IN THE COURT OF COMMON PLEAS
STARK COUNTY, OHIO

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BRIAN W. GORTNEY,)
et al.,)
Plaintiffs,)
vs.)Case No. 2002 CVO 3755
WESTERN RESERVE CENTER,)
et al.,)
Defendants.)

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Deposition of JOHN F. ZAK, M.D., D.M.D., a Defendant herein, called by the Plaintiffs for cross-examination pursuant to the Ohio Rules of Civil Procedure, taken before me, the undersigned, Kelley E. Spears, a Notary Public in and for the State of Ohio, at the offices of Reminger & Reminger, 1400 Midland Building, Cleveland, Ohio, on Monday, the 4th day of August, 2003, at 1:50 o'clock p.m.

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On Behalf of the Plaintiffs:
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On Behalf of the Defendants:
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ALSO PRESENT:

Gerald Leb
Connie Gortney
Nicholas Diamantis, D.M.D.

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I N D E X

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JOHN F. ZAK, M.D., D.M.D.

of lawful age, a Defendant herein, called for examination, as provided by the Ohio Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

CROSS-EXAMINATION

BY MR. HENRETTA:

Q. All right. Tell us your name.

A. John Zak, Z-a-k.

Q. All right. I met you informally a moment ago. I'm Tom Henretta. I represent the Gortneys in this case.

I'm going to ask you some questions in a general way, two areas, real broad, and that is you are a party in this action so you're a defendant in this action so I've got to ask you questions, you know, along those lines that I would of any defendant or any party in a lawsuit.

And this is a discovery deposition, and it's not your trial deposition, at least at this point it's not. And also you're an expert in this case. You've been identified as an expert so you'll

put that hat on for a while.
A. Sure.
Q. And I'll be inquiring of you as an expert who's going to give expert opinions in this case. So those are two different capacities.
I talk sometimes fast. That's just my nature. I'm trying to slow it down as I age on this journey, but I still seem to fly and court reporters tell me that from time to time.
I will try not to talk while you're talking and I would ask the same courtesy of you. And the reason we do that is so that there is a clear record of the proceedings here. Court reporters don't like it when people step on each other's sentences.
I would ask you to, when the question requires an answer, and most of them will, that you give it audibly. Now, I know -- I see you over there shaking your head and, you know, in common conversation amongst people we know what that means, but for this purpose, we need to give audible answers and if it's a yes it would be a yes --
A. Sure.

Q. __ no, no, you know what I'm saying?
A. Understood.
Q. So that we can get -- so I know what the answer is so somebody reading this some day will say I don't know what he said, he was nodding his head, but we don't know which way, okay, so if you could do that.
And then if you don't understand a question or want me to -- better put it -- if you want me to rephrase it or state it again, please ask me to do that and I will attempt to do that.
I would like, however, so we have an understanding, that if you do answer the question, I'm going to rely upon the fact that you understood the question or you wouldn't be answering it, fair enough?
A. Reasonable.
Q. Okay. All right. I think that's most of the ground rules. All right. Okay.
What is your residence address?
A. 7960 Darby's Run, Chagrin Falls, Ohio 44023.
Q. And what about your business address?
A. I have multiple business addresses.

Q. Okay. If you could please --
A. Would you like all of them?
Q. Yes.
A. 14700 Detroit, Lakewood, Ohio 44107; 3215 Cleveland Avenue N.W., Canton, Ohio 44079, I believe; and Professional Plaza South, 7057 West 130th Street, Parma Heights, Ohio, and I'm not sure of the Zip Code there.
Q. Where -- for the time that we're talking about in this case, it's going to be '98, '99, or the period of time you treated Brian Gortney, those business addresses you just gave, were those also the addresses at that time?
A. The Lakewood address was the same. The Canton address, we were at a different location. It was at 13th -- excuse me -- 12th and -- no, it was 13th, 13th and Cleveland Avenue.
Q. All right. Now, what is your profession?
A. Surgeon.
Q. Okay. Do you have a -- tell me about your degrees. What sort of degrees do you have?

A. I'm doubled degreed. I have a degree in dental medicine as well as an M.D., went and completed both dental school as well as medical school.

Q. Okay. Give me some dates and places and -- you know what I mean.

A. Where would you like me to start?

Q. Well, where did you go to medical school?

A. Case Western Reserve University --

Q. All right.

A. -- Cleveland, Ohio.

Q. All right. And you got an M.D. from there?

A. Uh-huh.

Q. And when was that?

A. Well, I finished in the spring of '96 and got my license to practice medicine shortly thereafter.

Q. Then did you receive a dental degree before that?

A. Yes, before that.

Q. Okay. And that was at the University of Pennsylvania?

A. That's correct.

Q. And you were -- now are you -- tell me about your licensure.

A. What wouid you like to know about it?

Q. Where you are licensed, which states, what licenses do you hold?

A. I currently hold a dental license in the state of Ohio as well as a medical license in the state of Ohio as well I did at the time of treating Mr. Gortney.

Q. Thank you. Okay. What sort of continuing -- let's go with medical first -- medical education do you participate in? Do you have so many seminar hours you're required to attend?

A. Yes. I think the state stipulations are a hundred credit hours in a two year period. We well exceed that. Especially having dual licensure, I think I exceed that for dentistry as well as medicine.

Q. And for how long have you exceeded that?

A. Ever since my residency. Continuing education is something I value and take seriously.

Q. Okay. Tell me about publications that you have written, circulated, distributed, that

sort of thing. Any books, articles?
A. Yeah. My most recent is a text chapter in a seven volume series by -- edited by Ray Fonseca who is a very respected individual within the field of maxillofacial surgery and I coauthored a chapter on facial implants for him on that.
Q. Do you -- do you teach?
A. Do I teach? I have a teaching assistant's position at Case Western Reserve University School of Dentistry. I, however, don't actively at this time teach there. I devote most of my time to private practice.
Q. And what would the -- besides your clinical practice, would you say your clinical practice is now a hundred percent?
A. Of my time?
Q. Yes.
A. 99 -- well, outside of family, yeah.
Q. Well, I mean personal. Now, do you have hospital privileges in the area?
A. I do.
Q. And where would those be?
A. University Hospitals of Cleveland, Lakewood Hospital and Mt. Sinai Medical Center.

Q. How about at the time of 1998 and 1999, which hospitals?

A. Those same, and I also held privileges at Aultman Hospital which is also located in Canton.

Q. All right. And since '99 and the present, any additional hospital privileges that you didn't mention?

A. '99 to present, initially in '99 I held privileges at Robinson Memorial Hospital as -- I was a house surgical physician for them. I had held that position towards the end of my residency and I think I stayed on staff for about a year in private practice and then resigned from there as well.

Q. Have your privileges at any hospital ever been suspended?

A. Suspended not for any other reason than timely chart completion.

Q. Well, explain when you mean by that.

A. Well, it's a common problem that fraughts many surgeons is signing and/or dictating charts on a timely fashion. Due to current government stipulations, the hospital must insist that timely chart completion is

upheld and therefore, the only way to, I guess, insure that the surgical staff is getting that done on time is to suspend privileges if not done within 30 days. That's standard for most hospitals.

Q. But, I mean, did they -- did you actually receive a suspension for that?

A. Yeah. You get a letter saying that you're -- until you complete your charts, be they signatures or dictations, be they op reports or clinical resumT, or merely just signing an order that was given over the telephone, you're told that your privileges are suspended until you get those charts completed.

Q. Do you know how many times you've received those?

A. No recollection of how many times.

Q. Are those a matter of public record?

A. I'm not sure of your question.

Q. Well, if I wanted to find out and you didn't give me an authorization to get it, would I be able to determine that, how many times it's happened, if you know?

A. I have no idea.

Q. Okay. Are you presently taking any

medication for any reason?
A. Presently, yes.
Q. What are you taking?
A. I take Propecia for male pattern baldness and Celexa for mild depression.
Q. Who prescribed the Celexa?
MR. MINGUS: Objection. His medical condition is not an issue in this case.
MR. HENRETTA: Well, all right.
MR. MINGUS: I actually let you go farther than I think you were entitled to go with that last question.
MR. HENRETTA: Well, all right. If you want to instruct him, then we'll -- I don't know what he wants to do with it and I don't know if I'm going to need it later --
MR. MINGUS: Sure.
MR. HENRETTA: -- but I think -- I would ask -- if you instruct him not to answer, I will ask the court reporter to tell him to answer and then we'll ask Lee what he wants -- when I say Lee, Lee the judge. Sorry.
BY MR. HENRETTA:
Q. Okay. You're presently taking -- well, for how long have you been taking this mild

depressant -- I guess mild depressant?

MR. MINGUS: Objection. I don't believe that's a proper area of inquiry.

MR. HENRETTA: Okay.

BY MR. HENRETTA:

Q. Well, let's put it this way: I think it might be. Were you taking this medicine as a result of a diagnosis?

MR. MINGUS: Objection. Not a proper area of inquiry. What basis is this?

MR. HENRETTA: Well, I want to know if he had a diagnosis back in 1998 or 1999.

THE WITNESS: No. I've only been taking the medication for about a year.

BY MR. HENRETTA:

Q. Okay. When did you get the diagnosis?

MR. MINGUS: Objection.

THE WITNESS: Do you want me to answer?

MR. MINGUS: Was it a year ago?

THE WITNESS: Approximately a year. It certainly wasn't when I was treating Mr. Gortney if that's what you're implying there.

BY MR. KENRETTA:

Q. Okay. You were diagnosed with mild depression a year ago?

A. Approximately.

Q. Okay. Who is your treating physician?

MR. MINGUS: Objection. You're not entitled to find that out, Tom.

MR. HENRETTA: Well, I just -- again, I want to go back in that area so Lee -- Judge Sinclair will have to tell us.

Will you instruct the witness to answer that question?

THE NOTARY: You need to answer the question.

MR. MINGUS: And I would instruct you not to answer that question. I don't believe it's a proper area of inquiry.

THE WITNESS: Under the advisement of my attorney, I'm not going to answer the question.

BY MR. HENRETTA:

Q. Okay. You're -- let's see. For how long had you -- let me ask you this: Did you see a counselor before the psychiatrist who presumably prescribed the medicine --

MR. MINGUS: Objection.

BY MR. HENRETTA:

Q. -- at any time prior to your treatment with -- first of all, prior to your treatment of Brian Gortney?

I'll stop there. He's instructing you not to answer. I'm asking the court reporter to tell you to answer the question.

THE NOTARY: Sir, please answer the question.

MR. MINGUS: I'm instructing you not to answer.

MR. HENRETTA: In all of these I'm asking the court reporter to instruct the witness to answer and counsel is indicating for him not to answer, we're just going to ask the Court. We're going to certify these questions to the Court so I want to make sure we get enough of them to take up his time --

THE WITNESS: Sure.

MR. HENRETTA: -- and we have the right inquiries.

BY MR. HENRETTA:

Q. During the period of time you treated Brian Gortney, were you taking any medicine for mild depression?

THE WITNESS: Do you want me to answer?

MR. MINGUS: May I have a moment with my client, Tom?

(Short break had.)

MR. HENRETTA: I don't know if we were in the middle *of* a question or what. Maybe you can read the last question because I can't recall what it was now.

(The last question was read back.)

MR. MINGUS: Objection.

Go ahead and answer.

THE WITNESS: No, I was not.

BY MR. HENRETTA:

Q. Okay.

A. Nor was I under the care of anyone's treatment for mild depression.

Q. Did you have any alcoholic beverages today prior to this deposition?

A. None.

Q. Take any, drink any?

A. None.

Q. Okay. Have you ever been treated for alcoholism?

A. No.

Q. Have you ever been assessed for alcoholism?

A. No.

Q. Tell me about your certifications, first medically, medical profession, Doctor, and then the dental profession.

A. Certifications? Would you elaborate?

Q. Well, tell me about your -- why don't we do it this way: Tell me about your specialty within the field of medicine. For your medical degree, what specialty do you or -- do you -- I'll ask you this: Do you hold yourself out as a specialist within the medical filed?

A. I hold myself out within the specialist of the medical field of what is called a maxillofacial surgeon. Maxillofacial surgeons, by definition, would be in charge of the care of anything in the head and neck, of that nature, or rather face and neck more specifically.

And I also concentrate my skills in cosmetic facial plastic surgery. I don't hold myself out as a plastic surgeon, I don't hold myself out as an otolaryngologist.

Q. As a what?

A. Otolaryngologist; ENT surgeon.
Q. Okay. Are there certifications issued by the state of Ohio for -- for the subspecialty you just mentioned?
A. Are there certifications?
Q. Well, you have a certification through the state of Ohio, I guess, the medical board for maxo- --
A. Maxillofacial surgeon.
Q. Yes.
A. Yes. No. To my knowledge, nothing like that exists.
Q. All right. Now, how about in the dental, your D.D.S., do you have any certification or subspecialty?
A. It would be oral and maxillofacial surgery.
Q. And is there a certification process for that in Ohio?
A. Certification other than completing a -- a qualified residency program which is what I did.
Q. You did that? Okay.
A. Yeah.
Q. You did that in '98?

A. Finished.
Q. When?
A. I'm sorry?
Q. When did you complete that?
A. I think it was end of April, beginning of May was when I finally left there.
Q. Well, your CV says post-residency 6/98 to present. What does that mean?
A. Where are you looking at? I'm sorry.
Q. The very first page.
A. No, that's just in facial plastics, not specifically procedures devoted to cosmetic surgery. That's not the residency itself. The residency comes prior to that, 6/93 to 5/98.
Q. I see it. Okay. Now, did you at any time -- well, how did you hold yourself out to the public in terms of your specialty?
A. As an oral maxillofacial surgeon.
Q. Okay. And how did you do that, in what medium?
A. Um-m, in terms of -- are you referring --
Q. Signage, telephone book?
A. Both.
Q. Both?

A. Yeah.
Q. Any websites?
A. At that time of treating Mr. Gortney there was no website.
Q. Do you do that now?
A. Yeah, we do have a website now.
Q. And what does your website say and what's the site if you will?
A. Um-m --
Q. First of all, what does it say?
A. Sure. I believe it's the title of our practice which is Western Reserve Center for Oral, Facial and Cosmetic Surgery.
Q. Okay. And what is that website?
A. Can I refer to my partner? He knows it.
Q. Sure.
THE WITNESS: Do you know what that is?
DR. DIAMANTIS: WRC -- no, I'm sorry. Westernreserve@aol.com.
THE WITNESS: Just recently came on line within the past year.
BY MR. HENRETTA:
Q. All right.
A. I don't visit it too often.

Q. Did you develop that or did somebody else develop that?
A. I had minimal input into it.
Q. Okay. Now, let's see. Have you, in connection with your practice as a -- first as a physician or as an M.D., have you ever been sued for professional malpractice or professional negligence in the past other than this suit?
MR. MINGUS: Objection.
Go ahead.
Can I have a continuing objection to other suits, Tom?
MR. HENRETTA: Sure.
THE WITNESS: I'm sorry. So repeat the question.
BY MR. HENRETTA:
Q. Did anybody ever sue you for malpractice before Brian Gortney?
A. Before Brian Gortney?
Q. Yes.
A. Well, I have a suit that was recently dismissed. We were iet go of the case. We were a minor attachment to the case. Lakewood Hospital was the major player in it. They took

a deposition and determined that we had no guilt in the case and let us out of the case.

Q. Sure. Now, was that suit filed before this one?

A. I don't recall which one came first. I know Mr. Gortney's initial lawsuit which was filed a number of years ago was first and how your 180-day things go, it was dropped and then it was picked up again.

I'm not exactly sure of the timing, but I know his first initial suit against us which was later dropped came first.

Q. And the lawsuit that you're talking about, is that the one that Peter Weinberger brought on behalf of a patient?

A. Who's Peter Weinberger?

Q. He's a lawyer. Maybe you don't recall. Do you recall who filed that on behalf of the plaintiff?

MR. MINGUS: If you recall it.

THE WITNESS: I'm not sure who Peter Weinberger is.

BY MR. HENRETTA:

Q. Well, let me just ask you this: Do you recall who filed the case against you on behalf

of the plaintiff, the patient?
A. On behalf of the plaintiff?
Q. Yes. Somebody sued you --
A. Right.
Q. -- and they probably had a lawyer.
A. I don't recall who the law firm was.
Q. Okay.
MR. MINGUS: Tom, he doesn't recall who it is, but I'll tell you that Pete Weinberger was the attorney.
MR. HENRETTA: That's what I thought. Okay.
THE WITNESS: I didn't pay attention to who the law firm was.
BY MR. HENRETTA:
Q. All right. And did he take your deposition in that case?
A. Yes, he did. Yes, he did.
Q. And that was -- is it fair to say that was last month?
A. Yeah, about last month.
Q. Was it recently?
A. Recently. It was recent.
Q. Okay.
A. Exactly. You got it.

Q. Okay. So we're talking about -- I'm aware of that case. I just wanted to make sure that's the case you're talking about.

A. Sure. That's the one.

Q. All. right. Okay. And then you were let out of that case for whatever reason. It's been dismissed. Okay. All right.

Now, besides that one, are there any others in the past where you've been sued for professional negligence or malpractice as some like to say --

A. No.

Q. -- as an M.D.?

A. No.

Q. Okay. And now how about since Mr. Gortney?

A. Since Mr. Gortney, so to present day is what you're asking?

Q. Yes.

A. We recently received a letter of one other lawsuit by a patient in Stark County who again, we are the secondary people named on the case. It's a Dr. David Pavlich who's a general dentist is the primary defendant.

Q. When you say -- Doctor, the patient or

the patient's attorney indicating that he or she was going to bring a claim against you?

A. No, they've brought a claim in the last -- in the last -- in the last month.

Q. You've been served with a suit?

A. Yes.

Q. Okay. All right. Okay. And that was down in Stark --

A. That's in Stark County, yes.

Q. -- County? Okay. Now, are there any others?

A. None.

Q. Then I've limited it to your medical doctor status. Now, I'd ask the same question for D.D.S. status.

A. Medical or dental, that's the only issues that I'm aware of.

MR. MINGUS: You're referring to medical malpractice?

MR. HENRETTA: Medical malpractice, dental malpractice.

THE WITNESS: That's it.

BY MR. HENRETTA:

Q. Well, have you been sued in any other capacity for --

A. No.
Q. -- contract breach or anything *of* that nature?
A. No.
MR. MINGUS: The dental license issue?
MR. HENRETTA: Well, that's a separate issue. We'll talk about that. And I don't need that one. That's in the matter of, I think.
BY MR. HENRETTA:
Q. Okay. Have you -- besides that deposition with -- we kno as Peter Weinberger just last month, have you given deposition testimony before?
A. Just in a legislative case with the Dental Board.
Q. Okay. And that's when — that would be in the matter of John F. Zak, D M.D., M.D., brought by the Ohio — it would be for the Ohio State Dental Board?
A. That's correct. Right. Uh-huh.
Q. Okay. All right. What was that all about, Dr. Zak?
A. Sure. My dealings with the Dental

Board?

Q. Yes. Why did they bring that action against you? I guess that's what it is, an action?

A. Yeah, sure. I'll be happy to answer that.

MR. MINGUS: Objection.

Go ahead and answer.

THE WITNESS: I'll be pleased to answer that. That is an ongoing legislative case which is being -- currently being reviewed by the Common Pleas Court and Appeals Court in Cuyahoga County regarding the Dental Board's attempt to revoke my dental license based mainly in part on the theory of I'm allowing an unlicensed person to practice dentistry, specifically, they refer to my partner, Nicholas Diamantis, who holds a medical license, not a dental license which is an accepted practice under AMOS which is the American Association of Oral/Maxillofacial Surgeons.

By the way, Dr. Diamantis is board certified by the American Association of Oral/Maxillofacial Surgeons.

BY MR. HENRETTA:

Q. He went to dental school?

A. He went to dental school and medical. school.

Q. Yes, I knew that.

A. He completed dental school, completed medical school and completed a residency in oral/maxillofacial surgery.

Q. What did he not do that gave rise to this?

A. He did not get a dental license. A dental license is something that tests four things: Making of a denture, doing a root canal, doing a common filling and I think doing a scaling and root planing, none of which are done by oral/maxillofacial surgeons.

Q. Had he ever attempted to do that to your knowledge?

A. I believe he did attempt and did not pass, that's correct.

Q. Do you know when?

A. I don't recall the dates. I wasn't finished answering the question.

Q. Sorry. Go ahead.

A. So it was based in theory that I was

allowing an unlicensed person to practice dentistry. They actually brought a criminal suit against my partner for removal of a tooth from a patient that was thrown out in Stark County Municipal Court for lack of validity and then therefore Dr. Diamantis was no longer under the jurisdiction of the Dental Board.

He has a medical license, he is a licensed medical practitioner; therefore, they had no jurisdiction over him. Therefore, I believe, in their frustration they then pursued me because I did have a dental license as well as a medical license.

And again, it was based largely in theory on that I was allowing an unlicensed person to practice dentistry. The law in the dental practice are quite gray and vague in regards to what is dentistry and what is medicine if you've ever read it.

BY MR. HENRETTA:

Q. What did the Board do? Did they issue an adjudication order?

A. They did. Eventually they have did and it was stayed by the Court of Common Pleas in Cuyahoga County for further review.

Q. What was the order?
A. The order?
Q. Yes. What was the order?
A. What was the word that you said, adjudication?
Q. Yes. Do you know what adjudication held, do you recall?
A. I'm unsure of the legalese that you're using.
Q. What was the upshot of their order? What did they say, what did they do?
A. To remove my dental license.
Q. Okay. So they revoked it?
A. They revoked it and it was stayed by the courts and therefore I still have a valid, active dental license.
Q. Okay. And for what period of time, do you recall -- well, looks like September 18th, 2002 was the adjudication order.
A. Yeah, that sounds correct.
Q. How soon after was it stayed, do you recall?
A. I think within a month or so.
Q. Okay.
A. Almost immediately.

Q. And that was done by?
A. Once -- it's my understanding that once the -- they chose not to enforce it until we got a filing from a court. The court reviewed it and it said that it was stayed.
Q. Now, who represents you in that?
A. Attorney by the name of David Levine for Benesch, Friedlander.
Q. Okay.
A. I just wanted to state also that the -- the adjudication and counseling question have nothing to do with patient care, strictly legislative and --
Q. Well, you said it twice, legislative.
A. Yeah.
Q. What do you mean by that?
A. Well, it is our position that it is the Dental Board's attempt to gain proprietorship over a single procedure, specifically tooth extractions, and that it has --
Q. All right. Now, there are how many counts? Well, let me just --
A. Yeah, because I don't recall.
Q. I have them right here. Were, let me --
MR. HENRETTA: I think we should

mark that.

(Plaintiff's Exhibit Zak 1 was marked for identification.)

BY MR. HENRETTA:

Q. All right. Here is -- Doctor, here is Plaintiff's Exhibit No. 1. Now, is that the -- of course, there's a cover letter from Lili C. Reitz. Do you know that individual?

A. I've met her before.

Q. Is she still serving in the capacity of executive director?

A. I don't know. I don't know.

Q. Okay. And then the -- I guess it would be page 3 and don't count blank 4 and written for -- which is page 2 of the adjudication order, is that where your understanding that on paragraph 1 your license was revoked at that time? I guess it would be on page 2 of the revocation order?

A. Does that look right?

Q. Yes. At the bottom. is that what it says?

A. That's what it says, uh-huh.

Q. And then -- actually, is it your understanding then that the order was never in

effect because you immediately filed a -- for a stay and was granted because this order looks like it became effective 15 days after the date of mailing?

A. Right. It was -- it's my understanding that within that 15-day period that via the Attorney General's office and our attorney, they received written, what have you -- I'm not sure of the legal terms, but an agreement to not uphold the order until the appeal could be presented to the court.

Q. Okay. And I guess it's fair to say your license, there was no cessation in the treatment of your patients?

A. There was never --

Q. Okay.

A. -- nor has there ever been.

Q. Okay. Do you know -- I just want to go through some of these counts. Would you have any idea who these patients are that they -- for instance, Count One, "On or about the following dates, you permitted an unlicensed operator to perform dentistry."

Now, each time they say that they allege that in these counts and there are --

well, 30 -- looks like 39 counts?
A. Uh-huh.
Q. At least up to 38 because up to 38 it keeps mentioning an unlicensed dentist.
A. Sure.
Q. Is each one of those referring to Dr. Diamantis?
A. Yes, it is.
Q. Okay. Do you have any idea who these patients --
A. No, I don't.
Q. -- would be? There's a reference to them by number only and I -- withdraw that. Okay. I don't think I need to know who they are.

MR. MINGUS: You're inquiring into potential privilege areas.

MR. HENRETTA: Yes, I am. We've got enough problems with HIPPA today.

BY MR. HENRETTA:
Q. All right. I guess we can say this though. Maybe, maybe we can't. How many patients was the Board talking about or how many incidents? Would it just be a simple matter of doing the math from this document as

far as you know?

A. I'm not sure how the board extrapolated their charges.

Q. Okay. For instance, they list Patient No. 1, Patient No. 2 and -- I don't know. I guess I would read this as -- if I go to -- if you look at paragraph 39 on the -- that would be page 5 at the top left-hand corner there?

A. Sure. Go ahead.

Q. They talk about or it addresses Patient No. 27. Was it your understanding that there were about 27, 28 patients involved in these allegations or don't you know?

A. I believe so although I don't have a clear understanding of what they were allegating.

Q. Okay. Okay. Because they're not going to mention patient's names?

A. Correct.

Q. And we know why, but they just say you billed Patient No. 21's insurance carrier for services that were not provided by you, but by an unlicensed dentist. That seems to be the theme in a lot of these allegations and they have them couched in counts.

A. Uh-huh.
Q. So I would probably share your view of the number of patients involved in this, at least according to the Dental Board; is that fair?
MR. MINGUS: Objection to form.
Go ahead.
MR. HENRETTA: That was a tough one. Okay.
MR. MINGUS: Let him answer.
MR. HENRETTA: Yes, I know. It was awkward.
BY MR. HENRETTA:
Q. Do you think that it involves -- these allegations involve anywhere between 25 and 30 patients?
A. I'm not sure of the exact number of patients, but it's been our contention always that -- first off, that Dr. Diamantis was not practicing dentistry, okay.
Q. Now, I'm just talking about the allegations. Were you provided anything other than these very broad-balled, I guess, allegations -- counts, I mean --
A. No.

Q. -- you know what I mean? Did they ever say Mrs. Smith, let's say --

A. Sure.

Q. -- or were you just given Patient No. 22? I'm just trying to get an idea how many we're talking about.

A. I don't know the specific number of patients that were included. I think for patient privacy concerns, they're referred to by number.

Q. Sure.

A. Again, these patients were not -- generally not treated by me. And again, my involvement with them is little, if none, and the -- it is all based on their theory, again, that he was practicing dentistry and that because I was associated in our partnership, that I was allowing him to do so.

Q. Okay. I understand. I appreciate that. Again, just so maybe we can leave this alone for a while, do you believe that it's fair to say that the Dental Board had -- was alleging misconduct, if you will, involving approximately 20 to 30 patients and not 50 to a hundred?

A. That sounds correct.
Q. Okay. Well, it appears that every allegation's the same, that you billed a patient's insurance carrier for services that were not provided by you, that were provided by an unlicensed dentist. That seems to be the theme of this whole thing. Is that your understanding?
A. I'm not sure what they're claiming.
Q. Well, why don't you look at it?
A. I've looked at it before.
Q. You see the allegations?
A. Sure, I see the --
Q. I mean, they all seem to say the same thing.
A. Right.
Q. So I guess if one were to develop a one sentence theme, that would be it. I imagine that's what they're saying?
A. We've disputed all their claims from the beginning.
Q. I understand, but that's what they're saying?
A. I think that's what the Dental Board is saying.

Q. All right. Where are you now? Where is that case, in which court?
A. It is in the Appeals Court of Cuyahoga County or going before the Appeals Court of Cuyahoga County. Has not been assigned to them yet.
Q. All right. After the Dental Board issued it adjudication order, is that where this case went or did it go to the common pleas --
A. Went to common pleas first.
Q. All right. And what happened there?
A. It was held there for a few months and tnen a three by five card upholding the Dental Board's recommendation was given with no explanation of law or concern.
Q. And then --
A. And then it was filed for appeals court which ultimately it keeps in effect the stay. That's my understanding of it.
Q. Okay. Yes. All right. Yes.
(Discussion had off the record.)
BY MR. HENRETTA:
Q. Okay. You gave an affidavit as an expert in this case. Do you recall that? I'm

going to mark that as Plaintiff's Exhibit No. 2.

(Plaintiff's Exhibit Zak 2 was marked for identification.)

BY MR. HENRETTA:

Q. You are looking at Plaintiff's Exhibit 2. Is that an affidavit that you signed?

A. Yes. That's my signature.

Q. All right. Now -- and then in that -- now you have your expert hat on.

A. Okay.

Q. Okay. And again, you understand that you, in addition to listing Dr. Armitage and Dr. Hauser as experts in this case, you listed yourself and Dr. Diamantis as well as experts. In other words, people who will give expert opinions in this case as to standards of care. You understand that, don't you?

A. I understand it, but didn't realize we were until you've enlightened me of that.

Q. Okay. Well, your lawyer said you are so --

A. I would consider myself one.

Q. I understand, and I know it's done from time to time. I haven't come across it where

the defendant also serves as the expert.
A. Sure.
MR. MINGUS: I just intend to have him testify as to the appropriateness of his own care.
MR. HENRETTA: Okay.
BY MR. HENRETTA:
Q. With respect to which is, I guess, standard of care in this case, do you understand that, that professional negligence cases are about a standard of care in a particular field of medicine or dentistry and a breach of that standard of care which is alleged to have caused harm?
A. Sure.
Q. Which is basically what we're here for?
A. Sure.
Q. Okay. Wow, No. 4, you indicate, "On each occasion that I rendered care and treatment to the plaintiff" -- and, of course, we're talking about Brian Gortney -- "in my capacity as a treating doctor, I did so in accordance with the skill, care and diligence required by the accepted recognized standards of the medical and dental communities, given

the presenting conditions and circumstances." Okay?

A. Sure.

Q. And earlier above that you said you -- under oath, you state this as being true. Now, I would ask you to tell me what is the recognized -- the accepted recognized standards of the medical and dental community given the presenting conditions and circumstances in your capacity as a treating doctor when you treated this man? What are those standards?

MR. MINGUS: Objection.

BY MR. HENRETTA:

Q. In other words, what do you base this on? I want to know what your opinion is so -- because that's what you're going to give testimony on and I have a right to know the basis of it so just tell me what that means.

MR. MINGUS: Objection to the breadth of the question.

Go ahead.

THE WITNESS: Yeah, can you narrow --

BY MR. HENRETTA:

Q. Do you know what the standard of care is

when you treat -- first of all, why did you treat him?

A. Which is your question, why did I treat him or what is the standard of care?

Q. Yes, why did you treat him?

A. Sure. I treated Mr. Gortney because he came to us with significant -- or description of significant symptoms and based on some of his radiologic findings and so that's where we began treatment.

Q. What's the standard of care?

A. In reference to what?

Q. Treating him. Here's what you said: "On each occasion." So I want you to tell me -- first of all, I want you to tell me every occasion you saw him. Let's do that. That's the easiest way to do it. How many times did you see him?

A. I don't know the specific number of times.

Q. Do you have a file here that would tell us when you saw him because you state here, "On each occasion that I rendered care and treatment to the Plaintiff in my capacity as a treating doctor." So what I need to know is

what are those occasions?
A. Well, we have the patient's chart right here.
Q. I want to know each time you saw him.
A. Sure.
Q. And when you rendered care and treatment.
A. Uh-huh.
Q. And tell me what you base the statement on, "I did so in accordance with the skill, care and diligence required by the accepted recognized standards of the medical and dental communities." You got tell me what you mean by that because I want to know.
A. Sure.
MR. MINGUS: Objection to form.
Go ahead.
Do you want him to go through --
MR. HENRETTA: Every time he saw him, everything he did, and how that complies with the standard of care to back up this No. 4 that you state here. That's all.
THE WITNESS: Okay.
BY MR. HENRETTA:
Q. That's pretty basic.

A. Basic, but very broad.

MR. MINGUS: Okay. Objection.

BY MR. HENRETTA:

Q. Just go through each one and tell me --

A. Okay.

Q. -- what you did, first of all.

A. Okay.

MR. MINGUS: My objection is just to the multiple nature of your question, Tom.

BY MR. HENRETTA:

Q. Well, first of all, let's go through the first time you ever saw him. We're going do it just like a regular doctor depo.

Why did you see him, what did he present with, what history did you take, what physical exam did you take. And then you're going to tell me why that is or is not within the standard of care. That's every time you saw him.

A. Okay.

Q. When did you first see him?

A. First record of seeing Mr. Gortney was 10/31/98.

Q. Why did you see him?

A. Well, he came in for an initial

examination for evaluation of some symptoms that he presented with.

Q. Did he tell you what those were?

A. Sure.

Q. Did he give a history?

A. Am I going to be allowed to answer the question?

Q. Did he give a history? You're going right into findings. Just tell me did he give a history?

MR. MINGUS: My objection is he was still answering the question when you posed a couple more.

BY MR. HENRETTA:

Q. Well, let's break it down. When he called you and he came to your office, what did he say on the phone, what was your first recollection of a note, of a problem, why is the patient here?

A. I didn't take the initial phone call when he came to the office.

Q. Who did?

A. One of my receptionists.

Q. And what did you learn, why he's coming in?

A. For initial consult regarding facial pain.

Q. Okay. Where did you learn that information?

A. Would have been from his history that he filled out in the waiting room.

Q. What does it say?

A. Yeah, he lists under past hospitalizations surgical procedures performed in Mexico in '98 for cavitation procedures.

Q. What did you learn about those Mexican procedures for cavitational -- tell me what that means, first of all.

A. Sure. Well, Mr. Gortney's initial examination was brief. I did not go into detail with him. He came with multiple journal articles in hand regarding cavitation syndrome and a collection of some x-rays from past treating doctors.

He described to me that he'd had wisdom teeth which were removed 20-plus years ago and that he suffered from unrelenting facial pain and quote/unquote "drainage for many years ever since." He came with a working diagnosis, as I would call it, of cavitation

syndrome.

Q. Tell me about the Mexico treatment.

A. As described by the patient, his Mexico treatments included multiple trips to Mexico for what he described as curettage procedures which would be consistent with removal of bone -- repeated removal of bone of a certain area.

Q. Did you obtain the records from Mexico?

A. No, I did not.

Q. Why?

A. Well, it was my recommendation to -- actually, Brian asked me should I go back to Mexico for further treatments. I said to him that first off, the diagnosis was an unclear one. The treatment at best can be described as controversial and that I wanted a chance to review his records before I could ever recommend him traveling to a Third World country where standard of care would certainly be in question for procedures which may or may not be recognized here in the United States.

Q. What treatment was controversial?

A. The multiple curettage treatments of cavitation syndrome.

Q. Explain that. Why is it controversial?

What do you mean?

A. Well, I think that you would be able to find a multitude of physicians who might question the diagnosis of cavitation syndrome to begin with as a real or theoretical entity.

Q. Well, just explain what it is and tell me why it's controversial.

A. Sure. Well, it's thought to be a necrosis of bone in a given area, again, thought to be due to a prior surgical site and/or trauma to an area which then results in nonhealing necrotic bone.

Q. Why is that controversial?

A. Well, the reason it's controversial is because the diagnosis of necrotic bone is quite often not well documented.

Q. You did not feel it important before you went on to treat Brian further to get those records, I take it?

A. Certainly not. I would assume that was because I didn't place a larqe amount of value on what I would be obtaining from them.

Q. Okay. You think in general though it's important to have a patient's full medical history including records from the past --

A. Well --
Q. -- or not?
A. Well, Mr. Gortney was a -- at least thought to be at the time a very good historian as to what was done on him and he gave a pretty in-depth description as to the procedure at hand so there was not going to be a lot more offered from an operative report from a foreign country.
Q. All right. So what did you then do on that first visit after you got the history?
A. Looked in his mouth, the area of question, which was unimpressive upon examination.
Q. What do you mean by that?
A. I mean that there was no signs of active disease in the tissues of the mouth and the areas he was talking about.
Q. Any diagnostic testing or is it just palpation and visual?
A. Yeah, based on clinical signs and symptoms, signs being what the doctor is visually seeing and symptoms, what the patient is describing.
Q. And next what did you do?

A. Next what I did was told him that we would consider a CT scan to further evaluate the area and that we would call him to help him schedule that.

Q. Okay. And now had you -- was that the end of that first visit?

A. *Yes.*

Q. Okay. That's the first occasion you saw him and it is your opinion that what you just described, that conduct you engaged in as an M.D., I guess, and a D.D.S. was conduct falling within the recognized standards of care --

A. Certainly.

Q. -- am I right, for this patient given the presenting conditions and circumstances? When was the next time you saw him?

A. Looks like our next visit is on 11/20/98.

Q. How soon was that? How much time in between that?

A. Two and a half weeks.

Q. Okay. Tell me about that visit.

A. We reviewed the CT scan results and discussed moving forward based on his symptoms and the radiologic findings.

Q. All right. So who performed the CAT scan?
A. Let me check my chart here.
Q. It was a hospital?
A. It was a hospital, specifically Mercy Medical Hospital.
Q. What was the findings on that?
A. Impression: Almost complete pacification of a few of the left ethmoid air cells and mild to moderate diffuse mucosal thickening throughout the sinuses and left nasal cavity.
Q. What does all that mean, if you can give a breakdown so somebody can understand?
A. Sure. It's a fair way to describe chronic sinusitis which were also certainly in the realm of description of his clinical symptoms.
Q. Okay. What was done at that particular day?
A. Which day?
Q. The one you just talked about you shared with him -- did you share with him the results of the diagnostic?
A. Yes.

Q. Did you do any further treatment that day or schedule something?

A. I believe we talked about surgical options for him as well as what potential benefit that would provide.

Q. Okay. Tell me a little more specific what did you tell him, what benefits? Just explain what you just told me.

A. Sure. Based on the radiographic findings of -- consistent with chronic sinusitis and his symptoms of left-sided discomfort, facial discomfort, specifically atypical neuralgia, what the patient was describing --

Q. What's that mean, atypical neuralgia?

A. Atypical neuralgia would be a term I would use to describe a neuralgic type symptom or neurologic type symptom or pain, if you will, that is not typical, okay. It does not hold itself to find any one certain diagnosis, okay?

So based on the radiologic findings and Mr. Gortney's symptomatology, I thought it was prudent to do two things. I thought -- well, first off, let me back up. His repeated

insistence that curettage, opening the area and sampling bone which is what was needed based on his readings of cavitation syndrome.

Q. Explain cavitation syndrome again.

A. My understanding of it is that area of necrotic bone, separative or nonseparative, that is --

Q. What's that mean, separative?

A. Pus is located there, bacteria. An area of dead bone which refuses to heal.

Q. How is that normally treated?

A. By -- if you read the curettage literature and prescribe to that, it would be by multiple episodes of curettage of which, by description, Mr. Gortney had prior to our treatment.

Q. How would you treat that?

A. Well, I had a long discussion with Brian and his wife, I believe, stating that he has gone to many different surgeons, he has had multiple curettage procedures done, and there appears to be unrelenting discomfort. So in other words, he's not getting better.

And therefore, doing solely the same thing did not appear to be of good surgical

decision to me. That we did have documentable radiographic findings for sinusitis, that going in and cleaning out the sinus and eliminating that as a factor would allow us to do so and at the same time obtain a direct biopsy from the area in question. So that was reviewed in detail with Brian.

It was discussed that -- again, the diagnosis is probably still unclear whether this was true cavitation syndrome, whether this was simply true sinusitis with subsequent neuralgia or do you have the diagnosis of just a typical neuralgia with unclear causative factors.

Q. At what point in time did you arrive at the diagnosis?

A. I think we arrived at a working diagnosis -- and again, it still was possibly multiple working diagnoses throughout his care.

Q. How many times did you treat him?

A. As in an operative procedure?

Q. In your office, consultations, 20, 30, 40, 50?

A. No.

Q. How many?

A. Well, we can count the number of consultations, most of which were probably just checks or visits, discussions, nothing hands on, but one, two, three, four, five, six, seven eight, nine, ten, eleven, twelve, thirteen, fourteen, fifteen, sixteen, seventeen, eighteen, nineteen, twenty, twenty-one, twenty-two. Twenty-two times it appears approximately.

Q. Okay. All right. And it's your testimony through your affidavit that each time that you rendered care and treatment to Brian, you did so with the skill, care and diligence required by the accepted recognized standards of the medical and dental community --

A. Certainly.

Q. -- given the presenting conditions and circumstances? What's that mean, given the presenting conditions and circumstances?

A. How the patient presents at the time.

Q. Okay. Did Brian ever ask you to perform a particular procedure?

A. Ask me to request a particular procedure?

Q. Yes.

A. Yes.
Q. And what was that?
A. Curettage of the areas.
Q. Do you know when he asked that?
A. That would be -- I've got some letters from Brian and I know we've got those documented in there. First one is dated December 20th of 1998. He is requesting procedures in that letter.
Q. And did you respond to him?
A. Sure. And again, my -- my response to Brian is that his symptoms were somewhat misaligned with the signs that we were seeing. However, with the documentation of the radiographic findings and the symptoms he was describing, I thought it reasonable to perform the procedures that we performed.
Q. And was that the curettage he was asking for or something else?
A. No, it was the -- it was the combination of biopsy of the area and Caldwell-Luc of the sinus, of the left sinus cavity.
Q. I didn't hear that last term.
A. Caldwell-Luc. It's a name referring to a sinus procedure.

Q. Tell me about the biopsy. When did you have the biopsy performed?
A. At that time.
Q. What tissue -- okay.
A. Sure.
Q. Where did you send it?
A. We sent it two places. One would be to the hospital pathology department. Biopsy of tissue was sent as well as multiple cultures both for fungus, microbacterium as well as bacteria.
Q. Was that Mercy Hospital?
A. No, that was Lakewood Hospital.
Q. Okay. And what was the result of the biopsy?
A. Sure. The hard tissue specimen showed -- and I'll read you -- the microscopic diagnosis was "Chronically inflamed respiratory mucosa which is consistent with a patient with chronic sinusitis. Fragments of bone and minute portions of hypocellular debris with apparent calcified material and cholesterol clefts." And the stain for fungus was negative.
Q. All right. Do you believe it was

sinusitis or, I guess, that's information --
A. Sure. Within a sinus cavity, yes. Yes, we believe that.
Q. And what was your opinion as to the etiology of that information?
A. Sinusitis? Very difficult to say. Again, treating Brian after multiple surgeons have been into his tissues, it's extremely -- I would say impossible to determine what caused his sinusitis.
Was it iatrogenic, caused by another caregiver? Was it caused by the patient himself? Was it just a factor of disease? Hard to say.
Q. So then what procedure did you perform? First of all, did you perform surgery on Brian?
A. Yes.
Q. Okay. On how many occasions?
A. Twice.
Q. Okay. And when? When was the first one?
A. The first one was dated -- it was December, '98. The exact date, I believe, is -- tell you in a moment. Looks like 12/21/98.
Q. Who assisted you in that procedures?

A. My partner, Dr. Nicholas Diamantis.
Q. Did he also -- assisting as a nurse or assisting as a surgeon?
A. Assisting as a doctor.
Q. Okay.
A. He's not a nurse.
Q. Okay. Well, I -- just so I understand.
A. Okay.
Q. He performed work as a surgeon same as you?
A. Yeah.
Q. Okay. On both occasions?
A. Yes. Both operations he was assisting.
Q. Okay. And what was the goal of the first surgery and again, the name of the first surgery and the goal?
A. Sure. It was two part. One was the Caldwell-Luc procedure which was to eradicate his element of sinus disease which was documented radiographically by the CT scan; and two, was to obtain a biopsy specimen.
Q. Okay.
A. Biopsy specimen and/or curettage of the area. They essentially are the same procedure, removing bone for biopsy, removing bone because

you're purposely removing it.

Q. How do we rate success or failure in that particular procedure?

A. How would I rate it?

Q. How do you do that?

A. Symptoms.

Q. Okay.

A. Symptoms as well as obtaining a demonstrable diagnosis from specimens and/or lack of diagnosis.

Q. All right. So what did you learn from that procedure?

A. Sure. What we learned from that procedure -- well, clinically we learned that he did have element of sinus disease. It was, we felt, eradicated. Most patients do quite well from that procedure. We base that on their healing process as well as their symptomatology afterwards.

It is a disease which can revert back to its previous state. It's one that can be eradicated forever. It's very patient-dependent.

In terms of the success of the curettage and/or biopsy, we were able to obtain

a specimen which was representative of the tissues in the area and also free the patient of any visible signs of disease.

We had good, healthy, bleeding bone and no reason to suspect that further curettage at that time was warranted.

Q. Okay. How would you rate the success of that surgical procedure?

A. At the time of the surgery it seemed to go just fine. The patient seemed to heal well postoperatively.

Q. Okay. But you saw him after that?

A. Sure. You always see surgical patients afterwards.

Q. Was there any difficulty that he expressed to you in terms of his recovery?

A. No more out of the ordinary for anyone who undergoes a Caldwell-Luc. The patient leaves the operating room with intraantrum packing which is packing within the sinus cavity.

This is done as standard of care for a few reasons, but specifically to prevent hematoma and formation within the sinus antrum and that's periodically advanced throughout the

next 7 to 10 to 14 days, depending on the situation at hand.

And patients -- that is uncomfortable for patients, both while the packing is in place and as well as their removal of that.

Q. All right. Now, do you see Brian after that in the office --

A. Yes.

Q. -- for further complaints?

A. Uh-huh.

Q. Okay. What are the natures of those?

A. Sure. Let me just -- well, we saw him -- so in -- by 1/5/99 the entire packing was removed from the sinus and he was seen again on 1/8/99 for a check. There was no evidence of drainage, no fistula. The patient was healing well.

I had spoken with Brian in regards to -- any further neurologic symptoms would probably need to be addressed with intervention or interruption of the nerve which is responsible for the atypical neuralgia.

Brian expressed to me that he has already had consultations with neurosurgeons

regarding rhizotomies and that was something -- it was something he was familiar with, but it was not something he was interested in.

Q. How about patient complaints, was he complaining of any neuralgia at that time, any pain?

A. Let me just check further notes.

Q. Again, we're talking about after the surgical procedure.

A. Sure. Uh-huh. Yeah. He, at the time, healed nicely from the Caldwell-Luc procedure. I think -- again, we have a handwritten note by Brian saying that it took him a mere three days to recover from that and did quite well and this was in reference to a letter written before his second surgery. So by the patient's own admission, I take it he did quite well.

Q. Were there any patient complaints of pain at any time after the first surgery?

A. Sure. He -- he complained of a recurrence of the discomfort and he, by his own request, wanted to seek consultation in Kentucky which, to my knowledge, is a group affiliated with Dr. Hussar and the Mexico group.

Q. How many times did he complain about pain after the first surgery?

A. Let me look at the notes here. After the first surgery and before the second I assume you're asking?

Q. Yes. I want to know what the patient's complaining about, if at all --

A. Sure.

Q. -- between the two surgeries.

A. Let's see. We saw him in January in which case --

Q. What year is that?

A. It's '99, so that's after his first surgery. He then chose to go off to Kentucky to have a second consultation. He requested his records and x-rays. They were given. He went to Kentucky. "Dr. Zak indicates that we should review the surgeon's recommendations before having anything done."

Q. Okay. Now, do you know who the doctor was in Kentucky?

A. I have no idea who the doctor was.

Q. When you say review the surgeon's -- what's that reference, review the surgeon's records?

A. Yeah. Review his recommendations, not review his records. Review his recommendations.

Q. Which surgeon? In Kentucky?

A. Yeah. Again, the person in Kentucky. I didn't know this individual and this was on Brian's recommendation.

Q. All right. So then you perform another surgical procedure?

A. Sure.

Q. When is that?

A. That was in May and the reason we performed that --

Q. 1999 or 2000?

A. '99.

Q. Okay. Why another one?

A. Sure. The reason we performed another one was also multi-fold. We had at the conclusion of the first surgery a sample which was sent to Kentucky for evaluation of possible cavitation syndrome and --

Q. Where in Kentucky?

A. Let me look -- check the laboratory. It's again the same group that's associated with the Mexico group. It appears to be

University of Kentucky, Lexington, Dr. Haley, I believe it is.

Q. Haley? All right. When you say affiliated with the Mexico group, what's that mean?

A. Sure. Well, my understanding, if you do any type of research on the cavitation syndrome, you will find a focus of these articles, one being the doctor who's in Mexico which, I believe, it's a doctor whose license was banned in Colorado and therefore he practices in Mexico for that reason.

Q. Do you know his name?

A. I don't know his name.

Q. Okay.

A. And then also this Kentucky group.

Q. And you don't know tne name of the Kentucky group?

A. I don't know the name of the Kentucky group. I know that they have a -- what I would describe as a journal club which focuses their practice on cavitation syndrome.

Q. And are they at the University of Kentucky?

A. I don't know.

Q. Okay. So tell me again about this second procedure you're going to do and why you're going to do it.

A. Sure. We're doing it for a couple of reasons. Again, increased symptomatology. I have a letter here from Brian dated in March which I'm going to go ahead and read because I think it does an adequate job of describing the patient's words themselves.

"The pain in my face is getting worse. It's affecting the whole left side of my body and skull. I would like to move ahead with the plans to clean out the necrotic bone and tissue as soon as possible.

"John" -- he refers to me by my first name -- "I spent most of this weekend on an ice bag and I sleep on an ice bag every night. I haven't been able to fly my airplane in over four years. This has destroyed the quality of life for me. I have a number of concerns. Number one, could you write a short letter to my insurance company explaining the planned procedure and estimated costs?

And it goes on, "I would like to do this at University Hospitals. If we need

replacement bone, could we go to the bone bank or is it better to use my own? Could you also clean out the lower left third molar site at that time, preferably do all four procedures. This would preclude having to repeat these treatments.

"All third -- all four third molar sites are painful; however, the upper left is by far the worst followed by the lower left.

He says that he's self-employed. "How long do I estimate my downtime will be? I was able to go back to the shop the day after my triple discectomy and was only down a couple of days after the Caldwell-Luc procedure.

"I have to have something done, John. All these symptoms I described in my earlier letter are still present. Please let me know with your earliest convenience. Are you still planning to do the curettage procedure using methylene blue? Thank you for your understanding and care, Brian Gortney.

"Also, I had root canals with both of the missing upper teeth sites. They found black necrotic residue in these in Mexico. Should they be cleaned out and checked again?"

So his s-
recurring and sympt
area of pain, drain
and swelling was no
to witness or demon
However, erythema,
we were able to eli
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Q. Well --
A. Okay. So we
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test result for cav
the Kentucky labora
Q. What was dor
procedure?
A. The Caldwel
and/or biopsy.
Q. What did you
can tell it didn't
A. Sure.
Q. So what did
sense?
A. Sure. It e
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So his symptoms by the patient are recurring and symptoms -- I say he describes area of pain, drainage and swelling. Drainage and swelling was nothing that we were ever able to witness or demonstrate within the office. However, erythema, which is a term for redness, we were able to elicit in the site upon examination at one or two occasions.

Q. Well --

A. Okay. So we have before us a patient with recurring symptomatology and a positive test result for cavitation syndrome by way of the Kentucky laboratory.

Q. What was done for him in the first procedure?

A. The Caldwell-Luc procedure, curettage and/or biopsy.

Q. What did you do for him? From what I can tell it didn't delete the pain --

A. Sure.

Q. So what did it do for him in a positive sense?

A. Sure. It eradicated his present sinus disease and it allowed us to obtain a direct biopsy of the tissues. All of those, by the

way, with the exception of the laboratory from Kentucky and the enzyme assay testing, the H & E stain of the bone, the cultures of the tissue, be they fungal, microbacterium and bacterial, all came back negatives.

So I think it did a lot for us. I was able to rule out all of those things. So diagnostic in terms of ruling out possibilities is extremely valuable.

Q. All right. So then we go for another procedure and what is this second one called?

A. Sure. The second procedure is we are going to go back to the same area where the patient's chief complaints exist, specifically the left maxilla.

We are going to go in under the understanding by patient and doctor that we will take a larger representative sample, in a sense more curettage, which is recommended by the cavitation -- those who support the diagnosis of cavitation syndrome.

However, we've been back there once before -- excuse me -- we've operated once before. There have been multiple surgeons in various countries who have operated there. If

we are going to create a larger defect, we wanted to reconstitute that area and so we used otogenous bone graft which is the patient's own bone; Gold standard in bone grafting.

Q. Well, tell me about the surgery. Where was it performed, how long did it take?

A. The procedure probably -- and again, I don't recall specifically, but probably took on the order of one to two hours.

Q. Was that in your office?

A. No, it was in the hospital.

Q. Okay.

A. It was done at University Hospitals.

Q. Okay.

A. And the procedure consisted of developing a flap to expose the area in question and remove a representative sample down to the level of what we felt was healthy bone. And we base that clinically on healthy, bleeding tissue. Bleeding tissue, bleeding bone is good, healthy tissue.

Q. Where was the -- specifically in the anatomy, where are we talking about?

A. Probably the easiest place to describe that, it would be the retromolar pad area of

the maxilla adjacent or rather distal to the second molar.

Q. Was there any bone grafting done at any time?

A. Yes.

Q. Which procedure?

A. The second procedure.

Q. And where was the bone obtained?

A. The bone was harvested from the patient's -- I believe it was his right hip.

Q. And how successful or not was that graft, do you know?

A. Well, you wouldn't know that unless you did a core sample of that. When you do have that show up on a CT scan or a bone scan, healing bone is going to -- and grafted bone is going to look like necrotic bone or osteomyelitis.

And you then have to follow that with a gallein scan or white cell tag scan which will then only light up in areas of necrosis or osteomyelitis. And to my knowledge, Mr. Gortney had that done by recommendation of, I think, an ENT surgeon in town and that showed no evidence of

osteomyelitis. And that was done approximately four months after our care.

Q. When did you last see or treat Brian Gortney?

A. I last saw Brian on -- make sure we've got our -- it appears to be in September of '99, at the end of September '99. However, I did have conversations his wife after that.

Q. In between the — now, this surgery was in what month in '99?

A. It was in May of '99.

Q. May of '99?

A. Yeah.

Q. What complaints, if any, did he present with or did you learn came from him after the surgery?

A. After the surgery? Right. Yeah. Well, then let's go to the chart there and review post '99. He had some minor complaints of some left ear pain which we referred him to an ENT surgeon for and was being treated that way.

We saw him in July. His oral cavity was healing well. He had continued description of neuralgic type symptoms and I again recommended that he see the ENT surgeon as well

as the neurosurgeon, Dr. Tabett.

In July here we have a conversation with Mrs. Gortney that they saw the doctor for a possible inner ear infection which was being treated by him and should clear up without -- or is uneventful.

We then have a letter, multiple letters, from Brian that I think warrant reading and I'll start with those in just a moment here.

Q. And tell us the date.

A. Sure. Be happy to. The first is dated September of '99. "Doc, thanks for taking the time to examine me last Saturday. As you know, I'm still having a problem. I can never remember things when I see you so I decided to write it down.

"Number one, the area behind the left maxillary second molar was swollen for some time. When I probed and punctured it last week, I got a lot of bitter, thick drainage and it relieved the pain somewhat and changed the nature of it. The pain is localized at this area now.

"Number two, now that the swelling

is down, I can feel a" -- can't read it -- "channel in the bone, a slot or channel in the bone behind the second molar to the focal point of the bad spot. Are there bone fistulas?" he questions.

"Number three, I had pain and problems in this area even prior to the third molar extractions in 1980 and 1981. Number four, I urinate very often with a lot of debris and gas in my urine. Could it by a crypt or another cavitation or both? It feels like I've lost bone. Please open the area up and explore the channel behind the second molar and the bad spot for cavitations and necrosis, et cetera, and debride it as well as possible.

"It is still draining a bitter drainage; however, the facial and neck pain is reduced. If I need another bone graft, let's proceed. Your previous work has healed nicely and is pain free. Thank you. Brian Gortney."

There's a letter dated 9/22 which would be one day after. "Frequent stabbing pains below naval at bladder with frequent urination. Urine has a lot of gas and debris for some time now, over a year. Still have a

bitter, burnt tasting drainage from open area behind second maxillary molar. Hard pallet only hurts at this site since draining. Not painful all along back of pallet at this time. Feel warm and fevered all the time; however, only 98 degrees or so usually.

"It feels like something is eating at the bad area, anaerobes, mycotic infection," he questions. Next note, September 28th.

So in other words, in the period *of* less than a week there's a flurry *of* these -- what I would describe as at best contradicting symptoms.

Q. Is that the last date? 9/28's the last letter you got?

A. Yeah, last letter from Brian.

Q. Final letter? There's no more beyond that?

A. Yeah. Yeah. To my knowledge, yeah.

Okay. "Doc, after I opened the swollen area" _- after he opened the swollen are — "behind the left maxillary second molar, the swelling decreased as the did the pain in the neck, cheek, pallet and" -- I can't read that.

"The hissing in the ear and stinging

sensation along the corraded area and the debris in the urine and bladder pains have decreased. I also urinated much less frequently.

"Now that the gingival tissue is nearly healed, all symptoms are increasing. I believe the toxins are once again forced to escape betwezn the periosteum and bone going into the lymph and bloodstream instead of draining into the oral cavity as they did while the area was open.

"I had a bitter, burnt-like drainage that has now stopped for the most part. It's sweet tasting at this time. Brian. Could it be a remote lesion draining at the tuberosity? Could it be in the pterygomaxillary area? I fell with a pencil in my mouth and drove it up into me years ago.

"Could it be on the lateral wall of the nasopharynx above the soft palate? It's always tender right there just above the zygomatic arch."

Okay. So what I interpreted as a practitioner from this is that we have a patient who is self-diagnosing, a patient who

is self-treating and that raises a grave concern for me. I expressed that with the Gortneys.

Q. How did you express it?

A. I had told them on their visit that I felt that it was inappropriate for him to be probing and dissecting the tissues of his mouth.

Q. Do you have a note to that effect in your chart?

A. No, no. Well. I have -- I do have one, a phone conversation with Mrs. Gortney, which again, follows that, but not at the time.

Q. That isn't noted in the chart?

A. Yeah. Says phone conversation with wife. Again, reiterated zero signs of infection, erythema concerns about Brian's self-diagnosis, self-mutilation. Again, recommend referrals to neurosurgeon, pain management options and return to ENT treatment.

Q. What date was that document?

A. It was 11/99. I wasn't sure of the conversation date exactly. I didn't want to put down something erroneously.

Q. The last date you have in your chart

with anything with Brian would be when?
A. That would be 9/29/99, and that was --
Q. Well, is there 11/99 did you say?
A. That would be a phone conversation with Mrs. Gortney. That's not with Brian, okay.
Q. Okay. I see. Well, it connects with his treatment. Is November of '99 the very last --
A. That's what we're -- yes.
MR. MINGUS: There's entries after that related to the records, but --
MR. HENRETTA: Well, yeah. Aside from that and payments.
THE WITNESS: Right.
BY MR. HENRETTA:
Q. Okay.
A. Okay? So beyond that, we have -- I'm sorry. I lost my train of thought with that question, I guess.
So I have a patient that is admittedly self-diagnosing, admittedly sel-treating. We have gone in twice and have been unable to demonstrate with any accuracy significant pathologic findings, i.e., a positive culture, a positive bone graft.

And as a matter of fact, our biopsy from the surgery showed no evidence of necrotic bone. Showed new bone and, in essence, healing bone from the first surgery.

So I told Brian and his wife at that time I saw no benefit to Brian to go in further and chat I was not able to recommend that for him for treatment.

I recommended that he seek help for multiple issues, psychiatric not alone.

Q. All right. Did you and Brian have a discussion about so-called cavitation syndrome early on in your treatment of Brian?

A. Yeah. As I said, on his initial visit he came with multiple journal articles concerning cavitation.

Q. Did you agree that it was a cavitational syndrome?

A. No. I told him that I was not willing to at that time state that it was definitively cavitation syndrome, but at the same time I wasn't willing to rule that out. Just because a diagnosis is not popular, if you will, I was not of the conviction that that could be -- that that might not be the diagnosis at hand.

Q. Had you had experience with cavitation syndrome with other patients before Brian?

A. Sometimes you will have -- patients don't necessarily refer to that, but it may be NICO Syndrome that they refer to. Again, NICO Syndrome is positively described in the articles very similar to cavitation syndrome; however, again, also a diagnosis that is not well accepted.

Q. NICO again is -- explain that. That's N-i-c-o; is that right, Doctor?

A. Yeah.

Q. And those letters stand for what?

A. I'm not a -- you'll have to get those.

Q. We'll find it.

A. Necrotizing infectious cavitation osteo something or other, I believe, but you better check that.

Q. In a sense, what does it mean?

A. Again, that's not a well accepted diagnosis. It's not one that I care to treat on a regular basis due to the lack of demonstrable findings --

Q. All right.

A. -- arid I believe it's very similar to --

to that.

Q. I have it. I have an — I don't know. It says NICO. That's a neuralgia inducing cavitational osteonecrosis. I guess pain causing -- forming a cavity, dead and dying bone.

A. Very similar to cavitation syndrome descriptions.

Q. Right. And your opinion of NICO lesions is -- I mean, isn't that a malady that's accepted?

A. Is it a malady that is accepted?

Q. Yes. I mean --

A. I suppose it depends on who you're asking.

Q. Okay. All right. Fair enough.

A. I'm sure you'll find a number of physicians who say it does not exist.

Q. Okay. Christian Bouquot, B-o-u-q-u-o-t, are you familiar with that physician's name?

A. No, I'm not. Never heard of him.

Q. Okay. How about the term trigeminal neuralgia?

A. Sure. Trigeminal neuralgia is trigeminal type symptoms, shooting pain along

the distribution of the trigeminal nerve.
Q. And that's located where?
A. It's in the face. Applies sensory feeling to teeth, face, sinus. Again, Brian's neuralgia was described as atypical because it cannot follow the guidelines specifically of trigeminal neuralgia.
Q. And what are those guidelines?
A. In a nutshell, it's sharpshooting electrical like stimulations that last just a period of seconds, usually triggered by a nidus of action, wisp of cotton across the face.

Typically a patient will describe when the wind blows across their cheek they'll get a shooting electrical stimulation that lasts mere seconds and then goes away. That's the classic trigeminal neuralgic symptoms.

Anything outside of those parameters would probably more appropriately be described as atypical neuralgia.
Q. My experience with Brian is that he's a pretty articulate individual.
A. I agree.
Q. Is that your understanding?
A. Sure, which is why I recited his notes.

Q. Can you tell me -- Brian is -- and let me know if heresy is coming out of my mouth.

Tell me, did Brian tell you that he believed that he had cavitational syndrome? Was that your understanding, that he said he had that?

A. He came to my office with a working diagnosis of cavitational syndrome. So whether it was Brian's unprofessional assessment or whether he was told that by the group in Mexico, I can't tell you.

Q. Okay. I guess my question would be what differential diagnosis did you then engage in in order to rule that out?

A. Sure. Would have been cavitation syndrome, neuralgia, both trigeminal as well as atypical facial neuralgia. Sinusitis, common odontogenic origin, of tooth origin. All of those can be referred down that path. And cavitation syndrome.

Q. And you had a biopsy check, right?

A. Yeah, at the time of the Caldwell-Luc, that's correct.

Q. Did you have a conversation with -- well, Dr. Boyd Haley or Hacksley, it's the name

that -- I believe from the University of Kentucky?

A. Sure, I did.

Q. Is that where the biopsy was sent or did you have a conversation with this -- and I believe he's a Ph.D., isn't he?

A. I'm not sure of his qualifications, but yeah, I had both. It was sent to a laboratory where he is as well as I had a phone conversation sometime after the 5th of January, '99. The phone conversation consisted of reviewing Brian's care to date and what we planned to do in the future due to Brian's symptoms.

I think that Dr. Haley -- I can say was -- I was concerned in that he was overly complimentary on my acceptance of cavitation syndrome and that he specifically noted that he did not receive the same due diligence from a lot of other physicians, specifically in the University where he was, okay.

And I told him that -- well, I had not determined as of yet that it was cavitation syndrome that we were dealing with; however, I wasn't quick to -- I was not quick to dismiss

that as a diagnosis, okay.
Q. You have a -- you referred to a note, looks like while you were out, one of those notes we used to get before voice mail?
A. Yeah. You got it.
Q. And does that reference the conversation, Doctor?
A. No, it doesn't. I recall the conversation because it was so bizarre.
Q. Okay. And you have some idea of the date when that occurred?
A. Yeah, after the 5th of January.
Q. Okay. And before what other dates?
A. Before our second procedure.
Q. Which was in?
A. May.
Q. Okay.
A. So somewhere between the beginning of January and the end of May.
Q. Okay. How did you -- well, how did you leave it with Brian or how did Brian leave it with you? Was he satisfied with your care and treatment?
A. At the end of treatment?
Q. Yes.

A. Brian was -- we had a very -- what I would describe as amicable relationship throughout his care. We received Christmas cards, we received a calendar from his automotive shop. He was very complimentary, very thankful of our care and I think in our letter there I quoted him, "I am pain free now. Thank you for your care. I have healed nicely."

It did not become acrimonious until September, late September, beginning of October.

Q. 1999, Doctor? Excuse me.

A. Correct, 1999, when Brian was requesting that we operate again. And I reviewed the following findings with Brian stating that Brian, I don't have good sound surgical reason to go in and operate on you again, that our last biopsy from the last procedure showed new bone, not necrotic bone. We have every reason to believe you're healing well. Your tissues look good.

That, in combination with his own self-admission for probing, diagnosis, and what I would describe as mutilation of the tissues

__ let me back up. Not in the notes, and I don't have a note of it, but Brian, very much in detail, described -- he's a mechanic and he described fashioning what he termed a nasopharyngoscope.

Again, Brian's well versed in medical terminology and he described fashioning a nasopharyngoscope which he used to investigate his sinuses in the area of the back of his throat.

Q. Can you describe that apparatus?

A. I have no idea what he made. You'd have to ask your client.

Q. Okay. That's the term he used?

A. That's the term he used, okay. There is such a thing, a nasopharyngoscope, and it's a camera that's used to go in through the patient's nose and look through the back of their throat. This was described by the patient that he fashioned it, he did, okay, along with the documentation of the probing into the area, opening the area.

I felt very uncomfortable at that point with a patient who was -- it was documented that he was self-diagnosing, he was

self-treating, and I did not see a benefit to him going in and operating on again. That's when I recommended to him that he A, stop doing those things to himself; B, seek another person's care, specifically --

Q. Do you have a note to that effect?

A. Yeah.

Q. If you would, just tell me the date and what your note says, your chart says?

A. Well, it was again our phone conversation with his wife. The note with Brian's last visit, I didn't note that.

Q. I think you referenced that.

A. However --

MR. MINGUS: There is a September, 18th note too, just so you get it all here, Tom.

THE WITNESS: So in September I did reference that he see an ENT surgeon and neurosurgeon. For patient confidentiality with you, I don't believe that I referenced that he see a psycniatrist, but I know that was in the conversation. And I unfortunately have come to realize that is where the disposition of my patient and my relationship with the patient

then turned from amicable to acrimonious.
BY MR. HZNRETTA:
Q. From that suggestion?
A. I think from that suggestion and my refusal to treat him further. I told him there's nothing more I can do for him and I recommend he seek other specialists' help.
Q. At that time I take it then that he's still complaining of pain?
A. He is complaining of a recurrence of symptoms; however, with a complete lack of clinical signs other than some mild erythema. And we've got an admission of the patient probing the area. Obviously that's reason enough for him to have erythema or redness in the area.
Q. All right. How different were the -- if you can you characterize the difference between complaints after the first surgery and the complaints after the second surgery. Were they the same?
A. I believe they were relatively the same.
Q. Okay.
A. He had periods of quiescence where we operated on him. He got better by his own

admission and then once it -- it appears to be that once a few months had gone by and care was -- repeated visits into the office were not occurring, Brian would research to the office again seeking care and describing symptoms and wanting us to operate.

Q. Do you have in your chart there the amount of his charges or is that not with you today?

A. There's some financial things here, but I have no idea as to what the charges were.

Q. Is there like a bottom line, a final bill?

A. Again, that's not something I reference when I --

MR. MINGUS: We can try to add it up for you.

MR. HENRETTA: Okay.

THE WITNESS: Patient's charges are not something that I generally reference when deciding their care, unless it's a --

BY MR. HENRETTA:

Q. I'm not suggesting you do. I just wanted to know a rough estimate, how many times you saw him. We can obtain that.

A. I really don't know what his complete charges were.
Q. And do you know whether or not he still owes you money or if money is due on that account?
A. I have no idea.
Q. Okay.
A. I try to distance myself from those issues.
Q. Smart. Very smart.
MR. HENRETTA: All right. We're going to take a break.
MR. MINGUS: Maybe we can try to work on these emerging piles here.
(Short break had.)
BY MR. HENRETTA:
Q. Doctor, also in your affidavit you stated No. 5 and that would be Exhibit probably 1 over there -- No. 5 that you state that based on your education, training and experience, that while you deny that departure from the accepted standards of medical practice, by arguendo, if such exists, it was not a direct and proximate cause of any injury or damage whatsoever to the Plaintiff.

What do you mean by that statement in your affidavit?

A. Let me read it again since this isn't by my pen.

Q. Well --

A. Let me read it, if you don't mind.

Q. You signed it, right?

A. Sure, but let me just read it again. "I further state that based upon my education, training and experience that, while I deny departure from the accepted standards of medical practice, by arguendo, if such exists, it was not a direct and proximate cause of any injury or damage whatsoever to the Plaintiff." Yes. Okay.

Q. Okay.

A. What I do mean by that statement? What I mean by is that due to my education, training and experience, I did not deviate from the standards of medical practice regarding the care of this patient and if he is making claims that such deviation occurred, it did not cause any injury or damage to the Plaintiff.

Q. What is the injury or damage that the plaintiff has?

A. I'm not sure what he's claiming.
Q. But all you're saying is whatever it is, I didn't cause it?
A. No. I'm basing it on the fact that Brian came to us with significant symptoms. We rendered treatment on two occasions. He improved, albeit for a brief period of time after each occasion, and throughout we referred him to multiple specialists for extended care and opinions.
Q. Do you believe you caused any injuries to --
A. No, I don't.
Q. -- do you believe you caused any injury to Brian Gortney as a result of your care?
A. No. We, if anything, improved his state and then --
Q. Well, tell me about that. In what respect did you improve it?
A. Well, by his own pen we have documentation.
Q. How did you medically improve it?
A. We improved his symptomatology and got a -- ruled out certain definitive diagnoses.
Q. How did you improve the symptomatology

that he's still complaining about?

A. Well, again, for a while he had gotten better and we -- based on the lack of demonstrable pathologic evidence, we didn't feel that we could do anything further for him and therefore recommended that he seek other specialists.

Q. And you say for a while he had gotten better. For how long of a while?

A. Well, if you look at the case, initially it was just a matter of weeks after the first surgery. And after the second it appeared, in my judgment, to be on the order of a few months.

Q. And then it returned again, his symptoms?

A. And then his symptoms, as he described them, returned. Again, my goal here when Brian first approached me was this was, what I think, a somewhat confused man in the sense that he had a lot of practitioners telling him a lot of different things, things that I think are confusing to practitioners themselves --

Q. What --

A. -- and that my goal was -- he was asking

for help and my goal was to help him. That's what I do for a living and that's my goal when I treat my patients is to help them. And -- I'm not finished with my answer -- and my goal was to help him.

We went about helping him in very deliberate manners that were minimally invasive, that were known to render success, and at the very least obtain results which could rule in or rule out certain maladies.

When we felt we could no longer help Brian and that we felt that our relationship was deteriorated, we, as all along, recommend that he seek other opinions.

Q. What was it that sent you to signal that the relationship had deteriorated?

A. Again, after Brian's insistence on reoperating again and we were telling him no, Brian, I did not feel that it was in his best interest to operate again.

Q. You knew Brian from the beginning, so to be a -- first of all, I guess a student of medicine in the sense that he certainly read up on some stuff. I mean, he knew -- at least as you said earlier, he was familiar with medical

terms and dental terms, correct?

A. Whether he understands these medical terms or not I'm not going to make a statement on.

Q. Are you of the opinion that in the beginning that he brought in his own diagnosis? Is that when you told us that he had self-diagnosed?

A. No, I did not tell you that. I said that he came to the office with a working diagnosis. Whether that was from his own hand or whether it was from prior practitioners in Mexico, I don't know.

When a patient presents in the office on initial consult with journal articles and x-rays, whether it's a diagnosis that you see frequently or that you believe in, you have to bear some credence to it.

Q. Why didn't you get those Mexico records?

A. I told you. It was a Third World country done by, to my knowledge, a practitioner who was questionable in his approach.

Q. So you did not -- so I understand, you did not think it appropriate to obtain those

records in order to assist you in not only arriving at the diagnosis, but a treatment plan?

A. Right. Brian was very articulate in his complaints and his symptoms and I was not treating necessarily his preexisting diagnosis, I was treating his symptoms --

Q. I just want to make sure --

A. -- I was treating his symptoms.

Q. Okay.

MR. MINGUS: Did you have any luck in getting them?

MR. HENRETTA: I was going to ask you that question.

MR. MINGUS: I haven't had any luck in getting them.

THE WITNESS: So five years later they're still unattainable.

BY MR. HENRETTA:

Q. You referred him to, I think you said, numerous physicians?

A. Uh-huh.

Q. Who?

A. The only specific -- excuse me. That's not true. Specifically I recommended that he

see J.C. Tabett who's a neurosurgeon which is documented in the notes. ENT surgeon. I'm not sure if we gave him a specific name or not, but he did receive care both for a possible inner ear infection as well as place in the PD tubes from an ENT surgeon and I don't recall who that individual is.

Also, I referred him for evaluation by the pulmonologist who runs the HBQ Center that he went to as to the efficacy of HBO treatment in a possible diagnosis of osteonecrosis.

Q. After you treated Brian, did he have or did your notes -- chart notes reflect, did he have good days or bad days or were they all the same, all good or all bad?

A. No. I would say they were good days and bad days. I would say that just by his letters, dated all within a week apart, he in one sentence says that he's doing better with no pain and the next sentence says that he has pain.

Q. That would not be untypical? I mean, I imagine a lot of your patients have good days and bad days or no?

A. I'm not sure how to answer that question.
Q. Okay. Well, I just heard that. Most docs I talk to --
A. Right. I suppose it depends on the diagnosis at hand.
Q. Sure. Wno said that Brian Gortney was experiencing good bone growth? Was that you or did you read that?
A. Good bone growth?
Q. Yes.
A. No. His pathology report from the second surgery, from the specimen taken from the second surgery, describes it as new bone. There is no evidence of osteomyelitis or osteonecrosis noted.
Q. Does that translate into bone growth?
A. New bone?
Q. Yes.
A. That sound like bone formation.
Q. Tell me about the hyperbaric treatment. What is that term?
A. Stands for hyperbaric oxygen which is a standard procedure in evidence of osteonecrosis where vascular: ingrowth is a concern. Just by

definition, osteonecrosis would be an avascular area of bone, nonhealing. One way you can promote that healing is by angiogenesis which is promoted via two extras of oxygen pressure.

Q. Did you recommend that?

A. I recommended that that would be a possibility and recommended that he see the pulmonologist for further consult prior to commencing it which we got a letter back.

Let me just reference that. It's dated April 21st, 1999 which is prior to his second surgery and I'll just read the assessment: "Apparent osteonecrosis of the left maxilla, reverses osteoma."

Q. Can you explain the difference?

A. Osteoma is a benign mass of the maxilla and would be just that, a benign lesion that would be biopsied, removed and could or could not recur.

Plan, based upon his descriptions, "Preoperative hyperbaric oxygen therapy as well as postoperative therapy would be warranted to support the intended grafting and hopefully provide neovascularization or ingrowth of new blood vessels to the surgical site. I hope to

speak to you personally regarding the specifics of the case. Tentatively I plan for X number of dies."

Q. Is that written to whom?

A. That is written to me by James Kelling, M.D.

Q. Where is he?

A. Dr. Kelling runs the pulmonology and critical care department at Mercy.

Q. And you discussed that with Brian?

A. Yes.

Q. Okay. Again, was that performed?

A. Was the HBO performed? Yes, it was.

Q. Is there a result somewhere that you can share with us about the HBO?

A. Again, that is not something that would be obtainable unless a core sample was taken from the bone. However, he underwent ten dives preoperatively and then during the operation we biopsied bone which then showed new bone growth. So the reasoning would tell you that the neovascularization did occur and new bone did grow.

Q. Okay. Okay. Who's Dr. Ossakow?

A. I don't know.

MR. MINGUS: Ossakow?
MR. HENRETTA: Ossakow. Excuse me.
THE WITNESS: I believe's an ENT surgeon.
BY MR. HENRETTA:
Q. All right. What is your relationship, if any, with him?
A. None.
Q. How many cavitational procedures had you performed before you treated Brian?
A. Again, as I stated to Brian on his initial exam, cavitation syndrome was not a -- to my knowledge, a widely accepted diagnosis as was NICO not a widely accepted diagnosis. And that cavitation procedure really by description is a curettage of the bone. So how many curettages or biopsies of the bone have I performed prior to Brian? Thousands.
Q. How many times have you found it necessary during that procedure to take the bone from the iliac, chest, and put it in the oral cavity?
A. Sure. We do it often for reconstitution of the anatomy of the jawbone. This enables the patient to be defect free and to obtain --

and possible dental work, be it removable or fixed prostheses afterwards.

Q. Is there a --

A. It's a very common practice.

Q. Is there a -- tell me about -- and this is in layman's terms.

A. Sure.

Q. Only because I've experienced this myself years ago. I had what was referred to as a bone implant. This was about 25 years ago.

A. Okay.

Q. And it came not from my anatom , but from a bone bank. And from what I was told was from the hip of some --

A. Cadaver.

Q. Okay. Wonderful. My body apparently said I don't want that and it rejected or whatever, but it didn't take. Now, is there any percentage that you're aware of when that occurs? I guess what's the success rate, if you will?

A. Sure. When discussing bone graft options with Brian to reconstitute the anatomy, clearly the gold standard, if you will, what is

most supported, is otogenous grafting which is the patient's own bone.

And specifically in this case, where we have a question of vascularization of the bone, we would want healthy, living bone to be transplanted, not dead, cadaveric bone. And so it was my recommendation to Brian that we use his own bone rather than cadaveric bone.

Q. Okay. What is the rate of reconstitution?

A. What is the rate of reconstitution?

Q. Yes. Is it high?

A. For otogenous bone?

Q. Yes?

A. Very high.

Q. The gold standard because it was used on him because it's his own anatomy?

A. Right. I would say very high.

Q. 75 to a hundred?

A. Certainly not a hundred. I would say somewhere between 75 and 85 percent.

Q. Okay.

A. And allografts or graft from other sources would be considerably less. That's conservative.

Q. Okay. Thank you. Okay. How did you meet Dr. Diamantis?
A. Met him in residency training.
Q. So you've known him --
A. Approximately ten years, ten plus years.
Q. Do you know why he has not obtained a dental license?
A. His specific reasons?
Q. Yes.
A. You'd have to ask him.
Q. Well, I'm just asking. You don't know?
A. I don't know the specific reasons.
Q. Okay. The practice that you have today, did you open it with Dr. Diamantis?
A. Yes, I did. Yes, from inception.
Q. When you were done treating Brian Gortney, was it your opinion that he was -- well, I guess you've said already that you believe that your surgeries were successful or not.
A. What's your question?
Q. Well --
A. Do I believe my surgeries were successful?
Q. Yes.

A. Yes, I do. Again, we had a patient -- significant patient symptoms, we had radiologic -- specifically initially a CT scan, evidence of some element of disease, whether it was sinusitis or whether it was cavitation syndrome. We achieved some level of relief for a period of time.

We also obtained very valuable biopsy specimens and cultures of the area. And during the second surgery, we have months of relief and patient admission of pain-free periods. So I would describe that as successful.

Q. Okay. Did you feel that you ascertained all of the necessary facts and circumstances about Brian, in particular his medical history, that was necessary for you to properly treat him?

A. Yeah. When I reviewed Brian's history there was -- he was forthright. I had every reason to believe he was forthright. There was no reason for me to believe otherwise. He was very knowledgeable regarding his previous surgeries and I thought that was certainly within the realm of reasonable to proceed with

treating the patient based on what we had and documented radiologic findings and symptoms versus trying to pursue charts that may or may not exist in Mexico.

Brian was very descriptive in terms of who he saw, in regards to -- he did see the neurosurgeon. The neurosurgeon did recommend a rhizotomy. He did not wish to pursue that route.

Q. What -- what is that again?

A. A rhizotomy is a severing of a cranial nerve, specifically in this case, cranial nerve No. 5 at the base of the cranial base to render it permanently nonfunctional or numb, in this case, which would cure -- ultimately cure any type of neuralgia, be it atypical or trigeminal in description.

Q. The surgeries that were performed, were they at the same hospital or different hospitals?

A. No. The one was at Lakewood Hospital, the second one was at University Hospitals.

To answer your last question, to go back to finish my answer to your last question, you asked if I helped Brian or that if I felt

that our care helped Brian. Well, I think that our diagnosis or our biopsy of the tissue which was questioned as to whether it was necrotic and came back as new bone or non-necrotic or not osteomyelitis, showed that we did help him.

We reconstituted the area that was debrided and subsequently he underwent a gallein scan that showed that there was no evidence of necrosis or osteomyelitis.

So again, I think it supported that we certainly helped him, left him in better shape than he arrived.

Q. Did your final diagnosis differ from your initial diagnosis? Would your records reflect that or do you recall?

the record here. Whether the records reflect it or not, we have irrefutable facts that the patient has no evidence of a biopsy of necrosis or osteomyelitis and so therefore I think that he was helped in that manner.

I'm sorry. Your question also was?

Q. Well, I guess I just want to know if your final diagnosis was --

A. Was consistent with cavitation syndrome?

Q. Well, with your initial diagnosis.

A. Well, my initial diagnosis, I think, was undetermined and was this coming from sinusitis. Was this an atypical neuralgia of unbeknownst sources or was this cavitation syndrome?

Frequently when you have a patient with facial neuralgia there are a laundry list, if you will, of differential diagnoses and you may never know what the source is. The goal is to -- like most things, is to eliminate those sources which are of grave concern and move on.

In someone who has an atypical pain, you may not find the diagnosis. You can treat it, you may get rid of it. If it persists, you recommend things like cryosurgery and rhizotomies.

So is my working diagnosis at the end of treatment the same as at the beginning of treatment? I would have to say that I don't know that we ever finalized the diagnosis. I knew however that with biopsies that showed no evidence of necrosis, I couldn't recommend continuing further as the group in Mexico and in, I believe, Nevada were recommending, to

continue to go in and curettage an area that was showing up as new, healthy bone.

Q. I'm going to go to that area again because earlier you had -- and I believe your testimony, at least a sentence, seemed to lump together, Kentucky, Mexico and Hussar.

A. Sure.

Q. Now, you said Nevada and I think we're talking about the same group. What is the relationship?

A. I don't know of their specific relationship.

Q. Well, in general. What do you -- why do you describe them as a group? What is the connection?

A. I'm sure they're in -- they are -- I'm not sure, but I assume --

MR. MINGUS: Don't assume. Answer what you know.

THE WITNESS: I don't know whether they're in private practice or whether they're in some sort of group affiliation or not. I know that all prescribe to the belief of the diagnosis of NICO and/or cavitation syndrome and that's why the assimilation was made.

BY MR. HENRETTA:

Q. All right. I understand. How is it that you know that?

A. Through conversations regarding NICO and cavitation syndrome amongst professionals in the specialty.

Q. Did you know that before you met Brian Gortney?

A. Did I know it before I met them? I didn't know the specific names of these doctors, but I knew that they existed.

Q. Okay. Have you -- well, what have you learned since your treatment of Brian about those doctors or those individuals who share that particular group -- sorry -- that idea of NICO, I think you said, and treating cavitational syndrome?

A. What do I know about them? Nothing more than hearsay and I generally don't like to promote hearsay.

Q. I understand. And apparently, as I understand you and your experts who offer opinions in this case, is that there is a division within the medical/dental community regarding that, certain modalities of treatment

and certain diagnoses, and this may well fall into the area.

A. I think that's a reasonable statement.

Q. Okay. Did you become aware that the doctors in Mexico, if you will, had recommended a further treatment for Brian Gortney after the 5/99 surgery?

A. After the 5/99 surgery? I know that Brian -- I don't know specifically, but I know that Brian was in contact with either Kentucky or Mexico throughout our treatment.

As I told you, I had a phone conversation with Dr. Haley and he had gone to Kentucky once for additional recommendations for a quote/unquote coagulation treatment which I told Brian that I had known nothing about.

Q. What would that be?

A. You'd have to ask them. That they wanted to do some sort of treatment of the blood itself. And again, that I could -- that there was none to my knowledge, no sound medical documentation of that, and that there was no way I could recommend that. And therefore he chose, on my recommendation, not to pursue that coagulation treatment for

cavitation syndrome. Did I answer your question completely?

Q. That's okay. That's all right. Tell me about infections of the oral cavity. Are you of the opinion that they do or do not spread to other parts of the body?

A. Am I of the opinion that they do or do not -- yeah, if you have a flagrant separative infection, separative meaning of bacteria origin producing pus, can it spread to other parts of the body? Yes. First it spreads locally and then systemically and it's commonly referred to as of odontogenic origin or tooth origin.

Q. Do you order biopsies frequently in your practice?

A. Sure.

Q. Do you have roughly an idea how many on a monthly basis?

A. You're talking about interoffice procedures, that type of thing?

Q. Well, I guess we have to go beyond that.

A. On an average month how many biopsies do I do on patients? For various reasons being hard tissue, soft tissue, of the mouth, of the

face, of the head and neck, I don't know. Roughly probably 30 a month. Probably one a day.

Q. How about of the mouth?

A. Depending on the month, most of those would be in the mouth. Some of them would be in the face, some of them would be in the neck, but the majority of them would be within the mouth or the oral cavity.

Q. Was there any recommendation by you at or about the end of your treatment of Brian of a 6th nerve block lesion or lesion creation?

A. I would not make a recommendation of a 6th nerve block to any patient.

Q. And what does that mean?

A. That you're, in a sense, blocking the cranial nerve No. 6, okay, and I would not make that recommendation for anyone. I would reserve that for the neurosurgeon.

Q. Okay. So was your final diagnosis atypical neuralgia or was that one of your diagnoses?

A. Yeah. I would say that atypical neuralgia, chronic sinusitis and possible cavitation syndrome remained the diagnoses,

potential diagnoses.

Q. Okay. You say possible cavitational syndrome?

A. Even though we found on both occasions no evidence of necrotic bone by pathology.

Q. Okay.

A. Other than after the first surgery, the Kentucky enzyme test which showed, in their opinion, enzymes consistent with osteonecrosis.

Q. What is the Kentucky enzyme test? What is that?

A. Again, that was a test that was brought to me by Brian and Dr. Haley.

Q. So in other words, it was performed in Kentucky?

A. Exactly. Sent by a biopsy specimen done by us.

Q. Okay.

A. And their results I have here and came back consistent with enzyme activity, consistent with necrotic bone.

Q. Is that something we have in our -- okay. I see everybody nodding their head affirmatively.

MR. HENRETTA: Jerry, do we have --

why don't we just get the records marked.

(Discussion had off the record.)

BY MR. HENRETTA:

Q. There was a coagulation study. Isn't that just a term for a thrombotic state? Is that why we're looking for a --

A. Again, I wasn't ordering it. This was the Kentucky folks that ordered it and I believe they termed it coagulation treatment, not a coagulation study. They were recommending some sort of coagulation treatment.

Q. You have no idea what that means?

A. No idea what they're talking about which is why I told Brian I can't recommend it.

Q. Okay. Because --

A. Can't discount it, can't recommend it.

Q. Okay. Because you heard treatments?

A. Yeah. And I believe that's what our notes reflect.

Q. Okay. What, if any, antibiotics did you prescribe or utilize during either one of those surgical procedures?

A. Augmentin.

Q. What is the rate?

A. Augmentin was used postoperatively and preoperatively at different states and intraoperatively. Its comparison would have been Unisom.

Q. Do you know what was used preoperatively?

A. If anything was used -- well, preoperatively prior to the second surgery would have been Augmentin. Postsurgically we chose clindamycin. Preoperatively for the second, I think we chose to wait for cultures so that the cultures were not interrupted.

At that time again, we saw no evidence of swelling, we saw no evidence of separation or drainage and therefore wanted to obtain what we would determine as clean cultures.

Q. Did Dr. Diamantis assist you on both surgical procedures?

A. Yes, he did.

Q. Okay. Would it be proper record keeping for his name to appear on both?

A. Sure.

Q. Okay. Have you seen that --

A. I'll be glad to look at it right now.

record? Okay.

(Short break had.)

(Plaintiff's Exhibits Zak 3 and 4 were marked for identification.)

BY MR. HENRETTA:

Q. We have -- first of all, I want to use -- the next number will be the entire chart of Dr. Zak. We're going put that little exhibit on the top.

Now, we're up to 4 then and 4 would be Lakewood Hospital records so I'm going to show you what's marked as Exhibit 4, okay, and ask you if you can look at that document?

A. Exhibit 4, Lakewood? Yes, I've got it.

Q. Tell me what that represents.

A. It's an operative note that was dictated by me regarding the first surgery which took place on 12/21/98.

Q. Okay. And what's generally included on that -- well, I can see the preop diagnosis, the postop diagnosis.

A. Operation performed, assisting surgeons, anesthesia, fluids, blood loss.

Q. All right. And then I guess co-surgeon on that was Dr. Diamantis?

A. Correct.
Q. All right. Was there anybody else that assisted you in that?
A. No.
Q. Okay. And as far as you know, is that your op note?
A. That is.
Q. Okay.
MR. HENRETTA: Find a home for that. Know that that is -- Brian, you may want to -- just so you know, No. 4.
(Plaintiff's Exhibit Zak 5 was marked for identification)
BY MR. HENRETTA:
Q. Number 5, Doctor, is what?
A. This is an op report from University Hospitals which would be in reference to the 5/24/99 the second surgery.
Q. Okay. Did Dr. Diamantis assist in that procedure?
A. Yes, he did.
Q. Okay. I just -- did they -- other than at the back, I don't know if -- what is that in reference to the back? Is that how UH does theirs? The reason I say it, there's an

assistant surgeon of Dr. Bath and Khanuja --
A. Yeah, Ashoo Khanuja and Manraj Bath were two assisting surgeons. They are residents at University Hospitals of Cleveland who also assisted in the surgery. Dr. Diamantis also assisted in the surgery. This appears to only reference the hip graft though.
Q. I see. Okay.
A. Okay?
Q. All right.
A. And this is not dictated by me, this is dictated by one of the residents.
Q. Okay. All right. I see. I think I asked you earlier about the name of Christian Bouquot, all right, and I believe you said you don't recognize that name?
A. No, I don't.
Q. Okay. There's an article I'm reading and I guess I would just ask you whether or not you know the statement is true. Dr. Bouquot is by far the world's leading expert regarding NICO lesions. Do you know that to be true or not?
A. I don't know Dr. Bouquot so how could I know if he was the expert?

Q. Okay. Well -- okay. Let's see.

MR. MINGUS: What are you reading from, may I ask?

MR. HENRETTA: Something that came off the -- looks like the Internet, NICO -- apparently his website.

BY MR. HENRETTA:

Q. Okay. You haven't heard of him so that's all right. Did you consult with any other surgeons before you performed the surgery on the -- on Brian, the first one or the second one, other than Dr. Diamantis?

A. No. Again we were dealing with at the time a working diagnosis of sinusitis doing a Caldwell-Luc procedure, something that we do many times, and basically taking a glorified biopsy or curettage, call it what you like, both of which are minimally invasive routine procedures for someone of our training and didn't feel it necessary to do so.

Q. Did you refer to any medical literature for that procedure?

A. To do those procedures? No. Again, those are commonplace procedures in our practice.

Q. Is there medical literature that addresses the -- that — those procedures that you performed?

A. The Caldwell-Luc procedure? Sure there is.

Q. Okay. And is there one that has a name that stands out in your mind?

A. There's hundreds of them.

Q. Really?

A. Yeah.

Q. Do you have some in your office?

A. In my office? No. There's textbooks that describe the procedure in my office, but not journal articles.

Q. What are the textbooks?

A. That would be described in ENT textbooks as -- you know, as well as frequently described throughout ENT journals as well as oral/maxillofacial journals, the Journal of Oral Maxillofacial Surgery.

Q. Are there any leading authorities in that field that you know of?

A. I don't know. No, not off the top of my head.

Q. Now, you use antibiotics in all of your

surgeries?
A. Yes.
MR. MINGUS: And you're referring to Caldwell-Luc surgeries?
MR. HENRETTA: Well, it was more general than that.
THE WITNESS: In general, do I use them in all of my surgical procedures, yes.
BY MR. HENRETTA:
Q. Preop?
A. Well, they're given at the time of preop holding or at the commencement of the surgery. Usually there's a standing order and if there's any derivation from that standing order, we'll tell the anesthesia team and they'll institute that at the time.
Q. Again, I think you used some antibiotics with Brian. How did you use them? Describe how you administered --
A. What time are you referencing?
Q. Well, let's go with each surgery preop.
A. Again, that would have been given intravenously by the anesthesia team.
Q. Okay. And who selects the antibiotic?
A. The surgeon.

Q. So did you select it?
A. Yeah.
Q. Okay.
A. Yeah.
Q. And I don't know if you told us what that was or not?
A. I'd have to look. It's either going to be Unison or Ancien.
MR. MINGUS: Which one do you want him to look for, Tom, first, the Lakewood?
MR. HENRETTA: The first surgery, Lakewood.
MR. MINGUS: Here's the Lakewood records, so...
THE WITNESS: Beginning right here? Beginning right here?
MR. MINGUS: What are the orders?
THE WITNESS: It's going to be in the anesthesia a record. Yeah, I see a notation for Unison denoted here.
BY MR. HENRETTA:
Q. Okay. Now, was that done preoperatively or postoperatively or both?
A. I would imagine it's both. I'm looking specifically at the postoperative order, but I

would imagine it was done both.

Q. More important question then would be the second surgery. You have bone graft in that one?

MR. MINGUS: UH, Tom?

MR. HENRETTA: Yes. That would be No. 5.

THE WITNESS):: No, it's not going to list it there. You have to look in the hospital records.

BY MR. HENRETTA:

Q. Okay.

A. Here it appears we chose cephalazone which again would be the preference in harvest of a hip graft.

Q. And when was that administered?

A. I saw one notation for it there at -- looks like 21:00 hours, but I'm sure there are other notations here.

Q. Is that before surgery?

A. I'll have to look. Shows up again there. Wait a minute. Let's see. Yeah, Keflex. It says Keflex right here.

Q. When was that?

A. It's the anesthesia record. This would

be in the operative report.
Q. Okay. So far as you can tell, Keflex and is that the only one --
A. Yeah, that's the only one.
Q. -- that was done before the surgery?
A. We chose that due to the hip graft.
Q. Okay. Well, what antibiotics -- well, I hate to -- I want to know what antibiotics you had prescribed for Brian to take after the surgery?
A. After the surgery? Let me check here. Can we go back to UH? Sorry.
MR. MINGUS: Tab X.
THE WITNESS: I would imagine it would be Keflex or possibly Augmentin, but we'll verify it here by looking, if we can.
BY MR. HENRETTA:
Q. Okay.
(Discussion had off the record.)
THE WITNESS: Your question was what postoperative antibiotics was the patient discharged on. That would have been denoted on the -- either the patient orders or the patient note which seem to be missing from the University Hospitals chart, so we're unable to

find them at the moment.
BY MR. HENRETTA:
Q. Okay. All right. So what we --
A. But presumably it would have been under Keflex.
Q. And why do you say that, because --
A. Not required as a prophylactic. So after a hip graft, that would have been something that would have been done. Once the patient's been given multiple intravenous doses, there's really not a strong reason for it. And the patient very easily could have been discharged with nothing without a concern. However, as a general rule, we tend to give the PO antibiotics afterwards.
Q. All right. Well, where does Keflex fall? I mean, are antibiotics in stages of strength?
A. No, it's a cephalosporin which has good coverage for bugs that would be found on the skin. When you're doing the type of procedure that we're doing on Brian, the mouth is already contaminated with bugs so you are not attempting to eradicate bugs from there. But rather, the hip is a sterile procedure which

you would want to protect the patient for which is why in that surgery Kefzol or Keflex was chosen.

Q. All right. Now, just again, we learned from one of the op notes that Dr. Diamantis did not participate in the hip procedure.

A. Yeah.

Q. I believe -- you stated you think he was there?

A. No, I know he was there.

Q. He was there?

A. Yeah. Dr. Diamantis and I were both there during the entire surgery. When you go to a resident-run hospital, the residents are allowed to participate in the surgery. The order of the procedures would have been to open the patient's oral cavity and --

Q. Go ahead, Doctor.

A. -- and determine was the graft indeed needed. Once that was done, one and/or both of us would have gone down and taken the hip graft.

Q. Okay. Now, on either one of the procedures for -- first, of all, the May, '99 procedure, if we could be so general, was

two-fold; is that correct?

A. Yeah. Hip graft and curettage of the area.

Q. Okay. And were there two separate operative notes, Doctor?

A. There should have been. Again, these were dictated by the resident. I know that they went unreviewed by me for some time and then when I think once there was notification of a lawsuit, the hospital requested that I come down and put my signature on one or both of them. And at that time I read the operative report.

I think I made a few errors -- or correction of errors made by the resident or which I thought were made by the resident, and struck those with a line and then I believe the hospital went ahead and corrected those.

Q. Now, the part of the procedure which was the operation as debridement -- I don't know how you pronounce it --

A. Debridement.

Q. -- debridement of the posterior left maxilla and the posterior left mandible, did Dr. Diamantis in that procedure serve as the

surgeon with you as an assistant?
A. No. It was probably more appropriately described as me as the primary surgeon and he as the assistant surgeon, but we were both there. Our input was valued. Both of our inputs was valuable to the patient.
Q. All right. And then Dr. Bath and Khanuja, are these residents?
A. Those are resident doctors, that's correct. So they would have been taking part in the surgery as well.
Q. Okay. Now, I don't know -- this is probably in your -- do you have a -- with page 11, I think you've got your hand on it. Have we discussed that particular operative report earlier or is that not the one we were talking about?
MR. MINGUS: He's got page 8 in front of him. Page 11, this one?
MR. HENRETTA: Yes, 11 and -- okay.
THE WITNESS: Yeah.
BY MR. HENRETTA:
Q. What is the date on that op note?
A. The op note itself?
Q. Yes.

A. As to when it was dictated? This was -- as I described to you, the initial dictation was on 5/24/99 by Manraj Bath and it was not reviewed by me until 8/14/2001 when we were notified that there was a lawsuit. The hospital would not release it until there was a signature on it and I wasn't going to sign it until I reviewed it.

Q. All right.

A. And that's when I made a few corrections to what I deemed as the resident's error.

Q. All right. I want to show you -- I mean, I'm just confused here, Doctor.

A. Okay.

Q. Here is a -- and we probably should mark this.

(Plaintiff's Exhibit Zak 6 was marked for identification.)

MR. MINGUS: I don't think this one came from the UH records, I think it came from their records.

MR. HENRETTA: Okay.

THE WITNESS: Maybe I can help you.

BY MR. HENRETTA:

Q. Here. Let me show you what is marked as Plaintiff's Exhibit 6 and tell me one, what is that; two, is it a complete record. What's missing --

A. Sure. This is -- all I can glean from this -- since there is not the final page behind it so it doesn't say the time and the date that it was dictated -- it is a dictation by the resident. As to whether this is the corrected version or the one that I had a chance to proofread or not, I don't know.

Q. Okay. And who is the surgeon on that particular one?

A. Listed on this as the surgeon is Nicholas Diamantis and assistant surgeon is listed as John Zak. Now, again, this is dictated by a resident. These are residents that served under Nicholas and myself. They don't know whose case it is, who's the primary surgeon, who's doing the assisting, who's not. They're merely doing a dictation based on their job and that's what it's perceived as by a resident doctor, a job.

Q. So is that not correct, that record?

A. It may or may not be. I'd have to read

it specifically and review the notes. What I'm telling you -- and I'll repeat myself -- is that they -- both the hip graft procedure as well as the intraoral procedure were supervised by both of us. They were participated in by both of us. They were dictated by one of the resident surgeons which I never reviewed until requested to by University Hospitals which I reviewed and struck in just a few spots, made notations and returned that to the chart and then University Hospitals retyped that.

Q. Do you have the third page to that?

A. No. It's not. -- this is what you gave me.

Q. Do you have that in your records?

A. I'd be happy to look.

Q. Okay.

A. Which one are you referring to, if I may --

Q. Well, just —

A. It appears to be this right here and there's a third page right here. Again, this is dictated on 5/24 by Manraj Bath, a resident surgeon, and then transcribed on the 26th by the transcription department at University

Hospitals.

Q. Okay.

A. Okay?

Q. All right. Okay.

A. So again, in terms of correctness and errors, it was dictated by the resident after the surgery and whether it is correct in terms of who's listed as the surgeon, assistant versus assistant surgeon, I don't see that as all that relevant.

MR. HENRETTA: All right. Plaintiff's Exhibit 6 is missing page 3. The page 3 is contained in Dr. Zak's record which is under Exhibit 3 in the aggregate form and if we could, maybe -- I don't know.

Your lawyer may just write on there, somewhere so that we know that that particular piece of paper references page -- Plaintiff's Exhibit 6.

MR. MINGUS: Why don't we copy it after the deposition?

MR. HENRETTA: Okay. If you want to keep this over here -- those are -- I know. We want the third page. We want the third page from there to put here so we've got a complete

record.
BY MR. HENRETTA:
Q. Okay. All right. What is the term anaerobic bacterial tests? What does that mean?
A. That refers to bacteria that are anaerobes or are present or prosper devoid of oxygen, anaerobic, okay.
Q. Okay. And did you order those on Brian or for Brian at any time?
A. Yes.
Q. And can you share with me the results?
A. Yeah. They were negative after the first procedure.
Q. Okay. And what are you looking for? Is this a differential diagnosis?
A. Yes. It's eliminating possible causes of what we're trying to eliminate so we sent for culture and sensitivity which would be standard bacteria. We sent for anaerobics, we sent for fungi, we sent for microbacteria, all of which came back negative.
Q. All right. When you saw Brian, is it safe to say that he presented with facial pain?
A. That's safe to say.

Q. Okay. And did -- in the beginning or at any time did you believe that part of that was caused by so-called cavitation syndrome?
A. As I had told you before, he came on initial visit with a working diagnosis of cavitation syndrome and so that was appropriately placed on the differential diagnosis.
Q. Well, I'm asking you: Did you believe that part of the pain was caused by that?
A. By cavitation syndrome? I was unsure.
Q. Okay. All right. Fair enough. Okay. As a -- do you consider yourself an oral surgeon?
A. I consider myself an oral maxillofacial surgeon. An oral surgeon, in my mind, is someone who restricts their care to dental processes or exodontia of teeth. An oral maxillofacial surgeon is someone who incorporates the facial skeleton, perhaps the head and neck and reconstructive in nature.
Q. Okay. Would then -- an oral surgeon, I know them as those who pull teeth, correct?
A. Right.
Q. Now, remember, I used to get sent to an

oral surgeon.
A. I'll let you say that.
Q. All he did was pull my teeth.
A. I'm being diplomatic.
Q. And are you saying that oral surgeons, unlike maxillo- -- how do you --
A. Oral maxillofacial surgeons.
Q. Oral maxillofacial, you treat — your branch of medicine/dentistry treats diseases of the mouth, I would imagine, as one of the things you do?
A. One of this things. Mouth, face, head, neck.
Q. Okay. And you deal with infections, don't you?
A. That's part of our treatment.
Q. Okay. Is there -- now, do you believe that Brian presented with a disease of the mouth?
A. A disease of the mouth?
Q. Yes.
A. I'm not sure what you mean by that.
Q. Well, was his mouth, his dentition normal?
A. No. I think that his -- I think that

his -- on presentation, his clinical symptoms and signs, be they radiographic or clinically, were more consistent with sinus and facial issues ratner than diseases of the mouth.

Q. Okay. Did you detect the presence of infection?

A. No. There was no evidence of drainage or swelling at. that time. We were basing our decision for biopsy and/or curettage, whichever you care to call it, and the Caldwell-Luc procedure based on the radiographic findings of the CT as well as the patient's symptoms.

Q. Well, I guess the questions would be -- this goes back to the differential diagnosis. What did you do to rule out the presence of infection, if any?

A. We took biopsies and cultures. We took biopsies and cultures.

Q. Okay. All right.

A. All of which came back as negative.

Q. Explain the necessity of the bone graft in Brian's case.

A. Sure. You're referring to the second surgery?

Q. Yes.

A. Again, this is a patient who had multiple procedures done. There -- by his own description as well as our description -- there was a concavity created there where these multiple procedures were. We were contemplating going in and doing further curettage and removal of bone and we thought it necessary to reconstitute the area, again, to allow him to have a normal anatomy to the posterior palate.

Q. Do you know whether or not any infection remained in Brian's -- oh, I don't know if you want to call it cavitation in his mouth -- his jaw after surgery two?

MR. MINGUS: Objection. You're saying remained and I think you haven't established that it was there to begin with.

MR. HENRETTA: Okay.

BY MR. HENRETTA:

Q. Was there any infection? Did you learn about the presence of infection?

A. There was no evidence of infection clinically at the time of operation. And then following our care, we know that he had a negative gallein scan which showed no evidence

of infection.

Q. Therefore I take it you didn't remove any necrotic tissue?

A. Well, what we removed was questionable tissue and that came back as healthy new bone which is why when Brian prompted to re-operate again for another curettage procedure as recommended by treatment of cavitation syndrome, I could not agree with that and I could not move forward with that treatment plan.

Q. When was the questionable tissue removed?

A. At both surgeries.

Q. And what is it that gives rise to that opinion? Why do you say questionable? What is it about the tissue?

A. Well, when we looked at it, it was not clear, obvious osteonecrotic tissue. It was not black, it was not separative. There were no signs of particular pathology to it. It looked or appeared somewhat different.

We biopsied the area in light of his symptoms and subsequently came back with a negative result in terms of necrotic bone and

that's when we said that we're done there.
Q. On the antibiotics, do you know for how long a period of time he was prescribed the Keflex after surgery number two?
A. It would have been for a week and no more.
Q. One week?
A. A week, five to seven days, and no more. Again, at the time of surgery the IV antibiotics would be been sufficient.
Q. What is the normal dose and what was his dose?
A. Would have been 500 milligrams TID, three times a day.
Q. Three times?
A. Again, as prescribed.
Q. Again, would you be able to tell us what that specific prescription was?
A. Again, that would have been in the University Hospital records and they don't seem to be in there.
Q. Okay. All right. Let me move on to some other areas here and try to -- patients with facial pain, if I could be so general, how many of those do you see in a week?

A. In a week?
Q. Yes.
A. On an average week I would say two to three.
Q. Okay.
A. Specifically neuralgic type pain. I see people with facial pain every day, you know, 10 to 12 a day, but other than obvious odontogenic origin, I would say two to three a week.
Q. Okay. At the time you treated Brian Gortney, who worked for you and Dr. Diamantis on your staff?
A. At -- where he was seen initially?
Q. Yes.
A. That would have been Jenny Foss, Christine Pannier. They were dental assistants, and Charlene Rundquist who was a front office person.
Q. Are they still employed by you?
A. One of them is.
Q. Who?
A. Charlene Rundquist.
Q. Do you know where the other two would have gone?
A. No idea.

Q. Would Charlene know?
A. She might know where Jenny Foss is, but that's about it.
Q. Okay. Now, you're not sure what -- because you never saw the records -- what the Mexican procedure that predated Brian's visit with you, you're not sure what that procedure was?
A. I have the description that Brian gave me.
Q. Okay. Do you -- and you don't need to relate that to us again, but do you believe that procedure, in light of what Brian came to see you for --
A. Sure.
Q. -- okay. Do you believe that that procedure impeded your ability to help him?
A. I believe it clouded the picture.
Q. Okay. If you can sort of expand on that a little bit?
A. Sure. Any time you have multiple practitioners treating a patient, it clouds the picture in terms of what's causing what. Was his questionable osteonecrosis caused by the procedures done in Mexico under uncertain

conditions or were they preexisting? Hard to say.

i think that's a major question which is one of the reasons why I couldn't recommend that he travel back to Mexico to have uncertain procedures done under uncertain conditions, especially when he's sitting in a mecca for healthcare in northeast Ohio.

Q. Did you learn from any source of his subsequent treatment -- now, when I say -- I mean, after your treatment, did you learn of any procedures Brian underwent after he saw you?

A. Sure, just by conversation with my attorney --

MR. MINGUS: Which -- allow me to --

MR. HENRETTA: I understand. Privilege.

BY MR. HENRETTA:

Q. I just want to know did you read expert --

A. It's just real minimal as to my knowledge afterwards and I'll be happy to share that with you.

Q. Okay.

A. And that is that he did have a negative gallein scan showing no evidence of osteomyelitis of the area in question.

Q. Okay. Now, where was that done?

A. I don't recall. I remember reading the report and I believe it was ordered by an ENT surgeon, perhaps the fellow you mentioned earlier, Ossakow, and that showed no evidence of osteomyelitis. And that would have been, I think, maybe three or four months after our departure from his care.

And then I had heard through our attorney that he had --

MR. MINGUS: No. Not allowed to --

THE WITNESS: Okay.

MR. MINGUS: -- discuss that.

BY MR. HENRETTA:

Q. Okay. Did you read any expert reports of either Dr. Hussar, Dr. Armitage or Dr. Hauser? Have you read those expert reports that you can tell me --

A. Before coming in nere I looked at Dr. Hussar's report.

Q. Okay. And what is your opinion of Dr. Hussar's report.

THE WITNESS: Am I allowed to give my opinion of Dr. --

MR. MINGUS: You want to know of his opinions?

MR. HENRETTA: Well, he's got that expert hat on now.

MR. MINGUS: You want his opinions in his report? You want to show it to him, maybe because -- I just --

to him again. Let's find Hussar and Hauser and Armitage and I think there's --

MR. MINGUS: I think I have Hussar's report here.

MR. HENRETTA: Hussar did one, Hauser did two, maybe. We don't have Dr. Hussar.

MR. MINGUS: Do you want me to go get Hussar?

MR. HENRETTA: Yes. We probably

(Discussion had off the record.)

BY MR. HENRETTA:

Q. Okay, Again, now we're back to you're being an expert. Well, first of all, maybe you

can just tell me, do you know what opinions you're going to offer in this case?

A. In regards to?

Q. In regards to the allegations of the plaintiff. Now, the plaintiff is saying that you, through your treatment of him, breached the standard of care and that breach of standard of care caused injuries to him.

And you have probably read, I would imagine, your expert's reports?

A. Not in detail.

Q. Okay. Well, we're going to have to go through that. And I just want to know what opinions -- because, you know, no longer do we have trial by ambush in this country, at least to the extent that we get prepared. And we're entitled to learn -- and that's why we're here today --

A. Sure.

Q. -- what opinions people are going give at trial so after it's all said and done, something new comes off the witness stand. So I just want to know what opinions you're going to offer at trial in this case?

MR. MINGUS: I can help you out,

Tom.

MR. HENRETTA: Okay.

MR. MINGUS: I'm going to ask him about his care, whether it was reasonable and comportive with the standard of care and whether anything he did caused injury to Mr. Gortney. And that's really about what I can think of at this time asking him.

MR. HENRETTA: Okay. All right. I guess what I'm looking for -- and I don't want to have to come up -- are standards of care, specifics that we are not addressing with our -- you know, either are not addressed by Armitage or Hauser and that Hussar doesn't address it and all of a sudden we've got another expert, the defendant, who comes up with a new theory. I just want to be ready for it.

MR. MINGUS: Tom, I identified him as an expert to testify that his own care was reasonable. There was some issue with the Court of Appeals' opinion that came out of Cuyahoga County about a year or year and a half ago that reports were required for experts. I didn't know if it was going to be required for'

this judge in this case.

MR. HENRETTA: I understand.

MR. MINGUS: Generally speaking, it's been my experience with experts that defendants will typically get up on the stand and typically say my care was reasonable within the standard of care and I didn't cause harm. And that's really about all I'm going to have him do.

MR. HENRETTA: That's fine.

MR. MINGUS: The affidavit was a formality in light of that Court of Appeals' opinion --

MR. HENRETTA: I understand.

MR. MINGUS: — just to put you on notice that he's going to say his own care met the standard of care.

MR. HENRETTA: I understand. Okay. All right.

(Discussion had off the record.)

MR. MINGUS: And a part of that, Tom, certainly, if appropriate, we might show him and say Dr. Hussar accused you of this. What do you think?

I can't possibly know what Dr.

Hussar's going to say until we pull --
(Plaintiff's Exhibit Zak 7 was marked for identification.)
BY MR. HENRETTA:
Q. All right. Doctor, I've shown you what's been marked as Plaintiff's Exhibit No. 7. I will tell you that that is a letter directed to me by Christopher J. Hussar, DDS, DO and dated -- not dated. I don't know. It's not dated.
A. Uh-huh.
Q. I had provided him with certain material and the records that we had and in this letter to comply with a court rule, Dr. Hussar has offered various opinions that ycur lawyer is going to discover when we go to Reno in a week or so. In other words, the same process that we're going through, I presume Ron Mingus is going to go through the same one out there.
So I would ask you to just look at chat and his is short so it won't take us too long. His first sentence, what is your -- I don't want to say reaction, but what is your opinion to that first sentence?
A. For the court recorder's benefit, "After

reviewing the materials supplied by Mr. Gortney regarding his treatment by Dr. Zak it is apparent 'chat the standard of care was violated in the fact there was a failure to diagnoses and treat infection of the oral cavity." My response to that sentence is that is incorrect.

Q. And it is incorrect because?

A. For multiple reasons. One is that there were the possibility of multiple diagnoses at the time of intervention and that there was no evidence of -- collected that supports the idea of infection of the oral cavity.

Q. Okay.

A. And part of what our treatment was was to narrow the diagnoses and determine whether this was infection of the oral cavity.

Q. So you disagree with that first sentence?

A. I disagree with the first sentence.

Q. All right. So then how about No. 2, "Mr. Gortney had the infections prior to any intervention by Dr. Zak or Dr. Diamantis."

Do you disagree or agree with that statement?

A. I can't speak to whether they were

infections or whether it was necrotic bone or what the diagnosis was prior to us.

Q. He says that -- well, one, he says there were obviously misdiagnoses and I think you've already disagreed with that.

He further says, doesn't he, that, e biopsy reports or the procedure performed by these gentlemen" -- I guess he means those two together -- "were totally unnecessary and essentially useless."

What is your opinion there?

A. My opinion of that statement is I totally disagree. Whether you're describing something as a biopsy of bone or whether you use the terms decortication, saucerization and curettage, I generally would think them much to be the same clinically in what you're doing, okay. A biopsy, simply described, can be used synonymously with those other terms.

So if he's saying that our bone biopsy and its results were unnecessary and useless, then he is also saying that his decortication, saucerization and curettage is useless because essentially, in my mind, they're one in the same.

Q. All right. The next one is, "As infections in the mandible and maxilla do tend to disseminate the delay in not treating the actual condition most likely resulted in bodily damage."

What is your reaction to that?

A. First off, tend to disseminate I think is a misrepresentation. Could disseminate, yes. And I think that many experts in the medical field would -- would have content with the comment that it causes bodily damage, especially in the absence of active infection and the production of purulence.

Q. Of what?

A. Purulence. Pus.

Q. Okay. "As *of* this day it is most likely," he says, "that Mr. Gortney will require further surgical interventions especially to his left maxilla and mandible as evidenced by the nature and consistency *of* my surgical interventions."

Do you know anything about Dr. Hussar's surgical interventions?

A. That have occurred with the patient?

Q. Yes.

A. Other than what I'm reading here, no. However, I read this statement and again, I contend that he contradicts himself saying that a biopsy of bone or a removal of bone and decortication, saucerization and/or curettage -- again, whichever term you'd like to use -- is required and that's recommended treatment.

So again, I find contention with his comments in that he contradicts himself saying that multiple biopsies and curettage of bone is unnecessary, but yet decortication, saucerization and curettage is necessary.

Q. What is meant to you by that last sentence of that paragraph that you're reading right now?

A. I'm sorry?

Q. What is meant by this last sentence to you? How do you interpret this last sentence, "The surgeries themselves"?

A. I think he's referencing the surgeries that he's planning and so he's saying the surgeries tnemselves would most likely resemble what he, meaning Dr. Zak, has done.

Q. Okay.

A. So I'm a little confused. It seems as

though he contradicts himself. He says my surgery is unnecessary, but yet says he plans to do the same surgery.

Q. Okay.

A. That's how I read it.

Q. Okay.

A. Is that fair?

Q. I just wanted to know your opinion. That's fine.

A. Okay.

(Plaintiff's Exhibit Zak 8 was marked for identification.)

BY MR. HENRETTA:

Q. All right. I want to show you now 8, Plaintiff's 8, sir. It was -- first of all, have you seen that before?

A. Again, in passing in my attorney's office before arriving here. Have not read it in detail.

Q. Okay. He, Dr. -- well, let's ask you about him. Do you know Dr. Hauser, Michael --

A. Yes, I know Michael Hauser.

Q. Can you tell me about your relationship with Dr. Hauser?

A. My exposure to Dr. Hauser was through

the Mt. Sinai Medical Center facility which is now closed. Dr. Hauser was the director of oral surgery at Mt. Sinai. I did some of my rotations there at Mt. Sinai Hospital.

Q. Would you characterize your relationship with him as personal or professional or both?

A. Strictly professional.

Q. Have you ever served as an expert witness in any case --

A. No.

Q. -- involving professional negligence?

A. No.

Q. Okay. That is to say you've not given deposition testimony in any case other than that dental proceeding in this case and the one involving the hospital and Peter Weinberger who was representing the plaintiff in which you were dismissed?

A. That's correct.

Q. Okay. Would you read this letter from beginning to end, Dr. Hussar -- Hauser -- excuse me -- July 19, 2001 letter, Plaintiff's Exhibit 8?

A. You'd like me to read it?

Q. Have you read it?

A. No. From beginning to end, no.
Q. Well, I need to know what you think about it so I'm going to run to the restroom. Why don't you look at that?
(Short break had.)
BY MR. HENRETTA:
Q. All right. Have you now read -- I know it's only been in the last five minutes -- Dr. Hauser's report?
A. Yes, I have.
Q. Okay. And I don't want to go through it line for line because it takes too long. Is it essentially your opinion that you are in agreement with Dr. Hauser?
A. Yes, it is.
Q. Because he makes various conclusions.
A. Yes, it is. Essentially I share the same opinions.
Q. Okay. Was there anything in here that you disagreed with?
A. Just chat he failed to note when describing some of patient's visits that -- specifically I'm going refer to the entry towards the bottom of page 2, second paragraph up, he states that Mr. Gortney continued to

have pain and some yellow mucous draining from the lower sinus.

He failed to note that that was by patient recollection, not by clinical exam, but he does later state that there is no drainage or swelling ever evident by our exam.

Q. I missed that, Doctor. Where is that?

A. Page 2, second paragraph on the bottom, "By 7-28-99 Mr. Gortney continued to have pain and some yellow mucous draining."

Dr. Hauser fails to note that that's per patient recollection, not by clinical exam, but he does -- later in his summation does state that swelling and drainage was never evidenced by a clinician, it was only by Mr. Gortney's recollection.

Q. Okay. The anaerobic -- how do we pronounce it?

A. Anaerobic, yes.

Q. Could you tell us where -- in your records where the negative results were so we could note it?

A. Yes. That was Lakewood Hospitals notes ana it's right here. Let's see. That's fungal, no anaerobes culture. Lakewood

Hospital.

Q. All right. Okay. All right. Here's another one he did. He submitted -- and this is much shorter --

A. Let me return this back to --

Q. Yes, that's our exhibit. Here is number 10. Excuse me, 9.

(Plaintiff's Exhibit Zak 9 was marked for identification.)

BY MR. HENRETTA:

Q. Okay. In front of you now, Doctor, is No. 9. It's the October 19th, 2001. If you could just -- and it won't take you as long.

A. Okay. Want me to just peruse this?

Q. I'm looking for the same thing, agreement, disagreement, problems, that sort of thing.

A. Okay.

Q. All right?

A. Do I agree? Yeah, essentially I do agree with what Dr. Hauser is stating on that form.

Q. All right. How long has Dr. Hauser been practicing --

A. I don't know.

Q. -- medicine? Well, how old is he roughly?
A. He's roughly 50.
Q. Okay. All right.
A. And he may hit me for that estimate or he may thank me. I don't know. I don't know his age and it's a substantial amount of time he's been practicing.
Q. All right. Well-regarded, I guess, in the --
A. Extremely well-regarded.
Q. Okay. Did -- now, did you read Brian Gortney's deposition testimony that was taken earlier in this case?
A. No, no. Have not read it.
Q. Okay. All right. Let's take a look at -- who is Dr. Keith Armitage? Do you know him?
A. I know his name. I believe he's chief of medicine or internal medicine, I think, of University Hospitals of Cleveland.
Q. You don't know him personally?
A. Personally, no, I don't. Nor professionally for that matter.
Q. Okay.

MR. MINGUS: It's my understanding Dr. Armitage is not going to testify on the standard of care. He's proximate cause.

MR. HENRETTA: Oh, okay. Is that right?

MR. MINGUS: He's not an oral maxillofacial surgeon.

MR. HENRETTA: I see that. Okay. Okay. Okay.

MR. MINGUS: At least with regard to the surgery itself.

MR. HENRETTA: All right.

BY MR. HENRETTA:

Q. Okay. I don't need to talk about him other than you have no personal relationship with him?

A. No, I don't.

Q. Okay. I want to just go over a few more things, Doc, and see if we -- the sample for the anaerobic biopsy, how was it transported or gotten to where it had to go? How did you get it there?

A. That would have been up to -- to the OR staff. A fresh sample was sent, handed off to the back table, and it was requested that

culture sensitivity, anaerobes, microbacterium be tested. That's not something the surgeon generally takes care of.

Q. Okay. Do you -- I want to ask you whether or not you agree with some of these statements --

A. Okay.

Q. -- whether or not the standards of dental practice require that prior to an examination that a record be made of the patient's chief complaints along with a record of the patient's medical and dental history. Do you believe that's good practice?

A. Do I believe it's good practice for a dentist to make documentation of that? Sure.

Q. Okay. In your area, do you believe that it is of good practice to conduct, in the clinical examination process, an extra oral examination of the facial area, neck, swelling, that sort of thing?

A. Sure, as was done in this case.

Q. And would that include the temporal mandibular joints as well?

A. Sure.

Q. Do you think it is -- would be

substandard not to conduct that type of examination?

A. I suppose it would depend on what the patient was presenting for.

Q. Well, how about in Brian's case?

A. The examination that you reference was done, and if I recall correctly, there was nothing extraordinary about it.

Q. Can you characterize -- because there's, really two different, I guess, medicines -- well, how does medicine, medical practice differ from dental practice? Is there any way you can characterize that? I mean -- or is that just --

A. I'm not sure what your question is.

Q. Well, someone says you're a medical doctor --

A. I think you could write a book on that.

Q. -- okay you're a dentist. Well, what's the difference between a medical doctor and a dentist, a medical doctor and a dentist? What would you say?

A. What I would say, in my practice we utilize some of our dental knowledge to better treat the patients as well we use our medical

knowledge to better treat the patient. It really is a unique subspecialty, if you will, that allows, I think, the patient population to receive extraordinary care where they've got someone with complete dental knowledge and complete medical knowledge, able to bring that together in one practitioner which is extremely unusual.

And I think that's based on just the few numbers of those of us who have the degrees, but also practice to the scope of medicine and dentistry that we do in our practice.

Q. Do you know anything about the transportation of biopsy tissue or you do not get involved in that?

A. Again, I don't get involved with that ever.

Q. I imagine that's OR staff?

A. Exactly. It's OR staff and OR controlled. Hospital run. That's not done by the surgeon.

Q. Okay. Is it fair to say that oral and maxillofacial surgery is a specialty that concerns itself in some respects with the

diagnosis and treatment of infections and diseases of the teeth, Jaws and associated structures?

A. Yeah.

Q. Yes?

A. Yes.

Q. Okay. I don't know if we can really define this, but in your field, you know, we hear these terms in a lot of medical and dental fields and they go like this: Well, let's do some conservative treatment or let's do some aggressive treatment.

Can you opine on the difference between those two and maybe give an example?

For example, Brian presents with what he presented and you have some sense of his self-diagnosis and something that happened in Mexico. What is the conservative treatment for his problems?

A. I think that depends on the reference point in the frame of mind. Some physicians would consider some surgical intervention as very conservative depending on what it was. Others would consider it radical. Depends on, I would think, your reference point, where your

training comes from, and what is perceived by you and your patient population as was conservative versus aggressive.

Q. Well, what would you consider your treatment?

A. Conservative, minimally invasive surgery that was performed. I wouldn't consider anything we did as extreme.

Q. So you're equating extreme with aggressive, apparently leaning that way?

A. I think that's fair.

MR. HENRETTA: I think that's all for you, Doctor. Let me check with the folks.

(Discussion had off the record.)

(Plaintiff's Exhibit Zak 10 was marked for identification.)

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(Deposition concluded at 5:34 o'clock p.m.)

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I, JOHN F. ZAK, M.D., D.M.D., do verify that I have read this transcript consisting of one hundred and sixty-eighr (168) pages and that the questions and answers herein are true and correct with corrections as noted on the errata sheet.

JOHN F. ZAK, M.D., D.M.D.

Sworn to before me, ----------, a Notary Public in and for the State of ----------, this ------- day of ----------, 2003.

Notary Public in and for the State of ----------.

My commission expires ----------.

JOHN F. ZAK, M.D., D.M.D.

-Page-	-Line-	

C E R T I F I C A T E

STATE OF OHIO,)
) SS:
SUMMIT COUNTY.)

I, Kelley E. Spears, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named witness, JOHN F. ZAK, M.D., D.M.D., was by me first duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by the witness was by me reduced to Stenotypy in the presence of said witness, afterwards transcribed upon a computer; and that the foregoing is a true and correct transcription of the testimony so given by the witness as aforesaid.

I do further certify that this deposition was taken at the time and place in the foregoing caption specified, and was completed without adjournment.

I do further certify that I am not a relative, employee of or attorney for any of the parties in the above-captioned action; I am not financially interested in the action; and I am not, nor is the court reporting firm with which I am affiliated, under a contract as defined in Civil Rule 28(D).

IN WITNESS HEREOF, I have hereunto set my hand and affixed my seal of office at Akron, Ohio on this 15th day of August, 2003.

_____

Kelley E. Spears, a Notary Public
in and for the State of Ohio.
My Commission expires June 3, 2004.