

THE COURT OF COMMON PLEAS

GEAUGA COUNTY, OHIO

ROBIN KIDD, etc.,
et al.,

Plaintiffs,

- VS -

JUDGE FORREST W. BURT
CASE NO. 03 PT 216

CAROL NOALL, M.D.,
et al.,

Defendants.

NAME	DATE	TIME	TYPE
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Deposition of ROBERT B. KELLY, M.D., taken as if upon cross-examination before Dawn M. Fade, a Registered Merit Reporter and Notary Public within and for the State of Ohio, at the Center for Family Medicine, 18200 Lorain Avenue, Cleveland, Ohio, at 10:07 a.m. on Tuesday, July 13, 2004, pursuant to notice and/or stipulations of counsel, on behalf of the Plaintiffs in this cause.

Species	Age	Sex	Size
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On behalf of the Defendants.

1 ROBERT B. KELLY, M.D., of lawful age,
2 called by the Plaintiffs for the purpose of
3 cross-examination, as provided by the Rules of
4 Civil Procedure, being by me first duly sworn, as
5 hereinafter certified, deposed and said as
6 follows:

7 CROSS-EXAMINATION OF ROBERT B. KELLY, M.D.

8 BY MS. KOLIS:

9 Q. Doctor, simply for identification purposes, my
10 name is Donna Kolis. We've just been introduced.
11 As you obviously are aware, I represent the
12 Estate of Thomas Kidd.

13 It's my understanding from Mr. Walters that
14 you are ready, willing, and able to come to court
15 and give some testimony in this matter, is that
16 correct?

17 A. That's correct.

18 Q. All right. You've given depositions before,
19 correct?

20 A. Correct.

21 Q. All right. Every attorney has their own set of
22 rules and I'd just like to put mine up front in
23 the record so there is no confusion.

24 I assume based upon your experience level
25 that you are currently aware that you are

1 required to answer each and every question
2 verbally, you do understand that, correct?

3 A. I do.

4 Q. All right. And you understand that you are in
5 fact under oath in this room just as if you were
6 in a courtroom, correct?

7 A. Correct.

8 Q. All right. There may come a point in the
9 deposition, highly unlikely, but there may come a
10 point where Erin will object, so you should not
11 answer anything until she and I work out our
12 differences. Can I secure your agreement on
13 that?

14 A. You can.

15 Q. Great. If you promise not to be abusive in this
16 regard, if I ask you a question that you clearly
17 don't understand, and not at the prompting of the
18 attorney that you don't understand it, but you,

19 yourself, if you don't understand it, will you
20 let me know that you don't understand what
21 information I'm seeking?

22 A. I will.

23 Q. Okay. Excellent. Doctor, I did a Common Pleas
24 index on you and it seems that you have enjoyed a
25 career in Cleveland and not been sued. Is the

1 computer information correct?

2 A. I was named once and dropped almost immediately.

3 Q. There you go. Now, see, the computer is actually
4 pretty accurate.

5 How frequently do you review medical/legal
6 matters?

7 A. Probably an average of about four times a year
8 for the last 10, 12 years.

9 Q. Okay. And predominantly you are reviewing for
10 physicians, is that correct?

11 A. Correct.

12 Q. Okay. Have you ever testified in a courtroom for
13 a patient?

14 A. No.

15 Q. Have you testified in a courtroom for a doctor?

16 A. Yes.

17 Q. Okay. How many occasions?

18 A. Four.

19 Q. Okay. When is your most recent appearance in a
20 courtroom?

21 A. It was this year about a month ago.

22 Q. And in which court? If you know the judge's name
23 that's okay, but what county?

24 A. Which court? It was in Akron, so I'm not sure of
25 the county.

1 Q. Do you remember --

2 MS. HESS: Summit County.

3 MS. KOLIS: Sure.

4 A. Probably, but I wouldn't swear to that.

5 Q. Whom did you testify for?

6 A. You mean for the doctor or for --

7 Q. I'm sorry. I was shaking my head. Yes.

8 MS. HESS: Or maybe the attorney,
9 do you want that?

10 Q. Whatever way you can best describe whoever it was
11 you were working with or for.

12 A. Yeah. You know, I'm just terrible with names if
13 I don't need to remember them any more.

14 It was the Reminger & Reminger office that's
15 based in Akron, I believe.

16 Q. Okay.

17 A. Attorney's name was Brad Longbrake.

18 Q. All right.

19 A. And there was another attorney as well.

20 Q. Okay. In your past 10 to 12, I think you said it
21 was 10 to 12 years that you have done these about
22 four times a year or so?

23 A. Right.

24 Q. Have you predominantly worked for Reminger &
25 Reminger?

1 A. No, not predominantly. No.

2 Q. What other law firms have you worked for?

3 A. Ulmer & Berne in Cleveland.

4 Q. Murray Lenson?

5 A. Murray Lenson, yes, but there have been some
6 other attorneys as well.

7 Q. All right.

8 A. There's a Toledo firm, Kitch, Drutchas and
9 something.

10 Q. Uh-huh.

11 A. There's Hanna, Campbell & Powell; Fifner &
12 Jeffers; Flaherty, Sensabaugh, Bonasso in
13 Wheeling. There's a couple of other firms as
14 well.

15 Q. Suffice it to say, let me just ask this question
16 because I wasn't able to get this information
17 from an extraneous source at all, have you ever
18 written a report on behalf of a patient in a
19 medical malpractice case?

20 A. On behalf of a patient?

21 Q. Or the patient, the plaintiff.

22 A. The plaintiff. No.

23 Q. If I called you tomorrow and asked you to look at
24 a medical negligence case on behalf of a patient
25 in Cleveland, would you do it?

1 A. Yes.

2 Q. Okay. Doctor, what are you billing me per hour
3 for your deposition?

4 A. \$250 an hour with a two-hour minimum for
5 depositions.

6 Q. Okay. That's usually a detail we clear up up
7 front, but we've all been kind of busy. All
8 right.

9 I'm not going to go through your CV very
10 extensively. With great envy I noted that you
11 got to go to UVA, correct?

12 A. I did.

13 Q. And subsequent to that medical training, then you
14 went to New York for a little while, is that
15 right?

16 A. I was in residency in Rhode Island which is in
17 Nantucket, Rhode Island.

18 Q. Oh, you did a three-year residency in family
19 medicine?

20 A. Yes. Right.

21 Q. And then you went to New York?

22 A. After residency I came to Cleveland, subsequently
23 went to Stoneybrook, which is on Long Island in
24 New York, for two years, and then came back to
25 Cleveland in terms of location.

1 Q. Okay. Today we are at the Center For Family
2 Medicine, is that right?

3 A. That's right.

4 Q. And that's affiliated with MetroHealth Medical
5 Center?

6 A. No.

7 Q. Okay. There was confusion. Who is the center
8 affiliated with?

9 A. Okay. This is the Center For Family Medicine for
10 Fairview Hospital.

11 Q. Okay.

12 A. But since Fairview Hospital is part of the
13 Cleveland Clinic Health System, I'm actually a
14 Cleveland Clinic staff physician. Okay?

15 Q. Okay.

16 A. But the center is owned and operated by the
17 hospital, so it's not as simple as you might
18 think, but it has nothing to do with MetroHealth.

19 I did work at MetroHealth for eight years.

20 Q. All right. So the CV that I received that says
21 Department of Family Practice MetroHealth Medical
22 Center is a little outdated?

23 A. Yeah.

24 Q. I apologize for that.

25 A. Yeah.

1 Q. That's why I was confused when I got here, I went
2 hmm.

3 A. Yeah. I've been here for three years so this CV
4 is more than three years old.

5 Q. Do you want to supplement?

6 A. I can give you a new one at some point.

7 Q. That was current until about three years ago?

8 A. Right. I came here, it will be three years the
9 end of August three years ago.

10 Q. And you are a Cleveland Clinic employee, staff
11 physician?

12 A. That's correct.

13 Q. All right. You were board certified and
14 recertified in family practice, correct?

15 A. Correct.

16 Q. Doctor, tell me what you do, tell me what kind of
17 family practice you have?

18 A. Okay. This center is the teaching practice for
19 the residency program based in Fairview Hospital
20 in family practice.

21 Q. All right.

22 A. Which is also the Cleveland Clinic's family
23 practice residency program. So I'm one of six
24 full-time faculty, we call ourselves.
25 Administratively I'm the associate director for

1 education for the residency program, so that's
2 really the curriculum functions. We have another
3 associate director who runs the practice as the
4 medical director.

5 In terms of patient care, I spend about 70
6 percent of my time in patient care either in care
7 of my own patients or the care of patients that
8 I'm seeing with residents. I do hospital work
9 across the street at Fairview Hospital and I'm on
10 call for all of the patients that we admit and I
11 round on them every day one week out of six in
12 rotation with the other five faculty members.

13 Q. Okay.

14 A. And I teach residents and medical students. Most
15 of that teaching is done right here, some of it
16 is done elsewhere, but that's much the minority.

17 Q. Like the teaching lesson for syncope on the board
18 back there?

19 A. Right. This would have been part of a, you know,
20 a morning report kind of chalk talk discussion.

21 Q. All right. So customarily when you're not
22 sitting in a room with me giving a deposition
23 you're actually seeing patients?

24 A. Correct.

25 Q. You have a full patient calendar, so to speak, in

1 the mornings?

2 A. Well, I have my own, the way the practice is
3 divided is every patient has an assigned
4 physician, so I have my own practice plus
5 whenever residents are seeing their assigned
6 patients they have one or more faculty preceptors
7 who are essentially taking care of those patients
8 as supervisors of the residents.

9 Q. Okay. Good enough. I went through your CV and I
10 couldn't detect, just based on title alone,
11 whether or not you had the opportunity to author
12 any original material or put together a med
13 analysis relative to anything pertinent to this
14 case, that being retropharyngeal abscesses. Have
15 you written in that area?

16 A. No.

17 Q. In your career as a family practice physician,
18 have you ever had the opportunity to diagnose a

19 retropharyngeal abscess?

20 A. There is no specific case that I remember. It
21 might have happened once.

22 Q. Okay.

23 A. But I'm not sure about that.

24 Q. As you are actively involved in the instruction
25 of hopefully the best and the brightest of our

1 future residency family practice, I take it that
2 you would be teaching them about Strep throat?

3 A. Sure.

4 Q. Okay. Specifically, as you use the term, Strep
5 pharyngitis, correct?

6 A. Correct.

7 Q. Doctor, is a retropharyngeal abscess a
8 foreseeable possibility as a suppurative
9 complication of Strep pharyngitis?

10 A. It's a rare one, but it can happen, yes.

11 Q. Okay. I would gather that in the education of
12 our young men and young women who are going into
13 family practice that it's an area that you would
14 cover for them to be aware of?

15 A. Well, when we talk about Strep throat it's
16 usually at a much more basic, fundamental level,
17 but it certainly is a known complication and so
18 it might or might not get mentioned in any

19 particular discussion. But it certainly is not
20 something that we would be, you know, avoiding
21 mention of or anything like that.

22 Q. All right. I guess my point is this, that in
23 instructing young physicians you would want them
24 to be aware of the deadliest potential
25 complication of any particular kind of illness,

1 wouldn't you?

2 A. In a general sense, yes.

3 Q. Okay. What is your familiarity with the medical
4 literature regarding the survival statistics for
5 a person who acquires a retropharyngeal abscess?

6 A. I have no specific knowledge of that literature.

7 Q. Okay. Will you be testifying at trial, sometimes
8 we don't know what we're going to testify to, but
9 that's my purpose in being here today --

10 A. Right.

11 Q. -- is to find out everything you actually know.

12 A. Right.

13 Q. To your knowledge, will you be asked to provide a
14 statistical probability for survival in Mr. Kidd
15 based upon the progression of the illness?

16 A. I doubt that I'd be asked that. You're not
17 planning to ask me that, are you?

18 Q. Sometimes people are there to be the standard of
19 care experts and sometimes they're there to be
20 the causation experts.

21 A. Right.

22 Q. So that's all I'm trying to flush out.

23 A. Right. Yeah.

24 Q. You authored a report sometime ago, December 8,
25 2003. I just want to show you and make sure that

1 this is the only report that you authored?

2 A. That's correct.

3 Q. Okay. Had you worked with Steve Walters before
4 this?

5 A. I believe I might have, yes.

6 Q. Okay. It doesn't stick in your mind --

7 A. No.

8 Q. But you think you might have?

9 A. Yeah.

10 Q. Okay. When did Mr. Walters initially contact you
11 relative to offering an opinion on behalf of
12 Dr. Noall?

13 A. Probably not quite a year ago. I want to say
14 something like August or September 2003.

15 Q. Okay. Did he initially provide you -- let me ask
16 it this way: what did he initially provide you
17 with?

18 A. Certainly the medical record and I believe

19 Dr. Noall's deposition as well was part of what I
20 got initially. I believe these were the two
21 things I got at first.

22 Q. And at that point --

23 A. Subsequently I got other deposition testimony.

24 Q. Okay. And you got that other deposition
25 testimony before you wrote your report, is that

1 accurate?

2 A. Correct. I think in the report it lists what I
3 had reviewed at the time, so I could look at that
4 and tell you exactly.

5 Q. Yes. It says the materials I reviewed to date,
6 that's what I just didn't know, are copies of
7 pertinent medical records; copies of deposition
8 testimony transcript of Dr. Noall, several of her
9 office staff, Mrs. Kidd; plaintiffs' expert
10 opinion letters from Barnhart, Bogdasarian, and
11 Burke, and the autopsy?

12 A. That's correct.

13 Q. Okay. So you would have, initially did you offer
14 an opinion to Mr. Walters in a telephone
15 conversation?

16 A. Yes.

17 Q. Based on the medical records and Dr. Noall's --

18 A. And probably, I believe also on the basis of her

19 deposition.

20 Q. Okay. And then you subsequently received more
21 materials and then authored a report?

22 A. That's correct.

23 Q. Okay. Have you read the expert report of
24 Dr. Michael Papsidero?

25 A. No.

1 Q. Have you seen his deposition?

2 A. Yes.

3 Q. Okay. If I understand your opinion correctly,
4 and I think it's not that hard to understand
5 since you wrote it in plain English, you do not
6 believe that Dr. Noall deviated from the accepted
7 standards of medical care, correct?

8 A. Correct.

9 Q. Is it your belief and will you be testifying that
10 the actions of Mr. Kidd were the cause of his own
11 death?

12 A. I think they probably contributed to it.

13 Q. Based upon the continuum of time from first
14 presentation to the office until time of death,
15 do you have an opinion, doctor, to a reasonable
16 degree of medical probability, that you will be
17 offering, as to the last moment in time that
18 Mr. Kidd would have been salvageable had the

19 diagnosis been made?

20 A. I don't plan on testifying to that, no.

21 Q. Okay. You've indicated in your report, if you
22 have it obviously feel free to reference it, on
23 the second page you are discussing what you
24 believe to be behavior on the part of Mr. Kidd
25 that demonstrates a pattern of not following

1 medical recommendations and I'd like to talk
2 about those.

3 Your first, and I'm going to call it a
4 complaint against Mr. Kidd, is that he
5 demonstrated an inability to follow
6 recommendations by not taking prednisone; am I
7 reading that fairly?

8 A. Tell me where you are so I'm with you.

9 Q. Okay. Sorry. You've got a very long second to
10 last paragraph.

11 A. Okay.

12 Q. And it's in the middle towards the end. It says,
13 "During this episode, 11/26/01 through 2/1/01,
14 Mr. Kidd and/or Mrs. Kidd showed a pattern of not
15 following medical recommendations as demonstrated
16 by not taking prednisone." We will start with
17 that.

18 A. Right.

19 Q. Okay.

20 A. Now I know where you are.

21 Q. Okay. You have Dr. Noall's office records, do
22 you not, doctor?

23 A. I do.

24 Q. If we could turn to her office record,
25 specifically the one that was generated on

1 November 27th, 2001?

2 A. Okay.

3 Q. I direct your attention, doctor, to the last
4 sentence as transcribed in Dr. Noall's office
5 notes under assessment where it says, "He does
6 not have to use the prednisone if he chooses not
7 to," do you agree that's what Dr. Noall has
8 written?

9 A. Yes.

10 Q. Okay. And you've reviewed her testimony, have
11 you not?

12 A. Yes.

13 Q. Okay. Would you now agree with me that, contrary
14 to what you have put in your report, that she did
15 not direct him to take the prednisone, but left
16 it as an optional treatment modality should he
17 elect to do so?

18 MS. HESS: Objection.

19 A. That's correct. Although later in the same day
20 the emergency room suggested, based on seeing him
21 with a very severe sore throat, that he in fact
22 fill and take the prednisone and he doesn't.

23 Q. Okay. And, doctor, do you have some opinion to a
24 reasonable degree of medical probability based
25 upon your training and current occupation as a

1 family medicine physician that prednisone would
2 have helped Mr. Kidd in this case?

3 A. I don't think it would have affected his eventual
4 outcome. It probably would have helped the pain
5 that he was having.

6 Q. So it would have addressed only the pain.

7 Do you believe, doctor, that there might have
8 been a risk for a person with this particular
9 suppurative complication becoming sicker even
10 more quickly if he had taken prednisone?

11 A. Probably not.

12 Q. Okay. So medically in terms of the ultimate
13 outcome for Mr. Kidd, not taking prednisone is of
14 absolutely no effect, would you agree with that?

15 MS. HESS: Objection.

16 A. That's what I say in my report.

17 Q. Okay. Just so that we're very clear about that.

18 A. Yes.

19 Q. All right. Let's talk about the ED instructing
20 Mr. Kidd to follow up with Dr. Noall. Mr. Kidd
21 went to the ED in the evening on November 27th,
22 2001, agreed?

23 A. That's correct.

24 Q. Okay. So if someone tells you to follow up with
25 someone in two days you sort of add 48 hours,

1 would you agree with that?

2 A. No.

3 Q. Well, if someone doesn't tell a patient a date
4 and says, see your doctor in two days or contact
5 your doctor in two days, how do you know what the
6 patient interprets that to mean?

7 A. I don't know for sure what the patient would
8 interpret that to mean. I'm only telling you
9 what I would normally think it means.

10 Q. Okay. But that's you as a physician, correct, or
11 you as a person?

12 A. Me as a person.

13 Q. Okay. Because would you agree with me that the
14 ED doesn't list a date, they just say two days?

15 A. Right. But they usually mean not the next day
16 but the day after that and I think that would be
17 the most, what most people would understand with
18 that advice. They're not talking about see

19 Dr. Noall again on the evening of the second day.

20 Q. But see your doctor in two days leaves it kind of
21 open as to when that two days actually is, would
22 you agree with that?

23 MS. HESS: Objection. He just
24 answered that.

25 A. I think that what my understanding of that

1 recommendation would be to not be seen the
2 following day but the day after that.

3 Q. But you didn't know what Thomas Kidd thought that
4 meant, do you?

5 A. No, I don't.

6 Q. Okay. Your next complaint regarding Thomas Kidd
7 is followed by your ED complaint, refusal to be
8 evaluated by Dr. Noall on 11/30/01.

9 Doctor, did you read the deposition of Bob
10 Whelchel?

11 A. I did.

12 Q. I'm going to ask you to take out your copy. And
13 by the way, just for the record, the doctor did
14 graciously allow me to review his entire chart, I
15 have looked at the depositions and there are no
16 markings on any of the pages in any of them.

17 If you can turn to page 11 in Bob Whelchel's
18 deposition. Did you have an opportunity to read

19 pages 11, 12, and 13 of this deposition?

20 A. I read the entire deposition, yes.

21 Q. Okay. When you read it, did you come to
22 understand that Mrs. Kidd didn't refuse to come
23 in, but indicated that she'd prefer not to if
24 they didn't have to?

25 A. Well, let me just look through this again.

1 Q. Sure. Not a problem.

2 A. And refresh. Well, I see that he says, "so I
3 suggested that she take him to an urgent care.
4 She said he's been here the day before and the
5 two previous days before this." It sounds like
6 she doesn't want to go.

7 Q. Okay.

8 A. They don't have insurance and she really doesn't
9 want to do that if she doesn't have to.

10 Q. And he said, "Well, Dr. Noall is here in the
11 building, let me talk to her and see what she
12 suggests or recommends you to do," do you see
13 that?

14 A. Right.

15 Q. Okay. Now, no place else in that deposition does
16 he say that Robin Kidd refused to bring her
17 husband in, would you agree with that?

18 A. Well, this says, he didn't document the
19 insurance, he did document refused appointment at
20 urgent care, so he did document that. In fact
21 that's what's there. He didn't write about the
22 insurance aspect of it. But I think it's, to me
23 it's clear from the chart and the deposition
24 testimony that a recommendation to be seen was
25 made and the patient, through his wife's

1 interaction, decided not to do that, they chose
2 not to do that.

3 Q. I'm sorry for interrupting you. Did you read
4 Dr. Noall's deposition?

5 | A. I did.

6 Q. Can you point out where she says when Bob
7 Whelchel came to her and reported chest tightness
8 in Thomas Kidd that she said get him in here, is
9 that her testimony?

10 MS. HESS: Objection. I think
11 that's a different question.

12 A. I'd have to go back and look at what her
13 testimony is. We can look at that, if you want
14 to.

15 Q. You can. I'm going to ask you to make me aware
16 of where Dr. Noall testifies that in response to
17 receiving report from Bob Whelchel that she
18 instructs Bob to tell the patient to come in?

19 MS. HESS: Well, first, I don't
20 think he said that. I don't know why we're
21 looking for that.

22 A. Well, do you know where in this --

23 Q. No. I'm asking you if you're aware that there's
24 any such testimony?

25 MS. HESS: Well, I just want to

1 make sure the record is clear --

2 A. I think that she's made aware by her medical
3 assistant, by Bob, that this call is there, that
4 the patient does not want to come in and then,
5 based on that takes the action she takes. So
6 she's aware of the fact the patient is choosing
7 not to come in or go to urgent care. So it
8 depends what question she was asked as far as
9 what she may have answered.

10 Q. Is it clear to you that Dr. Noall did not speak
11 with the patient or the patient's wife?

12 A. Correct.

13 Q. And based upon a new report of chest tightness
14 she writes a prescription, doesn't she?

15 A. Well, she has a conversation with Bob and
16 following that she suggests, again, because she's
17 aware of the insurance, that they look for
18 samples of Soma, which is a muscle relaxant,

19 which the patient was requesting a muscle
20 relaxant for their symptoms. Apparently they
21 didn't have those samples, as best I can tell,
22 and so a prescription was called in.

23 Q. Doctor, did you --

24 A. So she didn't call that in, but she had Bob, I
25 believe, call it in.

1 Q. Do you give prescriptions for muscle relaxers to
2 patients who you haven't seen?

3 MS. HESS: Objection.

4 A. I wouldn't do that for someone I've never seen,
5 but I might well do that for someone that I knew.

6 Q. Is the same true for Vicodin?

7 A. On occasion, yes.

8 Q. Do you think that's good medical practice?

9 A. I think it's something that a physician needs to
10 decide, whether they're going to try and help
11 somebody that won't come in to see them or just
12 leave them hanging.

13 I think in this case Dr. Noall did the best
14 she could over the phone with the patient who had
15 a symptom that she thought she knew why she
16 thought he had it and wasn't willing to come in
17 to see her or be seen at urgent care, so she did
18 the best she could to treat it over the phone. I

19 think that's something that many family
20 physicians would do.

21 Q. Is the basis of your opinion in being supportive
22 of Dr. Noall that you've chosen to believe that
23 Robin Kidd refused for her husband to be seen on
24 the 30th?

25 MS. HESS: Objection to the word

1 chosen. Go ahead.

2 A. I would say that there's much more to it than
3 that as a basis.

4 Q. Well, first I'd like the answer to that question.
5 Is that one of your bases, that in order to
6 support your opinion are you telling me that the
7 jury will have to agree with you or believe that
8 Thomas Kidd refused treatment on November 30th?

9 MS. HESS: Well, object. I don't
10 know that he's going to say what the jury
11 is going to believe, but he can tell you
12 what his testimony will be. So go ahead.

13 A. Well, I believe that a recommendation was made
14 for them to either be seen in the office or in an
15 urgent or by somebody, urgent care, and that they
16 were, it was clear they didn't want to do that,
17 and based on that and based on a sense of what
18 she thought was going on to cause this new

19 symptom, she prescribed something over the phone.
20 So that, to me, is a sequence of events that's
21 not unusual in family practice, particularly for
22 patients that have financial means issues or not
23 adequate insurance coverage issues. It happens
24 day in and day out and in each case it's a
25 judgment call as far as the physician's side of

whether you just say, I'm sorry, I can't treat you unless I see you or you try your best to treat it over the phone. And I think that's the decision that was made in this case and it's not unusual or out of the standard of care to do that.

Q. Do you believe that if you're a physician -- well, you are a physician.

Do you believe a physician should, in circumstances where there's the onset of a new symptom in the situation where a couple of days previous you were concerned about the possibility of even a peritonsillar abscess, that you should insist that the patient come in and document that you believe that you need to see the patient?

A. I think that Dr. Noall's impression of this symptom was that it was unrelated to the visit of three days earlier and based on that, and based on a working diagnosis that this was a musculoskeletal problem related to the deer hunting that the patient had done, that's, that was the thought process that she was going through here. I think if she had thought that this was in fact related to the sore throat in some way that would have been a different

1 scenario.

2 Q. When Mrs. Kidd called in describing chest
3 tightness, how would Dr. Noall have known whether
4 that was musculoskeletal or the onset of a new
5 symptom not related to musculoskeletal pain?

6 A. Well, she had a conversation with, let's see,
7 which day was that, the 30th, so that was Bob,
8 right?

9 Q. Uh-huh.

10 A. So she had a conversation with Bob. Bob would
11 have relayed to her what, you know, how this was
12 described, which would have been in more detail
13 than just what's on this phone message, and it
14 would really be based on that conversation that
15 the decision was made. I mean, as well as what's
16 in the phone message, but there would have been a
17 lot more information conveyed to her than what's
18 in the phone message.

19 Q. And what's your level of understanding of Bob's
20 degree of medical training and his ability to
21 determine what the etiology of chest tightness is
22 from?

23 A. Well, he's a medical assistant. He has medical
24 assistant training. I don't think he's telling
25 Dr. Noall what the etiology is, I think he's just

1 describing the phone call that he's having with
2 the patient. And that's what he should do.
3 That's his job.

4 Q. Sitting here today do you have an opinion as to
5 what was the cause of the chest tightness on
6 November 30th?

7 A. It probably was related to infection in the
8 mediastinum.

9 Q. Okay. Do you have an opinion, doctor, that you
10 care to share with me as to why Mr. Kidd was
11 hallucinating on December 1st?

12 MS. HESS: In retrospect?

13 A. Well, he had taken some medication, Soma, that's
14 possible, he certainly had an infection, serious
15 infection, so it's one or more of those factors.
16 You could blame the Soma or you could blame the
17 infection or you could blame the Soma and the
18 infection. They're all possibilities.

19 Q. Based upon the autopsy, do you believe that he
20 was probably more likely than not septic at 10:50
21 on December 1st, 2001?

22 A. Probably he was, yes.

23 Q. And you think the patient should have taken the
24 Vicodin when she told him to take it the night
25 before?

1 A. Well, I think that in general I would expect a
2 patient to do what the doctor recommends, so in
3 this case I would say yes.

4 Q. And would taking the Vicodin have extended Thomas
5 Kidd's lifespan in this instance?

6 A. No.

7 Q. Okay. Generally speaking, past this criticism of
8 Mr. Kidd, can you outline for me what opinions
9 you're actually going to render at trial?

10 MS. HESS: Objection. Go ahead.

11 A. Well, I think they're all probably contained in
12 this letter, but I'm assuming that I'll be asked
13 about standard of care as it applies to
14 Dr. Noall's care. I don't know what other
15 questions I might be asked. I'll try to answer
16 any question you ask me.

17 Q. All right. Let's do it a different way.

18 A. I'm assuming I'm going to be asked that question.

19 Q. Okay.

20 A. Because that's what I was asked to review the
21 case about.

22 Q. All right. Do you have a reason to believe based
23 upon the materials that you've reviewed that we
24 have a specific criticism of Dr. Noall for
25 November 26th, 2001?

1 MS. HESS: Objection. I don't
2 know what you mean by "we".

3 A. Well, your plaintiffs' expert, Dr. Barnhart, has
4 lots of criticisms.

5 Q. Uh-huh.

6 A. So I would assume that you might have a criticism
7 based on his opinion letter.

8 Q. I'm sorry. I was just curious if you had
9 knowledge that we had a specific criticism of how
10 Dr. Noall cared for this patient on the 26th?

11 A. Didn't I just answer that?

12 Q. I don't think so.

13 MS. HESS: Other than Barnhart you
14 mean?

15 MS. KOLIS: Yeah.

16 MS. HESS: I don't understand the
17 question.

18 A. The only criticism that I've seen of what she did
19 on the 26th, that I can recall, anyway, was
20 Dr. Barnhart's criticism. Since he's your expert
21 I'm assuming that you might criticize what he did
22 that day.

23 Q. You mean what she did that day?

24 A. I'm sorry. What she did that day, yes.

25 Q. Okay. Doctor, do you instruct patients to keep

1 an eye out for uvular deviations?

2 MS. HESS: Objection. Go ahead.

3 A. It's not something I routinely do, but it's not
4 something that we routinely see either. I think
5 if there is a physical finding that I think a
6 patient is capable of appreciating that would
7 lead me to take some different action I will
8 usually try and inform the patient about that so
9 they have as much ability to help me help them as
10 I can. So I can imagine doing that with uvular
11 deviation, but it's not something I've done
12 before.

13 Q. How would you explain to a patient to watch for a
14 uvular deviation? Tell me how you would teach
15 them how to do that?

16 A. Well, if you look inside your mouth and in the
17 mirror or you have someone else look inside your
18 mouth, you look inside someone else's mouth, you
19 see that little uvula hanging down and it's right
20 in the middle. If you have uvular deviation it
21 would mean it's pushed off to one side. So I
22 would bring, if I were doing what Dr. Noall did,
23 I would take them to the mirror in the examining
24 room, I'd have them open their mouth and I'd show
25 them and I'd say there it is, that's what we're

1 talking about, that's what I'm looking for,
2 that's what I don't see today. If you looked at
3 it and you saw it off to one side call me right
4 away. I could imagine doing that. It's not
5 something I've done, but it doesn't seem
6 unreasonable to me to do that.

7 Q. Would they have to have a flashlight?

8 A. I mean, if they, if there's enough ambient light
9 in the room they might not. It would certainly
10 help to have a light.

11 Q. Do you think that someone could have an
12 accumulation of pus or whatever -- I hate that
13 word, I don't know why -- and it could be
14 deviated but they can't really appreciate it
15 because they're not medically trained?

16 MS. HESS: Objection. Go ahead.

17 A. I think it's very easy to see that it's in the
18 middle or not. That actually isn't very subtle

19 at all, so I think a layperson, once they
20 understood what a uvula was, what they were to
21 look at, they could see that. It's not hard to
22 see.

23 Q. What would you instruct your residents as to
24 being the signs and symptoms of a retropharyngeal
25 abscess?

1 A. Well, it's really a pretty wide spectrum of
2 possible signs and symptoms, so a lot depends on
3 what the mechanism of infection was. In this
4 case it was, it began as a Strep throat. In
5 other cases it might, for example, be a foreign
6 body penetration, like a fish bone or something
7 like that, so the presentation would vary a lot
8 on that.

9 Q. Let's talk about the presentation that's found in
10 association with Strep.

11 A. Okay. If you have a Strep throat you're going to
12 generally have sore throat as one of the symptoms
13 because you have a Strep throat there and that's
14 going to produce a sore throat. Other than that,
15 there might not be a lot of other symptoms.

16 Q. Can you not think of any other symptoms that you
17 would tell your residents would be indicative of
18 the existence of a retropharyngeal abscess?

19 A. Well, a lot depends on whether the collection of
20 pus stays localized or immediately tracks
21 downward. If it immediately tracks downward
22 you're not going to have much symptoms with a
23 Strep as the beginning of this, other than the
24 sore throat that the Strep has anyway, until it
25 actually gets down into the mediastinum and

1 starts to cause a mediastinitis, in which case
2 you're going to start to have some chest
3 symptoms.

4 Now, in either case you're probably going to
5 have some fever. That's a very nonspecific
6 symptom. You'd have that with a Strep infection
7 anyway most of the time. You may have some
8 difficulty swallowing because your throat is
9 sore. People may say I just feel like I have
10 some swelling in my neck, a very vague sort of
11 thing, but I wouldn't rely on that because that
12 can be absent. It's a hard diagnosis to make.

13 Q. Do you agree with Dr. Papsidero that a family
14 physician can't make this diagnosis?

15 MS. HESS: Objection. I don't
16 think that was the testimony.

17 A. I don't think that's what he said.

18 Q. If someone were to offer testimony that a family
19 practitioner cannot make this diagnosis, would
20 you agree or disagree with that?

21 MS. HESS: Objection. Go ahead.

22 A. Cannot I would disagree with.

23 Q. Okay. Would you agree or disagree that a family
24 practitioner is unlikely to make this diagnosis?

25 A. Well, in the sense that it's a rare event, it's

1 not something that we see a lot, and I think it's
2 a difficult diagnosis to make period.

3 Q. If you suspected, based on a continuum of
4 whatever symptoms it is that you're looking at,
5 that your patient was developing or had a
6 retropharyngeal abscess, would you refer them to
7 a specialist? What would you do with them?

8 A. If I were fairly sure that they had a
9 retropharyngeal abscess I would refer to a
10 specialist immediately. If I was not sure I
11 might do some kind of an imaging study.

12 Q. Such as?

13 A. Probably a CT scan, if that were available. If
14 it were not available I would do something else,
15 probably a lateral neck would almost always be
16 available. That would probably be the sort of
17 poor man's CT. And I would be somewhat reassured
18 by a normal lateral neck, but if I were still

19 concerned I might get the ENT involved. But a CT
20 would make the diagnosis for sure.

21 Q. All right. You wouldn't send them over to the ED
22 if you thought they had retropharyngeal abscess,
23 would you?

24 A. It would depend on the situation. Not if I could
25 get them into the ENT right away, no.

1 Q. All right. What, if anything, did you make of
2 Mr. Kidd's change in symptomatology that he
3 presented with on November 27th indicating that
4 one side of his throat seemed to be fine but now
5 the other side seemed more painful, did that have
6 any medical significance to you?

7 A. No.

8 Q. Okay. In preparing your opinions either for your
9 written report or those which you intend to
10 render at trial, doctor, have you relied upon any
11 medical literature?

12 A. No.

13 Q. Okay. I gather that since you're running the
14 residency program in family practice, that in
15 anticipation of preparing your kids -- we will
16 call them kids because they're kind of young --
17 to sit for their boards in family medicine, you
18 probably commend to their attention some

19 literature, would I be fair in thinking that?

20 MS. HESS: About this in
21 particular or just in general?

22 MS. KOLIS: No, just in general.

23 A. We use medical literature all the time.

24 Q. Harrison's Internal Medicine, is that something
25 you would consider to be reliable?

1 A. No.

2 Q. What sources do you use, to ask your residents to
3 use and read?

4 A. I suggest that they read a lot of things, none of
5 which I consider reliable.

6 Q. In terms of comprehensively reliable across the
7 board --

8 A. Particularly textbooks are notoriously out of
9 date, so it depends what the topic is as to
10 whether they would really even be worth looking
11 at.

12 Q. If you wanted your residents to educate
13 themselves about retropharyngeal abscesses, what
14 would you ask them to look at?

15 A. Well, we have a, it's not really on line, it's
16 more CD based, something called Up-to-Date and
17 that would be a good place to start. But it
18 would really depend on what the question was

19 about retropharyngeal abscess as to the best
20 place to look.

21 Q. How about how to make the diagnosis of
22 retropharyngeal abscess?

23 A. I haven't checked Up-to-Date to see what they
24 have, but since it's right here in the computer
25 and they have immediate access to it it would be

1 a good place to start. If they had an article on
2 it I would probably start there.

3 Q. Do you know Dr. Noall?

4 A. No.

5 Q. Never had any interaction with her?

6 A. As far as I know, I have not.

7 MS. KOLIS: Okay. Doctor, I don't
8 have any further questions for you.

9 A. Okay.

10 MS. HESS: We will have him read
11 it, but you can send it to him or me,
12 whatever is easier.

13 MS. KOLIS: We can waive the seven
14 days.

15 MS. HESS: Okay.

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ROBERT B. KELLY, M.D.

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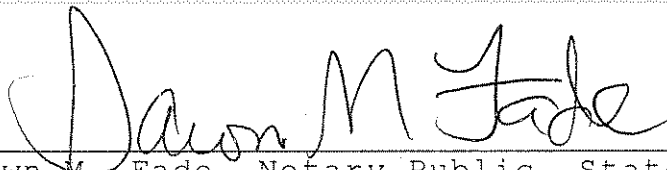
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C E R T I F I C A T E

The State of Ohio,) SS:
County of Cuyahoga.)

I, Dawn M. Fade, a Notary Public within and for the State of Ohio, authorized to administer oaths and to take and certify depositions, do hereby certify that the above-named witness was by me, before the giving of their 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 stenotypy, and was later transcribed into typewriting under my direction; that this is a true record of the testimony given by the witness; that said deposition was taken at the aforementioned time, date and place, pursuant to notice or stipulation of counsel; and that I am not a relative or employee or attorney of any of the parties, or a relative or employee of such attorney, or financially interested in this action; that I am not, nor is the court reporting firm with which I am affiliated, under a contract as defined in Civil Rule 28(D).

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office, at Cleveland, Ohio, this 21st day of July A.D. 20 07.



Dawn M. Fade, Notary Public, State of Ohio
1750 Midland Building, Cleveland, Ohio 44115
My commission expires October 27, 2007

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