

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.)	Case No. 96-CV-2055
)	Judge John M. Durkin
JUAN RUIZ, M.D., et al.,)	
)	
Defendants.)	

- - -

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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SCANNED
2/5/03

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1 APPEARANCES:

2

3 On behalf of the Plaintiffs:

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

9 JAMES L. BLOMSTROM, ESQ.
 10 Harrington, Hoppe & Mitchell, Ltd.
 11 1200 Mahoning Bank Building
 Youngstown, Ohio 44503
 (330) 744-1111

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

15 THOMAS J. TRAVERS, JR., ESQ.
 16 Manchester, Bennett, Powers & Ullman
 17 Atrium Level Two
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 201 East Commerce Street
 Youngstown, Ohio 44502-1641
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18 On behalf of Defendant Alan J. Cropp, M.D., Pulmonary
 19 Medicine Consultants, Pulmonary Rehabilitation
 Associates and Robert DeMarco, M.D:

20 GARY BANAS, ESQ.
 21 Buckingham, Doolittle & Burroughs, L.L.P.
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 P.O. Box 35548
 Canton, Ohio 44735
 (330) 492-9625

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CROSS-EXAMINATION BY

MR. RUF

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- - -

OBJECTIONS BY

MR. TRAVERS

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MR. BANAS

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MR. BLOMSTROM

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

2 a witness, called for examination by the Plaintiffs,
 3 under the Rules, having been first duly sworn, as
 4 hereinafter certified, deposed and said as follows:

5 CROSS-EXAMINATION

6 BY MR. RUF:

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

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

11 Q. What is your address. Dr. Rozman:

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

14 Q. Doctor, my name is Mark Ruf, and I along with
 15 David Malik represent the estate of David Gonda.

16 If at any time I ask you a question and you do
 17 not understand my question, please tell me. If you
 18 give me an answer to the question, I will assume you
 19 have understood the question, okay?

20 A. Yes.

21 Q. Did you bring your whole file with you?

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

25 Q. Could you quickly tell me what medical records

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

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

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

10 A. I'm sorry.

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

13 A. Yes.

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

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

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

20 A. Those are the only two depositions, yes.

21 Q. Have you reviewed any reports in this case?

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

25 Q. Any others other than Dr. Hoffman?

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1 A. I don't believe so, no.

2 Q. Does that cover everything that you reviewed in
3 order to form your opinions in this case?

4 A. Yes.

5 Q. I notice that you have two documents that are
6 annotations of depositions; is that correct?

7 A. Yes, there was one for the deposition of Dr. Ruiz
8 as well as one for the deposition of Dr. Hadley
9 Morgenstern-Clarren that were provided by Mr. Travers.

10 Q. Whose handwriting is on the annotations?

11 A. Mine

12 MR. RUF I would
13 request a copy of **those** two annotations.

14 MR. TRAVERS: I would be
15 willing to provide **those** to you since
16 you're a nice guy.

17 MR. RUF Thanks, Tom.

18 Same to you.

19 BY MR. RUF

20 Q. Doctor, when were you first contacted about
21 rendering an opinion in this case?

22 A. I believe it was sometime in 1998. I don't
23 recall exactly when Mr. Travers called me. It was
24 sometime in 1998.

25 Q. Have you exchanged any written correspondence

Page 7

1 with Mr. Travers?

2 A. Yes, I authored a brief report that I mailed to
3 Mr. Travers.

4 Q. Did you prepare a draft of that report?

5 A. No.

6 Q. Do you have any written correspondence between
7 you and Mr. Travers?

8 A. I have some letters provided to me by
9 Mr. Travers. I don't have them with me. They were
10 just brief summaries of the case.

11 MR. RUF I'd request
12 an opportunity to review **those** letters.

13 MR. TRAVERS: I'll consider
14 **it, Mark, if on your examination**

15 of Dr. Ro I mean, if **there are**
16 **in there that he relied upon for**
17 your &position, obviously you're entitled
18 to review them, but as far as if they
19 offered any assistance to him in rendering
20 his opinions for his deposition, I'm not
21 sure you're entitled to **see** them.

22 THE WITNESS: I can state I
23 have not used any communications from
24 Mr. Travers to formulate my opinions.

25 ///

1 BY MR. RUF:

2 Q. Do any of the letters contain factual summaries
3 or factual descriptions of Mr. Travers' impressions in
4 the case?

5 A. There is a brief summary of details of the case
6 in terms of dates of presentation, but not any specific
7 opinions of Mr. Travers.

8 Q. You did review those letters, correct?

9 A. Yes. It was generally prior to reviewing the
10 case. I believe I received a letter. That was the
11 first thing that I reviewed before I reviewed any
12 documents or other documents in the case.

13 Q. Did you use that correspondence to form a
14 preliminary opinion in the case?

15 A. No.

16 Q. When did you first give Mr. Travers your opinion
17 in the case?

18 A. I don't have with me the report that I authored.

19 MR. BANAS: Here, Tom.

20 Q. Did you do it by written report or orally?

21 A. I first spoke with Mr. Travers on the phone, and
22 based on our conversation at his request I authored a
23 report which was mailed to him June 29th of 1998.

24 Q. Did you give Mr. Travers any opinion by
25 telephone?

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1 A. Yes.

2 Q. What opinion did you give him?

3 A. I told him I felt that the actions of Dr. Ruiz
4 were appropriate and that they were within the
5 reasonable standard of care in this case.

6 Q. When you were first contacted by Mr. Travers did
7 you render any kind of opinion in the case at that
8 point?

9 A. Prior --

10 MR. TRAVERS: You mean

11 before receiving the records.

12 A. -- to receiving any documents?

13 Q. Correct.

14 A. No.

15 Q. Did he give you a factual summary of the case,
16 and did you give him your impressions of the case at
17 that time?

18 A. I don't remember that I did. He mentioned to me
19 he would be sending me some information and asked me to
20 review it and formulate my opinion based on that.

21 Q. What exactly did Mr. Travers ask you to do in
22 this case?

23 A. He asked me to review the records and to offer an
24 opinion as to whether Dr. Ruiz acted appropriately in
25 his care of Mr. Gonda.

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Page 12

1 Q. Do you know Dr. Ruiz?

2 A. No.

3 Q. Have you acted as an expert witness for

4 Mr. Travers in the past?

5 A. No.

6 Q. Do you know if you have served as an expert

7 witness for his law firm in the past?

8 A. I have not.

9 Q. Have you ever served as an expert witness for

10 Gary Banas in the past?

11 A. No.

12 Q. Have you ever served as an expert witness for

13 Mr. Blomstrom?

14 A. No.

15 Q. Have you ever served as an expert witness for the

16 law firm of Buckingham, Doolittle & Burroughs?

17 A. Yes, I have.

18 Q. How many times have you done that?

19 A. I believe in two cases.

20 Q. What were the issues in those cases?

21 A. I'm trying to recall the details of the cases.

22 It has been a while since I have reviewed those

23 records.

24 Q. Did either of those cases involve the failure to

25 diagnose a cardiac condition?

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Page 13

1 A. I can't recall.

2 Q. Do you know where those cases were?

3 A. No, I don't.

4 Q. What lawyer did you work with at the Buckingham,

5 Doolittle office?

6 A. Christopher Humphrey.

7 Q. Were you an expert witness on gastroenterology

8 issues or internal medicine issues in those cases?

9 A. I believe they were internal medicine, but I

10 can't recall specifically.

11 Q. Do you keep written records of the cases that you

12 have testified in or cases that you've served as an

13 expert witness in?

14 A. No.

15 Q. Do you keep track of that on the computer?

16 A. No.

17 Q. Are you Board Certified?

18 A. Yes.

19 Q. In what areas are you Board Certified?

20 A. In internal medicine and gastroenterology.

21 Q. Could you describe your practice for me, what

22 areas of medicine do you practice?

23 A. The majority of my practice is general internal

24 medicine, probably 85 percent or so. I also have a

25 subspecialty practice in gastroenterology which

1 comprises probably the other 15 percent of the

2 practice. I see patients in my office and do

3 gastroenterologic procedures at the surgery center in

4 this building.

5 Q. As part of your internal medicine practice do you

6 order blood cultures?

7 A. Yes.

8 Q. As part of your internal medicine practice do you

9 order echocardiograms?

10 A. Yes.

11 Q. Do you order TEEs as part of your internal

12 medicine practice?

13 A. Yes.

14 Q. Do you believe that the standard of care requires

15 the primary care physician to order those kinds of

16 tests if they're necessary to reach a diagnosis of a

17 patient?

18 A. If they are necessary, yes.

19 Q. How many times have you served as a witness in a

20 legal case?

21 A. Reviewing cases or --

22 Q. Either as an expert or a defendant.

23 A. I've been a defendant twice. I've not kept track

24 of the number of cases that I have been an expert in.

25 I would estimate it at probably 20 to 30 although

1 that's just a guess.

2 Q. It's 20 to 30 cases over what period of time?

3 A. Probably over a period of the past five or six

4 years.

5 Q. Have those cases all been local, or have

6 they been all around the state of Ohio and the

7 state of Ohio?

8 A. They have been generally local. I've reviewed

9 some cases in the, I guess, the Akron/Canton area, but

10 none really further than that.

11 Q. Did either of the cases in which you were a

12 defendant involve the failure to diagnose a cardiac

13 condition?

14 A. Yes.

15 Q. What was the issue in that case?

16 A. It was the first case in which I was named as a

17 defendant. He, the patient of a colleague of mine,

18 called me when I was on call on a Sunday morning

19 complaining of chest discomfort. I advised the patient

20 to go to an urgent care center which he did. He was

21 evaluated there and eventually was sent home and later

22 that day suffered a myocardial infarction. I was named

23 as a defendant in that case.

24 Q. Did you ever see that patient?

25 A. No.

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1 Q. Did you give a deposition in that case?
 2 A. Yes.
 3 Q. What was the name of that case?
 4 A. The patient's name was Dratler.
 5 Q. Do you know how to spell that?
 6 A. D-R-A-T-L-E-R, Phillip Dratler.
 7 Q. Was that a Cuyahoga County case?
 8 A. Yes.
 9 Q. Did the case go to trial?
 10 A. No.
 11 Q. It was resolved?
 12 A. Yes. I was dismissed as a defendant.
 13 Q. In the 20 to 30 cases where you have served as an
 14 expert witness, how often are you an expert for the
 15 doctor?
 16 A. All but two of the cases have been for the
 17 defense.
 18 Q. Do you in any way advertise your services to be
 19 an expert witness?
 20 A. No.
 21 Q. Have you ever served as an expert witness in a
 22 case involving the failure to diagnose endocarditis?
 23 A. Not I no.
 24 Q. I'm sure you have never served as an expert
 25 witness on a case involving endomyocardial fibrosis.

Page 15

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

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1 Q. What internal medicine texts do you have here in
 2 the library?
 3 A. Harrison's Principles of Internal Medicine.
 4 Q. Do you know what edition that is?
 5 A. I believe there is an older edition here in the
 6 library. The edition in my office is more recent.
 7 This is the tenth edition. I believe I have a more
 8 recent edition in my office.
 9 Q. Do you also have Cecil's?
 10 A. Yes, this is the 18th edition of Cecil. I also
 11 have Cecil in my office. I don't know what edition.
 12 Q. Do you have any other internal medicine texts
 13 here in the library?
 14 A. There are a number of them, yes.
 15 Q. What other ones do you have?
 16 A. You want me to list all of those?
 17 Q. Yes, please.
 18 A. Many of these are subspecialty textbooks relating
 19 to various subspecialties of medicine.
 20 Q. I'm just asking about internal medicine texts,
 21 Doctor.
 22 MR. TRAVERS: why don't we
 23 save this part of the examination until
 24 the end after we move across the hall?
 25 MR. RUF NO.

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1 A. I believe those are the only two general internal
 2 medicine textbooks. The others are subspecialty
 3 textbooks.
 4 Q. Have you found the information in those internal
 5 medicine textbooks to be accurate and reliable?
 6 A. Generally so, yes. I don't always agree with
 7 what I read there, but I think it is usually reliable
 8 and helpful.
 9 Q. Do you have any cardiology text or text on
 10 cardiovascular medicine?
 11 A. In the library?
 12 Q. Yes.
 13 A. The Braunwald textbook on cardiology is kept
 14 here.
 15 Q. Do you find the information listed in that
 16 textbook to be accurate and reliable?
 17 A. Generally so, yes.
 18 Q. If you were going to look up information on
 19 either bacterial endocarditis or endomyocardial
 20 fibrosis, would the Braunwald text be a reasonable
 21 source of information to consult?
 22 A. Yes.
 23 Q. Do you use any pocket diagnostic textbooks in
 24 your practice?
 25 A. Only one, the J. Sanford internal disease pocket

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Page 20

1 **handbook.**

2 Q. Do you regularly use the textbook of J. Sanford
3 in your practice?

4 A. I refer to the handbook, not to any textbook by
5 Dr. Sanford.

6 Q. What do you use that for?

7 A. If I need to choose an antibiotic for a specific
8 infection, often there are useful listings of
9 antibiotics for specific infections in that handbook.

10 Q. Do you find the information that is in that
11 handbook to be accurate and reliable?

12 A. Generally so.

13 Q. Does the standard of care require a physician to
14 consult medical texts and medical literature if the
15 physician cannot reach a diagnosis for a patient?

16 A. Not in all cases, no.

17 Q. In what cases would the standard of care require
18 consultation of literature or medical textbooks?

19 A. If the physician felt that he was unfamiliar with
20 the facts in the presentation of the patient, then
21 referring to a textbook would be within the standard of
22 care.

23 Q. Do you agree that neither Dr. Ruiz nor Dr. Cropp
24 ever consulted a medical textbook or medical literature
25 during the time they treated David Gonda?

Page 19

Page 21

1 A. I'm not aware that they did.

2 Q. Do you think that David Gonda's clinical
3 presentation required his treating physician to consult
4 either medical texts or medical literature?

5 A. Not necessarily, no.

6 Q. Why not?

7 A. I don't believe that there was any, from what I
8 can tell from the records, any question in Dr. Ruiz's
9 mind in terms of any factual issue in the case that
10 would require him to consult a textbook.

1 Q. I'm going to ask you whether you are qualified to
2 render opinions in a number of areas.

3 First of all, do you think you are qualified to
4 render an opinion as to the appropriate standard of
5 care for Dr. Ruiz?

6 A. Yes.

7 Q. Do you think you are qualified to render an
8 opinion as to the appropriate standard of care for
9 Dr. Cropp?

10 A. Yes.

1 Q. Have you formally been retained as an expert
2 witness for Dr. Cropp?

3 A. No.

4 Q. Do you think you are qualified to render an
5 opinion as to the appropriate standard of care for

1 Dr. Hafiz?

2 A. No.

3 Q. Are you qualified to give an opinion as to the
4 appropriate standard of care for a cardiologist?

5 A. I'm not a cardiologist and not an expert in
6 cardiology, but as an internist I work closely with
7 cardiologists and am familiar with their practice, so I
8 believe I can comment on the standard of care in
9 general with respect to cardiologists.

10 Q. Would you agree that With respect to the
11 diagnosis and treatment of cardiac conditions that
12 there is a higher standard of care for a cardiologist
13 than an internist or family doctor?

14 A. I think that would vary with the particular
15 cardiac condition. I think for certain cardiac
16 conditions that is true.

17 Q. What about for the conditions of either bacterial
18 endocarditis or endomyocardial fibrosis?

19 A. I believe that the standard of care for an
20 internist is probably the same as the standard of care
21 for a cardiologist in infective endocarditis.

22 Endomyocardial fibrosis is very rare, not
23 something that internists or primary care physicians
24 generally see, and I don't know whether the standard of
25 care would be any different for a cardiologist in that

1 situation as compared to an internist.

2 Q. So either an internist or a doctor of cardiology
3 would be qualified to work a patient up and reach a
4 diagnosis of bacterial endocarditis?

5 A. Yes.

6 Q. Is that also true of a pulmonologist?

7 A. Yes.

8 Q. Do you believe you are qualified to render an
9 opinion as to the appropriate treatment for either
10 bacterial endocarditis or endomyocardial fibrosis?

11 A. For bacterial endocarditis, yes. For
12 endomyocardial fibrosis, no.

13 Q. Are you qualified to render an opinion as to the
14 tests that are necessary to diagnose either bacterial
15 endocarditis or endomyocardial fibrosis?

16 A. Yes.

17 Q. Yes in both cases?

18 A. Yes. Again, endomyocardial fibrosis is a very
19 rare entity, and I cannot speak from an expert's
20 position on that.

21 Q. So you don't think you have the qualifications
22 necessary to render opinions on endomyocardial
23 fibrosis?

24 MR. TRAVERS: I'm going to
25 object. That's not what he said. You

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Page 24

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

5 BY MR. RUF:

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

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

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

12 A. Yes.

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

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

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

20 A. Yes.

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

23 A. No.

24 Q. Do you agree that a cardiologist or a
25 cardiothoracic surgeon with knowledge superior to

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

4 A. Yes.

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

7 A. I don't know.

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

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

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

18 A. Yes.

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

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

Page 23

Page 25

1 yours on issues involving bacterial endocarditis?

2 A. Possibly.

3 Q. Why do you say possibly?

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

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

10 A. I believe he is a general internist.

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

14 A. Yes.

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

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

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

25 A. Yes.

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

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

6 A. Yes.

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

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

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

16 MR. TRAVERS: I would
17 object to the question, Mark, because it's
18 too leading. He has answered you
19 already about diagnosis, but you're trying
20 to put it all in the same breath. I'm not
21 sure that's appropriate.

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

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

1 point to involve either a cardiologist or a
2 cardiovascular surgeon. As I mentioned earlier, it's
3 conceivable that a series of tests ordered by either an
4 internist or a cardiologist could result in that
5 diagnosis or at least a suspicion of that diagnosis.

6 Q. Do you have an opinion as to whether Dr. Ruiz or
7 Dr. Cropp at some point had an obligation to refer
8 David Gonda to either a cardiologist or infectious
9 disease specialist?

10 A. Could you repeat that, please?

11 MR. RUF: Could you
12 please read the question back?

13 THE NOTARY Question:

14 "Do you have an opinion as to whether
15 Dr. Ruiz or Dr. Cropp at some point had an
16 obligation to refer David Gonda to either
17 a cardiologist or infectious disease
18 specialist?"

19 A. I do have an opinion.

20 Q. What is your opinion?

21 A. That they were not obligated to refer Mr. Gonda
22 either to an infectious disease specialist or a
23 cardiologist.

24 Q. Why not?

25 A. I believe that based on their evaluation of the

1 patient when they saw him that there was no clear
2 evidence of a significant enough cardiovascular
3 condition to require that referral.

4 Q. If you were going to bring in a doctor as a
5 consultant to treat bacterial endocarditis, what type
6 of doctor would you consult?

7 A. An infectious disease specialist.

8 Q. If you were going to bring in a consultant to
9 treat a patient with endomyocardial fibrosis, what type
10 of doctor would you consult?

11 A. Probably either a cardiologist or a
12 cardiothoracic surgeon.

13 Q. Does the standard of care require a physician to
14 reach a diagnosis that explains a patient's symptoms?

15 A. Not necessarily, no.

16 Q. Why not?

17 A. It's not uncommon for us to treat a patient
18 without a definitive diagnosis, to treat the patient
19 empirically based on the patient's presentation without
20 ever having arrived at a definitive diagnosis. We
21 commonly give empiric treatment.

22 Q. So you do not believe it's a violation of the
23 standard of care not to reach a diagnosis for a
24 patient?

25 A. That's correct. That's our aim, but we're not

1 always able to achieve that, and often we institute
2 treatment prior to reaching a definitive diagnosis.

3 MR. BANAS: Mark, when
4 this is over I want to have a chat with
5 you because I want to make sure this
6 deposition never gets to a particular
7 place.

8 MR. RUF Fine. I'll
9 be happy to talk to you.

10 MR. BANAS: you know what
11 I'm talking about.

12 BY MR. RUF:

13 Q. Do you believe that the appropriate standard of
14 care not only requires a physician to treat a patient's
15 symptoms or disease, but it also requires that
16 physician to determine the underlying cause of those
17 symptoms?

18 A. As I mentioned, our goal is to try through
19 evaluating the patient to reach a diagnosis. But in
20 the practice of medicine we're not always able to
21 achieve that goal, and even prior to reaching a
22 definitive diagnosis the standard of care requires us
23 to treat the patient based on the presentation.

24 Q. If as a physician you are treating a patient's
25 symptoms and the patient is not getting better, does

1 the standard of care require you to go back and
2 reassess your treatment as well as your diagnosis?

3 A. Yes.

4 Q. Does the standard of care require a treating
5 physician to form a differential diagnosis for a
6 patient?

7 A. Yes.

8 Q. And the physician forms a differential diagnosis
9 based on signs and symptoms that the patient has?

10 A. Yes.

11 Q. When you're working with a differential
12 diagnosis, you rule in certain diagnoses and you rule
13 out certain diagnoses?

14 A. That's true. I should point out that we don't
15 always write that down, but that often we will not
16 write it down but still act on that differential
17 diagnosis.

18 Q. But whether or not it's written, there is an
19 obligation of the physician to form a differential
20 diagnosis?

21 A. Yes.

22 Q. Do you agree that a diagnosis is part of the
23 differential and it is not

24 A. Through evaluating the patient and tests we often
25 rule diagnoses in or out of the differential diagnosis

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1 is probably the best way you could describe it.

2 Q. Does the standard of care require a primary care
3 physician to reassess his diagnosis and treatment if a
4 consultant rules out the working diagnosis of that
5 primary care physician?

6 A. Not necessarily. If we reach a point where we
7 call a consultant in to evaluate a patient, often at
8 that point the evaluation of the patient is in the
9 realm of the consultant and not necessarily going back
10 to the primary care physician.

11 Q. What if as a primary care physician you refer a
12 patient to a consultant because you suspect a
13 particular condition in that patient, the consultant
14 evaluates the patient and tells you that that diagnosis
15 is not correct, at that point what is your obligation?

16 A. I think there would be an agreement between the
17 consulting physician and the primary care physician as
18 to who would evaluate the patient further.

19 MR. TRAVERS: I generally
20 don't like to interrupt, Mark, but I
21 thought you knew this case. You're losing
22 me here. Are you talking about Adornato
23 as a consultant for Ruiz?

24 MR. RUF: I'm talking
25 about in general first. He is rendering

1 in addition to that, but it is not true that we must do
2 diagnostic tests to reach a definitive diagnosis if
3 that is reachable without specific testing.

4 Q. But if you cannot reach a definitive diagnosis
5 just based on the history and physical, then there is
6 an obligation to perform diagnostic tests. Is that
7 correct?

8 A. With the exception of the situation that I
9 mentioned earlier, that's fairly common where we use
10 empiric treatment where we treat a patient as if they
11 have a particular diagnosis, often giving the patient a
12 so-called therapeutic trial, and at that point we will
13 often deliver the treatment rather than to do further
14 testing. The response or reaction to the treatment is
15 even then used to either rule in or rule out the
16 diagnosis.

17 Q. In this case would it be the medical
18 history for Dr. Ruiz and Dr. Cropp to leave
19 David Gonda's high fever and general malaise
20 as far as the diagnosis?

21 MR. B.: Now, I object
22 to that. That's based on the records
23 show, but go ahead, Doctor.

24 A. All I can say is as I mentioned earlier, that we
25 do not necessarily do diagnostic tests up until the

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1 opinions as to standard of care, and I
2 think I'm entitled to ask some general
3 questions first.

4 MR. TRAVERS: Not if they
5 don't have anything to do with the case.
6 I'm not going to argue with you. You can
7 ask your questions, but I genuinely can't
8 follow you, and I'm at a point here where
9 I'm lost.

10 BY MR. RUF:

11 Q. Did Dr. Ruiz and Dr. Cropp have a duty to perform
12 diagnostic testing on David Gonda until they reached a
13 definitive diagnosis?

14 A. Diagnostic tests are often done in the evaluation
15 of a patient. It doesn't necessarily have to be done
16 either at or subsequent to each patient visit.

17 Obviously diagnostic testing is commonly done in trying
18 to reach a definitive diagnosis, but not necessarily at
19 every visit.

20 Q. Does the standard of care require sufficient
21 diagnostic testing so that you can reach a definitive
22 diagnosis for a patient?

23 A. We can sometimes reach a definitive diagnosis
24 based on the history and physical alone. There are
25 times quite often where we need to do diagnostic tests

1 point we reach a definitive diagnosis and then
2 institute treatment. Often treatments and evaluations
3 go in parallel. We will often treat a patient at the
4 same time we're getting tests done. As I mentioned
5 earlier, we'll sometimes treat a patient empirically
6 without getting any further tests, and only test
7 further if the empiric treatment is not effective.

8 So it seems with your questions that you're
9 suggesting that we do a series of tests until we reach
10 a definitive diagnosis and at that point institute
11 treatment, and that's not necessarily the case. Often
12 treatment and evaluation go parallel. There are times
13 when successful, let's say, resolution of symptoms with
14 empiric treatment will preclude further tests. If
15 symptoms persist or worsen or new symptoms develop,
16 then often times that will mandate further testing.
17 I hope that's clear.

18 Q. Well, given the persistence of David Gonda's
19 symptoms do you believe there was an obligation to do
20 further testing on him?

21 MR. TRAVERS: At what point
22 in time are we talking about?

23 MR. RUF: Mid July.

24 A. May I refer to the notes?

25 Q. Certainly.

1 A. At a July 5th visit with Dr. Ruiz, Mr. Gonda
2 reported the continued cough and fever despite
3 Doxycycline, and at that point I believe it was
4 appropriate for Dr. Ruiz to refer Mr. Gonda to a
5 specialist, for example, Dr. Cropp and/or Dr. Adornato.
6 I believe that's the last time Dr. Ruiz saw Mr. Gonda.
7 I'm looking for Dr. Cropp's record. Dr. Cropp
8 saw Mr. Gonda in the office on July 13th, 1995, and at
9 that point Mr. Gonda reported persistent symptoms.
10 Dr. Cropp mentioned that he had been on a number of
11 antibiotics, but pointed out he had taken the
12 Doxycycline only for seven days, and based on his
13 evaluation that day he recommended a 21-day course of
14 Doxycycline as well as other treatments, Vanceryl and
15 Tessalon perles, and he arranged follow-up for the
16 patient.
17 So as of that July 13th, '95 visit, I assume
18 that's what you mean by mid July, I think at that point
19 it was appropriate for Dr. Cropp to continue the
20 Doxycycline because especially for atypical pathogens
21 as he was considering in this case, it is necessary to
22 use Doxycycline for longer than a 7-day course because
23 quite commonly for an atypical infection the
24 Doxycycline needs to be used for a longer period of
25 time. So I think that was appropriate.

1 Q. Do you agree that David Gonda's symptoms
2 persisted despite the administration of " " "
3 A. He saw Dr. Cropp again on July 25th, 1995, and at
4 that point he appeared to have improved somewhat but
5 still was not normal. He still had a number of
6 respiratory complaints.
7 Q. He continued to have fever on that visit,
8 correct?
9 A. Yes.
10 Q. And he continued to have a cough on that visit,
11 correct?
12 A. Yes.
13 Q. So would you agree that those symptoms persisted
14 despite the administration of Doxycycline?
15 A. They improved but were still present, and based
16 on that presentation on the 25th, Dr. Cropp recommended
17 discontinuing the Tessalon and Vanceryl and asked the
18 patient to use a decongestant, Deconasil, too, and
19 placed a PPD. He again arranged follow-up in two weeks
20 and mentioned if the patient was not better at that
21 time he would proceed with a further diagnostic test, a
22 bronchoscopy.
23 Q. Do you agree that the standard of care for a
24 physician requires that physician to provide treatment
25 to a patient that improves the patient's condition?

1 A. Yes.
2 Q. Do you agree that David Gonda when he presented
3 to St. Elizabeth's hospital had a history of coughing,
4 fever and general malaise for ten weeks?
5 A. Yes.
6 Q. Do you agree that on every office visit to
7 Dr. Cropp that David Gonda had abnormal vital signs?
8 A. Yes.
9 Q. Do you agree that on every office visit to
10 Dr. Ruiz that David Gonda had abnormal vital signs?
11 A. Yes.
12 Q. Based on your review of the records was there any
13 improvement in David Gonda's condition during that
14 ten-week period of time?
15 A. There appeared to be some temporary improvement
16 in some of his symptoms.
17 Q. But even though there was temporary improvement,
18 his symptoms persisted, correct?
19 A. Yes.
20 Q. Do you agree that the standard of care requires a
21 physician to reassess their treatment if the treatment
22 is not working?
23 A. Yes.
24 Q. Do you agree that there was no reassessment by
25 either Dr. Cropp or Dr. Ruiz of their diagnosis and

1 treatment?
2 A. I believe they did reassess the patient.
3 Q. When?
4 A. I believe they did that at each office visit.
5 Q. Do you know if Dr. Cropp or Dr. Ruiz ever changed
6 their diagnosis?
7 A. Yes, they did.
8 Q. Who changed their diagnosis?
9 A. At the 6-27-95 visit, Dr. Ruiz. His assessment
10 was viral pharyngitis, rule out pneumonitis, and then
11 at the subsequent visit on July 5th, 1995 -- let me
12 find it here -- his assessment was that of
13 laryngitis. Based on the presentation he was concerned
14 enough at that point to refer Mr. Gonda to Dr. Cropp.
15 Q. If an ENT consultant ruled out either pharyngitis
16 or laryngitis as the cause of David Gonda's symptoms,
17 does the acceptable standard of care require Dr. Ruiz
18 to reassess David Gonda and perform further testing?
19 A. I think it required him to reassess the patient,
20 but not necessarily to do further testing. At that
21 July 5th visit he referred the patient on to a
22 specialist which I think is one of the things that the
23 standard of care requires a physician to do if the
24 patient has not yet improved fully.
25 So I think it was appropriate for Dr. Ruiz at

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

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

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

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

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

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

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

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

21 A. I agree.

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

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

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

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

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

18 A. That's true.

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

21 A. Yes.

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

25 A. That's correct.

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

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

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

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

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

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

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

1 believe that he had other typical symptoms of
2 endocarditis.

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

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

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

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

1 A. Some of them are, yes.

2 Q. I ask that because often there is embolization of
3 portions of the vegetation, and if it's on the right
4 side of the heart it's going to go to different
5 portions of the body than the left side of the heart.

6 A. Some of the symptoms and signs of endocarditis
7 are related to vegetations, it's true. Others are
8 related to what is called circulating immune complexes
9 which are combinations of antigens which may be
10 infectious material, it may be other material or
11 combinations of those along with antibodies, and those
12 circulating immune complexes can go through the
13 bloodstream and can cause various systemic complaints.
14 As I mentioned earlier, that can occur in both right
15 and left.

16 Q. Do you agree that in right-sided endocarditis you
17 have embolization to the lung?

18 A. Yes.

19 Q. If you have embolization with left-sided
20 endocarditis where does it go?

21 A. It can go anywhere in the body depending where
22 the bloodstream carries the embolus. It can go to the
23 brain. It can go to the spleen. It can go to the
24 kidneys, really any organ.

25 Q. Wouldn't you agree there was a much greater

1 A. One abnormality is the heart rate which on that
2 date on the EKG was 120 beats per minutes. There are
3 also some STT wave changes in a few of the leaves.

4 Q. Do you have an opinion based on medical
5 probability as to the cause of that abnormality?

6 A. There are a number of possibilities that would
7 include systemic illness. Sometimes electrolyte
8 abnormalities can lead to changes like this.
9 Dehydration can lead to changes like this sometimes or
10 even related to the heart rate itself being high.
11 Those are not, as I mentioned before, they are
12 non-specific, and they don't necessary suggest a
13 specific cardiac abnormality.

14 Q. Could bacterial endocarditis cause that type of
15 abnormality?

16 A. Indirectly, yes, it can.

17 Q. Could endomyocardial fibrosis cause that kind of
18 abnormality?

19 A. Yes.

20 Q. Doctor, isn't it more probable than not that
21 David Gonda was suffering either from bacterial
22 endocarditis or endomyocardial fibrosis at the time of
23 that EKG in 1995?

24 A. More likely than what?

25 Q. More likely than not.

1 probability of there being outward signs of
2 endocarditis if a patient had left-sided endocarditis
3 as opposed to right-sided?

4 A. Yes.

5 Q. So with right-sided endocarditis you can have
6 pulmonary conditions because of embolization to the
7 lung?

8 A. Yes, as one of the manifestations of right-sided
9 endocarditis.

10 Q. Do you agree that if the emboli are small enough
11 they would not show up on a chest X-ray?

12 A. That's true.

13 Q. So even if David Gonda had a normal chest X-ray,
14 that does not rule out embolization either from a
15 thrombosis in his right ventricle or from a vegetation
16 in his right ventricle to the lung, correct?

17 A. That does not rule it out, that's true.

18 Q. Does the standard of care require a doctor to
19 follow-up on an abnormality found during diagnostic
20 testing?

21 A. Yes.

22 Q. Do you agree that the EKG that Dr. Ruiz performed
23 in 1995 was abnormal?

24 A. Yes.

25 Q. What was the abnormality?

1 A. Yes.

2 Q. Do you have an opinion based on medical
3 probability as to the onset of David Gonda's either
4 bacterial endocarditis or endomyocardial fibrosis?

5 A. I believe that it was present for several weeks
6 prior to his death.

7 Q. Is it more probable than not that either
8 endomyocardial fibrosis or bacterial endocarditis were
9 causing David Gonda's symptoms in June of 1995?

10 A. I think that may have been responsible for some
11 of his symptoms; however, the presentation with cough
12 and sore throat and some of the other respiratory
13 symptoms I think are more consistent with a respiratory
14 infection than with either endomyocardial fibrosis or
15 infective endocarditis.

16 It's certainly possible he may have had more than
17 one condition. For example, he may have indeed had
18 either endomyocardial fibrosis or infective
19 endocarditis at that time, but I believe that he may
20 also have had a respiratory infection.

21 Q. Are you aware of whether or not a person can have
22 both a bacterial endocarditis and endomyocardial
23 fibrosis simultaneously?

24 A. I don't know.

25 Q. If David Gonda had bacterial endocarditis and

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1 there was embolization to the lung, could that produce
2 a cough?

3 A. Yes.

4 Q. So that would be one explanation for the cause of
5 David Gonda's cough?

6 A. That would be one explanation for the cause of
7 his cough, yes.

8 Q. Is there anything about the disease process of
9 endomyocardial fibrosis that could cause a patient to
10 cough?

11 A. Again, I'm not an expert on that illness. I
12 suspect that there could also be embolization from the
13 lesions on the endocardium which could then embolize to
14 the lungs and also cause a cough.

15 Q. If a patient is coughing, should the physician
16 consider that the cough could be caused by an
17 embolization to the lungs?

18 A. A cough is one of the most frequent symptoms that
19 we encounter. A day does not go by in the office that
20 somebody does not complain of a cough, and frequently
21 we don't consider embolization to the lungs as a common
22 cause of a cough.

23 Q. Isn't a cough for a week or two different than a
24 continuous cough for ten weeks?

25 A. We see patients with both cough short duration

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1 and long duration. It's not unusual to see a patient
2 who has had a persistent cough for a period of many
3 weeks.

4 Q. If you had a patient that had both cough and
5 fever for a week or two, would that
6 lead you to consider there might be some more serious
7 underlying condition?

8 A. You would consider that, yes, but what I can also
9 say is that it's not unusual to see patients who have a
10 persistent cough that persists despite appropriate
11 empiric therapy which eventually over a period of weeks
12 or even months goes away with the empiric therapy. So
13 a persistent cough is not an unusual complaint.

14 Q. Would either laryngitis or pharyngitis cause the
15 abnormality that was found on the EKG in 1995?

16 A. No.

17 Q. Laryngitis or pharyngitis does not cause a heart
18 abnormality, correct?

19 A. Well, I guess it could indirectly in that it's
20 common to have a fever associated either with
21 pharyngitis or laryngitis, and fever is one of the
22 causes of a sinus tachycardia which this patient had,
23 and there are patients with sinus tachycardia that have
24 developed related changes. That's because their heart
25 is beating so fast that they develop STT abnormalities

1 which are not present when their heart is beating at a
2 more normal rate. So it's conceivable that pharyngitis
3 and laryngitis could cause tachycardia changes because
4 of the increase in the rate.

5 Q. Would either laryngitis or pharyngitis cause
6 fever, cough, tachycardia, general malaise and a high
7 white blood cell count?

8 A. They could, yes.

9 Q. Do you agree bacterial endocarditis could also
10 cause those conditions?

11 A. Yes.

12 Q. Doctor, you have not reviewed the deposition
13 transcript of Dr. Adornato?

14 A. No.

15 Q. So you have not taken his testimony into
16 consideration in rendering your opinion, correct?

17 A. That's true.

18 Q. I want you to assume that on July 10th, 1995
19 Dr. Adornato called Dr. Ruiz and told him that he had
20 done a fiberoptic laryngoscopy and as a result of that
21 he ruled out laryngitis as a cause of David Gonda's
22 symptoms.

23 What is the obligation of Dr. Ruiz at that point?

24 A. He mentions in his July 5th note that the patient
25 was to see Dr. Adornato, and he mentioned in his plans

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1 from that day to refer to Dr. Cropp if nothing was
2 found by Dr. Adornato, so apparently based on this
3 fiberoptic laryngoscopy done by Dr. Adornato the
4 patient was indeed referred to Dr. Cropp, and I believe
5 that was indeed appropriate.

6 Q. If the fiberoptic laryngoscopy was negative and
7 there was no gross pathology found, can you agree that
8 as of July 10th, 1995 Dr. Ruiz had no diagnosis for
9 David Gonda's condition?

10 A. His stated diagnoses of pharyngitis and
11 laryngitis at that point had been ruled out. The fact
12 that he referred the patient to Dr. Cropp suggests that
13 he was considering a pulmonary problem as the cause of
14 the patient's symptoms. I think the referral to a
15 pulmonologist was appropriate for either a pulmonary
16 condition or pulmonary infection.

17 Q. Doctor, do you agree that the standard of care
18 required him to have David Gonda come in so that he
19 could reassess at that point given that he did not have
20 a diagnosis for his condition?

21 A. No.

22 Q. Why not?

23 A. The testing that had been ordered by Dr. Ruiz and
24 testing done by Dr. Adornato had ruled out certain
25 diagnoses, and at that point on for a patient who had

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1 fever, a cross-referral to a pulmonologist is very
2 appropriate. The standard of care does not require at
3 that point Dr. Ruiz as a primary care physician to
4 bring the patient in to see himself.

5 Q. Do you agree that after July 10th, 1995 Dr. Cropp
6 did not perform any diagnostic testing of David Gonda?

7 A. That's true.

8 Q. Do you agree that Dr. Ruiz did not order any
9 diagnostic testing of David Gonda?

10 A. That's true.

11 Q. And you *think* that is meeting the acceptable
12 standard of care when David Gonda was continuing to
13 have fever and cough and general malaise?

14 MR. BANAS: I object. He
15 has already testified to that.

16 A. As I mentioned earlier, there are times in
17 evaluating and treating a patient that we treat the
18 patient empirically, and that's entirely within the
19 standard of care. The standard of care does not
20 require that we necessarily continue the testing until
21 we reach a definitive diagnosis. We use empiric trials
22 of various agents in and at the same time to relieve
23 the patient's symptoms.

24 There are times that when a patient's therapy is
25 given and the patient improves, we never end up making

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1 a definitive diagnosis, and it happens quite commonly
2 where after empiric treatment the patient feels better
3 that we never put a name on what the patient had. So I
4 don't think the standard of care necessarily requires
5 further testing at that point.

6 Q. If on July 10th, 1995 you were treating
7 D Gonda d pharyngitis and laryngitis had been
8 ruled out, what diagnostic ti g would you order at
9 that point?

10 A. I'm not sure I would have ordered any testing at
11 that point. I think, as Dr. Ruiz did, I would have
12 considered sending the patient to a pulmonary
13 consultant. So I think the referral to the pulmonary
14 consultant at that point was appropriate.

15 Q. Do you think that was acceptable even though the
16 treatment was n working and a was no diagnosis
17 for his condition?

18 A. That's true. In a patient with fever and cough
19 which is not responding to empiric therapy, I believe
20 that referral to a pulmonologist is appropriate.

21 Q. What was Dr. Cropp's diagnosis for David Gonda?

22 A. Chronic cough. He felt that it probably started
23 with a viral infection, but his diagnosis as stated in
24 his July 13th letter to Dr. Adornato was chronic cough.
25 Based on his recommendation of the use of Doxycycline

1 it appears as if he felt that the chronic cough was
2 perhaps related to an atypical pathogen.

3 Q. Do you agree that his diagnosis was sinusitis for
4 David Gonda?

5 A. He mentioned in his July 26th letter to Dr. Ruiz
6 that the patient did have sinus drainage, and he
7 recommended the Deconsal which is a decongestive
8 medication.

9 Q. Did you read Dr. Cropp's deposition?

10 A. No.

11 Q. Are you aware of whether or not he testified that
12 his diagnosis for David Gonda was sinusitis?

13 A. I don't know if he testified as to that
14 diagnosis. What I can state though is based on the
15 treatment of the patient with a decongestant for sinus
16 drainage, that he appeared to treat the patient for
17 sinusitis. I would point out that in the differential
18 diagnosis of chronic cough, sinusitis is fairly high on
19 that.

20 Q. Would sinusitis cause tachycardia, an abnormal
21 EKG, fever, general malaise and cause the patient to be
22 anemic?

23 A. It can, yes.

24 MR. TRAVERS: Could you go
25 off the record for a moment?

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1 Thereupon, there was a brief
2 recess.)

3 MR. RUF could you
4 read back the t question?

5 THE NOTARY: ti

6 "Would sinusitis cause tachycardia, an
7 abnormal EKG, fever, general malaise and
8 cause the patient to be anemic

9 ver:

10 "It can, yes."

11 BY M RUF:

12 Q. t what did Dr. Ruiz do to follow-up on the
13 abnormal EKG?

14 A. He ordered a pericardial ultrasound

15 Q. In your practice have you ever ordered a
16 pericardial t and?

17 A. No.

18 Q. Why not?

19 A. I've not been faced with a clinical situation in
20 which I felt it was appropriate.

21 Q. Why isn't it appropriate?

22 A. I'm sorry?

23 Q. Why have you not been faced with a clinical
24 situation in which it was appropriate?

25 Strike that. I'll ask another question.

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1 Have you diagnosed and treated patients with
2 bacterial endocarditis?

3 A. Yes.

4 Q. And I never ordered a pericardial
5 ultrasound to evaluate that patient; is that correct?

6 A. That's true.

7 Q. Do you agree that the appropriate diagnostic test
8 to order if you suspect the patient has
9 endocarditis is an echocardiogram or a TEE?

10 A. I believe the test that would be most appropriate
11 if you consider a patient to possibly have endocarditis
12 would be a blood culture and probably an
13 echocardiogram.

14 Q. Doctor, could you take a look at Dr. Cropp's
15 letter of July 26th, 1995 to Dr. Ruiz, page 2? Let me
16 give you this, Doctor.

17 Would you agree that it is unlikely
18 that he has any causes of chronic cough such as
19 sinusitis, asthma or gastric reflux?

20 A. Yes, it does say that.

21 Q. So given that letter would it be reasonable for
22 Dr. Cropp to continue to have the diagnosis of
23 sinusitis for David Gonda?

24 A. Well, in that letter he states that he felt the
25 patient at that point did not have sinusitis.

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1 Q. At that point he realized the patient did not
2 have sinusitis

3 Did the standard of care require him to go back
4 and reassess the patient?

5 A. Yes.

6 Q. What did he do to reassess?

7 A. May I see that letter, again, please?

8 Q. Certainly, Doctor.

9 MR. BLOMSTROM: what was the
10 date of that?

11 THE WITNESS: That's the
12 July 13th letter.

13 A. At that point his plan was to have Mr. Gonda
14 continue using Doxycycline for the full 21-day course
15 which, as I mentioned earlier, is important if one is
16 considering an atypical pathogen. So he did not
17 request any further evaluation at that time, but
18 continued empiric treatment.

19 Q. Would you agree that as of the date of that
20 letter neither Dr. Cropp nor Dr. Ruiz had a diagnosis
21 for David Gonda's condition?

22 A. I believe that Dr. Cropp in recommending a 21-day
23 course of Doxycycline was acting on a working diagnosis
24 of an atypical respiratory infection. He did not state
25 that specifically, but based on that prescription I

1 believe that's what his working diagnosis was.

2 Q. Where in the records or in testimony do you find
3 that Dr. Cropp diagnosed David Gonda as having an
4 atypical -- I forgot.

5 A. Atypical respiratory infection.

6 I have not read his deposition. As I mentioned,
7 based on this statement in his letter of July 13th,
8 that using Doxycycline for a full 21-day course
9 suggests that the physician is empirically treating an
10 atypical infection.

11 Q. Does the letter state that he thinks David Gonda
12 had an atypical infection?

13 A. No, although he does mention in the previous
14 paragraph that the cause of the cough is likely viral,
15 but certainly TWAR cannot be excluded. TWAR is a
16 strain of chlamydia. That's one of the strains of an
17 atypical pathogen, so it appears that he was treating
18 an atypical infection, perhaps a TWAR infection, that
19 he referred to in the previous paragraph.

20 I might point out if you're considering an
21 atypical infection such as TWAR or microplasma, there
22 aren't any good reliable tests for those atypical
23 pathogens, so usually they're considered based on the
24 clinical setting, in this case a persistent cough and
25 fever not responsive to antibiotics. Usually if you

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1 consider that diagnosis and feel that it's at least
2 likely, then you'll empirically treat with an agent
3 such as Doxycycline.

4 Q. Could an atypical infection of the lung be caused
5 by a piece of vegetation breaking off in a patient with
6 bacterial endocarditis and embolizing to the lung?

7 A. I think that can be a cause of a persistent cough
8 and fever. It's on what would be a list of atypical
9 pathogens.

10 Q. If you had a pathogen in the heart and there was
11 an embolization to the lung, could it also then cause
12 an infection to the lung?

13 A. Yes.

14 Q. What diagnostic testing would you use to diagnose
15 bacterial endocarditis?

16 A. As I mentioned earlier, usually blood cultures
17 and echocardiogram.

18 Q. And that's blood cultures off antibiotics,
19 correct?

20 A. True.

21 Q. But if you performed blood cultures on
22 antibiotics they can produce a false negative, correct?

23 A. That's true.

24 Q. By the way, can I have that letter back so I
25 don't lose it? It's two pages.

1 Now, if you had performed blood cultures to
 2 diagnose bacterial endocarditis, would you have
 3 performed serial blood cultures?
 4 A. Usually that's done, yes.
 5 Q. How would you do that?
 6 A. Usually I would refer the patient to a laboratory
 7 to have that done.
 8 Q. Why would you perform serial cultures as opposed
 9 to just one culture?
 10 A. There are times where bacteria can be
 11 intermittent, and if you do only the one blood culture
 12 you might miss the pathogen. A series of blood
 13 cultures would increase the likelihood that you would
 14 detect the pathogen in the blood.
 15 Q. Would you agree that no serial blood cultures
 16 were performed on David Gonda from the time he first
 17 presented to Drs. Cropp and Ruiz up until his admission
 18 to St. Elizabeth's Hospital?
 19 A. I agree.
 20 Q. Do you agree that a blood culture is the single
 21 most important test in the diagnosis of endocarditis?
 22 A. Yes.
 23 Q. Do you agree that performing a blood culture is
 24 necessary to rule out bacterial endocarditis?
 25 MR. TRAVERS: In who, Mark?

1 MR. RUF In a patient
 2 in which bacterial endocarditis is part of
 3 the differential.
 4 MR. BANAS: well, I
 5 object because that's too broad a
 6 question.
 7 MR. TRAVERS: Doctor, you
 8 can answer the question.
 9 A. Could you repeat that, please?
 10 Q. Sure. Do you agree that a blood culture is
 11 necessary to rule out bacterial endocarditis in a
 12 patient that has a differential that includes bacterial
 13 endocarditis?
 14 A. That's difficult to answer. Certainly, as I
 15 mentioned earlier, the blood culture is the most
 16 important test in ruling in endocarditis. There are
 17 times where a patient can have so-called culture
 18 negative endocarditis. There can be some unusual
 19 organisms which don't grow in standard culture media.
 20 I don't think that it's necessary to have a blood
 21 culture to rule that out. It's helpful to have the
 22 blood culture to rule it in.
 23 Q. If you wanted to rule out bacterial endocarditis
 24 you would need to perform blood cultures plus either an
 25 echo or TEE?

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

1 fever made the diagnosis of a respiratory infection
 2 very appropriate and empiric treatment of this
 3 respiratory infection very appropriate.
 4 If a patient has fever alone without other
 5 associated symptoms that point to a probable diagnosis,
 6 then I think that endocarditis is more of a
 7 possibility. In a patient with fever and cough and
 8 respiratory symptoms, endocarditis is less likely.
 9 Q. Do you think that bacterial endocarditis should
 10 have been included in the differential given that he
 11 had a fever of unknown origin and he had an abnormal
 12 EKG?
 13 MR. BANAS: I'm going to
 14 object because Dr. Cropp did not know
 15 about the abnormal EKG.
 16 BY MR. RUF:
 17 Q. Go ahead, Doctor.
 18 A. I think it would be included in a broad
 19 differential diagnosis. I might point out that in that
 20 differential diagnosis it is not necessary and not in
 21 the standard of care necessarily to specifically with
 22 specific diagnostic tests rule in or rule out every
 23 item in the differential diagnosis.
 24 Q. Doctor, do you agree that the only diagnostic
 25 tests performed by Dr. Ruiz were a blood culture and a

1 pericardial ultrasound?

2 A. He also performed a chest X-ray.

3 Q. And a chest X-ray?

4 A. That's true.

5 Q. Do you agree that those tests did not provide him
6 with enough information to reach a definitive diagnosis
7 for David Gonda?

8 A. That's true.

9 Q. I believe you also said that Dr. Cropp did not
10 perform any type of diagnostic testing, correct?

11 A. I'm not aware of any.

12 Q. And he did not have enough information to reach a
13 definitive diagnosis for David Gonda, correct?

14 A. That's true.

15 Q. Do you think that these doctors had an obligation
16 to do anything further to try to reach a diagnosis?

17 MR. TRAVERS: Mark, we have
18 been down that road a couple of times
19 already. I'll suggest if the doctor cares
20 to respond again he is welcome to, but if
21 you ask this question again I'm going to
22 start losing my patience.

23 MR. RUIZ: Fine Tom.

24 A. As I mentioned earlier, I think it was
25 appropriate and within the standard of care to

1 empirically treat this patient for a possible atypical
2 respiratory infection rather than to do further
3 diagnostic tests. Dr. Cropp mentions in his letters
4 that further diagnostic testing would be done if there
5 was not a satisfactory response.

6 Q. Doctor, could you take a look at the CBC in
7 Dr. Ruiz's chart?

8 Do you agree that David Gonda had a high white
9 blood count?

10 A. Yes.

11 Q. Would that be consistent With an infectious
12 process going on in his body?

13 A. Yes.

14 Q. And fever would also be consistent with an
15 infectious process going on in his body?

16 A. Yes.

17 Q. Would the symptom of general malaise also be
18 consistent with an infectious process going on inside
19 his body?

20 A. Yes.

21 Q. Could an infectious process also cause
22 tachycardia?

23 A. Yes.

24 Q. Let's go down. His hemoglobin was low, correct?

25 A. Yes.

1 Q. What types of things could cause a low

2 hemoglobin? Let me go through a couple of these first.

3 He had a low hemoglobin. He had a low

4 hematocrit. He had a low MCV. He had a low MCH. He
5 had low lymphocytes. He had high polys and high
6 monocytes.

7 What types of conditions could cause this type of
8 CBC?

9 A. Infections can cause this type of CBC. A
10 neoplasm can cause this type of CBC. Essentially a
11 lymphatic malignancy such as a lymphoma can cause that
12 type of CBC. I think the differential could include
13 two general categories; that being infectious
14 malignancy, and connective tissue disease would be
15 lower in that broad differential.

16 Q. Would any of those values suggest a low output
17 from the heart?

18 A. Not necessarily, no.

19 Q. Could it be consistent with that?

20 A. I don't think that a low output of the heart
21 would be necessarily the cause of those abnormalities,
22 no.

23 Q. If another doctor suggested to Dr. Ruiz to do a
24 further evaluation of this patient, would he have an
25 obligation to perform a further evaluation of the

1 patient?

2 MR. BLOMSTROM I'm going to
3 object. That's such a vague question. I
4 don't know how he can be reasonably
5 expected to respond to it.

6 A. I think that he would have an obligation to
7 insure that a further evaluation was performed, if not
8 by himself, then by an appropriate consultant. In this
9 case, in July after the patient was seen by
10 Dr. Adornato, Dr. Ruiz referred the patient to
11 Dr. Cropp for further evaluation.

12 Q. Let me read from Dr. Adornato's deposition on
13 page 42.

14 Question: "Do you have any more observations of
15 your telephone conversation with Dr. Ruiz other than
16 what is recorded there?"

17 Answer: "Some substance of the conversation was
18 probably that I looked this kid over, and I don't have
19 anything more to help you with. Maybe you ought to
20 evaluate him more thoroughly. That would be about it."

21 If that conversation in fact occurred, what would
22 be Dr. Ruiz's obligation at that point?

23 A. His obligation would be either to evaluate the
24 patient carefully himself or to refer the patient to a
25 specialist who might be more qualified to perform that

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1 evaluation.

2 Q. Doctor, would you take a look at the chart note
3 in the St. Elizabeth's report of 08-17-95?

4 A. The progress notes?

5 Q. I believe it's in the progress notes. Yes, it's
6 in the progress notes. Do you have it?

7 A. There are a number of 08-17-95 entries. Which
8 one?

9 Q. Let me show you. The 8:30 a.m. entry.

10 A. Pulmonary -- yes, I have that.

11 Q. Would you agree at the bottom of that note it
12 states the 2 echo, question mark, tricuspid vegetation,
13 clinically that could be put together if he did in fact
14 have right-sided endocarditis?

15 A. It does say that, yes.

16 Q. Do you agree with that statement, Doctor, do you
17 agree that right-sided endocarditis clinically would
18 fit within the whole picture for David Gonda?

19 MR. TRAVERS: If as the
20 note suggests, Mark, that there was
21 vegetation on the tricuspid valve which
22 was not the case here, right?

23 MR. BANAS: That's
24 correct.

25 MR. RUF: Your

1 case, if someone does have that it would explain some
2 portion of his presentation, specifically the fever,
3 but not other portions of his presentation, for
4 example, the respiratory symptoms, the sore throat, the
5 cough that he complained of and the absence of other
6 signs of right-sided endocarditis.

7 Q. Do you believe that an acceptable standard of
8 care only requires a physician to make a diagnosis if
9 the patient's presentation fits within clear classical
10 symptoms of a disease?

11 A. No.

12 Q. Do you agree that medicine is an art?

13 A. It is both an art and science, yes.

14 Q. You agree that part of your skill as a
15 professional comes into play when the patient has more
16 subtle signs of a disease?

17 A. Yes.

18 Q. You would agree that recognizing more subtle
19 signs of a disease or a more subtle clinical
20 presentation is part of your education and training as
21 a physician?

22 A. Yes.

23 Q. Do you agree that after David Gonda's death we
24 still cannot rule out bacterial endocarditis as the
25 cause of his death?

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1 objection is noted.

2 BY MR. RUF:

3 Q. Please answer the question, Doctor.

4 A. If the patient did have a right-sided -- I'm
5 sorry. If the patient did have a tricuspid vegetation,
6 then it's conceivable that his symptoms might be
7 explained by that.

8 Q. So one of the explanations for David Gonda's
9 clinical course could be right-sided endocarditis?

10 MR. BANAS: I'm going to
11 object because you're not giving him the
12 full -- you're not asking him to look to
13 see whether or not there was vegetation.

14 Q. I'm asking you from a clinical perspective,
15 Doctor.

16 A. Whether that would explain his entire
17 presentation or his presentation at St. Elizabeth's
18 Hospital in August?

19 Q. His entire presentation up to August 17th, 1995.

20 A. I don't think it explains his entire
21 presentation, no.

22 Q. Why would it not explain his entire presentation?

23 A. Well, I think if someone has a tricuspid
24 vegetation if they have a right-sided endocarditis, and
25 as I mentioned earlier it's not clear that was the

1 A. The diagnosis made by the Cleveland Clinic
2 pathologist was endomyocardial fibrosis, and
3 Dr. Hoffman has offered the opinion that this was
4 actually endocarditis. I guess based on that we cannot
5 rule out that the patient did have endocarditis.

6 Q. We agree that it is especially true in
7 light of the fact that blood cultures were
8 performed on David Gonda off antibiotics while he was
9 alive?

10 A. That's true.

11 Q. What are the characteristics of bacterial
12 endocarditis?

13 A. Clinical characteristics?

14 Q. Why don't you start with symptoms. What are the
15 symptoms of bacterial endocarditis?

16 A. I believe I mentioned them earlier.

17 MR. BANAS: I think we
18 already answered that

19 BY MR. RUF:

20 Q. I don't think I asked you what all the symptoms
21 are.

22 A. The primary symptom is fever. In addition to
23 fever patients usually have musculoskeletal complaints,
24 often low back pain, joint aches, sometimes joint
25 effusion, swelling of the joints. In addition they

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1 have at times other signs including Osler nodes,
 2 Janeway lesions, splinter hemorrhages, splenomegaly,
 3 enlargement of the spleen. Right-sided endocarditis
 4 will be accompanied by hepatomegaly, enlargement of the
 5 liver. A general malaise is often complained of. I
 6 think those are the primary clinical characteristics.
 7 Q. Do you agree that typically the fever spikes at
 8 night in a patient with endocarditis?
 9 A. Well, I think that's true with many or most
 10 infectious illnesses. In fact, the normal temperature
 11 is normally higher at night; so when someone is ill,
 12 often the fever spikes are higher at night.
 13 Q. Do you agree that David Gonda's fever spiked at
 14 night?
 15 A. I believe so. I think that's characteristic of
 16 but not exclusive to the diagnosis of endocarditis. As
 17 I mentioned, just about any infection with just perhaps
 18 a few exceptions will have the highest temperatures at
 19 night.
 20 Q. Do you agree that bacterial endocarditis is
 21 described as a flu-like illness?
 22 MR. TRAVERS: By whom?
 23 MR. BANAS: By whom?
 24 MR. RUE By doctors
 25 and the medical literature.

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1 A. It has been described as such if the patients
 2 complain of fever, malaise, diffuse aches, yes.
 3 Q. After July 10th of 1995 what were the most likely
 4 diagnoses to explain David Gonda's condition?
 5 A. At that point he was a patient with persistent
 6 fever, persistent cough and some other respiratory
 7 symptoms including drainage, and based on that
 8 presentation I think that the most likely diagnostic
 9 considerations would include various respiratory
 10 infections including atypical pathogens.
 11 Q. Do you agree that the functions of the heart and
 12 lungs are interlinked?
 13 A. Yes.
 14 Q. So a problem with the heart could cause a problem
 15 with the lung?
 16 A. Yes.
 17 Q. And a problem with the lung could cause a problem
 18 with the heart?
 19 A. Yes.
 20 Q. Is that something that a physician should take
 21 into consideration in either treating a heart or a lung
 22 condition?
 23 A. I think it should be considered, yes.
 24 Q. Do you agree that modern echocardiographic
 25 imaging is essential for optimal management of

1 infective endocarditis?
 2 A Not necessarily.
 3 Q. If a patient has endomyocardial fibrosis will
 4 that produce an abnormal echocardiogram?
 5 A. I believe so, yes.
 6 Q. Do you agree that no echocardiogram was performed
 7 on David Gonda until August 16th, 1995?
 8 A. I agree.
 9 Q. Do you have an opinion based on a reasonable
 10 medical probability as to whether an echocardiogram had
 11 been done on 06-27-95 whether that would have been
 12 abnormal?
 13 A. I don't have an opinion. I don't know.
 14 Q. Do you have an opinion based on medical
 15 probability as to whether an echocardiogram would have
 16 been abnormal on 07-10-95?
 17 A. I don't know.
 18 Q. Do you have an opinion based on medical
 19 probability as to whether an echocardiogram or TEE
 20 would have been abnormal at any time prior to the
 21 admission to St. Elizabeth's Hospital on August 15th,
 22 1995?
 23 A. I don't know when the echocardiogram or TEE would
 24 have become abnormal.
 25 Q. Have you diagnosed or treated patients with

1 bacterial endocarditis?
 2 MR. BANAS: I object. He
 3 has already answered that.
 4 A. Yes, I have.
 5 Q. Have you treated or diagnosed patients with both
 6 subacute and acute bacterial endocarditis?
 7 A. Only subacute bacterial endocarditis.
 8 Q. Do you agree that the difference between acute
 9 and subacute bacterial endocarditis is the amount of
 10 time that it takes place for the disease to occur?
 11 That was probably an inarticulate question.
 12 MR. BANAS: Motion to
 13 strike.
 14 BY MR. RUE:
 15 Q. What is the difference between acute and subacute
 16 bacterial endocarditis?
 17 A. Primarily the time course of the illness, and
 18 that often is determined by the organism causing the
 19 infection.
 20 Q. And do you agree with acute bacterial
 21 that usually involves a matter of days?
 22 A. Yes.
 23 Q. And with subacute it involves a matter of weeks
 24 and months?
 25 A. Yes.

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1 Q. Have you ever made the diagnosis of bacterial
2 endocarditis?
3 A. Yes.
4 Q. How did you do that?
5 A. Through blood cultures and echocardiogram.
6 Q. Have you ever missed the diagnosis of bacterial
7 endocarditis and it was subsequently diagnosed by
8 another doctor?
9 A. Not that I'm aware of.
10 Q. For the patients that you have had with bacterial
11 endocarditis, have you referred those patients to
12 another type of physician, or have you treated them
13 yourself?
14 A. I referred them to an infectious disease
15 specialist.
16 Q. Is there a specific infectious disease specialist
17 that you refer them to?
18 A. No.
19 Q. Do you know what the treatment is for bacterial
20 endocarditis?
21 A. Usually the treatment is based on antibiotic
22 therapy. There are times when surgery is required, but
23 usually it's antibiotics.
24 Q. Do you have an opinion as to the survival rate
25 for a patient with bacterial endocarditis?

1 involvement, and I can't state specifically how the
2 survival compares without valve involvement.
3 Q. Do you agree for all pathogens that can cause
4 bacterial endocarditis the survival is between 50 and
5 90 percent?
6 A. I believe that number is quoted in the
7 literature, yes.
8 Q. And there is no way to determine the exact
9 survival rate for David Gonda assuming that he had
10 bacterial endocarditis without blood cultures being
11 performed off antibiotics, correct?
12 A. If I assume that he had bacterial endocarditis,
13 yes.
14 Q. Yes? You can't predict what his mortality would
15 be unless he had blood cultures, correct?
16 A. I'm not sure I understand the question, Mark.
17 Q. Well, you said the survival rate depends on the
18 type of pathogen involved, correct?
19 A. Yes, that was one of the factors involved, yes.
20 Q. And the only way to determine the type of
21 pathogen involved is to perform blood cultures off
22 antibiotics, correct?
23 A. Yes.
24 Q. And this was not done in this case, correct?
25 A. That's correct.

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1 A. It varies considerably based on a number of
2 factors including the patient's age and whether or not
3 they have preexisting heart disease and which organism
4 is causing the endocarditis and how early or late it is
5 diagnosed and whether appropriate antibiotics are used
6 and whether surgery is necessary. It is at times a
7 treatable infection; other times it leads to valve
8 dysfunction and sometimes can lead to death.
9 Q. Do you agree there was no valve involvement With
10 David Gonda?
11 A. True, true. The pathology report mentioned the
12 valves were delicate.
13 Q. Would you agree that increases his chance of
14 survival and probability of cure?
15 A. I don't know that he had infectious endocarditis.
16 Q. Assuming he had infectious endocarditis --
17 I TRAVERS: omp ring him
18 to a patient I ve d been
19 destroyed?
20 BY MR. RUF:
21 Q. -- is the survival rate for a patient with
22 bacterial endocarditis with valve involvement lower
23 than or higher than a patient without valve
24 involvement?
25 A. I think it's unusual to have no valve

1 Q. Do you agree that bacterial endocarditis is fatal
2 if untreated?
3 A. It usually is, yes.
4 Q. Are you familiar with mural endocarditis?
5 A. That refers to endocarditis which involves the
6 endocardium on the cardiac wall rather than the valves.
7 Q. You are familiar with that entity?
8 A. Yes. It is rare.
9 Q. Are you aware that you do not always have a
10 murmur with bacterial endocarditis?
11 A. I'm aware of that, yes.
12 Q. Wouldn't you only have a murmur if there was
13 valve involvement?
14 A. I don't know that that's true. I think, for
15 example, if someone had mural endocarditis, the blood
16 rushing past that large vegetation can cause a sound
17 that would be interpreted as a murmur.
18 Q. Could you have a mural endo is hich does
19 not cause a murmur?
20 A. That's conceivable, yes.
21 Q. Do you have an opinion as to whether the mass
22 that was observed on autopsy at the Cleveland Clinic is
23 the type of mass that you would find with bacterial
24 endocarditis? If you don't have an opinion, tell me.
25 If you do, then tell me.

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1 **A. Based on the fact that they did not make that**
 2 **diagnosis, I suspect that it would not be the sort that**
 3 **would be seen in infective endocarditis.**

4 Q. Could it be consistent with bacterial
 5 ~~infection~~

6 **A. I guess it could, but I have no reason to**
 7 **question the diagnosis of the pathologist.**

8 Q. Do you know the training and experience of the
 9 pathologist that performed the autopsy at the Clinic?

10 **A. I do not.**

11 MR. BANAS: How much more
 12 time are we dealing with here?

13 MR. RUF: I have got
 14 some more, and I've got to go through
 15 endomyocardial fibrosis.

16 MR. TRAVERS: You're
 17 talking about another hour.

18 MR. RUF: At least.
 19 I'll try to speed it up. I might have
 20 covered some of this already.

21 BY MR. RUF:

22 Q. Did you ever hear of endomyocardial fibrosis
 23 before this case?

24 **A. No.**

25 Q. Would you agree that everything you know about

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1 endomyocardial fibrosis comes from the medical
 2 literature?

3 **A. Yes.**

4 Q. You have had no personal experience with
 5 endomyocardial fibrosis?

6 **A. That's true.**

7 Q. Did you perform any type of research on
 8 endomyocardial fibrosis?

9 **A. I previously read the section in the cardiology**
 10 **textbook on endomyocardial fibrosis.**

11 Q. Which cardiology textbook?

12 **A. Braunwald.**

13 Q. Do you know what edition that was?

14 **A. No, I don't.**

15 Q. So all of the knowledge that you have about
 16 endomyocardial fibrosis comes from reading Braunwald's
 17 textbook?

18 **A. Yes.**

19 Q. Do you know who first diagnosed endomyocardial
 20 fibrosis as a pathological entity?

21 **A. No.**

22 Q. Have you reviewed any medical literature about
 23 the survival of treatment of endomyocardial fibrosis?

24 **A. Other than what is mentioned in the Braunwald**
 25 **chapter, no.**

1 Q. What do you understand about endomyocardial
 2 fibrosis?

3 MR. BANAS: No. You want
 4 a long dissertation as to everything he
 5 knows about it; is that what you want?

6 MR. RUF: Sure.

7 BY MR. RUF:

8 Q. Why don't you tell me in general what you know
 9 about it?

10 **A. As I mentioned a number of times earlier, it's a**
 11 **rare illness and is difficult to treat. Treatment**
 12 **often requires cardiac surgery, and the illness is**
 13 **often fatal.**

14 Q. Do you know what the reported survival rates are
 15 for a patient that has undergone surgery for
 16 endomyocardial fibrosis?

17 **A. No.**

18 Q. Would it surprise you if there is literature that
 19 reports survival rates as high as 80 percent with
 20 surgical treatment?

21 **A. Yes.**

22 Q. Would you agree that if untreated endomyocardial
 23 fibrosis is universally fatal?

24 **A. I believe it is, yes.**

25 Q. Would you agree that the diagnosis is almost

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1 exclusively found in Africa and tropical countries?

2 **A. I believe there have been reports of cases**
 3 **outside of that area.**

4 Q. Do you know if there were more than a dozen
 5 reported cases in the U.S. in the last 20 years?

6 **A. I don't know how many.**

7 Q. Do you think it possible that doctors in the U.S.
 8 may have misidentified endomyocardial fibrosis in the
 9 U.S.?

10 **A. I have no reason to believe that they have.**

11 Q. Well, given that most doctors have no personal
 12 experience with endomyocardial fibrosis?

13 **A. I think it reasonable to assume that some doctors**
 14 **may have made a mistake in diagnosing that disease in**
 15 **this country.**

16 MR. BANAS: I object.

17 BY MR. RUF:

18 Q. Go ahead, Doctor.

19 MR. BANAS: If you know.

20 Q. Would you --

21 **A. I don't know.**

22 Q. Would you agree that's a possibility?

23 **A. I guess it's possible.**

24 Q. Are there other diseases that can cause fibrosis
 25 in the heart?

1 A. Yes.
 2 Q. What other diseases?
 3 A. It can occur in conditions which involve
 4 excessive serotonin, and that would include carcinoid
 5 syndrome. Other instances in which serotonin is
 6 elevated include some of the diet drugs which have been
 7 used.
 8 Q. Would a cardiothoracic surgeon be more qualified
 9 to testify as to the survivability of a patient with
 10 endomyocardial fibrosis than you?
 11 A. Yes.
 12 Q. Do you know any of the factors that are involved
 13 in the survivability for a patient with endomyocardial
 14 fibrosis?
 15 A. No.
 16 Q. Would a cardiothoracic surgeon be more qualified
 17 to testify as to the survivability for endomyocardial
 18 fibrosis than an infectious disease doctor or
 19 cardiologist?
 20 A. Not necessarily.
 21 Q. Well, a cardiothoracic surgeon is the one that
 22 would perform the type of surgery necessary to treat a
 23 patient with endomyocardial fibrosis, correct?
 24 A. Yes.
 25 Q. Do you know what the symptoms are of

1 Q. Do you agree that endomyocardial fibrosis can
 2 cause a rapid Y descent?
 3 A. I don't know.
 4 Q. Do you agree that David Gonda did not have a
 5 rapid Y descent?
 6 A. I don't recall that I read that he was ever
 7 assessed for that.
 8 Q. Here, actually I'm taking these statements out of
 9 Braunwald's heart disease;. Why don't I hand you a copy
 10 of that, Doctor?
 11 Do you agree that endomyocardial fibrosis
 12 produces a protodiastolic gallop sound that may be
 13 heard along the lower sternal border?
 14 MR. BANAS well, are we
 15 now to read Braunwald and :::
 16 whether or not what you're saying is the
 17 same thing that's in Braunwald; is that
 18 what we're doing?
 19 BY MR. RUF
 20 Q. I want to see whether David Gonda had any of
 21 these conditions according to this, Doctor.
 22 A. That's listed in the section on right ventricular
 23 EMF.
 24 Q. Do you agree that David Gonda did not have a
 25 protodiastolic gallop sound along the lower sternal

1 endomyocardial fibrosis?
 2 A. I believe they are primarily symptoms of
 3 congestive heart failure or congestive pericarditis
 4 which would include shortness of breath, swelling of
 5 the legs. I believe cough can be a symptom. I believe
 6 that fever is probably included in the list of
 7 symptoms.
 8 Q. Do you agree that the clinical manifestations of
 9 endomyocardial fibrosis with right-sided involvement
 10 include elevated jugular venous pressure?
 11 A. As I mentioned, that would include symptoms of
 12 heart failure.
 13 Q. Would you agree that David Gonda did not have
 14 elevated jugular venous pressure?
 15 A. I don't recall that I have specifically said
 16 whether that was assessed for or not.
 17 Q. It was not noted by any of the treating
 18 physicians in his records, correct?
 19 A. Not that I could recall reading, no.
 20 Q. Would you agree that endomyocardial fibrosis
 21 causes a prominent V wave?
 22 A. I don't know.
 23 Q. Would you agree that David Gonda did not have a
 24 prominent V wave?
 25 A. I didn't read that was ever observed.

1 border?
 2 A. I don't know if he had it or not. It was not
 3 specifically described by any examiner. That does not
 4 mean that he did not have that. It was not described
 5 by anyone that examined him.
 6 Q. Do you agree that in endomyocardial fibrosis the
 7 liver is usually large and pulsatile?
 8 A. That's stated here.
 9 Q. And do you agree that David Gonda's liver was not
 10 large and pulsatile?
 11 A. No one who examined him described that.
 12 Q. Would you agree that with endomyocardial fibrosis
 13 that splenomegaly is common?
 14 A. Yes.
 15 Q. Do you agree that David Gonda did not have
 16 splenomegaly?
 17 A. Again, that was not described by any examiner.
 18 Q. Do you agree with endomyocardial fibrosis
 19 peripheral edema is common?
 20 A. Yes.
 21 Q. And do you agree that David Gonda did not have
 22 peripheral edema?
 23 A. I agree.
 24 Q. Do you agree that the right atrium is often
 25 enlarged, sometimes massively so?

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1 A. I do.

2 Q. Do you agree that David Gonda did not have an
3 enlarged atrium, right atrium?

4 A. I don't believe that he did.

5 Q. Do you agree that with endomyocardial fibrosis a
6 chest X-ray often shows cardiac enlargement?

7 A. Yes.

8 Q. Do you agree that the chest X-rays that were done
9 on David Gonda did not show cardiac enlargement?

10 A. That's true.

11 Q. Do you agree that typically an echocardiogram for
12 a patient with endomyocardial fibrosis demonstrate
13 right ventricular thickening, obliteration of the apex
14 or a dilated atrium?

15 A. That's stated here, yes.

16 Q. Doctor, you agree that the 08-16 echocardiogram
17 and 08-17 TEE did not show any of those findings?

18 A. I agree.

19 Q. Do you agree that right ventricle endomyocardial
20 fibrosis is characterized by fibrous obliteration of
21 the right ventricular apex that diminishes the capacity
22 of the chamber?

23 A. Yes.

24 Q. Do you agree that even on autopsy David Gonda did
25 not have fibrous obliteration of the right ventricular

1 pericardial effusion to his a to St.

2 Elizabeth's Hospital?

3 A. I agree.

4 Q. Do you agree that endomyocardial fibrosis is
5 typified by fibrous endocardial lesions of the inflow
6 portion of the right ventricle?

7 A. Yes.

8 Q. Do you agree that at autopsy the mass involved
9 in David Gonda involved the outflow

10 A. Yes.

11 Q. Given all those things that we just went through,
12 Doctor, don't you think it's more probable than not
13 that David Gonda did not have endomyocardial fibrosis?14 A. I believe that it's certainly true that a number
15 of the clinical findings were not present prior to his
16 death. I have no reason to question, though, the
17 autopsy done at the Cleveland Clinic. I know there
18 have been opinions to the contrary from another
19 pathologist, but I don't have any reason to question
20 what was done at the Cleveland Clinic.21 Q. Do you agree that in the autopsy performed at the
22 Cleveland Clinic in the description of the
23 cardiovascular system the words fibrosis or scarring
24 are not used?

25 MR. TRAVERS: Mark, we'll

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1 apex that diminished the capacity of the chamber?

2 MR. TRAVERS: I don't think
3 the doctor has been provided with
4 Dr. Hook's deposition transcript. Do you
5 have the autopsy report from the Cleveland
6 Clinic, Doctor?

7 THE WITNESS: Yes, I do.

8 A. That's not mentioned in the autopsy report.

9 Q. Have you ever seen a picture of endomyocardial

10 fibrosis?

11 A. Mr. Travers showed me a picture of that today.

12 Q. Do you agree that typically it is a distortion of
13 the wall in the heart such as that it appears that the
14 heart is indented?

15 A. I don't know.

16 Q. Do you agree that this is not true of
17 David Gonda?18 A. I don't know whether his heart appeared indented
19 or not.

20 Q. Is that noted in the autopsy report?

21 A. It is not in those terms, no.

22 Q. Do you agree With endomyocardial fibrosis
23 pericardial effusion may be present?

24 A. Yes.

25 Q. Doctor, do you agree that David Gonda did not

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1 stipulate to the report. Do you want him
2 to read the whole report and see if those
3 words are in there? Do you think it
4 serves a useful purpose at this time of
5 day?6 MR. RUF yes, I think
7 it does.8 MR. TRAVERS: You don't
9 have to do that, Doctor.

10 A. I don't see the word fibrosis.

11 Q. Doctor, do you agree that you have to have
12 fibrosis or scarring of the heart to have
13 endomyocardial fibrosis?

14 A. I don't know.

15 Q. Do you agree that unusual presentations of
16 infections are becoming more common?

17 A. Yes.

18 Q. And that's something that doctors should be alert
19 to these days?

20 A. Yes.

21 Q. Do you agree that mitral valve prolapse can be a
22 predisposing factor to endocarditis?23 MR. TRAVERS: Mark, that's
24 enough. You're not going to ask any more
25 questions that have nothing to do with

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1 this case. Is there any evidence that he
2 had mitral valve prolapse?
3 MR. RUF There was a
4 concern that he had it in years prior.

5 BY MR. RUF:

6 Q. Doctor, could you please answer the question?

7 A. What I can state is if in prior years the patient
8 had a systolic click which can be a sign of mitral
9 valve prolapse, the concern is that a patient with
10 mitral valve prolapse is predisposed to infection of
11 the mitral valve which there is no concern that this
12 patient had at that time. Also, mitral valve prolapse
13 does not predispose to infectious endocarditis in the
14 right side of the heart.

15 Q. Doctor, do you agree that David Gonda may have
16 had a defect in the heart that caused the difference
17 between the 1989 EKG and the 1995 EKG?

18 MR. TRAVERS: I don't think
19 he has established that there was a
20 difference.

21 Q. Doctor, was there a difference between the 1989
22 EKG performed by Dr. Ruiz and the 1995 EKG?

23 A. I believe there was. The 1989 EKG was very
24 difficult to read, though, such a light copy.

25 Q. Do you agree that David Gonda developed a defect

1 You have got a double negative in there.

2 BY MR. RUF

3 Q. Did you understand the question, Doctor?

4 A. No.

5 Q. If a physician is not qualified to perform a
6 diagnostic test, what is his obligation?

7 A. If he feels that the diagnostic test is
8 necessary, to refer the patient to another physician
9 that is qualified to perform that test.

10 Q. If a radiologist has a technician perform a test,
11 should the technician be qualified to perform that
12 test?

13 MR. BLOMSTROM: Objection.

14 A. Yes.

15 Q. I'm reading from the deposition of Janet Sainato,
16 the technician that worked for Dr. Hafiz, page 14.

17 MR. TRAVERS: Mark, I can
18 make this easier for you, if you let me
19 interrupt. You are entitled to question
20 the doctor ad nauseam concerning opinions
21 that we plan to use at trial through his
22 direct testimony. He has already
23 indicated to you at the very outset that
24 he did not consider himself qualified to
25 render opinions on Dr. Hafiz and the

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1 in his heart in that period of time that caused the
2 difference?

3 A. I mentioned earlier that the difference in the
4 EKG could very well have been explained by a number of
5 factors related to his illness at that time. I don't
6 think we need to consider a heart defect as the cause
7 of the difference.

8 Q. If he had a defect in his heart, wouldn't that
9 make him susceptible to developing bacterial
10 endocarditis?

11 MR. BANAS: He just said
12 he had no defect. You can't have it both
13 ways.

14 BY MR. RUE?

15 Q. Assuming that he did have a defect, would that
16 make him susceptible to developing bacterial
17 endocarditis?

18 A. Preexisting cardiac disease is a risk factor for
19 infective endocarditis. I have no evidence at all that
20 Mr. Gonda had any kind of heart defect prior to his
21 illness.

22 Q. Does the standard of care require a physician to
23 not perform a diagnostic test if the physician is not
24 qualified to perform the test?

25 MR. BLOMSTROM: objection.

1 practice of radiology.

2 We have no intention of using this
3 witness to introduce any evidence in that
4 regard, and you're not going to ask him a
5 bunch of radiology questions at this
6 point.

7 MR. RUF No, but I am
8 going to ask him some limited questions.

9 MR. TRAVERS: Not having to
10 do with the practice of radiology, you're
11 not.

12 BY MR. RUF:

13 Q. Doctor, the following testimony was given by the
14 identified witness:

15 Question: "Had you ever prior to the day you did
16 the ultrasound on David Gonda looked for fluid around
17 the heart?"

18 Answer: "No."

19 Question: "Have you done it since?"

20 Answer: "No."

21 Question: "Are you specifically trained to look
22 for fluid around the heart?"

23 Answer: "No."

24 Given that was the testimony, what was the
25 obligation of Dr. Hafiz as far as whether or not to

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1 continue this test and whether or not to write a
2 report?

3 MR. BLOMSTROM objection.

4 MR. TRAVERS: Doctor, you
5 are welcome to use your independent
6 judgment as to whether you want to answer
7 the questions or not. I'm telling you
8 that as a matter of law you have no duty
9 to answer them. I'll leave that up to
10 you.

11 BY MR. RUE

12 Q. Please, answer the question.

13 MR. BLOMSTROM YOU have not
14 read all of the relevant information that
15 was in the deposition.

16 Q. Doctor, can you please answer the question?

17 A. Could you repeat the question, please?

18 Q. Would you want a radiologist with a technician
19 who was not qualified to perform a test, to actually
20 perform a test on your patient and render a report?

21 A. If I assume that the radiologist is qualified to
22 perform the test --

23 Q. Yes?

24 A. -- and if that radiologist was present during the
25 performance of the test.

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1 Q. Don't you think that the operator of the
2 ultrasound has something to do with the accuracy of the
3 test?

4 A. Yes, that's true. On the other hand it's fairly
5 common to have some testing done with the supervision
6 of a qualified person, and I would assume that if
7 Dr. Hafiz felt that the test had been performed
8 appropriately and he felt that the conclusion of the
9 test was accurate, then he would not need to do
10 anything further.

11 Q. If he did not think he was qualified to perform
12 the test would he have an obligation to notify the
13 primary care physician of that fact?

14 A. He being the radiologist or the technician?

15 Q. The radiologist.

16 MR. BLOMSTROM I'm going to
17 object. Actually the evidence is to the
18 contrary.

19 BY MR. RUE:

20 Q. Please, answer the question, Doctor.

21 A. I guess, again not knowing the specifics of
22 Dr. Hafiz's training and qualifications to do a
23 pericardial ultrasound, if you ask me the hypothetical
24 question, if the physician feels that he is not
25 qualified to either perform or interpret or evaluate

1 the test, then I believe it is his obligation to inform
2 either the referring physician or to find someone who
3 can do the test. Given that that was based on a
4 hypothetical that you presented to me without any
5 knowledge of the facts.

6 Do we have the report? I can't find the report
7 of the echocardiogram that was done in August. I have
8 the preliminary report. Is there a formal report?

9 MR. BLOMSTROM: Of the one in
10 August that was done in the hospital?

11 There is one in the progress record by
12 that I know of. That I have

13 nothing to do with my client, but it is in
14 the progress note.

15 BY MR. RUE:

16 Q. Do you agree there was not much correspondence or
17 communication between Drs. Cropp and Ruiz during the
18 treatment of David Gonda?

19 MR. TRAVERS: You mean
20 every time they saw him?

21 A. We referred to a series of letters written from
22 Dr. Cropp to Dr. Ruiz during July and August of 1995.

23 I believe that after each of those visits Dr. Cropp
24 communicated to Dr. Ruiz. There was a letter written
25 after the July 13th visit, the July 25th visit and also

1 I believe the August 8th visit.

2 Q. When you refer a patient to a specialist do you
3 call the specialist to find out what their findings are
4 and discuss the situation with the patient?

5 A. If I don't hear from the specialist by some other
6 means, there are times where I'll call the specialist.
7 Often the specialist will call me. Usually the
8 communication is via letter.

9 Q. Do you know Dr. Hoffman?

10 A. No.

11 Q. Do you know Dr. Morgenstern-Clarren?

12 A. Yes.

13 Q. He's in the same facility?

14 A. Yes.

15 Q. Do you respect him as an internist?

16 A. Yes, I do.

17 Q. Do you know any other doctors that are involved
18 in this case?

19 A. No.

20 Q. Do you have a friendship with any of the lawyers
21 or doctors that are involved in this case?

22 A. No.

23 Q. Do you think that David Gonda's death was
24 inevitable?

25 MR. BANAS: well, I'm

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1 going to object. That's an unfair
 2 question, and I would suggest the doctor
 3 not answer that one. What you're doing is
 4 taking this out of the realm of medical
 5 malpractice.
 6 MR. RUF: No, it isn't.
 7 MR. BANAS: It certainly
 8 is.
 9 MR. TRAVERS: Mark, I can
 10 absolutely guarantee you that David
 11 Gonda's death was inevitable. Are you
 12 asking about the timing of it?
 13 BY MR. RUF:
 14 Q. Do you think that there was anything that medical
 15 science could do for David Gonda?
 16 MR. TRAVERS: I'm going to
 17 object to that question.
 18 Q. Please, answer the question, Doctor.
 19 A. Could we go off the record? I want to confer
 20 with Mr. Travers.
 21 MR. TRAVERS: certainly.
 22 MR. RUF Sure.
 23 (Thereupon, there was a discussion
 24 off the record.)
 25 MR. TRAVERS: I'd just like

1 questions. Good-bye.
 2 MR. TRAVERS: Doctor, you
 3 have the right to review this transcript
 4 to make sure that the questions and
 5 answers were accurately taken down and
 6 transcribed by the reporter, or it's
 7 within your right to waive that if you
 8 don't care to read it. We've been at this
 9 a long time with a lot of technical words.
 10 If you're willing, it would be my
 11 suggestion that you read it.
 12 THE WITNESS: I'd like to
 13 read the transcript.
 14 - - -
 15 (DEPOSITION CONCLUDED.)
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RAYMOND W. ROZMAN, JR., M.D. DATE

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1 to state for the record in case there are
 2 any questions about this later, I have had
 3 a conference in private with the doctor
 4 who wanted my legal advice as to whether
 5 he had to answer the question, thinking
 6 that it's pretty impossible to answer if
 7 there is anything in the world that can be
 8 done for anybody, and I have told him he
 9 can answer the question if he chooses to.
 10 As to whether there was anything
 11 within medicine that could have been done,
 12 he is prepared to answer the question that
 13 way, but he is not going to answer the
 14 question if there is anything in the whole
 15 universe that could be done for the
 16 patient.
 17 BY MR. RUF
 18 Q. Please, answer the question given that statement.
 19 A. I don't believe that there was anything within
 20 the reasonable standard of care that Dr. Ruiz or
 21 Dr. Cropp should have done or could have done to
 22 prevent his death.
 23 MR. RUF Thank you,
 24 Doctor.
 25 MR. BANAS: I have no

1 CERTIFICATE
 2 state of Ohio, } ss:
 3 County of Cuyahoga.
 4 I, Cynthia A. Sullivan, Notary Public within and
 5 for the State of Ohio, duly commissioned and qualified,
 6 do hereby certify that the within-named witness,
 7 RAYMOND W. ROZMAN, JR., M.D., was by me first duly
 8 sworn to tell the truth, the whole truth and nothing
 9 but the truth in the cause aforesaid; that the
 10 testimony then given by him was reduced to stenotypy in
 11 the presence of said witness, and afterwards
 12 transcribed by me through the process of computer-aided
 13 transcription, and that the foregoing is a true and
 14 correct transcript of the testimony so given by him as
 15 aforesaid.
 16 I do further certify that this deposition was
 17 taken at the time and place in the foregoing caption
 18 specified.
 19 I do further certify that I am not a relative,
 20 employee or attorney of either party, or otherwise
 21 interested in the event of this action.
 22 IN WITNESS WHEREOF, I have hereunto set my hand
 23 and affixed my seal of office at Cleveland, Ohio, on
 24 this 22nd day of February 1999.
 25 Cynthia A. Sullivan, Notary Public
 in and for the State of Ohio.

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