

<p style="text-align: right;">Page 1</p> <p>1 IN THE COURT OF COMMON PLEAS 2 OF CUYAHOGA COUNTY, OHIO 3 ----- 4 LESLIE WALTER, 5 ADMINISTRATOR, ETC., 6 Plaintiff, 7 vs Case No. 393899 8 METROHEALTH MEDICAL 9 CENTER, et al., 10 Defendants. 11 ----- 12 DEPOSITION OF LOUIS RAKITA, M.D. 13 WEDNESDAY, FEBRUARY 7, 2001 14 ----- 15 Deposition of LOUIS RAKITA, M.D., a Witness 16 herein, called by counsel on behalf of the 17 Plaintiff for examination under the statute, 18 taken before me, Vivian L. Gordon, a Registered 19 Diplomate Reporter and Notary Public in and for 20 the State of Ohio, pursuant to agreement of 21 counsel, at the offices of MetroHealth Medical 22 Center, 2500 MetroHealth Drive, Cleveland, Ohio, 23 commencing at 3:30 o'clock p.m. on the day and 24 date above set forth. 25</p>	<p style="text-align: right;">Page 3</p> <p>1 LOUIS RAKITA, M.D., a witness herein, called 2 for examination, as provided by the Ohio Rules of 3 Civil Procedure, being by me first duly sworn, as 4 hereinafter certified, was deposed and said as 5 follows: 6 EXAMINATION OF LOUIS RAKITA, M.D. 7 BY MS. TOSTI: 8 Q. Doctor, would you please state your 9 name for us. 10 A. Louis Rakita, R-A-K-I-T-A. 11 Q. What is your home address? 12 A. 24151 South Woodland Road, Shaker 13 Heights, Ohio, 44122. 14 Q. Is that a single-family home? 15 A. Yes. 16 Q. Is your current business address here 17 at MetroHealth Medical Center? 18 A. Yes. 19 Q. Is your current employer MetroHealth 20 Medical Center? 21 A. Yes. 22 Q. In May of 1998, was your business 23 address and your employer the same? 24 A. Absolutely. 25 Q. Do you currently render professional</p>
<p style="text-align: right;">Page 2</p> <p>1 APPEARANCES: 2 On behalf of the Plaintiff 3 Becker & Mishkind, by 4 JEANNE M. TOSTI, ESQ. 5 Skylight Office Tower Suite 660 6 Cleveland, Ohio 44113 7 216-241-2600 8 9 On behalf of the Defendant MetroHealth Medical 10 Center 11 Reminger & Reminger, by 12 THOMAS B. KILBANE, ESQ. 13 The 113 St. Clair Building 14 Cleveland, Ohio 44114 15 216-687-1311 16 ----- 17 18 19 20 21 22 23 24 25</p>	<p style="text-align: right;">Page 4</p> <p>1 services for any other entity besides MetroHealth 2 Medical Center? 3 A. None. 4 Q. And was that also true in 1998? 5 A. Yes. 6 Q. Have you ever had your deposition 7 taken before? 8 A. Yes. 9 Q. How manytimes? 10 A. Maybe four or five. 11 Q. Of those four or five times, was your 12 deposition ever taken as a defendant in a medical 13 negligence case? 14 MR. KILBANE: Objection. 15 A. Yes. 16 Q. How manytimes? 17 MR. KILBANE: Objection. An 18 outstanding objection to old lawsuits. 19 A. Once or twice. I'm not sure. Once, I 20 think. 21 Q. Now, I am sure counsel has had a 22 chance to talk with you. I am going to go over 23 some of the ground rules for a deposition. 24 This is a question and answer 25 session. It's under oath. It's important that</p>

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1 you understand my questions. If you don't
2 understand them or if I phrase them inartfully,
3 let me know and I'll be happy to repeat the
4 question or to rephrase the question. Otherwise,
5 I'm going to assume that you understood my
6 question and that you are able to answer it.
7 If at any point during this deposition
8 you would like to look at the medical records,
9 please feel free to do so.
10 It's also important that you give all
11 of your answers verbally, because our court
12 reporter can't take down head nods or hand
13 motions.
14 At some point during this deposition,
15 defense counsel may choose to enter an
16 objection. You are still required to answer my
17 question unless he instructs you not to do so.
18 Do you understand those directions?
19 A. Got them.
20 Q. Now, doctor, you mentioned that you
21 had been named as a defendant in a medical
22 negligence case once before.
23 A. I have been named more than once. I
24 was named once for a patient I never saw in a
25 hospital I was never in and I got notification

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1 that I was part of that. I think it was
2 subsequently dismissed and I never found out who
3 the patient was or why I was named.
4 Q. Okay.
5 A. So it was more than once.
6 Q. Aside from that instance, there were
7 other instances that you had been named as a
8 defendant in a medical negligence case?
9 A. I don't think so.
10 Q. Have you ever acted as an expert in a
11 medical negligence proceeding?
12 A. I have acted as an expert for
13 attorneys with the intent of merely informing
14 them as to whether there is severity in the case;
15 that is, whether I thought the allegations were
16 true or not.
17 Q. How many times have you done that?
18 A. Maybe about three or four.
19 Q. Was that for the plaintiff or for the
20 defendant in that case?
21 A. It came, for example, from Kaiser. I
22 would get the case and provide an opinion for
23 them with the clear understanding that I would
24 not be required to testify.
25 Q. So just as a reviewer, but not as a

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1 legal expert that would provide expert testimony
2 at trial; correct?
3 A. Right. Just to give them some sense
4 of the validity of the case.
5 Q. But that was for a legal matter as to
6 whether or not there was a basis for malpractice?
7 A. I would think so.
8 Q. Aside from being a reviewer that did
9 not want to testify, have you ever been a medical
10 expert in which you agreed to testify if you
11 found an adequate basis to do so?
12 A. I have testified only one time in
13 court with regard to a patient and his health as
14 to whether his health would allow him to be
15 incarcerated.
16 Q. That wasn't a medical negligence
17 proceeding?
18 A. It was not.
19 Q. In the case reviews that you have
20 done, have you ever done a case review involving
21 issues dealing with bacterial endocarditis?
22 A. No.
23 Q. Now, doctor, counsel has told me that
24 you have not brought a curriculum vitae with you,
25 and so I am going to ask you a few questions

Page 8

1 about your background.
2 Could you tell me where you went to
3 medical school?
4 A. McGill University in Montreal, Quebec.
5 Q. When did you complete that program?
6 A. 1949.
7 Q. Did you serve a residency after that
8 or an internship?
9 A. Yes, I did. I had three years of
10 residency, one year added to that as a chief
11 resident, one year as a research fellow in
12 cardiology.
13 Q. Where was the three-year residency
14 that you served?
15 A. The ~~first~~ year at Montreal General,
16 the second year -- that's in Montreal -- the
17 second year at the Montreal Jewish Center; the
18 third year Ochsner Clinic in New Orleans; the
19 fourth year, a chief resident here at Metro, at
20 that time, City Hospital. My fellowship was at
21 the Institute for Medical Research in Los Angeles
22 under the direction of Dr. Princeman.
23 Q. The three-year residency, was that in
24 internal medicine?
25 A. Yeah.

2 (Pages 5 to 8)

<p style="text-align: right;">Page 9</p> <p>1 Q. And did you then specialize in</p> <p>2 cardiology? Was that in your fourth year or in</p> <p>3 your fellowship?</p> <p>4 A. Both. My fourth year was</p> <p>5 predominantly a cardiology year and the fifth</p> <p>6 year was pure cardiologic research.</p> <p>7 Q. When did you receive your Ohio medical</p> <p>8 license, approximately?</p> <p>9 A. It's up in my office and I can't</p> <p>10 really tell you the exact date. I'm sorry.</p> <p>11 Q. Can you tell me what decade it was?</p> <p>12 A. In the '50s.</p> <p>13 Q. Aside from your medical license in</p> <p>14 Ohio, have you ever been licensed in any other</p> <p>15 states?</p> <p>16 A. In California.</p> <p>17 Q. And currently, are you licensed</p> <p>18 anywhere besides Ohio?</p> <p>19 A. No. Last year I gave up my California</p> <p>20 license.</p> <p>21 Q. Has your license in Ohio or any other</p> <p>22 state ever been suspended, revoked or called into</p> <p>23 question?</p> <p>24 A. No.</p> <p>25 Q. Doctor, are you board certified in any</p>	<p style="text-align: right;">Page 11</p> <p>1 Q. When was that?</p> <p>2 A. That was from 1965 until 1987. At</p> <p>3 that point, I was 65 years of age and they</p> <p>4 decided they have to appoint somebody else, with</p> <p>5 good reason.</p> <p>6 Q. How old are you now, doctor?</p> <p>7 A. I am 78.</p> <p>8 Q. Do you currently have privileges at</p> <p>9 any other hospitals besides Metro's main campus?</p> <p>10 A. At present, not.</p> <p>11 Q. Was that also true in 1998?</p> <p>12 A. I think that's right.</p> <p>13 Q. Have your hospital privileges ever</p> <p>14 been suspended, revoked or called into question?</p> <p>15 A. Never.</p> <p>16 Q. The privileges that you had in 1998,</p> <p>17 were those admitting privileges?</p> <p>18 A. Yes.</p> <p>19 Q. Have you authored or co-authored any</p> <p>20 medical journal articles or textbook chapters?</p> <p>21 A. Yes, I have.</p> <p>22 Q. Any dealing with the subject matter of</p> <p>23 bacterial endocarditis?</p> <p>24 A. None.</p> <p>25 Q. Any dealing with the subject matter of</p>
<p style="text-align: right;">Page 10</p> <p>1 areas of medicine?</p> <p>2 A. Internal medicine.</p> <p>3 Q. And can you tell me approximately when</p> <p>4 you received that board certification?</p> <p>5 A. It would have been around '56 or '57,</p> <p>6 something like that.</p> <p>7 Q. When did you first become employed at</p> <p>8 MetroHealth Medical Center?</p> <p>9 A. I came here as chief resident, that</p> <p>10 would be 1952, '53. I came back on the full-time</p> <p>11 staff in 1954. I have been employed here ever</p> <p>12 since. I'm an old timer.</p> <p>13 Q. Do you currently hold any</p> <p>14 administrative positions here at Metro?</p> <p>15 A. Presently, not.</p> <p>16 Q. And how about in 1998, did you hold</p> <p>17 any administrative --</p> <p>18 A. No, I did not.</p> <p>19 Q. We have to talk one at a time, because</p> <p>20 she will have problems taking us down. So let me</p> <p>21 ask my question again.</p> <p>22 In 1998, did you hold any</p> <p>23 administrative positions at Metro?</p> <p>24 A. None. But I used to be chief of</p> <p>25 cardiology here.</p>	<p style="text-align: right;">Page 12</p> <p>1 prosthetic heart valves?</p> <p>2 A. None.</p> <p>3 Q. Have you ever given a formal</p> <p>4 presentation or a class on the subject matter of</p> <p>5 endocarditis or prosthetic heart valves?</p> <p>6 A. I couldn't tell you for sure. I have</p> <p>7 given lectures over a period of almost 50 years.</p> <p>8 Somewhere in there, there could have been a</p> <p>9 lecture.</p> <p>10 Q. Well, my next question would be, if</p> <p>11 you have given a lecture, would you have any type</p> <p>12 of printed material, outlines, videotapes, audio</p> <p>13 tapes from such a lecture?</p> <p>14 A. None.</p> <p>15 Q. Tell me what you have reviewed in</p> <p>16 preparation for this deposition.</p> <p>17 A. I looked at this and my charts and</p> <p>18 that's it.</p> <p>19 Q. Well, I need a little bit more</p> <p>20 specifics as to what's contained in there, and I</p> <p>21 am going to ask you a couple things and maybe you</p> <p>22 can tell me if you reviewed any of it.</p> <p>23 Earline Mizsey was seen at Southwest</p> <p>24 General Hospital's emergency room a couple</p> <p>25 times. I believe once in March of '98 and once</p>

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1 in May of '98.
2 Did you look at any of the Southwest
3 General Hospital medical records?
4 A. I probably did. But I can't tell you
5 the details.
6 MR. KILBANE: If it makes it easier,
7 he was provided some of these that he reviewed:
8 The outpatient chart from Metro, which I think
9 spans, begins in January of 1995. Included in
10 that, I think there is the faxed copy of the
11 Southwest General chart, emergency room chart.
12 He has also seen the Metro emergency room visits
13 from April 21st, April 26th, May 6th, and the
14 Southwest General emergency room visit from May
15 8th and then the Metro admission.
16 MS. TOSTI: Broadview Multicare
17 records that you know of?
18 MR. KILBANE: I don't think he has
19 seen that.
20 MS. TOSTI: Any Cleveland Clinic
21 records?
22 MR. KILBANE: No, just the Metro
23 records.
24 Q. Doctor, have you reviewed any
25 deposition testimony in this case?

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

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

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1 Q. Have you participated in any research
2 here at Metro dealing with the referral of
3 patients for echocardiography to evaluate
4 endocarditis?
5 A. No.
6 Q. Have you heard of any such research
7 project here at Metro?
8 A. No.
9 Q. Doctor, in May of 1998, what was your
10 title and position at Metro?
11 A. Visiting physician, and carried with
12 that professor emeritus of medicine at CWRU.
13 Q. And what does it mean to be a visiting
14 physician in medicine?
15 A. I'm an attending physician with
16 privileges.
17 Q. How does that differ from a staff
18 physician?
19 A. The same.
20 Q. Are all of the physicians at Metro
21 designated as visiting physicians?
22 A. I have no idea. I really don't know.
23 Q. I am just interested in that. I
24 haven't heard any of the physicians that I have
25 previously deposed in this case refer to

4 (Pages 13 to 16)

Page 17

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

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1 Q. Is one like a telemetry unit?
2 A. Yes.
3 Q. And one a cardiology unit?
4 A. Yes.
5 Q. And you were making rounds on the
6 telemetry unit?
7 A. I think at that time.
8 Q. Did you have any responsibilities in
9 the intensive care unit?
10 A. By that time I think I was off.
11 Q. In May of 1998, were you seeing
12 patients both in the outpatient department as
13 well as acutely in the hospital?
14 A. Yes.
15 Q. In May of 1998, were you doing any
16 type of invasive diagnostic or invasive
17 therapeutic cardiology procedures?
18 A. No.
19 Q. In that time period, could you give me
20 kind of an idea as to what your usual schedule
21 was as far as seeing patients in the outpatient
22 department, as well as in the hospital?
23 A. I see patients in the outpatient
24 department three half days a week. I precept
25 cardiology fellows three half days a week. I

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

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

5 (Pages 17 to 20)

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1 A. Yes. Starting back in my internship
2 days.
3 Q. Have you diagnosed patients with
4 prosthetic valve endocarditis?
5 A. Yes.
6 Q. What are the factors that would place
7 a patient at increased risk for developing
8 prosthetic valve bacterial endocarditis?
9 A. Anything that would produce a
10 bacteremia or septicemia. Anything that will
11 cause the circulation of bacteria in the
12 bloodstream would put them at risk.
13 Q. Would a patient be at increased risk
14 for developing prosthetic valve bacterial
15 endocarditis if they were diabetic?
16 A. Yes.
17 Q. In a patient that has a bioprosthetic
18 heart valve, what would cause you to be
19 suspicious for bacterial endocarditis?
20 A. If the patient came to me with
21 symptoms of fever, petechia, spondylomegaly and
22 on examination I were to find the development of
23 a new murmur that had not been present before,
24 that would raise my suspicions.
25 Q. Would symptoms of anorexia be seen in

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1 me to the diagnosis of endocarditis.
2 Q. Can bacterial endocarditis be ruled
3 out on the basis of a single blood culture?
4 A. No.
5 Q. Does a patient have to have a positive
6 blood culture before a presumptive diagnosis of
7 bacterial endocarditis can be made?
8 A. A presumptive diagnosis can be made,
9 but a specific diagnosis could not be made.
10 Q. Doctor, is there a higher rate of
11 negative blood cultures in patients with
12 prosthetic valve endocarditis as compared to
13 endocarditis patients without prosthetic valves?
14 A. I don't know.
15 Q. Is there a higher rate of negative
16 cultures in subacute bacterial endocarditis as
17 compared to acute bacterial endocarditis?
18 A. I don't really know, but probably.
19 Q. And how is prosthetic valve
20 endocarditis treated?
21 A. With antibiotics, if you can identify
22 an organism.
23 Q. Is surgical replacement of the
24 prosthetic valve usually necessary with
25 prosthetic valve endocarditis?

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1 some cases of bacterial endocarditis that was
2 associated with the prosthetic valve?
3 A. That's a rather nonspecific kind of
4 symptom. That wouldn't raise my suspicion.
5 Q. How about fatigue?
6 A. Not necessarily.
7 Q. Weight loss?
8 A. Not necessarily. It could be due to
9 many different things.
10 Q. Are there any diagnostic studies that
11 are helpful in diagnosing a patient with
12 bacterial endocarditis?
13 A. Echocardiography and blood cultures.
14 Q. Is a sedimentation rate at all helpful
15 in assisting you to make the diagnosis?
16 A. Not specifically.
17 Q. Isn't a sedimentation rate almost
18 always elevated in a patient that has bacterial
19 endocarditis?
20 A. It's elevated in so many different
21 things.
22 Q. But isn't it always usually elevated
23 in bacterial endocarditis?
24 A. Most likely, if there is an infection,
25 it's likely to be elevated. That wouldn't lead

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1 A. Usually, I don't know what that
2 means. More commonly than not?
3 Q. Yes.
4 A. I don't know. I really don't know
5 what the percentage is.
6 Q. Would you agree that one of the main
7 goals of treatment in prosthetic valve
8 endocarditis is to eradicate the infecting
9 organism as soon as possible?
10 A. Yes.
11 Q. And would you agree that the sooner a
12 prosthetic valve endocarditis is treated with
13 antibiotics, the more likely the outcome will be
14 positive?
15 MR. KILBANE: Objection. Go ahead.
16 A. I am trying to think. Let me get that
17 question again. The sooner it's treated --
18 Q. Would you agree that the sooner
19 prosthetic valve endocarditis is treated with
20 antibiotics, the more likely the outcome will be
21 positive?
22 A. It depends entirely on the organism
23 that you are treating.
24 Q. What type of complications are
25 associated with prosthetic valve endocarditis?

6 (Pages 21 to 24)

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1 A. Arrhythmias, congestive heart failure,
2 new valve lesions, abscesses. And it's not
3 specific for a prosthetic valve endocarditis.
4 That would be true for any endocarditis.
5 Q. Thromboembolism?
6 A. A thromboembolism can occur.
7 Q. Would you agree that there has to be a
8 high degree of vigilance for bacterial
9 endocarditis in a patient with bioprosthetic
10 heart valve?
11 MR. KILBANE: Objection.
12 A. It depends on the other factors that
13 are involved in the case. For example, it
14 depends on how the patient presents and what the
15 other circumstances are that the embolism
16 presents with or the thrombus presents with.
17 Q. Well, I didn't mention anything about
18 thromboembolism. I just asked you if you would
19 agree that there has to be a high degree of
20 vigilance for bacterial endocarditis in a patient
21 with a bioprosthetic heart valve; that as a
22 physician, you have to be vigilant for signs and
23 symptoms because of the fact that the patient has
24 a bioprosthetic heart valve?
25 A. You need to be vigilant in any

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

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

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

7 (Pages 25 to 28)

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

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

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1 A. Chances are it would be within that
2 period of time. Again, it depends on a lot of
3 other circumstances.
4 Q. Do you do, you personally do
5 echocardiograms?
6 A. No.
7 Q. Doctor, on average, how long does a
8 porcine aortic valve usually last before it
9 starts to deteriorate in a patient?
10 A. Somewhere around seven to ten years, I
11 think.
12 Q. Would it be unusual to see a
13 bioprosthetic valve deteriorating in less than
14 four years?
15 A. No, not unusual.
16 Q. That only occurs in a very small
17 percentage of patients, doesn't it?
18 MR. KILBANE: Objection.
19 A. I would think so, but I don't really
20 know. I don't know what the time frame is.
21 Q. Can bacterial endocarditis in some
22 instances cause deterioration of a porcine heart
23 valve?
24 A. That's not usually the cause of
25 deterioration, no.

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

8 (Pages 29 to 32)

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1 endocarditis can be made?
2 A. No. But it helps.
3 Q. And from the perspective of a
4 cardiologist -- and I understand that a surgeon
5 also has input into this, but from the
6 perspective of a cardiologist, what would be the
7 indications for valve replacement in a patient
8 that had prosthetic valve endocarditis?
9 MR. KILBANE: Objection. Go ahead.
10 A. If the patient was deteriorating
11 rapidly, going into acute heart failure, that
12 would be a major indication.
13 Q. If you had a diagnosis established or
14 an organism identified, and the patient had
15 received appropriate antibiotic therapy and was
16 not responding, would that be an indication,
17 would multiple embolic events be an indication
18 for replacement of a prosthetic valve in a
19 patient that had prosthetic valve endocarditis?
20 MR. KILBANE: Objection.
21 A. Not necessarily.
22 Q. Doctor, do you have an independent
23 recollection of Earline Mizsey? Do you recall
24 her as we sit here today?
25 A. Not really.

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

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1 looked at.
2 A. The ones I have, I think 1995.
3 Q. But you believe that you actually saw
4 her before that time?
5 A. I think I did. I would say under the
6 name Swindell. Again, I think I lost track of
7 her and she came back as Mizsey and I remember
8 being confused as to who I am dealing with.
9 Q. And what was the reason that -- and I
10 am going to refer to her as Earline Mizsey --
11 that Earline Mizsey was coming to see you?
12 A. Because she had heart disease.
13 Q. And what, in particular, in regard to
14 her heart disease? What was wrong with her
15 heart?
16 A. I think she had a valvular lesion, the
17 aortic valve.
18 Q. Now, at some point Earline Mizsey had
19 heart surgery while she was under your care; is
20 that correct?
21 A. Correct.
22 Q. What type of surgery did she have?
23 A. She had valve replacement, and I
24 believe she had coronary bypass, but I'm not
25 certain of that. She had valve replacement for

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1 certain.
2 Q. And did you care for her after the
3 valve replacement and the bypass surgery?
4 A. I think so.
5 Q. Following the surgical procedure for
6 the valve replacement and the bypass, what was
7 the condition of her health?
8 A. Variable. Sometimes she would come in
9 with complaints. She complained of dizziness,
10 lightheadedness. Sometimes she would come in --
11 not very often -- and say she felt perfectly
12 well, had no complaints, a routine follow up.
13 Q. Now, she was a diabetic; is that
14 correct?
15 A. That's correct.
16 Q. Was her diabetes in reasonably good
17 control while under your care?
18 A. As far as I know, but I was not
19 responsible for her diabetic care.
20 Q. Did you receive any type of
21 information from Dr. Thomas Murphy, an
22 endocrinologist, that he felt that her diabetes
23 was in reasonably good control?
24 A. I think I did,
25 Q. Doctor, I believe you saw her in

9 (Pages 33 to 36)

<p>Page 37</p> <p>1 October of 1998. And I am going to ask you if 2 you can find your notes from that particular 3 visit. 4 A. October of '98. 5 Q. I think it was October 21st of 1998. 6 MR. KILBANE: You mean '97. 7 MS. TOSTI: I'm sorry, '97. I have 8 the wrong year. 9 A. Yes, I have it, 10-21-97. 10 Q. Now, I have a copy that is extremely 11 difficult to read and I am going to ask -- 12 A. Not my handwriting, is it? 13 Q. No, I think the copy is horrible. 14 MR. KILBANE: Do you want me to see if 15 I can run a quick copy of it? 16 THE WITNESS: Whatever you like. 17 MS. TOSTI: Actually, I would like 18 both, so I have a copy for my chart, as well. 19 MR. KILBANE: Go ahead and read it. 20 We will get her a copy. 21 Q. I was going to ask you to read through 22 it and tell us what you have written there. 23 MR. KILBANE: Before you read it, read 24 it literally and do it slowly for the convenience 25 of our court reporter.</p>	<p>Page 39</p> <p>1 There is an appendage to that. It 2 says 2-4-98. Not in my handwriting. Xanax 0.25 3 milligram number 60, one BID with five refills 4 per Dr. Rakita. It's appended above my 5 signature, which goes with the previous note. 6 Q. Doctor, the systolic ejection murmur 7 that you heard, was that something that she had 8 had right along in the care that you had been 9 giving her? 10 A. That's very common with prosthetic 11 valves. 12 Q. And what was the reason that she was 13 seeing you on that particular day? 14 A. Probably on a routine follow-up visit. 15 Q. And from what you can tell, was there 16 anything that was concerning from that visit? 17 Anything that was a change in her condition from 18 anything previous you had seen? 19 A. No. Sounds like she was stable. 20 Q. Now, doctor, in March of '98, did Dr. 21 Vrobel occasionally take call for some of your 22 patients when you were not available or you were 23 off duty? 24 A. Yes. 25 Q. And when Dr. Vrobel would take call on</p>
<p>Page 38</p> <p>1 A. I will start at the top of the page, 2 which is out of context in relation to what you 3 ordinarily do. 4 Her weight was 170.5 pounds. Blood 5 156 over 74. Pulse, 62 per minute. Temperature 6 97.8. Glucose 176 and three and a half percent 7 with the sugar. She still has vaginal itching, 8 but it's not all gone. Saw Dierker, who did a 9 biopsy, and says she has been told everything is 10 okay. Now her legs are not very strong. 11 Physical examination. Overweight 12 female in no acute distress. Chest clear to P&A, 13 stands for percussion and auscultation. Midline 14 surgical scar. Cardiovascular system, JSP 15 normal, bilateral carotid bruits, left greater 16 than right. A grade three over six systolic 17 ejection murmur SEM heard in all areas, maximum 18 in the second right interspace parasternally and 19 radiating up. No S3 or S4 and no diastolic 20 murmur. Abdomen obese. No tenderness, masses or 21 bruits in extremities, no edema. 22 Impression. One, prosthetic aortic 23 valve, systolic ejection murmur, aortic 24 stenosis. Two, mild carotid vascular disease. 25 Three, diabetes, mild.</p>	<p>Page 40</p> <p>1 your patients, what was your understanding as to 2 his responsibilities? 3 A. To take care of the patient as far as 4 he could go. 5 Q. Now, if he took calls on one of your 6 patients, would he usually notify you about that 7 call? 8 MR. KILBANE: Objection. 9 A. Usually, but not always. 10 Q. If one of your patients were seen in 11 the emergency room, would he usually notify you 12 in that type of an instance? 13 MR. KILBANE: Objection. 14 A. It depends on the circumstances. If 15 everything was taken care of and nothing needed 16 to be followed up, no. 17 Q. Did you keep any type of a phone log 18 or other documentation in regard to -- let me 19 rephrase that. 20 Were you given any type of a phone log 21 or any type of documentation when calls were 22 taken on your patients by Dr. Vrobel? 23 A. No. 24 Q. Now, doctor, there was a visit by 25 Earline Mizsey to Southwest General Hospital on</p>

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

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

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

15 MR. KILBANE: Objection.

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

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

25 MR. KILBANE: Objection.

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

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

5 MR. KILBANE: Objection.

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

10 Should it be anywhere?

11 Q. Yes.

12 A. Yes, it should be somewhere in there.

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

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

17 Q. March 10th, yes.

18 A. Okay.

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

21 A. Not necessarily, no.

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

25 A. She may have had a standing

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1 A. I have no idea.

2 Q. Did Dr. Vrobel contact you about
3 Earline Mizsey's presentation to Southwest
4 General Hospital on March 3rd -- I'm sorry, March
5 10th of '98?

6 A. I don't recall any such communication.

7 Q. Do you recall or have any
8 documentation that would indicate such that you
9 contacted Earline Mizsey on the morning of March
10 11th of '98?

11 A. I have no notation to that effect.

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

21 MR. KILBANE: Objection.

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

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1 appointment. That might have been quite
2 appropriate.

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

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

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

16 You have no recollection of speaking
17 to her?

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

21 Q. Why is that?

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

11 (Pages 41 to 44)

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1 Q. Well, doctor, she was seen three days
2 after this by Dr. Einstadter in the Metro
3 outpatient department.
4 A. Okay.
5 Q. And if you look at the tail end of Dr.
6 Einstadter's notes, where he has his assessments,
7 he indicates symptoms consistent with acute CVA.
8 Do you see that?
9 A. Yes.
10 Q. So if she presented to the ER with
11 what appeared to be TIA symptoms and three days
12 later Dr. Einstadter is saying symptoms are
13 consistent with acute CVA, it wouldn't suggest
14 that her symptoms cleared up, would it?
15 MR. KILBANE: Objection.
16 A. Could I hear the first part of that
17 question again?
18 Q. I said, if she presented to the
19 emergency room with symptoms that appeared to be
20 a TIA and then she is seen by Dr. Einstadter
21 three days later and he is saying that her
22 symptoms are consistent with acute CVA, it
23 wouldn't appear that her symptoms cleared up,
24 would it?
25 MR. KILBANE: Objection.

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

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

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1 said that.
2 MR. KILBANE: I guess my point is, he
3 wasn't involved with this interaction with the
4 patient. This is Dr. Einstadter. You have taken
5 his deposition.
6 I am just asking, to be fair to this
7 witness and to be accommodating to everybody's
8 time, I think it would be only fair to ask him
9 about his involvement and try not to ask him
10 standard of care questions about care he wasn't
11 involved in.
12 MR. TOSTI: Well, he was involved
13 before and after these events and so some of this
14 information may impact as to what his care was
15 down the road. So I do think that they are
16 pertinent.
17 MR. KILBANE: I think asking him what
18 Dr. Einstadter was thinking or why he was
19 thinking it, I'm not sure how that fits in. And
20 I understand and you are entitled to your
21 discovery.
22 MS. TOSTI: I didn't ask what Dr.
23 Einstadter was thinking.
24 MR. KILBANE: You are asking him to
25 interpret these records and determine why he is

12 (Pages 45 to 48)

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

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1 A. The fact is that he did set a sequence
2 that he thought was appropriate for what the
3 patient came in with. He was considering emboli,
4 and obviously I think his priority for the
5 carotids as a prime source is evidenced by the
6 fact that it's the first thing that he mentioned,
7 not the second thing he mentioned.
8 And my assumption is that if he felt
9 no source in the carotids, we then consider it a
10 possibility for an echo, but that was not his top
11 priority. And the way he put the thing together,
12 that was the sequence he felt that should be
13 followed. And I can't fault that.
14 Q. Should the carotid ultrasound have
15 been done on a high priority basis then?
16 MR. KILBANE: Objection.
17 A. That I would defer to the
18 neurologist. Does he need it quickly? Does it
19 make any difference? Does he want a CT scan?
20 There are a lot of factors. I don't know.
21 Q. Did you have any conversations with
22 Dr. Einstadter regarding Earline Mizsey's visit
23 to Southwest General Hospital on March 10th or
24 his findings when he saw her on March 13th of
25 '98?

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

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

13 (Pages 49 to 52)

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1 Q. If you have no opinion, we will move
2 on to the next question. But if you do, I would
3 like to hear what that is.
4 A. Fairenough.
5 Q. Doctor, you have the chart opened to
6 the transthoracic echo that was done on April
7 9th, I believe; is that correct?
8 A. Yes.
9 Q. Now, at the very bottom of that
10 report, the last two lines, it indicates that the
11 above suggests bioprosthetic deterioration which
12 could be a potential embolic source. TEE may be
13 helpful in further clarifying.
14 Do you see where I am reading from?
15 A. Yes.
16 Q. With this type of a result, do you
17 have an opinion as to when a TEE should have been
18 done?
19 MR. KILBANE: Objection.
20 A. No. No, I don't.
21 Q. Do you have an opinion as to whether a
22 TEE was indicated after this type of a report on
23 Earline Mizsey?
24 A. Not necessarily, no.
25 Q. And why do you say not necessarily?

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1 rest. She also had a temperature at the time of
2 her presentation, a small one. I think it was
3 37.6.
4 Given the results of that echo that we
5 just looked at that indicated bioprosthetic valve
6 deterioration, that suggested a potential embolic
7 source, and these new symptoms of sudden onset of
8 pain that is not relieved by rest, should there
9 have been a heightened suspicion for arterial
10 embolism in this patient?
11 MR. KILBANE: Objection.
12 A. Not necessarily. Again, it's in the
13 context of a lady with diabetes, hypertension,
14 hyperlipidemia, known vascular disease, and a
15 prime setup for occlusions anywhere.
16 Q. Doctor, you can have peripheral
17 vascular disease and also have embolism to the
18 legs, couldn't you?
19 A. Absolutely.
20 Q. Now, doctor, you cared for Earline
21 Mizsey after she was admitted into the hospital
22 during a portion of the time of her May 8th
23 admission, through, I believe, May 15th.
24 Do you have an opinion as to whether
25 the deterioration suggested on her echo that we

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

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1 just looked at was due to bacterial
2 endocarditis?
3 MR. KILBANE: Objection.
4 A. Do you have the date of that? You say
5 I took care of her or I saw her?
6 Q. During her May 8th through May 15th --
7 A. A consultation?
8 Q. Yes.
9 A. Where would that be?
10 MR. KILBANE: Do you want to see the
11 consultation?
12 THE WITNESS: Yes.
13 A. I think I did render an opinion with
14 regard to that.
15 Q. I think the first progress note that I
16 saw was on the 12th.
17 A. On the 12th?
18 Q. Yes, here, right.
19 A. Right, and my opinion was she had no
20 stigmata of endocarditis at the time.
21 Q. Was May 1st the first time you saw her
22 during that admission?
23 A. I think that's probably correct. What
24 was the date of that?
25 MR. KILBANE: The admission starts

14 (Pages 53 to 56)

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1 here on the 8th.
2 THE WITNESS: The date I saw her?
3 MR. KILBANE: On the 12th also.
4 A. I think that was the first and
5 apparently the only time, as far as I can tell.
6 There may have been one other note here.
7 Q. We will look through that in a
8 minute. I have a couple other notes that we may
9 look at.
10 How is it that you came to see her on
11 May 12th of '98?
12 A. It is probable that the personnel on
13 the ward asked us to come see her.
14 Q. As a consult?
15 A. As a consult.
16 Q. So one of her attending physicians
17 requested that you consult on the patient?
18 A. Right.
19 Q. Do you know who that was?
20 A. I have no idea.
21 MR. KILBANE: Do you want to see the
22 order?
23 THE WITNESS: No, I want to see the
24 fellow's note. It's on that. It said who
25 requested.

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1 A. According to the fellow's note, Dr.
2 McKinley requested the consult.
3 Q. Are you referring to a consultation
4 sheet that has, I believe, Dr. Sakiewicz and
5 Rakita at the top?
6 A. That's correct.
7 Q. Dr. Sakiewicz, is he a fellow?
8 A. He is a fellow -- was a fellow at the
9 time.
10 Q. So the note that he wrote would have
11 been written in consultation with you, would that
12 be correct?
13 A. He would have written it beforehand
14 and then presented it to me.
15 Q. Did you and he see the patient
16 together?
17 A. I can't recall.
18 Q. Based on your review of the records,
19 what was your understanding as to what brought
20 her to the hospital on May 8th and that
21 subsequently caused you to see her?
22 A. My understanding was that she had had
23 a stroke and had had an obstruction to an artery
24 that is, in the note, in her right popliteal.
25 Q. And was the reason that you were

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

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1 your patient previously; correct?
2 A. I knew her background history, yes.
3 Q. Did you do an examination of Earline
4 Mizsey when you saw her on the 1st?
5 A. I did an examination and I think I
6 recorded that. I also had an opinion as to her
7 status at that time, because what happened is
8 these pages are out of order in here, okay? The
9 continuation of the note that you have on the
10 12th has an end to it. It says, I believe she
11 needs to be treated as endocarditis in spite of
12 the -- I can't read my handwriting -- absence of
13 signs of bacterial endocarditis. No petechia, no
14 Osler nodes, no Roth spots, no spondylomegaly, et
15 cetera.
16 She does have a prosthetic valve, high
17 white count and multiple peripheral emboli -- I
18 assume they were emboli at that point, my
19 assumption. Will continue to follow. And I
20 said, please send her to my clinic for follow up
21 for post discharge. Do you have that one?
22 Q. Yes, I have both pages. Mine are in
23 the right order.
24 A. These are not.
25 Q. So, doctor, did you believe at the

15 (Pages 57 to 60)

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1 time that you saw her on the 12th that she likely
2 had endocarditis?
3 A. I believe that there was a possibility
4 that she had endocarditis.
5 Q. Did you think it was likely?
6 A. I had no idea.
7 Q. When you saw her on the 1st, were you
8 aware of any positive blood cultures that she
9 had?
10 A. No, I was not.
11 Q. And the reason that I ask is there is
12 a note by Dr. McKinley that comes just before
13 yours. If you turn back one page.
14 A. Right.
15 Q. And in the middle of that note on
16 about the 7th line down, it now says, now one
17 blood culture is positive.
18 A. Yes.
19 Q. And I'm wondering if at the time that
20 you saw the patient, since your note appears to
21 fall after Dr. McKinley's, whether you were aware
22 of the positive blood culture at that time?
23 A. I don't believe I was, because my note
24 doesn't even mention that.
25 Q. If she had a positive blood culture at

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

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

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1 A. According to my note, I suggested that
2 she be treated, based on, I presume, on the echo,
3 based on the positive blood culture. Putting all
4 those together, it sounds like a good bet.
5 Q. And what would that treatment entail?
6 A. Antibiotics, appropriate for the
7 organism that was identified.
8 Q. Did you confer with anyone in regard
9 to what the appropriate antibiotics would be?
10 A. No, I would leave that to the
11 infectious disease consultant.
12 Q. Did you review any of the tapes from
13 any of her echoes at any time?
14 A. I can't recall.
15 Q. When she first came in, she had a -- I
16 believe it was a transesophageal echo done. Do
17 you know whether that study fully evaluated her
18 aortic valve?
19 A. This is on the 8th?
20 Q. Yes, the 8th.
21 A. I can't really tell you. I can just
22 tell you what it says and you can read it as well
23 as I can. He said he saw the valve and there was
24 no evidence of any thrombus at that time on the
25 8th.

16 (Pages 61 to 64)

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1 Q. Dr. Josephy, I believe, also wrote a
2 note in the progress note in regard to that
3 echocardiogram on the 8th, and he indicated in
4 his note unable to fully evaluate the aortic
5 valve.

6 A. I will take his word for it.

7 Q. If that study did not fully evaluate
8 the aortic valve, would it be reliable in noting
9 vegetations?

10 A. He couldn't rule out vegetations.

11 Q. Okay.

12 A. And that's why the TEE is the next
13 step.

14 Q. Well, I believe that one was a TEE.

15 A. That was a TEE, right.

16 Q. Assuming that that TEE study did not
17 fully evaluate the aortic valve, would it be
18 reliable for ruling out vegetations?

19 A. If it is not adequate, then it's not
20 adequate for totally ruling it out, no.

21 Q. Now, doctor, I noted another note that
22 I think may have been yours that was written on
23 May 13th, and I would like you to turn to the
24 clinical notes of May 13th, and if you could tell
25 me if that is indeed a note that you wrote.

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1 believe the only hope is for the valve to be
2 replaced. Will obtain the patient's agreement.
3 Consider this very high risk surgery. If she
4 says yes, we will contact the appropriate surgeon
5 to see if they would agree to operate.

6 Q. Why did you consider the replacement
7 of the valve as her only hope?

8 A. Because the presence of an abscess
9 already being there makes the possibility of cure
10 of antibiotic less likely. The possibility of
11 perforation by that abscess also becomes a
12 problem.

13 Q. Now, you noted that this was very high
14 risk surgery.

15 A. Right.

16 Q. Was that in a large part due to the
17 multiple strokes that she had had?

18 A. Multiple strokes, her prior disease,
19 the effects on her heart, her diabetes, and other
20 vascular problems, all that made her a high risk
21 candidate, and she was -- I hate to say this --
22 an elderly lady.

23 Q. Now, I believe she was transferred
24 into the coronary care unit on May 14th of '98.
25 Did you participate in her care after her

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1 I have a copy of it here. Is this a
2 note that you wrote on May 13th?

3 A. Yes, that's my handwriting.

4 Q. Could you just read that note for us,
5 please.

6 A. Speech is worse. I think repeat TEE
7 is warranted. I cannot hear any new murmurs
8 today. However, I think logically the aortic
9 valve is the site of these multiple emboli.

10 Q. Why on the 13th did you think the
11 aortic valve was the site of the multiple emboli?

12 A. Because they had demonstrated thrombus
13 on the valve.

14 Q. And would that be based on the echo
15 that we had just looked at on the 12th?

16 A. On the 12th, right.

17 Q. Now, doctor, I think that there is
18 another note on the 14th that may also be in your
19 handwriting. And if you could turn to the
20 clinical notes of the 14th. If you would read
21 that note to us, I would appreciate it, if it is
22 yours.

23 A. That's my signature. We have been
24 informed that the TEE confirmed the presence of
25 vegetations and the probability of an abscess. I

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1 transfer into the intensive care?

2 A. I believe not. Once she is in the
3 CCU, then Dr. Vrobel would become the responsible
4 physician.

5 Q. Did you make any attempts to obtain
6 permission from her for surgery?

7 A. I can't recall.

8 Q. Did you make any contact with any
9 thoracic surgeons regarding her surgery?

10 A. I would think that Dr. Vrobel would be
11 responsible at that time. I can't recall that.

12 Q. I am asking whether you did.

13 A. I'm not even sure.

14 Q. Did you discuss your impressions with
15 the Mizsey family, anyone in the Mizsey family?

16 A. I don't recall that.

17 Q. Do you recall any conversations with
18 Earline Mizsey?

19 A. I recall very little about the whole
20 incident.

21 Q. Doctor, in her state of health at the
22 time that you saw her, did you have an opinion as
23 to what her chances of surviving the surgery
24 would have been?

25 A. No. I would leave that to the

17 (Pages 65 to 68)

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1 surgeons.
2 Q. After she was transferred to Cleveland
3 Clinic, did you have any contact with any of the
4 physicians at Cleveland Clinic regarding this
5 patient?
6 A. None whatsoever. To my knowledge.
7 Q. And after she left Metro on the 15th,
8 did you have any further contact with Earline
9 Mizsey?
10 A. I don't recall any contact with her.
11 Q. Do you know whether Earline Mizsey
12 ever underwent replacement of her infected valve?
13 A. I read the note from Dr. Tomford, and,
14 no, she did not have.
15 Q. Now, doctor, she had an echo done
16 almost two months after discharge.
17 A. From the Clinic?
18 Q. Almost two months after discharge from
19 Metro.
20 A. From Metro.
21 Q. And it was done at the Clinic on July
22 9th. And she was found to have mobile echo
23 densities on that echo. Would that be suggestive
24 of ongoing endocarditis if she had mobile echo
25 densities two months after discharge?

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1 Mizsey developed her bacterial endocarditis?
2 A. I really don't know.
3 Q. Do you have an opinion as to a point
4 in time when Earline Mizsey became too high risk
5 for surgical replacement of her infected heart
6 valve?
7 MR. KILBANE: Objection.
8 A. I am trying to think back. If I can go
9 back to your last question.
10 Q. Yes.
11 A. It seems to me we have a
12 transesophageal on the 8th with no question of
13 changes on the 12th, which would suggest to me
14 that sometime between the 8th and 12th is when
15 the endocarditis became manifest, between May 8th
16 and May 12th, but exactly when, I can't tell you.
17 Q. We also looked at a note that was
18 written by the physician that performed the May
19 8th echo where he indicated that he wasn't able
20 to fully evaluate the aortic valve, and I think
21 you told me that you could not reliably rule out
22 vegetations if, in fact, you were unable to fully
23 evaluate the aortic valve?
24 A. That's correct, you couldn't rule it
25 out, but the probability of having such

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

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

18 (Pages 69 to 72)

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1 wrote on May 12th then. In the second part of
2 that note that's written on the other page about
3 halfway through it you indicate there that the
4 patient had multiple peripheral emboli.
5 A. Right.
6 Q. Two to the head and one to her leg.
7 A. Right.
8 Q. Now, when did you think that those two
9 emboli to her head occurred?
10 A. Somewhere between the 8th and the
11 12th.
12 Q. Okay. And how about to her leg?
13 A. When did she come in? What was the
14 date of that?
15 Q. She came in on May 8th.
16 A. Somewhere between the 8th and 12th
17 when she began to have the trouble.
18 Q. You are aware in the admission note
19 they documented two events that occurred prior to
20 the admission?
21 A. Yes, she could have had those, as I
22 say, on the basis of her other disease. I have
23 no way of knowing whether those related to the
24 same process that was now ongoing.
25 Q. So it's your understanding that she

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

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1 had two emboli to her head and one to her leg
2 after the time of her admission?
3 A. I suspect. Were those clinical events
4 noted?
5 Q. I am asking you, doctor.
6 A. I am trying to recall. I don't
7 recall. When were those events noted?
8 Q. Well, I believe one was noted back in
9 March and another one in May and that she also
10 had an emergency room visit where she had the
11 severe pain, that we reviewed, in her leg that
12 was of sudden onset.
13 A. Yes.
14 Q. And so I am asking what your
15 impressions were.
16 A. My impressions are that we had
17 diagnosed endocarditis on the 12th definitively,
18 and prior to that we had not.
19 Q. And it was your impression that she
20 had had multiple embolic events as a result of
21 her endocarditis; correct?
22 A. My interpretation on the 12th, when
23 the data were in, that those could have been
24 related to the same process.
25 Q. Now, if she had the embolic events,

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

19 (Pages 73 to 76)

<p style="text-align: right;">Page 77</p> <p>1 Q. Then I take it you do not have an 2 opinion as to her cause of death? 3 A. I have none. 4 Q. You had no contact with the family 5 after her death; is that correct? 6 A. Not that I can recall. 7 Q. If her prosthetic valve endocarditis 8 had been successfully treated before she suffered 9 a stroke on May 8th, do you have an opinion as to 10 what her reasonable life expectancy would have 11 been? 12 A. I have no idea. 13 Q. Do you have any criticisms of anyone 14 that rendered care to her? 15 A. I have none. I think they did what 16 was appropriate. 17 Q. Do you blame Earline Mizsey in any way 18 for the complications that she suffered? 19 MR. KILBANE: Objection. 20 A. Blame Mrs. Mizsey? 21 Q. Yes. 22 A. No. 23 MS. TOSTI: I don't have any further 24 questions for you, doctor. 25 MR. KILBANE: We will read it.</p>	<p style="text-align: right;">Page 79</p> <p>1 AFFIDAVIT 2 I have read the foregoing transcript from 3 page 1 through 78 and note the following 4 corrections: 5 PAGE LINE REQUESTED CHANGE 6 7 8 9 10 11 12 13 14 15 16 17 18 LOUIS RAKITA, M.D. 19 Subscribed and sworn to before me this 20 day of , 2001. 21 22 23 Notary Public 24 25 My commission expires</p>
<p style="text-align: right;">Page 78</p> <p>1 2 (Deposition concluded at 5:55 p.m.) 3 (Signature not waived.) 4 5 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;">Page 80</p> <p>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 LOUIS RAKITA, M.D. Was by me first duly 9 sworn to testify to the truth, the whole truth 10 and nothing but the truth in the cause aforesaid; 11 that the testimony as above set forth was by me 12 reduced to stenotypy, afterwards transcribed, and 13 that the foregoing is a true and correct 14 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 IN WITNESS WHEREOF, I have hereunto set my 21 hand and affixed my seal of office at Cleveland, 22 Ohio, on this 14th day of February, 2001. 23 24 25 Vivian L. Gordon, Notary Public Within and for the State of Ohio My commission expires June 8, 2004.</p>

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