IN THE COURT OF COMMON PLEAS
OF CUYAHOGA COUNTY, OHIO

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LESLIE WALTER,
ADMINISTRATOR, ETC.,

Plaintiff,

vs Case No. 393899

METROHEALTH MEDICAL
CENTER, et al.,
Defendants.

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DEPOSITION OF LOUIS RAKITA, M.D.
WEDNESDAY, FEBRUARY 7,2001

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Deposition of LOUIS RAKITA, 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 3:30 o'clock p.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 B. KILBANE, ESQ.
The 113 St. Clair Building
Cleveland, Ohio 44114
216-687-1311

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LOUIS RAKITA, 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 LOUIS RAKITA, M.D.
BY MS. TOSTI:

Q. Doctor, would you please state your name for us.
A. Louis Rakita, R-A-K-I-T-A.
Q. What is your home address?
A. 24151 South Woodland Road, Shaker Heights, Ohio, 44122.
Q. Is that a single-family home?
A. Yes.
Q. Is your current business address here at MetroHealth Medical Center?
A. Yes.
Q. Is your current employer MetroHealth Medical Center?
A. Yes.
Q. In May of 1998, was your business address and your employer the same?
A. Absolutely.
Q. Do you currently render professional

services for any other entity besides MetroHealth Medical Center?
A. None.
Q. And was that also true in 1998?
A. Yes.
Q. Have you ever had your deposition taken before?
A. Yes.
Q. How manytimes?
A. Maybe four or five.
Q. Of those four or five times, was your deposition ever taken as a defendant in a medical negligence case?
MR. KILBANE: Objection.
A. Yes.
Q. How manytimes?
MR. KILBANE: Objection. An outstanding objection to old lawsuits.
A. Once or twice. I'm not sure. Once, I think.
Q. Now, I am sure counsel has had a chance to talk with you. I am going to go over some of the ground rules for a deposition.
This is a question and answer session. It's under oath. It's important that

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you understand my questions. If you don't understand them or if I phrase them inartfully, let me know and I'll be happy to repeat the question or to rephrase the question. Otherwise, I'm going to assume that you understood my question and that you are able to answer it.

If at any point during this deposition you would like to look at the medical records, please feel free to do so.

It's also important that you give all of your answers verbally, because our court reporter can't take down head nods or hand motions.

At some point during this deposition, defense counsel may choose to enter an objection. You are still required to answer my question unless he instructs you not to do so.

Do you understand those directions?

A. Got them.

Q. Now, doctor, you mentioned that you had been named as a defendant in a medical negligence case once before.

A. I have been named more than once. I was named once for a patient I never saw in a hospital I was never in and I got notification

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that I was part of that. I think it was subsequently dismissed and I never found out who the patient was or why I was named.

Q. Okay.

A. So it was more than once.

Q. Aside from that instance, there were other instances that you had been named as a defendant in a medical negligence case?

A. I don't think so.

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

A. I have acted as an expert for attorneys with the intent of merely informing them as to whether there is severity in the case; that is, whether I thought the allegations were true or not.

Q. How many times have you done that?

A. Maybe about three or four.

Q. Was that for the plaintiff or for the defendant in that case?

A. It came, for example, from Kaiser. I would get the case and provide an opinion for them with the clear understanding that I would not be required to testify.

Q. So just as a reviewer, but not as a

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legal expert that would provide expert testimony at trial; correct?

A. Right. Just to give them some sense of the validity of the case.

Q. But that was for a legal matter as to whether or not there was a basis for malpractice?

A. I would think so.

Q. Aside from being a reviewer that did not want to testify, have you ever been a medical expert in which you agreed to testify if you found an adequate basis to do so?

A. I have testified only one time in court with regard to a patient and his health as to whether his health would allow him to be incarcerated.

Q. That wasn't a medical negligence proceeding?

A. It was not.

Q. In the case reviews that you have done, have you ever done a case review involving issues dealing with bacterial endocarditis?

A. No.

Q. Now, doctor, counsel has told me that you have not brought a curriculum vitae with you, and so I am going to ask you a few questions

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about your background.

Could you tell me where you went to medical school?

A. McGill University in Montreal, Quebec.

Q. When did you complete that program?

A. 1949.

Q. Did you serve a residency after that or an internship?

A. Yes, I did. I had three years of residency, one year added to that as a chief resident, one year as a research fellow in cardiology.

Q. Where was the three-year residency that you served?

A. The first year at Montreal General, the second year -- that's in Montreal -- the second year at the Montreal Jewish Center; the third year Ochsner Clinic in New Orleans; the fourth year, a chief resident here at Metro, at that time, City Hospital. My fellowship was at the Institute for Medical Research in Los Angeles under the direction of Dr. Princeman.

Q. The three-year residency, was that in internal medicine?

A. Yeah.

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Q. And did you then specialize in cardiology? Was that in your fourth year or in your fellowship?
A. Both. My fourth year was predominantly a cardiology year and the fifth year was pure cardiologic research.
Q. When did you receive your Ohio medical license, approximately?
A. It's up in my office and I can't really tell you the exact date. I'm sorry.
Q. Can you tell me what decade it was?
A. In the '50s.
Q. Aside from your medical license in Ohio, have you ever been licensed in any other states?
A. In California.
Q. And currently, are you licensed anyplace besides Ohio?
A. No. Last year I gave up my California license.
Q. Has your license in Ohio or any other state ever been suspended, revoked or called into question?
A. No.
Q. Doctor, are you board certified in any

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areas of medicine?
A. Internal medicine.
Q. And can you tell me approximately when you received that board certification?
A. It would have been around '56 or '57, something like that.
Q. When did you first become employed at MetroHealth Medical Center?
A. I came here as chief resident, that would be 1952, '53. I came back on the full-time staff in 1954. I have been employed here ever since. I'm an old timer.
Q. Do you currently hold any administrative positions here at Metro?
A. Presently, not.
Q. And how about in 1998, did you hold any administrative --
A. No, I did not.
Q. We have to talk one at a time, because she will have problems taking us down. So let me ask my question again.
In 1998, did you hold any administrative positions at Metro?
A. None. But I used to be chief of cardiology here.

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Q. When was that?
A. That was from 1965 until 1987. At that point, I was 65 years of age and they decided they have to appoint somebody else, with good reason.
Q. How old are you now, doctor?
A. I am 78.
Q. Do you currently have privileges at any other hospitals besides Metro's main campus?
A. At present, not.
Q. Was that also true in 1998?
A. I think that's right.
Q. Have your hospital privileges ever been suspended, revoked or called into question?
A. Never.
Q. The privileges that you had in 1998, were those admitting privileges?
A. Yes.
Q. Have you authored or co-authored any medical journal articles or textbook chapters?
A. Yes, I have.
Q. Any dealing with the subject matter of bacterial endocarditis?
A. None.
Q. Any dealing with the subject matter of

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prosthetic heart valves?
A. None.
Q. Have you ever given a formal presentation or a class on the subject matter of endocarditis or prosthetic heart valves?
A. I couldn't tell you for sure. I have given lectures over a period of almost 50 years. Somewhere in there, there could have been a lecture.
Q. Well, my next question would be, if you have given a lecture, would you have any type of printed material, outlines, videotapes, audio tapes from such a lecture?
A. None.
Q. Tell me what you have reviewed in preparation for this deposition.
A. I looked at this and my charts and that's it.
Q. Well, I need a little bit more specifics as to what's contained in there, and I am going to ask you a couple things and maybe you can tell me if you reviewed any of it.
Earline Mizsey was seen at Southwest General Hospital's emergency room a couple times. I believe once in March of '98 and once

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in May of '98.
Did you look at any of the Southwest General Hospital medical records?
A. I probably did. But I can't tell you the details.
MR. KILBANE: If it makes it easier, he was provided some of these that he reviewed: The outpatient chart from Metro, which I think spans, begins in January of 1995. Included in that, I think there is the faxed copy of the Southwest General chart, emergency room chart. He has also seen the Metro emergency room visits from April 21st, April 26th, May 6th, and the Southwest General emergency room visit from May 8th and then the Metro admission.
MS. TOSTI: Broadview Multicare records that you know of?
MR. KILBANE: I don't think he has seen that.
MS. TOSTI: Any Cleveland Clinic records?
MR. KILBANE: No, just the Metro records.
Q. Doctor, have you reviewed any deposition testimony in this case?

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A. None.
Q. When did you become aware that there was a lawsuit pending relative to Earline Mizsey's care?
A. I think it was about two weeks ago.
Q. Well, since --
A. About the time that I received this.
Q. And since the time you became aware that there was a lawsuit, have you discussed this case with any physicians?
A. No.
Q. And other than with counsel, have you discussed it with anyone else?
A. No.
MR. KILBANE: One thing I forgot, the doctor has a separate chart that they call a shadow chart, separate and apart from the hospital chart that he keeps in his department, and I just got a copy of it myself recently and I will provide that to you.
MS. TOSTI: Do I have to make a formal request for it?
MR. KILBANE: You do not. But knowing my own practice, it might be good for you to follow up with a letter, but I will have a copy

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made and have it sent to you.
MS. TOSTI: Could I take a look at it?
MR. KILBANE: Absolutely
(discussion off the record.)
Q. Aside from the medical records that are in front of you in the blank binder, as well as what's been referred to as the shadow chart, do you have any other notes or file on the care you provided to Earline Mizsey?
A. No, I have none.
Q. Doctor, is there a textbook in your field of practice that you consider to be the best or the most reliable?
MR. KILBANE: Objection. It assumes he finds any reliable. But you can answer.
A. No.
Q. Are there any publications, as you sit here today, that you feel have particular relevance to the issues in this case?
A. None that I know of.
Q. Have you participated in any research dealing with the subject matter of bacterial endocarditis?
A. I have not.

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Q. Have you participated in any research here at Metro dealing with the referral of patients for echocardiography to evaluate endocarditis?
A. No.
Q. Have you heard of any such research project here at Metro?
A. No.
Q. Doctor, in May of 1998, what was your title and position at Metro?
A. Visiting physician, and carried with that professor emeritus of medicine at CWRU.
Q. And what does it mean to be a visiting physician in medicine?
A. I'm an attending physician with privileges.
Q. How does that differ from a staff physician?
A. The same.
Q. Are all of the physicians at Metro designated as visiting physicians?
A. I have no idea. I really don't know.
Q. I am just interested in that. I haven't heard any of the physicians that I have previously deposed in this case refer to

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themselves as visiting physicians and I am wondering if your category is something different than the other physicians here?
A. No, the same. You sometimes hear them referred to as visiting and sometimes as attendings, but they are one and the same.
Q. Has that always been your title since you have been here at Metro, aside from administrative titles that you held?
A. I really don't know what my titles have been over the years. Only recently I became aware of the fact that I have a title.
Q. Well, in May of 1998, what were your duties and responsibilities as a visiting physician?
A. The same. Teaching, seeing patients on rounds, consultation rounds, and in '98, I was probably doing -- I'm not certain when I came off, but at that time, I think I was doing attending rounds on the intensive care unit, cardiac intensive care unit. That's different than the cardiac care unit.
Q. There is a cardiac unit and then there is a cardiac intensive care unit?
A. Yes.

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Q. Is one like a telemetry unit?
A. Yes.
Q. And one a cardiology unit?
A. Yes.
Q. And you were making rounds on the telemetry unit?
A. I think at that time.
Q. Did you have any responsibilities in the intensive care unit?
A. By that time I think I was off.
Q. In May of 1998, were you seeing patients both in the outpatient department as well as acutely in the hospital?
A. Yes.
Q. In May of 1998, were you doing any type of invasive diagnostic or invasive therapeutic cardiology procedures?
A. No.
Q. In that time period, could you give me kind of an idea as to what your usual schedule was as far as seeing patients in the outpatient department, as well as in the hospital?
A. I see patients in the outpatient department three half days a week. I precept cardiology fellows three half days a week. I

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read electrocardiograms, and depending on the time of the year, I make consultation rounds on assignment, and then participate in the division's ongoing activities of grand rounds and things like that.
Q. What were the consultation rounds that you mentioned at certain times during the year?
A. I'm sorry, what were they?
Q. Yes.
A. Well, what would happen is that the division of cardiology would get a request to see a patient. The fellow or resident or a student would be assigned to see the patient. They would then present the findings to me. We would then go either singly or as a group to see that patient and provide consultative services to the requesting service or physician.
Q. How often would you be responsible for doing those type of consultation rounds?
A. When I was on service, it would be five and a half days a week.
Q. And how often were you on service?
A. At that time, I think I was on for three months of the year.
Q. Was that a three month continuous time

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period?
A. I don't know when it changed, but I think it was then broken down into two week blocks.
Q. And you trade off with another cardiologist then?
A. And then they would take over, right.
Q. Now, doctor, the patients that you were seeing in May of 1998, was your practice limited to seeing patients with cardiology problems?
A. Right.
Q. How often in your practice do you see patients with bacterial endocarditis?
A. Not too often anymore.
Q. Can you give me a little better idea as to what you mean by that?
A. Well, we used to see it not infrequently, when there was more rheumatic heart disease. I may see one or two cases a year now.
Q. Would that be true in 1998 also; approximately one or two cases a year?
A. I would think so.
Q. Have you personally diagnosed patients with bacterial endocarditis?

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A. Yes. Starting back in my internship days.
Q. Have you diagnosed patients with prosthetic valve endocarditis?
A. Yes.
Q. What are the factors that would place a patient at increased risk for developing prosthetic valve bacterial endocarditis?
A. Anything that would produce a bacteremia or septicemia. Anything that will cause the circulation of bacteria in the bloodstream would put them at risk.
Q. Would a patient be at increased risk for developing prosthetic valve bacterial endocarditis if they were diabetic?
A. Yes.
Q. In a patient that has a bioprosthetic heart valve, what would cause you to be suspicious for bacterial endocarditis?
A. If the patient came to me with symptoms of fever, petechia, spondylomegaly and on examination I were to find the development of a new murmur that had not been present before, that would raise my suspicions.
Q. Would symptoms of anorexia be seen in

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some cases of bacterial endocarditis that was associated with the prosthetic valve?
A. That's a rather nonspecific kind of symptom. That wouldn't raise my suspicion.
Q. How about fatigue?
A. Not necessarily.
Q. Weight loss?
A. Not necessarily. It could be due to many different things.
Q. Are there any diagnostic studies that are helpful in diagnosing a patient with bacterial endocarditis?
A. Echocardiography and blood cultures.
Q. Is a sedimentation rate at all helpful in assisting you to make the diagnosis?
A. Not specifically.
Q. Isn't a sedimentation rate almost always elevated in a patient that has bacterial endocarditis?
A. It's elevated in so many different things.
Q. But isn't it always usually elevated in bacterial endocarditis?
A. Most likely, if there is an infection, it's likely to be elevated. That wouldn't lead

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me to the diagnosis of endocarditis.
Q. Can bacterial endocarditis be ruled out on the basis of a single blood culture?
A. No.
Q. Does a patient have to have a positive blood culture before a presumptive diagnosis of bacterial endocarditis can be made?
A. A presumptive diagnosis can be made, but a specific diagnosis could not be made.
Q. Doctor, is there a higher rate of negative blood cultures in patients with prosthetic valve endocarditis as compared to endocarditis patients without prosthetic valves?
A. I don't know.
Q. Is there a higher rate of negative cultures in subacute bacterial endocarditis as compared to acute bacterial endocarditis?
A. I don't really know, but probably.
Q. And how is prosthetic valve endocarditis treated?
A. With antibiotics, if you can identify an organism.
Q. Is surgical replacement of the prosthetic valve usually necessary with prosthetic valve endocarditis?

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A. Usually, I don't know what that means. More commonly than not?
Q. Yes.
A. I don't know. I really don't know what the percentage is.
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 a prosthetic valve endocarditis is treated with antibiotics, the more likely the outcome will be positive?
MR. KILBANE: Objection. Go ahead.
A. I am trying to think. Let me get that question again. The sooner it's treated --
Q. Would you agree that the sooner prosthetic valve endocarditis is treated with antibiotics, the more likely the outcome will be positive?
A. It depends entirely on the organism that you are treating.
Q. What type of complications are associated with prosthetic valve endocarditis?

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A. Arrhythmias, congestive heart failure, new valve lesions, abscesses. And it's not specific for a prosthetic valve endocarditis. That would be true for any endocarditis.
Q. Thromboembolism?
A. A thromboembolism can occur.
Q. Would you agree that there has to be a high degree of vigilance for bacterial endocarditis in a patient with bioprosthetic heart valve?
MR. KILBANE: Objection.
A. It depends on the other factors that are involved in the case. For example, it depends on how the patient presents and what the other circumstances are that the embolism presents with or the thrombus presents with.
Q. Well, I didn't mention anything about thromboembolism. I just asked you if you would agree that there has to be a high degree of vigilance for bacterial endocarditis in a patient with a bioprosthetic heart valve; that as a physician, you have to be vigilant for signs and symptoms because of the fact that the patient has a bioprosthetic heart valve?
A. You need to be vigilant in any

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circumstance, right, but you need to be vigilant for endocarditis in anybody who has an endocardio lesion.
Q. In a patient with a bioprosthetic heart valve who presents with fever, elevated white blood cell count, and symptoms suggestive of stroke or transient ischemic attack, would you agree that endocarditis should be included in the differential diagnosis?
MR. KILBANE: Objection. Go ahead.
A. Should be included in the differential diagnosis? The degree of suspicion and where you would put it depends upon the circumstances.
Q. Doctor, bacterial endocarditis can cause catastrophic embolic stroke; correct?
A. Bacterial endocarditis can, yes.
Q. You previously mentioned that echocardiography is helpful in assisting in making the diagnosis of bacterial endocarditis. What type of echo is more sensitive for picking up signs of prosthetic valve endocarditis?
A. Transesophageal echo.
Q. If a prosthetic valve patient presents with stroke symptoms and there is a suspicion that the cause may be cardiac embolic, as the

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course, would you agree that an echocardiogram should be done on a high priority basis?
MR. KILBANE: Objection.
A. The standard echo, yes.
Q. And that it should be done on a high priority if the patient has presented with symptoms of stroke and there is a suspicion that it may be caused by a cardiac embolic source?
MR. KILBANE: Objections. I mean, your question is vague in terms of the degree of suspicion, but go ahead, if you can answer it.
A. No. The question is, where in the scheme of things you place bacterial endocarditis as a possible entity causing the patient's symptoms and signs of that time.
If, in fact, you feel that the event that occurred was more likely related to something else that the patient had, that would not be a high priority.
Q. I didn't mention bacterial endocarditis in my question. I mentioned a cardiac embolic source.
A. The same. Whatever the source might be, if there are other reasons for whatever was happening to that patient, it would depend where

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in the hierarchy of suspicion you have it at that particular moment, whether you would choose an echo at that particular moment in time.
Q. Well, doctor, if there is a concern that the emboli are being emitted from the heart, shouldn't that warrant a high priority echo because of the catastrophic nature of stroke?
A. You have taken me one step beyond. In other words, you are making the assumption for me, I think, that there is endocarditis. I am saying, depending on the circumstances, when I see that patient, that if my suspicion is higher that they may have other reasons for having the events that are occurring, then my direction of investigation might be entirely different.
Q. But assuming that you believe emboli may be being emitted from the heart, assuming that as a basis, would that warrant a high priority echo?
MR. KILBANE: Objection. He has answered the question. He told you it depends on how high that suspicion is. Go ahead and answer again.
A. Yes, it comes back again that the question is -- if I understand your question, if,

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in fact my thinking at the time was, yes, this patient has endocarditis as a top priority item in my thinking rather than something else, then certainly I would ask for an echo.
Q. Can you have emboli coming from the heart from things other than endocarditis?
A. You are making another assumption that I am thinking that the emboli, or if there are emboli, are the cause of what the patient has.
Q. No. I asked, doctor, if you can have emboli coming from the heart from something other than endocarditis?
A. Yes. You could have endocardial tumors that could metastasize. Not very common, but it's possible. But that would be the more common.
Q. Doctor, if you decide that a patient needs to have a transthoracic echo on a high priority basis, if that's a decision that you've made, how long would it take you at Metro to have an echo done?
A. It probably would take me less time than most others. I walk in with my white hair and ask them to do it, and they frequently will accommodate me.

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Q. Could you get it done the same day if you felt it was necessary?
A. Well, it depends. I don't order them to do that. So it really is at their discretion, but very frequently they will accommodate me, and we will try to do it that same day. And I think they can sense my sense of urgency.
Q. If, in your opinion, a patient needs to have a transesophageal echo done on a high priority basis, how long would it take you to have that accomplished?
A. That depends entirely on the operator. It's a little different. This is another physician who then has to reorder his priorities in order to respond, and I have to communicate my sense of urgency to him about that particular patient, and he has to put that in his priorities in relation to everybody else who has some urgency with regard to their request. So I really couldn't tell you. They will respond as quickly as they can. They will do it that day or even the next day or sometimes the following day.
Q. Within a day or two with a transesophageal if you felt it was a high priority need?

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A. Chances are it would be within that period of time. Again, it depends on a lot of other circumstances.
Q. Do you do, you personally do echocardiograms?
A. No.
Q. Doctor, on average, how long does a porcine aortic valve usually last before it starts to deteriorate in a patient?
A. Somewhere around seven to ten years, I think.
Q. Would it be unusual to see a bioprosthetic valve deteriorating in less than four years?
A. No, not unusual.
Q. That only occurs in a very small percentage of patients, doesn't it?
MR. KILBANE: Objection.
A. I would think so, but I don't really know. I don't know what the time frame is.
Q. Can bacterial endocarditis in some instances cause deterioration of a porcine heart valve?
A. That's not usually the cause of deterioration, no.

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Q. Can it in some instances cause it?
A. If you ask me on a theoretical basis can it, I would say rather than deterioration, it might cause destruction of the valve. Deterioration is a different connotation.
Q. How do you differentiate between destruction and deterioration?
A. Well, a valve can deteriorate because it's infiltrated by cholesterol and cells and becomes fibrotic and becomes fused, and has nothing to do with any bacteria, as far as we know.
Q. And when you say destruction, what do you refer to? What does that mean to you?
A. That means something is chewing up the valve.
Q. Let me rephrase my question. Can bacterial endocarditis cause destruction of a porcine heart valve?
A. I would assume that it could. But I would say deterioration, just to add something, that the deterioration is a much more common phenomenon than destruction by endocarditis.
Q. Do valvular vegetations have to be present before the diagnosis of prosthetic valve

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endocarditis can be made?
A. No. But it helps.
Q. And from the perspective of a cardiologist -- and I understand that a surgeon also has input into this, but from the perspective of a cardiologist, what would be the indications for valve replacement in a patient that had prosthetic valve endocarditis?
MR. KILBANE: Objection. Go ahead.
A. If the patient was deteriorating rapidly, going into acute heart failure, that would be a major indication.
Q. If you had a diagnosis established or an organism identified, and the patient had received appropriate antibiotic therapy and was not responding, would that be an indication, would multiple embolic events be an indication for replacement of a prosthetic valve in a patient that had prosthetic valve endocarditis?
MR. KILBANE: Objection.
A. Not necessarily.
Q. Doctor, do you have an independent recollection of Earline Mizsey? Do you recall her as we sit here today?
A. Not really.

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Q. Now, you have had an opportunity to look through the records that counsel provided to you. Can you tell me approximately when you first provided care to Earline Mizsey?
A. I think I provided care for her earlier than my chart indicates under another name. And if I remember correctly, her name this time was Mizsey?
Q. Yes.
A. I think her name was Swindell at one time.
Q. Yes, that's correct.
A. I don't have that chart. And I think there may have been a gap in my care for her. I think after a certain period of time, if the patient hadn't come, those charts were taken out of the file. They may be in the hospital record under the Swindell name, in which case I may have notes in that, but I have not looked for them.
Q. Well, can you tell me approximately when you think you began caring for her?
A. I couldn't even begin to tell you. I have no idea. But it would have been quite some time ago.
Q. Well, based on the records that you

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looked at.
A. The ones I have, I think 1995.
Q. But you believe that you actually saw her before that time?
A. I think I did. I would say under the name Swindell. Again, I think I lost track of her and she came back as Mizsey and I remember being confused as to who I am dealing with.
Q. And what was the reason that -- and I am going to refer to her as Earline Mizsey -- that Earline Mizsey was coming to see you?
A. Because she had heart disease.
Q. And what, in particular, in regard to her heart disease? What was wrong with her heart?
A. I think she had a valvular lesion, the aortic valve.
Q. Now, at some point Earline Mizsey had heart surgery while she was under your care; is that correct?
A. Correct.
Q. What type of surgery did she have?
A. She had valve replacement, and I believe she had coronary bypass, but I'm not certain of that. She had valve replacement for

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certain.
Q. And did you care for her after the valve replacement and the bypass surgery?
A. I think so.
Q. Following the surgical procedure for the valve replacement and the bypass, what was the condition of her health?
A. Variable. Sometimes she would come in with complaints. She complained of dizziness, lightheadedness. Sometimes she would come in -- not very often -- and say she felt perfectly well, had no complaints, a routine follow up.
Q. Now, she was a diabetic; is that correct?
A. That's correct.
Q. Was her diabetes in reasonably good control while under your care?
A. As far as I know, but I was not responsible for her diabetic care.
Q. Did you receive any type of information from Dr. Thomas Murphy, an endocrinologist, that he felt that her diabetes was in reasonably good control?
A. I think I did,
Q. Doctor, I believe you saw her in

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October of 1998. And I am going to ask you if you can find your notes from that particular visit.
A. October of '98.
Q. I think it was October 21st of 1998.
MR. KILBANE: You mean '97.
MS. TOSTI: I'm sorry, '97. I have the wrong year.
A. Yes, I have it, 10-21-97.
Q. Now, I have a copy that is extremely difficult to read and I am going to ask --
A. Not my handwriting, is it?
Q. No, I think the copy is horrible.
MR. KILBANE: Do you want me to see if I can run a quick copy of it?
THE WITNESS: Whatever you like.
MS. TOSTI: Actually, I would like both, so I have a copy for my chart, as well.
MR. KILBANE: Go ahead and read it. We will get her a copy.
Q. I was going to ask you to read through it and tell us what you have written there.
MR. KILBANE: Before you read it, read it literally and do it slowly for the convenience of our court reporter.

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A. I will start at the top of the page, which is out of context in relation to what you ordinarily do.
Her weight was 170.5 pounds. Blood 156 over 74. Pulse, 62 per minute. Temperature 97.8. Glucose 176 and three and a half percent with the sugar. She still has vaginal inching, but it's not all gone. Saw Dierker, who did a biopsy, and says she has been told everything is okay. Now her legs are not very strong.
Physical examination. Overweight female in no acute distress. Chest clear to P&A, stands for percussion and auscultation. Midline surgical scar. Cardiovascular system, JSP normal, bilateral carotid bruits, left greater than right. A grade three over six systolic ejection murmur SEM heard in all areas, maximum in the second right interspace parasternally and radiating up. No S3 or S4 and no diastolic murmur. Abdomen obese. No tenderness, masses or bruits in extremities, no edema.
Impression. One, prosthetic aortic valve, systolic ejection murmur, aortic stenosis. Two, mild carotid vascular disease. Three, diabetes, mild.

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There is an appendage to that. It says 2-4-98. Not in my handwriting. Xanax 0.25 milligram number 60, one BID with five refills per Dr. Rakita. It's appended above my signature, which goes with the previous note.
Q. Doctor, the systolic ejection murmur that you heard, was that something that she had had right along in the care that you had been giving her?
A. That's very common with prosthetic valves.
Q. And what was the reason that she was seeing you on that particular day?
A. Probably on a routine follow-up visit.
Q. And from what you can tell, was there anything that was concerning from that visit? Anything that was a change in her condition from anything previous you had seen?
A. No. Sounds like she was stable.
Q. Now, doctor, in March of '98, did Dr. Vrobel occasionally take call for some of your patients when you were not available or you were off duty?
A. Yes.
Q. And when Dr. Vrobel would take call on

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your patients, what was your understanding as to his responsibilities?
A. To take care of the patient as far as he could go.
Q. Now, if he took calls on one of your patients, would he usually notify you about that call?
MR. KILBANE: Objection.
A. Usually, but not always.
Q. If one of your patients were seen in the emergency room, would he usually notify you in that type of an instance?
MR. KILBANE: Objection.
A. It depends on the circumstances. If everything was taken care of and nothing needed to be followed up, no.
Q. Did you keep any type of a phone log or other documentation in regard to -- let me rephrase that.
Were you given any type of a phone log or any type of documentation when calls were taken on your patients by Dr. Vrobel?
A. No.
Q. Now, doctor, there was a visit by Earline Mizsey to Southwest General Hospital on

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March 10th of '98. The emergency room record, if you have a copy of it, it might be helpful to look at. I am going to refer you to, I believe, the dictated note of the doctor.

On the dictated note, I believe towards the end of it, the emergency room physician, he has indicated in the note that the patient was discussed in detail with Dr. Vrobel who was covering for Dr. Rakita, who will call the patient early in the morning.

Now, was that a usual procedure for you to call a patient in the morning if the patient was seen in the emergency room and Dr. Vrobel was covering?

MR. KILBANE: Objection.

A. Is that an usual procedure? No. It would depend on many different things. It depends on what time Dr. Vrobel caught up with me, it depends on what time I became available to make phone calls. I usually make my phone calls in the evening.

Q. Do you know why Dr. Vrobel would have told the emergency room physician that you would call his patient in the morning?

MR. KILBANE: Obiection.

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A. I have no idea.

Q. Did Dr. Vrobel contact you about Earline Mizsey's presentation to Southwest General Hospital on March 3rd -- I'm sorry, March 10th of '98?

A. I don't recall any such communication.

Q. Do you recall or have any documentation that would indicate such that you contacted Earline Mizsey on the morning of March 11th of '98?

A. I have no notation to that effect.

Q. Doctor, when Earline Mizsey presented to the emergency room on March 10th of '98, she was diagnosed with a transient ischemic attack, and she had an elevated white blood cell count that was at 15.4, temperature was 100.9. She had labored respirations, and she gave a history of having had a porcine aortic valve. Should there have been a heightened concern in her case for endocarditis?

MR. KILBANE: Objection.

A. It depends on the circumstances, you know. I don't know with what emphasis she described her symptoms to the physician. This is a lady who had multiple problems, so it's hard

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for me to put myself in that position and say yes or no to that question.

Q. Well, should it have been included in the differential diagnosis?

MR. KILBANE: Objection.

A. Yes. It comes back to what we said before, and that is, it depends where in the hierarchy of differential diagnosis you should put it.

Should it be anywhere?

Q. Yes.

A. Yes, it should be somewhere in there.

Q. Given the presenting symptoms that are described in the record --

A. Is that the same day we are talking about? March 10th.

Q. March 10th, yes.

A. Okay.

Q. -- should Earline Mizsey have been seen at Metro the following day for follow up?

A. Not necessarily, no.

Q. Do you have an opinion as to when she should have been seen or if she should have been seen?

A. She may have had a standing

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appointment. That might have been quite appropriate.

Q. But based on her presenting symptoms if she did not have a standing appointment, do you have an opinion as to when she should have been seen following this emergency room visit? And if you don't know, you can tell me. I am asking if you do.

A. No, I really don't know. She may herself have decided not to follow up. If she felt better the next day, she may not have followed up at all. I have no idea.

Q. Well, according to the record, the ER record indicates Dr. Rakita will call you in the morning.

You have no recollection of speaking to her?

A. None whatsoever. I don't remember this whole event. I'm impressed by the description.

Q. Why is that?

A. White female in no acute distress, alert. By the next day she may have felt perfectly well and decided not to follow up. I don't know.

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Q. Well, doctor, she was seen three days after this by Dr. Einstadter in the Metro outpatient department.
A. Okay.
Q. And if you look at the tail end of Dr. Einstadter's notes, where he has his assessments, he indicates symptoms consistent with acute CVA. Do you see that?
A. Yes.
Q. So if she presented to the ER with what appeared to be TIA symptoms and three days later Dr. Einstadter is saying symptoms are consistent with acute CVA, it wouldn't suggest that her symptoms cleared up, would it?
MR. KILBANE: Objection.
A. Could I hear the first part of that question again?
Q. I said, if she presented to the emergency room with symptoms that appeared to be a TIA and then she is seen by Dr. Einstadter three days later and he is saying that her symptoms are consistent with acute CVA, it wouldn't appear that her symptoms cleared up, would it?
MR. KILBANE: Objection.

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A. I don't know whether they cleared up and she got new ones or it was a sequence of what was happening before.
Q. Now, doctor, Dr. Einstadter, when he saw her, under his plan of care, he indicates will schedule for carotid ultrasound and echo to look for the embolic source. Do you see that?
A. Yes.
Q. Doctor, if there was a reason to suspect an embolic source for her stroke, would you agree that it would be prudent to do a prompt echocardiogram on the patient?
A. No, not necessarily. This is a lady with diabetes, known vascular disease, documented lesions in the carotid before, and so the priorities that the physician sets at the time depends on how he evaluates the situation. What I say I would do now doesn't necessarily even mean anything about what I would have done or what he should do.
Q. Well, doctor, if there was an embolic source causing the stroke, and there is an intention to do an echocardiogram to look for an embolic source, wouldn't it be prudent to do it on a high priority basis before another stroke

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occurred?
MR. KILBANE: Objection. Go ahead.
A. He was looking for an embolic source in the carotids, not in the heart.
Q. Well, he has carotid ultrasound and an echocardiogram is what he has written.
A. That was his sequence of thinking -- I will look for the source. And he thought the carotids were the more likely source of the embolism.
Q. Why do you say that?
MR. KILBANE: Objection. Let me interrupt for a minute. I mean, to be fair to this witness, he is a fact witness. He has limited interaction with this patient.
To be fair to him, could we talk about what his involvement is with this patient instead of trying to turn him into an expert against other care providers.
MS. TOSTI: He has cared for this patient for a number of years. And so he has just told me that he felt this doctor was looking for an embolic source in the carotids and I want to know --
THE WITNESS: I didn't say that. He

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said that.
MR. KILBANE: I guess my point is, he wasn't involved with this interaction with the patient. This is Dr. Einstadter. You have taken his deposition.
I am just asking, to be fair to this witness and to be accommodating to everybody's time, I think it would be only fair to ask him about his involvement and try not to ask him standard of care questions about care he wasn't involved in.
MR. TOSTI: Well, he was involved before and after these events and so some of this information may impact as to what his care was down the road. So I do think that they are pertinent.
MR. KILBANE: I think asking him what Dr. Einstadter was thinking or why he was thinking it, I'm not sure how that fits in. And I understand and you are entitled to your discovery.
MS. TOSTI: I didn't ask what Dr. Einstadter was thinking.
MR. KILBANE: You are asking him to interpret these records and determine why he is

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ordering different studies.
MS. TOSTI: I didn't ask him anything why he ordered the studies. I asked him in a patient that presented with these particular symptoms, if you are concerned that they may be an embolic source to the stroke, wouldn't you want to do an echocardiogram on the patient on a high priority basis.
MR. KILBANE: He wasn't involved with this patient and doesn't know what Dr. Einstadter's thinking was.
MS. TOSTI: He was involved. He has been caring for this lady for years. He saw her in October and saw her after this point in time.
MR. KILBANE: I don't want to argue with you, Jeanne. I don't think it's fair to have him answer questions about an interaction with a patient he wasn't involved with. I am asking as an accommodation to him and to everybody. Let's move on.
MS. TOSTI: I don't think that I can accommodate you, since I do think that this impacts his later care.
MR. KILBANE: We will go for a while and see how we do.

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A. The fact is that he did set a sequence that he thought was appropriate for what the patient came in with. He was considering emboli, and obviously I think his priority for the carotids as a prime source is evidenced by the fact that it's the first thing that he mentioned, not the second thing he mentioned.
And my assumption is that if he felt no source in the carotids, we then consider it a possibility for an echo, but that was not his top priority. And the way he put the thing together, that was the sequence he felt that should be followed. And I can't fault that.
Q. Should the carotid ultrasound have been done on a high priority basis then?
MR. KILBANE: Objection.
A. That I would defer to the neurologist. Does he need it quickly? Does it make any difference? Does he want a CT scan? There are a lot of factors. I don't know.
Q. Did you have any conversations with Dr. Einstadter regarding Earline Mizsey's visit to Southwest General Hospital on March 10th or his findings when he saw her on March 13th of '98?

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A. None that I can recall.
Q. Earline Mizsey had an echocardiogram done on April 9th of '98. Do you have an opinion as to whether the timing of that echo was appropriate?
A. April 9th?
Q. Yes.
MR. KILBANE: Objection. Go ahead.
A. I am trying to remember the circumstances under which it was ordered. Do we have that here?
MR. KILBANE: Sure. What do you want to see?
THE WITNESS: I want to see the echoes and the events occurring at the time.
MR. KILBANE: Here is Dr. Einstadter's next visit.
A. The echo was done when?
Q. April 9th. He saw her on the 13th and indicated, will schedule for carotid ultrasound and echo to look for embolic source. And then on April 9th I believe she had both the ultrasound of the carotids and the echocardiogram. And I am asking whether you have an opinion as to whether that was appropriately scheduled as far as the

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timing of it?
MR. KILBANE: I am going to enter my objection, because I think it's unfair to this witness who wasn't involved with the patient during this period of time, who wasn't seeing this patient, who wasn't consulted on this patient, to sit here and answer questions whether it was appropriate or not. I think it's clear from his answer that he hasn't even reviewed the records with an eye towards forming that opinion.
MS. TOSTI: The doctor can tell me he has no opinion.
MR. KILBANE: I can enter my objection. I am telling you --
MS. TOSTI: What you are doing is cuing the witness and I object to that.
MR. KILBANE: No, I'm not. I am trying to be fair to this witness. It's disrespectful to him.
MS. TOSTI: If he has no opinion, he can tell me, but if he does, I would like to hear what that is, doctor.
THE WITNESS: I have no opinion because I don't even know the circumstances.

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Q. If you have no opinion, we will move on to the next question. But if you do, I would like to hear what that is.
A. Fairenough.
Q. Doctor, you have the chart opened to the transthoracic echo that was done on April 9th, I believe; is that correct?
A. Yes.
Q. Now, at the very bottom of that report, the last two lines, it indicates that the above suggests bioprosthetic deterioration which could be a potential embolic source. TEE may be helpful in further clarifying.
Do you see where I am reading from?
A. Yes.
Q. With this type of a result, do you have an opinion as to when a TEE should have been done?
MR. KILBANE: Objection.
A. No. No, I don't.
Q. Do you have an opinion as to whether a TEE was indicated after this type of a report on Earline Mizsey?
A. Not necessarily, no.
Q. And why do you say not necessarily?

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A. Because, again, it depends on the thinking of the physician in terms of what his priorities are as to the cause of this lady's symptoms.
Q. And so you don't have an opinion as to whether a TEE was or wasn't appropriate in Earline Mizsey's case after this transthoracic echo; correct?
MR. KILBANE: Objection.
A. At that time, no.
Q. Doctor, on April 26th of '98, Earline Mizsey presented to MetroHealth's emergency department complaining of pain throughout her right leg and thigh, beginning yesterday evening that was sudden in onset.
Did you review those records when you looked at this chart?
A. I probably did, but I can't recall them.
Q. And she described, after stepping out of the shower, she had this sudden onset of pain.
A. Yes.
Q. And she also described that the pain was worse when walking and it didn't improve by

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rest. She also had a temperature at the time of her presentation, a small one. I think it was 37.6.
Given the results of that echo that we just looked at that indicated bioprosthetic valve deterioration, that suggested a potential embolic source, and these new symptoms of sudden onset of pain that is not relieved by rest, should there have been a heightened suspicion for arterial embolism in this patient?
MR. KILBANE: Objection.
A. Not necessarily. Again, it's in the context of a lady with diabetes, hypertension, hyperlipidemia, known vascular disease, and a prime setup for occlusions anywhere.
Q. Doctor, you can have peripheral vascular disease and also have embolism to the legs, couldn't you?
A. Absolutely.
Q. Now, doctor, you cared for Earline Mizsey after she was admitted into the hospital during a portion of the time of her May 8th admission, through, I believe, May 15th.
Do you have an opinion as to whether the deterioration suggested on her echo that we

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just looked at was due to bacterial endocarditis?
MR. KILBANE: Objection.
A. Do you have the date of that? You say I took care of her or I saw her?
Q. During her May 8th through May 15th --
A. A consultation?
Q. Yes.
A. Where would that be?
MR. KILBANE: Do you want to see the consultation?
THE WITNESS: Yes.
A. I think I did render an opinion with regard to that.
Q. I think the first progress note that I saw was on the 12th.
A. On the 12th?
Q. Yes, here, right.
A. Right, and my opinion was she had no stigmata of endocarditis at the time.
Q. Was May 1st the first time you saw her during that admission?
A. I think that's probably correct. What was the date of that?
MR. KILBANE: The admission starts

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here on the 8th.
THE WITNESS: The date I saw her?
MR. KILBANE: On the 12th also.
A. I think that was the first and apparently the only time, as far as I can tell. There may have been one other note here.
Q. We will look through that in a minute. I have a couple other notes that we may look at.
How is it that you came to see her on May 12th of '98?
A. It is probable that the personnel on the ward asked us to come see her.
Q. As a consult?
A. As a consult.
Q. So one of her attending physicians requested that you consult on the patient?
A. Right.
Q. Do you know who that was?
A. I have no idea.
MR. KILBANE: Do you want to see the order?
THE WITNESS: No, I want to see the fellow's note. It's on that. It said who requested.

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A. According to the fellow's note, Dr. McKinley requested the consult.
Q. Are you referring to a consultation sheet that has, I believe, Dr. Sakiewicz and Rakita at the top?
A. That's correct.
Q. Dr. Sakiewicz, is he a fellow?
A. He is a fellow -- was a fellow at the time.
Q. So the note that he wrote would have been written in consultation with you, would that be correct?
A. He would have written it beforehand and then presented it to me.
Q. Did you and he see the patient together?
A. I can't recall.
Q. Based on your review of the records, what was your understanding as to what brought her to the hospital on May 8th and that subsequently caused you to see her?
A. My understanding was that she had had a stroke and had had an obstruction to an artery that is, in the note, in her right popliteal.
Q. And was the reason that you were

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seeing her is that there was concern that she may have possible endocarditis?
A. No. I really don't know why they asked.
Q. Well, doctor, at the top of the consult sheet, it indicates reason for referral, possible endocarditis.
A. Yes. That would be the reason they asked us. What I am saying is I don't recall specifically why they asked us.
Q. Doctor, in the record, in the notes, there is a note written by Dr. McKinley before your note that describes Earline Mizsey as acutely worse that morning. She says increased facial droop, dysarthria, decreased strength, and then after your note is a neurology consult that describes abrupt onset of increased dysarthria and right hemiparesis, and the impression is noted as recurrent cerebral embolism. When you saw her on the 12th, were you aware of any change in her condition on that date?
A. No. My note doesn't indicate that, does it?
Q. When you saw her, you were familiar with her history, though, because she had been

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your patient previously; correct?
A. I knew her background history, yes.
Q. Did you do an examination of Earline Mizsey when you saw her on the 1st?
A. I did an examination and I think I recorded that. I also had an opinion as to her status at that time, because what happened is these pages are out of order in here, okay? The continuation of the note that you have on the 12th has an end to it. It says, I believe she needs to be treated as endocarditis in spite of the -- I can't read my handwriting -- absence of signs of bacterial endocarditis. No petechia, no Osler nodes, no Roth spots, no spondylomegaly, et cetera.
She does have a prosthetic valve, high white count and multiple peripheral emboli -- I assume they were emboli at that point, my assumption. Will continue to follow. And I said, please send her to my clinic for follow up for post discharge. Do you have that one?
Q. Yes, I have both pages. Mine are in the right order.
A. These are not.
Q. So, doctor, did you believe at the

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time that you saw her on the 12th that she likely had endocarditis?
A. I believe that there was a possibility that she had endocarditis.
Q. Did you think it was likely?
A. I had no idea.
Q. When you saw her on the lst, were you aware of any positive blood cultures that she had?
A. No, I was not.
Q. And the reason that I ask is there is a note by Dr. McKinley that comes just before yours. If you turn back one page.
A. Right.
Q. And in the middle of that note on about the 7th line down, it now says, now one blood culture is positive.
A. Yes.
Q. And I'm wondering if at the time that you saw the patient, since your note appears to fall after Dr. McKinley's, whether you were aware of the positive blood culture at that time?
A. I don't believe I was, because my note doesn't even mention that.
Q. If she had a positive blood culture at

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the time that you saw her, would that be an indication of likely endocarditis?
A. No.
Q. That would --
A. Not necessarily. Again, it depends on the organism, all kinds of organisms. And some of them, a single culture may be a contaminant rather than an actual infection.
Q. She also had a transesophageal echo done on May 12th. Did you have the results of the transesophageal echo when you saw her?
A. I have a feeling not, because I don't allude to it in the note.
Q. Doctor, do you have a copy of the transesophageal echo there?
A. The word that I had trouble reading is overt.
The transesophageal echo on that day.
Q. And if you would just take a look at the findings on that echo.
A. Right.
MR. KILBANE: Are you talking about the one on the 8th or 12th?
MS. **TOSTI:** The one on the 12th. He saw the patient on the 12th and my question was

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whether he was aware of the transesophageal echo. He said he didn't think so because it wasn't noted. And I just wanted to give him an opportunity to look at those results.
A. No, probably not. Because my indication in my note was that she should be treated in spite of everything. Had that been present with a paravalvular abscess, there wouldn't be any question.
Q. So once these results were known, would there be any question about whether she had endocarditis or not?
A. No. She had vegetations.
MR. KILBANE: Could we take a five minute break?
MS. **TOSTI:** Sure.
(Recess had.)
(Record read.)
Q. We were looking at the echocardiogram from the 12th. And it indicated that there were vegetations present and that's what we were referring to.
A. Right.
Q. Doctor, when you saw her on the 12th, what was your plan of care for this patient?

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A. According to my note, I suggested that she be treated, based on, I presume, on the echo, based on the positive blood culture. Putting all those together, it sounds like a good bet.
Q. And what would that treatment entail?
A. Antibiotics, appropriate for the organism that was identified.
Q. Did you confer with anyone in regard to what the appropriate antibiotics would be?
A. No, I would leave that to the infectious disease consultant.
Q. Did you review any of the tapes from any of her echoes at any time?
A. I can't recall.
Q. When she first came in, she had a -- I believe it was a transesophageal echo done. Do you know whether that study fully evaluated her aortic valve?
A. This is on the 8th?
Q. Yes, the 8th.
A. I can't really tell you. I can just tell you what it says and you can read it as well as I can. He said he saw the valve and there was no evidence of any thrombus at that time on the 8th.

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Q. Dr. Josephy, I believe, also wrote a note in the progress note in regard to that echocardiogram on the 8th, and he indicated in his note unable to fully evaluate the aortic valve.
A. I will take his word for it.
Q. If that study did not fully evaluate the aortic valve, would it be reliable in noting vegetations?
A. He couldn't rule out vegetations.
Q. Okay.
A. And that's why the TEE is the next step.
Q. Well, I believe that one was a TEE.
A. That was a TEE, right.
Q. Assuming that that TEE study did not fully evaluate the aortic valve, would it be reliable for ruling out vegetations?
A. If it is not adequate, then it's not adequate for totally ruling it out, no.
Q. Now, doctor, I noted another note that I think may have been yours that was written on May 13th, and I would like you to turn to the clinical notes of May 13th, and if you could tell me if that is indeed a note that you wrote.

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I have a copy of it here. Is this a note that you wrote on May 13th?
A. Yes, that's my handwriting.
Q. Could you just read that note for us, please.
A. Speech is worse. I think repeat TEE is warranted. I cannot hear any new murmurs today. However, I think logically the aortic valve is the site of these multiple emboli.
Q. Why on the 13th did you think the aortic valve was the site of the multiple emboli?
A. Because they had demonstrated thrombus on the valve.
Q. And would that be based on the echo that we had just looked at on the 12th?
A. On the 12th, right.
Q. Now, doctor, I think that there is another note on the 14th that may also be in your handwriting. And if you could turn to the clinical notes of the 14th. If you would read that note to us, I would appreciate it, if it is yours.
A. That's my signature. We have been informed that the TEE confirmed the presence of vegetations and the probability of an abscess. I

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believe the only hope is for the valve to be replaced. Will obtain the patient's agreement. Consider this very high risk surgery. If she says yes, we will contact the appropriate surgeon to see if they would agree to operate.
Q. Why did you consider the replacement of the valve as her only hope?
A. Because the presence of an abscess already being there makes the possibility of cure of antibiotic less likely. The possibility of perforation by that abscess also becomes a problem.
Q. Now, you noted that this was very high risk surgery.
A. Right.
Q. Was that in a large part due to the multiple strokes that she had had?
A. Multiple strokes, her prior disease, the effects on her heart, her diabetes, and other vascular problems, all that made her a high risk candidate, and she was -- I hate to say this -- an elderly lady.
Q. Now, I believe she was transferred into the coronary care unit on May 14th of '98. Did you participate in her care after her

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transfer into the intensive care?
A. I believe not. Once she is in the CCU, then Dr. Vrobel would become the responsible physician.
Q. Did you make any attempts to obtain permission from her for surgery?
A. I can't recall.
Q. Did you make any contact with any thoracic surgeons regarding her surgery?
A. I would think that Dr. Vrobel would be responsible at that time. I can't recall that.
Q. I am asking whether you did.
A. I'm not even sure.
Q. Did you discuss your impressions with the Mizsey family, anyone in the Mizsey family?
A. I don't recall that.
Q. Do you recall any conversations with Earline Mizsey?
A. I recall very little about the whole incident.
Q. Doctor, in her state of health at the time that you saw her, did you have an opinion as to what her chances of surviving the surgery would have been?
A. No. I would leave that to the

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surgeons.
Q. After she was transferred to Cleveland Clinic, did you have any contact with any of the physicians at Cleveland Clinic regarding this patient?
A. None whatsoever. To my knowledge.
Q. And after she left Metro on the 15th, did you have any further contact with Earline Mizsey?
A. I don't recall any contact with her.
Q. Do you know whether Earline Mizsey ever underwent replacement of her infected valve?
A. I read the note from Dr. Tomford, and, no, she did not have.
Q. Now, doctor, she had an echo done almost two months after discharge.
A. From the Clinic?
Q. Almost two months after discharge from Metro.
A. From Metro.
Q. And it was done at the Clinic on July 9th. And she was found to have mobile echo densities on that echo. Would that be suggestive of ongoing endocarditis if she had mobile echo densities two months after discharge?

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MR. KILBANE: Objection.
A. Not necessarily endocarditis. She could have heel endocarditis and have thrombus.
THE WITNESS: Do we have a copy of that echo?
MR. KILBANE: I don't have it with me.
THE WITNESS: I wanted a copy of that echo as a matter of interest.
MR. KILBANE: I can get that for you later if you want to see it.
Q. Doctor, I think I do have a copy of the report, so hang on just one minute, if I can find it here.
A. It's not essential.
Q. This is The Cleveland Clinic Foundation July 9th, '98 report of transthoracic echo and there is also a handwritten note that refers to that echo.
A. Okay.
Q. Now, doctor, you have just had an opportunity to review the report of that transthoracic echo of July 9th, '98. Would those findings be suggestive of ongoing endocarditis?
A. No, as I said, not necessarily.
Q. Do you have an opinion when Earline

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Mizsey developed her bacterial endocarditis?
A. I really don't know.
Q. Do you have an opinion as to a point in time when Earline Mizsey became too high risk for surgical replacement of her infected heart valve?
MR. KILBANE: Objection.
A. I am trying to think back. If I can go back to your last question.
Q. Yes.
A. It seems to me we have a transesophageal on the 8th with no question of changes on the 12th, which would suggest to me that sometime between the 8th and 12th is when the endocarditis became manifest, between May 8th and May 12th, but exactly when, I can't tell you.
Q. We also looked at a note that was written by the physician that performed the May 8th echo where he indicated that he wasn't able to fully evaluate the aortic valve, and I think you told me that you could not reliably rule out vegetations if, in fact, you were unable to fully evaluate the aortic valve?
A. That's correct, you couldn't rule it out, but the probability of having such

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significant changes four days later would suggest -- and none on the 8th that he could see -- make it highly unlikely; that somewhere in that interval was the time frame, and I can't prove that.
Q. Well, doctor, she had had a stroke on the 8th. If she had a mobile vegetation that broke off that caused her stroke, it wouldn't be there to see in an echo; correct?
A. Yes, but I can go back to the fact that she had lots of reason for having a stroke.
Q. Well, it was your opinion that the most likely reason was from an embolic source; correct?
A. No, I have no idea where it was from.
Q. You never mentioned in any of your notations that that's what you thought occurred?
A. On the 12th. By that time we had the vegetations and we had the positive culture.
Q. And on the 12th, did you think that she had had multiple peripheral emboli, two to her head and one to her leg?
A. On the 12th, yes. We are talking about the 8th.
Q. Let's go back to your note that you

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wrote on May 12th then. In the second part of that note that's written on the other page about halfway through it you indicate there that the patient had multiple peripheral emboli.
A. Right.
Q. Two to the head and one to her leg.
A. Right.
Q. Now, when did you think that those two emboli to her head occurred?
A. Somewhere between the 8th and the 12th.
Q. Okay. And how about to her leg?
A. When did she come in? What was the date of that?
Q. She came in on May 8th.
A. Somewhere between the 8th and 12th when she began to have the trouble.
Q. You are aware in the admission note they documented two events that occurred prior to the admission?
A. Yes, she could have had those, as I say, on the basis of her other disease. I have no way of knowing whether those related to the same process that was now ongoing.
Q. So it's your understanding that she

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had two emboli to her head and one to her leg after the time of her admission?
A. I suspect. Were those clinical events noted?
Q. I am asking you, doctor.
A. I am trying to recall. I don't recall. When were those events noted?
Q. Well, I believe one was noted back in March and another one in May and that she also had an emergency room visit where she had the severe pain, that we reviewed, in her leg that was of sudden onset.
A. Yes.
Q. And so I am asking what your impressions were.
A. My impressions are that we had diagnosed endocarditis on the 12th definitively, and prior to that we had not.
Q. And it was your impression that she had had multiple embolic events as a result of her endocarditis; correct?
A. My interpretation on the 12th, when the data were in, that those could have been related to the same process.
Q. Now, if she had the embolic events,

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though, in March, and in May --
A. I don't know that those were embolic events in March.
Q. Well, I guess we get back to what were the dates of the embolic events that you refer to in your note? And if you would like to look back in the record, please feel free to do so.
A. Remember, I am doing this in retrospect.
Q. I am trying to discern what it is you are referring to.
A. And even if I am making the assumption at this point, it wouldn't say what I thought it was at the time that I first saw her.
Q. I understand that, doctor. I am just trying to discern the dates of the embolic events that you are referring to in your note.
A. Well, I don't know exactly what the sequence was now.
Let's see when she came in here. She had something happen to her on the 8th; right?
Q. Yes.
A. Right sided weakness, okay.
(Record read.)
MR. KILBANE: Do you know which ones

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you are referring to in your note?
THE WITNESS: That's what I am looking for. I don't recall which of the two events and when they occurred in time sequence. We know there was one on the 8th. Was there an event after the 8th is what we are looking for.
MR. KILBANE: If you don't know what you are thinking --
THE WITNESS: I really don't know, unless I can find whether there was another event subsequent to that.
Q. And doctor, if you don't know, just tell me that.
A. I don't recall.
Q. Now, she was eventually, after her stay at Cleveland Clinic, transferred to an extended care facility called Broadview Multicare after her discharge. Did you have any contact with Broadview Multicare or any of the care providers at Broadview Multicare?
A. None whatsoever, that I know of.
Q. Did you ever discuss Earline Mizsey's death with any of the physicians that treated her?
A. None. I didn't even know she died.

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Q. Then I take it you do not have an opinion as to her cause of death?
A. I have none.
Q. You had no contact with the family after her death; is that correct?
A. Not that I can recall.
Q. If her prosthetic valve endocarditis had been successfully treated before she suffered a stroke on May 8th, do you have an opinion as to what her reasonable life expectancy would have been?
A. I have no idea.
Q. Do you have any criticisms of anyone that rendered care to her?
A. I have none. I think they did what was appropriate.
Q. Do you blame Earline Mizsey in any way for the complications that she suffered?
MR. KILBANE: Objection.
A. Blame Mrs. Mizsey?
Q. Yes.
A. No.
MS. TOSTI: I don't have any further questions for you, doctor.
MR. KILBANE: We will read it.

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(Deposition concluded at 5:55 p.m.)
(Signature not waived.)
- - - - -

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AFFIDAVIT

I have read the foregoing transcript from page 1 through 78 and note the following corrections:

PAGE	LINE	REQUESTED CHANGE

LOUIS RAKITA, M.D.

Subscribed and sworn to before me this day of , 2001.

Notary Public

My commission expires

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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 LOUIS RAKITA, 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 14th day of February, 2001.

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