

1 THE COURT OF COMMON PLEAS

2 GEAUGA COUNTY, OHIO

3 ROBIN KIDD, etc.,
4 et al.,

5 Plaintiffs,

6 -vs-

JUDGE FORREST W. BURT
 CASE NO. 03 PT 216

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

9 Defendants.

10 - - - -

11 Deposition of CAROL L. NOALL, M.D., taken as
12 if upon cross-examination before Dawn M. Fade, a
13 Registered Merit Reporter and Notary Public
14 within and for the State of Ohio, at the offices
15 of Reminger & Reminger, 1400 Midland Building,
16 Cleveland, Ohio, at 10:10 a.m. on Wednesday,
17 August 20, 2003, pursuant to notice and/or
18 stipulations of counsel, on behalf of the
19 Plaintiffs in this cause.

20 - - - -

21 MEHLER & HAGESTROM
 Court Reporters

22 CLEVELAND
23 1750 Midland Building
 Cleveland, Ohio 44115
 216.621.4984
 FAX 621.0050
24 800.822.0650

 AKRON
 1015 Key Building
 Akron, Ohio 44308
 330.535.7300
 FAX 535.0050
 800.562.7100

APPEARANCES:

Thomas E. Conway, Esq.
Friedman, Domiano & Smith
600 Standard Building
Cleveland, Ohio 44113
(216) 621-0070,

On behalf of the Plaintiffs;

Stephen E. Walters, Esq.
Reminger & Reminger
1400 Midland Building
101 West Prospect Avenue
Cleveland, Ohio 44115
(216) 687-1311,

On behalf of the Defendants.

W I T N E S S I N D E XPAGE

CROSS-EXAMINATION
CAROL L. NOALL, M.D.
BY MR. CONWAY

4

E X H I B I T I N D E XEXHIBIT:PAGE

Plaintiffs' Exhibit 1, six-page
Autopsy Report

10

Plaintiffs' Exhibit 2, three-pages,
phone message copies

41

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

7 CROSS-EXAMINATION OF CAROL L. NOALL, M.D.

8 BY MR. CONWAY:

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

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

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

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

1 fact that you understood it, is that fair?

2 A. Yes.

3 Q. If at any time you want to take a break to talk
4 with your attorney or take a break for any other
5 reason just indicate that to us and we will be
6 glad to do so.

7 If at any time during the deposition you
8 decide that you want to go back and change,
9 supplement, modify an answer you are free to do
10 so, you may go on the record and say whatever you
11 want, okay?

12 A. Yes.

13 Q. This is going to be my only opportunity to talk
14 with you prior to trial and I want to make sure
15 that you have an opportunity to say whatever
16 you'd like, okay?

17 A. Yes.

18 Q. You've had an opportunity to prepare for this
19 deposition with your attorney, correct?

20 A. Yes.

21 Q. Have you been deposed previously?

22 A. For this case?

23 Q. For any case.

24 A. Yes.

25 Q. Approximately how many times have you given prior

1 depositions?

2 A. Just once.

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

8 A. Yes.

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

12 A. I think the accurate diagnosis was mediastinal
13 abscess.

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

16 A. No.

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

19 A. At the office.

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

22 A. I didn't know to.

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

25 MR. WALTERS: I forgot. I

1 apologize.

2

3

MR. CONWAY: Okay.

4

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

8

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

10

MR. CONWAY: Okay.

11

MR. WALTERS: -- if in fact

12

Mr. Conway has additional questions as it
13 relates to reviewing the original chart we
14 will make, Dr. Noall will be available for
15 you.

16

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

18

MR. WALTERS: That's fine.

19

MR. CONWAY: All right. Fine.

20

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

22

MR. CONWAY: Correct.

23

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

25

MR. CONWAY: That were involved in

1 the charting.

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

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

6 A. Actually I have not.

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

11 A. Yes.

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

14 A. Yes.

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

17 A. No.

18 Q. Why not?

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

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

25 A. Can you repeat that?

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

3 - - - -
4 (Thereupon, the requested portion of
5 the record was read by the Notary.)
6 - - - -

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

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

11 A. No.

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

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

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

18 A. I think so.

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

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

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

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

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

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

12 MR. WALTERS: Object to the form.

13 A. Yes.

14 Q. Because after that the cause of death --

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

18 - - - -
19 (Thereupon, Plaintiffs' Exhibit 1, six-page
20 Autopsy Report, was marked for purposes of
21 identification.)

22 - - - -
23 Q. Showing you what has been marked for
24 identification as Plaintiffs' Exhibit Number 1,
25 this is Dr. Rizzo's autopsy report listing the

1 cause of death. Do you agree with --

2 MR. WALTERS: Well, wait a second.

3 Let her review. I don't want her -- the
4 final diagnosis is contained on page 2. I
5 would like, if you're going to ask her
6 questions about Dr. Rizzo's opinions then I
7 want her to have an opportunity, since she
8 has not seen this document before, to take
9 a look at it.

10 MR. CONWAY: That's fine.

11 MR. WALTERS: See what he actually
12 says.

13 A. Should I read this?

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

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

22 A. Yes.

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

25 A. From the emergency room.

1 MR. WALTERS: We have emergency
2 room records.

3 MR. CONWAY: Yes. Okay.

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

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

10 A. Okay.

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

12 A. Yes.

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

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

18 A. Yes.

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

21 MR. WALTERS: Objection.

22 A. It was -- yes.

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

1 A. At the time of the visit that I saw him, is that
2 what you mean?

3 Q. Your office was rendering medical care and
4 treatment to Mr. Kidd up through December 1st,
5 correct?

6 A. I treated him over the phone.

7 Q. Okay. So from the time period of November 26th
8 up and through December 1st you were rendering
9 medical care and treatment to Thomas Kidd,
10 correct?

11 A. Yes.

12 Q. And during that time period he had a
13 retropharyngeal abscess, correct?

14 A. He developed it, yes, during that time period.

15 Q. All right. And his death was caused by your
16 failure to diagnose and treat that
17 retropharyngeal abscess, correct?

18 MR. WALTERS: Objection.

19 A. I was unable to diagnose it adequately.

20 Q. And you were, you did not treat it, correct?

21 A. I treated the initial Strep infection and that
22 part was treated adequately. At the second visit
23 I gave him a prescription for Prednisone which
24 would have helped to treat a peritonsillar
25 abscess presuming that that was starting at that

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

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

10 - - - - -
11 (Thereupon, the requested portion of
12 the record was read by the Notary.)

13 - - - - -
14 A. I think --

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

17 Q. Do you believe that you adequately treated --

18 MR. WALTERS: Let him ask another
19 question.

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

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

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

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

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

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

23 A. No.

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

1 A. I was really unable to diagnose that condition.

2 Q. Your failure to diagnose and treat that condition
3 was the cause of his death, correct?

4 MR. WALTERS: You don't even have
5 to answer that question. She said she was
6 unable to diagnose it. You then said her
7 failure. She answered your question when
8 you said you failed to diagnose it, she
9 said I was unable to diagnose it, and then
10 you followed up with a misconstrued answer
11 by saying your failure.

12 MR. CONWAY: All right.

13 MR. WALTERS: Maybe you should
14 listen to her answers before she answers,
15 before you ask the next question.

16 Q. Let's use the term inability then, doctor. Your
17 inability to diagnose Mr. Kidd's retropharyngeal
18 abscess caused his death, correct?

19 MR. WALTERS: No. Objection.

20 A. Am I still supposed to answer this?

21 Q. Yes.

22 MR. WALTERS: If you can.

23 A. I don't know that I can answer that.

24 Q. Why not?

25 A. The cause of his death doesn't necessarily have

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

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

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

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

12 A. Yes.

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

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

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

21 A. Yes.

22 Q. Okay.

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

1 Q. Doctor, are you a family practice physician?

2 A. Yes.

3 Q. Okay. Did you pass the board certifications on
4 your first attempt?

5 A. Yes.

6 Q. Is there a journal that's recognized by family
7 practice physicians in this country as being a
8 reliable family practice journal?

9 A. I think we pretty much all read the American
10 Family Physician.

11 Q. Do you have a subscription to that journal?

12 A. Yes.

13 Q. Do you keep current with the literature in that
14 journal?

15 A. Pretty much.

16 Q. Do you find that journal to be reliable in your
17 practice of family practice medicine?

18 A. Pretty much.

19 Q. Okay. Where is, where would a retropharyngeal
20 abscess develop as opposed to a peritonsillar
21 abscess, doctor, in your opinion?

22 A. Anywhere in the pharynx, basically anywhere like
23 below, I don't really know the exact semantics,
24 an ear, nose, and throat doctor probably would be
25 better at saying what the retropharyngeal space

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

3 Q. Is considered what space?

4 A. The retropharyngeal space.

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

7 A. All around the tonsil.

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

10 A. No.

11 Q. Why not?

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

14 MR. WALTERS: At which point?

15 You're talking about ever?

16 MR. CONWAY: Correct.

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

1 Q. Doctor, at any time during your care and
2 treatment of Mr. Kidd did you consider referring
3 him to an ear, nose, and throat specialist?

4 A. No.

5 Q. Why not?

6 A. When I saw him initially he had Strep which we
7 treat in our office routinely and does not
8 require an ear, nose, and throat specialist. The
9 second day that I saw him, I was looking for a
10 peritonsillar abscess at that point in time, I
11 did not see one and there was no need to see an
12 ear, nose, and throat doctor at that time. I did
13 give him the Prednisone treatments to help
14 decrease the swelling, which is also given in the
15 case of a peritonsillar abscess, and I felt at
16 that time if one was starting that would prevent
17 it from going anywhere and at that time I also
18 told him to let me know if any signs of a
19 peritonsillar abscess should develop.

20 Q. How about on November 30th, did you at any time
21 consider referring him to an ear, nose, and
22 throat specialist?

23 A. That's when he called? At that point in time
24 this seemed to be a completely different problem,
25 when my nurse had talked to him he actually said

1 that the throat problem was better.

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

4 A. I think it's documented on the one from December
5 1st.

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

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

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

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

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

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

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

1 Q. From deer hunting prior to November 26th you
2 believed that that had caused him muscle soreness
3 resulting in his symptoms on November 30th and
4 December 1st?

5 A. That's what I thought.

6 Q. Doctor, what is a differential diagnosis?

7 A. It is a list of diagnoses that we think of when a
8 certain symptom complex occurs.

9 Q. Okay. It would be a list of possible causes of a
10 patient's condition?

11 A. Yes.

12 Q. Would you agree that you need to list the
13 possible serious or life-threatening conditions
14 at the top of that differential whether or not
15 they are necessarily the most common conditions?

16 A. Yes.

17 Q. Doctor, what is an abscess?

18 A. It's an infected space.

19 Q. Is it filled with anything?

20 A. Pus.

21 Q. Okay. Now, on November 27, 2001 you considered
22 the possibility that Mr. Kidd had a peritonsillar
23 abscess, correct?

24 A. Could you repeat that?

25 Q. On November 27th, 2001 you considered the

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

3 A. Yes.

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

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

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

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

17 Q. And peritonsillar abscess occurs to men in their
18 30s and 40s, would you agree?

19 A. It can happen.

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

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

1 Q. You made a determination here that in fact on
2 November 26th that Mr. Kidd was suffering from
3 Strep A, correct?

4 A. Yes.

5 Q. Would you agree that a retropharyngeal abscess
6 also occurs in the throat and is also caused by
7 group A beta-hemolytic Streptococcus?

8 A. It may be caused by that, yes.

9 Q. Would it have been reasonable for you to consider
10 the possibility that in addition to possibly
11 suffering from a peritonsillar abscess on
12 November 27th Mr. Kidd may also have been
13 suffering from a retropharyngeal abscess?

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

17 A. Well, I'm basically using peritonsillar and
18 retropharyngeal abscess as the same terminology.

19 Q. Does the medical literature recognize a
20 difference between those two conditions?

21 A. I don't know.

22 Q. Would that be something important to know?

23 A. Not for --

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

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- 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

1 out the existence of a peritonsillar abscess?

2 A. Physical exam.

3 Q. Okay. Anything else?

4 A. That's it.

5 Q. How about a neck x-ray?

6 A. Physical exam is the thing that we use first to
7 determine if anything else is required. I have
8 really never had to get an x-ray on anybody for a
9 peritonsillar abscess. You can visually see it.

10 Q. Have you ever diagnosed any previous patients
11 with a peritonsillar abscess?

12 A. Yes.

13 Q. Okay. Approximately how many?

14 A. I don't really know. Definitely in the tens,
15 probably 50. Maybe not that many.

16 Q. How was your diagnosis of peritonsillar abscess
17 confirmed?

18 A. I'm sorry, could you repeat that?

19 Q. Yeah. How were, in those particular cases where
20 you had patients who were diagnosed with
21 peritonsillar abscess, how were those diagnoses
22 confirmed?

23 A. When I diagnosed it myself I sent them to ear,
24 nose, and throat doctors who would subsequently
25 drain it.

1 Q. Would have done a needle aspiration and
2 determined in fact there was an abscess, correct?

3 A. Yes.

4 Q. And then at that point you would have run a
5 culture on the pus to determine antibiotic
6 sensitivity or resistance, correct?

7 A. I'm not sure what they would do next. Usually we
8 treat empirically. I don't know if they
9 routinely send it for culture or not.

10 Q. Can you diagnose, doctor, to your knowledge, a
11 peritonsillar abscess by way of an x-ray of the
12 neck?

13 A. An x-ray of the neck would show up sometimes, not
14 necessarily even all the time, evidence of an
15 abscess.

16 Q. Would a CT scan of the neck show evidence of a
17 peritonsillar abscess?

18 A. It certainly could.

19 Q. Would an ultrasound of the neck show a
20 peritonsillar abscess?

21 A. I don't know about an ultrasound. I'm not sure
22 if that modality is used for that.

23 Q. Do you know which of those modalities that I've
24 just asked you questions about is considered the
25 most reliable way to diagnose a peritonsillar

1 abscess?

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

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

6 Why did you not -- strike that.

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

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

12 A. The physical exam didn't warrant it.

13 Q. Is a peritonsillar abscess a medical emergency?

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

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

19 A. Yes.

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

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

24 Q. Cause sepsis?

25 A. Yes.

1 Q. Septic shock and death, correct?

2 A. Sure.

3 Q. At any time did you consider having a CBC count
4 of Mr. Kidd's blood taken or performed?

5 MR. WALTERS: You mean on the 26th
6 or 27th?

7 Q. On the 26th or the 27th. We can start there.

8 MR. WALTERS: Okay. Well, I don't
9 know where else to start. He refused to
10 come in on the other occasions.

11 MR. CONWAY: Okay. Steve, if I
12 can just go on the record for a second.

13 MR. WALTERS: Sure. You're on the
14 record. You're always on the record unless
15 we go off.

16 MR. CONWAY: But I can't talk
17 while you're talking simultaneously so
18 that's why I make that little request.

19 Q. If you don't understand a question just indicate
20 that to me and I'll be glad to rephrase it for
21 you. If Mr. Walters doesn't understand a
22 question I'm going to do him the same gracious
23 favor. However, regardless, he has made this
24 clear, I don't know, three or four times, that
25 Mr. Kidd did not come in on certain dates. I'm

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

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

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

12 A. No.

13 Q. Why not?

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

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

18 A. No.

19 Q. -- at any time?

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

22 A. Not on the phone.

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

1 is that correct?

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

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

7 A. Correct.

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

11 A. Yes.

12 Q. And they were employed by you, correct?

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

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

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

22 MR. CONWAY: Would you read it
23 back.

24 - - - -

25 (Thereupon, the requested portion of

1 the record was read by the Notary.)

2 - - - -

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

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

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

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

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

1 Prednisone comports with the standard of care?

2 A. Steroids are used in that instance, yes.

3 Q. Can you cite me any supporting authority?

4 A. No.

5 Q. Why would you treat a patient who possibly has a
6 peritonsillar abscess with Prednisone?

7 A. It helps with the inflammation.

8 Q. Any other reasons you would use Prednisone?

9 A. It's helpful in mono for that same reason, as
10 another, that's another thing on the differential
11 diagnosis. Once again, at this visit he did not
12 have evidence of that at this time.

13 Q. What would be the mechanics of Prednisone for
14 treating a peritonsillar abscess?

15 A. It helps shrink the tissues down.

16 Q. It doesn't get rid of the purulent material,
17 though, does it?

18 A. No.

19 Q. In fact Prednisone is a steroid, correct?

20 A. Yes.

21 Q. And steroids are immunosuppressive agents, aren't
22 they?

23 A. In the long run, yes.

24 Q. And they lower the body's ability to fight
25 infections, specifically bacterial infections,

1 correct?

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

6 Q. That involve abscesses?

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

12 - - - -
13 (Thereupon, the requested portion of
14 the record was read by the Notary.)

15 - - - -

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

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

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

25 Q. What antibiotics are standard of care to treat a

1 peritonsillar abscess, doctor?

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

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

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

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

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

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

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

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

22 A. Correct.

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

1 drain the abscess, is that correct?

2 A. Yes.

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

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

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

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

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

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

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

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

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

6 A. It's variable. You're definitely contagious for
7 24 hours. The shot is not totally effective for
8 24 hours so at least 24 hours, but it can take
9 longer.

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

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

17 Q. Are they variables that count, doctor?

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

20 Q. For a patient to become non-symptomatic?

21 A. Asymptomatic, yes.

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

25 A. Yes.

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

5 A. Yes.

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

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

24 MR. WALTERS: Is that how it
25 works?

1 MR. CONWAY: Yeah.

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

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

16 MR. WALTERS: They do.

17 MR. CONWAY: Okay.

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

24 MR. CONWAY: Yes, we will.

25 MR. WALTERS: Okay. Go ahead.

1 MR. CONWAY: Yes, we will.

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

7 A. Yes.

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

10 A. Correct.

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

14 A. Yes.

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

19 A. Yes.

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

25 A. Yes.

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

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

5 - - - -
6 (Thereupon, Plaintiffs' Exhibit 2,
7 three-pages, phone message copies, was marked
8 for purposes of identification.)

9 - - - -
10 Q. Doctor, I'm showing you photostatic copies of
11 different office message sheets which we've
12 received from your office pursuant to a records
13 request. You still have the originals in your
14 possession at your office, correct?

15 A. Yes.

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

20 Have you had an opportunity to look those
21 over?

22 A. Yes.

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

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

3 A. Yes.

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

10 A. Yes.

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

15 A. Not that I recall.

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

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

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

22 MR. WALTERS: You made a reference
23 to 2001 in your question, that's why I was
24 confused. It says, there is a June 9th,
25 2000 message that says 4th message.

1 MR. CONWAY: Right.

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

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

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

15 MR. CONWAY: No.

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

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

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

25 A. I don't recall.

1 MR. WALTERS: If she remembers.

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

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

11 A. How so?

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

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

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

23 A. The more we document the better.

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

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

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

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

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

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

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

20 A. No.

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

1 A. No.

2 Q. There is a phone message on November 30, 2001,
3 8:40 a.m., same question, is there anything
4 outside of the written contents of this phone
5 message that you recall regarding the
6 circumstances of this case?

7 A. I probably remember a little more on this one
8 because I was in a meeting at the time and my
9 medical assistant came and asked me about this
10 just because he had the chest tightness, and I
11 recall that it was more just like a muscle spasm,
12 not a typical chest pain that we would be worried
13 about with like a heart attack.

14 Q. Anything else outside of what's written here that
15 you recall about the circumstances of this phone
16 message?

17 A. No.

18 Q. Okay. Going to November 30th at 1:42 p.m., is
19 there anything outside the written contents of
20 this phone message that you recall?

21 MR. WALTERS: I'm sorry, which one
22 are we on now?

23 MR. CONWAY: November 30th at
24 1:42.

25 A. The only thing I remember is being surprised that

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

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

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

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

24 A. No.

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

1 phone messages yours?

2 A. The Vicodin prescription. I put Soma samples on
3 that one from November 30th at 8:40. And then on
4 the one from 1:42, the Vicodin number 40 PO Q4
5 hours PRN pain.

6 Q. On December 1st, any of that writing yours?

7 A. No.

8 Q. Doctor, how do you treat a retropharyngeal
9 abscess?

10 A. It requires an incision and drainage and
11 antibiotics.

12 Q. What type of antibiotics for retropharyngeal
13 abscess?

14 A. A broad spectrum that usually covers Staph and
15 Strep.

16 Q. Could you tell me why you went to the Lake County
17 Coroner's office while Dr. Rizzo was performing
18 the autopsy?

19 A. Dr. Rizzo invited me and I was interested to see
20 what happened.

21 Q. Can you tell me what the conversation was between
22 you and Dr. Rizzo which led to you coming down to
23 view the autopsy?

24 A. He knows I have an interest in pathology and at a
25 point in time being the coroner so he just

1 invites me at times.

2 Q. You have an interest in pathology?

3 A. I have an interest in being a coroner, so.

4 Q. Do you have any expertise in the area of
5 pathology?

6 A. No.

7 Q. Do you recall your discussions with Dr. Rizzo
8 regarding this case while you were at the
9 coroner's office?

10 A. We were all talking about what we thought was the
11 cause of death.

12 Q. Prior to him doing the autopsy?

13 A. Yes.

14 Q. And what was your belief as to what the cause of
15 death was prior to doing the autopsy?

16 A. I thought possibly heart attack, possibly
17 gastrointestinal bleeding.

18 Q. Why did you think it could have been GI bleeding?

19 A. One of the assistants to the coroner said that
20 there was some black color coming out of his
21 mouth at the scene.

22 Q. Why did you think a heart attack might have been
23 a cause?

24 A. The suddenness of his death basically.

25 Q. Do you have any criticism of any medical care and

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

3 A. No.

4 Q. Do you have any criticism of any other medical
5 provider who rendered care and treatment to
6 Mr. Kidd between the time periods of November
7 26th and the date of his death on December 1st?

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

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

11 A. No.

12 Q. Okay.

13 MR. WALTERS: Is there anyone
14 else?

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

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

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

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

1 December 1st, correct?

2 A. No. Correct.

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

7 A. Employee.

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

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

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

13 A. Lake County Family Practice.

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

16 A. About 15 months.

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

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

20 Q. Who was that?

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

22 Q. No, I know how to spell it.

23 Prior to Lake County Family Practice where
24 were you employed?

25 A. I was in my residency.

1 Q. Where?

2 A. Akron City which is now Summa Health System.

3 Q. You have an employment contract or, excuse me,
4 back in 2001 you had an employment contract with
5 Prime Health, Incorporated, is that correct?

6 A. Yes.

7 Q. And I take it all, everything you were doing
8 regarding your care and treatment of Mr. Kidd was
9 within the scope of your employment with Prime
10 Health, Incorporated, would that be correct?

11 A. Yes.

12 Q. Now, Prime Health, Incorporated, from the answers
13 I got in discovery is, it seems to also be owned
14 by Lake Hospital Systems, Incorporated.

15 A. Yes.

16 Q. Have you discussed Mr. Kidd's case with anyone
17 from Lake Hospital?

18 A. Just the coroner.

19 Q. Is he employed by Lake Hospital?

20 A. I don't think so. He's Lake County, I believe.

21 Q. How about any employee or agent of Lake Hospital
22 have you discussed this case with?

23 A. Not that I recall.

24 Q. Do you know what type of drug Metronidazole is?

25 A. Yes

1 Q. What type of drug is that.

2 A. It's an antibiotic.

3 Q. Okay. Have you ever prescribed that antibiotic?

4 A. Yes.

5 Q. What type conditions do you prescribe that drug
6 for?

7 A. Mostly intestinal problems, some vaginal
8 problems.

9 Q. Are you aware of any literature recommendations
10 regarding its use to treat peritonsillar
11 abscess --

12 A. No.

13 Q. -- with that drug?

14 A. Is that a continuation?

15 Q. Well, it was kind of the whole sentence, but you
16 answered it before I was done.

17 A. Sorry.

18 Q. That's all right.

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

24 A. Correct.

25 MR. CONWAY: Very well put,

1 Mr. Walters.

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

7 A. I think it would be the same.

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

12 A. No.

13 Q. Why not?

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

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

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

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

25 MR. CONWAY: Could you read that

1 back.

2 - - - -

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

5 - - - -

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

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

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

12 MR. CONWAY: We can use Thomas
13 Kidd.

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

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

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

24 Q. Thomas Kidd was diagnosed with Strep throat?

25 A. Yes.

1 Q. A possible sequela of Strep throat, you're aware,
2 can be peritonsillar abscess, correct?

3 A. Yes.

4 Q. The day following his diagnosis and the day
5 following the administration of a penicillin shot
6 Mr. Kidd was seen again by you at which time you
7 considered the possibility of peritonsillar
8 abscess, correct?

9 A. Yes.

10 Q. At that point in time didn't the standard of care
11 require that he be admitted to the hospital for
12 the performance of CBC, culturing of any type of
13 purulent fluid which was able to be aspirated by
14 a needle and radiology diagnostic films taken?

15 A. No.

16 Q. Have you ever used Metronidazole in connection
17 with penicillin to treat a patient you suspected
18 of peritonsillar abscess?

19 A. No.

20 Q. Do you know what percentages of patients with
21 peritonsillar abscess have penicillin resistant
22 bacteria?

23 A. No.

24 Q. You're doing some, a research paper, I believe,
25 according to your CV, on Streptococcus A?

1 A. I did that in my residency. It didn't turn out
2 to be a paper.

3 Q. Okay. What, there is an item in your CV that
4 refers to some type of research on Streptococcus
5 A, what were you researching or what were you
6 writing that you're referring to in your CV?

7 A. It was about children and schools having the
8 carrier state. The research didn't pan out, so
9 it's kind of --

10 Q. Why is that in your CV?

11 A. That's an old CV. I think I had it from back
12 when it was still going on or still partly in
13 process.

14 Q. When did you find out that that paper was not
15 going to pan out?

16 A. Probably right at the end of my residency.

17 Q. Which was what year?

18 A. '96.

19 Q. So there is no paper then?

20 A. No. I did the research but no paper.

21 Q. What are the signs and symptoms of a
22 peritonsillar abscess?

23 A. Sore throat, the typical sign is that one --
24 that's my phone.

25 MR. WALTERS: Go ahead.

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

3 A. No.

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

8 MR. CONWAY: An hour and six
9 minutes.

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

12 THE WITNESS: I could use one.

13 - - - -

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

16 - - - -

17 A. Should I just continue?

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

20 A. Yes.

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

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

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

4 Q. So we have uvula deviation?

5 A. Uh-huh.

6 Q. What else?

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

8 Q. What else?

9 A. Trismus.

10 Q. What is that?

11 A. Inability to open your mouth all the way.

12 Q. Okay. What else?

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

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

19 A. Yes, that goes along with it.

20 Q. How about fever?

21 A. That can go along with it.

22 Q. How about nonresponse to penicillin?

23 A. That doesn't necessarily indicate it.

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

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

3 A. You would certainly consider it.

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

6 A. Yes.

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

11 MR. WALTERS: Gold standard to
12 diagnose it?

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

16 MR. WALTERS: Okay. Go ahead.

17 A. Yes.

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

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

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

3 A. Yes.

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

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

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

11 A. Repeat the prior question.

12 Q. Okay. All right.

13 - - - -

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

16 - - - -

17 A. Yes.

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

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

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

1 A. Yes.

2 Q. Did you consider at any time on November 30th or
3 December 1st that possibly Mr. Kidd was suffering
4 from a peritonsillar abscess?

5 A. At that point I thought that was resolved.

6 Q. So your answer would be no?

7 A. I wasn't really considering it at that point in
8 time, no.

9 Q. What information did you have regarding whether
10 or not Mr. Kidd was still suffering from pain in
11 his throat?

12 A. My nurse had told me in one of those messages
13 that his throat problem was better and I think I
14 mentioned before she indicated that he thought
15 that his back was hurting from where the shot was
16 given, it kind of emanated from where the shot
17 was given.

18 Q. Can you show me what date and where it indicates
19 that the, there's no longer any sore throat?

20 A. December 1st. It's hard to read because all that
21 writing is impacted in there. I don't know if
22 you can see the part where she says slight fever,
23 no throat, I think it says better underneath
24 there or something. I think the throat was
25 better.

1 Q. Well, what does a circle with a slash through it
2 mean?

3 A. That means no.

4 Q. Okay. So does that say throat not better?

5 A. No. I remember specifically asking her, she told
6 me that is not a problem any more. I can't
7 really read what the writing is there. She might
8 have put that in there because I specifically
9 asked her, so she might have put it in
10 parentheses there to indicate that that was
11 something I subsequently asked her.

12 Q. Who wrote the writing here along the right?

13 A. That was my nurse Cheryl Keller.

14 Q. And she checked by urgent yes, is that correct?

15 A. That would be the person taking the message that
16 checked urgent.

17 Q. And circled it?

18 A. Yes.

19 Q. And was this message brought to you for you to
20 read prior to giving your response?

21 A. Yes.

22 Q. At the time you saw this message was this in
23 parentheses, no throat better, or your reading?

24 A. I can't tell for sure, I'm not sure if that says
25 better or no throat -- I can't read it.

1 Q. Was that written on the note at the time you
2 first saw this note back on December 1st?

3 A. I don't remember.

4 Q. So you can't answer whether or not that was
5 written after?

6 A. I don't know.

7 Q. Okay. I noticed there was no charting in any of
8 the patient progress notes for any of the
9 interaction that was going on between your office
10 and Mr. Kidd and Mr. Kidd's wife. Am I correct?

11 A. In the progress notes?

12 Q. Yes.

13 A. We just put the messages in a separate section
14 because just for efficiency from the standpoint
15 of taking up space in the chart. That way we can
16 put several messages on one sheet rather than
17 having it interspersed with office visits.

18 Q. Do you believe that a primary care physician
19 should chart in the patient's progress notes
20 interactions of significance that take place
21 between the patient and the physician's office?

22 A. This is still in the chart, it's just in a
23 different section. We don't have it in the same
24 section just for efficiency of room.

25 MR. WALTERS: I don't know if

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

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

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

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

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

12 Q. Sure.

13 - - - -

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

16 - - - -

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

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

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

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

6 A. Yes.

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

8 A. Yes.

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

11 A. Yes.

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

15 A. Yes.

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

18 A. Yes.

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

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

24 MR. CONWAY: Right.

25 MR. WALTERS: I didn't know if

1 you're saying that was all the history.

2 MR. CONWAY: No, it's not.

3 Obviously the medical records speak for
4 themselves.

5 MR. WALTERS: All right. Go
6 ahead.

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

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

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

17 A. Yes.

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

21 A. Yes.

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

25 A. Yes.

1 Q. You stated earlier in the deposition that based
2 on your training, experience it could take one to
3 five days for a patient to become asymptomatic
4 from Strep throat following a penicillin
5 injection, correct?

6 A. Yes.

7 Q. Did you tell Mr. Kidd that as well?

8 A. I told him that certainly in the note before he
9 came on the 27th and then when he came on the
10 27th I reiterated that, but I also warned him
11 about the possible signs of the peritonsillar
12 abscess.

13 Q. But you did on at least two occasions tell him
14 that it could take one to five days for his
15 symptoms to go away following his penicillin
16 shot, correct?

17 A. I don't know if I told him specifically up to
18 five days. I told him over 24 hours for sure.

19 Q. Could you have told him five days?

20 A. I don't know what I specifically told him. I
21 know I specifically said over 24 hours because
22 that's contagious for that long.

23 Q. Being contagious of Strep throat, is that related
24 to whether or not you have symptoms?

25 A. Usually, but not always.

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

4 A. Yes.

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

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

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

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

14 A. The thing they go home with.

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

22 MR. CONWAY: Right.

23 A. And fill a prescription.

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

1 this.

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

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

13 MR. CONWAY: Well, can you obtain
14 that?

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

18 MR. CONWAY: I will send you an
19 authorization.

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

24 Q. Anyway --

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

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

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

7 A. That's what it says.

8 Q. Which he in fact did, correct?

9 A. No.

10 MR. WALTERS: No.

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

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

16 A. There is no time out here.

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

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

24 A. Yes.

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

1 November 30th?

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

3 Q. In the morning?

4 A. Yes.

5 Q. What time does your office open?

6 A. 8:30.

7 Q. And what time does it close?

8 A. The phone is off at 4:30.

9 Q. In the afternoon?

10 A. Yes.

11 Q. Okay. So if someone wanted to talk with you or
12 your nurse about something and not go through an
13 answering system they would call between 8:30 and
14 4:00 p.m.?

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

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

19 A. On November 30th?

20 Q. Yes.

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

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

24 A. No.

25 Q. I mean is that correct?

1 A. That's correct.

2 Q. Why didn't you at any time between November 30th
3 and December 1st speak personally with Thomas
4 Kidd or his wife, if you know?

5 A. I rely upon my staff to do that for me.

6 Q. Have you ever gotten on the phone and spoken with
7 a patient over the phone when they've called in
8 with problems?

9 A. At various times.

10 Q. Is there a certain criteria used as to when you
11 will get on the phone and speak with the patient
12 or wife and when you won't?

13 A. Some, just sometimes a feeling that I need to
14 talk to them, if I know them well sometimes I
15 will talk to them, for the most part I don't.

16 Q. Do you typically prescribe Soma over the phone
17 without examining a patient?

18 A. Not typically.

19 Q. Why did you do it in this case?

20 A. I felt that the patient was aware of what was
21 occurring and since he refused to come in to be
22 seen to have me evaluate him I figured I'd at
23 least help him out with what he thought was going
24 on.

25 Q. How do you know that he was refusing to come in

1 and see you on November 30th?

2 A. My staff told me.

3 Q. You never confirmed that yourself, did you?

4 A. I didn't call him up and ask him, no.

5 Q. And what are you referring to on November 30th to
6 lead you to the conclusion that he refused to
7 come in?

8 A. On the right-hand side of that November 30th 8:40
9 note it says refused appointment and urgent care,
10 just wants prescription.

11 Q. Whose handwriting is that?

12 A. Bob Whelchel, my medical assistant.

13 Q. What type of drug is Soma?

14 A. It's a muscle relaxant.

15 Q. You had not been treating Thomas Kidd prior to
16 November 30th for any type of muscle, musculature
17 type pain, is that correct?

18 A. I don't recall if I treated him in the remote
19 past, but certainly not in that recent past.

20 Q. You knew he was over age 40, is that correct?

21 A. Yes.

22 Q. Was he a smoker?

23 A. Yes.

24 Q. And he was complaining of chest tightness,
25 correct?

1 A. Yes.

2 Q. What does that say below there?

3 A. Which one, right here?

4 Q. Yeah.

5 A. Prescription called, RX called, patient aware.

6 Q. So did you call in the prescription?

7 A. My medical assistant Bob did. I wrote on there
8 Soma samples and he didn't want to come and even
9 get the samples, he just wanted the prescription
10 called in.

11 Q. Why did he say he didn't want to come in and see
12 you?

13 A. I don't know.

14 Q. Would that have been important to find out?

15 A. I don't know.

16 MR. WALTERS: You mean in
17 retrospect?

18 MR. CONWAY: No. At the time.

19 Q. I mean, you're prescribing --

20 MR. WALTERS: It doesn't say he's
21 unable to come, it says he refuses to come.

22 Q. Is that something that's important to know prior
23 to prescribing Soma for a patient as to why they
24 would refuse to come in and see you for a
25 complaint?

1 A. The more information the better always.

2 Q. With his complaint of a chest tightness, did you
3 have cardiac problems on your deferential
4 diagnosis at the time you were given this
5 message?

6 A. Certainly that's why it was transferred back to
7 the nurses in the first place, the clinical
8 people, and as I said before, I was in a meeting
9 at the time and my medical assistant came in to
10 the meeting and asked me. And he wasn't really
11 having cardiac symptoms, he was just describing
12 muscle spasms going up his back.

13 Q. Has chest tightness underlined, was that you that
14 underlined it or Bob Whelchel?

15 A. It could have been Bob. I'm not sure. It was
16 probably more likely Cindy who took the message
17 because they have a protocol, you know, if
18 there's certain things people call for they get
19 the nurse or medical assistants immediately.

20 Q. What is Cindy's last name?

21 A. Manley, M-a-n-l-e-y.

22 Q. Is she a nurse?

23 A. No, she's a receptionist. She actually has some
24 medical assistant experience.

25 Q. And Bob Whelchel, how do you spell that?

1 A. W-h-e-l-c-h-e-l.

2 Q. And is he a nurse?

3 A. Medical assistant.

4 Q. What is a medical assistant?

5 A. Medical assistant does clinical, all the clinical
6 skills, almost all that a nurse will do in our
7 office -- actually even more because they can do
8 blood draws, but they room the patients, they
9 take patient information, they give injections,
10 they do cultures, they do all sorts of
11 procedures.

12 Q. So he's not an RN nor is he an LPN, is that
13 right?

14 A. Correct.

15 Q. And I take it there is some type of certificate
16 that you get to be a medical assistant?

17 A. Yes. And then they do a lot of training with the
18 doctors.

19 Q. So is it possible to discern who actually spoke
20 with the Kidds on November 30th, would that have
21 been Bob Whelchel or Cindy Manley?

22 A. Well, they both, actually then there was another
23 Cindy that talked to them also.

24 Q. Which Cindy would that have been?

25 A. On that second message is Cindy Moses.

1 Q. Now, Cindy Manley, is she a medical assistant?

2 A. She has a medical assisting certificate, but she
3 works as a receptionist in our office.

4 Q. Who is Cindy Moses?

5 A. She's our other receptionist.

6 Q. Is she a medical assistant?

7 A. No, not that I'm aware of.

8 So the front desk takes the message initially
9 so both of them wrote on the initial portions and
10 then Bob Whelchel answered.

11 Q. Call given to Cheryl I see on November 27th, 2001
12 at 12:05. Who is Cheryl?

13 A. Cheryl is my nurse.

14 Q. What is her last name?

15 A. Cheryl Keller, K-e-l-l-e-r.

16 Q. Is she an RN or an LPN?

17 A. LPN.

18 Q. When a 40-year-old smoker calls in complaining of
19 chest tightness and back pain, is there a
20 protocol that any of your medical assistants use
21 in questioning the caller in order to rule in or
22 rule out the possibility of a cardiac problem?

23 A. Well, the biggest thing that they need to do is
24 decide whether they needed to come in and see me
25 or decide to go to the ER and in this case if

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

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

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

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

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

17 Q. Anything else that you recall?

18 A. That's it.

19 Q. All right. It doesn't appear that on November
20 30th at that time anybody inquired or asked
21 Mr. Kidd or his wife about the status of his sore
22 throat, would that be correct, as documented
23 here?

24 A. As documented, no.

25 Q. So what was on your differential diagnosis as to

1 any possible conditions that Thomas Kidd may be
2 suffering from as of November 30th at around
3 8:40?

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

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

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

15 Q. That you were aware of?

16 A. Correct.

17 Q. All right. And then we go to the, well, let's go
18 back to that note on November 27th, 2001 at
19 12:05. The message appears to be going to ER,
20 can't breathe, call given to Cheryl, correct?

21 A. Yes.

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

1 don't understand this note. What's your
2 understanding of what went on regarding this
3 12:05 p.m. telephone conversation?

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

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

21 A. Which he did.

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

25 A. Yes.

1 Q. Then let's, while we're on these, go back to
2 November 27th, 2001 at 8:30. He calls in and
3 says one side of throat is still sore and then
4 follow up says what?

5 A. INB, if no better, call if no better it says.

6 Q. And what is written under 11/27/01?

7 A. Patient aware.

8 Q. Patient aware of what?

9 A. Of give it a little bit of time, call if no
10 better.

11 Q. And that was your response that you wanted
12 communicated to him when he called in complaining
13 that the one side of the throat is still sore,
14 correct?

15 A. Yes.

16 Q. All right. And in fact four hours,
17 three-and-a-half hours later he followed your
18 recommendation and called in, correct?

19 A. Yes.

20 Q. And then presumably he was told to come into the
21 office and he came into the office for his
22 11/27/01 office visit, right?

23 A. Right. He was probably given a choice of going
24 to the ER or coming right down because we had to
25 squeeze him in obviously because I was already

1 booked.

2 Q. And he did both because he went to the ER later
3 that day as well?

4 A. He subsequently went to the ER, yeah.

5 Q. Now, on 11/30/01 at 8:40, can you read what it
6 says at follow up there?

7 A. Muscles in chest tight causing to have trouble,
8 refused appointment and urgent care, just wants
9 prescription called in.

10 Q. Causing to have trouble what?

11 A. It doesn't say.

12 Q. Did you inquire from any of your staff what that
13 trouble related to that was written on this note?

14 A. As I said, Bob did come to me and talk to me
15 while I was in the meeting and we talked about
16 what was occurring.

17 Q. All right. I understand about the chest
18 tightness and back pain, but that was causing him
19 trouble, did Bob ever determine trouble what,
20 what was the chest pain and back pain causing
21 trouble with?

22 A. Just --

23 Q. Breathing?

24 A. Just discomfort.

25 Q. Then we go to 11/30, November 30th at 1:42 p.m.,

1 what do you recall about this phone message?

2 A. That it was very quick to indicate that there was
3 no response from the muscle relaxer. Most people
4 that are on muscle relaxers don't get that quick
5 of relief, most things take a little while to get
6 better. I was also surprised initially that he
7 only wanted a muscle relaxer called in because
8 almost anybody who has back complaints, muscle
9 complaints will always want like a pain reliever
10 as well as a muscle relaxer called in, so that's
11 why I called in the Vicodin, because he had
12 already taken the four Motrin it says there and
13 it didn't help his pain.

14 Q. Do you typically prescribe Darvocet or, excuse
15 me, do you typically prescribe Vicodin over the
16 phone without examining a patient?

17 A. Not typically.

18 Q. Why did you do it in this case?

19 A. He wouldn't come in, I figured I would at least
20 try to help relieve some of his symptoms.

21 Q. Is there any indication on that phone message
22 that he was refusing to come into the office?

23 A. Not on that one. The time before.

24 Q. I take it there was, his throat condition was not
25 on your differential diagnosis as of 11, as of

1 November 30th at 1:42, would that be correct?

2 A. No.

3 Q. And then we come to --

4 A. Excuse me, can I answer that, I should say that
5 would be correct. I said no, but that would be
6 correct.

7 Q. Who is CJM at the bottom of that note?

8 A. That's Cindy Moses.

9 Q. Who is CN, that's you, correct, at the top where
10 it says for?

11 A. Yes.

12 Q. And then we go to the December 1st note which
13 indicates urgent, whose handwriting is the urgent
14 and the yes.

15 A. That's the person taking the call initially which
16 would be Cindy Manley.

17 Q. And it says, what's the message that you would
18 have been presented with?

19 A. That RYC is returning your call. I don't know
20 for a fact, but since it says returning your
21 call, oftentimes my nurses will call back and see
22 how people are doing so since it says returning
23 your call I think that must be what happened. It
24 says regarding pain meds, up all night due to
25 pain, hallucinating and then it says refused

1 appointment.

2 Q. Who wrote in that R circled appointment?

3 A. Cindy Manley.

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

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

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

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

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

8 Q. Call us ASAP for what?

9 A. If there's problems.

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

12 A. Yes.

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

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

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

21 A. My nurse.

22 Q. What nurse was that?

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

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

1 A. It's not charted.

2 Q. Is that an inappropriately large amount of drugs?

3 A. Yes. Quite large, yes.

4 Q. Could that kill somebody?

5 A. Probably not kill somebody, it should zonk you a
6 little bit.

7 Q. But that's definitely risky for a patient to be
8 taking that amount of Soma, is that correct?

9 A. Yes, that's not what he should have done.

10 Q. So did you think that was causing his
11 hallucinations?

12 A. I thought that was making him a little goofy,
13 yes.

14 Q. Well, it says hallucinations here.

15 A. And the lack of sleep.

16 Q. So your response to that was to tell him to take
17 Vicodin, is that correct?

18 A. Yes. His wife said they didn't get the Vicodin
19 prescription.

20 Q. And how much Vicodin was he supposed to start
21 taking then?

22 A. He could take one or two to help with the pain
23 and we were going to see if that helped.

24 Q. Why didn't you get on the phone and talk with
25 Mr. or Mrs. Kidd at this point, if you know?

1 A. Cheryl seemed to be handling everything okay, I
2 didn't think I needed to get on the phone at that
3 time.

4 Q. Cheryl is an LPN?

5 A. Yes.

6 Q. All right. Is it below the standard of care in
7 this particular case for you to have basically
8 prescribed Vicodin to a patient who calls in with
9 a complaint of hallucinations?

10 A. I had prescribed it previously and I was just
11 reiterating what I had suggested to do to help.

12 Q. I'm asking you was your advice at this point
13 below the standard of care?

14 A. I don't know the answer to that. I don't know if
15 there is a standard of care based on this.

16 Q. It doesn't indicate here anywhere in this note
17 that he was told to go to an emergency room, does
18 it?

19 A. It says refused appointment, it doesn't say
20 emergency room there, but he wouldn't come in to
21 see me.

22 Q. He was never told to go to an emergency room, was
23 he, doctor, on this date?

24 MR. WALTERS: Well, according to
25 the document you're saying?

1 Q. Yes, according to the document.

2 A. According to the document. But I know Cheryl
3 discussed it.

4 Q. As we sit here today, what did Cheryl discuss
5 with Mrs. Kidd?

6 A. His symptoms and his possibly going to the
7 emergency room.

8 Q. Why didn't your nurse Cheryl document on that
9 note that he refused to go to the emergency room?

10 A. I don't know. Cheryl would be better to answer
11 that.

12 Q. As a family practice physician what would be on
13 your differential diagnosis for a patient with a
14 history of Strep throat where you were
15 considering possible abscess who calls in
16 subsequent to your diagnosis with complaints of
17 hallucination?

18 A. Infection can do stuff like hallucinations,
19 meningitis, other types of infections, strokes,
20 any type of neurologic things that can cause
21 hallucinations, medications.

22 Q. In light of your -- strike that.

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

1 possibility of a peritonsillar abscess on
2 December 1st?

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

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

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

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

12 A. Yes.

13 Q. And you relied upon Cheryl telling you that?

14 A. Yes.

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

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

1 the shot that I gave him.

2 Q. And you chose not to talk with either Mr. or Mrs.
3 Kidd on December 1st, correct?

4 A. I did not call them back, no, myself.

5 Q. Now, you saw the autopsy while it was being
6 performed, correct?

7 A. Yes.

8 Q. All right. And you have an interest in being the
9 Lake County pathologist?

10 A. The coroner.

11 Q. The coroner. Does it seem possible that in light
12 of his condition at the time of autopsy that he
13 would have no throat complaints?

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

15 Q. You know the condition of Mr. Kidd's pharynx and
16 throat, neck as of the time he's autopsied on
17 December 2nd, correct?

18 A. Yes.

19 Q. All right. Does it seem likely that he would
20 have been, that his throat would have been pain
21 free or had very little pain on December 1st in
22 light of his condition at autopsy?

23 MR. WALTERS: Do you want to read.

24 A. From what I recall --

25 Q. Yeah, take your time.

1 A. From what I recall --

2 Q. You're reading your attorney's copy of the
3 autopsy, correct?

4 A. Yes.

5 Q. All right.

6 MR. WALTERS: I hope my copy is
7 the same copy you have.

8 MR. CONWAY: I'm sure it is.

9 A. Actually the very interesting thing about this
10 was there really wasn't a whole lot of
11 inflammation right there at the tonsil but there
12 was a perforation, so the perforation actually
13 occurred without any significant amount of
14 swelling there, so the lack of throat symptoms
15 probably does make sense because it had all been
16 drained down now.

17 Q. Do you have an opinion as to when the abscess
18 perforated in the pharynx?

19 A. No.

20 Q. In your discussions with Dr. Rizzo I'm sure that
21 came up as to when that perforation of the
22 abscess occurred when you were discussing this
23 case, correct?

24 A. I don't know that it could be really elucidated
25 how long before the death.

1 Q. Okay. So I take it that Dr. Rizzo didn't
2 indicate to you his opinion as to when this
3 possibly could have perforated?

4 A. No.

5 Q. Okay. And you don't think it would have been,
6 you would have been able to determine that?

7 A. No. I think it could have been draining for a
8 little while down into his chest. I don't know
9 how long before it would have occurred.

10 Q. And Dr. Rizzo didn't know either?

11 A. No.

12 Q. The posterior pharynx indicates abscess with
13 perforation to retropharyngeal space. That's on
14 page 6.

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

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

20 A. In the microscopic descriptions?

21 Q. Yeah.

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

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

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

3 A. No.

4 MR. WALTERS: You just asked her
5 that.

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

9 MR. WALTERS: You asked her twice.

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

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

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

18 Q. Sure.

19 A. They see inflammatory cells.

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

23 A. No.

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

1 irreversible, meaning unsurvivable?

2 A. No.

3 Q. And Dr. Rizzo didn't convey to you an opinion
4 regarding that issue?

5 A. No.

6 Q. And you understand my question regarding
7 survivability, at what point, what was the last
8 point in time he could have been given medical
9 treatment which would have saved his life?

10 MR. WALTERS: With certainty or
11 probability, to a possibility? I don't
12 know what that question --

13 Q. No, I'm just asking if you have an opinion?

14 A. I don't have an opinion.

15 Q. And Dr. Rizzo didn't have an opinion either, did
16 he?

17 A. No. Not that we discussed.

18 Q. Okay.

19 MR. WALTERS: Yeah, Dr. Rizzo may
20 have all sorts of opinions. I don't --

21 MR. CONWAY: He may.

22 Q. Wouldn't it have been reasonable to personally
23 examine Mr. Kidd on December 1st prior to
24 recommending that he continue to take Darvocet?

25 A. Vicodin, it was Vicodin.

1 Q. I'll strike that question.

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

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

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

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

12 A. Yes.

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

16 A. No, you don't have to.

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

20 A. Yes.

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

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

25 MR. CONWAY: Well, I don't recall

1 and if I did I apologize.

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

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

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

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

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

3 MR. CONWAY: I've forgotten.

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

6 MR. CONWAY: Want to see my notes?

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

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

15 MR. WALTERS: I'm not wrong.

16

- - - -

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

19

- - - -

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

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

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

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

6 MR. CONWAY: Okay. That's fine.

7 MR. WALTERS: Go ahead.

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

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

14 A. I did not specifically ask them.

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

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

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

20 A. Right.

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

24 A. Prior to that are you saying?

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

1 Mr. Kidd a compliant patient?

2 A. To my knowledge.

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

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

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

12 A. Uh-huh. Yes.

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

15 A. I'm sorry, now repeat this.

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

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

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

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

1 then she asked me to repeat.

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

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

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

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

16 A. I say you need to go, yes.

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

20 A. Yes.

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

23 A. No.

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

1 abscess first began?

2 A. No.

3 Q. Did you discuss that issue with him?

4 A. I don't think we discussed timing.

5 Q. If Mr. Kidd's retropharyngeal abscess had been
6 diagnosed and appropriately treated by 12:00 noon
7 on December 1st, 2001, would you agree that more
8 likely than not he would have survived?

9 A. I don't think I can answer that question.

10 Q. Okay. So you can't answer a question -- well,
11 let's take it to November 30th, would you have an
12 opinion regarding Mr. Kidd's survivability on
13 that date had his retropharyngeal abscess been
14 diagnosed and appropriately treated?

15 A. This isn't really my area of expertise. I think
16 somebody would do better to answer that question.

17 Q. So you don't have an opinion regarding that?

18 A. No.

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

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

1 his retropharyngeal abscess on December 1st,
2 2001?

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

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

5 A. Correct.

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

11 A. No.

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

14 A. Very unlikely.

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

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

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

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

1 Q. And what would your differential diagnosis have
2 been at that time?

3 A. I would be worried still about peritonsillar
4 abscess, cellulitis is another event that's not
5 quite as bad as an abscess, mono is always a
6 possibility in that case, then you can have other
7 processes, you can even have a tumor of some
8 sort, but it's less likely.

9 Q. On December 1st had your office personnel
10 communicated to you that in addition to his
11 hallucinations, the hallucinations he had, that
12 his throat was much worse than it had been on
13 November 27th, what would your reaction have
14 been?

15 A. If they had said that to me?

16 Q. If your office staff had communicated to you
17 that --

18 A. His throat is worse.

19 Q. That Mr. Kidd's throat was much worse than it was
20 on November 27th and additionally he's
21 hallucinating, what would your reaction have
22 been?

23 A. Come in right now or go to the emergency room.

24 Q. Would you have communicated that it's a necessity
25 that he go to the emergency room or come in?

1 A. Almost every time we try to get somebody on the
2 schedule we indicate that to them.

3 Q. Back on November 27th, if you want to go to
4 your --

5 A. Office visit.

6 Q. Chart note, yes. It says here under plan, I have
7 discussed with him -- well, let's go back.

8 Prednisone 10 milligrams, number 20, four per day
9 every day times five days, right?

10 A. Yes.

11 Q. To be used if he continues to have a lot of pain
12 in the throat. He was complaining of a lot of
13 pain in the throat correct?

14 A. Yes.

15 Q. I have discussed with him the possibility of
16 having a peritonsillar abscess so he is to keep
17 an eye on it and see if there is any uvular
18 deviation at all during the rest of the day, is
19 that what you communicated to him?

20 A. Yes.

21 Q. Did you communicate to him exactly what a
22 peritonsillar abscess is?

23 A. Yes.

24 Q. What did you tell him?

25 A. I told him it's an infection surrounding the

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

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

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

7 Q. And he understood that?

8 A. He seemed to.

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

12 A. Absolutely.

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

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

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

22 A. No.

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

1 A. No.

2 Q. I'd like to know the timing as best I can of the
3 different phone calls. If you can even tell from
4 your records.

5 MR. WALTERS: Yeah, what's
6 contained on the time.

7 Q. Well, I see that there's some timing, but I don't
8 know what the time means, but if you explain it
9 I'll pick up pretty quickly and we won't have to
10 go through every one.

11 MR. WALTERS: It says, it has a
12 date and a time.

13 MR. CONWAY: Okay.

14 MR. WALTERS: I'm assuming there
15 are things that occur around that, but.

16 Q. Well, let's just, for instance, go to the
17 11/27/01 note which is Bates stamped page 4 of
18 your exhibit. At the bottom it says 8:30. Is
19 that when Tom Kidd would have called in?

20 A. In this case he called in through the service at
21 7:42 a.m. You can see that on the top.

22 Q. All right.

23 A. So my secretary received that from the service
24 and actually took the message at 8:30.

25 Q. Then there's the 11/27/01 follow up, we don't

1 know what time that call was made, correct?

2 A. Where are you talking about?

3 Q. On the right of that. It says follow up 11/27.

4 A. I have no idea what time that was spoken.

5 Q. All right. And the same then if we go over to
6 the next page, 11/27/01 at 12:05, that would be
7 what time Tom Kidd called into your office,
8 correct?

9 A. Yes.

10 Q. We don't know what time you would have responded
11 or had your office respond to him after you were
12 aware of the message, correct?

13 A. This one my nurse talked to him immediately and
14 he was told to come right now and then I saw him
15 within an hour after that.

16 Q. Going to 11/30/01 at 8:40 a.m., it appears Robin
17 Kidd called in at that time of day, right?

18 A. Yes.

19 Q. And we don't know what time that you had your
20 office respond to them, is that correct?

21 A. Once again, the call was given to the clinical
22 staff, they talked to either the patient or
23 Mrs. Kidd immediately and then he came back and
24 talked to me immediately. It was, that was quick
25 timing there. I know that was very fast

1 turn-around then.

2 Q. Because you have a recollection of this?

3 A. Right.

4 Q. Then we go to November 30th at 1:42 p.m., that's
5 Robin once again apparently calls in, gives a
6 message to your staff, then when is your response
7 communicated to Robin Kidd, do you know the
8 timing?

9 A. No.

10 Q. When do you call the Vicodin prescription in, do
11 you know?

12 A. It looks, I can't tell if Bob called, put a time
13 on there or not. It might have been 3 -- I can't
14 tell if that says 3:30. I'm not sure.

15 Q. Let's go to December 1st, 2001, what's the
16 chronology of what occurred on this date
17 according to the custom and practice of your
18 office and your review of this note?

19 A. Same thing, the call was probably given to Cheryl
20 immediately or very soon because it was a
21 returning a call, so usually the office, the
22 front desk will call back to the nurses to see if
23 they're sitting there or if they're busy, then
24 they will just tell the person that they will
25 call them right back as soon as they get out of

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

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

7 A. Yes.

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

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

17 A. Cindy Manley.

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

20 A. Cheryl Keller.

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

22 A. Yes.

23 Q. She's your LPN?

24 A. Yes.

25 Q. All right. Anybody else?

1 A. Not on that one.

2 Q. Going to the 11/27/01, 12:05 note.

3 A. The same.

4 Q. Cindy Manley and Cheryl Keller?

5 A. Yes.

6 Q. The November 30th, 8:40 a.m. note?

7 A. Cindy Manley and Bob Whelchel.

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

11 MR. WALTERS: Of what?

12 MR. CONWAY: Of these notes.

13 MR. WALTERS: No.

14 Q. Anybody else on this one?

15 A. No.

16 Q. The November 30th, 1:42?

17 A. Cindy Moses.

18 Q. She's another medical assistant?

19 A. No. Receptionist.

20 Q. All right. Is she the one who took the call?

21 A. Yes.

22 Q. All right.

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

25 Q. And who else?

1 A. Bob Whelchel.

2 Q. How long has Bob Whelchel been medical assistant?

3 A. Five years, I think. I'm sorry, on the one
4 before that I wrote the Soma samples, so that's
5 my writing on the Soma samples.

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

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

12 - - - -

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

15 - - -

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

19 A. I can tell you you didn't finish the last one.

20 Q. Okay. Which one were we on before we were
21 interrupted by your counsel?

22 A. The November 30th, 1:42.

23 Q. All right. Bob Whelchel, Cindy Moses and who
24 else?

25 A. And then I wrote the Vicodin.

1 Q. Okay. Then we can go to December 1st at 10:50.

2 A. Cindy Manley, Cheryl Keller.

3 Q. Going to the autopsy report, in retrospect
4 Mr. Kidd's symptoms and his clinical presentation
5 was being caused by that retropharyngeal abscess,
6 would you agree?

7 MR. WALTERS: Objection. We've
8 already covered this at the very beginning.

9 A. Yes.

10 Q. Okay. On December 4th, patient Thomas Kidd,
11 caller Kathy from Public Health?

12 A. Yes.

13 Q. Okay. Are the cultures back. I don't understand
14 this.

15 A. I am not sure. I presume this is cultures from
16 his autopsy. I don't really know the answer to
17 that.

18 Q. I'm just, I mean, it's in your chart, I'm just
19 wondering what this note refers to.

20 MR. WALTERS: I don't know, what
21 was so suspicious about I don't know what
22 this is talking about?

23 MR. CONWAY: That's two of us then
24 that don't know.

25 MR. WALTERS: I'm just curious

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

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

4 Q. Were you involved at all in this?

5 A. No. Cheryl handled it.

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

8 A. Yes.

9 Q. How many times did you call her?

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

12 Q. When was the first time you called her?

13 A. After I found out he died.

14 Q. Would that have been on the 1st?

15 A. Yes, in the evening.

16 Q. Around 6:00 p.m.?

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

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

20 A. I asked her what happened.

21 Q. And what did she tell you?

22 A. She said she didn't know.

23 Q. What else did you talk about?

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

1 Q. Are you her primary or were you her primary care
2 physician at the time?

3 A. I was, yeah.

4 Q. What else did you two talk about?

5 A. That's all I remember.

6 Q. All right. Was there a conversation that you
7 recall after December 1st?

8 A. I had talked to Robin about anxiety. She was
9 having anxiety.

10 Q. On what date?

11 A. I don't have her chart. I don't know.

12 Q. And do you recall what that conversation was,
13 what was said?

14 A. She was having a lot of anxiety and she wanted
15 medication and, once again, didn't want to come
16 in. And I told her I have things I can help you
17 with and I can call in a couple things for her
18 but I'd rather see her and make sure everything
19 is okay and she didn't want to come in.

20 Q. Both of those phone calls were instigated by you,
21 correct?

22 A. Well, I think the one she had called for
23 medications and then I called her back. There
24 might have been another one, too, because when I
25 talked to Dr. Rizzo he wanted the kids to get

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

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

8 MR. WALTERS: Did you mean a
9 minute?

10 MR. CONWAY: Yes, sir. I
11 misspoke.

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

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

17 Q. What are exudates?

18 A. Little pockets of pus on the tonsils.

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

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

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

1 A. Correct.

2 Q. So, going to the Exhibit Number 1 Bates stamped
3 page 004, on the November 27th, 8:30 a.m. --

4 A. I'm sorry.

5 Q. Oh, I'm sorry.

6 MR. WALTERS: Exhibit Number 1 was
7 the autopsy.

8 MR. CONWAY: Correct. I
9 apologize.

10 Q. Exhibit Number 2.

11 MR. WALTERS: The phone messages.

12 Q. The November 27th, 2001 8:30 a.m. message, it
13 says 11/27/01, give it time, did you specify to
14 Mr. Kidd how much time he should give it?

15 A. Once again, this was Cheryl relaying the message
16 for me.

17 MR. WALTERS: Objection.

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

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

1 Q. Have you ever had any type of disciplinary action
2 taken against you or your license?

3 A. No.

4 Q. Any type of action taken against your privileges
5 at a hospital?

6 A. We were not allowed to renew our privileges at
7 Geauga because we were owned by another hospital.

8 Q. Other than that?

9 A. No.

10 Q. Have you ever been asked to review a case as an
11 expert witness?

12 A. No. Wait. In a, a, what do you call those
13 claims?

14 MR. WALTERS: Motor vehicle
15 accident.

16 A. In a motor vehicle accident. I think I did two
17 of them.

18 Q. On behalf of who, the insurance company or the
19 injured?

20 A. The defense.

21 Q. The insurance company?

22 A. Yes.

23 Q. Okay.

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

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

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

6 A. No.

7 Q. How about a retropharyngeal abscess?

8 A. Just Tom Kidd.

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

15 MR. WALTERS: We will read it.

16

17

18

CAROL L. NOALL, M.D.

19

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21

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1
2
3 C E R T I F I C A T E
4

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

7 I, Dawn M. Fade, a Notary Public within and
8 for the State of Ohio, authorized to administer
9 oaths and to take and certify depositions, do
10 hereby certify that the above-named witness was
11 by me, before the giving of their deposition,
12 first duly sworn to testify the truth, the whole
13 truth, and nothing but the truth; that the
14 deposition as above-set forth was reduced to
15 writing by me by means of stenotypy, and was
16 later transcribed into typewriting under my
17 direction; that this is a true record of the
18 testimony given by the witness; that said
19 deposition was taken at the aforementioned time,
20 date and place, pursuant to notice or stipulation
21 of counsel; and that I am not a relative or
22 employee or attorney of any of the parties, or a
23 relative or employee of such attorney, or
24 financially interested in this action; that I am
25 not, nor is the court reporting firm with which I
am affiliated, under a contract as defined in
Civil Rule 28(D).

17 IN WITNESS WHEREOF, I have hereunto set my
18 hand and seal of office, at Cleveland, Ohio, this
19 29th day of August A.D. 20 03.

20 
21 Dawn M. Fade, Notary Public, State of Ohio
22 1750 Midland Building, Cleveland, Ohio 44115
23 My commission expires October 27, 2007
24
25

0

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46:4, 14, 19; 47:9, 23;
64:1, 5; 79:5; 82:6; 83:13;
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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.

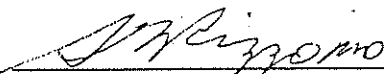
Date and Time of Autopsy: 12/2/01 at 9:00 A.M.

Case Number: LC01-91

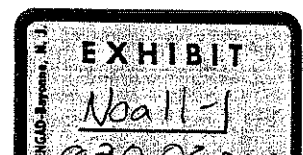
CAUSE OF DEATH: Abscess of retropharynx, paratracheal and paraesophageal soft tissue, mediastinum, and pleural spaces

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

MANNER OF DEATH: Natural


S. G. Rizzo, Coroner

Jan 7, 2002
Date



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 (Twarts) 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.

GENTOURINARY 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, uncus, 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 (Tworks) of purulent pleuritis showing mixed infection with Gram positive cocci and bacilli and Gram negative cocci and bacilli

PHONE MESSAGE FOR Cindy M. 4th message

URGENT ☒ Yes ☐ No

Patient Thomas Kida ☐ New ☐ Est.

Caller Thomas

Phone (216) 509-2885

Allergies cell phone Age _____

Message _____

Follow Up _____

Pharmacy Dr. L. Wall

Medication _____

Dosage _____

Refill ☐ Yes ☒ No

Date 10-9-00 Time 2:45p By SUH

PHONE MESSAGE FOR DW 5th message

URGENT ☒ Yes ☐ No

Patient Thomas Kida ☐ New ☐ Est.

Caller _____

Phone 254-8706

Allergies paper # Age _____

Message 1-216-1670-1472
He would like has his
called in.

Follow Up 11/9/00

Pharmacy East Washington St.

Medication _____

Dosage Dr. L. Wall

Refill ☐ Yes ☒ No

Date 10-9-00 Time 3:45p By SUH

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.

Follow Up 11/27/01

Pharmacy Praxys

Medication Dr. L. Wall

Dosage _____

Refill ☐ Yes ☐ No

Date 11/27/01 Time 8:30 By CV

000004



DATE 11/27/01 DIAGNOSIS SEVERE THROAT PAIN

PHONE MESSAGE FOR CN URGENT ☐ Yes ☐ No

Patient Tom Kidd ☐ New ☐ Est.

Caller 254 2706

Phone 254 2706

Allergies going to ER cant breathe - call given to Cheryl Age 40

Message going to ER cant breathe - call given to Cheryl

Follow Up 11/27/01 Pt has SEVERE throat pain. Had to swallow. Refused to go to ER. Pharmacy Pt will come down. Medication hydrocodone Dosage 2 tabs Refill ☐ Yes ☐ No

Date 11/27/01 Time 1:05 By CN

PHONE MESSAGE FOR CN URGENT ☐ Yes ☐ No

Patient Tom ☐ New ☐ Est.

Caller Robin Kidd

Phone 254 2076

Allergies 40 chest tightness & back pain wants muscle relaxer Age 40

Message Call given to Rob

Follow Up muscle relaxer in chest tightness to have back pain. Refused to go to ER. Just want to be able to walk.

Pharmacy Phone # 254 2076

Medication Soma

Dosage 2 tabs

Refill ☐ Yes ☐ No

Date 11/30/01 Time 8:40 By CN

PHONE MESSAGE FOR CN URGENT ☐ Yes ☐ No

Patient Tom Kidd ☐ New ☐ Est.

Caller Robin

Phone 254-2706

Allergies RX - Carisoprodol (muscle relaxer) Age 40

Message it is not working

Follow Up already took a bottle of 12 + more pain 8:30 pm

Pharmacy Phone # 254 2706

Medication Vicodin

Dosage #40 4 tabs

Refill ☐ Yes ☐ No 1 tab

Date 11/30 Time 1:42 By CN

000003

DATE 12/1/01 DIAGN PHONE MESSAGE FOR W

Patient Tom Kidd ☐ New ☐ Est.

Caller Mrs

Phone _____

Allergies _____

Message Ryoc - Re: pain meds
up all night & 1st pain
exacerbating - @ appt.

URGENT ☒ Yes ☐ No

Follow Up 12/1/01 Had to get
through base. Mark
breathing. Last
dose some 11A yesterday.
MADE slight fever (101.2)
Fuller's - sorry.
Things make no sense.
Sleep in 48 hrs.
RYOC for 1st dose of
Warlin Rx by that well

Date 12/1/01 Time 10:50 By W

help pain sleep. Mark condition
call as appt.

PHONE MESSAGE FOR W

Patient Thomas Kidd ☐ New ☐ Est.

Caller Kathy Public Health

Phone 350-8554

Allergies _____

Message Are the cultures
back

URGENT ☐ Yes ☐ No

Follow Up 12/5/01 Results
let per Dr. Small.
Kathy away to

Pharmacy Phone # _____

Medication _____

Dosage _____

Refill ☐ Yes ☐ No

Date _____ By _____

Date 12/4 Time 9:40 By W

PHONE MESSAGE FOR W

Patient Thomas Kidd ☐ New ☐ Est.

Caller Athy: Michael Sanson

Phone 216-861-4100

Allergies _____

Message Records were received but
message for 12/1/01 phone
message was cut off. Please
fax or mail to athy.
216-861
0418

URGENT ☐ Yes ☐ No

Follow Up _____

Pharmacy Phone # _____

Medication _____

Dosage _____

Refill ☐ Yes ☐ No

Date _____ By _____

Date 12/26/02 Time 11:40 By W

LAWYER'S NOTES

[illegible]