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1 IN THE COURT OF COMMON PLEAS
2 OF CUYAHOGA COUNTY, OHIO
3 -----
4 FRED W. PULTZ, Individually
5 and as Administrator of the
6 Estate of BARBARA A. PULTZ,
7 deceased,
8 Plaintiff,
9
10 vs Case No. 433332
11 Judge Kilbane-Koch
12 DOUGLAS N. FLAGG, M.D.,
13 et al.,
14 Defendants.
15 -----
16 DEPOSITION OF SUBHASH C. MAHAJAN, M.D.
17 WEDNESDAY, JANUARY 23, 2002
18 -----
19 Deposition of SUBHASH C. MAHAJAN, M.D., a
20 Defendant herein, called by counsel on behalf of
21 the Plaintiff for examination under the statute,
22 taken before me, Vivian L. Gordon, a Registered
23 Diplomat Reporter and Notary Public in and for
24 the State of Ohio, pursuant to agreement of
25 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.

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1 APPEARANCES:
2 On behalf of the Plaintiff
3 Becker & Mishkind
4 HOWARD D. MISHKIND, ESQ.
5 660 Skylight Office Tower
6 Cleveland, Ohio 44113
7 216-241-2600
8
9 On behalf of the Defendant Flagg
10 Weston, Hurd, Fallon, Paisley & Howley
11 STEPHEN WALTERS, ESQ.
12 2500 Terminal Tower
13 Cleveland, Ohio 44113
14 216-241-6602
15 On behalf of the Defendant Mahajan, M.D.
16 Hanna, Campbell & Powell
17 GREGORY ROSSI, ESQ.
18 P. O. Box 5521
19 3737 Embassy Parkway
20 Akron, Ohio 44334
21 330-670-7300
22 On behalf of the Defendant Jones, M.D.
23 Gallagher, Sharp, Fulton & Norman
24 ERNEST AUCIELLO, ESQ.
25 Bulkley Building
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1 SUBHASH C. MAHAJAN, M.D., a witness herein,
2 called for examination, as provided by the Ohio
3 Rules of Civil Procedure, being by me first duly
4 sworn, as hereinafter certified, was deposed and
5 said as follows:
6 EXAMINATION OF SUBHASH C. MAHAJAN, M.D.
7 BY MR. MISHKIND:
8 Q. Would you please state your name for
9 the record.
10 A. Subhash Mahajan.
11 Q. You are a physician; is that true?
12 A. Yes.
13 Q. What is your area of specialization?
14 A. I specialize in gastroenterology.
15 Q. My name is Howard Mishkind and I
16 represent the family of your former patient. I
17 think you realize that.
18 A. Yes.
19 Q. Have you had your deposition taken
20 before, sir?
21 A. Yes.
22 Q. How many times?
23 A. A few times, a couple times.
24 Q. Is that two or three times?
25 A. Two.

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1 Q. This is now the third?
2 A. Yes.
3 Q. Have any of those prior occasions
4 been in connection with a claim against you?
5 MR. ROSSI: Objection. Go ahead, you
6 may answer, doctor.
7 A. It was a while ago, less than ten
8 years ago.
9 Q. I didn't ask about the time. I just
10 wanted to know whether or not your deposition
11 was taken in connection with a lawsuit filed
12 against you. And the answer would be yes?
13 A. Yes.
14 Q. One of them was, did you say, more
15 than ten years ago?
16 A. Between eight or ten years.
17 Q. And what was the other time that your
18 deposition was taken?
19 MR. ROSSI: Objection. Howard, can I
20 have a continuing objection to former, prior
21 medical malpractice cases?
22 MR. MISHKIND: Yes.
23 MR. ROSSI: Go ahead, doctor, you can
24 answer his questions.
25 A. Would you like me to explain the

<p style="text-align: right;">Page 5</p> <p>1 case?</p> <p>2 Q. Actually right now I'm just trying to</p> <p>3 get a temporal relationship. I understand that</p> <p>4 one was eight to ten years ago, and it was a</p> <p>5 lawsuit against you.</p> <p>6 A. They were between that period of</p> <p>7 time, like two years of time, between eight --</p> <p>8 one was about eight years and another was about</p> <p>9 ten years, so there were two within two years</p> <p>10 period of time, yes.</p> <p>11 Q. Fair enough. Is it fair to say that</p> <p>12 since eight or ten years ago, up until now, your</p> <p>13 deposition has not been taken?</p> <p>14 A. Yes.</p> <p>15 Q. Are you currently named in any other</p> <p>16 medical negligence cases other than this case?</p> <p>17 A. No.</p> <p>18 Q. You have been sued then three times</p> <p>19 in your career?</p> <p>20 A. Yes.</p> <p>21 Q. Can you tell me briefly what the</p> <p>22 subject matter of those prior two cases was?</p> <p>23 A. One case was a patient I saw for</p> <p>24 abdominal pain, GI symptoms, and some weight</p> <p>25 loss, and this patient was worked up for</p>	<p style="text-align: right;">Page 7</p> <p>1 evening. I was called for consult after</p> <p>2 midnight, and it was not a stat consult. The</p> <p>3 patient was stable. I didn't get a chance to</p> <p>4 see that patient, but during the night the</p> <p>5 patient had a thromboembolic complication, which</p> <p>6 is not uncommon after the surgery. So he</p> <p>7 stroked out and had a massive mesenteric</p> <p>8 insufficiency causing bleeding from everywhere,</p> <p>9 and I was blamed that I didn't see the patient</p> <p>10 at midnight or 1:00 o'clock, whenever I was</p> <p>11 called.</p> <p>12 Q. What was the result of that case?</p> <p>13 A. Well, there were actually several</p> <p>14 people in that, and it was also settled out of</p> <p>15 court.</p> <p>16 Q. So neither of the cases went to</p> <p>17 trial; true?</p> <p>18 A. Yes.</p> <p>19 Q. Do you remember the name of either or</p> <p>20 both of the patients?</p> <p>21 A. No, I don't.</p> <p>22 Q. Both cases were here in Cuyahoga</p> <p>23 County?</p> <p>24 A. Right.</p> <p>25 Q. Do you practice alone or with any</p>
<p style="text-align: right;">Page 6</p> <p>1 colitis, colon cancer, which were negative. And</p> <p>2 he did not come back for follow up for almost a</p> <p>3 year.</p> <p>4 About a year and a half later, he was</p> <p>5 diagnosed with a rare tumor called carcinoid,</p> <p>6 which takes a long time to diagnose, so I</p> <p>7 haven't seen that patient for all that time. He</p> <p>8 was seeing somebody else, but now he came back</p> <p>9 to see me. So I was, you know, named. That's</p> <p>10 why I did not diagnose it a year and a half ago.</p> <p>11 Q. Where is the tumor located, this</p> <p>12 carcinoid tumor located?</p> <p>13 A. Well, this actually can be a small,</p> <p>14 very small, tiny lesion that can start in the</p> <p>15 small intestine.</p> <p>16 Q. What was the end result of that case,</p> <p>17 if you recall?</p> <p>18 A. I think it was settled out of court.</p> <p>19 Q. Was it here in Cuyahoga County?</p> <p>20 A. Yes.</p> <p>21 Q. The other case, briefly, can you tell</p> <p>22 me the allegation or the facts of that matter?</p> <p>23 A. That patient had coronary bypass</p> <p>24 surgery and came here with anemia and GI</p> <p>25 bleeding. The patient came to ICU in the</p>	<p style="text-align: right;">Page 8</p> <p>1 other gastroenterologists in your office</p> <p>2 practice?</p> <p>3 A. Alone.</p> <p>4 Q. Has that pretty much been your</p> <p>5 practice, to be solo?</p> <p>6 A. Yes.</p> <p>7 Q. I don't have a CV, but Mr. Rossi</p> <p>8 promised me that he would provide me with one.</p> <p>9 I want to ask you a few questions about your</p> <p>10 background and then we will get into the</p> <p>11 specifics of this case.</p> <p>12 A. Sure.</p> <p>13 Q. Fair enough?</p> <p>14 A. Sure.</p> <p>15 Q. Where did you go to medical school?</p> <p>16 A. I did my medical school back in</p> <p>17 India. The name of the medical school was</p> <p>18 Government Medical College, Bunjab, B-U-N-J-A-B.</p> <p>19 Q. And where in India is that located?</p> <p>20 A. That is in the State of Bunjab.</p> <p>21 Q. Did you do any training after</p> <p>22 graduating from the medical school in India or</p> <p>23 did you do your training here?</p> <p>24 A. After that is when I came here in</p> <p>25 '72.</p>

<p style="text-align: right;">Page 9</p> <p>1 Q. Had you been living in the U.S. and 2 went back to India? 3 A. No, I have been living since '72 4 here. 5 Q. So you were born and raised in India? 6 A. Yes. 7 Q. Did your primary and then your 8 medical school education in India? 9 A. Yes. 10 Q. And then came to the U.S. to do your 11 residency and training? 12 A. Right. 13 Q. What city did you come to? 14 A. Well, I did my first year of 15 internship in Canton, Ohio, Aultman Hospital, 16 from '72 to '73. Then I came to Cleveland. I 17 was at Lutheran Medical Center and Metro General 18 Hospital from '73 to '76. I did my two years of 19 medical residency and one year of fellowship in 20 gastroenterology. Then I went to M.D. Anderson 21 Hospital in Houston, Texas and did my second 22 year of fellowship in GI there. 23 Q. What did you do after that then? 24 A. Then I came back here in '77 and 25 started my practice.</p>	<p style="text-align: right;">Page 11</p> <p>1 MR. ROSSI: Objection. Go ahead. 2 A. '79, I think. 3 Q. Do you have any other family members 4 that are physicians? 5 A. Yes, my brother, younger brother. 6 Q. Is he a neurologist? 7 A. No. I know that guy also. 8 My brother also specializes in GI and 9 he works with me in the office, but we have both 10 solo practices. We cover each other and sign 11 out for each other. 12 Q. What is your brother's name? 13 A. Suresh, S-U-R-E-S-H. 14 Q. Did your brother ever see Mrs. Pultz? 15 A. No. 16 Q. I know that there was a period of 17 time in the early '90s that Mrs. Pultz was seen 18 in this office. Was that by you? 19 A. Yes. 20 Q. And then the incident which was prior 21 to her death, that was you? 22 A. Yes. 23 Q. I just want to make sure it wasn't 24 your brother or someone else. 25 Since I don't have your CV at this</p>
<p style="text-align: right;">Page 10</p> <p>1 Q. Do you have any other licenses or 2 fellowship training other than what you have 3 described? 4 A. No. 5 Q. I take it you have privileges here at 6 Southwest? 7 A. Yes. Southwest, Parma Hospital, and 8 also at Akron-Medina. 9 Q. Which of those three hospitals do you 10 do most of your procedures at? 11 A. Mostly at Southwest. 12 Q. Has that been pretty much the 13 majority of your hospital practice being at 14 Southwest over the years? 15 A. Yes. 16 Q. Have you ever had your privileges to 17 practice medicine suspended or revoked? 18 A. No. 19 Q. Ever applied for privileges at any 20 hospital and been denied? 21 A. No. 22 Q. I take it you are a U.S. citizen? 23 A. Yes. 24 Q. What year did you become a U.S. 25 citizen?</p>	<p style="text-align: right;">Page 12</p> <p>1 point, tell me whether you have done any writing 2 at all in the medical literature. 3 A. No. 4 Q. You have not published anything? 5 A. No. 6 Q. Have you ever had occasion to serve 7 as an expert witness in any medical negligence 8 cases? 9 A. No. 10 Q. Do you remember Mrs. Pultz? 11 A. Yes. 12 Q. Do you remember Mr. Pultz? 13 A. Yes. 14 Q. When is the last time you saw 15 Mr. Pultz? 16 A. He was seen -- 17 Q. Before you answer that, it's 18 Mr. Pultz, not Mrs. Pultz. 19 A. I saw him, the last time I saw him in 20 the hospital was when his wife was admitted. 21 Q. You haven't had any contact with him, 22 for example, since his wife passed away? 23 A. No. 24 Q. Mr. Rossi showed me your chart, which 25 is in the manila file, and also he has presented</p>

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1 to you a copy of various records for Mrs. Pultz'
2 treatment prior to seeing you and then prior to
3 being admitted to Southwest. And you have those
4 records, as well; correct?
5 A. Yes.
6 Q. Have you reviewed anything in the
7 medical literature in preparation for today's
8 deposition?
9 A. No.
10 Q. Have you reviewed Dr. Flagg's
11 records?
12 A. No.
13 Q. You know Dr. Flagg; right?
14 A. Yes.
15 Q. Have you read Dr. Flagg's deposition?
16 A. No.
17 Q. Have you been provided with any type
18 of a written summary of his testimony?
19 A. No.
20 MR. ROSSI: Objection. Go ahead, you
21 may answer that.
22 Q. When is the last time you had any
23 contact with Dr. Flagg in any way?
24 A. I think maybe a month ago I saw him
25 in the hospital. He was making his rounds and I

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1 A. I don't recall.
2 Q. You had the benefit of the autopsy
3 information before signing the death
4 certificate; true?
5 A. I think so.
6 Q. In fact, I'm just looking at a copy
7 of the death certificate, and rather than
8 marking it as an exhibit, we can certainly agree
9 that it's your signature on October 22nd, 1999
10 to the death certificate; correct?
11 A. Yes.
12 Q. And on there, it says, was an autopsy
13 performed and were the autopsy findings
14 available prior to completion of cause of death,
15 and yes is checked on both of them?
16 A. Yes.
17 Q. And you have as the primary cause of
18 death acute peritonitis secondary to perforated
19 ulcer; true?
20 A. Yes.
21 Q. You also have cirrhosis of the liver,
22 diabetes melitis and rheumatoid arthritis;
23 correct?
24 A. Yes.
25 Q. Do you still stand by those

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1 was making my rounds and we said hello.
2 Q. Have you ever had occasion since this
3 lawsuit has been pending to have any
4 conversation with him at all, whether it was
5 informally or otherwise?
6 A. No.
7 Q. He has never said anything to you
8 about the case; is that true?
9 A. Right.
10 Q. And you have never said anything to
11 him about the case?
12 A. That's true.
13 Q. Have you had occasion to talk with
14 the pathologist from the hospital --
15 Dr. Rabinowitz I think is his name -- that did
16 the autopsy on Mrs. Pultz?
17 A. Yes.
18 Q. When did you talk with him?
19 A. We discussed it after, I think, he
20 finished his exam, even before. He wanted to
21 have some information about her, which I gave
22 him whatever I knew, and then we discussed it
23 after he finished the autopsy exam.
24 Q. Did you have that discussion with him
25 before you signed the death certificate?

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1 statements in the death certificate as to the
2 cause of death in this case being acute
3 peritonitis secondary to a perforated ulcer?
4 MR. ROSSI: Objection.
5 MR. WALTERS: Objection.
6 A. No.
7 Q. You don't?
8 A. There are other causes, but that's
9 not the only cause.
10 Q. Well, there on the death certificate
11 it has other significant conditions contributing
12 to death but not resulting in the underlying
13 cause, and you didn't fill anything in on the
14 death certificate, did you?
15 A. I don't remember that.
16 Q. I'll hand it to you. My question to
17 you is, am I correct that in the area for other
18 contributing factors you do not have anything
19 listed there; is that correct?
20 A. Yes, I have not.
21 Q. And before signing the death
22 certificate -- again, I just want to understand
23 mechanically -- you had the autopsy results and
24 then you filled out the death certificate after?
25 A. I don't recall if I had the autopsy

4 (Pages 13 to 16)

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

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1 MR. ROSSI: That's fine. Wait for
2 his question.
3 Q. Just answer my question.
4 MR. ROSSI: Just answer his question.
5 Q. Just so we can agree, this document
6 that you signed indicates that an autopsy was
7 performed; true?
8 A. Right.
9 Q. And this document that you signed
10 indicates that the results, the autopsy findings
11 were available prior to the completion of the
12 cause of death; correct?
13 A. Well, it says that.
14 Q. That's my only question for you.
15 And when you filled out the death
16 certificate, you did not put down any other
17 significant conditions contributing to
18 Mrs. Pultz' death other than what is stated on
19 the death certificate; true?
20 A. Yes.
21 Q. Now, I asked you before I got into
22 the death certificate some questions about your
23 conversations with Dr. Rabinowitz, and I also
24 asked you whether or not the death certificate
25 accurately reflects the cause of death. I'm

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1 in fairness to you, you want to hear what I'm
2 asking before you say something.
3 Can we agree that the death
4 certificate states that --
5 (Mr. Auciello entered.)
6 MR. ROSSI: We have gone through some
7 background, and we were just getting into the
8 death certificate that he signed.
9 Q. Just so that the record is clear,
10 before you signed the death certificate, you are
11 certifying the cause of death as stated on this
12 document; true?
13 A. Yes.
14 Q. And this death certificate says,
15 number one, that an autopsy had been performed;
16 true? Isn't that what it says?
17 A. Yes.
18 Q. And doesn't this document say that at
19 the time you signed the death certificate that
20 the autopsy findings were available?
21 A. No.
22 Q. Doctor --
23 A. Well, I don't know how it got there,
24 but I don't think that the autopsy findings were
25 available in a day or two.

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

5 (Pages 17 to 20)

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1 She had acute peritonitis secondary
2 to perforated ulcer; correct?
3 A. Yes.
4 Q. What significance or relationship, if
5 any, in your opinion was there between the acute
6 peritonitis secondary to perforated ulcer and
7 the acute myocardial infarction?
8 A. They are two separate events,
9 absolutely separate events.
10 Q. Do you have an opinion to a
11 probability, more likely than not, what was the
12 precipitating event in this woman that caused
13 her to have an acute myocardial infarction?
14 MR. ROSSI: Objection.
15 MR. WALTERS: Objection.
16 MR. AUCIELLO: Objection.
17 A. No.
18 Q. Can a low hemoglobin and a low
19 hematocrit secondary to a bleed cause a patient
20 that has underlying coronary artery disease to
21 sustain a myocardial infarction?
22 A. If there is active bleeding, yes.
23 Q. And do you have reason to suggest
24 that Mrs. Pultz did not have active bleeding
25 leading up to the time that she sustained an

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1 signs, yes.
2 Q. Simply by having a patient that is
3 quiac positive on examination, with a history of
4 dropping hematocrit and hemoglobin, can you on
5 those facts alone rule out an acute bleed?
6 A. It depends on how much was the drop.
7 Q. Can we agree that you need to know
8 what the patient's baseline was and what the
9 hemoglobin and the hematocrit had been over the
10 course of a 30 day period?
11 A. Yes.
12 Q. So is it fair to say that there are
13 circumstances where a patient that has a fairly
14 significant drop in their hemoglobin and
15 hematocrit over a 30 day period, that presents
16 with and is quiac positive, you at least have to
17 consider the possibility that there might be an
18 acute bleed?
19 MR. ROSSI: Objection. You may
20 answer.
21 MR. WALTERS: Objection.
22 A. I'm sorry, would you repeat that
23 question?
24 Q. Would you agree that in a patient
25 that has a fairly significant drop in their

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1 acute myocardial infarction?
2 A. She did not.
3 Q. And how do you know that?
4 A. I will go by my exam the evening
5 before when I saw her in the office. She had no
6 sign of any active bleeding on my physical exam,
7 and even by conversation with her, there was no
8 sign of acute bleed.
9 Q. She was quiac positive, was she not,
10 on rectal exam?
11 A. That only means that there might have
12 been a chronic bleeding. It does not mean an
13 acute bleed.
14 Q. Well, you can be quiac positive on an
15 examination and, in fact, have an acute bleed;
16 true?
17 A. No. The signs of acute bleeding are
18 two. If you are vomiting blood, which is called
19 hematemesis; or if you have black tarry stool --
20 she did not have black tarry stool. Black tarry
21 stool does not mean acute bleeding. It can be
22 from several causes.
23 Q. Can you rule out an acute bleed when
24 a patient is quiac positive?
25 A. Yes, by physical exam and by other

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

6 (Pages 21 to 24)

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1 Q. And do you have any knowledge or
2 understanding as to the significance of that
3 underlying malignancy in terms of whether or not
4 that, at that time in October of 1999, was a
5 contributing factor to her death?

6 A. I don't think so.

7 Q. Do you have an opinion as to what her
8 prognosis would have been had she not died of
9 whatever it is that she died of; whether it was
10 an acute MI or the acute peritonitis, do you
11 have an opinion as to what Mrs. Pultz' life
12 expectancy would have been given this finding on
13 the omentum?

14 MR. WALTERS: Objection.

15 MR. ROSSI: Objection. Go ahead.

16 A. Well, this omentum malignancy, it's
17 adenocarcinoma, papillary carcinoma, which can
18 be sometimes of ovarian origin, and it will
19 cause peritoneal metastasis, cause cirrhosis,
20 can cause anemia, can cause abdominal pain. It
21 is very difficult to diagnose also by any means
22 except if the patient is explored.

23 I would say that it definitely will
24 affect somebody's longevity and life expectancy
25 and also the state of her life, yes, it will,

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1 as a cause of her death; it would be just an
2 incidental finding?

3 A. Yes.

4 Q. The primary cause you would have
5 indicated to be an acute myocardial infarction?

6 A. Yes.

7 Q. You would have still continued to
8 indicate the acute peritonitis secondary to a
9 perforated ulcer as being a contributing factor;
10 correct?

11 A. Yes.

12 Q. Would you have included the cirrhosis
13 of the liver and diabetes and rheumatoid
14 arthritis in the same categories that you had on
15 the death certificate or would that have
16 changed?

17 A. No, that's true.

18 Q. Just so I understand, before I go
19 back and ask you about your treatment and jump
20 to the very end, are there any other changes
21 that you would make to the death certificate
22 which you obviously didn't make, based upon
23 information that you obtained from
24 Dr. Rabinowitz or any source at the time of her
25 death?

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1 because a tumor, if not taken care of, will keep
2 on getting bigger and cause bleeding also.

3 Q. Would the omentum tumor be something
4 that would likely be discovered during an
5 exploratory surgery?

6 A. Yes.

7 Q. Do you know -- and if you do, fine;
8 if you don't, just tell me -- but do you know
9 whether there was any metastatic disease
10 secondary to the omentum that was described by
11 Dr. Rabinowitz at the time of the autopsy?

12 A. No.

13 Q. No, there wasn't, or no, you don't
14 know?

15 A. I don't know.

16 Q. Assuming that there was no metastasis
17 of the omentum cancer, do you know statistically
18 what percentage of patients that are diagnosed
19 with omentum cancer at the stage that hers was,
20 what percentage of patients survive, what
21 percentage of patients have a good recovery?

22 A. No.

23 MR. ROSSI: Objection.

24 Q. What I understand you to say is that
25 you would have indicated omentum cancer but not

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1 A. Only I would add that acute cause of
2 death, acute myocardial infarction.

3 Q. The cause of which you do not have an
4 opinion?

5 A. No.

6 Q. Did you talk with Dr. Rabinowitz
7 about the acute MI?

8 A. As far as I can recollect, we
9 discussed that, and then he mentioned that there
10 was significant blockage in one of the arteries
11 which caused the myocardial infarction and it
12 was acute. That's the only information I could
13 get from him.

14 Q. Did you talk with Dr. Rabinowitz at
15 all about the omentum cancer?

16 A. This was an incident of findings, so
17 we briefly discussed it, yes.

18 Q. Did he indicate to you his feeling
19 about whether this omentum cancer was a
20 significant cause to her death, or did he, from
21 what you understood, did he give you the
22 impression that he just thought it was
23 incidental and not causative of her death?

24 MR. ROSSI: Objection. Go ahead.

25 MR. WALTERS: Objection.

7 (Pages 25 to 28)

Page 29

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

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

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1 A. No.
2 Q. Did you ever discuss Mrs. Pultz' care
3 with Dr. Tasse, the intensive care doctor that
4 saw Mrs. Pultz in the hospital?
5 A. No.
6 Q. Do you know Dr. Tasse?
7 A. Yes.
8 Q. Have you ever seen the emergency room
9 records from September of '99, approximately a
10 month before Mrs. Pultz was seen by you and then
11 ultimately admitted to the hospital?
12 A. No.
13 Q. The records are in, I believe, the
14 set of records that Mr. Rossi provided you. Is
15 it your testimony that you have not reviewed
16 those?
17 A. I did not. I only reviewed the day
18 she was in the hospital. I did not review in
19 detail about what happened before, but I was
20 told a few things, which I had mentioned in my
21 note also when I saw her in the office; that a
22 month ago she had some abdominal pain and she
23 was seen in the ER and she was diagnosed with
24 UTI, which was treated with antibiotics.
25 Q. Did you know at the time that you saw

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1 Mrs. Pultz in your office that she had been seen
2 in the emergency room not only with what you
3 have just described, but also with findings of a
4 hemoglobin of 8.0 and a hematocrit of 24.5
5 during that emergency room visit of September
6 25, 1999?
7 A. I didn't know that.
8 Q. Is that of any significance in terms
9 of evaluating a patient that presents with the
10 type of symptoms that you saw her with, if, in
11 fact, she has had a hemoglobin of 8 without any
12 transfusions from that time up until the time
13 you saw her?
14 A. Yes.
15 Q. Of what concern is that?
16 A. Well, it will help you in your
17 physical exam as to whether this lady since that
18 time is having any acute kind of bleeding or
19 not. But I had the information on this case
20 that her hematocrit was 22, just four or five
21 days before she was seen in the office.
22 This information was given by her
23 husband, who worked in the hospital. So I took
24 his information as kind of valid. And this is
25 the time that she was started on iron.

8 (Pages 29 to 32)

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

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1 a hemoglobin of 8.0 and a hematocrit of 24.5,
2 would that change your opinion?
3 MR. ROSSI: Objection.
4 MR. WALTERS: Objection.
5 MR. AUCIELLO: Objection.
6 A. No.
7 Q. Would that increase your index of
8 concern to determine why the patient who has
9 rheumatoid arthritis, who is on aspirin, who is
10 on methotrexate, who has a normal hemoglobin and
11 a hematocrit, all of a sudden has a drop in
12 their hemoglobin and hematocrit?
13 MR. ROSSI: Objection.
14 MR. WALTERS: Objection.
15 MR. AUCIELLO: Objection.
16 A. As I mentioned before, if there is a
17 significant drop, then you will be concerned
18 about it and then you will go by your clinical
19 exam and by the findings, that rather than this
20 has happened in a short period of time, it
21 happened over several weeks. Because if it
22 happened over a short period of time, then you
23 will see, you will be very -- you will be
24 definitely more, I would say, concerned than if
25 it happened over a long period of time.

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

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

9 (Pages 33 to 36)

<p style="text-align: right;">Page 37</p> <p>1 MR. WALTERS: Objection. 2 A. I really don't know because I did not 3 have any of the information. The only way to 4 find out is if you check the iron in the blood, 5 which I would assume she might have, because she 6 was started on supplement iron by mouth. 7 Q. And that sort of begs my next 8 question. When one has true iron deficiency 9 anemia, what is the treatment of choice? 10 A. Well, first of all, to find out the 11 cause. 12 Q. How do you go about determining the 13 cause? 14 A. The cause can be, as I mentioned, 15 malnutrition, malabsorption. You can also lose 16 blood and you will need a GI blood cup, and 17 there will be other causes of loss of blood, as 18 in a female, if they are having heavy periods, 19 they will lose a lot of blood and that will 20 cause anemia. 21 Q. If you suspect that the cause of the 22 iron deficiency anemia is an acute bleed, what 23 diagnostic studies do you as a GI doctor use to 24 determine, number one, the location or the 25 source of the bleed?</p>	<p style="text-align: right;">Page 39</p> <p>1 the history, if somebody is telling me that he 2 is vomiting blood or having black stools, which 3 will tell you right away that there is a GI 4 bleeding which is significant, which is acute. 5 Active blood. 6 If somebody does not have those 7 symptoms by a history, and you do a rectal exam 8 and you check the stool for occult blood, if it 9 is a positive, then they will give you some clue 10 that, okay, you look in the GI system, whether 11 it can be upper, lower, whatever, and then you 12 go by your exam. 13 If somebody is having abdominal pain 14 in the upper part of the abdomen, they are 15 taking nonsteroidal antiinflammatory medications 16 like aspirin, Motrin, Advil, Naprosyn, you then 17 suspect it could be upper. 18 Q. In fact, Mrs. Pultz was on a 19 nonsteroidal antiinflammatory? 20 A. Yes. 21 Q. And you recommended that she stop 22 that when you saw her on the 19th, didn't you? 23 A. Yes. 24 Q. To your knowledge, had she been 25 advised prior to the 19th, according to any</p>
<p style="text-align: right;">Page 38</p> <p>1 A. Number one, acute GI bleeding does 2 not cause iron deficiency anemia. It is a 3 chronic blood loss which will cause you iron 4 deficiency anemia. Your iron levels are normal 5 in an acute bleed. 6 Q. Got you. So that to diagnose someone 7 with iron deficiency anemia, you would expect 8 that they had a chronic anemia as opposed to an 9 acute event with a drop in their hematocrit and 10 hemoglobin? 11 A. Yes. 12 Q. If you have an acute drop in 13 hematocrit and hemoglobin in a patient and you 14 want to search for the source of the drop in the 15 hematocrit and hemoglobin, number one, one thing 16 you would consider is whether or not there is, 17 in fact, a GI bleed; correct? 18 A. Yes. 19 Q. Or an intraabdominal bleed? 20 A. Right. 21 Q. And as a gastroenterologist, what 22 modalities do you have available to you to try 23 to isolate the source of a bleed if you suspect 24 that it's either GI or intraabdominal? 25 A. Well, it's a simple thing. Firstly,</p>	<p style="text-align: right;">Page 40</p> <p>1 information that you had, to stop the 2 nonsteroidal antiinflammatories? 3 A. If it was me, I would have. 4 Q. That's not my question. Are you 5 aware from any information that someone 6 suggested prior to November 19th that she stop 7 the nonsteroidal antiinflammatories? 8 A. No. 9 Q. You said a moment ago that if it was 10 you, you would have stopped the nonsteroidal 11 antiinflammatories; correct? 12 MR. WALTERS: Objection. 13 A. Yes. 14 Q. And that's because the nonsteroidal 15 antiinflammatory can only worsen the GI 16 condition; correct? 17 MR. WALTERS: Objection. 18 A. Yes. 19 Q. So if there is an acute bleed and the 20 patient is taking nonsteroidal 21 antiinflammatories, what from a physiologic 22 standpoint, what risk does that create? 23 A. Well, the risk would be that it can 24 cause the ulcer to become worse. There will be 25 more bleeding. The patient may not be having</p>

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1 acute bleeding to start with. Maybe a slow kind
2 of bleed, very, very slow, but it can become an
3 acute and it can also cause a perforation of the
4 ulcer, which we see it all the time.
5 Q. Do ulcers, gastric ulcers, do they
6 more often bleed or do they more often
7 perforate?
8 A. Well, incidence of bleeding is much
9 higher than a perforation.
10 Q. Do gastric ulcers that bleed
11 frequently or infrequently perforate?
12 A. Infrequently.
13 Q. You have encountered gastric ulcers
14 that were bleeding ulcers that perforated; true?
15 A. Well, I won't say bleeding ulcer.
16 Actively bleeding ulcer. I would say that
17 somebody that has an ulcer can have a slow
18 bleed, which is a complication, and it can
19 perforate if it is not taken care of.
20 Q. And that sort of got to my next
21 question. A gastric ulcer that has a slow bleed
22 that goes on to perforate, one of the
23 circumstances would be that intervention had not
24 been provided to treat the slow GI bleed?
25 MR. WALTERS: Objection.

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1 Q. Is that true?
2 MR. ROSSI: Objection.
3 A. Yes.
4 Q. If you suspect a slow GI bleed and
5 are concerned about the possibility of it going
6 on, if not treated, to a perforation, what steps
7 do you take as a GI doctor to treat a slow
8 gastric ulcer?
9 A. Well, first you will stop the
10 medicine which they are on, which is a
11 nonsteroidal antiinflammatory.
12 Q. Was she on Ketoprofen?
13 A. It's called Orudis. Orudis is one of
14 the antiinflammatories, and that can cause the
15 ulcer -- cause that kind of bleeding.
16 Q. Cause further irritation of the
17 ulcer?
18 A. Yes, it will.
19 Q. So you take them off the insulting
20 medication and what else do you do?
21 MR. ROSSI: Objection. You can
22 answer.
23 MR. WALTERS: Show my objection.
24 A. You first start the patient on
25 treatment for that, which is either you use H2

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

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1 Q. If the patient has a gastric ulcer
2 that has perforated, is that a surgical issue or
3 can that be handled through the endoscope?
4 A. No, that's strictly a surgical issue.
5 Q. A gastric ulcer that is just seeping
6 or bleeding but hasn't perforated, is that an
7 issue that can be handled endoscopically?
8 A. Absolutely.
9 Q. And you basically would cauterize off
10 the bleeder?
11 A. Yes.
12 Q. And then take away the offending
13 medication and treat the patient medically?
14 A. Yes.
15 Q. More often than not, does the
16 bleeder, does the bleeding gastric ulcer when
17 treated properly, does it more often than not
18 avoid -- strike that.
19 If a bleeding gastric ulcer is
20 diagnosed and treated endoscopically, more often
21 than not, the patient avoids a gastric --
22 A. Surgery.
23 Q. -- gastric surgery?
24 A. Yes.
25 Q. Thank you for helping me with my

11 (Pages 41 to 44)

<p style="text-align: right;">Page 45</p> <p>1 terms. They weren't coming out freely. 2 I want to just ask you a few 3 questions about your visit with Mrs. Pultz back 4 in '93. Take a look at your office record. I 5 want to know what that visit was for back in 6 '93, and ask you a few questions about that. 7 But let me get to it first. 8 First, you were referred to her -- 9 she was referred to you by a Dr. Baladori? 10 A. Yes. 11 Q. Do you know who Dr. Baladori is? 12 A. He specializes -- he is a 13 rheumatologist. 14 Q. So that I don't miss anything, 15 although your handwriting is pretty legible and 16 I thank you for that, but can you read into the 17 record below the weight what you have stated 18 there? 19 A. Patient known to have it's called 20 cirrhotic arthritis and had been on medicine, 21 methotrexate, 2.5 milligram, three tablets each 22 Monday for the past six to seven years. 23 She was referred to me for liver 24 biopsy. Patient had a liver biopsy three to 25 four years prior to being referred to me and</p>	<p style="text-align: right;">Page 47</p> <p>1 1993? 2 A. Yes. 3 Q. And you then have certain labs and 4 orders that you had requested to be done, 5 including the PT and PTT and CBC. 6 A. Right. At that time her CBC was 7 normal. Her hemoglobin was 13.8. Her PT, PTT 8 was also within normal limits. 9 Q. The hemoglobin of 13.8 is within 10 normal limits; correct? 11 A. Yes. She underwent a liver biopsy. 12 Her biopsy at that time, the pathological report 13 showed that she did not have cirrhosis at that 14 time. 15 Q. And you then, I take it, reported to 16 the patient that she did not have any type of 17 toxic response from her methotrexate? 18 A. Right. 19 Q. And told her to just continue to 20 follow up, I presume, with her rheumatologist? 21 A. Yes. 22 Q. And up until October of '99, you 23 never saw her again; true? 24 A. Yes. 25 Q. Now, the appointment that you saw her</p>
<p style="text-align: right;">Page 46</p> <p>1 that was normal. Her other medication was 2 Zaroxolyn, Oridus, Darvocet, folic acid. 3 During her visit, first visit to me, 4 her liver enzymes were elevated. And that is 5 why she was referred to me for liver biopsy, 6 because methotrexate is very highly hepatotoxic 7 and liver functions can be minimal, high, or may 8 be even normal, but the only way to diagnose 9 toxicity is by liver biopsy. So she was 10 referred to me for that. 11 A liver biopsy was performed to rule 12 out cirrhosis of the liver. 13 Q. You took her blood pressure at that 14 time? 15 A. At that time, her blood pressure was 16 normal, 140 over 80. Examination of the heart 17 and lungs was normal. Abdomen was normal. She 18 had a deformity of the hands, which is mostly 19 from her underlying disease, rheumatoid 20 arthritis. 21 Diagnosis at that time was cirrhotic 22 arthritis. Patient on methotrexate, and rule 23 out cirrhosis of the liver. So she was 24 scheduled for a liver biopsy. 25 Q. And that was done on November 12th,</p>	<p style="text-align: right;">Page 48</p> <p>1 on October 19, 1999, do you know when that 2 appointment was scheduled? 3 A. No. 4 Q. How would we go about determining 5 when prior to or on October 19, 1999 Mrs. Pultz 6 or her husband caused your office to schedule 7 the appointment? 8 A. Well, I really don't think that I can 9 answer that, because this patient was already 10 seen in the office, so she is not a new patient. 11 My office girls, they probably ask the patient 12 about what are your complaints, and mostly go by 13 that. We make an effort to see the patient as 14 soon as possible, depending on the severity of 15 their disease and symptoms. 16 Q. Is it fair to say that from what you 17 have available to you right now, you are unable 18 to tell me exactly when it was that Mrs. Pultz 19 or her husband called to schedule the October 19 20 appointment? 21 A. Yes. 22 Q. Would you have calendars that would 23 reflect the date that the appointment was 24 scheduled or anything that would permit us to 25 determine the patient called in on the 14th or</p>

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

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1 Q. And just to try to abbreviate things,
2 you don't know of anything that would indicate
3 what date she called in?
4 A. No.
5 Q. Prior to seeing Mrs. Pultz on October
6 19, '99, did you talk to Dr. Flagg?
7 A. No.
8 Q. Did Dr. Flagg provide you with any
9 labs, a printout of any of the labs from his
10 office visit of October 5?
11 A. No.
12 Q. Did he provide you with any
13 information relative to his office visit of
14 October 14?
15 A. No.
16 Q. So is it fair to say that when
17 Mrs. Pultz came to see you on the 19th,
18 apparently accompanied by her husband, as you
19 stated earlier --
20 A. Yes.
21 Q. -- you had not been provided with
22 any information at all from Dr. Flagg; true?
23 A. Yes.
24 Q. I take it you didn't have any of
25 Dr. Flagg's office records either?

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

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1 A. In the epigastrium.
2 Q. Was it midline?
3 A. The upper.
4 Q. The upper. It wasn't more to the
5 left or to the right?
6 A. Well, when we examined -- the
7 epigastric area is the upper part. It can be in
8 the middle, on the right or left, it really
9 doesn't make much of a difference.
10 Q. Do you recall whether it was left or
11 right upper quadrant?
12 A. I really can't say that for sure, but
13 most of the time, I would say in the mid.
14 Q. You don't have it recorded, though,
15 do you?
16 A. No. Only I record it in the
17 epigastric.
18 Q. But in fairness, your record doesn't
19 reflect whether it was left upper quadrant,
20 right upper quadrant, just epigastric pain;
21 correct?
22 A. Yes.
23 Q. Do you record how severe the pain
24 was?
25 A. Mild. It is written mild tenderness.

13 (Pages 49 to 52)

<p style="text-align: right;">Page 53</p> <p>1 Q. What was your diagnosis? 2 A. Well, number one, that she was pale 3 looking, and her hematocrit, which I was told by 4 her husband was low. My diagnosis was anemia 5 and to rule out gastric ulcer probably caused by 6 use of nonsteroidal antiinflammatory medication. 7 And she also had dysphagia, which is some 8 difficulty in swallowing. 9 Q. The history that you have that she 10 had been seen by Dr. Flagg with a hematocrit of 11 22, it's your testimony that that history was 12 provided to you solely by Mr. Pultz? 13 A. Yes. 14 Q. Dr. Flagg did not forward over to you 15 any of the labs from his office visit? 16 A. No. 17 Q. And you didn't pick up the phone and 18 call to obtain any of the labs from Dr. Flagg; 19 true? 20 A. Well, I didn't feel it was kind of 21 necessary. 22 Q. With the hematocrit of 22, what was 23 your assumption as to what her hemoglobin was? 24 A. Around 8. 25 Q. And were you at all concerned about</p>	<p style="text-align: right;">Page 55</p> <p>1 she also took Rezulin, 400 milligram QD, also 2 Keratin and insulin 90 units. She was also on 3 Feosol BID. 4 Patient feeling tired, weak, with 5 epigastric pain and intermittent dysphagia. 6 She was seen by Dr. Flagg with 7 hematocrit of 22. Started on Feosol, one BID 8 four to five days prior to my visit, and she was 9 feeling somewhat better. A month ago she had 10 abdominal pain, seen in the ER, diagnosed with 11 UTI, treated with antibiotics. Patient also 12 complained of constipation and excessive 13 bloatedness. 14 Physical examination. Patient pale 15 looking, blood pressure 130 over 84. Lungs and 16 heart was normal. Abdominal examination showed 17 soft abdomen, tender, mild tenderness in the 18 epigastrium and her bowel sounds were normal. 19 Rectal examination was negative, but it showed 20 stools being dark and they were occult blood 21 positive. 22 Diagnosis at that time was anemia, 23 rule out gastric ulcer, secondary to use of 24 nonsteroidal antiinflammatory medication, and 25 dysphagia.</p>
<p style="text-align: right;">Page 54</p> <p>1 this patient having a hematocrit of 22 and a 2 hemoglobin of 8? 3 A. Yes. 4 Q. What was within your differential in 5 terms of the likely cause of the hematocrit and 6 the hemoglobin being at those levels? 7 A. I thought she has an underlying ulcer 8 disease, gastric ulcer, as I mentioned, with use 9 of nonsteroidal antiinflammatory medication, and 10 that needed to be taken care of. 11 Q. Did you ask her why she had not been 12 taken off the nonsteroidal antiinflammatories 13 prior to coming to see you? 14 A. I don't remember. 15 Q. Is it fair to say, though, that you 16 are the one that prompted her being taken off 17 the nonsteroidal antiinflammatory? 18 A. Yes. It's called Ansaids. Very 19 simple. 20 Q. Would you read into the record what 21 your note for October 19, 1999 says? 22 A. Patient weighed 179 pounds. Her 23 present medications were Darvocet 100 and Oridus 24 75 milligram TID, Zocar, 20 milligram 25 QD, methotrexate 2.5, three, once a week, and</p>	<p style="text-align: right;">Page 56</p> <p>1 Q. Before you get to the plan -- I'm 2 going to have you read that in a second -- but I 3 wanted to ask you a couple questions about the 4 exam itself, okay, and then we will have you 5 read the rest of note in terms of the plan. 6 Did you obtain part of the history 7 from the patient or is it your testimony that 8 the history was being given to you entirely by 9 the husband? 10 A. I would say both, but mostly by her 11 husband. 12 Q. Do you know of any reason in October 13 of 1999 that you could not have seen Mrs. Pultz 14 earlier than October 19? 15 A. Well, on my exam, I don't feel that 16 -- I try to see the patient very, very, in a 17 very short period of time. I would say that 18 there was no reason for her to be seen a lot 19 sooner, because she was not showing any sign of 20 active bleeding. 21 Q. But again, my question to you is, if 22 it was felt necessary for you to see her prior 23 to October 19, 1999, is there any reason why you 24 couldn't have seen her? 25 A. No. I would have seen her any time</p>

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1 before that.
2 Q. When you saw her on October 19, you
3 were not aware that on September 25, '99, her
4 hemoglobin had been 8 and her hematocrit had
5 been 24.5; correct?
6 A. No -- yes.
7 Q. And you were not aware when you saw
8 her on October 19th that her hemoglobin had been
9 7.6 and the hematocrit had been 22.9, other than
10 Mr. Pultz' statement about her hematocrit; true?
11 A. Yes.
12 Q. You weren't aware on that date that
13 her hemoglobin and her hematocrit in the past,
14 prior to September, for years had been normal
15 with nonsteroidal antiinflammatories and with
16 methotrexate?
17 MR. AUCIELLO: Objection.
18 A. I didn't know that.
19 Q. With a history of hemoglobin of 8
20 dropping down to 7.6, with her abdominal
21 symptoms, and with the medications that
22 Mrs. Pultz was on when you saw her on October
23 19, 1999, you felt that she needed to have a
24 gastrointestinal workup; true?
25 A. Yes.

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

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

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

15 (Pages 57 to 60)

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

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

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

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

16 (Pages 61 to 64)

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

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1 office. Perforation, gastric perforation, acute
2 abdominal condition, you cannot walk around
3 without not being taken care of.
4 Q. Were you insistent on October 19th,
5 1999 that the patient be admitted to the
6 hospital?
7 A. Absolutely. I talked to both of
8 them, the husband and wife. Her husband said
9 that, doc, I will do what my wife wants and she
10 did not want to.
11 Q. Did you ask her why she didn't want
12 to be admitted to the hospital?
13 A. She just wanted to go home. I
14 couldn't answer that question. Many patients do
15 that.
16 Q. Your testimony is that you told
17 Mrs. Pultz that you were insistent that she be
18 admitted to the hospital that day; true?
19 A. Right.
20 Q. And tell me just as if I was
21 Mrs. Pultz how you would have indicated to her
22 as diplomatically as you can as a physician why
23 it was that you were insistent upon her being
24 admitted and why doing anything other than being
25 admitted was not what you wanted to have done.

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

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1 MR. ROSSI: Objection. Go ahead, you
2 may answer.
3 A. See, they were explained about what
4 can happen if you refuse to be in the hospital,
5 they were explained about the complications, and
6 one of the complications they were told was the
7 gastric ulcer with perforation and also kind of
8 bleeding. And they were very well explained
9 about that.
10 Q. Was anyone in the room with you -- I
11 take it Mr. Pultz was in the room when you
12 explained this to his wife?
13 A. I explained to both of them.
14 Q. Right. They were both there?
15 A. Right.
16 Q. Was anybody from your office in the
17 room when you explained it to them?
18 A. No.
19 Q. Tell me, do you recall any questions
20 being asked of you by either of them as to
21 whether or not this could be done on an
22 outpatient basis?
23 A. Well, they wanted to have it done as
24 an outpatient. They did not want to be in the
25 hospital.

17 (Pages 65 to 68)

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1 Q. And when they said that they wanted
2 it done on an outpatient basis, did you advise
3 against that?
4 A. No. I said that was fine if that's
5 what their intentions are. If a patient doesn't
6 want to be in the hospital, that means either
7 they are not feeling that bad, they are not
8 having devastating symptoms that they are not
9 going to stand it, then many times we have to do
10 that.
11 Q. Did you tell them that you felt that
12 doing it on an outpatient basis was a poor
13 decision on their part?
14 MR. ROSSI: Objection. I think he
15 has already said that. Do you understand what
16 he means by the question, doctor?
17 A. Well, I don't know.
18 Q. Did you tell your patient that? Did
19 you say it was okay for her to have it done on
20 an outpatient basis?
21 MR. ROSSI: Objection.
22 MR. AUCIELLO: Objection.
23 MR. WALTERS: Objection.
24 A. Well, under the circumstances, yes,
25 it was okay.

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

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

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

18 (Pages 69 to 72)

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

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

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1 and by my judgment.
2 Q. Do you recall receiving a telephone
3 call from Mr. Pultz the next day indicating that
4 his wife was not doing well?
5 A. Yes.
6 Q. Tell me what you remember about that.
7 A. Well, I was still working in the lab,
8 like we will do the endoscopy on the first
9 floor, and I got a call from him that she was
10 not feeling well; she was having some more
11 abdominal pain, and he said that she did not
12 feel well last night also. She thought that she
13 was constipated and she took some medicine to
14 move her bowels, which she did, but in the
15 morning, her abdominal pain got worse, and he
16 said that, doc, she is now willing to come to
17 the hospital.
18 Q. He said now she is willing to come to
19 the hospital?
20 A. Now she is willing to come to the
21 hospital.
22 Q. You remember him saying that?
23 A. Yes.
24 Q. Did you note that she is willing to
25 come to the hospital?

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1 A. Yes.
2 Q. But what you are telling me is before
3 you called, before you called and gave the
4 orders and before it became a direct admit, what
5 you are saying is that you had suggested to
6 Mr. Pultz that he take his wife to the emergency
7 room rather than a direct admit; true?
8 A. Right.
9 Q. And your testimony is that he didn't
10 want to do that; he wanted her directly admitted
11 to the hospital?
12 A. Well, the reason he said that, she
13 may not have to wait there for an hour or two
14 hours, and I said, okay, I will get a bed for
15 you.
16 Q. Do you think that the outcome would
17 have been different had she been a direct, had
18 she been seen in the emergency room as opposed
19 to a direct admit to the floor?
20 MR. ROSSI: Objection. Go ahead.
21 MR. WALTERS: Objection.
22 A. I don't think so.
23 Q. You wrote a brief note, apparently a
24 progress note, a brief admission note on October
25 20th; is that correct?

<p>Page 77</p> <p>1 A. Yes. 2 Q. You can use mine to save some time. 3 A. Yes. 4 Q. Can you tell me, you have in front of 5 you a copy of your brief admission note; is that 6 correct? 7 A. Yes. 8 Q. Can you tell me what time that 9 admission note was written? 10 A. You know, it has to be, it was 11 probably in the evening after I saw her briefly, 12 and I don't recall the exact time. Maybe after 13 6:30 or something like that. I don't have a 14 time on that. 15 Q. Mrs. Pultz was admitted, according to 16 the records, at 4:00 p.m., and you gave orders 17 at 4:15, or actually orders that you gave were, 18 I think, they were 4:15? 19 A. Yes. 20 Q. You didn't in the orders ask that she 21 be typed and crossmatched for a transfusion, did 22 you? 23 A. Well, we wanted to know what her stat 24 CBC is, what her H and H is, and then you go 25 from there, because that way you know what the</p>	<p>Page 79</p> <p>1 6:00 p.m. as opposed to between 4:00 and -- 2 A. I was still working around 4:00 3 o'clock, yes. 4 Q. Why didn't you go up and see your 5 patient? 6 A. I was taking care of somebody else. 7 I was in endo, and the reason I gave them the 8 order was so things could be taken care of right 9 away. And we do that many times, because I have 10 seen her already the evening before and I knew, 11 I have some idea what I was dealing with. 12 Q. When the labs were drawn, were you 13 surprised to learn that her hemoglobin was 4.6? 14 A. But you know, I don't know what time 15 they are going to draw the lab, but this lab, I 16 think, looks like that. They did not do the stat 17 kind of lab test. I think it was done later on, 18 because there should be a time. Yeah, that is 19 almost around 6:55 and we even did not have any 20 knowledge of this at that time. 21 Q. Your orders say CBC with dif to be 22 done on a stat basis? 23 A. Yes. 24 Q. And what does that mean to nurses at 25 the hospital?</p>
<p>Page 78</p> <p>1 numbers are. 2 Q. You didn't feel that a CT of the 3 abdomen and pelvis was warranted until the 4 following morning; correct? 5 A. Yes. 6 Q. Why? 7 A. First thing that I do is I want to 8 get her chest x-ray and KUB on that evening to 9 find out if there was anything acute going on, 10 because a CT scan takes a lot longer time to get 11 it done, especially in the evening. They have 12 to get contrast, they have to get IV contrast 13 and oral contrast, so it's a little bit more, I 14 would say, time consuming thing. But KUB and 15 chest x-ray can be done right away and that 16 gives you an idea whether you are dealing with 17 an acute abdomen or not. That was the main 18 thing I wanted to find out on that evening. 19 Q. You gave orders at 4:15 and your 20 testimony was your brief admit note was sometime 21 after 6:00 p.m., did you say? 22 A. Yes. 23 Q. But it's not timed, is it? 24 A. No, it's not. 25 Q. How do you know it was sometime after</p>	<p>Page 80</p> <p>1 A. Well, they are supposed to call the 2 lab right away and get it done right away. 3 Q. And how quickly is right away? 4 A. Well, if we are lucky, we can get it 5 within an hour. Sometimes it can take longer, 6 but I think, as a rule, you should have it 7 within an hour. 8 Q. So with the orders at 4:15, it should 9 have been available at 5:15? 10 A. I would say -- well, I'm saying that 11 it should have been done within an hour or so 12 depending on what is going on, but on the 13 floors, I just don't know what was going on, 14 because it looks like to me it was not drawn 15 right away. 16 Q. But again, what you expected when you 17 gave a stat order was that it be drawn right 18 away? 19 MR. ROSSI: Objection. 20 A. That's what it means, stat, right 21 away. 22 Q. And if it was done stat, right away, 23 you would expect that within an hour you would 24 have the results back? 25 MR. ROSSI: Objection.</p>

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1 A. Yes.
2 Q. If you had a stat CBC with a dif done
3 and it was reported back to you by 5:15, roughly
4 an hour after the order was given, and you were
5 at that time made aware of her hemoglobin being
6 4.6 or somewhere in that general range, what
7 would you have done?
8 A. Well, then she will need, she would
9 have been given at least three units of blood.
10 Q. Okay.
11 A. Right away, yeah.
12 Q. And do you have an opinion if she had
13 been given three units of blood right away,
14 whether or not she would have experienced the
15 acute MI?
16 MR. WALTERS: Objection.
17 A. I don't think so.
18 Q. You don't think that she would have?
19 A. I would say, really, if she has been
20 given the blood, I don't think it would have
21 prevented an acute MI at that time, whatever
22 time it kind of happened.
23 Q. On what do you base that?
24 A. Well, number one, I think that this
25 is drawn a lot later on. I think this -- see,

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1 this is at 6:55. I don't know they mention a
2 time, but this was -- I don't think we have any
3 initial kind of lab on her, so I really can't
4 say anything, because this, I think, is a lot
5 later on.
6 Q. Well, doctor, what I'm asking you, if
7 the labs had been done as you say you expected
8 them to be done on a stat basis, and you had
9 results back by 5:15, and if the hemoglobin was
10 at or near 4.6 or somewhere in that general
11 range at that time, you have told me that you
12 would have given the order for three units of
13 packed red blood cells; right?
14 A. Right.
15 Q. And my question to you was, under
16 that scenario, with transfusion at or around
17 5:15 or with the order to start the process of
18 transfusing, whether or not she would have
19 avoided the MI. Recognizing that it takes time
20 to type and crossmatch, do you have an opinion
21 as to whether or not the acute MI would have
22 been avoided?
23 MR. ROSSI: Objection. He told you
24 he didn't think it would have made a difference.
25 MR. WALTERS: I'll object. Asked and

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

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

21 (Pages 81 to 84)

<p>Page 85</p> <p>1 A. I would say it has to be after that, 2 between 6:00 and 7:00, because around that time, 3 I don't recall the exact time, but it has to be 4 in that kind of vicinity. 5 Q. Were you present when she coded? 6 A. Well, I then -- 7 MR. ROSSI: Let me interject. When 8 you say present, physically in the hospital or 9 in her room? 10 MR. MISHKIND: We will start 11 physically in the hospital. 12 A. Yes, I was in the hospital. 13 Q. Where were you in the hospital? 14 A. I think on one of the other floors. 15 Q. How did you learn about what had 16 transpired? Were you paged? 17 A. No, there is a stat page. I have 18 seen her. I knew her room number, what room 19 number she was in, and they also give you a stat 20 page, whoever is the attending doctor, yes. 21 Q. Did you then come to the room? 22 A. Yes. 23 Q. Were you present during the code? 24 A. Yes. 25 Q. Did you participate in the</p>	<p>Page 87</p> <p>1 a delay in getting the CBC done from when you 2 gave the order to when it was done? 3 MR. ROSSI: Objection. 4 MR. WALTERS: Objection. 5 A. Yes. 6 Q. And do you feel that it should have 7 been done sooner? 8 MR. ROSSI: Objection. Go ahead. 9 A. Well, stat would mean you want to get 10 it done right away, yes. 11 Q. If the stat CBC had been done right 12 away and the results had been given to you, 13 would you likely have ordered a blood 14 transfusion at that time? 15 MR. ROSSI: Objection. Asked and 16 answered. 17 A. Yes. 18 Q. Whose responsibility was it to have 19 done the stat CBC? Was it a nursing issue or 20 was it a house doctor's? 21 A. No, it's a nursing issue. 22 Q. Have you ever had any of the nurses 23 explain to you why your stat order for a CBC 24 with dif was not done on a stat basis? 25 A. I don't really recall now, but I</p>
<p>Page 86</p> <p>1 resuscitative efforts? 2 A. Yes. 3 Q. What did you do? 4 A. Well, in the resuscitation, we had a 5 person which is -- like one of them is an 6 intensivist. 7 Q. Dr. Tasse? 8 A. Right. One of them is somebody from 9 anesthesia who has to intubate. 10 Q. Okay. 11 A. And you are there. You are also 12 watching a monitor. It's a teamwork. I was 13 there all the time during, and we, you know, 14 one, two, three, whatever needed to be done, it 15 was done. Cardiac meds were given. Blood was 16 given. The pumping was done and everything was 17 done. 18 Q. Being present during the 19 resuscitative effort, are you critical of anyone 20 in terms of what was done or was not done during 21 the resuscitation, during the code? 22 A. No. I think everybody worked very 23 hard on that evening. 24 Q. We talked a moment ago about your 25 wanting stat CBC. Do you believe that there was</p>	<p>Page 88</p> <p>1 don't know if they were very busy. That could 2 have been the reason, but I don't really 3 remember what was the delay. 4 Q. Are there any other orders that you 5 gave, verbal orders that you gave at 4:00 6 o'clock or 4:15, that were not complied with 7 within the period of time that you had expected 8 them to be? 9 A. Well, really, I don't think there was 10 anything not done. I think they were in the 11 process of doing all the things when this 12 unfortunate event happened. So I really have 13 nothing -- I mean, really nothing was not done 14 in the period of time. 15 Q. Well, again, my question to you is, 16 we talked about the CBC not being done on a stat 17 basis and that you have already told me should 18 have been done sooner; true? 19 A. Yes. 20 Q. I'm asking, is there anything else 21 that was ordered specifically by you that was 22 not done in the time period that you expected it 23 to be done? 24 A. Well, there was a blood test also, 25 which is a CMP, lipase, amylase</p>

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

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

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

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1 hemoglobin, hematocrit, et cetera, would she
2 likely have been evaluated in the emergency room
3 with an EKG?
4 A. I would say so, yes.
5 Q. Do you have an opinion, given the
6 fact that she likely would have been in the
7 emergency room, say, 4:00 to 5:00 p.m., whether
8 or not the EKG would likely have shown any type
9 of an electrical disturbance consistent with an
10 acute or evolving MI?
11 MR. ROSSI: Objection.
12 MR. WALTERS: Objection.
13 MR. AUCIELLO: Objection.
14 A. I don't think I can make a comment on
15 that.
16 Q. You defer to a cardiologist on that?
17 A. Yes.
18 Q. Assuming that she was experiencing an
19 acute MI when she would have been in the
20 emergency room, would this patient have been a
21 candidate for streptokinase given her GI
22 condition?
23 MR. ROSSI: Objection. If you can
24 answer that question.
25 MR. AUCIELLO: Objection.

23 (Pages 89 to 92)

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

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

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

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

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

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1 long-standing perforation, and I think that it
2 may or may not have been a factor. I think she
3 probably had significant coronary artery disease
4 and that caused her MI.
5 Q. Are you suggesting that the
6 perforation of the ulcer, that you can rule out
7 the perforation of the ulcer as being a
8 contributing factor to the MI?
9 A. No. I didn't say that.
10 Q. Is it your testimony that you believe
11 that she had the perforated ulcer first and then
12 had the acute MI at sometime later that day? Is
13 that most likely what happened, in your opinion?
14 A. Yes.
15 Q. And can you state to a probability if
16 she had been admitted to the hospital and
17 treated before the ulcer perforated whether or
18 not that would have prevented her from
19 sustaining an acute MI?
20 A. No.
21 Q. No, you can't say? You don't have an
22 opinion? You defer to a cardiologist on that?
23 A. Yes.
24 Q. Fair enough. Any other conversations
25 that you remember with the family after the

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1 death?
2 A. No. I don't remember anything else,
3 except probably I think maybe the autopsy
4 report.
5 Q. And that we have talked about in
6 terms of what you discussed with Dr. Rabinowitz?
7 A. Yes.
8 MR. MISHKIND: Nothing further,
9 doctor. Thanks.
10 EXAMINATION OF SUBHASH C. MAHAJAN, M.D.
11 BY MR. WALTERS:
12 Q. I have one question. I just want to
13 clear this up, doctor. I introduced myself
14 before we started. I'm Steve Walters and I
15 represent Dr. Flagg.
16 Am I correct that when Mr. and Mrs.
17 Pultz were in your office on October 19th --
18 (Discussion off the record.)
19 Q. Doctor, am I correct that when Mr.
20 and Mrs. Pultz were in your office on October
21 19th, you strongly advised that Mrs. Pultz be
22 admitted to the hospital that day, October 19th?
23 A. Yes.
24 Q. And am I correct that it was not a
25 situation of you saying, well, you can be

Page 100

1 admitted today, or you can have it done on an
2 outpatient basis tomorrow or the next day, it's
3 up to you; it wasn't that sort of thing, was it?
4 A. No.
5 Q. Is there any question in your mind
6 that Mr. Pultz and Mrs. Pultz understood how
7 important you felt it was for her to go into the
8 hospital that day?
9 A. Well, he was explained very well and
10 the same time he was told that if anything
11 changes, please contact me. That's the best I
12 could do. And that's what he did the next day.
13 Q. When were you contacted the next day?
14 A. In the afternoon, around 2:00, 3:00,
15 4:00. I think it was in the late afternoon. I
16 was still working.
17 MR. WALTERS: That's all I have.
18 MR. ALICIELLO: I have nothing. Thank
19 you, doctor.
20 MR. MISHKIND: One other question for
21 you.
22 EXAMINATION OF SUBHASH C. MAHAJAN, M.D.
23 BY MR. MISHKIND:
24 Q. Was it your responsibility to
25 emphasize to your patient the importance of

25 (Pages 97 to 100)

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

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1 MR. MISHKIND: I understand his
2 testimony and you summarized it fairly well in a
3 couple words.
4 Q. But I'm asking you, if you did not
5 tell Mr. and Mrs. Pultz that it was okay to wait
6 and have the testing done on an outpatient
7 basis, that it needed to be done on an inpatient
8 basis, would you agree that that would not have
9 been -- hypothetically that's what occurred --
10 that that would not be acceptable care on your
11 part?
12 MR. ROSSI: I'm going to object,
13 again, Howard, because by the way you have
14 worded the question, ultimately he had to say
15 that was how it was going to be done because
16 that was the only alternative he gave them.
17 MR. MISHKIND: That's his testimony,
18 but what I'm saying to him --
19 Q. Hypothetically, if you --
20 MR. ROSSI: If he had presented it
21 that way versus how he did present it?
22 MR. MISHKIND: Let me ask the
23 question.
24 MR. ROSSI: I don't want this record
25 to be confused.

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

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

26 (Pages 101 to 104)


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1 Q. Did you feel based upon what you knew
2 at that point that it was reasonable --
3 A. Yes.
4 Q. -- for the patient to have the test
5 done the next day or 48 hours later?
6 A. Yes.
7 MR. MISHKIND: No further questions.
8 MR. ROSSI: Doctor, you have the
9 right to read the transcript and I would urge
10 you to tell her that you will read the
11 transcript.
12 THE WITNESS: I will read the
13 transcript.
14 -----
15 (Deposition concluded at 4:35 p.m.)
16 (Signature not waived.)
17 -----
18
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24
25

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1 AFFIDAVIT
2 I have read the foregoing transcript from
3 page 1 through 105 and note the following
4 corrections:
5 PAGE LINE REQUESTED CHANGE
6
7
8
9
10
11
12
13
14
15
16
17
18 SUBHASH C. MAHAJAN, M.D.
19 Subscribed and sworn to before me this
20 day of , 2002.
21 Notary Public
22
23 My commission expires .
24
25

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1 CERTIFICATE
2
3 State of Ohio,
4 SS:
5 County of Cuyahoga.
6
7
8 I, Vivian L. Gordon, a Notary Public within
9 and for the State of Ohio, duly commissioned and
10 qualified, do hereby certify that the within
11 named SUBHASH C. MAHAJAN, M.D. was by me first
12 duly sworn to testify to the truth, the whole
13 truth and nothing but the truth in the cause
14 aforesaid; that the testimony as above set forth
15 was by me reduced to stenotypy, afterwards
16 transcribed, and that the foregoing is a true
17 and correct transcription of the testimony.
18
19 I do further certify that this deposition
20 was taken at the time and place specified and
21 was completed without adjournment; that I am not
22 a relative or attorney for either party or
23 otherwise interested in the event of this
24 action. I am not, nor is the court reporting
25 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, Notary Public
Within and for the State of Ohio
My commission expires June 8, 2004.

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