
DOROTHY A. GONDA vs JUAN RUIZ, M.D.; et al

PAGE 1 TO PAGE 104

KENNETH L. LEHRMAN, M.D.

**CONDENSED TRANSCRIPT AND CONCORDANCE
PREPARED BY:**

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(1) IN THE COURT OF COMMON PLEAS
 (2) MAHONING COUNTY, OHIO
 (3) --o0o--
 (4) DOROTHY A. GONDA, INDIVIDUALLY)
 AND AS ADMINISTRATRIX OF THE)
 (5) ESTATE OF DAVID PAUL GONDA)
 DECEASED.)
 (6))
 Plaintiff.)
 (7))
 -vs-) CASE NO. 96 CV 2055
 (8))
 JUAN RUIZ, M.D., ET AL..) COURTROOM NO. 4
 (9))
 Defendants)
 (10))
 (11))
 DEPOSITION OF KENNETH L. LEHRMAN, M.D.
 (12)
 (13)
 (14) SCHEDULED FOR: 10:00 A.M.
 (15) ON THE RECORD 10:18 A.M. TO 12:45 P.M.
 (16) DATE: Friday, January 29, 1999
 (17) TAKEN AT: OFFICES OF KENNETH L. LEHRMAN, M.D.
 901 Campus Drive, Suite 306
 (18) Daly City, California 94015
 (650) 755-2007
 (19)
 (20) BY THOMAS J. TRAVERS, JR., ATTORNEY AT LAW
 (21)
 (22) REPORTER: HARRIET MARCH PAGE, CSR NO. 1284
 (23) PEREIRA & ASSOCIATES
 CERTIFIED SHORTHAND REPORTERS
 (24) P. O. BOX 4339
 Daly City, California 94016-0339
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 (5)
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 (10)
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(1) BE IT REMEMBERED that, pursuant to Notice.
 (2) and on FRIDAY, JANUARY 29, 1999, commencing at the
 (3) hour of 10:18 a.m. thereof, at 901 Campus Drive,
 (4) Suite 306, Daly City, California 94015, before me,
 (5) Harriet March Page, CSR No. 1284, authorized to
 (6) administer the oath, personally appeared KENNETH L.
 (7) LEHRMAN, M.D., who was examined as a witness in said
 (8) cause.
 (9) KENNETH L. LEHRMAN, M.D.,
 (10) called as a witness by the Defendants, who, being by
 (11) me first duly sworn, was thereupon examined and
 (12) testified as is hereinafter set forth.
 (13) --o0o--
 (14) APPEARANCES OF COUNSEL
 (15)
 FOR THE PLAINTIFF
 (16) LAW OFFICES OF DAVID MALIK
 BY: DAVID MALIK, ATTORNEY AT LAW
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 (19)
 LAW OFFICES OF MARK W. RUF
 (20) BY: MARK W. RUF, ATTORNEY AT LAW (By Phone)
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 (23) ---o0o---
 (24)
 (25)

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(1) APPEARANCES OF COUNSEL (CONTINUED)
 (2)
 (3) FOR THE DEFENDANT JUAN RUIZ, M.D.:
 MANCHESTER, BENNETT, POWERS & ULLMAN
 (4) BY: THOMAS J. TRAVERS, JR., ATTORNEY AT LAW
 Atrium Level Two
 (5) The Cwmerce Building
 201 East Cwmerce Street
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 (7)
 FOR THE DEFENDANTS ALAN J. CROPP, M.D. AND ROBERT DE
 (8) MARCO, M.D.:
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 P.O. Box 35519
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 (11) 1-800-686-2822
 (12) FOR THE DEFENDANT ABDUL HAFIZ, M.D.:
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 (13) BY: JAMES L. BLOMSTROM, ATTORNEY AT LAW
 1200 Mahoning Bank Building
 (14) Youngstown, Ohio 44505
 (303) 744-1111
 (15)
 (16) ---o0o---
 (17)
 (18)
 (19)
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 (21)
 (22)
 (23)
 (24)
 (25)

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- (1) KENNETH L. LEHRMAN, M.D.,
 (2) having been first duly sworn to tell the truth, the
 (3) whole truth and nothing but the truth, was thereupon
 (4) examined and testified as is hereinafter set forth:
 (5) ---oOo---
 (6) EXAMINATION
 (7) BY MR. TRAVERS:
 (8) Q. Doctor, state your full name, please.
 (9) A. It's Kenneth Lehrman, L-E-H-R-M-A-N, M.D.
 (10) Q. You are a physician, I understand?
 (11) A. That's correct.
 (12) Q. What is the nature of your specialty?
 (13) A. I am a specialist in cardiology and
 (14) internal medicine.
 (15) Q. I have been handed a copy of your CV here
 (16) today. I don't recall having seen it before. So I
 (17) am going to go through it since the lawyers on the
 (18) phone have not received a copy of it yet.
 (19) But real briefly, you were born in New
 (20) York and then went to Case Western College in
 (21) Cleveland; is that right?
 (22) A. For both undergrad and medical school.
 (23) Q. You did an Internship and Residency in
 (24) Internal Medicine at Mount Zion Medical Center in
 (25) San Francisco?

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- (1) My practice includes about 60 or 70
 (2) percent primary - probably 60 percent primary care
 (3) of cardiology and internal medicine patients, about
 (4) 40 percent consultive, about 60-40
 (5) outpatient-inpatient.
 (6) And I do invasive and interventional
 (7) cardiology involved in my inpatient care.
 (8) (Interruption.)
 (9) MR. TRAVERS: Q. Doctor, when you talk
 (10) about providing primary care to cardiology and
 (11) internal medicine patients, my perception is that's
 (12) different than the primary care that a family
 (13) practice physician would be involved in.
 (14) I mean, it's specialized care rather than
 (15) just ordinary everyday primary medical care.
 (16) Or am I wrong about that?
 (17) A. It's - you're wrong. Basically, a small
 (18) portion of my practice, about 20 to 30 percent is
 (19) the primary care of normal, well people, which is
 (20) basically what a family practitioner would do.
 (21) I don't do children, which a family
 (22) practitioner would do. But in terms of the adult
 (23) care of these patients I act as an internist or a
 (24) family practitioner.
 (25) A bulk of my patients have cardiac-related

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- (1) A. That's correct.
 (2) Q. And your Fellowship in Cardiology at
 (3) Stanford?
 (4) A. Yes.
 (5) Q. You are Board certified in both Internal
 (6) Medicine and Cardiology?
 (7) A. Yes.
 (8) Q. I am glancing here at your academic
 (9) positions, doctor. Do you have any present
 (10) academic -
 (11) A. The only present position is the - I'm a
 (12) clinician at the San Francisco Heart Institute,
 (13) clinical faculty there.
 (14) Q. Can you give me a thumbnail sketch of the
 (15) nature of your private practice?
 (16) A. I spend about 90 percent of my time in
 (17) primarily patient care activities and associated
 (18) administrative activities for patient care.
 (19) Less than ten percent of my time is
 (20) involved with medical-legal and about one percent
 (21) of
 (22) my time is administrative duties with the hospital
 (23) that - the hospitals that I'm involved with, which
 (24) are Mills-Peninsula Medical Center in Burlingame
 (25) and
 (26) Seton Medical Center in Daly City, California, which
 (27) is a suburb of San Francisco.

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- (1) problems, is what I mean by the primary care. And
 (2) that aspect - and I take care of all aspects of
 (3) those patients at well.
 (4) Q. What type of invasive and interventional
 (5) cardiology do you practice?
 (6) A. I do coronary arteriography and cardiac
 (7) catheterization, which is diagnostic test, and then
 (8) I do angioplasty as well, which is an intervention
 (9) for treatment of coronary disease.
 (10) Q. Could you estimate for me the approximate
 (11) number of angioplasties you would do on an annual
 (12) basis?
 (13) A. About 50.
 (14) Q. You are licensed to practice medicine?
 (15) A. Yes. In California only.
 (16) Q. Do you presently provide medical care on
 (17) any patients suffering from endocarditis?
 (18) A. Currently?
 (19) Q. Correct.
 (20) A. Only in terms of post-endocarditis. I
 (21) don't have anyone in the hospital with endocarditis
 (22) now, if that's what you mean.
 (23) I still have patients in my practice who
 (24) have survived endocarditis.
 (25) Q. Can you estimate the number of patients

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- (1) that you have seen who suffered from that disease?
- (2) A. About one a year. And I've been in
- (3) practice about 20 years.
- (4) Q. Can you identify the hospitals that you
- (5) are affiliated with?
- (6) Apparently you have two different offices:
- (7) one in Daly City and one in Burlingame?
- (8) A. That's correct. I have an office near
- (9) each of the hospitals. The office in Burlingame is
- (10) a satellite office where I see patients two
- (11) afternoons a week.
- (12) Q. Are either of the hospitals that you
- (13) practice at teaching hospitals?
- (14) A. At the present time, no.
- (15) Q. How many beds are in each of those
- (16) hospitals?
- (17) A. Approximately 200 each.
- (18) Q. Where is Burlingame?
- (19) A. Burlingame's right next to the airport.
- (20) Q. Okay. Explain for me, if you would,
- (21) Doctor, how you view your role in this case?
- (22) A. Basically, I was asked to review the
- (23) records and see if there was a breach of the
- (24) standard of care.
- (25) Q. So if I understand that correctly, you are

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- (1) for the San Mateo County Medical Society reviewing
- (2) cases of doctors who had suits filed against them,
- (3) to determine whether or not there was a defensible
- (4) claim on behalf of the defendants – the defendant
- (5) in the case.
- (6) I have been deposed over the last twelve
- (7) years about a hundred **25** times. I have actually
- (8) appeared in trial about eight times over the last
- (9) twelve years as well.
- (10) Q. When you say that the majority of your
- (11) case reviews are for patients, can you estimate what
- (12) percentage that would be?
- (13) A. About 98 percent have been for plaintiff,
- (14) when I review them separately from the committee.
- (15) Q. Have any of those cases involved either
- (16) endocarditis or endomyocardial fibrosis?
- (17) A. Yes, they have. And I can't tell you
- (18) which ones.
- (19) Q. How many times would you say you have
- (20) testified in cases – well, let me ask a different
- (21) question first.
- (22) Any of them involving endomyocardial
- (23) fibrosis?
- (24) A. No.
- (25) Q. How many cases do you think you have been

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- (1) here to answer our questions concerning your
- (2) opinions in your area of expertise as opposed to
- (3) acting as an advocate or giving speeches supportive
- (4) of the plaintiff's claims?
- (5) A. That's correct.
- (6) It's – I'm basically – basically, I
- (7) review the case in an unbiased manner, and my
- (8) opinions are based on the record rather than
- (9) anything I read in depositions.
- (10) Q. Have you been a defendant in any medical
- (11) malpractice cases yourself?
- (12) A. No.
- (13) Q. I assume from your earlier response that
- (14) this is not the first case in which you've been
- (15) involved as an expert witness; correct?
- (16) A. That's correct. I've reviewed about, over
- (17) the last twelve years, about **500** cases, about **50**
- (18) percent of which I found no breach of the standard
- (19) of care. The vast majority of those were for
- (20) plaintiff.
- (21) I've reviewed several cases for defense;
- (22) again, about **50** percent found no breach of the
- (23) standard of care.
- (24) I sat on a – up until this year, when my
- (25) term expired, on a medical legal advisory committee

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- (1) involved in as an expert where the issue of
- (2) endocarditis was involved?
- (3) A. I have probably reviewed under ten for
- (4) sure. Probably about five or six.
- (5) I have never – I don't think I have ever
- (6) been deposed in a case with regard to it and I don't
- (7) know the status of the cases, either, so I can't
- (8) tell you.
- (9) Q. Have those all been in regard to whether
- (10) there was a breach of the standard of care for
- (11) failure to diagnose endocarditis?
- (12) A, That's correct. And again, to the best of
- (13) my knowledge, it's about **50-50** in terms of breach in
- (14) these cases as well.
- (15) Q. If I understand your answer correctly,
- (16) there are circumstances in which a physician can
- (17) exercise reasonable care toward his patient and yet
- (18) fail to diagnose the existence of endocarditis?
- (19) A. Exactly.
- (20) MR. MALIK: Objection.
- (21) MR. TRAVERS: Q. Do **you** know how it was
- (22) that you were secured as an expert in this case?
- (23) A. Yes, as a matter of fact I do.
- (24) In December of 1996 I had the original
- (25) files along with a time line forwarded to me from

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(1) Rieback Medical Legal Consultants out of Fort
 (2) Lauderdale, Florida, to review and set up a phone
 (3) conference, oh, I guess in November. I received it
 (4) in December.
 (5) Q. Do you know how this group identified you
 (6) as a prospective individual to review the case?
 (7) A. On a regular basis during that time period
 (8) I was receiving cases from this medical-legal
 (9) consultant firm which connected lawyers with
 doctors
 (10) to review cases.
 (11) Q. You were on their roster of potential
 (12) experts at that time?
 (13) A. Exactly.
 (14) Q. You are no longer –
 (15) A. I am, but I don't receive them on as
 (16) regular a basis.
 (17) Q. Are you registered with any other
 (18) organizations who assist lawyers in securing expert
 (19) witnesses?
 (20) A. I am – I don't think I am registered. We
 (21) have a loose affiliation. She bills for me.
 (22) I don't think she uses my name to
 (23) advertise, so I don't know how you would say it.
 (24) Q. "She" is who?
 (25) A. Ellen Rieback, who is the nurse who is in

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(1) except for the museum and the symphony.
 (2) Q. And the Browns?
 (3) A. Yeah, they were still – they were
 (4) training on our – next to my dormitory, and they
 (5) were there.
 (6) Q. Doctor, do you claim any higher degree of
 (7) expertise concerning endocarditis than the average
 (8) practitioner in internal medicine or cardiology?
 (9) A. No.
 (10) Q. Have you ever lectured or published any
 (11) articles pertinent to that medical condition?
 (12) A. I have probably given talks to medical
 (13) students during my time on the faculty at Stanford
 (14) but, no, I have not been paid to lecture around the
 (15) country.
 (16) And I have written – I don't believe I
 (17) have written any papers related to infectious
 (18) endocarditis. Can we shorten that to IBE maybe?
 (19) Q. IB – infectious –
 (20) A. Infectious endocarditis. I will use that
 (21) as my brief identification if that's okay.
 (22) Q. That is fine with me.
 (23) Can you tell me what you have done both to
 (24) formulate your opinions in this case and to prepare
 (25) yourself for rendering your deposition testimony

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(1) charge and the sole person in this medical-legal
 (2) consultant firm.
 (3) Q. Okay. Other than Rieback, are there any
 (4) other groups with which you have some type of
 (5) affiliation through which you receive cases for
 (6) review?
 (7) A. No.
 (8) Q. Do you take any other steps to make your
 (9) availability known to lawyers to serve in this
 (10) capacity?
 (11) A. No.
 (12) Q. What is your fee structure for acting as
 (13) an expert in this case?
 (14) A. I receive **250** dollars an hour for review,
 (15) reports, conferences, and predeposition
 conference,
 (16) or any written reports or oral reports, phone calls.
 (17) For a deposition I receive **500** dollars an
 (18) hour, and for trial testimony it would be 3,000
 (19) dollars a day plus expenses.
 (20) Q. Do you know whether you will be coming to
 (21) Ohio to testify as a live witness in this case?
 (22) A. I look forward to seeing the Rock and Roll
 (23) Hall of Fame.
 (24) Q. Wasn't there when you were a kid?
 (25) A. No. Nothing was there when I was there,

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(1) today?
 (2) A. I reviewed the initial packet, which was
 (3) the records of – with regard to Ms. Gonda,
 (4) including the St. Elizabeth admission, **1975**, St.
 (5) Elizabeth admission, University Hospital admission
 (6) in **'94**, University Health Services records, records
 (7) from Dr. Ruiz and Dr. Cropp's offices, St. Elizabeth
 (8) admission on **8-15**, and Cleveland Clinic admission
 of
 (9) approximately **8-16** or **8-17**, I'm not sure which.
 (10) I also reviewed the autopsy and the report
 (11) from Dr. Hoffman on the – his interpretation of the
 (12) slides and autopsy.
 (13) In addition, I received – my opinions
 (14) were formulated on the basis of the initial records
 (15) and autopsy and basically were confirmed by
 (16) Dr. Hoffman. I did not change my opinions at that
 (17) point.
 (18) I also received depositions from
 (19) innumerable people, including Dr. Cropp, Dr. Hadley
 (20) Morgenstern-Clarren, Dr. Ruiz, Dr. – I'm sorry,
 (21) Paul Gonda, a report from Dr. Anthony de Marco.
 (22) Some articles on endomyocardial fibrosis
 (23) which were forwarded to me.
 (24) Deposition of Dr. Sharon Hook. Second
 (25) deposition of Dr. Juan Ruiz.

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- (1) A deposition of Dr. Robert Hoffman, II.
- (2) Another copy of Dr. Juan Ruiz's chart, A deposition
- (3) of Robert de Marco, M.D.
- (4) Deposition of Alejandro Franco, M.D.
- (5) I didn't use those in formulating my
- (6) opinion, though, but I have reviewed them.
- (7) Q. "Those," meaning all of these depositions?
- (8) A. That's correct.
- (9) Q. By "reviewed them," you mean you have read
- (10) them?
- (11) A. I have skimmed them, I have not read them
- (12) word for word.
- (13) Q. Okay.
- (14) A. If you tell me something is in here and
- (15) show it, I'll agree with you, is basically how -
- (16) Q. The medical journal articles that you have
- (17) in your documents there, who forwarded those to you?
- (18) I believe Mr. Malik. Is that correct?
- (19) It came probably with some of the
- (20) depositions. Again, I skimmed them; I didn't review
- (21) them in detail.
- (22) Q. All of the journals pertain to
- (23) endomyocardial fibrosis?
- (24) A. Yes. That's correct. It's a British
- (25) Heart Journal from - 1955 British Heart Journal

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- (1) A. I'm not talking about - at - in my
- (2) testimony, I'm not going to be talking about
- (3) survivability of end-stage EMF.
- (4) Q. That's exactly what I was trying to find
- (5) out.
- (6) The opinions that will be introduced by
- (7) you in this case are based on the proposition that
- (8) the patient's disease process was IBE?
- (9) A. For the most part. My other opinion is
- (10) going to be that if the EMF, if it did exist, were
- (11) diagnosed in an appropriate and timely manner,
- (12) then
- (13) treatment could be afforded.
- (14) And I would defer to another expert on the
- (15) surgical treatment and the survivability from that.
- (16) Q. I am going to say, no.
- (17) Do you hold opinions concerning whether or
- (18) not there was a failure of the standard of care by
- (19) any of the physicians in this case, if we assume
- (20) that the patient's disease process was EMF?
- (21) A. Yes.
- (22) Q. Do you hold any opinions concerning what
- (23) the likely outcome would have been in David Gonda's
- (24) case had EMF been diagnosed earlier?
- (25) A. No.

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- (1) from 1978. Thoracic and Cardiovascular Surgery
- (2) from
- (3) 1983. And Circulation from 1985.
- (4) Q. You suggested we use the acronym "IBE." I
- (5) am going to suggest we use EMF. That will save me a
- (6) mouthful, too.
- (7) Is that okay with you?
- (8) A. That's fine with me.
- (9) Q. To mean "endomyocardial fibrosis."
- (10) A. I understand.
- (11) Q. Do you claim any particular expertise in
- (12) that disease process?
- (13) A. No way.
- (14) Q. Had you ever heard of it before this case?
- (15) A. Sure, I have heard - I have heard of it.
- (16) We learned about it in our training. I have never
- (17) seen a case.
- (18) Q. Do you feel you know enough about that
- (19) disease process to render opinions concerning its
- (20) mortality rate, for example?
- (21) A. Only on the basis of these articles. I
- (22) would defer to someone who claimed anything that
- (23) was
- (24) in - that was consistent with these articles that
- (25) are reported.
- (26) I am not claiming any special knowledge.
- (27) Q. Well, do you -

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- (1) Q. Are you familiar with a subcategory of
- (2) that disease called non-African endomyocardial
- (3) fibrosis?
- (4) A. Only on the basis of the articles.
- (5) Q. You -
- (6) A. I have heard of it. That's about my
- (7) limited knowledge of it.
- (8) Q. So we can anticipate that you were not
- (9) going to come into court and say that the only place
- (10) that that disease ever occurs is in Africa?
- (11) A. That's correct.
- (12) Q. In addition - I got a little off course
- (13) there. I'm trying to finish up my preparatory
- (14) questions here, Doctor.
- (15) A. Sure.
- (16) Q. In addition to reviewing those documents
- (17) have you discussed the case with anyone?
- (18) A. No.
- (19) Q. None of your colleagues?
- (20) A. No.
- (21) Q. You have never spoken with any of the
- (22) family members?
- (23) A. No.
- (24) Q. I assume to some extent you have had
- (25) conversations either with Mr. Ruf or Mr. Malik about

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- (1) the case?
- (2) A. That's about it.
- (3) Q. Have they reviewed –
- (4) A. Before I finish that, there – Ellen
- (5) Rieback's involvement in the communications between
- (6) us is only as a conduit.
- (7) I do not discuss anything with regard to
- (8) the case to her except billing.
- (9) Q. In your conversations with Mr. Ruf or
- (10) Mr. Malik, were any facts made known to you that are
- (11) important in your opinions that are not contained in
- (12) the records that you had available for your review
- (13) otherwise?
- (14) A. No.
- (15) Q. Did you review any medical literature
- (16) either in forming your opinions in this case or in
- (17) preparing for your deposition testimony?
- (18) A. Only these, As mentioned, I briefly
- (19) reviewed these. But no – no other literature.
- (20) Q. You have reviewed no literature, then,
- (21) pertaining to the IBE disease process?
- (22) A. Correct.
- (23) Q. I assume you did not because in your
- (24) training and experience you have familiarity with
- (25) that disease and didn't feel the need to do that?

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- (1) depends on which edition you are looking at.
- (2) But if we were to look at the, for
- (3) example, the '94 edition of Harrison's, which I
- (4) think was the most recent edition at the time of
- (5) David Gonda's disease, do you believe that the
- (6) materials contained in that volume were reliable at
- (7) that time?
- (8) A. Well, the Harrison book is about another
- (9) two-to-three-year lag time, in its timeliness. It's
- (10) reasonable – there were probably more current
- (11) reviews available but I couldn't pull them off the
- (12) top of my head.
- (13) About every year or so some authoritative
- (14) quote, unquote, journal has a review of IBE.
- (15) MR. TRAVERS: Are you telephone guys
- (16) hearing us okay? We're getting a lot of static
- (17) here.
- (18) MR. BANAS: We are getting static but I am
- (19) understanding most of it.
- (20) THE WITNESS: If you need me to speak
- (21) louder or slower, let me know.
- (22) MR. BANAS: Louder but not slower.
- (23) MR. TRAVERS: Q. You used the term, I
- (24) think, when I posed that question originally, try to
- (25) distinguish between something authoritative and

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- (1) A. That's correct.
- (2) Q. Rather, in your training or practice.
- (3) If I were to try to fully inform myself
- (4) about IBE, is there a text or journal that you would
- (5) direct me toward that would be helpful?
- (6) MR. MALIK: Objection.
- (7) THE WITNESS: Do you mean, in terms of
- (8) something authoritative or some – a good review of
- (9) it?
- (10) MR. TRAVERS: Q. Well, my question, I
- (11) think, is there a good review of it?
- (12) A. Okay. Then I would suggest any of the
- (13) internal medicine or cardiology texts which are
- (14) available, such as Cecil Logue, Harrison, Hurst,
- (15) H-U-R-S-T, and Logue, L-O-G-U-E, is a hard text, or
- (16) Braunwald, B-R-A-U-N-W-A-L-D.
- (17) It's also available in the Scientific
- (18) American Textbook of Medicine. It's readily
- (19) available.
- (20) Q. Do you find any of those texts to be
- (21) reasonably authoritative on the condition of
- (22) infectious –
- (23) A. They are reasonably up to date.
- (24) (Static on the telephone.)
- (25) Q. I guess both – well, to some extent it

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- (1) something just being good general guideline, I am
- (2) not sure that I understand the distinction in your
- (3) mind.
- (4) A. I am not sure I understand it, either.
- (5) Many times I'm asked if it's – if there is an
- (6) authoritative article or a journal, and most of them
- (7) are reliable.
- (8) Medicine changes continually and there is
- (9) a responsibility of a physician for continuing
- (10) medical education, such as lawyers.
- (11) And we hear things in conferences, if we
- (12) attend them, that may not be in the textbook. Or
- (13) they may be in the newspapers and they may not be
- (14) in the textbooks. So I can't say.
- (15) "Reliable" is a better term than
- (16) "authority." That is basically why I asked.
- (17) Q. So the term that you have identified, in
- (18) your judgment, is "reliable," for a practicing
- (19) physician?
- (20) A. Practicing.
- (21) Q. And you have not reviewed any of these
- (22) before your testimony today?
- (23) A. No. I review them when I'm unfamiliar
- (24) with a disease or process, just like any physician
- (25) would, or I pull something up on my – on a – an

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- (1) **Internet Web Medical Review Site.**
 (2) Q. Of the various texts that you identified,
 (3) do you find some of them to be more reliable than
 (4) others, or not?
 (5) **A. Not really. They are all good books.**
 (6) Q. When you say, "reliable," what I perceive
 (7) you mean is, even though they may not be entirely up
 (8) to date or up to the moment that, as a general
 (9) principle, the information contained in them is
 (10) accurate?
 (11) **A. Yes.**
 (12) Q. You have never worked with Mr. Malik or
 (13) Mr. Ruf previously, or have you?
 (14) **A. No, I haven't.**
 (15) Q. You don't know the Gonda family at all?
 (16) **A. Not at all.**
 (17) Q. You don't know any of the defendants in
 (18) this case?
 (19) **A. No.**
 (20) Q. When you were reviewing these voluminous
 (21) file materials in front of you, did you make any
 (22) notes, Doctor, along the way to help you chronicle
 (23) the events in that case?
 (24) **A. No.**
 (25) Q. You never have made any written notes at

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- (1) MR. BANAS: Okay. I don't have copies of
 (2) 1-17-97 or April 21, '97.
 (3) THE WITNESS: Should we attach them to the
 (4) deposition for you?
 (5) MR. BANAS: That would be fine. Go ahead,
 (6) Tom.
 (7) MR. TRAVERS: Okay. I am looking at these
 (8) reports myself for the first time. Gary, give me
 (9) one second, if I may.
 (10) (Off the record.)
 (11) MR. BANAS: Tom?
 (12) MR. TRAVERS: Yes.
 (13) MR. BANAS: Mr. Banas again.
 (14) If there is anything different or
 (15) additional that is not in the two that I have, maybe
 (16) they could be faxed to us so that I can see them at
 (17) the time that I question Dr. Lehrman.
 (18) THE WITNESS: Sure.
 (19) MR. BANAS: The fax number where I am is
 (20) 330 -
 (21) THE WITNESS: Just a second. Okay.
 (22) MR. BANAS: 330-758-1835.
 (23) THE WITNESS: Okay. 330-758-1835.
 (24) MR. BANAS: Correct. Oh, 1833. **I'm**
 (25) sorry.

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- (1) all?
 (2) **A. That's not my usual practice. I don't -**
 (3) **I don't usually make notes.**
 (4) Q. And in this case you have made none?
 (5) **A. That's correct.**
 (6) Q. You have, to my knowledge, been involved
 (7) with two - I will call them reports, although I
 (8) think one technically is just a question and answer
 (9) session, with Mr. Malik?
 (10) **A. There were - there are two letters dated**
 (11) **January 17, '97 and April '97, which can be**
 (12) **considered reports.**
 (13) **And then a third report on March 25, 1998,**
 (14) **which is more specific.**
 (15) MR. BANAS: Will you repeat that, Doctor?
 (16) THE WITNESS: Sure. There are three
 (17) letters dated January 17, 1997, April 21, 1997, and
 (18) then one in March of 1998, which were to Mr. Malik.
 (19) MR. BANAS: So you have a report of
 (20) January 17th, '97, April 17th -
 (21) MR. TRAVERS: April 21.
 (22) MR. BANAS: 21. Sorry. I have a March
 (23) 25th, '98, and a November 23rd. Are all those
 (24) correct?
 (25) THE WITNESS: Okay.

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- (1) THE WITNESS: That's okay. I don't know
 (2) my fax number, either.
 (3) MR. BANAS: I can't read **my** writing.
 (4) Thank you.
 (5) MR. TRAVERS: Gary, what ones do you have?
 (6) MR. BANAS: I only have the two, March
 (7) 25, '98, and the one that I got a little while ago,
 (8) November 23, '98.
 (9) I don't have 1-17-97 or April 21, '97.
 (10) THE WITNESS: Okay. We'll get them faxed
 (11) over to you.
 (12) MR. BANAS: Thank you.
 (13) MR. TRAVERS: We're going to take care of
 (14) that right now off the record, and then we're going
 (15) to reconvene.
 (16) (Off the record.)
 (17) MR. TRAVERS: Q. We have now identified,
 (18) if I'm correct, four separate reports, Doctor, that
 (19) we've seen this morning.
 (20) Are those the only reports you have
 (21) drafted in the case?
 (22) **A. That's correct. And I don't see a copy of**
 (23) **that report from November in my record. I don't**
 (24) **know why.**
 (25) Q. I have a copy of it if you'd like to see

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- (1) it.
- (2) A. Thank you. I would love to.
- (3) (Witness examines document.)
- (4) A. I remember this. That was shortly after
- (5) this one here.
- (6) Q. I am frankly impressed, Doctor, that you
- (7) can come to this deposition and have your opinions
- (8) without having made any notes of the sequence of
- (9) events here.
- (10) I'd like to get some sense in my own mind
- (11) of your degree of familiarity with the medical facts
- (12) in the case.
- (13) Can you tell me your understanding of the
- (14) progression of events with this patient and the
- (15) medical care provided to him which you are now
- (16) rendering criticisms of?
- (17) A. Sure. I will refer to the records.
- (18) Mr. Gonda presented to the University
- (19) Health Service in May of 1994, with upper
- (20) respiratory complaints and a rash on his face.
- (21) He was treated at that time for a
- (22) folliculitis on the left side of his face, and
- (23) received dyloxycillin for a facial cellulitis.
- (24) His left cheek was found to be swollen and
- (25) tender and his left upper lip was swollen as well.

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- (1) On the 28th he denied any fever or chills
- (2) and the induration in his face " I'm sorry, this is
- (3) a '94 record.
- (4) Q. While you get back to the '95 records, let
- (5) me ask - I was - at least I had intended to when
- (6) you commented.
- (7) Do you believe that any of the
- (8) symptomology presented by Mr. Gonda when he had
- (9) treatment in May of '94 at the University Health
- (10) Center was in any way related to the process that
- (11) ultimately led to his death?
- (12) A. No.
- (13) On 5-19-95 he presented with complaints of
- (14) an upper respiratory infection and some pain in his
- (15) chest.
- (16) He admitted to smoking and he was found to
- (17) be I afebrile. And this was a six-day history.
- (18) On the 22nd, he presented again and he was
- (19) being treated with arrythromycin at that time.
- (20) They did a chest x-ray which showed a
- (21) slightly elevated right diaphragm with an increased
- (22) density in the chest.
- (23) On physical examination his lungs were
- (24) clear and they felt, because of an elevated white
- (25) count with a shift, that he had early pneumonia and

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- (1) he was continued with treatment at that time.
- (2) On the 26th he saw Dr. Adornato, and he
- (3) was complaining of a viral pharyngitis with a fever
- (4) and he received another antibiotic with some
- (5) improvement but continued fever.
- (6) On the 27th he saw Dr. Ruiz, and despite
- (7) antibiotics he continued to have a fever.
- (8) He had been treated at that time and was
- (9) found with a fever of 99.2 and an increased heart
- (10) rate.
- (11) The physical examination showed clear
- (12) lungs and an electrocardiogram was obtained. This
- (13) was felt to be a juvenile variant, T pattern of - a
- (14) T pattern on the anterior leads versus ischemia.
- (15) And his white count was found to be
- (16) elevated.
- (17) A chest x-ray showed clear lung fields and
- (18) a normal heart size.
- (19) I believe at that time, although I am not
- (20) clear on the timing, that a limited echocardiogram
- (21) was obtained which showed no pericardial effusion
- by**
- (22) a verbal report. I don't have any record of a
- (23) written report on that in my records.
- (24) On the - on the 5th of July he presented
- (25) again for " continued not feeling well, continued

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- (1) fever and continued increased heart rate.
- (2) He was felt to have laryngitis and
- (3) referred to Dr. Adornato who, on 7-10, saw him with
- (4) a fever again, and had negative laryngoscopy.
- (5) He then presented on the 13th to Dr. Cropp
- (6) with complaints of a six-to-seven-week cough,
- which
- (7) is consistent " which is consistent with the visits
- (8) to the University Health Service.
- (9) Q. I'm sorry to interrupt you, Doctor. I
- (10) generally try not to do that. But it appears to
- (11) me - and you are welcome to correct me if I'm
- (12) wrong - that your factual understanding of the
- (13) case, as you have testified to here, is based on
- (14) some set of documents.
- (15) I mean, you are not going through all the
- (16) records, you have something there that basically you
- (17) are reading from that forms the basis of your
- (18) understanding of the medical facts?
- (19) A. No. That's not true. I am referring to a
- (20) time line which was forwarded to me which, after my
- (21) review of the records, I concede is consistent with
- (22) the records that I have available.
- (23) And it's much easier to just follow
- (24) through them than go through the records
- themselves.
- (25) Q. You believe that the information contained

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- (1) in that time line accurately reflects the care
- (2) provided to this patient by his various medical
- (3) providers?
- (4) A. It's consistent with my review of the
- (5) records, yes.
- (6) Q. Okay. Can we get a copy of that, please,
- (7) as well?
- (8) A. Sure. I'll be glad to. When I'm through.
- (9) Okay. Do you want it before -
- (10) Q. Well, when you're through with your answer
- (11) or through the deposition.
- (12) A. Yeah.
- (13) Q. I'd like to see it before the deposition
- (14) is over, but -
- (15) A. Why don't we take a break then?
- (16) Q. Okay.
- (17) MR. BANAS: Tom?
- (18) MR. TRAVERS: Yes.
- (19) MR. BANAS: Fax that to us, too.
- (20) THE WITNESS: Okay.
- (21) (Off the record.)
- (22) MR. TRAVERS: If I may, I will withdraw my
- (23) last question about your understanding of the facts
- (24) of the case and move on, since you don't have that
- (25) available to review.

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- (1) Q. Is that okay with you?
- (2) A. Sure.
- (3) Q. Doctor, do you hold opinions concerning
- (4) whether or not David Paul Gonda had infectious
- (5) endocarditis?
- (6) A. Yes, I do. It's more likely than not that
- (7) he did have IBE.
- (8) Q. What is the basis of your reaching that
- (9) opinion?
- (10) A. Mr. Gonda, when he presented in June of
- (11) '95 to Dr. Ruiz, had significant changes in his
- (12) electrocardiogram from his prior electrocardiogram.
- (13) He also had a persistent febrile illness.
- (14) As we review the case further on in its course a
- (15) transesophageal echocardiogram was obtained
- (16) which was consistent with a mass in the right ventricle,
- (17) which is also consistent with IBE.
- (18) And the findings of emboli in the lungs
- (19) are also consistent with IBE.
- (20) The most likely diagnosis in this case is
- (21) IBE, based on these findings in the clinical course
- (22) as well as the autopsy findings.
- (23) Q. Well, the last two things you mentioned,
- (24) the right ventricular mass identified on the TEE and
- (25) some pulmonary embolization, you say are consistent

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- (1) with IBE; correct?
- (2) A. That's correct.
- (3) Q. They are not diagnostic of IBE, certainly?
- (4) A. No. The only diagnostic test would be the
- (5) presence of a mass and blood cultures which
- (6) unfortunately were never obtained while off
- (7) antibiotics, and never obtained until August 16th.
- (8) Q. Well, here's what I'm trying to determine,
- (9) Doctor, is the - I am not trying to identify
- (10) everything in his case consistent with IBE, but
- (11) those things about his case that you believe show
- (12) that he did have IBE.
- (13) Certainly, that TEE, nobody would look at
- (14) that and say this man has endocarditis?
- (15) A. Endocarditis would be one of the
- (16) significant differentials in that TEE.
- (17) Others would be a myxoma. In this case,
- (18) would be endomyocardial fibrosis, as another,
- (19) because it's such a rare disease.
- (20) But the more common diseases, the most
- (21) common and most likely would be either a clot, for
- (22) some reason, which I can't find the reason for in
- (23) this case, but the most common reason for a mass
- (24) would be bacterial endocarditis.
- (25) So more than being consistent, the febrile

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- (1) illness, the fact that he persisted in having this,
- (2) that he had a mass, that he had a change in his
- (3) electrocardiogram, all lead that the most likely
- (4) diagnosis still is bacterial endocarditis.
- (5) So, yeah, they're consistent. But the
- (6) entire picture is consistent.
- (7) Q. Do you agree that the entire picture is
- (8) consistent with EMF as well?
- (9) A. The febrile course I don't think is as
- (10) consistent with it. But, yes, everything is
- (11) consistent with EMF.
- (12) Q. So the reason - if everything is
- (13) consistent with both of those diseases, the reason
- (14) you think it is IBE is because that's a more common
- (15) disease process that you encounter?
- (16) A. Yes. It's the most likely diagnosis, and
- (17) it hasn't been ruled out in this case.
- (18) Q. Do you discount the conclusions of the
- (19) autopsy report at the Cleveland Clinic?
- (20) A. No. The autopsy report is consistent with
- (21) EMF or IBE.
- (22) Q. Well, their conclusion and finding that he
- (23) had EMF is not consistent with IBE?
- (24) A. I understand. But, again, the findings
- (25) are still consistent with IBE. So, yes, I would

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- (1) disagree with their final finding. I don't believe
 (2) in this case it has been ruled out, even by the
 (3) autopsy.
 (4) Q. Do you have any information concerning the
 (5) autopsy findings other than the Cleveland Clinic
 (6) report and Dr. Hoffman's conclusions?
 (7) A. **No.** And I think Dr. Hoffman's conclusions
 (8) are consistent with IBE.
 (9) Q. But all I'm trying to determine is, you
 (10) have never seen slides from the autopsy; you have
 (11) never seen photos of the heart; all you have is the
 (12) report of those findings; correct?
 (13) A. The report and the descriptions in the -
 (14) in the depositions, which confirm the reports,
 (15) basically.
 (16) I will let them fight it out about their
 (17) conclusions. I am not claiming to be an expert on
 (18) autopsy. I am just saying that either of those
 (19) findings is consistent.
 (20) Q. You don't claim to know whether David
 (21) Gonda had endomyocardial fibrosis or not?
 (22) A. **No.**
 (23) (Documents returned to deposition room.)
 (24) A. That was quick.
 (25) Q. As I'm sure you are aware, Doctor, it is

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- (1) haven't excluded a cause, particularly.
 (2) Q. Well, do you know the causes?
 (3) A. Well, **no**, I don't. We don't have an
 (4) adequate blood culture off antibiotics where we
 (5) could find the causes.
 (6) Q. Are you familiar with the findings
 (7) concerning what pathogens were identified?
 (8) A. Yes, I have seen that.
 (9) Q. Do you think that any of those that were
 (10) identified were the causative organism in this case?
 (11) A. I can't tell you.
 (12) Q. Do you know when David Gonda developed
 (13) endocarditis?
 (14) A. Before June of 1995, and that's all I can
 (15) say.
 (16) Q. Do you know whether it was during calendar
 (17) year 1995?
 (18) A. I can't tell you. It's more likely that
 (19) it developed early. It's more likely that it
 (20) developed during the time period when he was
 having
 (21) his initial symptomology which presented at the
 (22) University Health Service.
 (23) But I can't tell you exactly when and I
 (24) can't tell you the causative reason for it, either.
 (25) Q. Would you agree that this would be an

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- (1) not agreed by Dr. Ruiz or Dr. Cropp or de Marco or
 (2) their lawyers that this patient had IBE.
 (3) But for my questions at this point I am
 (4) going to assume that your opinion is correct and
 (5) that that is the disease process we are dealing
 (6) with. Okay?
 (7) A. Fine.
 (8) Q. Do you have an opinion as to whether his
 (9) condition was acute or subacute?
 (10) A. That term, even in 1995, was going by the
 (11) wayside, and we find that there is a spectrum of
 (12) bacterial endocarditis, rather than a separation
 (13) into subacute **or** acute.
 (14) His disease would fit a course of
 (15) progressive endocarditis which became fulminant at
 (16) the end.
 (17) Q. Because -
 (18) A. Is that clear?
 (19) Q. I -
 (20) A. We don't really split it into subacute or
 (21) acute anymore, **or** then.
 (22) Q. I'm assuming, because you use the term
 (23) "IBE," that you have excluded fungal infection. You
 (24) think this is bacterial?
 (25) A. It's more likely that it's bacterial. I

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- (1) extremely unusual presentation of that disease?
 (2) A. **No.** I would say it's unusual but not
 (3) extremely unusual. I have seen people present with
 (4) upper respiratory symptomology as the presentation
 (5) for IBE.
 (6) Q. Do you agree that David had no risk
 (7) factors for developing endocarditis?
 (8) A. I am not sure. Again, autopsy showed a
 (9) scar on the right heart. I am not sure whether that
 (10) was a nidus, N-I-D-U-S, for the planting or seeding
 (11) of bacteria.
 (12) But in terms of valvular abnormalities,
 (13) no, he had no predisposing factors. And I also
 (14) don't think he was an intravenous drug abuser.
 (15) Q. This would be a native valve endocarditis
 (16) then?
 (17) A. A native mural endocarditis, in this case.
 (18) Q. Would you agree that that aspect of IBE is
 (19) less common than valve involvement?
 (20) A. Yes.
 (21) Q. Can you estimate what percentage of
 (22) patients who have IBE have no valvular involvement?
 (23) A. I can't.
 (24) Q. Minute?
 (25) A. It's small. It's unusual.

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- (1) Q. Extremely unusual?
- (2) A. Yes. But in the -
- (3) MR. MALIK: Objection.
- (4) THE WITNESS: It is unusual, but in the
- (5) face of a changing electrocardiogram and a fever of
- (6) unknown origin in this case it might not be so
- (7) unusual.
- (8) MR. TRAVERS: Q. I'm sorry. I don't
- (9) understand that answer. For a patient -
- (10) A. If you take out of the brew how common it
- (11) is that a mural endocarditis with no valvular
- (12) involvement occurs, yes, it's unusual.
- (13) But in this clinical setting it's not that
- (14) unusual, with a fever and a change in the
- (15) electrocardiogram.
- (16) It has to be included as a possible, even
- (17) probable cause of this patient's symptoms. In each
- (18) case it's a hundred percent basically or zero.
- (19) Q. Can you - do you have any idea of the
- (20) percentages of patients with IBE who have native
- (21) valves?
- (22) A. I don't understand what you mean.
- (23) Q. Well, would you agree that a large
- (24) percentage of patients who develop endocarditis have
- (25) prosthetic valves?

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- (1) Q. You indicate that the biggest cause of
- (2) endocarditis today is mitral valve prolapse?
- (3) A. That's correct.
- (4) Q. David Gonda had no mitral valve prolapse?
- (5) A. No. Apparently, by autopsy, his mitral
- (6) valve was not involved.
- (7) Q. These questions, just by way of assisting
- (8) you in trying to understand where I am here, is
- (9) still a subcategory of risk factors or his lack of
- (10) risk factors.
- (11) Do you hold an opinion concerning whether
- (12) his age would place him substantially less at risk
- (13) for these - for this disease than someone
- (14) substantially older?
- (15) A. Again, mitral valve prolapse is a disease
- (16) of young women. So in young males it's rare unless
- (17) they were IV drug abusers.
- (18) Q. Okay. I am not asking about mitral valve
- (19) prolapse. I am asking about IBE.
- (20) A. No, but you're asking about risk factors
- (21) in terms of age. So - young women are at risk for
- (22) it but young men are at less risk. So it's uncommon
- (23) in this age group.
- (24) Q. For a male?
- (25) A. For a male without significant valvular

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- (1) A. A significant proportion. The most common
- (2) cause today of endocarditis is mitral valve prolapse
- (3) in a native valve which is abnormal.
- (4) So that's the most common cause. And I
- (5) don't know the exact percentages.
- (6) But, yeah, a significant proportion have
- (7) prosthetic valves as well, and a significant
- (8) proportion are IV drug abusers.
- (9) However, in this case, with a fever and
- (10) changing electrocardiogram, it has to be included in
- (11) a differential diagnosis.
- (12) Q. In all fairness, Doctor, I asked you early
- (13) on whether you were going to be an expert or an
- (14) advocate. And these last couple of answers, in my
- (15) view, are definitely advocate. You keep wanting to
- (16) bring up information and give little speeches
- (17) concerning which I have not asked you.
- (18) And I am going to ask, if you would, to
- (19) just please answer my question. Okay?
- (20) A. They can be considered, in your opinion,
- (21) advocacy, but I am reviewing the data in this case
- (22) as well as the literature as a whole.
- (23) And in order to answer your question fully
- (24) I feel I have to answer that way. That is not
- (25) advocacy; that is honesty.

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- (1) problems.
- (2) Q. Would you have any idea what percentage of
- (3) patients with endocarditis would be - what male
- (4) patients would be under 30 years of age?
- (5) A. No.
- (6) Q. Minute?
- (7) A. It's small again.
- (8) Q. Well, "small" is a term that is not -
- (9) less descriptive.
- (10) A. Less than ten percent maybe of cases.
- (11) Unless they're IV drug abusers.
- (12) Q. I am including IV drug abusers.
- (13) Less than two percent?
- (14) A. I don't know.
- (15) Q. Do you know if it would be less than a
- (16) half a percent?
- (17) A. I don't know.
- (18) Q. The patient had no congenital heart
- (19) disease that we're aware of; correct?
- (20) A. That's correct.
- (21) Q. That could be a risk factor for
- (22) endocarditis?
- (23) A. Yes.
- (24) Q. The patient had no history of damage to
- (25) any of his valves; correct?

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- (1) A. That's correct.
- (2) Q. He had no malignant or premalignant lesion
- (3) that we are aware of?
- (4) A. That we're - no.
- (5) Q. That's also a potential risk factor?
- (6) A. Yes.
- (7) Q. He had no trauma that we're aware of;
- (8) correct?
- (9) A. Correct.
- (10) Q. He's had no GI tract surgery that we're
- (11) aware of?
- (12) A. No.
- (13) Q. He's not an IV drug abuser?
- (14) A. To the best of our knowledge, that's
- (15) correct.
- (16) Q. Would you agree that all of these areas
- (17) that I have questioned you about were risk factors
- (18) for the development of IBE?
- (19) A. Yes.
- (20) Q. Isn't it true that in retrospect, when you
- (21) have a patient with endocarditis, looking back, you
- (22) can always identify some type of risk factor that
- (23) led to the development of that disease?
- (24) A. No.
- (25) Q. I am not a physician, Doctor, but from a

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- (1) process?
- (2) A. No. You asked me what was consistent with
- (3) it, what would lean toward it, and fever and
- (4) tachycardia are consistent with it.
- (5) Those were the only signs he presented
- (6) with: fevers of unknown origin and tachycardia.
- (7) Q. Would you agree that there is a huge
- (8) variety of physical presentations that normally
- (9) endocarditis patients have?
- (10) A. Yes. It can be a wide variety of
- (11) presentations.
- (12) Q. Murmur is certainly high on the list?
- (13) A. When the valve is involved, yes.
- (14) Q. Do you have any idea of the percentage of
- (15) cases in which there is nonvalve disease?
- (16) A. It's small. I think I answered that
- (17) already.
- (18) Q. Did the patient - is splenomegaly a
- (19) presenting symptom for IBE patients, generally?
- (20) A. A sign. And generally, it's found - I
- (21) wouldn't say, generally.
- (22) Q. Frequently?
- (23) A. Sometimes.
- (24) Q. That was not present in David; correct?
- (25) A. No.

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- (1) lay person's perspective it seems to me that there
- (2) has to be a reason why a patient would get a disease
- (3) of this nature.
- (4) And we have identified a huge number of
- (5) different reasons why that sometimes happens.
- (6) But in this case we have no idea why David
- (7) Gonda got endocarditis; is that fair?
- (8) A. That's correct. That's why medicine is an
- (9) art, not a science.
- (10) Q. That's not troubling to you at all that
- (11) you have no explanation as to how he could have
- (12) gotten this?
- (13) A. **No**, not at all. Many times we don't find
- (14) the initial insult.
- (15) Q. Other than fever, can you identify any
- (16) physical manifestations of the disease that David
- (17) presented with?
- (18) A. Tachycardia.
- (19) And that's in the initial phase of his -
- (20) of his illness. Toward the end, the emboli are
- (21) consistent, also, and the hemoptysis are consistent
- (22) with the endocarditis.
- (23) Q. Are you suggesting that tachycardia is
- (24) specifically indicative of endocarditis or is simply
- (25) indicative of some disease process or infectious

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- (1) Q. Petechiae?
- (2) A. As I said, the only things that were
- (3) present - you can go through the whole list but the
- (4) only things that were found at this time were the
- (5) tachycardia and fever.
- (6) Q. I suppose your suggestion is a good one,
- (7) at 500 dollars an hour, to not go through all of
- (8) these. But there is -
- (9) MR. MALIK: Objection; motion to strike.
- (10) MR. TRAVERS: Q. - a variety of signs
- (11) that IBE patients normally have that David Paul
- (12) Gonda did not have; correct?
- (13) A. And those are usually associated with
- (14) left-sided IBE, yes.
- (15) Q. Is shortness of breath a sign of
- (16) endocarditis?
- (17) A. It's a symptom that can be associated with
- (18) it. A sign is a physical thing that you can touch.
- (19) Okay?
- (20) A symptom is a complaint that's
- (21) subjective. Yes, it can be associated with it. Can
- (22) be associated with fever; it can be associated with
- (23) tachycardia as well.
- (24) Q. And in this huge - not huge, but half a
- (25) dozen textbooks that you thought had reliable

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- (1) information, would you expect that at least one of
- (2) them perhaps would indicate that shortness of breath
- (3) is a common symptom for endocarditis?
- (4) A. I didn't say it was common; I said it
- (5) could be associated with it. Especially a
- (6) right-sided endocarditis.
- (7) And I don't know if it would be mentioned,
- (8) to tell you the truth. But it's - it's logical
- (9) that if the right heart is being involved, and
- (10) emboli are going to the lungs and - that shortness
- (11) of breath could be associated with it.
- (12) I stated before that the two things that I
- (13) saw related in this case were the fever and the
- (14) tachycardia.
- (15) And I'll accede to the fact that there
- (16) weren't any other signs, but we still have the
- (17) abnormality in the electrocardiogram to explain and
- (18) the significant change.
- (19) Q. Okay. And we're going to get to those,
- (20) Doctor. But I just wanted to make sure that we are
- (21) in agreement that shortness of breath is not a
- (22) symptom that a clinician - that that symptom in and
- (23) of itself wouldn't suggest including IBE in his
- (24) differential diagnosis?
- (25) A. It doesn't suggest excluding it, either.

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- (1) A. Embolic episodes. Those are all
- (2) associated with left-sided IBE.
- (3) Q. Murmur?
- (4) A. Valvular IBE, yes,
- (5) Q. Neurologic manifestations?
- (6) A. Again, associated with left-sided IBE.
- (7) Q. But these are acknowledged signs and
- (8) symptoms of a patient who has that disease; correct?
- (9) A. When it's on the left side, yes.
- (10) Q. And we know that because, after decades of
- (11) study, authors have written texts such as those you
- (12) have identified saying these are the things that
- (13) when you see them you think of IBE; correct?
- (14) MR. MALIK: Objection.
- (15) MR. TRAVERS: Q. Are suggestive of that
- (16) disease process?
- (17) A. When it's left-sided, yes. Which is the
- (18) more common side.
- (19) Q. Are you aware of any article, any text,
- (20) any journal that indicates that shortness of breath
- (21) or cough are suggestive of the existence of
- (22) endocarditis?
- (23) A. I can't say off the top of my head. I can
- (24) only say, again, that if it's right-sided and there
- (25) is lung involvement, it's logical to presume that

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- (1) Q. It does not suggest including it, though;
- (2) correct?
- (3) A. It does not suggest excluding it. Any
- (4) febrile illness should include infectious bacterial
- (5) endocarditis as an initial differential.
- (6) Q. Is a cough something that would be
- (7) considered a normal sign or symptom of IBE?
- (8) A. Only as I've described in the previous
- (9) questions. If it's right-sided and there is some
- (10) lung involvement, yes, a cough could be associated
- (11) with it. It's not the most common thing.
- (12) But again, if you're considering a
- (13) right-sided endocarditis, yeah, you'd expect either
- (14) a cough or shortness of breath or some lung signs
- (15) to be associated with it.
- (16) Q. I am going to have to back up, Doctor.
- (17) When we talked about signs or symptoms suggestive of
- (18) SPE, there is splenomegaly, petechiae, splinter
- (19) hemorrhages; correct?
- (20) A. Correct.
- (21) Q. Roth's spots?
- (22) A. Roth's spots.
- (23) Q. Osler's nodes?
- (24) A. Osler's nodes.
- (25) Q. Embolic episodes?

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- (1) there would be some pulmonary symptoms as well.
- (2) And in the cases that I have seen of
- (3) right-sided endocarditis, there have been pulmonary
- (4) signs.
- (5) So I'm basing it on my clinical experience
- (6) and the logic of the disease process.
- (7) Q. Doctor, I am going to ask one more time to
- (8) stop giving speeches and answer my question.
- (9) A. I answered your question to the best of my
- (10) ability.
- (11) Q. My question was, are you aware of any
- (12) literature supporting those, and you said you are
- (13) not, and then feel compelled, on my 500 dollars an
- (14) hour, to give another five-minute speech
- (15) unresponsive to my question.
- (16) I am suggesting that you cease doing that.
- (17) MR. RUF: I am going to object; that's -
- (18) the doctor can answer the questions any way that he
- (19) sees fit.
- (20) If you don't like the answer, then that's
- (21) too bad. But he can answer the questions the way he
- (22) thinks is appropriate.
- (23) MR. TRAVERS: It's not an answer, Mark.
- (24) It's not the question I asked. And I'm not gonna
- (25) sit here and pay him to give speeches. I am not

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- (1) gonna do it.
- (2) Q. I am going to ask, Doctor, to please stop
- (3) doing that. Would you?
- (4) A. I answer the questions as to the best of
- (5) my ability.
- (6) Q. Are you aware of any text or journal
- (7) suggestive that shortness of breath or cough are
- (8) common signs or symptoms of IBE?
- (9) A. There are no articles that say they are
- (10) common. I am not aware whether they say that they
- (11) are associated with right heart, SPE or IBE or not.
- (12) Q. Thank you.
- (13) MR. MALIK: Objection back there.
- (14) MR. TRAVERS: Q. How about laboratory
- (15) values, Doctor, do you expect any changes in lab
- (16) values in a patient with IBE?
- (17) A. Yes.
- (18) Q. And what are those, generally?
- (19) A. The most common thing is an abnormal
- (20) sedimentation rate, which was not done in this case.
- (21) You would also expect a leukocytosis,
- (22) which was present in this case. You may also see,
- (23) in left-sided IBE, liver function abnormalities,
- (24) hematuria and anemia.
- (25) Q. Are you aware, Doctor, as to whether or

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- (1) not you can have endocarditis without developing
- (2) cardiac vegetations?
- (3) A. By definition, there has to be something
- (4) in the heart to have it be an endocarditis, so I
- (5) don't think that's possible.
- (6) Q. Would you agree with the statement that
- (7) infective endocarditis is an infection which
- (8) produces vegetations on the endocardium?
- (9) A. It produces a mass on the endocardium.
- (10) Either on the valve or on the wall.
- (11) I don't know what you mean by a
- (12) vegetation. Could you define what you mean?
- (13) Q. Doctor, you are the one Board certified in
- (14) cardiology and internal medicine, and you don't know
- (15) what the term "vegetation" means; is that what
- (16) you're telling me?
- (17) A. I know what the term "vegetation" means,
- (18) but that doesn't – that doesn't describe –
- (19) Q. What does the term "vegetation" mean?
- (20) A. A vegetation is a fibrinous mass which may
- (21) or may not include the bacteria to a degree that
- (22) they are visible somewhere on the coating of the
- (23) heart, the interior wall of the heart, or valves.
- (24) Q. Any kind of mass, a myxoma, is that a
- (25) vegetation?

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- (1) A. No. That's a specific tumor. I think I
- (2) described vegetation, and that's why I say that is a
- (3) mass, because a veg- –
- (4) Q. Not all masses are vegetation?
- (5) A. No. A fibrosis mass, which may or may not
- (6) include bacteria to the degree to be visualized on
- (7) the interior wall or valves of the heart.
- (8) Q. Are you aware as to whether or not
- (9) vegetations were ever identified in Mr. Gonda?
- (10) A. There was a fibrinous mass identified that
- (11) could be consistent with a vegetation.
- (12) Q. What's the most common organism that
- (13) causes infectious bacterial endocarditis?
- (14) A. There are two fairly common ones. They
- (15) switch in communities. So it would be Staph. and
- (16) strep, are the two most common nowadays, strep
- (17) viridans.
- (18) The bulk of them are Staph., strep; strep
- (19) viridans enterococcus at this time.
- (20) A small portion of gram negatives, a small
- (21) portion are fungal. But those are the most common.
- (22) Q. Do you agree that strep viridans is the
- (23) most common of all of them?
- (24) A. Depends on the community.
- (25) Q. You mean, geographic community?

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- (1) A. Geographic community. Out here strep
- (2) viridans is not the most common. And I couldn't
- (3) tell you worldwide.
- (4) Q. What's the most common in California?
- (5) A. The most common in California is Staph.
- (6) aureus now. A bad one.
- (7) Followed closely by strep pneumonia, and
- (8) strep viridans, almost the same.
- (9) Q. That's because of the California
- (10) population having more depressed immune symptoms
- (11) than we do in Ohio?
- (12) A. I think so.
- (13) Q. Do you agree that IBE that is caused by
- (14) strep viridans on damaged valves occurs and, if
- (15) untreated, takes more than six weeks or even a year
- (16) to be fatal?
- (17) A. In most cases, yes. Unless they're immune
- (18) suppressed, or in some other way –
- (19) Q. We are not aware that David Gonda was
- (20) immune suppressed in any fashion; is that correct?
- (21) A. That's correct.
- (22) Q. So if strep viridans is the most common
- (23) form of endocarditis in the Midwest – and I think
- (24) that you acknowledge that to be true?
- (25) A. I believe that's so. I am not sure, I

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- (1) haven't been back there practicing medicine or
- (2) learning medicine in 27 years.
- (3) Q. But you would expect an extended period
- (4) before the disease would result in mortality?
- (5) A. Yes.
- (6) Q. Longer, certainly, than what David Gonda
- (7) presented with?
- (8) A. Most likely, yes.
- (9) Q. I am going to make a statement that I will
- (10) tell you frankly is from Harrison's, and I'd just
- (11) like to know whether you agree with it or not.
- (12) Endocarditis should be suspected either
- (13) when a heart murmur and unexplained fever are
- (14) present for at least one week or in febrile IV drug
- (15) abusers even in the absence of a murmur.
- (16) A. That's a reasonable statement.
- (17) Q. In David's case all we have is unexplained
- (18) fever without a murmur and without a history of drug
- (19) abuse that we know of; correct?
- (20) A. As symptoms, yes. Or signs.
- (21) Q. If he had endocarditis and it was
- (22) diagnosed, do you believe that that necessarily
- (23) would have avoided his death?
- (24) A. It's more likely than not that he would
- (25) have survived, if it was — if it was diagnosed and

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- (1) Staph.
- (2) It's more — I go back to the same
- (3) statement, it's more likely than not that if it was
- (4) diagnosed in an appropriate and timely manner, that
- (5) his treatment would have prevented his death.
- (6) Q. Without knowing what the bug was?
- (7) A. Regardless of the bacteria.
- (8) Q. If it's Staph. aureus aren't 40 percent of
- (9) those cases resulting in mortality?
- (10) A. If it was Staph. aureus, then in June he
- (11) would have had a fulminant course, according to
- you,**
- (12) that would have killed him before August.
- (13) So it's not likely that it was Staph.
- (14) aureus.
- (15) Q. Well, if it was Staph. aureus isn't there
- (16) a 40-percent mortality rate associated with that?
- (17) A. Yes. So there is a 60-percent survival
- (18) rate.
- (19) MR. MALIK: Objection.
- (20) MR. TRAVERS: Q. It's those kinds of
- (21) figures that prompted you to say it's more likely
- (22) than not?
- (23) A. Exactly. And medical certainty is greater
- (24) than 50-percent likelihood.
- (25) Q. If there had been cultures done of

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- (1) treated in an appropriate and timely manner.
- (2) Q. Can you translate that into percentages?
- (3) MR. MALIK: Objection.
- (4) THE WITNESS: No. Because I don't have
- (5) the data at the time it should have been diagnosed.
- (6) But — the vast majority of cases can be
- (7) treated, 80 to 85 percent. But, again, I can't say
- (8) in his case because the data was never obtained.
- (9) MR. TRAVERS: Q. Would you agree that in
- (10) order to reach an informed opinion on the
- (11) prospective mortality of his disease, it would be
- (12) necessary to have an understanding of what the
- (13) pathogens were that caused it?
- (14) A. Yes.
- (15) Q. I mean, fungal infections have a very
- (16) grave prognosis; correct?
- (17) A. Yes. But that's not likely in this case.
- (18) Q. Well, the Staph. disease, that I think you
- (19) told me is the most prevalent here in California,
- (20) that has a very fulminant course with death from
- (21) bacteremia within days of onset; isn't that true?
- (22) A. Not necessarily. There is — again, there
- (23) is a whole spectrum of Staph. out here as well., and
- (24) there are more built-in, solid statistics. Are much
- (25) less than 50 percent in the cases out here. Even in

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- (1) Mr. Gonda, do you think that they would have been
- (2) positive?
- (3) A. If they were done appropriately, yeah.
- (4) Q. Can you say that they most — that they
- (5) definitely would have been positive?
- (6) A. No. There is a small number of cases that
- (7) are culture negative.
- (8) Q. And we don't know whether his disease was
- (9) caused by a pathogen that's culture negative?
- (10) A. Exactly.
- (11) Q. So there — you cannot say with any
- (12) certainty as to whether cultures would have been
- (13) positive or not without knowing what the pathogen
- (14) was?
- (15) A. It's more likely than not that the
- (16) cultures would have been positive. Much more
- likely
- (17) than not.
- (18) In bacterial endocarditis over 90 percent
- (19) of the cultures are positive if done appropriately.
- (20) Q. How long would he have had to have been
- (21) taken off antibiotics in order —
- (22) A. Three or four days would have been
- (23) adequate.
- (24) Q. If a 2-D echo would have been done would
- (25) that have positively identified the existence of his

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- (1) heart lesion?
- (2) A. No. In more cases than not, the 2-D echo
- (3) is negative in known IBE.
- (4) An appropriate test is transesophageal
- (5) echocardiogram if you suspect IBE.
- (6) Q. There are a lot of different experts in
- (7) this case, Doctor, with a lot of different opinions.
- (8) I had the impression that you were critical of
- (9) Dr. Ruiz for not having gotten 2-D echo in this
- (10) patient. Am I mistaken about that?
- (11) A. An echocardiogram. My criticisms of
- (12) Dr. Ruiz are that he did not take the patient off -
- (13) did not make a differential diagnosis which included
- (14) bacterial endocarditis, did not take the patient off
- (15) antibiotics when he found the abnormalities on
- (16) physical and electrocardiogram, and take
- (17) appropriate
- (18) blood cultures.
- (19) And if the blood cultures were positive,
- (20) which more likely than not they were, do either a
- (21) transesophageal echocardiogram or a 2-D echo
- (22) cardiogram.
- (23) If the blood cultures were positive the
- (24) patient would have been hospitalized and treated
- (25) with intravenous antibiotics, which is the treatment
- (26) at that point.

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- (1) a little higher.
- (2) Q. But if you're attributing a duty to him
- (3) owed by an internal medicine specialty, you say he
- (4) should order a 2-D echo even though we agree that
- (5) they are very often negative in patients with IBE?
- (6) A. Exactly. Because the training in internal
- (7) medicine at that time was to get 2-D echos.
- (8) At this time it's no longer 2-D echos as a
- (9) minimum standard, with the training that's gone on
- (10) and the conferences that people should be
- (11) attending.
- (12) Q. But we are in agreement that even if he
- (13) ordered a 2-D echo it would - there is certainly
- (14) a - it would not necessarily have helped diagnose
- (15) his condition?
- (16) A. That's correct. The blood cultures were
- (17) much more sensitive. And he would have been
- (18) treated
- (19) with intravenous antibiotics appropriately and
- (20) perhaps gotten the cardiac consultation for the
- (21) abnormalities in his electrocardiogram which were
- (22) significantly changed.
- (23) Q. Let's talk about the electrocardiograms
- (24) for a minute, Doctor.
- (25) A. Sure.
- (26) Q. Your report suggests that you reviewed
- (27) both the '88 and the '95 EKG; correct?

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- (1) Are those opinions clear?
- (2) Q. In my view, not by including both 2-D echo
- (3) and TEE in the same answer.
- (4) Either one of those tests would have
- (5) satisfied your criticism?
- (6) A. If the blood cultures were positive, which
- (7) I assume they were, the more appropriate test is a
- (8) TEE.
- (9) Doctor - cardiologist would order that
- (10) test. And Dr. Ruiz is holding himself out as a
- (11) cardiologist.
- (12) If he - if he is found to be strictly an
- (13) internist, then the standard of care would include
- (14) only a 2-D echo at that time.
- (15) Q. What makes you say that Dr. Ruiz was
- (16) holding himself out as a cardiologist?
- (17) A. I received from Mr. Ruf his yellow pages
- (18) ad which includes cardiovascular diseases in his
- (19) advertising.
- (20) Q. Internal medicine specialists do not
- (21) address cardiovascular diseases?
- (22) A. Well, there's a subspecialty of internal
- (23) medicine. And if you're holding yourself out to be
- (24) an expert in cardiovascular disease as well, and
- (25) label it specifically as that, then the standard is

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- (1) A. Was it '88?
- (2) Q. I think it was '88. I may be wrong about
- (3) that.
- (4) A. Is this the one? I don't see a date on
- (5) this.
- (6) (Witness examines document.)
- (7) Suffice it to say the prior
- (8) electrocardiogram - and I'll assume it's 1988 -
- (9) was normal.
- (10) Q. Well, he was - the one that you have
- (11) handed us, he was age 21. So -
- (12) A. That's about it.
- (13) Q. I am guessing that's about it.
- (14) A. I think this is the one. It popped into
- (15) my hand so easily.
- (16) Q. And your interpretation of those strips
- (17) is -
- (18) A. He has a -
- (19) Q. - within normal limits?
- (20) A. Yeah. He has what we call a low atrial
- (21) rhythm, but otherwise it's normal.
- (22) Q. You can read that copy sufficiently to
- (23) make that determination?
- (24) A. Yeah.
- (25) MR. MALIK: Is this the same one? There

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- (1) is a date on the bottom.
- (2) THE WITNESS: It's '89, actually. Yeah.
- (3) This is the same. Do you have the other one handy?
- (4) I have it here. Here's a better copy of
- (5) that one. And it says '89 at the bottom.
- (6) MR. MALIK: You want this one?
- (7) THE WITNESS: No.
- (8) MR. MALIK: Okay.
- (9) MR. TRAVERS: Q. What is your
- (10) interpretation of the '95 study?
- (11) A. The patient now has a sinus tachycardia
- (12) rather than a low HO rhythm. He also has a
- (13) prominent R wave in V1 and V2, with flipped T waves
- (14) across the anterior precordium.
- (15) There has been an axis shift with an S
- (16) wave in V1 which is present now. And this is not a
- (17) remnant of a juvenile T pattern when compared to
- (18) 5-15-89 and is consistent with either right
- (19) ventricular overload or anterior ischemia.
- (20) The more likely interpretation is right
- (21) ventricular overload.
- (22) Q. Which of the findings that you identified
- (23) do you find most significant to suggesting right
- (24) ventricular overload?
- (25) A. The prominent R wave, V1 and V2, as well

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- (1) interpretation.
- (2) Q. So you don't believe that he considered
- (3) that a possible explanation?
- (4) A. If he did or he didn't, I – hemisread
- (5) this electrocardiogram.
- (6) Did you want to put these in?
- (7) Q. No. I think everybody has copies of those
- (8) studies.
- (9) Was there ever a time, Doctor, in which
- (10) the opinions that you held critical of the doctors
- (11) were based on an underlying opinion that – other
- (12) than the patient having endocarditis'?
- (13) A. In our initial discussions, I specifically
- (14) stated to Mr. Malik that I thought it was
- (15) endocarditis. And the underlying autopsy did not
- (16) confirm this, although it was consistent with it.
- (17) So, no, there was never a time that I did
- (18) not think it was endocarditis.
- (19) Q. In describing the cardiac lesion that
- (20) would be caused by endocarditis, would you ever
- (21) refer to that as a tumor?
- (22) A. No.
- (23) Q. If you were to use the word, "tumor,"
- (24) then, you would be thinking of a disease process
- (25) different than endocarditis; correct?

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- (1) as the flipped T waves anteriorly, the slight axis
- (2) shift in AVR.
- (3) Q. Can you translate into degrees the nature
- (4) of the abnormality identified in those strips?
- (5) A. You mean, which one leads me more to it?
- (6) Q. Well, how –
- (7) A. This is a highly significant change from
- (8) 5-15-89. It needs to be addressed. And a person
- (9) who is reading the electrocardiogram, whether he's
- (10) an internist or cardiologist, needs to address these
- (11) changes and find the reason for them.
- (12) Q. Is pericardial effusion a possible
- (13) explanation for those EKG changes?
- (14) A. Highly unlikely.
- (15) In pericardial effusion you might see a
- (16) lowering of the voltage of the QRS. And if it was
- (17) pericarditis that he was looking for, these findings
- (18) are not consistent with pericarditis. They would be
- (19) consistent with a localized change but not an acute
- (20) pericarditis.
- (21) Besides which, he doesn't even state that
- (22) in his interpretation or impression.
- (23) Q. Doesn't state what?
- (24) A. Dr. Ruiz does not say, suggestive of
- (25) pericarditis or pericardial effusion in his

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- (1) A. On the initial letter I stated that had
- (2) the right ventricular tumor been diagnosed it could
- (3) have been treated. And that was on the basis of the
- (4) findings of the autopsy, which were consistent with
- (5) an endomyocardial fibrotic tumor.
- (6) My opinion at that time and still is that
- (7) it was infectious bacterial endocarditis.
- (8) However, my opinion is that, if it truly
- (9) and really is an endomyocardial fibrosis, which I
- (10) don't think it is, it could have been treated in
- (11) June at that time and the patient would have been –
- (12) would have survived.
- (13) Q. I thought we – I don't want to go back to
- (14) two hours ago, but I thought we established a long
- (15) time ago that you don't claim to know whether he
- (16) would have survived or not if he had EMF?
- (17) A. I said it could be diagnosed, it could
- (18) have been treated, and I would leave the survival
- (19) aspects up to the – and I'm sorry, I misspoke at
- (20) that time. I meant, could have been treated and I
- (21) leave the survival aspects up to the person who
- (22) would treat it.
- (23) Q. It could be treated, but you don't have an
- (24) opinion as to whether it could be successfully
- (25) treated?

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- (1) A. That's right. But my opinion at that
- (2) time, and still is, that it was more likely than not
- (3) infectious endocarditis.
- (4) There just was no evidence available
- (5) because appropriate diagnostic tests were not
- (6) performed. I was asked specifically to address this
- (7) issue in this letter.
- (8) Q. When you drafted that report – and we're
- (9) referring to the one January 17th of '97,
- (10) endocarditis was not part of that report; would you
- (11) agree?
- (12) A. That's correct.
- (13) Q. You were addressing the issue of whether
- (14) failure to diagnose the right ventricular tumor
- (15) constituted medical negligence?
- (16) A. That's correct.
- (17) Q. And you thought that it did, that there
- (18) was negligence in not diagnosing the tumor?
- (19) A. My opinion at that time was that the
- (20) changes, the fever and – the persistent fever and
- (21) electrocardiographic changes would have warranted
- (22) blood cultures and an echocardiogram.
- (23) And on that echocardiogram, if a right
- (24) ventricular tumor did exist, it would have been
- (25) found.

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- (1) A. Correct. And again, this was specifically
- (2) asked to address the diagnosis of the mass,
- (3) whatever
- (4) the cause.
- (5) Q. And believed in April of 1997 that the
- (6) right ventricular tumor could have been treated;
- (7) correct?
- (8) A. Yes.
- (9) Q. As it turns out, it wasn't a tumor at all;
- (10) right?
- (11) A. If everybody decides that it's a tumor and
- (12) it's not infectious endocarditis, it still could
- (13) have been treated, is the basic thing.
- (14) It's my opinion that it's infectious
- (15) endocarditis, and I believe that's confirmed by a
- (16) reevaluation of the autopsy.
- (17) Q. You say you reviewed Dr. Hook's deposition
- (18) transcript?
- (19) A. Yes, I did.
- (20) Q. Do you disagree with any of her testimony
- (21) concerning the opinions or the – her findings at
- (22) autopsy?
- (23) MR. MALIK: Objection.
- (24) THE WITNESS: Which ones specifically do
- (25) you mean?
- (26) MR. TRAVERS: Q. You're right. That's

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- (1) But also that the blood cultures and the
- (2) echocardiogram would have found a right infectious
- (3) endocarditis. I was not asked to include that in
- (4) this report, therefore didn't.
- (5) Q. You then did another report dated April
- (6) 21st?
- (7) A. That's exactly right, Yes.
- (8) Q. This apparently was after a couple of
- (9) conversations you had with Mr. Malik; yes?
- (10) A. That's correct.
- (11) Q. And when you drafted the report in April
- (12) of 1997, it does not address the issuing of
- (13) endocarditis, either, does it?
- (14) A. It specifically states the right
- (15) ventricular mass would have been diagnosed at that
- (16) time. And it's my opinion that the right
- (17) ventricular tumor could have been treated.
- (18) It was not – again, it does not address
- (19) endocarditis specifically, but it addresses a right
- (20) ventricular mass, which could have been either at
- (21) the time.
- (22) Q. But they go on to call it tumor. You use
- (23) the word in your April 21 letter, you were using the
- (24) words "mass" and "tumor" to identify the same
- (25) lesion?

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- (1) not a fair question. I am not gonna pursue that.
- (2) Do you believe that any of the physicians
- (3) at the University Health Center or Dr. Adornato were
- (4) negligent in the care which they rendered to
- (5) Mr. Gonda?
- (6) A. No.
- (7) Q. Do you know when Dr. Adornato saw the
- (8) patient in comparison to when Dr. Ruiz saw him?
- (9) A. Dr. Adornato saw him specifically for a
- (10) pharyngitis on **6-14-95** and **7-10-95**.
- (11) Q. David came to him with a sign on him that
- (12) said he had pharyngitis, you mean?
- (13) A. That was his impression. **6-14**, wax in
- (14) both ears; **6-24**, viral pharyngitis; **6-26**, patient
- (15) telephoned; and he was seen again on **7-10**.
- (16) Q. What is it about Dr. Adornato's assessment
- (17) of this patient when he had the same symptoms as
- (18) when Dr. Ruiz saw him that makes him free of
- (19) negligence, but Dr. Ruiz subject to your criticism?
- (20) MR. MALIK: Objection.
- (21) THE WITNESS: Well, I'm not commenting on
- (22) the specifics of the standard of care for his
- (23) subspecialty, but he found findings of pharyngitis
- (24) and he was unaware of the electrocardiographic
- (25) changes, and I don't expect that he would know them

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- (1) if they were misread.
- (2) So I don't believe he had the full
- (3) information that Dr. Ruiz had.
- (4) I believe if he had awareness of the
- (5) changes in the electrocardiogram and the persistence
- (6) of the fever, he would be below the standard of care
- (7) of a physician.
- (8) Q. Had cultures been ordered in this case by
- (9) Dr. Ruiz and they were found to be negative, would
- (10) you then have no criticisms of him?
- (11) MR. MALIK: Objection.
- (12) MR. RUF: Objection; on or off
- (13) antibiotics? This is Mark Ruf.
- (14) THE WITNESS: If appropriate cultures were
- (15) obtained, I would have no complaints; that would be
- (16) an appropriate evaluation.
- (17) MR. TRAVERS: Q. If the patient had EMF
- (18) would you agree that cultures would likely be
- (19) negative?
- (20) A. Yes.
- (21) Q. Doctor, do you – you do acknowledge that
- (22) this patient's medical condition was substantially
- (23) different in August than it had been in June?
- (24) A. Yes.
- (25) Q. He had a clear chest x-ray in June?

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- (1) A. It depends. Sometimes it's easy. If the
- (2) blood culture's positive and they have a heart
- (3) murmur, it's real easy. Other cases, it may take
- (4) time.
- (5) Q. Would you agree, though, that generally
- (6) when you see patients with that disease, that you
- (7) recognize them as being substantially ill?
- (8) A. No, that's not true at all. They have a
- (9) wide spectrum. They can be mildly ill to
- (10) fulminantly ill.
- (11) I have seen all types.
- (12) Q. When David came to Dr. Ruiz in June would
- (13) you consider his condition mildly ill?
- (14) A. He was sick. And it's obvious from the
- (15) notes that he was sick, and he was persistent in
- (16) follow-up, because he continued to be sick.
- (17) I – I think the key here is that Dr. Ruiz
- (18) thought he was sick enough to do an
- (19) electrocardiogram in a young guy.
- (20) MR. TRAVERS: We have paid you for three
- (21) hours and I have already taken close to two of them.
- (22) So I think what I'm going to do is give these other
- (23) guys a chance, especially since Jim came all the way
- (24) out here to California, and if there is any time
- (25) left there is a couple other less important things I

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- (1) A. Yes.
- (2) Q. And by August it was a grossly abnormal
- (3) study?
- (4) A. Yes.
- (5) Q. Do you – I have come all the way out here
- (6) to California. I want you to look me in the eye and
- (7) tell me truthfully that when Dr. Ruiz saw this
- (8) patient on two times in early summer of 1995 that
- (9) you believe that he committed malpractice by not
- (10) diagnosing this man's condition?
- (11) MR. MALIK: Objection.
- (12) THE WITNESS: That isn't what I stated.
- (13) I – if he had done the appropriate tests and failed
- (14) to diagnose it, he would not have committed
- (15) malpractice, because the appropriate tests would
- (16) have been ordered.
- (17) My problem is – and I think anybody's
- (18) problem would be – the misdiagnosing of an
- (19) electrocardiogram in the face of persistent fevers,
- (20) and not even including it in the differential and
- (21) not doing the appropriate tests; that is
- (22) malpractice.
- (23) MR. TRAVERS: Q. When a patient has
- (24) endocarditis and comes to you with symptoms, is it
- (25) an easy or difficult diagnosis to make?

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- (1) want to quiz you about.
- (2) THE WITNESS: Can I take a five-minute
- (3) break to answer?
- (4) (Whereupon, a recess was taken from 12:01
- (5) p.m. to 12:07 p.m.)
- (6) MR. BLOMSTROM: Gary, why don't you go
- (7) ahead? You said you only have a couple.
- (8) EXAMINATION
- (9) BY MR. BANAS:
- (10) Q. Dr. Lehrman, my name is Gary Banas. I
- (11) represent Dr. Cropp and Dr. de Marco, who are
- (12) Board-certified pulmonologists.
- (13) I don't have many questions, but they're
- (14) very concise, and if you have a problem with them,
- (15) stop me, because I am going to presume that you
- (16) understood the question if you answered it; fair
- (17) enough?
- (18) A. Okay.
- (19) Q. Am I loud enough?
- (20) A. Yes.
- (21) Q. Do you have the Cleveland Clinic records?
- (22) A. Yes, I do.
- (23) Q. I note that the patient was transferred to
- (24) the Cleveland Clinic. The records from St.
- (25) Elizabeth went along?

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- (1) **A. Yes.**
- (2) Q. I note, then, that the impression at the
- (3) Cleveland Clinic was probable angiosarcoma.
- (4) **A. Yes.**
- (5) Q. In other words, as I look at this set of
- (6) records, the people at the Cleveland Clinic, after
- (7) having reviewed the St. Elizabeth records, did not
- (8) come to the IBE diagnosis?
- (9) **A. Yes.**
- (10) Q. Significantly, if you look a little
- (11) further across the final anatomic diagnosis – I
- (12) have page 16 of your time line.
- (13) **A. Okay.**
- (14) Q. The myocardial fibrosis of right ventricle
- (15) with associated thrombus extending from the
- (16) ventricular free wall into pulmonary outflow tract.
- (17) Have I read that correctly?
- (18) **A. Correct.**
- (19) Q. Their final anatomic diagnosis was EMF?
- (20) **A. Correct.**
- (21) Q. Now, Doctor, let's go to your letter of
- (22) March 25, 1998.
- (23) You have that?
- (24) **A. Yes.**
- (25) Q. Sorry. I am having a drink of coke.

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- (1) **A. No, I did not.**
- (2) Q. They did not have that information. I
- (3) will tell you that that will be the testimony, that
- (4) they did not have that.
- (5) **A. Okay.**
- (6) Q. Not having that, how can they determine
- (7) from the EKGs that there is some sort of change
- (8) between '89 and '95?
- (9) **A. They cannot, and I would withdraw that**
- (10) **complaint.**
- (11) Q. All right. Now, let's go to the next
- (12) paragraph where you talk about the TEE.
- (13) We know that the TEE was done, and my
- (14) recollection was, on the 17th of August.
- (15) You agree with that; I hope I'm right?
- (16) **A. Yeah, this is around there.**
- (17) Q. Okay. I want you also to assume that
- (18) Dr. Cropp never saw the TEE because the patient was
- (19) transferred to the Cleveland Clinic prior to the
- (20) time that Dr. Cropp saw the TEE or any piece of
- (21) paper referable –
- (22) (Phone disconnected.)
- (23) (Off the record.)
- (24) MR. BANAS: Q. I'm not sure what my
- (25) question was, but let me ask this one.

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- (1) Number 2 in the first paragraph, the TEE which I
- (2) reviewed is consistent with this diagnosis.
- (3) **A. Yes.**
- (4) Q. This was consistent with IBE?
- (5) **A. That's correct.**
- (6) Q. Consistent with?
- (7) **A. Yes.**
- (8) Q. Yes, but what?
- (9) **A. There is a mass in the right ventricle.**
- (10) Q. Okay. What was the TEE consistent with?
- (11) If it was consistent with IBE was it consistent with
- (12) anything else?
- (13) **A. Yes.**
- (14) Q. Tell me what it was consistent with?
- (15) **A. Okay. It was also consistent with a**
- (16) **myxoma, an angiosarcoma or possibly**
- (17) **endomyocardial**
- (18) **fibrosis.**
- (19) Q. Let's go a little further down the same
- (20) report of March 25, 1998.
- (21) There is a reference here to two EKGs or
- (22) two CK, June 27, '95 and May 15, '89.
- (23) You see that?
- (24) **A. Yes.**
- (25) Q. Do you know that Dr. Cropp or Dr. de Marco
- (26) did not have any of that information?

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- (1) **A. You were assuming that the TEE was not**
- (2) **seen.**
- (3) Q. Right. In other words, as I look at the
- (4) TEE, it was done on – wait a minute till I find it.
- (5) I think was it was done on the 17th.
- (6) **A. It was either the 16th or 17th.**
- (7) Q. There are two on the 17th and, of course,
- (8) Dr. Cropp did not see it or did not get a piece of
- (9) paper, the results, until after the patient was
- (10) transferred to Cleveland Clinic.
- (11) I want you to assume that.
- (12) **A. Yes.**
- (13) Q. If that's the case, then obviously he
- (14) can't very well be responsible for what's in the
- (15) TEE, can he?
- (16) **A. No, he cannot.**
- (17) Q. Incidentally, I – I happened to look at
- (18) the records and the sed rate was within normal
- (19) rates, was it not?
- (20) **A. The sed rate was taken while the patient**
- (21) **was on antibiotics, so I can't really tell.**
- (22) Q. But it is – the sed rate that's in the
- (23) records is within normal limits?
- (24) **A. That's correct.**
- (25) Q. Okay. Now, your report of November 23,

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- (1) '98 talks in terms about a cardiac ultrasound?
 (2) **A. Yes. That's an echocardiogram.**
 (3) Q. Okay. I want you further to assume that
 (4) again Dr. Cropp did not have that result either.
 (5) Can he be held – in other words, he
 (6) didn't get anything until after the patient was
 (7) transferred.
 (8) Can he be responsible for knowing what's
 (9) there?
 (10) **A. No.**
 (11) Q. Doctor, we know that Dr. Cropp is a
 (12) Board-certified pulmonologist.
 (13) **A. Yes.**
 (14) Q. Okay. And we also know that Dr. de Marco
 (15) is a Board-certified pulmonologist.
 (16) **A. Yes.**
 (17) Q. And my understanding from Mr. Ruf is that
 (18) apparently nobody is critical and, of course, the
 (19) nobody in this case would be you, are critical of
 (20) Dr. de Marco; is that true?
 (21) **A. That's correct.**
 (22) Q. Now, let's go to Dr. Cropp. Having gone
 (23) through the two reports, and I have also read your
 (24) report of April 21 and your report of January 17,
 (25) and, of course, those are talking in terms of the

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- (1) show an x-ray report where there is a, quote, no
 (2) pericardial effusion, unquote; correct?
 (3) **A. That's correct.**
 (4) Q. In other words, what – and this was noted
 (5) by ultrasound, was it not?
 (6) **A. That's correct.**
 (7) Q. All right. Now, would Dr. Cropp have
 (8) assumed that an echo had been done, or could he
 (9) assume that?
 (10) **A. He could. But there – usually, we get a**
 (11) **full, separate report on a cardiac ultrasound, and**
 (12) **this would be an unusual way to have it presented to**
 (13) **him.**
 (14) Q. That could have been sent to one of the
 (15) other physicians rather than Dr. Cropp; correct?
 (16) **A. This report, yes.**
 (17) Q. Doctor, I am trying to cut this down. I
 (18) have many more questions, but let me just ask this.
 (19) Look at your report, March 25, and having
 (20) looked at your report, your report of November 23,
 (21) and knowing what we know that Dr. Cropp did not
 (22) know, and knowing that there are many reasons for
 (23) fever; correct?
 (24) **A. That's correct.**
 (25) Q. Are you critical of Dr. Cropp for, in any

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- (1) results that were shown on the TEE; correct?
 (2) **A. I don't understand your question. Could**
 (3) **you say that again?**
 (4) Q. Well, what's in the reports of January 17,
 (5) 1997 where you talk about a right ventricular tumor,
 (6) and April 21, 1997 where, again, you're talking
 (7) about a right ventricular overload and the tracings
 (8) and so forth, all of this is based upon either the
 (9) EKGs or the TEE?
 (10) **A. No. This is based on the fact that an**
 (11) **echocardiogram would have been the appropriate**
 (12) **test**
 (13) **to order in June of 1995. And had that been**
 (14) **ordered, a mass more likely than not would have**
 (15) **been**
 (16) **present at the time of the – of the examination.**
 (17) Q. We know there is an x-ray report in
 (18) Dr. Cropp's office records which there is a mention
 (19) of, quote, no pericardial effusion, end quote.
 (20) **A. Yeah. But that's irrelevant to the**
 (21) **findings that would be inside the heart. You can't**
 (22) **see that on an x-ray or the quote, unquote, limited**
 (23) **echocardiogram that was performed.**
 (24) Q. Okay. That's not my question. Let me
 (25) start again.
 (26) **A. Okay.**
 (27) Q. You know that Dr. Cropp's office records

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- (1) way, that he fell below the standard of care of a
 (2) reasonably prudent Board-certified pulmonologist?
 (3) **A. No.**
 (4) MR. BANAS: I have nothing further.
 (5) MR. BLOMSTROM: I have a few questions
 (6) now. As you know, I represent Dr. Hafiz.
 (7) EXAMINATION
 (8) BY MR. BLOMSTROM:
 (9) Q. Let me ask you this.
 (10) Do you like to think of yourself as being
 (11) an open-minded fellow when presented with additional
 (12) information?
 (13) Or looking at information a bit closer
 (14) than you may have before, are you willing to change
 (15) your opinions when that's necessary?
 (16) **A. That's obvious.**
 (17) Q. I think you just did it; right?
 (18) **A. That's correct.**
 (19) Q. Well, we're going to start talking about
 (20) Dr. Hafiz at this point.
 (21) **A. Okay.**
 (22) Q. You claim any expertise in the field of
 (23) radiology?
 (24) **A. No.**
 (25) Q. Are you aware of how it was that the

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- (1) pericardial ultrasound came to be performed on June
 (2) 27, 1995?
 (3) **A. Apparently, Dr. Ruiz requested that**
 (4) **Dr. Hafiz perform it.**
 (5) Q. You have a copy of Dr. Ruiz's second
 (6) deposition among your materials; correct?
 (7) **A. Yes.**
 (8) Q. Now, you indicated that you just briefly
 (9) scanned that, if I recall what you said earlier; is
 (10) that correct?
 (11) **A. I reviewed it. I did not read it in**
 (12) **detail.**
 (13) Q. Okay. Well, we're not going to read the
 (14) whole thing in detail right here, but we are going
 (15) to turn to one particular part of the October 23,
 (16) 1998 deposition.
 (17) And in particular we'll start with page
 (18) 24, line 1, and we'll go to line 11. You can follow
 (19) along with me.
 (20) The question was –
 (21) "Okay. That's fine. So then the type of
 (22) study done by Dr. Hafiz was not for the purpose of
 (23) determining the etiology of any cardiac condition;
 (24) correct?
 (25) "Answer: That's correct.

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- (1) avoided assessing a cardiac condition as to the
 (2) etiology for Mr. Gonda's symptoms; correct?"
 (3) Then there is several objections there.
 (4) And he says, "I don't understand the
 (5) question.
 (6) "Question: Well, I'll read it to you
 (7) slowly. By performing the limited ultrasound you
 (8) avoided assessing a cardiac condition as to the
 (9) etiology for David Gonda's symptoms?
 (10) "Answer: No, sir. I was looking for one
 (11) particular thing and I got my answer.
 (12) "Question: Okay. But you didn't get your
 (13) answer with respect to anything else of the heart.
 (14) "Answer: I wasn't looking for anything
 (15) else in the heart. Just that."
 (16) And we're gonna do one more short excerpt
 (17) and then we'll be done for the time being.
 (18) This goes to 31, line 17, and we'll go to
 (19) 23.
 (20) "Question: Okay. But you were not
 (21) looking for problems with the internal structure of
 (22) the heart?
 (23) "Answer: I was not.
 (24) "Question: And you did not ask Dr. Hafiz
 (25) to look at the internal structures of the heart such

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- (1) "Question. Okay. And had you wanted to
 (2) know the etiology of a cardiac condition, you would
 (3) have sent the patient for a two-dimensional
 (4) ultrasound; correct?
 (5) "Answer: Had I been looking for that,
 (6) that would have been the next step.
 (7) "Question: Okay.
 (8) "Answer: Yes."
 (9) Now, we are going to turn to page 29.
 (10) **A. Just a second.**
 (11) (Witness examines document.)
 (12) **A. Okay.**
 (13) Q. And go from 29, line 1.
 (14) "Question: I stand corrected. Is it a
 (15) fair statement to say that by ordering the
 (16) ultrasound study of the pericardium, that you
 (17) limited your diagnostic capability only to the
 (18) pericardium, and did not – and not – did not
 (19) include the rest of the heart?
 (20) "Answer: I was only checking for the
 (21) pericardium.
 (22) "Question: So the answer would be yes?
 (23) "Answer: That's yes.
 (24) "Question: Okay. By performing the
 (25) limited ultrasound we have then avoided, or you

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- (1) as the ventricle or atrium?
 (2) "Answer: No, sir."
 (3) Did I read all of this correctly?
 (4) **A. Well, there you have it.**
 (5) Q. There I have it. So –
 (6) **A. So I withdraw any complaints for**
 (7) **Dr. Hafiz.**
 (8) Q. Well, that will –
 (9) **A. That's –there you have it. I did not**
 (10) **have that information when I did that, my report,**
 (11) **obviously.**
 (12) MR. BLOMSTROM: Okay. Well, then I'm
 (13) done. Thank you very much.
 (14) THE WITNESS: Okay.
 (15) MR. BANAS: Tom, you have any more?
 (16) MR. TRAVERS: I have some time left, so –
 (17) MR. BANAS: I don't have any more. Go
 (18) ahead.
 (19) FURTHER EXAMINATION
 (20) BY MR. TRAVERS:
 (21) Q. Doctor, when in time do you think that TEE
 (22) or perhaps a 2-D echo would have been able to
 (23) identify a lesion in David's heart?
 (24) **A. It's more likely than not that in June it**
 (25) **would have been present.**

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- (1) Q. Did you read Dr. Hoffman's deposition
 (2) transcript?
 (3) A. I reviewed it and obviously I don't agree
 (4) with his timing.
 (5) I don't know — my experience with
 (6) pathologists is that they can't really time how long
 (7) a mass has been present, and I don't know how he
 (8) did
 (9) that.
 (10) It's my opinion that it would have been
 (11) there in June.
 (12) Q. Don't you think that a person who has
 (13) actually seen the lesion is in a better position to
 (14) make a judgment as to how long it would have been
 (15) present?
 (16) A. I would like to hear a better explanation
 (17) of it. It's — it's my opinion that it would be
 (18) there in June something.
 (19) Q. I understand that. But my question is,
 (20) don't you think that a person who actually
 (21) visualizes the lesion itself would be in a better
 (22) position to make a judgment as to how long it was
 (23) there?
 (24) A. That's a reasonable statement.
 (25) Q. How about someone who had visualized
 (26) photographs or slides from the autopsy study, would

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- (1) Q. That would tell you whether the cough was
 (2) related?
 (3) A. Well, if the blood cultures, more likely
 (4) than not, were positive, and there was the mass
 (5) there, it's — it's likely or possible that the
 (6) cough is related to pulmonary complications of the
 (7) right-sided — right-sided IBE.
 (8) So it could also be an associated cough
 (9) related to an upper respiratory infection. I really
 (10) can't say. An unassociated upper respiratory
 (11) infection.
 (12) Q. If there was an unassociated upper
 (13) respiratory infection, could that lead to the
 (14) development of infectious endocarditis?
 (15) A. Conceivably.
 (16) Q. That's not normally the route that a
 (17) patient develops that disease, though; correct?
 (18) A. It would lead to a pneumonia. You would
 (19) look for something before the right heart in the
 (20) venous return system to account for it.
 (21) It would have to filter through the lung
 (22) and then back through the system again to filter
 (23) through again, and that would seem unlikely that a
 (24) lung infection could cause — sinus could cause it,
 (25) obviously.

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- (1) that person be in a better position to make that
 (2) judgment than someone who had seen neither?
 (3) A. Again, that's a reasonable statement. I'd
 (4) like to add, if it's okay with you, that the slides
 (5) were taken from different areas, and I don't know
 (6) the specific areas.
 (7) It's very conceivable that the areas that
 (8) were not — where the slides were not taken from,
 (9) particularly the base, might have been more
 (10) likely — in my opinion, again, were there at the
 (11) time in June.
 (12) Q. Do you think that the patient's cough was
 (13) attributable to his endocarditis that you believe he
 (14) had?
 (15) A. I can't say.
 (16) Q. It is equally possible one way or another
 (17) that it was — I think Dr. Morgenstern-Clarren used
 (18) the term, "red herring."
 (19) A. I can't — I can't really say one way or
 (20) the other. That I — I just can't say.
 (21) It could be related to it; it couldn't. I
 (22) don't have enough information to tell you.
 (23) Q. What other information would be helpful to
 (24) you?
 (25) A. The blood cultures.

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- (1) Q. Do you recognize that his cough was
 (2) Mr. Gonda's primary complaint when he went to these
 (3) various physicians?
 (4) A. Yes.
 (5) Q. And in your judgment, that may or may not
 (6) have been related to his underlying disease?
 (7) A. That's correct.
 (8) Q. Are you aware as to whether or not the
 (9) patient had episodes of chills?
 (10) A. I don't believe he had chills.
 (11) I could be wrong.
 (12) Q. You wouldn't expect a patient with
 (13) endocarditis to have chills?
 (14) A. They can.
 (15) Q. In a patient with a fever and a cough
 (16) presenting to an internal medicine specialist, do
 (17) you agree that it is reasonable of that clinician to
 (18) secure the consultation of a pulmonologist?
 (19) A. Not necessarily. Most of the upper
 (20) respiratory infections can be treated by family
 (21) practitioners or internists.
 (22) If it becomes problematic, then it's
 (23) appropriate, or if there are other signs or symptoms
 (24) that it's a difficult disease, such as — if you
 (25) have a pulse oximeter in the office and they're

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- (1) hypoxic, then it might be reasonable.
- (2) Q. Does it depend upon how many different
- (3) antibiotics had been attempted to treat the
- (4) patient's condition unsuccessfully?
- (5) A. Again, that's getting into the problematic
- (6) areas of the disease, and it's appropriate at that
- (7) time to get a consultation.
- (8) Q. With the pulmonologist?
- (9) A. With a pulmonologist or an infectious
- (10) disease doctor.
- (11) Q. When a physician such as Dr. Ruiz secures
- (12) a consultation with the pulmonologist, what would
- (13) you expect the role of the pulmonologist to be at
- (14) that point?
- (15) A. To evaluate the patient and treat the
- (16) patient and make recommendations.
- (17) Q. And it's reasonable, then, for the
- (18) referring clinician to rely upon the assessment and
- (19) recommendations of his consultant?
- (20) A. If it's based on full and factual
- (21) information, yes.
- (22) Q. In this case, though, you don't believe
- (23) that it was reasonable of Dr. Ruiz to go along with
- (24) the suggested course of treatment by the
- (25) pulmonologist?

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- (1) A. Not really.
- (2) Q. You're certainly not suggesting that there
- (3) is evidence that the patient had a murmur or a valve
- (4) involvement because of having - of a clinician
- (5) having heard a systolic click?
- (6) A. No. One of the reasons for a click can
- (7) be - a click can be confused with a tumor or
- (8) vegetation thump, also. And I don't know the level
- (9) of Dr. Ruiz's knowledge with regard to this. So it
- (10) may have been that the click was really a clunk.
- (11) MR. BLOMSTROM: Medically speaking.
- (12) THE WITNESS: Yes. It's a nice,
- (13) descriptive, scientific term, isn't it?
- (14) MR. TRAVERS: Q. But not pertinent to the
- (15) issues in this case.
- (16) A. No, not really.
- (17) Q. Is there a normal range of temperature
- (18) that a bacter- - or IBE patient experiences?
- (19) A. No. Again, what is normal? They usually
- (20) have fever. And it can be either an intermittent
- (21) fever or a persistent fever, but they usually have a
- (22) temperature above normal.
- (23) And he, Mr. Gonda, repeatedly had
- (24) temperatures in waves, despite treatment. This is
- (25) consistent with what we would call a fever of

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- (1) A. Well, now that I know that they didn't
- (2) have access to the electrocardiographic report
- which
- (3) was misread, no, that's not full and factual
- (4) information.
- (5) It might have been reasonable - they - I
- (6) didn't see this in the records, but he may have
- (7) given them a report that the electrocardiogram was
- (8) unremarkable, and it's remarkable. And that might
- (9) lead a prudent doctor to suspect something with the
- (10) heart.
- (11) Q. Certainly, a patient who presents with a
- (12) cough and a fever, in establishing a differential
- (13) diagnosis based on those two conditions, heart
- (14) involvement is way down the list; wouldn't you
- (15) agree?
- (16) A. In a patient who presents with that, it's
- (17) way down the list. Except when there's a change in
- (18) the electrocardiogram.
- (19) Q. You're aware that Dr. Ruiz had heard a
- (20) systolic click at one point -
- (21) A. Yes.
- (22) Q. - in this patient?
- (23) A. Yes.
- (24) Q. Do you find that to be of any
- (25) significance?

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- (1) unknown origin.
- (2) Q. Is it of any significance to the clinician
- (3) what the temperature was, how high?
- (4) A. No, not really.
- (5) Q. It's your opinion that there is not a
- (6) normal range of elevation of temperature in patients
- (7) with IBE?
- (8) A. No. More commonly it's low grade, if
- (9) that's what you're driving at.
- (10) But, again, the spectrum of IBE is
- (11) wide-ranging, and this is entirely consistent with
- (12) it.
- (13) Q. What do you categorize as low-grade fever?
- (14) A. Ninety-nine to a hundred one. He had a
- (15) couple at 102.
- (16) Q. Are you aware as to whether or not
- (17) Dr. Adornato had reached a tentative diagnosis and
- (18) embarked upon a course of therapy for this patient?
- (19) A. Only in the sense that he decided that it
- (20) was pharyngitis and treated him with antibiotics.
- (21) Q. And that's what I was referring to.
- (22) Don't you believe that it would be
- (23) prudent, then, of Dr. Ruiz to refrain from
- (24) interrupting with the suggested therapy of the
- (25) specialist?

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- (1) A. Had begun, you mean?
- (2) Q. I'm sorry?
- (3) A. I was finishing your question. I thought
- (4) there was more to the question. I'm sorry. Had
- (5)** embarked on or something. Had to be a verb in there
- (6) somewhere.
- (7) Q. I don't always use verbs.
- (8) A. Okay. In the face of the remarkable
- (9) changes in the electrocardiogram, I think it would
- (10) have been prudent to obtain blood cultures.
- (11) But since he misread the
- (12) electrocardiogram – you know, we're dealing with a
- (13) hypothetical.
- (14) If he had known that the electrocardiogram
- (15) had been remarkably changed, he would have – a
- (16) prudent doctor would have embarked on his own course
- (17) of evaluation.
- (18) So with false knowledge, following the
- (19) recommendations of Dr. Adornato is not – not
- (20) unreasonable.
- (21) But if he had known the knowledge, a
- (22) different, a whole different course of action would
- (23) have been pursued.
- (24) Q. So the interpretation of this EKG study is
- (25) pretty critical to your opinions?

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- (1) tool is a sed rate and blood cultures off
- (2) antibiotics and a good clinical exam to hopefully
- (3) hear a murmur which may or may not be present.
- (4) Q. Do you believe you have some insight into
- (5)** why Dr. Ruiz ordered an EKG in this case?
- (6) A. I think it was because of the chest
- (7) discomfort associated with the cough. But that's
- (8) about the best I can come up with.
- (9) Q. You have some understanding of the nature
- (10) or severity of Mr. Gonda's chest discomfort
- (11) complaints?
- (12) A. No.
- (13) Q. Are you aware as to whether or not a
- (14) sputum culture was ordered?
- (15) A. I believe a throat culture was ordered,
- (16) but I don't remember a sputum culture being ordered
- (17) at that time.
- (18) Q. Is a throat culture –
- (19) A. I think the throat culture was ordered by
- (20) Dr. Adornato.
- (21) Q. Is that a reasonable test for a person
- (22) with these symptoms?
- (23) A. Yes.
- (24) Q. Do you know the results of that culture?
- (25) A. No. I'd have to look it up. The throat

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- (1) A. Yes.
- (2) Q. Are these tracings – or are EKG tracings
- (3) generally subject to opinion?
- (4) A. Yes. Yes.
- (5)** Q. Would you agree that this tracing is
- (6)** subject to different interpretations?
- (7) A. Yes. But in comparison to the one prior,
- (8) I don't think there is any disagreement that this is
- (9) a remarkable change, a significant change.
- (10) Q. What are other theoretical possibilities
- (11) to explain that change, in addition to lesion of the
- (12) endocardium?
- (13) A. As I said, anything which would indicate
- (14)** right ventricular overload or hypertrophy, there are
- (15) many conditions that can cause that.
- (16) Q. What are they?
- (17) A. Pulmonary hypertension is one. Pulmonic
- (18) stenosis is another. Intracardiac shunts would be a
- (19) third one.
- (20) Off the top of my head those are the most
- (21) causes. Or an AV fistula somewhere in the body.
- (22) Anything that causes right ventricular overload.
- (23) Q. Do you believe that EKG is an appropriate
- (24) screening tool for IBE?
- (25)** A. Not usually. The appropriate screening

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- (1) culture?
- (2) Q. Yes.
- (3) A. I think it was negative.
- (4) Q. Do individuals with IBE sometimes present
- (5)** with positive throats or sputum cultures?
- (6) A. I'm not sure. It's conceivable.
- (7) Q. Other than not ordering blood cultures
- (8) and, in your judgment, misinterpreting the EKG, do
- (9) you have any other criticisms of Dr. Ruiz in this
- (10) case?
- (11) A. Only as we mentioned, the echocardiogram
- (12) would have been a reasonable and prudent test in the
- (13) presence of the EKG.
- (14) MR. TRAVERS: I believe those are all the
- (15) questions I have, Doctor.
- (16) THE WITNESS: Good. You have anything
- (17) there?
- (18) MR. BANAS: Tom, are you done?
- (19) MR. TRAVERS: Yes, sir.
- (20) MR. BANAS: I'm done. And Tom, why don't
- (21) you order a copy **and** we'll split it with you,
- (22) because you and I have the same client essentially.
- (23) Okay?
- (24) MR. TRAVERS: That's fine.
- (25)** MR. BANAS: Thank you, Doctor.

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- (1) THE WITNESS: Okay. Thank you.
 (2) THE REPORTER: Who is ordering a copy of
 (3) the transcript?
 (4) MR. BLOMSTROM: I do need a copy.
 (5) MR. BANAS: We're shutting down at this
 (6) end.
 (7) MR. RUF: Bye. Thanks.
 (8) MR. BANAS: And Mr. Malik, we will send
 (9) you a check Monday.
 (10) MR. RUF: I designate Dr. Lehrman as an
 (11) expert.
 (12) THE WITNESS: I am not an expert in
 (13) radiology. I already said that in your -
 (14) THE REPORTER: Mr. Malik?
 (15) MR. MALIK: Yes. Ordering a copy of the
 (16) transcript. ASCII and condensed.
 (17) MR. TRAVERS: I don't need a disk.
 (18) (Whereupon, the deposition of KENNETH L.
 (19) LEHRMAN, M.D. was adjourned at 12:45 p.m.)
 (20)
 (21)
 (22)
 (23) ---oOo---
 (24)
 (25)

(24)

(25) Signature:

Date:

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- (1) CERTIFICATE OF DEPONENT
 (2) NOTE: If you are adding to your testimony, print
 the exact word you want to add. If you are deleting
 (3) from your testimony, print the exact word you want
 to delete. Specify with "Add" or "Delete" and sign
 (4) this form. If there are no corrections to your
 testimony, please sign and date this form.
 (5)
 EXAMINATION OF: KENNETH L. LEHRMAN, M.D.
 (6) CASE: DOROTHY A. GONDA, et al vs JUAN RUIZ,
 M.D., et al
 (7) DATE OF EXAMINATION: FRIDAY, JANUARY 29, 1999
 (8) I, _____, have the
 following corrections to make to my examination.
 (9) Page Line Change/Add/Delete
 (10)
 (11)
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 (23)

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(1) STATE OF CALIFORNIA)
) SS.
 (2) COUNTY OF SAN FRANCISCO)
 (3)
 (4) I, HARRIET MARCH PAGE, CSR NO. **1284**, hereby
 (5) certify that the witness in the foregoing deposition
 (6) was by me duly sworn to tell the truth, the whole
 (7) truth, and nothing but the truth in the
 (8) within-entitled cause;
 (9) That said deposition was taken in
 (10) shorthand by me, a certified shorthand reporter and
 (11) a disinterested person, at the time and place
 (12) therein stated and that the testimony of the said
 (13) witness was thereafter reduced to typewriting, by
 (14) computer, under my direction and supervision;
 (15) I further certify that I am not of counsel
 (16) or attorney for either or any of the parties to the
 (17) said deposition, nor in any way interested in the
 (18) event of this cause and that I am not related to any
 (19) of the parties thereto.
 (20) In witness whereof, I have hereunto set my
 (21) hand and affixed my signature this
 (22) day of, **1999**.
 (23)
 (24) CERTIFIED SHORTHAND REPORTER,
 (25) STATE OF CALIFORNIA

If you are represented by an attorney,
 (16) you may choose to examine your attorney's copy. If
 you choose to come to our office, please call to
 (17) arrange a time which will be convenient for you.
 Also, bring this letter as a reference.
 (18) If you have any questions, please contact
 your counsel.
 (19) Thank you for your cooperation in this
 matter.
 (20) Sincerely,
 (21)
 Mercia Pereira Tiscornia,
 (22) RPR, CSR
 cc: Original
 (23) Thomas J. Travers, Jr., Attorney at Law
 Gary Banas, Attorney at Law (Letter)
 (24) James L. Blomstrom, Attorney at Law
 David Malik, Attorney at Law
 (25) Mark W. Ruf, Attorney at Law (Letter)

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(1) PEREIRA & ASSOCIATES
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 (4) February **20, 1999**
 Kenneth L. Lehrman, M.D.
 (5) **901** Campus Drive, Suite **306**
 Daly City, California **94015**
 (6)
 IN RE: DOROTHY A. GONDA, et al., vs JUAN RUIZ,
 (7) M.D., et al.
 CASE NUMBER: **96 CV 2055**
 (8) DATE TAKEN: January **29, 1999**
 OUR FILE NUMBER: **99-1 10**
 (9)
 Dear **Dr.** Lehrman,
 (10)
 Please be advised that the original
 (11) transcript taken in the above-captioned matter has
 been completed and is now ready for your review,
 (12) corrections, if necessary, and signature.
 You have thirty (30) days from receipt of
 (13) this letter in which to read and sign your
 deposition. If you choose not to read or sign your
 (14) deposition within thirty days, it will be deemed
 correct as is, and soon thereafter filed with the
 (15) noticing attorney.

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UNIQUE WORDS: **1,674**
 TOTAL OCCURRENCES:
5,425
 NOISE WORDS: **385**
 TOTAL WORDS IN FILE:
16,781

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NUMBER OF WORDS
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 THRESHOLD: **5**

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