COPY

IN THE COURT OF COMMON PLEAS

OF TRUMBULL COUNTY, OHIO

THOMAS W. MONROE,
Individually and as
Executor of the Estate of :
Deborah L. Monroe,
Plaintiff,

v. : Case No: 00CV2380
: Judge Kontos
JOHN MAXFIELD, M.D., :
Et al., :
Defendants. :

- - -

Deposition *of* BRUCE D. JANIAK, M.D., a Witness herein, called by the Defendant as upon Cross Examination pursuant to the Ohio Rules of Civil Procedure, taken before Julie K. Latham, Registered Merit Reporter, Notary Public in and for the State of Ohio, at the offices of Bruce D. Janiak, M.D., 27087 Oakmead, Perrysburg, Ohio, on Friday, September 13, 2002, commencing at 9:00 a.m.

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I N D E X

DEPOSITION OF BRUCE D. JANIAK, M.D.:

APPEARANCES:

On behalf of the Plaintiff:

FRIEDMAN, DOMIANO & SMITH L.P.A.:
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Cleveland, Ohio 44113 216-621-0070

On behalf of the Defendants:

HANNA, CAMPBELL AND POWELL, LLP:
Michael Ockerman
P.O. 5521
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Akron, Ohio 44334 330-670-7300

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BRUCE D. JANIAK, M.D.,

being first duly sworn, as hereinafter certified, testified and said as follows:

CROSS EXAMINATION

BY MR. OCKERMAN:

Q Good morning.

A Good morning.

Q My name is Michael Ockerman. I'm here on behalf of Dr. Maxfield and his corporation in which a lawsuit has been filed by the estate of Deborah Monroe. I understand that you have been retained as an expert on behalf of the estate of Deborah Monroe, is that correct?

A Yes, sir.

Q You've had your deposition taken before, but just

so we're clear, it's important that you speak your answers rather than nods of the head, shrugs of the shoulders because the court reporter, Julie, cannot take those down.

Also, if you do not understand a question please tell me to rephrase it and I will; and, otherwise, I'll assume that you understood the question. Is that fair?

A Yeah.

Q You have been involved in lawsuits yourself?

A Right.

Q Do you know how many?

A Personally?

Q Personally.

A Yeah, two.

Q Did any of those lawsuits have to do with the failure to diagnosis an aortic dissection and/or an aortic aneurysm?

A No, they did not.

Q Or have you given testimony in the past in regard to cases involving the diagnosis of a thoracic dissection and/or aneurysm?

A I would say almost certainly I have. Certainly I've done cases in dealing with the aorta. I would guess two or three on the thoracic aorta and

the rest in the abdominal aorta, the rest being another four or five, I ,suppose.

Q And can you recall any of the cases involving the thoracic aorta any information, whether attorneys' names --

A I understand the question and I wouldn't know the names and nothing recent. It's been years.

Q Do you keep any records of the cases that you review?

A Yeah, I have billing records and in the billing records actually would be probably the main point of the case. So, it would be possible for me to look up "aorta", for instance.

Q And are these kept on computer and they're readily available to you?

A That's -- I wish I could say that. My old computer, which is dying but could still be functioning, has all the cases on it. They are all in Microsoft Word Perfect, which as you know is an antique system. I had it all backed up to disk and I'm unable to get it extracted from the disk. If the old computer still works I could probably without any trouble find the word aorta and see what there is and if you'd like I'd be happy to get that for you.

Q Please. Can we get it today or --

A I don't see why we couldn't get it today if -- my computer's at home, so perhaps she could get it today.

Q Okay.

A All I would be able to get you, since I have no printer that connects to this computer, would be the names of the cases and the dates I could get that today.

Q All right If you could kindly that to Ms Kolis I would greatly appreciate it

Doctor, do you know, how were you first contacted to review this case?

A I would guess by telephone

Q Have you reviewed any cases for Ms Kolis?

A I have I would -- my guess is this is the third, but t at's my guess

Q Do you know when you were first contacted?

A I wouldn't know the date of the telephone conversation, but in the file there could be a letter that -- a transmittal letter.

Q And the earliest letter I see in the file is September 15th, 2000 That would be on Ms Kolis's letterhead

A You looked more recently than I did, so I have no

reason to doubt that at all.

Q Can we just verify that if you --

A You say September 2000?

Q September 2000.

A You are correct, September 15th.

Q Doctor, can you tell us what you reviewed?

A Medical records for Deborah Monroe at St. Joseph Health Center on the 16th of July of 1999. I think there was an E.M.S. run sheet associated with that. The medical records from St. Joseph Family Medical Center for the same date. I believe it -- that is Dr. Shah's evaluation. And depositions of Dr. Shah and Dr. Maxfield. I think those are the only two depositions.

Q You have two reports I see in your file?

A Right. First one and then a supplemental one after I reviewed the two depositions of Shah and Maxfield.

Q Any other handwritten notes or computer generated notes?

A The billing record in my computer.

Q I see that on the outside of the depositions you have some notes written down.

A That is correct. It would be the amount of time it took me to read the deposition, the date I read

the deposition, or finished reading the deposition, and then page references on things that interested me when I read the deposition.

Q Okay. Why don't we go through those page references.

A Since you stepped out, do you -- if we could start with Dr. Shah's deposition that has a date of 19 January '02, which is the date I read it, and there were no page references.

Q Okay. So, nothing really drew your attention?

A Nothing jumped out at me.

Q Okay.

A For Dr. Maxfield's deposition, the 28th of November of 2001, the following page references. Would you like me to go through and read what I thought about each reference?

Q Give me the page and we can go through.

A Page nine, this was a question regarding whether he was researching anything about aneurysms and he was -- his answer was he was wanting to know if there as a physiologic basis for someone with low back pain and only low back pain to have a thoracic level dissection. And I had checked that because Dr. Shah's records indicates it was pain in the upper back, nurses' note indicates mid back

pain, so the research is interesting but I don't know what it had to do with this patient. I say that in quotes.

Page 12, this is in reference to Dr. Maxfield's conversation with Dr. Shah He indicates that Dr. Shah was considering an aneurysm and he, some reason or other, thought Dr. Shah was embarrassed to suggest that, but he wanted to send the patient anyway for me to look at it and he mentioned CT scan of the chest So that indicates that Dr. axfield knew that Dr. Shah was concerned about an aortic disease in the chest.

Next is page 18, and this is where Dr. Maxfield nicely credited me with being an editor of a journal and I'm not, so I was impressed, I'd guess, anyhow.

Q Let me stop you there Do you know Dr. Maxfield?

A No idea. Don't know who he is

Twenty-eight is the next page. This is where Maxfield says he's reading a document where it says, 'Patient complains of a severe back pain in scapular region," and then he is trying to interpret these words and he has -- he understands there's a word suddenly there EMS called, another

reference to chest pain. That just is more information to me what there was -- there was indication there to indicate it was chest discomfort

Page 29, no. I think what he's referring to is Shah's records because he talks about discussed this patient with St Joe's ER. Will transfer for further evaluation. Something about a CT and then consider back pain, hypertension, rule out any evidence of aorta. That just is what -- he's trying to read something that's handwritten I think. That's, once again, more reference to the aorta.

And the last one is page 31, where he's -- there's -- he's asked a question about the relationship between the previous history given by Dr. Shah and the patient's complaint according to Dr. Maxfield of sudden diffused lower back pain, onset three hours prior to arrival So, there's a discrepancy there.

And that is all my references

Q And that discrepancy is between what was recorded at the earlier institution and what the patient was telling Dr. Maxfield?

A Well, I think the discrepancy is between what was

recorded at the earlier institution and what was communicated even according to Dr. Maxfield by Dr. Shah to Dr. Maxfield. And then there is an -- and then, you're correct, there is -- that is not -- does not jibe exactly with what Dr. Maxfield wrote down as the patient's own history in his emergency medicine record.

Q Well, what, based upon your review of the depositions, what is it, what discrepancy existed between Dr. Shah and Dr. Maxfield?

A Well, I think I can only answer the discrepancy between Dr. Shah's's history as recorded and verbalized and Dr. Maxfield's recorded history. Dr. Maxfield says, quote, "Patient complains of sudden diffuse lower back pain, onset three hours prior to arrival." And he also says there has been no chest pain and he also says the condition has remained unchanged since onset. None of that is consistent with even what Dr. Maxfield says Dr. Shah told him.

Q So -- and that's what I'm trying to get at. Dr. Maxfield -- so as far as what Dr. Shah told Dr. Maxfield there is no discrepancy?

A It seems like Dr. Maxfield agrees that Dr. Shah told him that there was -- that he was concerned

about a disease of the aorta in the chest because the patient had chest discomfort.

Q Upper back?

A Upper back, right.

Q Okay.

A Posterior chest area.

Q So, the discrepancy really exists between what Dr. Shah recorded -- no, strike the question. The discrepancy seems to be between what the patient told Dr. Maxfield versus what she told Dr. Shah?

A Yes, and also is the inconsistency of what Dr. Maxfield did about that history.

Q Isn't it a fact that the most important information you receive is from the patient themselves?

A If that's the only history source of course that is true. The patient's history is really the primary history you go on, but that doesn't mean it's the only history.

Q And do you see in Dr. Maxfield's report there where he indicates on three occasions that this is -- she's only complaining -- or infer from that, that she's only complaining of lower back pain?

A Yes.

Q And that was dictated the same day she was there?

A I never looked at that. According to that, that's true. According to the record.
Q Doctor, what type of practice are you in now?
A I'm still practicing emergency medicine. My most recent shift was this last Saturday evening at North Oakland Medical Center in Pontiac, Michigan. Since you and I last met I have been -- I'm now on the staff at Mercy Memorial Hospital in Monroe, Michigan. And I'm just waiting to have them call me and tell me what days they're going to have me work.
Q Are you going to be an employee of the ER group there or an independent contractor?
A You know what? I never asked that question. It sounds funny, but since it's part-time work and, as you well know from our previous conversation I'm considering moving south, I wanted to keep active until I get that done. But just to complete the whole process I spent the last two days in Augusta, Georgia finishing up my relationships with the Medical College of Georgia and I went from an initial three day a month to four day a month sort of teaching position down there, which will probably evolve beyond that.
Q So, you're teaching down there fours days?

A Four days a month And that I can't tell you what day that will start because there's still another -- one more medical staff document I need to give them before they'll finalize my privileges

Q And then you would plan to move down to Augusta, Georgia?

A Well, the answer to that is if I sell my house here it would be ninety-five percent certainty I would do that

Q Do you know Dr. Phyllis Dorger?

A Never heard of that doctor.

Q Do you know Dr. Charles Emmerman?

A Yes, I do.

Q And how do you know Emmerman?

A I believe Dr Emmerman would tell you that I am the reason he went into emergency medicine If you want to go way back, he went to medical school at the medical College of Ohio at Toledo and I think he rotated through the Toledo Hospital emergency department Now, this is many years ago Got excited about emergency medicine and went into it since that time I have run into him at meetings I would say two or three times and about two years ago I visited his emergency department, but I can't remember the reason.

Q Do you at all know the Monroe family?
A I do not.
Q Do you advertise your services?
A I do not.
Q Do you lend your services out to name -- to any type of firms that hook you up with other attorneys?
A I do not.
Q What do you understand plaintiff's -- or I'm sorry, what do you understand the decedent's medical history to be prior to her presentation to St. Joseph's?
A Primarily it was high blood pressure.
Q Have you had the chance to look at her family practice records or any other medical records?
A I have not.
Q Have you asked to see --
A I have not.
Q Have you asked to see anything in this case that you haven't been shown?
A I have not.
Q Have you looked at the x-rays?
A I do not believe so.
Q Or the CT scan of the abdomen?
A I have not.

Q Didn't feel that was important to your review of this case?
A That's correct.
Q Was it Dr. Maxfield had ordered chest x-rays?
A You are correct.
Q Do you know why?
A No. That's an interesting point. The patient, as he even pointed out in the records several times, only complained of back pain. His records indicate the chest was clear, there was no temperature and no history of cough, so you would wonder why anyone given that would order a chest x-ray.
Q And would a chest x-ray be the first step in determining whether a patient does have pathology which could cause upper back pain?
A Sure, it could be.
Q Does the standard of care require the emergency room physician to review that chest x-ray?
A If they take it the standard does not require that the emergency physician him or herself review it. It depends on whether timely radiological evaluation is available.
Q And in this case was timely radiological evaluation available?

A I do not know the answer to that

Q Have you seen the readings that were done on the chest x-rays that were supplied to Dr. Maxfield?

A I think I know Dr. Oxfield's records say chest normal according to radiologist

Q So, that would be an indication to you from that statement that the radiologist looked at the x-rays and reported them to Dr. Maxfield as normal?

A Yes, indeed.

Q But you don't know if you've seen the -- y I take a quick look at what you have there? I've handed you what I'll call a radiologist read form Have you seen that before?

A Now, that you point it out, yes

Q And that would indicate that the chest x-ray was reviewed and was found to be negative?

A That is correct.

Q What kind of signs and symptoms of pathology can be seen on a chest x-ray w ich would explain someone's upper back pain, mid scapular back pain?

A One could see especially on the lateral chest x-ray a fractured vertebra. You could see evidence of inflammatory condition, pneumonia being the most common. You could see a collapsed

lung. You could see an enlarged heart and then make an assumption that the enlargement was secondary to a pericardial effusion which would be a cause of pain. And you could see vascular abnormalities including a widened mediastinum. You could also see evidence of lung tumor. All of those -- those be the most common abnormalities that you would see on chest x-ray that could explain back pain, mid back pain, mid chest posterior back pain.

Q Did you have a chance to read the autopsy?

A I did, just about half hour ago.

Q Okay. And what did that indicate to you or was that important to your opinions?

A Well, the autopsy itself, I mean, I had known verbally that the patient had an aortic dissection; and so, I guess it didn't add anything.

Q Okay.

A Except to confirm that that was true.

Q Do you know the cause of the aortic dissection?

A Well, I -- no, 1 don't think so. The most common causes would be a history of hypertension or diseases of the aorta itself.

Q You're going *to* give opinions in this case in

regard to the standard of care?
A Yes, sir.
Q Are you going to give opinions in the case in regard to proximate cause?
A No.
Q Going to give opinions in regard to had Mrs. Monroe had surgery Mrs. Monroe's prognosis?
A I'm not because I don't know enough about the surgical aspects of this to be able to say that.
Q Are you going to give opinions about Mrs. Monroe's life expectancy had she --
A No. I would defer that to the surgical folks.
Q Okay. Define the standard of care for me.
A I believe it's what the average -- well, in emergency medicine it's what the average competent emergency physician would do in terms of evaluating and perhaps treating a patient in a -- with similar -- presenting with similar signs and symptoms.
Q And assuming that Mrs. Monroe's complaints were to her lower back then you would agree that Dr. Maxfield met the appropriate standard of care in his evaluation?
A If he never had any information from any source and the patient never had any chest pain or upper

back pain of any kind and also he didn't receive a phone call from a physician suggesting that he was concerned about aneurysm, if all of that is true, then, no, I wouldn't have a problem.

Q Have you seen the face sheet of the St. Joseph's Medical Center, this one here?

A Well, I mean, yes, of course.

Q What's it say down at the bottom?

A Says severe back pain and hypertension, rule out aneurysm of abdomen.

Q Do you know where that information came from?

A I do not know who wrote that down. The handwriting is so good it's probably not a doctor's, but I can't tell.

Q Does standard of care require perfect care?

A Of course not.

Q Does a bad result equate to negligence?

A It does not.

Q What are your opinions in regard to the standard of care in this matter?

A Well, I believe that this patient had -- was sent for evaluation of possible aortic disease and that the complaint was in the chest and then the complaint was lower down in the -- in the back. And that to meet the standard of care you would

have to evaluate the entire aorta, not just the abdominal aorta. And either one of two tests could have been done to meet the standard; a chest CT or a transesophageal echocardiogram. Either one would have been fine.

Q Do you interpret transesophageal echocardiograms?

A I do not.

Q And those are interpreted by whom?

A I would say in most institutions cardiology I'm sure there is an occasional radiologist that does it, but I think it's almost all cardiology.

Q Do you interpret CTs of the chest?

A I do not.

Q And that's done by a radiologist?

A That's radiology.

Q And what is the basis of your opinions? Why are you saying that there was a breach of the standard of care?

A Well, when an emergency physician gets called by other physicians with information where the sending physician says I'm really concerned about a specific disease process, it certainly is appropriate for the receiving physician to do their own evaluation. But you must respect the concerns of the sending physician because a

sending physician has gotten their own history which should be about as valid as a receiving physician's history

We also know that history changes over time either because the patient has a different slant on the questions or because, as I believe happened in this case, the disease process is actually progressing, and so it causes a different type of discomfort

At any rate, in this case the index of suspicion for aortic disease was high for the following reasons Number one, another physician says I have a suspicion for aortic disease, and that really puts it at the top of the list

Number two, the patient's numerous occasions had sudden onset of pain, even if you just talk about the low back Sudden onset of pain you have to consider strongly a vascular emergency

Number three, the patient was hypertensive which is a known precursor of vascular disease and aneurysmal disease anywhere in the body

Putting all those things together -- and by the way, to be fair, this patient was young, and so it -- you would think just looking at a 39-year-old patient that that aneurysm would be

unlikely, but once you have all the information that I listed prior to saying she was young you must go ahead an evaluate the aorta. And I think the abdominal aorta needed to be evaluated and it was but because the patient started with mid thoracic pain there and posterior thoracic chest pain the thoracic aorta also needed to be evaluated.

Q Do you have any textbooks or literature that would support your opinion?

A Well, I think that's an expected and excellent question in this case especially because I would say there you never find a textbook that talked about information from a sending physician to a receiving physician. I mean, that's -- so, that answer would be experiential. But I certainly -- and I -- I can't site one now, but I can't imagine we cannot find sudden onset of mid thoracic chest pain in a hypertensive patient be issues that are not associated with aneurysm, because they are -- I'm sorry -- aneurysmal disease in a decision because plain aneurysm you usually doesn't cause pain.

Q A plain aneurysm?

A If you just have an aneurysm and it's not

dissecting or leaking it is probably not going to be painful.

Q You indicated that you're going to be teaching down in Augusta. What textbooks are you going to use to refer your residents and/or students to in the field of emergency room medicine?

A I don't -- I don't even know what textbooks they have in the emergency department However, I do know the director of the emergency department and so I cannot imagine they do not have the standard textbooks which would be Tintinalli, Rosen, that is number two, and Parkin is number three. They have a very nice library there, so I'm sure they'd have all those things

Q What causes the pain?

A As I understand it, and maybe I'm getting a little far afield, the pain is caused because there are nerves within the wall of the large blood vessel, in this case the aorta, and it is a stretch receptor, so that when there's a sudden dilation or sudden injury you have pain.

No, I want to differentiate that from a gradual creation of the aneurysm over a period of years or months that expansion is so slow that there may not be any pain at all But when

there's a sudden disruption of the lining of the aorta it's my understanding that it's from stretch receptors in the aortic wall.

Q Have you diagnosed aortic dissection, thoracic aortic dissection, in someone less than 40 years old?

A I -- hoo -- I don't know. I would say probably not. I think there's a couple in their forties and I know there are people in their thirties that I have sent for chest CT and one I think with a TE, but I'm not sure about the age of that one, but certainly I've done chest CT's on people younger than 40 to look for it because their symptoms were consistent or I thought consistent with that.

Q From your review of the information provided to you do you believe that this was a -- that her hypertension was that this -- that this dissection was either -- was it a dissection or an aneurysm?

A Well, there was an aneurysm that had to pre-exist -- that is not necessarily true. You can dissect without an aneurysm. Usually there's an aneurysm. Whether or not the events of dissection then obliterate the evidence for dissection -- evidence for aneurysm I don't know. I'm not a vascular

pathologist. I suppose it's possible you could have a small aneurysm and dissection which you wouldn't be able to see anything In this case we know there was dissection.

Q Do we have any evidence of an aneurysm?

A I don't know that I'd have to read the autopsy again. I don't know if they mention aneurysm.

Q If we had -- have an aneurysm that developed before the dissection does that aneurysm indicate to you one way or the other whether this was due to chronic uncontrolled hypertension or an acute event of uncontrolled hypertension?

A I would say whether there was an aneurysm or not it would be the disease process, the aneurysm and the dissection or just the dissection alone would be related to the chronic hypertension.

Q Do you know what the sensitivity is for a TE in picking up a thoracic dissection?

A It's my understanding that sensitivity and specificity are quite high if done by an experienced cardiologist Quite high would I believe be over 90 percent And in some standards it's a little bit tighter than a CT of the chest, but that's not true everywhere So either test is acceptable.

Q Do you what the sensitivity and specificity --

A They're very close -- of the CT, they're very close, yes Nothing is a hundred percent.

Q Do you know what time Mrs Monroe died?

A No, I don't Have to go back and look that up

Q Do you know whether they were capable at St Joseph's to do this type of operation that would have to be done?

A No, I have to look that up. I have no idea.

Q If the diagnosis would have been made do you agree with me that it would have been an emergency --

A Sure.

Q -- to take the patient to surgery?

A My answer is I don't know. And the reason I'm answering that that way is there are -- there are some types of dissections in which initial medical management is indicated, and therefore, I would defer the answer to that question to a thoracic surgeon.

Q And you're not going to give any opinions about the surgical outcomes?

A Right.

Q The risks, benefits, the morbidity, mortality?

A Exactly correct

Q Do you know -- we agree in general that a patient with -- a morbidly obese patient has a decreased life expectancy?

A I think that that's true.

Q And a patient with hypertension has a decreased life expectancy?

A I think that's true. I know it's true for untreated. I'm not sure if it's always true for treated. But it -- it's a disease with a lot of complications. It would be very hard to believe that even treated hypertensive patients would live as long as people who never have hypertension.

Q And what about people with vascular disease in general, do they have a decreased life expectancy?

A It depends on what vascular disease they have. Some do, some don't.

Q Aortic disease?

A They would in general have a decreased life expectancy

Q Doctor, I'm going to ask you to take a look at the chest x-ray, tell me what you think You look at chest x-rays?

A I certainly do.

Q And as part of your daily ER care when a radiologist isn't available?

A Even if they are available.
Q Do we have any viewboxes,?
A We don't.
Q Can you look at them in the florescent light?
A I can do this.
Q Doctor, what -- again, Doctor, we are here in your office. You don't have a viewbox?
A Correct.
Q And this is the first time you've looked at the chest x-rays done --
A I believe so.
Q -- of Deborah Monroe?
A Yes, sir.
Q Tell us what do you see in the area -- you're looking at the PA or AP chest x-ray?
A It appears to be a PA chest.
Q Okay.
A Yeah, and my answer to what it looks like, it looks pretty normal to me.
Q Okay. Now you have what is the lateral chest x-ray?
A Correct, and same feeling, it looks pretty normal to me.
Q And just for completeness sake, these are the abdominal x-rays taken on Mrs. Monroe.

A I see nothing abnormal.
Q Would you expect that Mrs. Monroe's pain would improve while she was in the emergency room while under the care of Dr. Maxfield?
A There is no expectation on the pain course in patients like this. And I need to preface my answer by saying knowing that she had a dissection there is no expectation on the pain course. It is common for pain to be persistent, unremitting and minimally responsive to narcotic medication. It is common for the patient to be intermittent as the dissection progresses a centimeter and progresses and then stops again so you can't use the pain course as a marker for presence or absence of aneurysmal disease or dissection disease.
Q If we can turn to the St. Joseph's records for a moment.
A All right.
Q The dictation, yes. Dr. Maxfield indicates, "That patient complains of sudden diffuse lower back pain, onset three hours prior to arrival. There had been no radiation of pain. There's been no tingling. There's been no numbness. There had been no weakness." Just taking those statements

there, assuming that Dr. Maxfield took this history accurately, would that indicate to him that the patient should be evaluated for a thoracic dissection?

A No.

Q He goes on to say, "The symptoms are aggravated by movement." Is that consistent or inconsistent with a thoracic dissection?

A I don't think I know the answer to that. There's not very much data on how patients answer that question.

Q Okay. "There has been no abdominal pain. Patient without any recent history of trauma. There has been no chest pain." Does that go -- does -- is that consistent or inconsistent with a thoracic dissection?

A Up to that point that's inconsistent with it.

Q It goes on to say that the condition has remained unchanged since it's onset. So, does that indicate to you that the patient is telling him one thing, yet the information he had received from Dr. Shah is different?

A I think that would be the most likely explanation; is that he has two different sets of information.

Q All right. Do you agree that his -- that his

physical examination was within the standard of care?

A Yes, I have no problem with that.

Q Was it within the standard of care to give the patient some pain medication?

A Sure.

Q Do you see his differential diagnosis down there?

A Yes.

Q And does it -- his differential diagnosis does that meet the standard of care?

A I don't think there is a standard for writing down a differential, so whatever you write down would probably be the same answer.

Q And do you see that he includes this aortic problem unlikely on the basis of history?

A Yes, I see he says that.

Q Going to the patient's labs, anything in the labs that raise a flag to you? Actually I think there's a printed out sheet. Keep going.

A Oh, great. Thank you. I'll just scroll through it here for a second. I would say nothing.

Q Going to urinalysis. There seems to be a large amount of blood in the urine. Is that consistent or inconsistent with a dissection?

A This is a female 39, she could be having a period.

I don't know. I don't know what it is.

Q If she was not having a period would that be consistent or inconsistent with the disse'ction?

A It would -- in the thoracic aorta it would be inconsistent with that. But .then again it would be consistent with other disease processes which were not addressed. in the narrative.

Q Such as?

A The narrative didn't say. It said kidney stones unlikely based on the history and the CT, but that is just a stone. There might be urological disease causing blood in the urine in the absence of a period. And so, with this blood in the urine which was read as large, you would still want to know what's wrong with the urinary tract and the way you would deal with that would be a referral to a urologist or back to the primary care physician and document that in the record. In addition you'd probably do a urine culture which I don't think was done. None of which is going to be relevant to the outcome of this case, but it -- I mean now there's another issue of data which was not addressed. The first data not addressed is the information from Dr. Shah. The second data not addressed is the large amount of blood in the

urine.

Q Do you see that Dr. Maxfield told the patient to return to her family practice physician within three to four days?

A Yes, but it should be for a specific reason in this case. I mean that's a fine generic note. I have no problem with that, but if it should be there should be another sentence to show the blood -- to see if you still have blood in your urine, so that the primary care physician when he gets the record knows that there is this issue that you have to look at. And since we're bringing it up in talking about this issue, the way you solve the problem and not get the patient to worry about all this is to do a catheterized urine specimen and check it for blood and which wasn't done

Q Any other opinions in regard to the standard of care that we haven't already discussed?

A No, that's it

Q Your fees for reviewing cases?

A $300 an hour for review, $400 an hour for trial and deposition.

Q Number of hours in this case?

A Boy, I don't know, but I can come up with some -- I think I sent two hours of bills so far now th t

I remember, so $600.

Q How many cases do you review on the average per year?

A Oh, go through the whole answer there. I have in twenty-five years looked at 800 files. Those files, some of them, in the range of fifty, would have been for insurance carriers and not for specific attorneys. Eighty percent of the work is defense, twenty percent is plaintiff. And in the last two years I probably have gotten somewhere between 30 and 35 cases.

Q How many depositions this year, 2002?

A I think this is my fourth. Well, I'm sorry. It's probably my sixth or seventh.

Q When was the last time you appeared at trial?

A Couple of months ago in -- somewhere in Detroit. I think Wayne County, yes, court, courthouse.

Q Did you appear for the plaintiff or the defendant?

A That was defendant.

Q Doctor, I don't have any further questions. I would ask you to see if you can -- what information you can find on any cases you reviewed from your computer system on aorta. Supply me with whatever information you have available for that. Okay?

A Sure will.

MS. TAYLOR-KOLIS,: I have a couple of questions I want to ask on redirect. I don't usually do that, but once in a while I do especially if defense counsel asks questions that don't lend themselves to refreshing your recollection that there are other things that you reviewed.

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REDIRECT EXAMINATION

BY MS. TAYLOR-KOLIS:

Q Doctor, can you identify what I'm handing you?

A This is the emergency nurse's notes for this patient in the emergency department.

Q All right. And those notes generated do they contain information which was history taken by the patient to the best of you're ability to recognize the same?

A Sure. This would be what the nurses recorded as what the patient told them.

Q Customarily in your emergency room does the nurse see the patient before you do?

A Almost all the time. Not every time, but most the time.

Q All right. In those notes what does the nurse

indicate that the patient's chief complaint is?

A Under chef complaint it says transfer from another area. It's Dr. Shah's urgent care area. With back pain and then the nurse goes on to say subjectively the patient states sudden onset of mid back pain, a throbbing pain.

Q Okay. Is the information contained in the nurse's notes something else that Dr. Shah -- Dr. Maxfield needed to take into consideration in doing a workup for the patient?

A I think, yes. I think the standard of care is to look at the nurse's notes and the standard of care is not necessarily to -- is not to -- let me rephrase that. I'm going to -- the standard of care is to do your own history and physical, but you also look at the nurse's notes.

Q And additionally, Doctor, handing you this document. Just identify what it is?

A This is an E.M.S. report and it's for Deb Monroe and it was looks like 16, July, '99, chief complaint is upper back pain and then they also refers to standing in the doctor's office complaining of an upper back pain, which the doctor's office I believe refers to the urgent care center. There is pain on palpation of the

upper back.

Q Okay. Do you -- if they're available, yourself do a reading of the emergency room reports when patients are transported, the run report?

A The run reports? Occasionally, but I will have to say I do not believe it is the standard of care that you read an E.M.S. report. There's a good reason for that; they're not available on a regular basis, timely basis.

Q Mr. Ockerman asked you a question about the ED, the emergency department, Doctor, dictation that was generated by Dr. Maxfield indicating the date of dictation was the date of the visit.

A Right.

Q Doctor, based upon your experience and training and your familiarity with hospitals can you tell us what your best opinion is to what kind of ED document that is?

MR. OCKERMAN: Objection.

A Well, it is an -- it is a dictation, but it's a dictation that's not done in, I guess what I call, free'speech in which you speak into a Dictophone. It is dictation that is an assisted one either by a voice activated dictation or a template system in which the computer adds phrases and words to it

based on a key word the physician adds.

Q Is it possible, to the best of your ability to know, for a person to enter back into the computer and change a date or words?

MR. OCKERMAN: Objection.

A Sure it is possible to do that. I believe there is an end point where you -- it finally goes away and it becomes a permanent part of the medical record, but up until that time I think it's possible to -- certainly is possible to change and edit because that's how the computer works.

MS. TAYLOR-KOLIS: Thank you. You've anything else?

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RECROSS EXAMINATION

BY MR. OCKERMAN:

Q Doctor, do you work with these template dictation systems?

A I do not. Now, wait, let me be very honest about that. As you know I'm changing jobs here. I never worked with a template system at the Toledo Hospital. At the North Oakland Medical Center they had what's called a T-Chart which is a handwritten check-off type of chart. I cannot tell you what systems they are using at Mercy

Monroe right now. I don't know.

Q Let's go to the history. The history -- what is it that you're saying? Are you going to offer testimony that some of the words in the history were entered by the computer; and if you are, which ones?

A Well, I'll answer the second question first. I could not do that in the history without looking at the computer system. But I can give you the evidence for this being a computerized system. Midway through the first page it says the history of present illness, review of symptoms and past and social history are complete to the best the patient or the patient's representative was capable of reporting, et cetera, et cetera. That is stilted computer lingo that has to do with billing and it's going to be found on every single record in this -- in this system.

There's another piece there -- give me a moment and I'll find -- there is a piece in the history, which is classic for a computerized entry system, but I can't say with a hundred percent certainty, I can tell you it's probably 95 percent on the systems are aggravated by, on the third line it says, "colon movement". The way we

normally speak in to Dictophones is not to say -- it would be to say, quote, the symptoms are aggravated by my movement or not relieved by being still You couldn't say these symptoms are not relieved by being still But that is a classic finding in the computerized system.

Q Is it below the standard of care to use these templates?

A Absolutely not.

Q Did you find any information within this dictation by Dr. Maxfield to be inaccurate?

A I would say in a positive sense probably no. In the next sense I would normally, if you get a patient that is transferred from another physician, you write down that doctor so and so sent me this patient because he was concerned about, for instance, a problem with aorta now because the history was A, B, C, D, E and then you go on with your own. That isn't here. So, I guess in terms of leaving that out I find that surprising.

Q Did the standard of care require Dr. Maxfield to put that in there?

A Let me just cogitate about that for a moment because that's a very interesting question The

answer to that is I do not know because that would be a consensus and in order for me to be honest about standard I have to go and ask a lot of colleagues about that. But one week from now I bet I have the answer.

Q But as you sit here today you can't say that?

A I don't think I could say that honestly. I would have to ask. I think it is the standard, but I'm not going to make a statement that it is.

MR. OCKERMAN: I don't have any further questions.

Q Have I given you a fair opportunity to answer all my questions?

A You certainly have.

Q Thank you.

MS. TAYLOR-KOLIS: We'll read.

(Deposition concluded at 9:54 a.m.)

BRUCE D. JANIAK, M.D.

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C E R T I F I C A T E

STATE OF OHIO)
) SS.
COUNTY OF LUCAS)

I, Julie K. Latham, Registered Merit Reporter and Notary Public in and for the State of Ohio, duly commissioned and qualified, do hereby certify that BRUCE D. JANIAK, M.D. was by me first duly sworn; that the testimony then given was by me reduced to stenotype, afterwards transcribed upon a computer; that the foregoing is a true and correct transcript of the testimony so given as aforesaid; 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, employee, or attorney of any of the parties or counsel employed by the parties hereto or financially interested in this action, nor am I or the court reporting firm with which I am affiliated under a contract as defined in Civil Rule 28(D).

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my notarial seal of office at Toledo, Ohio, this 13th day of September, 2002.

Julie K. Latham

JULIE K. LATHAM, RMR
Notary Public in and for the
State of Ohio

My Commission expires February 3, 2004.