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IN THE COURT OF COMMON PLEAS
OF CUYAHOGA COUNTY, OHIO

MARIA O'DONNELL, et al.,
Plaintiffs,
vs Case No. 414050
Judge Sutula
DAVID C. PARRIS, M.D., et al.,
Defendants.

DEPOSITION OF CHRISTINE M. ZIRAFI, M.D.
TUESDAY, MARCH 13,2001

Deposition of CHRISTINE M. ZIRAFI, M.D., a Defendant 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 Cardiovascular Clinic, Incorporated, 6525 Powers Boulevard, Parma, Ohio, commencing at 8:45 o'clock a.m. on the day and date above set forth.

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APPEARANCES:
On behalf of the Plaintiffs
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On behalf of the Defendants Center for Internal Medicine, Inc. and Sharon Balanson, M.D.
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On behalf of the Defendants John Hollin, D.O. and MedCenter, Inc.
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On behalf of the Defendants Christine M. Zirati, M.D. and Cardiovascular Clinic, Inc.
Buckingham, Doolittle & Burroughs
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On behalf of the Defendants Chris Kalucis, D.O. and ENT Health Services
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CHRISTINE M. ZIRAFI, 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 CHRISTINE M. ZIRAFI, M.D.
BY MS. TOSTI:

Q. Doctor, would you please state your name for us.
A. Christine M. Zirafi.
Q. And your home address?
A. 21330 Avalon Drive, Rocky River, Ohio.
Q. And your current business address?
A. 6525 Powers Boulevard, Suite 301, Parma, Ohio.
Q. Who is your current employer?
A. Well, I am in partnership with several other physicians and we own the corporation.
Q. What is the name of your corporation?
A. Cardiovascular Clinic.
Q. In January of 1999, were you also in partnership in Cardiovascular Clinic?
A. No.
Q. Who was your employer in January of 19997

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A. Actually, nobody was. At that point I had recently quit another practice and was renting space from Cardiovascular Clinic at another office and negotiating with them.
Q. So were you an independent practitioner at that point in time?
A. At that point in time, I was, yes. I didn't have a signed contract. I subsequently did sign a contract with Cardiovascular Clinic that was made retroactive.
Q. How were you doing your billings then for the services?
A. I was paying them for billing services.
Q. Did you own the receipts from the services that you provided?
A. Yes.
Q. Were you individually incorporated as a professional practice in January of '99?
A. No.
Q. Your business address in January of 1999, was that here?
A. It was Medical Arts 2 Building.
Q. Does that have a different street address than this building?

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A. No.
Q. Do you currently render professional services for any other entity besides Cardiovascular Clinic, Incorporated?
A. No.
Q. In January of 1999, aside from your private practice, did you render services for any other entity, professional services?
A. No.
Q. Have you ever had your deposition taken before?
A. Yes.
Q. How manytimes?
A. I want to say two times, I believe.
Q. The two times that your deposition was taken, were they in medical negligence proceedings?
A. Oneofthem was.
Q. Were you named as a defendant in that case?
A. Yes. Actually, I had my deposition taken three times. Two were for malpractice cases.
Q. Were you named as a defendant in both of those?

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A. Yes.
Q. The other time -- twice in a medical negligence as a defendant -- what was the other time?
A. One was in a civil lawsuit.
Q. I want to go over some of the ground rules for depositions. This is a question and answer session and it's under oath. It's important that you understand my questions. If you don't understand the question, let me know and I'll be happy to rephrase the question or to repeat the question; otherwise, I'm going to assume that you understood my question and that you are able to answer it.
It's important that you give all of your answers verbally, because the court reporter can't take down head nods or hand motions. It's also important that you let me finish my question before you answer it, because the court reporter has difficulty taking down two people at one time.
If at some point you would like to refer to the medical records to refresh your memory, feel free to do so.
Also, at some point during this

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deposition, one of the defense counsel or more may choose to enter an objection. You are still required to answer my question unless your counsel instructs you not to do so.
Do you understand those directions?
A. Yes.
Q. Now, doctor, in regard to the cases in which you were named as a defendant, aside from this case, are any of those cases currently still pending?
A. No.
Q. Can you tell me the plaintiffs names of the two cases in which you were named as a defendant?
A. No.
MR. WILT: Just so I'm clear, I think there is one case that is still pending which Dr. Zirafi has been named as a defendant, and that would be a Sally Houster.
MS. TOSTI: Is that in addition to the two that she is telling me about?
MR. WILT: I believe so.
THE WITNESS: I haven't given a deposition in that case.
MR. WILT: It's a little confusing

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there.
Q. Doctor, the one that is currently pending, is that in Cuyahoga County?
A. Yes.
Q. So in addition to that one in Cuyahoga County, there are two other ones in which you have been named?
A. There are two old ones.
Q. That you were named as a defendant. And you don't recall the names of the plaintiffs in those cases?
A. No.
Q. Were those also in Cuyahoga County?
A. Yes.
Q. Doctor, in regard to the three cases in which you have been named as a defendant, could you tell me what the allegation of negligence or substandard care was? What is it that they said that was done improperly?
A. One of them was related to a patient who had a small stroke related to a catheterization I performed. We went to court and I won. The **jury** ruled in favor of me.
Another one had to do actually with endocarditis -- a case involving several

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physicians -- in a patient that had surgery, and that case was settled with no settlement against me.

MR. WILT: The present case, we don't know what their allegations are.

Q. The two that have been resolved, when was that resolution for each of those cases? How long ago?

A. One was probably about nine or ten years ago and the other one was probably about five years ago.

Q. When was the endocarditis case resolved?

A. Probably about five years ago.

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

A. Just written expert.

Q. What do you mean by written expert?

A. I have rendered expert opinions.

Q. How many times have you rendered expert opinions?

A. Probably around three or four times.

Q. And those were in medical negligence cases?

A. Yes.

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Q. Was your deposition taken any of those three or four times that you acted as an expert?

A. No.

Q. Can you tell me in those cases what the allegations of negligence that you were asked to review were?

A. One had to do with a patient who had presented to the emergency room with chest pain. I believe another one had to do with a case involving someone who had a complication related to a catheterization at surgery. I can't remember the other one or two.

Q. The three cases in which you acted as a medical/legal expert, were they for plaintiff or for defendant?

A. They were for defendants.

Q. And I take it you never were asked to testify at trial in any of those cases --

A. Yes.

Q. -- because your deposition never was taken; is that correct?

A. Yes.

Q. Have you ever acted as an expert in any case dealing with the subject matter of bacterial endocarditis?

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A. No.

Q. In regard to the cases -- well, strike that.

Doctor, did you bring a copy of your curriculum vitae?

A. Yes.

Q. I see that you did.

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

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Q. Doctor, I am handing you what's been marked as Plaintiff's Exhibit 1. If you would just identify that document for us, please.

A. It's a curriculum vitae.

Q. That's your curriculum vitae; is that correct?

A. Yes, ma'am.

Q. Is that curriculum vitae current and up to date?

A. Yes.

Q. Are there any corrections or additions that you would like to make to it?

A. The only addition would be that I am

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the co-director of the heart center at Parma Community General Hospital.

Q. I am going to ask if you can keep your voice up a little bit because the fan is kind of overriding your voice.

A. All right.

Q. May I have that to look at? Thank you.

Now, you are currently licensed to practice in the State of Ohio; correct?

A. Yes, I am.

Q. Have you ever been licensed in any other states?

A. Yes. Texas.

Q. Is that license current?

A. No.

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

A. No.

Q. And doctor, you are board certified; is that correct?

A. Yes, I am triple board certified in internal medicine, cardiology and interventional cardiology.

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Q. Those board certifications, did you pass them on your first try?
A. Medicine I did, cardiology was on my second and interventional cardiology my first.
Q. In 1999, could you tell me what hospitals you had hospital privileges at?
A. At Parma Community General Hospital, Deaconess Hospital, Southwest General Hospital, Fairview General Hospital, St. Vincent Charity Hospital and University Hospitals of Cleveland.
Q. And were those admitting privileges at all the hospitals?
A. Yes.
Q. Have your hospital privileges ever been called into question, suspended or revoked?
A. No.
Q. Have you ever been denied hospital privileges?
A. No.
Q. Doctor, you have several publications that are listed on your curriculum vitae. Do any of these publications deal with the subject matter of bacterial endocarditis?
A. No.
Q. Have you ever taught or given a formal

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lecture on the subject matter of bacterial endocarditis?
A. Possibly, back when I was on faculty at the University of Texas.
Q. Any presentations that you have given on that subject matter, do you have any outlines, handouts, syllabus, tapes, videos?
A. No. That would have been over 12 years ago.
Q. Tell me what you have reviewed in preparation for this deposition today.
A. My office chart.
Q. Have you reviewed any textbooks or journal articles?
A. No.
Q. Have you reviewed any medical records from any other physician's office?
A. No.
Q. You haven't seen the Mt. Sinai Medical Center hospital records of Maria O'Donnell?
A. No.
Q. Have you reviewed any echocardiogram tapes?
A. No.
Q. Since this case was filed, have you

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discussed this case with any physicians?
A. I mentioned it to one or two of my associates.
Q. Did you discuss the subject matter of the case with your associates?
A. No.
Q. What is it that you discussed with the people that you worked for?
A. That I am in a lawsuit. They called me to do an angioplasty at 8:30 this morning and I needed to say I couldn't do that because I am in deposition, things like that.
Q. And other than with counsel, have you discussed this case with anyone else?
A. No.
Q. Do you know Dr. Mostow, the cardiologist?
A. Yes, I do.
Q. Have you ever worked with him?
A. No.
Q. Have you ever had any discussions with him about Maria O'Donnell?
A. No.
Q. Do you know Dr. Parris?
A. I think I have met him once.

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Q. Dr. Balanson?
A. No.
Q. Dr. Kalucis?
A. Yes.
Q. When is the last time you had contact with Dr. Kalucis?
A. I know him only to say hello to him walking in the hallway. Probably several months ago.
Q. Have you ever discussed Maria, since this case was filed, have you ever discussed this case with Dr. Kalucis?
A. No.
Q. Aside from your office records, do you have any other personal notes or personal file on this case?
A. No.
Q. Have you ever generated any such notes?
A. No.
Q. Doctor, is there a textbook in your field of practice that you consider to be the best or the most reliable?
A. Well, there are several. I mean, I don't know if one is better than another.

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Q. Well, which ones do you find to be the better textbooks?
A. Oh, probably Hurst's Textbook of Cardiovascular Disease, Braunwald's Textbook of Cardiovascular Disease, Toppel's Textbook of Cardiovascular Disease.
Q. Do you refer to them from time to time in your practice?
A. Yes.
Q. Do you consider the material in them authoritative, reliable?
A. I wouldn't consider it authoritative.
Q. Do you rely on the information in your practice?
A. I use the information to help guide me in practice. It's more of a reference.
Q. Is there a particular book that -- I see that you are a senior clinical instructor with Case Western Reserve University. Is that in cardiology?
A. Yes.
Q. Is there a particular book that you use with the students that you work with?
A. No, not really.
Q. What book do they use in their

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clinical practice?
A. Well, for one, I didn't teach the students. I dealt more with fellows. So most of the time we would be dealing with articles, not textbooks.
Q. On your curriculum vitae, it says 1997 to the present, senior clinical instructor. Are you currently still senior clinical instructor?
A. Yes.
Q. And the work that you do is chiefly with fellows?
A. Yes, although I am on a leave of absence from University Hospital right now.
Q. When did you take your leave of absence?
A. I think it was just granted recently, but I asked for it a few months ago.
Q. What was the reason that you asked for a leave from that position?
A. Because they wanted our group to change malpractice carriers and we weren't sure for the amount of time I went out there it was worthwhile doing it.
Q. Are there any publications as you sit here today that you believe have particular

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relevance to the issues in this case?
A. No.
Q. Have you participated in any research dealing with the subject matter of bacterial endocarditis?
A. No.
Q. Doctor, in regard to your practice, **do** you limit your practice of cardiology in any way, subspecialize?
A. Well, I have a subspecialty in interventional cardiology, but as far as practicing cardiology, I see general cardiology patients and really provide full cardiac service. I also have a subspecialty in nuclear cardiology.
Q. I take it that you do the interventional cardiology, cardiac catherizations, angioplasties; correct?
A. Yes.
Q. Would you describe for me just in general terms what your usual practice schedule was in January of 1999?
A. At that point, I was taking all of my own call. I would round, do all of my own office, all of my consults, do any procedures

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that I am competent to do related to those patients, such as catheterizations or angioplasties, pacemaker. I would do stress testing, read echocardiograms, **EKG's,** Holter monitors, that kind of thing.
Q. In January of 1999, you told me you did not have a formalized association with Cardiovascular Clinic; correct?
A. That's true.
Q. Am I using the correct term? Is it Cardiovascular Clinic, Incorporated?
A. Yes.
Q. When did you formalize that relationship with Cardiovascular Clinic?
A. It would have been around June or July of that year.
Q. Did you have any particular office schedule where you had office hours where you saw patients in the office in January of 1999?
A. I tended to see patients on Mondays all day and Wednesday mornings.
Q. And then the rest of the time you would be doing diagnostic testing or seeing patients in the hospital?
A. Rounds in the hospital, yes.

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Q. Doctor, what is rheumatic fever?
A. Rheumatic fever is a disease that we don't see too often anymore in the United States. It's a disease primarily of childhood. That's an infectious disease.
Q. What causes it?
A. It's a bacteria.
Q. Is it usually seen as a result of a strep infection?
A. Oftentimes, yes. I think predominantly.
Q. Can rheumatic fever cause damage to the heart valves?
A. It can.
Q. And how does the damage occur to the heart valves when a person has rheumatic fever?
A. Personally, I have never seen a case of rheumatic fever, because it tends to be a childhood disease and I am an adult physician. I believe that the organisms may damage the valve. There normally is not acute valvular damage, but over the years, the wear and tear subsequently causes a valvular problem in some of the people who have had prior rheumatic fever as a child.

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Q. Are there certain heart valves that are more likely to be damaged by rheumatic fever?
A. The aortic and mitro valves.
Q. Now, if a heart valve has been damaged by rheumatic fever, are there clinical signs and symptoms that may be observed by a physician in some instances?
A. I don't know what you mean.
Q. If a patient has heart valve damage from rheumatic fever, are there things as a physician that you may be able to observe in that patient?
A. Clinically, it's normally not any different than other causes of valvular pathology.
Q. So what is it that you would be looking for to determine if a patient had valvular damage?
A. You would look to see on your examination if there was any signs of heart damage that would suggest that the patient may develop left ventricular dysfunction or congestive heart failure. You can look for abnormal lung sounds, look for ascites. You can look for organomegaly. You can look for edema.

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You can listen to the heart, and you may hear abnormal heart sounds or murmurs.
Q. Are there any precautions that can be taken to decrease the risk for endocarditis in a patient that has heart valve damage from rheumatic fever?
MR. WILT: Objection.
A. Depending on the history of the patient, there are recommendations as to sometimes prophylaxis with antibiotics, although I believe there really have been no studies to discover if that's efficacious or not.
Q. Do you recommend prophylaxis for some patients that have a history of rheumatic fever with heart damage?
MR. LEAK Objection.
MR. WILT: Objection.
A. Yes.
Q. Could you tell me what criteria you use for making recommendations for prophylaxis?
MR. LEAK Objection.
A. Normally, if they have echographic damage to the middle.
Q. And under what conditions would you recommend that the prophylaxis be used?

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MR. LEAK: Objection.
Q. What do you tell your clients why they should have prophylaxis?
MR. LEAK: Objection.
A. Normally, I would tell them if they are getting any type of surgical procedure or dental procedures, and I also, you know, tell them to tell the physician performing it, because I believe the ultimate decision is in that person's hand to weigh any allergies they may have, the risks and benefits of the antibiotics versus the procedure, since that would be in their area of expertise also.
Q. How often in your practice do you see patients with damaged heart valves as a result of rheumatic fever?
A. It's relatively rare.
Q. And can you tell me in the last month or year how many patients you have seen?
A. I would say if I see a hundred valve patients, I am not even sure if it's one.
Q. How often in your practice do you see patients with bacterial endocarditis?
A. Well, it's not a common disease. But because we have a large cardiovascular practice,

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we may see it, you know, several times a year.
Q. Would you say more or less than five patients a year, on average?
A. I would say that I would see probably five or less.
Q. Have you ever personally diagnosed a patient with bacterial endocarditis?
A. Yes.
Q. How many times have you done that, just approximately, doctor?
A. Approximately, I would say less than ten.
Q. Would you agree that bacterial endocarditis can be a life-threatening disease?
A. Yes.
Q. Are there risk factors that would place a patient at increased risk for developing bacterial endocarditis?
A. Yes.
Q. Could you tell me what those risk factors are?
A. They have a prosthetic valve in place. They have an intracardiac shunt. If they have significant deformation of the valve.
Q. Would it be fair to say that if a

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patient has a history of rheumatic fever with damage to the valve, that patient would be at increased risk for bacterial endocarditis?
A. Possibly.
Q. Could you tell me what the signs and symptoms of bacterial endocarditis are?
A. Well, it depends whether it's more of an acute onset or subacute onset.
Q. Let's take subacute onset first.
A. Normally, they would have a fever and chills. Weight loss. Oftentimes will have headache. They may have musculoskeletal complaints. They may be tired.
Then there are physical signs that you would look for. There are peripheral manifestations such as conjunctival hemorrhages, splinter hemorrhages of the fingers, Osler nodes, and Janeway lesions. They may have an auscultating murmur. You can have signs of valvular decompensation that would go along with congestive heart failure. They may have abnormal heart gallops.
Q. In regard to acute bacterial endocarditis, are any of the signs or symptoms different than what you mentioned?

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A. Yes. They tend to look ill or the patients oftentimes will have a high fever. They oftentimes will have acute cardiac decompensation, signs of pulmonary edema or emboli or other complications.
Q. Are there certain criteria that you look at to differentiate between acute and subacute bacterial endocarditis? How do you divide the two?
A. There are certain criteria. I mean, commonly, if you are talking related to surgery, I believe it's about a 30 day cutoff. It tends to be more by the manifestation. If someone suddenly develops a valve rupture or different things like that, it's more of a dramatic presentation. The organisms involved may be different.
Q. So in a patient that has subacute bacterial endocarditis, if you as a physician have a high suspicion for that, what would be the appropriate diagnostic workup for the patient? What would you do to further investigate that?
A. Normally, you would do an echocardiogram. You would normally do blood work, a CBC and differential, do a urinalysis.

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You can do a chest x-ray. You can do an EKG, blood cultures and an echocardiogram.
Q. Doctor, in a patient that has subacute bacterial endocarditis, is anemia frequently associated with that?
A. It's associated with it.
Q. In subacute bacterial endocarditis, is the sedimentation rate affected by the disease?
A. It can be elevated.
Q. Is it usually elevated when a patient has subacute bacterial endocarditis?
A. I would say usually.
Q. Now, doctor, you mentioned doing blood cultures. What would be the procedure for doing blood cultures if you were suspicious for subacute bacterial endocarditis? What would be the procedure that you follow?
A. Well, the procedure would be, normally, if based on their clinical presentation, I would think that was a possibility, you would normally do three blood cultures from three different sites an hour apart.
Q. Can endocarditis be ruled out on the basis of one echocardiogram?

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A. No.
Q. What are the complications associated with bacterial endocarditis?
A. You can have enough damage to the valve that you will maybe require a valve replacement. You can have congestive heart failure. You can develop emboli to various parts of the body. Those are the main ones.
Q. Would you agree that there has to be a high degree of vigilance for bacterial endocarditis in a patient that has rheumatic fever and a history of valve damage?
MR. WILT: Objection.
MS. SMALL: Objection.
MR. LEAK: Objection.
A. I don't understand what you mean by high degree of vigilance.
Q. Well, each time that you see a patient with a history of rheumatic fever and valvular damage, that you as a physician have to make specific inquiry of the patient as to whether there has been any problems for the ongoing infectious process.
A. Yes, if you want to ask them how they are feeling or that type of thing.

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Q. I'm sorry, I didn't hear what you said.
A. I said, I guess if you are getting at, normally when you see people, you ask them how they have been feeling and that type of thing.
Q. Would you make a specific inquiry of a patient with a history of rheumatic fever and valvular problems as to whether they had any type of fever or other signs or symptoms of infection?
MR. WILT: Let me object. What is the patient presenting for? Just seeing a patient off the street for any reason?
MS. TOSTI: With that history.
MR. WILT: Would an orthopedic surgeon see someone that comes in with an ankle problem? Is she coming to see a cardiologist for something related to cardiology? You are including everybody?
MS. TOSTI: I am asking the doctor, as a cardiologist, when you see a patient that has a history of rheumatic fever and valvular damage from rheumatic fever, do you as a cardiologist make an inquiry of the patient each time you see the patient as to whether there has been any

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problems with infection, fever, those signs and symptoms that would be associated with an ongoing infectious process?
MR. WILT: Objection. You can answer, doctor, if you can.
A. Yes. As I said, I normally ask them how they have been feeling, that type of thing. Do I go over every one of those symptoms or queries, no.
Q. Doctor, in regard to bacterial endocarditis, what is a vegetation?
A. A vegetation is normally a growth that's on the valve related to the bacterial infection. If it's bacterial. It doesn't have to be related to the infectious cause.
Q. And if a patient with endocarditis develops a vegetation on a heart valve, is that cause for concern in the patient?
A. Yes.
Q. And why is that?
A. Well, because just based on the fluid dynamics of the valve, over time it puts extra weight on the valve, it changes the architecture of the valve, it deforms it. Over time that can end, causing a valvular problem that might need

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to be fixed. There also is some risk for part of that breaking loose and embolizing.
Q. Doctor, do valvular vegetations have to be present before a presumptive diagnosis of bacterial endocarditis can be made?
A. No.
Q. And how is bacterial endocarditis treated?
A. With antibiotics.
Q. Would you agree that one of the main goals of treatment of bacterial endocarditis is to eradicate the infecting organism as soon as possible?
A. Yes.
Q. And would you agree that the sooner bacterial endocarditis is treated with antibiotics, the more likely the outcome will be positive?
MR. WILT: Objection.
MS. SMALL: Objection.
MR. WILT: You can answer, doctor.
A. Possibly.
Q. Would you agree that the earlier the treatment, the better the chance for a cure?
A. I'm not sure -- I don't know what you

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mean by cure. It may cure the infection. There are still times where there will be residual damage to the valve.
Q. But cure the bacterial endocarditis and cure the infection. You cure the endocarditis; correct?
A. Yes.
Q. You may still have valvular damage, but you have cured the infectious process.
A. Yes.
Q. Doctor, if there is a high suspicion for bacterial endocarditis once adequate blood cultures have been obtained similar to the procedure that you've outlined, would you agree that antibiotic therapy should be initiated for the patient?
MR. WILT: Objection.
A. Yes. There are two approaches to that, depending on the severity of the illness of the patient.
One approach is if they are not clinically decompensated, some physicians prefer to wait to see what grows and then start antibiotics. Other ones will start them immediately after the cultures are done if the

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patient is acutely ill.
Q. Do you adhere to one or the other of those two methods?
A. It tends to be, like I said, depending on the clinical course of the patient. If anything, I tend to lean on starting the antibiotics.
Q. Doctor, in a patient that has a history of rheumatic fever and heart murmur, if there is a recent history of intermittent and persistent, should bacterial endocarditis be included in the differential diagnosis?
MS. SMALL: Objection.
MR. WILT: Objection.
A. Yes.
Q. I am going to talk to you a little bit about your care of Maria O'Donnell now. First off, do you have an independent recollection of her? Do you remember her?
A. I remember her very well, actually unusually well.
Q. Is there a particular reason why you remember her well.
A. Yes. She came to see me one time for what she stated was just a routine checkup

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because it had been over a decade since she had seen a cardiologist. She really was not having any acute problems and we spent a large part of the visit, I remember talking about -- she was very concerned about a problem with her son who was amassing enormous Internet bills and she was afraid her husband was going to throw him out of the house, and she was asking me if I knew any psychologist to refer them to and how to handle this problem.
Q. From your recollection or review of the records, when was the time that you saw Maria O'Donnell?
A. January 25th, 1999.
Q. And is that the only time that you saw Maria?
A. Yes.
Q. Now, your understanding as to the reason that she came to see you that day was for routine follow up on her cardiac condition; is that correct?
A. Yes.
Q. Tell me what your understanding is to why she came.
A. My understanding was she just decided

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-- she was getting in her 40s. She had been tired and she decided she was due to get her heart checked out because she knew starting at around her age that that is the time that you could start seeing damage from rheumatic fever.
Q. Why is it that at that age valvular damage starts to cause some symptomatology?
A. I don't know if we know for sure. We think it's just because there is -- it might be very minute microscopic damage, and as I say, over the years, just the wear and tear of the valve opening over a hundred thousand times a day for that many years, it finally, you know, has enough damage to it that we may start to see problems.
Q. And when she came to see you, she told you that she had had a previous history of rheumatic fever and had also been told that she had a heart murmur; is that correct?
A. I don't believe she told me that she had a heart murmur. She told me that she had a history of rheumatic fever.
MS. TOSTI: Doctor, if you need to answer that, you may.
A. I don't have it noted that she told me

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that she had a history of a heart murmur.
Q. At the time that you saw her, what was your understanding as to who her primary care provider was?
A. It's my understanding that she had no primary care provider.
Q. Were you assuming responsibility as a primary care provider?
A. No, ma'am. In fact, I referred her to a primary care physician.
Q. Who did you refer her to?
A. Dr. Amy Rosenfield.
Q. Is that indicated in your notes anywhere that you made that referral?
A. I don't believe so.
Q. Now, Maria was a new patient to you on that January 25th, '99 visit; correct?
A. Yes.
Q. Is there a particular procedure that is followed or that you followed in your office when a patient would come in to see you for the first time as far as collecting information?
A. There are a couple things missing from this chart. Normally, the nurse will weigh them, put them in the room, take their pulse, find out

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what they are here for.
In fact, there was a note written by a nurse that -- it's not in here and I am not sure why. There is some handwritten papers that are not in there.
What I do is I go in and I sit down and I talk with them, find out why they are here, if they are having a specific complaint or do they just want to see a cardiologist. I tend to take their history, if they pinpoint a problem, a cardiac problem, and I do a physical examination, normally an electrocardiogram, and based on that, if I feel further testing is needed, I would recommend that.
Q. So in January of 1999, you had a nurse that was seeing the patient before you would see the patient?
A. Somebody would put them in the room, yes.
Q. And they would normally do a set of vital signs on the patient?
A. Yes.
Q. I do not have any papers that indicate that information. I have one sheet of paper with handwriting on it and we will mark this as

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Plaintiff's Exhibit 2.
- - - - -
(Thereupon, ZIRAFI Deposition Exhibit 2 was marked for purposes of identification.)
- - - - -
A. There are three or four pages that are not there, I can tell you that.
Q. I am handing you what has been marked as Plaintiff's Exhibit 2. And doctor, this is a handwritten sheet. Now, is it your belief that there is an additional set of handwritten notes aside from what's been marked as Plaintiff's Exhibit 2 that --
A. There is like a little note on a sticky, kind of like a post-it note.
MS. TOSTI: I am going to make a request for a complete copy, because I don't have anything additional and it doesn't appear that the doctor has it.
MR. WILT: I don't have it either, but I will check and see on her chart.
Q. What do you believe is contained on the sheets of paper that are not currently in the records that you have and that I have?

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A. Like I said, there is a post-it note from the nurse saying, here for no particular reason, I believe history of rheumatic fever.
Then there is another, a couple correspondences. There is a message from a phone call from Maria O'Donnell saying that she couldn't get in to see Dr. Rosenfield, who I referred her to; that she saw Dr. Parris and that he was a jerk and she was going elsewhere.
Then there is another phone message from her saying that she was in the hospital and had endocarditis. Just wanted to let me know, but she wasn't mad at me.
Then there is a correspondence from one of my nurses reminding me to call the patient about her echocardiogram reports.
Then there is a message from a family member who was trying to get her records and using the name of a surgeon, and we just advised them that we don't release medical records without the appropriate papers in place.
Q. Doctor, you seem to be fairly familiar with these particular items. Have you reviewed them recently?
A. I looked at the chart the other day.

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Q. You were looking at the original chart?
A. Yes.
Q. Okay.
A. I didn't realize you didn't have those loose papers in there.
MS. TOSTI: At this point, since I haven't seen those records, I am going to request to continue the deposition pursuant to those records once we have a look at them if we believe it's necessary. I don't know what's in them and I don't know whether it will be necessary or not, but obviously we will take a look at them and I would ask that you produce those to us as soon as possible.
MR. WILT: Sure. I will definitely produce them.
Q. Now, doctor, it's your testimony that a nurse saw Maria O'Donnell at this visit before you saw her?
A. Yes.
Q. And from your review of the records that we don't currently have in front of us, do you recall if vital signs were taken on Maria O'Donnell when she came in?

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A. I don't know. I am not going to recall anything without anything in front of me.
Q. Do you have any recollection as to whether or not she had a fever at the time that she came in or whether there even was a temperature taken?
A. I believe there wouldn't have been a temperature taken. I believe I state that she denied any fever, chills, in my history.
Q. Was Maria accompanied by anyone when she came to see you on the 25th of January?
A. Not that I know of. Not in the room anyway. I don't know if anybody drove her or anybody came with her in the waiting room.
Q. Now, you obtained a history from her at that visit; is that correct?
A. Yes.
Q. Could you just outline what history Maria gave you?
A. I can read it. A patient presents as a 44-year-old white female. She was employed as a music teacher at North Royalton City Schools.
Q. Don't go too fast, because our court reporter is going to have problems taking it down.

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A. She states that she did have a prior history of rheumatic fever and did have a cardiac catherization previously at the age of eight years old. At that time, apparently there was obviously no significant disease present, no surgical procedure was entertained.
She also states that ten years ago she had an echocardiogram performed with Dr. Ader and was told, in quotation marks, it was okay, period, end of quotation marks.
She really has done well from a cardiac standpoint and reports no symptoms. At this point in time, her main problems appear to be that of fatigue and hoarseness. She is presently seeing an ENT physician for further evaluation.
She states she is very active. She has five children as well as working full time as a music teacher. She denies any fever or chills. She has no chest pain, shortness of breath, PND, orthopnea or pedal edema. She also reported no syncope, lightheadedness or palpitation. She had no signs of cough.
Q. Doctor, was there anything that you considered to be of significance in her history

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in regard to her complaints of fatigue and hoarseness? Anything significant that you found in that history that she provided?
A. If I recall, she said she had been having some problems with that and she had been seeing an ENT, I believe, for over a month or so, maybe a little longer and she was, you know, getting that worked up. And she said she thought she would see a cardiologist; that she probably was due for another echocardiogram.
Q. Did she tell you that she had undergone an evaluation with the ENT specialist with a flexible laryngoscope?
A. No.
Q. Would the fact of that exam be of any significance to you in your evaluation of Maria that she had undergone examination with a flexible laryngoscope by an ENT?
A. At that point in time, based on that history, really not.
Q. Should Maria have received -- do you have an opinion whether Maria should have received prophylaxis with antibiotics prior to examination with a flexible laryngoscope?
MR. LEAK: Objection.

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MR. WILT: Objection. You qualified her as an expert in ENT plus she hasn't reviewed that.

Doctor, if you feel you can give an opinion.

A. You know, I think that's -- as I said, I don't deal with those procedures. I think it can be very subjective.

As I stated, the recommendations based on whether you prophylaxis people or not are not based on scientific studies in humans, as far as I know.

Number two, this woman had a history of rheumatic fever. She did not have any type of murmur that would be obvious, I think, to most physicians, so it might be difficult.

I do know she had some allergies to common antibiotics that they may use, and so, like I said, I'm not sure how they go about making their decisions.

Q. Well, doesn't the recommendation for prophylaxis for procedures come from the cardiologist?

MR. WILT: Objection.

MR. LEAK: Objection.

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Q. When a patient has rheumatic fever and a history of valvular disorder, isn't it the cardiologist who makes the recommendation for prophylaxis?

A. I don't know. I was not that woman's cardiologist at that time.

Q. I am asking you as to whether you have an opinion as to whether in her case, knowing her history from your evaluation, whether prophylaxis would have been indicated for that procedure?

And if you don't have an opinion, just tell me that and we will move on to something else. I am interested in knowing if you do have an opinion.

MR. WILT: Objection.

A. As I state, like I said, normally we will lean toward recommending prophylaxis for most patients with history of rheumatic fever. However, as I told you before, you know, each specialty and each physician has their own area of literature and expertise in that area where they make their own decisions.

Q. Is it the cardiologist that recommends to the patient when a procedure is going to be done whether or not prophylaxis is appropriate?

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MR. LEAK: Objection.

MR. WILT: Objection.

A. As I state, we make general recommendation and then other decisions are based on what that physician does. I mean, I make recommendations every day regarding surgical procedures. The surgeon then decides how they are going to do their own surgery and that type of thing.

Q. In this case it would be the ENT specialist that would prescribe the antibiotics for the patient if the patient was undergoing a procedure? I am asking as to what the usual procedure is. If you recommend prophylaxis, do you order the prophylaxis or does the actual person who is doing the procedure order it?

MR. LEAK: Objection.

A. In my instance, normally the actual person who does the procedure.

Q. Now, you also did a physical examination of Maria O'Donnell at this visit; correct?

A. Yes.

Q. Did you find any deviations from normal that you considered to be significant on

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your physical exam?

A. Not really. She had a questionable and I felt early mild heart murmur which is not uncommon for me to hear in anybody I examine. And other than that, no. I believe she had a normal physical examination.

Q. Now, in a patient with -- I think the way you described it was an early systolic murmur that you heard in the apex. In Maria O'Donnell's case with a history of rheumatic fever, what would be the significance of that finding?

A. I'm not sure if it's of any significance. I mean, if I see a hundred patients, probably 80 of them will have heart murmurs or more.

I ordered an echocardiogram on her not based on that auscultation finding of that murmur because it did not appear to be hemodynamically significant, but based just on her history of rheumatic fever.

Q. Now, you also did an EKG on her at that visit; correct?

A. Yes.

Q. And what were your findings on the EKG?

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A. I think sinus rhythm. She had nonspecific ST changes and there was a lot of artifact. And I put a questionable persistent juvenile pattern.
Q. What does a questionable persistent juvenile pattern mean?
A. You can have T wave inversions.
Q. Is that a normal deviation?
A. It can be a normal variant. It's a juvenile type of pattern that can persist more commonly in women even into their 40s.
Q. Did you find anything on EKC that you considered to be of concern?
A. Not really.
Q. Now, I believe the computer or unverified preliminary reading indicates cannot exclude ischemia. Were you able when you read the EKG to exclude ischemia on this EKG?
A. Well, that reads any -- they put that for any abnormal deviation from the ST segments and I wrote what I thought possibly that was from.
Q. So your evaluation was that this EKC didn't represent ischemia; is that correct?
A. At that point it wasn't high on my

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list, no.
Q. When you did your physical exam of Maria, you did not find any evidence of cardiac decompensation; correct?
A. No.
Q. Did she have any complaints of fever when you saw her?
A. No.
Q. Did you make any determination as to what was causing her fatigue?
A. I believe that's why I referred her to a medical doctor, because she also, if I recall, she stated to me she didn't have one. She hadn't had any type of checkup for a while. I was concerned about a thyroid which can cause fatigue and hoarseness and so I ordered the TSH level.
Q. And did you anticipate after you made that referral that the primary care physician then would do a complete physical and evaluate her for that particular symptom?
A. Yes.
Q. Do you know how long she had been having the fatigue?
A. Off the top of my head, I don't recall.

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Q. Can fatigue be seen as a symptom of bacterial endocarditis?
A. Fatigue, I think, can be seen as a symptom of pretty much anything, yes.
Q. Do you know how long she had had the hoarseness that she complained of?
A. If I recall, I believe it had been going on a while, because she had been under medical care for that.
Q. You don't know how long, though; is that correct?
A. I don't know how long, no.
Q. What was your plan of care then after you completed your history and physical for Maria on the 25th?
A. My plan of care was to do an echocardiogram, refer her to a medical doctor, because she was at the age where she needed a full, complete checkup, and then depending on what the echocardiogram showed, I would probably, if I needed to, contact her in the future, just let her know the results, and to see if there were problems, whether I needed to recommend a yearly follow up.
Q. Now, the reason that you did the

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echocardiogram, was that to get a baseline on what her cardiac valvular function was?
A. Yes.
Q. And I believe in your note, you indicate at the bottom under assessment and plan that she is approaching the age where she can be having significant valvular disease.
Would you tell me what you consider to be significant valvular disease, how you define that?
A. Well, I mean, I define it primarily if she is starting to have any signs of valvular decompensation or anything like that.
Q. Now, the echocardiogram, at least from what I can see, appears to have been done on the same date as your office visit.
A. No, that's incorrect. I believe it was done on the 28th.
Q. On the 28th?
A. Yes, according to the date on the records.
Q. Oh, you are right. I have a wrong date here.
Were you present at the time that the echocardiogram was done?

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A. No.
Q. Did you receive the report of the study in written form or did someone call you with it?
A. I believe up there it says received. Yes.
Q. I am just wondering, typically, would the echo lab give you a call and give you a verbal report or would they just send you along the written report?
A. No, they would only send a written report unless there is something very acutely going on.
Q. And in regard to the echocardiogram, could you tell us what the results of that were that you considered to be significant?
A. Well, there was normal left ventricular function. Normal left ventricular size. The left atrium was mildly dilated. The mitral valve was thickened but it opened normally. The aortic valve was normal. The right sided chambers were normal. There was no pericardial effusion and there was evidence of mitral regurgitation that was moderate to severe.
Q. And in Maria O'Donnell's case, in

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regard to her physical condition, what would be the significance of those findings that you just reviewed for us?
A. I mean, the significance of those findings would be just that she likely has developed some valvular dysfunction and probably, as I stated, may need to follow up at six months or a year.
Q. Did you make any recommendation -- well, we will get to that in a minute.
Did the echo findings confirm the question of a murmur that you heard when you listened to her chest?
A. Well, it appeared to be more prominent than I appreciated based on her physical examination. But if I recall, I think she had some larger breasts which is not necessarily the easiest person to auscultate. But what you heard as a systolic murmur would be consistent with what you saw as a report on the echocardiogram. On the apex it would be a mitral murmur.
Q. After you received the echo report, did you communicate the result of that report to Maria?
A. I was on vacation through part of

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February, and when I came back, I did try to call her at her school. In fact, I spoke to a secretary there. And then I believe at some point, like I said, by that time I also knew that she had seen -- that she was having further medical care. She had seen, I know, at least Dr. Parris, and then the next thing I knew she was going to see another doctor and then she was in the hospital.
Q. Did you ever get a chance to talk to Maria and communicate to her what the results of the echo was?
A. No.
Q. Did you forward the echo report and the other laboratory studies that you did to Dr. Rosenfield or Dr. Parris?
A. No. I didn't know who she was seeing. As I stated, I referred her to Dr. Rosenfield, who she never saw.
Q. Now, you mentioned that you wanted to check her out, I think, for hypothyroidism; is that correct?
A. Yes.
Q. And that was in relation to the hoarseness that she had?

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A. The hoarseness and fatigue.
Q. What would be the relationship between hoarseness and fatigue in hypothyroidism?
A. Those are signs or symptoms of.
Q. And you did a TSH in order to at least initially evaluate that?
A. Yes.
Q. What was the finding in regard to the TSH? Was there any relationship? Did you find anything that would lead you to believe that she was hypothyroid?
A. No, it was normal.
Q. Now, did you instruct Maria that she should come back to see you at any point for follow up?
A. No. Normally what I would do in those cases is, like I said, if nothing, if the person has no acute complaints, which she did not, and if she had no acute problems, we would do the testing, and depending on what the testing shows, to notify them that they would need some type of follow up or let them know that everything was fine.
Q. But in this case, you never were able to contact Maria?

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A. Well, she was seeing other physicians, and you are talking about she was in the hospital, I believe, within one month's time period, so that's not really too long.
When I see people, normally if you were to see me with a complaint, a cardiac complaint, normally I would do your testing and not see you back for maybe six to eight weeks.
Q. Now, doctor, I notice one of the lab sheets in your records, the copy that I have indicates at the bottom of the page facts to Dr. Rosenfield. Do you have that copy in front of you?
A. Yes.
Q. Now, I previously asked you if you sent any of the lab tests or the echocardiogram reports to Dr. Rosenfield and yet this particular lab sheet has a notation on the bottom of it. Do you recall?
A. When I send nothing out, physicians call for the studies, you know, and we will send them. I do know also that Mrs. O'Donnell got a copy of her echo report at some point.
Q. How do you know that?
A. How do I know that?

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MR. WILT: She is not going to answer that question. Go ahead.
MS. TOSTI: Why isn't she going to answer that question?
Q. How do you know that Maria O'Donnell got a copy of her echo report?
MR. WILT: I think it's clear from prior testimony that Maria O'Donnell had an echo report with her when she went to see Dr. Balanson.
MS. TOSTI: I am asking the doctor as to how she knows.
MR. WILT: I am telling you she is not going to tell you how she knows, because if she acquired that information from me, you have no right to know it.
Q. Well, other than with counsel -- and if it was with counsel, you don't have to answer -- but did you acquire that information from some other source other than counsel that she had a copy of her echo report?
A. No.
Q. Okay. And in regard to the notation on the bottom of this laboratory sheet, do you have any knowledge as to whether the echo report

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was sent with this particular lab sheet to Dr. Rosenfield?
A. No, I don't know. Like I said, oftentimes we do stuff, and people, if they go on to see another doctor, they will say I had some blood work or this done and that stuff and the offices will call and the secretaries will fax them out, so I don't know what was sent.
Q. So the office could do that without actually contacting you and asking you for permission?
A. Yes.
Q. Following this January 25th visit, did you have any conversations with any of the physicians that cared for her; such as Dr. Parris?
A. No.
Q. Or Dr. Rosenfield or anyone else that cared for her after the point that you saw her?
A. Well, like I said, as far as I know, I referred her to Dr. Rosenfield, who she did not see, and then I never knew what happened to her other than when she called the office.
THE WITNESS: I think I am going to have to go.

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MR. WILT: Do you have much more?
MS. **TOSTI:** I have just a couple more, maybe five minutes left.
THE WITNESS: Okay.
(Recess had.)
Q. Doctor, in Maria O'Donnell's case, after she saw you, I want you to assume that she had continued complaints of fatigue and hoarseness and also had intermittent persistent fever. Would you agree that those symptoms with the history that you are aware of would warrant investigation by a physician?
MR. LEAK: Objection.
MS. SMALL: Objection.
MR. WILT: Let me object. She is here as a fact witness, not as an expert witness against other defendants. She hasn't reviewed any other depositions, and I don't think it's fair to ask her to give opinions on very little information.
Doctor, if you feel like you can give an opinion, fine. If not, then just tell her you don't have an opinion.
A. I mean, I guess, you know, I don't know the circumstances of the complaints when she

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was seeing other physicians.
Q. So you have no opinion on that, doctor?
A. Yes.
Q. When you saw her on January 25th of '99, did she have any signs or symptoms that would be consistent with bacterial endocarditis?
A. I believe not. Like I said, the only stretch you could make is fatigue, and I will venture to say that probably some of the people in this room were pretty tired at any time during the past week and I would say they probably don't have endocarditis.
Q. Doctor, I am going to ask you a number of questions, and if you have no opinion, just tell me that and we will move on to the next one. But if you do, then I would like to know what it is.
Do you have an opinion as to whether Maria O'Donnell likely had bacterial endocarditis at the time you saw her on the 25th of January?
A. I believe she did not.
Q. You are aware that Maria O'Donnell eventually was diagnosed with bacterial endocarditis; correct?

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A. I do know that.
Q. Do you have an opinion as to when she developed bacterial endocarditis?
A. No, I don't.
Q. Are you also aware that she suffered complications of a stroke?
A. I know that.
Q. Do you have an opinion as to what caused her stroke on February 26th of '99?
A. No.
Q. Doctor, at the time that you saw her on January 25th, do you have an opinion as to what her reasonable life expectancy was?
A. Well, she had a family history of her father dying of a heart attack at the age of 54 and her mother has a history of breast carcinoma, so she does have a predisposition to two bad diseases.
As far as predicting somebody's life span, I don't know how to do that. I am not an actuarial.
Q. Did you ever speak to any of Maria O'Donnell's family at any time?
A. I don't believe so.
Q. And aside from the one visit that you had with her on the 25th, did you have any other contact with Maria O'Donnell?
A. No. Like I said, I tried to call her. I left a message. When she got back in touch with me, she said she was seeing another physician and was being evaluated.
Q. Now, you've mentioned a couple of pieces of the medical records that we do not currently have in front of us. Are one of those related to the conversation that you had with her, the telephone conversation?
A. One of them is not related to the conversation. There is a note in there saying remember to call her.
Q. Did you have direct contact with Maria on the phone where you spoke with her?
A. No. As I told you, I spoke with the secretary at her school. They said she was not available, so I left a message for her to contact me, but she did not at that point.
Q. I am a little confused. After the 25th, did you ever speak to her again?
A. No, I did not.
Q. Do you have any criticisms of anyone else that provided care to Maria O'Donnell?

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A. I reviewed nothing. I have no contact with anything that was done after that date.
Q. Are you critical of Maria O'Donnell in any way for how she cared for herself?
A. Again, since I don't know anything that subsequently went on, I can't comment on that.
MS. TOSTI: I don't have any further questions for you.
MS. SMALL: I have no questions.
MR. WILT: Anybody else?
- - - - -
(Deposition concluded at 10:05 a.m.)
(Signature not waived.)
- - - - -

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AFFIDAVIT

I have read the foregoing transcript from page 1 through 64 and note the following corrections:

PAGE LINE REQUESTED CHANGE

CHRISTINE M. ZIRAFI, M.D.

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

Notary Public

My commission expires

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CERTIFICATE

State of Ohio,
S S
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 CHRISTINE M. ZIRAFI, 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 16th day of March, 2001.

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