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.

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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.

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On behalf of the Defendants.

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

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

BY MS. KOLIS:

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

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

A. That's correct.

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

A. Correct.

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

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

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

A. I do.

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

A. Correct.

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

A. You can.

Q. Great. If you promise not to be abusive in this regard, if I ask you a question that you clearly don't understand, and not at the prompting of the attorney that you don't understand it, but you, yourself, if you don't understand it, will you let me know that you don't understand what information I'm seeking?

A. I will.

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

computer information correct?
A. I was named once and dropped almost immediately.
Q. There you go. Now, see, the computer is actually pretty accurate.
How frequently do you review medical/legal matters?
A. Probably an average of about four times a year for the last 10, 12 years.
Q. Okay. And predominantly you are reviewing for physicians, is that correct?
A. Correct.
Q. Okay. Have you ever testified in a courtroom for a patient?
A. No.
Q. Have you testified in a courtroom for a doctor?
A. Yes.
Q. Okay. How many occasions?
A. Four.
Q. Okay. When is your most recent appearance in a courtroom?
A. It was this year about a month ago.
Q. And in which court? If you know the judge's name that's okay, but what county?
A. Which court? It was in Akron, so I'm not sure of the county.

Q. Do you remember --

MS. HESS: Summit County.

MS. KOLIS: Sure.

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

Q. Whom did you testify for?

A. You mean for the doctor or for --

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

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

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

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

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

Q. Okay.

A. Attorney's name was Brad Longbrake.

Q. All right.

A. And there was another attorney as well.

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

A. Right.

Q. Have you predominantly worked for Reminger & Reminger?

A. No, not predominantly. No.
Q. What other law firms have you worked for?
A. Ulmer & Berne in Cleveland.
Q. Murray Lenson?
A. Murray Lenson, yes, but there have been some other attorneys as well.
Q. All right.
A. There's a Toledo firm, Kitch, Drutchas and something.
Q. Uh-huh.
A. There's Hanna, Campbell & Powell; Fifner & Jeffers; Flaherty, Sensabaugh, Bonasso in Wheeling. There's a couple of other firms as well.
Q. Suffice it to say, let me just ask this question because I wasn't able to get this information from an extraneous source at all, have you ever written a report on behalf of a patient in a medical malpractice case?
A. On behalf of a patient?
Q. Or the patient, the plaintiff.
A. The plaintiff. No.
Q. If I called you tomorrow and asked you to look at a medical negligence case on behalf of a patient in Cleveland, would you do it?

A. Yes.
Q. Okay. Doctor, what are you billing me per hour for your deposition?
A. $250 an hour with a two-hour minimum for depositions.
Q. Okay. That's usually a detail we clear up up front, but we've all been kind of busy. All right.

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

A. I did.
Q. And subsequent to that medical training, then you went to New York for a little while, is that right?
A. I was in residency in Rhode Island which is in Nantucket, Rhode Island.
Q. Oh, you did a three-year residency in family medicine?
A. Yes. Right.
Q. And then you went to New York?
A. After residency I came to Cleveland, subsequently went to Stoneybrook, which is on Long Island in New York, for two years, and then came back to Cleveland in terms of location.

Q. Okay. Today we are at the Center For Family Medicine, is that right?
A. That's right.
Q. And that's affiliated with MetroHealth Medical Center?
A. No.
Q. Okay. There was confusion. Who is the center affiliated with?
A. Okay. This is the Center For Family Medicine for Fairview Hospital.
Q. Okay.
A. But since Fairview Hospital is part of the Cleveland Clinic Health System, I'm actually a Cleveland Clinic staff physician. Okay?
Q. Okay.
A. But the center is owned and operated by the hospital, so it's not as simple as you might think, but it has nothing to do with MetroHealth. I did work at MetroHealth for eight years.
Q. All right. So the CV that I received that says Department of Family Practice MetroHealth Medical Center is a little outdated?
A. Yeah.
Q. I apologize for that.
A. Yeah.

Q. That's why I was confused when I got here, I went hmm.
A. Yeah. I've been here for three years so this CV is more than three years old.
Q. Do you want to supplement?
A. I can give you a new one at some point.
Q. That was current until about three years ago?
A. Right. I came here, it will be three years the end of August three years ago.
Q. And you are a Cleveland Clinic employee, staff physician?
A. That's correct.
Q. All right. You were board certified and recertified in family practice, correct?
A. Correct.
Q. Doctor, tell me what you do, tell me what kind of family practice you have?
A. Okay. This center is the teaching practice for the residency program based in Fairview Hospital in family practice.
Q. All right.
A. Which is also the Cleveland Clinic's family practice residency program. So I'm one of six full-time faculty, we call ourselves. Administratively I'm the associate director for

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

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

Q. Okay.

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

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

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

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

A. Correct.

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

the mornings?

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

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

A. No.

Q. In your career as a family practice physician, have you ever had the opportunity to diagnose a retropharyngeal abscess?

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

Q. Okay.

A. But I'm not sure about that.

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

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

A. Sure.

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

A. Correct.

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

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

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

A. Well, when we talk about Strep throat it's usually at a much more basic, fundamental level, but it certainly is a known complication and so it might or might not get mentioned in any particular discussion. But it certainly is not something that we would be, you know, avoiding mention of or anything like that.

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

wouldn't you?
A. In a general sense, yes.
Q. Okay. What is your familiarity with the medical literature regarding the survival statistics for a person who acquires a retropharyngeal abscess?
A. I have no specific knowledge of that literature.
Q. Okay. Will you be testifying at trial, sometimes we don't know what we're going to testify to, but that's my purpose in being here today --
A. Right.
Q. -- is to find out everything you actually know.
A. Right.
Q. To your knowledge, will you be asked to provide a statistical probability for survival in Mr. Kidd based upon the progression of the illness?
A. I doubt that I'd be asked that. You're not planning to ask me that, are you?
Q. Sometimes people are there to be the standard of care experts and sometimes they're there to be the causation experts.
A. Right.
Q. So that's all I'm trying to flush out.
A. Right. Yeah.
Q. You authored a report sometime ago, December 8, 2003. I just want to show you and make sure that

this is the only report that you authored?
A. That's correct.
Q. Okay. Had you worked with Steve Walters before this?
A. I believe I might have, yes.
Q. Okay. It doesn't stick in your mind --
A. No.
Q. But you think you might have?
A. Yeah.
Q. Okay. When did Mr. Walters initially contact you relative to offering an opinion on behalf of Dr. Noall?
A. Probably not quite a year ago. I want to say something like August or September 2003.
Q. Okay. Did he initially provide you -- let me ask it this way: what did he initially provide you with?
A. Certainly the medical record and I believe Dr. Noall's deposition as well was part of what I got initially. I believe these were the two things I got at first.
Q. And at that point --
A. Subsequently I got other deposition testimony.
Q. Okay. And you got that other deposition testimony before you wrote your report, is that

accurate?
A. Correct. I think in the report it lists what I had reviewed at the time, so I could look at that and tell you exactly.
Q. Yes. It says the materials I reviewed to date, that's what I just didn't know, are copies of pertinent medical records; copies of deposition testimony transcript of Dr. Noall, several of her office staff, Mrs. Kidd; plaintiffs' expert opinion letters from Barnhart, Bogdasarian, and Burke, and the autopsy?
A. That's correct.
Q. Okay. So you would have, initially did you offer an opinion to Mr. Walters in a telephone conversation?
A. Yes.
Q. Based on the medical records and Dr. Noall's --
A. And probably, I believe also on the basis of her deposition.
Q. Okay. And then you subsequently received more materials and then authored a report?
A. That's correct.
Q. Okay. Have you read the expert report of Dr. Michael Papsidero?
A. No.

Q. Have you seen his deposition?
A. Yes.
Q. Okay. If I understand your opinion correctly, and I think it's not that hard to understand since you wrote it in plain English, you do not believe that Dr. Noall deviated from the accepted standards of medical care, correct?
A. Correct.
Q. Is it your belief and will you be testifying that the actions of Mr. Kidd were the cause of his own death?
A. I think they probably contributed to it.
Q. Based upon the continuum of time from first presentation to the office until time of death, do you have an opinion, doctor, to a reasonable degree of medical probability, that you will be offering, as to the last moment in time that Mr. Kidd would have been salvageable had the diagnosis been made?
A. I don't plan on testifying to that, no.
Q. Okay. You've indicated in your report, if you have it obviously feel free to reference it, on the second page you are discussing what you believe to be behavior on the part of Mr. Kidd that demonstrates a pattern of not following

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

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

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

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

A. Okay.

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

A. Right.

Q. Okay.

A. Now I know where you are.

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

A. I do.

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

November 27th, 2001?

A. Okay.

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

A. Yes.

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

A. Yes.

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

MS. HESS: Objection.

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

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

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

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

Q. So it would have addressed only the pain.

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

A. Probably not.

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

MS. HESS: Objection.

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

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

A. Yes.

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

A. That's correct.

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

would you agree with that?
A. No.
Q. Well, if someone doesn't tell a patient a date and says, see your doctor in two days or contact your doctor in two days, how do you know what the patient interprets that to mean?
A. I don't know for sure what the patient would interpret that to mean. I'm only telling you what I would normally think it means.
Q. Okay. But that's you as a physician, correct, or you as a person?
A. Me as a person.
Q. Okay. Because would you agree with me that the ED doesn't list a date, they just say two days?
A. Right. But they usually mean not the next day but the day after that and I think that would be the most, what most people would understand with that advice. They're not talking about see Dr. Noall again on the evening of the second day.
Q. But see your doctor in two days leaves it kind of open as to when that two days actually is, would you agree with that?
MS. HESS: Objection. He just answered that.
A. I think that what my understanding of that

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

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

A. No, I don't.

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

Doctor, did you read the deposition of Bob Whelchel?

A. I did.

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

If you can turn to page 11 in Bob Whelchel's deposition. Did you have an opportunity to read pages 11, 12, and 13 of this deposition?

A. I read the entire deposition, yes.

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

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

Q. Sure. Not a problem.
A. And refresh. Well, I see that he says, "so I suggested that she take him to an urgent care. She said he's been here the day before and the two previous days before this." It sounds like she doesn't want to go.
Q. Okay.
A. They don't have insurance and she really doesn't want to do that if she doesn't have to.
Q. And he said, "Well, Dr. Noall is here in the building, let me talk to her and see what she suggests or recommends you to do," do you see that?
A. Right.
Q. Okay. Now, no place else in that deposition does he say that Robin Kidd refused to bring her husband in, would you agree with that?
A. Well, this says, he didn't document the insurance, he did document refused appointment at urgent care, so he did document that. In fact that's what's there. He didn't write about the insurance aspect of it. But I think it's, to me it's clear from the chart and the deposition testimony that a recommendation to be seen was made and the patient, through his wife's

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

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

A. I did.

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

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

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

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

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

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

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

MS. HESS: Well, I just want to

make sure the record is clear --

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

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

A. Correct.

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

A. Well, she has a conversation with Bob and following that she suggests, again, because she's aware of the insurance, that they look for samples of Soma, which is a muscle relaxant, which the patient was requesting a muscle relaxant for their symptoms. Apparently they didn't have those samples, as best I can tell, and so a prescription was called in.

Q. Doctor, did you --

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

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

MS. HESS: Objection.

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

Q. Is the same true for Vicodin?

A. On occasion, yes.

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

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

I think in this case Dr. Noall did the best she could over the phone with the patient who had a symptom that she thought she knew why she thought he had it and wasn't willing to come in to see her or be seen at urgent care, so she did the best she could to treat it over the phone. I think that's something that many family physicians would do.

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

MS. HESS: Objection to the word

chosen. Go ahead.

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

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

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

A. Well, I believe that a recommendation was made for them to either be seen in the office or in an urgent or by somebody, urgent care, and that they were, it was clear they didn't want to do that and based on that and based on a sense of what she thought was going on to cause this new symptom, she prescribed something over the phone. So that, to me, is a sequence of events that's not unusual in family practice, particularly for patients that have financial means issues or not adequate insurance coverage issues. It happens day in and day out and in each case it's a 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

scenario.

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

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

Q. Uh-huh.

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

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

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

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

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

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

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

MS. HESS: In retrospect?

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

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

A. Probably he was, yes.

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

A. Well, I think that in general I would expect a patient to do what the doctor recommends, so in this case I would say yes.
Q. And would taking the Vicodin have extended Thomas Kidd's lifespan in this instance?
A. No.
Q. Okay. Generally speaking, past this criticism of Mr. Kidd, can you outline for me what opinions you're actually going to render at trial?
MS. HESS: Objection. Go ahead.
A. Well, I think they're all probably contained in this letter, but I'm assuming that I'll be asked about standard of care as it applies to Dr. Noall's care. I don't know what other questions I might be asked. I'll try to answer any question you ask me.
Q. All right. Let's do it a different way.
A. I'm assuming I'm going to be asked that question.
Q. Okay.
A. Because that's what I was asked to review the case about.
Q. All right. Do you have a reason to believe based upon the materials that you've reviewed that we have a specific criticism of Dr. Noall for November 26th, 2001?

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

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

Q. Uh-huh.

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

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

A. Didn't I just answer that?

Q. I don't think so.

MS. HESS: Other than Barnhart you mean?

MS. KOLIS: Yeah.

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

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

Q. You mean what she did that day?

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

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

an eye out for uvular deviations?

MS. HESS: Objection. Go ahead.

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

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

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

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

Q. Would they have to have a flashlight?

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

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

MS. HESS: Objection. Go ahead.

A. I think it's very easy to see that it's in the middle or not. That actually isn't very subtle at all, so I think a layperson, once they understood what a uvula was, what they were to look at, they could see that. It's not hard to see.

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

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

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

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

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

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

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

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

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

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

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

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

MS. HESS: Objection. Go ahead.

A. Cannot I would disagree with.

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

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

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

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

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

Q. Such as?

A. Probably a CT scan, if that were available. If it were not available I would do something else, probably a lateral neck would almost always be available. That would probably be the sort of poor man's CT. And I would be somewhat reassured by a normal lateral neck, but if I were still concerned I might get the ENT involved. But a CT would make the diagnosis for sure.

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

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

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

A. No.

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

A. No.

Q. Okay. I gather that since you're running the residency program in family practice, that in anticipation of preparing your kids -- we will call them kids because they're kind of young -- to sit for their boards in family medicine, you probably commend to their attention some literature, would I be fair in thinking that?

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

MS. KOLIS: No, just in general.

A. We use medical literature all the time.

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

A. No.
Q. What sources do you use, to ask your residents to use and read?
A. I suggest that they read a lot of things, none of which I consider reliable.
Q. In terms of comprehensively reliable across the board --
A. Particularly textbooks are notoriously out of date, so it depends what the topic is as to whether they would really even be worth looking at.
Q. If you wanted your residents to educate themselves about retropharyngeal abscesses, what would you ask them to look at?
A. Well, we have a, it's not really on line, it's more CD based, something called Up-to-Date and that would be a good place to start. But it would really depend on what the question was about retropharyngeal abscess as to the best place to look.
Q. How about how to make the diagnosis of retropharyngeal abscess?
A. I haven't checked Up-to-Date to see what they have, but since it's right here in the computer and they have immediate access to it it would be

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

Q. Do you know Dr. Noall?

A. No.

Q. Never had any interaction with her?

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

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

A. Okay.

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

MS. KOLIS: We can waive the seven days.

MS. HESS: Okay.

ROBERT B. KELLY, M.D.

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 04.

Dawn M. Fade

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

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