ORIGINAL

STATE OF OHIO)
) SS.
COUNTY OF LUCAS)

COURT OF COMMON PLEAS

JAMES LOVETT, Adm., et cetera, :

Plaintiff, :

vs. : Case No. 83600

MEMORIAL HOSPITAL OF GENEVA, et al., :

Defendants. :

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Deposition of BRUCE D. JANIAK, M.D., a witness herein, called by the Defendant Memorial Hospital of Geneva, as if upon Oral Examination under the Ohio Rules of Civil Procedure, taken before me, the undersigned, Lori L. Udowski, a Notary Public in and for the State of Ohio, taken pursuant to Notice and stipulations of Counsel as hereinafter set forth at the Sheraton Westgate, Secor Road, Toledo, Ohio, on Monday, May 16, 1988, at 1:00 o'clock p.m.

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COMPUTER TRANSCRIPT

APPEARANCES:

On behalf of the Plaintiff

CHARLES I. KAMPINSKI CO., L.P.A.
By: Charles I. Kampinski
Christopher M. Mellino

On behalf of the Defendant Memorial Hospital of Geneva

REMMINGER & REMMINGER
By: Marc Groedel

On behalf of the Defendant Geneva Emergency Group, Inc., and David Conant, M.D., and Kishore Desai, M.D.

JACOBSON, MAYNARD, TUSCHMAN & KALUR CO., L.P.A.
By: Michael M. Djordjevic

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BRUCE D. JANIAK, M.D.

A Witness herein, after being duly sworn, as hereinafter certified, was deposed and said as follows:

ORAL EXAMINATION

BY MR. KAMPINSKI:

Q. Would you state your full name, please?

A. Bruce David Janiak.

Q. And Doctor, I've been provided with your curriculum vitae. As a matter of fact got it

this morning. Let me just hand it to you and first of all, ask you if it's up to date?

A. Well, there's just a couple of small things that I'm doing now that I wasn't doing last issue. One of them is the member of the executive committee of the American Board of Emergency Medicine. That CV says I'm a member of the board --

Q. Anything else?

A. -- but doesn't say the executive committee.

Q. Any additional publications?

A. There's a paper I'm going to give at an international meeting this next year that I haven't put on there yet.

Q. What's the name of the paper?

A. That has to do with technology, television technology for delivery of health care. Nothing to do with any clinical thing.

Q. All right. Any other additions that you feel significant, Doctor?

A. No, nothing significant.

Q. I'm going to ask you a number of questions

this afternoon. If you don't understand me, tell me. I'll be happy to rephrase them.

A. Okay.

Q. When you respond, do so verbally. The court reporter will be taking down everything said verbally. She can't take down a nod of your head.

A. Correct.

Q. Doctor, when were you retained to give expert assistance in this case?

A. Well, I certainly don't remember exactly, but it seems to me it was about a year ago.

Q. And that was by Mr. Coakley?

A. Well, yes. As far as I remember it was just about a year ago and it was Mr. Coakley.

Q. When you say as far as you remember, do you have correspondence from him asking you to get involved?

A. No, I don't have any correspondence like that. I just have a letter from him which refers to a letter of May 20, 1987. So, I'm assuming that the initial contact was in May of 1987.

Q. Let's go slowly. You say you have a

letter dated what?

A. June 9.

Q. And it refers to a previous letter of May 20?

A. Right.

Q. Where is that letter?

A. I have no idea.

MR. GROEDEL: I have the May letter.

Q. Was something removed from --

MR. KAMPINSKI: I want his testimony, not yours.

A. The only letter that I know about is the one he's talking about, but the only communication that I remember is that I received a phone call from Mr. Coakley asking if I would be interested in this case. He sent me a confirming letter indicating that with the initial materials and then sent this letter which has a report of Robert A. Bideman, M.D.

Q. Obviously there's a May letter, correct, Doctor?

A. I'm sorry?

Q. Obviously there's a May letter, correct,

Doctor?

A. Yes. Well, it says -- refers to it. I could not tell you for sure. I didn't go over the file in detail before I came in here. There must be. Yes, there's a May letter. I'm just not going to lay my life on the line.

Q. Was it removed from your file today?

A. I think we did.

Q. What did it say, Doctor?

A. I don't remember.

Q. Did it give you any facts about the case?

A. I don't believe so, but I really don't remember.

Q. You don't know why Mr. Groedel won't let me see it?

A. No.

Q. Is there anything in the letter you relied on in formulating your opinions?

A. No.

Q. In that letter, did it contain the requests of the attorneys in terms of what it was they wanted you to do?

A. I don't remember. I can tell you this; A,

I have never received a request from an attorney that says here's the opinions I want you to give me in any case I have done. And B, the materials and opinions I have are based on the various medical records and depositions that I had reviewed and I just don't --

Q. My difficulty, and I appreciate your answer, my difficulty is you don't remember what was in it?

A. That's right.

Q. How is it you can say what wasn't in it?

A. Well, that's pretty easy. If I have something that's unusual for me, something I have never seen before, then I think I would remember it. I just haven't received --

Q. You didn't look at it today before it was removed from your file?

A. No, sir. I did not.

Q. What is it you were provided with, Doctor, to render your opinion?

A. Initially there are some records that have to do with the visits of Lovett and a deposition of a Dr. Bideman; a deposition of a Dr.

McCabe, a letter from Dr. McCabe, and I think the -- whatever you call that kind of document.

Q. Pleadings?

A. Pleadings, I guess. And then the medical records that deal with the case.

Q. Dr. Bideman's report?

A. Right.

Q. Okay.

A. And those medical records include the records of the clinic visit, the emergency visits and ambulance report and an autopsy.

Q. Did you receive any depositions of -- well, did you receive the deposition of the nurse involved in this case?

A. No, sir.

Q. Did you ask for it?

A. No.

Q. Did you receive the deposition of the plaintiff, Mr. Lovett?

A. No.

Q. Did you ask for it?

A. No.

Q. Why not as to both of those depositions?

A. Well, I think the reason I didn't ask for the nurse's deposition is that I didn't know there was a nurse's deposition.

Q. That's fair.

A. Thank you.

Q. How about Mr. Lovett?

A. And I didn't no Mr. Lovett had given a deposition either.

Q. Well, part of what is attached to Dr. Bideman's -- this is a part of his deposition.

A. I don't know. I'd have to look at it again.

Well, I certainly don't know what that deposition material is from just glancing at it. So, I don't know what it is.

Q. It's part of a transcript of somebody's. You don't know whose it is?

A. No.

Q. You wrote your report in June of -87; is that right, Doctor?

A. That's right.

Q. You had not received at that time the deposition of Dr. Bideman or Dr. McCabe; is

that correct?
A. That is correct.
Q. Have your opinions or conclusions changed in any fashion since you've received those depositions?
A. No, sir, they haven't.
Q. All right. I'm sorry. I apologize. I was only half listening when you answered why you didn't ask for Mr. Lovett's deposition.
A. I didn't know Mr. Lovett had a deposition. I don't want to insinuate if I had known he had a deposition that I would have asked for it. I guess the reason for that is that I don't normally request a specific series of documents from attorneys.
Q. It was important, was it not, to know what occurred in the emergency room on the night of -- the morning Mrs. Lovett passed away, wasn't it, Doctor?
A. I'm sorry, which night?
Q. The night prior to her passing.
A. Yes.
Q. Didn't you feel the testimony of the

people that were there would be of assistance to you?

A. Any testimony could potentially be helpful. Remember, I didn't know he had any testimony. It seems to me it would be a moot point as to whether or not I would ask.

Q. You weren't told by the attorneys he was deposed?

A. I don't remember being told by anyone.

Q. Were you told of any testimony of his or what he would say about what occurred that evening?

A. No.

Q. Would that be important to you at all in rendering an opinion in this case?

A. I suppose any testimony could be important if it presented information that was in gross conflict with what I had already had information about.

Q. Have you testified before, Doctor?

A. Yes.

Q. How many times roughly?

A. Are you talking about depositions or

trials?

Q. Let's start with trial.

A. Trials?

Q. Yes.

A. I believe I have testified in three trials in ten years.

Q. And do you recall the names of those?

A. I don't know the names of the cases, no.

Q. Where were the cases?

A. One was in Grand Rapids. I'm sorry. One was in Green Bay, Wisconsin.

Q. All right.

A. One was in West Palm Beach, Florida and one was in Defiance, Ohio.

Q. Would you have in your office somewhere the names of the cases?

A. I believe that I would have the last two. The Defiance, Ohio was probably fifteen years ago. So, I don't know if I have that. The other two I would certainly have.

Q. Were they for the defence or plaintiff?

A. Both of those were defence.

Q. All right. Now, in terms of how many

times you've been deposed, roughly or specifically.

A. I wish I could tell you specifically, but I would say fifteen times in ten years.

Q. Have they been for the defence?

A. No, I think three plaintiff, but I just don't -- I'm not sure.

Q. Have they been malpractice cases, all those fifteen?

A. No. As a matter of fact, I left out a civil trial.

Q. Where was that?

A. That was in Toledo. Sylvania, Ohio, a suburb of Toledo.

Q. I take it that was not a malpractice case?

A. No, not at all.

Q. Have you testified for the plaintiff in a malpractice case?

A. In depositions but none in trials.

Q. Have you testified for any attorneys of Mr. Groedel's firm before, Remminger and Remminger?

A. Yes.
Q. When and where?
A. Where? Cleveland, Ohio. When? About five years ago.
Q. Deposition?
A. Yes.
Q. One case?
A. One case.
Q. Do you remember the name of the case?
A. No, I don't.
Q. How about for Jacobson, Maynard, Tuschman and Kalur, have you ever been retained by them as an expert?
A. I don't remember. I don't think so, but it could be. It could be.
Q. Would you have in your office, Doctor, a list of the cases that you have been retained as an expert witness or would that be obtainable by you?
A. Sure.
Q. Can we get an agreement that the Doctor will do that at your leisure and provide it to Mr. Stoedel?

A. Sure, if you don't mind if I have you or him remind me in writing. It's a lot on easier to have you to remember to do a task than to try to remember yourself.

Q. Have these cases generally involved emergency room care, Doctor?

A. I think they have all involved emergency care with the exception of the Defiance case I mentioned years ago.

Q. Have any of them in terms of facts been similar to this case?

A. No.

Q. Who are you insured by, Doctor?

MR. GROEDEL: Objection go ahead.

A. Personally?

Q. Yes.

A. PIE.

Q. Have you, yourself ever been named as a defendant in a case?

A. No.

Q. Has a claim ever been brought against you?

A. Yes. I want to be clear about the answer

to my previous question. As the head of a corporation providing emergency services, of course, whenever one of my physician employees is involved in a case, then I would also be named. So, I answered your question as personally have I been a defendant in a case personally, and the answer is no.

Q. And I take it your corporation is insured by PIE also?

MR. GROEDEL: Objection.

A. Yes.

Q. They have been defended, your corporation, in those claims where suits have been brought?

MR. DJORDJEVIC: Objection.

Q. Is that correct?

A. They have defended my corporation in claims when suit has been brought when they have been insured by them. We have not been insured by them forever.

Q. A moment ago you mentioned claims have been brought against you --

A. Yes.

Q. -- that haven't gone to suit?

A. Yes.

Q. How have they been resolved? Just gone away, settled, whatever?

A. I believe in ten years we have had one settled. All the rest have been dismissed.

Q. And that settled before a suit was brought?

A. Yes.

Q. What were the facts of the case?

A. I don't think I can remember. Give me a moment. I don't think I could help you. It was several years ago.

Q. How long ago was it?

A. Several years ago.

Q. All right. Do you remember the name of the case?

A. No, sir.

Q. Did PIE represent you in this that particular case?

MR. DJORDJEVIC: Objection.

A. I can't tell you that. I don't remember.

Q. Would you be able to determine the name of the case given some time in your office?

A. I think so, sure.
Q. Can we reach an agreement you will provide that to your attorney also?
A. Sure.
Q. Any other claims, Doctor?
A. I'm sorry. Any other claims aside from the one that was settled?
Q. Yes.
A. There are a couple of pending cases.
Q. Pending in suit?
A. No, when I refer to pending, 180 day letter of extension will be written in the process of reviewing the case.
Q. How many of those are pending?
A. Probably two.
Q. And what are the facts of those cases?
A. I can't tell you.
Q. Yes, you can.
A. No, I mean I can't tell you because I don't remember the facts of the case. I'm not trying to withhold anything. Maybe I -- we see about sixty thousand patients a year and there are seven emergency physicians and one of them

has a job of risk manager. So, when I get a letter, there's a problem or potential problem, I passed it onto the physician. I can't tell you the names and all the --

Q. I made myself unclear. I was referring to claims against you personally.

A. No, I have no other claims against me personally.

Q. These are claims against your corporation?

A. I have never had a personal claim against me or settle or go to trial or have a deposition or any of those things.

Q. So, what you were telling me before about the case settling was not against you personally, but against a member of your corporation?

A. That's correct.

Q. Is there board certification for emergency room specialists?

A. Yes, for emergency physicians, that's correct.

Q. And you are board certified?

A. Yes, I am.
Q. And you are also on the board of examiners?
A. Yes, I am.
Q. Is it important, Doctor, that people seen and treated in an emergency room be competent to understand what's being told to them and if necessary, be competent in order to sign out against medical advice?
A. Well, those are two different questions.
Q. Take them one at a time.
A. The answer to the first question is I don't understand the question. It doesn't seem to be relevant. The answer to the second one was is it important that they are competent when they are asked to sign against medical advice, the answer is yes.
Q. If there are family members with the person in the emergency room who is going to sign out against medical advice, is it important to speak to the family member and apprize them of the situation if there's any question of the competence of the individual?

A. If you have a question regarding competence, then it would be important to speak to family members. That's right.

Q. What's colicystitis, Doctor?

A. That refers to inflammation of the gall bladder.

Q. And how is it diagnosed?

A. Well, the ultimate diagnosis for colicystitis is to make an incision of the abdomen and remove the gall bladder and examine it in sections under the microscope and look for inflammatory cells. Then one can say the gall bladder was inflamed.

That being inconvenient for most people, you make a presumptive diagnosis based on history and physical findings.

Q. What physical findings and history would be indicative of the diagnosis?

A. There's no one history or one set of physical findings which would make a diagnosis like that. However, if one were faced with a patient that had abdominal pain with nausea and sometimes with vomiting with the pain being

located in the upper part of the abdomen, usually on the right side, with the pain radiating towards the back with fever, usually low grade, and with the physical findings of tenderness in the gall bladder area, then one could make a potential presumptive diagnosis of inflammation of the gall bladder or colicystitis.

Q. What is the treatment for colicystitis?

A. Well, there are conservative therapies and surgical therapies. A patient who has mild inflammation of the gall bladder might be treated with intravenous fluids and observation and nasogastric fluids, antibiotics. This is pro or con because I haven't reviewed that and if it all subsided, the episode of colicystitis would be self limiting.

Other patients would require surgery to remove the gall bladder to have the disease cured.

Q. Are there other problems that could have the same symptomology as colicystitis?

A. Absolutely.

Q. So that when you make a differential

diagnosis you would take into account other potential problems?

A. Yes.

Q. What kind of other problems could be associated with the same symptoms?

A. No matter what I say the list cannot be complete because there are basically all kinds of things. Certainly pelvic inflammatory disease can cause the same symptoms. Actually inflammation to almost any organ within the abdomen can do that. Urinary infection, pancreatitis, pneumonia, even certain kinds of trauma could cause those kinds of symptoms. I probably am incomplete by several hundred diseases, but those are the main ones.

Q. How about peritonitis?

A. Yes, I said perforation, inflammation within the abdomen which is secondary to any one of a number of things, perforation could be one.

Q. In seeing a person in the emergency room, do you always do the history and physical or do you rely on a nurse for any portion of that before you see the person?

A. Well, most emergency physicians practice almost as a team and a nurse may gather some information and the doctor will gather information also. Much of it is overlapping. Most of the time the nurse will take a history and the doctor will take another history and medical exam.

Q. Does the nurse do anything in terms of determining physical findings?

A. Certainly.

Q. What's that?

A. Depends on which department, which nurse, and what time of the day and how busy it is. The nurse may merely do a rapid triage and say the nurse will in essence have done except make a split second decision. The other cases the nurse may do a part and tell me about the way the abdomen feels and what the chest sounds like and whatever the extremities are inflamed.

Q. How about vital signs?

A. What about vital signs? Does the nurse do them? Yes.

Q. Would you rely on her to do that?

A. Yes.
Q. And that would include what?
A. The normal vital signs include blood pressure, the pulse and the respiratory rate and temperature.
Q. You mentioned temperature before, Doctor, in determination of one of the ways you would diagnosis colicystitis, correct?
A. No, I didn't say it's a way to diagnosis colicystitis. I said it was one of the findings which you would use to consider whether or not there was colicystitis. Any diagnosis is really a composite of multiple pieces of findings.
Q. Temperature could be indicative of a number of things?
A. Sure.
Q. What was the temperature on Mrs. Lovett the night before she died?
A. You have the chart in front of you.
Q. No, as a matter of fact I don't.
A. Could you hand it to me?
Q. There's all your records right there.
MR. GROEDEL: On October 5, Doctor.

Q. Right.
A. The October 5 Memorial Hospital of Geneva emergency medical record there's no temperature recorded on the record.
Q. Why not?
A. I thought this -- I'm kind of confused, are you testing me on why not?.
Q. Should there have been? Given her presentation should there have been, Doctor?
A. Should there have been a temperature?
Q. That's right.
A. Let me see what her chief complaint was. Yes, I believe there should have been because the chief complaint was pain in the right side and right shoulder.
Q. And pain in the right side and shoulder would be consistent with what potential problems?
A. An incredibly long list.
Q. Perforated ulcer?
A. Pain in the right side and right shoulder is consistent with perforated ulcer as it is with acute anxiety.
Q. If the person was seen two times before

with pain in the emergency room, would it be more consistent with perforated ulcer than acute anxiety?

A. No.

Q. No?

A. No.

Q. If a person presents in an emergency room that you are in charge of, Doctor, three times within 36 hours with symptomology such as Mrs. Lovett presented with, what would your method of examining that person be?

MR. GROEDEL: Objection. Go ahead, Doctor.

A. I would examine that patient with the same methodology I used for any other patients whether it's the first visit or tenth visit, physical and history.

Q. Would your treatment be changed if she had [illegible] within the previous 36 hours?

A. No.

Q. Would your method of approaching the patient be any different based on that?

A. Yes.
Q. How would it be different, sir?
A. When a patient presents with a decubiti, that's the same kind of complaint --
Q. Yes.
A. -- as a patient who sprains the ankle on day one.
Q. Sure.
A. Especially if a patient complains of pain in the abdomen or in the chest, if it's a consistent complaint you would be more concerned about what the potential diagnosis might be and if it's not obvious in the emergency department, you would recommend the patient be admitted in most cases.
Q. All right. Would Demerol be an appropriate medication to give a person such as Mrs. Lovett in the manner in which she presented?
A. Which visit are you talking about?
Q. The last visit.
A. The 5th of October?
Q. Yes.

A. Yes, it certainly would be.
Q. And what kind of drug is it?
A. Demerol is a narcotic analgesic.
Q. Does it have any affect on the ability or capability of the individual to understand what's being said to them? Can it have the affect?
A. Yes, it's dose related.
Q. Do you believe it had any affect or do you have any opinion on whether or not it had any affect on Mrs. Lovett?
A. Yes.
Q. What's your opinion?
A. At that dose it wouldn't have any affect.
Q. 75 milligrams?
A. That's correct.
Q. Were you told anything about what her condition was in the emergency room other than what you see in the record?
A. No, I wasn't told anything.
Q. Were you told that she almost collapsed coming out of the bathroom right before she was let go?
A. No, I was not told that. I don't know

what almost collapsed means so --

Q. Almost collapsed means being unable to bear her own weight.

A. No, I wasn't told that.

Q. Would that have any affect on any opinions that you have in this case, Doctor?

A. No, I don't think so.

Q. Why not?

A. Well, who gave the history?

Q. What's the difference if the history is accurate?

A. There is an incredible difference in histories depending on who you get it from, absolutely, because there's a -- because acting crazy is a subjective not an objective term and so there certainly could be an enormous difference.

Look at a three year old child tells you something and an adult's view point might be equally accurate to them. Certainly one would place different levels of emphasis on the two statements. The same can be true of patients or relatives that may not have a very accurate

Q. You've labeled it subjective and let's put it subjective, in terms of what you believe it would have to mean, sir.

A. I think if I personally observed or someone that I have worked with for a long time observed a person who appeared to be quite comfortable and in no distress have an episode of instability manifested by a loss of balance which was not associated with a misstep, that is tripping or catching the foot on something, and associated with perhaps a change in skin color and/or a change in mentations somewhat briefly necessitating -- excuse me.

Q. Go ahead.

A. Well --

Q. I'm listening to you, Doctor. Go ahead.

A. I'd rather wait. I was hoping you would be interested enough to listen. But anyhow --

Q. I told you I'm listening.

A. A patient who had this loss of balance and inability to walk that I have observed having this happen and then it corrected itself, perhaps by having someone assist them because you thought

they were going to fall, that would be significant enough for me to require more evaluation.

If I got this all secondhand, I would be concerned and ask questions about it, but I would not be able to place a great deal of weight on it is exactly what it meant to me.

Q. How about if it happened to somebody who was not looking well and did not have good skin color?

A. Didn't look very well and didn't have good skin color and someone reported to me this person almost collapsed, might have some significance. I would need to know more about what it meant.

Q. What was the condition of Mrs. Lovett when she was seen at the emergency room on the 5th, was it good?

A. No, according to the emergency records she was complaining of pain in her side and that she had been having pain for 24 hours and that on examination she had tenderness over her entire abdomen especially in the right subcostal region which is over the gall bladder.

Q. How was her color?
A. Well, unless I am missing something I

Q. Should that be, in your opinion, at least reflected in the chart based on her condition?
A. Not necessarily. It wouldn't be something that one would expect to see on every emergency record, a reference to the color.
Q. Would it matter to you if her color was not good?
A. Yes, it would.
Q. And why is that?
A. Well, it's very general symptom, color that appears to be quote not good unquote. I'd have to see it once again to have some hope of interpreting it. It would make you consider the patient isn't feeling well. It's not a specific sign
Q. Should in your opinion Mrs. Lovett have remained in the hospital that evening?
A. I think I would have advised her to stay in the hospital that's right.
Q. And should testing have been done on her

that evening?

A. Well, a patient who comes in with this kind of complaint would normally receive certain admission tests and although if they were not ordered at that admission but ordered to be done in the morning, I would not be critical of that.

Q. Even if she had been seen twice the prior day?

A. Yes, even if she had been seen twice.

Q. Do you know if there were tests available at the hospital that night, Doctor?

A. No, I don't know.

Q. Wouldn't that be important for you to know?

A. No, not necessarily.

Q. Was Mrs. Lovett dehydrated when she was seen in the emergency room?

A. Which visit is this?

Q. The last visit.

MR. GROEDEL: Second visit.

MR. KAMPINSKI: The second visit there.

MR. GROEDEL: Okay.

A. The physical examination said mucous membrane, dry skin, turgor good. She had been vomiting earlier. She would be classified as minimal dehydration.

Q. What is orthostatistic dehydration?

A. I don't know.

Q. What is the treatment for perforated ulcer?

A. Referral to a surgeon.

Q. What does the surgeon do?

A. Not being a surgeon I can't speak as an expert. Most of the time they operate and do a repair that closes the hole. The hole being the one where there's perforations through the bowel.

Q. And if that's not done, what's the likely result? Death?

A. It depends what part of the bowel is perforated. If [illegible] there's a pretty high mortality rate. I don't know what it is.

Q. So, it's pretty important, Doctor, as a emergency room [illegible] to recognize the

potential of that particular problem because the alternative of not recognizing it can be a person's death?

A. Absolutely right.

Q. Based upon Mrs. Lovett's complaints, was that not a potential diagnosis that could have been made?

MR. GROEDEL: Objection. Go ahead, Doctor.

A. Based upon Mrs. Lovett's complaints, it was certainly not a likely diagnosis.

Q. It was not, why not?

A. She had been seen in the emergency department the day before and had had some testing done. At this time she was not vomiting, had pain in her upper abdomen.

Q. I'm sorry, which time?

A. The 5th of October.

Q. The day before the last visit?

A. The 5th of October at 19 hundred.

Q. Okay. Go ahead.

A. And the physical exa[illegible]ion shows that there were -- the abdomen was flat but tender in

the right subcostal region and epigastium -- or other masses and the peristalsis was normal. With those findings one would certainly not suspect the presence of a perforated ulcer and wouldn't do tests to investigate that presence.

Q. What specifically that you just read would not -- would lead you to conclude there's no suspicion of perforated ulcer?

A. The tenderness is localized in the right subcostal region and epigastral area. The abdomen can be palpated and there are good bowel sounds. All those things are not consistent with a perforated ulcer.

Q. When did her ulcer perforate?

A. I don't have any idea. I think it perforated after this visit, but when, I don't know exactly.

Q. Did you review the autopsy?

A. Yes, I did.

Q. Does that give you any assistance in terms of a reaching a conclusion as to when perforated?

No, sir.

Q. There was tenderness; is that correct?
A. According to this record, tenderness right subcostal area, epigastral area.
Q. Was there guard?
A. No organic megali. The word guarding is not used.
Q. Rebound?
A. Rebound is not used.
Q. What are the words? What do they mean?
A. Guarding refers to an involuntary contraction of the abdominal muscle wall in resistance of the physician's palpating hand. Rebound refers to pain that patients feel when you quickly release the pressure on the abdominal wall. In other words, you put pressure on it and release quickly. If there's a sudden onset of pain, that's referred to as rebound. Tenderness and that is associated with inflammation in the lining of the bowel and abdomen which is called the peritoneum.
Q. Are tests to determine guarding and rebound normally done or done on patient such as this?

A. Tests? I don't know what tests you mean.
Q. Just placing your hand --
A. Certainly, when you examine the abdomen, yes.
Q. Should they have been done in this case?
A. If you read the record it says no organic megali or other masses. If there was guarding and rebound you would be unable to do all of that.
Q. Organic megali refers to --
A. Enlargements of organs of the abdomen.
Q. Does it say there was no guarding or rebound?
A. No, it does not say that. The words guard and rebound are not used.
Q. By the way, would those be findings that you would have be consistent with colicystitis, guarding and rebound?
A. Guarding would be. Rebound is a little bit. It's common. It all depends on the degree of inflammation.
Q. Should x-ray studies have been repeated on Mrs. Lovett when she was seen in the emergency

room on the 5th?
A. No, I don't think so.
Q. Why not?
A. Well, the first visit which was -- I'm sorry. I think it was the 4th; is that right?
Q. Yes.
A. She had certainly to my mind in reading that, indications to do the tests. But in this visit based on the medical findings here, I don't think there was any indication to do any films.
Q. Why should she have been kept in the hospital in your opinion?
A. Why hypothetically, but why did she?
Q. Why should she have been kept in the hospital that night on the 5th? I thought you said earlier that you would have.
A. Yes. Why would I have kept her in the hospital?
Q. Sure.
A. Sure. Because if I thought she had an acute colicystitis or inflammation of the gall bladder, we know the kinds of problems can get much worse and one of the problems can be

perforation of the gall bladder itself and it could be spread of infections throughout the body. Those patients are advised to be admitted and a surgeon evaluate them and see what sort of therapy they might need.

Q. What we talked about just a moment ago, guarding and rebound. Are they peritoneal signs?

A. Yes.

Q. And if you are considering when one has colicystitis or another abdominal problem, wouldn't those be things you would expect to see in a chart, the presence or absence of guarding and rebound?

A. Well, I would say that a textbook physical examination of the abdomen would always. In a textbook one would always have reference to the absence of guarding and rebound on a normal patient, on patients that have some tenderness. There are certainly variations in the way physicians write down their physical findings. The particular approach here, even though it does not refer to rebound specifically or to guarding specifically, is totally consistent with the

diagnostic impression and with the suggestion to admit. So, I really can't find fault with the fact that there was no discussion of rebound or guarding per se. Although one can infer since there was no organic megali, he was able to push on the abdomen to feel the things.

Q. With colicystitis don't you expect to see focal tenderness, guarding and sometimes rebound?

A. With classic colicystitis you would expect certainly tenderness and guarding in the right upper quadrant and sometimes rebound, it depends on how inflamed.

Q. Are any of those in there?

A. The tenderness, yes, certainly tenderness right subcostal region, epigastral area.

Q. Isn't it consistent with a host of potential problems?

A. Yes.

Q. How is it you could make that particular diagnosis as opposed to any other diagnosis just based on the finding?

A. The diagnosis of colicystitis?

Q. Yes.
A. Well, I don't agree with that emergency records should have the word diagnosis on there. It should be initial impression.
Q. They do?
A. Sure, and the joint commission on accreditation of hospitals requires that that be down there and it is really not very possible for emergency physicians to make a definitive diagnosis on most of these cases. None the less, you can quibble about the words put down the exam. I think it was appropriate and the idea of getting the patient admitted was also appropriate.
Q. Is an acute abdomen evidence of peritonitis?
MR. GROEDEL: Objection. Go ahead.
A. I will agree the other way around. Peritonitis will usually -- the patient with peritonitis will have the findings which we call acute abdomen.
Q. What is acute abdomen, Doctor?
A. It's nothing more than a patient who

appears to have a serious relatively rapid onset problem going on within the belly and it is almost always associated with inflammation of the peritoneum or peritonitis.

Q. How does that present itself?

A. I can answer the question a thousand ways.

Q. Including what we see with Mrs. Lovett?

A. Yes. Sure.

Q. Was a differential diagnosis made by Dr. Conant of perforated ulcer?

A. There's no written differential down here.

Q. Did you say before that it was all right to not repeat x-ray studies on the 5th?

A. Yes, I did.

Q. And that it was okay for Dr. Conant to rely on the previous x-ray studies?

A. No, I said that in reviewing the history that the previous x-ray studies had already been done -- that was the day before?

Q. Right.

A. And that the findings were not consistent

with a need to do films on the second visit which was the 5th.

Q. You confused me. The findings, the physical findings?

A. Right.

Q. The fact that she had returned or had been seen three times within a 36 hour period wouldn't indicate to you as an emergency room physician to do additional diagnostic studies on the last visitation?

A. As an emergency physician, I'm sorry, could you say emergency physician rather than emergency room physician? It's only ego and I apologize for that.

Q. That's fine. I would be more than happy to.

A. If you have a patient like this that comes back having been seen before, you certainly, as I think I said before, should have a higher index of suspicion regarding some problem you can't figure out.

Q. Right.

A. Further testing is not necessary if the

patient -- if a disposition is decided upon. In this case admit the patient. Other tests can be done in the hospital. In looking at that I asked myself what decisions would have been changed? What would have been changed with certain tests? I couldn't think of any changes with decisions regardless of the test results.

Q. If x-rays had showed free air wouldn't that have reflected a certain course of conduct different than what was taken?

A. Yes, but the answer would be the same if the brain scan had showed a brain tumor or cardiogram had showed a heart attack.

Q. You are leaping ahead of me and saying it wouldn't make any difference?

A. I'm saying when -- there have to be indications to do tests. If to a physician there are no indications to do them, it doesn't mean it's impossible the test wouldn't show anything. In his judgement, and I agree with it, there weren't any indications to repeat the x-rays in this case.

Q. Were there indications to do x-rays the

previous day?

A. Yes.

Q. What were the indications at that time?

A. I would have to go back over that record.

Q. Sure. X-rays by Dr. Desai.

A. This patient had defused tenderness with no vomiting but had pain of one hour duration. There's one other thing, I think it's important. And that is the patient at Richmond Heights said she had a sudden onset of pain. And then there not only was right upper but also left upper quadrant tenderness. And the impression at that time they are fair which I -- I think means not as noisy, the bowel.

Additionally, this seemed to be a relatively new disease for the patient at that time. And the nurse's note said severe epigastric pain. The initial evaluation of a patient like this may include the abdominal series and some laboratory tests that were done, chest x-ray, CBC, EKG, flattened decubitous abdomen.

Q. What is it, I'm sorry?

A. Why is it --

Q. That would have caused one to do x-rays on the 5th as opposed to the 6th?

MR. GROEDEL: 4th instead of the 5th?

A: All right. The number one thing aside from everything that's written down on these is physician judgement rather than all the findings. However, on the 4th the patient had more defused tenderness than on the 5th and on the 4th this disease had been relatively short term; on the 5th it had been going on. So, the more acute onset, the sudden onset of abdominal pain is more likely to be associated with the taking of films than pain that's been going on or reoccurring.

Q. You lost me, Doctor. If somebody continues to complain of pain, there's less need to do studies?

A. We're not talking about studies, we're talking about abdominal plain x-rays.

Q. Those are studies?

A. Well, there may be in a second visit or third visit more of a need. In the hypothetical

case for angiography or abdominal CAT scanning. Those kinds of things the first visit with sudden abdominal pain there may be more indication for plain abdominal x-rays.

Q. How does a perforated ulcer -- well, would you be able to diagnosis perforated ulcer by x-ray? Would it be the presence of free air that would tell you that?

A. It would tell you about a perforation of the bowel. Most likely if the pain went along with it, then yes.

Q. And certainly based on what you tell me before and that is you don't think the perforations occurred until after she left the emergency room?

A. Right.

Q. That can happen at any time, right?

A. Right.

Q. So, if you were all suspicions of that particular problem, you would do a repeat x-ray, wouldn't you?

A. If you thought patient had perforated or something new had happened, if that was in your

differential you would certainly repeat x-rays even if she had them two hours ago.

Q. That wasn't in the differential in this case?

A. That's correct.

Q. There's no differential, is there?

A. Every time an emergency patient is seen by an emergency physician there's some differential. It is not a standard.

Q. My question was should have been in the record, there's no differential?

A. That's correct.

Q. Do you have any belief or opinion, Doctor, as to whether or not Dr. Conant impressed upon Mrs. Lovett the seriousness or the potential seriousness of her illnesses, the ramifications of her illnesses.

MR. DJORDJEVIC: Objection.

A. No.

Q. And the answer may be no and I don't know. That's why I'm asking.

A. I do know that he wrote patient advised admission on chart and that the patient signed

out AMA.

Q. Right.

A. So, in order to have a patient sign that, there usually has to be some conversation. But my direct knowledge is aside from that, none. I have no knowledge.

Q. Would it make a difference to you in terms of your opinion, and let's leave aside the proximate cause aspect for a moment. We'll get to that. Whether or not he did discuss the potential seriousness of her leaving that evening?

A. The words that he said would make a difference to me.

Q. Why?

A. Well, let us look at one end of the spectrum which might be I think you should be admitted and the patient says why? The doctor says I don't know. I just feel you ought to be. It wouldn't make any difference what you do. The other end of the spectrum, if you don't agree to be admitted you will die in ten minutes. There are two ends. The assumption is there's some

communication in between those two ends of the spectrum and I don't know where that communication was.

Q. If a comment was made by the doctor as Mrs. Lovett and her husband were leaving to the effect of well, if it keeps acting up we'll have to take the sucker out, referring to the gall bladder. What end of the spectrum would that be?

MR. GROEDEL: Objection. Go ahead.

A. It would certainly be in the middle if that were the only comment that was made and there was no other conversation regarding signing out against medical advice, then that would be at the minimal communication end of the spectrum.

Q. Wouldn't that almost lead you to conclude that it was at the bottom end? Is that what you just said?

A. Yes.

Q. All right. Because that sort of makes light of the fact that they are leaving, doesn't it, if that was said?

A. I cannot agree to that because communication with every person that we come in

contact with in our life is a little bit different. Some physicians use some sarcasm and harsher words with some people than we do with others. As we communicate with others we never hit it exactly right and sometimes we are a little bit off. And I make an assumption that A, they write and angry letter and other times you were straight and honest and very, very stayed and they write a letter saying I have no sense of humor. So, I can't just say take that sucker out is something evil or wrong or bad because I don't know the answers of the way they were communicating all along. It might have been completely appropriate to say that.

Q. You would have the to be asked to assume the way in which that was said for it to make any impression on you as far as rating it on a communication scale?

A. We would like to say that's wrong and it's silly. I have been in this too long to be able to say that.

Q. Should Mrs. Lovett or Mr. Lovett or both have been impressed with the potential

seriousness of her leaving?

A. They should have been aware that the physicians wanted to take care of her in the hospital and aware some complications could develop.

Q. Should Mrs. Lovett's husband have been involved in these discussions since he was there?

A. That is another judgement call. Most of the time a --

Q. Let me stop you. He was awake. He was alert. He wasn't sick. Okay. Shouldn't he have been involved in the discussions under the circumstances?

A. Not necessarily, no.

Q. No, why not?

A. Because emergency physicians, whenever a patient makes a decision about their own body usually respect that decision and usually don't drag other family members into it. One is when they are a minor you always talk to the parents about what you do with a minor. Adults, it's common to discuss a problem with an adult and let

them make up their own mind.

Q. Regardless of their condition?

A. No, if their condition is one of incompetence, you get the family involved.

Q. Were you provided, Doctor, with a report from a handwriting expert relating to the competence of Mrs. Lovett at the time that she signed out?

MR. GROEDEL: Objection.

A. I did not see that.

Q. Were you told of that?

MR. GROEDEL: Objection.

A. Not that I know about.

MR. GROEDEL: It didn't relate to her competence.

Q. Would it matter to you that someone had an opinion that Mrs. Lovett was not competent to understand what was being told to her?

A. Does this question have something to do with the previous question, the handwriting expert? The first time you asked me about a handwriting expert and the last time is someone. The answer to the second one is yes and the

answer to the first one is I don't know anything about handwriting experts.

Q. What difference would it make to you if, in fact, you are asked to assume Mrs. Lovett was not competent to understand the ramifications to her signing out against medical advice or her condition?

A. If I'm asked to assume hypothetically that the patient is incompetent, then it makes a difference.

Q. What difference?

A. If you have an incompetent, you discuss it with relatives, courts, whatever.

Q. Should an IV have been started and a nasogastric tube started if, in fact, Dr. Conant was intending to admit Mrs. Lovett?

A. Yes, normally that would have been done. I don't know what point in the proceedings she decided not to be admitted, so --

Q. Why should that be done?

A. If you are going to admit a patient for diagnosis of colicystitis and their complaint is nausea, with or without vomiting, it would be

fairly normal to give their stomach a rest by giving fluids intravenously.

Q. That was done in the first visitation, was it not?

A. Yes, it was.

Q. Do you know if the hospital had the facilities to do routine -- I'm sorry, the capabilities to do routine lab work on the evening of the 5th?

A. I don't have any specific information about the evening of the 5th, no.

Q. Should routine laboratory studies have been started if she was to be admitted that night?

MR. GROEDEL: Objection. Go ahead.

A. Well, normally when a patient like this is admitted, the admitting physician writes the orders and does all that ordering so the emergency physician wouldn't.

Q. Well, okay. Is it my understanding of this particular hospital that the emergency physician was the admitting physician in that particular hospital that's a very small hospital

say three or four hours, during that time period I would expect the IV to be started and nasogastric tube inserted. I don't see that in this case though.

Q. How did -- well, she was given medication, was she not?

A. Demerol and Atropine.

Q. How did she respond to the medication?

A. As far as I know there's no specific comment that says patient responded in any particular way to that.

Q. In other words it's just not there?

A. I don't see anything that says anything about that.

Q. Is there any type of initial nursing assessment regarding blood pressure changes?

A. All of the information that I see seems to be in one handwriting which looks to me like the physician's handwriting. So, I don't see a nurse's note for the October 5, 1985, 1900 hours visit.

Q. So, they are not there? Nothing there from the nurse, is that what you are saying?

MR. GROEDEL: Objection. Go ahead.

A. I was saying I didn't see it.

Q. Is the physical examination findings that lead you to believe that the perforations occurred after Mrs. Lovett was discharged?

A. Yes.

Q. That and that alone, correct?

A. Well, no. It's not that alone. There's a pulse of 80 and blood pressure of 116/70. There's a history that's consistent and refers back about what happened the day before and the physical findings.

Q. Would you have expected the pulse and blood pressure to be different if the perforations had occurred?

A. Yes. Well, the blood pressure, not necessarily although probably higher, the pulse certainly higher.

Q. Why do you believe that even had she been admitted that she would not have survived?

A. Well, if you look at the October 5 record at 1900 hours, apparently had certain physical findings which to me are totally inconsistent

with the perforations. They are consistent with a colicystitis or gall bladder irritations without actually inflammation requiring surgery. That patient had she been admitted at that time had no indication to either have a surgeon operate on her instantly or to go to intensive care.

Therefore, I assume that she would have been admitted to the regular floor because that's the only place to put a patient like this. The therapies that would have been instituted would probably have been limited to intravenous line and perhaps some more pain medicine and nasogastric tube. Tests would have been ordered to further determine her condition and some of the tests could have been done there and if they were ordered for the morning that would be perfectly reasonable. Sometime about, what is it, four or five hours later, 3:45 in the morning the similar event would have occurred because I believe it occurred very suddenly. I don't believe this patient left at 1900 and had a very gradual, slow progressive course for the next

eight hours. I believe she had sudden deterioration and I don't think they could have reversed it in the hospital.

Q. Did you view the records for the Richmond Heights Clinic?

A. Yes, I did.

Q. Dr. Zires?

A. Yes, I did.

Q. Were you told about his deposition testimony that was just taken last week? Obviously you couldn't have seen it.

A. No, I don't know what he said.

Q. Are you aware of the fact that he wanted to refer her to a surgeon on the 4th?

A. No.

Q. Are you aware of the fact that he called a surgeon at Richmond Heights Hospital and had a surgeon on call to see her if she should desire to go to Richmond Heights, are you aware of that, Doctor?

A. No.

Q. Do you have any idea?

A. I haven't read that deposition, that's why

I'm not aware.

Q. Do you have any idea why in the world he would have done that if all she had was colicystitis or that's all he suspected?

MR. GROEDEL: Objection. Go ahead, Doctor.

A. Well, if I can look at the Richmond Heights Clinic report here.

Q. Sure.

A. Is this a transcript of it. This is when she --

Q. I'm sorry. Transcript of -- what do you mean a transcript?

A. Well --

Q. As opposed to the record?

A. Written and typed.

Q. I see.

A. Just to make it easier to read.

Q. Okay.

A. All right. This patient had a presentation where she appeared clammy and complaining of abdominal pain for the past couple of hours. She stated that she had sudden onset

of abdominal pain and on evaluation he found that the slightest palpations especially in the epigastral area elicited significant discomfort. Clearly at that time he was concerned about what was going on in her abdomen and that's why he started an IV and did all the things he did. His decision to look for a surgeon is perfectly consistent with her presentation.

Q. What is it that caused her presentation to get better, Doctor?

A. I don't know.

Q. Could it be the examiners?

MR. GROEDEL: Objection.

A. I don't think are you trying to say that one clinician was more astute than the other. I suppose they are -- we are all different, but I don't believe that different.

Q. What made her presentation get better?

A. I have no idea.

Q. Would it have been prudent for an emergency physician to have checked with the prior doctor to determine what her presentation was the prior day at a different institution?

A. That really is a judgement call depending on the clinical condition of the patient at that time.

Q. If she presented for the third time within 36 hours?

A. What one could do in that case is admit the patient and at a later time go through all the stuff.

Q. If it's a perforated ulcer, Doctor, there might not be a later time.

A. If it's a brain tumor or brain hemorrhage or myocardial infarction --

Q. That's why we have emergency room physicians to assist us.

A. We don't prevent perforated ulcer, we may be able to diagnosis them.

Q. Prevent them from killing us?

A. We hope we can make the diagnosis early enough to get the patient to the right place.

Q. The symptomotology was [illegible] in the first visitation, was it not, to make the diagnosis?

A. I don't know. No, I think the first visit, the Richmond Heights Clinic visit, his

diagnosis was severe abdominal pain of unclear ideology. There was considerable stone in the bile duct, secondary colicystitis and perforated peptic. He couldn't rule anything out. He was faced with a patient who appeared very acutely ill at that time.

Q. What happened in the next day to make her look that much better?

MR. GROEDEL: Objection.

A. I don't know.

Q. But her presentation, you are saying looked totally --

A. Totally and completely different.

Q. Was she given any medications that could have changed or masked the symptoms, Doctor?

A. I don't see a record of Richmond Heights discharge medications.

Q. I don't think there was medication given there because she was taken by ambulance.

A. I can't see all the --

Q. She was taken by ambulance to the Richmond Heights Hospital.

A. No, I thought she went to Memorial

Hospital.

Q. Correct.

A. When she got to Memorial Hospital she seemed to be sick enough to require laboratory tests. Certainly the transfer you would get information when the patient was transferred. At that time there was communication between the first and second physician.

Q. You do or you should get information?

A. On a direct transfer you certainly should. I can't prove that there was, but you certainly should.

Q. Okay.

A. And she had further studies which ruled out almost every disease that concerned the first physician.

Q. Ruled out perforated ulcer?

A. Perforated ulcer because there was no free air. I think there was no evidence whatsoever of an aneurism on the second visit.

Q. We know what she had now that an autopsy was performed.

A. I don't think we should look at them

retrospectively.

Q. We have the advantage of now knowing what she had?

A. Right.

Q. We can put it into context?

A. Even if we didn't, we know there was no evidence of that on the second visit, on the Memorial Hospital Geneva October 4 visit.

Q. And you have no idea what changed her presentation; is that correct, Doctor?

A. That's right.

Q. If there was testimony that you are asked to assume that the presentation was not different, would that change your opinions in any fashion, Doctor?

MR. GROEDEL: Objection. Go ahead, Doctor.

A. That there was no difference between the Richmond Clinic presentation and the Memorial Hospital of Geneva October 4 presentation?

Q. You got it.

A. No, I don't think that would change anything because tests were done to evaluate and

look for those things. So, I would be critical if no tests were done if that testimony were true.

Q. Doctor, Dr. Desai did not recommend admission on the 4th, did he?

A. No, I don't believe he did.

Q. He just sent her home?

A. Yes.

Q. Any medications?

A. It says Tylenol 3 every 6 hours, to see her doctor and be on liquid diet. That's the only medication that I had documentation on. Okay.

Q. What views would you do in an x-ray to determine free air?

A. I don't know. It depends on the patient and the clinical condition. I can't answer your question.

Q. Well --

A. Do you want to know what the textbooks say?

Q. Sure. Why not?

A. Most textbooks will tell you to do a flat

abdomen and a chest film.

Q. What will an erect film do?

A. That's the chest film.

Q. Was Mrs. Lovett able to stand up so that they could do an erect film?

A. I don't know.

Q. Would that make any difference to you?

MR. GROEDEL: Which visit are you talking about?

MR. KAMPINSKI: On the 4th, that's the only one they did any x-rays.

A. It might make a difference. It might not make a difference.

Q. Why would it make a difference?

A. Why would it?

Q. Yes.

A. Let's say she couldn't stand up because her blood pressure was 40/0 and she was not, if she stood up there was not enough blood to her brain or she couldn't stand up because she lost her balance and fell over and smashed her face, then that would make a difference.

Q. What if she couldn't stand up because of

pain?

A. That wouldn't make a difference.

Q. How many x-ray films did they do?

A. I don't know. I don't know if that's anywhere in the record.

Q. Do you want a person to be either erect or laying down for some period of time so that you can determine whether there's free air before you take the film or do you just leave that to the radiologist?

A. The radiological technologists will put the patients through whatever movements they need to put them through in order to get the film. On a decubitous film they usually have the patients laying there for a period of time and it allows air to percolate up into the abdomen.

Q. Have you reviewed the films?

A. No, sir.

Q. Have you asked for them?

A. No, sir.

Q. Do you review films taken of patients you see in the emergency room or do you just rely on the radiologist?

A. When I see patients?
Q. Yes.
A. I look at all my x-rays.
Q. Had a differential diagnosis of perforated ulcer been made and Mrs. Lovett admitted, you still believe that she would have died?
MR. GROEDEL: Objection. Go ahead.
A. Yes, I do.
Q. Why?
A. Well, if a diagnosis of perforated ulcer had been made, a surgeon would have evaluated the patient. The surgeon would have had the same findings here and would have not believed that diagnosis, therefore wouldn't have done surgery and therefore ordered tests for the same day and the patient would have gone through the scenario I described earlier.
Q. How do you know what a surgeon would have done?
A. Well, you asked me to make an assumption. It's quite possible and you are correct that a surgeon would have inappropriately operated on this patient.

Q. And inappropriately saved her life?
A. It's possible. You can do the wrong thing and end up the right way, but I think surgeons faced with the findings would certainly not have operated on the patient.
Q. You did your residency in emergency medicine, Doctor?
A. That is correct.
Q. I'm just looking for any specialized training in surgery, do you have any, sir?
A. No, no specific surgical training in terms of being a surgical resident.
Q. Is there anything else about this case, Doctor, that any other factors that you believe either added or detracted from your conclusions?
MR. GROEDEL: Objection. Go ahead.
A. Not at this time.
Q. Well, do you plan to receive any additional factors, Doctor?
A. Do I plan to?
Q. Have you asked for any additional information or do any additional work on the case that you just haven't gotten to yet?

A. No. No.
Q. All right. If, in fact, there are additional facts that come to your attention that you believe you will be commenting on at the time of trial, can we agree that you will at least provide me with some notice of that?
A. Yes, absolutely.
MR. GROEDEL: Maybe Mr. Coakley will be doing that, I'm not sure the Doctor will.
MR. KAMPINSKI: I'm sure that Mr. Coakley will act as a conduit as passing the information. I want to make sure we have something on the record in terms of an agreement I will get the information. That's all.
(Break taken at this time.)
MR. DJORDJEVIC: I have nothing.
MR. KAMPINSKI:
Q. Just a few more questions. If a person has a diagnosis of colicystitis, they can be treated, can they not, with IV and nasogastric

tube even if they are not going to admitted, that can be done in the emergency room?

A. They can be treated even as outpatients, that's right.

Q. Should that have been done with Mrs. Lovett on the 5th?

A. I don't know. She was not having continued vomiting. Here it says nausea, no vomiting, burps and belching. It's not necessary it would have been done.

Q. How much had she eaten?

A. I have no idea how much.

Q. Does that make a difference in terms of vomiting?

A. Well, if patient has nothing in their stomach when they gag rather than vomit and nothing comes up, it makes a difference in what comes up, yes.

Q. If a patient had colicystitis without peritoneal signs, what's the treatment discharge, does that require hospitalization?

A. I don't know if I could diagnosis the colicystitis without the peritoneal signs.

Q. If you have peritoneal signs, that then requires admission, does it not?
A. In most cases, I wish I could tell you one hundred percent. I would say the great majority of patients with right upper quadrant pain where the emergency room physician feels it's colicystitis do get admitted.
Q. You couldn't diagnose it without peritoneal signs, what signs are you talking about?
A. The tenderness and guarding and not necessarily as I said before rebound.
Q. Where did you see guarding? You just referred to guarding. Where did you see guarding in the record?
A. I didn't say I saw guarding in the record. You just said it.
Q. I'm sorry. You are telling me peritoneal signs, not necessarily in this case?
A. Okay.
Q. Go ahead, Doctor.
A. I'm done.
Q. Guarding, what was the other one?

A. Tenderness.
Q. Peritoneal signs are consistent with perforated ulcer or peritonitis, aren't they, Doctor?
A. Would you please repeat that?
Q. Peritoneal signs are consistent with perforated ulcer or with peritonitis, are they not?
A. I don't know if they are consistent with an ulcer, just a plain ulcer.
Q. Perforated ulcer?
A. Peritoneal -- if there's a perforated ulcer you would usually see peritoneal signs, if there's peritonitis, you would usually see peritoneal signs.
Q. All right. In your report you've indicated the second paragraph that this evaluation, you are referring to the October 5 visitation, you can refer to the report if you want, was not consistent with a perforated ulcer or with peritonitis?
A. Right.
Q. Yet the diagnosis of colicystitis?

A. Yes.
Q. Which requires according to you peritoneal signs?
A. Right. There's a difference between peritonitis and peritoneal signs. You can have localized irritation of the peritoneum as in appendicitis when a patient has tenderness over the area tone as McBurney's Point and you are considering a possibilities of appendicitis maybe but they certainly have peritoneal signs but certainly does not have peritonitis. They are worlds apart.
Q. Peritoneal signs are consistent with peritonitis, are they not?
A. Yes, I guess peritoneal signs are consistent with peritonitis.
Q. And perforated ulcer?
A. And with pericarditis and appendicitis and any one of thousands.
Q. I'm reading the words in your report, peritonitis and perforated ulcer. That's why I dealt with those two.
A. I didn't know that I said in my reports

that peritoneal signs are consistent with peritonitis.

Q. You said this evaluation was not consistent with a perforated ulcer or with peritonitis?

A. Right.

Q. I thought we just went through and you indicated that if you have colicystitis diagnosis that you have to have peritoneal signs or that you would expect to have peritoneal --

A. You would expect them if you have a diagnosis of colicystitis.

Q. Are you saying the diagnosis made by Dr. Conant was incorrect?

A. No, not at all.

Q. She had colicystitis?

A. She had tenderness.

Q. Is that consistent or inconsistent with perforated ulcer or colicystitis?

A. Is tenderness consistent? It's consistent with either one of the those.

Q. Why did you say it was not consistent?

A. I said the physical evaluation on this

patient was not consistent with peritonitis or with the perforated ulcer. The reason for that is the findings you see in the two problems are not down here.

Q. Which are what?

A. Patients have a perforated ulcer the most common presenting findings of perforated ulcer is rigidity, the patient's belly is like a board. You can't feel organs, you can't describe tenderness in any one area, you don't say the abdomen is flat, you can't hear peristalsis because everything is shut down and the patient has such generalized irritation that she resists palpation anywhere and that is no where near what this evaluation shows.

Q. You indicated, Doctor, that you found no fault or you would have found no fault with doing testing the following morning, referring now to the evening of October 5?

A. Yes, that's right.

Q. Do you know what day of the week the following morning would have been, sir?

A. No, I have to look that up.

Q. If the patient were told that tests wouldn't be done until two days after, would that be appropriate in terms of medical care given to this patient?

MR. GROEDEL: Objection.

Q. Would that be okay?

MR. GROEDEL: Go ahead.

A. I can't answer your question because I don't know what tests you are referring to.

Q. X-rays, lab tests, blood work, any tests that you think might have been appropriate, sir.

A. This patient here would have been told no tests can be done for two days?

Q. That's right, Doctor.

MR. GROEDEL: Objection. Go ahead.

A. Well, I suppose that would be extremely unusual. As long as there was the IV's started and nasogastric tube and repeated evaluations, I wouldn't find fault with that unless the patient's condition changed.

Q. It would be okay, for example, not to do any tests on Mrs. Lovett until she was admitted on the 7th of October?

A. Until the next morning, reevaluate her and at that point it might or might not have been appropriate to not do any tests until the next day. I don't know the answer to your question.

Q. Would it be appropriate to tell the patients on the evening of the 5th when she was in the hospital and when you were discussing admitting her that sure, we'd like to admit you but we're not going to do any tests on you until the morning of the 7th, would that have been appropriate?

A. Based on her physical findings at that time if that were the truth, it may have been appropriate to say that.

Q. It may have been, you don't know?

A. That's right. Based on her physical findings it may have been appropriate to tell her that. Now, the reason for that is that I don't know what the relationship was between the physician and the patient at that time and how she would react to that kind of statement.

Q. She had never seen the physician before. You lost me, Doctor. What are you talking about,

A. This is a Saturday and what we are taking it would be Monday before tests could be done?

Q. That's right.

MR. GROEDEL: Objection. Go ahead, Doctor.

A. I guess I'm not sure whether it's appropriate to tell her or should a health care facility offer the things?

Q. Take them one at a time.

A. I think anybody who needs to know the truth ought to be told the truth. If that is the truth, then I think it's totally appropriate to tell that to somebody.

Q. Okay.

A. I think any health care facility ought to be able to on emergency basis do a limited number of evaluations and the nature of those evaluations depends on where the facility is, now big it is and what its finances are and what the expectations of the public are of that particular place.

MR. KAMPINSKI: That's all I have, Doctor. Thank you.

MR. DJORDJEVIC: Nothing Doctor.

Thank you.

(Deposition concluded at 2:45 p.m.)

(Signature waived.)

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C E R T I F I C A T E

STATE OF OHIO)
) SS.
COUNTY OF LUCAS)

I, Lori L. Udowski, a Notary Public in and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within-named witness, BRUCE D. JANIAK, M.D., was by me first duly sworn to tell the truth, the whole truth, and nothing but the truth in the cause aforesaid; that the testimony then given by him was by me reduced to stenotype in the presence of said witness, afterwards transcribed upon a computer, and that the foregoing is a true and accurate transcription of the testimony so given by him as aforesaid.

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

I do further certify that I am not a relative, counsel, or attorney of any party or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Toledo, Ohio, on this 25th day of May, 1988.

Lori L. Udowski

LORI L. UDOWSKI
Notary Public
in and for the State of Ohio

My Commission expires December 19, 1991.

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