STATE OF OHIO)
) SS: IN THE COURT OF COMMON PLEAS
MAHONING COUNTY)

CASE NO. 96 CV 2055

DOROTHY A. GONDA, Individually and as Administratrix of the Estate of DAVID PAUL GONDA, Deceased

Plaintiff

VS.

HM HEALTH SERVICES, ET AL

Defendants

DEPOSITION

OF

ALEJANDRO FRANCO, M.D.

DEPOSITION taken before me, Mary J. Carney, a Notary Public within and for the State of Ohio, on the 15th Day of November, A.D., 1997, pursuant to agreement and at the time and place therein specified, to be used pursuant to the Rules of Civil Procedure or by agreement of counsel in the above cause of action, pending in the Court of Common Pleas, within and for the County of Mahoning, State of Ohio.

APPEARANCES

On Behalf of Plaintiff:

Mark W. Ruf, Attorney at Law
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700 West St. Clair Avenue
Cleveland, OH 44113-1230

On Behalf of Defendant, Dr. Franco:

James L. Blomstrom, Attorney at Law
Harrington & Mitchell Ltd.
1200 Mahoning Bank Building
Youngstown, OH 44503

On Behalf of Defendant, Dr. Ruiz:

Charles Scott Lanz, Attorney at Law
Manchester, Bennett, Powers & Ullman
Atrium Level Two
The Commerce Building
Youngstown, OH 44503

On Behalf of Defendants,
Drs. Cropp and DeMarco:

Scott A. Richardson, Attorney at Law
Buckingham, Doolittle & Burroughs
624 Market Avenue, North
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STIPULATIONS

It is stipulated and agreed by and between counsel for the parties hereto that this deposition may be taken at this time, 10:15 a.m., November 15, 1997, in the offices of Harrington & Mitchell Ltd., 1200 Mahoning Bank Building, Youngstown, Ohio.

It is further stipulated and agreed by and between counsel that the deposition may be taken in shorthand by Mary J. Carney, a Notary Public within and for the State of Ohio, and may be by her transcribed with the use of computer-assisted transcription; that the witness will read and sign the finished transcript of his deposition.

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WHEREUPON,

ALEJANDRO FRANCO, M.D.,

of lawful age, being by me first duly sworn to testify the truth, the whole truth, and nothing but the truth, as hereinafter certified, deposes and says as follows:

CROSS EXAMINATION:

By Mr. Ruf

Q Could yc state your name and spell your name, please?

A Alejandro Franco, A-L-E-J-A-N-D-R-0, Franco, F-R-A-N-C-0.

Q Dr. Franco, my name is Mark Ruf. I'm here on behalf of the estate of David Gonda. 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, then I'll assume that you've understood the question. Okay?

A Okay.

Q Also, you need to give verbal answers during the deposition so that the court reporter can take down your answers. Okay?

A Okay. Okay.

Q Are you licensed to practice medicine in

the State of Ohio?
A Yes.
Q How long have you been licensed to practice?
A Since 1979.
Q And where do you practice; what s the address?
A Currently 540 Parmalee Avenue, P-A-R-M-A-L-E-E Avenue, Suite 300. That is in Youngstown, zip code 44510.
Q Are you in a group?
A No, by myself.
Q Do you practice under a corporate name?
A Individually, under my name. I do have a professional corporation, though.
Q Could you tell me the name of the professional corporation?
A Thoracic and Vascular Consultants.
Q Is that Thoracic and Vascular Consultants, Inc.?
A Correct.
Q And that's a corporation in good standing in the State of Ohio?
A Correct.
Q During the t me you treated David Gonda,

did you have the professional corporation Thoracic and Vascular Consultants, Inc.?

A Yes, I did.

Q Do you specialize in any area of medicine?

A Yes, I do.

Q What area of medicine?

A Thoracic and vascular surgery.

Q And what is thoracic and vascular surgery?

A Treatment of diseases involving the chest cavity and major blood vessels in the body.

Q Do you treat both pulmonary and cardiac conditions?

A Yes.

Q What types of cardiac conditions do you treat?

A Mostly acquired diseases, like, acquired diseases like coronaries, valvular diseases.

Q Does that include endocarditis?

MR. BLOMSTROM: Objection. Can you tell me what you mean by the word "treat" in this circumstance?

Q Well, do you regularly treat patients that have endocarditis?

A Can you be more specific with your question, please?

Q If one of your patients has endocarditis, do you treat the patient, or do you refer them to someone else?

A Generally endocarditis is a medical condition that is treated by internist or a cardiologist or an infectious disease specialist.

Q So if you have a patient that you suspect has endocarditis, you would refer that patient to somebody else?

A For the most, yes, I will.

Q What types of pulmonary conditions do you treat?

MR. BLOMSTROM: Again, can you tell us what you mean by the word "treat"? Dr. Franco has already indicated that he's a surgeon.

MR. RUF: Right.

MR. BLOMSTROM: You mean perform surgery on?

MR. RUF: Yes.

MR. BLOMSTROM: Okay.

A Mostly, again, acquired diseases, neoplastics.

Q I'm sorry; I didn't hear.

A Neoplastics, or in some cases some diagnostic tests.

Q What is your relationship with St. Elizabeth's Hospital?

A I am an attending physician affiliated with that hospital.

Q What hospitals are you on staff?

A St. Elizabeth only.

Q No other hospitals?

A No.

Q What's your relationship with Dr. Ruiz?

A Other than sometimes taking care of some of his patients on a referral basis.

Q Does he regularly refer patients to you?

A If you are more specific in your question, I can answer you.

Q Well, on a periodic basis does he refer patients to you or bring you in as a consult?

A Occasionally he will.

Q What's your relationship with Dr. Cropp?

A In the same, the similar basis.

Q What's your relationship with Dr. DeMarco?

A Likewise.

Q Have you ever lost your staff privileges

at St. Elizabeth's Hospital?

A Never.

Q Have you ever been subject to disciplinary proceedings at St. Elizabeth's Hospital?

A No.

Q Have you ever given a deposition prior tc today?

A Yes, I have.

Q How many times have you given depositions?

A I do not recall the number.

Q Is it more than ten, less than ten?

A Less than ten probably.

Q And when you gave the depositions, were you a defendant in a case, or did you serve as an expert?

A Defendant.

Q Have you ever served as an expert in a medical malpractice case?

A No.

Q How many times have you been sued for malpractice?

A I do not recall.

Q More than ten, less than ten?

A Will that include those, called 180 days letters?

MR. BLOMSTROM: No, it doesn't.

Q No, I'm talking about actual court proceedings

A I will say less than ten. Exact numbers I would not remember.

Q Are you board certified?

A No.

Q What does it mean to be board certified?

A It's the passing a test given by the national boards of the different specialties.

Q Why have you not become board certified?

A I just took a fellowship.

Q What was your fellowship in?

A Thoracic and cardiovascular surgery at the Cleveland Clinic.

Q How long was the fellowship?

A Two years.

Q Where did you go to medical school?

A San Marcos University School of Medicine in Lima, L-I-M-A, Peru, P-E-R-U.

Q And after you graduated from medical school, you did a fellowship at Cleveland Clinic?

A No.

Q Or what did you do after medical school?

A I stayed, I worked in my country for

three years. Then I came to this country in 1972, to Youngstown. I served an internship and residency in general surgery for five years from June 1972 through -- I'm sorry -- July 1972 through June 1977. From July the lst, 1977, until June 30th, 1979, I was at the Cleveland Clinic.

Q How did you wind up in Youngstown?

A Just liked this area. Like anybody else, just moves on.

Q And when did you come to Youngstown?

A 1972. That's the -- that's when I arrived here, June 1972.

Q So you did your internship and residency in Youngstown?

A Correct. That was in St. Elizabeth Hospital.

Q What did you review prior to your deposition today?

A The records I have in my office.

Q Is that your office chart that you brought with you?

A Correct.

Q Could I please take a look at your office chart?

A (Complying).

MR. RUF: Let's go off the record fo a minute.

(Whereupon an off-the-record discussion was had and the reporter marked for identification Plaintiff's Exhibit, 1 and 2.)

Q When did you first become involved in David Gonda's care and treatment?

A August 15, 19, whatever it was, 1995.

Q Why did you become involved in his care and treatment?

A At the request of one of the patients involved in his care at that time.

MR. BLOMSTROM: You mean one of the doctors?

THE WITNESS: Yeah.

MR. BLOMSTROM: Okay.

Q You were brought in as a consult?

A Yes, sir.

MR. BLOMSTROM: Yes, he's looking for the consult right now.

A There is a request written in the chart by, on August 15 at 8:15, signed by one of the residents but was at the request of Dr. Ruiz and Dr. DeMarco. And that request was, "Consult Dr. Franco for open lung biopsy."

Q Were you only brought in as a consult to perform a lung biopsy?
A Correct.
Q Were you involved in assessing the patient and reaching a diagnosis for the patient?
A Not exactly. The request was specifically obtain a piece of the lung so we can come out with better answers for this person.
Q What time did you see the patient?
A I'll look at the nurses' notes.
MR. BLOMSTROM: Page 82.
A 9:40 in the morning, August 15.
Q Why did you see the patient at 9:40?
A That's the time I arrived to the floor to see him.
Q Did you conduct a history and physical when you saw the patient?
A Yes. I usually review what is available in the chart, interview the patient.
Q Did you rely on the history and physical that was performed in the emergency room, or did you perform a separate history and physical?
A It's usually an added on. We look through the chart, see what information we have, and do my own question and information.

Q What information did you have from the history and physical?

A It's in the consult.

MR. BLOMSTROM: Page 33 in your chart, Doctor, is the consult. Page 3 is the initial admitting note by someone else.

A Okay. It's listed in, described in consult that I wrote for this patient. Do you want me to read it?

Q Yes, please read it out loud.

A Says, "Patient seen as requested. History reviewed and patient examined. Patient admitted with increasing shortness of breath, cough and hemoptysis. Chest X-ray showing bilateral densities above the hilum with surrounding infiltrates. Patient gave history of intermittent and recurrent episodes of fever and cough for several weeks, aggravated by smoking and cold weather.

"Patient appears dyspneic, pale and rather thin-built. Case discussed with Dr. DeMarco, and patient, as well as family, informed of potential causes of ongoing clinical condition and consideration for tissue diagnosis via a VAT," which stands for video assisted thoracoscopy, "or thoracotomy. The risks and benefits explained to the patient and family. All understood and agreeable. Will repeat the chest X-ray in a.m. and proceed with the surgery

tomorrow."

Q What does --

A "Thank you for allowing me to see Mr. Gonda."

Q And you just read from the S-1 Consultation from the St. Elizabeth's Hospital record dated 8/15/95?

A Correct.

Q What discussion did you have with Dr. DeMarco about the patient?

A The findings related to the X-rays that had been performed on him up until that moment; the fact that he had not been able to come up with an answer as to the diagnosis and potential -- and cause for his condition; and that he felt that, at that particular point in time, maybe obtaining a tissue diagnosis rather than just waiting for another sputum, which up until that point in time has been non-diagnostic, so he requested a piece of the lung. He asked me to do an open lung biopsy.

Q So as of 8/15/95, Dr. DeMarco did not have a diagnosis for David Gonda?

MR. RICHARDSON: Objection.

A They had -- I'm sorry. Maybe you can rephrase the question; I will be able to give you a more specific answer.

Q Well, on August 15th, 1995, what was the differential diagnosis for David Gonda?

MR. RICHARDSON: Objection. Do you mean by Dr. DeMarco or by Dr. Franco, or whose differential diagnosis are you referring to?

Q Well, you discussed the potential diagnoses with Dr. DeMarco; correct?

A Correct.

Q And you were brought in to help establish a diagnosis; correct?

MR. BLOMSTROM: Well, he already said why he was brought in.

A Yeah. Up until that point, we had a diagnosis, a person with diagnosis of cough, diagnosis of fever, diagnosis of hemoptysis. All are syndromes. We want to find etiology for all these syndromes. That's what we were working at. Everyone have a diagnosis, but we do not have the etiologic diagnosis for those symptoms.

Q Did you discuss the potential etiology for the symptoms with Drs. DeMarco, Ruiz and Cropp?

A I discussed it with Dr. DeMarco.

Q And could you tell me what you discussed; do you remember the specific discussion you had?

A No, I do not.

Q What do you remember?

A That we were looking at a, what could possibly give us the clinical picture, the clinical picture that he had. And those were infectious process; a tumor, most likely metastatic; we mentioned also a possible, among the infectious process, also the possibility of tuberculosis was entertained; and also a viral process.

Q And those were all part of the differential diagnosis?

A Correct.

Q Was infective endocarditis part of the differential diagnosis?

MR. BLOMSTROM: At that time?

MR. RUF: Yes.

A No.

Q Was infective endocarditis part of the differential diagnosis at any time during your involvement in the treatment of David Gonda?

A I, if I should be more specific, I was requested to come and give a tissue diagnosis; never to treat this patient. So I actually never treated Mr. Gonda. I was just asked as a consultant to obtain a tissue diagnosis to aid in the diagnosis of this person; never to treat him.

Q What is your understanding of who was responsible for David Gonda's care and treatment at the

hospital?

A Usually the admitting physician is responsible for the care of the patient.

Q And who was the admitting physician?

A Dr. Ruiz.

Q Were you involved in any of the decisions that were made with respect to what diagnostic tests to be performed, other than the biopsy?

A Not up until -- on the 8th -- oh, I'm sorry. On Page 8, August 16, I wrote a note in the chart. It says, "Above noted." And it related to a report of an echocardiogram that was performed that morning on Mr. Gonda that reported -- in which an abnormal pathological finding was reported on the right ventricle.

And the note that I wrote states, "Above noted," which relates to that findings on the echocardiogram. "Chest X-ray shows a new infiltrate in left side. Patient continues to hemoptysis and dyspnea. 2-D echo, questionable flail chorda versus vegetation in right ventricle. Discussed it with Dr. DeMarco, Mr. Gonda and family. Will postpone surgery and obtain a TEE," which stands for transesophageal echocardiogram, "and blood cultures. Should rule out BE," stands for bacterial endocarditis, "with embolization to pulmonary artery and lung."

Q Do you know why the echocardiogram was performed?
A Was at the request of Dr. DeMarco.
MR. BLOMSTROM: You're referring to the 2 D echo now, Mr. Ruf?
MR. RUF: Yes.
MR. BLOMSTROM: Okay.
Q The echocardiogram that you mentioned previous was a 2-D echocardiogram?
A Correct.
Q And as a result of that echocardiogram, a decision was made to perform a TEE?
A Correct.
Q Why was a decision made to perform a TEE?
A After we obtained, the 2-D echo was obtained and that shadow was in, on the right ventricle, then we felt that a transesophageal echocardiogram could be more -- could give us a more clear picture of what it was inside the ventricle. It technically allows to see the ventricular chambers more clearly.
Q Do you know who made the decision to perform a TEE?
A Was a suggestion that I, I made to Dr. DeMarco.
Q So you made the recommendation?

A (Nodding head in the affirmative).

Q Was the first time that vegetation in the right ventricle was considered as a potential diagnosis on August 16th, '95?

A It --

MR. BLOMSTROM: You mean by Dr Franco?

MR. RUF: Yes.

A I should mention that this is an interpretation, is a questionable vegetation. I'm not stating that this is a vegetation, per se. It specifically says, questionable flail chorda versus vegetation of the right ventricle. I'm not stating yes, it is a vegetation or it's a flail chorda.

Q But that was something to be considered as part of the differential diagnosis?

A Correct. But at the same time, I should re-emphasize again, I did not state it is a vegetation.

Q And that was because, based on the echocardiogram, it showed a questionable intracavitary mass?

A Correct. Excuse me.

Q Do you need to explain something?

A No.

Q To your knowledge, was an intracavitary

mass or bacterial endocarditis considered before August 16th of '95 as part of the diagnosis?

A Not 'chat I'm aware of.

Q How were the results of the 2-D echocardiogram reported to you?

A I have come up to the floor to see Mr. Gonda, and this patient scheduled for surgery that day; and I found out that an echocardiogram was performed that morning. And I went to look for the echocardiogram or a cardiologist to read the echo, and the echocardiogram had not been reported up until that moment.

Whatever you have in there now, it was reported afterwards. After I have wrote this note in here, I went and looked at echocardiogram. And by looking at that, my own interpretation was, I'm not a cardiologist; I'm just trying to get something that I saw something that wasn't normal, and I was questioning something that could potentially be.

Q Other than vegetation, what other possible conditions would explain this intracavitary mass?

A Could be a clot.

Q Anything else?

A By just looking at the echo myself, I don't know if I could come up with any more answers to you.

Q So based upon your interpretation of the

echocardiogram, the mass was either a clot or a vegetation?

A Or a flail chorda, which is a piece of the valvular apparatus which sometimes breaks and moves around.

Q What was that term; I'm sorry?

A A piece of the valve that could be rupturing and floating around in there inside; it's been in the wrong place.

Q And what was the term that you used for that?

A Flail chorda. Flail, which means move around; chorda, C-H-O-R-D-A.

Q And what's the first word, frail?

A Flail.

MR. BLOMSTROM: Flail.

A Flail, F-L-A --

MR. BLOMSTROM: A-I-L.

A A-I-L. Sorry.

Q Did you discuss that with either Dr. DeMarco, Dr. Ruiz or Dr. Cropp?

A I spoke with Dr. DeMarco.

Q And what was your discussion?

A What I have seen in the echo. And the suggestion that I made for him to have a TEE. That could be more sensitive.

Q So after the 2-D echocardiogram, vegetation was part of the differential diagnosis?

A Correct.

Q And that's why you've stated that bacterial endocarditis should be ruled out?

A Correct.

Q And when something is part of the differential diagnosis, is it kept in the differential until it's ruled out?

A Correct.

Q To your knowledge, was bacterial endocarditis ever ruled out during David Gonda's stay at St. Elizabeth's Hospital?

A There were no cultures to prove that.

Q But it was not ruled out during his stay at St. Elizabeth's; correct?

A Not that I'm aware of.

Q Could you take a look at the 2-D echocardiogram report, please?

A (Complying).

Q Could you tell me what findings would be consistent with bacterial endocarditis?

A The only thing reported here by a cardiologist -- I'm just going to read it all, and we'll just go from there.

"This echocardiogram was of only fair technical quality as the patient was sitting upright with an underlying sinus tachycardia. Note is made that the left ventricle appears to be of normal size and appears to be hypokinesis of the posterobasal segment. Estimated ejection fraction 55 percent.

"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, however. The left ventricle -- no significant delineation could be made from this study, however. The left ventricle, likewise there was small antero-apical effusion noted. The mitral valve was not a specific" -- no, I'm sorry -- "The mitral valve has nonspecific thickening. The tricuspid valve appeared grossly normal.

"Note was made of prominent papillary muscle within the left ventricle cavity, which appears as the posteromedial papillary muscle. The atria are of normal size. Doppler analysis was of poor technical quality. Thus no definitive comments can be made.

"Conclusions: Questionable mass in area of right ventricular moderator band; mildly abnormal left ventricular systolic function as described above; a small amount of pericardial effusion" -- I'm sorry -- "fluid seen

antero-apically. Suggest clinical correlation is warranted."

Q What was it about the echocardiogram that led you to consider bacterial endocarditis?

A What is described here as a questionable mass in the right ventricular moderator band.

Q Is there anything else about the echocardiogram that led you to suspect endocarditis?

A There was an abnormal structure in there that did not belong to the right ventricle, and that is what was suspected.

Q When was the transesophageal echocardiogram performed?

A August 17.

Q And what was the result of the transesophageal echocardiogram?

A There is a note written by Dr. Hunt on August 17th. States, "Right ventricle hypokinesis with mobile popcorn-appearing mass in right ventricle apex. No valvular abnormalities. Normal pulmonary arteries. This may represent clot in transit. Right ventricle tumor also possible but less likely. Will send tape to CCF as soon as possible."

Q So did the transesophageal echocardiogram help narrow the potential diagnoses?

A It seemed to be the case.

Q And how did it narrow down the potential diagnoses?

A There was an abnormal structure in the right ventricle. But up until that point there was no etiologic diagnosis. We have a tumor mass; still we do not know what it is.

Q So you still did not know whether the mass was a clot, vegetation, a tumor or flail chorda?

A Correct.

Q And did you do anything to make a determination whether the mass was a clot, vegetation, flail chorda or a tumor?

A I will repeat once again, I was asked to -- I was called in, asked to perform a lung biopsy; not to treat this patient.

Q Well, after you suggested a transesophageal echocardiogram, did your involvement in David Gonda's care and treatment cease?

A More or less like stepping aside, was waiting for them to come to narrow diagnosis tell me, yes, proceed with this; no, don't do anything.

Q So did you leave it up to the treating physicians to narrow the diagnosis further?

A Correct.

Q Did you communicate that to the other physicians; and if so, who did you communicate that to?

A The -- it says here on August 16, once again, "Discussed it with Dr. DeMarco, Mr. Gonda and family. Will postpone surgery, obtain TEE and blood cultures. Should rule out BE with embolization to pulmonary artery and lung."

By that I'm writing that I'm going to postpone the surgery until we get more information and make a decision as to, is it correct to proceed with the lung biopsy, or is there anything else that needs to be done.

Q So based upon the echocardiogram, you decided to wait to perform the lung biopsy?

A Correct,

Q Because the ventricular mass would explain David Gonda's condition?

A Not necessarily, but it will be something to take into consideration as to one of the potential diagnoses. We're trying to figure out up until this point what was going on with him.

Q After the TEE was performed, did you tell the doctors that you were leaving it up to them to further narrow the potential diagnoses?

A No. It was a -- there is a note written here in the chart, Dr. Hunt, after he completed

echocardiogram, he wrote in the chart, "Will send tape to CCF as soon as possible." Was Dr. Hunt recommendation and suggestion to send the films to Cleveland. I did not participate in that decision.

Q Did you have any further involvement in David Gonda's care and treatment after you recommended the TEE?

A No, I did not.

Q Did you discuss the results of the echocardiogram and TEE with any other physicians?

A No, I was informed of the, after the fact.

Q Did you have any discussions with Dr. DeMarco, Dr. Ruiz or Dr. Cropp --

A No.

Q -- about the results of the echocardiogram and TEE?

A No.

Q Did you communicate the statement in your note that bacterial endocarditis had to be ruled out with any of the treating doctors?

MR. BLOMSTROM: You mean other than writing it in the chart?

MR. RUF: Yes.

MR. BLOMSTROM: Is that what you're

saying?

A Yeah.

Q Who did you communicate that to?

A Dr. DeMarco, stated in the chart.

Q And what was Dr. DeMarco's response to tha ?

MR. RICHARDSON: Objection.

A I -- to, to what? I'm sorry. Can you --

Q Well, you told Dr. DeMarco that you though bacterial endocarditis should be ruled out; correct?

A Correct.

Q And what was his response to that?

MR. RICHARDSON: Objection.

A I made the recommendation, suggestion to have a transesophageal echocardiogram, and that was performed.

Q At the time you recommended the TEE, what diagnostic tests were you aware of?

A He had X-rays done. He had sputum analysis done. He had laboratory tests done. He had a CAT scan done. All which is in the chart.

Q And by X-rays, you're referring to the plain chest films?

A Plain chest films, CAT scan of the chest

also.

Q And the plain chest films show infiltrates in the lungs?

A The hila; correct.

Q And that could be emboli?

A Could be anything.

Q But one explanation would be emboli?

A Not necessarily. The infiltrates in the lungs, it's a vague description of a radiological finding. It's the appearance on an X-ray of the lungs, I mean, in this case, the lungs.

Q With bacterial endocarditis, you can have embolization; correct?

A It's possible.

Q Were the plain chest films consistent with embolization to the lungs?

A Not necessarily. Excuse me. Let me rephrase the answer. You cannot make a diagnosis of embolization just based on a plain chest X-ray.

Q Well, if you have embolization to the lungs, will that show up on a plain chest X-ray; and if so, how does it show up?

A Plain X-ray will not show too well. The embolus itself will not do anything to the -- will not -- if I see an X-ray immediate following embolization, you may

not see anything. You may see the aftermath of it later on.

Q And what would the aftermath be?

A It could be some damage to the lung tissue which could be seen as an infiltrate, which can also be seen with infections, too. Infectious process can give you the same picture or similar pictures.

Q So if you had embolization to the lungs, it could show up as infiltrates on plain chest X-ray?

A May or may not.

Q Was there anything else about the plain chest X-ray that would be consistent with a diagnosis of bacterial endocarditis?

A Once again, the radiological examinations, the plain chest X-ray shows infiltrate which could be anything; not necessarily embolization, not necessarily bacterial endocarditis.

Q What else could the infiltrates be?

A Could be a tumor; could be an inflammation around a tumor. Could be a primary infection of the lung, bacterial, viral. Could be tuberculosis.

Q What about the CAT scan of the chest, what did that reveal?

A Again, shows -- I will describe the findings of the CAT scan. This is written in the report

dated August 15.

"Findings: 5-millimeter axial slices through the hila -- 5-millimeter axial slices through the hila as well as 10-millimeter axial slices through the remainder of the chest were obtained with the use of intravenous contrast. There is conglomeration of masses in the left hila extending to involve the left lower lobe parenchyma, extending over a 15-centimeter area superior to inferior 7 centimeters right to left and 8 centimeters anterior to posterior.

"In addition, there is a 4-centimeter right hilar mass. In addition, there is a 1-centimeter parenchymal lesion involving the right upper lobe seen best on Image 17, as well as a right upper lobe lesion measuring 3 centimeters.

"There are several other 1- to 2-centimeter lesions scattered throughout essentially all lobes of the lung. There are patchy areas of pneumonitis involving the right lower lobe, the right lower lobe and right middle lobe. These may represent post-obstructive pneumonitis.

"There are no pleural effusions. The lesions in the lung are relatively uniform and after enhancement are markedly enhanced -- enhancing. No definite peri-aortic, pretracheal subcarinal lymphadenopathy greater than 1 centimeter is identified. There are no pleural effusions.

visualized portions of the upper abdomen are unremarkable.

"Impression: Multiple parenchymal and hilar uniform solid masses with associated pneumonitis. The uniform attenuation of the lesion as well as lack of pleural effusion suggests that these may not be of infectious etiology. The post-obstructive pneumonitis may represent hemorrhage given the patient's hemoptysis.

"Differential possibilities would include: Metastatic disease from a primary such as testicular; Wegener's granulomatosis or other inflammatory type process; other primary or secondary tumors such as lymphoma. Although the enhancement of these lesions is marked, it is unlikely that these represent AVM's," stands for arteriovenous malformation, "without congestive heart failure."

Q What did you think was significant about that finding?

A We have multiple lesions in the lung, not in one lobe but in both lobes.

Q And would embolization to the lungs be a possible explanation for that?

A It's a very remote possibility.

Q Other than the possibilities listed in the report, were there other possibilities for the lesions in the lungs?

A This is a radiological interpretation.

He's looking at the pictures downstairs.

Q I understand, but as a cardiothoracic surgeon, did you have any other possible explanations for the masses in the lungs?

A Already have mentioned, listed them before at the beginning.

Q Which were what?

A I'm sorry; you have to go back again and see what I said.

Q Would bacterial endocarditis with embolization be a possible explanation for these masses in the lungs?

MR. BLOMSTROM: You mean at the time? Was that what --

MR. RUF: Yes.

A No, it was never a consideration.

Q Do you know why it was not a consideration?

A He did not have the clinical manifestation to suggest that he had bacterial endocarditis.

Q Well, looking back now, is it a possible explanation for the masses that showed up in the lungs?

A Looking back of what, when? Back on August 15, ugust 17, or looking at November the 16th or

17th?

Q Well, as we sit here today, would you say that the masses in the lungs could be explained by embolization of the bacterial endocarditis?

MR. RICHARDSON: Objection.

MR. BLOMSTROM: What bacterial endocarditis? Your question assumes that that's been diagnosed.

A See, if I go on the basis of assumptions, really, no, it's anybody's assumption, anybody's guess. If I go based on the information that we have now in this particular date, no, there was never diagnosis of bacterial endocarditis.

Q What are the clinical symptoms of bacterial endocarditis?

A Fever, general malaise, compromised hemodynamics. Sometimes could be in shock. There is some manifestations in the skin; it's called petechiae, which is seen from micro-embolizations, or the septic emboli, we call them. They can go anywhere in the body. These can be in the eyes; it can be in the hands; can be in the feet, in the fingers, in the toes.

Q Do you agree that the presenting symptoms for bacterial endocarditis can be highly variable?

A Most of the times we will see, if person

has bacterial endocarditis, generally will be a sick person. But when you make a diagnosis or you make a presumptive diagnosis, you have to look at the whole individual, not just one symptom or one sign.

And we're looking here at one individual with multiple signs, multiple symptoms, and trying to narrow the diagnosis. And as far as I can tell you, up until the moment that the echocardiogram was done, there was nothing there to indicate that he may have potential endocarditis.

Q Well, flu-like symptoms or general malaise is a symptom of endocarditis; correct?

A General malaise, yes. It's one of them.

Q And David Gonda had flu-like symptoms the whole summer; correct?

A Correct, if I go by the records.

Q Well, you said you were aware of the history and physical that was done; correct?

A Correct.

Q And as part of the history and physical, it's stated that David Gonda had a fever and cough all summer; correct?

A Correct, on and off. Intermittent, it's intermittent. He didn't say constant fever every day.

Q Is shortness of breath also a symptom of endocarditis?

A One of the complications of endocarditis, yes.
Q What complication is it a symptom of?
A Congestive failure from the valves in the heart is damaged.
Q Is chest pain a symptom of endocarditis?
A If I may say something, really, you are trying, you know, you're trying to ask me numerous questions here and trying to --
MR. BLOMSTROM: Just respond.
Q Please respond to my question.
A Okay.
Q Is chest pain a symptom of endocarditis?
A May be there; it may not be there.
Q But chest pain can occur with endocarditis; correct?
A May or may not.
Q What about coughing up of blood from the respiratory tract, can that occur with endocarditis?
A May or may not.
Q But it is consistent with endocarditis?
A Not necessarily.
Q Is irregularity in the heart rhythm a symptom of endocarditis?
A May or may not.

Q What do you mean, it may or may not?

A May or may not. May be present; it may not be present. I mean, you have to be more specific when you talk about irregularities of heart rhythm, you know, more specific, what kind of irregularities of heart rhythm you may be referring to.

Q What about a systolic click?

A That is not a rhythm. That is a clinical finding.

Q Is a systolic click consistent with bacterial endocarditis?

A No, it is not. Systolic click is just an auscultatory sign.

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

A Once again, you look at the whole patient, just not one sign, one symptom. If I go in and just treat one symptom, I'm not treating the patient; I'm treating a symptom.

Q Do you agree or disagree with that statement?

A Can you repeat the question, please?

Q Sure. That bacterial endocarditis must be considered during the workup of every patient with a

fever of unknown origin?

A Depends on the circumstances, because --

Q Under what circumstances should bacterial endocarditis be considered in a patient with fever?

A If I have another clinical manifestation that would direct me towards that diagnosis.

Q Okay. And what other clinical manifestation could direct you toward the diagnosis?

A I already mentioned them before, and one of them is general malaise, fever, as you mentioned, clinical manifestations in the skin that indicate, you know, septic embolization.

Q And David Gonda had general malaise all summer; correct?

A Correct.

Q So given that David Gonda had general malaise all summer, should bacterial endocarditis have been considered as part of the differential diagnosis?

MR. BLOMSTROM: By whom?

A I wasn't involved in the care at that time.

Q I understand. But should it have been considered as part of the diagnosis?

MR. BLOMSTROM: By whom at what time?

MR. RICHARDSON: Objection.

MR. BLOMSTROM: Your question is vague and ambiguous.

Q Do you understand the question?

A No, I don't.

Q Given that David Gonda had general malaise all summer, should bacterial endocarditis have been considered in the differential diagnosis prior to his admission at St. Elizabeth's?

MR. RICHARDSON: Objection.

MR. BLOMSTROM: Objection. Again, by whom and at what time?

Q Please answer the question.

A Once again, if a patient is going to be treated, is to be based on the diagnosis, working diagnosis. Not having treated this patient before nor having seen him before, you know, I cannot make any assumption or conclusions about it.

If you are asking me a general question about, should have some, somebody who thought about this, I, the answer is, if all the clinical conditions, all the clinical manifestations, signs and symptoms were there, yes, somebody should work him up in that direction.

Q Is it your understanding that you were the first physician to consider bacterial endocarditis as a potential diagnosis?

MR. RICHARDSON: Objection.

MR. LANZ: Objection.

Q Go ahead.

A From the records I have available from the hospital, that was the first time I think it was mentioned.

Q Are you aware of whether or not serial blood cultures were done prior to your involvement in David Gonda's care and treatment?

MR. BLOMSTROM: I'm going to object to that question as a misleading question under the circumstances of the facts of this case.

Q Please answer the question subject to the objection.

MR. BLOMSTROM: So that I understand your question, you're asking him whether serial blood cultures were done prior to 9:45 a.m. on August 15th? Is that what --

MR. RUF: Correct.

MR. LANZ: Objection.

MR. BLOMSTROM: So that would cover an hour and 45 minutes? Mr. Ruf, just so that we're clear about this?

Q Do you know whether or not serial blood cultures were done prior to David Gonda's admission to St.

Elizabeth Hospital?

A No, I'm not. I was -- no, I do not know.

Q What is the treatment for bacterial endocarditis?

A Specific to the bacteria involved as a cause for endocarditis, it's antibiotics.

Q Do you know how the determination is made what antibiotic or antibiotics to give?

A You have to identify the offending or the bacteria or whatever it is that is involved or causing the endocarditis. Once you identify that, you obtain cultures, I mean, the cultures are obtained; and they, the organism that is involved that is causing the endocarditis then is placed against antibiotics in the laboratory. It's called sensitivity.

Q How do you obtain cultures of the offending bacteria?

A Usually it's based on the, his whole clinical picture, really. Most of the time the diagnosis is obtained from blood cultures.

Q Would you agree that the chief goal in treating endocarditis is to eradicate the infecting organism as soon as possible?

A I'm sorry; I didn't understand the question.

Q Sure. Would you agree that the chief goal in treating bacterial endocarditis is to eradicate the infecting organism as soon as possible?

A Once organism, once it is identified, it should be treated with antibiotics; correct.

Q And it's treated with the antibiotics over a four- to six-week period?

A Depends, and that will be the call of the infectious disease specialist or the clinician involved in the care.

Q Is there a surgical treatment for bacterial endocarditis?

A Usually when there is hemodynamic compromise, when the valves are affected and the patient is hemodynamically compromised, then it is something that cannot be treated with, you know, medically, stabilize it with drugs.

Q Did David Gonda have hemodynamic compromise?

A Not that I'm aware of. Not related to valvular dysfunction, anyways.

Q Were you aware of whether or not David Gonda was treated with long-term antibiotic therapy prior to his admission at St. Elizabeth's Hospital?

A No, I'm not aware of.

Q Would you agree that bacterial endocarditis is almost universally fatal if it's untreated?

MR. RICHARDSON: Objection.

A No, I'm not aware of that. I -- there are cases sometimes that, depends on the degree of the endocarditis.

Q Would you agree that bacterial endocarditis has a very high mortality rate if it's untreated?

A Correct.

Q And would you agree that, depending on the bacteria, the survival rate for somebody that's treated for bacterial endocarditis is over 90 percent?

A Given the proper antibiotic treatment, yes.

Q Would you agree that the median time of initiation of bacterial endocarditis to death is approximately six months?

A I'm sorry?

Q Do you agree that the median time of initiation of bacterial endocarditis until death is approximately six months?

A I still am lost with your question. I'm sorry.

Q You do not understand the question?

A No.

Q Generally how long is the time period from the time bacterial endocarditis starts until death?

A Once again, it depends on the, on the organism and depends whether you treat it. If you treat it -- I mean, are you talking about treated or untreated?

Q Untreated.

A Depends. There's organisms which are virulent, very virulent, and they can produce a sepsis; and you don't have to wait six months. Untreated, person can die within weeks, a week, two weeks. You know, septic shock and they are dead in a matter of a week sometimes.

Q So what is the range for the time period from initiation until death?

A I think it varies really. I mean, I'm not a specialist in infectious diseases.

Q Sure.

A Okay. But it's variable. It's variable and depends on the organism really. There are some organisms which there is low pathology and some other ones which are very virulent really. Depends on the organism.

Q So it can be anywhere from weeks to a year?

MR. LANZ: Objection.

MR. RICHARDSON: Objection.

MR. BLOMSTROM: You're asking for speculation.

MR. LANZ: He also just said he's not an infectious disease specialist.

A I cannot answer that question. I think it's too vague. I'm sorry.

Q Was David Gonda given antibiotic therapy at St. Elizabeth's Hospital?

A Yes, he was, I understand.

Q What antibiotic therapy was he given?

A There's an order on, written on August 15 at 8:15, Bactrim DS. And there is another order on August 17th, 8:35 a.m., to give him Ancef, 1 gram IV, q 8 hours. Or every eight hours; I'm sorry.

Q Did the antibiotic therapy provide any relief of David Gonda's symptoms?

A No.

Q Was a definitive diagnosis ever reached at St. Elizabeth's Hospital?

MR. RICHARDSON: Objection.

A Not that I'm aware of.

Q Do you know why David Gonda was transferred to the Cleveland Clinic?

A It was my understanding the family request.

Q The family's request?
A Correct.
Q Do you know why they transferred him to the Cleveland Clinic?
MR. LANZ: Objection.
A Once again --
MR. BLOMSTROM: You mean aside from what he just said?
MR. RUF: Yes.
MR. BLOMSTROM: The family's request? You're asking for him to say why the family wanted him --
MR. RUF: I just want to know if he knows.
A No.
Q What was David Gonda's condition when he was transferred to the Cleveland Clinic?
A I am not aware of.
Q Do you know if an echo-guided biopsy of the ventricular mass via right heart catheterization was considered by you or the other physicians at St. Elizabeth's Hospital?
MR. RICHARDSON: Objection.
A No.
Q That was not considered?
A I'm sorry? We were going through the

preliminary stages of making the diagnosis what we had in the right ventricle first. A diagnosis of an abnormal right ventricle was made. The family was informed. I understand by this note the family requested him to be transferred to the Cleveland Clinic.

Q Would that be a method of determining the etiology of the lesion in the ventricle?

A We're talking in general? We're talking about --

Q Yes.

A -- in general? If you have a mass in the ventricular cavity, in the right ventricle, you can attempt to do a, you know, a transvenous biopsy. If it is in an area which is accessible, an area which, by doing it, is not going to compromise the intracavitary structures.

Q Do you perform echo-guided biopsies of ventricular masses?

A I do not.

Q What type of doctor performs that procedure?

A I understand it's done by cardiologists most of the time, in general. Generally done by cardiologists.

Q Was a cardiologist consulted on David Gonda's case while he was at St. Elizabeth's?

A There was a request for a stat 2-D echo on August 16 at 10:45 p.m., request by Dr. DeMarco. Not a specified -- there is no specification as to a particular cardiologist to read the test in the chart. The test was interpreted by Dr. Hoffman. It was read by him. And the next is a request on August 16th, had to be in past 24 hours because there's no time in here, "Consult Dr. Hunt for TEE."

Q So the involvement of a cardiologist at St. Elizabeth's was limited to interpretation of the echocardiogram?

A Perform the test and interpret it, yeah.

Q And the TEE?

A Correct.

Q When you first discussed the symptoms and possible etiology of those symptoms with Dr. DeMarco, did he think that the etiology was pulmonary, or did he also suspect a cardiac problem?

MR. RICHARDSON: Objection.

A We were working with a, trying to work out the problems of cough, hemoptysis, trying to find the cause of that.

Q Did he tell you whether or not he thought that the etiology was pulmonary or cardiac?

A We didn't know. At that point in time we

are suspecting a primary infiltrate; we are suspecting a tumor, a metastatic tumor from anywhere in the body.

Q Did he tell you what he thought the most likely etiology was?

A No. We were -- at that particular time we had different, at least three potential diagnoses in the workup then.

Q Do you have an opinion now based upon medical probability as to what the diagnosis was for David Gonda?

MR. LANZ: Objection.

MR. RICHARDSON: Objection.

A The only information I have on this patient is up to this point whatever is in the records at St. Elizabeth Hospital and whatever records there were, information that was provided by the Cleveland Clinic later on.

Q So you don't have an opinion independent of what's written in the St. Elizabeth's records?

MR. BLOMSTROM: No, I think he said not as of today he didn't.

MR. RUF: That's what I'm asking.

Q Do you have an opinion independent of the St. Elizabeth's records as to what the diagnosis was?

MR. RICHARDSON: Objection.

Q Or should have been?
A What do you mean by independent? I'm sorry; I think I got lost there.
Q Well, I'd like to know if, as of today's date, you have an opinion as to what the diagnosis should have been for David Gonda?
MR. RICHARDSON: Objection.
MR. LANZ: Objection.
MR. BLOMSTROM: Objection.
A I, in the retrospective way, diagnosis should have been, as back again, I'm like trying to be, I'm going to tell this gentleman, okay, you die because you had cancer; you die because you have an infection, because you have something else. Should have been, it's one thing as should have been as was. It's just, it's like me trying to, yes, label somebody with a diagnosis. The way I want him to be is not an accurate diagnosis.

I mean, I think your question is still very vague really because you're trying to tell me, give this young man diagnosis, whatever you think should have been. I mean, is not should have been. He had a diagnosis. Unfortunately, no, it's the diagnosis, you know, we have there on the chart. He's a deceased person. But as far as should have been, is a different story. I think just -- I'm sorry; I cannot, should have, I cannot --

Q Well, if you have no opinions, say you have no opinion. If you have an opinion, I would like to know what your opinion is.

A I have no opinion based on this, your question. I don't know. I should say, based on his question, I have no opinion.

Q Do you believe it's more probable than not that, no matter what treatment David Gonda was given at St. Elizabeth's Hospital, that he was going to die?

MR. RICHARDSON: Objection.

A Based on the final diagnosis, post-mortem examination, unfortunately, yes.

Q So it's more probable than not that, by the time David Gonda was admitted to St. Elizabeth's Hospital, that he was going to die?

MR. LANZ: Objection.

MR. RICHARDSON: Objection.

A Based on the information that we have now, yes.

Q Do you have an opinion based on medical probability as to what point he could have received treatment and survived?

MR. LANZ: Objection.

A No.

Q You have no opinion on that?

A No.

Q Okay. I'm handing you what's been marked as Plaintiff's Exhibit 1. Could you please identify Plaintiff's Exhibit 1?

A Yeah, copies of my office records.

Q Is Plaintiff's Exhibit 1 a complete copy of your office records for David Gonda?

A Yes, that's all I have.

Q Yes?

A Yes.

Q And is Plaintiff's Exhibit 1 an accurate copy of your office chart?

A Correct.

Q Did you only see David Gonda at St. Elizabeth's Hospital?

A Correct.

Q There is a typed page in Plaintiff's Exhibit 1 with two initials and a date of 9/18/96. What is that typed copy?

A It's a transcription of the consultation that I wrote at St. Elizabeth's Hospital on Mr. Gonda on August 15th.

MR. RUF: Okay. Why don't we mark these.

(Whereupon the reporter marked for identification

Plaintiff's Exhibits 1-A and 1-B.)

Q So the record is clear, Plaintiff's Exhibit 1-A is the handwritten record from the hospital?

A Correct.

Q And Plaintiff's Exhibit 1-B is a transcription of that handwritten record?

A Thank you. Yes, correct.

Q And Plaintiff's Exhibit 1-A is handwritten by you?

A Correct.

Q Could you please identify Plaintiff's Exhibit 2?

A It's an affidavit.

Q That's a copy of a sworn statement under oath that you have made?

A Correct.

Q And in Plaintiff's Exhibit 2, you make the statement, "I thought that bacterial endocarditis with embolization should be ruled out"?

MR. BLOMSTROM: You're talking about where he is talking after the 2-D echocardiogram came back?

MR. RUF: Correct.

A Correct.

Q Wouldn't bacterial endocarditis explain the medical symptoms that David Gonda was having?

MR. LANZ: Objection.

A Not necessarily.

Q What else would explain the medical symptoms that he was having?

MR. LANZ: Just so I'm clear, you mean the symptoms at the time of his hospitalization?

MR. RUF: Correct.

A A pneumonia, primary pneumonia, tuberculosis, a far-advanced neoplastic process with metastasis to the lung.

Q I'm sorry; what was that?

MR. BLOMSTROM: A far-advanced metastatic process, neoplastic process.

A With metastasis to the lungs.

Q Anything else?

A No, I think I listed them already in the beginning.

Q With pneumonia, you would not have a mass in the heart; correct?

A We're talking about the thinking processes back August 15 or now, November 1997?

Q November 1997.

A If --

Q Oh, I'm not talking about David Gonda in particular. ith pneumonia, you do not have a mass in the

heart; correct?

A Depends on what the type of mass we're looking at. If I have -- are we talking about in general?

Q In general.

A Not Mr. Gonda?

Q Now I'm talking in general; not --

A We're talking about in general?

Q Correct.

A We're generalizing now; we're not specific about Mr. Gonda; correct?

Q Correct.

A One scenario, have a person that comes into the hospital with whatever condition, has an infection or comes from home with a pneumonia. Sits in the hospital for 24 hours. They will develop venothrombosis, embolize to the heart and sits in the heart. There I have a mass in the heart, have a clot in the heart.

Q Well, if David Gonda had only had --

A Excuse me. I'm sorry; we're talking -- excuse my interrupting, but you asked me in general.

Q Yes.

A Okay.

Q Pneumonia is a condition of the lungs; correct?

A Correct.

Q It's not a condition of the heart; correct?

A Correct.

Q And if somebody only has pneumonia, they're not going to have a mass in the heart; correct?

A They can have it. If a person is ill enough with a pneumonia to lay in bed for 24 hours, or six hours, that's enough; can develop the venothrombosis in the legs or in the pelvis. That clot can travel, in other words, embolize, and it's embolized from the veins to the right side of the heart. Sits in the heart, and we have a thrombus in there. So we have a mass in the right ventricle now.

Q So a mass in the right ventricle can cause pneumonia; correct?

A No, sir. Talking about the reverse situation. You asked me about a person with a pneumonia, can have a mass in the right heart? Yes, he can have it. And I explained to you, it's now I have a person with an infectious process, is very ill, ill enough to lay in bed for 24 hours or even for a few hours in bed. Venous stasis can lead to thrombus formation in the veins in the legs or pelvis. That clot can travel.

All it needs is to cough or go to the bathroom, move his bowels; increase the venous pressure, sucks up the

clot, goes to the heart and from there travels to the lungs. So I can have both; I can have a clot in the lungs and have a clot in the heart, too.

Q What about with tuberculosis, will a person have a mass in the heart?

A You're looking at a very far remote possibility, somebody develops an emboli, which is a condition that is, you know, which can affect the kidneys.

Q So that would be a very rare occurrence?

A Very rare occurrence.

Q What about with, I'm sorry, is it neoplastic metastatic disease?

A Yes.

Q What was the term you used?

A Neoplastic, no, far-advanced neoplastic process with metastasis to the lungs.

Q With that condition, would you have a mass in the heart?

A The same explanation like in pneumonia. If a person has a far-advanced neoplastic process, they have a predilection for thrombocytosis, in other words, aggravation from platelets and forming clots. And they form a clot in the legs, we have the same picture again, potentially.

Q Okay. I'd like to review the progress

note for 8/17/95 of 8:30 a.m.

MR. LANZ: Which note was that?

MR. RUF: 8/17/95, 8:30 a.m.

Q Do you know who signed that note?

A It appears to be Dr. DeMarco's handwriting.

Q Can you read the last three sentences?

A "2-D echo, questionable tricuspid vegetation. Clinically this could be put to," I think it's "could be put together if he did, in fact, have a right-sided endocarditis."

Q Do you remember having any discussions with Dr. DeMarco about this statement?

A No.

Q Did you ever have a discussion with Dr. DeMarco that clinically the whole picture could be put together if David Gonda did, in fact, have right-sided endocarditis?

A No, I did not.

Q Did you have that discussion with either Dr. Cropp or Dr. Ruiz?

A No. And I would like to make a comment. You're talking about August 17; correct?

Q Yes. No, at any time.

A No, you asked me the question which

started with the premise of these three sentences here.
Q Right.
A And you followed the question after question after question based on this here.
Q Yes.
A It was a continuation of questions.
Q At any time did you --
A Okay. You --
Q Did you have a discussion with Dr. Cropp, Dr. DeMarco or Dr. Ruiz that clinically David Gonda's picture could be put together if he did, in fact, have right-sided endocarditis?
A No, I did not. Other than the statement that was made previously about rule out endocarditis.
Q What discussions do you remember having with the Gonda family?
A Initially, in the initial interview about going over, interviewing him about symptoms, history, doing a physical on him. And then discussing with him about the potential diagnoses and the reason why I was called in. And discussed with him about the means in which I was -- they were planning on doing the biopsy of the lungs and the intention. We had initial plans to do it through thoracoscopic biopsy of the lung. And he was also informed that -- and the family was also present -- informed that we

were, that sometimes we do have to resort to an open biopsy if the thoracoscopic procedure did not allow us to obtain an adequate amount of tissue, or, in the event of bleeding, the chest would require to be opened.

Q What --

A I also told him that the reason that we, that obtaining the tissue diagnosis will -- I mean, the tissue of the lung will allow us to obtain some cultures and do some histopathologic studies that might aid us with his diagnosis and also on the steps to be taken in his treatment.

Q What did you tell him that the potential diagnoses were?

A Were mentioned, I mentioned in the chart again. I had mentioned them before.

Q Did you have any additional conversations with the family?

A We discussed about, you know, potential bleedings, complications of the surgery, the potential need for blood transfusions. They requested that they wanted to donate blood, and we took the necessary steps to arrange for the family to donate blood for him.

Q So that was a second conversation that you had?

A I do not remember. I remember this as a

whole, the conversations that I had with them.
Q Do you remember how many conversations you had with them?
A At least two.
Q In the nurse's note of 8/16/95 at 9:40, it states, "Dr. Franco has spoken with patient's family. Patient coughing and vomiting up bright red blood."
A I'm sorry; what date was that?
Q August 16th of '95. Here, I can give you the note if you'd like.
A Uh-huh.
Q Do you remember what conversation you had with the family at that time?
A Is that 15th or 16th? I believe this is 15th.
Q Maybe I misread it. It's hard to read at the top.
MR. BLOMSTROM: That looks like a 15 to me.
A 15, because you have the first page is, "Admitted to 4411," so that's the date he was admitted, on August 15th.
Q Okay. Is that the initial discussion that you had with the family?
A Correct. That's the initial interview I

had with them.

Q Do you remember any conversations with Dr. DeMarco that we have not discussed?

A No, I don't.

Q Do you remember any conversations with Dr. Cropp that we have not discussed?

A No.

Q Do you remember any conversations with Dr. Ruiz that we have not discussed?

A No.

MR. LANZ: Objection.

Q Just let me look over my notes, and I think I'm finished.

If you were going to conduct any research on bacterial endocarditis, what literature source would you consult?

A Can you be more specific about research? What do you mean by research?

Q Well, do you ever do medical research in treating patients? Do you ever consult medical literature or medical textbooks?

A Are you talking about if I am going to review some information but not research as to research, because talk about research can be taken in a broad concept, as investigative type of things; or I'm just going to investigate something in general?

Q Yes, if you wanted to look up information on bacterial endocarditis --

A Uh-huh.

Q -- what would you look to?

A I would just try to look at any informa ion hat is available in medical journals, in textbooks.

Q Is there a cardiology textbook that you would consult?

A There are so many, really, that is difficult to say really.

Q Is there one that you regularly use in your practice?

A There are more than one really. Just pick up textbook, you know, read your notes, try to comprehend information.

Q Do you use any medical textbooks regularly in your practice?

A There are a couple textbooks that we read as a general information.

Q What textbooks do you regularly use on the issues of cardiology?

A I'm not a cardiologist.

Q Do you receive any periodicals at your office?

A Yes.
Q What periodicals do you receive?
A General Thoracic and Cardiovascular Surgery and the General Cardiac Surgery. And there is a -- what is -- I forgot the name. Sorry. Drew a blank. It's a red textbook. I can see it. It's a periodical, too.
Q Do you regularly review those periodicals?
A Yes, I review whatever information is pertinent, that I find that is of interest; I read it.
Q And do you rely on those periodicals in your practice?
A Not -- not necessarily.
Q But you read the articles to keep updated?
A Yes.
MR. RUF: Okay. Thank you. That's all I have.
MR. BLOMSTROM: Mr. Richardson?
CROSS EXAMINATION:
By Mr. Richardson
Q Dr. Franco, I represent Dr. DeMarco and Dr. Cropp. Do you have any criticisms of Dr. Cropp in his involvement in this particular matter?
A No. And as a matter of fact, I don't --

I believe the person I spoke with most of the, just about every, all the time was Dr. DeMarco rather than Dr. Cropp.

Q And do you have any specific criticisms of Dr. DeMarco with his involvement in this particular matter?

A Not during this gentleman's hospitalization.

MR. RICHARDSON: Okay. I have no further questions.

MR. LANZ: I have no questions.

MR. BLOMSTROM: Okay. Thank you. He'll read.

SIGNATURE NOT WAIVED

REPORTER'S CERTIFICATE

I HEREBY CERTIFY that the above and foregoing is a true and correct transcript of all the testimony introduced and proceedings had in the taking of the testimony in the above-entitled matter as shown by my stenotype notes taken by me at the time said testimony was taken.

Mary J. Carney
Registered Merit Reporter

STATE OF OHIO)
) SS: CERTIFICATE
MAHONING COUNTY)

I, ALEJANDRO FRANCO, M.D., depose and say that I have read the foregoing deposition and find it true and correct, unless otherwise specifically excepted to and indicated on Page 69-A, and any following numbered pages thereafter, if applicable, and I subscribe my signature to the aforesaid deposition this _____ Day of _____, 19__.

_____
ALEJANDRO FRANCO, M.D.

Before me, a Notary Public within and for the State of Ohio, personally appeared ALEJANDRO FRANCO, M.D., who, being first duly sworn, deposes and says that he has read the foregoing deposition and finds it true and correct to the best of his knowledge, information and belief, unless otherwise specifically excepted to and indicated on Page 69-A, and any following numbered pages thereafter, if applicable.

SWORN AND SUBSCRIBED before me this _____ Day of _____, 19__.

_____
Notary Public, State of Ohio
My Commission Expires _____

(MC)