In The Matter Of:

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

Jacob Zatuchni, M.D. February 87 1999

BRUSILOW & ASSOCIATES 260 South Broad Street Suite 200 Philadelphia, PA 19102 (215) 875-0060 FAX: (215) 875-0065

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Jacob Zatuchni, M.D.

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February 8, 1999 Juan Ruiz, et. al. Page 3 Page 1 INDEX IN THE COURT OF COMMON PLEAS [1] [1] (2) MAHONING COUNTY, OHIO [2] [3] 131 DOROTHY GONDA, etc., : 96CV 2055 WITNESS: Jacob Zatuchni, M.D. Plaintiffs [4] [4] [5] vs PG. LN. [5] JUAN RUIZ, et al., BY MR. MALIK:. 4 7 [6] BYMR. BLOMSTROM:114 23 Defendants BY MR. TRAVERS:115 4 [6] m m [8] Monday, February 8, 1999 [8] [9] 191 [10] EXHIBITS PG. LN. Pretrial oral examination of [11] JACOB ZATUCHNI, M.D., held at the 10] Plaintiff's Exhibit 1, an autopsy [12] Pennsylvania Hospital, 8th and Spruce [13] Streets, Philadelphia, Pennsylvania 11] report. 17 3 [14] commencing at 1:40 p.m., on the above dale, 12] [15] before Mickey Dinter. Registered Professional Plaintiis Exhibii2, medical [16] Reporter and Commissioner of Deeds for the 13] literature... [17] Commonwealthof Pennsylvania. 141 [18] 15 16] [19] [20] 17] **BRUSILOW & ASSOCIATES** [8] [21] 260 South Broad Street, Suite 200 191 Philadelphia, Pa. 19102 20] [22] (215) 875-0060 21] [23] 221 31 [4] Page 2 Page 4 [1] APPEARANCES: [1] JACOB ZATUCHNI, M.D., 801 [2] [2] Spruce Street, Philadelphia,
 [3] Pennsylvania 1910/7, having been first DAVID MALIK. ESQUIRE [3] 8228 Mayfield Road, Suite 5B Chesterland. Ohio 44026 [4] duly sworn, was examined and testified [5] as follows: Counselfor Plaintiffs [4] EXAMINATION) [6] [5] BY MR. MALIK: [7] MANCHESTER, BENNETT, POWERS& ULLMAN Q: Can you tell me why you are [8] [6] BY: THOMAS J. TRAVERS, JR., ESQUIRE involved in this case? [9] Atrium Level Two A: Mr. Banas invited me. 101 [7] The Commerce Building Q: By phone call or by a letter? 11 Youngstown, Ohio 44503 A: Pardon? 2j [8] 330-743-1171 Q: By a phone call or did he invite 3] Counsel for Defendant, Ruiz you by a letter? 41 19 A: Well, I think he said that I'm 51 [10] BUCKINGHAM, DOOLITTLE & BURROUGHS. LLP sending you a case, so I think it was by 61 BY: GARY BANAS, ESQUIRE phone call. 7] [11] 3721 Whipple Avenue, Q: Have you worked with Mr. Banas 8] NW P.O.Box 3554% 9] before? [12] Canton, Ohio 44735 A: Yes. !0] 330-492-8717 Q: Howmanytimes? !1] [13] Counsel for Defendants Drs. Cropp and A: Perhaps, two other cases. 221 DeMarco **Q**: Have you worked for the firm of Buckingham Doolittle before? 131 (14) 41 [15] HARRINGTON, HOPPE& MITCHELL, LTD. BY: JAMES L. BLOMSTROM, ESQUIRE [16] 1200 Mahoning Bank Building Youngstown, Ohio 44503 [17] 330-744-1111 Counsel for Defendants Dr. Hafiz and [18] Youngstown Associates in Radiology, Inc. 119 [20] [21] [22] [23] [24]

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

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11 November 20, 19967 Are all the opinions 11 C. Do you intend to give a 12 contained in those reports? 12 deposition in that case? 13 A: Yes. 13 A: Yes. 14 Q: Ob you know when you intend to (15 give a deposition in that case? 15 Buckingham, Doolitte & Burroughs, have you 15 give a deposition in that case? 16 been an expert witness for any other 17 Q: Do you know when you intend to (15 17 defines firm? 13 A: No.1 do not. 17 17 Q: Do you think it will be this 19 year? 19 18 A: Stach one is usually a different 20 Q: Do you think it will be this 19 19 Q: How many firms would you say? 21 A: Each one is usually a different 22 A: Each one is usually a different 21 22 A: Each one is usually a different 22 22 A: Each one is usually a different 22 A: Do, Io don't know off 21 A: No. 21 20: And can you tell me who the 22 22 A: Each one is usually a different 23 Q: And can you tell me who the 24 1awyer is?				
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[14] communicate with my secretary and I have[14] Q: Have you ever reviewed the[15] told her to divulge anything you want.[15] records in that case?[16] Q: Do you think it's evenly split?[16] A: Yes.[17] A: Yes; perhaps, a little bit more[17] Q: Have you written a report in that[18] for the defense.[19] Q: Have you had your deposition[20] taken before?[21] A: Yes.[21] A: Yes.[22] Q: Have you had your deposition[23] taken before with respect to any cases in[23] Q: How many times would you say that	[13] have any exact number, but you can		A : I think it's Philadelphia.	
 [16] Q: Do you think it's evenly split? [17] A: Yes; perhaps, a little bit more [18] for the defense. [19] Q: Have you had your deposition [20] taken before? [21] A: Yes. [22] Q: Have you had your deposition [23] taken before with respect to any cases in [24] B: The second seco	[14] communicate with my secretary and I have			
 [17] A: Yes; perhaps, a little bit more [18] for the defense. [19] Q: Have you had your deposition [20] taken before? [21] A: Yes. [22] Q: Have you had your deposition [23] taken before with respect to any cases in [24] C: Have you written a report in that [25] The defense. [26] C: Have you had your deposition [27] A: Yes. [28] C: Have you had your deposition [29] C: Have you had your deposition [20] C: Have you had your deposition [21] A: Yes. [22] C: Have you had your deposition [23] C: Have you had your deposition [24] C: Have you had your deposition [25] C: Have you had your deposition [26] C: Have you had your deposition [27] C: Have you written a report in that case? [28] C: Have you had your deposition [29] C: Have you had your deposition [20] C: Have you had your deposition [21] C: Have you had your deposition [22] A: No. [23] C: How many times would you say that 				
[18] for the defense.[19] Q: Have you had your deposition[19] Q: Have you had your deposition[19] A Yes.[21] A: Yes.[22] Q: Have you had your deposition[23] taken before with respect to any cases in[23] Q: How many times would you say that				
[20] taken before?[21] A: Yes.[22] Q: Have you had your deposition[21] report in that case?[22] Q: Have you had your deposition[22] A: No.[23] taken before with respect to any cases in[23] Q: How many times would you say that		18	ase?	
[21] A: Yes.21 report in that case?[22] Q: Have you had your deposition22] A: No.[23] taken before with respect to any cases in23] Q: How many times would you say that	[19] Q: Have you had your deposition			
[22] Q: Have you had your deposition[22] A: No.[23] taken before with respect to any cases in[23] Q: How many times would you say that		20	y Q: nave you written more than one in report in that case?	
[23] taken before with respect to any cases in [23] Q: How many times would you say that				
[24] Ohio?	[23] taken before with respect to any cases in	2	Q: How many times would you say that	
	[24] Ohio?	2	you have testified in depositions?	

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	Page 11		Page 14
A: I would say about two to three		[1] Q : When you wrote that —	
2) times a year.		[2] A: Excuse me. I mean I think some	
Q: Over how many years?		[3] of the depositions were recently in coming.	
4) (A: Perhaps, five years.		[4] For instance, this one by Morgan, Stern &	
Q: And how many times have you		[5] Clarin and the pathologist's report came	
⁶ testified live in court?		subsequent to the April thing. It just	
A: Perhaps, one or two times a year.		[7] came this year.	
Q: Have you had your videotape		[8] Q : When you wrote the November 20,	
g] deposition taken before?		[9] 1996, report, was it your understanding	
oj A: Yes.		10] that you were going to then write a	
Q: How many times would that have		11] supplemental report?	
2] been?		12] A : No.	
3 A: Perhaps, three or four.		Q: How did it come about that the	
		[4] April 15,1998,report was produced then?	
4] Q: Do you recall the names of those 5] cases?		A: I think there was a letter to the	
		[6] effect that he had sent these depositions	
		17] for my review.	
7] Q: Were any of them in Ohio?		18] Q: So, you would agree that the	
8] A: I thirk there was one in Ohio,			
9] yes.		19] April 15,1998, report was written after	
0] Q: Do you recall who the attorney		20] you received the depositions you had	
1] was?		21] mentioned in the first paragraph?	
2) A: No. I think this attorney — he		22] A: Yes.	
3] called me for a case and I forgot his		23] Q: And would you also agree that you	
a name. Bill something or other.		24] did not have those depositions when you	
	Page 12		Page 1
Q: Do you recall when that was?	0	[1] wrote the November 20,1996, report?	
A: It was for the plaintiff I		[2] A: Yes.	
²] A. It was for the plaintif. I 3] forgot his last name.		Or Course and an arrest of the	
\hat{O} W ' \hat{O} 1 1 10		[3] Q: So when you wrote the [4] November 20,1996, report, were the medical	
4] Q: Was it Cleveland?			
5] A: It was, I think, Youngstown.		[5] records of David Gonda the only information	
6] Q: Bill Summers?		[6] that you had?	
7] A: No.		[7] A: And the autopsy report.	
B] MR. BLOMSTROM: He said		[B] Q: And the autopsy report?	
9) "Bill something."		[9] A: Yes.	
0] BY MR. MALIK		Q: With respect to the autopsy	
Q: When did you give that video?		11] report, do you have that with you today?	
2] A: That must have been about three		12] A It's in here somewheres.	
3] or four years ago.		13] MR. BANAS: I will find it.	
		14] BY MR. MALIK:	
4] Q: And the subject matter of the			
is] case?		15] Q: When was the last time you 16] reviewed the medical records of	
6] A: It was a question of coronary			
7] artery disease.		17] David Gonda?	
8] Q: With respect to the November 20,		^{18]} A Every day for the past week.	
9] 1996, report, Doctor, can you tell me the		^{19]} Q: Can you tell me how many pages	
og document or information you relied upon to		20] there are to that autopsy report?	
a) produce that report?		A To the autopsy report?	
A: I have these two things that I		22] Q : Yes, sir.	
3] took from my office.		231 A: Eight. I think that would be	
4] Q: Can you tell me what they are?		24] it.	
	D 12		Page
	Page 13	ND DAMAC TI	1 ugo
1] A: Okay. One is called the medical		[1] MR. BANAS: There is a	
2] records of David Gonda which I received		[2] clinical correlation.	
3] from Mr. Banas's office; the other are some		[3] BYMR. MALIK:	
4] depositions.		[4] Q: With respect to the clinical	
Q: Tell me from who, please?		[5] correlation, how many pages are there?	
A: From the Hadley, Morgan, Stern,		[6] A: Seven.	
7] Clarin firm. Dr. Ruiz, Dr. DeMarco. I		[7] Q: When you wrote these reports,	
⁸ have a copy of a letter from Dr. Lerman.		[8] were you in possession of any lab results	
		[9] of David Gonda?	
		io] A The lab report from his lungs?	
 A: March 25,1998. Q: And then a letter of Burt Rosen & 		11] Q: Correct?	
2] Associates about the economics of the		12] A: Be more specific. I saw the	
3) situation.		13] autopsy report.	
		14] Q: I will try to be more specific.	
41 MB. BANAS: Lalso sent you		is] Have you ever seen any lab	
		16] report attached to the autopsy report?	
15] the pathologist's report.			
 15 the pathologist's report. 16 THE WITNESS: And the 			
 5 the pathologist'sreport. 6 THE WITNESS: And the 7 pathologist'sreport. 		17] A I have seen mention made of it by 18] a pathologist.	
 5 the pathologist'sreport. 6 THE WITNESS: And the 7 pathologist'sreport. 8 BY MR. MALIK: 		17] A I have seen mention made of it by 18] a pathologist.	
 the pathologist's report. THE WITNESS: And the pathologist's report. BY MR. MALIK: Q: Sharon Hook? 		 A I have seen mention made of it by a pathologist. Q: Who is that? 	
 15 the pathologist's report. 16 THE WITNESS: And the 17 pathologist's report. 18 BY MR. MALIK: 19 Q: Sharon Hook? 20 A: Yes 20 The many state Depter with 		 A I have seen mention made of it by a pathologist. Q: Who is that? A: The pathologist at the 	
 15 the pathologist's report. THE WITNESS: And the 17 pathologist's report. 18 19 Q: Sharon Hook? 20 A: Yes 21 Q: The same question, Doctor, with 		 A I have seen mention made of it by a pathologist. Q: Who is that? A: The pathologist at the university. 	
 5) the pathologist's report. 6) THE WITNESS: And the 7) pathologist's report. 8) BY MR. MALIK: 9) Q: Sharon Hook? A: Yes A: Yes 		 A I have seen mention made of it by a pathologist. Q: Who is that? A: The pathologist at the university. 	

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cob M.D. t 5,1999	Juan Ruiz, et. al
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you also review Plaintiff's Exhibit 1 or is	 [1] A: No, I did not. [2] Q: Are your opinions going to deal
this the first time that you have seen it?	[2] Q: Are your opinions going to deal[3] with the slides in this case?
(Plaintiff's Exhibit 1, an autopsy report, marked for	[4] A: Only from the standpoint of what
identification.)	[5] was reported.
THE WITNESS: I saw this.	[6] Q : But you have not looked at those
BY MR. MALIK:	7) slides under a microscope, correct?
Q: You did see that?	 [8] A: That is correct. [9] Q: Do you intend to look at those
A: Yes. Q: Do you recall when?	[9] Q : Do you intend to look at those [0] slides?
A: I thirk when I saw the pathology	MR. BANAS: He will not see
report in relationship to that because it	12] them. I will make it perfectly clear
was mentioned by the university	13] on the record, he will not see them.
pathologist.	141 BY MR. MALIK
Q : Do you recall when that was? A : No.	15] Q: So, your opinions with respect to16] the slides is going to be limited to what
Q : It was prior to writing your	17] other printed reports say?
report, sir?	A: No. It will be limited to my
A No. It had to be after because	19] interpretation of the significance of the
it was just relatively recently that	10) finding as I would address it from a
I Q: Having reviewed it as the	21] clinical point of view. 22] Q : Tell me what material you have
information contained in Exhibit 1,does	22] Q: Tell me what material you have 23] reviewed or are going to review with
the information contained in Exhibit 1 in	24] respect to the slides that you would
Page 18	Page 21
any way, shape or form change your two	[1] interpret?
reports?	[2] A: Well, I reviewed "Endomyocardial
A: No, it does not.	[3] Fibrosis'' and I reviewed "Endocarditis."[4] <i>Q</i>: When you say you reviewed those
Q: Is it consistent with your two reports?	[4] Q : When you say you reviewed those [5] two, what do you mean?
A: Well, there are findings that are	[6] A: Well, I did what I could to find
reported here which required thought.	[7] out from a search of the literature the
Q : Is it consistent with your two	[8] nature of the lesion.
reports?	[9] Q : What literature did you search
A: Well, let me put it this way: There wasn't anything that changed my	10] dealing with endomyocardial fibrosis? 11] \boldsymbol{A} Well, first, there are $-I$
opinion.	12] pointed out one of the articles. There are
Q : I will ask you the question	(a) other articles on endomyocardial fibrosis.
again. Can you say that it was consistent,	[4] The second thing we used was Brownwell's
the exhibit was consistent, with both your	15] which is the classic text in cardiology and
reports? A: Yes.	16] Donald Kaye's book on endocarditis.17] searched the literature also for mural
Q : Did you rely on any books,	181 endocarditis.
journals or other information, other than	9 Q: When you say you searched the
what you have described here today to	20] literature, can you tell me what process
render either report?	21] of —
A: Yes.	2] A: Pardon? 23] Q: Can you tell me the process of
<i>Q</i> : Can you tell me what that is ? A: This is called "Endomyocardial	^{23]} Q : Can you tell me the process of ^{24]} searching the literature, what you did?
A: This is called "Endomyocardial Page 1	
Fibrosis" by Moody, Baum, Gil & Ratliff.	[1] A As part of it, I called the
Q: Do you know any of those authors?	[2] American College of Cardiology, their
A: No.	[3] library center, and they found certain
Q : Having looked at that report,	[4] articles for me and then I had my own
would you agree that the main author would	[5] articles. [6] Q : Where are those articles?
be the first person listed on the report?A: Characteristically.	[6] W : where are those articles? [7] MR. BANAS: Right here.
A: Characteristically. Q: And, then, what would the second,	[8] BY MR. MALIK
third and fourth authors be there for?	[9] Q : Can you tell me what the articles
A: It was a collective endeavor.	10] are?
<i>Q</i> : But the one — strike that. Have you conducted any tests	11] A: Yes. One is endomyocardial 12] fibrosis hemodynamic data in 2090 patients,
with respect to this case?	131 the results of surgery, infective
A: Tests?	14] endocarditis confined to the mural
Q: Yes. A: Elaborate.	15] endocardium. There are a list of articles16] from the American College of Cardiology.
A: Elaborate. Q: Did you perform any lab tests?	[17] Q: I would like you to tell me what
Did you perform any type of test	18] they are. Is that all that's there?
whatsoever? In other words, did you have,	 A: Yes. Q: The list of articles?
first of all,did you have anything to perform tests on, any tissues?	20] Q: The list of articles? 21] A: Right; and the articles
A: No.	22] themselves.
Q : Did you review the slides in this	[23] MR. MALIK: Would you be

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Juan Ruiz, et. al.	February 8, 1999
Page 23	Page 26
(1) MR. BANAS: I will be happy	[1] never seen a patient with endomyocardial
[2] to provide you copies.	[2] fibrosis? A Most of us have never seen a
[3] MR. MALIK: <i>Thank</i> you very [4] much.	[3] A Most of us have never seen a [4] case.
[5] BY MR, MALIK	[5] Q: Your expertise is limited to what
[6] Q : When you called the American	[6] you have read?
[7] College, did you tell them you wanted this	[7] A: That is correct.
[8] material sent to you by mail?	[8] Q: Have you ever reviewed slides?
[9] A Yes.	[9] A: Excuse me, I became an expert in
[10] Q: Where is the American College of	10] muscular dystrophy. That was based on one
(11) Cardiology?	11] case.
[12] A Bethesda. [13] Q: Did you talk to any physicians at	12] Q: Have you ever reviewed slides13] with respect to endomyocardialfibrosis?
[13] Q. Did you tak to any physicians at [14] the American College of Cardiology?	14] A: It was handed around as part of
[15] A Thelibrarian.	15] my pathology training in school, but not
[16] Q: Okay.	16] since.
[17] A Her name is Gwen. Funny, I	Q: You went to school, if I remember
[18] remember that better than the lawyers.	18] correctly, from 1941 to 1944.
[19] Q: Other than the information there,	19] A: Yes.
[20] did you rely on any, and the books you have	20) Q : So, is that the period of time
[21] told me, did you rely on any other books,	21) that it was handed around to you?
[22] journals or information?	22] A Yes. 23] Q: How much time would you say that
[23] A: No. [24] Q: So, the only article with respect	24) you have spent reviewing the records for
	Page 27
Page 24	[1] your November 20th report?
[1] to endomyocardial fibrosis is the one[2] written by Moody?	[2] A: I hate to tell you guys <i>this</i> , but
[3] A: No.	[3] I really spend an awful lot of time on
[4] MR. BANAS: There is more in	[4] these. I charge what seems to be
[5] there. Whatever is in here. I just	[5] reasonable, but if I had to charge you, you
[6] happened to have that one out.	[6] would think it was preposterous. I do
THE WITNESS: I listed one	[7] spend a lot of time.
[8] for you.	[8] Q : I'mmore concerned about a lot of
^[9] BY MR. MALIK	[9] time than the money. How much is a lot of
[10] Q: With respect to exhibits, can we	io] time?
[11] just make that Exhibit 2? Did you review	 11] A: In preparing for this today, I 12] did this, again, every day for at least an
[12] that literature recently, Doctor? [13] A : Yes.	13] hour including this morning.
0: Did you review it in propagation	14] Q: Can you tell me, then, how many
[14] Q. Did you review it in preparation [15] for the deposition?	15] hours you consider to be a lot of time?
[16] A: Yes.	16] A: Well, I would —
Q: Have you spoken to any colleagues	17] Q: I'm not trying to be
[18] with respect to this case?	18] argumentative.
[19] A: No.	19] A: For the total thing from the
[20] Q: Have you, since you have received	20] beginning?
[21] this case, gained a greater knowledge of	21] Q: For your November 20 report,
[22] endomyocardial fibrosis? [23] A: I was always interested in	 22] correct. 23] MR. BANAS: For the first
[23] A: I was always interested in [24] endomyocardial fibrosis because I have been	23] MR. BANAS: For the first24] report. Go ahead.
Page 25	
[1] a teacher most of my life. It represents	[1] THE WITNESS : The official
[2] one of the rare things that happens to the	[2] charge was \$1,500. That included
[3] heart and, so, I had a passing kind of	[3] everything. But, my point is that
[4] interest in it. I was the first to write	[4] it's basically \$400 an hour. I said
[5] about the heart and muscular dystrophy	[5] for the first thing it's \$1,500. In
[6] which enabled me to get interested in this	[6] the review $-$ I spent certainly triple
[7] problem of fibrosis of the heart, so I have	[7] that amount in reviewing things, so
[8] had a long-standing interest.	[8] the answer to your question would be
[9] Q: Have you ever treated patients	 [9] certainly about fifteen hours. 10] BYMR. MALIK
[io] who have had endomyocardial fibrosis? [11] A: No.	11) Q: For your November 20th report?
[12] Q: Is this the first review of	12] A That's correct.
[13] records with respect to endomyocardial	13] Q: And then how much time in
[14] fibrosis that you have done?	 14] addition for your April 15th report? 15] A: Again, a good fifteen hours
[15] A: Yes. I told you it was a [16] constant review. I have always done that.	15] A: Again, a good fifteen hours16] reviewing everything.
[17] I told you this is not anythmg new for	17] Q: So, we have ffteen hours for the
[18] me. What is new — I collected them to	18) first report, fifteen for the second
[19] renew my knowledge of it.	19] report. And how much time for the
[20] Q: Do you claim to be an expert in	20) deposition?
[21] the field of endomyocardial fibrosis?[22] A: Well, as much as anyone is from a	 21] A: Well, at least five hours. 22] Q: Okay And that was over what
[22] A. Weil, as inden as anyone is norm a	23) period of time?
[24] Q: And how can that be if you have	24] A: When I first heard of the case
	Equinto (7) Dago 73 Dago 28

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Jacob Zatuchni, M.D.

Dorothy Gonda, etc. v.

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ebruary 8,1999	e de la composición d	Juan	Ruiz, et. al.
	Page 29		Page 32
1) back in 1996 or so.		[1] chief of medicine and was the stairway to	
Q : How many times would you say that		[2] riches by many lawyers, so I got involved	
you have rendered written medico-legal		[3] that way. I had to defend myself. I had	
4] opinions since you have been a physician?		[4] nothing really much to do with it.	
A: Well, I indicated to you that I		[5] I was at a poor hospital	
g get cases about five times a year.		[6] taking care of the poor as part of my	
7] Certainly, that.		[7] academia and we got sued. It was	
Q: How many reports would you say		[8] fascinating to see the cases and so forth.	
you have written?		[9] Q : It was about the time that you	
o] A: In each case I get, there is a		io] were ordained a defendant in a case that	
written report.		i1] you got involved?	
Q: Five times a year for five years?		12] A Yes.	
A Yes.		Q: That you were named.	
• • • • • • • • • • • • • • • • • • •		A I saw the doctors that some of	
		15) you called upon. I said, my gosh, we can	
		16) do better than that.	
y write the reports, too?		Q: In terms of coming in live fortestimony in court, what are your fees?	
A Yes.			
Q : Can you tell me how many years		19] A: I'm not sure; but, about \$5,000.	
you have been working with Mr. Banas's		20] Q: Per day?	
] firm?		21] A: Yes.	
A: I would say it goes back,		22] Q: Plus expenses?	
perhaps, at least five years. I couldn't		A: Plus expenses.	
be certain about that.		24] Q: With respect to your role as a	
	Page 30		Page 33
Q: Can you tell me what states you	-	[1] physician, do you have more of a clinical	
have testified in?		[2] practice or are you more in a teaching role	
A. Donneydynamia New Jansay Ohio		[3] at this point?	
Delaware.		[4] A No, clinical.	
O: How many times have you given		• Harrisch of second and the is	
		[5] G : How much of your practice is [6] clinical, percentagewise?	
actual live testimony for the firm of		A. Alasst ninets Essenance if not	
Buckingham, Doolittle in court?			
A I don't think ever.		[8] more. I do very little teaching today.	
Q : Was your trial testimony then		[9] Q: Have you ever authored any	
y videotaped for them?		10] articles of any type?	
MR. BANAS: I can answer		11] A Yes.	
g that. There was one time I put him on		12] Q : On the subject of endomyocardial	
by videotape back in the days when we had		13] fibrosis?	
arbitrations. I think he has seen		14] A : No.	
5] three cases, one a giant cell		is] Q: What about bacterial	
myocardial endocarditis case which		16] endocarditis?	
there was a deposition. There was no		17] A: What are you looking — I don't	
videotape or anything else. I think		18] remember offhand any particular one. I	
that's it. That's my recollection.		19] mentioned the one about muscular dystrophy	
The one where you testified		20] that I was involved in. The answer to	
on videotape, that must have just		21] endomyocardial fibrosis, no.	
j disappeared because it was never used		22] Q: I want to tell you something,	
in court.		23] there's no trick questions here. If you	
BY MR. MALIK:		24) need to refer to something, please do it.	
	Dama 24	es need to refer to something, preuse do it.	Page 34
	Page 31	If you had written an	r ago 54
Q: What is it that interests you		[1] If you had written an	
about the medico-legal cases that causes		[2] article on bacterial endocarditis, would it	
you to get involved with them?		[3] have been listed in the resume?	
A: Well, first, the retrospective		[4] A: Yes.	
sj scope when you know the outcome. It's much		[5] Q : If it's not listed, then it	
nicer to practice medicine that way, but		[6] didn't happen?	
the second thing, and far more important,		[7] A That's correct.	
is that you have to know what you are		[8] Q: Do you know what the symptoms of	
i talking about and, so, it stimulates you to		[9] endomyocardial fibrosis are in a 27-year	
make sure you know what you are talking		io] old male?	
about; and then the confrontation with		11] A: The major symptom would be	
a lawyers is exceedingly appealing to me.		12] related to heart failure, so that that	
Q: It gets your blood going?		13] would manifest itself as shortness of	
A: Yes.		14] breath. And the reason that comes about is	
Q: You feel revitalized after that?		15] because of the scar tissue, so to speak,	
6] A : Yes.		16] would involve the valvular apparatus and	
7] Q: It'skind of like learning a new		17) not permit the valves to function	
B) piece on the piano; once you get it, it's		18] adequately and then encroach upon the	
		^{19]} myocardium. _{20]} What I was thinking about, I	
s] great.		201 What I was thinking about, I	
اع] great. 0] A: Yes.		20] What I was uninking about, I	
 a) great. a) A: Yes. a) Q: Was there anything that occurred 		21] did write a case where the endocardium got	
s) great. A: Yes. What there exists a that a second d		 21) did write a case where the endocardium got 22] filled with clots which eventually became 23] fibrotic which interfered with left 	

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	Page 35	Page 38
1) Q: Was that in the case dealing with	[1] instrument that we have available today,	Fayes
2] muscular dystrophy?	[2] namely a transesophageal echocardiogram,	2117.4
A: No. This was in one of the	[3] how often they have recognized	
4) reports about clot formation in the left	[4] endomyocardialfibrosis; and I have some	
5) ventricle.	[5] pieces \mathbf{c} literature in that same pack, and	
6] Q: Doctor, what would be the early	[6] the interesting thing is that disease is	
7] warning signs of endomyocardial fibrosis in [8] a 27 year-old man?	[7] never mentioned. They mention tumors and [8] clots and so forth, but no one sees	
	[9] endomyocardialfibrosis.	
9 A: The early warning sign? It's 9 such an unusual thing that actually you	10 Q: Let me break it down a little	
1] have to go on the basis of the literature,	11] it. You are talking about aTEE being the	
2] what has been reported. And most of the	12] more accurate than the 2D Doppler echo?	
3) reports emphasize the pathologic	A: I cited that in response to your	
4] manifestation: I have this case in Africa	14] question, yes.	
5] and this is what I found and so forth.	15] Q: Will aTEE properly performed	
6] They go back and say, well,	16] pick up scarring in the heart, scar tissue?	
7] during life he had heart failure and so you	17] A: The answer is yes.	
8) transcribe that into shortness of breath	18] Q: Will it pick up an inflammatory	
9) and swelling of the liver or legs and so	19] process going on in the heart?	
no forth. To my knowledge, no one has taken	20] A Not particularly. We are trying 21) to develop methods for differentiating	
the reverse, let's say, from the beginning	21] to develop methods for differentiating22] tissue, but when you say inflammation, that	
2] because who knows where the beginning is. Q: You are speaking from a	22] depends upon what you mean by that. In	
(3) Q: You are speaking from a (4) postmortem aspect?	24] other words, if one has an abscess, the	
4] postmortem aspect?		Page 3
1] A: Yes.	[1] answer is yes. If one has a valvular	-
2] Q: Would fever be consistent with	[2] lesion which might be inflammatory, the	
3) endomyocardial fibrosis?	[3] answer is yes.	
[4] A: Usually, it's not emphasized.	[4] Q: What about an abscess in the	
5] Q: What about a persistent cough?	[5] right atrium extending into the outflow	
6 A: No.	[6] track?	
Q: What about a cough so severe that	A: Well, again, if it were an	
8j it wakes you up at night? 9j A: No.	[8] abscess, the answer is, yes, it should.[9] Q: The same thing with the right	
 a: No. Q: Shortness of breath? 	[9] Q: The same thing with the right 10] ventricle, correct?	
A: The cough would only be part of	11] A: That is correct.	
2] heart failure and that would be apparent.	12] Q: What about blood clots?	
a) Q: So, at the point there is	13] A: Yes.	
4] congestiveheart failure?	Q: What size blood clot could aTEE	
5] A: That's correct.	15] pick up?What would be the smallest?	
Q: You are saying the cough would be	A: Could be one centimeter.	
7) a significant symptom?	(7) Q: Could it be less than one	
A: Only if there were congestion of	18] centimeter?	
9] the lungs; that would be apparent.	19] A Yes.	
Q: Absent congestion of the lungs	$_{20]}$ Q: Would it pick up — would the TEE	
and a cough, would that be consistent with	21] pick up malformations of the chambers in	
2] endomyocardialfibrosis?	22] the heart? For example, if there were a	
3] A: No.	23) dent in the right ventricle, the veil of	
4] Q: You indicated in one of your	24] the right ventricle, would the TEE pick Page 37	Page
1] reports, there is no therapy for	[1] that up?	
2] endomyocardialfibrosis,correct?	[2] A Yes.	
3] A That is correct.	[3] Q: Let me talk to you a little bit,	
4] Q: What do you base that statement	[4] please, about bacterial endocarditis. How	
5] on?	[5] many cases of bacterial endocarditis would	
A: I base it on the fact that so far	[6] you say you have treated in your career?	
7] in the cases that were reported in Africa,	A: Oh, perhaps, one a year.	
8] it's not clear what the etiology was due	[8] Q: You have been practicing medicine	
9) to. So, to this day we are unclear whether	[9] for how long?	
0) it was an epidemic at that particular time, 1) whether it was bacterial, viral and so	10] A Since 1950. 11] Q: What is your age?	
2] forth. No one ever isolated things. We	121 A: 78.	
3] don't know whether it was nutritional.	13) Q: What causes bacterial	
4] We have no knowledge as to what the	14] endocarditis?	
5] etiologic agent is, other than the fact	15] A: Well, it's infective	
6] that we saw it in Africa. There have been	16] endocarditis. That's to indicate there is	
7] some isolated cases here but, again, there	17) an involvement by micro organisms other	
is is no apparent cause for its development	18] than bacteria, so it's actually the	
[8] is no apparent cause for its development.		
9 Q: Would an echocardiogram reveal	19] invasion of tissue by micro organisms. We	
 Q: Would an echocardiogram reveal endomyocardial fibrosis? 	20) use the term endocarditis to emphasize the a] fact that the site of the invasion is the	
 Q: Ŵould an echocardiogram reveal endomyocardial fibrosis? A: That's one of the questions I 	 20) use the term endocarditis to emphasize the a] fact that the site of the invasion is the 22] heart. 	
9] Q: Ŵould an echocardiogram reveal 20] endomyocardial fibrosis?	20) use the term endocarditis to emphasize the a] fact that the site of the invasion is the	

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[1] A: That is correct.		[1] A: That's why I emphasized yes.
[2] Q : They may be a fungus?		[2] Q: It can be present, but it may not
[3] A: That is correct.		[3] have been heard on that examination?
[4] Q: They may be viral?		[4] A: More often than not, it's missed
5 A: That is correct.		[5] by others. Or some people imagine they[6] hear it.
[6] Q: Have I missed anything? A: No.Those would be the major		[7] Q: Is shortness of breath a
[7] A: No. mose would be the major [8] ones.		[8] characteristic of infective endocarditis?
[9] Q: Can you tell me what the symptoms		[9] Would you prefer I use the word
[10] of bacterial endocarditis in a 27 year-old		10] infective –
[11] man would be?		11] A As long as we understand we are
[12] A: Well, there is one man that I		12] talking about the same thing.
[13] have that is still alive. His initial [14] manifestation was depression and by looking		 Q: Okay. Shortness of breath. A: Of and by itself, no.
[15] at his eye grounds we were able to find		[14] A. Or and by risentino.[15] Q: You reviewed Dr. Ruiz's records
[16] certain lesions that indicated to me that		16] of David Gonda?
[17] he had endocarditis.Moreover,he had a		17] A Yes.
[18] heart murmur.		18] Q: Can you tell me – can you refer
[19] The first sine qua non is		19] to those records on June 27,1995.
[20] not really related to a symptom, but the		20] A Perhaps, I can remember it. I
[21] person may volunteer I have known of a		21] can relate —
[22] heart murmur. That kind of person may [23] present himself with fever. He may present		22] Q: I can find it for you. 23] A You said —
[23] present himsen with level. He may present [24] himself with fatigue or malaise, which is		24] Q: June 27,1995.
[24] minisch with fatigue of malaise, which is	Page 42	Page 45
[1] our favorite word. So I think the person	1 age 42	ND PANASi Do you want man
[2] just doesn't feel welt, and with that kind		[1] MA. DANAS. Do you want more [2] than that?
[3] of background about the heart that I told		[3] MR. MAUK Is that all you
[4] you about —		[4] have?
[5] Q: Let me ask you this: Is fever a		[5] MR. BANAS: I didn't put
[6] sign of infective endocarditis?		[6] these books together.
[7] A: Yes.		[7] BY MR. MALIK
[B] Q: Is cough a sign of infective		[8] Q: Have you seen those records
[9] endocarditis?		[9] before? 10] A: Yes.
[io] A: By itself, no.		11 Q: On that date, can you tell me
[11] Q: What about the patient with a [12] systolic click, but no heart murmur?		12] what David Gonda's symptoms were?
[13] A That is an interesting phenomenon		13] A: It is stated here that he was
[14] because we have always emphasized that wh	en	14] treated by Dr. Adrinata (phonetic) for
you have a systolic click, just make sure		15] several days for a sore throat and fever.
[16] you don't categorize the person as having		16] He was given Duracef by Dr. Adrinata. The
[17] heart disease because it may be a normal		17] symptoms didn't improve. He was then put
[18] phenomenon. To explain that, there are		18) on Xynthromax. He continued to have fever
[19] heart sounds, the first heart sound, second		19) white taking the antibiotic. It goes on 20) that the fever is daily.
[20] heart sound. In this one, he had a		21] Q: Based on that medical record —
[21] systolic click. [22] I think Dr. Ruiz was the		22) we are going to make that Exhibit Number
[22] only one that found it when he went to the		23] 3 — is there anything in there consistent
[24] University Hospital. And at the Cleveland		24] with infective endocarditis?
	Page 43	Page 46
[1] Clinic, no mention was made of any click,	e	[1] A: Well, not specifically.
[2] so that's part of the problem. A person		Q: Is there anything significant in
[3] might hear something that others may not		[3] there consistent with an infection?
[4] hear. The second thing is: What does it		[4] A: Yes.
[5] actually mean? If I can just describe it		[5] Q : What is that?
[6] as when the heart contracts, the blood that		[6] A: Fever.
[7] is ejected may smack against the aorta or		[7] Q: Now, would that infection be[e] bacterial or would it be something else?
[8] the pulmonary artery and the sudden		[9] A: It could be anything.It doesn't
[9] movement of that produces a clicking [io] sound. The same thing may occur with the		io] have to be infection.
[11] mitral valve where that billowing wind gets		11] Q: Okay. So, as we sit here today,
[12] into the valve or the sail and you see the		12] and I'm looking at the June 27,1995,
[13] sail billow and it produces that sound. So		13] records, it's your testimony, to a14] reasonable degree of medical certainty,
[14] of and by itself, it has limited or no [15] meaning; and be careful that you don't		15] that cough is not consistent with infective
[16] ascribe it to heart disease that may not be		16] endocarditis?
[17] there.		17] A: I say it's not characteristic of
[18] Q: In all fairness, though, it's a		18) endocarditis.
[19] characteristic of systolic clicks that		 19] Q: Is it consistent with it, though? 20] A: Part of the background — in
[20] sometimes they are heard and sometimes the [21] are aren't heard, correct?	ey	21 other words, you have this person with
[21] A: Yes.		22] fever. I mean he can have cough and sore
[23] Q: Sometimes they are heard and		23] throat in addition to that which doesn't
[24] sometimes they aren'theard?		241 minimize that possibility, but it makes you
		$\mathbf{D}_{\mathbf{r}}$

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ink in terms of something related to the pre throat and cough rather than to the	Page 5
ore throat and cough rather than to the	
e e	[1] whether or not that increases the[2] likelihood of infective endocarditis?
eart.	[3] A: No relationship at all because,
Q: So, cough is, to a reasonable	[4] again, to elaborate on it —
egree of medical certainty in this case,	[5] MR. BANAS: That's all
onsistent with infective endocarditis?	[6] right.
A: Yes.	[7] BY MR. MALIK:
MR. TRAVERS: Objection.	[B] Q : If you want to elaborate, it's
THE WITNESS: Endocarditis	[9] fine with me.
ould be the last thing that one would	101 A: For every degree of elevation of
urkabout. There are things way	11] temperature, there is a ten percent rise in
head of it.	12] metabolism, so that one would anticipate,
BY MR. MALIK:	13] unless there is a specific kind of fever
Q: What else —	14] like Typhoid fever and so forth or a
A: Respiratory infection is way	15] certain kind of viral infection that might
head of it. I wouldn't think of an	16] produce a relative bradycardia, a slowing
ndocarditis.	17] of the heart rate.
Q: What else?	18] Q: Doctor, with these symptoms,
A: Pardon?	19] would you order blood cultures?
Q : What else?	20] A Absolutely not.
A: What else is the cough due to?	21] Q: Why not?
Q : I think you were telling me what	A It's not our practice that you
our differential diagnosis was wh en I said	23] associate this with respiratory infection.
ough.	24] Most of us feel that it is not related to
Page 48	Page 5
A: Yes. We would be thinking of, in	[1] bacteria, so that it would be senseless and
ldition to a respiratory infection, we	[2] very costly to order a blood culture.
ould be thinking of, for instance, a	[3] Q: Why was David Gonda on
eoplasm.	[4] antibiotics at this time?
Depending upon if it were a	[5] A: We do what we call imperically,
garette smoker or older, we would be	[6] that is, today's example of the epidemic
inking of, perhaps, some local process	[7] that's going around, even though we feel it
fecting the vocal cords and the like, but	[a] might be viral in origin, most people get
e cough itself is not the trigger to	^[9] an antibiotic and the antibiotic is not
unk of endocarditis.	10] helpful.
Q: Now, can you characterize for me	11] It's possible when you look
e type of cough that David Gonda had on	12) the other way and say, maybe, there will be
ine 27, 1995?	13] a secondary infection, so I want to give
A Other than what is stated here?	14] the antibiotic to prevent the secondary
Q: What does it say?	15] infection that might occur; or there might
A: "Coughingfrequently,but doesn't	16] be a sinusitis that I just can't put my
eem to be distressed."	17] fingers on or there might be this or there
I saw some – I don't know	18] might be that, so you take the risk. And
here I can put my finger on it, but there	19] what is the risk? He will have an allergy
as some mention made that it was	20] to the antibiotic. So you say, well,
roductive of mucus.	21] that's a little thing. The patient has put
Q : Now, when you add fever into the	22] pressure on you to use an antibiotic.
quation so that you now have cough and	23] That's why we use it.
ver, is that consistent with infective	Q: Do you know what antibiotic he
Page 49	Page 5
ndocarditis?	[1] was on at that time?
A: Certainly doesn't exclude it.	[2] A: Well, he mentioned Duracef and
ut, we are looking more in terms of	[3] Xynthromax and, I think, later on
pmething that reduced fever and cough.	[4] Doxycycline came into the forum.
here, we would think primarily in terms of	[5] Q: Are you able to tell me the
cute respiratory disease.	[6] specific type of bug erythromycin would
Q : Would any of those acute	[7] affect?
espiratory diseases call for the	[a] A: I told you before that the use
nplementation of an echocardiogram?	[9] would be empiric. This is part of our
A: No, sir.	ioj standard of practice. 11] Q: Empiric meaning broad spectrum?
Q: What about the cough with the ever, would that $-$	 Q: Empiric meaning broad spectrum? A: No. Meaning I smell acute
A: No, sir.	13] respiratory infection to prevent a
Q: Is there anything in the records	14] secondary invasion and so forth or, maybe,
June 27,1995 that would indicate to	15] it will be helpful. We use these
bu that an echocardiogram should have been	16] antibiotics and, I think, it would be fair
	17) to say that Duracef and Xynthromax and
rdered?	18] Doxycycline are the commonly-employed
A: Well, not really because the	
A: Well, not really because the mphasis is on the fever and cough. I	191 antibiotics.
A: Well, not really because the mphasis is on the fever and cough. I on't know how he addressed the problem of	antibiotics.Q: But they have different functions
A: Well, not really because the mphasis is on the fever and cough. I on't know how he addressed the problem of ystolic click.	 antibiotics. Q: But they have different functions in terms of they attack different bugs,
A: Well, not really because the mphasis is on the fever and cough. I on't know how he addressed the problem of	antibiotics.Q: But they have different functions

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Q: Let's assume for a moment you	[1] into the interpretation as you ask me.
have a patient that is on erythromycin and	[2] Q: Let's break it down a little
it's your decision to order blood cultures, would you take that patient off of the	[3] bit. What does it say on the strip in[4] terms of what Dr. Ruiz found?
antibiotic before ordering a blood culture?	[5] A Sinustachycardia. That refers
A The answer is yes.	[6] to the fact that the heart rate is greater
Q: Why would you do that?	[7] than 100. Then, it says "increaseseptal
A: Well, there is a possibility that	[8] forward, "which simply refers to the fact
the erythromycin is holding the bacteria in check.	[9] that the R-wave is a tiny, little bit more jop prominent than usual; so, no great shakes
Q: Would that also be applicable to	11] about that.
y Xynthromax and to Duracef?	12] Q: Anything else?
a) A: Yes.	13] A And then it says "remnant of14] juvenileT-pattern."
q Q: OnJune 27,1995, Dr. Ruiz performed an electrocardiogram, correct?	15] What that means is that when
a) b) b) A: Yes.	16] you are young, that part of the
Q: He had also performed one	17] electrocardiogram is characteristically
earlier. I believe it was in 1989,	18] what you see here. And then as you grow
a) correct?	19] older, it gets less and less, so that we20] call that the juvenile pattern. This might
always been too light. I can't see it. Do	21] be, as the doctor reported, that it might
zy you have that.	22] be simply a variant of the juvenile
Q: Does this look any better to	23] pattern.
ij you?	24] Q : Are you able to compare the two
Page 54	Page 57 [1] EKGs?
1] MR. TRAVERS: It looks 2] better to me than the original I	[2] A: Not really. I told you in one
a) have. Other than taking some steps	[3] way there seems to be sinus rhythm and not
i to have it laminated —	[4] atrial rhythm. I can see where the early
MR. MALIK Other than	[5] repolarization is not here anymore. And[6] that's about it.
6) taking it to Kinko's and having it 7) laminated,I would have not done	[7] The voltage, where I see
7) laminated, I would have not done 8) anything to this.	[8] this voltage, this seems to be lower than
THE WITNESS: No, it is not	[9] the voltage that I see there.
adequate.	10] Q: Can you tell me what the lower
1] BY MR. MALIK 21 Q: Can you read on the bottom what	11) voltage indicates? 12) A It could be a question of
2] Q: Can you read on the bottom what 3] Dr. Ruiz wrote?	12] A recould be a question of 13] technique. And there isn't anything here
4] A : Yes.	14] that indicated to me their
Q : Is there any part of it that you	is] standardization.
ej can see that is consistent with what he 7] wrote?	16] I may be missing it, but I17] have not seen that. In other words, we put
B) A: Well, for instance, I can see	18] in a certain voltage to get a certain
g) where he wrote "low atrial rhythm," and the	19] deviation, so I'm just giving you the
og P-wave is positive in one and negative in	20] general principle. The voltage may be less
1) two and three. That would be justified.	21] simply because you standardize it22] differently.Let's assume that the
2) That simply means a wandering pacemaker,3) which is a normal variant.	23] standardization was the same and, in which
4] Q: You lost me.	24] case the voltage is different.So then
Page 55	Page 58
1] A: He says "low atrial rhythm." The	[1] there are several possibilities for that.
2] 1'-wave that I was referring to refers to	[2] The individual may have gotten fatter; he
3] the deep polarization of the sinus4] pacemaker or the liter of the heart when it	[3] may have developed more air emphysema or he[4] may have developed something regarding the
5] comes to rhythm. It originates in a	[5] pericardium that surrounded the heart to
6] certain place.	[6] short circuit the electric current that's
7] If for one reason or other,	7] produced by the heart.
aj nerve impulses occurred so that that aj pacemaker loses the baton, another part of	[8] Q: Does the lower voltage indicate a[9] less efficient heart?
b) the heart becomes the pacemaker. That's	io] A: No, it may not have anything to
1] all that refers to. It's a normal	11] do with — it could have, but it may not 12] be.
2] phenomenon. I would agree that I see 3] enough here to say, okay, there is no great	13] Q: Would it have anything to do with
4] shakes about that.	14] the pumping ability of the left ventricle?
[Is] Q: Is there anything on there that	15] A No. Let me elaborate. In other 16] words, we don't ascribe force to what we
 a) indicates a bundle branch block? A: I didn't see any bundle branch 	17] see in the electrocardiogram.
⁷ A. I dian (see any bundle branch 8) block.	re] Q: Is there anythmg, by comparison
9) Q: You saw the EKG of June 27?	19] in those two EKGs, that would lead you to
 A: Yes. Q: Can you interpret that for me? 	20] perform an echocardiogram? 21] A: Yes.
A: Yes. There is a sinus rhythm.	221 Q: What would that be?
3) and it shows low voltage of the QRS. It	A: Well, for instance, the low

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[1] Q: Let's assume for the moment you	[1] BY MR. MALIK:	Paye 62
[2] have had an echocardiogram performed.	[2] Q: What will the 2D echo show the	가 가 가 있는 것을 가 가 있었다.
[3] First of all, what type of echo would you	[3] examiner? A It depends what you are looking	
[4] order?[5] A: I would be primarily concerned	[4] A It depends what you are looking [5] for.	
[6] with something affecting the pericardial	[6] Q: Tell me again when you are	
[7] layer and, so, we would inquire about that.	[7] looking for pericardial effusion.	
[8] Q : Would you use aTEE or a 2D	[e] A: For instance, if I say to you [9] "I'mconcerned about this fellow, would	
 [9] Doplar echo? [io] A: In 1995 and 1999, we don'torder 	10] you tell me if he has any pericardial	
[11] the TEE as the first procedure.	11] fluid,"he will say "Ilooked at him and	
[12] Q: Can you tell me whether or not,	12] there is no pericardial fluid."End of	
[13] to a reasonable degree of medical	13] report. That's all.	
[14] certainty, whether the 2D echo would be the	Q: How much more difficult would it be to take a look at the atrium, the	
 [15] appropriate echo? [16] A: Yes. We would start with the 	16] ventricles, the valves, the way the heart	
[17] transthoracic echocardiogram.	17] isfunctioning?	
[18] Q: What is pericardial effusion?	is] A: Essentially, nothing at all.	
[19] A: What is it?	19] Q: If I told you that this exam for	
[20] Q: Yes. A: A collection of fluid between the	20] pericardial effusion was done by an21] examiner not licensed for a 2D echo, would	
[21] A. A conection of fluid between the [22] outer layer and the middle layer of the	22] you consider that below the standard of	
[23] heart.	23] care?	
[24] Q: Looking at these two EKGs, is	24] A: Obviously.The answer to the salido	Dogo 63
Page 60 [1] there anything in there that would lead you	[1] question is obvious. If he is not	Page 63
(2) to believe there could be pericardial	[2] licensed, my life depends upon what the	
[3] effusion?	[3] echocardiographer reports to me.	
[4] A: Well, it indicated the low	[4] Q : That's to a reasonable degree of	
[5] voltage of the QRS.	[5] medical certainty, correct?[6] A: If he reports something to me, I	
 [6] Q: Okay. [7] A: But, again, I hasten to tell you, 	[6] A: If he reports something to me, I [7] have to accept that because I'm at his	
[7] A. But, again, i hasten to ten you, [8] it'snot pathognomonic. You can't say it	[8] complete mercy. My reputation is at	
[9] and say pericardial effusion.	[9] stake. There is nothing I can do	
[10] Q : Performing the 2D echo — strike	10] clinically or by any other procedure to say	
[11] that.What did you mean when you — [12] A: When you look at the	in that situation whether he is right orwrong.	
[12] A: when you look at the [13] electrocardiogram and you see low voltage,	13] Q: But, to a reasonable degree of	
[14] it's not an absolute finding of pericardial	14] medical certainty, it is below the standard	
[15] effusion.More people with low voltage	15] of care for a nonlicensed examiner in 2D	
[16] have no pericardial effusion.	16] echo to look for pericardial effusion?17] MR. BLOMSTROM: Objection.	
[17] Q : When you are looking for that on [18] echo, what are you looking for?	18) There is no licensure for that.	
[19] A That's it, fluid.	19] You are asking trick	
[20] Q : Are you looking into the interior	20) questions despite several times saying	
[21] of the heart?	21) that you are not doing that because	
[22] A: Here is the ventricle and here is	22] the licensure has to do with the23] license issued by the state of Ohio.	
[23] the pericardium; and, so, fluid accumulates [24] between the two.	24] There is no evidence in this case that	
Page 61		Page 64
[1] Q : Would you be looking into the	[1] Dr. Hafiz does not have a license by	
[2] interior of the heart upon that echo?	[2] the state of Ohio, which he does. BY MR. MALIK:	
 [3] A: Well, it depends on what you want [4] to look for. It doesn't — it's not like 	[3] DT MR. MALIN: [4] Q: Do you need me to read the	
[5] taking a picture of the face. I'm taking	[5] question back?	
[6] just a picture of the nose. Forget the	[6] A: Well, let me just put it this	
[7] rest of the face. So, one can simply look	[7] way: We do the echocardiograms in our	
[8] at the pericardial fluid and you won't	[8] office. They are not shipped out. But [9] even if our office, the individuals that	
 [9] have — you don't pay too much attention to [i0] the anterior of the heart. 	i_{0} are doing it — I'm the only one certified	
[11] Q: When performing the 2D Doppler	ii) by the Society of Echocardiography. The	
[12] echo, what will the echo show the [13] radiologist?	12] rest are not. They are doing it. So when13] I say my life is dependent upon them, I	
[14] MR. BLOMSTROM: Objection	14] know what I'm getting.	
[15] unless there is some evidknce —	15] If a stranger came in, I	
[16] unless this is a test performed by a [17] radiologist.	16j wouldn't be happy with that. In answer to17j your question, yes, it could be. They	
[is] MR, BANAS: You may answer.	18] don'thave any license, but they are	
[19] THE WITNESS: First of all,	19] reporting their finding to me.	
[20] whose priority is it? It's not	20] Q: Is it below the standard of care 21] for a noncertified echocardiographer to	
[21] necessarily the radiologist. So at [22] any rate, when the question implied	22] perform an echo for pericardial effusion	
[23] that the radiologist had control over	23) hot using the 2D Doppler echo?	
[24] it, which isn't necessarily so —	A: That is correct, it's not below	
	$\mathbf{C} = \mathbf{r}^{\dagger} \mathbf{r} \mathbf{t} \mathbf{c}$ (12) $\mathbf{D} \mathbf{c} \mathbf{c} \mathbf{c}$	su _ Dage h4

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ebruary 8, 1999		a dagar	al la gilga			Juan Ruiz, etc.
		Pierre Pi	age 65	¥ ĝ		Page 6
1) the standard of care.			1	[1]	answer that. The only thing that I	
2] Q: Is it below the stand:				[2]	can tell you is that I assume that the	
A: It is not below the st			1	[3]	doctor who saw this said that there	
are. These people, to my k	nowledge,to				was no pericardial effusion and that	
this day are not licensed.			1	[5]	he was looking for it.	
Q: Do you have non-2D	Doppler echos		1	[6]	BYMR. MALIK	
in your office?			1	[7]	Q: In your practice, do you always	
A: Yes.					have either an image or a video?	
Q: So what you are tellin	ng me, you		n l	[9]	A: Yes. This is the one that I	
have people who are not c	ertified using the				saw.	
2D echo to perform exami	nations?		(t	11]	Q: Is that a sufficient report?	
A: That is correct.				2]	A: Yes. I thought that you were	
Q: When that occurs, ar	e you always				referring specifically to an ultrasound	
present?					report by itself. That's what I have,	
A No, sir.					right.	
Q: How is the echo reco	orded?		1	[6]	Q: Did you see an ultrasound report	
A. Marris is it as a sub- 19			1-	-	by itself?	
Q: Yes.			-	8]	A: No. That's the only one that I	
A. T. (1	anner					
0. D	laimei.		-	-	saw. I mean later there was a	
Q: Do you use tapes?				•	transthoracic echo and a TEE.	
A: There are tapes.	.0		1.1	21]	Q: Dr. Hafiz has testified that this	
Q: Is there anything else			-	-	was the only time he has ever done an echo	
A Documentation. Dop					for pericardial effusion in that office.	
Q: I'm curious. In Penns	ylvania, is		[2	24]	Typically, they do other organs of the	
		Pa	age 66			Page 6
there a certification to be a	n examiner		1	[1]	body.	-
with 2D Doppler echo?				[2]	Do you have an opinion as to	
A: No, not to my knowle	dge. I think		-		whether or not it's below the standard of	
all of us, at least in my offic					care to perform an echo under those	
certified in the subspecialty					circumstances, not having performed them i	n
cardiovascular diseases, and						11
			1		that office before?	
step further. There are peop			1	[7]	MR. BLOMSTROM: Objection.	
their lives simply to echoca				[8]	MR. BANAS: If you can	
There is no such person in	our office or in		[8	9	answer it, go ahead.	
the hospital.			[10	-	THE WITNESS: It's really	
Q: Are you aware of who			[[1]	1]]	unfair to ask that question. I don't	
there is a certification in O	hio to being		[12	2]	know what their – I don't know what	
an examiner with a 2D Do	ppler echo?		[13	3]	their setup was. He may say this is	
A: I'm not aware. I don'	know		[14	4] 1	the first one that he has done, which	
their rules.					is just amazing to me. If that would	
Q: Is there an indication	in the				be the first one that he did and not	
records on June 27,1995, th					make mention of it, why wouldn't he	
performed?					say that in his report I never did	
A I'm not so sure about	the date.			-	this before? I mean I don't see	
I know that an echo was do					anything like that that he was	
the presence or absence of						
effusion.	pericardiai				expressing in experience.	
			[22	-	BY MR. MALIK:	
Q: Is it below the standa			[23		Q: Assuming that I'm correct that	
not to record those finding	<u>s?</u>			4] 1	this was the first one that he had done in	
		Pa	age 67			Page 70
A: I saw it written some			[1	1] 1	that office, would you expect him to inform	-
there was no pericardial eff	fusion.				the patient of that?	
Q: Is it below the standa				3]	MR, BANAS: The first one he	
not to record those finding					did in that office?	
A: It depends upon the o			[5	-	MR. MALIK For pericardial	
under which — I don't kno					effusion.	
We would certainly want so						
that someone saw it.	me accumentation			7]	MR. BANAS: Are you	
Q: Other than video, what	at other				suggesting he had never done any	
documentation is there?	at Other				others anywhere?	
A: Well, there is — you c	an get an		[i0	ןי אוי	MR. MÁLIK Exactly, that's what I'm saying.	
	't need the				MR. BANAS: I don'tknow	
image teproduced Vou don			[12		what you are suggesting.	
image reproduced. You don			[14		BY MR. MALIK	
image reproduced. You don video.			11.14	-	Q: Assuming this is the first time	
image reproduced. You don video. Q: How do you get an in			140		w. Assume uns is the first time	
image reproduced. You don video. Q: How do you get an in reproduced?	nage		[15		that Dr Hafiz at Youngstown Padiology had	
image reproduced. You donvideo.Q: How do you get an inreproduced?A: Just push the right but	nage		[16	6] 1	that Dr. Hafiz at Youngstown Radiology had	
image reproduced. You don video.Q: How do you get an in reproduced?A: Just push the right bu you get an image.	nage		[16 [17	6] 1 7] 1	that Dr. Hafiz at Youngstown Radiology had performed and echo for pericardial	
 image reproduced. You don video. Q: How do you get an in reproduced? A: Just push the right buy you get an image. Q: Like a Polaroid? 	nage		(16 [17 [18	6] 1 7] 1 8] 6	that Dr. Hafiz at Youngstown Radiology had performed and echo for pericardial effusion, would you expect him to have told	
 image reproduced. You don video. Q: How do you get an in reproduced? A: Just push the right bu you get an image. Q: Like a Polaroid? A: Yes. 	age ttons and		(16 [17 [18 [19	6] 1 7] 1 8] 6 9] 6	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	
 image reproduced. You don video. Q: How do you get an in reproduced? A: Just push the right bu you get an image. Q: Like a Polaroid? A: Yes. Q: To go back to my que 	age ttons and stion: Is it		[16 [17 [18 [19 [20	6] 1 7]] 8] 6 9] 6 0] 1	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?	
 image reproduced. You don video. Q: How do you get an in reproduced? A: Just push the right bu you get an image. Q: Like a Polaroid? A: Yes. Q: To go back to my que or is it not below the standard to below to below the standard to below the standard to below the standard to below the standard to below to bel	age ttons and stion: Is it ard of care to		(16 [17 [18 [19 [20 [20	6] 1 7] 1 8] 6 9] 6 0] 1	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.	
 image reproduced. You donvideo. Q: How do you get an in reproduced? A: Just push the right buy you get an image. Q: Like a Polaroid? A: Yes. Q: To go back to my que 	nage ttons and stion: Is it ard of care to mage produced?		[16 [17 [18 [19 [20	6] 1 7] 1 8] 6 9] 6 9] 1 1] 2]	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?	

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Min-U-Script®

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[1] patient. He doesn't know what's going to	[1] i' : 1r) ic there is)
[2] be done by Dr. Ruiz or what's going to be	[2] cardiologist in this matter.
[3] done with the report. He doesn't know	[3] MR. BANAS: If there is
[4] anything about those circumstances. He is	
[5] giving it as though he is the world's	[5] THE WITNESS: The person [6] asking me that question, I would ask
[6] authority on it. If he wants to express[7] uncertainty about his finding and say,	[7] them to elaborate.
[8] look, this is the first I have done it, I	[8] BY MR. MALIK:
[9] don't know why he would do that, even.	[9] Q : My son has a fever, my son has a
[io] That's the kind of remark he should make to	10] cough, my son has sinus tachycardia, he is
[11] the doctor, not to the patient.	11] 27-years old; I call you because I'm really
[12] Q: Do you think that he should have	12) worried about his heart. Before you give
[13] told Dr. Ruiz that they don't do ultrasound	13] me information — actually, I'm calling you
[14] for pericardial effusion in that office?	14] for reassurance. Before you give me any
[15] A I would think that he would do	15] information, what information would you16] want to have?
[16] that.[17] Q: Would you say it's below the	A: Well, you indicated to me that
[18] standard of care to have not told Dr. Ruiz	18] you were concerned about —
[19] that?	MR. BANAS: Let's talk about
[20] A: If that's the picture that you	in the privilege. You are talking about
[21] are describing. As I keep on coming back,	21] somebody calling. Has there been a
[22] I can't imagine that.	21 release of any information of the
[23] Q : Doctor, would you agree with me	3) privilege?
[24] that it is deceiving and deception to the	24] MR. MALIK The privilege
Page 72	Page 75
[1] patient to have performed a so-called	[1] has nothing to do with this.
[2] ultrasound, but to have, number one, been	[2] MR. BANAS: Who is calling?
[3] the first time in that office with that	[3] MR. MALIK A patient's
[4] equipment that it was performed and, number	 [4] mother or father. [5] MR. BANAS: This is an
 [5] two, limited in scope? [6] A: Absolutely not. We do this all 	[5] MR. BANAS: This is an [6] adult.
[6] A: Absolutely not. We do this all [7] the time.When a new person comes on	7 MR. MALIK: The patient is
[8] board, he does even a TEE. If it's the	[8] 27-years old. The person calling is a
[9] first time he has done it, he doesn't,	[9] parent, an adult. The privilege is
[io] like, shake the patient and say this is the	0] not an issue.
[11] first time I have done that. That has	1) BY MR. MALIK
[12] never happened.	2] Q: What information would you want
[13] Q : My question goes to don't you	3] to have before giving me an answer?
[14] think it's deceptive to perform an echo	4] A: I would say to the person why are
[15] under those circumstances and not tell the	5) you worried about the heart? Where did
[16] patient?[17] A: Absolutely not.	6) that come from? 71 Q: I want an answer from you. What
 [17] A: Absolutely not. [18] Q: What if the patient thinks he has 	^{7]} G : I want an answer from you. what ^{8]} can you tell me?
[19] a complete ultrasound of the heart when in	β_{1} A That would be my answer, "Why did
[20] fact —	you say the heart? What is it about him
[21] A: He doesn't know anything about	11] that you mentioned heart?"
[22] it.	[2] Q : Let's add into the equation this
[23] Q: Okay.	3] occurred on June 27, 1995. Would you still
[24] A: He can't differentiate what is	!4] give that same answer?
Page 73	Page 76
[1] complete and incomplete.	[1] A Yes.
[2] Q : It's your testimony that the	[2] Q : Dr. Ruiz has on his door at his
[3] physician has no obligation to tell the	[3] office the indication that he is involved
[4] patient whether or not the ultrasound is	[4] in internal medicine and cardiovascular
 [5] Limited or complete? [6] A: It's irrelevant. He doesn't tell 	[5] disease. Do you consider that[6] representation of cardiovascular disease to
[6] A: It's irrelevant. He doesn't tell [7] him that. The ultrasound answered the	[5] representation of cardiovascular disease to[7] indicate that he is a cardiologist?
[8] question for the doctor. Does this patient	[8] A: Well, certainly, in his own mind
[9] have a pericardial effusion, the answer	[9] he is specializing or he is interested in
[io] comes back no.	0] diseases of the heart and great vessels
[11] Q : Assume for the moment that I give	1] which is the function of a cardiologist.
[12] you a phone call and I tell you that I'm	 2) He may not be certified in it, but that 3) doesn't mean he can't be interested and
[13] really concerned about my 27-year old son,[14] I'm concerned about the condition of his	4) experienced.
[15] heart, what can you reassure me about	$\hat{\mathbf{Q}}$: Okay Are any of the symptoms of
[16] before giving that answer?What	6] endomyocardial fibrosis similar in nature
[17] information would you want to have?	7) to infectious endocarditis?
[18] MR. BANAS: Talking about a	 8] A: Usually not. 9] Q: Can endomyocardial fibrosis
[19] cardiologist?[20] MR. MALIK: To a cardiologist,	9) Q: Can endomyocardial fibrosis 9) infectious endocarditis coexist in the
[20] MR. MALIK: To a cardiologist, [21] correct.	1) heart!
[22] MR. BANAS: There is no	
	12] A: What, sir?
[23] defendant cardiologistin this case. [24] MR. MALIK: I understand	 A: what, sh? B: Q: Can they coexist in the heart? A: As I indicated, you are dealing

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	Page 77		Dago Do
with a rare lesion.		[1] of view what I gathered from the Dr. Ruiz	Page 80
Q: What would be your answer, no?		[2] deposition, he had acute respiratory	
		[3] diseases and he was concerned about the	
A: The answer is not to my knowledge.			
		[4] possibility of something affecting the	
Q: Okay. You could say that to a preasonable degree of medical certainty,		[5] upper respiratory tract such as sinuses and	
correct?		[6] the like. And being at a limit as to what	
		[7] he knew, because he went over the patient	
A: That is correct. Q: Can endomyocardial fibrosis or		[e] thoroughly, he couldn't find any	
		[9] abnormality, he referred the patient	
infective endocarditis manifest themselves in hearts other than a human heart?		elsewhere. That was the reasonable thing	
A. The second of the second of the second		11] to do.	
A: I have not reviewed the nonhuman		Q: Is the EKG he took on that day,	
literature.		3 June 27, abnormal?	
Q : You are not aware whether dogs or		14] A Yes.	
cats or rats		Q: Is the EKG from 1989 abnormal?	
A No, that's correct.		A: Well, I indicated I can't define	
Q : All right. Other than		17] that with certainty. Whatever I saw, I	
antibiotics, is there any other treatment		e] told you that there were certain	
for infective endocarditis?	1	19] differences that I addressed.	
A: Of course, surgery.	1	Q: Are you able, from what you saw,	
Q : What type of surgery?		to classify that EKG as abnormal in 1989?	
A: Well, removal of the valve.		A: Well, it indicated that it showed	
Q: Let's assume as in this case		13 low atrial rhythm. I can't define anything	
David Gonda had infective endocarditis;		else with it with certainty.	
r -	Page 78		Dago 91
let's assume that based upon the autopsy	-	O: Is low stried rhythm on	Page 81
report there was no valvular involvement;		[1] Q: Is low atrial rhythm an	
		[2] abnormality?	
let's further assume that $-$ let's delete		[3] A: It was a variant of a wandering	
the last part of that.	!	[4] pacemaker.	
Based upon the lack of		[5] Q : I'm trying to get a definition.	
valvular involvement, is there any surgery		[6] MR. BANAS: Was it	
that could be performed to cure infective		abnormal?	
endocarditis?	ſ	[8] THE WITNESS: From what —	
A: No, sir.		[9] the way I would report this , I can't	
Q : So the surgery that we are		io] give you an opinion.	
talking about is limited to the valve?		11 BY MR. MALIK:	
A: Thevalve.		2 Q: Because you can't read it?	
Q: Talking about the mitral valve?		A: I can't see it.	
A: Mitral or aortic. Sometimes the		Q : Okay.Let'sput yourself in	
tricuspid or even remotely the pulmonary.		5] Dr. Ruiz's place on June 27.	
Q: Does an autopsy always show		6] A: Yes.	
floppy valves?		-	
		7] Q : In your differential diagnosis,	
A: Does an autopsy always show		8] what factors are you considering?	
floppy valves?		9] A : Here, you have a 27-year old	
Q: Let's assume a patient has a		oj fellow going to law school;he comes in	
floppy valve, would that always show up on		n with fever. You put him on an antibiotic.	
autopsy?		2] If you can't find any abnormality after	
A: There is a counterpart of it.		3] going over him, you say, well, let me keep	
It's what we call mixometous degeneration,		4] on looking. I will take a chest x-ray.	
	Page 79		Page 82
and we would anticipate that kind of	-	1] The chest x-ray is done and it's reported	1 450 02
finding. We would expect a kind of		[2] as normal. That is the route we would go.	
redundancy of the valve. So, in answer to			
your question, yes, I would anticipate some			
		(4) x-ray of the sinuses at that particular	
finding on autopsy to confirm the diagnosis		[5] time, but most of us would simply say we	
of floppy valve.		[6] will go ahead with the x-ray of the chest.	
Q : In your opinions today, are you		71 Then, secondly, he said, gee, I took an	
rendering those opinions as a specialist in		a electrocardiogram, there is low voltage	
internal medicine?	[9) here. Fever goes along with pericarditis	
A: I'm certified in internal medicine Whatavar I do in cerdiology I		0] sometimes. Maybe I'm missing something,	
medicine. Whatever I do in cardiology, I		1] even though the heart seems normal, so he	
hope, is based on my expertise in internal		2) does that and he finds no pericardial	
medicine.		3] effusion.He said let me see if I can get	
Q: So then you are rendering those		4] some help.	
opinions both as somebody board certified in internal medicine and cardiology?		5] Q: On June 27, are you rendering a	
an internal interior and cardiology?		6) differential diagnosis?	
		7] A: Well, he did. He went through 8] whatever he had considered.	
A: That's right. I'm very proud	11	9 Q: What is included in the category	
A: That's right. I'm very proud that I don't separate the two.			
A: That's right. I'm very proud that I don't separate the two. Q: Okay. You have a board	1	of differential diagnosis for this nation?	
A: That's right. I'm very proud that I don't separate the two. Q: Okay. You have a board certification in each?	5	of differential diagnosis for this patient?	
 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. 	5 	0] of differential diagnosis for this patient? A: Again, the only thing I can tell	
A: That's right. I'm very proud that I don't separate the two. Q: Okay. You have a board certification in each?	5 5 1	of differential diagnosis for this patient?	

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		Page 83	Тергиа у	Page 86
[1] pa	itient told about all of the above.		[1] don't actually know, so we play for two	
	lvised to have repeat physical and		[2] things. One is the input of someone else	
	evation."		[3] and time. The third thing is a response to	
	I didn't see him. In some		[4] what you are doing.	
	the deposition it was related that he		[5] Q: With respect to the input of [6] someone else, Dr. Ruiz referred Mr. Gonda	
	ought he had an acute respiratory		[6] someone else, Dr. Kuz referred Mr. Gonda [7] to a pulmonologist?	
	sease; and sinusitis was mentioned. I on't see that here.		[8] A: Yes.	
	Q: Those two things would be in your		Q: At the time he referred him to	
	fferential diagnoses?		10] the pulmonologist, or at the time Mr. Gonda	
	A: I'm saying what Dr. Ruiz felt.I		[1] went to the pulmonologist, what information	
	on't disagree with that.		12] would you expect the pulmonologist to have	
[13]	Q: Okay. In your opinion, to a		13] from Dr. Ruiz?	
[14] re	asonable degree of medical certainty,		A: Usually, nothing, except, listen,	
	ould anything else have been included in		15] I have a guy with a cough, I don't know	
[16] th	at differential diagnosis at that time?		16] what the hell is going on.	
[17]	A: I'm sure that there were things		17] Q: No medical records?	
	at were in his mind. I mean could this		18] A: No.	
	e something else like — that's why he		19] Q : No EKGs?	
	ent through this, Why in the world is he		20] A: No. They wouldn't know what to	
	aving a fever and so forth?		21] do with it.	
	I don't know how to address		Q: Would you agree that as a physician, it's critically important to the second seco	
	is finding of systolic click. There was		24) have as much accurate information a ^s	
[24] SU	pmething about his mother having it and	Page 84		Page 87
643 XX/	hether he concluded it because he could	raye04	[1] possible in order to come up with an	
	ever End anything, it was one of those		[2] accurate differential diagnosis?	
	enign findings that had no meaning.		[3] A : Yes.	
[4]	Later on, I searched		[4] Q : Just <i>so</i> we are clear, can you	
	arefully if anybody else found it. The		[5] tell me your definition of differential	
	nswer was no. You keep on coming back and		[6] diagnosis?	
	bu say, my gosh, I can't find anything in		A: You list the various	
[8] th	is nice, healthy guy, I'm not sure about		[8] possibilities in your mind that one would	
[9] hi	m. Let me see if someone else finds		[9] want to consider on the basis of a symptom	
[io] \$0	mething. You don't have any specific		10] or constellation of symptoms.	
[11] di	agnosis.		11] Q: And the purpose of listing those	
[12]	Q: So at that time, are you telling		12] would be what?	
	e other than the sinusitis and the		13] A: Well, to make certain that you	
	ossible respiratory infection, there is no		14] are considering the various possibilities	
	ther diagnosis that can be attributable to		15] of the cause of your patient's16] symptomatology or abnormality.	
	ese symptoms?		17] Q : Turning your attention to your	
[17]	A: No. I think that Dr. Ruiz was orried about things. We don't list them.		18] report dated 11/20/96, on 7/13/95, who did	
	b, we go through them. That's why I said		19] David Gonda present himself to for the	
	at he is still worried about what's going		20) evaluation of a cough and fever?	
	n with this guy. So as part of that		21] A Dr. Cropp.	
	ffort, he is not pigeonholed into any		Q: From the records, am I correct	
	ategory.It's an open book.		23) you are unable to describe the type of	
[24]	Q: Why don't you list them.		24] cough that he had?	
		Page 85		Page 88
[1]	A Pardon?	-	[1] A: I saw that. I indicated to you	
[2]	Q: Why don't you list them, the		[2] where Dr. Ruiz said something that the	
	ther —		[3] cough was productive of mucus and looked	
[4]	A: There are too many		[4] like saliva and was more a clearing of the	
[5] P	ossibilities. So, we go over the person		[5] throat than a harassing cough.	
[6] ai	nd we say where else do we go?At the		[6] Q: That was on what date?	
	noment, sometimes you take the empiric		[7] A Pardon?	
	pproach and give an antibiotic. Almost		[8] Q: What date was that?	
	lways the fever disappears. That's the		[9] A: Well, I know I saw that in 10] Dr. Cropp'sreport. Here is a report. "He	
	nd of your study.		11] has a persistent cough and needs to clear	
[11] [12]]i:	Q: You say there's too many to st. How many?		12) his throat all the time."	
[12] 11	A: Well, I indicated there are many		13] Q: The date of that?	
	auses for fever that one can list ad		14] A : The date of this 8/27/95.	
	auseum.		15] MR. BANAS: June.	
[16]	Q: What number is "many"?		16] THE WITNESS: June, I'm	
[17]	A: Adnauseam.		17] SOITY. 18] BYMR, MALIK:	
[18]	Q: Ten?		18] BY MR. MALIK: 19] Q: You indicated in your report that	
• •				
[19]	A It's kind of a textbook thing		20] his chest x-ray was normal. What	
[19] [20] tł	nat we all go through it. He could		20] his chest x-ray was normal. What 21] structures on the x-ray were normal?	
[19] [20] th [21] h [22] li	hat we all go through it. He could ave — if you want to say with abnormal ver enzymes, does he have hepititis,		 21) structures on the x-ray were normal? A: Well, I read that before. When 	
[19] [20] th [21] h [22] li [23] V	nat we all go through it. He could ave — if you want to say with abnormal		21) structures on the x-ray were normal?	

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Q: You didn't see the actual film,	[1] pipes and not just on the outside. The CT
did you?	[2] scan may give you information about other
3] A: No.	[3] parts, especially the mediastinum that you
Q: When you say the heart, you are	[4] can't decide with certainty what might be
is talking the exterior of the heart?	[5] present.
A: About the cardiac silhouette.	[6] Q: And am I correct in understanding [7] that you find no fault with Dr. Ruiz in
Q: Talking about the size?	[8] ordering a limited ultrasound of the heart?
 A: The size? Q: Talking about the size? 	A TT 11 1 A. 1 11 1. 1
A: Vos normal I thought you wara	 [9] A: He didn'torder a limited io] ultrasound. He simply ordered does the
ij trying to differentiate do I see the heart	11) patient have a pericardial effusion?
g or — we see the cardiac silhouette which	12] mean, it wasn't a studied-kind of response,
j means the period cardium also.	13] I'm going to ignore something else, I have
Q: You use the term "symptomatic	14] this fever and I have low voltage, I want
5] therapy."You said that was prescribed.	15] to make sure there is no pericardial
What did you mean by "symptomatictherapy	16] effusion, period.
y was prescribed?	Q: And you are telling me, it's
A He was given something to ease	re] within the standard of care to just take a
his cough and teslon pearls and the like.	19] look for pericardial effusion?
Q: And the date of that?	20] A: If that was his thing, nothing
A: That was in July when he saw	21] wrong. He didn't find anything.
him.	22] Getting back, there are
Q: Who did Mr. Gonda — strike	23] places on here where Dr. Ruiz says the
hat.	24] cardiac examination is normal. So, if he
Page 90	Page 93
Vou indicated in your report	[1] were concerned about that systolic click,
that consideration was given appropriately	[2] apparently, he paid no more attention to
i to bronchoscope and CT scan. Do you see	[3] it. That's as much as I can gather.
y that?	[4] Q: So as we sit here today, you are
5] A: Yes.	[5] telling me that it's okay for Dr. Ruiz to
Q: When was consideration given to	[6] have just taken a look for pericardial
rj that?	[7] effusion, correct?
B A: At the end of July.	[8] MR. BANAS: Objection. He
Q: At the end of July?	[9] said that three or four times. This
$\hat{\mathbf{A}}$ To make appointments to have it	io] is the last time. Yes or no.
t] done.	11] THE WITNESS: It was
2] Q: In terms of timeliness of a CT	12] appropriate.
3 scan, when would you have expected the CT	13] BY MR. MALIK
4] scan to have been done then?	14] Q: Did that indicate to you then
A: When he had the normal chest	15] that he was not concerned with what was
x-ray, we certainly wouldn't do it.	16] going on in the inside of the heart?
Q: If somebody is going to be making	17] A: No.That has nothing to do with
an appointment for a CT scan, as you	18] it.
j indicated in this case, what is the amount	19] Q: Had he been concerned with the
of time you would expect that CT scan to be	20] inside of the heart, you would have
1) done??Aweek?Two weeks?Three weeks?	21] expected him to have had a more complete
2] Four weeks?	22] ultrasound?
3) A: I didn't see any particular	A: I can't <i>think</i> for him. I'm sure
4] urgency about that.	24] that he would have done that.
Page 91	Page 94
1] Q: What about the bronchoscopy?	[1] Q: What did you mean when you noted
2] A: Well, again, I think he really	[2] in your report "manifestationsof
3) didn't believe that there was tumor or	[3] endomyocardial fibrosis were bizarre and
4) Hodgkin's disease. He mentioned it and	[4] not typical"?
5] said we ought to look for this. But ,	[5] A I simply emphasized the fact
6] again, as part of the differential	[6] that, first, its presence by itself doesn't
7] diagnosis, I don't have anything to hang on	do much of anything, but then when it
a) to that that was really present. I said,	[8] envelopes the valve apparatus and
9) "Let'sschedule him.Can it be done in	[9] interferes with filling of the heart, then
oj two weeks?""Yes." That's the kind of	10) you get various manifestations and the
1] reasoning. Nothing wrong with that.	111 major one is heart failure.121 Q: Did David Gonda have heart
2] Q: We can agree that the 3] bronchoscope and CT scan were the idea of	13) failure?
a) Dr.Cropp?	14] A: No.
5] A Yes.	15] Q: So, if the major manifestation is
6] Q: Then, I guess, I'm unclear as to	16] heart failure, what are you talking about
7] why the two tests were appropriate then.	17] in that statement?
A: Dr. Cropp was bothered by the	18] A: I said the manifestations of
9) fact that he continued to have a cough.	19] endomyocardial fibrosis are bizarre simply
And compating a your look at the cheat y new	20) because it might occur in the presence of [21] an environment of a nutritional
20] And sometimes you look at the chest x-ray	
and even though everything looks normal,	
	22) deficiency. That has nothing at all to do 23) with the heart itself. Nobody knows that.

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Ju	an Ruiz, ct. a.	1 CD1 um 7 0, 177
	Page 95	Page 98
[1]	Q: You didn't say "are bizarre."	[1] pericardial effusion; and since then, we
	They are more bizarre in David Gonda than	[2] have moved away from that.
	other cases? A: Bizarre only in the sense that	[3] Q: Turning your attention to your [4] report dated April 15,1998, who is the
[4]	it's an enigma. You can't put your finger	[5] report addressed to?
	on any symptom and say endomyocardial	[6] MR. BANAS: Steve Griffin,
	fibrosis.	[7] who is an associate of mine.
[8]	Q : Do you have an opinion, to a	BY MR. MALIK:
	reasonable degree of medical certainty,	[9] Q: Do you know Mr. Griffm
	whether or not the cough and the fever were	10] personally?
[11]	out of the ordinary for the disease of	11] A: No, I do not.
	endomyocardial fibrosis?	Q: Has your conversation with himbeen limited to the telephone?
[13]	A: I do have an opinion. Q: What is that?	14] A I believe I got a telephone call
[14] [15]	A The opinion is that that is the	15] from him that he was taking over this case
	last thing I would ever think of.	for from Gary; that's as much as I remember.
[17]	Q : You indicated you read	Q : Have you received any
	Dr.Weiderman's deposition.	18] correspondence from him regarding this
[19]	A: Yes.	19] case?
[20]	Q : Were you aware at the time you	20] A: No. I don't know if he is still
	read it that Dr. Weiderman did not consider	21] there.
	himself an expert in the area of	22] MR. BANAS: He left and he 23] came back about a month ago.
	endomyocardial fibrosis?	23] came back about a month ago. 44 BY MR. MALIK
[24]	A 165.	Page 95
641	Page 96	O Am Learnest in understanding
[1]	<i>Q</i> : What was it in Dr. Weiderman's letter that you felt was important?	[1] G : An 1 correct in understanding [2] that you rendered an opinion that
[3]	A: Well, he explained the fact that	[3] David Gonda did not die from bacterial
	he did have a rare condition and that there	[4] endocarditis?
	was, even if recognized, there wouldn't	[5] A: That is correct.
	have been anything that they could have	[6] Q : And what are you relying on for
	doneanyhow.	[7] that opinion? What information?
[8]	Q : Is that something you agree with,	[8] A: My knowledge of the case and my
[9]	even if recognized?	[9] knowledge of medicine.
[10]	A Yes.	[i0] Q: Are you relying upon the
[11]	Q : So it's your opinion, to a	1] Cleveland Clinic autopsy? A Well, yes, in a way.
	reasonable degree of medical certainty,	The set of
	that if endomyocardial fibrosishad been recognized in an early stage, nothing could	 In other words, If the Cleveland Clinic said is this unequivocal
	have been done?	[4] Crevenand Chine said is this unequivocal[5] endocarditis, if I saw other things that
[16]	MR. BANAS: No more.	16] were reported; for instance if I suspected
[17]	THE WITNESS: That's	[7] endocarditis and they reported a tumor,
• •	correct.	B certainly I would have to rely on their
[19]	MR. MALIK Don't point your	19] diagnosis.
	finger at me.	20] Q : But the main document you are
[21]	MR. BANAS: I'm not. That	i] relying on is the autopsy report?
[22]	is the end of that question.	2] A: That is correct. But, also,
[23]	MR. MALIK I will tell you,	3] clinically my knowledge of what transpired.
[24]	treat me this way and I will treat you	24] Q : When you reviewed this case, did
	Page 97	Page 100
	the same way in your depositions.	[1] you go to the autopsy report before you
[2]		[2] went to the other medical information?
[3]		 [3] A: Well, I knew only in the sense [4] that this was endomyocardial fibrosis and I
	you sent a patient in for an ultrasound for just pericardial effusion?	[5] never thought that anybody would raise the
	A: We don't select that way.	[6] specter of bacterial endocarditis. It was
[6] [7]		[7] only after the pathology was reviewed by
[8]		[a] another pathologist that that report was
	ultrasound just for some specific purposes,	[9] given to me and endocarditis was
[10]	but our knowledge has increased greatly, so	10] questioned.
	actually we, when we say echocardiogram,I	1] Q : In terms of the process that you
	suspect pericardial effusion or I suspect	12] used to review <i>this</i> case, was one of the13] first documents you reviewed, would that be
	valvular lesion so, please, give me the entire study, but pay particular attention	iii) the Cleveland Clinic autopsy report?
[is]	to what I'm talking about.	is] A That is correct.
[is]	Q : How long have you been doing	is] Q : Doctor, what is pulmonary
	that, getting the entire study?	17] thromboembolism disease?
[18]	A: Manyyears.	A That refers to the fact that a local temperature of the fact that a
[19]		[9] clot has embolized and has moved from20] elsewhere in the body through the heart to
[20]		?1] the lung.
	O : How much time before that?	
[21] [22]		2] Q : Are you going to render any
[21] [22] [23]		

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February 8, 1999	lan a Maria Ka ta Kata Kata Kata Kata Kata Kata Ka	X († 8)	Juan Ruiz, e	et. al.
	Page 10		그는 그는 것 같은 것은 것은 것은 것 같은 것 같은 것 같은 것 같은 것 같은	age 104
m heart?		[ti		
[2] A How long they wer	re present?		n significance of that is?	
[3] Q: Yes.	· · · · · · · ·	[3]		
[4] A I have no basis; onl			bacterial or infective endocarditis means	
[5] what is stated here sever			 b) that you have to have some demonstration of b) valve involvement, and in the absence of 	
[6] And, certainly, they were[7] before he died.	present long		y valve involvement, and in the dissence of y valve involvement the diagnosis of mural	
	"longhafora"		endocarditisis a very tenuous one starting	
[8] Q: And when you say [9] what do you mean?	long berore,		first with the premise that it is a very	
[10] A: There is no way of	knowing in		are lesion.	
[11] other words, how long a		11]	·	
[12] heart. And I don'thave a			endocarditis can exist in the absence of	
[13] are silent lesions unless t			valvular involvement, are you?	
[14] Q: But you have an im		14]		
[is] you give me a range?		15]	it can exist, but there are certain	
[16] MR. BANAS: If you can	n.	16]	s extenuating circumstances that you better	
[17]	BY MR. MALIK:	17	define before you assume that there is	
[18] Q: Tell me what you r	neant by "they	18]	aj mural endocarditis.	
[19] were there long before h		19]	Q: Referring to Dr. Lerman's report	
[20] MR. BANAS: You don'		20	y which you address in your report, why is	
[21] to guess.		21]] Dr. Lerman's position that the	
[22] THE WITNESS: There	is no	22]	e chocardiogramis consistent with	
[23] way of determining that	with certainty	23]	g infectious bacterial endocarditis in error?	
[24] because the clot could have		_24]	A: Well, I indicated that actually	
	Page 10	2	P	age 105
[1] and then embolized. And	8		when we diagnose endocarditis, we want	
[2] clot was there is unclear.			evidence of valve involvement, so that puts	
[3] only way you can do tha			a up a red flag right away that your	
[4] some measurement from			diagnosis is in error. And if you diagnose	
[5] the end, and we almost a			and ocarditis and don't see any value	
[6] have that.			involvement —	
[7]	BYMR. MALIK			
[8] Q: So, is it your opinio			echocardiogram you are referring to?	
[9] reasonable degree of me		[9]		
[10] that you cannot tell with			b] died.	
[11] long the clot was there?		11]	Q: You indicated in your report that	
[12] A: That is correct. And	1 we depend	12	the electrocardiograph comparative tracing	
[13] upon the pathologist to 1			sy suggests possible right ventricular right	
[14] time. And in the absence		14]	a) overload when compared to the prior	
[15] clinically, that is, and from	m the	15]	5] tracing. And my question to you is: Did	
[16] standpoint of the lung, y		16]	5) you have a clear strip at the time you	
[17] chest x-ray. So he did not		17	7] wrote that?	
[18] And then he has masses		18]		
[19] had it then and somethin	ng happened in the	19]	9] want to see that.	
[20] interim.		20		
[21] Q: But, clearly we can	agree that if	21	1] will tell you.	
[22] it was there on June 27th		22		
[23] would have been done, i	t would have been	23	aj talked about that.	
[24] found?		24	4] MR. MALIK: Did I point to	
	Page 10	3	Р	Page 106
[1] A Correct.	0	[1]	1) the wrong one?	
[2] Q: Do you have the st	atement in that	[2		
[3] report, "Endocarditisis u		[3	3) that.	
[4] absence of ." Is that your	r report?	[4		
[5] A : Pardon?	•	15	Q: May I see that, please. I will	
[6] Q: Is that in your repo	ort? Do you	[6	ej withdraw that.	
[7] see that sentence, "Endo	ocarditisis	[7	7] Which of the following	
[E] unlikely in the absence of		[8]	8] symptoms, Doctor, can be caused by a	
[9] MR. BANAS: Where s			9) cardiac problem? (1) sinus tachycardia;	
[10] look?			b] and (2) fever of unknown origin; (3)	
[11] MR. MALIK: I have to	look		1) persistent cough; and (4) shortness of	
[12] for it myself.	. •		2] breath? 3] A Allofthem.	
[13] THE WITNESS: Here i		13	• • • • • • •	
[14] "In the absence of verru- [is] the presence of unaffect			5) the electrocardiogram, "Disregard the	
[16] valves."			6] suggested diagnosis given by the	
[16] valves. [17]			7) echocardiographer or the radiologist of the	
• •		1 10	⁸] CT scan or possible metastatic tumor" —	
[18] Q: What are verrucae	BY MR. MALIK:	1 10		
A. C'1	?	19	9] A: I don't understand.	
[19] A: Simply wart-like ex [20] the valve.	? xcrescence from	19 20	 9) A: I don⁵t understand. 0) Q: His comments, do you see that? 	
 [19] A: Simply wart-like ex [20] the valve. [21] Q: You also indicate i 	? xcrescence from n your report	19 20 21	 9) A: I don⁵t understand. 0) Q: His comments, do you see that? 1) A: His comments ignores the efforts 	
 A: Simply wart-like ex the valve. Q: You also indicate i that Dr. Hoffman makes 	? xcrescence from n your report no mention of the	19 20 21 22	 9 A: I don⁵t understand. 9 Q: His comments, do you see that? 11 A: His comments ignores the efforts 2) made by the physician to establish a 	
 [19] A: Simply wart-like ex [20] the valve. [21] Q: You also indicate i 	? xcrescence from n your report no mention of the	19 20 21 22 23	 9) A: I don⁵t understand. 0) Q: His comments, do you see that? 1) A: His comments ignores the efforts 	

	a da segunda	l te dese		Alternational Contraction
	Page 107			Page 110
[1] Q: And right here, his comments on			why did you go to Dr. Cropp, why didn't you	
[2] the electrocardiogram, "Discard the			go to an infectious disease doctor because	
[3] suggested diagnosis given by the			it turned out to be bizarre?	
[4] echocardiogram, "do you see where I'm		[4]	Q: So, you believe that sending	
5 talking about?			David Gonda to a pulmonologist was the	
[6] MR. BANAS: Diagnosis			proper consultation? A: Yes.	
[7] suggested, is that what you are		[7]		
[8] talking about?		. [8]	Q: What about Dr. Cropp, do you foult Dr. Cropp in any way for not sending	
[9] THE WITNESS: His comments			fault Dr. Cropp in any way for not sending	
[10] on the electrocardiogram, "Disregard			David to a cardiologistor infectious disease doctor?	
[11] the suggested diagnosis given by the			A Well, he better not. And I mean	
[12] echocardiographer as above or the		[12]	whatever he finds, he better report to	
[13] radiologist of possible metastatic			Dr. Ruiz. It's up to Dr. Ruiz. There's	
[14] tumor or Wagner's lymphoma."			some specialists that do that, but they	
(15) BY MR. MALIK:			don't see a patient referred by the other	
[is] Q : Why do you believe that?			doctor anymore.	
[17] A: I have to see Dr. Lerman's		[18]		
[18] comment on the electrocardiogram.			consulting has the obligation to go back to	
[19] MR. BLOMSTROM: His comments			the primary care doctor, in this case,	
[20] on the electrocardiogram			Dr. Ruiz?	
[21] THE WITNESS: He made a		1	A: Certainly; and you must be very	
[22] comment.		[22]	careful. First, you list him as a primary	
[23] MR. BANAS: Give me a moment			and then you indicate to me that he has a	
[24] and I will find it.		[[24]	and then you indicate to the that he has a	
	Page 108			Page 111
[1] MR. BANAS: The problem is		[1]	sign saying that he is knowledgeable in	
[2] there were four reports and we only			cardiac diseases.	
[3] have one or two. I'm not sure what		[3]	Q: He does.	
[4] you were sent. There's one, but I'm		[4]	A So I mean you can't — can you	
[5] not sure that's the right one. That			imagine Dr. Cropp announcing to the world	
[6] may have been one I got after the			saying I'm going to send him to a	
[7] deposition.		[7]	cardiologist?	
[8] THE WITNESS: Do you have		[8]	Q: Sending him back to Dr. Ruiz was	
[9] it?Do you have his report?		[9]	the proper move then, right?	
[10] MR. MALJK: No, I don't.		[10]		
[11] MR. BANAS: We don't have		[11]	Q : Does anybody have any way of	
[12] it.			knowing the length of time it would take to	
BYMR. MALIK			develop an intracavity mass, for example,	
[14] Q : You can't answer that question?			including sarcoma, thrombus, lymphoma or	
[15] A I was addressing something there			any of the structural changes caused by	
[16] and I didn't repeat what he said.		[16]	Wagner's granuloma?	
[17] Q: Did Dr. Ruiz at anytime fall		[17]	A We have no method. We know the	
[18] below the standard of care by not calling a		[18]	end. We don't know the beginning.	
[19] consultation with a cardiologist?		[19]		
[20] A : No, sir.		[20]		
[21] Q: Why not?		[21]		
[22] A: Well, he did what he could and he		[22]	endocarditis?	
[23] found no — he went over the patient		[23]	A If it were present, you have no	
[24] clinically and he found no evidence of any		[24]	clear-cut evidence when it began. And	
	Page 109			Page 112
[1] cardiac abnormality.		[1]	because you are dealing with a destroyed	
Z I addressed myself		[2]	valve to begin with, you don't know when it	
[3] previously to the systolic click which,			became infected.	
[4] apparently, he dismissed and he felt that		[4]	Q: Well, let's assume it is the	
5 it was an infectious process that he was		[5]	endocarditis in this case where there is	
6 dealing with and that the heart was not			no, where there appears to be no valvular	
[7] involved.		[7]	involvement.	
[8] Q: What about the abnormal EKG, that		[8]	A The interesting thing is, even	
[9] wouldn't be grounds to call in a		[9]		
[io] cardiologist?			endocarditis recognized endocardial	
[11] A: No. I think it would be			myocardial fibrosis.	
[12] reasonable if he has a sign that he is		[12]	Q: The two entities can get	
[13] announcing to the world that he is an			A Well, according to him it could	
[14] expert in cardiac diseases and he went over [15] the patient and recognized the fact that		[14] [15]	have existed.	
[16] the electrocardiogram was abnormal and he		[16]		
[17] was concerned and he put it together and he			stages of the development of the mass that	
[18] thought it was pericardial effusion, I			was found on autopsy?	
[19] can't fault him at all.		[19]	A No, sir.	
[20] Q: So, is it a fair statement to say		[20]		
[21] that a cardiologist would not have			render any opinion whether or not there was	
[22] contributed anything else?			inflammatory tissue in the heart on	
[23] A: It's not fair; and, certainly, in			June 27, 1995? A: No. All I can tell is what the	
[24] retrospect, you say why didn't you call,		[24]	A. MO.MITCHICIIIS WHAT UIC	

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Jacob Zatuchni, M.D.

Dorothy Gonda, etc. v.

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icob Zatuchni, M.D. ebruary 8, 1999			Dorothy Gonda, <i>etc.</i> Juan Ruiz, et. a	
	Page 113		Page 11	<u>—</u> 16
] autopsy was.	222 - 11 - 14 (1	n endocarditis. In that sense, ves, the	e	한 김 사람 김 씨는 것
Q: Was bacterial endocarditis ever	6	e] toothache is related. And if you ha	we that	
ruled out in this case?	G	B] kind of history, yes.		
A Yes.		4] Q: I was trying to be flip, I gue	ess,	
Q: When was that?	Į.	and I shouldn'tbe.		
A: Well, from the standpoint that	[0			
clinically there was no evidence of any	0	j toothache or hemorrhoids in this	patient.	
valvular lesion. And, I think, even when	[4	B] What I'm trying to determine is w	vhen	
he went to this fountainhead of knowledge,	[1	Mr. Malik asked you are these syn	nptoms	
the Cleveland Clinic, consideration was not	ىن	consistent with endocarditis,prac	tically	
given to endocarditis and there was	1	anything in the world is consister	nt with	
angiosarcoma.	1:	endocarditis, isn't it?		
Q: As we sit here today, it's	1:	A: That's what I wanted to con	ivey.	
absolutely your belief that bacterial	14	MR. MALIK Objection.	-	
endocarditis was ruled out in this case; is	1		TRAVERS:	
i that correct?	10	Q: Can you identify any clinica		
A: That is correct.	1	y symptom or sign that, because of	its	
Q: In taking the patient off		existence, you would be able to s		
antibiotics prior to blood cultures, does	15	therefore, the patient does not ha	ve	
the patient have to be hospitalized or	24	endocarditis?		
is should the patient be hospitalized for		A: That is incorrect.		
g that?	2	MR. MALIK: Objection.		
A: No.The only thing that you	2		n a	at the for
would consider hospitalization for is if he		() constellation of symptoms and sig		
	Page 114		Page 1	17
	-	u so vou con'tiust isolate comethir	0	
were \mathbf{so} seriously ill and the second thing		1] so, you can't just isolate somethir	ıg,	
is to document his fever. Patients tell		2) fever, endocarditis.	ut the	
you they have fever, but it may not be		3] Q: I'm talking about to rule ou	it the	
present.		4) existence of endocarditis.		
Q: For an internal medicine		5] A: Nothing rules it out.	.1	
physician such as Dr. Ruiz who claims extra		Q: Every medical symptom in	the	
knowledge in cardiovascular disease, can	[7) world is consistent with the exist	tence of	
you tell me what diagnostic tests are	[B) endocarditis?		
available to him to check the human heart	l l	A That is correct.		
) for abnormalities?	1	MR. MALIK Objection.		
A The echocardiogram.	1	· 1	TRAVERS:	
2] MR. BANAS: Anything else?		2] Q: The only other area of follo		
3) THE WITNESS : Well, he did		3] I would like to pursue concerns t		
4] the chest x-ray. And, of course, it		4] study that was ordered by Dr. Rui	iz to rule	
5) starts with the clinical examination.	1	5] out pericardial effusion.		
6] BY MR. MALIK	1	6] First of all, do I		
Q: But the most important thing		7] understand you correctly to say t		
would be?	1	abnormalities evidenced on the E	KG are	
A: What was left out was the	1	9] suggestive of the possibility of		
echocardiogram.	2	oj pericardial effusion?		
MR. MALIK I have nothing		1] A: Yes.		
further.	2	2] Q: So, was an appropriate requ	uest of	
BY MR. BLOMSTROM	2	3] Dr. Ruiz to order a study addressi		
Q: Doctor, do you have any opinions	2	issue of whether pericardial effus	sion	
<u>, </u>	Page 115		Page 1	118
aritically of my alignt Dr. Hafiz the	-	1] existed?	5	
critically of my client, Dr. Hafiz, the		2] A: Yes.		
radiologist?	-	•	rc.	
A: No, sir.		3] Q: Is there anything on the EK 4] suggestive of the existence of a c	ordiaa	
BY MR. TRAVERS:			arutac	
Q : I have a few questions, primarily		5] lesion in his ventricle?	only	
j just things that came up during your		6] A: The interesting thing is the		
testimony,Doctor,that I want to make sure		7] thing characteristic of endocardi		
that I understand correctly.		 8] the standpoint of the — is a concept 9] abnormality which is not present 	here from	
Can a toothache be		a) the electrocardiogram.	there from	
consistent with endocarditis?Hemorrhoids, maybe?		1] Q: I had anticipated Mr. Malik		
		2] asking you about blood cultures,	and I	
 A: I was trying to answer you appropriately. We always have that sort of 		3] don't remember that part of the		
problem. I can give you the analogy. You		4] you critical of Dr. Ruiz concernin		
[] mentioned hemorrhoids and you have cough	1	5] decision to imperically treat the	patient	
and so you have A & B. And are they both		6] rather than immediately order bl	ood	
7] related to C, namely lung cancer?Yes.	1	7) cultures?		
^{8]} And because the guy coughed		8] A: No, that is standard practic	e.	
and he developed a hemorrhoid — he really		9] MR. TRAVERS: Those are all		
of coughed because he had cancer of the lung.		0) my questions, Doctor. Thank you		
1) And that's how they are related. And the		MR. BANAS: Mail the		
2) same thing, a guy could have a toothache,		2] transcript to him (Deposition concluded 4:07		
	2	(Deposition concluded, 4:07 (a) p.m.)		

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	and the proceedings in the aforegoing		
[7]	matter are contained fully and accurately		
[8]	in the stenographic notes taken by me, and		
(9)	that the copy is a true and correct		
(10)	transcript of the same		
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[4]	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.		
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