
DEPOSITION OF DONALD JUNGLAS, M.D.

Dorothy Ross vs. Bennie Allison, M.D.

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CONDENSED TRANSCRIPT AND CONCORDANCE
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(1) The State of Ohio,)
 (2) County of Cuyahoga.)SS:
 (3) IN THE COURT OF COMMON PLEAS
 (4) Dorothy Ross,)
 (5) Plaintiff,)Case No.
 (6) -vs-)98CV358014
 (7) Bennie Allison, M.D.,)
 (8) et al.,)
 (9) Defendants.)
 (10)
 (11)
 (12) Deposition of DONALD JUNGLAS, M.D., an
 (13) expert witness herein, called by the
 (14) Plaintiff as if upon cross-examination under
 (15) the statute, and taken before Luanne Stone,
 (16) a Notary Public within and for the State of
 (17) Ohio, pursuant to the agreement of counsel,
 (18) and pursuant to the further stipulations of
 (19) counsel herein contained, on Friday, the
 (20) 11th day of February, 2000 at 1611 South
 (21) Green Road, the City of South Euclid, the
 (22) County of Cuyahoga and the State of Ohio.
 (23) --- o0o ---
 (24) APPEARANCES:
 (25)

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(1) On behalf of the Plaintiff:
 (2) Chattman, Gaines & Stern, by:
 (3) John Scharon, Esq.
 (4) Dale Nowak, Esq.
 (5)
 (6) On behalf of the Defendants:
 (7) Roetzel & Andress, by:
 (8) Joseph E. Herbert, M.D.
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 (11)
 (12) --- o0o ---
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(1) P R O C E E D I N G S
 (2) DONALD JUNGLAS, M.D., being of
 (3) lawful age, having been first duly sworn
 (4) according to law, deposes and says as
 (5) follows:
 (6) CROSS-EXAMINATION OF DONALD JUNGLAS, M.D.
 (7) BY MR. SCHARON:
 (8) Q Doctor, if you'd just state your
 (9) complete name for the record.
 (10) A Donald W. Junglas, J-U-N-G-L-A-S. My
 (11) address is 1611 South Green Road, South
 (12) Euclid, Ohio, 44121.
 (13) Q Doctor, by profession, you are a
 (14) physician?
 (15) A General internal medicine physician.
 (16) Q Okay.
 (17) A Since 1964, December.
 (18) Q And you've provided us with a copy of
 (19) your CV which I'll ask to be marked and
 (20) attached.
 (21) A Right.
 (22) Q I'm looking through the materials that
 (23) you've brought with you to the deposition,
 (24) and there are various medical records and
 (25) correspondence from Mr. Herbert and some

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(1) depositions. Is this all the material that
 (2) you've reviewed in the case?
 (3) A Right.
 (4) Q Okay.
 (5) (At this time Plaintiffs Exhibit
 (6) 1 was marked for identification purposes.)
 (7) BY MR. SCHARON:
 (8) Q I didn't see any notes.
 (9) A No, I didn't take any.
 (10) Q Did you make any?
 (11) A I didn't take any.
 (12) Q You've been Board certified in internal
 (13) medicine since 1966 with a recertification
 (14) in '74 according to your CV. Are you due
 (15) for another recertification?
 (16) A I'm grandfathered. My son who is an
 (17) internist will have to take it again in
 (18) seven years, but I'm grandfathered.
 (19) Q Okay. Were you able to complete your
 (20) certification on your first and only attempt?
 (21) A Yes.
 (22) Q Okay.
 (23) A Luckily.
 (24) Q Yes.
 (25) A It's no fun to go through it a second

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(1)time.
 (2) Q If a physician has to go through it a
 (3)second time, assuming he passes the second
 (4)time, does that reflect negatively on his
 (5)qualifications as an internal medicine
 (6)physician?
 (7) MR. HERBERT: Objection.
 (8) THE WITNESS: No. Some people
 (9)don't test very well. So --
 (10) BY MR. SCHARON:
 (11) Q It doesn't mean he's not competent?
 (12) MR. HERBERT: Objection. It
 (13)depends on the physician.
 (14) THE WITNESS: No.
 (15) BY MR. SCHARON:
 (16) Q I'm sorry?
 (17) A No.
 (18) Q Okay.
 (19) A Not at all.
 (20) Q Sometimes those gestures, if you make a
 (21)shake of the head or a nod, it's not clear
 (22)on the record.
 (23) A I know.
 (24) Q I'll just try to remind you, not to be
 (25)rude, but so that it gets accurately on the

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(1)record.
 (2) A I know you have to have the information
 (3)verbally.
 (4) Q Thank you. Your hospital privileges
 (5)are at University Hospitals?
 (6) A Yes.
 (7) Q And Veterans?
 (8) A I don't use Veterans. I just use
 (9)University.
 (10) Q Okay.
 (11) A I must say very much rarely nowadays.
 (12)Most people get taken care of, for almost
 (13)everything, right here.
 (14) Q In the office?
 (15) A Yeah.
 (16) Q If you have patients that you need to
 (17)refer for minor surgical procedures, they're
 (18)also referred right within this center?
 (19) A Yes, and they have a minor surgical
 (20)procedure place here. I had my hernia fixed
 (21)here. I was in and out of here in two
 (22)hours.
 (23) Q Okay. Obviously, in a case like this,
 (24)we may be concerned about talking about a
 (25)lymph node biopsy. Is that something that

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(1)would be done right within this office?
 (2) A I'm not sure of that. There may be
 (3)now. I don't know exactly what they do
 (4)there in total.
 (5) Q Okay. I assume you have patients from
 (6)time to time that you need to refer for
 (7)lymph node biopsy. Is that true?
 (8) A Once in a great while.
 (9) Q Okay. Do you do that by referring to
 (10)an ENT first?
 (11) A Usually, uh-huh.
 (12) Q Please don't be offended at some of
 (13)these questions. They are routine questions
 (14)that we ask of all physicians in this
 (15)circumstance.
 (16) Has any action ever been taken
 (17)against your medical licensure?
 (18) A No.
 (19) Q How about your hospital privileges?
 (20) A No.
 (21) Q That's the end of the apology, okay.
 (22) A I understand.
 (23) Q Thank you. Do you have an appointment
 (24)as a teacher of medicine?
 (25) A Yes.

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(1) Q At Case Western Reserve?
 (2) A I'm a clinical professor now. I've
 (3)gotten that old.
 (4) Q You've gone through the ranks of
 (5)assistant clinical professor?
 (6) A You start out as a demonstrator, then
 (7)assistant, associate. Not everybody makes
 (8)it up the ladder, but they felt sorry for
 (9)me.
 (10) Q Okay. You started to talk a little bit
 (11)about the general nature of your practice.
 (12)It's practically exclusively an office
 (13)practice at this point?
 (14) A Yes, headaches to hemorrhoids I tell
 (15)people.
 (16) Q Headaches to hemorrhoids, so from top
 (17)to bottom?
 (18) A Right.
 (19) Q And have you had patients in your
 (20)career with Hodgkin's disease?
 (21) A Very rarely.
 (22) Q Good.
 (23) A Maybe two cases in 35 years.
 (24) Q Is that right? Now, were these
 (25)patients that were diagnosed with Hodgkin's

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(1) while you were their doctor, or did they
 (2) come to you afterwards?
 (3) A I believe they were diagnosed while I
 (4) was their doctor.
 (5) Q Were you involved in their workup to
 (6) come to the diagnosis?
 (7) A What happens today is, if you find
 (8) somebody with an abnormality, you refer them
 (9) on for a biopsy, whatever, and if they're
 (10) found to have some problem, they always end
 (11) up with an oncologist, and you rarely see
 (12) them again unless there's a problem while
 (13) the oncologist is taking care of them in the
 (14) general internal medicine field. If the
 (15) patient is cured, and they are then followed
 (16) by the oncologist, then they come back to
 (17) you.
 (18) Q Do you happen to recall in those couple
 (19) of Hodgkin's patients that you had how the
 (20) diagnosis was arrived at?
 (21) A You know, I don't know. I'd have to
 (22) look up their charts.
 (23) Q Can you remember at least in general
 (24) terms the time frame when those cases were
 (25) diagnosed?

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(1) A No, I do not.
 (2) Q Has it been more than five years, more
 (3) than ten?
 (4) A Oh, you mean how long ago they were?
 (5) Q Yes, I'm sorry.
 (6) A One was maybe five, and one was
 (7) probably 15.
 (8) Q In your 35 years of practice, Doctor,
 (9) have you ever been a party to a medical
 (10) negligence case?
 (11) A Once.
 (12) MR. HERBERT: Just note my
 (13) objection.
 (14) MR. SCHARON: That's fine.
 (15) THE WITNESS: I was defended by
 (16) Bob Maynard, and we won.
 (17) BY MR. SCHARON:
 (18) Q What kind of case was it?
 (19) A It was an orthopedic case with an
 (20) infected patella.
 (21) Q Off the record.
 (22) (At this time a discussion was
 (23) held off the record.)
 (24) BY MR. SCHARON:
 (25) Q How much experience have you had,

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(1) Doctor, as an expert witness in medical
 (2) negligence cases?
 (3) A Oh, I do maybe three cases, three or
 (4) four cases a year.
 (5) Q Okay.
 (6) A Most of the time, it's just reports.
 (7) Once in a while, it's depositions. In this
 (8) particular week, I happened to have one
 (9) other deposition this week which is highly
 (10) unusual. I testified once last year in
 (11) court. I maybe have testified two times in
 (12) court, once as a plaintiffs expert and once
 (13) as a defense expert.
 (14) Q Okay. In the case in which you
 (15) testified as a plaintiffs expert, did that
 (16) come to you as an independent consultant?
 (17) A Yes.
 (18) Q Or was this a patient of yours?
 (19) A No. Well, it was a patient of mine,
 (20) yes.
 (21) Q Oh, it was a patient?
 (22) A Yes.
 (23) Q So, you testified on behalf of your
 (24) patient?
 (25) A Right.

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(1) Q For how long have you averaged, you
 (2) know, three or four cases a year?
 (3) A Maybe ten years.
 (4) Q Have you --
 (5) A I don't make it a large part of my
 (6) activities. I consider it a service rather
 (7) than an employment.
 (8) Q Sure. What was it that led you to get
 (9) involved in it?
 (10) A You know, I don't really know.
 (11) Q Okay.
 (12) A I think somebody asked me once, and I
 (13) said: well, I might be interested in
 (14) looking at it, and then your name gets
 (15) around a little bit.
 (16) Q Sure. So, what percentage of your time
 (17) would you think you spend?
 (18) A A half of one percent.
 (19) Q Have you ever worked for Mr. Herbert
 (20) here before?
 (21) A Only, I think in the one case where I
 (22) was a plaintiffs expert, if you will, or,
 (23) you know, gave testimony on my patient, but
 (24) otherwise not.
 (25) Q So --

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(1) A He reminded me of that today. I had
 (2) forgotten.
 (3) Q Was he on the other side, or was he
 (4) representing the plaintiff?
 (5) A I think his firm was on the other side.
 (6) Q Okay, representing the physician?
 (7) A (At this time the witness nodded his
 (8) head.)
 (9) Q Yes?
 (10) A Right.
 (11) Q Have any of the cases that you've been
 (12) involved in as a medical/legal consultant
 (13) involved Hodgkin's disease?
 (14) A No.
 (15) Q Do you recall about how long you've
 (16) been aware of and involved in this case,
 (17) when you would have first been contacted
 (18) essentially?
 (19) A Probably some time prior to November of
 (20) '99. So, I would suspect, maybe, October.
 (21) Q Okay. Shortly before you wrote your
 (22) report?
 (23) A Yeah.
 (24) Q Except for that one situation in which
 (25) you testified on behalf of your patient,

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(1) have any of your other medical/legal
 (2) consulting work or cases been on behalf of
 (3) plaintiffs?
 (4) A On occasion, maybe one in ten.
 (5) Q Okay. In addition to looking at the
 (6) materials in front of you, did you do any
 (7) medical or on-line research?
 (8) A No.
 (9) Q Can you tell me which, if any, of the
 (10) physicians involved in this case you're
 (11) personally familiar with?
 (12) A None.
 (13) Q None, not Dr. Lazarus at UH?
 (14) A Oh, I'm sorry. I didn't realize you
 (15) were talking about those people. Yes, I
 (16) know Dr. Lazarus. He's the only one.
 (17) Q Allright.
 (18) A I thought you meant of the people that
 (19) are the defendants.
 (20) Q I should have been clearer. It was an
 (21) ambiguous question. You don't know Drs.
 (22) Tyler or Allison?
 (23) A No.
 (24) Q Or how about the other experts in the
 (25) case, either Dr. John Petrus --

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(1) A No.
 (2) Q -- an oncologist from Akron, or Barry
 (3) Singer --
 (4) A No.
 (5) Q -- from Pennsylvania?
 (6) A No.
 (7) Q Okay. The report of November 18, 1999
 (8) --
 (9) A Yes.
 (10) Q -- is that the only writing that you've
 (11) produced?
 (12) A Well, there was a previous report which
 (13) I unfortunately don't have. It's on the
 (14) computer upstairs which I don't know how to
 (15) access. My secretary that runs that isn't
 (16) here today, but I think the only difference
 (17) between that and this was the fact that I
 (18) hadn't -- I hadn't reviewed the plaintiff
 (19) expert report of Barry Singer, and the
 (20) report of John Petrus. I believe that's the
 (21) only difference. I think that the opinions
 (22) are the same. I think it just didn't have
 (23) that information on it.
 (24) Q Okay. If it wouldn't be too much of an
 (25) inconvenience, at the time your secretary is

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(1) back and able to access that --
 (2) A She'll be back Monday.
 (3) Q --would you ask her to print it and
 (4) provide it to Mr. Herbert?
 (5) MR. HERBERT: I'm assuming she
 (6) can do that. If I have a copy of it, I'll
 (7) see what I can do.
 (8) BY MR. SCHARON:
 (9) Q Okay. Just to be clear, the reference
 (10) on the bottom of your November 18th, 1999,
 (11) report to "corrected version, 11/23/99,"
 (12) does that mean that you think that the
 (13) version of November 18 did not have items
 (14) five and six on this list?
 (15) A That's what I think, but I'm not sure.
 (16) Q Have you discussed the case with any of
 (17) your colleagues or other physicians?
 (18) A No.
 (19) Q Your first and primary opinion in the
 (20) case is that Drs. Allison and Tyler met
 (21) acceptable standards of care.
 (22) A Yes.
 (23) Q You're basing that obviously on your
 (24) review of the records and, of course, on
 (25) your knowledge and experience.

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- (1) A Yes.
- (2) Q Can you tell me factually what the
- (3) basis is for your opinion?
- (4) A They took care of this patient for
- (5) intercurrent illnesses of which she had a
- (6) number that involved her upper respiratory
- (7) tract, and during the period when she had
- (8) complaints in that area, she had lymph nodes
- (9) that were discovered on several occasions,
- (10) and this is not inconsistent with the
- (11) symptoms that she was complaining of at the
- (12) time, and I felt that the treatment plan
- (13) that was outlined was at the standard of
- (14) care.
- (15) Q With respect to the upper respiratory
- (16) infections, are you talking primarily about
- (17) sinus infections?
- (18) A Sinus, she had some throat pain here
- (19) and there, and that kind of issue.
- (20) Q Okay, and they were also treating her
- (21) for anemia?
- (22) A Well, they were trying to investigate
- (23) her anemia, yes.
- (24) Q Well --
- (25) A She was discovered to be mildly anemic,

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- (1) I believe, in June of '96, and had a little
- (2) bit of a workup at that time which didn't
- (3) really tell them what the cause of the
- (4) anemia was. She then was discovered to have
- (5) a more severe anemia, I believe it was in
- (6) January of '97, and at that time a more
- (7) thorough workup was begun.
- (8) Q Following the initial discovery of the
- (9) mild anemia in May of 1996 --
- (10) A Right.
- (11) Q -- she was given an iron supplement.
- (12) A Yes.
- (13) Q So, she was treated for that condition.
- (14) A That's correct.
- (15) Q And she was thought to have iron
- (16) deficiency anemia?
- (17) A Yes. There was some question about
- (18) whether this was the only cause, but it's
- (19) the most common cause in somebody of her age
- (20) group, but there are other things,
- (21) obviously, that can cause it.
- (22) Q In your evaluation of the case, did you
- (23) in your evaluation of the case focus on
- (24) whether the doctor's investigation of the
- (25) anemia --

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- (1) A Yes.
- (2) Q -- met acceptable standards of care?
- (3) A Initially, when they first discovered
- (4) the anemia, the treatment with iron was
- (5) appropriate. When they discovered the
- (6) anemia to be more severe in January,
- (7) obviously, they had considered more serious
- (8) diagnoses, and they began a series of
- (9) investigations through gastroenterologists
- (10) initially which culminated, I believe, at
- (11) the end of April, and then she terminated
- (12) the relationship with these doctors in May,
- (13) so that no further workup was done, although
- (14) they had contemplated doing something
- (15) further in regards to bone marrow
- (16) investigation if the GI investigation didn't
- (17) work.
- (18) Q We'll talk in some more detail about
- (19) those things as we move along. At this
- (20) time, I'd like to focus on the question of
- (21) these lymph nodes, at least for a few
- (22) moments.
- (23) In your experience, patients,
- (24) female patients in their forties who have
- (25) upper respiratory infections, do they

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- (1) usually or typically have lymphadenopathy?
- (2) A They may. Each person reacts in a
- (3) different way, so they may have
- (4) lymphadenopathy, yes.
- (5) Q If you surveyed, for instance, ten
- (6) patients in that class of females in their
- (7) forties --
- (8) A Right,
- (9) Q --with upper respiratory infections,
- (10) how many would you typically see with lymph
- (11) node involvement?
- (12) A I would say maybe two out of ten.
- (13) Q Okay, and would it be typical or would
- (14) it be unusual for the patients who had
- (15) lymphadenopathy to have it in the cervical
- (16) chains as opposed to submandibularly?
- (17) A Well, that's a variable thing. I don't
- (18) know that I've ever really tried to
- (19) correlate that. Most of the time, the lymph
- (20) nodes you feel in adults are in the cervical
- (21) chain for the most part.
- (22) Q In the presence of upper respiratory
- (23) infections, are the lymph nodes in adults
- (24) typically in the neck or are they typically
- (25) submandibular?

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(1) A No, they're typically in the neck.
 (2) Q In the neck?
 (3) A Yes, usually on either side of the
 (4) mandible.
 (5) Q If I wanted to look in the medical
 (6) literature to see some description of
 (7) patients in this age range with upper
 (8) respiratory infections and the presence of
 (9) cervical lymph nodes --
 (10) A Yes.
 (11) Q -- is there any literature that you
 (12) would suggest that I go to? Where would I
 (13) find it, I guess is my question?
 (14) A You might find a short reference to the
 (15) fact that, when people get upper respiratory
 (16) illnesses, they may manifest cervical
 (17) lymphadenopathy. I don't think you'd find
 (18) that there would be a big write-up about it.
 (19) Q In a patient in her forties who's got
 (20) an upper respiratory infection and positive
 (21) lymph nodes who's treated with antibiotics,
 (22) how long would you expect that the lymph
 (23) nodes would remain enlarged?
 (24) A Well, many times lymph node enlargement
 (25) isn't due to just bacterial infection; it's

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(1) due to viral infection, and sometimes they
 (2) remain for a long period of time and then
 (3) gradually resolve. Sometimes they remain,
 (4) to a smaller degree, indefinitely. I mean,
 (5) they have this enlargement, and then the
 (6) enlargement may decrease, the so-called
 (7) waning of it, but it never completely
 (8) disappears. So, they may have a few what
 (9) they call shotty nodes left, little marble
 (10) size.
 (11) Q When you say shotty, that's S-H --
 (12) A O-T-T-Y.
 (13) Q Not "shoddy."
 (14) A Right.
 (15) Q Okay. Would you expect those lymph
 (16) nodes in the presence of treatment to last
 (17) for weeks or months?
 (18) A They usually last for weeks at least,
 (19) yes.
 (20) Q Would you expect them to last for as
 (21) much as three months?
 (22) A It might be a little unusual.
 (23) Q Okay.
 (24) A In the absence of yet another
 (25) infection, obviously.

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(1) Q All right.
 (2) A Some people are more reactive with
 (3) their lymph nodes than others.
 (4) Q And you mentioned that the infection
 (5) could be either viral or bacterial?
 (6) A Yes.
 (7) Q Is it important to you in your practice
 (8) to try to differentiate?
 (9) A Well, in general, the only bacteria you
 (10) usually identify is a strep germ. So, you
 (11) do a throat culture in some individuals who
 (12) look as though they have strep. Many times,
 (13) you just don't bother because it doesn't
 (14) really look like that, or the patient's
 (15) symptoms don't warrant a throat culture.
 (16) Q If you have a patient in which you've
 (17) done a culture, and it turns out that you've
 (18) got a bacterial agent, then the appropriate
 (19) treatment is antibiotics?
 (20) A Yes.
 (21) Q If you have a patient where you don't
 (22) think that it's bacterial --
 (23) A Right.
 (24) Q -- so you don't even do the culture, do
 (25) you still treat with antibiotics?

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(1) A Well, it depends upon the patient. If
 (2) the patient has a co-existing ear infection
 (3) or sinus infection, you may not be able to
 (4) culture anything significant, but you may
 (5) treat them on that basis alone, and, so,
 (6) especially with sinus infections, it's not
 (7) uncommon to treat, even though many of them
 (8) are viral, with antibiotics because it's a
 (9) closed space.
 (10) Q What do you need to do to make the
 (11) diagnosis of a sinus infection?
 (12) A Well, most of them are made clinically
 (13) by the symptoms and signs: a lot of
 (14) purulent drainage from the nose, headache, a
 (15) lot of congestion in the nose. Many times
 (16) people have blocking of the ears in
 (17) addition. If you really want to be
 (18) academic, you get a CAT scan of their sinus
 (19) to see if they have fluid levels, but even
 (20) that doesn't tell you if it's bacterial.
 (21) Q Sure.
 (22) A It just tells you they've got --
 (23) Q Something in there?
 (24) A -- something in there, and it may be
 (25) pus, or it may be just mucus.

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(1) Q Are plain film X-rays of any
 (2) assistance?
 (3) A We used to use them. Nowadays they've
 (4) sort of fallen by the wayside.
 (5) Q And would you culture the purulent
 (6) drainage?
 (7) A You do on occasion.
 (8) Q Okay.
 (9) A Most of the time, you use a broad
 (10) spectrum antibiotic.
 (11) Q Something like Ampicillin?
 (12) A Amoxicillin, cephalosporins.
 (13) Q From your review of the records, did
 (14) you notice whether Drs. Allison or Tyler
 (15) ever either cultured --
 (16) A I don't believe they cultured anything.
 (17) Q Or X-rayed?
 (18) A No.
 (19) Q Let me ask you this question by
 (20) prefacing this. In retrospect now, do you
 (21) think that the lymphadenopathy was related
 (22) to or was a reactive process from the upper
 (23) respiratory infections?
 (24) MR. HERBERT: Just note my
 (25) objection.

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(1) THE WITNESS: That's what I'd
 (2) think, as we're looking at the patient at
 (3) the time she's visiting. On each occasion
 (4) after the diagnosis is established, later
 (5) on, one can go back and say it's possible
 (6) that this could have represented Hodgkin's
 (7) disease.
 (8) BY MR. SCHARON:
 (9) Q Allright.
 (10) A Doctors think in the future, and
 (11) lawyers think in the past. So, when I, you
 (12) know, look at a case, I'm always thinking:
 (13) what would I think on the basis of what this
 (14) complaint is and the findings? Would I
 (15) think this, or would I not think this? And,
 (16) unfortunately for this lady, she got struck
 (17) by lightning. She got a bad disease and had
 (18) other symptoms that could have been
 (19) interpreted as something very relatively
 (20) minor when she was having something
 (21) relatively major.
 (22) Q I won't agree to being consigned to
 (23) thinking about the past, okay, with all of
 (24) the other lawyers, but --
 (25) A Well, you know what I mean. You know

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(1) the answer, but --
 (2) Q I understand.
 (3) A I didn't know the answer as I'm looking
 (4) at it.
 (5) Q Okay. Is it possible in your mind that
 (6) the upper respiratory symptoms that she was
 (7) having were because of obstruction from
 (8) Hodgkin's disease that involved the lymph
 (9) nodes?
 (10) A It wouldn't be obstruction. That's the
 (11) wrong term. It could be that the lymph
 (12) nodes were involved with Hodgkin's disease.
 (13) That is possible.
 (14) Q And, then, could that have caused the
 (15) --
 (16) A Oh, could that have been the cause of
 (17) her symptoms?
 (18) Q Yes.
 (19) A I don't know how, no.
 (20) Q Did you think, as you reviewed her
 (21) chart, that there ever should have been any
 (22) additional investigation of the upper
 (23) respiratory infections to nail down the
 (24) mechanism of the infection?
 (25) A Nothing struck me as being too unusual.

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(1) Most people in this climate develop
 (2) something like 3.78 upper respiratory
 (3) infections per year. They once did a study
 (4) at Reserve about that, and I don't think she
 (5) -- I don't think she, you know, was over
 (6) that number. She had a number of them, but
 (7) she used to go to the clinic for them all.
 (8) Many people don't bother to do that.
 (9) Q I want to go back to the anemia issue
 (10) for a moment.
 (11) A All right.
 (12) Q I think you may have said in June of
 (13) '96, but I think probably you meant in May
 (14) of '96 --
 (15) A Okay.
 (16) Q -- her blood work showed some mild
 (17) anemia; is that right?
 (18) A Yes. I think they did a serum iron at
 (19) that time which was really -- it was not
 (20) terribly consistent with iron deficiency but
 (21) could have been iron deficiency and
 (22) something else.
 (23) Q Are you referring to the fact that the
 (24) serum iron level was low, but that the total
 (25) iron --

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- (1) A The total was low also.
 (2) Q --the total iron binding capacity was
 (3) also low?
 (4) A Right.
 (5) Q In iron deficiency anemia, you would
 (6) have expected that to be high as opposed to
 (7) low?
 (8) A That's correct.
 (9) Q It's kind of a mixed pattern of anemia?
 (10) A Yes. Those are very difficult for a
 (11) doctor, because especially if you're a
 (12) family practitioner, general internist, and
 (13) you're not aware of all the differentials
 (14) that can go with this, many times you choose
 (15) to select the thing that you think is the
 (16) most likely, and in somebody of this age
 (17) with this history, that's a pretty likely
 (18) scenario, you know, absent their having some
 (19) kind of hemoglobinopathy, sickle cell
 (20) disease or thalassemia or something like
 (21) that.
 (22) Q So, is it appropriate to give the
 (23) patient iron presumptively?
 (24) A Yes.
 (25) Q Do you --

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- (1) A That's almost always done.
 (2) Q You do that even before you've had
 (3) blood drawn for the iron studies?
 (4) A Many times you do.
 (5) Q Yes?
 (6) A Yes.
 (7) Q Good.
 (8) A In the older age group, you would be
 (9) more careful. I mean, in people that you
 (10) might suspect might have more serious
 (11) disease in the older age group, you probably
 (12) don't do that, but in people of this age
 (13) group, almost assuredly you'd try that.
 (14) Q Why wouldn't you do it in the older age
 (15) group?
 (16) A Because there's much more malignancy in
 (17) the older age group, colon cancer and that
 (18) type of thing.
 (19) Q The TIBC level being low --
 (20) A Right.
 (21) Q --that's more indicative, is it, of
 (22) anemia due to chronic illness?
 (23) A Yes, some kind of chronic disease, and
 (24) there was a history in there someplace that
 (25) she'd had arthritis which later was called

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- (1) rheumatoid arthritis. There was never any
 (2) workup done for that, and I have no idea
 (3) whether she had that or not, but if they
 (4) were thinking that that's what she had, it
 (5) might have been that they were blaming that
 (6) on the rheumatoid. I have no idea. I can't
 (7) think for them, so I don't know.
 (8) Q Would the presence of any type of
 (9) arthritis be sufficient to explain an anemia
 (10) of chronic illness?
 (11) A No, usually it has to be rheumatoid or
 (12) lupus or some more serious form.
 (13) Q So, not just --
 (14) A Osteoarthritis, no.
 (15) Q No, okay. In that connection, this
 (16) lady came to these physicians in March of
 (17) 1995 as a new patient.
 (18) A Yes.
 (19) Q Because she had to leave her old
 (20) physician.
 (21) A Yes.
 (22) Q Okay. If such a patient came to you
 (23) after leaving another physician, would you
 (24) make any attempt to get her prior records to
 (25) see what kind of a past history she's had?

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- (1) A In general, I personally do, but many
 (2) times you don't get them.
 (3) Q You mean --
 (4) A For whatever reason.
 (5) Q You ask, but you may not get them?
 (6) A Yes. I usually ask the patient to try
 (7) to get them, have the record forwarded, but
 (8) sometimes it just doesn't happen.
 (9) Q Okay, but you think it ought to be
 (10) asked for at least?
 (11) MR. HERBERT: Note my objection.
 (12) THE WITNESS: In an ideal world,
 (13) you do that.
 (14) BY MR. SCHARON:
 (15) Q Do you think that it's standard of
 (16) care?
 (17) A Not necessarily. Some people just
 (18) prefer to start their own record and take
 (19) the history.
 (20) Q Okay. Did you notice from your review
 (21) of records of her prior physician -- let me
 (22) ask you this: did you see any records of
 (23) her prior physician?
 (24) A No, not that I know of.
 (25) Q Allright.

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(1) A Maybe I did, but I don't recall seeing
 (2) them. Who --
 (3) MR. HERBERT: Say the name of the
 (4) prior physician, and that might jog his
 (5) memory.
 (6) BY MR. SCHARON:
 (7) Q Dr. Askari was the prior physician.
 (8) A I didn't see any records from him.
 (9) Q His records would have been in a bundle
 (10) under the title of, maybe, Bureau of
 (11) Disability Determination records.
 (12) A No, I never saw anything like that.
 (13) Q You didn't see those?
 (14) A I saw his name listed in the record,
 (15) but I didn't know where he came in.
 (16) Q Okay. He was a prior doctor. What
 (17) diagnostic tests would you ordinarily order
 (18) to determine whether a patient had
 (19) rheumatoid arthritis?
 (20) MR. HERBERT: Objection.
 (21) Assuming it's indicated.
 (22) THE WITNESS: Personally, I would
 (23) do a CBC, a sedimentation rate, a rheumatoid
 (24) factor or an arthritis profile, as they put
 (25) it on our lab sheets.

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(1) BY MR. SCHARON:
 (2) Q All right.
 (3) A That gives you some idea. Some people
 (4) that have rheumatoid arthritis test negative
 (5) for everything, and they may have a high sed
 (6) rate, and that's all you'll find.
 (7) Q In that connection, I looked at some
 (8) blood work that was done in March of 1993
 (9) and again in June of 1994, and I'll ask you
 (10) to assume for purposes of the question that
 (11) her sedimentation rate in 1993 was 35.
 (12) A That's --
 (13) Q That lab normal was zero to 15, and her
 (14) RA screen was negative. Her ANA was
 (15) negative, less than one to 40. Would that
 (16) --
 (17) A Those don't jump out at me. They don't
 (18) jump out at me as being wildly abnormal.
 (19) Q Okay. In June of '94, the
 (20) sedimentation rate was 27, lower.
 (21) A Again.
 (22) Q And the RA screen and the ANA were not
 (23) positive either.
 (24) A Okay.
 (25) Q So, would you think, based on those

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(1) results, that she was a rheumatoid arthritis
 (2) patient?
 (3) A No, I would not.
 (4) Q If you have placed a patient with mild
 (5) anemia on iron presumptively, how long
 (6) should you wait before you get some
 (7) follow-up blood work to see what the result
 (8) has been?
 (9) A I would say three to four months.
 (10) Q Okay. What effect would you like to
 (11) see on the blood chemistry then?
 (12) A I'd like to see the hematocrit rise.
 (13) Q The hematocrit?
 (14) A The hemoglobin, hematocrit; the red
 (15) blood cell indices should rise.
 (16) Q And if they don't, what's the next step?
 (17) A Then, your therapy is obviously not
 (18) doing any good, and, then, you have to go
 (19) further, I would think, and try to figure
 (20) out why it is that she's anemic.
 (21) Q That would be an indication that the
 (22) presumption that this is iron deficiency is
 (23) not correct.
 (24) A That's correct.
 (25) Q All right. Did you pay attention in

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(1) your review, Doctor, to Dorothy Ross's
 (2) alkaline phosphatase levels?
 (3) A No, but I know it was slightly elevated.
 (4) Q I'll represent to you, and you can
 (5) assume for purposes of the question, that in
 (6) March of '95 the level was 102. That's a
 (7) slight elevation.
 (8) A Right.
 (9) Q In May of '96, 143, and in January of
 (10) '97, 202, all right?
 (11) A Yes.
 (12) Q What's the significance, or is there
 (13) any significance to those measurements?
 (14) A Many times there are patients who come
 (15) in and have a single elevated alkaline
 (16) phosphatase level, and I have stopped
 (17) investigating alkaline phosphatase levels
 (18) because, most of the time, it proves of no
 (19) value. So, as a single elevated value, I
 (20) mark it down, but I haven't so far been
 (21) tripped up. It's not very common that you
 (22) find a reason.
 (23) Q Okay.
 (24) A I know there was a reason here, but
 (25) it's not very common in somebody that you do

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{1} find a reason.

{2} Q What do you mean?

{3} A Well, some patients may have a small
{4} degree of Paget's disease somewhere, and
{5} that raises their alkaline phosphatase, and
{6} you have to do a total body bone survey and
{7} run up the costs, and when you end up, you
{8} don't have anything therapeutic you can do
{9} about it anyway.

{10} Q What --

{11} A In conjunction with other findings, it
{12} may be important, but by itself, I don't put
{13} much stock in it.

{14} Q Okay. In considering her blood work in
{15} general, her red blood cell count, her
{16} hemoglobin, hematocrit, MCV and looking also
{17} in conjunction with that --

{18} A Yes.

{19} Q -- analysis at the alkaline phosphatase
{20} level, do you have any opinion about whether
{21} those values are significant?

{22} A Well, there was a relationship in
{23} retrospect, but at the time, looking at the
{24} patient, I would probably not have put it
{25} together in my own mind. I would probably

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{1} A Yes.

{2} Q In view of that entire pattern, you
{3} know, the hemoglobin, and the red blood cell
{4} count, and the alkaline phosphatase changes,
{5} should they have done something to
{6} investigate further?

{7} A Well, if they feel the way I have just
{8} told you that I do, they may have chosen to
{9} ignore the alkaline phosphatase and focus on
{10} the anemia, which is what I think they did.

{11} Q And that's acceptable?

{12} A Pardon me?

{13} Q That would be acceptable?

{14} A It's acceptable to me.

{15} Q And consistent with --

{16} A Because, as I say, I have had
{17} difficulty finding the cause of the high
{18} alkaline phosphatase in most people.

{19} Q And it would be consistent with the
{20} standard of care to ignore the changes in
{21} the alkaline phosphatase in this scenario?

{22} A In my opinion, yes.

{23} Q And these changes in blood values and
{24} in alkaline phosphatase chemistry, that is
{25} all consistent with a serious disease such

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{1} have done exactly what they did.

{2} Q In retrospect, what's it indicative of?

{3} A When we know what was going on with
{4} this lady, it makes sense that she had these
{5} problems; that is, anemia and rising
{6} alkaline phosphatase, is what I'm saying.

{7} Q And why does that make sense in this
{8} patient?

{9} A Well, because she probably had
{10} Hodgkin's disease during this period of time
{11} as a cause for both the anemia and the high
{12} alkaline phosphatase, or rising alkaline
{13} phosphatase. "Probably" I say; we don't
{14} know that for sure.

{15} Q Are there any other conditions which
{16} could cause a similar pattern?

{17} A I'm sure there are. I can't tell you
{18} what they are. They probably would be
{19} malignant type conditions, in general. I
{20} mean, they would probably be serious
{21} conditions.

{22} Q Well, of course, the red blood values
{23} and the alkaline phosphatase were reported
{24} to the doctors at various times, to Allison
{25} and Tyler.

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{1} as Hodgkin's disease?

{2} A It could be.

{3} Q It could be. Do you have an opinion as
{4} to when Dorothy Ross had Hodgkin's disease
{5} that involved her bone marrow?

{6} A I have no opinion.

{7} Q Okay. You stated in your report of
{8} November 18th, 1999 that you thought that
{9} she had Stage IV Hodgkin's disease as early
{10} as January 14th of 1997.

{11} A Yes.

{12} Q All right.

{13} A That isn't very early in terms of what
{14} we're talking about in the whole record. By
{15} the time she developed the more severe
{16} anemia, I believe she did have it at that
{17} time.

{18} Q And that's in January of '97?

{19} A Yes. I thought you were referring back
{20} to when she first developed a high alkaline
{21} phosphatase.

{22} Q What I'm trying to do is explore with
{23} you --

{24} A I'm sorry.

{25} Q -- the point in time at which you would

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(1) --
 (2) A I would say that as of the discovery of
 (3) the severe anemia in January of '97.
 (4) Q Okay. In January of '97, she did have
 (5) this additional blood work.
 (6) A Yes.
 (7) Q I wanted to refer to the date of that.
 (8) A I think it was January 14th.
 (9) Q January 14th of '97?
 (10) A Yes, I believe so.
 (11) Q Okay, and the results showed an
 (12) increase in her anemia.
 (13) A Yes.
 (14) Q A significant increase.
 (15) A Yes.
 (16) Q The progression of the anemia, was it
 (17) enough that it should have caused these
 (18) doctors concern?
 (19) A Yes. I believe it did, actually.
 (20) Q Okay, and what did the standard of care
 (21) require those physicians to do in acting on
 (22) that concern?
 (23) A I think they should have embarked upon
 (24) a thorough workup of her GI tract which she
 (25) had had a portion of, seemingly a portion

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(1) of. I'm not sure how far the endoscopist
 (2) looked when she had this fish bone in
 (3) November, but if that had not covered the
 (4) upper GI tract, then she should have had a
 (5) colonoscopy and upper endoscopy.
 (6) Q Anything else?
 (7) A If that proved negative, she should
 (8) have had further workup for investigation of
 (9) some other cause.
 (10) Q I assume it was acceptable to do the
 (11) stool cards to look for some evidence of --
 (12) A Yes.
 (13) Q -- GI tract blood?
 (14) A Unfortunately, in many people that have
 (15) GI bleeding, they only have it
 (16) intermittently.
 (17) Q Yes.
 (18) A And you don't pick it up.
 (19) Q If you've gotten back a blood result
 (20) such as came back on her on January 14th of
 (21) 1997 --
 (22) A Yes.
 (23) Q --what's an acceptable length of time
 (24) that might go by before the colonoscopy is
 (25) done?

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(1) A Well, I don't know how things are done
 (2) there. You know, in general, I refer the
 (3) patient, and within the next month or so
 (4) they have it done.
 (5) Q In this case, following the January
 (6) 17th of 1997 blood results, it wasn't until
 (7) March 4th of 1997 that she was referred to
 (8) Dr. Yang for the upper GI series, all right?
 (9) A Yes.
 (10) Q Is that too long?
 (11) A It's not too long, but it's longer than
 (12) it would have taken me.
 (13) Q Allright.
 (14) A At least she was referred for it.
 (15) Q You indicated in your report that a
 (16) note was made in the chart that, if Dr.
 (17) Yang's workup was not revealing of the
 (18) source of the anemia, a bone marrow
 (19) examination would be in order.
 (20) A Yes.
 (21) Q And that's an appropriate step-wise
 (22) procedure.
 (23) A Yes.
 (24) Q All right. Dr. Yang's --
 (25) A His final report, I think, was issued

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(1) --
 (2) Q On April 28th?
 (3) A Some time in April.
 (4) Q Yes, April 28th of '97.
 (5) A Right.
 (6) Q And the biopsies were reported the same
 (7) day.
 (8) A Right.
 (9) Q All right, and when Mrs. Ross next saw
 (10) Dr. Tyler on May 19th --
 (11) A Yes.
 (12) Q -- did Dr. Tyler do anything --
 (13) A No.
 (14) Q --to obtain the bone marrow
 (15) examination?
 (16) A No.
 (17) Q And --
 (18) A It seems to me that that visit was for
 (19) something totally unrelated, but --
 (20) MR. HERBERT: Go ahead and take a
 (21) look at it.
 (22) THE WITNESS: Pardon me?
 (23) MR. HERBERT: Go ahead and take a
 (24) look at it.
 (25) BY MR. SCHARON:

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(1) Q This is not a memory test. You can
(2) look at the records.
(3) A Yes. She was there for pain in the
(4) right arm and shoulder, felt like it was
(5) broken. I can't tell what she was taking.
(6) That's when he mentions about the diagnosis
(7) of rheumatoid arthritis. No mention is made
(8) of -- well, he mentions rheumatoid
(9) arthritis, iron deficiency anemia, and he
(10) gives her medication for her stomach, and,
(11) then, an anti-inflammatory and he orders an
(12) X-ray of the shoulder.
(13) Q Just to be clear, you referred to "he,"
(14) but that was actually Dr. Tyler, a she, on
(15) the 19th of May.
(16) A Yes.
(17) Q Okay. My question for you, Doctor, is
(18) this: given Dr. Yang's report and the
(19) biopsy report of April 28th of 1997, didn't
(20) the standard of care require Dr. Tyler on
(21) May 19th to refer her for this bone marrow
(22) examination?
(23) A It would have been appropriate for him
(24) to do so. He did not.
(25) Q Again, her, Dr. Tyler.

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(1) A I'm sorry. I don't know --
(2) Q Dr. Tyler is a her.
(3) A Yes. I don't know whether she saw it
(4) or didn't see it at that time.
(5) Q I want to go back to the subject of
(6) lymphadenopathy.
(7) A Yes.
(8) Q And appreciating that you've had a
(9) couple of Hodgkin's patients in your career,
(10) did those patients have lymphadenopathy?
(11) A Usually. Sometimes you find it by
(12) doing a chest X-ray and finding enlarged
(13) mediastinum lymph nodes.
(14) Q Are swollen lymph nodes in the neck
(15) which are due to Hodgkin's disease always
(16) tender or nontender?
(17) A They're classically described as
(18) matted. They grow together, and they don't
(19) form a single node, but rather a
(20) conglomeration of many nodes that are sort
(21) of stuck together. They're pretty dramatic
(22) if you see somebody who's got Hodgkin's
(23) lymphadenopathy.
(24) Q What about the question of tenderness?
(25) A Smaller -- you know, I'm not -- I

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(1) haven't seen enough of it to really know.
(2) So, I can't really answer that question.
(3) Q Okay.
(4) A I can tell you that many times the
(5) lymph nodes that you feel in patients who
(6) you have sent for biopsies, sometimes a
(7) single needle biopsy, which is what the ear,
(8) nose and throat people usually do, comes
(9) back showing nothing or showing reactive
(10) lymph node hyperplasia, and it sometimes
(11) takes quite a while to make a diagnosis of
(12) Hodgkin's because there's a particular cell
(13) that a pathologist must see before he can
(14) diagnose it. So, sometimes you miss them.
(15) Q Sure. I appreciate that. I appreciate
(16) your statement to me about the relative lack
(17) of frequency with which you've seen such
(18) patients.
(19) A Correct.
(20) Q Let me ask you this, then.
(21) Hypothetically, if a patient came to you
(22) with lymph nodes, would you dismiss the
(23) possibility that they could be a sign of
(24) malignancy just because they were tender?
(25) MR. HERBERT: Just object to the

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(1) form of the question. You can answer. I
(2) think it's argumentative, but you can
(3) answer.
(4) THE WITNESS: Probably not. Some
(5) people are tender when they don't have lymph
(6) nodes.
(7) BY MR. SCHARON:
(8) Q And the tenderness can be related to
(9) other structures in the same area?
(10) A Yes, exactly.
(11) Q The neck muscles?
(12) A Some people are just a little --
(13) they're just sensitive.
(14) Q Have you reached any conclusions about
(15) when Dorothy Ross first would have had
(16) Hodgkin's disease, how long she had it for?
(17) MR. HERBERT: Objection. Asked
(18) and answered. I think it was.
(19) THE WITNESS: Well, I think she
(20) probably had it --
(21) BY MR. SCHARON:
(22) Q We talked about Stage IV. Now I guess
(23) I'm trying to go beyond that.
(24) A First of all, I'm not a staging expert.
(25) So, I won't even get into that, okay?

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(1) Q Okay.
 (2) A I think she had Hodgkin's as early as
 (3) August of '96, and she probably had
 (4) Hodgkin's in May of '96.
 (5) Q Okay. That's without regard to any
 (6) opinion about staging.
 (7) A That's correct. I wouldn't even get
 (8) into that.
 (9) Q Okay. So, --
 (10) A I don't know enough about it.
 (11) Q I just want to be clear --
 (12) A Right.
 (13) Q --that that's not something about
 (14) which you will express an opinion.
 (15) A Absolutely not.
 (16) Q Why is it, Doctor, that the severe
 (17) anemia that she exhibited in January of '97
 (18) indicates to you Stage IV?
 (19) A Because I feel that by that time, her
 (20) bone marrow is not producing cells very well.
 (21) Q And that's the reason for the anemia?
 (22) A Yes. If you know that she has
 (23) Hodgkin's, you're pretty sure that she has
 (24) it in the bone marrow.
 (25) Q At that point?

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(1) A Yes.
 (2) Q Allright.
 (3) A I never say "always," and I never say
 (4) "never."
 (5) Q Could her anemia, as exhibited in May
 (6) of '96, the prior year, be due to a
 (7) combination of iron deficiency and anemia of
 (8) chronic disease?
 (9) MR. HERBERT: Objection.
 (10) THE WITNESS: Yes.
 (11) BY MR. SCHARON:
 (12) Q And I appreciate your statement about
 (13) not wanting to get into the issues of
 (14) staging, and I don't mean to do that with
 (15) you. So, let me ask you: do you know at
 (16) what stage Hodgkin's is most often
 (17) diagnosed, or is this something that you
 (18) would consider to be beyond your expertise?
 (19) A It's beyond my ability to tell you.
 (20) Q Okay.
 (21) MR. HERBERT: Off the record for
 (22) a second.
 (23) (At this time a short recess was
 (24) had.)
 (25) BY MR. SCHARON:

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(1) Q We just had a brief colloquy here about
 (2) whether you have any opinions or not
 (3) concerning Dorothy Ross's prognosis.
 (4) A No.
 (5) Q Okay, you don't. Likewise, would you
 (6) have any opinions about her survival chances
 (7) given various treatment regimens for her
 (8) Hodgkin's disease?
 (9) A No.
 (10) Q Obviously, I don't want to belabor
 (11) areas about which you haven't reached any
 (12) conclusions and don't expect to talk about.
 (13) A Right.
 (14) Q Is it within the scope of your
 (15) knowledge to tell us whether Hodgkin's
 (16) disease is curable?
 (17) A I believe it is.
 (18) Q Okay.
 (19) A But I believe people that have had it
 (20) always have follow-up, at least in my
 (21) experience, from their oncologists for
 (22) evermore. So, there is always that nagging
 (23) doubt, I think.
 (24) Q And is it within the scope of your
 (25) training and knowledge to tell us whether

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(1) the success rates for treating Hodgkin's
 (2) disease are better if the disease is
 (3) diagnosed at Stage I or II versus Stage IV?
 (4) MR. HERBERT: Objection.
 (5) THE WITNESS: I don't know.
 (6) BY MR. SCHARON:
 (7) Q Okay, Doctor. This is my only chance
 (8) to ask you about your opinions, and to
 (9) explore with you what the basis for them is,
 (10) okay? Have you reached any other
 (11) conclusions, or do you plan to express any
 (12) other opinions other than those that we've
 (13) talked about here?
 (14) A No.
 (15) MR. HERBERT: Just note my
 (16) objection. It's the same thing that I said
 (17) the last time, but --
 (18) MR. SCHARON: I know it's
 (19) difficult.
 (20) MR. HERBERT: Right.
 (21) MR. SCHARON: I find that that
 (22) question is objected to by both sides all
 (23) the time.
 (24) MR. HERBERT: Right. You do the
 (25) best you can.

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(1) BY MR. SCHARON:
(2) Q My colleague points out that you
(3) testified earlier today that Drs. Allison
(4) and Tyler, in your opinion, appropriately
(5) treated Ms. Ross's anemia initially.
(6) A Yes.
(7) Q Do you have an opinion about whether
(8) their continuing treatment of her anemia
(9) remained in accordance with acceptable
(10) standards?
(11) A They just continued what they began,
(12) and then, when they found it was more
(13) severe, they began a workup for the cause of
(14) this. So, in a sense, they were already
(15) suspecting something else but had to rule
(16) out a GI lesion first.
(17) Q Not to argue with you, did the doctors
(18) not also treat her as though they still
(19) believed it was iron deficiency anemia by
(20) increasing her dosages of iron?
(21) MR. HERBERT: Objection.
(22) THE WITNESS: They did, but this
(23) was in conjunction with beginning the workup
(24) and considering other avenues of approach.
(25) BY MR. SCHARON:

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(1) Q I'm reading here from the record. I
(2) asked you: do you have an opinion about
(3) whether their continuing treatment of her
(4) anemia remained in accordance with
(5) acceptable standards, and you said they just
(6) continued what they began, and then when
(7) they found it was more severe, they began a
(8) workup for the cause of this. So, in a
(9) sense they were already suspecting something
(10) else but had to rule out a GI lesion first.
(11) A Yes.
(12) Q Are you saying that their treatment
(13) continued to be in accordance with
(14) acceptable standards of care?
(15) A Well, what you do is, you continue what
(16) you're already doing while you're pursuing
(17) other avenues.
(18) Q So, that is acceptable?
(19) A Yes.
(20) Q All right.
(21) MR. SCHARON: If we can just have
(22) a minute.
(23) (At this time a short recess was
(24) had.)
(25) BY MR. SCHARON:

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(1) Q Did your review of her records give you
(2) a list of her, I'll call them, preexisting
(3) conditions, preexisting to the time that she
(4) first became a patient of Drs. Allison and
(5) Tyler in March of '95?
(6) A There's some reference to arthritis, I
(7) think, in one of her -- I think it's June
(8) 5th of '96. There's a medical history. It
(9) says "arthritis," which I assume they
(10) thought was rheumatoid arthritis. It
(11) doesn't say that.
(12) Q Okay.
(13) A And that is the only thing that I see
(14) there.
(15) Q Okay. In view of the blood work that
(16) had been done in May of '96, should the
(17) doctors have done any investigation of this
(18) rheumatoid arthritis or the hypothesis that
(19) she had rheumatoid arthritis?
(20) A In general, if the patients are not
(21) terribly symptomatic of it, you may not do
(22) any further workup. If their complaints are
(23) that they have a lot of hot, swollen, tender
(24) joints, yes. If their complaints are not of
(25) that nature, which in her case they weren't,

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(1) they might have just chosen not to further
(2) investigate that.
(3) Q And just assume that, yes, that's
(4) rheumatoid arthritis, but it's not active?
(5) A That's correct. Some people with
(6) rheumatoid arthritis have so-called burnout;
(7) that is, they have an anemia. They have had
(8) their arthritis. It just doesn't manifest
(9) itself subsequently, or it may crop up
(10) later. It's a very difficult disease many
(11) times.
(12) Q Have you reached any conclusion,
(13) Doctor, about whether Mrs. Ross's
(14) presentation was unusual for a Hodgkin's
(15) patient?
(16) A No.
(17) Q When you were talking about the fact
(18) that referral of patients for lymph node
(19) biopsy can result in needle aspiration which
(20) may not be diagnostic of a problem, I just
(21) want to understand. Are you saying that
(22) that's the type of lymph node biopsy that
(23) would be done in a patient referred for
(24) workup, a patient such as Mrs. Ross?
(25) A Well, ordinarily, what you do is, you

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(1) send the patient to somebody, and you say to
 (2) them: see if you can find out the cause for
 (3) this, and if they do a needle biopsy, and
 (4) it's negative, you then rely upon their
 (5) judgment and expertise as to whether they
 (6) think, you know, an open biopsy would be
 (7) indicated.

(8) Q Okay, but you're not rendering any
 (9) opinion about what type of biopsy would be
 (10) appropriate?

(11) A Oh, no.

(12) Q Do you have an opinion as to whether a
 (13) patient with Stage IV Hodgkin's disease
 (14) would have lymphadenopathy due to the
 (15) disease?

(16) MR. HERBERT: Objection.

(17) THE WITNESS: Oh, I'm sure they
 (18) would.

(19) BY MR. CHARON:

(20) Q Okay. All right.

(21) A Many times the lymph nodes are
 (22) intra-abdominal, and you don't even know
 (23) they have them, or, as they say, they're on
 (24) the mediastinum, and you take a plain film
 (25) for some other reason and find big lymph

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(1) nodes. So, then the diagnosis is Hodgkin's,
 (2) sarcoidosis.

(3) Q How would those nodes on the
 (4) mediastinum show up on a plain film X-ray?

(5) A Just a big, white blob on a black
 (6) background,

(7) Q Does the scope of your knowledge
 (8) permit you to tell us whether, or does it
 (9) permit you to form a conclusion about
 (10) whether Hodgkin's disease can begin in the
 (11) bone marrow?

(12) A No.

(13) MR. CHARON: I don't have any
 (14) other questions for you. Thanks

(15) MR. HERBERT: We'll reserve the
 (16) right to read it.

(17) MR. CHARON: I appreciate your
 (18) time.

(19)

(20)

(21) --- oOo ---

(22)

(23)

(24)

(25)

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(1) CERTIFICATE

(2) The State of Ohio,)

(3) County of Cuyahoga.)

(4) I, Luanne Stone, a Notary Public within
 (5) and for the State of Ohio, duly commissioned
 (6) and qualified, do hereby certify that the
 (7) above-named witness, DONALD JUNGLAS, M.D.,
 (8) was by me first duly sworn to testify to the
 (9) truth, the whole truth and nothing but the
 (10) truth in the case aforesaid; that the
 (11) testimony then given by the above-referenced
 (12) witness was by me reduced to stenotypy in
 (13) the presence of said witness; afterwards
 (14) transcribed; and that the foregoing is a
 (15) true and correct transcription of the
 (16) testimony so given by the above-referenced
 (17) witness.

(18) I do further certify that this
 (19) deposition was taken at the time and place
 (20) in the foregoing caption specified and was
 (21) completed without adjournment.

(22) I do further certify that I am not a
 (23) relative, counsel or attorney for either
 (24) party, or otherwise interested in the
 (25) event of this action.

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(1)
 (2) IN WITNESS WHEREOF, I have hereunto set
 (3) my hand and seal of office at Cleveland,
 (4) Ohio this _____ day of _____
 (5) A.D., 2000.

(6)

(7)

(8)

(9) _____
 Luanne Stone, f.k.a., Protz-

(10) Notary Public

(11) Within and for the State of Ohio

(12) My commission expires 4/6/03.

(13)

(14)

(15)

(16)

(17)

(18)

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(20)

(21)

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(25)

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