for embolic sources, but also 17 that she had multiple medical problems; that some 18 of these might be able to be explained on the 19 basis of her long-standing vascular disease and 20 atherosclerotic disease. 21 Q. Doctor, if you have a concern about 22 embolic events in a patient with other criteria 23 for endocarditis, such as fluctuating 24 temperature, elevated white blood cell count, 25 mild anemia, weight loss, wouldn't this be a</p>	<p style="text-align: right;">68</p> <p>1 Q. So you didn't discuss her actual case 2 with Dr. Vrobel until then? 3 A. No. The case had been discussed with 4 Dr. Rakita, who was the consulting 5 cardiologist who certainly did talk to Dr. 6 Vrobel. 7 Q. Well, I am asking in regard to 8 conversations you had. 9 A. No, I did not. 10 Q. With either. Let me clarify. 11 Did you have any conversations with 12 Dr. Rakita or Dr. Vrobel between the 9th when you 13 saw her and the 14th when she had her 14 transesophageal echo done? 15 A. Yes, we had the cardiology service 16 involved. 17 Q. And what became involved on the 12th? 18 A. On the 12th? 19 Q. What information did they provide you 20 with in regard to her condition? What were they 21 saying in regard to her condition? 22 A. Well, on the 12th, we had a blood 23 culture positive, and again, they were certainly 24 in agreement that she had possible endocarditis. 25 Q. And what was the reason that they</p>

<p style="text-align: right;">69</p> <p>1 became involved on the 12th in this case? Was it 2 because of the positive blood cultures? 3 A. I would say yes. I mean, we had 4 enough pieces to put the puzzle together. 5 Q. Were you the ones that called in the 6 cardiologists to become involved in the case? 7 A. Yes. 8 Q. And you did that on or about the 12th? 9 A. Yes. 10 Q. As a result of the positive blood 11 cultures? 12 A. I believe, yes. 13 Q. Any other reason why you were calling 14 them in besides the blood cultures? 15 A. Well, we were concerned about 16 endocarditis in a lady with a prosthetic valve. 17 That's why we called the cardiologists. 18 Q. Well, she had been there for four 19 days, though. 20 A. But we hadn't been able, using the 21 best tests that we had, we hadn't been able to 22 make the diagnosis, and even our infectious 23 disease colleagues note on the 12th with two 24 positive blood cultures they still said this was 25 possible or probable, not definite.</p>	<p style="text-align: right;">71</p> <p>1 A. No. And I don't know whether or not 2 the cardiologists did. 3 Q. When did you learn that Earline Mizsey 4 had died? 5 A. I don't think I knew that until this 6 case was presented to me. 7 Q. If Earline Mizsey had had a 8 transesophageal echo done before her stroke on 9 May 8th, when she entered Metro Hospital, do you 10 think it would have likely showed indications of 11 vegetations? 12 MR. KILBANE: Objection. Go ahead. 13 MS. HARRIS: Objection. 14 A. I have no way of knowing. I mean, the 15 one on the 8th didn't show obvious vegetations. 16 Q. After stroke? 17 A. After her stroke, right. 18 Q. Do you have an opinion as to what 19 point in time she became, as you put it, 20 extremely high risk for surgery? 21 A. I think she was always at risk because 22 of her diabetes and hypertension and coronary 23 artery disease and her vascular disease, but she 24 became somewhat higher risk after her coronary 25 events.</p>
<p style="text-align: right;">70</p> <p>1 Q. Do you have an opinion as to when 2 Earline Mizsey developed prosthetic valve 3 endocarditis? 4 A. Boy, I don't know. 5 Q. After Earline Mizsey was transferred 6 to Cleveland Clinic, were you ever informed that 7 they had declined to take her to surgery for 8 valve replacement? 9 A. I did receive a letter from Dr. 10 Tomford, the infectious disease consultant at the 11 Clinic, saying they had chosen to treat her 12 medically with antibiotics. 13 Q. Do you know why they made that 14 decision? 15 A. No, I don't know all of what went into 16 that decision. 17 Q. Did you speak to any of Earline 18 Mizsey's family after she was transferred out of 19 Metro? 20 A. No. 21 Q. Did you speak to any of the physicians 22 that were treating her at Cleveland Clinic? 23 Aside from the correspondence you just mentioned, 24 did you have any conversations with anybody over 25 there that was treating her?</p>	<p style="text-align: right;">72</p> <p>1 Q. After? 2 A. After her stroke. 3 Q. At which point? Which stroke? She 4 had several. 5 MR. KILBANE: Objection. 6 MS. HARRIS: Objection. That's a 7 conclusion. 8 A. I am still not sure that we know that 9 she had several. She may have had an extension. 10 I forgot the question. 11 Q. Well, you indicated that she was 12 extremely high risk for surgery in one of your 13 notes, and my question is, at what point do you 14 think she became extremely high risk for 15 surgery? 16 MR. KILBANE: Objection. Asked and 17 answered. Go ahead. 18 A. Again, I think she was always at risk, 19 probably at higher risk when her symptoms 20 deteriorated. 21 Q. And at what point in time do you 22 consider her symptoms to have deteriorated? 23 A. Probably around the 12th. But I think 24 anyone with a stroke is at risk for cardiac 25 bypass.</p>

<p style="text-align: right;">73</p> <p>1 Q. Doctor, your note of 5-13, if you 2 could turn to that. 3 A. Yes. 4 Q. Under the AP section of your note, you 5 refer to two CVA's. 6 A. Yes. 7 Q. What -- 8 A. Which two am I referring to? 9 Q. Correct. 10 A. The first being the one out of the 11 hospital in March, the second one being the one 12 on the 8th. 13 Q. Do you have an opinion as to what 14 caused Earline Mizsey's death? 15 A. No. I wasn't involved in her care 16 when she died, so I don't know exactly. It 17 certainly could have been related to her 18 endocarditis. 19 Q. Do you think that Earline Mizsey had 20 endocarditis at the time of her admission on 21 5-8-98? 22 A. I think it's possible, yes, and it 23 took us -- I mean, we did the appropriate workup 24 and found the diagnosis, but it wasn't simple. 25 Q. If she had been diagnosed and cured of</p>	<p style="text-align: right;">75</p> <p>1 MS. HARRIS: No questions. 2 MR. KILBANE: We will read. 3 ----- 4 (Deposition concluded at 12:25 a.m.) 5 (Signature not waived.) 6 ----- 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25</p>
<p style="text-align: right;">74</p> <p>1 her endocarditis prior to the stroke on 5-8, do 2 you have an opinion as to what her reasonable 3 life expectancy would have been, given her 4 medical conditions? 5 MS. HARRIS: Objection. 6 MR. KILBANE: Objection. Go ahead. 7 MS. HARRIS: It's a lot of 8 assumptions. 9 A. Again, I can't predict the future. 10 She had a number of medical problems. I don't 11 think she would have had a normal life 12 expectancy. 13 Q. Do you have any opinion as to how many 14 years she likely would have lived had she been 15 diagnosed, treated and cured prior to that stroke 16 on May 8th? 17 MR. KILBANE: Objection. 18 A. No. 19 Q. Do you have any criticisms of anyone 20 that rendered care to Earline Mizsey? 21 A. No, I don't. 22 Q. Any criticisms of the family? 23 A. No. They were very responsive. 24 MS. TOSTI: I don't have any further 25 questions for you.</p>	<p style="text-align: right;">76</p> <p>1 AFFIDAVIT 2 I have read the foregoing transcript from 3 page 1 through 74 and note the following 4 corrections: 5 PAGE LINE REQUESTED CHANGE 6 7 8 9 10 11 12 13 14 15 16 17 18 Elizabeth Dorr McKinley, M.D. 19 Subscribed and sworn to before me this 20 day of ,2000. 21 22 Notary Public 23 24 25 My commission expires</p>

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1 CERTIFICATE

2 State of Ohio,


SS:

3 County of Cuyahoga.

4  
5 I, Vivian L. Gordon, a Notary Public within  
6 and for the State of Ohio, duly commissioned and  
7 qualified, do hereby certify that the within  
8 named ELIZABETH DORR MCKINLEY, M.D., was by me  
9 first duly sworn to testify to the truth, the  
10 whole truth and nothing but the truth in the  
11 cause aforesaid, that the testimony as above set  
12 forth was by me reduced to stenotypy, afterwards  
13 transcribed, and that the foregoing is a true and  
14 correct transcription of the testimony

15 I do further certify that this deposition  
16 was taken at the time and place specified and was  
17 completed without adjournment, that I am not a  
18 relative or attorney for either party or  
19 otherwise interested in the event of this action  
20  
21 IN WITNESS WHEREOF, I have hereunto set my  
22 hand and affixed my seal of office at Cleveland,  
23 Ohio, on this 27th day of December, 2000.

24  
25

  
Vivian L. Gordon, Notary Public

Within and for the State of Ohio

My commission expires June 8, 2004.

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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 Metropolitan 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 4<sup>th</sup> year medical students  
Committee member, Women's Health in the Millennium Curriculum, CWRU School of Medicine  
Manuscript Reviewer, *Journal of Women's Health*  
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 12<sup>th</sup> 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." 25<sup>th</sup> 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 21<sup>st</sup> 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 21<sup>st</sup> 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