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.

- - - -

Deposition of CAROL L. NOALL, 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 offices of Reminger & Reminger, 1400 Midland Building, Cleveland, Ohio, at 10:10 a.m. on Wednesday, August 20, 2003, 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.

W I T N E S S I N D E X

E X H I B I T I N D E X

CAROL L. NOALL, 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 CAROL L. NOALL, M.D.

BY MR. CONWAY:

Q. Doctor, would you state your name for the record spelling your full name for the court reporter.

A. Carol Lynn Noall, Carol is C-a-r-o-l, Lynn is L-y-n-n, and Noall is N-o-a-l-l.

Q. Doctor, I'm going to be taking your deposition this morning. I represent the family of Thomas Kidd who was formerly a patient of yours. I'm going to be asking you questions of your knowledge of the care and treatment that was rendered to Mr. Kidd as well as any opinions you may have regarding this case.

I would ask that you don't answer a question that you don't understand. If you don't understand a question make sure you indicate that to me and I'll be glad to restate or rephrase it so that you do understand it. If you do answer a question I'm going to assume and rely upon the

fact that you understood it, is that fair?
A. Yes.
Q. If at any time you want to take a break to talk with your attorney or take a break for any other reason just indicate that to us and we will be glad to do so.

If at any time during the deposition you decide that you want to go back and change, supplement, modify an answer you are free to do so, you may go on the record and say whatever you want, okay?
A. Yes.
Q. This is going to be my only opportunity to talk with you prior to trial and I want to make sure that you have an opportunity to say whatever you'd like, okay?
A. Yes.
Q. You've had an opportunity to prepare for this deposition with your attorney, correct?
A. Yes.
Q. Have you been deposed previously?
A. For this case?
Q. For any case.
A. Yes.
Q. Approximately how many times have you given prior

depositions?

A. Just once.

Q. So you understand that everything you say is being taken down by the court reporter, that you're under oath and that this has the same legal significance as if you were in front of a judge and jury, you understand all that?

A. Yes.

Q. All right. Would you agree that Thomas Kidd's death was caused by an untreated and undiagnosed retropharyngeal abscess?

A. I think the accurate diagnosis was mediastinal abscess.

Q. By the way, did you bring your original chart today?

A. No.

Q. Okay. Do you have an original chart that you possess in this case?

A. At the office.

Q. Okay. Is there any reason you didn't bring the original chart today?

A. I didn't know to.

Q. Okay. There was a notice of deposition sent out in which I had requested the original chart.

MR. WALTERS: I forgot. I

apologize.

MR. CONWAY: Okay.

Q. Doctor, I'll contact your attorney, I'm going to want to set up a time convenient to you where I can inspect the original chart as well as any phone messages or billing statements.

MR. WALTERS: Just so it's clear, that was my fault, I forgot and --

MR. CONWAY: Okay.

MR. WALTERS: -- if in fact Mr. Conway has additional questions as it relates to reviewing the original chart we will make, Dr. Noall will be available for you.

MR. CONWAY: All right. But I'd like to set up a time where I can review --

MR. WALTERS: That's fine.

MR. CONWAY: All right. Fine.

MR. WALTERS: You want to take depos of the other people --

MR. CONWAY: Correct.

MR. WALTERS: -- that were involved in this case.

MR. CONWAY: That were involved in

the charting.

MR. WALTERS: We will do that on a day -- okay. Let's go.

Q. You've had an opportunity to review the autopsy report in this case, haven't you?

A. Actually I have not.

Q. Okay. You were present during the time period, you were present in the company of the coroner, Dr. Rizzo, R-i-z-z-o, while he was conducting part of the autopsy, correct?

A. Yes.

Q. All right. So you had an opportunity to talk to Dr. Rizzo regarding his autopsy, correct?

A. Yes.

Q. Did you request of Dr. Rizzo to view the final autopsy report?

A. No.

Q. Why not?

A. I thought it would just be sent to me, I didn't know I had to request one. I've had others sent to me without asking.

Q. Did Dr. Rizzo tell you at the time you were present with him during the autopsy what his opinion was regarding the cause of death?

A. Can you repeat that?

MR. CONWAY: Could you read that back, please.

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(Thereupon, the requested portion of the record was read by the Notary.)

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A. Dr. Rizzo probably himself did not, the actual person doing the autopsy did.

Q. Well, were you present with Dr. Rizzo when he spoke with Robin Kidd?

A. No.

Q. What days were you at the coroner's office when Dr. Rizzo was involved in parts of the autopsy of this case?

A. I believe the autopsy was December 2nd. I was there at the actual autopsy.

Q. Were you there the whole time during the autopsy?

A. I think so.

Q. And you never followed up with Dr. Rizzo following the autopsy to see what his conclusions were?

A. It was obvious at the time of the autopsy when it was happening.

Q. Dr. Rizzo in the autopsy report says after cause, abscess of the retropharynx, paratracheal and

paraesophageal soft tissue, mediastinum, and pleural spaces. Is that a retropharyngeal abscess we're talking about?

A. I would say a retropharyngeal abscess, it's probably a matter of semantics, but retropharyngeal abscess would be in this area, he truly had an abscess in his mediastinum which was the major cause of his death.

Q. The abscess in the mediastinum, was that a consequence or did that flow from a retropharyngeal abscess?

MR. WALTERS: Object to the form.

A. Yes.

Q. Because after that the cause of death --

MR. CONWAY: We can mark the autopsy report. Why don't we mark this as an exhibit.

- - - -

(Thereupon, Plaintiffs' Exhibit 1, six-page Autopsy Report, was marked for purposes of identification.)

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Q. Showing you what has been marked for identification as Plaintiffs' Exhibit Number 1, this is Dr. Rizzo's autopsy report listing the

cause of death. Do you agree with --

MR. WALTERS: Well, wait a second. Let her review. I don't want her -- the final diagnosis is contained on page 2. I would like, if you're going to ask her questions about Dr. Rizzo's opinions then I want her to have an opportunity, since she has not seen this document before, to take a look at it.

MR. CONWAY: That's fine.

MR. WALTERS: See what he actually says.

A. Should I read this?

MR. WALTERS: It's up to you. I don't know where he's going with this, so I can't -- if he asks a question and you need to review that document more specifically as it relates to the individual anatomic description then do it. So go ahead, Tom.

Q. By the way, doctor, you have available in front of you a copy of your chart, is that correct?

A. Yes.

Q. Do you have in front of you available a copy of the chart from Lake Hospital?

A. From the emergency room.

MR. WALTERS: We have emergency room records.

MR. CONWAY: Yes. Okay.

MR. WALTERS: I don't know if there are other records.

Q. All right. If at any time you want to refer to the autopsy protocol, the Lake emergency room hospital records, or your chart feel free at any time to do so, okay?

A. Okay.

Q. Do you agree with Dr. Rizzo's cause of death?

A. Yes.

Q. Do you agree that with the language following the due to?

MR. WALTERS: Well, wait. I'll object to the form of the question. Go ahead. Do you agree with the due to?

A. Yes.

Q. Okay. Ultimately Thomas Kidd died as a result of an untreated retropharyngeal abscess, correct?

MR. WALTERS: Objection.

A. It was -- yes.

Q. All right. He had that retropharyngeal abscess at the time you were rendering medical care and treatment to him, correct?

A. At the time of the visit that I saw him, is that what you mean?
Q. Your office was rendering medical care and treatment to Mr. Kidd up through December 1st, correct?
A. I treated him over the phone.
Q. Okay. So from the time period of November 26th up and through December 1st you were rendering medical care and treatment to Thomas Kidd, correct?
A. Yes.
Q. And during that time period he had a retropharyngeal abscess, correct?
A. He developed it, yes, during that time period.
Q. All right. And his death was caused by your failure to diagnose and treat that retropharyngeal abscess, correct?

MR. WALTERS: Objection.

A. I was unable to diagnose it adequately.
Q. And you were, you did not treat it, correct?
A. I treated the initial Strep infection and that part was treated adequately. At the second visit I gave him a prescription for Prednisone which would have helped to treat a peritonsillar abscess presuming that that was starting at that

time. So I did attempt to treat it in the event that it was occurring. I wasn't sure if indeed it was occurring at that time. I don't believe he ever took that prescription. If it was a, if it was, if it was occurring at that time that would have been a good medication to take at the time.

MR. CONWAY: Can you read back my question, please.

- - - -

(Thereupon, the requested portion of the record was read by the Notary.)

- - - -

A. I think --

MR. WALTERS: Wait. Wait. You answered it once. Let him ask --

Q. Do you believe that you adequately treated --

MR. WALTERS: Let him ask another question.

Q. Do you believe that you adequately treated Mr. Kidd's retropharyngeal abscess?

MR. WALTERS: First of all, objection. I'm not -- you started with the autopsy of a retropharyngeal abscess and now you're suggesting that that diagnosis

was made during the care and treatment and that's what you're suggesting based upon your question and that diagnosis wasn't made during the care and treatment of this patient and you know that.

MR. CONWAY: That wasn't what my question was.

MR. WALTERS: Yeah, it is. It's an unfair question. It's like saying, Tom, it's equivalent to saying I have, I end up on the autopsy table tomorrow and I have cancer and my doctor has seen me for, because I had some breathing problems along the line and you say to my doctor, do you believe you had adequately treated his cancer, well, I didn't know he had the cancer. You know, it's two separate things.

Q. Doctor, going back to my question prior to your last answer. You did not at the time that you were treating Mr. Kidd know that he had a retropharyngeal abscess, did you?

A. No.

Q. All right. So you failed to diagnose that condition, correct?

A. I was really unable to diagnose that condition.
Q. Your failure to diagnose and treat that condition was the cause of his death, correct?
MR. WALTERS: You don't even have to answer that question. She said she was unable to diagnose it. You then said her failure. She answered your question when you said you failed to diagnose it, she said I was unable to diagnose it, and then you followed up with a misconstrued answer by saying your failure.
MR. CONWAY: All right.
MR. WALTERS: Maybe you should listen to her answers before she answers, before you ask the next question.
Q. Let's use the term inability then, doctor. Your inability to diagnose Mr. Kidd's retropharyngeal abscess caused his death, correct?
MR. WALTERS: No. Objection.
A. Am I still supposed to answer this?
Q. Yes.
MR. WALTERS: If you can.
A. I don't know that I can answer that.
Q. Why not?
A. The cause of his death doesn't necessarily have

to do with my ability or inability to answer it or to diagnose it anyways. If it was, if he indeed developed this mediastinal abscess it's a, it's tough to get better from that regardless.

Q. How did he develop, in your opinion, this mediastinal abscess, doctor?

A. He did develop a peritonsillar abscess which perforated and went down into the mediastinal cavity.

Q. You're stating that he developed a peritonsillar abscess?

A. Yes.

Q. Is there a difference, doctor, between a retropharyngeal abscess and a peritonsillar abscess?

A. I think peritonsillar is just an area in the retropharynx, so it's basically the same thing.

Q. Is that your understanding of Dr. Rizzo's autopsy report, that the use of retropharyngeal is synonymous with peritonsillar?

A. Yes.

Q. Okay.

MR. WALTERS: I'll object only because I don't know how she could know what Dr. Rizzo means, but go ahead.

Q. Doctor, are you a family practice physician?
A. Yes.
Q. Okay. Did you pass the board certifications on your first attempt?
A. Yes.
Q. Is there a journal that's recognized by family practice physicians in this country as being a reliable family practice journal?
A. I think we pretty much all read the American Family Physician.
Q. Do you have a subscription to that journal?
A. Yes.
Q. Do you keep current with the literature in that journal?
A. Pretty much.
Q. Do you find that journal to be reliable in your practice of family practice medicine?
A. Pretty much.
Q. Okay. Where is, where would a retropharyngeal abscess develop as opposed to a peritonsillar abscess, doctor, in your opinion?
A. Anywhere in the pharynx, basically anywhere like below, I don't really know the exact semantics, an ear, nose, and throat doctor probably would be better at saying what the retropharyngeal space

would be, but behind the tonsils or around the tonsils and below.

Q. Is considered what space?

A. The retropharyngeal space.

Q. All right. And where, in your opinion, is the peritonsillar space?

A. All around the tonsil.

Q. Doctor, did you ever consider referring Mr. Kidd to an ear, nose, and throat specialist?

A. No.

Q. Why not?

A. At this point in time when I had seen him he did not --

MR. WALTERS: At which point? You're talking about ever?

MR. CONWAY: Correct.

MR. WALTERS: Well, I'm only, Tom, I'm not trying to be, but he refused to come in on three separate occasions so I don't know which date you want her to refer, make the referral. Are you talking about the 26th, the 27th? You know, that's why I'm struggling with this in terms of fairness to the questions that are being asked.

Q. Doctor, at any time during your care and treatment of Mr. Kidd did you consider referring him to an ear, nose, and throat specialist?
A. No.
Q. Why not?
A. When I saw him initially he had Strep which we treat in our office routinely and does not require an ear, nose, and throat specialist. The second day that I saw him, I was looking for a peritonsillar abscess at that point in time, I did not see one and there was no need to see an ear, nose, and throat doctor at that time. I did give him the Prednisone treatments to help decrease the swelling, which is also given in the case of a peritonsillar abscess, and I felt at that time if one was starting that would prevent it from going anywhere and at that time I also told him to let me know if any signs of a peritonsillar abscess should develop.
Q. How about on November 30th, did you at any time consider referring him to an ear, nose, and throat specialist?
A. That's when he called? At that point in time this seemed to be a completely different problem, when my nurse had talked to him he actually said

that the throat problem was better.

Q. Is that documented anywhere on your nurses' notes?

A. I think it's documented on the one from December 1st.

Q. Where on December 1st does it say the throat was better?

A. There's a thing in parentheses, it says slight fever and no throat, I can't read what it says there, but no throat problems I think is what it says there.

Q. We'll come back to going through all these in a moment.

So those would be reasons why you didn't consider it appropriate to refer him to an ear, nose, and throat specialist?

A. At this point in time I didn't think the throat was the issue any more. I thought it was all muscle spasms that he was having.

Q. What did you believe was causing the muscle spasms on December 1st and November 30th?

A. He had been deer hunting prior to coming in for the initial Strep infection and I thought that he had just developed some muscle soreness from the deer hunting.

Q. From deer hunting prior to November 26th you believed that that had caused him muscle soreness resulting in his symptoms on November 30th and December 1st?
A. That's what I thought.
Q. Doctor, what is a differential diagnosis?
A. It is a list of diagnoses that we think of when a certain symptom complex occurs.
Q. Okay. It would be a list of possible causes of a patient's condition?
A. Yes.
Q. Would you agree that you need to list the possible serious or life-threatening conditions at the top of that differential whether or not they are necessarily the most common conditions?
A. Yes.
Q. Doctor, what is an abscess?
A. It's an infected space.
Q. Is it filled with anything?
A. Pus.
Q. Okay. Now, on November 27, 2001 you considered the possibility that Mr. Kidd had a peritonsillar abscess, correct?
A. Could you repeat that?
Q. On November 27th, 2001 you considered the

possibility that Mr. Kidd had a peritonsillar abscess, correct?

A. Yes.

Q. And was one of the reasons you were considering that condition was because he did not have adequate improvement after his penicillin shot the day previous?

A. I had considered that because that can happen. Actually I told him that it takes about 24 hours for the shot to kick in and at that point in time it had only been about 18 hours.

Q. On November 27th why did you consider the possibility that he may have a peritonsillar abscess?

A. It just needs to be considered as a possible worse thing than Strep.

Q. And peritonsillar abscess occurs to men in their 30s and 40s, would you agree?

A. It can happen.

Q. And that specific type of infection or abscess is caused by the group A beta-hemolytic Streptococcus, correct, most commonly?

A. I'm not an ear, nose, and throat doctor, but I believe Staph and Strep are the two biggest causes.

Q. You made a determination here that in fact on November 26th that Mr. Kidd was suffering from Strep A, correct?
A. Yes.
Q. Would you agree that a retropharyngeal abscess also occurs in the throat and is also caused by group A beta-hemolytic Streptococcus?
A. It may be caused by that, yes.
Q. Would it have been reasonable for you to consider the possibility that in addition to possibly suffering from a peritonsillar abscess on November 27th Mr. Kidd may also have been suffering from a retropharyngeal abscess?

MR. WALTERS: I'll object to the form as to a reasonable possibility. Go ahead.

A. Well, I'm basically using peritonsillar and retropharyngeal abscess as the same terminology.
Q. Does the medical literature recognize a difference between those two conditions?
A. I don't know.
Q. Would that be something important to know?
A. Not for --

MR. WALTERS: Depends on what literature you're talking about.

MR. CONWAY: American family practice literature.

A. Peritonsillar abscess is usually the wording that I see and that's what, when I've spoken with ear, nose, and throat doctors that's usually the wording we use. I believe retropharyngeal abscess is synonymous, but an ear, nose, and throat doctor probably would be better to say the difference.

Q. Do you think the standard of care would require, if there is a distinction between those two conditions, for a family practice physician to know them?

A. I think the treatment is the same regardless.

Q. Do you think the standard of care, though, would require the family practice physician to know the difference if one exists between a retropharyngeal abscess and a peritonsillar abscess?

MR. WALTERS: Objection. Go ahead.

A. I don't really think so because I think it's the same thing.

Q. What diagnostic tools are used to rule in or rule

out the existence of a peritonsillar abscess?
A. Physical exam.
Q. Okay. Anything else?
A. That's it.
Q. How about a neck x-ray?
A. Physical exam is the thing that we use first to determine if anything else is required. I have really never had to get an x-ray on anybody for a peritonsillar abscess. You can visually see it.
Q. Have you ever diagnosed any previous patients with a peritonsillar abscess?
A. Yes.
Q. Okay. Approximately how many?
A. I don't really know. Definitely in the tens, probably 50. Maybe not that many.
Q. How was your diagnosis of peritonsillar abscess confirmed?
A. I'm sorry, could you repeat that?
Q. Yeah. How were, in those particular cases where you had patients who were diagnosed with peritonsillar abscess, how were those diagnoses confirmed?
A. When I diagnosed it myself I sent them to ear, nose, and throat doctors who would subsequently drain it.

Q. Would have done a needle aspiration and determined in fact there was an abscess, correct?
A. Yes.
Q. And then at that point you would have run a culture on the pus to determine antibiotic sensitivity or resistance, correct?
A. I'm not sure what they would do next. Usually we treat empirically. I don't know if they routinely send it for culture or not.
Q. Can you diagnose, doctor, to your knowledge, a peritonsillar abscess by way of an x-ray of the neck?
A. An x-ray of the neck would show up sometimes, not necessarily even all the time, evidence of an abscess.
Q. Would a CT scan of the neck show evidence of a peritonsillar abscess?
A. It certainly could.
Q. Would an ultrasound of the neck show a peritonsillar abscess?
A. I don't know about an ultrasound. I'm not sure if that modality is used for that.
Q. Do you know which of those modalities that I've just asked you questions about is considered the most reliable way to diagnose a peritonsillar

abscess?

A. I don't know the answer to that. I would bet a CT, but I'm not the person to ask on that.

Q. Okay. Why did you not consider having any type of radiology or radiological -- strike that.

Why did you not -- strike that.

Why didn't you consider having a neck x-ray or a CT scan or an ultrasound performed on Thomas Kidd?

MR. WALTERS: Object to the three questions, but go ahead.

A. The physical exam didn't warrant it.

Q. Is a peritonsillar abscess a medical emergency?

A. I would say it's probably a medical urgency. We usually get them in with the ear, nose, and throat doctor that day.

Q. If untreated a peritonsillar abscess can cause serious illness as well as death, correct?

A. Yes.

Q. And do you know the mechanics as to how an untreated peritonsillar abscess can cause death?

A. I think as evidenced in this case if it perforates it can cause worse abscess elsewhere.

Q. Cause sepsis?

A. Yes.

Q. Septic shock and death, correct?
A. Sure.
Q. At any time did you consider having a CBC count of Mr. Kidd's blood taken or performed?
MR. WALTERS: You mean on the 26th or 27th?
Q. On the 26th or the 27th. We can start there.
MR. WALTERS: Okay. Well, I don't know where else to start. He refused to come in on the other occasions.
MR. CONWAY: Okay. Steve, if I can just go on the record for a second.
MR. WALTERS: Sure. You're on the record. You're always on the record unless we go off.
MR. CONWAY: But I can't talk while you're talking simultaneously so that's why I make that little request.
Q. If you don't understand a question just indicate that to me and I'll be glad to rephrase it for you. If Mr. Walters doesn't understand a question I'm going to do him the same gracious favor. However, regardless, he has made this clear, I don't know, three or four times, that Mr. Kidd did not come in on certain dates. I'm

not asking whether he came in on those days at this point. What I'm asking is at any time during your care and treatment of Mr. Kidd did you consider getting a CBC performed? That's all.

A. No, for the Strep you don't require a CBC. Oftentimes white blood count is going to be elevated and it doesn't suggest anything.

Q. Did you consider on either November 27th or November 30th or December 1st of having a CBC done?

A. No.

Q. Why not?

A. I didn't see him to be able to do it anyways.

Q. Did you discuss over the phone with either him or his wife the fact that, the issue of having a CBC performed --

A. No.

Q. -- at any time?

In fact, you never spoke with Mr. Kidd or his wife directly on the phone, did you?

A. Not on the phone.

Q. Okay. So from November, following November 27th you had no personal contact with either Mr. Kidd or his wife either in person or over the phone,

is that correct?

A. I actually talked to her after he died, but that was it.

Q. All right. But prior to his death, subsequent to your office visit on the 27th, you never spoke with either him or his wife, correct?

A. Correct.

Q. Those would have been your office staff that would have been speaking with either him or the wife, correct?

A. Yes.

Q. And they were employed by you, correct?

A. They were employed by Prime Health which is also my employer.

Q. Does the standard of care require a family practice physician, if that family practice physician suspects that a patient is suffering from a peritonsillar abscess, to immediately take steps to determine whether or not there is a peritonsillar abscess?

A. I'm sorry, could you repeat that one more time?

MR. CONWAY: Would you read it back.

- - - -

(Thereupon, the requested portion of

the record was read by the Notary.)

- - - -

A. That question is kind of confusing to me. I basically determine if the patient has a peritonsillar abscess so I guess I don't know that there's other steps to take. I would refer to the ear, nose, and throat doctor to treat it. It's not basically to confirm my diagnosis, I basically have made the diagnosis and the ear, nose, and throat doctor would just treat it, so I don't understand what you mean as far as confirming the diagnosis.

Q. Well, you were considering the possibility that he had a peritonsillar abscess on November 27th, right?

A. I was considering it when I saw his exam, I knew at that time he did not have one. With the Prednisone treatment I was hoping to --

MR. WALTERS: You answered. Let him ask another question.

Q. Let's talk about the Prednisone treatment. Do you believe treating a patient such as Thomas Kidd who has confirmed Strep throat with the possibility of a peritonsillar abscess, do you believe that treating such a patient with

Prednisone comports with the standard of care?
A. Steroids are used in that instance, yes.
Q. Can you cite me any supporting authority?
A. No.
Q. Why would you treat a patient who possibly has a peritonsillar abscess with Prednisone?
A. It helps with the inflammation.
Q. Any other reasons you would use Prednisone?
A. It's helpful in mono for that same reason, as another, that's another thing on the differential diagnosis. Once again, at this visit he did not have evidence of that at this time.
Q. What would be the mechanics of Prednisone for treating a peritonsillar abscess?
A. It helps shrink the tissues down.
Q. It doesn't get rid of the purulent material, though, does it?
A. No.
Q. In fact Prednisone is a steroid, correct?
A. Yes.
Q. And steroids are immunosuppressive agents, aren't they?
A. In the long run, yes.
Q. And they lower the body's ability to fight infections, specifically bacterial infections,

correct?

A. Not in the acute phase of it. If you're on long-term steroids that would be the case. Steroids are routinely used in acute infections in patients with --

Q. That involve abscesses?

MR. WALTERS: Let her finish the answer. You cut her off. I don't know what the end of the answer was because I heard you, you talk louder, I didn't hear her.

- - - -

(Thereupon, the requested portion of the record was read by the Notary.)

- - - -

A. In patients with lung problems in particular we use Prednisone along with antibiotics.

Q. People that would -- okay. What I'm talking about is someone with an abscess with a collection of pus, do you believe it's standard of care to treat such a condition with Prednisone?

A. Yes, we usually do use a combination of steroids and antibiotics for a peritonsillar abscess.

Q. What antibiotics are standard of care to treat a

peritonsillar abscess, doctor?

A. Usually a broad spectrum that will cover Strep and Staph.

Q. If you were treating a patient with antibiotics for a peritonsillar abscess, what antibiotics or combinations of antibiotics would you use?

A. Most often I'll use Augmentin which is a penicillin base that covers Staph and Strep.

Q. Why didn't you prescribe Augmentin to Mr. Kidd on November 27th?

A. Because he didn't have a peritonsillar abscess at the time. He had been given a shot of penicillin the day before which covers Strep.

Q. Would you agree that penicillin by itself is not the standard of care antibiotic treatment for either peritonsillar abscess or retropharyngeal abscess?

A. It wouldn't be the best choice, no.

Q. It would be below the standard of care to attempt to treat either one of those conditions with penicillin by itself, would that be correct?

A. Correct.

Q. In order to effectively treat an abscess not only do you have to treat the bacterial infection with appropriate antibiotics, but you also have to

drain the abscess, is that correct?

A. Yes.

Q. A peritonsillar abscess or retropharyngeal abscess will not ever resolve on antibiotic therapy alone, you'd agree with that?

A. I think that's probably true. I suppose there are some cases that happen. An ear, nose, and throat doctor would be better to answer.

Q. Did you take any steps after November 27th to determine whether or not Mr. Kidd was suffering from a peritonsillar abscess?

A. No. On the 27th I told him what to watch out for and he needed to get back to me if anything changed.

Q. Do you believe that in light of your suspicion that peritonsillar abscess -- well, strike that.

In light of your concern over the possibility of a peritonsillar abscess, don't you believe the standard of care required a follow-up appointment to be set as of November 27th to see in fact whether or not his condition had gotten better or worse?

A. At that point in time I told him what to watch out for and if anything developed he should get back in. At this point in time he did not have a

peritonsillar abscess so I didn't feel it was necessary just to have a follow-up for that.

Q. How long after an injection of penicillin will it take for a patient to become non-symptomatic if all he has is Strep throat?

A. It's variable. You're definitely contagious for 24 hours. The shot is not totally effective for 24 hours so at least 24 hours, but it can take longer.

Q. What, based upon your training and experience what's the range where usually it takes a shot of penicillin to render a patient non-symptomatic?

MR. WALTERS: What dose are you talking about, what size patient? I'm assuming those are all variables that count.

Q. Are they variables that count, doctor?

A. The literature that I have seen is that it just takes up to about one to five days.

Q. For a patient to become non-symptomatic?

A. Asymptomatic, yes.

Q. Obviously in deciding what dosage to inject into Mr. Kidd you're taking into account his weight, right?

A. Yes.

Q. So you're picking what you believe to be an appropriate medication with an appropriate dose for his age and weight or whatever other factors, correct?

A. Yes.

MR. WALTERS: So that question you asked before presumed the shot that was given to Mr. Kidd? Because you asked it in almost a hypothetical format. You didn't ask with regard to Mr. Kidd. You asked her how long does a shot of penicillin take to treat Strep, I believe was your question, you didn't say with regard to Mr. Kidd and that's why I made my statement just in fairness to the doctor. Because I assume you'll use those general questions in an effort to try to repeat with regard to Mr. Kidd sometime in the future, so.

MR. CONWAY: My whole deposition, for the record, is an attempt to be fair to the doctor and find out what she knows about the case and the chips fall where they may.

MR. WALTERS: Is that how it works?

MR. CONWAY: Yeah.

MR. WALTERS: You know, I've been doing it 20 years now, what I find out in depositions, Tom, is plaintiffs lawyers don't come to try to find out where the chips fall where they may, they come to try to win their case and that's what we deal with, so I think that's more truthful about what happens in depositions than let the chips fall where they may. But go ahead.

MR. CONWAY: What I also find to be evident is that where there is the length of speaking objections which is taking place the depositions tend to go a lot longer.

MR. WALTERS: They do.

MR. CONWAY: Okay.

MR. WALTERS: But I also believe that the length, in lieu of this, in lieu of justice being served and the administration of justice being served that if in fact it takes a little bit longer we will take a little bit longer.

MR. CONWAY: Yes, we will.

MR. WALTERS: Okay. Go ahead.

MR. CONWAY: Yes, we will.

Q. If your, if the employees who worked in your office failed to accurately convey messages that were given to them by Robin Kidd or her husband they would be below the standard of care, correct?

A. Yes.

Q. You obviously can't answer the phone every time a patient calls, right, doctor?

A. Correct.

Q. So you rely and depend upon your office personnel to answer the phone, take accurate messages and convey those messages to you, correct?

A. Yes.

Q. Then you further rely upon those office personnel to convey your responses back to the patient and/or the patient's wife in this particular case, correct?

A. Yes.

Q. All right. The failure of those office personnel to either appropriately and accurately convey the patient's communication to you or your communication to the patient would be below the standard of care, correct?

A. Yes.

Q. You've had an opportunity -- and in fact we will mark these as an exhibit.

MR. CONWAY: Why don't we mark this as Exhibit Number 2.

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(Thereupon, Plaintiffs' Exhibit 2, three-pages, phone message copies, was marked for purposes of identification.)

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Q. Doctor, I'm showing you photostatic copies of different office message sheets which we've received from your office pursuant to a records request. You still have the originals in your possession at your office, correct?

A. Yes.

Q. Take your time and look over the contents of these messages from the November 27th 8:30 a.m. message till the December 1st, 2001 message. And refer to them at any time you wish.

Have you had an opportunity to look those over?

A. Yes.

Q. Okay. Before we begin, on the first page which is Bates stamped page 4 of this exhibit, I happened to notice that there were other phone

messages that were taken chronologically before these and some of them went back to June of 2000.

A. Yes.

Q. All right. And I notice, in fairness to you, if you want to use your, the medical records you have in front of you feel free, on this particular page, though, it appears that there were, it says on the top here 4th message and then 5th message, do you see that?

A. Yes.

Q. Were you having any problems with, any communication problems at your office back in the years 2000, 2001 with receiving messages or responding to calls from patients?

A. Not that I recall.

Q. Okay. Was anyone at your office ever disciplined for failing to --

MR. WALTERS: You're talking about these 2000 messages?

MR. CONWAY: Yeah. I saw that and I'm just asking --

MR. WALTERS: You made a reference to 2001 in your question, that's why I was confused. It says, there is a June 9th, 2000 message that says 4th message.

MR. CONWAY: Right.

MR. WALTERS: And a June 9th, 2000 message which says 5th message.

MR. CONWAY: I believe my question was back in the years 2000, 2001, had you had any communication problems with your staff regarding adequately conveying messages from patients to you or vice versa.

MR. WALTERS: Yeah. But there is no evidence of that kind of, on the 2001, that's why my question, that's why I'm confused. You seemed to lump 2001 in there with the effort to try to lump --

MR. CONWAY: No.

Q. I'm looking at the time period, 2000/2001 time period, doctor.

A. No. On that the 4th message and 5th message is an hour apart, there are times I don't answer any messages in a certain time frame.

Q. But then presumably there were three messages before that regarding the same issue? I'm asking, doctor, I don't know the answer to those questions.

A. I don't recall.

MR. WALTERS: If she remembers.

A. I don't recall. But I can just tell you in that time frame there is a good chance that I wouldn't have answered any of those. And there was no urgency to those either, he just wanted a prescription called in.

Q. Looking at these specific written messages -- first of all, do you have an independent recollection of this case apart from the written medical records you possess?

A. How so?

Q. Well, are there things that you recall having taken place that haven't been documented by you or your office staff in writing?

A. I remember he was deer hunting and stuff, I don't know if I had that documented, so I mean, I remember certain things.

Q. I assume that the standard of care for a family practice physician is to document or chart significant communications from a patient and/or significant physical and medical historical findings, would that be correct?

A. The more we document the better.

Q. Okay. But the standard of care requires a family practice physician to document significant

aspects of a patient's medical history, would you agree with that?

MR. WALTERS: Object. I don't know what that means. Go ahead if you understand what it means.

A. Actually any more it's for litigation purposes. I don't know that the standard of care is that per se. The more the better is from the litigation standpoint.

Q. How about the more the better from the standpoint of being able to have continuity of care and being able to treat a patient appropriately, is that important?

A. I can remember usually from one day to the next, so for my own memory it's not an issue.

Q. Is there anything that, let's go to the first message on November 27th, 2001, 8:30, is there anything that you recall regarding this phone message that's not contained in writing?

A. No.

Q. There's a second phone message on 11/27/01 which is on Bates stamped page 03 at I believe 12:05, is there anything outside of this message, other than what's written on this phone message surrounding the circumstances that you recall?

A. No.
Q. There is a phone message on November 30, 2001, 8:40 a.m., same question, is there anything outside of the written contents of this phone message that you recall regarding the circumstances of this case?
A. I probably remember a little more on this one because I was in a meeting at the time and my medical assistant came and asked me about this just because he had the chest tightness, and I recall that it was more just like a muscle spasm, not a typical chest pain that we would be worried about with like a heart attack.
Q. Anything else outside of what's written here that you recall about the circumstances of this phone message?
A. No.
Q. Okay. Going to November 30th at 1:42 p.m., is there anything outside the written contents of this phone message that you recall?
MR. WALTERS: I'm sorry, which one are we on now?
MR. CONWAY: November 30th at 1:42.
A. The only thing I remember is being surprised that

he was surprised that it wasn't working that quickly. Most people who want muscle relaxers called in are not expecting it to work within, you know, a few hours. But nothing else specifically.

Q. All right. Let's go to Bates stamped page, it's cut off at the bottom, but at the very top it's the December 1st, 2001, 10:50 a.m. note. Anything in addition to what's written here on this message, this phone note that you recall regarding the circumstances of that call?

A. Actually I remember talking to my nurse on this day, because this was a Saturday, and I had said does he think this is all from deer hunting and she said no, he still thinks it's from the shot that I gave him and so we were just kind of actually laughing. I said what did you do with that shot. We were just teasing each other. But that's the only thing. So we actually found out at that point in time that he thought it was all coming from where he had been given a shot.

Q. Anything else you recall outside of what is written here?

A. No.

Q. Okay. Is any of the handwriting on any of these

phone messages yours?
A. The Vicodin prescription. I put Soma samples on that one from November 30th at 8:40. And then on the one from 1:42, the Vicodin number 40 PO Q4 hours PRN pain.
Q. On December 1st, any of that writing yours?
A. No.
Q. Doctor, how do you treat a retropharyngeal abscess?
A. It requires an incision and drainage and antibiotics.
Q. What type of antibiotics for retropharyngeal abscess?
A. A broad spectrum that usually covers Staph and Strep.
Q. Could you tell me why you went to the Lake County Coroner's office while Dr. Rizzo was performing the autopsy?
A. Dr. Rizzo invited me and I was interested to see what happened.
Q. Can you tell me what the conversation was between you and Dr. Rizzo which led to you coming down to view the autopsy?
A. He knows I have an interest in pathology and at a point in time being the coroner so he just

invites me at times.
Q. You have an interest in pathology?
A. I have an interest in being a coroner, so.
Q. Do you have any expertise in the area of pathology?
A. No.
Q. Do you recall your discussions with Dr. Rizzo regarding this case while you were at the coroner's office?
A. We were all talking about what we thought was the cause of death.
Q. Prior to him doing the autopsy?
A. Yes.
Q. And what was your belief as to what the cause of death was prior to doing the autopsy?
A. I thought possibly heart attack, possibly gastrointestinal bleeding.
Q. Why did you think it could have been GI bleeding?
A. One of the assistants to the coroner said that there was some black color coming out of his mouth at the scene.
Q. Why did you think a heart attack might have been a cause?
A. The suddenness of his death basically.
Q. Do you have any criticism of any medical care and

treatment that Mr. Kidd received at Lake County Hospital on November 27th?

A. No.

Q. Do you have any criticism of any other medical provider who rendered care and treatment to Mr. Kidd between the time periods of November 26th and the date of his death on December 1st?

A. Was there anybody else besides me and the ER?

Q. I don't know. I'm asking. Are you aware of anyone else?

A. No.

Q. Okay.

MR. WALTERS: Is there anyone else?

MR. CONWAY: Not that I'm aware of.

MR. WALTERS: All right. I just wanted to make sure because when you asked you said I don't know.

MR. CONWAY: No, that's just a blanket statement.

Q. I take it you don't have any criticism of any other medical providers who provided medical care and treatment to Thomas Kidd during the time periods of November 26th through his death on

December 1st, correct?

A. No. Correct.

Q. Your relationship with Prime Health Family Practice, are you the owner, partner, or employee? Back in 2001 what was your relationship?

A. Employee.

Q. How long had you been an employee of Prime Health Family Practice as of November of 2001?

A. I started in March of '98, so.

Q. Prior to being with Prime Health Family Practice where were you employed?

A. Lake County Family Practice.

Q. And how long were you at Lake County Family Practice?

A. About 15 months.

Q. And why did you leave Lake County Family Practice to go to the Prime Health Family Practice?

A. I didn't really like the main partner.

Q. Who was that?

A. Mark Komar. Do you need me to spell it?

Q. No, I know how to spell it.

Prior to Lake County Family Practice where were you employed?

A. I was in my residency.

Q. Where?
A. Akron City which is now Summa Health System.
Q. You have an employment contract or, excuse me, back in 2001 you had an employment contract with Prime Health, Incorporated, is that correct?
A. Yes.
Q. And I take it all, everything you were doing regarding your care and treatment of Mr. Kidd was within the scope of your employment with Prime Health, Incorporated, would that be correct?
A. Yes.
Q. Now, Prime Health, Incorporated, from the answers I got in discovery is, it seems to also be owned by Lake Hospital Systems, Incorporated.
A. Yes.
Q. Have you discussed Mr. Kidd's case with anyone from Lake Hospital?
A. Just the coroner.
Q. Is he employed by Lake Hospital?
A. I don't think so. He's Lake County, I believe.
Q. How about any employee or agent of Lake Hospital have you discussed this case with?
A. Not that I recall.
Q. Do you know what type of drug Metronidazole is?
A. Yes

Q. What type of drug is that.
A. It's an antibiotic.
Q. Okay. Have you ever prescribed that antibiotic?
A. Yes.
Q. What type conditions do you prescribe that drug for?
A. Mostly intestinal problems, some vaginal problems.
Q. Are you aware of any literature recommendations regarding its use to treat peritonsillar abscess --
A. No.
Q. -- with that drug?
A. Is that a continuation?
Q. Well, it was kind of the whole sentence, but you answered it before I was done.
A. Sorry.
Q. That's all right.

MR. WALTERS: If I have the gist of the question, I think it was she's not aware of literature that suggests that you use Metronidazole to treat peritonsillar abscess; correct?

A. Correct.

MR. CONWAY: Very well put,

Mr. Walters.

Q. Doctor, you've told me how you would treat a peritonsillar abscess. Back in 2001 can you tell me what the standard of care for a family practice physician would be to treat a peritonsillar abscess?

A. I think it would be the same.

Q. If a doctor suspects a peritonsillar abscess doesn't the standard of care require that either an ultrasound or a CT scan or a neck x-ray be performed on the patient?

A. No.

Q. Why not?

A. The diagnosis is really based on the physical exam.

Q. Would you agree that patients with a questionable diagnosis of peritonsillar abscess who display signs of complications require immediate hospital admission?

MR. WALTERS: I don't, I'm going to object because, I'll object to the form of the question because I don't know what questionable diagnosis means. Go ahead.

A. I'm sorry, could you repeat it?

MR. CONWAY: Could you read that

back.

- - - -

(Thereupon, the requested portion of the record was read by the Notary.)

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A. I don't understand what you mean by complications.

Q. Let's say a patient such as Thomas Kidd has a confirmed diagnosis of Strep throat.

MR. WALTERS: Are we using Thomas Kidd or such as Thomas Kidd?

MR. CONWAY: We can use Thomas Kidd.

MR. WALTERS: You've got to tell me, because you said such as and I always get confused on that. I've been learning over the 20 years I've been doing this when people say such as I don't know if they mean Thomas Kidd or somebody else.

MR. CONWAY: No, I mean Thomas Kidd. I wouldn't use Thomas --

MR. WALTERS: I understand. I just want to clarify.

Q. Thomas Kidd was diagnosed with Strep throat?

A. Yes.

Q. A possible sequela of Strep throat, you're aware, can be peritonsillar abscess, correct?
A. Yes.
Q. The day following his diagnosis and the day following the administration of a penicillin shot Mr. Kidd was seen again by you at which time you considered the possibility of peritonsillar abscess, correct?
A. Yes.
Q. At that point in time didn't the standard of care require that he be admitted to the hospital for the performance of CBC, culturing of any type of purulent fluid which was able to be aspirated by a needle and radiology diagnostic films taken?
A. No.
Q. Have you ever used Metronidazole in connection with penicillin to treat a patient you suspected of peritonsillar abscess?
A. No.
Q. Do you know what percentages of patients with peritonsillar abscess have penicillin resistant bacteria?
A. No.
Q. You're doing some, a research paper, I believe, according to your CV, on Streptococcus A?

A. I did that in my residency. It didn't turn out to be a paper.
Q. Okay. What, there is an item in your CV that refers to some type of research on Streptococcus A, what were you researching or what were you writing that you're referring to in your CV?
A. It was about children and schools having the carrier state. The research didn't pan out, so it's kind of --
Q. Why is that in your CV?
A. That's an old CV. I think I had it from back when it was still going on or still partly in process.
Q. When did you find out that that paper was not going to pan out?
A. Probably right at the end of my residency.
Q. Which was what year?
A. '96.
Q. So there is no paper then?
A. No. I did the research but no paper.
Q. What are the signs and symptoms of a peritonsillar abscess?
A. Sore throat, the typical sign is that one -- that's my phone.
MR. WALTERS: Go ahead.

MR. CONWAY: If you need to answer the phone, do so.

A. No.

MR. WALTERS: Why don't you look, Carol, so you know. Want to take a break any way? We've been at it for an hour and twenty minutes.

MR. CONWAY: An hour and six minutes.

MR. WALTERS: Okay. Do you want to take a break?

THE WITNESS: I could use one.

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(Thereupon, the requested portion of the record was read by the Notary.)

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A. Should I just continue?

Q. Doctor, you had an opportunity to take a break, are you ready to resume?

A. Yes.

Q. Okay. Go ahead, why don't you tell me what the signs and symptoms of a peritonsillar abscess are?

A. The biggest sign that we see is one tonsil jutting out more and causing the uvula, which is

the little thing in the back of your throat, to deviate because of the abscess putting pressure on it.

Q. So we have uvula deviation?

A. Uh-huh.

Q. What else?

A. The one tonsil enlarged more so than the other.

Q. What else?

A. Trismus.

Q. What is that?

A. Inability to open your mouth all the way.

Q. Okay. What else?

A. Those are the big signs. Usually you will see like that affected side is redder in addition to more swelling and just more infected looking than the opposite side.

Q. Is a progressively worsening sore throat also a sign and symptom?

A. Yes, that goes along with it.

Q. How about fever?

A. That can go along with it.

Q. How about nonresponse to penicillin?

A. That doesn't necessarily indicate it.

Q. Would that be something that would alert you to the fact that you might be dealing with a

peritonsillar abscess, if the patient is nonresponsive to a penicillin shot?

A. You would certainly consider it.

Q. Would another sign and symptom be more pain on one side of the throat?

A. Yes.

Q. Would you agree that the gold standard for diagnosis of a peritonsillar abscess is collection of pus from the peritonsillar abscess through needle aspiration?

MR. WALTERS: Gold standard to diagnose it?

Q. Gold standard for diagnosis of a peritonsillar abscess is collection of pus from the peritonsillar abscess through needle aspiration?

MR. WALTERS: Okay. Go ahead.

A. Yes.

MR. WALTERS: I'm sorry, I just misheard you. I didn't mean to -- go ahead.

Q. So this would seem to me to mean that if a primary care physician suspected based upon the clinical presentation of a patient that they were suffering from a peritonsillar abscess, the patient would then be referred to an ear, nose,

and throat specialist to have a needle aspiration of that area performed, would that be correct?

A. Yes.

Q. All right. And that would be -- and that would be the -- sorry. That would be the standard of care, is that correct?

A. To have the ear, nose, and throat doctor excise the drainage -- I'm sorry, I got off track. Can you repeat it?

Q. Yeah. That would be the standard of care?

A. Repeat the prior question.

Q. Okay. All right.

- - - -

(Thereupon, the requested portion of the record was read by the Notary.)

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A. Yes.

Q. What was your thinking back in 2001 as to whether or not penicillin would effectively treat a peritonsillar abscess?

A. That would not be my drug of choice. It won't cover the Staph component.

Q. Do you believe, did you believe back in 2001 that penicillin would cover the Strep component of a peritonsillar abscess?

A. Yes.
Q. Did you consider at any time on November 30th or December 1st that possibly Mr. Kidd was suffering from a peritonsillar abscess?
A. At that point I thought that was resolved.
Q. So your answer would be no?
A. I wasn't really considering it at that point in time, no.
Q. What information did you have regarding whether or not Mr. Kidd was still suffering from pain in his throat?
A. My nurse had told me in one of those messages that his throat problem was better and I think I mentioned before she indicated that he thought that his back was hurting from where the shot was given, it kind of emanated from where the shot was given.
Q. Can you show me what date and where it indicates that the, there's no longer any sore throat?
A. December 1st. It's hard to read because all that writing is impacted in there. I don't know if you can see the part where she says slight fever, no throat, I think it says better underneath there or something. I think the throat was better.

Q. Well, what does a circle with a slash through it mean?
A. That means no.
Q. Okay. So does that say throat not better?
A. No. I remember specifically asking her, she told me that is not a problem any more. I can't really read what the writing is there. She might have put that in there because I specifically asked her, so she might have put it in parentheses there to indicate that that was something I subsequently asked her.
Q. Who wrote the writing here along the right?
A. That was my nurse Cheryl Keller.
Q. And she checked by urgent yes, is that correct?
A. That would be the person taking the message that checked urgent.
Q. And circled it?
A. Yes.
Q. And was this message brought to you for you to read prior to giving your response?
A. Yes.
Q. At the time you saw this message was this in parentheses, no throat better, or your reading?
A. I can't tell for sure, I'm not sure if that says better or no throat -- I can't read it.

Q. Was that written on the note at the time you first saw this note back on December 1st?
A. I don't remember.
Q. So you can't answer whether or not that was written after?
A. I don't know.
Q. Okay. I noticed there was no charting in any of the patient progress notes for any of the interaction that was going on between your office and Mr. Kidd and Mr. Kidd's wife. Am I correct?
A. In the progress notes?
Q. Yes.
A. We just put the messages in a separate section because just for efficiency from the standpoint of taking up space in the chart. That way we can put several messages on one sheet rather than having it interspersed with office visits.
Q. Do you believe that a primary care physician should chart in the patient's progress notes interactions of significance that take place between the patient and the physician's office?
A. This is still in the chart, it's just in a different section. We don't have it in the same section just for efficiency of room.
MR. WALTERS: I don't know if

you're trying to suggest this isn't in the chart, part of the chart.

MR. CONWAY: I'm just asking the question.

MR. WALTERS: I know, but -- maybe I'm reading too much into your question.

Q. Is it reasonable for an emergency department doctor to rely upon the diagnosis and treatment rendered to a patient by the patient's primary care physician?

A. I'm sorry, can you repeat that?

Q. Sure.

- - - -

(Thereupon, the requested portion of the record was read by the Notary.)

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MR. WALTERS: Object because I don't know that Dr. Noall is qualified as an emergency medicine specialist. But go ahead, answer the best you can.

A. Certainly they have to take every bit of information into account. That doesn't mean that what they've seen before is necessarily everything involved, so --

Q. Well, let's deal specifically with this case.

Following your office, following Mr. Kidd's office visit with you on November 27th he found it necessary that evening to go to Lake County Hospital or, excuse me, to Lake Hospital, is that correct?

A. Yes.

Q. And he went to the emergency department, correct?

A. Yes.

Q. And he gave a history to the nurses and physician there, correct?

A. Yes.

Q. And in that history he gave information that he had been treating with you for his Strep throat, correct?

A. Yes.

Q. And that he had seen you as of that afternoon, correct?

A. Yes.

Q. All right. As a physician, from a physician's standpoint --

MR. WALTERS: Well, let me finish, he gave you a little more history than that.

MR. CONWAY: Right.

MR. WALTERS: I didn't know if

you're saying that was all the history.

MR. CONWAY: No, it's not. Obviously the medical records speak for themselves.

MR. WALTERS: All right. Go ahead.

Q. But it was reasonable for the physician who treated Mr. Kidd at the Lake County emergency, excuse me, at the Lake Hospital emergency department to rely upon the diagnosis and treatment that you had earlier made, would you agree with that?

A. It's part of the history, yeah.

Q. Okay. On both November 26th and November 27th you told Thomas Kidd personally that he had Strep throat, is that correct?

A. Yes.

Q. You told him on those occasions that the penicillin would effectively treat his condition, correct?

A. Yes.

Q. And you told him on October 27th to be patient, that it takes time for the penicillin to work, correct?

A. Yes.

Q. You stated earlier in the deposition that based on your training, experience it could take one to five days for a patient to become asymptomatic from Strep throat following a penicillin injection, correct?
A. Yes.
Q. Did you tell Mr. Kidd that as well?
A. I told him that certainly in the note before he came on the 27th and then when he came on the 27th I reiterated that, but I also warned him about the possible signs of the peritonsillar abscess.
Q. But you did on at least two occasions tell him that it could take one to five days for his symptoms to go away following his penicillin shot, correct?
A. I don't know if I told him specifically up to five days. I told him over 24 hours for sure.
Q. Could you have told him five days?
A. I don't know what I specifically told him. I know I specifically said over 24 hours because that's contagious for that long.
Q. Being contagious of Strep throat, is that related to whether or not you have symptoms?
A. Usually, but not always.

Q. All right. He, that is Thomas Kidd was given discharge instructions on November 27th after he had left Lake Hospital, correct?

A. Yes.

Q. All right. And you've seen those discharge instructions?

A. I saw them briefly. I could use them again.

Q. All right. I'm sure Mr. Walters will move that in front of you.

MR. WALTERS: There's got to be -- you know, knowing these charts there is a separate instruction that I appear not to have.

A. The thing they go home with.

MR. WALTERS: All we have, I don't know if you have it, Tom, the only thing we have -- I guarantee you there is a separate instruction that goes with this. The only thing we have is the discharge order information which is follow up with Dr. Noall in two days.

MR. CONWAY: Right.

A. And fill a prescription.

MR. WALTERS: But I guarantee there is a separate set of instructions for

this.

MR. CONWAY: Well, is it possible, if you could, since obviously it's a corporate association with you, that you could obtain that. All I can go by is when I request something from the medical provider that they provide me with everything that I ask for and I asked for a complete chart.

MR. WALTERS: Yeah. There is a separate set of instructions. That's all I'm telling you.

MR. CONWAY: Well, can you obtain that?

MR. WALTERS: I don't know if I can without an authorization from Mrs. Kidd.

MR. CONWAY: I will send you an authorization.

MR. WALTERS: But I will get them and remind the hospital that this does not appear, that it appears that the discharge instructions aren't in here.

Q. Anyway --

A. It never usually comes to us. I don't know if

they even copy it. I usually get it when the patient comes and they show me what the hospital gave them.

Q. Well, there was, it appears here from the records that I have a discharge instruction that he contact you in two days, correct?

A. That's what it says.

Q. Which he in fact did, correct?

A. No.

MR. WALTERS: No.

Q. He didn't? What time was he discharged on November 27th?

MR. WALTERS: We've got to figure that out. He came in at 8:06. He was seen at 8:50.

A. There is no time out here.

MR. WALTERS: I don't know what time he went home. He had a -- I've got a hard time believing they kept him for four hours. 9:10 it looks like he was discharged.

Q. So he was discharged at about 9:10 on the evening of the 27th of November, correct?

A. Yes.

Q. All right. And what time did he call you on

November 30th?

A. The first one was his wife called at 8:40.

Q. In the morning?

A. Yes.

Q. What time does your office open?

A. 8:30.

Q. And what time does it close?

A. The phone is off at 4:30.

Q. In the afternoon?

A. Yes.

Q. Okay. So if someone wanted to talk with you or your nurse about something and not go through an answering system they would call between 8:30 and 4:00 p.m.?

A. 8:30 to 4:30, yeah.

Q. Okay. On November 30th did you or anyone from your office inquire of Mr. Kidd or his wife as to Mr. Kidd's throat condition?

A. On November 30th?

Q. Yes.

A. I don't recall if we asked on that day.

Q. There is nothing in the medical records that indicates that you inquired, is that correct?

A. No.

Q. I mean is that correct?

A. That's correct.
Q. Why didn't you at any time between November 30th and December 1st speak personally with Thomas Kidd or his wife, if you know?
A. I rely upon my staff to do that for me.
Q. Have you ever gotten on the phone and spoken with a patient over the phone when they've called in with problems?
A. At various times.
Q. Is there a certain criteria used as to when you will get on the phone and speak with the patient or wife and when you won't?
A. Some, just sometimes a feeling that I need to talk to them, if I know them well sometimes I will talk to them, for the most part I don't.
Q. Do you typically prescribe Soma over the phone without examining a patient?
A. Not typically.
Q. Why did you do it in this case?
A. I felt that the patient was aware of what was occurring and since he refused to come in to be seen to have me evaluate him I figured I'd at least help him out with what he thought was going on.
Q. How do you know that he was refusing to come in

and see you on November 30th?
A. My staff told me.
Q. You never confirmed that yourself, did you?
A. I didn't call him up and ask him, no.
Q. And what are you referring to on November 30th to lead you to the conclusion that he refused to come in?
A. On the right-hand side of that November 30th 8:40 note it says refused appointment and urgent care, just wants prescription.
Q. Whose handwriting is that?
A. Bob Whelchel, my medical assistant.
Q. What type of drug is Soma?
A. It's a muscle relaxant.
Q. You had not been treating Thomas Kidd prior to November 30th for any type of muscle, musculature type pain, is that correct?
A. I don't recall if I treated him in the remote past, but certainly not in that recent past.
Q. You knew he was over age 40, is that correct?
A. Yes.
Q. Was he a smoker?
A. Yes.
Q. And he was complaining of chest tightness, correct?

A. Yes.
Q. What does that say below there?
A. Which one, right here?
Q. Yeah.
A. Prescription called, RX called, patient aware.
Q. So did you call in the prescription?
A. My medical assistant Bob did. I wrote on there Soma samples and he didn't want to come and even get the samples, he just wanted the prescription called in.
Q. Why did he say he didn't want to come in and see you?
A. I don't know.
Q. Would that have been important to find out?
A. I don't know.
MR. WALTERS: You mean in retrospect?
MR. CONWAY: No. At the time.
Q. I mean, you're prescribing --
MR. WALTERS: It doesn't say he's unable to come, it says he refuses to come.
Q. Is that something that's important to know prior to prescribing Soma for a patient as to why they would refuse to come in and see you for a complaint?

A. The more information the better always.
Q. With his complaint of a chest tightness, did you have cardiac problems on your deferential diagnosis at the time you were given this message?
A. Certainly that's why it was transferred back to the nurses in the first place, the clinical people, and as I said before, I was in a meeting at the time and my medical assistant came in to the meeting and asked me. And he wasn't really having cardiac symptoms, he was just describing muscle spasms going up his back.
Q. Has chest tightness underlined, was that you that underlined it or Bob Whelchel?
A. It could have been Bob. I'm not sure. It was probably more likely Cindy who took the message because they have a protocol, you know, if there's certain things people call for they get the nurse or medical assistants immediately.
Q. What is Cindy's last name?
A. Manley, M-a-n-l-e-y.
Q. Is she a nurse?
A. No, she's a receptionist. She actually has some medical assistant experience.
Q. And Bob Whelchel, how do you spell that?

A. W-h-e-l-c-h-e-l.
Q. And is he a nurse?
A. Medical assistant.
Q. What is a medical assistant?
A. Medical assistant does clinical, all the clinical skills, almost all that a nurse will do in our office -- actually even more because they can do blood draws, but they room the patients, they take patient information, they give injections, they do cultures, they do all sorts of procedures.
Q. So he's not an RN nor is he an LPN, is that right?
A. Correct.
Q. And I take it there is some type of certificate that you get to be a medical assistant?
A. Yes. And then they do a lot of training with the doctors.
Q. So is it possible to discern who actually spoke with the Kidds on November 30th, would that have been Bob Whelchel or Cindy Manley?
A. Well, they both, actually then there was another Cindy that talked to them also.
Q. Which Cindy would that have been?
A. On that second message is Cindy Moses.

Q. Now, Cindy Manley, is she a medical assistant?
A. She has a medical assisting certificate, but she works as a receptionist in our office.
Q. Who is Cindy Moses?
A. She's our other receptionist.
Q. Is she a medical assistant?
A. No, not that I'm aware of.
So the front desk takes the message initially so both of them wrote on the initial portions and then Bob Whelchel answered.
Q. Call given to Cheryl I see on November 27th, 2001 at 12:05. Who is Cheryl?
A. Cheryl is my nurse.
Q. What is her last name?
A. Cheryl Keller, K-e-l-l-e-r.
Q. Is she an RN or an LPN?
A. LPN.
Q. When a 40-year-old smoker calls in complaining of chest tightness and back pain, is there a protocol that any of your medical assistants use in questioning the caller in order to rule in or rule out the possibility of a cardiac problem?
A. Well, the biggest thing that they need to do is decide whether they needed to come in and see me or decide to go to the ER and in this case if

they refuse they get more information to see if they can help in any way and he really didn't have any other symptoms suggestive of heart disease.

Q. At least there's no other symptoms written on this piece of paper that you would have looked at, correct?

A. Bob and I discussed it also. I don't think Bob wrote everything down there, but.

Q. What else do you recall regarding your discussion with Bob?

A. That he wasn't really like short of breath, wasn't really having any other associated numbness or tingling down the arms, that it was more like just spasming feeling, you know, coming up from the back.

Q. Anything else that you recall?

A. That's it.

Q. All right. It doesn't appear that on November 30th at that time anybody inquired or asked Mr. Kidd or his wife about the status of his sore throat, would that be correct, as documented here?

A. As documented, no.

Q. So what was on your differential diagnosis as to

any possible conditions that Thomas Kidd may be suffering from as of November 30th at around 8:40?

A. The big one was just muscle spasm which I thought was related to the deer hunting. Certainly it runs by your mind that cardiac disease is occurring, but I can't really make that diagnosis over the phone.

Q. What about your differential, what was on your mind regarding the, his throat condition at that point?

A. I wasn't really thinking too much on the throat condition at this point. He hadn't complained of that for three days.

Q. That you were aware of?

A. Correct.

Q. All right. And then we go to the, well, let's go back to that note on November 27th, 2001 at 12:05. The message appears to be going to ER, can't breathe, call given to Cheryl, correct?

A. Yes.

Q. And then on the right it says 11/27/01, patient has no shortness of breath. Severe throat pain. Hard to swallow. Refuses to go to ER. Then it says patient will come right down to office. I

don't understand this note. What's your understanding of what went on regarding this 12:05 p.m. telephone conversation?

A. I can't tell you exactly since I didn't take any of the message, but he called indicating he was having trouble breathing and I don't know if he told her that he thought he should go to the ER, most people just go. So I don't know if he was calling for advice on whether to go to the ER or what, but most people just go without calling, so I can't tell you exactly why it initially says he was going to the ER. But the call is, on a case like this it's sent back to the clinical staff. And, you know, he wasn't really having true shortness of breath, it was more just trouble breathing because of the sore throat.

Q. Regardless, it does at one point indicate that he's going to go to the ER and he does indicate that he will come right down to the office, correct?

A. Which he did.

Q. All right. Which he in fact did and then he saw you and that's documented in your progress note, is that correct?

A. Yes.

Q. Then let's, while we're on these, go back to November 27th, 2001 at 8:30. He calls in and says one side of throat is still sore and then follow up says what?
A. INB, if no better, call if no better it says.
Q. And what is written under 11/27/01?
A. Patient aware.
Q. Patient aware of what?
A. Of give it a little bit of time, call if no better.
Q. And that was your response that you wanted communicated to him when he called in complaining that the one side of the throat is still sore, correct?
A. Yes.
Q. All right. And in fact four hours, three-and-a-half hours later he followed your recommendation and called in, correct?
A. Yes.
Q. And then presumably he was told to come into the office and he came into the office for his 11/27/01 office visit, right?
A. Right. He was probably given a choice of going to the ER or coming right down because we had to squeeze him in obviously because I was already

booked.
Q. And he did both because he went to the ER later that day as well?
A. He subsequently went to the ER, yeah.
Q. Now, on 11/30/01 at 8:40, can you read what it says at follow up there?
A. Muscles in chest tight causing to have trouble, refused appointment and urgent care, just wants prescription called in.
Q. Causing to have trouble what?
A. It doesn't say.
Q. Did you inquire from any of your staff what that trouble related to that was written on this note?
A. As I said, Bob did come to me and talk to me while I was in the meeting and we talked about what was occurring.
Q. All right. I understand about the chest tightness and back pain, but that was causing him trouble, did Bob ever determine trouble what, what was the chest pain and back pain causing trouble with?
A. Just --
Q. Breathing?
A. Just discomfort.
Q. Then we go to 11/30, November 30th at 1:42 p.m.,

what do you recall about this phone message?
A. That it was very quick to indicate that there was no response from the muscle relaxer. Most people that are on muscle relaxers don't get that quick of relief, most things take a little while to get better. I was also surprised initially that he only wanted a muscle relaxer called in because almost anybody who has back complaints, muscle complaints will always want like a pain reliever as well as a muscle relaxer called in, so that's why I called in the Vicodin, because he had already taken the four Motrin it says there and it didn't help his pain.
Q. Do you typically prescribe Darvocet or, excuse me, do you typically prescribe Vicodin over the phone without examining a patient?
A. Not typically.
Q. Why did you do it in this case?
A. He wouldn't come in, I figured I would at least try to help relieve some of his symptoms.
Q. Is there any indication on that phone message that he was refusing to come into the office?
A. Not on that one. The time before.
Q. I take it there was, his throat condition was not on your differential diagnosis as of 11, as of

November 30th at 1:42, would that be correct?
A. No.
Q. And then we come to --
A. Excuse me, can I answer that, I should say that would be correct. I said no, but that would be correct.
Q. Who is CJM at the bottom of that note?
A. That's Cindy Moses.
Q. Who is CN, that's you, correct, at the top where it says for?
A. Yes.
Q. And then we go to the December 1st note which indicates urgent, whose handwriting is the urgent and the yes.
A. That's the person taking the call initially which would be Cindy Manley.
Q. And it says, what's the message that you would have been presented with?
A. That RYC is returning your call. I don't know for a fact, but since it says returning your call, oftentimes my nurses will call back and see how people are doing so since it says returning your call I think that must be what happened. It says regarding pain meds, up all night due to pain, hallucinating and then it says refused

appointment.

Q. Who wrote in that R circled appointment?

A. Cindy Manley.

Q. So the note gets taken to you with just the RYC - Re: Pain meds, up all night due to pain, hallucinating. Refused appointment. Is that what you recall?

A. I believe Cheryl Keller, the nurse again spoke to his wife because they probably passed that back to her immediately and then she's got -- I can't read this one, let me see if I can see on the other one.

MR. WALTERS: I gave you those bad copies on purpose, sometimes it's a trick. No. That's our fault, we forgot the original chart. I apologize.

A. I can't really read that, but it looks like hallucination and then there's, it looks like a no, zero with a line across, I can't read the next word, can't breathe through nose. Mouth breathing. Looks like last dose Soma 11A yesterday. Maybe slight fever. And then this is his problem again with no throat, I can't really tell what that says there. I don't think it says no throat better, but I don't know what it says

either. Hallucinations - saying things make no sense. No sleep in 48 hours. And then she wrote again here this is 12/1. So she had taken that message first and then talked to me and then it says, per Noall, get Vicodin prescription, that will help with pain and sleep. Monitor condition and call us ASAP.

Q. Call us ASAP for what?

A. If there's problems.

Q. So you were made aware that this patient was hallucinating, correct?

A. Yes.

Q. All right. And your response was to prescribe Vicodin, is that correct?

A. I was told, once again this is not in here, but I was told that he had taken eleven Soma since the day before and the prescription is one four times a day, so he had taken eleven the day before.

Q. Who told you he had taken eleven Soma the day before?

A. My nurse.

Q. What nurse was that?

A. Cheryl. She's the one who talked to his wife.

Q. That's not charted anywhere, anywhere in your medical file, is that correct?

A. It's not charted.
Q. Is that an inappropriately large amount of drugs?
A. Yes. Quite large, yes.
Q. Could that kill somebody?
A. Probably not kill somebody, it should zonk you a little bit.
Q. But that's definitely risky for a patient to be taking that amount of Soma, is that correct?
A. Yes, that's not what he should have done.
Q. So did you think that was causing his hallucinations?
A. I thought that was making him a little goofy, yes.
Q. Well, it says hallucinations here.
A. And the lack of sleep.
Q. So your response to that was to tell him to take Vicodin, is that correct?
A. Yes. His wife said they didn't get the Vicodin prescription.
Q. And how much Vicodin was he supposed to start taking then?
A. He could take one or two to help with the pain and we were going to see if that helped.
Q. Why didn't you get on the phone and talk with Mr. or Mrs. Kidd at this point, if you know?

A. Cheryl seemed to be handling everything okay, I didn't think I needed to get on the phone at that time.
Q. Cheryl is an LPN?
A. Yes.
Q. All right. Is it below the standard of care in this particular case for you to have basically prescribed Vicodin to a patient who calls in with a complaint of hallucinations?
A. I had prescribed it previously and I was just reiterating what I had suggested to do to help.
Q. I'm asking you was your advice at this point below the standard of care?
A. I don't know the answer to that. I don't know if there is a standard of care based on this.
Q. It doesn't indicate here anywhere in this note that he was told to go to an emergency room, does it?
A. It says refused appointment, it doesn't say emergency room there, but he wouldn't come in to see me.
Q. He was never told to go to an emergency room, was he, doctor, on this date?
MR. WALTERS: Well, according to the document you're saying?

Q. Yes, according to the document.
A. According to the document. But I know Cheryl discussed it.
Q. As we sit here today, what did Cheryl discuss with Mrs. Kidd?
A. His symptoms and his possibly going to the emergency room.
Q. Why didn't your nurse Cheryl document on that note that he refused to go to the emergency room?
A. I don't know. Cheryl would be better to answer that.
Q. As a family practice physician what would be on your differential diagnosis for a patient with a history of Strep throat where you were considering possible abscess who calls in subsequent to your diagnosis with complaints of hallucination?
A. Infection can do stuff like hallucinations, meningitis, other types of infections, strokes, any type of neurologic things that can cause hallucinations, medications.
Q. In light of your -- strike that.

In light of on November 27th at that point you were considering the possibility of a peritonsillar abscess, did you consider the

possibility of a peritonsillar abscess on December 1st?

A. Actually I talked to Cheryl, I specifically remember saying how is his throat and she said his throat is better so that wasn't really on the top of my list any more.

Q. Cheryl told you that she had talked with who?

A. I don't know if she got that through Mrs. Kidd or if in her conversations with Thomas Kidd that it had improved.

Q. And that's what Cheryl conveyed to you?

A. Yes.

Q. And you relied upon Cheryl telling you that?

A. Yes.

Q. Because the thought of possible peritonsillar abscess did come into your head, is that correct, in light of the complaint of hallucinations?

A. Well, the peritonsillar abscess had been in my head as a possibility previously and I specifically said to her, yes, how is his throat. And she said that part is better. And I think I actually think this is the day where we had all the conversation of does he have any reason why he's having all these pains and stuff and that's when she said that's, he says it's because of my,

the shot that I gave him.
Q. And you chose not to talk with either Mr. or Mrs. Kidd on December 1st, correct?
A. I did not call them back, no, myself.
Q. Now, you saw the autopsy while it was being performed, correct?
A. Yes.
Q. All right. And you have an interest in being the Lake County pathologist?
A. The coroner.
Q. The coroner. Does it seem possible that in light of his condition at the time of autopsy that he would have no throat complaints?
A. I'm sorry, can you repeat that.
Q. You know the condition of Mr. Kidd's pharynx and throat, neck as of the time he's autopsied on December 2nd, correct?
A. Yes.
Q. All right. Does it seem likely that he would have been, that his throat would have been pain free or had very little pain on December 1st in light of his condition at autopsy?
MR. WALTERS: Do you want to read.
A. From what I recall --
Q. Yeah, take your time.

A. From what I recall --
Q. You're reading your attorney's copy of the autopsy, correct?
A. Yes.
Q. All right.
MR. WALTERS: I hope my copy is the same copy you have.
MR. CONWAY: I'm sure it is.
A. Actually the very interesting thing about this was there really wasn't a whole lot of inflammation right there at the tonsil but there was a perforation, so the perforation actually occurred without any significant amount of swelling there, so the lack of throat symptoms probably does make sense because it had all been drained down now.
Q. Do you have an opinion as to when the abscess perforated in the pharynx?
A. No.
Q. In your discussions with Dr. Rizzo I'm sure that came up as to when that perforation of the abscess occurred when you were discussing this case, correct?
A. I don't know that it could be really elucidated how long before the death.

Q. Okay. So I take it that Dr. Rizzo didn't indicate to you his opinion as to when this possibly could have perforated?
A. No.
Q. Okay. And you don't think it would have been, you would have been able to determine that?
A. No. I think it could have been draining for a little while down into his chest. I don't know how long before it would have occurred.
Q. And Dr. Rizzo didn't know either?
A. No.
Q. The posterior pharynx indicates abscess with perforation to retropharyngeal space. That's on page 6.

MR. WALTERS: Is that a question or a statement?

MR. CONWAY: No, I'm just directing, the purpose is of directing your attention to page 6.

A. In the microscopic descriptions?
Q. Yeah.

MR. WALTERS: And what do you want to know?

Q. Although Dr. Rizzo according to you didn't have an opinion as to when the perforation occurred,

do you have an opinion as to when the perforation occurred?

A. No.

MR. WALTERS: You just asked her that.

MR. CONWAY: I'm not a pathologist nor am I going to become the Lake County Coroner.

MR. WALTERS: You asked her twice.

Q. What does acute inflammatory reaction, with edema and fibrinoid deposition mean to the right of posterior pharynx?

MR. WALTERS: I'll object to the form of the question, but go ahead.

A. Once again, this is really more a question for a pathologist which I'm not, but, and this is under microscopic so they're looking under, at slides.

Q. Sure.

A. They see inflammatory cells.

Q. Did Dr. Rizzo and you discuss as to a time frame in which Mr. Kidd's condition became irreversible?

A. No.

Q. Do you have an opinion as to when Mr. Kidd, at what time period Mr. Kidd's condition became

irreversible, meaning unsurvivable?
A. No.
Q. And Dr. Rizzo didn't convey to you an opinion regarding that issue?
A. No.
Q. And you understand my question regarding survivability, at what point, what was the last point in time he could have been given medical treatment which would have saved his life?
MR. WALTERS: With certainty or probability, to a possibility? I don't know what that question --
Q. No, I'm just asking if you have an opinion?
A. I don't have an opinion.
Q. And Dr. Rizzo didn't have an opinion either, did he?
A. No. Not that we discussed.
Q. Okay.
MR. WALTERS: Yeah, Dr. Rizzo may have all sorts of opinions. I don't --
MR. CONWAY: He may.
Q. Wouldn't it have been reasonable to personally examine Mr. Kidd on December 1st prior to recommending that he continue to take Darvocet?
A. Vicodin, it was Vicodin.

Q. I'll strike that question.

Wouldn't it be reasonable to examine Mr. Kidd on December 1st prior to instructing him to continue taking Vicodin?

MR. WALTERS: What about the part that he refused an appointment don't you get? I mean, I don't know what to say.

A. It would have been preferable if I could have examined him, yes.

Q. Have you ever had patients that you wanted to examine and refused an examination?

A. Yes.

Q. Okay. Do you have to prescribe medication, including a medication such as Vicodin to a patient just because they ask you?

A. No, you don't have to.

Q. Okay. Have you ever refused to prescribe a painkiller such as Vicodin to a patient who refused to come in and allow you to examine him?

A. Yes.

Q. And why didn't you do it in this case?

MR. WALTERS: I think we've been over that about four times. You certainly covered it once.

MR. CONWAY: Well, I don't recall

and if I did I apologize.

MR. WALTERS: Well, here, let me, before you answer --

MR. CONWAY: No, I'm going to ask her for her answer, Steve.

MR. WALTERS: No, I don't want her to give it twice. My point is, Tom, you've been through this, you covered that appointment in detail and then said do you typically prescribe Vicodin over the phone, she said no, I don't, then the question was why did you and she described that. You even asked her about the standard of care as it relates to Vicodin over the phone. I don't know what else you want to do on that same area and ask the question again. I realize you have it written down, but you already asked it. You thought of it before.

MR. CONWAY: No, I'll show you where I have it written. I would not waste my time writing a question twice. What I'm saying is I'm not infallible, but I don't believe I've asked it. I have written it right here.

MR. WALTERS: What was the question? Go ahead.

MR. CONWAY: I've forgotten.

MR. WALTERS: Let the court reporter read it back.

MR. CONWAY: Want to see my notes?

MR. WALTERS: No, I don't doubt it, but you deviate from the notes every now and then and ask some additional questions and you've already asked this and I don't want to be here until 4:00 in the afternoon. It's unfair to the doctor.

MR. CONWAY: And to everyone if in fact you're wrong.

MR. WALTERS: I'm not wrong.

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(Thereupon, the requested portion of the record was read by the Notary.)

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MR. WALTERS: It's been asked and answered. Go ahead.

A. I knew the family fairly well, I did not think they were going to abuse narcotics, they were refusing to come in, I wanted to do something to try to help him.

Q. Did anybody tell you or explain allegedly to your staff as to why he didn't want to come in?

MR. WALTERS: What does explain allegedly mean? I'll object to the form of the question.

MR. CONWAY: Okay. That's fine.

MR. WALTERS: Go ahead.

A. I don't know his exact words or reason for not wanting to come in.

Q. Did you ask Cheryl or whoever the other guy was or any of your medical assistants to find out what the Kidds' reasoning was for not wanting to come in for an appointment?

A. I did not specifically ask them.

Q. And I take it none of your assistants asked them, is that correct?

A. I don't know if they did or not.

Q. They didn't communicate anything to you, that's fair, right?

A. Right.

Q. Prior to this office visit on November 26th when he presents to you for Strep throat, which you diagnose --

A. Prior to that are you saying?

Q. Prior to that, yeah, prior to that time was

Mr. Kidd a compliant patient?

A. To my knowledge.

Q. Is there a difference between telling a patient he can go to the emergency room versus telling a patient he must go to the emergency room?

A. I think there is an urgency going along with that.

Q. And I take it you've been in positions where you've told a patient that it's optional, they can go to the emergency room if they want, correct?

A. Uh-huh. Yes.

Q. But you don't really feel it's medically necessary, correct?

A. I'm sorry, now repeat this.

Q. Okay. I take it there has been, there's a difference in how you phrase the, there's a difference in telling -- strike that.

There's a difference between telling a patient he can go to the emergency room if he wants versus telling him that he should or must go to the emergency room?

MR. WALTERS: Objection. She just, she's not going to answer it again.

Q. And you said yes, I'm asking the next question,

then she asked me to repeat.

MR. WALTERS: Yeah, repeat the question. We don't need to go over the old one.

Q. And I did repeat the question. You've had situations where you've told a patient they can go to the emergency room if they desire, correct?

A. Usually I say you can go if it gets worse. If I tell somebody to go it's not an iffy thing, if I'm telling them to go I think they should go.

Q. Okay. So you would have two ways of handling the subject of an emergency room visit, one is if you feel it's medically necessary you tell them they must go to the emergency room, correct? Is that correct?

A. I say you need to go, yes.

Q. Okay. The other situation is much more optional with the patient, you can say or you would say you can go if things don't improve, correct?

A. Yes.

Q. Do you have an opinion as to when Mr. Kidd's retropharyngeal abscess first began?

A. No.

Q. Did Dr. Rizzo, in your discussions, indicate an opinion as to when Mr. Kidd's retropharyngeal

abscess first began?
A. No.
Q. Did you discuss that issue with him?
A. I don't think we discussed timing.
Q. If Mr. Kidd's retropharyngeal abscess had been diagnosed and appropriately treated by 12:00 noon on December 1st, 2001, would you agree that more likely than not he would have survived?
A. I don't think I can answer that question.
Q. Okay. So you can't answer a question -- well, let's take it to November 30th, would you have an opinion regarding Mr. Kidd's survivability on that date had his retropharyngeal abscess been diagnosed and appropriately treated?
A. This isn't really my area of expertise. I think somebody would do better to answer that question.
Q. So you don't have an opinion regarding that?
A. No.

MR. WALTERS: If she ultimately develops an opinion based upon reviews of additional records, anything else, we will advise you of that and give you the opportunity to ask the question.

Q. Do you have any opinion regarding the life expectancy of Thomas Kidd had he not died from

his retropharyngeal abscess on December 1st, 2001?

A. I don't make those kind of --

Q. You don't have that kind of an opinion?

A. Correct.

Q. Have you done any type of literature search whether hard copy or through journals or on the internet of the subject matter of either a retropharyngeal abscess or a peritonsillar abscess?

A. No.

Q. Would you agree that a retropharyngeal abscess will not heal or resolve without drainage?

A. Very unlikely.

Q. Did you consider a chest x-ray for Mr. Kidd when he complained of chest symptomology to your medical assistant on November 30th?

A. Since I wasn't really seeing him I didn't suggest any tests at all to him other than providing him with what he wanted.

Q. If your medical assistants had communicated to you that Thomas Kidd's throat had actually gotten worse on November 30th from the way it was on November 27th, what would you have done?

A. I would have wanted him to come back in.

Q. And what would your differential diagnosis have been at that time?
A. I would be worried still about peritonsillar abscess, cellulitis is another event that's not quite as bad as an abscess, mono is always a possibility in that case, then you can have other processes, you can even have a tumor of some sort, but it's less likely.
Q. On December 1st had your office personnel communicated to you that in addition to his hallucinations, the hallucinations he had, that his throat was much worse than it had been on November 27th, what would your reaction have been?
A. If they had said that to me?
Q. If your office staff had communicated to you that --
A. His throat is worse.
Q. That Mr. Kidd's throat was much worse than it was on November 27th and additionally he's hallucinating, what would your reaction have been?
A. Come in right now or go to the emergency room.
Q. Would you have communicated that it's a necessity that he go to the emergency room or come in?

A. Almost every time we try to get somebody on the schedule we indicate that to them.
Q. Back on November 27th, if you want to go to your --
A. Office visit.
Q. Chart note, yes. It says here under plan, I have discussed with him -- well, let's go back. Prednisone 10 milligrams, number 20, four per day every day times five days, right?
A. Yes.
Q. To be used if he continues to have a lot of pain in the throat. He was complaining of a lot of pain in the throat correct?
A. Yes.
Q. I have discussed with him the possibility of having a peritonsillar abscess so he is to keep an eye on it and see if there is any uvular deviation at all during the rest of the day, is that what you communicated to him?
A. Yes.
Q. Did you communicate to him exactly what a peritonsillar abscess is?
A. Yes.
Q. What did you tell him?
A. I told him it's an infection surrounding the

tonsil that will cause a pushing out of the tonsil and will cause the uvula to deviate.

Q. Did you tell him what the repercussions of having that infection would be?

A. I told him we would have to send him to an ear, nose, and throat doctor if that was the case.

Q. And he understood that?

A. He seemed to.

Q. Do you believe that that's the standard of care, to have a patient monitor himself for a possible condition of peritonsillar abscess?

A. Absolutely.

Q. You don't believe the standard of care would require you to schedule a follow-up appointment if you believe that he possibly could be suffering from that condition?

A. A follow-up would occur if he was developing signs of it.

Q. Were any of your medical records, to your knowledge, doctor, altered in any way by any of your office staff?

A. No.

Q. Have you spoken with any of your office staff regarding whether or not they altered any medical records?

A. No.
Q. I'd like to know the timing as best I can of the different phone calls. If you can even tell from your records.
MR. WALTERS: Yeah, what's contained on the time.
Q. Well, I see that there's some timing, but I don't know what the time means, but if you explain it I'll pick up pretty quickly and we won't have to go through every one.
MR. WALTERS: It says, it has a date and a time.
MR. CONWAY: Okay.
MR. WALTERS: I'm assuming there are things that occur around that, but.
Q. Well, let's just, for instance, go to the 11/27/01 note which is Bates stamped page 4 of your exhibit. At the bottom it says 8:30. Is that when Tom Kidd would have called in?
A. In this case he called in through the service at 7:42 a.m. You can see that on the top.
Q. All right.
A. So my secretary received that from the service and actually took the message at 8:30.
Q. Then there's the 11/27/01 follow up, we don't

know what time that call was made, correct?
A. Where are you talking about?
Q. On the right of that. It says follow up 11/27.
A. I have no idea what time that was spoken.
Q. All right. And the same then if we go over to the next page, 11/27/01 at 12:05, that would be what time Tom Kidd called into your office, correct?
A. Yes.
Q. We don't know what time you would have responded or had your office respond to him after you were aware of the message, correct?
A. This one my nurse talked to him immediately and he was told to come right now and then I saw him within an hour after that.
Q. Going to 11/30/01 at 8:40 a.m., it appears Robin Kidd called in at that time of day, right?
A. Yes.
Q. And we don't know what time that you had your office respond to them, is that correct?
A. Once again, the call was given to the clinical staff, they talked to either the patient or Mrs. Kidd immediately and then he came back and talked to me immediately. It was, that was quick timing there. I know that was very fast

turn-around then.
Q. Because you have a recollection of this?
A. Right.
Q. Then we go to November 30th at 1:42 p.m., that's Robin once again apparently calls in, gives a message to your staff, then when is your response communicated to Robin Kidd, do you know the timing?
A. No.
Q. When do you call the Vicodin prescription in, do you know?
A. It looks, I can't tell if Bob called, put a time on there or not. It might have been 3 -- I can't tell if that says 3:30. I'm not sure.
Q. Let's go to December 1st, 2001, what's the chronology of what occurred on this date according to the custom and practice of your office and your review of this note?
A. Same thing, the call was probably given to Cheryl immediately or very soon because it was a returning a call, so usually the office, the front desk will call back to the nurses to see if they're sitting there or if they're busy, then they will just tell the person that they will call them right back as soon as they get out of

the room. So that was pretty quick that Cheryl got, talked to her and then the same thing with my discussion with Cheryl was fairly quick.

Q. So according to this it appears that the response here at 12/1/01 was made soon after the call was first received by your office?

A. Yes.

MR. WALTERS: I don't know if you know when the initial, there is an initial call obviously made, I don't know what time, whether that represents this time or the other time.

Q. Now, let's just go through real quick with who we can identify as charting on each note. Let's start with the 11/27/01, that's taken, this message is taken by who?

A. Cindy Manley.

Q. Anybody else from your office involved in this office note?

A. Cheryl Keller.

Q. Is that K-e-l-l-e-r?

A. Yes.

Q. She's your LPN?

A. Yes.

Q. All right. Anybody else?

A. Not on that one.
Q. Going to the 11/27/01, 12:05 note.
A. The same.
Q. Cindy Manley and Cheryl Keller?
A. Yes.
Q. The November 30th, 8:40 a.m. note?
A. Cindy Manley and Bob Whelchel.

MR. CONWAY: Boy, I hope this isn't my only copy. You have a copy, right?

MR. WALTERS: Of what?

MR. CONWAY: Of these notes.

MR. WALTERS: No.

Q. Anybody else on this one?
A. No.
Q. The November 30th, 1:42?
A. Cindy Moses.
Q. She's another medical assistant?
A. No. Receptionist.
Q. All right. Is she the one who took the call?
A. Yes.
Q. All right.

MR. WALTERS: Here's an extra copy for you.

Q. And who else?

A. Bob Whelchel.
Q. How long has Bob Whelchel been medical assistant?
A. Five years, I think. I'm sorry, on the one before that I wrote the Soma samples, so that's my writing on the Soma samples.

MR. WALTERS: We've covered most of this. You're compelled to go over it again. Are you almost done? Tom, are you almost done?

MR. CONWAY: I don't know, Steve. Off the record for just a second.

- - - -

(Thereupon, a discussion was had off the record.)

- - -

MR. CONWAY: Now, because of that can I please have the last question reread again so I can recall what it was.

A. I can tell you you didn't finish the last one.
Q. Okay. Which one were we on before we were interrupted by your counsel?
A. The November 30th, 1:42.
Q. All right. Bob Whelchel, Cindy Moses and who else?
A. And then I wrote the Vicodin.

Q. Okay. Then we can go to December 1st at 10:50.
A. Cindy Manley, Cheryl Keller.
Q. Going to the autopsy report, in retrospect Mr. Kidd's symptoms and his clinical presentation was being caused by that retropharyngeal abscess, would you agree?
MR. WALTERS: Objection. We've already covered this at the very beginning.
A. Yes.
Q. Okay. On December 4th, patient Thomas Kidd, caller Kathy from Public Health?
A. Yes.
Q. Okay. Are the cultures back. I don't understand this.
A. I am not sure. I presume this is cultures from his autopsy. I don't really know the answer to that.
Q. I'm just, I mean, it's in your chart, I'm just wondering what this note refers to.
MR. WALTERS: I don't know, what was so suspicious about I don't know what this is talking about?
MR. CONWAY: That's two of us then that don't know.
MR. WALTERS: I'm just curious

about what was confusing about I don't know as an answer to you.

MR. CONWAY: It's not. It's not.

Q. Were you involved at all in this?

A. No. Cheryl handled it.

Q. All right. Did you have, did you contact Robin Kidd following Thomas's death?

A. Yes.

Q. How many times did you call her?

A. I'm not really sure. I think I might have talked to her twice. I'm not positive.

Q. When was the first time you called her?

A. After I found out he died.

Q. Would that have been on the 1st?

A. Yes, in the evening.

Q. Around 6:00 p.m.?

A. I thought it was a little bit later, but I don't know.

Q. And what did you tell her at that time?

A. I asked her what happened.

Q. And what did she tell you?

A. She said she didn't know.

Q. What else did you talk about?

A. I know that she has an alcohol problem and I asked her if she had thought about drinking.

Q. Are you her primary or were you her primary care physician at the time?
A. I was, yeah.
Q. What else did you two talk about?
A. That's all I remember.
Q. All right. Was there a conversation that you recall after December 1st?
A. I had talked to Robin about anxiety. She was having anxiety.
Q. On what date?
A. I don't have her chart. I don't know.
Q. And do you recall what that conversation was, what was said?
A. She was having a lot of anxiety and she wanted medication and, once again, didn't want to come in. And I told her I have things I can help you with and I can call in a couple things for her but I'd rather see her and make sure everything is okay and she didn't want to come in.
Q. Both of those phone calls were instigated by you, correct?
A. Well, I think the one she had called for medications and then I called her back. There might have been another one, too, because when I talked to Dr. Rizzo he wanted the kids to get

throat cultures so I had talked to her about having throat cultures for the kids, which she didn't do either. And that may be what that one message alluded to. I don't know what that was about.

Q. Doctor, if you can give me one second to look over my materials.

MR. WALTERS: Did you mean a minute?

MR. CONWAY: Yes, sir. I misspoke.

Q. Why did you decide to treat Thomas Kidd's Strep throat on November 26 with an IM injection of penicillin versus an oral prescription?

A. That's the standard of care, it ensures that the patient gets the entire dose.

Q. What are exudates?

A. Little pockets of pus on the tonsils.

Q. Do you think or do you have an opinion as to whether or not Mr. Kidd's decision not to take the Prednisone contributed to his death?

A. I think it might have helped. I don't know if it would have prevented it.

Q. And you've explained previously so I don't have to ask why it would have helped, right?

A. Correct.
Q. So, going to the Exhibit Number 1 Bates stamped page 004, on the November 27th, 8:30 a.m. --
A. I'm sorry.
Q. Oh, I'm sorry.

MR. WALTERS: Exhibit Number 1 was the autopsy.

MR. CONWAY: Correct. I apologize.

Q. Exhibit Number 2.

MR. WALTERS: The phone messages.

Q. The November 27th, 2001 8:30 a.m. message, it says 11/27/01, give it time, did you specify to Mr. Kidd how much time he should give it?
A. Once again, this was Cheryl relaying the message for me.

MR. WALTERS: Objection.

A. And I said it's contagious for 24 hours, it takes about at least 24 hours before you start to feel better.

MR. WALTERS: She answered that question before. I think now the only thing you can do is duplicate your questions. You've asked every question that you can think of.

Q. Have you ever had any type of disciplinary action taken against you or your license?
A. No.
Q. Any type of action taken against your privileges at a hospital?
A. We were not allowed to renew our privileges at Geauga because we were owned by another hospital.
Q. Other than that?
A. No.
Q. Have you ever been asked to review a case as an expert witness?
A. No. Wait. In a, a, what do you call those claims?

MR. WALTERS: Motor vehicle accident.

A. In a motor vehicle accident. I think I did two of them.
Q. On behalf of who, the insurance company or the injured?
A. The defense.
Q. The insurance company?
A. Yes.
Q. Okay.

MR. WALTERS: Well, I'm sure it wasn't for an insurance company, it was

probably for an individual who was insured through an automobile policy.

Q. Have you ever had a patient die from a peritonsillar abscess other than -- have you had any patient die from a peritonsillar abscess?

A. No.

Q. How about a retropharyngeal abscess?

A. Just Tom Kidd.

Q. Okay, doctor. I don't have anything else. Thanks. The only thing I would ask is that, obviously, if there's something I have a question about regarding, that flows from my review of your original chart that I get an opportunity to question you about that. Thank you.

MR. WALTERS: We will read it.

_____

CAROL L. NOALL, 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 29th day of August A.D. 2003.

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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COUNTY OF LAKE

SALVATORE G. RIZZO M.D.
LAKE COUNTY CORONER
104 E. ERIE STREET
PAINESVILLE, OHIO 44077
(440) 350-2789 or (440) 974-4999

AUTOPSY REPORT

Name: Kidd, Thomas J.
Age: 41 years
Date and Time of Death: 12/1/01 at approximately 1:00 to 2:00 P.M.
Date and Time of Autopsy: 12/2/01 at 9:00 A.M.
Case Number: LC01-91

CAUSE OF DEATH: Abscess of retropharynx, paratracheal and paraesophageal soft tissue, mediastinum, and pleural spaces

DUE TO: Streptococcal pharyngitis with perforation of pharyngeal abscess into retropharynx

MANNER OF DEATH: Natural

S. G. Rizzo, Coroner

JAN 7, 2002
Date

EXHIBIT
Noall-1

FINAL DIAGNOSES:

I. Streptococcal pharyngitis, clinical, anamnestic
   A. Ulcer of posterior pharynx with rupture to retropharyngeal space
   B. Abscess, continuous, descending from retropharynx to paratracheal and paraesophageal tissue, and into mediastinum and bilateral pleural spaces
      1. Abscess of soft tissue posterior to right lobe of thyroid gland
      2. Fibrinous pleuritis, severe
         a. Pus in pleural cavities: left, approximately 200 mL; right, approximately 700 mL
      3. Tissue Gram stain (Tworts) of purulent pleuritis showing mixed infection with Gram positive cocci and bacilli and Gram negative cocci and bacilli
      4. Diffuse alveolar damage
         a. Vascular congestion
         b. Interstitial edema with sparse inflammatory infiltrate
         c. Hemorrhagic intra-alveolar edema
         d. Multifocal hyaline membrane formation with focal intraluminal fibrinoid deposition
         e. Increased intra-alveolar macrophages
      5. Fibrinous pericarditis
      6. Necrotizing esophagitis

II. Hypertrophic cardiomyopathy, probably hypertensive
   A. Coronary atherosclerosis, severe
   B. Cardiomegaly, 470 gm
   C. Biventricular hypertrophy: left, 1.5 cm; right, 0.4 cm
   D. Aortic atherosclerosis, mild

GROSS ANATOMIC DESCRIPTION

EXTERNAL EXAMINATION: The body is that of a 41 year old white man, weighing approximately 160 to 175 pounds and measuring 70½ inches in length. The body appears normally developed and the nutritional status is good. Rigor mortis is partial. Livor mortis is posterior and fixed. There is plethora of the head, neck, and superior thorax. The body is cold. The hair is brown and of normal amount, distribution, and texture. The face is unshaven. The conjunctivae are injected. There are occasional conjunctival petechiae. The corneas are clear. The irides are blue. The pupils are unremarkable. The ears, nose, and mouth show no abnormalities. The teeth are natural and in good repair. The neck is of normal configuration, and there are no palpable masses. The thorax is symmetrical and normal in configuration. The abdomen is normal. The external genitalia are of normal male conformation, and there are no external lesions. The extremities appear normal, and the joints are not deformed. All digits are present. The skin is of normal pliability and texture and presents no significant lesions. There is no icterus.

SCARS AND IDENTIFYING MARKS: None

EXTERNAL AND INTERNAL EVIDENCE OF RECENT THERAPY: None

EXTERNAL AND INTERNAL EVIDENCE OF RECENT INJURY: None

INTERNAL EXAMINATION: The body is opened by means of the usual "Y" and biparietal incisions. The viscera of the thoracic and abdominal cavities occupy their normal sites. There is a marked amount of pleural and mediastinal pus, and there are fibrinoid deposits over the pleural surfaces. There are approximately 200 mL of pus in the left pleural cavity and 700 mL of pus in the right pleural cavity. There is fibrinous pericarditis. The abdominal cavity appears normal. There are no abnormal masses present. The diaphragmatic leaves are normally situated. The margins of the liver and spleen are in proper relationship to their costal margins. The weights of the organs are as follows and, unless specified below, show no additional evidence of congenital or acquired disease.

Heart - 470 grams,
Right lung - 750 grams,
Left lung - 870 grams,
Spleen - 150 grams,
Liver - 2520 grams,
Right kidney - 200 grams,
Left kidney - 220 grams,
Brain - 1490 grams.

NECK: The neck organs are excised *en bloc* and examined separately. The strap muscles show

no contusions or hemorrhage. The cartilaginous structures are intact. There is moderate erythema and edema of the pharynx, epiglottis, and true and false vocal cords. A small amount of white exudate is present on the epiglottis. There is a small, deep, ulcer or ruptured abscess in the right posterior pharynx, measuring approximately 0.3 cm in diameter. Insertion of a probe into this defect demonstrates that it communicates freely with the retropharyngeal space. There is frank pus and deposition of fibrinous material in the retropharyngeal space. The retropharyngeal abscess tracks downward continuously along the right side of the trachea and esophagus. It forms a communicating abscess posterior to the right lobe of the thyroid gland. Further dissection demonstrates continuity of the abscess along the larynx and trachea into the right side of the mediastinum, where purulence becomes diffuse in the mediastinum and continuous with the pleural spaces bilaterally, where there are marked, confluent pleural purulent deposits and bilateral accumulations of pus in the pleural cavities. The paravertebral musculature is unremarkable. The cervical spine is unremarkable.

CARDIOVASCULAR: The heart is normal in configuration but enlarged.

The coronary arteries have a normal anatomic distribution, and multiple cross sections show moderate to severe atherosclerosis with no evidence of thrombosis. The left anterior descending artery is approximately 75% stenotic. The circumflex artery is over 50% stenotic. The right coronary artery, which is dominant, is over 75% stenotic.

The epicardium is roughened by fibrinous pericarditis. There is a normal amount of subepicardial fat and its distribution is normal. The great vessels enter and leave the heart in a normal manner. The cardiac chambers have a normal configuration. The septa are intact, and there are no congenital abnormalities. The myocardium is of normal consistency and appearance. The left and right ventricles are 1.5 cm. and 0.4 cm. thick, respectively. The heart valves are thin, pliable, and delicate, and are free of deformity. Valve dimensions appear within normal limits.

Aorta and its major branches: The aorta and its principal branches are patent throughout. There are no thrombi, areas of erosion, or zones of significant narrowing present. There is diffuse, mild, aortic atherosclerosis.

Venae cavae and their major tributaries: The superior and inferior venae cavae and their major tributaries are patent throughout. No significant areas of extrinsic or intrinsic stenosis are present.

RESPIRATORY: The major bronchi have a normal caliber and are free of obstruction. The right and left lungs have a normal lobar configuration. The visceral pleura is thickened and coated with confluent, purulent, fibrinous deposits. There are no subpleural emphysematous bullae. The pulmonary arteries are free of emboli and thrombi. The lungs have diminished crepitance. The parenchyma is severely congested. There is possible early pneumonia or consolidation in the right upper and middle lobes.

HEMIC AND LYMPHATIC: The spleen has a normal configuration. The capsule is blue-gray and smooth, without areas of thickening. On section, the splenic pulp is of normal consistency and appearance.

No abnormal lymph nodes are encountered.

DIGESTIVE: The esophagus shows longitudinal black streaks along the tops of the mucosal ridges in the distal 1/3 segment. These stop abruptly at the gastroesophageal junction. The stomach has a normal configuration. The serosa is smooth and glistening. The wall is of normal thickness and the mucosa is thrown into rugal folds. There are no areas of ulceration. It contains 10 mL of coffee-ground mucous material. The duodenum is free of ulceration and other intrinsic lesions. The remainder of the small bowel, the colon, and the rectum are normal in appearance. The appendix is present and is unremarkable.

LIVER: The capsule is smooth and glistening. The liver configuration is normal. Multiple cross sections reveal a normal lobular pattern with patchy yellowing of the parenchyma.

The gallbladder is of normal size and configuration. The wall is thin and the mucosa is bile-stained. It contains 25 mL of sludgy bile. No calculi are present.

PANCREAS: The pancreas is of firm consistency and normally lobulated. Multiple cross sections reveal normal tan-pink parenchyma without intrinsic lesions.

GENITOURINARY SYSTEM:

Kidneys: The right and left kidneys are similar. The capsules strip with ease to reveal smooth subcapsular surfaces. The renal arteries and veins are patent and free of stenosing lesions. On section, the renal cortices are of normal thickness and the corticomedullary demarcations are distinct. The medullae are unremarkable. The pelvocalyceal systems are normal in appearance. The ureters are unremarkable.

Bladder: The bladder is of normal configuration. The mucosa is intact and free of ulcerations or other lesions. It contains approximately 5 mL of cloudy, yellow-green urine.

Prostate and seminal vesicles: Multiple cross sections through the prostate reveal rubbery, firm, gray-white parenchyma, free of lesions. The seminal vesicles are unremarkable.

Testes: The testes are both present within the scrotal sac, and bivalve sections show a normal parenchyma.

ENDOCRINE SYSTEM: No abnormalities are present in the pituitary, thyroid, or adrenal glands.

MUSCULOSKELETAL: The axial and appendicular skeleton show no abnormalities. The exposed musculature is unremarkable.

HEAD/BRAIN: The scalp shows no evidence of contusions or subgaleal hemorrhage. The skull is intact. The dura is smooth and glistening. The convexities of the cerebral hemispheres are symmetrical. The leptomeninges are thin and transparent. The subarachnoid space does not contain any hemorrhage. The cerebrum presents normal convolutions, with no flattening of the gyri or deepening or widening of the sulci. There is no evidence of subfalcial, uncal, or cerebellar

tonsillar herniation present. The major cerebral arteries show no significant atherosclerosis and appear to be patent throughout. The roots of the cranial nerves are unremarkable. Serial coronal sections through the cerebral hemispheres show a grossly normal cortical ribbon and underlying white matter. The basal ganglia and diencephalon show no gross abnormalities. Serial cross sections through the brain stem and coronal sections through the cerebellum fail to show any gross lesions or abnormalities. The ventricular system is symmetrical and of normal size and configuration. After removal of the brain, the base of the skull does not demonstrate any fractures.

The cervical spinal cord segment usually obtained at autopsy is unremarkable. A section of thoracic spinal cord is unroofed and resected. There is no epidural collection of pus, and the cord itself appears normal.

MICROSCOPIC DESCRIPTIONS

Coronary arteries:	Atherosclerosis, severe
Heart:	Fibrinous pericarditis with chronic inflammation
Posterior pharynx:	Abscess with perforation to retropharyngeal space Acute inflammatory reaction, with edema and fibrinoid deposition
Thyroid:	Normal thyroid parenchyma Abscess and necrosis of adjacent soft tissue
Esophagus:	Paraesophageal abscess with acute inflammation Necrotizing esophagitis
Lungs:	Fibrinous pleuritis, severe Vascular congestion Interstitial edema with sparse inflammatory infiltrate Hemorrhagic intra-alveolar edema Multifocal hyaline membrane formation with focal intraluminal fibrinoid deposition Increased intra-alveolar macrophages Tissue Gram stain (Tworts) of purulent pleuritis showing mixed infection with Gram positive cocci and bacilli and Gram negative cocci and bacilli

NAME
ADDRESS
OCCUPATION / EMPLOYER
MEDICATION
DATE
DIAGNOSIS

4th message

PHONE MESSAGE FOR Cindy M. URGENT ☒ Yes ☐ No

Patient Thomas Kida ☐ New ☐ Est.
Caller Thomas
Phone (216) 509-2885
Allergies Cell phone Age
Message

Date 6-9-00 Time 2 45p By SLH

Follow Up
Pharmacy Phone #
Medication
Dosage
Refill ☐ Yes ☐ No
Date By

5th message

PHONE MESSAGE FOR DW URGENT ☒ Yes ☐ No

Patient Thomas Kida ☐ New ☐ Est.
Caller
Phone 254-2706
Allergies pager # Age
Message 1-216-670-1472 — He would like his Rx called in.

Date 6-9-00 Time 3 45p By SLH

Follow Up
Pharmacy East Washington St.
Phone #
Medication
Dosage
Refill ☐ Yes ☐ No
Date By

PHONE MESSAGE FOR CV (service 11/27 7:42am) URGENT ☐ Yes ☐ No

Patient Tom Kidd ☐ New ☐ Est.
Caller 254 2706
Phone
Allergies Age
Message One side of throat is still sore.

Date 11/27/01 Time 8 30 By CV

Follow Up 11/27/01 Give it time. Just had PCN inj. yest. evening. Call 11/27/01
Pharmacy Phone #
Medication
Dosage
Refill ☐ Yes ☐ No
Date By

000004

PLAINTIFF'S EXHIBIT No. 11-2

DATE
DIAGNOSIS

PHONE MESSAGE FOR CW

URGENT ☐ Yes ☐ No

Patient Tom Kidd ☐ New ☐ Est.

Caller

Phone 254-2706

Allergies Age

Message going to ER Cant breathe — call given to Cheryl

Date 11/27/01 Time 1705 By CW

Follow Up 11/27/01 Pt has @ SOB. Severe throat pain. Hard to swallow. refuses to go to ER.

Pharmacy Phone # Pt will come

Medication right down

Dosage

Refill ☐ Yes ☐ No

Date By

PHONE MESSAGE FOR CW

URGENT ☐ Yes ☐ No

Patient Tom ☐ New ☐ Est.

Caller Robin Kidd

Phone 254 2076

Allergies Age

Message C/o chest tightness & back pain wants muscle relaxer
Call given to Rob

Date 11/30/01 Time 840 By CW

Follow Up [illegible]

Pharmacy Phone #

Medication

Dosage

Refill ☐ Yes ☐ No

Date By

Called

PHONE MESSAGE FOR CN

URGENT ☐ Yes ☐ No

Patient Tom Kidd ☐ New ☐ Est.

Caller Robin

Phone 254-2706

Allergies Age

Message RX- Carisoprodol (muscle relaxer) it's not working

Date 11/30 Time 1:42 By CM

Follow Up [illegible]

Pharmacy Phone #

Medication Vicodin

Dosage #40

Refill ☐ Yes ☐ No

Date By

PHONE MESSAGE FOR a/

URGENT ☑ Yes ☐ No

Patient: Tom Kidd

Caller: Mrs ☐ New ☐ Est.

Phone:

Allergies: Age:

☐ Call back ☐ Rx Refill ☐ Illness ☐ Test Results ☐ Injury ☐ Insurance ☐ Other ☐ Billing

Message: RYC - Re: pain meds up all night c/ + pain hallucinating - (R) appt. CONT.

Date: 12/01/01 Time: 10:50 By: (a)

halpi pain asleep. Monitor condition + call us asap.

Follow Up: 12/1/01 hallucination ... can't breath through nose. Mouth breathing. [illegible] dose [illegible] 11A yest. Pharmacy Phone #: slight fever (Ø [illegible]) Medication: hallucinations - saying things make no sense. Dosage: Ø sleep in 48hrs. Refill: [illegible] Vicodin Rx By: [illegible]

PHONE MESSAGE FOR CD

URGENT ☐ Yes ☐ No

Patient: Thomas Kidd

Caller: Kathy - Public Health ☐ New ☐ Est.

Phone: 350-8554

Allergies: Age:

Message: Are the cultures back

9:15

Date: 12/4 Time: 9:40 By: CJK

Follow Up: 12/5/01 results [illegible] per Dr. [illegible]. Kathy aware [illegible]

Pharmacy Phone #:

Medication:

Dosage:

Refill ☐ Yes ☐ No

Date: By:

PHONE MESSAGE FOR a/

URGENT ☐ Yes ☐ No

Patient: Thomas Kidd

Caller: Atty: Michael Sunsan ☐ New ☐ Est.

Phone: 216-861-4100

Allergies: Age:

Message: Records were received but message for 12/01/01 phone message was cut off please fax or mail to atty.

216-861-0418

Date: 02/26/02 Time: 11:40 By: (a)

Faxed 1640

Follow Up:

Pharmacy Phone #:

Medication:

Dosage:

Refill ☐ Yes ☐ No

Date: By:

[illegible] 2/26/02

LAWYER'S NOTES

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