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.
Video & Court Reporting by Professionals
175 South Third Street
Suite 540
Columbus, OH USA 43215-5134
(614) 431-1344 or (800) 498-2451

Original File 042402SK.VI, 61 Pages
Min-U-Script® File ID: 1669391378

Word Index included with this Min-U-Script®

Page 1

IN THE COURT OF COMMON PLEAS
CUYAHOGA COUNTY, OHIO

Lynn Martello, Executrix of the Estate of Edna P. Martello,)

Plaintiff,)

vs.) Case No. 427286
) Judge Eileen A. Gallagher

Southwest General Health Center, et al.,)

Defendants.)

Deposition of Samuel J. Kiehl III, M.D., a witness herein, called by the Defendants for cross-examination under the statute, taken before me, Sandra L. Krosner-Martin, Registered Professional Reporter and Notary Public in and for the State of Ohio, pursuant to notice and agreement, at the offices of the Deponent, Physicians Professional Management Corporation, 4619 Kenny Road, Columbus, Ohio, on Wednesday, April 24,2002, beginning at 3:00 o'clock p.m. and conciuding on the same day.

Page 2

APPEARANCES:

ON BEHALF OF THE PLAINTIFF:

Joseph L. Coticchia. Esq.
Standard Building- Suite 1640
1370 Ontario Street
Cleveland, Ohio 44113-1701
(216) 861-6622
Fax (216) 861-0418

ON BEHALF OF THE DEFENDANT- SOUTHWEST GENERAL HEALTH CENTER:
(VIA TELEPHONE)

Donald H. Switzer, Esq.
Bonezzi, Switzer, Murphy & Polito
526 Superior Avenue
Cleveland, Ohio 44114-1491
(216) 875-2767
Fax (216) 875-1570

ON BEHALF OF THE DEFENDANT- EMERGENCY PHYSICIANS SERVICES, INC.:
(VIA TELEPHONE)

Jeffrey W. VanWagner, Esq.
Penton Medical Center - Suite 900
1300 East Ninth Street
Cleveland, Ohio 44114-1583
(216) 621-8400
Fax (216) 621-7488

ON BEHALF OF THE DEFENDANTS- DR. GROSSMAN. DR. HILL AND DR. THOMAS:

Douglas G. Leak, Esq.
Roetzel& Andress LPA
1375 East Ninth Street
One Cleveland Center -Tenth Floor
Cleveland, Ohio 44114
(216) 623-0150
Fax (216) 623-0134

Page 3

STIPULATIONS

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

Page 4

INDEX

Page 5

PROCEEDINGS

Wednesday, April 24, 2002
Afternoon Session

MR. VANWAGNER: Is everyone ready?
MR. LEAK: Jeff, this is Doug. Just so we are clear, and I know Joe sent me a letter to this effect, I want to — the Court Reporter is taking this down on the record right now — I want to put on the record that Joe has stipulated that since we were added to the case late and we have not produced any expert report on behalf of Dr. Grossman and Drs. Hill and Thomas, we are participating in this deposition but we are not waiving our right to producing an expert report later if we need to.

I am also going to render an objection to any new opinions not set forth in Dr. Kiehl's report of October 30, 2000, I believe. So I just wanted to put that on the record.
MR. VANWAGNER: Did you say the Court Reporter is taking this down?
MR. LEAK: Yes.
MR. COTICCHIA: Yes, it was taken down.
Jeff, this is Joe. I faxed a handwritten note on Doug's letter requesting that I stipulate that the Defendants, Drs. Hill and Thomas and Dr. Grossman, would not be precluded

Page 6

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

Page 7

MR. COTICCHIA Jeff, he was just sworn in.
MR. VANWAGNER: Okay.

Page 8

SAMUEL J. KIEHL 111, M.D.
of lawful age, being first duly placed under oath, as prescribed by law, was examined and testified as follows:

CROSS-EXAMINATION

BY MR. VANWAGNER:

Q: Doctor, I am Jeff VanWagner. I represent Joe Cooper, D.O. in connection with this case concerning the Estate of Edna Martello that we have been involved in at least 18 months.

I will be taking your deposition. I will ask you some questions regarding your background, what you looked at in this case and some of your opinions. I would ask you to listen to my questions carefully and answer them to the best of your ability. Okay?

A: Yes, sir.

Q: All right. Can you state your full name for the record, please?

A Samuel J. Kiehl III.

Q: Doctor, what is your age?

A Fifty-six. I will be 56 in May.

Q: Where did you attend undergraduate and medical school?

A Ohio State University.

Q: Where did you do your residency?

A I did a year of residency at York, Pennsylvania. That was all.

Q: What kind of a residency was that?

Page 9

A It was medicine.

Q: Are you there, Doctor?

A. Yes. I said it was medicine. It was internal medicine.

Q: Lnternal medicine?

A: Yes.

Q: It was one year?

A Yes.

Q: Any subsequent residencies or fellowships?

A: No.

Q: Did you have any formal training in emergency medicine?

A: No residency training, if that is what you mean. I have attended many CME course work during the many years

Q: Doctor, are you Board Certified in emergency medicine?

A: Yes, I am.

Q: When did you obtain your Board certification?

A: In 1980, which was the first examination that was given.

Q: As part of your curriculum, will there be a bibliography of publications that you have authored or cc-authored?

A: I am not — I have not published. So the answer is no. Actually I participated in a couple of things and I got them mentioned, but I don't routinely publish.

Page 10

Q: All right. Doctor, have you ever done any research on emergency medicine as it relates to an acute abdomen?

A. By "research," do you mean original research or do you mean looking at literature? What do you mean by "research"?

Q: I mean original research. Thank you.

A: No, I have not done any original research or publication relative to that.

Q: Okay. Doctor, can you describe for me what your practice consists of these days?

A: I am working now at The Ohio State University as an emergency physician. I spend 25 to 30 hours a week in the emergency department seeing patients and proctoring students and residents.

I also am involved in one research project right now on vascular access and I also do some or I have agreed to do some didactic teaching as well.

Q: Doctor, which hospital do you spend those 25 to 30 hours a week at?

A: I just started there in April, this month, and the first month I have been spending all of my time at their east facility. Next month I will be spending part of my time at both campuses.

Q: What was your clinical practice like prior to April of 2002?

A: Well, for three years prior to that I spent in a small

Page 11

rural county hospital called hladison County Hospital whichisin London, Ohio, which is a farming community with a signifcant amount of industry. We saw about 12,000 emergency visits a year. I worked typically two shifts a week which were 12-hour shifts. So I worked 24 hours a week during that three-year period.

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

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

A: Yes.

Q: Why did you leave Riverside?

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

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

A: John VanSchoyck, who was the Director at the other hospital.

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

Page 12

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

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

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

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

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

Q: I agree. Is OSU now your employer?

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

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

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

Page 13

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

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

A: I am.

Q: Are you licensed in any other states?

A: Not currently; I am not.

Q: Have you been licensed in other states?

A: I was licensed in California when I was in the military.

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

A: You are correct.

Q: Do you currently have any academic appointments or responsibilities?

A: Yes.

Q: What are those?

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

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

Page 14

you think you have been called upon to review medical/legal matters where you have been asked whether aphysician has met or breached the standard of care?

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

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

A: Possibly. It has been in that ballpark but it may be a tittle bit higher.

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

A: Yes, there is a breakdown.

Q: What would that be?

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

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

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

Page 15

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

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

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

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

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

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

Page 16

either live at trial or in a videotape deposition?

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

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

A I believe this was the first one that I have reviewed for him.

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

A I have never advertised in my — in any of my career.

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

A No, I have not.

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

A: Many, many times for both sides.

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

A You know, I don't categorize people by where they are from. I would feel uncomfortable trying to remember and maybe say somebody that is somewhereelse. I don't remember them by location too well.

Page 17

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

Q: You are working with him?

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

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

A: I am sorry, say that again.

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

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

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

A: I can't specifically remember. No.

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

A: Again I can't specifically remember

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

Page 18

ruptured sigmoid colon, secondary to diverticuhtis. Have you ever encountered that in any of your expert consultations prior to the Martello case or since the Martello case?

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

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

A: I don't remember. I don't.

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

A Correct.

Q: Do you remember what materials Mr. Coticchia provided to you for review?

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

Q: Do you have materials in front of you?

A: I do. Yes.

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

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

Q: That is fme.

A. I have my own report. I have a report to Mr.

Page 19

VanWagner from Dr. McNamara. I have a report to Mr. VanWagner from Dr. Charles Emmerman. I have a deposition of Dr. Joseph Cooper.

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

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

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

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

A: Yes, I think that is correct.

Q: Doctor?

A: Yes, I think that is correct.

Page 20

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

A: Yes, I think that is fair.

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

A: No.

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

A: I believe it is.

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

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

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

A Yes, I remember.

Q: Did you review anything?

A: I did not.

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

A: I did not.

Page 21

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

MR. COTICCHIA: Objection. That deals with privileged communication. Without waiving the objection, the Doctor may answer.

THE WITNESS: I have not.

BY **MR. VANWAGNER:**

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

A: I looked through the material that I just read off to you.

Q: Did you meet with Mr. Coticchia briefly?

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

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

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

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

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

Page 22

Tintinalli's Textbook on Emergency Medicine; Rosen's Textbook on Emergency Medicine; and Schwartz' Textbook on Emergency Medicine.

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

A I know Dr. Emmerman.

Q: How do you know Dr. Emmerman?

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

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

A: I do.

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

A I can. Yes.

Q: Pleased o.

A Diverticulitis is an inflammation of a diverticulum. Typically one is referring to a diverticulum of the large intestine, usually the sigmoid colon.

A diverticulum is an outpouching of the wall beyond the extent that one would expect it to be, and this usually is associated with a perforating artery through the wall. Diverticulosis refers to the presence, the condition wherein there are diverticuli present.

Q: What is the Likelihood of a person having diverticuli present at 77 years of age?

A: I would say probably close to 100 percent.

Q: Doctor, you made a reference to the sigmoid colon. Anatomically, where is that located in a person?

A: You mean where would I map it on the abdominal surface? What do you mean?

Q: That's a good way of putting it.

A: It would be down in the lower abdomen in the super pubic area.

Q: Which side would that be?

A: That is central.

Q: Okay. Can you and I agree that the first presenting complaint of a person with diverticular disease is fever and localized tenderness in the left lower quadrant of the abdomen?

MR. COTICCHIA: Objection. Are you referring in general or are you referring to Edna Martello?

MR. VANWAGNER: I am just referring in general right nor;.

MR. COTICCHIA Thank vou. Okav.

A: Well, according to the nurse's note — let me get that. First of all, the emergency squad stated that she had had abdominal pain. Let me again just make sure that I state these things correctly.

There were several renditions of what — also looking from the nursing notes here — I think I turned everything upside down here when I went through **this** (indicating).

Are you looking at your stuff or my stuff?

MR. COTICCHIA: My stuff.

THE WITNESS: Okay. The emergency squad said that she was complaining of lower abdominal pain. She was also complaining of difficulty urinating apparently.

The emergency nursing notes at 17:10 — which was about the time that she was first evaluated after her initial triage — said that she was complaining of severe right-sided abdominal pain since the morning. So that was apparently what her presenting symptoms were.

BY MR. VANWAGNER:

Q: Is that a reasonable period of time between her arrival in the emergency department and the initial assessment of her by the physicians and nurses?

A: A reasonable time — You mean between 15:26 and 17:00?

Q: For her to be triaged, brought to a bed, assessed, that sort of thing?

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

A: Well, I have read what Dr. Cooper said about that, if that **is** what you mean.

Q: Okay.

A: And Mr. Coticchia **has** answered a couple of questions

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

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

Page 27

to me, so I think he is going to send it to me.
Q: Did Mr. Coticchia represent to you what the witness had to say on that issue?
MR. COTICCHIA: Let me enter an objection. It is privilege. We are talking about the daughter, Lynn Martello, and a neighbor named Louise Haar. From what I understand, there is no — there will be no testimony that they ever heard what Dr. Cooper is claiming regarding this patient's refusal to get treatment or she would leave the emergency room.
THE WITNESS: That is what he told me.
MR. VANWAGNER: Joe, now are both of those individuals going to testify at trial?
MR. COTICCHIA Well, one of them, is Lynn Martello.
MR. VANWAGNER: She has been deposed. What about the other one?
MR. COTICCHIA: The other one is Louise Haar. At one time Mr. Switzer and I talked about taking her deposition. He never got back to me.
MR. SWITZER: I think I did. I thought you indicated that she was not going to be testifying or we can set it up.
MR. COTICCHIA Yes. I left you a voice mail. I think she is going to say basically the same thing that Lynn Martello said. But if you want to depose her, she is available.
MR. SWITZER: Can you spell her last name?
MR. COYICCHIA It's spelled H-a-a-r.

Page 28

MR. SWITZER: Thank you.
BY MR. VANWAGNER:
Q: Dr. Kiehl, are you aware of, by having reviewed Dr. Cooper's deposition, that his position on this is that he wanted to undertake some studies, x-ray, blood work, et cetera, before doing any type of therapeutic procedure but the patient refused any offer of diagnostic studies and insisted on an enema to relieve her constipation, otherwise she would leave the emergency department?
I mean I — You know, I recognize that Mr. Coticchia will present an opposing point of view. But you realize from Dr. Cooper's deposition that is his recollection of the events; correct?
MR. COTICCHIA: I will enter an objection because nowhere in the emergency room record nor in Dr. Cooper's ernergencyroom report does he saythepatientrefusedanything. Having entered that objection, the Doctor may answer the question.
THE WITNESS: I am aware that Dr. Cooper has attested that what you said is correct.
BY MR. VANWAGNER:
Q: You are also aware that Page 3 of his dictated Emergency Department records says, quote, "The patient's initial request, she asked for a soapsuds enema. I did not want any other workup other than this." You are aware that that is in the records; correct?
A Yes, I am.
Q: She had her first soapsuds enema, according to the record, at 6:25 p.m., 350 cc's, and a second at 6:40 p.m., 400 cc's. Is that your interpretation of the record as well?
A: Yes, sir, it is.
Q: Once the soapsuds enema failed to produce stool, the patient did undergo blood work and did have a KUB; correct?
A: Yes.
Q: Can you describe for me the role of the KUB in working up abdominal symptoms?
A: Well, KUB is sometimes referred also as a flap map of the abdomen. It can give you some information about certain types of pathology including kidney stones, gallstones, obstruction, perforations, things that are — sometimes that can be helped by that x-ray. A single view x-ray is not the best way to assess that, but it — depending on the severity of a patient's illness, that sometimes is all one can do.
Q: When you talked about a KUB can be used to look for a perforation, do you mean a perforation of the viscus?
A Yes, that is what I mean.
Q: How would it show up on a KUB?
A: Well, there would be air outside of the lumen of the bowel.
Q: Okay. Was it appropriate for Dr. Cooper to order a KUB for a patient with Edna Martello's complaints?
A: Well, again, that — I don't know whether Mrs. Martello was just not able to sit up or what. But that is not a typical study that you would order in this particular situation. One typically would order what we call an acute abdominal series which is not only a supine film, but also an upright abdomina1 film and a chest x-ray including the diaphragm.
So I mean, I am not saying that it was a terrible thing that he did that, and I don't know why he just did that single view, but that is not a typical thing to do.
Q: Okay. If a KUB in a setting such as that with Edna Martello is interpreted as normal, what is the significance of that interpretation?
A Well, it just means that we were not able to determine what the cause of her pain was with that particular study.
Q: And after that study is completed and if it is reported out as normal, would you then move to this acute abdominal series that you referenced or would you move to a CT scan?
A: Well, I don't know if I — First of all, I am not sure that I would have followed exactly the path that you are going down. You are asking me questions that give me very limited choices. I am not sure that it is the best way to do things to start with. So I don't know exactly how to answer your

Page 31

question.
Q: Did you ever have an opportunity to look at the actual KUB films that were done that night?
A: I did, or a copy of them.
Q: Did you see anything in those films?
A: I didn't personally. No.
Q: Okay.
A: I mean I saw things, but I didn't see free air, which was apparently subsequently seen.
Q: Right. You knew that is what I meant. I understand you saw a copy of the films but not the original films; is that correct?
A: Yes, sir, that's correct.
Q: If the KUB had been reported out at approximately 9:00 p.m. that evening as demonstrating free air, what would be the next step?
A: Well, a patient like Mrs. Martello needs to have early surgical consultation. And whether one does studies before or after depends on the circumstances. But assuming that it was okay to hold off on getting a surgeon involved right away, if one knew that there was free air at some point, say after the KCB, then that requires urgent or — rather an emergent surgical consultation.
Q: So if the KUB had been reported out at approximately 9:00 p.m. on January 31st as demonstrating free *air* in the

Page 32

abdomen, that then requires an emergent surgical consultation?
A: It does. Yes, sir.
Q: In the case of Edna Martello, we know that was reported as being a normal film but that around 3:30 a.m. or prior, maybe between 3:00 a.m. and 3:30 a.m. on February 1st, the CT scan was reported as showing free air. Would that also hold true that this be an emergent situation for a surgical consultation?
MR. LEAK Objection.
Go ahead, Doctor.
THE WITNESS: Okay. Once free air is diagnosed, then that finding does require emergent surgical intervention. There are other things in this particular case that require emergent surgical involvement which you have not been asking me about. But, you know, again, I just don't want to give you the wrong idea that I am agreeing with you as to — I am not even suggesting that you are suggesting that this is the way it is supposed to be done. But I just don't want you to be confused by the line of questioning that you are asking me, that I am agreeing that this was handled appropriately given the presentation and findings of this patient. But given your question, if a patient has free air diagnosed on CT, that becomes an emergent surgical problem.
BY MR. VANWAGNER:
Q: What does "emergent surgical problem" mean exactly?

Page 33

A: Well, it means that I need to call a surgeon immediately when I find something of that nature. That means that I don't have time to do additional studies to try to figure out why, or to do anything else other than to get a physician's input on what should be done next. And that would be within minutes of making that diagnosis. Minutes, meaning it sometimes takes a little while to get a hold of the surgeon. But within reason, as quickly as possible to get a hold of the surgeon, explain to the surgeon what type of a patient I am dealing with, including the findings of free air.
Q: I assume that in your years as an emergency department physician you have encountered this free air in the abdomen on a number of occasions; is that correct?
A: That's correct.
Q: When you had encountered that, did you consider that to be an emergent situation requiring immediate surgical consultation? Is that a fair statement?
A: If I had not previously consulted a surgeon and I found that, yes, that is correct.
Q: Based on your experience, what is a reasonable expectation for a surgical consult to occur after you have made the contact with the surgeon?
A: Well, depends on the nature of the problem. I mean if I have got somebody that has a ruptured spleen, I expect the surgeon to have that patient in the operating room in 30 minutes

Page 34

or less
Q: What about where you have a perforated viscus?
A: Well, I would expect to have a physician on the phone within rninutes and indicate to them what I have in front of me, and then essentially the surgeon runs the show from that point on
Q: In your experience with the surgeon running the show from that point on, what is the typical time lapse between contact and having the patient on the table?
A: Well, it varies quite a bit relative to what the concern is. But typically it is within an hour or so. Sometimes additional testing needs to be done to get a better idea. If the patient is at all unstable, like for instance not having any urine output for six hours or having hypotensive — be hypotensive, or anything that would suggest this patient is in shock or having a difficult time, those patients are typically — an attempt *is* try to fluid resuscitate them as quickly as you can, meaning over an hour, and so — and get them to the O.R as quickly as possible after the resuscitation.
Q: In light of all of the circumstances with Edna Martello, do you feel that a four-plus hour interval between contacting the general surgeon and having the patient on the table was a reasonable period of time?
A: No, I don't think it is. I am not a surgeon, but that does not comport with my experience in these kinds of

Page 35

situations.
Q: Doctor, as I look at your report, I note that obviously you talk about a lot of the negligence of my client. Then there is a sentence in there — second to the last paragraph — in which you state, "Finallythese negligent acts reacted in prolonged and unnecessary pain, suffering and mental anguish." Do you see that line?
A: Yes.
Q: Should I assume from that statement that it is not your opinion that the delay actually caused her death?
A No, you should not assume that.
Q: That is not contained in your report though, is it?
A You mean those specific words or — What are you asking?
Q: I guess I am asking whether your October 30,2000 report anywhere indicates that it is your opinion that the delay occasioned by the negligence of Dr.Joe Cooper caused the death of Edna Martello?
A: I think it is implied, but I don't think I maybe specifically said that, and that was not really the focus. I think I stated things a little bit different than what you just said.
Q: I guess I'm going to have to ask you this question. At trial, if Mr. Coticchia asks you to a reasonable degree of medical probability on issues regarding causation, would you

Page 36

render an opinion that Edna Martello's death was caused by the delay in surgically addressing her condition?
A: I think delay contributed significantly to her likelihood of death. I am not a surgeon. I will probably not — I cannot tell you when she was irretrievable. I don't know that. I don't consider myself an expert in that field, so I don't know exactly what Mr. Coticchia is going to ask me in that regard. But I would not — What I can say to a reasonable degree of medical certainty, given my area of expertise, that there was an unreasonable delay from her presentation to the time that that surgical consultation was obtained and that that likely significantly decreased her likelihood of recovery.
Q: But you are not able to tell me when the window of opportunity to save her life actually closed?
A I cannot. That's correct.
Q: Do you think it was — Do you *think* it is more or less probable she would have survived if a surgical consultation had been obtained before midnight?
A I think it is more — I think it is more likely that she would have survived. I don't know whether it — I don't know whether it is to a probability that she would survive. I don't know that.
Q: Okay. Dr. Cooper went off duty at 1:00 in the morning and the patient was then managed by a Dr. Graber from about 1:00 a.m. until Dr. Narachania became heavilyinvolved sometimeafter

Page 37

6:00 a.m. Do you have any criticism of Dr. Graber's management of the patient?
A: No, I do not.
Q: I want to go through with you in your report the second page of the report which details your opinions regarding Dr. Cooper's care of this patient and your perception of his negligence.
I would like you to just itemize for me where you see Dr. Cooper fell below the accepted standard of care beginning with his initial involvement with Edna Martello until he went off his shift at 1:00a.m. the following day.
A: Okay. Well, I mean I may not do this exactly the way you are expecting me to. But my criticism of Dr. Cooper is that he was faced with a patient who had — was an elderly lady who had severe — from all indications that I can find — lower abdominal pain. It had been going on all day long. And when a patient like that presents, a reasonable emergency physician must assume that that patient has a potential surgical problem. There is a high percentage of those people who have a surgical problem at that point. And that has to be the assumption that the physician operates under.
And there are a number of different potential surgical problems that might be going on. And if a reasonable emergency physician cannot typically make a distinction — I mean there are — sometimes you can, but most times, say when a patient of

Page 38

this nature presents, it is difficult to know exactly what is happening. And so the standard of care requires an expeditious evaluation of them and early surgical involvement. And again, it varies from patient to patient when the surgeon is involved. Sometimes it is right from the minute when the emergency physician notes that the patient has signifcant tenderness and then calls the surgeon and indicates the problem and they coordinate together the diagnostic process from that point on.
It's also appropriate to — If the patient does not have immediate signs of intraperitoneal irritation, then it is appropriate for a physician in that particular situation to initiate some laboratory studies and then — laboratory and x-ray studies — and then consult a surgeon at some point in the future if a diagnostic determination is not able to be made initially.
Dr. Graber fell below the standard of care because — I am sorry, not Dr. Graber. Dr. Cooper fell below the standard of care because he did not treat this as a potential surgical problem. He inappropriately administered or ordered to have administered enemas times two. He then, in my opinion, took an extremely long time from that point on, from the eime that it should have been terribly obvious that this is something gone awry, that this patient should have been in the hands of a surgeon almost immediately at that point.
So sometime after 8:00 o'clock when this misadventure

Page39

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

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

A: That's one of my opinions. Yes.

Q: Okay. Another one of your opinions —

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

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

THE WITNESS: Maybe I did. I meant — let me see. Those times — I sometimes get things confused. Yeah. Yes, that is correct. Sometime around 8:00 o'clock. Between 7:00 and 8:00, after the second enema, at 6:40; Demerol was administered at 9:00. The patient, according to the nurses' notes, **pain** continues — which I assume was the severe pain that was referenced earlier. So somewhere in that 7:00 to 8:00 range. So your statement by 8:00 o'clock I think is an accurate statement. You were characterizing my opinion. I can say that is correct.

BY MR. VANWAGNER:

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

Page 40

A: I am.

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

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

Q: Why is that?

A: Because you can cause significant damage by doing that.

Q: What would the damage be if you gave somebody a soapsuds enema?

A A ruptured viscus is the most common problem thae happens as a result of that.

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

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

Page 41

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

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

Q: When do you think the viscus perforated with Edna Martello?

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

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

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

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

Page 42

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

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

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

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

Page43

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

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

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

Page44

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

So that is essentially what I would have done in this case.

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

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

Page 45

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

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

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

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

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

A: I would. Yes.

Q: So if you put all of that together and added the fact you now hare absolute proof of a perforated viscus, you would espect the surgeon to be there in even less time?

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

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

Page 46

antibiotics and that sort of thing. So it would trigger an emergent response in that particular case. So the surgeon may or may not come down to the ER in an hour. But he would certainly have that patient in the — In my experience, they typically have these patients in the O.R. in an hour.

Q: I see. Is it your belief that Dr. Narachania deviated from the standard of care?

A: I am not a surgeon, like I said, so I am not going to

Page 47

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

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

MR. VANWAGNER: Joe, this is a hypothetical.

MR. COTICCHIA: You're saying a patient of this type. Note my objection.

You may answer the question, Doctor.

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

MR. VANWAGNER: Are you guys still there?

MR. COTICCHIA: Yes.

MR. LEAK: Can you hear us?

MR. VANWAGNER: We did not hear anything.

MR. LEAK: Can you speak up?

MR. VANWAGNER: Okay.

THE WITNESS: Where did you lose us?

MR. VANWAGNER: Joe's objection. I said to Joe this

Page 48

is a hypothetical question. It does not really matter what is in the record.

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

MR. VANWAGNER: Okay. What was the answer?

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

BY MR. VANWAGNER:

Q: That is a correct hypothetical?

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

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

Page 49

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

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

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

Page 50

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

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

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

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

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

Page 51

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

A. Well, I must have confused you by something that I have said. I am not suggesting that everything would have been f i e had he gotten a surgical consultation at 8:00 o'clock. I am saying that it was blatantly obvious at 8:00 o'clock a surgeon should have been involved.

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

Q: Okay.

A: So I have given everybody that — I believe that that does complete my criticisms of Dr. Cooper.

MR. VANWAGNER: Okay. Doctor, thank you. I think the others might have some questions.

Page 52

CROSS-EXAMINATION

BY MR. SWITZER:

Q: Can you hear me, Doctor?

A: Yes.

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

A. okay.

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

A. No, I am not.

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

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

Q: Your letter of October 30, 2000 references an enclosure. What was the enclosure?

A. It may have been — I don't know.

MR. COTICCHIA I can answer that question. The enclosure was his curriculum vitae.

MR. SWITZER: Okay. Thank you.

MR. COTICCHIA You know, I have his CV (indicating) marked as an exhibit I think during some deposition.

MR. LEAK: That is Dr. Cooper's.

MR. COTICCHIA: I'm sorry, I got Dr. Cooper's. Sorry. I'm sorry.

BY MR. SWITZER:

Q: Did you make any notes in your review of the case?

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

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

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

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

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

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

Page 54

what I am asking him, Joe. We will incorporate what he said about Dr. Cooper.

MR. COTICCHIA: Yeah.

BY MR. SWITZER:

Q: Doctor, do you understand my question?

A: I think I do.

Q: Will you answer it then?

MR. COTICCHIA: He can answer the question with my objection.

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

BY MR. SWITZER:

Q: Do you still have your billing company?

A: Yes, I do.

Q: But you no longer work at Madison County Emergency?

A. That's correct, as of this month.

Q: Okay. You no longer do the pre-surgical or PAT exams at Riverside?

A. As of this month, that's correct.

Q: Doctor, have you ever been a defendant in a malpractice case?

MR. CORCCHIA Objection; not relevant.

You may answer the question.

THE WITNESS: Not for care that I have personally given. No, I have not been.

Page 55

BY MR. SWITZER:

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

A I did.

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

A: I really don't consider myself expert in reviewing those films.

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

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

MR. SWITZER: Okay. I have no other questions.

CROSS-EXAMINATION

BY MR. LEAK:

Q: Doctor, we met earlier. I am Doug Leak. I represent Dr. Grossman, the radiologist, his group, Drs. Hills and Thomas. I first want to start with Dr. Grossman. What is your understanding as to what Dr. Grossman's involvement in this case was?

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

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

A: Yes, I read that.

Q: And that was issued by Dr. Grossman.

Page 56

A Okay.

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

A: I don't believe I did.

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

A No, I don't.

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

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

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

A No, I don't have any.

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

A: Correct.

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

A: I agree with that.

Q: Is it fair to say that you will not be rendering any standard of care opinions critical of Dr. Grossman's radiological interpretation?

A: That is a correct assumption.

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

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

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

BY MR. LEAK:

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

A: No, I cannot.

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

A: I don't know of any.

Q: Is it fair to say then that as it relates to any radiologist. you will not be rendering any standard of care opinions critical of the radiologist?

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

Page 57

Page 58

perspective.

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

Page 59

radiologist. I will not opine relative to standard of care relative to interpretation of these films, if that is your question.

Q: Let me ask some questions of what I anticipate in terms of hypotheticals that you may be faced with.

Do you know if KUB's can be interpreted by teleradiology?

A: Well, at Ohio State, as an example, all of our radiograms are digitalized and they are all interpreted by a web-based radiologic situation, so I don't know — including KUB — so I don't know whether that answers your question. But we look at KUB's, digitalized KUB's every day. We don't see any hard films at all.

Q: You don't know what happened in this case, though, with regard to the KUB on the evening of January 31st, do you?

A: I don't know. That is correct.

Q: Doctor, what percentage of your professional time is devoted to the clinical practice of medicine?

A: It's 75 percent or more.

MR. LEAK: Thank you, Doctor. That is all I have.

THE WITNESS: You are welcome.

MR. COTICCHIA: Any other questions?

(No response.)

THE WITNESS: I want to read the transcript.

(Signature not waived.)

Page 60

(Thereupon, the deposition was concluded at 4:45 o'clock p.m. on Wednesday, April 24, 2002.)

Page 61

AFFIDAVIT

STATE OF _____,)
) SS:
COUNNOF_____,)

Samuel J. Kiehl III, M.D., having been duty placed under oath, deposes and says that:

I have read the transcript of my deposition taken on Wednesday, April 24, 2002, and made all necessary changes and/or corrections as noted on the attached correction sheet, if any.

Samuel J. Kiehl III, M.D.

Placed under oath before me and subscribed in my presence this _____ day of _____, _____.

Notary Public

My Commission Expires: _____

D

E

F

G

H

I

J

K

L

M

N

O

P

Q

R

S

T

U

V

W

X

Y