

COURT OF COMMON PLEAS
CUYAHOGA COUNTY
CASE NO. 388614

DIANE COLVIN,
Administratrix,

Plaintiff,

v.

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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Medical Group, Inc., Kaiser
Foundation Health Plan of Ohio,
Inc., Kaiser Foundation Health
Plan, Inc., and Kaiser Foundation
Hospitals

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I N D E X

WITNESS

DIRECT

CRAIG R. SAUNDERS, M.D.

Ms. Tosti

4

E X H I B I T S

NUMBER

DESCRIPTION

IDENTIFICATION

P-1

Dr. Saunders'
Curriculum Vitae

4

P-2A

Cardio-Thoracic
Surgery Assessment
Form

31

P-2B

Second page of
Cardio-Thoracic Surgery
Assessment Form

31

P-3

Echocardiography
Preliminary Report

48

P-4

Echocardiography
Final Report

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1 (P-1, marked for Identification.)

2 C R A I G R. S A U N D E R S, M.D.,

3 Newark Beth Israel Hospital,

4 201 Lyons Avenue,

5 Newark, New Jersey 07112, sworn.

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

15 MS. KINKOPS-ZAJAC: Kinkops-Zajac.

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

19 DIRECT EXAMINATION BY MS. TOSTI:

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

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

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

Q. And your current business address?
Is it what is listed on your Curriculum Vitae
3 also?

4 A. Yes.

5 Q. Who is your current employer?

6 A. St. Barnabas Health Care System.

7 Q. And in February through May of
8 1998, who was your employer?

9 A. Cleveland Clinic.

10 Q. And was Cleveland Clinic's main
11 campus your business address at that time?

12 A. Yes.

13 Q. Have you ever had your deposition
14 taken before?

15 A. Yes.

16 Q. How many times?

17 A. Three or four.

18 Q. And were those depositions taken in
19 a medical negligence case?

20 A. Yes.

21 Q. I'm going to go over some of the
22 ground rules for a deposition. I'm sure defense
23 counsel has had an opportunity to speak with you.

24 This is a question-and-answer
25 session. It's under oath. It's important that

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

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

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

18 A. Yes.

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

21 A. Yes.

22 Q. How many times?

23 A. Three or four times.

24 Q. Where were those cases filed?

25 A. One in California and the rest in Ohio.

1 Q. Could you tell me the names of the
2 plaintiffs in those cases?

3 A. No, I don't recall.

4 Q. Do you recall any of them?

5 A. The one in California, her name was Peggy
6 Taylor.

7 Q. What about the Ohio cases?

8 A. I don't recall them at this time.

9 Q. What was the allegation of
10 negligence in those cases? Start with the
11 California case.

12 A. The California case was a young lady that
13 clotted off her mitral valve several months
14 following valve replacement. She was operated on
15 by a partner of mine and had an arrest.

16 Q. What was the allegation of
17 negligence?

18 A. Frankly, I don't know.

19 Q. In the Ohio cases?

20 A. There was a patient by the name of
21 Broadwater (phonetic) who had serious
22 complications following his fifth open-heart
23 operation. He had a Ross procedure. He died
24 several months following that procedure.

25 a. And what was the alleged

1 negligence?

2 A. It involved whether a totally obstructed
3 right coronary artery should have been ligated and
4 whether that contributed to his ultimate demise.

5 Q. What about the other Ohio cases?

6 MR. SKITTER: Jeanne, just for the
7 record, I'm going to have a running objection to
8 all of these cases. Go ahead, Doctor.

9 MS. TOSTI: Fine.

10 A. I don't recall the specifics nor the names
11 of any other cases that have been filed.

12 Q. How was the California case
13 resolved?

14 A. I don't know how it was ultimately
15 resolved. I was not held negligent.

16 Q. Do you know if the case was settled
17 or if it went to trial?

18 A. I don't believe it went to trial.

19 Q. How about the Ohio cases?

20 A. I don't believe that went to trial either.

21 Q. Were any of those cases settled in
22 favor of plaintiff?

23 A. I think the Broadwater case was. I don't
24 know the details.

25 Q. What about the other Ohio cases?

1 A. I don't recall them.

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

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

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

15 A. New Jersey.

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

18 A. Ohio.

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

22 A. Never.

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

25 A. No.

Q. Have you ever given testimony at trial or in deposition in a case involving issues
3 dealing with bacterial endocarditis?

4 A. No.

5 Q. Do you recall the case of --

6 A. Excuse me. That may be an error because
7 the Broadwater case maybe started off as
8 endocarditis.

9 Q. Do you recall the case of the
10 client by the name of Charlotte Herbert that
11 developed endocarditis?

12 A. Yes, I do.

13 Q. Did you give deposition testimony
14 in that case?

15 A. Yes, I did.

16 Q. And that case involved issues of
17 endocarditis. Correct?

18 A. I believe it did. I don't recall the
19 details.

20 Q. Doctor, counsel has provided me
21 with a copy of your curriculum vitae. You have a
22 copy in front of you. We've marked it as
23 Plaintiff's Exhibit 1.

24 If you would tell me whether this
25 curriculum vitae is current and up-to-date and as

1 to whether there are any additions or corrections
2 you would like to make to it.

3 A. It's the current one that I'm using. I
4 don't want to make any additions or corrections.

5 Q. You are board certified in general
6 surgery and thoracic surgery. Is that correct?

7 A. I'm board certified in thoracic surgery.

8 Q. Is there a subspecialty board
9 certification in cardiothoracic surgery?

10 Is there one available in
11 cardiothoracic surgery?

12 A. I don't understand your question.

13 Q. You are certified in thoracic
14 surgery. I'm just inquiring as to whether there
15 is a professional board certification that's a
16 subspecialty in cardiothoracic surgery.

17 A. That includes cardiothoracic surgery.

18 Q. There isn't a separate one for
19 cardiothoracic. Is that correct?

20 A. This is the one for cardiothoracic.

21 Q. You've completed a fellowship at
22 Cleveland Clinic in thoracic and cardiovascular
23 surgery as part of your training. Is that
24 correct?

25 A. That's correct.

1 Q. Between 1978 and 1980?

2 A. Yes.

3 Q. And following that, you practiced
4 in California for a period of time and then
5 returned to Cleveland Clinic. Is that correct?

6 A. Yes.

7 Q. You returned as a staff physician
8 in the Department of Thoracic and Cardiovascular
9 Surgery?

10 A. Yes.

11 Q. In 1998, is that the date that you
12 returned to Cleveland Clinic?

13 MR. SKIVER: 1998?

14 MS. TOSTI: I'm sorry.

15 Q. Let me withdraw that.

16 In 1998, did you hold any
17 administrative positions at the Cleveland Clinic?

18 A. I had the title of Director of Affiliate
19 Programs.

20 Q. What were your duties and
21 responsibilities as Director of Affiliate
22 Programs?

23 A. To help develop the Affiliate Surgical
24 Programs at Elyria, E-l-y-r-i-a, Memorial
25 Hospital. Also at Lake West.

1 Q. In 1998, would you describe what
2 your typical work schedule was? How you broke
3 down your typical workweek.

4 A. Well, I was doing an average of two or
5 three open-hearts a day and worked from between
6 six, seven o'clock in the morning until whenever
7 it was done late at night. Occasionally I would
8 visit one of the affiliate hospitals and
9 occasionally do a case there.

10 Q. So the majority of your surgeries
11 were done at Cleveland Clinic's main campus. Is
12 that correct?

13 A. Yes.

14 Q. Were you at Cleveland Clinic then
15 on a daily basis?

16 A. Yes.

17 Q. Were you there on the weekends at
18 all?

19 A. Yes.

20 Q. Routinely were you there on
21 Saturdays and Sundays?

22 A. Yes.

23 Q. When you were doing surgeries at
24 Cleveland Clinic's main campus, was there a
25 particular time of the day that you would make

rounds on patients?

2 A. In the mornings, between cases and in the
3 evenings.

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

7 A. No.

8 Q. Doctor, in regard to your
9 curriculum vitae that we have marked as
10 Plaintiff's Exhibit 1, do any of the publications
11 listed on your vitae deal with the subject matter
12 of infective endocarditis?

13 A. No.

14 Q. Any with prosthetic heart valves?

15 A. No.

16 Q. I believe you've also listed a
17 number of presentations that you've made.

18 Do any of the presentations deal
19 with the subject matter of infective endocarditis?

20 A. No.

21 Q. And the same question with regard
22 to prosthetic heart valves.

23 A. They do not.

24 MR. SKIVER: Doctor, could you try
25 and keep your voice up so she can hear on the

1 phone?

2 Can you hear all right, Ingrid?

3 MS. KINKOPS-ZAJAC: That's okay.

4 MR. SKIVER: All right.

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

7 A. No.

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

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

12 Q. Anything else?

13 A. No.

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

17 A. The records provided to me by my attorney.

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

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

25 MR. TOSTI: He has not reviewed

1 Kaiser records. Is that correct?

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

5 MR. POLITO: Did not?

6 MR. SKIVER: Did not.

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

9 A. No.

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

13 A. No.

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

17 A. No.

18 Q. Have you discussed this case with
19 anyone else?

20 A. No.

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

25 A. No.

1 Q. Have you ever generated any such
2 notes?

3 A. No.

4 Q. Have you ever seen any personal
5 notes or summaries generated by Dr. Keith
6 Kruithoff relative to Gregory Colvin?

7 A. No.

8 Q. Have you ever discussed any such
9 notes with Dr. Kreithoff?

A. No.

11 Q. Doctor, is there a textbook in your
12 field of practice that you consider to be the best
13 or the most reliable?

14 A. No, I don't know what that would be.

15 Q. Are there any that you use in your
16 clinical practice, any textbooks?

17 A. No.

18 Q. Are there any specific
19 publications, as you sit here today, that you
20 believe have particular relevance to the issues in
21 this case?

22 A. No.

23 Q. Have you ever participated in any
24 research dealing with the subject matter of
25 infective endocarditis?

1 A. No.

2 Q. Is your current thoracic surgery
3 practice limited to any particular type of
4 thoracic surgery?

5 A. Adult acquired heart disease.

6 MS. KINKOPS-ZAJAC: Doctor, if you
7 could please speak up, I would greatly appreciate
8 it.

9 Q. What is early prosthetic valve
10 endocarditis?

11 A. It's an infection of the valve that's been
12 placed -- the artificial valve that's been placed
13 in the early postoperative period which is defined
14 variably, but within the first six months maybe.
15 Maybe as much as the first 12 months.

16 Q. And what's the incidence of early
17 prosthetic valve endocarditis after valve
18 replacement surgery?

19 A. Very low. Probably about one percent.

20 Q. And was that also true in 1998?
21 Approximately one percent?

22 A. Yes.

23 Q. How often do you see patients with
24 prosthetic valve endocarditis in your practice?

25 A. It's pretty rare. Maybe once or twice a

year.

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

6 A. No.

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

10 A. No.

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

14 A. Yes.

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

18 A. The department kept the statistics.

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

22 A. Of course.

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

1 A. Yes.

2 Q. What are those factors?

3 A. It would include but not be limited to the
4 patient's immunologic status, his general health,
5 etiology of his valvular disease, social habits
6 and circumstances surrounding the valve
7 replacement.

8 Q. What type of circumstances
9 surrounding the valve replacement would increase
10 the risk for prosthetic valve endocarditis?

11 A. Difficult technical aspects, the presence
12 of -- the preexisting presence of endocarditis,
13 long pump runs, any contamination that could
14 possibly occur at the time of the surgery or in
15 the perioperative period. Basic surgical tenets.

16 Q. Would you agree that there has to
17 be a high degree of vigilance for bacterial
18 endocarditis in a patient with prosthetic valve --

19 A. Yes.

20 Q. What are the signs and symptoms of
21 prosthetic valve endocarditis?

22 A. Well, they can be variable, but they
23 normally include fevers, chills, sweats, positive
24 blood cultures, possible emboli, congestive heart
25 failure, renal failure.

1 Q. An elevated white blood cell
2 count. Would that be one?

3 A. Yes.

4 Q. Anemia?

5 A. Could be.

6 Q. Increased erythrocyte sedimentation
7 rate?

8 A. Yes.

9 Q. Anorexia and weight loss?

10 A. Sure.

11 Q. Heart murmur?

12 A. Yes.

13 Q. Are there any diagnostic studies
14 that are helpful aside from the ones that we just
15 mentioned that would be helpful in diagnosing
16 prosthetic valve endocarditis?

17 A. Echocardiogram.

18 Q. And in regard to the
19 echocardiogram, what would you be looking for in
20 order to determine whether or not there was
21 present prosthetic valve endocarditis?

22 A. Vegetations or valvular leaks.

23 Q. Does the patient have to have
24 positive blood cultures before a presumptive
25 diagnosis of prosthetic valve endocarditis can be

1 made?

2 A. Not necessarily.

3 Q. What is culture negative
4 endocarditis?

5 A. It's endocarditis where the cultures are
6 negative.

7 Q. Would you agree that negative blood
8 cultures are more likely to occur in a patient
9 with prosthetic valve endocarditis than in an
10 endocarditis patient without a prosthetic valve?

11 A. I don't know if that's true or not.

12 Q. And would you agree that blood
13 cultures of some patients with active bacterial
14 endocarditis may persistently culture negative
15 after receiving a short course of antibiotics?

16 A. It's possible.

17 Q. Would you agree that you cannot
18 exclude the diagnosis of endocarditis on the basis
19 of a negative echocardiogram alone?

20 A. I'm not an expert in making the diagnosis
21 of endocarditis.

22 Q. Would you defer to a cardiologist
23 with expertise in echocardiography on that issue?

24 A. Yes.

25 Q. Do you know whether the presence of

1 a prosthetic valve sometimes interferes with the
detection of vegetations on an echocardiogram?

3 A. I'm not an expert in echocardiograms.

4 Q. As a cardiothoracic surgeon, do you
5 have the expertise to diagnose prosthetic valve
6 endocarditis? Is that something that falls within
7 your expertise?

8 A. The diagnosis is almost always made by a
9 cardiologist or a medical physician before it's
10 seen by the surgeons.

11 Q. What types of complications are
12 associated with prosthetic valve endocarditis?

13 A. Well, the ones that we've talked about:
14 Fevers, chills, sweats, malaise, weight loss,
15 congestive heart failure, renal insufficiency,
16 emboli, anemia, to list a few.

17 Q. And how is prosthetic valve
18 endocarditis treated?

19 A. It's treated most often with a combined
20 medical and surgical approach.

21 Q. And when you say medical approach,
22 are you speaking about antibiotic therapy?

23 A. Antibiotics, treatment of congestive
24 failure, treatment of any associated symptoms or
25 sequelae that could occur.

1 Q. Doctor, would you agree that there
2 has to be a high index of suspicion for bacterial
3 endocarditis when a prosthetic valve patient
4 presents with a fever, fatigue and night sweats?

5 A. Yes.

6 Q. Would you agree that sequential
7 echocardiograms performed during the treatment of
8 prosthetic valve endocarditis can assist in making
9 the decision on the necessity for and the timing
10 of surgery?

11 A. It could be one of the tools to help make
12 the decision, yes.

13 Q. In prosthetic valve endocarditis,
14 isn't it usually necessary to replace the infected
15 valve in order to cure the endocarditis? In most
16 cases isn't it usually necessary to replace the
17 valve?

18 A. That's probably correct.

19 Q. And would you agree that the timing
20 of surgery for replacing an infected prosthetic
21 valve is extremely important in the management of
22 a patient with prosthetic valve endocarditis?

23 A. Yes.

24 a. And if the surgery to replace the
25 infected valve is delayed too long, the patient's

1 hemodynamic status may deteriorate so seriously
2 that surgery is no longer feasible. Correct?

3 A. That's one possible outcome.

4 MS. KINKOPS-ZAJAC: I didn't hear
5 the answer to that.

6 THE WITNESS: I said that's one
7 possible outcome.

8 MS. KINKOPS-ZAJAC: Thank you.

9 Q. And isn't it also true that if
10 prosthetic valve endocarditis goes untreated, it's
11 usually fatal?

12 A. Well, I'm not sure that that's true. All
13 diseases occur in a bell-shaped curve and although
14 that may be true for the majority of them, I think
15 it would be an error to say that it occurs in all
16 of them.

17 Q. Well, my question was, it's usually
18 fatal if it goes untreated. Would you agree with
19 that?

20 A. I'm not sure that that's true.

21 Q. Would you agree that one of the
22 main goals of treatment in prosthetic valve
23 endocarditis is to eradicate the infecting
24 organism as soon as possible?

25 A. Yes.

1 Q. Now, in a patient with prosthetic
2 valve endocarditis, what would be the indicators
3 for undertaking surgical removal and replacement
4 of the infected valve?

5 A. Would you repeat the question?

6 MS. TOSTI: Would you read the
7 question back?

8 (The record is read by the
9 reporter.)

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

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

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

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

different in every patient.

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

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

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

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

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

1 in prosthetic valve endocarditis?

2 A. I can't specifically answer that question.
3 Usually we rely on the transesophageal echo in
4 surgery a lot. But I know that there are times
5 when the transthoracic echo has advantages over
6 the TEE and vice versa.

7 Q. Is there a reason why you rely on
8 the transesophageal echo in surgery?

9 A. Yes. With the chest open, you can't do a
10 transthoracic echo.

11 Q. Do valvular vegetations have to be
12 present before the diagnosis of prosthetic valve
13 endocarditis can be made?

14 A. I don't believe so.

15 Q. Would you agree that in the
16 presence of prosthetic valve endocarditis, if the
17 patient develops heart failure that is
18 unresponsive to therapy, surgical treatment should
19 not be delayed?

20 A. No, I don't think that you could say that
21 across the board. I think that there may be cases
22 where in severe congestive heart failure, there
23 would still be contraindications to doing the
24 surgery.

25 Q. Let me refine that question then.

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

8 A. That sounds appropriate.

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

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

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

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

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

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

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

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

9 A. Every temperature elevation raises a
10 concern.

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

14 A. Could you be more specific?

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

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

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

1 feel free to do so.

2 A. It was February of 1998.

3 Q. There is in the medical records a
4 Cardio-Thoracic Surgery Assessment Form that, I
5 believe, is dated January 22nd of 1998. It has
6 your name listed on it as the surgeon.

7 Do you know whether or not you saw
8 him on that date?

9 MR. SKIVER: Do you know whether or
10 not you saw him?

11 A. I don't specifically recall.

12 Q. I have a copy of it. I'm just
13 interested in knowing whether this was --

14 MS. TOSTI: Can you put a
15 plaintiff's sticker on this as Plaintiff's Exhibit
16 No. 2A, 2B?

17 (P-2A and P-2B, marked for
18 Identification.)

19 Q. Doctor, I've handed you what's been
20 marked as Plaintiff's Exhibit 2A and 2B that is
21 entitled Cardio-Thoracic Surgery Assessment Form.

22 On page 2 of that -- 2B of that
23 particular exhibit, is that any of your
24 handwriting?

25 A. Yes.

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

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

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

15 A. Yes.

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

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

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

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

25 Q. So that would be typically what you

1 would do is confirm what was written by the nurse
2 that took the initial information?

3 A. Yes.

4 Q. When you had an opportunity to
5 assess him, can you tell me what your findings
6 were?

7 A. Well, as the assessment form says, he was a
8 49-year-old male with known mitral valve disease
9 and recent history of congestive heart failure and
10 atrial fibrillation. He had an echocardiogram in
11 December. It was listed on the review here that
12 showed he had a four plus mitral insufficiency and
13 a two to three plus tricuspid insufficiency.

14 Q. And aside from the cardiac problems
15 that you've just indicated, were there any other
16 medical problems that were of concern in this
17 patient?

18 A. No.

19 Q. Was it your recommendation that he
20 undergo mitral valve replacement and repair of his
21 tricuspid valve as a result of your assessment?

22 A. Yes.

23 Q. Now, you discussed the surgery with
24 Gregory Colvin. Is that correct?

25 A. I don't specifically recall that, but that

1 would have been the standard.

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

6 A. "Risks and benefits discussed."

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

9 A. Yes.

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

12 A. My response is the same. Yes.

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

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

25 We would talk about the risk of

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

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

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

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

14 A. I don't specifically recall.

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

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

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

1 he came into Cleveland Clinic for his cardiac
2 surgery which, I believe, was on February 4th?

3 A. I don't recall.

4 Q. And the surgery that you performed
5 on Gregory Colvin, what surgery was that?

6 A. Replacement of his mitral valve with a
7 mechanical prosthesis and angioplasty, tightening
8 of his tricuspid valve.

9 Q. The type of valve that you
10 surgically implanted, does it have a certain life
11 expectancy?

12 A. The mechanical valves -- the current
13 mechanical valves that we use generally do not
14 have mechanical failures and do not wear out.

15 Q. Now, I believe his was a number 33
16 Medtronic mechanical valve. Is that the type of
17 valve that would be expected not to wear out?

18 A. I think that is a typographical error. I
19 think it was a CarboMedics mechanical valve. It
20 says it down here in the text. And these valves
21 have been almost entirely free of -- I think
22 they've been completely free of mechanical
23 complications and failure.

24 Q. Now, in Mr. Colvin's case with
25 successful completion of his surgery, was there

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

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

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

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

1 going to need work done on his aortic valve?

2 A. It is possible.

3 Q. Was it likely he was going to need
4 any additional work done on his tricuspid valve
5 down the road?

6 A. That's a good question because tricuspid
7 angioplasties are difficult and sometimes it
8 reoccurs. There are different types of
9 angioplasties that are done. That's why I chose
10 to put in a prosthesis to minimize that chance.
11 But somebody with rheumatic heart disease and all
12 three valves are infected, that certainly is a
13 possibility.

14 Q. So it was possible but you wouldn't
15 be able to say that more likely than not he was
16 going to need additional surgery.

17 A. It's a possibility.

18 Q. Did you encounter any problems
19 during his initial valve surgery?

20 A. Well, as we stated before, we came off --
21 the record shows we came off bypass; his right
22 heart didn't really respond well. There was
23 increased tricuspid insufficiency. So we went
24 back and fixed that. He did well after that.
25 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?

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

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

7 A. No.

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

11 A. Yes.

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

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

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

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

25 Q. And when a central venous catheter

1 is inserted, it's usually secured to the skin with
2 a suture. Correct?

3 A. I believe so.

4 Q. And when the central venous
5 catheter is removed, the suture is also supposed
6 to be removed. Correct?

7 A. Yes.

8 Q. Now, in Gregory Colvin's case, do
9 you know who was responsible for removing his
10 central venous catheter during his February 4th,
11 1998 admission to the Cleveland Clinic?

12 A. I do not.

13 Q. Would that be something that you as
14 a surgeon would do typically?

15 A. No.

16 Q. Who would typically be responsible
17 as far as category of personnel for removing a
18 central venous catheter that is sutured to the
19 skin?

20 A. It could be the ICU nurse; it could be the
21 ICU, the PAs; it could be the floor nurses; it
22 could be the residents; it could be anesthesia.

23 Q. Now, Gregory Colvin was discharged
24 from his admission when he had his valve surgery
25 on February 12th of 1998.

1 Did you assess him prior to the
2 time of his discharge?

3 A. I don't recall.

4 MS. KINKOPS-ZAJAC: I'm sorry.
5 What was the response?

6 MR. SKIVER: He doesn't recall.

7 MS. KINKOPS-ZAJAC: Thank you.

8 Q. Would you look at the medical
9 records and tell me if you did any type of an
10 assessment prior to the time of his discharge?

11 MR. SKIVER: You mean what's noted
12 in the chart?

13 MS. TOSTI: Yes.

14 A. And the date was the 12th?

15 Q. I believe he was discharged on
16 February 12th.

17 A. Here is the 12th. There's a note on
18 February 12th, "CD surgery post-op day eight."
19 I don't recognize the signature. And there's no
20 indication that I saw him at that time.

21 Q. Did you have a fellow or resident
22 that was working on your service at that time that
23 was seeing your surgical patients?

24 A. Yes.

25 Q. Do you know who that person was?

A. I know that Dr. Christie (phonetic) was the assistant in the operation.

3 Q. Was he a surgical fellow at the
4 time?

5 A. Yes.

6 Q. Or resident?

7 A. Yes.

8 Q. Would he normally be making rounds
9 on your surgical patients after surgery?

10 A. Yes.

11 Q. From your review of the records,
12 did Gregory Colvin have any signs of infection at
13 the time of his discharge?

14 A. The only indication I have is that he's
15 afebrile, hemodynamically stable, blood pressure
16 144/58, heart rate -- I believe it says 77 with
17 atrial flutter. I believe it says he was on room
18 air, not receiving oxygen, his wounds are clean,
19 the sternum is stable. It says "For discharge if
20 labs okay."

21 Q. Following his discharge on February
22 12th, did you see him in follow-up at any time
23 after that discharge?

24 A. I don't recall.

25 Q. Would you normally see a patient

that you did surgery on for follow-up?

2 A. No.

3 Q. Who would normally do follow-up on
4 the patient after you've done a valve replacement?

5 A. He would be discharged home to his
6 cardiologist.

7 Q. So normally it would be the
8 cardiologist then that would see the patient for
9 the first time after discharge from the hospital
10 for valve replacement. Correct?

11 A. Yes.

12 Q. Now, Gregory Colvin was seen in
13 Cleveland Clinic's emergency room on February 23rd
14 of 1998 and he was complaining of intermittent
15 chills and fever, night sweats, generalized body
16 weakness, decreased appetite off and on for a
17 week.

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

22 MS. KINKOPS-ZAJAC: Objection.

23 A. What were those symptoms?

24 Q. Chills, fevers, night sweats,
25 generalized body weakness, decreased appetite off

1 and on for a week.

2 A. Prosthetic valve endocarditis would be in
3 the differential diagnosis.

4 Q. Now, as his surgeon, were you
5 notified that he was admitted to the Cleveland
6 Clinic with the impression of rule out bacterial
7 endocarditis?

8 A. I don't recall.

9 Q. Should you have been notified of
10 his admission with that diagnosis considering you
11 were his surgeon?

12 MS. KINKOPS-ZAJAC: Objection.

13 A. Having not been there or seen the
14 circumstances, I can't answer that question
15 whether I should have been notified or not.

16 Q. Well, Doctor, when you put a
17 prosthetic valve into a patient and then shortly
18 thereafter they're back in the emergency room with
19 fever and chills, night sweats and weakness and
20 they come in with an impression of rule out
21 bacterial endocarditis, wouldn't it be prudent to
22 notify the surgeon of record that that patient has
23 come back into the hospital?

24 MS. KINKOPS-ZAJAC: Objection.

25 A. Yeah, that would normally be done.

1 Q. Do you know whether anyone from
2 cardiothoracic surgery was notified that Gregory
3 Colvin was admitted back into the hospital?

4 A. I don't know.

5 Q. You would agree that when there's a
6 suspicion of prosthetic valve endocarditis just a
7 few weeks after surgery, cardiothoracic surgery
8 should be involved in the management of the
9 patient. Correct?

10 A. Yes.

11 Q. Now, did you at any time see
12 Gregory Colvin during his February 23rd, 1998
13 admission to the Cleveland Clinic?

14 A. I don't recall.

15 Q. Well, I would like you to look
16 through the records of that admission unless
17 Mr. Skiver has already done so and
18 determine --

19 MR. SKIVER: I haven't. I don't
20 have them with me. Do you have them with you?

21 MS. TOSTI: I do not have a copy
22 that is not annotated.

23 Q. So you don't know whether you saw
24 the patient during the February 23rd admission?

25 A. No, I don't.

1 Q. Did you at any point ask to see
2 those records to see if you had seen the patient
3 during that admission?

4 A. No.

5 Q. Is there a reason why you didn't do
6 that?

7 A. I was never asked.

8 Q. Well, Doctor, you knew you had a
9 deposition coming. Weren't you interested to know
10 what care this patient received and what care you
11 participated in in preparation for this
12 deposition?

13 A. I reviewed the records that I had and the
14 time that I had available.

15 Q. During that February 23rd hospital
16 admission, Gregory Colvin was noted to have a
17 stitch abscess from a retained silk suture on the
18 right side of his neck at the site of a prior
19 central venous line from which purulent drainage
20 was expressed on more than one occasion.

21 Would you agree that someone made
22 an error when they did not remove that suture
23 before his discharge from Cleveland Clinic on
24 February 12th of 1998?

25 A. Well, the suture should have been removed.

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

5 MR. SKITTER: Objection. Go ahead,
6 Doctor.

7 A. I suppose it's possible.

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

14 A. Yes.

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

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

20 Can I take a break while you're
21 organizing?

22 Q. Sure.

23 (A brief recess is taken.)

24 (P-3, marked for Identification.)

25 Q. Doctor, I'm going to hand you

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

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

12 A. Yes.

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

16 A. I don't know.

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

24 MR. POLITO: Objection.

25 MS. KINKOPS-ZAJAC: Objection.

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

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

8 MR. POLITO: Objection.

9 MS. KINKOPS-ZAJAC: Objection.

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

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

16 MR. POLITO: Objection.

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

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

22 A. No.

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

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

5 MR. POLITO: Objection.

6 A. Yes.

7 MS. KINKOPS-ZAJAC: Objection.

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

12 A. I have no knowledge of that.

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

15 THE WITNESS: Okay.

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

18 MS. KINKOPS-ZAJAC: Thank you.

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

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

5 MR. POLITO: Objection.

6 MR. SKIVER: I object.

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

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

14 A. I don't recall.

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

18 A. I did not.

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

25 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
4 on a patient and the patient came into the Kaiser
5 emergency room several months later with those
6 types of symptoms, would Cleveland Clinic's system
7 notify you?

8 A. What's throwing me there is the Cleveland
9 Clinic system.

10 Q. The system that was in place in the
11 Kaiser Cleveland Clinic emergency room, would they
12 typically notify you if it was a patient that you
13 had done surgery on and was coming in with those
14 types of complaints?

15 A. Yes, I think so.

16 Q. But in this instance, you don't
17 have any recollection of being notified that he
18 was in the emergency room. Correct?

19 A. I have no specific recall of that.

20 Q. And you didn't see anything in the
21 records that you reviewed that you were notified.
22 Correct?

23 A. I didn't review any records with regards to
24 that.

25 Q. Do you have an opinion as to

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

4 MR. POLITO: Objection.

5 MS. KINKOPS-ZAJAC: Objection.

6 MS. TOSTI: Let me finish my
question.

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

11 MR. POLITO: Objection.

12 MS. KINKOPS-ZAJAC: Objection.

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

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

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

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

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

A. I don't know what the timing was.

2 Q. Is there a date on the note that
3 you are referring to?

4 A. The date on the note I'm referring to is
5 5/13 at 8:20 in the evening.

6 Q. Can I see the note that you are
7 looking at?

8 A. (The witness complies.)

9 Q. Okay. The note that you are
10 referring to, who was that written by?

11 A. I believe that is Pat Ginley (phonetic) who
12 is one of the physicians' assistants, one of the
13 registered nurses.

14 Q. And would that individual have
15 notified you of the admission or would you have
16 notified that individual of the admission?

17 A. He would have notified me.

18 Q. Do you know what you were told in
19 regard to the patient's condition?

20 A. No, I don't recall any of the specifics.

21 Q. Once you were notified that a
22 patient you had done surgery on had been admitted
23 to the hospital with a diagnosis of endocarditis,
24 what would be your normal procedure? What actions
25 would you take following notification?

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

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

5 A. I don't recall.

6 MS. KINKOPS-ZAJAC: What was the
7 response?

8 MR. SKIVER: He doesn't recall.

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

12 A. No.

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

15 (P-4, marked for Identification.)

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

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

24 A. (The witness complies.)

25 Q. Would you agree that when a

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

7 A. Yes.

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

12 A. Not necessarily.

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

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

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

21 A. It can happen, yes.

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

25 A. I don't recall.

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

5 A. In conversations with my counsel --

6 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
14 family and visited the patient in his room. I
15 didn't have a specific recollection of that
16 initially, but after being told that and thinking
17 about it, I do have some recollection of going to
18 see him.

19 Q. Do you know when that occurred?

20 A. I don't.

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

25 A. I do not.

1 Q. Do you know whether you saw him
2 more than once?

3 A. I saw him at least twice.

4 Q. And what's the basis for you saying
5 that you saw him at least twice?

6 A. I saw him initially in his room and then in
7 the ICU on Saturday morning.

8 Q. Saturday morning, I believe, was
9 the 16th. So you saw him one time prior to the
10 16th and then you saw him on the 16th.

11 MR. SKIVER: He said at least.

12 Q. To the best of your recollection,
13 you saw him at least once prior to the 16th.
14 Correct?

15 A. Yes.

16 Q. And then you also saw him on the
17 16th. Correct?

18 A. Yes.

19 Q. On either of those occasions, did
20 you do an assessment of him?

21 A. Yes.

22 Q. And what was his condition at the
23 time that you did your assessment?

24 A. The first time I saw him, to the best of my
25 recollection, he was comfortable. He was in a

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

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

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

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

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

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

1 products to improve that.

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

8 MR. SKIVER: Did you say
9 instability or stability?

10 THE WITNESS: Hemodynamic
11 stability.

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

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

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

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

10 Q. And what caused his condition to
11 deteriorate from when you saw him prior to the
12 16th as to when you saw him on the 16th?

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

17 Q. What could cause that to happen?

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

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

23 A. I don't recall.

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

1 A. As I recall, it was morning.

2 Q. Now, I'd like you to explain the
3 surgical scheduling procedure used at Cleveland
4 Clinic in 1998 for cases where urgent reoperation
5 was needed to replace a heart valve.

6 A. Well, any emergent or urgent operation
7 would take precedent over the elective schedule
8 and we would just make room for them.

9 Q. Who would receive the request for
10 the surgery initially? What was the procedure if
11 the cardiologist felt the patient was
12 deteriorating?

13 A. Well, he may pick up the phone and call the
14 surgeon; he may call the scheduler; he may call
15 the resident. Anybody on the surgical team might
16 be contacted.

17 Q. And was there any particular
18 information that they were required to provide if
19 they were calling the surgical scheduler?

20 A. Well, just -- no particular. Just the
21 circumstances; the routine medical report; the
22 reasons they were calling.

23 Q. And if you were then to be the
24 surgeon, how would you be notified by the surgical
25 scheduler that there was a surgery that needed to

1 be done?

2 A. Well, as I said, it may come from the
3 surgical scheduler; it may come from the attending
4 cardiologist picking up the phone or from the
5 resident. It could come from any member of the
6 team.

7 Q. But if it was, in fact, coming from
8 the surgical scheduler, how would they contact
9 you?

10 A. By phone, by walking across the hall, by
11 pager, by whatever mechanism.

12 Q. Were you carrying a pager at that
13 point in time in 1998?

14 A. We always had pagers. Whether it was on my
15 person at that time or not, I have no recall.

16 Q. And what information would the
17 surgical scheduler typically give you on an urgent
18 surgery?

19 A. He would give me the details of the
20 emergency.

21 MS. KINKOPS-ZAJAC: What was the
22 response?

23 THE WITNESS: He would give me the
24 details of the emergency or of the urgency.

25 MS. KINKOPS-ZAJAC: Thank you.

1 Q. And if you're notified of an urgent
2 surgery, then what steps would you take?

3 A. Well, I would go see the patient if I was
4 available or I would send a member of the team to
5 see them and determine the need. It would depend
6 upon the information that was given us.

7 Q. Did you ever find that the surgical
8 scheduler at Cleveland Clinic failed to give you
9 complete or accurate information regarding a
10 patient's condition?

11 A. I think the schedulers always gave us as
12 much information that they had to the best of
13 their ability. I'm aware of no circumstances
14 where they gave inaccurate or wrong information.

15 Q. And did you ever find that the
16 surgical scheduler failed to appropriately
17 prioritize an urgent surgical case?

18 A. You're asking me to make judgment calls and
19 to comment on situations that I don't know about.

20 Q. No, Doctor, I'm asking your
21 experience. Did you ever find that the surgical
22 scheduler failed to appropriately prioritize an
23 urgent surgical case in your experience?

24 A. In my experience they did a great job and
25 did it to the best of their abilities and with the

1 information that they had.

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

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

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

15 Q. Let me rephrase the question then.
16 What's the fastest that a patient
17 could be taken into surgery once you as a surgeon
18 were notified and the decision had been made to
19 take the patient to surgery? And I understand
20 that there can be a range.

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

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

1 get into surgery once the decision is made and
2 you've been notified at Cleveland Clinic in 1998?

3 A. You mean in a hypothetical situation?

4 Q. Yes.

5 A. Under ideal terms, however long it takes to
6 push the patient from the ICU up the elevators and
7 into the operating room.

8 Q. Is the complete surgical team
9 available 24 hours a day at Cleveland Clinic for
10 cardiothoracic surgery?

11 A. I believe so.

12 Q. Were you ever notified on Friday,
13 May 15th, 1998 that Gregory Colvin needed urgent
14 reoperation to replace his infected valve?

15 A. I don't recall the specifics. I know that
16 he was being followed. I know that the
17 cardiologists were concerned about this. We had
18 him on our radar, so to speak, but he remained
19 hemodynamically stable. His bleeding times were
20 abnormal, although were improving. And the
21 judgment was made that the timing of the medical
22 and the surgical treatment did not warrant that he
23 be taken emergently to the operating room on the
24 15th.

25 Q. On the 15th were you prepared to do

1 urgent surgery if that decision was made?

2 A. If he needed it, we could have done it,
3 yes.

4 Q. And you don't have any recollection
5 and there's nothing in the records that indicate
6 to you that you were notified on Friday, May 15th
7 that Gregory Colvin needed urgent reoperation.
8 Correct?

9 A. I don't recall.

10 Q. You did not receive any
11 notification from the surgical scheduler on May
12 15th in regard to Gregory Colvin?

13 A. I don't recall specifics. But, again, the
team would have been looking at it; we would have
15 been monitoring the situation and the residents,
16 the schedulers, the surgeons would have been aware
17 of what was going on.

18 Q. Who was your secretary in May of
19 1998?

20 A. Well, I think at that time -- I don't
21 know. I changed secretaries at some point. My
22 main secretary there was Marge -- I can't recall
23 her last name right at this point. I'm not sure
24 when she left. So to answer your question in one
25 word, I don't know or in three words.

1 Q. Did your office keep a record of
2 phone messages?

3 A. I don't know.

4 Q. You don't recall whether they had
5 one of those self-carbonizing books where they jot
6 down the phone message and give you the top layer
7 of the message?

8 A. I don't know if they had that or not.

9 Q. Were you told at any time that
10 Gregory Colvin needed urgent surgery?

11 A. Again, I don't know specifics. We knew
12 that he was going to need surgery. The urgency of
13 it was yet to be determined. The timing of it, I
14 should say. The appropriate timing when we could
15 minimize his perioperative risks and improve that
16 risk-benefit ratio.

17 Q. You were not told at any point in
18 time that his condition was becoming unstable and
19 that he needed surgery urgently on Friday, May
20 15th of 1998?

21 A. It's my recollection after a superficial
22 review of the charts that he had an episode of
23 congestive failure, that he was transferred to the
24 Intensive Care Unit, he responded very rapidly and
25 appropriately and was quite stable.

Q. Were you in the hospital on Friday,
2 May 15th of 1998?

3 A. I don't recall.

4 Q. When you saw him on the 16th, were
5 you contemplating surgery at that point in time
6 for him?

7 A. No.

8 Q. And was that because his condition
9 had deteriorated to a point that he was too high a
10 risk for surgery?

11 A. Yes.

12 Q. Following Gregory Colvin's death,
13 were you contacted by Dr. Kreithoff?

14 A. Yes.

15 Q. When did he contact you?

16 A. I believe it was the following Monday.

17 Q. Did you meet with him in person?

18 A. I believe so.

19 Q. Where did you meet?

20 A. I believe he came to my office.

21 Q. Was anyone else present for that
22 meeting besides you and Dr. Kreithoff?

23 A. I don't believe so.

24 Q. What was the purpose of that
25 meeting?

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

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

6 A. I don't recall specifics.

7 Q. Did Dr. Kreithoff appear angry to
8 you?

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

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

16 A. I don't recall.

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

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

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

1 for reoperation on May 15th, 1998?

2 A. Well, I don't recall the specifics of that,
3 but it's pretty easy to say yes in retrospect and
4 knowing the results on the 16th. But I'm not sure
5 how that has any bearing on the
6 decision-making on the 15th.

7 Q. Did you ever tell Dr. Kreithoff
8 that you received false information from the
9 surgical scheduler regarding the status of Gregory
10 Colvin?

11 A. That would have been out of character for
12 me. I don't recall doing that.

13 Q. Did you ever tell Dr. Kreithoff
14 that the triage system of having the surgical
15 scheduler schedule patients for surgery was a poor
16 one?

17 A. I don't have a specific recollection of
18 that and I doubt that I would have been that
19 critical. It would have been more in character to
20 say it was a difficult one.

21 Q. Why was it a difficult one?

22 A. There are 15 to 20 patients going to
23 surgery at the Cleveland Clinic on any one day.
24 And the management of that schedule is very
25 difficult.

1 Q. Did you ever have any problems with
2 the scheduling of surgical patients at Cleveland
3 Clinic?

4 A. Can I go off the record and say that that's
5 like asking a question when did you stop beating
6 your wife? Because it's just not an appropriate
7 question. Of course there's problems in
8 everything you do. Do you ever have problems with
9 anything? Do you ever have problems with your
10 husband? Of course there's difficulties.

11 Q. What difficulties did you have in
12 regard to the surgical scheduling of patients at
13 the Cleveland Clinic, Doctor?

14 A. Well, I'm simply saying it's a very high
15 volume, a very difficult job and the scheduling of
16 patients is -- and the appropriate timing of it is
17 always difficult.

18 Q. Did you ever find that you couldn't
19 get a patient into surgery at a time that you in
20 your clinical judgment felt was best for the
21 patient?

22 A. No.

23 Q. Did you ever tell Dr. Kreithoff
24 that the triage system of having surgical
25 schedulers schedule patients for surgery was the

1 nail in the coffin as to why you were leaving the
2 Cleveland Clinic?

3 A. I heard that statement. I did not leave
4 the clinic under any adverse conditions or under
5 any complaints. And certainly the scheduling
6 problems would not be the reason that I would
7 leave the Cleveland Clinic. I think the Cleveland
8 Clinic is a premier institution in the country and
9 the reason I left is because I had a job where I
10 could head the department and I looked at it as a
11 professional advancement that was afforded to me
12 by my participation and being on the staff at the
13 Cleveland Clinic.

14 Q. My question to you was, did you
15 ever say that to Dr. Kruithoff? Is your answer to
16 that question no?

17 A. My answer to that is, I have no
18 recollection of saying anything like that and as I
19 explained, it would have been totally out of
20 character to say something like that for me.

21 Q. Did you ever tell Dr. Kreithoff
22 that the case of Gregory Colvin had conclusively
23 made up your mind to leave the Cleveland Clinic?

24 A. Absolutely not. The case of Gregory Colvin
25 was never an issue of whether or not I would

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

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

11 A. Not that I'm aware.

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

16 A. I don't recall specifics of them.

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

21 A. I don't recall.

22 Q. At any time during his May 12th,
23 1998 admission or thereafter, do you recall having
24 any conversations with Gregory Colvin's family?

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

1 Q. Yes. I'm asking whether during his
2 admission of May 12th, 1998 or after his death,
3 did you have any conversations with Gregory
4 Colvin's family?

5 A. Well, I do have a recollection of seeing
6 him preoperatively going to his room. I don't
7 recall specifics of talking to them afterwards,
8 although I may have. I'm trying to recall. I'm
9 trying to draw up some memories of that, whether I
10 talked to them after his death in the ICU or the
11 placement of the ECMO. And most likely I would
12 have. As you jog my memory here, I think maybe I
13 did talk to them in the hallway but I don't
14 recall.

15 Q. You don't have a specific
16 recollection of the conversation.

17 A. No, I don't. No, I don't.

18 Q. Do you have an opinion as to when
19 Gregory Colvin developed bacterial endocarditis?

20 A. Well, in retrospect, it's easy to go back
21 and look at his temperatures and connect the dots
22 back to his hospitalization. But that's only with
23 the benefit of reviewing and having retrospect.

24 Q. Well, in retrospect, Doctor, do you
25 have an opinion as to when Gregory Colvin

1 developed bacterial endocarditis?

2 MR. POLITO: Objection.

3 MR. SKIVER: Objection. Go ahead,
4 Doctor.

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

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

13 MR. SKIVER: Objection. Go ahead,
14 Doctor.

15 A. Having not been involved and having not
16 seen it, I couldn't say that the stitch abscess
17 had anymore to do with it than the temperature of
18 38.8 on whatever postoperative day it was. It
19 would be impossible to pinpoint for me.

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

24 MR. SKIVER: Objection.

25 MR. POLITO: Objection.

1 A. I would defer that to the echocardiography
2 experts.

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

6 A. Yes.

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

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

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

13 A. No.

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

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

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

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

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

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

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

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

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

24 Q. Well, on Friday his INR wasn't ten,
25 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.)

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

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24	My Commission expires March 19, 2001
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