In The Matter Of:

Dorothy Gonda, etc. v.
Juan Ruiz, et. al.

Jacob Zatuchni, M.D.
February 8 7 1999

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IN THE COURT OF COMMON PLEAS
MAHONING COUNTY, OHIO

DOROTHY GONDA, etc., : 96CV 2055
Plaintiffs
vs
JUAN RUIZ, et al.,
Defendants

Monday, February 8, 1999

Pretrial oral examination of JACOB ZATUCHNI, M.D., held at the Pennsylvania Hospital, 8th and Spruce Streets, Philadelphia, Pennsylvania commencing at 1:40 p.m., on the above dale, before Mickey Dinter. Registered Professional Reporter and Commissioner of Deeds for the Commonwealth of Pennsylvania.

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INDEX

WITNESS: Jacob Zatuchni, M.D.

PG. LN.
BY MR. MALIK: 4 7
BY MR. BLOMSTROM: 114 23
BY MR. TRAVERS: 115 4

EXHIBITS PG. LN.

Plaintiff's Exhibit 1, an autopsy report 17 3
Plaintiis Exhibii 2, medical literature.....

JACOB ZATUCHNI, M.D., 801 Spruce Street, Philadelphia, Pennsylvania 19107, having been first duly sworn, was examined and testified as follows:

(EXAMINATION)
BY MR. MALIK:

Q: Can you tell me why you are involved in this case?
A: Mr. Banas invited me.
Q: By phone call or by a letter?
A: Pardon?
Q: By a phone call or did he invite you by a letter?
A: Well, I think he said that I'm sending you a case, so I think it was by phone call.
Q: Have you worked with Mr. Banas before?
A: Yes.
Q: Howmanytimes?
A: Perhaps, two other cases.
Q: Have you worked for the firm of Buckingham Doolittle before?

Page 5

A: No; only through Mr. Banas.
Q: Is he the only attorney that you have worked with at that firm?
A: To the best of my knowledge. In that firm, I don't know of any — I think some of the communication was with a Mr. Griffin. I don't know if he belongs to the firm.
Q: But, other than Mr. Griffin and Mr. Banas, you have not worked for anybody else or with anybody else in that firm?
A: Not to my knowledge.
Q: When you are paid for your services, are you paid by a Buckingham Doolittle check or a different type of check?
A: I wish I knew with certainty, because frequently the one who is responsible for the deposition, the check comes from them.
Q: When you have testified in court, you receive payment for your services?
A: Yes.
Q: Does that come from the law firm

Page 6

or from another entity?
A: To the best of my knowledge, from the law firm.
Q: When you get a W-2, you get them from the law firm?
A: Yes.
Q: Are all the opinions that you intend to give in this case contained in the *two* reports that you have written, one dated April 15, 1998, and one dated November 20, 1996? Are all the opinions contained in those reports?
A: Yes.
Q: Other than the firm of Buckingham, Doolittle & Burroughs, have you been an expert witness for any other defense firm?
A: Yes.
Q: How many firms would you say?
A: Perhaps, a handful a year.
Q: How many different firms?
A: Each one is usually a different firm.
Q: But, how many would that

Page 7

constitute?
A: About five.
Q: Five?
A: Yes.
Q: So, is it a fair statement to say that you have testified for five defense firms? How would you characterize it, on a regular basis?
A: No. I'm sorry, when you used the word "defense," I was talking about the entirety because some are for the plaintiff and some are for defense. Roughly, I don't have any exact number, but you can communicate with my secretary and I have told her to divulge anything you want.
Q: Do you think it's evenly split?
A: Yes; perhaps, a little bit more for the defense.
Q: Have you had your deposition taken before?
A: Yes.
Q: Have you had your deposition taken before with respect to any cases in Ohio?

Page 8

A: Yes.
Q: Do you recall what cases those were?
A: Not clearly. I don't remember.
Q: Would your secretary know?
A: I doubt it. They are listed. I know Gary was here, but I don't remember the particular case.
Q: So, Mr. Banas has been here with respect to an Ohio case at least once before?
A: Yes.
Q: More than once before?
A: I think it was once. He is always in my dreams. It seems more than that.
Q: Can you characterize the nature of those cases?
A: I really can't. I think he had a case with some cardiac problems. I got a call.
Q: Were any of those other cases dealing with endomyocardial fibrosis?
A: Yes.

Page 9

Q: Dealing with bacterial endocarditis?
A: No.
Q: Have you ever given a deposition with respect to a case dealing with bacterial endocarditis?
A: I think one is in progress now.
Q: Have you given that deposition already?
A: No.
Q: Do you intend to give a deposition in that case?
A: Yes.
Q: Do you know when you intend to give a deposition in that case?
A: No, I do not.
Q: Do you think it will be this year?
A: I think so.
Q: Is that a plaintiff's case or defense case?
A: That is a plaintiffs case.
Q: And can you tell me who the lawyer is?

Page 10

A: No.
Q: Or the plaintiff?
A: No. I don't know off the top of my head.
Q: Who the lawyer is for the defense, do you know?
A: I do not know.
Q: You don't recall the case name?
A: I don't even know that.
Q: Do you recall what state it's in?
A: The state?
Q: Um-hum.
A: I think it's Philadelphia.
Q: Have you ever reviewed the records in that case?
A: Yes.
Q: Have you written a report in that case?
A: Yes.
Q: Have you written more than one report in that case?
A: No.
Q: How many times would you say that you have testified in depositions?

Page 11

A: I would say about two to three times a year.
Q: Over how many years?
A: Perhaps, five years.
Q: And how many times have you testified live in court?
A: Perhaps, one or two times a year.
Q: Have you had your videotape deposition taken before?
A: Yes.
Q: How many times would that have been?
A: Perhaps, three or four.
Q: Do you recall the names of those cases?
A: No, I do not.
Q: Were any of them in Ohio?
A: I think there was one in Ohio, yes.
Q: Do you recall who the attorney was?
A: No. I think **this** attorney — he called me for a case and I forgot **his** name. Bill something or other.

Page 12

Q: Do you recall when that was?
A: It was for the plaintiff. I forgot **his** last name.
Q: Was it Cleveland?
A: It was, I think, Youngstown.
Q: Bill Summers?
A: No.
MR. BLOMSTROM: He said "Bill something."
BY MR. MALIK
Q: When did you give that video?
A: That must have been about three or four years ago.
Q: And the subject matter of the case?
A: It was a question of coronary artery disease.
Q: With respect to the November 20, 1996, report, Doctor, can you tell me the document or information you relied upon to produce that report?
A: I have these two things that I took from my office.
Q: Can you tell me what they are?

Page 13

A: Okay. One is called the medical records of David Gonda which I received from Mr. Banas's office; the other are some depositions.
Q: Tell me from who, please?
A: From the Hadley, Morgan, Stern, Clarin firm. Dr. Ruiz, Dr. DeMarco. I have a copy of a letter from Dr. Lerman.
Q: And the date on that, please?
A: March 25, 1998.
Q: And then a letter of Burt Rosen & Associates about the economics of the situation.
MR. BANAS: I also sent you the pathologist's report.
THE WITNESS: And the pathologist's report.
BY MR. MALIK:
Q: Sharon Hook?
A: Yes
Q: The same question, Doctor, with respect to the April 15, 1998, report, what did you rely upon?
A: The same thing.

Page 14

Q: When you wrote that —
A: Excuse me. I mean I **think** some of the depositions were recently in coming. For instance, **this** one by Morgan, Stern & Clarin and the pathologist's report came subsequent to the April thing. It just came **this** year.
Q: When you wrote the November 20, 1996, report, was it your understanding that you were going to then write a supplemental report?
A: No.
Q: How did it come about that the April 15, 1998, report was produced then?
A: I think there was a letter to the effect that he had sent these depositions for my review.
Q: So, you would agree that the April 15, 1998, report was written after you received the depositions you had mentioned in the **first** paragraph?
A: Yes.
Q: And would you also agree that you did not have those depositions when you

Page 15

wrote the November 20, 1996, report?
A: Yes.
Q: So when you wrote the November 20, 1996, report, were the medical records of David Gonda the only information that you had?
A: And the autopsy report.
Q: And the autopsy report?
A: Yes.
Q: With respect to the autopsy report, do you have that with you today?
A: It's in here somewheres.
MR. BANAS: I will find it.
BY MR. MALIK:
Q: When was the last time you reviewed the medical records of David Gonda?
A: Every day for the past week.
Q: Can you tell me how many pages there are to that autopsy report?
A: To the autopsy report?
Q: Yes, **sir.**
A: Eight. I think that would be it.

Page 16

MR. BANAS: There is a clinical correlation.
BY MR. MALIK:
Q: With respect to the clinical correlation, how many pages are there?
A: Seven.
Q: When you wrote these reports, were you in possession of any lab results of David Gonda?
A: The lab report from **his** lungs?
Q: Correct?
A: Be more specific. I saw the autopsy report.
Q: I **will** try to be more specific. Have you ever seen any lab report attached to the autopsy report?
A: I have seen mention made of it by a pathologist.
Q: Who is that?
A: The pathologist at the university.
Q: I'm handing you what I will mark as Plaintiffs Exhibit 1. When you reviewed the autopsy report, Doctor, did

Page 17

you also review Plaintiff's Exhibit 1 or is this the first time that you have seen it?
(Plaintiff's Exhibit 1, an autopsy report, marked for identification.)
THE WITNESS: I saw this.
BY MR. MALIK:
Q: You did see that?
A: Yes.
Q: Do you recall when?
A: I think when I saw the pathology report in relationship to that because it was mentioned by the university pathologist.
Q: Do you recall when that was?
A: No.
Q: It was prior to writing your report, sir?
A No. It had to be after because it was just relatively recently that I . . .
Q: Having reviewed it as the information contained in Exhibit 1, does the information contained in Exhibit 1 in

Page 18

any way, shape or form change your two reports?
A: No, it does not.
Q: Is it consistent with your two reports?
A: Well, there are findings that are reported here which required thought.
Q: Is it consistent with your two reports?
A: Well, let me put it this way: There wasn't anything that changed my opinion.
Q: I will ask you the question again. Can you say that it was consistent, the exhibit was consistent, with both your reports?
A: Yes.
Q: Did you rely on any books, journals or other information, other than what you have described here today to render either report?
A: Yes.
Q: Can you tell me what that is?
A: This is called "Endomyocardial

Page 19

Fibrosis" by Moody, Baum, Gil & Ratliff.
Q: Do you know any of those authors?
A: No.
Q: Having looked at that report, would you agree that the main author would be the first person listed on the report?
A: Characteristically.
Q: And, then, what would the second, third and fourth authors be there for?
A: It was a collective endeavor.
Q: But the one — strike that.
Have you conducted any tests with respect to this case?
A: Tests?
Q: Yes.
A: Elaborate.
Q: Did you perform any lab tests? Did you perform any type of test whatsoever? In other words, did you have, first of all, did you have anything to perform tests on, any tissues?
A: No.
Q: Did you review the slides in this case?

Page 20

A: No, I did not.
Q: Are your opinions going to deal with the slides in this case?
A: Only from the standpoint of what was reported.
Q: But you have not looked at those slides under a microscope, correct?
A: That is correct.
Q: Do you intend to look at those slides?
MR. BANAS: He will not see them. I will make it perfectly clear on the record, he will not see them.
BY MR. MALIK
Q: So, your opinions with respect to the slides is going to be limited to what other printed reports say?
A: No. It will be limited to my interpretation of the significance of the finding as I would address it from a clinical point of view.
Q: Tell me what material you have reviewed or are going to review with respect to the slides that you would

Page 21

interpret?
A: Well, I reviewed "Endomyocardial Fibrosis" and I reviewed "Endocarditis."
Q: When you say you reviewed those two, what do you mean?
A: Well, I did what I could to find out from a search of the literature the nature of the lesion.
Q: What literature did you search dealing with endomyocardial fibrosis?
A Well, first, there are — I pointed out one of the articles. There are other articles on endomyocardial fibrosis. The second thing we used was Brownwell's which is the classic text in cardiology and Donald Kaye's book on endocarditis. I searched the literature also for mural endocarditis.
Q: When you say you searched the literature, can you tell me what process of —
A: Pardon?
Q: Can you tell me the process of searching the literature, what you did?

Page 22

A As part of it, I called the American College of Cardiology, their library center, and they found certain articles for me and then I had my own articles.
Q: Where are those articles?
MR. BANAS: Right here.
BY MR. MALIK
Q: Can you tell me what the articles are?
A: Yes. One is endomyocardial fibrosis hemodynamic data in 2090 patients, the results of surgery, infective endocarditis confined to the mural endocardium. There are a list of articles from the American College of Cardiology.
Q: I would like you to tell me what they are. Is that all that's there?
A: Yes.
Q: The list of articles?
A: Right; and the articles themselves.
MR. MALIK: Would you be able to provide me copies.

Page 23

MR. BANAS: I will be happy to provide you copies.
MR. MALIK: *Thank* you very much.

BY MR. MALIK

Q: When you called the American College, did you tell them you wanted this material sent to you by mail?
A Yes.
Q: Where is the American College of Cardiology?
A Bethesda.
Q: Did you talk to any physicians at the American College of Cardiology?
A Thelibrarian.
Q: Okay.
A Her name is Gwen. Funny, I remember that better than the lawyers.
Q: Other than the information there, did you rely on any, and the books you have told me, did you rely on any other books, journals or information?
A: No.
Q: So, the only article with respect

Page 24

to endomyocardial fibrosis is the one written by Moody?
A: No.
MR. BANAS: There is more in there. Whatever is in here. I just happened to have that one out.
THE WITNESS: I listed one for you.

BY MR. MALIK

Q: With respect to exhibits, can we just make that Exhibit 2? Did you review that literature recently, Doctor?
A: Yes.
Q: Did you review it in preparation for the deposition?
A: Yes.
Q: Have you spoken to any colleagues with respect to **this** case?
A: No.
Q: Have you, since you have received this case, gained a greater knowledge of endomyocardial fibrosis?
A: I was always interested in endomyocardial fibrosis because I have been

Page 25

a teacher most of my **life.** It represents one of the rare things that happens to the heart and, so, I had a passing kind of interest in it. I was the first to write about the heart and muscular dystrophy which enabled me to get interested in **this** problem of fibrosis of the heart, so I have had a long-standing interest.
Q: Have you ever treated patients who have had endomyocardial fibrosis?
A: No.
Q: Is this the first review of records with respect to endomyocardial fibrosis that you have done?
A: Yes. I told you it was a constant review. I have always done that. I told you this is not anythmg new for me. What is new — I collected them to renew my knowledge of it.
Q: Do you claim to be an expert in the field of endomyocardial fibrosis?
A: Well, **as** much as anyone is from a clinical point of view.
Q: And how can that be if you have

Page 26

never seen a patient with endomyocardial fibrosis?
A Most of **us** have never seen a case.
Q: Your expertise is limited to what you have read?
A: That **is** correct.
Q: Have you ever reviewed slides?
A: Excuse me, I became an expert in muscular dystrophy. That was based on one case.
Q: Have you ever reviewed slides with respect to endomyocardial fibrosis?
A: It was handed around as part of my pathology training in school, but not since.
Q: You went to school, if I remember correctly, from **1941** to **1944.**
A: **Yes.**
Q: So, is that the period of time that it was handed around to you?
A Yes.
Q: How much time would you say that you have spent reviewing the records for

Page 27

your November 20th report?
A: I hate to tell you guys ***this,*** but I really spend an awful lot of time on these. I charge what seems to be reasonable, but if I had to charge you, you would think it was preposterous. I do spend a lot of time.
Q: I'm more concerned about a lot of time than the money. How much is a lot of time?
A: In preparing for **this** today, I did **this,** again, every day for at least an hour including **this** morning.
Q: Can you tell me, then, how many hours you consider to be a lot of time?
A: Well, I would —
Q: I'm not trying to be argumentative.
A: For the total thing from the beginning?
Q: For your November 20 report, correct.
MR. BANAS: For the first report. Go ahead.

Page 28

THE WITNESS: The official charge was $1,500. That included everything. But, my point is that it's basically **$400** an hour. I said for the first thing it's $1,500. In the review — I spent certainly triple that amount in reviewing things, so the answer to your question would be certainly about fifteen hours.

BY MR. MALIK

Q: For your November 20th report?
A That's correct.
Q: And then how much time in addition for your April **15th** report?
A: Again, a good fifteen hours reviewing everything.
Q: So, we have ffteen hours for the first report, fifteen for the second report. And how much time for the deposition?
A: Well, at least five hours.
Q: Okay. And that was over what period of time?
A: When I first heard of the case

Page 29

back in 1996 or so.
Q: How many times would you say that you have rendered written medico-legal opinions since you have been a physician?
A: Well, I indicated to you that I get cases about five times a year. Certainly, that.
Q: How many reports would you say you have written?
A: In each case I get, there is a written report.
Q: Five times a year for five years?
A Yes.
Q: Is that what you said?
A Yes, more or less.
Q: And do you charge $400 an hour to write the reports, too?
A Yes.
Q: Can you tell me how many years you have been working with Mr. Banas's firm?
A: I would say it goes back, perhaps, at least five years. I couldn't be certain about that.

Page 30

Q: Can you tell me what states you have testified in?
A: Pennsylvania, New Jersey, Ohio, Delaware.
Q: How many times have you given actual live testimony for the firm of Buckingham, Doolittle in court?
A I don't think ever.
Q: Was your trial testimony then videotaped for them?
MR. BANAS: I can answer that. There was one time I put him on videotape back in the days when we had arbitrations. I think he has seen three cases, one a giant cell myocardial endocarditis case which there was a deposition. There was no videotape or anything else. I think that's it. That's my recollection.
The one where you testified on videotape, that must have just disappeared because it was never used in court.
BY MR. MALIK:

Page 31

Q: What is it that interests you about the medico-legal cases that causes you to get involved with them?
A: Well, first, the retrospective scope when you know the outcome. It's much nicer to practice medicine that way, but the second thing, and far more important, is that you have to know what you are talking about and, so, it stimulates you to make sure you know what you are talking about; and then the confrontation with lawyers is exceedingly appealing to me.
Q: It gets your blood going?
A: Yes.
Q: You feel revitalized after that?
A: Yes.
Q: It's kind of like learning a new piece on the piano; once you get it, it's great.
A: Yes.
Q: Was there anything that occurred five years ago that just caused you to get involved in these cases?
A: Well, in a way yes because I was chief of medicine and was the stairway to riches by many lawyers, so I got involved that way. I had to defend myself. I had nothing really much to do with it.
I was at a poor hospital taking care of the poor as part of my academia and we got sued. It was fascinating to see the cases and so forth.
Q: It was about the time that you were ordained a defendant in a case that you got involved?
A Yes.
Q: That you were named.
A I saw the doctors that some of you called upon. I said, my gosh, we can do better than that.
Q: In terms of coming in live for testimony in court, what are your fees?
A: I'm not sure; but, about $5,000.
Q: Per day?
A: Yes.
Q: Plus expenses?
A: Plus expenses.
Q: With respect to your role as a

Page 32

Page 33

physician, do you have more of a clinical practice or are you more in a teaching role at this point?
A No, clinical.
Q: How much of your practice is clinical, percentagewise?
A: About ninety-Eve percent, if not more. I do very little teaching today.
Q: Have you ever authored any articles of any type?
A Yes.
Q: On the subject of endomyocardial fibrosis?
A: No.
Q: What about bacterial endocarditis?
A: What are you looking — I don't remember offhand any particular one. I mentioned the one about muscular dystrophy that I was involved in. The answer to endomyocardial fibrosis, no.
Q: I want to tell you something, there's no trick questions here. If you need to refer to something, please do it.

Page 34

If you had written an article on bacterial endocarditis, would it have been listed in the resume?
A: Yes.
Q: If it's not listed, then it didn't happen?
A That's correct.
Q: Do you know what the symptoms of endomyocardial fibrosis are in a 27-year old male?
A: The major symptom would be related to heart failure, so that that would manifest itself as shortness of breath. And the reason that comes about is because of the scar tissue, so to speak, would involve the valvular apparatus and not permit the valves to function adequately and then encroach upon the myocardium.
What I was thinking about, I did write a case where the endocardium got filled with clots which eventually became fibrotic which interfered with left ventricular filling.

Page 35

Q: Was that in the case dealing with muscular dystrophy?
A: No. This was in one of the reports about clot formation in the left ventricle.
Q: Doctor, what would be the early warning signs of endomyocardial fibrosis in a 27 year-old man?
A: The early warning sign? It's such an unusual thing that actually you have to go on the basis of the literature, what has been reported. And most of the reports emphasize the pathologic manifestation: I have this case in Africa and this is what I found and so forth. They go back and say, well, during life he had heart failure and so you transcribe that into shortness of breath and swelling of the liver or legs and so forth. To my knowledge, no one has taken the reverse, let's say, from the beginning because who knows where the beginning is.
Q: You are speaking from a postmortem aspect?

Page 36

A: Yes.
Q: Would fever be consistent with endomyocardial fibrosis?
A: Usually, it's not emphasized.
Q: What about a persistent cough?
A: No.
Q: What about a cough *so* severe that it wakes you up at night?
A: No.
Q: Shortness of breath?
A: The cough would only be part of heart failure and that would be apparent.
Q: So, at the point there is congestive heart failure?
A: That's correct.
Q: You are saying the cough would be a significant symptom?
A: Only if there were congestion of the lungs; that would be apparent.
Q: Absent congestion of the lungs and a cough, would that be consistent with endomyocardial fibrosis?
A: No.
Q: You indicated in one of your

Page 37

reports, there is no therapy for endomyocardial fibrosis, correct?
A: That is correct.
Q: What do you base that statement on?
A: I base it on the fact that so far in the cases that were reported in Africa, it's not clear what the etiology was due to. So, to this day we are unclear whether it was an epidemic at that particular time, whether it was bacterial, viral and so forth. No one ever isolated things. We don't know whether it was nutritional. We have no knowledge as to what the etiologic agent is, other than the fact that we saw it in Africa. There have been some isolated cases here but, again, there is no apparent cause for its development.
Q: Would an echocardiogram reveal endomyocardial fibrosis?
A: That's one of the questions I asked myself. So what I did was actually go to the literature and see. Even with the most exacting

Page 38

instrument that we have available today, namely a transesophageal echocardiogram, how often they have recognized endomyocardial fibrosis; and I have some pieces of literature in that same pack, and the interesting thing is that disease is never mentioned. They mention tumors and clots and so forth, but no one sees endomyocardial fibrosis.
Q: Let me break it down a little it. You are talking about aTEE being the more accurate than the 2D Doppler echo?
A: I cited that in response to your question, yes.
Q: Will aTEE properly performed pick up scarring in the heart, scar tissue?
A: The answer is yes.
Q: Will it pick up an inflammatory process going on in the heart?
A: Not particularly. We are trying to develop methods for differentiating tissue, but when you say inflammation, that depends upon what you mean by that. In other words, if one has an abscess, the

Page 39

answer is yes. If one has a valvular lesion which might be inflammatory, the answer is yes.
Q: What about an abscess in the right atrium extending into the outflow track?
A: Well, again, if it were an abscess, the answer is, yes, it should.
Q: The same thing with the right ventricle, correct?
A: That is correct.
Q: What about blood clots?
A: Yes.
Q: What size blood clot could aTEE pick up? What would be the smallest?
A: Could be one centimeter.
Q: Could it be less than one centimeter?
A: Yes.
Q: Would it pick up — would the TEE pick up malformations of the chambers in the heart? For example, if there were a dent in the right ventricle, the wall of the right ventricle, would the TEE pick

Page 40

that up?
A: Yes.
Q: Let me talk to you a little bit, please, about bacterial endocarditis. How many cases of bacterial endocarditis would you say you have treated in your career?
A: Oh, perhaps, one a year.
Q: You have been practicing medicine for how long?
A: Since 1950.
Q: What is your age?
A: 78.
Q: What causes bacterial endocarditis?
A: Well, it's infective endocarditis. That's to indicate there is an involvement by micro organisms other than bacteria, so it's actually the invasion of tissue by micro organisms. We use the term endocarditis to emphasize the a] fact that the site of the invasion is the heart.
Q: So the micro organisms, they may be bacterial?

Page 41

A: That is correct.
Q: They may be a fungus?
A: That is correct.
Q: They may be viral?
A: That is correct.
Q: Have I missed anything?
A: No. Those would be the major ones.
Q: Can you tell me what the symptoms of bacterial endocarditis in a 27 year-old man would be?
A: Well, there is one man that I have that is still alive. His initial manifestation was depression and by looking at his eye grounds we were able to find certain lesions that indicated to me that he had endocarditis. Moreover, he had a heart murmur.
The first sine qua non is not really related to a symptom, but the person may volunteer I have known of a heart murmur. That kind of person may present himself with fever. He may present himself with fatigue or malaise, which is

Page 42

our favorite word. So I think the person just doesn't feel welt, and with that kind of background about the heart that I told you about —
Q: Let me ask you this: Is fever a sign of infective endocarditis?
A: Yes.
Q: Is cough a sign of infective endocarditis?
A: By itself, no.
Q: What about the patient with a systolic click, but no heart murmur?
A That is an interesting phenomenon because we have always emphasized that when you have a systolic click, just make sure you don't categorize the person as having heart disease because it may be a normal phenomenon. To explain that, there are heart sounds, the first heart sound, second heart sound. In this one, he had a systolic click.
I think Dr. Ruiz was the only one that found it when he went to the University Hospital. And at the Cleveland

Page 43

Clinic, no mention was made of any click, so that's part of the problem. A person might hear something that others may not hear. The second thing is: What does it actually mean? If I can just describe it as when the heart contracts, the blood that is ejected may smack against the aorta or the pulmonary artery and the sudden movement of that produces a clicking sound. The same thing may occur with the mitral valve where that billowing wind gets into the valve or the sail and you see the sail billow and it produces that sound. So of and by itself, it has limited or no meaning; and be careful that you don't ascribe it to heart disease that may not be there.
Q: In all fairness, though, it's a characteristic of systolic clicks that sometimes they are heard and sometimes they are aren't heard, correct?
A: Yes.
Q: Sometimes they are heard and sometimes they aren't heard?

Page 44

A: That's why I emphasized yes.
Q: It can be present, but it may not have been heard on that examination?
A: More often than not, it's missed by others. Or some people imagine they hear it.
Q: Is shortness of breath a characteristic of infective endocarditis? Would you prefer I use the word infective —
A As long as we understand we are talking about the same thing.
Q: Okay. Shortness of breath.
A: Of and by itself, no.
Q: You reviewed Dr. Ruiz's records of David Gonda?
A Yes.
Q: Can you tell me — can you refer to those records on June 27, 1995.
A Perhaps, I can remember it. I can relate —
Q: I can find it for you.
A You said —
Q: June 27, 1995.

Page 45

MR. BANAS: Do you want more than that?
MR. MAUK Is that all you have?
MR. BANAS: I didn't put these books together.

BY MR. MALIK

Q: Have you seen those records before?
A: Yes.
Q: On that date, can you tell me what David Gonda's symptoms were?
A: It is stated here that he was treated by Dr. Adrinata (phonetic) for several days for a sore throat and fever. He was given Duracef by Dr. Adrinata. The symptoms didn't improve. He was then put on Xynthromax. He continued to have fever white taking the antibiotic. It goes on that the fever is daily.
Q: Based on that medical record — we are going to make that Exhibit Number 3 — is there anything in there consistent with infective endocarditis?

Page 46

A: Well, not specifically.
Q: Is there anything significant in there consistent with an infection?
A: Yes.
Q: What is that?
A: Fever.
Q: Now, would that infection be bacterial or would it be something else?
A: It could be anything. It doesn't have to be infection.
Q: Okay. So, as we sit here today, and I'm looking at the June 27, 1995, records, it's your testimony, to a reasonable degree of medical certainty, that cough is not consistent with infective endocarditis?
A: I say it's not characteristic of endocarditis.
Q: Is it consistent with it, though?
A: Part of the background — in other words, you have this person with fever. I mean he can have cough and sore throat in addition to that which doesn't minimize that possibility, but it makes you

Page 47

think in terms of something related to the sore throat and cough rather than to the heart.

Q: So, cough is, to a reasonable degree of medical certainty in this case, consistent with infective endocarditis?

A: Yes.

MR. TRAVERS: Objection.

THE WITNESS: Endocarditis would be the last thing that one would think about. There are things way ahead of it.

BY MR. MALIK:

Q: What else —

A: Respiratory infection is way ahead of it. I wouldn't think of an endocarditis.

Q: What else?

A: Pardon?

Q: What else?

A: What else is the cough due to?

Q: I think you were telling me what your differential diagnosis was when I said cough.

Page 48

A: Yes. We would be thinking of, in addition to a respiratory infection, we would be thinking of, for instance, a neoplasm.

Depending upon if it were a cigarette smoker or older, we would be thinking of, perhaps, some local process infecting the vocal cords and the like, but the cough itself is not the trigger to think of endocarditis.

Q: Now, can you characterize for me the type of cough that David Gonda had on June 27, 1995?

A Other than what is stated here?

Q: What does it say?

A: "Coughing frequently, but doesn't seem to be distressed."

I saw some — I don't know where I can put my finger on it, but there was some mention made that it was productive of mucus.

Q: Now, when you add fever into the equation so that you now have cough and fever, is that consistent with infective

Page 49

endocarditis?

A: Certainly doesn't exclude it. But, we are looking more in terms of something that reduced fever and cough. There, we would think primarily in terms of acute respiratory disease.

Q: Would any of those acute respiratory diseases call for the implementation of an echocardiogram?

A: No, sir.

Q: What about the cough with the fever, would that —

A: No, sir.

Q: Is there anything in the records of June 27, 1995, that would indicate to you that an echocardiogram should have been ordered?

A: Well, not really because the emphasis is on the fever and cough. I don't know how he addressed the problem of systolic click.

Q: When you add sinus tachycardia into the equation, can you tell me, to a reasonable degree of medical certainty,

Page 50

whether or not that increases the likelihood of infective endocarditis?

A: No relationship at all because, again, to elaborate on it —

MR. BANAS: That's all right.

BY MR. MALIK:

Q: If you want to elaborate, it's fine with me.

A: For every degree of elevation of temperature, there is a ten percent rise in metabolism, so that one would anticipate, unless there is a specific kind of fever like Typhoid fever and so forth or a certain kind of viral infection that might produce a relative bradycardia, a slowing of the heart rate.

Q: Doctor, with these symptoms, would you order blood cultures?

A Absolutely not.

Q: Why not?

A It's not our practice that you associate this with respiratory infection. Most of us feel that it is not related to

Page 51

bacteria, *so* that it would be senseless and very costly to order a blood culture.

Q: Why was David Gonda on antibiotics at this time?

A: We do what we call imperically, that is, today's example of the epidemic that's going around, even though we feel it might be viral in origin, most people get an antibiotic and the antibiotic is not helpful.

It's possible when you look the other way and say, maybe, there will be a secondary infection, *so* I want to give the antibiotic to prevent the secondary infection that might occur; or there might be a sinusitis that I just can't put my fingers on or there might be this or there might be that, so you take the risk. And what is the risk? He will have an allergy to the antibiotic. So you say, well, that's a little thing. The patient has put pressure on you to use an antibiotic. That's why we use it.

Q: Do you know what antibiotic he

Page 52

was on at that time?

A: Well, he mentioned Duracef and Xynthromax and, I think, later on Doxycycline came into the forum.

Q: Are you able to tell me the specific type of bug erythromycin would affect?

A: I told you before that the use would be empiric. This is part of our standard of practice.

Q: Empiric meaning broad spectrum?

A: No. Meaning I smell acute respiratory infection to prevent a secondary invasion and so forth or, maybe, it will be helpful. We use these antibiotics and, I think, it would be fair to say that Duracef and Xynthromax and Doxycycline are the commonly-employed antibiotics.

Q: But they have different functions in terms of they attack different bugs, correct?

A: In general, they are broad-spectrum antibiotics.

Page 53

Q: Let's assume for a moment you have a patient that is on erythromycin and it's your decision to order blood cultures, would you take that patient off of the antibiotic before ordering a blood culture?
A The answer is yes.
Q: Why would you do that?
A: Well, there is a possibility that the erythromycin is holding the bacteria in check.
Q: Would that also be applicable to Xynthromax and to Duracef?
A: Yes.
Q: On June 27, 1995, Dr. Ruiz performed an electrocardiogram, correct?
A: Yes.
Q: He had also performed one earlier. I believe it was in 1989, correct?
A: That's correct. But that has always been too light. I can't see it. Do you have that.
Q: Does this look any better to you?

Page 54

MR. TRAVERS: It looks better to me than the original I have. Other than taking some steps to have it laminated —
MR. MALIK Other than taking it to Kinko's and having it laminated, I would have not done anything to this.
THE WITNESS: No, it is not adequate.

BY MR. MALIK

Q: Can you read on the bottom what Dr. Ruiz wrote?
A: Yes.
Q: Is there any part of it that you can see that is consistent with what he wrote?
A: Well, for instance, I can see where he wrote "low atrial rhythm," and the P-wave is positive in one and negative in two and three. That would be justified. That simply means a wandering pacemaker, which is a normal variant.
Q: You lost me.

Page 55

A: He says "low atrial rhythm." The 1'-wave that I was referring to refers to the deep polarization of the sinus pacemaker or the liter of the heart when it comes to rhythm. It originates in a certain place.
If for one reason or other, nerve impulses occurred so that that pacemaker loses the baton, another part of the heart becomes the pacemaker. That's all that refers to. It's a normal phenomenon. I would agree that I see enough here to say, okay, there is no great shakes about that.
Q: Is there anything on there that indicates a bundle branch block?
A: I didn't see any bundle branch block.
Q: You saw the EKG of June 27?
A: Yes.
Q: Can you interpret that for me?
A: Yes. There is a sinus rhythm, and it shows low voltage of the QRS. It shows some SDT abnormality. I will get into the interpretation as you ask me.
Q: Let's break it down a little bit. What does it say on the strip in terms of what Dr. Ruiz found?
A Sinus tachycardia. That refers to the fact that the heart rate is greater than 100. Then, it says "increase septal forward," which simply refers to the fact that the R-wave is a tiny, little bit more prominent than usual; so, no great shakes about that.
Q: Anything else?
A And then it says "remnant of juvenile T-pattern."
What that means is that when you are young, that part of the electrocardiogram is characteristically what you see here. And then as you grow older, it gets less and less, so that we call that the juvenile pattern. This might be, as the doctor reported, that it might be simply a variant of the juvenile pattern.
Q: Are you able to compare the two

Page 56

Page 57

EKGs?
A: Not really. I told you in one way there seems to be sinus rhythm and not atrial rhythm. I can see where the early repolarization is not here anymore. And that's about it.
The voltage, where I see this voltage, this seems to be lower than the voltage that I see there.
Q: Can you tell me what the lower voltage indicates?
A It could be a question of technique. And there isn't anythmg here that indicated to me their standardization.
I may be missing it, but I have not seen that. In other words, we put in a certain voltage to get a certain deviation, so I'm just giving you the general principle. The voltage may be less simply because you standardize it differently. Let's assume that the standardization was the same and, in which case the voltage is different. So then

Page 58

there are several possibilities for that. The individual may have gotten fatter; he may have developed more air emphysema or he may have developed something regarding the pericardium that surrounded the heart to short circuit the electric current that's produced by the heart.
Q: Does the lower voltage indicate a less efficient heart?
A: No, it may not have anything to do with — it could have, but it may not be.
Q: Would it have anything to do with the pumping ability of the left ventricle?
A No. Let me elaborate. In other words, we don't ascribe force to what we see in the electrocardiogram.
Q: Is there anythmg, by comparison in those two EKGs, that would lead you to perform an echocardiogram?
A: Yes.
Q: What would that be?
A: Well, for instance, the low voltage of the KRS.

Page 59

Q: Let's assume for the moment you have had an echocardiogram performed. First of all, what type of echo would you order?
A: I would be primarily concerned with something affecting the pericardial layer and, so, we would inquire about that.
Q: Would you use aTEE or a 2D Doplar echo?
A: In 1995 and 1999, we don't order the TEE as the first procedure.
Q: Can you tell me whether or not, to a reasonable degree of medical certainty, whether the 2D echo would be the appropriate echo?
A: Yes. We would start with the transthoracic echocardiogram.
Q: What is pericardial effusion?
A: What is it?
Q: Yes.
A: A collection of fluid between the outer layer and the middle layer of the heart.
Q: Looking at these two EKGs, is

Page 60

there anything in there that would lead you to believe there could be pericardial effusion?
A: Well, it indicated the low voltage of the QRS.
Q: Okay.
A: But, again, I hasten to tell you, it's not pathognomonic. You can't say it and say pericardial effusion.
Q: Performing the 2D echo — strike that. What did you mean when you —
A: When you look at the electrocardiogram and you see low voltage, it's not an absolute finding of pericardial effusion. More people with low voltage have no pericardial effusion.
Q: When you are looking for that on echo, what are you looking for?
A: That's it, fluid.
Q: Are you looking into the interior of the heart?
A: Here is the ventricle and here is the pericardium; and, so, fluid accumulates between the two.

Page 61

Q: Would you be looking into the interior of the heart upon that echo?
A: Well, it depends on what you want to look for. It doesn't — it's not like taking a picture of the face. I'm taking just a picture of the nose. Forget the rest of the face. So, one can simply look at the pericardial fluid and you won't have — you don't pay too much attention to the anterior of the heart.
Q: When performing the 2D Doppler echo, what will the echo show the radiologist?
MR. BLOMSTROM: Obiection unless there is some evidknce — unless this is a test performed by a radiologist.
MR. BANAS: You may answer.
THE WITNESS: First of all, whose priority is it? It's not necessarily the radiologist. So at any rate, when the question implied that the radiologist had control over it, which isn't necessarily so —

Page 62

BY MR. MALIK:
Q: What will the 2D echo show the examiner?
A It depends what you are looking for.
Q: Tell me again when you are looking for pericardial effusion.
A: For instance, if I say to you "I'mconcerned about this fellow, would you tell me if he has any pericardial fluid," he will say "I looked at him and there is no pericardial fluid." End of report. That's all.
Q: How much more difficult would it be to take a look at the atrium, the ventricles, the valves, the way the heart isfunctioning?
A: Essentially, nothing at all.
Q: If I told you that this exam for pericardial effusion was done by an examiner not licensed for a 2D echo, would you consider that below the standard of care?
A: Obviously. The answer to the

Page 63

question is obvious. If he is not licensed, my life depends upon what the echocardiographer reports to me.
Q: That's to a reasonable degree of medical certainty, correct?
A: If he reports something to me, I have to accept that because I'm at his complete mercy. My reputation is at stake. There is nothing I can do clinically or by any other procedure to say in that situation whether he is right or wrong.
Q: But, to a reasonable degree of medical certainty, it is below the standard of care for a nonlicensed examiner in 2D echo to look for pericardial effusion?
MR. BLOMSTROM: Objection. There is no licensure for that.
You are asking trick questions despite several times saying that you are not doing that because the licensure has to do with the license issued by the state of Ohio. There is no evidence in this case that

Page 64

Dr. Hafiz does not have a license by the state of Ohio, which he does.
BY MR. MALIK:
Q: Do you need me to read the question back?
A: Well, let me just put it this way: We do the echocardiograms in our office. They are not shipped out. But even if our office, the individuals that are doing it — I'm the only one certified by the Society of Echocardiography. The rest are not. They are doing it. So when I say my life is dependent upon them, I know what I'm getting.
If a stranger came in, I wouldn't be happy with that. In answer to your question, yes, it could be. They don't have any license, but they are reporting their finding to me.
Q: Is it below the standard of care for a noncertified echocardiographer to perform an echo for pericardial effusion not using the 2D Doppler echo?
A: That is correct, it's not below

Page 65

the standard of care.
Q: Is it below the standard of care?
A: It is not below the standard of care. These people, to my knowledge, to this day are not licensed.
Q: Do you have non-2D Doppler echos in your office?
A: Yes.
Q: So what you are telling me, you have people who are not certified using the 2D echo to perform examinations?
A: That is correct.
Q: When that occurs, are you always present?
A No, sir.
Q: How is the echo recorded?
A: Now is it recorded?
Q: Yes.
A: In the conventional manner.
Q: Do you use tapes?
A: There are tapes.
Q: **Is** there anythmg else?
A Documentation. Doppler. Sound.
Q: I'm curious. In Pennsylvania, **is**

Page 66

there a certification to be an examiner with 2D Doppler echo?
A: No, not to my knowledge. I think all of us, at least in my office, are certified in the subspecialty of cardiovascular diseases, and we went one step further. There are people that devote their lives simply to echocardiography. There is no such person in our office or in the hospital.
Q: Are you aware of whether or not there is a certification in Ohio to being an examiner with a 2D Doppler echo?
A: I'm not aware. I don't know their rules.
Q: **Is** there an indication in the records on June 27, 1995, than an echo was performed?
A I'm not so sure about the date. I know that an echo **was** done in regard to the presence or absence of pericardial effusion.
Q: **Is** it below the standard of care not to record those findings?

Page 67

A: I saw it written someplace that there was no pericardial effusion.
Q: Is it below the standard of care not to record those findings on videotape?
A: It depends upon the circumstances under which — I don't know what they did. We would certainly want some documentation that someone saw it.
Q: Other than video, what other documentation is there?
A: Well, there is — you can get **an** image reproduced. You don't need the video.
Q: How do you get an image reproduced?
A: Just push the right buttons and you get an image.
Q: Like a Polaroid?
A: Yes.
Q: To go back to my question: **Is** it or is it not below the standard of care to have neither a video or an image produced?
MR. BLOMSTROM: Objection.
THE WITNESS: I really can't

Page 68

answer that. The only thing that I can tell you is that I assume that the doctor who saw **this** said that there was no pericardial effusion and that he was looking for it.

BY MR. MALIK:

Q: In your practice, do you always have either an image or a video?
A: Yes. This is the one that I saw.
Q: Is that a sufficient report?
A: Yes. I thought that you were referring specifically to an ultrasound report by itself. That's what I have, right.
Q: Did you see **an** ultrasound report by itself?
A: No. That's the only one that I saw. I mean later there was a transthoracic echo and a TEE .
Q: Dr. Hafiz has testified that this was the only time he has ever done an echo for pericardial effusion in that office. Typically, they do other organs of the

Page 69

body.
Do you have an opinion as to whether or not it's below the standard of care to perform an echo under those circumstances, not having performed them in that office before?
MR. BLOMSTROM: Objection.
MR. BANAS: If you can answer it, go ahead.
THE **WITNESS:** It's really unfair to ask that question. I don't know what their — I don't know what their setup was. He may say **this** is the first one that he has done, which is just amazing to me. If that would be the first one that he did and not make mention of it, why wouldn't he say that in **his** report I never did **this** before? I mean I don't see anything like that that he was expressing inexperience.

BY MR. MALIK:

Q: **Assuming** that I'm correct that **this** was the first one that he had done in

Page 70

that office, would you expect him to inform the patient of that?
MR. BANAS: The first one he did in that office?
MR. MALIK For pericardial effusion.
MR. BANAS: Are you suggesting he had never done any others anywhere?
MR. MALIK Exactly, that's what I'm saying.
MR. BANAS: I don't know what you are suggesting.

BY MR. MALIK

Q: Assuming this is the first time that Dr. Hafiz at Youngstown Radiology had performed and echo for pericardial effusion, would you expect **him** to have told either the patient or the patient's parents that that was the case?
A. Certainly not.
Q: Why not?
A: He would be foolish to say that. First of all, you are not harming the

Page 71

patient. He doesn't know what's going to be done by Dr. Ruiz or what's going to be done with the report. He doesn't know anything about those circumstances. He is giving it as though he is the world's authority on it. If he wants to express uncertainty about his finding and say, look, this is the first I have done it, I don't know why he would do that, even. That's the kind of remark he should make to the doctor, not to the patient.

Q: Do you think that he should have told Dr. Ruiz that they don't do ultrasound for pericardial effusion in that office?

A I would think that he would do that.

Q: Would you say it's below the standard of care to have not told Dr. Ruiz that?

A: If that's the picture that you are describing. As I keep on coming back, I can't imagine that.

Q: Doctor, would you agree with me that it is deceiving and deception to the

Page 72

patient to have performed a so-called ultrasound, but to have, number one, been the first time in that office with that equipment that it was performed and, number two, limited in scope?

A: Absolutely not. We do this all the time. When a new person comes on board, he does even a TEE. If it's the first time he has done it, he doesn't, like, shake the patient and say this is the first time I have done that. That has never happened.

Q: My question goes to don't you think it's deceptive to perform an echo under those circumstances and not tell the patient?

A: Absolutely not.

Q: What if the patient thinks he has a complete ultrasound of the heart when in fact —

A: He doesn't know anything about it.

Q: Okay.

A: He can't differentiate what is

Page 73

complete and incomplete.

Q: It's your testimony that the physician has no obligation to tell the patient whether or not the ultrasound is Limited or complete?

A: It's irrelevant. He doesn't tell him that. The ultrasound answered the question for the doctor. Does this patient have a pericardial effusion, the answer comes back no.

Q: Assume for the moment that I give you a phone call and I tell you that I'm really concerned about my 27-year old son, I'm concerned about the condition of his heart, what can you reassure me about before giving that answer? What information would you want to have?

MR. BANAS: Talking about a cardiologist?

MR. MALIK: To a cardiologist, correct.

MR. BANAS: There is no defendant cardiologist in this case.

MR. MALIK: I understand

Page 74

i' : ir > ic there is > cardiologist in this matter.

MR. BANAS: If there is one —

THE WITNESS: The person asking me that question, I would ask them to elaborate.

BY MR. MALIK:

Q: My son has a fever, my son has a cough, my son has sinus tachycardia, he is 27-years old; I call you because I'm really worried about his heart. Before you give me information — actually, I'm calling you for reassurance. Before you give me any information, what information would you want to have?

A: Well, you indicated to me that you were concerned about —

MR. BANAS: Let's talk about the privilege. You are talking about somebody calling. Has there been a release of any information of the privilege?

MR. MALIK The privilege

Page 75

has nothing to do with this.

MR. BANAS: Who is calling?

MR. MALIK A patient's mother or father.

MR. BANAS: This is an adult.

MR. MALIK: The patient is 27-years old. The person calling is a parent, an adult. The privilege is not an issue.

BY MR. MALIK

Q: What information would you want to have before giving me an answer?

A: I would say to the person why are you worried about the heart? Where did that come from?

Q: I want an answer from you. What can you tell me?

A That would be my answer, "Why did you say the heart? What is it about him that you mentioned heart?"

Q: Let's add into the equation this occurred on June 27, 1995. Would you still give that same answer?

Page 76

A Yes.

Q: Dr. Ruiz has on his door at his office the indication that he is involved in internal medicine and cardiovascular disease. Do you consider that representation of cardiovascular disease to indicate that he is a cardiologist?

A: Well, certainly, in his own mind he is specializing or he is interested in diseases of the heart and great vessels which is the function of a cardiologist. He may not be certified in it, but that doesn't mean he can't be interested and experienced.

Q: Okay. Are any of the symptoms of endomyocardial fibrosis similar in nature to infectious endocarditis?

A: Usually not.

Q: Can endomyocardial fibrosis infectious endocarditis coexist in the heart!

A: What, sir?

Q: Can they coexist in the heart?

A: As I indicated, you are dealing

Page 77

with a rare lesion.
Q: What would be your answer, no?
A: The answer is not to my knowledge.
Q: Okay. You could say that to a reasonable degree of medical certainty, correct?
A: That is correct.
Q: Can endomyocardial fibrosis or infective endocarditis manifest themselves in hearts other than a human heart?
A: I have not reviewed the nonhuman literature.
Q: You are not aware whether dogs or cats or rats —
A: No, that's correct.
Q: All right. Other than antibiotics, is there any other treatment for infective endocarditis?
A: Of course, surgery.
Q: What type of surgery?
A: Well, removal of the valve.
Q: Let's assume as in this case David Gonda had infective endocarditis;

Page 78

let's assume that based upon the autopsy report there was no valvular involvement; let's further assume that — let's delete the last part of that.
Based upon the lack of valvular involvement, is there any surgery that could be performed to cure infective endocarditis?
A: No, sir.
Q: So the surgery that we are talking about is limited to the valve?
A: The valve.
Q: Talking about the mitral valve?
A: Mitral or aortic. Sometimes the tricuspid or even remotely the pulmonary.
Q: Does an autopsy always show floppy valves?
A: Does an autopsy always show floppy valves?
Q: Let's assume a patient has a floppy valve, would that always show up on autopsy?
A: There is a counterpart of it.
It's what we call mixometous degeneration,

Page 79

and we would anticipate that kind of finding. We would expect a kind of redundancy of the valve. So, in answer to your question, yes, I would anticipate some finding on autopsy to confirm the diagnosis of floppy valve.
Q: In your opinions today, are you rendering those opinions as a specialist in internal medicine?
A: I'm certified in internal medicine. Whatever I do in cardiology, I hope, is based on my expertise in internal medicine.
Q: So then you are rendering those opinions both as somebody board certified in internal medicine and cardiology?
A: That's right. I'm very proud that I don't separate the two.
Q: Okay. You have a board certification in each?
A: That is correct.
Q: What was the diagnosis of David Gonda on June 27, 1995?
A: You want me to — from my point

Page 80

of view what I gathered from the Dr. Ruiz deposition, he had acute respiratory diseases and he was concerned about the possibility of something affecting the upper respiratory tract such as sinuses and the like. And being at a limit as to what he knew, because he went over the patient thoroughly, he couldn't find any abnormality, he referred the patient elsewhere. That was the reasonable thing to do.
Q: Is the EKG he took on that day, June 27, abnormal?
A: Yes.
Q: Is the EKG from 1989 abnormal?
A: Well, I indicated I can't define that with certainty. Whatever I saw, I told you that there were certain differences that I addressed.
Q: Are you able, from what you saw, to classify that EKG as abnormal in 1989?
A: Well, it indicated that it showed low atrial rhythm. I can't define anything else with it with certainty.

Page 81

Q: Is low atrial rhythm an abnormality?
A: It was a variant of a wandering pacemaker.
Q: I'm trying to get a definition.
MR. BANAS: Was it abnormal?
THE WITNESS: From what — the way I would report this, I can't give you an opinion.
BY MR. MALIK:
Q: Because you can't read it?
A: I can't see it.
Q: Okay. Let's put yourself in Dr. Ruiz's place on June 27.
A: Yes.
Q: In your differential diagnosis, what factors are you considering?
A: Here, you have a 27-year old fellow going to law school; he comes in with fever. You put him on an antibiotic. If you can't find any abnormality after going over him, you say, well, let me keep on looking. I will take a chest x-ray.

Page 82

The chest x-ray is done and it's reported as normal. That is the route we would go.
I would have included the x-ray of the sinuses at that particular time, but most of us would simply say we will go ahead with the x-ray of the chest. Then, secondly, he said, gee, I took an electrocardiogram, there is low voltage here. Fever goes along with pericarditis sometimes. Maybe I'm missing something, even though the heart seems normal, so he does that and he finds no pericardial effusion. He said let me see if I can get some help.
Q: On June 27, are you rendering a differential diagnosis?
A: Well, he did. He went through whatever he had considered.
Q: What is included in the category of differential diagnosis for this patient?
A: Again, the only thing I can tell you, he wrote here "Good general health, systolic clicks, straight upper back, unexplained elevation of liver enzymes,

Page 83

patient told about all of the above.
Advised to have repeat physical and
elevation."
I didn't see him. In some
of the deposition it was related that he
thought he had an acute respiratory
disease; and sinusitis was mentioned. I
don't see that here.
Q: Those two things would be in your
differential diagnoses?
A: I'm saying what Dr. **Ruiz** felt. I
don't disagree with that.
Q: Okay. In your opinion, to a
reasonable degree of medical certainty,
should anything else have been included in
that differential diagnosis at that time?
A: I'm sure that there were things
that were in **his** mind. I mean could **this**
be something else like — that's why he
went through this, Why in the world is he
having a fever and so forth?
I don't know how to address
this finding of systolic click. There was
something about **his** mother having it and

Page 84

whether he concluded it because he could
never End anything, it was one of those
benign findings that had no meaning.
Later on, I searched
carefully if anybody else found it. The
answer was no. You keep on coming back and
you say, my gosh, I can't find anything in
this nice, healthy guy, I'm not sure about
him. Let me see if someone else finds
something. You don't have any specific
diagnosis.
Q: So at that time, are you telling
me other than the sinusitis and the
possible respiratory infection, there is no
other diagnosis that can be attributable to
these symptoms?
A: No. I **think** that Dr. Ruiz was
worried about things. We don't list them.
So, we go through them. That's why I said
that he is still worried about what's going
on with this guy. So as part of that
effort, he is not pigeonholed into any
category. It's an open book.
Q: Why don't you list them.

Page 85

A Pardon?
Q: Why don't you list them, the
other —
A: There are too many
possibilities. So, we go over the person
and we say where else do we go? At the
moment, sometimes you take the empiric
approach and give an antibiotic. Almost
always the fever disappears. That's the
end of your study.
Q: You say there's too many to
list. How many?
A: Well, I indicated there are many
causes for fever that one can list ad
nauseum.
Q: What number is "many"?
A: Adnauseam.
Q: Ten?
A **It's** kind of a textbook thing
that we all go through it. He could
have — if you want to say with abnormal
liver enzymes, does he have hepititis,
virus? It would drive you crazy by listing
all the things that you could have. We

Page 86

don't actually know, so we play for two
things. One is the input of someone else
and time. The third thing is a response to
what you are doing.
Q: With respect to the input of
someone else, Dr. **Ruiz** referred Mr. Gonda
to a pulmonologist?
A: Yes.
Q: At the time he referred him to
the pulmonologist, or at the time Mr. Gonda
went to the pulmonologist, what information
would you expect the pulmonologist to have
from Dr. Ruiz?
A: Usually, nothing, except, listen,
I have a guy with a cough, I don't know
what the hell is going on.
Q: No medical records?
A: No.
Q: No EKGs?
A: No. They wouldn't know what to
do with it.
Q: Would you agree that as a
physician, it's critically important to
have as much accurate information as

Page 87

possible in order to come up with an
accurate differential diagnosis?
A: Yes.
Q: Just *so* we are clear, can you
tell me your definition of differential
diagnosis?
A: You list the various
possibilities in your mind that one would
want to consider on the basis of a symptom
or constellation of symptoms.
Q: And the purpose of **listing** those
would be what?
A: Well, to make certain that you
are considering the various possibilities
of the cause of your patient's
symptomatology or abnormality.
Q: Turning your attention to your
report dated 11/20/96, on 7/13/95, who did
David Gonda present himself to for the
evaluation of a cough and fever?
A Dr. Cropp.
Q: From the records, am I correct
you are unable to describe the type of
cough that he had?

Page 88

A: I saw that. I indicated to you
where Dr. **Ruiz** said something that the
cough was productive of mucus and looked
like saliva and was more a clearing of the
throat than a harassing cough.
Q: That was on what date?
A Pardon?
Q: What date was that?
A: Well, I know I saw that in
Dr. Cropp's report. Here is a report. "He
has a persistent cough and needs to clear
his throat all the time."
Q: The date of that?
A: The date of **this 8/27/95.**
MR. BANAS: June.
THE WITNESS: June, I'm
sorry.
BY MR. MALIK:
Q: You indicated in your report that
his chest x-ray was normal. What
structures on the x-ray were normal?
A: Well, I read that before. When
they report normal, they indicate the heart
and the lungs.

Page 89

Q: You didn't see the actual film, did you?
A: No.
Q: When you say the heart, you are talking the exterior of the heart?
A: About the cardiac silhouette.
Q: Talking about the size?
A: The size?
Q: Talking about the size?
A: Yes, normal. I thought you were trying to differentiate do I see the heart or — we see the cardiac silhouette which means the period cardium also.
Q: You use the term "symptomatic therapy." You said that was prescribed. What did you mean by "symptomatictherapy was prescribed?
A He was given something to ease his cough and teslon pearls and the like.
Q: And the date of that?
A: That was in July when he saw him.
Q: Who did Mr. Gonda — strike that.

Page 90

You indicated in your report that consideration was given appropriately to bronchoscope and CT scan. Do you see that?
A: Yes.
Q: When was consideration given to that?
A: At the end of July.
Q: At the end of July?
A To make appointments to have it done.
Q: In terms of timeliness of a CT scan, when would you have expected the CT scan to have been done then?
A: When he had the normal chest x-ray, we certainly wouldn't do it.
Q: If somebody is going to be making an appointment for a CT scan, as you indicated in this case, what is the amount of time you would expect that CT scan to be done? ? A week? Two weeks? Three weeks? Four weeks?
A: I didn't see any particular urgency about that.

Page 91

Q: What about the bronchoscopy?
A: Well, again, I think he really didn't believe that there was tumor or Hodgkin's disease. He mentioned it and said we ought to look for this. But, again, as part of the differential diagnosis, I don't have anything to hang on to that that was really present. I said, "Let'sschedule him. Can it be done in two weeks?" "Yes." That's the kind of reasoning. Nothing wrong with that.
Q: We can agree that the bronchoscope and CT scan were the idea of Dr. Cropp?
A Yes.
Q: Then, I guess, I'm unclear as to why the two tests were appropriate then.
A: Dr. Cropp was bothered by the fact that he continued to have a cough. And sometimes you look at the chest x-ray and even though everything looks normal, there might be things that might be uncovered by additional procedures. The bronchoscope permits you to look inside the pipes and not just on the outside. The CT scan may give you information about other parts, especially the mediastinum that you can't decide with certainty what might be present.
Q: And am I correct in understanding that you find no fault with Dr. Ruiz in ordering a limited ultrasound of the heart?
A: He didn't order a limited ultrasound. He simply ordered does the patient have a pericardial effusion? I mean, it wasn't a studied-kind of response, I'm going to ignore something else, I have this fever and I have low voltage, I want to make sure there is no pericardial effusion, period.
Q: And you are telling me, it's within the standard of care to just take a look for pericardial effusion?
A: If that was his thing, nothing wrong. He didn't find anything.
Getting back, there are places on here where Dr. Ruiz says the cardiac examination is normal. So, if he

Page 92

Page 93

were concerned about that systolic click, apparently, he paid no more attention to it. That's as much as I can gather.
Q: So as we sit here today, you are telling me that it's okay for Dr. Ruiz to have just taken a look for pericardial effusion, correct?
MR. BANAS: Objection. He said that three or four times. This is the last time. Yes or no.
THE WITNESS: It was appropriate.
BY MR. MALIK
Q: Did that indicate to you then that he was not concerned with what was going on in the inside of the heart?
A: No. That has nothing to do with it.
Q: Had he been concerned with the inside of the heart, you would have expected him to have had a more complete ultrasound?
A: I can't *think* for him. I'm sure that he would have done that.

Page 94

Q: What did you mean when you noted in your report "manifestationsof endomyocardial fibrosis were bizarre and not typical"?
A I simply emphasized the fact that, first, its presence by itself doesn't do much of anything, but then when it envelopes the valve apparatus and interferes with filling of the heart, then you get various manifestations and the major one is heart failure.
Q: Did David Gonda have heart failure?
A: No.
Q: So, if the major manifestation is heart failure, what are you talking about in that statement?
A: I said the manifestations of endomyocardial fibrosis are bizarre simply because it might occur in the presence of an environment of a nutritional deficiency. That has nothing at all to do with the heart itself. Nobody knows that. I have no idea.

Page 95

Q: You didn't say "are bizarre."
They are more bizarre in David Gonda than other cases?
A: Bizarre only in the sense that it's an enigma. You can't put your finger on any symptom and say endomyocardial fibrosis.
Q: Do you have an opinion, to a reasonable degree of medical certainty, whether or not the cough and the fever were out of the ordinary for the disease of endomyocardial fibrosis?
A: I do have an opinion.
Q: What is that?
A The opinion is that that is the last thing I would ever think of.
Q: You indicated you read Dr. Weiderman's deposition.
A: Yes.
Q: Were you aware at the time you read it that Dr. Weiderman did not consider himself an expert in the area of endomyocardial fibrosis?
A Yes.

Page 96

Q: What was it in Dr. Weiderman's letter that you felt was important?
A: Well, he explained the fact that he did have a rare condition and that there was, even if recognized, there wouldn't have been anything that they could have doneanyhow.
Q: Is that something you agree with, even if recognized?
A Yes.
Q: So it's your opinion, to a reasonable degree of medical certainty, that if endomyocardial fibrosis had been recognized in an early stage, nothing could have been done?
MR. BANAS: No more.
THE WITNESS: That's correct.
MR. MALIK Don't point your finger at me.
MR. BANAS: I'm not. That is the end of that question.
MR. MALIK I will tell you, treat me this way and I will treat you

Page 97

the same way in your depositions.
BY MR. MALIK
Q: Doctor, when was the last time you sent a patient in for an ultrasound for just pericardial effusion?
A: We don't select that way.
Q: Why not?
A: There was a time when we did ultrasound just for some specific purposes, but our knowledge has increased greatly, so actually we, when we say echocardiogram, I suspect pericardial effusion or I suspect valvular lesion so, please, give me the entire study, but pay particular attention to what I'm talking about.
Q: How long have you been doing that, getting the entire study?
A: Manyyears.
Q: How many is "many"?
A: Well, certainly in 1995.
Q: How much time before that?
A: Well, I think it was just about fifteen years ago when they were using echocardiography primarily to determine

Page 98

pericardial effusion; and since then, we have moved away from that.
Q: Turning your attention to your report dated April 15,1998, who is the report addressed to?
MR. BANAS: Steve Griffin, who is an associate of mine.
BY MR. MALIK:
Q: Do you know Mr. Griffm personally?
A: No, I do not.
Q: Has your conversation with him been limited to the telephone?
A I believe I got a telephone call from him that he was taking over this case from Gary; that's as much as I remember.
Q: Have you received any correspondence from him regarding this case?
A: No. I don't know if he is still there.
MR. BANAS: He left and he came back about a month ago.
BY MR. MALIK

Page 99

Q: Am I correct in understanding that you rendered an opinion that David Gonda did not die from bacterial endocarditis?
A: That is correct.
Q: And what are you relying on for that opinion? What information?
A: My knowledge of the case and my knowledge of medicine.
Q: Are you relying upon the Cleveland Clinic autopsy?
A Well, yes, in a way.
In other words, if the Cleveland Clinic said is this unequivocal endocarditis, if I saw other things that were reported; for instance if I suspected endocarditis and they reported a tumor, certainly I would have to rely on their diagnosis.
Q: But the main document you are relying on is the autopsy report?
A: That is correct. But, also, clinically my knowledge of what transpired.
Q: When you reviewed this case, did

Page 100

you go to the autopsy report before you went to the other medical information?
A: Well, I knew only in the sense that this was endomyocardial fibrosis and I never thought that anybody would raise the specter of bacterial endocarditis. It was only after the pathology was reviewed by another pathologist that that report was given to me and endocarditis was questioned.
Q: In terms of the process that you used to review *this* case, was one of the first documents you reviewed, would that be the Cleveland Clinic autopsy report?
A That is correct.
Q: Doctor, what is pulmonary thromboembolism disease?
A That refers to the fact that a clot has embolized and has moved from elsewhere in the body through the heart to the lung.
Q: Are you going to render any opinion as to the length of time that the clots or masses existed in David Gonda's

Page 101

heart?
A How long they were present?
Q: Yes.
A I have no basis; only to indicate what is stated here several days before. And, certainly, they were present long before he died.
Q: And when you say "longbefore," what do you mean?
A: There is no way of knowing, in other words, how long a clot was within the heart. And I don't have any evidence they are silent lesions unless they embolize.
Q: But you have an impression. Can you give me a range?
MR. BANAS: If you can.
BY MR. MALIK:
Q: Tell me what you meant by "they were there long before he died"?
MR. BANAS: You don't have to guess.
THE WITNESS: There is no way of determining that with certainty because the clot could have been there

Page 102

and then embolized. And how long that clot was there is unclear. And the only way you can do that is to have some measurement from the beginning to the end, and we almost always never have that.
BY MR. MALIK
Q: So, is it your opinion, to a reasonable degree of medical certainty, that you cannot tell with certainty how long the clot was there?
A: That is correct. And we depend upon the pathologist to tell us more about time. And in the absence of anything clinically, that is, and from the standpoint of the lung, you saw a negative chest x-ray. So he did not have it then. And then he has masses in the lung, so he had it then and something happened in the interim.
Q: But, clearly we can agree that if it was there on June 27th and a 2D echo would have been done, it would have been found?

Page 103

A Correct.
Q: Do you have the statement in that report, "Endocarditis is unlikely in the absence of ." Is that your report?
A: Pardon?
Q: Is that in your report? Do you see that sentence, "Endocarditis is unlikely in the absence of ."?
MR. BANAS: Where should we look?
MR. MALIK: I have to look for it myself.
THE WITNESS: Here it is. "In the absence of verrucae and in the presence of unaffected cardiac valves."
BY MR. MALIK:
Q: What are verrucae?
A: Simply wart-like excrescence from the valve.
Q: You also indicate in your report that Dr. Hoffman makes no mention of the fact that mural endocarditis is a —
A: That's a rare bird.

Page 104

Q: Can you tell me what the significance of that is?
A: All I'm emphasizing is that the bacterial or infective endocarditis means that you have to have some demonstration of valve involvement, and in the absence of valve involvement the diagnosis of mural endocarditis is a very tenuous one starting first with the premise that it is a very rare lesion.
Q: You are not saying mural endocarditis can exist in the absence of valvular involvement, are you?
A That is correct. And I say that it can exist, but there are certain extenuating circumstances that you better define before you assume that there is mural endocarditis.
Q: Referring to Dr. Lerman's report which you address in your report, why is Dr. Lerman's position that the echocardiogramis consistent with infectious bacterial endocarditis in error?
A: Well, I indicated that actually

Page 105

when we diagnose endocarditis, we want evidence of valve involvement, so that puts up a red flag right away that your diagnosis is in error. And if you diagnose endocarditis and don't see any valve involvement —
Q: Do you know the date of the echocardiogram you are referring to?
A: I think it was shortly before he died.
Q: You indicated in your report that the electrocardiograph comparative tracing suggests possible right ventricular right overload when compared to the prior tracing. And my question to you is: Did you have a clear strip at the time you wrote that?
A: Where are you quoting from? I want to see that.
Q: If I could see your report, I will tell you.
MR. BANAS: He already talked about that.
MR. MALIK: Did I point to

Page 106

the wrong one?
MR. BANAS: Yes. I don't see that.
BY MR. MALIK:
Q: May I see that, please. I will withdraw that.
Which of the following symptoms, Doctor, can be caused by a cardiac problem? (1) sinus tachycardia; and (2) fever of unknown origin; (3) persistent cough; and (4) shortness of breath?
A Allofthem.
Q: Why does Dr. Lerman's comments on the electrocardiogram, "Disregard the suggested diagnosis given by the echocardiographer or the radiologist of the CT scan or possible metastatic tumor" —
A: I don't understand.
Q: His comments, do you see that?
A: His comments ignores the efforts made by the physician to establish a diagnosis in the fact that there were no valvular lesions.

Page 107

Q: And right here, his comments on the electrocardiogram, "Discard the suggested diagnosis given by the echocardiogram," do you see where I'm talking about?
MR. BANAS: Diagnosis suggested, is that what you are talking about?
THE WITNESS: His comments on the electrocardiogram, "Disregard the suggested diagnosis given by the echocardiographer as above or the radiologist of possible metastatic tumor or Wagner's lymphoma."
BY MR. MALIK:
Q: Why do you believe that?
A: I have to see Dr. Lerman's comment on the electrocardiogram.
MR. BLOMSTROM: His comments on the electrocardiogram —
THE WITNESS: He made a comment.
MR. BANAS: Give me a moment and I will find it.

Page 108

MR. BANAS: The problem is there were four reports and we only have one or two. I'm not sure what you were sent. There's one, but I'm not sure that's the right one. That may have been one I got after the deposition.
THE WITNESS: Do you have it? Do you have his report?
MR. MALJK: No, I don't.
MR. BANAS: We don't have it.
BY MR. MALIK
Q: You can't answer that question?
A I was addressing something there and I didn't repeat what he said.
Q: Did Dr. Ruiz at anytime fall below the standard of care by not calling a consultation with a cardiologist?
A: No, sir.
Q: Why not?
A: Well, he did what he could and he found no — he went over the patient clinically and he found no evidence of any

Page 109

cardiac abnormality.
I addressed myself previously to the systolic click which, apparently, he dismissed and he felt that it was an infectious process that he was dealing with and that the heart was not involved.
Q: What about the abnormal EKG, that wouldn't be grounds to call in a cardiologist?
A: No. I think it would be reasonable if he has a sign that he is announcing to the world that he is an expert in cardiac diseases and he went over the patient and recognized the fact that the electrocardiogram was abnormal and he was concerned and he put it together and he thought it was pericardial effusion, I can't fault him at all.
Q: So, is it a fair statement to say that a cardiologist would not have contributed anything else?
A: It's not fair; and, certainly, in retrospect, you say why didn't you call,

Page 110

why did you go to Dr. Cropp, why didn't you go to an infectious disease doctor because it turned out to be bizarre?
Q: So, you believe that sending David Gonda to a pulmonologist was the proper consultation?
A: Yes.
Q: What about Dr. Cropp, do you fault Dr. Cropp in any way for not sending David to a cardiologist or infectious disease doctor?
A Well, he better not. And I mean whatever he finds, he better report to Dr. Ruiz. It's up to Dr. Ruiz. There's some specialists that do that, but they don't see a patient referred by the other doctor anymore.
Q. So, the doctor who is already consulting has the obligation to go back to the primary care doctor, in this case, Dr. Ruiz?
A: Certainly; and you must be very careful. First, you list him as a primary and then you indicate to me that he has a

Page 111

sign saying that he is knowledgeable in cardiac diseases.
Q: He does.
A So I mean you can't — can you imagine Dr. Cropp announcing to the world saying I'm going to send him to a cardiologist?
Q: Sending him back to Dr. Ruiz was the proper move then, right?
A: Right.
Q: Does anybody have any way of knowing the length of time it would take to develop an intracavity mass, for example, including sarcoma, thrombus, lymphoma or any of the structural changes caused by Wagner's granuloma?
A We have no method. We know the end. We don't know the beginning.
Q: What about in a postmortem way?
A: No.
Q: What about bacterial endocarditis?
A If it were present, you have no clear-cut evidence when it began. And

Page 112

because you are dealing with a destroyed valve to begin with, you don't know when it became infected.
Q: Well, let's assume it is the endocarditis in this case where there is no, where there appears to be no valvular involvement.
A The interesting thing is, even the pathologist who claims it to be endocarditis recognized endocardial myocardial fibrosis.
Q: The two entities can get together?
A Well, according to him it could have existed.
Q: Are you able to tell me the stages of the development of the mass that was found on autopsy?
A No, sir.
Q: Do you have, or are you going to render any opinion whether or not there was inflammatory tissue in the heart on June 27, 1995?
A: No. All I can tell is what the

Page 113

autopsy was.
Q: Was bacterial endocarditis ever ruled out in this case?
A Yes.
Q: When was that?
A: Well, from the standpoint that clinically there was no evidence of any valvular lesion. And, I think, even when he went to this fountainhead of knowledge, the Cleveland Clinic, consideration was not given to endocarditis and there was angiosarcoma.
Q: As we sit here today, it's absolutely your belief that bacterial endocarditis was ruled out in this case; is that correct?
A: That is correct.
Q: In taking the patient off antibiotics prior to blood cultures, does the patient have to be hospitalized or should the patient be hospitalized for that?
A: No. The only thing that you would consider hospitalization for is if he

Page 114

were so seriously ill and the second thing is to document his fever. Patients tell you they have fever, but it may not be present.
Q: For an internal medicine physician such as Dr. Ruiz who claims extra knowledge in cardiovascular disease, can you tell me what diagnostic tests are available to him to check the human heart for abnormalities?
A The echocardiogram.
MR. BANAS: Anything else?
THE WITNESS: Well, he did the chest x-ray. And, of course, it starts with the clinical examination.

BY MR. MALIK

Q: But the most important thing would be?
A: What was left out was the echocardiogram.
MR. MALIK I have nothing further.

BY MR. BLOMSTROM:

Q: Doctor, do you have any opinions

Page 115

critically of my client, Dr. Hafiz, the radiologist?
A: No, sir.

BY MR. TRAVERS:

Q: I have a few questions, primarily just things that came up during your testimony, Doctor, that I want to make sure that I understand correctly.
Can a toothache be consistent with endocarditis? Hemorrhoids, maybe?
A: I was trying to answer you appropriately. We always have that sort of problem. I can give you the analogy. You mentioned hemorrhoids and you have cough and so you have A & B. And are they both related to C, namely lung cancer? Yes.
And because the guy coughed and he developed a hemorrhoid — he really coughed because he had cancer of the lung. And that's how they are related. And the same thing, a guy could have a toothache, an infected tooth. Without adequate prophylaxis, that may predispose the guy to

Page 116

endocarditis. In that sense, yes, the toothache is related. And if you have that kind of history, yes.
Q: I was trying to be flip, I guess, and I shouldn't be.
And there is no evidence of toothache or hemorrhoids in this patient. What I'm trying to determine is when Mr. Malik asked you are these symptoms consistent with endocarditis, practically anything in the world is consistent with endocarditis, isn't it?
A: That's what I wanted to convey.
MR. MALIK Objection.

BY MR. TRAVERS:

Q: Can you identify any clinical symptom or sign that, because of its existence, you would be able to say, therefore, the patient does not have endocarditis?
A: That is incorrect.
MR. MALIK: Objection.
A: The diagnosis depends upon a constellation of symptoms and signs and,

Page 117

so, you can't just isolate something, fever, endocarditis.
Q: I'm talking about to rule out the existence of endocarditis.
A: Nothing rules it out.
Q: Every medical symptom in the world is consistent with the existence of endocarditis?
A That is correct.
MR. MALIK Objection.

BY MR. TRAVERS:

Q: The only other area of follow-up I would like to pursue concerns the cardiac study that was ordered by Dr. Ruiz to rule out pericardial effusion.
First of all, do I understand you correctly to say that the abnormalities evidenced on the EKG are suggestive of the possibility of pericardial effusion?
A: Yes.
Q: So, was an appropriate request of Dr. Ruiz to order a study addressing the issue of whether pericardial effusion

Page 118

existed?
A: Yes.
Q: Is there anything on the EKG suggestive of the existence of a cardiac lesion in his ventricle?
A: The interesting thing is the only thing characteristic of endocarditis from the standpoint of the — is a conduction abnormality which is not present here from the electrocardiogram.
Q: I had anticipated Mr. Malik asking you about blood cultures, and I don't remember that part of the exam. Are you critical of Dr. Ruiz concerning the decision to imperically treat the patient rather than immediately order blood cultures?
A: No, that is standard practice.
MR. TRAVERS: Those are all my questions, Doctor. Thank you.
MR. BANAS: Mail the transcript to him
(Deposition concluded, 4:07 p.m.)

CERTIFICATION

I hereby certify that the testimony and the proceedings in the aforegoing matter are contained fully and accurately in the stenographic notes taken by me, and that the copy is a true and correct transcript of the same

MICKEY DINTER
Registered Professional Reporter

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SIGNATURE PAGE

I hereby acknowledge that I have read the foregoing transcript, and the same is a true and correct transcription of the answers given by me to the questions propounded, except for the changes, if any, noted on the errata sheet.

SIGNATURE:
DATE:

ERRATA SHEET

PAGE	LINE	CORRECTION

Lawyer's Notes