IN THE COURT OF COMMON PLEAS

CUYAHOGA COUNTY, OHIO

JANET L. PORACH, etc.,

Plaintiff,

-vs-

JUDGE CALABRESE
CASE NO. 316045

LORENZO S. LALLI, M.D.,

Defendant.

- - - -

Video deposition of BRUCE D. JANIAK, M.D., taken as if upon direct examination before Aneta I. Fine, a Registered Merit Reporter and Notary Public within and for the State of Ohio, at The Toledo Hospital, 2142 North Cove Boulevard, Toledo, Ohio, at 10:15 a.m. on Saturday, April 4, 1998, pursuant to notice and/or stipulations of counsel, on behalf of the Defendant in this cause.

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On behalf of the Plaintiff;

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On behalf of the Defendant.

ALSO PRESENT:

Randy Andrews, Video Technician.

MR. RISPO: Let the record reflect that this is the direct examination of Dr. Bruce Janiak to be taken on direct examination for use in evidence at trial pursuant to notice and agreement of counsel. Any defects in the notice or agreement have been waived.

MR. MISHKIND: That's correct.

MR. RISPO: And that will you waive the filing requirement, the one day filing requirement?

MR. MISHKIND: Sure, not a problem.

MR. RISPO: Good. Now we're ready to go on the record.

If you will swear the witness, please.

BRUCE D. JANIAK, M.D., of lawful age, called by the Defendant for the purpose of direct examination, as provided by the Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

DIRECT EXAMINATION OF BRUCE D. JANIAK, M.D.

BY MR. RISPO:

Q. Good morning, doctor.
A. Good morning.
Q. My name is Ron Rispo. I represent the -- Dr. Lalli in this case, the defendant in this matter and I'd like if you would please to introduce this testimony by explaining where are we at the present time.
A. We are in a conference room at the Toledo Hospital in Toledo, Ohio.
Q. And it's Saturday, the 4th of April, I believe it is?
A. Yes, it is.
Q. And where will you be next week?
A. Next week I am scheduled to be in Washington, D.C. attending a meeting as a representative of the American College of Emergency Physicians.

The meeting has to deal with the, what's called the Med Teams project which is a government-sponsored project that attempts to improve communications in chaotic situations like an emergency department or an airplane cockpit to reduce errors and accidents and omissions.

Q. Okay. And according to your original plans do you expect that you'd be available to testify in

trial on this matter on Tuesday of next week?
A. No. My original plans would prevent that.
Q. Okay. We will then proceed with your videotape deposition, doctor.

First of all, would you please explain to us, are you licensed in the State of Ohio?
A. Yes, I am.
Q. And do you hold any Board-certifications?
A. Yes. I am Board-certified in emergency medicine.
Q. And what offices or titles do you currently hold?
A. Well, I'm director of the emergency center here at Toledo Hospital and I am president, currently of the Emergency Department Benchmarking Alliance which is a group of emergency physicians and nurses from large hospitals that are looking to evaluate and share best practices to improve patient care.
Q. How long have you been director at Toledo -- Emergency Services at Toledo Hospital?
A. Since 1974.
Q. Would you give us a brief thumbnail of your education and training?
A. Well, I went to Marietta College in Marietta,

Ohio then the University of Cincinnati for medical school which was 1965 through '69 and then I did internship and residency at the Cincinnati General Hospital through 1972 and finished an emergency medicine residency training program in '72 and then I served in the Navy for two years at the Pensacola Naval Hospital and in 1974 then I came here to Toledo.

Q. And where did you pursue your internship?

A. At the Cincinnati General Hospital in Cincinnati.

Q. And what subject areas did you pursue?

A. An internship by definition is a broad exposure so it's multiple areas.

Q. How about your residency?

A. That was focused on emergency medicine.

Q. Along the way did you have time to get married?

A. Yeah, I did.

Q. And do you have any children?

A. Yes, I do.

Q. How many do you have?

A. I have 14 children.

Q. 14?

A. 14.

Q. Are they all your children, natural children?
A. No. There's three natural and 11 adopted.
Q. Okay. Thank you, doctor.

Are you familiar with the standards of care for an internist in the City of Cleveland in 1994 as it relates to the care and treatment of myocardial infarctions?

A. Sure, inasmuch as whenever I see patients that have myocardial infarctions and many of them are transferred to the care of cardiologists but many others are transferred to internists so I certainly know what they do in the early phases of their evaluation, yes.
Q. Okay. Same question as it relates to nurses doing triage in the emergency room.

Are you familiar with the standard of care for them in the care and treatment of a myocardial infarction?

A. I'm aware of the standard of care for them in the way they triage patients and what their key evaluation should be in the triage area and then as they assist us in the emergency department itself and how they help us, yes.
Q. Okay. And have you any special expertise in that area, nurses, triage and emergency room?

A. Well, I don't know that I would regard myself as a, certainly not an author in nurse triage but have worked with them for over 20 years on how they do it, so sure, from an experiential viewpoint, yes.

Q. And as a specialist in emergency room care you see it every day?

A. Every day.

Q. Okay. Is there a published standard for nurses in an internist's office who take calls and set appointments for the recognition and care of myocardial infarctions?

MR. MISHKIND: Let me just show an objection to relevance. Go ahead.

A. Not that I'm aware of.

Q. Okay. Are you aware of any published standard for receptionists in that setting?

A. I am not.

Q. Would the standard or the expectation for a receptionist be different from the standard which would apply to a Board-certified cardiologist?

A. Certainly.

Q. Would it be different from the standard which applies to a specialist in emergency medicine?

A. Certainly.
Q. Would it be different from the standard that would be expected of a Board-certified internist?
A. Yes.
Q. Have you reviewed the case of John Porach at my request?
A. Yes, I have.
Q. What materials have you reviewed?
A. Well, I've reviewed the medical records, multiple depositions of the personnel involved in the care, and the relatives, and the electrocardiogram taken from Dr. Lalli's office, autopsy report.
Q. Okay. And the EKG?
A. And the EKG, and there's also an emergency record that was created I think by Dr. Gershman when the patient was trying to be resuscitated at the hospital emergency department.
Q. Okay. Before we go into the details of John's case, could you define a few terms for us?
First of all, angina?
A. Angina in its broadest definition refers to pain that is caused by lack of enough oxygen to a particular tissue. So even though we don't

operationally use it this way you could have angina in your abdomen if you didn't have enough blood supply to your bowel, called abdominal angina, but normally when we use the word angina we refer to pain which is caused by lack of enough oxygen to the muscle tissue of the heart. That is a common, if you don't define it any further when you talk about angina, you talk about heart angina.

Q. Is angina the same thing as a myocardial infarction?

A. No. Angina is actually and characteristically short duration, maybe 20 minutes, sometimes 30 minutes at the most, and is not by definition associated with heart muscle damage.

Q. Can you define the term ischemia?

A. Ischemia would be a gray zone which is almost between angina and infarction. The pain in the heart muscle caused by a lack of oxygen is called angina. The ischemia is usually used when we can actually medically prove that the heart muscle is not receiving enough oxygen and so when we do an electrocardiogram there are certain changes when this is occurring, you look at the electrocardiogram and you say ah-ha, that

is ischemia of the heart because there's not enough oxygen to the muscle. So the angina refers to the pain, the ischemia refers to what's physiologically happening in the heart.

Q. And in the context of the previous definitions, what is myocardial infarction?

A. Myocardial infarction is actual death of muscle tissue of the heart caused by lack of adequate blood supply to that part of the heart, usually by a narrowed or closed artery.

Q. What is the typical sequence of angina, ischemia, and/or myocardial infarction?

A. Well, although some patients go through all of these events in a very short time frame, actually some of them go through this time frame in seconds, there are other patients that, and probably very commonly have for a while some pain which is called ischemia then they have diagnostic evaluation which we can -- I'm sorry, the pain is angina, the diagnostic evaluation shows ischemia, and then untreated and then progressive if that goes on the patient can end up with a myocardial infarction.

Sometimes you can do things to prevent that, the most common thing is called bypass

surgery, then there are other techniques of actually putting wires in the arteries and opening them up. There are things that prevent infarction.

Q. Are angina and ischemia always prior in time to the myocardial infarction?

A. No. It doesn't always happen that way. Sometimes there can be what's called a thrombosis or a clot in which the artery is cut off on an instantaneous basis and then the patient suffers instantaneous pain and the beginning of a infarction or death begins right at that second so there's not months that go by, it's seconds that go by.

Q. Can you have a myocardial infarction in the morning and angina in the afternoon?

A. Oh, I think that's quite possible.

Q. On the same day?

A. Sure.

Q. And can you have angina in the morning and ischemia in the afternoon?

A. I think it's possible, too. Sure.

MR. MISHKIND: Objection. Move to strike.

Q. What is meant by the term sudden death syndrome?

A. Sudden death really in very general terms refers to a human being who looks well and does not seem to be in great distress and then within seconds is dead. There are numerous causes for that.
Q. What is a fatal arrythmia?
A. A fatal arrythmia is an irregular heartbeat which is so irregular that the heart is not able to pump blood sufficient to keep the person alive.
Q. Can that occur without a myocardial infarction?
A. Yes, it can.
Q. Can it occur with a myocardial infarction?
A. Yes, it can.
Q. Is it always associated with a MI, myocardial infarction or a heart attack?
A. No, it is not.
Q. Is it predictable?
MR. MISHKIND: Objection.
A. Sudden cardiac death is never predictable.
Q. In terms of time?
A. In terms of time.
Q. Okay. Are you familiar with the statistics published by any recognized or authoritative references that establish annually the number of

deaths due to coronary vascular disease?

MR. MISHKIND: Objection.

Q. I'm sorry, cardiovascular disease?

MR. MISHKIND: Objection.

A. Yes, there's some material put out by the American Heart Association that indicates that there is --

MR. MISHKIND: Excuse me for one second. Let me show an objection to reference on direct examination to articles as evidence in defendant's case in chief. Go ahead, doctor.

A. There's articles put out by the American Heart Association, cite figures in the range of just under a million patients who die of cardiovascular disease every year and probably around half a million patients that actually have heart attacks and somewhere a little over half of those are defined as death which is relatively sudden but not the same as the definition I just gave you because the American Heart Association is looking to educate people with regards to seeking care when they have signs and symptoms of a heart attack. So these statistics indicate that when they say over half

of that half a million are those patients who die before they can seek hospital, before they choose to seek hospital care or before they can seek hospital care.

MR. MISHKIND: Let me just interject and move to strike for a number of bases. Number one, again, Ohio does not adopt the learned treatise on direct examination; there's no opportunity to cross-examine the author of these articles on cross-examination; it's directly prohibited on direct examination; further, the answer was not responsive to the question.

Q. Based upon your education, training and experience, doctor, do you have an idea of what the statistics are for the number of deaths annually due to coronary vascular disease?

MR. MISHKIND: Objection.

A. As far as I understand it it's about half a million.

Q. Okay. And do you have any idea from --

MR. MISHKIND: Move to strike.

Q. -- your general reading what the number of deaths are due to sudden death syndrome?

MR. MISHKIND: Objection.

A. I don't think I know sudden death syndrome. I think within a couple of hours of the onset of symptoms the answer is a little over half of those half a million according to the American Heart Association.

MR. MISHKIND: Objection. Move to strike.

A. As I said before, I define sudden death as something instantaneous and the American Heart Association is looking at this as something before the person elects to seek medical care or can seek medical care and they use two hours.

MR. MISHKIND: Objection. Move to strike, reference to they, and American Heart Association, same basis.

Q. Okay. Given those statistics, doctor, do you have an explanation for the reasons for patients' failure to seek treatment?

MR. MISHKIND: Objection.

A. Well, I think I'd characterize that in two ways.

MR. MISHKIND: Excuse me. Let me just show that it's so vague and speculative. Go ahead.

A. One is there are certain subsets of patients who

die before they can seek treatment even if they so choose but from evaluating hundreds of patients like this myself there is an element of denial in all of us and that is that a patient, we all tend to minimize our symptoms and hope it's nothing bad and people are somewhat concerned about their hearts and don't want to really believe that that's the problem so one of the primary reasons for this delay is that the patients are denying that that could be their heart and they don't come in to seek care fast enough. That's the reason for the American Heart Association's educational program.

MR. MISHKIND: Objection. Move to strike.

Q. Are MI's, heart attacks, always presented with typical symptoms?

A. No.

Q. Are there situations where they're atypical symptoms?

A. There certainly are.

Q. And the cases in which there are atypical symptoms, does that contribute to the delay in treatment?

MR. MISHKIND: Objection.

A. Well, that's an excellent question. I don't know if anyone's ever studied it. I can only tell you from my personal experience that the more atypical the symptoms the harder it is to end up with a diagnosis even when the patient presents to us in the emergency department so I would have to think that normal human beings, when the symptoms were not classic and not those taught by the media and the American Heart Association would be more likely to delay seeking care.

MR. MISHKIND: Objection. Move to strike.

Q. And do you have an idea what the incidence of denial is among male, especially younger male patients?

MR. MISHKIND: Objection. w/p

A. You know, I've never read a study specifically on that but --

Q. What is your experience?

A. My experience is that it's very common.

Q. Okay.

MR. MISHKIND: Move to strike. w/p

Q. Referring or going back to John Porach, then, doctor, and based upon your reading of the

materials, what is the understanding you have of his case, what occurred on October 14th of '94?

A. My understanding is that he woke up along with his wife and they were as usual going to go to work but he felt ill and told her about the fact that he did not want to go to work and he wanted to stay home and characterized his illness in a almost generalized, he had problems of I think he was, felt sweaty, he felt weak, he felt, he had diarrhea, and he was aching and I think he may have had tingling in his hands at that time, and indicated that he was going to stay home.

Later in the day, after she convinced him to call for an appointment he called a physician's office, described his symptoms to the receptionist who indicated that she would get back to him about getting in later that day but could not fit him in in the morning.

Later in the afternoon in the mid afternoon he complained as I understand it to his daughter that he was having achiness in his chest at least if not actual chest pains and some shortness of breath and she picked up the phone, dialed the doctor's office and put him on the phone in which he described to the receptionist

that he would like to come in and get evaluated since she had not gotten back to him. She said she could get him in to the office and he said fine, he would like to have an electrocardiogram because his family felt that he should have one and she agreed that that was -- she could do that, and he made his way to the office driving his own car and got into the office, waited in the range of 30 minutes, had an electrocardiogram, during that time he was not reported to be in significant distress, went to the bathroom, collapsed and resuscitation was attempted but it was unsuccessful.

Q. Referring to the symptoms that were reported as early as 6 in the morning, would you consider those symptoms diagnostic for myocardial infarction?

A. I would not.

Q. Would they be considered typical?

A. No.

Q. Atypical?

A. Atypical.

Q. As of 9:30 in the morning, if the evidence establishes that before that period of time Mr Porach's symptoms were relieved and eased by 7

in the morning and at 9:00 he called, 9:30 he called and spoke to the receptionist, Jan Schoch and asked if he could get an appointment that day and she asked him why, or what was his complaint and he said, I awoke this morning feeling crummy, and she asked him, what do you mean, and he said, well, I'm achy all over, I have tingling in my arms, legs, including my chest, and may or may not have also added that he had diarrhea, cold sweats, heartburn, and/or a fever.

And the receptionist then asked him, do you have chest pain, and his answer was, no, and the receptionist asked him further, do you have a history of heart disease, and he answered, no, and she then responded, well, I have no appointments that I can get you in, but I'll try and fit you in later in the day, I'll call you back.

I want you to assume those are the facts that are present in this case and I want to ask you whether based upon your education, training and experience you have an opinion as a matter of reasonable medical probability whether the present -- whether the action taken by the

receptionist was appropriate and reasonable under the circumstances.

MR. MISHKIND: Before he answers let me just interpose an objection to the hypothetical as put because it does not accurately set forth the facts that are in evidence in this case or will be in evidence, but go ahead.

MR. RISPO: Okay. Since we're in deposition at this stage I'd like you to ask him now on the record what did I leave out.

MR. MISHKIND: What did you leave out. The statement by Mrs. Schoch in terms of the description of the symptoms.

MR. RISPO: Mrs. Schoch.

MR. MISHKIND: Mrs. Schoch has already testified as to what Mr. Porach said and what she said in response and the way that you --

MR. RISPO: What was that?

MR. MISHKIND: And the way that you've categorized it it was not accurate. I'm not going to state the question properly for you, but you have not

categorized, you have not stated the facts accurately

MR RISPO: You won't even tell me what it is I've left out.

MR. MISHKIND: This is your direct examination I'm objecting If you want to reword the question

MR RISPO: You're going to play games with me.

MR. MISHKIND: No. If you want to reword the question.

MR RISPO: In absence of a specific complaint or objection I would consider you've waived that objection.

MR MISHKIND: No. My objection is noted for the record the hypothetical does not accurately set forth the facts. If you want to reword the question to accurately set forth the facts in this case especially as admitted by Mrs. Schoch then I would be happy to withdraw it. Absent that I don't think I have to reword the question for you, Mr. Rispo.

MR RISPO: Well, I think I've accurately stated the testimony of Miss Jan

Schoch so I'll proceed.

Q. Given that predicate, doctor, do you have an opinion based upon your education, training and experience whether as a matter of reasonable medical probability the receptionist responded in an appropriate manner?

MR. MISHKIND: Objection.

A. Yes, I have an opinion.

Q. And what is your opinion?

A. That she did respond in an appropriate manner.

MR. MISHKIND: Move to strike.

Q. Do you have an opinion based upon the same facts and circumstances whether Jan Schoch acted reasonably at 9:30 in the morning when she told Mr. Porach that she had no openings but would try to fit him in later in the day, and when she did not refer him immediately to an emergency room. Do you have an opinion?

A. Yes, I do.

Q. And what is your opinion?

A. That that was reasonable based on the information she had.

Q. Okay. Based upon the same facts and circumstances do you have an opinion as a matter of reasonable medical certainty whether the

patient, Jack Porach, acted reasonably when he omitted or failed to call for emergency assistance at 6 in the morning before he even called the receptionist?

MR. MISHKIND: Objection.

A. Yes, I have an opinion.

Q. What is your opinion?

A. That based on the description of the signs and symptoms from his viewpoint that he should have -- he did fail, he should have called for help, based on the information that Miss Schoch had, it was reasonable to not call for help.

Q. Okay. If I added the symptom shortness of breath in the morning at 6:00 in the morning, would that be significant?

A. Yes, it could be, sure.

Q. And how is it significant?

A. Well, it's just more additive information, it's not definitive, it doesn't make a diagnosis but it would make one more concerned if that's what you heard from the patient.

Q. Okay. If the patient reported to his wife that he had shortness of breath, aching and tingling in his arms and legs, along with all of the other symptoms, would it be reasonable for him

or her to fail to call for emergency assistance?

MR. MISHKIN: Objection. Form.

A. I'm going to ask you to repeat the question because I think you asked if it was reasonable to fail and it sounded like a double negative. I'm not sure I understood.

Q. Reasonable for them to have waited until 9:30 in the morning to call the doctor's office?

A. No. Based on those symptoms with the shortness of breath it would have been very reasonable for them to seek care right then rather than wait to call the doctor's office.

Q. And why do you say it would be reasonable for them to call for emergency care?

A. If he was then complaining of shortness of breath and chest pain or chest achiness, then it would be reasonable to at least seek immediate medical advice at 6:00 in the morning. If the information is characterized as more abdominal discomfort and diarrhea then it would be perfectly reasonable to wait.

Q. If, in fact, Mr. Porach did complain of shortness of breath to his wife at 6 in the morning but then failed to include it in his symptoms when he described it to the

receptionist, and did describe all of the previously listed symptoms including achiness in the arms, legs, including his chest, diarrhea, cold sweats, heartburn, and/or fever, was the patient acting reasonably in failing to report his shortness of breath?

A. No, I think --

MR. MISHKIND: Objection.

A. Sorry. No, I think you have to describe the range of symptoms that you are experiencing.

Q. Was the patient, Jack Porach, acting reasonably when he laid around at his home from 6 in the morning to at least 3:30 in the afternoon without calling for an emergency medical team or himself to drive him to the emergency room?

MR. MISHKIND: Objection.

A. Well, no, my opinion is I don't think he was acting reasonably although it's pretty typical for patients to deny these kinds of symptoms.

During the time frame from 6 in the morning as it was starting to get better one could see why someone would tend to minimize the symptoms. Once you get to the middle of the afternoon when the symptoms are worse that's when it was clear that he should of sought

emergency medical care.

Q. Okay. Now, I'd ask you to assume that the testimony is and the facts are, as of 3:15 or 3:30 in the afternoon Jack Porach called Jan Schoch, the receptionist in the doctor's office again and asked, and introduced himself and asked her again if he could get in for an appointment, and her answer was, yes, come on in, I'll fit you in later whenever you can ge here, and then he, Jack asked, can I get an EKG, and the receptionist asked, why, and his response was either, my family is concerned, or I -- it would make my family feel better, and she answered, sure, but she did not refer him immediately to an emergency room.

Based upon your education, training and experience and knowledge of this case, including the symptoms as reported earlier in the day and the denial of chest pain, do you have an opinion as to whether the receptionist acted reasonably when she told him to come on in for an appointment on the same day and did not refer him immediately to the emergency room?

A. Yes, she did.

MR. MISHKIND: Excuse me for one

second, doctor.

THE WITNESS: I'm sorry.

MR. MISHKIND: Objection to the hypothetical based upon the facts stated in the hypothetical.

MR. RISPO: I understand there's a difference of view.

Q. Do you have an opinion, doctor?

A. Yes.

Q. And what is your opinion?

A. That that was reasonable action for her to take based on that information.

~~MR. MISHKIND: Move to strike.~~

Q. And did she or Dr. Lalli breach any standard of care when she took the actions and gave the advice that she gave?

A. Not that I'm aware of.

Q. Assuming that Dr. Lalli instructed his receptionist to listen to a patient's complaints, inquire where appropriate if there is any chest pain or a history of heart disease, and if the patient responds positively or affirmatively, instructs her to refer the patient immediately to the emergency room, or in the alternative if he says no, or the patient

says no to any of those, to schedule an appointment on the same day, whether Dr. Lalli acted reasonably and/or conformed with the standard of care in training his receptionist?

A. Yes, I think that he did act reasonably and conformed to the standard to do that. As a matter of fact, I think Dr. Botti in his deposition indicated that he actually has the receptionist refer the patient to a physician when they have those complaints rather than directing them to the emergency department and personally I think Dr. Lalli's is a better approach because it gets the patient to the emergency department sooner.

MR. MISHKIND: Objection. Move to strike. Not responsive to the question.

Q. Okay. Do you have an opinion based upon your review of this case as to what was the cause of death?

A. Yes.

Q. And what was it?

A. I think it was ventricular fibrillation.

Q. And do you have an opinion as to when and how many myocardial infarctions there were?

A. Well, I think I've said before in my deposition

I wasn't even sure there was a heart attack and I base that on the fact that I was not very impressed with the electrocardiographic changes and the diffuse symptoms the patient had, however, I recognize that the pathologist has indicated that at least on histopathological or cellular evaluation that he thinks there was one and I believe I said I would defer to the pathologist in that knowledge, that my view is if this patient had a heart attack it certainly happened at 5:30 in the morning or that range or earlier than that because the electrocardiogram is consistent only with an older myocardial infarction, not one that's quite that fresh.

Q. Do you have an opinion as to what occurred later in the day at 3:30 in the afternoon, how would that be explained if the myocardial infarction occurred at or before 5 in the morning?

A. Yes, I have an opinion.

Q. What is that?

A. My opinion is that the patient was having anginal pain in the afternoon and I base that upon the fact that he was having that complaint even though he didn't characterize it very well, at least there is some evidence that he told

some people about it; and that the electrocardiogram that was taken was more consistent with angina than ischemia or infarction; and then thirdly, he had a sudden death, that is, a death characterized that occurred within seconds when he walked into the bathroom. That would be consistent with angina and fibrillation rather than infarction and fibrillation.

Q. Given the facts of this case, all that we have been through to this point in time, in your opinion, was Mr. Porach's death avoidable?

A. Well, it certainly was not avoidable in the office. The only way it could have been avoidable would have been for him to have avoided the sudden cardiac death component by going into an emergency department very early in the day, but in the way the case played out in the doctor's office my opinion is it was not avoidable.

Q. Okay. Among the materials that you have reviewed have you seen the autopsy?

A. Yes.

Q. And in particular with reference to the findings on autopsy, of moderate to severe multifocal

sclerotic heart disease, and 20 percent blockage, this is Dr. Hoffman I'm quoting now, 20 percent blockage of the left coronary artery and 80 percent sclerosis of the right coronary artery, do you have an opinion as to whether those conditions would have an effect upon normal life expectancy?

MR. MISHKIND: Objection.

A. Yes.

Q. What is your opinion?

A. Well, keep in mind I don't do these statistics and I'm not a cardiologist so I can't give an exact number, but it is common knowledge that when patients have this degree of heart disease that their life expectancy is shortened by some amount, I just don't know the amount.

MR. MISHKIND: Objection. Move to strike. Lack of foundation.

Q. It would be reduced in any event?

A. Yes.

MR. RISPO: Thank you, doctor. I have no further questions.

Mr. Mishkind.

MR. MISHKIND: Thank you very much.

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CROSS-EXAMINATION OF BRUCE D. JANIAK, M.D.

BY MR. MISHKIND:

Q. Doctor, I have a few questions for you this afternoon or this morning I should say. I met you for the very first time I believe back in November of 1997 when I took your discovery deposition. You recall that, don't you?

A. Yes.

Q. And at that time you had written back in July a letter to a nurse in Mr. Rispo's office by the name of Kathleen Mulligan on Janiak Consulting, Incorporated stationery, correct?

A. That is correct.

Q. And that's the only letter that you have written relative to your opinions in this case, correct?

A. Also correct.

Q. Janiak Consulting, Incorporated, that is a private corporation that you have set up for your consulting work which primarily involves medical-legal work, correct?

A. Exactly correct.

Q. And your medical-legal work that you have been providing has been a service that you have been providing since the mid 1970's, correct?

A. Yes, sir.
Q. So the jury understands your experience in this area since the 1970's, the testifying that you have done has been approximately 75 to 85 percent as an expert witness defending a doctor or a hospital, correct?
A. That is correct.
Q. And --
A. Closer to the higher number if you take the whole spectrum.
Q. All right. And you have served as an expert witness not only in the State of Ohio but in other states as well?
A. Yes, sir.
Q. You've also served as an expert witness in multiple counties in the State of Ohio, in Lucas County, in Dayton, in Stark County, in Franklin County, in --
A. Hamilton.
Q. Cuyahoga County, Hamilton County. Just to name a few, correct?
A. That is correct.
Q. And when I took your deposition back in 1997 you indicated to me at that time that you were reviewing approximately 15 to 20 cases a year

involving medical malpractice issues, correct?
A. That was true for I think '96 and '97.
Q. And when I took your deposition I think you told me that you had approximately 40 cases that you were serving as an expert in one capacity or another at that time?
A. I think that's correct. It might be more actually. Now that I look back at the files.
Q. With this experience, doctor, that you've had as an expert witness is it fair to say that you have at least as of the time that I took your deposition, that you had never appeared as an expert witness on behalf of a plaintiff in the Cleveland, Ohio area?
A. I think that's correct, to my memory, best of my memory.
Q. And can we agree also that that has not changed since November of 1997?
A. I'm not sure. I've gotten a few cases, several plaintiff's cases since November, but I just can't tell you if it's Cleveland, but if there are any it's one.
Q. Okay. And, in fact, doctor, outside of the Cleveland area can we agree that at the time that I took your deposition and up to this

present time that it had been the late 70's or about 20 years since you had testified in the State of Ohio as an expert witness on behalf of a plaintiff?

A. As far as my memory hasn't changed from the deposition I think that's still correct.

Q. You give depositions on the average twice per month, correct?

A. That was true for '96 and '97. It's not true for '98 but you're right.

Q. Has it increased for '98?

A. No. It's decreased. Remarkably.

Q. And you told me when I took your deposition that you charge $300 per hour to provide your testimony, correct?

A. Yes, sir.

Q. And has that changed?

A, That has not changed.

Q. And you told me that in 1997 in terms of testifying and working in medical-legal matters that the additional income that you made from this consulting work was somewhere in the range of $50,000?

A. Right. In the range. Yes, that's what I told you.

Q. And that constitutes approximately five to eight percent of your income?
A. That's what I told you
Q. And that was accurate?
A. No. I went back and looked at that. It's a little bit high.
Q. So what you told me wasn't accurate?
A. That's right.
Q. All right.
A. I gave you a range though so a range by definition is not meant to be totally accurate.
Q. Well, is it still within that range or outside of that range?
A. It's very close but I'll explain it again. It's probably closer to 40,000 rather than 50,000 and the eight percent is ten percent but it's pretty close.
Q. All right. You are not an internist, are you?
A. I am not.
Q. You have never practiced as an internist?
A. I have never done that.
Q. Yet you were asked at the very beginning of the deposition whether or not you had opinions concerning whether or not Dr. Lalli and the -- his office met accepted standards of care

in this case, correct?
A. I think I was asked, the first question I was asked dealt with whether I knew about how the standard of care for internists in dealing with myocardial infarction and my answer dealt with yes, from the standpoint of handing them off from the emergency department to their initial early care. The second part of it dealt with the standard behaviors of a receptionist, and I indicated that I felt I knew about that.
Q. You've had some limited experience with health maintenance plans, correct?
A. That's correct.
Q. As a medical director with health maintenance plans?
A. That is correct.
Q. So that in that capacity, you're familiar with to a certain extent even though you've never practiced as an internist in a doctor's office like Dr. Lalli or Dr. Selwin or some of the other experts in this case --
A. Yes.
Q. -- you've had some outside exposure to the policies and procedures that go on in offices, correct?

A. I have indeed.
Q. And in that connection you've indicated to me previously that you realized that physicians' offices have to have policies and procedures that permit the office to operate in a reasonable manner, correct?
A. I agree with that, yes.
Q. And you would certainly agree that a physician's office has to have policies and procedures to handle medical emergencies in order to operate in a reasonable manner?
A. That was certainly one of the things we dealt with in health maintenance plan.
Q. And you would certainly agree that a medical office has to have a policy so that it's easy for nonmedical personnel to know what to do or not to do when a patient calls with an acute or recent onset of symptoms, correct?
A. I believe that everyone who's in a medical office who's answering the phone has to have some background, training, experience, guidelines to control their behavior when they answer the phone.
Q. Because in essence those people are an extension of the physician in a office, correct?

A. Certainly from the patient's viewpoint they are and I think in reality they are, sure.
Q. So that the standard of care that one is evaluating is the standard of care of the office, sometimes the initial contact with the physician is by nonmedically trained people but the physician has to make sure that the office is operating in a safe and reasonable manner, correct?
A. I think that's fair, yes.
Q. And if it isn't then ultimately the physician is the one that has violated the standard of care, correct?
A. I think that's the way it works here in America, right?
Q. I mean you agree with that, I'm not saying anything --
A. Oh, sure. Sure.
Q. You provided opinions on direct examination relative to life expectancy but yet you're not a cardiologist and have never practiced as a cardiologist, correct?
A. Exactly.
Q. And certainly an internist operating an office on a day to day basis would be in a better

position to comment on the responsibilities of an office staff in terms of opinions on standard of care then you as an emergency room doctor, correct?

A. Well, except that I've had a little more experience in terms with the health maintenance plan in looking at how offices operate so I would say that I would agree with you for some internists and disagree with you with others. It would be an individual thing.

Q. At the time that you wrote your report back in July 7, 1997 you had not seen the autopsy on John Porach, had you?

A. As far as I remember I had not.

Q. At the time of the deposition you had not seen the deposition of Mary Nary or Jacqueline DeWitt or Dawn DeWitt, had you?

A. I think that is correct.

Q. In fact, doctor, at the time I took your deposition you didn't even know who Mary Nary or Jacqueline DeWitt or Dawn DeWitt were, did you?

A. I think that's correct.

Q. Having served as an expert witness as many times as you have, doctor, you would agree that it's important that you consider as much relevant

information as possible in order to arrive at honest and objective opinions in a case, correct?

A. I couldn't agree more.

Q. Now doctor, in your report -- do you have a copy of your report handy?

A. I do if you'll hang on a second I'll look for it. Unless someone else has one right in front of them.

Q. Well, I'll let you reference -- here, I'll give you a copy of it, save some time here.

A. Thank you.

Q. Sure. In your report, doctor, if you would read the first two sentences, starting with, "At your request"?

A. Certainly.

"At your request, I have reviewed the case of Porach versus Lalli. I find that this was a gentleman who was having nonspecific discomfort with tingling in his arms and legs and diarrhea and other symptomatology who called the physician's office for an appointment. They were able to 'get him in' during the afternoon of the phone call."

Q. Okay. Now, in your report you make no mention

other than tingling in the arms and legs and diarrhea, you don't make any mention at all about aching in the chest, in the arms, in the head, in that report, do you?

A. That's right. Specifically I do not do that, you're right.

Q. And the patient requesting electrocardiogram that you mentioned in the report, have you -- are you aware of the fact that the stepdaughter was present when the telephone call was made to the doctor's office in the afternoon?

A. Right. I think her name was Jacqueline.

Q. Okay. And is there -- I take it you are accepting the testimony of Mrs. Schoch and rejecting the testimony of Jacqueline in terms of concluding that it was Mr. Porach that requested the electrocardiogram?

A. Yes.

Q. And you would agree, doctor, that Mr. Porach when he woke up in the morning, had a number of symptoms which could be descriptive of a number of different conditions?

A. Yes, sir.

Q. And certainly a patient doesn't diagnose his own

condition, correct?
A. Correct.
Q. The fact that the patient stayed home from work in order to seek medical care is a reasonable thing for the patient to do, correct?
A. I guess the way I understand it is he stayed home from work because he didn't feel well and then the decision to seek medical care was something that happened after his decision to stay home from work.
Q. When did the decision to seek medical care take place based upon your review in this case?
A. Well, that would have been at 9 something in the morning when he made a phone call. That's the first objective evidence we have of that.
Q. Okay. And certainly if the facts are different in terms of when the decision to seek medical care occurred, that might affect some of the opinions that you hold in this case?
A. Always possible.
Q. If the patient stayed home from work and the decision to seek medical care was at the time, the point in time, the decision to seek medical care was made at the point in time when his symptoms occurred that would certainly be a

reasonable thing for the patient to do, correct?
A. To seek medical care, yes.
Q. And to make the decision to seek medical care more importantly. You got to make the decision first before you seek it?
A. Yes. I agree with you. I see what you're saying.
Q. And if the patient's symptoms subsided somewhat and the patient was feel somewhat better would it be reasonable for a patient to say that he would call his doctor's office as soon as the doctor's office called to obtain an opinion from the doctor?
A. Yes. Well, obviously, it depends on what the symptoms are in a generic patient, but yes, that would be reasonable as I think I indicated earlier.
Q. And certainly if a patient calls a doctor's office, you would expect that there would be enough discussion between the patient and the doctor's office so that decisions can be made as to whether or not the patient needs to be seen or whether or not the patient doesn't need to be seen, correct?
A. I'm not sure about that and I don't want to be

unfair, I want to try to answer the question.
Q. Go right ahead, doctor.
A. I can see a decision between needs to be seen in the office or needs to be seen elsewhere, but needs to be seen versus doesn't need to be seen, I'm not aware of an office saying they won't see anybody. There might be a time frame, it might be next week or three days or a month but I don't think never seeing them is an option. That's what I was getting at.
Q. Do you have any understanding as to what Dr. Lalli's policy was with regard to which patients his receptionist would turn over to the doctor to talk to and which patients would be scheduled for an appointment as the time allowed?
A. Only with respect to patients that appeared to be having significant coronary symptoms. My understanding is is that Miss Schoch would be authorized to tell the patient to seek emergency care evaluation on an immediate basis. In terms of patients with other complaints, abdominal, urological complaints, I do not have an understanding of those.
Q. And you didn't gather such an understanding from your review of the depositions in this case?

A. I did not.
Q. Okay. How long had Mr. Porach been a patient of Dr. Lalli's based upon your review in this case?
A. I'd have to go back and look at that.
Q. When I took your deposition --
A. I had to look it up then, too.
Q. You didn't have a specific recollection of that at that time --
A. Right.
Q. -- and as you sit here right now --
A. Right this second, no. That's a piece of information that keeps slipping out of my mind.
Q. Okay. Do you know what Mr. Porach's cholesterol level was?
A. I want to guess -- that's not fair. 252 or something like that but I don't -- I'm not sure I'm right.
Q. Are there medications that are on the market for treatment of people with high cholesterol?
A. Yes, there are.
Q. Is that something new or is that something that's been on the market for --
A. It's been on the market for a number of years, probably in excess of ten years and of course there's also other things you do for

cholesterol. Exercise and diet.
Q. In addition to exercise and diet, there are medications that doctors, internists and the like can get patients to help reduce the cholesterol levels?
A. That's what they're supposed to do.
Q. Okay. Do you know where Dr. Lalli was when Mr. Porach called in the morning?
A. No. I think that was my answer in the deposition, too, I don't know where he was during that first phone call.
Q. Do you know where Dr. Lalli was when Mr. Porach called in the afternoon on October 14th?
A. Yes, I do. He was in the office.
Q. And certainly you would agree with me that based upon your review in the case Mrs. Shock promised Mr. Porach that she would get back in touch with him after their first telephone call, correct?
A. Yes, that's what I understand.
Q. But she never did call back, did she?
A. That's right. She didn't call, he called instead.
Q. Right. He called at 3:15, 3:30 in the afternoon?
A. Exactly.

Q. There's no evidence as to the fact that she tried to reach him before that, is there?
A. No. I think the evidence is to the contrary, that she had not accomplished that at that point.
Q. Okay. And do you have any evidence as you sit here right now that would indicate to you that she was, in fact, going to call him back that day?
A. Well, I think she indicated that she had a series of notes or of tests that she would accomplish during the day and that would normally be her policy is to go back and do what she said she was going to do but I don't know there could be any evidence that would predict the future, in other words. I have no evidence for that.
Q. And certainly when you say about a series of tests she had to do and policies, did you gather that from something that you read in her deposition?
A. I think in her deposition she said she kept a series of notes on a piece of paper of little tests that she had to accomplish as the day went on.

Q. And she also said you recall in the deposition that she would mark down symptoms that a patient would call up in in like a day sheet or a --
A. Yes, I think.
Q. Or I think a note pad?
A. Yeah. Excuse me. Yes, I think she did.
Q. All right. And have you ever seen those notes?
A. No. As a matter of fact, I think she testified that they were destroyed every day.
Q. Do you find it at all unusual, doctor, that a patient that calls twice to a doctor's office, that communicates complaints to the doctor's office, that then essentially dies in the doctor's office or very close to dies in the doctor's office, has ventricular fibrillation in the doctor's office later that day, that the notes written about the patient's symptoms would not be retained by the doctor's office?
A. I've never actually thought about that. I don't know whether that would be unusual or not because that piece of her operation I don't, I just don't have any knowledge about. I don't know.
Q. Let me ask you about an emergency room. If someone calls, if someone comes into an

emergency room and something's marked down relative to the patient's symptoms or a patient calls in and then comes in to the emergency room, is information put down and maintained in the patient's chart relative to the symptoms that the patient described?

A. Let me describe what happens in my emergency department. We get phone calls from either physician's offices or from patients or people referring patients to us and there is a note created that indicates that Mr. or Mrs. So and So will be in with a certain kind of complaint. When that patient arrives, if there is further instruction, i.e., please -- let's say a private physician has called us and the physician will say please check the patient and call me, that note is kept until he or she is called and then it is destroyed, so that would be, we would throw the same piece of information away that the office did.

Q. You would expect that there would be some information recorded once the patient comes in in the chart indicating what had transpired, though?

A. Oh, yes, absolutely.

Q. And in this case, is there any indication that the symptoms that the patient described in the -- in either of the telephone calls was recorded in Mr. Porach's chart?
A. I see what you're asking and the answer is I don't think there is anything like that, right.
Q. Mr. Porach certainly was considered enough about his condition to call the doctor's office when the doctor's office opened, correct?
A. Well, I think that's part of it and part of it is the testimony indicated is his family was pushing him to do so, so it's a combination of his concern and their concern.
Q. I'd like for you to explain to the jury when you say the family was pushing him to the call the office in the morning. Where did you gather that idea?
A. Well, I think his wife indicated that she, that when he looked sick she indicated why don't you call the doctor and get something done and I think the daughter is the one who actually picked up the phone and dialed the call so that would be **I** think pushing to get communication established.
Q Doctor, you're talking about two different

episodes. I'm talking about in the morning, was it reasonable for Mr. Porach to have made the telephone call to the doctor's office?

A. Oh, yes. I'm sorry. Maybe I misunderstood you. Sure.

Q. And you said that someone was pushing him to make the telephone call in the morning. Who was it that was pushing him?

A. I think his wife suggested that he do that. You asked if it was all his doing and I said as for most of us we have our relatives who say why don't you call and get that checked. It's not a major issue, it's just normal.

Q. You're not faulting Mr. Porach for calling the office when the office opened in the morning because he felt ill and wanted some help to determine what was wrong with him, are you?

A. No, not at all.

Q. That was certainly a reasonable thing for him to do?

A. Absolutely.

Q. And do patients, if you have such knowledge do patients call doctor's offices sometimes with a set of symptoms and not knowing whether or not they need to talk to the doctor or whether they

just need to schedule an appointment to come in to see the doctor?
A. I would say that's very common.
Q. And frequently that's a decision that's made by the doctor's office as to whether or not the symptoms need to be seen right away or whether they're just going to schedule the patient, correct?
A. I would say that is true.
Q. And if the office is too busy to see the patient but the symptoms are described in a sufficient manner to cause some degree of concern would you agree that instructions need to be given to the patient so that he or she knows to go to the urgent care center or the emergency room because we just simply can't fit you in?
A. Sure. It's the subjectivity of the way the symptoms are described.
Q. And if instructions aren't given to the patient under those circumstances, would you agree that that would not be in compliance with accepted standards of practice?
A. If the patient describes symptoms that are triggering symptoms for the office staff that they knew or should have known were triggering

symptoms and are described in a way that convinces them that that's what's going on then they should follow their own unwritten if necessary policies and procedures and refer the patient for immediate care.

Q. And that would be the reasonable and prudent thing to do in order to comply with accepted standards of care?

A. I agree.

Q. Failing to do that would be a violation, it would be negligence?

A. Well, I don't know that I can personally make the decision of the negligence because I know it's a legal term but yes, it would be a certainly a failure of the standard failing to do that, sure.

Q. And it's Dr. Lalli's responsibility to assure that all of his personnel are appropriately instructed and are capable of performing within their job description in doing their job especially as it relates to triaging of telephone calls?

A. Let me answer your question technically because I think from your questioning viewpoint, yes, in terms of interacting with patients but you said

all of his personnel and some personnel who don't have patient contact can be instructed by those who do. There's office hierarchy, see what I mean. If it's a lab tech it may be irrelevant but for your purposes for communicating with patients I agree with you.

Q. I agree with you as well, someone that doesn't, isn't going to have contact with patients on the phone doesn't need to have that kind of acuity or that kind of knowledge from Dr. Lalli as to someone that is going to be having day-to-day contact?

A. Correct.

Q. Sort of on the front line so to speak.

A. Right.

Q. Because essentially those people are the gatekeeper to the doctor's office, correct?

A. Exactly.

Q. And you have to have the gatekeeper doing the right work otherwise the door isn't opened at the appropriate times?

A. Right. Or the physician is so tied up with doing the gatekeeping himself or herself that they can't function.

Q. Right. And they might as well go ahead and

answer the phone themselves?
A. Exactly.
Q. But on the other hand, the physician is there to respond to his patients and if the physician is too busy to respond to them he also has a duty, does he not, to make sure that the patient isn't left out in the cold so to speak?
A. I agree.
Q. Okay. Now, when I took your deposition I asked you whether or not you felt that Mr. Porach had had a myocardial infarction and I think you told me at that time that you were not sure, correct?
A. Yes, I think I said that, yes.
Q. And at that time when I took your deposition you already had Dr. Hoffman's opinions, you had the autopsy information, and yet you told me at that point that you weren't certain whether he did suffer a myocardial infarction, correct?
A. Yes.
Q. And doctor, if all of the experts testify in this case that to a reasonable degree of medical certainty Mr. Porach did suffer a myocardial infarction, including Dr. Barry Effron, cardiologist retained by Dr. Lalli, would you defer to those experts with regard to whether or

not he did, in fact, have a myocardial infarction or do you still stand on your opinion that he didn't have a heart attack?

A. No, I think I would defer to them, I think he had one. The issue is timing, obviously.

Q. There's certainly no evidence to suggest that he had a heart attack, at least to a reasonable degree of medical probability -- strike that.

There's no evidence to suggest that he had more than one heart attack, is there?

A. I didn't see that.

Q. And if he had one heart attack and the evidence suggests that the heart attack occurred sometime no earlier than four hours before his death and no later than 12 hours after his death -- excuse me, let me rephrase that.

No earlier than four hours before his death and no later than 12 hours before his death, and that's the testimony of Dr. Hoffman, you would not have any basis whatsoever to dispute that, would you?

A. No. That's based on his histology, I'm not a pathologist, I can't dispute that. The only basis I would have would be on the electrocardiographic findings which are

consistent with something older than 12 hours, but I can't dispute his opinion based on his evidence.

Q. And certainly when one looks at an electrocardiogram you don't just diagnose a heart attack based upon looking at a electrocardiogram?

A. Absolutely you do not.

Q. You need to have symptoms described by the patient and then you look at the electrocardiogram and you decide whether or not the picture fits together, correct?

A. Yes. It's a little bit complicated. I suppose I could have been a little inaccurate because it's possible in this extremely classical case to see a obvious heart attack, an acute heart attack on electrocardiogram in a patient as you suggested that doesn't have the correct symptoms and you'd have to scratch your head and say, am I right, is this an error in the cardiogram and maybe redo it, but that would be very, very rare instance.

Q. Can we agree that the electrocardiogram that was done in the doctor's office was done after Mr. Porach had already collapsed in the office, had

already experienced ventricular fibrillation, cardiac arrest, was taken off to Fairview General Hospital for further resuscitative efforts?

MR. RISPO: Excuse me?

A. No, I don't think we can.

MR. RISPO: Did you say the EKG was taken after?

Q. I'm sorry, the interpretation, excuse me. I'm sorry. I stand corrected.

The interpretation on the EKG was made after the patient had been in the office, had experienced ventricular fibrillation, had experienced cardiac arrest and had been taken to Fairview General Hospital?

A. I wouldn't have any reason to dispute that but, and I don't know when. If you're talking about Dr. Lalli's handwritten interpretation, it's not timed so I don't know when he would have written that but it was certainly done after the cardiogram was taken but how long after, I don't know.

Q. The best place to be, doctor, would you agree, to survive if one is going to experience ventricular fibrillation is in an emergency

department or in an intensive care unit?
A. Intensive or coronary care unit, the data show that's the best place to be.
Q. And the reason you want to be there is because there's the equipment to cardiovert your electrical rhythm or to provide antiarrhythmic medications to try to combat that electrical disturbance?
A. Exactly.
Q. And ventricular fibrillation can occur several hours to many hours after a myocardial infarction, correct?
A. Right. As the hours go by, the frequency decreases but it's always there. There's always, in any of us, a tiny chance that it could happen.
Q. And would you agree that there is a direct causal relationship in this case between the myocardial infarction that Mr. Porach suffered and the ultimate ventricular fibrillation that he experienced?
A. Yes, I think there is, we just don't know the time, which we just discussed, we don't know how many hours, but there should be a direct relationship between some damage or ischemia or

something caused by the heart attack, whether it was weeks or days or hours ago, and the fibrillation.

Q. But in terms of the actual time as to when he had the onset of the heart attack, that is something from a pathologic standpoint that you would defer to Dr. Hoffman?

A. That's what I said, yes.

Q. And knowing as we do now when the heart attack occurred, you certainly agree that there's a direct causal relationship between the myocardial infarction that he had and the ventricular fibrillation that developed, correct?

A. I'm saying that that would be true even if we didn't know when it occurred.

Q. But we do, we have the benefit of that because of the autopsy information, correct?

A. Well, we have the autopsy information but I said I can't dispute what he found at autopsy but the cardiogram is not consistent in timing and obviously there aren't any medical tests that are always perfectly coincidental.

MR. MISHKIND: Let's go off the record for just one second, please.

VIDEO TECHNICIAN: Off the record.

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(Thereupon, a discussion was had off the record.)

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VIDEO TECHNICIAN: On the record.

Q. What is your definition of the term ache?

A. Ache. I cannot describe it any further than a discomfort in some part of the body. It's obviously an extremely subjective term.

Q. And are you familiar with the medical definition of that in the medical --

A. The Dorland's Dictionary --

Q. Yes.

A. -- or one of the --

Q. Yes.

A. No. I'd have to go back and look that up.

Q. Okay. So if it indicated that ache is defined as pain you wouldn't dispute that, would you?

A. Boy, ache defined as pain. No. That's fine. That's a stretch to me but if that's what the dictionary wants to say, that's fine.

Q. As far as your statement in your report that the patient did not verbalize chest pain to the receptionist prior to coming to the office,

again, you are entirely discounting the testimony of Dawn DeWitt when she said that she was present and heard her stepfather say on the phone, this is Jack Porach calling back again, I have chest pain, shortness of breath, and then there was silence on the line and he then got off the phone and said to her that we're going into the office, they told me to come into the office for an EKG, you would dispute that, or you have eliminated that from your consideration in this case, correct?

MR. RISPO: Objection. Only because you said Dawn DeWitt.

Q. I'm sorry. Jackie.

A. Yes. I understand. Yes, I'm discounting that, yes.

Q. And you are, for purposes of the jury, you are accepting Mrs. Schoch's testimony that he called up and said hi, this is Jack Porach, I'm calling back again, can you fit me in, and by the way, my family's concerned about me so can I come in for an EKG?

A. Yes, sir.

Q. That's what you're accepting?

A. Yes, I am.

Q. Okay. And in a patient that does not have any cardiac history, that does not have any complaints of pain, chest pain, you don't find that at all unusual that they would call up, a patient would call up, request to come into the office, request an EKG when there's no indication at all that they're having cardiac symptoms?

A. Right. I would not find it unusual that they would request an EKG, but remember that there's testimony that she asked if he was having chest pain when he requested the EKG and once he said no, and I'm accepting that testimony that that was totally reasonable because I don't think it's that unusual for patients to request these tests.

Q. And if what you just said is not an accurate statement of the facts in this case might that affect the opinions that you hold?

A. As I said before, anything that changes what ends up being accurate might affect my opinion.

Q. Okay. And I just want to make sure that the jury understands what you've just said and if that's not an accurate statement of the facts that might affect the opinions.

A. Absolutely might. I agree with that.
Q. All right. Thank you very much.
We can certainly agree that if Mr. Porach had been directed to an emergency room in the morning of October 14, 1994 and if he had had even vague symptoms suggesting myocardial ischemia or vague symptoms suggesting the potential for myocardial infarct he would have immediately been placed on continuous monitoring with a stat ECG or EKG being obtained, correct?
A. I don't dispute that those things would have happened. I have a dispute with 1994 and immediately because I think the whole medical, the whole emergency medical profession was heading towards immediately but if you're talking about the standard of care in 1994, it might have been within 20 minutes or 30 minutes. Just to show how things have changed, if this happened today you'd be more accurate.
Q. But doctor, we have to talk about 1994.
A. Exactly. So that's what I'm doing.
Q. So it would have been within 20 minutes rather then a fire sale type of thing.
A. Sure. That's all I'm trying to say.
Q. And because the greatest reduction in mortality

occurs in patients treated early time is of the essence when they arrive in the emergency room and in 1994 that time of the essence was to get them on continuous monitoring with stat EKG within 20 minutes or so?

A. 20 minutes or so, sure.

Q. And part of the workup for someone that has even vague symptoms suggesting a myocardial infarction would be cardiac enzymes?

A. Yes, if you're going to do the electrocardiogram in 1994 then cardiac enzymes would be part of it assuming the electrocardiogram doesn't give you the diagnosis.

Q. And the cardiac enzymes would take a while to come back, wouldn't they?

A. Yes. That's changed, too. In '94 we're probably talking an hour.

Q. In the meantime the patient's not being left to go home from the hospital, the patient is continuously being monitored while a number of things are going on to make sure that the patient is stable and is safe and either is having a heart attack or isn't having a heart attack, correct?

A. You are correct.

Q. The greatest survival improvement can be anticipated with an anterior infarction, correct?
A. Yes. There are more complications with an inferior infarction.
Q. Okay. Mr. Porach had an anterior infarction, though, correct?
A. Yes. The electrocardiogram shows that.
Q. And the measures that are implemented in an emergency room such as the facility here or facilities back in Cleveland, where there is a concern and a workup being done as to whether or not the patient is having a heart attack includes initial measures such as providing medication to relieve pain, to improve oxygenation, to provide vasodilation as necessary, and to be in a position to control any arrhythmias that may develop, correct?
A. All those things are true. The vasodilation dilation would be the least consistent of all those but yes, in general they're true.
Q. And if a patient were to be directed to the emergency room from his primary care physician where the differential would include a number of things, including a heart attack or potentially

less serious things such as the flu, arriving at the hospital there would be a detailed history that would be taken from the patient, correct?

A. Yes. Correct.

Q. And usually in most emergency rooms isn't the history taken by a nurse and then by the physician?

A. I think that's true. The first history would be either by the triage -- actually, sometimes, which is very annoying to patients, it's taken by the triage nurse and then the nurse in the room and then the physician.

Q. And the reason being is because they're in this acute setting and you want to make sure that all of the history and all of the facts are derived, correct?

A. All the relevant ones, yes.

Q. Sure. So that directing someone that has a differential of a potential heart attack to an emergency room also has the potential of eliciting a far greater medical history than trying to get something over the telephone, correct?

A. Oh, I think that -- sure, absolutely. It's much easier in person than over the phone.

Q. Dr. Janiak, would you agree that if Mrs. Schoch told Jack Porach that his symptoms sounded like the flu that that would not be appropriate for her to have done?
A. No, I would not agree that that would be inappropriate, no.
Q. So that if Dr. Lalli has testified and I suspect will testify that Mrs. Schoch was not supposed to tell patients that their symptoms sounded like the flu, over the phone, then you essentially would disagree with Dr. Lalli himself, correct?
A. I guess there's two issues. First of all, I think you're correct, but I would not personally think it was inappropriate but if he told her don't do that and she did, then that would be inappropriate in her job.
Q. And certainly in a doctor's office that has to have policies and procedures that are provided by the physician, so that the nonmedically trained people know what to do correctly and properly, if that's the requirement and the receptionist violates that, that's a violation of the standard of care, correct?
A. No. I think it's a violation of the

requirement. I can't say it's a violation of the standard of care.

Q. You would defer to an internist on that point?

A. I don't even know if anybody knows what the standard is on that point. I don't know who I would defer to.

Q. Well, you certainly recognize that a receptionist being a nonmedically related person is an extension of the physician, right?

A. Absolutely.

Q. And so certainly the standard of care is the standard of care for the physician merely because the receptionist happens to be the one that is gathering the information, you're still judging it by what a reasonable and prudent practitioner would have done under like or similar circumstances, correct?

A. No. I don't believe that's true at all.

Q. Well, do you feel that there is a standard of care for a receptionist?

A. No. I think I said there was not but I can't agree that the standard of care for a physician is the same as the standard of care for a nurse or for a receptionist.

Q. Can you explain to me then doctor why at Page 90

of your deposition, Line 10 you indicated to me on the fact that if you say your symptoms sound like the flu that's a far different case than saying you have the flu. I think receptionists have an ability and can within the standard of care be somewhat reassuring to patients without making diagnoses.

Did you tell me that at the time of your deposition?

A. Yes.

Q. Well, when you said that they can, the receptionist can within the standard of care, what standard of care are you referring to?

A. Well, first of all I indicated there was no written standard of care.

Q. But I'm asking you now what standard of care are you referring to, forgetting about whether it's written or oral when you said that in your deposition. Can you tell me that?

A. Sure. The experiential one that I have knowing how receptionists deal with people and knowing how my clerks deal with patients when they talk to them and how my -- years ago how my clerks dealt before we had triage nurses with patients. It's reasonable to be somewhat

reassuring.

Just for an example, if a patient calls up an office and says gee, I really have this aching all over, I'm tingling, I'm sweating, and I have diarrhea, gee, do you think it could be the flu. For the receptionist to say could be, I think you ought to be seen would be reasonable behavior within the standard of care in which the receptionist never really told him what the diagnosis was.

I will admit though that many patients will accept that as the diagnosis because they listen to what part they want to listen to and that's by way of explaining my opinion.

Q. Okay. Well, thank you very much for sharing that with me.

A. You're welcome, sir.

Q. If Mr. Porach had been directed to the emergency room in the afternoon of October 14, 1994 at the time that he made his telephone call sometime between 3:15 and 3:30, or had been told to call 911 and was transported to an emergency room, again, he would have been put into a monitored setting, a cardiac consultation would have been obtained?

A. Or an internist, not necessarily cardiac.
Q. And certainly he in all likelihood would have been in the hospital at the time that, assuming that he would have developed a ventricular fibrillation, he would have been in the hospital at the time that he went in to defib, correct?
A. I would say it would be very likely he would be in the emergency department still but he certainly would be in the hospital.
Q. And he would have been hooked up to monitors?
A. Correct.
Q. He would have had an I.V. in him?
A. Yes.
Q. They would have been in an immediate position to provide cardioversion, cardiac treatment to cardiovert his rhythm?
A. I agree.
Q. And he would have had a substantially greater probability of surviving a ventricular fibrillation than being in a doctor's office where there is not that kind of emergency medical attention?
A. I agree completely. For the short term. We don't know about years but we certainly know about right then, yes, you're exactly right.

Q. And you're certainly not going to provide opinions with regard to the long term in terms of years, correct?
A. I am not.
MR. MISHKIND: I don't believe I have any further questions for you, doctor. I thank you for your time.
THE WITNESS: Thank you, sir.

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REDIRECT EXAMINATION OF BRUCE D. JANIAK, M.D.
BY MR. RISPO:

Q. Doctor, if you're okay we can continue.
A. Sure.
Q. In light of all the points raised by Mr. Mishkind in his discussion of the case with you, do you have any reason to reconsider or modify any of the opinions that you've previously stated in this deposition?
A. No, sir.
Q. Or in your reports earlier?
A. I do not.
Q. Were your opinions today given based upon the facts as I have recounted them to you and the assumptions, including the trial testimony as adduced thus far as described by Jan Schoch

among others?
A. Amongst -- opinions based on that plus the materials, sure.
Q. Okay. And you have discounted however the testimony of Jacqueline DeWitt?
A. Yes, sir.
Q. In your experience is the recollection of a 12-year-old girl such as the stepdaughter here, Jacqueline DeWitt, several years ago reliable in establishing a medical diagnosis?
MR. MISHKIND: Objection. How can he possibly testify to that.
Go ahead, doctor.
A. My answer, my answer would be I certainly would not use as defining characteristics being female or being 12 to being 3, but being female or 12, not at all, but patients in general have a certain impression they take away from most medical interactions, which in retrospect is not the same impression that is garnered by the medical professionals or their ancillary help.
As a matter of fact, if we could solve this problem and learn how to really understand what's in a patient's heads we would be doing a lot better medicine but unfortunately as I can

testify from, you know, hundreds of miscommunications over 25 years of emergency medicine between myself and my staff and our patients, patients will say that we've for instance never examined them, no doctor was ever in the room yet we have records that prove that so there's a wide range of impressions patients get and that is why I discounted that testimony.

MR. MISHKIND. Objection. Move to strike.

Q. If the evidence at trial is that the patient, Jack Porach, awoke sometime between 5 and 6 in the morning and described certain symptoms to his wife which included shortness of breath, diarrhea, tingling in the arms and legs and so forth, but then later at 7 in the morning described those symptoms as easing or moderating, and that he did not report the same symptoms at 7 a.m. or at 9:30 a.m. to Jan Schoch or at 11:00 to his mother-in-law, Mary Nary when she called and he did not report the same symptoms to Jan Porach, his wife when she called home at 12 noon, and he did not report any complaints of shortness of breath or chest pain to his daughter, Jacqueline DeWitt when she

awoke that day around 12 noon, and he did not report the symptoms of chest pain or shortness of breath to Jan -- Jacqueline DeWitt at 2:00 when she spoke to him in between General Hospital and One Life To Live, and if the evidence was that he, the testimony of Jacqueline DeWitt was that he did complain, however, of shortness of breath and chest pain at 3:15, but that even Jacqueline DeWitt reported that on the hour, one hour trip from his home to Fairview General, excuse me, not to the emergency room, but to the doctor's office at Fairview Hospital, that he made no further report or complaint of chest pain or radiating pain or shortness of breath in the car, and if the evidence is that the patient reported to the doctor's office and the reception desk and asked the receptionist to stamp his parking ticket but made no complaint or reference to shortness of breath or radiating pain and that he sat in the reception room in the doctor's office for approximately 20 to 30 minutes longer without making any complaint even in the testimony of his stepdaughter of the same symptoms of chest pain or shortness of breath, and if the evidence

is that the receptionist approached him at about 5:30 p.m. and invited him into one of the examining rooms where she conducted an EKG exam and that he made no report of complaint of shortness of breath or radiating pain while the EKG was in progress or immediately thereafter, do you have an opinion based upon your experience and training whether the stepdaughter was a more reliable historian than the receptionist, Jan Schoch who had 30 years of experience in the doctor's office?

MR. MISHKIND: Objection.

A. Yes.

Q. And what is your opinion?

A. That the receptionist would be better at taking that information than a, his daughter or if it had to be a son, a son.

MR. MISHKIND: Objection. Move to strike.

Q. Is it still your opinion that Dr. Lalli acted appropriately in instructing his patient -- his receptionist to refer to emergency room or immediate medical care patients who complained of all three or some one of the complaints of aching or pain in the chest radiating to the

arms or shortness of breath, is it your opinion he acted reasonably in instructing his receptionist to that effect?

MR. MISHKIND: Objection to the form.

A Yes, it is.

MR. MISHKIND: Move to strike.

Q. And is it still your opinion that the receptionist, Jan Schoch acted reasonably under all the circumstances presented in this case?

MR. MISHKIND: Objection. Leading question.

A Yes.

MR. MISHKIND: Move to strike.

Q And is it still your opinion that Jan Schoch acted in accordance with the instructions that she received from Dr. Lalli?

MR. MISHKIND: Objection. Leading.

A Yes.

MR. MISHKIND: Move to strike.

MR. RISPO: Nothing further.

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RECROSS-EXAMINATION OF BRUCE D JANIAK, JR.

BY MR. MISHKIND:

Q. Doctor, would you agree that if Jan Schoch told Mr. Porach to drive to the office in the face of a description on the phone by the patient of shortness of breath and chest pain, and failed to advise the doctor that the patient was coming into the office to be seen regardless of whether he requested the EKG or she suggested to come in for the EKG, and further waited not only to the point in time after the patient had arrived at the office which was about 4:56 or 5:00 but then had that patient sit very quietly in the lobby for 20 to 30 minutes without advising the doctor that that patient had arrived, went ahead and did an EKG, still not advising the doctor that that patient who had called and had come into the office that had had chest pain and shortness of breath, and also failed to ask the patient when he arrived how he was feeling and whether or not he was still having shortness of breath and chest pain, if you assume those facts to be in evidence, would you agree that the standard of care would not have been complied with by the doctor's office?

A. I would agree.

Q. Okay.

MR. MISHKIND: Nothing further. Thank you very much.

THE WITNESS: You're welcome.

MR. RISPO: I have one further, doctor.

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FURTHER REDIRECT EXAMINATION OF BRUCE D. JANIAK, M.D.

BY MR. RISPO:

Q. Given all of the facts and circumstances here that you've described and have been described to you, would it be reasonable for the patient to fail to report all the symptoms he was having if he had them?

A. Would that be reasonable to fail to report? It would be unreasonable to not disclose that.

MR. RISPO: Okay. Thank you.

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FURTHER RECROSS-EXAMINATION OF BRUCE D. JANIAK, M.D.

BY MR. MISHKIND:

Q. Doctor, I hate to do this to you.

A. That's okay.

Q. But lay people are not trained to diagnose their own conditions, are they?

A. They are not.
Q. You agree that physicians or people that want to be physicians that go to medical school and become physicians are trained to arrive at differential diagnoses?
A. Yes.
Q. And they are trained to recognize risk factors for diseases?
A. Yes.
Q. And they are trained to recognize the urgency or the nonurgency of various conditions?
A. Yes.
Q. And that patients frequently trust and rely on their doctors to tell them what to do or what not to do?
A. Yes.
Q. And it's good for a patient to call his doctor and to trust his doctor to advise him as to what medical care he or she needs to take?
A. In general, yes.

MR. MISHKIND: Okay. Thank you very much. Nothing further.

MR. RISPO: So that we don't have a problem here we want to be sure that we win this contest I have to ask you one more

question, doctor.

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FURTHER REDIRECT EXAMINATION OF BRUCE D. JANIAK, M.D.

BY MR. RISPO:

Q. Would John Porach have survived if he reported to the emergency room at 7:00 in the morning?

MR. MISHKIND: Let me object because that certainly is beyond the scope of my recross but --

MR. RISPO: I'm not so sure.

MR. MISHKIND: It is, but --

A. Would he have survived if he reported to the emergency department at 7:00 in the morning?

Q. Right.

A. Well, we have to make some assumptions. An assumption is that he gives a history of chest pain and creates enough suspicion if that's the problem and that he's placed on the monitor as we discussed earlier and that he fibrillates while he is there the chances of recovery from that fibrillation would be greater than 50 percent if he went to the emergency department, sure.

Q. Okay. And if he didn't have those symptoms and

reported to the emergency room at 7:00 in the morning is it possible that he would have been discharged to his home?

MR. MISHKIND: Objection. Move to strike. Form of question.

Go ahead, doctor.

A. It is possible, yes.

MR. MISHKIND: Objection. Move to strike.

Q. Based upon the facts and circumstances as now known to you and described in the trial testimony, who is the person or persons responsible, if anyone, for the fact that Mr. Porach died?

MR. MISHKIND: Objection. Calls for a legal opinion.

A. Boy. It's a difficult question to answer. I think in my view it's primarily Mr. Porach who had symptoms and didn't call the right place and actually passed up some hospitals on the way to the doctor's office, but you need to link that up with what my comments were about survival and I don't know how long and all that stuff, but if thepe is one person he would be the one who would carry most of the weight, sure.

MR. MISHKIND: Objection. Move to strike.

MR. RISPO: Thank you, doctor. Nothing further.

MR. MISHKIND: That's it.

VIDEO TECHNICIAN: Doctor, you have a right to view this tape in its entirety or you can waive that right.

THE WITNESS: Since there's going to be a trial coming up very shortly I wouldn't physically have time to look at the tape.

MR. RISPO: Waive that.

THE WITNESS: So I waive it because of that.

VIDEO TECHNICIAN: Thank you, doctor.

Can we stipulate possession of the videotape remains in the custody of Mehler & Hagestrom?

MR. MISHKIND: Sure.

VIDEO TECHNICIAN: Off the record.

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(Thereupon, a discussion was had off

the record.)

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(Signature waived.)

C E R T I F I C A T E

The State of Ohio,) SS:
County of Cuyahoga.)

I, Aneta I. Fine, a Notary Public within and for the State of Ohio, authorized to administer oaths and to take and certify depositions, do hereby certify that the above-named BRUCE D. JANIAK, M.D. was by me, before the giving of his deposition, first duly sworn to testify the truth, the whole truth, and nothing but the truth; that the deposition as above-set forth was reduced to writing by me by means of stenotypy, and was later transcribed into typewriting under my direction; that this is a true record of the testimony given by the witness, and the reading and signing of the deposition was expressly waived by the witness and by stipulation of counsel; that said deposition was taken at the aforementioned time, date and place, pursuant to notice or stipulation of counsel; and that I am not a relative or employee or attorney of any of the parties, or a relative or employee of such attorney, or financially interested in this action.

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office, at Cleveland, Ohio, this 7th day of April A.D. 19 98.

Aneta I. Fine

Aneta I. Fine, Notary Public, State of Ohio
1750 Midland Building, Cleveland, Ohio 44115
My commission expires February 28, 2001

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OBJECTION INDEX