THE STATE OF OHIO,)
) SS:
COUNTY OF HURON.

IN THE COURT OF COMMON PLEAS

KENNETH M. STRONG, Executor, etc.,)
)
Plaintiffs,)
)
v.) Case No. CVA-92-866
)
DR. RONALD D. WINLAND, et al.,)
)
Defendants.)

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Deposition of ALFRED GEORGE ERNEST KITCHEN, **M.D.**, taken by the Defendants as if upon cross-examination before Faye M. Farley, a Stenographic Reporter and Notary Public within and for the State of Ohio, at the offices of St. Vincent Charity Medical Building, 2322 East 22nd Street, Cleveland, Ohio, on Tuesday, the 14th day of June, **1994**, commencing at 2:25 p.m., pursuant to agreement of counsel.

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APPEARANCES:

Howard D. Mlshklnd, Esq.,
and
Law Offices of Michael F. Becker Co., L.P.A.,
By: Jeanne M. Tostl, Esq.,

On behalf of the Plaintiff.

Jacobson, Maynard, Tuschman & Kalur,
By: Steven A. Sklver, Esq.,

On behalf of the Defendants.

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STIPULATIONS

It Ie stipulated by and between counsel for the respective parties that this deposition may be taken in stenotypy by Faye M. Farley; that her stenotype notes may be subsequently transcribed in the absence of the witness; and that all requirements of the Ohio Rules of Civil Procedure with regard to notice of time and place of taklng this deposition are waived.

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I N D E X

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ALFRED **GEORGE ERNEST** KITCHEN, M.D.,
called by the Defendants for the purpose of cross-examination, as provided by the Ohio Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposes and says as follows:

CROSS-EXAMINATION

BY MR. **SKIVER:**

Q. For the record, would you state your full name, please?
A. Alfred George Ernest Kitchen.
Q. And your current business address?
A. 2322 East 22nd Street, Suite 303.
Q. Doctor, have you given a deposition before?
A. Yes, I have.
Q. So you know that if you don't understand any of my questions, just let me know and I will rephrase it.

Doctor, what materials have you reviewed in preparation for today's testimony?

A. I've been forwarded a whole stack of information relative to this lady with hospital stays from 18/26/91 to 18/28/91. Hospital records from her subsequent admission on 11/26/91 through to her demise. And there's some information from Flsher-Titus Hospital and from Lorain Community Hospital.

Q. All right.
A. I have also reviewed depositions of the principal physicians, Dr. Winland and Dr. McLoney. And the depositions of the nurses in -- the nurse and the LPNs involved in the case.
Q. Any others?
A. And copies of the letters from Dr. Abraham.
Q. Do you have all the material that you need to reach your opinion?
A. Yes, I do.
Q. Okay. Did you review any x-rays?
A. Just the report, not the actual x-rays.
Q. Okay. What are your criticisms? Let's start with Dr. McLoney.
A. I think Dr. McLoney's error in this particular case was not handling the situation appropriately on the evening of the 27th.
Q. What should he have done?
A. I believe he should have either gone to the hospital to evaluate the patient himself or made arrangements for some other physician to evaluate the patient.
Q. And if he had done so, what in your opinion would he have found?
A. I believe he would have found the lady to be in heart failure. And with her combination of

problems, I think she should have been moved into the Intensive Care Unit at that time for more close observation to proceed with diagnostic testing in order to make the appropriate diagnosis as to the lady's problem on that occasion, and to initiate appropriate management.

Q. Now, you say with her combination of problems, what problems are you talking about?

A. The main problems are the documentation of dehydration and electrolyte imbalance.

Q. Why were those important?

A. That combination is very difficult or can be very difficult to treat.

Q. Do you feel it was difficult to treat in her case?

A. With the reported problems that she apparently had, with the suspicious history of coronary artery disease, a documented history of aortic valvular disease, a suspected history of congestive failure as suspected by Dr. Winland, it would have been more appropriate to manage this lady very, very closely rather than try to watch her on a regular floor.

Q. What would that monitoring very closely consist of in your opinion?

A. Well, that would have depended entirely on what evaluations he would have arrived at on that evening

at 10:00. The diagnostic possibilities included a myocardial infarction, included rhythm abnormalities, a congestive heart failure, and it included pulmonary embolism as the major diagnostic possibilities,

Q. In terms of the monitoring that you feel -- Well, let me back up a second. What do you feel that she had on the evening of November 27th at the time she had her symptoms?

A. I think she was going Into heart failure.

Q. All right. You don't believe she was having a heart attack?

A. There is no way for me to know that.

Q. All right. And as to rhythm disturbance or pulmonary embolism, would it be the same, there would be no way to know?

A. That's why I said certain diagnostic testing at that time, that instance, would have been very valuable in helping to decide which direction to go. I think she was going into heart failure based upon the evidence in the chart. Pulmonary embolism would have been another distinct possibility, and that's where the chest x-rays at that time would have been very helpful. If the x-ray was clear on the evening of the 10th, I would have --

MR. MISHKIND: On what evening?

A. On the evening -- 10:00 on the evening of the 27th, I would have leaned very clearly towards the pulmonary embolism. I think a chest x-ray would have been particularly beneficial.

Q. (BY MR. SKIVER) What do you feel a pulmonary embolism would have shown?

A. Congestive failure.

Q. What do you base that upon?

A. Her clinical symptoms,

Q. Specifically what?

A. Her complaint was basically shortness of breath PND, which subsequently progressed to orthopnea.

Q. Assuming that a diagnosis of congestive heart failure had been reached on the evening of the 27th, what would the standard of care have required of Dr. McLoney to do?

A. Well, at that point in time, with that diagnosis, and with the combined diagnosis of dehydration, electrolyte imbalance, and congestive heart failure, he should have had -- I would have placed a Swan-Ganz catheter in her immediately. So if he wasn't capable of doing that, it would have been appropriate for him to contact someone who could.

Q. All right. You said you would have, but my question

though is does the standard of care require that he put a Swan-Ganz in?

A. Absolutely, absolutely.

Q. All right. And what do you base that upon?

A. That's the only way you can manage that combined problem. You must know exactly where you are with respect to the hemodynamic parameters, and the only way you can do that is with a Swan-Ganz.

Q. How were you managing the electrolyte abnormality?

A. The initial approach was to hydrate her with saline, which is a very slow way of dealing with it. And with somebody who doesn't go into heart failure, it will eventually correct itself. But when you add the combination of requiring fluid restriction to treat congestive failure, and rehydration to treat electrolyte abnormalities, it becomes a very precarious situation.

Q. To your knowledge, was the patient on any fluid restrictions at any point n time?

A. There was an order by Dr. Winland, I believe, on the morning of the 28th. He was going to restrict fluids at 8:00. "11/28/91, Will start fluid restriction and continue IV saline." Those two things are exactly opposite from one another. If you are going to restrict fluids, you are not going

to give IV saline.

Q. Why do you say that?

A. Because saline is a fluid.

Q. I understand that, but why would you say that they're exactly opposite of each other in terms of treatment?

A. Well, it depends on what you're treating. If you are treating congestive failure, you are going to restrict fluids. If you are treating electrolyte abnormalities, the best way to treat hyponatremia is with fluid restrictions. If you're treating dehydration, you are going to give fluids.

My point is that at that point in time they weren't sure. It doesn't appear they were sure what the diagnosis was or how to treat it.

Q. Other than placing a Swan-Ganz catheter, what did the standard of care require of Dr. McLoney that night?

A. It would have depended upon a host of relatively simple evaluations. She would have needed an electrocardiogram. She would have needed continuous EKG monitoring. She may have benefited from arterial lines, certainly. I did mention EKG. I did mention chest x-rays. Continuous monitoring of her rhythm. Chest x-rays. I did say a Swan-Ganz

should have been initiated. Probably an arterial line. And I would have repeated all her blood laboratory studies at that point in time.

You would be looking for electrolyte abnormalities for any evidence of any CPK changes that might indicate myocardial infarction. And I also would have done blood gases.

Q. Anything else that Dr. McLoney should have done?

A. Offhand, I can't think of anything else at this time. There may have been -- it would have been predicated upon the results of the above list of testing.

Q. What happened to the patient throughout that night and the following day when she was seen by Dr. Winland?

A. I think the nursing notes clearly indicate that the lady continued to deteriorated. Based upon the nurse's deposition, she was concerned about this lady enough to contact her supervisor on at least two occaslons. And it was through the supervisor that McLoney was contacted again. And I thlnk when Dr. Winland arrived at 8:00 or so that following morning, that he should have been tuned to the fact that the nursing personnel were very concerned about this lady.

Q. So it was your opinion from reading the testimony of the nurse that they felt she was continuing to deteriorate throughout the night?
A. I think that's evident from the nursing notes, yes.
Q. Any specific notes that point that out to you?
A. There is one on the 27th at 0900, Complaint of feeling short of breath. 1300, Feels dyspneic. I should back up. There was another one. Confused at 11:00 and agitated and creates a disturbance.

Again, 1300, Dyspneic. 1400, Complained of feeling wheezy. Wheezy heard in left lower lobe on auscultation. 1530, Not able to breathe. 1900, Returned to bed. Stated she needed some oxygen. 2000 hours, Can't breath. Slightly confused. 2210, Assessment unchanged. 2240, Dr. McLoney notified; orders received. There's a documentation of 0230 calling out "Kenny." Taping phone on bed rail.

There are number of observations by the nursing personnel that would indicate to me that something was going on wlth this patient.

Q. You made the statement, and perhaps you said the nursing notes indicated that the patient was deteriorating?
A. It's my opinion based upon the information that the nurses documented that the patient was

deteriorating, yes.
Q. That's your interpretation as to what you're seeing there?
A. That's correct.
Q. As opposed to their testimony?
A. That's correct.
Q. Okay. Any other criticisms of Dr. McLoney?
MR. MISHKIND: Let me object. I think he indicated before that he can't think of any others at this particular point.
MR. SKIVER: I understand that.
A. I think he made the same mistake at 6 in the morning as he made the evening before in not responding appropriately to the -- basically the request from the nursing personnel.
Q. (BY MR. SKIVER) All right. And that's by and large your major criticism of Dr. McLoney, right?
A. That's correct.
Q. Okay. Then let's move on to Dr. Winland.
A. Okay.
Q. I presume you're going to give a ditto for him on all the same things that you criticized Dr. McLoney on?
A. Yes.
Q. Okay. Is it your opinion that at the time he saw

Mrs. Strong that he should have moved her over to the intensive care area?

A. Yes.

Q. Why do you say that?

A. Because the combination of problems that she had would require more sophisticated monitoring in order to tell you exactly where you were. She would have needed much more closer observation by the nursing personnel and he would have needed the added advantage of using sophisticated monitoring capabilities in order to know exactly what you're dealing with.

Q. Is it your opinion, Doctor, that it is impossible to treat a patient like this through the use of hemodynamic monitoring?

A. In a 77 year old lady with what Dr. Winland has documented to be her past history, a history of congestive heart failure, and seeing the deterioration in this lady from the time of her admission until he saw her at 8:00 that morning, yes, he should have admitted her to the intensive care unit.

Q. It sounds like you're basing an awful lot upon what Dr. Winland seen at the time, correct?

A. He had access to the same things I did. He had

access to the nursing notes. He would have known that Dr. McLoney was called on at least two occasions with concern from the supervisors.

Q. But aren't you indeed saying this really is a call that's based upon the judgment of the physician seeing the patlent at the time?

MR. MISHKIND: Objection.

A. Yes. It's in his judgment as to what to do and how to handle the situation. My point is, it was inappropriate.

Q. (BY MR. SKIVER) I understand what your point is. But do you feel it's Inappropriate to treat a patient with congestive heart failure on a regular floor?

MR. MISHKIND: You're talking in general or specifically in this case?

Q. (BY MR. SKIVER) Doctor, if you have any questions about what my question is, feel free to ask me to explain it to you.

A. I am going to ask you to be a little more specific.

Q. In general, do you feel that a congestive heart failure patient cannot be treated on the regular floor of a hospital?

A. In general?

Q. Yes.

A. And not as it relates to this patient?
Q. In general first.
A. It is possible in some situations to monitor patients effectively on a regular floor, yes.
Q. And what are the criteria that you would use to determine whether or not a patient could be monitored on a regular floor?
A. By being monitored, I mean, on a 24-hour continuous EKG monitor. In patients who have perhaps had a chronic history of congestive heart failure with repeated admissions who don't have any complications that are in addition to the congestive heart failure that would make their management more complicated, plain, ordinary, simple uncomplicated congestive heart failure could be managed on a regular floor, yes.
Q. You're saying they have to be continuously monitored with EKGs?
A. I think it would be -- one of the things you can't rule out is rhythm abnormalit es. You have to study that.
Q. Is that the standard of care, to use a continuous EKG on a patient with congestive heart failure?
A. I would say so, yes.
Q. Can you point to anything in the literature that

would support that position?
A. I'm not sure that I have ever looked for anything.
Q. Do you treat patients with congestive heart failure in your hospital out on a regular floor without continuous monitoring?
A. Certainly not for the initial 24 to 48 hours, no.
Q. Why not for the first 24 to 48 hours?
A. Because you don't know whether or not rhythm abnormalities are contributing to the congestive failure or not.
Q. Once you rule out rhythm abnormalities, would you feel comfortable in removing them off of the continuous EKG monitoring?
A. Yes.
Q. What other criteria do you use to admit a patient to the hospital with a congestive heart failure?
A. I don't think any patient with congestive heart failure can be safely handled as an outpatient with the exception of those chronic long-standing heart failure patients who have been on borderline failure for a long period of time and have demonstrated they can be safely managed as an outpatient.
Q. Well, perhaps I should have you define what congestive heart failure -- your opinion of what

the symptoms of congestive heart failure are.

A. Well, initial symptoms are what we call PND orthopnea, shortness of breath, wheezing. They may or may not have chest pain. They may have associated coronary disease. Shortness of breath on exertion. Shortness of breath or difficulty breathing with any kind of stress be it physical or emotional or psychological.

Q. Anything else?

A. Uhn-uhn.

Q. All right. That was a no?

A. That was a no.

Q. All right. Would you require that all those be present in order to make your diagnosis of congestive failure or would some of those symptoms in your mind be consistent with congestive failure?

A. There's certainly some that are hallmarks of Congestive failure. Particularly, shortness of breath, be it rest or on exertion. PND Orthopnea. And probably some bronchial spasms are the highlights of congestive failure.

Q. Are you saying that if a patient were to present themselves to your office with complaints of wheezing and shortness of breath on exertion, that you would admit them to the hospital?

A. I didn't say that.
Q. What are you saying?
A. I'm saying if they had the full constellation of symptoms, plus clinical signs. If I saw them in my office, and it would also depend upon whether or not I had seen this patient before or had any previous Information or history or any other information that would help to assist me.
Q. Knowledge of the patient is important, correct?
A. To some extent, yes.
a. You said clinical signs, what clinical signs are you talking about?
A. Basically the hallmarks that you frequently deal with are jugular venous distension, gallops, as far as heart sounds are concerned. You would listen for any evidence of rales. You would look for any evidence of peripheral edema. You may look for any evidence of hepato-jugular reflux. Those are perhaps the hallmarks of congestive heart failure.
Q. Now, in terms of those hallmarks, those, of course, can all been caused by things other than congestive heart failure, correct?
A, To some extent, certain disease processes overlap with clinical signs, that's correct.
Q. Are there any of those symptoms or clinical signs

that you feel can be caused by congestive heart failure only and not caused by any other disease process?

A. The constellation that I mentioned is pretty diagnostic with congestive heart failure.

Q. You're talking about taking them all together, correct?

A. Yes.

Q. But singularly, any one of those clinical signs --

A. Can be found in a variety of different disease processes, absolutely.

Q. Okay.

A. Absolutely.

Q. So what you as a physician do is you take the symptoms that the patient presents and the clinical findings that the patient presents, and you couple that with your knowledge of the patient, their background, and you come to a diagnosis as to whether or not they have any underlying disease process, correct?

A. That's correct.

Q. All right. And at that point in time, you determine the severity of that process?

A. That's correct.

Q. All right. In Mrs. Strong's case you've already testified you believe she had congestive heart failure on November 27?

A. That's correct.

Q. All right. Did she have it any earlier than this in your opinion?

A. I don't believe there's sufficient information in the physician progress notes or in the nurses notes to be certain about that.

Q. Is it the shortness of breath that you're hanging your hat on for the most part in terms of the diagnosis of November 27 as to this congestive heart failure?

A. No. The shortness of breath, as she described, wheezing, as the nurse described, wheezing on expiration. Inappropriate behavior certainly can be a manifestation of congestive heart failure. I think the concern I have in this particular case is that with the constellation of symptoms, I believe she was in congestive heart failure and I belleve that he should have made the determination at 10:00 on that evening and 7:00 in the morning or 8:00 in the morning to admit her to a place where appropriate diagnostic testing could have been done.

Q. With regard to the inappropriate behavior, *you*

would agree with me, would you not, that the inappropriate behavior that was documented in the chart consists of a number of probable causes, isn't that true?

A. Absolutely correct.

Q. In fact, her electrolyte imbalance alone could cause that inappropriate behavior, could it not?

A. Except she didn't demonstrate any inappropriate behavior when she had abnormal electrolytes, so something changed.

Q. My question to you though is, Doctor, the sodium level alone in a patient of Mrs. Strong's age can cause inappropriate behavior, can't it?

A. But it didn't. It didn't at the time. It can under certain circumstances. Situations change. But my point is that at the time I was in the emergency room originally, there was no documentation of confusion or inappropriate behavior at a time when she had abnormal electrolytes,

Q. But we are in agreement that you can see that with a sodium level of the level she had in her age?

A. Yes.

Q. And in fact, you can also see inappropriate behavior in patients who are 77 years old just after being admitted to the hospital and taken out of their

normal environment, isn't that true?
A. That can be.
Q. You have seen that before, haven't you?
A. Yes.
Q. I believe you've indicated then that you felt -- you indicated that prior to the 28th she was in congestive heart failure based upon the data that was presented to you, is that true?
A. She was certainly in congestive heart failure on the evening when the first call was made to Dr. McLoney.
Q. All right.
A. But remember, the development of progressive congestive heart failure is usually a slow progressive event.
Q. Do you have an opinion as to whether or not the congestive heart failure got better between the evening of November 27th and her subsequent arrest?
A. No. It got worse.
Q. So in fact if she had improved, that would be inconsistent with your diagnosis of congestive heart failure as of the 27th, isn't that true?
A. I don't know what you mean by improved.
Q. What does improve mean to you?
A. Well, it could mean any number of things. I mean, if you're asking me did she demonstrate certain

clinical signs or symptoms that would have indicated an improvement, I don't know what signs or symptoms you're talking about. The point is she Continued to be short of breath. She continued to sit in her bed upright. She continued to want oxygen. She continued to have episodes of confusion, erratic breathing, and all of this would suggest to me that the situation was not improving.

Q. But if in fact it was the opinion of those people who were taking care of her that she did show -- she did indeed show some improvement, that would be Inconsistent with your diagnosis of congestive heart failure as of the 27th, isn't that true?

A. If indeed they believed that, I believe they would have been incorrect in reading the records.

Q. I understand that, but my question is that would be inconsistent with your diagnosis, correct?

MR. MISHKIND: Are you talking about the 27th or 28th?

Q. (BY MR. SKIVER) If from the 27th on she showed improvement in the minds of the people who were taking care of her, that would be Inconsistent with your diagnosis of congestive heart failure starting on the 27th?

A. If in fact those opinions were correct, then you're

absolutely rlght. I would have been incorrect.
Q. All right. In terms of treatment of congestive heart failure, what Is the standard of treatment, Doctor?
A. That's a very wide question, a very general question. If you would like to be a little bit more specific, I will try to answer it.
Q. What are you having problems with?
A. Congestive heart failure is just one part of many other kinds of problems. Is it due to rhythm abnormality? Is it due to LV dysfunction? Is it due to valvular disease? It is due to fluid overload? Is due to failure to take medications? Is it due to salt abuse? It depends entirely on what the diagnosis is how you would go ahead and treat.
Q. In Mrs. Strong's case, what do you believe her congestive heart failure was due to?
A. Fluid overload.
Q. Therefore, in Mrs. Strong's case, what would you have done?
A. I would have put a Swan-Ganz catheter in her so I would have known exactly where she was with respect to the hemodynamic parameters so I would have known precisely what to do for her, whether or not she

needed some volume diuretics, afterload reduction, whether she needed inotropic support. I would have known exactly what to do for the lady based upon the hemodynamic profile.

Q. Did you review her I & O?

A. I have reviewed some of the numbers some time ago, but I don't have the numbers with me.

Q. How much do you allow for insensible loss for a patient of her age and activities?

A. I think the general rule of thumb is probably in the nature of 5 to 600 cc's in 24 hours.

Q. Can you site me to anything for that?

A. I'm sure it's in the standard medical text. I haven't looked at them for that aspect for years. I think it's a number that most physicians use as an estimate of insensible loss.

Q. If textbooks on critical care medicine were to indicate Insensible loss of a patient is between 800 and 1,200 cc's a day, would you agree with that?

MR. MISHKIND: Objection.

A. It would be based upon the clinical situation. There are certain situations where 600 would be excessively low and appropriate situations where 2,400 would be on the top end. But that depends on the clin cal situation.

Q. (BY MR. SKIVER) Okay. By the way, what do you believe was the cause -- Let me ask you this. Do you believe the admitting diagnosis for Mrs. Strong were correct?
A. In that she had electrolyte imbalance and dehydration, yes, I do.
Q. What in your opinion causes electrolyte imbalance?
A. It appears to me she had some kind of flu-like illness and basically became dehydrated. And what usually happens in those situations Is patients try to rely on themselves by taking basically water which produces electrolyte abnormalities.
Q. Do you have an opinion as to how dehydrated she was?
A. I would have had to been able to clinically examine her at that point in time.
Q. There is no way for you to tell from the laboratory tests that you have been provided with?
A. No precise way to be able to tell.
Q. Do you have any criticisms of the initial treatment of her up until the 27th of November?
A. In retrospect, yes. In my own personal handling of that situation, I think she should have been in the Intensive Care Unit from the get go.
Q. Do you believe it was below the standard of care to not put her in intensive care from the beginning?

A. That depends on the way in which that institution operates. If It's the responsibility of the emergency room physician to make that particular decision, then I would have felt that it would have been inappropriate for him not to admit her.

If the emergency lies with the attending physician to make A, the decision to admit, and B, where to go, then I would have said yes, it's Inappropriate, particularly because of her past history and the combination of dehydration and electrolyte abnormalities of a 77 year old lady is very difficult to treat.

Q. I might have gotten lost in all that. Let's cut to the bottom. Are you basically saying you're opinion is it was below the standard of care to not admit her to the Intensive Care Unit from day one?

A. In my opinion, yes.

Q. Okay. For all the reasons that you just listed?

A. All the reasons I listed.

Q. Okay. How often do you treat patients with electrolyte disturbance?

A. Routinely, frequently.

Q. How often have you treated patients with the type of electrolyte disturbance that Mrs. Strong had?

A. I would probably see that kind of abnormality maybe

three, four times a year.

Q. And you do treat patients with electrolyte disturbances on the regular floor under the appropriate circumstances; is that correct?

A. Yes.

Q. Electrolyte disturbance in and of itself doesn't require admission to the Intensive Care Unit, does it?

A. No.

Q. What was the severity of her underlying coronary artery disease?

A. Based upon the catheterization of the report from, I believe, '89 from Dr. Shaffer in Lorain, she had minor coronary disease involving the right coronary artery. Her LV function, I believe, was acceptable. And she also had a minor aortic valvular stenosis.

Q. Taking it all together, how would you categorize her cardiac status based upon this information that she had no significant major cardiac problems at least as it relates to coronary disease or aortic valvular disease? If a Swan-Ganz had been placed in her, do you have any opinion as to what it would have shown?

A. It would have shown a pulmonary capillary wedge pressure probably above 20. It would have shown an elevated jugular venous pressure. It could very

well have shown a slow cardiac output and index. And if an arterial line was included, It probably would have shown elevated systemic vascular resistance.

Q. At what point in time do you believe she developed pulmonary edema?

A. There's a continuum from what people would call congestive failure to ultimately what we call fulminant pulmonary edema. It's a gradual continuum, ultimately getting to the point where patients are literally frothing at the mouth and unable to even speak they're so short of breath. They are sitting bold upright in bed, probably mottle and blue. Their neck veins are engorged up to their ears. That's pulmonary edema.

Q. At what point in time do you think she was in pulmonary edema?

A. Immediately for the few hours prior to cardlac arrest.

Q. What do you believe was the cause of her cardiac arrest?

A. Are you asking me to speculate?

Q. Would it be speculation on your part as to what caused her cardiac arrest?

A. She had cardiac pulmonary arrest. She basically

had failure of cardiac and respiratory systems. It was probably a rhythm abnormality.

Q. Do you have an opinion as to what type of rhythm abnormal1ty?

A. She could very well have ventricular fibrillation.

Q. Is that to a reasonable degree of medical probability?

A. I would put it at the top of the list.

Q. Okay. What caused the fibrillation In your opinion?

A. The combination of progressive congestive failure to pulmonary edema. The fact that she had conduction abnormalities on her resting to begin with. The fact that she had documented electrolyte imbalance. The fact that she was hypoxic as documented by blood gases. The fact that she had coronary artery disease and the fact she had to some degree aortic valvular disease; that is a bad combination.

Q. Do you believe her cardiac arrest was preventable?

A. Yes.

Q. Why?

A. Because all of her problems were preventable. I think had she been appropriately dealt with to begin with in the Intensive Care Unit, they could have monitored her more closely and ruled out other possibilities. With the establishment of monitoring

capabilities, it would have allowed you to know precisely where you are, how much fluid to give, how much not to give, what other treatment modalities you might have. Afterload reduction or even preload reduction in this particular case would have allowed you to more appropriately treat this combination of problems.

Q. So in your opinion was --

A. Is the whole thing preventable, is that what you're asking me?

Q. Yes. Is the cardiac arrhythmia preventable?

A. Yes, absolutely.

Q. Did she die a sudden death?

A. Well, her ultimate demise was the direct consequence of cerebral hypoxic encephalopathy. Did she die a sudden cardiac death on the 28th and was she resuscitated? Yes. Most cardiologists today would call that episode of sudden death from which she was subsequently resuscitated.

Q. In your opinion sudden death is preventable?

A. It sure can be.

Q. To a probability is sudden death preventable?

A. Yes. That's what I am in the business for.

Q. How do you prevent sudden death?

A. By identifying the risk factors that would put

somebody at a higher risk for sudden death and dealing with those risk factors.

Q. Isn't it true, Doctor, that despite identifying risk factors and treating risk factors, that people still die of a sudden death?

A. Yes, they do.

Q. And there are those patients who despite everything, still have a cardiac arrest and die?

A. That population is becoming smaller and smaller.

Q. But there is a population like that?

A. Yes.

Q. And the people at greatest risk are those with underlying coronary artery disease?

A. That's only one portion of the population.

Q. But those at greatest risk are those with underlying coronary artery disease, correct?

A. I'm not so sure I'd necessarily agree with that.

Q. Have you done any publications, doctor?

A. Not as it relates to cardiology, no.

Q. What did it relate to?

A. I did some publications when I was in graduate school related to immune functions and I did some publications on malaria research.

Q. Okay. What are the recognized causes of rafes?

A. The predominant two causes of rales are probably

pulmonary disease and congestive heart failure. Those are the most two common ones.

Q. You can also see it in patients with underlying atelectasis?

A. Under the coronary?

Q. Under pulmonary.

A. Yes.

Q. Okay. Do you believe she had unresolved angina at any point in time?

A. I don't believe there is any documentation to support that. Certainly it would not be expected based upon her catheter results.

Q. Pain from herpes zoster can certainly cause a patient to complain of shortness of breath due to splinting, isn't that true?

A. It could happen, yes. But if it did that, I wouldn't have expected it to produce rales and PND orthopnea.

Q. Certainly if atelectasis were present, secondary to insufficient expansion of her lungs, that could lead to rales, could it not?

A. It could, but again, if you're asking me would it be associated with other --

Q. That is not what I said.

A. Then I would have to say it's underlying.

Q. That is not what I asked you. I said if atelectasis were present, secondary to insufficient expansion of her lungs, that could lead to rales, could it not?

A. That's correct.

Q. Okay. How do you classify congestive heart failure?

A. Well, you can use the -- some people use what used to be called Willis scale which is a combination of where you utilize hemodynamics to classify patients based upon their volume status and cardiac output and you can essentially put them into four risk categories depending on what their hemodynamic status is to get some estimate on what their morbidity/mortality might be.

Q. From a clinical standpoint, with hemodynamic monitoring, can you classify patients into mild, moderate, severe?

A. Yes, you can.

Q. How would you separate patients into mild, moderate, and severe?

A. As it relates to this case?

Q. No. In general.

A. In general? I would basically use a New York heart kind of classification as to how active a patient is, what they do, what level they may have symptoms,

basically what funneled category they're in would give you a clue as to mild, moderate and severe pulmonary edema.

Q. What would be the break out? ER classification what?

A. One.

Q. Would there be any specific physical findings that you would expect to find in a patient with mild congestive heart failure?

A. Other than that they would complain about rhythm restriction and how much they're capable of doing, how fast they can go about doing things, whether it's a walk to the grocery store, going up or down stairs, or what have you. They may get a little short of breath at night, a little puffiness of the feet or ankles. Basically, it's a mild restriction, but a distinct and noticeable reduction in their function capabilities.

Q. All right. How about moderate, what would you classify as moderate?

A. They would be more severe than what I just listed. Basically the same kind of things, but more severe, more restriction on how much they could do. They are a little more short of breath. More PND orthopnea, more swelling of the feet or ankles.

They have to take a lot more time in doing the things that they're capable of doing.

Q. Would you expect to see them showing sweat or being cold and clammy?

A. Particularly under stressful situations of physical activity. For example, under temperature extremes, particularly higher temperatures, perspiration and sweating is an indication there's a catecholamine release that's trying to drive something. It would be an Indication that these patients are starting to get into more than a mild failure.

Q. So you would expect to see that in a patient who has severe congestive heart failure?

A. Not necessarily, but it's with a combination. You said moderate, I thought.

Q. Well, because you said you would expect to see that in severe --

A. Severe, yes. Then they are much more sensitive to the stress involved, and you begin to see things like profuse diaphoresis with the expectation of more tachycardia with it. You may hear more in the way of gallops and rales in the lungs, yes.

Q. That would be one way to break out moderate to severe with congestive heart failure?

A. Yes. That would be one way, yes.

Q. What in your opinion happened to her on the 28th in terms of the sequence just prior to her arrest?
A. I think she was in progressive fulminate pulmonary edema. These patients can't breath. They are tachypneic. They usually sit bold upright in bed. They're so tachypneic they maintain they can't even speak. Until you see one, you can't imagine how bad it is for patients to actually be this tachypneic. They may be mottle. They may have white or even blue extremities.
Q. All right. So you felt that she was in this progression and she went on and developed a severe arrhythmia?
A. Severe arrest, yes.
Q. All right. You based that upon the records that you've reviewed?
A. Absolutely, and also on the most likely scenario as to what transpired.
Q. How long does it take fulminate pulmonary edema like you've described to develop?
A. It can be anywhere from two minutes to several hours or days depending on the clinical circumstances.
Q. How long do you think she had fulminate pulmonary edema?
A. It was certainly there during the 28th, on the day

of the 28th.

Q. So throughout the 28th?

A. I think the documentation on the x-ray reports, I believe, said pulmonary edema, if I'm not mistaken. Yes. 11/28/91, 6:30 p.m. Chest impression, pulmonary edema.

Q. So it's your opinion that throughout the 28th she had fulminant pulmonary edema?

A. She certainly had it as of 6:30 p.m. based upon the chest x-ray.

Q. Do you know how long during the 27th she had --

A. As I said to you before, I think there was a progression from the 27th through to fulminant pulmonary edema as of 6:30 on the 28th, so it's a continuum.

Q. All right. A chronic worsening, if you will?

A. Yeah. Yeah.

Q. Was there any evidence that Mrs. Strong had a myocardial infarction?

A. I did not see any evidence to that effect, no.

Q. Now, you earlier testified, I think it was probably in your letter, that Mrs. Strong had risk factors for congestive heart failure. What were her risk factors again?

A. She did have documented coronary disease, although

it wasn't major. She did have a history of hypertension. She did have a history of aortic valvular disease, albeit, minor. She did have a history of hypertension. That's important, because to see somebody with this status go downhill this quickly, I think she probably had some end-diastolic dysfunction which would have put her at major risk for volume replacement in this situation.

Q. But there was no evidence of diastolic dysfunction in her cardiac catheterization earlier, correct?

A. The cardiac catheterization wouldn't find that.

Q. The ventriculogram would also not have shown any evidence of a diastolic dysfunction, correct?

A. No.

Q. Do you fault Dr. Winland for not being able to place a Swan-Ganz in this patient?

A. From the record, he had some difficulty and eventually never did get It put in, I believe, but I think by then, the horse was out of the barn.

Q. Well, the question though is do you fault him for not being able to place it?

A. I don't know what his capabilities are or are not. I don't have knowledge of that.

Q. Have you ever had a patient that you were ever not able to place a Swan-Ganz in?

A. Occasionally.
Q. You indicated in your letter that you felt that Mrs. Strong's life expectancy was at least five years. How did you arrive at that number?
A. Personal experience, and I think I'm being very conservative in that regard.
Q. Personal experience of what?
A. In my practice of dealing with older patients and heart disease in general. The reason I say that is based upon the catheterization in '89. If you would use life table statistics for that age and sex, she would probably have approximately ten years life expectancy from 1989.
Q. That, of course, doesn't factor in what diseases she had, did it?
A. That's all-comers.
Q. That doesn't factor in whatever disease processes, does it?
A. Those statistics include all-comers.
Q. Are you saying, Doctor, that if someone ha8 cancer, that they have a ten year life survival based upon the mortality table?
A. What they are saying is if you take all-comers at that age and that sex, that their life expectancy at that age, the overall age, is 10.

Q. That doesn't allow for specific diseases, does it?
A. It includes all-comers.
Q. Do you know how they arrived at the mortality tables?
A. Yes, I do.
Q. Are you saying then that a patient, once they have a specific disease, can still go back to the mortality table?
A. I didn't say that. That's why I said in this particular case where she had a minor degree of coronary disease and she had aortic valvular disease, relatively minor, and she also had a history of diabetes mellitus, I was being more conservative in saying her life expectancy would be about five years.
Q. What you're saying is you can't use the life expectancy table, isn't that true?
A. You can use them to get a general impression of what the life expectancy would be for somebody that age, and then you can modify from your own experience based upon your own clinical practices as to what may reduce that under certain circumstances.
Q. Did she have any underlying neurological problems?
A. Not to my knowledge.
Q. Did she have any underlying paravalvular disease

other than coronary artery disease?
A. It's reported in one of the charts that she had clots occasionally, but I did not see any documentation of any testing to confirm that.
Q. The presence of peripheral edema certainly would alter your diagnosis for her life expectancy, would it not?
A. No. It's part of a nuance in that it's life limiting.
Q. How about the presence of carotid artery disease?
A. Only if it's significant.
Q. Do you know whether she had significant carotid artery disease?
A. I don't believe she did. She had some DSA reports that she had done way back in '84, I believe. Dr. Shaffer indicated that she had some minor carotid artery disease in his report.
Q. Is it the natural history of diseases to progress?
A. It's the natural history of everything to progress, yes.
Q. As to what it was at the time of her death in 1991, you have no way of knowing?
A. That's correct.
Q. We're getting there. When did you first get this case to review, doctor?

A. I don't know.
Q. Do you recall when you first --
THE WITNESS: Was it after I did that case for Michael?
MS. TOSTI: Let me see if I've got some notes that show it.
A. I would have to think that it was sometime in the late spring of '93 because my correspondence to you is November 1993, and I was away all of July and the first week of August in that year, so --
Q. (BY MR. SKIVER) Now, you've previously testlfled for Mr. Becker's office; is that correct?
A. No. I was on the other side.
Q. Okay. Have you reviewed any cases for Mr. Beckers' before?
A. I don't believe I have. No. This is the first one.
Q. How many times have you testlfled in medical malpractice cases?
A. I have reviewed approximately anywhere from 6 to 10 to 12 cases a year, and I have done that since about 1983.
Q. What percentage of that is for the plaintiff and what percentage Is for the defendant?
A. It's probably 60/40. 60 being defendant, and 40 being plaintiff.

Q. Okay. How many times have you testified in trial?
A. About three. Three and one arbitration.
Q. Okay. What do you charge, Doctor, to review?
A. It's usually $200 an hour.
Q. Deposition?
A. Same.
Q. Trial?
A. Same.
Q. You're familiar with the CASS study, aren't you?
A. Yes.
Q. Do you agree with the findings of the CASS study?
A. Not entirely.
Q. What do you disagree with?
A. My objections are basically the same as those that have been authored by Robert -- I'll give you a copy, if you want.
Q. Copy of what?
A. This is the article, The Coronary Artery Surgery Study, CASS. Do the Results Apply to the Patient? There's some concern as to whether or not the CASS study can be applied to particular patients who are unstable.
Q. In what way?
A. The CASS study basically relates to patients who are relatively stable from a cardiac standpoint in that

their signs and symptoms have been relatively chronic and they're not showing any evidence of acute or sudden deterioration.

Q. And what is it that you believe?

A. I believe the CASS study, if you look at the randomization and the registry, basically tells you the life expectancy of patients who have chronic stable coronary disease as opposed to those who have acute unstable coronary disease. In the latter group, I don't believe the CASS study is correct.

Q. All right. Do you feel that you can say anything about that latter group and the CASS study?

A. I know they're essentially worse than the prediction in the CASS study.

Q. Any particular journals or books that you would go to to determine information regarding congestive heart failure?

MR. MISHKIND: Objection.

A. I'm sorry? What was that? Repeat that.

MR. SKIVER: I'll let her do that.

(Question read by reporter.)

MR. MISHKIND: Objection. You can answer the question.

A. I think the bibles of cardiology are William Hurst book and Braum Wald's text on heart disease, but for

really updated information, you need to look at journals like the journal of the American College of Cardiology and the American Heart Journal.

Q. (BY MR. SKIVER) Okay. Other than the fact that this patient was complaining of shortness of breath, was there anything else that was particularly ominous to you in her history on the 27th or the 28th that would lead you to believe that she was in imminent danger of having an arrest?

A. As I said earlier, the constellation of somebody who has hypertension, probably diastolic dysfunction, aortic valvular disease, minor coronary disease, who comes in with a combination of electrolyte imbalance and dehydration, are notoriously difficult to treat. And that's why it's my opinion that she should have been placed in the Intensive Care Unit right away so they would have been able to monitor things appropriately and tell when they are getting into trouble in order to make the appropriate adjustments in the treatment.

Q. I know that, but my question was is there anything specific in the history on the 27th?

A. That's why I say the whole constellation of things, not one thing.

Q. My question is on the 27th -- just listen to the

question. I understand what you're saying. I understand where you're coming from. My question is on the 27th until the time she had her arrest, was there any specific symptoms that she was having that to you was ominous?

A. Any single symptom?

Q. Yes.

A. Not any single symptom, no.

Q. All right. What were the constellation of symptoms that were ominous to you?

A. The continuing problems with shortness of breath, the complaints she can't breath. The periods of confusion and agitation. The fact that she ultimately got to the point where she was sitting bold upright in bed. That whole sequence tells you, and if you read the nurses' reports, you will find out that these complaints became more frequent, more progressive, ultimately, getting to the point where prior to her arrest she was sitting bold upright in bed unable to breath.

Q. Okay.

MR. SKIVER: That's all the questions I have. Thanks.

MR. MISHKIND: Okay. The doctor will read the deposition.

THE STATE OF OHIO,)
) SS: CERTIFICATE
COUNTY OF CUYAHOGA.)

I, Faye M. Farley, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that ALFRED GEORGE ERNEST KITCHEN, M.D. was by me, before the giving of his deposition, first duly sworn to testify the truth, the whole truth and nothing but the truth; that the deposition as above set forth was reduced to writing by me by means of Stenotype and was subsequently transcribed into typewriting by means of computer-aided transcription under my direction; that said deposition was taken at the time and place aforesaid pursuant to notice and agreement of counsel; that the reading and signing of the deposition by the witness were expressly waived; and that 1 am not a relative or attorney of either party or otherwise Interested in the event of this action.

IN WITNESS WHEREOF, I hereunto set my hand and seal of office at Cleveland, Ohio, this 28th day of June, 1994.

Faye M. Farley

Faye M. Farley, Notary Public
Within and for the State of Ohio
848 Terminal Tower
Cleveland, Ohio 44113

My Commission Expires: July 16, 1996.

I have read the foregoing transcript of my deposition taken on Tuesday, June 14, 1994 from page 1 to page 48 and note the following corrections:

PAGE:	LINE:	CORRECTION:	REASON:
14	14	a THROUGH to WITHOUT	
22	16	a I to SHE	
30	1	a SLOW to LOW	
throughout		a BOLD to BOLT.	

8/24/94
DATE

ALFRED KITCHEN, M.D.