

In The Matter Of:

*Lynn Martello, Executrix, v.
Southwest General Health Center; et al.,*

*Samuel J. Kiehl III, M.D.
April 24, 2002*

*McGinnis & Associates, Inc.
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[1] IN THE COURT OF COMMON PLEAS
[2] CUYAHOGA COUNTY, OHIO
[3]
[4] Lynn Martello, Executrix of
the Estate of Edna P. Martello,)
[5] Plaintiff,)
[6] vs.) Case No. 427286
[7]) Judge Eileen A. Gallagher
Southwest GeneralHealth)
[8] Center, et al.,)
[9] Defendants.)
[10]
[11] Deposition of Samuel J. Kiehl III, M.D., a witness
[12] herein, called by the Defendants for cross-examination under the
[13] statute, taken before me, Sandra L. Krosner-Martin, Registered
[14] Professional Reporter and Notary Public in and for the State of
[15] Ohio, pursuant to notice and agreement, at the offices of the
[16] Deponent, Physicians Professional Management Corporation,
[17] 4619 Kenny Road, Columbus, Ohio, on Wednesday, April 24, 2002,
[18] beginning at 3:00 o'clock p.m. and concluding on the same day.
[19]
[20]
[21]

[23]
[24]
~~125~~

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[25]

STIPULATIONS

[1] It is stipulated by and among counsel for the
 [2] respective parties herein that the deposition of Samuel J. Kiehl
 [3] III, M.D., a witness herein, called by the Defendants for
 [4] cross-examination under the statute, may be taken at this time
 [5] and reduced to writing in stenotype by the Notary, whose note
 [6] may thereafter be transcribed out of the presence of the
 [7] witness; that proof of the official character and qualification
 [8] of the Notary is waived; that the witness may sign the
 [9] transcript of his deposition before a Notary other than the
 [10] Notary taking his deposition; said deposition to have the same
 [11] force and effect as though the witness had signed the transcrip
 [12] of his deposition before the Notary taking it.

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PROCEEDINGS

[1] Wednesday, April 24, 2002
 [2] Afternoon Session
 [3] MR. VANWAGNER: Is everyone ready?
 [4] MR. LEAK: Jeff, this is Doug. Just so we are
 [5] clear, and I know Joe sent me a letter to this effect, I want to
 [6] — the Court Reporter is taking this down on the record right
 [7] now — I want to put on the record that Joe has stipulated that
 [8] since we were added to the case late and we have not produced
 [9] any expert report on behalf of Dr. Grossman and Drs. Hill and
 [10] Thomas, we are participating in this deposition but we are not
 [11] waiving our right to producing an expert report later if we need
 [12] to.
 [13] I am also going to render an objection to any new
 [14] opinions not set forth in Dr. Kiehl's report of October 30,
 [15] 2000, I believe. So I just wanted to put that on the record.
 [16] MR. VANWAGNER: Did you say the Court Reporter is
 [17] taking this down?
 [18] MR. LEAK: Yes.
 [19] MR. COTICCHIA: Yes, it was taken down.
 [20] Jeff, this is Joe. I faxed a handwritten note on
 [21] Doug's letter requesting that I stipulate that the Defendants,
 [22] Drs. Hill and Thomas and Dr. Grossman, would not be precluded

[1] from submitting an expert report pursuant to Local Rule 21. So
 [2] I am not stipulating or agreeing with this objection or anything
 [3] else at this point.
 [4] MR. VANWAGNER: Joe, did the Doctor provide to you a
 [5] curriculum vitae, because I have never seen one?
 [6] MR. COTICCHIA: Yes. I think it is a short one. I
 [7] did have a curriculum vitae at one time.
 [8] MR. VANWAGNER: Maybe you can get a current one and
 [9] circulate it after the deposition. I will not go very much into
 [10] his background.
 [11] MR. COTICCHIA: I am sure I sent one to you and Don,
 [12] but maybe I did not. But you can ask him what his curriculum
 [13] vitae reflects. He may have a copy with him.
 [14] DR. KIEHL: I don't have it with me, but I have one
 [15] here at the office that I can get either now or later, whichever
 [16] is good for you.
 [17] MR. COTICCHIA: Okay.
 [18] MR. VANWAGNER: Joe will send copies of it around to
 [19] defense counsel. I will briefly go through some of your
 [20] background information.
 [21] Are we all set?
 [22] DR. KIEHL: I am all set.
 [23] MR. VANWAGNER: Would the Court Reporter swear in the
 [24] witness, please?
 [25] (Witness sworn.)

Page 7	Page 9
Page 8 <p>[1] SAMUEL J. KIEHL III, M.D.</p> <p>[2] of lawful age, being first duly placed under oath, as prescribed</p> <p>[3] by law, was examined and testified as follows:</p> <p>[4] CROSS-EXAMINATION</p> <p>[5] BY MR. VANWAGNER:</p> <p>[6] Q: Doctor, I am Jeff VanWagner. I represent Joe Cooper,</p> <p>[7] D.O. in connection with this case concerning the Estate of Edna</p> <p>[8] Martello that we have been involved in at least 18 months.</p> <p>[9] I will be taking your deposition. I will ask you some</p> <p>[10] questions regarding your background, what you looked at in this</p> <p>[11] case and some of your opinions. I would ask you to listen to my</p> <p>[12] questions carefully and answer them to the best of your ability.</p> <p>[13] Okay?</p> <p>[14] A: Yes, sir.</p> <p>[15] Q: All right. Can you state your full name for the</p> <p>[16] record, please?</p> <p>[17] A: Samuel J. Kiehl III.</p> <p>[18] Q: Doctor, what is your age?</p> <p>[19] A: Fifty-six. I will be 56 in May.</p> <p>[20] Q: Where did you attend undergraduate and medical school?</p> <p>[21] A: Ohio State University.</p> <p>[22] Q: Where did you do your residency?</p> <p>[23] A: I did a year of residency at York, Pennsylvania. That</p> <p>[24] was all.</p> <p>[25] Q: What kind of a residency was that?</p>	Page 10 <p>[1] A It was medicine.</p> <p>[2] Q: Are you there, Doctor?</p> <p>[3] A: Yes. I said it was medicine. It was internal</p> <p>[4] medicine.</p> <p>[5] Q: Internal medicine?</p> <p>[6] A: Yes.</p> <p>[7] Q: It was one year?</p> <p>[8] A: Yes.</p> <p>[9] Q: Any subsequent residencies or fellowships?</p> <p>[10] A: No.</p> <p>[11] Q: Did you have any formal training in emergency</p> <p>[12] medicine?</p> <p>[13] A: No residency training, if that is what you mean. I</p> <p>[14] have attended many CME course work during the many years</p> <p>[15] Q: Doctor, are you Board Certified in emergency medicine?</p> <p>[16] A: Yes, I am.</p> <p>[17] Q: When did you obtain your Board certification?</p> <p>[18] A: In 1980, which was the first examination that was</p> <p>[19] given.</p> <p>[20] Q: As part of your curriculum, will there be a</p> <p>[21] bibliography of publications that you have authored or</p> <p>[22] co-authored?</p> <p>[23] A: I am not — I have not published. So the answer is</p> <p>[24] no. Actually I participated in a couple of things and I got</p> <p>[25] them mentioned, but I don't routinely publish.</p> <p>[1] Q: All right. Doctor, have you ever done any research on</p> <p>[2] emergency medicine as it relates to an acute abdomen?</p> <p>[3] A: By "research," do you mean original research or do you</p> <p>[4] mean looking at literature? What do you mean by "research"?</p> <p>[5] Q: I mean original research. Thank you.</p> <p>[6] A: No, I have not done any original research or</p> <p>[7] publication relative to that.</p> <p>[8] Q: Okay. Doctor, can you describe for me what your</p> <p>[9] practice consists of these days?</p> <p>[10] A: I am working now at The Ohio State University as an</p> <p>[11] emergency physician. I spend 25 to 30 hours a week in the</p> <p>[12] emergency department seeing patients and proctoring students and</p> <p>[13] residents.</p> <p>[14] I also am involved in one research project right now</p> <p>[15] on vascular access and I also do some or I have agreed to do</p> <p>[16] some didactic teaching as well.</p> <p>[17] Q: Doctor, which hospital do you spend those 25 to 30</p> <p>[18] hours a week at?</p> <p>[19] A: I just started there in April, this month, and the</p> <p>[20] first month I have been spending all of my time at their east</p> <p>[21] facility. Next month I will be spending part of my time at both</p> <p>[22] campuses.</p> <p>[23] Q: What was your clinical practice like prior to April of</p> <p>[24] 2002?</p> <p>[25] A: Well, for three years prior to that I spent in a small</p>

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[1] rural county hospital called Hladison County Hospital which is in
[2] London, Ohio, which is a farming community with a significant
[3] amount of industry. We saw about 12,000 emergency visits a
[4] year. I worked typically two shifts a week which were 12-hour
[5] shifts. So I worked 24 hours a week during that three-year
[6] period.

[7] Prior to that I was the Director of the Emergency
[8] Department at Riverside Hospitals in Columbus, Ohio for about 18
[9] years, and before that I was a staff emergency physician for
[10] about six years at Riverside. So I had a total of about 24
[11] years of clinical and leadership work at Riverside.

[12] Q: Did I hear you say that you were Director of Emergency
[13] Medicine at Riverside for 18 years?

[14] A: Yes.

[15] Q: Why did you leave Riverside?

[16] A: They underwent a — what do you call it — a merger
[17] with another hospital here in town and as part of the merger, I
[18] was not invited to continue as the Director, and I elected not
[19] to continue as a staff physician.

[20] Q: I see. Who took over the position of Director at that
[21] time?

[22] A: John Van Schoyck, who was the Director at the other
[23] hospital.

[24] Q: As an emergency physician, do you have what we might
[25] refer to as privileges at hospitals?

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[1] A: Yes. In order to practice at any hospital, you need
[2] to have privileges commensurate with your practice.

[3] Q: At your current position at The Ohio State University,
[4] do you have admitting privileges?

[5] A: I am not an attending physician for admitted patients,
[6] if that is what you mean.

[7] Q: Okay. Are you in a position at Ohio State University
[8] wherein the emergency department you are able to direct, admit
[9] patients, or do you need an attending physician to issue such an
[10] order?

[11] A: I need to have an attending physician to care for the
[12] patient when they are admitted. And the attending physician has
[13] to accept the admission. I think you are probably saying the
[14] same thing that I just said.

[15] Q: I agree. Is OSU now your employer?

[16] A: Actually I am a subcontractor, is the way it is
[17] structured with the group of emergency physicians who staff the
[18] Emergency Department at Ohio State. I may also — I may be an
[19] employee also. I am not 100 percent sure how that works. I
[20] know that I am — I think that I am also considered an employee
[21] of the University, but I don't know exactly how that works. I
[22] don't receive a check from them.

[23] Q: Okay. Doctor, can you identify for me this group that
[24] does have the contract with Ohio State?

[25] A: You know, I don't know what their name is actually.

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[1] They just staff the one organization, Ohio State. It is not a
[2] multi-hospital staffing organization. So I am not exactly sure
[3] what their formal name is, to be honest with you. I have not
[4] received my first paycheck, so I don't know what it will say on
[5] it.

[6] Q: Okay. Doctor, are you licensed to practice medicine
[7] in the State of Ohio?

[8] A: I am.

[9] Q: Are you licensed in any other states?

[10] A: Not currently; I am not.

[11] Q: Have you been licensed in other states?

[12] A: I was licensed in California when I was in the
[13] military.

[14] Q: Am I correct in assuming you never had your license
[15] suspended or revoked in any state?

[16] A: You are correct.

[17] Q: Do you currently have any academic appointments or
[18] responsibilities?

[19] A: Yes.

[20] Q: What are those?

[21] A: Well, I am a clinical professor at Ohio State and that
[22] again — I had a clinical academic appointment for about 20
[23] years which I had not had for a number of years. Then it was
[24] just reestablished this month.

[25] Q: Doctor, during the last five years, how frequently do

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[1] you think you have been called upon to review medical/legal
[2] matters where you have been asked whether a physician has met or
[3] breached the standard of care?

[4] A: I have over a 22-year period been asked on an average
[5] of about 30 to 35 times per year to render such an opinion.

[6] Q: During the last five years has it been greater than 30
[7] to 35 times per year?

[8] A: Possibly. It has been in that ballpark but it may be
[9] a little bit higher.

[10] Q: Of that 30 to 35 times where you have been asked to
[11] review, is there a breakdown as to whether you have looked at
[12] them for lawyers representing patient plaintiffs or lawyers
[13] representing physicians/hospitals?

[14] A: Yes, there is a breakdown.

[15] Q: What would that be?

[16] A: Probably over the entire 22-year career it has been
[17] maybe 60 to 70 percent by defense representatives. In the last
[18] three years it has been more 50/50.

[19] Q: Doctor, how often are you called upon to prepare a
[20] report of the type you prepared on October 30, 2000 in the Edna
[21] Martello matter?

[22] A: I don't know for sure. My guess has been that I have
[23] been deposed — I know that is not the question you asked. I
[24] don't really know the answer to that question. But I know or I
[25] have an idea that I am deposed on close to 50 percent of the

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[1] things that I am asked to review. It could be a little less
[2] than that. I suppose it is close to 50 percent of the time. It
[3] seems that I am deposed approximately once or twice a month, so
[4] somewhere in the ten to 20 times a year I am deposed. So it is
[5] approximately half of what I review. And I am not — even when
[6] I am deposed, I am not asked to give a report. That is part of
[7] the reason I really don't know exactly. It seems like only
[8] sporadically am I asked to give a report.

[9] Q: Do you do much out-of-state consultation work in these
[10] medical/legal matters?

[11] A: It seems that the majority of what I do is in-state.
[12] Again I don't have an exact breakdown of that. In the last
[13] three years I would say a few more have been from out of state.
[14] Prior to that I would say at least three quarters are in-state.
[15] Now it may be a little bit less than that are in-state, but it
[16] seems to me that the majority of them are in-state.

[17] Q: What percentage of your annual income over the last
[18] three years do you think has been in medical/legal cases as an
[19] expert?

[20] A: If you are talking about income relative to the
[21] practice of medicine including this as being a part of my
[22] practice, it — the last three years, it has been approximately
[23] — it has been a little less than, but approximately 50 percent,
[24] maybe 40 percent, but it is in that range.

[25] Q: Okay. How often do you think you appear per year

[1] I do know that I am working with — let's see. It's
[2] somebody I just talked to this week from up there. It's Spisak
[3] Les Spisak.

[4] Q: You are working with him?

[5] A: Yes. He has asked me to review a case.

[6] Q: Okay. Can you recall any patient/plaintiff cases that
[7] you have actually come up to Cleveland to testify in?

[8] A: I am sorry, say that again.

[9] Q: Do you recall any cases where you were retained by the
[10] attorney representing the plaintiff/patient where you actually
[11] came up to Cleveland and testified?

[12] A: Well, I know that I have. I can't remember any — I
[13] can't remember any names right now.

[14] Q: Have you ever reviewed a case in the last — let's
[15] make it in the last three to five years — for either a
[16] plaintiff or a defendant in which the thrust of the medical
[17] issue in the case relates to a delay in addressing an acute
[18] abdomen?

[19] A: I can't specifically remember. No.

[20] Q: Doctor, in the last three to five years, have you been
[21] involved either for the plaintiff or for the defendant in a case
[22] where a patient suffered a ruptured viscus?

[23] A: Again I can't specifically remember

[24] Q: In the Edna Martello case we are dealing with what
[25] appears to be a diagnosis made by the general surgeon of a

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[1] either live at trial or in a videotape deposition?

[2] A: It has been about one to two times a year.

[3] Q: Prior to this case, the Edna Martello case, did you
[4] ever have occasion to work with Joe Coticchia?

[5] A: I believe this was the first one that I have reviewed
[6] for him.

[7] Q: Doctor, in the last three years — let's make it the
[8] last three to five years — have you advertised at all your
[9] services as an expert witness in any publication?

[10] A: I have never advertised in my — in any of my career.

[11] Q: Have you been a member of any of those expert select
[12] services or expert search service?

[13] A: No, I have not.

[14] Q: Doctor, can you recall whether in the last several
[15] years you have worked with any of the attorneys, either defense
[16] counsel defending a physician/hospital or a plaintiff's attorney
[17] representing a patient?

[18] A: Many, many times for both sides.

[19] Q: Doctor, can you identify for me at least several that
[20] you have been involved on behalf of the defendants that were in
[21] the Cleveland area over the last few years?

[22] A: You know, I don't categorize people by where they are
[23] from. I would feel uncomfortable trying to remember and maybe
[24] say somebody that is somewhere else. I don't remember them by
[25] location too well.

[1] ruptured sigmoid colon, secondary to diverticulitis. Have you
[2] ever encountered that in any of your expert consultations prior
[3] to the Martello case or since the Martello case?

[4] A: I can't remember. I mean I have seen plenty of them
[5] personally, but I am not sure whether I have reviewed any as a
[6] part of a medical malpractice review or not. I cannot remember.

[7] Q: Thank you. Doctor, do you remember how you were first
[8] contacted by Mr. Coticchia?

[9] A: I don't remember. I don't.

[10] Q: It could have been by telephone, it could have been by
[11] letter, you just don't remember?

[12] A: Correct.

[13] Q: Do you remember what materials Mr. Coticchia provided
[14] to you for review?

[15] A: He sent me material in several packets and I don't
[16] remember specifically which came when.

[17] Q: Do you have materials in front of you?

[18] A: I do. Yes.

[19] Q: Maybe you can state on the record for us what you
[20] currently have available to you for review in this case.

[21] A: Sure, I can do that. I am just going to — If it is
[22] okay, I will go right straight through the file of papers that I
[23] have here (indicating). Is that okay?

[24] Q: That is fine.

[25] A: I have my own report. I have a report to Mr.

[1] VanWagner from Dr. McNamara. I have a report to Mr. VanWagner
[2] from Dr. Charles Emmerman. I have a deposition of
[3] Dr. Joseph Cooper.

[4] I have the emergency record related to the admission
[5] of Edna Martello, the date that we are considering. Then I have
[6] the medical records associated with the admission of Mrs.
[7] Martello which culminated in her death.

[8] I have the depositions of J. Morrow, Dr. Larry
[9] Narachania, Dr. Graber. I have a list of nursing procedures
[10] from Southwest General Health Center Nursing Services. I have a
[11] report to Ms. Conley from
[12] Dr. Hirotus.

[13] I have a report to Mr. VanWagner from — this one is
[14] dated March 21, 2002 — from Dr. McNamara. This is different
[15] than the other one that I referenced. This is a very short
[16] report. I have an affidavit of Dr. Cooper dated 10 April 2002.
[17] And that is all.

[18] Q: Doctor, when I look at your October 30, 2000 report,
[19] it occurs to me that at that time, the only thing that you had
[20] to look at was the actual Southwest General Hospital medical
[21] records for Edna Martello. Is that what you believe to be the
[22] case?

[23] A: Yes, I think that is correct.

[24] Q: Doctor?

[25] A: Yes, I think that is correct.

[1] Q: And it is fair for me to infer from that that all of
[2] the other materials that you listed were provided to you since
[3] October 30, 2000; is that fair?

[4] A: Yes, I think that is fair.

[5] Q: Did Mr. Coticchia submit any materials to you that are
[6] not part of what we might call an official record of witness
[7] statement, any sort of summary or memorandum upon which you
[8] relied in formulating your opinions?

[9] A: No.

[10] Q: Was that October 30th report the first and only report
[11] that you prepared for Mr. Coticchia?

[12] A: I believe it is.

[13] Q: There is no subsequent addendum or amendments to that
[14] report then; is that correct?

[15] A: I don't believe there are that preceded or followed
[16] this as far as I know.

[17] Q: Do you remember whether you conducted any type of
[18] literature search or review of medical literature to assist you
[19] in preparing your October 30, 2000 report?

[20] A: Yes, I remember.

[21] Q: Did you review anything?

[22] A: I did not.

[23] Q: How about prior to today in preparation for your
[24] deposition, did you do any medical research?

[25] A: I did not.

[1] Q: Have you been provided any articles in the medical
[2] literature by Mr. Coticchia to review in an effort to assist you
[3] to prepare for today's deposition?

[4] MR. COTICCHIA: Objection. That deals with
[5] privileged communication. Without waiving the objection, the
[6] Doctor may answer.

[7] THE WITNESS: I have not.

[8] BY MR. VANWAGNER:

[9] Q: Doctor, what did you do in order to prepare for
[10] today's deposition?

[11] A: I looked through the material that I just read off to
[12] you.

[13] Q: Did you meet with Mr. Coticchia briefly?

[14] A: Yes, we met maybe ten minutes prior to this. Yes.

[15] Q: Are there any publications in the field of emergency
[16] medicine which you believe are authoritative regarding the
[17] emergency management regarding a patient such as Edna Martello?

[18] A: I don't know exactly. This has been asked of me many
[19] times. And "authoritative" is a word that is somewhat
[20] ambiguous. I can tell you the textbooks that we typically use
[21] in our training, if that will be helpful to you.

[22] Q: Maybe you can tell me what textbooks you might refer
[23] to today in an emergency department setting if you had a
[24] question.

[25] A: Yes, that would be good. I can do that.

[1] Tintinalli's Textbook on Emergency Medicine; Rosen's Textbook on
[2] Emergency Medicine; and Schwartz' Textbook on Emergency
[3] Medicine.

[4] Q: In your identification of the materials you have
[5] before you, you indicated that you got in front of you both
[6] reports issued by Dr. Narachania, Dr. Emmerman's report, and
[7] Dr. Horitus' report. Do you know any of those three physicians
[8] either by name or reputation?

[9] A: I know Dr. Emmerman.

[10] Q: How do you know Dr. Emmerman?

[11] A: Well, we have had some, I wouldn't call it close
[12] association, but we had some association in our Ohio chapter of
[13] the American College of Emergency Physicians. I have talked to
[14] him on the phone a couple of times, I believe, and we have also
[15] reviewed the same case on a number of occasions of this nature.

[16] Q: Do you recognize Dr. Emmerman to be a respected and
[17] informed member of the medical profession?

[18] A: I do.

[19] Q: Can you distinguish for me, Doctor, the difference
[20] between diverticulitis and diverticulosis?

[21] A: I can. Yes.

[22] Q: Pleasedo.

[23] A: Diverticulitis is an inflammation of a diverticulum.
[24] Typically one is referring to a diverticulum of the large
[25] intestine, usually the sigmoid colon.

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[1] A diverticulum is an outpouching of the wall beyond
[2] the extent that one would expect it to be, and this usually is
[3] associated with a perforating artery through the wall.
[4] Diverticulosis refers to the presence, the condition
[5] wherein there are diverticuli present.
[6] Q: What is the Likelihood of a person having diverticuli
[7] present at 77 years of age?
[8] A: I would say probably close to 100 percent.
[9] Q: Doctor, you made a reference to the sigmoid colon.
[10] Anatomically, where is that located in a person?
[11] A: You mean where would I map it on the abdominal
[12] surface? What do you mean?
[13] Q: That's a good way of putting it.
[14] A: It would be down in the lower abdomen in the super
[15] pubic area.
[16] Q: Which side would that be?
[17] A: That is central.
[18] Q: Okay. Can you and I agree that the first presenting
[19] complaint of a person with diverticular disease is fever and
[20] localized tenderness in the left lower quadrant of the abdomen?
[21] MR. COTICCHIA: Objection. Are you referring in
[22] general or are you referring to Edna Martello?
[23] MR. VANWAGNER: I am just referring in general right
[24] nor;.
[25] MR. COTICCHIA Thank you. Okay.

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[1] A: Well, according to the nurse's note — let me get
[2] that. First of all, the emergency squad stated that she had had
[3] abdominal pain. Let me again just make sure that I state these
[4] things correctly.
[5] There were several renditions of what — also looking
[6] from the nursing notes here — I think I turned everything
[7] upside down here when I went through **this** (indicating).
[8] Are you looking at your stuff or my stuff?
[9] MR. COTICCHIA: My stuff.
[10] THE WITNESS: Okay. The emergency squad said that she
[11] was complaining of lower abdominal pain. She was also
[12] complaining of difficulty urinating apparently.
[13] The emergency nursing notes at 17:10 — which was
[14] about the time that she was first evaluated after her initial
[15] triage — said that she was complaining of severe right-sided
[16] abdominal pain since the morning. So that was apparently what
[17] her presenting symptoms were.
[18] BY MR. VANWAGNER:
[19] Q: Is that a reasonable period of time between her
[20] arrival in the emergency department and the initial assessment
[21] of her by the physicians and nurses?
[22] A: A reasonable time — You mean between 15:26 and 17:00?
[23] Q: For her to be triaged, brought to a bed, assessed,
[24] that sort of thing?

[12] Q: Now, when Edna Martello presented to the emergency
[13] department on the evening of January 31, 2000, she was
[14] complaining of right-sided pain and had a recorded temperature
[15] of 97.7. Do you remember seeing that?

[12] A: Well, I have read what Dr. Cooper said about that, if
[13] that is what you mean.
[14] Q: Okay.
[15] A: And Mr. Coticchia has answered a couple of questions

[22] Q: Tell me, based on your review of the records, your
[23] understanding of what her presenting complaints were when she

[22] could affirm or deny what Dr. Cooper attests is the conversation
[23] that you referenced, and he said there were. He said there was

[1] to me, so I think he is going to send it to me.

[2] Q: Did Mr. Cotichia represent to you what the witness
[3] had to say on that issue?

[4] MR. COTICCHIA: Let me enter an objection. It is
[5] privilege. We are talking about the daughter, Lynn Martello,
[6] and a neighbor named Louise Haar. From what I understand, there
[7] is no — there will be no testimony that they ever heard what
[8] Dr. Cooper is claiming regarding this patient's refusal to get
[9] treatment or she would leave the emergency room.

[10] THE WITNESS: That is what he told me.

[11] MR. VANWAGNER: Joe, now are both of those individuals
[12] going to testify at trial?

[13] MR. COTICCHIA: Well, one of them, is Lynn Martello.

[14] MR. VANWAGNER: She has been deposed. What about the
[15] other one?

[16] MR. COTICCHIA: The other one is Louise Haar. At one
[17] time Mr. Switzer and I talked about taking her deposition. He
[18] never got back to me.

[19] MR. SWITZER: I think I did. I thought you indicated
[20] that she was not going to be testifying or we can set it up.

[21] MR. COTICCHIA: Yes. I left you a voice mail. I
[22] think she is going to say basically the same thing that Lynn
[23] Martello said. But if you want to depose her, she is available.

[24] MR. SWITZER: Can you spell her last name?

[25] MR. COYICCHIA: It's spelled H-a-a-r.

[1] MR. SWITZER: Thank you.

[2] BY MR. VANWAGNER:

[3] Q: Dr. Kiehl, are you aware of, by having reviewed Dr.
[4] Cooper's deposition, that his position on this is that he wanted
[5] to undertake some studies, x-ray, blood work, et cetera, before
[6] doing any type of therapeutic procedure but the patient refused
[7] any offer of diagnostic studies and insisted on an enema to
[8] relieve her constipation, otherwise she would leave the
[9] emergency department?

[10] I mean I — You know, I recognize that Mr. Cotichia
[11] will present an opposing point of view. But you realize from
[12] Dr. Cooper's deposition that is his recollection of the events;
[13] correct?

[14] MR. COTICCHIA: I will enter an objection because
[15] nowhere in the emergency room record nor in Dr. Cooper's
[16] emergency room report does he say the patient refused anything.
[17] Having entered that objection, the Doctor may answer the
[18] question.

[19] THE WITNESS: I am aware that Dr. Cooper has attested
[20] that what you said is correct.

[21] BY MR. VANWAGNER:

[22] Q: You are also aware that Page 3 of his dictated
[23] Emergency Department records says, quote, "The patient's initial
[24] request, she asked for a soapsuds enema. I did not want any
[25] other workup other than this." You are aware that that is in

[1] the records; correct?

[2] A: Yes, I am.

[3] Q: She had her first soapsuds enema, according to the
[4] record, at 6:25 p.m., 350 cc's, and a second at 6:40 p.m., 400
[5] cc's. Is that your interpretation of the record as well?

[6] A: Yes, sir, it is.

[7] Q: Once the soapsuds enema failed to produce stool, the
[8] patient did undergo blood work and did have a KUB; correct?

[9] A: Yes.

[10] Q: Can you describe for me the role of the KUB in working
[11] up abdominal symptoms?

[12] A: Well, KUB is sometimes referred also as a flap map of
[13] the abdomen. It can give you some information about certain
[14] types of pathology including kidney stones, gallstones,
[15] obstruction, perforations, things that are — sometimes that can
[16] be helped by that x-ray. A single view x-ray is not the best
[17] way to assess that, but it — depending on the severity of a
[18] patient's illness, that sometimes is all one can do.

[19] Q: When you talked about a KUB can be used to look for a
[20] perforation, do you mean a perforation of the viscus?

[21] A: Yes, that is what I mean.

[22] Q: How would it show up on a KUB?

[23] A: Well, there would be air outside of the lumen of the
[24] bowel.

[25] Q: Okay. Was it appropriate for Dr. Cooper to order a

[1] KUB for a patient with Edna Martello's complaints?

[2] A: Well, again, that — I don't know whether
[3] Mrs. Martello was just not able to sit up or what. But that is
[4] not a typical study that you would order in this particular
[5] situation. One typically would order what we call an acute
[6] abdominal series which is not only a supine film, but also an
[7] upright abdominal film and a chest x-ray including the
[8] diaphragm.

[9] So I mean, I am not saying that it was a terrible
[10] thing that he did that, and I don't know why he just did that
[11] single view, but that is not a typical thing to do.

[12] Q: Okay. If a KUB in a setting such as that with Edna
[13] Martello is interpreted as normal, what is the significance of
[14] that interpretation?

[15] A: Well, it just means that we were not able to determine
[16] what the cause of her pain was with that particular study.

[17] Q: And after that study is completed and if it is
[18] reported out as normal, would you then move to this acute
[19] abdominal series that you referenced or would you move to a CT
[20] scan?

[21] A: Well, I don't know if I — First of all, I am not sure
[22] that I would have followed exactly the path that you are going
[23] down. You are asking me questions that give me very limited
[24] choices. I am not sure that it is the best way to do things to
[25] start with. So I don't know exactly how to answer your

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[1] question.

[2] Q: Did you ever have an opportunity to look at the actual

[3] KUB films that were done that night?

[4] A: I did, or a copy of them.

[5] Q: Did you see anything in those films?

[6] A: I didn't personally. No.

[7] Q: Okay.

[8] A: I mean I saw things, but I didn't see free air, which

[9] was apparently subsequently seen.

[10] Q: Right. You knew that is what I meant. I understand

[11] you saw a copy of the films but not the original films; is that

[12] correct?

[13] A: Yes, sir, that's correct.

[14] Q: If the KUB had been reported out at approximately 9:00

[15] p.m. that evening as demonstrating free air, what would be the

[16] next step?

[17] A: Well, a patient like Mrs. Martello needs to have early

[18] surgical consultation. And whether one does studies before or

[19] after depends on the circumstances. But assuming that it was

[20] okay to hold off on getting a surgeon involved right away, if

[21] one knew that there was free air at some point, say after the

[22] KCB, then that requires urgent or — rather an emergent surgical

[23] consultation.

[24] Q: So if the KUB had been reported out at approximately

[25] 9:00 p.m. on January 31st as demonstrating free air in the

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[1] abdomen, that then requires an emergent surgical consultation?

[2] A: It does. Yes, sir.

[3] Q: In the case of Edna Martello, we know that was

[4] reported as being a normal film but that around 3:30 a.m. or

[5] prior, maybe between 3:00 a.m. and 3:30 a.m. on February 1st,

[6] the CT scan was reported as showing free air. Would that also

[7] hold true that this be an emergent situation for a surgical

[8] consultation?

[9] MR. LEAK Objection.

[10] Go ahead, Doctor.

[11] THE WITNESS: Okay. Once free air is diagnosed, then

[12] that finding does require emergent surgical intervention. There

[13] are other things in this particular case that require emergent

[14] surgical involvement which you have not been asking me about.

[15] But, you know, again, I just don't want to give you the wrong

[16] idea that I am agreeing with you as to — I am not even

[17] suggesting that you are suggesting that this is the way it is

[18] supposed to be done. But I just don't want you to be confused

[19] by the line of questioning that you are asking me, that I am

[20] agreeing that this was handled appropriately given the

[21] presentation and findings of this patient. But given your

[22] question, if a patient has free air diagnosed on CT, that

[23] becomes an emergent surgical problem.

[24] BY MR. VANWAGNER:

[25] Q: What does "emergent surgical problem" mean exactly?

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[1] A: Well, it means that I need to call a surgeon

[2] immediately when I find something of that nature. That means

[3] that I don't have time to do additional studies to try to figure

[4] out why, or to do anything else other than to get a physician's

[5] input on what should be done next. And that would be within

[6] minutes of making that diagnosis. Minutes, meaning it sometimes

[7] takes a little while to get a hold of the surgeon. But within

[8] reason, as quickly as possible to get a hold of the surgeon,

[9] explain to the surgeon what type of a patient I am dealing with,

[10] including the findings of free air.

[11] Q: I assume that in your years as an emergency department

[12] physician you have encountered this free air in the abdomen on a

[13] number of occasions; is that correct?

[14] A: That's correct.

[15] Q: When you had encountered that, did you consider that

[16] to be an emergent situation requiring immediate surgical

[17] consultation? Is that a fair statement?

[18] A: If I had not previously consulted a surgeon and I

[19] found that, yes, that is correct.

[20] Q: Based on your experience, what is a reasonable

[21] expectation for a surgical consult to occur after you have made

[22] the contact with the surgeon?

[23] A: Well, depends on the nature of the problem. I mean if

[24] I have got somebody that has a ruptured spleen, I expect the

[25] surgeon to have that patient in the operating room in 30 minutes

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[1] or less

[2] Q: What about where you have a perforated viscus?

[3] A: Well, I would expect to have a physician on the phone

[4] within minutes and indicate to them what I have in front of me,

[5] and then essentially the surgeon runs the show from that point

[6] on

[7] Q: In your experience with the surgeon running the show

[8] from that point on, what is the typical time lapse between

[9] contact and having the patient on the table?

[10] A: Well, it varies quite a bit relative to what the

[11] concern is. But typically it is within an hour or so.

[12] Sometimes additional testing needs to be done to get a better

[13] idea. If the patient is at all unstable, like for instance not

[14] having any urine output for six hours or having hypotensive —

[15] be hypotensive, or anything that would suggest this patient is

[16] in shock or having a difficult time, those patients are

[17] typically — an attempt is try to fluid resuscitate them as

[18] quickly as you can, meaning over an hour, and so — and get them

[19] to the O.R. as quickly as possible after the resuscitation.

[20] Q: In light of all of the circumstances with Edna

[21] Martello, do you feel that a four-plus hour interval between

[22] contacting the general surgeon and having the patient on the

[23] table was a reasonable period of time?

[24] A: No, I don't think it is. I am not a surgeon, but that

[25] does not comport with my experience in these kinds of

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[1] situations.

[2] Q: Doctor, as I look at your report, I note that
[3] obviously you talk about a lot of the negligence of my client.
[4] Then there is a sentence in there — second to the last
[5] paragraph — in which you state, “Finally these negligent acts
[6] reacted in prolonged and unnecessary pain, suffering and mental
[7] anguish.” Do you see that line?

[8] A: Yes.

[9] Q: Should I assume from that statement that it is not
[10] your opinion that the delay actually caused her death?

[11] A: No, you should not assume that.

[12] Q: That is not contained in your report though, is it?

[13] A: You mean those specific words or — What are you
[14] asking?

[15] Q: I guess I am asking whether your October 30, 2000
[16] report anywhere indicates that it is your opinion that the delay
[17] occasioned by the negligence of Dr. Joe Cooper caused the death
[18] of Edna Martello?

[19] A: I think it is implied, but I don't think I maybe
[20] specifically said that, and that was not really the focus. I
[21] think I stated things a little bit different than what you just
[22] said.

[23] Q: I guess I'm going to have to ask you **this** question.
[24] At trial, if Mr. Cotichia asks you to a reasonable degree of
[25] medical probability on issues regarding causation, would you

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[1] render an opinion that Edna Martello's death was caused by the
[2] delay in surgically addressing her condition?

[3] A: I think delay contributed significantly to her
[4] likelihood of death. I am not a surgeon. I will probably not
[5] — I cannot tell you when she was irretrievable. I don't know
[6] that. I don't consider myself an expert in that field, so I
[7] don't know exactly what Mr. Cotichia is going to ask me in that
[8] regard. But I would not — What I can say to a reasonable
[9] degree of medical certainty, given my area of expertise, that
[10] there was an unreasonable delay from her presentation to the
[11] time that that surgical consultation was obtained and that that
[12] likely significantly decreased her likelihood of recovery.

[13] Q: But you are not able to tell me when the window of
[14] opportunity to save her life actually closed?

[15] A: I cannot. That's correct.

[16] Q: Do you think it was — Do you *think* it is more or less
[17] probable she would have survived if a surgical consultation had
[18] been obtained before midnight?

[19] A: I ~~think~~ it is more — I **think** it is more likely that
[20] she would have survived. I don't know whether it — I don't
[21] know whether it is to a probability that she would survive. I
[22] don't know that.

[23] Q: Okay. Dr. Cooper went off duty at 1:00 in the morning
[24] and the patient was then managed by a Dr. Graber from about 1:00
[25] a.m. until Dr. Narachania became heavily involved sometime after

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[1] 6:00 a.m. Do you have any criticism of Dr. Graber's management
[2] of the patient?

[3] A: No, I do not.

[4] Q: I want to go through with you in your report the
[5] second page of the report which details your opinions regarding
[6] Dr. Cooper's care of this patient and your perception of **his**
[7] negligence.

[8] I would like you to just itemize for me where you see
[9] Dr. Cooper fell below the accepted standard of care beginning
[10] with his initial involvement with Edna Martello until he went
[11] off his **shift** at 1:00 a.m. the following day.

[12] A: Okay. Well, I mean I may not do this exactly the way
[13] you are expecting me to. But my criticism of Dr. Cooper is that
[14] he was faced with a patient who had — was an elderly lady who
[15] had severe — from all indications that I can find — lower
[16] abdominal pain. It had been going on all day long. And when a
[17] patient like that presents, a reasonable emergency physician
[18] must assume that that patient has a potential surgical problem.
[19] There is a high percentage of those people who have a surgical
[20] problem at that point. And that has to be the assumption that
[21] the physician operates under.

[22] And there are a number of different potential surgical
[23] problems that might be going on. And if a reasonable emergency
[24] physician cannot typically make a distinction — I mean there
[25] are — sometimes you can, but most times, say when a patient of

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[1] **this** nature presents, it is difficult to know exactly what is
[2] happening. And so the standard of care requires an expeditious
[3] evaluation of them and early surgical involvement. And again,
[4] it varies from patient to patient when the surgeon is involved.
[5] Sometimes it **is** right from the minute when the emergency
[6] physician notes that the patient has significant tenderness and
[7] then calls the surgeon and indicates the problem and they
[8] coordinate together the diagnostic process ~~from~~ that point on.

[9] It's also appropriate to — If the patient does not
[10] have immediate signs of intraperitoneal irritation, then it **is**
[11] appropriate for a physician in that particular situation to
[12] initiate some laboratory studies **and** then — laboratory and
[13] x-ray studies — and then consult a surgeon at some point in the
[14] future if a diagnostic determination is not able to be made
[15] initially.

[16] Dr. Graber fell below the standard of care because —
[17] I **am** sorry, not Dr. Graber. Dr. Cooper fell below the standard
[18] of care because he did not treat **this** as a potential surgical
[19] problem. He inappropriately administered or ordered to have
[20] administered enemas times two. He then, in my opinion, took an
[21] extremely long time from that point on, from the time that it
[22] should have been terribly obvious that **this is** something gone
[23] awry, that **this** patient should have been in the hands of a
[24] surgeon almost immediately at that point.

[25] So sometime after 8:00 o'clock when **this** misadventure

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[1] with enemas took place, then he should have gotten the surgeon
[2] involved immediately and done whatever the surgeon wanted him to
[3] do at that point.

[4] Q: So your criticism, if I understand it, and I don't
[5] mean to mischaracterize it, but your criticism is that certainly
[6] no later than around 8:00 p.m., Dr. Cooper should have had a
[7] general surgical consult?

[8] A: That's one of my opinions. Yes.

[9] Q: Okay. Another one of your opinions —

[10] MR. SWITZER: I'm sorry, what time did you say again?

[11] MR. VANWAGNER: I thought you said 8:00 p.m.

[12] THE WITNESS: Maybe I did. I meant — let me see.

[13] Those times — I sometimes get things confused.

[14] Yeah. Yes, that is correct. Sometime around 8:00
[15] o'clock. Between 7:00 and 8:00, after the second enema, at
[16] 6:40; Demerol was administered at 9:00. The patient, according
[17] to the nurses' notes, **pain** continues — which I assume was the
[18] severe pain that was referenced earlier. So somewhere in that
[19] 7:00 to 8:00 range. So your statement by 8:00 o'clock I think
[20] is an accurate statement. You were characterizing my opinion.
[21] I can say that is correct.

[22] BY MR. VANWAGNER:

[23] Q: You are also critical of Dr. Cooper for ordering the
[24] administration of the soapsuds enemas in the first place; is
[25] that correct?

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[1] A: I am.

[2] Q: I believe in your report you indicate that it is
[3] because that has the potential of increasing intraluminal
[4] pressure to the point that a diverticulum is ruptured?

[5] A: I think that is what happened in this case. That is
[6] not the — I mean that is one of the reasons you don't do that.
[7] You do not a — One of the Cardinal Rules, you do not do an
[8] enema on somebody when you don't know what the problem is.

[9] Q: Why is that?

[10] A: Because you can cause significant damage by doing
[11] that.

[12] Q: What would the damage be if you gave somebody a
[13] soapsuds enema?

[14] A: A ruptured viscus is the most common problem that
[15] happens as a result of that.

[16] Q: Is there literature out there that supports the
[17] proposition that **an** enema can increase intraluminal pressure to
[18] the point that a rupture can be caused?

[19] A: I am sure there is. I know that I have learned that.
[20] And I don't think it **is** something that is frequently written. I
[21] think it **is** somewhat intuitive. I can tell you that on a
[22] regular basis when we are considering doing a diagnostic enema,
[23] meaning with some kind of a Contrast in somebody that is having
[24] abdominal pain, we routinely discuss that. We will routinely
[25] use Gastrografin and watch and do it under fluoroscopic control

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[1] to make sure that we don't cause a perforation. And if there is
[2] already a perforation, **that we can pick it up** immediately and we
[3] use small volumes and we use a contrast medium that is water
[4] soluble so we don't cause more damage by barium. I think it is
[5] just like vital signs, as far as understanding them.

[6] The medical community — I am surprised that anybody
[7] would not be aware that there is that concern. I mean that is
[8] something that I talk about with the radiologist I would say at
[9] least every month.

[10] Q: When do you think the viscus perforated with Edna
[11] Martello?

[12] A: Well, it is possible it was perforated when she first
[13] came in. I mean she may have had a micro perforation or a small
[14] perforation at the time she presented.

[15] I think **all** that fecal material that was forced in the
[16] peritoneal clearly occurred after the enema was administered. I
[17] don't think there is any other good explanation for that.

[18] Q: Did Edna Martello have any signs or symptoms of
[19] peritoneal irritation when she first presented to the emergency
[20] department?

[21] A: Well, she had abdominal tenderness and that is
[22] something that we see with early peritoneal irritation. She was
[23] tender in the right lower quadrant, according to the nurse.
[24] Localized tenderness is always a very, very concerning finding.
[25] **Again**, when I say things like that — Like I said, an emergency

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[1] physician must consider a surgical consult in someone that is
[2] older, of a person over 55 years, and I am not suggesting
[3] everyone. I am suggesting that is a — meaning a high
[4] percentage, which could be 20, 30, 40 percent. When somebody
[5] has localized tenderness, I **am** not suggesting that everybody has
[6] peritoneal irritation. **But** I am saying that when a — as a
[7] teacher and one who has been doing this for 30 years, if I see
[8] somebody that has localized tenderness, then that **is** a concern,
[9] and that typically requires a surgical consultation before a
[10] patient leaves.

[11] Q: Maybe it would be helpful if you were to tell me what
[12] you would have done if **this** patient presented to you in the
[13] emergency department.

[14] A: Okay. I will be happy to do that. If I had a
[15] 77-year-old lady who came in with a ten-hour period or 12-hour
[16] period or multiple-hour period of severe lower abdominal pain
[17] that was essentially continuous and had cramping, then I would
[18] have been very concerned about **this** patient right from the
[19] start. I would have started **an** i.v. — and I know she refused
[20] an i.v. — but I would have.

[21] I have been doing **this** a long time. I have people who
[22] are very sick. I never had a situation that I **can** recall that I
[23] have not been able to help the person understand the potential
[24] severity of their problem and why I want to have something done.
[25] So I would have started **an** i.v. I would have started

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[1] giving her fluid resuscitation at that point. I would have —
[2] If she had right lower quadrant tenderness, localized
[3] tenderness, I would have likely drawn blood work at that point,
[4] including CBC, electrolytes, possible liver, lipase test. I
[5] would have consulted a surgeon at that point and told them of my
[6] concern; that is, multiple hours of lower abdominal pain,
[7] localized right lower quadrant tenderness, and that I have
[8] ordered **this** laboratory work.

[9] And I usually in a situation like this would get an
[10] acute abdominal series at the same time I would have ordered it,
[11] but I would not wait for the results. Call the surgeon, tell
[12] the surgeon the story, and ask the surgeon at that point how he
[13] or she would like to interface with **this** patient at this point.
[14] And the reason I do that is because surgeons are often in the
[15] operating room. And so if they are, I want them to be able to
[16] either say, you know, "Call my partner or I will be down as soon
[17] as I do this, or why don't you do this and this and this, and I
[18] will be down as quickly I can, whatever." So we strategize
[19] together. A lot of their decision-making depends on what I tell
[20] them. So I am very careful to make sure that they understand or
[21] my concern in a situation like **this**.

[22] If **this** patient had told me, "Dr. Kiehl, I am not
[23] **going** to let you do any of this stuff unless you give me an
[24] enema." And I have people do stuff like that all the time to
[25] me. You know, they **will** say, "I just want this." I'll say,

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[1] "Well, that is why you came to me so I can help you understand
[2] why you don't want that." Then I explain to them what is going
[3] on or what potentially **is** going on and why we need to do this
[4] and that. If the reason is you want this enema or whatever,
[5] then **is** that because you cannot stand the pain anymore, in which
[6] case let me give you something for your pain to help you with
[7] that while we do what is necessary." I am not going to do
[8] something to a patient that is potentially damaging just because
[9] the patient won't let me do what I need to do.

[10] So that is essentially what I would have done in this
[11] case.

[12] Q: Would it be your expectation that when you called the
[13] general surgeon, that the general surgeon would come down to the
[14] emergency department and examine the patient?

[15] A: At some point, yes. Like I said, my experience **is**
[16] that they come down sort of based on what their schedule is. If
[17] they are out of the O.R. and in between cases, whatever, and I
[18] called them, and I tell them, you know, "I have seen this
[19] patient. I have ordered these tests. Here are my concerns.
[20] What do you want to do?" I have surgeons that will say, "I will
[21] be right down." And if they are just getting ready to go into
[22] surgery, they may say, "I want to feel the belly before I go
[23] into surgery and decide." Or if they are in surgery, they may
[24] say, "Why don't you do **this** and **this** and I will be down as soon
[25] as I'm finished." Or they may say, "Why don't you call my

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[1] partner and talk this over with my partner." So it just depends
[2] on the circumstances what they do.

[3] But my expectation would be that this patient would be
[4] seen by a surgeon within probably an hour at the outset — at
[5] the outside. And an hour would be approximately what I would
[6] have expected for me to take to get the initial round of studies
[7] and results back.

[8] Q: That is before you have any evidence that there is a
[9] serious problem going on?

[10] A: I think I got evidence that there is a serious problem
[11] going on when a patient has continuous abdominal pain for
[12] multiple hours and has localized right lower quadrant
[13] tenderness. That, in my opinion, is a surgical emergency in and
[14] of itself. I don't want to wait for something to rupture before
[15] I consider an emergency. That I think is standard practice.

[16] Q: So your expectation would be under the circumstances
[17] you just described, that the general surgeon would be down to
[18] look at the patient within **an** hour?

[19] A: I would. Yes.

[20] Q: So if you put all of that together and added the fact
[21] you now have absolute proof of a perforated viscus, you would
[22] expect the surgeon to be there in even **less** time?

[23] A: I am sorry, I did not follow your question.

[24] Q: If you expect the surgeon to be there within an hour
[25] and you do not even have any studies to demonstrate a surgical

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[16] antibiotics and that sort of **thing**. So it would trigger an
[17] emergent response in that particular case. So the surgeon may
[18] or may not come down to the ER in an hour. But he would
[19] certainly **have** that patient in the — In my experience, they
[20] typically have these patients in the O.R. in an hour.
[21] Q: I see. Is it your belief that Dr. Narachania deviated
[22] from the standard of care?
[23] A: I **am** not a surgeon, like I said, so I am not going to

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[1] you have indicated to me you have never encountered the
[2] situation with a patient you couldn't overcome. But what would
[3] a physician do with a patient in the emergency department who
[4] was absolutely recalcitrant and refused any diagnostic studies,
[5] any blood work, any x-rays, I mean anything, and indicated that
[6] she would leave if she didn't have an enema — which is what she
[7] came in for and couldn't administer it herself at home —
[8] administered to her?

[9] MR. COTICCHIA: Objection to the characterization of
[10] Edna Martello in her refusal and recalcitrant to leave. That is
[11] nowhere in the record. That is strictly —

[12] MR. VANWAGNER: Joe, **this** is a hypothetical.

[13] MR. COTICCHIA: You're saying a patient of **this** type.
[14] Note my objection.

[15] You may answer the question, Doctor.

[16] THE WITNESS: Well, I guess I am getting a lot of
[17] feedback. Are you? Can you hear me?

[18] MR. VANWAGNER: Are you guys **still** there?

[19] MR. COTICCHIA: Yes.

[20] MR. LEAK: Can you hear us?

[21] MR. VANWAGNER: We did not hear anything.

[22] MR. LEAK: Can you speak up?

[23] MR. VANWAGNER: Okay.

[24] THE WITNESS: Where did you lose **us**?

[25] MR. VANWAGNER: Joe's objection. I said to Joe **this**

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[1] is a hypothetical question. It does not really matter what is
[2] in the record.

[3] MR. COTICCHIA: We heard that. I said with the
[4] objection, the Doctor may answer the question.

[5] MR. VANWAGNER: Okay. What was the answer?

[6] THE WITNESS: What I was saying is that I was assuming
[7] that what you just stated to me was a hypothetical, not this
[8] case, and that was correct.

[9] BY MR. VANWAGNER:

[10] Q: That is a correct hypothetical?

[11] A: Your question, so I am sure I understand, would you
[12] state it again?

[13] Q: I'm asking in a general and hypothetical way, say a
[14] patient comes to the emergency department that you're staffing
[15] and wants a relatively simple procedure done to alleviate pain.
[16] You are more concerned and believe that a workup is indicated
[17] whether it be blood work, x-ray study, CT scan or whatever, and
[18] the patient indicates that he or she does not want any such
[19] workup, they want — let's just use **as** an example they want an
[20] enema for what they believe to be constipation. And you're
[21] concerned about that. You are concerned about the patient and
[22] want to do other studies and you explain to her the need to do
[23] these studies to assure the patient's safety, but the patient
[24] says to you, "Well, if that is the way it is going to be, I will
[25] just leave." What would you do?

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[1] A: If it was me personally in that setting that you just
[2] described, and realize again what you have stated before, I
[3] never had that happen. Never in my 30-plus or 30 years of
[4] medical practice I never had that happen. I have had people
[5] threaten. I have had people leave where in my opinion they were
[6] just seeking drugs or things like that. But I refuse in every
[7] case to do **anything** for a patient that I believe is improper.

[8] So if I were concerned that a patient had a potential
[9] surgical problem, and they were asking me to do an enema, which
[10] I know is a potential risk, I would explain all that to the
[11] patient. I would explain it to the patient's family. I would
[12] call their family doctor and say, "Look, your patient is crazy
[13] here. I need some help. I need you to talk to her and explain
[14] to her that she is dealing with a potential life-threatening
[15] problem. It seems to be reasonable early at this point, but it
[16] has been going on for a number of hours. When it has been going
[17] on for a number of hours, I know that the likelihood of
[18] perforation goes up and I want to have this patient in the hands
[19] of a surgeon as soon as I can." I would explain all that.

[20] If all of that fails, including the family doctor
[21] getting involved, including the family getting involved, if she
[22] says I am going to leave, if you don't want to give me an enema,
[23] well, then I would say, "Then you are going to leave and I will
[24] have you sign **a** thing saying that I am taking my life in my own
[25] hands; I understand full well by leaving this room I may have a

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[1] ruptured viscus, some kind of emergent surgical problem that can
[2] take my life. I am willing to take that chance." I would have
[3] her sign it. I would have the nurse witness it. I would tell
[4] her please come back and let me do what I can. If you want
[5] something for pain, I will give you something for pain, but I
[6] need you here to do the proper thing. If you refuse to do that,
[7] I am not going to do something to you that I think might cause
[8] additional harm. So you choose. I am not going to hurt you in
[9] order for me to help you."

[10] Q: Is there an age cut-off point where an individual
[11] ought not to have an enema to facilitate stool?

[12] A: Unexplained abdominal pain should never have an enema
[13] until the etiology of that pain is determined. So you never,
[14] never do an enema on somebody unless you know there is not a
[15] potential or there is not a surgical problem going on. So that
[16] requires evaluation.

[17] Usually **a** patient who has constipation has
[18] intermittent pain or even no pain and their pain is typically in
[19] the rectal area and it does elicit tenderness on examination. I
[20] mean there are exceptions and there are many causes for
[21] constipation. But typically constipation is a pretty benign
[22] appearing disease. And this patient's description by the nurse
[23] and by the squad at least is not a benign presentation.

[24] Q: Doctor, other than Dr. Cooper's failure to bring in a
[25] general surgeon at or around 8:00 o'clock and his failure to

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[1] initiate blood work and other studies before 8:00 o'clock and
[2] giving or ordering a soapsuds enema under the circumstances, are
[3] there any other specific criticism you have of **his** involvement
[4] in the care of Edna Martello?

[5] **A** Well, I must have confused you by something that I
[6] have said. I am not suggesting that everything would have been
[7] if he had gotten a surgical consultation at 8:00 o'clock. I
[8] am saying that it was blatantly obvious at 8:00 o'clock a
[9] surgeon should have been involved.

[10] My opinion is if I were seeing **this** patient and I
[11] believe the standard of care is that at 6:00 when he saw the
[12] patient, he should have recognized **this** is a potential surgical
[13] emergency, meaning that **this** is a patient who has had prolonged
[14] abdominal pain with localized tenderness and therefore is at
[15] risk for, in this particular case, appendicitis, possibly
[16] diverticulitis, but certainly a big concern for a potential
[17] ruptured viscus, and therefore surgical involvement needs to be
[18] done either then after I evaluate the patient or after I have
[19] done the first round of testing. So that's — I hope that
[20] clarifies that 8:00 o'clock time that we talked about earlier.

[21] **Q**: Okay.

[22] **A**: So I have given everybody that — I believe that that
[23] does complete my criticisms of Dr. Cooper.

[24] **MR. VANWAGNER**: Okay. Doctor, thank you. I think the
[25] others might have some questions.

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[1]
[2] CROSS-EXAMINATION
[3] BY **MR. SWITZER**:

[4] **Q**: Can you hear me, Doctor?

[5] **A**: Yes.

[6] **Q**: This is Don Switzer. I represent the hospital. I
[7] think we met a couple years ago in a case.

[8] **A** okay.

[9] **Q**: Are you going to give any opinions in **this** case on
[10] Edna Martello's life expectancy, assuming she would have
[11] survived had that been performed at some point?

[12] **A** No, I am not.

[13] **Q**: Are you aware of any co-morbid condition that she had
[14] such as cardiac status or renal status unrelated to the events
[15] that occurred in the ER?

[16] **A** I read over some of those things but I have not
[17] focused on that. I cannot cite them to you if that **is** what you
[18] are asking.

[19] **Q**: Your letter of October 30, 2000 references an
[20] enclosure. What was the enclosure?

[21] **A** It may have been — I don't know.

[22] **MR. COTICCHIA** I can answer that question. The
[23] enclosure was **his** curriculum vitae.

[24] **MR. SWITZER**: Okay. Thank you.

[25] **MR. COTICCHIA** You know, I have **his** CV (indicating)

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[1] marked as an exhibit I think during some deposition.

[2] **MR. LEAK**: That is Dr. Cooper's.

[3] **MR. COTICCHIA**: I'm sorry, I got Dr. Cooper's. Sorry.

[4] I'm sorry.

[5] BY **MR. SWITZER**:

[6] **Q**: Did you make any notes in your review of the case?

[7] **A**: Well, I made some highlights and there is a
[8] possibility I had some marginal notes. Sometimes I do that. I
[9] don't know for sure.

[10] **Q**: But there is no separate taking a piece of paper and
[11] writing notes as you go through?

[12] **A**: No. I have the written report that you have but I
[13] don't have any other notes other than, like I said, I made
[14] some — I know I made highlights and I possibly could have made
[15] some marginal notes.

[16] **Q**: Are you going to be giving any opinions that Southwest
[17] General Hospital or its nurses deviated from the standard of
[18] care?

[19] **MR. COTICCHIA**: Objection. As you know, the basis of
[20] the objection is that the law holds the hospital responsible
[21] when the patient looks at the hospital for care. Clark versus
[22] Southview.

[23] **MR. SWITZER**: Can I just rephrase the question then,
[24] Joe? I guess I can ask you, aside from **his** criticism of Dr.
[25] Cooper which I think he explained in **his** letter, I guess that is

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[1] what I am asking him, Joe. We **will** incorporate what he said
[2] about Dr. Cooper.

[3] **MR. COTICCHIA**: Yeah.

[4] BY **MR. SWITZER**:

[5] **Q**: Doctor, do you understand my question?

[6] **A**: I think I do.

[7] **Q**: Will you answer it then?

[8] **MR. COTICCHIA**: He can answer the question with my
[9] objection.

[10] **THE WITNESS** I don't have **any** criticisms of the
[11] nurses or the non-physician staff in **this** case.

[12] BY **MR. SWITZER**:

[13] **Q**: Do you **still** have your billing company?

[14] **A**: Yes, I do.

[15] **Q**: But you no longer work at Madison County Emergency?

[16] **A** That's correct, as of **this** month.

[17] **Q**: Okay. You no longer do the pre-surgical or **PAT** exams
[18] at Riverside?

[19] **A** As of this month, that's correct.

[20] **Q**: Doctor, have you ever been a defendant in a
[21] malpractice case?

[22] **MR. COTICCHIA** Objection; not relevant.

[23] You may answer the question.

[24] **THE WITNESS**: Not for care that I have personally
[25] given. No, I have not been.

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[1] BY MR. SWITZER:

[2] Q: Did you review the CAT scan films Of February 1, 2000?

[3] A I did.

[4] Q: Okay.What is your interpretation of those films? Do
[5] you agree with the radiological interpretation?

[6] A: I really don't consider myself expert in reviewing
[7] those films.

[8] Q: Okay.Doctor, have we covered all of the standard of
[9] care opinions that you will be giving in this case either
[10] through your testimony or your report? We will incorporate your
[11] report.

[12] A: Not that I know of. I think you covered everything.

[13] MR. SWITZER: Okay.I have no other questions.

[14]

[15]

CROSS-EXAMINATION

[16]

BY MR. LEAK:

[17] Q: Doctor, we met earlier. I am Doug Leak. I represent
[18] Dr. Grossman, the radiologist, his group, Drs. Hills and Thomas.

[19] I first want to start with Dr. Grossman. What is your
[20] understanding as to what Dr. Grossman's involvement in this case
[21] was?

[22] A: I don't understand what his involvement is.

[23] Q: You have reviewed the x-ray report regarding the KUB?

[24] A: Yes, I read that.

[25] Q: And that was issued by Dr. Grossman.

[1] standard of care opinions critical of Dr. Grossman's

[2] radiological interpretation?

[3] A: That is a correct assumption.

[4] Q: I want to talk about Drs. Hills and Thomas which is a
[5] radiology group. Do you have any evidence that any radiologist
[6] from Drs. Hill and Thomas provided a wet read or preliminary
[7] report?

[8] MR. COTICCHIA: I'm going to enter an objection. The
[9] doctor may answer after my objection. However, there has been a
[10] significant amount of material, affidavits and opinions
[11] submitted in Edna Martello's brief in opposition to Hill and
[12] Thomas' motion for summary judgment.

[13] With that objection, Doctor, you may answer. This
[14] Doctor has not seen all of that material.

[15] BY MR. LEAK:

[16] Q: Based upon your review, can you identify any
[17] radiologist that was on the premises on January 31st?

[18] A: No, I cannot.

[19] Q: Can you point to any evidence that there was a wet
[20] read or preliminary report on January 31st by a radiologist?

[21] A: I don't know of any.

[22] Q: Is it fair to say then that as it relates to any
[23] radiologist, you will not be rendering any standard of care
[24] opinions critical of the radiologist?

[25] A: Only if I am given a hypothetical of something. You

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[1] A Okay.

[2] Q: Did you review any affidavit provided by Dr. Grossman?

[3] A: I don't believe I did.

[4] Q: Do you have any evidence or facts that would put
[5] Dr. Grossman in the hospital on the evening of January 31st?

[6] A No, I don't.

[7] Q: Any evidence that Dr. Grossman provided any wet read
[8] or preliminary report on January 31st?

[9] A The only reason I am hesitating, I did read the
[10] affidavit of Dr. Cooper. He didn't reference a name, as I
[11] recall.

[12] Q: In Dr. Grossman's affidavit, he states that he did not
[13] arrive at the hospital until February 1st in between 7:30 and
[14] 8:00. You have no reason to dispute that, do you?

[15] A No, I don't have any.

[16] Q: His radiological interpretation, according to
[17] Dr. Grossman, was after — at about 8:00 o'clock or thereafter.
[18] You have no reason to dispute that; correct?

[19] A: Correct.

[20] Q: So if Dr. Grossman's only involvement in this case was
[21] the final interpretation on the morning of February 1, you will
[22] agree that that interpretation played no role whatsoever in the
[23] outcome of this case; correct?

[24] A: I agree with that.

[25] Q: Is it fair to say that you will not be rendering any

[17] perspective.

[18] A: Well, I know what radiologists are supposed to do when

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[1] radiologist. I **will** not opine relative to standard of care
[2] relative to interpretation of these films, if that *is* your
[3] question.
[4] **Q:** Let me ask some questions of what I anticipate in
[5] terms of hypotheticals that you may be faced with.
[6] Do you know if KUB's can be interpreted by
[7] teleradiology?
[8] **A:** Well, at Ohio State, as an example, all of our
[9] radiograms **are** digitalized and they are all interpreted by a
[10] web-based radiologic situation, so I don't know — including KUB
[11] — so I don't know whether that answers your question. But we
[12] look at KUB's, digitalized KUB's every day. We don't see any
[13] hard films at all.
[14] **Q:** You don't know what happened in this case, though,
[15] with regard to the KUB on the evening of January 31st, do you?
[16] **A:** I don't know. That is correct.
[17] **Q:** Doctor, what percentage of your professional time is
[18] devoted to the clinical practice of medicine?
[19] **A:** It's **75** percent or more.
[20] **MR. LEAK** Thank you, Doctor. That is all I have.
[21] **THE WITNESS:** **You** are welcome.
[22] **MR. COTICCHIA:** Any other questions?
[23] (No response.)
[24] **THE WITNESS:** I want to read the transcript.
[25] (Signature not waived.)

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[1]
[2] (Thereupon, the deposition was concluded at 4:45
[3] o'clock p.m. on Wednesday, April 24, 2002.)
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[1] AFFIDAVIT
[2]
[3] STATE OF _____,)
[4]) SS:
[5] COUNNOF _____,)
[6] Samuel J. Kiehl III, **M.D.**, having been duly placed
[7] under oath, deposes and says that:
[8] I have read the transcript of my deposition taken on
[9] Wednesday, April 24, 2002, and made all necessary changes and/or
[10] corrections as noted on the attached correction sheet, if any.
[11]
[12] Samuel J. Kiehl III, **M.D.**
[13] Placed under oath before me and subscribed in my
[14] presence this _____ day of _____, _____.
[15]
[16]
[17] Notary Public
[18] My Commission Expires: _____
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