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

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IN THE COURT OF COMMON PLEAS

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DOROTHY A. GONDA, et al.,
Plaintiffs,
v.
JUAN RUIZ, M.D., et al.,
Defendants.

Case No. 96-CV-2055
Judge John M. Durkin

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THE DEPOSITION OF RAYMOND W. ROZMAN, JR., M.D.

TUESDAY, FEBRUARY 9, 1999

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The deposition of RAYMOND W. ROZMAN, JR., M.D. a witness, called for examination by the Plaintiffs, under the Ohio Rules of Civil Procedure, taken before me, Cynthia A. Sullivan, Notary Public in and for the State of Ohio, pursuant to notice, at the University Suburban Health Center, 1611 South Green Street, South Euclid, Ohio, commencing at 4:10 p.m., the day and date above set forth.

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APPEARANCES:

On behalf of the Plaintiffs:

MARK. W. RUF, ESQ.
Hoyt Block, Suite 300
700 West St. Clair Avenue
Cleveland, Ohio 44113
(216) 687-1999

on behalf of Defendants Alejandro Franco, M.D., Abdul Hafiz, M.D., and Youngstown Associates in Radiology:

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

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

THOMAS J. TRAVERS, JR., ESQ.
Manchester, Bennett, Powers & Ullman
Atrium Level Two
The Commerce Building
201 East Commerce Street
Youngstown, Ohio 44502-1641
(330) 143-1171

On behalf of Defendant Alan J. Cropp, M.D., Pulmonary Medicine Consultants, Pulmonary Rehabilitiation Associates and Robert DeMarco, M.D:

GARY BANAS, ESQ.
Buckingham, Doolittle & Burroughs, L.L.P.
3721 Whipple Avenue, N.W.
P.O. Box 35548
Canton, Ohio 44735
(330) 492-9625

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INDEX

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

CROSS-EXAMINATION

BY MR. RUF:

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

A. Raymond William Rozman, Jr., R-A-Y-M-O-N-D, W-I-L-L-I-A-M, R-O-Z-M-A-N.

Q. What is your address, Dr. Rozman?

A. My professional address is 1611 South Green Road, South Euclid, Ohio, 44121.

Q. Doctor, my name is Mark Ruf, and I along With David Malik represent 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 the question, I will assume you have understood the question, okay?

A. Yes.

Q. Did you bring your whole file with you?

A. Yes, although I'm looking for Dr. Ruiz's office notes which I know I had earlier. Here they are. Yes, I did.

Q. Could you quickly tell me what medical records

you have reviewed in this case in order to formulate your opinions?

A. Dr. Ruiz's office chart, the office charts of Drs. DeMarco and Cropp, records of the Youngstown Associates in Radiology, the Cleveland Clinic autopsy report, records from the Cleveland Clinic Foundation, St. Elizabeth Hospital Medical Center admission and Dr. Ruiz's deposition --

Q. Wait, let's start with the records.

A. I'm sorry.

Q. Does that encompass the records that you have reviewed in this case?

A. Yes.

Q. What depositions have you reviewed in this case in order to form your opinions?

A. I reviewed Dr. Ruiz's deposition and the deposition of Dr. Hadley Morgenstern-Clarren.

Q. Those were the two depositions that you have reviewed?

A. Those are the only two depositions, yes.

Q. Have you reviewed any reports in this case?

A. This morning via fax I received a report from a Dr. Hoffman which I have glanced at but not read in detail.

Q. Any [illegible] other th[illegible] Dr. Hoffman ?

Page 6

A. I don't believe so, no.
Q. Does that cover everything that you reviewed in order to form your opinions in this case?
A. Yes.
Q. I notice that you have two documents that are annotations of depositions; is that correct?
A. Yes, there was one for the deposition of Dr. Ruiz as well as one for the deposition of Dr. Hadley Morgenstern-Clarren that were provided by Mr. Travers.
Q. Whose handwriting is on the annotations?
A. Mine
MR. RUF: I would request a copy of those two annotations.
MR. TRAVERS: I would be willing to provide those to you since you're a nice guy.
MR. RUF: Thanks, Tom. Same to you.
BY MR. RUF
Q. Doctor, when were you first contacted about rendering an opinion in this case?
A. I believe it was sometime in 1998. I don't recall exactly when Mr. Travers called me. It was sometime in 1998.
Q. Have you exchanged any written correspondence

Page 7

with Mr. Travers?
A. Yes, I authored a brief report that I mailed to Mr. Travers.
Q. Did you prepare a draft of that report?
A. No.
Q. Do you have any written correspondence between you and Mr. Travers?
A. I have some letters provided to me by Mr. Travers. I don't have them with me. They were just brief summaries of the case.
MR. RUF: I'd request an opportunity to review those letters.
MR. TRAVERS: I'll consider [illegible], Mark, [illegible] on y [illegible] examination of Dr. Ro I mean, if th are i in there that he relied upon for your &position, obviously you're entitled to review them, but as far as if they offered any assistance to him in rendering his opinions for his deposition, I'm not sure you're entitled to see them.
THE WITNESS: I can state I have not used any communications from Mr. Travers to formulate my opinions.
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Page 8

BY MR. RUF:
Q. Do any of the letters contain factual summaries or factual descriptions of Mr. Travers' impressions in the case?
A. There is a briefsummary of details of the case in terms of dates of presentation, but not any specific opinions of Mr. Travers.
Q. You did review those letters, correct?
A. Yes. It was generally prior to reviewing the case. I believe I received a letter. That was the first thing that I reviewed before I reviewed any documents or other documents in the case.
Q. Did you use that correspondence to form a preliminary opinion in the case?
A. No.
Q. When did you first give Mr. Travers your opinion in the case?
A. I don't have with me the report that I authored.
MR. BANAS: Here, Tom.
Q. Did you do it by written report or orally?
A. I first spoke with Mr. Travers on the phone, and based on our conversation at his request I authored a report which was mailed to him June 29th of 1998.
Q. Did you give Mr. Travers any opinion by telephone?

Page 9

A. Yes.
Q. What opinion did you give him?
A. I told him I felt that the actions of Dr. Ruiz were appropriate and that they were within the reasonable standard of care in this case.
Q. When you were first contacted by Mi. Travers did you render any kind of opinion in the case at that point?
A. Pri[illegible] or --
MR. TRAVERS: You mean before receiving the records.
A. -- to receiving any documents?
Q. Correct.
A. No.
Q. Did he give you a factual summary of l case, and did you give him your impressions of the case at that time?
A. I don't remember that I did. He mentioned to me he would be sending me some information and asked me to review it and formulate my opinion based on that.
Q. What exactly did Mr. Travers ask you to do in this case?
A. He asked me to review the records and to offer an opinion as to whether Dr. Ruiz acted appropriately in his care of Mr. Gonda.

Page 10

Q. Do you know Dr. Ruiz?
A. No.
Q. Have you acted as an expert witness for Mr. Travers in the past?
A. No.
Q. Do you know if you have served as an expert witness for his law firm in the past?
A. I have not.
Q. Have you ever served as an expert witness for Gary Banas in the past?
A. No.
Q. Have you ever served as an expert witness for Mr. Blomstrom?
A. No.
Q. Have you ever served as an expert witness for the law firm of Buckingham, Doolittle & Burroughs?
A. Yes, I have.
Q. How many times have you done that?
A. I believe in two cases.
Q. What were the issues in those cases?
A. I'm trying to recall the details of the cases. It has been a while since I have reviewed those records.
Q. Did either of those cases involve the failure to diagnose a cardiac condition?

Page 11

A. I can't recall.
Q. Do you know where those cases were?
A. No, I don't.
Q. What lawyer did you work with at the Buckingham, Doolittle office?
A. Christopher Humphrey.
Q. Were you an expert witness on gastroenterology issues or internal medicine issues in those cases?
A. I believe they were internal medicine, but I can't recall specifically.
Q. Do you keep written records of the cases that you have testified in or cases that you've served as an expert witness in?
A. No.
Q. Do you keep track of that on the computer?
A. No.
Q. Are you Board Certified?
A. Yes.
Q. In what areas are you Board Certified?
A. In internal medicine and gastroenterology.
Q. Would you describe your practice for me, what areas of medicine do you practice?
A. The majority of my practice is general internal medicine, probably 85 percent or so. I also have a subspecialty practice in gastroenterology which comprises probably the other 15 percent of the practice. I see patients in my office and do gastroenterologic procedures at the surgery center in this building.
Q. As part of your internal medicine practice do you order blood cultures?
A. Yes.
Q. As part of your internal medicine practice do you order echocardiograms?
A. Yes.
Q. Do you order TEEs as part of your internal medicine practice?
A. Yes.
Q. Do you believe that the standard of care requires the primary care physician to order those kinds of tests if they're necessary to reach a diagnosis of a patient?
A. If they are necessary, yes.
Q. How many times have you served as a witness in a legal case?
A. Reviewing cases or --
Q. Either as an expert or a defendant.
A. I've been a defendant twice. I've not kept track of the number of cases that I have been an expert in. I would estimate it at probably 20 to 30 although

Page 12

that's just a guess.
Q. It's 20 to 30 cases over what period of time?
A. Probably over a period of the past five or six years.
Q. Have those cases all been local, or have they been all around the state of Ohio and to the state of Ohio?
A. They have been generally local. I've reviewed some cases in the, I guess, the Akron/Canton area, but none really further than that.
Q. Did either of the cases in which you were a defendant involve the failure to diagnose a cardiac condition?
A. Yes.
Q. What was the issue in that case?
A. It was the first case in which I was named as a defendant. He, the patient of a colleague of mine, called me when I was on call on a Sunday morning complaining of chest discomfort. I advised the patient to go to an urgent care center which he did. He was evaluated there and eventually was sent home and later that day suffered a myocardial infarction. I was named as a defendant in that case.
Q. Did you ever see that patient?
A. No.

Page 13

Page 14

Q. Did you give a deposition in that case?
A. Yes.
Q. What was the name of that case?
A. The patient's name was Dratler.
Q. Do you know how to spell that?
A. D-R-A-T-L-E-R, Phillip Dratler.
Q. Was that a Cuyahoga County case?
A. Yes.
Q. Did the case go to trial?
A. No.
Q. It was resolved?
A. Yes. I was dismissed as a defendant.
Q. In the 20 to 30 cases where you have served as an expert witness, how often are you an expert for the doctor?
A. All but two of the cases have been for the defense.
Q. Do you in any way advertise your services to be an expert witness?
A. No.
Q. Have you ever served as an expert witness in a case involving the failure to diagnose endocarditis?
A. Not I no.
Q. I'm sure you have never served as an expert witness on a case involving endomyocardial fibrosis.

Page 15

A. I have not.
Q. Do you receive medical periodicals in your practice?
A. Yes.
Q. What periodicals do you receive?
A. One of my positions is the director of medical education at this facility, so all of the journals that you see here in the library come through my office, so all of these cross my desk. Some of them I review as if I was receiving them on my own; others I put right into the library.
Q. What journals do you think are quality journals on the issue of cardiology?
A. There is a journal entitled Cardiology which I believe is a quality journal. There is the American Journal of Cardiology. In other journals, general internal medicine journals, there are often articles regarding cardiology like the New England Journal of Medicine and also Internal Medicine.
Q. Do you find the information stated in those journals to be generally accurate and reliable?
A. Generally.
Q. Are you also responsible for determining what medical texts are kept in the library?
A. Yes.

Page 16

Q. What internal medicine texts do you have here in the library?
A. Harrison's Principles of Internal Medicine.
Q. Do you know what edition that is?
A. I believe there is an older edition here in the library. The edition in my office is more recent. This is the tenth edition. I believe I have a more recent edition in my office.
Q. Do you also have Cecil's?
A. Yes, this is the 18th edition of Cecil. I also have Cecil in my office. I don't know what edition.
Q. Do you have any other internal medicine texts here in the library?
A. There are a number of them, yes.
Q. What other ones do you have?
A. You want me to list all of those?
Q. Yes, please.
A. Many of these are subspecialty textbooks relating to various subspecialties of medicine.
Q. I'm just asking about internal medicine texts, Doctor.
MR. TRAVERS: why don't we save this part of the examination until the end after we move across the hall?
MR. RUF NO.

Page 17

A. I believe those are the only two general internal medicine textbooks. The others are subspecialty textbooks.
Q. Have you found the information in those internal [illegible] textbooks to be accurate and reliable?
A. Generally so, yes. I don't always agree with what I read there, but I think it is usually reliable and helpful.
Q. Do you have any cardiology text or [illegible] on cardiovascular medicine?
A. In the library?
Q. Yes.
A. The Braunwald textbook on cardiology is kept here.
Q. Do you find the information listed in that textbook to be accurate and reliable?
A. Generally so, yes.
Q. If you were going to look up information on either bacterial endocarditis or endomyocardial fibrosis, would the Braunwald text be a reasonable source of information to consult?
A. Yes.
Q. Do you use any pocket diagnostic textbooks in your practice?
A. Only one, the J. Sanford internal disease pocket

Page 18

handbook.
Q. Do you regularly use the textbook of J. Sanford in your practice?
A. I refer to the handbook, not to any textbook by Dr. Sanford.
Q. What do you use that for?
A. If I need to choose an antibiotic for a specific infection, often there are useful listings of antibiotics for specific infections in that handbook.
Q. Do you find the information that is in that handbook to be accurate and reliable?
A. Generally so.
Q. Does the standard of care require a physician to consult medical texts and medical literature if the physician cannot reach a diagnosis for a patient?
A. Not in all cases, no.
Q. In what cases would the standard of care require consultation of literature or medical textbooks?.
A. If the physician felt that he was unfamiliar with the facts in the presentation of the patient, then referring to a textbook would be within the standard of care.
Q. Do you agree that neither Dr. Ruiz nor Dr. Cropp ever consulted a medical textbook or medical literature during the time they treated David Gonda?

Page 19

A. I'm not aware that they did.
Q. Do you think that David Gonda's clinical presentation required his treating physician to consult either medical texts or medical literature?
A. Not necessarily, no.
Q. Why not?
A. I don't believe that there was any, from what I can tell from the records, any question in Dr. Ruiz's mind in terms of any factual issue in the case that would require him to consult a textbook.
Q. I'm going to ask you whether you are qualified to render opinions in a number of areas.
First of all, do you think you are qualified to render an opinion as to the appropriate standard of care for Dr. Ruiz?
A. Yes.
Q. Do you think you are qualified to render an opinion as to the appropriate standard of care for Dr. Cropp?
A. Yes.
Q. Have you formally been retained as an expert witness for Dr. Cropp?
A. No.
Q. Do you think you are qualified to render an opinion as to the appropriate standard of care for

Page 20

Dr. Hafiz?
A. No.
Q. Are you qualified to give an opinion as to the appropriate standard of care for a cardiologist?
A. I'm not a cardiologist and not an expert in cardiology, but as an internist I work closely with cardiologists and am familiar with their practice, so I believe I can comment on the standard of care in general with respect to cardiologists.
Q. Would you agree that With respect to the diagnosis and treatment of cardiac conditions that there is a higher standard of care for a cardiologist than an internal medicine doctor?
A. I think that would vary with the particular cardiac condition. I think for certain cardiac conditions that is true.
Q. What about for the conditions of either bacterial endocarditis or endomyocardial fibrosis?
A. I believe that the standard of care for an internist is probably the same as the standard of care for a cardiologist in infective endocarditis.
Endomyocardial fibrosis is very rare, not something that internists or primary care physicians generally see, and I don't know whether the standard of care would be any different for a cardiologist in that

Page 21

situation as compared to an internist.
Q. So either an internist or a doctor of cardiology would be qualified to work a patient up and reach a diagnosis of bacterial endocarditis?
A. Yes.
Q. Is that also true of a pulmonologist?
A. Yes.
Q. Do you believe you are qualified to render an opinion as to the appropriate treatment for either bacterial endocarditis or endomyocardial fibrosis?
A. For bacterial endocarditis, yes. For endomyocardial fibrosis, no.
Q. Are you qualified to render an opinion as to the tests that are necessary to diagnose either bacterial endocarditis or endomyocardial fibrosis?
A. Yes.
Q. Yes in both cases?
A. Yes. Again, endomyocardial fibrosis is a very rare entity, and I cannot speak from an expert's position on that.
Q. So you don't think you have the qualifications necessary to render opinions on endomyocardial fibrosis?
MR. TRAVERS: I'm going to object. That's not what he said. You

Page 22

asked before about the treatment of the disease. You're asking a different question. I ask that you phrase it appropriately.

BY MR. RUF:

Q. If you need to, qualify your answer. Go ahead.

A. I can't present myself as an expert in endomyocardial fibrosis.

Q. Are you qualified to render an opinion as to David Gonda's survivability assuming that he had bacterial endocarditis?

A. Yes.

Q. Are you qualified to render an opinion as to David Gonda's survivability assuming that he had endomyocardial fibrosis?

A. I can offer an opinion, but not as an expert on endomyocardial fibrosis.

Q. Are you qualified to render an opinion as to the cause of David Gonda's death?

A. Yes.

Q. Do you consider yourself to be an expert in bacterial endocarditis?

A. No.

Q. Do you agree that a cardiologist or a cardiothoracic surgeon has knowledge superior to

Page 23

yours on issues involving bacterial endocarditis?

A. Possibly.

Q. Why do you say possibly?

A. I believe that there probably are cardiologists that have more experience with endocarditis than I have and as a result would be more expert in that area, but not necessarily all cardiologists.

Q. What is your understanding as to what type of doctor Dr. Ruiz is?

A. I believe he is a general internist.

Q. In rendering your opinions in this case did you apply the standard of an internal medicine doctor to Dr. Ruiz?

A. Yes.

Q. If a doctor held himself out to the public as treating cardiovascular cases, do you believe that the doctor should be held to the standard of care for a cardiologist

A. I don't think so, not necessarily. I think as internists we care for patients with cardiovascular diseases very commonly.

Q. You would agree that treating and caring for cardiovascular diseases involves diagnosing and treating conditions of the heart, correct?

A. Yes.

Page 24

Q. Do you believe that a doctor has an obligation to tell a patient if that doctor is not qualified to diagnose or treat a condition that the patient has?

A. Yes.

Q. Do you know if Dr. Ruiz has the credentials to qualify as a cardiologist?

A. I don't know.

Q. What is your understanding of how Dr. Ruiz held himself out to the public?

A. I believe he held himself out to the public as an internist. I did see one copy of a Yellow Pages ad where it also mentioned that he treats cardiovascular diseases.

Q. Would you agree that if Dr. Ruiz's door had on it internal medicine and cardiovascular diseases that that creates the perception to the patient that Dr. Ruiz treats conditions of the heart?

A. Yes.

Q. If Dr. Ruiz suspected that David Gonda had a cardiac condition, did the standard of care require him to refer David to a cardiologist.

A. Not necessarily. As I mentioned earlier, as internists we commonly treat cardiovascular patients, and only if we feel that we're not qualified to treat that particular cardiac condition, then do we refer to

Page 25

a cardiologist. But in everyday practice we do diagnose and treat cardiovascular conditions as internists.

Q. Would Dr. Ruiz be qualified to diagnose and treat bacterial endocarditis?

A. Yes.

Q. Would Dr. Ruiz be qualified to diagnose and treat endomyocardial fibrosis?

A. As I mentioned earlier, it's a very rare condition. It's certainly conceivable that he could undergo and recommend a series of tests which would result in that diagnosis.

Q. But the diagnosis and treatment of endomyocardial fibrosis would probably involve consulting a cardiologist --

MR. TRAVERS: I would object to the question, Mark, because it's t ions. He has answered you already about diagnosis, but you trying to put it all in the same t I'm not sure that's appropriate.

You can answer that, Doctor, if you think you can.

A. I believe that in the diagnosis and treatment of endomyocardial fibrosis it would be appropriate at some

Page 26

point to involve either a cardiologist or a cardiovascular surgeon. As I mentioned earlier, it's conceivable that a series of tests ordered by either an internist or a cardiologist could result in that diagnosis or at least a suspicion of that diagnosis.
Q. Do you have an opinion as to whether Dr. Ruiz or Dr. Cropp at some point had an obligation to refer David Gonda to either a cardiologist or infectious disease specialist?
A. Could you repeat that, please?
MR. RUF: Could you please read the question back?
THE NOTARY Question: "Do you have an opinion as to whether Dr. Ruiz or Dr. Cropp at some point had an obligation to refer David Gonda to either a cardiologist or infectious disease specialist?"
A. I do have an opinion.
Q. What is your opinion?
A. That they were not obligated to refer Mr. Gonda either to an infectious disease specialist or a cardiologist.
Q. Why not?
A. I believe that based on their evaluation of the

Page 27

patient when they saw him that there was no clear evidence of a significant enough cardiovascular condition to require that referral.
Q. If you were going to bring in a doctor as a consultant to treat bacterial endocarditis, what type of doctor would you consult?
A. An infectious disease specialist.
Q. If you were going to bring in a consultant to treat a patient with endomyocardial fibrosis, what type of doctor would you consult?
A. Probably either a cardiologist or a cardiothoracic surgeon.
Q. Does the standard of care require a physician to reach a diagnosis that explains a patient's symptoms?
A. Not necessarily, no.
Q. Why not?
A. It's not uncommon for us to treat a patient without a definitive diagnosis, to treat the patient empirically based on the patient's presentation without ever having arrived at a definitive diagnosis. We commonly give empiric treatment.
Q. So you do not believe it's a violation of the standard of care not to reach a diagnosis for a patient?
A. That's correct. That's our aim, but we're not

Page 28

always able to achieve that, and often we institute treatment prior to reaching a definitive diagnosis.
MR. BANAS: Mark, when this is over I want to have a chat with you because I want to make sure this deposition never gets to a particular place.
MR. RUF Fine. I'll be happy to talk to you.
MR. BANAS: You know what I'm talking about.
BY MR. RUF:
Q. Do you believe that the appropriate standard of care not only requires a physician to treat a patient's symptoms or disease, but it also requires that physician to determine the underlying cause of those symptoms?
A. As I mentioned, our goal is to try through evaluating the patient to reach a diagnosis. But in the practice of medicine we're not always able to achieve that goal, and even prior to reaching a definitive diagnosis the standard of care requires us to treat the patient based on the presentation.
Q. If as a physician you are treating a patient's symptoms and the patient is not getting better, does

Page 29

the standard of care require you to go back and reassess your treatment as well as your diagnosis?
A. Yes.
Q. Does the standard of care require a treating physician to form a differential diagnosis for a patient?
A. Yes.
Q. And the physician forms a differential diagnosis based on signs and symptoms that the patient has?
A. Yes.
Q. When you're working with a differential diagnosis, you rule in certain diagnoses and you rule out certain diagnoses?
A. That's true. I should point out that we don't always write that down, but that often we will not write it down but still act on that differential diagnosis.
Q. But whether or not it's written, there is an obligation of the physician to form a differential diagnosis?
A. Yes.
Q. Do you agree that a diagnosis is part of the differential until it is ruled out?
A. Through evaluating the patient and tests we often rule diagnoses in or out of the differential diagnosis

Page 30

is probably the best way you could describe it.
Q. Does the standard of care require a primary care physician to reassess his diagnosis and treatment if a consultant rules out the working diagnosis of that primary care physician?
A. Not necessarily. If we reach a point where we call a consultant in to evaluate a patient, often at that point the evaluation of the patient is in the realm of the consultant and not necessarily going back to the primary care physician.
Q. What if as a primary care physician you refer a patient to a consultant because you suspect a particular condition in that patient, the consultant evaluates the patient and tells you that that diagnosis is not correct, at that point what is your obligation?
A. I think there would be an agreement between the consulting physician and the primary care physician as to who would evaluate the patient further.
MR. TRAVERS: I generally don't like to interrupt, Mark, but I thought you knew this case. You're losing me here. Are you talking about Adornato as a consultant for Ruiz?
MR. RUF: I'm talking about in general first. He is rendering

Page 31

opinions as to standard of care, and I think I'm entitled to ask some general questions first.
MR. TRAVERS: Not if they don't have anything to do with the case. I'm not going to argue with you. You can ask your questions, but I genuinely can't follow you, and I'm at a point here where I'm lost.
BY MR. RUF:
Q. Did Dr. Ruiz and Dr. Cropp have a duty to perform diagnostic testing on David Gonda until they reached a definitive diagnosis?
A. Diagnostic tests are often done in the evaluation of a patient. It doesn't necessarily have to be done either at or subsequent to each patient visit. Obviously diagnostic testing is commonly done in trying to reach a definitive diagnosis, but not necessarily at every visit.
Q. Does the standard of care require sufficient diagnostic testing so that you can reach a definitive diagnosis for a patient?
A. We can sometimes reach a definitive diagnosis based on the history and physical alone. There are times quite often where we need to do diagnostic tests

Page 32

in addition to that, but it is not true that we must do diagnostic tests to reach a definitive diagnosis if that is reachable without specific testing.
Q. But if you cannot reach a initive osis just b d on the history and physical, then there is an obligation to perform diagnostic tests· is a correct?
A. With the exception of the situation that I mentioned earlier, that's fairly common where we use empiric treatment where we treat a patient as if they have a particular diagnosis, often giving the patient a so-called therapeutic trial, and at that point we will often deliver the treatment rather than to do further testing. The response or reaction to the treatment is even then used to either rule in or rule out the diagnosis.
Q. In th case would it l t medical t for Dr. uiz and Dr. Cropp to leave David Gonda' igh fever and general malaise :p as far as the diagnosis?
MR. B/ Now, I object to th t That's t t th records show, but go ahead, Doctor.
A. All I can say is as I mentioned earlier, that we do not necessarily do diagnostic tests up until the

Page 33

point we reach a definitive diagnosis and then institute treatment. Often treatments and evaluations go in parallel. We will often treat a patient at the same time we're getting tests done. As I mentioned earlier, we'll sometimes treat a patient empirically without getting any further tests, and only test further if the empiric treatment is not effective.
So it seems with your questions that you're suggesting that we do a series of tests until we reach a definitive diagnosis and at that point institute treatment, and that's not necessarily the case. Often treatment and evaluation go parallel. There are times when successful, let's say, resolution of symptoms with empiric treatment will preclude further tests. If symptoms persist or worsen or new symptoms develop, then often times that will mandate further testing.
I hope that's clear.
Q. Well, given the persistence of David Gonda's symptoms do you believe there was an obligation to do further testing on him?
MR. TRAVERS: At what point in time are we talking about?
MR. RUF: Mid July.
A. May I refer to the notes?
Q. Certainly.

Page 34

A. At a July 5th visit with Dr. Ruiz, Mr. Gonda reported the continued cough and fever despite Doxycycline, and at that point I believe it was appropriate for Dr. Ruiz to refer Mr. Gonda to a specialist, for example, Dr. Cropp and/or Dr. Adornato. I believe that's the last time Dr. Ruiz saw Mr. Gonda.

I'm looking for Dr. Cropp's record. Dr. Cropp saw Mr. Gonda in the office on July 13th, 1995, and at that point Mr. Gonda reported persistent symptoms. Dr. Cropp mentioned that he had been on a number of antibiotics, but pointed out he had taken the Doxycycline only for seven days, and based on his evaluation that day he recommended a 21-day course of Doxycycline as well as other treatments, Vanceril and Tessalon perles, and he arranged follow-up for the patient.

So as of that July 13th, '95 visit, I assume that's what you mean by mid July, I think at that point it was appropriate for Dr. Cropp to continue the Doxycycline because especially for atypical pathogens as he was considering in this case, it is necessary to use Doxycycline for longer than a 7-day course because quite commonly for an atypical infection the Doxycycline needs to be used for a longer period of time. So I think that was appropriate.

Page 35

Q. Do you agree that David Gonda's symptoms persisted despite the administration of [illegible]

A. He saw Dr. Cropp again on July 25th, 1995, and at that point he appeared to have improved somewhat but still was not normal. He still had a number of respiratory complaints.

Q. He continued to have fever on that visit, correct?

A. Yes.

Q. And he continued to have a cough on that visit, correct?

A. Yes.

Q. So would you agree that those symptoms persisted despite the administration of Doxycycline?

A. They improved but were still present, and based on that presentation on the 25th, Dr. Cropp recommended discontinuing the Tessalon and Vanceril and asked the patient to use a decongestant, Deconsil, too, and placed a PPD. He again arranged follow-up in two weeks and mentioned if the patient was not better at that time he would proceed with a further diagnostic test, a bronchoscopy.

Q. Do you agree that the standard of care for a physician requires that physician to provide treatment to a patient that improves the patient's condition?

Page 36

A. Yes.

Q. Do you agree that David Gonda when he presented to St. Elizabeth's hospital had a history of coughing, fever and general malaise for ten weeks?

A. Yes.

Q. Do you agree that on every office visit to Dr. Cropp that David Gonda had abnormal vital signs?

A. Yes.

Q. Do you agree that on every office visit to Dr. Ruiz that David Gonda had abnormal vital signs?

A. Yes.

Q. Based on your review of the records was there any improvement in David Gonda's condition during that ten-week period of time?

A. There appeared to be some temporary improvement in some of his symptoms.

Q. But even though there was temporary improvement, his symptoms persisted, correct?

A. Yes.

Q. Do you agree that the standard of care requires a physician to reassess their treatment if the treatment is not working?

A. Yes.

Q. Do you agree that there was no reassessment by either Dr. Cropp or Dr. Ruiz of their diagnosis and

Page 37

treatment?

A. I believe they did reassess the patient.

Q. When?

A. I believe they did that at each office visit.

Q. Do you know if Dr. Cropp or Dr. Ruiz ever changed their diagnosis?

A. Yes, they did.

Q. Who changed their diagnosis?

A. At the 6-27-95 visit, Dr. Ruiz. His assessment was viral pharyngitis, rule out pneumonitis, and then at the subsequent visit on July 5th, 1995 -- let me find it here -- his assessment was that of laryngitis. Based on the presentation he was concerned enough at that point to refer Mr. Gonda to Dr. Cropp.

Q. If an ENT consultant ruled out either pharyngitis or laryngitis as the cause of David Gonda's symptoms, does the acceptable standard of care require Dr. Ruiz to reassess David Gonda and perform further testing?

A. I think it required him to reassess the patient, but not necessarily to do further testing. At that July 5th visit he referred the patient on to a specialist which I think is one of the things that the standard of care requires a physician to do if the patient has not yet improved fully.

So I think it was appropriate for Dr. Ruiz at

Page 38

that visit to refer the patient on to either Dr. Adornato or Dr. Cropp. I think it was an appropriate referral.

Q. But even though he referred the patient to Dr. Cropp he still remained the primary care physician, correct?

A. He was still Mr. Gonda's primary care physician, yes.

Q. As a matter of fact, Dr. Cropp sent Dr. Ruiz letters informing him of his findings, correct?

A. I believe the letters written by Dr. Cropp were addressed to -- the first one was addressed to Dr. Adornato, and subsequent letters were addressed to Dr. Ruiz.

Q. When was the last time Dr. Ruiz saw David Gonda?

A. I don't know that he saw him after that July 5th visit.

Q. Would you *agree* that Dr. Ruiz performed no further assessment of David Gonda or diagnostic testing after July 5th, 1995?

A. I agree.

Q. If a physician has not come up with a diagnosis to explain a patient's condition, does the standard of care require that physician to schedule the patient for another appointment for further assessment?

Page 39

A. If that physician plans to continue to be the provider for the patient, yes. As I mentioned earlier, I think it was appropriate at the July 5th visit for Dr. Ruiz to refer the patient to a specialist, so the standard of care does not necessarily require that you schedule a visit with that patient to yourself if you plan to send the patient to a specialist.

Q. Do you think the standard of care requires a physician to come up with a diagnosis involving the organ that's actually causing the patient's signs and symptoms?

A. As I mentioned earlier, I don't think the standard of care requires that we necessarily come up with a definitive diagnosis.

Q. Do you agree that neither Dr. Ruiz nor Dr. Cropp came up with any diagnosis involving a condition of the heart?

A. That's true.

Q. Can we agree that David Gonda either died of endomyocardial fibrosis or bacterial endocarditis?

A. Yes.

Q. And neither Dr. Cropp nor Dr. Ruiz diagnosed either of those conditions prior to David Gonda's death, correct?

A. That's correct.

Page 40

Q. As a matter of fact, their diagnoses involved conditions of the head and neck, correct?

A. That's true, although based on the plans for further evaluation it appears as if they were considering other diagnoses as well.

Q. How did they meet the acceptable standard of care if they did not even get the organ right?

A. As I mentioned earlier, the standard of care requires that we act appropriately in evaluating the patient in terms of the patient's complaints and the patient's symptoms. It does not necessarily require that we come to a definitive diagnosis. Obviously that's the goal, but that's not always achievable.

So I don't think it was a deviation from the standard of care in that case to, as you put it, not to get the organ right. I don't believe there was any clear evidence either to Dr. Ruiz or to Dr. Cropp that suggested that this patient had, for example, endocarditis or endomyocardial fibrosis.

Q. What kind of symptoms or test results would suggest either bacterial endocarditis or endomyocardial fibrosis?

A. The primary symptom of endocarditis is fever which the patient obviously had, that was one of his primary complaints or primary symptoms, but I don't

Page 41

believe that he had other typical symptoms of endocarditis.

For example, he did not have the musculoskeletal complaints that often go along with endocarditis. I don't know that he complained of the back pain which is often part of that. He did not have the joint pains that are often seen with endocarditis.

He did not have any of the peripheral symptoms of endocarditis or signs of endocarditis, for example, the Osler nodes or Janeway lesions. He did not have splinter hemorrhages. He did not have splenomegaly. He did not have hepatomegaly. I think the only symptom that Mr. Gonda had of infective endocarditis was fever.

In addition to his fever he had a number of other respiratory complaints, specifically cough, as well as other respiratory complaints. I believe at the time that he was seen by Dr. Ruiz and then subsequently Dr. Cropp the combination of fever and respiratory complaints suggested to them the possibility of a respiratory infection which caused the infection which they appropriately empirically treated and did not suggest to them that he had infective endocarditis.

Q. Do you agree that the signs of right-sided endocarditis can be different than the signs and symptoms of left-sided endocarditis?

Page 42

A. Some of them are, yes.
Q. I ask that because often there is embolization of portions of the vegetation, and if it's on the right side of the heart it's going to go to different portions of the body than the left side of the heart.
A. Some of the symptoms and signs of endocarditis are related to vegetations, it's true. Others are related to what is called circulating immune complexes which are combinations of antigens which may be infectious material, it may be other material or combinations of those along with antibodies, and those circulating immune complexes can go through the bloodstream and can cause various systemic complaints. As I mentioned earlier, that can occur in both right and left.
Q. Do you agree that in right-sided endocarditis you have embolization to the lung?
A. Yes.
Q. If you have embolization with left-sided endocarditis where does it go?
A. It can go anywhere in the body depending where the bloodstream carries the embolus. It can go to the brain. It can go to the spleen. It can go to the kidneys, really any organ.
Q. Wouldn't you agree there was a much greater

Page 43

probability of there being outward signs of endocarditis if a patient had left-sided endocarditis as opposed to right-sided?
A. Yes.
Q. So with right-sided endocarditis you can have pulmonary conditions because of embolization to the lung?
A. Yes, as one of the manifestations of right-sided endocarditis.
Q. Do you agree that if the emboli are small enough they would not show up on a chest X-ray?
A. That's true.
Q. So even if David Gonda had a normal chest X-ray, that does not rule out embolization either from a thrombosis in his right ventricle or from a vegetation in his right ventricle to the lung, correct?
A. That does not rule it out, that's true.
Q. Does the standard of care require a doctor to follow-up on an abnormality found during diagnostic testing?
A. Yes.
Q. Do you *agree* that the EKG that Dr. Ruiz performed in 1995 was abnormal?
A. Yes.
Q. What was the abnormality?

Page 44

A. One abnormality is the heart rate which on that date on the EKG was 120 beats per minutes. There are also some STT wave changes in a few of the leaves.
Q. Do you have an opinion based on medical probability as to the cause of that abnormality?
A. There are a number of possibilities that would include systemic illness. Sometimes electrolyte abnormalities can lead to changes like this. Dehydration can lead to changes like this sometimes or even related to the heart rate itself being high. Those are not, as I mentioned before, they are non-specific, and they don't necessary suggest a specific cardiac abnormality.
Q. Could bacterial endocarditis cause that type of abnormality?
A. Indirectly, yes, it can.
Q. Could endomyocardial fibrosis cause that kind of abnormality?
A. Yes.
Q. Doctor, isn't it more probable than not that David Gonda was suffering either from bacterial endocarditis or endomyocardial fibrosis at the time of that EKG in 1995?
A. More likely than what?
Q. More likely than not.

Page 45

A. Yes.
Q. Do you have an opinion based on medical probability as to the onset of David Gonda's either bacterial endocarditis or endomyocardial fibrosis?
A. I believe that it was present for several weeks prior to his death.
Q. Is it more probable than not that either endomyocardial fibrosis or bacterial endocarditis were causing David Gonda's symptoms in June of 1995?
A. I think that may have been responsible for some of his symptoms; however, the presentation with cough and sore throat and some of the other respiratory symptoms I think are more consistent with a respiratory infection than with either endomyocardial fibrosis or infective endocarditis.
It's certainly possible he may have had more than one condition. For example, he may have indeed had either endomyocardial fibrosis or infective endocarditis at that time, but I believe that he may also have had a respiratory infection.
Q. Are you aware of whether or not a person can have both a bacterial endocarditis and endomyocardial fibrosis simultaneously?
A. I don't know.
Q. If David Gonda had bacterial endocarditis and

Page 46

there was embolization to the lung, could that produce a cough?
A. Yes.
Q. So that would be one explanation for the cause of David Gonda's cough?
A. That would be one explanation for the cause of his cough, yes.
Q. Is there anything about the disease process of endomyocardial fibrosis that could cause a patient to cough?
A. Again, I'm not an expert on that illness. I suspect that there could also be embolization from the lesions on the endocardium which could then embolize to the lungs and also cause a cough.
Q. If a patient is coughing, should the physician consider that the cough could be caused by an embolization to the lungs?
A. A cough is one of the most frequent symptoms that we encounter. A day does not go by in the office that somebody does not complain of a cough, and frequently we don't consider embolization to the lungs as a common cause of a cough.
Q. Isn't a cough for a week or two different than a continuous cough for ten weeks?
A. We see patients with both cough short duration

Page 47

and long duration. It's not unusual to see a patient who has had a persistent cough for a period of many weeks.
Q. If you had a patient that had both cough and [illegible] for six to seven weeks, would that lead you to consider there might be some more serious underlying condition?
A. You would consider that, yes, but what I can also say is that it's not unusual to see patients who have a persistent cough that persists despite appropriate empiric therapy which eventually over a period of weeks or even months goes away with the empiric therapy. So a persistent cough is not an unusual complaint.
Q. Would either laryngitis or pharyngitis cause the abnormality that was found on the EKG in 1995?
A. No.
Q. Laryngitis or pharyngitis does not cause a heart abnormality, correct?
A. Well, I guess it could indirectly in that it's common to have a fever associated either with pharyngitis or laryngitis, and fever is one of the causes of a sinus tachycardia which this patient had, and there are patients with sinus tachycardia that have developed related changes. That's because their heart is beating so fast that they develop STT abnormalities

Page 48

which are not present when their heart is beating at a more normal rate. So it's conceivable that pharyngitis and laryngitis could cause tachycardia changes because of the increase in the rate.
Q. Would either laryngitis or pharyngitis cause fever, cough, tachycardia, general malaise and a high white blood cell count?
A. They could, yes.
Q. Do you agree bacterial endocarditis could also cause those conditions?
A. Yes.
Q. Doctor, you have not reviewed the deposition transcript of Dr. Adornato?
A. No.
Q. So you have not taken his testimony into consideration in rendering your opinion, correct?
A. That's true.
Q. I want you to assume that on July 10th, 1995 Dr. Adornato called Dr. Ruiz and told him that he had done a fiberoptic laryngoscopy and as a result of that he ruled out laryngitis as a cause of David Gonda's symptoms.
What is the obligation of Dr. Ruiz at that point?
A. He mentions in his July 5th note that the patient was to see Dr. Adornato, and he mentioned in his plans

Page 49

from that day to refer to Dr. Cropp if nothing was found by Dr. Adornato, so apparently based on this fiberoptic laryngoscopy done by Dr. Adornato the patient was indeed referred to Dr. Cropp, and I believe that was indeed appropriate.
Q. If the fiberoptic laryngoscopy was negative and there was no gross pathology found, can you *agree* that as of July 10th, 1995 Dr. Ruiz had no diagnosis for David Gonda's condition?
A. His stated diagnoses of pharyngitis and laryngitis at that point had been ruled out. The fact that he referred the patient to Dr. Cropp suggests that he was considering a pulmonary problem as the cause of the patient's symptoms. I think the referral to a pulmonologist was appropriate for either a pulmonary condition or pulmonary infection.
Q. Doctor, do you agree that the standard of care required him to have David Gonda come in so that he could reassess at that point given that he did not have a diagnosis for his condition?
A. No.
Q. Why not?
A. The testing that had been ordered by Dr. Ruiz and testing done by Dr. Adornato had ruled out certain diagnoses, and at that point on for a patient who had

Page 50

fever, a cross-referral to a pulmonologist is very appropriate. The standard of care does not require at that point Dr. Ruiz as a primary care physician to bring the patient in to see himself.
Q. Do you agree that after July 10th, 1995 Dr. Cropp did not perform any diagnostic testing of David Gonda?
A. That's true.
Q. Do you agree that Dr. Ruiz did not order any diagnostic testing of David Gonda?
A. That's true.
Q. And you *think* that is meeting the acceptable standard of care when David Gonda was continuing to have fever and cough and general malaise?
MR. BANAS: I object. He has already testified to that.
A. As I mentioned earlier, there are times in evaluating and treating a patient that we treat the patient empirically, and that's entirely within the standard of care. The standard of care does not require that we necessarily continue the testing until we reach a definitive diagnosis. We use empiric trials of various agents in and at the same time to relieve the patient's symptoms.
There are times that when a patient's therapy is given and the patient improves, we never end up making

Page 51

a definitive diagnosis, and it happens quite commonly where after empiric treatment the patient feels better that we never put a name on what the patient had. So I don't think the standard of care necessarily requires further testing at that point.
Q. If on July 10th, 1995 you were treating D Gonda d pharyngitis and laryngitis had been ruled out, what diagnostic ti g would you order at that point?
A. I'm not sure I would have ordered any testing at that point. I think, as Dr. Ruiz did, I would have considered sending the patient to a pulmonary consultant. So I think the referral to the pulmonary consultant at that point was appropriate.
Q. Do you think that was acceptable even though the treatment was n working and ei was no diagnosis for his condition
A. That's true. In a patient with fever and cough which is not responding to empiric therapy, I believe that referral to a pulmonologist is appropriate.
Q. What was Dr. Cropp's diagnosis for David Gonda?
A. Chronic cough. He felt that it probably started with a viral infection, but his diagnosis as stated in his July 13th letter to Dr. Adornato was chronic cough. Based on his recommendation of the use of Doxycycline

Page 52

it appears as if he felt that the chronic cough was perhaps related to an atypical pathogen.
Q. Do you agree that his diagnosis was sinusitis for David Gonda?
A. He mentioned in his July 26th letter to Dr. Ruiz that the patient did have sinus drainage, and he recommended the Deconsal which is a decongestive medication.
Q. Did you read Dr. Cropp's deposition?
A. No.
Q. Are you aware of whether or not he testified that his diagnosis for David Gonda was sinusitis?
A. I don't know if he testified as to that diagnosis. What I can state though is based on the treatment of the patient with a decongestant for sinus drainage, that he appeared to treat the patient for sinusitis. I would point out that in the differential diagnosis of chronic cough, sinusitis is fairly high on that.
Q. Would sinusitis cause tachycardia, an abnormal EKG, fever, general malaise and cause the patient to be anemic?
A. It can, yes.
MR. TRAVERS: Could you go off the record for a moment?

Page 53

Thereupon, there was a brief recess.)
MR. RUF could you read back the t question?
THE NOTARY: ti "Would sinusitis cause tachycardia, an abnormal EKG, fever, general malaise and cause the patient to be anemic wer: "It can, yes."
BY M RUF:
Q. t what did Dr. Ruiz do to follow-up on the abnormal EKG?
A. He ordered a pericardial ultrasound
Q. In your practice have you ever ordered a pericardial nd?
A. No.
Q. Why not?
A. I've not been faced with a clinical situation in which I felt it was appropriate.
Q. Why isn't it appropriate?
A. I'm sorry?
Q. Why have you not been faced with a clinical situation in which it was appropriate?
Strike that. I'll ask another question.

Page 54

Have you diagnosed and treated patients with bacterial endocarditis?
A. Yes.
Q. And) ε never ordered a pericardial ultrasound to evaluate that patient; is that correct?
A. That's true.
Q. Do you agree that the appropriate diagnostic test to order if you suspect the p ıa : endocarditis is an echocardiogram or a TEE?
A. I believe the test that would be most appropriate if you consider a patient to possibly have endocarditis would be a blood culture and probably an echocardiogram.
Q. Doctor, could you take a look at Dr. Cropp's letter of July 26th, 1995 to Dr. Ruiz, page 2? Let me give you this, Doctor.
Would you agree that it t t it is unlikely that he has any causes of chronic cough such as sinusitis, asthma or gastric reflex?
A. Yes, it does say that.
Q. So given that letter would it be reasonable for Dr. Cropp to continue to have the diagnosis of sinusitis for David Gonda?
A. Well, in that letter he states that he felt the patient at that point did not have sinusitis.

Page 55

Q. At that point he realized the patient did t hav sinusitis
Did the standard f care require him to go back and reassess the patient?
A. Yes.
Q. What did he do to reassess?
A. May I see that letter, again, please?
Q. Certainly, Doctor.
MR. BLOMSTROM: what was the date of that?
THE WITNESS: That's the July 13th letter.
A. At that point his plan was to have Mr. Gonda continue using Doxycycline for the full 21-day course which, as I mentioned earlier, is important if one is considering and atypical pathogen. So he did not request any further evaluation at that time, but continued empiric treatment.
Q. Would you agree that as of the date of that letter neither Dr. Cropp nor Dr. Ruiz had a diagnosis for David Gonda's condition?
A. I believe that Dr. Cropp in recommending a 21-day course of Doxycycline was acting on a working diagnosis of an atypical respiratory infection. He did not state that specifically, but based on that prescription I

Page 56

believe that's what his working diagnosis was.
Q. Where in the records or in testimony do you find that Dr. Cropp diagnosed David Gonda as having an atypical -- I forgot.
A. Atypical respiratory infection.
I have not read his deposition. As I mentioned, based on this statement in his letter of July 13th, that using Doxycycline for a full 21-day course suggests that the physician is empirically treating an atypical infection.
Q. Does the letter state that he thinks David Gonda had an atypical infection?
A. No, although he does mention in the previous paragraph that the cause of the cough is likely viral, but certainly TWAR cannot be excluded. TWAR is a strain of chlamydia. That's one of the strains of an atypical pathogen, so it appears that he was treating an atypical infection, perhaps a TWAR infection, that he referred to in the previous paragraph.
I might point out if you're considering an atypical infection such as TWAR or microplasma, there aren't any good reliable tests for those atypical pathogens, so usually they're considered based on the clinical setting, in this case a persistent cough and fever not responsive to antibiotics. Usually if you

Page 57

consider that diagnosis and feel that it's at least likely, then you'll empirically treat with an agent such as Doxycycline.
Q. Could an ypical infection of the ng be caused l a piece f vegetation breaking off in a patient with bacterial endocarditis and embolizing to the lung?
A. I think that can be a cause of a persistent cough and fever. It's on what would be a list of atypical pathogens.
Q. If you had a pathogen in the heart and there was an embolization to the lung, could it also then cause an infection to the lung?
A. Yes.
Q. What diagnostic testing would you use to diagnose bacterial endocarditis?
A. As I mentioned earlier, usually blood cultures and echocardiogram.
Q. And that's blood cultures off antibiotics, correct?
A. True.
Q. But if you performed blood cultures on antibiotics they can produce a false negative, correct?
A. That's true.
Q. By the way, can I have that letter back so I don't lose it? It's two pages.

Page 58

Now, if you had performed blood cultures to diagnose bacterial endocarditis, would you have performed serial blood cultures?
A. Usually that's done, yes.
Q. How would you do that?
A. Usually I would refer the patient to a laboratory to have that done.
Q. Why would you perform serial cultures as opposed to just one culture?
A. There are times where bacteria can be intermittent, and if you do only the one blood culture you might miss the pathogen. A series of blood cultures would increase the likelihood that you would detect the pathogen in the blood.
Q. Would you agree that no serial blood cultures were performed on David Gonda from the time he first presented to Drs. Cropp and Ruiz up until his admission to St. Elizabeth's Hospital?
A. I agree.
Q. Do you agree that a blood culture is the single most important test in the diagnosis of endocarditis?
A. Yes.
Q. Do you agree that performing a blood culture is necessary to rule out bacterial endocarditis?
MR. TRAVERS: In who, Mark?

Page 59

MR. RUF: In a patient in which bacterial endocarditis is part of the differential.
MR. BANAS: well, I object because that's too broad a question.
MR. TRAVERS: Doctor, you can answer the question.
A. Could you repeat that, please?
Q. Sure. Do you agree that a blood culture is necessary to rule out bacterial endocarditis in a patient that has a differential that includes bacterial endocarditis?
A. That's difficult to answer. Certainly, as I mentioned earlier, the blood culture is the most important test in ruling in endocarditis. There are times where a patient can have so-called culture negative endocarditis. There can be some unusual organisms which don't grow in standard culture media. I don't think that it's necessary to have a blood culture to rule that out. It's helpful to have the blood culture to rule it in.
Q. If you wanted to rule out bacterial endocarditis you would need to perform blood cultures plus either an echo or TEE?

Page 60

A. Yes.
Q. And you would agree that was not done on David Gonda prior to his admission at St. Elizabeth's Hospital?
A. I agree.
Q. Do you agree that subacute bacterial endocarditis must be considered in the evaluation of every patient with fever of an unknown origin?
A. Not necessarily every patient.
Q. When would you not consider it as part of the differential?
A. If there appeared to be other signs and symptoms which would make the likelihood of some other diagnosis fairly likely.
Q. In a patient that had a fever for six to seven weeks, shouldn't bacterial endocarditis be included in the differential?
A. I think if there are signs or symptoms that suggest the possibility of another illness as the cause of the fever as well as those other symptoms, you would not necessarily need to include initially the endocarditis in the differential. For example, in this case, I can state specifically in this case that certainly the patient had fever, but the presence of cough and other respiratory symptoms along with the

Page 61

fever made the diagnosis of a respiratory infection very appropriate and empiric treatment of this respiratory infection very appropriate.
If a patient has fever alone without other associated symptoms that point to a probable diagnosis, then I think that endocarditis is more of a possibility. In a patient with fever and cough and respiratory symptoms, endocarditis is less likely.
Q. Do you think that bacterial endocarditis should have been included in the differential given that he had a fever of unknown origin and he had an abnormal EKG?
MR. BANAS: I'm going to object because Dr. Cropp did not know about the abnormal EKG.
BY MR. RUF:
Q. Go ahead, Doctor.
A. I think it would be included in a broad differential diagnosis. I might point out that in that differential diagnosis it is not necessary and not in the standard of care necessarily to specifically with specific diagnostic tests rule in or rule out every item in the differential diagnosis.
Q. Doctor, do you agree that the only diagnostic tests performed by Dr. Ruiz were a CBC, an EKG and a

Page 62

pericardial ultrasound?
A. He also performed a chest X-ray.
Q. And a chest X-ray?
A. That's true.
Q. Do you agree that those tests did not provide him with enough information to reach a definitive diagnosis for David Gonda?
A. That's true.
Q. I believe you also said that Dr. Cropp did not perform any type of diagnostic testing, correct?
A. I'm not aware of any.
Q. And he did not have enough information to reach a definitive diagnosis for David Gonda, correct?
A. That's true.
Q. Do you think that these doctors had an obligation to do anything further to try to reach a diagnosis?
MR. TRAVERS: Mark, we have been down that road a couple of times already. I'll suggest if the doctor cares to respond again he is welcome to, but if you ask this question again I'm going to start losing my patience.
MR. RUIZ: Fine. Tom.
A. As I mentioned earlier, I think it was appropriate and within the standard of care to

Page 63

empirically treat this patient for a possible atypical respiratory infection rather than to do further diagnostic tests. Dr. Cropp mentions in his letters that further diagnostic testing would be done if there was not a satisfactory response.
Q. Doctor, could you take a look at the CBC in Dr. Ruiz's *chart?*
Do you *agree* that David Gonda had a high white blood count?
A. Yes.
Q. Would that be consistent With an infectious process going on in his body?
A. Yes.
Q. And fever would also be consistent with an infectious process going on in his body?
A. Yes.
Q. Would the symptom of general malaise also be consistent with an infectious process going on inside his body?
A. Yes.
Q. Could an infectious process also cause tachycardia?
A. Yes.
Q. Let's go down. His hemoglobin was low, correct?
A. Yes.

Page 64

Q. What types of things could cause a low hemoglobin? Let me go through a couple of these first.
He had a low hemoglobin. He had a low hematocrit. He had a low MCV. He had a low MCH. He had low lymphocytes. He had high polys and high monocytes.
What types of conditions could cause this type of CBC?
A. Infections can cause this type of CBC. A neoplasm can cause this type of CBC. Essentially a lymphatic malignancy such as a lymphoma can cause that type of CBC. I think the differential could include two general categories; that being infectious malignancy, and connective tissue disease would be lower in that broad differential.
Q. Would any of those values suggest a low output from the heart?
A. Not necessarily, no.
Q. Could it be consistent with that?
A. I don't think that a low output of the heart would be necessarily the cause of those abnormalities, no.
Q. If another doctor suggested to Dr. Ruiz to do a further evaluation of this patient, would he have an obligation to perform a further evaluation of the

Page 65

patient?
MR. BLOMSTROM I'm going to object. That's such a vague question. I don't know how he can be reasonably expected to respond to it.
A. I think that he would have an obligation to insure that a further evaluation was performed, if not by himself, then by an appropriate consultant. In this case, in July after the patient was seen by Dr. Adornato, Dr. Ruiz referred the patient to Dr. Cropp for further evaluation.
Q. Let me read from Dr. Adornato's deposition on page 42.
Question: "Do you have any more observations of your telephone conversation with Dr. Ruiz other than what is recorded there?"
Answer: "Some substance of the conversation was probably that I looked this kid over, and I don't have anything more to help you with. Maybe you ought to evaluate him more thoroughly. That would be about it."
If that conversation in fact occurred, what would be Dr. Ruiz's obligation at that point?
A. His obligation would be either to evaluate the patient carefully himself or to refer the patient to a specialist who might be more qualified to perform that

Page 66

evaluation.
Q. Doctor, would you take a look at the chart note in the St. Elizabeth's report of 08-17-95?
A. The progress notes?
Q. I believe it's in the progress notes. Yes, it's in the progress notes. Do you have it?
A. There are a number of 08-17-95 entries. Which one?
Q. Let me show you. The 8:30 a.m. entry.
A. Pulmonary -- yes, I have that.
Q. Would you agree at the bottom of that note it states the 2 echo, question mark, tricuspid vegetation, clinically that could be put together if he did in fact have right-sided endocarditis?
A. It does say that, yes.
Q. Do you agree with that statement, Doctor, do you agree that right-sided endocarditis clinically would fit within the whole picture for David Gonda?
MR. TRAVERS: If as the note suggests, Mark, that there was vegetation on the tricuspid valve which was not the case here, right?
MR. BANAS: That's correct.
MR. RUF: Your

Page 67

objection is noted.
BY MR. RUF:
Q. Please answer the question, Doctor.
A. If the patient did have a right-sided -- I'm sorry. If the patient did have a tricuspid vegetation, then it's conceivable that his symptoms might be explained by that.
Q. So one of the explanations for David Gonda's clinical course could be right-sided endocarditis?
MR. BANAS: I'm going to object because you're not giving him the full -- you're not asking him to look to see whether or not there was vegetation.
Q. I'm asking you from a clinical perspective, Doctor.
A. Whether that would explain his entire presentation or his presentation at St. Elizabeth's Hospital in August?
Q. His entire presentation up to August 17th, 1995.
A. I don't think it explains his entire presentation, no.
Q. Why would it not explain his entire presentation?
A. Well, I think if someone has a tricuspid vegetation if they have a right-sided endocarditis, and as I mentioned earlier it's not clear that was the

Page 68

case, if someone does have that it would explain some portion of his presentation, specifically the fever, but not other portions of his presentation, for example, the respiratory symptoms, the sore throat, the cough that he complained of and the absence of other signs of right-sided endocarditis.
Q. Do you believe that an acceptable standard of care only requires a physician to make a diagnosis if the patient's presentation fits within clear classical symptoms of a disease?
A. No.
Q. Do you agree that medicine is an art?
A. It is both an art and science, yes.
Q. You agree that part of your skill as a professional comes into play when the patient has more subtle signs of a disease?
A. Yes.
Q. You would agree that recognizing more subtle signs of a disease or a more subtle clinical presentation is part of your education and training as a physician?
A. Yes.
Q. Do you agree that after David Gonda's death we still cannot rule out bacterial endocarditis as the cause of his death?

Page 69

A. The diagnosis made by the Cleveland Clinic pathologist was endomyocardial fibrosis, and Dr. Hoffman has offered the opinion that this was actually endocarditis. I guess based on that we cannot rule out that the patient did have endocarditis.
Q. W y agree that it is especially true in light of the a- tha blood cultures were : performed on David Gonda off antibiotics while he was alive?
A. That's true.
Q. What are the characteristics of bacterial endocarditis?
A. Clinical characteristics?
Q. Why don't you start With symptoms. What are the symptoms of bacterial endocarditis?
A. I believe I mentioned them earlier.
MR. BANAS: I think we already answered that
BY MR. RUF:
Q. I don't think I asked you what all the symptoms are.
A. The primary symptom is fever. In addition to fever patients usually have musculoskeletal complaints, often low back pain, joint aches, sometimes joint effusion, swelling of the joints. In addition they

Page 70

have at times other signs including Osler nodes, Janeway lesions, splinter hemorrhages, splenomegaly, enlargement of the spleen. Right-sided endocarditis will be accompanied by hepatomegaly, enlargement of the liver. A general malaise is often complained of. I think those are the primary clinical characteristics.

Q. Do you agree that typically the fever spikes at night in a patient with endocarditis?

A. Well, I think that's true with many or most infectious illnesses. In fact, the normal temperature is normally higher at night; so when someone is ill, often the fever spikes are higher at night.

Q. Do you agree that David Gonda's fever spiked at night?

A. I believe so. I think that's characteristic of but not exclusive to the diagnosis of endocarditis. As I mentioned, just about any infection with just perhaps a few exceptions will have the highest temperatures at night.

Q. Do you agree that bacterial endocarditis is described as a flu-like illness?

MR. TRAVERS: By whom?

MR. BANAS: By whom?

MR. RUE By doctors and the medical literature.

Page 71

A. It has been described as such if the patients complain of fever, malaise, diffuse aches, yes.

Q. After July 10th of 1995 what were the most likely diagnoses to explain David Gonda's condition?

A. At that point he was a patient with persistent fever, persistent cough and some other respiratory symptoms including drainage, and based on that presentation I think that the most likely diagnostic considerations would include various respiratory infections including atypical pathogens.

Q. Do you *agree* that the functions of the heart and lungs are interlinked?

A. Yes.

Q. *So* a problem with *the* heart could cause a problem with the lung?

A. Yes.

Q. And a problem with *the* lung could cause a problem with the heart?

A. Yes.

Q. Is that something that a physician should take into consideration in either treating a heart or a lung condition?

A. I think it should be considered, yes.

Q. Do you *agree* that modern echocardiographic imaging is essential for optimal management of

Page 72

infective endocarditis?

A. Not necessarily.

Q. If a patient has endomyocardial fibrosis will that pro[illegible] an abnormal echocardiogram?

A. I believe so, yes.

Q. Do you agree that no echocardiogram was performed on David Gonda until August 16th, 1995?

A. I agree.

Q. Do you have an opinion based on a reasonable medical probability as to whether an echocardiogram had been done on 06-27-95 whether that would have been abnormal?

A. I don't have an opinion. I don't know.

Q. Do you have an opinion based on medical probability as to whether an echocardiogram would have been abnormal on 07-10-95?

A. I don't know.

Q. Do you have an opinion based on medical probability as to whether an echocardiogram or TEE would have been abnormal at any time prior to the admission to St. Elizabeth's Hospital on August 15th, 1995?

A. I don't know when the echocardiogram or TEE would have become abnormal.

Q. Have you diagnosed or treated patients with

Page 73

bacterial endocarditis?

MR. BANAS: I object. He has already answered that.

A. Yes, I have.

Q. Have you treated or diagnosed patients with both subacute and acute bacterial endocarditis?

A. Only subacute bacterial endocarditis.

Q. Do you agree that the difference between acute and subacute bacterial endocarditis is the amount of time that it takes place for the disease to occur?

That was probably an inarticulate question.

MR. BANAS: Motion to strike.

BY MR. RUF:

Q. What is the difference between acute and subacute bacterial endocarditis?

A. Primarily the time course of the illness, and that often is determined by the organism causing the infection.

Q. And do you agree with acute bacterial that usually involves a matter of days?

A. Yes.

Q. And with subacute it involves a matter of weeks and months?

A. Yes.

Page 74

Q. Have you ever made the diagnosis of bacterial endocarditis?
A. Yes.
Q. How did you do that?
A. Through blood cultures and echocardiogram.
Q. Have you ever missed the diagnosis of bacterial endocarditis and it was subsequently diagnosed by another doctor?
A. Not that I'm aware of.
Q. For the patients that you have had with bacterial endwarditis, have you referred those patients to another type of physician, or have you treated them yourself?
A. I referred them to an infectious disease specialist.
Q. Is there a specific infectious disease specialist that you refer them to?
A. No.
Q. Do you know what the treatment is for bacterial endocarditis?
A. Usually the treatment is based on antibiotic therapy. There are times when surgery is required, but usually it's antibiotics.
Q. Do you have an opinion as to the survival rate for a patient with bacterial endocarditis?

Page 75

A. It varies considerably based on a number of factors including the patient's age and whether or not they have preexisting heart disease and which organism is causing the endocarditis and how early or late it is diagnosed and whether appropriate antibiotics are used and whether surgery is necessary. It is at times a treatable infection; other times it leads to valve dysfunction and sometimes can lead to death.
Q. Do you agree there was no valve involvement With David Gonda?
A. True, true. The pathology report mentioned the valves were delicate.
Q. Would you agree that increases his chance of survival and probability of cure?
A. I don't know that he had infectious endocarditis.
Q. Assuming he had infectious endocarditis --
MR. TRAVERS: Objection. Comparing him to a patient where he had been destroyed?
BY MR. RUF:
Q. -- is the survival rate for a patient with bacterial endocarditis with valve involvement lower than or higher than a patient without valve involvement?
A. I think it's unusual to have no valve

Page 76

involvement, and I can't state specifically how the survival compares without valve involvement.
Q. Do you agree for all pathogens that can cause bacterial endocarditis the survival is between 50 and 90 percent?
A. I believe that number is quoted in the literature, yes.
Q. And there is no way to determine the exact survival rate for David Gonda assuming that he had bacterial endocarditis without blood cultures being performed off antibiotics, correct?
A. If I assume that he had bacterial endocarditis, yes.
Q. Yes? You can't predict what his mortality would be unless he had blood cultures, correct?
A. I'm not sure I understand the question, Mark.
Q. Well, you said the survival rate depends on the type of pathogen involved, correct?
A. Yes, that was one of the factors involved, yes.
Q. And the only way to determine the type of pathogen involved is to perform blood cultures off antibiotics, correct?
A. Yes.
Q. And this was not done in this case, correct?
A. That's correct.

Page 77

Q. Do you agree that bacterial endocarditis is fatal if untreated?
A. It usually is, yes.
Q. Are you familiar with mural endocarditis?
A. That refers to endocarditis which involves the endocardium on the cardiac wall rather than the valves.
Q. You are familiar with that entity?
A. Yes. It is rare.
Q. Are you aware that you do not always have a murmur with bacterial endocarditis?
A. I'm aware of that, yes.
Q. Wouldn't you only have a murmur if there was valve involvement?
A. I don't know that that's true. I think, for example, if someone had mural endocarditis, the blood rushing past that large vegetation can cause a sound that would be interpreted as a murmur.
Q. Could you have a mural endocarditis which does not cause a murmur?
A. That's conceivable, yes.
Q. Do you have an opinion as to whether the mass that was observed on autopsy at the Cleveland Clinic is the type of mass that you would find with bacterial endocarditis? If you don't have an opinion, tell me. If you do, then tell me.

Page 78

A. Based on the fact that they did not make that diagnosis, I suspect that it would not be the sort that would be seen in infective endocarditis.
Q. Could it be consistent with bacterial endocarditis?
A. I guess it could, but I have no reason to question the diagnosis of the pathologist.
Q. Do you know the training and experience of the pathologist that performed the autopsy at the Clinic?
A. I do not.
MR. BANAS: How much more time are we dealing with here?
MR. RUF: I have got some more, and I've got to go through endomyocardial fibrosis.
MR. TRAVERS: You're talking about another hour.
MR. RUF At least. I'll try to speed it up. I might have covered some of this already.
BY MR. RUF:
Q. Did you ever hear of endomyocardial fibrosis before this case?
A. No.
Q. Would you *agree* that everything you know about

Page 79

endomyocardial fibrosis comes from the medical literature?
A. Yes.
Q. You have had no personal experience with endomyocardial fibrosis?
A. That's true.
Q. Did you perform any type of research on endomyocardial fibrosis?
A. I previously read the section in the cardiology textbook on endomyocardial fibrosis.
Q. Which cardiology textbook?
A. Braunwald.
Q. Do you know what edition that was?
A. No, I don't.
Q. So all of the knowledge that you have about endomyocardial fibrosis comes from reading Braunwald's textbook?
A. Yes.
Q. Do you know who first diagnosed endomyocardial fibrosis as a pathological entity?
A. No.
Q. Have you reviewed any medical literature about the survival of treatment of endomyocardial fibrosis?
A. Other than what is mentioned in the Braunwald chapter, no.

Page 80

Q. What do you understand about endomyocardial fibrosis?
MR. BANAS: No. You want a long dissertation as to everything he knows about it; is that what you want?
MR. RUF Sure.
BY MR. RUF:
Q. Why don't you tell me in general what you know about it?
A. As I mentioned a number of times earlier, it's a rare illness and is difficult to treat. Treatment often requires cardiac surgery, and the illness is often fatal.
Q. Do you know what the reported survival rates are for a patient that has undergone surgery for endomyocardial fibrosis?
A. No.
Q. Would it surprise you if there is literature that reports survival rates as high as 80 percent with surgical treatment?
A. Yes.
Q. Would you agree that if untreated endomyocardial fibrosis is universally fatal?
A. I believe it is, yes.
Q. Would you agree that the diagnosis is almost

Page 81

exclusively found in Africa and tropical countries?
A. I believe there have been reports of cases outside of that area.
Q. Do you know if there were more than a dozen reported cases in the U.S. in the last 20 years?
A. I don't know how many.
Q. Do you think it possible that doctors in the U.S. may have misidentified endomyocardial fibrosis in the U.S.?
A. I have no reason to believe that they have.
Q. Well, given that most doctors have no personal experience with endomyocardial fibrosis?
A. I think it reasonable to assume that some doctors may have made a mistake in diagnosing that disease in this country.
MR. BANAS: I object.
BY MR. RUF:
Q. Go ahead, Doctor.
MR. BANAS: If you know.
Q. Would you --
A. I don't know.
Q. Would you agree that's a possibility?
A. I guess it's possible.
Q. Are there other diseases that can cause fibrosis intheheart?

Page 82

A. Yes.
Q. What other diseases?
A. It can occur in conditions which involve excessive serotonin, and that would include carcinoid syndrome. Other instances in which serotonin is elevated include some of the diet drugs which have been used.
Q. Would a cardiothoracic surgeon be more qualified to testify as to the survivability of a patient with endomyocardial fibrosis than you?
A. Yes.
Q. Do you know any of the factors that are involved in the survivability for a patient with endomyocardial fibrosis?
A. No.
Q. Would a cardiothoracic surgeon be more qualified to testify as to the survivability for endomyocardial fibrosis than an infectious disease doctor or cardiologist?
A. Not necessarily.
Q. Well, a cardiothoracic surgeon is the one that would perform the type of surgery necessary to treat a patient with endomyocardial fibrosis, correct?
A. Yes.
Q. Do you know what the symptoms are of

Page 83

endomyocardial fibrosis?
A. I believe they are primarily symptoms of congestive heart failure or congestive pericarditis which would include shortness of breath, swelling of the legs. I believe cough can be a symptom. I believe that fever is probably included in the list of symptoms.
Q. Do you agree that the clinical manifestations of endomyocardial fibrosis with right-sided involvement include elevated jugular venous pressure?
A. As I mentioned, that would include symptoms of heart failure.
Q. Would you agree that David Gonda did not have elevated jugular venous pressure?
A. I don't recall that I have specifically said whether that was assessed for or not.
Q. It was not noted by any of the treating physicians in his records, correct?
A. Not that I could recall reading, no.
Q. Would you agree that endomyocardial fibrosis causes a prominent V wave?
A. I don't know.
Q. Would you agree that David Gonda did not have a prominent V wave?
A. I didn't read that was ever observed.

Page 84

Q. Do you agree that endomyocardial fibrosis can cause a rapid Y descent?
A. I don't know.
Q. Do you agree that David Gonda did not have a rapid Y descent?
A. I don't recall that I read that he was ever assessed for that.
Q. Here, actually I'm taking these statements out of Braunwald's heart disease;. Why don't I hand you a copy of that, Doctor?
Do you agree that endomyocardial fibrosis produces a protodiastolic gallop sound that may be heard along the lower sternal border?
MR. BANAS well, are we now , to read Braunwald and see whether or not what you're saying is the same thing that's in Braunwald; is that what we're doing?
BY MR. RUF
Q. I want to see whether David Gonda had any of these conditions according to this, Doctor.
A. That's listed in the section on right ventricular EMF.
Q. Do you agree that David Gonda did not have a protodiastolic gallop sound along the lower sternal

Page 85

border?
A. I don't know if he had it or not. It was not specifically described by any examiner. That does not mean that he did not have that. It was not described by anyone that examined him.
Q. Do you agree that in endomyocardial fibrosis the liver is usually large and pulsatile?
A. That's stated here.
Q. And do you agree that David Gonda's liver was not large and pulsatile?
A. No one who examined him described that.
Q. Would you agree that with endomyocardial fibrosis that splenomegaly is common?
A. Yes.
Q. Do you agree that David Gonda did not have splenomegaly?
A. Again, that was not described by any examiner.
Q. Do you agree with endomyocardial fibrosis peripheral edema is common?
A. Yes.
Q. And do you agree that David Gonda did not have peripheral edema?
A. I agree.
Q. Do you agree that the right atrium is often enlarged, sometimes massively so?

age 86

A. I do.
Q. Do you agree that David Gonda did not have an enlarged atrium, right atrium?
A. I don't believe that he did.
Q. Do you agree that with endomyocardial fibrosis a chest X-ray often shows cardiac enlargement?
A. Yes.
Q. Do you agree that the chest X-rays that were done on David Gonda did not show cardiac enlargement?
A. That's true.
Q. Do you agree that typically an echocardiogram for a patient with endomyocardial fibrosis demonstrate right ventricular thickening, obliteration of the apex or a dilated atrium?
A. That's stated here, yes.
Q. Doctor, you agree that the 08-16 echocardiogram and 08-17 TEE did not show any of those findings?
A. I agree.
Q. Do you agree that right ventricle endomyocardial fibrosis is characterized by fibrous obliteration of the right ventricular apex that diminishes the capacity of the chamber?
A. Yes.
Q. Do you agree that even on autopsy David Gonda did not have fibrous obliteration of the right ventricular

Page 87

apex that diminished the capacity of the chamber?
MR. TRAVERS: I don't think the doctor has been provided with Dr. Hook's deposition transcript. Do you have the autopsy report from the Cleveland Clinic, Doctor?
THE WITNESS: Yes, I do.
A. That's not mentioned in the autopsy report.
Q. Have you ever seen a picture of endomyocardial fibrosis
A. Mr. Travers showed me a picture of that today.
Q. Do you agree that typically it is a distortion of the wall in the heart such as that it appears that the heart is indented?
A. I don't know.
Q. Do you agree that this is not true of David Gonda?
A. I don't know whether his heart appeared indented or not.
Q. Is that noted in the autopsy report?
A. It is not in those terms, no.
Q. Do you agree With endomyocardial fibrosis pericardial effusion may be present?
A. Yes.
Q. Doctor, do you agree that David Gonda did not

Page 88

pericardial effusion t his a to St. Elizabeth's Hospital?
A. I agree.
Q. Do you agree that endomyocardial fibrosis is typified by fibrous endocardial lesions of the inflow portion of the right ventricle?
A. Yes.
Q. Do you agree that at autopsy the mass involved Gonda involved outflow
A. Yes.
Q. Given all those things that we just went through, Doctor, don't you think it's more probable than not that David Gonda did not have endomyocardial fibrosis?
A. I believe that it's certainly true that a number of the clinical findings were not present prior to his death. I have no reason to question, though, the autopsy done at the Cleveland Clinic. I know there have been opinions to the contrary from another pathologist, but I don't have any reason to question what was done at the Cleveland Clinic.
Q. Do you agree that in the autopsy performed at the Cleveland Clinic in the description of the cardiovascular system the words fibrosis or scarring are not used?
MR. TRAVERS: Mark, we'll

Page 89

stipulate to the report. Do you want him to read the whole report and see if those words are in there? Do you think it serves a useful purpose at this time of day?
MR. RUF yes, I think it does.
MR. TRAVERS: You don't have to do that, Doctor.
A. I don't see the word fibrosis.
Q. Doctor, do you agree that you have to have fibrosis or scarring of the heart to have endomyocardial fibrosis?
A. I don't know.
Q. Do you agree that unusual presentations of infections are becoming more common?
A. Yes.
Q. And that's something that doctors should be alert to these days?
A. Yes.
Q. Do you agree that mitral valve prolapse can be a predisposing factor to endocarditis?
MR. TRAVERS: Mark, that's enough. You're not going to ask any more questions that have nothing to do with

Page 90

this case. Is there any evidence that he had mitral valve prolapse?
MR. RUF: There was a concern that he had it in years prior.
BY MR. RUF:
Q. Doctor, could you please answer the question?
A. What I can state is if in prior years the patient had a systolic click which can be a sign of mitral valve prolapse, the concern is that a patient with mitral valve prolapse is predisposed to infection of the mitral valve which there is no concern that this patient had at that time. Also, mitral valve prolapse does not predispose to infectious endocarditis in the right side of the heart.
Q. Doctor, do you *agree* that David Gonda may have had a defect in the heart that caused the difference between the 1989 EKG and the 1995 EKG?
MR. TRAVERS: I don't think he has established that there was a difference.
Q. Doctor, was there a difference between the 1989 EKG performed by Dr. Ruiz and the 1995 EKG?
A. I believe there was. The 1989 EKG was very difficult to read, though, such a light copy.
Q. Do you agree that David Gonda developed a defect

Page 91

in his heart in that period of time that caused the difference?
A. I mentioned earlier that the difference in the EKG could very well have been explained by a number of factors related to his illness at that time. I don't think we need to consider a heart defect as the cause of the difference.
Q. If he had a defect in his heart, wouldn't that make him susceptible to developing bacterial endocarditis?
MR. BANAS: He just said he had no defect. You can't have it both ways.
BY MR. RUF:
Q. **Assuming that he did have a defect, would that make him susceptible to developing bacterial endocarditis?**
A. Preexisting cardiac disease is a risk factor for infective endocarditis. I have no evidence at all that Mr. Gonda had any kind of heart defect prior to his illness.
Q. Does the standard of care require a physician to not perform a diagnostic test if the physician is not qualified to perform the test?
MR. BLOMSTROM: objection.

Page 92

You have got a double negative in there.
BY MR. RUF:
Q. **Did you understand the question, Doctor?**
A. No.
Q. If a physician is not qualified to perform a diagnostic test, what is his obligation?
A. If he feels that the diagnostic test is necessary, to refer the patient to another physician that is qualified to perform that test.
Q. If a radiologist has a technician perform a test, should the technician be qualified to perform that test?
MR. BLOMSTROM: Objection.
A. Yes.
Q. I'm reading from the deposition of Janet Sainato, the technician that worked for Dr. Hafiz, page 14.
MR. TRAVERS: Mark, I can make this easier for you, if you let me interrupt. You are entitled to question the doctor ad nauseam concerning opinions that we plan to use at trial through his direct testimony. He has already indicated to you at the very outset that he did not consider himself qualified to render opinions on Dr. Hafiz and the

Page 93

practice of radiology.
We have no intention of using this witness to introduce any evidence in that regard, and you're not going to ask him a bunch of radiology questions at this point.
MR. RUF: No, but I am going to ask him some limited questions.
MR. TRAVERS: Not having to do with the practice of radiology, you're not.
BY MR. RUF:
Q. Doctor, the following testimony was given by the identified witness:
Question: "Had you ever prior to the day you did the ultrasound on David Gonda looked for fluid around the heart?"
Answer: "No."
Question: "Have you done it since?"
Answer: "No."
Question: "Are you specifically trained to look for fluid around the heart?"
Answer: "No."
Given that was the testimony, what was the obligation of Dr. Hafiz as far as whether or not to

Page 94

continue this test and whether or not to write a report?
MR. BLOMSTROM objection.
MR. TRAVERS: Doctor, you are welcome to use your independent judgment as to whether you want to answer the questions or not. I'm telling you that as a matter of law you have no duty to answer them. I'll leave that up to you.
BY MR. RUE
Q. Please, answer the question.
MR. BLOMSTROM YOU have not read all of the relevant information that was in the deposition.
Q. Doctor, can you please answer the question?
A. Could you repeat the question, please?
Q. Would you want a radiologist with a technician who was not qualified to perform a test, to actually perform a test on your patient and render a report?
A. If I assume that the radiologist is qualified to perform the test --
Q. Yes?
A. -- and if that radiologist was present during the performance of the test.

Page 95

Q. Don't you think that the operator of the ultrasound has something to do with the accuracy of the test?
A. Yes, that's true. On the other hand it's fairly common to have some testing done with the supervision of a qualified person, and I would assume that if Dr. Hafiz felt that the test had been performed appropriately and he felt that the conclusion of the test was accurate, then he would not need to do anything further.
Q. If he did not think he was qualified to perform the test would he have an obligation to notify the primary care physician of that fact?
A. He being the radiologist or the technician?
Q. The radiologist.
MR. BLOMSTROM I'm going to object. Actually the evidence is to the contrary.
BY MR. RUE:
Q. Please, answer the question, Doctor.
A. I guess, again not knowing the specifics of Dr. Hafiz's training and qualifications to do a pericardial ultrasound, if you ask me the hypothetical question, if the physician feels that he is not qualified to either perform or interpret or evaluate

Page 96

the test, then I believe it is his obligation to inform either the referring physician or to find someone who can do the test. Given that that was based on a hypothetical that you presented to me without any knowledge of the facts.
Do we have the report? I can't find the report of the echocardiogram that was done in August. I have the preliminary report. Is there a formal report?
MR. BLOMSTROM: Of the one in August that was done in the hospital? There is one in the progress record that I have of. That has nothing to do with my client, but it is in the progress note.
BY MR. RUE:
Q. Do you agree there was not much correspondence or communication between Drs. Cropp and Ruiz during the treatment of David Gonda?
MR. TRAVERS: You mean every time they saw him?
A. We referred to a series of letters written from Dr. Cropp to Dr. Ruiz during July and August of 1995. I believe that after each of those visits Dr. Cropp communicated to Dr. Ruiz. There was a letter written after the July 13th visit, the July 25th visit and also

Page 97

I believe the August 8th visit.
Q. When you refer a patient to a specialist do you call the specialist to find out what their findings are and discuss the situation with the patient?
A. If I don't hear from the specialist by some other means, there are times where I'll call the specialist. Often the specialist will call me. Usually the communication is via letter.
Q. Do you know Dr. Hoffman?
A. No.
Q. Do you know Dr. Morgenstern-Clarren?
A. Yes.
Q. He's in the same facility?
A. Yes.
Q. Do you respect him as an internist?
A. Yes, I do.
Q. Do you know any other doctors that are involved in this case?
A. No.
Q. Do you have a friendship with any of the lawyers or doctors that are involved in this case?
A. No.
Q. Do you think that David Gonda's death was inevitable?
MR. BANAS: well, I'm

going to object. That's an unfair question, and I would suggest the doctor not answer that one. What you're doing is taking this out of the realm of medical malpractice.

MR. RUF: No, it isn't.

MR. BANAS: It certainly is.

MR. TRAVERS: Mark, I can absolutely guarantee you that David Gonda's death was inevitable. Are you asking about the timing of it?

BY MR. RUF:

Q. Do you think that there was anything that medical science could do for David Gonda?

MR. TRAVERS: I'm going to object to that question.

Q. Please, answer the question, Doctor.

A. Could we go off the record? I want to confer with Mr. Travers.

MR. TRAVERS: certainly.

MR. RUF Sure.

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

MR. TRAVERS: I'd just like

to state for the record in case there are any questions about this later, I have had a conference in private with the doctor who wanted my legal advice as to whether he had to answer the question, thinking that it's pretty impossible to answer if there is anything in the world that can be done for anybody, and I have told him he can answer the question if he chooses to.

As to whether there was anything within medicine that could have been done, he is prepared to answer the question that way, but he is not going to answer the question if there is anything in the whole universe that could be done for the patient.

BY MR. RUF

Q. Please, answer the question given that statement.

A. I don't believe that there was anything within the reasonable standard of care that Dr. Ruiz or Dr. Cropp should have done or could have done to prevent his death.

MR. RUF Thank you, Doctor.

MR. BANAS: I have no

questions. Good-bye.

MR. TRAVERS: Doctor, you have the right to review this transcript to make sure that the questions and answers were accurately taken down and transcribed by the reporter, or it's within your right to waive that if you don't care to read it. We've been at this a long time with a lot of technical words. If you're willing, it would be my suggestion that you read it.

THE WITNESS: I'd like to read the transcript.

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(DEPOSITION CONCLUDED.)

RAYMOND W. ROZMAN, JR., M.D. DATE

CERTIFICATE

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

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

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

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

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this 22nd day of February 1999.

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