ORIGINAL

COURT OF COMMON PLEAS
CUYAHOGA COUNTY
CASE NO. 388614

DIANE COLVIN,
Administratrix, :

Plaintiff, : Deposition of:

v. : CRAIG R. SAUNDERS, M.D.

KEITH KRUITHOFF, M.D., et al., :

Defendants.

TRANSCRIPT of testimony as taken by and before VERA TIBEKIN SITZE, a Certified Shorthand Reporter and Notary Public of the State of New Jersey, at NEWARK BETH ISRAEL MEDICAL CENTER, 201 Lyons Avenue, Newark, New Jersey, on Wednesday, September 20, 2000, commencing at 1:10 in the afternoon.

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I N D E X

E X H I B I T S

(P-1, marked for Identification.)

C R A I G R. S A U N D E R S, M.D.,
Newark Beth Israel Hospital,
201 Lyons Avenue,
Newark, New Jersey 07112, sworn.

MS. TOSTI: Let the record show that this deposition is being taken by agreement of counsel in Newark, New Jersey and Ohio rules apply. And Attorney Steve Skiver is here on behalf of Cleveland Clinic. I'm Jeanne Tosti. I'm here on behalf of plaintiff and Attorney John Polito is here on behalf of defendant Keith Kruithoff and Attorney Ingrid -- Ingrid, would you say your last name for us, please?

MS. KINKOPS-ZAJAC: Kinkops-Zajac.

MS. TOSTI: Is here via speaker phone on behalf of Kaiser and Ohio Permanente Medical Group.

DIRECT EXAMINATION BY MS. TOSTI:

Q. Doctor, would you tell us what your home address is, please?

A. 75 Hardscrabble, H-a-r-d-s-c-r-a-b-b-1-e, Road, Basking Ridge, New Jersey 07920.

MR. SKIVER: It's on your CV, Doctor.

Q. And your current business address? Is it what is listed on your Curriculum Vitae also?
A. Yes.
Q. Who is your current employer?
A. St. Barnabas Health Care System.
Q. And in February through May of 1998, who was your employer?
A. Cleveland Clinic.
Q. And was Cleveland Clinic's main campus your business address at that time?
A. Yes.
Q. Have you ever had your deposition taken before?
A. Yes.
Q. How many times?
A. Three or four.
Q. And were those depositions taken in a medical negligence case?
A. Yes.
Q. I'm going to go over some of the ground rules for a deposition. I'm sure defense counsel has had an opportunity to speak with you.
This is a question-and-answer session. It's under oath. It's important that

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

If at any point you would like to refer to the medical records, I'm sure counsel has provided you with a copy to look at, feel free to do so. Also, I would ask that you give all of your answers verbally because the court reporter cannot take down head nods or hand motions.

At some point during the deposition, defense counsel may choose to enter an objection. You are still required to answer my question unless counsel tells you not to do so. Do you understand those directions?

A. Yes.

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

A. Yes.

Q. How many times?

A. Three or four times.

Q. Where were those cases filed?

A. One in California and the rest in Ohio.

Q. Could you tell me the names of the plaintiffs in those cases?
A. No, I don't recall.
Q. Do you recall any of them?
A. The one in California, her name was Peggy Taylor.
Q. What about the Ohio cases?
A. I don't recall them at this time.
Q. What was the allegation of negligence in those cases? Start with the California case.
A. The California case was a young lady that clotted off her mitral valve several months following valve replacement. She was operated on by a partner of mine and had an arrest.
Q. What was the allegation of negligence?
A. Frankly, I don't know.
Q. In the Ohio cases?
A. There was a patient by the name of Broadwater (phonetic) who had serious complications following his fifth open-heart operation. He had a Ross procedure. He died several months following that procedure.
Q. And what was the alleged

negligence?
A. It involved whether a totally obstructed right coronary artery should have been ligated and whether that contributed to his ultimate demise.
Q. What about the other Ohio cases?
MR. SKITTER: Jeanne, just for the record, I'm going to have a running objection to all of these cases. Go ahead, Doctor.
MS. TOSTI: Fine.
A. I don't recall the specifics nor the names of any other cases that have been filed.
Q. How was the California case resolved?
A. I don't know how it was ultimately resolved. I was not held negligent.
Q. Do you know if the case was settled or if it went to trial?
A. I don't believe it went to trial.
Q. How about the Ohio cases?
A. I don't believe that went to trial either.
Q. Were any of those cases settled in favor of plaintiff?
A. I think the Broadwater case was. I don't know the details.
Q. What about the other Ohio cases?

A. I don't recall them.

Q. Do you have any -- aside from this case currently against Cleveland Clinic, do you have any medical negligence actions currently pending against you?

A. There's a case that was just filed here in New Jersey. The patient's name is Sheehan (phonetic). She had open-heart surgery. She bled from the arterial line from her femoral artery placed by the anesthesiologist. She died of a retroperitoneal hemorrhage and I was listed in that case. It's in the discovery phase.

Q. Doctor, in what states are you currently licensed?

A. New Jersey.

Q. And in 1998, what states were you licensed in?

A. Ohio.

Q. Has your medical license in Ohio or in any other state ever been suspended, revoked or called into question?

A. Never.

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

A. No.

Q. Have you ever given testimony at trial or in deposition in a case involving issues dealing with bacterial endocarditis?
A. No.
Q. Do you recall the case of --
A. Excuse me. That may be an error because the Broadwater case maybe started off as endocarditis.
Q. Do you recall the case of the client by the name of Charlotte Herbert that developed endocarditis?
A. Yes, I do.
Q. Did you give deposition testimony in that case?
A. Yes, I did.
Q. And that case involved issues of endocarditis. Correct?
A. I believe it did. I don't recall the details.
Q. Doctor, counsel has provided me with a copy of your curriculum vitae. You have a copy in front of you. We've marked it as Plaintiff's Exhibit 1.
If you would tell me whether this curriculum vitae is current and up-to-date and as

to whether there are any additions or corrections you would like to make to it.
A. It's the current one that I'm using. I don't want to make any additions or corrections.
Q. You are board certified in general surgery and thoracic surgery. Is that correct?
A. I'm board certified in thoracic surgery.
Q. Is there a subspecialty board certification in cardiothoracic surgery?
Is there one available in cardiothoracic surgery?
A. I don't understand your question.
Q. You are certified in thoracic surgery. I'm just inquiring as to whether there is a professional board certification that's a subspecialty in cardiothoracic surgery.
A. That includes cardiothoracic surgery.
Q. There isn't a separate one for cardiothoracic. Is that correct?
A. This is the one for cardiothoracic.
Q. You've completed a fellowship at Cleveland Clinic in thoracic and cardiovascular surgery as part of your training. Is that correct?
A. That's correct.

Q. Between 1978 and 1980?
A. Yes.
Q. And following that, you practiced in California for a period of time and then returned to Cleveland Clinic. Is that correct?
A. Yes.
Q. You returned as a staff physician in the Department of Thoracic and Cardiovascular Surgery?
A. Yes.
Q. In 1998, is that the date that you returned to Cleveland Clinic?
MR. SKIVER: 1998?
MS. TOSTI: I'm sorry.
Q. Let me withdraw that.
In 1998, did you hold any administrative positions at the Cleveland Clinic?
A. I had the title of Director of Affiliate Programs.
Q. What were your duties and responsibilities as Director of Affiliate Programs?
A. To help develop the Affiliate Surgical Programs at Elyria, E-1-y-r-i-a, Memorial Hospital. Also at Lake West.

Q. In 1998, would you describe what your typical work schedule was? How you broke down your typical workweek.
A. Well, I was doing an average of two or three open-hearts a day and worked from between six, seven o'clock in the morning until whenever it was done late at night. Occasionally I would visit one of the affiliate hospitals and occasionally do a case there.
Q. So the majority of your surgeries were done at Cleveland Clinic's main campus. Is that correct?
A. Yes.
Q. Were you at Cleveland Clinic then on a daily basis?
A. Yes.
Q. Were you there on the weekends at all?
A. Yes.
Q. Routinely were you there on Saturdays and Sundays?
A. Yes.
Q. When you were doing surgeries at Cleveland Clinic's main campus, was there a particular time of the day that you would make

rounds on patients?
A. In the mornings, between cases and in the evenings.
Q. Have you ever had your hospital privileges called into question, suspended or revoked?
A. No.
Q. Doctor, in regard to your curriculum vitae that we have marked as Plaintiff's Exhibit 1, do any of the publications listed on your vitae deal with the subject matter of infective endocarditis?
A. No.
Q. Any with prosthetic heart valves?
A. No.
Q. I believe you've also listed a number of presentations that you've made.
Do any of the presentations deal with the subject matter of infective endocarditis?
A. No.
Q. And the same question with regard to prosthetic heart valves.
A. They do not.
MR. SKIVER: Doctor, could you try and keep your voice up so she can hear on the

phone?

Can you hear all right, Ingrid?

MS. KINKOPS-ZAJAC: That's okay.

MR. SKIVER: All right.

Q. Have you given any formal presentations or lectures on those two subjects?

A. No.

Q. Tell me what you have reviewed in preparation for this deposition.

A. I've superficially reviewed the copy of the medical records that was given to me.

Q. Anything else?

A. No.

Q. When you mentioned the medical records, were those Cleveland Clinic medical records?

A. The records provided to me by my attorney.

MS. TOSTI: I'm going to ask, I'd like to know --

MR. SKIVER: It was the first hospitalization, a portion of that for the admission of 2/4/98. He was not sent the entire record. And then I think a portion of the record for the admission of 5/12.

MR. TOSTI: He has not reviewed

Kaiser records. Is that correct?

MR. SKIVER: That's correct, he has not. And he did not look at the records from the mid-February admission.

MR. POLITO: Did not?

MR. SKIVER: Did not.

Q. Have you reviewed any deposition testimony in this case?

A. No.

Q. And have you at any time reviewed any tapes of the echocardiograms done on Gregory Colvin?

A. No.

Q. And since this case was filed, have you discussed this case with any physicians other than Dr. Skiver (sic)?

A. No.

Q. Have you discussed this case with anyone else?

A. No.

Q. And aside from any notes that may appear in the Cleveland Clinic records, do you have any personal notes or personal file on this case?

A. No.

Q. Have you ever generated any such notes?
A. No.
Q. Have you ever seen any personal notes or summaries generated by Dr. Keith Kruithoff relative to Gregory Colvin?
A. No.
Q. Have you ever discussed any such notes with Dr. Kreithoff?
A. No.
Q. Doctor, is there a textbook in your field of practice that you consider to be the best or the most reliable?
A. No, I don't know what that would be.
Q. Are there any that you use in your clinical practice, any textbooks?
A. No.
Q. Are there any specific publications, as you sit here today, that you believe have particular relevance to the issues in this case?
A. No.
Q. Have you ever participated in any research dealing with the subject matter of infective endocarditis?

A. No.
Q. Is your current thoracic surgery practice limited to any particular type of thoracic surgery?
A. Adult acquired heart disease.
MS. KINKOPS-ZAJAC: Doctor, if you could please speak up, I would greatly appreciate it.
Q. What is early prosthetic valve endocarditis?
A. It's an infection of the valve that's been placed -- the artificial valve that's been placed in the early postoperative period which is defined variably, but within the first six months maybe. Maybe as much as the first 12 months.
Q. And what's the incidence of early prosthetic valve endocarditis after valve replacement surgery?
A. Very low. Probably about one percent.
Q. And was that also true in 1998? Approximately one percent?
A. Yes.
Q. How often do you see patients with prosthetic valve endocarditis in your practice?
A. It's pretty rare. Maybe once or twice a

year.

Q. Do you know what Cleveland Clinic's rate of early prosthetic valve endocarditis after surgery was during the last year that you were at Cleveland Clinic?

A. No.

Q. Did you keep statistics on the cases that you did to determine your own rate of early prosthetic valve endocarditis?

A. No.

Q. As a surgeon, wouldn't you want to know how many of your patients were developing infected valves after valve replacement?

A. Yes.

Q. Is there a reason why you didn't keep specific statistics on the cases that you did?

A. The department kept the statistics.

Q. So Cleveland Clinic would have statistics specifically on the cases that you did in regard to early prosthetic valve endocarditis.

A. Of course.

Q. Are there any factors that would increase the patient's risk for early prosthetic valve endocarditis?

A. Yes.
Q. What are those factors?
A. It would include but not be limited to the patient's immunologic status, his general health, etiology of his valvular disease, social habits and circumstances surrounding the valve replacement.
Q. What type of circumstances surrounding the valve replacement would increase the risk for prosthetic valve endocarditis?
A. Difficult technical aspects, the presence of -- the preexisting presence of endocarditis, long pump runs, any contamination that could possibly occur at the time of the surgery or in the perioperative period. Basic surgical tenets.
Q. Would you agree that there has to be a high degree of vigilance for bacterial endocarditis in a patient with prosthetic valve --
A. Yes.
Q. What are the signs and symptoms of prosthetic valve endocarditis?
A. Well, they can be variable, but they normally include fevers, chills, sweats, positive blood cultures, possible emboli, congestive heart failure, renal failure.

Q. An elevated white blood cell count. Would that be one?
A. Yes.
Q. Anemia?
A. Could be.
Q. Increased erythrocyte sedimentation rate?
A. Yes.
Q. Anorexia and weight loss?
A. Sure.
Q. Heart murmur?
A. Yes.
Q. Are there any diagnostic studies that are helpful aside from the ones that we just mentioned that would be helpful in diagnosing prosthetic valve endocarditis?
A. Echocardiogram.
Q. And in regard to the echocardiogram, what would you be looking for in order to determine whether or not there was present prosthetic valve endocarditis?
A. Vegetations or valvular leaks.
Q. Does the patient have to have positive blood cultures before a presumptive diagnosis of prosthetic valve endocarditis can be

made?
A. Not necessarily.
Q. What is culture negative endocarditis?
A. It's endocarditis where the cultures are negative.
Q. Would you agree that negative blood cultures are more likely to occur in a patient with prosthetic valve endocarditis than in an endocarditis patient without a prosthetic valve?
A. I don't know if that's true or not.
Q. And would you agree that blood cultures of some patients with active bacterial endocarditis may persistently culture negative after receiving a short course of antibiotics?
A. It's possible.
Q. Would you agree that you cannot exclude the diagnosis of endocarditis on the basis of a negative echocardiogram alone?
A. I'm not an expert in making the diagnosis of endocarditis.
Q. Would you defer to a cardiologist with expertise in echocardiography on that issue?
A. Yes.
Q. Do you know whether the presence of

a prosthetic valve sometimes interferes with the detection of vegetations on an echocardiogram?
A. I'm not an expert in echocardiograms.
Q. As a cardiothoracic surgeon, do you have the expertise to diagnose prosthetic valve endocarditis? Is that something that falls within your expertise?
A. The diagnosis is almost always made by a cardiologist or a medical physician before it's seen by the surgeons.
Q. What types of complications are associated with prosthetic valve endocarditis?
A. Well, the ones that we've talked about: Fevers, chills, sweats, malaise, weight loss, congestive heart failure, renal insufficiency, emboli, anemia, to list a few.
Q. And how is prosthetic valve endocarditis treated?
A. It's treated most often with a combined medical and surgical approach.
Q. And when you say medical approach, are you speaking about antibiotic therapy?
A. Antibiotics, treatment of congestive failure, treatment of any associated symptoms or sequelae that could occur.

Q. Doctor, would you agree that there has to be a high index of suspicion for bacterial endocarditis when a prosthetic valve patient presents with a fever, fatigue and night sweats?
A. Yes.
Q. Would you agree that sequential echocardiograms performed during the treatment of prosthetic valve endocarditis can assist in making the decision on the necessity for and the timing of surgery?
A. It could be one of the tools to help make the decision, yes.
Q. In prosthetic valve endocarditis, isn't it usually necessary to replace the infected valve in order to cure the endocarditis? In most cases isn't it usually necessary to replace the valve?
A. That's probably correct.
Q. And would you agree that the timing of surgery for replacing an infected prosthetic valve is extremely important in the management of a patient with prosthetic valve endocarditis?
A. Yes.
Q. And if the surgery to replace the infected valve is delayed too long, the patient's

hemodynamic status may deteriorate so seriously that surgery is no longer feasible. Correct?
A. That's one possible outcome.
MS. KINKOPS-ZAJAC: I didn't hear the answer to that.
THE WITNESS: I said that's one possible outcome.
MS. KINKOPS-ZAJAC: Thank you.
Q. And isn't it also true that if prosthetic valve endocarditis goes untreated, it's usually fatal?
A. Well, I'm not sure that that's true. All diseases occur in a bell-shaped curve and although that may be true for the majority of them, I think it would be an error to say that it occurs in all of them.
Q. Well, my question was, it's usually fatal if it goes untreated. Would you agree with that?
A. I'm not sure that that's true.
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. Now, in a patient with prosthetic valve endocarditis, what would be the indicators for undertaking surgical removal and replacement of the infected valve?

A. Would you repeat the question?

MS. TOSTI: Would you read the question back?

(The record is read by the reporter.)

A. Well, one of the first things that you want to do as completely as possible is to attempt to sterilize the valve and to reduce the bacterial infection to eliminate as much as possible the recurrence *of* the endocarditis.

The other thing would be to get the patient in the best shape to survive the surgery.

Q. How do you make a decision as to when you take the patient to surgery then?

A. It's a complicated decision. It's made in conjunction with the recommendations of the cardiologist, if it's an infectious disease, of all the physicians taking care of the patient, and based on the risk-benefit ratio of when the risk is going to be the smallest and the benefit is going to be the greatest. And that's probably

different in every patient.

Q. Isn't one of the objectives to take the patient to surgery for replacement of the prosthetic valve before the patient becomes hemodynamically unstable?

A. Well, that is one of the objectives. But it's also very important, especially in early bacterial endocarditis to try and eliminate the organism and give yourself the best tissue as possible to work with because these are very, very difficult and high-risk operations to get a new valve to fit into that infected site and to stay there and not be infected. So it's a very complex decision and a very complex procedure with a very high risk associated, with the decision to operate or not to operate.

Q. Would you agree that because of the probability of needing valve replacement during the course of prosthetic valve endocarditis, that the patient should be managed in consultation with cardiothoracic surgery?

A. Of course. It's a team effort.

Q. Doctor, do you know whether transesophageal echo or transthoracic echo is more sensitive in picking up signs of vegetative growth

in prosthetic valve endocarditis?
A. I can't specifically answer that question. Usually we rely on the transesophageal echo in surgery a lot. But I know that there are times when the transthoracic echo has advantages over the TEE and vice versa.
Q. Is there a reason why you rely on the transesophageal echo in surgery?
A. Yes. With the chest open, you can't do a transthoracic echo.
Q. Do valvular vegetations have to be present before the diagnosis of prosthetic valve endocarditis can be made?
A. 1 don't believe so.
Q. Would you agree that in the presence of prosthetic valve endocarditis, if the patient develops heart failure that is unresponsive to therapy, surgical treatment should not be delayed?
A. No, I don't think that you could say that across the board. I think that there may be cases where in severe congestive heart failure, there would still be contraindications to doing the surgery.
Q. Let me refine that question then.

If there are no other contraindications for doing the surgery, if a patient becomes unresponsive to therapy and has developed congestive heart failure, would you agree that surgical treatment should not be delayed barring any other complications that would prevent surgery from going forward?

A. That sounds appropriate.

Q. Doctor, I want to talk a little bit just about valve surgery in general, not in conjunction with endocarditis.

Is it typical after initial valve replacement surgery for a patient to have an elevation of temperature for a period of time?

A. Yes, that would be true for anybody having the surgery. It wouldn't be specifically related to the valve -- necessarily specifically related to the valve.

Q. And how long after initial valve replacement surgery would you expect to see temperature fluctuations, elevations?

A. In a hypothetical situation, it could last for several days.

Q. When you say several days, how many days are you referring to?

A. I don't think I could say in a court of law how many days a patient is going to have a temperature. It's such a variable situation. The clinical situations are so variable, patients are so variable, I couldn't say how many days.

Q. Well, is there a point in time after surgery that a temperature elevation would raise a concern in a patient?

A. Every temperature elevation raises a concern.

Q. Doctor, do you have an independent recollection of Gregory Colvin as you sit here today?

A. Could you be more specific?

Q. I'm asking you if you specifically recall Gregory Colvin, any care that you rendered to Gregory Colvin?

A. I remember some generalities. It's very difficult to remember any specifics. I have reviewed the records and have gotten some information from that.

Q. From your recollection or your review of the records, when was the first time that Gregory Colvin came under your care? And if you would like to refer to the records, please

feel free to do so.
A. It was February of 1998.
Q. There is in the medical records a Cardio-Thoracic Surgery Assessment Form that, I believe, is dated January 22nd of 1998. It has your name listed on it as the surgeon.
Do you know whether or not you saw him on that date?
MR. SKIVER: Do you know whether or not you saw him?
A. I don't specifically recall.
Q. I have a copy of it. I'm just interested in knowing whether this was --
MS. TOSTI: Can you put a plaintiff's sticker on this as Plaintiff's Exhibit No. 2A, 2B?
(P-2A and P-2B, marked for Identification.)
Q. Doctor, I've handed you what's been marked as Plaintiff's Exhibit 2A and 2B that is entitled Cardio-Thoracic Surgery Assessment Form.
On page 2 of that -- 2B of that particular exhibit, is that any of your handwriting?
A. Yes.

Q. Okay. The date on this -- about halfway down the page on Exhibit 2B, it looks like a nurse's signature. Would you have seen the patient on or about January 22nd after the nurse did the initial information collection on this patient?

A. I believe so. I think it's safe to assume from this note.

Q. Typically -- and I'm asking what the normal procedure was -- when a patient was scheduled for an elective aortic valve surgery, would a nurse normally see the patient at or about the time that you also would do an examination of the patient?

A. Yes.

MR. SKIVER: This was a mitral valve, not an aortic valve.

MS. TOSTI: I'm sorry. Mitral valve replacement surgery.

Q. When you saw him on or about this date, did you do a physical exam of this patient?

A. I don't specifically recall, but I would have confirmed the findings on the assessment form, yes.

Q. So that would be typically what you

would do is confirm what was written by the nurse that took the initial information?
A. Yes.
Q. When you had an opportunity to assess him, can you tell me what your findings were?
A. Well, as the assessment form says, he was a 49-year-old male with known mitral valve disease and recent history of congestive heart failure and atrial fibrillation. He had an echocardiogram in December. It was listed on the review here that showed he had a four plus mitral insufficiency and a two to three plus tricuspid insufficiency.
Q. And aside from the cardiac problems that you've just indicated, were there any other medical problems that were of concern in this patient?
A. No.
Q. Was it your recommendation that he undergo mitral valve replacement and repair of his tricuspid valve as a result of your assessment?
A. Yes.
Q. Now, you discussed the surgery with Gregory Colvin. Is that correct?
A. I don't specifically recall that, but that

would have been the standard.

Q. On Plaintiff's Exhibit 2B at the bottom of the page under the area that says "Informed Consent Note," would you read us what you wrote there?

A. "Risks and benefits discussed."

Q. And that's your signature at the bottom of the page. Correct?

A. Yes.

Q. So based on that note, did you discuss this with him?

A. My response is the same. Yes.

Q. And what risks and benefits would you typically tell the patient would be a part of this particular type of surgery?

A. I tell them that the risk involved with mitral valve replacement may range from three to seven percent, but that in a young otherwise healthy male, it would certainly be in the lower portion of that. That the risk of not having it done would be one of progressive congestive heart failure and heart deterioration and worsening cardiac problems. So that the risk would be less having the valve replaced than not treating it.

We would talk about the risk of

bleeding, infection, irregular heartbeats and pleural fusions are the main complications that I usually discuss with patients having heart surgery.

Q. Now, you mentioned that the risks were three to seven percent for mitral valve replacement. In Gregory Colvin's case, where do you think he fell?

A. As I said, with him being an otherwise healthy male, he would be in the lower risk of mitral valve replacements.

Q. And in regard to infection, what did you tell him?

A. I don't specifically recall.

Q. Well, what typically would you tell patients in regards to infection for this type of surgery?

A. We tell them that anyone undergoing surgery has a small chance of infection. It could involve incision infections or it could be valve infections. That risk is probably in the range of about one percent.

Q. Now, aside from that assessment that we Just looked at, to your knowledge, did you see him at any other time prior to the time that

he came into Cleveland Clinic for his cardiac surgery which, I believe, was on February 4th?
A. I don't recall.
Q. And the surgery that you performed on Gregory Colvin, what surgery was that?
A. Replacement of his mitral valve with a mechanical prosthesis and angioplasty, tightening of his tricuspid valve.
Q. The type of valve that you surgically implanted, does it have a certain life expectancy?
A. The mechanical valves -- the current mechanical valves that we use generally do not have mechanical failures and do not wear out.
Q. Now, I believe his was a number 33 Medtronic mechanical valve. Is that the type of valve that would be expected not to wear out?
A. I think that is a typographical error. I think it was a CarboMedics mechanical valve. It says it down here in the text. And these valves have been almost entirely free of -- I think they've been completely free of mechanical complications and failure.
Q. Now, in Mr. Colvin's case with successful completion of his surgery, was there

any contemplated future surgery in his case at any point in time that you could reasonably project from your evaluation of this patient?

A. Well, he had rheumatic heart disease as the etiology of his valvular problems. His mitral valve was the worst infected. We hadn't planned on really doing anything with the tricuspid valve because frequently that improves when you replace the mitral valve.

In his situation, a review of the records show that we came off bypass but his right heart didn't do that well and he had kind of an increased insufficiency of the tricuspid valve. So we decided at that point to put the Carpentier-Edwards ring around the tricuspid valve. But he also had a mild amount of aortic insufficiency. It was felt at the time that that was not a significant -- significant enough to warrant valve replacement but certainly in the future, it is possible that he would have progression of the rheumatic process in the aortic valve and require aortic valve replacement.

Q. At the time that you evaluated him, were you in a position to say whether it was likely at some point down the road that he was

going to need work done on his aortic valve?
A. It is possible.
Q. Was it likely he was going to need any additional work done on his tricuspid valve down the road?
A. That's a good question because tricuspid angioplasties are difficult and sometimes it reoccurs. There are different types of angioplasties that are done. That's why I chose to put in a prosthesis to minimize that chance. But somebody with rheumatic heart disease and all three valves are infected, that certainly is a possibility.
Q. So it was possible but you wouldn't be able to say that more likely than not he was going to need additional surgery.
A. It's a possibility.
Q. Did you encounter any problems during his initial valve surgery?
A. Well, as we stated before, we came off -- the record shows we came off bypass; his right heart didn't really respond well. There was increased tricuspid insufficiency. So we went back and fixed that. He did well after that. That would be the only out of the ordinary event.

Q. And were you satisfied with the outcome after you completed the surgery on Gregory Colvin?
A. Yes.
Q. And what was your prognosis for him?
A. Prognosis in what respect?
Q. Following his surgery, you had an opportunity, I'm sure, to see how he was doing. What was your prognosis for his cardiac condition at that point from the perspective of a surgeon?
A. Well, at that point in time having undergone successful mitral valve replacement without complications, we felt that the prognosis was good. Whether there's going to be progression of the other valves or not, we talked about. Frankly, I can't comment on that.
Q. Did you have any idea as to what his reasonable life expectancy would be following the surgery?
A. You know, I couldn't comment on that.
Q. Now, several days after surgery, Gregory Colvin began running a temperature elevation. Why in your opinion did he have a fever several days after surgery?

A. I'm sorry. That would just be conjecture on my part to answer that question at this point.

Q. Would it be typical to see a temperature elevation to 38.8 degrees centigrade six days after the type of surgery that Gregory Colvin had?

A. No.

Q. Would that type of temperature raise a concern for the possibility of infection in a patient?

A. Yes.

Q. In Gregory Colvin's case, was there any type of a work-up for infection done on him during the course of his hospitalization for his valve replacement surgery?

A. I don't recall and I haven't reviewed the records in that regards.

Q. Now, after surgery or in conjunction with the surgery, Gregory Colvin had a central line catheter in place when he was in the ICU. Correct?

A. That would be common, **I** would assume, since he had open-heart surgery, but I have not reviewed the chart and know the specifics of that.

Q. And when a central venous catheter

is inserted, it's usually secured to the skin with a suture. Correct?
A. I believe so.
Q. And when the central venous catheter is removed, the suture is also supposed to be removed. Correct?
A. Yes.
Q. Now, in Gregory Colvin's case, do you know who was responsible for removing his central venous catheter during his February 4th, 1998 admission to the Cleveland Clinic?
A. I do not.
Q. Would that be something that you as a surgeon would do typically?
A. No.
Q. Who would typically be responsible as far as category of personnel for removing a central venous catheter that is sutured to the skin?
A. It could be the ICU nurse; it could be the ICU, the PAs; it could be the floor nurses; it could be the residents; it could be anesthesia.
Q. Now, Gregory Colvin was discharged from his admission when he had his valve surgery on February 12th of 1998.

Did you assess him prior to the time of his discharge?
A. I don't recall.
MS. KINKOPS-ZAJAC: I'm sorry. What was the response?
MR. SKIVER: He doesn't recall.
MS. KINKOPS-ZAJAC: Thank you.
Q. Would you look at the medical records and tell me if you did any type of an assessment prior to the time of his discharge?
MR. SKIVER: You mean what's noted in the chart?
MS. TOSTI: Yes.
A. And the date was the 12th?
Q. I believe he was discharged on February 12th.
A. Here is the 12th. There's a note on February 12th, "CD surgery post-op day eight." I don't recognize the signature. And there's no indication that I saw him at that time.
Q. Did you have a fellow or resident that was working on your service at that time that was seeing your surgical patients?
A. Yes.
Q. Do you know who that person was?

A. I know that Dr. Christie (phonetic) was the assistant in the operation.
Q. Was he a surgical fellow at the time?
A. Yes.
Q. Or resident?
A. Yes.
Q. Would he normally be making rounds on your surgical patients after surgery?
A. Yes.
Q. From your review of the records, did Gregory Colvin have any signs of infection at the time of his discharge?
A. The only indication I have is that he's afebrile, hemodynamically stable, blood pressure 144/58, heart rate -- I believe it says 77 with atrial flutter. I believe it says he was on room air, not receiving oxygen, his wounds are clean, the sternum is stable. It says "For discharge if labs okay."
Q. Following his discharge on February 12th, did you see him in follow-up at any time after that discharge?
A. I don't recall.
Q. Would you normally see a patient

that you did surgery on for follow-up?
A. No.
Q. Who would normally do follow-up on the patient after you've done a valve replacement?
A. He would be discharged home to his cardiologist.
Q. So normally it would be the cardiologist then that would see the patient for the first time after discharge from the hospital for valve replacement. Correct?
A. Yes.
Q. Now, Gregory Colvin was seen in Cleveland Clinic's emergency room on February 23rd of 1998 and he was complaining of intermittent chills and fever, night sweats, generalized body weakness, decreased appetite off and on for a week.

Would you agree that those symptoms in a patient who had recently undergone valve replacement should raise a high index of suspicion for prosthetic valve endocarditis?

MS. KINKOPS-ZAJAC: Objection.
A. What were those symptoms?
Q. Chills, fevers, night sweats, generalized body weakness, decreased appetite off

and on for a week.
A. Prosthetic valve endocarditis would be in the differential diagnosis.
Q. Now, as his surgeon, were you notified that he was admitted to the Cleveland Clinic with the impression of rule out bacterial endocarditis?
A. I don't recall.
Q. Should you have been notified of his admission with that diagnosis considering you were his surgeon?
MS. KINKOPS-ZAJAC: Objection.
A. Having not been there or seen the circumstances, I can't answer that question whether I should have been notified or not.
Q. Well, Doctor, when you put a prosthetic valve into a patient and then shortly thereafter they're back in the emergency room with fever and chills, night sweats and weakness and they come in with an impression of rule out bacterial endocarditis, wouldn't it be prudent to notify the surgeon of record that that patient has come back into the hospital?
MS. KINKOPS-ZAJAC: Objection.
A. Yeah, that would normally be done.

Q. Do you know whether anyone from cardiothoracic surgery was notified that Gregory Colvin was admitted back into the hospital?
A. I don't know.
Q. You would agree that when there's a suspicion of prosthetic valve endocarditis just a few weeks after surgery, cardiothoracic surgery should be involved in the management of the patient. Correct?
A. Yes.
Q. Now, did you at any time see Gregory Colvin during his February 23rd, 1998 admission to the Cleveland Clinic?
A. I don't recall.
Q. Well, I would like you to look through the records of that admission unless Mr. Skiver has already done so and determine --
MR. SKIVER: I haven't. I don't have them with me. Do you have them with you?
MS. TOSTI: I do not have a copy that is not annotated.
Q. So you don't know whether you saw the patient during the February 23rd admission?
A. No, I don't.

Q. Did you at any point ask to see those records to see if you had seen the patient during that admission?
A. No.
Q. Is there a reason why you didn't do that?
A. I was never asked.
Q. Well, Doctor, you knew you had a deposition coming. Weren't you interested to know what care this patient received and what care you participated in in preparation for this deposition?
A. I reviewed the records that I had and the time that I had available.
Q. During that February 23rd hospital admission, Gregory Colvin was noted to have a stitch abscess from a retained silk suture on the right side of his neck at the site of a prior central venous line from which purulent drainage was expressed on more than one occasion.
Would you agree that someone made an error when they did not remove that suture before his discharge from Cleveland Clinic on February 12th of 1998?
A. Well, the suture should have been removed.

Q. Would you agree that an abscess in the neck that was emitting several cc's of pus over a couple of days placed Gregory Colvin at risk for infection of his prosthetic valve?

MR. SKITTER: Objection. *Go* ahead, Doctor.

A. I suppose it's possible.

Q. Doctor, when a patient with a prosthetic valve comes into the hospital with an abscess in his neck and fever of unknown origin and complaints of chills and night sweats, would you agree that the standard of care would require that that purulent drainage be sent for culture?

A. Yes.

Q. And if that wasn't done in Gregory Colvin's case, that would be substandard care. Correct?

A. I don't know the circumstances of his care and I wouldn't want to conjecture.

Can I take a break while you're organizing?

Q. Sure.

(A brief recess is taken.)

(P-3, marked for Identification.)

Q. Doctor, I'm going to hand you

what's been marked as Plaintiff's Exhibit No. 3 which is a report of a transesophageal echocardiogram dated February 24th, 1998 on Gregory Colvin.

Now, Doctor, under the conclusions of that report, it indicates under item number 1 that there's a small echodensity in the anterolateral part of the annulus which is most likely from a suture and suggests a follow-up TEE is recommended to ascertain benign nature of this echodensity. Do you see where I'm reading?

A. Yes.

Q. In Gregory Colvin's case, do you know whether any follow-up on that transesophageal echo was ever done?

A. I don't know.

Q. Would you agree that with Gregory Colorado's history of a prosthetic valve and a fever of unknown origin, night sweats and an abscess in his neck draining pus, it would have been prudent to do a follow-up transesophageal echo specifically to determine if there was any change in that echodensity?

MR. POLITO: Objection.

MS. KINKOPS-ZAJAC: Objection.

A. I'm not an echocardiography expert nor an expert in making the diagnosis.

Q. Well, Doctor, this was your patient and assuming this patient had a fever of unknown origin, complaints of night sweats, would you agree that a follow-up echo would have been prudent in this case?

MR. POLITO: Objection.

MS. KINKOPS-ZAJAC: Objection.

A. He needs to be followed up. Whether he needs a transesophageal echo, whether he needs a transthoracic echo, I have to leave it to the other people.

Q. Doctor, you would agree that anemia is often seen with endocarditis. Correct?

MR. POLITO: Objection.

A. It's one of the many things anemia is seen with.

Q. Following Gregory Colvin's valvular surgery, would you expect his hemoglobin and hematocrit to continue to fall?

A. No.

Q. And in Gregory Colvin's case, would you agree that with his history of a prosthetic valve, fever, night sweats and a stitch abscess as

well as an undetermined echodensity on his echocardiogram, that there should have been a high index of suspicion for prosthetic valve endocarditis?

MR. POLITO: Objection.

A. Yes.

MS. KINKOPS-ZAJAC: Objection.

Q. Now, I take it you have no opinion as to whether or not prosthetic valve endocarditis was ruled out during that February 23rd admission. Is that correct?

A. I have no knowledge of that.

MS. KINKOPS-ZAJAC: Doctor, I'm sorry. Could you speak up, please?

THE WITNESS: Okay.

MR. POLITO: He said he had no knowledge of that.

MS. KINKOPS-ZAJAC: Thank you.

Q. Do you have -- assuming what I told you is correct, you've had an opportunity to see the report of the transesophageal echo, and assuming that when he came into the hospital his complaints were fever as well as the night sweats and that he had a stitch abscess in his neck that was draining purulent material for at least two

days, assuming that to be true, do you have any opinion as to whether a blood culture should have been done on Gregory Colvin after his discharge from Cleveland Clinic on February 27th of 1998?

MR. POLITO: Objection.

MR. SKIVER: I object.

A. It's very difficult for me to answer what should be done in a situation where I've not been involved with and don't know the circumstances.

Q. Did you see Gregory Colvin at any time between the time of his discharge on February 27th and his readmission to Cleveland Clinic on May 12th?

A. I don't recall.

Q. And in the records that you reviewed, did you note anything that would indicate to you that you saw him?

A. I did not.

Q. On May 10th of 1998, Gregory Colvin was seen in the Kaiser of Cleveland emergency room with shortness of breath, fever, complaints of night sweats and a drop in his hemoglobin to 8.8 from a previous level of 10.1 in his last discharge of February 27th of 1998.

Were you notified at that time that

he was seen in the emergency room?
A. I don't recall.
Q. Typically, if you had done surgery on a patient and the patient came into the Kaiser emergency room several months later with those types of symptoms, would Cleveland Clinic's system notify you?
A. What's throwing me there is the Cleveland Clinic system.
Q. The system that was in place in the Kaiser Cleveland Clinic emergency room, would they typically notify you if it was a patient that you had done surgery on and was coming in with those types of complaints?
A. Yes, I think so.
Q. But in this instance, you don't have any recollection of being notified that he was in the emergency room. Correct?
A. I have no specific recall of that.
Q. And you didn't see anything in the records that you reviewed that you were notified. Correct?
A. I didn't review any records with regards to that.
Q. Do you have an opinion as to

whether it was appropriate to discharge him to home following his May 10th, 1998 presentation to the emergency room --

MR. POLITO: Objection.

MS. KINKOPS-ZAJAC: Objection.

MS. TOSTI: Let me finish my question.

Q. -- with complaints of fever, night sweats off and on, shortness of breath and a drop in his hemoglobin?

MR. POLITO: Objection.

MS. KINKOPS-ZAJAC: Objection.

A. I can't comment on specific things that I was not involved with.

Q. Gregory Colvin was eventually admitted to Cleveland Clinic on May 12th of 1998 with a diagnosis of endocarditis.

Were you notified of his admission on May 12th of 1998?

A. There was a note in the chart that I was. Again, I don't specifically recall or don't recall specifics.

Q. Were you notified at the time of his admission on the 12th that he had come into the hospital based on the note that you reviewed?

A. I don't know what the timing was.
Q. Is there a date on the note that you are referring to?
A. The date on the note I'm referring to is 5/13 at 8:20 in the evening.
Q. Can I see the note that you are looking at?
A. (The witness complies.)
Q. Okay. The note that you are referring to, who was that written by?
A. I believe that is Pat Ginley (phonetic) who is one of the physicians' assistants, one of the registered nurses.
Q. And would that individual have notified you of the admission or would you have notified that individual of the admission?
A. He would have notified me.
Q. Do you know what you were told in regard to the patient's condition?
A. No, I don't recall any of the specifics.
Q. Once you were notified that a patient you had done surgery on had been admitted to the hospital with a diagnosis of endocarditis, what would be your normal procedure? What actions would you take following notification?

A. Well, it would depend on the circumstances, but we would go to the floor and see the patient.

Q. On May 13th, did you see the patient?

A. I don't recall.

MS. KINKOPS-ZAJAC: What was the response?

MR. SKIVER: He doesn't recall.

Q. Is there anything in the records that you've looked at that would indicate that you saw Gregory Colvin on May 13th?

A. No.

MS. TOSTI: Would you mark this as an exhibit?

(P-4, marked for Identification.)

Q. Doctor, I'm going to hand you what's been marked as Plaintiff's Exhibit No. 4 which is an echocardiogram report on Gregory Colvin from May 13th, 1998. I believe it's a transesophageal echocardiogram report.

I'd like you to read over the conclusion of that report. I'll give you a second to do that.

A. (The witness complies.)

Q. Would you agree that when a

prosthetic valve patient has vegetations and rocking and dehiscence of the valve with four plus mitral regurgitation, cardiothoracic surgery should be directly involved in the management of that patient in anticipation of valve replacement surgery?

A. Yes.

Q. Would you agree that Gregory Colvin was at high risk for cardiac collapse with a rocking and dehisced valve as described in that transesophageal echo report?

A. Not necessarily.

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

A. The basis of the opinion is, sometimes mitral insufficiency can be well tolerated for extended periods of time.

Q. But, Doctor, when the valve is rocking and dehisced, can that patient tolerate that for an extended period of time also?

A. It can happen, yes.

Q. Did you have any conversations with Dr. Kruithoff about Gregory Colvin's condition before the time of his death?

A. I don't recall.

Q. In your review of the records or your recollection, do you recall seeing Gregory Colvin during this 5/12/98 admission to Cleveland Clinic?

A. In conversations with my counsel --

MR. SKIVER: No. Doctor, don't talk about any conversations with me. The issue is whether or not you saw anything in the records specifically.

Q. Or that you recall seeing this patient while he was a patient there prior to his death.

A. I was told that I went and visited the family and visited the patient in his room. I didn't have a specific recollection of that initially, but after being told that and thinking about it, I do have some recollection of going to see him.

Q. Do you know when that occurred?

A. I don't.

Q. Do you know how many times you saw Gregory Colvin during the course of his hospitalization from May 12th of 1998 until the time of his death?

A. I do not.

Q. Do you know whether you saw him more than once?
A. I saw him at least twice.
Q. And what's the basis for you saying that you saw him at least twice?
A. I saw him initially in his room and then in the ICU on Saturday morning.
Q. Saturday morning, I believe, was the 16th. So you saw him one time prior to the 16th and then you saw him on the 16th.
MR. SKIVER: He said at least.
Q. To the best of your recollection, you saw him at least once prior to the 16th. Correct?
A. Yes.
Q. And then you also saw him on the 16th. Correct?
A. Yes.
Q. On either of those occasions, did you do an assessment of him?
A. Yes.
Q. And what was his condition at the time that you did your assessment?
A. The first time I saw him, to the best of my recollection, he was comfortable. He was in a

regular hospital bed on the floor. He was not in severe failure. He was hemodynamically stable and at that time had a rather markedly prolonged INR. I had been informed of the results of the echos, the problems that he had, and so was aware of the situation.

Q. And was any decision made regarding surgery at that time after your first visit with him?

A. The decision at that time was that surgery would best be deferred because of his bleeding problems because he was hemodynamically stable and that we could decrease the risk of the surgery by postponing it.

Q. Doctor, at that point in time, could he have been taken to surgery even at increased risk?

Was there anything that could be done to take him to surgery at that point in time, albeit an increased risk?

A. Surgery for early prosthetic valve endocarditis is, as we said before, a very high-risk procedure. And bleeding most surely would have been a major complication with an INR of ten. He could have been administered blood

products to improve that.

The risk of that: Massive transfusions, bleeding complications, with his renal insufficiency, and in light of his hemodynamic instability did not seem to be a reasonable approach for the treatment at that time.

MR. SKIVER: Did you say instability or stability?

THE WITNESS: Hemodynamic stability.

Q. The decision as to when to take a patient to surgery, is that a decision made by the cardiothoracic surgeon or is that a joint decision between the cardiologist and the cardiothoracic surgeon?

A. It's a dynamic decision that's made ultimately by the cardiothoracic surgeon with the recommendations of the consultants and depending upon the patient's condition at the time and the recent course of his condition.

Q. Now, you indicated that you also saw him on May 16th which, I believe, was Saturday. Did you do an assessment on him at that point in time?

A. Well, at that time, to the best of my recollection, he was in the treatment room of the CCU and had arrested and they were putting in lines, monitoring lines and trying to resuscitate him and the assessment at that time was that he certainly was not a surgical candidate and we made the decision that the best chance for him to survive this would be if we would place him on extracorporeal membrane oxygenation, ECMO.

Q. And what caused his condition to deteriorate from when you saw him prior to the 16th as to when you saw him on the 16th?

A. Well, I don't know. But he apparently had progressive heart failure and progressive -- not progressive but sudden deterioration of the mitral valve mechanism.

Q. What could cause that to happen?

A. If the valve became clotted or obstructed or if the dehiscence progressed would be the most likely cause for a patient like Gregory Colvin.

Q. Do you know what time you saw him on May 16th?

A. I don't recall.

Q. Do you recall if it was morning or afternoon?

A. As I recall, it was morning.
Q. Now, I'd like you to explain the surgical scheduling procedure used at Cleveland Clinic in 1998 for cases where urgent reoperation was needed to replace a heart valve.
A. Well, any emergent or urgent operation would take precedent over the elective schedule and we would just make room for them.
Q. Who would receive the request for the surgery initially? What was the procedure if the cardiologist felt the patient was deteriorating?
A. Well, he may pick up the phone and call the surgeon; he may call the scheduler; he may call the resident. Anybody on the surgical team might be contacted.
Q. And was there any particular information that they were required to provide if they were calling the surgical scheduler?
A. Well, just -- no particular. Just the circumstances; the routine medical report; the reasons they were calling.
Q. And if you were then to be the surgeon, how would you be notified by the surgical scheduler that there was a surgery that needed to

be done?
A. Well, as I said, it may come from the surgical scheduler; it may come from the attending cardiologist picking up the phone or from the resident. It could come from any member of the team.
Q. But if it was, in fact, coming from the surgical scheduler, how would they contact you?
A. By phone, by walking across the hall, by pager, by whatever mechanism.
Q. Were you carrying a pager at that point in time in 1998?
A. We always had pagers. Whether it was on my person at that time or not, I have no recall.
Q. And what information would the surgical scheduler typically give you on an urgent surgery?
A. He would give me the details of the emergency.
MS. KINKOPS-ZAJAC: What was the response?
THE WITNESS: He would give me the details of the emergency or of the urgency.
MS. KINKOPS-ZAJAC: Thank you.

Q. And if you're notified of an urgent surgery, then what steps would you take?
A. Well, I would go see the patient if I was available or I would send a member of the team to see them and determine the need. It would depend upon the information that was given us.
Q. Did you ever find that the surgical scheduler at Cleveland Clinic failed to give you complete or accurate information regarding a patient's condition?
A. I think the schedulers always gave us as much information that they had to the best of their ability. I'm aware of no circumstances where they gave inaccurate or wrong information.
Q. And did you ever find that the surgical scheduler failed to appropriately prioritize an urgent surgical case?
A. You're asking me to make judgment calls and to comment on situations that I don't know about.
Q. No, Doctor, I'm asking your experience. Did you ever find that the surgical scheduler failed to appropriately prioritize an urgent surgical case in your experience?
A. In my experience they did a great job and did it to the best of their abilities and with the

information that they had.

Q. If a patient needed urgent reoperation to have an infected prosthetic valve replaced, how long would it take to get the patient into surgery once you were notified at the Cleveland Clinic in 1998?

Once the decision was made to take the patient to surgery, how long does that process take to actually get them into surgery?

A. Well, it depends on the circumstances. If I had patients that needed to get there immediately get there immediately. But there are varying degrees of urgency. We always usually had rooms available.

Q. Let me rephrase the question then.

What's the fastest that a patient could be taken into surgery once you as a surgeon were notified and the decision had been made to take the patient to surgery? And I understand that there can be a range.

A. This is a hypothetical question. Is that correct?

Q. I understand that there can be a range depending on the patient's condition, but if speed is a necessity, how quickly can a patient

get into surgery once the decision is made and you've been notified at Cleveland Clinic in 1998?
A. You mean in a hypothetical situation?
Q. Yes.
A. Under ideal terms, however long it takes to push the patient from the ICU up the elevators and into the operating room.
Q. Is the complete surgical team available 24 hours a day at Cleveland Clinic for cardiothoracic surgery?
A. I believe so.
Q. Were you ever notified on Friday, May 15th, 1998 that Gregory Colvin needed urgent reoperation to replace his infected valve?
A. I don't recall the specifics. I know that he was being followed. I know that the cardiologists were concerned about this. We had him on our radar, so to speak, but he remained hemodynamically stable. His bleeding times were abnormal, although were improving. And the judgment was made that the timing of the medical and the surgical treatment did not warrant that he be taken emergently to the operating room on the 15th.
Q. On the 15th were you prepared to do

urgent surgery if that decision was made?
A. If he needed it, we could have done it, yes.
Q. And you don't have any recollection and there's nothing in the records that indicate to you that you were notified on Friday, May 15th that Gregory Colvin needed urgent reoperation. Correct?
A. I don't recall.
Q. You did not receive any notification from the surgical scheduler on May 15th in regard to Gregory Colvin?
A. I don't recall specifics. But, again, the team would have been looking at it; we would have been monitoring the situation and the residents, the schedulers, the surgeons would have been aware of what was going on.
Q. Who was your secretary in May of 1998?
A. Well, I think at that time -- I don't know. I changed secretaries at some point. My main secretary there was Marge -- I can't recall her last name right at this point. I'm not sure when she left. So to answer your question in one word, I don't know or in three words.

Q. Did your office keep a record of phone messages?
A. I don't know.
Q. You don't recall whether they had one of those self-carbonizing books where they jot down the phone message and give you the top layer of the message?
A. I don't know if they had that or not.
Q. Were you told at any time that Gregory Colvin needed urgent surgery?
A. Again, I don't know specifics. We knew that he was going to need surgery. The urgency of it was yet to be determined. The timing of it, I should say. The appropriate timing when we could minimize his perioperative risks and improve that risk-benefit ratio.
Q. You were not told at any point in time that his condition was becoming unstable and that he needed surgery urgently on Friday, May 15th of 1998?
A. It's my recollection after a superficial review of the charts that he had an episode of congestive failure, that he was transferred to the Intensive Care Unit, he responded very rapidly and appropriately and was quite stable.

Q. Were you in the hospital on Friday, May 15th of 1998?
A. I don't recall.
Q. When you saw him on the 16th, were you contemplating surgery at that point in time for him?
A. No.
Q. And was that because his condition had deteriorated to a point that he was too high a risk for surgery?
A. Yes.
Q. Following Gregory Colvin's death, were you contacted by Dr. Kreithoff?
A. Yes.
Q. When did he contact you?
A. I believe it was the following Monday.
Q. Did you meet with him in person?
A. I believe so.
Q. Where did you meet?
A. I believe he came to my office.
Q. Was anyone else present for that meeting besides you and Dr. Kreithoff?
A. I don't believe so.
Q. What was the purpose of that meeting?

A. Well, I believe he was disappointed that the patient died and that he hadn't been operated on before he deteriorated.

Q. Did he tell you he had requested that he go to surgery on Friday, May 15th?

A. I don't recall specifics.

Q. Did Dr. Kreithoff appear angry to you?

A. Again, I have a vague recollection of this /conversation. Angry, I don't know if he was angry but he was concerned about the issues.

Q. Did he ever tell you that a request had been made to the surgical scheduler to schedule urgent valve replacement surgery for Gregory Colvin on Friday, May 15th?

A. I don't recall.

Q. Did you ever tell Dr. Kreithoff that you took full responsibility for not taking Gregory Colvin to surgery on May 15th, 1998?

A. That would have been in line with the way I would have responded. I would have assumed the responsibility for the schedulers, for the PAs and everyone else, yes.

Q. Did you ever tell Dr. Kreithoff that you thought Gregory Colvin should have gone

for reoperation on May 15th, 1998?
A. Well, I don't recall the specifics of that, but it's pretty easy to say yes in retrospect and knowing the results on the 16th. But I'm not sure how that has any bearing on the decision-making on the 15th.
Q. Did you ever tell Dr. Kreithoff that you received false information from the surgical scheduler regarding the status of Gregory Colvin?
A. That would have been out of character for me. I don't recall doing that.
Q. Did you ever tell Dr. Kreithoff that the triage system of having the surgical scheduler schedule patients for surgery was a poor one?
A. I don't have a specific recollection of that and I doubt that I would have been that critical. It would have been more in character to say it was a difficult one.
Q. Why was it a difficult one?
A. There are 15 to 20 patients going to surgery at the Cleveland Clinic on any one day. And the management of that schedule is very difficult.

Q. Did you ever have any problems with the scheduling of surgical patients at Cleveland Clinic?
A. Can I go off the record and say that that's like asking a question when did you stop beating your wife? Because it's just not an appropriate question. Of course there's problems in everything you do. Do you ever have problems with anything? Do you ever have problems with your husband? Of course there's difficulties.
Q. What difficulties did you have in regard to the surgical scheduling of patients at the Cleveland Clinic, Doctor?
A. Well, I'm simply saying it's a very high volume, a very difficult job and the scheduling of patients is -- and the appropriate timing of it is always difficult.
Q. Did you ever find that you couldn't get a patient into surgery at a time that you in your clinical judgment felt was best for the patient?
A. No.
Q. Did you ever tell Dr. Kreithoff that the triage system of having surgical schedulers schedule patients for surgery was the

nail in the coffin as to why you were leaving the Cleveland Clinic?
A. I heard that statement. I did not leave the clinic under any adverse conditions or under any complaints. And certainly the scheduling problems would not be the reason that I would leave the Cleveland Clinic. I think the Cleveland Clinic is a premier institution in the country and the reason I left is because I had a job where I could head the department and I looked at it as a professional advancement that was afforded to me by my participation and being on the staff at the Cleveland Clinic.
Q. My question to you was, did you ever say that to Dr. Kruithoff? Is your answer to that question no?
A. My answer to that is, I have no recollection of saying anything like that and as I explained, it would have been totally out of character to say something like that for me.
Q. Did you ever tell Dr. Kreithoff that the case of Gregory Colvin had conclusively made up your mind to leave the Cleveland Clinic?
A. Absolutely not. The case of Gregory Colvin was never an issue of whether or not I would

accept this position. And leaving the Cleveland Clinic -- I want it perfectly clear on the record that leaving the Cleveland Clinic was not of my -- my leaving the Cleveland Clinic was never anything negative that happened there or the operation of the Cleveland Clinic.

Q. Did you ever tell the administration of Cleveland Clinic that you were dissatisfied with the triage system of scheduling surgical patients?

A. Not that I'm aware.

Q. During Gregory Colvin's admission of May 12th, 1998 to the Cleveland Clinic, do you recall having any contact with any of the physicians that rendered care to him?

A. I don't recall specifics of them.

Q. Aside from the conversation that you had with Dr. Kreithoff, do you recall after his death having any discussions with any of his physicians?

A. I don't recall.

Q. At any time during his May 12th, 1998 admission or thereafter, do you recall having any conversations with Gregory Colvin's family?

A. I'm sorry. Would you repeat that?

Q. Yes. I'm asking whether during his admission of May 12th, 1998 or after his death, did you have any conversations with Gregory Colvin's family?
A. Well, I do have a recollection of seeing him preoperatively going to his room. I don't recall specifics of talking to them afterwards, although I may have. I'm trying to recall. I'm trying to draw up some memories of that, whether I talked to them after his death in the ICU or the placement of the ECMO. And most likely I would have. As you jog my memory here, I think maybe I did talk to them in the hallway but I don't recall.
Q. You don't have a specific recollection of the conversation.
A. No, I don't. No, I don't.
Q. Do you have an opinion as to when Gregory Colvin developed bacterial endocarditis?
A. Well, in retrospect, it's easy to go back and look at his temperatures and connect the dots back to his hospitalization. But that's only with the benefit of reviewing and having retrospect.
Q. Well, in retrospect, Doctor, do you have an opinion as to when Gregory Colvin

developed bacterial endocarditis?

MR. POLITO: Objection.

MR. SKIVER: Objection. Go ahead, Doctor.

A. Mr. Colvin would be classified as an early postoperative endocarditis. When that occurred would be impossible for me to say.

Q. Do you have an opinion as to whether the stitch abscess found during Gregory Colvin's February 23rd, 1998 admission to the Cleveland Clinic played a role in his development of prosthetic valve endocarditis?

MR. SKIVER: Objection. Go ahead, Doctor.

A. Having not been involved and having not seen it, I couldn't say that the stitch abscess had anymore to do with it than the temperature of 38.8 on whatever postoperative day it was. It would be impossible to pinpoint for me.

Q. Do you have an opinion as to whether the echodensity that was seen on his February 24th, 1998 echocardiogram was an indication of early endocarditis?

MR. SKIVER: Objection.

MR. POLITO: Objection.

A. I would defer that to the echocardiography experts.

Q. Doctor, at the time that you saw him on May 16th, 1998, was it your opinion he was terminally ill at that point?

A. Yes.

Q. Were you then notified of his death or were you present at the time of his death?

A. I was not present. I was notified. I don't remember exactly when or the specifics.

Q. Do you have an opinion as to what point in time his condition was irreversible?

A. No.

Q. Do you have an opinion as to whether his death was preventable?

A. **No** one's death is preventable. It's a question of timing and whether you can alter that time. And I would not be able to tell you at what stage intervention would have changed that.

Q. So, Doctor, if Gregory Colvin had gone to surgery on Friday, May 15th before his cardiovascular collapse, do you have an opinion as to whether he would have survived the surgery?

A. It would have been a highly risky surgery. There's no guarantee that the results would have

been any better than the outcome and there was no guarantee that we could have cured the endocarditis. There was a very good chance he could have died right on the operating room table.

Q. In prosthetic valve endocarditis where a valve replacement is required, what is the rate of survival after that type of surgery?

A. I think that's a little bit too general a question to answer because it depends upon the clinical setting in which it occurs. And medical literature, the number of cases is relatively low in any series or anything that's reported. But, you know, the survival rate of early prosthetic valve endocarditis may range from -- or the mortality rate may range from 30 to 70 percent.

Q. And in Gregory Colvin's case, are you in a position to render an opinion as to what his survivability would have been if he had gone to surgery?

A. That is my opinion. I think if we had taken him to surgery with an INR of ten, that he would have bled to death.

Q. Well, on Friday his INR wasn't ten, was it?

A. I can't make any comment on what we would have found around the valve or the viability of the tissue or what we would have had to work with to put the valve in. But historically in cases like this, it's very difficult and very high risk.

Q. Do you have any criticisms of anyone that participated in Gregory Colvin's care?

A. I don't believe that there was anyone caring for Mr. Colvin that wasn't trying to do the very best that they knew how to do.

Q. I have no further questions for you. I don't know if Mr. Polito has some.

MR. POLITO: I have no questions.

MR. SKIVER: Ingrid, any questions?

MS. KINKOPS-ZAJAC: No questions.

(Deposition adjourned at 3:30 p.m.)

(Exhibits retained by the reporter.)

C E R T I F I C A T E

I, VERA TIBEKIN SITZE, a Certified Shorthand Reporter and Notary Public of the States of New Jersey and New York, do hereby certify that prior to the commencement of the examination the witness was sworn by me to testify the truth, the whole truth and nothing but the truth.

I DO FURTHER CERTIFY that the foregoing is a true and accurate transcript of the testimony as taken stenographically by and before me at the time, place and on the date hereinbefore set forth.

I DO FURTHER CERTIFY that I am neither of counsel nor attorney for any party in this action and that I am not interested in the event nor outcome of this litigation.

Vera T. Sitze

Notary Public of the State of New Jersey
New Jersey Certificate No. XI01037

My Commission expires March 19, 2001