

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.

1 APPEARANCES:
2 HOWARD D. MISHKIND, ESQ. ERNEST W. AUCIELLO, JR., ESQ.
3 Becker & Mishkind, Co., L.P.A. Gallagher Sharp Fulton
4 Skylight Office Tower & Norman
5 1660 W. 2nd Street, Ste. 660 Seventh Floor Bulkley Bldg.
6 Cleveland, Ohio 44113 1501 Euclid Avenue
7 Cleveland, Ohio 44115
8 On Behalf of the Plaintiffs
9 On Behalf of Defendant
10 Allen J. Jones, M.D.
11 (Appearing telephonically) (Appearing telephonically)
12 GREGORY T. ROSSI, ESQUIRE STEVE WALTERS, ESQUIRE
13 Hanna, Campbell & Powell, LLP Weston, Hurd, Fallon,
14 P.O. Box 5521 Paisley & Howley, LLP
15 3737 Embassy Parkway, Ste. 100 2500 Terminal Tower
16 Akron, Ohio 44334 50 Public Square
17 Cleveland, Ohio 44113
18 On Behalf of Defendant
19 Subhash C. Mahajan, M.D. On Behalf of Defendants
20 Douglas N. Flagg, M.D.,
21 Richard M. Banozic, M.D.,
22 Primary Care Physicians
23 Practices and University
24 Hospitals Health Systems,
25 Inc.

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1 THEREUPON
2 ALLEN JAMES JONES, M.D.
3 was called as a witness and, having first been duly sworn,
4 testified as follows:
5 DIRECT EXAMINATION
6 BY MR. MISHKIND:
7 Q Would you please state your name for the record.
8 A Allen James Jones.
9 Q Tell me where your ... your home address. Where
10 do you live?
11 A My home address is 1932 Southcreek --
12 "Southcreek" is one word -- Boulevard; that's Daytona
13 Beach, Florida, 32128.
14 Q And your professional address.
15 A Drawing a blank. The building address ... I
16 believe it's ... I'm drawing a blank. I believe it's
17 2701 South Ridgewood, but I wouldn't swear to that. I
18 don't recall offhand. I'd have to ...
19 Q Are you self-employed or are you employed by an
20 entity?
21 A Presently, I'm with a group. The name of the
22 group is West Volusia Emergency Physicians, P.A.
23 Q West --
24 MR. ROSSI: Howard, if I could interrupt ...
25 Doctor, if you could keep your voice up just a little

1 bit. And, Howard, if you can try to talk louder. I
2 can't speak for Steve, but I'm having a hard time
3 hearing you.
4 MR. MISHKIND: You've never said that to me
5 before, Greg.
6 THE WITNESS: Okay. Keep reminding me. I've got
7 a cold and a sore throat, so it keeps fading ...
8 MR. AUCIELLO: Move closer to the phone anyhow.
9 MR. ROSSI: Right now, Doctor, you're perfect.
10 THE WITNESS: Okay.
11 All right. I'll try again. I'm sorry, the
12 question ...
13 BY MR. MISHKIND:
14 Q I was asking you to ... you said the name of the
15 group is West ... and I didn't catch the name.
16 A West Volusia, like the county. V-O-L-U-S-I-A.
17 Q And is that a group of emergency room physicians?
18 A That's correct.
19 Q How long have you been affiliated with that
20 group?
21 A Since December of 1999.
22 Q Doctor, I'm going to hand you what I've marked as
23 Plaintiff's Exhibit One, and ask you if you would take a
24 look at this document -- it's two pages -- and tell me
25 whether or not you recognize that document.

1 A Yes, I do; it's my ... a copy of my CV.
2 Q Okay. Is that a current copy of your CV?
3 A Yes, fairly current.
4 Q Is there anything that needs to be added to the
5 CV to bring it up-to-date?
6 A No.
7 Q It's current and it's accurate?
8 A Yes, sir, with the exception ... some of the
9 certifications may have lapsed on the ACLS ... the Advanced
10 Cardiac Life Support and things like that on the front.
11 Q Why don't you just take a look and tell me just
12 for the record what certifications may have lapsed just so
13 that --
14 A Possibly the Advanced Cardiac Life Support
15 instructor and things like that. I don't recall the
16 expiration dates on some of those, but ...
17 Q Okay. Is Plaintiff's Exhibit One, then, with
18 those potential modifications in terms of lapsing
19 certifications, is it an accurate and up-to-date Curriculum
20 Vitae?
21 A Yes, it is.
22 Q Do you have any other additions or versions of
23 your CV that you use for accreditation purposes or
24 licensure purposes or is this the one and only CV that you
25 have?

1 A This would be it at the present time.
 2 Q In looking at the CV, I do not notice any
 3 indication of any publications; have you written --
 4 A That's correct.
 5 Q -- anything?
 6 A No, I have not.
 7 Q You are an emergency room physician.
 8 A Yes.
 9 Q What hospitals do you work at?
 10 A At the present time, the two hospitals are
 11 Florida Hospital-Fish Memorial in Orange City and Florida
 12 Hospital-DeLand in DeLand, Florida.
 13 Q You mentioned the group that you're with as of
 14 December '99?
 15 A Correct.
 16 Q Is that when you left Cleveland?
 17 A Yes.
 18 Q How long had you been practicing in Cleveland?
 19 A Since 1980.
 20 Q What caused you to move to Florida in December of
 21 '99?
 22 A The weather. My wife and I both decided to ...
 23 we had been wanting to move somewhere warm for a long time,
 24 so we decided to ... it was a good time to make a move. A
 25 good opportunity came up down here.

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

1 A I know him professionally, mostly speaking to him
 2 by phone regarding his patients.
 3 Q And that's the extent of your ...
 4 A Yes.
 5 Q You have had occasion to see his patients, other
 6 than obviously Mrs. Pultz, in the emergency room in the
 7 past; true?
 8 A Yes.
 9 Q Have you had any contact with Dr. Flagg at any
 10 time since September 25, 1999, where you called him or he
 11 called you relative to this patient?
 12 A No, no.
 13 Q Is it fair to say that you've never talked to
 14 Dr. Flagg about Mrs. Pultz?
 15 A That's correct.
 16 Q Is it fair to say that you have not discussed any
 17 aspect of this litigation with Dr. Flagg?
 18 A That's correct.
 19 Q Dr. Mahajan; he's a gastroenterologist; do you
 20 know him?
 21 A Yes.
 22 Q How do you know Dr. Mahajan?
 23 A Again, professionally.
 24 Q Where you have had patients that have come in
 25 through the emergency room and he has seen the patients on

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

1 regard to the dictation, it appears that was done after
 2 seeing the patient but prior to the final disposition.
 3 Q Whether we look at the dictation or any of your
 4 notes, can we agree that it doesn't reflect any
 5 communication with either of those doctors while the
 6 patient was at the hospital?
 7 A There is no record of any communication, that's
 8 correct.
 9 Q And do you have any reason to believe that you
 10 did communicate, while the patient was at the hospital,
 11 with either of those doctors?
 12 A No, I do not.
 13 Q Okay. There are several other names in the
 14 record. It looks like there's a couple of nurses that were
 15 involved. Do you know ... are you able to identify the
 16 nurses that were involved in the emergency room by name?
 17 A I mean, if you told me the names, I would
 18 recognize them.
 19 Q Let me ask you this, just to try to speed things
 20 along: In connection with preparing for today's
 21 deposition, what have you reviewed?
 22 A I've only reviewed the emergency room report
 23 itself, a copy of which I have that was provided by my
 24 attorney. Feel free to review it, if you'd like. It's
 25 basically the same thing you have.

1 Q You have the entire Southwest General Hospital
 2 emergency room record, including the radiology report,
 3 including the labs that were done, including the discharge
 4 instructions --
 5 A Yes.
 6 Q -- correct?
 7 A Correct.
 8 Q You have not talked to either of the doctors,
 9 Mahajan or Flagg.
 10 A I have not discussed the case with anyone other
 11 than Mr. Auciello.
 12 Q What about reviewing any deposition testimony;
 13 have you seen either of the doctors, Dr. Flagg or
 14 Dr. Mahajan's depositions?
 15 A I don't believe I have, unless they were sent --
 16 MR. AUCIELLO: I think I told you about them, but
 17 I don't think I sent you the transcripts.
 18 THE WITNESS: No, I have not.
 19 BY MR. MISHKIND:
 20 Q Have you made any notes at all --
 21 A No.
 22 Q -- in reviewing --
 23 A No, I have not.
 24 Q -- the records?
 25 A No.

1 Q Have you made any notes at all with regard to
 2 anything about the deposition testimony of either of the
 3 doctors?
 4 A No.
 5 Q So what you have in front of you, which is the
 6 Southwest ER record, is that the totality of the --
 7 A Yes.
 8 Q -- information that you have?
 9 A Yes, it is.
 10 Q And I'm not going to look through your little
 11 briefcase there, but there's nothing --
 12 A An e-mail regarding the deposition and a blank
 13 legal pad.
 14 Q Fair enough.
 15 Have you seen the autopsy in this case?
 16 A No.
 17 Q I take it, then, you don't hold any opinions in
 18 this case as to the ultimate cause of death --
 19 A That's correct.
 20 Q -- of Mrs. Pultz; is that true?
 21 A That's correct.
 22 Q Let me ask you, on September 25, 1999, who was
 23 your employer?
 24 A Emergency Professional Services.
 25 Q Were you working exclusively at Southwest General

1 Hospital in September of '99?
 2 A I believe at that time, I may have been working a
 3 few shifts at Geauga Community Hospital also for EPS, but
 4 the bulk of my practice was at Southwest.
 5 Q Within that entity, Emergency Professional
 6 Services, did you hold a title or a position?
 7 A At that time ... at that time, no.
 8 Q At any time.
 9 A Prior to the group being bought out by a larger
 10 group, I was a shareholder. I think we were all assistant
 11 vice presidents while we were shareholders, but there was
 12 about 50 assistant vice presidents.
 13 Q When was Emergency Professional Services bought
 14 out; was it before September of '99?
 15 A Oh, yes. To the best of my recollection, '96 or
 16 '97.
 17 Q Who was the entity that bought out Emergency
 18 Professional Services?
 19 A Team Health.
 20 Q Now a moment ago, I asked you who your employer
 21 was at the time and you said Emergency Professional
 22 Services; you didn't say Team Health.
 23 A Right.
 24 Q Why is that?
 25 A It still kept the name that ... I believe

1 they ... The individual corporations under ... that were
 2 bought out by Team Health, still kept their identities
 3 as ... kept their original names.
 4 MR. AUCIELLO: I think by a stock purchase.
 5 BY MR. MISHKIND:
 6 Q Do you know whether or not you were considered an
 7 employee of Emergency Professional Services or did you have
 8 an agreement that used fancy language defining you as an
 9 independent contractor?
 10 A I believe after the buy-out, we were independent
 11 contractors.
 12 Q Were you an independent ... was Emergency
 13 Professional Services your employer or were you an
 14 independent contractor through Emergency Professional
 15 Services, if you know?
 16 A I don't know how to answer that.
 17 Q Do you still have copies, if necessary, of any of
 18 the agreements that you had with Team Health or with
 19 Emergency Professional Services back in the '96 to '99 time
 20 period?
 21 A I think I disposed of all of that.
 22 Q Have you ever had your deposition taken before,
 23 sir?
 24 A Yes.
 25 Q How many times?

1 A Somewhere between five and 10 would be my best
 2 guess.
 3 Q Putting this case aside, have you ever been named
 4 as a defendant in a medical negligence case?
 5 MR. AUCIELLO: A general objection for the record
 6 for this line?
 7 MR. MISHKIND: Sure.
 8 THE WITNESS: Yes.
 9 BY MR. MISHKIND:
 10 Q On how many occasions?
 11 A Probably six ... probably seven.
 12 Q This would be the eighth case?
 13 A I would guess.
 14 Q Is that a reasonable estimate?
 15 A Yes.
 16 Q The reason I came back and asked that, because
 17 when lawyers hear the word "guess", that makes our ... the
 18 hair stand up on our arms, so I just want to make sure that
 19 that's a reasonable estimate. You may be off by one or so?
 20 A Yes.
 21 Q Were all the cases up in Cleveland or --
 22 A Yes.
 23 Q -- have any of the cases been down here?
 24 A No. So far, none down here.
 25 MR. MISHKIND: If I could have the CV back ...

1 THE WITNESS: Sure.
 2 BY MR. MISHKIND:
 3 Q Were any of the cases --
 4 MR. MISHKIND: Strike that.
 5 BY MR. MISHKIND:
 6 Q Have any of the cases that you've been named as a
 7 defendant gone to trial?
 8 MR. AUCIELLO: With him in it?
 9 THE WITNESS: No, at least not with me in them.
 10 So some of them I don't know the final resolution of,
 11 but I was not a party to those cases at the time,
 12 so ...
 13 BY MR. MISHKIND:
 14 Q To your knowledge, are any of the other seven or
 15 eight cases still pending?
 16 A No, they're not.
 17 Q This is the only headache that you have?
 18 A It is.
 19 Q Okay. Did any of the other cases involve issues
 20 that you understand to be similar to this particular case?
 21 A No.
 22 Q Were you deposed in all of the cases?
 23 A No. Probably one or two.
 24 Q So when I asked you about depositions and you
 25 said five to 10 times --

1 A Yes.
 2 Q -- once or twice before now as a defendant?
 3 A Possibly three ... possibly as many as three of
 4 those would have gotten to the deposition stage.
 5 Q The other two to five cases, your deposition was
 6 taken in some other capacity; is that true?
 7 A Yes, as an expert witness.
 8 Q Are you currently serving as an expert witness in
 9 any medical negligence cases?
 10 A By that, do you mean are there any cases pending?
 11 Q Much better put than the way I asked you.
 12 A There's one case in Texas that's currently
 13 pending.
 14 Q Does the Texas case, or have any of the other
 15 cases that you've served as an expert where you've been
 16 deposed, involve any issues similar to the issues that you
 17 understand to exist in this case?
 18 A No, they don't.
 19 Q Of the three to five other cases that you have
 20 been deposed in ... of the two to five other cases,
 21 roughly, that you've been deposed in as an expert, were you
 22 serving as an expert for an emergency room doctor or
 23 serving as an expert for a patient bringing a claim against
 24 the emergency room doctor?
 25 A Two of the cases were for the plaintiff and the

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

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

1 A With any of the attorneys there? Yeah, it was
 2 another case with Weston, Hurd.
 3 Q Do you happen to remember the attorney that --
 4 A Sure. Ken Torgersen.
 5 Q When was the last time you were deposed?
 6 A I believe that was the Texas case; that was
 7 probably last summer.
 8 Q Do you recall what city or county in Texas that
 9 case ...
 10 A The deposition was here in Daytona. The case was
 11 in Lubbock, Texas.
 12 Q That was the plaintiff's case?
 13 A Yes.
 14 Q Do you remember the name of the plaintiff's
 15 attorney that you were working for?
 16 A The plaintiff's name was Leon Davis. The
 17 attorney was ... Bowers was the law firm -- B-O-W-E-R-S --
 18 in Lubbock.
 19 Q Are you scheduled to give deposition testimony or
 20 to testify at trial in any cases in the immediate ... in
 21 the foreseeable future?
 22 A No.
 23 Q I understand you do not remember Mrs. Pultz; is
 24 that correct?
 25 A That's correct.

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

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

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

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

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

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

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

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

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

1 Q Sure.
 2 A Yes.
 3 Q So even though you may be seeing a patient for a
 4 suspected diagnosis ... and in this case, the diagnosis
 5 that she came in with was a urinary tract infection --
 6 A Hmm-hmm.
 7 Q -- true?
 8 A Yes.
 9 Q Even though you're seeing the patient for a
 10 presumed diagnosis of a urinary tract infection, one cannot
 11 ignore, in evaluating the patient, an incidental finding of
 12 anemia, even though there may be diagnostic findings
 13 consistent with a urinary tract infection; true?
 14 A In general, yes.
 15 Q And in general, the reason that that would not be
 16 good practice is that the incidental finding of anemia may
 17 require, in certain circumstances, emergent treatment, even
 18 though the patient may have a urinary tract infection as
 19 well; true?
 20 A True.
 21 Q And if the clinical picture and the evidence
 22 suggest that the anemia is emergent, you, as an emergency
 23 room physician, have certain steps that you need to take to
 24 determine what treatment needs to be given for that anemia;
 25 correct?

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

1 A No.
 2 Q The hematocrit and hemoglobin were indicative of
 3 this patient having some form of anemia; true?
 4 A Yes.
 5 Q Her hemoglobin was 8.0; her hematocrit I believe
 6 was 23.5 or ...
 7 A Somewhere in that ballpark, yeah; 24.5.
 8 Q 24.5 --
 9 A Hmm-hmm.
 10 Q -- correct?
 11 A Correct.
 12 Q And would you agree that, at least from a
 13 laboratory standpoint, those values were ... first, were
 14 consistent with the patient having some form of anemia?
 15 A Yes.
 16 Q And would you agree that this patient was very
 17 anemic?
 18 A Not necessarily "very anemic" in terms of
 19 when ... when we say "very anemic", I think of someone
 20 emergently needing a blood transfusion and that sort of
 21 thing.
 22 Q So if you had labs that suggested that the
 23 patient was very anemic, would that suggest that the
 24 patient would need to have a blood transfusion?
 25 A Generally, yes.

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

1 whether or not the patient has a GI bleed or some type of
 2 intra-abdominal bleed?
 3 A Yes.
 4 Q An intra-abdominal bleed perhaps due to trauma?
 5 A Right.
 6 Q Or other possible causes; true?
 7 A Yes.
 8 Q And a GI bleed would not necessarily be due to
 9 trauma; it could be due to a number of potential
 10 etiologies; true?
 11 A Correct.
 12 Q You tested and saw that she was guaiac-positive?
 13 A Correct.
 14 Q And was that of any significance to you in a
 15 patient who has a hemoglobin of eight in terms of being
 16 guaiac-positive?
 17 A That would indicate some bleeding in the
 18 gastrointestinal tract.
 19 Q Did you attempt to determine where the source in
 20 the GI tract that that bleeding was emanating from?
 21 A No, that's really not possible in the ER.
 22 Q So the answer would be no.
 23 A Correct.
 24 Q Okay. What's a differential diagnosis?
 25 A A differential diagnosis is a list of diagnoses

1 related to a disease process.
 2 Q In evaluating a patient that has anemia, are
 3 there different classifications that anemia falls into or
 4 different groups that anemia falls into?
 5 A Oh, sure.
 6 Q How many different classifications or groups,
 7 generally speaking, are there when you're evaluating a
 8 patient with anemia? And this is in the emergency room
 9 setting.
 10 A Well, the anemia can be chronic or it could be
 11 acute. It could be due to blood loss, either from trauma
 12 or in the gastrointestinal tract. It could be due to the
 13 body itself not producing sufficient red blood cells.
 14 Q So it could be due to decreased red blood cell
 15 production.
 16 A Hmm-hmm. Yes.
 17 Q It could be due to increased red blood cell
 18 destruction.
 19 A Hmm-hmm.
 20 Q And it could be due to blood loss or trauma.
 21 A Yes.
 22 Q Would that be a fair sort of overview of the
 23 classifications?
 24 A Sure.
 25 Q Did you attempt in this case to ascertain which

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

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

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

1 Q You would not expect that you would go through
 2 seeing a patient like this and not ask the patient whether
 3 she has a history of rectal bleeding; true?
 4 A True.
 5 Q Hypothetically, if you didn't ask the patient
 6 whether she's had any prior anemias or whether she's had a
 7 history of rectal bleeding, that would not, in your
 8 opinion, be good care; correct?
 9 A To ask those questions would be something I would
 10 normally do.
 11 Q And the flip side is, hypothetically, if you
 12 didn't do that, would you agree that that would not be, in
 13 your opinion, good medical care?
 14 MR. AUCIELLO: Objection.
 15 THE WITNESS: I don't think I could answer that.
 16 All I could say is what I would normally do.
 17 BY MR. MISHKIND:
 18 Q And you normally do that because you consider it
 19 to be good practice; true?
 20 A Yes.
 21 Q Knowing whether or not a patient has a prior
 22 anemia and has had rectal bleeding is important in
 23 evaluating whether or not the patient's blood loss is
 24 chronic or acute; correct?
 25 A It's part of the overall picture and would be

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

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

1 A That's correct.
 2 Q In a patient that has abdominal pain, that has
 3 anemia that is in the range that she has, and also has an
 4 elevation in the platelet count, which is also something
 5 that she had; 490,000 was her platelet count; correct?
 6 A Correct.
 7 Q Those findings -- the elevation of the platelet
 8 count and the low H&H and abdominal pain -- are all
 9 consistent with a patient -- and a guaiac-positive -- are
 10 all consistent with a patient that may have an acute bleed;
 11 correct?
 12 A May have, correct.
 13 Q And it's something that needs to be evaluated;
 14 correct?
 15 A It needs to be evaluated at some point, yes.
 16 Q It may or may not need to be evaluated on an
 17 emergent basis; true?
 18 A True.
 19 Q In any event, the continuation of a nonsteroidal
 20 anti-inflammatory in a patient with abdominal pain and the
 21 clinical findings on the lab with the platelets and the H&H
 22 can precipitate additional bleeding, can it not?
 23 A It can, yes.
 24 Q You didn't advise her to stop taking the Orudis,
 25 did you?

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

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

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

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

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

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

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

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

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

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

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

1 A And as we say, if it's not written, it's not
2 done, so ...
3 Q Did Southwest or Emergency Professional Services
4 in September of '99, to your knowledge, have transfusion
5 protocols that you would follow in terms of patients that
6 present either with a specific finding or an incidental
7 finding of anemia?
8 A I don't know. The transfusion protocols would be
9 more, I would think, with regard to nursing as far as how
10 to infuse the blood; over what period of time; what
11 filter ... you know, using a blood filter ... things like
12 that; just procedural things, rather than hard and fast,
13 "If the blood count is below this, then they need to be
14 transfused."
15 Q As an emergency room doctor, do you provide
16 transfusions without admission?
17 A No.
18 Q So if a transfusion's going to be given, is it
19 after admission or have you on occasion transfused and then
20 admitted the patient?
21 A In rare instances, usually because of a traumatic
22 bleed or a catastrophic gastrointestinal bleed.
23 Q So the normal practice would be if you felt the
24 patient needed a transfusion on an emergent basis and it
25 wasn't a catastrophic bleed, you would facilitate whatever

1 steps were necessary to have the patient admitted and then
2 the transfusion would take place upon admission; is that
3 correct?
4 A Correct.
5 Q And that would ... with a family doctor on file,
6 that would be in conjunction with consultation with
7 Dr. Flagg; true?
8 A Yes, whoever the patient's doctor was or with the
9 on-call physician if they didn't have their own doctor.
10 Q What was her clinical condition upon discharge?
11 A Well, I never send anyone home unless they're
12 pain-free and there's a note in the nurse's notes,
13 "Discharged home, pain-free."
14 Q Do you know how she got to the hospital?
15 A The record indicates she got there by ambulance.
16 Q Do you know how she got home?
17 A No, I don't. I'm assuming it was with family.
18 Q As opposed to by ambulance.
19 A Yeah, that's probably not a good thing to do.
20 MR. MISHKIND: Guys, we're going to take about a
21 three- or four-minute break.
22 (WHEREUPON the proceedings were in recess from
23 3:09 p.m. until 3:14 p.m.)
24 BY MR. MISHKIND:
25 Q Doctor, on the dictated emergency room record, it

1 starts with ... it's two pages; correct?
2 A Correct.
3 Q It starts with "Chief Complaint" and it ends
4 with, "Please refer to emergency room chart for final
5 diagnosis --
6 A Yes.
7 Q -- and disposition on this patient"; true?
8 A Yes.
9 Q And you dictated --
10 MR. ROSSI: Howard, hang on one second.
11 Steve, can you hear everybody?
12 MR. WALTERS: No.
13 MR. ROSSI: Can you hear anything --
14 MR. WALTERS: No.
15 MR. ROSSI: -- other than me?
16 MR. WALTERS: Other than you.
17 MR. ROSSI: Howard, why don't you guys ... I can
18 hear you, but, Howard, why don't you go ahead and say
19 something.
20 MR. MISHKIND: What would you like me to say?
21 MR. WALTERS: I heard that.
22 MR. ROSSI: Okay. All right, go ahead. I think
23 it was just maybe a bad connection.
24 MR. MISHKIND: Okay. Steve, I just asked him to
25 identify the typed emergency room record, it's two

1 pages, and I was about to ask him whether that was
2 dictated while the patient was still in the emergency
3 room or after she had left the emergency room.
4 BY MR. MISHKIND:
5 Q That is my question.
6 A All right. It appears it was dictated after I
7 saw her, prior to the labs coming back; in fact, the time
8 is documented as 10:15 that ... at the bottom of the
9 record, that it was ... I guess that it was transcribed.
10 Q And do you have any reason to believe that the
11 time on this is incorrect? When I say on "this", I mean on
12 the typed dictation.
13 A No, I would assume that's fairly ... fairly
14 accurate.
15 Q So you would dictate ... where it says, Please
16 refer to emergency chart for final diagnosis and
17 disposition, you would have dictated that expecting that
18 you would hand-write out the final diagnosis and the
19 disposition; true?
20 A Correct.
21 Q When I looked at this, I wasn't certain whether
22 perhaps this time of the dictation was off. So, in fact,
23 you dictated it before the final diagnosis and disposition
24 had been arrived at.
25 A We ... or at least I frequently do that, because

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

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

16 A Right. As Paul Harvey would say.

17 Q Yes.

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

22 A Yes.

23 Q And you've got UTI as one.

24 A Yes.

25 Q And it looks like, Medication gas ...

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

3 A Orudis.

4 Q Orudis.

5 A Hmm-hmm.

6 Q That's a yes?

7 A Yes. Yes. I'm sorry.

8 Q That's all right.

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

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

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

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

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

1 A Gastritis.

2 Q Gastritis.

3 A Hmm-hmm.

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

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

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

14 A Yes.

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

18 A True.

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

21 A Yes.

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

25 A That's a fair statement, yes.

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

2 Which is "discharge."

3 A Correct.

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

5 A Yes, 0015.

6 Q "Stable"?

7 A Yes.

8 Q And is that your signature?

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

12 Q ... out the door?

13 A Yes.

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

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

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

23 A No, not from the record.

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

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

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

1 Q There are no diagnoses that you made of anemia of
 2 any type; correct?
 3 A Correct.
 4 Q And there were no discharge instructions given to
 5 the patient relative to her anemia; correct?
 6 A That's correct.
 7 Q She wasn't treated in any way for her anemia.
 8 A That's correct.
 9 Q And all of the medications that were prescribed
 10 were to be for treatment of her urinary tract infection;
 11 correct?
 12 A Yes.
 13 Q And you wanted the patient to follow up with her
 14 family doctor relative to her urinary tract infection;
 15 correct?
 16 A And her abdominal pain, yes.
 17 Q And what did you attribute the abdominal pain to?
 18 A I don't recall specifically having a ... other
 19 than the medication, again, possibly because of something
 20 the patient had said related to the Cipro.
 21 Q Is it fair to say that ... I'm sorry, did I cut
 22 you off?
 23 A No.
 24 Q Is it fair to say that you did not advise the
 25 patient that the abdominal pain may be a symptom associated

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

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

1 BY MR. MISHKIND:
 2 Q Do you know when the emergency room record from
 3 front to back was received by Dr. Flagg?
 4 A No.
 5 Q Do you know when the KUB report was sent to
 6 Dr. Flagg?
 7 A No.
 8 Q On the copy of your record, does it have anything
 9 indicated in the lower left-hand corner?
 10 A In the ... what are we looking at? On the x-ray
 11 report?
 12 Q Hmm-hmm.
 13 A No.
 14 Q Let me see your --
 15 A You mean a hand-written note or a courtesy copy?
 16 Q See where it says, "Delivered to Flagg, Douglas"?
 17 A Hmm-hmm.
 18 Q "Cc Flagg, Douglas"?
 19 A Yes.
 20 Q Do you know from your record when that was sent
 21 to Dr. Flagg?
 22 A No.
 23 Q Do you know why this report would be reflected as
 24 something that would be sent to Dr. Flagg?
 25 A The usual practice was to send a copy of all

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

1 the doctor; correct?
 2 A Oh, sure. I mean, it would be good to have it.
 3 Frequently, we give the patients ... at least I give the
 4 patients copies of their labs in the ER.
 5 Q Do you know whether that was done in this case?
 6 A Again, no ... no record of that.
 7 Q I'm going to tell you that the record would
 8 suggest that ...
 9 MR. MISHKIND: In fact, let me ... rather than
 10 telling you that, let me just mark as Exhibit Two ...
 11 BY MR. MISHKIND:
 12 Q I'm going to show you what I've marked as Exhibit
 13 Two ...
 14 MR. AUCIELLO: Do we have Dr. Flagg's records?
 15 MR. MISHKIND: Yes.
 16 MR. AUCIELLO: Because I don't have Dr. Flagg's
 17 records and I object to the fact that I can't get
 18 them. I keep asking Dr. Flagg's counsel for them and
 19 I don't have them yet.
 20 BY MR. MISHKIND:
 21 Q Okay. Exhibit Two is --
 22 MR. MISHKIND: What was that?
 23 MR. WALTERS: What don't you have?
 24 MR. AUCIELLO: I don't have Dr. Flagg's records.
 25 We keep writing Deirdre and she doesn't send them to

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

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

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

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

1 A Correct. Now the results would have been
2 available to him, but ... I mean, he may not have had a
3 written report, but they could have ... he could have
4 gotten the results.
5 Q So if Dr. Flagg received on September 27th, as an
6 example, two days after the emergency room visit the KUB
7 results, would that normally, as you understand it, let the
8 doctor know that the patient had been seen in the emergency
9 room if it's documented as such? Not a terribly
10 well-worded question, but do you follow me on that?
11 MR. WALTERS: I'm going to object to the question
12 asked.
13 THE WITNESS: I mean, if this was the first piece
14 of paper that Dr. Flagg had received, he would know, I
15 suppose, that the patient was in the emergency room.
16 BY MR. MISHKIND:
17 Q And then just to follow that up, would he then
18 have access to the emergency room record if he wanted to
19 determine anything further as to why the patient had been
20 seen or what else was done for the patient?
21 A Yes.
22 Q And I take it you have no knowledge as to what,
23 if anything, Dr. Flagg or his office did two days later on
24 September 27th when they received this KUB; correct?
25 A Correct.

1 Q Okay. The triage nurse appears to be Nurse Vana?
2 A Yes.
3 Q What's Nurse Vana's first name?
4 A It's Raemarie; it's one word, I guess.
5 Q Disposition at 12:15 a.m.; 0015?
6 A Yes.
7 Q "Stable." Is that signed by a different nurse
8 than ...
9 A Yes, it would appear to be, but I don't know who
10 that nurse is.
11 Q On the Patient Progress Record, those notes
12 written up to the time of discharge are nursing notes --
13 A Yes.
14 Q -- is that true?
15 A Yes.
16 Q Are you able to identify who that nurse was?
17 A No, not at all.
18 Q What else did you consider, if anything, as an
19 explanation for her being guaiac-positive at the time that
20 you saw her after having the labs back or was a GI bleed
21 the top on your "differential"?
22 A That would have to be the top. I mean, there was
23 really nothing else that would ... you know, hemorrhoids or
24 something like that, but ... you know.
25 Q No history of hemorrhoids that you're aware of;

1 correct?
2 A No.
3 Q And your record doesn't reflect in any way --
4 dictation or written -- anything about the patient having a
5 gastrointestinal bleed as a diagnosis that you made in the
6 emergency room; correct?
7 A That's correct.
8 Q There's nothing indicating that you expected the
9 patient to have further follow-up or evaluation for a
10 gastrointestinal bleed; true?
11 A As far as the record, no. Again, I ... whether I
12 said ... I would assume I mentioned something to her at
13 that time, but there's no record of that.
14 Q And, again, if you didn't do that, that would not
15 be good practice --
16 MR. AUCIELLO: Objection.
17 BY MR. MISHKIND:
18 Q -- correct?
19 A Well, if I didn't ... if I failed to tell ... to
20 instruct her?
21 Q Yes.
22 A It would not be ideal, yes.
23 Q It would not be what you would consider to be
24 reasonable practice; true?
25 MR. AUCIELLO: Objection.

1 You can answer.
2 THE WITNESS: I would not be pleased with myself,
3 yes.
4 MR. MISHKIND: Fair enough.
5 Doctor, I have no further questions. Thank you.
6 MR. ROSSI: Doctor, this Greg Rossi. I've got a
7 few questions for you.
8 CROSS-EXAMINATION
9 BY MR. ROSSI:
10 Q If we go to the discharge instructions, that
11 type-written form?
12 A Okay.
13 Q At the end of that, where it says, "Follow-up
14 care"?
15 A Okay.
16 Q First of all, Ms. Pultz signed this form at the
17 bottom, didn't she?
18 A Yes.
19 Q I take it that means that somebody reviewed these
20 with her and, to the best of their knowledge, she
21 understood what she was supposed to do; right?
22 A Yes.
23 Q And you would agree that in this situation, that,
24 indeed, part of the responsibility falls upon the patient,
25 doesn't it?

1 A Absolutely.

2 Q And she would have been provided a copy, if not

3 the original of these discharge instructions; true?

4 A The patient gets the original.

5 Q Okay. Part of your discharge instructions, as I

6 understand it, were for Mrs. Pultz to ... as I read this

7 above, quote: Please call the above doctor -- who would

8 have been Dr. Flagg -- within 24 hours, unless otherwise

9 specified, unquote; is that what it says?

10 A Yes, it does.

11 Q So understanding that September 25th, 1999, was a

12 Saturday and September 26th was a Sunday, was it your

13 intention for her that she was to call Dr. Flagg on Monday?

14 A Yes.

15 Q And it doesn't say here, Call him only about your

16 UTI; it says just to call him; right?

17 A Correct.

18 Q And was it your intention that she was to call

19 him and seek his follow-up care about her condition

20 generally?

21 A That's correct; that's the usual understanding.

22 Q And if the evidence in this case shows that she

23 didn't make that telephone ... or her husband didn't make

24 that telephone call on her behalf on Monday, September

25 27th, 1999, you would agree with me that she was not being

1 compliant with your instructions, was she?

2 MR. MISHKIND: Objection.

3 THE WITNESS: Yes.

4 BY MR. ROSSI:

5 Q I believe that Dr. Flagg told us that this

6 patient did call him on Wednesday, September 29th, 1999,

7 but I think he also said the purpose of that phone call was

8 merely to obtain prescriptions for her routine medications

9 and she came in the office that day to pick up her routine

10 medications; that type of phone call doesn't comply with

11 your instructions, does it?

12 MR. MISHKIND: Let me object to your

13 hypothetical, because it's not consistent with the

14 facts in this case, but he can certainly answer the

15 question.

16 BY MR. ROSSI:

17 Q If the evidence shows that that's what happened

18 on September 29th, 1999, you would agree with me, Doctor,

19 that that type of phone call from this patient is not

20 consistent with your instructions, is it?

21 MR. MISHKIND: Objection.

22 THE WITNESS: If that were the case, that's

23 correct. I would expect the patient to see their

24 doctor for a visit, rather than obtain prescriptions.

25 BY MR. ROSSI:

1 Q I represent Dr. Mahajan. You have no knowledge

2 of Dr. Mahajan's involvement in this case, do you,

3 Dr. Jones?

4 A I understand that he saw her at ... sort of at

5 the end of her disease process.

6 Q But beyond that, you don't know the specifics?

7 A No, sir.

8 MR. ROSSI: Okay. That's all I have for you.

9 Thank you very much, Dr. Jones.

10 THE WITNESS: My pleasure.

11 MR. AUCIELLO: Steve?

12 CROSS-EXAMINATION

13 BY MR. WALTERS:

14 Q Doctor, real briefly, in the emergency room

15 record of Southwest General Health Center, you refer to

16 there being a trace of guaiac-positive on examination.

17 MR. MISHKIND: Steve, you're breaking up. We're

18 getting every other word.

19 MR. ROSSI: Why don't I try to translate?

20 THE WITNESS: I understand him to say that the

21 record indicates a trace guaiac-positive.

22 BY MR. WALTERS:

23 Q Yes. It says, Stool is trace guaiac-positive.

24 A Correct.

25 Q Did you use the term "trace" intentionally?

1 A I'm sorry, the term "trace" what?

2 Q Did you use that intentionally? Does that have a

3 meaning?

4 A Yes, it does. It would indicate that the blue

5 coloration that one gets on the guaiac test did not appear

6 very strongly or develop immediately as would be the case

7 with a large amount of blood. Usually when you indicate

8 "trace guaiac-positive", that indicates only a slight

9 degree of blueness, which would indicate only a small

10 amount of bleeding.

11 MR. WALTERS: That's all I have.

12 MR. MISHKIND: Nothing further.

13 MR. AUCIELLO: We'll read it.

14 (THEREUPON the testimony was concluded at 3:49 p.m.)

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1 CERTIFICATE OF OATH

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4 STATE OF FLORIDA
5 COUNTY OF VOLUSIA
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7
8 I, the undersigned authority, certify that Allen
9 James Jones, M.D., personally appeared before me and was duly
10 sworn.
11

12
13 WITNESS my hand and official seal this _____
14 day of _____, 2002.
15
16
17
18

19 Julie L. Weston
Notary Public - State of Florida
My Commission No.: CC 799630
Expires: February 20, 2003
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1 CERTIFICATE
2 STATE OF FLORIDA
3 COUNTY OF VOLUSIA
4

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

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

15 Dated this 8th day of April, 2002.
16
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19 Julie L. Weston
Registered Professional Reporter
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V value 48:17				

ALLEN JAMES JONES, M.D., FACEP

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Daytona Beach, FL 32128-7378
Home: 386-781-5062
Work: 386-917-5107
Fax: 386-781-5063

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

Actively 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

Allen Jones

Cleveland State University, Cleveland, OH
Bachelor of Science, Biology, 1978

Cuyahoga Community College, Cleveland, OH
Associate in Science, With Honors, Surgical Assistant 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 1989
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
DATE OF SERVICE: 25SEP99

DOCTOR: JONES, ALLEN

AGE/SEX: 65 YRS, FEMALE
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

Footnotes:

L = Low, H = High

PULTZ, BARBARA A

10/01/99 0925

MED REC: (00000)408760

PAGE NO:

1

Continued on next page...

PLAINTIFF'S
EXHIBIT

2
JONES

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

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	17.0 - 47.0	%	24.5L
MCV	82.0 - 101.0	FL	32.0
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+

Footnotes:

L = Low, H = High, f = Footnote

RBC (19DEC97 -- Current)

Note: RBC morphology is normal unless otherwise stated.

PULTZ, BARBARA A

10/01/99 0925

MED REC: (00000)408760

PAGE NO:

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Continued on next page...

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

Specimen Date 25SEP99
Date of Specimen SAT 001
Time of Specimen 2211
Procedure Reference Range & Units

-----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+*
GLUCOSE	NEG	NEG
KETONES	NEG	NEG
BILIRUBIN	NEG	NEG
BLOOD	NEG	LARGE*
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*

Footnotes:

* = 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+

PULTZ, BARBARA A

164-1836

MED REC: (00000)408760

PAGE:

3

* * * END OF CHART * * *

SOUTHWEST GENERAL HEALTH CENTER18697 BAGLEY ROAD
MIDDLEBURG HEIGHTS, OHIO 44130-3497

PATIENT NO: (000000)408760

ROOM NO:

NAME: PULTZ, BARBARA A

DOB: 09/01/1934 F

Flagg
ALLEN JONES, M.D.
DEPT. OF EMERGENCY
MIDDLEBURG HTS

OH 44130

ACCT NO: 164-1836
ACCESSION NO: RA-99-34742**DIAGNOSTIC RADIOLOGY**

EXAM DATE/TIME

EXAM

REASON FOR EXAM

09/25/99 23:12
23:12ABDOMEN KUB
CHEST 2V (PA/LAT)ER
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
SJH:LEBDictated by: L. B. GROSSMAN, M.D.
Signed by: L. B. GROSSMAN, M.D.
(Electronic Signature)
Signed out: 09/26/99 20:38

Transcribed: 09/26/99 13:51

Deliver to: FLAGG, DOUGLAS
CC: FLAGG, DOUGLAS

JONES, ALLEN

PLAINTIFF'S
EXHIBIT

3

DEPARTMENT OF RADIOLOGY
END OF REPORT