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IN THE [illegible]

CUYAHOGA COUNTY, OHIO

TRAVIS CATES, et al., Doc. 436

Plaintiffs,

-vs-

JUDGE BURNSIDE
CASE NO. 167835

CLEVELAND METROPOLITAN GENERAL HOSPITAL, et al.,

Defendants.

- - - -

Deposition of J. WALTON TOMFORD, M.D. taken as if upon cross-examination before Sandra L. Mazzola, a Registered Professional Reporter and Notary Public within and for the State of Ohio, at Cleveland Clinic Foundation, 9500 Euclid Avenue, Cleveland, Ohio, at 5:00 p.m. on Tuesday, September 17, 1991, pursuant to notice and/or stipulations of counsel, on behalf of the Plaintiffs in this cause.

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On behalf of Defendant Dr. Matejczyk.

J. WALTON TOMFORD, M.D., of lawful age, called by the Plaintiffs for the purpose of cross-examination, as provided by the Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

CROSS-EXAMINATION OF J. WALTON TOMFORD, M.D.

BY MR. MELLINO:

Q. Will you state your full name, please?

A. John Walton Tomford.

Q. And where do you live, Dr. Tomford?

A. Cleveland Heights.

Q. What's your address?

A. 3145 Fairmount.

Q. And apparently you were employed by Metropolitan General Hospital in November of '87, is that true?

A. That's correct.

Q. And now you're employed at the Cleveland Clinic?

A. That's correct.

Q. How long have you been employed at the Clinic?

A. Since February of 1989.

Q. And did you go from Metro to the Clinic?

A. Yes, I did.

Q. Okay. Why did you leave Metro?

A. It's a long story. I left Metro because I felt the job at the Clinic was a better position for me in terms of a small salary increase, better patient opportunities and better support in terms of my colleagues in terms of time off.

Q. Okay.

A. Is that fair game?

Q. What was your involvement with Mr. Cates in November of 1987?

A. I was the attending physician on the infectious disease service for the month of November and into December, usually a four-week block, assigned to be the attending physician for the hospital on that particular service.

Q. What was the four-week block? When did it start and when did it end?

A. I don't exactly remember the dates, but I was involved in his case throughout that time period of his hospitalization.

Q. All right. So your block would have started before he was admitted?

A. Correct.

Q. And you were still on the service when he was discharged?

A. That's correct.

Q. How many attendings were on the staff at Metro in '87?

MR. ALLISON: In infectious disease, you mean?

MR. MELLINO: Yes.

A. We had three and a half to four full-time equivalents.

Q. Pardon?

A. Three and a half to four full-time equivalents, FTEs.

Q. What does that mean?

A. Well, a full-time equivalent means a body that is full-time based in that particular job. In other words, if a person does half administration and half consulting work, they're considered a half FTE.

Q. How many doctors, infectious disease doctors, would take one of these blocks during the year --

A. In a relatively small hospital like Metro with less than a thousand beds you generally would need one infectious disease doctor per month block.

Q. Okay. And how many blocks did you take that year?

A. Probably three or four. We would usually split it up equally.
Q. Well, who would you split it up among? Who were the doctors?
A. The other staff doctors?
Q. Yes.
A. Dr. Wolinsky, Dr. Frengley would do several months, Dr. Marino would do several months and Dr. Spagnoulo would do the rest.
Q. Do you have any recollection of Travis Cates?
A. I certainly do. I have known the patient well since early 1980 when I consulted on him on an outpatient basis, and I generally remember my patients very well.
Q. Okay. What do you mean when you say you consulted with him on an outpatient basis? What were the circumstances that you came to see him?
A. Well, I was asked to see him for a skin infection in his arm.
Q. By who?
A. Stan Ballou.
Q. And how many times did you see him?

MR. ALLISON: If you recall, Doctor, exactly how many times you saw him.

A. Two or three times, but --
Q. This was for the skin infection?
A. For the skin infections.
Q. And this was in early '80?
A. Early 1980s I saw him, and then I saw him again in, I believe the mid 1980s.
Q. Okay. Well, what were the circumstances in --
A. And again in '87.
Q. What were the circumstances that you saw him in the mid '80s?
A. Again, cutaneous infections.
Q. And who asked you to see him?
A. I believe it was Dr. Ballou again.
Q. And when did you see him in '87?
A. I saw him in '87 when I was the visitant in November, and Dr. Bender was my fellow. And we were asked to see him by Dr. Matejczyk.
Q. Okay. How many times did you personally see him in that hospitalization?
A. I saw him at least once. I know I saw him once if not several other times.
Q. Okay. And this is based on your recollection or your --

MR. ALLISON: Do you need to get that, Doctor? You can make a call if you

need to.

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

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Q. You said you saw him once --

MR. ALLISON: At least once, I believe was his testimony.

A. Right, at least once.

Q. I wasn't done with my question, but is that based on your memory or from your review of the chart?

A. It's based from both.

Q. Okay. Where is it documented in the chart that you saw him?

A. There is no signature of mine on the chart.

Q. Okay.

A. But Dr. Bender did say, Will discuss cultures with Dr. Tomford, and I well remember seeing him during the initial part of his hospitalization when we were asked to see him by Dr. Matejczyk.

Q. Okay. Well, what do you remember from seeing him?

A. Well, I was called.

MR. ALLISON: Independent of the

medical records? Is that what you're asking, Chris, what he specifically recalls independent of the medical records?

MR. MELLINO: Well, he just said there's nothing in the medical records.

MR. ALLISON: No, that is not exactly what he said. He said that he recalls Mr. Cates --

Q. Well, Doctor, why don't --

MR. ALLISON: Based on his memory and the chart and there was no signature of his in the chart. So what's your question.

MR. MELLINO: Read the question back.

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(Thereupon, the requested portion of the record was read by the Notary.)

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MR. ALLISON: So independent of the chart, is that correct?

MR. MELLINO: Yeah.

A. We were called to see a man who was admitted to the orthopedic service that Dr. Matejczyk wanted to see us with regard to antibiotic management of what she felt was an infection, and it is

customary in the I.D. service at that hospital, and in many other institutions that the fellow, Dr. Bender, saw the patient before me, presented the findings in the infectious disease consult quarter or room across from the microbiology lab. And then we would go up, as we did in this case, in the afternoon and see the patient together, which we did.

Q. Why would it be customary for her to see him first?

A. Because that's the way a training hospital works, a teaching hospital works.

Q. Well, I'm not sure that answered the question. Why is that?

MR. ALLISON: Do you have a better answer than that, Doctor? Or if you know exactly why that is, that's fine, you can try and answer his question.

A. Oh, yeah. The general philosophy is that the fellow, particularly a person as seasoned and as excellent as Dr. Bender is and was, sees the patient before the attending.

Q. What was Dr. Bender's level of training in November of '87?

A. She had completed her internal medicine training

after three years and was a fellow in infectious disease. I can't remember whether she was -- this was her first year of fellowship or second year, but she was not brand new to the infectious disease consultation service. She had had at least five months at that point.

Q. Do you still have contact with Dr. Bender?

A. Surely. In Northeast Ohio, the infectious disease doctors are assembled twice a month to try to stump one another with difficult cases, and it's a good continuing medical education forum.

Q. All right. Do you have any contact with her outside of these meetings?

A. Once in a while we have shared patients simply because she has seen them at another hospital and the patient is then referred to the Cleveland Clinic.

Q. Anything else?

A. Well, if there's a lecture in town by a world class authority in infectious disease, I might see her there, too.

Q. Isn't it customary for you to write a note in the chart when you see a patient?

MR. ALLISON: You mean at Metro in

November and December of 1987?

MR. MELLINO: Not necessarily, no.

MR. ALLISON: Okay. Well, that's what I wanted to know. What is your time frame?

MR. MELLINO: It was open-ended. I think you picked that up from the question.

MR. ALLISON: Okay. I was just trying to be a little more specific.

MR. MELLINO: Why?

MR. ALLISON: Why not?

MR. MELLINO: Well, because I'm asking questions and I ask them how I please. That's why not.

MR. ALLISON: I understand.

Q. Can you answer the question, Doctor?

A. Maybe can you repeat it, please?

Q. Sure. Isn't it customary for you to write a note in the chart when you see a patient?

MR. ALLISON: Objection. You may answer, Doctor, as to the entire constellation of what customs may exist in different institutions and et cetera as you can do to that open-ended question.

A. At Metropolitan Hospital, in a teaching hospital of that sort, it is customary on our service for the infectious disease -- for the fellow to write the notes. We were encouraged, but not absolutely demanded, to sign it. And far more importantly would it be that we saw the patient and changed the fellow's recommendations if we felt that was appropriate, or if we felt that the fellow was doing the right thing, which I did in this case, we would simply let them write the note and continue to follow along, which we did.

Q. Okay. And if you don't write a note in the chart, there's no documentation that you actually saw the patient?

MR. ALLISON: Objection. You may answer, Doctor.

Q. Would that be a true statement?

A. Well --

MR. SEIBEL: What did the note say?

MR. MELLINO: We know what the note said in this case.

MR. SEIBEL: We do?

MR. MELLINO: Yeah. Doesn't say

anything about him seeing the patient.

A. In the record there, there is no signature of mine on the hospital chart.

Q. And the note doesn't say that you saw the patient?

MR. ALLISON: Which note is that, Chris?

MR. MELLINO: Well, the only note that he's mentioned in.

MR. ALLISON: Do you want to read it to him? Do you want to let him look at it?

Here, Doctor, you're free to refer to the records at any time.

MR. MELLINO: He already said what the note said.

A. There are multiple notes from Dr. Bender during Mr. Cates' hospitalization.

Q. Well, do any of them say that you saw the patient?

A. No.

MR. ALLISON: If you recall, Doctor.

A. If I recall, none of them -- one of them says, Will discuss culture results with Dr. Tomford.

Q. One of them says that?
A Correct.
Q. Right. Okay. And you already said that.
A. And she did discuss it with me and I did examine the patient.
Q. And you're basing that on your recollection?
A. That's correct.
Q. Okay.
A. And every patient on the I.D. service that was presented by the fellow was seen by the attending.
a. Did you talk to Dr. Matejczyk on December 30?
A. I do not recall discussing the case with her at that time.
Q. Okay.
A. I realize that there was a phone call made to infectious disease. Whether that was me or not, I cannot remember.
Q. Okay.
A. It would be unfair for me to say otherwise.
Q. All right. So you have no recollection of talking to her?
A. Correct.
Q. Would it be customary for her to call you or to call the fellow?

MR. ALLISON: Objection. If you know what Dr. Matejczyk's custom was.

Q. Well, I didn't ask you what Dr. Matejczyk's custom was. I just asked you if it was customary.

A. It's general custom as in the case of the consultation was to go up through the pecking order, and the pecking order would start with the fellow.

Q. Okay.

A. If the fellow could not be reached or there was question or concern, the attending would be consulted.

Q. All right. But you have no recollection in this case of discussing it with her?

A. Right.

MR. ALLISON: Objection. Asked and answered three times.

Q. And would you agree with the fellows that it would be inappropriate for the infectious disease doctor, whoever it was, to give the advice -- have you seen that December 30th note, by the way?

A. I have.

Q. Okay. -- that it would be inappropriate to give

the advice that's contained in that note without actually seeing the wound?

MR. ALLISON: Objection. I believe that that is a mischaracterization of both of the fellows' testimony.

MR. MELLINO: Well, that's fine.

MR. ALLISON: If you want to pose a question --

MR. MELLINO: Don't point your glasses at me. I posed a question to him.

MR. ALLISON: -- to Dr. Tomford, that's fine.

MR. MELLINO: I posed it to him. You can make an objection.

MR. ALLISON: Don't mischaracterize prior testimony in the form of a question. If you want to make a hypothetical, that's fine.

MR. MELLINO: Don't lecture me.

MR. ALLISON: I'm not lecturing you.

Q. Answer the question, Doctor.

MR. ALLISON: Don't answer the question, Doctor, until Mr. Mellino rephrases it.

It's a mischaracterization of their testimony, Chris.

MR. MELLINO: Well, I don't think it is. And it's written up, so what's the big deal?

MR. ALLISON: Well --

Q. Doctor, if you had been the one that had been called, would you have given the advice that was contained in that note?

MR. ALLISON: Objection. You may answer, Doctor.

THE WITNESS: What did you say?

MR. ALLISON: Objection. You may answer.

A. Well, do I have to answer?

MR. ALLISON: Yes. Go ahead and answer his question.

THE WITNESS: In other words, you filed an objection, but I have to answer?

MR. ALLISON: Right. That's just for the record.

THE WITNESS: For the record?

MR. ALLISON: Uh-huh.

A. Would you repeat it, please?

Q. Sure. If you had been the doctor that was

called on the 30th by Dr. Matejczyk, would you have given the advice that's contained in her note?

MR. ALLISON: Objection. You may answer.

A. The note states, as I recall --

Q. Yes, why don't you get the note out.

A. Yeah, can we get that out here?

MR. SEIBEL: Here, Doctor.

MR. ALLISON: Mr. Seibel has a ready copy today.

A. The note states 12-30-87. No treatment, presumably antibiotics, per I.D., if wound fine.

MR. ALLISON: Read the whole thing, Doctor.

A. Path report from the surgical specimen from the 22nd of December states, Rheumatoid nodule, wound checked, excellent, 12-30. Would I have given this advice?

Q. The advice not to give antibiotics if wound fine. Would you have given that --

A. I agree with that.

Q. You would have given that advice. Would you yourself have wanted to check the wound or would you rely on Dr. Matejczyk to check the wound?

A. This was a phone consultation that she placed and the advice that was given to her, I would agree with. If the wound was fine, no antibiotics would have been indicated. And she wrote that the wound check was excellent, 12-30, as a good surgeon should, following up, and stated it was excellent in which case no therapy is indicated.

Q. Okay. And that would be true even if a culture of the wound from December 22 was positive?

A. My interpretation of that culture is that it was a superficial colonization of a rheumatoid nodule on the surface of the skin. Mr. Cates was a methicillin resistant staph aureus carrier, so if you had cultured his pinky, it would have shown methicillin resistant staph aureus.

Q. Would it have shown a colony of staph?

A. Sure. It would have shown growth. A colony, one colony, two colonies. It's all the same.

Q. Do you know what it is specifically that you're going to be asked to testify about in the trial of this case?

MR. ALLISON: No, he doesn't. Hasn't been discussed. Go ahead and

answer.

A. No. I don't know.

Q. You can probably answer these questions without Mr. Allison's suggesting them to you, couldn't you?

A. I'll do the best I can.

Q. Okay. Go ahead.

A But I don't know what I'm going to be asked.

e. Okay. You haven't discussed that with Mr. Allison or anybody on behalf of the hospital?

A. I have a general idea of my opinions about this case after reviewing the medical records.

Q. Well, I asked you if you had had any discussions with Mr. Allison or anybody on behalf of the hospital regarding what your testimony was going to be.

MR. ALLISON: Objection. You may answer, Doctor.

A. I've had general discussions with Mr. Allison about --

MR. ALLISON: Just answer his question yes or no to the extent that you can. Because you realize that Dr. Tomford was an employee of Cleveland Metropolitan General Hospital at the time of the

incidents giving rise to this lawsuit and the substance of our conversations is privileged. Now if you want to go ahead.

MR. MELLINO: No. Let me just stop you right there because I don't want to invade your privilege. I just want to shortcut this thing and find out what it is that he's going to say if he knows. And if he doesn't, that's fine and we can continue through this process and I'll just ask him some general questions about the case.

MR. ALLISON: Chris, any substantive conversations we had, including what his anticipated trial testimony might be, as you well know, is privileged. To be perfectly blunt and honest with you, I haven't decided nor has anyone else from our office what Dr. Tomford may be asked to testify at trial. So that's the answer to your question.

MR. MELLINO: Okay. Fine.

Q. I take it you have an opinion as to whether or not this was a deep knee infection or a superficial wound infection, is that true?

A. Yeah, I have a opinion, certainly.

Q. And what is it?
A. My opinion is this was a wound infection of the skin but it did not involve the joint nor the prosthesis.
Q. And what do you base that opinion on?
A. My review of the records.
Q. Okay. And what in the records leads you to that conclusion?
A. Several findings. First of all, that the aspirate of the knee taken early in the hospitalization shows a joint fluid which did not grow staph aureus, that the findings in that joint fluid are compatible with a joint fluid of a person with rheumatoid arthritis, not of a person with a septic prosthetic knee.
Q. Is that the only finding your opinion is based on?

MR. ALLISON: Objection. You said based on the records.

Q. Well, I don't want you to go through the record and tell me what findings your opinion is based on.

MR. ALLISON: Doctor, if you need to look at the record to refresh your recollection as to each test and et cetera

and the results of those tests that were done, then please feel free to do that because he's asking for every single item you considered.

A. Okay. Sure. The glucose in the joint fluid was low. That is in keeping with rheumatoid arthritis. The cell count was low which is in keeping with rheumatoid arthritis and certainly not compatible with an infected joint. Most importantly, however, is the fact that the joint aspirate did not grow any organisms and was sterile. And that's the bona fide proof of an infection in the joint.

MR. ALLISON: If you could please, Doctor, just review the medical records as to any other tests that may have been done on November 13 that would also support your opinion.

Q. Well, I didn't ask you that question, Doctor. So --

MR. ALLISON: Actually, that is what you asked him, I think, Chris.

MR. MELLINO: No, that is not --

MR. ALLISON: I think you wanted every single point that he considered in

determining that, and I don't want you to come up later and say, Well, why didn't you mention this to me.

MR. MELLINO: Well, that's fine then. Go ahead.

MR. ALLISON: I mean if that's what you want, he can sure do that and look for every single test that was run on that fluid and on that stuff on November the 13th.

MR. MELLINO: Well, I didn't ask him to do that but, you know, if you want him to do that, then --

Q. Are you satisfied that you've given me the foundation of your opinion?

A. My opinion concerning what, sir?

Q. The fact that this was a superficial wound infection.

A. Well, the physical examination of the wound at the bedside is just -- is as important as is the laboratory data which I mentioned to you. And the wound was infected.

Q. Well, could his wound have been infected and he also have a joint infection?

MR. ALLISON: Objection. You may

answer.

A. Could this patient have had a joint infection --?

MR. SEIBEL: I missed the question, Chris. I'm sorry.

Q. The question is could this patient have had both an infected knee and a wound over the knee infected?

MR. ALLISON: Objection. You may answer.

A. He could have both, of course.

Q. But I'm saying --

MR. ALLISON: Are you talking about at that time in the November hospitalization he could have had both based upon the things that Dr. Tomford testified, gave you the opinion he didn't have an infection over the joint?

MR. MELLINO: I asked the question and he answered it. I don't think there's any reason to go back and clarify it.

A. I would like to clarify it though.

Q. Okay.

A. Prior to the joint aspiration, based on the examination --

Q. No. I understand that you don't think that he did have both.
A. Correct.
Q. But it is possible for both to occur in the same person?
MR. SEIBEL: That's a different question.
MR. ALLISON: That's a different question, Chris.
A. That's an entirely different question.
Q. Yes, I understand that.
A. He could have infection one place, the other or both. I mean that's just because infection can be anywhere.
Q. Okay. All right. So the fact that you saw an infection in his wound doesn't rule out a knee infection?
MR. ALLISON: Objection. You may answer.
A. But it is ruled out by the fact that the aspirate was no growth.
Q. Right.
A. And the other laboratory corroboration that I mentioned.
Q. Is it possible that the knee aspirate missed

areas of sepsis within the knee?

MR. ALLISON: Objection. You may answer.

A. In my opinion, no.

Q. Why not?

A. Because the joint fluid is continuous in a moving joint. It is homogeneous fluid. It is not loculated.

Q. Do you have any opinions on the care rendered by Dr. Matejczyk?

A. I think her care was first rate in this case.

Q. Why is that?

A. Because I interpret this case in November as a wound infection that was superficial and it was handled appropriately with the appropriate length of antibiotics and local wound care.

Q. How about after he was discharged, do you have any opinions on her care?

A. I think the care was excellent there as well.

Q. Did you see Mr. Cates after he was discharged in November?

MR. ALLISON: At any time?

Q. I mean December --.

A. I saw him in January.

Q. Okay. When he was back in the hospital?

A. Correct.
Q. Why did you see him then? Were you the attending again?
A. I was not the attending but the residents wished my opinion as well.
Q. What residents?
A. The residents taking care of him on the medical service as well as the fellows at that time.
Q. And why did --
A. As I recall also, it was a teaching forum at that time where every morning or three times a week the residents present interesting cases and so forth, and he was presented and we went to the bedside to see and discuss the case.
Q. This was presented at some kind of forum as an interesting case, is that what you said?
A. Well, most cases that are presented at a teaching report by the residents to selected attending of various subspecialties are interesting or have some teaching value or physical findings or many other things. I mean that's how I learn. That's how any physician learns.
Q. Well, what was it that was interesting about this case?

A. Well, he had meningitis. There's no denying that. And the residents wanted my opinion about how to treat meningitis.
Q. How did he get the meningitis?
A. My theory on how he got meningitis is that this gentleman has been a methicillin resistant staph aureus carrier for years. He has multiple skin nodules all over the place. Carbuncles, furuncles, rheumatoid nodules, whatever you want to call them. He is a very poor immunologic host and has been for ten years.

He has underlying heart disease of a valvular type, mitral valve disease and IHSS. I think he seeded his heart valve from his skin, which can happen in anybody like this, and that it therefore spread into his bloodstream and into his meninges.

Q. So this could have happened at any time to him?
A. Absolutely.
Q. It was just coincidence that it happened after this November hospitalization?
A. I agree with that.
Q. What did his knee look like in December after he was discharged from the hospital? Did you see it at all in December?

A. I did not see the patient after discharge in December.
Q. All right. So you don't know what it looked like?
A. Correct.
Q. Could his knee have seeded the meningitis?
A. I don't think so.
Q. You don't think it could have?
A. I don't think it could have, no.
Q. Okay. Just not possible?
A. It's not possible.
Q. Why not?
A. Because the knee joint wasn't infected for the reasons that I alluded to above.
Q. Well, if you have staph over the knee joint isn't it possible for it to become infected?
MR. ALLISON: For what to become infected? I'm sorry.
Q. The joint.
A. Staph usually attacks a joint hematogenously through the bloodstream rather than a direct invasion. That is the much more common path of genesis.
Q. All right. But is it possible, if there's staph on a wound over the knee joint, for that joint

to become infected?
A. It's possible.
Q. Okay. And he had staph in that wound over the knee joint from November 13 to at least December 22?
MR. ALLISON: Objection.
A. The culture from December the 1st of the ulcer was no growth.
Q. The culture from December 22 --
A. Showed staph aureus. It's right here. But that was a superficial ulcer and his skin was colonized with staph aureus.
Q. But there was staph present over the knee joint?
A. In the skin.
Q. Yes. And I think you said before it's possible for that staph to infect the knee joint?
MR. ALLISON: Objection.
A. The staph can -- I told you, but it's more likely that it seeds a joint hematogenously.
Q. Are you going out of town this week?
A. Yeah. My father has colon cancer and needs surgery Thursday.
Q. I'm sorry to hear that.
A. Yes. That's the way it goes.
Q. Are you planning on returning to testify at

trial?
A. I'll be back on Sunday night.
Q. Do you have any other opinions about this case that we haven't talked about this afternoon?
MR. ALLISON: If you have any other opinions that you recall at this time without being asked a specific question.
A. I think it's important to note that the path report from the 12-22 debridement and cleaning up of the wound showed rheumatoid nodule with chronic inflammation rather than acute inflammation, again confirming my opinion that this was a superficial culture of the skin above the rheumatoid nodule, and to me connotes that there was no evidence of deep infection at that time.
Q. Is there anything else?
A. Specific to what, may I ask?
Q. Well, any other opinions you have or facts you think you might be testifying about at trial that we haven't talked about.
A. Well, you asked the other reason why I don't think the joint was infected upon the initial evaluation, was that the x-rays of the joint did not suggest loosening or infection

radiographically.
Q. Which x-rays are these?
A. In mid to late November.
Q. Okay. If the knee -- well, is there anything else?
A. I don't think so.
Q. Okay. If the knee is red and swollen and warm, is that evidence of draining infection?
A. It can simply be a wound infection or cellulitis, which is wound and skin infection.
Q. Okay. So it could be a wound infection. Did he have a wound infection or was his knee, right knee, infected on January 3 when he was admitted to the hospital?
A. I have not entirely reviewed those records. I would be happy to do that.
Q. What records did you review?
A. I've reviewed the records from the December and November hospitalization.
Q. That's it?
A. By my recollection, there was pus in the right knee during the January '88 hospitalization.
MR. SEIBEL: In both knees?
A. Both knees, which supports my hypothesis that it was hematogenously seeded from his heart valve.

Q. Because there was pus in both knees?
A. Correct.
Q. All right. Does pus in the knee mean the joint's infected?
A. Pus staph aureus isolated from a knee aspirate means the joint's infected.

MR. MELLINO: Read that answer back again.

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(Thereupon, the requested portion of the record was read by the Notary.)

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Q. I guess I got confused because I asked you pus and you said pus staph aureus. Is there a difference?
A. Well, pus simply means inflammatory cells that almost invariably contain microorganisms. They don't have to, but it usually means that. And it did grow at that time.
Q. And what's pus staph aureus mean?
A. It means pus that is culturing or showing staph aureus on the gram stain as opposed to E. coli, Klebsiella pneumoniae. That's another pathogen.
Q. Is it likely that a wound on a knee would look

excellent and then three days later would be infected?

MR. ALLISON: Objection.

A. Can you tell me the context in which you're talking about?

Q. Well, in Mr. Cates, I'm talking about.

A. At what time, during the hospitalization or --

Q. No. I'm talking about that his knee would look excellent on 12-30-87 and could be infected on January 3.

MR. ALLISON: I think the problem I'm having, maybe the doctor is too, Chris, is you're not differentiating the superficial wound over the knee from the knee joint. I mean that's two obviously separate things. And you've stated the question differently when you've asked it both times, and I don't know what you are looking for.

Q. Okay. Well, I'll see if I can ask it better this time. Is it likely that the knee wound, Mr. Cates' knee wound or his knee in general, would look excellent on 12-30-87 and then for him to have an infected knee joint on January 3?

MR. SEIBEL: Objection.

MR. ALLISON: Objection. You may answer if you can, Doctor.

A. My hypothesis about what happened is that he seeded his heart valve from the skin from anyplace, a boil, a zit. It then seeded the two joints, right and left, hematogenously through the bloodstream as well as his brain, meaning the meningitis.

Q. How long would it take for this to happen?

A. It can occur extremely rapidly, 24, 48 hours. I've seen it happen.

Q. Can it take longer than that to happen?

A. Not commonly.

Q. You're saying it most commonly occurs in 24, 48 hours?

A. Usually very rapidly.

Q. Okay. And this is according to your hypothesis?

A. Correct. I mean based on clinical experience and knowledge about the behavior of this organism and those diseases.

Q. What if hypothetically this was all seeded through the artificial knee joint that was infected?

MR. SEIBEL: I'm sorry. I missed that. Were you done?

MR. MELLINO: No, I wasn't done.

MR. SEIBEL: I'm sorry.

Q. Is it likely that the appearance of the knee would be excellent on 12-30 and that he would have the presentation that he did on January 3?

MR. ALLISON: Objection. You may answer that.

A. My hypothesis is that the two events are -- that the two findings are separate.

Q. Yeah, I understand that was your hypothesis. I asked to you accept my hypothesis, and that is that the knee joint was infected and that's what seeded the heart valve and caused the meningitis.

A. I don't accept that hypothesis.

Q. Well, I'm asking you to accept that for purposes of answering the question that I'm going to ask you, and that question is given those facts, is it likely that the knee would have looked excellent on December 30 and that he would have had the presentation that he did on January 3?

MR. ALLISON: Objection. You may answer that.

A. It is unlikely.

Q. Did you answer?

A. Yeah. If the knee is primarily infected, it's going to hurt like hell for a day or a period of time followed by the scenario of seeding the heart valve. But that's not what occurred according to my review of the records and opinion on the case.

Q. It's based on this 12-30-89 note?

A. Correct.

MR. SEIBEL: '87.

A. 12-87.

Q. '87. I'm sorry. Well, I guess if you don't have anything else to tell me, I don't have anything else to ask.

MR. ALLISON: Mr. Seibel?

MR. SEIBEL: No questions.

MR. ALLISON: Doctor, you have the right to read this transcript for its accuracy. Although we know our court reporter has taken down everything accurately, I would suggest that you do read this thing for its accuracy and sign it because of the medical terminology and that type of thing.

Are we going to have waiver of filing requirements on this transcript? Yes or

no?

MR. MELLINO: Yeah.

MR. ALLISON: Would you please inform the court reporter you don't waive signature?

A. I don't waive signature.

MR. MELLINO: I'm not going to waive the filing requirements.

MR. ALLISON: Are you going to order this?

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

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J. WALTON TOMFORD, M.D.

C E R T I F I C A T E

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

I, Sandra L. Mazzola, a Notary Public within and for the State of Ohio, authorized to administer oaths and to take and certify depositions, do hereby certify that the above-named J. WALTON TOMFORD, M.D., was by me, before the giving of his deposition, first duly sworn to testify the truth, the whole truth, and nothing but the truth; that the deposition as above-set forth was reduced to writing by me by means of stenotypy, and was later transcribed into typewriting under my direction; that this is a true record of the testimony given by the witness, and was subscribed by said witness in my presence; that said deposition was taken at the aforementioned time, date and place, pursuant to notice or stipulations of counsel; that I am not a relative or employee or attorney of any of the parties, or a relative or employee of such attorney or financially interested in this action.

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office, at Cleveland, Ohio, this _____ day of _____, A.D. 19 __.

_____

Sandra L. Mazzola, Notary Public, State of Ohio
1750 Midland Building, Cleveland, Ohio 44115
My commission expires January 6, 1992

WITNESS INDEX

OBJECTION INDEX

LAWYER'S NOTES

PAGE	LINE	

J. Walton Tomford, M.D.
Curriculum Vitae

CURRENT POSITION

Staff Physician
Department of Infectious Disease
Cleveland Clinic Foundation
Cleveland, Ohio

PAST POSITION

Assistant Professor of Medicine
Case Western Reserve University at
Cleveland Metropolitan General Hospital
Division of Infectious Diseases
3395 Scranton Road
Cleveland, Ohio *44109*

ACADEMIC APPOINTMENTS

Clinical Assistant Professor of Medicine
Case Western Reserve University, School of Medicine

PAST CLINICAL RESPONSIBILITIES

Cleveland Metropolitan General Hospital Attending Physician
Cuyahoga County Tuberculosis Clinic Attending Physician
Cleveland Metropolitan General Hospital Sexually Transmitted Disease Clinic

CURRENT ATTENDING PRIVILEGES AND HOSPITAL STAFF PRIVILEGES

Cleveland Clinic Foundation
Associate Staff, Cleveland Metropolitan General Hospital
Associate Staff, Cleveland Veterans Hospital

CURRENT COMMITTEES

Co-Chairman, Scientific and Technical Issues Subcommittee of the AIDS Commission of Greater Cleveland

Chairman, Medical Student Committee, Cleveland Clinic Foundation

Member, Physician Education Council, Cleveland Clinic Foundation

Member, General Medical Review Committee, Cleveland Clinic Foundation

Member, Task Force for Medical Student Programs, Ohio State University Affiliation Development

COMPLETED RESEARCH PROJECTS

Lederle Laboratories: "A Double-Blind Multi-Center Study *to* Compare the Efficacy of CL284635 Versus Amoxicillin in the Treatment of Acute Lower Respiratory Tract Infections Including Pneumonia."

Evaluation of Skin Test Antigens in Evaluation of Diagnosis of Mycobacterial Diseases, CDC Sponsored Program.

BOARD CERTIFICAlION

American Board of Internal Medicine, September, 1978
Subspecialty Board of Infectious Diseases, June, 1980

LICENSURE

Parts I, 11, III of National Boards completed
Ohio License # 041458

PROFESSIONAL SOCIETIES

Infectious Diseases Society of America, 1984
Cleveland Medical Library Association, Life Member

HOUSE STAFF TRAINING

Internship: The Johns Hopkins Hospital
Department of Medicine, 1975-1977

Residency: Junior Residency: Johns Hopkins Hospital, 1976-1977
Senior Residency: University Hospitals of Cleveland, 1977-1978

Fellowship: University Hospitals of Cleveland
Department of Medicine
Division of Infectious Diseases, 1978-1980

Chief Residency: University Hospitals of Cleveland, 1980-1981

EDUCATION

The Choate School, Connecticut 9/63-9/67
Harvard College, B.A. Summa Cum Laude 9/67-6/71
The Johns Hopkins School of Medicine, M.D., 9/71-6175

ACADEMIC HONORS

Phi Beta Kappa
Alpha Omega Alpha

ABSTRACTS PRESENTED

Tomford JW, Hershey CO, Cohen DI: The Effect of an Intravenous Therapy Team on Peripheral Venous Catheter Associated Phlebitis: A Controlled Trial. Presented November **1982** - Central Society for Clinical Research, Chicago.

Tomford JW, Kumar ML, Frengley JD, Halvorsen P, Frantz NA, Fratianne RB, Roizman B: Herpes Simplex Burn Wound Infection. Presented November **1984** - Central Society for Clinical Research, Chicago.

OTHER PROFESSIONAL ACTIVITIES

Member, AIDS Commission of Northeast Ohio

GRAND ROUND PRESENTATIONS

Cleveland Metropolitan General Hospital
University Hospitals of Cleveland
Lutheran Medical Center
Southwest General Hospital
Barberton Citizens Hospital
Fairview General Hospital
Brecksville VA Hospital
CWRU School of Dentistry
Cuyahoga Falls Hospital
St. Luke's Hospital
St. Alexis Hospital
Case Western Reserve University, School of Medicine

MEDICAL SCHOOL TEACHING ACTIVITIES

Medical Apprenticeship **1987-1988 (2** students for **6** weeks each)
Type A Elective - CWRU - Infectious Diseases: A Problem Oriented Approach
(2-3 two weeks sessions/year, **1982** - present)

PUBLICATIONS

Hirshfield IN, Tomford JW, Zamecnik PC: Thiosine-Resistant Mutants of E. Coli **K-12** with Growth-Medium-Dependent Lysyl-tRNA Synthetase. Biochimica et Biophysica Acta, **259:344-356, 1972.**

Baylin SB, Abeloff MD, Weiman KC, Tomford JW, Ettinger DS: Elevated Histaminase Activity in Small Cell Carcinoma of the Lung. New Engl J Med, **293:1286-1290, 1975.**

Tomford JW, Alving BM, Torretti D: Ureteral Obstruction and Pyelonephritis Caused by an Inguinal Hernia: Case Report. J Urol, **115:333-334, 1976.**

Tomford JW, Laskin Θ, Dec W: A New Technique for Fistula Visualization Through Use of a Swan-Ganz Catheter. Res and Staff Phys., Accepted for Publication

Tomford JW, Whittlesey D, Ellner JJ, Tomashefski J: Invasive Primary Cutaneous Phycomycosis in Diabetic Leg Ulcers. Arch Surg.,115:770-771, 1980.

Spagnuolo PJ, Ellner JJ, Bouknight R, Tomford JW, Kleinhenz ME, Edmonds KB: Interrelationships of Immunoregulatory Cells and Serum Factors in Sarcoidosis. J Immunol., 125:1071, 1980.

Aronoff S, Tomford JW, Bertino JJ, Speck WT: Antibiotic-Induced Meningitis Associated with Cefamandole. Pediatrics, 67:727, 1981.

Tomford JW, Hershey CO, Cohen DI: The Effect of an Intravenous Therapy Team on Peripheral Venous Catheter Associated Phlebitis. Clin Res, 30:770A, 1982.

Moede AL, Artsob H, Tomford JW, Jawicki MO, Tesh RB, Brandriss MW, Kothari H, Brandt WE: Imported Dengue Fever - United States 1982. Morbidity and Mortality Weekly Report, 32:145, 1983.

Moede AL, Artsob H, Tomford JW, Jawicki MO, Tesh RB, Brandriss MW, Kothari K, Brandt WE: Dengue Fever Surveillance. Weekly Epidemiological Record, 25:1985, 1983.

Sorenson RU, Tomford JW, Gyves MT, Judge NE, Polmar SH: Use of Intravenous Immune Globulin in Pregnant Women with Common Variable Hypogammaglobulinemia. Am J Med, 76(3A):73, 1984.

Tomford JW, Hershey CO, McLaren CE, Porter DK, Cohen DI: Intravenous Therapy Team and Peripheral Venous Catheter-Associated Complications. Arch Int Med, 144:1191, 1984.

Hershey CO, Tomford JW, McLaren CE, Porter DK, Cohen DI: The Natural History of Intravenous Catheter-Associated Phlebitis. Arch Int Med, 144:1373, 1984.

Tomford JW, Kumar ML, Frantz NA, Frengley JD, Halvorsen P, Roizman B, Fratianne RB: Burn Wound Infection with Herpes Simplex. Clin Res, 32:794A, 1984.

Tomford JW, Hershey CO: The IV Therapy Team - Impact on Patient Care and Costs of Hospitalization. NITA 8:387, 1985.

Wenger JD, Whalen CC, Lederman MM, Speck TJ, Carey JT, Tomford JW, and Landefeld CS: Prognostic Factors in Patients with the Acquired Immunodeficiency Syndrome. J GEN INT MED, 3:464-470, 1988.

Toosi Z, Edmonds KL, Tomford JW, Ellner JJ: Suppression of PPD-Induced Interleukin-2 Production by Interaction of CD16 (Leu-11 Reactive) Lymphocytes and Adherent Mononuclear Cells in Tuberculosis. J Infect Dis, 159(2):352-356, February, 1989.

Liu YC, Tomashefski JF, Tomford JW, Green H: Necrotizing Pneumocystis Carinii Vasculitis. Arch Pathol and Lab Med, 113:494-497, May, *1989.*

Tomford JW: Septic Sternoclavicular Arthritis". Cleve Clin J Med, Jan/Feb, *1990.*

PERSONAL INFORMATION

Born : February *15, 1949* - Memphis, Tennessee

Married : Gretchen A. Hallerberg (Medical Librarian)

Activities : Woodworking/Home Repairs, Cross-Country Skiing

Address : *3145* Fairmount Blvd.
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SPECIAL PRESENTATIONS

Ohio Thoracic Society, "Mycobacterial Diseases - Update," March, *1986*
St. Michael Hospital, Oregon, Ohio, "Chlamydial Infections", April, *1986*
St. Charles Hospital, Milwaukee, Wisconsin, "AIDS Update", March, *1986*
St. John Westshore Seminar on Sexually Transmitted Diseases, May, *1986*
Cleveland Metropolitan General Hospital "Update on Tuberculosis", April, *1987*
Huron Road Hospital "Diagnosis and Management of AIDS," September, *1987*
Marymount Hospital Conference on Diabetes Mellitus "Infectious Complications of Diabetes Mellitus" September, *1987*
Greater Cleveland Hospital Association, "AIDS: Impact on Employment Practices", September, *1987*
Cleveland Metropolitan General Hospital Medicine Update, "Sexually Transmitted Diseases", October, *1987*
"AIDS Update"
May, *1986:* Lorain Community College
November, *1986:* Lake County Community College
April, *1987:* United Churches of Chagrin Falls
May, *1987:* Pharmacist's Association of Cleveland
September, *1987:* Greater Cleveland Pharmacist's Association
September, *1987:* Lorain County Community College
September, *1987:* First Congressional Church of Elyria
October, *1987:* United Methodist Church of Chagrin Falls
November, *1987:* Cleveland Surgieal Society
December, *1987:* Mayfield School System
January, *1988:* Chagrin Falls School System
January, *1988:* Bainbridge Church of Christ
February, *1988:* Orthopaedic Society of Cleveland
March, *1988:* Perinatal Network Mt. Sinai and University Hospitals of Cleveland
April, *1988:* Cleveland Clinic Foundation
June 20, *1990:* Cleveland Clinic Foundation
May 1, *1991:* Cleveland Clinic Foundation

OTHER SPECIAL PRESENTATIONS

CWRU Dental School, "Osteomyelitis of the Jaw," Special Symposium on Infections in Oral Surgery, November, 1981.

American College of Physicians State Meeting, October, 1983, "Acquired Immunodeficiency Syndrome," Akron, Ohio.

Case Western Reserve University - Medicine, 1984 Antibiotic Update.

National IV Therapy Association National Meeting, Phoenix, Tuscon, Arizona, May, 1985, "The IV Therapy Team: Its Role in Improved Patient Care."

Ohio Society of Oral and Maxillofacial Surgeons, July, 1985, Antibiotic Update.

International Symposium on Allergy, Immunology and Infectious Diseases, Bombay, India, December, 1985. "Update AIDS, 1985," "Antibiotic Update", and "Serious Nongenital Herpes Infection."

All India Physicians Annual Scientific Session, Delhi, India, December, 1985, "AIDS Update, 1985".

Medicine Today Presentations: January, 1986: Urinary Tract Infections; January, 1988: Antibiotic Update 1988

Lake Hospital System, Inc., East-Painesville, Ohio: "Newer Antibiotics - Indication and Side Effects". May 2, 1989.

Metropolitan Health Center, Medical Grand Rounds: "Odonotogenic Infections: What the Internist Needs to Know", May 4, 1989.

Cleveland State University: "Sexually Transmitted Diseases". May 11, 1989.

University Hospitals of Cleveland, International Health Summer Course: 1989. "Leprosy", August 1, 1989.

Madison High School Students, "AIDS Education", October 17, 1989.

Northeast Ohio Society of Oral & Maxillofacial Surgeons, Cleveland, Ohio. "Bacterial Endocarditis", December, 1989.

St. Luke's Hospital Medical Grand Rounds: "Methicillin Resistant Staph Aureus", January, 17, 1990.

AIDS Symposium: AIDS and the Health Care Professional. "HIV Positive Health Care Worker: A View From the Clinical Arena", Highland View Pavilion, March 13, 1990.

John Hay High School Students, "Sexually Transmitted Diseases", March, 1990.

St. Alexis Hospital, "Community and Nosocomial Acquired Pneumonias", January 20, 1990.

Ohio Society Medical Technology (OSMT): Networking for Opportunity. "Bizarre Clinical Case Studies in Microbiology", Holiday Inn, Rockside, April 26, 1990.

University Hospitals of Cleveland. "Infectious Complications of Median Sternotomy. April, 1990.

13th District Academy of the Ohio Osteopathic Association. Radisson Hotel, Sandusky, Ohio. "HIV Complications", May 12, 1990.

Internal Medicine Symposium. Stouffer's Hotel, Cleveland, Ohio. "Tuberculosis, 1990", June 3-8, 1990..

Case Western Reserve University, School of Medicine. "Relationship Between AIDS and Other STD'S July 20, 1990.

Ohio School of Podiatry, Cleveland, Ohio. "AIDS & the Health Care Worker". September 26, 1990.

Cleveland Metropolitan General Hospital. "Anti-Anaerobic Drugs". October 3, 1990.

Case Western Reserve University, School of Medicine. AOA Lecture. "History of Bedside Diagnostics". October 10, 1990.

Lorain County Osteopathic Society, CME Lecture: "Infectious Complications of Median Sternotomy". November 21, 1990.

Akron City Hospital, Akron, Ohio. "The IV Therapy Team". March 4, 1991.

Renaissance Inn, Lorain, Ohio. Seminar on AIDS. "Infectious Disease and the AIDS Patient". March 16, 1991.

Cleveland Clinic Foundation, Bunts Auditorium. Neurosurgical & Neurological Intensive Care Update & Review. "Infectious Disorders of the Intracranial CNS of Importance for the Neurosurgeon/Neurologist." (Meningitis and Encephalitis) May 16-18, 1991.

Intensive Review of Internal Medicine. Stouffer's Hotel, Cleveland, Ohio. "Tuberculosis", June 2-7, 1991.