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STATE OF OHIO)
) SS. 57106
COUNTY OF CUYAHOGA)

COURT OF COMMON PLEAS

PATRICK J. CONROY, ADMINISTRATOR OF THE ESTATE OF ROBERT E. CONROY,

Plaintiffs,

vs.

JEFFREY R. BECK, D.O., et al.,

Defendants.

Case No. 246550
Judge Sweeney

- - -

Telephone deposition of BRUCE DAVID JANIAK, M.D., a witness herein, called by the Plaintiffs as if upon Cross Examination under the Ohio Rules of Civil Procedure, taken before me, the undersigned, Philip H. Gaines, a Notary Public in and for the State of Ohio, pursuant to Notice and stipulations of Counsel as hereinafter set forth, at the Toledo Hospital Emergency Center Conference Room, Toledo, Ohio, on Thursday, December 22, 1994, commencing at 2:00 p.m..

APPEARANCES:

On behalf of the Plaintiffs:

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On behalf of Defendant Jeffrey R. Beck, D.O.:

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On behalf of Defendant Fairview General Hospital:

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By: Beth Whitmore
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BRUCE DAVID JANIAK, M.D.,
being first duly sworn as hereinafter certified, was deposed and testified as follows:

CROSS EXAMINATION

BY MS. SACKS:

Q. Doctor, can you please state your full name?

A. Bruce David Janiak.

Q. Your address?

A. Home or office, which one?

Q. It doesn't matter.

A. Office is 2142 North Cove Boulevard, Toledo, Ohio, 43606.

Q. Doctor, I'm not in front of you so I can't hand you a copy of your CV, but I was wondering if you could identify your current copy of your CV for the record. Do you have one there?

A. It's in the other office. I can get one in about twenty seconds if you want to wait while I do it.

Q. Maybe we can just do that at the conclusion of the deposition. I just would like to have a current copy of your CV identified

as Exhibit 1, if that's okay with everyone.

MR. WALTERS: We can agree to do that, Ellen, and just attach it to the depo, okay?

MS. SACKS: All right. I want to make sure I have the most current copy and if you want to attach it to the depo that's fine.

MR. WALTERS: That's fine.

Q. Okay, Doctor, you have that in your office and you can get that?

A. Yes, right. Will do.

Q. Where are you working?

A. Well, at the Toledo Hospital Emergency Department.

Q. Your position there?

A. Chairman of the Department Of Emergency Medicine.

Q. What are your responsibilities?

A. My responsibility is to make sure that the department is appropriately staffed, that quality standards are maintained, and patient satisfaction issues are addressed, and to participate in helping the

department grow and making the institution successful, but all of that is subservient to doing quality emergency care for all the patients that present.

Q. How much time do you spend directly with patients here, that is seeing patients?

A. I have to give you an average. I would say in the last six months probably a minimum of twenty to a maximum of twenty-six hours a week.

Q. And the remainder of the week work hours are administrative?

A. Well, some of it is administrative. Some of it is preparing lectures for grand rounds. Some of it is spending time one-on-one with residents. Some of it is just doing medical reviews and chart reviews because that's part of the quality issue. Then some is just strictly administrative such as developing a budget for the purchase of a new piece of equipment for instance.

Q. I want to ask you some questions about your work as an expert witness.

A. Go ahead.
Q. Can you tell me approximately how many times you have reviewed cases, that is medical/legal cases?
A. Correct. I would have to say now in taking a closer look at it since I first started back in the mid 1970's I would say somewhere between 150, maybe 175 total cases.
Q. How many in the last year or two?
A. In the last two years I think somewhere between fifteen and eighteen would be pretty close.
Q. You said about fifteen to eighteen?
A. In the year and a half to two years. I can't tell you exactly, but that's pretty close.
Q. So that's not per year, that's over about the last two years?
A. Well, yeah, year and a half to two years, and the reason for that is it has to do with my board service and sort of taking a small hiatus there.
Q. What about in the last four years?

A. I would guess fifty to sixty.
Q. What percentage of those cases have been on behalf of the defense?
A. It would be fairly close to 90 percent with the trend being closer to 85 percent in the last two years.
Q. So you said about fifty to sixty I believe in the last four years, was that your last answer?
A. Yes, ma'am.
Q. And, I'm sorry, did you say about 85 percent on behalf of the defense?
A. That's correct within the last two years. It was closer to 90 percent four years ago.
Q. Have you ever testified for or been involved in a case with Mr. Walters before?
A. I don't believe so, no.
Q. How about any member of his law firm?
A. Yes.
Q. Would you tell me about that, please?
A. I have reviewed I would say six cases in the last ten or twelve years for Reminger & Reminger.
Q. Six cases in the last ten or twelve years

did you say?

A. Right.

Q. How did you get into the consulting business?

MS. WHITMORE: Objection.

A. No, I don't remember ten years ago or twenty years ago, but I know it had to have been because a local attorney contacted me, because I don't think I would have thought to do that, and it was actually a plaintiff's attorney the first case. I would have to assume after that that all other contacts from attorneys were by word of mouth.

Q. Do you know for example how the law firm of Reminger & Reminger happened to contact you?

A. Actually, no, I don't.

Q. Can you tell me who your insurance carrier is?

A. Mine?

MR. WALTERS: Objection, but go ahead, Doctor.

MS. WHITMORE: Objection.

A. My carrier is PIE.
Q. How long have they been your carrier?
A. I would guess eight to ten years.
Q. Have you ever testified for PIE?
A. Yes, I have.
Q. How many?
MR. WALTERS: Well, and I don't know that PIE is not involved in this case. I don't know where we're going with this.
MS. SACKS: Just asking a question.
MR. WALTERS: All right, go ahead.
Q. Tell me?
A. I would say if taking into account the fact that they have offices in several states that I probably have reviewed fifteen cases for PIE over the years.
Q. You have reviewed, I'm sorry?
A. Approximately fifteen cases over the years.
Q. Okay, my speaker phone is not very good in here and the one I intended to use is in a room that is filled with people that I

couldn't ask to leave. So I'm sorry that I keep having to ask you to repeat some things here.

A. That is no problem at all because this is the first time ever this speaker phone has worked.

Q. Okay, so you understand?

A. Yes.

Q. Can you tell me how many cases you are involved in right now that are pending, that you are either reviewing or have written a report on?

A. I understand and I would say it's probably twenty different cases.

Q. Do you generally have about twenty going at a time?

A. I think that's pretty fair. Every once in a while you go to your files and find out that many of them have been settled long ago and you never found out about it. So keeping that in mind I would say twenty.

Q. About how much time a week do you spend in connection with your consulting work on these cases?

A. I probably, maybe a couple of hours a week on average.
Q. How do you charge?
A. By the hour.
Q. What do you charge per hour?
A. $150.
Q. What about for testimony?
A. Same for testimony and same for trial. The only expenses I look for in terms of time are when I have to drive locally, but if I fly I don't charge for that time unless it's a turbo prop.
Q. How much time did you spend, have you spent all together on this case?
A. I could tell you that in just a minute, maybe less than a minute. Hang on.
Q. Okay, sure.
A. Somewhere between five and seven hours.
Q. Can you tell me how you spent that five to seven hours?
A. Sure, reading the medical records.
Q. About how long did that take?
A. Somewhere in the range of five to six.
Q. Five to six hours?

A. Right, and then the rest of the time would be just meeting with the attorney, Mr. Walters.
Q. What medical records did you review?
A. Fairview General Hospital's Emergency Department record dated -- boy, I can't read the date, sorry. Looks like 30 January, '91.
Q. Any other medical records that you reviewed?
A. And that's it.
Q. And have you reviewed any other documents?
A. Yes, depositions.
Q. What depositions have you -- did you read them or just flip through them or what?
A. No, I read them and the answers are a deposition of Sue Ann O'Connor, Jeffrey Beck, Kathleen Quinn, Chad Murdock.
Q. How long did it take you to review the depositions?
A. I don't write down the number of minutes, but I can tell you that the total time was, let's see, one, two, three, just about five hours total, in that range.

Q. So you told me you had spent five to seven hours all together on the case?
A. Right.
Q. And was reviewing the depositions part of that time?
A. Yes, ma'am.
Q. And when you said reading the medical records did you include the depositions in that?
A. No.
Q. Okay, so let me try to go through that again. You said you read the medical records?
A. Correct.
Q. And you said that, I wrote down that you said that that took five to six hours?
A. No, no, I'm sorry.
Q. That's wrong?
A. Must have misunderstood. I said the total amount of time I spent was five to seven and of that around five was the depositions and the remainder was the medical records and the meeting with Mr. Walters.
Q. Okay, was there anything else that you

reviewed?
A. No.
Q. Did you meet with Mr. Walters today?
A. Yes.
Q. Did you meet with anyone else?
A. No.
Q. Did you meet at all with Miss Woodford?
A. Well, I met Miss Woodford, but I didn't meet with Miss Woodford. She wasn't here when I had the meeting.
MS. WHITMORE: Whitmore.
Q. Did you discuss this case with her at all?
A. Whitmore is the name she says.
Q. Sorry, Whitmore.
A. And, I'm sorry, I missed your last question.
Q. Did you discuss the case with her at all?
A. Did not.
Q. You did discuss the case with Mr. Walters?
A. Yes, I did.
Q. On how many occasions?
A. Well, I know today. I would imagine, and I don't have any direct memory, we must have had a conversation on the telephone, but I

don't have a record of it and I can't tell you when that was. I just have a vague memory of doing so.

Q. So the conversation, the one and only conversation that you remember was one which you had today before this deposition, is that right?

A. Yeah.

Q. I assume you had some contact in order for you to get the case?

A. Oh, of course, right.

Q. You don't remember that?

A. Well, that contact was with a different attorney in the same firm whose name was Mr. Marmaros, Pete Marmaros.

Q. Oh, Pete Marmaros.

A. Unless it's Marmaros and I have accented the wrong syllable.

Q. And do you remember speaking to him about the case?

A. Yes.

Q. Can you tell me what you recall about that?

MR. WALTERS: Wait one second. Objection, and I would represent to

you that that's attorney work product, Ellen. You can certainly ask him what his opinions are.

MS. SACKS: That's a new objection to me.

MR. WALTERS: Well, I don't know that it's a new objection. I don't know that I've ever heard anybody ask what they've discussed with opposing, with counsel before.

MS. SACKS: Really?

MR. WALTERS: Yes. I mean I don't --

MS. SACKS: My experts are always asked that, Steve.

MR. WALTERS: I mean you were fine to ask it. I'll let him answer it, but he'll answer it over my objection.

MS. SACKS: Okay.

MR. WALTERS: I don't care. Go ahead, Doctor.

Q. Do you remember your conversation with Mr. Marmaros about the case?

A. The answer is no. I have a note on the file here that says I did have such a conversation. The only thing I could tell you is that he must have told me that there was such a case and outlined it, but I don't remember it.

Q. Okay, and what about your conversation with Mr. Walters today, what do you recall about that?

A. That we discussed the case from our standpoint on what I felt about the appropriateness of the evaluation by Dr. Beck of Mr. Conroy.

Q. Can you tell me about that in some more detail, please?

A. Sure. I told him that I thought Dr. Beck met the standard of care in the way he approached the case of Mr. Conroy and I told him that I thought that he, that I did not expect him to be responsible for actually arranging and being sure that the patient had a specific appointment at a specific time with a physician in that, and the way Dr. Beck dealt with it was within

the standard of care.

Q. I could not hear the last comment that you made.

A. I said the way Dr. Beck dealt with this case met the standard of care.

Q. The way that he dealt with the case?

A. Correct.

Q. Okay, anything else?

A. Boy, it was a pretty general conversation. Hang on a second. Oh, yes, I told him that I thought that it was appropriate that he documented a physical examination on a patient with psychiatric problems, that was good, and I told him that I thought that the medication that the patient was sent home on was more of an anti-anxiety agent and that was perfectly fine because anti-depressants would not take effect within the short time frame that he was to have a psychiatric appointment anyhow.

Q. Because anti what would not take effect?

A. Anti-depressants.

Q. Okay, and this was an anti-anxiety medication?

A. Yeah, more so. That's its predominant effect.
Q. Okay, anything else?
A. That's all I remember.
Q. And I guess in a way you're telling me what your opinions are as well?
A. I think that's what we're doing, yeah.
Q. Went over your opinions with Mr. Walters?
A. I think that's, yeah, see, you know how to say this better than I do.
Q. Well, I don't think so, Dr. Janiak.
Did Mr. Walters tell you anything in particular, anything specific?
A. No. I mean the only thing we talked about that was very specific was whether or not you were going to call us or he was going to call you when we started this deposition. Otherwise, we just talked as I said about my opinions.
Q. Let me make sure that I understand your opinions then. I think you wrote a report. Maybe we can have that report marked as Exhibit 2. Do you have a copy of your report, Doctor?

A. Yes, I do.
Q. Before I get into your opinions again I want to ask you just a few questions about the report.
A. All right, can I ask you, do you want me to have a copy of this given to the -- we'll do that then.
MR. WALTERS: We'll mark it at the end, yes.
A. Okay, go ahead.
Q. There's a report that's written to Mr. Abbarno?
A. That's correct.
Q. Do you know who he is?
A. I must have had a phone conversation with him to, but I don't know who he is.
Q. You have a reference here dated March the 1st, 1994, and that's in the report that you have in front of you, is that right?
A. No, it is not. Hold on.
Q. Did you write more than one report?
A. No, I didn't. I'm just having trouble with the date though.
I've got one dated February 22nd, but

I don't have one dated March the 1st. I don't understand why that's, why that happened, because I only did one.

Q. But the report that's dated February 22nd, is marked as Exhibit 2, maybe you can read that to me?

A. I sure will. "Dear Mr. Abbarno, I have reviewed the materials you have sent me regarding this particular case. I have especially focused on the emergency department records of January 30th, 1991.

"Mr. Conroy came in to the emergency department with a history of depression. The history that was taken by Dr. Beck was adequate as was the physical examination. Dr. Beck specifically asked questions with regards to suicide and determined that the patient was, quote, not actively suicidal, unquote. This is a perfectly reasonable and appropriate approach for an emergency physician to take and certainly is within the standard of care.

"Based on these findings the outpatient referral was also completely

appropriate. Dr. Beck started the patient on Buspar, 5 milligrams, three times a day, but indicated most appropriately to the patient that this medication would not take effect immediately.

"Finally, Dr. Beck indicated in his referral that the patient should call Dr. Murdock as soon as possible for follow-up. This was also reasonable and appropriate in view of the history and physical findings.

"In summary, I find absolutely no deviation from the standard of care on the part of Dr. Beck. His evaluation, treatment and recommendations were completely within the standard of care for an emergency physician. Sincerely, Bruce Janiak."

Q. Doctor, I wanted to ask you in your report where you said Dr. Beck specifically asked questions with regard to suicide?

A. Right.

Q. What questions did he ask?

A. When I said that he specifically asked questions I was referring to the fact that

he noted that the patient was not actively suicidal. The inference is that you must ask the patient questions about suicide in order to be able to state that you're not actively suicidal. So you are technically correct in that there is no documented question, but there is a documented answer.

Q. What do you think in your opinion is the appropriate standard of care for an emergency room physician with respect to assessment of a suicide risk?

A. The emergency physician needs to do a history which is appropriate to that, in other words ask questions with regards to the patient's feelings, needs to do a physical examination, and then needs to make a judgment as to the appropriate disposition for that patient.

Q. You said needs to do a history and needs to do a physical and then you said make a judgment?

A. That is correct.

Q. Isn't that the same thing that you do with any patient?

A. Absolutely.
Q. So what specifically do you do with a patient with depression who may be a suicide risk?
A. Well, you ask appropriate questions and those questions are --
Q. I'd like some more detail relating to the case.
A. Sure. How do you feel. Tell me your story.
Q. Okay, what else?
A. And when the patient tells you the story -- well, I can't tell you what else because everything, all the what elses, derive from the first answer, but in --
Q. There's no basic or standard type of questioning that is supposed to be done in order to determine whether or not someone is a high suicide risk or not?
A. Except for the question do you feel suicidal and that could be worded several different ways, or do you want to kill yourself, do you feel like killing yourself now.

Q. Anything else?
A. No, that's really it. Everything else is not standard.
Q. And do you feel like killing yourself now, are you suicidal?
A. Well, those are the topics. The wording could be somewhat different and still be acceptable. There is no standard wording which is absolute.
Q. Anything else that you can tell me about in terms of what an emergency room physician, emergency medical physician is supposed to do in a situation where a patient is depressed and an assessment needs to be made regarding suicide?
A. No, because all of the other things that one would do are really branches that depend on the answers to the first questions and what judgment you make with regard to the risk.
Q. Is there anything the physician is supposed to do other than talk to the patient?
A. Well, certainly, the physical examination as I indicated before.

Q. What is so important about the physical examination?
A. Every time you see a patient with a psychiatric problem you must have at least a cursory evaluation for the possibility that this is a physical problem and not a mental problem.
Q. Okay, you're making a determination whether it's medical or psychiatric?
A. That is correct.
Q. Organic versus psychiatric?
A. Yes, correct.
Q. Anything else the emergency room physician is supposed to do?
A. Well, certainly --
Q. Not generally, but specifically in a case like this?
A. Sure. Well, no. No, I guess the answer is no because you would always have a diagnosis and a plan. So that would be for any patient.
Q. So the diagnosis was depression?
A. Correct.
Q. You agree with the diagnosis?

A. Yes.
Q. Is that the same diagnosis you believe you would have made based on what's presented in the record?
MR. WALTERS: Objection.
Go ahead, Doctor.
A. Yes, I agree. I think I would have made the same diagnosis.
Q. And then you said that the next thing the doctor has to do is to exercise his judgment and come up with a plan?
A. Right.
Q. Do you agree with the plan in this case?
A. Yes.
Q. What was the plan?
A. The plan was to place the patient on medication, although the patient was notified that it was not expected to have a miraculous instantaneous effect, and then also to arrange for follow-up to a psychiatrist, and both of those things were done.
Q. In your emergency setting at your hospital do your emergency room physicians treat

psychiatric patients or are they seen by a psychiatrist?

A. We, that is the emergency physicians, see the patients first.

Q. We spoke to another doctor earlier this week who said at their hospital the psychiatrist saw the psychiatric patients. That's why I thought it was more standard that the emergency room physician would see the patient and then if needed would call a psychiatrist.

A. You are exactly correct.

Q. Now, would you have any criticism in a case like this if the emergency room physician would have called the psychiatrist on call?

A. No.

Q. That would be okay?

A. Yes.

Q. That would have been an okay thing to do?

A. Correct.

Q. What about calling the family? Do you have any feelings about or opinions about whether or not any family members should have been contacted?

A. Well, I would not have a criticism if the family were contacted, making an assumption that that was okay with the patient. I would have to assume that.
Q. If it was okay with the patient?
A. Yes.
Q. Then you think that would be acceptable?
A. I would not have a criticism.
Q. You would not have a criticism?
A. Right.
Q. Do you think that a family member should have been called?
A. No, I think that's another judgment. In this case I didn't see any indication that a family member needed to be contacted.
Q. Why is that?
A. Because there is no evidence of one of two possibilities. One is that the patient is so confused or mentally disabled that he is unable to communicate in a reasonable way, or, two, is that the patient has an organic impairment that, like alcoholism or heavy alcohol use, that renders him incapable of making reasonable judgments, and I guess I

should add, three, the patient, there's no documentation at least, that the patient requested that Dr. Beck call his relatives.

Q. Have you ever heard of the concept of calling a family member in a situation where the patient is depressed and may be suicidal so that it can be a support mechanism for the patient until they get to a psychiatrist?

MR. WALTERS: Objection.

Go ahead, Doctor.

MS. WHITMORE: Objection.

A. Have I ever heard of that happening? The answer is yes, I have heard of that happening.

Q. And are you critical of that kind of conduct?

A. No, that is something else a physician can do, but not doing it is not a violation of the standard. It's perfectly reasonable to not do that.

Q. Well, what is the objective of the plan when you let a patient go who needs to see a psychiatrist or needs to be treated?

A. The objective is that the patient will understand what your instructions are, in this case call Dr. Murdock ASAP, and actually carry through with that phone call, and I believe that the record show that that happened.

Q. And do you have any criticisms of any of the doctors who were involved in this case in any way?

A. You mean other physicians.

Q. Anybody other than Dr. Beck. I mean do you have any criticisms of any of the medical care providers?

A. I was never asked to look at this case from that viewpoint so I don't know. I haven't evaluated it from that viewpoint.

Q. So I take it that you're not going to be offering an opinion regarding any criticisms of any medical care providers?

A. You are correct.

Q. Okay, and what about Fairview General Hospital, do you have any criticisms of any of their procedures or policies?

A. I do not.

Q. Have you treated patients in emergency rooms who have come in with depression or where you have diagnosed depression?
A. Yes. I was going to say I wouldn't say I've actually treated them, but I certainly have diagnosed it.
Q. Diagnosed it, and then you haven't treated them you said?
A. I have not, right.
Q. Would a psychiatrist?
A. Either that or to their family physician depending on in my judgment what type of support the patient needs.
Q. Have you ever called the psychiatrist on call to see a patient because of depression?
A. Many times.
Q. And in this hospital or in the hospitals in which you have worked has there always been a system where there's been a psychiatrist on call?
A. Yes, ma'am.
Q. So then it would be the psychiatrist's decision at that point whether to admit the

patient or not?

A. I think the answer to that is somewhat complex. It technically is the decision of the psychiatrist or for purposes of discussion any potential attending physician who has to rely on the information given to him or her by the emergency physician. So in that sense it is a somewhat joint decision, but the technical act of admitting and the responsibility for the patient rests solely with the attending physician.

Q. Okay, but it might be, are you saying that it might be a joint decision of the emergency room doctor, the psychiatrist, maybe the family physician?

A. Right, that's always a possibility because the psychiatrist or family physician or surgeon or whoever may need more information, ask more questions, and end up being a joint type of decision.

Q. In a situation where a patient has been in an emergency psychiatric setting has been diagnosed with depression and the

psychiatrist, where a patient has been diagnosed with depression, when do you think it is appropriate to call the psychiatrist on call?

A. That decision is in most cases a judgmental one which falls on the shoulders of the emergency physician and it is so because except for some very explicit pieces of information, for instance I am going to kill myself right now, quote/unquote, absent that it is a judgment the emergency physician has to make and it's made based on the constellation of information acquired in evaluating the patient.

Q. Well, what kind of information would lead you or in your opinion lead a reasonable emergency room physician to call the psychiatrist on call?

A. When I see a patient --

Q. Again, it's a judgment call, but I want to know under what circumstances that judgment would be exercised in terms of making the phone call.

MR. WALTERS: You're asking that

absent the example he's given you already, is that correct? He's given you one example already.

THE WITNESS: Did you hear that?

MS. SACKS: Yes. I guess I'm not sure I heard it that way, but I heard what he said.

MR. WALTERS: Okay, go ahead, Doctor.

A. Then I'll give you another example. A patient comes in who actually has slashed his wrist or her wrist deep enough to injure the artery. To me that is a rather severe message that a patient is quite disturbed.

Another example would be a patient who says that they are thinking constantly about suicide and that they are going to commit suicide and they don't really want to do it and that's why they came in to see a physician because they need help.

Those are two where it's pretty clear that a psychiatrist needs to be called and of course we call them when we see patients

like that.

Q. Okay, any other examples you can think of?

A. Sure, the answer is now a gradation of ways patients present with an infinite variety and judgment has to be exercised. That's the only way I can answer it.

Q. Judgment has to be exercised as to how to treat the patient and whether or not to call a psychiatrist, is that fair?

A. That's right, because we're looking at one end of the spectrum being admission to the psychiatric intensive care unit and the other end of the spectrum being discharge without any follow-up whatsoever, and in between there's a lot of gray zones.

Q. Is the purpose of the psychiatric consult only for purposes of admitting or is it also for purposes of consultation?

A. It can be both. In many institutions it's both where a psychiatrist will render their opinion to be additive to that of the emergency physician or the emergency physician may simply feel they don't have the data or the expertise to make a

judgment. That happens not just in psychiatry but of course in every other disease entity.

Q. Do you know, Doctor, and I don't know if this is beyond your field or not, but do you know whether or not people who suffer from depression or patients who suffer from depression are notoriously good or bad about following up on appointments such as this, following up on things that need to be done?

MR. WALTERS: I'll object to the form.

Go ahead, Doctor.

A. No, I think I will tell you that I have never read a study on that and so I just don't know.

Q. Okay, so that may be beyond your expertise then?

A. Maybe.

Q. In any event you didn't have any problem with Mr. Conroy being released with saying follow up as soon as possible?

A. No, because now we're talking about Mr.

Conroy. Your question was about psychiatric patients and I don't know the data there.

Q. Right.

A. But I do know that patients who seem to be alert and oriented and respond normally have an excellent chance of following through with what you tell them to do.

Q. Are you talking about depressed patients or are you just talking about generally as an emergency room physician?

A. No, I'm talking about, well, I'm talking both I guess, but depressed patients that are alert and oriented and fairly comfortable, who are thought to be not actively suicidal, are motivated to come in to the Emergency Department and are motivated to follow through, and actually are I think quite grateful to have access to a support system. So they in my experience do follow through.

Q. How do you know?

A. The answer to that is that you do over a period of years get feedback from your

colleagues in other specialties including psychiatry as you walk past them in the hall and say did Mr. Jones, quote/unquote, see you as he was supposed to and the answer is yes. Or, occasionally, you'll even ask a nurse to call a patient and find out how they're doing and the answer seems to be yes.

Q. Which leads me to another series of questions and that is whether or not you've ever been involved in any hospital where there's been follow-up to see if the patient did go see who he was supposed to see or do what he or she was supposed to do by either having a doctor call or a nurse call or some sort of procedure where a follow-up was verified?

A. The answer is that I've been involved in places, including the Toledo Hospital, in which that is done on a random basis, but I've never been in an institution where it's done on a 100 percent basis or even a 50 percent basis for that matter.

Q. But sometimes it might be done if there's a

particular concern about a patient for example?

A. Correct.

Q. Is that what you mean by random?

A. That's correct.

Q. Okay, so you really want to make sure that Mr. Smith did what he was supposed to do?

A. Correct.

Q. Okay, and would you call under those circumstances where there were these random, I guess what you call random follow-up was made, would it be with the physicians to whom the patient was referred or to the patient or to a family member?

A. I would say 90 percent of the time it would be to the patient. 9 percent of the time, and I obviously don't have a study here by the way, 9 percent of the time it would probably be to the physician, and 1 percent of the time it would be to a family member and the reason for that is that they're the ones who answer the phone when you call.

Q. Have you worked in an emergency department where there has been any system in place,

whether formal or informal, of letting the referring doctors know that these patients had been referred to you, they were in the emergency room and they were given your name, by either leaving part of the record or any other kind of communication?

A. Yeah, I think the answer is that in most places that communication is done by virtue of a copy of the emergency record.

Q. Where does it go?

A. If the system works correctly the Medical Records Department would forward a copy to the attending physician that was identified as the follow-up physician.

Q. Is that fairly standard as far as you know?

A. Excellent question. Actually it's one I'm going to write a note about to try to see if I can figure it out.

I would say that I don't know. I'm going to be real honest. I don't know if it's a standard so I can't answer.

Q. Okay, but that's the way it is at your institution?

A. Right.

Q. Are the referrals made to physicians that are on the staff of the hospital?
A. That's correct. Mostly that's true.
Q. Okay, and so would they, would the sheet from the emergency room that goes to the referring doctor, do you know if that would be left in a box or that would be mailed or how that communication is made, at least in your hospital?
A. At this institution it would be either mailed or faxed depending on a number of circumstances and how fast the chart was ready and how soon the doctor needed it.
Q. Is that done each day?
A. Yes. Well, I can't speak for holidays and Sundays, but I think it's done the rest of the days of the week.
Q. So that's a normal routine?
A. Right.
Q. And you do have some familiarity with hospitals outside of your own?
A. Correct.
Q. From teaching or speaking or whatever, and do you know if there's other hospitals that

have a similar kind of system, that is that the referring doctors are notified?

A. As far as I know that's what most of the hospitals in the Toledo area do in northwest Ohio. You know, I have my experience with southern Ohio hospitals is now over ten years old so I can't speak for what they do now.

Q. What do you understand the reason to be for that communication?

A. The reason for that communication is that it is always helpful, well, nothing's always, it is frequently helpful for one physician to know what another physician thought about a patient because it sets them off on a, hopefully on the correct path with regards to that patient's evaluation.

Q. Doctor, I want to ask you a couple of questions about the medications here.

A. All right.

Q. Do you prescribe Buspar?

A. No.

Q. Have you?

A. No.
Q. Why not?
A. I limit the medications I use and Buspar is not on that list. If I want an anti-anxiety agent for an adult I usually use Valium. It's just a personal choice.
Q. Do you prescribe medications to psychiatric patients who you believe have a diagnosis of depression?
A. Yeah. Not on all of them, but I certainly have. I've given anti-depressants before, sure.
Q. I mean if some -- I guess you would have the view that the psychiatrist should be prescribing the anti-depressants. I just didn't know what your view was on that. But you have?
A. Yes, and I also understand the other view, and I think both views are okay.
Q. Would you have prescribed medication based on what we know from the chart to Mr. Conroy?
A. All right, you want me to assume that I'm seeing Mr. Conroy and I've gotten through

to the diagnosis and I know he's going to be calling his doctor as soon as possible?

Q. You know you're giving him a slip saying call your doctor as soon as possible.

A. I understand.

Q. Yes, you know what we know here from this record.

A. Okay.

MR. WALTERS: Show my objection. Go ahead, Doctor.

A. No, I probably wouldn't have.

Q. You probably would not have prescribed any medication?

A. That's right.

Q. Because you would think he's going to be going to a psychiatrist and he needs to go to a psychiatrist?

A. Well, I think that's part of it. The other part of it is just personally I don't like medicines so I try to stay away from them, period. So no matter what the disease is I am less likely to prescribe medicines than some of my colleagues.

Q. I want to ask you, Doctor, about Dr. Beck's

plan which is he's got it as part of the chart here.

A. Correct.

Q. The patient was started on Buspar and that I believe you have said, and I think is what has been said by others, is an anti-anxiety medication?

A. That's correct.

Q. And then it says that he was told it would take two to three weeks for the medicine to work?

A. That's what it says.

Q. What do you understand that to mean?

A. Well, there are a number of psychiatric medicines that seem to reach their maximal therapeutic effect after they've been taken for a couple of weeks, and I think that's all it was. He was trying to indicate to the patient that he shouldn't expect much in the way of a change in the way he feels just from this.

Therefore, one could infer that's also a reason that you need to see the psychiatrist because medicine is not going

to cure you.
Q. Well, that medicine wouldn't cure the depression anyway, right?
A. That's right.
Q. And you understand that that was made clear to Mr. Conroy, that he was not given medication for depression but he was given medication for anxiety but it would take two to three weeks to work, or don't you know?
A. I think I know he was told it would take two to three weeks to work. I'm not clear about exact wording on whether or not what, I don't believe there's any way for me to know what Mr. Conroy understood the medicine would do. So I don't --
Q. I'm not sure that there is either. I just wanted to make sure that we were on the same page here.
A. I think we are.
Q. So what you understand is that it is I guess medically or clinically correct that Buspar would take two to three weeks to work as a medication?

A. As far as I understand. As I said I don't prescribe it myself.
Q. Okay, so what it was prescribed for, for whatever it was prescribed for?
A. Right.
Q. Okay, and you don't understand that that was prescribed for the depression, correct?
A. Correct.
Q. Did you say that you read Dr. Murdock's deposition?
A. Yes, I did.
Q. And maybe a report by him, a short report, did you read that?
A. You know, I think that that's true. Hang on, let me just confirm that. Yep, I do, I have it. Dated December 14th, 1993?
Q. I don't have it in front of me, but it's a very short report.
A. Okay, yes, I have it.
Q. Letter, it's really a letter. Did you understand from reading Mr. Murdock's deposition and that report that he feels that he should have been called that evening, that morning actually, he as the

psychiatrist on call believes that he should have been called in this case?

A. That's what he said.

Q. And do you have any, can you understand his perspective?

MR. WALTERS: I object. Go ahead, Doctor.

MS. WHITMORE: Objection.

A. Well, I think I have a very clear understanding of his objective.

Q. Perspective.

A. Perspective, I'm sorry. Yes, I think I --

Q. You said you have a clear understanding of his perspective?

A. I think I do.

Q. Okay, is that because you worked with psychiatrists in emergency psychiatric settings?

A. No.

Q. Okay, why is that?

A. Because I think I work with people and I understand some things about human nature, or at least I think I do.

Q. And what do you mean by that?

A. I mean when any of us feel we might be in trouble we tend to look for ways to defend ourselves.

Q. And do you think that Mr. Murdock did anything wrong or do you think he was giving this opinion because he felt that others may think that or something along those lines?

A. Well, I think in answer to your first question I already said I wasn't going to testify about the behavior of Dr. Murdock so I'm not sure, you know, what I'm supposed to say there.

Q. So you don't have an opinion as to whether Dr. Murdock acted negligently?

A. Not now because I've not been asked to review it from that standpoint. I haven't even looked at Mr. Murdock. I just read the letter.

Q. Have you ever had any conversations with any psychiatrists in an emergency setting where maybe it didn't involve you but somebody else on your staff in reviewing the disposition of a patient where

psychiatrists had said well I think we should have been called in this case or I think it would be a good idea to call us in cases like this, any dialogue of that kind?

A. Let me think just a moment because that's another good question. No, I have to tell you that I don't remember having that kind of issue. I've had psychiatrists say why did you call me, but I've not had them say why didn't you call me.

Q. Oh, you've had them say you really didn't need to call me in this case?

A. Correct.

Q. So sometimes they feel like they're being overused?

A. I don't know if I could --

Q. You're speaking of a specific example?

A. No, I'm not thinking of a specific example. I just am not sure what their motivation would be for that. I don't know.

Q. Do you go over cases with them at all, like either, you know, weekly, yearly, quarterly?

A. The answer to that is there may have been

cases that have been presented at our Emergency Medicine Grand Rounds, but I personally have not participated in those particular rounds.

Q. Have you ever, are you aware of the circumstances in your own experience or in your position of Chair of the Department, where that had a similar to this one where someone was seen at the emergency room and released and then committed suicide?

A. Yes.

MR. WALTERS: I'll object. Go ahead.

A. The answer is yes.

Q. Yes?

A. Yes.

Q. Are those reviewed internally, those cases?

MR. WALTERS: Objection. Go ahead, Doctor.

A. Yes.

Q. And in any of those situations do you ever recall any involvement of the psychiatrist?

MR. WALTERS: I'm going to object because I think this is

dangerously getting close to what's protected information, Ellen, under the Peer Review Statutes in the Ohio Revised Code. So I don't think the doctor is allowed to testify to what he's learned in a peer review meeting.

MS. SACKS: I think he can if it's not, we're not talking about a specific case or a specific patient.

MR. WALTERS: I'll leave that to the doctor, but I don't think that's true. I don't think you're allowed to discover information at all from those meetings because if you could you could go a long way in a lot of different cases of proving different things based upon peer review.

A. Maybe I could simplify this by saying that I am thinking of a specific case and it happened so long ago that that particular case was not presented at any conference.

Q. Okay, so you remember a case where somebody was released and committed suicide, but you don't remember it being reviewed?

A. That is exactly right.
Q. Am I right?
A. I don't remember it being reviewed in a formal way. I mean other than knowing about it within the department, no, there was no presentation or case discussion.
Q. I wasn't really asking about peer review or anything formal frankly. I was just wondering if you had a circumstance that was similar or that you knew of where somebody was released and committed suicide and I think you said the answer was yes.
A. I did say that.
Q. Was that only one time and was that the one that you were remembering?
A. It's the only one I can remember.
Q. Okay, and that was quite a while ago?
A. As a matter of fact it was probably 1975.
Q. I want to make sure, Doctor, that I have covered all of your opinions. Do you believe that you have expressed all the opinions about the care given to Mr. Conroy about any other issues in which you intend to express an opinion?

MR. WALTERS: I'll object, but you've had the opportunity to ask him questions. I don't know that he's got to, that he can exhaust his memory. But go ahead, Doctor, as best you can.

A. No, right now I think you've asked me all the pertinent points.

Q. So in other words you believe that the history was taken properly?

A. Yes, ma'am.

Q. Do you believe everyone was contacted who should have been contacted or interviewed, which was Mr. Conroy?

A. Right.

Q. And you think the history was appropriate, correct?

A. Correct.

Q. The judgment was appropriate?

A. Correct.

Q. And you don't believe that there was anything more that Dr. Beck should have done?

A. No, I don't.

Q. And I take it you don't feel that he failed in any way?
A. That is correct.
Q. And you don't think that there's anything more that should have been done in terms of policy or procedure with respect to the disposition of the patient?
A. That is also correct.
Q. By the hospital or the procedures or --
A. Right, no hospital procedures.

MS. SACKS: Okay, Doctor, I don't think I have any other questions.

We have the two exhibits?

MR. WALTERS: Right, the CV and the report.

MS. SACKS: 1 and the report is 2.

MR. WALTERS: Right. I think that's what we said.

THE WITNESS: That's all I remember.

MS. SACKS: And those will be

attached to the transcript?

MR. WALTERS: Correct.

THE WITNESS: That's right.

MS. SACKS: I don't know if you want the doctor to read or waive.

MR. WALTERS: He'll read it.

MS. SACKS: Okay, then I think we're all set.

(Whereupon, Plaintiff's Exhibits 1 and 2 were marked for identification.)

(Whereupon, the deposition was concluded at 3:05 p.m..)

I, BRUCE DAVID JANIAK, M.D., do hereby certify that I have read the foregoing transcript of my deposition given on December 22, 1994, and that together with the correction page attached hereto, noting changes in form or substance, if any, it is true and correct.

_____ _____

DATE BRUCE DAVID JANIAK, M.D.

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C E R T I F I C A T E

STATE OF OHIO)
) SS.
COUNTY OF LUCAS)

I, Philip H. Gaines, a Notary Public in and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within-named witness, BRUCE DAVID JANIAK, M.D., was by me first duly sworn to tell the truth, the whole truth, and nothing but the truth in the cause aforesaid; that the testimony then given by him was by me recorded on audio cassette in the presence of said witness, afterwards transcribed upon a word processor, and that the foregoing is a true and accurate transcription of the testimony so given by him as aforesaid.

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

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

action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Toledo, Ohio, on this 3Rd day of January 3, 1995.

PHILIP H. GAINES
Notary Public
in and for the State of Ohio.

My Commission expires February 1, 1998.

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