IN THE COURT OF COMMON PLEAS
OF CUYAHOGA COUNTY, OHIO
- - - - -
FRED W. PULTZ, Individually and as Administrator of the Estate of BARBARA A. PULTZ, deceased,

Plaintiff,

vs Case No. 433332
Judge Kilbane-Koch
DOUGLAS N. FLAGG, M.D., et al.,

Defendants.
- - - - -
DEPOSITION OF SUBHASH C. MAHAJAN, M.D.
WEDNESDAY, JANUARY 23, 2002
- - - - -
Deposition of SUBHASH C. MAHAJAN, M.D., a Defendant herein, called by counsel on behalf of the Plaintiff for examination under the statute, taken before me, Vivian L. Gordon, a Registered Diplomate Reporter and Notary Public in and for the State of Ohio, pursuant to agreement of counsel, at the offices of Subhash C. Mahajan, M.D., 7215 Old Oak Boulevard, Middleburg Heights, Ohio, commencing at 2:00 o'clock p.m. on the day and date above set forth.

APPEARANCES:
On behalf of the Plaintiff
Becker & Mishkind
HOWARD D. MISHKIND, ESQ.
660 Skylight Office Tower
Cleveland, Ohio 44113
216-241-2600

On behalf of the Defendant Flagg
Weston, Hurd, Fallon, Paisley & Howley
STEPHEN WALTERS, ESQ.
2500 Terminal Tower
Cleveland, Ohio 44113
216-241-6602

On behalf of the Defendant Mahajan, M.D.
Hanna, Campbell & Powell
GREGORY ROSSI, ESQ.
P. O. Box 5521
3737 Embassy Parkway
Akron, Ohio 44334
330-670-7300

On behalf of the Defendant Jones, M.D.
Gallagher, Sharp, Fulton & Norman
ERNEST AUCIELLO, ESQ.
Bulkley Building
Cleveland, Ohio 44115
216-241-5310

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SUBHASH C. MAHAJAN, M.D., a witness herein, called for examination, as provided by the Ohio Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, was deposed and said as follows:

EXAMINATION OF SUBHASH C. MAHAJAN, M.D.
BY MR. MISHKIND:

Q. Would you please state your name for the record.
A. Subhash Mahajan.
Q. You are a physician; is that true?
A. Yes.
Q. What is your area of specialization?
A. I specialize in gastroenterology.
Q. My name is Howard Mishkind and I represent the family of your former patient. I think you realize that.
A. Yes.
Q. Have you had your deposition taken before, sir?
A. Yes.
Q. How many times?
A. A few times, a couple times.
Q. Is that two or three times?
A. Two.

Q. This is now the third?
A. Yes.
Q. Have any of those prior occasions been in connection with a claim against you?
MR. ROSSI: Objection. Go ahead, you may answer, doctor.
A. It was a while ago, less than ten years ago.
Q. I didn't ask about the time. I just wanted to know whether or not your deposition was taken in connection with a lawsuit filed against you. And the answer would be yes?
A. Yes.
Q. One of them was, did you say, more than ten years ago?
A. Between eight or ten years.
Q. And what was the other time that your deposition was taken?
MR. ROSSI: Objection. Howard, can I have a continuing objection to former, prior medical malpractice cases?
MR. MISHKIND: Yes.
MR. ROSSI: Go ahead, doctor, you can answer his questions.
A. Would you like me to explain the

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case?
Q. Actually right now I'm just trying to get a temporal relationship. I understand that one was eight to ten years ago, and it was a lawsuit against you.
A. They were between that period of time, like two years of time, between eight -- one was about eight years and another was about ten years, so there were two within two years period of time, yes.
Q. Fair enough. Is it fair to say that since eight or ten years ago, up until now, your deposition has not been taken?
A. Yes.
Q. Are you currently named in any other medical negligence cases other than this case?
A. No.
Q. You have been sued then three times in your career?
A. Yes.
Q. Can you tell me briefly what the subject matter of those prior two cases was?
A. One case was a patient I saw for abdominal pain, GI symptoms, and some weight loss, and this patient was worked up for

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colitis, colon cancer, which were negative. And he did not come back for follow up for almost a year.
About a year and a half later, he was diagnosed with a rare tumor called carcinoid, which takes a long time to diagnose, so I haven't seen that patient for all that time. He was seeing somebody else, but now he came back to see me. So I was, you know, named. That's why I did not diagnose it a year and a half ago.
Q. Where is the tumor located, this carcinoid tumor located?
A. Well, this actually can be a small, very small, tiny lesion that can start in the small intestine.
Q. What was the end result of that case, if you recall?
A. I think it was settled out of court.
Q. Was it here in Cuyahoga County?
A. Yes.
Q. The other case, briefly, can you tell me the allegation or the facts of that matter?
A. That patient had coronary bypass surgery and came here with anemia and GI bleeding. The patient came to ICU in the

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evening. I was called for consult after midnight, and it was not a stat consult. The patient was stable. I didn't get a chance to see that patient, but during the night the patient had a thromboembolic complication, which is not uncommon after the surgery. So he stroked out and had a massive mesenteric insufficiency causing bleeding from everywhere, and I was blamed that I didn't see the patient at midnight or 1:00 o'clock, whenever I was called.
Q. What was the result of that case?
A. Well, there were actually several people in that, and it was also settled out of court.
Q. So neither of the cases went to trial; true?
A. Yes.
Q. Do you remember the name of either or both of the patients?
A. No, I don't.
Q. Both cases were here in Cuyahoga County?
A. Right.
Q. Do you practice alone or with any

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other gastroenterologists in your office practice?
A. Alone.
Q. Has that pretty much been your practice, to be solo?
A. Yes.
Q. I don't have a CV, but Mr. Rossi promised me that he would provide me with one. I want to ask you a few questions about your background and then we will get into the specifics of this case.
A. Sure.
Q. Fair enough?
A. Sure.
Q. Where did you go to medical school?
A. I did my medical school back in India. The name of the medical school was Government Medical College, Bunjab, B-U-N-J-A-B.
Q. And where in India is that located?
A. That is in the State of Bunjab.
Q. Did you do any training after graduating from the medical school in India or did you do your training here?
A. After that is when I came here in '72.

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Q. Had you been living in the U.S. and went back to India?
A. No, I have been living since '72 here.
Q. So you were born and raised in India?
A. Yes.
Q. Did your primary and then your medical school education in India?
A. Yes.
Q. And then came to the U.S. to do your residency and training?
A. Right.
Q. What city did you come to?
A. Well, I did my first year of internship in Canton, Ohio, Aultman Hospital, from '72 to '73. Then I came to Cleveland. I was at Lutheran Medical Center and Metro General Hospital from '73 to '76. I did my two years of medical residency and one year of fellowship in gastroenterology. Then I went to M.D. Anderson Hospital in Houston, Texas and did my second year of fellowship in GI there.
Q. What did you do after that then?
A. Then I came back here in '77 and started my practice.

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Q. Do you have any other licenses or fellowship training other than what you have described?
A. No.
Q. I take it you have privileges here at Southwest?
A. Yes. Southwest, Parma Hospital, and also at Akron-Medina.
Q. Which of those three hospitals do you do most of your procedures at?
A. Mostly at Southwest.
Q. Has that been pretty much the majority of your hospital practice being at Southwest over the years?
A. Yes.
Q. Have you ever had your privileges to practice medicine suspended or revoked?
A. No.
Q. Ever applied for privileges at any hospital and been denied?
A. No.
Q. I take it you are a U.S. citizen?
A. Yes.
Q. What year did you become a U.S. citizen?

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MR. ROSSI: Objection. Go ahead.
A. '79, I think.
Q. Do you have any other family members that are physicians?
A. Yes, my brother, younger brother.
Q. Is he a neurologist?
A. No. I know that guy also.
My brother also specializes in GI and he works with me in the office, but we have both solo practices. We cover each other and sign out for each other.
Q. What is your brother's name?
A. Suresh, S-U-R-E-S-H.
Q. Did your brother ever see Mrs. Pultz?
A. No.
Q. I know that there was a period of time in the early '90s that Mrs. Pultz was seen in this office. Was that by you?
A. Yes.
Q. And then the incident which was prior to her death, that was you?
A. Yes.
Q. I just want to make sure it wasn't your brother or someone else.
Since I don't have your CV at this

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point, tell me whether you have done any writing at all in the medical literature.
A. No.
Q. You have not published anything?
A. No.
Q. Have you ever had occasion to serve as an expert witness in any medical negligence cases?
A. No.
Q. Do you remember Mrs. Pultz?
A. Yes.
Q. Do you remember Mr. Pultz?
A. Yes.
Q. When is the last time you saw Mr. Pultz?
A. He was seen --
Q. Before you answer that, it's Mr. Pultz, not Mrs. Pultz.
A. I saw him, the last time I saw him in the hospital was when his wife was admitted.
Q. You haven't had any contact with him, for example, since his wife passed away?
A. No.
Q. Mr. Rossi showed me your chart, which is in the manila file, and also he has presented

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to you a copy of various records for Mrs. Pultz' treatment prior to seeing you and then prior to being admitted to Southwest. And you have those records, as well; correct?
A. Yes.
Q. Have you reviewed anything in the medical literature in preparation for today's deposition?
A. No.
Q. Have you reviewed Dr. Flagg's records?
A. No.
Q. You know Dr. Flagg; right?
A. Yes.
Q. Have you read Dr. Flagg's deposition?
A. No.
Q. Have you been provided with any type of a written summary of his testimony?
A. No.
MR. ROSSI: Objection. Go ahead, you may answer that.
Q. When is the last time you had any contact with Dr. Flagg in any way?
A. I think maybe a month ago I saw him in the hospital. He was making his rounds and I

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was making my rounds and we said hello.
Q. Have you ever had occasion since this lawsuit has been pending to have any conversation with him at all, whether it was informally or otherwise?
A. No.
Q. He has never said anything to you about the case; is that true?
A. Right.
Q. And you have never said anything to him about the case?
A. That's true.
Q. Have you had occasion to talk with the pathologist from the hospital -- Dr. Rabinowitz I think is his name -- that did the autopsy on Mrs. Pultz?
A. Yes.
Q. When did you talk with him?
A. We discussed it after, I think, he finished his exam, even before. He wanted to have some information about her, which I gave him whatever I knew, and then we discussed it after he finished the autopsy exam.
Q. Did you have that discussion with him before you signed the death certificate?

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A. I don't recall.
Q. You had the benefit of the autopsy information before signing the death certificate; true?
A. I think so.
Q. In fact, I'm just looking at a copy of the death certificate, and rather than marking it as an exhibit, we can certainly agree that it's your signature on October 22nd, 1999 to the death certificate; correct?
A. Yes.
Q. And on there, it says, was an autopsy performed and were the autopsy findings available prior to completion of cause of death, and yes is checked on both of them?
A. Yes.
Q. And you have as the primary cause of death acute peritonitis secondary to perforated ulcer; true?
A. Yes.
Q. You also have cirrhosis of the liver, diabetes melitis and rheumatoid arthritis; correct?
A. Yes.
Q. Do you still stand by those

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statements in the death certificate as to the cause of death in this case being acute peritonitis secondary to a perforated ulcer?
MR. ROSSI: Objection.
MR. WALTERS: Objection.
A. No.
Q. You don't?
A. There are other causes, but that's not the only cause.
Q. Well, there on the death certificate it has other significant conditions contributing to death but not resulting in the underlying cause, and you didn't fill anything in on the death certificate, did you?
A. I don't remember that.
Q. I'll hand it to you. My question to you is, am I correct that in the area for other contributing factors you do not have anything listed there; is that correct?
A. Yes, I have not.
Q. And before signing the death certificate -- again, I just want to understand mechanically -- you had the autopsy results and then you filled out the death certificate after?
A. I don't recall if I had the autopsy

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report. Let's see, what date was that? It was signed on 10-22-99; right?
Q. Correct.
A. No, but the autopsy was not available at that time. The autopsy we got, it was -- the family agreed to have the autopsy done, but the autopsy is not done in a day. It takes a long time. So I don't think that when this was signed to release the body, which was on 10-22, I don't think I had the autopsy report.
Q. Doctor, when did Mrs. Pultz die?
MR. ROSSI: Look at the chart, doctor.
A. 10-20-99.
Q. She died on October 20th, 1999; true?
A. Right.
Q. Now, according to the autopsy, the autopsy was performed on October 22nd, 1999. You don't have any reason to dispute that, do you?
A. No.
Q. I guess what I want to just understand, doctor -- and stay with my question first because you seem to want to make a comment before I'm done with the question. And

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in fairness to you, you want to hear what I'm asking before you say something.
Can we agree that the death certificate states that --
(Mr. Auciello entered.)
MR. ROSSI: We have gone through some background, and we were just getting into the death certificate that he signed.
Q. Just so that the record is clear, before you signed the death certificate, you are certifying the cause of death as stated on this document; true?
A. Yes.
Q. And this death certificate says, number one, that an autopsy had been performed; true? Isn't that what it says?
A. Yes.
Q. And doesn't this document say that at the time you signed the death certificate that the autopsy findings were available?
A. No.
Q. Doctor --
A. Well, I don't know how it got there, but I don't think that the autopsy findings were available in a day or two.

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MR. ROSSI: That's fine. Wait for his question.
Q. Just answer my question.
MR. ROSSI: Just answer his question.
Q. Just so we can agree, this document that you signed indicates that an autopsy was performed; true?
A. Right.
Q. And this document that you signed indicates that the results, the autopsy findings were available prior to the completion of the cause of death; correct?
A. Well, it says that.
Q. That's my only question for you.
And when you filled out the death certificate, you did not put down any other significant conditions contributing to Mrs. Pultz' death other than what is stated on the death certificate; true?
A. Yes.
Q. Now, I asked you before I got into the death certificate some questions about your conversations with Dr. Rabinowitz, and I also asked you whether or not the death certificate accurately reflects the cause of death. I'm

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going to give you an opportunity to amplify on those points, okay? I'm not trying to shut you off.
Do you still stand by the primary cause of death on October 20th, 1999 being acute peritonitis secondary to perforated ulcer?
A. No. After the autopsy report things have changed.
Q. Did you ever process or file an amended death certificate?
A. No.
Q. Tell me if you were to fill out a death certificate now, based upon things that you learned after signing this certificate of death with the Ohio Department of Vital Statistics, what you would have indicated as the primary cause of death.
A. Acute myocardial infarction.
Q. Caused by what?
A. Anybody can have -- she had an underlying, has to have an underlying kind of disease, and I don't think we know the cause.
Q. Of what significance or what relationship, if any, was the acute peritonitis -- strike that.

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She had acute peritonitis secondary to perforated ulcer; correct?
A. Yes.
Q. What significance or relationship, if any, in your opinion was there between the acute peritonitis secondary to perforated ulcer and the acute myocardial infarction?
A. They are two separate events, absolutely separate events.
Q. Do you have an opinion to a probability, more likely than not, what was the precipitating event in this woman that caused her to have an acute myocardial infarction?
MR. ROSSI: Objection.
MR. WALTERS: Objection.
MR. AUCIELLO: Objection.
A. No.
Q. Can a low hemoglobin and a low hematocrit secondary to a bleed cause a patient that has underlying coronary artery disease to sustain a myocardial infarction?
A. If there is active bleeding, yes.
Q. And do you have reason to suggest that Mrs. Pultz did not have active bleeding leading up to the time that she sustained an

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acute myocardial infarction?
A. She did not.
Q. And how do you know that?
A. I will go by my exam the evening before when I saw her in the office. She had no sign of any active bleeding on my physical exam, and even by conversation with her, there was no sign of acute bleed.
Q. She was quiac positive, was she not, on rectal exam?
A. That only means that there might have been a chronic bleeding. It does not mean an acute bleed.
Q. Well, you can be quiac positive on an examination and, in fact, have an acute bleed; true?
A. No. The signs of acute bleeding are two. If you are vomiting blood, which is called hematemesis; or if you have black tarry stool -- she did not have black tarry stool. Black tarry stool does not mean acute bleeding. It can be from several causes.
Q. Can you rule out an acute bleed when a patient is quiac positive?
A. Yes, by physical exam and by other

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signs, yes.
Q. Simply by having a patient that is quiac positive on examination, with a history of dropping hematocrit and hemoglobin, can you on those facts alone rule out an acute bleed?
A. It depends on how much was the drop.
Q. Can we agree that you need to know what the patient's baseline was and what the hemoglobin and the hematocrit had been over the course of a 30 day period?
A. Yes.
Q. So is it fair to say that there are circumstances where a patient that has a fairly significant drop in their hemoglobin and hematocrit over a 30 day period, that presents with and is quiac positive, you at least have to consider the possibility that there might be an acute bleed?
MR. ROSSI: Objection. You may answer.
MR. WALTERS: Objection.
A. I'm sorry, would you repeat that question?
Q. Would you agree that in a patient that has a fairly significant drop in their

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hemoglobin and hematocrit over a 30 day period, and that patient presents to you and is quiac positive on exam, would you agree that you have to at least consider the possibility that the patient may have an acute bleed?
A. No, sir.
Q. Are you telling me that you can rule out on those facts -- listen to my question first before you answer -- that you can rule out on those facts the possibility of an acute bleed?
A. Yes.
Q. Let's talk further about your conversation with Dr. Rabinowitz. And if I'm mispronouncing his name, I'll apologize over and over again.
From your conversation with him, what else would you change, if anything, in the certificate of death other than indicating that the cause of death was an acute myocardial infarction?
A. Well, she also had underlying abdominal malignancy.
Q. That was in the omentum?
A. Yes.

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Q. And do you have any knowledge or understanding as to the significance of that underlying malignancy in terms of whether or not that, at that time in October of 1999, was a contributing factor to her death?
A. I don't think so.
Q. Do you have an opinion as to what her prognosis would have been had she not died of whatever it is that she died of; whether it was an acute MI or the acute peritonitis, do you have an opinion as to what Mrs. Pultz' life expectancy would have been given this finding on the omentum?
MR. WALTERS: Objection.
MR. ROSSI: Objection. Go ahead.
A. Well, this omentum malignancy, it's adenocarcinoma, papillary carcinoma, which can be sometimes of ovarian origin, and it will cause peritoneal metastasis, cause cirrhosis, can cause anemia, can cause abdominal pain. It is very difficult to diagnose also by any means except if the patient is explored.
I would say that it definitely will affect somebody's longevity and life expectancy and also the state of her life, yes, it will,

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because a tumor, if not taken care of, will keep on getting bigger and cause bleeding also.
Q. Would the omentum tumor be something that would likely be discovered during an exploratory surgery?
A. Yes.
Q. Do you know -- and if you do, fine; if you don't, just tell me -- but do you know whether there was any metastatic disease secondary to the omentum that was described by Dr. Rabinowitz at the time of the autopsy?
A. No.
Q. No, there wasn't, or no, you don't know?
A. I don't know.
Q. Assuming that there was no metastasis of the omentum cancer, do you know statistically what percentage of patients that are diagnosed with omentum cancer at the stage that hers was, what percentage of patients survive, what percentage of patients have a good recovery?
A. No.
MR. ROSSI: Objection.
Q. What I understand you to say is that you would have indicated omentum cancer but not

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as a cause of her death; it would be just an incidental finding?
A. Yes.
Q. The primary cause you would have indicated to be an acute myocardial infarction?
A. Yes.
Q. You would have still continued to indicate the acute peritonitis secondary to a perforated ulcer as being a contributing factor; correct?
A. Yes.
Q. Would you have included the cirrhosis of the liver and diabetes and rheumatoid arthritis in the same categories that you had on the death certificate or would that have changed?
A. No, that's true.
Q. Just so I understand, before I go back and ask you about your treatment and jump to the very end, are there any other changes that you would make to the death certificate which you obviously didn't make, based upon information that you obtained from Dr. Rabinowitz or any source at the time of her death?

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A. Only I would add that acute cause of death, acute myocardial infarction.
Q. The cause of which you do not have an opinion?
A. No.
Q. Did you talk with Dr. Rabinowitz about the acute MI?
A. As far as I can recollect, we discussed that, and then he mentioned that there was significant blockage in one of the arteries which caused the myocardial infarction and it was acute. That's the only information I could get from him.
Q. Did you talk with Dr. Rabinowitz at all about the omentum cancer?
A. This was an incident of findings, so we briefly discussed it, yes.
Q. Did he indicate to you his feeling about whether this omentum cancer was a significant cause to her death, or did he, from what you understood, did he give you the impression that he just thought it was incidental and not causative of her death?
MR. ROSSI: Objection. Go ahead.
MR. WALTERS: Objection.

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A. Yes.
Q. Tell me what, if anything, else you recall from your discussion with Dr. Rabinowitz.
A. Well, we talked about that she had an ulcer in the stomach, which got perforated and caused peritonitis, but it was not very significant, not affirmative peritonitis. It was in the very beginning stage.
She also had some ascites, which is a fluid collection in the abdomen and also in the lungs, which can be caused by omentum malignancy and also by underlying cirrhosis of the liver, and she had significant cirrhosis, because her liver was small with enlargement of the spleen, which indicates portal hypertension. And the significance of that is that it will affect your body in kind of general. You can be anemic, you can have low proteins, which would also affect your body in kind of general.
Q. Anything else that you recollect from your discussion, what you learned from your discussion with Dr. Rabinowitz, other than what you have told me?
A. I think the only other thing he mentioned, she also had some, I think,

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infarction of the lung, old, which I don't think had anything to do with this acute kind of event.
Q. Was this conversation within days or weeks of the death or was it long after?
A. It has to be weeks.
Q. Why do you say that?
A. Because I have no kind of knowledge of all these things when I signed this death certificate, and I remember it takes, for the final result to come back, it can take even a month. So it was several weeks, yes.
Q. Knowing what you knew several weeks later, why didn't you file an amended death certificate?
MR. ROSSI: Objection. Go ahead.
A. I don't recall, to answer that. I did not know what the procedures are, whether I should have done that or not. I had no knowledge of that.
Q. Did you just have one conversation with Dr. Rabinowitz, whenever it was?
A. Yes.
Q. Have you talked to Dr. Rabinowitz at all over the past several years about this case?

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A. No.
Q. Did you ever discuss Mrs. Pultz' care with Dr. Tasse, the intensive care doctor that saw Mrs. Pultz in the hospital?
A. No.
Q. Do you know Dr. Tasse?
A. Yes.
Q. Have you ever seen the emergency room records from September of '99, approximately a month before Mrs. Pultz was seen by you and then ultimately admitted to the hospital?
A. No.
Q. The records are in, I believe, the set of records that Mr. Rossi provided you. Is it your testimony that you have not reviewed those?
A. I did not. I only reviewed the day she was in the hospital. I did not review in detail about what happened before, but I was told a few things, which I had mentioned in my note also when I saw her in the office; that a month ago she had some abdominal pain and she was seen in the ER and she was diagnosed with UTI, which was treated with antibiotics.
Q. Did you know at the time that you saw

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Mrs. Pultz in your office that she had been seen in the emergency room not only with what you have just described, but also with findings of a hemoglobin of 8.0 and a hematocrit of 24.5 during that emergency room visit of September 25, 1999?
A. I didn't know that.
Q. Is that of any significance in terms of evaluating a patient that presents with the type of symptoms that you saw her with, if, in fact, she has had a hemoglobin of 8 without any transfusions from that time up until the time you saw her?
A. Yes.
Q. Of what concern is that?
A. Well, it will help you in your physical exam as to whether this lady since that time is having any acute kind of bleeding or not. But I had the information on this case that her hematocrit was 22, just four or five days before she was seen in the office.
This information was given by her husband, who worked in the hospital. So I took his information as kind of valid. And this is the time that she was started on iron.

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Q. We are going to talk about that in a moment, but what I want to understand is a hemoglobin of 8 and a hematocrit of 24.5 one month prior to your office visit in a patient that presents with abdominal pain, at least has to raise in your mind, and correct me if I am wrong, the suspicion of an acute bleed?
MR. ROSSI: Objection.
MR. WALTERS: Objection.
MR. AUCIELLO: Objection.
MR. ROSSI: Go ahead.
A. No. On the physical exam that I mentioned before -- as I mentioned, there are signs of acute bleeding. Hemoglobin of 8 in a patient with a chronic illness that she had is not very low in my opinion, because a patient with rheumatoid arthritis, cirrhosis, diabetes, they have a chronically low hemoglobin. Normal for them can be 8, 9 even.
Q. Let me interrupt you for one second. If you knew that this patient with rheumatoid arthritis did not have a chronic, low hemoglobin, but in fact her hemoglobin was within normal limits up until shortly before she is seen in the emergency room, and then she has

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a hemoglobin of 8.0 and a hematocrit of 24.5, would that change your opinion?
MR. ROSSI: Objection.
MR. WALTERS: Objection.
MR. AUCIELLO: Objection.
A. No.
Q. Would that increase your index of concern to determine why the patient who has rheumatoid arthritis, who is on aspirin, who is on methotrexate, who has a normal hemoglobin and a hematocrit, all of a sudden has a drop in their hemoglobin and hematocrit?
MR. ROSSI: Objection.
MR. WALTERS: Objection.
MR. AUCIELLO: Objection.
A. As I mentioned before, if there is a significant drop, then you will be concerned about it and then you will go by your clinical exam and by the findings, that rather than this has happened in a short period of time, it happened over several weeks. Because if it happened over a short period of time, then you will see, you will be very -- you will be definitely more, I would say, concerned than if it happened over a long period of time.

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Q. So the shorter the period of time that you see the drop in the hemoglobin and the hematocrit, the more reason there is to be concerned?
A. Significant drop.
MR. WALTERS: Objection.
Q. What would you define as a significant drop?
A. Well, 10, even from 8 to 10. If somebody has a hemoglobin of 10 and it drops down to 8, that is very significant, yes.
Q. It's a 20 percent drop; right?
A. Yes.
Q. And can that portend or suggest to you that the patient may be experiencing an acute GI bleed?
MR. ROSSI: Objection.
MR. WALTERS: Objection.
MR. AUCIELLO: Objection.
A. Still, it may not. As I said, there still may not be an acute GI bleeding, because you go by your exam. As I mentioned before, that if somebody is having -- I mean, there can be some other cause of a bleeding.
Q. Doctor, I'm not suggesting there

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might not be other causes, but do you at least have to consider the possibility that the patient is experiencing an acute GI bleed if you see a 20 percent drop in their hemoglobin over a short period of time?
MR. ROSSI: Objection.
MR. WALTERS: Objection.
MR. AUCIELLO: Objection.
MR. ROSSI: Objection to short period of time. You may answer.
A. Yes.
(Recess had.)
Q. What is iron deficiency anemia?
A. Well, whenever there is a loss of blood, or there is a sign of malnutrition or malabsorption, that your body is not getting enough either by mouth or you are losing it somewhere, it will cause, your body stores will be depleted and it will be deflected in your blood test that you have iron deficiency and that will cause low blood count. So there are several different causes of that.
Q. Did Mrs. Pultz, in your opinion, have true iron deficiency anemia?
MR. ROSSI: Objection. Go ahead.

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MR. WALTERS: Objection.
A. I really don't know because I did not have any of the information. The only way to find out is if you check the iron in the blood, which I would assume she might have, because she was started on supplement iron by mouth.
Q. And that sort of begs my next question. When one has true iron deficiency anemia, what is the treatment of choice?
A. Well, first of all, to find out the cause.
Q. How do you go about determining the cause?
A. The cause can be, as I mentioned, malnutrition, malabsorption. You can also lose blood and you will need a GI blood cup, and there will be other causes of loss of blood, as in a female, if they are having heavy periods, they will lose a lot of blood and that will cause anemia.
Q. If you suspect that the cause of the iron deficiency anemia is an acute bleed, what diagnostic studies do you as a GI doctor use to determine, number one, the location or the source of the bleed?

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A. Number one, acute GI bleeding does not cause iron deficiency anemia. It is a chronic blood loss which will cause you iron deficiency anemia. Your iron levels are normal in an acute bleed.
Q. Got you. So that to diagnose someone with iron deficiency anemia, you would expect that they had a chronic anemia as opposed to an acute event with a drop in their hematocrit and hemoglobin?
A. Yes.
Q. If you have an acute drop in hematocrit and hemoglobin in a patient and you want to search for the source of the drop in the hematocrit and hemoglobin, number one, one thing you would consider is whether or not there is, in fact, a GI bleed; correct?
A. Yes.
Q. Or an intraabdominal bleed?
A. Right.
Q. And as a gastroenterologist, what modalities do you have available to you to try to isolate the source of a bleed if you suspect that it's either GI or intraabdominal?
A. Well, it's a simple thing. Firstly,

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the history, if somebody is telling me that he is vomiting blood or having black stools, which will tell you right away that there is a GI bleeding which is significant, which is acute. Active blood.
If somebody does not have those symptoms by a history, and you do a rectal exam and you check the stool for occult blood, if it is a positive, then they will give you some clue that, okay, you look in the GI system, whether it can be upper, lower, whatever, and then you go by your exam.
If somebody is having abdominal pain in the upper part of the abdomen, they are taking nonsteroidal antiinflammatory medications like aspirin, Motrin, Advil, Naprosyn, you then suspect it could be upper.
Q. In fact, Mrs. Pultz was on a nonsteroidal antiinflammatory?
A. Yes.
Q. And you recommended that she stop that when you saw her on the 19th, didn't you?
A. Yes.
Q. To your knowledge, had she been advised prior to the 19th, according to any

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information that you had, to stop the nonsteroidal antiinflammatories?
A. If it was me, I would have.
Q. That's not my question. Are you aware from any information that someone suggested prior to November 19th that she stop the nonsteroidal antiinflammatories?
A. No.
Q. You said a moment ago that if it was you, you would have stopped the nonsteroidal antiinflammatories; correct?
MR. WALTERS: Objection.
A. Yes.
Q. And that's because the nonsteroidal antiinflammatory can only worsen the GI condition; correct?
MR. WALTERS: Objection.
A. Yes.
Q. So if there is an acute bleed and the patient is taking nonsteroidal antiinflammatories, what from a physiologic standpoint, what risk does that create?
A. Well, the risk would be that it can cause the ulcer to become worse. There will be more bleeding. The patient may not be having

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acute bleeding to start with. Maybe a slow kind of bleed, very, very slow, but it can become an acute and it can also cause a perforation of the ulcer, which we see it all the time.
Q. Do ulcers, gastric ulcers, do they more often bleed or do they more often perforate?
A. Well, incidence of bleeding is much higher than a perforation.
Q. Do gastric ulcers that bleed frequently or infrequently perforate?
A. Infrequently.
Q. You have encountered gastric ulcers that were bleeding ulcers that perforated; true?
A. Well, I won't say bleeding ulcer. Actively bleeding ulcer. I would say that somebody that has an ulcer can have a slow bleed, which is a complication, and it can perforate if it is not taken care of.
Q. And that sort of got to my next question. A gastric ulcer that has a slow bleed that goes on to perforate, one of the circumstances would be that intervention had not been provided to treat the slow GI bleed?
MR. WALTERS: Objection.

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Q. Is that true?
MR. ROSSI: Objection.
A. Yes.
Q. If you suspect a slow GI bleed and are concerned about the possibility of it going on, if not treated, to a perforation, what steps do you take as a GI doctor to treat a slow gastric ulcer?
A. Well, first you will stop the medicine which they are on, which is a nonsteroidal antiinflammatory.
Q. Was she on Ketoprofen?
A. It's called Orudis. Orudis is one of the antiinflammatories, and that can cause the ulcer -- cause that kind of bleeding.
Q. Cause further irritation of the ulcer?
A. Yes, it will.
Q. So you take them off the insulting medication and what else do you do?
MR. ROSSI: Objection. You can answer.
MR. WALTERS: Show my objection.
A. You first start the patient on treatment for that, which is either you use H2

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blockers, which is like Zantac, or Pepcid or a newer medicine, which is like, it's called PPI, and there are many of them.
Q. What does that stand for?
A. PPI is proton pump inhibitor. And these are all the medicines like Prevacid, Prilosec, Aciphex, and any of those, so you will definitely start them on that, one of the two.
But the main thing is you stop the offending agent, and then you also want to check to find out how bad the ulcer is, so you would take a look in the stomach, do an EGD.
Q. Do you do exploratory laparoscopies?
A. No.
Q. Are there circumstances where you have a GI bleed or a concern about a GI bleed or concern about an intraabdominal bleed that you will call in a surgeon to assist in the diagnostic workup?
A. Well, a surgeon, I don't think a surgeon will be of much help, because nowadays, you have the endoscopy and you scope the patient to find out the cause of bleeding, and you can do the angiograms, which will also help. You can do a GI bleeding scan which will also help.

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Q. If the patient has a gastric ulcer that has perforated, is that a surgical issue or can that be handled through the endoscope?
A. No, that's strictly a surgical issue.
Q. A gastric ulcer that is just seeping or bleeding but hasn't perforated, is that an issue that can be handled endoscopically?
A. Absolutely.
Q. And you basically would cauterize off the bleeder?
A. Yes.
Q. And then take away the offending medication and treat the patient medically?
A. Yes.
Q. More often than not, does the bleeder, does the bleeding gastric ulcer when treated properly, does it more often than not avoid -- strike that.
If a bleeding gastric ulcer is diagnosed and treated endoscopically, more often than not, the patient avoids a gastric --
A. Surgery.
Q. -- gastric surgery?
A. Yes.
Q. Thank you for helping me with my

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terms. They weren't coming out freely.
I want to just ask you a few questions about your visit with Mrs. Pultz back in '93. Take a look at your office record. I want to know what that visit was for back in '93, and ask you a few questions about that. But let me get to it first.
First, you were referred to her -- she was referred to you by a Dr. Baladori?
A. Yes.
Q. Do you know who Dr. Baladori is?
A. He specializes -- he is a rheumatologist.
Q. So that I don't miss anything, although your handwriting is pretty legible and I thank you for that, but can you read into the record below the weight what you have stated there?
A. Patient known to have it's called cirrhotic arthritis and had been on medicine, methotrexate, 2.5 milligram, three tablets each Monday for the past six to seven years.
She was referred to me for liver biopsy. Patient had a liver biopsy three to four years prior to being referred to me and

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that was normal. Her other medication was Zaroxolyn, Oridus, Darvocet, folic acid.
During her visit, first visit to me, her liver enzymes were elevated. And that is why she was referred to me for liver biopsy, because methotrexate is very highly hepatotoxic and liver functions can be minimal, high, or may be even normal, but the only way to diagnose toxicity is by liver biopsy. So she was referred to me for that.
A liver biopsy was performed to rule out cirrhosis of the liver.
Q. You took her blood pressure at that time?
A. At that time, her blood pressure was normal, 140 over 80. Examination of the heart and lungs was normal. Abdomen was normal. She had a deformity of the hands, which is mostly from her underlying disease, rheumatoid arthritis.
Diagnosis at that time was cirrhotic arthritis. Patient on methotrexate, and rule out cirrhosis of the liver. So she was scheduled for a liver biopsy.
Q. And that was done on November 12th,

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1993?
A. Yes.
Q. And you then have certain labs and orders that you had requested to be done, including the PT and PTT and CBC.
A. Right. At that time her CBC was normal. Her hemoglobin was 13.8. Her PT, PTT was also within normal limits.
Q. The hemoglobin of 13.8 is within normal limits; correct?
A. Yes. She underwent a liver biopsy. Her biopsy at that time, the pathological report showed that she did not have cirrhosis at that time.
Q. And you then, I take it, reported to the patient that she did not have any type of toxic response from her methotrexate?
A. Right.
Q. And told her to just continue to follow up, I presume, with her rheumatologist?
A. Yes.
Q. And up until October of '99, you never saw her again; true?
A. Yes.
Q. Now, the appointment that you saw her

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on October 19, 1999, do you know when that appointment was scheduled?
A. No.
Q. How would we go about determining when prior to or on October 19, 1999 Mrs. Pultz or her husband caused your office to schedule the appointment?
A. Well, I really don't think that I can answer that, because this patient was already seen in the office, so she is not a new patient. My office girls, they probably ask the patient about what are your complaints, and mostly go by that. We make an effort to see the patient as soon as possible, depending on the severity of their disease and symptoms.
Q. Is it fair to say that from what you have available to you right now, you are unable to tell me exactly when it was that Mrs. Pultz or her husband called to schedule the October 19 appointment?
A. Yes.
Q. Would you have calendars that would reflect the date that the appointment was scheduled or anything that would permit us to determine the patient called in on the 14th or

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the 15th and the 19th was the earliest appointment or anything of that nature?
A. Well, that information is available only in a new patient who is referred to me for a consult, then the office girls will make a little note for them. They write on the day they called and when they were given the appointment, so I know that this patient called like, say, a week ago and was seen within a week or so, or two weeks, or the patient called yesterday and was seen the next day.
Q. You don't have such a document for her?
A. No, but the follow-up, this is not -- it's not being done, it's not possible.
Q. The fact that you had only seen her one time or for one incident back in '93, when she called in '99, you still considered her to be an active patient; true?
A. Sure.
Q. So that little note that would show the date would not be filled out by your office staff in terms of the date that the call was made; is that correct?
A. Yes.

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Q. And just to try to abbreviate things, you don't know of anything that would indicate what date she called in?
A. No.
Q. Prior to seeing Mrs. Pultz on October 19, '99, did you talk to Dr. Flagg?
A. No.
Q. Did Dr. Flagg provide you with any labs, a printout of any of the labs from his office visit of October 5?
A. No.
Q. Did he provide you with any information relative to his office visit of October 14?
A. No.
Q. So is it fair to say that when Mrs. Pultz came to see you on the 19th, apparently accompanied by her husband, as you stated earlier --
A. Yes.
Q. -- you had not been provided with any information at all from Dr. Flagg; true?
A. Yes.
Q. I take it you didn't have any of Dr. Flagg's office records either?

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A. No.
Q. Is that true?
A. Yes.
Q. Do you recall Mr. Pultz being present with Mrs. Pultz on that office visit?
You mentioned early in the deposition, even perhaps before Mr. Auciello arrived, that you knew that Mr. Pultz had worked in a hospital?
A. Yes.
Q. What was your personal knowledge of that?
A. No, I didn't know him that well at all. I mean, I knew he worked in x-ray, so once in a while you will pass by and say hello, but I have nothing medically, personal, did not have any kind of conversation with him.
Q. When you saw Mrs. Pultz on October 19th, was she pale?
A. Yes.
Q. Did she appear weak?
A. Somewhat.
Q. Was she having abdominal pain?
A. She had a mild epigastric discomfort.
Q. And where?

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A. In the epigastrium.
Q. Was it midline?
A. The upper.
Q. The upper. It wasn't more to the left or to the right?
A. Well, when we examined -- the epigastric area is the upper part. It can be in the middle, on the right or left, it really doesn't make much of a difference.
Q. Do you recall whether it was left or right upper quadrant?
A. I really can't say that for sure, but most of the time, I would say in the mid.
Q. You don't have it recorded, though, do you?
A. No. Only I record it in the epigastric.
Q. But in fairness, your record doesn't reflect whether it was left upper quadrant, right upper quadrant, just epigastric pain; correct?
A. Yes.
Q. Do you record how severe the pain was?
A. Mild. It is written mild tenderness.

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Q. What was your diagnosis?
A. Well, number one, that she was pale looking, and her hematocrit, which I was told by her husband was low. My diagnosis was anemia and to rule out gastric ulcer probably caused by use of nonsteroidal antiinflammatory medication. And she also had dysphagia, which is some difficulty in swallowing.
Q. The history that you have that she had been seen by Dr. Flagg with a hematocrit of 22, it's your testimony that that history was provided to you solely by Mr. Pultz?
A. Yes.
Q. Dr. Flagg did not forward over to you any of the labs from his office visit?
A. No.
Q. And you didn't pick up the phone and call to obtain any of the labs from Dr. Flagg; true?
A. Well, I didn't feel it was kind of necessary.
Q. With the hematocrit of 22, what was your assumption as to what her hemoglobin was?
A. Around 8.
Q. And were you at all concerned about

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this patient having a hematocrit of 22 and a hemoglobin of 8?
A. Yes.
Q. What was within your differential in terms of the likely cause of the hematocrit and the hemoglobin being at those levels?
A. I thought she has an underlying ulcer disease, gastric ulcer, as I mentioned, with use of nonsteroidal antiinflammatory medication, and that needed to be taken care of.
Q. Did you ask her why she had not been taken off the nonsteroidal antiinflammatories prior to coming to see you?
A. I don't remember.
Q. Is it fair to say, though, that you are the one that prompted her being taken off the nonsteroidal antiinflammatory?
A. Yes. It's called Ansaid. Very simple.
Q. Would you read into the record what your note for October 19, 1999 says?
A. Patient weighed 179 pounds. Her present medications were Darvocet 100 and Oridus 75 milligram TID, Zocar, 20 milligram QD, methotrexate 2.5, three, once a week, and

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she also took Rezulin, 400 milligram QD, also Keratin and insulin 90 units. She was also on Feosol BID.
Patient feeling tired, weak, with epigastric pain and intermittent dysphagia.
She was seen by Dr. Flagg with hematocrit of 22. Started on Feosol, one BID four to five days prior to my visit, and she was feeling somewhat better. A month ago she had abdominal pain, seen in the ER, diagnosed with UTI, treated with antibiotics. Patient also complained of constipation and excessive bloatedness.
Physical examination. Patient pale looking, blood pressure 130 over 84. Lungs and heart was normal. Abdominal examination showed soft abdomen, tender, mild tenderness in the epigastrium and her bowel sounds were normal. Rectal examination was negative, but it showed stools being dark and they were occult blood positive.
Diagnosis at that time was anemia, rule out gastric ulcer, secondary to use of nonsteroidal antiinflammatory medication, and dysphagia.

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Q. Before you get to the plan -- I'm going to have you read that in a second -- but I wanted to ask you a couple questions about the exam itself, okay, and then we will have you read the rest of note in terms of the plan.
Did you obtain part of the history from the patient or is it your testimony that the history was being given to you entirely by the husband?
A. I would say both, but mostly by her husband.
Q. Do you know of any reason in October of 1999 that you could not have seen Mrs. Pultz earlier than October 19?
A. Well, on my exam, I don't feel that -- I try to see the patient very, very, in a very short period of time. I would say that there was no reason for her to be seen a lot sooner, because she was not showing any sign of active bleeding.
Q. But again, my question to you is, if it was felt necessary for you to see her prior to October 19, 1999, is there any reason why you couldn't have seen her?
A. No. I would have seen her any time

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before that.
Q. When you saw her on October 19, you were not aware that on September 25, '99, her hemoglobin had been 8 and her hematocrit had been 24.5; correct?
A. No -- yes.
Q. And you were not aware when you saw her on October 19th that her hemoglobin had been 7.6 and the hematocrit had been 22.9, other than Mr. Pultz' statement about her hematocrit; true?
A. Yes.
Q. You weren't aware on that date that her hemoglobin and her hematocrit in the past, prior to September, for years had been normal with nonsteroidal antiinflammatories and with methotrexate?
MR. AUCIELLO: Objection.
A. I didn't know that.
Q. With a history of hemoglobin of 8 dropping down to 7.6, with her abdominal symptoms, and with the medications that Mrs. Pultz was on when you saw her on October 19, 1999, you felt that she needed to have a gastrointestinal workup; true?
A. Yes.

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Q. Did you feel that the gastrointestinal workup needed to be done as soon as possible?
A. Yes.
Q. Why?
A. Well, with not knowing her background, what her blood counts were before, and by her symptoms, I felt that she should be worked up as soon as possible on a kind of urgent basis and not let it go further, because she could develop problems from the ulcer and from the low blood count.
Q. And I guess in your mind, what did you feel on October 19th, recognizing you had not seen her before October 19th, but seeing her on the 19th, what was it that you were concerned about that caused you to feel that this patient needed to be worked up on an urgent basis?
A. Well, the whole thing. The lady looked pale. She was weak. She was having -- you know, her appetite was not even good -- all kinds of symptoms. And though she is not bleeding actively, you just don't let it go forever. I think it needed to be taken care of as soon as possible.

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Q. You say although she wasn't bleeding actively at that time, how do you know she wasn't bleeding actively?
A. Well, from my exam, I can tell you that she was not bleeding actively. There was no sign of active bleeding, because, number one, she did not indicate to me that she was nauseated or she was vomiting, number one. Her stools were not black tarry or red, okay? Her stool was dark, because she was taking iron pills, which would make your stools to become dark.
Q. How long had she been taking the iron pills?
A. Four to five days.
Q. Would that be a sufficient period of time to cause the stool to be dark?
A. Absolutely.
Q. Okay.
A. And I felt that this is -- I mean, she had some chronic bleeding, and it needed to be taken care of. And that's why she was advised to be in the hospital.
Q. So you felt she had chronic bleeding but not any acute bleeding?

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A. Right.
Q. Did you feel that this patient needed to be worked up immediately as opposed to on an outpatient basis?
A. Well, I felt that. That's what my recommendations were to her on that evening.
Q. I'm going to have you read the plan in a moment, but I want to get a sense from you. It appears that you felt there was some emergency to have her worked up rather than over, say, a 24 or 48 hour period into the future. Tell me what was motivating you or what was causing you to say to the patient you need to be admitted rather than doing it on an outpatient basis?
MR. ROSSI: Objection. He did not say emergently, but go ahead, you may answer.
A. I didn't say that it is -- I said that it is urgent to admit her and find out what is going on, but not like on an emergency basis, because, you know, her symptoms have been going on for -- it's not anything changed overnight. She has been having these symptoms for a while.
Q. For how long?
A. Well, to me, from talking to the

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patient, I think she is having symptoms for almost a month, even when she had abdominal pain and came to ER the first time.
Q. When you say she needed to be worked up on an urgent basis, how do you define urgent?
A. Well, under these kind of circumstances, with somebody who is -- how old is she -- 60 some-year-old, with multiple medical problems, insulin dependent diabetic, okay, I would say that this is something that you do not want to -- it's a lot safer to have her in the hospital and find out what is going on, because these people are more prone to have other complications.
See, somebody who is on nonsteroidal medications, which is a culprit for bleeding and perforation, it can cause penetration of the ulcer and the bleeding can be very severe and then the next step is the perforation. So I was concerned about the whole thing; her having abdominal pain, being on the medication that she was on, that she should not go on for days with not anything being done. The best circumstances would have been to admit her the same night. That's what they were both recommended.

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Q. In your way of thinking, the sooner you had this patient worked up and treated, the greater the likelihood that you were going to be able to avoid a gastric perforation, if, in fact, her bleeding was being caused by that?
A. Sure.
Q. If you had seen this patient four or five days earlier with the same symptoms and had known that her hemoglobin was 7.6 at that time, would your recommendation have been to admit the patient for a GI workup at that time?
MR. ROSSI: Objection.
MR. AUCIELLO: Objection.
MR. WALTERS: Objection.
A. It depends on her symptoms. And you know, the safest thing is to admit the patient and take care of it so that you know what the circumstances are, because you can monitor them very well, any change in their symptoms, hemoglobin, hematocrit, and whatever needed to be done, you will do it. But again, it should be taken care of emergently, not like I will wait for a week.
Q. I'm sorry?
A. Taken care of in the right way and I

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will not wait -- even if I see her four or five days ago, sure, I would like to find out how bad she has the ulcer disease.
See, the important thing is to start taking care of her, which means stop the nonsteroidal, start her on the medicine to heal the ulcer and find out how bad the ulcer is. And I think these are the things that, the issues that we have to take care of.
Q. Got it. Why don't you order an H and H when you saw her on the 19th?
A. Her hemoglobin, according to her husband, it was just done recently, and she was on the iron pills and felt better. So I did not feel that it needed to be done. I wanted to do that, to keep her in the hospital, but I thought, okay, if she is not showing an active bleeding, we will go along and do the blood workup and find out what is going on.
Q. There was nothing preventing you on the 19th from doing an H and H, was there?
A. I didn't feel that it was absolutely necessary.
Q. I'm not suggesting absolutely necessary. I'm asking, there was nothing

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preventing you from a physical standpoint from doing an H and H, was there?
MR. ROSSI: Objection. Go ahead.
A. No.
Q. Had you admitted her to the hospital on the 19th as you had suggested, part of the initial labs that would have been done would have been an H and H; correct?
A. Yes.
Q. The fact that the patient opted to do it on an outpatient basis, not to be admitted that day, did that enter at all into your thought process in terms of getting an H and H on the 19th rather than waiting until she came in 48 hours later for the outpatient procedure?
MR. ROSSI: Objection. Do you understand the question?
MR. AUCIELLO: Objection.
A. Well, it's not that she did not want to be in the hospital on that day. She did not want to be in the hospital, period.
Q. Well, you knew that and we will talk about that in a moment, but you knew that this patient, if she had her way, was not going to be admitted to the hospital to have the GI workup

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on the 19th; true?
MR. ROSSI: Objection.
MR. WALTERS: Objection.
MR. AUCIELLO: Objection.
A. Yes.
Q. And you knew on the 19th that if she was going to have it done on an outpatient basis, it wasn't going to be done on the 19th; true?
A. No. Actually, I wanted to do her the next day, but they did not want that. Under the circumstances like this, I don't wait even a day. I think as far as I can kind of recall, that I wanted to do it even the next day, because I have a full day, for an exam I do on Wednesdays, and I think there was something that they had to do and they did not want to come even on Wednesday.
Q. Doctor, let me suggest this to you, just to save some time. If the evidence in this case shows that the scheduling to have it done on an outpatient basis, the first available time that you could do it on an outpatient basis was Thursday, October 21, 1999, and the evidence further shows that you didn't recommend that if

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it was going to be done on an outpatient basis that it be done the following day on Wednesday, October 20th, would you have any basis to dispute that?
MR. ROSSI: Objection. Go ahead.
MR. AUCIELLO: Objection.
A. I don't think that would have made any difference, because I had already taken care of what needed to be done; to stop the medication, which was causing her gastric ulcer and to start her on the medicine, Zantac, which would start to help the ulcer, so I think it was already taken care of that day.
Q. But if she was getting close to having a gastric perforation, what good was her being out of the hospital for the next 48 hours and not having a GI workup going to do?
A. A gastric perforation can happen any time.
Q. I know that. But -- go ahead.
A. I mean, I did not feel that she was having perforation the day I saw her in my office. If I felt that way, I would say that she would have more symptoms, she would probably have not been even able to walk out of my

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office. Perforation, gastric perforation, acute abdominal condition, you cannot walk around without not being taken care of.
Q. Were you insistent on October 19th, 1999 that the patient be admitted to the hospital?
A. Absolutely. I talked to both of them, the husband and wife. Her husband said that, doc, I will do what my wife wants and she did not want to.
Q. Did you ask her why she didn't want to be admitted to the hospital?
A. She just wanted to go home. I couldn't answer that question. Many patients do that.
Q. Your testimony is that you told Mrs. Pultz that you were insistent that she be admitted to the hospital that day; true?
A. Right.
Q. And tell me just as if I was Mrs. Pultz how you would have indicated to her as diplomatically as you can as a physician why it was that you were insistent upon her being admitted and why doing anything other than being admitted was not what you wanted to have done.

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MR. ROSSI: Objection. Go ahead, you may answer.
A. See, they were explained about what can happen if you refuse to be in the hospital, they were explained about the complications, and one of the complications they were told was the gastric ulcer with perforation and also kind of bleeding. And they were very well explained about that.
Q. Was anyone in the room with you -- I take it Mr. Pultz was in the room when you explained this to his wife?
A. I explained to both of them.
Q. Right. They were both there?
A. Right.
Q. Was anybody from your office in the room when you explained it to them?
A. No.
Q. Tell me, do you recall any questions being asked of you by either of them as to whether or not this could be done on an outpatient basis?
A. Well, they wanted to have it done as an outpatient. They did not want to be in the hospital.

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Q. And when they said that they wanted it done on an outpatient basis, did you advise against that?
A. No. I said that was fine if that's what their intentions are. If a patient doesn't want to be in the hospital, that means either they are not feeling that bad, they are not having devastating symptoms that they are not going to stand it, then many times we have to do that.
Q. Did you tell them that you felt that doing it on an outpatient basis was a poor decision on their part?
MR. ROSSI: Objection. I think he has already said that. Do you understand what he means by the question, doctor?
A. Well, I don't know.
Q. Did you tell your patient that? Did you say it was okay for her to have it done on an outpatient basis?
MR. ROSSI: Objection.
MR. AUCIELLO: Objection.
MR. WALTERS: Objection.
A. Well, under the circumstances, yes, it was okay.

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Q. Did you tell them when you said it was okay to have it done on an outpatient basis how soon you would get them scheduled to have it done?
A. As I said, I wanted to do it in the next day or so, so I think she was scheduled for Thursday.
Q. Which would be two days later?
A. The day after the visit in the office, yes.
Q. Your office visit was the 19th and she was scheduled for Thursday, the 21st?
A. Right.
Q. Why didn't you have her scheduled for Wednesday the 20th?
A. As I said, if I can recall, probably they did not want to have it done the next day. Really, I cannot remember, because mostly if I see somebody like that, I will do them the next day. If that's the way they want to have it done, I will do it the next day.
Q. Did you feel that given her clinical findings and the information that you had that if she was going to have it done on an outpatient basis that it should have been done

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on the 20th as opposed to scheduling it for two days later on the 21st?
MR. WALTERS: Objection.
MR. ROSSI: Objection. You may answer.
A. Well, it would have been, you know, the ideal would have been to do it the next day if they would have agreed, but to have it done on the 21st, I would say that it would not have made much of a difference unless something happens, a complication, which they were explained.
I mean, I don't think that was an issue. I think the issue was that complications they were told about, and I would say that even if she would have it done on the 21st as it was scheduled, that would have been okay.
Q. Just to be complete with regard to the note, the plan then, if you will read the rest of the language there.
A. Patient was advised admission, but she was very reluctant and confused and wanted to have it done as an outpatient. It was discussed with her husband. The patient was then advised to discontinue Oridus and she was

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started on Zantac, 150 milligram BID. She was scheduled for EGD and advised to have a colonoscopy later on. Patient was also told that she might need blood transfusion.
Q. Now, with regard to a blood transfusion, what factors would play into your decision whether to order a blood transfusion or not?
A. Well, I would say that if she had a further GI workup, which, especially the colonoscopy is more stress on your body, you want your hemoglobin to be at least around 9 and 10. So with the 7.6 or 8, you would like to have cardiovascular stability. And because a colonoscopy is a little more tedious on the body, she would have done better after we improve her hemoglobin, which is normally what we do.
Q. With a hemoglobin in the low 7's, how many units of blood would she have had to have been transfused with?
A. Well, I think probably two.
Q. And when would that transfusion with hemoglobins in the 7's, when would that have been done? Before any colonoscopy?

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A. Well, I would say that definitely before. But we would have followed her with her kind of blood count on the day of her EGD, and if it was low, she would have been given on the same day.
Q. Would she have been given a blood transfusion if it was 7.6 or lower, would she have been given a blood transfusion before the EGD?
A. Really, an EGD is a very safe and simple procedure, and if you are not having an active bleeding and there is no underlying cardiovascular problem documented, then we can do that always without giving them a blood transfusion.
Q. Why didn't you pick up the phone and call Dr. Flagg's office to get more information on his patient before making the recommendations that you did?
MR. ROSSI: Objection.
MR. WALTERS: Objection. Asked and answered.
MR. AUCIELLO: Objection.
A. I didn't think it was necessary. I think I went by my history, the physical exam,

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and by my judgment.
Q. Do you recall receiving a telephone call from Mr. Pultz the next day indicating that his wife was not doing well?
A. Yes.
Q. Tell me what you remember about that.
A. Well, I was still working in the lab, like we will do the endoscopy on the first floor, and I got a call from him that she was not feeling well; she was having some more abdominal pain, and he said that she did not feel well last night also. She thought that she was constipated and she took some medicine to move her bowels, which she did, but in the morning, her abdominal pain got worse, and he said that, doc, she is now willing to come to the hospital.
Q. He said now she is willing to come to the hospital?
A. Now she is willing to come to the hospital.
Q. You remember him saying that?
A. Yes.
Q. Did you note that she is willing to come to the hospital?

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A. Yes.
Q. You wrote that in your note?
A. Well, this is a conversation on the phone.
Q. I'm just asking whether you wrote that?
A. I don't remember.
Q. This is just something you remember?
A. Yes.
Q. You had him bring her in as a direct admit; correct?
A. I told him to bring her to the ER so that she can be seen, she can be taken care of right away, because there is no way of my knowing what else is going on.
So he was advised to bring her to the ER, which he did not want. He said, you know, there is a couple of hours waiting period and would you admit her direct? So then I said, okay, I will call the admitting office and get a bed for her and bring her down.
Q. Let me just clarify something. Can we agree that the records reflect, and your orders reflect, that this was a direct admit to the hospital?

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A. Yes.
Q. But what you are telling me is before you called, before you called and gave the orders and before it became a direct admit, what you are saying is that you had suggested to Mr. Pultz that he take his wife to the emergency room rather than a direct admit; true?
A. Right.
Q. And your testimony is that he didn't want to do that; he wanted her directly admitted to the hospital?
A. Well, the reason he said that, she may not have to wait there for an hour or two hours, and I said, okay, I will get a bed for you.
Q. Do you think that the outcome would have been different had she been a direct, had she been seen in the emergency room as opposed to a direct admit to the floor?
MR. ROSSI: Objection. Go ahead.
MR. WALTERS: Objection.
A. I don't think so.
Q. You wrote a brief note, apparently a progress note, a brief admission note on October 20th; is that correct?

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A. Yes.
Q. You can use mine to save some time.
A. Yes.
Q. Can you tell me, you have in front of you a copy of your brief admission note; is that correct?
A. Yes.
Q. Can you tell me what time that admission note was written?
A. You know, it has to be, it was probably in the evening after I saw her briefly, and I don't recall the exact time. Maybe after 6:30 or something like that. I don't have a time on that.
Q. Mrs. Pultz was admitted, according to the records, at 4:00 p.m., and you gave orders at 4:15, or actually orders that you gave were, I think, they were 4:15?
A. Yes.
Q. You didn't in the orders ask that she be typed and crossmatched for a transfusion, did you?
A. Well, we wanted to know what her stat CBC is, what her H and H is, and then you go from there, because that way you know what the

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numbers are.
Q. You didn't feel that a CT of the abdomen and pelvis was warranted until the following morning; correct?
A. Yes.
Q. Why?
A. First thing that I do is I want to get her chest x-ray and KUB on that evening to find out if there was anything acute going on, because a CT scan takes a lot longer time to get it done, especially in the evening. They have to get contrast, they have to get IV contrast and oral contrast, so it's a little bit more, I would say, time consuming thing. But KUB and chest x-ray can be done right away and that gives you an idea whether you are dealing with an acute abdomen or not. That was the main thing I wanted to find out on that evening.
Q. You gave orders at 4:15 and your testimony was your brief admit note was sometime after 6:00 p.m., did you say?
A. Yes.
Q. But it's not timed, is it?
A. No, it's not.
Q. How do you know it was sometime after

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6:00 p.m. as opposed to between 4:00 and --
A. I was still working around 4:00 o'clock, yes.
Q. Why didn't you go up and see your patient?
A. I was taking care of somebody else. I was in endo, and the reason I gave them the order was so things could be taken care of right away. And we do that many times, because I have seen her already the evening before and I knew, I have some idea what I was dealing with.
Q. When the labs were drawn, were you surprised to learn that her hemoglobin was 4.6?
A. But you know, I don't know what time they are going to draw the lab, but this lab, I think, looks like that. They did not do the stat kind of lab test. I think it was done later on, because there should be a time. Yeah, that is almost around 6:55 and we even did not have any knowledge of this at that time.
Q. Your orders say CBC with dif to be done on a stat basis?
A. Yes.
Q. And what does that mean to nurses at the hospital?

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A. Well, they are supposed to call the lab right away and get it done right away.
Q. And how quickly is right away?
A. Well, if we are lucky, we can get it within an hour. Sometimes it can take longer, but I think, as a rule, you should have it within an hour.
Q. So with the orders at 4:15, it should have been available at 5:15?
A. I would say -- well, I'm saying that it should have been done within an hour or so depending on what is going on, but on the floors, I just don't know what was going on, because it looks like to me it was not drawn right away.
Q. But again, what you expected when you gave a stat order was that it be drawn right away?
MR. ROSSI: Objection.
A. That's what it means, stat, right away.
Q. And if it was done stat, right away, you would expect that within an hour you would have the results back?
MR. ROSSI: Objection.

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A. Yes.
Q. If you had a stat CBC with a dif done and it was reported back to you by 5:15, roughly an hour after the order was given, and you were at that time made aware of her hemoglobin being 4.6 or somewhere in that general range, what would you have done?
A. Well, then she will need, she would have been given at least three units of blood.
Q. Okay.
A. Right away, yeah.
Q. And do you have an opinion if she had been given three units of blood right away, whether or not she would have experienced the acute MI?
MR. WALTERS: Objection.
A. I don't think so.
Q. You don't think that she would have?
A. I would say, really, if she has been given the blood, I don't think it would have prevented an acute MI at that time, whatever time it kind of happened.
Q. On what do you base that?
A. Well, number one, I think that this is drawn a lot later on. I think this -- see,

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this is at 6:55. I don't know they mention a time, but this was -- I don't think we have any initial kind of lab on her, so I really can't say anything, because this, I think, is a lot later on.
Q. Well, doctor, what I'm asking you, if the labs had been done as you say you expected them to be done on a stat basis, and you had results back by 5:15, and if the hemoglobin was at or near 4.6 or somewhere in that general range at that time, you have told me that you would have given the order for three units of packed red blood cells; right?
A. Right.
Q. And my question to you was, under that scenario, with transfusion at or around 5:15 or with the order to start the process of transfusing, whether or not she would have avoided the MI. Recognizing that it takes time to type and crossmatch, do you have an opinion as to whether or not the acute MI would have been avoided?
MR. ROSSI: Objection. He told you he didn't think it would have made a difference.
MR. WALTERS: I'll object. Asked and

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answered.
Q. And my next question really is, what do you base that on? Why do you feel that an earlier transfusion on October 20th, earlier hemoglobin and hematocrit levels leading to a blood transfusion, why don't you believe that that would have prevented this patient from suffering an acute MI?
MR. ROSSI: Objection. Asked and answered. Go ahead. You can answer it one more time.
MR. WALTERS: Objection.
A. Well, number one, I would say that it has to be very low if it was going to make a difference. But I would say that on my examination on that evening, she did not seem to be in a state of an acute deficiency, because she did not have any signs at all. She did not have any shortness of breath, she did not have any tachycardia, she did not have any black tarry stools, so I would say that probably would not have made a difference. I think the whole thing is that 7.5 or 8 hemoglobin, again, I think it is an issue in this case, but I would say that she never had an acute GI kind of bleed

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as far as, to our knowledge, and I think there is more, something else going on.
Q. When you say EKG tonight, when did you want the EKG done?
A. Well, this is the normal standard thing we do. This is our routine order that you do as soon as the patient is admitted.
Q. She was admitted at 4:00 o'clock. When that night did you want it done? Did you want it done at 6:00, midnight, or it didn't make any difference?
A. See, on that kind of floor, it really does not work that way, because if I wrote tonight, I'm sure it would have been done on that evening, yes. Most likely it would have been done around whatever, 7:00, 8:00 o'clock or so, because if you look at the record, she was being admitted at 5:00 o'clock.
Q. After you did your brief admit note, did you leave the hospital?
A. I was still here. That day I was here all day from morning until evening.
Q. You told me that you probably did the brief admit note sometime at or around 6:00 o'clock or after 6:00 o'clock?

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A. I would say it has to be after that, between 6:00 and 7:00, because around that time, I don't recall the exact time, but it has to be in that kind of vicinity.
Q. Were you present when she coded?
A. Well, I then --
MR. ROSSI: Let me interject. When you say present, physically in the hospital or in her room?
MR. MISHKIND: We will start physically in the hospital.
A. Yes, I was in the hospital.
Q. Where were you in the hospital?
A. I think on one of the other floors.
Q. How did you learn about what had transpired? Were you paged?
A. No, there is a stat page. I have seen her. I knew her room number, what room number she was in, and they also give you a stat page, whoever is the attending doctor, yes.
Q. Did you then come to the room?
A. Yes.
Q. Were you present during the code?
A. Yes.
Q. Did you participate in the

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resuscitative efforts?
A. Yes.
Q. What did you do?
A. Well, in the resuscitation, we had a person which is -- like one of them is an intensivist.
Q. Dr. Tasse?
A. Right. One of them is somebody from anesthesia who has to intubate.
Q. Okay.
A. And you are there. You are also watching a monitor. It's a teamwork. I was there all the time during, and we, you know, one, two, three, whatever needed to be done, it was done. Cardiac meds were given. Blood was given. The pumping was done and everything was done.
Q. Being present during the resuscitative effort, are you critical of anyone in terms of what was done or was not done during the resuscitation, during the code?
A. No. I think everybody worked very hard on that evening.
Q. We talked a moment ago about your wanting stat CBC. Do you believe that there was

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a delay in getting the CBC done from when you gave the order to when it was done?
MR. ROSSI: Objection.
MR. WALTERS: Objection.
A. Yes.
Q. And do you feel that it should have been done sooner?
MR. ROSSI: Objection. Go ahead.
A. Well, stat would mean you want to get it done right away, yes.
Q. If the stat CBC had been done right away and the results had been given to you, would you likely have ordered a blood transfusion at that time?
MR. ROSSI: Objection. Asked and answered.
A. Yes.
Q. Whose responsibility was it to have done the stat CBC? Was it a nursing issue or was it a house doctor's?
A. No, it's a nursing issue.
Q. Have you ever had any of the nurses explain to you why your stat order for a CBC with dif was not done on a stat basis?
A. I don't really recall now, but I

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don't know if they were very busy. That could have been the reason, but I don't really remember what was the delay.
Q. Are there any other orders that you gave, verbal orders that you gave at 4:00 o'clock or 4:15, that were not complied with within the period of time that you had expected them to be?
A. Well, really, I don't think there was anything not done. I think they were in the process of doing all the things when this unfortunate event happened. So I really have nothing -- I mean, really nothing was not done in the period of time.
Q. Well, again, my question to you is, we talked about the CBC not being done on a stat basis and that you have already told me should have been done sooner; true?
A. Yes.
Q. I'm asking, is there anything else that was ordered specifically by you that was not done in the time period that you expected it to be done?
A. Well, there was a blood test also, which is a CMP, lipase, amylase

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Q. All of that was on a stat basis?
A. Yes.
Q. And all of those were not done on a stat basis; true?
A. I would say no.
Q. And again, do you have any basis to explain in this case why the amylase, the lipase, the CBC with dif, the CMP were not done on a stat basis?
A. I have no explanation for that.
Q. Do you have an opinion whether a blood transfusion given prior to 8:00 o'clock or the time of her arrest --
A. 7:20.
Q. Is that it? 7:20?
A. Yes.
Q. -- a blood transfusion started prior to 7:20, whether or not that would have decreased the likelihood of the patient suffering an acute MI?
MR. WALTERS: Objection.
A. I don't think so.
Q. Why?
MR. ROSSI: Objection. He answered that. Go ahead.

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A. She is already having a coronary insufficiency MI. A blood transfusion will not do anything. The reason you want to give the blood transfusion is to prevent extension of her MI. It was already there. Blood is not going to do anything.
Q. So it's your opinion that even though the orders were not taken off and implemented in the time that you wanted them taken off in terms of the ultimate cause of death, you don't believe that those delays contributed to her death; is that a fair statement?
A. Yes.
MR. WALTERS: Objection.
Q. You never requested a surgical consult, did you?
A. Well, first thing, you know, I have to find out first whether we are dealing --
MR. ROSSI: Answer his question.
A. No.
Q. Why didn't you request a surgical consult?
A. There was not any indication of an acute abdomen at that time.
Q. Did you talk to Mr. Pultz after his

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wife passed at the hospital?
A. Yes.
Q. Do you remember that conversation?
A. Yes.
Q. Tell me what was said.
A. You know, I talked to him that I was very sorry this thing happened, because we, on that EKG, we have seen it has shown some acute changes. So I explained that it looks like it's a cardiac event and also explained to him about whatever else I knew at that time, but I think it was an acute. She surprised all of us.
Q. You say that there were findings on the EKG that showed --
A. Well, we saw some ST changes on the EKG during the time of the resuscitation, yes.
Q. Was she on any type of telemetry?
A. Oh, yeah, when you are doing the resuscitation --
Q. No, no. Before she arrested, was she on any telemetry on the floor?
A. No, there was no indication for that.
Q. If she had been admitted through the emergency room with her symptoms with the abdominal pain, the history of the low

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hemoglobin, hematocrit, et cetera, would she likely have been evaluated in the emergency room with an EKG?
A. I would say so, yes.
Q. Do you have an opinion, given the fact that she likely would have been in the emergency room, say, 4:00 to 5:00 p.m., whether or not the EKG would likely have shown any type of an electrical disturbance consistent with an acute or evolving MI?
MR. ROSSI: Objection.
MR. WALTERS: Objection.
MR. AUCIELLO: Objection.
A. I don't think I can make a comment on that.
Q. You defer to a cardiologist on that?
A. Yes.
Q. Assuming that she was experiencing an acute MI when she would have been in the emergency room, would this patient have been a candidate for streptokinase given her GI condition?
MR. ROSSI: Objection. If you can answer that question.
MR. AUCIELLO: Objection.

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A. I would say one of the contraindications for streptokinase if somebody has a GI kind of bleeding and ulcer disease, because they can perfuse, they can bleed massively. So that is one of the contraindications to that. So I really don't think that that would have been a very kind of optimal choice.
Q. So again, assuming that she was seen, and assuming there was EKG evidence of an acute MI, the only probable treatment would have been to take her to the cath lab?
MR. ROSSI: Objection.
MR. WALTERS: Objection.
A. I would answer, I don't think she was stable enough to be taken to the cardiac cath lab, and if she had a perforated ulcer, that's another risk.
Q. You have a copy of the in-path statement in your record that was part of the autopsy. Do you recall seeing that?
(Pause.)
Q. Is that of any significance? You are now looking at the in-path statement?
A. Yes. I am looking at that. That's

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referencing the omentum cancer that we talked about before. Right.
Q. Are you able to tell me whether or not that in-path report describes any type of metastatic disease or not?
A. No.
Q. No, it doesn't, or no, you don't know?
A. Really, it does not indicate any metastatic disease.
(Pause.)
A. Well, I really can't make a comment on that, because I'm not very -- I don't have much knowledge about it. No, I really don't want to make any comment.
Q. That's fine, doctor.
A moment ago I asked you about your conversation with Mr. Pultz after the events, and I just want to make sure that we have covered everything that you can remember that you said to him or that he said to you at the time. And if we haven't, please continue.
In other words, have you told me everything that he said to you after?
A. Well, you know, you always like kind

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of think back, and retrospectively, you think about it and say, oh, doc, I should have forced her to stay in the hospital the evening before and this and that, but that is not going to happen, so I don't think that there was any more talk about that, because time was past. It was just a very sad issue.
Q. Is it your testimony that when you spoke with Mr. Pultz after his wife passed that he said to you, I should have insisted that she go into the hospital the night before?
A. No. Retrospectively, he said that he should have, said they should have done what they were told, but again, I mean, time was gone.
Q. I understand that. I'm just asking you, is it your testimony that he said this to you after his wife died; that in retrospect, we should have gone into the hospital the night before?
A. Something like that.
Q. Is there anything else that you remember him saying at the time?
A. No. I requested that we should get an autopsy and the family agreed.

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Q. Do you remember what other family members were there?
A. I think maybe their daughter, I think. There were a lot of members, family, 15 people. But if I remember, I think one of them was the daughter.
Q. Do you have an opinion if Mrs. Pultz had listened to you, as you claim, and gone into the hospital on the 19th rather than waiting, whether or not she would have survived?
MR. ROSSI: Objection.
MR. WALTERS: Objection.
MR. ROSSI: He has not seen all the records.
A. I really can't say anything on that. But I would comment on one thing; that it's an unfortunate event, even if she was in the hospital the day before, and say she perforated the ulcer, okay, and she had an acute MI, she would have been a very high risk surgical candidate and nobody would have touched her. So I think unfortunately that perforated ulcer, which is an acute abdomen surgical problem and does not go away medically, she would not have been a candidate for surgery, so I think the

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outcome could have been very poor.
Q. Are you suggesting that if she had been in the hospital and had a perforated ulcer that she would have already sustained the acute MI preventing a surgical --
A. Well, what I'm saying is a perforated ulcer does not -- it can happen, if the ulcer was that bad, no matter what you do, if the ulcer has perforated, that is more stress on your body because your body goes into shock.
Q. There was no evidence that she had a perforated ulcer when she was in the office on the 19th?
A. No, absolutely not.
Q. Can you tell me whether the perforated ulcer occurred before or after her heart attack?
A. I would say that it could have happened. She probably might have, my guess is might have --
MR. ROSSI: Don't guess.
A. She might have a perforated ulcer in the morning of the day, because her husband called me that she was having pain. It's quite possible. But it was not a chronically

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long-standing perforation, and I think that it may or may not have been a factor. I think she probably had significant coronary artery disease and that caused her MI.
Q. Are you suggesting that the perforation of the ulcer, that you can rule out the perforation of the ulcer as being a contributing factor to the MI?
A. No. I didn't say that.
Q. Is it your testimony that you believe that she had the perforated ulcer first and then had the acute MI at sometime later that day? Is that most likely what happened, in your opinion?
A. Yes.
Q. And can you state to a probability if she had been admitted to the hospital and treated before the ulcer perforated whether or not that would have prevented her from sustaining an acute MI?
A. No.
Q. No, you can't say? You don't have an opinion? You defer to a cardiologist on that?
A. Yes.
Q. Fair enough. Any other conversations that you remember with the family after the

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death?
A. No. I don't remember anything else, except probably I think maybe the autopsy report.
Q. And that we have talked about in terms of what you discussed with Dr. Rabinowitz?
A. Yes.
MR. MISHKIND: Nothing further, doctor. Thanks.
EXAMINATION OF SUBHASH C. MAHAJAN, M.D.
BY MR. WALTERS:
Q. I have one question. I just want to clear this up, doctor. I introduced myself before we started. I'm Steve Walters and I represent Dr. Flagg.
Am I correct that when Mr. and Mrs. Pultz were in your office on October 19th --
(Discussion off the record.)
Q. Doctor, am I correct that when Mr. and Mrs. Pultz were in your office on October 19th, you strongly advised that Mrs. Pultz be admitted to the hospital that day, October 19th?
A. Yes.
Q. And am I correct that it was not a situation of you saying, well, you can be

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admitted today, or you can have it done on an outpatient basis tomorrow or the next day, it's up to you; it wasn't that sort of thing, was it?
A. No.
Q. Is there any question in your mind that Mr. Pultz and Mrs. Pultz understood how important you felt it was for her to go into the hospital that day?
A. Well, he was explained very well and the same time he was told that if anything changes, please contact me. That's the best I could do. And that's what he did the next day.
Q. When were you contacted the next day?
A. In the afternoon, around 2:00, 3:00, 4:00. I think it was in the late afternoon. I was still working.
MR. WALTERS: That's all I have.
MR. AUCIELLO: I have nothing. Thank you, doctor.
MR. MISHKIND: One other question for you.
EXAMINATION OF SUBHASH C. MAHAJAN, M.D.
BY MR. MISHKIND:
Q. Was it your responsibility to emphasize to your patient the importance of

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being admitted to the hospital on the 19th to have the testing done then as opposed to having it done on an outpatient basis?
A. Yes.
Q. Would it have been below accepted practice on your part to have indicated to the family we can do it on an outpatient basis or we can do it on an inpatient basis and it really doesn't make any difference?
MR. ROSSI: Objection.
MR. WALTERS: Objection.
MR. AUCIELLO: Objection.
MR. ROSSI: Do you understand the question?
A. No.
Q. Do you want me to rephrase it for you, doctor? I will rephrase it so you can give a fair answer, at the risk of asking maybe one or two additional questions.
MR. ROSSI: I want it to be clear, Howard, and I have not said much during this deposition, but I think he has made it clear to you that he told this woman and her husband on October 19th that she needed to be admitted. This was not an either/or scenario.

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MR. MISHKIND: I understand his testimony and you summarized it fairly well in a couple words.
Q. But I'm asking you, if you did not tell Mr. and Mrs. Pultz that it was okay to wait and have the testing done on an outpatient basis, that it needed to be done on an inpatient basis, would you agree that that would not have been -- hypothetically that's what occurred -- that that would not be acceptable care on your part?
MR. ROSSI: I'm going to object, again, Howard, because by the way you have worded the question, ultimately he had to say that was how it was going to be done because that was the only alternative he gave them.
MR. MISHKIND: That's his testimony, but what I'm saying to him --
Q. Hypothetically, if you --
MR. ROSSI: If he had presented it that way versus how he did present it?
MR. MISHKIND: Let me ask the question.
MR. ROSSI: I don't want this record to be confused.

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MR. MISHKIND: It's definitely getting confused with your testimony now.
MR. ROSSI: I'm not testifying.
MR. MISHKIND: Let me finish. You have been delightful so far, Mr. Rossi, and I don't want you to go off track.
Q. Hypothetically, if you said to the Pultzes it can be done on an outpatient basis, I prefer to have it done on an inpatient basis, but it's okay to do it on an outpatient basis, and you didn't emphasize to them the importance and the urgency that we have described, would that have been below accepted practice?
A. No.
Q. Why?
A. No, it's not. Because the issue was on that day not just to do the test. The issue was to take care of the patient in whole and in general. And a patient with her multiple medical problems, preferably very much emphasize to be at the hospital and have all the things done, but many times if the patient does not want it, you don't have any other option. It's not below the standard. It is being done and has been done, it can be done.

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Q. So it would have been reasonable for you to have said to them, okay, well, we can do the testing tomorrow, Thursday, as necessary, and that's okay without increasing the risk to you, my patient?
A. Well, the main thing is that I do not have any other option. If they did not want to be in the hospital, then I said, okay, we will do it as an outpatient. There was no other option left to me.
Q. I understand that. Again, my question to you is, was it reasonable under those circumstances to say to the patient that if we do it tomorrow or the next day, that we are not going to increase the risk of harm to you?
MR. WALTERS: Objection.
A. First of all, you cannot tell what is the risk of harm to you. You cannot tell that by seeing the patient on the evening, a day before, who is having some pain, weak or anemic, there is no sign of a perforation. I cannot guess that she is going to perforate tonight, tomorrow, you cannot. And it's not below the standard. You can do that, yes.

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Q. Did you feel based upon what you knew at that point that it was reasonable --
A. Yes.
Q. -- for the patient to have the test done the next day or 48 hours later?
A. Yes.
MR. MISHKIND: No further questions.
MR. ROSSI: Doctor, you have the right to read the transcript and I would urge you to tell her that you will read the transcript.
THE WITNESS: I will read the transcript.
- - - - -
(Deposition concluded at 4:35 p.m.)
(Signature not waived.)
- - - - -

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AFFIDAVIT

I have read the foregoing transcript from page 1 through 105 and note the following corrections:

PAGE	LINE	REQUESTED CHANGE

SUBHASH C. MAHAJAN, M.D.

Subscribed and sworn to before me this day of , 2002.

Notary Public

My commission expires .

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CERTIFICATE

State of Ohio,
SS:
County of Cuyahoga.

I, Vivian L. Gordon, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named SUBHASH C. MAHAJAN, M.D. was by me first duly sworn to testify to the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony as above set forth was by me reduced to stenotypy, afterwards transcribed, and that the foregoing is a true and correct transcription of the testimony.

I do further certify that this deposition was taken at the time and place specified and was completed without adjournment; that I am not a relative or attorney for either party or otherwise interested in the event of this action. I am not, nor is the court reporting firm with which I am affiliated, under a contract as defined in Civil Rule 28 (D).

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this 31st day of January, 2002.

Vivian L. Gordon

Vivian L. Gordon, Notary Public
Within and for the State of Ohio
My commission expires June 8, 2004.

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DEPOSITION OF SUBHASH MAHAJAN, M.D.