THE STATE of OHIO, :
: SS:
COUNTY of CUYAHOGA.:

Doc. 236

- - - - - -

IN THE COURT OF COMMON PLEAS

- - - - - -

LESTER WEITZEL, executor of the ESTATE of SHARON WEITZEL, deceased, and LESTER WEITZEL, plaintiffs,	:
vs.	: Case No. 226946
SAINT VINCENT CHARITY HOSPITAL, et al., defendants.	:

- - - - - -

Deposition of ALFRED KITCHEN, M.D., a defendant herein, called by the plaintiffs for the purpose of cross-examination pursuant to the Ohio Rules of Civil Procedure, taken before Frank P. Versagi, a Registered Professional Reporter, a Certified Legal Video Specialist, a Notary Public within and for the State of Ohio, at Saint Vincent Charity Hospital, 2351 East 22nd Street, Cleveland, Ohio, on Tuesday, the 8th day of September, 1992, commencing at 2:25 p.m., pursuant to notice.

APPEARANCES:

ON BEHALF OF THE PLAINTIFFS:

Charles Kampinski, Esq.
Christopher M. Mellino, Esq.
Charles Kampinski Co., L.P.A.
1530 Standard Building
Cleveland, Ohio 44113.
and
David J. Elk, Esq.
Elk and Elk
Chagrin Richmond Plaza
25550 Chagrin Boulevard - Suite 204
Beachwood, Ohio 44122.

- - - - -

ON BEHALF OF THE DEFENDANT SAINT VINCENT CHARITY HOSPITAL:

William J. Coyne, Esq.
Standard Building
Cleveland, Ohio 44113.

- - - - -

APPEARANCES: (continued)

ON BEHALF OF THE DEFENDANTS DRS. ROLLINS, KITCHEN, STEELE, KHADDAM:

John V. Jackson, II, Esq.
Jacobson, Maynard, Tusehman & Kalur
1001 Lakeside Avenue
Cleveland, Ohio 44114.

- - - - -

ON BEHALF OF THE DEFENDANT DR. VARMA:

Burt J. Fulton, Esq.
Lynn L. Moore, Esq.
Gallagher, Sharp, Fulton & Norman
Sixth Floor - Bulkley Building
Cleveland, Ohio 44115.

- - - - -

ON BEHALF OF THE DEFENDANTS RADIOLOGY CONSULTANTS, INC. and DRS. J. PORTER, SMITH, WIRTZ:

Robert D. Warner, Esq.
Reminger & Reminger
The 113 Saint Clair Building
Cleveland, Ohio 44114-1273.

APPEARANCES: (continued)

ON BEHALF OF DEFENDANTS CENTRAL ANESTHESIA of CLEVELAND, INC. and DRS. SOPKO, MOASIS, STEFFEE:

Robert C. Seibel, Esq.
Jacobson, Maynard, Tuschman & Kalur
1001 Lakeside Avenue
Cleveland, Ohio 44114.

- - - - -

ON BEHALF OF DEFENDANTS DRS. MAGIERA, CHMIELEWSKI & VAIDYA:

David Matia, Jr., Esq.
Jacobson, Maynard, Tuschman & Kalur
1001 Lakeside Avenue
Cleveland, Ohio 44114.

- - - - -

ON BEHALF OF DEFENDANT CLEVELAND CLINIC FOUNDATION:

Ronald S. Okada, Esq.
Baker & Hostetler
3200 National City Center
Cleveland, Ohio 44114.

- - - - -

I-N-D-E-X

WITNESS: ALFRED_KITCHEN,_M.D.

- - - - -

(NO_EXHIBITS_MARKED)

- - - - -

INDEX of OBJECTIONS

- - - - -

ALFRED KITCHEN, M.D.

of lawful age, a defendant herein, called by the plaintiffs for the purpose of cross-examination pursuant to the Ohio Rules of Civil Procedure, being first duly sworn, as hereinafter certified, was examined and testified as follows:

- - - - -

CROSS-EXAMINATION

BY MR. KAMPINSKI:

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

A. Alfred George Ernest Kitchen.

Q. State your residence address, if you would, sir?

A. 32312 Acacia Court, Avon lake.

Q. I've been handed your CV. You are currently employed where?

A. I am self-employed.

Q. Are you with a group?

A. We have an association of cardiologists but we're not formally as a group together.

Q. When you say self-employed, are you self-employed as an employee of a corporation?

A. My own corporation.

Q. And the name of your corporation is what?

A. AGK, M.D., Inc. Alfred George Kitchen, M.D., Inc.

Q. And your corporate address is what?
A. 2322 East 22nd Street, Suite 303, Cleveland.
Q. Who else is employed by your corporation in a physician capacity?
A. No one.
Q. Who else is a shareholder of the corporation?
A. No one.
Q. Other than --
A. Other than myself.
Q. How long has that corporation been in existence?
A. 1978.
Q. Have you been the shareholder since that time?
A. Yes.
Q. Sole shareholder?
A. That's correct.
Q. Have there been other employees of the corporation other than yourself since that time?
A. For the first I'd say eight years the office secretarial staff were employed by --
Q. How about other physicians?
A. No other physician.
Q. Since its inception?
A. That's correct.
Q. When you said you're associated with other cardiologists, explain that to me.

A. We all share in the operating expenses of the office and the personnel. The personnel in the office are technically employed by Cleveland Cardiology Associates, which is basically an umbrella group that the three associates are proprietors of Cleveland Cardiology Associates, and the office personnel are employed through that corporation.

Q. Cleveland Cardiology Associates, is that a corporation?

A. Yes.

Q. Are you a shareholder of that --

A. Correct.

Q. -- corporation?

A. Yes.

Q. Where is its business address?

A. Same address.

Q. 2322 East 22nd, Suit 303?

A. Yes.

Q. Who else is a shareholder of that corporation?

A. Dr. Robert Steele, and Dr. Michael Rollins.

Q. Do each of them have their own corporation that employs them?

A. Steele does, Rollins does not.

Q. And who is he employed by, do you know?

A. In this day and age it doesn't -- it's no

benefit to incorporate as a physician any longer. Rollins came along, he just never bothered to incorporate.

Q. The purpose of Cleveland Cardiology Associates, Inc. is what?

A. Basically to operate the office.

Q. Do you have an employment contract with them?

A. No.

Q. Do you have an employment contract with AGK, M.D., Inc.?

A. I hope I do. Not that I know if there is one on paper.

Q. When you bill out for your professional services, under which corporation are patients billed?

a. AGK, M.D.

Q. Do you have a separate billing as relates to Sharon Weitzel?

A. I am not aware of any billing from my office for her.

Q. Do you know if there were any billings from Cleveland Cardiology Associates, Inc. for her?

A. I would have no knowledge of that. I would assume that there was, but I have no knowledge of it.

Q. Would such a billing include any services that you would have provided?

A. No.
Q. Did you provide any services for Mrs. Weitzel?
A. Yes.
Q. When?
A. I was on call physician the weekend of I believe March 8th and 9th.
Q. When you say "On call," on call between the three of you?
A. Yes.
Q. Dr. Steele, Dr. Rollins, and yourself?
A. Yes.
Q. Do you rotate weekends?
A. We rotate weekly.
Q. Weekly?
A. Yes, which means we would cover the -- from the Monday through to the following Sunday, would be my responsibilities to cover for the other two nights and weekends.
Q. So you would have been on call then at other times that she was in the hospital?
A. I can't specifically tell you the answer to that yes or no, because we frequently rotate and change schedules depending on personal trips, a family situation, things like that. So for me to tell you that I was on call at other times when she was in the

hospital, I don't recall that I was. I may have been, I may have not been. I don't recall.

Q. Is the reason that you recall the 8th or 9th because you reviewed the charts and there's some mention of your involvement?

A. I reviewed as it relates to the notes specifically that I made on the -- I believe it was the 9th, Saturday morning.

Q. Are you saying you don't have any independent recollection of any other contact with her?

A. Not to my knowledge.

Q. Were you at home or at the hospital when you were called regarding Mrs. Weitzel?

A. I was in the coronary care unit at Charity Hospital.

Q. What happened?

A. I was advised that a problem had been detected on the Friday evening before. I then reviewed the information in the chart as it relates to that particular incident. I reviewed the x-rays that were accumulated in the unit, and I called Dr. Rollins at home to discuss with him the circumstance that he noted the evening before.

Q. Doctor, this is the original chart, is this the note you are referring to, sir?

A. That's correct.

MR. KAMPINSKI: Do you have a copy of that that he can look at, Mr. Jackson?

MR. JACKSON: No, I don't.

Q. When is the last time you reviewed this before coming here today?

A. Yeah.

Q. When is the last time?

A. Today

Q. Ten minutes ago or --

A. Half hour, 45 minutes ago.

Q. So you're pretty familiar with this note?

A. Yes

MR. JACKSON: The other one is marked up, that's why I said I don't have it.

Q. You can look at the original. Why don't you read it for me first.

A. It's dated 3-9, it says "Kitchen/Rollins, reviewed x-rays, guide wire prolapsed on itself from left iliac up to base of neck, question mark, i.c., which is internal carotid, or vertebral apparently being in place approximately ten days, wire snapped in two in neck, Dr. Rollins aware yesterday; because of patient condition decision not to attempt removal at this time. Will discuss again with him today,

discussed options with Dr. Khaddam."
Q. What led you to believe that, first of all, the guide wire prolapsed on itself?
A. When I looked at the x-rays it appeared that the guide wire went up and back down, kind of a hairpin configuration?
Q. Did you then conclude that it was one guide wire?
A. It was my impression that there -- the possibilities that existed included a number of things, it was my interpretation looking at that, that the wire had snapped in two, this was in two portions. That it -- it was one wire that was snapped in two is the impression that I had looking at the x-rays.
Q. Did you ever change that belief?
A. I really had no other information on which to go beyond that impression at that time.
Q. No. I mean did you ever subsequently learn anything to the contrary?
A. Only indirectly I heard that one wire was removed in the cardiac lab, and I understood that a second was removed in the operating room, but I was not present at either of those procedures.
Q. So at least from what you can view on x-ray, the possibility that it was one wire that had snapped in

two was something that you felt existed?
A. That was my impression at the time, yes. Yes.
Q. When you say wire snapped in two in neck, what led you to believe that?
A. Well --
Q. Is that Just saying the same thing?
a. Basically saying the same thing, it snapped in the place where the wire happened to be, snapped in the location is where the catheters were in the -- or the wires were in the neck.
Q. And you determined this from reviewing the x-rays?
A. Yes.
Q. Did you review them with anybody?
A. I believe one or two of the residents were there at the time, but 1 can't recall who they were.
Q. Did you review it with anybody from the radiology department?
A. No.
Q. You mentioned that Dr. Rollins had become aware of this you said the Friday before, did you mean the day before or --
A. Yes, the day before.
Q. Was this a Saturday?
A. That's correct.

Q. Had he told you about this before you came in?
A. No. I learned of it after I came into the unit.
Q. When was that?
A. I would say 10:00, ten o'clock Saturday morning.
Q. And that was because you were going to be on call that weekend?
A. I was covering, and what we routinely do is to review all of the cases that are in the unit with the residents and the nursing personnel, and this one was on top of the list.
Q. So it was a resident or a nurse that told you about the existence of the wire?
A. I don't recall who specifically told me, whether it was a nurse or whether it was one of the residents.
Q. What were you told?
A. That there was a problem that had been identified on the Friday, and that they thought that there was a wire in the patient,
Q. Do you know if the resident was Dr. Varma or not?
A. I know he was on the service at the time. Who was -- else was there, who else on the service, I don'trecall at that point.
Q. Do you recall. having any discussions with him that day?

A. No, I don't.
Q. Did you have any discussions with Dr. Rollins prior to looking at the x-rays or familiarizing yourself with the chart?
A. No. I did that first and then contacted him to learn what he thought of the situation, and to see whether or not it concurred with my evaluation and decision about what to do or what not to do.
Q. First of all, your evaluation of the situation and what you wanted to do and what you talked about with Dr. Rollins we'll discuss in a minute, but based upon your review of the x-rays in the chart, what was your evaluation of the situation?
A. There appeared to be either two wires or one wire broken in two, that was somewhere in the vascular tree in this lady that appeared to go from the left iliac up to the -- or the left internal carotid or the vertebral on the left side. It was my impression that the wire may have been snapped in two. They're were two portions of it.
Q. That would be your assessment?
A. That was my assessment.
Q. What was your plan or what is it that you felt ought to have been done?
A. Well, he did what I thought we ought to at that

point, nothing.

Q. Why was that your plan?

A. The evaluation of this lady, she was too critically ill to undergo what procedure would be necessary to remove these wires.

Q. When you say "Procedure necessary," what kind of procedure are you talking about?

A. You would -- once you embark on a decision to do something, you never know how far you are going to have to go to get them out. There are techniques that are relatively simple that might work; you have to also be prepared to go so far as to call in a vascular surgeon, depending upon what success you may have with it or what other complications you might have with that procedure.

In knowing that a major operative procedure might be required, she was in no condition to tolerate that.

Q. Why is that?

A. She had multiple system problems that were very severe, complex. It had been noted in the chart I believe two days prior to this that she was in no condition to be transported anywhere €or anything. So it was my decision on that day after reviewing the x-rays and the situation with Dr. Khaddam, who is a

vascular surgeon, that it was our opinion, his and mine and Rollins, not to do anything on that particular occasion.

Q. You jumped ahead to the possibility of a vascular surgeon being involved to presumably remove the guide wire, or wires, whichever the case might have ultimately proven to be, are there less invasive procedures that could be employed to remove the guide wires?

A. Yes.

Q. Such as?

A. I had -- I used a technique that I designed several years ago to rescue these things from wherever they might be in the vascular bed, snare them, and hopefully remove them.

Q. What technique is that?

A. Use a cardiac catheterization catheter, we make a snare with a flexible guide wire, similar to what was left in this lady, and try to get it in position in close proximity to the guide wire, and actually slide a snare over it, pull the snare tight, and extract the guide wire.

Q. Had you employed that technique in the past?

A. Yes. Several times.

Q. To extricate guide wires?

A. Yes.
Q. How is it a guide wire needs extricating?
A. Well, variety of things: guide wires and catheters unfortunately --
Q. Let's talk about guide wires.
A. They just unfortunately get loose in the system. It can happen purely by accident, it can happen by poor technique. There are things like that that unfortunately can happen.
Q. When they happen, what do you have to do?
A. You got several decisions that you have to make as it relates to the specific item, whether A, it needs to be removed; B, if it does need to be removed, what technique you have available to go get it depending upon where it is, what the risks are, what the complications are, and what the risk of the complication might be for not going after it.
Q. How many occasions would you say that you have encountered where guide wire as opposed to catheters has gotten loose in the system?
A. Probably one or two. Not very many.
Q. And has it happened to you or a resident or --
A. It has not happened to me. I have been the one to rescue it. It has not been me that lost it in the first place.

Q. How is it that you were or became involved in rescuing it?

Was it here at this hospital, first of all?

A. Yes,

Q. How long ago?

A* Oh, the first occasion -- first occasion was probably 1979.

Q. Here?

A. Yes.

Subsequently the last time was probably five years ago.

Q. So twice we're talking about?

A. i think there was a third one in there too at one time, It's not very common.

Q. All three have been here?

A. Yes.

Q. Did you ever publish anything about the system for retrieving?

A. Tried to patent it but I couldn't get anybody to do it.

Q. Who did the patent papers for you?

A. Company in California who were originally considering to market it.

Q Do you still have those?

A. They felt that there wasn't sufficient volume or usage to justify going ahead with it.

Q. Do you still have the papers?

A. I believe they're around somewhere.

Q. How is it that you were then contacted to remove these guide wires; I mean, were you the attending?

A. I guess they thought I was the only one crazy enough to try and know how to go about doing it back in those days. Several other cardiologists were asked but nobody wanted to try it, and I put -- designed the system and it worked.

Q. In other words, you were able to extricate the guide wires?

A. Yes.

Q. Where in this instance would you have attempted the extrication from?

A. Probably from the left femoral artery.

Q. And the reason that you would have done that would have been what?

A. Be because you have a direct shot to the left iliac and you would have had -- you would be less likely to have some of the potential complications in removing it by going from that approach.

Q. On the other occasions that you were contacted to try to, or to do this, and in fact did do it, were

you the attending in any of these situations?

A. No.

Q. If you lose a guide wire in the system, is that something that you would know?

A. If I was doing the procedure?

Q. If anybody was?

A. You should know.

Q. Aren't you supposed to remove the guide wire after you put the catheter in?

A. Yes.

Q. So that if you didn't remove the guide wire, you'd know it was still in the person?

A. You should know.

Q. You indicated what you felt ought or ought not to be done, you then talked to Dr. Rollins?

A. After I had reviewed the case I made a decision for myself as to what I thought ought to be done, it was at that point that I discussed it with Dr. Khaddam, and that's when I called Rollins to see if he felt the way I did on that morning.

Q. Dr. Khaddam was a vascular surgeon?

A. That's correct.

Q. Given that you had devised this system that did not require a vascular surgeon, why is it that you had a discussion with him?

A. Because of the potential complication that can exist when you have a loose guide wire in the vascular bed, there are certain complications that would have required somebody with his expertise to get the guide wire out, rather than things that I am capable of doing.

Q. In other words, if surgical intervention would have been necessary, it would have been by a surgeon?

A. A vascular surgeon, that's correct.

Q. So are you saying you would have needed one to be standing by in the event you couldn't successfully do the procedure?

A. That would have been a separate bridge to cross. I was more concerned about the potential complication that could exist while the catheter is still in place, complication that might require surgical intervention urgently in order to extricate them.

Q. Such as?

A. Well, these things can migrate. They can move places and cause problems.

I€, for example, it had migrated up the internal carotid, it could have created serious problems with perfusion of brain. Same as if it follows the vertebral arteries. So mobility or movement of the guide wire is one issue.

They are thrombogenic and the possibility of blood clots could form on the catheter and then migrate, produce a stroke; and they could also penetrate and perforate blood vessels and produce significant bleeding. Those are all complications I am not particularly comfortable in dealing with. That's why you need a vascular surgeon to deal with those kinds of things.

Q. Those complications could have arisen in the attempted extrication or could have arisen just on their own?

A. Both.

Q. So that's why you talked to a vascular surgeon, and what did Dr. Rhaddam tell you in terms of his opinion?

A. It was based -- he was not asked to do anything or asked to make a decision or anything. I just felt it was necessary for he as a vascular surgeon on call that weekend to be aware of the circumstance so that if there was a problem, that if I called him at two o'clock in the morning, I don't have to read him 75 pages worth of stuff. He would be aware of it.

Q. So you just made him aware of the situation in the event he is needed?

A. That's correct.

Q. So there was nothing that he told you then that caused you to change your opinion or to formulate your opinion, you knew what you were dealing with, what you wanted to do3

A. That's correct.

Q. Certainly the attempted removal of the wire or wires at least by your own procedure did not involve a surgeon, correct?

A. That's correct.

Q. In light of her condition, which you have told us about a few minutes ago, was the danger one of surgery as opposed to the attempt to remove it by your procedure?

a. The issues at that point in time were one of she would have had to be transported from a coronary care unit to the cardiac catheterization laboratory. I'll relate back to the comments that were in the chart from two days before, this lady wasn't in a situation where she can be transported anywhere, number one; secondly --

Q. Excuse me. Could you point -- I'm looking at the notes of Dr. Rollins of March the 8th.

a. I believe this is a note prior to that.

Q. Let's look at that then, that would have been subsequent, "She's improving"?

A. "I think."
Q. "I think ABG's much better," down below under number 3. She is "Stable and improving"; do you see that?
A. You point that out to me, if you would.
Q. Yes.
A. Okay.
Q. So apparently she is getting better, right?
A. I agree with you from the standpoint of his note, indicates that she was getting better, but if you put in it context of how bad she was to begin with, she still wasn't a rose at this point in time.
Q. So you were still concerned about being able to move her to the cath lab to even do your procedure; would that be a fair statement?
A. Absolutely.
Q. Is there not increased mortality statistically for a patient undergoing any kind of surgical procedure, surgery requiring general anesthetic following myocardial infarction?
MR. JACKSON: Objection.
A. I am sorry. I don't understand that question.
Q. All right. Maybe 1 didn't state it sufficiently to be understood.
Is there increased mortality for

patients undergoing surgery within a certain time frame after having a heart attack?

MR. JACKSON: Objection again. Go ahead, Doctor. Answer if you can.

A. In think in the standard concept of risk involved for patients with coronary disease, the general answer would be yes,

The specific answer may not be yes, it may in fact be no, depending upon the type of surgery: Example, coronary bypass surgery post myocardial infarction may be of insufficient benefit.

Q. That's fair. I suppose I didn't mean to include that.

I meant some unrelated surgery.

A. In general terms again, possibly: Specific instance, if for example, the other condition that you are talking about is potentially a life-threatening situation, then the answer is obviously no.

Q. Have there been studies done with respect to surgical mortality following M.I.?

A. Yes. And you are talking about elective surgical procedures, and the answer again is -- the specific answer is yes, that's correct.

Q. Was that one of the things that you were considering then in terms of making your decision not

to possibly subject her to vascular surgery?

A. You always have to think a step or two ahead. The technique that I would have used to try at least initially was the example of the contraption I talked about earlier. The potential for complication with that procedure still exists: Example is, you're putting a larger diameter catheter in the femoral artery, there is always the possibility of lacerating the blood vessel; even if you snare the guide wire, you somehow have to get it out of the femoral arteries, at which point you can lacerate the arteries.

Point being is that in order to do that procedure, you have to be prepared for all of the potential complications, which may include vascular surgery, major operative procedure.

Q. I understand that. You said that before.

My question now is, I thought was: With respect to doing or possibly having to do surgery on this lady, was that one of the factors that caused you to believe that, that no intervention should be done at that time?

A. That's correct.

Q. You then called Dr. Rollins.

A. That's correct.

Q. And tell me what you and he discussed.
A. We discussed what the problem was as it relates specifically to the guide wire, and whether or not he felt or had any difference of opinion from what he had indicated the evening before, as to whether or not this patient should undergo a procedure to try to remove these wires; and I indicated to him what my thoughts were at that point, the fact that I discussed this with Dr. Khaddam, and that I felt it was not indicated to subject her to that type of procedure at that time.
Q. Dr. Rollins concurred?
A. It wasn't so much a question of concurring, because he wasn't there to evaluate what was going on on the Saturday morning.
Q. Well, was he of the same opinion?
A. He was of that opinion the night before. I basically indicated nothing had significantly changed.
Q. Where was Dr. Steele?
a. He was out of town. I don't recall where. It's my understanding I think Dr. Rollins had been covering for him the -- most of the previous week. I don't recall specifically where he was.
Q. How many x-rays did you review when you looked at these x-rays?

A. The specific number, I can't tell you, but I can tell you that we looked at the x-rays back to a time at which the wires were not present.

Q. You put in your note that they -- it had been in place for ten days?

A. I said approximately ten days.

Q. Okay. And you made that determination as a result of looking at the x-rays?

A. That's correct.

Q. Did you have to go down to the x-ray department to get them?

A. I believe they were in the coronary care unit.

Q. Had they been brought up?

A. I believe so, yes.

Q. Do you know if Dr. Varma or Dr. Rollins had brought them up specifically to --

A. I would have no knowledge who brought them up.

Q. Did you have any discussion with Dr. Varma as to how this had occurred?

A. I believe the only person that I talked to, at least as far as in the coronary care unit that day, was the senior resident. I believe he was the only one that I talked to in the unit.

Q. Did you ever talk to Dr. Varma about the guide wires?

A. I don't know if I can even identify Dr. Varma. I don't know if I've ever seen him.

Q. He was a resident that apparently was rotating through your service from the Clinic?

A. I understand that.

Q. And you are saying that you didn't have any involvement with him while he was doing his rotation?

A. Not to my knowledge, no. I don't recall that I can even identify a picture of him.

Q. Let me ask you this, Doctor: I assume that you did have some involvement with various residents as they would rotate through your service?

A. Yes. But Pet me clarify that for you.

Q. Sure.

A. They don't rotate through my service. They cover what is called a teaching service in coronary care unit. I may or may not have a patient in the coronary care unit who may or may not be a teaching case, so my exposure would be only limited to those cases that I had that were in the unit that were in -- which in fact were a teaching case.

Q. Was Mr. Weitzel a teaching case?

A. I don't know.

Yes, she would have had to be if she would have been seen by the residents.

Q. What makes a person a teaching versus a non-teaching case?

A. Certain services and certain physicians agree to allow their patients to be on the teaching service, which means being followed by the residents,

Q. So in this case since Dr. Steele was the attending, he would have had to have agreed that Mrs. Weitzel could be a teaching patient?

A. That's correct.

Q. And how do you as a physician determine who you are going to allow to be a teaching patient?

A. I will have to say up front that the majority of our patients that we admit to the coronary care unit by our -- Steele, Rollins, and myself, are teaching patients.

The ones that we don't make teaching patients are cases that we don't expect to be in there for more than a day or two, there is no significant teaching value to the particular cases. We don't want to overload the residents to just make them be care takers.

Q. So you make a patient a teaching patient, that automatically means that you are going to have residents see that patient; is that correct?

A. You will have the residents who are in the

teaching program seeing the patients, that's correct.

Q. These residents, how often do they rotate through the cardiology service?

A. Approximately every two months the junior residents rotate. The seniors have a slightly different schedule. They may be here a little bit longer, up to three months. There's an overlap and a continuity from change to change.

Q. Is it typical to allow the junior residents as part of their responsibilities to insert catheters?

A. Only to the extent that they have documentation of adequate training to do so.

Q. Wow do you determine that they have such documentation?

A. It's my understanding that for all of the residents that come over here, particularly from the Cleveland Clinic, there is documentation provided to the physician in charge of the education program to document what they have been trained to do what they have experience doing, and that that information is communicated to the senior resident.

Q. So you're relying then on the documentation being provided through the residency program?

A. That's the major source, yes.

The other source is any time we find

the residents change, they change every two months, if a procedure is required, I make a point of asking the senior, does he know how to do this, is he experienced, does he have the, or she, have the ability to do these kinds of procedures.

Q. Would you watch them do one before you allowed them to do it on their own?

A. It depends upon the experience of the senior. If the senior themselves has been here before, if they demonstrated capability of doing these procedures, if they demonstrated ability to teach these procedures, then I wouldn't necessarily be present or instruct them on how to do it.

Q. Who was the senior on February 26th, do you know?

A. I don't know.

Q. Was it Dr. Jayne?

A. I would have no knowledge of verifying that.

Q. Do you know who she is?

A. Yeah.

Q. Was she an experienced resident?

A. I'd have to go back and recall what her training and expertise was at that particular time. I can't tell you today what her capabilities were back then.

Q. You already told me you wouldn't know Varma if

you saw him?

A. Right. I wouldn't know him if I saw him.

Q. You would have been responsible for the cardiac care that Mrs. Weitzel received on the 9th and 10th, that being the weekend?

A. That's correct.

Q. Do you have any other notes after the 9th?

A. Not to my knowledge. You asked earlier whether I covered her at other points in time after that, I don't specifically recall whether I did or not.

Q. Is this the only note then of yours in the chart?

A. I have not looked through it to find out.

MR. JACKSON: I am not aware of any others. Anybody else aware of any others?

MR. KAMPINSKI: I am not. He is the one that was there,

MR. JACKSON: I understand you got about six inches of charts, If there is a note here that you're aware of, then point it out. We'll address it.

MR. KAMPINSKI: I told you I'm not.

MR. JACKSON: I am not aware either.

A. No. I don't see any. That was my answer.
Q. What did you do the rest of the weekend as related to her care, or can't you tell because there's no note in there?
A. There isn't a note from me on the Sunday; however, I know that I did review the situation with the nursing personnel and reviewed her vital sheets and other information, but there is no note from here on the occasion.
Q. So did you do anything other than just observe her over the weekend?
A. Other than to make a decision not to do anything any differently as relates to wires.
Q. In other words, you continued any decision-making process the following day?
A. Not to intervene, yes.
Q. Were you involved at all in the decision-making process by Dr. Steele to do surgery when he did it on the 13th?
A. No. Only that I learned that he was going to use the technique that I had shown him.
Q. When did you show him how to do that technique?
A. Years ago.
Q. Had he done it?
A. I believe so. I don't recall. It's not

particularly difficult. It's unique. It's not particularly difficult.

Q. Did he ask you to assist him?

A. No.

Q. You're aware of the fact that he got one wire and he didn't get another one?

A. I heard that.

Q. Did he contact you after the initial attempt to ask you to assist him in trying to get the second one?

A. No.

Q. Can radiologists also do this procedure, that is the removal of an item from the arterial system --

MR. WARNER: Objection.

Q. -- percutaneously?

A. I guess if they had some practice or experience they might be able to.

Q. You do angiography?

A. Yes.

Q. They do too, don't they?

A. Yes, different kinds of angiography.

Q. I understand they don't do cardiac?

A. That's correct. And I don't do peripheral.

Q. How would you describe the attempt to remove the guide wire, cardiac or peripheral?

A. It could be either.

Q. What equipment do you maintain in the cardiac cath lab for this type of procedure? Maybe that's not a fair question.

I suppose because of the fact that you didn't patent it, this equipment isn't maintained at all?

A. It is incredibly unique.

I think radiologists are not as experienced as cardiologists in manipulating guide wires or catheters, in getting them into places where we need to get them. That is why they don't do the things that we do. Just simply inserting a catheter into a major vessel is not the issue. We go beyond that. We manipulate the catheter through various chambers of the heart, the pulmonary arteries, whatnot. Techniques that we're experienced in, manipulation of catheters, that they aren't.

Q. Could a trained radiologist have done the procedure to remove this guide wire?

MR. WARNER: Objection.

MR. JACKSON:: Objection. What do you mean by "trained"?

MR. KAMPIMSKI: Trained in doing invasive procedures.

MR. WARNER: Objection.

A. In general, no. No.
Q. How does a person develop a pneumothorax or how can a person develop a pneumothorax?
A. The probably simplest explanation is introduction of a connection between the atmosphere and the thorax by any one of several means.
Q. How did Mrs. Weitzel develop hers?
A. I have no idea.
Q. Was she receiving -- had she developed it already by the time you came on service?
A. I don't recall anything as relates to pneumothorax.
Q. So it's your recollection that she didn't have any pneumothorax when you were on service that week?
MR. JACKSON: Objection.
A. I don't have any recollection of that, no.
Q. Were you involved in any of the decision-making process after that weekend in terms of the care to Mrs. Weitzel?
A. No.
Q. So neither Dr. Rollins nor Dr. Steele consulted you as to what ought to be done or what they might do?
A. Not to my knowledge.
Q. Did you have any discussions with them or the radiologists or anybody involved in the residency

program regarding Dr. Varma's conduct or actions as pertains to the guide wire, after you found out about them obviously?

A. I think that the only brief discussion I had was a hallway discussion with Dr. Kathy Keating, who was the director of the program at that point in time; and I basically indicated to her, you obviously are aware that there was a problem, and indicated that if she needed anything from me, to get in contact with me, and that's the extent of it.

Q. What was her response?

A. If she needed something, she would.

Q. Is leaving a guide wire in a person failure to adhere to the appropriate standard of care required of somebody putting it in in the first place?

A. That's a difficult question,

Q. Is it?

A. Geez, I think -- can you rephrase that?

Q. Well, tell me what your problem is with the way I did phrase it and I'll try to -- I can keep asking questions, I might not answer your concern.

MR. JACKSON: Maybe I can help. Are you talking piece of guide wire that may have been sheared, are you talking about entire guide wire, what are you talking about?

MR. KAMPINSKI: We'll start with one guide wire, entire one, then we'll go to two.

MR. JACKSON: Okay.

Q. Is leaving an entire guide wire in a person failure to adhere to appropriate standard of care?

A. Could be.

Q. Was it in this case?

A. I believe so.

Q. If I asked you to assume that two separate ones were put into Mrs. Weitzel and left in her, I assume that would be a failure to adhere to appropriate standard of care as well?

A. Yes.

Q. How would you characterize, Doctor, the failure to let anybody know that that had occurred by a physician?

A. Inexcusable.

Q. A guide wire is a foreign body in a person, correct?

A. That is correct.

Q. And it was in Mrs. Weitzel?

A. That's correct.

Q. Was she septic at all?

A. She had -- had been for some time. Basic process that she had as far as her pulmonary status

was one of sepsis.

Q. In other words, she had infections?

A. She had infections.

Q. And can you clear sepsis in a person so long as there's a foreign body inside of them?

MR. JACKSON: I'll object, but go ahead and answer if you can.

A. Yes, you can.

Q. Is it harder to do?

A. Only in the circumstance where the infection is on the foreign body itself.

Q. To your knowledge, was there ever a cheek done on the guide wire or wires to determine if there was infection on them?

A. I would have no knowledge of that.

MR. KAMPINSKI: Why don't we take about one minute.

- - - - -

(Brief recess had.)

- - - - -

MR. KAMPINSKI: That's all the question I have. Some of the other attorneys may have some questions of you, Doctor.

MR. SEIBEL: I don't.

MR. COYNE: No questions.

MISS MOORE: I represent Dr. Varma. My name is Lynn Moore. I have some questions for you.

- - - - -

CROSS-EXAMINATION

BY MISS MOORE:

Q. You indicated you had some experience in retrieving guide wires in the past on three occasions?

A. One was a guide wire, two were other devices.

Q. Could you tell us about that, you said one was a guide wire?

A. Yes.

Q. Was that an intact guide wire or a piece that was sheared off?

A. It was an intact guide wire. A short guide wire as opposed --

Q. How long was that?

A. Approximately 16 to 18 inches.

Q. Where was that removed from?

A. Down in the abdominal aorta.

Q. You did that removal yourself?

A. That's correct.

Q. And you were able to remove the whole guide wire?

A. Yes.

Q. That was in 1979, you said?
A. I can't give you specific dates. In the early '80s.
Q. Then the second time you mentioned was five years ago?
A. The last time -- correction. The first time was in 19, probably, '79, and that was a catheter that was removed from the right ventricle and pulmonary artery.
The last time was approximately a year ago and we removed a portion of intravenous catheter from the left pulmonary artery.
Q. And all those occasions you were successful in retrieving --
A. Yes.
Q. -- what you went in after?
A. Yes.
Q. You made a distinction earlier about a piece of a guide wire being sheared off as opposed to an entire guide wire.
MR. KAMPINSKI: That was Mr. Jackson.
MR. JACKSON: I made that distinction.
BY MISS MOORE:
Q. There's a distinction, correct?

A. There is a difference, yes, as to the size of the device you are going to be recovering.
Q. Does that change the technique that you developed in going in?
A. It doesn't so much change the technique as it changes the likelihood of success.
Q. How does it change the likelihood of success?
A. The smaller the piece, the much more difficult it would be to snare it.
Q. Are you familiar in retrieving these guide wires, that some guide wires are defective, have you ever encountered that?
A. Not very often.
Q. Wave you in fact encountered that?
A. Personally, no.
Q. But you are aware of it?
A, I have heard of it, yes.
Q. Have you heard of -- how have you heard of it?
A. Just from some brief notes in cardiology journals where they describe things Like that, that have happened.
Q. You haven't experienced that yourself?
A. Never.
Q. And not in your removal techniques either, correct?

A. I have not experienced what in removal techniques?

Q. Defective guide wires.

A. I have never had any experience with defective guide wires in 16 years.

Q. In your experience of retrieving guide wires in these attempts, have you encountered guide wires fraying or coming apart?

A. In my experience that is extremely uncommon. The most common experience is through misuse.

Q. What do you mean by that?

A. I'm sorry?

Q. What did you mean by that?

A. In a hospital this big and the hospitals I've practiced at, it's not uncommon for guide wires and intravascular devices to get away from the people that are putting them in. I don't profess to be the only person in the city to remove them, and you frequently hear stories where they have been rescued by a variety of different technique procedures.

Q. And you were not involved in removing the items from Mrs. Weitzel, correct?

A. I was not personally involved. I recall going by the lab the day that they wheeled her in. It took an army of people to transport her into the unit, and I

rnew that Dr. Steele was going to try that procedure that day, but that's all I know.

Q. And you never had any conversations with Dr. Varma about this?

A. I don't recall having any discussions with him, no.

MISS MOORE: Thank you. Nothing else.

MR. KAMPINSKI: Anybody?

MR. OKADA: Nothing here.

MR. COYNE: Nothing.

- - - - -

RECROSS-EXAMINAIION

BY MR. KAMPINSKI:

Q. Now did you know that he was going to try the procedure that day?

A. Just simply because I knew I showed him how to do that years ago, and we never had any specific discussions about how to get them out, but that's the simplest and easiest approach, and he is a good cardiologist. I knew he was trying it.

Q. My question is: How did you know he was going to do it that day?

A. Just saw him wheeling her into the cath lab, that's the only place you would do it is in the cath

lab. You got everybody involved.

Q. So just by deductive reasoning you figured it out?

A. Yes.

Q. In other words, you didn't have any discussion with him before that?

A. Not that I know of.

Q. That he was going to do it or how he was going to do it or whether or not to do it?

A. No, but when I in the past have done these things, he kind of looked over my shoulder through the door to watch what was happening. We talked about these things in the past, how to use this device.

Q. So that's how he learned how to do it, by looking over your shoulder through the door?

A. Yes.

MR. KAMPINSKI: Okay. That's all I have.

MR. JACKSON: That's it?

MR. KAMPINSKI: Yes.

You have the right to read your testimony or you have you the --

MR. JACKSON: He'il read it.

- - - - -

(Deposition concluded; signature not waived.)

ERRATA SHEET

PAGE LINE

I have read the foregoing transcript and the same is true and accurate.

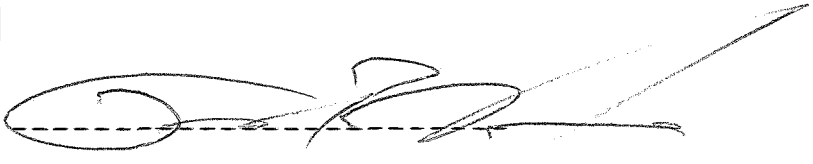
ALFRED KITCHEN, M.D.

The State of Ohio, :

County of Cuyahoga. : CERTIFICATE:

I, Frank P. Versagi, Registered Professional Reporter, a Certified Legal Video Specialist, a Notary Public within and for the State of Ohio, do hereby certify that the within named witness, was by me first duly sworn to testify ALFRED KITCHEN, M.D., the truth in the cause aforesaid; that the testimony then given was reduced by me to stenotypy in the presence of said witness, subsequently transcribed onto a computer under my direction, and that the foregoing is a true and correct transcript of the testimony so given as aforesaid. I do further certify that this deposition was taken at the time and place as specified in the foregoing caption, and that I am not a relative, counsel, or attorney of either party, or otherwise interested in the outcome of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, this 15th day of September, 1992.



Frank P. Versagi, Registered Professional Reporter, a Certified Legal Video Specialist, Notary Public/State of Ohio. Commission expiration: 2-25-93.