1

IN THE COURT OF COMMON PLEAS
OF CUYAHOGA COUNTY, OHIO

LESLIE WALTER,
ADMINISTRATOR, ETC.,

Plaintiff,

vs Case No. 393899

METROHEALTH MEDICAL
CENTER, et al.,
Defendants.

DEPOSITION OF THOMAS RAYMOND VROBEL, M.D.
WEDNESDAY, NOVEMBER 29,2000

Deposition of THOMAS RAYMOND VROBEL, M.D., a Witness herein, called by counsel on behalf of the Plaintiff for examination under the statute, taken before me, Vivian L. Gordon, a Registered Diplomate Reporter and Notary Public in and for the State of Ohio, pursuant to agreement of counsel, at the offices of MetroHealth Medical Center, 2500 MetroHealth Drive, Cleveland, Ohio, commencing at 9:40 o'clock a.m. on the day and date above set forth.

2

APPEARANCES:
On behalf of the Plaintiff
Becker & Mishkind, by
JEANNE M. TOSTI, ESQ.
Skylight Office Tower Suite 660
Cleveland, Ohio 44113
216-241-2600

On behalf of the Defendant MetroHealth Medical Center
Reminger & Reminger, by
JAMES MALONE, ESQ.
The 113 St. Clair Building
Cleveland, Ohio 44114
216-687-1311

On behalf of the Defendant Emergency Professional Services and Thomas W. Graber, M.D.
Mazanec, Raskin & Ryder, by
BEVERLY HARRIS, ESQ.
100 Franklin's Row
34305 Solon Road
Solon, Ohio 44139
440-248-7906

3

THOMAS RAYMOND VROBEL, M.D., a witness herein, called for examination, as provided by the Ohio Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, was deposed and said as follows:

EXAMINATION OF THOMAS RAYMOND VROBEL, M.D.

BY MS. TOSTI:

Q. Doctor, would you please state your full name for us.

A. Thomas Raymond Vrobel.

Q. And your home address?

A. 2135 Miami Road, Euclid, 44117.

Q. Is your current business address here at MetroHealth Medical Center?

A. That'scorrect.

Q. Is your current employer MetroHealth Medical Center?

A. That'scorrect.

Q. In March of 1998, was your business address and your employer the same?

A. Correct.

Q. Do you currently render professional services for anyone other than MetroHealth Medical Center?

A. I do not.

4

Q. In March of 1998, were you providing professional services for anyone other than MetroHealth Medical Center?

A. I was not.

Q. Have you ever had your deposition taken before?

A. Yes, I have.

Q. How many times?

A. Ten times, approximately.

Q. Have you ever been named as a defendant in a medical malpractice suit?

A. Yes, I have.

Q. How many times?

A. That came to what stage?

Q. Named in a lawsuit, doctor.

A. What do you define --

Q. A suit filed against you.

THE WITNESS: I mean, I get these letters of inquiry.

Q. My question is in regard to suits that have been filed. Have you ever been named as a defendant in a suit that was filed?

A. I know of at least two. Again, depending on what the definition is, it might have been more than that, but it was at least

5

two.
Q. I am sure counsel has had a chance to talk with you about the ground rules for a deposition. I am just going to go over them briefly.
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, please tell me and I'll be happy to repeat the question or to rephrase it; otherwise, I'm going to assume that you understood my question and that you are able to answer it.
I would also ask that you give all of your answers verbally because our court reporter can't take down head nods or hand motions.
If at any point you would like to refer to the medical records, please feel free to do so.
During the course of this deposition, defense counsel may choose to enter an objection. You are still required to answer my question unless counsel instructs you not to do so.
Do you understand those directions?
A. Yes, I do.

6

Q. Now, doctor, in regard to the two times that you reference that you were named as a defendant in a medical negligence suit, when were those cases filed?
A. Approximately 1980, '81. And when was that other one? 1990, somewhere in there.
MR. MALONE: Yes.
Q. How were those cases resolved?
A. As far as I know, they were dismissed.
Q. Was there any type of settlement to the plaintiff in those cases?
A. In the first one, there was a settlement of a couple thousand dollars for the plaintiff. I honestly don't know whatever happened with that one.
Q, Can you tell me what the allegation of negligence was in those cases?
A. The first one was that I hadn't properly supervised the cardiology fellow in relationship to removing the catheter, which resulted in a large hematoma.
Q. Do you recall the name of that plaintiff?
A. I do not.
Q. What about the second case?

7

A. The second case was related to a patient with acute myocardial infarction and shock. We attempted to place a balloon pump in her right femoral artery, were unable to do so effectively, and she ended up losing the limb.
Q. Do you recall the plaintiff in that case?
A. I do not.
Q. Both of those cases were filed in Cuyahoga County?
A. I believe so.
Q. Have you ever acted as an expert in a medical/legal proceeding?
A. Yes, I have.
Q. How many times?
A. I have been asked 50 to 100 times. I have actually gotten to the point of giving a deposition about seven or eight times.
Q. The times that you acted as an expert in a medical/legal proceeding, was it for plaintiff or for defendant in a case?
A. Both.
Q. Have you ever given trial testimony?
A. Once.
Q. Was that in a medical/legal

8

proceeding?
A. Correct.
Q. Have you ever given testimony in any case involving issues dealing with bacterial endocarditis?
A. I have not.
Q. Doctor, did you happen to bring a copy of your curriculum vitae with you today?
A. I did not.
MR. MALONE: I did not ask him. I apologize for that.
Q. Would you tell me where you went to medical school.
A. University of Wisconsin.
Q. And the year that you graduated?
A. 1969.
Q. Did you serve a residency after medical school?
A. I did. 1969 to 1974 at MetroHealth Medical Center.
Q. Was that in a particular specialty?
A. Internal medicine, pulmonary and chief residency.
Q. Was that a combined residency for internal medicine and pulmonary?

9

A. No, that was sequential, three years of internal medicine and one year of pulmonary and one year of chief residency.
Q. Did you serve any additional fellowships after your residency?
A. From 1976 to 1979, at the University of Minnesota in cardiology.
Q. You are licensed in the State of Ohio; is that correct?
A. That's correct.
Q. Are you licensed in any other states?
A. I was licensed at one point in Wisconsin and Minnesota. I don't know if they are still active. I don't know if those are lifetime licenses.
Q. Has your license in Ohio or any other state ever been called into question, suspended or revoked?
A. It has not.
Q. Are you board certified in any areas, doctor?
A. Internal medicine, pulmonary medicine, and cardiovascular medicine.
Q. And from the time of your medical school training through your residency and

10

fellowship, did you work at any other places other than what you have previously described?
A. From 1974 to 1976 I worked at the Milwaukee Medical Clinic in Milwaukee, Wisconsin in internal medicine, pulmonary medicine, intensive care medicine, but that was private practice.
Q. When did you become affiliated with MetroHealth Medical Center as a staff physician?
A. July Ist, 1979.
Q. And was that upon completion of your cardiology fellowship?
A. That is correct.
Q. And in March of 1998, could you tell me what your title and position was at MetroHealth Medical Center?
A. Staff physician. I was director of the coronary care unit. Intermittently I have been director of the cardiac cath lab. I don't believe I was at that particular point.
Q. What is your current position at MetroHealth?
A. Staff physician in cardiology, director of the coronary care unit.
Q. When did you first assume the position

11

of director of the coronary care unit?
A. I would think sometime in the late 1980s.
Q. And in March of 1998, did you have hospital privileges anywhere else besides MetroHealth Medical Center?
A. I did not.
Q. Were your privileges admitting privileges at MetroHealth Medical Center?
A. Theywere.
Q. Have you ever had your hospital privileges called into question, suspended or revoked?
A. I have not.
Q. Doctor, have you authored or co-authored any medical journal articles or textbook chapters?
A. Yes, I have.
Q. Any of them dealing with the subject matter of bacterial endocarditis?
A. No.
Q. Any dealing with the subject matter of prosthetic heart valves?
A. No.
Q. Have you ever taught or given formal

12

lectures on the subject matter of bacterial endocarditis?
A. I gave at least one grand rounds. I think there were two.
Q. Has either of those presentations ever been reduced to a written form, a tape, an outline?
A. No.
Q. Tell me what you have reviewed for this deposition.
A. The medical record that was provided to me, which I believe is a copy of that record.
Q. And the title on that particular record, would you just tell us what it says, if there is any type of a --
MR. MALONE: The title on the original that's copied is volume three of Earline Mizsey's MetroHealth system chart.
MS. TOSTI: And the copy volume three, is that the copy that the doctor has currently in front of him or does he have additional records aside from what is in volume three?
MR. MALONE: In the binder he has looked at, there are the two ER visits to Southwest General Hospital of which we have

13

knowledge. Other than that, I believe that -- I am not going to go through it page by page, and I don't think you need me to, but you are welcome to look at what he has got, Jeanne.

He has a copy of her care at Metro that goes back to January of 1995 at about the time he catherized this patient. There are records that refer to her valve surgery done here by Dr. Chavez, as I understand it. And then there is a host of outpatient and inpatient care going up to the time that I believe she was transferred to Cleveland Clinic.

MS. TOSTI: And then in addition to that, he has also reviewed the March 10th, '98 emergency room visit records from Southwest General?

MR. MALONE: That was shown to him this morning, to my knowledge for the first time.

THE WITNESS: I just saw this moments before.

MS. TOSTI: And I believe also there was another Southwest General emergency room visit on May 8th.

THE WITNESS: Yes, that's in here.

14

MR. MALONE: That's in his packet, May 8th of '98.

Q. Have you reviewed any records from The Cleveland Clinic that are not contained in the MetroHealth Medical Center records?

A. I have not. There is a letter from Dr. Tomford in here which I believe should be mentioned.

Q. Have you reviewed any records from Broadview Multicare, which is the extended care facility she was sent to after Cleveland Clinic?

A. I havenot.

Q. Have you seen the death certificate on this lady?

A. I have not.

Q. Have you reviewed any tapes of her echocardiograms?

A. I have not.

Q. When did you become aware that there was a lawsuit pending, just approximately?

THE WITNESS: Do you know when that was?

MR. MALONE: I don't.

A. It was about – I believe it was in August of this year.

15

Q. And were you informed by counsel?

A. By counsel, yes.

Q. Since you became aware that there was a lawsuit pending, have you discussed this case with any physicians?

A. Just Dr. Finkelhor. I went over the echocardiogram report that he had written.

Q. And which echocardiogram are you referring to?

MR. MALONE: On admission?

THE WITNESS: Well, I showed him the report from admission.

A. It would be the one that he did. Well, no, the one done on May 14th, 1998.

- - - - -

(Thereupon, VROBEL Deposition Exhibit 1 was marked for purposes of identification.)

- - - - -

Q. Doctor, I am handing you what's been marked as Plaintiffs Exhibit Number 1. I would ask, is that the report that you went over with Dr. Finkelhor?

A. Actually, I went over the typed report with him, which is actually dated May 12th, but

16

that's an error, it should be May 14th, '98.

- - - - -

(Thereupon, VROBEL Deposition Exhibit 2 was marked for purposes of identification.)

- - - - -

Q. I am handing you what's been marked as Plaintiffs Exhibit Number 2. I would ask, is this a copy of the echocardiogram that you went over with Dr. Finkelhor?

A. Correct. I went over this report with him. Not the original tape.

Q. Why is it that you reviewed this particular report with Dr. Finkelhor?

A. I can't remember exactly why. I think I just wanted to – this is a vague recollection – I think I just wanted to make sure that all the facts in here were appropriate.

Q. When did you have this conversation with Dr. Finkel?

A. Finkelhor.

Q. Sorry, Finkelhor.

THE WITNESS: When did I get this book?

MR. MALONE: Probably about August,

17

but I am guessing, Tom, and I would caution you not to guess. If you know an answer, give it.
A. I don't honestly know. It's been over a month.
Q. What did Dr. Finkelhor tell you in regard to this echocardiogram?
A. I honestly can't remember. It wasn't anything substantial.
Q. Is there a particular reason why you went to Dr. Finkelhor?
A. Well, he is our echo expert here.
Q. But I mean, why you picked out –
A. I have no specific questions to ask him about the case.
Q. Let me finish my question. She has difficulty taking us both down at the same time.
Is there a particular reason why you chose this particular echocardiogram to discuss with Dr. Finkelhor?
A. There probably is, but I don't remember what it was.
Q. And other than with Dr. Finkelhor, did you have any other conversations with physicians after you became aware that there was a lawsuit pending?

18

A. Just briefly with Dr. Einstadter when we initially met with counsel. I believe I bumped into him once in the cafeteria and asked him what was happening with the case; had he been deposed yet.
Q. And what did Dr. Einstadter tell you?
A. He said no, he hadn't heard of anything about it yet and was surprised it was taking so long.
Q. Have you reviewed Dr. Einstadter's deposition?
A. I have not.
Q. Have you reviewed Dr. Graber's deposition in this case?
A. I have not.
Q. And other than with counsel, have you discussed this case with anyone else?
A. I have not.
Q. Now, aside from whatever notations you have made in the MetroHealth Medical Center records, do you have any notes or a file on this case?
A. I do not.
Q. Have you ever made any such notes or file on this case?

19

A. When I reviewed it, I put a time line on things initially on a piece of paper when I was first reviewing it, and then I marked, subsequently marked the spots I wanted to remember. Then I went over those this morning.
Q. Do you have that with you?
A. What?
Q. Your time line.
MR. MALONE: I am not going to give it to you. That's for me.
Q. Did counsel ask you to produce that?
A. No. I just had it when we were discussing the case. When was that? About a week or so ago, I had the time line.
Q. What was contained in the time line?
MR. MALONE: You don't need to tell her anything about the time line.
This is an employee of the defendant. He's not a hired expert. If he was a hired expert, that's different, Jeanne, but he is an employee of the defendant institution.
MS. TOSTI: I think I have a right to know what he considered to be significant in his review of the records.
MR. MALONE: You can ask him that.

20

MS. TOSTI: I just did. What was contained in his time line.
MR. MALONE: If you want to know what is significant, if anything, about the chart, ask him.
MS. TOSTI: Are you telling him he cannot answer my question as to what was contained in the time line that he prepared in reviewing these records?
MR. MALONE: That's correct.
MS. TOSTI: You are instructing him not to answer that question?
MR. MALONE: Yes.
MS. TOSTI: For the record, I am making a request for a copy of the notations that the doctor prepared.
Q. Is there a textbook in your field of practice in cardiology that you consider to be the best or the most reliable?
A. No.
Q. Are there any publications as you sit here today that you believe have particular relevance to the issues in this case?
A. Well, there is a lot of them.
Q. Well, I am asking you –

21

A. Is there any one?
Q. Is there a particular one that you are aware of as we sit here today that you think has particular relevance to the issues in this case?
A. Yes.
Q. Will you tell me what that is?
A. There is an article on the criteria called the Duke Criteria for Diagnosis of Endocarditis that I reviewed.
Q. The Duke Criteria for Diagnosis of Endocarditis. Where is it that you reviewed this? In other words, what type of a publication was this?
A. A journal article, but I can't give you the exact citations. I can get that for you if you need that.
MS. TOSTI: I can make a request.
MR. MALONE: You can do your own research in the literature. He got that from me.
Q. What was it that you reviewed?
MR. MALONE: He told you.
Q. What was the publication in which you found this particular criteria?
MR. MALONE: He told you he doesn't remember.

22

A. I don't remember.
Q. Doctor, do you have a copy of this?
MS. TOSTI: I would make a request for a copy of what he reviewed that he considers *to* be particularly relevant to the issues in this case.
MR. MALONE: He has identified for you the Duke Criteria for Diagnosis of Endocarditis. You can find it in the library.
Q. Was there an article with this particular Duke Criteria?
A. There is an article that gives the Duke Criteria.
Q. Do you know who the author of this article is?
A. No, I do not.
Q. What is it that you consider to be particularly relevant in that article that you reviewed?
A. What are considered the criteria for diagnosis and suspecting endocarditis.
Q. Do you consider that article with that criteria to be authoritative?
A. I consider it to be very interesting.
Q. Well, I am asking you if you consider

23

it *to* be authoritative; in other words, reliable information that you would rely on in your clinical practice?
A. Yes.
Q. Have you participated in any research dealing with the subject matter of bacterial endocarditis?
A. I have not.
Q. Doctor, what were your duties and responsibilities as a staff cardiologist at Metro in March of 1998?
A. The broad area of cardiology and specifically working the cardiac catherization lab and working the coronary care unit.
Q. Did you see both inpatients and outpatients?
A. Very few inpatients in those days.
Q. Were you seeing patients in the clinic area?
A. Very few. I didn't have time to see very many outpatients in those days.
Q. Were most of your responsibilities involved in the cath lab or the coronary care unit at that point in time?
A. Correct.

24

Q. I just want to clarify. You did not have a panel of patients that you routinely saw for follow-up cardiology care?
A. That is correct.
Q. And were all of your clinical responsibilities here at Metro's main campus?
A. Correct.
Q. Now, doctor, you indicated previously, I believe, that you were the head of the cath lab. I take it you do invasive diagnostic and therapeutic cardiac procedures; is that correct?
A. That's correct.
Q. Could you just describe for me generally what your routine hours were back in March of '98?
A. When I was in the coronary care unit, I would arrive at 7:00 in the morning and leave 7:00, 8:00 at night and answer telephone calls all night. I would come in if there were emergencies.
Q. Did you have dual responsibilities both in the cardiac care unit as well as the cardiac cath lab unit? In other words, you were both seeing patients in the unit as well as doing cath lab responsibilities?

25

A. During the daylight hours there was someone else covering the cath lab. At night I would be responsible for emergency catheterizations.
Q. Did you have any type of routine schedule for the cath lab during the day?
A. Not during the period --when scheduled in the coronary care unit, not scheduled in the cath lab.
Q. You would trade off between those two responsibilities?
A. Correct.
Q. How many cardiologists were on staff at that time at Metro in March of '98?
A. I honestly can't tell you that.
Q. Can you tell me approximately?
A. My best guess would be six to eight, somewhere in that range.
Q. Did you have an on-call system for the various cardiologists when cardiologists would be off that you would take call from them?
A. The person in the coronary cafe unit was on call for everybody when they weren't around.
Q. So on weekends or at night, did the

26

person in the coronary care unit take call for the cardiologists that may have been following patients in the clinic?
A. That's correct.
Q. Did all of the cardiologists have some responsibilities in the coronary care unit for covering the unit, generally?
A. No.
Q. Who else besides yourself had responsibilities for the coronary care unit at that period of time?
A. I suspect it would have been most everybody, short of a couple. Probably about five or six different cardiologists, but not all of them.
We have changed the system a number of times over the years, so I am a little vague as to what our system was at that particular moment.
Q. With five or six cardiologists, would they rotate responsibility in the coronary care unit?
A. That's correct.
Q. So how often would you in March of '98 be responsible to cover the coronary care unit?
A. Five or six times a year.

27

Q. And how long a period of time would you be responsible then?
A. I knew you were going to ask that. Either two to four weeks, but I can't be more precise.
Q. Then you would take on responsibilities in the cardiac cath lab alternately?
A. For the most part, that's what I was doing in those days, yes.
Q. How long would you have responsibilities over the cardiac cath lab then?
A. Pretty much if I wasn't in the coronary care unit I was in the cath lab.
Q. Was the majority of your time spent in the cardiac cath lab in 1998?
A. I believe so, yes.
Q. When you were on call, what were your duties, responsibilities?
A. Primarily to take care of any cardiac emergencies that occurred within the system, and to answer telephone calls from, you know, any outside people.
Q. When you would take call for the physicians, would you then contact a particular

28

cardiologist to inform them about the call that you took for them?
A. If you are saying if somebody called in relationship to one of their patients?
Q. Yes.
A. Yes.
Q. Was there any type of a telephone log or other written document made in regard to calls that you took at that time?
A. No.
Q. Did you have any routine as far as when you would contact the attending cardiologist to inform them about the call?
A. The next available time that they were there.
Q. How often in your practice do you see patients with bacterial endocarditis?
A. I would guesstimate about a half dozen times a year.
Q. And have you personally diagnosed patients with bacterial endocarditis?
A. Oh, yes.
Q. Have you diagnosed any patients that had prosthetic valve endocarditis?
A. Yes.

29

Q. How often do you see patients with prosthetic valve endocarditis in your practice, approximately?
A. Once or twice a year.
Q. Are there any factors that would place a patient at increased risk for developing prosthetic valve bacterial endocarditis?
A. Any factors that would lead to frequent infections.
Q. Can you tell me what those would be?
A. A myriad.
Q. Can you give me some examples?
A. Chronic skin infections, chronic urinary tract infection, chronic pneumonias, frequent pneumonias. Those would probably be the major ones.
Q. Would a patient with a bioprosthetic valve that also had diabetes be at increased risk?
A. Be at somewhat increased risk because of the diabetes, yes.
Q. In a patient with a bioprosthetic valve, what would cause you to be suspicious for bacterial endocarditis?
A. The usual signs and symptoms of

30

endocarditis.
Q. And what are those?
A. Fever, constitutional symptoms, peripheral embolic manifestations, immunologic manifestations, new murmur.
Q. Anorexia and weight loss, is that associated?
A. Constitutional symptoms that would fall under.
Q. What else do you consider to be constitutional symptoms then?
A. Fatigue, weight loss, malaise.
Q. Is anemia associated with bacterial endocarditis?
A. Yes.
Q. Elevated white blood cell count?
A. Yes.
Q. Increased erythrocyte sedimentation rate?
A. Yes.
Q. Now, aside from the things that we just mentioned, are there any diagnostic studies that are helpful in the diagnosis of bacterial endocarditis?
A. Blood pressure cultures and

31

echocardiographic findings.
Q. Can bacterial endocarditis be ruled out on the basis of a single blood culture?
A. No.
Q. Why not?
A. There is a possibility that a single blood culture may miss the bacteremia. The bacteremia is basically intermittent.
Q. Does a patient have to have a positive blood culture before a presumptive diagnosis of bacterial endocarditis can be made?
A. For practical purposes, yes.
Q. Have you ever heard the term culture negative endocarditis?
A. Yes, I have.
Q. Isn't there a higher rate of negative blood cultures in patients with prosthetic valve endocarditis as compared to endocarditis patients without prosthetic valves?
A. I am not familiar with that at all. I would tend to say no to that, but I don't honestly know what the statistics are.
Q. Doctor, is there a higher rate of negative cultures in subacute bacterial endocarditis as compared to acute bacterial

32

endocarditis?
A. I don't know the exact statistics on that. I think it's possible.
Q. How is prosthetic valve endocarditis treated?
A. With antibiotics, but a high priority for valve replacement is given, because it's more difficult to sterilize the prosthetic valves.
Q. Would you agree that one of the main goals of treatment in prosthetic valve endocarditis is to eradicate the infected organism as soon as possible?
A. Correct.
Q. And would you agree that the sooner that prosthetic valve endocarditis is treated with antibiotics, the more likely the outcome will be positive?
MS. HARRIS: Objection.
MR. MALONE: I have to object because I don't know what that means.
Q. Do you understand my question, doctor?
A. I believe I do.
The answer is yes.
Q. What type of complications are associated with prosthetic valve endocarditis?

33

A. Locally, abscesses of the heart, destruction of the valve leading to predominantly regurgitation problems, heart failure, pericarditis, prolonged infection.
Q. Would you agree that there has to be a high degree of vigilance for bacterial endocarditis in a patient with a prosthetic valve?
MS. HARRIS: Objection.
A. Yes.
Q. In a patient with a bioprosthetic valve who presents with fever, elevated white blood cell count and symptoms suggestive of transient ischemic attack or stroke, would you agree that endocarditis should be included in the differential diagnosis?
MS. HARRIS: I'm going to object. He is not here as an expert. He is here as a treating physician, and if you want to demonstrate that that was the information that he had, fine, but he is not here as an expert; at least not the last time I checked.
Q. Doctor, you may answer my question.
A. Could you repeat the question?
Q. In a patient with a bioprosthetic

34

valve who presents with fever and elevated white blood cell counts, symptoms of transient ischemic attack, would you agree that endocarditis should be included in the differential diagnosis?
MS. HARRIS: Objection.
A. Yes.
Q. Would you agree that in some instances bacterial endocarditis can cause catastrophic embolic stroke?
A. Yes.
Q. Doctor, which type of echocardiogram is more sensitive for picking up signs or suggestions of prosthetic valve endocarditis?
A. Transesophageal echo.
Q. Do you do in your practice echocardiography?
A. No. Are you saying do I perform them?
Q. Yes.
A. I utilize them, but I do not perform them.
Q. You don't personally perform transesophageal or transthoracic echocardiograms?
A. That's correct. I order them, though.
Q. Have you at some point in your past

35

experience performed transesophageal echoes or transthoracic echoes?
A. I have never performed transesophageal. In my cardiology training in the late '70s, I did transthoracic echoes with very crude equipment.
Q. Is one type of echocardiogram better than the other for assessing aortic regurgitation?
A. I do not believe so.
Q. Doctor, if a prosthetic valve patient presents with stroke symptoms and there is a suspicion that the cause may be cardiac embolic origin, would you agree that an echocardiogram should be done on a high priority basis?
MS. HARRIS: Objection. The same reason.
THE WITNESS: Run that by me one more time.
(Record read.)
MR. MALONE: Absent anything else going on, is that the question?
MS. TOSTI: My question is just as stated
MR. MALONE: Absent everything else?

36

Everything else is perfectly normal? Is that the question?
MS. TOSTI: The question is as I stated.
MR. MALONE: I want to make that clear. If that's the question, then we will answer it.
Q. Doctor, do you understand my question?
A. I understand the question.
MS. HARRIS: Show an objection.
MR. MALONE: Show an objection to the question.
A. The way you phrased it, yes.
Q. Doctor, if you see a patient and in your opinion the patient requires a transthoracic echo be done on a high priority basis -- I want you to assume that that's your opinion – how long does it take you to get the patient in for an echo at MetroHealth Medical Center?
A. Transthoracic on a high priority, five minutes.
Q. And if in your opinion a patient required a transesophageal echo be done on a high priority basis, how long would it take you to get the patient in to have a transesophageal done?

37

A. A very high priority, 20, 30 minutes. An outpatient or inpatient? Once the patient is physically in the building, 20, 30 minutes.
Q. How long do porcine aortic valves usually last before they start to naturally deteriorate?
A. Depends on the age of the patient that the valve was put.
Q. In a patient that's in their 70s, is there any rule of thumb?
A. The general rule of thumb is they start anticipating deterioration by ten years.
Q. Would you agree that it would be unusual to see bioprosthetic deterioration of a porcine valve after three years or four years?
A. No.
Q. How often would you see that in a patient?
A. I have seen them many times.
Q. What percentage of patients that have a porcine bioprosthetic valve would be expected to have deterioration in their valve within three or four years?
A. It would be in the minority, but it's not unheard of.

38

Q. Can you give me a percentage?
A. I can't give you an exact number.
Q. Can bacterial endocarditis cause deterioration of a porcine heart valve?
A. If you are talking about the same deterioration like you were talking about in the previous question, no, but it can cause a different type of deterioration.
Q. What type of deterioration can bacterial endocarditis cause?
A. In a porcine valve, it can destroy the leaflets.
Q. Doctor, if prosthetic valve endocarditis is within the differential diagnosis, what should the clinical workup include?
A. It would include – well, it would depend on how high it's in the differential diagnosis.
Q. Well, if it's high in the differential diagnosis, what should you do?
A. If you felt that endocarditis was high on the differential diagnosis, get an echocardiogrann.
Q. Would that be a transthoracic?

39

A. Transthoracic first, yes.
Q. Anything else?
A. Blood cultures.
Q. And how should the blood cultures be done?
A. They best would be done as a series of blood cultures. The best is between three and six blood cultures done from different sites over a period of time, usually obtained, if possible, when a peak of a fever occurs.
Q. And over how long a period of time should these blood cultures be obtained?
A. That depends on the priority of endocarditis in the picture and whether they can be done very rapidly if there is a high suspicion. If it's a low suspicion, then they may be done over a series of days.
Q. Do valvular vegetations have to be present before the diagnosis of prosthetic valve endocarditis can be made?
A. Not necessarily, but it's very difficult to make it without them. It's much more difficult.
Q. When a patient has an aortic valve replacement with a porcine heart valve, do they

40

generally have murmurs afterwards?
A. Yes.
Q. That's a typical finding?
A. Yes.
Q. Are there any particular types of murmurs that would be associated specifically with prosthetic valve endocarditis?
A. You look for regurgitant murmurs.
Q. And if a patient had a prosthetic valve replacement and had a postoperative murmur, would you expect to hear a regurgitant murmur in that type of patient?
MS. HARRIS: Objection.
A. If someone --
Q. Let me clarify my question. Previously I think you answered that it's not unusual for a patient after receiving a porcine prosthetic aortic valve to have a heart murmur.
A. Correct.
Q. What type of heart murmur do those patients have when they do have a murmur postoperatively? What's typical?
A. Porcine aortic valve?
Q. Yes.
A. Systolic ejection murmur.

41

Q. So if that type of patient then developed a regurgitant murmur, what would that indicate to you?
A. That either the valve is deteriorating or it is possible that – well, deteriorating due to a number of different reasons.
Q. So if an aortic regurgitation murmur was a new finding in a patient that had received a prosthetic bioprosthetic porcine heart valve, would that cause the heightened concern for valve deterioration?
A. Yes.
Q. And under those circumstances, are there any diagnostic steps that would be undertaken to further evaluate that?
A. Echocardiogram.
Q. Now, doctor, if one of your patients is diagnosed with prosthetic valve endocarditis, would you as a cardiologist manage the care and treatment for that patient?
A. I don't have specific patients. I have very few specific patients, so our system, if a patient came in, they would be admitted to a medical floor or the coronary care unit, and unless I was running that floor, that unit, I

42

wouldn't personally manage the patient. I would be interested in their follow-up and discuss it, but I wouldn't personally manage it. If I were in the unit, I may be taking care *of* my own patient.
Q. You wouldn't necessarily refer the patient to another person to manage just because it was prosthetic valve endocarditis if the patient was cared for by one of the other cardiologists, it would be because of the way the work is divided at Metro; is that correct?
A. Well, it is the way the work is divided who would be the primary care physician, but all valve cases like this, as you describe, would be managed by a team of consultants.
Q. Who would be on the team of consultants?
A. Thoracic surgery, infectious disease.
Q. Cardiology too?
A. And cardiology, yes. Cardiology gets all these patients. As soon as they are diagnosed as endocarditis, they come to the cardiology floor.
Q. Obviously a cardiologist is always going to be involved in the care of a patient

43

with prosthetic valve endocarditis?
A. Correct.
Q. Doctor, in a patient with a prosthetic valve endocarditis, what are the indications for valve replacement surgery? And I am asking from your perspective as a cardiologist, realizing that the thoracic surgery people would also have their perspective.
A. The indications are abscess formation, significant hemodynamic deterioration of the valve, large vegetations, recurrent emboli, a valve that you didn't think you could adequately sterilize due to the nature of the organism.
Q. Do most patients with prosthetic valve endocarditis require surgical valve replacement to eradicate the infection?
A. Many do. I can't tell you -- if you are talking about the possible and probable thing, I can't tell you if it meets 50 percent, but it's a high percentage of them.
Q. Now, doctor, do you have an independent recollection of Earline Mizsey as you sit here today?
A. A vague recollection of the events, a pretty solid recollection of the events of May

44

14th, 1998.
Q. When is the first time that Earline Mizsey came under your care?
And if you would like to refer to any of the medical records, please feel free to do so.
A. I believe it was in 1995, I did a cardiac catherization on her.
Q. Aside from the cardiac cath, did you provide her with any other follow-up care?
A. None until 1998.
Q. So the reason that you saw her in '95 was simply to do her cardiac cath? She was being managed by someone else from a cardiology perspective?
A. That is correct.
Q. The cath that you did in 1995, was that prior to the time that she had her surgery done?
A. That's correct.
Q. And then you did not see her again until 1998; is that correct?
A. To the best of my recollection.
Q. Now, doctor, you have had an opportunity today to review the March 10th, '98

45

Southwest General Hospital emergency room department records; correct?
A. Very briefly, yes.
Q. I would like you to – I am going to have some questions regarding those records, so if you would take a moment.
All right. Now, if you would turn to the typewritten summary of that emergency room visit that is signed by Dr. Graber, and I believe the note at the end indicates that the patient was discussed in detail with Dr. Vrobel covering for Dr. Rakita, who will call the patient early in the morning.
Do you see that section?
A. Yes.
Q. Do you have a recollection of a conversation with Dr. Graber?
A. Absolutely not. I get many of these telephone calls, so I wouldn't remember.
Q. Do you have any reason to disagree with what Dr. Graber has written down there; that he spoke with you and that was told that Dr. Rakita would call in the morning?
A. I have no reason to disagree with that, no.

46

Q. Now, in March of '98, did you have occasion to take calls which resulted in you being – did you have occasion to be on call for some of Dr. Rakita's patients in March of '98?
A. Well, yes, I would have been on call for anybody's patients if it were off hours.
Q. I think you mentioned previously, if you were on call for one of the cardiologists, if you were contacted by an emergency room physician about one of the other cardiologist's patients that you would provide telephone consultation for that patient on behalf of the cardiologist that wasn't available?
A. Yes.
Q. And in this particular instance, if you spoke with Dr. Graber, is this the type of instance where you would then contact Dr. Rakita at the next opportunity and inform him about the call?
A. That's correct.
Q. And you have indicated that you don't have any type of written record or a log or anything of calls that you took at that time; correct?
A. I do not.

47

Q. Now, that particular note indicates that Dr. Rakita will call the patient early in the morning. Is that the type of information that you would routinely give when you took calls for Dr. Rakita? Would he normally call a patient back in the morning if you received a call about the patient during the night?
A. Oh, yes, absolutely.
Q. So that was a typical type of information being provided when you would cover for him on an on-call basis?
A. Correct.
Q. You don't have any recollection of providing any recommendationsto Dr. Graber from this emergency room visit, do you?
A. Absolutely not. This was news to me today.
Q. Now, when Earline Mizsey presented to the emergency room on this date, I believe Dr. Graber's notes indicated that his impressions were that she had a TIA. She also had a white blood cell count, I believe, of 15.4.
A. Yes.
Q. And I believe the nurse's notes indicate that her temperature was 100.9

48

Fahrenheit; that she was having some labored respirations. I believe that's also in the nurse's notes that's checked off. I believe it's a checklist someplace up at the top of the page?
A. Temperature of 100 point something or other.
Q. It's repeated in another place. I believe you can see it better, 100.9.
MS. HARRIS: Looks like 100.4.
A. I only see it in one spot.
Q. Okay. Well, my record appears, looks like --
A. Here is another one. It is 100 point something or other, too. I can't see what that is.
Q. Mine looks like it says 100.9. But given her history of a porcine valve replacement with the elevated white blood cell count, the impressions of a TIA, and the elevation in her temperature, should porcine valve endocarditis have been within the differential diagnosis?
MS. HARRIS: Objection. You have given him half of the information from the emergency department. I don't think it's fair to this doctor to say pick out these couple things

49

without the whole clinical picture and ask him to be an expert.
MS. TOSTI: The doctor has the medical records from the emergency room visit sitting before him and he had an opportunity to briefly review them before this deposition. He can feel free to review any other portion.
But based on the facts and his knowledge of this patient, because it was a patient that he was a treating physician for --
Q. Based on your knowledge of her history, when she presented to the emergency room on March 10th of '98 with what is described as a TIA, elevated white blood cell count, elevated temperature, and a history of a porcine aortic valve in place, would you agree that prosthetic valve endocarditis should have been in the differential diagnosis of this patient?
MR. MALONE: I am going to show an objection, because you asked him to base his judgment on his knowledge of her medical history. He didn't have the patient in front of him. He hadn't seen the patient at this window of time in three years.
MS. TOSTI: I am asking about the

50

medical records before him.
MR. MALONE: It implies he had the patient in front of him and he did not. He will answer the question. In other words, you are asking him does he think that Dr. Graber was negligent in not doing something else.
MS. TOSTI: I have not asked him anything about negligence.
MS. HARRIS: That's exactly what you asked him.
MS. TOSTI: I asked him what the clinical diagnosis should have entailed. This is a patient he treated.
MR. MALONE: He didn't treat her. He did a diagnostic study on her. Don't mix your words. He never treated the lady. He did a diagnostic procedure.
MS. TOSTI: After this point in time and he treated her before.
Q. And I am asking you based on this lady's history, which you have knowledge of the fact that she had a porcine aortic valve in place, and the fact that with the impressions of a transient ischemic attack, with an elevated white blood cell count, with elevations in her

51

temperature, should prosthetic valve endocarditis have been within the differential diagnosis for this lady?
MS. HARRIS: I'm going to object once again.
MR. MALONE: Same objection.
MS. HARRIS: He has to throw out the results of the CAT scan, all of the other information that was gleaned by Dr. Graber, is that what you are saying?
Q. Doctor, do you understand my question?
A. Well, I guess if you are confining it to the information you are giving me, then the answer is obviously, yes.
Q. Okay.
A. But I think there is other information in here that's relevant, too.
Q. Tell me what that other information is.
A. The other information appears to be a clinical diagnosis of sinusitis, which could also explain the fever, the high white count. And therefore, I mean, if you say within the realm of the differential diagnosis, I have to answer yes, but how high I would put that would depend on

52

these other factors.
Q. And differential diagnosis means that there is several things that may be the cause of a patient's symptoms; correct?
A. Correct, yes.
Q. And within the differential diagnosis, would you agree that given what you see in these emergency room records, that prosthetic valve endocarditis should have been within that differential diagnosis?
MS. HARRIS: Objection.
A. Within that realm of the way you are stating that, yes.
Q. Now, based on your review of those medical records from that emergency room visit on March 10th, do you have an opinion as to whether Earline Mizsey should have been seen the following day at Metro for follow-up?
MS. HARRIS: Objection. Again, he is not here as an expert.
A. Seen?
Q. Seen.
A. I would think that it could possibly have been appropriate enough just to contact her and see how she was doing.

53

Q. And what information would be appropriate to obtain if she was just contacted the following day?
A. If she had sinusitis, she could have recovered from that. The temperature was gone and she was back to normal.
Q. Okay. And if she continued to have the stroke or TIA type symptoms, continued to have a temperature, would it be appropriate then for her to come in and be seen?
A. If her neurologic syndrome was advancing or her illness in any way was advancing, then it would be appropriate to see her. On the other hand, if she was much better, fully recovered, I don't know that it would be necessary to see her immediately.
Q. How about if she stayed the same as to the way she presented in the emergency room?
A. That's hard to tell over the telephone. I mean, I can go a lot on how people sound over the telephone.
Q. Do you have any recollection of a conversation with Dr. Rakita the morning after this emergency room visit or at any point shortly after the emergency room visit?

54

A. Absolutely none.
Q. Now, Earline Mizsey was seen by Dr. Einstadter, I believe, on March 13th, '98. If you would like to look at that, that's fine.
And he indicated, I believe, in his clinical notes that her symptoms were consistent with acute CVA and that he was going to schedule her for carotid ultrasound and echoes to look for an embolic source.
I will give you a minute so you can find that portion of the record.
A. Yes, it says it there.
Q. Do you see that he indicates her symptoms were consistent with acute CVA?
A. Yes.
Q. And that he was going to schedule her for carotid ultrasound and echo to look for the embolic source?
A. Yes.
Q. Do you have an opinion in Earline Mizsey's case, given her position of the endocarditis, what we looked at, white blood cell count elevated, the temperature, the stroke symptoms, how soon an echo should have been done in her case?

55

A. It's hard for me to say that precisely based on what I have here. I get the impression that he doesn't think there is an acute infection going on, and if there were not an acute infection, I wouldn't have made it a high priority for either of these.
Q. Well, doctor, considering that she had a prosthetic aortic valve and had presented with stroke symptoms, which Dr. Einstadter is confirming at this visit, and had the temperature, elevation in the white blood cell count, wouldn't that place her at risk for another stroke if it was prosthetic valve endocarditis?
A. if it were, yes.
Q. So wouldn't it be prudent to schedule an echocardiogram to assist in determining if there was an embolic source to that stroke rather than allowing her to remain at risk and untreated for a longer period of time?
A. Well, he was looking for an embolic source, but there doesn't appear to be any. Temperature is 37.4 at the time he sees her, so I believe when I see this, that he didn't believe that an infection was going on, therefore he

56

wasn't considering endocarditis,
I don't know if he had the information from the emergency room from a couple days before. I rather doubt that he would have had that, therefore he wouldn't know there was a white count and wouldn't have known there was a fever.
He is not faced with a febrile patient and I don't see any reason why he would have looked at this as a high priority in the sense that he would've gotten an immediate echocardiogram.
Q. If, in fact, he is looking for an embolic source and ordering an echocardiogram, wouldn't you want that done at a high priority? I mean, obviously that's in his own handwriting. He says he is looking for an embolic source. If you are going to do it, wouldn't you want to do it as a high priority if there is concern that there is maybe an embolic source to this?
A. Again, depends on his threshold for concern about that. If he doesn't think – I mean, this patient as presenting right now could have had any cause for the stroke, embolic or not embolic. If he did not feel that embolic was a

57

high priority, then I wouldn't have called for high priority echo.
Q. Now, Earline Mizsey ,eventually had a transthoracic echo done on April 9th of '98, which was almost four weeks later. Did you review the report of that study?
A. I did review the report.
Q. Would you expect -- well, I would like you to take a look at that, if you turn to it.
A. Okay.
Q. And you have the echo of the April 9th, '98 report that you are looking at currently, doctor?
A. Yes.
Q. Would you expect aortic regurgitation to be present in a patient who received a surgical implantation of a porcine aortic valve now three years after the implantation?
A. I think it would not be unusual to have it to the degree that they are describing here.
Q. Is a transesophageal echo or transthoracic echo more sensitive for picking up indications of aortic root abscesses?
A. Transesophageal is much more

58

sensitive.
Q. Isn't it true that when endocarditis is associated with abscess formation, that the infection can sometimes spread into the conduction system of the heart?
A. Correct.
Q. Are there any particular type of heart rhythm problems that would be associated with this type of an infectious invasion into the conduction system?
A. Heart block.
Q. Any particular types of heart block?
A. First degree, second degree, third degree, that's variable.
Q. Now, doctor, that report indicates that the time intervals in filling profile are consistent with abnormal relaxation as seen with myocardial ischemia or hypertrophy or abduction abnormalities or hypervolemia. Do you see that portion of the report that I am referring to?
A. Yes.
Q. In Earline Mizsey's case, could that time interval in filling profile reflect invasion of infection into her conduction system?
A. Not the way it's defined here.

59

Q. Okay. Why not?
A. They are talking basically about left bundle branch block which would not be a typical finding from infectious endocarditis infecting the conduction system.
Q. Now, that same report indicates in, I believe, the last two lines that the above suggests bioprosthetic deterioration which could be a potential embolic source. TEE may be helpful in further clarifying.
Do you see that reference?
A. Yes, I do.
Q. Assuming that this report accurately reflects the findings of that echocardiogram on April 4th of '98, would you agree that she should have had a prompt follow-up TEE?
A. No.
Q. Why not?
A. The way this is worded, it's a maybe it would be helpful. It's a very vague suggestion. They are talking about bioprosthetic deterioration, which is – what they are talking about is stenosis of the valve. Noninfectious stenosis of the valve and given the overall gestalt of the patient, I would not make this a

60

high priority.
Q. Why do you say that they are referring to noninfectious deterioration here?
A. Bioprosthetic deterioration, Dr. Finkelhor was referring to the fact that these valves stenose with time totally devoid of infections, and that was based on relatively high gradient. The chances that that would lead to embolization is relatively unlikely. I personally would not have probably even gotten the transesophageal echo based on this report. In the context of someone, you know, that you have talked about, I would have to give that further consideration.
Q. So you would disagree with this report in that the bioprosthetic deterioration could be a potential embolic source?
A. I don't disagree with that, but it's not a very likely cause for the embolism. I have never seen an echo show an embolic source in a deteriorating porcine valve.
Q. Doctor, we spoke earlier in regard to infectious endocarditis causing some type of deterioration of the bioprosthetic valve, and I think you spoke about deterioration in the

61

leaflets.
Can you by looking at this report discern whether infectious endocarditis could cause any of the changes that are documented on this report? And I am only asking based on what you see in the report.
Can you say that none of these findings would be consistent with a patient that was suffering from infectious endocarditis that was attacking the porcine heart valve?
A. There is nothing in this report that would lead me to believe that infectious endocarditis is going on.
Q. Knowing that Earline Mizsey had had a CVA and now it showed on her echocardiogram that she had bioprosthetic valve deterioration, even knowing those two things, you still believe that it was not likely that the bioprosthetic valve was or would be a potential embolic source; correct?
A. I believe it's unlikely that the bioprosthetic valve deterioration that you describe here would have been the source of the TIA stroke phenomena that she had on the 10th.
Q. And I believe you told me that based

62

on what you see in this report, you would not have moved to do a transesophageal echo on her; correct?
A. Not based on this report alone, no. I mean, again, putting it in the overall context, I might have wanted to get one eventually, but I wouldn't have made it a high priority.
Q. And based on the overall context, what would lead you to want to get one eventually?
A. Well, if I had seen her and she was having signs of infection going on, on an ongoing basis, then I would probably move to get a transesophageal echo with some degree of speed.
Q. Now, on April 26th of '98, Earline Mizsey presented to MetroHealth's emergency room department complaining of pain throughout her right leg and thigh which started the day before and was of sudden onset after stepping out of the shower. And she described it as being worse when she walked, but it didn't improve at rest. And I believe at that time her temperature was also 37.6 degrees centigrade.
MS. HARRIS: What day was that again, please, Jeanne?
MS. TOSTI: I believe it was April

63

26th.
A. It's April 26th, yes.
Q. Now, given the results of that echo that we just looked at, and with this symptomatology, do you think that there should have been a heightened level of suspicion for embolism of cardiac origin that was causing her leg problems at this visit?
A. Well, I have a difficult time interpreting this whole emergency room visit, but all I can say is they come to the conclusion this was a nonvascular problem, and if that's the conclusion, then no, in answer to your question. If they thought it was a vascular problem, then the answer would be yes, but the conclusion I am getting is they thought it wasn't a vascular problem.
Q. But I'm asking whether you have an opinion, a personal opinion after reviewing this. And if you don't, just tell me that. But I am interested in knowing whether you believe with the symptoms described as they are in that particular emergency room visit whether there should have been a heightened suspicion for arterial embolism to the leg originating from the

64

heart?
MR. MALONE: Arterial embolism of the leg?
MS. TOSTI: To the leg that originated from the heart.
A. I can only answer that in retrospect. Knowing the final diagnosis and then going back and looking at this, I would say it is possible, but I wouldn't say definite that this was an embolic event, but I can't say that for sure.
Q. Knowing the results of that echocardiogram that was done on April 9th of '98 followed by her presentation in the emergency room on April 26th, we know that she was having deterioration of her bioprosthetic valve. Would that lead you as a cardiologist to have a heightened concern for embolism from the deterioration of her bioprosthetic valve?
A. No. Deteriorating bioprosthetic valves don't commonly embolize. They stenose, they cause heart failure, but they don't necessarily embolize. As I said, I have never seen a deteriorating aortic valve embolize. I am sure it can happen.
Q. Doctor, when a patient that you are

65

caring for – well, would you normally receive a copy of a Metro emergency room visit if you were caring for a patient as the cardiologist? Would Metro send you a copy of that emergency room visit?
A. Sometimes.
Q. Now, Earline Mizsey was admitted to Metro Hospital on May 8th of '98 and you cared for her at some point during that admission; correct?
A. I picked her up on the 14th.
Q. Now, doctor, were you her attending physician during that visit?
A. Yes, When she came to the coronary care unit, I think it was late in the afternoon of the 14th, I assumed her care.

- - - - -

(Thereupon, VROBEL Deposition Exhibit 3 was marked for purposes of identification.)

- - - - -

Q. I am going to hand you what's been marked as Plaintiffs Exhibit 3.
MS. TOSTI: Let me show it to counsel first.

66

MR. MALONE: I'm sorry, Jeanne, what is it? The discharge note?
THE WITNESS: Discharge diagnosis, yes.
Q. And I would ask, is that your signature on the bottom of the page?
A. That's my signature, yes.
Q. Is this the list of diagnoses that Earline Mizsey had while she was a patient during that May 8th, '98 admission?
A. Yes. It appears to be an accurate list of diagnoses.
Q. Your signature appears at the bottom of the page on a line that says attending physician: correct?
A. Correct.
Q. You were only her attending physician while she was in the coronary care unit?
A. Correct. Less than 24 hours, probably.
Q. Why is it that you signed this particular sheet?
A. Because I was the last physician that had her in the hospital.
Q. And in signing this sheet, did you

67

agree with the diagnoses that were listed on the sheet?
A. Yes, theoretically, yes.
Q. Now, you cared for Earline Mizsey -- and correct me if I am wrong – on May 14th and May 15th; is that correct?
A. Correct.
Q. What is your understanding as to what brought her to the hospital for that admission?
A. She had another cerebral vascular accident on the 8th.
Q. And have you had an opportunity to review the emergency room records from Southwest General Hospital that immediately preceded that admission to MetroHealth on May 8th?
A. Yes.
Q. And in your review, you saw that at the time of the presentation she had an elevated temperature?
A. Yes.
Q. Was unable to speak or had difficulty speaking?
A. Had a cerebral vascular event, yes.
Q. And was suffering from right sided problems related to the cerebral vascular

68

accident?
A. Yes.
Q. She also had urinary tract infection?
A. Yes.
Q. And was it your understanding that this now was her second cerebral vascular accident?
A. Yes.
Q. Now, doctor, Earline Mizsey had undergone vascular studies, I believe, just the day before, on May 7th, '98, and they found her to have an occlusion in her right leg with severe distal ischemia.
A. Correct.
Q. Were you aware of that when you cared for her in the coronary care unit?
A. I wasn't aware of those vascular studies, per se. I was aware of a lot of different things, but I don't believe I was aware of those. I was aware that she had had an arteriogram before I saw her.
Q. You were aware that she had an occlusion, though, in her right leg?
A. I was, yes.
Q. Were you also aware that Dr. Alexander

69

had been contemplating doing an embolectomy to remove the blockage in her leg?
A. When I saw her, yes, on the 14th.
Q. Doctor, when you saw her on the 14th, did you think it was –
A. Can I go back to the last question?
Q. Yes.
A. I don't know, I don't believe I talked with Dr. Alexander on the day of the 14th, but the angiogram did not indicate an embolism. So on the day of the 14th I don't believe that an embolectomy was in consideration, but I had read the note from the 13th where he said he was contemplating an embolectomy.
Q. So based on his note prior to the time that you cared for her, you were aware that his note indicated that he was contemplating the embolectomy?
A. On the day of the 13th. On the day of the 14th and subsequent, I don't know that he was continuing to consider an embolectomy.
Q. Because she did have a condition change, I believe?
A. Correct.
Q. At the time that she went into the

70

unit.
A. Correct. Number one. And number two, based on the arteriograms, I don't know that I had a specific conversation with him, but the arteriogram did not indicate an embolism was the cause of the occlusion.
Q. Well, didn't you think it odd then that Dr. Alexander would be contemplating embolectomy –
A. That was before the arteriogram.
Q. What date was the arteriogram?
A. The 13th, I believe. I think his note was the 12th. I will get the specific dates. The arteriogram is the 13th and – that's May 11th. May 11th he is contemplating, like all the other physicians were considering that the right lower extremity ischemic was embolic in nature.
My interpretation of the arteriogram of the 13th, two days later, would be it's nonembolic in nature, and so I don't have any recollection of any further conversations with Dr. Alexander about that.
Q. You didn't speak with him, and what you are telling me is what you discerned is from the record, progress notes and whatever reports

71

are available?
A. Correct. I don't see any further notes from Dr. Alexander contemplating further embolectomies.
Q. Doctor, at the time that you cared for her, did you believe that her stroke on March 10th, May 8th, and the one that preceded transfer to the coronary care unit, which I believe took place on May 12th, were caused by emboli originating from her heart?
MS. HARRIS: I'm going to object. First off, you are assuming she had a stroke on March 10th.
A. Run this by me again.
Q. Dr. Einstadter reviewed it and said that he felt she had a CVA.
MS. HARRIS: Three days later.
A. When I saw her on the 14th.
Run the whole question by me again, please.
Q. When you saw her on the 14th –
MS. HARRIS: Okay.
A. Of May.
Q. – was it your opinion that her March stroke, her stroke of May 8th that brought her to

72

Metro Hospital and the event that took place just prior to transfer to the coronary care unit were caused by emboli originating from an infected heart valve?
A. I have a strong opinion that the stroke of the 8th, deterioration on what was it, the 12th, 13th, something like that, were probably embolic in nature. I have no idea what the stroke of the 10th of March was related to: whether that was related to an emboli or not. She had plenty of other reasons to have strokes besides endocarditis.
Q. Now, the reason that Earline Mizsey came under your care was because she was transferred into the coronary care unit and you were responsible for that unit at that particular time; is that correct?
A. Yes. On May 14th, the definite diagnosis of endocarditis was solid. As soon as that diagnosis was made, as I said previously, a patient like this would have been transferred to a cardiac unit, and with a neurologic status, that was the coronary care unit.
Q. You did not see her any time before she came into the coronary care unit?

73

A. The first time I saw her was when she arrived in the coronary care unit, yes.
Q. Did you have any conversations with anyone, with Dr. Rakita, about her prior to May 14th when you actually became involved in her care?
A. To the best of my recollection, I think it's pretty strong no. I remember that afternoon she sort of like suddenly appeared out of the blue and I hadn't heard anything about her up until then. That's my best recollection.
Q. Do you recall any recollection with Dr. Einstadter or any other physicians prior to the time that you saw her in the unit on May 14th?
A. To the best of my recollection -- I am pretty strong on this -- I don't think I knew anything about her until then.
Q. Did Dr. Rakita participate in her care while she was in the coronary care unit?
A. No.
Q. So you assumed all the cardiology responsibilities once she came into the coronary care?
A. In conjunction with the consultant.

74

Q. What was her condition when you first became involved in her care on May 14th?
A. My notes say that she had significant expressive aphasia, but had been stable since the previous date. Had no fever. Hemodynamically stable. Had an ejection murmur. Had an ischemic right lower extremity and had the various laboratory findings that had been found. So I don't know if you want any further definition of the condition. She was sick with endocarditis.
Q. Doctor, I'm going to hand you what's been marked Exhibit Number 4.

(Thereupon, VROBEL Deposition Exhibit 4 was marked for purposes of identification.)

MS. TOSTI: It's just doctor's notes.
Q. I would ask if you would -- it's a two-page document. It was originally a double-sided document, but I Xeroxed it as two pages. If you could identify for me what this document is?
A. This is my admitting note when she came to the coronary care unit. That's the top

75

one. The second note is related to the status of trying to get her transferred for surgery. And then on the 15th there was a note related to the fact that we had gotten her transferred for surgery.
Q. Now, at the time that you saw her in the unit, she had already suffered three strokes; is that correct?
A. The nature of the deterioration on the 12th or 13th -- I am getting a little vague on what date it was -- nobody was sure what that represented; whether that was a new stroke or just intensification of the previous stroke due to other factors. So she had had at least one major stroke on admission, possibly a second and then there was this prior history of a third stroke.
Q. And she had vegetations on her valves and an abscess of her myocardium; correct?
A. Correct.
Q. And she also had an ischemic right leg when you saw her?
A. Correct.
Q. And she was suffering from aphasia; correct?

76

A. Correct.
Q. Now, would you tell us what you wrote in the last paragraph of your May 14th, '98 coronary care admission note. The last four lines. It looks like a paragraph to me. Or I'm sorry, the last paragraph where there is indention there.
A. Discussed with?
Q. Yes.
A. We had a conference as to what to do with her under these circumstances.
Q. I would ask that you read that for us.
A. Discussed with thoracic surgery, infectious disease, the patient's famiiy, Dr. McKinny, previous 9-C attending, and the patient. Feelings were that the patient needed aortic valve replacement with homograph or she will die from this episode of bacterial endocarditis. Patient and family agree to this but the patient needed to go to The Cleveland Clinic for this. Attempting to contact The Cleveland Clinic and discuss with their cardiac surgical team. Will need cath first, question mark, here versus at Cleveland Clinic.

77

Q. Who was the thoracic surgeon that was involved in this conversation that you discuss here?
A. Dr. Chavez, Altagracia Chavez.
Q. Who was the infectious disease person that you spoke to in this conversation?
A. I honestly don't know and I am not sure I will be able to tell you that directly at what level I was discussing that.
Q. What was Dr. Chavez's opinions regarding Earline Mizsey's case?
A. That she felt that surgery was theoretically indicated but a very high risk.
Q. And the infectious disease person that you spoke to, what were that individual's opinions?
A. That he didn't believe that we would be able to sterilize the patient without surgery.
Q. Was Earline Mizsey able to indicate in any way her agreement with plan of care?
A. I believe she was, but that's kind of vague. I gleaned from my note that I was able to communicate with her to some degree.
Q. Do you have some recollection other than what you have in your notes?

78

A. My vague recollection was that she understood what she had. She had expressive aphasia, which means she understands things but couldn't express it, so she understands what we are were talking about.
Q. Did the family make any comments to you regarding the plan?
A. I assume they did, but I can't say exactly what they were. I don't remember at all the family.
Q. And why did you feel she needed surgery or she would die from --
A. She had three major indications for surgery, so she was, you know, between the proverbial rock and a hard place, in a sense.
Q. What were the three major indications?
A. Recurrent embolization, a bacteria that was going to be hard to sterilize and a valve abscess, a brain abscess.
Q. And did you also agree that medical treatment would not likely result in a cure of her endocarditis?
A. That's what I was being told by infectious disease.
Q. Now, you mentioned a homograph valve

79

as the replacement for her infected valve. Is there a reason why a homograph valve would be contemplated in her case?
A. Yes. I am not an expert on this – thoracic surgeons are better experts – but this is sort of the treatment of choice for deep seeded endocarditis because you are able to sew the tissue in better.
Q. Why did Earline Mizsey need to go *to* Cleveland Clinic for surgery?
A. Because Dr. Chavez couldn't perform this operation. Didn't have experience with it.
Q. Was Metro doing aortic valve replacement surgeries at that time?
A. Yes, they were.
Q. What in particular about Earline Mizsey's surgery made it different than --
A. The homograph valve.
Q. So Dr. Chavez was not doing homograph valves?
A. Was not, yes.
Q. Now, were you the person who contacted Cleveland Clinic to discuss the possible surgery?
A. Yes.
Q. Can you tell me who it is that you

80

spoke to there when you contacted them?
A. The first person, I believe, was a thoracic surgery fellow, but I couldn't give you a name or anything like that. Whoever was taking calls for thoracic surgery transfers.
Q. And in that conversation, can you tell me what was discussed and what the final determination was after that conversation?
A. I presented the patient to them and they said this sounds like too high a risk patient, we will think about it, but probably not.
Q. Now, there is another note at the bottom of the page of Plaintiffs Exhibit Number 4 that is also dated May 14th, '98. Is that also your note?
A. That's my note, yes.
Q. And it indicates that you talked to cardiac surgery at Cleveland Clinic. Does that refer to your conversation with the fellow that you just described?
A. Correct. As I stated.
Q. Your note says they do not wish to accept the patient, feeling too high risk; correct?

81

A. Yes, that's correct.
Q. So following that particular conversation, was it your understanding that Cleveland Clinic was not going to take her?
A. Well, I think they left it a little vague. They said they would -- I think this was a fellow and he said he would kick it up the ladder, but he wasn't too keen about the transfer process. And some of this is sort of in retrospect, because somehow Dr. Lytle heard about the patient and ultimately accepted the patient. I don't know what he finally left it at. All I know, he said it was too high risk and said he wasn't accepting the patient at that point.
Q. That was the fellow you were talking to?
A. I believe it was the fellow. I don't know who it was.
Q. What was the reason that she was considered too high a risk for surgery?
A. Because of the recurrent or the extent of her neurologic problems.
Q. Now, after you had that first conversation with the cardiac fellow at Cleveland Clinic, did you have any conversations with the

82

family immediately or shortly after that conversation?
A. I have no recollection of when I talked with the family or where we were at that point.
Q. Now, doctor, I believe that note that's on the bottom of Plaintiffs Exhibit Number 4 also indicates that you talked to another physician at University Hospitals; is that correct?
A. That's correct.
Q. Who was it that you talked to at University Hospital?
A. Dr. Alan Markowitz.
Q. And were you at that point attempting to see if they would accept her for surgery?
A. That's correct.
Q. What did Dr. Markowitz say in regard to Earline Mizsey?
A. He felt that she was a surgical candidate and he felt that he was personally willing to do the surgery, but had a full schedule the next day that he didn't want to bump. And he said he would ask around. I mean, he appreciated this was a high

83

risk patient and was fraught with problems, but he was a fairly aggressive surgeon and was willing to do it. But he couldn't speak for any of his colleagues.
Q. Did Dr. Markowitz ever get back to you as to whether any of the other cardiac thoracic surgeons at University Hospitals would accept Earline Mizsey for surgery?
A. He did not, because Dr. Lytle subsequently called me out of the blue. I didn't know how he was informed of the case, but he said he had been informed of the case and said he would provisionally accept the patient and consider her for surgery.
But again we discussed the risks and benefits and he wasn't sure that he would ultimately do the surgery, but would have his neurologist evaluate the patient.
Subsequent to that, I got back to Dr. Markowitz and told him that the patient was going to go to The Cleveland Clinic.
Q. Now, doctor, on the second page of Plaintiffs Exhibit Number 4, there is another note towards the bottom of the page dated 5-15-98. Is that also a note that is written by

84

you?
A. Yes.
Q. And what was Earline's Mizsey's condition on that second day that you were involved in her care on the 15th?
A. My note doesn't reflect it at all, but to the best of my recollection, it hadn't changed from the day before, from admission.
Q. And could you tell me what the doctor's name is in your note there? It says talked to Dr. -
A. Bruce Lytle.
Q. So from your conversation with Dr. Lytle, what was your understanding as to the plan after Earline Mizsey would be transferred to Cleveland Clinic?
A. They would take her there. They would consider the operation, but they weren't guarateeing they were going to do it. And I believe that's what I told the family, ultimately.
Q. So after you talked with Dr. Lytle, you had a conversation with the Mizsey family?
A. Yes, to tell them that the patient was going to be transferred. You have to let the

85

family know where the patient is going.
Q. Who did you talk to in the family?
A. I have no idea.
Q. Did you talk to more than one person?
A. I have no idea.
Q. And other than telling them that she was going to be transferred, did you give them any other information about what would be the expectations after she got to Cleveland Clinic?
A. You know, I am just projecting that I probably would have told them what is reflected in the note that Dr. Lytle said; this was a high risk patient and he would consider surgery, but he wasn't saying definitely he would do it.
Q. Now, at the time that she was transferred to The Cleveland Clinic, was it still your opinion that she would die from the bacterial endocarditis if she did not have an aortic valve replacement?
A. I felt it was probably very high risk that she would die without it, without the surgery, but you know, that doesn't mean absolutely that it had to be done.
Q. To a reasonable degree of probability?
A. To a reasonable degree. If it weren't

86

for the neurologic problems, she would have had the surgery, which everybody agreed to that, but the hangup was if she went for surgery, would they save the heart but lose the brain and that's a difficult choice.
Q. Do you know whether endocarditis was a causative factor in her death?
A. I have no idea what happened to her after she went to The Cleveland Clinic. All I know is in general she didn't have the surgery and was subsequently sent to a nursing home.
Q. Do you have an opinion as to what point in time Earline Mizsey became too high risk for surgical replacement of her infective heart valve?
A. No.
Q. Do you have an opinion as to when Earline Mizsey likely developed bacterial endocarditis in her prosthetic valve?
A. I have been racking my brain on that. I honestly can't tell you when, having reviewed this multiple times, when I think she had endocarditis. Before the 8th, but I don't have any idea when it perked up.
Q. When you say the 8th, you are saying

87

May 8th?
A. May 8th, yes. She obviously had it on May 8th.
Q. After she was transferred to The Cleveland Clinic, did you have any further contact with Earline Mizsey?
A. Nobody ever contacted me.
Q. You didn't speak with any of the physicians caring for her?
A. Never contacted them.
Q. Did you have any further contact with any of the family members after she was transferred to The Cleveland Clinic?
A. To the best of my recollection, no.
Q. Were you notified by any means that she did not undergo surgery at Cleveland Clinic?
A. First time I found that out was when this case was presented to me.
Q. So when you sent her to The Cleveland Clinic, you were under the assumption they would evaluate her and make a determination and you didn't participate in any of her care after that?
A. That's correct.
Q. Do you have an opinion as to whether there was any avoidable delay by any of the

88

physicians caring for her in diagnosing her prosthetic valve endocarditis?
A. I say this with all sincerity. I think the diagnosis was made as soon as possible given all the variabilities in this case; namely, the diagnosis was certain on May 14th.
Q. Do you have an opinion as to whether Earline Mizsey should have been taken for aortic valve replacement surgery rather than receiving medical management in this case?
A. That's a judgment call. I didn't see her subsequently, so I can't speak to that.
Q. I think I asked you this, but you do not have an opinion as to her cause of death; is that correct?
A. I don't know anything about her death, so I have no idea what the cause of her death was.
Q. If Earline Mizsey had been successfully cured of her prosthetic valve endocarditis, do you have an opinion as to her reasonable life expectancy?
MS. HARRIS: At what time?
MR. MALONE: I'll going to object because I am not sure which way she was cured,

89

and if that would have been an issue, cured by surgery, cured by antibiotics, cured by whatever.

MS. HARRIS: And when?

A. That would be my first major -- when? After the degree of --

Q. At the point that you cared for her, if she had been cured by either medical treatment or surgical treatment, do you have an opinion as to her reasonable life expectancy?

A. I would have expected it wouldn't have been very long. I can't put that in one year, five years, ten years, but I don't think – she had suffered a lot of damage by that point and I don't think she would have, even if the infection were magically cured by holy water on the day of the 14th, I don't think she would have lived an extended period of time.

Q. And is part *of* the reason why she would not have lived an extended period of time the fact that she had suffered such extensive neurological insult to her system from the strokes?

A. Multiple organs are in trouble, yes. Neurologic troubles, heart troubles,

90

cardiovasculartroubles, peripheralvascular troubles. She was a sick woman and she was having recurrent urinary tract infections, which could have, you know, added complications to that.

Q. Do you have any criticisms of anyone that rendered care to Earline Mizsey?

A. Honestly, no.

Q. Do you blame Eariine Mizsey or any of her family for the complications that she suffered?

A. Oh, absolutely not.

MS. TOSTI: I don't have further questions for you. I don't know if Ms. Hams does.

EXAMINATION OF THOMAS RAYMOND VROEEL, M.D.

BY MS. HARRIS:

Q. Doctor, I am going to be very, very brief.

I just want to be clear. The conversationthat is recorded in the Southwest General Hospital emergency department record that Dr. Graber spoke with you at the time this patientwas in the emergency department, you don't remember it, but you are not saying it

91

didn't take place?

A. I am sure it took place. I have absolutely no reason to believe that it didn't take place. I am sure it took place, but I don't have any recollection of it.

Q. When Dr. Graber put in that Southwest General emergency department record that Dr. Rakita would call this patient the following morning, that would be, if you assume this conversationtook place, something you would have told him?

A. It would be contingent on me passing informationto Dr. Rakita.

Q. And that's something you would normally do?

A. We always do that, yes.

Q. But you then would not follow up to see if that conversation took place --

A. No, I would not.

Q. -- or anything took place?

And you are accustom, are you not, from when you are on call, having physicians from outlying hospital emergency departments contact you about MetroHealth patients?

A. Yes, it's a frequent occurrence.

92

Q. So when you talk with these physicians from the emergency department, they present the patient, if you will, to you; is that correct?

A. That's correct.

Q. And then if you need additional information, I take it, you will ask them that information, if they haven't given you a complete –

A. If they haven't given me adequate information, but that's pretty rare.

Q. That's pretty rare?

A. Yes.

Q. This is something that's common in the community?

A. Yes.

Q. And if you felt that additional testing needed to be done, I take it, you would have recommended it?

A. Yes.

Q. And if you felt that this patient should be hospitalized either at Southwest General or even at Metro, that is something that you would have recommended; correct?

A. Yes, but basically it's impossible to second guess somebody over the telephone, so I basicallyjust rubber stamp whatever they are

telling me.
Usually the conversation goes this is what is happening, this is what my plans are, do you agree with those and it's hard to say no to any of those.
Q. But the fact is that if a patient has a suspected TIA, that doesn't dictate immediate hospitalization, does it?
A. Not necessarily, no.
Q. A patient can go home and be followed by the primary care physicians; correct?
A. Correct.
MS. HARRIS: That's all. Thank you.
MS. TOSTI: No follow up.
- - - - -
(Deposition concluded at 11:40 a.m.)
(Signature not waived.)
- - - - -

AFFIDAVIT
I have read the foregoing transcript from page 1 through 93 and note the following corrections:

PAGE	LINE	REQUESTED CHANGE

THOMAS RAYMOND VROBEL, M.D.

Subscribed and sworn to before me this day of ,2000.

Notary Public

My commission expires

CERTIFICATE
State of Ohio.
SS:
County of Cuyahoga.

I, Vivian L. Gordon, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named THOMAS RAYMOND VROBEL, M.D., was by me first duly sworn to testify to the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony as above set forth was by me reduced to stenotypy, afterwards transcribed, and that the foregoing is a true and correct transcription of the testimony..

I do further certify that this deposition was taken at the time and place specified and was completed without adjournment; that I am not a relative or attorney for either party or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland Ohio, on this 6th day of December, 2000.

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

INDEX
EXAMINATION OF THOMAS RAYMOND VROBEL, M.D.

BY MS. TOSTI:	3	7
BY MS. HARRIS:	90	16
Exhibit 1 was marked	15	17
Exhibit 2 was marked	16	4
Exhibit 3 was marked	65	18
Exhibit 4 was marked	74	14

A
abduction 58:18
able 5:12 77:8,18 77:19,22 79:7
abnormal 58:17
abnormalities 58:19
about 5:3 6:25 7:18 13:6 14:24 16:25 17:14 18:8 19:13 19:17 20:4 26:13 28:1,13,18 38:5,6 43:18 46:10,18 47:6 49:25 50:8 53:17 56:22 59:2 59:21,23 60:13,25 70:22 73:4,10,18 78:5 79:16 80:11 81:8,10 85:8 88:16 91:24
above 1:25 59:7 95:7
abscess 43:9 58:3 75:19 78:19,19
abscesses 33:1 57:24
Absent 35:21,25
absolutely 45:18 47:8,16 54:1 85:23 90:12 91:3
accept 80:24 82:16 83:7,13
accepted 81:11
accepting 81:14
accident 67:11 68:1 68:7
accurate 66:11
accurately 59:13
accustom 91:21
acted 7:12,19
action 95:12
active 9:14
actually 7:17 15:24 15:25 73:5
acute 7:2 31:25 54:7,14 55:3,4
added 90:4
addition 13:13
additional 9:4 12:21 92:5,15
address 3:11,13,20
adequate 92:8
adequately 43:12
adjournment 95:11
ADMINISTRAT... 1:4
admission 15:10,12 65:9 66:10 67:9 67:15 75:15 76:4 84:8
admitted 41:23 65:7
admitting 11:8 74:24
advancing 53:12,13
AFFIDAVIT 94:1
affiliated 10:8
affixed 95:13
aforesaid 95:7
after 8:17 9:5 14:11 17:24 37:15 40:17 50:18 53:23,25 57:18 62:18 63:19 80:8 81:23 82:1 84:15 84:22 85:9 86:9 87:4,12,22 89:6
afternoon 65:15 73:9
afterwards 40:1 95:8
again 4:23 44:21 51:5 52:19 56:21 62:5,23 71:14,19 83:15
against 4:17
age 37:7
aggressive 83:2
ago 19:14
agree 32:9,14 33:5 33:15 34:3,7 35:14 37:13 49:16 52:7 59:15 67:1 76:20 78:20 93:4
agreed 86:2
agreement 1:21 77:20
al 1:8
Alan 82:14
Alexander 68:25 69:9 70:8,22 71:3
allegation 6:16
allowing 55:19
almost 57:5
alone 62:4
already 75:7
Altagracia 77:4
alternately 27:8
always 42:24 91:16
anemia 30:13
angiogram 69:10
Anorexia 30:6
another 13:23 42:7 48:7,13 55:13 67:10 80:13 82:9 83:23
answer 5:6,13,22 17:2 20:7,12 24:18 27:22 32:23 33:23 36:7 50:4 51:14,24 63:13,15 64:6
answered 40:16
answers 5:15
antibiotics 32:6,16 89:2
anticipating 37:12
anybody's 46:6
anyone 3:23 4:2 18:17 73:4 90:6
anything 17:8 18:8 19:17 20:4 35:21 39:2 46:23 50:8 73:10,18 80:4 88:16 91:20
anywhere 11:5
aortic 35:8 37:4 39:24 40:18,23 41:7 49:15 50:22 55:8 57:15,17,24 64:23 76:18 79:13 85:19 88:8
aphasia 74:4 75:24 78:3
apologize 8:11
appear 55:22
APPEARANCES 2:1
appeared 73:9
appears 48:11 51:20 66:11,13
appreciated 82:25
appropriate 16:18 52:24 53:2,9,13
approximately 4:9 6:5 14:20 25:16 29:3
April 57:4,11 59:15 62:14,25 63:2 64:12,14
area 23:12,19
areas 9:20
around 25:24 82:24
arrive 24:17
arrived 73:2
arterial 63:25 64:2
arteriogram 68:21 70:10,11,14,18
arteriograms 70:3 70:5
artery 7:4
article 21:7,14 22:10,12,15,18,22
articles 11:16
aside 12:22 18:19 30:21 44:9
asked 7:16 18:3 49:20 50:7,10,11 88:13
asking 20:25 22:25 43:5 49:25 50:5 50:20 61:5 63:18
assessing 35:8
assist 55:17
associated 30:7,13 32:25 40:6 58:3,8
assume 5:11 10:25 36:17 78:8 91:9
assumed 65:16 73:22
assuming 59:13 71:12
assumption 87:20
attack 33:14 34:3 50:24
attacking 61:10
attempted 7:3
attempting 76:22 82:15
attending 28:12 65:12 66:14,17 76:16
attorney 95:11
August 14:25 16:25
author 22:14
authored 11:15
authoritative 22:23 23:1
available 28:14 46:13 71:1
avoidable 87:25
aware 14:19 15:3 17:24 21:3 68:15 68:17,18,19,20,22 68:25 69:16
a.m 1:24 93:16

B
back 13:6 24:14 47:6 53:6 64:7 69:6 83:5,19
bacteremia 31:7,8
bacteria 78:17
bacterial 8:4 11:20 12:1 23:6 28:17 28:2 129:7,24 30:13,23 31:2,11 31:24,25 33:6 34:8 38:3,10 76:19 85:18 86:18
balloon 7:3
base 49:20
based 49:8,11 50:20 52:14 55:2 60:7 60:11 61:5,25 62:4,8 69:15 70:3
basically 31:8 59:2 92:23,25
basis 31:3 35:15 36:16,24 47:11 62:12
became 15:3 17:24 73:5 74:2 86:13
Becker 2:3
become 10:8 14:19
before 1:19 4:6 13:21 31:10 37:5 39:19 49:5,6 50:1 50:19 56:4 62:17 68:11,21 70:10 72:24 84:8 86:23 94:19
behalf 1:17 2:2,9,17 46:12
being 3:3 44:13 46:3 47:10 62:19 78:23
believe 7:11 10:20 12:12 13:1,11,22 14:7,24 18:2 20:22 24:9 27:17 32:22 35:10 44:7 45:9 47:19,22,24 48:2,3,8 54:3,5 55:24,24 59:7 61:12,17,21,25 62:21,25 63:21 68:10,19 69:8,11 69:23 70:12 71:6 71:8 77:17,21 80:2 81:17 82:6 84:20 91:3
benefits 83:16
besides 11:5 26:9 72:12
best 20:19 25:17 39:6,7 44:23 73:7 73:11,16 84:7 87:14
better 35:7 48:8 53:14 79:5,8
between 25:10 39:7 78:14
BEVERLY 2:20
binder 12:23
bioprosthetic 29:17 29:22 33:11,25 37:14,21 41:9 59:8,21 60:4,16 60:24 61:16,18,22 64:15,18,19
blame 90:9
block 58:11,12 59:3
blockage 69:2
blood 30:16,25 31:3 31:7,10,17 33:13 34:2 39:3,4,7,8,12 47:22 48:18 49:14 50:25 54:22 55:11
blue 73:10 83:10
board 9:20
book 16:24

both 7:9,22 17:16 23:15 24:22,24
bottom 66:6,13 80:14 82:7 83:24
brain 78:19 86:4,20
branch 59:3
brief 90:19
briefly 5:5 18:1 45:3 49:5
bring 8:7
broad 23:12
Broadview 14:10
brought 67:9 71:25
Bruce 84:12
building 2:13 37:3
bump 82:24
bumped 18:3
bundle 59:3
business 3:13,19

C

cafeteria 18:3
call 25:21,23 26:1 27:18,24 28:1,13 45:12,23 46:3,5,8 46:19 47:2,5,6 88:11 91:8,22
called 1:17 3:2 9:17 11:12 21:8 28:3 57:1 83:10
calls 24:18 27:22 28:8 45:19 46:2 46:23 47:4 80:5
came 4:14 41:23 44:3 65:14 72:14 72:25 73:23 74:25
campus 24:6
candidate 82:21
cardiac 10:19 23:13 24:11,22,23 27:7 27:12,16,20 35:13 44:8,9,13 63:7 72:22 76:23 80:19 81:24 83:6
cardiologist 23:10 28:1,12 41:19 42:24 43:6 46:12 64:16 65:3
cardiologists 25:13 25:20,20 26:2,5 26:14,19 42:10 46:8
cardiologist's 46:10
cardiology 6:19 9:7 10:12,23 20:18 23:12 24:3 35:4 42:19,20,20,23 44:14 73:22
cardiovascular 9:23 90:1
care 10:6,18,24 11:1 13:5,10 14:10 23:14,23 24:3,16,22 25:8 25:22 26:1,6,10 26:20,24 27:14,20 41:19,24 42:4,13 42:25 44:3,10 65:15,16 66:18 68:16 71:8 72:2 72:14,15,23,25 73:2,6,19,20,24 74:2,25 76:4 77:20 84:5 87:22 90:7 93:11
cared 42:9 65:8 67:4 68:15 69:16 71:5 89:7
caring 65:1,3 87:9 88:1
carotid 54:8,17
case 1:6 6:25 7:1,7 7:21 8:4 15:4 17:14 18:4,14,17 18:22,25 19:13 20:23 21:4 22:6 54:21,25 58:22 77:11 79:3 83:11 83:12 87:18 88:5 88:10
cases 6:4,8,11,17 7:9 42:14
CAT 51:8
catastrophic 34:8
cath 10:19 23:23 24:9,23,25 25:2,6 25:9 27:7,12,14 27:16 44:9,13,17 76:24
catherization 23:13 44:8
catherized 13:7
catheter 6:20
catheterizations 25:4
causative 86:7
cause 29:23 34:8 35:13 38:3,7,10 41:10 52:3 56:24 60:19 61:4 64:21 70:6 88:14,17 95:7
caused 71:9 72:3
causing 60:23 63:7
caution 17:1
cell 30:16 33:13 34:2 47:22 48:18 49:14 50:25 54:22 55:11
center 1:8,23 2:10 3:14,17,24 4:3 8:20 10:9,16 11:6 11:9 14:5 18:20 36:19
centigrade 62:22
cerebral 67:10,23 67:25 68:6
certain 88:6
certificate 14:13 95:1
certified 3:4 9:20
certify 95:5,10
chance 5:2
chances 60:8
change 69:23 94:5
changed 26:16 84:7
changes 61:4
chapters 11:17
chart 12:18 20:4
Chavez 13:9 77:4,4 79:11,19
Chavez's 77:10
checked 33:22 48:3
checklist 48:4
chief 8:22 9:3
choice 79:6 86:5
choose 5:21
chose 17:18
chronic 29:13,13,14
circumstances 41:13 76:11
citations 21:15
Civil 3:3
Clair 2:13
clarify 24:1 40:15
clarifying 59:10
clear 36:6 90:20
Cleveland 1:23 2:6 2:14 13:12 14:4 14:11 76:21,23,25 79:10,23 80:19 81:4,24 83:21 84:16 85:9,16 86:9 87:5,13,16 87:19 95:13
clinic 10:4 13:12 14:4,11 23:18 26:3 76:22,23,25 79:10,23 80:19 81:4,25 83:21 84:16 85:9,16 86:9 87:5,13,16 87:20
clinical 23:3 24:5 38:15 49:1 50:12 51:21 54:6
colleagues 83:4
combined 8:24
come 24:19 42:22 53:10 63:11
commencing 1:24
comments 78:6
commission 94:25 95:18
commissioned 95:5
common 1:1 92:12
commonly 64:20
communicate 77:23
community 92:13
compared 31:18,25
complaining 62:16
complete 92:7
completed 95:11
completion 10:11
complications 32:24 90:4,10
concern 41:10 56:19,22 64:17
concluded 93:16
conclusion 63:11,13 63:15
condition 69:22 74:1,10 84:4
conduction 58:5,10 58:24 59:5
conference 76:10
confining 51:12
confirming 55:10
conjunction 73:25
consider 20:18 22:17,22,24,25 30:10 69:21 83:14 84:18 85:13
consideration 60:14 69:12
considered 19:23 22:20 81:20
considering 55:7 56:1 70:16
considers 22:4
consistent 54:6,14 58:17 61:8
constitutional 30:3 30:8,11
consultant 73:25
consultants 42:15 42:17
consultation 46:11
contact 27:25 28:12 46:17 52:24 76:22 87:6,11 91:23
contacted 46:9 53:2 79:22 80:1 87:7 87:10
contained 14:4 19:15 20:2,8
contemplated 79:3
contemplating 69:1 69:14,17 70:8,15 71:3
context 60:12 62:5 62:8
contingent 91:12
continued 53:7,8
continuing 69:21
conversation 16:19 45:17 53:23 70:4 77:2,6 80:6,8,20 81:3,24 82:2 84:13,23 90:21 91:10,18 93:2
conversations 17:23 70:21 73:3 81:25
copied 12:17
copy 8:7 12:12,19 12:20 13:5 16:9 20:15 22:2,4 65:2 65:4
coronary 10:18,24 11:1 23:14,23 24:16 25:8,22 26:1,6,10,20,24 27:14 41:24 65:14 66:18 68:16 71:8 72:2 72:15,23,25 73:2 73:20,23 74:25 76:4
correct 3:15,18,21 8:2 9:9,10 10:13 16:11 20:10 23:25 24:4,7,11 24:12 25:12 26:4 26:22 32:13 34:24 40:19 42:11 43:2 44:16 44:20,22 45:2 46:20,24 47:12 52:4,5 58:6 61:20 62:3 65:10 66:15 66:16,19 67:5,6,7 68:14 69:24 70:2 71:2 72:17 75:8 75:19,20,23,25 76:1 80:22,25 81:1 82:10,11,17 87:23 88:15 92:3 92:4,22 93:11,12 95:9
corrections 94:4
counsel 1:17,22 5:2 5:21,23 15:1,2 18:2,16 19:11 65:24
count 30:16 33:13 47:22 48:18 49:14 50:25 51:22 54:23 55:12 56:6
counts 34:2
county 1:2 7:10

95:3
couple 6:13 26:13 48:25 56:3
course 5:20
court 1:1 5:15
cover 26:24 47:10
covering 25:2 26:7 45:11
co-authored 11:16
criteria 21:7,8,10 21:23 22:8,11,13 22:20,23
criticisms 90:6
crude 35:6
culture 31:3,7,10 31:13
cultures 30:25 31:17,24 39:3,4,7 39:8,12
cure 78:21
cured 88:20,25 89:1 89:2,2,8,16
current 3:13,16 10:21
currently 3:22 12:20 57:13
curriculum 8:8
cuyahoga 1:2 7:10 95:3
CVA 54:7,14 61:15 71:16

D

damage 89:14
date 1:25 47:19 70:11 74:5 75:11
dated 15:25 80:15 83:24
dates 70:13
day 1:24 25:6 52:18 53:3 62:17,23 68:11 69:9,11,19 69:19 82:23 84:4 84:8 89:16 94:20 95:14
daylight 25:1
days 23:17,21 27:10 39:17 56:3 70:19 71:17
dealing 8:4 11:19 11:22 23:6
death 14:13 86:7 88:14,16,17
December 95:14
deep 79:6
defendant 2:9,17 4:11,22 6:3 7:21 19:18,21
Defendants 1:9
defense 5:21
define 4:16
defined 58:25
definite 64:9 72:18
definitely 85:14
definition 4:24 74:9
degree 33:6 57:20 58:13,13,14 62:13 77:23 85:24,25 89:6
degrees 62:22
delay 87:25
demonstrate 33:20
department 45:2 48:24 62:16 90:22,24 91:7 92:2
departments 91:23
depend 38:18 51:25
depending 4:24
depends 37:7 39:13 56:21
deposed 3:5 18:5
deposition 1:13,16 4:5 5:4,20 7:18 12:10 15:16 16:3 18:11,14 49:6 65:18 74:14 93:16 95:10
describe 24:13 42:14 61:23
described 10:2 49:13 62:19 63:22 80:21
describing 57:20
destroy 38:11
destruction 33:2
detail 45:11
deteriorate 37:6
deteriorating 41:4 41:5 60:21 64:19 64:23
deterioration 37:12 37:14,22 38:4,6,8 38:9 41:11 43:10 59:8,22 60:3,4,16 60:24,25 61:16,22 64:15,18 72:6 75:9
determination 80:8 87:21
determining 55:17
developed 41:2 86:18
developing 29:6
devoid 60:6
diabetes 29:18,21
diagnosed 28:20,23 41:18 42:22
diagnoses 66:8,12 67:1
diagnosing 88:1
diagnosis 21:8,10 22:8,21 30:23 31:10 33:16 34:4 38:15,19,21,23 39:19 48:21 49:18 50:12 51:2 51:21,24 52:2,6 52:10 64:7 66:3 72:19,20 88:4,6
diagnostic 24:10 30:22 41:14 50:15,17
dictate 93:7
die 76:19 78:12 85:17,21
different 19:20 26:14 38:8 39:8 41:6 68:19 79:17
differential 33:16 34:4 38:14,18,20 38:23 48:21 49:18 51:2,24 52:2,6,10
difficult 32:8 39:22 39:23 63:9 86:5
difficulty 17:16 67:21
Diplomate 1:20
directions 5:24
directly 77:8
director 10:17,19 10:24 11:1
disagree 45:20,24 60:15,18
discern 61:3
discerned 70:24
discharge 66:2,3
discuss 17:18 42:2 76:23 77:2 79:23
discussed 15:4 18:17 45:11 76:8 76:14 80:7 83:15
discussing 19:13 77:9
disease 42:18 76:15 77:5,14 78:24
dismissed 6:9
distal 68:13
divided 42:11,13
doctor 3:8 4:15 6:1 8:7 9:21 11:15 12:20 15:20 20:16 22:2 23:9 24:8 31:23 32:21 33:23 34:11 35:11 36:8,14 38:13 41:17 43:3 43:21 44:24 48:25 49:3 51:11 55:7 57:13 58:15 60:22 64:25 65:12 68:9 69:4 71:5 74:11 82:6 83:22 90:18
doctor's 74:18 84:10
document 28:8 74:20,21,23
documented 61:4
doing 24:24 27:10 50:6 52:25 69:1 79:13,19
dollars 6:13
done 13:8 15:14 35:15 36:16,23,25 39:5,6,8,15,17 44:19 54:24 56:15 57:4 64:12 85:23 92:16
double-sided 74:21
doubt 56:4
down 5:16 17:16 45:21
dozen 28:18
Dr 13:9 14:7 15:6 15:23 16:10,14,20 17:5,10,19,22 18:1,6,10,13 45:9 45:11,12,17,21,22 46:4,16,17 47:2,5 47:14,19 50:5 51:9 53:23 54:2 55:9 60:4 68:25 69:9 70:8,22 71:3 71:15 73:4,13,19 76:15 77:4,10 79:11,19 81:10 82:14,18 83:5,9 83:19 84:11,13,22 85:12 90:23 91:6 91:7,13
Drive 1:23
dual 24:21
due 41:5 43:13 75:13
Duke 21:8,10 22:8 22:11,13
duly 3:4 95:5,6
during 5:20 25:1,6 25:7 47:7 65:9,13 66:9
duties 23:9 27:19

E

earlier 60:22
Earline 12:17 43:22 44:2 47:18 52:17 54:2,20 57:3 58:22 61:14 62:14 65:7 66:9 67:4 68:9 72:13 77:11,19 79:9,16 82:19 83:8 84:15 86:13,18 87:6 88:8,19 90:7,9
Earline's 84:3
early 45:12 47:2
echo 17:11 34:14 36:16,19,23 54:17 54:24 57:2,4,11 57:22,23 60:11,20 62:2,13 63:3
echocardiogram 15:7,8 16:9 17:6 17:18 34:11 35:7 35:14 38:24 41:16 55:17 56:12,14 59:14 61:15 64:12
echocardiograms 14:17 34:23
echocardiographic 31:1
echocardiography 34:16
echoes 35:1,2,5 54:8
effectively 7:5
eight 7:18 25:17
Einstadter 18:1,6 54:3 55:9 71:15 73:13
Einstadter's 18:10
either 12:5 27:4 41:4 55:6 89:8 92:20 95:11
ejection 40:25 74:6
elevated 30:16 33:12 34:1 48:18 49:14,14 50:24 54:23 67:18
elevation 48:19 55:11
elevations 50:25
embolectomies 71:4
embolectomy 69:1 69:12,14,18,21 70:9
emboli 43:11 71:9 72:3,10
embolic 30:4 34:9 35:13 54:9,18 55:18,21 56:14,17 56:20,24,25,25 59:9 60:17,20 61:19 64:10 70:17 72:8
embolism 60:19 63:7,25 64:2,17 69:10 70:5
embolization 60:9 78:17
embolize 64:20,22

64:23
emergencies 24:20 27:21
emergency 2:17 13:15,23 25:3 45:1,8 46:9 47:15 47:19 48:24 49:4 49:12 52:8,15 53:18,24,25 56:3 62:15 63:10,23 64:13 65:2,4 67:13 90:22,24 91:7,23 92:2
employee 19:18,21
employer 3:16,20
end 45:10
ended 7:5
endocarditis 8:5 11:20 12:2 21:9 21:11 22:8,21 23:7 28:17,21,24 29:2,7,24 30:1,14 30:24 31:2,11,14 31:18,18,25 32:1 32:4,11,15,25 33:7,15 34:3,8,13 38:3,10,14,22 39:14,20 40:7 41:18 42:8,22 43:1,4,15 48:20 49:17 51:1 52:9 54:22 55:14 56:1 58:2 59:4 60:23 61:3,9,13 72:12 72:19 74:10 76:20 78:22 79:7 85:18 86:6,19,23 88:2,21
enough 52:24
entailed 50:12
enter 5:21
episode 76:19
equipment 35:6
ER 12:24
eradicate 32:11 43:16
error 16:1
erythrocyte 30:18
ESQ 2:4,12,20
et 1:8
ETC 1:4
Euclid 3:12
evaluate 41:15 83:18 87:21
even 60:10 61:16 89:15 92:21
event 64:10 67:23 72:1 95:12
events 43:24,25
eventually 57:3 62:6,9
ever 4:5,10,21 7:12 7:23 8:3 9:17 11:11,25 12:5 18:24 31:13 8315 87:7
everybody 25:23 26:13 86:2
everything 35:25 36:1
exact 21:15 32:2 38:2
exactly 16:15 50:9 78:9
examination 1:18 3:2,6 90:16 96:2
examples 29:12
Exhibit 15:17,21 16:4,8 65:19,23 74:12,15 80:14 82:7 83:23 96:5,6 96:7,8
expect 40:11 57:8 57:15
expectancy 88:22 89:10
expectations 85:9
expected 37:21 89:11
experience 35:1 79:12
expert 7:12,19 17:11 19:19,20 33:18,21 49:2 52:20 79:4
experts 79:5
expires 94:25 95:18
explain 51:22
express 78:4
expressive 74:4 78:2
extended 14:10 89:18,20
extensive 89:21
extent 81:21
extremity 70:17 74:7

F

faced 56:8
facility 14:11
fact 50:22,23 56:13 60:5 75:4 89:21 93:6
factor 86:7
factors 29:5,8 52:1 75:14
facts 16:18 49:8
Fahrenheit 48:1
failure 33:3 64:21
fair 48:24
fairly 83:2
fall 30:9
familiar 31:20
family 76:15,20 78:6,10 82:1,4 84:20,23 85:1,2 87:12 90:10
far 6:9 28:11
Fatigue 30:12
febrile 56:8
feel 5:18 44:5 49:6 56:25 78:11
feeling 80:24
Feelings 76:17
fellow 6:19 80:3,20 81:7,15,17,24
fellowship 10:1,12
fellowships 9:5
felt 38:22 71:16 77:12 82:20,21 85:20 92:15,19
femoral 7:4
fever 30:3 33:12 34:1 39:10 51:22 56:7 74:5
few 23:17,20 41:22
field 20:17
file 18:21,25
filed 4:17,21,22 6:4 7:9
filling 58:16,23
final 64:7 80:7
finally 81:12
find 22:9 54:11
finding 40:3 41:8 59:4
findings 31:1 59:14 61:8 74:8
fine 33:21 54:4
finish 17:15
Finkel 16:20
Finkelhor 15:6,23 16:10,14,21,22 17:5,10,19,22 60:5
first 3:4 6:12,18 10:25 13:18 19:3 39:1 44:2 58:13 65:25 71:12 73:1 74:1 76:24 80:2 81:23 87:17 89:5 95:6
five 26:14,19,25 36:20 89:13
floor 41:24,25 42:23
follow 91:17 93:14
followed 64:13 93:10
following 26:2 52:18 53:3 81:2 91:8 94:3
follows 3:5
follow-up 24:3 42:2 44:10 52:18 59:16
foregoing 94:2 95:8
form 12:6
formal 11:25
formation 43:9 58:3
forth 1:25 95:8
found 21:23 68:11 74:8 87:17
four 27:4 37:15,23 57:5 76:4
Franklin's 2:21
fraught 83:1
free 5:18 44:5 49:7
frequent 29:9,15 91:25
from 9:6,24 10:3 12:22 13:15 14:3 14:6,9 15:12 18:19 21:19 25:21 27:22 30:21 39:8 43:5 44:9,14 47:14 48:23 49:4 52:15 53:5 56:3,3 59:4 61:9 63:25 64:5 64:17 67:13,24 69:13 70:24 71:3 71:10 72:3 75:24 76:19 77:22 78:12 84:8,8,13 85:17 89:22 91:22,22 92:2 94:2
front 12:21 49:22 50:3
full 3:9 82:22
fully 53:15
further 41:15 59:10 60:13 70:21 71:2 71:3 74:9 87:5,11 90:13 95:10

G

gave 12:3
general 12:25 13:16 13:23 37:11 45:1 67:14 86:10 90:22 91:7 92:21
generally 24:14 26:7 40:1
gestalt 59:25
gets 42:20
getting 63:16 75:10
give 5:14 17:2 19:9 21:14 29:12 38:1 38:2 47:4 54:10 60:13 80:3 85:7
given 7:23 8:3 11:25 32:7 48:17 48:23 52:7 54:21 59:24 63:3 88:5 92:7,8
gives 22:12
giving 7:17 51:13
gleaned 51:9 77:22
go 5:4 13:2 53:20 69:6 76:21 79:9 83:21 93:10
goals 32:10
goes 13:6 93:2
going 5:4,11 13:2 13:11 19:9 27:3 33:17 35:22 42:25 45:4 49:19 51:4 54:7,16 55:4 55:25 56:18 61:13 62:11 64:7 65:22 71:11 74:11 78:18 81:4 83:20 84:19,25 85:1,7 88:24 90:18
gone 53:5
Gordon 1:19 95:4 95:16
gotten 7:17 56:11 60:10 75:4
Graber 2:18 45:9 45:17,21 46:16 47:14 50:5 51:9 90:23 91:6
Graber's 18:13 47:20
gradient 60:8
graduated 8:15
grand 12:3
ground 5:3
guarateeing 84:19
guess 17:2 25:17 51:12 92:24
guessing 17:1
guesstimate 28:18

H

half 28:18 48:23
hand 5:16 53:14 65:22 74:11 95:13
handing 15:20 16:7
handwriting 56:16
hangup 86:3
happen 8:7 64:24
happened 6:15 86:8
happening 18:4 93:3
happy 5:10
hard 53:19 55:1 78:15,18 93:4

harris 2:20 32:18 33:9,17 34:5 35:16 36:10 40:13 48:9,22 50:9 51:4,7 52:11 52:19 62:23 71:11,17,22 88:23 89:4 90:14,17 93:13 96:4
having 48:1 62:11 64:14 86:21 90:3 91:22
head 5:16 24:9
hear 40:11
heard 18:7 31:13 73:10 81:10
heart 11:23 33:1,3 38:4 39:25 40:18 40:20 41:9 58:5,7 58:11,12 61:10 64:1,5,21 71:10 72:4 86:4,14 89:25
heightened 41:10 63:6,24 64:17
helpful 30:23 59:10 59:20
hematoma 6:21
hemodynamic 43:10
Hemodynamically 74:5
hereinafter 3:4
hereunto 95:13
high 32:6 33:6 35:15 36:16,20,23 37:1 38:18,20,22 39:15 43:20 51:22,25 55:5 56:10,15,19 57:1 57:2 60:1,7 62:7 77:13 80:10,24 81:13,20 82:25 85:12,20 86:13
higher 31:16,23
him 8:10 12:21 13:17 15:11,25 16:12 17:14 18:3 18:4 19:25 20:5,6 20:11 46:18 47:11 48:23 49:1 49:5,20,23 50:1,3 50:5,7,10,11 70:4 70:23 83:20 91:11
hired 19:19,19
history 48:17 49:12 49:15,22 50:21 75:16
holy 89:16
home 3:11 86:11 93:10
homograph 76:18 78:25 79:2,18,19
honestly 6:14 17:3 17:7 25:15 31:22 77:7 86:21 90:8
hospital 11:5,11 12:25 45:1 65:8 66:24 67:9,14 72:1 82:13 90:22 91:23
hospitalization 93:8
hospitalized 92:20
Hospitals 82:9 83:7
host 13:10
hours 24:14 25:1 46:6 66:19
hypertrophy 58:18
hypervolemia 58:19

I

idea 72:8 85:3,5 86:8,24 88:17
identification 15:18 16:5 65:20 74:16
identified 22:7
identify 74:22
illness 53:12
immediate 56:11 93:7
immediately 53:16 67:14 82:1
immunologic 30:4
implantation 57:17 57:18
implies 50:2
important 5:7
impossible 92:23
impression 55:2
impressions 47:20 48:19 50:23
improve 62:20
include 38:16,17
included 33:15 34:4
increased 29:6,18 29:20 30:18
indention 76:7
independent 43:22
INDEX 96:1
indicate 41:3 47:25 69:10 70:5 77:19
indicated 24:8 46:21 47:20 54:5 69:17 77:13
indicates 45:10 47:1 54:13 58:15 59:6 80:18 82:8
indications 43:4,9 57:24 78:13,16
individual's 77:15
infarction 7:2
infected 32:11 72:3 79:1
infecting 59:4
infection 29:14 33:4 43:16 55:3,5 55:25 58:4,24 62:11 68:3 89:15
infections 29:9,13 60:7 90:3
infectious 42:18 58:9 59:4 60:23 61:3,9,12 76:15 77:5,14 78:24
infective 86:14
inform 28:1,13 46:18
information 23:2 33:20 47:3,10 48:23 51:9,13,16 51:18,20 53:1 56:2 85:8 91:13 92:6,7,9
informed 15:1 83:11,12
initially 18:2 19:2
inpatient 13:10 37:2
inpatients 23:15,17
inquiry 4:19
instance 46:15,17
instances 34:7
institution 19:21
instructing 20:11
instructs 5:23
insult 89:22
intensification 75:13
intensive 10:6
interested 42:2 63:21 95:12
interesting 22:24
intermittent 31:8
Intermittently 10:18
internal 8:22,25 9:2 9:22 10:5
interpretation 70:18
interpreting 63:10
interval 58:23
intervals 58:16
invasion 58:9,23
invasive 24:10
involved 23:23 42:25 73:5 74:2 77:2 84:5
involving 8:4
ischemia 58:18 68:13
ischemic 33:14 34:2 50:24 70:17 74:6 75:21
issue 89:1
issues 8:4 20:23 21:4 22:5

J

JAMES 2:12
January 13:6
jeanne 2:4 13:4 19:20 62:24 66:1
journal 11:16 21:14
judgment 49:21 88:11
July 10:10
June 95:18
just 5:4 12:14 13:20 14:20 15:6 16:16 16:17 18:1 19:12 20:1 24:1,13 30:22 35:23 42:7 52:24 53:2 63:4 63:20 68:10 72:1 74:18 75:13 80:21 85:10 90:20 92:25

K

keen 81:8
kick 81:7
kind 77:21
knew 27:3 73:17
know 4:23 6:9,14 9:13,14 14:21 17:2,3 19:23 20:3 22:14 27:22 31:22 32:2,20 53:15 56:2,5 60:12 64:14 69:8 69:20 70:3 74:9 77:7 78:14 81:12 81:13,18 83:11 85:1,10,22 86:6 86:10 88:16 90:4 90:14
knowing 61:14,17 63:21 64:7,11
knowledge 13:1,18 49:9,11,21 50:21
known 56:6

L

L 1:19 95:4,16
lab 10:19 23:14,23 24:10,23,25 25:2 25:6,9 27:7,12,14 27:16
laboratory 74:8
labored 48:1
ladder 81:8
lady 14:14 50:16 51:3
lady's 50:21
large 6:21 43:11
last 33:22 37:5 59:7 66:23 69:6 76:3,4 76:6
late 11:2 35:5 65:15
later 57:5 70:19 71:17
lawsuit 4:15 14:20 15:4 17:24
lead 29:8 60:8 61:12 62:9 64:16
leading 33:2
leaflets 38:12 61:1
least 4:23,25 12:3 33:22 75:14
leave 24:17
lectures 12:1
left 59:2 81:5,12
leg 62:17 63:8,25 64:3,4 68:12,23 69:2 75:21
LESLIE 1:4
Less 66:19
let 17:15 40:15 65:24 84:25
letter 14:6
letters 4:19
level 63:6 77:9
library 22:9
license 9:16
licensed 9:8,11,12
licenses 9:15
life 88:22 89:10
lifetime 9:15
like 5:17 38:6 42:14 44:4 45:4 48:9,12 48:16 54:4 57:8 70:15 72:7,21 73:9 76:5 80:4,10
likely 32:16 60:19 61:18 78:21 86:18
limb 7:5
line 19:1,8,14,15,17 20:2,8 66:14 94:5
lines 59:7 76:5
list 66:8,12
listed 67:1
literature 21:19
little 26:17 75:10 81:5
lived 89:17,20
Locally 33:1
log 28:7 46:22
long 18:9 27:1,11 36:18,24 37:4 39:11 89:12
longer 55:20

look 13:4 40:8 54:4 54:8,17 57:9
looked 12:24 54:22 56:10 63:4
looking 55:21 56:13 56:17 57:12 61:2 64:8
looks 48:9,11,16 76:5
lose 86:4
losing 7:5
loss 30:6,12
lot 20:24 53:20 68:18 89:14
low 39:16
lower 70:17 74:7
Lytle 81:10 83:9 84:12,14,22 85:12

M

M 2:4
made 18:20,24 28:8 31:11 39:20 55:5 62:7 72:20 79:17 88:4
magically 89:16
main 24:6 32:9
major 29:16 75:15 78:13,16 89:5
majority 27:15
make 16:17 21:17 22:3 36:5 39:22 59:25 78:6 87:21
making 20:15
malaise 30:12
MALONE 2:12 6:7 8:10 12:16,23 13:17 14:1,23 15:10 16:25 19:9 19:16,25 20:3,10 20:13 21:18,21,24 22:7 32:19 35:21 35:25 36:5,11 49:19 50:2,14 51:6 64:2 66:1 88:24
malpractice 4:11
manage 41:19 42:1 42:3,7
managed 42:15 44:14
management 88:10
manifestations 30:4 30:5
many 4:8,13 7:15 23:21 25:13 37:19 43:17 45:18
March 3:19 4:1 10:14 11:4 13:14 23:11 24:15 25:14 26:23 44:25 46:1,4 49:13 52:16 54:3 71:6,13,24 72:9
mark 76:25
marked 15:17,21 16:4,7 19:3,4 65:19,23 74:12,15 96:5,6,7,8
Markowitz 82:14 82:18 83:5,20
matter 11:20,22 12:1 23:6
may 5:21 13:24 14:1 15:14,25 16:1 26:2 31:7 33:23 35:13 39:17 42:4 43:25 52:3 59:9 65:8 66:10 67:5,6,15 68:11 70:14,15 71:7,9,23,25 72:18 73:4,14 74:2 76:3 80:15 87:1,2,3 88:6
maybe 56:20 59:19
Mazanec 2:19
McKinny 76:16
mean 4:18 17:12 51:23 53:20 56:16,23 62:5 82:25 85:22
means 32:20 52:2 78:3 87:15
medical 1:7,22 2:9 3:14,17,24 4:3,11 5:18 6:3 8:13,18 8:20 9:24 10:4,9 10:16 11:6,9,16 12:11 14:5 18:20 36:19 41:24 44:5 49:3,21 50:1 52:15 78:20 88:10 89:8
medical/legal 7:13 7:20,25
medicine 8:22,25 9:2,22,22,23 10:5 10:5,6
meets 43:19
members 87:12
mentioned 14:8 30:22 46:7 78:25
met 18:2
Metro 13:5 23:10 25:14 42:11 52:18 65:2,4,8 72:1 79:13 92:21
metrohealth 1:7,22 1:23 2:9 3:14,16 3:23 4:3 8:19 10:9,16,22 11:6,9 12:18 14:5 18:20 36:19 67:15 91:24
MetroHealth's 62:15
Metro's 24:6
Miami 3:12
might 4:24 62:6
Milwaukee 10:4,4
Mine 48:16
Minnesota 9:7,13
minority 37:24
minute 54:10
minutes 36:21 37:1 37:3
Mishkind 2:3
miss 31:7
mix 50:15
Mizsey 43:22 44:3 47:18 52:17 54:2 57:3 61:14 62:15 65:7 66:9 67:4 68:9 72:13 77:19 79:9 82:19 83:8 84:15,23 86:13,18 87:6 88:8,19 90:7 90:9
Mizsey's 12:17 54:21 58:22 77:11 79:17 84:3
moment 26:18 45:6
moments 13:20
month 17:4
more 4:25 27:4 32:7,16 34:12 35:18 39:23 57:23,25 85:4
morning 13:18 19:5 24:17 45:13,23 47:3,6 53:23 91:9
most 20:19 23:22 26:12 27:9 43:14
motions 5:16
move 62:12
moved 62:2
much 27:13 39:22 53:14 57:25
Multicare 14:10
multiple 86:22 89:24
murmur 30:5 40:10 40:11,18,20,21,25 41:2,7 74:6
murmurs 40:1,6,8
myocardial 7:2 58:18
myocardium 75:19
myriad 29:11
MD 1:13,16 2:18 3:1,6 90:16 94:17 95:6 96:2

N

name 3:9 6:22 80:4 84:10
named 4:10,15,21 6:2 95:6
namely 88:5
naturally 37:5
nature 43:13 70:17 70:20 72:8 75:9
necessarily 39:21 42:6 64:22 93:9
necessary 53:16
need 13:3 19:16 21:16 76:24 79:9 92:5
needed 76:17,21 78:11 92:16
negative 31:14,16 31:24
negligence 6:3,17 50:8
negligent 50:6
neurologic 53:11 72:22 81:22 86:1 89:25
neurological 89:22
neurologist 83:18
never 35:3 50:16 60:20 64:22 87:10
new 30:5 41:8 75:12
news 47:16
next 28:14 46:18 82:23
night 24:18,19 25:2 25:25 47:7
nobody 75:11 87:7
nods 5:16
none 44:1 1 54:1 61:7
nonembolic 70:20
noninfectious 59:23 60:3
nonvascular 63:12
normal 36:1 53:6
normally 47:5 65:1 91:15
Notary 1:20 94:23 95:4,16
notations 18:19 20:15
note 45:10 47:1 66:2 69:13,15,17 70:12 74:24 75:1 75:3 76:4 77:22 80:13,16,17,23 82:6 83:24,25 84:6,10 85:12 94:3
notes 18:21,24 47:20,24 48:3 54:6 70:25 71:3 74:3,18 77:25
nothing 61:11 95:7
notified 87:15
NOVEMBER 1:14
number 15:21 16:8 26:16 38:2 41:6 70:2,2 74:12 80:14 82:8 83:23
nurse's 47:24 48:3
nursing 86:11

O

oath 5:7
object 32:19 33:17 51:4 71:11 88:24
objection 5:21 32:18 33:9 34:5 35:16 36:10,11 40:13 48:22 49:20 51:6 52:11 52:19
obtain 53:2
obtained 39:9,12
obviously 42:24 51:14 56:16 87:2
occasion 46:2,3
occlusion 68:12,23 70:6
occurred 27:21
occurrence 91:25
occurs 39:10
odd 70:7
off 25:10,21 46:6 48:3 71:12
office 2:5 95:13
offices 1:22
often 26:23 28:16 29:1 37:17
Oh 28:22 47:8 90:12
ohio 1:2,21,23 2:6 2:14,23 3:3 9:8 9:16 95:2,5,14,17
Okay 48:11 51:15 53:7 57:10 59:1 71:22
once 7:24 18:3 29:4 37:2 51:4 73:23
one 6:6,12,15,18 9:2,3,12 12:3 15:13,14 21:1,2 28:4 32:9 35:7,18 41:17 42:9 46:8 46:10 48:10,13 62:6,9 70:2 71:7 75:1,14 85:4 89:12

ones 29:16
ongoing 62:11
only 48:10 61:5 64:6 66:17
onset 62:18
on-call 25:19 47:11
operation 79:12 84:18
opinion 36:15,17,22 52:16 54:20 63:19,19 71:24 72:5 85:17 86:12 86:17 87:24 88:7 88:14,21 89:9
opinions 77:10,16
opportunity 44:25 46:18 49:5 67:12
order 34:24
ordering 56:14
organism 32:12 43:13
organs 89:24
origin 35:14 63:7
original 12:16 16:12
originally 74:20
originated 64:4
originating 63:25 71:10 72:3
other 3:23 4:2 6:6 9:11,16 10:1,2 13:1 17:22,23 18:16 21:12 23:1 24:23 28:8 35:8 42:9 44:10 46:10 48:6,14 49:7 50:4 51:8,16,18.20 52:1 53:14'70:16 72:11 73:13 75:14 77:24 83:6 85:6,8
otherwise 5:11 95:12
out 17:12 31:3 48:25 51:7 62:18 73:9 83:10 87:17
outcome 32:16
outline 12:7
outlying 91:23
outpatient 13:10 37:2
outpatients 23:16 23:21
outside 27:23
over 5:4 15:6,22,24 16:10,11 17:3 19:5 26:17 27:12 39:8,11,17 53:19 53:21 92:24
overall 59:24 62:5,8
own 21:18 42:4
56:16
o'clock 1:24

P

packet 14:1
page 13:2,2 48:4 66:6,14 80:14 83:22,24 94:3,5
pages 74:22
pain 62:16
panel 24:2
paper 19:2
paragraph 76:3,5,6
part 27:9 89:19
participate 73:19 87:22
participated 23:5
particular 8:21 10:20 12:13 16:14 17:9,17,18 20:22 21:2,4,23 22:11 26:18 27:25 40:5 46:15 47:1 58:7,12 63:23 66:22 72:16 79:16 81:2
particularly 22:5 22:18
party 95:11
passing 91:12
past 34:25
patient 7:2 13:7 29:6,17,22 31:9 33:7,11,25 35:11 36:14,15,18,22,25 37:2,7,9,18 39:24 40:9,12,17 41:1,8 41:20,23 42:1,5,7 42:9,25 43:3 45:10,12 46:12 47:2,5,7 49:9,10 49:18,22,23 50:3 50:13 56:8,23 57:16 59:25 61:8 64:25 65:3 66:9 72:21 76:17,17,20 76:21 77:18 80:9 80:11,24 81:11,11 81:14 83:1,13,18 83:20 84:24 85:1 85:13 90:24 91:8 92:3,19 93:6,10
patients 23:18 24:2 24:24 26:3 28:4 28:17,21,23 29:1 31:17,18 37:20 40:21 41:17,21,22 42:21 43:14 46:4 46:6,10 91:24
patient's 52:4 76:15
peak 39:10
pending 14:20 15:4 17:25
people 27:23 43:7 53:20
per 68:18
percent 43:19
percentage 37:20 38:1 43:20
perfectly 36:1
perform 34:17,20 34:22 79:11
performed 35:1,3
pericarditis 33:4
period 25:7 26:11 27:1 39:9,11 55:20 89:18,20
peripheral 30:4 90:1
perked 86:24
person 25:22 26:1 42:7 77:5,14 79:22 80:2 85:4
personal 63:19
personally 28:20 34:22 42:1,3 60:10 82:21
perspective 43:6,8 44:15
phenomena 61:24
phrased 36:13
physically 37:3
physician 10:9,17 10:23 33:19 42:13 46:9 49:10 65:13 66:15,17,23 82:9
physicians 15:5 17:23 27:25 70:16 73:13 87:9 88:1 91:22 92:1 93:11
pick 48:25
picked 17:12 65:11
picking 34:12 57:23
picture 39:14 49:1
piece 19:2
place 7:3 29:5 48:7 49:16 50:23 55:12 71:9 72:1 78:15 91:1,2,4,4 91:10,18,20 95:10
places 10:1
plaintiff 1:5,18 2:2 6:11,14,23 7:6,21
Plaintiffs 15:21 16:8 65:23 80:14 82:7 83:23
plan 77:20 78:7 84:14
plans 93:3
PLEAS 1:1
please 3:8 5:9,18 44:5 62:24 71:20
plenty 72:11
pneumonias 29:14 29:15
point 5:17 7:17 9:12 10:20 23:24 34:25 48:5,14 50:18 53:24 65:9 81:14 82:5,15 86:13 89:7,14
porcine 37:4,15,21 38:4,11 39:25 40:17,23 41:9 48:17,20 49:15 50:22 57:17 60:21 61:10
portion 49:7 54:11 58:20
position 10:15,21 10:25 54:21
positive 31:9 32:17
possibility 31:6
possible 32:3,12 39:9 41:5 43:18 64:8 79:23 88:4
possibly 52:23 75:15
postoperative 40:10
postoperatively 40:22
potential 59:9 60:17 61:19
practical 31:12
practice 10:7 20:18 23:3 28:16 29:2 34:15
preceded 67:14 71:7
precise 27:5
precisely 55:1
predominantly 33:2
prepared 20:8,16
present 39:19 57:16 92:2
presentation 64:13 67:18
presentations 12:5
presented 47:18 49:12 53:18 55:8 62:15 80:9 87:18
presenting: 56:23
presents 33:12 34:1 35:12
pressure 30:25
presumptive 31:10
pretty 27:13 43:25 73:8,17 92:9,10
previous 38:7 74:5 75:13 76:16
previously 10:2 24:8 40:16 46:7 72:20
Primarily 27:20
primary 42:13 93:11
prior 44:18 69:15 72:2 73:4,13 75:16
priority 32:6 35:15 36:16,20,24 37:1 39:13 55:6 56:10 56:15,19 57:1,2 60:1 62:7
private 10:6
privileges 11:5,8,9 11:12
probability 85:24
probable 43:18
probably 16:25 17:20 26:13 29:15 60:10 62:12 66:20 72:8 80:11 85:11,20
problem 63:12,14 63:17
problems 33:3 58:8 63:8 67:25 81:22 83:1 86:1
procedure 3:3 50:17
procedures 24:11
proceeding 7:13,20 8:1
process 81:9
produce 19:11
professional 2:17 3:22 4:2
profile 58:16,23
progress 70:25
projecting 85:10
prolonged 33:4
prompt 59:16
properly 6:19
prosthetic 11:23 28:24 29:2,7 31:17,19 32:4,8 32:10,15,25 33:7 34:13 35:11 38:13 39:19 40:7 40:9,18 41:9,18 42:8 43:1,3,14 49:16 51:1 52:8 55:8,13 86:19 88:2,20
proverbial 78:15
provide 44:10 46:11
provided 3:2 12:11 47:10

providing 4:1 47:14
provisionally 83:13
prudent 55:16
Public 1:20 94:23 95:4,16
publication 21:12 21:22
publications 20:21
pulmonary 8:22,25 9:2,22 10:5
pump 7:3
purposes 15:18 16:5 31:12 65:20 74:16
pursuant 1:21
put 19:1 37:8 51:25 89:12 91:6
putting 62:5

Q

qualified 95:5
question 4:20 5:6 5:10,12,22 9:17 11:12 17:15 20:7 20:12 32:21 33:23,24 35:22,23 36:2,3,6,8,9,12 38:7 40:15 50:4 51:11 63:13 69:6 71:19 76:24
questions 5:8 17:13 45:5 90:14

R

racking 86:20
Rakita 45:12,23 46:17 47:2,5 53:23 73:4,19 91:8,13
Rakita's 46:4
range 25:18
rapidly 39:15
rare 92:9,10
Raskin 2:19
rate 30:19 31:16,23
rather 55:18 56:4 88:9
raymond 1:13,16 3:1,6,10 90:16 94:17 95:6 96:2
read 35:20 69:12 76:12 94:2
realizing 43:6
realm 51:23 52:12
reason 17:9,17 35:17 **44:**12 45:20,24 56:9 72:13 79:2 81:19 89:19 91:3
reasonable 85:24 85:25 88:22 89:10
reasons 41:6 72:11
recall 6:22 7:6 73:12
receive 65:1
received 41:8 47:6 57:16
receiving 40:17 88:9
recollection 16:16 43:22,24,25 44:23 45:16 47:13 53:22 70:21 73:7 73:11,12,16 77:24 78:1 82:3 84:7 87:14 91:5
recommendations 47:14
recommended 92:17,22
record 12:11,12,14 20:14 35:20 46:22 48:11 54:11 70:25 90:22 91:7
recorded 90:21
records 5:18 12:21 13:8,15 14:3,5,9 18:21 19:24 20:9 44:5 45:2,5 49:4 50:1 52:8,15 67:13
recovered 53:5,15
recurrent 43:11 78:17 81:21 90:3
reduced 12:6 95:8
refer 5:18 13:8 42:6 44:4 80:20
reference 6:2 59:11
referring 15:9 58:20 60:2,5
reflect 58:23 84:6
reflected 85:11
reflects 59:14
regard 4:20 **6:**1 17:6 28:8 60:22 82:18
regarding 45:5 77:11 78:7
Registered 1:19
regurgitant 40:8,11 41:2
regurgitation 33:3 35:9 41:7 57:15
related 7:1 67:25 72:9,10 75:1,3
relationship 6:20 28:4
relative 95:11
relatively 60:7,9
relaxation 58:17
relevance 20:23 21:4
relevant 22:5,18 51:17
reliable 20:19 23:1
rely 23:2
remain 55:19
remember 16:15 17:7,21 19:5 21:25 22:1 45:19 73:8 78:9 90:25
Reminger 2:11,11
remove 69:2
removing 6:20
render 3:22
rendered 90:7
repeat 5:10 33:24
repeated 48:7
rephrase 5:11
replacement 32:7 39:25 40:10 43:5 43:15 48:17 76:18 79:1,14 85:19 86:14 88:9
report 15:7,12,22 15:24 16:11,14 57:6,7,12 58:15 58:20 59:6,13 60:11,15 61:2,5,6 61:11 62:1,4
reporter 1:20 5:15
reports 70:25
represented 75:12
request 20:15 21:17 22:3
REQUESTED 94:5
require 43:15
required 5:22 36:23
requires 36:15
research 21:19 23:5
residency 8:17,23 8:24 9:3,5,25
resolved 6:8
respirations 48:2
responsibilities 23:10,22 24:6,21 24:25 25:11 26:6 26:10 27:7,12,19 73:23
responsibility 26:20
responsible 25:3 26:24 27:2 72:16
rest 62:20
result 78:21
resulted 6:21 46:2
results 51:8 63:3 64:11
retrospect 64:6 81:10
review 19:24 44:25 49:6,7 52:13,14 57:6
reviewed 12:9 13:14 14:3,9,16 16:13 18:10,13 19:1 21:9,11,20 22:4,19 71:15 86:21
reviewing 19:3 20:9 63:19
revoked 9:18 11:13
rhythm 58:8
right 7:4 19:22 45:7 56:23 62:17 67:24 68:12,23 70:16 74:7 75:21
risk 29:6,19,20 55:12,19 77:13 80:10,24 81:13,20 83:1 85:13,20 86:13
risks 83:15
Road 2:22 3:12
rock 78:15
room 13:15,23 45:1 45:8 46:9 47:15 47:19 49:4,12 52:8,15 53:18,24 53:25 56:3 62:15 63:10,23 64:14 65:2,4 67:13
root 57:24
rotate 26:20
rounds 12:3
routine 24:14 25:5 28:11
routinely 24:2 47:4
Row 2:21
rubber 92:25
rule 37:10,11
ruled 31:2
rules 3:3 5:3
Run 35:18 71:14,19
running 41:25
Ryder 2:19

S

same 3:20 17:16 35:16 38:5 51:6 53:17 59:6
save 86:4
saw 13:20 24:2 44:12 67:17 68:21 69:3,4 71:18,21 73:1,14 75:6,22
saying 28:3 34:17 51:10 85:14 86:25 90:25
says 12:14 48:16 54:12 56:17 66:14 80:23 84:10
scan 51:8
schedule 25:6 54:7 54:16 55:16 82:23
scheduled 25:8,9
school 8:13,18 9:25
se 68:18
seal 95:13
second 6:25 7:1 58:13 68:6 75:1 75:15 83:22 84:4 92:24
section 45:14
sedimentation 30:18
see 23:15,20 28:16 29:1 36:14 37:14 37:17 44:21 45:14 48:8,10,14 52:7,25 53:13,16 54:13 55:24 56:9 58:19 59:11 61:6 62:1 71:2 72:24 82:16 88:11 91:18
seeded 79:7
seeing 23:18 24:24
seen 14:13 37:19 49:23 52:17,21,22 53:10 54:2 58:17 60:20 62:10 64:23
sees 55:23
send 65:4
sense 56:10 78:15
sensitive 34:12 57:23 58:1
sent 14:11 86:11 87:19
sequential 9:1
series 39:6,17
serve 8:17 9:4
services 2:18 3:23 4:2
session 5:7
set 1:25 95:7,13
settlement 6:10,13
seven 7:18
several 52:3
severe 68:12
sew 79:7
sheet 66:22,25 67:2
shock 7:3
short 26:13
shortly 53:24 82:1
show 36:10,11 49:19 60:20 65:24
showed 15:11 61:15

shower 62:19
shown 13:17
sick 74:10 90:2
sided 67:24
signature 66:6,7,13 93:17
signed 45:9 66:21
significant 19:23 20:4 43:10 74:3
signing 66:25
signs 29:25 34:12 62:1 1
simply 44:13
since 15:3 74:4
sincerity 88:3
single 31:3,6
sinusitis 51:21 53:4
sit 20:21 21:3 43:23
sites 39:8
sitting 49:4
six 25:17 26:14,19 26:25 39:8
skin 29:13
Skylight 2:5
solid 43:25 72:19
Solon 2:22,23
some 26:5 29:12 34:7,25 45:5 46:4 48:1 60:23 62:13 65:9 77:23,24 81:9
somebody 28:3 92:24
somehow 81:10
someone 25:2 40:14 44:14 60:12
someplace 48:4
something 48:5,14 50:6 72:7 91:10 91:14 92:12,21
sometime 11:2
sometimes 58:4 65:6
somewhat 29:20
somewhere 6:6 25:18
soon 32:12 42:21 54:24 72: 1988:4
sooner 32:14
sorry 16:22 66:I 76:6
sort 73:9 79:6 81:9
sound 53:21
sounds 80:10
source 54:9,18 55:18,22 56:14,17 56:20 59:9 60:17 60:20 61:19,23
Southwest 12:25 13:15,23 45:1 67:13 90:21 91:6 92:20
speak 67:21 70:23 83:3 87:8 88:12
speaking 67:22
specialty 8:21
specific 17:13 41:21 41:22 70:4,13
specifically 23:13 40:6
specified 95:10
speed 62:13
spent 27:15
spoke 45:22 46:16 60:22,25 77:6,15 80:1 90:23
spot 48:10
spots 19:4
spread 58:4
SS 95:2
St 2:13
stable 74:4,6
staff 10:9,17,23 23:10 25:13
stage 4:14
stamp 92:25
start 37:5,12
started 62:17
state 1:21 3:8 9:8 9:17 95:2,5,17
stated 35:24 36:4 80:22
states 9:11
stating 52:13
statistics 31:22 32:2
status 72:22 75:1
statute 1:18
stayed 53:17
stenose 60:6 64:20
stenosis 59:23,24
stenotypy 95:8
stepping 62:18
steps 41:14
sterilize 32:8 43:13 77:18 78:18
still 5:22 9:14 61:17 85:16
stroke 33:14 34:9 35:12 53:8 54:23 55:9,13,18 56:24 61:24 71:6,12,25 71:25 72:6,9 75:12,13,15,17
strokes 72:11 75:7 89:23
strong 72:5 73:8,17
studies 30:22 68:10 68:18
study 50:15 57:6
subacute 31:24
subject 11:19,22 12:1 23:6
Subscribed 94:19
subsequent 69:20 83:19
subsequently 19:4 83:10 86:11 88:12
substantial 17:8
successfully 88:20
sudden 62:18
suddenly 73:9
suffered 75:7 89:14 89:21 90:11
suffering 61:9 67:24 75:24
suggestion 59:21
suggestions 34:13
suggestive 33:13
suggests 59:8
suit 4:11,17,22 6:3
Suite 2:5
suits 4:20
summary 45:8
supervised 6:19
sure 5:2 16:17 64:10,24 75:1 1 77:8 83:16 88:25 91:2,4
surgeon 77:I 83:2
surgeons 79:5 83:7
surgeries 79: 14
surgery 13:8 42:18 43:5,7 44:18 75:2 75:5 76:14 77:12 77:18 78:12,14 79:10,17,23 80:3 80:5,19 81:20 82:16,22 83:8,14 83:17 85:13,22 86:2,3,10 87:16 88:9 89:2
surgical 43: 15 57: 17 76:24 82:20 86:14 89:9
surprised 18:8
suspect 26:12
suspected 93:7
suspecting 22:21
suspended 9: 17 11:12
suspicion 35:13 39:16,16 63:6,24
suspicious 29:23
sworn 3:4 94:19 95:6
symptomatology 63:5
symptoms 29:25 30:3,8,11 33:13 34:2 35:12 52:4 53:8 54:6,14,24 55:9 63:22
syndrome 53:11
system 12:18 25:19 26:16,18 27:21 41:22 58:5,10,24 59:5 89:22
Systolic 40:25

T

take 5:16 24:10 25:21 26:1 27:6 27:20,24 36:18,24 45:6 46:2 57:9 81:4 84:17 91:1,4 92:6,16
taken 1:19 4:6 88:8 95:10
taking 17:16 18:9 42:4 80:4
talk 5:3 85:2,4 92:1
talked 60:13 69:8 80:18 82:4,8,12 84:11,22
talking 38:5,6 43:18 59:2,21,22 78:5 81:15
tape 12:6 16:12
tapes 14:16
taught 11:25
team 42:15,16 76:24
TEE 59:9,16
telephone 24:18 27:22 28:7 45:19 46:11 53:20,21 92:24
tell 5:9 6:16 8:12 10:14 12:9,14 17:5 18:6 19:16 21:6 25:15,16 29:10 43:17,19 51:18 53:19 63:20 76:2 77:8 79:25 80:6 84:9 84:24 86:21
telling 20:6 70:24 85:6 93:1
temperature 47:25 48:5,20 49:15 51:1 53:5,9 54:23 55:11,23 62:21 67:19
ten 4:9 37:12 89:13
tend 31:21
term 31:13
testify 95:6
testimony 7:23 8:3 95:7,9
testing 92:16
textbook 11:17 20:17
Thank 93:13
their 28:4 37:9,22 42:2 43:8 76:23
theoretically 67:3 77:13
therapeutic 24: 11
t:high 62:17
thing 43:19
things 19:2 30:21 48:25 52:3 61:17 68:19 78:3
think 11:2 12:4 13:3 16:15,17 19:22 21:3 32:3 40:16 43:12 46:7 48:24 50:5 51:16 52:23 55:3 56:22 57:19 60:25 63:5 65:15 69:5 70:7 70:12 73:8,17 80:11 81:5,6 86:22 88:4,13 89:13,15,17
third 58:13 75:16
thomas 1:13,16 2:18 3:1,6,10 90:16 94:17 95:6 96:2
thoracic 42:18 43:7 76:14 77:1 79:5 80:3,5 83:6
though 34:24 68:23
thought 63:14,16
thousand 6:13
three 9:1 12:17,19 12:22 37:15,22 39:7 49:24 57:18 71:17 75:7 78:13 78:16
threshold 56:21
through 9:25 13:2 94:3
throughout 62:16
throw 51:7
thumb 37:10,11
TIA 47:21 48:19 49:14 53:8 61:24 93:7
time 9:24 13:7,11 13:19 17:16 19:1 19:8,14,15,17 20:2,8 23:20,24 25:14 26:11 27:1 27:15 28:9,14 33:22 35:19 39:9 39:11 44:2,18 46:23 49:24 50:18 55:20,23 58:16,23 60:6 62:21 63:9 67:18 69:15,25 71:5 72:17,24 73:1,14

75:6 79:14 85:15 86:13 87:17 88:23 89:18,20 90:23 95:10
times 4:8,9,13 6:2 7:15,16,18,19 26:17,25 28:19 37:19 86:22
tissue 79:8
title 10:15 12:13,16
today 8:8 20:22 21:3 43:23 44:25 47:17
told 21:21,24 45:22 61:25 78:23 83:20 84:20 85:11 91:11
Tom 17:1
Tomford 14:7
top 48:4 74:25
TOSTI 2:4 3:7 12:19 13:13,22 19:22 20:1,6,11 20:14 21:17 22:3 35:23 36:3 49:3 49:25 50:7,11,18 62:25 64:4 65:24 74:18 90:13 93:14 96:3
totally 60:6
towards 83:24
Tower 2:5
tract 29:14 68:3 90:3
trade 25:10
training 9:25 35:4
transcribed 95:8
transcript 94:2
transcription 95:9
transesophageal 34:14,23 35:1,4 36:23,25 57:22,25 60:11 62:2,13
transfer 71:7 72:2 81:8
transferred 13:12 72:15,21 75:2,4 84:15,25 85:7,16 87:4,13
transfers 80:5
transient 33:14 34:2 50:24
transthoracic 34:23 35:2,5 36:15,20 38:25 39:1 57:4 57:23
treat 50:14
treated 32:5,15 50:13,16,19
treating 33:19 49:10
treatment 32:10 41:20 78:21 79:6 89:8,9
trial 7:23
trouble 89:24
troubles 89:25,25 90:1,2
true 58:2 95:8
truth 95:6,7,7
trying 75:2
turn 45:7 57:9
twice 29:4
two 4:23 5:1 6:1 12:4,24 25:10 27:4 59:7 61:17 70:2,19 74:21
two-page 74:20
type 6:10 12:15 21:12 25:5 28:7 32:24 34:11 35:7 38:8,9 40:12,20 41:1 46:16,22 47:3,9 53:8 58:7 58:9 60:23
typed 15:24
types 40:5 58:12
typewritten 45:8
typical 40:3,22 47:9 59:3

U

uitimately 81:11 83:17 84:21
ultrasound 54:8,17
unable 7:4 67:21
under 1:18 5:7 30:9 41:13 44:3 72:14 76:11 87:20
undergo 87:16
undergone 68:10
understand 5:8,9 5:24 13:9 32:21 36:8,9 51:11
understanding 67:8 68:5 81:3 84:14
understands 78:3,4
understood 5:12 78:2
undertaken 41:15
unheard 37:25
unit 10:18,24 11:1 23:14,24 24:16,22 24:23,24 25:8,22 26:1,6,7,10,21,24 27:14 41:24,25 42:4 65:15 66:18 68:16 70:1 71:8 72:2,15,16,22,23 72:25 73:2,14,20 74:25 75:7
University 8:14 9:6 82:9,13 83:7
unless 5:23 41:25
unlikely 60:9 61:21
until 44:11,22 73:11,18
untreated 55:19
unusual 37:14 40:17 57:19
urinary 29:14 68:3 90:3
usual 29:25
usually 37:5 39:9 93:2
utilize 34:20

V

vague 16:16 26:17 43:24 59:20 75:10 77:22 78:1 81:6
valve 13:8 28:24 29:2,7,18,23 31:17 32:4,7,10 32:15,25 33:2,8 33:12 34:1,13 35:11 37:8,15,21 37:22 38:4,11,13 39:19,24,25 40:7 40:10,18,23 41:4 41:9,10,18 42:8 42:14 43:1,4,5,11 43:12,14,15 48:17 48:20 49:16,17 50:22 51:1 52:8 55:8,13 57:17 59:23,24 60:21,24 61:10,16,18,22 64:15,18,23 72:4 76:18 78:19,25 79:1,2,13,18 85:19 86:15,19 88:2,9,20
valves 11:23 31:19 32:8 37:4 60:6 64:20 75:18 79:20
valvular 39:18
variabilities 88:5
variable 58:14
various 25:20 74:7
vascular 63:14,16 67:10,23,25 68:6 68:10,17 90:1
vegetations 39:18 43:11 75:18
verbally 5:15
versus 76:25
very 22:24 23:17,20 23:21 35:6 37:1 39:15,21 41:22 45:3 59:20 60:19 77:13 85:20 89:12 90:18,18
vigilance 33:6
visit 13:15,24 45:9 47:15 49:4 52:15 53:24,25 55:10 63:8,10,23 65:2,5 65:13
visits 12:24
vitae 8:8
Vivian 1:19 95:4,16
volume 12:17,19,22
vrobel 1:13,16 3:1 3:6,10 15:16 16:3 45:11 65:18 74:14 90:16 94:17 95:6 96:2
vs 1:6

W

W 2:18
waived 93:17
walked 62:20
WALTER 1:4
want 20:3 24:1 33:19 36:5,16 56:15,18 62:9 74:9 82:23 90:20
wanted 16:16,17 19:4 62:6
wasn't 17:7 27:13 46:13 56:1 63:16 68:17 81:8,14 83:16 85:14
water 89:16
way 36:13 42:10,12 52:12 53:12,18 58:25 59:19 77:20 88:25
WEDNESDAY 1:14
week 19:14
weekends 25:25
weeks 27:4 57:5
weight 30:6,12
welcome 13:3
well 15:11,14 17:11 20:24,25 22:25 24:22,24 38:17,20 41:5 42:12 46:5 48:11 51:12 55:7 55:21 57:8 62:10 63:9 65:1 70:7 81:5
went 8:12 15:6,22 15:24 16:9,11 17:10 19:5 69:25 86:3,9
were 4:1 6:2,3,8,9 7:4,9 11:8,10 12:4 15:1 16:18 19:12 23:9,18,22 24:5,9,14,19,23 25:13 27:3,18,18 28:14 38:6 42:3 46:6,8,9 47:21 54:6,14 55:4,15 65:2,12 66:17 67:1 68:15,22,25 69:16 70:16 71:9 72:2,7,16 76:17 77:15 78:5,9,16 79:15,22 81:15 82:4,15 84:4,19 87:15,20 89:16
weren't 25:23 84:18 85:25
WHEREOF 95:13
while 66:9,18 73:20
white 30:16 33:12 34:1 47:21 48:18 49:14 50:25 51:22 54:22 55:11 56:6
whole 49:1 63:10 71:19 95:7
willing 82:22 83:3
window 49:23
Wisconsin 8:14 9:13 10:4
wish 80:23
witness 1:17 3:1 4:18 13:20,25 14:21 15:11 16:23 35:18 66:3 95:13
woman 90:2
worded 59:19
words 21:12 23:1 24:23 50:4,16
work 10:1 42:11,12
worked 10:3
working 23:13,14
workup 38:15
worse 62:19
wouldn't 42:1,3,6 45:19 55:5,12,16 56:5,6,15,18 57:1 62:7 64:9 89:11
would've 56:11
written 12:6 15:7 28:8 45:21 46:22 83:25
wrong 67:5
wrote 76:2

X

Xeroxed 74:21

Y

year 8:15 9:2,3 14:25 26:25

28:19 29:4 89:12
years 9:1 26:17 37:12,15,15,23 49:24 57:18 89:13,13

1

1 15:17,21 94:3 96:5
1st 10:10
10th 13:14 44:25 49:13 52:16 61:24 71:7,13 72:9
100 2:21 7:16 48:5 48:14
100.4 48:9
100.9 47:25 48:8,16
11th 70:15,15
11:40 93:16
1132:13
12th 15:25 70:13 71:9 72:7 75:10
13th 54:3 69:13,19 70:12,14,19 72:7 75:10
1496:8
14th 15:14 16:1 44:1 65:11,16 67:5 69:3,4,9,11 69:20 71:18,21 72:18 73:5,15 74:2 76:3 80:15 88:6 89:17
1596:5
15th 67:6 75:3 84:5
15.4 47:22
1696:4,6
1796:5
1896:7
1969 8:16,19
1974 8:19 10:3
1976 9:6 10:3
1979 9:6 10:10
1980 6:5
1980s 11:3
1990 6:6
1995 13:6 44:7,17
1998 3:19 4:1 10:14 11:4 15:14 23:11 27:16 44:1,11,22

2

2 16:4,8 96:6
20 37:1,3
2000 1:14 94:20 95:14
2004 95:18
2135 3:12
216-241-2600 2:7
216-687-1311 2:15
24 66:19
2500 1:23
26th 62:14 63:1,2 64:14
29 1:14

3

3 65:19,23 96:3,7
30 37:1,3
34305 2:22
37.4 55:23
37.6 62:22
393899 1:6

4

4 74:12,15 80:15 82:8 83:23 96:6,8
4th 59:15
440-248-7906 2:24
44113 2:6
44114 2:14
44117 3:12
44139 2:23

5

5-15-98 83:25
50 7:16 43:19

6

6th 95:14
65 96:7
660 2:5

7

7 96:3
7th 68:11
7:00 24:17,18
70s 35:5 37:9
74 96:8

8

8 95:18
8th 13:24 14:2 65:8 66:10 67:11,15 71:7,25 72:6 86:23,25 87:1,2,3
8:00 24:18
81 6:5

9

9th 57:4,12 64:12
9-C 76:16
9:40 1:24
90 96:4
93 94:3
95 44:12
98 13:14 14:2 16:1 24:15 25:14 26:23 44:25 46:1 46:4 49:13 54:3
57:4,12 59:15 62:14 64:12 65:8 66:10 68:11 76:3 80:15

THOMAS RAYMOND VROBEL, M.D.

Subscribed and sworn to before me this day of , 2000.

Notary Public

My commission expires.

telling me.
Usually the conversation goes this is what is happening, this is what my plans are, do you agree with those and it's hard to say no to any of those.
Q. But the fact is that if a patient has a suspected **TIA,** that doesn't dictate immediate hospitalization, does it?
A. Not necessarily, no.
Q. **A** patient can go home and be followed by the primary care physicians; correct?
A. Correct.
MS. HARRIS: That's all. Thank you.
MS. TOSTI: No follow up.
- - - - -
(Deposition concluded at 11:40 a.m.)
(Signature not waived.)
- - - - -

AFFIDAVIT
I have read the foregoing transcript from page 1 through 93 and note the following corrections:
PAGE LINE **REQUESTED** CHANGE

THOMAS RAYMOND VROBEL, M.D.

Subscribed and sworn to before me this day of ,2000.

Notary Public

My commission expires

State of Ohio CERTIFICATE
SS:
County of Cuyahoga.

I, Vivian L. Gordon, a Notary Public within and far the State of Ohio, duly commissioned and qualified, do hereby certify that the within named **THOMAS** RAYMOND VROBEL, **M.D.,** was by me first duly sworn to testify to the truth, the whole truth and nothing **but** the truth in the cause aforesaid; that the testimony as above **set** forth was **by** me reduced to stenotypy, afterwards transcribed, and that the foregoing is a true and correct transcription of the testimony.
I do further certify that this deposition was taken at the time and place specified and was completed without adjournment; that I am not a relative or attorney for either party or otherwise interested in the event of this action.
IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this 6th day of December, 2000.

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

INDEX
EXAMINATION **OF** TXOMAS RAYMOND VROBEL, **M.D.**

BY MS. TOSTI:	3	**7**
BY MS. HARRIS:	90	**16**
Exhibit 1 **was** marked	**15**	**17**
Exhibit **2** was marked	**16**	**4**
Exhibit **3 was** marked	65	18
Exhibit **4 was** marked	**74**	**14**

40411

0249228
MIZSEY, EARLINE
F X W CAT 07/29/1924

METROHEALTH MEDICAL CENTER
2500 MetroHealth Drive
Cleveland, Ohio 44109-1998

A/CLVEA INPATIENT/

Location: COU

05120

ECHOCARDIOGRAPHY SUMMARY*

Date Performed: 5-14-98 Report Date (if different from performed): _____

2D and Doppler ___, Exercise Echo ___, Dobutamine Echo ___, TEE X

Left ventricular function:

LV Ejection Fraction: 55 %

Description of wall motion: wl (hyperdynamic)

Right ventricular function: N

Valves: Perivalvular aortic valve abscess is present
2mm x 4mm vegetation on Aortic valve; mild AI
Tricuspid + Mitral valves OK

Hemodynamics: _____

Misc.: C/u TEE 5/8/98 diminute vegetation and perivalvular abscess now present

C Cavanaugh / FINKELHOR M.D.

*Place in the ECG section of the patient's chart.

PLAINTIFF'S EXHIBIT Urobel 1
PENGAD-Bayonne, N.J.

DATE OF STUDY: 5/12/98 DOCTOR REQUESTING STUDY: DR MCKINLEY

Tape #: TEE 153 Start #: 3305 Stop #: 3843
LOCATION: CCU
Procedures performed: TEE (93312)
Saline contrast (90784, J7030)
Color Doppler (93325)
NURSE: Unit Nurse
Performed by: Fellow and Attending
Interpreting Attending: Finkelhor

FELLOW: Casserly
CLINICAL DIAGNOSIS: Endocarditis; acute & subacute (421.0)
AGE: 73 yrs. GENDER: Female

TEE MEDICATIONS: Versed 4 mg
Morphine 2 mg

COMPLICATIONS: None

Estimated Ejection Fraction: 75%

IMAGE QUALITY: Excellent DIAGNOSTIC CONFIDENCE: High

INTERPRETATIONS & ASSESSMENTS

****

TRANSESOPHAGEAL ECHOCARDIOGRAM

* Endocarditis involving the prosthetic valve is present.
  Vegetation(s) is/are mobile and pedunculated.
  The mass measures 4 mm by 2 mm in dimension.
  Perivalvular abscess is present.
* Aortic regurgitation is present. It is mild.
  It was both valvular and perivalvular.
* A porcine valve is present.
  It is in the aortic valve position.
  See the surface echo for its hemodynamic status.
* The mitral valve appears normal.
* The tricuspid valve appears normal.
* Right ventricular contraction is normal.
* The left ventricle is hyperdynamic.
* Compared to the prior study dated 5/08/98, significant changes have occurred. Definite vegetation and abscess now seen.
* Because of CNS status the patient was electively intubated for this study.

MetroHealth Medical Center
2500 MetroHealth Drive
Cleveland, Ohio 44109

Patient Name	Sex	Birthdate	Age	Medical Record Number	Account Number
MIZSEY, EARLINE	Female	07/29/24	73	0249228	404111221

Admit Date	Discharge Date	LOS	Disposition
05/08/98 11:38 AM	05/15/98 12:05 PM	7	Transfer to Short Term Hospital

Primary Pay Source: Medicare

Attending Physician	PIN Num	Attending Physician Service
VROBEL, THOMAS R.	020297	MED

DRG Code	HCFA Weight	Coder
126	2.4879	CJW

Prin. DX	*Principal Diagnosis Text*
4210	ACUTE/SUBACUTE BACTERIAL ENDOCARDITIS

DX Code	*Secondary Diagnosis Text*
4241	AORTIC VALVE DISORDER
5990	URINARY TRACT INFECTION, SITE NOT SPECIFIED
43411	CEREBRAL EMBOLISM WITH CEREBRAL INFARCTION
14422	ARTERIAL EMBOLISM OR THROMBOSIS OF LOWER EXTREMITY
11400	CORONARY ATHEROSCLEROSIS OF UNSPECIFIED TYPE OF VESSEL, NATIVE OR GRAFT
V4581	POSTSURGICALAORTOCORONARY BYPASS STATUS
J433	HEART VALVE REPLACEMENT STATUS
25000	DIABETES MELLITUS WITHOUT COMPLICATION. TYPE II (NON-INSULIN DEPENDENT/NIDDM/ADULT-ONSET) OR UNSPECIFIED
3414	ESCHERICHIA COLI [E. COLI] INFECTION IN CONDITIONS CLASSIFIED ELSEWHERE &/OR OF UNSPECIFIED SITE
7843	APHASIA
4019	ESSENTIAL HYPERTENSION, UNSPECIFIED BENIGN OR MALIGNANT

PX Code	*Procedure Text*
3968	MONITORING OF CARDIAC OUTPUT

PLAINTIFF'S EXHIBIT 3

Thomas Vrobel

Attending Physician

6/24/98

Date

MetroHealth Medical Center
2500 MetroHealth Drive
Cleveland, Ohio 44109-1998

EACH NOTE MUST BE DATED AND SIGNED

DATE

5/14/98 CCU Attending

73 yo WO c DM, HTN and AVR c porcine valve in 2/1995 c CABG (? vessels). [illegible] mo ago suffered CVA but recovered almost completely x for [illegible]. ~2wks ago [illegible]

On 5/8/98 had (L) CVA and [illegible]. TEE then neg but 2d ago blood cultures (+) for peptostreptococcus in anaerobic bottles. Pt was improving from CVA but 2d ago (R) hemiplegia & aphasia worse. Repeat TEE today showing vegetation on [illegible] valve c abscess of myocardium. Able to [illegible] but significant expressive aphasia (told she is neurologically stable since yesterday). Tavg 37-37.5

60-70, 20-24 140/80 lungs - Clear

Cor: RR S1S2 2/6 SEM [illegible] (R) [illegible]

WBC 20,000 BC - as above

Discussed c Surgery (ID) / Family / Dr McKinney (9C attending) and pt. Feeling that pt needs AV replacement c [illegible] or she will die from this SBE. Pt and family agree to this but wish to go to CCF for this. [illegible] contact CCF and discuss with Cardiac Surgery. Will need cath first; ? here vs CCF.

[signature]

Rx PCN
Gent
Vanco

PLAINTIFF'S EXHIBIT 4

5/14/98 CCU Attending

Talked to Cardiac Surgery at CCF - they do not wish to accept pt feeling too high risk.

Talked to Dr [illegible] at UH who feels pt is a reasonable operating candidate but has full schedule tomorrow. He will discuss case c colleague tomorrow to see if any other Cardiac Surgeons would accept pt. [illegible]

031010501

PROGRESS NOTES

5/15/98 Nutrition Consult

Consult Received, however pt is to be transferred to CCF for Surgery → valve Replacement today.
(Est Nees 5/9/98?)
Per Staff - MBS not done yet.
Pt will need swallow eval prior to p.o. initiation + probable nutrition support to meet her nutritional Needs for healing / Repletion.
↓ baseline albumin level.

Heather RDN

5/15/98 Call Attendance

Pt same today as yesterday.
Talked to Dr. Bruce Lytle at CCF last PM about case. He is willing to take pt to CCF today to evaluate for surgery but agrees this is a high risk procedure. Will get cath at CCF if necessary if going for AVR. Family aware of situation. Dr Lytle's office called this AM & will transfer pt when OR bed available.

[signature]
4C S2