

State of Ohio,) **SS:**

County of Mahoning.)

- - -

IN THE COURT OF COMMON PLEAS

- - -

DOROTHY A. GONDA, et al.,)

Plaintiffs,)

v.)

Case No, 96-CV-2055
Judge John M. Durkin

JUAN RUIZ, M.D., et al.,)

Defendants.)

- - -

THE DEPOSITION OF SAMUEL ADORNATO, M.D.

THURSDAY, MAY **28**, 1998

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The deposition of SAMUEL ADORNATO, M.D., a witness, called for examination by the Plaintiffs, under the Ohio Rules of Civil Procedure, taken before me, Cynthia A. Sullivan, Notary Public in and for the State of Ohio, pursuant to notice, at the offices of Samuel Adornato, M.D., 7227 Glenwood Avenue, Boardman, Ohio, commencing at 3:30 p.m., the day and date above set forth.

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1 APPEARANCES:

2

3 On behalf of the Plaintiffs:

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10 On behalf of the Defendants Juan Ruiz, M.D., Robert E.
11 Hunt, H.D., Diagnostic Cardiology Associates, Gregory
12 Mazanek, M.D., J. Ronald Hicolich, M.D., Nicola
13 Niciloff, M.D. Gary A. Young, M.D., and Paul Stefek,
14 M.D:

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18 on behalf of the Defendants Alan J. Cropp, M.D.,
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1 SAMUEL ADORNATO, M.D.

2 a witness, called for examination by the Plaintiffs,
3 under the Rules, having been first duly sworn, as
4 hereinafter certified, deposed and said as follows:

5 CROSS-EXAMINATION

6 BY MR. MALIK:

7 Q. Doctor, my name is David Malik. I'm representing
8 the family of David Gonda in this matter. The
9 questions I'm going to ask you have to do with your
10 treatment of him, and I'll ask you some general medical
11 questions, too. If there is anything you don't
12 understand, please let me know.

13 A. If you could, just speak up a little bit.

14 Q. I have a form that I just saw called the patient
15 registration in front of me which for the record is
16 going to be Exhibit A. Do you have that in your
17 records?

18 A. Yes, I do.

19 Q. Whose handwriting is on that form?

20 A. The patient listed. It's David Gonda's
21 handwriting.

22 Q. Why is that form generated?

23 A. Why is it generated?

24 Q. Yes, why did he fill out that form?

25 A. Simply, it's a form that's filled out when a

1 patient comes in, and from that patient registration
2 form we are able to make up a chart with his name,
3 address and phone number. On the front of my sheet it
4 also gives us any pertinent employment information and
5 also the necessary medical insurance information. It's
6 routine.

7 Q. Do you consider this a form for cc use to
8 treatment?

9 A. Wow, no.

10 Q. Do you consider this a form to allow you to
11 discuss his condition with anybody other than the
12 insurance company, for example, or other physicians?

13 A. I would hesitate to even answer that question.

14 Q. But there came a time when you did discuss his
15 visit with you with Dr. Ruiz, correct?

16 A. That's correct.

17 Q. Do you recall when that was?

18 A. Yes, it was July the 10th, 1995.

19 Q. What was the reason you discussed his condition
20 or symptoms with Dr. Ruiz?

21 A. Very simply that at that point I did not have a
22 concrete diagnosis as to the etiology of the chronic
23 cough, so I always tell patients when I'm going to call
24 their family doctor, I'm going to call Dr. Ruiz and
25 discuss it with him.

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1 Q. When was the first date that David presented to
2 you?
3 A. The first date here in this office or first date
4 regarding the chronic cough?
5 Q. Does my memory serve me correct that you were the
6 one who removed his tonsils?
7 A. That's correct. I might have. It is probably
8 correct because I have known the Gonda family, I don't
9 know if I know this branch of the Gonda family as well
10 as I do others, but go ahead.
11 Q. In line with that, are you still performing
12 surgeries?
13 A. Yes.
14 Q. What type of surgeries do you perform?
15 A. You name it in the head and neck. The only thing
16 I don't do in the head and neck, I don't do any thyroid
17 or major ear surgery, but beyond that if it presents
18 I'm still doing major surgery of all types.
19 Q. Does that include cancer-related surgeries?
20 A. Yes, cancer of the head and neck is a
21 subspecialty that I have.
22 Q. Aside from the time you took his tonsils out,
23 which was the next date that you saw him?
24 A. The first date on this chart is November 12th,
25 1994.

1 had a chronic cough, would I check it and see whether I
2 could help him with it.
3 Q. Do you recall that examination?
4 A. Yes, in a sense that I recall it by what I have
5 written in the chart here. Do I see it in my mind, no.
6 Q. Do you recall the degree of cough that he had; in
7 other words, was it a small cough, a chronic cough, how
8 would you characterize it?
9 A. It didn't, I would say, alarm me at all. It just
10 sounded like so many other patients I have seen over a
11 period of years, literally thousands, with chronic
12 coughs.
13 Q. This is not very scientific, just to give me a
14 feel for it on a scale of one to ten where was his
15 cough?
16 A. Ten being the worst?
17 Q. Yes.
18 A. Probably about a three. That was the first
19 visit.
20 Q. Did he present with any other symptoms at that
21 time?
22 A. None whatsoever, nothing that he gave to me.
23 Q. Did you prescribe any medication for him?
24 A. Yes, I ordered an antibiotic which is called
25 Duricef.

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1 Q. And why did he present to you?
2 A. Wax in his ears. He felt there was some problem
3 with his inner ear. He had it five to seven days. He
4 was somewhat dizzy, cleaned the wax out of his ears,
5 put him on Antivert, and we got a phone call six days
6 later that he was better and would not be coming in for
7 the post-op visit.
8 Q. You seem to have a pretty good memory because
9 when I looked at the chart, all I saw was wax in the
10 ears.
11 A. I know what people present with. My shorthand is
12 such that it leads me to what people present with. If
13 I were to write it out it would take half a page, and I
14 would spend all my time writing.
15 Q. But you can recall today from 1994 that he called
16 you six days afterwards or somebody did?
17 A. I have got it in the chart.
18 Q. When was the next time you saw him?
19 A. First, the next visit was supposed to be
20 November 25th of '94. He did not show up. That was to
21 check his inner ear. The next time I saw him was
22 June 14th of 1995.
23 Q. Why did he present to you?
24 A. Again, he was complaining of his ears being
25 plugged. Just as an afterthought he mentioned that he

1 Q. How long was he to take the antibiotic?
2 A. He was to take that -- I only prescribed the
3 antibiotic for five days.
4 Q. By prescribing the antibiotic were you thinking
5 in your mind he had a bacterial infection?
6 A. Probably, but more likely a virus which responded
7 to Duricef. Even though the literature says that's a
8 bacterial medication, patients with viral pharyngitis
9 respond to Duricef, whether you should make a point of
10 whether or not it was going to cure itself in six days
11 or six days with the antibiotic.
12 Q. Is Duricef a broad-spectrum antibiotic that would
13 cover both bacterial and viral?
14 A. It's reported to have some viral effect, yes.
15 Q. Is its primary purpose to deal more with
16 bacterial pharyngitis?
17 A. Yes.
18 Q. At that time did you culture his throat or
19 anything?
20 A. No. I have a reason for that. While I was in
21 the military during the Viet Nam War, I had the ability
22 to culture throats, I cultured 5,000 throats, and we
23 ended up with about 75 percent of the patients who
24 would have strep or some sort of bacteria in the throat
25 asymptomatic, so I got to the point where it wasn't

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1 I worth it. I rarely culture a sore throat unless it's
2 one that really worries me.

3 Q. When you were in the military and you were doing
4 the throat cultures, did you also have the opportunity
5 to culture throats that you thought were positive but
6 came up negative?

7 A. I don't recall that. We would just culture
8 throats of asymptomatic people. We were just going to
9 see what we could find by doing patients without any
10 sore throats.

11 Q. Now, in your practice when you do perform a
12 throat [redacted] which lab does it go to?

13 A. Well, the ones that we would do originally would
14 go to St. Elizabeth. I would have them go over to
15 St. Elizabeth's actually and have the technologists
16 there do the culture. Now of course the lab comes, and
17 they pick it up for us.

18 Q. When you in 1995, do you recall?

19 A. At that point I think we were probably using
20 Brodmor Labs, I think. I can't be certain where they
21 were going at that point.

22 Q. What would you expect the [redacted] to be
23 [redacted]?

24 A. I don't know.

25 Q. What possibilities are there?

1 Q. When you saw him on June 24th of '95 did you take
2 his temperature?

3 A. Yes, we did.

4 Q. What method in this office did you use to take
5 temperatures in 1995?

6 A. I think we were using the -- we didn't have an
7 ear temp., so we were using the instant
8 under-the-tongue temperature, not the usual mercury,
9 but under-the-tongue.

10 Q. Is that the one with the plastic cover?

11 A. Yes.

12 Q. Is the temperature [redacted] you would take?

13 A. No, one of the nurses would take that.

14 Q. Is there a reason that you can't [redacted] of [redacted]
15 temperature wasn't taken in the previous visit?

16 A. Probably clinically I didn't feel the need for it
17 at that point.

18 Q. What were his symptoms, what were his symptoms on
19 June 24th other than the temperature?

20 A. On June 24th the patient came in, and I recall he
21 didn't -- he looked like someone who had a viral
22 infection. He was still complaining of the cough. He
23 was still complaining of an irritated throat. At that
24 point we did a temperature on him, and we got the 101.4
25 oral temp.

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1 MS. HARRIS: Objection.

2 A. I don't know.

3 MS. HARRIS: Objection.

4 A. I'm not a clinical bacteriologist. I don't have
5 any idea. I can recall going back years when I was in
6 medical school, but that's a long time ago.

7 Q. Was it July 14th that you saw him?

8 A. Saw him July 14th, 1995.

9 MS. HARRIS: June.

10 BY MR. MALIK:

11 Q. June 14th?

12 A. June, yes, June 14th.

13 Q. Now, at that time did you report any of your
14 findings to Dr. Ruiz?

15 A. No.

16 Q. Can you remember anything else from that visit as
17 we sit here today?

18 A. No, not really.

19 Q. When was the next time you saw him?

20 A. I think the next time was ten days later. He
21 would have come back as requested for a follow-up
22 visit. That was on June 24th, 1995.

23 Q. When you saw him on June 14th of 1995 did you
24 take his temperature?

25 A. No.

1 Q. You said he looked like a person with a
2 temperature and looked like a person with a cough.

3 A. He looked like a person with a viral infection.

4 Q. What does a person look like with a viral
5 infection?

6 A. Looks miserable, that's all.

7 Q. Can you also look miserable when you have a
8 bacterial infection?

9 A. I have not been aware of that. Patients come in
10 with some bacterial infections, and with the exception
11 of the local area that's infected, they don't really
12 look clinically as sick as someone who has got a common
13 cold or a viral infection, no.

14 Q. Can you describe to me how he looked, can you
15 tell me how he looked?

16 A. No. You mean looking at him?

17 Q. Starting from the top of his head to the bottom
18 of his chin, how did he look?

19 A. No, not according to what I have written here.

20 Q. Then how is it that you remember that he looked
21 like he had a viral infection?

22 A. Because I have got it written.

23 Q. So a viral infection in your mind means that he
24 didn't look right?

25 A. In fact, that's what prompted me to take the

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1 temperature, the fact that the youngster came in,
 2 didn't look like he was feeling very well, still had a
 3 cough, again, just not looking good.
 4 I think you're asking a question that if I were
 5 to see one patient per day I could probably in great
 6 detail describe everything from the top of his head to
 7 the bottom of his feet, just as you would with a client
 8 if you only had one, but when you're dealing with an
 9 office practice, I don't know that I could describe
 10 anyone as you wanted me to.
 11 Q. What I'm thinking is that part of your job is to
 12 be a diagnostician, correct?
 13 A. Correct.
 14 Q. How many years have you been doing this?
 15 A. Thirty-six years.
 16 Q. In 1995 you were doing it for 34 years; is that
 17 right?
 18 A. It would be about 33, 34 years.
 19 Q. This young man presented to you and he didn't
 20 look right?
 21 A. Yes, that's right.
 22 Q. Did you take any weight measurements?
 23 A. No.
 24 Q. What else does your note reveal?
 25 MS. HARRIS: Do you want him

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1 to read it himself?
 2 Q. If you could, read the note.
 3 A. June 24th, temp. 101.4, viral pharyngitis,
 4 treated him with Zithromax, patient still coughing, and
 5 I have got written down here the diagnosis -- at this
 6 point I'm becoming a little concerned because I'm not
 7 getting a good response with the medication, so I put
 8 diagnosis and three question marks after it.
 9 Q. What is Zithromax?
 10 A. It's one of the newer generation of products that
 11 is an Erythromycin derivative. Zithromax is an
 12 antibiotic that has very specific functions as far as
 13 pharyngeal, tonsillar and pharyngeal infections, very
 14 specific.
 15 Q. Very specific to that part of the body?
 16 A. Very specific to that part of the body.
 17 Q. Are you again at that point thinking of a
 18 bacterial infection?
 19 A. No, I'm still thinking that it's a viral problem
 20 with the pharyngitis overlying it. Again, I'm treating
 21 it as I would based on clinical experience, and I would
 22 treat with a second antibiotic.
 23 Zithromax would affect or counter bacterial
 24 infections, too, wouldn't it?
 25 A. That's correct.

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1 Q. Do you know what types of bacteria it would
 2 affect?
 3 A. Not specifically, no.
 4 Q. As of this date as you just indicated, you have
 5 diagnosis and three question marks --
 6 A. That's Correct
 7 Q. -- because you did not have a diagnosis?
 8 MS. HARRIS: Objection.
 9 A. A specific diagnosis.
 10 Q. Is it a fair statement to say that the
 11 pharyngitis diagnosis is a provisional diagnosis?
 12 A. I would say it's fair, but based on clinical
 13 experience.
 14 Q. Let's get this down to basics, what is
 15 pharyngitis?
 16 A. It is very simply the appearance of an
 17 inflammatory process of the posterior aspect of the
 18 throat from above the palate all the way down to the
 19 area just above the larynx.
 20 Q. I brought with me a page out of one of the Netter
 21 books, that book that you have right there, and I'm
 22 going to mark it as Exhibit B.
 23 Can you circle the area we're talking about?
 24 A. We are talking about the pharynx, the nasopharynx
 25 and the laryngopharynx.

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1 Q. That is the area you considered to be affected?
 2 A. The area that's specifically able to be seen is
 3 an area right between the two marks (indicating); that
 4 is to be seen using just a tongue depressor.
 5 Q. And what is that area called?
 6 A. The pharynx.
 7 Q. What is the function of the pharynx?
 8 A. Two functions; basically it serves as an airway,
 9 transfers air either through the mouth or the nose
 10 through the area of the larynx through the trachea
 11 going into the lungs, and it is also an area where food
 12 is propelled down the esophagus into the stomach. It
 13 has two functions.
 14 Q. Did you conduct any other type of physical exam
 15 of David or did you limit your exam to the head?
 16 A. Just to the head and neck.
 17 Q. Do you recall talking to David about what his
 18 symptoms were?
 19 A. Not specifically, no.
 20 Q. The next time you saw David was what date?
 21 A. Well, June 26th. I asked him specifically on the
 22 24th to call me two days later. I wanted to know if we
 23 were going in the right direction with the treatment.
 24 David did call and say his temperature was down
 25 from 101 to 99. He still had a cough. He called in

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1 about ten o'clock in the morning. I told him it
 2 sounded like we were going in the right direction and
 3 to continue the medication and see me back in the
 4 office for a follow-up visit.
 5 Q. In your mind in : [] of using this
 6 medication all Zithromax a ature [] fr
 7 101 [] 5), are you still i it's viral or are .
 8 thinking it's bacterial?
 9 A. Still thinking it's viral with a secondary
 10 irritation of the pharynx, yes.
 11 Q. You had verbally requested that David call you?
 12 A. That's correct.
 13 Q. And he followed up on this request?
 14 A. He called, yes.
 15 Q. During the time you had seen David, had you been
 16 able to form an opinion as to whether or not he was
 17 reliable as a patient?
 18 A. I thought he was very reliable as a patient.
 19 Q. Do you also know his family?
 20 A. I know the Gonda family. I don't specifically
 21 know whether I know that arm of the family. I'm
 22 talking back 40, 45 years I have known the Gonda
 23 family, and I believe this is one of the relatives of
 24 some of the people that I know.
 25 Q. Do ou recall whether or not D expressed to

1 A. Yes-
 2 Q. What was your purpose in doing that?
 3 A. Very concerned now that the chronic cough was
 4 there, and I didn't have an answer.
 5 Q. Is it a fair statement to y th you ha e s en
 6 up through this : 1 your career s c
 7 patients?
 8 A. With sore throats or thousands of patients?
 9 Q. With sore throats.
 10 A. Probably more than thousands, yes.
 11 Q. You certainly saw them in the service, right?
 12 A. No question about that.
 13 Q. Were you a medic or physician in the service?
 14 A. We performed both. We were medics in a sense
 15 that we had to run an outpatient clinic, and then
 16 specifically in my specialty we ran a clinic for the
 17 ears, nose, throat, head and neck.
 18 Q. You used the words very concerned. You have got
 19 quite a bit of experience in you here, so what was it
 20 that you were very concerned about?
 21 A. The inability to get rid of the chronic cough.
 22 Q. Do you recall what was going through your mind at
 23 that time?
 24 MS. HARRIS: At hat time?
 25 MR. MALIK: I'm talking

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1 you his concern about his condition?
 2 A. He did. I don't know specifically as to what he
 3 said, but I remember he was quite concerned. On the
 4 visit of the 24th I think he was very concerned about
 5 it.
 6 Q. Do you remember whether or not he expressed to
 7 you things he couldn't do because of his condition?
 8 A. No.
 9 Q. According to your records it looks as though you
 10 next saw him on July 10th.
 11 A. July 10th, that was two weeks later, and he came
 12 in for the last visit at that time.
 13 Q. Can you read your note, please?
 14 A. Temperature is 99.7, fiberoptic laryngoscopy
 15 negative, pharyngitis, no good pathology, period. That
 16 was it for that note.
 17 Q. Now, did you perform the laryngoscopy in this
 18 office?
 19 A. Yes.
 20 Q. What is a fiberoptic laryngoscopy?
 21 A. You slide a fiberoptic in through the nose and
 22 you come into the pharynx from above, and you're able
 23 to see the entire pharynx, the tonsils, down to the
 24 larynx and even the trachea.
 25 Q. You performed that procedure?

1 about July 10th of '95.
 2 A. No.
 3 Q. Are you doing anything with respect to thinking
 4 in terms of a differential diagnosis?
 5 A. At that point a differential diagnosis simply
 6 limited to the head and neck, yes, and that's the
 7 reason that I performed the fiberoptic laryngoscopy.
 8 His mother was with me at that time, and she and I
 9 discussed it, and the whole family was concerned as
 10 well.
 11 Q. Do you recall her concern for David?
 12 A. Oh, certainly. I don't recall specifically, but
 13 I knew that she was very concerned. Otherwise, she
 14 wouldn't have come.
 15 Q. Between the time you first saw him on June 14th
 16 of '95 through July 10th of '95 had he also seen
 17 Dr. Ruiz?
 18 A. I don't know that.
 19 Q. Did there ever come a time when you were informed
 20 that David had an abnormal EKG?
 21 A. Run that by me again.
 22 Q. Did there ever come a time that you were informed
 23 that D [] had an [] EKG?
 24 A. No.
 25 Q. You were not told on June 27th of 1995 an EKG was

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1 taken and it was abnormal?
 2 A. No.
 3 Q. Were you ever informed that David Gonda had an
 4 EKG taken?
 5 A. No.
 6 Q. Between June 27th of '95 and July 10th of '95 had
 7 Dr. Ruiz contacted you, has that been reflected in your
 8 records?
 9 A. It would be reflected in the writing, yes, but I
 10 don't have that.
 11 Q. Let's go down to the papillary elastoma; what was
 12 that?
 13 A. Again, not being a cardiologist, that was written
 14 very simply when we found out that the patient expired,
 15 had passed away, because of whatever. I contacted
 16 Dr. Ruiz and asked him what was the problem, and at
 17 that point he said it was a papillary elastoma, so I
 18 wrote it down as the diagnosis.
 19 Q. So that reflects what you were told by Dr. Ruiz?
 20 A. I believe so, yes.
 21 Q. That's not something you came up with on your own
 22 accord?
 23 A. No, I'm not a cardiologist, sir.
 24 Q. Going to Exhibit C which is the bill, first of
 25 all, that is a computer generated bill, right?

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1 A. That's correct.
 2 Q. It is done out of this office?
 3 A. Yes.
 4 Q. For June 14th of '95 we have minimal exam, est.
 5 pt.; what does that mean?
 6 A. Good heavens, I don't know. That's the front
 7 office. Minimal exam means I didn't get involved in
 8 any great detail of looking.
 9 Q. The CPT codes and ICD codes?
 10 A. Don't ask me about those. I don't know anything
 11 about those.
 12 Q. Are those computer generated?
 13 A. Those are generated in the computer and our
 14 office personnel.
 15 Q. Did you give David a professional discount when
 16 you saw him?
 17 A. Yes, I did.
 18 Q. What was the reason for that?
 19 A. It had to do with the family.
 20 Q. The last entry in your notes, 01-23-96, can you
 21 read that -- or actually there is one before that.
 22 A. Patient expired 08-18-95. That's one of my
 23 secretaries who wrote that. I had an office manager
 24 who was one of the greatest people for remembering
 25 names, people and things. She was up on practically

Page 24

1 everything that went on. When she left there was a big
 2 hole in the office. She would be able using her memory
 3 to pick up on if someone had expired or got married or
 4 something, graduated or what have you.
 5 Q. Let me go back to the papillary elastoma note.
 6 Did you have a conversation with Dr. Ruiz with respect
 7 to that?
 8 A. I remember that I did, and, you know, it's not
 9 written as such.
 10 Q. In your mind the conversation was about a cardiac
 11 condition, correct?
 12 A. That's basically what I understood it to be.
 13 Q. When David presented to you did he present with
 14 the presence of any respiratory symptoms?
 15 A. Not that I recall. No, sir, not that I recall.
 16 Q. What was the main complaint that you noticed, was
 17 it the fever or was it the cough?
 18 A. Chronic cough was the main complaint.
 19 Q. In terms of importance what did you consider the
 20 most important, the cough or fever or both?
 21 A. I think -- again, you want me to look
 22 retrospectively?
 23 Q. I know it's difficult, but do you recall what you
 24 were thinking at that time?
 25 A. I think the chronic cough was the thing that

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1 probably alarmed me more at the end than at the
 2 beginning, yes. The temperature I think was there, but
 3 it was a symptom, a sign of something going on.
 4 Q. Is it a fair statement to say that when you have
 5 a chronic cough like this there is one set o
 6 possibilities that a cough could be from a
 7 but to add to that is a set of possibilities that
 8 is an additional set of possibilities.
 9 MS. HARRIS: objection.
 10 A. No, I still think you have your original set of
 11 possibilities. The fever may be just an adjunct to the
 12 original set. I don't think it adds a new set of
 13 possibilities, no, with the exception of one which
 14 would be if you had a fulminating pneumonia. Boy, you
 15 don't see those anymore.
 16 Q. When you're thinking differential diagnosis, you
 17 didn't eliminate anything from your differential
 18 diagnosis here?
 19 MS. HARRIS: objection, I'm
 20 not sure what you mean by eliminating.
 21 Y MR. MALIK:
 22 Q. Did you eliminate any possibilities?
 23 A. In regards to the ears, nose and throat, at the
 24 beginning I didn't eliminate any, you're right. As far
 25 as at the beginning, we are just talking ears, nose and

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1 throat.

2 Now, again, there are many reasons for a chronic
3 cough, you know. You can elicit a cough in a patient
4 by cleaning wax out of the ears. There are a number of
5 reasons from an ENT standpoint.

6 Q. From an ENT standpoint what would be a reason for
7 a chronic cough?

8 A. The most predominant would be post nasal drainage
9 for some reason whether it be a viral infection, common
10 cold, allergy, hay fever, some irritant.

11 Q. Did David have any vocal cord dysfunction when
12 you saw him?

13 A. No, not according to my chart.

14 Q. Doctor, what is the difference between
15 pharyngitis and laryngitis?

16 A. The location. In the diagram that you pointed to
17 the pharynx would go anywhere from the back of the nose
18 all the way to the larynx. You have your nasopharynx,
19 oropharynx, hypopharynx, so any one of those three are
20 still in the pharynx. Once you get to the vocal cords
21 you're not confined to the larynx.

22 Q. What are the causes of laryngitis?

23 A. Multiple, multiple causes for laryngitis. You
24 can get laryngitis from cancer, you can get laryngitis
25 from vocal cord nodules, you can get laryngitis from

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1 post nasal discharge, from having surgery with a tube
2 they put in the throat; I can go on and on.

3 Q. The first time I asked you is that at some point
4 Dr. Ruiz' name became laryngitis; were you aware
5 of that?

6 A. No.

7 Q. Did he ever consult with you regarding that?

8 A. No.

9 Q. When you saw David did you agree or disagree that
10 he had laryngitis?

11 A. I did not detect any laryngitis. Again, let's
12 back off. The first two examinations would not have
13 demonstrated laryngitis, but the third exam with the
14 fiberoptic scoping would, and it did not show it.

15 Q. What was the first diagnosis?

16 A. Ear infection.

17 Q. Can you tell me based upon your experience what
18 percentage of cases are typically bacterial pharyngitis
19 and what percentage are viral?

20 A. Probably less than 5 percent of the sore throats
21 that I see.

22 Q. Are?

23 A. Bacterial.

24 Q. The majority being viral?

25 A. The majority being viral or irritative of some

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1 sort.

2 Q. In this case you were never able to determine
3 which one with David?

4 A. That's correct. I think we treat this type of
5 case based on experience and based on the lack of any
6 other clinical findings.

7 MR. MALIK: Doctor, I think

8 I'm just about done. Can I have a minute?

9 (Thereupon, there was a brief
10 recess.)

11 BY MR. MALIK:

12 Q. I'm handing you what I have marked as Exhibit D.

13 Is that an accurate representation of your credentials?

14 A. Except for the publications. There have been a
15 lot more since then.

16 Q. From that I gather you're licensed to practice
17 medicine in the State of Ohio?

18 A. That's correct, sir.

19 Q. And you are Board Certified?

20 A. That's correct.

21 Q. I ran you on the Internet, and it came up that
22 you are not a member of the American Medical
23 Association.

24 A. That's correct, sir. I have not been for
25 probably about 15 years.

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1 Q. Could you please state everything I you
2 recall a conversation with Dr. Ruiz fit
3 David's death?

4 A. I can't, other than what I just said. In fact, I
5 called him. I said, I just noticed that Mr. Gonda has
6 died, and that was that. What was the diagnosis? As
7 to specifically, no, I can't recall specifically what
8 was asked or talked about.

9 Q. Your diagnosis of no gross pathology on
10 July 10th of 1995, what does that mean?

11 A. That means as I examined everything from the nose
12 all the way past the nasopharynx, hypopharynx,
13 oropharynx, involving the base of the tongue, larynx, I
14 saw nothing there that I could hang my hat on and say
15 this is it, this is the reason for his cough, even
16 looking at the trachea.

17 Q. Do you recall the date the note about the
18 papillary elastoma was written?

19 A. No, I don't. That's the one date that's not on
20 there. That's my writing, and that's the reason there
21 is probably no date there. I don't know when it was.

22 I would think it was probably after August the 18th. I
23 would say it was a day or two afterwards because it was
24 of interest to me what had happened.

25 Q. Are your notes written in chronological order?

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1 A. Yes, they are. I have a copy right here.

2 Q. So the one after that says, patient expired
3 08-18-95?

4 A. I see what you mean. You know, the elastoma
5 should have been above that.

6 Q. But again, you don't recall the day.

7 Do you recall how it came about you had the
8 conversation with Dr. Ruiz?

9 A. No, I don't know.

10 Q. You don't know if you called him or he called
11 you?

12 A. I called him.

13 Q. How did it come about that you heard of David's
14 death?

15 A. Again, I had a secretary who would -- she read
16 the newspaper from front to back, and whatever she
17 would see, whether it be a birth, an obituary, a
18 wedding or new promotion, she would remember that we
19 had seen the patient and she would bring it in. That's
20 basically it.

21 MR. MALIK: Thank you,
22 Doctor. I don't have anything else.

23 ---
24 BY MR. TRAVERS:

25 Q. Doctor, my name is Tom Travers. I'm the attorney

1 November 12th, 1994?

2 A. Not necessarily. Again, that space, referred by,
3 I think is probably a misnomer in the sense that he may
4 not have been sent in by Dr. Ruiz. I think it's
5 probably incorrect. In this particular case he may
6 have just come in on his own.

7 Q. So he may have been asked who his family doctor
8 was, and because he identified Dr. Ruiz that
9 information was included there as referred by?

10 A. That's correct.

11 Q. I think you were asked to read all of your notes
12 other than the one from 1994, and I can't make that
13 out. It looks like it's questionable.

14 A. Inner ear problem. He had it for about five to
15 seven days. I examined him, he had wax in his ears,
16 and the ear drums were normal. Once I examined him and
17 the ear drums being normal, I assumed that was an inner
18 ear problem, put him on Antivert which is specific for
19 inner ear, and he was called and was asked about it
20 five days later, six days later.

21 He was doing better, but had a numbness in his
22 check and wanted to know if he should finish off the
23 treatment, and the answer was yes.

24 Q. Do you know how long his regimen of antibiotics
25 was going on?

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1 in the case for Dr. Ruiz. I have some questions which
2 I would like to ask you as well.

3 A. Certainly.

4 Q. First of all, turning your attention to your
5 chart again and looking in the far right upper corner,
6 there appears to be a telephone number, right?

7 A. Yes.

8 Q. What does it say right above that phone number;
9 do you know?

10 A. Work number, W-O-R-K, work. I didn't write it.
11 That's a work phone number, that much I know.

12 Q. You don't know when that was recorded, do you?

13 A. No, sir.

14 Q. What is the F after Dr. Ruiz's name?

15 A. Family.

16 Q. Family doctor?

17 A. M-hm. We make -- let me just make a statement.
18 We make it a very important issue here at this office
19 to refer back to family physicians, family
20 practitioners, any time a patient is being sent here.

21 Q. It says referred by Dr. Ruiz up here
22 (indicating)?

23 A. That's correct.

24 Q. Would it be a correct conclusion that information
25 was included prior to the patient's visit of

1 A. That's not an antibiotic. Antivert is a balance
2 mechanism medication. Antivert means antivertigo,
3 basically. It's similar to Dramamine, Bonine,
4 Meclizine; they are all the same. Basically it's
5 specific for inner ear function.

6 Q. Did he present to you a list of symptoms
7 prompting you to put in your note there was a question
8 concerning whether he had an inner ear problem?

9 A. His history, in other words, I wasn't certain
10 whether it was dizziness or lightheadedness, and many
11 times I'll put down questionable inner ear as I'm
12 talking to the patient because it doesn't sound like an
13 inner ear problem.

14 Q. Do you remember in this particular circumstance
15 what he told you that prompted you to reach that
16 conclusion?

17 A. Only that it was a five- or seven-day history.
18 Let me explain to you. They'll say, Doctor, I have
19 been dizzy for six years, and you say, stop a minute,
20 don't use the word dizzy and tell me how you feel.
21 Then they would tell me every time they stand up the
22 room spins until they sit down. That's not a dizzy
23 patient. They'll tell you the room has been spinning
24 for the last three or four days, and it isn't any
25 better. Now you have got an inner ear problem. At

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1 this point he didn't give me a history for inner ear.
 2 Q. It's clear, though, as to what symptoms he told
 3 you he had?
 4 A. That's correct, other than I just questioned
 5 whether it was the inner ear.
 6 Q. The numbness that he identified in his left
 7 cheek?
 8 A. Yes.
 9 Q. Can you account for that?
 10 A. No.
 11 Q. That's not a common development of a person
 12 taking the Antivert?
 13 A. No, no.
 14 Q. It's not a symptom normally presented with an
 15 inner ear infection?
 16 A. That's correct, it is not.
 17 Q. I had understood you to say that you knew in
 18 advance that he was not going to come on the 25th, or
 19 did he just not show up?
 20 A. He just did not show up. He thought he was
 21 better. He had the appointment, but he didn't show up.
 22 Q. Had he called to cancel would that have been
 23 noted on your chart?
 24 A. Yes.
 25 Q. Now, according to this record you did not see or

1 A. If it were an emergency, for example, if you
 you
 3 morning and said, look, I have got a bad ear infection,
 4 I've been coming to Dr. Babyak, but what are we going
 5 to do about this ear infection, the girls would tell
 6 you to come in right now and whoever was available at
 7 that point would see you.
 8 Q. Would you have any way of knowing when David
 9 called in to make the June 14th appointment?
 10 A. I don't know that our appointment books if we
 11 were to go back that far would record that, but I would
 12 have to answer no.
 13 Q. Currently do you make a note of when someone
 14 calls to schedule an appointment?
 15 A. I'm saying if we would have had the appointment
 16 book, but I don't know if we have it from that date.
 17 It may have been noted on there when the patient
 18 called. Now with the computer we're able to give you
 19 all that information in a blink of an eye.
 20 Q. When you saw him then on the 14th of June he had
 21 wax in each ear, correct?
 22 A. That's correct.
 23 Q. I'm not sure I read correctly the note you have
 24 about his cough, does it say chronic?
 25 A. Chronic cough, etiology I wasn't sure.

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1 hear from David from November of 1994 until the first
 2 time on June 14th, 1995.
 3 A. That's correct.
 4 Q. I'm unfamiliar with your office, but I can see by
 5 your parking lot that there are a lot of patients that
 6 come through.
 7 How long is it typically that a patient must wait
 8 to actually get into the office from the time he calls
 9 seeking an appointment?
 10 A. In 1995 we would have had, let's see, four of us,
 11 so probably 24 hours at the maximum unless I'm out of
 12 town or somebody is out of town and he wanted to
 13 specifically see us.
 14 Q. Do you share patients among your colleagues?
 15 A. Oh, sure. This morning I probably saw three
 16 patients of my colleagues that had problems. I said
 17 slide them on in, and I took a look at them.
 18 Q. Do you know whether or not David had ever been
 19 seen by any of the other physicians in your group?
 20 A. If it's not in here, he was not.
 21 Q. Do you know whether he scheduled an appointment
 22 specifically when you would be available to see him?
 23 A. I'm assuming, yes.
 24 Q. I just want to make sure I understand. He could
 25 see someone within 24 hours, but not necessarily you?

1 Q. Chronic cough, C-O-U-G-H?
 2 A. That's right. I have the world's worst
 3 handwriting.
 4 Q. Going from your original chart, the entries in
 5 red are from the nurse and the ones in blue are
 6 primarily from you?
 7 A. That's correct. Some of the entries in blue,
 8 however, could be from the nurses as well.
 9 Q. Did he identify to you on that visit how long he
 10 had that cough?
 11 A. I don't remember.
 12 Q. Do you know whether he used the word chronic or
 13 that was a medical conclusion that you reached?
 14 A. That was just my conclusion which would lead me
 15 to believe that it had been going on, but specifically
 16 you asked me, no, he didn't say. If I put chronic it
 17 must have meant it was going on before I saw him.
 18 Q. If a patient presents to you with a cough, that
 19 certainly is one type of symptom which could
 20 conceivably be caused by a condition that an ENT
 21 specialist has been trained to treat?
 22 A. That's correct.
 23 Q. Are there reasons that a patient may have a cough
 24 concerning which an ENT I not be the
 25 specialist?

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1 A. Yes, I think if you had some damage to the
2 diaphragm or any type of injury to the phrenic nerve
3 which could cause a cough, sometimes injuries to the
4 vagus nerve will cause a cough, or patients with
5 pulmonary problems whether it be infection, bacterial
6 pneumonia, whether they have tumors or foreign bodies.

7 Now, foreign bodies we as ENT men would treat
8 that. You have a chronic cough for a long period of
9 time, you do an X-ray, and something is stuck in a
10 lung, there is a piece of plastic in there. That's a
11 chronic cough.

12 So there are reasons that we would get into the
13 lungs. Not necessarily infection or inflammatory or
14 phrenic or diaphragmatic or vagus; those would be areas
15 that we would not be looking at.

16 Q. Would it be correct, Doctor, that upon your
17 evaluation of a patient presenting with no symptoms,
18 one of the things you have to do is identify whether
19 you are the type of specialist that should be
20 overseeing his care; is that correct?

21 A. That's correct, absolutely.

22 Q. Can you conclude from the fact that you made a
23 prescription for him and arranged for his follow-up
24 care that you determined the reason he was having this
25 cough was something that an ENT specialist would be

1 Q. I was just trying to get an example. If you
2 thought the problems were related to the lungs?

3 A. Certainly I would call the family physician
4 first, and if he said, let's refer him to a
5 pulmonologist, I'd say, do you want me to do it or you
6 do it.

7 Q. You did not refer this to any other
8 consultants at all during the course of his treatment?

9 A. That's correct.

10 MS. HARRIS: Excluding the
11 call to Dr. Ruiz.

12 A. Dr. Ruiz, right. He's asking for other
13 specialists other than Dr. Ruiz, or are you saying
14 Dr. Ruiz as well. Are you including him in that group?

15 Q. Let's include him. I wasn't thinking of him when
16 I asked the question.

17 A. If you were to include him, yes, my call would be
18 to him.

19 Q. I don't know if I misheard you earlier or if you
20 misstated yourself, but you said that chart reflected
21 you had a conversation with Dr. Ruiz on the 10th of
22 July. I thought I heard you say that.

23 A. That's correct.

24 Q. How do you know that, I guess, is my question.

25 A. Excuse me just a moment.

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1 able to appropriately treat?

2 A. That's correct.

3 Q. If it had been your suspicion that it was a
4 condition that someone else would be in a better
5 position to diagnose and treat, would you then have
6 recommended a referral to that patient?

7 A. Certainly, in a blink of an eye.

8 Q. That certainly is something within your regular
9 practice, is that correct?

10 A. On a daily basis. In fact, I can specifically
11 think of two patients this morning that I said, look, I
12 don't have an answer for you, and I'm going to call
13 someone who might.

14 Q. For if you had some suspicion that a
15 patient was cardiac in origin, you would have
16 made arrangements for him to have seen a cardiologist?

17 A. I will answer that question by saying, I don't
18 know that I would be suspicious of a cardiac problem
19 since I'm not a cardiologist, and I would have no idea
20 of what symptoms would arise from a cardiac problem.
21 The one area where we do is when we see a right vocal
22 cord paralysis. Right vocal cord paralysis in most
23 instances is due to a hypertrophy of the right side of
24 the heart, but that is the only time in my mind I would
25 say cardiac.

1 MS. HARRIS: You can say
2 what you want.

3 A. Whenever there is a patient that something is not
4 quite right, I dictate notes, so I have a note here
5 dictated shortly after I had heard that the patient
6 expired. It's a brief summary of everything that went
7 on in the case that I recalled at that point.

8 MS. HARRIS: Just so you
9 know, that's not a part of his chart.
10 That was because he anticipated
11 that so this would be privileged.

11 THE WITNESS: Not for
12 that, I'm telling you, I dictated it
13 myself. I dictated it if you want to read it.
14 That's in there. This has nothing to do
15 with that (indicating). That's not part
16 of the medical record, but that's
17 something I keep.

18 MR. MALIK: Is there
19 another copy of it?

20 THE WITNESS: NO.

21 MR. TRAVERS: off the record.
22 (Thereupon, there was a discussion
23 off the record.)

24 MR. MALIK: I'm paying for
25

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1 the deposition, and I want you to take
2 this down.

3 THE WITNESS: -- conceal
4 anything from anybody, but primarily to
5 make certain that when you ask me
6 questions about it, I can at least recall
7 it.

8 MR. TRAVERS: Are we on the
9 record or off?

10 MR. MALM: I just asked
11 her to go on the record.

12 BY MR. TRAVERS:

13 Q. Basically what you have shown us is a *summary* of
14 what is on your chart?

15 A. No major variations there, but when I was asked
16 how did I remember certain things like that, it was
17 going back to the sheet like this and looking at it.

18 Q. Do you recall when it was that you prepared that
19 sheet you are holding?

20 A. Probably shortly after August the 18th.

21 Q. Do you have any-more observations of your
22 telephone conversation with Dr. Ruiz other than what is
23

24 A. Some substance of the conversation was probably
25 that I have looked this kid over, and I don't have

1 recess.)

2 BY MR. TRAVERS:

3 Q. Doctor, I'll tell you the reason I asked. I'm
4 not interested in seeing what his tonsils look like,
5 but in Dr. Ruiz's chart he had a note from the latter
6 part of May indicating when David came to see him he
7 had previously been to see you sometime shortly before
8 that, and there is no appointment of that nature
9 identified in the records.

10 A. November the 12th of '94.

11 Q. Well, he hadn't complained of coughing at that
12 point in time?

13 A. That would probably be the visit. I don't know
14 what more to say to you.

15 Q. I'm just wondering if perhaps you had an old
16 chart?

17 A. That's the current chart. The old chart would
18 probably represent whatever might have been done, if
19 anything, 20 years ago, 15 years ago. No, this was the
20 only record that we would have, and the only visits are
21 there. There would be no way he would have gotten in
22 and seen me and left without anything going on the
23 record.

24 Q. I see that there is a note on June 26th
25 concerning the telephone call.

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1 anything more to help you with. Maybe you ought to
2 evaluate him more thoroughly. That would be about it.
3 That would be the sum and substance, to make sure he
4 got back to the family physician.

5 I do this quite regularly. I have been around
6 here long enough to know I don't know all the answers,
7 and when I don't know the answer, by God, I'm going to
8 get him to someone who does. I do that quite regularly
9 without any games or any vain attempt to think that I
10 can do everything. I can't, and I know it.

11 Q. Do you recall whether or not you had any other
12 conversations with Dr. Ruiz during the summer of '95
13 about that patient, from June the 14th until after his
14

15 A. After his death, just to find out what was wrong,
16 what happened, because I didn't hear anything. I
17 didn't get any feedback other than the notice from the
18 pulmonologist.

19 Q. Is it possible, Doctor, that you have another
20 chart on David Gonda somewhere?

21 A. No, I don't.

22 Q. You had indicated that you took his tonsils out
23 you thought. Would that record still be around?

24 A. Let me ask one of my girls if it is on microfilm.
25 (Thereupon, there was a brief

1 A. That's correct.

2 Q. Whenever a patient makes a call to the office is
3 it recorded in this chart?

4 A. Just a second, not June 26th -- yes, yes, we
5 record all phone calls, anything that's said, anything
6 that's discussed, anything that's commented on, yes.

7 Q. Well, for example, if a patient calls to schedule
8 an appointment, that's not necessarily recorded on this
9 chart?

10 A. That would go to scheduling, go into the
11 scheduling book, not necessarily on the chart.

12 Q. Has there ever been a circumstance when someone
13 called for an appointment and someone from your office,
14 you or probably a clerk, would take care of calling in
15 a prescription for the patient based upon the telephone
16 report while he was ready to come in or awaiting a
17 conference with you?

18 A. We regularly do that, yes. I don't think we're
19 alone there. Let's put it that way.

20 Q. I don't mean to suggest that you are. I'm
21 wondering whether such an event occurred with Mr. Gonda
22 prior to his first presenting to you upon June 14th?

23 A. If I were to state it's impossible, that's not a
24 correct statement, but it would be highly unlikely.

25 Q. Because if a call of that nature had been made

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1 the likelihood is it would have been recorded in this
2 chart?

3 A. Yes.

4 Q. Between the 14th of June and the 10th of July of
5 1995 were you aware of whether or not David was
6 receiving medical care from any other providers
7 contemporaneously with your own?

8 A. No, sir, I was not.

9 Q. Would you agree, Doctor, that during that period
10 from June 14th to July 10th that in your own mind you
11 were the person who was orchestrating the investigation
12 to try to identify the etiology of his chronic cough?

13 MS. TRAVIS: Objection.

14 A. Was I the physician that was taking care of him,
15 yes. As far as orchestrating anything --

16 Q. That's not a medical term?

17 A. I was basing all of what I did based on clinical
18 judgment and previous experience, yes.

19 Q. That's all I was asking. I guess what I meant
20 was you were not relying on counsel from other
21 consultants or practitioners.

22 A. No.

23 Q. You believed that you were the only doctor seeing
24 this patient for this condition?

25 A. That's correct.

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1 Q. During that period of four weeks or so you were
2 primarily concerned with trying to identify the cause
3 of his cough?

4 A. That's correct.

5 Q. And you were unable to do so?

6 A. I eventually found that to be the case, yes.

7 Q. Have you ever had patients come to your office
8 who suffered from endocarditis?

9 A. I wouldn't know. I would know it only by the
10 history that they had told me they had it. We do a
11 number of procedures on patients who will tell me they
12 had either a valvular problem or endocarditis that had
13 been treated. If we are going to do surgery we have to
14 give them preoperative antibiotics and postoperative
15 antibiotics. That's the only way I would know is if
16 the patient made me aware that we would have to do
17 that.

18 This is not an uncommon thing with children,
19 either, who have cardiological problems that need
20 treatment with antibiotics with surgery. I'll refer to
21 the cardiologist and say, okay, I'm going to do ear
22 surgery, would you get the kid ready, or they would
23 send me a memo of what they wanted me to do.

24 Q. You see a lot of patients with coughs, I'm sure.

25 A. Yes.

1 Q. Do you know, Doctor, from your training and
2 experience whether a cough is a symptom that can be
3 suggestive that a patient has endocarditis?

4 A. I'm sure if you were to catch me back in 1959 or
5 '58 I might have answered that question. Since I have
6 not treated endocarditis or any type of cardiac
7 problem, I wouldn't know.

8 Q. But when a patient comes in to you With a cough,
9 endocarditis is certainly not something that pops into
10 your mind?

11 A. That's correct. There is about a thousand and
12 one reasons that a patient would have a cough.

13 Q. Did you consider whether or not to do any
14 cultures, blood cultures, on the patient?

15 A. Blood cultures, I don't think that I have with
16 any patients other than patients in the hospital with
17 pulmonitis infections. Blood cultures, no.

18 Q. Doctor, believe me, I think we all realize that
19 you would be out of business if you wrote down every
20 word that every patient told you coming through your
21 office, but if a patient came in with substantial
22 physical complaints you would normally make some note
23 of that specifically on your initial assessment,
24 correct?

25 A. Of course.

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1 MR. MALM: objection.

2 BY MR. TRAVERS:

3 Q. So when this patient came in on the 14th of June
4 he did not report to you any substantial symptoms other
5 than having this chronic cough; would that be accurate?

6 A. That's correct.

7 Q. With your 30-some years of experience, at that
8 point in time were you able to make a reasonably
9 accurate judgment as to whether a patient was seriously
10 ill when he came in to see you for the first
11 assessment?

12 A. I would hope so.

13 Q. If a patient did present in that circumstance,
14 you would make a note of that in your chart?

15 A. Certainly.

16 Q. That's not the case with David?

17 A. That's correct.

18 Q. This young man had a cough but did not appear to
19 be in serious physical distress?

20 A. That's correct.

21 Q. When you prescribed the Duricef on June 14th, the
22 way it is written is not entirely clear, the Duricef
23 was not for his ear wax; is that correct?

24 A. That's correct. Again, a lot of this is written
25 after the fact; in other words, after I'm sitting there

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1 talking to the patient and we're getting ready to head
 2 out the door I'll write a whole series of things
 3 together, and they might not be in chronological order.
 4 Q. The Duricef was prescribed --
 5 A. For the cough, for what I felt was the etiology
 6 of the chronic cough which was pharyngitis, again,
 7 probably on a viral basis. That was basically it.
 8 Q. When the patient came back ten days later --
 9 could you just read this to me?
 10 A. There was viral pharyngitis that I was still
 11 thinking of as my diagnosis. The temperature was
 12 elevated. We switched antibiotics, switched to a very
 13 specific pharyngeal antibiotic as I implied earlier.
 14 Q. My sense was that by writing Viral pharyngitis
 15 there you were communicating to yourself through your
 16 chart that you were a little more concerned about his
 17 condition on the 24th than you had been on the 14th.
 18 A. That plus the temperature, yes.
 19 Q. Had his physical condition in your judgment
 20 deteriorated between the 14th and the 24th?
 21 A. Not his physical condition, just his overall
 22 demeanor. He just looked like he wasn't feeling well
 23 that day. I have said that on several occasions.
 24 Q. Which you felt was a change since the last time
 25 he visited you?

1 didn't have a clue as to what was going on at that
 2 point. I just knew when I examined him with the
 3 fiberoptic scope that I wasn't seeing a whole lot in
 4 there that was out of line.
 5 Q. Generally, though, a patient with a cough that
 6 you cannot diagnose from an ENT perspective, your next
 7 suspicion would be that it was a pulmonary problem;
 8 would that be accurate?
 9 MR. MALIK: Objection.
 10 A. Yes. Based on the question that you asked, yes,
 11 it would be, yes.
 12 MR. TRAVERS: That's all the
 13 question that I have, Do . Thank .
 14 very much.
 15 MR. GRIFFIN: You know, I
 16 don't have any questions. I just want to
 17 make sure that I get the part of the
 18 patient registration or history form that
 19 was filled out by David Gonda and a copy
 20 of whatever it is that was referred to
 21 here ;
 22 MS. HARRIS: No . . . ,
 we'll get you both. Steve, . . . I want
 that registration form faxed to you?
 MR. GRIFFIN: I didn't see

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1 A. Yes.
 2 Q. You were not aware during the time you were
 3 seeing this patient that Dr. Cropp had any involvement
 4 in the patient's care?
 5 A. I did not until after I received the letter which
 6 was on the 13th of July.
 7 Q. The first communication you received from the
 8 pulmonologist's office was after the last appointment
 9 you had with David?
 10 A. That's correct.
 11 Q. What was your anticipation on the 10th of July
 12 concerning any follow-up that David would have with
 13 your office?
 14 A. He would not.
 15 Q. I'm sorry?
 16 A. He would not have any further follow-up.
 17 Q. After the 10th of July you didn't plan to see him
 18 anymore?
 19 A. That's correct.
 20 Q. When you suggest in your little summary there
 21 that you communicated to Dr. Ruiz the possibility of a
 22 medical problem, would a pulmonary complication be
 23 something that you had in mind?
 24 A. I was again thinking that was a possibility, but
 25 I didn't have anything specific in mind. I really

1 that.
 2 MS. HARRIS: It's a
 3 handwritten sheet by the patient. We'll
 4 get it to you, no problem.
 5 MR. TRAVERS Don't hold your
 6 breath, Steve. It's not going to
 7 determine the outcome of the case.
 8 MR. GRIFFIN: okay, Tom.
 9 MR. MALIK: I have a few
 10 more questions.
 11 - - -
 12 BY MR. MALIK:
 13 Q. Doctor, are there any other documents related to
 14 David Gonda that you have not shown us?
 15 A. I don't like that term, but I'll answer the
 16 question. It's not that I didn't want to show them to
 17 you, but those are just private notes. Basically, no,
 18 there are none. Well, let me ask one more thing.
 19 Let's see whether anything has happened here.
 20 (Thereupon, there was a brief
 21 recess.)
 22 A. The answer is no.
 23 Q. Did Dr. Ruiz refer David Gonda to you for his
 24 appointment, I think it was on June 14th of '95?
 25 A. I have no knowledge if he did or did not.

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1 Q. Do you know Dr. Ruiz socially?

2 A. I know Dr. Ruiz because he and I basically
3 started to practice about the same time, and when I was
4 living in Poland he lived about a quarter of a mile
5 away. Socially, no, just to know him and talk to him
6 about the kids and how things were going and how his
7 house was doing and that sort of thing.

8 Q. How long have you had a professional relationship
9 with Dr. Ruiz?

10 A. Oh, good heavens, it has got to be 30 years or
11 more.

12 Q. When you *think* of Dr. Ruiz, do you *think* of
13 Dr. Ruiz as a family practitioner or do you *think* of
14 Dr. Ruiz as a cardiologist?

15 A. I think of Dr. Ruiz as a darned fine family
16 practitioner. That's what I can tell you about it. I
17 wouldn't hesitate to send anybody to him.

18 Q. Are you aware that he holds himself out in the
19 community as a cardiologist?

20 MR. TRAVERS: objection. He
21 does not, David.

22 BY MR. MALIK:

23 Q. In terms of the coordination of David Gonda's
24 care during the time you saw him, is it your opinion
25 that Dr. Ruiz, for lack of a better term, was a field

1 A. That's correct.

2 Q. Then how did it come about that Dr. Ruiz called
3 you when David died to inform you?

4 A. He did not; I called him.

5 Q. How did that come about, then?

6 MS. HARRIS: Asked and
7 answered for the third time.

8 A. It was just professional curiosity. Why I want
9 to know is maybe they have got a reason for the chronic
10 cough that I might look for the next time around, that
11 sort of thing. He didn't call me; I called him.

12 Q. Do you as a physician have an obligation to refer
13 patients to the proper specialist when you suspect
14 another cause for an illness or when you can't
15 determine it yourself?

16 A. That's correct. I do that quite regularly.

17 Q. Did you refer David to anybody else?

18 A. No, sir.

19 MS. HARRIS: other than
20 Dr. Ruiz.

21 A. Other than Dr. Ruiz. When you phrase the
22 question, I'm assuming you mean that.

23 Q. You indicated earlier that you knew the Gonda
24 family. Who in the Gonda family did you know?

25 A. I don't know if they are related to the Gonda's

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1 general with respect to his care?

2 MS. HARRIS: objection. Now
3 we're getting far afield, David. Just let
4 me finish. As an attorney I have the
5 right to tell you my objection, and then
6 you can clear the question up if you want.

7 Using a term like field general is
8 improper in terms of describing the
9 relationship. He has already testified
10 that he had no knowledge, and we have no
11 knowledge because we have never seen any
12 record as to whether or not Dr. Ruiz was
13 treating him in the June/July time period,
14 so to say field general or any of those
15 terms is totally inappropriate in a
16 deposition such as this.

17 MR. MALM: Thank you,
18 Beverly.

19 MS. HARRIS: YOU have heard
20 those speeches before.

21 BY MR. MALM:

22 Q. I'm going to go back to my question, Doctor, is
23 it in fact your testimony today that you had no
24 knowledge that Dr. Ruiz was involved in David's care
25 while you were seeing him?

1 one way or another, but I think they all are. Steve
2 Gonda was a very close friend of mine. Steve Gonda
3 used to run a dry-cleaning shop in the lower south
4 side. I lived right across the street. Steve Gonda
5 was kind enough to provide me with a job during summer
6 vacations. I knew Steve, Cyril, there were four or
7 five daughters. They had sons and daughters, and I'm
8 sure they kept growing up to be more Gondas.

9 Q. I your rec Doctor, do you refer pa
10 for echocardiography?

11 A. Absolutely not.

12 ? Whose job would it be to refer the ti for an
13 echo, refer David for an echo?

14 A. I would say anybody that's versed in cardiology
15 that would suspect there was a cardiological problem
16 would do so. I can't answer the question other than to
17 say I would not.

18 Q. In your practice do you interpret EKGs?

19 A. No, sir. I read the interpretations, but I don't
20 interpret them.

21 Q. When you referred David back to Dr. Ruiz you
22 referred him to for the remainder of his treatment,
23 correct?

24 A. That's correct.

25 Q. Did you refer him back with the idea that you

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1 were going to leave the diagnosis up to Dr. Ruiz?
 2 A. The phrasing of the question -- I'll answer it
 3 this way. I gave Dr. Ruiz no indication that an ear,
 4 nose and throat specialist could help him in any way.
 5 I could not help him with the diagnosis, period.
 6 As to what steps he was to take, that would be
 7 entirely up to him as a family physician. I merely
 8 implied to him that I had no further answers for him, I
 9 could be of no further help, and perhaps he should look
 10 for a complete work up which is what I said to him.

11 Q. You had said to me in your direct examination,
 12 and these were the words you used, that you were very
 13 concerned.

14 A. That's correct.

15 Q. About the cough?

16 A. That's correct.

17 Q. Just so we're clear on the record, you weren't
 18 just a little concerned as Mr. Travers said, this was a
 19 significant event to you; is that correct?

20 MS. HARRIS: When?

21 A. At the time this occurred, and that was when his
 22 mother came in with him, there was a concern on both
 23 parts that this was a youngster that wasn't getting
 24 better. When I have got family members that are
 25 concerned, by God, I get concerned, too, okay, and

1 problems?

2 MS. HARRIS: objection.

3 A. I don't know if I would phrase it that way, but I
 4 know on the 10th of July my thought was that he's about
 5 the same age as my son and, by God, we ought to get to
 6 the bottom of it.

7 Q. But you're really thinking as a physician what is
 8 causing these problems?

9 A. Yes.

10 - - -

11 BY MR. TRAVERS:

12 Q. Just to clarify one point, and I promise that's
 13 all.

14 A. Certainly.

15 Q. There was a discussion about your referring the
 16 patient back to Dr. Ruiz.

17 A. It was not a referral. I just called Dr. Ruiz
 18 and told him, your patient. It's not a referral. I
 19 let the word go by simply because it's just a matter of
 20 wording.

21 Q. Did you talk to David about continuing to secure
 22 follow-up care for his condition?

23 A. Sure, when he and his mother were there. That
 24 was one of the things I always ask. We have a lot of
 25 patients that come in here with a lot of problems.

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1 that's basically it.

2 MS. HARRIS: Tell him the
 3 date of that so it's clear on the record
 4 for everyone.

5 A. The date was the 10th of July that she came in
 6 with him, and she had not come in before.

7 Q. Is it a fair statement to say that we have David
 8 concerned, you indicated that to me?

9 A. Right.

10 Q. We have his mother concerned?

11 A. Right, no question.

12 Q. We have you concerned?

13 A. Right, and that was why when I couldn't find
 14 anything on the fiberoptic laryngoscopy I felt it was
 15 time for him to move on and look for a more definitive
 16 cause.

17 I'd like to make a statement. I looked back in
 18 this case and I tried to review whether I should have
 19 done anything different, and the answer is no. I don't
 20 think that based on clinical experience I would have
 21 changed any part of the treatment that I did even
 22 knowing the outcome.

23 Q. At any time during your treatment of David did
 24 you say to yourself, why is this 27 year old kid who
 25 used to love to play basketball sick or have these

1 Some types I can't handle. I tell the family, look,
 2 there is a guy over in Warren by the name of Lippy. I
 3 know him personally. Do you want to go see him? If
 4 they say yes, I make arrangements.

5 Q. But you didn't make specific inquiries as to the
 6 exact type of follow-up care that David would pursue?

7 A. No, I did not. Did I make a phone call the next
 8 day to find out, no.

9 MR. TRAVERS: Thanks. That's
 10 all I have.

11 MS. HARRIS: Steve?

12 MR. GRIFFIN: Nothing here.

13 - - -

14 (Thereupon, Plaintiff's Exhibits A,
 15 B, C and D to the deposition of SAMUEL
 16 ADORNATO, M.D. were marked for
 17 identification.)

18 - - -

19 (DEPOSITION CONCLUDED.)

20 - - -

21

22

23

24

25

SAMUEL ADORNATO, M.D.

DATE

CERTIFICATE

1 state of Ohio,
2 County of Cuyahoga.

} ss:

3

4 I, Cynthia A. Sullivan, Notary Public within and
5 for the ~~State~~ of ~~Ohio~~, duly commissioned and qualified
6 do hereby certify that the within-named witness,
7 SAMUEL ADORNATO, M.D. ~~was~~ by me first duly sworn to
8 tell the truth, the whole truth and nothing but the
9 truth in the cause aforesaid; that the testimony then
10 given by him was reduced to stenotypy in the presence
11 of said witness, and afterwards transcribed by me
12 through the process of computer-aided transcription,
13 and that the foregoing is a true and correct transcript
14 of the testimony so given by him as aforesaid.

15 I do further certify that this deposition was
16 taken at the time and place in the foregoing caption
17 specified.

18 I do further certify that I am not a relative,
19 employee or attorney of either party, or otherwise
20 interested in the event of this action.

21 IN WITNESS WHEREOF, I have hereunto set my hand
22 and affixed my seal of office at Cleveland, Ohio, on
23 this 11th day of June 1998.

24 Cynthia A. Sullivan, Notary Public

25 in and for the State of Ohio.

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