State of Ohio,) SS:

County of Mahoning.)

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IN THE COURT OF COMMON PLEAS

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DOROTHY A. GONDA, et al.,)

Plaintiffs,)

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

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

Defendants.)

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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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APPEARANCES:

On behalf of the Plaintiffs:

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

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on behalf of the Defendants Alan J. Cropp, M.D., Pulmonary Medicine consultants, Pulmonary Rehabilitation Associates and Robert DeMarco, M.D:

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Also Present:

Betty Clarke
Marnie Loveland

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SAMUEL ADORNATO, M.D.
a witness, called for examination by the Plaintiffs, under the Rules, having been first duly sworn, as hereinafter certified, deposed and said as follows:

CROSS-EXAMINATION

BY MR. MALIK:

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

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

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

A. Yes, I do.

Q. Whose handwriting is on that form?

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

Q. Why is that form generated?

A. Why is it generated?

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

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

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

Q. Do you consider this a form for consent to treatment?

A. Wow, no.

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

A. I would hesitate to even answer that question.

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

A. That's correct.

Q. Do you recall when that was?

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

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

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

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

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

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Q. Do you recall that examination?
A. Yes, in a sense that I recall it by what I have written in the chart here. Do I see it in my mind, no.
Q. Do you recall the degree of cough that he had; in other words, was it a small cough, a chronic cough, how would you characterize it?
A. It didn't, I would say, alarm me at all. It just sounded like so many other patients I have seen over a period of years, literally thousands, with chronic coughs.
Q. This is not very scientific, just to give me a feel for it on a scale of one to ten where was his cough?
A. Ten being the worst?
Q. Yes.
A. Probably about a three. That was the first visit.
Q. Did he present with any other symptoms at that time?
A. None whatsoever, nothing that he gave to me.
Q. Did you prescribe any medication for him?
A. Yes, I ordered an antibiotic which is called Duricef.

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

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worth it. I rarely culture a sore throat unless it's one that really worries me.
Q. When you were in the military and you were doing the throat cultures, did you also have the opportunity to culture throats that you thought were positive but came up negative?
A. I don't recall that. We would just culture throats of asymptomatic people. We were just going to see what we could find by doing patients without any sore throats.
Q. Now, in your practice when you do perform a throat [illegible] which lab does it go to?
A. Well, the ones that we would do originally would go to St. Elizabeth. I would have them go over to St. Elizabeth's actually and have the technologists there do the culture. Now of course the lab comes, and they pick it up for us.
Q. W[illegible] bou[illegible] 1995, dc you recall?
A. At that point I think we were probably using Brodmor Labs, I think. I can't be certain where they were going at that point.
Q. What would [illegible]u expect the [illegible]lt [illegible]i[illegible]t be [illegible]d?
A. I don't know.
Q. What possibilities are there?

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MS. HARRIS: Objection.
A. I don't know.
MS. HARRIS: Objection.
A. I'm not a clinical bacteriologist. I don't have any idea. I can recall going back years when I was in medical school, but that's a long time ago.
Q. Was it July 14th that you saw him?
A. Saw him July 14th, 1995.
MS. HARRIS: June.
BY MR. MALIK:
Q. June 14th?
A. June, yes, June 14th.
Q. Now, at that time did you report any of your findings to Dr. Ruiz?
A. No.
Q. Can you remember anything else from that visit as we sit here today?
A. No, not really.
Q. When was the next time you saw him?
A. I think the next time was ten days later. He would have come back as requested for a follow-up visit. That was on June 24th, 1995.
Q. When you saw him on June 14th of 1995 did you take his temperature?
A. No.

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Q. When you saw him on June 24th of '95 did you take his temperature?
A. Yes, we did.
Q. What method in this office did you use to take temperatures in 1995?
A. I think we were using the -- we didn't have an ear temp., so we were using the instant under-the-tongue temperature, not the usual mercury, but under-the-tongue.
Q. Is that the one with the plastic cover?
A. Yes.
Q. Is the temperature [illegible] you would take?
A. No, one of the nurses would take that.
Q. Is there a reason that you ca[illegible]inl of [illegible]h[illegible]s temperature wasn't taken in the previous visit?
A. Probably clinically I didn't feel the need for it at that point.
Q. What were his symptoms, what were his symptoms on June 24th other than the temperature?
A. On June 24th the patient came in, and I recall he didn't -- he looked like someone who had a viral infection. He was still complaining of the cough. He was still complaining of an irritated throat. At that point we did a temperature on him, and we got the 101.4 oral temp.

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Q. You said he looked like a person with a temperature and looked like a person with a cough.
A. He looked like a person with a viral infection.
Q. What does a person look like with a viral infection?
A. Looks miserable, that's all.
Q. Can you also look miserable when you have a bacterial infection?
A. I have not been aware of that. Patients come in with some bacterial infections, and with the exception of the local area that's infected, they don't really look clinically as sick as someone who has got a common cold or a viral infection, no.
Q. Can you describe to me how he looked, can you tell me how he looked?
A. No. You mean looking at him?
Q. Starting from the top of his head to the bottom of his chin, how did he look?
A. No, not according to what I have written here.
Q. Then how is it that you remember that he looked like he had a viral infection?
A. Because I have got it written.
Q. So a viral infection in your mind means that he didn't look right?
A. In fact, that's what prompted me to take the

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temperature, the fact that the youngster came in, didn't look like he was feeling very well, still had a cough, again, just not looking good.

I think you're asking a question that if I were to see one patient per day I could probably in great detail describe everything from the top of his head to the bottom of his feet, just as you would with a client if you only had one, but when you're dealing with an office practice, I don't know that I could describe anyone as you wanted me to.

Q. What I'm thinking is that part of your job is to be a diagnostician, correct?

A. Correct.

Q. How many years have you been doing this?

A. Thirty-six years.

Q. In 1995 you were doing it for 34 years; is that right?

A. It would be about 33, 34 years.

Q. This young man presented to you and he didn't look right?

A. Yes, that's right.

Q. Did you take any weight measurements?

A. No.

Q. What else does your note reveal?

MS. HARRIS: Do you want him

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to read it himself?

Q. If you could, read the note.

A. June 24th, temp. 101.4, viral pharyngitis, treated him with Zithromax, patient still coughing, and I have got written down here the diagnosis -- at this point I'm becoming a little concerned because I'm not getting a good response with the medication, so I put diagnosis and three question marks after it.

Q. What is Zithromax?

A. It's one of the newer generation of products that is an Erythromycin derivative. Zithromax is an antibiotic that has very specific functions as far as pharyngeal, tonsillar and pharyngeal infections, very specific.

Q. Very specific to that part of the body?

A. Very specific to that part of the body.

Q. Are you again at that point thinking of a bacterial infection?

A. No, I'm still thinking that it's a viral problem with the pharyngitis overlying it. Again, I'm treating it as I would based on clinical experience, and I would treat with a second antibiotic.

Q. Zithromax would affect or counter bacterial infections, too, wouldn't it?

A. That's correct.

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Q. Do you know what types of bacteria it would affect?

A. Not specifically, no.

Q. As of this date as you just indicated, you have diagnosis and three questions marks --

A. That's Correct

Q. -- because you did not have a diagnosis?

MS. HARRIS: Objection.

A. A specific diagnosis.

Q. Is it a fair statement to say that the pharyngitis diagnosis is a provisional diagnosis?

A. I would say it's fair, but based on clinical experience.

Q. Let's get this down to basics, what is pharyngitis?

A. It is very simply the appearance of an inflammatory process of the posterior aspect of the throat from above the palate all the way down to the area just above the larynx.

Q. I brought with me a page out of one of the Netter books, that book that you have right there, and I'm going to mark it as Exhibit B.

Can you circle the area we're talking about?

A. We are talking about the pharynx, the nasopharynx and the laryngopharynx.

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Q. That is the area you considered to be affected?

A. The area that's specifically able to be seen is an area right between the two marks (indicating); that is to be seen using just a tongue depressor.

Q. And what is that area called?

A. The pharynx.

Q. What is the function of the pharynx?

A. Two functions; basically it serves as an airway, transfers air either through the mouth or the nose through the area of the larynx through the trachea going into the lungs, and it is also an area where food is propelled down the esophagus into the stomach. It has two functions.

Q. Did you conduct any other type of physical exam of David or did you limit your exam to the head?

A. Just to the head and neck.

Q. Do you recall talking to David about what his symptoms were?

A. Not specifically, no.

Q. The next time you saw David was what date?

A. Well, June 26th. I asked him specifically on the 24th to call me two days later. I wanted to know if we were going in the right direction with the treatment. David did call and say his temperature was down from 101 to 99. He still had a cough. He called in

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

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

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A. Yes-
Q. What was your purpose in doing that?
A. Very concerned now that the chronic cough was there, and I didn't have an answer.
Q. Is it a fair statement to [illegible]y th[illegible] you ha[illegible]e s[illegible]n up through this [illegible] your career [illegible] patients?
A. With sore throats or thousands of patients?
Q. With sore throats.
A. Probably more than thousands, yes.
Q. You certainly saw them in the service, right?
A. No question about that.
Q. Were you a medic or physician in the service?
A. We performed both. We were medics in a sense that we had to run an outpatient clinic, and then specifically in my specialty we ran a clinic for the ears, nose, throat, head and neck.
Q. You used the words very concerned. You have got quite a bit of experience in [illegible], so what was it that you were very concerned about?
A. The inability to get rid of the chronic cough.
Q. Do you recall what was going through your mind at that time?
MS. HARRIS: At [illegible]hat time?
MR. MALIK: I'm talk[illegible]

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

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

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

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

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probably alarmed me more at the end than at the beginning, yes. The temperature I think was there, but it was a symptom, a sign of something going on.
Q. Is it a fair statement to say that when you have a chronic cough like this there is one set o
ossibilities that cough could rom
but o add pt a that
an additional set of s
MS. HARRIS: objection.
A. No, I still think you have your original set of possibilities. The fever may be just an adjunct to the original set. I don't think it adds a new set of possibilities, no, with the exception of one which would be if you had a fulminating pneumonia. Boy, you don't see those anymore.
Q. When you're thinking differential diagnosis, you didn't eliminate anything from your differential diagnosis here?
MS. HARRIS: objection, I'm not sure what you mean by eliminating.
BY MR. MALIK:
Q. Did you eliminate any possibilities?
A. In regards to the ears, nose and throat, at the beginning I didn't eliminate any, you're right. As far as at the beginning, we are just talking ears, nose and

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throat.
Now, again, there are many reasons for a chronic cough, you know. You can elicit a cough in a patient by cleaning wax out of the ears. There are a number of reasons from an ENT standpoint.
Q. From an ENT standpoint what would be a reason for a chronic cough?
A. The most predominant would be post nasal drainage for some reason whether it be a viral infection, common cold, allergy, hay fever, some irritant.
Q. Did David have any vocal cord dysfunction when you saw him?
A. No, not according to my chart.
Q. Doctor, what is the difference between pharyngitis and laryngitis?
A. The location. In the diagram that you pointed to the pharynx would go anywhere from the back of the nose all the way to the larynx. You have your nasopharynx, oropharynx, hypopharynx, so any one of those three are still in the pharynx. Once you get to the vocal cords you're not confined to the larynx.
Q. What are the causes of laryngitis?
A. Multiple, multiple causes for laryngitis. You can get laryngitis from cancer, you can get laryngitis from vocal cord nodules, you can get laryngitis from

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post nasal discharge, from having surgery with a tube they put in the throat; I can go on and on.
Q. The [illegible] I asked you is that at some point Dr. Ruiz' [illegible] became laryngitis; were you [illegible] of that?
A. No.
Q. Did he ever consult with you regarding that?
A. No.
Q. When you saw David did you agree or disagree that he had laryngitis?
A. I did not detect any laryngitis. Again, let's back off. The first two examinations would not have demonstrated laryngitis, but the third exam with the fiberoptic scoping would, and it did not show it.
Q. What was the first diagnosis?
A. Ear infection.
Q. Can you tell me based upon your experience what percentage of cases are typically bacterial pharyngitis and what percentage are viral?
A. Probably less than 5 percent of the sore throats that I see.
Q. Are?
A. Bacterial.
Q. The majority being viral?
A. The majority being viral or irritative of some

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sort.
Q. In this case you were never able to determine which one with David?
A. That's correct. I think we treat this type of case based on experience and based on the lack of any other clinical findings.
MR. MALIK: Doctor, I think I'm just about done. Can I have a minute?
(Thereupon, there was a brief recess.)
BY MR. MALIK:
Q. I'm handing you what I have marked as Exhibit D. Is that an accurate representation of your credentials?
A. Except for the publications. There have been a lot more since then.
Q. From that I gather you're licensed to practice medicine in the State of Ohio?
A. That's correct, sir.
Q. And you are Board Certified?
A. That's correct.
Q. I ran you on the Internet, and it came up that you are not a member of the American Medical Association.
A. That's correct, sir. I have not been for probably about 15 years.

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Q. [illegible]ould you please state everything [illegible] you [illegible]re [illegible]t [illegible] conversation with Dr Ruiz [illegible]t David's death?
A. I can't, other than what I just said. In fact, I called him. I said, I just noticed that Mr. Gonda has died, and that was that. What was the diagnosis? As to specifically, no, I can't recall specifically what was asked or talked about.
Q. [illegible]ur di[illegible] of no gross pathology [illegible]n July 10th of 1995, what does that mean?
A. That means as I examined everything from the nose all the way past the nasopharynx, hypopharynx, oropharynx, involving the base of the tongue, larynx, I saw nothing there that I could hang my hat on and say this is it, this is the reason for his cough, even looking at the trachea.
Q. Do you recall the date the note about the papillary elastoma was written?
A. No, I don't. That's the one date that's not on there. That's my writing, and that's the reason there is probably no date there. I don't know when it was. I would think it was probably after August the 18th. I would say it was a day or two afterwards because it was of interest to me what had happened.
Q. Are your notes written in chronological order?

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A. Yes, they are. I have a copy right here.
Q. So the one after that says, patient expired 08-18-95?
A. I see what you mean. You know, the elastoma should have been above that.
Q. But again, you don't recall the day.
Do you recall how it came about you had the conversation with Dr. Ruiz?
A. No, I don't know.
Q. You don't know if you called him or he called you?
A. I called him.
Q. How did it come about that you heard of David's death?
A. Again, I had a secretary who would -- she read the newspaper from front to back, and whatever she would see, whether it be a birth, an obituary, a wedding or new promotion, she would remember that we had seen the patient and she would bring it in. That's basically it.
MR. MALIK: Thank you, Doctor. I don't have anything else.
- - -
BY MR. TRAVERS:
Q. Doctor, my name is Tom Travers. I'm the attorney

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in the case for Dr. Ruiz. I have some questions which I would like to ask you as well.
A. Certainly.
Q. First of all, turning your attention to your chart again and looking in the far right upper corner, there appears to be a telephone number, right?
A. Yes.
Q. What does it say right above that phone number; do you know?
A. Work number, W-O-R-K, work. I didn't write it. That's a work phone number, that much I know.
Q. You don't know when that was recorded, do you?
A. No, sir.
Q. What is the F after Dr. Ruiz's name?
A. Family.
Q. Family doctor?
A. M-hm. We make -- let me just make a statement. We make it a very important issue here at this office to refer back to family physicians, family practitioners, any time a patient is being sent here.
Q. It says referred by Dr. Ruiz up here (indicating)?
A. That's correct.
Q. Would it be a correct conclusion that information was included prior to the patient's visit of

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November 12th, 1994?
A. Not necessarily. Again, that space, referred by, I think is probably a misnomer in the sense that he may not have been sent in by Dr. Ruiz. I think it's probably incorrect. In this particular case he may have just come in on his own.
Q. So he may have been asked who his family doctor was, and because he identified Dr. Ruiz that information was included there as referred by?
A. That's correct.
Q. I think you were asked to read all of your notes other than the one from 1994, and I can't make that out. It looks like it's questionable.
A. Inner ear problem. He had it for about five to seven days. I examined him, he had wax in his ears, and the ear drums were normal. Once I examined him and the ear drums being normal, I assumed that was an inner ear problem, put him on Antivert which is specific for inner ear, and he was called and was asked about it five days later, six days later.
He was doing better, but had a numbness in his cheek and wanted to know if he should finish off the treatment, and the answer was yes.
Q. Do you know how long his regimen of antibiotics was going on?

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A. That's not an antibiotic. Antivert is a balance mechanism medication. Antivert means antivertigo, basically. It's similar to Dramamine, Bonine, Meclizine; they are all the same. Basically it's specific for inner ear function.
Q. Did he present to you a list of symptoms prompting you to put in your note there was a question concerning whether he had an inner ear problem?
A. His history, in other words, I wasn't certain whether it was dizziness or lightheadedness, and many times I'll put down questionable inner ear as I'm talking to the patient because it doesn't sound like an inner ear problem.
Q. Do you remember in this particular circumstance what he told you that prompted you to reach that conclusion.
A. Only that it was a five- or seven-day history. Let me explain to you. They'll say, Doctor, I have been dizzy for six years, and you say, stop a minute, don't use the word dizzy and tell me how you feel. Then they would tell me every time they stand up the room spins until they sit down. That's not a dizzy patient. They'll tell you the room has been spinning for the last three or four days, and it isn't any better. Now you have got an inner ear problem. At

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

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

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

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

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

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

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

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

A. That's correct, absolutely.

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

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able to appropriately treat?

A. That's correct.

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

A. Certainly, in a blink of an eye.

Q. That certainly is something within your regular p i t y u do on ɔɛ: s ɔ ?

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

) For ıp if ou had some suspicion t a ti t' t was cardiac in origin, you would hav made arrangements for him to have seen a cardiologist?

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

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Q. I was just trying to get an example If you thought the problems were p t . ʃ in ı ɛ?

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

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

A. That's correct.

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

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

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

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

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

A. That's correct.

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

A. Excuse me just a moment.

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MS. HARRIS: You can say what you want.

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

MS. HARRIS: Just so you kn , t not a p t of his chart. That was because he anticipated ti so this would be privileged.

THE WITNESS: Not for ti ıg me, t liti ti itself. I t' it if you want t read it. That in there. This has nothir g to do with that (indicating). That's not part of the medical record, but that's something I keep.

MR. MALIK: Is there another copy of it?

THE WITNESS: NO.

MR. TRAVERS: off the record.

(Thereupon, there was a discussion off the record.)

MR. MALIK: I'm paying for

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the deposition, and I want you to take this down.
THE WITNESS: -- conceal anything from anybody, but primarily to make certain that when you ask me questions about it, I can at least recall it.
MR. TRAVERS: Are we on the record or off?
MR. MALM: I just asked her to go on the record.
BY MR. TRAVERS:
Q. Basically what you have shown us is a *summary* of what is on your chart?
A. No major variations there, but when I was asked how did I remember certain things like that, it was going back to the sheet like this and looking at it.
Q. Do you recall when it was that you prepared that sheet you are holding?
A. Probably shortly after August the 18th.
Q. Do you have any-more observations of your telephone conversation with Dr. Ruiz other than what is

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

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anything more to help you with. Maybe you ought to evaluate him more thoroughly. That would be about it. That would be the sum and substance, to make sure he got back to the family physician.
I do this quite regularly. I have been around here long enough to know I don't know all the answers, and when I don't know the answer, by God, I'm going to get him to someone who does. I do that quite regularly without any games or any vain attempt to think that I can do everything. I can't, and I know it.
Q. Do you recall whether or not you had any other conversations with Dr. Ruiz during the summer of '95 about that patient, from June the 14th until after his

A. After his death, just to find out what was wrong, what happened, because I didn't bear anything. I didn't get any feedback other than the notice from the pulmonologist.
Q. Is it possible, Doctor, that you have another chart on David Gonda somewhere?
A. No, I don't.
Q. You had indicated that you took his tonsils out you thought. Would that record still be around?
A. Let me ask one of my girls if it is on microfilm.
(Thereupon, there was a brief

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recess.)
BY MR. TRAVERS:
Q. Doctor, I'll tell you the reason I asked. I'm not interested in seeing what his tonsils look like, but in Dr. Ruiz's chart he had a note from the latter part of May indicating when David came to see him he had previously been to see you sometime shortly before that, and there is no appointment of that nature identified in the records.
A. November the 12th of '94.
Q. Well, he hadn't complained of coughing at that point in time?
A. That would probably be the visit. I don't know what more to say to you.
Q. I'm just wondering if perhaps you had an old chart?
A. That's the current chart. The old chart would probably represent whatever might have been done, if anything, 20 years ago, 15 years ago. No, this was the only record that we would have, and the only visits are there. There would be no way he would have gotten in and seen me and left without anything going on the record.
Q. I see that there is a note on June 26th concerning the telephone call.

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A. That's correct.
Q. Whenever a patient makes a call to the office is it recorded in this chart?
A. Just a second, not June 26th -- yes, yes, we record all phone calls, anything that's said, anything that's discussed, anything that's commented on, yes.
Q. Well, for example, if a patient calls to schedule an appointment, that's not necessarily recorded on this chart?
A. That would go to scheduling, go into the scheduling book, not necessarily on the chart.
Q. Has there ever been a circumstance when someone called for an appointment and someone from your office, you or probably a clerk, would take care of calling in a prescription for the patient based upon the telephone report while he was ready to come in or awaiting a conference with you?
A. We regularly do that, yes. I don't think we're alone there. Let's put it that way.
Q. I don't mean to suggest that you are. I'm wondering whether such an event occurred with Mr. Gonda prior to his first presenting to you upon June 14th?
A. If I were to state it's impossible, that's not a correct statement, but it would be highly unlikely.
Q. Because if a call of that nature had been made

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the likelihood is it would have been recorded in this chart?
A. Yes.
Q. Between the 14th of June and the 10th of July of 1995 were you aware of whether or not David was receiving medical care from any other providers contemporaneously with your own?
A. No, sir, I was not.
Q. Would you agree, Doctor, that during that period from June 14th to July 10th that in your own mind you were the person who was orchestrating the investigation to try to identify the etiology of his chronic cough?
MS. [illegible]RIS: Objection.
A. Was I the physician that was taking care of him, yes. As far as orchestrating anything --
Q. That's not a medical term?
A. I was basing all of what I did based on clinical judgment and previous experience, yes.
Q. That's all I was asking. I guess what I meant was you were not relying on counsel from other consultants or practitioners.
A. No.
Q. You believed that you were the only doctor seeing this patient for this condition?
A. That's correct.

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Q. During that period of four weeks or so you were primarily concerned with trying to identify the cause of his cough?
A. That's correct.
Q. And you were unable to do so?
A. I eventually found that to be the case, yes.
Q. Have you ever had patients come to your office who suffered from endocarditis?
A. I wouldn't know. I would know it only by the history that they had told me they had it. We do a number of procedures on patients who will tell me they had either a valvular problem or endocarditis that had been treated. If we are going to do surgery we have to give them preoperative antibiotics and postoperative antibiotics. That's the only way I would know is if the patient made me aware that we would have to do that.
This is not an uncommon thing with children, either, who have cardiological problems that need treatment with antibiotics with surgery. I'll refer to the cardiologist and say, okay, I'm going to do ear surgery, would you get the kid ready, or they would send me a memo of what they wanted me to do.
Q. You see a lot of patients with coughs, I'm sure.
A. Yes.

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Q. Do you know, Doctor, from your training and experience whether a cough is a symptom that can be suggestive that a patient has endocarditis?
A. I'm sure if you were to catch me back in 1959 or '58 I might have answered that question. Since I have not treated endocarditis or any type of cardiac problem, I wouldn't know.
Q. But when a patient comes in to you With a cough, endocarditis is certainly not something that pops into your mind?
A. That's correct. There is about a thousand and one reasons that a patient would have a cough.
Q. Did you consider whether or not to do any cultures, blood cultures, on the patient?
A. Blood cultures, I don't think that I have with any patients other than patients in the hospital with pulmonitis infections. Blood cultures, no.
Q. Doctor, believe me, I think we all realize that you would be out of business if you wrote down every word that every patient told you coming through your office, but if a patient came in with substantial physical complaints you would normally make some note of that specifically on your initial assessment, correct?
A. Of course.

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MR. MALM: objection.
BY MR. TRAVERS:
Q. So when this patient came in on the 14th of June he did not report to you any substantial symptoms other than having this chronic cough; would that be accurate?
A. That's correct.
Q. With your 30-some years of experience, at that point in time were you able to make a reasonably accurate judgment as to whether a patient was seriously ill when he came in to see you for the first assessment?
A. I would hope so.
Q. If a patient did present in that circumstance, you would make a note of that in your chart?
A. Certainly.
Q. That's not the case with David?
A. That's correct.
Q. This young man had a cough but did not appear to be in serious physical distress?
A. That's correct.
Q. When you prescribed the Duricef on June 14th, the way it is written is not entirely clear, the Duricef was not for his ear wax; is that correct?
A. That's correct. Again, a lot of this is written after the fact; in other words, after I'm sitting there

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

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

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

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

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Q. Do you know Dr. Ruiz socially?
A. I know Dr. Ruiz because he and I basically started to practice about the same time, and when I was living in Poland he lived about a quarter of a mile away. Socially, no, just to know him and talk to him about the kids and how things were going and how his house was doing and that sort of thing.
Q. How long have you had a professional relationship with Dr. Ruiz?
A. Oh, good heavens, it has got to be 30 years or more.
Q. When you think of Dr. Ruiz, do you think of Dr. Ruiz as a family practitioner or do you think of Dr. Ruiz as a cardiologist?
A. I think of Dr. Ruiz as a darned fine family practitioner. That's what I can tell you about it. I wouldn't hesitate to send anybody to him.
Q. Are you aware that he holds himself out in the community as a cardiologist?
MR. TRAVERS: objection. He does not, David.
BY MR. MALIK:
Q. In terms of the coordination of David Gonda's care during the time you saw him, is it your opinion that Dr. Ruiz, for lack of a better term, was a field

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general with respect to his care?
MS. HARRIS: objection. Now we're getting far afield, David. Just let me finish. As an attorney I have the right to tell you my objection, and then you can clear the question up if you want.
Using a term like field general is improper in terms of describing the relationship. He has already testified that he had no knowledge, and we have no knowledge because we have never seen any record as to whether or not Dr. Ruiz was treating him in the June/July time period, so to say field general or any of those terms is totally inappropriate in a deposition such as this.
MR. MALM: Thank you, Beverly.
MS. HARRIS: YOU have heard those speeches before.
BY MR. MALM:
Q. I'm going to go back to my question, Doctor, is it in fact your testimony today that you had no knowledge that Dr. Ruiz was involved in David's care while you were seeing him?

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A. That's correct.
Q. Then how did it come about that Dr. Ruiz called you when David died to inform you?
A. He did not; I called him.
Q. How did that come about, then?
MS. HARRIS: Asked and answered for the third time.
A. It was just professional curiosity. Why I want to know is maybe they have got a reason for the chronic cough that I might look for the next time around, that sort of thing. He didn't call me; I called him.
Q. Do you as a physician have an obligation to refer patients to the proper specialist when you suspect another cause for an illness or when you can't determine it yourself?
A. That's correct. I do that quite regularly.
Q. Did you refer David to anybody else?
A. No, sir.
MS. HARRIS: other than Dr. Ruiz.
A. Other than Dr. Ruiz. When you phrase the question, I'm assuming you mean that.
Q. You indicated earlier that you knew the Gonda family. Who in the Gonda family did you know?
A. I don't know if they are related to the Gonda's

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one way or another, but I think they all are. Steve Gonda was a very close friend of mine. Steve Gonda used to run a dry-cleaning shop in the lower south side. I lived right across the street. Steve Gonda was kind enough to provide me with a job during summer vacations. I knew Steve, Cyril, there were four or five daughters. They had sons and daughters, and I'm sure they kept growing up to be more Gondas.
Q. I your ic c Doctor, do you refer pa for echocardiography?
A. Absolutely not.
Q. Whose job would it be to refer the ti for an echo, refer David for an echo?
A. I would say anybody that's versed in cardiology that would suspect there was a cardiological problem would do so. I can't answer the question other than to say I would not.
Q. In your practice do you interpret EKGs?
A. No, sir. I read the interpretations, but I don't interpret them.
Q. Wh you referred David back to Dr. Ruiz you referred him t for the remainder of his t t correct?
A. That's correct.
Q. Did you refer him back with the idea that you

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were going to leave the diagnosis up to Dr. Ruiz?
A. The phrasing of the question -- I'll answer it this way. I gave Dr. Ruiz no indication that an ear, nose and throat specialist could help him in any way. I could not help him with the diagnosis, period.
As to what steps he was to take, that would be entirely up to him as a family physician. I merely implied to him that I had no further answers for him, I could be of no further help, and perhaps he should look for a complete work up which is what I said to him.
Q. You had said to me in your direct examination, and these were the words you used, that you were very concerned.
A. That's correct.
Q. About the cough?
A. That's correct.
Q. Just so we're clear on the record, you weren't just a little concerned as Mr. Travers said, this was a significant event to you; is that correct?
MS. HARRIS: When?
A. At the time this occurred, and that was when his mother came in with him, there was a concern on both parts that this was a youngster that wasn't getting better. When I have got family members that are concerned, by God, I get concerned, too, okay, and

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that's basically it.
MS. HARRIS: Tell him the date of that so it's clear on the record for everyone.
A. The date was the 10th of July that she came in with him, and she had not come in before.
Q. Is it a fair statement to say that we have David concerned, you indicated that to me?
A. Right.
Q. We have his mother concerned?
A. Right, no question.
Q. We have you concerned?
A. Right, and that was why when I couldn't find anything on the fiberoptic laryngoscopy I felt it was time for him to move on and look for a more definitive cause.
I'd like to make a statement. I looked back in this case and I tried to review whether I should have done anything different, and the answer is no. I don't think that based on clinical experience I would have changed any part of the treatment that I did even knowing the outcome.
Q. At any time during your treatment of David did you say to yourself, why is this 27 year old kid who used to love to play basketball sick or have these

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problems?
MS. HARRIS: objection.
A. I don't know if I would phrase it that way, but I know on the 10th of July my thought was that he's about the same age as my son and, by God, we ought to get to the bottom of it.
Q. But you're really thinking as a physician what is causing these problems?
A. Yes.
- - -
BY MR. TRAVERS:
Q. Just to clarify one point, and I promise that's all.
A. Certainly.
Q. There was a discussion about your referring the patient back to Dr. Ruiz.
A. It was not a referral. I just called Dr. Ruiz and told him, your patient. It's not a referral. I let the word go by simply because it's just a matter of wording.
Q. Did you talk to David about continuing to secure follow-up care for his condition?
A. Sure, when he and his mother were there. That was one of the things I always ask. We have a lot of patients that come in here with a lot of problems.

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Some types I can't handle. I tell the family, look, there is a guy over in Warren by the name of Lippy. I know him personally. Do you want to go see him? If they say yes, I make arrangements.
Q. But you didn't make specific inquiries as to the exact type of follow-up care that David would pursue?
A. No, I did not. Did I make a phone call the next day to find out, no.
MR. TRAVERS: Thanks. That's all I have.
MS. HARRIS: Steve?
MR. GRIFFIN: Nothing here.
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(Thereupon, Plaintiff's Exhibits A, B, C and D to the deposition of SAMUEL ADORNATO, M.D. were marked for identification.)
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(DEPOSITION CONCLUDED.)
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SAMUEL ADORNATO, M.D. DATE

CERTIFICATE

State of Ohio,) SS:
County of Cuyahoga.)

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

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

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

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

Cynthia A. Sullivan, Notary Public
in and for the State of Ohio.