CONDENSED TRANSCRIPT

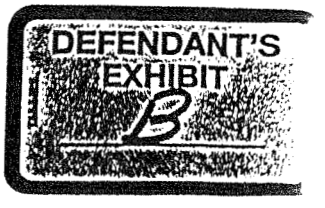
DEPOSITION

OF

DR. SHARON HOOK

12/09/98

Linda **York,** RPR
Scribe **Associates**
352-377-6852



M THE COURT OP COMMON PLEAS
MAHONMG COUNTY, OHIO

CASE NO: 96 CV 2055
COURTROOM NO. 4

DOROTHY CONDA, ETC.,

Plaintiffs,

vs.

JUAN RUIZ, ET AL,

Defendants.

DEPOSITION

OF

DR. SHARON HOOK
taken on behalf of the Defendants

DATE: Wednesday, December 9th, 1998

TIME: 2:00 p.m.

PLACE: Veterans Hospital
Lake City, Florida

REPORTER: Linda York, RPR
Notary Public, State of
Florida at Large

APPEARANCES:

MARK W. RUF, ESQUIRE (via telephone)
Hoyt Block Suite 300
7M) W. St. Clair Avenue
Cleveland, OH 44113-1230

MARK FRASURE, ESQUIRE (via telephone)
3721 Whipple Avenue NW
Port Office Box 35548
Canton, OH 44735

R. MARK JONES, ESQUIRE
1400 Bank One Center
Cleveland, OH 44114-2652

THOMAS J. TRAVERS, JR., ESQUIRE
Manchester, Bennett, Powers & Ullman
Atrium Level Two
The Commerce Building
201 East Commerce Street
Youngstown, OH 44503-1641

JAMES L. BLOMSTROM. ESQUIRE
1200 Mahoning Bank Building
Youngstown. OH 44503

INDEX

Errata sheet attached

REPORTERS KEY TO PUNCTUATION:

- At end of question or answer references interruption.

, , , References a trail-off by the speaker. No testimony omitted.

"Uh-huh" References an affirmative sound.

"Huh-uh" References a negative sound.

Thereupon, DR. SHARON HOOK, having been first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. TRAVERS:

Q. Good afternoon, Dr. Hook. My name is Tom Travers. I'm a lawyer from Youngstown, Ohio representing Dr. Juan Ruiz. He is one of several defendants in a lawsuit that's pending in Youngstown. We lawyers have gathered today either in penon or by telephone here in Lake City, Florida, which is as I understand it where you practice, for purposes of asking you some questions in regard to your involvement in the autopsy that was performed by David Gonda. That's your understanding of the reason we're all here, correct?

MR, BLOMSTROM: On David Gonda, not by David Gonda.

MR. TRAVERS: Sorry.

Q. Would you please tell me your full name?

A. Sharon Hook.

Q. And, Dr. Hook, where do you reside presently7

A. Gainesville, Florida.

Q. What is your profession?

A. Im a pathologist.

Page 5

Q. You're a medical doctor?
A. I'm an osteopath. but that's equivalent to a medical doctor.
Q. Do you have a license to practice medicine?
A. Yes.
Q. And where is that license?
A. State of Florida.
Q. Are you still licensed in Ohio as well?
A. No.
Q. That's lapsed after you moved?
A. Yes.
Q. Can you give us a thumbnail sketch please, Dr. Hook, concerning your medical education and training?
A. I went to medical school at Nova Southeastern University in Miami, Beach. Then I did an internship in Largo, Florida, general rotating internship. I did pathology residency for four years at the Cleveland Clinic in Ohio. Followed by one year of clinical associate, which is like equivalent to a staff member, at the Cleveland Clinic. I went back and did a year fellowship in cytopathology at Montiefiore Medical Center in the Bronx. Then staff last year at the University of

Page 6

Miami as an anatomic pathologist and a cytopathologist. Now I'm here at the Lake City VA where I'm the chief of pathology of this division.
Q. Do you have any board certifications in pathology?
A. Im board certified in anatomic pathology, clinical pathology, and cytopathology.
Q. And you're the chief of the pathology department here?
A. Of this division. So at the Lake City division of the VA.
Q. What were you doing in August of 1995 if you remember?
A. I war a clinical associate at the Cleveland Clinic. which is a staff member.
Q. So you had already completed your four years of pathology residency by that time?
A. Yes. And a year of internship which completes the entire pathology residency.
Q. David Gonda was a young man who died as a patient at the Cleveland Clinic on August 18th of 1995 and the records suggest that an autopsy was performed upon him following his death at that facility. Do you have any personal recollection of that case?

Page 7

A. Yes. I do remember the case.
Q. Is there anything that stands out about the case that prompts you to be able to have a personal recollection?
A. Yes, it was an unusual, rare case.
Q. You had some participation in this autopsy?
A. Yes.
Q. Would you tell me when autopsies are performed at the Cleveland Clinic Foundation is it just a single physician who's involved or is it more of a team approach?
A. It's a team approach.
Q. Do you recall the identities of other individuals from the clinic who participated in performing the autopsy and reaching the anatomical diagnosis7
A. Yes.
Q. Could you identify those for me, please?
A. Nancy Wang, who was a first year resident, Joseph Sreenan, who was a fifth year resident, myself, and I consulted with Dr. Norman Ratliff.
Q. I'm sorry. Dr -
A. Norman Ratliff.

Page 8

Q. The other individuals that you have identified are named on the autopsy report but, at least my recollection is, I don't see Dr. Ratliff's name. Who is he?
A. He is the cardiac pathologist and actually the pathologist in charge of autopsies, at least that was his position at the time I was there.
Q. And your recollection is that he had some involvement in this autopsy as well?
A. I consulted him.
Q. If you can do so, Dr. Hook, either by particular recollection of the case or by what you would believe following standard protocol would have happened. can you tell me the involvement of the various individuals that we've identified?
A. Nancy Wang as the first year resident would have performed the actual autopsy from the time of evisceration and had done the dissection. She was to be supervised by the senior resident at that time which was Joseph Sreenan. He would have reviewed the entire case with her, all of the gross organs. They in turn would present the cam to me as the staff pathologist and I would review the pertinent organs, the organ:, that were involved by disease would be closely looked at and then the

Page 9

others sort of gone over in a cursory fashion.

The first year resident and the senior resident would form the. they write the description, submit the sections, and they form the preliminary anatomic diagnosis. And then when the slides, the glass slides arc received they also form sort of a preliminary final diagnosis, which is sort of fine tuned by the staff pathologist.

Q. Staff pathologist being you?

A. Me, yeah.

Q. As far as the report itself then would it be correct that that's probably not your actual dictation but rather one of the residents?

A. It's not my dictation.

Q. Do you know who dictated the report?

A. Nancy Wang.

Q. Before it reaches its final form does it require your approval?

A. Yes.

Q. Is the autopsy report that you have reviewed something then that you actually approved before it was determined as the final report?

A. Yes.

Q. And if you could, Dr. Hook, tell me then I guess Im not clear how Dr. Ratliff's involvement

Page 10

was secured and what involvement he would have had in this case.

A. This is an extremely unusual finding within the heart in this patient. Dr. Ratliff has extensive experience in cardiac pathology and since I was unfamiliar with this entity I consulted him and showed him the glass slides. We discussed what the entity was. He was quite familiar with it, even had some references available.

Q. After your consultation with Dr. Ratliff and upon your review of the procedures performed by the residents did the clinic then reach a final anatomical diagnosis in the case?

A. Yes.

MR. RUF Objection as to any discussion with Dr. Ratliff.

Q. What was the final anatomical diagnosis in this care, Doctor?

A. Endomyocardial fibrosis of the right ventricle.

Q. Is that a disease process that you have familiarity with?

A. No.

Q. Had you seen a case of this nature prior to Mr. Gonda?

Page 11

A. No.

Q. Have you seen one since?

A. No.

Q. Do you know whether Dr. Radiff has seen cases of this nature previously?

A. Yes.

MR. RUF Objection.

MR. TRAVERS: Mark, I've never spoken with Dr. Hook before my arrival hem thu afternoon in Lake City. I have indicated that this is a discovery deposition and it's really entirely unclear to me why you're objecting if I'm asking her questions that will identify discoverable information in the case.

MR. RUF Well, I'm going to object on the record just in case this deposition is read in at trial. I want to make sure all my objections are preserved in the deposition, especially since this is being taken out of state with a doctor that's in Florida and she may not be able to attend the trial.

MR. TRAVERS: Okay.

MR. BLOMSTROM: This is Jim Blomstrom speaking. I'm unclear even if this is read at trial what tho basis of your objection would

Page 12

be. Would you mind expressing that?

MR. RUF: What was the question again? Oh, I think the question was is Dr. Ratliff familiar with this entity.

MR. TRAVERS: Correct, words to that effect.

MR. RUF: That goes to Dr. Ratliff's knowledge, not hers. And if she's aware of that fact it's hearsay because it's discussions between Dr. Ratliff and Dr. Hook.

MR. BLOMSTROM: Okay. Fair enough.

MR. RUF: Go ahead. You want to answer the question?

MR. TRAVERS: I think she did, Mark.

MR. FRASURE: I didn't hear the answer. This is Mark Frasure.

MR. TRAVERS: Let me ask again.

Q. Dr. Hook, do you know whether or not Dr. Ratliff had previously seen cases of endomyocardial fibrosis?

MR. RUF Objection.

A. Yes.

Q. He had expressed to you that he had seen cases like this before?

A. Yes.

Page 13

MR. RUP: Objection.

Q. Since the time that the report was finalized I assume that you have not had occasion to review this case for quite some time until again just recently?

A. No.

Q. At my request through counsel for the Cleveland Clinic have you again looked at the microscopic slides from the autopsy?

A. Yes.

Q. And have you reviewed the dictation of the gross findings?

A. Yes.

Q. Do you hold an opinion today, Dr. Hook. concerning the final anatomical diagnosis in this case?

MR. RUF Objection.

Q. You may answer.

A. Yes.

Q. And is it any different than the diagnosis that was identified at the time that the report was completed?

A. No.

Q. Can you tell me, Doctor, how confident you are in that opinion?

Pago 14

A. Extremely.

Q. Tell me why, if you would.

A. Having read the literature on this entity and reviewing that literature, this case is quite consistent with :he diagnosis as rendered on :he final anatomic diagnosis.

Q. We were yesterday in Cleveland taking discovery deposition of a witness identified by counsel for the Gonda family, his name is Dr. Hoffman from University Hospital. And he expressed some opinions contrary to the conclusion reached at the clinic. It's his suggestion that the final diagnosis should have included right sided endocarditis. Do you hold an opinion based on reasonable medical certainty as to whether endocarditis would be a correct pathological diagnosis in this case?

A. Yes,

Q. What would that opinion be?

A. This is not a case of endocarditis.

Q. Explain your reasoning for that statement, if you would

A. The cardiac valves are not sampled and were not involved By definition endocarditis is a disease or inflammation of the cardiac valves.

Page 15

Q. Dr. Hoffman suggested that his review of the microscopic findings prompted him to conclude that there was a rampant ongoing infectious process that Mr. Gonda was suffering from at the time of his death. Do you hold any opinions on whether or not that would be true?

A. Yes.

Q. And what would your opinions today be based upon?

MR. RUF: Objection.

A. That's not true.

Q. Explain why, if you would.

A. Histologically there's evidence of a thrombus that is present over an area of fibrosis in the heart, often confused by some pathologists as being inflammation. It's actually just a clot. We did perform some stains to see if there wem any detectable microorganisms in thb area and there were not. It really appears like a classic thrombus.

MR. RUF Objection. Move to strike,

Q. Do you - is it important for the pathologist, Dr. Hook, to be able to examine the gross specimen in order to determine whether or not this was a thrombus or by-product of an infectious

Page 16

process?

A. It can support either diagnosis when one reviews the gross.

Q. Was a review of the gross finding in this case instrumental in ruling out an ongoing infectious process?

A. It was helpful.

Q. Didn't look like an infection, it looked like thrombus?

A. Yes.

Q. Would a person who did not have the opportunity to review the gross specimens be at a disadvantage in attempting to determine whether that specimen was a thmmbus or evidence of an ongoing infectious process?

A. Possibly,

Q. I have juri a couple questions about the report itself. First of all, have you had an opportunity to look at the postmortem microbiology data from the Cleveland Clink?

A, Yes.

Q. Am those microbiology findings of any significance in your professional conclusions in this case?

A. No.

Page 17

Q. Explain why not, if you would.
A. It's a polymicrobial isolate which means that more than one bacteria or organism was isolated. It's documented in many publications that in autopsy material this finding just represents a postmortem flourishing of the bacteria.
Q. The pathogens identified in the microbiology report then you don't feel have any connection to the patient's disease process?
A. No.
Q. Do you know why - I believe I'm correct in representing that these specimens were secured from the lung tissue, I can't find any record that there was microbiology study done of heart tissue. Do you know whether or not that's true or - let me start with that question.
A. Can you repeat the question?
Q. Do you know whether or not there was any microbiology study of heart tissue in the care?
A. Per the document that I've just seen there was not.
Q. Can you tell me why, if you know.
A. These cultures preliminarily are left up to the first year resident who often will sample tissue just to be sure not to miss anything. Once

Page 18

the senior resident looks at the tissue it is better determined whether it's infectious or not and more tissue could be taken at that time. It's evident from this that the first year most likely took a piece of lung and then no further cultures were taken.
Q. Would the lack of cultures be suggestive of an opinion from the senior resident or the attending pathologist that there was no suggestion of an ongoing infectious process that needed to be sampled?
A. Yes.
MR. RUF: Objection.
Q. I note on the report, Dr. Hook, that there is no dictation concerning the microscopic findings. Is that unusual at the facility that you were working at at that nme?
A. No.
Q. What was the standard protocol as far as microscopic dictation?
A. They're not done.
Q. So the lack of microscopic dictation is not any different in this case than any other ease done at the clinic at that time?
A. No.

Page 19

Q. There were a couple photographs taken of the patient's heart. Do you know why that was done?
A. It was an interesting case.
Q. Can you determine, Dr. Hook, from your review of the fibrotic lesion of the patient's heart how long that lesion may have been present there?
A. No.
Q. You have looked at all of these slides again today. as I understand it. with Mr. Jones?
A. Yes,
Q, And have reviewed the report?
A. Yes.
Q. The original autopsy report?
A. Yes.
Q, And then remains no question in your mind that the correct anatomical diagnosis in this case was endomyocardial fibrosis?
MR. RUF Objection.
A. Yes.
MR. TRAVERS: Those are all the questions I have, Doctor. Thanks very much.

CROSS EXAMINATION

BY MR. BLOMSTROM:

Q. Hi. I'm Jim Blomstrom, I represent Dr. Hafiz. I only have a few questions. With

Page 20

respect to the opinions that you expressed in response to Mr. Traven' questions, were all of those opinions expressed to a reasonable degree of medical certainty?
A. Yes,
Q. You indicated that you didn't think that the culture results were significant, correct?
A. Yes.
Q. Can you explain why that is, so that it's a little more apparent to me?
A. Sun. Most people that do autopsies feel that the postmortem cultures are fairly unreliable and that's due in part to the fact that once a person is deceased the commensal organisms that are within the gut begin to inhabit the entire body so that when things are, things, organisms arc cultured they're often organism chat are normal to that individual in some extent. So it's really contamination u how we look at it.
The oniy way to reliably validate that the findings in postmortem cultures are true is to have a premortem blood culture and if that organism is the same as tho organism identified on the postmortem culture then you can say that was the cause of the disease or the pneumonia, whatever

Page 21

you're trying to Identify.

Q. Will you explain for us what is meant by the term contaminant?

MR. RUF: Excuse me? What did you say, Jim?

MR. BLOMSTROM: I've asked her to explain what is meant by the term contaminant.

A. Extraneous bacteria. One not responsible for the disease process.

Q. On the autopsy report itself, if you could locate that.

A. Sure.

Q. We have here listed on microscopic segments right ventricular mass, the same words from number 11 through number 14, correct?

A. Uh-huh.

MR. JONES: You need to answer out loud.

A. Yes.

Q. What is that right ventricular mass, having reviewed the slides from 11 through 14 and then I'll ask you about the number 15 after that.

A. The right ventricular mass is a thrombus.

Q. Now, there is a number 15 right ventricular mass along the right ventricular free wall. Can you tell me what that is?

Page 22

A. A thrombus.

Q. And 16, clot covering the right ventricular mass, what is that?

A. That's actually a newer area of blood clot, the right ventricular mass, the thrombus is more organized and the clot is actually a more viable, fresher area.

Q. Now, you indicated that some pathologists who may look at this right ventricular mass may misidentify it as an inflammatory area; is that correct?

A. Yes.

Q. With respect to the right ventricular mass that is a thrombus, can you tell me how long the thrombus had been present?

A. No.

Q. From a pathological point of view that cannot be determined?

A. Yes.

Q. Is there anything that usually occurs with a thrombus inside a heart as far as consolidation or anything like that?

A. Thrombi anywhere undergo a form of organization with sort of a vascular network that forms within them. That's what's called

Page 23

organization. That would happen in any organ where there was a thrombus.

Q. Is that present here?

A. Yes.

Q. To what extent? Or doesn't the question make any sense?

A. I'm not sure how to answer that.

Q. It's either there or not?

A. Exactly.

Q. It's a binary system?

A. Yes.

MR. BLOMSTROM: Thank you very much.

MR. FRASURE: Doctor, my name's Nark Frasure on behalf of Dr. Cropp.

CROSS EXAMINATION

BY MR. FRASURE:

Q. Did Dr - Is it Ratliff?

A. Yes.

Q. He looked at the slides, am I correct?

A. Yes.

Q. Did he look at the body?

A. No.

Q. Now, you looked at, am I correct both the slides and the body?

A. Not the external portion of the body just

Page 24

the internal organs.

Q. The internal organs?

A. Yes.

Q. Did you look at the portion of the internal pan of the body that is described in the gross description?

A. Yu.

Q. Lung?

A. Yes.

Q. Okay. There's mention made in the report, Doctor. if you would turn to Page 4 of the autopsy.

A. Okay.

Q. There's mention made about half way down starting out with the word right ventricle there is a soft -

A. Im looking hold on. Okay.

Q. It goes on to say it describes as a soft pliable white colored mass which extends from the apex to the ventricle. Can you see that on any of the slides?

A. You can ye the attachment of the clot to the wall, but there's on a slide it's impossible to show that length of tissue, you know what I'm saying. There's not enough space on a slide to show

Page 25

that.
Q. Was the apex of the ventricle actually involved with this material?
A. Yes.
Q. As of the time you were invoked in this autopsy back three years ago had you ever seen an autopsy involving infective endocarditis?
A. Yes.
Q. So were you familiar then with the vegetation that is normally seen in infective endocarditis?
A. Yes.
Q. Did you see any vegetation, the type of vegetation chat you see in endocarditis did you see any such vegetation of any type here in this patient?
A. No.
Q. How is one able to distinguish on gross examination as a pathologist whether what your seeing is vegetation or thrombus as you described?
A. The vegetation involves the valve and is usually attached as a small nodule to the valve, it grossly looks very similar to a thrombus, however, in this case the thrombus was originating from the myocardial wall which is distinctly different in

Page 26

appearance than what endocarditis appears.
Q. Thrombus is distinctly different in appearance from vegetation?
A. Vegetation can appear - a vegetation is a small red nodule which looks very much in consistency like a thrombus. however. this was a large mass that extended from the wall of the ventricle so it wasn't involving the valve. Does that make sense?
Q. Not involving any valves, correct?
A. True.
Q. Did you believe that the slides that were obtained were adequate to show the pathology?
A. Yes.
Q. Do you know, Dr. Hook, if any article was written on this case? Sometimes they are at the Cleveland Clinic I know.
A. Yes.
Q. There was?
A. Yes.
Q. Do you know where we could find it?
A. No.
Q. Do you know who wrote it?
A. Yes.
Q. Who was that?

Page 27

A. Dr. Ratliff.
Q. He did?
A. I don't know that he exactly was the first author on that, but I know he's involved in one.
Q. Do you know if it was published in a Cleveland Clinic journal?
A. I'm sorry, but I don't.
Q. Do you believe he was one of the authors?
A. Yes.
Q. Have you ever seen the article?
A. Yes.
Q. Can you tell us generally what it says, if you remember?
A. It's been over three years so I'm sorry, no.
Q. And I'm correct there were no cultures taken from the heart beyond the preliminary cultures?
A. Yes.
MR. FRASURE: All right. That's all I have. Thank you.

CROSS EXAMINATION

BY MR. RUP:

MR. RUP: Doctor, my name is Mark Ruf. I

Page 28

am representing the Plaintiff Gonda family in this case. I have soma questions for you as well.
Q. Doctor, prior to giving this deposition you met with Attorney Travers and Attorney Blomstrom; is that correct?
A. No.
Q. You did not spend any time with them before this deposition?
A. No.
MR. TRAVERS: You mean other than the time, Mark, that we waited for you to be ready for the deposition because you indicated you thought it was at 3:00 rather than at 2:00?
MR. RUF Yes. Sorry about that.
MR. TRAVERS: That's okay. I mean we were sitting here with the doctor waiting to reach you if that's your question, but that was the first we've met with her, or I have at least.
Q. Doctor, can you tell me what the protocol is for keeping organs or tissue samples at the Cleveland Clinic?
A. Actual tissue samples like fresh tissue?
Q. Yes.

Page 29

A. At the time of autopsy the whole organs am saved until the case u signed out; they're refrigerated. Once the preliminary anatomic diagnosis is made those are discarded. But a small piece of each organ is kept, and anything that's very interesting, sometimes the whole organ is kept. But a small piece is kept. And by - I'm not sure if it's the CAP, the College of American Pathologists. requires that those are kept I believe for three months, but I could actually be wrong. So those are kept at least until the case is signed out. The paraffin that the tissue is embedded to make the slides they're actually samples of tissue that are now sort of held forever in paraffin needs to be kept for a five-year period, however, I think they're kept a lot longer.

Q. Do you know if any organs or tissue samples were kept from David Gonda?

A. I do not know other than the paraffin embedded blocks.

Q. Is there any condition in David Gonda's heart that was not shown in the photographs that were taken of the heart?

A. I have *not* reviewed those photographs so I don't know,

Page 30

Q. At the time you performed this autopsy did you perform any research?

A. I don't know.

Q. Did you consult any medical textbooks in order to render the diagnosis that you did in the autopsy?

A. Can you ask that again, please?

Q. Yes. Did you consult any medical textbooks to assist you in rendering the diagnosis that's found in the autopsy report?

A. Dr. Ratliff knew of the diagnosis and I confirmed that diagnosis by looking in some textbooks, however, I did not search textbooks looking for this diagnosis.

Q. What textbooks did you look in to confirm the diagnosis?

A. They were textbooks that belonged to Dr. Ratiiff and I do not what their names are. I'm terribly sorry.

Q. Are there any standard pathology textbooks that you find to be accurate and reliable?

A. There are textbooks that I find to be accurate and reliable however cardiopathology is a very specialized area and has textbooks all to itself. And there are quite a few, the number is

'age 31

extensive and the only ones that I've looked at are the ones that Dr. Ratliff has.

Q. What standard pathology textbooks do you find to be accurate and reliable?

MR. BLOMSTROM: Objection because your question is unclear as to whether you're talking about cardiopathology or pathology in general.

MR. RUF Pathology textbooks in general.

A. Stemberg's and Ackerman's. It's Ackerman's Surgical Pathology and Stemberg's Diagnostic Surgical Pathology.

Q. What is the title of the first book?

A. Ackerman. Ackerman is like the writer, I guess he's not - Juan Rosai is the writer. Ackerman's Surgical Pathology. Those am two sort of general surgical pathology books.

Q. How many autopsies had you performed at the time you were involved in David Gonda's autopsy?

A. SO.

Q. Arid at the time I believa you said you were an intern?

A. No, I was a clinical associate, which is sort of a junior staff member; that's the title they give junior staff.

Page 32

Q. Were you still in training to become a pathologist?

A. No, I had completed my training.

Q. How long had it been since you had completed your training?

A. What month was the autopsy done?

MR. JONES: August of '95.

A. One month.

Q. So all of the doctors involved in actually performing the autopsy were either doctors in training or yourself that had just completed the training one month prior to performing this autopsy. correct?

A. True.

Q. Would you agree that the pathologist involved in performing this autopsy or the doctors involved in performing this autopsy were less qualified than a pathologist who has been performing autopsies for more than 20 yean?

A. No.

Q. why do you say no?

A. Because the training at the Cleveland Clinic is quite extensive. I've been exposed to some pathologists recently who've been trained for 20 years and I don't think they know anymore than I

Pago 33

do.

Q. Are you familiar with Dr. Hoffman at University Hospital7

A. No.

Q. Do you agree that the only physicians that are listed on the autopsy report arc Dr. Sreenan, yourself, and Dr. Wang?

A. Yes.

Q. Do you agree that Dr. Ratliff's name does not appear anywhere on the autopsy report?

A. That's true.

Q. Im sorry. Did you give an answer?

A. Yes.

Q. As a thorough physician did you write down all significant findings on the autopsy report?

A. Im not sure what you're asking.

Q. Were all the significant findings determined at autopsy listed in the autopsy report?

A. Yes.

Q. And you agree that the autopsy report does not list any findings on the autopsy slides?

A. I don't understand that either. I'm sorry.

Q. Do you agree that there are no findings listed based upon the review of autopsy slides?

Pago 34

A. No, I don't agree with that.

Q. What microscopic findings aro luted as a rwult of reviewing the slides?

A. The final anatomic diagnosis.

Q. Would you agree that lor each of the 20 microscopic sections listed there are no specific findings listed in the autopsy report?

A. Im sorry. I don't understand. Say it again.

Q. Do you agree that for the 20 microscopic sections listed in the autopsy report there is no specific finding written for each of those sections in the autopsy report?

A. I still don't understand. Can you phrase it another way? I don't really know what you're saying.

Q. Will you agree that there's not a microscopic section in the autopsy report, correct?

A. There's not a microscopic description for each slide in the report.

Q. Okay. Thank you, Doctor.

MR. TRAVERS: Does that mean you're done, Mark, or you liked her answer?

MR. RUF: No, Im not finished yet.

MR. TRAVERS: Oh, okay.

Page 35

Q. Can you comment on whether slide numbers 11 through 15 show an inflammatory process?

A. Do you want me to look at them or just say what I've reviewed?

Q. Id just like to know if you can comment on whether slide numbers 11 through 15 show an inflammatory process?

A. From previous review, no.

Q. Do you agree that there is no microbiological testing listed in the autopsy report?

A. Yes.

Q. And do you agree that there is no discussion in the autopsy report of performing any cultures?

A. Yes.

Q. Do you agree that you cannot make a determination of whether an organ has microorganisms without performing a culture?

A. Say it again. I'm sorry.

Q. Do you agree that you cannot determine an autopsy whether an organ has microorganisms without performing a culture?

A. That's a doublo negative. Do I agree that you cannot determine you can determino without

Page 36

doing it.

Q. Let me re-ask it. Do you agree thar a culture is necessary to determine whether or not an organ contains microorganisms?

A. No.

Q. How can you determine what microorganisms there are in an organ without a culture?

A. You can't identify the specific microorganism, however, the presence of microorganisms can be determined through the use of special fungal or bacterial or microbacterial stains.

Q. So if you want to determine whether a specific microorganism is involved the only way to do that is with a culture?

A. Yes.

Q. And you agree that there were no cultures done of David Gonda's blood?

A. At the time of autopsy?

Q. Yes.

A. Yes.

Q. And you agree that at tho time of autopsy no cultures wem done of the mass that was found in David Gonda's heart?

A. Yes.

Page 37

Q. Do you know if any of the slides were stained?
A. Stained how?
Q. Were stained to determine whether there were microorganisms involved?
A. Yes.
Q. Which slides were stained?
A. Slide number 13.
Q. What was the type of stain that was used?
A. A Twort's and GMS.
Q. Based on that stain are any microorganisms seen in slide number 13?
A. No.
Q. Were any of the other slides stained?
A. From microorganisms?
Q. Yes.
A. No.
Q. Would you agree that you cannot determine the type of infection in a dead penon without performing cultures?
A. It's kind of an ambiguous question. I can't answer that.
Q. To determine the type of infection that a patient had at autopsy what would you do to make that determination?

Page 38

A. I would take a section and bok at it under the microscope.
Q. So the only way to determine the specific type of bacteria involved would be to perform a culture?
A. A premortem culture, cultures that are done before the time of death. Cultures are highly unreliable that are performed at autopsy.
Q. Did you take reasonable precautions to avoid contamination of the microscopic slides and tissue blocks that were prepared at the clinic?
A. You have to better define that question. An autopsy is not a sterile procedure. The site is inherently contaminated.
Q. Did you follow protocols at the clinic to try and avoid contamination of the slides and tissue blocks that were prepared?
A. As I said, an autopsy is not a sterile procedure. The body is already contaminated prior to even opening it up, it's just the fact that the penon is dead there's contamination.
Q. You were ruling out endocarditis as the diagnosis here because there was no valve involvement; is that correct?
A. Yes.

Page 39

Q. Based upon your opinion somebody does not have endocarditis unless they have valve involvement; is that correct?
A. It is possible in rare instances to have forms of endocarditis where there is no valve involvement. however, in this case there was no acute inflammation only granulation tissue present consistent with that of a thrombus.
Q. So you do agree that a penon can have endocarditis in which there's a vegetation on the wall of the heart?
A. No.
Q. Are you familiar with the term mural endocarditis?
A. Yes.
Q. What does that mean?
A. That's where the valve is involved and spreads to involve the heart so there's involvement of the heart concomitantly with that of the valve.
Q. Are you aware of whether or not endocarditis can be present without valve involvement?
A. I'm not aware of that,
Q. Do you agree that endomyocardial fibrosis is found almost exclusively in Africa or tropical

Page 40

countries?
A. No.
Q. On what do you base that opinion?
A. A search of the literature.
Q. Do you know if more than a dozen cases of endomyocardial fibrosis have been found in the United States?
A. Not in the United States.
Q. So there's less than a dozen cases of endomyocardial fibrosis reported in the literature?
A. That I discovered.
Q. And over what time period does that cover, Doctor?
A. I don't know.
Q. Well, how far back did you go in your research?
A. It's a Med Line search so I don't really know how far the Med Line goes back, The paper with the oldest date is 1989.
Q. Do you know whether or not David Gonda traveled to Africa or a tropical country?
A. No.
Q. If he did not travel to Africa or a tropical country would you agree that it makes the diagnosis of endomyocardial fibrosis less likely'?

Page 41

A. No.
Q. Do you agree that fibrosis is a scarring of the heart?
A. Yes.
Q. Do you agree that with endomyocardial fibrosis there essentially is a filling in process involving the scarring of the heart?
A. That doesn't make any sense, I'm sorry.
Q. Are you aware of whether or not when a patient has endomyocardial fibrosis that generally there is a filling in of the ventricles starting with the apex?
A. That doesn't make any sense at all. I don't know what you're saying, like does the whole heart get full? The ventricle gets full. is that what you're saying? I don't know what you're saying, I'm sorry.
Q. With endomyocardial fibrosis you have scar tissue forming in the heart, correct?
A. Yes.
Q. Does that make the chambers of the heart smaller as a scar tissue is forming?
A. If the process is restrictive it *can*, but that remains to be determined, with each patient it's different.

Page 42

Q. Do you agree that endomyocardial fibrosis can distort the appearance of the heart from the outside?
A. Not necessarily. Most in fact look normal.
Q. Would you agree that that is typical in the case of endomyocardial fibrosis that you have this appearance of a denting in of the heart from the outside?
A. No.
Q. Have you ever seen any pictures of endomyocardial fibrosis?
A. In books.
MR. TRAVERS: And in this case?
THE WITNESS: And this case, yeah. Sorry. I thought you meant others.
Q. Do you agree that there was no distortion of the wall of David Gonda's heart due to fibrosis?
MR. TRAVERS: Externally are you talking about, Mark?
MR. RUF Either internally or externally.
A. The inside of the heart appeared abnormal.
Q. So there was no defect that was visible

Page 43

externally?
A. No.
Q. Do you agree that endomyocardial fibrosis usually starts with the apex of the heart?
A. My belief is that it's idiopathic entity and that no one really knows where it starts, so my belief doesn't really matter probably.
Q. Would you agree that based on the literature the typical presentation is fibrosis starting at the apex of the heart?
A. The typical presentation is in the opposite ventricle than in the case we'm talking about and it has been identified in the apex, however, I don't know that anyone knows the exact disease course. I don't remember having read anything that said where this begins.
Q. Do you agree that there was not fibrotic thickening of the apex of David Gonda's heart?
A. You know, I don't know.
Q. Do you agree that fibrotic thickening of the apex of David Gonda's heart was not noted in the autopsy report?
A. Yes, it's not noted specifically.
Q. And do you agree that tho word fibrosis is not even used in the description of tho

Page 44

cardiovascular system in the autopsy report?
A. Fibrosis is a histologic finding. It's not necessarily a morphologic or gross finding so it would be sort of extraneous to see it in the report.
Q. Would you agree there is no use of the word fibrosis in the description of the cardiovascular system in the autopsy report?
A. Because it's inappropriate, yes.
Q. And do you agree that fibrosis must be present if you have endomyocardial fibrosis?
A. By definition.
Q. Are there any areas of fibrotic thickening noted in the portion of the autopsy report entitled cardiovascular system?
A. I'll state once again that fibrosis is a histologic finding and not a gross anatomic finding so that it really is not appropriate to put the word fibrosis within that part of the — so no, it's not there, but it's inappropriate.
Q. Would it be appropriate to use the term scarring?
A. Scarring probably would bo appropriate.
Q. Do you agree that there is no note of waning under cardiovascular system in tho autopsy report?

A. No — dol agree. yes. Sorry,
Q. Do you agree that endomyocardial fibrosis usually involves the in-flow track of the heart?
A. Usually yes.
Q. And do you agree that the mass or lesion that was found in David Gonda's heart involves the outflow track?
A. Yes.
Q. Do you agree that usually with endomyocardial fibrosis you see abnormalities of the liver?
A. Repeat that again.
Q. Do you agree that with endomyocardial fibrosis you usually see abnormalities of the liver?
A. There are so few cases of this that there's M usually. So I would have to say no.
Q. Are you just guessing or do you know that for sure?
A. In the articles that I looked at this morning there were probably two of the cases that involved the liver and they thought that that was an unusual finding so that's what I'm basing that on.
Q. Do you agree that endomyocardial fibrosis is described as Davy's disease?
A. In Davy's disease there is endomyocardial

fibrosis but it u not a unique entity to Davy's disease.
Q. But that is the entity that's typically found in either Africa or tropical countries, correct?
A. Yes.
Q. Are you aware of the term Loffler's endocarditis?
A. Yes.
Q. Do you agree that Loffler's endocarditis is found in temperate countries such as the United States?
A. Yes.
Q. Are you aware that Loffler's endocarditis and endomyocardial fibrosis may have the same pathological findings in advanced cases?
A. Can you say thar again? I'm sorry.
Q. Yes. Are you aware that endomyocardial fibrosis and Loffler's endocarditis may have the same pathological finding in advanced cases?
A. That's true.
Q. Do you agree that the stages of Loffler's endocarditis are a necrotic stage, then a thrombus stage, then a fibrotic stage?
A. To the best of my knowledge, yes.

Q. So fibrosis of the heart could actually be the end stage of Loffler's endocarditis, correct?
A. Yes.
Q. Given that that's the case isn't it possible that David Gonda died of Loffler's endocarditis since the pathological findings can be the same in advanced caws?
A. His heart represents an end stage of some process. Without any key as to what the previous etiology was for an example the presence of eosinophil it really is possible for one to point to what that initial event was that led up to the fibrosis,
Q. So David Gonda could have actually had Loffler's endocarditis?
A. Could have.
Q. So basically the two choices are Loffler's endocarditis which progressed to an end stage or endomyocardial fibrosis?
A. Well, it's referred to as endomyocardial fibrosis, that's sort of like descriptive term and that's the end stage of Loffler's. Bur there are other sort of idiopathic forms of endomyocardial fibrosis that no one has a " there's a tot of supposition as to what the cause is, but no one can

actually point to what the exact causes of those cases.
Q. So David Gonda could have had Loffler's endocarditis but you can't make that determination based upon performing this autopsy, correct?
A. Yes.
Q. Do you agree that the cause of David Gonda's death was pulmonary hemorrhage due to tumor emboli resulting from a mass lesion of the myocardium?
A. No.
Q. What is the cause of David Gonda's death?
A. Endomyocardial fibrosis that led to pulmonary hypertension.
Q. Wasn't the pulmonary hypertension caused by emboli?
A. Probably, but the emboli were a result of the endomyocardial fibrosis, inflammation of the thrombus is due to the fact that there was thrombus on that wall.
Q. Couldn't the emboli be pieces breaking off from this mass in the heart?
A. Sure, that's whaf they were.
Q. Do you agree that with endomyocardial fibrosis typically you don't have a breaking off of

Page 49

fibrosis from the heart?
A. It's not the fibrosis, it's the thrombus that breaks off. And there is one - exactly two reports that I pulled up today that report tho exact same thing, the patient had a thrombus, had pulmonary hypertension, in fact one of these cases is exactly similar to this case.
Q. Did you decide the cause of death for David Gonda?
A. I had the final decision, with input from Dr. Ratliff.
Q. So the final decision was youn as to what diagnosis to put on the autopsy report?
A. Yes.
Q. Do you agree that bacteria were found in the postmortem microbiology report that was issued for the specimen in the lung?
A. Bacterial contaminants, yes.
Q. Do you agree that there is - the word bacterial contaminant is not listed on the postmortem microbiology report?
A. And that's because when it's polymicrobial it is intuitive to anyone that's trained in pathology that those are contaminants.
Q. But you agree it does not state

Page 50

contaminants on the report?
A. It does m.
Q. Do you know whether or not tho bacteria that were found in the postmortem microbiology report could cause endocarditis?
A. I can't really read them. Hang on. I think in certain immuno-compromised situations, yes, they could. but they aren't the typical bacteria that in a healthy person that has an attacked immune system causes endocarditis.
Q. Would you agree that Bacteroides fragilis - am I pronouncing that correctly?
A. Bacteroides fragilis.
Q. Yes. OOyou agree that that can be a cause for bacterial endocarditis in the heart?
A. Not in a normal situation. That's a very, a rare situation. It's more common a contaminant in this sort of setting, an autopsy setting.
Q. If a penon had some type of defect in their heart could the Bacteroides fragilis cause endocarditis?
A. Like, what is that called, like a porcine valve, sure, if somebody had a valve stuck in their or a prosthetic something, sure.

Page 51

MR. RUF Thank you, Doctor. I don't have any other questions.
MR. TRAVERS: Doctor, I was looking at my list of questions and I skipped over one that I meant to ask before.

REDIRECT EXAMINATION

BY MR. TRAVERS:

Q. In your review of these slides are you able to identify anything suggestive that this patient had an abscess of his lung?
A. No.
MR. TRAVERS: That's all I have. Thanks.

RECROSS EXAMINATION

BY MR. BLOMSTROM:

Q. You referred to granulation tissue consistent with a thrombus during your testimony, can you tell mc what that means?
A. I think I'm improperly using that. Granulation tissue in the true sense of the word is any time the body heals. granulation tissue is an ingrowth of blood vessels that try to heal that area. In a thrombur that would never happen; so really the true terminology from a pathologist should actually be an organized thrombur, so there's evidence of organization whkh is where tho blood

Page 52

vessels, so it's not true granulation tissue. It's actually just organization of the thrombus.
Q. Mr. Ruf asked you whether &herewere any culture results listed on the autopsy report and you indicated that there weren't. Tell us why they weren't.
A. The cultures are done at the discretion of the first year resident who has very little experience in these matters. When the finding are significant and it's believed to be the cause of disease where one organism is identified that is definitely reported. But as I said in this case there are multiple bacteria so it would have been known at that time this was just representative of autopsy contamination.
MR. BLOMSTROM: Thank you very much.
MR. FRASURE: Just a few questions follow up.

RECROSS EXAMINATION

BY MR. FRASURE:

Q. Had you ever seen lung abscesses on autopsies as of this time when you did this?
A. Yes.
Q. And you did not see any lung abscesses here?

A. No.
Q. Did you see any suppurating lesion of tho endocardial surface?
A. No.
Q. And am I correct that you believe that the lesion that you found did involve the apex of the ventricle?
A. Yes.
Q. Doctor, you were asked by Mr. Ruf about slide 13 I think you raid that was stained for microorganisms and none were seen; is that correct?
A. Yes.
Q. What part of the body is slide 13 of?
A. The heart.
Q. Was that a representative sample of the heart?
A. Yes.
Q. Doctor, do you currently spend more than half of your professional time in the practice of pathology?
A. Yes.
Q. And did you spend back in 1995 when you performed this autopsy more than half of your professional tine in the active practice of pathology?

A. Yes.
MR. PRASURE: That's all I have. Thank you.
MR. RUF: I just have one last question, Doctor.

RECROSS EXAMINATION

BY MR. RUF:
Q. Do you agree that there is an extremely low probability of somebody in the United States dying from endomyocardial fibrosis?
A. Yes.
MR. RUF: Thank you, Doctor. That's all I have.

FURTHER DIRECT EXAMMATION

BY MR. TRAVERS:
Q. Doctor, I assume you mean getting it -
A. Getting it, yeah.
Q. - rather than -
A. If they get it, they die. I'm sorry. I probably should have said that. Extremely low probability of someone getting it in the U.S. Is very rare but once someone has it, it's pretty downward spiralling course.
MR. RUF: Thank you, Doctor. That's all I have.

MR. JONES: The doctor will sign it if it gets written up.

(Thereupon, the deposition was concluded and the witness excused at 3:35 p.m.)

CERTIFICATE OF OATH

STATE OF FLORIDA
COUNTY OF COLUMBIA

I, the undersigned authority, certify that the witness, DR. SHARON HOOK, personally appeared before me and was duly sworn.

WITNESS my hand and official seal this 28th day of December, 1998.

Linda York, RPR
Notary Public-State of Florida
My Commission No. CC575702
Expires: 9/20/2000

CERTIFICATE

STATE OF FLORIDA

COUNTY OF COLUMBIA

I, Linda York. Registered Professional Reporter and Notary Public, certify that I was authorized to and did stenographically report the deposition of DR. SHARON HOOK; that a review of the transcript was requested: and that the transcript is a true and complete record of my stenographic notes.

I further certify that I am not a relative, employee, attorney or counsel of any of the parties, nor am I a relative or employee of any of the parties' attorney or counsel connected with the action, nor am I financially interested in the action.

DATED this 28th day of December, 1998.

LINDA YORK, RPR