# In The Matter Of:

Shirley Bolden vs. St. Lukes Hospital Court of Common Pleas, Cuyaboga County, Obio

> Deposition of Bruce Janiak, M.D. December 15, 1992

> > Mebler & Hagestrom Court Reporters 1750 Midland Building Cleveland, OH 44115 (216) 621-4984

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## Shirley Bolden vs. St. Lukes Hospital Court of Common Pleas, Cuyahoga County, Ohio

## Deposition of Bruce Janiak, M.D. December 15, 1992

Court of Common Pleas, Cuyanog	ga County, Onio	<b>December</b> 15, 1992
Page 1	[24] Q: Okay. I'd like to hand you some-	[20] Q: Goldblatt. Dr. Peter Goldblatt?
IN THE COURT OF COMMON PLEAS	thing that has [25] been given to me and	[21] <b>A:</b> That sounds like a cardiologist.
CUYAHOGA COUNTY, OHIO SHIRLEY BOLDEN,	represents your curriculum	[22] Q: Okay. These are not trick ques
ADMINISTRATRIX, ETC.,	Page 4	tions.
Plaintiffs, JUDGE CLEARY	[1] vitae.	[23] A: These aren'ttrick answers. It's be
-vs- CASE NO. 217,592	[2] Is that updated? Is that current?	cause you [24] mentioned a name like
ST. LUKE'S HOSPITAL, ET AL.,	[3] A: Hangonjusta second Actually this	that, obviously there are [25] a lot of
Defendants.	one looks [4] a little bit old. It has several	similar names. That sounds like a
Deposition of BRUCE JANIAK, M.D., taken as if upon cross-examination before Linda A. Astuto, a	missing [5] children and it doesn't have	Page
Registered Professional Reporter and Notary	the fact that I was [6] president of the	[1] gentleman that I probably read an
Public within and for the State of Ohio, at the offices of The Toledo Hospital, 2142 North Cove	American Board of Emergency [7] Medicine. So this is a little bit old.	article or two [2] or reviewed an article
Boulevard, Toledo, Ohio, at 9:30 a.m. on	[8] Q: When were you president of that	[3] Q: Okay.
Tuesday, December 15, 1992, pursuant to notice and/or stipulations of counsei, on behalf of the	organization?	[4] A: There are, I'm sure, Goldblatts in
Plaintiffs in this cause.	[9] <b>A:</b> Three years ago.	every [5] specialty.
MEHLER & HAGESTROM Court Reporters	[10] Q: For how long? One year?	[6] Q: Dr. Geoffrey Mendelsohn?
1750 Midland Building		[7] <b>A:</b> No, I don'tknow him.
Cleveland, Ohio 44115 216.621.4984	[11] <b>A</b> : One year.	[8] Q: Dr. Ralph Lach?
FAX 621.0050	[12] Q: So 1989?	[9] <b>A:</b> No.
800.822.0650	[13] <b>A:</b> 1990to ' <b>91.</b>	
Page 2	[14] <b>Q</b> : Okay.	[10] Q: Dr. Michael Frank?
APPEARANCES: David Paris, Esg.	[15] A: Mid-year to mid-year.	[11] <b>A</b> : I know a Michael, I think a Michael Frank, an [12] emergency room
Harley Gordon, Esq.	[16] Q: Any other additions, modifica-	physician somewhere in Ohio years [13]
Nurenberg, Pievin, Heiler & McCarthy First Floor	tions?	ago. If there was a Michael Frank who a
1370 Ontario Street	[17] <b>A:</b> I don't think there's anything sig-	one [14] point in his life sat on the Board
Cleveland, Ohio 44113 (216) 621-2300,	nificant.	of Directors [15] of the Ohio Chapter of
On behalf of the Plaintiffs;	[18] Q: Have you written anything,	Emergency Physicians, [16] that is
Victoria L. Vance, Esq.	presented any papers, [19] any publica-	probably the same Michael Frank.
Arter & Hadden 1100 Huntington Buiiding	tions dealing with diagnosis and [20]	[17] <b>MS. VANCE:</b> I think we'retalking [18
Cleveland, Ohio 44115	treatment of acute myocardial infarc- tions?	about one and the same.
(216) 696-1100, On behalf of the Defendant		[19] Q: You've had no contact with him
St. Luke's Hospital;	[21] <b>A</b> : I have not.	except for [20] several years ago, I take it
Alan B. Parker, Esq. Reminger & Reminger	[22] Q: Have you written any publica-	[21] A: Probably 10 years since I've seen him.
7th Floor 113 St. Clair Building	tions or presented [23] any papers deal- ing with emergency care of [24] patients	[22] Q: Do you know a Dr. David Cooke
Cleveland, Ohio 44114 (216) 687-1311,	with acute myocardial infarctions?	- ·
On behalf of the Defendant	[25] <b>A:</b> I have not.	[23] <b>A:</b> Does not sound familiar.
Emergency Department Physicians, Dr. Barron and Dr. Baumgartner		[24] Q: Dr. Kenneth McCarty?
Page 3	Page 5	[25] <b>A</b> : No.
[1] BRUCE JANIAK, M.D., of lawful age,	[1] Q: Do you now or have you ever had any privileges [2] at St. Luke's Hospital in	Page 7
called [2] by the Plaintiff for the purpose	Cleveland, Ohio?	[1] <b>Q:</b> Dr.Jerome Aarons?
of [3] cross-examination, as provided by	[3] <b>A:</b> I have not.	[2] <b>A:</b> No.
the Rules of [4] Civil Procedure, being by		[3] <b>Q</b> : I take it you have consulted as an
me first duly sworn, [5] as hereinafter	[4] Q: Do you know Dr. Bass?	expert [4] witness over the years?
certified, deposed and said as [6] follows:	[5] <b>A:</b> I do not.	[5] <b>A</b> : Yes, I have.
[7] CROSS-EXAMINATION OF BRUJCE	[6] Q: Do you know Dr. Hoke?	[6] Q: When did you first begin consult
JANIAK, M.D.	[7] <b>A:</b> I do not.	ing?
[8] BY MR. PARIS:	[sl Q: Dr. Seballas?	[7] <b>A:</b> I think the first case I did was in
[9] <b>Q</b> : Doctor, my name is David Paris	[9] <b>A</b> : No.	the mid [8] seventies, perhaps '76,'77,in
and I'mone of [10] the lawyers that rep-	[10] Q: Dr. Barron?	that range.
resent Thelma Lloyd in [11] connection with this litigation.		[9] Q: And on an average yearly basis,
[12] I'dlike to ask you some questions this	[11] <b>A:</b> No.	about how many [10] cases did you con-
[13] morning about your background,	[12] <b>Q</b> : Do you know Dr. William Boden	sult with in the medical [11] malpixctice
about the [14] opinions that you have in	personally or by [13] reputation?	context?
regard to the care and [15] treatment that	[14] <b>A:</b> It seems I may have heard his name before but I [15] can't remember	[12] A: Let's see. Probably an average of
she received at St. Luke's [16] Hospital.	where.	four to five [13] a year.
[17] I will try to keep my questions [18]	[16] <b>Q</b> : Do you know what his specialty	[14] <b>Q</b> : This is just reviewing cases, it's
understandable, but being a layman and	is?	not [15] necessarily giving testimony, preparing [16] reports.
	[17] A: I guess pathology but I'm not	1 1171 A. Exactly right
work with me. If [20] my questions are	[17] <b>A:</b> I guess pathology but I'm not sure.	[17] <b>A:</b> Exactly, right.
not a [19] physician, I hope that you'll work with me. If [20] my questions are inartfully phrased, or [21] convoluted or not understandable, will you do [22] that?	• • •	<ul> <li>[17] A: Exactly, right.</li> <li>[18] Q: So for the past 15 years ballpark- ing it, [19] somewhere in the range of</li> </ul>

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December 15,1992

[21] A: I'd say probably 80 cases in that [18] A: That is one of the thoughts I have. materials, then I do. If not, [17] then I do time. I have [19] consulted with them, and I keep them and they'reall in my attic [18] know I've consulted [20] with them in at home. [22] Q: Not all of these cases, I take it, are Kentucky and in, I think something [21] cases [23] that you ultimately gave in Southern Ohio but I don't remember depositions on, is that [24] correct? €or sure [22] if there was one in [25] A: That is correct. Cleveland. this issue before? Page a [23] O: Have you ever consulted on any cases involving [24] St. Luke's Hospital in [1] Q: Not all of these cases are ones in Cleveland, Ohio? which you [2] prepared expert reports [25] A: No, I don't think so. on? [3] A: That is also correct. Page 10 [4] O: Have you consulted in cases other [1] Q: Have you ever consulted with any than medical [5] malpractice cases? plaintiff's law [2] firms in Cleveland, [11 have that ability. Ohio? [6] A: Yes. [2] Q: Would you mind doing that? [3] A: No, I don'tthink so. [7] **Q:** And what types of cases? [3] MS. VANCE: Arrangements [4] Q: Have any of the occasions that you [8] A: There were two civil cases that have [5] consulted with lawyers on cases dealt with, one [9] was an injury that doctor for any [5] time he spent. prior to today [6] involved the diagnosis occurred on the school ground [10] and and care and treatment of [7] a potential another was an automobile accident. acute myocardial infarction? [11] Q: Do Iunderstand just two over the rsl A: Yes. past 15 years? [9] Q: Do you recall the name of that [12] A: That's all I can think of. case? 101 that. [13] Q: Okay. I just wanted to get your [10] **A:** No, I don't. familiarity [14] with the medical/legal sys-[11] Q: Do you recall how many cases tem. where you were so [12] consulted? [15] A: Sure. [13] A: Well, I can't imagine it was one or we'll [15] discuss it. [16] **Q**: Have you kept track apless because [14] as we all know, myocarproximately what [17] percentage of dial infarction problems [15] are frequent your consultations are with [18] plaintiffs casions prior to [17] today? litigation issues. as distinguished from defendants?

some form or another.

[20] **A:** Well, one I do.

the issues presented.

tion very

tack.

cases?

[1] accurately.

[19] A: I would say the ratio is probably five to one [20] defendant/plaintiff.

[21] Q: Five times more for defendant than with the [22] plaintiff?

[23] A: I think that's pretty accurate.

[24] Q: Have you ever consulted with the law firm of [25] Arter & Hadden prior to this case?

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[1] A: I don't believe so.

[2] Q: How about for the law firm Reminger & Reminger?

[3] A: Yes.

[4] **Q**: Do you recall who specifically you've worked [5] with over there?

[6] MR. PARKER: Let me make a [7] continuing objection.

[8] A: Mr. Spisak is the name that comes to mind.

[9] Q: Do you recall approximately how many times [10] you've consulted with that firm?

[11] A: I think twice.

[12] Q: Have you consulted with any other law firms in [13] the Cleveland area?

[14] A: Well, that's a good question. I don't know the [15] answer. I just don't know

1161 Q: Have you ever consulted with for example, [17] Jacobson, Maynard?

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minute or so. [10] Jinks & Cowdrey.

[11] Q: Anything else about the other

[12] **A:** Just nothing is coming to mind.

[13] Q: Do you keep files on the cases that you have [14] consulted on?

[15] A: Once a case is over. if the firm

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[19] **Q**: You have the ability to make a determination of [20] the cases that you may have in your attic that [21] dealt with [22] A: Just manually. I mean those are not filed in a [23] filing cabinet. They are sort of in a file. I [24] would have to go through each folder and see [25] what the issues are in each case. Certainly I Page 12 would have [4] to be made to compensate the [6] A: I would not mind doing that if you agree to [7] compensate me because it will take some time and [8] I respectfully request that you wait until after [9] the holiday season. But I'll be happy to do [11] MS. VANCE: We'll talk further [12] about that. We'll make the arrangements. [13] If that is something that they, upon [14] further reflection, want to pursue, [16] Q: You've given testimony on oc-[18] A: I have. [16] I would say probably three cases dealt with [17] myocardial infarction in [19] Q: And how many times do you think you've given [20] testimony total? [18] Q: Do you recall any of the par-[21] A: Probably 25. ticulars about any [19] of those cases? [22] Q: And of those occasions, how many were in a [23] courtroom setting? [21] Q: When, try to confine the question [24] A: I think four or five. to where the [22] case was pending, what [25] Q: And how many — and the rest county, the law firms [23] involved and/or were in a Page 13 [24] A: Well, without a review of the files, [1] deposition setting? I'mnot [25] sure I could answer the ques-[2] A: Right. Page 11 [3] **Q**: Doctor, in your file — are you able to tell [4] from your file when you were first contacted [5] with respect to this [2] It was a case in Dayton, it was an 131 case? automobile accident in which there was [6] A: Not without picking up the file a thought [4] that the patient had **a** and going [7] through the papers. myocardial infarction and [5] the physicians paid more attention to the [6] [8] Q: All right. Let's do that. injuries than the possibility of heart at-[9] A: Well, it was prior to August of 1992. My guess [10] it was in the early part of [7] And I just can't think of the name of this year. the [8] law firm right now in Dayton but it will [9] probably come to me in another

[11] MS. VANCE: Actually not. As you [12] know, David, I only entered the case the [13] beginning of July. It was in that window [14] of time between the month of July and [15] August. We know the date of his report, so [16] it is a date in the month of July or [17] August.

[18] Q: Would you agree with Miss Vance's [19] representation?

1201 A: Sure.

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		court of common r leas, cuyanog
<ul> <li>[21] Q: Did you receive all these materials in one lump [22] package or did you receive materials [23] periodically?</li> <li>[24] A: I received more than one set. think two.</li> </ul>	the 23 hour observation policies as [21] near as I remember. [22] Q: Do you have that handy as part of your file? [23] <b>A</b> : Well,I'll look again.I didn't see it.	[21] Q: What were you requested to do? [22] A: I was requested to review this case with [23] specific focus on whether or not there were, in [24] my opinion, any violations of the COBRA statutes [25]
[25] Q: Two packages?	[24] Q: Yes, that's why I mentioned it be-	with regard to patient transfer.
Page 18	cause I didn't [25] see it either.	Page 14
[1] <b>A:</b> Yes.	Page 16	[1] Q: What documents were you
[2] <b>Q:</b> Do you know whether or not your report, which is [3] dated whatever date it has on it, was prepared [4] after receiv ing both packages from Miss Vance?	[1] <b>A:</b> I remember seeing it but I don't know where it [2] is given the fact I could skip over it looking [3] like this. I don't think it's in here.	provided with? [2] <b>A:</b> Deposition of a Dr. Bass and a deposition of a [3] Dr. Barron. Plaintiff's expert witness reports [4] from Dr. Mc- Carty, Dr. Silberman, Dr. Aarons and [5] Dr.
<ul> <li>[5] A: The observation unit documen that I referred [6] to, I did not have that prior to writing my [7] repoi-t.</li> <li>[8] Q: And your report is dated August</li> </ul>	<ul> <li>[4] Q: I may be calling it something that it's not. It [5] may not be a protocol. It could be a standard [6] or guideline.</li> <li>[7] A: Right.</li> </ul>	Cooke. Autopsy report on the patient. [6] Emergency department records and records of the [7] observation unit admis- sion at St. Luke's [8] Hospital.
28, 1992.	[8] Q: Did you review any such protocol,	[9] Q: That would be the $12/17/90$
[9] Is it your recollection that you received [10] the 23 hour observation unit materials after you [1] prepared that report?	standards or [9] guidelines relative to admission to the coronary [10] care unit at St. Luke's Hospital? [11] <b>A</b> : I did not.	records? [10] <b>A</b> : Right. And then some medical records from [11] MetroHealth Medical Center from the 21st to the [12] 22nd of
[12] <b>A:</b> Yes.	[12] Q: How about to their stepdown	December, 1990.
[13] <b>Q:</b> Anything else that you received	telemetry unit?	[13] MS. VANCE: And you also had the
after preparing [14] your report?	[13] <b>A:</b> I did not.	[14] autopsy report?
[15] <b>A:</b> Nothing other than I'msure there was a cover [16] letter with the observation unit material. But [17] that was it.	[14] Q: How about with regard to their pathology or [15] laboratory?	<ul><li>[15] MR. PARIS: Yes, he said that.</li><li>[16] Q: I take it, Doctor, you did not review Mrs. [17] Lloyd's medical records</li></ul>
[18] Q: Did you obtain or review a	[16] <b>A:</b> No.	from 1978to 1990from [18] the Kenneth
deposition of a lab [19] technician Matousek?	[17] Q: Did you see a document called	Clement Center?
[20] <b>A:</b> No.	the laboratory [18] summary sheet from St.Luke's Hospital? Let me [19] show you	[19] <b>A:</b> No, I haven't seen that.
[21] <b>Q</b> : Did you review a report from an expert by the [22] name of Dr. Watts?	that. It is a document that has [20] pre- viously been marked as Plaintiff's Ex- hibit [21] 4. It's the second page that I	[20] Q: You did not review the actual GI filmstaken at [21] St. Luke'son December 17, 1990?
[23] <b>A:</b> Not familiar with that.	would be [22] interested in knowing if	[22] <b>A:</b> That is correct.
[24] Q: Dr. Michael Frank?	you saw that before.	[23] Q: You did not look at the actual
[25] MS. VANCE: No. He's only seen the	[23] <b>A:</b> I honestly don' tremember seeing it. If I did, [24] I wouldn' tbe surprised that	chest x-ray taken [24] on December 17,
Page 19	I did. I just [25] don't have a memory of	1990?
[1] plaintiff's expert report, not [2] co-	it.	[25] <b>A:</b> That is correct.
defendants.	Page 17	Page 15
[3] <b>MR. PARIS:</b> I understand. I just [4 wanted to hear it from the doctor, what he [5] has reviewed and not reviewed.	[1] <b>MS. VANCE:</b> So you are clear, he [2] has not seen that specific sheet that you [3] have put before him but I have sent	<ol> <li>Q: You did not look at the pathology slides of [2] Thelma Lloyd'sautopsy?</li> <li>A: That's correct.</li> </ol>
[6] Q: Is there anything else that you have reviewed in [7] connection with	him [4] policy and procedure manuals relevant to [5] the admission to the car-	[4] Q: You did not review the deposition of Shirley [5] Bolden?
this case that I have not [8] addressed on that is not contained in your [9] package	diovascular unit, [6] the cardiac step- down unit and that the [7] patient is	[6] A: Correct.
of materials?	admitted on an observation [8] status.	[7] <b>Q:</b> Dr. Brenda Smith?
[10] A: Well, there are some materials	[9] Those are sent to him. Obviously,[10]	[8] A: Correct.
and knowledge [11] that I reviewed	just so you are clear as to what he has or	[9] Q: Dr.Ahmet Hoke?
before the case ever occurred.[12] It had nothing to do with the case at the time.	[11] has not seen.	[10] <b>A:</b> Correct.
[13] Materials that I read, COBRA regula	[12] His other statements about not seeing [13] the other depositions is ac-	[11] <b>Q:</b> Dr. Seballas?
tions, things [14] like that, but they are not in connection with [15] this. I looked at that before the case.	curate, nor has [14] he been provided with the actual autopsy [15] slides or the	<ul><li>[12] A: Correct.</li><li>[13] Q: Did you review any of the</li></ul>
[16] Q: You had familiarity with that before you were [17] even approached	films, other than the reports [16] that are reported in the hospital record.	protocols of the [14] emergency room at St. Luke's Hospital?
by Miss Vance, is that correct? [18] <b>A</b> : That's correct.	[17] Q: Will you adopt what Miss Vance said as accurate, [18] Doctor, as to what you've seen?	[15] A: Yes, I did. Well, I'm not sure that I did. [16] I've reviewed something that
[19] Q: Did you go back and do any addi- tional research [20] after you were ap- proached by Miss Vance?	[19] <b>A</b> : Sure. If she said she sent me that. I remember [20] the observation unit policy.	was a protocol. [17] I'm not sure, I don't know if I have it. I'm [is]not sure it was an emergency department [19] protocol. I think it dealt with the [20] observation,

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[21] A: I just looked at the COBRA regula-	[20] A: You may be making an assump-	Page 24
tions again.	tion that my [21] knowledge is equal to	[1] A: Sometimes.
[22] Q: Where did you find those regula-	what I read. I will ask [22] my secretary to see what I can find.	[2] <b>Q:</b> Quotations or something?
tions?	[23] Q: Sure.	[3] <b>A:</b> What would be on the page that's
[23] <b>A:</b> I think they were in a publication that was, or [24] in a letter or something	-	referenced [4] would be a circled para-
that came from the [25] American Col-	[25] (Thereupon, a recess was had.)	graph or a mark.
lege of Emergency Physicians, plus	Page 22	[5] Q: And I take it that means that
Page 20	[2] <b>MS. VANCE:</b> This is Mr. Krugh's[3] ar- ticle.	there's something [6] significant in there
[1] an article that was written by an attor-		that had some bearing on [7] your opinions?
ney about [2] the COBRA regulations.	[4] <b>MR. GORDON:</b> He's not with your law [5] firm, is he?	[8] <b>A:</b> Well, that's not necessarily true.
[3] Q: An article written by which attor-	[6] MS. VANCE: No.	When I read [9] them, if something
ney?	[7] MR. PARIS: I'd like to take a look [8]	strikes me as possibly [10] significant,
[4] <b>A:</b> Timothy Krugh.	at that.	then I would circle it. I would [11] have to decide afterwards really what is [12]
[5] Q: C-r-e-w?	[9] MS. VANCE: I'm not at liberty to [10]	significant.
[6] <b>A:</b> K-r-u-g-h.	release this draft of Mr. Krugh's article,	[13] Q: And did you make any other
[7] <b>Q:</b> Where is that article found?	[11] which is a substantial — I'mlooking at [12] his cover letter.	reports than the one [14] that I have?
[8] A: Now, I don't know. I'm not sure	[13] <b>MR. PARIS:</b> You're paging through	[15] <b>A:</b> No, sir. That's it.
where it was [9] published. I just know Mr. Krugh, he sent me a [10] draft copy	[13] MR. PARIS. Fou ie paging through	[16] Q: That's your first and only?
of it.	[15] <b>MS. VANCE:</b> I am trying to find out	[17] <b>A:</b> Yes, sir.
[11] Q: Do you have that handy?	[16] how long it is. There are several [17]	[18] Q: No drafts?
[12] A: Well, I don'tknow if I do or not.	footnotes and he has a cover letter dated	[19] $\mathbf{A}$ : No drafts.
[13] MS. VANCE: If it's a draft [14]	[18] March 27, 1991 to Dr.Janiak.	[20] Q: Have you discussed this case with
manuscript, I don't know where it	[19] I've not looked at it. I've never [20] seen it in published form anywhere. So	anyone other [21] than Miss Vance?
stands in [15] the publication process. I	I [21] don't feel at liberty to release that	[22] <b>A:</b> No, I haven't.
would be [16] hesitant, without Mr. Krugh'spermission, [17] to be circulating	to [22] you at this point. There is another	[23] Q: Have you done any independent
that.	[23] newspaper journal that Dr.Janiak has on [24] the subject.	research on [24] cardiology?
[18] A: He asked me to look at it	[25] MR. PARIS: Let me see if I	[25] <b>A:</b> None.
prepublication and [19] comment on it,	Page 23	Page 25
which is what I did.But I think [20] I sent it back to him along with the comments.	-	[1] O: Have you done any independent
it back to him along with the comments.	[1] understand.	[1] Q: Have you done any independent research on any of [2] the other legal
it back to him along with the comments. [21] Q: You were asked — an attorney sent you a draft [22] of a publication, a	[1] understand. [2] Q: Is some of the knowledge you	research on any of [2] the other legal issues in this case after you [3] were
it back to him along with the comments. [21] Q: You were asked — an attorney sent you a draft [22] of a publication, a draft of something that he [23] wanted to	[1] understand.	research on any of [2] the other legal issues in this case after you [3] were retained by Miss Vance?
it back to him along with the comments. [21] Q: You were asked — an attorney sent you a draft [22] of a publication, a draft of something that he [23] wanted to publish.	<ul> <li>[1] understand.</li> <li>[2] Q: Is some of the knowledge you profess to have [3] about COBRA derived</li> </ul>	research on any of [2] the other legal issues in this case after you [3] were retained by Miss Vance? [4] <b>A</b> : The answer to that is, just to be
it back to him along with the comments. [21] Q: You were asked — an attorney sent you a draft [22] of a publication, a draft of something that he [23] wanted to publish. [24] <b>A</b> : Uh-huh.	<ul> <li>[1] understand.</li> <li>[2] Q: Is some of the knowledge you profess to have [3] about COBRA derived from the article given to [4] you by Attorney Krugh?</li> <li>[5] A: No, I don't think so. I think he was</li> </ul>	research on any of [2] the other legal issues in this case after you [3] were retained by Miss Vance? [4] <b>A</b> : The answer to that is, just to be totally honest [5] is yes, but I'llexplain to you what I looked 161 at. It was merely
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Page 26 [1] Q: SGOT.What is the purpose of that	mal [23] electrocardiogram or electrocar- diogram that has [24] no acute injury	[25] <b>Q:</b> And when you use determina- tion, Doctor, would
test, [2] obtaining that lab value, running that test?	pattern on it. [25] MR. PARIS: Could you read that	Page 30
[3] <b>A</b> : I don'tknow that I could tell you.	Page 28	[1] you tell us what you mean by that and define it?
I never [4] order it. Other doctors order it, so you'd have [5] to ask them.	[1] answer back?	[2] <b>A:</b> Well, determination I think would indicate that [3] there is inability but it is
<ul><li>[6] Q: What about LDH, what is that?</li><li>[7] A: It's a nonspecific enzyme that goes</li></ul>	[3] (Thereupon, the requested portion of [4] the record was read by the Notary.)	in a negative [4] direction. It's towards worsening of a disease [5] process.
up when [8] there is tissue damage and I never order it.	[6] Q: And that is one of the contexts in which you [7] order cardiac isoenzymes?	[6] Q: What is amylase?
[9] Q: Is that part of any other labs that are [10] customarily ordered by you in an emergency room [11] setting?	<ul> <li>[8] A: Right.</li> <li>[9] Q: When you use the term instability of vital [10] signs, what do you mean by</li> </ul>	[7] <b>A:</b> It's another chemical found in the blood, enzyme [8] chemical which will change with certain disease [9] proces-
[12] <b>A:</b> No.	that term of terms?	ses. [10] Q: Have you ever ordered it?
[13] Q: What is the CPK?	[11] A: I mean that on repeated measure-	mi <b>A</b> : Yes.
[14] <b>A:</b> CPK is an enzyme that the C is	ments of vital [12] signs, and in this in- stance we're referring to [13] pulse and	[12] <b>Q</b> : Under what circumstances?
creatine,PK is [15] phosphokinase. It is, I guess you could call it [16] a generic	blood pressure, that there is abnormal	[13] <b>A:</b> When I have a patient that I think
muscle enzyme.	[14] variation in the measurements, the results are [15] divergent in what I would	may have a [14] disease process that would be associated with an [15] eleva-
<ul><li>[17] Q: Do you ever order it?</li><li>[18] A: I don'tthink so.</li></ul>	considerto be by [16] abnormal amounts.	tion of amylase.
[19] Q: Do you know why the CPK	[17] Q: Is that to suggest that any abnor- mality means [18] that the patient would	[16] Q: For example?
values rise or elevate?	be unstable by your [19] definition?	[17] A: Parotitis and pancreatitis.
[20] <b>A:</b> Oh, they rise and elevate when- ever there is [21] damage to muscle tis-	[20] <b>A:</b> Any abnormality, anything that I would determine [21] in my judgment to	[18] Q: Have you ever ordered that stat from your lab?
sue. [22] Q: Isoenzymes, what are those?	be an abnormality or variation [22] would be unstable.	[19] <b>A:</b> I don't believe I ordered it any other way but [20] stat.
[23] <b>A:</b> There are several different kinds. Which one?	[23] Technically speaking a blood pres- sure of [24] zero and a pulse of zero taken	[21] Q: Have you ever ordered cardiac isoenzymes stat?
[24] Q: In connection with CPK.	at 9:00, and the [25] same measurements zero, zero at 9:15, that	[22] <b>A:</b> Yes.
[25] <b>A:</b> There is a subset of CPK which	Page 29	[23] <b>Q: Why</b> ?
relates to the Page 27	[1] patient is stable, dead but stable.	[24] <b>A:</b> Primarily because — I guess I ought to be very [25] specific, none of the
III muscle which is in the heart, cardiac muscle.	<sup>121</sup> And although it sounds humorous, the reason [3] I say that and emphasize that	tests in my emergency
[2] Q: And what is the purpose of order-	is when I teach [4] it, I do not believe that one blood pressure and [5] pulse, regard-	Page 31 [1] department have the word stat after
ing isoenzymes [3] in connection with the CPK?	less, is evidence of using the word [6] stable in the chart.	them because [2] any test ordered in my department is considered [3] to be stat.
[4] <b>A:</b> Usually it's to try to make a deter- mination as [5] to whether or not there's an abnormal level of [6] such enzymes, and then to correlate that [7] clinically	<ul> <li>[7] Stability means to me that things are</li> <li>[8] staying the same when they're measured [9] repeatedly.</li> <li>[10] Q: So then have we also just defined</li> </ul>	[4] In order to have a stat on not stat [5] routine, an emergency physician must [6] specifically request that. So all tests or- dered [7] are stat.
with what is happening to the [8] patient. [9] Q: Ever order it?	stable?	[8] Q: Unless specifically indicated
[9] Q: Even order It?	[11] A: I guess we did.	routine or ASAP or [9] do you have a designation for ASAP at this [10] institu-
[11] Q: Can you order isoenzymes	[12] Q: All right. Doctor, would you tell	tion?
without ordering a CPK [12] at this in-	us what you [13] mean by reasonable medical certainty or what [14] your un-	[11] <b>A:</b> Do not.
stitution? [13] <b>A:</b> Sure.	derstanding of reasonable medical [15]	1121 Q: Do you have a designation as
[14] Q: Is it your custom and habit to order cardiac [15] isoenzymes without ordering a CPK?	certainty is?You did not use that term in your [16] report, but would you tell me what your [17] understanding of that term is?	routine? [13] <b>A</b> : I believe so. I've never seen a book with that [14] in it but I would guess there would be such a [15] thing.
<ul> <li>[16] A: Yes.</li> <li>[17] Q: In what context would you order isoenzymes?</li> </ul>	[18] <b>A</b> : I think in the context in which we're all [19] sitting, it means that in my judgment or in the [20] judgment of an	[16] Q: And tell me, I don't know if you answered my [17] question, what is the purpose of ordering [18] cardiac isoen-
[18] <b>A:</b> Well, various contexts. Primarily	expert that there is greater than [21] 50 percent probability of an event occur-	zymes stat?

[18] **A:** Well, various contexts. Primarily it is one in [19] which a patient is suffering with complaints [20] that could be related to the heart, and that [21] same patient also has no evidence of any [22] cardiovascular instability and has a nor-

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[22] Q: And what is your understanding

of what a CHEM 12 [23] is, it consists of?

[24] A: I have no understanding of that.

ring.

[19] A: That really is an excellent ques-

tion and [20] probably one that would be

the subject of a [21] several day con-

ference. However, I'lltry to [22] deal with

it.

[23] I don't think there is any different reason [24] to order cardiac isoenzymes stat from any other [25] test stat.

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[1] All you are saying you would like to get [2] the results as soon as they can get it to you. [3] Your message is to drop all your work and focus [4] on mine.

[5] In the emergency room we try to get them as [6] soon as possible.

[7] Q: Are there, are you familiar with how the lab [8] runs cardiac isoenzymes in this institution?

[9] A: Yes.

[10] **Q:** How are they run?

[11] **A:** They'rerun on a scheduled basis. I believe [12] they've changed this recently. I believe it's [13] three times a clay and not, I think it was four [14] times a day.

[15] I think the times are 6:00p.m., in the [16] 6:00 to 7:00 p.m. range in the early afternoon, [17] and early morning, like midnight to 1:00 a.m.

[18] Q: Directing your attention to your report, Doctor,[19] are all of the opinions that you have in 1201connection with this case expressed in your [21] report?

[22] **A:** All of the ones that I was asked to render with [23] regards to this, yes.

[24] Q: Do you have any other opinions with regard to [25] this case that have not been expressed in your

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#### [1] report?

[2] **MS. VANCE:** The only opinions he is [3] expressing are those which he is expected [4] to be asked at trial. I've not asked him [5] any personal opinions he might hold on any [6] other aspect of the case, with the [7] exception of the alleged COBRA violations.

[8] He has not been asked to undertake a [9] review, for example, of the care rendered [10] by the emergency room physicians in [11] consideration of whether or not it meets or [12] complies with any standard of care. He may [13] well have opinions on that. He is not [14] going to be asked to express them. That is [15] not why he was retained in this case.

[16] I don'teven know that he's reviewed [17] the case with that thought in mind. He's [18] looked at the case from the standpoint of [19] COBRA violations and that is essentially [20] what is set forth in the report.

[21] Obviously reports do not substitute [22] for depositions. But insofar as the rules [23] of evidence limits your discovery [24] deposition of this defense expert to those [25] opinions which he will be asked to express

#### Page 34 [6] H

[1] on direct exam at trial, I think you're
[2] generally confined to the subject of the [3] COBRA violations as set forth in the [4] report.

[5] **MR. PARIS:** To the extent there is [6] factual overlays between what can [7] constitute a COBRA violation and what can [8] be a departure from accepted standards of [9] care, I'mgoing to pursue what I think I [10] have to pursue to cover it.

[11] **MS. VANCE:** We'll take the [12] questions obviously one at a time.

[13] Q: Doctor, are you, do you have any opinion whether [14] or not the emergency room doctor, Dr. Barron, [15] deviated from accepted standards of medical care [16] in the treatment of Thelma Lloyd?

[17] **MS. VANCE:** I just answered that, I [18] said he is not going to be asked to express [19] any opinions on that subject. [20] **MR. PARKER:** I object. I don'tsee [21] how that relates to COBRA. It does not [22] express standards in standards of care.

[23] **MS. VANCE**: It is a matter of [24] whether the patient is stable or not, and [25] as you well know, that is the orientation

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iii he brought to the case.

[2] **MR. PARIS:** I understand the [3] doctor's answer would be no?

[4] **MS. VANCE:** The doctor has not [5] reviewed the case nor has he been asked to [6] express any opinions as to whether or not [7] any individual physicians deviated or [si violated any standards of care or complied [9] with it.

[10] **MR. PARIS:** He is not going to be [11] expressing any opinions on that question?

[12] **MS. VANCE:** No. He's not.

[13] MR. PARIS: Same as it relates to [14] the deviations by the staff physicians?
[15] MS. VANCE: Alleged deviations, [16] same answer. He is not looking at that.
[17] He is looking at what COBRA is, which is [18] not medical malpractice.

[19] **MR. PARIS:** I take it the doctor [20] has no opinions as to whether any alleged [21] deviation by either the ER doctor or the [22] staff physicians were a proximate cause of [23] Thelma Lloyd's ultimate death, is that [24] correct?

[25] MS. VANCE: He is looking at the

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11 status of the patient as she departed from [2] the St. Luke's Hospital and whether or not [3] upon discharge and upon transfer, as that [4] term is used in -he statute, there was a [5] COBRA violaion. [6] He's not looked into, he's got the [7] records, I provided him with everything, he [8] is not going to be expressing opinions [9] about proximate causation.

[10] **MR. PARIS:** I take it the doctor is [11] not going to be expressing an opinion as to [12] Thelma Lloyd's life expectancy, various [13] type of cardiac care?

[14] **MS. VANCE:** That is exactly right, [15] he will not.

[16] Q: Doctor, do you have an opinion based upon a [17] reasonable degree of medical certainty as to [18] whether Thelma Lloyd was having an acute MI [19] while at St. Luke's Hospital on December 17,[20] 1990?

[21] **A:** I haven't really looked at it from that [22] standpoint but give me a moment just to think [23] about that because I have reviewed the [24] materials, so I could discuss that.

[25] Q: I understand that is not an opinion that you

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[1] gave in your report.

[2] **A:** Yes. I'm clear on that. But inasmuch as it [3] relates to stability of the patient, in my [4] opinion, that would be relevant, so my answer is [5] yes.

[6] Q: Yes, you have an opinion?

[7] **A:** Yes, that's correct.

[8] Q: What is your opinion?

[9] **A:** That she was not having an acute **MI** at that [10] time.

[11] Q: And you will be expressing an opinion as to [12] whether or not a COBRA violation occurred in the [13] care of Thelma Lloyd at St. Luke's Hospital, is [14] that right?

[15] A: Yes, sir.

[16] **Q:** What does it mean to be board certified in [17] emergency room care?

[18] **A:** Well, it's board cei-tified in emergency [19] medicine. What that means is that one has taken [20] an examination that has been offered by either [21] the American Board of Emergency Medicine, or the [22] American Board of Osteopathic Emergency [23] Medicine, and passed that examination.

[24] Q: Okay. Doctor, would you agree that a patient [25] who may have two or more conditions responsible

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[1] for their complaints, and one of those [2] conditions is potentially life threatening and [3] the other is not, can we agree that the accepted [4] standard of medical care is to rule out the most [5] critical condition first?

a MR. PARKER: Objection.

7] **MS. VANCE:** Object. You are [8] getting back to standards of care. That is [9] not what he is here for. [10] **MR. PARIS:** It is very important in [11] terms of determining stability of a [12] patient.

[13] **MS. VANCE:** I don't see how, Can [14] you rephrase the question?

[15] MR. PARIS: No.

[16] **MS. VANCE:** Questioning him as to [17] what the standard of care calls for, I [18] don'tsee the relevance of that to the [19] issue of stability under COBRA analysis [20] which is what we're here about and what [21] this witness is here about.

[22] **MR. PARIS:** Bear with me and you'll [23] find out.

[24] **MS. VANCE:** I'd like to hear the [25] question either rephrased or put to him

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[1] otherwise because I just don't see that [2] there's any relevance at all.

[3] Q: When you have a patient with two conditions, [4] Doctor, I'm sorry, a patient who may have two or [5] more conditions responsible for their [6] complaints, one of those conditions is [7] potentially life threatening and the other is [8] not, why is it important to rule out the most [9] lethal condition first?

[10] MS. VANCE: Objection.

[11] **MR. PARKER:** Join in the [12] objection.

[13] Q: First of all, do you agree with me it is [14] essential to rule out the most lethal condition [15] first?

[16] **MR. PARKER:** Objection.

[17] MS. VANCE: Objection.

[18] MR. GORDON: I don'thave to.

[19] A: Actually, I was waiting for - I do not agree [20] with you.

[21] Q: Why don'tyou agree with me?

[22] **A:** Because your question leaves out relative [23] probabilities of the existence of the entities [24] and the judgment.

[25] So it is not the way medicine is practiced,

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[1] it is not the standard of care to do what you're [2] suggesting and, as a matter of fact, it is [3] inappropriate to do what you're suggesting.

[4] Q: It is inappropriate to rule out the most lethal [5] condition first?

[6] **A:** Absolutely, for the reasons I mentioned.

[7] Q: And those are again?

[8] **A:** Relative probability of existing condition, not [9] to mention side effects of the procedures one [10] might have to go through eo rule out such a [11] condition.

[12] Q: As between a heai-t attack and a hiatal hernia, [13] Doctor, which is the more life threatening?

[14] **MS. VANCE:** Objection insofar as it [15] is not a complete recitation of several of [16] the conditions present in Thelma Lloyd on [17] December 17,1990.

[18] **MR. PARKER:** It's not only not a [19] complete description of the ultimate [20] diagnosis or rule out diagnoses that were [21] written, it also is incomplete as to the [22] presentation of the patient.

[23] Q: You may answer.

[24] **A:** I don'tknow.

[25] Q: You don't know what is the most life

[1] threatening, a heart attack or hiatal hernia?

[2] **A**: No. How would anybody know that?

[3] Q: I don't know.

[4] Have you treated patients who have died of [5] a hiatal hernia?

[6] **A:** I believe I have but I haven't followed every [7] patient through to their demise. So I don't [s] know.

[9] Q: Have you treated patients who died of a heart [10] attack?

[11] A: Certainly.

[12] **Q**: Have you treated more patients that die of a [13] heai-t attack than hiatal hernia?

[14] A: I believe so.

[15] Q: As between a heai-t attack and an esophageal [16] reflex, which is the more threatening life [17] threatening condition?

[18] **MS. VANCE:** Same objection.

[19] **MR. PARKER:** Objection.

1201 **A:** In that case, the answer usually would be the [21] heart attack.

[22] Q: Why is that?

[23] **A:** A reflex is such a common entity that rarely [24] results in esophageal perforation, which can be [25] life threatening, then I think the general

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[1] consensus would be that the heart attack has the [2] higher chance of being lethal.

[3] But the way you presented the first case, [4] comparing it to a complete hiatal hernia with [5] the entire contents of the abdomen and the [6] chest, the hiatal hernia is much more life [7] threatening.

[8] So your questions don'ttake into account [9] the range of disease processes. That is why [10] they are so difficult to answer. They leave out [11] important factors.

1121 Q: I didn't insert the facts that you just [13] recited.

[14] **A:** That's right. And that's why I answered the [15] question the way I did, because the potential, [16] the range of

## Deposition of Bruce Janiak, M.D. December 15, 1992

possible answers, range of entities [17] is so wide. [18] Q: Doctor, is a GI series for epigastric discomfort [19] a test that is generally performed on an 1201 outpatient basis at this institution?

[21] A: I believe it is, yes.

[22] Q: Was there anything that you saw in Thelma [23] Lloyd's record which would indicate that her [24] epigastric discomfort was life threatening?

#### [25] **A: N**O.

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[1] Q: Do you agree that Thelma Lloyd presented with [2] significant risk factors for coronary artery [3] disease?

[4] **A:** I have to tell you, I didn't review the case to [5] look at that. So I don't know.

[6] Q: Would a patient such as a **63** year old black [7] woman who had been a smoker for many years, who [8] was overweight, had high cholesterol, had a [9] history of hypertension, be one with a [10] significant risk for coronary ai-tery disease?

[11] **A:** Yes.

[12] Q: And can we agree that to determine the [13] relationship between chest pain and an acute MI,[14] it'sappropriate to do serial EKGs?

[15] **MS. VANCE:** I'm sorry, can you [16] restate it?

[17] Q: To determine the relationship between chest pain [18] and acute MI, is it appropriate to do serial [19] EKGs?

[20] **A**: That depends on much more information than [21] you've given me in that question, so I can't 1221 answer the question.

[23] Q: Can you answer the question whether it is [24] appropriate to run CPKs and isoenzymes?

[25] **A:** No.

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[1] Q: You can't answer the question or it is not [2] appropriate?

[3] **A:** It is just not enough information to be able to [4] answer your question.

[5] Q: If you have an index of suspicion of either [6] unstable angina, or myocardial infarction, is it [7] appropriate to do serial EKGs?

[8] **MS. VANCE:** Objection. I think [9] this is getting back into the standard of [10] care.

[11] **MR. PARIS:** It deals with stability [12] and deterioration.

[13] **MS. VANCE:** I don't believe it [14] does, not the path you're taking.

[15] **MR. PARIS:** And it deals with [16] emergency medical conditions and it deals [17] with appropriate screening

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processes and [18] tests, it deals with every COBRA issue.

[19] **MS. VANCE:** 1 disagree.

[20] **MR. PARKER:** I join in the [21] objection.

[22] **MR. PARIS:** That's fine. Certainly [23] you will let the doctor answer the [24] question.

[25] MS. VANCE: Sure. Read it back.

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[2] (Thereupon, the requested portion of[3] the record was read by the Notary.)

[5] **MS. VANCE:** I object insofar as it [6] doesn't accurately reflect the presentation [7] of the patient.

[8] **A:** Can you define index of suspicion a little more [9] for me or not? Are you talking about [10] possibility or probability?

[11] Q: Tell me as an emergency room doctor how you [12] would define index of suspicion?

[13] **A**: That is an easier question for me to answer. If [14] I thought that there was a reasonable [15] possibility that the patient's complaint was [16] related to the heart, and I did not think that [17] it was a problem which came from another system [18] such as the gastrointestinal system, and in that [19] same patient the, over the course of treatment I [20] had no other information which changed my [21] thinking, and in that same patient the original [22] electrocardiogram was normal, then I think it [23] would be appropriate to do serial cardiograms.

[24] Q: Same response as it relates to serial cardiac [25] isoenzymes?

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[1] A: Right.

[2] **Q:** Why is it necessary for you before doing those [3] tests or ordering those tests, why is it [4] important for you in that setting not to think [5] that complaints would be from GI?

[6] Why wouldn't it be sufficient if you have a [7] reasonable possibility that the patient's [8] complaints is related to the heart solely to run [9] those tests?

[10] **A:** Well, I think I mentioned that over time, a [11] patient — let's describe a patient over time. [12] A patient with an initial chief complaint which [13] makes you think there is a reasonable [14] possibility that it's cardiac comes in and you [15] evaluate that patient and you order an [16] electrocardiogram and you give the patient [17] something to try to relieve their pain.

[18] If you're leaning towards heai-t problems, [19] you may order nitroglycerin. If you're leaning [20] toward gastrointestinal problems, you may give [21] an antacid preparation and the cardiogram comes [22] back normal and the pain either doesn't go away [23] with the nitro or does go away with the antacid [24] preparation, and then you get more history which [25] leads you to think more about the stomach.

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[1] In that particular case you may decide this [2] is gastrointestinal and not rule —

[3] Q: How do you rule out acute MI, Doctor?

[4] **A:** If you use, if the word rule out means 100 [5] percent, and the cardiogram is normal, you'd [6] probably have to do either angiography or I [7] guess sensitivity of thallium scanning is [8] better, but the 100 percent rule out would be a [9] biopsy of the heai-t muscle itself.

[10] Q: As a diagnostician, how do you rule out MI?

[11] **MR. PARKER:** I'm real confused [12] whether the scenario you're positing is for [13] the patient's care both in an emergency [14] room setting and on a floor or are we [15] talking hypothetically about an emergency [16] room setting only? Because I'm confused.

[17] **MR. PARIS:** I'minthe emergency [18] room now.

[19] Q: How do you rule out acute MI?

[20] **A:** In the emergency department? I don'tknow.

[21] Q: Have you ever?

[22] A: I don't think so.

[23] Q: What steps do you take to assist the patient's[24] evaluation so that acute MI is ruled out?

[25] MR. PARKER: I'm going to object.

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[1] I think that goes into standard of care and [2] I also think it's presupposing a function [3] on an emergency room that I'mnot sure an [4] emergency room has.

[5] **MR. PARIS:** It deals with [6] appropriate medical testing.

[7] **MS. VANCE:** I'm going to object as [8] well.

[9] **MR. PARIS:** It deals with [10] stability. It deals with a determination [11] of an emergency medical condition. These [12] are all COBRA issues, folks.

[13] **MR. PARKER:** That wasn't the basis [14] of my objection. If you listened to my [15] objection, you are presupposing a role for [16] an emergency room that has not been [17] established is the role for the emergency [18] room, that is to completely rule out a [19] patient's medical condition. I think [20] that's a gross —

[21] **MR. PARIS:** I didn't say that [22] though.

[23] **MR. PARKER:** That is what your [24] question presupposes and that is the basis [25] of my objection.

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[1] MR. GORDON: That's good. Can the[2] doctor answer the question?

[3] MR. PARIS: Could you read it back?

[5] (Thereupon, the requested portion of [6] the record was read by the Notary.)

[8] **MS. VANCE:** Join in all those [9] objections.

[10] **A:** There are numerous approaches to that. One [11] approach is to seek consultation and have the [12] patient cared for by another physician in an [13] inpatient setting.

[14] Another approach is one in which over a [15] period of time further testing can be done [16] either in an emergency room department that is [17] set up to do that, or in another intermediate [18] cart: setting which is set up to do that which [19] may be located near the emergency department of [20] on the floor, commonly termed an observation [21] unit.

[22] Other than that, I don't think there's any [23] way to rule out an acute MI. All one can do is [24] make a determination that it is just two [25] unlikely an event that does not warrant further

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[1] evaluation.

[2] Q: Did Dr. Barron entertain a differential [3] diagnosis of myocardial infarction for Thelma [4] Lloyd?

[5] **A:** I don'tthink I know that answer.

[6] Q: Did you read her deposition?

[7] **A:** Yes.

[8] Q: Did she, she so testified.

[9] **MS. VANCE:** If you want him to, [10] refer him to a particular page to assist [11] him. He has read it.

[12] Q: I want to know whether you have a recollection [13] of that or not.

[14] **A:** I don't have a recollection of her specific [15] words.

[16] Q: Did Dr. Barron's differential diagnosis include [17] chest pain cardiac versus GI?

[18] **A:** Yes.

[19] Q: Was that appropriate?

[20] A: I thought that was appropriate.

[21] Q: Did Dr. Barron order CPK and cardiac [22] isoenzynies?

[23] MS. VANCE: Objection.

[24] **A:** It is my memory that at some point in the [25] emergency room a CPK was ordered.

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[1] Q: And cardiac isoenzymes?[2] A: I don'tknow about that.

# Shirley Bolden vs. St. Lukes Hospital

# Deposition of Bruce Janiak, M.D.

Court of Common Pleas, Cuyahog	December 15, 1992	
•		December 15, 1992[10] Q: You are aware that she had an elevated CPK, is [11] that correct?[12] A: I'm aware that the CPK number from the lab was [13] elevated according to that particular lab, yes.[14] Q: You are aware that her LDH was elevated?[15] A: I do. I didn't pay much attention to that. I [16] think that is true, too.[17] Q: And her AST?[18] A: Right.[19] Q: Do you know the significance of those [20] elevations?[21] A: The CPK is for muscle. The other two are more [22] nonspecific and in general any organ can cause [23] eleva- tion. So I have no opinion about the other [24] elevations.[25] Q: Do you know the significance of those three
question?	tions was Thelma	Page 56
[21] <b>MR. PARIS:</b> I'll withdraw that. [22] Q: Did Dr. Barron appropriately order CPK and [23] cardiac isoenzymes in an effort to rule in or [24] rule out acute MI?	Page 54 [1] Lloyd suffering from that were caus- ing her [2] complaints and symptoms at St. Luke's Hospital [3] on December 17, 1990?	[1] values being elevated in the face of a patient [2] having chest pain with sig- nificant coronary [3] ai-tery disease risk factors?
[25] <b>MS. VANCE:</b> I'mjust going to	[4] <b>A</b> : You're asking me for my opinion	<ul><li>[4] A: No, I don't.</li><li>[5] Q: Did any of the physicians on the</li></ul>
Page 52 [1] object and ask for clarification of the [2] term appropriate. In the context of a [3] COBRA analysis? [4] Q: Was it appropriate to do that, to	of what was [s] bothering her? [6] Q: Yes. I want to know in your opinion what [7] conditions or condition she was suffering from [8] that were causing her complaints and symptoms.	<ul> <li>[5] Q. Did any of the physicians on the general floor [6] perform one test to rule in or rule out an acute [7] MI of Thelma Lloyd?</li> <li>[8] MS. VANCE: Objection.</li> <li>[9] MR. PARKER: Objection.</li> </ul>
determine [5] whether or not an emer- gency medical condition [6] existed? [7] <b>A:</b> I guess I don't think that the tests are [8] inappropriate but I wouldn't say they are done [9] to determine if an acute emergency medical [10] condition ex- isted.	<ul> <li>[9] MS. VANCE: I object. I think it [10] goes beyond the scope of what this witness' [11] testimony is intended to be about in terms [12] of what COBRA requires.</li> <li>[13] MR. PARIS: It goes to emergency [14] medical condition, stability.</li> </ul>	<ul> <li>[10] A: Are you referring to either further enzyme [11] testing or electrocardiographic testing?</li> <li>[12] Q: Any test that you feel would be appropriate to [13] rule in or rule out an acute MI.</li> </ul>
<ul> <li>[11] Q: Would ordering a CPK and cardiac isoenzymes be [12] an appropriate test to order if you were trying [13] to rule in or rule out an acute MI?</li> <li>[14] MS. VANCE: Objection to the form [15] of the question.</li> </ul>	<ul> <li>[15] MR. PARKER: I join in the [16] objection.</li> <li>[17] Q: Do you know, Doctor?</li> <li>[18] A: Well, yes, in looking at that, I do have an [19] opinion.</li> <li>[20] Q: What is your opinion?</li> </ul>	<ul> <li>[14] MS. VANCE: Object. Assumes facts</li> <li>[15] not in evidence.</li> <li>[16] MR. PARKER: Join.</li> <li>[17] MS. VANCE: It makes assumptions</li> <li>[18] about what should or should not have been [19] appropriately done in that</li> </ul>
<ul> <li>[16] A: See, the answer is yes, it's okay to order the [17] tests, but the patient has to be evaluated over [18] time. So the test alone is only one small piece [19] of the picture.</li> <li>[20] Q: There is no question. I just want</li> </ul>	<ul> <li>[21] A: I think she was suffering from some esophageal [22] reflex.</li> <li>[23] Q: Anything else?</li> <li>[24] A: Not on the 17th of — I'm sorry, I forgot the [25] month.</li> </ul>	scenario and in [20] that situation. [21] <b>A</b> : I don't remember any specific tests that related [22] to myocardial in- farction. [23] Q: When she came in — strike that.
to know if [21] that is a step in the right direction in ruling [22] in or ruling out an	Page 55 [1] MR. GORDON: December.	[24] Were her vital signs stable on the [25] emergency ambulance run in any of the documents
acute MI? [23] <b>A</b> : We have the same problem with ruling in or [24] ruling out. But ordering the test is a step in [25] the right direction.	<ul> <li>[2] A: December.</li> <li>[3] Q: December 17, 1990?</li> <li>[4] A: Correct.</li> </ul>	Page 57 [1] that you have? This should not be a guessing [2] game for you, Doctor. [3] <b>A:</b> It can't be because I don't guess
Page 53 [1] <b>Q</b> : And it's a seep in the right direc- tion in trying [2] to determine whether or not the patient is [3] having an acute MI?	<ul> <li>[5] Q: Do you have an opinion based upon a reasonable [6] degree of medical certainty as to the cause of [7] her elevated CPK?</li> <li>[8] MS. VANCE: Same objections.</li> </ul>	<ul> <li>[4] MR. GORDON: Here, let me help [5] you.</li> <li>[6] A: Thank you.</li> </ul>
[4] MR. PARKER: Objection. Asked and [5] answered.	[9] <b>A:</b> I've never looked at that. I don't know.	[7] Q: What were her vital signs? [8] <b>MS. VANCE:</b> In the ambulance?

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#### **Deposition of Bruce Janiak**, M.D. Deceinber 15, 1992

[9] **A:** Yes. In the ambulance. Cuyahoga County EMS [10] run, I think dated 17 December, she had a blood [11] pressure of 108 systolic over something [12] diastolic. I don'tknow what.

[13] O: Is that P?

[14] A: It means palpable. The pulse was 80 and [15] respirations was 20.

[16] Q: Is that normal?

[17] A: Cei-tainly can be.

[18] Q: What are the normal ranges?

[19] A: Well, for — I'm not sure. Normal ranges for [20] what? For patients of this age riding in [21] ambulances or for patients of this age or for [22] all humans? [23] Q: How would you make a determination of whether or [24] not this was a normal vital sign for this [25] person?

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[1] A: By doing a history and physical examination.

[2] Q: Based on what you know about this patient, based [3] on the history and the physical exam that was [4] performed by others, do you have an opinion as [5] to whether these vital signs are normal?

[6] **A:** Yes.

[7] Q: And what is your opinion?

[8] A: That they are totally normal. They're fine.

[9] Q: In the emergency room, are you aware of what her [10] vital signs were?

[11] A: I have to look that up, too.

[12] Q: I think I saw a blood pressure of 130 -

[13] MR. GORDON: Page 24, Doctor.

[14] Q: 130 over 90? I think that appears there.

[15] A: On that page I see 130 over 90.

[16] Q: How does that compare to her prior blood [17] pressure?

[18] A: Well, a systolic increase of 22 points.

[19] **Q**: What is the significance of that?

[20] A: None that I'm aware of.

[21] Q: There's no change or divergence there between [22] the two blood pressures?

[23] A: Absolutely. There is a 22 point systolic [24] difference.

[25] Q: One would not be normal and one would not be

Page 59	[24] A: I would like to le
[1] abnormal, they are both normal?	sheet of paper [25] a
[2] A: They are both within normal	physician's record in th
limits.	
[3] Q: Anybody check her pulse or	[1] emergency departme
respiration?	[2] MR. GORDON: That'
[4] <b>A:</b> Well, there's a pulse of 64 written	Page 24.
down and a [5] respiration rate of 16.	[4] A: All right. Okay. I
[6] Q: Is that stable?	thing on this [5] particu

Shirley Bolden vs. St. Lukes Hospital Court of Common Pleas, Cuyahoga County, Ohio

[7] A: Well, it represents a change in pulse of 16 and [8] a change in respiratory rate of four.

(9) O: But is it stable?

[10] A: Strict technical definition of instability [11] meaning change over time that one thinks is [12] significant, I think it's stable.

[13] Q: Is it nornlal?

[14] A: Yes.

[15] **Q**: So in the ambulance, her vital signs are normal [16] and stable? I don't want to misquote you.

[17] A: You would be misquoting me if you said that.

[18] Q: In the ambulance, are her vital signs normal?

[19] A: Yes.

[20] **Q**: Are they stable?

[21] A: I don'tknow.

[22] Q: You don't know because you don' thave anything [23] to compare it to?

[24] A: Right.

[25] **Q**: In the emergency room, are her vital signs

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11 normal?

[2] A: Yes.

[3] **Q**: Are they stable?

[4] A: Now I'dhave to look further to see if they were [5] taken again.

[6] Q: In the emergency room, is that what you're [7] saying?

[8] A: Right. If you're just looking at that, if you [9] have in the emergency department the information [10] from the ambulance, then you have two sets of [11] vital signs. Normally you do have such a [12] thing.

[13] Q: Look at page 10 or 11, Doctor. I don'thave [14] anything else in the emergency room.

[15] A: There's your page number 30, St. Luke's [16] Hospital.

[17] Q: That is the history and physical? [18] A: Yes.

[19] Q: That's up on the floor?

[20] A: I am just asking you.

[21] Q: That's up on the floor. Is there anything else [22] in the emergency room that you were able to spot [23] that would give us an indication of —

look at one more and that is the he

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nent. 'sit right [3] there.

do not see anything on this [5] particular sheet which indicates anything [6] further as to blood pressures or pulses.

[7] **Q**: If her blood pressure by, let's say, 1:30 in the [8] morning was 130 over 65, would that indicate [9] that that was normal and stable?

[10] A: Right.

[11] Q: Can you have an emergency medical condition, [12] Doctor, and still have vital signs that are [13] normal?

[14] MS, VANCE: Objection. Again [15] you're using the phrase as it is defined in [16] the COBRA statute?

[17] Q: What do you understand emergency medical [18] condition to mean, Doctor?

[19] **MS. VANCE:** It is your question.

[20] Q: I would like to know what your understanding is, [21] Doctor.

[22] A: You want to know what my definition of an [23] emergency. medical condition is? Any condition [24] which prompts a patient to come in to the [25] emergency department to seek advice or care.

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[1] Q: Would that include a condition which if left [2] untreated would in all likelihood lead the [3] patient to some serious health problems?

[4] MS. VANCE: Objection.

[5] MR. PARKER: I join in the [6] objection.

[7] MS. VANCE: If you're quoting the [8] COBRA statute, why don'tyou do so [9] accurately.

[10] MR. PARIS: I am not trying to do [11] SO.

[12] Q: I would just like to know if that would include [13] that scenario.

[14] **A:** If your scenario was a condition which prompted [15] a patient to come in to the emergency [16] department, yes.

[17] Q: Can one under that definition, Doctor, an [18] emergency medical condition, have vital signs [19] that are normal?

[20] A: Yes.

[21] Q: And —

[22] A: Excuse me, I'm sorry, nlay I ask you a question? [23] I'mnot sure I understood your question. Under [24] what condition? Under my definition?

[25] Q: Did you accept my addition to your definition?

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[1] A: I had a very broad definition and you had one [2] that was a subset of that. I said if your [3] subset is what prompted the patient to come in, [4] yes, it was.

[5] Q: We are agreed on the definition then as between [6] ourselves for the purposes of this next [7] question.

#### [8] **MS. VANCE:** Your subset?

[9] **MR. PARIS:** Yes. Which includes my [10] subset.

[11] Q: Are we on the same wavelength?

[12] **A**: I don't think so. Anything that prompts the [13] patient to come into the emergency room, gunshot [14] wound to the head or hangnail, it is an [15] emergency medical condition to them. That is my [16] definition.

[17] Q: Can one have vital signs that are normal and [18] still have an emergency medical condition?

[19] **A:** Based on my definition, absolutely.

[20] Q: Can one have vital signs that are stable and [21] still have an emergency medical condition?

[22] **A:** Yes.

[23] Q: Doctor, how do you come by your knowledge of the [24] COBRA law?
[25] A: Well, I suppose the term osmosis might be a good

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[1] one. It is just a matter of having the [2] responsibility for being director of a 131 department and having read the litemture which [4] has come out with analysis of such law by [5] various organizations to which I belong.

[6] Q: Well, are you the house officer in charge of [7] this hospital's compliance with COBRA?

[8] A: Well, I'm not a house officer.

[9] Q: I'm sorry. Are you the person at this [10] institution who's in charge to insure that this [11] institution complies with the COBRA laws?

[12] A: I would say no.

[13] Q: Who is at this institution, if anyone?

[14] **A**: I would guess, and I'm not sure, but I would [15] guess the institutional responsibility would [16] probably lie with the hospital's counsel.

[17] Q: And do I understand that the publications that [18] you have read that have providedyou with this [19] knowledge of COBRA includes the news letter that [20] we're going to mark as an exhibit and the [21] undisclosed publication by Attorney Krugh?

[22] **A:** Correct, plus other materials and discussions.

[23] Q: Have you attended any seminars?

[24] **A:** I have never attended a seminar that related [25] specifically to COBRA.

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[1] Q: Would you tell LTS what are the purposes of [2] COBRA?

[3] **A:** I think that you would have to ask Congress. I [4] don't know but the original idea was a [5] Congressional reaction to a perception that [6] patients were being inappropriately transferred [7] but it was referred to as dumping, quote, [5] unquote, and Congress formulated what they [9] thought was a law that tried to prevent this.

[10] Q: Would you agree that one of the purposes of [11] COBRA is to insure that poor patients without [12] private doctors or without insurance or without [13] wealth get the same standard of medical care as [14] patients with insurance or with wealth or with [15] private doctors?

[16] **MS. VANCE:** Objection. I think you [17] are confusing standard of care.

[18] MR. PARIS: No, I'mnot.

[19] Q: Can you answer the question, Doctor?

[20] MR. PARKER: I join in the [21] objection.

[22] **A:** I don't think I could tell you what was in [23] Congress' mind when they formulated this thing.

[24] Q: Would you agree that COBRA requires hospitals to [25] conduct an appropriate screening test to

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[1] determine if the patient has an emergency [2] medical condition?

[3] **MS. VANCE:** Objection. You are [4] misstating the statute.

[5] Q: Would you agree with that?

[6] **A:** I don't think that's what it says. That is my [7] memory.

[8] **Q**: What is your understanding —

[9] MS. VANCE: Well, he's not —

[10] Q: — of what that requirement is?

[11] **MS. VANCE:** I don't think it is [12] incumbent on him to quote the statute. If [13] you have it before you, you can just [14] rephrase your question.

[15] Q: Doctor, tell me the elements which constitute [16] COBRA violations based on your understanding of [17] the law.

[18] **A**: Based on my understanding, a failure to perform, [19] to evaluate a patient and to dismiss that [20] patient without such evaluation would be a [21] violation.

[22] A transfer of a patient from one [23] institution to another without a screening [24] evaluation would be a violation.

[25] A transfer of an unstable patient in

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[1] certain circumstances could be a violation, if [2] that transfer were done, at least originally the [3] intent was for financial reasons, and I believe [4] another element was that the patient had to [5] suffer some harm in that transfer.

[6] **Q**: Any other components relevant to COBRA that [7] you're familiar with?

## Deposition of Bruce Janiak, M.D. December 15, 1992

[8] **A:** Well, the answer to that is yes but it's like [9] asking me is there anything I'm familiar with in [10] a text book. I can'trecite them. I'dhave to [11] study it.

[12] Q: Can we agree that COBRA requires that all tests, [13] evaluations and transfers of a patient be [14] conducted on the basis of needs of the patient, [15] and not on whether the patient is a private [16] paying patient or a poor Welfare recipient?

[17] MS. VANCE: Objection.

[18] **Q:** Can we agree on that?

[19] **A**: I think in general we could agree but I'm not [20] sure, you use the word all tests, and every time [21] the word all is thrown in, I will withdraw and [22] say I'm not sure about all.

[23] Q: Same question, I'll rephrase the question.

[24] Would you agree that COBRA requires that [25] tests, evaluations and transfers of a patient be

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[1] conducted on the basis of the needs of the [2] patient?

[3] A: The medical needs of the patient.

[4] Q: Yes, the medical needs.

[5] A: Yes.

[6] Q: And not on whether the patient is a private [7] paying patient as opposed to a poor Welfare [8] recipient, would you agree with that?

[9] **MS. VANCE:** Objection to the form [10] of the question.

[11] **A:** I'mnot sure I can agree with that because I [12] think they don't even have to be Welfare [13] recipients. I think they could just be people [14] without any money.

[15] So I don't think — as I remember, it [16] didn't single out alleged mistreatment of [17] Welfare people.

[18] Q: So people without funds, is that right?

[19] **A:** Yes.

[20] **Q:** People without private doctors?

[21] A: There could be people, yes.

[22] Q: Are you familiar with the penalty set forth in [23] COBRA?

[24] **A:** I don'tremember the number but I think there's [25] some per incident which is moderately

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[1] substantial.I don'tknow whether it is \$10,000[2] or \$50,000.

[3] Q: Are you familiar with any penalties that is [4] associated with the hospital's receipt of or [5] participation in Medicare or Medicaid programs?

[6] **A:** Yes.

[7] **Q:** What are the penalties?

### Deposition of Bruce Janiak, M.D. December 15, 1992

[8] **A:** Well, if, I think if an appeal is lost, it is [9] possible for a hospital to lose its affiliation [10] with Medicare. I don't remember Medicaid. But [11] I'm sure Medicare.

[12] Q: Doctor, would an acute myocardial infarction in [13] a patient constitute a medical condition which [14] could be reasonably expected to result in [15] placing that patient'shealth in jeopardy if [16] left untreated?

[17] **MS. VANCE:** Objection. Either [18] restate the question or read it.

[20] (Thereupon, the requested portion of [21] the record was read by the Notary.)

[23] MS. VANCE: Object to the form of[24] the question, particularly in light of[25] COBRA, insofar as it is taking into

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[1] consideration diagnoses that was not then [2] known or appreciated.

[3] **MR. PARKER:** I object **as** well.

[4] **A:** I need to answer your question in this [5] particular way. You said if left untreated, and [6] I believe that patient's health would be in [7] jeopardy if complications of an acute myocardial [8] infarction were left untreated.

[9] Leaving the MI itself untreated may not [10] necessarily change anything in terms of the [11] patient' shealth or future health.

[12] Q: Well, are some of the dangers in leaving an [13] acute myocardial infarction untreated, at least [14] which are foreseeable, are those that relate to [15] extension of the MI?

[16] **MS. VANCE:** Objection.

[17] **A:** The answer to that is yes.

[18] Q: And reinfarction?

[19] A: I don'tknow the answer to that. I don'tknow [20] whether reinfarction —
[21] Q: But certainly extension, is that right?

[22] **A:** Extension is one of the complications.

[23] Q: It is more likely than not, is it, Doctor, that [24] an untreated acute MI will — strike that.

[25] Are patients who have an acute MI more

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[1] likely to have a better prognosis with admission [2] to a coronary care unit and access to the full [3] range of cardiac care than with being sent home [4] to exert themselves and receiving no treatment [5] at all?
[6] MS. VANCE: Objection.

[7] MR. PARKER: Objection.

[8] **MS. VANCE:** Incomplete statement of [9] the facts. Doesn't accurately reflect the [10] presentation of the patient.

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[11] Q: As a general proposition, Doctor,

[15] Q: Does this institution have any

[17] A: I believe we have, we have some.

They're [18] probably, for our purposes

in the emergency [19] department, re-

[21] Q: Including discharge, is that right?

[23] Q: Do you consider a transfer dis-

[25] Q: Do you consider a discharge a

[2] **Q:** Is it your understanding that —

[3] Did Thelma Lloyd have any clinical

evidence [4] of an acute MI on December

[5] A: Not any more so than clinical

evidence of other [6] disease processes.

[9] **Q:** It was both equally the same?

[10] A: I'm not sure what that question

[11] Q: You said not any more so than

other disease [12] processes being GI, I

symptomatology could have [14] been

caused by GI but probably more so than

[15] myocardial infarction, if you add in

some of the [16] other findings over time.

[17] Q: By how much percentage wise?

[19] Q: One percent cardiac, 99 percent

[22] **MS. VANCE:** He said he can't do [23]

[25] Q: You can't give us any measure-

3] Q: Based on her clinical presenta-

5] Q: It could be 51 percent GI, 49 car-

iii quantitative measurement at all?

4] A: More likely than not.

а **MS. VANCE:** Objection.

7] A: More likely.

is

that

her

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answer

[18] A: I can't give it a percent.

[20] **MS. VANCE:** Objection.

[24] **A:** I don't know.

[21] MR. PARKER: Objection.

[7] O: GI disease processes?

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lated to a checklist for [20] transfers.

regulations [16] related to CQBRA?

would you [12] agree with me?

[13] MS. VANCE: Objection,

[24] A: Not that I know of.

[14] A: Yes.

[22] **A:** No.

charge?

transfer?

[1] A: No.

strike that.

17.1990?

means.

suppose?

[13] **A:** My

GI?

that.

ment, any

21 A: No.

tion?

diac?

[8] A: Correct.

[8] **MR. PARKER:** Objection.

[9] **MS. VANCE:** He stated he cannot do [10] that.

[11] Q: It is your understanding more likely than not in [12] the medical/legal context is anything over 50 [13] percent?

[14] **A**: I think that is the system you people use.

[15] Q: And what is the basis of your opinion that [16] Thelma Lloyd did not have an acute MI or was not [17] suffering the effects of an acute MI when she [18] presented at St. Luke'son December 17, 1990?

[19] **A:** There are several things. She did not have a [20] tachycardia. She did not have any arrythmia [21] that was significant. She may have had an extra [22] breath. I don'tknow the answer to that.

[23] No significant arrythmia. She had pain [24] that was alleviated by antacids. She had no [25] response to nitroglycerin.

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[1] **MR. GORDON:** Did you say no [2] response?

[3] **A:** No significant pain relief from nitroglycerin, [4] and if one reviews well, I don'tremember, I [5] was going to say if one reviews the autopsy, but [6] I guess I don'tremember what the autopsy [7] shows. So give me a moment to take a look at [8] that.

[9] Oh, yes. Autopsy revealed extensive recent [10] myocardial infarction 24 to 48 hours old.

[11] Q: Absent the autopsy, Doctor, and on a clinical [12] basis, have we discussed all of your opinions 1131 why you don't believe she had an MI while, she [14] was suffering from an acute MI while at St. [15] Luke's Hospital?

[16] **A:** All I can think of right now.

[17] Q: Do you know why, Doctor, her chest –

[18] A: Excuse me. You asked the question so I thought [19] of something else.[20] Q: Okay.

[21] **A:** As I remember, although I didn't see the x-rays, [22] I told you I didn't, that the x-rays were [23] consistent with esophageal reflex.

[24] *Q*: The GI series?

[25] **A:** The GI series, correct. That is the other

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in thing. I'm sorry to interrupt.

21 Q: That is why you feel she did not have an acute [3] MI?

41 **A:** That whole list of reasons.

5] Q: Doctor, what was the reason that her chest pain [6] returned after she was given antacids? [7] **A:** I don'tthink we know the answer. I don'tknow [8] the answer to that.

[9] Q: Do you know what her response was on the second [10] time she was given sublingual nitro?

[11] **A:** No, I don't.

[12] **Q**: Would it affect your opinion if she received [13] questionable relief?

[14] **MS. VANCE:** You're referring to St. [15] Luke's or now you're referring to [16] Metropolitan?

[17] **MR. PARIS:** St. Luke's. I'm on [18] December 17,1990.

[19] **A:** No, it would not.

[20] Q: Would it affect your opinion if her chest pain [21] came back after she was given antacids?

[22] **A:** No.

[23] **Q**: And I take it her elevated LDH, CPK and AST have [24] no significance to you in your opinion that she [25] was not suffering an acute MI, is that right?

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[1] A: That is correct.

[2] Q: Doctor, is it a violation of COBRA to elect not [3] to review a patient's laboratory studies because [4] she is a staff patient as distinguished from a [5] private patient?

[6] **MS. VANCE:** Objection. It [7] misstates the fact. It misstates Dr. Bass' [8] testimony. It is not what the record in [9] this case would present.

[10] Q: Assume that could be true.

[11] **A:** If I assume that, I do not feel that is a [12] violation of COBRA.

[13] Q: Do you consider that to be providing a separate [14] system of medical care based upon the [15] classification of a patient?

[16] **MS. VANCE:** Objection, all the [17] reasons previously stated. It is an [18] incomplete recitation of facts relating to [19] this case.

[20] **A:** I'm not sure what you mean. Could you ask the [21] question differently?

[22] Q: All right. Does a COBRA violation encompass [23] providing a separate diagnostic and treatment [24] approach to a patient based upon their [25] designation as a staff patient versus their

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designation as a private patient?
 MS. VANCE: Objection. [3] Incomplete. It is not what the record [4] shows.
 A: I don't know how to answer the question.

[6] **Q:** Why?

[7] **A:** Well, because I'm not sure what you mean by [8] separate diagnostic and treatment approach. If [9] you are saying that patients who are insured can [10] receive some life saving diagnosis or therapy, [11] and patients who are not insured will have that [12] deliberately withheld, then I would say that [13] probably would be a violation.

[14] If you're saying that private patients [15] aren'tcared forby private physicians and staff [16] patients are treated by a team, then I don't [17] think that is any violation or anything to do [18] with COBRA.

[19] Q: Do you have a designation in this hospital [20] between staff patients and private patients?

[21] A: Yes.

[22] Q: And who, how are they categorized? Who [23] comprises the staff patients in this hospital?

[24] **A**: Staff patients are patients that do not have a [25] relationship with a private physician that is on

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[1] the staff of this hospital.

[2] Q: Anybody else or is that it?

[3] **A:** This is the end of the definition.

[4] Q: Private patients are who?

[5] **A:** Patients who have a relationship with a private [6] physician that is on the staff of this hospital.

[7] Q: A physician at this hospital, I want you to [8] assume that a physician at this hospital is [9] assigned a staff patient, and because the person [10] is a staff patient, this attending physician [11] consciously elects not to review the patient's [12] laboratory studies, whereas he would review the [13] patient's laboratory studies if it was his own [14] private patient, and the staff patient was then [15] discharged without having the labomtory studies [16] looked at by the attending physician.

[17] Does that conduct constitute a COBRA [18] violation in your opinion?

[19] **MS. VANCE:** Objection.

[20] **A:** No.

[21] **Q:** What does that constitute, if not a COBRA [22] violation?

[23] **A**: It is a system of health care in which an [24] attending physician has a relationship with [25] physicians who are in training in that

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[1] particular specialty and it's different [2] communication methodology. It is nothing more.

[3] Q: Do you work with residents and interns in the [4] emergency room?

[5] A: Every day.

[6] **Q**: Do you review their work?

[7] **A:** It depends on your definition of review their [8] work.

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[9] Q: Well, I mean do you allow them to make life and [10] death decisions without any input?

[11] **A**: I don't think they make, I don't think they make [12] any decisions without any input. But whether [13] the input is general or specific to that [14] particular patient, it varies with each patient.

[15] Q: Well, if one of the interns or residents that [16] you're working with orders a test, do you review [17] it with them?

[18] A: Not necessarily.

[19] Q: Under what circumstances would you not review a [20] test that was ordered by an intern, resident on [21] a patient of yours?

[22] **A:** If their laboratory values, they just ask them [23] if they're normal or not.

[24] Q: Why? Why would you rely on them?

[25] **A:** Because it's a very reasonable thine. to do, to

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[1] rely on another physician to communicate to you [2] written information.[3] Q: How do you teach them if they're right or wrong?

[4] **A:** In terms of being able to read?That part is [5] taken care of in the high schools and in [6] colleges and in medical school in terms of [7] looking at tests and interpreting results. That [8] is not part of the educational process in the [9] medical post-graduate system anywhere in the [10] country.

[11] Q: You don't consider correlating laboratory [12] studies with a clinical presentation important [13] to the teaching process?

[14] MS. VANCE: Objection.

[15] **MR. PARKER:** That is different from [16] your previous question.

[17] A: My answer is yes, sure, I do.

[18] Q: And is it important to review those laboratory [19] data with your students to correlate the [20] clinical complaints with the laboratory data?

[21] **A**: It is not necessarily important that I myself [22] look at a piece of paper and see, for instance, [23] that a white count is 10,800 if they told me [24] that the white count is 10,800.

[25] MR. PARIS: Let'stake a break.

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[2] (Thereupon, a recess was had.)

[4] Q: Doctor, what was causing Thelma Lloyd — was her [5] EKG normal or abnormal? Did you read the [6] tracing?
[7] A: Oh, I did. I have to kind of glance at that [8] again. I have to find it real quick. As I [9] remember, it was slightly

abnormal. It had one [10] premature ventricular contraction.

[11] Q: What was causing that?

[12] **A:** I don'tthink anybody knows why patients have [13] premature ventricular contiactions in an [14] individual patient but they're very common and [15] one is not considered to be of significance.

[16] So you have no, it doesn't mean anything [17] one way or the other. There was no acute [18] changes on the electrocardiogram.

[19] There was one millimeter of ST segment [20] depression, and one millimeter is not considered [21] significant.

[22] Q: Do you know what was causing that?

[23] A: It is a normal variant but a lot of ST segment [24] depression is abnormal.[25] Q: But this was not an abnormal ST?

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[1] **A:** This was not an abnormal ST segment depression, [2] so I would say the same thing. There are some [3] abnormalities or variance but no acute changes.

[4] **Q**: Are you familiar with the term non-Q wave [5] infarction?

[6] **A:** Yes, I have heard that before.

[7] Q: Is this EKG compatible with a non-Q wave [8] infarction?

[9] **MS. VANCE:** Objection.

[10] **A**: My answer is all EKGs without Q waves are [11] compatible with non-Q wave infarction.

[12] Q: Is this an abnormal EKG?

[13] **A:** Yes.I think I said that.

[14] Q: I understand, Doctor, forgive me if I'm being [15] redundant, does an esophageal reflex cause [16] elevated CPKs?

[17] **A:** You did not ask that I remember and I don't[18] know.

[19] Q: Have you ever given testimony regarding COBRA [20] violations prior to today?

[21] A: I have not.

[22] Q: This is the first time you've been asked?

[23] A: Yes, sir.

sues in this case?

[24] Q: Turning to your report, top of the second page, [25] and before I specifically get to that question,

[1] why is it, Doctor, that you feel

qualified to [2] speak to the COBRA is-

[3] **A:** Well, because I'vebeen practicing

emergency [4] medicine as an emergen-

cy medicine departmental [5] director

for 18 years, and because I have served

[6] as president of the American College

of [7] Emergency Physicians and presi-

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dent of the Ohio [8] Chapter of Emergency Physicians and during that [9] course of time have had enumerable meetings with [10] both the Government Affairs Committee of our [11] college and our chairman of the college and am a [12] regular recipient of materials that are [13] published by the Government Affairs section of [14] the American College of Emergency Physicians, [15] many of which reference changes in law of all [16] kinds that relate to emergency medicine, and [17] many of those relate to COBRA and its [18] implication for the practice of emergency [19] medicine.

[20] Q: And can you tell me why in your opinion there [21] was no COBRA violation in this case?

[22] **A:** Yes, my opinion is that Congress, when they [23] wrote the law, were nonspecific and left the law [24] open to interpretation, because they just had no [25] concept of what they were trying to do.

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[1] That is my opinion. And that's one of the [2] reasons we're sitting here today.

[3] However, what the main issue that I felt [4] that Congress wanted to deal with was [5] Representative Stark's concern about, A, getting [6] re-elected; and B, stopping patient dumping.

[7] The way he wanted to stop patient dumping, [8] especially for people who were uninsured or [9] underinsured, was to mandate that patients have [10] an evaluation.

[11] I do not believe it was the intent of [12] Congress now or then to mandate that all [13] possible disease processes be totally and [14] completely evaluated prior to the patient being [15] cared for in another setting.

[16] Q: And why is it specifically that you feel that [17] there was no COBRA violations involving Thelma [18] Lloyd?

[19] **A**: Very specifically because not only did she have [20] a physical exam in the emergency department, but [21] she was kept in the hospital for an evaluation [22] over several more hours, it was approximately [23] 24, and at that time had no significant change [24] in her vital signs, did not go into shock, did [25] not develop arrythmia which produced cvanosis.

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[1] did not develop any significant issues like [2] nausea, vomiting, diarrhea, intractable pain, [3] none of those things happened. She pretty much [4] remained the same. She was stable and they [5] proved it in spades.

[6] Q: Who proves it?

[7] **A:** The interns and the doctors that were taking [8] care of her.

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[9] Q: How did they prove it?

[10] **A:** My answer to that would be would be read back, [11] just print it again.

[12] **Q**: All right. Fine. So then do I understand, [13] Doctor, it is your opinion that St. Luke's[14] Hospital conducted an appropriate medical [15] screening test for Thelma Lloyd?

[16] A: Absolutely.

[17] Q: And it was reasonable?

[18] **A:** Absolutely.

[19] **Q**: Do I understand it is also your opinion that St. [20] Luke's Hospital — strike that — that a [21] determination was not made that she was [22] suffering from an acute MI on 12/17/90?

[23] **A:** The decision to focus in on gastrointestinal [24] disease as part of her problem was made after [25] the evaluation based on the physician's judgment

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[1] and some tests that they had done. That to me [2] has nothing to do with COBRA.

[3] Q: I take it it is your opinion she was not [4] suffering from an emergency medical condition [5] while she was at St. Luke's Hospital?

[6] A: Correct.

[7] **Q:** And that there was no need for St. Luke's [5] Hospital to do anything to stabilize her [9] condition before discharging her at 3:00 or 4:00 [10] on the 17th?

[11] **A:** Her condition was already stable so there was [12] nothing more to stabilize.

[13] Q: Do you know what the cause of her myocardial [14] infarction was subsequent to her discharge at [15] St. Luke's Hospital?

[16] **A**: I think it was atherosclerotic heai-t disease.

[17] Q: Was there any connection in your opinion, based [18] upon reasonable medical certainty, between any [19] conditions that she presented with at St. Luke's [20] Hospital, and her infarction after discharge?

[21] MS. VANCE: Objection.

[22] A: Well, I think I answered that by saying I [23] thought it was more likely than not that the [24] reflex was the cause of her pain on the 17th.

[25] So I guess the obverse of that is saying

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[1] that the myocardial infarction that she [2] suffered a couple of clays later was a [3] coincidental event.

[4] Q: With regard to the second page of your repoi-t, [5] Doctor, what do you mean by the first [6] sentence?

[7] A: The sentence that begins with the words "with [8] regards to"? my opinion, [sl probably not been more elevated. [9] Q: Yes. What do you mean by "unrecognized CPK dash [10] MP enzyme [9] Q: So when you say feeling, you're talking about a [10] reasonable degree of medical certainty, an [11] opinion? threatening at that time? [11] A: I think what I meant, I remember something in [12] the deposition about [12] **A:** Right. [13] A: There was not. the emergency physician not [13] being [13] Q: Is it your opinion, Doctor, that aware that that result was back. That is Thelma Lloyd's [14] elevated CPK was [14] what I was referring to. from some injury to the muscle [15] JANIAK, M.D. [15] Q: So what you're referring to is Dr. when she got the venipuncture? [17] **BY MR. PARIS**: Barron did [16] not recognize that CPK [16] A: No. I think I said I didn't know what her CPK [17] reading was. [17] **A:** Correct. [18] Q: Have you ever gone to law [18] MR. PARKER: I'llobject. school, Doctor? [21] A: I have no idea. [19] A: That is what I was referring to. [19] **A:** No. [20] Q: What do you mean, was it your [20] Q: Have you ever taken any law understanding Dr. [21] Bass was aware of courses? that CPK enzyme result? [21] A: No. Would you like to know if I [22] A: I don'tremember that. I'd have to want ever to do [22] that? I can answer look that [23] back up. you that. them [24] Q: What do you mean by the next [23] MR. GORDON: Yes, I would like to sentence, "the [25] absolute value of that [24] know that. [1] stat, is that right? number does not effect

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[1] the fact that the patient was stable and quite [2] comfortable while an inpatient"?

[3] A: If the CPK were a billion or zero, that doesn't [4] detract from the fact of stability and that's [5] what we're talking about when we're talking [6] about COBRA.

[7] Q: So that I understand that if her CPK was, as you [8] said, a billion, that would not render her, in [9] youropinion, unstable?

[10] A: That's right, exactly right.

[11] Q: Given this presentation of the patient?

[12] A: That's right.

result"?

result?

[13] Q: And that is because she appeared to be quite [14] comfortable while an inpatient, is that [15] right?

[16] A: Yes. Right. All of the things I said [17] before.

[18] Q: You indicate that you have a feeling that had [19] additional CPKs been done later, the results [20] would have been normal or more towards normal, [21] is that right?

[22] A: Correct.

[23] Q: What do you mean by feeling? [24] A: Well, because I felt that the

patient, the [25] patient's problem was probably from esophageal

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[1] reflex and because as I indicated to you [2] earlier, I didn't know whether that would [3] produce this mild elevation in the CPK, and [4] because it is possible eo have CPK elevations [5] from minor events like a venipuncture, if you [6] injure some muscle, that repeating

the test [7] would have in retrospect, in

[25] A: No.

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[1] MR. PARIS: I don't have any [2] further questions.

[3] MR. PARKER: I have very few [4] questions, just to make sure.

[6] CROSS-EXAMINATION OF BRUCE JANIAK, M.D.

#### [7] BY MR. PARKER:

[8] Q: Did I understand laboratory tests for LDH is [9] nonspecific for cardiac conditions?

[10] A: That's what I'm telling you. That is my [11] understanding of it, too. I don't use it and my [12] colleagues don'tuse it. Our cardiologists [13] don't come down and order it.

[14] So if all that's true, then I don't think [15] we'd be using it for myocardial infarctions.

[16] Q: Is the same thing true for AST, it is [17] nonspecific?

[18] A: That's right.

[19] Q: When the materials you reviewed, do you know if [20] the CPK results were available to Dr. Barron, [21] the ER physician, while Thelma Lloyd was still [22] in the emergency room?

[23] A: I don't know. I'm not sure what you mean by [24] available. I don't think she had them as near [25] is my memory.

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[1] Q: Do you know, do you even know if the CPK test [2] had been run?

[3] A: I do not know that.

[4] Q: I believe I heard you indicate that in your [5] opinion there was nothing in Thelma Lloyd's [6] emergency room records eo suggest that her [7] gastric condition was life threatening?

[s] A: Correct.

[9] Q: Was there anything in Thelma Lloyd's emergency [10] room records to indicate she was suffering a [11] cardiac condition which appeared life [12]

[14] MR. PARKER: That's all I have.

[16] CROSS-EXAMINATION OF BRUCE

[18] **Q:** Do you know why the physicians, pathologists and [19] labomtory people at St. Luke's Hospital utilize [20] ÅST, LDH?

[22] Q: When you're ordering a CPK and cardiac [23] isoenzymes from the emergency room, is it your [24] custom and habit to order them, I think you told [25] me it is your custom and habit to order

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[2] A: The way I characterized that any test that we [3] order in our department is automatically stat.[4] So we don'twrite the word stat or say the word [5] stat.

[6] Q: How do you facilitate getting that requisition [7] over to the lab?

[8] **A:** It's done by computer.

[9] Q: You order it via the computer?

[10] A: Well, I tell, I write it down on the emergency [11] record or check a box, depending on which [12] desk it is, and a clerk types it into a [13] computer.

[14] Q: And it automatically goes to the lab?

[15] **A:** To the lab, right.

[16] Q: Do you customarily document your ordering of the [17] CPK, I'm sorry, cardiac isoenzymes?

[18] MR. PARKER: I object.

[19] A: Yes, I do.

[20] Q: Why?

[21] A: If I don't write it down on the chart, nobody [22] would know that I wanted it. So there's not [23] much choice.

[24] To be fair, it's possible for me to [25] verbally do that, but it is just my habit to

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[1] write it down on the chart in the rare instances [2] when I do verbally do that. [3] Q: What is the importance of having anybody else [4] know if you ordered it? [5] MR. PARKER: Objection.

[6] A: I think the same, the same answer would be true [7] generically for documentation. It is always [8] better to document what you've done and what [9] you're thinking than it is not to document it, [10] and I recognize "weall would

do better with [11] documentation, that is true for all emergency [12] records, but in general you document all you can [13] document.

[14] *Q*: How does that come into play in the transfer of [15] the care of the patient from the emergency room [16] to the floor?

[17] **A**: It is another interesting question because, you [18] know, I'dlike to tell you how critically [19] important it is, but I can't do that because of [20] the logistics of the way the pieces of paper go [21] up to the floor.

[22] Many times the emergency room record, which [23] is not yet dictated, doesn'tarrive for 14 [24] hours. So much of this is done verbally and then [25] all of this material arrives.

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[1] So ideally I think it ought to be more [2] important than it is. Practically speaking, [3] there is a delay in our hospital. I can't speak [4] for every other hospital.

[5] Q: As a practical matter, when there is a delay in [6] this hospital of getting the written, your [7] written notes up to the floor for the continuity [8] of care of a patient, how do you impart that [9] information to the subsequent care giver?[10] Verbally?

[11] **A**: Yes, over the telephone, or in person, depending [12] on where the person is.

[13] Q: Why is that important to do?

[14] **MR. PARKER:** Objection.

[15] **A**: Well, I don't know that I can answer that. [16] That's so obvious.

[17] Q: Help me.

[18] **A:** Okay.

[19] **MR. PARKER:** Objection. I think [20] this is beyond COBRA.

[21] **A:** A physician who is accepting the care of a [22] patient from another physician usually will [23] benefit from some knowledge about the initial [24] thought process and diagnostic and treatment [25] activities that the original first physician had

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[1] undertaken.

[2] In some instances it's helpful. I [3] would guess in the majority of instances [4] it is helpful. It is sometimes when it [5] isn't.

[6] Q: Is that your custom and practice at this [7] hospital?

[8] A: Yes, it is.

[9] Q: Do you know whether or not an elevated CPK is [10] consistent or compatible with an acute MI?

[11] MS. VANCE: Objection.

well, actually [13] the answer to your

question is yes, elevated [14] CPK, regardless of whether it is isoenzyme, [15] would be compatible with acute myocardial [16] infarction.

[17] Q: Would an elevated LDH be compatible with an [18] acute MI, if you know?

[19] **A:** I just don'tremember.

[20] Q: If you remember, would an elevated AST be [21] compatible or consistent with an acute MI?

[22] A: I don'tknow.

[23] **MR. PARIS:** Okay. I think that's[24] it. Thank you very much, Doctor.

[25] THE **WITNESS**: You're welcome.

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[1] **MS. VANCE:** We'll not waive [2] signature.

BRTJCE JANIAK, M.D.

[s] (Thereupon, Plaintiffs'Exhibit 1, [9] an article, was mark'd for purposes of [10] identification.)

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CERTIFICATE
The State of Ohio, ) SS:
County of Cuyahoga.)
I, Linda A. Astuto, a Notary Public within
and for the State of Ohio, authorized to
administer oaths and to take and certify
depositions, do hereby certify that the
above-named BRUCE JANIAK, M.D., was by me,
before the giving of his deposition, first duiy
sworn to testify the truth, the whole truth, and
nothing but the truth; that the deposition as
above-set forth was reduced to writing by me by
means of stenotypy, and was later transcribed
into typewriting under my direction; that this
is a true record of the testimony given by the
witness, and was subscribed by said witness in
my presence; that said deposition was taken at
the aforementioned time, date and place,
pursuant to notice or stipulations of counsel;
that I am not a relative or empioyee or attorney
of any of the parties, or a relative or employee
of such attorney or financially interested in
this action.
IN WITNESS WHEREOF, I have hereunto set my
hand and seal of office, at Cleveland, Ohio,
this day of, A.D. 19
Linda A. Astuto, Notary Public, State of Ohio
1750 Midland Building, Cieveiand, Ohio 44115
My commission expires October 24, 1977
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Sometimes - zero

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