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:

PEREIRA & ASSOCIATES
P. O. Box 4339
Daly City, CA 94016-0339
Phone: (415)469-9219
FAX: (415)586-6183

Page 1

IN THE COURT OF COMMON PLEAS
MAHONING COUNTY, OHIO
---oOo---

DOROTHY A GONDA. INDIVIDUALLY AND AS ADMINISTRATRIX OF THE ESTATE OF DAVID PAUL GONDA. DECEASED.

Plaintiff.

-vs-

JUAN RUIZ. M.D., ET AL..

Defendants

CASE NO. 96 CV 2055

COURTROOM NO. 4

DEPOSITION OF KENNETH L. LEHRMAN. M.D

SCHEDULED FOR: 10:00 A.M.
ON THE RECORD 10.18 A.M. TO 12.45 P.M.
DATE. Friday. January 29. 1999
TAKEN AT: OFFICES OF KENNETH L LEHRMAN. M D
901 Campus Drive. Suite 306
Daly City. California 94015
(650) 755-2007

BY THOMAS J TRAVERS. JR.. ATTORNEY AT LAW

REPORTER: HARRIET MARCH PAGE. CSR NO 1284
PEREIRA & ASSOCIATES
CERTIFIED SHORTHAND REPORTERS
P. O. BOX 4339
Daly City. California 94016-0339
(415) 469-9219

Page 2

INDEX OF EXAMINATION

---oOo---

INDEX OF EXHIBITS

NO EXHIBITS

---oOo---

Page 3

BE IT REMEMBERED that. pursuant to Notice. and on FRIDAY. JANUARY 29. 1999. commencing at the hour of 10:18 a.m. thereof. at 901 Campus Drive. Suite 306. Daly City. California 94015. before me. Harriet March Page, CSR No 1284. authorized to administer the oath. personally appeared KENNETH L. LEHRMAN. M D , who was examined as a witness in said cause.

KENNETH L. LEHRMAN. M.D..

called as a witness by ?he Defendants. who. being by me first duly sworn. was thereupon examined and testified as is hereinafter set forth.

---oOo---

APPEARANCES OF COUNSEL

FOR THE PLAINTIFF
LAW OFFICES OF DAVID MALIK
BY: DAVID MALIK. ATTORNEY AT LAW
The May Building
8228 Mayfield Road. Suite IV B
Chesterland. Ohio 44026
(440) 729-8260

LAW OFFICES OF MARK W RUF
BY. MARK W. RUF. ATTORNEY AT LAW (By Phone)
Hoyt Block. Suite 300
700 W St. Clair Avenue
Cleveland, Ohio 44113-1230
(216) 687-1999

---oOo---

Page 4

APPEARANCES OF COUNSEL (CONTINUED)

FOR THE DEFENDANT JUAN RUIZ. M.D.:
MANCHESTER, BENNETT. POWERS & ULLMAN
BY: THOMAS J. TRAVERS. JR.. ATTORNEY AT LAW
Atrium Level Two
The Cwnnerce Building
201 East Cwnnerce Street
Youngstown. Ohio 44503-1641
(330) 743-1171

FOR THE DEFENDANTS ALAN J. CROPP. M.D. AND ROBERT DE MARCO. M.D.:
BUCKINGHAM. DOOLITTLE & BURROWS
BY: GARY BANAS. ATTORNEY AT LAW (By Phone)
P.O. Box 35519
3721 Whipple Avenue
Canton. Ohio 44735
1-800-686-2822

FOR THE DEFENDANT ABDUL HAFIZ. M.D.:
HARRINGTDN. HOPPE & MITCHELL. LTD.
BY: JPMES L. BLOMSTROM. ATTORNEY AT LAW
1200 Mahoning Bank Building
Youngstown. Ohio 44505
(303) 744-1111

---oOo---

Page 5

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

Page 6

A. That's correct.
Q. And your Fellowship in Cardiology at
Stanford?
A. Yes.
Q. You are Board certified in both Internal
Medicine and Cardiology?
A. Yes.
Q. I am glancing here at your academic
positions, doctor. Do you have any present
academic -
A. The only present position is the - I'm a
clinician at the San Francisco Heart Institute,
clinical faculty there.
Q. Can you give me a thumbnail sketch of the
nature of your private practice?
A. I spend about 90 percent of my time in
primarily patient care activities and associated
administrative activities for patient care.
Less than ten percent of my time is
involved with medical-legal and about one percent
of
my time is administrative duties with the hospital
that - the hospitals that I'm involved with, which
are Mills-Peninsula Medical Center in Burlingame
and
Seton Medical Center in Daly City, California, which
is a suburb of San Francisco.

Page 7

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

Page 8

problems, is what I mean by the primary care. And
that aspect - and I take care of all aspects of
those patients at well.
Q. What type of invasive and interventional
cardiology do you practice?
A. I do coronary arteriography and cardiac
catheterization, which is diagnostic test, and then
I do angioplasty as well, which is an intervention
for treatment of coronary disease.
Q. Could you estimate for me the approximate
number of angioplasties you would do on an annual
basis?
A. About 50.
Q. You are licensed to practice medicine?
A. Yes. In California only.
Q. Do you presently provide medical care on
any patients suffering from endocarditis?
A. Currently?
Q. Correct.
A. Only in terms of post-endocarditis. I
don't have anyone in the hospital with endocarditis
now, if that's what you mean.
I still have patients in my practice who
have survived endocarditis.
Q. Can you estimate the number of patients

Page 9

that you have seen who suffered from that disease?
A. About one a year. And I've been in
practice about 20 years.
Q. Can you identify the hospitals that you
are affiliated with?
Apparently you have two different offices:
one in Daly City and one in Burlingame?
A. That's correct. I have an office near
each of the hospitals. The office in Burlingame is
a satellite office where I see patients two
afternoons a week.
Q. Are either of the hospitals that you
practice at teaching hospitals?
A. At the present time, no.
Q. How many beds are in each of those
hospitals?
A. Approximately 200 each.
Q. Where is Burlingame?
A. Burlingame's right next to the airport.
Q. Okay. Explain for me, if you would,
Doctor, how you view your role in this case?
A. Basically, I was asked to review the
records and see if there was a breach of the
standard of care.
Q. So if I understand that correctly, you are

Page 10

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

Page 11

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

Page 12

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

Page 13

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

Page 14

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

Page 15

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

Page 16

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

Page **17**

A deposition of Dr. Robert Hoffman, II. Another copy of Dr. Juan Ruiz's chart, A deposition of Robert de Marco, M.D. Deposition of Alejandro Franco, M.D. I didn't use those in formulating my opinion, though, but I have reviewed them.

Q. "Those," meaning all of these depositions?

A. That's correct.

Q. By "reviewed them," you mean you have read them?

A. I have skimmed them, I have not read them word for word.

Q. Okay.

A. If you tell me something is in here and show it, I'll agree with you, is basically how -

Q. The medical journal articles that you have in your documents there, who forwarded those to you?

I believe Mr. Malik. Is that correct?

It came probably with some of the depositions. Again, I skimmed them; I didn't review them in detail.

Q. All of the journals pertain to endomyocardial fibrosis?

A. Yes. That's correct. It's a British Heart Journal from - **1955** British Heart Journal

Page 18

from **1978.** Thoracic and Cardiovascular Surgery from 1983. And Circulation from **1985.**

Q. You suggested we use the acronym "IBE." I am going to suggest we use EMF. That will save me a mouthful, too. Is that okay with you?

A. That's fine with me.

Q. To mean "endomyocardial fibrosis."

A. I understand.

Q. Do you claim any particular expertise in that disease process?

A. No way.

Q. Had you ever heard of it before this case?

A. Sure, I have heard - I have heard of it. We learned about it in our training. I have never seen a case.

Q. Do you feel you know enough about that disease process to render opinions concerning its mortality rate, for example?

A. Only on the basis of these articles. I would defer to someone who claimed anything that was in - that was consistent with these articles that are reported. I am not claiming any special knowledge.

Q. Well, do you -

Page 19

A. I'm not talking about - at - in my testimony, I'm not going to be talking about survivability of end-stage EMF.

Q. That's exactly what I was trying to find out.

The opinions that will be introduced by you in this case are based on the proposition that the patient's disease process was IBE?

A. For the most part. My other opinion is going to be that if the EMF, if it did exist, were diagnosed in an appropriate and timely manner, then treatment could be afforded. And I would defer to another expert on the surgical treatment and the survivability from that. Is that clear?

Q. I am going to say, no. Do you hold opinions concerning whether or not there was a failure of the standard of care by any of the physicians in this case, if we assume that the patient's disease process was EMF?

A. Yes.

Q. Do you hold any opinions concerning what the likely outcome would have been in David Gonda's case had EMF been diagnosed earlier?

A. No.

Page *20*

Q. Are you familiar with a subcategory of that disease called non-African endomyocardial fibrosis?

A. Only on the basis of the articles.

Q. You -

A. I have heard of it. That's about my limited knowledge of it.

Q. So we can anticipate that you were not going to come into court and say that the only **place** that that disease ever occurs **is** in Africa?

A. That's correct.

Q. In addition - I got a little off course there. I'm trying to finish up my preparatory questions here, Doctor.

A. Sure.

Q. In addition to reviewing those documents have you discussed the case with anyone?

A. No.

Q. None of your colleagues?

A. No.

Q. You have never spoken with any of the family members?

A. No.

Q. I assume to some extent you have had conversations either with Mr. Ruf or Mr. Malik about

Page 21

the case?
A. That's about it.
Q. Have they reviewed –
A. Before I finish that, there – Ellen Rieback's involvement in the communications between us is only as a conduit.
I do not discuss anything with regard to the case to her except billing.
Q. In your conversations with Mr. Ruf or Mr. Malik, were any facts made known to you that are important in your opinions that are not contained in the records that you had available for your review otherwise?
A. No.
Q. Did you review any medical literature either in forming your opinions in this case or in preparing for your deposition testimony?
A. Only these, As mentioned, I briefly reviewed these. But no – no other literature.
Q. You have reviewed no literature, then, pertaining to the IBE disease process?
A. Correct.
Q. I assume you did not because in your training and experience you have familiarity with that disease and didn't feel the need to do that?

Page 22

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

Page 23

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

Page 24

something just being good general guideline, I am not sure that I understand the distinction in your mind.
A. I am not sure I understand it, either.
Many times I'm asked if it's – if there is an authoritative article or a journal, and most of them are reliable.
Medicine changes continually and there is a responsibility of a physician for continuing medical education, such as lawyers.
And we hear things in conferences, if we attend them, that may not be in the textbook. Or they may be in the newspapers and they may not be in the textbooks. So I can't say.
"Reliable" is a better term than "authority." That is basically why I asked.
Q. So the term that you have identified, in your judgment, is "reliable," for a practicing physician?
A. Practicing.
Q. And you have not reviewed any of these before your testimony today?
A. No. I review them when I'm unfamiliar with a disease or process, just like any physician would, or I pull something up on my – on a – an

Page 25

Internet Web Medical Review *Site*.
Q. Of the various texts that you identified, do you find some of them to be more reliable than others, or not?
A. Not really. They are all good books.
Q. When you say, "reliable," what I perceive you mean is, even though they may not be entirely up to date or up to the moment that, as a general principle, the information contained in them is accurate?
A. *Yes*.
Q. You have never worked with Mr. Malik or Mr. Ruf previously, or have you?
A. No, I haven't.
Q. You don't know the Gonda family at all?
A. Not at all.
Q. You don't know any of the defendants in this case?
A. No.
Q. When you were reviewing these voluminous file materials in front of you, did you make any notes, Doctor, along the way *to* help you chronicle the events in that case?
A. No.
Q. You never have made any written notes at

Page 26

all?
A. That's not my usual practice. I don't – I don't usually make notes.
Q. And in this case you have made none?
A. That's correct.
Q. You have, to my knowledge, been involved with two – I will call them reports, although I think one technically is just a question and answer session, with Mr. Malik?
A. There were – there are two letters dated January 17, '97 and April '97, which can be considered reports. And then a third report on March 25, 1998, which is more specific.
MR. BANAS: Will you repeat that, Doctor?
THE WITNESS: Sure. There are three letters dated January 17, 1997, April 21, 1997, and then one in March of 1998, which were to Mr. Malik.
MR. BANAS: So you have a report of January 17th, '97, April 17th –
MR. TRAVERS: April 21.
MR. BANAS: 21. Sorry. I have a March 25th, '98, and a November 23rd. Are all those correct?
THE WITNESS: Okay.

Page 27

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

Page 28

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

Page 29

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

Page 30

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

Page 31

he was continued with treatment at that time.
On the 26th he saw Dr. Adornato, and he
was complaining of a viral pharyngitis with a fever
and he received another antibiotic with some
improvement but continued fever.
On the 27th he saw Dr. Ruiz, and despite
antibiotics he continued to have a fever.
He had been treated at that time and was
found with a fever of 99.2 and an increased heart
rate.
The physical examination showed clear
lungs and an electrocardiogram was obtained. This
was felt to be a juvenile variant, T pattern of - a
T pattern on the anterior leads versus ischemia.
And his white count was found to be
elevated.
A chest x-ray showed clear lung fields and
a normal heart size.
I believe at that time, although I am not
clear on the timing, that a limited echocardiogram
was obtained which showed no pericardial effusion
by
a verbal report. I don't have any record of a
written report on that in my records.
On the - on the 5th of July he presented
again for - continued not feeling well, continued

Page 32

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

Page 33

(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.

Page 34

(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
which
(16) 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

Page 35

(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

Page 36

(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

Page 37

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

Page 38

not agreed by Dr. Ruiz or Dr. Cropp or de Marco or their lawyers that this patient had IBE.
But for my questions at this point I am going to assume that your opinion is correct and that that is the disease process we are dealing with. Okay?
A. Fine.
Q. Do you have an opinion as to whether his condition was acute or subacute?
A, That term, even in 1995, was going by the wayside, and we find that there is a spectrum of bacterial endocarditis, rather than a separation into subacute or acute.
His disease would fit a course of progressive endocarditis which became fulminant at the end.
Q. Because -
A. Is that clear?
Q. I -
A. We don't really split it into subacute or acute anymore, or then.
Q. I'm assuming, because you use the term "IBE," that you have excluded fungal infection. You think this is bacterial?
A, It's more likely that it's bacterial. I

Page 39

haven't excluded a cause, particularly.
Q. Well, do you know the causes?
A. Well, no, I don't. We don't have an adequate blood culture off antibiotics where we could find the causes.
Q. Are you familiar with the findings concerning what pathogens were identified?
A. Yes, I have seen that.
Q. Do you think that any of those that were identified were the causative organism in this case?
A. I can't tell you.
Q. Do you know when David Gonda developed endocarditis?
A. Before June of 1995, and that's all I can say.
Q. Do you know whether it was during calendar year 1995?
A. I can't tell you. It's more likely that it developed early. It's more likely that it developed during the time period when he was having his initial symptomology which presented at the University Health Service.
But I can't tell you exactly when and I can't tell you the causative reason for it, either.
Q. Would you agree that this would be an

Page 40

extremely unusual presentation of that disease?
A. No. I would say it's unusual but not extremely unusual. I have seen people present with upper respiratory symptomology as the presentation for IBE.
Q. Do you agree that David had no risk factors for developing endocarditis?
A. I am not sure. Again, autopsy showed a scar on the right heart. I am not sure whether that was a nidus, N-I-D-U-S, for the planting or seeding of bacteria.
But in terms of valvular abnormalities, no, he had no predisposing factors. And I also don't think he was an intravenous drug abuser.
Q. This would be a native valve endocarditis then?
A. A native mural endocarditis, in this case.
Q. Would you agree that that aspect of IBE is less common than valve involvement?
A. Yes.
Q. Can you estimate what percentage of patients who have IBE have no valvular involvement?
A. I can't.
Q. Minute?
A. It's small. It's unusual.

Page 41

Q. Extremely unusual?
A. Yes. But in the –
MR. MALIK: Objection.
THE WITNESS: It is unusual, but in the face of a changing electrocardiogram and a fever of unknown origin in this case it might not be so unusual.
MR. TRAVERS: Q. I'm sorry. I don't understand that answer. For a patient –
A. If you take out of the brew how common it is that a mural endocarditis with no valvular involvement occurs, yes, it's unusual. But in this clinical setting it's not that unusual, with a fever and a change in the electrocardiogram. It has to be included as a possible, even probable cause of this patient's symptoms. In each case it's a hundred percent basically or zero.
Q. Can you – do you have any idea of the percentages of patients with IBE who have native valves?
A. I don't understand what you mean.
Q. Well, would you agree that a large percentage of patients who develop endocarditis have prosthetic valves?

Page 42

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

Page **43**

Q. You indicate that the biggest cause of endocarditis today is mitral valve prolapse?
A. That's correct.
Q. David Gonda had no mitral valve prolapse?
A. No. Apparently, by autopsy, his mitral valve was not involved.
Q. These questions, just by way of assisting you in trying to understand where I am here, is still a subcategory of risk factors or his lack of risk factors.
Do you hold an opinion concerning whether his age would place him substantially less **at** risk for these – for this disease than someone substantially older?
A. Again, mitral valve prolapse is a disease of young women. So in young males it's rare unless they were IV drug abusers.
Q. Okay. I am not asking about mitral valve prolapse. I am asking about IBE.
A. No, but you're asking about risk factors in terms of age. So – young women are at risk for it but young men are at less risk. So it's uncommon in this age group.
Q. For a male?
A. For a male without significant valvular

Page 44

problems.
Q. Would you have any idea what percentage of patients with endocarditis would be – what male patients would be under 30 years of age?
A. No.
Q. Minute?
A. It's small again.
Q. Well, "small"is a term that is not – less descriptive.
A. Less than ten percent maybe of cases. Unless they're IV drug abusers.
Q. I am including IV drug abusers.
Less than two percent?
A. I don't know.
Q. Do you know if it would be less than a half a percent?
A. I don't know.
Q. The patient had no congenital heart disease that we're aware of; correct?
A. That's correct.
Q. That could be a risk factor for endocarditis?
A. Yes.
Q. The patient had no history of damage to any of his valves; correct?

Page 45

A. That's correct.
Q. He had no malignant or premalignant lesion
that we are aware of?
A. That we're – no.
Q. That's also a potential risk factor?
A. Yes.
Q. He had no trauma that we're aware of;
correct?
A. Correct.
Q. He's had no GI tract surgery that we're
aware of?
A. No.
Q. He's not an IV drug abuser?
A. To the best of our knowledge, that's
correct.
Q. Would you agree that all of these areas
that I have questioned you about were risk factors
for the development of IBE?
A. Yes.
Q. Isn't it true that in retrospect, when you
have a patient with endocarditis, looking back, you
can always identify some type of risk factor that
led to the development of that disease?
A. No.
Q. I am not a physician, Doctor, but from a

Page 46

lay person's perspective it seems to me that there
has to be a reason why a patient would get a disease
of this nature.
And we have identified a huge number of
different reasons why that sometimes happens.
But in this case we have no idea why David
Gonda got endocarditis; is that fair?
A. That's correct. That's why medicine is an
art, not a science.
Q. That's not troubling to you at all that
you have no explanation as to how he could have
gotten this?
A. **No,** not at all. Many times we don't find
the initial insult.
Q. Other than fever, can you identify any
physical manifestations of the disease that David
presented with?
A. Tachycardia.
And that's in the initial phase of his –
of his illness. Toward the end, the emboli are
consistent, also, and the hemoptysis are consistent
with the endocarditis.
Q. Are you suggesting that tachycardia is
specifically indicative of endocarditis or is simply
indicative of some disease process or infectious

Page 47

process?
A. No. You asked me what was consistent with
it, what would lean toward it, and fever and
tachycardia are consistent with it.
Those were the only signs he presented
with: fevers of unknown origin and tachycardia.
Q. Would you agree that there is a huge
variety of physical presentations that normally
endocarditis patients have?
A. Yes. It can be a wide variety of
presentations.
Q. Murmur is certainly high on the list?
A. When the valve is involved, yes.
Q. Do you have any idea of the percentage of
cases in which there is nonvalve disease?
A. It's small. I think I answered that
already.
Q. Did the patient – is splenomegaly a
presenting symptom for IBE patients, generally?
A. A sign. And generally, it's found – I
wouldn't say, generally.
Q. Frequently?
A. Sometimes.
Q. That was not present in David; correct?
A. No.

Page 48

Q. Petechiae?
A. As I said, the only things that were
present – you can go through the whole list but the
only things that were found at this time were the
tachycardia and fever.
Q. I suppose your suggestion is a good one,
at *500* dollars an hour, to not go through all of
these. But there is –
MR. MALIK: Objection; motion to strike.
MR. TRAVERS: Q. – a variety of signs
that IBE patients normally have that David Paul
Gonda did not have; correct?
A. And those are usually associated with
left-sided IBE, yes.
Q. Is shortness of breath a sign of
endocarditis?
A. It's a symptom that can be associated with
it. A sign is a physical thing that you can touch.
Okay?
A symptom is a complaint that's
subjective. Yes, it can be associated with it. Can
be associated with fever; it can be associated with
tachycardia as well.
Q. And in this huge – not huge, but half a
dozen textbooks that you thought had reliable

Page **49**

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

Page 50

Q. It does not suggest including it, though; correct?
A. It does not suggest excluding it. Any febrile illness should include infectious bacterial endocarditis as an initial differential.
Q. Is a cough something that would be considered a normal sign or symptom of IBE?
A. Only as I've described in the previous questions. If it's right-sided and there is some lung involvement, yes, a cough could be associated with it. It's not the most common thing. But again, if you're considering a right-sided endocarditis, yeah, you'd expect either a cough or shortness of breath or some lung signs to be associated with it.
Q. I am going to have to back up, Doctor. When we talked about signs or symptoms suggestive of SPE, there is splenomegaly, petechiae, splinter hemorrhages; correct?
A. Correct.
Q. Roth's spots?
A. Roth's spots.
Q. Osler's nodes?
A. Osler's nodes.
Q. Embolic episodes?

Page 51

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

Page *52*

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

Page 53

gonna do it.
Q. I am going to ask, Doctor, to please stop
doing that. Would you?
A. I answer the questions as to the best of
my ability.
Q. Are you aware of any text or journal
suggestive that shortness of breath or cough are
common signs or symptoms of IBE?
A. There are no articles that say they are
common. I am not aware whether they say that they
are associated with right heart, SPE or IBE or not.
Q. Thank you.
MR. MALIK: Objection back there.
MR. TRAVERS: Q. How about laboratory
values, Doctor, do you expect any changes in lab
values in a patient with IBE?
A. Yes.
Q. And what are those, generally?
A. The most common thing is an abnormal
sedimentation rate, which was not done in this case.
You would also expect a leukocytosis,
which was present in this case. You may also see,
in left-sided IBE, liver function abnormalities,
hematuria and anemia.
Q. Are you aware, Doctor, as to whether or

Page 54

not you can have endocarditis without developing
cardiac vegetations?
A. By definition, there has to be something
in the heart to have it be an endocarditis, so I
don't think that's possible.
Q. Would you agree with the statement that
infective endocarditis is an infection which
produces vegetations on the endocardium?
A. It produces a mass on the endocardium.
Either on the valve or on the wall.
I don't know what you mean by a
vegetation. Could you define what you mean?
Q. Doctor, you are the one Board certified in
cardiology and internal medicine, and you don't know
what the term "vegetation" means; is that what
you're telling me?
A. I know what the term "vegetation" means,
but that doesn't – that doesn't describe –
Q. What does the term "vegetation" mean?
A. A vegetation is a fibrinous mass which may
or may not include the bacteria to a degree that
they are visible somewhere on the coating of the
heart, the interior wall of the heart, or valves.
Q. Any kind of mass, a myxoma, is that a
vegetation?

Page 55

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

Page 56

A. Geographic community. Out here strep
viridans is not the most common. And I couldn't
tell you worldwide.
Q. What's the most common in California?
A. The most common in California is Staph.
aureus now. A bad one.
Followed closely by strep pneumonia, and
strep viridans, almost the same.
Q. That's because of the California
population having more depressed immune symptoms
than we do in Ohio?
A. I think so.
Q. Do you agree that IBE that is caused by
strep viridans on damaged valves occurs and, if
untreated, takes more than six weeks or even a year
to be fatal?
A. In most cases, yes. Unless they're immune
suppressed, or in some other way –
Q. We are not aware that David Gonda was
immune suppressed in any fashion; is that correct?
A. That's correct.
Q. So if strep viridans is the most common
form of endocarditis in the Midwest – and I think
that you acknowledge that to be true?
A. I believe that's so. I am not sure, I

Page 57

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

Page 58

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

Page 59

Staph.
It's more - I go back to the same statement, it's more likely than not that if it was diagnosed in an appropriate and timely manner, that his treatment would have prevented his death.
Q. Without knowing what the bug was?
A. Regardless of the bacteria.
Q. If it's Staph. aureus aren't 40 percent of those cases resulting in mortality?
A. If it was Staph. aureus, then in June he would have had a fulminant course, according to you, that would have killed him before August.
So it's not likely that it was Staph. aureus.
Q. Well, if it was Staph. aureus isn't there a 40-percent mortality rate associated with that?
A. Yes. So there is a 60-percent survival rate.
MR. MALIK: Objection.
MR. TRAVERS: Q. It's those kinds of figures that prompted you to say it's more likely than not?
A. Exactly. And medical certainty is greater than 50-percent likelihood.
Q. If there had been cultures done of

Page 60

Mr. Gonda, do you think that they would have been positive?
A. If they were done appropriately, yeah.
Q. Can you say that they most - that they definitely would have been positive?
A. No. There is a small number of cases that are culture negative.
Q. And we don't know whether his disease was caused by a pathogen that's culture negative?
A. Exactly.
Q. So there - you cannot say with any certainty as to whether cultures would have been positive or not without knowing what the pathogen was?
A. It's more likely than not that the cultures would have been positive. Much more likely than not.
In bacterial endocarditis over 90 percent of the cultures are positive if done appropriately.
Q. How long would he have had to have been taken off antibiotics in order -
A. Three or four days would have been adequate.
Q. If a 2-D echo would have been done would that have positively identified the existence of his

Page 61

heart lesion?
A. No. In more cases than not, the 2-D echo
is negative in known IBE.
An appropriate test is transesophageal
echocardiogram if you suspect IBE.
Q. There are a lot of different experts in
this case, Doctor, with a lot of different opinions.
I had the impression that you were critical of
Dr. Ruiz for not having gotten 2-D echo in this
patient. Am I mistaken about that?
A. An echocardiogram. My criticisms of
Dr. Ruiz are that he did not take the patient off -
did not make a differential diagnosis which included
bacterial endocarditis, did not take the patient off
antibiotics when he found the abnormalities on
physical and electrocardiogram, and take
appropriate
blood cultures.
And if the blood cultures were positive,
which more likely than not they were, do either a
transesophageal echocardiogram or a 2-D echo
cardiogram.
If the blood cultures were positive the
patient would have been hospitalized and treated
with intravenous antibiotics, which is the treatment
at that point.

Page 62

Are those opinions clear?
Q. In my view, not by including both 2-D echo
and TEE in the same answer.
Either one of those tests would have
satisfied your criticism?
A. If the blood cultures were positive, which
I assume they were, the more appropriate test is a
TEE.
Doctor - cardiologist would order that
test. And Dr. Ruiz is holding himself out as a
cardiologist.
If he - if he is found to be strictly an
internist, then the standard of care would include
only a 2-D echo at that time.
Q. What makes you say that Dr. Ruiz was
holding himself out as a cardiologist?
A. I received from Mr. Ruf his yellow pages
ad which includes cardiovascular diseases in his
advertising.
Q. Internal medicine specialists do not
address cardiovascular diseases?
A. Well, there's a subspecialty of internal
medicine. And if you're holding yourself out to be
an expert in cardiovascular disease as welt, and
label it specifically as that, then the standard is

Page 63

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

Page 64

A. Was it '88?
Q. I think it was '88. I may be wrong about
that.
A. Is this the one? I don't see a date on
this.
(Witness examines document.)
Suffice it to say the prior
electrocardiogram - and I'll assume it's 1988 -
was normal.
Q. Well, he was - the one that you have
handed us, he was age 21. So -
A. That's about it.
Q. I am guessing that's about it.
A. I think this is the one. It popped into
my hand so easily.
Q. And your interpretation of those strips
is -
A. He has a -
Q. - within normal limits?
A. Yeah. He has what we call a low atrial
rhythm, but otherwise it's normal.
Q. You can read that copy sufficiently to
make that determination?
A. Yeah.
MR. MALIK: Is this the same one? There

Page 65

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

Page 66

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

Page 67

interpretation.
Q. So you don't believe that he considered
that a possible explanation?
A. If he did or he didn't, I – he misread
this electrocardiogram.
Did you want to put these in?
Q. No. I think everybody has copies of those
studies.
Was there ever a time, Doctor, in which
the opinions that you held critical of the doctors
were based on an underlying opinion that - other
than the patient having endocarditis'?
A. In our initial discussions, I specifically
stated to Mr. Malik that I thought it was
endocarditis. And the underlying autopsy did not
confirm this, although it was consistent with it.
So, no, there was never a time that I did
not think it was endocarditis.
Q. In describing the cardiac lesion that
would be caused by endocarditis, would you ever
refer to that as a tumor?
A. No.
Q. If you were to use the word, "tumor,"
then, you would be thinking of a disease process
different than endocarditis; correct?

Page 68

A. On the initial letter I stated that had
the right ventricular tumor been diagnosed it could
have been treated. And that was on the basis of the
findings of the autopsy, which were consistent with
an endomyocardial fibrotic tumor.
My opinion at that time and still is that
it was infectious bacterial endocarditis.
However, my opinion is that, if it truly
and really is an endomyocardial fibrosis, which I
don't think it is, it could have been treated in
June at that time and the patient would have been -
would have survived.
Q. I thought we – I don't want to go back to
two hours ago, but I thought we established a long
time ago that you don't claim to know whether he
would have survived or not if he had EMF?
A. I said it could be diagnosed, it could
have been treated, and I would leave the survival
aspects up to the - and I'm sorry, I misspoke at
that time. I meant, could have been treated and I
leave the survival aspects up to the person who
would treat it.
Q. It could be treated, but you don't have an
opinion as to whether it could be successfully
treated?

Page 69

A. That's right. But my opinion at that time, and still is, that it was more likely than not infectious endocarditis. There just was no evidence available because appropriate diagnostic tests were not performed. I was asked specifically to address this issue in this letter.
Q. When you drafted that report - and we're referring to the one January 17th of '97, endocarditis was not part of that report; would you agree?
A. That's correct.
Q. You were addressing the issue of whether failure to diagnose the right ventricular tumor constituted medical negligence?
A. That's correct.
Q. And you thought that it did, that there was negligence in not diagnosing the tumor?
A. My opinion at that time was that the changes, the fever and – the persistent fever and electrocardiographic changes would have warranted blood cultures and an echocardiogram.
And on that echocardiogram, if a right ventricular tumor did exist, it would have been found.

Page 70

But also that the blood cultures and the echocardiogram would have found a right infectious endocarditis. I was not asked to include that in this report, therefore didn't.
Q. You then did another report dated April 21st?
A. That's exactly right, Yes.
Q. This apparently was after a couple of conversations you had with Mr. Malik; yes?
A, That's correct.
Q. And when you drafted the report in April of 1997, it does not address the issuing of endocarditis, either, does it?
A. It specifically states the right ventricular mass would have been diagnosed at that time. And it's my opinion that the right ventricular tumor could have been treated.
It was not - again, it does not address endocarditis specifically, but it addresses a right ventricular mass, which could have been either at the time.
Q. But they go on to call it tumor. You use the word in your April 21 letter, you were using the words "mass" and "tumor" to identify the same lesion?

Page 71

A. Correct. And again, this was specifically asked to address the diagnosis of the mass, whatever the cause.
Q. And believed in April of 1997 that the right ventricular tumor could have been treated; correct?
A. Yes.
Q. As it turns out, it wasn't a tumor at all; right?
A. If everybody decides that it's a tumor and it's not infectious endocarditis, it still could have been treated, is the basic thing.
It's my opinion that it's infectious endocarditis, and I believe that's confirmed by a reevaluation of the autopsy.
Q. You say you reviewed Dr. Hook's deposition transcript?
A. Yes, I did.
Q. Do you disagree with any of her testimony concerning the opinions or the - her findings at autopsy?
MR. MALIK: Objection.
THE WITNESS: Which ones specifically do you mean?
MR. TRAVERS: Q. You're right. That's

Page 72

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

Page 73

if they were misread. So I don't believe he had the full information that Dr. Ruiz had. I believe if he had awareness of the changes in the electrocardiogram and the persistence of the fever, he would be below the standard of care of a physician.
Q. Had cultures been ordered in this case by Dr. Ruiz and they were found to be negative, would you then have no criticisms of him?
MR. MALIK: Objection.
MR. RUF: Objection; on or off antibiotics? This is Mark Ruf.
THE WITNESS: If appropriate cultures were obtained, I would have no complaints; that would be an appropriate evaluation.
MR. TRAVERS: Q. If the patient had EMF would you agree that cultures would likely be negative?
A. Yes.
Q. Doctor, do you – you do acknowledge that this patient's medical condition was substantially different in August than it had been in June?
A. Yes.
Q. He had a clear chest x-ray in June?

Page 74

A. Yes.
Q. And by August it was a grossly abnormal study?
A. Yes.
Q. Do you – I have come all the way out here to California. I want you to look me in the eye and tell me truthfully that when Dr. Ruiz saw this patient on two times in early summer of 1995 that you believe that he committed malpractice by not diagnosing this man's condition?
MR. MALIK: Objection.
THE WITNESS: That isn't what I stated. I – if he had done the appropriate tests and failed to diagnose it, he would not have committed malpractice, because the appropriate tests would have been ordered. My problem is – and I think anybody's problem would be – the misdiagnosing of an electrocardiogram in the face of persistent fevers, and not even including it in the differential and not doing the appropriate tests; that is malpractice.
MR. TRAVERS: Q. When a patient has endocarditis and comes to you with symptoms, is it an easy or difficult diagnosis to make?

Page 75

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

Page 76

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

Page 77

A. Yes.
Q. I note, then, that the impression at the
Cleveland Clinic was probable angiosarcoma.
A. Yes.
Q. In other words, as I look at this set of
records, the people at the Cleveland Clinic, after
having reviewed the St. Elizabeth records, did not
come to the IBE diagnosis?
A. Yes.
Q. Significantly, if you look a little
further across the final anatomic diagnosis – I
have page 16 of your time line.
A. Okay.
Q. The myocardial fibrosis of right ventricle
with associated thrombus extending from the
ventricular free wall into pulmonary outflow tract.
Have I read that correctly?
A. Correct.
Q. Their final anatomic diagnosis was EMF?
A. Correct.
Q. Now, Doctor, let's go to your letter of
March 25, 1998.
You have that?
A. Yes.
Q. Sorry. I am having a drink of coke.

Page 78

Number 2 in the first paragraph, the TEE which I
reviewed is consistent with this diagnosis.
A. Yes.
Q. This was consistent with IBE?
A. That's correct.
Q. Consistent with?
A. Yes.
Q. Yes, but what?
A. There is a mass in the right ventricle.
Q. Okay. What was the TEE consistent with?
If it was consistent with IBE was it consistent with
anything else?
A. Yes.
Q. Tell me what it was consistent with?
A. Okay. It was also consistent with a
myxoma, an angiosarcoma or possibly
endomyocardial
fibrosis.
Q. Let's go a little further down the same
report of March 25, 1998.
There is a reference here to two EKGs or
two CK, June 27, '95 and May 15, '89.
You see that?
A. Yes.
Q. Do you know that Dr. Cropp or Dr. de Marco
did not have any of that information?

Page 79

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

Page 80

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

Page 81

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

Page 82

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

Page 83

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

Page 84

way, that he fell below the standard of care of a reasonably prudent Board-certified pulmonologist?
A. No.
MR. BANAS: I have nothing further.
MR. BLOMSTROM: I have a few questions now. As you know, I represent Dr. Hafiz.
EXAMINATION
BY MR. BLOMSTROM:
Q. Let me ask you this. Do you like to think of yourself as being an open-minded fellow when presented with additional information? Or looking at information a bit closer than you may have before, are you willing to change your opinions when that's necessary?
A. That's obvious.
Q. I think you just did it; right?
A. That's correct.
Q. Well, we're going to start talking about Dr. Hafiz at this point.
A. Okay.
Q. You claim any expertise in the field of radiology?
A. No.
Q. Are you aware of how it was that the

Page 85

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

Page 86

"Question. Okay. And had you wanted to know the etiology of a cardiac condition, you would have sent the patient for a two-dimensional ultrasound; correct?
"Answer: Had I been looking for that, that would have been the next step.
"Question: Okay.
"Answer: Yes."
Now, we are going to turn to page 29.
A. Just a second.
(Witness examines document.)
A. Okay.
Q. And go from 29, line 1.
"Question: I stand corrected. Is it a fair statement to say that by ordering the ultrasound study of the pericardium, that you limited your diagnostic capability only to the pericardium, and did not – and not – did not include the rest of the heart?
"Answer: I was only checking for the pericardium.
"Question: So the answer would be yes?
"Answer: That's yes.
"Question: Okay. By performing the limited ultrasound we have then avoided, or you

Page 87

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

Page 88

as the ventricle or atrium?
"Answer: No, sir."
Did I read all of this correctly?
A. Well, there you have it.
Q. There I have it. So –
A. So I withdraw any complaints for Dr. Hafiz.
Q. Well, that will –
A. That's – there you have it. I did not have that information when I did that, my report, obviously.
MR. BLOMSTROM: Okay. Well, then I'm done. Thank you very much.
THE WITNESS: Okay.
MR. BANAS: Tom, you have any more?
MR. TRAVERS: I have some time left, so –
MR. BANAS: I don't have any more. Go ahead.
FURTHER EXAMINATION
BY MR. TRAVERS:
Q. Doctor, when in time do you think that TEE or perhaps a 2-D echo would have been able to identify a lesion in David's heart?
A. It's more likely than not that in June it would have been present.

Page 89

Q. Did you read Dr. Hoffman's deposition transcript? A. I reviewed it and obviously I don't agree with his timing. I don't know – my experience *with* pathologists is that they can't really time how long a mass has been present, and I don't know how he did that. It's my opinion that it would have been there in June. Q. Don't you think that a person who has actually seen the lesion is in a better position to make a judgment as to how long it would have been present? A. I would like to hear a better explanation of it. It's – it's my opinion that it would be there in June something. Q. I understand that. But my question is, don't you think that a person who actually visualizes the lesion itself would be in a better position to make a judgment as to how long it was there? A. That's a reasonable statement. Q. How about someone who had visualized photographs or slides from the autopsy study, would

Page 90

that person be in a better position to make that judgment than someone who had seen neither? A. Again, that's a reasonable statement. I'd like to add, if it's okay with you, that the slides were taken from different areas, and I don't know the specific areas. It's very conceivable that the areas that were not – where the slides were not taken from, particularly the base, might have been more likely – in my opinion, again, were there at the time in June. Q. Do you think that the patient's cough was attributable to his endocarditis that you believe he had? A. I can't say. Q. It is equally possible one way or another that it was – I think Dr. Morgenstern-Clarren used the term, "red herring." A. I can't – I can't really say one way or the other. That I – I just can't say. It could be related to it; it couldn't. I don't have enough information to tell you. Q. What other information would be helpful to you? A. The blood cultures.

Page 91

Q. That would tell you whether the cough was related? A. Well, if the blood cultures, more likely than not, were positive, and there was the mass there, it's – it's likely or possible that the cough is related to pulmonary complications of the right-sided – right-sided IBE. So it could also be an associated cough related to an upper respiratory infection. I really can't say. An unassociated upper respiratory infection. Q. If there was an unassociated upper respiratory infection, could that lead to the development of infectious endocarditis? A. Conceivably. Q. That's not normally the route that a patient develops that disease, though; correct? A. It would lead to a pneumonia. You would look for something before the right heart in the venous return system to account for it. It would have to filter through the lung and then back through the system again to filter through again, and that would seem unlikely that a lung infection could cause – sinus could cause it, obviously.

Page 92

Q. Do you recognize that his cough was Mr. Gonda's primary complaint when he went to these various physicians? A. Yes. Q. And in your judgment, that may or may not have been related to his underlying disease? A. That's correct. Q. Are you aware as to whether or not the patient had episodes of chills? A. I don't believe he had chills. I could be wrong. Q. You wouldn't expect a patient with endocarditis to have chills? A. They can. Q. In a patient with a fever and a cough presenting to an internal medicine specialist, do you agree that it is reasonable of that clinician to secure the consultation of a pulmonologist? A. Not necessarily. Most of the upper respiratory infections can be treated by family practitioners or internists. If it becomes problematic, then it's appropriate, or if there are other signs or symptoms that it's a difficult disease, such as – if you have a pulse oximeter in the office and they're

Page 93

hypoxic, then it might be reasonable.
Q. Does it depend upon how many different
antibiotics had been attempted to treat the
patient's condition unsuccessfully?
A. Again, that's getting into the problematic
areas of the disease, and it's appropriate at that
time to get a consultation.
Q. With the pulmonologist?
A. With a pulmonologist or an infectious
disease doctor.
Q. When a physician such as Dr. Ruiz secures
a consultation with the pulmonologist, what would
you expect the role of the pulmonologist to be at
that point?
A. To evaluate the patient and treat the
patient and make recommendations.
Q. And it's reasonable, then, for the
referring clinician to rely upon the assessment and
recommendations of his consultant?
A. If it's based on full and factual
information, yes.
Q. In this case, though, you don't believe
that it was reasonable of Dr. Ruiz to go along with
the suggested course of treatment by the
pulmonologist?

Page 94

A. Well, now that I know that they didn't
have access to the electrocardiographic report
which
was misread, no, that's not full and factual
information.
It might have been reasonable – they – I
didn't see this in the records, but he may have
given them a report that the electrocardiogram was
unremarkable, and it's remarkable. And that might
lead a prudent doctor to suspect something with the
heart.
Q. Certainly, a patient who presents with a
cough and a fever, in establishing a differential
diagnosis based on those two conditions, heart
involvement is way down the list; wouldn't you
agree?
A. In a patient who presents with that, it's
way down the list. Except when there's a change in
the electrocardiogram.
Q. You're aware that Dr. Ruiz had heard a
systolic click at one point –
A. Yes.
Q. – in this patient?
A. Yes.
Q. Do you find that to be of any
significance?

Page 95

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

Page 96

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

Page 97

A. Had begun, you mean?
Q. I'm sorry?
A. I was finishing your question. I thought there was more to the question. I'm sorry. Had embarked on or something. Had to be a verb in there somewhere.
Q. I don't always use verbs.
A. Okay. In the face of the remarkable changes in the electrocardiogram, I think it would have been prudent to obtain blood cultures. But since he misread the electrocardiogram - you know, we're dealing with a hypothetical. If he had known that the electrocardiogram had been remarkably changed, he would have - a prudent doctor would have embarked on his own course of evaluation.
So with false knowledge, following the recommendations of Dr. Adornato is not - not unreasonable. But if he had known the knowledge, a different, a whole different course of action would have been pursued.
Q. So the interpretation of this EKG study is pretty critical to your opinions?

Page 98

A. Yes.
Q. Are these tracings - or are EKG tracings generally subject to opinion?
A. Yes. Yes.
Q. Would you agree that this tracing is subject to different interpretations?
A. Yes. But in comparison to the one prior, I don't think there is any disagreement that this is a remarkable change, a significant change.
Q. What are other theoretical possibilities to explain that change, in addition to lesion of the endocardium?
A. As I said, anything which would indicate right ventricular overload or hypertrophy, there are many conditions that can cause that.
Q. What are they?
A. Pulmonary hypertension is one. Pulmonic stenosis is another. Intracardiac shunts would be a third one.
Off the top of my head those are the most causes. Or an AV fistula somewhere in the body. Anything that causes right ventricular overload.
Q. Do you believe that EKG is an appropriate screening tool for IBE?
A. Not usually. The appropriate screening

Page 99

tool is a sed rate and blood cultures off antibiotics and a good clinical exam to hopefully hear a murmur which may or may not be present.
Q. Do you believe you have some insight into why Dr. Ruiz ordered an EKG in this case?
A. I think it was because of the chest discomfort associated with the cough. But that's about the best I can come up with.
Q. You have some understanding of the nature or severity of Mr. Gonda's chest discomfort complaints?
A. No.
Q. Are you aware as to whether or not a sputum culture was ordered?
A. I believe a throat culture was ordered, but I don't remember a sputum culture being ordered at that time.
Q. Is a throat culture -
A. I think the throat culture was ordered by Dr. Adornato.
Q. Is that a reasonable test for a person with these symptoms?
A. Yes.
Q. Do you know the results of that culture?
A. No. I'd have to look it up. The throat

Page 100

culture?
Q. Yes.
A. I think it was negative.
Q. Do individuals with IBE sometimes present with positive throats or sputum cultures?
A. I'm not sure. It's conceivable.
Q. Other than not ordering blood cultures and, in your judgment, misinterpreting the EKG, do you have any other criticisms of Dr. Ruiz in this case?
A. Only as we mentioned, the echocardiogram would have been a reasonable and prudent test in the presence of the EKG.
MR. TRAVERS: I believe those are all the questions I have, Doctor.
THE WITNESS: Good. You have anything there?
MR. BANAS: Tom, are you done?
MR. TRAVERS: Yes, sir.
MR. BANAS: I'm done. And Tom, why don't you order a copy **and** we'll split it with you, because you and I have the same client essentially. Okay?
MR. TRAVERS: That's fine.
MR. BANAS: Thank you, Doctor.

Page 101

THE WITNESS: Okay. Thank you.
THE REPORTER: Who is ordering a copy of the transcript?
MR. BLOMSTROM: I do need a copy.
MR. BANAS: We're shutting down at this end.
MR. RUF: Bye. Thanks.
MR. BANAS: And Mr. Malik, we will send you a check Monday.
MR. RUF: I designate Dr. Lehrman as an expert.
THE WITNESS: I am not an expert in radiology. I already said that in your -
THE REPORTER: Mr. Malik?
MR. MALIK: Yes. Ordering a copy of the transcript. ASCII and condensed.
MR. TRAVERS: I don't need a disk.
(Whereupon, the deposition of KENNETH L. LEHRMAN, M.D. was adjourned at 12:45 p.m.)

---oOo---

Page 102

CERTIFICATE OF DEPONENT

NOTE: If you are adding to your testimony, print the exact word you want to add. If you are deleting from your testimony, print the exact word you want to delete. Specify with "Add"or "Delete"and sign this form. If there are no corrections to your testimony, please sign and date this form.

EXAMINATION OF: KENNETH L. LEHRMAN, M.D.

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

DATE OF EXAMINATION: FRIDAY, JANUARY 29,1999

I, , have the following corrections to make to my examination.

Page Line Change/Add/Delete

Signature: Date:

Page 103

STATE OF CALIFORNIA)
) SS.
COUNTY OF SAN FRANCISCO)

I, HARRIET MARCH PAGE, CSR NO. **1284,** hereby certify that the witness in the foregoing deposition was by me duly sworn to tell the truth, the whole truth, and nothing but the truth in the within-entitled cause;

That said deposition was taken in shorthand by me, a certified shorthand reporter and a disinterested person, at the time and place therein stated and that the testimony of the said witness was thereafter reduced to typewriting, by computer, under my direction and supervision;

I further certify that I am not of counsel or attorney for either or any of the parties to the said deposition, nor in any way interested in the event of this cause and that I am not related to any of the parties thereto.

In witness whereof, I have hereunto set my hand and affixed my signature this day of , **1999.**

CERTIFIED SHORTHAND REPORTER,
STATE OF CALIFORNIA

Page **104**

PEREIRA & ASSOCIATES
Certified Shorthand Reporters
P. O. Box **4339**
Daly City, CA **94016-0339**
Tele: **(415) 469-9219**
Fax: **(415) 586-6183**
February **20, 1999**
Kenneth L. Lehrman, M.D.
901 Campus Drive, Suite **306**
Daly City, California **94015**

IN RE: DOROTHY A. GONDA, et al., vs JUAN RUIZ, M.D., et al.
CASE NUMBER: **96** CV 2055
DATE TAKEN: January **29, 1999**
OUR FILE NUMBER: **99-1 10**

Dear **Dr.** Lehrman,

Please be advised that the original transcript taken in the above-captioned matter has been completed and is now ready for your review, corrections, if necessary, and signature. You have thirty (30) days from receipt of this letter in which to read and sign your deposition. If you choose not to read or sign your deposition within thirty days, it will be deemed correct as is, and soon thereafter filed with the noticing attorney. If you are represented by an attorney, you may choose to examine your attorney's copy. If you choose to come to our office, please call to arrange a time which will be convenient for you. Also, bring this *letter* as a reference. If you have any questions, please contact your counsel. Thank you for your cooperation in this matter.

Sincerely,

Mercia Pereira Tiscornia,
RPR, CSR
cc: Original
Thomas J. Travers, Jr., Attorney at Law
Gary Banas, Attorney at Law (Letter)
James L. Blomstrom, Attorney at Law
David Malik, Attorney at Law
Mark W. Ruf, Attorney at Law (Letter)

Look-See Concordance Report

- - -

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

- - -

SINGLE FILE CONCORDANCE

- - -

CASE SENSITIVE

- - -

NOISE WORD LIST(@): **NOISE.NOI**

- - -

COVER PAGES = 4

- - -

INCLUDES ALL TEXT OCCURRENCES

- - -

DATES **OFF**

- - -

IGNORES PURE NUMBERS

- - -

POSSESSIVE FORMS **OFF**

- - -

MAXIMUM TRACKED OCCURRENCE THRESHOLD: **50**

- - -

NUMBER OF WORDS SURPASSING OCCURRENCE THRESHOLD: **5**

- - -

LIST OF THRESHOLD WORDS:

- - -

case [56]
Dr [82]
endocarditis [63]
IBE [53]
patient [51]

– 1 –

1-17-97 [2]
27:2; 28:9
12:01 [1]
76:4
12:07 [1]
76:5
12:45 [1]
101:19
13th [1]
32:5
16th [2]
35:7; 80:6
17th [7]
26:20; 69:9; 79:14; 80:5, 6, 7

– 2 –

2-D [11]
60:24; 61:2, 9, 20; 62:2, 14; 63:4, 7, 8, 12; 88:22
21st [1]
70:6
22nd [1]
30:18
23rd [1]
26:23
25th [1]
26:23
26th [1]
31:2
27th [1]
31:6
28th [1]
30:1

– 3 –

330-758-1835 [2]
27:22, 23

– 4 –

40-percent [1]
59:16
469-9219 [1]
104:3

– 5 –

5-15-89 [2]
65:18; 66:8
5-19-95 [1]
30:13
50-50 [1]
12:13
50-percent [1]
59:24
586-6183 [1]
104:3
5th [1]
31:24

– 6 –

6-14 [1]
72:13
6-14-95 [1]
72:10
6-24 [1]
72:14
6-26 [1]
72:14
60-40 [1]
7:4
60-percent [1]
59:17

– 7 –

7-10 [2]
32:3; 72:15
7-10-95 [1]
72:10

– 8 –

8-15 [1]
16:8
8-16 [1]
16:9
8-17 [1]
16:9

– 9 –

94016-0339 [1]
104:2
99-110 [1]
104:8

– A –

ability [2]
52:10; 53:5
able [1]
88:22
abnormal [3]
42:3; 53:19; 74:2
abnormalities [4]
40:12; 53:23; 61:15; 63:19
abnormality [2]
49:17; 66:4
above-captioned [1]
104:11
absence [1]
57:15
abuse [1]
57:19
abuser [2]
40:14; 45:13
abusers [5]
42:8; 43:17; 44:11, 12; 57:15
academic [2]
6:8, 10
accede [1]
49:15
access [1]
94:2
according [1]
59:11
account [1]
91:20
accurate [1]
25:10
accurately [1]
33:1
acknowledge [2]
56:24; 73:21
acknowledged [1]
51:7
acronym [1]
18:3
act [1]
7:23
acting [2]
10:3; 14:12
action [1]
97:22
activities [2]
6:17, 18
acute [4]
38:9, 13, 21; 66:19
ad [1]
62:18
Add [2]
102:3, 9
add [2]
90:4; 102:2
adding [1]
102:2
addition [4]
16:13; 20:12, 16; 98:11
additional [2]
27:15; 84:11
address *[6]*
62:21; 66:10; 69:6; 70:12, 18; 71:2
addressed [1]
66:8
addresses [1]
70:19
addressing [1]
69:13
adequate [2]
39:4; 60:23
adjourned [1]
101:19
administrative [2]
6:18, 21
admission [5]
16:4, **5, 8**
admitted [1]
30:16
Adornato [9]
31:2; 32:3; 72:3, 7, 9, 16; 96:17; 97:19; 99:20
adult [1]
7:22
advertise [1]
13:23
advertising [1]
62:19
advised [1]
104:10
advisory [1]
10:25
advocacy [2]
42:21, 25
advocate [3]
10:3; 42:14, 15
afebrile [1]
30:17
affiliated [1]
9:5
affiliation [2]
13:21; 14:5
affixed [1]
103:21
afforded [1]
19:12
Africa [1]
20:10
afternoons [1]
9:11
age [5]
43:12, 21, 23; 44:4; 64:11
agree [22]
17:15; 36:7; 39:25; 40:6, 18; 41:23; 45:16; 47:7; 54:6; 55:22; 56:13; 57:11; 58:9; 63:4; 69:11; 73:18; 75:5; 79:15; 89:3; 92:17; 94:15; 98:5
agreed [1]
38:1
agreement [2]
49:21; 63:11
airport [1]
9:19
al [4]
102:6; 104:6, 7
Alejandro [1]
17:4
American [1]
22:18
anatomic [2]
77:11, 19
anemia [1]
53:24
angioplasties [1]
8:11
angioplasty [1]
8:8
angiosarcoma [2]
77:3; 78:16
annual [1]
8:11
Answer [9]
85:25; 86:5, 8, 20, 23; 87:10, 14, 23; 88:2
answer [19]
10:1; 12:15; 26:8; 33:10; 41:9; 42:19, 23, 24; 52:8, 18, 20, 21, 23; 53:4; 62:3; 76:3; 86:22; 87:11, 13
answered [3]
47:16; 52:9; 76:16
answers [1]
42:14
anterior [3]
31:14; 65:14, 19
anteriorly [1]
66:1
Anthony [1]
16:21
antibiotic [1]
31:4
antibiotics [12]
31:7; 35:7; 39:4; 60:21; 61:15, 24; 63:17; 73:13; 80:21; 93:3; 96:20; 99:2
anticipate [1]
20:8
anybody [1]
74:17
anymore [1]
38:21
Apparently [3]
9:6; 43:5; 85:3
apparently [2]
70:8; 81:18
appeared [1]
11:8
appears [1]
32:10
appropriate [18]
19:11; 52:22; 58:1; 59:4; 61:4, 16; 62:7; 69:5; 73:14, 16; 74:13, **15,** *21; 82:11; 92:23; 93:6; 98:23, 25*
appropriately [3]
60:3, 19; 63:17
approximate [1]
8:10
Approximately [1]

– D –

– E –

– P –

– G –

– H –

– I –

– J –

– K –

– L –

– M –

– N –

– Q –

– R –

– S –

– T –

– U –