IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF OHIO

EASTERN DIVISION

ESTATE OF DOROTHY PRINZLER, Plaintiff, versus LAKE HOSPITAL SYSTEM, INC., et al., Defendants.	CASE NO. 1:00CV0342 JUDGE O'MALLEY **TELEPHONE DEPOSITION OF BRUCE D. JANIAK, M.D.**

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TELEPHONE DEPOSITION OF BRUCE D. JANIAK, M.D., a Witness herein, called by the Plaintiff for Cross-Examination, pursuant to the Federal Rules of Civil Procedure, taken by the undersigned, Lisa A. Naiman, Registered Professional Reporter and Notary Public in and for the State of Ohio, at the offices of Reminger & Reminger, 101 Prospect Avenue West, Cleveland, Ohio, on Friday, October 10, 2003, at 1:07 p.m.

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APPEARANCES:

On behalf of the Plaintiff:

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On behalf of the Defendants John Posch, M.D. and University MedNet, Inc. (by phone):

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I N D E X

3/8/05

MR. KULWICKI: I guess at the outset I had agreed to make a record with regard to the scheduling foul-up today. I am coming out of a trial that lasted two-and-a-half weeks and ended on Wednesday of this week. I learned late yesterday that there was a possibility that there was a deposition scheduled for today, and I learned that via looking at my secretary's calendar, a secretary that I terminated immediately before going into this two-and-a-half week trial for reasons that might become apparent during the course of this record that I'm making right now.

But I saw penciled into her calendar that there was a tentative date for Dr. Janiak's deposition today, and I made some phone calls late yesterday and learned that in fact it was on. We got a court reporter scheduled, and then this morning it dawned on me that there may not have been notice given to the various Reminger firm attorneys that were involved, and I confirmed that in fact there was no notice provided to them. I told them that in light of Attorney White traveling to Atlanta for the deposition that I intended to proceed with it,

but I wanted to make clear on the record that this is proceeding under protest, that proper notice was not provided to three of the defendants, or at least all of the defendants represented by Reminger attorneys, and that if they feel as though they need to come back and depose Dr. Janiak in greater detail later that I will pay for the cost of Dr. Janiak's time in doing that.

I suspect that that will not be necessary given the limited focus of Dr. Janiak's opinions and what I anticipate he's going to tell me with regard to the care of the other physicians, and I assume he's not going to have any complaints about that care, so I don't think that's going to be necessary, but I certainly think that in fairness I should hold that open.

I did speak with Sue Seacrist this morning and told her of the problem, and she indicated to me that neither she, nor Tom Kilbane, nor Tracey McGurk, the other Reminger lawyers of record, were available for the deposition today. Kathleen Atkinson and Brad Longbrake have come in to cover, but they have assured me that they have not had adequate time

to prepare, and I certainly understand and appreciate that.

But with that being said, I want to begin the deposition with Dr. Janiak. Does anyone else want to add anything to the record at this point in time?

MR. LONGBRAKE: We would just add that we appreciate David's candor and professional handling of this matter throughout the issue, and it certainly isn't something that we believe was in any way intentional, and wanted that to be part of the record.

MR. KULWICKI: Okay. Doctor, we're going to swear you in from this end, so please raise your right hand, and Lisa Naiman, the court reporter, will swear you in.

WHEREUPON,

BRUCE D. JANIAK, M.D.,

after being first duly sworn, as hereinafter certified, testified as follows:

CROSS-EXAMINATION

BY MR. KULWICKI:

Q. Doctor, why don't you state your full name and spell your last name for us and give us your current business address.

A. Bruce A. Janiak, J-A-N-I-A-K, 405 Bradford Point, Peachtree City, Georgia 30269.

Q. Doctor, I note on the report that I've been provided in this case that your address as of February 2003 was a Perrysburg, Ohio address. Did you recently move to the Atlanta area?

A. Yes. First week in July, I think.

Q. Okay. And can you tell me what occasioned your move from Toledo to Atlanta?

A. Sure. I was Director of the Emergency Department at the Toledo Hospital in Toledo, Ohio. I had sold that contract a couple months before I moved, spent some time staying in the Toledo area working at hospitals in Michigan, had some surgery on my ankle which needed to be done, and at the same time commenced work at the Medical College of Georgia in Augusta, commuting from Toledo actually for several months before I moved down here.

So I relinquished my position in Toledo because the politics were horrible and the economics were getting worse than horrible, and decided to go into a more partly academic setting.

Q. Okay. Can you tell me roughly how your

professional time breaks down currently?

A. Currently I work eight shifts a month at the Medical College of Georgia in Augusta, and if the medical staff office at Fayette Community Hospital which is six miles from my house gets its act together, I will be on the staff there next month and will be able to work extra shifts there. They've just been fooling around with it now for six months.

Q. When you say eight shifts a month, what are we talking about; how long are each of the shifts?

A. Eight hours, eight-and-a-half hours, depending on how soon you can get out of there.

Q. Okay. So you're working roughly 64 hours a month in the clinical practice of emergency room medicine?

A. Well, I teach. I see the patients, but I also work with the residents, because they see the patients also. So it's a professorship.

Q. Okay. And that's about 64 hours a month?

A. Right.

Q. And then besides that, what other sort of professional activities are you engaged in?

A. Well, this month really is nothing until I get on the staff at Fayette Community Hospital. So the

only two things I'm doing right now is some medical legal reviews and the Medical College of Georgia. I'm just waiting to get on staff at Fayette Community.

Q. Okay. If you could, tell me what sort of time you spend with medical legal review.

A. Oh, gosh. I never really calculated the hours. I can tell you that I probably get -- in the last year I've probably been asked to review 30 cases I would think.

Q. Okay. And you review those through Janiak Consulting, Inc.; is that correct?

A. Yes.

Q. Is that company set up solely for the purposes of your own medical legal activities?

A. No, it also is I do some consulting also which is a little bit different from medical legal. It's just going to a hospital if they call me and doing site reviews. That probably is a, to put it in perspective, a once-a-year activity, so 90 percent of the Janiak Consulting income derives from medical legal review.

Q. Are there any employees of Janiak Consulting besides yourself?

A. Not today, no.

Q. Have there been in the past?

A. No. We were just talking to my accountant about whether my wife should be an employee, so I don't know that yet.

Q. And the 30 cases or so, are you saying that you've reviewed that many this year, meaning from January until October of 2003?

A. I'm saying from twelve months prior to today.

Q. Are all of those cases on behalf of defendants in lawsuits?

A. No.

Q. What's your percentage breakdown between defendant's and plaintiff's work?

A. Well, it used to be 85/15, and I've been saying it's 80/20, but I would think it's getting closer to 75/25 now with the 25 being plaintiffs.

Q. Okay. Have you reviewed a plaintiff's case involving emergency care of a patient with pulmonary embolism or deep vein thrombosis ever?

A. Oh, man. I can't tell you for sure. I would think so, but I just can't tell you for sure.

Q. What do you charge per hour, Doctor? And if it varies between activities like review versus deposition versus trial testimony, if you could lay that out for me.

A. Sure. Review is 300, meetings are 300, depositions and trial are 400. Obviously the expenses for deposition and trial will vary depending on the location where I have to go.

Q. Now, besides practice of medicine and your duties as a professor of medicine and your medical legal review, do you have any other income generating activities that you're currently engaged in?

A. Well, part of my income at the Medical College of Georgia is attributable to I guess what they call an outreach coordinator, something like that, where I do some meetings with small hospitals. To put that in perspective, I have spent I think three full days in the last six months doing that, and that would be it. In terms of generating income any other way, I don't think there's anything else I do currently.

Q. Doctor, have you ever sat down and calculated the amount of time that you spend in the active clinical practice of medicine or teaching medicine versus the time you spend in any administrative activities or as an outreach coordinator or in medical legal review?

A. No, I never have, but the vast majority of my time is clinical because the medical legal stuff

I just do while I'm either flying or on the weekends. The rest of my work is seeing patients, and I actually would be well over a hundred hours a month if I could get on the staff here. I was always over a hundred hours a month, but it's just been two months since I moved and it just takes awhile to get on the medical staff.

Q. Doctor, I have a report dated February 23, 2003. I understand that to be your one and only report in this matter; is that correct?

A. Certainly it's -- I'm trying to find it in front of me, but there was only one report, that is correct.

Q. Okay. And it's very brief. I'm going to read it just to make sure that I have the right one.

A. All right.

Q. It says, "At your request I have reviewed the University MedNet files for Dorothy Prinzler for January 27, 1999. This was a 59-year-old patient with foot pain and swelling. She had normal vital signs. Her history and physical were appropriate. It was appropriate to order and review the x-rays. The diagnosis was consistent with the physical findings. I find absolutely no deviation from the standard of care in this

case."

Is that your report in this matter?

A. Yes, sir.

Q. And does that contain all of your opinions in this matter?

A. That was all of my opinions with regards to the University MedNet files.

Q. Okay. Now, you understand that there are a variety of other defendants in this case and other care providers besides Dr. Datta, D-A-T-T-A, who saw Mrs. Prinzler on January 27, 1999; correct?

A. Yes, sir.

Q. And is it fair for me to conclude that you have no legal criticisms of any of these other care providers or defendants in this matter?

A. That's right.

Q. Okay. With regard to your opinion that you find no deviation from the standard of care in this case as to Dr. Datta, can I conclude that you base that in part on your review of the January 27, 1999, University MedNet records?

A. That is correct.

Q. And as I look at those records I see three pages, the first one being a sheet that's signed by Dr.

Datta at the bottom and timed out at 4:15 in the afternoon on January 27, 1999?

MS. WHITE: (Inaudible.)

MR. KULWICKI: Say that again, Darlene.

MS. WHITE: He's looking for it.

MR. KULWICKI: Okay.

A. We're getting there. Hang on a second. It's underneath all the potato chips and sandwich debris.

MS. WHITE: Hold on. I thought I just saw it.

Q. Doctor?

A. Yes.

Q. Are you looking for it or is Darlene, because I'm thinking I can ask you a few questions if Darlene is looking for it?

A. We're both looking for it, but why don't you go ahead.

Q. Okay. Doctor, have you been retained in the past by the Gallagher, Sharp law firm?

A. Yes, I have.

Q. How many times?

A. Probably half a dozen at least.

Q. And how many times have you been retained by the Reminger & Reminger law firm?

A. I would say probably 20.

Q. And how many times have you testified at trial total in your career as a medical legal consultant?

A. I would say that's probably at least 20.

Q. Have you ever testified at trial on behalf of a plaintiff?

A. Oh, yes.

Q. How many times?

A. At least five or six I would think.

Q. Did any of those cases involve pulmonary embolism?

A. Same answer as I had before, I don't remember for sure whether they did or they didn't. I mean and that went to trial. I mean you would think it must be, but I just don't remember specific ones.

Q. Okay. Doctor, while we're still dealing with background here and waiting to locate this report or these records, can you just define for us the term deep vein thrombosis?

A. Well, it's a blood clot, it's in a vein which is regarded as deep, which means it is not a vein that is subcutaneous, and it results -- well, I guess that's the definition, not result. But it's just a clot in a deep vein, a vein that is

not just under the skin but within the muscle tissue or deeper.

Q. What are the signs or symptoms of DVT?

A. Well, a small DVT may have no signs or symptoms. The most common signs or symptoms are pain, tenderness, and swelling. Sometimes there's redness depending on a lot of, many, many factors.

Q. And where might one see or find pain, tenderness, swelling, and/or redness associated with DVT?

A. It would be in the tissues that surround the involved vein.

Q. Might you find pain, tenderness, swelling, and/or redness in the calf?

A. Sure, if that's where the vein is, you might.

Q. And might you find these signs or symptoms in the area of the ankle?

A. That would be unusual to have all those signs and symptoms in the ankle, but if you had a vein that was way down distal in the calf, you could have those signs in the ankle, that's correct.

Q. Okay. And I didn't mean to say that all of these at the same time, but I mean one or the other, might you find them in the ankle associated with DVT?

A. Sure, it's possible.
Q. And can you find one or the other of these various symptoms, pain, tenderness, swelling, and/or redness in the foot as a result of DVT?
A. I would say the answer to that is it's possible, but I have never seen it in the foot myself.
Q. But certainly you're trained to recognize that that's a possibility?
A. You know what, I think we all recognize it's a possibility. I don't remember being trained for that, but I suppose it's -- I don't know where else you would get that from.
Q. And, Doctor, what is it physically or physically what happens, physiologically what happens to cause swelling associated with DVT?
A. I think that the biggest physiologic change is the increase in pressure in the capillaries, arterioles, and venules, all of which are in the circuit that just precedes the veins. When there's increased pressure that fluid, some of the serum from the blood tends to be squeezed out, so to speak, of the small vessels. That's called a transudate, T-R-A-N-S-U-D-A-T-E. And that fluid that remains in the tissue is associated with swelling.

Q. Now, Doctor, in preparing your February 23, 2003 report I assume, since you reference them, you had the University MedNet records; correct?
A. Right.
Q. Did you have the actual films that were taken on January 27, 1999?
A. I do not believe I have seen the x-rays.
MR. KULWICKI: Okay. We just lost one of our lawyers, so if you guys can keep looking for those records, we'll go off the record for a second.
MS. WHITE: Actually, Dave, we got them.
MR. KULWICKI: Okay. Give us two seconds. Kathleen has a frog in her throat, so --
(Discussion off the record.)
MR. KULWICKI: We're back on the record, and I should note that we've been joined by another attorney.
MS. JENNY: Yes. Leslie Jenny, J-E-N-N-Y. I'm here for Dr. Austria.
MR. KULWICKI: And everyone else is here as previously identified.
BY MR. KULWICKI:
Q. Doctor, you now have the records in front of you,

and as far as I can tell, and I want to confirm with you, it appears that there are only three pages that were generated by University MedNet relative to Mrs. Prinzler's January 27, 1999 visit there. Is that what you have?
A. Yes.
Q. Okay. And the first one would be a sheet that's signed by Dr. Datta at the bottom and timed out at 4:15 p.m.; correct?
A. 4:15, yes, 16:15.
Q. All right. And then the second one would be home-going instructions to Mrs. Prinzler; correct?
A. That's right.
Q. And then the third one would be the x-ray report from the x-ray that was done on that date; correct?
A. Let me see if that's the one -- I have the other stuff, but I don't have the x-ray report. I don't want to go through this forever, but I have those sheets but not the x-ray report.
Q. Well, while you're looking for that, let me ask you is it fair for me to assume that the focus of your inquiry and investigation was the workup, diagnosis, and treatment plan of Dr. Datta,

D-A-T-T-A, who is a defendant in this litigation?
A. Right, that was the initial focus, that's correct.
Q. Did the focus expand beyond that initial focus?
A. Maybe personally it did. I just reviewed the records from the emergency visit which was the 1st of February, I remember, and I thought that was okay too.
Q. Okay. You did not render any opinion or written record -- easy for me to say -- written report relative to your final findings from that day; correct?
A. That's correct.
Q. All right. With regard to the January 27, 1999 visit, you'll agree with me that the patient complained of or presented by history the fact that she was having right foot pain with edema; correct?
A. Right.
Q. And she denied any traumatic injury to that part of her anatomy; correct?
A. Yes.
Q. What do you think was causing her foot pain and edema, or do you have an opinion about that?
MS. JENNY: Objection.

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MR. LONGBRAKE: Objection.
A. You mean based on that information or based on a review of the records?
Q. Based on your review of the records.
A. Oh, I thought it was probably a soft tissue problem, most likely an inflammatory problem which could have been tendinitis.
Q. What is tendinitis?
A. It's an inflammation of the structure which connects the muscles to the bone.
Q. And what causes tendinitis?
A. Tendinitis can be caused by an acute injury or it can be caused by a repetitive chronic injury or it can be spontaneous. And finally it could be associated with actual bacterial infection, which would be extremely rare. It could be associated with patients who have complaints of chronic pain in the muscles and joints. And I characterize it that way because some doctors use the word fibromyalgia, I don't. But it can be also associated with connective tissue disease, which is probably the same mechanism that is easily strained soft tissues. And finally I suppose it could be associated with tumor, which is very rare, I've never seen it.

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Q. Doctor, do you agree with the principal that in evaluating an emergency room patient the emergency room physician has a duty to develop a differential of all possibilities that may account for the symptoms and historical complaints as presented in the emergency room?
MS. JENNY: Objection.
MR. LONGBRAKE: Objection.
A. No, I don't.
Q. Okay. So in terms of assessing a patient you don't use a differential?
A. No, I didn't say that.
Q. Okay. Tell me -- well, first of all, tell me how you define the term differential.
A. The differential diagnosis in classic terms is defined as a list of possible disease entities that can explain the patient's constellation of signs and symptoms.
Q. Okay. And do you utilize a differential in evaluating patients in the emergency room setting?
A. Certainly not a classic differential, no.
Q. Okay. Tell me about the differential according to Dr. Janiak.
A. It would be, and I believe this is a standard of

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care so I wouldn't make it my own, that emergency physicians develop a mental list of possibilities that are reasonable that could explain the signs and symptoms of a patient's presentation. And that means that the emergency physician can exclude from that list things that are significantly unlikely.
Q. And in developing this mental list of reasonable possibilities, is it incumbent upon the emergency room physician to take a history from the patient?
A. Even if you don't develop any list, you still take a history.
Q. And likewise it would be incumbent upon the emergency room physician to conduct some form of physical exam?
A. Exactly correct.
Q. And typically in the emergency room setting there would be a set of vitals that are taken, as well; correct?
A. That would be typically true.
Q. Okay. And then based on what sort of list, mental list of reasonable possibilities comes up from the vitals, the physical exam, and the history, there may be an obligation to proceed

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with some additional testing; correct?
A. That is correct. It depends on the judgment of the physician after they put together the information they get from the history and physical.
Q. Okay. Well, you suggest a term now, judgment, and I want to try to back that out of the equation in a fair way; and what I'm going to propose to you is that I would like to know from your opinions what complies with a minimum standard of care. Because obviously you can have a judgment that does not comply with accepted standards of medical care, and I want to sort of remove that possibility from our discussion, if we can. Can we do that?
A. I'll try. Let's move forward, see if we can do that.
Q. Okay. Well, specifically what I want to know is about minimum standards of medical care here, and in that regard did Dr. Datta have an obligation in your opinion to proceed after the history, physical, and vitals to obtain an x-ray?
A. No.
Q. Okay. So his obtaining an x-ray in your opinion was above and beyond the standard of care?

A. Well, I don't know if -- above and beyond implies it might be better. I would have been perfectly happy without the x-ray.
Q. Okay. Now, talking about the term differential and using your definition of a mental list of reasonable possibilities, once an emergency room doctor develops a mental list of reasonable possibilities, if that list includes a potentially life threatening condition, does the physician have an obligation to undertake testing to either rule in or rule out that life threatening condition?
MR. LONGBRAKE: Objection.
MS. JENNY: Objection.
MS. ATKINSON: Objection.
A. The answer is yes as long as we go back to the term a reasonable possibility.
Q. Fair enough. And I guess with respect to deep vein thrombosis, you certainly recognize that that condition has a potential for throwing a clot that lodges in the lung that can kill the patient; correct?
MR. LONGBRAKE: Objection.
A. Using the generic term, hypothetically anybody with a deep vein thrombosis that could happen.

Q. So it is indeed potentially a life threatening condition?
A. Well, no. A deep vein thrombosis can be potentially a life threatening condition, but a small deep vein thrombosis would not be. So it really depends on the vein and how extensive the involvement.
Q. Is DVT a treatable disease?
A. In most cases, yes.
Q. If you had been standing in Dr. Datta's shoes on January 27, 1999, and you had in your judgment determined that she had in fact had a DVT or you were strongly suspicious that she had a DVT, what would be the prudent thing to do at that point in time or what would you have done?
MR. LONGBRAKE: Objection.
MS. ATKINSON: Objection.
MS. JENNY: Objection.
MS. WHITE: Objection.
A. Well, now that you give me the patient with the DVT I'd want to know where is it and how big is it. And if it was very small and in the distal calf, I probably would then be calling in 1999 an internist to talk about whether they wanted that treated or not, because there's some data that

show that DVTs distal to the knee are not that particularly dangerous. However, I will tell you to be very fair that if I thought it was a large DVT and if it involved most of the calf, I would commence treatment.
Q. You would as the ER physician commence treatment yourself personally without -- even before you had an internist evaluate the patient?
A. As long as I thought it was a large DVT.
Q. And what would that treatment consist of?
A. Well, in 1999 it would probably be Heparin.
Q. And, again, sticking with 1999 and what you feel a reasonably prudent emergency room doctor should do or should have done back at that time, if indeed it was a large DVT and you began treatment with Heparin, would you also proceed with having another physician evaluate the patient and ultimately take over control of care for that patient?
MS. JENNY: Objection.
MS. ATKINSON: Objection.
MR. LONGBRAKE: Objection.
MS. WHITE: Objection.
A. Sure. Once you start the treatment with Heparin, then you have to pick up the phone and call the

primary care doctor or internist or whoever is on call and discuss the next step, do they want to admit the patient, do they want them to come to the office for another Heparin injection, those kinds of approaches.
Q. Now, let's go back to the patient who has a small DVT. I would assume that you would not necessarily just tell that patient, well, you just have a small DVT, shake it off, head home, forget about it. You would instead give them some advice about the dangers associated with a small DVT progressing to a big DVT; fair enough?
MR. LONGBRAKE: Objection.
MS. JENNY: Objection.
MS. ATKINSON: Objection.
A. Yes, that's fair.
Q. Okay. Anything else that you think you would do under those circumstances in 1999 with a patient with a small DVT to comply with accepted standards of medical care?
A. I would just arrange follow-up.
Q. You would nonetheless have them go see a medical doctor?
A. Somebody, sure.
Q. Okay. Anything else?

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A. I might do baseline clotting studies, probably would.
Q. PT, PTT?
A. Yeah, INR, one of those.
Q. And what kind of information would you be looking for there?
A. Well, I guess you would want to know if the patient was hypercoagulable, but if not you would at least want to know if somebody eventually wanted to treat them, they would have a baseline lab study that they could measure progress from.
Q. Okay. Now, in this patient she comes in complaining of right foot pain with edema, and I want you to assume if you haven't found yet the x-ray report shows that there's ankle soft tissue swelling as well as across the foot dorsum.
A. Okay. I haven't found it, but I will assume that.
Q. Okay. With that being the case and assuming what else you know about this patient as of January of 1999, I assume it's your opinion that DVT would not be in the differential?
A. That's correct.
Q. And why would you opine that or why would you rule that out of the differential based on the

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presentation that we have here?
A. Because the patient in the exam had tenderness around the ankle, which is extremely -- I mean I've never even seen that with a DVT. I've seen swelling, but no tenderness. So tenderness has to come from something else. In this case inflammation of the soft tissues, tendinitis makes excellent sense.
Q. Okay. And how are you able to rule out DVT based on that presentation?
MR. LONGBRAKE: Objection.
A. By going back to our previous conversation, since I don't think that's a reasonable likelihood, you don't rule it out. But if you wanted to, the foolproof way I suppose that you could actually do a venogram.
Q. Is that the same thing as a duplex ultrasound?
A. No.
Q. Okay. What are you talking about, the injection of dye?
A. Right.
Q. Now, in confirming a suspicion of tendinitis, is there any definitive test for doing so?
A. No. It's a physical finding. There isn't any test I can think of that would be laboratory test

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that would be diagnostic.
Q. So I assume you haven't talked to Dr. Datta; correct?
A. I wouldn't even know who he is. Or she.
Q. If in fact a DVT, even a small one was confirmed via venogram on January 27, 1999, can you give me some sense about how urgent follow-up is with such a patient? In other words, would you make sure that they saw someone that same day, or would it be reasonable to wait, you know, a month, or can you just give me some sense about what you consider to be a reasonable period of time for there to be further evaluation of the patient and follow-up?
MR. LONGBRAKE: Objection.
A. If you decided that the patient was going to be treated with anticoagulation, then you could delay the follow-up for a couple weeks if you wanted to. If you thought that you were not going to treat, just wanted to follow, then I would suspect within two to three days would be reasonable.
Q. And how does an emergency room physician go about making sure that the patient is, you know, handed off, if you will, to another doctor for follow-up

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within a reasonable period of time?
MR. LONGBRAKE: Objection.
MS. ATKINSON: Objection.
MS. JENNY: Objection.
A. I don't know any way to make sure. I only know what we try to do.
Q. What do you try to do?
MR. LONGBRAKE: Objection.
MS. JENNY: Objection.
MS. ATKINSON: Objection.
A. Call someone to arrange follow-up and then figure out a method for the patient and that particular follow-up physician to communicate, whether that be by telephone or just by showing up in the office. And then thirdly you make sure the patient knows what you did, "see Dr. Smith on Tuesday," quote/unquote.
Q. Okay. Doctor, looking again at the University MedNet records, my copy on the right-hand margin is cut off, and I'm wondering if you can read where it says x-ray, it says right foot and ankle, and then there is a parenthetical or an arrow, whatever you want to call it --
A. Yes.
Q. -- pointing to some things in the far right-hand

corner. Can you read those on your copy of records?
A. Mine says 13:55, I think, and then there's initials. That's all I -- what I take that to be is the initials of the person who took the order. The right foot and ankle is the order, and then the time and initials would be the time and the identity of the person who took the order off.
MS. WHITE: Our portion is partially cut off, too, Dave.
MR. KULWICKI: Okay.
Q. Doctor, just so I'm clear, you did not review the films that were taken on January 27, 1999?
A. That is correct.
Q. With respect to DVT, what are the risk factors for that condition?
A. I'll see if I can make up a mental list here. I would say that a history of prior DVTs would be a risk factor, history of serious injury to a lower extremity that would -- for example, a severely fractured lower extremity in the distant past, history of a recent injury or surgery to the lower extremity, taking of birth control pills, a history of hypercoagulability syndrome, and perhaps obesity, although I'm not sure it's as

much of a risk factor as we think it is.
Q. With regard to birth control pills, would Premarin fit within that category?
A. You know, I don't know. I really don't. I would have to go back and look up the literature. It's a minor risk factor, but it might get in there. I would have to look it up.
Q. And let me maybe clarify that and ask it a different way. Do you consider the use of Premarin to be a risk factor for DVT, or is that what you're telling me you would have to look up?
A. That's what I would have to go back and look up. I think it's not exactly the same as taking birth control pills, but it is a hormone, so it may have been associated with an increased risk, and I just as we talk, I would have to look it up.
Q. Can we agree that age is a risk factor for DVT?
A. I don't know. I mean my personal experience is that I don't think of it any more in a 90-year-old than I do in a 60-year-old, so I would have to look that up too.
Q. How about a sedentary life-style, is that considered to be a risk factor for DVT?
A. I don't think a sedentary life-style is. I think being sedentary could be. For instance, having

an injury and being wheelchair bound for a week might be. But being a person who is sort of a couch potato I don't think is associated with DVTs.
Q. Okay. And you mentioned going back to look at some literature with regard to Premarin as a risk factor. What sort of literature would you be looking at?
A. Oh, if I were going to look it up, I would probably start with --
Q. I'm sorry, start with what?
A. The PDR, Physician's Desk Reference.
Q. Okay. Now, did this patient have any particular risk factors for tendinitis?
A. Well, she claimed, you know, I'll put in parentheses this history of fibromyalgia. And those patients, whether you believe in fibromyalgia or not, do complain of soft tissue discomfort throughout their bodies on a regular basis. That's the only way I could characterize it. I can't say a risk factor, I could just say it's very common for those people to have those complaints.
Q. Doctor, where in these records do you see that Dr. Datta was considering fibromyalgia when he

evaluated Mrs. Prinzler?
A. I don't, but that wasn't your question.
Q. Okay. That was my question just then though. I guess in looking at this, I don't see that that entered into his thought process, do you?
A. No, I didn't either, but I was answering your question.
Q. Fair enough. Okay. Let me see here. That's all the questions I have, Doctor. Thank you for answering them. Have we covered all of your opinions with respect to this January 27, 1999 visit?
A. I believe we have.
MR. KULWICKI: Okay. Darlene, do you want to advise -- well, does anyone else have any questions? I mean we've obviously made a record that --
MR. LONGBRAKE: Just for the record, we would say this is an adjournment with a possibility of reopening. On behalf of Mr. Kilbane I would make that comment. But other than that, we'll reserve.
MR. KULWICKI: Agreed.
MS. JENNY: And I would also make the same reservation for Ms. McGurk.

MS. ATKINSON: And the same for Susan Seacrist.

MR. KULWICKI: Agreed. Darlene, do you want to advise him with regard to signature on the record and then we'll depart here.

MS. WHITE: Doctor, you have a right to read the record.

THE WITNESS: I'll read.

MR. KULWICKI: Okay. Take care.

MS. WHITE: Thanks a lot everyone.

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(The deposition was concluded at 1:57 p.m.)

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W I T N E S S C E R T I F I C A T E

I, Bruce D. Janiak, M.D., do hereby certify that I have read the foregoing deposition taken on October 10, 2003 in the case of Estate of Dorothy Prinzler versus Lake Hospital System, Inc., et al., consisting of thirty-seven pages, and that said deposition constitutes a true and correct transcription of my testimony given at the specified time.

_____
Bruce D. Janiak, M.D.

Dated this _____ day of _____, 2003.

Sworn to and subscribed before me this _____ day of _____, 2003.

_____
Notary Public

My commission expires _____.

LAN

C E R T I F I C A T E

STATE OF OHIO,)
) SS:
CARROLL COUNTY.)

I, Lisa A. Naiman, a Registered Professional Reporter and Notary Public in and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within-named witness, BRUCE D. JANIAK, M.D., was first duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony so given by him was by me reduced to Stenotype in the presence of the witness, and that the foregoing is a true and correct transcription of the testimony so given by him as aforesaid.

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

I further certify that I am not a relative of, employee of or attorney for any of the parties in the above-captioned action, that I am not a relative of or employee of an attorney of any of the parties in the above-captioned action, that I am not financially interested in this action, and that I am not, nor is the court reporting firm with which I am affiliated, under a contract as defined by Civil Rule 28(D).

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Malvern, Ohio on this 27th day of October, 2003.

_____
Lisa A. Naiman, RPR & Notary Public
My commission expires April 3, 2004.