STATE OF OHIO)
) SS.
COUNTY OF MONTGOMERY)

COURT OF COMMON PLEAS

WILLIE E. WEAVER, Administratrix of Estate of JESSE B. WEAVER, Deceased,

Plaintiff,

vs.

GRANDVIEW HOSPITAL & MEDICAL CENTER, et al.,

Defendants.

Case No. 88-3453

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Deposition of BRUCE DAVID 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, Jane Beckett, a Notary Public in and for the State of Ohio, pursuant to Notice and agreement of Counsel as hereinafter set forth, at the Toledo Hospital, Toledo, Ohio, on Monday, September 18, 1989, commencing at 2 o'clock p.m.

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APPEARANCES:

On behalf of the Plaintiff:

ROGER B. TURRELL & ASSOCIATES:
Valerie Stocklin
James D. Cole

On behalf of Defendant TMES, Inc. & Dr. Myers:

Robert F. Cowdrey

On behalf of Defendant Dr. Rank:

BIESER, GREER & LANDIS:
Howard P. Krisher

On behalf of Defendant Dr. Keighley:

MILLER, FINNEY & CLARK:
Jerome G. Menz

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BRUCE DAVID JANIAK, M.D.,

a Witness herein, after having been first duly sworn, was deposed and testified as follows:

MS. STOCKLIN: Dr. Janiak, we have met before.

THE WITNESS: Yes, ma'am.

MS. STOCKLIN: My name is Valerie Stocklin. I'm here on behalf of the Jesse B. Weaver family on this case. We're meeting her pursuant to the Ohio Civil Rules of

Procedure as well as agreement of Counsel with your convenience, and Notice.

Can we stipulate to the qualifications of the Court Reporter?

MR. COWDREY: Certainly.

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CROSS EXAMINATION

BY MS. STOCKLIN:

Q. Would you, Doctor, please state your full name and address?

A. Bruce David Janiak. Home address is 30267 Hickory Hill Drive, Perrysburg, Ohio, 43551. Do you want the professional hospital address too?

Q. Yes, please.

A. It's the Toledo Hospital, 2142 North Cove, C-o-v-e Boulevard, 43606.

Q. Thank you.

MS. STOCKLIN: Would you mark this, please?

(Plaintiff's Deposition Exhibit No.

1 was marked by the Court Reporter for purposes of identification.)

Q. Dr. Janiak, I was previously supplied by Mr. Cowdrey, or by you I believe, a copy of your curriculum vitae. I've had that marked as Exhibit 1 in this deposition, and I wondered if you would tell me if that is your most recent up-to-date curriculum vitae, please?

A. Yes, but I need to make another one because there are two additional items that have happened since this was -- since we printed this one.

Q. And are those items personal or professional?

A. They are professional. One is an award and one is a new position.

Q. Would you like to tell me about those?

A. The award is the Wiegenstein Award which is given by the American College of Emergency Physicians. I received that just last week in Washington. And the position is the position of President-elect of the American

Board of Emergency Medicine.

Q. So then you will be President of that Board for one year starting from now?

A. For one year starting in June of '90.

Q. Any other additions or changes?

A. No, I think that's it.

Q. All right, Doctor, we have had an opportunity before to discuss your -- you can hold onto this if you need it to refer to anything -- we have discussed before your education and training in the field of medicine, and specifically emergency medicine. So I don't want to go into a whole lot of detail about that, but I would like to ask you a couple of specific questions.

My understanding is, Doctor, that you have been the Director of the Department of Emergency Medicine here at Toledo Hospital since 1974; is that correct?

A. That is correct.

Q. And you completed your training in -- or

your residency in emergency medicine in 1972; is that correct?

A. That is also correct.

Q. And in between those two dates, you were in the Navy?

A. That's right.

Q. And what did you do in the Navy?

A. I was Director of the Naval Hospital Emergency Department in Pensacola, Florida Naval Hospital.

Q. It's my understanding, Dr. Janiak, that your specialty training in medicine and education is limited to the specialty of emergency medicine; is that correct?

A. That's right.

Q. You have not had any specific training in any other areas of medicine?

A. That's correct.

Q. Doctor, directing you to your last page of your curriculum vitae, under miscellaneous, you are listed as the President of EMB Professionals, Inc.?

A. Correct.

Q. Is that the case today?
A. Yes, it is.
Q. All right, so that's a current thing?
A. Yes.
Q. What is EMB Professionals, Inc.?
A. It's a billing company which specializes in billing for emergency medicine physicians.
Q. And that is a corporation?
A. Right.
Q. And am I correct in my understanding that there are three shareholders or owners of that corporation?
A. You are correct.
Q. And that's yourself and Dr. Michael Irvin?
A. Right.
Q. And a Marty Gillespie?
A. That's right.
Q. And you are the President of that. Does that corporation enter into contracts with various hospitals or emergency groups, or tell me how that works?
A. Well, normally we enter into a contract with an emergency group, although we could

enter into a contract with a hospital also to do the billing. Currently all our contracts are with the group of emergency physicians at particular hospitals.

Q. So this would be a group outside of your emergency group, a completely different group, and you enter into a contract to handle their billing for them?

A. That's correct, although my emergency group is also one of the groups that has a contract to have the billing done by this company.

Q. Are the three shareholders of this corporation, Dr. Janiak, equal shareholders?

A. No.

Q. Are you the majority shareholder?

A. No, Dr. Irvin and I are 40 percent, and Mrs. Gillespie is 20 percent.

Q. As President and one of the major shareholders of that corporation, Dr. Janiak, what are your duties? What do you do?

A. Well, our basic duty has been to look for new business by utilizing our contacts. By our, I mean Dr. Irvin's and my contacts throughout the State of Ohio and in other states.

We also obviously are responsible for making sure that the business is run appropriately, that the decisions are made regarding growth or no growth, advertising or no advertising, typical business kind of decisions that would be made. Currently for instance we're deciding whether or not we should purchase a new computer system. So those are the kinds of duties that we would have as officers and shareholders.

Q. Is there a home office for this corporation?

A. Yes.

Q. Is that in Dayton, Ohio?

A. Yes, ma'am.

Q. How much traveling if any, Doctor, do you do to Dayton, Ohio in regard to this particular corporation or business?

A. Well, it varies with the amount of need we see to meet. The first six months of this year I went to Dayton once. The last two months I've been there three times. So each time would be spending a day of work.

Q. And how does your corporation charge an emergency group for this service? Is it a flat yearly rate or a percentage of billing or what?

A. It's either percentage or per chart charge. So it's either based on a percentage of billed or based on the volume that a patient is seen by the emergency physicians and whichever method is more comfortable for our clients, we'll bill them that way.

Q. All right. Does this corporation, EMB Professionals, Inc., have any other function other than billing services for emergency groups?

A. No.

Q. How much time, Dr. Janiak, would you say you devote to this particular corporation or business endeavor?

A. Well, so far this year it's been four days, plus I would say six phone calls of less than 10 minutes each so far this year.
Q. All right, so there are not any weekly or monthly duties or functions that you serve?
A. No, there are not.
Q. All right. Now, you are also -- correct me if I am wrong, okay, but my understanding is that you are also the sole owner and shareholder of Professional Emergency Services, Inc.?
A. Correct.
Q. And this is your corporation which provides the emergency services for this particular hospital, Toledo Hospital?
A. Correct.
Q. Was that corporation formed, Doctor, when you became the Director of Emergency Services here?
A. Yes.
Q. And do you still employ six full-time emergency physicians?
A. In addition to myself, yes.

Q. And also some part-time physicians?
A. Correct.
Q. Are those all pediatricians?
A. No. We've added approximately four to five more emergency physicians in addition to the pediatricians.
Q. On a part-time basis?
A. On a part-time basis.
Q. All these physicians then are employees, direct employees of the Professional Emergency Services, Inc.?
A. Right.
Q. And how are your full-time emergency --
A. Well, let me correct that. That is not exactly correct. There are a couple of them who wish to be dealt with as independent contractors rather than employees, and so obviously they would receive their checks without the usual withholding taken out.
Q. And then they're compensated on a per day or per hour basis?
A. Per hour basis.

Q. All right, how about the other full-time physicians who are employees of this corporation, how are they compensated?
A. They are all compensated on an hourly basis.
Q. Do these physicians have a set number of hours that they work in the emergency room here at Toledo Hospital per week?
A. Yes. There is a basic schedule which is made out months in advance and they are asked to adhere to that schedule. Obviously there are things in life that make you change a schedule and they can switch whenever they so desire.
Q. All right, how many hours per week is each full-time physician allotted in the emergency room?
A. Well, they work 64 hours every 14 days, basic work. So that is 32 hours a week, and then they fill in for each other when there are vacations or meeting time or whatever else may be necessary, and that amount I've never calculated, but it

probably is somewhere between eight and ten extra hours in a week. But exactly what it is, I don't know.

Q. And how about your part-time emergency physicians?

A. They are asked to work on a variable basis between 6 o'clock in the evening and midnight, and we've been doing that now only for a month and most of them would be working certainly less than full time pro rated schedule, but probably around 12 hours a month per doctor or something like that.

Q. Is there 24-hour emergency physician coverage in this emergency room?

A. Yes, there is.

Q. All supplied by this corporation?

A. That's correct.

Q. You also operate as an emergency physician on a weekly or regular basis throughout this emergency room, correct?

A. Correct.

Q. And are you also, Doctor, scheduled for 64

hours every 14 days?

A. No, I am not.

Q. What are you scheduled?

A. I'm not scheduled except on Tuesday mornings. I have always worked Tuesday mornings from 8 a.m. till noon. So what I do is I work whenever we need backup and I work whenever someone has a shift that needs to be filled in.

Q. So other than the Tuesday morning, your schedule is erratic or unpredictable?

A. Very erratic. Totally unpredictable. For instance, I had no idea I'd be here most of the day this last Saturday, but I was so --

Q. What did the weeks of August of this year, Doctor, average for you as to hours in this emergency room?

A. I have that written down. It was pretty close to 26 hours a week I think actually in the department seeing patients on my own.

Q. During the month of August?

A. During the month of August.

Q. Would you say the month of August was typical, busy or less than usually busy for you personally?
A. For me personally, it was pretty typical for the way things have been now in this department.
Q. Doctor, is there any teaching involved with your practice here at Toledo Hospital?
A. Almost every day.
Q. All right, how is that done?
A. Well, each individual physician has residents with them when they're working so there's teaching that's done then, but at times when we're not working, we'll also do teaching either by lecturing or by just wandering over to the department and seeing patients with residents.

So that would be hours in addition to the 26 because there literally is never a day when I am here when I don't go over to the department and do that. So I'm always spending some time, I don't mark it down. But I would say that if you add that

up with the lectures and chart review and other clinically oriented things, you'll come out with another 20 hours.

Q. Are you scheduled for a certain number of hours of lecturing per week?

A. No, there is no -- some of my lectures take place here, so there's no schedule for that except for two sets of -- I usually give three sets of Grand Rounds a year, and that is not -- but it's not scheduled, it's an agreement to do that and what happens is the residency director will call and ask if I can give a Grand Rounds on a particular day, and I tell them whether I can or I can't.

But I wouldn't be able to tell you what day it's scheduled for next, for instance. I just don't know.

Q. So your teaching then I take it is not done on every Tuesday and Thursday afternoon from one to three basis?

A. That's right, you're exactly right, exactly right.

Q. Let's talk about the other 20 hours per week that you -- you said that that consisted of what?

A. Well, some of it is just speaking with residents. One of the things that has taken up some time recently is working with a resident about developing a fellowship, so we spent a lot of time working on that issue.

Others are just speaking with residents about clinical issues. Whenever I work, I review charts. And when I review the charts, I will find documentation that is not worded the way I would like it to, as nearly 100 percent of the time prompts a letter and a meeting with a resident, so I do that every time I work is come across a resident and say let's sit down and talk about this case, this issue, why did you write -- for instance, the last one was why did you write down gastritis on a patient that you gave Erythromycin to.

You don't give Erythromycin because

it irritates the stomach. So we have a discussion about that one minor clinical issue, and that happens -- I probably pick up three of those every time I work, something discussed with residents.

So there is that time, there is chart review, which is done on an informal basis whenever I'm in the building, and a formal basis with peer review forms in which we review on a more detailed level the care given by all of the attending physicians.

There is review of pediatricians' records and recently I've taken on the task of reviewing for clinical reasons the charts of all of the new part-time physicians in emergency medicine we talked about earlier.

Q. This is a probationary period or something to see how they're doing?

A. Right. And I'm responsible for making sure their clinical care is appropriate so I review all those too. So obviously all

this kind of review does take some time.

And then the other thing that happens is it's not particularly unusual for me to be sitting here reading those things, and then they'll call me to the department because it's busy and I'll see patients. And that's been happening as I said almost every day that I work. And why we're that busy right now, I'm not sure, but it's more likely than not that I'm over there seeing patients each day.

Q. Who is responsible for the administration and management of the activities of your emergency group, Professional Emergency Services, Inc.?

A. I am.

Q. You are?

A. Yes.

Q. How much time, Doctor, per week would you say that management and administration takes?

A. That's probably another 10 hours plus, 10, 15. It depends if it's routine financial

activities and all that is handled by my wife. All the bookkeeping, the check writing, making sure that we've paid our taxes and all the things that one has to do to keep it financially operating. I don't deal with that.

If it has to do with making a decision about a new benefit, then I would do that. If it has to do with making sure if one of the guys would ask me what the reimbursement rate is for a meeting, then I wouldn't answer that question.

So obviously most of the effort is not towards actually running Professional Emergency Services, but the administrative effort is towards interacting with the medical staff here at the hospital.

So as a representative of Professional Emergency Services, if there is a problem with patient care, either because we have alleged to have done something wrong or a problem that we have with a resident or a physician on another

service, then all those issues become issues that I have to handle on behalf of the group.

(Mr. Menz arrives at the deposition.)

A. To give you an idea of how much time it takes, all of our nurses were particularly unhappy with the behavioral characteristics of a particular resident from another service who was coming down to our department and being rather nasty to every single human being that he interacted with. So that would require interviewing the nurses, looking at all the records, discussing the issue with the Director of Medical Education for in this case the Surgery Department, discussing with the Director of Medical Education for Emergency Medicine and the Hospital's Director of Medical Education, and then making a decision about what to do next, whether that resident needed counseling or the resident was doing something inappropriate

clinically, because you have to check that.

And then finally it culminates in a letter where I indicate what our department's position is. In this particular case, our position was that that resident wasn't allowed in our department again, so in these kinds of things take -- that's where those 10 hours and sometimes 20, depending on which week it is, get eaten up.

Q. Doctor, what is the policy or is there a policy, or what do you do as far as coverage in the emergency room here? Do you always have one doctor covering more than one, does it depend on the time of day or what?

A. Right. There are two policies. Our contract says we have to have at least one physician present, however it's pretty easy to realize with a department as busy as ours that that wouldn't be adequate, so the contract also says that it's my job to be sure that the physician supply is adequate

to deliver reasonable patient care.

And so that means that we have to make decisions on looking at statistics which is another thing I have to do. What are the busiest shifts and when do we need coverage with two doctors, three doctors or four doctors. So currently we have five doctors in the evening on most evenings because evening times are busier than the middle of the day.

Q. You have five?

A. Yes.

Q. Are there times when you do just have one doctor covering?

A. No.

Q. Always at least two?

A. Always at least two unless there's an illness. There are always at least two scheduled.

Q. And how many beds in this emergency room?

A. Twenty-four.

Q. You do not have a care flight or a helicopter?

A. Not at this hospital.
Q. Does this hospital take charity or noninsured patients?
A. Anybody that comes in.
Q. Dr. Janiak, you're familiar I'm sure with JCAH accreditation for hospitals?
A. Actually JCAHO, since the last time --
Q. Right, it's new now, isn't it?
A. Yes. It's hard to get used to.
Q. And I'm sure Toledo Hospital is accredited by the JCAHO, am I correct?
A. You're right, right.
Q. What level does this hospital have accreditation for?
A. The problem I have with answering that question is that my mind doesn't ever register what the different levels are because there is the JCAHO and the American College of Surgeons and so many other groups that have levels, but we are the second level as far as trauma is concerned.
Q. Level II?
A. Level II, a trauma, for trauma. We're a

Level I for everything else.

Q. All right. So when you have to meet -- when your emergency room here has to meet the JCAHO standards, those would be the Level II standards set up for emergency rooms; is that right?

A. I'd have to review those again before I can answer your question completely. I just don't remember what all the standards were because of all these other organizations that have them. The only difference we have, and I don't mean to interrupt, but maybe I can answer it, the only difference between a Level I and what we have here is that we do not have surgical attending physicians in the building 24 hours a day.

We have every other specialist here and the anesthesiologist, the emergency physicians and all the other things you're supposed to have, but we don't have surgeons in the building 24 hours a day.

Q. So that's the only thing then that puts you at a Level II rather than the Level --

A. Right, right. Level I if that's what they call it, right.
Q. Now, when you say you don't have the surgical coverage 24 hours a day --
A. No, I said surgical attendings.
Q. Attendings, so you do have residents?
A. Oh, yes.
Q. Surgical residents, chief residents or third-year residents?
A. That's right.
Q. Well, am I correct, Doctor, that in these JCAHO accreditations for emergency rooms there are four separate levels, and each one of those levels dictates whatever standards have to be met by that particular emergency room; is that correct?
A. As far as I remember, I think you're right.
Q. Doctor, you list I believe eight publications on your curriculum vitae. It appears that they date from 1972 through one in 1987, am I right?
A. That is right.
Q. Are there any other publications of yours

that do not appear on this curriculum vitae?

A. No.

Q. Am I also correct, Doctor, that the majority of these publications deal with management in medicine rather than the clinical aspects of medicine?

A. You are right.

Q. And I believe there are two that deal with clinical aspects?

A. Right.

Q. Those being which ones?

A. Well, the one on, a case report on spontaneous rupture of the sigmoid colon, which was done primarily by Mark Spiro, the first author, at the time he was a resident, and I worked with him on that. And the last one, primarily by -- I was the last author, so obviously I had the least to do with it, but it was a study that we did on interpose abdominal compression and cardiopulmonary resuscitation and that was published in one of our journals a couple

years ago.

Q. Doctor, is there anything about either of those clinical publications that in your opinion has any relevance at all to the case we're here on today, the direct case?

A. No, not at all.

Q. Doctor, before we get into the specific facts of Jesse Weaver's hospitalization and eventual demise, I'd like to talk to you a little bit in generalities about what you see as the role of the emergency room physician in terms of patients brought in, unknown patient, no private physician on the picture brought in by emergency vehicle.

You're the emergency room physician and what do you see as your role when that patient is brought in?

A. Well, I think the role can be described in various ways, but certainly the job of the emergency physician is to perform an evaluation of the patient as expeditiously as possible based upon the patient's

complaint, determine if possible what potential life-threatening problems may be occurring and then intervene if possible in attempting to reverse those whatever life-threatening problems may be happening.

The secondary role would be to look at maybe less acute problems and make a determination as to whether or not the less acute problem can be handled on an inpatient or an outpatient basis. If an inpatient basis, then what kind of physician should that patient be referred to, for instance should it be a pediatrician or a surgeon.

And if on an outpatient basis, can a definitive treatment be made for that problem in the emergency department or must there be follow-up, and if so, how soon should that follow-up be.

Q. The follow-up on an outpatient basis?

A. Correct.

Q. Now, Doctor, when you said after the initial evaluation that's done as quickly

as possible on this patient it's important to determine if there are any life-threatening problems, and then intervene with those problems as quickly as you can.

A. Correct.

Q. Now when you say that, do you mean you as emergency physician intervening in those problems or calling for a specialist in whatever field you think is appropriate, or what do you mean by intervening?

A. Well, there are a couple of factors that make the definition of intervention change a little bit. One factor would be the acuteness of the problem. If this is a problem that is so life-threatening that the patient is indeed moribund on arrival, then basically any physical intervention or pharmacologic intervention that's appropriate should be done right then.

Q. By the emergency --

A. By the emergency physician. If the problem is either a determinate or seems to be not

quite as life-threatening, in other words not an immediate within seconds threat to life, then a decision has to be made whether or not there is anything that could be done to attempt to reverse the problem by the emergency physician, or if another decision may need to be made as to whether or not there is only one particular specialist who is qualified to attempt to reverse that problem.

There are some rather specific emergency problems which the definitive intervention is usually not done by the emergency physician.

Q. Like what?

A. An example of one of those would be an acute subdural hematoma. The patient has that injury to the head, is bleeding within the head, has a change in their behavior pattern that makes that fairly obvious and yet there is time to have a neurosurgeon come in and take the patient to the operating room and evacuate the blood clot.

It is normally not the job of the emergency physician to do that. However that same patient who may be dying right that second would be better to have the emergency physician try to cut a hole in the skull and release the blood than it would be to let the patient die. So that patient I guess describes both ends of that particular spectrum.

Q. So involved within the emergency physician's job when he's presented with this unknown patient is to determine how quickly something needs to be done, in other words, how crucial the situation is?

A. Right, that's right.

Q. Assume for a minute Doctor that you evaluate this patient, hypothetical patient that came in by emergency squad into your emergency room, and you determine that the appropriate specialist that you think needs to be called in is a surgeon, and you call in that surgeon and he's there within a few minutes. What does your role become at

that point?

A. The role of the emergency physician, once the surgeon is available -- or is present for instance a trauma case, is that is the end of the role for the emergency physician with the exception of the possibility of communicating some information. It's possible that the emergency physician forgot or didn't communicate some portion of the history, it would certainly be appropriate to go back and do that.

It's possible that a laboratory test ordered by the emergency physician would come back, the emergency physician would see that and say gee, that's very important, I want to go tell the surgeon. The emergency physician would do that.

As far as making any more treatment decisions for that patient or any physical interventions, that would strictly be in the hands of the surgeon or whoever else was called to take care of that patient.

Q. Would that include a surgical resident?

Assume it was a surgical resident that was called in-house rather than an attending surgeon?

A. Correct. That is a grayer zone. I think the emergency physician would have the responsibility if a surgical resident were taking care of the case to have a little more idea of what the surgical resident was doing. I'm not saying to intervene, to push the surgical resident aside, to demand that the surgical resident justify all activities, but the emergency physician would need to know a little bit more about how the case was going in a general way to determine whether or not the surgery resident needed some help or the surgery resident needed some information perhaps that the emergency physician could provide.

Q. All right. Let's assume then further, Doctor, that the specialist that was called in by you or the emergency physician was a surgery resident in the later years of his residency who was in telephone contact with

an attending surgeon. What does your role become then?

A. The role then would be one of almost complete absence from the case unless the nurses notified me that they noticed a gross and obvious malpractice.

Q. Otherwise it's the attending's job to direct the resident at that point?

A. That is correct.

Q. Even though he's not present in the hospital?

A. That is correct. But let me elaborate a little bit on the gross and obvious malpractice. For instance, a patient who is obviously in major trouble is being discharged to home by the surgery resident. It would be absolutely mandatory that the emergency physician say stop, you can't do this.

Q. But I take it what you're telling me is that it's not your position as the emergency department doctor to intervene if you don't particularly agree with what the

attending may be telling the surgical resident to do?

A. Well, no, that's not -- particularly agree is another kind of a gray way of putting it.

Q. Well, you said earlier blatant malpractice?

A. Right.

Q. And so what I'm doing is to make the next step and saying short of that, am I wrong in assuming you see your role as one of not really stepping in?

A. No, you are correct, not really stepping in.

Q. All right, Doctor, I'd like to talk a little bit about your experience personally in reviewing medical negligence cases.

A. Sure.

Q. How much experience have you had over the last 25 years while you have been here at Toledo Hospital?

A. Twenty-five?

Q. I beg your pardon, 15.

A. I was going to tell you that the first 10

years I didn't have any experience at all. I probably have reviewed in that time 50 cases I would say total. I've never counted them, but I would think that would come pretty close to that since that represents somewhere around what, seven a year, something like that, but I would also tell you that in the last year I've probably -- last two years I probably reviewed a little bit more than that. I would say I probably reviewed 15 in the last two years.

Q. Fifteen in two years or 15 per year?

A. No, 15 in 18 months would probably be pretty accurate. So probably going on a 20 -- 10 a year rate right now.

Q. Any reason for the increase?

A. I have no idea.

Q. Dr. Janiak, have you reviewed medical cases brought in medical negligence on behalf of patients?

A. Yes, I have.

Q. And how many of those 50 cases that you

have reviewed, Doctor, would you say were on behalf of patients?

A. I would say probably eight.

Q. And the rest were on behalf of emergency room physicians or hospitals?

A. Correct. Except for in that gamut of 50 there were two civil cases where I was just acting as a medical expert about extent of injuries and the possibility of receiving injuries and certain kinds of mechanics of injury.

Q. Without comment on standards of care?

A. That's correct.

Q. And, Doctor, how much of your time on a weekly basis in terms of hours would you say you spend on legal work?

MR. COWDREY: You mean work that we're talking about now, reviewing cases:

Q. Reviewing cases for litigation.

A. Oh, maybe two to three hours a week.

Q. Is that an average?

A. No, the average would be less than one, but

I'm speaking now just during this last busy time.

Q. During the last 18 months?

A. Right.

Q. And, Doctor, do you charge for these reviews?

A. Yes, I do.

Q. And what is your rate, hourly rate?

A. Two hundred dollars per hour.

Q. Is that the same amount, Doctor, that you charge for a deposition?

A. Yes, ma'am.

Q. Or trial testimony?

A. Yes, ma'am.

Q. Have you testified at a trial of any of these medical negligence cases?

A. Yes, I have.

Q. How many times?

A. I believe it was three.

Q. Any of those in Ohio?

A. Yes.

Q. Which counties?

A. One was in Defiance. Whether that's

Defiance County I can't tell you, I don't know what county that is.

The other one was in Florida and another one was in Green Bay, Wisconsin.

Q. I thought you said three times in Ohio trials?

A. Oh, I'm sorry, three trials.

Q. Three trials, one in Ohio?

A. Yes, I'm sorry, I didn't mean to confuse you there.

Q. So I assume then, Doctor, 50 some cases that you have had your deposition taken on a number of occasions?

A. I would say probably 15 total.

Q. Now am I correct, Doctor, in assuming that you were contacted on the Weaver case by Mr. Cowdrey?

A. That's right.

Q. You had previously reviewed a case or cases for the Jenks Cowdrey firm?

A. Yes.

Q. Now one of those cases is the Kim Sierra case; is that correct?

A. That's right, yes.
Q. How many other cases for the Jenks' firm besides the Kim Sierra case and the Jesse Weaver case?
A. I think there was one other.
Q. One other?
A. One other, but I don't remember the name of it right now.
Q. Did that case go to trial, the other one?
A. No, no.
Q. All right, were you contacted by letter or telephone by Mr. Cowdrey on the Weaver case?
A. I believe it was initially by telephone, and then asking me if I'd be interested in reviewing the case and then a follow-up letter.
Q. Now at the time you were contacted initially on the Weaver case, were you already obliging the Jenks' firm as an expert witness on the Sierra case?
A. I don't think so. I can tell you this, I think you and I have met before over the

Sierra case --

Q. Yes.

A. And at that time, I didn't know anything about this case, but the exact timing I don't know.

Q. At the time of the -- well, to pin this down, your deposition was taken in the Sierra case by me here in this same room on June 2nd of this year, 1989. Do you remember that?

A. I don't remember the date, I remember the deposition.

Q. That was June 2nd. Now at that time you had been contacted as I recall to review the Weaver case. Are you saying you had just agreed to review it and had not seen any of the records at that time?

A. I'm saying I don't remember, I just don't know.

Q. Doctor, when you first received a letter regarding the Weaver case, did you also receive some materials to review at that time?

A. Yes.
Q. What were they?
A. I received initially the records from Grandview Hospital and a copy of the Complaint. And then as time went on, and I can't tell you the timing, I received depositions of Dr. Radon, Dr. Myers, Dr. -- is it Keighley?
Q. Yes.
A. Dr. Rank, Dr. Fisher, Dr. Schaeffer. And that's all I've seen that I remember or know about.
Q. Well, I'm going to ask you about some other things and if you haven't seen them, just say so, that have come to -- or have happened in this case.

Have you ever seen any x-rays?

A. I have not.
Q. Have you ever seen an autopsy report?
A. Yes, I believe that was part of the initial medical record material, that I have seen an autopsy report.
Q. Have you ever seen any previous medical

records of Mr. Weaver? When I say previous, I mean previous to this Grandview incident on March 29th and 30th of '87?

A. I understand. I would have to look back and see whether I have looked at those records or not. I remember comments about previous health care problems, but I don't specifically remember seeing records, but I may have.

Q. You mentioned I believe six depositions that you had read; is that right?

A. That's right.

Q. There has also been a deposition of Mrs. Weaver. Have you read that?

A. I don't believe I have.

Q. There has also been a deposition of a Dr. Charles Johnson; have you read that?

A. No, ma'am.

Q. What was your understanding of the facts of this case, Dr. Janiak, prior to reviewing any of these materials?

A. That a patient was injured in an automobile accident and was brought into an emergency

department and was -- had a rather stormy, downhill course of deterioration which didn't respond to any interventions and died.

And a little bit of elaboration on that, it is apparent that they -- it seemed that the patient had chest injuries since the steering wheel had been damaged in the car, and that an emergency physician was involved initially. And the emergency physician contacted a surgeon and that a surgeon and surgical resident were involved in some way.

Q. How did you learn those facts prior to any review of the records?

A. Well, the answer I guess would require a total recall on my part and I don't remember that. But I --

Q. I mean, were those provided to you verbally by Mr. Cowdrey or in a letter or --

A. No, I think that was provided verbally in the outline of the case.

Q. Do you remember having any other facts

other than what you have recited to me?
A. No, I don't.
Q. Do you know Dr. Gordon Myers?
A. I do not.
Q. Or Dr. Keighley or Dr. Rank?
A. No.
Q. Do you know Dr. Donald Schaeffer?
A. No, I don't.
Q. Dr. Radon?
A. No.
Q. How about Dr. Charles Fisher?
A. No.
Q. Do you know of Dr. Fisher?
A. No.
Q. Now, Doctor, are you aware that the emergency group involved in the Weaver case is the same one that's involved in the Sierra case, the TMES, Thomas Moochey Emergency Group?
A. No.
Q. You were not aware of that?
A. No, I was not.
Q. Were you aware that Southview Hospital in

the Kimberly Sierra case is an affiliate hospital or satellite hospital of Grandview Hospital in this case?

A. No, I was not.

Q. Well, you do know that Dr. Bruce -- is it Bruce Rank? Dr. Bruce Rank is the same Defendant in the Sierra case and the Weaver case?

A. No, I didn't know that either.

Q. Did you then proceed, Dr. Janiak, to review the materials we've talked about?

A. Yes, I did.

Q. And I take it since we're all sitting here in Toledo today that you are prepared to offer opinions as to Mr. Weaver's treatment and care at the emergency room at Grandview Hospital; is that right?

A. That's correct.

Q. Are you also prepared to offer opinions at trial, Doctor, on Jesse Weaver's cause of death?

A. Yes.

Q. Have you been asked or are you prepared to

offer any opinions regarding the life expectancy of Jesse Weaver had he not expired on the 30th of March, 1987?

MR. COWDREY: Objection. Assumes that he would have an opinion concerning the fact that he would have survived that particular incident, but go ahead and answer, Doctor.

A. I have neither been asked nor do I intend to offer an opinion about his life expectancy.

Q. Well, we can eliminate one thing, right?

A. Hurray.

Q. Doctor, what are in the general sense the opinions that you are prepared to offer regarding the care of Jesse Weaver at Grandview emergency room on the 30th of March 1987?

A. In a general sense, they are that this gentleman suffered severe and irreversible injuries when he had his accident and that interventions would have been at best

prolonged his life by a space of hours, and that there is no relationship between the activities or action of the emergency physician and the patient's demise.

Q. Are you prepared to offer an opinion, Dr. Janiak, that the care received by Jesse B. Weaver on the evening of March 29th and the early morning hours of March 30th, 1987, met ordinary and reasonable standards of emergency care?

MR. COWDREY: Are we talking about Dr. Myers or what?

MS. STOCKLIN: Is that what I said?

MR. COWDREY: You said emergency care, but are you talking about -- you asked him a question as to --

MS. STOCKLIN: I'm talking about the totality of the care received by Dr. Myers, Dr. Keighley and Dr. Rank and any other medical personnel at Grandview emergency room during that time.

Q. Are you prepared to offer the opinion that all of that care met ordinary and reasonable standards of care?

MR. COWDREY: I'm going to -- let me object, Doctor. Dr. Janiak has been identified as an expert witness on behalf of Dr. Myers, his emergency room physician. He has not been asked to express any opinions as to Dr. Keighley or Dr. Rank, but go ahead and answer if you can, Doctor.

Q. If you need to break it down for me, feel free, Doctor.

A. Well, based on the depositions and the information in the emergency medical record, I'm prepared to state that Dr. Myers performed within the standard of care that I would expect. However, in retrospect, there certainly were many discussions about the timing of the intubation for this patient, and I want to point out that I would have differed from

Dr. Myers on the timing of the intubation, but that is a judgment call based on both the clinical and laboratory evidence.

So just to be very clear, I think he met the standards. I think if I were doing it, I would have intubated the patient a little sooner.

Q. Do you want to define a little for me?

A. Probably 30 to 60 minutes sooner.

Q. Is that the only difference, Doctor, that you see in the care that Dr. Myers provided and the care that you might have provided under the same circumstances?

A. That is a little bit hard to answer because since that did not happen, the approach would have been in my scenario a earlier intubation followed by repeat blood gases, and everything else I would have done would have depended on the results of those gases. And since this is hypothetical, we don't know what the results are.

Q. We only know what the results of the blood gases were after the intubation actually

took place?
A. That's right.
Q. About 12:50 or 1 a.m.?
A. Right.
MR. COWDREY: Objection. I think the record indicates 12:45 that there was an intubation, but go ahead.
Q. Is that your understanding, Doctor, that there was an intubation at 12:45?
A. I would have to look at the record again, I couldn't tell you.
Q. Here's a copy of the chart.
A. Well, according to the record it's timed at 12:45. It says several things. Patient's jaw clenched, Anectine given to facilitate intubation. So sometime right about that time it was attempted, but then there's a note at 12:50 that says endotracheal tube inserted by Dr. Keighley, so it would be fairly close to 12:50, recognizing that no emergency record is accurate to the minute.
Q. Doctor, just so -- because I've been having

some trouble with this myself, so I'm looking for a little help. Directing your attention to Page 20 of this record, which I believe are reports of portable chest x-rays, it appears that the third one on that page was a portable chest x-ray taken at 12:50.

A. All right, say that again, please?

Q. It appears that the third report down on that page is a report of a portable chest done at 12:50?

A. Right.

Q. And is it fair, Doctor, that an endotrach. tube would show up on this x-ray probably? See, I'm trying to narrow down this time and it looks to me like what we can probably deal with here is somewhere between 12:50 and 1 a.m. he was probably intubated, because had it been at 12:50 or before, we would have seen a tube there, wouldn't we?

MR. COWDREY: Objection. Go ahead and answer.

A. Well, making an assumption that the time is accurate to the minute, and the patient was intubated -- well, first of all it's impossible to take a chest x-ray and intubate a patient simultaneously.

Q. All right.

A. If the tube had gone in just seconds before the chest x-ray was taken, yes, you would see it and the standard of care in radiology is to comment on that. If the tube had gone in seconds after the x-ray was taken, then essentially the patient would be intubated before the x-ray was available, or even developed.

So I wish I could help you exactly and we are frustrated by this in all records, and until we get giant computers that record every movement of every person, we'll never be able to time everything to the second.

Q. Well, let's go back to your opinions, Doctor. Let me encapsulate where we are at this point, if I may. You correct me

please if I'm wrong. It's your opinion that Jesse Weaver suffered injuries that were destined to cause his demise at the time of his automobile accident; is that correct?

A. That is correct.

Q. And it's also your opinion if I understand you correctly that no medical intervention would have changed that projection?

A. Yes, that is my opinion.

Q. All right. Well, let's talk about what those injuries were in your opinion, Doctor?

A. Okay.

Q. What were they?

A. Oh, all right. I think the patient had injuries to two major structures within his chest, his heart and his lungs.

Q. What kind of injuries?

A. I think they were contusions to both of those organs or bruises.

Q. All right, Doctor, are bruises to the heart and/or the lungs fatal injuries?

A. No, like any bruises it depends on the extent.
Q. All right, so they may be fatal, they may not?
A. That's correct.
Q. In your opinion, the contusions to Mr. Weaver's heart and lungs were so severe as to be fatal no matter what the intervention?
A. Right.
Q. On what do you base that opinion, Doctor?
A. Well, on seeing a number of patients that have come in able to speak, able to walk, able to move. Perhaps somewhat uncooperative as this patient was who unfortunately had a very precipitous downhill course over a very short time period, that is a couple of hours, and could not be resuscitated regardless of the timing of the intubation or any further therapeutic measures that were taken on.

The main thing in this case is the progression, the rapid progression of his

problem. If a patient has an accident and within a couple of hours is in serious trouble, as this patient was, then chances of resuscitating that patient are very, very low and as a matter of fact, the major factor that would apply to survivability would probably be age.

This patient -- if this patient had been 18, I might think there would be a chance of surviving. I'm not sure what the chance would be. But at age 47 with a history of some heart disease, not terrible heart disease but some heart disease, these patients just don't make it. They just expire within a few hours no matter how much intervention there is from this kind of injury because this is not a surgically correctable injury that I'm describing.

It's one that is on a cellular level, and the cells are so damaged that they can't exchange oxygen. The heart cells are damaged so much so that the heart doesn't pump appropriately, so not only do

you have a poor oxygen exchange from the lung tissues, but you have a compromised ability of the heart to pump blood through the lungs and everywhere else in the system, and so you have an almost a -- well, it is an irreversible course which is apparent fairly early in the problem.

I have seen these patients very aggressively treated with paralyzation and intubation within oh, 15, 20 minutes to a half hour of their arrival placed on aggressive positive pressure ventilation with oxygen levels that get worse and worse and worse and worse and within a few hours they die.

So I'm saying it's more likely than not that's what this patient had.

Q. So I guess then, Doctor, the answer to my question to the basis for your opinion goes to your experience with trauma patients; is that correct?

A. Right.

Q. Does it go to anything in particular in

these records or this chart that you can point to as the basis of your opinion that this man died from pulmonary and myocardial contusions?

A. Well, certainly you have to ask yourself what else might it be that killed this patient. Maybe I'm totally wrong, I would say to myself, and there must be something else that happened. Did the patient have a stroke? Well, no, there's no real evidence that he behaved as if he had a stroke and he didn't have paralysis on one side or the other, so that doesn't seem to be reasonable.

Did the patient have a ruptured aorta which can happen with this? Well, it doesn't seem like that because that's not what we see on the chest x-rays, we don't see evidence of a ruptured aorta so I don't think that would be the problem.

Did he have severe bleeding inside of his abdomen? No, we don't seem to see that he's bleeding to death anywhere, so

that is not what caused his demise.

So then we're left with maybe some other problem that occurred which is not related to the injury. Maybe the patient died because he took an overdose of medication, but we don't see anything in the chart consistent with that.

And as some of the Plaintiff's experts have stated, maybe the patient had a heart attack. But we did an autopsy on the heart and we don't see severe narrowing of the coronary artery. As a matter of fact, we see coronary arteries that are not all that bad for a patient of this age who is obese.

And so I would have -- if the Plaintiff's experts were to be right, I would have to speculate an incredibly weird coincidence in that this patient had this heart attack without narrowed coronary arteries that caused the accident or occurred as the accident was occurring, and when you smash yourself into a tree or a

stationary object and crush the steering wheel, any emergency physician who immediately looks for a pre-existing heart attack is committing malpractice. And it has to be pulmonary and cardiac contusion that are causing this problem.

Q. All right, Doctor, do you disagree that Mr. Weaver suffered ischemia to his heart?

A. No, he suffered -- I do not. He suffered ischemia to all the cells of his body.

Q. All right, do you disagree that Mr. Weaver suffered prolonged severe hypoxia?

A. No, I agree. He certainly did.

Q. Would you agree, Doctor, that severe profound hypoxia causes a heart to arrest?

A. I would agree that it would cause any living tissue to stop functioning normally, and that would include the heart.

Q. In your opinion, Doctor, was Mr. Weaver's hypoxia irreversible at all points in time during the two and a half hours prior to intubation and following, for that matter?

A. Yes. I can elaborate a little bit on that.

In my opinion, and I think I said it in another way before, it would have been reversible but only temporarily. The course of his illness would have continued his pulmonary contusion, would have continued to prevent adequate oxygenation, his myocardial contusion would have continued to prevent adequate pumping, and so you would have seen most likely had there been more aggressive airway intervention a temporary increase in the oxygen level in the blood, a temporary decrease in the carbon dioxide, a temporary increase in the pH which would be a trend towards normalization followed by a re-reversal of conditions and a worsening followed by an increase in the levels on the respiration machine that would give you an increase again, and this seesaw course would have continued over several hours and the patient would have died like all the ones I've seen.

Q. So, Doctor, you know, I'm having trouble

following you here so if you can help me out I'd appreciate it. When you get patients that have an automobile accident in which the steering wheel is crushed, is it your opinion that the probability is those patients are going to die?

A. No. Do you have to add that to the patient's clinical condition? For instance, if the steering wheel is crushed and the patient is feeling fine and has no reduction in blood gas problems, no low blood pressure, no test evidence that there's anything wrong, no, it's not my opinion that they'll die. They'll probably do fine, although I'd be quite surprised that they would.

What my opinion is is if you add the historical findings as are related by the rescue squad with the patient's age and his course over the first two hours in the emergency department, it is my opinion that those patients will not survive.

Q. Doctor, if you are presented with possible

-- with blunt chest trauma like we have here and possible pulmonary or myocardial contusion or both, how do you treat it?

A. There's only two major ways you can treat this problem. The first one is with drugs to control the blood pressure, if that is a problem, or the heart rhythm if that is a problem, depending on the complications of the myocardial contusion.

The problem with low oxygenation basically can only be controlled by forcing more oxygen into the lungs to get that oxygen to go across the membranes and into the blood. That can be done either with or without intubation, although we always intubate because the physics of doing it without intubation are quite tough.

You have to put the patient in a hyperbaric chamber to increase pressure that way. So you increase the pressure just to the lungs by putting a tube in.

The tube itself in this patient is going to do pretty much next to nothing.

Q. In this particular patient?
A. In patients like this, yes.
Q. So in your opinion intubating wouldn't have helped anyway?
MR. COWDREY: Objection, that's not what he said. Go ahead.
A. Well, that's one way of saying it. In my opinion, if anyone would have intubated this patient and only intubated the patient at the beginning of this case or at any point in between, there would be -- it doesn't change the clinical position.
Q. Then what else needed to be done?
A. Then the next step after intubation is to first make a determination, you always have to question yourself, I did this to the patient, was there a change. You make a determination by doing a clinical assessment and appropriate tests. In this case, blood gases are probably the appropriate test.
And my opinion is, had that been done, the blood gases would have still been

bad. The only next step is positive pressure on the lungs. It's a --

Q. PEEP?

A. -- PEEP is what you would use, and the exact level is titrated or adjusted based on the blood gas response. What I'm saying is, given the PEEP, the patient would have shown a temporary improvement followed by a progression of the damage to the lungs with a decrease in oxygen level, an increase in PEEP pressure with another improvement, and that seesaw would have continued to happen until the patient eventually had a maximum PEEP, complications of PEEP or cardiac arrest or both.

Q. Dr. Janiak, you indicated that earlier that the other things to do besides oxygenating a patient where you suspect a pulmonary or myocardial contusion is to treat the blood pressure if there is a problem and treat the heart rhythm situation if there is a problem?

A. If those are problems, that's correct.

Q. If there's problems, all right. When you said treat the blood pressure if there is a problem, are you talking about high or low or either?

A. Basically I'm talking about low, because in a patient like this it would be very unusual to have very high blood pressure. Although, if the blood pressure was quite high, and I didn't see that in this particular case, but if it was very high, then one would look for a ruptured aorta because those two things happen to go together.

The blood pressure that this patient had on arrival is not particularly high, so I would never treat it. I think that that would be inappropriate.

Q. All right. And assuming a patient where you suspected a pulmonary contusion with low blood pressure which you would consider a problem, how would you treat that?

A. Well, the first thing -- is this patient just presented to me as this brand new --

Q. Well, I'm asking you, when you said treat the blood pressure if it's a problem, now you've told me it would probably be low, that it would be a problem, I'm asking you how would you treat it?

A. Okay.

Q. Whether it's on presentation or any other time?

A. Well, if it's on presentation, the first thing I'd want to do is try and make a determination of why it was low because this is a hypothetical patient that you gave me, so I'd want to know if the patient was bleeding or had another reason for low blood pressure.

The hypothetical patient could be a 26-year-old lady who weighs 85 pounds who always has low blood pressure, and if you can find that out, then treating what she always has is not appropriate.

But those things aside, if it's a low blood pressure cause of a myocardial contusion and the low blood pressure is so

low that it's causing some circulatory problems, then one would have to add medication to increase the blood pressure and the choice of medication varies depending on the literature, but it's basically an alpha stimulating drug that causes an increase in the strength of the contraction of the heart and increases the vessel spasm in the arteries to cause a pressure increase and improve profusion.

So there's 40 different drugs that we use for that. The choice depends on the physician at the time.

Q. All right, assuming a heart rhythm problem. Are you talking about arrhythmias?

A. Yes.

Q. And what would the treatment be for that?

A. It depends on which rhythm problem it would be. If the rhythm problem would be a ventricular fibrillation, then treatment would be counter shock. If the rhythm problem would be multiple premature ventricular contractions, then the normal

treatment would be a drug like Lidocaine intravenously.

If the rhythm problem would be a very, very fast rate with very poor blood pressure, then once again you might shock that patient. If it was a moderately fast rate with a moderate problem, you might use a drug to try to convert the rhythm. So it depends on which rhythm abnormality as to which treatment you'd use, but I think the bottom line is you'd use either a drug or electricity in some way to control the heart rate.

Q. Did you find anything, Doctor, in your review of the autopsy report which in your opinion confirms pulmonary or myocardial contusion in this case?

A. Well, two things. One of the common findings of myocardial contusion is that there aren't any real significant findings in the heart. One of the common findings in pulmonary contusion is that the lungs look kind of purple and mottled and swoosh,

just like you would if somebody punched you real hard in the arm and you get black and blue.

So it tends to show up a little bit more in the lungs than it does in the heart, although there are all varying degrees of contusion with varying degrees of findings.

Q. Well, in your opinion, these contusions were severe; is that right?

A. Yes, that's correct.

Q. Would you expect to find confirmation on the autopsy of that?

A. I would expect to see something in the lungs, and we did, and I would not be surprised if you saw nothing in the heart and that's basically what was found.

Q. I guess it's a matter of semantics here, Doctor, and what I'm looking for is the difference between anything on the autopsy report which may be consistent with your opinion that there is pulmonary contusion and anything on the autopsy report which in

your opinion confirms it. Are you following me?

A. Yes. I think that the autopsy confirms pulmonary contusion and is consistent with myocardial contusion; is that what you --

Q. And let's look at this if we can, and I would like you to tell me which part of the autopsy report which I've just handed to you in your opinion confirms pulmonary contusion?

A. Well, there are certain parts of the lung examination, the right lung weighs a lot, there is a deeper mottled red purple color to various parts of the lung, but he doesn't describe exactly where that is.

There are petechial hemorrhages noted in the lungs. I guess that's about all that one can say about the consistency.

Q. And in your opinion, Doctor, that confirms pulmonary contusion to the exclusion of any other diagnosis; is that right?

A. Well, I guess I have to be careful about that. If this patient had, if these were

the same findings on a patient that had died from cancer or something, I wouldn't be able to tell you, but I have to put these findings together with the history. So maybe I would be more accurate to say that unless you put the whole picture together, there is never anything on any report that is consistent with anything, and we could take that to some ridiculous extent, but --

Q. Well, Doctor, is it fair to say that the petechial hemorrhages appearing in the lungs are consistent with and could confirm hypoxia?

A. Well, I think it's fair to say they're consistent with, but it would only be fair to say as we have just gone over with what I said that they don't confirm hypoxia in the same sense --

Q. In the same sense that they don't --

A. Right, and that's exactly the same sense.

Q. Doctor, I've handed you the chart and please feel free to refer to the nurses'

notes or anything in there that you would like to refer to during the next questions I have for you.

As you will recall, this patient presented to the emergency room at about 10:30 p.m. on a Sunday evening, and in case you didn't know, it was a Sunday evening.

A. I didn't know that.

Q. And according to Page 6 of this chart, and Dr. Myers I believe notes, he presented with a respiratory rate of 44 and a blood pressure of 220 over 140; is that correct?

A. Right, right.

Q. And you were aware of that?

A. Yes.

Q. All right. What else, Doctor, is your understanding as to this patient's presentation besides a respiratory rate of 44 and that particular blood pressure?

A. Well, there's a -- you mean, are you asking me to read the history and physical?

Q. Well, now I'm just asking you to tell me about your understanding of how this

patient presented to the hospital at about 10:30?

A. Well, he's indicated to be combative, so he was uncooperative and as near as I can put everything together was pacing about the floor, was not -- and appeared to be extremely anxious. He had some wheezes in his chest, he was sitting up on the cart and just absolutely would not sit still.

I did not remember a note about him complaining of specific pain in his extremities or other kinds of complaints that would relate to localized trauma.

Q. He did present however a complaint of breathing problems, shortness of breath, et cetera, right?

A. Absolutely, right.

Q. He also presented, I'm not sure if he said this, with a history of the motor vehicle accident, one-car motor vehicle accident in which apparently the steering wheel was crushed?

A. Right, I think that information came from

their rescue squad or life squad, whoever picked him up. I'm not sure whether the patient told him that or he found that out from the squad or the doctor, I don't --

Q. Now, Doctor, you're also aware that this was a fairly large in size 46 I believe year old black male, correct?

A. Yes, ma'am.

Q. All right. Let's then using that presentation as you have -- as we have talked about, and I would like you to tell me what you see as the pertinent evaluation on this particular patient that you would make and what treatment, if any, you would proceed with?

MR. COWDREY: Objection. You know, Dr. Janiak is here and he's indicated to you that what he would have done in this particular case may have been different than what Dr. Myers did and he has indicated to you that that's based upon clinical judgment, and he's already

testified that in his opinion Dr. Myers met the standard of care as he was presented with this patient.

Now with that objection noted, you can ask him the questions, but I just want you to realize, you know, that what he would have done is different.

A. Faced with a patient like this, I would have -- and recognizing that he was pacing or moving about, and I believe the patient had a cervical collar on, I would have asked him briefly, since he was able to talk, whether or not there was any area of his body that was causing him particular pain, for instance his neck or his back.

If he said no, I would probably spend a few seconds pushing on those areas just to see whether I had missed something really obvious, and probably in 30 seconds would have made a determination that there really wasn't any significant spinal injury or head injury that I was dealing with.

Following that, and at the same time I would expect that the nurses would be starting an IV on the patient and that they would be administering supplemental oxygen since he obviously was having trouble breathing.

I would have the patient -- I would not have the patient, would be in a trauma evaluation room and would have very frequent vital signs taken without me asking because that would be a policy.

The physical examination would then focus on the heart and lungs and so would the laboratory tests that I would order, which would include a chest x-ray and blood gases and electrocardiogram.

Q. Doctor, when you say since this patient was complaining of problems breathing, you would assume that your nurses would be oxygenating this patient?

A. That's right.

Q. How would you assume they would be oxygenating this patient?

A. They would apply nasal oxygen by cannula.
Q. How much?
A. Well, I would expect it would be no more than 5 liters and no less than 2 liters.
Q. Than what?
A. No less than 2 liters.
Q. What would be your purpose in ordering the arterial blood gases?
A. Well, the other thing I probably left out is to ask the patient whether he always breathes like this and whether or not that was his major discomfort. I'm assuming his answer would be no, I don't always breathe like this and my major problem is I can't breathe right.

So recognizing from the history that the patient had smashed into the steering wheel and recognizing that we are dealing with probably a 90 percent chance of pulmonary contusion, which is already within a space of I guess an hour from the accident causing respiratory distress that I would want to get some idea of how bad

the blood gases were.

Q. And why would you get an electrocardiogram?

A. Because of the history of the mechanism or injury as associated with a very high incidence of cardiac contusion also.

Q. And would this be a 12 lead electrocardiogram?

A. Right. The patient already would have been automatically placed on a monitor pattern to see what his rhythm was.

Q. Would you have placed this patient at this point on any medication?

MR. COWDREY: Objection. Go ahead and answer.

A. Okay. Well, assuming that oxygen is a medication, yes, but aside from oxygen, no.

Q. Would you wait to see what the ABG's said first?

A. Well, not just the ABG's, I want to look at the blood gases, the chest x-ray and the cardiogram, all three, and then repeat the vital signs.

Q. On initial presentation that we have been

talking about, Doctor, you have told me what your first steps would have been. Would you at that point see the necessity of calling in an attending?

A. I would know that I was going to call an attending when the patient arrived within let's say a half-hour, but I wouldn't know which attending. So I wouldn't make the call.

Q. And how would you determine which attending?

A. By reviewing the results of the three tests that I outlined, the blood gases, the cardiogram and the chest x-ray.

Q. And what would your choices of an attending be in your own mind prior to reviewing those results?

A. Thoracic surgeon would be one choice. General surgeon would be a person I would call on a patient like this in 100 percent of the instances, and depending on the diagnosis, a pulmonologist.

Q. Now wait a minute, I didn't follow your

last comment. You said a general surgeon would be the person you would call 100 percent of the time?

A. Yes.

Q. What, with this patient as we know he turned out or what?

A. No, with all seriously injured patients in accidents.

Q. So that's sort of an automatic reflex, you call a general surgeon?

A. Right.

Q. In your opinion, Doctor, is that a standard of care in a multiple trauma like this?

MR. COWDREY: Objection.

A. We do that at this hospital. I believe the American College of Surgeons suggests that. I don't believe personally it would be a deviation from the standard of care in this particular case to call a thoracic surgeon alone.

Q. And at what point, Doctor, in time in your opinion would an attending, whether a thoracic surgeon or a general surgeon have

to be called in order to meet the standard of care in this case?

MR. COWDREY: Objection, go ahead and answer.

A. Assuming and optimally speaking one could have the results of all of the tests that I outlined within 45 minutes, I know that sounds like a long time, but when you're taking care of these patients it does take a little while. After reviewing the chest x-ray I would make a decision at that point.

So if I had the --

Q. So that would be the --

A. Decision point.

Q. The definitive test, the chest x-ray or all three?

A. Well, all three because I would need some more information. But I'm assuming that all three would be back. Whatever time they were all back, it was 45 minutes or an hour, would be the time when I would be prepared to make a phone call about ongoing

care for a patient that presented like this.

Q. Would a failure to do that at that point in time or very soon thereafter, Doctor, in your opinion in this case deviate from an ordinary and reasonable standard of care for an emergency room doctor?

MR. COWDREY: Objection. You're asking him to look at the ABG's in this case and the chest x-rays, or are you talking about a general case?

Q. Do you understand the question, Doctor?

A. Yes, and I'm thinking what a good question it is because it certainly deserves an answer. And the reason that I'm thinking about it is that I'm trying to make sure my answer is right not for my emergency department but for the general emergency departments because we do things a little bit differently here from other places.

I think that I have an answer. The answer is that if the chest x-ray showed a

widened mediastinum, then any further delay in calling would have been a deviation from the standard because one needs to move quickly if surgical repair is possible for a ruptured aorta.

If you look at the chest x-ray and it was normal, then I think it would be perfectly reasonable to make decisions and on any further intervention that could be done by the emergency physician and take some more time to see if more rapid intervention would be reasonable.

The reason for that is that the interventions that can be done in the first instances are strictly surgical. The scalpel is going to have to do that. The interventions that can be done after that are not surgical, and so depending on the degree of experience and expertise of the emergency physician, it would be quite reasonable to say look at the film, decide it's not an aorta, decide that it is a contusion and go ahead with determining a,

how bad is this contusion, do I need to repeat any tests, and then b, if those tests confirm the initial impression or if the patient's clinical course deteriorated, then institute measures as we discussed before, the intubation with PEEP, whatever else might be necessary to control palpations as they develop.

Probably not as good as a yes or no answer, but I think --

Q. Not nearly. Doctor, let's look at the blood gas, the first blood gas in this case which I believe is 19A.

A. Thank you.

Q. Now, it indicates on Page 19A that that blood gas was requested at 10:35 and drawn at 10:40. So I think we're safe to assume that this was the first blood gas after arrival?

A. It sounds reasonable.

Q. Now you indicated that that was one of the first things you would have done, along with a chest x-ray and an EKG?

A. Right. Testing, I mean I was doing the physical evaluation first, but you're right.

Q. Right. All right, and let's assume this is what you would have gotten back from the lab.

A. Okay.

Q. Now how, Doctor, do you interpret or would you interpret that first blood gas in this set of circumstances?

A. Well, I would look at that and say this doesn't look too bad because his oxygen level is 60 and he is able to exchange carbon dioxide well because it's normal and so is the pH.

Then I would say, well, how much oxygen did I have the patient on, and the answer is 5 liters per minute. Did the patient keep it on all the time or was he pulling it off. Then I have to ask the nurses about that and say -- and basically say this isn't too bad. What we need to do here is to monitor this case closely

because the patient looks a little bit sicker, if any, than these show and try to decide exactly what is it that's going on.

And perhaps the way to do that is to do more blood gases, to repeat them to make further decisions.

Q. All right. And in this patient and based only on the circumstances we have at 10:40 with this patient, Doctor, how soon would you do another blood gas?

MR. COWDREY: Objection. You're assuming the blood gas result came back to Dr. Myers at 10:40? Are you asking him to assume that?

MS. STOCKLIN: I'm asking him to assume the results of this blood gas.

A. Okay, was it this patient or the hypothetical patient we're talking about?

Q. This patient.

A. This particular patient? The answer to that is how bad does the patient look in another 10 to 15 minutes. If they look

terrible in 15 minutes or like they're worsening, then that's when I do it. If they look like they're getting better, I would probably hold off a little while.

Q. Now, Doctor, in your opinion does the fact that this man was having a respiratory rate of 44, breathing 44 times a minute have any relevance to the effectiveness of a nasal cannula in this patient, in your opinion?

A. Well, it would depending on whether he's breathing through his mouth or through his nose. If he were mouth breathing, then the inspired oxygen tension is a little bit lower than if he's doing nasal breathing. Because if it's nasal prongs, then you're breathing through your nose and you tend to suck in a little bit more oxygen than if you're breathing through your mouth.

If you're breathing through your mouth, you get kind of associated Venturi effect, but the mouth is bigger than the nose so the effect of the nasal oxygen is fairly minimal breathing through the mouth.

The more anxious you are, the more likely you are to mouth breathe.

Now that kind of question is one that you needed to be there kind of question, to actually see that person.

Q. Doctor, you also indicated that you would do a 12 lead EKG and I think we know that that was not done with this patient. However, there was a rhythm strip, am I correct?

A. Well, I don't know, I'd have to look through that too. Could you tell me what --

Q. Well, it looks like the first one that I see is on Page 8.

A. I think I see the same one that you do.

Q. Now, it appears, Doctor, if I am correct, and this was the first -- well, first of all, let me ask you this. What is a 12 lead EKG going to be able to tell you as a physician that a 1 lead rhythm strip will not?

A. Whether or not there has been definite

evidence of injury to the heart muscle. You can't tell that on a 1 lead.

Q. So this would be then in reference to the suspected myocardial contusion in this case?

A. Correct.

Q. And have very little to do with pulmonary contusion?

A. Correct.

Q. Is the rhythm strip that we have examples of in this chart going to help you in any way if the injury is myocardial contusion?

A. Perhaps minimally so because it indicates a rapid heart rate that you would expect some rapidity of the heart rate. A rate of -- this one was read as 139 by the machine. It's a little bit faster than you'd like to see.

So it will give you some hint, but in terms of relative value, this is minimal. Keeping in mind that a negative electrocardiogram is also consistent with a myocardial contusion.

Q. A normal, is that what you're saying?
A. Yes.
Q. All right, Doctor, once you had seen a chest x-ray in this patient and you had seen at least the initial blood gas, what's the next move?
A. I think in this particular patient I said we would repeat the blood gas based on the clinical condition.
Q. Well, the blood gas with this patient was in fact repeated, a second blood gas being drawn at 9:20, or something like that.
A. Eleven-twenty?
Q. I beg your pardon, 11:20. So we're talking about 40 minutes after the first was drawn.
A. Is that 19B?
Q. Yes.
A. All right.
Q. And it appears from the slip that the patient was on room air at that time, right?
A. Yes, that's right.
Q. Well, now we know that Mr. Weaver was

pulling out some IV's and I believe nasal cannula as well. In any event, approximately 40 minutes later he was on room air and apparently not receiving oxygen at that time when this was drawn.

Now, Doctor, how do you interpret the blood gas results that were drawn at 11:20?

A. The occasion is now assuming these are arterial gases now, and assuming that this indicates severe hypoxia and this level of hypoxia is not consistent with it doing well, as a matter of fact after a while you'd die if you left it like this.

Q. Let's see, and we're talking about 11:20. And my understanding is, Doctor, if this patient was still up and walking around and not talking, et cetera; is that correct?

A. I have to correlate that with the nurses' notes, but I think that at that time he was still moving around, that's correct.

Q. And, Doctor, what do you see as the appropriate course of action in light of

the first two blood gases and all the other circumstances that were going on which this patient at approximately 11:20?

MR. COWDREY: Objection. Go ahead and answer.

A. Good question. Can I interpret your question to ask me again what would I do at this point, or is your question -- well, what was your question, I'm sorry?

Q. My question was, what in your opinion is the appropriate action for this patient at that point, for you as an emergency doctor to take?

A. All right.

MR. COWDREY: Are you using the word appropriate meaning what's the standard of care for emergency room physicians?

MS. STOCKLIN: Yes.

A. All right. I would have to look at two potential things at this point. One is I would want to decide whether or not this blood gas with a high CO2 and a low O2 and

a pH which is somewhat acidotic and a low oxygen saturation was indeed an arterial gas, and so I wasn't there. And so either the two things that could be done is if one were convinced that it was arterial, then it would be appropriate to take steps to intubate the patient.

If one were not convinced it was arterial, then it would be appropriate to quickly repeat the gas and if it confirmed this, then to take steps to intubate the patient right then.

Q. So make sure this blood gas is giving you legitimate results?

A. No, I say this is a judgment. And so the physician would have to look at that and say I think that this gas is a, completely consistent with what I see, it must be right, or b, I'm still not sure it's consistent so before I get this guy who is thrashing about and smash into his airway potentially causing some other damage, I want to double check, it's only going to

take a few more minutes.

I'm saying that either one of those approaches would be consistent with the standard of care. I would support either one.

Q. Now, Doctor, it appears from this chart that neither of those routes were taken with this patient anywhere near 11:20, 11:30, 11:40; is that correct?

MR. COWDREY: Objection. We don't know at what particular point in time these results came back to Dr. Myers.

MS. STOCKLIN: That wasn't my question.

Q. Dr. Janiak, you've read all the depositions of the Defendant doctors in this case, and you've read the charge. Is it a fair statement that neither one of the options that you talked about were taken with this particular patient any time around 11:30 that night?

MR. COWDREY: I'm going to

object because Dr. Myers told you in his deposition two things. One, that he suspected that this could be venous blood and secondly, that he did not know the exact time that these results came back to him from the second blood gas study.

With that objection, go ahead and answer, if you can, Doctor.

A. Well, if we're going to look at the numbers exactly, and we just make an assumption that these numbers are really cast in stone, then certainly intubation didn't take place right then. As far as I remember, there wasn't an immediate blood gas, or there was another blood gas ordered, but it certainly was not at 11 -- well, I can't read mine, but I think it is 11:30.

There is another blood gas that is sort of confusing because it says time drawn, 12 something, and the time received,

11 something. So I don't know what that means, that probably refers to those numbers on 19C.

MR. COWDREY: I think that, Doctor, indicates time requested, 11:55 and time drawn, 12:10.

A. Is that requested?

Q. Yes.

A. I thought it was received. I apologize for that. So another was drawn, it was not drawn or requested immediately according to the record.

Q. In your opinion, Dr. Janiak, was a reasonable and ordinary standard of care met with Mr. Weaver between 11:30 and 12 a.m. on this particular evening when he was not intubated and another blood gas was not requested during that half-hour period?

MR. COWDREY: Objection. I think it indicates the request for the third blood gas was 11:55, but go ahead and answer if you can.

Q. With that correction, Doctor.

A. Yes, I think that's within the standard because I really can't look at a patient who's thrashing about like this and say that I'm going to give, say that somebody violated the standards for that few minutes of time. It was done, and there were some results that came back from that third set of blood gases.

It was reasonable to want to repeat them. There was a change in between those two. I would think that the change was that the patient was on room air and then was placed at it looks like -- somebody might help me, is that 6 liters per minute, 6.0 liters per minute? When you do that, you have to give the patient a few minutes to make an adjustment to that change. You can't put them on -- change it from 0 to 6 liters per minute and then draw a blood gas because the blood gases will be of no value.

You have to give them -- oh, most of us wait 10 minutes I suppose, and we'll

figure that there's been an effect, so giving him those 10 minutes and then a couple more minutes to reassess the patient, I think that's okay.

Q. Well, then let's go to the next step, Dr. Janiak, when the third set of blood gases were drawn at 12:10 a.m. What do those tell you?

A. This shows that one, the patient was on 6 liters per minute, the patient's oxygen level had gone up slightly, but the CO2 level is higher and there is increasing acidosis.

Q. What, Doctor, in your opinion would a reasonable and ordinary standard of care require with this patient regarding his respiratory status after the third set of blood gases?

MR. COWDREY: I'm going to object because unless you're going to ask him a question concerning Dr. Myers or are you asking reasonable standard of care for any

physician or emergency room physician? Because as I've indicated to you earlier, he's here to express opinions concerning Dr. Myers and I think the evidence is clear that after 12 o'clock came along, Dr. Myers wasn't necessarily involved with this patient's care. That objection --

MS. STOCKLIN: I was talking about the standard of care required for this patient under these circumstances regarding his respiratory status for any physician.

A. Okay.

Q. Do you have an opinion?

A. Yes, I do.

Q. What is that?

A. At this point, the standard of care would have been to aggressively intervene in the airway with intubation and then assess what that did, and take any other steps

depending on the results of what the intubation did.

Q. In your opinion, Doctor, was the failure to intubate this person until sometime after 12:45 in light of these three blood gases a deviation from reasonable and ordinary standards of medical care for this patient for any position?

MR. COWDREY: Objection. Go ahead and answer it.

MR. KRISHER: Same objection. Note my objection.

A. You asked me, was this a deviation from standard to not intubate at this point?

A. To not intubate until sometime after 12:45?

MR. COWDREY: Objection again.

MR. KIRSHER: Join in.

MR. MENZ: Note the same objection.

A. What I think I was saying is that at the time of the results of the 19C blood gases were available, that that patient should have been intubated then. What I was

saying was up until that time, it was not a violation to not intubate, or withholding intubation was okay.

After this set of tests, I'm saying that the patient should have been intubated and the people who did or didn't intubate did not perform up to the standards of care.

Q. I think I read you. Once this third set of blood gases was in, then it became in your opinion in order to meet a reasonable and ordinary standard of medical care for a physician, it became necessary to immediately begin intubation; is that correct?

A. That's right.

Q. Doctor, are you familiar with -- well, I assume you are familiar with the advanced trauma life support course and regarding primary survey of a trauma patient?

A. I know what a primary survey is, but I have not taken or given the advanced trauma life support course.

Q. I guess what I'm asking you about is your familiarity with that concept of a primary survey on a trauma patient.

A. Yes, that's what I described to you actually way back in this deposition when we discussed that.

Q. Well, let's -- I will try not to be redundant here, but let me ask you what that means to you, that sense of a primary survey. What's that mean?

A. It's extremely simple. A primary survey is a quick evaluation of all the patient's bodily areas excluding those which are not going to be life threatening. For instance, in a primary survey you would not be real worried about a fractured finger, so you're going to focus on the central nervous system, the abdomen and the chest. You want to know whether the patient's able to breathe and what their vital signs are, as opposed to secondarily when you go over each area again in somewhat more detail.

So the primary survey is -- focuses

on the central body systems and is relatively brief, and the secondary survey is more in depth and basically looks at the body again, but in a little more detail and more complete.

Q. When you're teaching your residents, Doctor, in the emergency room to deal with trauma patients, what do you tell them as far as what this primary survey should consist of?

A. Well, I suppose the most important thing to tell -- that we tell the residents regarding the primary evaluation of the patient is to keep it brief, keep it simple and don't look for nonlife-threatening potential problems, but look for the problems that are going to be potentially most severe to the patient.

Q. What are those?

A. Maybe I could give you an example. The patient that arrives via a rescue squad on a back board with a cervical collar in place having been in an automobile accident

who is complaining of neck pain, the survey should quickly make a determination that yes, there is pain in the neck. I mean I could touch the neck and it hurts, and the patient obviously is breathing and comfortable and not bleeding anywhere else, let's go back and look at the neck in detail radiologically.

Residents who look at the patient in detail initially and order too much may delay the appropriate care for that potential problem which in the case I just described is a neck fracture.

So you don't want the resident to get too involved in the case until he or she has focused in on that one -- on this particular patient I described, the life or limb threatening problem.

Q. All right, Doctor, now we know that certain medications were administered to Mr. Weaver dealing with this breathing problem he has complained of, right?

A. Right.

Q. Do you know what those medications were?
A. I know at least one of them. I think he had two, I think I remember Aminophylline and I think at one point some Epinephrine and obviously just the intravenous fluids themselves. He had some Valium and some Anectine and some physostigmine.
Q. Well, those last three, Doctor, came much later after -- or during or after intubation; is that correct?
A. Correct.
Q. All right, now I'm talking about initially to deal with these --
A. Breathing problems.
-- breathing problems. And you mentioned Aminophylline and Epinephrine?
A. Yes.
Q. I believe there were also some attempts at Alupent breathing treatments?
A. Yes, I believe that was true.
Q. Now, Doctor, can you tell me what the indications are for the use of Epinephrine?
A. Well, Epinephrine is used for -- to reverse

spasm in the lungs and to dilate the bronchi, make breathing easier. Epinephrine is used to reverse acute allergic reactions, to prevent cardiovascular collapse in most cases.

Epinephrine is used on wounds to control bleeding. Epinephrine is occasionally used to stimulate the heart if it stopped, and it's used to increase blood pressure, although we don't use it for that very often.

It's unusual to use that anymore, but it has been in the past.

Q. And, Doctor, what's the -- can you tell me what the time frame is that it takes Epinephrine to begin having an effect or kick in?

A. Five minutes to 15 minutes, very quick. It depends on how it's given, of course.

Q. Now, Doctor, I assume that you have dealt with a number of trauma patients at Toledo emergency room, and I'm assuming also that you have had more than a number of

occasions to administer Epinephrine for one reason or another.

A. Several thousand I would imagine.

Q. All right. Now, Doctor, when you consider administering Epinephrine and let's say you have an adult male black obese, known hypertensive over age 45, are you going to apply any restrictions to your use of Epinephrine?

A. I think there is some literature about that and some teaching that we should be more cautious in the use of Epinephrine. I certainly would not use as much as .5 cc's on somebody like that. As a matter of fact, personally I would use Terbutylene, which is a drug similar to Epinephrine but has less cardiac irritability than Epinephrine.

So yes, there is a little bit of caution in that. It's more often applied to patients who are in their 60's or 70's, but you certainly would think about it.

Q. All right, would you think about it further

if this particular patient had admitted to the emergency room with a blood pressure of 220 over 140?

A. If the patient had come in with that blood pressure and shortness of breath without a history of trauma, you would think about it a little further, that's right. With the history of trauma and this condition, you might not think about it quite so much, but you certainly would.

I'm not trying to minimize that, there is no -- there really is no time you wouldn't want to think about that.

Q. Do you see any problem whatsoever, Doctor, with administering Epinephrine to Mr. Weaver under the circumstances of this case?

A. No, I don't think so. It certainly would cause more cardiac irritability than the other drugs, but that doesn't mean there's an incredibly high incidence. And this patient was sick enough to make an attempt to reverse his pulmonary problem.

Sometimes patients like this have contusions to the lungs with primarily bronchospasm. Other patients have just bronchospasm and no contusion to the lung.

In that case, the patient', all the other patient's symptoms can be relieved by relieving the bronchospasm. And he may need to do nothing more, so it's certainly reasonable to try this.

Q. All right, this particular patient however according to your opinion, Doctor, had a myocardial contusion with cellular damage to the heart; is that right?

A. That's right.

Q. Under those circumstances, along with a pulmonary contusion is it still your opinion that Epinephrine was an appropriate drug to administer in this case?

MR. COWDREY: I'm going to object because I think he's indicated to you that it is his opinion that the patient had a myocardial contusion after seeing

everything in the case, and if you're asking him at the time that this patient was administered, the medication, that's all well and good. But I want to object to that question as it is now phrased.

Go ahead, Doctor.

A. If I had seen this patient at 11:20 with those conditions and there was a sign tattooed on his chest that says warning, myocardial contusion, then this would be the wrong drug to use.

Q. It would be contraindicated, wouldn't it?

A. Yes, right. But at 11:20 that wasn't a definitive diagnosis, and the patient was having plenty of trouble breathing, had a heart rhythm which was sinus and rapid, but certainly not irregular and was not complaining of chest pain so therefore trying to relieve the bronchospasm was very reasonable.

As a matter of fact, I believe the original record said expiratory wheezes.

So that's an appropriate treatment for that.

Q. Dr. Janiak, would you agree that hypoxia itself can result in restlessness in a patient, combativeness and confusion?

A. Yes.

Q. Doctor, do you have any opinion at all as to whether this particular patient who presented under the circumstances he did should have been permitted to walk around the emergency room?

A. I have a -- yes, I have an opinion about that.

Q. What is that?

A. Initially I think in order to decrease the patient's anxiety, it would not have been appropriate to restrain him right after he walked in the door. You need to get some sense of the history of the physical and a couple of laboratory results.

I think it's okay to have patients move around in a semi-controlled situation until you get some sense of where you are.

Now the next question is, well, when would you get that sense? And that is really a judgment -- I don't know, the judgment is up to the physician who's watching the patient. The variables are more than you and I could discuss if we were here for the rest of our lives.

It's just that sense of seeing the patient. There is no question, however, that at some point the patient will continue to pace, in this case, would have needed to be restrained and intubated, even against his will.

Q. Would you be comfortable in saying, Doctor, and would it be fair to say that certainly by 12:15 a.m. when Dr. Keighley arrived this patient should no longer have been walking around the emergency room?

MR. COWDREY: Objection. I don't know that we have any evidence that the patient was walking around the emergency room at 12:15 or Dr. Keighley got there.

and again Dr. Janiak's here to testify concerning Dr. Myers and not Dr. Keighley or Dr. Rank.

Go ahead and answer if you can, Doctor.

A. Well, I would but I'm not sure I can answer that because I'm not sure what the patient was doing right then. I think that a second physician has to evaluate the same patient, he deserves a few minutes to make up their own minds and it would have been, I think, inappropriate for Dr. Keighley to come down and as a first step say, restrain this patient and now we'll do something.

I think he'd have to go through his own brief assessment and then make a decision. Now whether that decision would have been at 12:17 or at 12:51, I can't answer that question.

Q. Well, Doctor, let's not talk about Dr. Keighley particularly, let's talk about the time frame between 10:30 when this patient arrived in the ER and 12:15, and knowing

what you know from your review of the chart and what took place during that time period, is it fair to say that by 12:15, if not much earlier, this patient should have no longer been allowed to walk around the emergency room?

MR. COWDREY: I'm going to object because I think he's indicated to you that that's a judgment call and the physician that's reviewing that particular patient. He indicated there's a lot of factors and variables.

Go ahead and answer if you can, Doctor.

A. No, I don't think that's fair, and the reason for that is that one of the things you -- one of the reasons this patient is pacing is he is so anxious, and you have to ask yourself is the pacing itself harming the patient significantly? Now certainly because the pacing uses up oxygen, it is harming the patient some in this particular

patient.

Is that significant or will restraining him make him so anxious that his blood pressure will go up 30 more points and his respiratory rate will go up 10 more points and will consume more oxygen just because he's anxious, which happens, it absolutely happens.

So you have to make a judgment on that as to whether or not you need to have that patient restrained. One of the judgment factors is what can I do to him while he's moving about that I -- or what can I do to him that if I restrain him that I can't do to him while he's moving about.

Will he tolerate the Alupent treatment or does he throw it away? Will he leave the IV in long enough for me to get some medicine in it or does he keep ripping it out every single time I do it?

If the answer is that you can't even get to the patient because he's pacing about and can't intervene pharmacologically

in any way, that patient needs to be restrained.

If you can get to him some of the time and get some of the medicine into him enough to decide that that's enough, which is one of those judgments, then let him pace for a little while.

Unless you think he's got a broken neck, there's no need to have to tie him down.

Q. Dr. Janiak, you indicated to me earlier on this deposition that Mr. Weaver's injuries were so severe at the time of this accident he was a doomed man to die from those injuries?

A. That's right.

Q. You have also indicated to me that the three blood gases that were accomplished by 12:15 that morning indicate a profound, severe hypoxia and acidosis?

A. Correct.

Q. You have also indicated to me that you are aware that this man was pulling out IV's

and pulling off his oxygen mask, nasal cannula, et cetera. Would you agree as well that the blood gases indicate that he was not getting the benefit of oxygenation at any time prior to 12:15?

A. No.

Q. You would not?

A. No.

Q. He was getting the benefit in your opinion of some oxygenation, then?

A. I don't know whether he was or he wasn't. I guess what I'm saying when I answer it so emphatically no is that he could have had all the oxygenation in the world, and the blood gases could still have been the way they were. It depends on the severity of the injuries.

Q. I guess what I'm failing to understand, Dr. Janiak, is a man with this severe of injuries and this dismal looking blood gases at 12:15 in the morning is fine to be up walking around the emergency room. I have problems reconciling that. Is that

your opinion?

A. I missed that. Is my opinion that it's okay for him to walk --

Q. Under these circumstances, it's all right for him to walk around the emergency room?

A. Yes, because my opinion is is that that is a judgment that they made, and I don't see anything in the standards that say that you can't make that judgment for a patient like this.

You have to be very flexible and treat each patient a little differently. If you could -- if somebody could indicate to me that keeping him flat and tied down was going to reduce his oxygen demand more than letting him pace and be anxious, you know, that would be fine. But I don't see where that act of letting him do that hurt him. I don't see the documentation that that was what was causing his problem.

His problem was caused by an extremely severe lung injury with a cardiac injury also.

MS. STOCKLIN: Let me take five minutes. I think I just have a few more questions.

(A short recess was taken.)

Q. Doctor, it's just going to be a short while. I just have a few more questions. If you were to fill out the death certificate on Mr. Weaver after reviewing this case and all the medical records and depositions that you have reviewed, how would you fill it out?

MR. COWDREY: Objection, go ahead and answer.

A. Well, you know, I don't fill those out, but I would say what I've been saying all along, is the patient died of a contusion to his heart and his lungs.

Q. And that's it? I mean, would that be the entire --

A. That would be it.

Q. Doctor, which of the hospitals in Dayton, Ohio does your corporation have a contract with to do the billing?

MR. COWDREY: Objection, assumes it does. But go ahead.

Q. For emergency services?

A. The billing company?

Q. Yes, I'm sorry. I switched gears --

A. That's all right, that's okay. I'm just trying to catch up with you, that's all. Miami Valley and -- you think I should know these things but I really don't look at the companies. I think we had a -- we don't have a specific contract with St. Elizabeth, that's why I'm trying to be accurate. I think we can get some money for the billing at St. Elizabeth's through another company which are not related, so I don't think we have a contract with St. Elizabeth's.

But we do have one with Springfield Physicians, which is near Dayton. So really the only contract in Dayton is with Miami Valley Hospital Emergency Physicians, I forget their name.

Q. Well, even though you're talking about

contract, do you do any of the billing or provide any of the services for any other emergency rooms in Dayton?

A. None other than what I have already mentioned.

Q. I assume then that you are involved with the billing for TMES out of Grandview or Southview Hospital?

A. No. As a matter of fact, I asked earlier when I had forgotten that those were in Dayton, I thought maybe Columbus.

Q. Doctor, are you prepared today to offer any opinions regarding whether or not Dr. Keighley or Dr. Rank met ordinary and reasonable standards of care in their treatment of Mr. Weaver?

A. No, I'm not going to comment on that.

Q. You're not prepared to make any comments?

A. Right.

Q. And do not intend to at trial?

A. Not at this time; no, I do not.

Q. All right.

MS. STOCKLIN: I think that's all

the questions I have for you today, Dr. Janiak. I would only request that should you make any additions or changes in your opinions, that you notify Mr. Cowdrey of that so that I can be notified of that prior to trial.

THE WITNESS: That would be more than fair. I promise.

MS. STOCKLIN: Thank you.

MR. COWDREY: I assume that you two gentlemen don't want to ask any questions; is that correct?

MR. KRISHER: Yes, that's correct.

MR. MENZ: That's correct.

MR. COWDREY: We will submit the deposition to the witness for review and signature.

MR. KRISHER: I would like a copy of it.

MR. MENZ: I would also.

MR. COWDREY: And I'll take a

copy. I assume you want the original?

MS. STOCKLIN: Yes, I'd like the original.

(The deposition was concluded at 4:35 o'clock p.m.)

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BRUCE DAVID 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, Jane Beckett, a Notary Public in and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within-named witness, BRUCE DAVID JANIAK, M.D., was by me first duly sworn to tell the truth, the whole truth, and nothing but the truth in the cause aforesaid; that

the testimony then given by him was by me recorded by audio tape in the presence of said witness, afterwards transcribed upon a word processor, and that the foregoing is a true and accurate transcription of the testimony so given by him as aforesaid.

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

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

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Toledo, Ohio, on this 3rd day of October, 1989.

JANE BECKETT
Notary Public
in and for the State of Ohio.

My Commission expires August 20, 1993.

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