IN THE COURT OF COMMON PLEAS
CUYAHOGA COUNTY, OHIO

FRED W. PULTZ, et al., CASE NO: 433332

Plaintiffs, JUDGE JUDITH KILBANE-KOCH

vs.

DOUGLAS N. FLAGG, M.D., et al.,

Defendants.

128 Live Oak Avenue
Daytona Beach, Florida
March 26, 2002
1:50 p.m.

DEPOSITION OF ALLEN JAMES JONES, M.D.

The above and foregoing cause came on for hearing before me, Julie L. Weston, Registered Professional Reporter and Notary Public, State of Florida at Large, at the above time and place, for the purpose of taking testimony and evidence in said cause.

APPEARANCES:

HOWARD D. MISHKIND, ESQ.
Becker & Mishkind, Co., L.P.A.
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Cleveland, Ohio 44113
On Behalf of the Plaintiffs

ERNEST W. AUCIELLO, JR., ESQ.
Gallagher Sharp Fulton & Norman
Seventh Floor Bulkley Blg.
1501 Euclid Avenue
Cleveland, Ohio 44115
On Behalf of Defendant Allen J. Jones, M.D.

(Appearing telephonically)
GREGORY T. ROSSI, ESQUIRE
Hanna, Campbell & Powell, LLP
P.O. Box 5521
3737 Embassy Parkway, Ste. 100
Akron, Ohio 44334
On Behalf of Defendant Subhash C. Mahajan, M.D.

(Appearing telephonically)
STEVE WALTERS, ESQUIRE
Weston, Hurd, Fallon, Paisley & Howley, LLP
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On Behalf of Defendants Douglas N. Flagg, M.D., Richard M. Banozic, M.D., Primary Care Physicians Practices and University Hospitals Health Systems, Inc.

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THEREUPON
ALLEN JAMES JONES, M.D.
was called as a witness and, having first been duly sworn, testified as follows:
DIRECT EXAMINATION
BY MR. MISHKIND:

Q Would you please state your name for the record.

A Allen James Jones.

Q Tell me where your ... your home address. Where do you live?

A My home address is 1932 Southcreek -- "Southcreek" is one word -- Boulevard; that's Daytona Beach, Florida, 32128.

Q And your professional address.

A Drawing a blank. The building address ... I believe it's ... I'm drawing a blank. I believe it's 2701 South Ridgewood, but I wouldn't swear to that. I don't recall offhand. I'd have to ...

Q Are you self-employed or are you employed by an entity?

A Presently, I'm with a group. The name of the group is West Volusia Emergency Physicians, P.A.

Q West --

MR. ROSSI: Howard, if I could interrupt ... Doctor, if you could keep your voice up just a little bit. And, Howard, if you can try to talk louder. I can't speak for Steve, but I'm having a hard time hearing you.

MR. MISHKIND: You've never said that to me before, Greg.

THE WITNESS: Okay. Keep reminding me. I've got a cold and a sore throat, so it keeps fading ...

MR. AUCIELLO: Move closer to the phone anyhow.

MR. ROSSI: Right now, Doctor, you're perfect.

THE WITNESS: Okay.

All right. I'll try again. I'm sorry, the question ...

BY MR. MISHKIND:

Q I was asking you to ... you said the name of the group is West ... and I didn't catch the name.

A West Volusia, like the county. V-O-L-U-S-I-A.

Q And is that a group of emergency room physicians?

A That's correct.

Q How long have you been affiliated with that group?

A Since December of 1999.

Q Doctor, I'm going to hand you what I've marked as Plaintiff's Exhibit One, and ask you if you would take a look at this document -- it's two pages -- and tell me whether or not you recognize that document.

A Yes, I do; it's my ... a copy of my CV.

Q Okay. Is that a current copy of your CV?

A Yes, fairly current.

Q Is there anything that needs to be added to the CV to bring it up-to-date?

A No.

Q It's current and it's accurate?

A Yes, sir, with the exception ... some of the certifications may have lapsed on the ACLS ... the Advanced Cardiac Life Support and things like that on the front.

Q Why don't you just take a look and tell me just for the record what certifications may have lapsed just so that --

A Possibly the Advanced Cardiac Life Support instructor and things like that. I don't recall the expiration dates on some of those, but ...

Q Okay. Is Plaintiff's Exhibit One, then, with those potential modifications in terms of lapsing certifications, is it an accurate and up-to-date Curriculum Vitae?

A Yes, it is.

Q Do you have any other additions or versions of your CV that you use for accreditation purposes or licensure purposes or is this the one and only CV that you have?

A This would be it at the present time.
Q In looking at the CV, I do not notice any indication of any publications; have you written --
A That's correct.
Q -- anything?
A No, I have not.
Q You are an emergency room physician.
A Yes.
Q What hospitals do you work at?
A At the present time, the two hospitals are Florida Hospital-Fish Memorial in Orange City and Florida Hospital-DeLand in DeLand, Florida.
Q You mentioned the group that you're with as of December '99?
A Correct.
Q Is that when you left Cleveland?
A Yes.
Q How long had you been practicing in Cleveland?
A Since 1980.
Q What caused you to move to Florida in December of '99?
A The weather. My wife and I both decided to ... we had been wanting to move somewhere warm for a long time, so we decided to ... it was a good time to make a move. A good opportunity came up down here.

Q I noticed in your CV that your wife is a nurse; is that correct?
A Yes.
Q Does she practice?
A Not at the present time, no. We have a surprise two-and-a-half-year-old, so she stays home with the baby.
Q Doctor, have you ever had your privileges suspended or revoked?
A No.
Q Have you ever applied for privileges and been denied privileges at any hospital?
A No.
Q Have you ever been the subject of any disciplinary action in any capacity as a physician?
A No.
Q You are board certified; you told me that a moment ago.
A Yes.
Q Were you successful the first time through?
A Yes.
Q There are several other individuals that are involved in this case and I'm going to ask you just a couple questions about them, okay?
A Sure.
Q Dr. Flagg; do you know him?

A I know him professionally, mostly speaking to him by phone regarding his patients.
Q And that's the extent of your ...
A Yes.
Q You have had occasion to see his patients, other than obviously Mrs. Pultz, in the emergency room in the past; true?
A Yes.
Q Have you had any contact with Dr. Flagg at any time since September 25, 1999, where you called him or he called you relative to this patient?
A No, no.
Q Is it fair to say that you've never talked to Dr. Flagg about Mrs. Pultz?
A That's correct.
Q Is it fair to say that you have not discussed any aspect of this litigation with Dr. Flagg?
A That's correct.
Q Dr. Mahajan; he's a gastroenterologist; do you know him?
A Yes.
Q How do you know Dr. Mahajan?
A Again, professionally.
Q Where you have had patients that have come in through the emergency room and he has seen the patients on

consultation or otherwise?
A Yes.
Q The same question that I asked you with regard to Dr. Flagg. Have you had an opportunity to talk to Dr. Mahajan at any time since this lawsuit was filed about this patient?
A No.
Q Now this patient was seen ... and this patient I'm obviously referring to is Barbara Pultz.
A Correct.
Q You saw her in the emergency room on September 25, 1999; true?
A Correct.
Q And on that day, did you have an occasion to talk to either Dr. Mahajan or Dr. Flagg?
A I don't believe I did. I have no recollection of the case itself, but I don't believe I discussed ... almost certainly not with Dr. Mahajan and I don't believe with Dr. Flagg, either.
Q Is it fair to say that had you discussed the case with either of those doctors on September 25, 1999, that there would be a notation or it would be included in your dictation relative to having contacted Dr. Flagg or contacted Dr. Mahajan?
A Ideally, there would, but not necessarily. With

regard to the dictation, it appears that was done after seeing the patient but prior to the final disposition.

Q Whether we look at the dictation or any of your notes, can we agree that it doesn't reflect any communication with either of those doctors while the patient was at the hospital?

A There is no record of any communication, that's correct.

Q And do you have any reason to believe that you did communicate, while the patient was at the hospital, with either of those doctors?

A No, I do not.

Q Okay. There are several other names in the record. It looks like there's a couple of nurses that were involved. Do you know ... are you able to identify the nurses that were involved in the emergency room by name?

A I mean, if you told me the names, I would recognize them.

Q Let me ask you this, just to try to speed things along: In connection with preparing for today's deposition, what have you reviewed?

A I've only reviewed the emergency room report itself, a copy of which I have that was provided by my attorney. Feel free to review it, if you'd like. It's basically the same thing you have.

Q You have the entire Southwest General Hospital emergency room record, including the radiology report, including the labs that were done, including the discharge instructions --

A Yes.

Q -- correct?

A Correct.

Q You have not talked to either of the doctors, Mahajan or Flagg.

A I have not discussed the case with anyone other than Mr. Auciello.

Q What about reviewing any deposition testimony; have you seen either of the doctors, Dr. Flagg or Dr. Mahajan's depositions?

A I don't believe I have, unless they were sent --

MR. AUCIELLO: I think I told you about them, but I don't think I sent you the transcripts.

THE WITNESS: No, I have not.

BY MR. MISHKIND:

Q Have you made any notes at all --

A No.

Q -- in reviewing --

A No, I have not.

Q -- the records?

A No.

Q Have you made any notes at all with regard to anything about the deposition testimony of either of the doctors?

A No.

Q So what you have in front of you, which is the Southwest ER record, is that the totality of the --

A Yes.

Q -- information that you have?

A Yes, it is.

Q And I'm not going to look through your little briefcase there, but there's nothing --

A An e-mail regarding the deposition and a blank legal pad.

Q Fair enough.

Have you seen the autopsy in this case?

A No.

Q I take it, then, you don't hold any opinions in this case as to the ultimate cause of death --

A That's correct.

Q -- of Mrs. Pultz; is that true?

A That's correct.

Q Let me ask you, on September 25, 1999, who was your employer?

A Emergency Professional Services.

Q Were you working exclusively at Southwest General

Hospital in September of '99?

A I believe at that time, I may have been working a few shifts at Geauga Community Hospital also for EPS, but the bulk of my practice was at Southwest.

Q Within that entity, Emergency Professional Services, did you hold a title or a position?

A At that time ... at that time, no.

Q At any time.

A Prior to the group being bought out by a larger group, I was a shareholder. I think we were all assistant vice presidents while we were shareholders, but there was about 50 assistant vice presidents.

Q When was Emergency Professional Services bought out; was it before September of '99?

A Oh, yes. To the best of my recollection, '96 or '97.

Q Who was the entity that bought out Emergency Professional Services?

A Team Health.

Q Now a moment ago, I asked you who your employer was at the time and you said Emergency Professional Services; you didn't say Team Health.

A Right.

Q Why is that?

A It still kept the name that ... I believe

they ... The individual corporations under ... that were bought out by Team Health, still kept their identities as ... kept their original names.

MR. AUCIELLO: I think by a stock purchase.

BY MR. MISHKIND:

Q Do you know whether or not you were considered an employee of Emergency Professional Services or did you have an agreement that used fancy language defining you as an independent contractor?

A I believe after the buy-out, we were independent contractors.

Q Were you an independent ... was Emergency Professional Services your employer or were you an independent contractor through Emergency Professional Services, if you know?

A I don't know how to answer that.

Q Do you still have copies, if necessary, of any of the agreements that you had with Team Health or with Emergency Professional Services back in the '96 to '99 time period?

A I think I disposed of all of that.

Q Have you ever had your deposition taken before, sir?

A Yes.

Q How many times?

A Somewhere between five and 10 would be my best guess.

Q Putting this case aside, have you ever been named as a defendant in a medical negligence case?

MR. AUCIELLO: A general objection for the record for this line?

MR. MISHKIND: Sure.

THE WITNESS: Yes.

BY MR. MISHKIND:

Q On how many occasions?

A Probably six ... probably seven.

Q This would be the eighth case?

A I would guess.

Q Is that a reasonable estimate?

A Yes.

Q The reason I came back and asked that, because when lawyers hear the word "guess", that makes our ... the hair stand up on our arms, so I just want to make sure that that's a reasonable estimate. You may be off by one or so?

A Yes.

Q Were all the cases up in Cleveland or --

A Yes.

Q -- have any of the cases been down here?

A No. So far, none down here.

MR. MISHKIND: If I could have the CV back ...

THE WITNESS: Sure.

BY MR. MISHKIND:

Q Were any of the cases --

MR. MISHKIND: Strike that.

BY MR. MISHKIND:

Q Have any of the cases that you've been named as a defendant gone to trial?

MR. AUCIELLO: With him in it?

THE WITNESS: No, at least not with me in them. So some of them I don't know the final resolution of, but I was not a party to those cases at the time, so ...

BY MR. MISHKIND:

Q To your knowledge, are any of the other seven or eight cases still pending?

A No, they're not.

Q This is the only headache that you have?

A It is.

Q Okay. Did any of the other cases involve issues that you understand to be similar to this particular case?

A No.

Q Were you deposed in all of the cases?

A No. Probably one or two.

Q So when I asked you about depositions and you said five to 10 times --

A Yes.

Q -- once or twice before now as a defendant?

A Possibly three ... possibly as many as three of those would have gotten to the deposition stage.

Q The other two to five cases, your deposition was taken in some other capacity; is that true?

A Yes, as an expert witness.

Q Are you currently serving as an expert witness in any medical negligence cases?

A By that, do you mean are there any cases pending?

Q Much better put than the way I asked you.

A There's one case in Texas that's currently pending.

Q Does the Texas case, or have any of the other cases that you've served as an expert where you've been deposed, involve any issues similar to the issues that you understand to exist in this case?

A No, they don't.

Q Of the three to five other cases that you have been deposed in ... of the two to five other cases, roughly, that you've been deposed in as an expert, were you serving as an expert for an emergency room doctor or serving as an expert for a patient bringing a claim against the emergency room doctor?

A Two of the cases were for the plaintiff and the

others were for the defense.
Q Besides the Texas case, did any of the cases involve matters up in the northeastern Ohio area?
A No. I'm sorry, which ... any of the cases?
Q That you've served as an expert witness where you've been deposed.
A Yes, they did. Those were with Weston, Hurd.
Q You were an expert defending a doctor that was --
A Yes.
Q -- that was being defended by Weston, Hurd.
A Correct.
Q How long have you served as an expert witness in medical negligence cases?
A Probably 10 or 12 years.
Q How many cases do you review on the average in any given year?
A Not more than one or two. It's one of those things where the more you do, the less credibility I think you have, so ...
Q Have you ever served as an expert where there have been issues similar to the issues that you understand to exist in this case?
A To the best of my recollection, I believe one of the cases with Weston, Hurd involved someone with abdominal pain. I don't recall the names involved offhand, but I

believe that case was dropped after a deposition.
Q Do you know what the ultimate outcome was with regard to the patient? Did the patient die?
A The patient died -- correct -- the following day.
Q Do you know what the ultimate cause of death was in that patient?
A I don't recall.
Q All right. So you've been deposed five to 10 times and we've talked about the basic breakdown between which ones have been as a defendant and which have been as an expert.
A Yes.
Q And you've been serving as an expert witness 10 to 12 years, one to two cases per year; correct?
A Correct. Most of those have involved reports and I haven't heard anything beyond the report stage.
Q Are you currently serving as an expert for any attorneys up in the Cleveland area?
A No.
Q When's the last ... I'm sorry, I may have cut you off.
A No, no. I was trying to make sure I didn't have anything going right now. When was the last one? I'm sorry, was that your question?
Q We'll make it my question. Go ahead.

A With any of the attorneys there? Yeah, it was another case with Weston, Hurd.
Q Do you happen to remember the attorney that --
A Sure. Ken Torgersen.
Q When was the last time you were deposed?
A I believe that was the Texas case; that was probably last summer.
Q Do you recall what city or county in Texas that case ...
A The deposition was here in Daytona. The case was in Lubbock, Texas.
Q That was the plaintiff's case?
A Yes.
Q Do you remember the name of the plaintiff's attorney that you were working for?
A The plaintiff's name was Leon Davis. The attorney was ... Bowers was the law firm -- B-O-W-E-R-S -- in Lubbock.
Q Are you scheduled to give deposition testimony or to testify at trial in any cases in the immediate ... in the foreseeable future?
A No.
Q I understand you do not remember Mrs. Pultz; is that correct?
A That's correct.

Q Did you ever have occasion to meet Mr. Pultz, the husband?
A No, I did not, to the best of my knowledge. I understand he works at the hospital, but I ... I don't recall ever having met him.
Q And is that understanding obtained from anyone other than conversations with your attorney?
A No.
Q So had Mr. Auciello not mentioned that to you, you wouldn't know ... in fact, you don't even know whether what he told you was true or not; correct?
MR. AUCIELLO: He doesn't know.
THE WITNESS: I'm assuming he's an honest man.
BY MR. MISHKIND:
Q That he is and I'll stipulate to that, but as far as whether or not Mr. Pultz was or was not employed at the hospital, you don't know that independent of any conversation you had with your attorney.
A That's correct.
Q Okay. You have not seen anything that would verify such employment; correct?
A Correct.
Q Aside from the record and looking at the record, do you remember anything about September 25, 1999, in terms of the patient volume that you were dealing with on that

particular day?
A No, I do not.
Q Or the type of issues that presented to you as an emergency room doctor on that day, on September 25, 1999?
A No. It was an evening shift and characteristically those are the busiest, but as far as any specific details in terms of volume, I don't remember.
Q Your shift would have started when and ended when on that day?
A I did look up in my daytimer the other day to get that information. It was four to twelve; four to midnight.
Q You looked at September 25, 1999?
A Yes.
Q Do you have any record at all of anything in daytimers, computers, miscellaneous notes, about this particular patient on September 25, 1999?
A No, I don't.
Q Have you ever taught emergency medicine, either to medical students or to residents?
A No.
Q I take it you subscribe to certain emergency medicine journals; true?
A Yes.
Q Which ones do you receive?
A I receive the Annals of Emergency Medicine.

Q Any others?
A There's another journal that's ... I think it's just called Emergency Medicine. It's ...
Q Are those two journals that you receive on a regular basis?
A Yes.
Q What about emergency texts or books; do you own any emergency room medicine texts?
A Actually, at the present time, when we were moving down here, I had old copies with anticipating getting newer copies and I ... since we had them at the hospital, I have not bought any newer editions.
Q Did you bring the old editions down with you or did you leave them up north?
A No, we got rid of them.
Q I take it you probably had older editions of Rosens?
A Yes.
Q What other emergency texts did you have?
A Tintinali's textbook.
Q And you have newer editions available to you at the hospitals that you work at; you just don't own the most recent?
A Actually, they're not the most current editions.
Q Rosens is a fairly well recognized emergency

medical text, is it not?
A It's one of several.
Q You mentioned another one as well; correct?
A Tintinali.
Q Right.
A That's I think generally regarded more as a study guide for the boards. There are several others that are ... I don't recall the authors of the other textbooks. There are several generally good texts in the field.
Q Is Rosens, in your opinion, probably, if not the best, one of the best in emergency medicine?
MR. ROSSI: Objection. This is Greg Rossi.
THE WITNESS: I wouldn't necessarily say it's the best. It's certainly the thickest, but it's just one of several good texts in the field.
BY MR. MISHKIND:
Q And certainly you'd consider it to be one of a number of good sources relative to emergency medicine; true?
MR. ROSSI: Howard, can I have a continuing objection to your questions on literature and it's ...
MR. MISHKIND: Sure.
MR. ROSSI: Great, thanks.
MR. WALTERS: This is Steve Walters. I'd like the same.

MR. MISHKIND: Okay. Even though your voice broke up, Steve, we sort of gotcha.
MR. AUCIELLO: I'll object, too, just to make it unanimous.
THE WITNESS: I'm sorry, could you rephrase the question?
BY MR. MISHKIND:
Q I forgot what the question was now.
Is Rosens, in your opinion, one of a number of good sources of information in the area of emergency medicine?
A Generally, yes. I couldn't address specific topics, but yes, in general.
Q And from time to time over the years, you've had occasion, since you've been practicing, to refer to Rosens for information on various topics in the area of emergency medicine; true?
A Correct.
Q You also refer to the Annals of Emergency Medicine and the Emergency Medicine Journal from time to time for information on advances or studies that deal with various issues --
A Yes.
Q -- in emergency medicine; true?
A Yes.

Q In preparing for today's deposition, have you reviewed any medical literature at all?
A No.
Q Have you ever taught or lectured on the topic of the emergency evaluation of a patient that presents to the emergency room with an acute anemia?
A No.
Q If you wanted a generally reliable source of information on the evaluation of a patient in the emergency setting that presents with anemia and you were to look to an emergency journal or an emergency textbook, would you look to Rosens as the first line of reference?
MR. AUCIELLO: Objection.
You can answer.
THE WITNESS: I don't know that it would ... specifically, what I would refer to, if anything.
BY MR. MISHKIND:
Q Well, you're a member of the American College of Emergency Physicians; true?
A Yes.
Q And you're familiar with the guidelines and standards that the American College of Emergency Medicine Physicians publish; correct?
A Some of them, yes.
Q You certainly ... as a member of the American

College of Emergency Medicine Physicians, you attempt to comply with the guidelines that are promulgated by that organization in your practice; true?
A Well, again, these are guidelines; they're not necessarily protocols or regulations.
Q Are you familiar with the specific standards that are promulgated by the American College of Emergency Physicians as it relates to the evaluation of a patient that presents to an emergency room with evidence of anemia?
A Not specifically, no.
Q Define for me "anemia." Let's start with a simple question.
A Anemia is generally regarded as a deficiency in the volume or size of red blood cells.
Q Can we agree that Mrs. Pultz, by definition, met that, that being a patient that was anemic?
A Yes.
Q Would you agree that a sound diagnostic approach to determining whether anemia is emergent or non-emergent is necessary when a patient presents to an emergency room?
MR. WALTERS: Howard, I didn't get that.
MR. ROSSI: Neither did I. You broke ... it's bizarre. When you were asking that question, it got fuzzy on our end of the phone, so ...
MR. MISHKIND: Actually, I threw in some fuzz

just to confuse you.
MR. ROSSI: It was probably a poorly worded question, so I'll just object and ask that it be stricken from the record.
MR. MISHKIND: You go right ahead.
BY MR. MISHKIND:
Q Would you agree that a sound diagnostic approach to determining whether an anemia is emergent or non-emergent is necessary in the emergency room?
A Whether it's ... yes, in general.
Q Would you agree that it would be below the standard of care not to have a sound diagnostic approach to determining whether the anemia is emergent or non-emergent?
MR. ROSSI: In the emergency room or otherwise?
MR. MISHKIND: Emergency room.
THE WITNESS: That can be a difficult question to answer. It's sometimes a matter of going by gut feeling whether something is emergent or non-emergent.
BY MR. MISHKIND:
Q Let me ask it to you this way and maybe it'll make it a little bit easier to respond: Would you agree that if a patient --
MR. MISHKIND: Well, strike that.
BY MR. MISHKIND:
Q Is it unusual to learn that a patient is anemic

as an incidental finding on a CBC obtained for other reasons?
A It's not unusual.
Q In fact, you determined as an incidental finding that this patient was anemic on a CBC which was obtained for other reasons; true?
A Correct.
Q Okay. And that happens not infrequently in an emergency room setting; correct?
A Correct.
Q And when that is encountered -- and "that" being an incidental finding of anemia when you're evaluating a patient for some other condition -- you, as an emergency room physician, must act in a reasonable manner in order to determine whether or not that incidental finding of anemia is emergent or non-emergent; true?
A I think it would all depend, in this specific instance, whether we felt it was emergent or non-emergent.
Q And in order to do that and to act reasonably and prudently, you have to take into account the clinical picture as well as the laboratory evidence that the patient presents as an incidental finding of anemia; true?
A By that, you mean you're taking the entire picture into account; the laboratory as well as how the patient appears and how they look, basically.

Q Sure.
A Yes.
Q So even though you may be seeing a patient for a suspected diagnosis ... and in this case, the diagnosis that she came in with was a urinary tract infection --
A Hmm-hmm.
Q -- true?
A Yes.
Q Even though you're seeing the patient for a presumed diagnosis of a urinary tract infection, one cannot ignore, in evaluating the patient, an incidental finding of anemia, even though there may be diagnostic findings consistent with a urinary tract infection; true?
A In general, yes.
Q And in general, the reason that that would not be good practice is that the incidental finding of anemia may require, in certain circumstances, emergent treatment, even though the patient may have a urinary tract infection as well; true?
A True.
Q And if the clinical picture and the evidence suggest that the anemia is emergent, you, as an emergency room physician, have certain steps that you need to take to determine what treatment needs to be given for that anemia; correct?

A Not necessarily what "steps", but I think in emergency medicine we paint with a broad brush. Does the patient need to be admitted or can they go home and be worked up as an outpatient.
Q And it's your duty and responsibility to determine whether or not that anemia -- if we're talking about anemia -- can be treated on an outpatient basis or whether it's emergent enough that additional steps need to be taken before the patient leaves the emergency room; true?
A Yeah, that would be a true statement.
Q You ordered a CBC; true?
A Yes.
Q You had a duty to evaluate those labs ... the CBC prior to discharge.
A Yes.
Q You had the results prior to discharge; true?
A I can only assume that that's correct.
Q One would hope --
A Again, without any independent recollection of the case, I would ...
Q Is there anything that you can gather from the record that would suggest that the labs ... all the labs were not available to you before you decided to discharge the patient?

A No.
Q The hematocrit and hemoglobin were indicative of this patient having some form of anemia; true?
A Yes.
Q Her hemoglobin was 8.0; her hematocrit I believe was 23.5 or ...
A Somewhere in that ballpark, yeah; 24.5.
Q 24.5 --
A Hmm-hmm.
Q -- correct?
A Correct.
Q And would you agree that, at least from a laboratory standpoint, those values were ... first, were consistent with the patient having some form of anemia?
A Yes.
Q And would you agree that this patient was very anemic?
A Not necessarily "very anemic" in terms of when ... when we say "very anemic", I think of someone emergently needing a blood transfusion and that sort of thing.
Q So if you had labs that suggested that the patient was very anemic, would that suggest that the patient would need to have a blood transfusion?
A Generally, yes.

Q What steps do you take as an emergency roon doctor to determine whether an anemia is caused by an active and ongoing blood loss or some other condition?
A One of the most common ones is intestinal bleeding. You do a rectal exam.
Q What else?
A Other than obvious ... some obvious injury where there's bleeding from an injury, there's really nothing much in the emergency room that you can do to evaluate. If it's not coming from an injury or bleeding internally -- you're speaking of an ongoing blood loss -- there are not too many other places it could come from.
Q Can you do a peripheral blood smear in the emergency room?
A I've never seen it done.
Q Are you familiar with what a peripheral blood smear is?
A Looking at a thin smear of blood under a microscope.
Q Do you know whether a peripheral blood smear will provide clues as to the cause of the anemia, therefore the cause of the blood loss?
A I don't know what information you could gain from that that you couldn't get from the CBC.
Q Okay. You said that you would look to determine

whether or not the patient has a GI bleed or some type of intra-abdominal bleed?
A Yes.
Q An intra-abdominal bleed perhaps due to trauma?
A Right.
Q Or other possible causes; true?
A Yes.
Q And a GI bleed would not necessarily be due to trauma; it could be due to a number of potential etiologies; true?
A Correct.
Q You tested and saw that she was guaiac-positive?
A Correct.
Q And was that of any significance to you in a patient who has a hemoglobin of eight in terms of being guaiac-positive?
A That would indicate some bleeding in the gastrointestinal tract.
Q Did you attempt to determine where the source in the GI tract that that bleeding was emanating from?
A No, that's really not possible in the ER.
Q So the answer would be no.
A Correct.
Q Okay. What's a differential diagnosis?
A A differential diagnosis is a list of diagnoses

related to a disease process.
Q In evaluating a patient that has anemia, are there different classifications that anemia falls into or different groups that anemia falls into?
A Oh, sure.
Q How many different classifications or groups, generally speaking, are there when you're evaluating a patient with anemia? And this is in the emergency room setting.
A Well, the anemia can be chronic or it could be acute. It could be due to blood loss, either from trauma or in the gastrointestinal tract. It could be due to the body itself not producing sufficient red blood cells.
Q So it could be due to decreased red blood cell production.
A Hmm-hmm. Yes.
Q It could be due to increased red blood cell destruction.
A Hmm-hmm.
Q And it could be due to blood loss or trauma.
A Yes.
Q Would that be a fair sort of overview of the classifications?
A Sure.
Q Did you attempt in this case to ascertain which

form of anemia Mrs. Pultz fell into or was classified as?
A By doing the rectal exam and the stool guaiac, there was evidence that there was some blood in the gastrointestinal tract. It didn't appear to be an acute or a significant blood loss.
Q You had evidence of blood loss.
A Hmm-hmm. Yes.
Q And you had evidence on labs that she was anemic; no question about that; true?
A Yes.
Q Did you attempt to determine from Mrs. Pultz or from the record, either your dictated note or your hand-written note, whether she had had any prior anemia or a family history of anemia?
A There's nothing on the record that would indicate that, but as far as any conversation, I would generally ask that.
Q You don't have anything recorded that would suggest that she had had any prior anemias; true?
A There's nothing recorded to that effect, that's correct.
Q And you don't remember whether you did or didn't inquire of the patient as to family history or prior anemias?
A Again, that would be my usual practice, but I

don't have any specific recollection of the case.
Q Would that be a reasonable and prudent practice on the part of an emergency room doctor that has evidence of a guaiac-positive rectal exam, that has evidence of a patient with abdominal pain and who has a hemoglobin of eight and a low hematocrit, to ask them whether or not you've had prior anemia and a family history of anemia?
A That would be my usual practice to do so.
Q And that would be what you would consider to be the standard of care; correct?
A Well, I don't know if I could address that as to the standard of care, but that would be my usual practice to do so.
Q You consider yourself to be a reasonable and prudent emergency room doctor; correct?
A I'd like to think so.
Q And in acting as a reasonable and prudent emergency room doctor, would you expect from yourself that in evaluating a patient that has abdominal pain, that has a hemoglobin of eight, a hematocrit of 23 to 24, that you would ask whether the patient has a history of prior anemia and a history ... a family history, in order to act as a reasonable emergency room doctor?
A Not so much the family history, but a past history of anemia or some ... you know, have they had this

problem before. I would think that I would do that.
Q Acting as a reasonable and prudent emergency room doctor; true?
A Yes.
Q Did you ask this patient about any recent history of rectal bleeding?
A Again, I don't recall and there's nothing in the record; however, it would be my practice to do so.
Q And, again, that would be what you would consider to be a reasonable and prudent thing to do, faced with abdominal pain, with a guaiac-positive rectal exam and with the H&H that she had?
A Yes.
Q You don't have any independent recollection of what she may have told you, assuming you asked that question?
A No. Unfortunately, I have absolutely no recollection of anything regarding this case at all. I wish I did.
Q With the abdominal pain, with her presenting symptoms and the laboratory results, a history-taking that would include asking the patient whether she has a history of rectal bleeding would be something that would be reasonable and prudent to do; true?
A Yes.

Q You would not expect that you would go through seeing a patient like this and not ask the patient whether she has a history of rectal bleeding; true?
A True.
Q Hypothetically, if you didn't ask the patient whether she's had any prior anemias or whether she's had a history of rectal bleeding, that would not, in your opinion, be good care; correct?
A To ask those questions would be something I would normally do.
Q And the flip side is, hypothetically, if you didn't do that, would you agree that that would not be, in your opinion, good medical care?
MR. AUCIELLO: Objection.
THE WITNESS: I don't think I could answer that. All I could say is what I would normally do.
BY MR. MISHKIND:
Q And you normally do that because you consider it to be good practice; true?
A Yes.
Q Knowing whether or not a patient has a prior anemia and has had rectal bleeding is important in evaluating whether or not the patient's blood loss is chronic or acute; correct?
A It's part of the overall picture and would be

important to know.
Q Now this patient came in with some information that you really ... you personally didn't have to ask her about because it was recorded in the chart as to the medications that she was taking, but that was information that was available to you when you saw her; true?
A It was available at some point. It may not have been available at the exact time I saw her.
Q She was taking Methotrexate for her rheumatoid arthritis; do you see that documented in the record?
A Yes.
Q Would that be information that you most likely would have known at the time of your exam?
A Again, it may or may not. It would be available at some point.
Q At some point during this process before the patient was discharged; true?
A Yes.
Q You would also have known that the patient was taking Orudis -- that's O-R-U-D-I-S -- and that's Ketoprofen?
A It a nonsteroidal anti-inflammatory similar to Motrin.
Q So that information at sometime during the visit would have been known to you; correct?

A Yes.
Q I want to just jump ahead. I'm going to come back. I'm not trying to jump ahead to confuse you, but you made ... you gave her certain indications with regard to treatment and one was to discontinue Cipro; correct?
A Yes.
Q You didn't tell her to discontinue the Orudis, did you?
A No, I did not. All I can say is, there ... most likely, it would have been something she had said to me to indicate that she felt the problem was due to the Cipro, as to maybe the onset of her discomfort began, beginning after taking the Cipro.
Q Do you have anything documented to that effect, that the patient told you that her abdominal pain was secondary to Cipro, such that you would say discontinue the Cipro as opposed to discontinuing the Orudis?
A No, there's nothing documented to that effect; only the fact that I did that, would be the reason ... the way I would usually do things.
Q Sort of your custom and practice; right?
A Yes.
Q But in this particular case, you can't tell me whether that is, in fact, why you told her to d/c the Cipro and not to d/c the Orudis; true?

A That's correct.
Q In a patient that has abdominal pain, that has anemia that is in the range that she has, and also has an elevation in the platelet count, which is also something that she had; 490,000 was her platelet count; correct?
A Correct.
Q Those findings -- the elevation of the platelet count and the low H&H and abdominal pain -- are all consistent with a patient -- and a guaiac-positive -- are all consistent with a patient that may have an acute bleed; correct?
A May have, correct.
Q And it's something that needs to be evaluated; correct?
A It needs to be evaluated at some point, yes.
Q It may or may not need to be evaluated on an emergent basis; true?
A True.
Q In any event, the continuation of a nonsteroidal anti-inflammatory in a patient with abdominal pain and the clinical findings on the lab with the platelets and the H&H can precipitate additional bleeding, can it not?
A It can, yes.
Q You didn't advise her to stop taking the Orudis, did you?

A If I did, it's certainly not in writing.
Q You didn't advise her that, "Continued taking of the Orudis may complicate your anemia"; true?
A Not in writing.
Q You don't have any recollection of telling her that, do you?
A I have no recollection of this case whatsoever.
Q Would it be reasonable in the emergency room setting on a patient that, hypothetically, you determined not to have an emergent anemia but one that needs to be evaluated, to advise them of the consequences of taking a nonsteroidal anti-inflammatory in the face of an unexplained or unevaluated anemia?
A That's a fair statement.
Q Failing to do that, hypothetically, would not be what you would consider to be reasonable care; true?
MR. WALTERS: Objection.
MR. AUCIELLO: Objection.
MR. ROSSI: Objection.
THE WITNESS: Again, it's what I would normally do.
BY MR. MISHKIND:
Q And because that's what you consider to be reasonable and prudent; correct?
You've got to answer ... your answer is yes?

A Yes.
Q Hypothetically in this case, if you did not advise the patient that the continued use of nonsteroidal anti-inflammatory medication could have consequences to her anemia and that she should discontinue taking the nonsteroidal anti-inflammatory, would that be unreasonable in your opinion?
MR. AUCIELLO: Objection.
MR. WALTERS: Objection.
THE WITNESS: I don't think it would necessarily be unreasonable, especially when she was instructed to follow up in such a specific short period of time with her own physician.
BY MR. MISHKIND:
Q And we're going to talk about that in a second in terms of the follow-up, but I'm talking about a conversation that you would have with a patient that has the lab results that we've talked about, that has the abdominal pain, that has the positive blood in the stool; normal practice for you as an emergency room doctor would suggest that the patient should be told that the continued use of a nonsteroidal anti-inflammatory poses a risk to the patient because of their laboratory results and their clinical findings; true?
A That's what I would generally do, yes.

Q Okay. Generally, would you ask the patient what medications they were taking that might cause a GI bleed or red blood cell destruction?
A Well, that would be asked by someone at some point, whether it be by the nurses or by myself.
Q And in this case you had ... whether it was written out or presented to you, that information probably came via the nurses; correct?
A Yes.
Q How long, according to the emergency room record, had she been taking the nonsteroidal anti-inflammatory medication?
A I don't recall seeing anything indicating how long she had been on that.
Q Of what significance, if any, was her use of Methotrexate in your evaluation of her anemia in the emergency room?
A Methotrexate is ... I believe can be irritating, also, but I'm ... Methotrexate is used primarily as a cancer drug and also for some types of arthritis.
Q And you believe the Methotrexate can be ... I'm sorry, what --
A I thought it might be irritating, but I'm not sure. I wouldn't swear to that.
Q Was there any evidence of blood loss in her

urine?
A Yes. I believe she did have some red blood cells in her urine, which is not unusual for a urinary tract infection.
Q Was it two plus blood in the urine?
A A hundred to two hundred red cells.
Q Does that give you any information at all as to whether or not the blood in her urine was a contributing factor to her low hematocrit or hemoglobin?
A None whatsoever; that's not a ... in and of itself, it's not a concern.
Q What significance is the high platelet count along with the low H&H when evaluating a patient for the cause of blood loss?
A I actually have never heard of that, the relation of the platelets; that's ... as far as the high platelets. I mean, theoretically it makes sense, but that was a new one on me.
Q And I take it, it would have been a new one on you when you saw it ... when you looked at the labs in the emergency room?
A The platelet count would not have triggered any alarms; it's only if it were below normal, which would raise a flag for an increased risk of bleeding.
Q So your knowledge of lab values, as it relates to

looking at a patient that has a low H&H, that has abdominal pain ... your knowledge and familiarity would suggest that a high platelet count would not be a significant finding?
A The platelet count itself ... hers was not excessively high; it's 490,000; normal is 450,000. So that would not have really ... as an isolated finding, that would not have triggered any alarms.
Q I'm not talking about isolated findings; I'm talking about in conjunction with the H&H. Did you not have any knowledge or experience to fall back on to be able to say a high platelet count and a low H&H, taken together in a patient that presents with abdominal pain is or is not significant?
A No, I mean the H&H would have been ...
Q The H&H would have been what?
A Would have been my main concern.
Q And just so that I can move onto the next question -- I'm not trying to beat a dead horse with a stick -- but is it fair to say that now, and probably back in September of 1999, you did not ... or you were not aware of any significance to be placed on a high platelet count of 490,000 as being important along with the low H&H?
A Again, it's minimally elevated, so no, I would not ... that would not have ... I was not aware of any association with a minimally elevated platelet count,

together with the low H&H.
Q Do you know what iron deficiency anemia is?
A Yes.
Q How is the diagnosis of iron deficiency anemia made?
A There are other blood tests that can be done; total iron binding capacity; serum iron; ferritin level ... things like that, that are not ... that are outside the scope of the emergency room.
Q Did you attempt in the emergency room by any of the labs, either incidentally or specifically, to determine whether or not her lab findings were consistent or inconsistent with an iron deficiency anemia?
A It would appear that they were not. As far as my understanding, usually an iron deficiency anemia would be what's called a microcytic anemia, meaning the cells are small, which would indicate a low value with the MCV and MCH, and those are within the normal range.
Q So she would fall more into the normal "cytic" range?
A Yes.
Q Not macrocytic.
A Correct.
Q But not microcytic as well.
A Yeah.

Q Did you attempt, based upon your entire clinical exam and the labs and the history, to determine the cause of her anemia in the emergency room?
A No.
Q You'll have to move your hand away.
A I'm sorry, no.
Q Are you familiar with any guidelines or standards or protocols -- I'm throwing three questions at you, but you can answer whichever one you want to -- that speak to the issue of assessment and treatment of the anemic patient in the emergency room?
A Specifically, no.
MR. WALTERS: Before he answers --
MR. MISHKIND: I'm sorry?
MR. WALTERS: -- keep your voice up; it's getting very difficult.
MR. AUCIELLO: We can't hear you.
MR. ROSSI: He said you're going to have to keep your voice up, Howard; it's getting difficult to hear you.
MR. MISHKIND: Would you like me to repeat the question, Steve? Steve?
MR. WALTERS: Yeah.
MR. MISHKIND: Do you want me to repeat the question for you?

MR. WALTERS: (No audible response)
MR. ROSSI: Please.
MR. MISHKIND: Okay. His answer was no to this question: Whether he was familiar with any standards, guidelines or protocols that speak to the issue of the assessment of and treatment of the anemic patient in the emergency room.
MR. WALTERS: Thank you.
MR. MISHKIND: You're welcome.
BY MR. MISHKIND:
Q As an emergency room doctor, there are occasions that patients present to an emergency room with severe anemia and a transfusion is indicated; true?
A True.
Q Are there situations where patients present to an emergency room with a significant enough degree of anemia such that hospitalization is recommended by you for the patient?
A Yes.
Q Are there circumstances where you will contact the family doctor to get further input as to whether the patient should or should not be admitted to the hospital for evaluation?
A Yes.
Q I take it you don't know, but I'll ask it anyway,

whether Dr. Flagg would have admitted the patient or asked you to admit the patient had you called him and said, We've got a patient ... your patient here that has abdominal pain; that has the following hematocrit and hemoglobin; that has the following platelet count; that has a guaiac-positive rectal exam; do you have any sense as to whether or not Dr. Flagg would have said, Admit that patient?
MR. WALTERS: Objection.
THE WITNESS: No, that's entirely speculative. I have no way of knowing that.
BY MR. MISHKIND:
Q Now, hypothetically, had you contacted Dr. Flagg -- and I know we've already said that you didn't -- but had you contacted, hypothetically, to discuss this patient, would you have given him the kind of information that I just gave to you, plus the fact that the patient presented with a diagnosis of a urinary tract infection as well?
A Yes.
Q And if Dr. Flagg had said, Let's go ahead and admit the patient either for a transfusion or for further workup, would you have deferred to him or would you have recommended against admission?
A No --

MR. AUCIELLO: Objection generally, but go ahead.
THE WITNESS: As a general rule, the patient's own physician determines in that case; otherwise, we wouldn't bother to call them.
BY MR. MISHKIND:
Q Now in this case, is there any ... was there anything preventing you -- and I know we've talked about that you don't remember the case and that you don't have any recollection of contacting Dr. Flagg -- but was there anything that you can point to that would have prevented you from contacting Dr. Flagg with the information that you had about the H&H, the platelets, her abdominal pain and her guaiac-positive status?
A No.
Q Did you consider, as part of your custom and practice, contacting Dr. Flagg?
MR. AUCIELLO: Wait a minute. Wait a minute. If he has no recollection, how can he say ...
MR. MISHKIND: Let me get it back to you a different way.
BY MR. MISHKIND:
Q Knowing how you approach cases and knowing what you believe to be your custom and practice, is it likely that you would have at least considered contacting Dr. Flagg given her abdominal pain; her being on the

nonsteroidal anti-inflammatory; her H&H; the elevated platelets?
MR. AUCIELLO: Objection.
THE WITNESS: It's kind of a generalized question. It's possible ... I'd rather say likely, maybe, have considered it ...
BY MR. MISHKIND:
Q Again ... and I don't mean to interrupt you. We've talked about what your normal custom and practice is and you have not seen Dr. Flagg's deposition -- I understand that --
A Right.
Q -- but I'm asking you whether you would have considered contacting him, based upon all this information, or based upon your custom and practice with this kind of information and with this patient and your diagnosis, is it more likely that your custom and practice would have been to discharge her, to give her the discharge instructions that you did and to opt not to even consider calling the doctor?
A It's likely that I would have considered it. Again, I wish I had some independent recollection to know why ... whether I did or made an attempt to or whatever, but there's no indication of that on the record.
Q Okay.

A And as we say, if it's not written, it's not done, so ...

Q Did Southwest or Emergency Professional Services in September of '99, to your knowledge, have transfusion protocols that you would follow in terms of patients that present either with a specific finding or an incidental finding of anemia?

A I don't know. The transfusion protocols would be more, I would think, with regard to nursing as far as how to infuse the blood; over what period of time; what filter ... you know, using a blood filter ... things like that; just procedural things, rather than hard and fast, "If the blood count is below this, then they need to be transfused."

Q As an emergency room doctor, do you provide transfusions without admission?

A No.

Q So if a transfusion's going to be given, is it after admission or have you on occasion transfused and then admitted the patient?

A In rare instances, usually because of a traumatic bleed or a catastrophic gastrointestinal bleed.

Q So the normal practice would be if you felt the patient needed a transfusion on an emergent basis and it wasn't a catastrophic bleed, you would facilitate whatever

steps were necessary to have the patient admitted and then the transfusion would take place upon admission; is that correct?

A Correct.

Q And that would ... with a family doctor on file, that would be in conjunction with consultation with Dr. Flagg; true?

A Yes, whoever the patient's doctor was or with the on-call physician if they didn't have their own doctor.

Q What was her clinical condition upon discharge?

A Well, I never send anyone home unless they're pain-free and there's a note in the nurse's notes, "Discharged home, pain-free."

Q Do you know how she got to the hospital?

A The record indicates she got there by ambulance.

Q Do you know how she got home?

A No, I don't. I'm assuming it was with family.

Q As opposed to by ambulance.

A Yeah, that's probably not a good thing to do.

MR. MISHKIND: Guys, we're going to take about a three- or four-minute break.

(WHEREUPON the proceedings were in recess from 3:09 p.m. until 3:14 p.m.)

BY MR. MISHKIND:

Q Doctor, on the dictated emergency room record, it

starts with ... it's two pages; correct?

A Correct.

Q It starts with "Chief Complaint" and it ends with, "Please refer to emergency room chart for final diagnosis --

A Yes.

Q -- and disposition on this patient"; true?

A Yes.

Q And you dictated --

MR. ROSSI: Howard, hang on one second. Steve, can you hear everybody?

MR. WALTERS: No.

MR. ROSSI: Can you hear anything --

MR. WALTERS: No.

MR. ROSSI: -- other than me?

MR. WALTERS: Other than you.

MR. ROSSI: Howard, why don't you guys ... I can hear you, but, Howard, why don't you go ahead and say something.

MR. MISHKIND: What would you like me to say?

MR. WALTERS: I heard that.

MR. ROSSI: Okay. All right, go ahead. I think it was just maybe a bad connection.

MR. MISHKIND: Okay. Steve, I just asked him to identify the typed emergency room record, it's two

pages, and I was about to ask him whether that was dictated while the patient was still in the emergency room or after she had left the emergency room.

BY MR. MISHKIND:

Q That is my question.

A All right. It appears it was dictated after I saw her, prior to the labs coming back; in fact, the time is documented as 10:15 that ... at the bottom of the record, that it was ... I guess that it was transcribed.

Q And do you have any reason to believe that the time on this is incorrect? When I say on "this", I mean on the typed dictation.

A No, I would assume that's fairly ... fairly accurate.

Q So you would dictate ... where it says, Please refer to emergency chart for final diagnosis and disposition, you would have dictated that expecting that you would hand-write out the final diagnosis and the disposition; true?

A Correct.

Q When I looked at this, I wasn't certain whether perhaps this time of the dictation was off. So, in fact, you dictated it before the final diagnosis and disposition had been arrived at.

A We ... or at least I frequently do that, because

the chart could get ... not "lost", but if a patient had to be admitted or if they were discharged and you hadn't dictated it yet, you'd give it to the nurse to take orders from the admitting physician or send the patient home and you'd get busy with something else and the chart would get filed away and you'd never see it again and there would be no record at all. So it's not an ideal practice to dictate it that way, but ... a partial dictation, but we did ... I did many of them like that.

Q So in this case, what we do is, we look at your dictation and then to see ultimately what your final diagnosis and your disposition is, we need to go back to the first page of the record under "Diagnostic Impressions and Treatment" to see the other side of the story, if you will; the rest of the story, as one commentator said.

A Right. As Paul Harvey would say.

Q Yes.

All right. So after we look at the dictation, which we don't need to go over because that's clear, the diagnostic impressions are your final diagnoses; is that correct?

A Yes.

Q And you've got UTI as one.

A Yes.

Q And it looks like, Medication gas ...

A Gastritis.

Q Gastritis.

A Hmm-hmm.

Q Did you indicate what you believed to be the cause of the medication gastritis?

A I can only assume, looking at that and ... that the patient said something to me, perhaps in indicating that her discomfort began after taking the Cipro; that would be my best guess without any recollection of the event.

Q From what you've just said, it sounds like you're speculating as to what the patient told you; is that correct?

A Yes.

Q There's no indication that the medication gastritis was secondary to the nonsteroidal anti-inflammatory; true?

A True.

Q And certainly a nonsteroidal anti-inflammatory can cause medication gastritis; correct?

A Yes.

Q But for whatever reason, in this case there is no indication that your thought process was directed toward that; correct?

A That's a fair statement, yes.

Q Otherwise, you would have d/c'd the Oridis (sic); correct?

A Orudis.

Q Orudis.

A Hmm-hmm.

Q That's a yes?

A Yes. Yes. I'm sorry.

Q That's all right.

What does it say below "UTI" and "medication gastritis"?

A It looks like she was given something for pain. She was given Demerol and Vistaril. I don't believe that that's my ... that's not my writing, so I don't know the time involved or who wrote that. It's a pain medication order, but it's written in the diagnosis area, so it leads to some confusion.

Q Were there other emergency room physicians that were involved in the care of this patient?

A I don't know. Looking at the time, she was discharged after midnight; that night, I was working four to midnight. It doesn't appear that I turned her over to another physician, but ... if I did, I certainly wish I had written it down. I can't say with certainty that there was no one else involved, but ...

Q Under the disposition, where it says ... on the

front page, it says "d/c" ...

Which is "discharge."

A Correct.

Q ... at "12:15", is that?

A Yes, 0015.

Q "Stable"?

A Yes.

Q And is that your signature?

A No, that would be the nurse's signature. They write in that ... that's when the ... apparently, when the patient's actually ...

Q ... out the door?

A Yes.

Q Okay. I knew that's what you were trying to say.

A Sometimes it's ... the time when the physician's done with the patient, there may be a half hour to an hour before the nurse can get to the patient and discharge them, so they write the actual time in there.

Q Is there any basis for you to say that you ... that any other physician -- emergency room doctor -- provided any hands-on care of this patient from start to finish?

A No, not from the record.

Q The treatment was "d/c Cipro"; that's the first thing; right?

A Yes.
Q And is that Levaquin?
A Yes.
Q That's an antibiotic, is it not?
A It's very similar to Cipro.
Q Okay. And, again, reading between the lines, do you have a thought as to why you d/c'd the Cipro and then gave her Levaquin?
A Again, as you say, reading between the lines, usually that would be because of something the patient said; that the problem started after taking the Cipro or the Cipro was upsetting her stomach. And, therapeutically, there's really no reason to prescribe something in the same category as the original drug, but only that it might be better tolerated by the patient than the other drug.
Q Would you agree that if that category of antibiotic, that being Cipro, was causing abdominal pain, that Levaquin could equally be causative of abdominal pain?
A Not necessarily. Some ... in the same group, some medications ... some drugs are better tolerated than others and are very similar.
Q Besides the Levaquin, what else did you prescribe or treat her with?
A She was given Pyridium, which is ... essentially, it's a bladder anesthetic. It relieves the burning and

urgency with urination. It prevents the bladder spasms and the pain with a urinary tract infection.
Q Were any of these treatments directed toward treating her anemia?
A No.
Q Your discharge instructions to the patient in terms of follow-up ... obviously, these are printed instructions. How are the discharge instructions chosen?
I guess the first question is, are you the one that says which discharge instructions to give to the patient?
A Yes. At that time, what we did was ... it's sort of obscured by the stamp, but there is a discharge code and it says UTI.
Q Okay.
A At that time, we used a computer-generated program that was called EPIC and it had three-letter codes for different problems, UTI being ... most of them were pretty easy to guess at, but ...
For example, UTI would print out the specific instructions regarding a urinary tract infection.
Q So the likelihood is, that when you marked down UTI, the discharge instructions then were chosen based upon the diagnosis of a urinary tract infection.
A Yes.

Q There are no diagnoses that you made of anemia of any type; correct?
A Correct.
Q And there were no discharge instructions given to the patient relative to her anemia; correct?
A That's correct.
Q She wasn't treated in any way for her anemia.
A That's correct.
Q And all of the medications that were prescribed were to be for treatment of her urinary tract infection; correct?
A Yes.
Q And you wanted the patient to follow up with her family doctor relative to her urinary tract infection; correct?
A And her abdominal pain, yes.
Q And what did you attribute the abdominal pain to?
A I don't recall specifically having a ... other than the medication, again, possibly because of something the patient had said related to the Cipro.
Q Is it fair to say that ... I'm sorry, did I cut you off?
A No.
Q Is it fair to say that you did not advise the patient that the abdominal pain may be a symptom associated

with a potential GI bleed?
A I don't know that. I would like to think that I mentioned that, given the laboratory results.
Q There's nothing in the record that would suggest that you told her that, is there?
A That's correct.
Q That's something that, acting reasonably and prudently, you should have told her; correct?
A Yes.
Q Are there specific discharge instructions that can be generated for a patient for follow-up where they have a GI bleed or need to be worked up for some potential GI ulcer or abdominal pain of a GI origin?
A I believe there were, but I don't recall specifically.
Q All of the instructions are directed toward the symptoms associated with the diagnosis of a urinary tract infection; the written instructions; true?
A True.
Q Now you ordered a KUB on the patient?
A Yes.
Q And the reason you did a KUB was for what purpose?
A Well, in the case of abdominal pain, basically a plain x-ray is a pretty nonspecific test, but you're

looking for signs of obstruction or perforation.
Q Would you agree that looking solely at the results of the KUB, you would not be able to determine why this patient was seen in the emergency room?
A True. Yes.
Q What is the normal routing system on an emergency room record where a patient is given discharge instructions to follow up with their physician for a urinary tract infection consistent with the printed instructions? What's the normal process with regard to the routing of the emergency room record data to the doctor?
A I don't know.
Q You recognize that the emergency room record ... or at least portions of the record are routinely provided to the primary care doctor for follow-up?
A Yes.
Q Whose responsibility is that to get the record or portions thereof from the emergency room to the primary care doctor?
A I have no idea.
Q In this case, do you know --
MR. WALTERS: What was the answer to the last question?
THE WITNESS: "I have no idea."
MR. WALTERS: Okay, thank you.

BY MR. MISHKIND:
Q Do you know when the emergency room record from front to back was received by Dr. Flagg?
A No.
Q Do you know when the KUB report was sent to Dr. Flagg?
A No.
Q On the copy of your record, does it have anything indicated in the lower left-hand corner?
A In the ... what are we looking at? On the x-ray report?
Q Hmm-hmm.
A No.
Q Let me see your --
A You mean a hand-written note or a courtesy copy?
Q See where it says, "Delivered to Flagg, Douglas"?
A Hmm-hmm.
Q "Cc Flagg, Douglas"?
A Yes.
Q Do you know from your record when that was sent to Dr. Flagg?
A No.
Q Do you know why this report would be reflected as something that would be sent to Dr. Flagg?
A The usual practice was to send a copy of all

records to the patient's primary attending physician if he was on-staff at that hospital.
Q Did you know Dr. Flagg to be on-staff?
A Yes.
Q Would the records be sent piecemeal or would they normally be sent together?
A I would have no idea.
Q Did you feel that this patient's anemia needed to be followed up when she was discharged from the emergency room or when --
MR. AUCIELLO: Let me object to the fact that he has no recollection of this patient, so he's speculating again.
BY MR. MISHKIND:
Q Well, based upon the anemia ... the levels of her anemia ...
A Oh, sure, it would need to be followed up.
Q Did you have in mind, at that time, what kind of time period this patient needed to be seen by her doctor with regard to the anemia?
A I would think within the next ... you know, certainly within the next few days.
Q And I take it, then, in order for the doctor to evaluate the patient for the anemia within the next few days, it would be important for the labs to be provided to

the doctor; correct?
A Oh, sure. I mean, it would be good to have it. Frequently, we give the patients ... at least I give the patients copies of their labs in the ER.
Q Do you know whether that was done in this case?
A Again, no ... no record of that.
Q I'm going to tell you that the record would suggest that ...
MR. MISHKIND: In fact, let me ... rather than telling you that, let me just mark as Exhibit Two ...
BY MR. MISHKIND:
Q I'm going to show you what I've marked as Exhibit Two ...
MR. AUCIELLO: Do we have Dr. Flagg's records?
MR. MISHKIND: Yes.
MR. AUCIELLO: Because I don't have Dr. Flagg's records and I object to the fact that I can't get them. I keep asking Dr. Flagg's counsel for them and I don't have them yet.
BY MR. MISHKIND:
Q Okay. Exhibit Two is --
MR. MISHKIND: What was that?
MR. WALTERS: What don't you have?
MR. AUCIELLO: I don't have Dr. Flagg's records. We keep writing Deirdre and she doesn't send them to

me.
MR. WALTERS: I'll mention it to her.
MR. AUCIELLO: Thank you.
MR. WALTERS: I have them in front of me.
BY MR. MISHKIND:
Q Exhibit Two is three pages of labs. I believe this is a copy of the labs that you have in your copy of the emergency room record?
A Okay.
Q If you want to just confirm that for the record.
MR. AUCIELLO: It's not a photocopy, though; it's a different format.
MR. MISHKIND: It has the same lab --
MR. AUCIELLO: The same information.
THE WITNESS: Yeah.
BY MR. MISHKIND:
Q Okay. The numbers aren't any different than what you have; correct?
A True.
Q And do you see on the upper left-hand corner there appears to be a date of October 1, 1999, with a fax, and the testimony in this case is that at least that appears to be the date that the labs were faxed to Dr. Flagg.
A Hmm-hmm.

Q I guess my question is, do you have any knowledge as to why the results were not ... if, in fact, this was the first time that they were sent to him, why they were not faxed or given to him prior to October 1?
A No, I ... I'm actually surprised. I just ... I had no idea of the customary ... I thought it was in a more timely fashion than that.
Q Especially in a patient that has the kind of anemia that she has, you would expect that these lab results would get to the doctor in a more timely manner than what's suggested by this; true?
A Well, in general, I would think they would; that was my belief, I guess, that ...
Q That would certainly be reasonable and prudent to have gotten them to the doctor sooner than October 1; true?
A I ... again, yes.
Q Okay. Now on Dr. Flagg's copy, he has marked down, "Very anemic; needs to return." I think we talked at the very beginning, looking at the same values, you didn't find her H&H to be "very anemic"; correct?
A Right. It's a matter of degree or a matter of opinion, I guess. I'm not sure what ... that RTC, RTL, I'm not sure.
Q Return to clinic, or, Return to ... but as far as "very anemic", when I asked you before whether you felt

that her labs were suggestive of her being very anemic, you told me that you didn't.
A Right.
Q Okay. Showing you what has been marked as Plaintiff's Exhibit Three, this is a copy of the KUB that was sent to Dr. Flagg; does that appear to be a copy of what you have in your chart?
A Yes.
Q In the upper left-hand corner, there is a date of September 27, that that was sent to Dr. Flagg, which would be four or five days --
A Two days later, isn't it? Yeah.
Q ... four or five days --
A Prior ... oh, sorry.
Q Let me finish.
... four or five days before the blood results were sent to him; correct?
A Correct.
Q Do you have any explanation for why the KUB was sent and then four to five days later, the labs were sent?
A No, I have no idea. Again, I have no idea what process is taken to transmit the information to the doctors' offices.
Q Would you agree that the most important piece of information for following up the anemia was the blood

results as opposed to the KUB?
A Yes.
Q And when you discharged this patient, the follow-up instructions that you gave to her were relative to her urinary tract infection; true?
A Yes.
Q Did you have any contact with Mrs. Pultz the following day or within a 24- to 48-hour period to check and see how she was doing with her urinary tract infection?
A No.
Q Is there a process in the emergency room whereby someone usually picks up the phone and calls the patient to find out are they satisfied with the care and perhaps are they ... how are they feeling?
A Not every ... I believe they would select random patients for re-call, but not everyone is called.
Q What I just showed you in term of copies from Dr. Flagg's records, is that the first time that you've seen any of his records?
A Yes.
Q So you're not aware of what he did or didn't do when he saw the patient in follow-up; correct?
A That's correct.
Q Or when he first saw the patient with regard to any issues of anemia; correct?

A Correct. Now the results would have been available to him, but ... I mean, he may not have had a written report, but they could have ... he could have gotten the results.

Q So if Dr. Flagg received on September 27th, as an example, two days after the emergency room visit the KUB results, would that normally, as you understand it, let the doctor know that the patient had been seen in the emergency room if it's documented as such? Not a terribly well-worded question, but do you follow me on that?

MR. WALTERS: I'm going to object to the question asked.

THE WITNESS: I mean, if this was the first piece of paper that Dr. Flagg had received, he would know, I suppose, that the patient was in the emergency room.

BY MR. MISHKIND:

Q And then just to follow that up, would he then have access to the emergency room record if he wanted to determine anything further as to why the patient had been seen or what else was done for the patient?

A Yes.

Q And I take it you have no knowledge as to what, if anything, Dr. Flagg or his office did two days later on September 27th when they received this KUB; correct?

A Correct.

Q Okay. The triage nurse appears to be Nurse Vana?

A Yes.

Q What's Nurse Vana's first name?

A It's Raemarie; it's one word, I guess.

Q Disposition at 12:15 a.m.; 0015?

A Yes.

Q "Stable." Is that signed by a different nurse than ...

A Yes, it would appear to be, but I don't know who that nurse is.

Q On the Patient Progress Record, those notes written up to the time of discharge are nursing notes --

A Yes.

Q -- is that true?

A Yes.

Q Are you able to identify who that nurse was?

A No, not at all.

Q What else did you consider, if anything, as an explanation for her being guaiac-positive at the time that you saw her after having the labs back or was a GI bleed the top on your "differential"?

A That would have to be the top. I mean, there was really nothing else that would ... you know, hemorrhoids or something like that, but ... you know.

Q No history of hemorrhoids that you're aware of; correct?

A No.

Q And your record doesn't reflect in any way -- dictation or written -- anything about the patient having a gastrointestinal bleed as a diagnosis that you made in the emergency room; correct?

A That's correct.

Q There's nothing indicating that you expected the patient to have further follow-up or evaluation for a gastrointestinal bleed; true?

A As far as the record, no. Again, I ... whether I said ... I would assume I mentioned something to her at that time, but there's no record of that.

Q And, again, if you didn't do that, that would not be good practice --

MR. AUCIELLO: Objection.

BY MR. MISHKIND:

Q -- correct?

A Well, if I didn't ... if I failed to tell ... to instruct her?

Q Yes.

A It would not be ideal, yes.

Q It would not be what you would consider to be reasonable practice; true?

MR. AUCIELLO: Objection.

You can answer.

THE WITNESS: I would not be pleased with myself, yes.

MR. MISHKIND: Fair enough.

Doctor, I have no further questions. Thank you.

MR. ROSSI: Doctor, this Greg Rossi. I've got a few questions for you.

CROSS-EXAMINATION

BY MR. ROSSI:

Q If we go to the discharge instructions, that type-written form?

A Okay.

Q At the end of that, where it says, "Follow-up care"?

A Okay.

Q First of all, Ms. Pultz signed this form at the bottom, didn't she?

A Yes.

Q I take it that means that somebody reviewed these with her and, to the best of their knowledge, she understood what she was supposed to do; right?

A Yes.

Q And you would agree that in this situation, that, indeed, part of the responsibility falls upon the patient, doesn't it?

A Absolutely.
Q And she would have been provided a copy, if not the original of these discharge instructions; true?
A The patient gets the original.
Q Okay. Part of your discharge instructions, as I understand it, were for Mrs. Pultz to ... as I read this above, quote: Please call the above doctor -- who would have been Dr. Flagg -- within 24 hours, unless otherwise specified, unquote; is that what it says?
A Yes, it does.
Q So understanding that September 25th, 1999, was a Saturday and September 26th was a Sunday, was it your intention for her that she was to call Dr. Flagg on Monday?
A Yes.
Q And it doesn't say here, Call him only about your UTI; it says just to call him; right?
A Correct.
Q And was it your intention that she was to call him and seek his follow-up care about her condition generally?
A That's correct; that's the usual understanding.
Q And if the evidence in this case shows that she didn't make that telephone ... or her husband didn't make that telephone call on her behalf on Monday, September 27th, 1999, you would agree with me that she was not being

compliant with your instructions, was she?
MR. MISHKIND: Objection.
THE WITNESS: Yes.
BY MR. ROSSI:
Q I believe that Dr. Flagg told us that this patient did call him on Wednesday, September 29th, 1999, but I think he also said the purpose of that phone call was merely to obtain prescriptions for her routine medications and she came in the office that day to pick up her routine medications; that type of phone call doesn't comply with your instructions, does it?
MR. MISHKIND: Let me object to your hypothetical, because it's not consistent with the facts in this case, but he can certainly answer the question.
BY MR. ROSSI:
Q If the evidence shows that that's what happened on September 29th, 1999, you would agree with me, Doctor, that that type of phone call from this patient is not consistent with your instructions, is it?
MR. MISHKIND: Objection.
THE WITNESS: If that were the case, that's correct. I would expect the patient to see their doctor for a visit, rather than obtain prescriptions.
BY MR. ROSSI:

Q I represent Dr. Mahajan. You have no knowledge of Dr. Mahajan's involvement in this case, do you, Dr. Jones?
A I understand that he saw her at ... sort of at the end of her disease process.
Q But beyond that, you don't know the specifics?
A No, sir.
MR. ROSSI: Okay. That's all I have for you. Thank you very much, Dr. Jones.
THE WITNESS: My pleasure.
MR. AUCIELLO: Steve?
CROSS-EXAMINATION
BY MR. WALTERS:
Q Doctor, real briefly, in the emergency room record of Southwest General Health Center, you refer to there being a trace of guaiac-positive on examination.
MR. MISHKIND: Steve, you're breaking up. We're getting every other word.
MR. ROSSI: Why don't I try to translate?
THE WITNESS: I understand him to say that the record indicates a trace guaiac-positive.
BY MR. WALTERS:
Q Yes. It says, Stool is trace guaiac-positive.
A Correct.
Q Did you use the term "trace" intentionally?

A I'm sorry, the term "trace" what?
Q Did you use that intentionally? Does that have a meaning?
A Yes, it does. It would indicate that the blue coloration that one gets on the guaiac test did not appear very strongly or develop immediately as would be the case with a large amount of blood. Usually when you indicate "trace guaiac-positive", that indicates only a slight degree of blueness, which would indicate only a small amount of bleeding.
MR. WALTERS: That's all I have.
MR. MISHKIND: Nothing further.
MR. AUCIELLO: We'll read it.
(THEREUPON the testimony was concluded at 3:49 p.m.)

CERTIFICATE OF OATH

STATE OF FLORIDA
COUNTY OF VOLUSIA

I, the undersigned authority, certify that Allen James Jones, M.D., personally appeared before me and was duly sworn.

WITNESS my hand and official seal this _____ day of _____, 2002.

_____
Julie L. Weston
Notary Public - State of Florida
My Commission No.: CC 799630
Expires: February 20, 2003

CERTIFICATE

STATE OF FLORIDA
COUNTY OF VOLUSIA

I, Julie L. Weston, Registered Professional Reporter, certify that I was authorized to and did stenographically report the deposition of Allen James Jones, M.D.; that a review of the transcript was requested; and that the transcript is a true and complete record of my stenographic notes.

I further certify that I am not a relative, employee, attorney or counsel of any of the parties, nor am I a relative or employee of any of the parties' attorneys or counsel connected with the action, nor am I financially interested in the action.

Dated this 8th day of April, 2002.

_____
Julie L. Weston
Registered Professional Reporter

ALLEN JAMES JONES, M.D., FACEP
1932 Southcreek Blvd.
Daytona Beach, FL 32128-7378
Home: 386-761-5062
Work: 386-917-5107
Fax: 386-761-5063

Date of Birth

April 23, 1948.

Place of Birth

Cleveland, Ohio

Current Position

Staff Emergency Physician, Florida Hospital Fish Memorial, Orange City, FL.

Florida Hospital DeLand, DeLand, FL

High acuity settings with 38,000 annual visits each.

Prior Experience

Staff attending physician in a busy emergency department and Level II Trauma Center. High Acuity setting with 40,000 annual visits, Southwest General Health Center Emergency Department, Middleburg Heights, Ohio, 1981 - 1999.

Staff physician, Emergency Department, Brown Memorial Hospital, Conneaut, OH 1980 – 1981

Past Co-Chairperson, Hospital Critical Care Committee, Southwest General

Member, Hospital Ethics Committee, Southwest General

Instructor and State Affiliate Faculty, Basic Trauma Life Support Course

Instructor, Advanced Cardiac Life Support

Instructor, Pediatric Advanced Life Support

Instructor, Pediatric Basic Trauma Life Support

Provider, Advanced Trauma Life Support

Past President, Northeast Ohio Society of Emergency Medicine

Acitvely involved in teaching and EMS activities

Education and Training

Akron General Medical Center, Akron, OH
Rotating Internship, 1979 - 1980

Ohio State University College of Medicine, Columbus, OH
Doctor of Medicine, 1979

PLAINTIFF'S EXHIBIT 1
3/6/02 Jones

Cleveland State University, Cleveland, OH
Bachelor of Science, Biology, 1976

Cuyahoga Community College, Cleveland, OH
Associate in Science, With Honors, Surgical Asistant Program, 1974

Medical Licensure

Ohio License 35-04-3951
Florida License ME-79075
Georgia License 046431

Board Certification

Board Certified by American Board of Emergency Medicine, 1989, Recertified 1999
Certificate No. 851137

Professional Affiliations

Fellow, American College of Emergency Physicians (FACEP)
Member, Florida Chapter, American College of Emergency Physicians

Military Experience

U. S. Army Security Agency (Army Intelligence) April, 1965 - November, 1971
Overseas Service
Republic of Korea, 1966 -1967
Republic of Vietnam, 1969 - 1971
Honorable Discharge, 1971

Malpractice Litigation History

None to Date

References

Available upon request.

Personal

Married to Jane E. Jones
Spouse's Occupation: Registered Nurse
Excellent Health

1-OCT-1999 09:25:44.72
Route to: DR. FLAGG

SOUTHWEST GENERAL HEALTH CENTER
18697 Bagley Rd. Middleburg Hts. OH 44130 (440)816-8850

NAME: PULTZ, BARBARA A PIN NUM: 164-1836 MED REC: (00000)408760

DIAGNOSIS: PT BY SQUAD UTI, ABD PAIN DOCTOR: JONES, ALLEN AGE/SEX: 65 YRS,FEMALE
DATE OF SERVICE: 25SEP99 LOCATION: ER

JONES, ALLEN

****

CHEMISTRY

	Specimen Date	25SEP99
	Date of Specimen	SAT 001
	Time of Specimen	2220

Procedure	Reference Range	S	Units	
---------GENERAL CHEMISTRY----------				
BUN	10 - 20		MG/DL	35H
SODIUM	135 - 145		MMOL/L	136
POTASSIUM	3.5 - 5.1		MMOL/L	5.2H
CHLORIDE	100 - 109		MMOL/L	108
CO2	24.0 - 32.0		MMOL/L	17.2L
GLUCOSE	72 - 110		MG/DL	179H
CREATININE	0.7 - 1.4		MG/DL	1.4
TOTAL PROTEIN	6.0 - 8.5		G/DL	7.3
ALBUMIN	3.3 - 5.0		G/DL	2.5L
CALCIUM	8.5 - 10.5		MG/DL	9.4
T BILI	.20 - 1.00		MG/DL	.38
ALP	30 - 120		U/L	165H
GOT	7 - 41		U/L	19
----------CALCULATED----------				
BUN/CREAT RT				25.0
CALC OSMOLALITY	275 - 295		MOS/KG	285
GLOBULIN	2.3 - 3.5		G/DL	4.8H
A/G RATIO				0.5

Very anemic - needs PRC 1 PM 10-1-99 RTC TM

Footnotes
L = Low, H = High

Continued on next page...

PLAINTIFF'S EXHIBIT 2 RLM Jones

Page 1, document continues ...

NAME: PULTZ, BARBARA A FIN NUM: 164-1836 MED REC: (00000)408760

DIAGNOSIS: PT BY SQUAD UTI, ABD PAIN DOCTOR: JONES, ALLEN AGE/SEX: 65 YRS,FEMALE
DATE OF SERVICE: 25SEP99 LOCATION: ER

JONES, ALLEN

****

HEMATOLOGY

	Specimen Date	25SEP99
	Date of Specimen	SAT 001
	Time of Specimen	2220

Procedure	Reference Range	S	Units	
----------CELL COUNTS----------				
WBC	4.5 - 11.0		X 1000	9.8
RBC	3.60 - 5.00		X 10*6	2.66LE
HGB	12.0 - 16.0		G/DL	8.0L
HCT	37.0 - 47.0		%	24.5L
MCV	82.0 - 101.0		FL	92.0
MCH	27.0 - 34.0		PG	30.0
MCHC	32.0 - 36.0		G/DL	32.6
RDW	11.5 - 14.5			17.3H
PLATELET	150 - 450		X 1000	490H
-------AUTOMATED DIFFERENTIAL-------				
LYMPH %	20.0 - 50.0		%	11.5L
MONO %	2.0 - 12.0		%	3.1
SEG %	40.0 - 75.0		%	83.9H
EOSIN %	< 10.0		%	1.1
BASOS %	< 3.0		%	.4
LYMPH COUNT	1.0 - 4.8			1.1
MONO COUNT	0.0 - 1.1			0.3
SEG COUNT	1.8 - 8.4			8.3
EOS COUNT	< 1.5			.1
BASO COUNT	< .2			.0
ANISOCYTOSIS			%	1+

Footnote:
L = Low, H = High, f = Footnote
RBC (19DEC97 -- Current)
Note: RBC morphology is normal unless otherwise stated.

Continued on next page...

Page 2, document continues ...

NAME: PULTZ, BARBARA A FIN NUM: 164-1836 MED REC: (00000)408760

DIAGNOSIS: PT BY SQUAD UTI, ABD PAIN DOCTOR: JONES, ALLEN AGE/SEX: 65 YRS,FEMALE
DATE OF SERVICE: 25SEP99 LOCATION: ER

JONES, ALLEN

****

URINALYSIS

Procedure	Reference Range	S	Unit:	Specimen Date: 25SEP99 Date of Specimen: SAT 001 Time of Specimen: 2211
--------URINE MACROSCOPIC----------				
COLOR				AMBER
APPEARANCE				HAZY
SPEC GRAVITY	1.001 - 1.035			1.005
PH	5.0 - 7.0			5.0
PROTEIN	NEG			POS 2+*f
GLUCOSE	NEG			NEG
KETONES	NEG			NEGf
BILIRUBIN	NEG			NEG
BLOOD	NEG			LARGE*f
UROBILINOGEN				0.2
NITRITE	NEG			NEG
LEUKOCYTE ESTER				MODERATE
---------URINE MICROSCOPIC---------				
UR MICROSCOPIC				INDICATE
RBC/HPF				100-200
WBC/HPF				50-100
SQUAMOUS EPITH				FEW
NONSQUAMOUS EPI				RARE
BACTERIA				FEW*

Footnote:
* = Abnormal, f = Footnote
PROTEIN..... 25SEP99 2211 Abnormal Glucose, Bilirubin, Protein, Urobilinogen, or Specific Gravity
rechecked manually _.

KETONES (Initial -- Current)
INTERP: 15 = SMALL, 40 = MODERATE, >=80 = LARGE
BLOOD (Initial -- Current)
INTERP: SMALL = 1+, MODERATE = 2+, LARGE = 3+

* * * END OF CHART * * *

Page 3, document continues ...

SOUTHWEST GENERAL HEALTH CENTER

18697 BAGLEY ROAD
MIDDLEBURG HEIGHTS, OHIO 44130-3497

PATIENT NO: (00000)408760 ROOM NO:

NAME: PULTZ, BARBARA A DOB: 09/01/1934 F

ACCT NO: 164-1836
ACCESSION NO: RA-99-34742

ALLEN JONES, M.D.
DEPT. OF EMERGENCY
MIDDLEBURG HTS OH 44130

DIAGNOSTIC RADIOLOGY

EXAM DATE/TIME	EXAM	REASON FOR EXAM
09/25/99 2312	ABDOMEN KUB	ER
2312	CHEST 2V (PA/LAT)	ER

TWO VIEW CHEST:

The heart and mediastinum are normal. The lungs are clear. There is a shallow inspiratory effort. There is no active disease.

ABDOMEN, TWO VIEW:

The gas pattern is unremarkable. There is some gas and feces in the colon. The decubitus view is negative for free air. There is no acute pathology. Bones are moderately osteopenic.

Job#60169

Technologist: DEY
SUH:LBG

Transcribed: 09/26/99 13:51

Dictated by: L. B. GROSSMAN, M.D.
Signed by: L. B. GROSSMAN, M.D.
(Electronic Signature)
Signed out: 09/26/99 20:38

Deliver to: FLAGG, DOUGLAS JONES, ALLEN
CC: FLAGG, DOUGLAS

PLAINTIFF'S EXHIBIT 3

DEPARTMENT OF RADIOLOGY
END OF REPORT