211293

ORIGINAL

STATE OF OHIO)
)
COUNTY OF STARK)

COURT OF COMMON PLEAS

G. IAN CRAWFORD, Guardian and Next Friend of Richard White,	)	
Plaintiff,	)	
vs.	)	Case No. 88-1291
DR. MILAND B. SANWARKEDER, et al.,	)	
Defendant.	)	

- - -

Deposition of BRUCE D. JANIAK, M.D., a Witness herein, called by the Plaintiff as if upon Cross-Examination under the Ohio Rules of Civil Procedure, taken before me, the undersigned, Renee E. Brass, a Notary Public in and for the State of Ohio, at the Toledo Hopsital, 2142 North Cove Boulevard, Toledo, Ohio, on Tuesday, June 19, 1990 at 1:25 p.m.

C O L L I N S R E P O R T I N G S E R V I C E, I N C.

Registered Professional Reporters

405 North Huron Street Toledo, Ohio 43604

(419) 244-9385

OBJECTIONS DR. BRUCE D. JANIAK

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of all, let me	OBJECT	, go on record as		28	19
MR. SCHOBERT:	OBJECT	.	A. I'm	51	1
I am going to	OBJECT		to the	74	2
MR. SCHOBERT:	OBJECT	.		77	17
MS. MINKLER:	OBJECT	.		77	18
MR. SCHOBERT:	OBJECT	.	You are arguing.	82	4
MR. SCHOBERT:	OBJECT	.	Q.	82	8
to a	OBJECTION	to any of that.	We	28	20
MR. SCHOBERT:	OBJECTION	.	A.	30	22
MR. SCHOBERT:	OBJECTION	.	A.	32	11
MR. SCHOBERT:	OBJECTION	.	Are you	33	14
MR. SCHOBERT:	OBJECTION	.	A. I	36	22
MR. SCHOBERT:	OBJECTION	.	A. I	39	13
MR. SCHOBERT:	OBJECTION	.	Go ahead,	46	8
MR. SCHOBERT:	OBJECTION	.	A.	46	20
MR. SCHOBERT:	OBJECTION	.	A. It	48	9
MR. SCHOBERT:	OBJECTION	.	A. I	54	12
that.	OBJECTION	.	I am confused.	54	16
SCHOBERT: Note my	OBJECTION	.	A.	54	22
MR. SCHOBERT:	OBJECTION	.	Q.	56	8
MR. SCHOBERT:	OBJECTION	.	A.	57	2
MR. SCHOBERT:	OBJECTION	.	Q. Is	57	19
MR. SCHOBERT:	OBJECTION	.	Q. --	58	12
MR. SCHOBERT:	OBJECTION	.	A. I	59	10
MR. SCHOBERT:	OBJECTION	.	A.	59	17
MR. SCHOBERT:	OBJECTION	.	A.	59	21
MR. SCHOBERT:	OBJECTION	.	Q.	62	14
MR. SCHOBERT:	OBJECTION	.	A.	62	18
MR. SCHOBERT:	OBJECTION	.	A.	64	7
MR. SCHOBERT:	OBJECTION	.	A.	65	5
MR. SCHOBERT:	OBJECTION	.	A.	67	8
MS. MINKLER:	OBJECTION	.		78	20
MS. MOORE CARULAS:	OBJECTION	.	A.	78	21
MS. MINKLER:	OBJECTION	.	A.	79	22
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MS. MOORE CARULAS:	OBJECTION	.	Q.	80	18
MR. SCHOBERT:	OBJECTION	.		80	23
MS. MINKLER:	OBJECTION	.		80	24
MS. MOORE CARULAS:	OBJECTION	.	A. I	81	1
MR. SCHOBERT:	OBJECTION	.	Q.	81	12
MR. SCHOBERT:	OBJECTION	.	Asked and	82	24
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MR. SCHOBERT:	OBJECTION	.	Q. Is	85	4
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MR. SCHOBERT:	OBJECTION	.	That's not	87	4
MR. SCHOBERT:	OBJECTION	.	A.	90	9
MS. MINKLER:	OBJECTION	.	A.	90	20

OBJECTIONS DR. BRUCE D. JANIAK

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MS. MINKLER:	OBJECTION	.	A.		91	1
MR. SCHOBERT:	OBJECTION	.	A.	I	96	4
MR. SCHOBERT:	OBJECTION	.	A.		96	19
MR. SCHOBERT:	OBJECTION	.	A.		97	2
MR. SCHOBERT:	OBJECTION	.	A.		100	7
MR. SCHOBERT:	OBJECTION	.	Q.		100	19
MR. SCHOBERT:	OBJECTION	,	that's not --		101	4
I withdraw the	OBJECTION				101	10
my reason for my	OBJECTION	.	Q.		101	12
MR. SCHOBERT:	OBJECTION	.	Withdraw		103	9
Withdraw	OBJECTION	.	A.	I	103	10
MR. SCHOBERT:	OBJECTION	.			104	9
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MR. SCHOBERT:	OBJECTION	.	A.		108	7
MR. SCHOBERT:	OBJECTION	.			108	13
MS. MINKLER:	OBJECTION	.	A.		108	14
MR. SCHOBERT:	OBJECTION	.	Q.		109	6
MR. SCHOBERT:	OBJECTION	.			110	4
MS. MINKLER:	OBJECTION	.	A.		110	5
MS. MOORE CARULAS:	OBJECTION	.			110	21
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MS. MINKLER:	OBJECTION	.			111	7
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MR. SCHOBERT:	OBJECTION	.	Q.		111	9
MR. SCHOBERT:	OBJECTION	.	Q.	--	114	16

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BRUCE D. JANIAK, M.D.,

a Witness herein, called by the Plaintiff as if upon Cross-Examination, was by me first duly sworn, as hereinafter certified, and deposed and said as follows:

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CROSS-EXAMINATION

BY MR. TRACI:

Q. Doctor, would you be kind enough to state your full name and office address for us, please.

A. Bruce David Janiak, 2142 North Cove Boulevard, Toledo, 43606.

Q. I am going to hand you a copy of your curriculum vitae that we got from Mr. Schobert through you, I guess, and ask you whether or not that's a current copy of it and whether you have any additions to make to it.

A. Yes. This is not a current copy, and the additions revolve around the heading American Board of Emergency Medicine. I am currently president elect of that board. I have served as secretary/treasurer.

Q. Is that board listed on your resume?

A. Right.

MR. SCHOBERT: It's the second --

Q. You were a member of the board of directors

from '86 to '90, and you were just made president elect of that group?

A. I assume the presidency next month.

Q. You've been president elect this past year?

A. Right.

Q. Okay. Are there any other additions?

A. That's the only one of any significance that I know of.

Q. Any other articles?

A. No, no articles.

Q. Okay. On your CV on the last page you list Emergency Management Consultants, partner, can you tell us what the group is.

A. I used to work with Dr. Michael Ervin in Dayton, Ohio, and I had a consulting business for about four or five years, in which we would respond to requests from colleagues in emergency departments throughout the United States and give them advice on whatever area they were interested in, giving advice on what we thought, what we know.

Q. This is advice to emergency groups that staff emergency departments?

A. Sometimes it would be emergency groups. Sometimes it would be hospital administrators who would

call.

Q. Okay. What types of things would you be giving advice on?

A. Almost all the time it would be advice on the management aspects of the emergency department, usually involving on how to improve such things as quality assurance, how to deal with staffing, once on hiring a new emergency director and helping with the contract for that director.

Q. That was with Dr. Michael Ervin?

A. Yeah.

Q. Could you spell the last name.

A. E-R-V-I-N.

Q. Was that a corporation? It says here partnership. Was it just a partnership?

A. I think it was a partnership. I can't remember.

Q. Okay. And is that still in operation?

A. No. That has not been in operation for, I think, five years.

Q. Okay. Now, it says president Professional Emergency Services.

A. I am, yes.

Q. Are you still in that?

A. Yes.

Q. What's that?

A. That's a name of the group that has the contract to provide the professional staffing in the emergency department at the Toledo Hospital.

Q. Okay. So the ER physicians who work under contract with the hospital -- let me strike that.

Toledo Hospital has a contract with Professional Emergency Services to staff their hospital?

A. Correct.

Q. The emergency room?

A. Correct.

Q. You are president of that group?

A. That's right.

Q. How many members are in that group, physicians? Does that keep changing?

A. That keeps changing. Right now there are seven full-time emergency physicians and about 12 to 15 pediatricians that get paid by that group.

Q. Okay. Do you staff any other hospitals?

A. No.

Q. This is the only one?

A. That's right.

Q. Okay. Then it says president EMB

Professionals, Inc.

A. Correct.

Q. What is that?

A. That's a billing company headquartered in Dayton, Ohio which provides billing services for emergency physicians at probably seven hospitals throughout Ohio. We still do one in Kentucky. I think it's Ohio and Kentucky.

Q. Do they bill for Professional Emergency Services, Inc.?

A. Yes, they do.

Q. Okay. Do you belong to any of the expert witness services?

A. I do not.

Q. Have you ever?

A. I have never.

Q. Okay. How is it that Mr. Schobert came in contact with you in this case?

A. I guess I would not able to answer that question to any detail. I know that I have testified before and perhaps they heard of me from some other attorneys somewhere in that part of the state. There is, I believe, one other case that -- I can't remember the name of -- I am working with that group, but that case --

I just don't remember.

Q. What group, meaning with the law firm?

A. Yes.

Q. Is that Buckingham, Doolittle & Burroughs?

A. Yes.

Q. Have you ever had contact with Mr. Schobert and the other attorney, Mark Fraser, prior to your involvement in this case from that firm?

A. I don't believe so.

Q. Mark Fraser represents Dr. Paulino in this case, that's Mr. Schobert's partner.

A. No, I have not. I don't remember talking to him, unless someone else did.

MR. SCHOBERT: Wish I was a partner. Still not a partner yet.

MR. TRACI: Okay. I should interject, he should be a partner in that firm. I think that ought to be on the record.

MS. MINKLER: I do too.

MR. TRACI: We'll stipulate --

MR. SCHOBERT: Get the checkbook out right now.

Q. Okay. You have been a practicing emergency room physician since 1972?

A. Practicing emergency physician, correct, since 1972.

Q. That's when you completed your residency?

A. That's right.

Q. Starting in 1972 up to the present time, have you been reviewing cases and acting as an expert witness in medical malpractice cases?

A. No, I have not.

Q. How long have you been doing that kind of work?

A. I believe the first case I did was somewhere in the late 70's, and I don't believe I did another case for perhaps seven, eight years. In the last six years is when I have done more cases, and I have probably reviewed maybe 40 cases in six years.

Q. All told?

A. All told.

Q. Does that include a review even on a case that you have rejected involvement on?

A. Yes, indeed.

Q. Okay. How many cases of the, say, 35 that you have reviewed have you actually become an expert witness in?

MR. SCHOBERT: You mean given

deposition testimony?

MR. TRACI: Well, no. Retained as an expert witness that prepared a report.

MR. SCHOBERT: Okay. Fine. Just wanted to qualify. You made a differentiation already.

Q. Okay.

A. Probably 20.

Q. Okay. Of those 20 cases, how many have been on behalf of the claimant or the patient and how many have been on behalf of the defendant physician or group?

A. Probably 80 percent defense and 20 percent plaintiff.

Q. Okay. And have they all been cases involving emergency services?

A. Well, I should point out there is a couple of civil cases that I have been asked to review, so they have not all been. But all the medical-legal cases have been -- or all the malpractice have been related to emergency medicine.

Q. What type of civil cases have you been asked to review? You piqued my curosity.

A. Well, it was strange to me too, but there was a case of a patient that was riding a motor bike who ran

into a pole and was suing the municipality that owned that area. I think it was near a playground or ball field, and there was something -- the allegation was that the pole was supposed to be tied in a certain way, and it was not, and he hit it and died. And I was asked to give my opinions as to how serious his injuries were, how salvagable he was after the injury, those kinds of things.

Q. Okay. So the lion's share of the cases you have reviewed have been medical-legal ones involving the claim of potential negligence on behalf of the emergency room physician or group?

A. I don't believe I've ever been asked to review anything that was not from an emergency physician, and indeed I wouldn't feel qualified to do it for in-patient medicine.

Q. Okay. How many times have you been deposed?

A. Probably 15.

Q. Does that include trial or just a discovery deposition like today?

A. That includes all of them, both.

Q. Okay. How many times have you actually appeared in court?

A. Three.

Q. Can you name, in any of the cases where you

appeared in court to testify, the name of the lawyers who were involved in the case or names of cases?

A. Give me a moment to think. Bill Connelly.

Q. Bill Connelly?

A. C-O-N-N-E-L-E-Y, (sic) something like that, here in Toledo was one of the attorneys. That particular was -- he was a plaintiff's attorney.

Q. That was a trial?

A. Correct.

Q. Okay.

A. Tim Krugh, K-R-U-G-H, that was a defense. That was here in Toledo, but his firm is not Krugh. I forget the -- I think it's Robison, Curphey & O'Connell is the name of his firm. I am sorry. There were four, not three.

Q. Okay.

A. One was in Green Bay, Wisconsin. I don't remember the name of the attorney. The other one was in Florida. I can't think of her name right now.

Q. Of the 20 cases you've been involved in, that you have been duly accepted to be an expert witness in, how many of those have been in Ohio?

A. All except the three that I mentioned. No. I am sorry. That's not correct. I think the firm in

Florida has asked me to review two others. I'm trying to be accurate. Apart from the two in Wisconsin --

Q. You don't need to give me that much detail.

A. Four and four. I am trying to answer.

Q. Fine. Give me a plaintiffs, defense. Who in Ohio -- so we can cut through that and be more frank about it, give me the name of a plaintiff's attorney.

A. Lafferty, L-A-F-F-E-R-T-Y.

Q. From where?

A. He's here in Toledo. He has deposed me once.

Q. Has Marty Williams ever deposed you?

A. No, I don't think so.

Q. Do you know Marty Williams?

A. He is in the same firm as Lafferty.

Q. Okay. Anybody from Cleveland and Akron or Canton?

A. There was one from Cleveland long ago. I can't remember the name.

Q. Tell me, if you would, what materials were you provided by Mr. Schobert in your review of this case.

A. I have a list of materials here.

Q. Okay.

A. Try to --

Q. If you would, if you would when you give me

this list, give me the list only up through the preparation of your report in this case. There were additional materials that you --

MR. SCHOBERT: There's two reports. You mean the first one and the second?

MR. TRACI: The first one.

MR. SCHOBERT: If you can, Doctor, go ahead.

MR. TRACI: If you can recollect.

MR. SCHOBERT: It just comes in a pack.

A. I don't think I can do that.

Q. Just do this for me, answer this question, since you have written both of your reports and those were in, have you received any transcripts of any of the arbitration testimony?

A. No, I have never seen that.

Q. Okay. Have you ever received any materials in writing after the submission of your second report?

A. Yes. The deposition of Dr. Schuda.

Q. Okay.

A. S-C-H-U-D-A.

Q. And any other depositions?

A. Yes. Cunningham. That was after.

Q. Okay. Is that --

A. That's all I remember, yeah.

Q. You received Dr. Schuda's deposition that was just taken last --

A. This morning I did.

Q. Did you read it?

A. Yes, I did.

Q. Okay. How did you get it this morning? Federal Expressed it up?

A. I don't have any idea.

MR. SCHOBERT: Uh-huh.

MR. TRACI: Okay.

MR. SCHOBERT: There is more to that. I sent him some of those reports that gave me --

Q. Did you receive the reports of the experts for the plaintiff in this case?

MR. SCHOBERT: I think you did.

A. Yes, I did, but I don't remember the timing. I'm trying to refer to your question.

Q. Why don't you give me a quick list, because your reports don't indicate which materials you had.

A. Right. The reports that I received were from Lipton, Schuda, Quinn, Fefferman (phonetic) and Kenney and the final was a copy of my own. The records were from --

emergency records from Doctors Hospital and from Timken Mercy and some in-patient records, and the depositions were Cunningham, Jeun, J-E-U-N, Schuda, Davis, and then there's -- I have some memory of something from a nurse, but I -- I know I saw a deposition of a nurse.

Q. Okay. Do you know which nurse? Was it a nurse from Timken-Mercy or was it our nursing expert or --

A. No, I --

MR. SCHOBERT: If you don't remember --

A. It seems to be Mullvey, something like that.

Q. Mulvaney?

A. That's right, Mulvaney.

MR. SCHOBERT: I may have sent that to him a long time ago.

A. I can't remember where that came from.

MR. SCHOBERT: I forget.

Q. Did you receive the transcript of the arbitration testimony of Dr. Davis?

A. No, I did not.

Q. Just his original deposition?

A. I didn't see anything from the arbitration. As a matter of fact, I didn't even know there was an arbitration.

Q. Okay. You didn't know there was an

arbitration?

A. No. It may have gone in one ear and out of the other.

Q. Mr. Schobert didn't tell you?

A. I heard about it this morning. I didn't know there was one.

Q. Did you know you won in the arbitration?

A. He told me.

Q. Apparently you were very convincing to the arbitrators.

A. He told me that.

Q. I just thought you'd like to know that.

A. Thank you.

Q. Did you --

MR. TRACI: Off the record.

(A discussion was held off the record.)

Q. Did you use any particular literature in the preparation of your report?

A. I did not.

Q. Is there any journals or literature in the field that you are an expert in that you consider to be particularly authoratative?

A. No, there is not.

Q. Is there any that you refer to in your

practice in keeping up to date that you consider to be informative?

A. There are a number of publications, both texts and journals that I will look up, very specifically look up items in.

Q. You don't consider those periodicals or texts to be generally authoratative, but they can have useful information?

A. That's correct.

Q. Can you tell me what -- do you, for example, subscribe to -- what is it, the Annals of Emergency Medicine?

A. Yes, I do.

Q. Any other periodicals like that?

A. Sure. There is the Journal of Emergency Medicine, and there is the American Journal of Emergency Medicine.

Q. Any others that you regularly subscribe to and use, know they're out there somewhere in the marketplace?

A. Let me give you the list. You may not even want the list. There are many journals I do review on a regular basis because I am editor of a taped journal which basically provides audio abstracts of articles of interest

to emergency physicians. And so I will review probably 15 or 20 journals on a monthly basis to see if there are appropriate articles in them I might abstract. I'd be happy to give you that list, if that's -- if you'd like that.

Q. Okay. Is that a list that you would have available easily?

A. It's in my head. Probably could name most of them.

Q. I don't want to take the time. I'm not going to take the time to go look at them anyway. That's just a question all lawyers pose.

A. I understand. I can tell you that it would not be helpful to you in the most honest way I can. I just don't want to waste your time.

Q. That's what I figured. Are there any texts that you have available to you that you periodically refer to in the field of emergency medicine?

A. Sure. There's Schwarts Principle and Practice of Emergency Medicine over there on the wall that I probably look at once a week. There is another one that I look at more often called Surgical Anatomy, which Young is the author. And there is the Study Guide on Emergency Medicine which I believe I review or look at certain

portions once a month maybe.

Q. Okay. What is Janiak Consulting, Inc.?

A. I told you before that I have done a number of reviews of legal cases. When I do that, you do get paid, but I get it basically as an independent contractor, so no taxes are taken out. I find that it is much safer for me to deposit that money in an entity that is forced to pay taxes or else I may be faced with large income tax bills, so I incorporated just to be able to solve that problem.

Q. So that group is just involved with the review of legal matters?

A. No. That group is not a group. It's just me. That group will also respond to requests from individual hospitals and do the work that the other corporation did, which I talked about earlier, the other entity, Emergency Management Consultants, and I do some of that on my own.

Q. What is your normal week like in terms of what do you do? Do you teach, do you work in the ER, do you write? What do you do?

A. Well, I do all those things. Normally I come in about eight o'clock in the morning and usually will end up responding to letters or reviewing charts. Then I

will --

Q. Review charts for what?

A. The patients that are seen in the emergency department are all evaluated obviously by physicians. Sometimes after that evaluation and treatment, a patient will have a question or complaint or concern. That chart will come on my desk. Sometimes a nurse will have a concern, and that chart will come on my desk. Sometimes a resident will have a complaint. They come from all these sources. The charts come to my desk every day, and I review the charts with specific reference to not only the problems that the complainant has but also to the quality of emergency care.

Q. When that's brought to your attention -- you don't on a regular basis in your emergency room review all the charts of all the people that come through?

A. That would be completely impossible. I don't think so. So by the time I finish that, the department is usually a little busier, and on four or five days I am called to see patients, and I go out and see them. Other days I am actually scheduled to see patients. I don't have a chance to get into the office, so --

Q. Scheduled to see patients in the emergency room here?

A. Right, yes. I am on the schedule like everyone else.

Q. How many days a week do you work on the schedule?

A. Well, it varies. In the last week I worked five days. The week before I worked three days. Depends. Every week is different.

Q. Do you work three days, at least, every week?

A. Not scheduled, but I see patients every day.

Q. Well, I'm talking about scheduled. Over the last six months what would you say the average week is in terms of scheduled in the ER?

A. Scheduled in the ER to see patients probably 15 hours a week.

Q. Okay. And if you are around here doing other work and there's a backup, whoever the physician is that's on the schedule can't get to everybody to assess the problem, then you are called in, then you will assist?

A. Right, correct.

Q. Okay. Your resume says that you are a clinical associate professor of EMS, Department of Surgery for the Medical College of Ohio at Toledo.

A. Yes.

Q. From '84 to the present?

A. Correct.

Q. Although it says at the bottom, "Please do not use this appointment as a citation in any brochure."

A. Correct.

Q. Can you tell me why? That piques my interest again.

A. Two reasons. It always piques the interest of attorneys, so I get a chance to discuss this.

Q. Do you do that to --

MR. SCHOBERT: You fell right into it.

A. I have already accomplished 80 percent of my goal. The reason is that I do speak around the nation, and my official affiliation is at Toledo Hospital. Unfortunately, organizations that ask you to speak focus on affiliations with medical colleges. I have been in another area of the country to speak and the brochure will come out that says, "Bruce Janiak from the Medical College of Ohio will be speaking." You can imagine that my administrators are not totally pleased with the fact that Toledo Hospital doesn't get mentioned, so I had to add that in there to prevent people who make up the brochures from having me primarily affiliated with the Medical College rather than with this hospital.

Q. Why don't you do the same with the clinical

associate professor, which is right above --

A. I can't tell you. I thought that's what it refers --

MR. SCHOBERT: That's current appointments, but --

A. Maybe that's it. At any rate, it's worked perfectly. I have not been listed as affiliated with the Medical College of Ohio in any brochures since then, so --

Q. And you are board certified in emergency medicine?

A. That's right.

Q. And you are on the staff at Toledo Hospital; is that right?

A. That's right.

Q. You also have there the University Association for Emergency Medicine.

A. Correct. It's an organization that doesn't exist because it merged with another one. It's now called Associated -- or Academic Emergency Medicine. Doesn't it say that? Maybe not. That merger just took place a few months ago.

Q. What does that group do?

A. It's a mechanism of bringing together those physicians who have a strong interest in teaching in

emergency medicine, and the common problem was dealing with residents, how to deal with discipline and how to teach are discussed, and it's a forum for improving what we do.

Q. Okay. Do you consider yourself an expert in anything other than emergency medicine?

A. Childcare, but that's all.

Q. Okay.

MR. SCHOBERT: He's got nine of them.

Q. You've got nine of them?

A. Yes, sir.

Q. I am one of 11. We are both from active Jewish families.

A. Why not.

Q. Do you have your reports there in front of you?

A. Yes, sir, I believe I do.

Q. On your first report dated April 24, 1990 to Mr. Schobert, you have in your first sentence that you reviewed the materials, which you already told me about --

A. Yes, sir.

Q. -- with the view towards determining any deviation from the standard of care delivered to Mr. White on March 7, 1987. First of all, was your view only

directed to the conduct of the emergency room department at Timken Mercy Hospital rather than to Dr. Paulino or Dr. Jeun or whoever else was involved?

A. Yes.

Q. I don't think I left anybody out.

A. Correct.

Q. Do you intend to have any opinions of any kind involving anybody other than Dr. Davis or the emergency room group that he's associated with at Timken Mercy Hospital?

A. Well, I think if prepared, I can render opinions regarding the emergency care either at Doctors Hospital or Timken Mercy. Otherwise I don't have any other opinions on other things that happened.

Q. Have you been asked to review the emergency care at Doctors Hospital?

A. That was part of the package, but I was not specifically asked to criticize or deal with that.

Q. Do you intend to be -- first of all, I don't think it's relevant.

MR. SCHOBERT: That's an argument for the court, but I did not ask him to tell whether he met the standard of care. I am certain if he has those records, certainly he

can tell us his views of the records.

Q. That's fine. I just wanted to make sure that if he is going to express opinions about that, then I want to know about it. If not --

MR. SCHOBERT: He wasn't asked to render any opinion, so --

MR. TRACI: You are dancing around the question. Do you intend to ask him for that? If you do, I will ask him about it. If not then --

MR. SCHOBERT: I intend to ask him questions about care provided as it relates to care provided by Dr. Davis, yes, I do.

MR. TRACI: That would be a comparison of those two?

MR. SCHOBERT: Yes.

Q. Do you have a --

MR. TRACI: First of all, let me object, go on record as reserving my right to a objection to any of that. We have had that argument before.

MR. SCHOBERT: I understand it may not be relevant to anything else, but since he is going to do that --

Q. Have you formulated any opinion concerning the conduct of the physicians at Doctors Hospital on 3-7-87?

A. Yes, I have.

Q. What is that opinion?

A. That they met the standard of care evaluating this patient.

Q. Okay. In your report you indicate that there was a note in the record that the gas was on in the room?

A. Correct.

Q. Correct?

A. Yes.

Q. Did you get that from Dr. Davis' dictated note?

A. Well, I wish I could answer that specifically. I may have seen that somewhere else. I may have had a copy of the ambulance run on that.

Q. I'm not sure of any ambulance run that --

MR. SCHOBERT: I am not sure of it either. Off the record.

(A discussion was held off the record.)

A. Well, I seem to remember something about an ambulance run.

Q. Did Dr. Davis in his dictation say he may have been trying to gas himself because the stove was on?

A. That's right.

Q. Okay. Well, a stove being on is not trying to gas yourself. You have two kinds of -- just because the stove is on, that doesn't mean you are trying to gas yourself?

A. That's correct, sure.

Q. I want to know if anywhere specifically in the records you found that and whether or not that was significant in your opinion.

A. Well, first of all, I don't have a specific recollection right now of where I found that. And, secondly, I don't think that's very significant in my opinion.

Q. Okay. The reason I am asking these questions in terms of significance is because you have gone through and selectively taken portions of Dr. Davis' dictation, and I assume since you did that, that you found those to be of some significance to you in your evaluation; is that a fair statement?

MR. SCHOBERT: Objection.

A. That's right.

Q. For example, you have down in your evaluation

or in your report that Davis' evaluation included the history that the patient was a slow learner, correct?

MR. SCHOBERT: You are asking if that's in the reports?

MR. TRACI: Yes, I am asking if that's in the reports.

A. It says included a history which revealed that the patient was a "slow learner".

Q. Was that significant, that fact, in your rendering your opinion or in judging Dr. Davis' conduct?

A. Well, I think it was significant as was the previous sentence which said was not very significant in that they indicated that Dr. Davis did ask questions related to the history, how the patient got there, why he was there, what the patient's past history was like, as opposed to evaluating a patient physically without asking any historical questions.

Q. I get it. So you left out, for example, that he had been out of work, and you put in instead that he was a slow learner. If you wanted to convey the fact that he asked questions, why did you not put both? Why did you only put in the slow learner? You understand the point I'm trying -- why did you select that out of that sentence and not the other half of this sentence?

A. Right. I did select half of that. I think we all look for points which tend to favor our positions and that in doing so you take a synopsis of all the material that you have. That's what I was attempting to do.

Q. Were you attempting to find information in this record to favor your position or support Dr. Davis' conduct or to objectively look at these to make the evaluation of whether or not the proper diagnosis was made?

MR. SCHOBERT: Objection.

A. Trying to be as objective as possible. The fact that the patient was out of work to me was not as significant as the fact that he indicated to -- that he had some sort of learning disorder or learning problem.

Q. Okay. Is that significant, the fact that he had -- he was a slow learner, had a learning deficit in terms of the obligation of the ER physician to go further or look to other sources for information than the history?

A. I don't know whether that would be. It would depend on the overall interpretation the physician would have on the case. That would be different with every patient.

Q. Going back to your report, you indicate

further history was not available from the patient. Does that require the emergency room physician to attempt to acquire a better history from family members or from other people that may be around?

A. Good question. I think that is strictly the emergency physician's judgment as to whether they need more information in order to arrive at some sort of working impression on what to do with the patient.

Q. Is it within the standard of care of an emergency physician to be communicating with the nurses working at the emergency room department to compare notes to see if they were able to elicit additional history other than what you as a physician may be able to elicit?

MR. SCHOBERT: Objection. Are you talking about at Doctors Hospital or at the same hospital? I wasn't sure if you meant -- you said emergency departments. Are you talking about --

MR. TRACI; No. I am talking about at an emergency department.

MR. SCHOBERT: Sorry, Bob. I'm not trying to trick you. I want to know if you said plural or singular. Go ahead, Doctor.

A. It is within the standard of care in emergency departments to utilize whatever information one can get if you think you need it, and many times you ask nurses to supplement or find out if they have information that's helpful to you, and other times you do not because you don't feel it will be helpful one way or another.

Q. Okay. And you would expect in the emergency department nurses to be communicating with the physicians as to any personal history that they may have obtained?

A. Yes.

Q. And would you as an emergency room physician -- do you have an opinion as to the standard of care required of an ER doctor in terms of reviewing the records and the nurses' notes and findings on evaluation?

A. I believe that the standard of care requires the emergency room physician to make a judgment as to how detailed they want to get about evaluating the emergency nurses' notes. Ideally if there is time, the emergency physician would read a nurse's note before they go in and see the patient. Sometimes that just isn't feasible or reasonable or possible. Then you see the patient and then make a secondary decision as to whether he needs more information or additional information from the nurse.

Q. I am talking about -- let's be more specific

now. Let's talk about a patient who is in the kind of condition that Mr. White was in when he came in, designated as a slow learner, confused, those kinds of circumstances. Is it not the standard care for a physician to be checking with the nurse and/or reading the nurse's notes to make sure that he has got as much information as possible in history on that patient?

A. I would honestly have to say that that is not -- ther is no standard of care in that area.

Q. Do you intend to express any opinions concerning the progress of the patient after he was admitted to the hospital and got out of Dr. Davis' care?

A. Do not.

Q. Okay. If a patient is exposed to gas, natural gas in a home --

A. All right.

Q. -- and a suspected suicide --

A. All right.

Q. -- what would that patient's symptoms be, what would you expect them to be?

A. The most common presentation would be no symptoms whatsoever.

Q. Does the length of time the patient is exposed to gas and the concentration of the gas make any

difference in that answer?

A. Those are -- yes, certainly.

Q. Okay.

A. Because most of the time either the concentration is lower or the length of time is short, so there are no symptoms.

Q. If you would -- from your reading of the notes the suspicion at the time that he was brought over to Timken Hospital was that he had been in his apartment for approximately four days, and they thought he was trying to gas himself.

A. Correct.

Q. In fact, looking at Dr. Davis' notes, he was barricaded in his apartment?

A. Yes.

Q. Okay. Under those circumstances a patient who had had a long-term exposure to gas -- which is what Dr. Davis should have suspected from the history that he wrote down -- what types of symptomatology would you expect a patient under those circumstances to have exhibited?

MR. SCHOBERT: Objection.

A. I am not sure I understand the question because in the middle of the question you said something

about Dr. Davis should have suspected something.

Q. Let me rephrase it.

A. I don't know what that meant.

Q. Dr. Davis, as you know from his deposition, said that or claims that he was told by the emergency room -- I am sorry, the EMS people that this man had tried to gas himself.

A. Correct.

Q. He was barricaded in his apartment.

A. Correct.

Q. And somewhere in here it says for four days -- but he was missing for four days. You knew that, right?

A. Yes.

Q. Under those circumstances what would you have expected the patient's symptoms to be if indeed it was true that he was trying to gas himself under those circumstances?

A. I guess under those circumstances I still would not have an expectation of any specific symptoms related to gas.

Q. Okay. As an emergency room physician if you came in and had gotten the information that Dr. Davis claimed to have gotten, is it not incumbent upon you as an

emergency room physician to evaluate the patient for that potential condition, that is, gas exposure?

A. Well, the treatment for natural gas exposure --

Q. Not treatment. I'm just asking what should be done to examine what impact this natural gas exposure would have had upon him before we get into treatment.

A. Correct. I understand your question. I don't know what would be done to examine a patient for natural gas exposure.

Q. Are there any lab tests that would be helpful in that regard?

A. Not that I am aware of.

Q. What's the treatment, if any?

A. The patient had already been treated because he was removed from the environment.

Q. Can gas exposure make you disorientated medically?

A. My answer to that is I don't know.

Q. How about can it make you confused?

A. I don't know that either.

Q. How about can it give you a headache?

A. I know that people with gas exposure can have headaches, but I don't know if there has ever been a

causal relationship established, a statistically significant one.

Q. We're in an enclosed room right now. If somebody opened up a gas valve, started filling the room up with gas, and the emergency group crashes in here, pulls us out, and you are the emergency room doctor in ER that's, you know, 500 -- not even 50 feet away from here, my limp body is carried over to you from this gas exposure, what would you do? What would you be looking for? I mean what -- I guess if somebody tried to kill himself with gas, I would expect the ER doctor to be doing something. What would you do?

MR. SCHOBERT: Objection.

A. I think laymen expect that the emergency room physician will do something. I hope that the emergency physician would do what is appropriate in this scenario you described. The first thing one would do would be to inspect for vital signs and satisfy that you are breathing on your own, you had a pulse, blood pressure.

Assuming that was true and knowing, I guess, from the history and the way you described it that the problem was unconsciousness secondary to gas exposure and knowing it would be natural gas, one could assume then that the gas had really taken the place of oxygen in the

room, so you would reverse that situation by supplying one with oxygen, but that natural gas doesn't have to be on for a long period for a patient to be unconscious. The second thing is to look for other complications.

Q. Like what?

A. Well, a long period of unconsciousness would be associated with complications like renal failure, cardiac arrhythmia, pressure sores from lying in one place for a long time. Really those would probably be the most prevalent ones, assuming normal vital signs are conducted.

Q. Is it fair to say that the physical examination done by Dr. Davis ruled out that this man was having any continuing problems from actual gas exposure?

A. Yes, it's fair to say that.

Q. Okay. Is it the standard of care for an emergency room physician to do a neurological examination of a patient brought in --

A. No.

Q. What would determine the standard of care when a patient ought to have a neurological examination?

A. If the emergency physician felt there was a possibility of neurological problem.

Q. Okay. Is a mental status examination part of the physical examination?

A. It certainly can be, but not routinely so.

Q. I mean -- okay. I am not suggesting that every physical examination should have a mental status examination. I am suggesting to you when you do a mental status evaluation or examination, that is indeed part of what you emergency room doctors call a physical examination?

A. Yes, you are right.

Q. Okay. It's not a history; it's part of the examination?

A. Correct. I got -- I misunderstood.

Q. It wasn't a very articulate question. Is mental status a significant portion of a neurological examination or evaluation?

A. Yes.

Q. Why is that true?

A. When you do a neurological examination, you really are looking primarily for gross problems. By gross problems, for example, would mean something -- the patient is unconscious, is completely paralyzed, things relatively obvious. It is also possible to look for disability in what are called higher cortical functions, that is, the thought processes. And in order to do that, one might perform a mental status examination. The classical

approach or formal approach is not always -- I probably shouldn't say that -- not even commonly used in the emergency department.

Q. Is altered mental status a neurological finding?

A. Yes.

Q. Are hallucinations normal?

A. No.

Q. You have in your report that a physical examination was done by Dr. Davis.

MR. SCHOBERT: Are you looking at the first one still?

MR. TRACI: Yes.

Q. Which showed no abnormal findings, correct?

A. Correct.

Q. And it included, you say most importantly, a normal neurological examination with the exception of patient's mental status?

A. Correct.

Q. So indeed it was not a normal neurological examination, it was abnormal because the mental status was abnormal, isn't that true?

A. That's a perfectly acceptable alternative way of stating what I said.

Q. So Dr. Davis on his examination in the emergency room did have abnormal findings, including an abnormal neurological examination, correct?

A. Same answer.

Q. Agitation, what is that indicative of to you as an emergency room physician?

A. Agitation can be indicative of a patient who is anxious, patient who has severe medical problems or a patient who has moderate or severe neurological problems.

Q. So it would be any of these?

A. Agitation is consistent with everything.

Q. Is it more consistent with organic medical problems rather than a psychiatric problem or would it be just as easily either one?

A. I don't know if it's consistent one way or another.

Q. Okay. Well, couldn't --

A. Meaning not weighted way one or another, I'm sorry.

Q. How about hearing voices?

A. Hearing voices is commonly associated with psychological, mental problems.

Q. You say more commonly. Is it ever associated with an organic or medical problem?

A. Yes.

Q. Altered mental status, is that more likely organic or a functional disorder?

A. That once again is not 100 percent associated with anything. I would -- when we use that, I think we have information that there is a problem, but it doesn't sway me one way once I know it's an organic problem or mental problem, so I am not sure which one it is.

Q. Further in the report you say that the patient had obvious behavioral problems, correct?

A. Correct.

Q. What are you referring to, obvious behavioral problems?

A. The findings of the rescue squad in the history regarding the suicidal behaviors the patient was having.

Q. Is that all?

A. Well, the other behavioral problem relates to, I think, the piece of information that I got from the deposition which indicates that the patient would respond to some things about history but did not respond to his psychological or psychiatric history.

Q. Okay. Isn't it true that emergency room physicians are required to collect information before you

come to conclusions? You should make your conclusions with your evaluations of a patient?

A. I think I would agree with that.

Q. Okay. For example, there is a big difference between a patient's inability to answer a question and a patient's unwillingness to answer a question?

A. That's right.

Q. Okay. I think ability to answer a question is more indicative of some serious problem rather than an unwillingness, which would be more indicative of just being contrary or perhaps a functional disorder; is that a fair statement?

A. No. I don't think so.

Q. If you can make the distinction between inability and unwillingness to answer a question, which of those, as an emergency room physician, would you consider to be the most significant?

A. Well, I think it depends on a particular setting because you can construct scenarios with each one being more important than the other, depending what the scenario was, so unless I had it related specifically to a case, I would really have some difficulty in deciding which one I would pick.

Q. Do you have any idea what information Dr.

Davis had available to him that would allow him to conclude that the patient knows he is in the hospital, cannot tell me where he is and will not tell me what the date is? What information do you know of that Dr. Davis had that allowed you to make the statement that the patient could not tell him where he was but actively would not tell him what the date was?

MR. SCHOBERT: Objection. Go ahead, Doctor.

A. Well, any of the information put on the chart by this emergency room physician. There really is no information that I have to verify that particular information or to tell you what kinds of bits of information he integrated into these sentences. That would be true with any evaluation about any physician anywhere.

Q. As written, this appears to suggest that this patient was being difficult on certain subjects; is that correct?

MR. SCHOBERT: Objection.

A. Not sure I would use difficult. It does indicate that he was attempting to obtain some information and did not get all the information he was attempting to get. I cannot tell you how he would interpret it.

Q. Have you assumed in your opinion that Dr. Davis knew or did not know of the history of three weeks of severe headaches and dizziness?

A. I am assuming that Davis did not know that the patient had a history of three weeks of severe headaches and dizziness.

Q. Would that make a difference in any of your opinions if that information was clearly in Dr. Davis' dictation?

A. No.

Q. Is there a greater obligation in terms of what an emergency room physician should do when a patient presents with a history of severe headaches for three weeks and that's all the information --

MR. SCHOBERT: That's all that's in the record was severe headaches for three weeks?

MR. TRACI: Yeah.

MR. SCHOBERT: What's the obligation of an ER doctor?

MR. TRACI: Yeah.

A. No, I don't think that history would change the obligation.

MR. SCHOBERT: He's saying that's it, that's all you get. I don't know what the

question would ask for.

Q. So if we could demonstrate that Dr. Davis knew that this patient had complaints of headache and had severe headaches for three weeks prior to -- two to three weeks prior to his admission, which would obviously predate when he was found in the bathtub, that information would not be of any significance to you in terms of the opinions you already rendered?

MR. SCHOBERT: Objection.

A. It would not unless -- I am not sure whether you are saying this or not. I would agree if Dr. Davis knew that this was the history and either deliberately ignored or refused to write it down, then I think that's a problem. I am not saying he has to write it. I am saying that if he discounts that, that would be -- that would be a problem, but that wouldn't change his obligation.

Q. The standard of care in this physical examination here or history, us that if Dr. Davis knew of severe headache for three weeks, that should be in the history?

A. Yes, indeed. When you have that in the past history, then it would be the standard of care to record that, although we don't always record everything that we hear and sometimes --

Q. I understand that. A history of severe headache is something you always record when you hear it, isn't that a fair statement, because that's a significant symptom?

A. I would say that if a patient comes to me with a history of severe headache, you should always record it. I may not always record it as severe.

Q. Well, the standard of care is you should record it because if someone is reviewing this chart or then following the patient, then that is documented in the chart what this patient's complaints are?

A. No question about that any more than any significant history that you get. If it's significant, you should write it down, if you know it's significant.

Q. That's what I was trying to get at before. A severe headache is a significant symptom?

A. It might or might not be. I don't know. I am saying any significant history --

Q. Well, Doctor, we're not talking about whether it eventually could lead to nothing or eventually would lead to something serious. What I am talking about is before you do your investigation and know whether the severe headache is going to be something serious or not to the patient, that is a significant -- that is a piece of

information in the history that should be followed up on, isn't that true?

A. Let me -- I am not sure -- let me just explain it briefly. Many patients will come in and have a sprained ankle or laceration of the foot, and you get to talking to them, and during the course of the conversation they are saying, "Not only am I a little bit nauseated, but I got this terrible headache for two or three weeks." And in that case they may not -- you may think it's a significant problem in relation to the chief complaint. If the patient is saying, "I have a severe headache for three weeks," and that's the only sypmtom, in those that are between those two extremes, it's a physicians judgment as to whether that should be recorded or not.

Q. What about a patient who comes in and is examined and is disorientated and confused and has complaints of severe headache?

A. That's significant.

Q. That's a significant history?

A. Right.

Q. That should be recorded, correct?

A. Right.

Q. That's something that should be followed up on and checked out, correct?

MR. SCHOBERT: Object.

A. I'm not sure who you are referring to when you mentioned that the patient should be followed up on, checked out.

Q. By the emergency room physician. We are always talking about the emergency room physician.

A. Okay. Yes. With the exception that there were -- I am a little concered with the word follow-up. An emergency room physician doesn't take care of the in-patient, so it certainly wouldn't be the obligation of the emergency room to follow-up.

Q. Follow up in your --

A. We just take the complaints.

Q. Correct.

A. Okay. Yes, I agree.

Q. Is disorientation a neurological finding?

A. In reference to the fact that disorientation refers to not normal function of the central nervous system, yes.

Q. Well, that's significant, the disorientation, isn't it?

A. Yes.

Q. That's a medical term?

A. Right.

Q. How about is there -- strike that. There is evidence in Dr. Davis' dictation that the patient was disoriented; isn't that true?

A. I believe he said that specifically, but let me look back on it. He doesn't use the word disoriented. I think the patient is awake, knows he's in the hospital, cannot tell me -- well, I can't read my copy. I am no --

MR. SCHOBERT: Where he is.

A. -- where he is, will not tell me what the date is, cannot tell me where he is. It's one of the parts of disorientation, so you are right. There is evidence of that.

Q. Okay. In fact, you know from the deposition he already indicated that the patient was disoriented?

A. Correct.

Q. Is disorientation coupled with confusion, headaches something of significance in terms of symptomatology to a patient that's present in the emergency room?

A. It certainly can be.

Q. Is that something that the standard of care would require a physician to check out?

A. Yes, it would.

Q. Are those symptoms consistent with among

other things -- there may be a whole constellation of other things -- are those consistent with an organic brain problem?

A. Yes.

Q. Are they consistent with a psychiatric condition?

A. Yes.

Q. Are they consistent with a potential medical problem?

A. Certainly.

Q. Okay. The emergency room physician, I assume, is required to come up with a differential diagnosis based upon the history and examination and their background and training; isn't that true?

A. Well, I never read that the emergency room physicians are required to come up with a differential diagnosis. We certainly would be required to make some decision about what the best disposition of a patient would be and what any additional treatment might be.

Q. And in addition, if the patient's condition is potentially permanently disabling, life threatening, the emergency room physician is required to take some action in the emergency room?

A. Depends.

Q. Isn't that true?

A. Yes, depending on the relative importance or relative degree of threat of the permanent disability or permanent life threat.

Q. Okay.

A. Maybe I didn't say that -- you understand what I mean?

Q. Yes, I did. It's true, is it not, in terms of how immediate a threat of potential organic brain problem is is more in the field of a neurosurgeon or neurologist than of an ER physician?

MR. SCHOBERT: Objection.

A. I would -- repeat that because I wanted to think about that for a second.

MR. SCHOBERT: I wasn't clear on that. Objection. I am confused.

MR. TRACI: Do me a favor and read that back.

(Court Reporter read back said question.)

Q. Do you understand that question?

MR. SCHOBERT: Note my objection.

A. Well, I think I understand it, and the answer is sometimes.

Q. Okay. Here, I am trying to make a distinction here. In your opinion is it true that an emergency room doctor is required to assess a problem, and if it is life threatening or potentially permanently disabling, then they are required to take some action on it?

A. Yes.

Q. And the judgment on whether something is immediately life threatening or not involves your making decisions that if you are wrong, it could be very harmful to a patient?

MR. SCHOBERT: You are talking about ER?

MR. TRACI: ER, correct.

A. Correct.

Q. Does not the standard of care -- because of the potential risk to a patient if the ER physician is wrong, if there is a doubt one way or another on is there an immediate problem that needs attention, that there needs to be an additional work-up, doesn't that require the ER physician to -- isn't that something that you consult with a neurologist or neurosurgeon and/or take a CAT scan to be sure you are ruling it out and not exposing the patient to danger?

A. Absolutely not.

Q. Okay. That is strictly a matter of judgment for the ER physician?

A. One hundred percent.

Q. And if he is wrong on that judgment, then the patient just suffers the consequences of that misjudgment?

A. Absolutely right.

MR. SCHOBERT: Objection.

Q. The purpose of a CAT scan is to very definitely rule in or rule out the presence of some pathology in the brain, for example, if you do a CAT scan of the head?

A. CAT scans are fairly good at ruling out some kinds of pathology but certainly not all pathologies 100 percent of the time or not 100 percent of all pathologies.

Q. Is it true that a CAT scan is almost certainly going to rule out any life -- immediately life threatening cause of brain injury such as a bleed or a tumor, things like that?

A. Most of the time that's true. The great majority of the time that would be true.

Q. Some of the things you are talking about that they might not always get, those things -- those are much more sophisticated problems that would be more in the

field of a neurosurgeon to determine?

MR. SCHOBERT: Objection.

A. No, I am not sure that's true. I don't think I could agree with that.

Q. Is severely increased motor activity a neurological finding?

A. Yes.

Q. What's the significance of that?

A. Totally unknown. I have no idea what the significance would be. It's different in every patient.

Q. Okay. I get the impression from listening to you with your opinions and from your testimony that the emergency room physician is supposed to be able to differentiate between normal and abnormal finding and then make some judgment whether or not those present any threat to the patient and then decide whether they can be released or be referred to someone else for appropriate follow-up and treatment.

MR. SCHOBERT: Objection.

Q. Is that a fair summary of what you are supposed to do?

A. Yes, with one exception.

Q. That would be when?

A. I think you have a degree of threat also to

be taken into consideration, so not just is there a threat to the relative likelihood of a particular threat, because in truth every single patient we see has a threat. For instance, being run over by a truck, there is the threat of having a heart attack no matter what their age is. There is a degree one has to add to make a judgment as to whether or not that is a reasonable consideration in the particular patient.

Q. Okay. The degree of threat goes to whether or not the ER physician should institute treatment rather than referring the patient on --

MR. SCHOBERT: Objection.

Q. -- without treatment?

A. That's part of it. Also relates to where the patient would go.

Q. Okay. Is rigid posture a neurological finding?

A. I guess. I don't know. I am not -- I don't know what that means. I am just not familiar with what that means to any other physician.

Q. Is bizarre behavior a neurological finding?

A. Yes.

Q. Is poor recent and poor remote memory a neurological finding?

A. Yes.

Q. ER physicians are supposed to guard against jumping to conclusions, correct?

A. I am not aware of that that is a particular requirement for an emergency physician as opposed to other physicians or surgeons or any other person anywhere, anyplace.

Q. Well, any physician should guard against jumping to conclusions?

MR. SCHOBERT: Objection.

A. I would agree with that.

Q. For example, it was improper for Dr. Davis to have jumped to the conclusion that this man was psychotic until he had put all the constellations of symptoms, signs together to see if there might be some explanation for this patient's problems, isn't that true?

MR. SCHOBERT: Objection.

A. No, that's not true.

Q. He would be entitled to jump to the conclusion that he was psychotic?

MR. SCHOBERT: Objection.

A. No, sir, not true.

Q. Well, tell me where I am wrong on that.

A. That's not true either. It's basically you

are giving me an all or none phenomenon. First of all, in this particular case there is no evidence of that -- what I would call jumping to the conclusion. Jumping to a conclusion would be a disposition of a patient without any particular history or physical. When you do a history and physical and then make a conclusion, that's not jumping to a conclusion.

Q. Do you know anything about subdural hematomas?

A. I have seen them. I don't know everything about them. I know something about them.

Q. How many have you seen?

A. I couldn't tell you exactly. I imagine it's been 15 or so.

Q. Okay. Is there a difference in the symptomatology presented between acute and chronic subdural hematoma?

A. Yes, quite a bit, as a matter of fact.

Q. Okay. What is the difference?

A. I think the primary difference in acute subdural hematoma, the history of head injury is usually a recent head injury problem, something that occurred actually was the cause of a patient coming into the emergency department. There also is a history of

relatively rapid neurological deterioration, which may or may not have proceeded all the way to coma, but frequently there are laterilizing signs that are neurological deficits that are on one side of the body and not on both sides of the body.

Q. Okay. Is that an all or nothing kind of situation?

A. Never.

Q. When you say that there is a recent indication of trauma typically in acute subdural -- do you recall that you said that?

A. That's what I said.

Q. Okay. Are you limiting that to any particular age group, or did you relate that to Richard White specifically or the general population, typically subdural hematoma related to trauma?

A. My comments were related to the general population of any age.

Q. Okay. And what is there in the history or information that Dr. Davis had available to him either that you read in his deposition or in his records that indicates that the patient did not have an acute head trauma in this case?

MR. SCHOBERT: Did not have?

Q. Did not have an acute head trauma.

A. Well, there is no specific discussion in the history of head trauma, and there is no specific findings with regards to a problem in the -- that are visible on the scalp, and there's no evidence of lateralizing signs.

Q. Okay. Well, put aside the symptomatology. I am just talking about in terms of the history itself. Is there any information that you have been able to glean from any of the records or the deposition that Dr. Davis was in good judgment able to rule out that there, in fact, had been a recent trauma? How do you know he didn't fall when he was in the bathtub and didn't hit his head on the tub?

MR. SCHOBERT: Objection.

Q. How do you know that he hadn't been in an automobile accident, you know, a half hour before he was found?

MR. SCHOBERT: Objection.

A. From the records.

Q. From the records?

A. We don't know these things.

Q. What's there about the record that allows Dr. Davis to conclude that there was not an acute trauma involved in this case, if anything?

A. This patient didn't have any, once again, history or physical findings that would be consistent with acute trauma.

Q. Well, he had a -- what did you consider the the onset of the acute episode?

MR. SCHOBERT: Of the chronic acute subdural?

MR. TRACI: Of the problems of a patient that's presented --

MR. SCHOBERT: In general?

MR. TRACI: In general.

MR. SCHOBERT: Okay. Just wanted to make --

Q. What do you mean by acute?

A. Most of the time the reason for the patient's presentation in the hospital emergency department would be that particular trauma, so the chief complaint would be trauma.

Q. Okay. Now, the man was found in a bathtub and brought to Doctors and brought to Timken.

A. Correct.

Q. Okay. We don't know how long he was in that bathtub, correct?

A. In terms of the exact number of minutes or

hours.

Q. Minutes or hours or days.

A. Well --

Q. I mean it could have been a week?

A. I don't think so.

Q. It's clearly -- that's not --

MR. SCHOBERT: Objection.

A. That's not possible from the findings here.

Q. Can you put some time period on how long he was in the bathtub?

A. Sure. I think he was -- from the records, he was in the bathtub probably less than four hours. Probably less than two hours.

Q. Why do you say that?

A. Because changes in the skin occur from constant submersion in the bathtub. If you are in the bathtub with no water for hours or days, you are probably going to have some pressure sores.

Q. Okay. Now, it is my understanding that, at least from the records, that the cold water was running when he was sitting in the bathtub.

A. Correct.

Q. There was no indication from anybody that the water was running all over the floor or anything, so the

drain must have been out, the stopper out?

A. Correct.

Q. Was that a fair assumption from what you read?

MR. SCHOBERT: Objection.

A. For -- no. The stopper could have been in and the water turned on a moment before somebody was there. We just don't know.

Q. It's your opinion that this man had been in that bathtub for less than four hours?

A. No. I think I finally said less than two hours.

Q. I am sorry. Less than -- I am sorry. Less than two hours?

A. Yeah, yeah.

Q. When he was found?

A. With the water on. The skin changes when it's been in water, so I thought it probably was for a short time.

Q. Well, if he had been in the bathtub sitting there as he was when he was found and I assume no water is on, there would have been pressure sores?

A. If he was moving, probably not, but if you were on the floor for several days, I would -- I can't

prove it because of the documents, but I think somebody something about that he was incontinent of urine or there was stool in his pants because he had been in that bathtub for days, let's say.

Q. How about pressure sores?

A. If he hadn't moved, he certainly would have those. For instance, if you were unconscious --

Q. Those are some things that the emergency room physician should on physical examination have picked up and noted?

A. Yes.

Q. Since they are not on there, you can safely assume that Dr. Davis did the appropriate examination, that he didn't have that kind of thing?

A. I agree.

Q. So we are now left with the situation based on your opinion that the man was in that bathtub for less than two hours, correct?

A. That's right.

Q. That's the standard of care you would expect of Dr. Davis to glean from that same evidence, using the same ability to conclude and put together the information?

A. I would think he would come to a similar conclusion, although he may disagree with two hours. That

was an arbitrary decision on my part.

Q. Based on that circumstance, isn't the fact that this man was found under these circumstances a sudden acute change of his condition, meaning that all that occurred that presented him to the emergency room had happened within two hours, that's an acute situation, isn't it?

MR. SCHOBERT: Objection.

A. What's acute about it is --

Q. Not subdural. I am talking about presentation of this patient, the conclusion should be there is some acute problem going on here to explain what happened?

A. No, I don't follow that at all. I don't know about the history of how long people had felt that he was missing or not responsive. I don't know that he would have -- that his behavior had been normal for quite some time, because he was just found in this condition. I can't make the conclusion that that presentation is necessarily acute.

Q. Okay. Is there anything acute about this guy's presentation?

A. I don't know that that's possible to tell that.

Q. In terms of any analysis of physical findings and examination and altered mental status, anything else, is there anything that would indicate that this is an acute situation?

A. No. I think that's why you do a history and phsyical to try to get some hand on whether or not there is an acute medical problem going on.

Q. I understand that, but given the history and physical --

MR. SCHOBERT: From the history and physical, is there any indication of acute situation?

MR. TRACI: Yeah.

A. I am sorry. I misunderstood the question. We originallly started with significant presentation.

MR. SCHOBERT: He has a habit of going back and forth.

A. After his -- no, sir, there is no evidence to me that it was an acute situation going on.

Q. Is there any indication in the physical and in the examination and the history that indicates that this man could have had a neurological problem?

A. Yes.

Q. He could have had an organic brain problem?

A. Yes.
Q. That could be a subdural hematoma?
A. Could be.
Q. Could be a brain tumor?
A. Could be.
Q. Could be an internal hemorrhage?
A. Internal other than a brain bleed.
Q. How about aortal risk?
A. Be no evidence whatever for that.
Q. Okay. Would you agree that a brain bleed or brain tumor are life threatening situations?
A. No.
Q. Are they serious medical problems?
A. Yes.
Q. Can an acute subdural hematoma -- just so we are clear on this, the difference between acute subdural hematoma and chronic subdural hematoma is only the recency of the bleed; is that correct?
A. As I understand it, yes, with one exception is that most of the time if it's acute, you diagnose acute subdural; that is, a patient that you had diagnosed it on, and that means that you have some history. Obviously if you have acute -- or a chronic, I am sorry, problem, there was a particular moment in time when that problem started.

Q. And it was acute?

A. It was acute except that there either was not the history that was obvious or there were not the physical findings that were obvious, so the patient's problem progressed and the bleeding progresses so slowly that there is no change in the patient's behavior. There is no immediate change in their neurological symptoms. They may not be paralyzed on one side, so it's not obvious when it starts.

Q. Acute subdural hematoma versus a chronic subdural hematoma, either one can have generalized neurological deficits, is that right, as opposed to focal neurological deficits?

A. I would guess that that might be possible. I would defer that question to a neurosurgeon.

Q. Well, you are making judgments in the emergency room about the fact that there were no focal neurological deficits, therefore he didn't have any obligation to diagnose a subdural hematoma. I would assume that if you are able to make those kinds of judgments and statements, you ought to know whether or not acute versus chronic subdural hematoma is a neurological deficit rather than focal?

A. But the key to your question is am I 100

percent.

Q. No, I don't -- no, no. It means more than 50 percent is more likely than not.

A. I can answer that.

Q. More likely than not?

A. No more than that, no. I would see focal generalized deficits with acute.

Q. Than with chronic?

A. With chronic, I just mentioned what --

Q. Is it also true that acute subdural hematoma cannot have focal neurological deficits, but only have generalized type of deficits such as disorientation, confusion, altered mental status, things like that?

A. You are referring in this question to acute?

Q. Yes.

MR. SCHOBERT: Acute?

MR. TRACI: Acute.

MR. SCHOBERT: I thought you said chronic.

MR. TRACI: No, no, acute.

MR. SCHOBERT: Can you read the question back. I am sorry.

Q. Let me restate it. Isn't it true that acute subdural hematoma can present without focal neurological

deficits?

A. This time you are saying can I say is it possible --

Q. Yes.

A. -- or more or less than that? Possible? Yes, it's possible.

Q. Is that something that an emergency room physician should know about, that it's possible that you could have acute subdural hematoma even without a focal neurological deficit?

A. Yes, I think an emergency room physician should know that.

Q. When a patient appears at the emergency room and does have an altered mental status, has disorienation, has severely increased motor activity, has agitation, complains of headache, given those types of symptoms, is it not true that an emergency room physician should consider the possibility of a brain bleed as a possible explanation for that constellation of symptoms?

A. If those constellation of symptoms appear in isolation from all other symptoms and all other things, then I think you should be considered as a possibility for brain bleed.

Q. In this case, in the context of all the

history and everything, with those same symptoms, should an emergency room physician consider the possibility of a brain bleed?

A. Yes. Looking at a patient like this with those symptoms, that would be one of the possibilities for that constellation of symptoms.

Q. And one of the possibilities would be some type of psychiatric disorder?

A. Correct.

Q. Okay. Of the two, which is more likely to be either a life threatening or permanent disabling situation, a brain bleed or psychiatric disorders?

A. Well, I can't tell you for sure. It seems to me if a patient is suicidal and has some history of suicidal problems, it seems more likely to me a psychiatric problem would be more life threatening than the non-acute bleed.

Q. Okay. I am talking about a patient who is going to be -- who is in the custody of people at a hospital, who is going to be kept in the hospital.

A. Correct.

Q. Is just goes to say he isn't going to commit suicide in the hospital?

A. I wish I could guarantee that, but depending

on what he's admitted to --

MR. SCHOBERT: I am going to object to the question. That assumes a whole lot of stuff.

Q. Should Dr. Davis have ordered a CAT scan?

A. I think not.

Q. Even though you acknowledge the fact that this could be a brain bleed based on the findings contained in the record, he should have not ordered a CAT scan to rule in or rule out a brain bleed?

A. They certainly don't have to be done in the emergency department.

Q. Would it be good practice to do that?

A. I don't think I would have objected from a clinical standpoint, although I think he would have to justify it, and I see not much of a justification for a CAT scan.

Q. What would he have to justify?

A. Well, any time you do tests and anybody does a test, you have to have a reasonable reason to do so on an acute basis, and you need to have justification for doing that test.

Q. Is there any more expense in doing a CAT scan if you ordered it as an ER physician or if a psychiatrist

orders it?

A. I think the technical answer is it might be, but the practical answer is that's not relevant.

MR. SCHOBERT: He never said expense.

Q. You have to -- you said there had to be a justification for it.

A. Why you should do the test. Just to do tests, you should have good reason to do that in this particular case.

Q. This patient. I had asked and you said a CAT scan --

MR. SCHOBERT: You meant in terms of immediate?

THE WITNESS: Right.

Q. Now, you are talking about the same thing?

MR. SCHOBERT: You interjected expense in.

MR. TRACI: He said there had to be a justification.

MR. SCHOBERT: He didn't say expense.

MR. TRACI: Okay. Well --

MR. SCHOBERT: He said reasonable justification. You never asked him what reasonable justification is or the basis

would be.

Q. What is the reasonable justification and basis for a CAT scan?

A. You are asking me a question? I am sorry.

Q. What is the reasonable basis and justification for doing a CAT scan?

MR. SCHOBERT: In this case?

A. In any case or justification in general?

Q. Yeah.

A. I think when the emergency room physician suspected there is an acute neurological problem, there is the likelihood of it being detected with CAT scan, which can be acutely life threatening and which may need intervention within a short time period, then you just do a CAT scan.

Q. Is the emergency room physician qualified to diagnose acute subdural hematoma?

A. Yes.

Q. Are they qualified to diagnose a chronic subdural hematoma?

A. I think so, yes.

Q. Okay. And is it your opinion that acute subdural hematomas are immediately life threatening?

A. They can be. They often are not, but they

certainly can be.

Q. If an emergency room physician does suspect acute subdural hematoma, he should order -- under the standard of care he should order a CAT scan?

A. Yes.

Q. Why is that?

A. Well, the possibility of acute subdural hematoma is that there is bleeding that will continue, and there would be so much pressure on the brain that the patient will die.

Q. In a chronic subdural hematoma, is it the standard of care to order a CAT scan if the physician suspects there is a chronic subdural hematoma?

A. I don't believe there is in emergency medicine at all, which specialty I am --

Q. For any doctor?

MR. SCHOBERT: Object.

MS. MINKLER: Object.

MR. SCHOBERT: He qualified earlier --

Q. You are an M.D., are you not?

A. Yes, sir.

Q. You went to medical school and you studied subdural hematomas and CAT scans and all kinds of stuff, maybe not CAT scans because they weren't in existence

then.

A. I was just going to say that I wish I was that young.

Q. You studied all kinds of problems with reference to the brain and what the impact of bleeding in the brain would have upon a person?

A. Yes.

Q. And that's something that you went over in much greater detail as an emergency room physician?

A. Right.

Q. Because of the constant exposure to trauma that you have down there?

A. Right.

Q. So speaking as a physician, an M.D. trained in medicine having gone to medical school, on chronic subdural hematomas, if you suspect that specific problem, is it not true that the standard of care is to order a CAT scan so that you can find out how large or how life threatening this subdural hematoma is?

MS. MINKLER: Objection.

MS. MOORE CARULAS: Objection.

A. That's not true.

Q. Okay. That depends on the findings and physical examination, correct?

A. That will help you determine how life threatening it may be.

Q. Chronic subdural hematoma, are you suggesting that there was a bleed that was completed and that the condition is a static condition in the head?

MR. SCHOBERT: In this case?

Q. A chronic subdural hematoma, what is your definition of that?

A. My definition is that there is one of two possibilities, either there is a bleed which is completed and the condition is static, or there is a bleed which is ongoing, but it's a rate that is very, very, very slow.

Q. Or is there not a condition where you have a chronic subdural hematoma and it continues to bleed at a faster rate?

A. Well, I would then say acute subdural hematoma superimposed on to chronic if I were asked to define that one.

Q. Is there a difference in the standard of care how you treat a chronic subdural with a superimposed acute hematoma on top of it?

MS. MINKLER: Objection.

A. Acute bleed on top of that?

MS. MOORE CARULAS: Objection.

A. Well, when you say treat --

Q. Let me restate it.

MR. SCHOBERT: Yeah.

Q. Is there a difference in the standard of care of what an ER physician is supposed to do with reference to ordering or testing or further follow-up when there is a chronic subdural hematoma that had previously leveled off in terms of any findings that is now acutely bleeding again?

MR. SCHOBERT: Assume he knows the -- that the ER physician knows all of that.

A. Well, I guess I don't know how to answer that question because you don't know if it's acute bleeding again unless you do the test.

Q. I understand. And is it not a dangerous condition for a patient just the same as a new acute bleed would be?

MS. MOORE CARULAS: Objection.

Q. That is a chronic that is -- re-bleeding is in essence the same thing as acute bleeding because it has now added extra volume and more displacement to the brain; isn't that a fair statement, medically?

MR. SCHOBERT: Objection.

MS. MINKLER: Objection.

MS. MOORE CARULAS: Objection.

A. I am -- I don't know because I don't know the element of extra volume in the new blood. Extra volume that is miniscule may not be as bad as if the volume were large.

Q. Okay. But those are conclusions after the fact. I am talking about when you are presented with the problem by the patient, number one, there is an acute bleed, you don't know what the volume of bleed is when you examine the patient?

A. Correct.

MR. SCHOBERT: Objection.

Q. You have no way of knowing without some diagnostic test?

A. Well, that's not true.

Q. How do you know?

A. Let's say I examine the patient, the findings are completely normal. There is no headaches. There is no -- blood pressure, neurological examination all is normal, and as you just propose, there is a bleed, given that circumstance I would propose that the bleed would be very small since it's not producing any symptoms. Give me blood with an unconscious patient, it's going to be a larger bleed.

Q. In the first circumstances, to be fair, you wouldn't diagnose a subdural hematoma because there are no symptoms, correct?

MR. SCHOBERT: Object. You are arguing with him. You are --

A. Certainly would get the diagnosis of subdural hematoma without symptoms.

MR. SCHOBERT: Object.

Q. Let's start from the beginning, okay? There is a situation where a physician is presented with whatever the man's symptoms are and it can be safely diagnosed as acute subdural, okay, minimal. You understand what I am saying?

A. Well, not -- rephrase. You can't make a presumptive diagnosis until you do the testing. The judgment of the emergency room physican is whether tests are necessary for the diagnosis or not.

Q. Okay.

A. Not whether the die flows there.

Q. When you make those judgments you have -- you have been taking into consideration that if that judgment is wrong, the patient could have a very serious brain injury or death from it?

MR. SCHOBERT: Objection. Asked and

answered.

Q. Correct?

A. Certainly.

Q. Okay. Under those circumstances is it not the standard of care to send the patient down for a CAT scan when the alternative may be his death or serious brain injury?

MR. SCHOBERT: Objection.

Q. That's the question.

A. The answer is no.

Q. Why not?

A. Because there is a relative likelihood -- we have already been over that -- when the likelihood is low and when it's more likely than not in your judgment the patient has a psychiatric versus organic, it is not the standard of care to go after the most miniscule things even if the potential outcome is death.

Q. If a subdural hematoma is on the differential diagnosis of a physican as would --

MR. SCHOBERT: ER physician?

MR. TRACI: Yeah. That's all ER.

MR. SCHOBERT: Well, I notice you've been skipping back and forth. I just wanted to make sure the record is clear.

A. All right.

Q. Do you agree Dr. Davis should have considered the possibility of a subdural hematoma from the signs that he had in this examination?

A. No. I think the possibility of organic brain problem would be about as limited as he could get with this history and physical.

Q. Okay. So you agree that he should have considered the possibility of an organic brain problem?

A. Possibly, yes.

Q. In this patient?

A. Yes.

Q. And should he have considered the possibility of a psychiatric problem?

A. Correct.

Q. Should he have considered the possibility of a medical problem here in this case other than an organic brain problem, meaning some mental disorder?

A. Or certainly some metabolic disorder.

Q. I am just separating out all the medical --

A. I understand. I am with you.

Q. Okay. Based on the fact that there is sufficient symptoms present that would require Dr. Davis to consider the possibility of organic brain syndrome, is

it nevertheless your opinion that he did not have to do anything to act on that, even though an organic brain problem could have been life threatening?

MR. SCHOBERT: Objection.

Q. Is that correct?

A. I think that's what I am telling you, yes.

MR. SCHOBERT: When you say acted upon it --

MR. TRACI: He has answered the question.

Q. Isn't it true that these symptoms at that time that Dr. Davis examined Mr. White -- well, strike that.

What do you consider an organic brain problem? Would a brain tumor be one?

A. Yes.

Q. Would a chronic subdural hematoma be one?

A. Yes.

Q. Could an subarachnoid hemorrhage be one?

A. Yes.

Q. Anything else?

A. Degenerative neurological diseases would all come under that.

Q. Okay. And once you as an emergency room

physician determine that it could be an organic brain problem, the standard of care at that time is to either order a CAT scan, MRI, if you believe it's immediately life threatening; is that right?

MR. SCHOBERT: Objection.

A. No.

Q. Tell me what the standard of care requires of an emergency room physician that believes a patient may have an organic brain problem, what are you supposed to do?

A. Supposed to try to make a decision as to what organic brain syndrome he might have.

Q. Supposed to go further and clarify what in that category it could be?

A. If that's what you thought the patient had. You presented me with a patient who had organic brain syndrome. I am telling you that presented with that particular patient, that it would be appropriate before you went ahead and tested to get some idea of what kind of syndrome it might be. For instance, if it's Alzheimer's disease, you may approach it differently from a gun shot wound to the head.

Q. Okay. In this case -- you just told me a moment ago that you thought that Dr. Davis could have

diagnosed or should have considered in this case an organic brain syndrome and you wanted to go more in general with it rather than to the subdural hematoma.

MR. SCHOBERT: Objection. That's not what he said.

Q. Is that not what you said?

A. I remember we discussed that. I don't remember my exact words.

Q. Could Dr. Davis have diagnosed acute subdural hematoma here?

A. Was it possible for him to diagnose --

Q. Yeah.

A. Based on the symptoms, no.

Q. How about chronic subdural hematoma?

A. Well, he could have diagnosed either one. I don't see the evidence for that, but could he have written that down? Sure.

Q. Once the emergency room physician believes he has -- must have enough evidence to make a diagnosis of some type of organic brain problem, isn't it true that the only way to rule in or rule out which one it is and how life threatening it is, is to run the diagnostic tests or to bring in a neurologist or neurosurgeon to more specifically clarify the diagnosis?

A. I don't know that bringing in a neurologist would help you determine the -- in determining the acuteness of life threat, but it would be appropriate to -- if you thought you had an organic syndrome, it would be appropriate for a referral like that if you thought it was not acute.

Q. What I would like to find out -- I mean other than the fact that you just say it's up to the judgment of the ER physician, is there any standard at all in terms of what you are supposed to do in making your judgment in whether it's acute or not?

A. Certainly.

MR. SCHOBERT: You never asked him --

A. The emergency physician has an obligation --

Q. What is that?

A. -- to a department to decide the acuteness of a patient's problem, first of all, how serious is the threat to life or limb of what the particular patient has. Once that determination is made, then the next obligation is to decide disposition on that particular patient. The disposition can range from being discharged to home without follow-up to being admitted to the intensive care unit or to the operating room; so to review, the disposition is the the relative acuteness of the problem,

and the secondary decision is to the disposition of the patient.

Q. If a chronic subdural hematoma -- strike that. On your May 15 report you have down that the normal approach after Doctors Hospital had examined him would be for them to contact Doctors Hospital to talk to the psychiatrist for direct admission. See that sentence?

A. Yeah. I think what I said was for the emergency physician from Doctors Hospital would be normal.

Q. Dr. Jeun?

A. To contact the psychiatrist.

Q. Where did you get that information from in this case? What information do you have that --

A. The normal approach for that kind of referral, a psychiatric referral from Hospital A to Hospital B in a normal approach would be for the emergency physician to contact a psychiatrist for admission.

Q. Okay. Well, the normal approach in this case is apparently for the ER at Timken to do the evaluation, no matter who referred the patient. Are you aware of that?

A. Yeah.

Q. You are aware of that?

A. That's fine.

Q. The ER physician, regardless of who else evaluated this patient, is required to make their own assessment and evaluation of a patient; is that correct?

A. That seems to be their policy.

Q. That is indeed the standard of care, the ER department is -- if you are examining the patient, you are supposed to do that examination yourself, correct, evaluate the patient yourself?

MR. SCHOBERT: Objection.

A. As opposed to -- I don't understand.

Q. Isn't it true for any physician, an ER physician or any other physician, that when you do an evaluation of a patient, you are supposed to do your own evaluation of the patient and come up with your own diagnosis and assessment?

A. Correct.

Q. You are not supposed to be relying on what some other prior physician has done, even though you could use that piece of information in your own assessment?

MS. MINKLER: Objection.

A. Correct.

Q. You should not conclude anything because someone else's evaluation may be organic or psychiatric or anything else; is that correct?

MS. MINKLER: Objection.

A. You are completely right. You need your own information. You may make a preliminary conclusion, but you need to add in your own.

Q. Whether or not Doctors Hospital did or did not diagnose an organic versus psychiatric condition does not relieve Dr. Davis of his own responsibility to make the appropriate diagnosis; is that true?

A. Can I explain what I was saying because --

Q. Just talking about the --

MR. SCHOBERT: Just answer.

Q. It's a different question.

A. All right. Reword the question.

Q. Whether or not anyone else did or did not diagnose organic versus a psychiatric condition, Dr. Davis has the independent obligation to make his own diagnosis and assessment?

A. Because he has seen that patient.

Q. Correct?

A. I agree.

Q. So if Doctors Hospital was right or wrong in their diagnosis, that does not relieve Dr. Davis of his standard of care in making his own evaluation and judgment, correct?

A. In this case it did not, right.

Q. So what Doctors Hospital did to that extent in their judgment or assessment or examination is irrelevant to Dr. Davis' standard of care?

A. I agree completely.

Q. Okay. When you say in your report that in your view the second evaluation at Timken exceeded the standard of care, that opinion would be changed, would it not, if you knew that the standard -- strike that.

In making that statement that it exceeded the standard of care, you were assuming that the normal practice was for Doctors Hospital to contact the psychiatrist directly?

A. Could have been, but you are -- I think we agree. I understand that. I think what you are saying --

Q. The fact that Davis examined him did not exceed the standard of care?

A. That's right.

Q. So that part of your opinion just is from an assumption that doesn't apply to this case in terms of what the procedure --

A. I think you are right.

Q. As to what the procedure is?

A. I think you're right.

Q. Okay. At one point you also have that Dr. Davis' history supports suicidal type ideation?

A. Right.

Q. Meaning gas on in stove or oven?

A. Right.

Q. First of all, again it doesn't say that the gas was emanating into the room. All it says was on in the stove, correct?

A. Right.

Q. And indeed that could be a suicidal type action?

A. Right.

Q. Wouldn't it?

A. I mean those are two different things. One assumes that if you have suicidal action, whether it's pointing a gun at your head or slashing your wrists. If it's ideation, wouldn't have that action.

Q. Okay. But isn't it true that as a physician referring to those -- you are making those distinctions between suicidal ideation and suicidal action because those mean two different things in terms of the patient's potential problem or diagnosis?

A. I think -- yes, I think what we mean is if there is action, we take it a little more seriously than

just the ideation. The ideation should be taken seriously too.

Q. You have then suicidal activities are rare in psychosis. Is that true?

A. No, I don't have that. What I have is "suicidal activity are rare is psychosis." That is a completely meaningless phrase, which I have reviewed prior to this, and I'm trying to think of what that meant. I am almost certain what I did was stop in the middle of the sentence and rewrite it, only my secretary -- either I enunciate it or she didn't pick it up. It's meaningless, and what I -- I have no idea what the rest of the phrase is.

Q. It isn't suicide activities are rare in psychosis?

A. No.

Q. Are they common in psychosis?

A. Common being greater than 50 percent, I don't know the answer to that.

Q. You don't have any --

A. They are common.

Q. That is not your recollection of what you intended to say in that sentence?

A. No. I guess it's a sentence because it ends

in a period. It's meaningless to me.

Q. That is not a typo with I-S that should be I-N?

A. It's an aborted thought.

Q. Well, you go on and say, "I should also say it is relatively rare organic brain disease." First of all, is that true, suicidal activity is relatively rare regarding organic brain disease?

A. Yes.

Q. When you take those two sentences together, it seems as if they flow right into each other in a logical way.

A. I agree it does, but I'm telling you I reviewed that, and it makes no sense whatever to me because it just isn't true. I have no idea. It's a typo. I apologize, but I guess I am human. My secretary is human. Suicidal activities are more common in psychosis than they are in organic brain disease.

Q. And you referred to the impression from Doctors Hospital that this patient had a psychiatric illness?

A. Yes, I did.

Q. From where did you get that? From the ER at Doctors Hospital?

A. Yes.

Q. Is this something that was known to Dr. Davis?

MR. SCHOBERT: Objection.

A. I have to tell you right now I don't remember what he said in his deposition about memory of the Doctors Hospital information, so I can't comment on it now.

Q. You have down here additional nurse reported hallucinations, correct? That's in Dr. Davis' dictation, correct?

A. Yes.

Q. They are a more active psychosis than organic brain disease?

A. Right.

Q. Do you have any explanation why the hallucination is mentioned here, but from the same psychiatric triage nurses notes his headache and dizziness is not?

MR. SCHOBERT: Objection.

A. Sorry. Are you talking about in my report or --

Q. Why is it that Dr. Davis would have only written down hallicunations rather than headache and dizziness when he is referring to the same psychiatric

triage nurse and the same notes?

MR. SCHOBERT: Objection.

A. No, I can't explain.

Q. Doesn't that give you an indication that Dr. Davis was picking and choosing to fit the conclusion he had come to in that psychiatric test, organic brain syndrome?

A. Not at all, no.

Q. Does it raise that question in your mind at all?

A. No.

Q. Is it the emergency room's duty to separate acute from a chronic subdural hematoma?

A. Emergency physician's duty?

Q. Yeah.

A. Emergency physician's duties to separate acute from chronic given a patient with a subdural, it would be the emergency physician's duty to try and separate acute and chronic.

Q. You have down on the bottom of the May 15 report, last line, in justifying the conduct of the emergency room physician, you say you base that on the

fact that, "There were no abnormalities of the vital signs or of the physical examination that would indicate an acute or organic brain problem"; isn't that true?

MR. SCHOBERT: Wait a second. Where are you at?

MR. TRACI: Last line, the May 15 report.

MR. SCHOBERT: I am sorry. I looked right at it. Go ahead. Sorry. Excuse me.

Q. Correct, Doctor?

A. Yes.

Q. "Specifically the neurological examination was grossly normal"?

A. Right.

Q. In fact, based on your prior testimony today that's not true, it's not grossly normal? It was not gross -- he had the altered mental status. He was disoriented. He was severely agitated, motor activity increased, all those things, so that statement in there is not accurate at this time; isn't that true?

A. The motor neurological or I guess I should say I have already indicated the altered mental status was abnormal.

Q. That's the neurological examination?

A. That's part of the neurological examination.

Q. That's a significant part of the neurological evaluation when you are talking about organic brain syndrome, aren't you?

A. It's a significant part of the neurological evaluation if you were talking about organic brain syndrome.

Q. An emergency room physician can't just do a neurological exam because that's only really looking for spinal cord type of injuries or things like that. That could more likely be that those would be symptoms of motor deficits?

A. That's right, yes, sir. You have to do both.

Q. And specifically your statement in terms of neurological examination, you put in there as grossly normal when he clearly had an altered mental.

A. I think I explained that in the next sentence which says no paralysis was detected. And I was -- I also said the patient was responsive to questioning and he's aroused. There is also no history of sudden or precipitating changes in the patient's behavior pattern.

Q. Okay. First of all --

A. That explained, I think, what I meant by grossly normal.

Q. First of all, the patient was responsive to questioning, and in fact Dr. Davis, as you had testified earlier, said that he wasn't responsive to questions, he wouldn't respond about his psychiatric history, he wouldn't tell them what day it was. Which is it, he was either responsive to questioning or he wasn't.

MR. SCHOBERT: Objection.

A. Well --

Q. What are you relying on?

A. I think he was responsive to questioning. If I asked a patient a question and the patient says, "I am not going to answer," that is a response. Not responsiveness refers to just absence of any verbal interaction.

Q. That is what the doctor indicated. The doctor indicated, I believe, in his testimony that the patient would not answer any question about psychiatric care. He didn't say, "I'm simply not going to tell you."

MR. SCHOBERT: Objection.

Q. Have you concluded that's what he said?

A. My conclusion is there was verbal interaction, that he was satisfied that the patient would not answer the question, but not that the patient remained completely silent to questions.

Q. You indicated a moment ago that you believe based on all the information this patient had been in the bathtub for a couple of hours?

MR. SCHOBERT: Objection, that's not --

Q. Or in that house exposed to the condition for a couple of hours, whatever was going on.

A. I said that if you were under water, he would be exposed to water, and that is less than a couple of hours.

MR. SCHOBERT: I withdraw the objection because he qualified my reason for my objection.

Q. Based upon your answer to those questions previously asked -- I don't want to get into all those again -- let me clarify that point which in your opinion was, I believe -- is it still your opinion that there was no history of a sudden or precipitating change in the patient's behavior pattern that Dr. Davis should have concluded at the time of the emergency room visit?

A. Yes, it's still my opinion.

Q. Both acute and chronic subdural hematoma can be detectable by CAT scan, correct?

A. Yes.

Q. And all it takes for the emergency room

physician, according to your report, is if there is a suspicion of acute problem, then he should order an CAT scan; is that right?

A. It says these tests. I think I referred to CAT scans --

Q. Right.

A. -- are ordered, there is a suspicion of acute problem within the brain that can be detectable by use of the CAT scan.

Q. Okay. So all it takes is a suspicion by the physician there can be acute problem in order to order a CAT scan?

A. In terms as I said before -- you're taking my sentence out of context and interpretting it literally. That would be any suspicion, but if you apply that to the statements I already made about relative risk, then certainly it would not. When suspicion is solo, it would be ridiculous to order that.

Q. If an emergency room physician determines that this patient may have an organic brain problem, it is your opinion that it may be appropriate under the circumstances to refer that patient to some other physician, either outpatient family doctor or attending physician in the hospital, to follow up with whatever

neurological testing or diagnosis must be made?

A. Correct.

Q. And is it the standard of care for the emergency room physician, knowing the fact that this involves a potential of damage to the brain, to convey specifically that concern they may have to the attending physician to make it clear that they suspect there is an organic problem?

MR. SCHOBERT: Objection. Withdraw objection.

A. I get -- if I may paraphrase your question, see if I understand it correctly. You are asking me if the emergency room physician suspects that there may be any condition which could be a potential problem for a patient refferal, is there an obligation to communicate that suspicion to the receiving physician, if he elects to refer that patient?

Q. Communicate --

A. I agree with that.

Q. Communicate it clearly.

A. Right. It could be verbally or in writing, but it needs to be communicated.

Q. Does acute psychosis communicate the fact that Dr. Davis believed there was an organic brain problem

involved here as one of the possibilities?

A. Well, since acute psychosis can be caused by organic problems, it certainly does communicate that there is some etiology for it, and it needs to be evaluated.

Q. Okay. There are two different things going on here. First of all, Dr. Davis has testified that he believed that this patient's problems could either have been functional or organic.

MR. SCHOBERT: Objection.

MR. TRACI: Well, that's true.

MR. SCHOBERT: I know, but I am just trying to protect the record. You may be right, but whenever you start paraphrasing testimony, I just get nervous.

MR. TRACI: Okay.

Q. It's my understanding, Doctor -- I think you read the history to know what he was saying -- that Dr. Davis from his evaluation of this patient and examination, et cetera, believed that this patient's problems as presented at that emergency room could have had an organic or psychiatric etiology.

MR. SCHOBERT: Objection.

Q. Is that a fair statement?

A. I have a memory like that also.

Q. Okay. Now, under those circumstances was it appropriate for Dr. Davis to have given or written a diagnosis that more likely than not conveys psychiatric rather than organic?

MR. SCHOBERT: Objection.

A. I guess that would not be appropriate, but I am not aware what happened.

Q. The diagnoses was acute psychosis. Doesn't that more than likely suggest a psychiatric --

A. No, it doesn't to me, so that's why I didn't understand.

Q. As an emergency room physician who is writing down a diagnosis on emergency room charts for referral to an attending physician upon admission, isn't it incumbent upon you to apprise yourself of what the general medical community of attending physicians would understand your diagnosis to be and mean?

MR. SCHOBERT: Objection.

A. I think we all come out of medical training with a certain understanding of the way communications occur and what certain things mean, and when we leave our state of training to go to other sites, there may be some difference; but in general throughout the country there is fairly the same level of understanding. But your question

relates to whether or not a physician has an obligation to ascertain how other physicians react to their ways of communicating, and the answer to that is I don't know.

Q. Well, isn't it important when you -- wouldn't it be important for an emergency room physician to make sure that whatever his impressions are, are accurate and properly communicated to the attending physician?

A. Yes.

Q. And if an emergency room physician is using terms that he knows aren't properly conveying the information to a treating physician, then it's incumbent upon that emergency room physician to make the proper communication?

A. Certainly.

Q. That's for the patient's benefit?

A. Certainly.

Q. So if there is any confusion or doubt associated with that communication, that falls upon perhaps both physicians but certainly the emergency room physician for the patient's benefit to make it clear what the diagnosis is, what his interpretations are?

A. I think the emergency room physician should make things clear, but there is no way for an emergency room physician to know if another physician has doubt

unless that second physician expresses such a doubt. I don't know that an emergency physician has the obligation to follow up with receiving physicians, and say, "By the way, did you have any doubts on what I wrote down or was anything unclear?"

Q. Okay. Now, given a circumstance where an emergency room physician is trying to convey the fact that this man may have some process going on in his brain physically that can cause him brain damage, isn't it inappropriate for Dr. Davis not to have made that more clear to raise the index of suspicion of the attending physician in this case?

MR. SCHOBERT: Objection. Asked and answered.

A. I believe from the sum total of the material I read that the diagnos of acute psychosis conveys that particular information, and Dr. Davis knows the patient got admitted and was not discharged to some nebulous outpatient follow-up, and that was enough. No further obligation is what I am saying.

Q. Okay. Is that true even if Dr. Davis was aware of the fact -- and I ask you to assume that this is true -- Dr. Davis is aware of the fact that the psychiatric nurses and perhaps the psychiatrists were

working under the assumption at the hospital that the emergency room physicians were medically clearing the patient; assume he had that kind of knowledge, would that not raise his obligation to make a very clear conveyance of the information that he suspected that this man had an organic problem?

MR. SCHOBERT: Objection.

A. No, not at all.

Q. He had a right to just do what he did do, and if the psychiatrist misunderstood or interpretted or believed that he was medically cleared, that's the psychiatrist's problem and not Dr. Davis?

MR. SCHOBERT: Objection.

MS. MINKLER: Objection.

A. There are two things. One is that actually you said it much better than I did several dozen pages ago when you talked about a physician has the obligation to evaluate a patient, formulate their own opinion, so I really can't state it any better than you did. Secondly, the term medically clear refers to the presence of acute problem right at that time, and it does not refer to any possibility of there not being a chronic problem or possiblity of change in the patient's condition, and so --

Q. I agree with that, but what does the ER

physician -- what is he required to do with reference to his duty to the patient when he knows that the physician he is referring the patient to, the attending physician, is working under the assumption this patient is cleared of all medical problems --

MR. SCHOBERT: Objection.

Q. -- as to the patient? Does that raise the obligation of the potential that the emergency room physician ought to give that physician --

A. If a hypothetical emergency physician thought -- if a hypothetical psychiatrist felt that they were operating under the assumption that there is 100 percent impossibility of any organic problem, then the emergency room physician would have the obligation to communicate further or do something.

Q. I guess the bottom line what I am saying is when you know as an emergency room physician that the people you are referring a patient to either are incompetent or don't understand your diagnosis or are making an erroneous assumption about what an emergency room physician does in terms of medically clearing a patient, under those circumstances doesn't the emergency room physician have as a standard of care designed to protect a patient a greater obligation to make sure that

he personally conveys his concern and interest and makes sure that the patient gets the proper test and procedures done?

MR. SCHOBERT: Objection.

MS. MINKLER: Objection.

A. Well, that's very long, and I think in terms of incompetence, the approach would be that we should not be referring to anybody that we think is incompetent. The second category -- I forget the third category -- that of a receiving physician who misunderstood the role of the emergency physician, if that was known, then the emergency physician would have the obligation to communicate that but would not have the obligation to, "be sure that certain tests and procedures were done."

Q. Vital signs in and of themselves do not rule in or rule out organic brain problem, do they?

A. Absolutely correct.

Q. If a chronic subdural causes acute symptoms, meaning now symptoms are starting, is that not then an acute problem --

MS. MOORE CARULAS: Objection.

Her: Objection.

Q. -- requiring investigation?

A. It sounds circuitous. Are you saying the

problem is acute or that is an acute problem?

Q. No. Is this chronic -- if you had a subdural or chronic problem of any kind that now presents acute symptoms, meaning recent new symptoms, does that not make what you have generally called a chronic problem an acute problem?

MS. MINKLER: Objection.

MS. MOORE CARULAS: Objection.

MR. SCHOBERT: Objection.

Q. That sounds obvious, but I guess I just need to have you agree or disagree.

A. I think the answer to that is yes, but you could say that about anything that's acute.

Q. What was there in this record that allowed Dr. Davis to conclude -- what support is there in the record of the symptoms that would allow you to say that Dr. Davis, with these neurological abnormal findings that he had, that this was not an acute problem requiring immediate treatment as opposed to something that could wait?

A. The fact that the patient was conscious, the patient moved all extremities, had no lateralizing signs, had no vital signs and also did not seem to be deteriorating and was under Dr. Davis observation, and I

think -- I wasn't clear on this -- depending on how much information Dr. Davis had and he did not have a marked deterioration during that time interval either, all that indicates that this is not a hyperacute problem.

Q. Well, what is hyperacute?

A. Hyperacture I was trying to differentiate intervention in the emergency center versus intervention at some later time after the patient is admitted.

Q. In terms of -- in order to be an acute problem -- that's what I tried to ask you before in terms of your definition of acute. In order to be an acute problem, do the symptoms have to change right before the doctor's eyes or in the hour or two in the ER or could that be an acute change from the day before ER or from six hours before or from a week before? What does acute mean?

A. The answer is that's a judgment the emergency physician has to make based on the total information they have, depending on what kind of disease process it has and what kind of interventions are available.

Q. Is it your statement that or your opinion then that because it's a matter of judgment, it is not a matter of standard of care with reference to the emergency room physician? There is no objective standard of care in terms of what is considered an acute problem and when one

is not?

A. To answer the question you asked specifically, no.

Q. There is no standard of care of acute versus non-acute in the action?

A. You're right.

Q. It's simply a matter of judgment?

A. Yes.

Q. If the emergency room physician makes the wrong judgment, that's tough, he wasn't below the standard of care as you as an emergency room physician understand it?

A. Depends within which entity it was, what happened. I mean you can make comments regarding standards, but standards are fairly specific, so you have to have a specific patient to compare the standards to. Just to say acute versus chronic, there is no standard that deals with that general term.

Q. Isn't it true that an emergency room doctor should be able to function as an internist, surgeon, psychiatrist, pediatrician, gynecologist, radiologist, and indeed several other specialties all in one?

A. In the acute aspect of the problems -- of some problems, yes.

Q. So he's supposed to be a jack-of-all trades, in other words?

A. He or she.

Q. He or she. I did not mean to make that exclusive.

A. That's okay.

Q. So the answer to that is yes?

A. Yes.

Q. You are supposed to know enough about those various areas in order to rule in or rule out or decide who a patient should be referred to?

A. To rule in or rule out is less common as to decide where the patient should go.

Q. Is it the standard of care that he should rule in or rule out certain things --

MR. SCHOBERT: Objection.

Q. -- in the emergency room?

A. It is the standard of care that there are some things that the emergency physician should definitely rule in or rule out.

Q. Do you intend to express any opinion other than what's contained in your report about what impact, if any, Mr. White's not being diagnosed and treated as a result of Dr. Davis' care had on his long-term result?

A. No. I won't have any opinions about that.

MR. TRACI: Okay. I don't think I have any further questions.

MS. MINKLER: No questions.

MS. MOORE CARULAS: No questions.

(A discussion was held off the record.)

MR. SCHOBERT: We will agree on the record if anybody needs this immediately to get it to the various people that he can get those corrections just as soon as possible to not hold up that process.

MR. TRACI: I don't care about waiver of signature.

MR. TRACI: You are going to hire him for trial any way.

(Deposition concluded and witness excused at 3:40 p.m.)

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BRUCE D. JANIAK, M.D.

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C E R T I F I C A T E

I, Renee E. Brass, 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 was by me reduced to stenotype in the presence of said witness and afterwards transcribed; that the foregoing is a true and correct transcription of the testimony so given as aforesaid.

I do further certify that this deposition was taken at the time and place in the foregoing caption specified.

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 June 1990.

Renee E. Brass

RENEE E. BRASS
Notary Public
in and for the State of Ohio

My Commission expires September 19, 1991.

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