IN THE COURT OF COMMON PLEAS

MAHONING COUNTY, OHIO

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PATRICK LORELLI, etc.,

Plaintiffs,

vs. Case No. 00-CV-539

A. JAMES GIANNINI, M.D., et al.,

Defendants.

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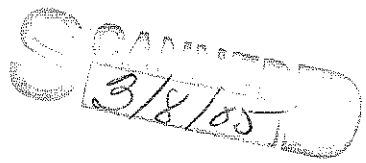

Deposition of:

RONALD J. DIAMOND, M.D.

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Date: Wednesday, October 8, 2003

Time: 3:10 o'clock p.m.

Reported by HEIDI L. DAVIS

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EXAMINATION INDEX

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DEPOSITION of RONALD J. DIAMOND, M.D., a witness in the above-entitled action, taken at the instance of the plaintiffs, under the provisions of Chapter 804 of the Wisconsin Statutes, pursuant to notice, before HEIDI L. DAVIS, a Notary Public in and for the State of Wisconsin, at the offices of Wisconsin Psychiatric Institute and Clinics, 6001 Research Park Boulevard, in the City of Madison, County of Dane, and State of Wisconsin, on October 8, 2003, commencing at 3:10 o'clock p.m.

A P P E A R A N C E S

HOWARD D. MISHKIND,
BECKER & MISHKIND COMPANY, LPA,
Attorneys at Law, 1660 West Second Street,
Suite 660, Cleveland, Ohio, 44113,
appearing on behalf of the plaintiffs;

WILLIAM E. PFAU, III,
PFAU, PFAU & MARANDO, Attorneys at Law,
P.O. Box 9070, Youngstown, Ohio, 44513,
appearing on behalf of the defendant
A. James Giannini, M.D.;

MICHAEL D. SHROGE, (By Telephone),
REMINGER & REMINGER COMPANY, LPA,
Attorneys at Law, 1400 Midland Building,
101 Prospect Avenue West, Cleveland, Ohio,
44115-1093, appearing on behalf of the
defendant Dan Newman, M.D.

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(Exhibits 1 through 4 are marked for identification)

RONALD J. DIAMOND, M.D.,

called as a witness, after being first duly sworn in the above cause, testified under oath as follows:

EXAMINATION

BY MR. MISHKIND:

Q Would you please state your full name for the record.

A Ronald J. Diamond.

Q And you are a physician?

A Yeah.

Q I understand you are a psychiatrist, is that true?

A Yes.

Q Dr. Diamond, my name is Howard Mishkind and I represent the Estate of Lawrence Lorelli in connection with a lawsuit that's been filed.

And it's my understanding that you have been retained on behalf of Dr. Giannini and his corporation to testify as an expert in their defense at the time of the trial of this matter, is that true?

A That is correct.

Q What I would like to do is have you identify for the record plaintiffs' Exhibit 4, which was marked before we began the deposition.

A It's a slightly out-of-date version of my CV, not materially different from the current version.

Q How out of date is it?

A I think it's more than a year old. It would only miss -- it's from June, '01, which means it misses some current publications and some current presentations.

Q Is there a current CV that is prepared but not printed out?

A At home, in my home computer. I could give you an updated version.

Q If you would do that --

A As I say, it would not -- I think for, my job description titles have not changed in that time, but I would be glad to do that.

Q All it will have is some additional publications and perhaps some speeches and things of that nature?
A Yes.
Q If you would provide a copy to Mr. Pfau and then he will send a copy to me.
A Sure.
Q In looking at your CV, Doctor, in the category of Consultant/Expert Witness for Class Action Litigation, there are a number of positions that you have held that are described on page 3 of your CV, is that true?
A Yes.
Q Can you tell me a little bit about what capacity you have served as an expert in this class action litigation referenced here?
A I was an expert witness in some cases that were brought in California and in Maine. They were all many years ago.

They were all basically large system change type rather than individual malpractice type situations.

Q What do you mean by that?
A That means an attempt was made to get a court injunction to change how the system of care operated and put more money into the systems of care. There was not an attempt to get redress for individual claims.

Q Were these malpractice claims?
A No.
Q Who were you serving as an expert on behalf of in the class action litigation?
A In all cases they were public interest law firms that were suing county systems of care or state systems of care trying to get those systems of care to change.
Q And those class actions were in California?
A California and Maine. That may have been old enough that it dropped off my CV.

And I was also involved after a judicial finding in Washington, D.C., that was post, posttrial.

Q When you say after judicial finding, what do you mean by that?
A There was a court master appointed in Washington, D.C. and I was brought in as a consultant expert witness to the master to see if certain court-ordered changes were in fact taking place.
Q And this all had to do with provision of care as opposed to standards of care?
A I'm not sure I understand the difference.
Q Well, you were testifying as an expert on behalf of public law interests?
A Right.
Q And your testimony was that the system in the various

states needed to be changed?
A Correct.
Q And what's, what essentially were you testifying needed to be changed?
A Well, for example, in California, I was testifying that large numbers of people were ending up involuntarily committed to hospitals that could have been treated in the community had community services been available.

In Maine it was largely the same thing, the people were staying at the state hospital, state institution and other people were found to be homeless, when in fact more adequate services would have allowed those people to have stable housing outside of hospital systems.
Q What states are you licensed in?
A California and Wisconsin.
Q Have you actually practiced in California?
A I was a resident there. I have not practiced there since I finished my training.
Q Have you ever practiced in the State of Ohio?
A No.
Q Your practice here in Wisconsin, is it a clinical practice?
A It's a bit complicated. I spend half my time as a

faculty person -- actually I'm full time at the University of Wisconsin faculty. As part of that, I have an outpatient clinical practice, garden variety psychiatry, about a day or a day and a half a week.

I'm also the medical director at the Mental Health Center of Dane County, which is the private, nonprofit providing services to county indigent patients. And about a day a week of that is as a consultant tertiary referral providing ongoing patient care to people I have had for a long time.

Q What else do you do with your professional time?

A I consult with the state one day a week. A lot of that is going around doing difficult case conferences, difficult patient second opinions.

I do teaching. I try and do some writing. I get involved in some policy issues at the state. I have some administrative responsibilities at the Mental Health Center.

Q How much of your professional time would you say is involved in the administrative function as opposed to clinical aspects of the practice of psychiatry?

A I'm probably a little bit over half time direct clinical, either with my own patients or as consultants to other people's patients or in some tertiary referral. I do second opinions on a variety

of cases.

Q And then the other slightly less than 50 percent of the time is more in the administrative?

A Some teaching and some administrative.

Q How much of that time that's slightly less than 50 percent consists of teaching?

A I'm probably formally teaching now about five hours a week. That goes up and down depending on when seminars start and stop.

Q What seminars or courses are you currently teaching?

A We just ended the emergency psychiatry seminar which is my seminar. We continue the community psychiatry seminar, which is a seminar on how to treat people with serious mental illness in the community.

I just started a best of call. I sit with residents once a week and we talk about the most difficult cases that have come through the emergency room in the last week.

Tonight I'm giving a guest lecture to the school of social work on psychopharmacology. So I have a variety of one-shot guest lectures.

Q I noticed, in doing some research, that you have published, in addition to those items which we will talk about on your CV, but two items that sort of came to the forefront as I did a little bit of research.

One was the Instant Psychopharmacology: A Guide for Nonmedical Mental Health Care Providers.

A Second edition is up on the shelf available for purchase if you would care to see it.

Q The first edition is now out of print?

A I expect so. It's out of date.

Q And then the other one is Breakthroughs in Antipsychotic Medications: A Guide for Consumers.

A Again, it's a book on the new generation of atypical antipsychotic medication. I have been involved in teaching consumers, family members and also nonmedical mental health professionals about medical issues for a long time.

Q Trying to simplify some of the medicine?

A Yes.

Q And also to make sure that nonmedical care providers recognize that there may be organic versus nonorganic explanations for various symptoms?

A We are now running a Friday morning lecture series on medical illnesses that can present as psychiatric problems for social workers, psychologists, for nonmedical people. So if somebody with depression or anxiety walked into your office, what should you worry about medically if you are not a physician.

I'm pleased to see that some consumers and some

family members have also attended that lecture series.

Q Doctor, in looking at your CV, I notice a number of visiting faculty positions as well as invited presentations?

A Yes.

Q Do any of those presentations touch on any of the topics that are germane to this case, and by that I mean anything dealing with the risk assessment or the evaluation of patients that are at risk for committing suicide?

A A number of them involve crisis intervention generally. For day-long workshops and crisis intervention, I typically will get into risk assessment.

And I teach the section here for psychiatry residents on suicide assessment and suicide epidemiology. So that's part of my area of teaching.

Q Let's talk about that for a moment. Is this a clinical or is this a classroom course that you teach?

A It's a very practical seminar for psychiatry residents who are beginning to be on call in the emergency room. Basically --

Q Tell me what it's called again, please.

A It's the emergency psychiatry seminar. It's a practical how-to seminar for young doctors who are

just beginning to take call themselves.

It's basically case based. So while there is reading and some formal discussion, much of the teaching is around suicidal patients, or aggressive patients or difficult patients that people are seeing that week and we talk about it within the context of how to do the assessment, how to intervene.

Q How do you provide the residents with case specific information for purposes of teaching?

A My co-teacher and I have been doing this work for more than 25 years. So we have our own experience.

We try as much as possible to get the residents to talk about the cases that they have seen in the last week or two.

Q Do you provide the residents with any printed material on cases or make available to them information, for example, on the Internet?

A We have handouts and readings for each of the sessions as one would for any other seminar. I don't typically provide cases.

We hope that they provide the cases. They are seeing people in the emergency rooms, so we want them to talk about people that they have recently seen.

Q The handouts that you give, are any of them specific to the risk factors for patients that would increase

the likelihood of a patient attempting to commit suicide?

A I have a handout on suicide assessment and intervention, if you would like to see that.

Q Do you have it here with you?

A It's in one of my piles. I could probably go through and get old copies of it.

Q Okay.

A The seminar just ended, so I'm not yet organized for next year yet.

Q What we will do is we will continue on just so that we don't take too much time, because Bill and I both have a plane to catch to get back to Cleveland, and we will see how we are doing time wise.

If we have time, we will pull it out and I will take a look at it and see if I have any questions. If not, we will have you provide it to us.

Is this document that's in the stack to my right, is this fairly typical of the type of material that you provide to the residents during the emergency psychiatric seminar?

A Right. Basically every week I will hand out readings, some that I have written, some that are from the other literature, to focus the seminar.

Q Other than to the residents here, have any of the

speeches or the invited presentations that you have done locally or out of state been related to the topic of suicidality or the risk factors for suicide?

A Yes. I have taught regularly on general crisis intervention dealing with chronic crisis patients, that is, people who are regularly involved in self-harm behavior, folks with borderline personality disorder, which are people at ongoing high risk.

When I talk about suicide, which is a regular topic, suicidality in people with schizophrenia is always a real fear because 10 percent of people with schizophrenia will eventually kill them self.

So in a variety of clinical areas, suicide is something to be discussed and is part of a regular teaching protocol for a variety of different topics.

Q What about the area of bipolar affective disorder, is that also, in your experience, an area that there is a high incidence of suicide in that patient population?

A Very high. The issue there is while I give overview talks, for example, I just did it for probation officers and for judges around the state and for clergy and different teachings, I wouldn't typically, because of my background and expertise, do an ongoing workshop just on bipolar.

I might do one on schizophrenia or an all day on

general psychopathology that would include bipolar, but bipolar is not a particular academic focused area of mine. I certainly see bipolar patients in my clinical experience.

Q What would you say is your area of expertise within the area of psychiatry?

A People who are difficult to treat, often people with schizophrenia or borderline disorder, or people with bipolar disorder who are considered fairly difficult to treat by other practitioners.

Q Of the patient population that you see out in the community or in clinic, what percentage of those patients are schizophrenics?

A Half.

Q So if I met you at a social function and I was talking to you and I asked you what area, what's your specialty in psychiatry, you would tell me my specialty is treating difficult patients?

A People, yes, community psychiatry, people who are perceived as difficult.

Q Have you ever functioned as a psychiatrist in a psychiatric clinic that was not a community-based clinic, one that was a private clinic that people either had to have insurance or the ability to pay for their services?

A My practice here is actually much more a general garden variety practice. I get some referrals because some people know my specialty area and I get secondary or tertiary referrals there, but in the general intake of the clinic, I have specifically put myself in the general intake rotation rather than letting the referrals just go to my academic specialty to broaden my clinical base. So I'm in the regular intake process and will get intakes once a week in rotation across the board of pathology.

Q I'm looking at, on your CV, you have got videotapes that are referenced?

A They are fairly old at this point.

Q Will your updated CV have newer videotapes?

A No. We have stopped doing that. They just weren't used enough to justify the cost of doing it.

It was an experiment the state did to see if we could distribute material. We are now doing statewide teleconferences and video conferences instead.

Q On what topics?

A We have just finished a series, actually we have one more, a series of statewide trainings for probation officers around the state. The next one is on psychopharmacology.

We had one on borderline disorder. The first one

was on general psychopathology, all of mental illness. That was a video conferencing series that we had.

We do a telephone conferencing series every two weeks the last seven years, that has every topic one could imagine to try and get mental health training out to rural areas of the state, so that, for example, we do topics for front line clinical staff, social workers, psychologists working in rural parts of Wisconsin that might include an update on diagnosis, on psychopharmacology, or suicide assessment, on borderline disorder, on spirituality.

And that's been going for seven years now. I think it's seven years.

That's under the state one-day-a-week contract that I have with them through the department here. They pay the department money and I get to do a variety of trainings of that sort.

Q Looking at this unpublished paper on Psychiatric Presentations of Medical Illness, are you the author of that publication?

A That's one of these things that I never got published but is spread around the Internet actually and has a certain play. That's been updated recently.

Q In fact, is this the --

(Counsel hands witness document)

A Yes, actually.

MR. PFAU: That's probably the updated one.

A It might have been. I don't know what year this is, but this is the Internet version of it. I think there is a more recent version of this.

This is from January of 1990. I'm not sure if that's the most recent version. Things pass around the Internet and you lose control of them.

Q Publications, I see you have published two books, one I think I touched on --

A Both of which you touched on.

Q Both of which I touched on. Do either of those, in your opinion, have any areas that deal specifically with the area of suicidality or risk factors for suicide?

A No.

Q Do any of the papers that you have published have any areas that are relevant to suicide issues?

A The only one that comes to mind is we published a chapter on crisis intervention, which I believe probably makes some mention of suicide assessment, although that's not the focus of the paper.

Q Could you perhaps identify that on your CV and circle the number and also state it into the record.

(Witness examines document)

A I could get a copy of that. Again, suicide is not the central focus of that paper, but I believe it gets mentioned.

Q And just for the record, on page 15 you circled an article which you and Dr. Factor, F-a-c-t-o-r, authored on Emergency Psychiatry and Crisis Resolution in Community Psychiatry, a Practitioner's Manual, and that's a 1996 publication, correct?

A I have copies of that if you would like one.

Q I would like that, if you could. So there is now two items that I have asked you for copies of.

Other than this one that touches on suicidality or risk factors for suicide, the other publications, is it fair to say, are not relevant to the topic of suicide?

A The other published publications. The informal handouts that I use for training would be more relevant. And I will make those available to you.

Q The book reviews, do any of them deal with the issue of suicide?

A I don't believe so.

Q Letters and newsletters, any of them deal with the topic of suicide?

A I don't believe so.

Q You have a category Current Active Research Projects. And I know that the institution that we are at is significantly research based, true?
A Yes.
Q Do any of your current research projects have anything to do with suicidality or risk factors associated with suicide?
A No.
Q Amongst psychiatrists, do you hold yourself out as an expert in the area of suicidality?
A I hold myself out as an expert in difficult behavior, suicide being one kind of that.
Q What component of difficult behavior or what percentage of difficult behavior would you say suicide or suicidality makes up the difficult patient, if you understood what I just asked you?
A If you talk about difficult people, difficult broadly defined, about a third of them are probably at risk for suicide. About a third of them scare other people whether they are actually assaultive or not. And about a third of them are causing problematic behavior that other people don't know how to deal with, peeing in public or just badgering people.

And I get involved, both in my clinical work as a consultant and as a policy person in our local area,

about how to deal with those kinds of behaviors.

Q Have you been involved on the policy level in terms of drafting any guidelines or protocols for practitioners as it relates to recognizing the risk factors that increase a patient's likelihood of attempting to commit suicide?

A No. And in fact, increasingly -- a listing of risk factors may in fact not be worth it. It may cause more problems than it helps, that the current strategy that I and others adopt is to be aware of some of the risk factors but then to think about clinical processes and the ways to extract clinical information rather than a cookbook of if you have five checkmarks or a particular score, you are a particular risk.

The research on trying to predict suicide based on risk factor algorithms demonstrates that it cannot be done that way.

Q So certainly a psychiatric evaluation of a patient, history and historical matters as well as current medical issues, coupled with the common risk factors are what needs to be integrated together, correct?

A Yes.

MR. SHROGE: Objection.

Q So the only item that's specific to your CV, Doctor, that would be relevant to the topics in this case with

a man who committed suicide, who had a history of bipolar affective disorder, who had been a patient of Dr. Giannini's in the past and who contacted his office in 1998 and then the issue of standard of care, which we are going to talk about, the only article that would touch on anything similar to those issues would be the one that you have circled for me, is that true?

MR. PFAU: I'm going to object to the question, but you can go ahead and answer.

A I think that's the only published work.

Q And recognizing that we talked about the material for the residents and the other item that, the other unpublished article that you are going to be providing to me which may or may not touch on that?

A Right.

Q Okay. Thank you.

(Counsel examines documents)

Q You are board certified, is that correct?

A Yes.

Q By what board?

A American Board of Psychiatry and Neurology.

Q Were you successful in becoming board certified on your first attempt?

A Yes.

Q When did you become board certified?
A I believe it was 1977. It might have been '78.
(Counsel examines document)
Q Are you a product of the Wisconsin area?
A No.
Q Where are you originally from?
A I grew up outside of Philadelphia, trained at Stanford in California and came here for an academic job. I am still in my first job.
Q You've never practiced in Cleveland, Ohio or northeast Ohio, have you?
A No.
Q The defendant in this case that you are appearing as an expert on behalf of, Dr. Giannini, do you know him?
A No.
Q Do you know anything about him by way of reputation?
A No.
Q Have you had an opportunity at any time since being involved in this case to talk with him in any respect?
A No.
Q The licensed professional counselor Dr. Newman, who is another party in this case, do you know him?
A No.
Q Do you know anything about his reputation?

A No.
Q Have you talked with him?
A No.
Q The report that you wrote I have marked as plaintiffs' Exhibit 1 and you probably have a copy of it, but just for the record, is plaintiffs' Exhibit 1, which is my copy, a true and accurate copy of your report?
(Witness examines documents)
A It appears to be so.
Q So I will either refer to Exhibit 1 or your report from time to time just so long as we know what we are talking about.
In looking at your file, which you were kind enough to provide to me, other than a few notes, at least one of which I have marked as an exhibit, I don't see that in the course of your review of this case that you made any type of notes, handwritten notes or printed out any typed notes?
A No.
Q So for purposes of your report, you would receive certain information and you were asked to assume certain facts by Mr. Pfau in arriving at the opinions that you expressed in your report, correct?
A Correct.
Q And obviously, depending upon the truth or the

accuracy of those assumed facts, that may or may not impact the opinions that you hold in this case, true?

A Correct.

Q We will talk about those assumptions a little bit further as well. Beside the information that was provided to you by Mr. Pfau for purposes of your report, did you review anything else to arrive at any of the opinions that you have expressed in your report?

A I had access to the various other reports from other physicians. I saw Dr. Morrison's after I had written mine, but I don't think that they materially influenced my opinion.

MR. PFAU: I think his question -- you meant stuff other than what I sent the doctor I thought from your question.

MR. MISHKIND: Yeah, it was.

Q Just so we can clean it up --

MR. MISHKIND: Thank you, Bill.

Q Just so we can clean it up, for purposes of your report, I think what you had was Dr. Sudak's --

A Yes.

Q You had Dr. Sudak's report, but I don't believe at the time you wrote your report that you had his deposition?

A I think that's correct.
Q You had Dr. Giannini's deposition, you had Dr. Newman's deposition and I think you may have had another deposition or two?
A Quite honestly, I was not asked to write a report based on matters of fact but based on assumptions. So that while I read a number of the other depositions, I did not go through them with a fine-tooth comb. I had Kathy Marie Ludt's deposition I believe at the time, but it may have come afterwards.
Q And beside Kathy Ludt, L-u-d-t, Kathy Ludt's deposition, Dr. Giannini --
A Dr. Newman.
Q -- Dr. Newman, have there been any other -- were there any other depositions that were provided to you prior to preparing your report dated in March of '03?
A No.
Q Subsequent to the report in March of '03 you received Dr. Sudak's deposition?
A Yes.
Q And you received Dr. Morrison's report?
A Yes.
Q Anything else other than transmittal letters?
A I received the office procedures manual at my request from Dr. Giannini's office.

Q And did you review that?
A I did.
Q Did you tab anything in the office manual or highlight anything?
A No.
Q Did you find anything in the office manual to be relevant to the opinions that you have arrived at based upon these assumed facts?
A I specifically looked on the written procedures, if patients identified themselves as being in extreme distress, what were staff supposed to do, what was written down formally. And I have also asked Mr. Pfau what the informal training was based on his discussions with office staff.
Q And what were you advised by Mr. Pfau were the informal training?
A Well, he then referred me back to some of the other, the reports from Ms. Ludt. And it suggested that if there is a real problem and if people cannot call, cannot contact a therapist, which is what is in the office procedure, staff is directed to send the people to the hospital.
Q And would you agree that if a crisis situation presents itself to an office staff person and there isn't a psychiatrist or another health care provider

available, that failure to refer that patient to an emergency room would be below the standard of care?

A I don't know what it means to have standard of care for office personnel. Standard of care is something I apply to professionals.

Q Okay. Have you ever had an office where you had nonmedical personnel working?

A All the time, here and at the Mental Health Center.

Q And you recognize that ultimately you are responsible for what the nonmedical personnel do, correct?

A I assume so.

Q You recognize that you have to have a procedure set up so that nonmedically trained people are, have buzz words or enough training, if they are going to be placed in the position of being on the front line to receive telephone calls and contact, to know what to do and what not to do if a crisis presents to them, true?

A True.

Q And let me ask you this. Are you aware first whether there are any published standards, or guidelines or protocols that apply to an office-based psychiatric clinic in terms of what nonmedical personnel need to do to comply with accepted standards when a crisis situation presents?

A No, I'm not aware of any published standards.
Q Would you agree that reasonable and ordinary care would dictate that a psychiatrist should have a system set up so that nonmedically trained personnel take appropriate steps either to refer a patient to the emergency room or to get that person in contact with a mental health care provider when a crisis situation presents to the office?
A It seems that front line administrative staff should have some training about what to do. I'm not sure that all small offices have that as a written policy. I don't work in small offices, so I don't know.
Q Whether it's written or not written --
A There should be some, some training.
Q So we can agree that ordinary and reasonable care or standard of care, whether it's written or not written, should be to provide reasonable training to the nonmedical personnel to be able to prudently handle crisis situations, true?
A Yes.
Q Failure to have that type of system in effect so that nonmedical personnel are unable to or don't know what to did when a crisis situation presents would be below the standard of care, true?
A Standard of care in this case is not -- I'm not

sure -- I don't know if it's a standard of care issue or not. I think -- if standard of care applies to that, then fine.

I'm not a lawyer, so I don't know if standard of care applies to that kind of issue. I think the front line staff should have training and should know what to do.

Q And it really wouldn't be reasonable and prudent not to have the front line people prudently and appropriately trained to handle crisis situations, true?

A Yeah, well, yeah. There is a problem, a serious issue about in that training how much inquiry front line staff should do. And one of the decisions that we have made here is that we do not want untrained secretarial staff asking people.

So if people present I'm about to kill myself, they have a course of action, but we do not want them to do any kind of clinical investigation. And that was a decision we made after some thought here.

Q In the employee manual or the, it's not an employee manual, but the handbook from Dr. Giannini's office, is there any definition in there as to what a crisis situation is?

A I could look, but I don't believe so.

(Witness examines document)

A It just says do not put emergency calls on hold, seek an available therapist, for example, suicidal calls, severe medication reactions, hopeless, helpless situations, use your best judgment. That's as much of a definition as they have come up with.

Q You would agree that a nonmedical person really shouldn't be exercising judgment as to whether or not a call is or is not a crisis situation, true?

A In a mental health facility, nonmedical people are making those judgment calls every day all the time. We can say that they shouldn't, but I can tell you that also in any physician's office, at some level people are making decisions what to pass through and how to triage things. That may not be something public, but it is in fact the case.

Q Well, would your dealing with a potential life or death situation, which certainly a crisis situation in psychiatry would include that, shouldn't nonmedically trained personnel have reasonable training to be able to understand what is or is not a potential crisis so that they are not placed in the position of making judgments that you or another psychiatrist or another mental health care provider would be better able to make?

MR. PFAU: I object to the question.

MR. SHROGE: Objection.

MR. PFAU: You kind of lost me, Howard, but if the doctor followed you --

Q Go ahead, Doctor. Did you understand my question?

MR. PFAU: -- if he didn't, you can restate it.

Q Go ahead.

A I get a whole variety of calls of people who are upset and my secretary is making a decision about which to leave as a message, which to page me on out of whatever I'm doing, which to alert me at different levels of priority, they can reach me by the end of the day, within the next couple of hours or right away.

One can say that we don't like untrained people making those triage decisions, but I can tell you that in every mental health practice, and probably in every medical practice, there is some of that triage going on. And without formal training, I can tell you that I give feedback to my secretary, a little bit at least, to help her get better at those triage decisions.

Now, I don't know how public to be about that,

but that's happening all over.

Q Well, going back to the issue of the responsibility of Dr. Giannini, any employee that is working in his clinic that is going to interact with patients that come to see him ultimately he is responsible for?

A And if somebody calls up and says I need to talk to Dr. Giannini now, the secretary is obviously not going to page him for every one of those calls. And so they are going to have to use their judgment at some point about how to triage or handle which of those calls.

Q And if it's a life or death situation or expressed to the secretary as a life or death situation that the patient is going through in the present as opposed to in the past, is that something that you would expect an office procedure or an office setting to have some mechanism in effect to get that information conveyed promptly to someone trained to handle a life or death situation?

A Yes. If the patient calls and says I'm about to kill myself, then that's going to automatically invoke various emergency procedures, grab somebody in the hall, contact somebody right away, page somebody out of an office.

Q Let me ask you this, Doctor. Rather than them saying I'm going to kill myself, if they say that I'm going

through a life or death situation, is it incumbent upon the nonmedical personnel to ask them what do you mean by going through a life or death situation, or is that enough of a buzz phrase that the nonmedical person should get a medically trained person to handle the call?

A Probably it would invoke a second question, but again I'm not exactly sure what the nature of the interaction was.

Q What would you expect the next question to be if someone calls in and says that I'm going through a life or death situation?

MR. SHROGE: Objection.

Q Go ahead. The objection is only for the record.

A Oh, okay.

MR. PFAU: You can go ahead.

A This is actually complicated because we ourselves have had a discussion about whether we want our secretaries at that point to say are you feeling suicidal now. That gets into a whole clinical dialogue very rapidly and do we want secretaries to be put in a position where somebody is now talking about their suicidality, because once you open that up, people's distress can get overwhelming pretty fast.

So on one hand, in common sense, it's tempting to

say somebody should ask are you feeling suicidal now. It's actually complicated to know if that's the right answer in all cases.

Q Well, if one doesn't go that route and ask whether or not they are feeling suicidal now, is it appropriate to take no action other than to schedule an appointment for three weeks later for the psychiatrist to see that patient?

A You probably want to get a message either to the primary therapist or to a backup for somebody to return the call or to investigate further, whether the secretary investigates further or someone else, it would be nice to get a sense of how much time you have; it may take me a while to get a message through to somebody, will you be okay for an hour or two, or whatever. How you investigate that becomes actually fairly complicated.

Q Would you agree that as complicated as it may be, that reasonable care in the area of psychiatry would be to investigate that type of call if the decision is not to have the secretary ask at that time?

A Something should happen.

MR. SHROGE: Objection.

Q And should that investigation take place days later or certainly within hours of that telephone call?

A I would expect within hours.
Q Okay. In going back just briefly to the office procedure manual for a moment, can we agree that this office procedure manual does not delineate the steps that one should take in exercising their best judgment to determine how acute the crisis is?
A I agree, it does not delineate. Actually, when I read it, I was impressed that it delineated as much as it did for a small office.
Q But be that as it may, it doesn't, it doesn't provide the secretary with what is meant by exercise your best judgment in terms of handling a potential crisis situation, true?
A The written document does not.
Q And do you know of any evidence that you have seen in this case, from your review of the depositions, that there was any additional training that the secretary had in terms of handling potential crisis situations?
A Mr. Pfau indicated to me that the staff had told him, and it's in some of their depositions, that they were to direct people to the hospital emergency room if they could not reach a therapist.
Q Do you see any evidence in any written record, either the secretary's note or anything that you have reviewed, that confirms that Mr. Lorelli was directed

to an emergency room during any of his interactions with Dr. Giannini's office?

A No.

Q Would you expect that if a patient calls expressing that they are going through a life or death situation and it's determined that this is an acute crisis and a referral is made to, for the patient to go to an emergency room, that under normal circumstances something should be noted in conjunction with that patient's entry about going through a life or death situation, that in fact the patient was told to go to the emergency room?

MR. SHROGE: Objection.

A It would be nice. We are not now talking about a medical record. We are talking about how administrative support people document their phone interactions. And I can tell you that those are not medical record entries and they tend to be scattered in my experience.

Q Reasonable practice, however, would be to make a notation that that patient was referred to an emergency room because the psychiatrist or the therapist was not available?

A It would be nice for that to have happened.

Q That would be reasonable, true?

A I don't think it's standard. I mean, I think that's what should happen. I'm not sure that that's what does happen.

Q Fair enough.

(Counsel examines document)

Q I'm going to go into detail about the opinions that you have that you have expressed in your report, but first I want to find out whether your report contains all of the opinions that you intend to provide on direct examination by Mr. Pfau at the time of the trial?

A My report is based on assumptions that he asked me to consider. If the assumptions change, then of course my opinions would change in keeping. My report did not go through or comment on issues of fact.

Q Okay. And again, your opinions are only as good as the assumptions that the attorney for Dr. Giannini asked you to make, correct?

A Correct.

Q I didn't know whether your head nodding also included a verbal correct. The court reporter is telling me it did.

MR. PFAU: Howard, if I might state for the record here today, because of the nature of, the speculative nature of the plaintiffs'

evidence in this case --

MR. MISHKIND: Well, I'm going to object to any statement about speculative.

MR. PFAU: My statement for the record is that I do not know and will not be able to know until the close of the plaintiffs' case what factual assumptions may be presented to my experts in the trial of this case.

MR. MISHKIND: Well, I'm here to take his deposition based upon --

MR. PFAU: I understand.

MR. MISHKIND: Let me finish, please. I'm here to take his deposition based upon the opinions that he had when he wrote his report, the opinions that he has right now. There have been a lot of depositions taken.

And certainly I object to your reference to speculation. There are certain disputes with regard to what the facts are in this case, but --

MR. PFAU: Go ahead, and then I will make my comment.

MR. MISHKIND: That's fine and you can do that, but to say that the doctor is going to come in and provide different opinions based

upon evidence that comes in at the time of the trial, you have the testimony of the plaintiffs' expert, you have the report, you have the depositions of all of the plaintiffs' witnesses. So I'm here to find out what his opinions are based upon all of the discovery.

And I would object if all of a sudden you elicited new opinions from him at the time of trial based upon a new set of assumptions which you didn't present to him prior to trial and which otherwise could have been presented to him.

MR. PFAU: Well, what I'm saying is I don't know what assumptions can be presented until the plaintiff rests, but let's go ahead with this deposition.

MR. MISHKIND: And just for the record, I would object to anything beyond the scope of his report and anything that has been made available to him at this point considering this is probably the only time I'm going to meet you before you are sitting in a courtroom in Mahoning County in January. So that's why I'm belaboring the issue, so bear with me. Okay?

THE WITNESS: Uh-huh.

MR. MISHKIND: Thank you. That

grunt was a yes?

THE WITNESS: That was a yes.

Q Your report, any drafts of your report prepared?

A I cleaned up some of the grammar and wording, but they are not available. They are deleted.

Q Did you review the report or the content of the report with Mr. Pfau before signing it and sending it off to him?

A I don't believe I did.

Q He can't answer.

A Oh.

Q As much as he would like to, he can't answer.

A I can't remember quite honestly, I'm sorry.

Q So you may have, you may not have?

A I don't believe I did.

Q Okay. And after reviewing Dr. Sudak's report, you did not, and Dr. Morrison's report and Dr. Sudak's deposition for that matter, you didn't issue any additional reports with any additional opinions, correct?

A No. We had phone conversations after those.

MR. PFAU: Just to clarify, understanding we are not in Cuyahoga County, that doesn't mean he doesn't have additional opinions. I'm sure you will get to that.

MR. MISHKIND: Well, yeah.

Q And based upon the additional information that you reviewed subsequent to this letter, have you arrived at any additional opinions in this case?

A I very much agreed with Dr. Morrison's report. I thought Dr. -- I disagree with Dr. Sudak's report and I wondered if, in his own practice, he followed the standards that he was presenting as standards of care.

Q You are referring to -- you are looking at Dr. Sudak's report now?

A I am.

Q Before you go into the particulars, do you know Dr. Sudak?

A No.

Q Do you know him by reputation?

A No.

Q Have you done any research to see whether he has written on, lectured on the topic of suicidality or the topic of suicide?

A I have not. I understand, and I can't remember where I got this information, that he is involved in a study of suicide assessment I think from a psychoanalytic point of view.

I know that his place of practice, Pennsylvania Hospital, is a very psychoanalytically oriented

facility, or at least used to be. And that, that was at least part of my thinking, but I did not go so far as to check any of that out.

Q Now, what I'm going to have you do is defer talking about the specific areas that you disagree with in Dr. Sudak's report and the specific areas that you agree with in Dr. Morrison's report until later during our chat today.

A Okay.

Q But other than agreeing or disagreeing with certain things that they have said in their reports, have you arrived at any additional opinions other than I don't agree with Dr. Sudak or I do agree with Dr. Morrison, any new opinions in terms of standard of care or what we refer to as proximate cause, meaning the ultimate cause of Mr. Lorelli's suicide, other than those which you have expressed in your report?

A I don't think so. I would just reinforce, and I think this is stated in the report that I wrote, that it doesn't seem to me, based on what I know, that a physician-patient relationship has been established. So that seems to be one of the cusps of the issue.

Q And that is based upon the assumption that Mr. Lorelli was not evaluated, in the assumption, by Dr. Newman or Dr. Giannini on September 4, 1998, correct?

A Correct.
Q And again --
MR. SHROGE: Objection.
Q -- if in fact Dr. Newman evaluated him, even if it wasn't a complete evaluation, but met him and had an opportunity to evaluate him and was provided with the history on this patient having scheduled an appointment to see Dr. Giannini, having called in and being given an earlier appointment and expressing that he was going through a life or death situation and then Mr. Lorelli presents at some time on September 4th, whether on time, at the end of the scheduled visit, but sufficiently enough that Dr. Newman and Mr. Lorelli had an opportunity to interact, how would that impact the opinions that you hold in this case?
MR. SHROGE: Objection.
MR. PFAU: I object. I hesitate to have her read it back, but go ahead.
Q Go ahead.
A I think that that's a very complicated question, but as an expert, let me give this as a scenario, which happens to me all the time.

At the Mental Health Center we have long waiting lists for services. And it's not at all unusual for somebody to call me up and say I really desperately

need to see you. And I say go through our intake process. And they say there is a long waiting list and I say go through the intake process.

And that same person may show up two days later in my waiting room. And as I'm walking out of my office, they say Dr. Diamond, and we will chat for 30 seconds, a minute, two minutes.

And I will, are you going to be okay, here is the crisis number, it's downstairs. I will not write a note, send out a bill. I do not consider myself as having taken on a fiduciary responsibility.

The question is what constitutes the chance for a true assessment. And I think that's the cusp of this kind of interaction.

If for a new patient walking out of my office after the end of the scheduled appointment, when I haven't had time to see him, he is in the waiting room and I have a minute or two minutes in the midst of a crowded day to say are you going to be okay until our next appointment, here is the emergency room number, if you have a problem, give me a call, I don't think I have done an assessment in a serious way and I don't think I have established a doctor-patient relationship.

Q Now, assume, however, that the clinician interacts

with the patient for however long he interacts with him and sufficient enough to recognize that the patient needs to be seen and takes steps so that an emergency appointment is scheduled after the holiday weekend with Dr. Giannini.

Assume further that the clinician provides the patient with a home telephone number, and assume further that the clinician will testify that giving a home telephone number in his mind would only be given if there was a potential emergency situation that he was dealing with.

Assume further that the information about the patient being, going through a life or death situation was made known to this clinician. Assume further that this clinician didn't have a whole waiting room of patients waiting. In fact, the patient right before him had cancelled the appointment --

A What do you mean the patient right before him?

Q The patient right before the time that Mr. Lorelli was scheduled to be seen cancelled his appointment, that and there were no patients scheduled for this mental health care provider to see anybody after the scheduled appointment with Mr. Lorelli. Okay. So there weren't people waiting, but this counselor had enough concern of a potential emergency situation to

give him his home telephone number, enough concern to take steps to schedule him to be seen on an urgent basis the following Tuesday by Dr. Giannini and twice that next week by this counselor, would all of that have taken place without there have been some evaluation done by the health care provider?

MR. SHROGE: Objection. And, Howard, I don't know where you are getting half of those facts that you have just said to Dr. Diamond, because I don't know where they are contained in the records that we have to date, but given the absolutely baseless facts in that assumption, I'm going to object.

MR. MISHKIND: Well, let me say something. Number one, your statement baseless I object to.

These are statements of fact based upon testimony in the case and this is based upon a number of facts, so it's a hypothetical.

If I'm wrong, Michael, then may I be stricken by lightning for giving such a poor, baseless hypothetical, but I'm asking given the fact that we have such a paucity of records maintained by the defendants in the case, we are recreating this based upon inferences and based

upon facts that have been derived in discovery.

So my hypothetical is based upon the encounter taking place --

A Let me -- again, I get accosted in all kinds of ways by people in various kinds of distress. And at some point I sit down with them and I take on responsibility as a physician and they take on the role of a patient.

And until that interaction happens, I may have various kinds of moral responsibility, but I don't have a fiduciary relationship.

And somebody that I'm talking to for a couple of minutes in the hall, or on the phone, or in a meeting or in a variety of ways in which I personally meet people who are in significant distress and at some various kinds of risk situations, I may try and get them an earlier appointment. I may give them phone numbers. I may be quite concerned about them.

The question is at what point are they my patient. And that's, that's the cusp of what you are trying to deal.

I personally think they are my patient when I have had a chance to sit down with them and to do what I think is a clinically appropriate assessment, which is not a two-minute interaction in a hallway, if in

fact that's what the occurrence is.
Q Would you give someone that's coming in, that you are seeing for the very first time, that you do a cursory assessment, whether it's in the office, whether it's in the hallway, your home telephone number?
A Would I or would some people?
Q Would you?
A Would I?
Q Yes.
A No, I would not, but that doesn't mean that other people would not.
Q No. My question was would you, Dr. Diamond, give your home telephone number to someone that you are meeting for the first time that was scheduled to be seen by you --
A On the other hand, I do give my card in situations and it has my E-mail. So people will use my personal E-mail in exactly that situation, not my phone.
Q My question was specifically the phone number.
A I understand. I'm just saying that in the short answer, the answer is no, I would not give my home phone number, but then I hate talking on telephones.
Q All right. Let's go back to --
MR. SHROGE: And, Howard, because I know there is a little bit of a delay here with

the speaker phone, I'm just going to object to the last question you asked assuming that that incorporated the previous three or four questions just because your first question said that Dr. Newman did a cursory assessment of Mr. Lorelli. So as to that, I don't know how you have established that, but that's why I'm objecting again.

Q All right. Exhibit 2 is a letter from Mr. Pfau to you dated March 12th. I actually have this, so you are not going to be able to find it very quickly.

A Oh, okay.

MR. PFAU: Do you want me to give the doctor a copy?

MR. MISHKIND: Sure.

Q And again, he's asked you to assume certain facts for the benefit of your opinions, correct?

A Correct.

Q One is that Mr. Lorelli was a patient of Dr. Giannini's seen only in '82 and '83?

A Correct.

Q And were you able to confirm that when you looked at any of the information that was provided to you?

A I don't remember where information came from. I based my report based on these assumptions.

Q But I'm asking because you have also been provided with a number of items, including some records from Dr. Giannini's office, which I believe is in the stack --

A Yes.

MR. PFAU: I think so.

Q Right.

MR. PFAU: I think those old records are in there.

Q You have also been provided with his deposition and Dr. Newman's depo?

A I think I have records from those visits, but I can't remember where the source of information came.

Q Now, the next note or the next assumption was sometime around September 1, '98 Mr. Lorelli called Dr. Giannini's office and related the information reflected in the note made by Kathy Ludt.

And the note is the note that we have been talking about. It says "Going through bad time, life or death situation," and then the next line 79, 80. Then it goes on to say "just wants meds." It says doesn't, "don't need counseling, need something for sleep or anxiety." You are familiar with that note?

A Yes.

Q And this assumption goes on to say that Kathy Ludt

scheduled Mr. Lorelli for an appointment with Dr. Giannini for September 24th, 1998 and also for an appointment with Dr. Newman September 4, 1998 at 1:30 p.m., correct?

A Correct.

Q Now, in this assumption it appears that Mr. Pfau is asking you to assume that there was one telephone call made by Mr. Lorelli and it was sometime around September 1st, and based upon that telephone call, she was, Kathy Ludt gave Mr. Lorelli a September 24th appointment and gave Mr. Lorelli an appointment with Dr. Newman for September 4th all on that September 1st interaction, correct?

A Correct.

Q Do you know whether that assumption is based on any fact or foundation based upon the testimony and the evidence in this case?

A There is several different interpretations. And it's possible that the appointment with Dr. Newman was based on a subsequent phone call. It's hard to quite disentangle this.

Q In this assumption letter, Mr. Pfau doesn't say anything to you about a subsequent telephone call, does he?

A No.

Q He doesn't ask you to assume that in the set of facts, correct?
A Correct.
Q And you didn't assume that in the set of facts for purposes of your opinion, correct?
A Correct.
Q Now, Mr. Pfau asked you to assume that Mr. Lorelli did not show for the September 4 appointment. And do you know for a fact in this case whether or not Mr. Lorelli did show for his September 4th appointment with Dr. Newman?
A It seems like there is mixed date about that.
Q One side of the data would suggest what?
A That evidently his family or friends attested that he showed and he was given a home phone number, which seems like that assumes some kind of contact.

On the other side, there was no entry note and no bill generated, which suggests that it wasn't what I would call a "real" appointment where you would have a chance to sit down and do an initial assessment.

Q Do you know how Mr. Lorelli obtained the cards that were presented? For sake of time --
A No.
Q -- have you seen those exhibits which were the scheduling cards?

A No.
Q You haven't seen those?
MR. PFAU: They might be attached to one of the depositions he has.
MR. MISHKIND: Yeah, they probably are.
Q Have you seen Dr. Newman's calendar for September 4th?
A I don't believe so.
(Counsel examines document)
A If so, I don't remember.
Q I'm just going to sort of hold this up for you.
A I did not see -- I have not seen that.
Q Okay. And the reference that I made before there was, he had four patients, one right before Mr. Lorelli was a Vince, last name redacted for confidentiality purposes, with a C next to it.
And what is your understanding on scheduling what a C means next to a patient's name?
A It could be cancelled.
Q Based upon the language that's used in this case, did you in fact learn that C does mean cancelled?
A I did not see the schedule or discuss this until this moment.
Q And I take it your review of the deposition testimony wasn't detailed enough for you to be able to say what

any particular witness said in their depositions?
A That's correct.
Q You have not been provided with any of the depositions of any of the family members of Mr. Lorelli, have you?
A No.
Q Nor any of the non-family members that have testified in this case, correct?
A Only one of the office staff.
Q I'm sorry. Any of the non-family members that were identified by plaintiffs' counsel in this case?
A No.
Q So you don't know even the names of those people?
A No.
Q You don't know what they testified to in deposition?
A No.
Q And you didn't take those facts into account in arriving at any of the assumptions that you have reached?
A No.
(Counsel examines document)
Q Mr. Pfau asked you further to assume that Mr. Lorelli had some contact with the office staff at some time and was scheduled for appointments with Dr. Giannini and Dr. Newman September 8th, September 10th respectively. And you assume those facts, correct?

A It's confusing, but I assume these facts.
Q Do you know when Mr. Pfau wanted you to assume that Mr. Lorelli made that contact and obtained those two appointment dates?
A The time chronology of all of this was quite confusing to me.
Q And what would have eliminated the confusion in your review of this case? What information would you have liked to have had to wipe out the confusion?
A It would have been nice if every phone contact had been documented with a nice date and time and a clear rendition of what happened. That would have been nice.
Q Would there have been anything else that you would have needed to have eliminated the confusion in this case so that either assumptions didn't need to be made or you weren't even confused by the assumptions that you were asked to make?
A An accurate dated office record is what comes to mind. There may be other things, but they are not immediately.
Q Both of those items would be generated by Dr. Giannini's office, true?
A Correct.
MR. MISHKIND: Off the record for

one second.

(Discussion off the record)

Q In your file I see that there is at least one E-mail communication between you and Mr. Pfau. I think it has to do with scheduling your trial testimony?

A Yes.

Q Did you have any other communication with Mr. Pfau by way of E-mail?

A I can tell you there was nothing material. I can't tell you if there was not some back and forth. And I did not look at my home computer to pull that off if I did.

Q Do you have with you today everything, even scribbled notes, on when you were first contacted by Mr. Pfau that constitutes your file?

A There may be some notes of contact in my computer that I did not think to pull off. I don't think so, but there may have been some E-mail communication back and forth. If so, I did not bring them with me.

Q How long ago was it -- strike that. Did you in fact read from cover to cover Dr. Giannini's deposition?

A I didn't read every line of it.

Q Did you read every other line?

A I read every other line. I got the --

Q Did you just sort of peruse through?

A I just sort of perused.
Q So you are not able to tell me, for example, what pages you concentrated on?
A No.
Q You didn't make any notes when you perused it, correct?
A No. I was not asked about the specific facts of the case.
Q Do you know why you were provided with these depositions if you weren't asked to comment or take into account the specific facts of this case?
A In my very limited experience with attorneys, I get big piles of stuff and I never know how much of it I'm supposed to read. This just fits.
Q Fits with lawyers?
A With lawyers.
Q Okay. But as to why you were provided this information when you were asked to assume certain facts, you don't know?
A I did read it as background. I did not go through taking detailed notes, which is what I would have done had I been expected to testify from the deposition or about the facts of the deposition.
Q Would the same thing apply with regard to Dr. Newman's deposition?

A Yes.
Q So if I asked you to tell me whether you agree or disagree with what Dr. Newman said in any given point in the deposition --
A I would need to reread the deposition at that point.
Q You would not be able to from memory tell me whether or not you agree or disagree?
A Correct.
Q Same thing with Dr. Giannini?
A Correct.
Q Let's divert for a moment and we will then jump back into the substance of your opinions. I want to talk now about, since you brought it up, lawyers, and that is, a little bit about your experience in the medical-legal area.

MR. PFAU: Howard, can I just clarify one thing. I don't know if the doctor has in his file materials what would be my original letter to him.

MR. MISHKIND: I think he does.

MR. PFAU: It would have come before my letter with the assumptions. As long as you are aware of that.

MR. MISHKIND: Yeah.

MR. PFAU: Okay.

Q In fact, Doctor, there is a letter where you were sent material from Mr. Pfau, correct?
A Yes.
Q And the date of that letter is?
A I'm looking for the letter.
(Witness examines document)
A I should be more organized.
Q That's all right.
MR. PFAU: I didn't even bring it.
(Witness examines documents)
A Evidently my first phone contact I believe was March 6th. That is not true. I have a contact from February 18th.
Q That was a -- is that a phone slip?
A No, that's the initial letter.
Q That's the one. If you grab that for a second, February 18th. And what material was sent to you in the February 18th --
A Deposition of Dr. Giannini, deposition of Dr. Newman, deposition of Rachel Bowman, deposition of Kathy Marie Ludt and the coroner's findings.
Q And then it was followed some weeks later with the March 12th letter that you were asked to assume certain facts?
A Yes.

Q And then six days later you generated your report which we have marked as an exhibit, true?
A Yes.
Q And is it fair to say that in generating the report for purposes of the opinion, that you were relying from a factual basis on the assumptions that Mr. Pfau gave to you in the March 12th letter as opposed to the review in detail of the depositions that accompanied his original letter?
A That is correct.
Q Do you know as you sit here right now how many hours you have put in on this case?
A I have a billing in here someplace.
(Witness examines documents)
A I do not know. I can tell you to the point of -- no, I do not know.
Q Do you know how Mr. Pfau obtained your name?
A I assume it was through another malpractice case that I was involved in that was handled through I believe his office.
Q And how long before this case was that case?
A It was earlier the same year.
Q So being contacted in February of 2003 --
A We had just finished up the other case I believe or were in the middle of the other case, which settled.

Q But you were an expert on behalf of an attorney in Mr. Pfau's office?
A Yes.
Q Was that a psychiatric malpractice case?
A Yes.
Q Who was the defendant in that case?
A Is that public?
Q It is.
A Charles Schultz.
Q Was your deposition taken in that case?
A No.
Q Charles Schultz is a psychiatrist?
A Yes.
Q And you were appearing as the expert on his behalf?
A Yes.
Q I take it you wrote a report in that case?
A I did.
Q Do you recall who the attorney was on the other side, the plaintiff's attorney?
A No.
Q I would have been surprised, considering your deposition wasn't taken, if you did remember it, but sometimes those things happen.

Beside the Schultz case, had you worked with Mr. Pfau's office on any other occasion?

A No.
Q Who was it from Mr. Pfau's office that you worked with on the Schultz case?
MR. PFAU: I'm not sure it was my office.
THE WITNESS: It wasn't your office.
MR. PFAU: But I may have gotten you through that case.
A I think there was a connection, but I don't remember what the connection was. It was not Mr. Pfau's office. I'm sorry if I misstated that.
Q With the reference that Bill just made that he doesn't think it was your office, does that cause you to think twice and come up with someone else that might have retained you besides Mr. Pfau or his office?
A There was another attorney. I can remember the case. I can tell you the details of the case. I can't remember the name of the attorney.
Q Was it a suicide case?
A Yes.
Q And in that case did you testify or was it your opinion that Dr. Schultz complied with the standard of care?
A Yes.

Q And that his conduct was not a proximate cause of the patient's suicide?
A That was my testimony.
Q And again that was your written testimony?
A Written testimony.
Q You never testified in court?
A No.
Q Are there any other cases that you have served as an expert in the State of Ohio other than the case with Dr. Schultz and now the Giannini case?
A I have written a report on one other case.
Q And who was the -- I take it it was a psychiatrist?

MR. PFAU: If I might interject and object. I don't know the status of that case. If that's a case where the doctor has not been disclosed as a witness --

MR. MISHKIND: I will take it step by step.

MR. PFAU: -- I don't think that he's, it's appropriate for him to disclose it.

MR. MISHKIND: I will take it step by step. I don't disagree with you.

MR. PFAU: Okay. Fair enough.

Q We are now talking about the third case in Ohio. Was this before the Schultz --

A It was after.
Q After. Is this a case that you are currently involved in?
A Yes.
Q And have you written a report in that case?
A Yes.
Q Have you provided it to the attorney on the other side, I mean the attorney that you have --
A Yes.
Q The other side, the other side of the country here?
A Yes.
Q Has your deposition been taken in that case?
A No.
Q Is that case a suicide case?
A No.
Q What's the subject matter of that case?

MR. PFAU: Howard, I don't think that the doctor should testify regarding any specifics of another case unless it's been established that he has been disclosed as an expert in the case.

Q Is your deposition scheduled to be taken in that case?
A No.
Q Do you know whether the case is set for trial?
A No.

Q What I would like you to do --
A It was not a suicide case if that helps.
Q Okay. Well, it helps just a little bit.
MR. PFAU: Do you want to explain the concern to the doctor or do you want me to?
MR. MISHKIND: No, I will.
Q What I would like you to do is I would like you to check with the attorney that has hired you and find out whether or not you have been disclosed as an expert to plaintiff's. I presume that you have been retained by the defense?
A In that case, yes.
Q Check with this lawyer, I'm not even going to ask you the name of the lawyer, but check with him, then let Mr. Pfau now whether or not this is a case that you have been disclosed as an expert that is likely to be called at trial.

If you have just been consulted and there is no intent to have you identified as a trial witness, then I'm not entitled to that information at this particular time. Okay?
A Okay.
Q Will you remember all these things, because I'm terrible at remembering?
MR. PFAU: Well, I don't know if

it's the doctor's burden to, but one of us has to remember it, Howard.

MR. MISHKIND: He is making a note.

MR. PFAU: Just so you understand, Doctor, it might be inappropriate for you to disclose that relationship and information if your name is not ultimately released by that lawyer.

THE WITNESS: I understand.

MR. MISHKIND: That's what I just said.

THE WITNESS: I understand.

Q So there are three cases that you have reviewed matters in the State of Ohio?

A Yes.

Q Have you reviewed medical malpractice cases in any other states besides Ohio?

A In the last five years I have reviewed one other case.

Q And where was that case venued?

A It did not go forward after my review and discussion with the attorney. A report was never written.

And I cannot tell you what state. I could look it up, but I do not know.

Q Do you have a record of cases that you have reviewed?

A Yes. We have just completed the entire set of cases I

reviewed in the last five years.
Q And what you are telling me is that there are four cases that you have reviewed in the last five years?
A Uh-huh.
Q Is that a yes?
A Yes.
Q In the medical malpractice area?
A Yes.
Q Are there any other areas that you have served as an expert witness in in the last five years other than in medical malpractice cases?
A Yes.
Q What type of cases?
A I'm currently involved in a patent law case as an expert witness.
Q Where is that case pending, what state?
A Isn't patent law typically federal?
Q It is. Is there an attorney in a particular state that you are working with?
A Yes.
Q Where is that lawyer?
A The attorney is from Wisconsin.
Q That has nothing to do with issues of standard of care?
A No.

Q Has your deposition been taken in that case?
A No.
Q Let me ask you, maybe to streamline things, beside this case, how many times has your deposition been taken in a medical malpractice case in your career?
A I was involved as a defendant for my system, although I was not named, in one occasion. That was I believe about five years ago.
Q You were named as --
A I was not named but my system, my mental health center was sued, and I was, I gave testimony as part of that suit.
Q What system was that?
A The Mental Health Center of Dane County.
Q Is that the system that you are still involved with?
A Yes.
Q Who was the plaintiff in that case? That is public knowledge if your deposition was taken.
A The plaintiff was a man who exsanguinated in jail. I don't remember his name. I could look it up easily enough.
Q Is that on a record also that you have?
A (Indicating).
Q That's a yes?
A Yes.

Q I would ask you to do that. So you have been deposed once in connection with the county health clinic or --
A Uh-huh.
Q We are taking your deposition today in a case where you are identified as an expert witness for a doctor. Other than those two occasions in the medical malpractice area, has your deposition ever been taken before?
A No.
Q The case that wrapped up that you thought was with Mr. Pfau's office, your deposition was not taken?
A No.
Q So this is the first time then that you have been deposed as an expert on defending a doctor in deposition?
A Yes.
Q Have you ever testified at trial in any, at any time whether it's medical malpractice or otherwise?
A I have testified a number of times in commitment hearings which are quasi-trials and in class action hearings. Those were more than a decade ago I believe.
Q Do you currently review cases for attorneys?
A On rare occasions.
Q How many cases a year do you review?

A Four cases this year.
Q And obviously we have got the one that you thought was -- well, actually now four new cases?
A No, I have just told you all the cases that -- there is one case that I reviewed that I said did not go anywhere and the other three that we have already discussed and that's my entire experience with malpractice.
Q Throughout your entire career?
A I reviewed one, oh, more than five years ago, wrote a report, did not go -- they settled after the report. That was well, more than five years ago, and I'm not even sure I have a copy of the report.
Q Have you ever written a report where you were providing testimony critical of a psychiatrist?
A I was asked to review a case critical of a psychiatrist. I had a long discussion with the potential plaintiff attorney and the decision was made not to go forward with the case.
Q Because you basically told him that you couldn't support the claim of substandard care on the part of the psychiatrist, correct?
A Correct.
Q Have you ever gone on record either by way of report, or deposition or statement to an attorney without

writing a report that you would be willing to support a claim by a patient or a family of a patient against a psychiatrist?

A No. Other cases have been brought to my attention. I have been involved in sanctions against psychiatrists, but not in the malpractice area.

Q Is that through the mental health board?

A There is a way that the state reviews death reports and there is currently a case pending which review is not yet completed. We are concerned about the care provided by the psychiatrist. That is still pending.

MR. PFAU: Howard, I object to your previous question just because I think it was ambiguous. I think the doctor and you both understood it, but to me it was ambiguous as to whether you were asking him whether he had ever in a specific case said he would testify adverse to a physician or whether as a matter of policy --

MR. MISHKIND: No, no, no, I didn't say, I didn't ask him as a matter of policy.

MR. PFAU: I know you didn't say, I'm saying your question was ambiguous.

MR. MISHKIND: No, it wasn't. It wasn't ambiguous. You want to make it ambiguous.

I asked him whether or not -- Bill,

just object. I mean, don't make speeches.
Q I asked you a very specific question and you --
A My entire malpractice experience in the last five years has been four cases, one plaintiff, three defense. The plaintiff case did not go forward. The three defense cases went to various stages. This is my first --
Q Deposition?
A -- deposition.
Q And simply put, the plaintiff's case that you looked at, you didn't find that there was evidence of malpractice?
A That is true.
Q Can we agree, based upon your review in this case of the information, that Mr. Lorelli called sometime end of August, early September seeking an appointment to see Dr. Giannini?
A That seems to be the case.
Q He did not call seeking to see Dr. Newman, true?
A As far as I can tell, that seems to be the case.
Q And in fact, Dr. Newman, or Mr. Lorelli was assigned to Dr. Newman by some process controlled by Dr. Giannini's office, correct?
A That is correct. Again, just to add, if you tried to see me at the Mental Health Center, the intake

appointment would never be with a psychiatrist. It would be with --

Q I'm not suggesting that there is anything wrong with that. I'm just asking whether or not we can agree on certain --

A That seems to be the case.

Q -- basic facts. Do you know in this case what involvement Dr. Giannini had in assigning Dr. Newman to see Mr. Lorelli?

A No.

Q Do you know what involvement the employees of Dr. Giannini had in assigning Dr. Newman?

A No.

Q Do you know whether Dr. Newman was in fact an employee of Dr. Giannini?

A My understanding is that's under contention.

Q And based upon statements made by Dr. Newman in his deposition, do you know whether or not he is of the mind that he was an employee of Dr. Giannini?

MR. SHROGE: Objection.

Q Go ahead. The objection again is for the record.

A I would want to go back. I read through that section. It seemed to be confusing and there seemed to be disagreement about it. I would want to reread it before I gave testimony to that.

Q So as you sit here right now, you are unclear in your mind as to whether or not Dr. Newman --
A Was an employee or an independent practitioner, independent contractor.
Q Okay. Do you know whether or not Dr. Newman saw patients of Dr. Giannini's independently or under Dr. Giannini's supervision?
A Again I would want to review the testimony before I answered that. I don't remember.
Q Okay. And again --
A I remember there was a whole discussion back and forth and back and forth and I did not take notes on that.
Q And again, Doctor, understand, I recognize that you have not testified a lot, but the purpose of the deposition is in part to test your knowledge of the underlying facts that correlate or go along with this case. So that's why I'm asking you specific facts as it relates to these issues in the case.
A The issue, quite honestly, as somebody who typically does one's homework, I did not go through and get a detailed understanding of all the facts because it seemed to me, even after reading through it, the facts were pretty confusing and difficult to disentangle.

I was asked to give expert witness on assuming various facts, was that, would that meet standard of

care. And so the determination of facts seems to be at some other part of this determination.

Q And the consideration of all of the facts that have been gathered by the lawyers in the depositions was not substantially relevant to you as it relates to your opinions in this case?

A As I understood it.

Q Is it fair to say then that you do not know as a fact in this case whether or not Dr. Newman was operating under the control of Dr. Giannini's corporation?

MR. SHROGE: Objection.

Q Go ahead. Again the objection is for the record.

A It seems to me that that's an area of disagreement between the various parties. I certainly do not know as an area of fact.

Q Okay. What hospitals do you practice at?

A I have active privileges at University of Wisconsin Hospital. I have courtesy privileges at St. Marys and Meriter. I also have courtesy privileges at the VA Hospital.

Q You have not been personally sued --

A No.

Q -- in a malpractice case?

A Please.

Q The other expert for the codefendant in this case,

Dr. Elizabeth Morrison, do you know her?
A No.
Q Do you know anything about her reputation?
A No.
Q I have brought with me a check today for $300, which I was told was your hourly charge for deposition.
A That is my hourly charge.
Q And what is your hourly charge for review of records?
A $300 an hour.
Q When you come to Youngstown to testify in January, what will be your charge to come?
A $300 an hour.
Q Plus I presume costs of transportation?
A We will make, I assume, some full-day arrangements for my time out of the office.
(Counsel examines document)
Q I take it, Doctor, that you have never had your privileges suspended, revoked or called into question?
A No.
Q Have you ever applied for privileges at a hospital and been denied?
A No.
Q Have you ever made your name available to any services that provide consultation to lawyers to provide experts?

A No.
Q Have you ever advertised that you are willing to serve as an expert?
A No.
Q I suspected that that was going to be your answer, but I don't want to assume anything.
MR. PFAU: If he has, he's not getting his money's worth.
Q That's right. Even though there have been assumptions made in this case, I don't want to assume anything when I take your deposition. Okay?
A I'm basically a clinician and a clinical teacher.
Q I hear you.
(Counsel examines document)
Q Back to some specifics on this case, okay?
A Yup.
Q What time was Mr. Lorelli's appointment scheduled for on September 4 in 1998?
A I believe it was scheduled for about 1:30.
Q And I think we can agree that you are not able to state as a fact that Mr. Lorelli did not come to the psychiatric clinic on September 4, 1998, correct?
A I don't believe anybody can testify to that. What we know is that no note was generated and no billing was generated.

Q The fact that no note was generated and no billing was generated doesn't prove that the patient was not seen on September 4, 1998, true?
A It doesn't prove it.
Q Okay.
A It does make less likely as significant what I call clinical contact.
Q I understand that, but simply because there is no note and no billing for that visit isn't a basis for you to say therefore Mr. Lorelli was not seen --
A Nope.
Q -- and evaluated?
A That's true.
Q Can we agree that if Mr. Lorelli did show for his appointment as scheduled and was seen by Dr. Newman, there should be a record made or should have been a record made by Dr. Newman of his assessment?
A Correct.
MR. SHROGE: Objection.
Q And if in fact Mr. Lorelli did show for his appointment and was seen by Dr. Newman for that appointment and there was no note generated from that visit, that appointment, that would be below the standard of care, correct?
MR. SHROGE: Objection.

A It would be a real concern. I guess it would be below the standard of care.

Q Tell me in general why it's important to write notes when a patient is seen, especially for the first time, by a clinician in a psychiatric office.

A Well, you are collecting an initial database that you will then subsequently use to refer back to. If there is a problem, especially in a situation of shared practices such as this, you will want to refer to the information gathered by the other person.

Certainly if there is an emergency, you want that. You want to be able to document what you yourself have done in case there is a disaster such as this.

And finally, none of us have perfect memory, so going back and looking at how we reconstruct information over time is often useful. Six months later I might have a very different perception and going back to my initial note when I didn't know the person often is quite revealing.

(Discussion off the record)

Q Tell me what your understanding is of Mr. Lorelli's psychiatric history.

A I understand that he had a bipolar disorder that had been treated many years before with medication, don't

know anything about how he had functioned or had been treated in the intervening years, and called up basically saying he needed to get back on medication, that he was not sleeping.

Q Do you know whether or not he had on any occasion evidenced any suicidal thoughts or suicidal ideations during the course of his psychiatric history?

A I have a recollection, but I can't tell you the basis of that, that he had expressed some suicidal ideation or feelings in his initial period of treatment.

Q Do you know what was the triggering event for those suicidal thoughts?

A I do not remember that.

Q Can you tell me whether or not there were any significant events in Mr. Lorelli's life that caused him to be hospitalized for psychiatric care at any time with the exception of -- well, let me just leave it, cross out with the exception of.

Do you know whether there were any occasions, significant events in his life where he was hospitalized for psychiatric care?

A I don't remember.

Q What's the difference between bipolar I disorder and a bipolar II disorder?

A Bipolar I disorder, during the highs or manic periods,

the person typically becomes psychotic or severely dysfunctional. Bipolar II, the high periods are typically hypomanic where the person may have certain problems with impulse control, certainly be symptomatic, but not to the same extent.

In both cases the depressions can be equally serious and severe.

Q Is it clinically significant to evaluate a patient as to whether they are bipolar I or bipolar II?

A It's useful in terms of the risk of people getting into serious trouble while they are high. If somebody has a history of only bipolar II disorder, then one doesn't need to jump on an incipient manic episode quite as aggressively because that's not typically going to give the person difficulty.

If somebody has a history of becoming very psychotic or really very out of control during the manic episodes, then one needs to attend to that in a different way. So to that extent, past history of the nature of the manic episodes or hypomanic episodes is useful.

Q Based upon your review of the facts and material in this case, can you tell me whether or not Mr. Lorelli fits the profile of a bipolar I or bipolar II disorder patient?

A I cannot.

MR. SHROGE: Howard, I didn't hear that last question.

MR. MISHKIND: I said based upon his review of the facts in this case, can he tell me whether or not Mr. Lorelli fits the profile of a bipolar I disorder or a bipolar II disorder.

MR. SHROGE: When?

MR. MISHKIND: At any time during his psychiatric history.

MR. SHROGE: Including the events of Newman and Giannini's office that we're talking about?

MR. MISHKIND: Well, I'm including that as well.

MR. SHROGE: Okay. Objection.

Q And the answer?

A I have very little clinical information about the deceased, so I really cannot talk about any of that.

Q Tell me what the common risk factors are -- I'm segueing into a different area now for the moment. I'm sort of giving you some highlights to let you know when I'm making a right or a left turn.

A Yeah. Well, the common risk factor for anybody with bipolar disorder is of course suicide. Something in

excess of 10 percent of people with bipolar disorder will kill them self, eight to 12 percent in different studies. And so that has to be taken as the most serious risk.

You also have the risk during manic episodes that people can really destroy their lives through criminal behavior, through destroying relationships, through other kinds of mayhem.

You also have a significant problem with comorbid substance abuse. You can imagine if you have these highs and lows, people will self-medicate often with alcohol as a common kind of problem.

People often have a lot of life instability and often have significant problems adhering to treatment that would help stabilize their lives.

Q A little bit of a different question as a follow-up, but tell me in your experience what are the common risk factors that are correlated with a greater likelihood of suicide risk?

A Again, I always have a problem citing risk factors and thinking that one knows something. So I can give you some of them, but that's not something you can just check off.

Certainly having a comorbid substance abuse history, having a family member who killed them self,

being male, being older, being alone, that is, not in a relationship, not married, having concomitant medical problems are all the kinds of things that one would worry about.

Q Is being paranoid, is that also a risk factor?

A I'm not aware that in a significant way that's associated with suicide.

Q Are homophobia or fear of or concern about being a homosexual, are those, is that a risk factor as well for suicide?

A There are a huge number of different correlational studies. And I'm sure that there is a study that shows there is some association between all of these things and suicide, but as one of the things that comes up repeatedly in multiple studies, I'm not aware that that's a factor.

Q Would you agree that there are risk factors that if seen in a mental health environment should cause a mental health care provider to be concerned that a patient might attempt to commit suicide?

MR. PFAU: Objection.

A Might attempt is a very strange word. Most of the people that I see in this office are at some potential risk for suicide and might in fact kill them self.

One of the problems with having a check-off

system is you are trying to figure out in this might attempt gradations and what to do about them. I will be glad to listen to the list, but almost anything you put there is going to add to the might attempt.

Q Your answer is an excellent answer to perhaps a poorly worded question. There are certain risk factors as well as clinical findings and history that if presented to a mental health care provider should create an index of concern that the patient is at risk of attempting harm to himself or to others, correct?

A Sure.

MR. SHROGE: Objection.

Q And depending upon what those, that clinical history is, the presenting psychiatric evaluation, as well as the risk factors, one would increase or decrease their index of concern as to whether the patient has an imminent potential for causing harm to himself or to others, correct?

A True.

Q It's the mental health care provider's responsibility to take into account, in doing their physical, their psychiatric assessment, the risk factors, the history on the patient, as well as the current events that the patient is going through in determining whether or not the patient presents with a risk of attempting

suicide?

A Correct. Let me reword that. Again, it's not presents with a risk, presents with how much of a risk.

Almost everybody I see, large numbers, present with some risk. So we are not talking between yes and no. We are talking about on a continuum where you are and how that's moving.

Q Sure. And a patient that presents in a crisis situation that you would objectively define as being a life threatening or potentially life-threatening situation, that would certainly increase your index of concern that the patient is at substantial risk of attempting suicide?

A Sure.

Q There are steps, are there not, Doctor, as a psychiatrist that you can take in a patient that is at substantial risk of committing suicide to reduce the likelihood of the patient causing himself harm or death, true?

A Yes.

Q And what are some of those steps that you can take if you foresee that the patient is at risk, at substantial risk of attempting to commit suicide?

A Well, you can intervene clinically. You can hear the

person out. You can try and do problem solving.

You can involve more of the person's support system. You can involve their family. You can try and engender hope.

You can sometimes start medication, which pharmacologically is not going to do anything for the immediate crisis because they take time to work, but just the idea that there may be hope for the future can help. There are a whole variety of clinical steps that you can take.

If you are asking what you can take if the person is not amenable to those clinical steps, what involuntary treatment can be imposed on somebody, is that the question?

Q Well, that's part of the question, but you are answering it fine.

A At the extreme end, you can certainly hospitalize somebody voluntarily, which, depending on the situation, may help and may actually make things worse. So it's not an automatic response.

But in the extreme case, if somebody is imminently suicidal and has done recent acts suggesting that they are at risk, you can invoke an emergency detention, which in Wisconsin requires involvement of legal authority, law enforcement.

Q Lawyers?
A No, cops.
Q Cops, okay.
A They actually file the fifth standard and they have to be the ones convinced that there is imminent risk.
Q As an aside, in your report you indicated that records only need to be kept for seven years?
A I believe that's the legal standard.
Q And where is that legal standard memorialized?
A You know, I don't know, but we had this discussion at the Mental Health Center of Dane County where we are being pushed out of our building because of records and they are now destroying older records of closed clients.

And at that point, not being the person who runs the record room, but being part of the senior administration, I was told that somebody looked it up and that seven years is the legal standard in Wisconsin.

Q Do you know what the legal standard is in Ohio for record retention?
A No, I do not.
Q We can agree, I think you told me this before, that suicide is certainly a significant -- strike that. Can we agree that suicide is the number one cause of

premature death among people with manic depressive illnesses?

A Yes.

Q And can we agree that extreme depression and psychosis can result from a lack of treatment of a patient that has bipolar affective disorder?

MR. SHROGE: Objection.

A It's a funny wording for a question. Treatment can certainly help people decrease the frequency and intensity of their depression. That's not exactly the same question you asked.

Q Well, lack of treatment?

A Can make things worse.

Q Yes.

A Yes.

Q So extreme depression and psychosis can result due to a lack of treatment --

A Yes.

Q -- in a patient that has a bipolar --

A It's a strange wording, but yes.

Q I told you that not all my questions are artful. What psychiatric journals do you subscribe to?

A American Journal of Psychiatry Archives, Psychiatric Services, Journal of Clinical Psychiatry and a whole bunch of newsletter type things.

Q Have you reviewed any literature at all in connection with this case?
A No.
Q If you wanted to find articles or book chapters that you felt to be generally good sources and reliable on the topic of suicidality or the measures to take in psychiatric evaluation and prevention of suicide, where would you look?
A I would take up Shawn Shea's book on suicide, which I think is the best treatise on the subject, S-h-e-a.
Q S-h-e-a.
A Any of his clinical articles or his book, and they are readily found on MEDLINE.
Q And you consider him to be an authority in the area of suicidality?
A I teach from his material.
Q That's a good endorsement. So I would take it the answer to my question is yes?
A Yes.
Q And the book and the journal articles that he's written on suicidality you consider to be reasonable sources of information on the topic?
A Yes.
Q Authoritative in the area?
A Yes.

Q Are you aware of any specific guidelines or standards that have been published with regard to evaluation of patients for risk factors for committing suicide?
A There are many different standards. The problem is when the subsequent research has been done, some of the proposed standards in fact are not very good at predicting suicide. And so it gets complicated, depending on which standard you are looking at, how to make sense of them clinically.
Q Are there any written standards that you consider to be applicable and generally followed in the psychiatric community today?
A I don't think there is actually any one standard. The one that I happen to like and that I teach is one that's promulgated by this guy Shea in his writing, which is a way to clinically investigate suicidality rather than a check-off of just risk factors. I would be glad to give you an hour treatise on how you do that if you'd like.
Q At $300 an hour, I will pass.

MR. PFAU: That's probably a bargain.

MR. MISHKIND: That's true.

(Counsel examines document)

Q Have you ever had a patient of yours commit suicide?

A Yes.
Q How many?
A I get more or less involved with different people because of my consulting arrangement, so it depends on how you count.

I can remember quite graphically the first patient of mine who ever killed himself, which is now more than 20 years ago. And I continue to have some contact with his parents.

I'm not exactly sure of the number, but there have probably been 10 people that I have been associated with. There have been at least four that I was clearly associated with as a primary therapist.

Q After the deaths took place, were there steps that you professionally said that you should have taken to have reduced the risk of that patient committing suicide?

MR. PFAU: Objection.

A You always do a certain amount of soul-searching and review and what could I have done different and if only I had done that different. I think that's part of the process.

Looking back in the cases that I have reviewed, did I come up with major errors that, going forward rather than looking back, I would have done different, no.

Q Were any of those patients outpatients or were they --
A They were all out. Well, actually one patient, I didn't even think of, killed herself on a locked unit at University Hospital on suicide precautions.
Q University Hospital where?
A Here.
Q Okay. Here in Madison?
A That was a long time ago. The others were all in the community.
Q While suicide can happen without errors being made by the psychiatrist, can we also agree that the risk of suicide can be, the potential of the patient committing suicide can be reduced by the psychiatrist providing ordinary and reasonable care for the patient?
A We hope. That's why we are here.
Q But that's a true statement, correct?
A That's true.
Q You can't prevent all of them, reasonable care in terms of appreciating that a patient is at risk of committing suicide and taking precautions because you foresee the potential of them committing suicide can reduce the risk of suicide happening?

MR. SHROGE: Objection.

A Again you are getting into complicated areas. The

first time you said it I agreed with it, which is appropriate treatment can decrease the risk, decrease suicides. You edged into something else.

Because I'm dealing all the time with people of varying degrees of potential, and if my primary job is to always eliminate suicide, I'm going to lock everybody up in a hospital. And therefore, as part of growth and change and a whole variety of competing needs, one often takes various kinds of risks. And that's part of the dilemma of being a clinician.

Q Doctor, let me ask you this. What's required to comply with the standard of care of a mental health care provider when a patient presents with suicidal ideations in order to comply with the standard of care?

A If one is --

MR. SHROGE: Objection.

A If one is doing an assessment, if one is functioning as that person's clinician and the person is, has acute changes, because the situations are different for people who are chronically suicidal, I deal with people who from one month from one week from one year to the next continue to be suicidal, and the assessment and the way you intervene them is really quite different, but for somebody who has not been

chronically suicidal, you want to do a suicide assessment, that is, you want to explore how it came on, how serious it is, what plans have been made, the degree of hopelessness, what kinds of coping the person has, has not done, what stresses are involved.

You want to understand clinically the current picture, relate it to past episodes of similar situations and then come up with a plan, if you can, to decrease the future risk, not always by putting the person in the hospital, but by doing some intervention with the client.

Q Is there an increased incidence of suicide at or around the time of holidays?

A You know, that has often been said, but when it's been studied, it's been difficult to find that reliable. Some studies have shown it, but others have not. And we used to teach it, but it doesn't seem to be as robust as we thought.

Q I asked you before whether you knew Dr. Sudak and you said you did not?

A I do not.

Q Are you familiar with the chapter that he's written in the Comprehensive Textbook of Pyschiatry?

A I'm familiar with the Comprehensive Textbook of Psychiatry. I have not reviewed his chapter.

Q From your review in this case and the knowledge that you have gained either directly, or assumptions that you have been asked to make or information that Mr. Pfau has given to you, accurate or inaccurate, did Mr. Lorelli have any characteristics of the type of patient that in your professional opinion would be at risk of committing suicide?

A He was male.

Q Okay.

A That increases risk. He had a bipolar diagnosis. That in and of itself increases risk.

He was saying that he wasn't sleeping, which I think to some slight extent increases risk in a bipolar patient, one worries about it, especially if that's been a change.

Other than that, I don't have enough clinical information to answer further.

Q If in fact he also indicated that he was going through a life or death situation, would that outward expression of that type of statement also increase the risk of the patient committing suicide?

A Sure. I wasn't exactly sure, in the different interpretations, about whether he is referring to a past event or current event. That's a bit confusing, but certainly if somebody now says, you know, I'm

going through a life and death situation, one would think that would increase risk.

Q How often do people that talk about committing suicide actually go ahead and execute their plan?

A Too often. On the one hand, most people who talk about suicide don't. On the other hand, most people who do suicide have talked about it. So it depends on how much is too much or too little.

Most people who talk about it don't, but that doesn't in any way leave us sanguine that it's okay. Most people who talk about killing somebody don't either, but the fact that somebody would make specific threats doesn't let us rest easy.

Q Earlier we talked about certain disagreements that you had with Dr. Sudak?

A Uh-huh.

Q And I would like you now, I would like to give you the opportunity to spill them out.

(Witness examines document)

A There are a couple of ones. One is the recordkeeping. He seems to suggest, let me just --

(Witness examines document)

A "Proper assessment would have indicated an emergency psychiatric admission was required to prevent a suicide." The question is this assumes that there was

an obligation to do what I would call a clinical assessment.

And there seemed to be an assumption built into this that even if he had been seen briefly outside of the scheduled appointment, there was a clinical obligation to then put off whatever else he was doing, Dr. Newman, Dr. Giannini, and attend to this one person and to take the half hour or hour, whatever it would take, to do that kind of true clinical assessment.

For somebody who was not my patient, I would not see myself as having that obligation. And so the question is is that a reasonable standard of care.

Q When you say for someone that's not my patient, if Dr. Giannini assigned Dr. Newman to see Mr. Lorelli on September 4th and hypothetically Mr. Lorelli did come for that appointment --

A If he did come for that appointment and that appointment was carried out, then he is a patient.

Q Okay.

MR. SHROGE: Objection.

Q And, Doctor, do you recall in Dr. Newman's testimony that he doesn't have any recollection of ever meeting Mr. Lorelli?

A I remember that.

Q He has no explanation for how Mr. Lorelli obtained the, his home telephone number. Do you recall that as well?

A I remember that.

MR. SHROGE: Objection.

A The other part of this is this is unfortunate, but I think much of the note taking done by receptionists is not at the same standards as medical records. And I think that's true virtually of every clinic I have seen or reviewed, including this one and the Mental Health Center.

I think that standards of recordkeeping for telephone notes handled by receptionists is a standard that is not supportable in the real world.

The other part of it, which I think I disagree with, is the idea that you would recognize or the reception staff would recognize a patient seen 15 years before as a previous patient. I think that's a standard that is extraordinarily unrealistic.

We are now beginning to be able to do that because we have automated computerized systems, but that starts at the time of our current computer system. I think there are very few places that would automatically recognize a patient from 15 years before as a patient or be able to pull the records with any

kind of reasonable time.

Around here it might take a significant number of days, even if you recognized that it was a patient, to get the records over here. So those would be the major areas of disagreement.

Q Of disagreement with Dr. Sudak?

A Yeah.

Q Okay. Is there any evidence that you see from anything that you have reviewed or assumptions that were given to you that Mr. Lorelli was showing "drug seeking behavior"?

A I don't have enough clinical information to know that. Evidently he called in saying he needed medication and he wasn't able to sleep. That can be somebody who is drug seeking sleeping pills or it can be somebody who is beginning a hypomanic episode and knows that not sleeping is an early sign that they need help. I don't think we have enough information to make that determination.

Q Can we agree that most drugs that are given for sleep are called --

A Hypnotics.

Q -- hypnotics, correct?

A That's correct.

Q And most of these drugs, with maybe a rare exception,

are not narcotics, correct?

A They are not narcotics. There are varying degrees of usability or addiction potential.

Q If you are presented with clinical evidence that a patient that is, that you see presents as a clear psychiatric emergency, what steps need to be taken to comply with the standard of care?

MR. SHROGE: Objection.

A Well, one question about standard of care is is this somebody who is my patient, do I have legal as well as moral responsibility here.

Q Let's assume that there is an undertaking, implicitly or expressly, either as a matter of law or factual determination, that there is a physician-patient relationship, assume that hypothetically, then --

A Then one either has to do enough of an assessment to figure out what's going on and whether it can be put off until one has time or one needs to transfer that person to a place where that assessment can be done.

So you are doing an initial triage. And the triage requires certain basic risk assessment.

Q Is it ever acceptable in a physician-patient relationship, where a patient presents with a clear psychiatric emergency, not to take steps to determine the degree of risk that that patient presents to

himself or to others?

MR. SHROGE: Objection.

A Once you determine that there is a psychiatric emergency, then one needs to intervene the same way that, whether you are somebody's physician or not, if they are bleeding, one staunches the blood flow. The question is does one automatically know, without doing more of an investigation, that there is an emergency going on.

And very often I deal with people who, when you first sit down with them, the emergency or the nature of the emergency may not be at all apparent.

So if somebody is clearly in an emergency, the answer is you have an obligation. The question is at what point do you have an obligation to find out if there is an emergency. That's often a harder question.

Q I think you said -- strike that. Would you agree that Kathy Ludt made a mistake in terms of not dating and timing Mr. Lorelli's telephone call?

A Yes.

Q Would you agree that she was also negligent in not recording the no-show or the cancellation on the calendar if in fact Mr. Lorelli did not appear for the appointment?

A I think negligent may have a different legal case than what I mean. She should have done it. It was against office procedure. And it would have made life a lot easier for a whole variety of reasons had she done it. Whether that's legally negligent or not is an issue beyond what I can talk to.

Q Good answer.

(Counsel examines document)

Q And we can certainly agree that the records that were maintained by the defendants, the one that you have been retained by and the other one that's represented by the guy on the other end of the phone, those records clearly do not indicate whether or not Mr. Lorelli was or was not seen on September 4, 1998, true?

A They don't speak to the issue at all.

Q I think you also acknowledge that there is substantial confusion in terms of exactly what was discussed on the phone when Mr. Lorelli first called, correct?

A That's correct.

Q And this issue of life or death situation, going through bad time, if in fact that was relating to current events as opposed to historical events, do you know whether that took place during the first call or the second call?

A I don't.
Q Why in your report do you assume that the note does not reflect a current or immediate life-threatening emergency?
A I took the note as saying that he wanted something for sleep or anxiety. That's what I thought was in the initial note.
Q Well, we know the note that says wants something --
MR. PFAU: Actually this isn't the actual note that I gave him though.
A I can't quite find it.
MR. PFAU: It's attached to that letter.
MR. MISHKIND: This is a transcription of the note. There is no question that this is what was written.
A Where are we here?
MR. PFAU: I will get you one.
MR. MISHKIND: Here, you got it attached here too. (Indicating)
MR. PFAU: Yeah.
Q This is attached to Mr. Pfau's letter to you --
A Yeah, you have it.
Q Just to reiterate, my question then to you is in your report you assume that the note does not reflect an

immediate, current life-threatening emergency?

A You know, there are different ways that one can take this note and read it depending on what one thinks the correct pronunciation of the syllables is.

The way I read it, which is not the only way to read it, was that he had gone through a life or death situation in '79 or '80, now he just wants meds, says he doesn't need counseling.

If he were now in a lot of distress, I would have assumed the tenor of the note would have sounded different than that, but certainly other reasonable people can make other assumptions.

Q It doesn't say he had gone through bad times, it says going through, correct?

A Yeah. Like I say, I think there are lots of different ways to read this.

Q And you are assuming, for purposes of being the expert for Dr. Giannini, that this did not present as an immediate, current life-threatening emergency because this was something historic as opposed to something current, is that true?

A That's true. The idea that they scheduled him fairly promptly for an appointment suggests that somebody had some levels of concern and tried to respond to it.

Q Well, let me ask you to assume that, since you don't

know when this information was conveyed, if in fact the patient was based upon going through a life or death situation, bad time, patient was given an appointment for September 24th.

A If somebody called up and said I'm going through a life or death situation, and the first appointment with me was three weeks hence, four weeks hence, I would have assumed that the person would have been told go to the emergency room, go to the crisis service.

Q That would have been a reasonable and prudent thing to do, correct?

A That would have been a reasonable and prudent thing to do. So the idea that an appointment was even made, when the first appointment was offered some weeks down the road, would have suggested that either the person did not present in that kind of distress, or was willing to wait for that kind of an appointment, or there was something about the interaction that suggested this was not an immediate, acute, life-threatening emergency.

Q Or isn't there another possibility that you have left out?

A It's possible that the receptionist could have been incompetent or untrained. That's certainly a

possibility.

Q And you can't rule that out?

A Cannot rule that out. Having said that, it's possible that then following that, the person then tried to wait for an appointment, got an appointment, didn't keep the appointment.

It's also -- one could hope that if the person was in that much distress, they would have gone to an emergency room or some kind of crisis service knowing that the first appointment was some time down the road.

There are lots of different possible scenarios, but the most likely one, as I read it, is not that he is now in that kind of acute distress because there is nothing about I told him to go to the emergency room, our first appointment is the 24th.

Q And again you are assuming because it's absent that therefore this individual, in her judgment, didn't feel that his statement was a crisis or an emergency?

A It makes me think that if she had heard correctly or incorrectly that this was a crisis or an emergency, she would have responded in some different way than an appointment some weeks down the road.

Q Do you know what caused the office to, after giving her the, giving him the appointment on September 24th,

what caused the office to give him an appointment on September, for September 4th, some two to three days after he had originally called the office?

A Dr. Morrison's assumption in her report was that he had called a second time. And that makes as much sense as anything else, given that we don't have any data or information and we are all guessing.

Q Do you have an opinion or a position as to when that second call was made?

A No.

Q And again for purposes of your opinions, you are not taking into account any of the testimony of the family members, or neighbor or friend in terms of the state of mind that they experienced --

A I have not seen any of that testimony.

(Counsel examines document)

Q If Mr. Lorelli had been seen on September 4th and evaluated in a session, he didn't need to undergo, during an initial session by a licensed professional counselor, an MMPI, did he?

A No.

Q Would you agree that the initial assessment on September 4th, if in fact one took place and Mr. Lorelli came in, would have been to ascertain perhaps, among other things, the following, a history

that would have included suicidal thoughts and ideations, a history concerning any paranoid thoughts, and a history concerning his level of depression as well as his level of mania that he was experiencing?

A All those things would be expected to be part of an adequate initial assessment.

Q And that would be something that you would expect whether it's by a psychiatrist or a licensed professional counselor seeing someone in a psychiatric clinic, true?

A Yes.

Q Standard of care wouldn't be any different for one versus the other, correct, in terms of the initial psychiatric evaluation?

A Not in terms of basic risk assessment, which is what you are talking about.

Q True. Okay.

(Counsel examines document)

Q Do you know how Mr. Lorelli took his life?

A It's in the coroner's report. I would have to review it.

(Witness examines documents)

A If I had done my homework better, I would know and I don't without looking.

MR. PFAU: You've answered his

question though, Doctor.

THE WITNESS: Yeah.

MR. PFAU: If he wants another one, he will ask it.

Q Doctor, if two days after the visit to the clinic, September 6th, Mr. Lorelli took his life and if in fact he had been seen on September 4th, 1998, do you have an opinion more likely than not as to whether Mr. Lorelli was suicidal on September 4, 1998?

A I can't answer that. At times these things develop over time and one can clearly catch them. At other times they can really be quite impulsive and the situation can change rapidly. So without some clinical data, it's hard to judge.

Q Can you rule out the likelihood of him committing suicide on September 6th, on September 6th -- strike that. It's never going to come out the way I wanted it and I didn't want you to criticize me for my question.

A Sorry about that.

Q That's all right, not a problem. Can we agree that Mr. Lorelli was at substantial risk on September 4 of committing suicide given what we know took place on September 6th?

MR. PFAU: Objection.

A Actually, surprisingly, we don't.

MR. SHROGE: I didn't hear the whole question, but I think I know the gist. I object.

MR. MISHKIND: Even if you don't know the question, you can object.

MR. SHROGE: What was the question?

A Given that we know that he killed himself on the 6th, couldn't we have predicted that on the 4th.

MR. SHROGE: I will definitely object.

A And the answer is no. There are times in which one can clearly, by doing a clinical interview and assessment, make these predictions, which is why we do them, but other times people become suicidal very impulsively and very rapidly and very unpredictably. And so I have certainly seen people days before who two days later become very suicidal in quite unexpected ways.

Q So you would need to know and understand the clinical picture that was taking place on September 4th to be able to tell me whether or not this patient, whether you could have predicted that this patient was going to commit suicide in the imminent future?

A Correct.
Q My question wasn't quite the way that you put it though. I asked you whether or not he was at substantial risk of committing suicide on September 6th, on September 4th knowing that he comitted suicide on September 6th. It was a little bit different than the way --
A Since we know the end, it's tempting to say that we should have known that earlier in the book. What I'm saying is that without knowing the clinical situation of the 4th, we don't know very much about how he was on the 4th.
Q So again, it would depend upon the clinical information that was available and/or presented on September 4th as to whether or not a reasonable mental health care provider should have known that or should have appreciated that Mr. Lorelli was at substantial risk of attempting to commit suicide?
A That's correct.
MR. PFAU: Objection.
MR. SHROGE: Objection.
A Can I ask for a return of this phone call?
(A short recess is taken)
Q You looked at the office policy or manual, true?
A I did.

Q And there is some reference to someone calling in a crisis should be referred to an emergency room, correct?

A There is a reference that they should be, a therapist should be contacted, they should not be put on hold.

I was told that the training includes calling an emergency room. I don't believe that that was part of the procedures manual.

Q Fair enough. We can agree that there is nothing in the record indicating that Mr. Lorelli at any time during any of the telephone calls or when he showed up on September 4th, assuming he did show up, was referred to an emergency room, correct?

A We have no information about that.

Q Nothing to indicate that he was referred?

A Right.

Q Okay.

(Counsel examines document)

Q What information have you been provided by Mr. Pfau or you have obtained on your own relative to the appropriateness of giving the home phone number in this practice, Giannini's practice, to a patient or a new patient?

A I don't know anything about their policies or practice. Since ethics and boundary issues is one of

the things I regularly lecture on, we can talk about that in some length if you'd like.

Q In terms of their office policy --

A I don't know about their office policy. There is tremendous individual variation from one practitioner to another about practice styles.

Q But as it relates to what the employees are instructed to do or not to do on a new patient or a patient that presents relative to giving the home phone number, you don't know, correct?

A I do not know.

(Counsel examines documents)

Q Doctor, do you blame Mr. Lorelli?

A For what?

Q For his death.

MR. PFAU: Objection.

A No. I actually consider the question somewhat bizarre actually.

Q Okay. That's all right. I take that as a compliment.

How do you define the term standard of care? We have been talking about that for two and a half hours or so, but I never bothered asking you to tell me what you meant by standard of care.

A Well, first of all, I think it's often a legal term,

but as I understand it, it is what I expect reasonable practitioners to actually do in their general day-to-day practice, not necessarily the standards to which we aspire, to which we would always like to do, but what we in fact generally accomplish in all of the vestige and compromises that we typically make.

Q And you would expect that Dr. Giannini and Dr. Newman would be judged by the national standards of care for what you would expect an ordinary and reasonable practitioner to do under like or similar circumstances, true?

A Yes. I think there is some areas where there may be differences from one community to another, but in terms of how to do a basic risk assessment, if that in fact is called for, that's pretty standard.

Q Doctor, I believe that I have finished my questions, but I just want to find out whether there are any other opinions that you hold with regard to specifics in this case as it relates to standard of care that you have defined for me or causation in terms of the cause of Mr. Lorelli's ultimate suicide that we have not talked about during our get-together this afternoon?

A I don't believe so.

Q Thank you. Exhibit 3, would you take a look at

Exhibit 3 for me.
A My scratches.
Q Yes. Is that in your handwriting?
A Yes.
Q It's on a piece of legal paper?
A Yes.
Q Dated March 11, '03?
A It was based on a phone conversation that I had with Mr. Pfau.
Q Can you read what it says there?
A "Patient 'seen' in the office by a doctor. Drug seeking - not an emergency. How did he know? Former patient issue. Failure to maintain a proper record." It took me about 15 minutes for the phone and the review of information he previously sent.

MR. MISHKIND: Okay. Very good. With that, Doctor, I thank you for your time. I have no further questions.

MR. PFAU: Michael?

MR. SHROGE: Yeah, I'm still here. I have not gone to sleep yet. I do have just a couple of very brief questions for the doctor, if I may be so obliged.

MR. PFAU: Go ahead.

MR. SHROGE: Can you hear me okay?

THE WITNESS: Yup.

MR. SHROGE: Hello?

THE WITNESS: Yup, go ahead.

EXAMINATION

BY MR. SHROGE:

Q Doctor, I did not have an opportunity to introduce myself prior to the start of your deposition. My name is Michael Shroge. I'm from the law firm of Reminger & Reminger and I represent Dr. Newman in this case.

First of all, in addition to the materials that you were provided and the facts you were asked to assume, you have been asked to assume some facts by Mr. Mishkind and provided other facts, given all that other information he provided to you today, have those changed the opinions that you have set forth in your report of March 18th, 2003?

MR. MISHKIND: Objection.

A Not substantially. Basically the issues are what are the relevant facts of the case. My best view is that the facts as maintained by Dr. Morrison seem to be as good a guess as any. And given that, I would concur with her opinion that I think that there were no deviations from standard of care primarily because there did not seem to be the development of an appropriate doctor-patient relationship that was in

force.

Q And absent Dr. Morrison's report, did you have materials available to you prior to writing your report that allowed you to make that assessment in and of itself?

A I did not try and review in detail the facts of the case, but based my report very largely on the assumptions that Mr. Pfau asked me to make.

Q I understand that. What I'm asking is did you feel that you had the facts necessary to author your report?

A Yes.

Q Okay. Doctor, would you ever put your reputation behind your report or author a report in a case if you did not believe that you had the necessary facts to reach your opinions?

MR. MISHKIND: Objection. Go ahead.

A No.

Q All right. Thank you.

A I don't need the business that much.

Q Do you have any criticisms, independent of what Mr. Mishkind has asked you, do you have any criticisms of Dr. Newman in this case?

MR. MISHKIND: Objection.

A No.

MR. SHROGE: All right. I don't have anything further.

(5:55 p.m.)

STATE OF WISCONSIN)
)ss.
COUNTY OF DANE)

I, HEIDI L. DAVIS, a Notary Public in and for the State of Wisconsin, do hereby certify that the above deposition was taken before me at the offices of Wisconsin Pyschiatric Institute and Clinics, 6001 Research Park Boulevard, in the City of Madison, County of Dane and in said State, on October 8, 2003, commencing at 3:10 p.m.; that it was taken at the request of the plaintiffs, upon verbal interrogatories; that it was taken in shorthand by me, a competent court reporter and disinterested person, approved by all parties in interest, and thereafter reduced to writing by me using computer-aided transcription; that said deposition is a true record of the deponent's testimony; that said deposition is to be used in the above-entitled action now pending; that the appearances were as shown on Page 3 of the deposition; that reading and signing was requested; that the said RONALD J. DIAMOND, M.D., before examination, was sworn by me to testify the truth, the whole truth, and nothing but the truth relative to said cause.

Dated October 15, 2003.

Heidi L. Davis
Notary Public, State of Wisconsin

ERRATA SHEET

CASE NAME: Patrick Lorelli vs.
A. James Giannini

REPORTED BY: Heidi Davis

DEPOSITION OF: RONALD J. DIAMOND, M.D.

TAKEN ON: October 8, 2003

Pg	Ln	Presently Reads	Should Read	Reason
53	12	date	data	transcription error
89	6	Fifth Standard	emergency detention	I mispoke
101 102	3	USABILITY	amusability	transcription error

I have read the deposition and am requesting the above corrections be appended to the original transcript.

WITNESS