IN THE COURT OF COMMON PLEAS
MAHONING COUNTY, OHIO
CASE NO. 96-CV-2055

DOROTHY A. GONDA, Individually and as Admx. of the Estate of DAVID PAUL GONDA, deceased Plaintiff	)	
vs.	)	DEPOSITION OF ROBERT DEMARCO, M.D.
H. M. HEALTH SERVICES, ET AL. Defendants	)	

Deposition taken before me, Kathleen Skowron, Notary Public within and for the State of Ohio, on the 18th day of December, **1997**, at 1:00 PM, pursuant to agreement between counsel, taken at the offices of Pulmonary Medicine Consultants, **925** Trailwood Drive, Youngstown, Ohio, to be used in accordance with the Ohio Rules of Civil Procedure or the agreement of the parties in the aforesaid cause of action pending in the Court of Common Pleas within and for the County of Mahoning and State of Ohio.

A P P E A R A N C E S

On Behalf of the Plaintiff:
Mark W. Ruf, Attorney at Law

On Behalf of the Defendant, H.M. Health Services, et al.:
Douglas J. Kress, Attorney at Law
COMSTOCK, SPRINGER & WILSON

On Behalf of the Defendant, Alejandro Franco, M.D.:
Martin J. Boetcher, Attorney at Law
HARRINGTON, HOPPE & MITCHELL

On Behalf of the Defendants, Robert DeMarco, M.D. and Alan J. Cropp, M.D.:
Stephen P. Griffin, Attorney at Law
BUCKINGHAM, DOOLITTLE & BURROUGHS

On Behalf of the Defendant, Juan Ruiz, M.D.:
Thomas J. Travers, Jr., Attorney at Law
MANCHESTER, BENNETT, POWERS & ULLMAN

I N D E X

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P R O C E E D I N G S

ROBERT DEMARCO, M.D.

having been duly sworn according to law, on his oath, testified as follows:

CROSS EXAMINATION BY MR. RUF:

MR. RUF: Doctor, my name is Mark Ruf, and I, along with David Malik, are representing the Plaintiff. If at any time I ask you a question and you do not understand my question, please tell me. If you give me an answer to a question, I will assume that you have understood the question. Okay?

THE WITNESS: Yes.

Q. Could you please state your name and spell your name?

A. Robert DeMarco. R O B E R T. DeMarco, capital D E, capital M A R C O.

Q. And what is your address, both professional and home address?

A. Professional is 925 Trailwood Drive, Post Office Box 14130, Youngstown, Ohio, 44514-7130. Home is 495 Presidential

Drive, Boardman, Ohio, 44512.
Q. Are you an employee or officer of any corporations?
A. Yes.
Q. What corporations?
A. My own, Robert DeMarco, M.D., Inc., and Pulmonary Medicine Consultants, Inc.
Q. And what is your position with each of those corporations?
A. Owner.
Q. Are you an employee of both of those corporations?
A. I guess if I own it, I'm an employee. I would guess so.
Q. Are those corporations still in good standing in the State of Ohio?
A. Yes.
Q. Do you have a CV?
A. Yes.
MR. GRIFFIN: I'll get you one to work from here, but it's my only copy. So, we will have to get you a copy afterward.

Q. Are you also employed at the Northeastern Ohio University College of Medicine?
A. No.
Q. Why does it state "Northeast Ohio University College of Medicine" on your CV?
A. Well, I'm not paid by them. I'm faculty, but I'm not employed there.
Q. Do you teach there?
A. Yes.
Q. What do you teach there?
A. Pulmonary medicine.
Q. Where did you go to medical school?
A. Autonomous University of Guadalajara.
Q. And what year did you graduate?
A. 1981.
Q. Why did you go to medical school in Mexico as opposed to the United States?
A. I don't understand why you are asking that.
Q. Well, were you born in the United States?
A. Yes.
Q. Then why did you wind up going to school in Mexico?

A. Because that's where I got in.
Q. Are you board certified in any area of medicine?
A. Yes.
Q. What are you board certified in?
A. Internal medicine, pulmonary medicine, critical care medicine.
Q. Are you still licensed to practice medicine in three states?
A. Yes.
Q. Is your license in good standing in each of those three states?
A. Yes.
Q. Have you ever had disciplinary action against your license in any of those three states?
A. No.
Q. What hospitals are you on staff at?
A. St. Elizabeth's Hospital and Western Reserve Care System.
Q. Have you ever had your privileges revoked at either of those two hospitals?

A. No.
Q. How long have you been on staff at St. Elizabeth's Hospital?
A. Five and a half years.
Q. How long have you been practicing medicine?
A. Seven years. Seven and a half years.
Q. And how long have you been affiliated with the corporations Robert DeMarco, M.D., Inc. and Pulmonary Medicine, Inc.?
A. Five and a half years.
Q. So, what did you do for the two years that you were in practice that you were not involved with those corporations?
A. I was with another practice.
Q. Could you tell me the name of that practice?
A. Eastern Ohio Pulmonary Consultants.
Q. Why did you leave that practice?
A. Because I wanted to.
Q. What is your affiliation with Dr. Cropp?
A. He's my partner.
Q. Do you have any affiliation with Dr. Ruiz?
A. No.

Q. Does he refer patients to you?
A. Yes.
Q. Does he do that on a regular basis?
A. Depends on what you mean by regular.
Q. How often does he refer patients to you?
A. Actually, I can't tell you because I'm not really sure.
Q. Is it more than one a month?
A. No.
Q. How many over a six-month period would you say?
A. Probably one or two.
Q. Do you have any type of affiliation with Dr. Franco?
A. No.
Q. Do you refer patients back and forth with Dr. Franco?
A. No.
Q. Have you given a deposition prior to today?
A. Yes.
Q. How many times have you given a deposition?
A. At least three.

Q. Why did you give a deposition? Were you a party?
A. As an expert witness on at least two occasions, and as a -- I don't know what it would be -- in a lawsuit.
Q. So, on one occasion it was as a defendant?
A. Yes.
Q. And two were as an expert witness?
A. Yes.
Q. In the two cases you testified as an expert witness, were those both in Mahoning County?
A. No.
Q. Where were those lawsuits?
A. I'm not sure where the lawsuits were, but it was for a firm in Cleveland.
Q. What were the issues in each of those two cases?
A. To be -- honestly, I don't remember.
Q. Do you remember the name of the law firm in Cleveland that you were involved with?
A. Jacobson, Maynard, Tuschman and Kalur.

Q. Do you remember the name of the attorney?

MR. TRAVERS: Former law firm.

MR. GRIFFIN: I remember them.

THE WITNESS: Well, they are still a law firm.

MR. TRAVERS: Well, I don't know.

A. Honestly, I don't know.

Q. Were the issues in those cases pulmonary medicine issues?

A. Yes.

Q. Did they involve any cardiac issues?

A. I don't really remember the cases.

Q. What is the status of the case that you testified in as a defendant?

A. Oh, it's closed.

Q. Did it go to jury trial?

A. No.

Q. Was it settled?

A. Yes.

Q. What did you review prior to your deposition today?

A. The autopsy report.

Q. Anything else?
A. No.
Q. Did you review your own chart?
A. No.
Q. Do you have a complete copy of your chart here with you?
A. I personally don't, no.
MR. GRIFFIN: Do you want a copy of the chart?
MR. RUF: Yes, I'd like to see it.
MR. GRIFFIN: Can you ask Sam for Gonda's chart?
THE WITNESS: We probably only have the office chart.
MR. GRIFFIN: That's all. Let's take a break.
(OFF THE RECORD)
(PLAINTIFF'S EXHIBIT 1 MARKED FOR IDENTIFICATION)
Q. Doctor, I've marked your CV as Plaintiff's Exhibit 1. To the best of your knowledge, is your CV up to date?
A. Yes, except the mailing address is slightly

inaccurate. our post office box has changed.

Q. What is the correct mailing address?

A. You have the correct mailing address, I gave it to you already.

Q. To the best of your knowledge, did you produce true and accurate copies of your entire chart?

A. I would guess.

MR. GRIFFIN: You mean previously?

MR. RUF: Yes.

A. I didn't reproduce anything, so I would assume yes.

Q. Well, are you aware that we requested a copy of your entire chart?

A. Yes.

Q. And to the best of your knowledge, were true and accurate copies produced of that chart?

A. Yes.

Q. Doctor, what do you do to stay current in your field of medicine?

A. I attend my CME courses.
Q. Do you regularly review any medical periodicals?
A. Regularly? No.
Q. Do you subscribe to any medical periodicals?
A. Yes.
Q. What do you subscribe to?
A. Chest.
Q. Anything else?
A. The American Review of Respiratory Diseases.
Q. Anything else?
A. No.
Q. Do you have any medical texts that you regularly rely on in your practice?
A. No.
Q. Are there any medical texts that you would consider authoritative in the field of cardiology?
A. No.
Q. Do you specialize in a certain area of medicine?
A. Yes.

Q. What do you specialize in?
A. Pulmonary medicine, critical care medicine.
Q. What is critical care medicine?
A. Intensive care medicine.
Q. Does that involve treating people with cardiac conditions?
A. Sometimes.
Q. What type of cardiac conditions do you treat in your practice?
A. None.
Q. If you have somebody with a cardiac condition, what do you do?
A. Refer them to a cardiologist.
Q. Why do you refer them to a cardiologist?
A. Because that is who treats cardiac conditions.
Q. Do you treat patients with endocarditis?
A. No.
Q. If you had a patient in which you suspected that they had endocarditis, would you refer that patient to a cardiologist?
A. It depends on the setting.
Q. Under what circumstances would you refer that

patient to a cardiologist?

MR. GRIFFIN: It doesn't require you to speculate, you can answer.

A. If I thought they needed one.

Q. Is there a cardiologist that you regularly refer patients to?

A. No.

Q. You use different physicians for that?

A. Yes.

Q. When did you first see David Gonda? You can refer to your chart, if you need to.

A. August 15, 1995.

Q. Why did you see him?

A. I was asked to see him by the emergency room physician.

Q. Do you remember the request that was made to you by the ER physician?

A. No.

Q. Why did you see him in the ER?

A. I didn't see him in the ER.

Q. You did not?

A. No.

Q. Where did you see him?
A. Medical intensive care unit at St. Elizabeth's Hospital.
Q. Do you know what time you saw him?
A. No.
Q. Did you have any discussions with David Gonda at that time?
A. Sure.
Q. Do you remember the discussions you had?
A. I took a history and physical.
Q. Could you tell me the history and physical that you took?
A. Want me to read it to you?
Q. Please.
A. "Mr. Gonda is a 27 year old male who is well known to Dr. Cropp, who has presented this morning with significant hemoptysis."

MR. GRIFFIN: She is taking it down as you read it. We are doing more than just listening here.

A. I'm sorry. He states that his hemoptysis

1 Pain with bloody streaking in his sputum
2 over the last day or so. However, last
3 evening he developed copious amounts of
4 bloody streaky sputum, which eventually
5 became frank hemoptysis Additionally,
6 he became significantly short of breath
7 and presented to the hospital He admits
8 to chronic fevers on and off throughout
9 the summer, as well as ongoing difficulty
10 with sinus congestion and post-nasal
11 drip Most recently because of the
12 significant cough he has developed
13 left-sided chest pain. He denies
14 significant sputum production. He denies
15 change in appetite or significant
16 constitution of complaints He denies
17 nausea, vomiting, abdominal pain, change
18 in bowel or bladder habits He denies
19 peripheral edema There are no
20 arthralgias and there are no rashes
21 Past medical history: Remarkable only
22 for chronic sinusitis. Social history:

He is a non-smoker, non-drinker, he denies illicit drug use or homosexual behavior. He denies unprotected sexual intercourse. Review of systems, unremarkable. Allergies, none. Physical examination, well developed, thin male who is visible, anxious, coughing continuously producing a significant amount of hemoptysis. His blood pressure is 100 over 60, his pulse is 160 and regular, his respiratory rate is 28, his temperature is 99.7. HEENT, unremarkable. Neck, supple. There is shotty bilateral lymphadenopathy. No audible bruits. The trachea is midline. Lungs remarkable for inspiratory ronchi, left greater than right, without expiratory wheeze. There are no audible pulmonary bruits. Cardiovascular, tachycardic. There is -- there is a typo error. This should read, "There is no audible murmurs, gallops, rubs." Abdomen

soft, bowel sounds active, non-tender. No palpable organomegaly. Genitalia normal male, normal testes, no palpable masses. The testes do feel somewhat atrophic. Extremities, no cyanosis, clubbing, edema, no palpable cords. Neurologic, grossly intact. Lymphatics, shotty axillary as well as inguinal lymphadenopathy. Laboratory data --

Q Please stop, Doctor. I just asked about the history and physical. Doctor, what were you reading from? A document from the St. Elizabeth's Hospital medical record?

A Yes.

Q And that is a document dated 8-15-95 and at the bottom it states, "S1 Consultation"?

A Correct.

Q Now, under cardiovascular, you read, "There is no audible murmurs." However the actual record states, "There is audible murmur," correct?

A And I told you those were typographical

errors.

Q. How do you know that's a typographical error?

A. Because no one would describe audible murmurs, gallops and rubs without description. Besides, the entire physical is written in the negative.

Q. I don't understand. Can you please explain?

A. I say, "there is no," continually throughout. And the grammar of that sentence makes sense that there would be a "no" in there.

Q. Is this the first time that you were aware of this typographical error in this document?

A. No.

Q. When did you first become aware of this error?

A. When I read it with my attorney.

Q. When was that?

A. One week ago.

Q. Have you done anything to try and correct the record?

A. No.

Q. Did you only see David Gonda at St. Elizabeth's Hospital?
A. Yes.
Q. How many times did you see him at St. Elizabeth's Hospital?
A. While he was admitted there.
Q. Do you know the number of times that you saw him?
A. No. But it was at least daily.
Q. Did you see him at all at the Pulmonary Rehabilitation Associates' offices?
A. No.
Q. Did Dr. Cropp discuss this patient with you prior to his admission at St. Elizabeth s Hospital?
A. No.
Q. So, at the time you saw David Gonda, you were aware that he had had a fever for the whole summer?
A. Only what he told me.
Q. And what did he tell you?
A. That he had chronic fevers.

Q. Based on the symptoms that he related to you, would you describe that condition as general malaise?
A. Yes.
Q. At the time you saw David Gonda, what was the differential diagnosis?
A. I thought he had Wegener's granulomatosis.
Q. Why did you feel that he had Wegener's granulomatosis?
A. He had hemoptysis, mass-like lesions on his chest X-ray and sinusitis.
Q. Was anything else part of the differential diagnosis at that time?
A. At that time, no, that was my working diagnosis. I shouldn't say that. Let's see what else I wrote.
Q. Feel free to refer to your records if you need to.
A. I also thought that possibly he could have lymphoma.
Q. Why did you think he might have lymphoma?
A. Because of persistent fevers in a young male.

I also stated in my assessment that it was unlikely that this was infectious in nature.

Q. Why did you state that?

A. Because I didn't feel that it was infectious in nature.

Q. Well, can you explain why? What was your reasoning behind that?

A. Because I thought it was Wegener's granulomatosis or lymphoma, which are not infectious in nature.

Q. Is a fever a sign of infection?

A. Yes.

Q. Is a white -- high white blood count a sign of infection?

A. Could be.

Q. At the time you saw him on August 15, were you aware of any CBC's that had been done?

A. Yes.

Q. What was the date of the CBC?

A. His white count was 23,600.

Q. Excuse me, Doctor, what was the date?

A. Oh. That, I don't know. I don't have that in my record here.
Q. So, you were aware he had a high white blood count?
A. Yes.
Q. And you indicated a high white blood count is a sign of infection?
A. I said, "could be."
Q. Well, if he had a chronic fever and high white blood count, why wouldn't you consider his condition to be infectious in nature?
A. I just told you, because I thought he had Wegener's granulomatosis or lymphoma.
Q. Well, shouldn't some type of infectious process have been included in the differential diagnosis?
A. I didn't think so.
Q. What are the possible causes of a chronic fever and cough?
A. Two of the things that I mentioned.
Q. Anything else?
A. There is a huge list of things that can cause

a chronic fever.

Q. Can endocarditis produce symptoms of chronic fever and cough?

A. Yes.

Q. Was endocarditis part of your differential diagnosis on August 15?

A. No.

Q. At any time during your care and treatment of David Gonda, was endocarditis part of your differential diagnosis?

A. Yes.

Q. When did it become part of your differential diagnosis?

A. August 16.

Q. What happened on August 16 to make it become part of your differential diagnosis?

A. He had a two dimensional echocardiogram.

Q. And what did the 2-D echocardiogram show?

A. It showed -- well, I don't remember the exact report, because I don't have it in front of me. I can only tell you what I saw at the bedside.

Q. Doctor, I'm handing you a copy of the 2-D echocardiogram report.
A. Would you like me to read their remarks?
Q. What was it in the 2-D echocardiogram that made endocarditis become part of your differential diagnosis?
A. A section that says, "The right ventricle appears to be of normal size. However, there is a questionable intracavitary mass noted at the level of the moderator band. No significant delineation could be made from this study."
Q. What is significant about that statement?
A. Well, there was some abnormal shadow on the right side that could not be well visualized, so I could not be sure if it was not something from the ventricle itself or something on the tricuspid valve.
Q. To the best of your knowledge, what doctor suggested that David Gonda might be suffering from endocarditis?

A. I don't know that any doctor suggested that.
Q. But to your knowledge? was Dr. Franco the first one to consider endocarditis as a possible cause for David Gonda's problems?
A. As far as I know, I didn't know that Dr. Franco made any diagnoses as a part of his assessment.
Q. Well, did bacterial endocarditis become part of your differential based upon your review of this 2-D echocardiogram?
A. Yes.
Q. It wasn't from the discussion with another doctor?
A. Correct.
Q. And when something becomes part of the differential diagnosis, it's part of the differential diagnosis until it's ruled out?
A. Reasonable.
Q. Was bacterial endocarditis ever ruled out during your care and treatment of David

Gonda?

A. Yes.

Q. At what point was it ruled out?

A. When the trans-esophageal echocardiogram demonstrated the mass lesion in the right ventricle and a normal tricuspid valve.

Q. Why would the TEE rule out bacterial endocarditis?

A. Because you can't have an endocarditis on a normal valve.

Q. Well, you can have endocarditis in some place other than a valve in the heart, can you not?

A. Sure.

Q. So, then, what was it about the TEE that ruled out bacterial endocarditis?

A. Well, that and the negative blood cultures.

Q. Well, are you aware that you can have negative blood cultures in someone with bacterial endocarditis?

A. Yes.

Q. So, then, why would the negative blood

cultures rule out bacterial endocarditis?
A. Because that wasn't part of the differential in the first place. And in the second place, there was an infiltrating lesion in the right ventricle on trans-esophageal echo with clot on it, which is not endocarditis. There was a normal tricuspid valve, which is not endocarditis. So, all of the reasons for not having endocarditis were there. So, therefore, it was ruled out.
Q. With endocarditis, you have a vegetation in the heart, correct?
A. If it's on the valve, yes.
Q. Can't you have vegetation in the heart that is not on the valve?
A. I guess.
Q. Do you know whether or not you can have vegetation that's in the heart that's not on the valve with endocarditis?
A. Absolutely? No, I do not.
Q. If you wanted to find that out, where would

you go and look?
A. Probably look in a textbook.
Q. What textbook would you look in?
A. Couldn't tell you.
Q. Did you do any medical research during your care and treatment of David Gonda?
A. No.
Q. Have you done any medical research since David Gonda's death?
A. No.
Q. Based on your history and physical on August 15, what symptoms would be consistent with bacterial endocarditis?
A. History of IV drug abuse, malaise and fever certainly would be consistent, then a physical examination with a murmur might be helpful.
Q. Are you aware that with right-sided endocarditis, that in a certain percentage of people there is no murmur?
A. There's always a murmur, you just may not be able to hear it.

Q. So, it's your position that with bacterial endocarditis there is always a heart murmur?
A. If it's on the valve, yes.
Q. What if you have bacterial endocarditis that's not on the valve?
A. Then there wouldn't be a murmur.
Q. To the best of your knowledge, were serial blood cultures ever done on David Gonda?
A. Yes.
Q. When were those serial blood cultures done?
A. I don't know the exact dates. They would be in the hospital record.
Q. Here, I'm handing you a copy of the St. Elizabeth's Hospital record. Could you tell me the date the serial blood cultures were done?
A. 8-17, 8-17, 8-16, 8-16.
Q. How many cultures were done?
A. Four.
Q. And at the time the cultures were done, was David Gonda on antibiotics?

A. I don't recall.
Q. You don't know one way or the other?
A. I can't recall.
Q. To the best of your knowledge, were serial blood cultures done during a time in which David Gonda was not on antibiotics?
A. I don't recall whether he was on them, so I can't answer the question.
Q. Would you be able to determine that by looking at the hospital record?
A. Probably.
Q. Well, please do that.
A. There does not appear to be antibiotics ordered during his hospitalization.
Q. Do you know whether or not he was on antibiotics just prior to his hospital admission?
A. No.
Q. Do you know whether or not a patient's taking of antibiotics can produce negative blood cultures?
MR. GRIFFIN: Hold on a second. Are

you done looking through the record or do you still have more record to look through to answer his question about whether antibiotics were ordered in the hospital? Because I don't want you looking for one thing while he's asking you other things. So, let us know when you're done.

A. No, I don't see them ordered.

Q. Do you need some additional time to look at the record?

A. If these are the only orders -- no. Wait, I'm sorry, he was. He was taking an oral antibiotic.

Q. What was the name of the antibiotic?

A. Bactrim.

Q. Do you know why he was on Bactrim?

A. No.

Q. Did you prescribe the Bactrim?

A. No.

Q. Who prescribed the Bactrim?

A. Don't know. Can't read his signature.

Q. So, at the time the cultures were taken, David Gonda was on antibiotics?

A. It appears that way, yes.
Q. If a --
A. Is there an ER note in here? Okay. I'm done.
MR. TRAVERS: I don't think there is a question pending.
MR. GRIFFIN: Not yet.
Q. If a patient has bacterial endocarditis and is on antibiotics, do you know whether or not that affects blood cultures that are taken?
A. It could.
Q. How could it affect blood cultures?
A. They could be negative.
Q. To your knowledge, were serial blood cultures ever done while David Gonda was not on antibiotics?
A. No.
Q. You don't know or the blood cultures were not done?
A. They don't appear to have been done while he was not on antibiotics. Wait, no, that's not true. First two sets were on

antibiotics, the second two he was off.

Q. But you do not know whether or not he was on antibiotics prior to the hospital admission?

A. Correct.

Q. Do you know how long it takes the human body to process antibiotics?

A. Depends on whether he absorbed them, it depends on whether -- the antibiotic, it depends on kidney function, liver function, etcetera.

Q. In general, do you know how long it takes for an antibiotic to go through the human body?

A. Like I said, it depends on the antibiotic, the route, the kidney function, the liver function. So, I wouldn't even venture to make that statement.

Q. Would the right ventricular mass shown on the TEE be consistent with bacterial endocarditis?

A. **No.**

Q. Why not?
A. Because that's not the typical appearance of endocarditis.
Q. What is the typical appearance of endocarditis?
A. I can only tell you that the cardiologist that read it said that this was consistent with an infiltrating tumor of the myocardium. I'm not an expert on echocardiographic evidence of endocarditis.
Q. Were you aware of the results of any chest X-rays that were performed on David Gonda?
A. Yes.
Q. What were the results of the chest X-ray?
MR. GRIFFIN: Let's talk about which one you are referring to first.
Q. Well, to your knowledge, how many chest X-rays were taken?
A. I can't tell you. There was at least one.
Q. If you need to, go ahead and refer to the

record.

A. There appears to have been three chest X-rays, and a CAT scan of the chest.

Q. Could you tell me the dates of the chest X-rays?

A. August 15, August 16 and August 17.

Q. Did you review the actual three chest X-rays?

A. Yes.

Q. What were the results of the chest X-ray on August 15?

A. There were bilateral mass-like densities on the left greater than the right, with bilateral hilar fullness or masses.

Q. Could those bilateral mass-like densities be embolization?

A. Certainly they could.

Q. With bacterial endocarditis, do you have embolization to the lungs?

A. Yes, but not to that size and extent.

Q. Why do you say, "Not to that size and extent"?

A. Because usually there are small flags of tissue that are embolized to the chest,

not larger clots.

Q. Have you ever treated a patient that had bacterial endocarditis that had larger size embolization to the lungs?

A. No.

Q. Over the past seven and a half years, how many patients have you treated with bacterial endocarditis?

A. Personally, none.

Q. Were you aware that an EKG was done on David Gonda?

A. There appears to be one on the chart.

Q. Do you know what the results of the EKG were?

A. I could read them to you.

Q. Please do that.

A. I can't read the dates because they are not copied on these, so I'm not sure when they were done. They have been cut off. But there was one done at 5:25 on the 15th of August, 1995. That says, "Regular sinus rhythm, with an RSR in lead V1-V2 consistent with right

ventricular conduction delay, abnormal rhythm EKG."

Q. Would a right ventricular conduction delay be consistent with bacterial endocarditis in the right ventricle?

A. Yes and/or anything else that would interfere with the conduction on the right side.

Q. What would cause right ventricular conduction delay?

A. Something wrong with the right conducting bundle.

Q. Other than a mass, what could cause a right ventricular conduction delay?

A. Heart disease, any infiltrating lesion in the area, abnormal size to the right ventricle.

Q. Would lymphoma cause a right ventricular conduction delay?

A. If it were infiltrating the heart muscle, yes.

Q. And I'm sorry, what was the other diagnosis that was part of your differential?

A. Wegener's granulomatosis.

Q. Would that cause a right ventricular conduction delay?
A. Not that I'm aware of.
Q. Would lymphoma produce a right ventricular mass?
A. It could.
Q. Under what circumstances would it produce a right ventricular mass?
A. When the lymphoma is involving the muscle of the heart.
Q. Did you have a discussion with David Gonda about the differential diagnosis?
A. I don't recall.
Q. Did you discuss the differential diagnosis with David Gonda's family?
A. On the 17th of August, myself and Dr. Hunt told the family about the abnormal trans-esophageal echocardiogram. What we saw on the study, we suggest -- we -- although I cannot be 100 percent sure what we actually told them it was, I don't recall, we suggested sending the

tape itself to the Cleveland Clinic to allow their cardiologist to look at it. They said, "No, you'll send our son to the Cleveland Clinic."

Q. Do *you* remember any other discussions you had with the family?

A. No.

Q. Who is Dr. Hunt?

A. He's the cardiologist that performed the trans-esophageal echocardiogram.

Q. Other than performing the TEE, was he involved in David Gonda's care and treatment?

A. No.

Q. Was a cardiologist's consultation obtained?

A. No.

Q. Do you know why a cardiologist's consultation was not obtained during his admission at St. Elizabeth's Hospital?

A. Because it wasn't until the trans-esophageal echocardiogram was done that a cardiac abnormality as the source of his problems became obvious, and since the family

requested he be transferred, there was little need at that point to get a cardiologist involved.

Q. Did you have any discussions with Dr. Cropp about David Gonda?

A. Yes.

Q. What discussions did you have with Dr. Cropp?

A. I spoke to Dr. Cropp the morning of David's admission. He told me that he did, in fact, know him and that he was scheduled for a CAT scan and that he had treated him for his sinusitis.

Q. Did Dr. Cropp give you his impression of what he thought was wrong with David Gonda?

A. I cannot recall.

Q. At any point did you have a discussion with Dr. Cropp about what Dr. Cropp thought was wrong with David Gonda?

A. Other than that that we just talked about?

Q. Yes.

A. No.

Q. Do you remember having any other discussions

with Dr. Cropp other than the one we just talked about?

A. Yes, when we sat with our lawyer last week.

Q. Did you have any discussions with Dr. Ruiz at the hospital?

A. Actually, no.

Q. Did you have any discussions with Dr. Ruiz after --

A. No.

Q. -- David Gonda died? Did you have any discussions with Dr. Franco at the hospital?

A. Other than to consult him to do the biopsy, no. And to tell him that the biopsy wouldn't be necessary on the 17th.

Q. Why did you tell him that the biopsy was not going to be necessary?

A. Because the patient was going to the Cleveland Clinic.

Q. Do you know who admitted David Gonda to St. Elizabeth's Hospital?

A. Who the attending of record is? Is that what

you are asking me?

Q. Yes.

A. Dr. Ruiz.

Q. Do you know why the decision was made to admit David Gonda to the hospital?

A. No, I'm not aware of the conversation he had with the emergency room people.

Q. What treatment did you provide to David Gonda while he was a patient at St. Elizabeth's?

A. My treatment was directed against decreasing the amount of blood he was coughing up, maintaining his oxygen levels normal, and minimizing cough.

Q. And what treatment did you provide to him?

A. Sorry, I just don't know how this thing is organized. He was given aerosol treatments with Albuterol. I had Social Service see him about paying for his hospital admission. I checked his blood counts. I ordered the 2-D echo. I ordered a transfusion when his blood

count was down. I ordered two sets of blood cultures -- twice -- two different sets of blood cultures. I ordered iron studies, urinalysis. That's it.

Q. Was there any improvement in David Gonda's condition based on the treatment that you rendered to him?

A. Yes.

Q. What improvement was there in his condition?

A. His -- the amount of blood he was coughing up decreased significantly, his oxygen levels became normal, his heart rate improved, he was less short of breath.

Q. What was his condition when he left St. Elizabeth's Hospital?

A. He was awake, alert, blood pressure was normal, his heart rate was 110, his breathing, 24 times a minute. His temperature was 99.7, and his oxygen saturation was 100 percent.

Q. At the time he left St. Elizabeth's Hospital, was there a definitive diagnosis for

David Gonda?

A. No.

Q. What diagnoses were part of the differential when he was transferred to the Cleveland Clinic?

A. Let me look at the progress notes, I'll tell you exactly what I said. I wrote, "The trans-esophageal echo demonstrates a large density in the right ventricle with echo characteristics of clot. Unfortunately I cannot explain this chest radiogram for the simple embolization of clot to the pulmonary vessels. I have an otherwise healthy 27 year old. Questionable neoplastic process or primary pulmonary parenchymal abnormality. Family has requested transfer to the Cleveland Clinic Foundation. Dr. Ruiz has arranged transfer to cardiothoracic services."

Q. Can I see the record, Doctor? Do you know whose note is the note of 8-17-95 at 8:30

a.m.?

A. Yes, mine.

Q. Could you read the last couple lines of that note?

A. "2-D echo, questionable tricuspid vegetation, clinically this could be put together if he did, in fact, have a right-sided endocarditis."

Q. On today's date of December 18, 1997, do you have an opinion based on reasonable medical probability as to what the cause was of David Gonda's symptoms?

A. Yes, embolization of blood clot from endomyocardial fibrosis of the right ventricle.

Q. Why is that your opinion?

A. Because that's what the autopsy found.

Q. Do you know whether or not the Cleveland Clinic actually reviewed the slides that were taken during the autopsy?

A. I can't tell you what the Cleveland Clinic Foundation did.

Q. If the autopsy at the Cleveland Clinic was inaccurate, would that change your opinion as to the cause of David Gonda's symptoms?

A. Blood clot from the ventricle was the cause of his symptoms. And that fits with the autopsy findings in the lung that demonstrated blood vessels with clot, pulmonary infarct, pulmonary alveolar hemorrhage.

Q. If the slides that were taken at autopsy show that David Gonda was suffering from endocarditis, would you disagree with that finding?

MR. GRIFFIN: That's so speculative that he can't even be asked to respond to that.

Q. Please answer the question, Doctor.

MR. GRIFFIN: I mean, if you can answer his question, by all means, go ahead. But I object to the question.

A. I can't answer that.

Q. Do you recognize that the presenting symptoms

of bacterial endocarditis can be highly variable?

A. Yes.

Q. And do you agree that with right-sided bacterial endocarditis, that typically there is pulmonary embolization?

A. I don't know that for a fact, no.

Q. Would you agree that because the clinical manifestations of bacterial endocarditis are numerous and non-specific, that the differential diagnosis of this disease is very wide?

MR. GRIFFIN: Objection.

A. I have no idea what you are asking me with that question.

Q. Do you recognize that bacterial endocarditis must be considered during the workup of every patient with a fever of unknown origin?

A. He didn't have a fever of unknown origin.

Q. What was the origin of his fever?

A. Blood clots from the right ventricle. And

definition of a fever of unknown origin is weeks of investigation for a fever. He had two days' worth of investigation. So, he did not have a fever of unknown origin.

Q. Would you agree that bacterial endocarditis must be considered during the workup of a patient with chronic general malaise?

A. That's so non-specific, that it could be any disease that we talk about.

Q. Would you agree that typically the symptoms of bacterial endocarditis are a flu-like i1lness?

A. I don't think that there's any typical symptoms.

Q. Well, since there aren't any typical symptoms, shouldn't it be part of the differential with somebody with chronic fever and flu-like symptoms?

A. As far as I was concerned, he didn't have chronic fever.

Q. Well, do you disagree with the statement in

the medical record that at the time of admission David Gonda had had ten weeks of fever?

MR. GRIFFIN: What part of the record --

A. Who --

MR. GRIFFIN: Wait a second. He asked you a question from the record. Let's look at it.

Q. What was your understanding as to the duration of his fever at the time of admission?

A. Only that he said he had been having fevers, but there were no documentation that that was, in fact, the case.

Q. Did you find David Gonda to be a credible patient?

A. Yes.

Q. Was David Gonda a compliant patient?

A. Couldn't tell you.

Q. Did you have any reason to distrust his statement that he had had fevers for ten weeks?

A. Only the fact that he said he had fevers, but that doesn't necessarily mean he did. A lot of people will tell you they have fevers when, in fact, they didn't take their temperature, they thought they had fever. So, that's not necessarily concrete proof that they had been having fever. As a matter of fact, there is no proof that he had been having fever.

Q. When making a decision as to his diagnosis, did you make a determination whether or not he had had fevers all summer?

A. I made my differential based on his symptoms at the time of his hospital admission, not based on his previous history of fevers that I may or may not have been able to prove.

Q. Isn't a patient's history important in rendering a diagnosis?

A. As far as symptoms, yes.

Q. So, did you take his history of symptoms into account in rendering your diagnosis?

A. Yes.
Q. Would you agree that the most consistent symptom of bacterial endocarditis is general malaise or flu-like symptoms?
A. Yes, as is general malaise a symptom of almost every chronic disease that we have.
Q. Do you recognize that if the diagnosis of bacterial endocarditis can be made on clinical grounds, that therapy should be initiated, despite negative blood cultures?
A. Yes.
Q. What's your opinion?
A. I agree that if that were a clinical decision, that endocarditis existed, that blood -- that antibiotics should be started.
Q. Do you know what the treatment is for bacterial endocarditis?
A. Usually it's antibiotics.
Q. Do you know what type of antibiotics?
A. Directed against the bacteria that's causing the infection.

Q. And how do you make a determination as to what type of antibiotics to give a patient?
A. Based on the bacteria that grows in the blood cultures.
Q. Would you agree that the chief goal in treating bacterial endocarditis is to irradicate the infecting organism as soon as possible?
A. Yes.
Q. Would you agree that, depending on the bacteria, the survival rate for treatment of a patient with bacterial endocarditis is over 90 percent?
A. That -- I can't tell you those statistics.
Q. Would you agree that bacterial endocarditis is almost universally fatal if untreated?
A. I can't state that with fact, either.
Q. Do you remember any other conversations with doctors that we have not discussed?
A. No.
Q. Would shortness of breath be consistent with bacterial endocarditis?

A. Wouldn't be a common complaint, no.
Q. Would coughing up blood be consistent with bacterial endocarditis?
A. No, not commonly, no.
Q. Do you remember any other conversations that you had with David Gonda that we have not discussed?
A. No.
Q. Have you had any discussions with any doctors about David Gonda since his death?
A. No.
Q. Did you have any difficulty in communicating with David Gonda --
A. No.
Q. -- while he was your patient?
A. No.
Q. After the echocardiogram was done, why wasn't a cardiologist consulted?
A. I told you.
MR. GRIFFIN: Yes, you did.
A. Patient went to the Cleveland Clinic.
Q. Did you have any discussions with anyone at

the Cleveland Clinic?

A. Yes.

Q. What discussions did you have and with who?

A. Dr. Weidemann. I presented our findings to that point.

Q. Do you specifically remember the discussions?

A. No.

Q. Could you tell me anything else about that conversation with Dr. Weidemann?

A. Only that I called him to discuss the case before he was transferred.

Q. Do you have an opinion based on medical probability as to David Gonda's chances of survival when he was discharged from St. Elizabeth's Hospital?

A. No.

Q. In your opinion, was it more probable than not that he was going to die when he was discharged from St. Elizabeth's Hospital?

A. Yes.

Q. Why do you say that?

A. Our diagnosis was an infiltrating tumor of the

ventricle, which would have required -- well, I'm not sure of the exact treatment, but, in all likelihood, it would have been a fatal disease.

Q. Was a consult brought in concerning the diagnosis of infiltrating tumor of the ventricle?

A. The patient was transferred to the Cleveland Clinic, so I can't answer that question.

Q. Do you know what type of tumor this infiltrating tumor of the ventricle was?

A. It was endomyocardial fibrosis, based on autopsy.

Q. Did you discuss your note of 8-17 with either Dr. Ruiz or Dr. Cropp?

A. Dr. Cropp was on vacation. So, I can pretty much assume the answer to that is no. And I know I spoke to Dr. Ruiz before he was transferred to the Cleveland Clinic. I don't specifically know if I discussed my note with him.

Q. When did Dr. Cropp go on vacation?

A. Sometime before David Gonda's admission to the hospital.
Q. Do you know how long before?
A. No. I mean, I don't recall.
Q. Were you asked to see him at the hospital because Dr. Cropp was on vacation?
A. Yes.
Q. So, you were covering for Dr. Cropp?
A. Correct.
Q. I forgot. Did you say how many times you saw him at the hospital?
A. I didn't, no.
MR. GRIFFIN: He said, "Daily."
A. I said at least daily.
Q. And what were the dates of admission?
A. 8-15-1995 through 8-17-1995.
Q. Did you have any discussions with Dr. Cropp about David Gonda before Dr. Cropp went on vacation?
A. No.
Q. Was Dr. Cropp's chart available to you at the time you treated David Gonda?

A. Yes.
Q. Did you review Dr. Cropp's chart during David Gonda's admission to St. Elizabeth's Hospital?
A. No, I did not.
Q. Did you obtain any other medical records during the time you treated David Gonda at St. Elizabeth's Hospital?
A. No.
Q. Do you know whether or not David Gonda's case was the subject of any morbidity and mortality meeting?
A. I have no idea.
Q. What documents did you produce in the hospital chart other than the S1 consultation of August 15?
A. I would have written progress notes on the times that I saw him.
Q. Could you tell me what dates you wrote progress notes?
A. I wrote on 8-15-1995, 9:00 a.m. A note when I first saw him, that I did see him. There

is a -- there is a note again, 8-16, and again, two notes on 8-17.

Q. Other than the one note of 8-17 that we discussed, which talks about bacterial endocarditis, was bacterial endocarditis discussed in any of the other of your notes?

A. No.

Q. Can I review your chart, please?

MR. GRIFFIN: He's talking about this one. (Indicating)

THE WITNESS: Oh. Which one do you want?

Q. When did you find out that David Gonda was deceased?

A. I don't recall.

Q. Do you know whose writing this is in the office notes for Pulmonary Rehabilitation Associates?

A. What are you specifically referring to?

Q. The handwritten note of July 17 -- I'm sorry, July 13, '95.

A. Dr. Cropp.

Q. Do you know whether any chest X-rays were taken at this office?

A. No.

Q. Do you have the capability of performing chest X-rays here at this office?

A. Yes.

MR. RUF: Thank you, Doctor. That's all I have for now.

MR. KRESS: I have no questions.

MR. TRAVERS: I have no questions.

MR. BOETCHER: I have no questions.

MR. GRIFFIN: He'll read.

(WHEREUPON THE DEPOSITION OF ROBERT DEMARCO, M.D., WAS CONCLUDED AT 2:28 PM)

REPORTER'S CERTIFICATE

I, Kathleen Skowron, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the above-named ROBERT DEMARCO, M.D., was by me first duly sworn to testify the truth, and that this deposition was written in the presence of the witness and by me transcribed, and that the deposition was taken at the time and place in the agreement specified.

I certify that I am not of counsel or relative to either party or otherwise interested in this action.

I further certify that the above and foregoing is a true and complete transcript of all the testimony and proceedings had in this deposition, as shown by stenotype notes written in the presence of the witness at the time of this deposition.

IN WITNESS WHEREOF, I have set my hand and Seal of Office at Warren, Ohio, this 13th day of January, 1998.

_____
Kathleen Skowron, Notary Public
My Commission Expires 10-30-2000

CORRECTION SHEET

PAGE NO.	LINE NO.	CORRECTION

SIGNATURE PAGE

I, ROBERT DEMARCO, M.D., have read or have had the opportunity to read the foregoing deposition and find it true and correct to the best of my knowledge, information and belief, unless otherwise specified and listed on page **65**, and I hereby subscribe my signature thereto, this _____ day of _____, **1998.**

_____

ROBERT DEMARCO, M.D.

Before me, a Notary Public, in and for the State of Ohio, personally appeared **ROBERT DEMARCO, M.D.,** who deposes and says that he has read or has had the opportunity to read the foregoing deposition, and that he finds it true and correct to the best of his knowledge, information and belief, unless otherwise specified and excepted to on page **65** of the deposition.

Sworn to and subscribed before me this ------ day of _____, **1998.**

_____

NOTARY PUBLIC