

Page 1

1 IN THE COURT OF COMMON PLEAS  
2 OF CUYAHOGA COUNTY, OHIO  
3 -----  
4 MARIA O'DONNELL, et al.,  
5 Plaintiffs,  
6 vs Case No. **41 4050**  
7 Judge Sutula  
8 DAVID C. PARRIS, M.D.,  
9 et al.,  
10 Defendants.  
11 -----  
12 DEPOSITION OF CHRISTINE M. ZIRAFI, M.D.  
13 TUESDAY, MARCH **13,2001**  
14 -----  
15 Deposition of CHRISTINE M. ZIRAFI, M.D., a  
16 Defendant herein, called by counsel on behalf of  
17 the Plaintiff for examination under the statute,  
18 taken before me, Vivian L. Gordon, a Registered  
19 Diplomate Reporter and Notary Public in and for  
20 the State of Ohio, pursuant to agreement of  
21 counsel, at the offices of Cardiovascular Clinic,  
22 Incorporated, **6525** Powers Boulevard, Parma, Ohio,  
23 commencing at **8:45** o'clock a.m. on the day and  
24 date above set forth.  
25

Page 3

1 CHRISTINE M. ZIRAFI, M.D., a witness herein,  
2 called for examination, as provided by the Ohio  
3 Rules of Civil Procedure, being by me first duly  
4 sworn, as hereinafter certified, was deposed and  
5 said as follows:  
6 EXAMINATION OF CHRISTINE M. ZIRAFI, M.D.  
7 BY MS. TOSTI:  
8 Q. Doctor, would you please state your  
9 name for us.  
10 A. Christine M. Zirafi.  
11 Q. And your home address?  
12 A. **21330** Avalon Drive, Rocky River, Ohio.  
13 Q. And your current business address?  
14 A. **6525** Powers Boulevard, Suite **301**,  
15 Parma, Ohio.  
16 Q. Who is your current employer?  
17 A. Well, I am in partnership with several  
18 other physicians and we own the corporation.  
19 Q. What is the name of your corporation?  
20 A. Cardiovascular Clinic.  
21 Q. In January of **1999**, were you also in  
22 partnership in Cardiovascular Clinic?  
23 A. No.  
24 Q. Who was your employer in January of  
25 **1999**

Page 2

1 APPEARANCES:  
2 On behalf of the Plaintiffs  
3 Becker & Mirhikind  
4 JEANNE M. TOSTI, ESQ.  
5 Skyline Office Tower Suite 660  
6 Cleveland, Ohio 44113  
7 216-241-2600  
8  
9 On behalf of the Defendants Center for Internal  
10 Medicine, Inc. and Sharon Balanson, M.D.  
11 Mazanec, Raskin & Ryder  
12 CHERYL ATWELL, ESQ.  
13 100 Franklin's Row  
14 34305 Solon Road  
15 Solon, Ohio 44139  
16 440-248-7906  
17  
18 On behalf of the Defendants John Hollin, D.O. and  
19 MedCenter, Inc.  
20 Hanna, Campbell & Powell  
21 JANICE L. SMALL, ESQ.  
22 P. O. Box 5521  
23 3737 Embassy Parkway  
24 Akron, Ohio 44334  
25 330-670-7300  
26  
27 On behalf of the Defendants Christine M. Zirafi,  
28 M.D. and Cardiovascular Clinic, Inc.  
29 Buckingham, Doolittle & Burroughs  
30 RONALD WILT, ESQ.  
31 One Cleveland Center Suite 1700  
32 Cleveland, Ohio 44114  
33 216-621-5300  
34  
35 On behalf of the Defendants Chris Kalucks, D.O.  
36 and ENT Health Services  
37 Boneui, Switzer, Murphy & Polito  
38 DOUGLAS G. LEAK, ESQ.  
39 Leader Building Suite 1400  
40 Cleveland, Ohio 44114  
41 216-875-2767  
42  
43  
44  
45

Page 4

1 A. Actually, nobody was. At that point I  
2 had recently quit another practice and was  
3 renting space from Cardiovascular Clinic at  
4 another office and negotiating with them.  
5 Q. So were you an independent  
6 practitioner at that point in time?  
7 A. At that point in time, I was, yes. I  
8 didn't have a signed contract. I subsequently  
9 did sign a contract with Cardiovascular Clinic  
10 that was made retroactive.  
11 Q. How were you doing your billings then  
12 for the services?  
13 A. I was paying them for billing  
14 services.  
15 Q. Did you own the receipts from the  
16 services that you provided?  
17 A. Yes.  
18 Q. Were you individually incorporated as  
19 a professional practice in January of '99?  
20 A. No.  
21 Q. Your business address in January of  
22 **1999**, was that here?  
23 A. It was Medical Arts 2 Building.  
24 Q. Does that have a different street  
25 address than this building?

1 (Pages 1 to 4)

Page 5

1 A. No.  
 2 Q. Do you currently render professional  
 3 services for any other entity besides  
 4 Cardiovascular Clinic, Incorporated?  
 5 A. No.  
 6 Q. In January of 1999, aside from your  
 7 private practice, did you render services for any  
 8 other entity, professional services?  
 9 A. No.  
 10 Q. Have you ever had your deposition  
 11 taken before?  
 12 A. Yes.  
 13 Q. How manytimes?  
 14 A. I want to say two times, I believe.  
 15 Q. The two times that your deposition was  
 16 taken, were they in medical negligence  
 17 proceedings?  
 18 A. One of them was.  
 19 Q. Were you named as a defendant in that  
 20 case?  
 21 A. Yes. Actually, I had my deposition  
 22 taken three times. Two were for malpractice  
 23 cases.  
 24 Q. Were you named as a defendant in both  
 25 of those?

Page 7

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

Page 6

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

Page 8

1 there.  
 2 Q. Doctor, the one that is currently  
 3 pending, is that in Cuyahoga County?  
 4 A. Yes.  
 5 Q. So in addition to that one in Cuyahoga  
 6 County, there are two other ones in which you  
 7 have been named?  
 8 A. There are two old ones.  
 9 Q. That you were named as a defendant.  
 10 And you don't recall the names of the plaintiffs  
 11 in those cases?  
 12 A. No.  
 13 Q. Were those also in Cuyahoga County?  
 14 A. Yes.  
 15 Q. Doctor, in regard to the three cases  
 16 in which you have been named as a defendant,  
 17 could you tell me what the allegation of  
 18 negligence or substandard care was? What is it  
 19 that they said that was done improperly?  
 20 A. One of them was related to a patient  
 21 who had a small stroke related to a  
 22 catheterization I performed. We went to court  
 23 and I won. The jury ruled in favor of me.  
 24 Another one had to do actually with  
 25 endocarditis -- a case involving several

2 (Pages 5 to 8)

Page 9

1 physicians -- in a patient that had surgery, and  
 2 that case was settled with no settlement against  
 3 me.  
 4 MR. WILT: The present case, we don't  
 5 know what their allegations are.  
 6 Q. The two that have been resolved, when  
 7 was that resolution for each of those cases? How  
 8 long ago?  
 9 A. One was probably about nine or ten  
 10 years ago and the other one was probably about  
 11 five years ago.  
 12 Q. When was the endocarditis case  
 13 resolved?  
 14 A. Probably about five years ago.  
 15 Q. Have you ever acted as an expert in a  
 16 medical/legal proceeding?  
 17 A. Just written expert.  
 18 Q. What do you mean by written expert?  
 19 A. I have rendered expert opinions.  
 20 Q. How many times have you rendered  
 21 expert opinions?  
 22 A. Probably around three or four times.  
 23 Q. And those were in medical negligence  
 24 cases?  
 25 A. Yes.

Page 11

1 A. No.  
 2 Q. In regard to the cases -- well, strike  
 3 that.  
 4 Doctor, did you bring a copy of your  
 5 curriculum vitae?  
 6 A. Yes.  
 7 Q. I see that you did.  
 8 -----  
 9 (Thereupon, ZIRAFI Deposition  
 10 Exhibit 1 was marked for  
 11 purposes of identification.)  
 12 -----  
 13 Q. Doctor, I am handing you what's been  
 14 marked as Plaintiff's Exhibit 1. If you would  
 15 just identify that document for us, please.  
 16 A. It's a curriculum vitae.  
 17 Q. That's your curriculum vitae; is that  
 18 correct?  
 19 A. Yes, ma'am.  
 20 Q. Is that curriculum vitae current and  
 21 up to date?  
 22 A. Yes.  
 23 Q. Are there any corrections or additions  
 24 that you would like to make to it?  
 25 A. The only addition would be that I am

Page 10

1 Q. Was your deposition taken any of those  
 2 three or four times that you acted as an expert?  
 3 A. No.  
 4 Q. Can you tell me in those cases what  
 5 the allegations of negligence that you were asked  
 6 to review were?  
 7 A. One had to do with a patient who had  
 8 presented to the emergency room with chest pain.  
 9 I believe another one had to do with a case  
 10 involving someone who had a complication related  
 11 to a catheterization at surgery. I can't  
 12 remember the other one or two.  
 13 Q. The three cases in which you acted as  
 14 a medical/legal expert, were they for plaintiff  
 15 or for defendant?  
 16 A. They were for defendants.  
 17 Q. And I take it you never were asked to  
 18 testify at trial in any of those cases --  
 19 A. Yes.  
 20 Q. -- because your deposition never was  
 21 taken; is that correct?  
 22 A. Yes.  
 23 Q. Have you ever acted as an expert in  
 24 any case dealing with the subject matter of  
 25 bacterial endocarditis?

Page 12

1 the co-director of the heart center at Parma  
 2 Community General Hospital.  
 3 Q. I am going to ask if you can keep your  
 4 voice up a little bit because the fan is kind of  
 5 overriding your voice.  
 6 A. All right.  
 7 Q. May I have that to look at? Thank  
 8 you.  
 9 Now, you are currently licensed to  
 10 practice in the State of Ohio; correct?  
 11 A. Yes, I am.  
 12 Q. Have you ever been licensed in any  
 13 other states?  
 14 A. Yes. Texas.  
 15 Q. Is that license current?  
 16 A. No.  
 17 Q. Has your license in Ohio or any other  
 18 state ever been suspended, revoked or called into  
 19 question?  
 20 A. No.  
 21 Q. And doctor, you are board certified;  
 22 is that correct?  
 23 A. Yes, I am triple board certified in  
 24 internal medicine, cardiology and interventional  
 25 cardiology.

3 (Pages 9 to 12)

Page 13

- 1 Q. Those board certifications, did you  
2 pass them on your first try?  
3 A. Medicine I did, cardiology was on my  
4 second and interventional cardiology my first.  
5 Q. In 1999, could you tell me what  
6 hospitals you had hospital privileges at?  
7 A. At Parma Community General Hospital,  
8 Deaconess Hospital, Southwest General Hospital,  
9 Fairview General Hospital, St. Vincent Charity  
10 Hospital and University Hospitals of Cleveland.  
11 Q. And were those admitting privileges at  
12 all the hospitals?  
13 A. Yes.  
14 Q. Have your hospital privileges ever  
15 been called into question, suspended or revoked?  
16 A. No.  
17 Q. Have you ever been denied hospital  
18 privileges?  
19 A. No.  
20 Q. Doctor, you have several publications  
21 that are listed on your curriculum vitae. Do any  
22 of these publications deal with the subject  
23 matter of bacterial endocarditis?  
24 A. No.  
25 Q. Have you ever taught or given a formal

Page 15

- 1 discussed this case with any physicians?  
2 A. I mentioned it to one or two of my  
3 associates.  
4 Q. Did you discuss the subject matter of  
5 the case with your associates?  
6 A. No.  
7 Q. What is it that you discussed with the  
8 people that you worked for?  
9 A. That I am in a lawsuit. They called  
10 me to do an angioplasty at 8:30 this morning and  
11 I needed to say I couldn't do that because I am  
12 in deposition, things like that.  
13 Q. And other than with counsel, have you  
14 discussed this case with anyone else?  
15 A. No.  
16 Q. Do you know Dr. Mostow, the  
17 cardiologist?  
18 A. Yes, I do.  
19 Q. Have you ever worked with him?  
20 A. No.  
21 Q. Have you ever had any discussions with  
22 him about Maria O'Donnell?  
23 A. No.  
24 Q. Do you know Dr. Parris?  
25 A. I think I have met him once.

Page 14

- 1 lecture on the subject matter of bacterial  
2 endocarditis?  
3 A. Possibly, back when I was on faculty  
4 at the University of Texas.  
5 Q. Any presentations that you have given  
6 on that subject matter, do you have any outlines,  
7 handouts, syllabus, tapes, videos?  
8 A. No. That would have been over 12  
9 years ago.  
10 Q. Tell me what you have reviewed in  
11 preparation for this deposition today.  
12 A. My office chart.  
13 Q. Have you reviewed any textbooks or  
14 journal articles?  
15 A. No.  
16 Q. Have you reviewed any medical records  
17 from any other physician's office?  
18 A. No.  
19 Q. You haven't seen the Mt. Sinai Medical  
20 Center hospital records of Maria O'Donnell?  
21 A. No.  
22 Q. Have you reviewed any echocardiogram  
23 tapes?  
24 A. No.  
25 Q. Since this case was filed, have you

Page 16

- 1 Q. Dr. Balanson?  
2 A. No.  
3 Q. Dr. Kalucis?  
4 A. Yes.  
5 Q. When is the last time you had contact  
6 with Dr. Kalucis?  
7 A. I know him only to say hello to him  
8 walking in the hallway. Probably several months  
9 ago.  
10 Q. Have you ever discussed Maria, since  
11 this case was filed, have you ever discussed this  
12 case with Dr. Kalucis?  
13 A. No.  
14 Q. Aside from your office records, do you  
15 have any other personal notes or personal file on  
16 this case?  
17 A. No.  
18 Q. Have you ever generated any such  
19 notes?  
20 A. No.  
21 Q. Doctor, is there a textbook in your  
22 field of practice that you consider to be the  
23 best or the most reliable?  
24 A. Well, there are several. I mean, I  
25 don't know if one is better than another.

4 (Pages 13 to 16)

Page 17

1 Q. Well, which ones do you find to be the  
2 better textbooks?  
3 A. Oh, probably Hurst's Textbook of  
4 Cardiovascular Disease, Braunwald's Textbook of  
5 Cardiovascular Disease, Toppel's Textbook of  
6 Cardiovascular Disease.  
7 Q. Do you refer to them from time to time  
8 in your practice?  
9 A. Yes.  
10 Q. Do you consider the material in them  
11 authoritative, reliable?  
12 A. I wouldn't consider it authoritative.  
13 Q. Do you rely on the information in your  
14 practice?  
15 A. I use the information to help guide me  
16 in practice. It's more of a reference.  
17 Q. Is there a particular book that -- I  
18 see that you are a senior clinical instructor  
19 with Case Western Reserve University. Is that in  
20 cardiology?  
21 A. Yes.  
22 Q. Is there a particular book that you  
23 use with the students that you work with?  
24 A. No, not really.  
25 Q. What book do they use in their

Page 19

1 relevance to the issues in this case?  
2 A. No.  
3 Q. Have you participated in any research  
4 dealing with the subject matter of bacterial  
5 endocarditis?  
6 A. No.  
7 Q. Doctor, in regard to your practice, **do**  
8 you limit your practice of cardiology in any way,  
9 subspecialize?  
10 A. Well, I have a subspecialty in  
11 interventional cardiology, but as far as  
12 practicing cardiology, I see general cardiology  
13 patients and really provide full cardiac  
14 service. I also have a subspecialty in nuclear  
15 cardiology.  
16 Q. I take it that you do the  
17 interventional cardiology, cardiac  
18 catheterizations, angioplasties; correct?  
19 A. Yes.  
20 Q. Would you describe for me just in  
21 general terms what your usual practice schedule  
22 was in January of 1999?  
23 A. At that point, I was taking all of my  
24 own call. I would round, do all of my own  
25 office, all of my consults, do any procedures

Page 18

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

Page 20

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

5 (Pages 17 to 20)

Page 21

1 Q. Doctor, what is rheumatic fever?  
 2 A. Rheumatic fever is a disease that we  
 3 don't see too often anymore in the United  
 4 States. It's a disease primarily of childhood.  
 5 That's an infectious disease.  
 6 Q. What causes it?  
 7 A. It's a bacteria.  
 8 Q. Is it usually seen as a result of a  
 9 strep infection?  
 10 A. Oftentimes, yes. I think  
 11 predominantly.  
 12 Q. Can rheumatic fever cause damage to  
 13 the heart valves?  
 14 A. It can.  
 15 Q. And how does the damage occur to the  
 16 heart valves when a person has rheumatic fever?  
 17 A. Personally, I have never seen a case  
 18 of rheumatic fever, because it tends to be a  
 19 childhood disease and I am an adult physician.  
 20 I believe that the organisms may  
 21 damage the valve. There normally is not acute  
 22 valvular damage, but over the years, the wear and  
 23 tear subsequently causes a valvular problem in  
 24 some of the people who have had prior rheumatic  
 25 fever as a child.

Page 22

1 Q. Are there certain heart valves that  
 2 are more likely to be damaged by rheumatic fever?  
 3 A. The aortic and mitro valves.  
 4 Q. Now, if a heart valve has been damaged  
 5 by rheumatic fever, are there clinical signs and  
 6 symptoms that may be observed by a physician in  
 7 some instances?  
 8 A. I don't know what you mean.  
 9 Q. If a patient has heart valve damage  
 10 from rheumatic fever, are there things as a  
 11 physician that you may be able to observe in that  
 12 patient?  
 13 A. Clinically, it's normally not any  
 14 different than other causes of valvular  
 15 pathology.  
 16 Q. So what is it that you would be  
 17 looking for to determine if a patient had  
 18 valvular damage?  
 19 A. You would look to see on your  
 20 examination if there was any signs of heart  
 21 damage that would suggest that the patient may  
 22 develop left ventricular dysfunction or  
 23 congestive heart failure. You can look for  
 24 abnormal lung sounds, look for ascites. You can  
 25 look for organomegaly. You can look for edema.

Page 23

1 You can listen to the heart, and you may hear  
 2 abnormal heart sounds or murmurs.  
 3 Q. Are there any precautions that can be  
 4 taken to decrease the risk for endocarditis in a  
 5 patient that has heart valve damage from  
 6 rheumatic fever?  
 7 MR. WILT: Objection.  
 8 A. Depending on the history of the  
 9 patient, there are recommendations as to  
 10 sometimes prophylaxis with antibiotics, although  
 11 I believe there really have been no studies to  
 12 discover if that's efficacious or not.  
 13 Q. Do you recommend prophylaxis for some  
 14 patients that have a history of rheumatic fever  
 15 with heart damage?  
 16 MR. LEAK: Objection.  
 17 MR. WILT: Objection.  
 18 A. Yes.  
 19 Q. Could you tell me what criteria you  
 20 use for making recommendations for prophylaxis?  
 21 MR. LEAK: Objection.  
 22 A. Normally, if they have echographic  
 23 damage to the middle.  
 24 Q. And under what conditions would you  
 25 recommend that the prophylaxis be used?

Page 24

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

6 (Pages 21 to 24)

Page 25

1 we may see it, you know, several times a year.  
 2 Q. Would you say more or less than five  
 3 patients a year, on average?  
 4 A. I would say that I would see probably  
 5 five or less.  
 6 Q. Have you ever personally diagnosed a  
 7 patient with bacterial endocarditis?  
 8 A. Yes.  
 9 Q. How many times have you done that,  
 10 just approximately, doctor?  
 11 A. Approximately, I would say less than  
 12 ten.  
 13 Q. Would you agree that bacterial  
 14 endocarditis can be a life-threatening disease?  
 15 A. Yes.  
 16 Q. Are there risk factors that would  
 17 place a patient at increased risk for developing  
 18 bacterial endocarditis?  
 19 A. Yes.  
 20 Q. Could you tell me what those risk  
 21 factors are?  
 22 A. They have a prosthetic valve in  
 23 place. They have an intracardiac shunt. If they  
 24 have significant deformation of the valve.  
 25 Q. Would it be fair to say that if a

Page 27

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

Page 26

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

Page 28

1 You can do a chest x-ray. You can do an **EKG**,  
 2 blood cultures and an echocardiogram.  
 3 Q. Doctor, in a patient that has subacute  
 4 bacterial endocarditis, is anemia frequently  
 5 associated with that?  
 6 A. It's associated with it.  
 7 Q. In subacute bacterial endocarditis, is  
 8 the sedimentation rate affected by the disease?  
 9 A. It can be elevated.  
 10 Q. Is it usually elevated when a patient  
 11 has subacute bacterial endocarditis?  
 12 A. I would say usually.  
 13 Q. Now, doctor, you mentioned doing blood  
 14 cultures. What would be the procedure for doing  
 15 blood cultures if you were suspicious for  
 16 subacute bacterial endocarditis? What would be  
 17 the procedure that you follow?  
 18 A. Well, the procedure would be,  
 19 normally, if based on their clinical  
 20 presentation, I would think that was a  
 21 possibility, you would normally do three blood  
 22 cultures from three different sites an hour  
 23 apart.  
 24 Q. Can endocarditis be ruled out on the  
 25 basis of one echocardiogram?

7 (Pages 25 to 28)

Page 29

1 A. No.  
 2 Q. What are the complications associated  
 3 with bacterial endocarditis?  
 4 A. You can have enough damage to the  
 5 valve that you will maybe require a valve  
 6 replacement. You can have congestive heart  
 7 failure. You can develop emboli to various parts  
 8 of the body. Those are the main ones.  
 9 Q. Would you agree that there has to be a  
 10 high degree of vigilance for bacterial  
 11 endocarditis in a patient that has rheumatic  
 12 fever and a history of valve damage?  
 13 MR. WILT: Objection.  
 14 MS. SMALL: Objection.  
 15 MR. LEAK: Objection.  
 16 A. I don't understand what you mean by  
 17 high degree of vigilance.  
 18 Q. Well, each time that you see a patient  
 19 with a history of rheumatic fever and valvular  
 20 damage, that you as a physician have to make  
 21 specific inquiry of the patient as to whether  
 22 there has been any problems for the ongoing  
 23 infectious process.  
 24 A. Yes, if you want to ask them how they  
 25 are feeling or that type of thing.

Page 31

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

Page 30

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

Page 32

1 to be fixed. There also is some risk for part of  
 2 that breaking loose and embolizing.  
 3 Q. Doctor, do valvular vegetations have  
 4 to be present before a presumptive diagnosis of  
 5 bacterial endocarditis can be made?  
 6 A. No.  
 7 Q. And how is bacterial endocarditis  
 8 treated?  
 9 A. With antibiotics.  
 10 Q. Would you agree that one of the main  
 11 goals of treatment of bacterial endocarditis is  
 12 to eradicate the infecting organism as soon as  
 13 possible?  
 14 A. Yes.  
 15 Q. And would you agree that the sooner  
 16 bacterial endocarditis is treated with  
 17 antibiotics, the more likely the outcome will be  
 18 positive?  
 19 MR. WILT: Objection.  
 20 MS. SMALL: Objection.  
 21 MR. WILT: You can answer, doctor.  
 22 A. Possibly.  
 23 Q. Would you agree that the earlier the  
 24 treatment, the better the chance for a cure?  
 25 A. I'm not sure -- I don't know what you

8 (Pages 29 to 32)



Page 33

1 mean by cure. It may cure the infection. There  
 2 are still times where there will be residual  
 3 damage to the valve.  
 4 Q. But cure the bacterial endocarditis  
 5 and cure the infection. You cure the  
 6 endocarditis; correct?  
 7 A. Yes.  
 8 Q. You may still have valvular damage,  
 9 but you have cured the infectious process.  
 10 A. Yes.  
 11 Q. Doctor, if there is a high suspicion  
 12 for bacterial endocarditis once adequate blood  
 13 cultures have been obtained similar to the  
 14 procedure that you've outlined, would you agree  
 15 that antibiotic therapy should be initiated for  
 16 the patient?  
 17 MR. WILT: Objection.  
 18 A. Yes. There are two approaches to  
 19 that, depending on the severity of the illness of  
 20 the patient.  
 21 One approach is if they are not  
 22 clinically decompensated, some physicians prefer  
 23 to wait to see what grows and then start  
 24 antibiotics. Other ones will start them  
 25 immediately after the cultures are done if the

Page 35

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

Page 34

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

Page 36

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

9 (Pages 33 to 36)

Page 37

1 that she had a history of a heart murmur.  
2 Q. At the time that you saw her, what was  
3 your understanding as to who her primary care  
4 provider was?

5 A. It's my understanding that she had no  
6 primary care provider.

7 Q. Were you assuming responsibility as a  
8 primary care provider?

9 A. No, ma'am. In fact, I referred her to  
10 a primary care physician.

11 Q. Who did you refer her to?

12 A. Dr. Amy Rosenfield.

13 Q. Is that indicated in your notes  
14 anywhere that you made that referral?

15 A. I don't believe so.

16 Q. Now, Maria was a new patient to you on  
17 that January 25th, '99 visit; correct?

18 A. Yes.

19 Q. Is there a particular procedure that  
20 is followed or that you followed in your office  
21 when a patient would come in to see you for the  
22 first time as far as collecting information?

23 A. There are a couple things missing from  
24 this chart. Normally, the nurse will weigh them,  
25 put them in the room, take their pulse, find out

Page 39

1 Plaintiff's Exhibit 2.

2 - - - - -

3 (Thereupon, ZIRAFI Deposition  
4 Exhibit 2 was marked for  
5 purposes of identification.)  
6 - - - - -

7 A. There are three or four pages that are  
8 not there, I can tell you that.

9 Q. I am handing you what has been marked  
10 as Plaintiff's Exhibit 2. And doctor, this is a  
11 handwritten sheet. Now, is it your belief that  
12 there is an additional set of handwritten notes  
13 aside from what's been marked as Plaintiff's  
14 Exhibit 2 that --

15 A. There is like a little note on a  
16 sticky, kind of like a post-it note.

17 MS. TOSTI: I am going to make a  
18 request for a complete copy, because I don't have  
19 anything additional and it doesn't appear that  
20 the doctor has it.

21 MR. WILT: I don't have it either, but  
22 I will check and see on her chart.

23 Q. What do you believe is contained on  
24 the sheets of paper that are not currently in the  
25 records that you have and that I have?

Page 38

1 what they are here for.

2 In fact, there was a note written by a  
3 nurse that -- it's not in here and I am not sure  
4 why. There is some handwritten papers that are  
5 not in there.

6 What I do is I go in and I sit down  
7 and I talk with them, find out why they are here,  
8 if they are having a specific complaint or do  
9 they just want to see a cardiologist. I tend to  
10 take their history, if they pinpoint a problem, a  
11 cardiac problem, and I do a physical examination,  
12 normally an electrocardiogram, and based on that,  
13 if I feel further testing is needed, I would  
14 recommend that.

15 Q. So in January of 1999, you had a nurse  
16 that was seeing the patient before you would see  
17 the patient?

18 A. Somebody would put them in the room,  
19 yes.

20 Q. And they would normally do a set of  
21 vital signs on the patient?

22 A. Yes.

23 Q. I do not have any papers that indicate  
24 that information. I have one sheet of paper with  
25 handwriting on it and we will mark this as

Page 40

1 A. Like I said, there is a post-it note  
2 from the nurse saying, here for no particular  
3 reason, I believe history of rheumatic fever.

4 Then there is another, a couple  
5 correspondences. There is a message from a phone  
6 call from Maria O'Donnell saying that she  
7 couldn't get in to see Dr. Rosenfield, who I  
8 referred her to; that she saw Dr. Parris and that  
9 he was a jerk and she was going elsewhere.

10 Then there is another phone message  
11 from her saying that she was in the hospital and  
12 had endocarditis. Just wanted to let me know,  
13 but she wasn't mad at me.

14 Then there is a correspondence from  
15 one of my nurses reminding me to call the patient  
16 about her echocardiogram reports.

17 Then there is a message from a family  
18 member who was trying to get her records and  
19 using the name of a surgeon, and we just advised  
20 them that we don't release medical records  
21 without the appropriate papers in place.

22 Q. Doctor, you seem to be fairly familiar  
23 with these particular items. Have you reviewed  
24 them recently?

25 A. I looked at the chart the other day.

10 (Pages 37 to 40)

Page 41

1 Q You were looking at the original  
2 chart?  
3 A Yes.  
4 Q Okay.  
5 A I didn't realize you didn't have those  
6 loose papers in there.  
7 MS. TOSTI: At this point, since I  
8 haven't seen those records, I am going to request  
9 to continue the deposition pursuant to those  
10 records once we have a look at them if we believe  
11 it's necessary. I don't know what's in them and  
12 I don't know whether it will be necessary or not,  
13 but obviously we will take a look at them and I  
14 would ask that you produce those to us as soon as  
15 possible.  
16 MR. WILIT: Sure. I will definitely  
17 produce them.  
18 Q Now, doctor, it's your testimony that  
19 a nurse saw Maria O'Donnell at this visit before  
20 you saw her?  
21 A Yes.  
22 Q And from your review of the records  
23 that we don't currently have in front of us, do  
24 you recall if vital signs were taken on Maria  
25 O'Donnell when she came in?

Page 43

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

Page 42

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

Page 44

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

11 (Pages 41 to 44)

Page 45

1 MR. WILT: Objection. You qualified  
2 her as an expert in ENT plus she hasn't reviewed  
3 that.  
4 Doctor, if you feel you can give an  
5 opinion.  
6 A. You know, I think that's -- as I said,  
7 I don't deal with those procedures. I think it  
8 can be very subjective.  
9 As I stated, the recommendations based  
10 on whether you prophylaxis people or not are not  
11 based on scientific studies in humans, as far as  
12 I know.  
13 Number two, this woman had a history  
14 of rheumatic fever. She did not have any type of  
15 murmur that would be obvious, I think, to most  
16 physicians, so it might be difficult.  
17 I do know she had some allergies to  
18 common antibiotics that they may use, and so,  
19 like I said, I'm not sure how they go about  
20 making their decisions.  
21 Q. Well, doesn't the recommendation for  
22 prophylaxis for procedures come from the  
23 cardiologist?  
24 MR. WILT: Objection.  
25 MR. LEAK: Objection.

Page 47

1 MR. LEAK: Objection.  
2 MR. WILT: Objection.  
3 A. As I state, we make general  
4 recommendation and then other decisions are based  
5 on what that physician does. I mean, I make  
6 recommendations every day regarding surgical  
7 procedures. The surgeon then decides how they  
8 are going to do their own surgery and that type  
9 of thing.  
10 Q. In this case it would be the ENT  
11 specialist that would prescribe the antibiotics  
12 for the patient if the patient was undergoing a  
13 procedure? I am asking as to what the usual  
14 procedure is. If you recommend prophylaxis, do  
15 you order the prophylaxis or does the actual  
16 person who is doing the procedure order it?  
17 MR. LEAK: Objection.  
18 A. In my instance, normally the actual  
19 person who does the procedure.  
20 Q. Now, you also did a physical  
21 examination of Maria O'Donnell at this visit;  
22 correct?  
23 A. Yes.  
24 Q. Did you find any deviations from  
25 normal that you considered to be significant on

Page 46

1 Q. When a patient has rheumatic fever and  
2 a history of valvular disorder, isn't it the  
3 cardiologist who makes the recommendation for  
4 prophylaxis?  
5 A. I don't know. I was not that woman's  
6 cardiologist at that time.  
7 Q. I am asking you as to whether you have  
8 an opinion as to whether in her case, knowing her  
9 history from your evaluation, whether prophylaxis  
10 would have been indicated for that procedure?  
11 And if you don't have an opinion, just  
12 tell me that and we will move on to something  
13 else. I am interested in knowing if you do have  
14 an opinion.  
15 MR. WILT: Objection.  
16 A. As I state, like I said, normally we  
17 will lean toward recommending prophylaxis for  
18 most patients with history of rheumatic fever.  
19 However, as I told you before, you know, each  
20 specialty and each physician has their own area  
21 of literature and expertise in that area where  
22 they make their own decisions.  
23 Q. Is it the cardiologist that recommends  
24 to the patient when a procedure is going to be  
25 done whether or not prophylaxis is appropriate?

Page 48

1 your physical exam?  
2 A. Not really. She had a questionable  
3 and I felt early mild heart murmur which is not  
4 uncommon for me to hear in anybody I examine.  
5 And other than that, no. I believe she had a  
6 normal physical examination.  
7 Q. Now, in a patient with -- I think the  
8 way you described it was an early systolic murmur  
9 that you heard in the apex. In Maria O'Donnell's  
10 case with a history of rheumatic fever, what  
11 would be the significance of that finding?  
12 A. I'm not sure if it's of any  
13 significance. I mean, if I see a hundred  
14 patients, probably 80 of them will have heart  
15 murmurs or more.  
16 I ordered an echocardiogram on her not  
17 based on that auscultation finding of that murmur  
18 because it did not appear to be hemodynamically  
19 significant, but based just on her history of  
20 rheumatic fever.  
21 Q. Now, you also did an EKG on her at  
22 that visit; correct?  
23 A. Yes.  
24 Q. And what were your findings on the  
25 EKG?

12 (Pages 45 to 48)

Page 49

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

Page 51

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

Page 50

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

Page 52

1 echocardiogram, was that to get a baseline on  
 2 what her cardiac valvular function was?  
 3 A. Yes.  
 4 Q. And I believe in your note, you  
 5 indicate at the bottom under assessment and plan  
 6 that she is approaching the age where she can be  
 7 having significant valvular disease.  
 8 Would you tell me what you consider to  
 9 be significant valvular disease, how you define  
 10 that?  
 11 A. Well, I mean, I define it primarily if  
 12 she is starting to have any signs of valvular  
 13 decompensation or anything like that.  
 14 Q. Now, the echocardiogram, at least from  
 15 what I can see, appears to have been done on the  
 16 same date as your office visit.  
 17 A. No, that's incorrect. I believe it  
 18 was done on the 28th.  
 19 Q. On the 28th?  
 20 A. Yes, according to the date on the  
 21 records.  
 22 Q. Oh, you are right. I have a wrong  
 23 date here.  
 24 Were you present at the time that the  
 25 echocardiogram was done?

13 (Pages 49 to 52)

Page 53

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

Page 55

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

Page 54

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

Page 56

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

14 (Pages 53 to 56)

Page 57

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

Page 59

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

Page 58

1 MR. WILT: She is not going to answer  
 2 that question. Go ahead.  
 3 MS. TOSTI: Why isn't she going to  
 4 answer that question?  
 5 Q. How do you know that Maria O'Donnell  
 6 got a copy of her echo report?  
 7 MR. WILT: I think it's clear from  
 8 prior testimony that Maria O'Donnell had an echo  
 9 report with her when she went to see  
 10 Dr. Balanson.  
 11 MS. TOSTI: I am asking the doctor as  
 12 to how she knows.  
 13 MR. WILT: I am telling you she is not  
 14 going to tell you how she knows, because if she  
 15 acquired that information from me, you have no  
 16 right to know it.  
 17 Q. Well, other than with counsel -- and  
 18 if it was with counsel, you don't have to answer  
 19 -- but did you acquire that information from  
 20 some other source other than counsel that she had  
 21 a copy of her echo report?  
 22 A. No.  
 23 Q. Okay. And in regard to the notation  
 24 on the bottom of this laboratory sheet, do you  
 25 have any knowledge as to whether the echo report

Page 60

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

15 (Pages 57 to 60)

Page 61

1 was seeing other physicians.  
 2 Q. So you have no opinion on that,  
 3 doctor?  
 4 A. Yes.  
 5 Q. When you saw her on January 25th of  
 6 '99, did she have any signs or symptoms that  
 7 would be consistent with bacterial endocarditis?  
 8 A. I believe not. Like I said, the only  
 9 stretch you could make is fatigue, and I will  
 10 venture to say that probably some of the people  
 11 in this room were pretty tired at any time during  
 12 the past week and I would say they probably don't  
 13 have endocarditis.  
 14 Q. Doctor, I am going to ask you a number  
 15 of questions, and if you have no opinion, just  
 16 tell me that and we will move on to the next one.  
 17 But if you do, then I would like to know what it  
 18 is.  
 19 Do you have an opinion as to whether  
 20 Maria O'Donnell likely had bacterial endocarditis  
 21 at the time you saw her on the 25th of January?  
 22 A. I believe she did not.  
 23 Q. You are aware that Maria O'Donnell  
 24 eventually was diagnosed with bacterial  
 25 endocarditis; correct?

Page 63

1 had with her on the 25th, did you have any other  
 2 contact with Maria O'Donnell?  
 3 A. No. Like I said, I tried to call  
 4 her. I left a message. When she got back in  
 5 touch with me, she said she was seeing another  
 6 physician and was being evaluated.  
 7 Q. Now, you've mentioned a couple of  
 8 pieces of the medical records that we do not  
 9 currently have in front of us. Are one of those  
 10 related to the conversation that you had with  
 11 her, the telephone conversation?  
 12 A. One of them is not related to the  
 13 conversation. There is a note in there saying  
 14 remember to call her.  
 15 Q. Did you have direct contact with Maria  
 16 on the phone where you spoke with her?  
 17 A. No. As I told you, I spoke with the  
 18 secretary at her school. They said she was not  
 19 available, so I left a message for her to contact  
 20 me, but she did not at that point.  
 21 Q. I am a little confused. After the  
 22 25th, did you ever speak to her again?  
 23 A. No, I did not.  
 24 Q. Do you have any criticisms of anyone  
 25 else that provided care to Maria O'Donnell?

Page 62

1 A. I do know that.  
 2 Q. Do you have an opinion as to when she  
 3 developed bacterial endocarditis?  
 4 A. No, I don't.  
 5 Q. Are you also aware that she suffered  
 6 complications of a stroke?  
 7 A. I know that.  
 8 Q. Do you have an opinion as to what  
 9 caused her stroke on February 26th of '99?  
 10 A. No.  
 11 Q. Doctor, at the time that you saw her  
 12 on January 25th, do you have an opinion as to  
 13 what her reasonable life expectancy was?  
 14 A. Well, she had a family history of her  
 15 father dying of a heart attack at the age of 54  
 16 and her mother has a history of breast carcinoma,  
 17 so she does have a predisposition to two bad  
 18 diseases.  
 19 As far as predicting somebody's life  
 20 span, I don't know how to do that. I am not an  
 21 actuarial.  
 22 Q. Did you ever speak to any of Maria  
 23 O'Donnell's family at any time?  
 24 A. I don't believe so.  
 25 Q. And aside from the one visit that you

Page 64

1 A. I reviewed nothing. I have no contact  
 2 with anything that was done after that date.  
 3 Q. Are you critical of Maria O'Donnell in  
 4 any way for how she cared for herself?  
 5 A. Again, since I don't know anything  
 6 that subsequently went on, I can't comment on  
 7 that.  
 8 MS. TOSTI: I don't have any further  
 9 questions for you.  
 10 MS. SMALL: I have no questions.  
 11 MR. WILT: Anybody else?  
 12 - - - -  
 13 (Deposition concluded at 10:05 a.m.)  
 14 (Signature not waived.)  
 15 - - - -  
 16  
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 25



Page 65

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

5 PAGE LINE REQUESTED CHANGE

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17

CHRISTINE M. ZIRAFI, M.D.

18  
19 Subscribed and sworn to before me this  
20 day of , 2001.

21

22

23 Notary Public

24

25 My commission expires

Page 66

1 CERTIFICATE

2 State of Ohio, § §

3 County of Cuyahoga.

4


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

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

13 IN WITNESS WHEREOF, I have hereunto set my  
hand and affixed my seal of office at Cleveland,  
14 Ohio, on this 16th day of March, 2001.

15

16

  
Vivian L. Gordon, Notary Public

17 Within and for the State of Ohio

18 My commission expires June 8, 2004.

19

20

21

22

23

24

25

17 (Pages 65 to 66)

<b>A</b>	ago 9:8,10,11,14 14:9 16:9 18:17 43:7	apparently 43:4 appear 39:19 43:13 48:18	back 14:3 55:1 56:14 57:8 63:4	body 29:8 Bonezzi 2: 19
able 6:14 22:11 49:17 56:24	agree 25:13 29:9 32:10,15,23 33:14 60:10	<b>APPEARANCES</b> 2:1	bacteria 2:17 bacterial 10:25 13:23 14:1 19:4 24:23 25:7,13,18 26:3,6,23 27:8,19 28:4,7,11,16 29:3 29:10 31:10,13,14 32:5,7,11,16 33:4 33:12 34:11 51:2 61:7,20,24 62:3	book 17:17,22,25 both 5:24 bottom 52:5 57:11 57:18 58:24
abnormal 22:24 23:2 26:21 49:20	agreement 1:20 ahead 58:2	appeared 54:14 appears 52:15 appreciated 54:15 approach 33:21 approaches 33:18 approaching 52:6 appropriate 27:21 40:21 46:25	bad 62:17 Balanson 2:6 16:1 58:10	Boulevard 1:22 3:14
about 7:21 9:9,10 9:14 15:22 27:12 34:17 35:4,5 40:16 45:19 50:15 57:2	Akron 2:13 al 1:4,7	architecture 31:23 area 24:13 46:20,21 around 9:22 20:15 36:4	<b>based</b> 28:19 31:21 38:12 44:19 45:9 45:11 47:4 48:17 48:19 54:15	<b>Box</b> 2:12
above 1:24 66:7	allegation 8:17	articles 14:14 18:4	baseline 52:1	Braunwald's 17:4
absence 18:13,15	allegations 9:5 10:5	artifact 49:3	basis 28:25	breaking 32:2
accompanied 42:10	allergies 24:10 45:17	Arts 4:23	Becker 2:2	breast 62:16
according 52:20	along 26:20 53:9	ascites 22:24	before 1:18 5:11 6:19 32:4 38:16 41:19 46:19 65:19	breasts 54:17
acquire 58:19	although 18:12 23:10	aside 5:6 7:8 16:14 39:13 62:25	<b>behalf</b> 1:16 2:2,5,10 2:14,18	breath 43:21
acquired 58:15	amassing 35:6	asked 10:5,17 18:17 18:18 57:15	being 3:3 63:6	bring 11:4
acted 9:15 10:2,13 10:23	amount 18:22	asking 30:20 35:8 46:7 47:13 58:11 59:10	belief 39:11	Buckingham 2:15
action 66:12	Amy 37:12	assessment 52:5	believe 5:14 7:22 10:9 18:25 21:20 23:11 24:9 27:12 36:20 37:15 39:23 40:3 41:10 42:7,8 44:6 48:5 49:15 50:11 51:7 52:4 52:17 53:5 55:3 56:10 57:3 61:8 61:22 62:24	building 2:20 4:23 4:25
active 43:17	anemia 28:4	associated 28:5,6 29:2 31:2	benefits 24:11	Burroughs 2:15
actual 47:15,18	angioplasties 19:18 20:3	associates 15:3,5 association 20:7 assume 6:13 60:7 assuming 37:7	besides 5:3	business 3:13 4:21
actually 4:1 5:21 8:24 34:20 59:10	angioplasty 15:10	atrium 53:19	best 16:23	<b>C</b>
actuarial 62:21	ankle 30:16	attack 62:15	better 16:25 17:2 32:24	C 1:7
acute 21:21 26:8,23 27:3,7 35:3 56:18 56:19	another 4:2,4 8:24 10:9 16:25 40:4 40:10 44:10 55:8 59:5 63:5	attorney 66:11	between 27:7 56:2	call 19:24 40:6,15 53:3,8 55:1 57:21 59:7 63:3,14
acutely 34:1 53:12	answer 6:8,14,19 7:3 31:4 32:21 36:24 58:1,4,18	ATWELL 2:7	billing 4:13	called 1:16 3:2 12:18 13:15 15:9 59:23
addition 7:20 8:5 11:25	answers 6:16	auscultate 54:18	billings 4:11	came 34:24 35:19 35:24 36:16 41:25 42:5,11,14 55:1
additional 39:12,19	antibiotic 33:15	auscultating 26:19	bills 35:6	Campbell 2:11
additions 11:23	antibiotics 23:10 24:11 32:9,17 33:24 34:7 44:23 45:18 47:11	auscultation 48:17	bit 12:4 34:16	carcinoma 62:16
address 3:11,13 4:21,25	anticipate 50:17	authoritative 17:11 17:12	blood 27:24 28:2,13 28:15,21 33:12 59:6	cardiac 19:13,17 27:3 35:20 38:11 43:2,12 50:3 52:2 57:6
adequate 33:12	anybody 42:13,14 48:4 64:11	available 63:19	board 12:21,23 13:1	cardiologist 15:17 30:17,21,23 35:2 38:9 44:9 45:23 46:3,6,23
Ader 43:8	anymore 2:13	Avalon 3:12		cardiology 12:24,25 13:3,4 17:20 19:8 19:11,12,12,15,17 30:18
adhere 34:2	anyone 15:14 42:10 59:18 63:24	average 25:3		cardiovascular 1:21 2:15 3:20,22 4:3,9 5:4 17:4,5,6 20:8,11,14 24:25
adjournment 66:11	anything 34:6 39:19 42:2,2 43:24 44:2 49:12 51:4 52:13 56:10 64:2,5	aware 60:11 61:23 62:5		care 8:18 34:17 37:3,6,8,10 50:18 51:9,13,16 55:6 63:25
admitting 13:11	anyway 42:13	a.m. 1:23 64:13		
adult 21:19	anywhere 37:14			
advised 40:19	aortic 22:3 53:21			
affected 28:8	apart 28:23			
<b>AFFIDAVIT</b> 65:1	apex 48:9 54:21			
affixed 66:13				
aforesaid 66:7				
afraid 35:7				
after 33:25 50:17 51:13 54:22 59:19 60:7 63:21 64:2				
afterwards 66:8				
again 63:22 64:5				
against 9:2 60:17				
age 36:4,6 43:3 51:18 52:6 62:15				
		<b>B</b>		

<p>cared 59:15,19 64:4 carriers 18:21 case 1:65:20 7:9,17 7:24 8:25 9:2,4,12 10:9,24 14:25 15:1,5,14 16:11 16:12,16 17:19 19:1 21:17 46:8 47:10 48:10 53:25 56:24 60:6 cases 5:23 7:7,9,13 8:11,15 9:7,24 10:4,13,18 11:2 56:17 catherization 43:3 catherizations 19:18 catheterization 8:22 10:11 catheterizations 20:2 cause 21:12 31:15 31:18 36:7 50:15 66:7 caused 62:9 causes 21:6,23 22:14 causing 31:25 50:10 CBC 27:25 center 2:5,16 12:1 14:20 certain 22:1 27:6 27:10 CERTIFICATE 66:1 certifications 13:1 certified 3:4 12:21 12:23 certify 66:5,10 chambers 53:22 chance 32:24 55:10 change 18:21 65:5 changes 31:23 49:2 Charity 13:9 chart 14:1237:24 39:22 40:25 41:2 check 39:22 55:21 checked 36:3 checkup 34:25 50:14 51:19 CHERYL 2:7 chest 10:8 28:1 43:20 54:13 chiefly 18:10</p>	<p>child 21:25 childhood 21:4,19 children 43:18 chills 26:11 42:9 43:20 choose 7:2 Chris 2:18 Christine 1:12,15 2:14 3:1,6,10 65:17 66:6 circumstances 60:25 City 42:22 civil 3:3 6:5 clear 7:16 58:7 Cleveland 2:4,16 2:17,21 13:10 66:13 clients 24:2 Clinic 1:21 2:15 3:20,22 4:3,9 5:4 20:8,11,14 clinical 17:18 18:1 18:7,8 22:5 28:19 34:5 clinically 22:13 33:22 collecting 37:22 come 37:21 45:22 56:14 comes 30:16 coming 30:17 commencing 1:23 comment 64:6 commission 65:25 66:18 commissioned 66:5 common 1:1 24:24 45:18 commonly 27:11 49:11 communicate 54:23 55:11 Community 12:2 13:7 competent 20:1 complained 51:6 complaint 38:8 57:6,7 complaints 26:13 44:1 50:6 56:18 60:8,25 complete 39:18 50:19 51:19</p>	<p>completed 51:14 66:11 complication 10:10 complications 27:5 29:2 62:6 computer 49:15 concern 31:18 49:13 concerned 35:5 50:15 concluded 64:13 condition 35:20 54:1 conditions 23:24 confirm 54:11 confused 63:21 confusing 7:25 congestive 22:23 26:21 29:6 conjunctival 26:16 consider 16:22 17:10,12 52:8 considered 43:25 47:25 49:13 53:16 consistent 54:19 61:7 consults 19:25 contact 16:5 51:21 56:25 63:2,15,19 64:1 contacting 59:10 contained 39:23 continue 41:9 continued 60:8 contract 4:8,9 conversation 63:10 63:11,13 conversations 59:14 copy 11:4 39:18 57:10,12,23 58:6 58:21 corporation 3:18 3:19 correct 10:21 11:18 12:10,22 19:18 20:8,10 33:6 35:21 36:19 37:17 42:16 47:22 48:22 49:24 50:4 51:11 55:22 61:25 66:9 corrections 11:23 65:4 correspondence</p>	<p>40:14 correspondences 40:5 cough 43:23 counsel 1:16,21 7:1 7:4 15:13 58:17 58:18,20 county 1:28:3,6,13 66:3 couple 37:23 40:4 60:2 63:7 course 34:5 court 1:1 6:16,19 8:22 42:23 co-director 12:1 criteria 23:19 27:6 27:10 critical 64:3 criticisms 63:24 cultures 28:2,14,15 28:22 33:13,25 cure 32:24 33:1,1,4 33:5,5 cured 33:9 current 3:13,16 11:20 12:15 currently 5:2 7:9 8:2 12:9 18:8 39:24 41:23 63:9 curriculum 11:5,16 11:17,20 13:21 18:6 cutoff 27:12 cuyahoga 1:28:3,5 8:13 66:3</p>	<p>dealing 10:24 18:4 19:4 dealt 18:3 decade 35:1 decided 35:25 36:2 decides 47:7 decision 24:9 decisions 45:20 46:22 47:4 decompensated 33:22 decompensation 26:20 27:4 50:4 52:13 decrease 23:4 defendant 1:16 5:19,24 6:3 7:8,14 7:18 8:9,16 10:15 defendants 1:8 2:5 2:10,14,18 10:16 60:17 defense 7:1 define 52:9,11 definitely 41:16 deformation 25:24 deforms 31:24 degree 29:10,17 denied 13:17 42:9 denies 43:19 dental 24:7 depending 23:8 33:19 34:4 51:19 56:20 depends 26:7 deposed 3:4 deposition 1:12,15 5:10,15,21 7:1,24 10:1,20 11:9 14:11 15:12 39:3 41:9 64:13 66:10 depositions 6:7 60:18 describe 19:20 described 48:8 determination 50:9 determine 22:17 develop 22:22 29:7 developed 54:6 62:3 developing 25:17 develops 27:14 31:17 deviation 49:8,20 deviations 47:24</p>
---	---	---	---	--

<b>diagnosed</b> 25:6 61:24 <b>diagnosis</b> 32:4 34:12 <b>diagnostic</b> 20:23 27:21 <b>different</b> 4:24 22:14 26:25 27:14,17 28:22 <b>differential</b> 27:25 34:12 <b>differentiate</b> 27:7 <b>difficult</b> 45:16 <b>difficulty</b> 6:20 <b>dilated</b> 53:19 <b>Diplomate</b> 1:19 <b>direct</b> 63:15 <b>directions</b> 7:5 <b>discover</b> 23:12 <b>discuss</b> 15:4 <b>discussed</b> 15:1,7,14 16:10,11 <b>discussions</b> 15:21 <b>disease</b> 17:4,5,6 21:2,4,5,19 24:24 25:14 28:8 43:5 52:7,9 <b>diseases</b> 62:18 <b>disorder</b> 46:2 <b>divide</b> 27:9 <b>doctor</b> 3:8 7:7 8:2 8:15 11:4,13 12:21 13:20 16:21 19:7 21:1 25:10 28:3,13 30:20 31:5,10 32:3,21 33:11 34:8 36:23 39:10,20 40:22 41:18 43:24 45:4 50:12 51:17 55:8 57:9 58:11 59:5 60:6,21 61:3,14 62:11 <b>document</b> 11:15 <b>doing</b> 4:11 18:23 20:23 28:13,14 47:16 <b>done</b> 8:19 25:9 33:25 43:11 46:25 52:15,18,25 59:6 64:2 <b>Doolittle</b> 2:15 <b>DOUGLAS</b> 2:20 <b>down</b> 6:17,20 38:6	42:25 <b>Dr</b> 7:18 15:16,24 16:1,3,6,12 37:12 40:7,8 43:8 55:6 55:15,16,19 57:11 57:17 58:10 59:1 59:15,18,21 <b>dramatic</b> 27:15 <b>Drive</b> 3:12 <b>drove</b> 42:13 <b>due</b> 36:2 44:10 <b>duly</b> 3:3 66:5,6 <b>during</b> 6:25 61:11 <b>dying</b> 62:15 <b>dynamics</b> 31:22 <b>dysfunction</b> 22:22 54:6 <b>D.O</b> 2:10,18 <hr/> <b>E</b> <hr/> <b>each</b> 9:7 29:18 30:24 46:19,20 <b>earlier</b> 32:23 <b>early</b> 48:3,8 <b>easiest</b> 54:18 <b>echo</b> 53:8 54:11,22 55:12,14 57:23 58:6,8,21,25 <b>echocardiogram</b> 14:22 27:24 28:2 28:25 40:16 43:8 44:10 48:16 51:17 51:20 52:1,14,25 53:14 54:20 57:16 <b>echocardiograms</b> 20:4 <b>echographic</b> 23:22 <b>edema</b> 22:25 27:4 43:21 <b>efficacious</b> 23:12 <b>effusion</b> 53:23 <b>eight</b> 43:3 57:8 <b>either</b> 39:21 66:11 <b>EKG</b> 28:1 48:21,25 49:12,18,18,23 <b>EKG's</b> 20:4 <b>electrocardiogram</b> 38:12 <b>elevated</b> 28:9,10 <b>elsewhere</b> 40:9 <b>Embassy</b> 2:12 <b>emboli</b> 27:5 29:7 <b>embolizing</b> 32:2 <b>emergency</b> 10:8	<b>employed</b> 42:21 <b>employer</b> 3:16,24 <b>end</b> 31:25 43:10 <b>endocarditis</b> 8:25 9:12 10:25 13:23 14:2 19:5 23:4 24:23 25:7,14,18 26:3,6,24 27:8,19 28:4,7,11,16,24 29:3,11 31:11,16 32:5,7,11,16 33:4 33:6,12 34:11 40:12 51:2 61:7 61:13,20,25 62:3 <b>enormous</b> 35:6 <b>enough</b> 29:4 36:14 <b>ENT</b> 2:19 43:15 44:6,12,18 45:2 47:10 <b>enter</b> 7:2 <b>entertained</b> 43:6 <b>entity</b> 5:3,8 <b>eradicate</b> 32:12 <b>ESQ</b> 2:3,7,11,16,20 <b>et</b> 1:4,7 <b>evaluate</b> 50:19 56:6 <b>evaluated</b> 63:6 <b>evaluation</b> 43:16 44:12,16 46:9 49:23 <b>even</b> 24:21 42:5 49:11 <b>event</b> 66:12 <b>eventually</b> 61:24 <b>ever</b> 5:10 9:15 10:23 12:12,18 13:14,17,25 15:19 15:21 16:10,11,18 25:6 55:10 62:22 63:22 <b>every</b> 31:8 47:6 <b>everybody</b> 30:19 <b>everything</b> 56:22 <b>evidence</b> 50:3 53:23 <b>exam</b> 44:15 48:1 50:2 <b>examination</b> 1:17 3:2,6 22:20 38:11 44:17,24 47:21 48:6 54:16 <b>examine</b> 48:4 <b>exclude</b> 49:17,18 <b>Exhibit</b> 11:10,14 39:1,4,10,14	<b>expectancy</b> 62:13 <b>expert</b> 9:15,17,18 9:19,21 10:2,14 10:23 45:2 60:16 <b>expertise</b> 24:13 46:21 <b>expires</b> 65:25 66:18 <b>extra</b> 31:22 <hr/> <b>F</b> <hr/> <b>fact</b> 37:9 38:2 44:15 55:2 60:16 <b>factors</b> 25:16,21 <b>facts</b> 57:11 <b>faculty</b> 14:3 <b>failure</b> 22:23 26:21 29:7 <b>fair</b> 25:25 60:19 <b>fairly</b> 40:22 <b>Fairview</b> 13:9 <b>familiar</b> 40:22 <b>family</b> 40:17 62:14 62:23 <b>fan</b> 12:4 <b>far</b> 19:11 37:22 45:11 59:20 62:19 <b>fast</b> 42:23 <b>father</b> 62:15 <b>fatigue</b> 43:14 44:1 50:10,15,23 51:1 51:3 56:1,3 60:8 61:9 <b>favor</b> 8:23 <b>fax</b> 59:7 <b>February</b> 55:1 62:9 <b>feel</b> 6:24 38:13 45:4 60:21 <b>feeling</b> 29:25 30:5 31:7 <b>fellows</b> 18:3,11 <b>felt</b> 48:3 <b>female</b> 42:21 <b>fever</b> 21:1,2,12,16 21:18,25 22:2,5 22:10 23:6,14 24:16 26:1,10 27:2 29:12,19 30:7,9,22,23 31:1 34:9 36:5,18,22 40:3 42:4,9 43:2 43:19 45:14 46:1 46:18 48:10,20 50:6 60:10 <b>few</b> 18:17	<b>field</b> 16:22 <b>file</b> 16:15 <b>filed</b> 14:25 16:11 <b>finally</b> 36:13 <b>find</b> 17:1 37:25 38:7 47:24 49:12 50:3 56:9 <b>finding</b> 48:11,17 56:8 <b>findings</b> 48:24 54:2 54:5,11 <b>fine</b> 56:23 60:22 <b>fingers</b> 26:17 <b>finish</b> 6:18 <b>first</b> 3:3 13:2,4 26:9 34:17 37:22 66:6 <b>five</b> 9:11,14 25:2,5 43:18 60:3 <b>fixed</b> 32:1 <b>flexible</b> 44:13,18,24 <b>fluid</b> 31:21 <b>follow</b> 28:17 35:20 51:24 54:7 56:15 56:22 <b>followed</b> 37:20,20 <b>following</b> 59:13 65:3 <b>follows</b> 3:5 <b>foregoing</b> 65:2 66:8 <b>form</b> 53:3 <b>formal</b> 13:25 <b>formalize</b> 20:13 <b>formalized</b> 20:7 <b>forth</b> 1:24 66:7 <b>forward</b> 55:14 <b>found</b> 44:2 <b>four</b> 9:22 10:2 39:7 <b>Franklin's</b> 2:7 <b>free</b> 6:24 <b>frequently</b> 28:4 <b>from</b> 4:3,15 5:6 7:8 14:17 16:14 17:7 18:13,19 22:10 23:5 28:22 30:23 35:11 36:5 37:23 39:13 40:2,5,6,11 40:14,17 41:22 42:15 43:11 45:22 46:9 47:24 49:20 49:22 52:14 58:7 58:15,19 62:25 65:2 <b>front</b> 41:23 42:2 57:12 63:9
---	--	--	--	---

<b>full</b> 19:13 43:18 51:19 <b>function</b> 52:2 53:18 <b>further</b> 27:22 38:13 43:15 55:5 64:8 66:10 <b>future</b> 51:21 <hr/> <b>G</b> <hr/> <b>G</b> 2:20 <b>gallops</b> 26:22 <b>gave</b> 42:19 <b>general</b> 12:2 13:7,8 13:9 19:12,21 47:3 <b>generated</b> 16:18 <b>getting</b> 24:6 30:3 36:1 44:8 <b>give</b> 6:15 45:4 53:8 53:8 60:19,21 <b>given</b> 7:23 13:25 14:5 <b>go</b> 6:6 26:20 31:8 38:6 42:23 45:19 58:2 59:4,25 <b>goals</b> 32:11 <b>going</b> 6:12 12:3 34:16 35:7 39:17 40:9 41:8 42:1,24 46:24 47:8 51:8 53:13 55:8 58:1,3 58:14 59:24 61:14 <b>Gordon</b> 1:18 66:4 66:16 <b>granted</b> 18:16 <b>ground</b> 6:6 <b>group</b> 18:20 <b>grows</b> 33:23 <b>growth</b> 31:12 <b>guess</b> 30:3 60:24 <b>guide</b> 17:15 <hr/> <b>H</b> <hr/> <b>hallway</b> 16:8 <b>hand</b> 6:17 24:10 66:13 <b>handing</b> 11:13 39:9 <b>handle</b> 35:9 <b>handouts</b> 14:7 <b>handwriting</b> 38:25 <b>handwritten</b> 38:4 39:11,12 <b>Hanna</b> 2:11 <b>happened</b> 59:22	<b>happy</b> 6:11 <b>having</b> 35:2 38:8 44:5 50:23 52:7 55:5 <b>head</b> 6:17 50:24 <b>headache</b> 26:12 <b>Health</b> 2:19 <b>hear</b> 23:1 30:1 48:4 <b>heard</b> 48:9 54:12 54:18 <b>heart</b> 12:1 21:13,16 22:1,4,9,20,23 23:1,2,5,15 24:15 26:21,22 29:6 31:17 34:9 36:3 36:19,21 37:1 48:3,14 62:15 <b>hello</b> 16:7 <b>help</b> 17:15 <b>hemodynamically</b> 48:18 <b>hemorrhages</b> 26:16 26:17 <b>her</b> 34:19,19,20,23 35:5,7,20 36:1,2,4 37:2,3,9,11 39:22 40:8,11,16,18 41:20 42:13,14,15 43:13,25 44:1 45:2 46:8,8 48:16 48:19,21 50:7,10 50:11,20 51:17,21 51:22 52:2 54:1 54:13,15 55:2,2 55:11,18,21 57:23 58:6,9,21 59:15 59:19,19,21,22 60:19,22 61:5,21 62:9,11,13,14,16 63:1,4,11,14,16 63:18,19,22 <b>hereinafter</b> 3:4 <b>hereunto</b> 66:13 <b>herself</b> 64:4 <b>high</b> 27:2,20 29:10 29:17 33:11 49:25 <b>him</b> 15:19,22,25 16:7,7 35:7 <b>history</b> 23:8,14 26:1 29:12,19 30:7,14,22 34:9 34:10 36:17,22 37:1 38:10 40:3 42:9,15,18 43:2	43:25 44:3,20 45:13 46:2,9,18 48:10,19 51:14 60:11 62:14,16 <b>hoarseness</b> 43:14 44:2 50:16 51:6 55:25 56:1,3 60:9 <b>Hollin</b> 2:10 <b>Holter</b> 20:4 <b>home</b> 3:11 <b>hospital</b> 12:2 13:6,7 13:8,9,10,14,17 14:20 18:13 20:24 20:25 40:11 55:9 57:3 <b>hospitals</b> 13:6,10 13:12 <b>hour</b> 28:22 <b>hours</b> 20:18 <b>house</b> 35:8 <b>Houster</b> 7:19 <b>humans</b> 45:11 <b>hundred</b> 24:20 36:12 48:13 <b>Hurst's</b> 17:3 <b>husband</b> 35:7 <b>hypothyroid</b> 56:11 <b>hypothyroidism</b> 55:21 56:3 <hr/> <b>I</b> <hr/> <b>identification</b> 11:11 39:5 <b>identify</b> 11:15 <b>ill</b> 27:1 34:1 <b>illness</b> 33:19 <b>immediately</b> 33:25 <b>important</b> 6:9,15 6:18 <b>improperly</b> 8:19 <b>Inc</b> 2:6,10,15 <b>included</b> 34:12 <b>including</b> 30:18 <b>incorporated</b> 1:22 4:18 5:4 20:11 <b>incorrect</b> 52:17 <b>increased</b> 25:17 26:3 <b>independent</b> 4:5 34:18 <b>indicate</b> 38:23 52:5 <b>indicated</b> 37:13 46:10 <b>indicates</b> 49:16	57:11 <b>individually</b> 4:18 <b>infecting</b> 32:12 <b>infection</b> 21:9 30:10 31:1,14 33:1,5 <b>infectious</b> 21:5 29:23 31:3,15 33:9 <b>information</b> 17:13 17:15 37:22 38:24 58:15,19 60:20 <b>initially</b> 56:6 <b>initiated</b> 33:15 <b>inquiry</b> 29:21 30:6 30:24 <b>instance</b> 47:18 <b>instances</b> 22:7 <b>instruct</b> 56:13 <b>instructor</b> 17:18 18:7,8 <b>instructs</b> 7:4 <b>interested</b> 46:13 66:12 <b>intermittent</b> 34:10 60:9 <b>internal</b> 2:5 12:24 <b>Internet</b> 35:6 <b>interventional</b> 12:24 13:4 19:11 19:17 <b>intracardiac</b> 25:23 <b>inversions</b> 49:7 <b>investigate</b> 27:22 <b>investigation</b> 60:12 <b>involved</b> 27:16 <b>involving</b> 8:25 10:10 <b>ischemia</b> 49:17,18 49:24 <b>issues</b> 19:1 <b>items</b> 40:23 <hr/> <b>J</b> <hr/> <b>Janeway</b> 26:18 <b>JANICE</b> 2:11 <b>January</b> 3:21,24 4:19,21 5:6 19:22 20:6,19 35:14 37:17 38:15 42:11 59:13 61:5,21 62:12 <b>JEANNE</b> 2:3 <b>jerk</b> 40:9 <b>John</b> 2:10	<b>journal</b> 14:14 <b>Judge</b> 1:6 <b>July</b> 20:15 <b>June</b> 20:15 66:18 <b>jury</b> 8:23 <b>just</b> 7:16 9:17 11:15 18:16 19:20 25:10 30:12 31:21 34:25 35:25 36:9,11 38:9 40:12,19 42:18 46:11 48:19 51:21 53:7,9 54:2 54:5 60:2,22 61:15 <b>juvenile</b> 49:4,6,10 <hr/> <b>K</b> <hr/> <b>Kalucis</b> 2:18 16:3,6 16:12 <b>keep</b> 12:3 <b>kind</b> 12:4 20:5 39:16 <b>knew</b> 35:8 36:3 55:4,7 59:22 <b>know</b> 6:10 9:5 15:16,24 16:7,25 22:8 24:7 25:1 32:25 36:8,8,13 40:12 41:11,12 42:1,12,13 44:7 45:6,12,17 46:5 46:19 50:22 51:5 51:10,12,22 55:6 55:17 56:22 57:21 57:22,24,25 58:5 58:16 59:3,8,20 60:24,25 61:17 62:1,7,20 64:5 <b>knowing</b> 46:8,13 <b>knowledge</b> 58:25 <b>knows</b> 58:12,14 <hr/> <b>L</b> <hr/> <b>L</b> 1:18 2:11 66:4,16 <b>lab</b> 53:8 57:9,16,18 59:1 <b>laboratory</b> 55:15 58:24 <b>large</b> 24:25 35:3 <b>larger</b> 54:17 <b>laryngoscope</b> 44:13 44:18,24 <b>last</b> 16:5 24:18 <b>lawsuit</b> 6:5 15:9
--	---	---	--	---

<b>lead</b> 56:10 <b>Leader</b> 2:20 <b>LEAK</b> 2:20 23:16 23:21 24:1,4 29:15 44:25 45:25 47:1,17 60:13 <b>lean</b> 34:6 46:17 <b>least</b> 52:14 55:6 56:5 <b>leave</b> 18:12,14,19 <b>lecture</b> 14:1 <b>left</b> 22:22 53:17,18 53:19 60:3 63:4 63:19 <b>lesions</b> 26:18 <b>less</b> 25:2,5,11 <b>let</b> 6:10,18 30:11 40:12 51:22 56:22 60:15 <b>Let's</b> 26:9 <b>level</b> 50:16 <b>license</b> 12:15,17 <b>licensed</b> 12:9,12 <b>life</b> 62:13,19 <b>life-threatening</b> 25:14 <b>lightheadedness</b> 43:22 <b>like</b> 6:22 11:24 15:12 27:15 34:4 39:15,16 40:1 45:19 46:16 52:13 55:4 56:17 59:3 59:20 60:21 61:8 61:17 63:3 <b>likely</b> 22:2 32:17 54:5 61:20 <b>limit</b> 19:8 <b>LINE</b> 65:5 <b>list</b> 50:1 <b>listed</b> 13:21 <b>listen</b> 23:1 <b>listened</b> 54:13 <b>literature</b> 46:21 <b>little</b> 7:25 12:4 34:16 39:15 44:7 60:19 63:21 <b>long</b> 9:8 50:22 51:5 51:10,12 57:4 <b>longer</b> 44:7 <b>look</b> 12:7 22:19,23 22:24,25,25 26:15 27:1,7 41:10,13 <b>looked</b> 40:25	<b>looking</b> 22:17 41:1 <b>loose</b> 32:2 41:6 <b>loss</b> 26:11 <b>lot</b> 49:2 <b>lung</b> 22:24 <hr/> <p style="text-align: center;"><b>M</b></p> <hr/> <b>M</b> 1:12,15 2:3,14 3:1,6,10 65:17 66:6 <b>mad</b> 40:13 <b>made</b> 4:10 32:5 37:14 50:17 <b>main</b> 29:8 32:10 43:13 <b>make</b> 11:24 29:20 30:6,24 39:17 46:22 47:3,5 50:9 54:9 61:9 <b>makes</b> 46:3 <b>making</b> 23:20 45:20 <b>malpractice</b> 5:22 18:21 <b>manifestation</b> 27:13 <b>manifestations</b> 26:16 <b>many</b> 5:13 9:20 24:19 25:9 36:13 <b>march</b> 1:13 66:14 <b>maria</b> 1:4 14:20 15:22 16:10 34:17 35:12,16 37:16 40:6 41:19,24 42:10,19 44:16,21 44:22 47:21 48:9 50:3 51:14 53:25 54:24 55:11 56:13 56:25 58:5,8 60:6 61:20,23 62:22 63:2,15,25 64:3 <b>mark</b> 38:25 <b>marked</b> 11:10,14 39:4,9,13 <b>marks</b> 43:9,10 <b>material</b> 17:10 <b>matter</b> 10:24 13:23 14:1,6 15:4 19:4 <b>may</b> 7:2 12:7 21:20 22:6,11,21 23:1 24:10 25:1 26:12 26:13,18,21 27:16 33:1,8 36:14,24 45:18 54:7	<b>maybe</b> 29:5 44:7 57:8 60:3 <b>Mazanec</b> 2:6 <b>ma'am</b> 11:19 37:9 <b>mean</b> 9:18 16:24 22:8 27:10 29:16 33:1 47:5 48:13 49:6 52:11 54:4 60:24 <b>MedCenter</b> 2:10 <b>medical</b> 4:23 5:16 6:2,23 9:23 14:16 14:19 40:20 50:12 51:9,17 55:6 63:8 <b>medical/legal</b> 9:16 10:14 <b>medicine</b> 2:6 12:24 13:3 <b>member</b> 40:18 <b>memory</b> 6:24 <b>mentioned</b> 15:2 26:25 28:13 55:20 63:7 <b>message</b> 40:5,10,17 63:4,19 <b>met</b> 15:25 <b>methods</b> 34:3 <b>microscopic</b> 36:10 <b>middle</b> 23:23 <b>might</b> 31:25 36:9 45:16 <b>mild</b> 48:3 <b>mildly</b> 53:19 <b>minute</b> 36:10 54:10 <b>minutes</b> 60:3 <b>Mishkind</b> 2:2 <b>missing</b> 37:23 <b>mitral</b> 53:20,24 54:21 <b>mitro</b> 22:3 <b>moderate</b> 53:24 <b>Mondays</b> 20:20 <b>monitors</b> 20:5 <b>month</b> 24:18 44:6 <b>months</b> 16:8 18:17 54:7 <b>month's</b> 57:3 <b>more</b> 7:1 17:16 18:3 22:2 25:2 26:7 27:13,15 32:17 48:15 49:10 54:14 60:1,2 <b>morning</b> 15:10 <b>mornings</b> 20:21	<b>most</b> 16:23 18:3 45:15 46:18 <b>Mostow</b> 15:16 <b>mother</b> 62:16 <b>motions</b> 6:17 <b>move</b> 46:12 61:16 <b>Mt</b> 14:19 <b>much</b> 51:4 60:1 <b>murmur</b> 26:19 34:9 36:19,21 37:1 45:15 48:3,8,17 54:12,19,21 <b>murmurs</b> 23:2 48:15 <b>Murphy</b> 2:19 <b>musculoskeletal</b> 26:12 <b>music</b> 42:22 43:19 <b>M.D</b> 1:7,12,15 2:6 2:15 3:1,6 65:17 66:6 <hr/> <p style="text-align: center;"><b>N</b></p> <hr/> <b>name</b> 3:9,19 40:19 <b>named</b> 5:19,24 7:8 7:13,18 8:7,9,16 66:6 <b>names</b> 7:12 8:10 <b>necessarily</b> 54:17 <b>necessary</b> 41:11,12 <b>need</b> 31:25 36:23 54:7 56:21 <b>needed</b> 15:11 38:13 51:18,21,23 <b>negligence</b> 5:16 6:3 8:18 9:23 10:5 <b>negotiating</b> 4:4 <b>never</b> 10:17,20 21:17 55:19 56:24 59:22 <b>new</b> 37:16 <b>next</b> 55:7 61:16 <b>nine</b> 9:9 <b>nobody</b> 4:1 <b>nodes</b> 26:17 <b>nods</b> 6:17 <b>nonspecific</b> 49:2 <b>normal</b> 47:25 48:6 49:8,9 53:17,18 53:21,22 56:12 <b>normally</b> 21:21 22:13 23:22 24:5 26:10 27:23,24 28:19,21 30:4	31:6,12 37:24 38:12,20 46:16 47:18 53:21 56:16 57:5,7 <b>North</b> 42:22 <b>Notary</b> 1:19 65:23 66:4,16 <b>notation</b> 57:18 58:23 <b>note</b> 38:2 39:15,16 40:1 52:4 63:13 65:3 <b>noted</b> 36:25 <b>notes</b> 16:15,19 37:13 39:12 <b>nothing</b> 56:17 57:20 64:1 66:7 <b>notice</b> 57:9 <b>notify</b> 56:21 <b>nuclear</b> 19:14 <b>number</b> 45:13 61:14 <b>nurse</b> 37:24 38:3,15 40:2 41:19 <b>nurses</b> 40:15 <hr/> <p style="text-align: center;"><b>O</b></p> <hr/> <b>O</b> 2:12 <b>oath</b> 6:8 <b>object</b> 30:11 60:15 <b>objection</b> 7:2 23:7 23:16,17,21 24:1 24:4 29:13,14,15 31:4 32:19,20 33:17 34:13,14 44:25 45:1,24,25 46:15 47:1,2,17 60:13,14 <b>observe</b> 22:11 <b>observed</b> 22:6 <b>obtained</b> 33:13 42:15 <b>obvious</b> 45:15 <b>obviously</b> 41:13 43:5 <b>occur</b> 21:15 <b>off</b> 30:13 34:18 50:24 <b>office</b> 2:3 4:4 14:12 14:17 16:14 19:25 20:17,18,19 37:20 52:16 59:9,23 66:13 <b>offices</b> 1:21 59:7
--	---	--	--	--

<p>often 21:3 24:14,22  oftentimes 21:10  26:11 27:2,3 59:4  Oh 17:3 52:22  ohio 1:2,20,22 2:4,8  2:13,17,21 3:2,12  3:15 12:10,17  66:2,5,14,17  okay 41:4 43:9  58:23 60:4  old 8:8 43:4  once 15:25 33:12  41:10  one 2:16 5:18 6:5  6:20 7:1,17 8:2,5  8:20,24 9:9,10  10:7,9,12 15:2  16:25 18:2 24:21  28:25 31:8 32:10  33:21 34:2,24  38:24 40:15 50:13  57:3,9 61:16  62:25 63:9,12  ones 8:6,8 17:1 29:8  33:24  ongoing 29:22 31:2  only 11:25 16:7  35:15 53:11 61:8  onset 26:8,8,9  opened 53:20  opening 36:12  opinion 44:22 45:5  46:8,11,14 60:22  60:23 61:2,15,19  62:2,8,12  opinions 9:19,21  60:19  order 47:15,16 56:5  ordered 48:16  50:16  organism 32:12  organisms 21:20  27:16  organomegaly  22:25  original 41:1  orthopedic 30:15  orthopnea 43:21  Osler 26:17  other 3:18 5:3,8 6:2  6:3 8:6 9:10 10:12  12:13,17 14:17  15:13 16:15 22:14  27:5 30:9 33:24</p>	<p>34:2 40:25 47:4  48:5 55:15 57:1  58:17,20,20 59:23  60:17,18 61:1  63:1  otherwise 6:12  66:12  out 18:22 28:24  35:7 36:3 37:25  38:7 55:21 57:20  59:8  outcome 32:17  outline 42:18  outlined 33:14  outlines 14:6  over 6:6 14:8 21:22  31:8,22,24 35:1  36:11,12 44:6  overriding 12:5  own 3:18 4:15  19:24,24 46:20,22  47:8  o'clock 1:23  o'donnell 1:4 14:20  15:22 34:17 35:13  40:6 41:19,25  47:21 57:22 58:5  58:8 61:20,23  63:2,25 64:3  O'Donnell's 48:9  53:25 60:6 62:23</p> <hr/> <p><b>P</b></p> <p>P 2:12  pacemaker 20:3  page 57:11 65:3,5  pages 39:7  pain 10:8 43:20  palpitation 43:23  paper 38:24 39:24  papers 38:4,23  40:21 41:6  Parkway 2:12  Parma 1:22 3:15  12:1 13:7  parris 1:7 15:24  40:8 55:7,16  59:16  part 32:1 35:3  54:25  participated 19:3  particular 17:17,22  18:25 20:17 34:22  37:19 40:2,23</p>	<p>50:20 57:17 59:1  partnership 3:17  3:22  parts 29:7  party 66:11  pass 13:2  past 61:12  pathology 22:15  patient 8:20 9:1  10:7 22:9,12,17  22:21 23:5,9 25:7  25:17 26:1,2  27:18,21 28:3,10  29:11,18,21 30:7  30:12,12,21,24,25  31:16,18 33:16,20  34:1,5,8 37:16,21  38:16,17,21 40:15  42:20 46:1,24  47:12,12 48:7  patients 19:13 20:2  20:19,20,24 23:14  24:15,19,21,23  25:3 27:2 46:18  48:14  pattern 49:4,6,10  paying 4:13  pedal 43:21  pending 7:10,17 8:3  people 6:20 15:8  21:24 30:4 45:10  57:5 59:4 61:10  performed 8:22  43:8  performing 24:8  pericardial 53:23  period 43:10 57:4  peripheral 26:15  permission 59:11  persist 49:10  persistent 34:11  49:3,5 60:9  person 21:16 47:16  47:19 54:18 56:17  personal 16:15,15  personally 21:17  25:6  person's 24:10  phone 40:5,10  63:16  physical 26:14  38:11 47:20 48:1  48:6 50:2,19  51:14 54:1,15</p>	<p>physician 21:19  22:6,11 24:8  27:19 29:20 37:10  43:15 46:20 47:5  50:18 60:12 63:6  physicians 3:189:1  15:1 33:22 45:16  57:1,20 59:15  61:1  physician's 14:17  pieces 63:8  pinpoint 38:10  place 25:17,23  40:21 66:10  plaintiff 1:17 10:14  plaintiffs 1:5 2:2  8:10  plaintiff's 7:12  11:14 39:1,10,13  plan 51:13,16 52:5  PLEAS 1:1  please 3:8 11:15  plus 45:2  PND 43:21  point 4:1,6,7 6:22  6:25 19:23 41:7  43:13 44:19 49:25  55:4 56:14 57:23  59:19 63:20  Polito 2:19  position 18:19  positive 32:18  possibility 28:21  possible 32:13  41:15  possibly 14:3 26:4  32:22 49:21  post-it 39:16 40:1  Powell 2:11  Powers 1:22 3:14  practice 4:2,19 5:7  12:10 16:22 17:8  17:14,16 18:1  19:7,8,21 24:14  24:22,25  practicing 19:12  practitioner 4:6  precautions 23:3  predicting 62:19  predisposition  62:17  predominantly  21:11  prefer 33:22</p>	<p>preliminary 49:16  preparation 14:11  prescribe 47:11  present 9:4 18:7  32:4 43:5 52:24  presentation 27:16  28:20  presentations 14:5  presented 10:8  presenting 30:12  presently 43:15  presents 42:20  presumptive 32:4  pretty 51:4 61:11  previous 36:17  previously 43:3  57:15  primarily 21:4  52:11  primary 37:3,6,8  37:10 50:18  prior 21:24 43:1  44:23 58:8  private 5:7  privileges 13:6,11  13:14,18  probably 9:9,10,14  9:22 16:8 17:3  25:4 44:9 48:14  51:20 54:6 61:10  61:12  problem 21:23  30:16 31:25 35:5  35:10 38:10,11  problems 29:22  30:8 31:1 35:3  36:15 42:24 43:13  44:5 51:23 56:19  procedure 3:3 24:6  24:12 28:14,17,18  33:14 37:19 43:6  46:10,24 47:13,14  47:16,19  procedures 19:25  24:7 45:7,22 47:7  proceeding 9:16  proceedings 5:17  process 29:23 31:3  33:9  produce 41:14,17  professional 4:19  5:2,8  prominent 54:14  prophylaxis 23:10</p>
--	---	---	--	---

23:13,20,25 24:3 44:23 45:10,22 46:4,9,17,25 47:14,15 prosthetic 25:22 provide 19:13 provided 3:2 4:16 44:3 63:25 provider 37:4,6,8 psychologist 35:9 Public 1:19 65:23 66:4,16 publications 13:20 13:22 18:24 pulmonary 27:4 pulse 37:25 purposes 11:11 39:5 pursuant 1:20 41:9 put 37:25 38:18 49:3,19 puts 31:22	recall 8:10 41:24 42:2 44:4 50:12 50:25 51:7 54:16 57:19 receipts 4:15 receive 53:2 received 44:21,23 53:5 54:22 recent 34:10 recently 4:2 18:16 40:24 Recess 60:5 recollection 34:18 35:11 42:3 recommend 23:13 23:25 38:14 47:14 51:23 recommendation 45:21 46:3 47:4 54:9 recommendations 23:9,20 45:9 47:6 recommending 46:17 recommends 46:23 records 6:23 14:16 14:20 16:14 35:12 39:25 40:18,20 41:8,10,22 52:21 57:10 63:8 reduced 66:8 refer 6:23 17:7 35:9 37:11 51:17 reference 17:16 referral 37:14 50:18 referred 37:9 40:8 50:11 55:18 59:21 refresh 6:23 regard 7:7 8:15 11:2 19:7 26:23 31:10 44:1 53:14 54:1 56:8 58:23 regarding 47:6 Registered 1:18 regurgitation 53:24 related 8:20,21 10:10 20:1 27:11 30:18 31:13,15 63:10,12 relation 55:24 relationship 20:14 56:2,9 relative 66:11	relatively 24:17 release 40:20 relevance 19:1 reliable 16:23 17:11 rely 17:13 remember 10:12 34:19,20,23 35:4 63:14 reminding 40:15 render 5:2,7 rendered 9:19,20 renting 4:3 repeat 6:12 rephrase 6:11 replacement 29:6 report 53:2,9,10,12 54:20,22,23 55:14 57:23 58:6,9,21 58:25 reported 43:22 reporter 1:19 6:16 6:19 42:24 reports 40:16 43:12 57:17 represent 49:24 request 39:18 41:8 REQUESTED 65:5 require 29:5 required 7:3 research 19:3 Reserve 17:19 residual 33:2 resolution 9:7 resolved 9:6,13 responsibility 37:7 rest 20:22 result 21:8 24:15 54:23 results 51:22 53:15 55:11 retroactive 4:10 review 10:6 35:11 41:22 reviewed 14:10,13 14:16,22 40:23 45:2 54:3 60:17 64:1 revoked 12:18 13:15 rheumatic 21:1,2 21:12,16,18,24 22:2,5,10 23:6,14 24:16 26:1 29:11 29:19 30:7,22,23	34:9 36:5,18,22 40:3 43:2 45:14 46:1,18 48:10,20 rhythm 49:1 right 12:6 18:13 52:22 53:22 58:16 risk 23:4 25:16,17 25:20 26:3 32:1 risks 24:11 River 3:12 Road 2:8 Rocky 3:12 RONALD 2:16 room 10:8 37:25 38:18 42:12,14 61:11 Rosenfield 37:12 40:7 55:16,19 57:12,17 59:2,18 59:21 round 19:24 Rounds 20:25 routine 34:25 35:20 Row 2:7 Royalton 42:22 ruled 8:23 28:24 rules 3:3 6:7 rupture 27:14 Ryder 2:6	22:19 24:14,20,22 25:1,4 29:18 30:4 30:16,17,21,24 33:23 34:24 35:19 36:14,16 37:21 38:9,16 39:22 40:7 42:11 44:9 48:13 51:22 52:15 55:8 56:14 57:5,6 57:8 58:9 59:5,22 seeing 20:23 30:12 36:5 38:16 43:15 44:6 55:18 57:1 61:1 63:5 seem 40:22 seen 14:19 21:8,17 24:19 35:2 41:8 51:1,3 55:5,6 segments 49:20 send 53:9,11 57:20 57:21 senior 17:18 18:7,8 sent 57:16 59:1,8 service 19:14 services 2:19 4:12 4:14,16 5:3,7,8 session 6:8 set 1:24 38:20 39:12 66:7,13 settled 9:2 settlement 9:2 several 3:17 8:25 13:20 16:8,24 25:1 severe 53:24 severity 33:19 Sharon 2:6 sheet 38:24 39:11 57:18 58:24 59:1 sheets 39:24 57:10 shortness 43:20 showed 51:20 shows 56:20 shunt 25:23 sided 53:22 sign 4:9 Signature 64:14 signed 4:8 significance 43:25 44:16 48:11,13 54:2,4 significant 25:24 43:5 44:2 47:25 48:19 52:7,9
<b>Q</b> qualified 45:1 66:5 queries 31:9 question 6:7,10,11 6:12,13,18 7:3 12:19 13:15 54:12 58:2,4 questionable 48:2 49:3,5 questions 6:9 61:15 64:9,10 quit 4:2 quotation 43:9,10	<b>R</b> rare 24:17 Raskin 2:6 rate 28:8 read 20:4 42:20 49:17 65:2 reading 49:16 reads 49:19 realize 41:5 really 17:24 19:13 23:11 35:2 43:11 44:20 48:2 49:14 57:4 reason 18:18 30:13 34:22 35:19 40:3 51:25 reasonable 62:13	<b>S</b> Sally 7:19 same 52:16 saw 20:18 35:12,15 37:2 40:8 41:19 41:20 50:7 54:20 55:19 59:19 60:7 61:5,21 62:11 saying 40:2,6,11 63:13 says 18:6 53:5 schedule 19:21 20:18 school 55:2 63:18 Schools 42:22 scientific 45:11 seal 66:13 second 13:4 secretaries 59:7 secretary 55:3 63:18 sedimentation 28:8 see 11:7 17:18 19:12 20:20 21:3		



53:16 <b>signs</b> 22:5,20 26:5 26:14,19,24 27:4 30:9 31:1 38:21 41:24 43:23 52:12 56:4 61:6 <b>similar</b> 33:13 <b>Sinai</b> 14:19 <b>since</b> 14:25 16:10 24:12 35:1 41:7 64:5 <b>sinus</b> 49:1 <b>sit</b> 18:24 38:6 <b>sites</b> 28:22 <b>six</b> 54:7 57:8 <b>size</b> 53:19 <b>Skylight</b> 2:3 <b>small</b> 2:11 8:21 29:14 32:20 34:13 60:14 64:10 <b>Solon</b> 2:8,8 <b>some</b> 6:6,22,25 21:24 22:7 23:13 32:1 33:22 36:7 38:4 44:5 45:17 54:6,17 55:3 56:21 57:23 58:20 59:5 61:10 <b>Somebody</b> 38:18 <b>somebody's</b> 62:19 <b>someone</b> 10:10 27:13 30:16 53:3 <b>something</b> 30:17 46:12 53:12 <b>sometimes</b> 23:10 <b>son</b> 35:5 <b>soon</b> 32:12 41:14 <b>sooner</b> 32:15 <b>sorry</b> 30:1 <b>sounds</b> 22:24 23:2 <b>source</b> 58:20 <b>Southwest</b> 13:8 <b>space</b> 4:3 <b>span</b> 62:20 <b>speak</b> 62:22 63:22 <b>specialist</b> 44:12 47:11 <b>specialty</b> 46:20 <b>specific</b> 29:21 30:6 38:8 <b>specified</b> 66:10 <b>spent</b> 35:3 <b>splinter</b> 26:17 <b>spoke</b> 55:2 63:16,17	<b>SS</b> 66:2 <b>st</b> 13:9 49:2,20 <b>standpoint</b> 43:12 <b>start</b> 33:23,24 36:5 36:14 <b>starting</b> 34:6 36:3 52:12 <b>starts</b> 36:7 <b>state</b> 1:20 3:8 12:10 12:18 42:8 46:16 47:3 66:2,5,17 <b>stated</b> 34:25 45:9 50:13 54:7 55:18 <b>states</b> 12:13 21:4 43:1,7,17 <b>statute</b> 1:17 <b>stenotypy</b> 66:8 <b>sticky</b> 39:16 <b>still</b> 7:2,9,17 18:8 33:2,8 <b>street</b> 4:24 30:13 <b>strep</b> 21:9 <b>stress</b> 20:3 <b>stretch</b> 61:9 <b>strike</b> 11:2 <b>stroke</b> 8:21 62:6,9 <b>students</b> 17:23 18:3 <b>studies</b> 23:11 45:11 55:15 57:21 <b>study</b> 53:3 <b>stuff</b> 59:4,6 <b>subacute</b> 26:8,9 27:8,18 28:3,7,11 28:16 <b>subject</b> 10:24 13:22 14:1,6 15:4 19:4 <b>subjective</b> 45:8 <b>Subscribed</b> 65:19 <b>subsequently</b> 4:8 21:23 64:6 <b>subspecialize</b> 19:9 <b>subspecialty</b> 19:10 19:14 <b>substandard</b> 8:18 <b>suddenly</b> 27:14 <b>suffered</b> 62:5 <b>suggest</b> 22:21 <b>Suite</b> 2:3,16,20 3:14 <b>sure</b> 18:21 24:21 32:25 36:8 38:3 41:16 45:19 48:12 <b>surgeon</b> 30:15 40:19 47:7 <b>surgery</b> 9:1 10:11	27:11 47:8 <b>surgical</b> 24:6 43:6 47:6 <b>suspended</b> 12:18 13:15 <b>suspicion</b> 27:20 33:11 <b>suspicious</b> 28:15 <b>Sutula</b> 1:6 <b>Switzer</b> 2:19 <b>sworn</b> 3:4 65:19 66:6 <b>syllabus</b> 14:7 <b>symptom</b> 50:20 51:1,4 <b>symptomatology</b> 36:7 <b>symptoms</b> 22:6 26:6,24 30:9 31:2 31:8 43:12 56:4 60:10 61:6 <b>syncope</b> 43:22 <b>systolic</b> 48:8 54:19	<b>ten</b> 9:9 25:12 43:7 <b>tend</b> 27:1 34:6 38:9 <b>tended</b> 20:20 <b>tends</b> 21:18 27:12 34:4 <b>term</b> 20:10 <b>terms</b> 19:21 <b>testify</b> 10:18 66:6 <b>testimony</b> 41:18 58:8 66:7,9 <b>testing</b> 20:4,23 38:13 56:20,20 57:7 <b>tests</b> 57:16 <b>Texas</b> 12:14 14:4 <b>textbook</b> 16:21 17:3 17:4,5 <b>textbooks</b> 14:13 17:2 18:5 <b>Thank</b> 12:7 <b>their</b> 9:5 17:25 24:13 28:19 37:25 38:10 45:20 46:20 46:22 47:8 49:11 <b>therapy</b> 33:15 <b>thickened</b> 53:20 <b>thing</b> 20:5 29:25 30:5 31:7 47:9 55:7 <b>things</b> 15:12 22:10 27:15 37:23 <b>think</b> 7:16 15:25 18:16 21:10 28:20 36:9 45:6,7,15 48:7 49:1 51:3 54:16 55:21 58:7 59:24 60:18 <b>though</b> 51:10 <b>thought</b> 44:8 49:21 <b>thousand</b> 36:12 <b>three</b> 5:22 8:15 9:22 10:2,13 28:21,22 39:7 <b>through</b> 54:25 65:3 <b>throw</b> 35:7 <b>thyroid</b> 50:15 <b>time</b> 4:6,7 6:2,4,21 16:5 17:7,7 18:4 18:22 20:22 29:18 30:24 31:22,24 34:24 35:12,15 36:4 37:2,22 42:4 43:4,13,18 44:19 46:6 52:24 55:4	57:3 61:11,21 62:11,23 66:10 <b>times</b> 5:13,14,15,22 9:20,22 10:2 25:1 25:9 33:2 36:12 <b>tired</b> 26:13 36:2 61:11 <b>today</b> 14:11 18:25 <b>told</b> 20:6 36:16,18 36:20,21,25 43:9 46:19 63:17 <b>top</b> 50:24 <b>Toppel's</b> 17:5 <b>TOSTI</b> 2:3 3:7 7:20 30:14,20 36:23 39:17 41:7 58:3 58:11 60:2 64:8 <b>touch</b> 63:5 <b>toward</b> 46:17 <b>Tower</b> 2:3 <b>transcribed</b> 66:8 <b>transcript</b> 65:2 <b>transcription</b> 66:9 <b>treated</b> 32:8,16 <b>treatment</b> 32:11,24 <b>trial</b> 10:18 <b>tried</b> 63:3 <b>triple</b> 12:23 <b>true</b> 20:9 66:8 <b>truth</b> 66:6,7,7 <b>try</b> 13:2 55:1 <b>trying</b> 40:18 <b>TSH</b> 50:16 56:5,9 <b>TUESDAY</b> 1:13 <b>twice</b> 6:2 <b>two</b> 5:14,15,22 6:20 7:13,21 8:6,8 9:6 10:12 15:2 27:9 33:18 34:3 45:13 62:17 <b>type</b> 24:6 29:25 30:5,8 31:7 45:14 47:8 49:10 50:14 56:21 <b>typically</b> 53:7
<b>T</b>				
<b>T</b> 49:7 <b>take</b> 6:17 10:17 18:14 19:16 26:9 37:25 38:10 41:13 <b>taken</b> 1:18 5:11,16 5:22 10:1,21 23:4 41:24 42:6,8 66:10 <b>taking</b> 6:20 19:23 42:24 <b>talk</b> 34:16 38:7 55:10 <b>talking</b> 27:11 35:4 57:2 <b>tapes</b> 14:7,23 <b>taught</b> 13:25 <b>teach</b> 18:2 <b>teacher</b> 42:22 43:19 <b>tear</b> 21:23 36:11 <b>telephone</b> 63:11 <b>tell</b> 7:12 8:17 10:4 13:5 14:10 23:19 24:2,5,7,8,18 25:20 26:5 35:23 39:8 44:11 46:12 52:8 53:15 58:14 60:22 61:16 <b>telling</b> 7:21 58:13 <b>temperature</b> 42:6,8				
<b>U</b>				
<b>ultimate</b> 24:9 <b>uncommon</b> 48:4 <b>under</b> 1:17 6:8 23:24 51:8 52:5 <b>undergoing</b> 47:12 <b>undergone</b> 44:12 44:17				

understand 6:9,10 7:5 29:16 understanding 35:18,23,25 37:3 37:5 understood 6:13 United 21:3 University 13:10 14:4 17:19 18:13 unless 7:3 53:12 unusually 34:21 unverified 49:16 urinalysis 27:25 use 17:15,23,25 23:20 45:18 used 23:25 using 20:10 40:19 usual 19:21 47:13 usually 21:8 28:10 28:12	Vincent 13:9 visit 35:4 37:17 41:19 42:16 47:21 48:22 52:16 59:13 62:25 vitae 11:5,16,17,20 13:21 18:6 vital 38:21 41:24 Vivian 1:18 66:4,16 voice 12:4,5 vs 1:6	while 50:14 51:8 white 42:21 whole 66:6 WILT 2:16 7:16,22 7:25 9:4 23:7,17 29:13 30:11,15 31:4 32:19,21 33:17 34:14 39:21 41:16 45:1,24 46:15 47:2 58:1,7 58:13 60:1,15 64:11 witness 3:1 7:23 59:24 60:4,16,16 66:13 woman 45:13 woman's 46:5 women 49:11 won 8:23 wondering 53:7 work 17:23 18:10 27:25 59:6 worked 15:8,19 44:8 working 43:18 workup 27:21 worthwhile 18:23 wouldn't 17:12 42:7 written 9:17,18 38:2 53:3,10,11 wrong 52:22 wrote 49:21	12 14:8 131:13 14002:20 16th 66:14 17002:16 1997 18:6 1999 3:21,25 4:22 5:6 13:5 19:22 20:6,19 35:14 38:15	8 66:18 8:30 15:10 8:45 1:23 80 48:14
<b>V</b>	<b>W</b>	<b>X</b>	<b>2</b>	<b>9</b>
vacation 54:25 valve 21:21 22:4,9 23:5 24:20 25:22 25:24 26:2 27:14 29:5,5,12 31:13 31:17,22,23,24 33:3 36:12 53:20 53:21 valves 21:13,16 22:1,3 24:15 valvular 21:22,23 22:14,18 26:20 29:19 30:8,22 31:25 32:3 33:8 36:6 46:2 52:2,7,9 52:12 54:6 variant 49:9 various 29:7 vegetation 31:11,12 31:17 vegetations 32:3 ventricular 22:22 53:18,18 venture 61:10 verbal 53:9 verbally 6:16 versus 24:12 very 34:20 35:5 36:10 43:17 45:8 53:12 60:19 videos 14:7 vigilance 29:10,17	wait 33:23 waiting 42:14 waived 64:14 walking 16:8 want 5:14 6:6 29:24 38:9 60:7 wanted 18:20 40:12 55:20 warrant 60:11 wasn't 40:13 49:25 wave 49:7 way 19:8 48:8 64:4 wear 21:22 36:11 Wednesday 20:21 week 61:12 weeks 57:8 weigh 24:10 37:24 weight 26:11 31:23 well 3:17 11:2 16:24 17:1 18:2 19:10 24:24 26:7 28:18 29:18 31:21 34:20,21,23 43:11 43:18 45:21 49:19 52:11 53:17 54:10 54:14 57:1 58:17 59:20 62:14 went 8:22 18:22 58:9 64:6 were 3:21 4:5,11,18 5:16,19,22,24 7:8 7:13 8:9,13 9:23 10:5,6,14,16,17 13:11 28:15 37:7 41:1,24 48:24 49:17 51:23 52:24 53:15,22 56:24 57:6 61:11 weren't 18:21 Western 17:19 WHEREOF 66:13	42:23 39:1,4,10,14 2001 1:13 65:20 66:14 2004 66:18 21330 3:12 216-241-2600 2:4 216-621-5300 2:17 216-875-2767 2:21 25th 35:14 37:17 42:11 51:15 59:13 61:5,21 62:12 63:1,22 26th 62:9 28th 52:18,19	24:23 39:1,4,10,14 2001 1:13 65:20 66:14 2004 66:18 21330 3:12 216-241-2600 2:4 216-621-5300 2:17 216-875-2767 2:21 25th 35:14 37:17 42:11 51:15 59:13 61:5,21 62:12 63:1,22 26th 62:9 28th 52:18,19	99 4:19 37:17 61:6 62:9
		<b>Y</b>	<b>3</b>	
		x-ray 28:1	30 27:12 3013:14 330-670-7300 2:13 34305 2:8 3737 2:12	
		<b>Z</b>	<b>4</b>	
		year 20:16 24:19 25:1,3 54:8 yearly 51:24 years 9:10,11,14 14:9 21:22 36:11 36:13 43:4,7	40s 36:1 49:11 414050 1:6 44-year-old 42:21 440-248-7906 2:9 44113 2:4 44114 2:17,21 44139 2:8 44334 2:13	
		<b>1</b>	<b>5</b>	
		111:10,14 65:3 10:05 64:13 1002:7	54 62:15 5521 2:12	
			<b>6</b>	
			64 65:3 6525 1:22 3:14 660 2:3	
			<b>8</b>	