In The Matter Of:

Dorothy A. Gonda, etc. v.
HM Health Services, et al.

Mark J. Botham, M.D.
February 24, 1999

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IN THE COURT OF COMMON PLEAS
OF MAHONING COUNTY, OHIO

DOROTHY A. GONDA,
Individually and As
Administratrix of the
Estate of David Paul Gonda,
Deceased
Plaintiff,
vs. Case No. 96CV2055
HM HEALTH SERVICES,
et al.,
Defendants.

Deposition of MARK J. BOTHAM, M.D., called for examination under the statute, taken before me, Terry D. Gimmellie, a Registered Professional Reporter and Notary Public, within and for the State of Ohio, pursuant to notice and stipulations, at the Mt. Sinai Medical Center, Room 4340, Cleveland, Ohio on Wednesday, February 24thd, 1999 at 4:30 p.m.

APPEARANCES

On behaf of the Plaintiff:

DAVID W. MALIK, ESQ.
The May Valley Building
8228 Mayfield Road, Suite IV B
Chesterland, Ohio 44026
440-729-8260
and
MARK W. RUF. ESQ.
Hoyt Block Suite 300
700 West St. Clair Avenue
Cleveland, Ohio 44113-1230
216-687-1999

On behalf of the Defendant Juan Ruiz, M.D.:

Manchester, Bennett, Powers & Ullman, by
THOMAS J. TRAVERS. ESQ.
Atrium Level Two
The Commerce Building
201 East Commerce Street
Youngstown, Ohio 44503-1641
330-743-1171

On behalf of the Defendant Dr. Hafiz and Youngstown Associates in Radiology, Inc.:

Harrington, Hoppe & Mitchell, LTD., by
JAMES L. BLOMSTROM, ESQ.
1200 Mahoning Bank Building
Youngstown, Ohio 44503
330-744-1111

On behaf of the Defendants Dr. Cropp and Dr. DeMarco:

GARY A. BANAS, ESQ.
3721 Whipple N.W.
Canton, Ohio 44718
1-800-686-2825

MARK J. BOTHAM, M.D., of lawful age, called for examination, as provided by the Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

EXAMINATION OF MARK J. BOTHAM, M.D.

BY MR. BLOMSTROM:

Q: Good afternoon.

A: Good afternoon.

Q: I'mJim Blornstrom.I represent Dr. Hafiz, radiologist in this case, along with Youngstown Associates in Radiology.

I'llbe asking you a number of questions. If there are any among them that you don't understand, I'llbe happy to eliminate whatever the problem is.Just speak up; will you do that?

A: Yes, I will.

Q: Can you tell me how you became involved in this case.

A: I was asked by Mr. Malik if I would review some hospital records to see if there was anything within the records that suggested a deviation from the standard of care.

Q: Had you worked with Mr. Malik and other

Page 5

cases?
A: No, I had not.
Q: Do you know how he got your name?
A: I have actually known Mr. Malik for some time. I operated on his father a number of years ago and met him at that time.
Q: Are you social friends?
A: No, I'm not.
Q: You have issued two reports; is that correct?
A: That's correct.
Q: There is one dated July of some identifiable year. What year was that?
A: This probably would have been July of '98.
Q: Can you tell me what led to the issuance of a second report then, the one dated November 25, 1998?
A: There were records that were sent to me that I had previously not had a chance to look at which included some studies that were done that I was unaware had been done at the initial review; primarily that being the pericardial ultrasound.
Q: Before you issued the November 25,1998

Page 6

report, did you review Dr. Ruiz's deposition of October 23,1998, or did you even have it at that point?
A: I did not have it at that time.
Q: Have you reviewed it since?
A: Dr. Hafiz's deposition.
Q: Dr. Ruiz.
A: Dr. Ruia, yes, I have.
Q: In issuing your reports, were you asked to make any assumptions concerning the cause of David Gonda's death?
A: Assumptions, no.
Q: Do you have an opinion as to the cause of his death?
A: Yes, I do.
Q: What is your opinion as to the cause of his death?
A: Cause of his death was directly attributable to multiple pulmonary emboli with

Q: As far as the cause of the emboli, what is your opinion, if you have one?
A: I think the emboli originated from the

Page 7

the deposition of a thrombus in the ventricle which then embolized to the lungs.
Q: Have you asked for any information or records which you haven't been given?
A: No, I have not.
Q: Do you have any radiology training or experience?
A: I have no formal radiologic training. But in the last 20 years of practicing as a physician, I routinely review chest X-rays on a regular basis as a part of my practice of cardiothoracic surgeon.
Q: Do you perform or interpret ultrasound?
A: I do not perform ultrasounds. I interpret cardiac echocardiograms to assess whether or not I need a new valve to repair the ventricle and that sort of thing.
Q: Are you referring to 2-D or transesophageal cardiograms or both?
A: Both.
Q: In the community in which you practice, are 2-D echoes interpreted mostly by cardiologists?
A: Solely by cardiologist.
Q: Can you tell me what you understand

Page 8

Dr. Ruia's training and experience to be?
A: You are going to have to be more specific with the question in terms of training in what.
Q: After Dr. Ruia received his medical degree, what is your understanding of the residency and fellowships that he took?
A: I'm not exactly sure what his background is. I have never seen a curriculum vitae of his.
Q: So you at least, until now, were unaware that he served a cardiology fellowship?
A: I was not aware that he did a cardiology fellowship, no.
Q: Do you have a copy of Dr. Ruiz's February 13,1998 deposition handy?
I know you have a mass of material here. I'm sure you haven't read it all.
A: I'm sure within that.

A: The date on that again is?
Q: February 13th, 1998.
A: I do have one.

Page 9

questions and answers so I know when I read this later on, that it referred to this deposition.

Beginning at page 9, line 10:

"Question: Did you do an internship and residency?

"Answer: Yes, sir.

"Question: Where did you do your internship?

"Answer: In one year at Dominican Republic. When I came to Youngstown, I had one year of internship at the Youngstown Hospital Association?

"Question: What was your residency in?

"Answer: In internal medicine. I spent two years at Youngstown Hospital Association, and my final year at St. Elizabeth Hospital.

"Question: Did you do any fellowships?

"Answer: Yes, sir. I had a year of fellowship in cardiology from the Heart Association at St. Elizabeth Hospital and also had a fellowship in cardiology at St. Vincent Charity Hospital in Cleveland. And the fellowship in intravascular diseases at the Cleveland Clinic."

Page 10

Then there is some discussion on the next page between the lawyers. And then skip down to line 8.

"Question: Could you please repeat the fellowships. I'm sorry I didn't catch all of them because we were interrupted.

"Answer: Okay, I had one year of fellowship from the American Heart Association in cardiology at St. Elizabeth Hospital in Youngstown, Ohio. And another year following that at St. Vincent Charity Hospital at Cleveland under Henry Zimmerman. And following that, one year of peripheral vascular diseases at the Cleveland Clinic under Victor D. Wolfe."

You are now aware of his experience, correct?

A: Yes.

Q: With reference to the pericardial ultrasound, can you describe for me how Dr. Ruiz said that developed in his October 23, 1998 deposition?

A: I'm sorry. You will have to be more clear with the question.

Q: Dr. Ruiz was deposed again?

Page 11

A: Yes.

Q: On October 23rd, 1998. And, of course, you already indicated that you did not have that transcript at the time of your November 25, 1998 report.

A: That's correct.

Q: Rather than me just asking that, we will do the same exercise here. Let's turn to his October 23, 1998 deposition.

A: I think it's in here actually.

Q: Turn to Page 24. We will begin with line 1.

"Question: Okay. That's fine. So then the type of study done by Dr. Hafiz is not for the purpose of determining the etiology of any cardiac condition, correct?

"Answer: That's correct.

"Question: Okay. And had you wanted to know the etiology of a cardiac condition, you would have sent the patient for a two-dimensional ultrasound, correct?

"Answer: Had I been looking for that, that would have been the next step.

"Question: Okay.

"Answer: Yes."

Page 12

Then we will turn to page 29. Again, begin with line 1.

"Question: I stand corrected. Is it a fair statement to stay that by ordering the ultrasound study of the pericardium, that you limited your diagnostic capabilities only to the pericardium and did not include the rest of the heart?

"Answer: I was only checking for the pericardium.

"Question: So the answer to that would be yes?

"Answer: That's yes.

"Question: Okay. By performing this limited ultrasound, we then avoided or you avoided accessing a cardiac condition as the etiology for Mr. Gonda's symptoms, correct?"

And there is some discussion among the attorneys.

"Answer: I don't understand the question.

"Question: Well, I'll read it to you slowly. By performing the limited ultrasound, you avoided accessing a cardiac condition as the etiology for David Gonda's symptoms?

Page 13

"Answer: No, sir, I was looking for one particular thing, and I got my answer.
"Question: Okay. But you didn't get your answer with respect to anything else in the heart?
"Answer: I wasn't looking for anything else in the heart. Just that."
Skip down to line 17. Question on page 31.
"Question: Okay. But you were not looking for problems with the internal structure of the heart?
"Answer: I was not.
"Question: And you did not ask Dr. Hafiz to look at the internal structures of the heart such as the ventricle or atrium?
"Answer: No, sir."
Are you aware now of how the pericardial ultrasound came to be in existence?
A: Well, I assume that Dr. Ruiz asked Dr. Hafiz to perform it. If that's how the study was done. I'm not aware there was documentation completed or what the results were.
Q: Well, there is documentation in the sense

Page 14

that the report indicated that the pericardial ultrasound was done and that it was negative, and that's in Dr. Ruiz's records?
A: As I'm aware, there is no tape or hard copy.
Q: That's correct.
Now, for what purpose would Mr. Gonda need more of an ultrasound than he received?
A: To have the appropriate evaluation performed so that you can assess that which is within the pericardium. The visceral pericardium, the parietal pericardium and all of the cardiac structure. There is no purpose to evaluate one portion. It's like looking at a car and examining only one wheel. It doesn't tell you very much about the car.
Q: Are you aware that in the Youngstown area, as apparently in the Cleveland area, 2-D echocardiograms and transesophageal cardiograms are interpreted only by cardiologists?
A: I think that's standard across the country.
Q: I would like you to assume that on June 27th, 1995, Mr. Gonda visited Dr. Ruiz's

Page 15

office which is in the Hitchcock Office Complex in Boardman, Ohio and that thereafter Dr. Ruiz sent Mr. Gonda to Hitchcock X-ray which is across the parking lot for a chest X-ray with a wet read.
Both Dr. Ruiz and Dr. Hafiz assume that when Dr. Hafiz called Dr. Ruiz with the wet read of the chest X-ray that Dr. Ruiz then asked him to do a pericardial ultrasound on the patient who was then in Dr. Hafiz's office.
With your understanding now of Dr. Ruiz's background, with your understanding that Dr. Ruiz had knowledge of how to get more information, if he wanted, and with that assumption as to how the pericardial ultrasound came into existence, are you still critical of my client?
A: I think I'm even more critical that he now has a background and should realistically have understood that from a pathophysiologic standpoint, to evaluate just the surface of the underlying cardiac structure is probably an incomplete study.
Q: Who are you more critical of? I have

Page 16

Dr. Hafiz, the radiologist?
A: I'm more critical of Dr. Ruiz for not ordering the appropriate study.
Q: Since I am concerned with Dr. Hafiz and the corporation that employs him, with these understandings, do you remain critical of Dr. Hafiz and Youngstown Associates?
A: I remain critical of Dr. Hafiz for not pointing out to Dr. Ruiz that the study that he performed is not an acceptable study to evaluate a patient with the potential problem related to either the cardiac structure or a pericardial structure.
He should have the radiologic fund of knowledge to understand that that is a limited study that doesn't give him the full assessment of the structures that he needs to make a clinical diagnosis.
Q: So you are suggesting that Dr. Hafiz has to tell Dr. Ruiz, the fellow who has had two years of fellowship training in cardiology, that if he wants to visualize the internal structures of the heart, he has to get something other than what he ordered?
A: That is correct.

Q: You don't think he knows that?
A: Well, obviously —
MR. MALIK: Objection.
A: Obviously he did not. He did not order the appropriate study. I very frequently get notification from the radiologist, who evaluated a patient of mine, and does a study that I request, and if they do not feel that the study that they performed is adequate to completely assess the patient, they will then ask me to perhaps perform an additive study, or to modify the study that I have requested.
It's a routine consultation that we obtain with a radiologist. It's done very frequently.
BY MR. BLQMSTRQM:
Q: Well, let's go back and explore a little bit your understanding of the standard of care of a radiologist in these circumstances and where you get that information.
You have never done an ultrasound, correct?
A: That is correct.
Q: You have never interpreted a plain ultrasound, correct?

A: I have never interpreted an ultrasound to be written as a report. I routinely look at ultrasounds in evaluating my patients.
Q: You haven't worked in a free-standing radiology office as Dr. Hafia has?
A: That is correct.
Q: And the basis that you claim familiarity with the standard of care of a radiologist under the circumstances of a radiologist working in a free-standing radiology office like Dr. **Hafiz** is what?
A: Is that he should have the basic fund of knowledge to understand that a limited pericardial ultrasound is an inappropriate test to perform, number one.
Q: For what purpose?
A: For any purpose. And number two, that to evaluate a patient who may or may not have a pericardial problem, be a more complete study to perform a complete evaluation which would detail the two-dimensional echocardiography.
Q: You are aware that could not be performed in Dr. Hafiz office?
A: That is irrelevant. If you feel the study should be performed, regardless of where

it could be performed, or what time it should be performed, the study should be performed
Q: You are not suggesting that Dr. Hafiz should have ordered that study, are you?
A: The study should have been ordered by the clinician. That is Dr. Ruiz.
Q: What you are saying is Dr. Hafiz should have told Dr. Ruiz you need to order another study, right?
A: He should have told him two things. Number one, that the study that he performed, the pericardial ultrasound, is an inappropriate study. That's the first thing he should have told him.
Number two, that the study that he should have performed to evaluate this patient should have been a two-dimensional echocardiography.
Q: Are there any other matters which you claim fall below the standard of care for Dr. Hafiz?
A: No.
Q: Does the standard of care require that a physician do a vane act?
A: I'm sorry?
Q: Does the standard of care require that a

physician do a vane act?
MR. RUF: Objection.
MR. BANAS: I will sustain that one. You don't have to answer that.
BY MR. BLOMSTROM:
Q: Yes, you do.
A: Why don't you tell me what a vane act is.
Q: Well, in this particular case, a vane act would be telling Dr. Ruiz, who demonstrated in his deposition that he knows what the 2-D echo does what a 2-D echo does.
MR. MALIK Objection.
BY MR. BLOMSTRQM:
Q: Telling him what he already knows. Sort of like placing a warning on the top step of a stepladder, don't step higher.
A: I routinely have conversations and consultations with cardiac surgeons that I work with, and we frequently discuss matters that we know each other are fully aware of. Reinforcement, reeducation and sometimes a little bit of collegian interaction reinforces those things so we learn and educate ourselves.
It's a standard way to speak among

Page 21

colleagues. I would think, at the least, that would have been something that he would have done.

MR. MALIK: Objection.

THE WITNESS: That's how you educate yourself in medicine.

BY MR. BLOMSTROM:

Q: Would the type of ultrasound that Dr. Hafiz did be able to show an unusual amount of fluid in the pericardium?

A: It may or may not depending upon the technician's ability to appropriately conduct a study and the radiologist to aptly read the study.

Q: And you are giving us that opinion based on what experience or training?

A: It's not experience. I mean the fact of the matter is, if somebody knows how to do the study, and a person who is reading it knows how to read it has experience reading it, then those two things will result in a study that will be able to evaluate whether or not there is fluid.

If the technician can't do the appropriate study, then the physician reading

Page 22

it can't give you appropriate assessment.

If the technician can do the study, but the physician doesn't know how to read it, you can't get a study. You have to have both things function effectively to get appropriate study.

Q: Do you have an opinion to a reasonable degree of medical certainty as to whether there was a pericardial effusion on June 27th, 1995?

A: I would be able to render that opinion if I were able to see a hard copy of the study, either a tape or a picture that delineated whether or not the study had been performed appropriately.

And in that instance, I would be able to tell you whether or not there is a pericardial effusion.

Q: Well, my question is, can you now?

A: I can't. I don't have those studies available.

MR. MALIK: Objection.

BY MR. BLOMSTROM:

Q: Is it fair to say then that you will not express any opinions that either the chest

Page 23

X-ray, or the pericardial ultrasounds, were inappropriately interpreted by Dr. Hafiz on June 27th, 1995?

A: I don't know that any statement can be rendered regarding the chest X-ray. I have neither seen that. I have seen the reports. But the pericardial ultrasound, I think, is probably a different issue.

Q: Well, then, are you saying that the pericardial ultrasounds should have been interpreted to show a pericardial effusion?

A: No. Again, I have said I have not seen the hard copy of the ultrasound, so I don't know whether there was fluid there or not. Without actually looking at it, I can't tell you that.

And all I can tell you is that a report was issued that stipulated that there was no identifiable fluid in the pericardium. That doesn't mean there was wasn't fluid in there.

That meant the interpretation that Dr. Hafiz made of the study obtained did not indicate to him that there was fluid. But that doesn't tell you that the study was performed completely and correctly.

Page 24

Without actually looking at the study, I can't tell you that.

Q: You can also not tell me that it was performed incorrectly?

A: Without seeing the study, I can't tell you whether it was done correctly or incorrectly.

Q: Would you admit that a radiologist is in a better position than you to evaluate whether or not Dr. Hafiz met the accepted standard of care for a radiologist?

A: No, I do not feel a radiologist would be better off at that.

Q: Was there any change in Mr. Gonda's condition between June 27, 1995 and the date of his death?

A: There was a progression in his disease process.

Q: Will **you** describe the change in his condition over that period of time?

MR. MALIK: Objection. As to what?

A: It's an extremely broad question. It has to be more focused.

BY MR. BLOMSTROM:

Page 25

Q: Fine. Please describe the change in the condition of Mr. Gonda's heart between June 27th, 1995 and August 18th, 1995?

MR. MALIK: Objection. Based on?

A: I think had the April echocardiographic evaluations were performed in June, we would have had an echocardiography that we could have compared it to that we eventually ended up getting and determined exactly if there was a change.

Q: Am I to interpret that to mean you have no opinion as to how his heart condition changed?

A: What I'm telling is a fact of substance. I don't have a documented study that I can compare the echocardiography to that which was eventually obtained that tells me that there was even a change at all.

There may well have been the exact same problem present in June. In fact, in all probability, the same problem probably was present back in June.

Q: Do you believe that on June 27th, 1995, the condition of David Gonda's heart was

Page 26

substantially the same as it was on the date of his death?

MR. MALIK: Objection.

A: I believe that the same disease process that eventually resulted in his demise was present and active in June similar to as it was in August.

BY MR. BLOMSTROM:

Q: Was the extent and severity of the process substantially the same?

A: There is no way to assess that because we don't have the echocardiography from June to compare the latter echocardiography to.

From a clinical standpoint, a pathophysiologic standpoint, the answer to that question is the disease process was clearly present in June, continued throughout and eventually progressed to the point where he ended up dying from pulmonary emboli originating from within the heart.

Q: Actually, that's not in answer to the question. Because the question was directly to the extent and severity of the process.

A: I have already answered that question. I told you, you can't assess that without having

Page 27

an echocardiography that should have been performed in June to compare it to the one that was eventually performed.

My response to your question is from a clinical and pathophysiologic standpoint.

The presence of the disease was there in June and progressed through to a point of his demise.

Q: Can you describe for me whether you had any personal experiences with the medical or surgical treatment of endomyocardial fibrosis?

A: I have not.

Q: Have you done any research in the medical literature for purposes of your review of this matter?

A: I have read textbook entries, and there are remote journal descriptions of endomyocardial fibrosis.

Q: Based upon your understanding of the natural history of the disease process itself, do you have an opinion as to the extent and severity of the endomyocardial fibrosis of Mr. Gonda's heart as of the end of June, 1995?

MR. MALIK: Objection.

A: I think it probably was in early stages

Page 28

in only one ventricle rather than both.

BY MR. BLOMSTROM:

Q: Is it your understanding that as of the date of his death, the endomyocardial fibrosis then involved both of Mr. Gonda's ventricles?

A: Just the right ventricle.

Q: So it was the endomyocardial fibrosis as of the date of his death at an early stage or a late stage?

A: An early stage.

Q: Was there a difference in the condition of Mr. Gonda's lungs as of June 27, 1995 and the date of his death?

MR. MALIK: Objection.

A: There is no question about that.

Q: Will you describe for me the change in the condition of his lungs over that period of time?

MR. MALIK: Objection.

A: He had further pulmonary emboli that became more progressive, obstructive to his pulmonary vasculature, and he eventually succumbed to probably mass pulmonary embolus resulting in hemoptysis and asphyxiation.

Q: As of May or June of 1995, what

Page 29

complaints did Mr. Gonda have referable to his lungs?
MR. MALIK: Objection. Are you referring to a specific document?
MR. BLOMSTROM: No. I'm asking him to give me an answer to that question.
MR. MALIK: Based on what?
A: I didn't see the patient at that time. Is there a specific document that you want me to refer to?
Q: What record have you reviewed?
A: I have reviewed the medical records of Dr. Ruiz, Dr. Adornato, Dr. Cropp, Dr. Hafiz's documents.
Those are the primary people who's records that I reviewed that were involved in his clinical care prior to his presentation to St. Elizabeth.
Q: As of the middle of June of 1995, what complaint did Mr. Gonda have referable to his lungs based on those records?
MR. MALIK: Objection.
A: Well, I think that you have to look at him from a clinical standpoint. I did not get the opportunity to do that and evaluate him to

Page 30

see, if, indeed, the complaints that he had were specifically directed toward his lung or to some other organ system.
Q: Are there any complaints that he had as of the middle of June of 1995 that you believe are referable to his lungs?
MR. MALIK: Objection.
A: Well, I think any generalized complaint of feeling ill and having fever and generalized malaise are something that you have to evaluate their lungs for and assess them to make sure the underlying problem resulting in that clinical constellation of symptoms is not originating from a pulmonary pathogenic process.
Q: Is it your opinion that Mr. Gonda did not have infective bacterial endocarditis?
A: I do not feel that he had bacterial endocarditis.
Q: If a patient was admitted by a regular internist and it was determined that that patient had endomyocardial fibrosis —
A: Let me interrupt for one second.
(Discussion off the record.)
BY MR. BLOMSTROM:

Page 31

Q: I will restate the question.
If a patient now was admitted to Mt. Sinai under the care of an internist and it was determined that that patient had endornyocardial fibrosis, would you accept a consultation for that patient, or would you suggest that the patient be referred elsewhere?
A: No, I would accept a consultation.
Q: Would you actually perform any surgery on that patient?
A: It would depend upon the clinical condition of the patient and the nature of the fibrosis.
Q: Have you ever performed surgery on an endomyocardial fibrosis patient?
A: I participated in a cardiac transplant when I was a resident at the University of Michigan in end-stage myocardial fibrosis patients; never done stripping, valve replacement, or valve repair.
Q: Would you venture to perform all of those surgeries or just a transplant?
A: No. I think you have to base the type of surgery upon the clinical picture that you're

Page 32

addressed with. A, in terms of their clinical presentation.
And B, the terms of the degree of involvement with the heart with the endomyocardial fibrosis.
There are various degrees in which the heart can be involved. Some of which mandate more vigorous types of therapy than others.
Q: Would you manage the case at that point?
A: If it required surgical intervention, yes. If it required medical intervention, no.

(Thereupon, Defendant's Deposition Exhibit A was marked for purposes of identification.)

BY MR. BLOMSTROM:

Q: I'm handing you now what is marked as Defendant's Exhibit A. Would you identify this for me, please.
A: This is a letter that I sent to Mr. Malik upon my initial review of the records of Mr. Gonda.
Q: When did you send that to Mr. Malik?
A: In July — this is not a year — I would

Page 33

suspect it is July of 1998.
Q: Do you have any idea why that particular report was not produced until today?
MR. RUF: We were ordered to produce a report. That's what we did. We complied with the Court's order.
MR. BLOMSTROM: That's your explanation.
MR. RUF: There was not an order to produce all reports including drafts.
BY MR. BLOMSTROM:
Q: Do you agree that the substance of your July report is not included within your November 27, 1998 report that was produced in this case?
A: I think that there is portions of it that are included in the subsequent report.
The pathologic evaluation that's indicated in the July report is not reiterated in the subsequent report of November. That is true.
Q: Let's return to this claimed deviation by Dr. Hafiz.
Do you have any information upon which you can venture an opinion that if Dr. Hafiz

Page 34

had told Dr. Ruiz during their telephone conversation that he should order a 2-D echo, that Dr. Ruiz would have ordered a 2-D echo?
A: I would have hoped that he would have done so.
Q: Do you have any information upon which you can express an opinion to a reasonable degree of medical certainty that, in fact, he would have ordered a 2-D echo under those circumstances?
MR. RUF: Objection.
A: I think that's a decision that would have had to have been made between Dr. Hafiz and Dr. Ruiz.
I would certainly had hoped that any clinician who is informed by a radiologist that the study he was undertaking was inappropriate.
And a more appropriate would have been a two-dimensional echocardiography, would have believed the consult, and ordered a two-dimensional echocardiography.
Q: The two-dimensional echocardiography would have shown the internal chambers of the heart, correct?

Page 35

A: That is correct.
Q: Isn't it true that Dr. Ruiz was not interested in visualizing the internal chambers of the heart according to his testimony?
A: According to his testimony, that is correct.
From a pathophysiologic standpoint, he was probably concerned that there was something going on within the pericardial space. Be it the pericardium, the space between the pericardium and the heart, or the heart itself. Otherwise, he would not have ordered these tests.
The two are not separable from a pathophysiologic standpoint. You cannot separate the pericardium from the heart. They are integral parts, and one behests the other.
A pathologic problem within the heart can be reflected in the pericardium and vice versa. You cannot separate the two.
Accordingly, when you do an evaluation, you have to evaluate both.
Q: Did Dr. Hafiz do what Dr. Ruiz asked him to do?

Page 36

A: Yes, he did.
Q: Is it true that you cannot say one way or another whether or not a 2-D echocardiogram performed on June 27th or 28th, or a few days thereafter, would have visualized fluid in the pericardium?
A: If there was fluid present in the pericardium, a 2-D echocardiography would have visualized it.
Q: That begs the question, I guess — Will you read the question back?
MR. MALIK Objection.
(Record read.)
A: We can go back to the same question that was asked and answered before. I don't know whether the study that was performed originally was an appropriate study. I don't know whether it was a complete study.
So I can't tell you whether there was fluid in the pericardial space. I don't have a hard copy to look at. I don't have a study to evaluate; whether or not the study was done appropriately or not.
Therefore, I can't make an assumption that there was fluid in the

pericardium at the time the ultrasound was done.

If, indeed there was fluid, a two-dimensional echocardiography would have identified that fluid.

BY MR. BLOMSTROM:

Q: But you have no opinion to a reasonable degree of medical certainty that there was fluid as of that period; is that correct?

MR. MALIK: Objection.

A: The only way that I can make a statement based upon factual basis, whether there was fluid in the pericardial space or not, is to see the study, see that it's a study that was completely done and correctly done so that it fully evaluated the pericardial space to assess whether there was fluid there or not. I don't have that available to review.

Q: Based upon everything that you have reviewed so far in the case, can you say to a reasonable degree of medical certainty that there was fluid in the pericardial space on June 27th, 1995?

MR. MALIK: Objection.

A: The answer is identical. Without having the study to look at, I can't tell you whether the study was done appropriately.

I cannot tell you, therefore, if there was or was not fluid that either was or was not identified.

BY MR. BLOMSTROM:

Q: You refer in your November 25, 1998 report to a right ventricular wall motion abnormality.

Can you tell me whether or not that wall motion abnormality was present on June 27th, 1995?

A: From a clinical standpoint, I feel very strongly that it was there in June. That was the night for thrombus to form on the right ventricle which then resulted in pulmonary emboli which were manifested by this gentleman's symptoms.

Q: Is a cough, what you ascribe to pulmonary emboli?

A: The cough, the tachycardia, the fever and generalized malaise are all consistent with

fever?

A: I think we have the luxury of looking back retrospectively now and realizing that the pathophysiologic process that eventually resulted in his demise was clearly present at the time of his initial presentation.

There is no reason to profess another cause for this whole constellation of anteceding then.

Q: Can you tell me how often you review medical-legal matters?

A: Relatively frequently.

Q: Over the last 12 months, how many times?

A: Seven or ten cases.

Q: How long have you been reviewing cases?

A: Thirteen years.

Q: Over that period of time, do you know how many cases you have reviewed?

A: Probably accelerated in the last five years. Probably close to *40* or 50.

Q: Over the last four or five years, how many have you reviewed?

Q: Will you describe the nature of your practice?

A: I'm a cardiothoracic surgeon. My practice is at this hospital, University Hospital at St. Vincent Charity Hospital.

Q: Is there a particular area of cardiothoracic surgery that makes up a large part of your practice?

A: I think if I were to look at the number of operative procedures, an overwhelming percentage of those would be coronary artery bypass surgery.

Q: You've been sent copies of many of the other experts' reports, correct?

A: Yes.

Q: Do you know any of them?

A: I do know Hadley Morganstern Cleron.

Q: How do you know him?

A: From my interactions with University

Q: Do you know Dr. Rovner?

Page 41

Q: With reference to the literature that you reviewed in connection with this case, did you perform the literature search, or was this literature that was provided to you?
A: I have literature in my possession at home, and I have literature provided to me by Mr. Malik and Mr. Ruf.
Q: Was the literature at your home directed to endomyocardial fibrosis?
A: Yes.
Q: Or was it a paragraph in a book?
A: It was directed towards endomyocardial fibrosis.
Q: What do you have at your home?
A: An article from, I think, the British Journal of Medicine about endomyocardial fibrosis that I suspect I probably picked up at the time that I was in Michigan. There is not a lot written about it, I think, in textbooks.
Q: The remainder of the literature was provided to you by Mr. Malik?
A: That is correct.
Q: You don't know Dr. Hoffman at University Hospital?

Page 42

A: I do not.
MR. BLOMSTROM: Thank you. That's all I have at this point.
EXAMINATION OF MARK J. BOTHAM, M.D.
BY MR. BANAS:
Q: Dr. Botham, my name is Gary Banas. I represent Dr. Cropp and Dr. DeMarco. I think I just have a few questions.
First of all, when the patient got to the Cleveland Clinic, what was the diagnosis at the clinic?
A: I think the transfer diagnosis was right ventricular mass. I think they didn't really know exactly what the right ventricular mass was.
Q: Well, according to the records, it says probable angiosarcoma.
A: That's more of a guess than anything else. I think if you do a histologic biopsy, tentative diagnoses really don't mean much.
Q: Did they do anything by way of anticoagulation?
A: They did not.
Q: Do you think they should have?
A: I think hindsight looking at it, yes, they probably should have.
Q: Doctor, apparently you don't have any problem that this particular patient had endomyocardial fibrosis?
A: I do not.
Q: We know that this patient got to Dr. Cropp, and I think the first day that the patient got there was — it takes me a minute to find the exact spot. July 5th the patient wasn't feeling well. But on July 13th was seen by Dr. Cropp.
He had a nonproductive cough, no chest pain, no wheezing. He apparently had been on several different cough medicines and several antibiotics. He was somewhat better on doxycycline and was on his second course of this drug. Was all of that appropriate?
A: I think at the time, I don't find a deviation from the standard of care.
Q: And his plan, that is Dr. Cropp's plan, was to continue Mr. Gonda on doxycycline for 21 days. He was given a prescription for Vanceril and Tessalon and was seen by Dr. Cropp on a follow-up visit on July 25th of '95.

Page 43

Page 44

Were those two prescriptions appropriate?
A: Yes.
Q: At this time, he was feeling better, Mr. Gonda, and I assume you have seen those records?
A: Yes.
Q: Mr. Gonda was feeling better but not normal. He had sinus drainage. He was clearing his throat and coughing significantly. No wheezes. And apparently noted a fever throughout the day.
And, of course, at this point, Dr. Cropp was thinking in terms of sinusitis. And I assume that's all appropriate?
A: I think it would be included in the differential diagnosis. As a clinician, I would be troubled by the duration of this young man's symptoms and persistent fever.
MR. MALIK: Can you show it to the doctor?
BY MR. BANAS:
Q: This is my notes that I have. If I'm allowed to use my notes.
A: It's probably from DeMarco, isn't it?
Q: Yes. He has seen it. It's easy for me

Page 45

to read this stuff rather than to remember.
He had no wheezes. Mr. Gonda noted fever throughout the day. Recommendations were to discontinue Tessalon and Vanceril. He was started on — is it Deconsal — which is a decongestant/antitussive medication, and I assume that was all appropriate?
A: Yes.
Q: I think the last time he saw him was then on August 8, and at that time he was feeling better. Do you remember that?
A: I would have to look back at the records.
Q: Take a look at Dr. Cropp's records. We are up to August 8th.
A: I have the records here.
Q: If it's not true, it is not true.
A These are Cropp'srecord you are reading from?
Q: At this rate, Mr. Gonda was doing somewhat better. His Nasal congestion cleared, and his cough had nearly vanished. At this point David states that his fever is essentially gone. All of which shows improvement, does it not?
A: It would suggest that he is feeling

Page 46

better.
Q: A CT scan of the chest and abdomen was advised, that would be appropriate?
A: Correct.
Q: Now, on the 1Sth, or seven days later, before he got the CT of the chest or the abdomen, he went into the hospital with hemoptysis and was admitted to St. Elizabeth Medical Center in Youngstown. Now, let's just stop there.
Do you want to take a look at those records and make sure I said it correctly? I don'twant to be —
A: Putting words in my mouth.
Q: — be accused of misleading any witness. And I see somebody has helped you with highlighting so that you can find the exact spot.
Of course, what you also see, Doctor, after every visit there was a letter sent which again is an appropriate thing for a consultant to do, correct?
A: That is correct.
Q: And, of course, the letters were sent by Dr. Cropp too?

Page 47

A: Dr. Ruiz.
Q: And of course, contained in there is the information which I have been talking about?
A: That is correct.
Q: Have I misstated anything so far?That's all I'mreally interested in up until the 15th.
A: No, you have not misstated anything.
Q: On the 15th, we know the patient goes to St. Elizabeth because he's got hemoptysis, St. Elizabeth Medical Center in Youngstown, and is seen by a Dr. DeMarco. Does that ring a bell?
A: Yes.
Q: Let me just ask one question. Are you critical of Dr. DeMarco?
A: No, I'm not.
Q: Now, we also know that this ends the relationship that the patient has with Dr. Cropp?
A: That's correct.
Q: In other words, Dr. Cropp saw the patient, as I get it, I think, on three occasions?
A: Yes.
Q: Maybe I missed something along the way, I

Page 48

think it'sthree times. You are a cardiovascular surgeon?
A: Correct.
Q: And I assume after going through all of this, you have really no criticism of Dr. Cropp?
A: I don't have any formal criticism of him. I think that as a pulmonary specialist, I guess I'mdisconcerted that he didn't, perhaps, entertain the possibility of their being the problem related to this young man's heart as an etiology for his symptoms.
Q: You are not prepared to say that'sbeen below the standard of care?
A: I am not. That's correct.
MR. BANAS: I told you I would be very quick.
EXAMINATION OF MARK J. BOTHAM, M.D.
BY MR. TRAVERS:
Q: By name is Tom Travers. I'm a lawyer for Dr. Ruiz. It'sprobably not a surprise to you that I have some questions as well.
I want to begin by questioning you concerning this pericardial ultrasound because I want to make sure that I am clear of the

Page 49

whole nature of your criticism in regard to that study.

Do I understand correctly, Doctor, that in your opinion, there is no circumstance in which a limited study by way of ultrasound just of the pericardium is appropriate?

A: There is no circumstance that I'm aware of in the field of medicine to perform a pericardial ultrasound, period.

Q: Are you aware as to whether or not tests of that nature are ever done?

A: They are. I have done probably 2 or 3,000 open heart surgeries and evaluated twice that many patients for cardiovascular disease. I have never heard of or seen a pericardial ultrasound performed by any physician.

Q: Do you agree that if properly performed and interpreted, a pericardial ultrasound would be able to identify effusion of the pericardium?

A: Yes.

MR. MALIK: I will object to that question.

BY MR. TRAVERS:

Page 50

Q: I want to take a step back from the time of that study. To see if, perhaps, I'm not understanding you correctly.

Let me ask straightforwardly. Do you have sufficient clinical information in this case to render a judgment as to whether Dr. Ruiz was negligent in his workup of the patient prior to the time that he ordered the ultrasound?

A: I think up until the point where he ordered the pericardial ultrasound, his workup had been appropriate.

Q: Do you believe that there was medical necessity to do a cardiac evaluation during the two times that Dr. Ruiz saw this patient?

A: I think at the time, he felt it appropriate to evaluate the pericardial space.

In his mind, he had the feeling that from a pathophysiologic standpoint, something within the pericardial space had the potential to be resulting in this young man's clinical symptoms. Otherwise, he would not have ordered the test.

And I think if you look at this patient from a clinical standpoint, that assessment

Page 51

was correct.

Unfortunately, despite the fact that he thought about it from a pathophysiologic standpoint, he did not evaluate from a correct clinical standpoint.

Q: Here is what I'm trying to find out, Doctor. From the prospective of an internist in seeing this patient on two occasions with symptoms of fever, cough, and some malaise, did the standard of care require an internist to perform a cardiac evaluation?

MR. MALIK: Objection.

A: I think if you as a clinician feel that you have the potential for a cardiac problem as an etioiogy for a patient's complaint, then, yes, it mandates that you perform an evaluation that gives you the information that you need. Inclusive in that is a two-dimension echocardiography.

BY MR. TRAVERS:

Q: Now, what I would like to do is segregate that answer as it applies to Dr. Ruiz.

Since he did order the ultrasound to a hypothetical situation, in which an internist had the same clinical information available to

Page 52

him did not order a pericardial ultrasound, or any cardiac diagnostic testing, do you believe that the failure to order any such testing, based upon the clinical information available to the internist on his two visits in late spring and early summer of 1995, would that constitute a violation of standard of care?

MR. RUF: Objection. Assumes facts not in evidence.

MR. BANAS: He said it was hypothetical question.

A: I think if you are taking this as a hypothetical case, and not specifically related to Mr. Gonda, the answer still would be, yes. I think if you feel there is a cardiac problem, as this physician did.

And again, to evaluate that patient, I would have to look at that patient and assess whether I feel there is a cardiac etiology to it.

If you feel there is a cardiac etiology, yes, the standard of care is to do a two-dimensional echocardiography.

BY MR. TRAVERS:

Q: I'm afraid that the problem is mine in

Page 53

the way that I'm phrasing the question, Doctor.
I want to remove from the equation the suspicion that Dr. Ruiz had of a possibility of pericardial etiology here.
And my question here is directed to an internist who did not have any such suspicion and ordered no cardiac testing at all, would the clinical information available to Dr. Ruiz, at the time that he evaluated David Gonda, would the failure to order any type of cardiac workup constitute a violation of the standard of care?
MR. RUF: Objection.
MR. MALIK: Objection.
A: I think that the answer to the question is yes. I think that it is bolstered simply by the fact that a clinician who saw this hypothetical patient, be it David Gonda, did feel that, and did order a test to evaluate the pericardial space, but did not evaluate that which is inclusive in the pericardial space, that being the heart.
So the answer is yes on both accords.
BY MR. TRAVERS:

Page 54

Q: You're telling me, number one, you feel comfortable in evaluating the workup an internist would perform on a patient with symptoms of cough and fever?
A: As a cardiac surgeon, I see every spectrum of disease that presents to patients in the hospital. I'm kind of a last stop on the bus. I see absolutely everything that anybody else has seen. I get a chance to evaluate every kind of workup that's done from family practice doctors to internists to cardiologists.
Then I have to make my assessment based on what I do upon the evaluations of what those people do.
So I get the luxury of seeing how those things are done, and I make my judgment based upon that.
So, I have a strong comfort level knowing when it is and when it is not appropriate to order specific tests.
Q: What about whether David Gonda's clinical presentation, in your judgment, was sufficiently significant to merit a cardiology workup by Dr. Ruiz?

Page 55

A: I think when you have a young man in his 20's who has had cough and generalized malaise, has had persistent tachycardia and an abnormal EKG, that warrants an echocardiography. I think it's the least study. The first screening study I would do.
Q: Have you seen this patient's EKG?
A: Yes.
Q: Did you see the one in '89?
A: Yes, I did.
Q: Were you able to interpret that?
A: I can't interpret the EKG in '89.
Q: How about the one in '95?
A. I think you can look at that EKG and see there are some abnormalities there.
Q: What abnormalities have you identified in that study?
A: Do you have that study for me?
MR. MALIK: Here you go.
A: I don't know where it is in here. I know I have seen it.
MR. BANAS: May the record reflect a frantic search is going on.
(Laughter)
A: Here it is.

Page 56

BY MR. TRAVERS:
Q: I assume, Doctor, just by way of prefatory question, in your specialty, do you have some expertise in interpretation of EKG?
A: I do read EKG's every now and then.
Q: What is your interpretation of that '95, June '95 study?
A: It does reflect some increased subtle forces. I'm not sure I agree with the assessment here about ischemic changes. He talks about the pattern on the EKG versus ischemic changes on the EKG. And it does suggest sinus tachycardia of the rate of 120.
Q: Well, his tachycardia we don't need.
A: You need to know whether it's a sinus or echo tachycardia or flutter or ventricular echocardiogram. We do need an EKG to assess that.
Q: He had the best kind of tachycardia?
A: He had a sinus tachycardia. That's correct.
Q: So other than the existence of tachycardia, the only other abnormality that you feel that you identified from that study is increase subtle forces?

A: I think if you have a young man who has this constellation of symptoms and this electrocardiogram, yes, he is more for electrocardiogram.

Q: Without the accompanying symptoms, is that EKG itself sufficiently abnormal to

That's why cardiologists or physicians, internal medicine doctors, see their patients, examine their patients and then get studies. An isolated test doesn't give you information.

Q: Well, the last time he had been in for EKG in '89 was simply for a preemployment physical.

Let's assume he came in and had this EKG for that same reason. Would the abnormalities

A: As your question, the way it's stated, would be yes. It's grossly abnormal for a 29-year-old, 26, however old, to have a resting heart rate of 120.

BY MR. TRAVERS:

Q: We have been from here to San Francisco and back fighting over whether this man had

A: Yes.

Q: Have you reviewed the case to reach your own independent determination on that issue?

A: Yes.

Q: You would disagree with those who espouse the endocarditis theory?

A: I do not feel that this patient had bacterial endocarditis.

Q: Do you have an opinion as to whether a

A: No. De novo there is no reason why they should have positive blood cultures unless they have an infection somewhere in their body.

Q: So in your opinion, had blood cultures been done on David Gonda back in June of 1995

A: I think based upon what I have reviewed, I don't feel that he had bacterial endocarditis.

I suspect those cultures would have been negative. I think it would warrant you in evaluating and doing those to make sure that he did not have endocarditis.

It's a diagnosis of exclusion. You do bacterial cultures to exclude it as a

cultures. And the other is to do an echocardiography.

BY MR. TRAVERS:

Q: What are the significant clinical features that you're aware of that prompt you to conclude that he did not have infectious endocarditis?

Q: How about right-sided endocarditis?

A: Any-sided endocarditis. Any-sided endocarditis is extremely rare to have it developed de novo, inside a ventricular cavity without involving a cardiac valve.

Q: Do you do heart transplants?

A: I don't do them anymore. It's for guys who have less gray hair.

Q: When you say "anymore," since your

Page 61

A: They are not.
Q: Any hospitals that you are on staff at?
A: University Hospital.
Q: Do you know Dr. Wiedemann from University Hospital?
A: I do not.
Q: Have you seen in the records the letter that he wrote to the Gonda family?
MR. RUF: You mean the clinic.
BY MR. TRAVERS:
Q: I'm sorry, from the Cleveland Clinic.
A: I don't know if I have had the chance to review that or not.
Q: This has previously been marked as Exhibit A from an earlier deposition. I'm going to ask you if you can take a look through that letter.
MR. MALIK: I'm going to object to the letter. Dr. Wiedemanm, anything he knows from EMF, he got from a pathologist.
BY MR. TRAVERS:
Q: I take it you're not in complete agreement with the conclusions expressed to the family by the treating physician from the clinic on the issue?

Page 62

A: I'm not in agreement with him.
Q: Let's start on the issue of the treatability of this disease by asking, are you aware of what category of development of the disease process Mr. Gonda had at the time of his death?
A: If you're referring specifically to endomyocardial fibrosis, that category was probably very early.
Q: This was probably naive of me, but since it caused his death, I would assume that it would have been later?
MR. MALIK: Objection.
A: It did not cause his death. His death was caused by multiple pulmonary emboli, hemoptysis on asphyxiation.
BY MR. TRAVERS:
Q: On that issue, you were careful to comment in your original report about the large laceration to the patient's lung. Did that play a role in his death?
A: There is no question that it was contributory to it.
Q: What is your understanding of how that laceration occurred?

Page 63

A. Probably during the emergent thoracotomy that was performed by the resident trying to resuscitate him.
Q: If they had not incised that lung, do you think David would have survived that episode?
A: He would have asphyxiated and died.
Q: That same evening?
A: That's correct.
Q: Is that based upon the pulmonary findings on pathology?
A: It's based upon the condition of the patient at the time he had the emergent thoracotomy.
Q: So you don't think the laceration of his lung —
A: In no way caused his death. His death was caused by the pulmonary emboli.
Q: Had he been anticoagulated upon trans er to the clinic, would that have prevented his death that evening?
A: It may have decreased the likelihood of him having a fatal pulmonary emboius. It could not have guaranteed he would not have experienced that same problem.
Q: Do you think there was a single large

Page 64

embolus that was the cause of his death or a shower of smaller?
A: I think there were multiple emboli that progressively blocked his pulmonary arterial circuit. The final event was probably a larger embolus that blocked the main pulmonary arterial flow and resulted in the hemoptysis and eventual asphyxiation.
Q: Do you think there was an acute episode in which the rate of embolization dramatically increased, or was this just a natural result of chronic embolization?
MR. MALIK: Objection.
A: I think the tendency in patients who have pulmonary emboli is to have multiple sentinel emboli, smaller emboli, that result in symptoms. And eventually a large embolus that obstructs a main pulmonary artery, or continues the acceleration of the emboli, but blocks off enough of the pulmonary arterial circuit, that they either develop heart failure or profound hemoptysis. And that's usually their modus of death.

Page 65

A: Yes, I do.
Q: Would earlier diagnosis and treatment have necessarily prevented David's death?
A: Yes.
Q: I'm surprised by your answer, Doctor. That wasn't my sense from your report. I thought that your theory here is that he would have had a better chance had earlier treatment been undertaken. But I never saw anything in your report saying that his death would necessarily have been prevented?
A: People who have multiple pulmonary emboli and eventually succumb to that, if they are appropriately diagnosed and treated at an early stage, have a significant chance not only of preventing progression in their disease, but they also have a significant chance of terms of preventing progression in their pulmonary hypertension and preventing the sequelae that we've seen play out with Mr. Gonda. That being a massive pulmonary embolus and eventual death.
Q: When you talk about embolization, in patients generally, it's not very frequently that the embolization is being caused by a

Page 66

large thrombus in one of the cardiac chambers, is it?
MR. MALIK: Objection.
A: If it's more frequent to have emboli from lower extremity veins or pelvic veins, upper extremity veins, and probably lastly from cardiac structures. It's a small percentage.
Q: The prognosis for patients would not be the same in all categories of where the thrombus were, is it not?
A: It depends upon how quickly the diagnosis is made and how appropriate the therapeutic management is rendered.
Q: It's your thought that there is some circumstances in which a patient would have a thrombus attach to the wall of one of his cardiac ventricles, would have the same prognosis with timely treatment as a woman with thrombus in her deep vein?
A: Yes.
MR. RUF: Objection.
A: I have removed thrombus from patients' ventricles during cardiac surgery procedures in patients who have had subsequently normal life expectancies.

Page 67

Q: Do you have any information concerning recurrence of thrombus formation in EMF patients?
A: I don't think specifically in EMF patients. But I think we know from our experience with left ventricular aneurysms, which we routinely operate and remove the aneurysm, and remove the inter-cavitary thrombus.
But if the thrombus is removed and the cavity appropriately treated, anticoagulation begun, those patients do not develop recurrent thrombus in their ventricle.
Q: Those patients don't have endomyocardial fibrosis?
A: No. But they have a problem that's worse. They have left ventricular aneurysm. That's more prone to developing mural thrombus.
Q: Well, Doctor, what is the cause of endomyocardial fibrosis?
A: I don't think anybody knows what the exact causes are.
MR. RUF: Objection.
BY MR. TRAVERS:

Page 68

Q: That would include you?
A: That's correct. I know there are specific subcategories of endomyocardial fibrosis that develop as a result of cardiac surgery.
But the ones that develop without cardiac surgery, I don't think anybody knows the cause of.
Q: Without knowing the cause of that condition, you are comfortable giving opinions upon recurrence of the disease after surgical intervention?
A: You asked me about recurrence of the thrombus, not of the disease. The disease won't change. The disease stays there. Whether it progresses or not. Nobody knows. I couldn't render an opinion based upon that. You asked me specifically about the likelihood of thrombus developing on that.
Q: You're right.
A: And the answer to that question is if it is appropriately treated, the likelihood is low that they will develop recurring thrombus.
Q: Okay. You don't claim though that through surgical intervention or

Page 69

anticoagulation you would be able to cure David Gonda of his underlying fundamental disease?

MR. RUF: Objection.

A: The endomyocardial fibrosis would not be reduced by removing the thrombus from the heart and anticoagulation.

Q: And there is certainly a morbidity attached to endomyocardial fibrosis even without pulmonary embolism?

A: Yes, there is.

Q: Would it be correct then that your statement, as far as the likelihood of effective intervening treatment, would be directed toward the embolization rather than to the underlying disease?

MR. MALIK: Objection.

A: I don't think that you can separate the two. The endomyocardial fibrosis is the Midas that allows for the development of the thrombus. The thrombus is then the pathologic process that results in progressive deterioration and demise. In order to treat one, you have to treat the other. They are part and parcel to each other.

Page 70

Q: Well, most patients who have endomyocardial fibrosis don't die of pulmonary embolism.

A: That is correct.

Q: Most of them die of heart failure?

A: Congestive heart failure.

Q: The removal of this thrombus would lessen the likelihood of the patient's fibrotic circumstance developing into congestive heart failure, would it?

A: It would not.

Q: Do you hold any opinions as to medical or surgical intervention could have cured him of his endomyocardial fibrosis?

MR. MALIK: Objection.

A: At the time that he presented, there was no surgical necessity to treat his endomyocardial fibrosis. He didn't have congestive heart failure. He had a very early stage of endomyocardial fibrosis.

Q: Had the thrombotic part of his lesion been addressed earlier, would you have any opinion on David's life expectancy based solely on his underlying disease?

A: I think with a reasonable probability, he would have had a relatively normal life expectancy.

MR. MALIK: Objection.

BY MR. TRAVERS:

Q: Even with the fibrotic lesions of his heart?

A: There is nothing that I am aware of that would stipulate that there is going to be progression in the degree of endomyocardial fibrosis that he had.

He would have had to have been followed echocardiographically and, perhaps, with right ventricular biopsies in various sites to determine whether or not there was progression in his disease.

Q: Well, it is a progressive disease, is it not?

A: We don't know that because we don't know the denominator. We don't know how many people have it and how long it takes to progress to a point where they develop congestive heart failure.

What you see is the one spectrum of the disease. You see the folks who have congestive heart failure. The denominator is

Page 72

when does it start. We don't know the answer to that.

I assume there are some people in whom it progresses rapidly. And some people it develops and is never even identified. And then there is a large group of people in the middle of that bell-shaped curve.

Q: You don't know where David would have fallen on that?

A: I do not.

Q: You do not agree that there is a high degree of morbidity just associated with the degree itself!

A: I don't think we know that. I think we now there is morbidity involved when you involve end-stage endomyocardial fibrosis. But even that has surgical option.

When you have very early endomyocardial fibrosis, I don't think we know the long-term track record of what happens to these patients from a clinical standpoint.

There is just not enough literature available to assess patients that have early endomyocardial fibrosis and that are followed clinically.

Page 73

Q: Well, I can't disagree with that, Doctor, but I suppose that's what I find most troubling about your testimony.

There is not that much information available, and it's surprising that you would sit here and tell me that this man would have a normal life expectancy.

A: There's nothing to tell me that he wouldn't otherwise. He didn't have any evidence of any congestive heart failure.

He didn't have any evidence of significant wall motion abnormalities that would preclude him from having a normal life span. And he had normal cardiac valvular anatomy and function.

Q: Do you think he would require a heart transplant?

A: There is no way to know that. At the time that he presented, certainly not.

Q: What are the facts that prompt your conclusion that he was in the early stages of the disease?

A: Because his cardiac involvement was minimal, one-sided. And his echocardiography suggested that his wall motion abnormality was

Page 74

minor. He had reasonably well-preserved contractility and normal valvular function.

Q: Do you believe that the disease always becomes two-sided or —

A: We don't know that. I don't know that. It may or may not. Again it's the same problem. We don't know the denominator. We don't know how many people are out there who have the disease, and it's subclinical. It's not detected, or it may never be detected. Some people may die with the disease and are never diagnosed.

What we do see is the end of the spectrum; patients who develop congestive heart failure. Those patients may know they have a limited life span.

Q: And you have no opinion as to whether his disease would progress?

A: I don't know.

MR. MALIK Objection.

A: I can't tell you. I don't have a series of tests to tell me that it has progressed or that it was even going to progress at all.

BY MR. TRAVERS:

Q: Is there any body of literature, whether

Page 75

by way of journal or text, that you believe is sufficiently reliable for you to recommend it to me if I were to attempt to educate myself on this disease?

MR. MALIK: Objection.

A: I don't think there is any specific tests that addresses this to a degree that would allow us to make specific conclusions.

I think this disease process is something that's been reported anecdotally.

The series of patients have been put together and report their clinical pathologic processes, and that's how we gained our knowledge about this disease.

If it were a more frequent disease, or picked up in an earlier stage, then we would have more information about which we could make a reliable prediction. We don't have that information.

Q: I think that was a good-faith effort to answer my question. In case I'm mistaken, are there any texts or journals that you believe have reliable information on them on this disease?

A: I think all of the texts written have

Page 76

reliable information. They are written to inform and educate physician.

MR. MALIK: Objection.

BY MR. TRAVERS:

Q: Are there any you believe are more authoritative than others?

MR. MALIK: Objection.

A: No.

Q: The whole body of literature, if it's mentioned there, is it equally reliable?

A: I think physicians write articles and publish texts to educate their colleagues in an effort to gain knowledge and allow their colleges to have that same knowledge. They are all authoritative. They express opinions based upon case summaries, clinical conditions and pathological disease. There is no one article that's more authoritative than another.

Q: Are you aware of information that you believe is accurate concerning the number of patients who die from endomyocardial fibrosis if they contract that disease?

MR. RUF: Objection. At what stage?

Page 77

MR. TRAVERS: You are welcome to redirect if you think that's appropriate or a different question is appropriate.

Q: I want to know whether you have opinions on that or whether you claim to know.

A: I think what you could say is there is a group of patients who develop end-stage endomyocardial fibrosis who die from the disease. There is a group of patients who develop complications of endomyocardial fibrosis who end up having surgical procedures.

There is a large subset of patients that have the disease and are not diagnosed and may never be diagnosed. They may die out-of-hospital deaths, and we may never know what their death was attributable to.

Q: Well, I tried to phrase my question to not address the people who have not been diagnosed. I'm asking about patients who are diagnosed as having this disease.

A: I think the body of literature, in that group of patients who are diagnosed, who are reported upon, are patients with end-stage endomvocardial fibrosis. Their life

Page 78

expectancy is not normal.

Q: Substantially impaired?

MR. MALIK: Objection.

Q: Most of them die soon?

A: They have a less-than-normal life span. I don't think you can really say over a time span how long they live. They certainly have a decreased life span.

Q: So that the huge majority of cases in which we are aware of the existence of the disease are not diagnosed until they reach the end stage of EMF?

A: That's correct.

MR. MALIK: Objection.

Q: Were all of these people guilty? Did they have malpractice committed on them, too, for not having the disease diagnosed early?

MR. RUF: Don't answer that. Objection. That's an inappropriate question.

A: Come on, guys.

MR. BANAS: I would rephrase it. I think its reasonable.

MR. RUF: We have no information about what happened clinically with any of those patients. So, I think it's

Page 79

an inappropriate question. He's got opinions with respect to this patient.

Q: I will try to rephrase the question, Doctor, so that we won't fight about whether you should answer it or not.

But let me ask it this way: We are in agreement that failure to diagnose endomyocardial fibrosis is not in and of itself a violation of the standard of care for a practicing internist?

MR. MALIK: Objection.

MR. RUF: Objection.

A: I think it's within the demand of a cardiologist to make that diagnosis.

Q: Not every patient who suffers that disease was rendered substandard medical care by not having had it diagnosed earlier?

MR. RUF: Objection.

MR. MALIK: Objection. Do you know that?

A: Let me answer the question. I think if they have the ability to perform the appropriate study, tbat then allows them to make the diagnosis, and that isn't offered to the patient, yes, I do believe it is

Page 80

malpractice.

Q: Have you actually viewed any of the imaging studies in this case?

A: You have to be more specific.

Q: Have you seen the chest film? Have you seen the TEE? Have you seen the 2-D echo?

A: I have not.

Q: Have you seen any imaging studies?

A: Personally looked at the studies?

Q: Correct.

A: No, I have not.

MR. MALIK He is talking about the video.

Q: I'm talking about any imaging study. I'm asking if he viewed the film or video.

A: I have not seen the chest X-rays, the 2-D electro or TEE.

Q: Are you aware whether pericardial effusion was evidenced on the 2-D electro or the TEE at the time he presented to the hospital?

A: It's my recollection there was no significance evidence of pericardial effusion on the TEE or 2-D.

Q: Isn't it likely if his condition cannot

Page 81

demonstrate pericardial effusion at the time he was at the hospital, it's likely he would not have had pericardial effusion two months earlier?

MR. MALIK: Objection.

A: I think that's a projection you are making. I don't think you can make that assumption. I think you have to have a test that tells you there, indeed, was not fluid there. There may have been or may not have been.

Q: We are dealing in likelihoods here, Doctor. The disease obviously progressed substantially between June and August. We have agreed on that, correct?

A: Correct.

MR. MALIK: Objection.

BY MR. TRAVERS:

Q: And yet still in August there is no evidence of pericardial effusion?

A: I think the likelihood is greater than not that had a two-dimensional echocardiography been performed earlier, it would not have shown fluid. I can't tell you that with certainty.

Page 82

Q: Okay. Can you estimate how long the lesion in the patient's right ventricle had been present before his death?

MR. MALIK: Objection.

A: Some form of the endomyocardial fibrosis thrombus was present from his initial presentation.

Q: How long before that?

A: There is no way to know. It clearly was there when he first started developing his cough. I suspect that was from pulmonary emboli.

Q: Are you aware of the testimony from any of the other witnesses as to how long he had his cough other than what's recorded in the medical record?

A: It's reflected in the records that's one of his original presenting symptoms was his cough.

Q: You have not been provided with transcript of any of the family members or the former fiance of Mr. Gonda?

A: I have. I have not had a chance to read through it.

Q: When is your recollection?

Page 83

A: I think when he started seeing Dr. Ruiz about his cough.

Q: The only patients you have ever treated who had endomyocardial fibrosis was during your residency in Michigan?

A: That's correct.

Q: Had that person traveled in Africa, do you know?

A: I don't remember whether it was a white or black person or their travel history. It was a young child.

Q: Did the patient survive?

A: I think the patient actually did survive. I don't know how long afterwards. I left there shortly after.

Q: What was the stage of that patient?

A: End-stage left-sided endomyocardial fibrosis.

Q: That had just been recently diagnosed?

A: As I recall. I don't remember the specifics surrounding it. As a resident, you don't always get involved with the workup.

MR. TRAVERS: I think those are all of my questions.

Page 84

EXAMINATION OF MARK J. BOTHAM, M.D.

BY MR. BLOMSTROM:

Q: During my examination of you, your CV was circulated. It never came back to me. I would like to get it marked.

A: I don't know that it came back to me.

(Thereupon, Defendant's Deposition Exhibit B was marked for purposes of identification.)

BY MR. BLOMSTROM:

Q: Is this a copy of your curriculum vitae?

A: Yes, it is.

Q: And it is Defendant's Exhibit what?

A: Exhibit B. Thank you.

MR. BANAS: I have no questions.

(Signature not waived.)

(Deposition concluded at 6:20 p.m.)

CERTIFICATE

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

I, Terry D. Gimmellie, a Notary Public within and for the State of Ohio, do hereby certify that the within named witness, MARK J. BOTHAM, M.D., was by me first duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by the above-referenced witness, was by me reduced to stenotypy in the presence of said witness; afterwards transcribed, and that the foregoing is a true and correct transcription of the testimony so given by the above-referenced witness.

I do further certify that this deposition was taken at the time and place in the foregoing caption specified and was completed without adjournment.

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

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this _____ day of _____, 1999.

Terry D. Gimmellie, Notary Public
within and for the State of Ohio

My commission expires November 7th, 2001.

Lawyer’s Notes

1

10 8:25; 9:4
120 56:13; 58:6
13 8:16
13th 8:22; 43:10
15th 46:5; 47:7, 9
17 13:8
18th 25:3
1995 14:25; 22:10; 23:3; 24:15; 25:3, 3, 24; 27:23; 28:12, 25; 29:19; 30:5; 37:23; 38:12; 52:6; 59:11
1998 5:18, 25; 6:2; 8:16, 22; 10:22; 11:2, 5, 9; 33:1, 14; 38:7

2

2-D 7:18, 22; 14:18; 20:10, 11; 34:2, 3, 9; 36:3, 8; 57:5; 80:6, 16, 19, 24
20's 55:2
23 6:2; 10:22; 11:9
23rd 11:2
24 11:11
25 5:18, 25; 11:5; 38:7
25th 43:24
26 58:5
27 24:15; 28:12; 33:14
27th 14:25; 22:9; 23:3; 25:3, 24; 36:4; 37:23; 38:11
28th 36:4
29 12:1
29-year-old 58:5

3

3,000 49:13
31 13:9

5

50 39:24
5th 43:9

6

6:20 84:19

8

89 55:9, 12; 57:21
8th 45:14

9

95 43:25; 55:13; 56:6, 7
98 5:15

A

abdomen 46:2, 7
ability 21:12; 79:22
able 21:9, 22; 22:11, 12, 6; 49:20; 55:11; 69:1
abnormal 55:4; 57:11; 58:4
abnormalities 55:15, 16; 57:24; 73:12
abnormality 38:9, 11; 56:23; 73:25
above-referenced 35:12, 16
absolutely 54:8
accelerated 39:23
acceleration 64:19
accept 31:5, 9; 24:10
acceptable 16:10
accessing 12:16, 24
accompanying 57:10
according 35:4, 6; 42:16
Accordingly 35:22
accords 53:24
accurate 76:21
accused 46:15
across 14:22; 15:4
act 19:23; 20:1, 7, 8
active 26:6
actually 5:4; 11:10; 23:15; 24:1; 26:21; 31:10; 80:2; 83:13
acute 64:9
additional 58:1
additive 17:11
address 77:19; 32:1; 70:22; 75:7
adequate 17:9
adjournment 85:20
admit 24:8; 30:20; 31:2; 46:8
Adornato 29:13
advised 46:3
aforesaid 85:11
afraid 52:25
Africa 83:7
afternoon 4:8, 9
afterwards 83:14; 85:14
again 8:21; 10:25; 12:1; 23:12; 46:21; 52:17; 74:6
age 4:1
ago 5:6
agree 33:12; 49:18; 56:9; 72:11; 81:15
agreement 61:23; 62:1; 79:7
allow 75:8; 76:13; 6:25; 44:23; 69:20; 79:23
along 4:11; 47:25
always 74:3; 83:22
American 10:8
among 4:14; 12:18; 20:25
amount 21:10
anatomy 73:15
anecdotally 75:10
aneurysm 67:8, 17, 6
angiosarcoma 42:17
answered 26:24; 36:15
antecedent 39:13
antibiotics 43:15
anticoagulated 63:18
anticoagulation 42:22; 57:11; 69:1, 7
Any-sided 60:14, 14
anymore 60:19, 21
apparently 14:18; 43:2, 13; 44:10
applies 51:22
appropriate 14:9; 16:3; 17:5; 21:25; 22:1, 5; 34:19; 36:17; 43:17; 44:1, 14; 45:7; 46:3, 21; 49:6; 50:12, 17; 54:20; 66:12; 77:2, 3; 79:23
appropriately 21:12; 22:15; 36:23; 38:2; 65:14; 57:11; 68:22
April 25:6
aptly 21:13
area 14:18, 18; 40:9
around 58:23
arterial 64:4, 7, 20
artery 40:14; 64:18
article 41:15; 76:18, 11
ascribe 38:19
asphyxiated 63:6
asphyxiation 6:20; 28:24; 62:16; 64:8
assess 7:15; 14:10; 17:10; 26:11, 25; 30:11; 37:17; 52:18; 56:17; 72:23
assessment 16:17; 22:1; 50:25; 54:13; 56:10
associated 72:12
Associates 4:12; 16:7
Association 9:13, 16, 21 10:8
assume 13:20; 14:24; 15:6; 44:4, 14; 45:7; 48:4; 56:2; 57:23; 62:11; 72:3; 52:8
assumption 15:16; 36:25; 81:8; 6:10, 12
atrium 13:16
attach 66:16; 69:9
attempt 75:3
attorneys 12:19
attributable 6:19; 77:17
August 25:3; 26:7; 45:10 14; 81:14, 19
authoritative 76:6, 15, 18
available 22:21; 37:18; 51:25; 52:4; 53:9; 72:23; 3:5
average 40:2
avoided 12:15, 16, 24
aware 8:13; 10:16; 13:18, 2; 14:4, 17; 18:22; 20:20; 9:7, 10; 58:11; 60:7; 62:4; 1:7; 76:20; 78:10; 80:18; 2:13

B

back 17:17; 25:23; 36:11, 4; 39:3; 45:12; 50:1; 58:9; 9:11; 84:4, 6
background 8:8; 15:13, 0
bacterial 30:17, 18; 8:10, 20; 59:4, 17, 24
BANAS 20:3; 42:5, 6; 4:21; 48:16; 52:10; 5:22; 78:21; 84:17
base 31:24; 21:15; 25:4; 7:19; 29:7, 21; 37:12, 19; 2:4; 54:13, 17; 57:14; 9:16; 63:9, 11; 68:17; 0:23; 76:16
basic 18:12
basis 7:11; 18:7; 37:12
became 4:19; 28:21
becomes 74:4
begin 11:12; 12:2; 48:23
Beginning 9:4
begs 36:10
begun 67:12
behests 35:18
bell 47:12
bell-shaped 72:7
below 19:19; 48:14
best 56:19
better 24:9, 13; 43:15; 44:3, 7; 45:11, 20; 46:1; 65:8
biopsies 71:13
biopsy 42:19
bit 17:18; 20:22
black 83:10
blocked 64:4, 6
blocks 64:20
BLOMSTROM 4:7, 10; 17:16; 20:5, 13; 21:7; 22:23; 24:25; 26:8; 28:2; 29:5; 30:25; 32:17; 33:7, 11; 37:6; 38:6; 42:2; 84:2, 12
blood 59:2, 7, 10
Boardman 15:2
body 59:9; 74:25; 76:9; 77:22
bolstered 53:17
book 41:11
both 7:19, 20; 15:6; 22:4; 28:1, 5; 35:23; 53:24
BOTHAM 4:1, 6; 42:4, 6; 48:18; 84:1; 85:8
British 41:15
broad 24:23
bus 54:8
bypass 40:15

C

called 4:2; 15:7
calling 58:24
came 9:11; 13:19; 15:17; 7:23; 84:4, 6
can 4:19; 5:16; 7:25; 0:20; 14:10; 22:2, 19; 3:4, 17; 24:3; 25:16; 27:9; 2:7; 33:25; 34:7; 35:19; 6:14; 37:11, 20; 38:10; 9:14; 44:19; 46:17; 5:14; 60:1, 2; 61:16; 9:18; 78:6; 81:7; 82:1
capabilities 12:6
caption 85:19
car 14:15, 16
cardiac 7:15; 11:16, 19; .2:16, 24; 14:13; 15:23; .6:12; 20:18; 31:17; 0:14; 51:11, 14; 52:2, 16, 9, 21; 53:8, 12; 54:5; 7:12; 58:1; 60:12, 17; 4:25; 66:1, 7, 17, 23; 8:4, 6; 73:14, 23
cardiograms 7:19; 14:20
cardiologist 7:24; 79:14; 7:23; 14:21; 54:12; 57:16
cardiology 8:12, 13; 0:20, 22; 10:9; 16:21; 4:24
cardiothoracic 7:12; 0:6, 10
cardiovascular 48:2; 49:14
Care 4:24; 17:18, 18:8; 19:19, 22, 25; 24:11; 29:17; 31:3; 43:19; 48:14; 51:10; 52:7, 22; 53:13; 79:9, 16
careful 62:18
case 4:11, 20; 20:8; 32:9; 33:15; 37:20; 41:2; 50:6; 52:13; 58:12, 14; 75:21; 76:16; 80:3; 5:1; 39:18, 19, 22; 58:23; 78:9
catch 10:5
categories 66:9
category 62:4, 8
cause 6:10, 13, 16, 18, 21; 39:8; 62:14; 64:1; 67:20; 68:7, 9; 85:10; 62:11, 15; 63:16, 17; 65:25; 67:23
cavity 60:16; 67:11
Center 46:9; 47:11
certainly 34:15; 69:8; 73:19; 78:7
certainty 22:8; 34:8; 37:8, 21; 81.25

CERTIFICATE 85:1
certified 4:4
certify 85:7, 17
chambers 34:24; 35:4; 66:1
chance 5:20; 54:9; 61:12; 65:8, 15, 18; 82:23
change 24:14, 19; 25:1, 11, 19; 28:16; 68:15; 25:14; 56:10, 12; 57:2
Charity 9:23; 10:11; 40:8
checking 12:9
chest 7:10; 15:4, 8; 22:25; 23:5; 43:12; 46:2, 6; 80:5, 16
child 83:11
chronic 38:25; 64:12
circuit 64:5, 21
circulated 84:4
circumstance 49:4, 7; 70:9; 17:19; 18:9; 34:10; 66:15
Civil 4:3
claim 18:7; 19:19; 68:24; 77:5; 33:22
clear 10:24; 48:25; 45:21; 44:9
clearly 26:17; 39:5; 82:9
Cleron 40:20
Cleveland 9:23, 25; 10:12, 14; 14:18; 42:10; 61:11
client 15:18
Clinic 9:25; 10:14; 42:10, 11; 61:9, 11, 25; 63:19
clinical 16:18; 26:14; 27:5; 29:17, 24; 30:13; 31:12, 25; 32:1; 38:13; 39:11; 50:5, 21, 25; 51:5, 25; 52:4; 53:9; 54:22; 57:14; 60:6; 72:21; 75:12; 76:16
clinically 72:25; 78:24
clinician 19:6; 34:16; 44:16; 51:13; 53:18
close 39:24
colleagues 21:1; 76:12
colleges 76:14
collegian 20:22
comfort 54:19
comfortable 54:2; 68:10
comment 62:19
committed 78:16
community 7:21
compare 25:17; 26:13; 27:2; 25:9
complaint 29:20; 30:8; 51:15; 29:1; 30:1, 4
complete 18:19, 20; 36:18; 61:22; 13:23; 85:19
completely 17:10; 23:25; 37:15
Complex 15:2
comolications 77:10
complied 33:6
concerned 16:4; 35:9
concerning 6:10; 48:24; 67:1; 76:21
conclude 60:8; 84:19
conclusion 73:21; 61:23; 75:8
condition 11:16, 19; 12:16, 24; 24:15, 20; 25:2, 13, 25; 28:11, 17; 31:13; 63:11; 68:10; 80:25; 76:16
conduct 21:12
congestion 45:20
Congestive 70:6, 9, 19; 71:22, 25; 73:10; 74:14
connection 41:2
consistent 38:22
constellation 30:13; 39:8; 57:7
constitute 52:7; 53:12
consult 34:21
consultant 46:22
consultation 17:13; 31:6, 9; 20:18
contained 47:2
continue 43:21; 26:17; 64:19
contract 76:23
contractility 74:2
contributory 62:23
conversation 34:2; 20:17
convinced 57:1
copies 40:16
copy 8:15; 14:5; 22:12; 23:13; 36:21; 84:13
coronary 40:14
corporation 16:5
corrected 12:3
correctly 23:25; 24:6; 37:15; 46:12; 49:3; 50:3
cough 38:19, 21, 25; 43:12, 14; 45:21; 51:9; 54:4; 55:2; 82:11, 15, 19; 83:2; 44:9
country 14:23
County 85:4
course 11:2; 43:16; 44:12; 46:19, 24; 47:2
Court's 33:6
critical 15:18, 19, 25; 16:2, 6, 8; 47:15
criticism 48:5, 7; 49:1
Cropp 29:13; 42:7; 43:7, 11, 24; 44:12; 46:25; 47:19, 21; 48:6; 43:20; 45:13, 17
cultures 59:2, 3, 7, 10, 13, 19, 24; 60:3
cure 69:1; 70:13
curriculum 8:9; 84:13
curve 72:7
Cuyahoga 85:4

D

date 8:21; 24:15; 26:1; 28:4, 8, 13; 38:24; 5:12, 17
David 6:11; 12:25; 25:25; 45:22; 53:10, 19; 54:22; 59:11; 63:5; 69:2; 72:8; 65:3; 70:23
day 43:7; 44:11; 45:3
days 36:4; 43:22; 46:5
dealing 81:12
death 6:11, 14, 17, 18; 24:16; 26:2; 28:4, 8, 13; 62:6, 11, 14, 14, 21; 63:16, 16, 20; 64:1, 23; 65:3, 10, 22; 77:17; 82:3; 77:16
decision 34:12
decongestant/antitussive 45:6
Deconsal 45:5
decreased 63:21; 78:8
deep 66:19
Defendant's 32:13, 19; 84:8, 15
degree 8:6; 22:8; 32:3; 34:8; 37:8, 21; 71:9; 72:12, 13; 75:7; 32:6
delineated 22:13
demand 79:13
DeMarco 42:7; 44:24; 47:12, 15
demise 26:5; 27:8; 39:5; 69:23
demonstrate 81:1; 20:9
denominator 71:19, 25; 74:7
depend 31:12; 21:11; 66:11
deposed 4:4; 10:25
deposition 6:1, 6; 7:1; 8:16; 9:3; 10:22; 11:9; 20:10; 32:13; 61:15; 84:8, 19; 85:18
describe 10:20; 24:19; 25:1; 27:9; 28:16; 40:4
descriptions 27:17
despite 51:2
detail 18:21
detected 74:10, 10
deterioration 69:23
determination 58:15
determine 71:14; 25:10; 30:21; 31:4
determining 11:15
develop 64:21; 67:12; 68:4, 6, 23; 71:21; 74:14; 77:7, 10; 10:21; 60:16; 67:18; 68:19; 70:9; 82:10; 72:5
development 62:4; 69:20
deviation 4:24; 33:22; 43:19
diagnose 79:7; 65:14; 74:12; 77:14, 15, 20, 21, 23; 78:11, 17; 79:17; 83:19; 42:20
diagnosis 16:18; 42:10, 12; 44:16; 59:23, 25; 65:2; 66:11; 79:14, 24
diagnostic 12:6; 52:2
die 70:2, 5; 74:11; 76:22; 77:8, 15; 78:4
died 63:6
difference 28:11
different 23:8; 43:14; 77:3
differential 44:16
directed 30:2; 41:8, 12; 53:6; 69:15
directly 6:18; 26:22
disagree 58:17; 73:1
disagreement 58:11
disconcerted 48:9
discontinue 45:4
discuss 20:19
discussion 10:1; 12:18; 30:24
disease 24:17; 26:4, 16; 27:6, 20; 49:14; 54:6; 62:3, 5; 65:17; 68:11, 14, 14, 15; 69:3, 16; 70:24; 71:15, 16, 24; 73:22; 74:3, 9, 11, 18; 75:4, 9, 14, 15, 24; 76:17, 23; 77:9, 14, 21; 78:11, 17; 79:16; 81:13; 9:24; 10:14
Doctor 43:2; 44:20; 46:19; 49:3; 51:7; 53:2; 56:2; 65:5; 67:20; 73:1; 79:4; 81:13; 54:11; 57:17
document 29:4, 9; 25:16; 29:14
documentation 13:23, 25
Dominican 9:10
done 5:21, 22; 11:14; 13:22; 14:2; 17:14, 21; 21:3; 24:6; 27:13; 31:20; 34:5; 36:23; 37:2, 15, 15; 38:2; 49:11, 12; 54:10, 17; 59:11; 60:24
down 10:2; 13:8
doxycycline 43:16, 21
Dr 4:11; 6:1, 6, 7, 8; 8:1, 5, 15; 10:21, 25; 11:14; 13:14, 20, 21; 14:3, 25; 15:3, 6, 6, 7, 7, 8, 10, 12, 14; 16:1, 2, 4, 7, 8, 9, 19, 20; 18:5, 11, 23; 19:3, 6, 7, 8, 20; 20:9; 21:9; 23:2, 22; 24:10; 29:13, 13, 13, 13; 33:23, 25; 34:1, 3, 13, 14; 35:2, 24, 24; 40:24; 41:24; 42:6, 7, 7; 43:7, 11, 20, 24; 44:12; 45:13; 46:25; 47:1, 12, 15, 19, 21; 48:6, 21; 50:7, 15; 51:22; 53:4, 9; 54:25; 61:4, 19; 83:1
drafts 33:10
drainage 44:8
dramatically 64:10
drug 43:17
duly 4:3; 85:9
duration 44:17
during 34:1; 50:14; 63:1; 66:23; 83:4; 84:3
dying 26:19

E

earlier 61:15; 65:2, 8; 70:22; 75:16; 79:17; 81:4, 23
early 27:25; 28:8, 10; 52:6; 62:9; 65:15; 70:19; 72:18, 23; 73:21; 78:17
easy 44:25
echo 20:10, 11; 34:2, 3, 9; 56:16; 80:6; 7:22
echocardiograrn 36:3; 56:17; 7:15; 14:19
echocardiographic 25:6
echocardiographically 71:12
echocardiography 18:21; 19:17; 25:8, 17; 26:12, 13; 27:1; 34:20, 22, 23; 36:8; 37:4; 51:19; 52:23; 55:5; 57:5; 60:4; 73:24; 81:23
educate 20:23; 21:6; 75:3; 76:2, 12
effective 69:14
effectively 22:5
effort 75:20; 76:13
effusion 22:9, 18; 23:11; 49:20; 80:19, 23; 81:1, 3, 20
eight 40:2
either 16:12; 22:13, 25; 38:4; 64:21
EKG 55:4, 7, 12, 14; 56:4, 11, 12, 17; 57:4, 11, 21, 23, 25
EKG's 56:5
electro 80:17, 19
electrocardiogram 57:8, 9
eliminate 4:15
Elizabeth 9:17, 21; 10:9; 29:18; 46:8; 47:10, 11
else 13:4, 7; 42:19; 54:9
elsewhere 31:8
emboli 6:19, 21, 23; 26:19; 28:20; 38:17, 20, 23, 25; 62:15; 63:17; 64:3, 15, 16, 16, 19, 24; 65:12; 66:4; 82:12; 7:2
embolism 69:10; 70:3
embolization 64:10, 12; 65:23, 25; 69:15
embolus 28:23; 63:22; 64:1, 6, 17; 65:22

emergent 63:1, 12
EMF 58:24; 59:1; 61:20; 67:2, 4; 78:12
employs 16:5
end 27:23; 74:13; 77:11; 78:12
end-stage 31:19; 72:16; 77:7, 24; 83:17
ended 25:9; 26:19
endocarditis 30:17, 19; 58:11, 18, 20; 59:4, 18, 22; 60:9, 11, 13, 14, 15
endomyocardial 6:25; 27:11, 18, 22; 28:4, 7; 30:22; 31:5, 16; 32:5; 41:9, 12, 16; 43:4; 58:10, 22; 59:5; 62:8; 67:14, 21; 68:3; 69:5, 9, 19; 70:2, 14, 18, 20; 71:9; 72:16, 18, 24; 76:22; 77:8, 10, 25; 79:8; 82:5; 83:4, 17
ends 47:17
enough 64:20; 72:22
entertain 48:10
entries 27:16
episode 63:5; 64:9
equally 76:10
equation 53:3
espouse 58:17
essentially 45:23
estimate 82:1
etiology 11:15, 19;12:17, 25; 48:12; 51:15; 52:19, 21; 53:5
evaluate 14:14; 15:22; 16:11; 18:18; 19:16; 21:22; 24:9; 29:25; 30:11; 35:23; 36:22; 50:17; 51:4; 52:17; 53:20, 21; 54:10; 17:7; 37:16; 49:13; 53:10
evaluating 18:3; 54:2; 59:21
evaluation 14:9; 18:20; 33:18; 35:22; 50:14; 51:11, 17; 25:7; 54:14
even 6:2; 15:19; 25:19; 69:9; 71:5; 72:5, 17; 74:23; 63:7, 20
event 64:5
eventual 64:8; 65:22
eventually 25:9, 18; 26:5, 18;27:3; 28:22; 39:4; 64:17; 65:13
evidence 52:9; 57:4; 59:12; 73:10, 11; 80:23; 81:20; 57:25; 80:19
exact 25:20; 43:9; 46:17; 67:23
exactly 8:8; 25:10; 42:14
examination 4:2, 6; 42:4; 48:18; 84:1, 3
examine 57:18
examining 14:15
exclude 59:24; 60:1, 2
exclusion 59:23
exercise 11:8
fxhibit 32:14, 19; 61:15; 84:9, 15, 16
existence 13:19; 15:17; 56:22; 78:10
exists 58:12
expectancies 66:25
expectancy 70:23; 71:2; 73:7; 78:1
experience 7:7; 8:1; 10:16; 21:16, 17, 20; 67:6; 53:24; 27:10
expertise 56:4
zxperts 40:17
zxpianation 33:8
zxplore 17:17
zxpress 22:25; 34:7; 76:15; 61:23
zxtent 26:9, 23; 27:21
extremely 24:23; 60:10, 15
extremity 66:5, 6

F

fact 21:17; 25:15, 21; 34:8; 51:2; 53:18; 52:9; 73:20
factual 37:12
failure 52:3; 53:11; 64:22; 70:5, 6, 10, 19;71:22, 25; 73:10; 74:15; 79:7
Fair 12:4; 22:24
Fall 19:19
fallen 72:9
familiarity 18:7
family 54:11; 61:8, 24; 82:21
far 6:21; 37:20; 47:5; 69:13
fatal 6:20; 63:22
father 5:5
features 60:7
February 8:16, 22
feel 17:8; 18:24; 24:12; 30:18; 38:13; 39:10; 51:13; 52:15, 19, 21; 53:20; 54:1; 56:24; 58:19; 59:17; 30:9; 43:10; 44:3, 7; 45:10, 25; 50:18
fellow 16:20
fellowship 8:12, 14; 9:20, 22, 24; 10:8; 16:21; 8:7; 9:18; 10:5
felt 50:16
fever 30:9; 38:21; 39:1; 44:11, 18; 45:2, 22; 51:9; 54:4
few 36:4; 42:8
fiance 82:22
fibrosis 6:25; 27:11, 18, 22; 28:4, 7; 30:22; 31:5, 14, 16, 19; 32:5; 41:9, 13, 17;43:4; 58:10, 22; 59:5; 62:8; 67:15, 21; 68:4; 69:5, 9, 19; 70:2, 14, 18, 20; 71:10; 72:16, 19, 24; 76:22; 77:8, 11, 25; 79:8; 82:5; 83:4, 18
fibrotic 70:8; 71:5
field 49:8
fight 79:4; 58:9
film 80:5, 15
final 9:17; 64:5
find 8:20; 43:9, 18; 46:17; 51:6; 73:2
findings 63:9
fine 11:13; 25:1
first 4:3; 19:13; 42:9; 43:7; 55:6; 82:10; 85:9
five 39:23, 25
flow 64:7
fluid 21:10, 23; 23:14, 19, 20, 23;36:5, 7, 20, 25; 37:3, 5, 9, 13, 17, 22; 38:4; 31:9, 24
flutter 56:16
focused 24:24
folks 71:24
follow-up 43:24
followed 71:11; 72:24
following 10:10, 13
follows 4:5
forces 56:9, 25; 57:4
foregoing 85:14, 19
form 38:15; 82:5
formal 7:8; 48:7
formation 67:2
former 82:22
four 39:25
Francisco 58:8
frantic 55:23
Free-standing 18:4, 10
Frequent 66:4; 75:15
frequently 17:5, 15; 20:19; 39:16; 65:24
friends 5:7
full 16:16
fully 20:20; 37:16
function 22:5; 73:15; 74:2
fund 16:14; 18:12
fundamental 69:2
further 28:20; 57:12; 85:17

G

gain 76:13; 75:13
Gary 42:6
generalized 30:8, 10; 38:22; 55:2
generally 65:24
gentleman's 38:18
Gimmellie 85:6
given 7:4; 43:22; 85:11, 6
lives 51:17
living 21:15; 68:10
goes 47:9
Gonda 14:7, 25; 15:3; 19:1, 20; 30:16; 32:23; 33:21; 44:4, 7; 45:2, 19; 52:14; 53:11, 19;59:11; 61:8; 62:5; 65:21; 69:2; 82:22; 6:11; 12:17, 25; 24:14; 25:2, 25; 27:23; 28:5, 12; 54:22
Good 4:8, 9
good-faith 75:20
gray 60:20
greater 81:21
grossly 58:4
group 72:6; 77:7, 9, 23
guaranteed 63:23
guess 36:10; 42:18; 48:9
guilty 78:15
guys 60:19; 78:20

H

Hadley 40:20
Hafiz 4:11; 11:14; 13:14, 11;15:6, 7; 16:1, 4, 7, 8, 19;18:5, 11, 23; 19:3, 7, 20; 21:9; 23:2, 22; 24:10; 33:23, 25; 34:13; 35:24; 5:6; 15:10; 29:13
hair 60:20
handing 32:18
handy 8:16
happened 78:24
happens 72:20
happy 4:15
hard 14:4; 22:12; 23:13; 36:21
heard 49:15
Heart 9:20; 10:8; 12:8; 13:5, 7, 12, 16; 16:23; 25:2, 13, 25; 26:20; 27:23; 32:4, 7; 34:25; 35:4, 12, 13, 17, 19; 48:12; 49:13; 53:23; 58:6; 60:18, 24; 64:21; 69:7; 70:5, 6, 9, 19; 71:6, 22, 25; 73:10, 16; 74:15
helped 46:16
hemoptysis 6:20; 28:24; 46:8; 47:10; 62:16;64:7, 22
Henry 10:12
hereby 85:7
hereinafter 4:4
high 72:11
higher 20:16
highlighting 46:17
hindsight 42:25
histologic 42:19
history 27:20; 83:10
Hitchcock 15:1, 3
Hoffman 41:24
hold 70:12
home 41:6, 8, 14
hoped 34:4, 15
hospital 4:22; 9:13, 16, 17, 21, 23; 10:9, 11; 40:7, 8, 8, 23; 41:25; 46:7; 54:7; 61:3, 5; 80:21; 81:2; 61:2
huge 78:9
hypertension 65:19
hypothetical 5 1:24; 52:11, 13;53:19

I

idea 33:2
identical 37:25
identifiable 5:13; 23:19
identification 32:15; 84:10
identified 37:5; 38:5; 55:16; 56:24; 72:5
identity 32:19; 49:20
ill 30:9
imaging 80:3, 8, 14
impaired 78:2
improvement 45:24
inappropriate 18:14; 19:13; 34:18; 78:19; 79:1
inappropriately 23:2
incised 63:4
include 12:7; 68:1; 5:21; 33:13, 17; 44:15
including 33:10
Inclusive 51:18; 53:22
incomplete 15:24
incorrectly 24:4, 7
increase 56:25; 57:4; 56:8; 64:11
indeed 30:1; 37:3; 81:9
independent 58:15
indicate 23:23; 11:3; 14:1; 33:19
infection 59:8
infectious 60:8
infective 30:17; 58:10; 60:11
inform 76:2; 34:16
information 7:3; 15:15; 17:20; 33:24; 34:6; 47:3; 50:5; 51:17, 25; 52:4; 53:9; 57:19; 67:1; 73:4; 75:17, 19, 23; 76:1, 20; 78:24
initial 5:23; 32:22; 39:6; 82:6
inside 60:16
instance 22:16
integral 35:18
inter-cavitary 67:8
interaction 20:22; 40:22
interested 35:3; 47:6
internal 9:15; 13:11, 15; 16:22; 34:24; 35:3; 57:17

internist 30:21; 31:3; 51:7, 10, 24; 52:5; 53:7; 54:3; 79:10; 54:11
internship 9:5, 9, 12
interpret 7:13, 15;25:12; 55:11, 12; 7:22; 14:20; 17:24; 18:1; 23:2, 11; 49:19
interpretation 23:21; 56:4, 6
interrupt 30:23; 10:6
intervening 69:14
intervention 32:10, 11; 68:12, 25; 70:13
into 15:17; 46:7; 70:9
intravascular 9:24
investigation 57:12
involve 72:16; 4:19; 28:5; 29:16; 32:7; 72:15; 83:22
involvement 32:4; 73:23
involving 60:17
irrelevant 18:24
ischemic 56:10, 12;57:2
isolated 57:15, 19
issuance 5:16
issue 23:8; 58:15; 61:25; 62:2, 18; 5:9, 25; 23:18
issuing 6:9

J

Jim 4:10
journal 27:17; 41:16; 75:1, 22
judgment 50:6; 54:17, 23; 57:14
July 5:12, 14; 32:25; 33:1, 13, 19;43:9, 10, 24
June 14:25; 22:9; 23:3; 24:15; 25:3, 7, 21, 23, 24; 26:6, 12, 17; 27:2, 7, 23; 28:12, 25; 29:19; 30:5; 36:4; 37:23; 38:11, 14; 39:12; 56:7; 59:11; 81:14

K

kind 54:7, 10; 56:19
knowing 54:19; 68:9
knowledge 15:14; 16:15; 18:13; 75:14; 76:13, 14
known 5:4
knows 17:1; 20:10, 14; 21:18, 19; 61:20; 67:22; 68:7, 16

L

laceration 62:20, 25; 63:14
large 40:10; 62:20; 63:25; 64:17; 66:1; 72:6; 77:13
larger 64:6
last 7:9; 39:17, 23, 25; 45:9; 54:7; 57:20
lastly 66:6
late 28:9; 52:5
later 9:2; 46:5; 62:12
latter 26:13
Laughter 55:24
lawful 4:1
lawyer 48:20; 10:2
learn 20:23
least 8:11; 21:1; 55:5
led 5:16
left 67:6, 17;83:14
left-sided 83:17
lesion 70:21; 82:2; 71:5
less 40:3; 60:20
less-than-normal 78:5
lessen 70:7
letter 32:21; 46:20; 61:7, 17, 19;46:24
level 54:19
life 66:25; 70:23; 71:1; 73:7, 13; 74:16; 77:25; 78:5, 8
likelihood 59:13; 63:21; 68:18, 22; 69:13; 70:8; 81:21, 12
likely 59:2; 80:25; 81:2
limited 12:6, 15, 23; 16:15;18:13; 49:5; 74:16
line 8:25; 9:4; 10:3; 11:12; 12:2; 13:8
literature 27:14; 41:1, 3, 4, 5, 6, 8, 21; 72:22; 74:25; 76:9; 77:22
little 17:17; 20:22
live 78:7
long 39:19; 71:20; 78:7; 82:1, 8, 14; 83:14
long-term 72:19
look 5:20; 13:15; 18:2; 29:23; 36:21; 38:1; 40:12; 45:12, 13; 46:11; 50:24; 52:18; 55:14; 61:16; 80:9; 11:22; 13:1, 6, 11; 14:14; 23:15; 24:1; 39:2; 42:25
lot 15:4; 41:19
low 68:23
lower 66:5
lung 30:2; 62:20; 63:4, 15;7:2; 28:12, 17; 29:2, 21;30:6, 11
luxury 39:2; 54:16

M

M.D 4:1, 6; 42:4; 48:18; 34:1;85:8
main 64:6, 18
majority 78:9
makes 40:10
making 81:7
malaise 30:10; 38:22; 51:9; 55:3
Malik 4:21, 25; 5:4; 17:3; 20:12; 21:4; 22:22; 24:21; 25:4; 26:3; 27:24; 28:14, 19;29:3, 7, 22;30:7; 32:21, 24; 36:12; 37:10, 24; 41:7, 22; 44:19; 49:23; 51:12; 53:15; 55:19; 59:15; 61:18; 62:13; 64:13; 66:3; 69:17; 70:15; 71:3; 74:20; 75:5; 76:3, 7; 78:3, 14; 79:11, 19; 80:12; 81:5, 17;82:4
malpractice 78: 16;80:1
man 55:1; 57:6; 58:9; 73:6
man's 44:18; 48:11; 50:21
manage 32:9
management 66:13
mandate 32:7; 51:16
manifested 38:17
many 39:17, 22; 40:1, 16; 49:14; 58:23; 71:19; 74:8
MARK 4:1, 6; 42:4; 48:18; 84:1; 85:8; 32:14, **18;** 61:14; 84:5, 9
mass 8:17; 28:23; 42:13, 14
massive 65:21
material 8:17
matter 21:18; 27:15; 19:18; 20:19; 39:15
may 18:18, 18; 21:11, 11; 25:20; 28:25; 55:22; 53:21; 74:6, 6, 10, 11, 15; 77:14, 15, 16; 81:10, 10
Maybe 47:25
mean 21:17; 23:20; 25:12; 42:20; 61:9
meant 23:21
medical 8:5; 22:8; 27:10, 13;29:12; 32:11; 34:8; 37:8, 21; 46:9; 47:11; 50:13;70:12;79:16;82:16
medical-legal 39:15
medication 45:6
medicine 9:15; 21:6; 41:16; 49:8; 57:17; 43:14
members 82:21
mentioned 76:10
merit 54:24
met 5:6; 24:10
Michigan 31:19; 41:18; 33:5
Midas 69:19
middle 29:19; 30:5; 72:7
mind 50:18
mine 17:7; 52:25
minimal 73:24
minor 74:1
minute 43:8
misleading 46:15
missed 47:25
misstated 47:5, 8
mistaken 75:21
modify 17:12
modus 64:23
months 39:17; 81:3
morbidity 69:8; 72:12, 15
more 8:2; 10:23; 14:8; 15:14, 19, 25; 16:2; 18:19; 24:24; 28:21; 32:8; 34:19; 40:3; 42:18; 57:8; 66:4; 67:18; 75:15, 17;76:5, 18; 80:4
Morganstern 40:20
most 70:1, 5; 73:2; 78:4
mostly 7:22
motion 38:8, 11; 73:12, 25
mouth 46:14
Mt 31:3; 60:25
much 14:16; 42:20; 73:4
multiple 6:19; 62:15; 64:3, 15; 65:12
mural 67:18
myocardial 31:19
myself 75:3

N

naive 62:10
name 5:3; 42:6; 48:20; 85:8
Nasal 45:20
natural 27:20; 64:11
nature 31:13; 40:4; 49:1, 11
nearly 45:21
necessarily 65:3, 11
necessity 50:14; 70:17
need 7:16; 14:8; 19:8; 51:18; 56:14, 15, 17; 16:17
negative 14:2; 59:14, 20
negligent 50:7
neither 23:6
new 7:16
next 10:1; 11:23
night 38:15
Nobody 68:16
nonproductive 43:12
normal 44:8; 66:24; 71:1; 73:7, 13, 14;74:2; 78:1
Notary 85:6
noted 44:11; 45:2
notes 44:22, 23
notification 17:6
November 5:18, 25; 11:4; 33:14, 20; 38:7
novo 59:6; 60:16
number 4:13; 5:5; 18:15, 17;19:11, 15; 40:12; 54:1; 76:21

O

object 49:23; 61:18
Objection 17:3; 20:2, 12; 21:4; 22:22; 24:21; 25:4; 26:3; 27:24; 28:14, 19; 29:3, 22; 30:7; 34:11; 36:12; 37:10, 24; 51:12; 52:8; 53:14, 15;57:13; 58:2; 59:15; 62:13; 64:13; 66:3, 21; 67:24; 69:4, 17; 70:15; 71:3; 74:20; 75:5; 76:3, 7, 24; 78:3, 14, 19; 79:11, 12, 18, 19; 81:5, 17; 82:4
obstructive 28:21
obstructs 64:18
obtain 17:14; 23:22; 25:18
obviously 17:2, 4; 81:13
occasions 47:23; 51:8
occurred 62:25
October 6:2; 10:21; 11:2, 9
off 24:13; 30:24; 64:20
offered 79:24
office 15:1, 1, 11;18:5, 10, 23
often 39:14
Ohio 10:10; 15:2; 85:2, 7
old 58:5
one 5:12, 17;6:22; 8:23; 9:10, 12; 10:7, 13;13:1; 14:14, 15; 18:15; 19:11; 20:4; 27:2; 28:1; 30:23; 35:18; 36:2; 47:14; 54:1; 55:9, 13; 60:2, 12; 66:1, 16;69:24; 71:23; 76:17; 82:17
one-sided 73:24
ones 68:6
only 12:6, 9; 14:15, 20; 28:1; 37:11; 39:11; 56:23; 60:1; 65:16; 83:3
onset 38:24, 25
open 49:13
operate 67:7; 5:5
operative 40:13
opinion 6:13, 16, 22; 21:15; 22:7, 11; 25:13; 27:21; 30:16; 33:25; 34:7; 37:7; 49:4; 58:21; 59:10; 68:17; 70:23; 74:17; 22:25; 68:10; 70:12; 76:15;77:4; 79:1
opportunity 29:25
option 72:17
order 17:4; 19:8; 33:6, 10; 34:2; 51:23; 52:1, 3; 53:11, 20; 54:21; 69:23; 16:24; 19:4, 5; 33:4; 34:3, 9, 21; 35:14; 50:8, 11, 23; 53:8; 12:4; 16:3
organ 30:3
original 62:19; 82:18

originally 36:17
originated 6:23
originating 26:20; 30:14
others 32:8; 76:6
Otherwise 35:13; 50:22; 73:9
ourselves 20:24
out 16:9; 51:6; 65:20; 74:8
out-of-hospital 77:16
over 24:20; 28:17; 39:17, 21, 25; 58:9; 78:6
overwhelming 40:13
own 58:15

P

p.m 84:19
page 8:24; 9:4; 10:2; 11:11; 12:1; 13:9
pain 43:13
paragraph 41:11
parcel 69:25
parietal 14:12
parking 15:4
part 7:11; 40:11; 69:25; 70:21; 35:18
participated 31:17
particular 13:2; 20:8; 33:2; 40:9; 43:3
pathogenic 30:15
pathologic 33:18; 35:19; 69:21; 75:12
pathological 76:17
pathologist 61:20
pathology 63:10
pathophysiologic 15:21; 26:15; 27:5; 35:8, 16; 39:4; 50:19; 51:3
patient 11:20; 15:10; 16:11; 17:7, 10; 18:18; 19:16; 29:8; 30:20, 22; 31:2, 4, 6, 7, 11, 13, 16; 42:9; 43:3, 6, 8, 9; 47:9, 18, 22; 50:8, 15, 24; 51:8; 52:17, 18; 53:19; 54:3; 57:15; 58:19, 22; 63:12; 66:15; 79:2, 15, 25; 83:12, 13, 16; 51:15; 55:7; 62:20; 70:8; 82:2; 18:3; 31:20; 49:14; 54:6; 57:17, 18; 59:1; 64:14; 65:24; 66:8, 22, 24; 67:3, 5, 12, 14; 70:1; 72:20, 23; 74:14, 15; 75:11; 76:22; 77:7, 9, 13, 20, 23, 24; 78:25; 83:3
pattern 56:11
pelvic 66:5
people 29:15; 54:15; 65:12; 71:20; 72:3, 4, 6; 74:8, 11; 77:19; 78:15
percentage 40:14; 66:7
perform 7:13, 14; 13:21; 17:11; 18:15, 20; 31:10, 22; 41:3; 49:8; 51:11, 16; 54:3; 79:22; 14:10; 16:10; 17:9; 18:22, 25; 19:1, 2, 2, 11, 16; 22:14; 23:25; 24:4; 25:7; 27:2, 3; 31:15; 36:4, 16; 49:16, 18; 63:2; 81:23; 12:14, 23
perhaps 17:11; 48:10; 50:2; 71:12
pericardial 5:24; 10:19; 13:18; 14:1; 15:9, 16; 16:13; 18:14, 19; 19:12; 22:9, 17; 23:1, 7, 10, 11; 35:10; 36:20; 37:13, 16, 22; 48:24; 49:9, 16, 19; 50:11, 17, 20; 52:1; 53:5, 21, 22; 80:18, 23; 81:1, 3, 20
pericardium 12:5, 7, 10; 14:11, 12, 12; 21:10; 23:19; 35:11, 12, 17, 20; 36:6, 8; 37:1; 49:6, 21
period 24:20; 28:17; 37:9; 39:21; 49:9
peripheral 10:13
persistent 44:18; 55:3
person 21:19; 83:7, 10
personal 27:10
Personally 80:9
phrase 77:18
phrasing 53:1
physical 57:22
physician 7:10; 19:23; 20:1; 21:25; 22:3; 49:17; 52:16; 61:24; 76:2; 40:23; 57:16; 76:11
picked 41:17; 75:16
picture 22:13; 31:25
place 85:18
placing 20:15
plain 17:24
plan 43:20, 20
play 62:21; 65:20
Please 8:24; 10:4; 25:1; 32:20
point 6:3; 26:18; 27:7; 32:9; 42:3; 44:12; 45:22; 50:10; 71:21; 16:9
portion 14:14; 33:16
position 24:9
positive 59:2, 7
possession 41:5
possibility 48:10; 53:4
potential 16:11; 50:20; 51:14
practice 7:11, 21; 40:5, 7, 11; 54:11
practicing 7:9; 79:10
preclude 73:13
prediction 75:18
preemployment 57:21
prefatory 56:3
prepared 48:13
prescription 43:22; 44:1
presence 27:6; 85:13
present 25:21, 23; 26:6, 17; 36:7; 38:11; 39:5, 11, 12; 82:3, 6; 70:16; 73:19; 80:20; 82:18; 54:6
presentation 29:17; 32:2; 39:6; 54:23; 82:7
prevented 63:19; 65:3, 11
preventing 65:16, 18, 19
previously 5:20; 61:14
primarily 5:23
primary 29:15
prior 29:17; 50:8
probability 25:22; 70:25
probable 42:17
probably 5:14; 6:24; 15:23; 23:8; 25:22; 27:25; 28:23; 35:9; 39:12, 23, 24; 41:17; 43:1; 44:24; 48:21; 49:12; 58:25; 62:9, PO; 63:1; 64:5; 66:6
problem 4:16; 16:11; 18:19; 25:21, 22; 30:12; 35:19; 43:3; 48:11; 51:14; 52:16, 25; 63:24; 67:16; 74:7; 13:11
Procedure 4:3; 40:13; 66:23; 77:12
process 24:18; 26:4, 10, 16, 23; 27:20; 30:15; 39:4; 62:5; 69:22; 75:9, 13
produce 33:5, 10, 3, 14
profess 39:7
profound 64:22
prognosis 66:8, 18
progress 71:21; 74:18, 23; 26:18; 27:7; 74:22; 81:13; 68:16; 72:4
progression 24:17; 65:16, 18; 71:9, 14
progressive 28:21; 69:22; 71:16
progressively 64:4
projection 81:6
prompt 60:7; 73:20
prone 67:18
properly 49:18
prospective 51:7
provided 4:2; 41:4, 6, 22; 82:20
Public 85:6
publish 76:12
pulmonary 6:19; 26:19; 28:20, 22, 23; 30:14; 38:16, 19, 23, 24; 48:8; 62:15; 63:9, 17, 22; 64:4, 6, 15, 18, 20; 65:12, 19, 21; 69:10; 70:2; 82:11
purpose 11:15; 14:7, 13; 18:16, 17; 27:14; 32:14; 84:9
put 75:11
Putting 46:14

Q

quick 48:17
quickly 66:11

R

radiologic 7:8; 16:14
radiologist 4:11; 16:1; 17:6, 14, 19; 18:8, 9; 21:13; 24:8, 11, 12; 34:16
Radiology 4:12; 7:6; 18:5, 10
rapidly 72:4
rare 60:15
rate 45:19; 56:13; 58:6; 64:10
Rather 11:7; 28:1; 45:1; 69:15
reach 58:14; 78:11
read 8:18, 25; 9:1; 12:22; 15:5, 8; 21:13, 20; 22:3; 27:16; 36:11, 13; 45:1; 56:5; 82:23; 21:19, 20, 25; 45:17
realistically 15:20
reality 39:10
realizing 39:3
really 42:13, 20; 47:6; 48:5; 78:6
reason 39:7; 57:24; 59:6
reasonable 22:7; 34:7; 37:7, 21; 70:25; 78:22
reasonably 74:1
recall 83:20
received 8:5; 14:8
recently 83:19
recollection 80:22; 82:25
recommend 75:2
Recommendations 45:3
record 29:11; 30:24; 36:13; 45:17; 55:22; 72:20; 82:16, 15; 4:22, 23; 5:19; 7:4; 14:3; 29:12, 16, 21; 32:22; 42:16; 44:5; 45:12, 13, 15; 46:12; 61:7; 82:17
recurrence 67:2; 68:11, 13
recurrent 67:12
recurring 68:23
redirect 77:2
reduced 69:6; 85:12
reeducation 20:21
refer 29:10; 38:7; 9:2; 31:7
referable 29:1, 20; 30:6
reference 10:19; 41:1
referring 7:18; 29:4; 62:7
reflect 55:23; 56:8; 35:20; 82:17
regard 49:1; 23:5
regardless 18:25
regular 7:11; 30:20
Reinforcement 20:21
reinforces 20:22
reiterated 33:19
related 16:12; 48:11; 52:14
relationship 47:18
Relatively 39:16; 71:1
reliable 75:2, 18, 23; 76:1, 10
remain 16:6, 8
remainder 41:21
remember 45:1, 11; 83:9, 20
remote 27:17
removal 70:7
remove 53:3; 67:7, 8; 66:22; 67:10
removing 69:6
render 22:11; 50:6; 68:17; 23:5; 66:13; 79:16
repair 7:16; 31:21
repeat 10:4
rephrase 78:21; 79:3
replacement 31:21
report 5:17; 6:1; 11:5; 14:1; 18:2; 23:17; 33:3, 5, 13, 14, 17, 19, 20; 38:8; 62:19; 65:6, 10; 75:12, 10; 77:24; 5:9; 6:9; 23:6; 33:10; 40:17
represent 4:10; 42:7
Republic 9:11
request 17:8, 12
require 19:22, 25; 51:10; 57:5, 12; 73:16; 32:10, 11
research 27:13
residency 8:7; 9:6, 14; 60:22, 23; 83:5
resident 31:18; 63:2; 83:21
respect 13:4; 79:2
response 27:4
rest 12:7; 58:6
restate 31:1
result 6:24; 21:21; 64:11, 16; 68:4; 26:5; 38:16; 39:5; 64:7; 28:24; 30:13; 50:21; 13:23; 69:22
resuscitate 63:3
retrospectively 39:3
return 33:22
review 4:22; 5:23; 6:1; 7:10; 27:14; 32:22; 37:18; 39:14; 61:13; 6:5; 29:11, 12, 16; 37:20; 39:22; 40:1; 41:2; 58:14; 59:16; 39:19
right 6:24; 19:9; 28:6; 38:8, 15; 42:12, 14; 68:20; 71:12; 82:2
right-sided 60:13
ring 47:12

role 62:21
routine 17:13
routinely 7:10; 18:2; 20:17;67:7
Rovner 40:24
RUF 20:2; 33:4, 9; 34:11; 41:7; 52:8; 53:14; 57:13; 58:2; 61:9; 66:21; 67:24; 69:4; 76:24; 78:18, 23; 79:12, 18
Ruiz 6:7, 8; 8:5; 10:21, 25 13:20; 15:3, 6, 7, 8, 14; 16:2, 9, 20; 19:6, 8; 20:9; 29:13; 34:1, 3, 14;35:2, 24; 47:1; 48:21; 50:7, 15; 51:22; 53:4, 10; 54:25; 83:1; 6:1; 8:1, 15; 14:3, 25; 15:12
Rules 4:3

S

same 11:8; 25:20, 22; 26:1, 4, 10; 36:14; 51:25; 57:24; 63:7, 24; 66:9, 17; 74:6; 76:14
San 58:8
saw 45:9; 47:21; 50:15; 53:18; 65:9
saying 19:7; 23:9; 65:10
scan 46:2
screening 55:6
search 41:3; 55:23
second 5:17; 30:23; 43:16
seeing 24:5; 51:8; 54:16; 57:15; 83:1
segregate 51:21
send 32:24
sense 13:25; 65:6
sent 5:19; 11:20; 15:3; 32:21; 40:16; 46:20, 24
sentinel 64:15
separable 35:15
separate 35:17, 21; 69:18
sequelae 65:20
series 74:21; 75:11
served 8:12
Seven 39:18; 46:5
several 43:14, 14
severity 26:9, 23; 27:22
shortly 83:15
show 21:9; 23:11; 44:19; 45:23
shower 64:2
shown 34:24; 81:24
Signature 84:18
significance 80:23
significant 54:24; 60:6; 65:15, 17; 73:12
significantly 44:10
similar 26:6
simply 53:17; 57:21
Sinai 31:3; 60:25
single 63:25
sinus 44:8; 56:13, 15, 20
sinusitis 44:13
sit 73:6
sites 71:13
situation 51:24
six 40:2
skip 10:2; 13:8
slowly 12:23
small 66:7
smaller 64:2, 16
social 5:7
Solely 7:24; 70:24
somebody 21:18; 46:16
sometimes 20:21
somewhat 43:15; 45:20
somewhere 59:8
soon 78:4
sorry 10:5, 23; 19:24; 61:11
sort 7:17; 20:14
source 64:24
space 35:11, 11; 36:20; 37:13, 16, 22; 50:17, 20; 53:21, 23
span 73:14; 74:16; 78:5, 7, 8
speak 4:16; 20:25
specialist 48:8
specialty 56:3
specific 8:2; 29:4, 9; 54:21; 68:3; 75:6, 8; 80:4; 83:21
specifically 30:2; 52:13; 62:7; 67:4; 68:18
specified 85:19
spectrum 54:6; 71:23; 74:14
spent 9:15
spot 43:9; 46:18
spring 52:6
SS 85:3
St 9:17, 21, 22; 10:9, 11; 19:18; 40:8; 46:8; 47:10, 0
itaff 61:2
tage 28:8, 9, 10; 65:15; 0:20; 75:16; 76:25; 8:12; 83:16; 27:25; 73:21
tand 12:3
tandard 4:24; 14:22; 7:18; 18:8; 19:19, 22, 25; 0:25; 24:10; 43:19; 8:14; 51:10; 52:7, 22; 3:13;79:9
tandpoint 15:22; 26:14, 5; 27:5; 29:24; 35:8, 16; 8:13; 39:11; 50:19, 25; 1:4, 5; 72:21
tart 8:25; 62:2; 72:1; 5:5; 82:10; 83:1; 60:11
State 85:2, 7; 58:3; 45:22
statement 12:4; 23:4; 37:11;69:13
stay 12:4; 68:15
stenotypy 85:13
step 11:23; 20:15, 16; 50:1
stepladder 20:16
still 15:17; 52:14; 81:19
stipulate 71:8; 23:18
stop 46:10; 54:7
straightforwardly 50:4
stripping 31:20
strong 54:19
strongly 38:14
structure 13:12; 14:13; 15:23; 16:12, 13; 13:15; 16:17, 23; 66:7
studies 5:21; 22:20; 57:18; 80:3, 8, 9
study 11:14; 12:5; 13:22; 15:24; 16:3, 9, 10, 16; 17:5, 7, 9, 11, 12; 18:19, 25; 19:2, 4, 5, 9, 11, 13, 15; 21:13, 14, 19, 21, 25; 22:2, 4, 6, 12, 14; 23:22, 24; 24:1, 5; 25:16; 34:17; 36:16, 17, 18, 22, 22; 37:14, 14; 38:1, 2; 49:2, 5; 50:2; 55:6, 6, 17, 18;56:7, 24; 79:23; 80:14
stuff 45:1
subcategories 68:3
subclinical 74:9
subsequent 6:20; 33:17, 20
subsequently 66:24
subset 77:13
substance 25:15; 33:12
substandard 79:16
substantially 26:1, 10; 78:2; 81:14
subtle 56:8, 25; 57:4
succumb 65:13; 28:23
suffers 79:15
sufficient 50:5; 57:25
sufficiently 54:24; 57:11; 75:2
suggest 31:7; 45:25; 56:13; 4:23; 73:25; 16:19; 19:3; 57:2
summaries 76:16
iummer 52:6
suppose 73:2
sure 8:8, 18, 19; 30:12; 46:12; 48:25; 56:9; 59:21
surface 15:22
surgeon 7:12; 40:6; 48:2; 54:5; 20:18
surgeries 31:23; 49:13
surgery 31:10, 15, 25; 0:10, 15; 66:23; 68:5, 7
surgical 27:11; 32:10; 8:11, 25; 70:13,17; 72:17; 77:11
surprise 48:21; 65:5
surprising 73:5
surrounding 83:21
survive 83:12, 13; 63:5
suspect 33:1; 41:17; 59:19;82:11
suspicion 53:4, 7
sustain 20:3
sworn 4:4; 85:9
symptoms 12:17, 25; 30:14; 38:18; 39:9; 44:18; 48:12; 50:22; 51:9; 54:4; 57:7, 10; 64:17; 82:18
system 30:3

T

tachycardia 38:21; 55:3; 56:13, 14, 16, 19, 20, 23
tachycardic 57:3
talk 65:23; 47:3; 80:12, 14;56:11
tape 14:4; 22:13
technician 21:24; 22:2; 21:12
TEE 80:6, 17, 20, 24
telephone 34:1
telling 20:9, 14; 25:15; 54:1
:ells25:18; 81:9
:en39:18
:endency 64:14
:entative 42:20
:erm 58:24, 25; 8:3; 32:1, 3; 44:13; 65:18
Terry 85:6
Tessalon 43:23; 45:4
est 18:15; 50:23; 53:20; 57:15, 19; 81:8; 52:2, 3; 63:8; 35:14; 49:10; 54:21; 74:22; 75:6
estify 85:9
estimony 35:5, 6; 73:3; 82:13; 85:11, 15
extbook 27:16; 41:20
exts 75:22, 25; 76:12
heory 58:18; 65:7
herapeutic 66:12
herapy 32:8
hereafter 15:2; 36:5
'herefore 36:24; 38:3
'hereupon 32:13; 84:8
hinking 44:13
'hirteen 39:20
horacotomy 63:1, 13
hough 68:24
hought 51:3; 65:7; 66:14
hree 47:22; 48:1
hroat 44:9
hrombotic 70:21
hrombus 7:1; 38:15; 64:25; 66:1, 10, 16, 19, 22; 67:2, 9, 10, 13, 19; 68:14, 19, 23; 69:6, 21, 21; 70:7; 82:6
throughout 26:17; 44:11; 45:3
timely 66:18
times 39:17; 48:1; 50:15
today 33:3
together 75:12
told 19:8, 10, 14; 26:25; 34:1; 48:16
Tom 48:20
took 8:7
top 20:15
toward 30:2; 69:15; 41:12
track 72:20
training 7:6, 8; 8:1, 3; 16:21; 21:16; 60:22
transcribed 85:14
transcript 11:4; 82:21
transcription 85:15
transesophageal 7:19; 14:19
transfer 42:12; 63:18
transplant 31:17, 23; 73:17; 60:18, 24
transplantation 60:23
travel 83:10, 7
TRAVERS 48:19, 20; 49:25; 51:20; 52:24; 53:25; 56:1; 58:7; 60:5; 61:10, 21; 62:17; 67:25; 71:4; 74:24; 76:4; 77:1; 81:18; 83:23
treat 69:23, 24; 70:17; 65:14; 67:11; 68:22; 83:3; 61:24
treatability 62:3
treatment 27:11; 65:2, 8; 56:18;69:14
tried 77:18
:roubled 44:17
:roubling 73:3
:rue33:21; 35:2; 36:2; 45:16, 16; 85:15
:ruth85:9, 10, 10
:ry8:20; 79:3
:rying 51:6; 63:2
urn 8:24; 11:8, 11;12:1
wice 49:13
wo 5:9; 9:16; 16:20; 8:17; 19:10, 15; 21:21; 5:15, 21; 44:1; 50:15; 1:8; 52:5; 60:2; 69:19; 1:3
wo-dimension 51:19
wo-dimensional 11:21; 8:21; 19:17; 34:20, 22, 3;37:4; 52:23; 81:22
wo-sided 74:4
ype 11:14; 21:8; 31:24; 3:11; 32:8

U

ultrasound 5:24; 7:13; 10:20; 11:21; 12:5, 15, 23; 13:19; 14:2, 8; 15:9, 17; 17:21, 25; 18:1, 14; 19:12; 21:8; 23:7, 13; 37:1; 48:24; 49:5, 9, 16, 19;50:9, 11; 51:23; 52:1; 7:14; 18:3; 23:1, 10
unaware 5:22; 8:11
under 10:12, 15;18:9; 31:3; 34:9
underlying 15:23; 30:12; 69:2, 16; 70:24
understandings 16:6
understood 15:21
undertaken 65:9
undertaking 34:17
Unfortunately 51:2
University 31:18; 40:7, 22; 41:24; 61:3, 4
unless 59:7
unusual 21:9; 60:10
up 4:16
upon 21:11; 27:19; 31:12, 25; 32:22; 33:24; 34:6; 37:12, 19; 52:4; 54:14, 18; 59:16; 63:9, 11, 18; 66:11; 68: 11, 17; 76: 16; 77:24
upper 66:5
use 44:23; 58:25
usually 64:23

V

valve 7:16; 31:20, 21; 60:17, 12
valvular 73:14; 74:2
Vanceril 43:23; 45:4
vane 19:23; 20:1, 7, 8
vanished 45:21
various 32:6; 71:13
vascular 10:14
vasculature 28:22
vein 66:19, 5, 5, 6
ventricle 6:24; 7:1, 17; 13:16; 28:1, 6; 38:16; 67:13; 82:2; 28:5; 66:17, 23
ventricular 38:8; 42:13, 14;56:16; 60:16; 67:6, 17; 71:13
venture 31:22; 33:25
versa 35:21
versus 56:11
vice 35:20
Victor 10:15
video 80:13, 15
viewed 80:2, 15
vigorous 32:8
Vincent 9:22; 10:11; 40:8
violation 52:7; 53:12; 79:9
visceral 14:11
visit 43:24; 46:20; 14:25; 52:5
visualize 16:22; 36:5, 9
visualizing 35:3
vitae 8:9; 84:13

W

waived 84:18
wall 38:8, 10; 66:16; 73:12, 25
wants 16:22
warning 20:15
warrant 58:1; 59:20; 55:4
way 20:25; 26:11; 36:2; 37:11; 42:21; 47:25; 49:5; 53:1; 56:2; 58:3; 60:1; 63:16; 73:18; 75:1; 79:6; 82:9
ways 60:2
welcome 77:1
well-preserved 74:1
wet 15:5, 7
what's 82:15
wheel 14:15
wheezes 44:10; 45:2
wheezing 43:13
white 83:9
who's 29:15
whole 39:8; 49:1; 76:9; 85:10
Wiedemanm 61:19
Wiedemann 61:4
within 4:23; 8:19; 14:11; 26:20; 33:13; 35:10, 19; 50:20; 79:13; 85:7, 8
Without 23:15; 24:1, 5; 26:25; 37:25; 57:10, 15; 60:11, 17; 68:6, 9; 69:10; 85:20
WITNESS 21:5; 46:15; 85:8, 12, 13, 16; 82:14
Wolfe 10:15
woman 66:18
words 46:14; 47:21
work 20:19; 4:25; 18:4, 10
workup 50:7, 11; 53:12; 54:2, 10, 25; 58:1; 83:22
worse 67:17
write 76:11
written 18:2; 41:19; 75:25; 76:1
wrote 61:8

X

X-ray 15:3, 5, 8; 23:1, 5; 7:10; 80:16

Y

year 5:13, 13; 9:10, 12, 17, 19; 10:7, 10, 13;32:25; 40:2; 5:6; 7:9; 9:16; 16:21; 39:20, 24, 25; 40:3, 3
young 44:18; 48:11; 50:21; 55:1; 57:6; 83:11
Youngstown 4:12; 9:11, 12, 16; 10:10; 14:17; 16:7; 46:9; 47:11

Z

Zimmerman 10:12

Lawyer's Notes