IN THE COURT OF COMMON PLEAS

GEAUGA COUNTY, OHIO

ROBIN KIDD, etc.,
et al.,

Plaintiffs,

-vs-

JUDGE FORREST BURT
CASE NO. 03 PT 000216

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

Defendants.

- - - -

Deposition of MICHAEL J. PAPSIDERO, M.D., F.A.C.S., taken as if upon cross-examination before Pamela S. Greenfield, a Registered Diplomate Reporter, Certified Realtime Reporter and Notary Public within and for the State of Ohio, at the offices of Reminger & Reminger, 1400 Midland Building, Cleveland, Ohio, at 10:03 a.m. on Friday, May 14, 2004, pursuant to notice and/or stipulations of counsel, on behalf of the Plaintiffs in this cause.

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

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

MICHAEL J. PAPSIDERO, M.D., F.A.C.S., of lawful age, called by the Plaintiffs for the purpose of cross-examination, as provided by the Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

CROSS-EXAMINATION OF

MICHAEL J. PAPSIDERO, M.D., F.A.C.S.

BY MS. KOLIS:

Q. Good morning, Dr. Papsidero.

A. Good morning.

Q. We've already been introduced, but for identification purposes on the record, my name is Donna Kolis and I represent the estate of Mr. Kidd.

It is my understanding from Mr. Walters that you have prepared written reports and are willing, ready and able to serve as an expert witness on behalf of Dr. Carol Noall; is that correct?

A. That's correct.

Q. We're going to go through the preliminaries, I suppose.

Doctor, you have testified as an expert witness on other occasions, correct?

A. Yes.
Q. Currently what amount of time do you spend on an annual basis say in the past two to three years?
A. Just a couple percent of my time. It's a very low percent. I usually do -- well, you know, there's the review of the case, depositions, all this stuff. I will review maybe four cases. End up doing a deposition on one or two. I've been at, in trial for a defendant or a plaintiff maybe four or five times.
Q. Doctor, when is the last time that you authored an expert report on behalf of a patient?
A. I think in the fall.
Q. Was that here locally?
A. No. That was a case that was a Texas case. That was actually for a plaintiff.
Q. Do you know how the attorney from Texas located you as an expert witness?
A. You know, I really don't know how he located me, to be quite honest. I, in terms of services and things like that, I did have my name on the SEAK, S-E-A-K, service, after I took a, kind of a disability management course once and I don't think it's on there anymore, so he may have gotten it off of that.

Q. All right. In the past five years, have you authored any reports on behalf of patients regarding claims of medical negligence that occurred in northeast Ohio?

A. Boy. I don't recall. I have done plaintiff work in northeastern Ohio; but relative to a medical malpractice issue, I don't know that I have.

Q. Well, I could not find one. That's why I'm asking you if you have a recollection.

A. I don't know that I have. I have done some plaintiff's work and I've testified in court for plaintiff, but it wasn't a medical malpractice case.

Q. You've testified for plaintiffs in cases where you become a treating physician relative to perhaps accident cases?

A. No. It was an expert, I could have been a treating physician. On a couple of occasions I recall I was. On a couple occasions I was sought out by plaintiff's attorney for an expert opinion.

Q. Which law firms do you generally work with, if there is such a thing as generally work with for you?

A. The ones, actually the ones that I have done the

most for locally plaintiff would be Hermann, Cahn & Schneider, several of their attorneys. I think that's all that comes to mind right off the top of my head.

Q. And what about defense firms? Have you testified for Reminger & Reminger before?

A. Yeah. A couple of times. Yes, a couple times.

Q. You worked with Mr. Walters before?

A. I don't believe we have. I think there was a case in which there was a conflict of interest or something in which I could not take the case and he had the case.

Q. Are you acquainted with Dr. Noall?

A. No.

Q. Have you had an opportunity to speak personally with her since you have been retained to be an expert?

A. No.

Q. Doctor, one of those administrative details that I didn't get to for whatever reason, what amount of money are you charging me per hour today?

A. I think we charge $2,000 for a deposition. It's just a straight fee. If you make it short, I'll refund some of it.

Q. Good enough.

I want to briefly go through your background. Mr. Walters on a prior occasion submitted to me what he represents to be your curriculum vitae. I'm going to hand it to you. Just take a quick look at it and then we'll have the court reporter mark it.

A. Yes. This looks to be my curriculum vitae.

MS. KOLIS: Pam, if you would mark this please.

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(Thereupon, Plaintiffs' Exhibit 1, Papsidero CV, was marked for purposes of identification.)

- - - -

Q. I think that your education is pretty self-explanatory to the degree that I understand things. You currently practice medicine as an ear, nose and throat physician?

A. I do not.

Q. You do not?

Tell me what you're doing currently.

A. I'm vice president of Marymount Hospital for surgical services and director of the department of surgery, so it's all an administrative job. And I do consulting work for healthcare firms

predominantly like Medical Mutual, Blue Cross.

Q. When did you take the position as the vice president of Marymount?

A. About a year ago.

Well, I actually took the position a couple years ago but it became more of a full-time job about a year ago.

Q. I gather, and without getting into too many personal details that are none of my business, there came a point where you got out of the hands-on practice of medicine and went into, as you're describing, your administrative consultation services and things of that nature?

A. Yes. I wanted to alter my career a little bit and try to do, try this area of administration and I had a particular link to Marymount over many years and I thought it needed some help; so the opportunity arose and I took it.

Q. When is the last time that you participated in your office-based practice?

A. About a year ago.

Q. Was that located in Garfield Heights?

A. Yes. My primary office has been in Garfield Heights.

Q. Doctor, have you ever been sued for medical

negligence?
A. Yes.
Q. How many occasions?
A. I don't recall exactly. I mean, I would guess I've been named on 10 or 12 suits over the years.
Q. To make this simple for you, to the best of your recollection, in any of those 10 to 12 suits, first of all, were any payments made on your behalf?
A. There were two payments made on my behalf that I recall over ten years ago. One was about $30,000 and the other 60,000.

One was a case of persistent headache and the second was a case of an esophageal tear when I was removing a foreign body.

Q. I'm going to gather based upon what you just told me about the settlements that neither of those particular situations resulted in anyone's death?
A. No, and I would like to say that, you know, that was a time when PIE was --
Q. Go ahead.
A. -- you know, proffering settlements very openly. We didn't really defend the case too much, or the cases.
Q. When you were practicing medicine, what was your

specialty, doctor?

A. Otolaryngology or ENT.

Q. Is it okay if I say ENT? Because I never say otolaryngology very accurately.

A. Yes. Please.

Q. As an ENT when you were practicing, what was the nature of your practice?

A. I think my practice evolved over the years. It started out being a general ENT practice. I still kept a large general component to it till the very end but focused more on nasal sinus and sleep apnea issues in the last few years prior; you know, few years of the practice.

Q. What percentage of your professional time in the five years before you went into administrative services was spent doing surgical procedures? Approximations are fine.

A. Approximately 40 percent.

Q. And what kind of surgeries were you performing?

A. Well, all types of ENT procedures but with an emphasis on procedures that dealt with the sinuses and procedures that dealt with the palate and sleep apnea issues.

Q. And those were performed at Marymount, I take it?

A. It could have been at Marymount or at Hillcrest.

I also did surgery at Hillcrest.

Q. Was the majority of your surgical treatment rendered at Marymount?

A. The majority was.

Q. When were you contacted to participate in this case, to the best of your recollection?

A. Oh, that's a good question.

I'd have to say within weeks of my first report, which was November 28th, so I don't know for sure but probably around October of 2003, something like that.

Q. In the materials you had, and once again I was sort of flipping through, I didn't see correspondence from Mr. Walters.

Do you have a correspondence file?

A. I don't. We don't -- I don't think I've gotten anything written from him at all. We talked on the phone for about half an hour once that I recall but I don't think I have anything written other than, you know, the stuff, the details, the depositions and so forth that were sent to me.

Q. You initially reviewed some material to reach your conclusions and I'm just going to read it sort of from the report. It says you reviewed the office records of Prime Health, Lake Hospital

emergency room, the autopsy results and then you did have the opportunity to read the depositions of Dr. Noall, Bob, and I can never pronounce Bob's name. We're going to call him Bob W.

A. Whelchel.

Q. Cynthia Manley, Cindy Jo Moses and Cheryl Keller?

A. And please don't ask me to differentiate the three.

Q. Okay.

A. I'm just kidding.

Q. That's fine. So these materials were sent to you, correct?

A. That's correct.

Q. And you reviewed those prior to writing this report?

A. This report, yes.

Q. I'm just going to ask a couple general questions and then probably go for some specifics, since I have some.

You read the depositions with an eye towards, I'm assuming, ferreting out in your own mind the course of events that occurred, correct?

A. Yes. This case appeared to me to be a little complex in terms of the order of the case and straightening out the communication issues of the

case. That was kind of difficult, contrary to most cases which involve a lot of detail about hospitalizations or, you know, doctors' offices and so forth.

Q. When you say straightening out the communication details, tell me what you're referring to.

A. Well, again, the communication between either Mr. Kidd or his wife with the office. Communication of the office with them, the nature of that communication and the timing of that communication.

That was more difficult because it involves really reading all of the depositions.

Q. You read Bob W.'s deposition, correct?

A. Yes.

Q. And you have a copy of it here available for reference?

A. Yes.

Q. Do you agree with me that Bob Whelchel's testimony indicates that Robin Kidd didn't refuse to bring her husband in but she said she would prefer if they did not have to come in?

A. I don't have a direct recollection of that. Maybe if we could look at that area.

Q. Sure. Because, well, let me ask you this

question and then you can look at any and all depositions you want.

Did Bob Whelchel testify that he instructed Mr. or Mrs. Kidd to come to the office and they outright refused?

A. I -- let me look at that because, again, I know that occurred at some time but not necessarily with him.

Well, on Page 12 of the, and I'm not sure I'm answering your question, so please correct me.

On Page 12 of his deposition towards the lower half, the answer, "She told me that she -- that he was having chest tightness and I asked her if he's having any trouble breathing and she said yes, so I suggested she take him to an urgent care which I didn't document and she said she's been there the day before and the two previous days before this."

I took that to mean that he instructed her to follow up at an urgent care center.

Q. And perhaps I'm not asking the question appropriately but we'll let it stand. I'm just going to ask it one other way.

A. I'm probably not interpreting you correctly.

Q. Well, communication problems are problems, aren't

they?

There has been an allegation in this case or through questioning of experts, et cetera, that the Kidds refused to come in for medical treatment and I'm asking you, first of all, based upon the testimony of Bob Whelchel if you have a recollection since you're going to be offering testimony in this case that Mrs. Kidd told Mr. Whelchel by his testimony that she'd prefer not to come in if they didn't have to?

A. I don't think that was documented as such.

Q. Do you believe that Dr. Noall as the primary care physician of Thomas Kidd had an obligation to speak with him on the telephone at any juncture where she thought that he might need medical attention?

A. That question is one of the questions that I, in trying to be objective in this case, certainly struggle with because that involves an interpretation in a sense of how family practices run, conduct their business and I know this is a long answer to a short question.

Q. That's all right. Go ahead.

A. But I know many, over the years I've had the opportunity to deal with many family physicians

and I know that certainly they, as you know, get many, many phone calls and that many, and that they utilize their staff very extensively to respond to phone calls.

Now, in this particular case, the question is, as the severity of the illness appeared to get worse, should Dr. Noall have spoken to Mr. Kidd and the issue that I had in deciding that in fact she probably didn't have an obligation to do that was that the information conveyed to her may not have been of a nature to make her think that he was having a worsening of some condition that was other than something like a muscular condition; so while the argument could be made, and I think I even refer to that in my note relative to the use of Vicodin, looking at the totality of the information that was being provided, again, a complex set of information to me, by several different people over several different times and several different settings in her office, I felt that it was reasonable for her to not necessarily have talked to doctor -- or Mr. Kidd but certainly respond to his needs.

Q. You are not a family practice physician, correct?

A. Correct.

Q. You are not board certified in internal medicine?
A. Correct.
Q. You have not taught family practice courses in a medical school setting, correct?
A. Correct.
Q. Do you currently still teach? I notice at one point you were an assistant clinical professor.
A. Yes, I am still an assistant clinical professor. I am not actively engaged in teaching right now.
Q. And when you taught, Dr. Papsidero, what were you teaching?
A. ENT related issues to a variety of types of students, everything from family practice to ER to ENT specialists to other types of specialists who might have, plastic surgeons and so forth.
Q. In this particular case, are you going to be offering testimony as to the standard of care that needed to be followed by Dr. Carol Noall?
A. I don't believe I've been asked to testify to the standard of care of a family practitioner.
Q. Okay. That kind of helps me. Sometimes it's me. I read too many expert reports a month but as I had an opportunity to reflect upon this last night, it was unclear to me as to whether or not you were retained as a causation expert or

causation and standard of care.

A. I see what you're saying.

Q. Right. So to the best of your knowledge, you are not going to be offering affirmative testimony that you believe that Dr. Noall met the standards of care required of a family practitioner?

A. To the best of my knowledge, I am not.

MR. KOLIS: Mr. Walters, is that fair for me to conclude, that I should deal with causation?

MR. WALTERS: Only, I mean in Dr. Papsidero's report of November 28 he indicates Dr. Noall met the standard of care. Obviously he's looking at it from his specialty and I, my intention is not to bring him in and tell the jury that he's something that he's not, but also to give his perception of what he expects would have happened if things would have gone differently; so I don't know --

MS. KOLIS: That's fair enough.

MR. WALTERS: I don't know how to distinguish that between standard of care and cause.

Q. All right. So you're going to have earn that

$2,000, I think, but we'll give it our best shot.

In reading your report, I guess I'm going to work it backwards, I was very surprised, which doesn't ever happen to me, of course, when I read the following sentence:

You indicate on the bottom of Page 2 of your first report, "Indeed had Mr. Kidd presented to the office as instructed, it would have been difficult if not impossible for Dr. Noall, a primary care physician, to make the diagnosis of retropharyngeal abscess and mediastinitis"?

A. Yes.

Q. Please tell me how you reached that conclusion.

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

A. Why I feel that way?

Well, a couple of reasons. One is that, firstly I think we have to distinguish between peritonsillar abscess and retropharyngeal abscess and retropharyngeal abscess is not quite as easy to diagnose as peritonsillar abscess. It's farther back. Involves retropharyngeal musculature. May be lateral. May involve the posterior tonsillar pillar. I looked at the autopsy report which demonstrated a .3 millimeter

ulcerative lesion which was, as I recall, lateral but I couldn't, I can't really attest to that in which the coroner probed it, found mucopus extending inferiorly.

If this were a retropharyngeal abscess, one of the uncommon ones that drain posteriorly in the retropharyngeal space, there may not have been much there to see; and so based upon that autopsy report and her observations as well as the observations of the ER doctors or the ER doctor, I had to come to that conclusion.

I would say, to give proper due credit, that the typical retropharyngeal abscess may most of the time be observable by a family physician.

The typical presentation of a retropharyngeal abscess is through an ED and what happens, a patient has pharyngeal complaints, goes to an ED. They get a lateral x-ray and then they see and it then they call you. That is kind of 95 percent of the way these things happen.

So this is all around a little bit of an atypical case but that's why I made that statement.

I felt that this was decompressing itself, maybe even as early as the 28th since he started

complaining the 28th of November, since he started complaining of chest symptoms, mediastinitis is a very difficult diagnosis to make in its own right without, in the absence of fever and other associated findings. I don't know that I'm the best person to make that diagnosis but I think that based on my experience at that stage, it would have been difficult to make that diagnosis.

Q. You said a lot of things and I didn't interrupt you so I'm going to try to do the best I can --

A. Tear it apart.

Q. -- to redact out some of the information which you provided to me. First of all let's go back to what you were saying about location of this particular abscess.

When you say that it might not be observable, you mean to the naked physician's eye if you're looking back in the throat you're not necessarily going to see a swelling or a bulge?

A. Correct.

Q. And specifically you're indicating that, you're making this assessment of what she could or couldn't have seen based upon location at autopsy, correct?

A. Yes.
Q. I'm with you so far.
Interestingly you're indicating that -- and I'm taking it you're going based on your life experience not something you've read in a textbook -- that the typical presentation occurs through an ED?
A. That's been my life experience, yes.
Q. And in this instance, this person had a family physician and went to the family physician with their complaints, correct?
A. Yes.
Q. And I wasn't surprised to hear that you're telling me that the diagnosis frequently is made because a lateral x-ray is performed and then they can see the abscess, correct?
A. Yes.
Q. Do you disagree with Dr. Barnhart and Dr. Bagdasarian that when there is a suspicion in your differential diagnosis of a suppurative complication, a pharyngitis, that it is the standard of care to obtain an x-ray, a lateral x-ray?
A. I think I disagree only to the degree that timing is an issue. That in fact if the diagnosis of

strep tonsillitis was made, which it was and properly made, I think, and the treatment I thought was proper, as well, that one wouldn't normally do something like that for several days.

I think mostly because in my experience it's taken several days for people with strep pharyngitis to start feeling better with antibiotics.

Q. So I suppose the answer is you disagree with my experts that that's the standard of care?

MR. WALTERS: I think he answered your question. I don't know that he's got to answer it again. He just answered it.

A. Well, I think, I think I disagree to the extent that during that period of time I would not have, and I don't think most reasonable otolaryngologists would have ordered an x-ray.

Q. When in your opinion, if you have one, did the mediastinitis begin?

A. I think probably it began when he started having chest pain and I don't have an absolute recollection of that, counselor, but I thought it might have been on the 28th --

Q. Did you bring your --

A. -- or 29th.

Q. I'm sorry to interrupt.
A. That's all right.
Q. Did you bring the medical records that you reviewed?
A. I brought, yes, I think I brought everything that I, well, maybe I didn't bring everything that I had.
MR. WALTERS: Do you want him to look at something?
Q. Just so that he could be certain as to the date.
A. The date he complained of chest pain?
Q. Chest pain, right.
A. I guess I'd like to review the records to determine that.
Q. Absolutely.
A. Okay. So that was documented on the 30th, 11/30/01. Is that the first time?
Q. Correct. And that's why when you said the 28th, I thought I had missed something, so I just wanted to be sure.
A. I'm sorry. I wasn't exactly certain and that clarifies it for me.
Q. Okay. So when you say probably, and I don't like to pick at things but just because the law requires us attorneys to be this way, is that

your opinion more likely than not --

A. Yes.

Q. -- based upon your training and experience that you believe that as of the 30th he would have been experiencing mediastinitis?

A. That is my opinion.

Q. Is it okay if I call it RPA so I don't have to keep saying retro --

A. Yes.

Q. We'll establish that as our code. Let's talk about RPAs.

Mr. Walters has as always challenged my intellectual curiosity by questions he asked other people in terms of morbidity and mortality, so I'm going to test you regarding what you believe regarding RPAs. Is it possible to make a diagnosis of RPA before it turns into a mediastinitis?

A. Yes.

Q. Okay. That would be an early RPA diagnosis. Can we call it that?

A. Well, I think that it's more related to the RPA behavior. I don't think that most early on track posteriorly and result in mediastinitis as quickly as in this case. That's one of my

premises, that in fact you can see RPA early that hasn't tracked posteriorly and can make a diagnosis, certainly an otolaryngologist could make a diagnosis. That's part of his or her job and then treat it usually through surgical intervention.

Q. Because the goal in treatment or making the diagnosis would be to not have it develop into a mediastinitis. Would you agree with that?

A. I think the goal in treatment would be to avoid any untoward consequences, one of which would be mediastinitis.

Q. What is the prognosis generally speaking if you diagnose an RPA before it starts to develop a track that drains into the mediastinum?

A. I don't know if I can answer that statistically, if you will.

I would say that my, from a personal experience perspective, that retropharyngeal abscess is in most cases a serious condition, that it often is a harbinger of other associated conditions, perhaps immunoinsufficiency problems or other types of issues but that most of the time it actually is just a spurious event.

If one were to catch it early and intubate,

put to sleep, drain it, the majority do well.

Q. In anticipation of either today's deposition or thinking down the road, which is far down the road, October or so before this case is set for trial, have you reviewed any literature looking at the morbidity and mortality issues?

A. No.

Q. Once a person develops mediastinitis, do you have a personal opinion about morbidity and mortality?

A. Yes. Well, I do have an opinion. Mediastinitis in my experience associated with my types of patients is, carries a very high mortality rate.

Q. And when you say your kinds of patients, what kinds of patients do you mean? I'm sorry to be that way.

A. Well, I would say patients that may have infections typically of the head and neck that spread and where do they spread? They spread usually through the lymphatic system and typically the mediastinum may be one of the sites that they would spread to, axillary lymph nodes, neck nodes and mediastinal area.

Q. Are you at all acquainted with the literature regarding what the probable statistics are in terms of survival once mediastinitis is

diagnosed?
A. No.
Q. Have you treated RPA?
A. Yes.
Q. I do understand that it is clinically a rare entity; so in your personal career, how many times have you seen this?
A. Oh, I would say, I'm obviously guessing.
Q. That's all right.
A. But over a 20-year period, maybe seven or eight times.
Q. Do you have a recollection of how your seven or eight patients did?
A. How they did?
Q. Yes.
A. Not for each of them, obviously. I think that most of them did pretty well.
Q. None of your patients died?
A. I can't recall any deaths.
Q. And so it was a matter of making the diagnosis and then surgically draining the abscess, correct?
A. Yes. Draining the abscess.
Q. And following your drainage and probably some sort of antibiotic regimen, I'm going to guess?

A. Yes.
Q. Did your patients go on to do well?
A. As far as I can recall, they did. It may have been an extended course of treatment, but --
Q. Doctor, how does one make the diagnosis of RPA?
A. You mean an otolaryngologist?
Q. Yes.
A. The, well, I guess it depends on the mode by which it gets to you. Obviously if a good quality emergency room doctor calls you up and says he has a lateral x-ray that shows a mass in the pharynx and believes it is a retropharyngeal abscess, then that is highly suspicious.

I think that, you know, when we do head/neck examinations on any patient with potential infection of various types, tonsillar and so forth, the instrumentation we use today is pretty thorough -- thoroughly examines the area, so that you could get a pretty good idea if there is a retropharyngeal abscess or tonsillar abscess or not.

Q. Would you say that the majority of people who you end up treating for RPA are delivered to your hands, the otolaryngologist, by other medical professionals be they family practitioners or ED

doctors?

A. Yes. I'd say the vast majority are ED doctors.

Q. Now, you told me that sometime ago you got that great title of assistant clinical professor down at Case and you were teaching issues?

A. Yes.

Q. What did you instruct your students, to the best of your recollection, to look for clinically to come to a suspicion of some form of RPA?

A. Well, I don't know if I have a direct recollection. I guess I can tell you what I think I would have likely taught students and it obviously depends on their level of achievement and where they are in their course.

Q. Okay.

A. If I were talking to residents in ENT, let's say, I would certainly say that part of an examination of any oropharyngeal, posterior oropharyngeal complaint involves a flexible laryngoscopy that's done gently and is done with the intent in mind that you may run into an infectious process.

If you were dealing with medical students, you might say that this is a possibility. It's a rare occurrence but it does occur and it's something to keep in mind in the future.

Q. Okay. Well, you probably gave me a good answer. A person presents with a sore throat, isn't that what Thomas Kidd presented with?
A. I believe that that was his primary complaint.
Q. His initial complaint on the 26th, correct? Do you remember that examination with Dr. Noall?
A. Yes.
Q. If you wouldn't mind looking at the medical records so you and I can go through them together, I just want to see where we are going to end up differing with each other.

You of course had an opportunity to read her deposition testimony?
A. Yes, I have.
Q. And then look at the medical records to see how they fit with one another.

He presents with, her typed version, with a sore throat since yesterday and she appropriately does a rapid strep test. Would you agree that was the appropriate thing to do?
A. Yes. I believe that's well within a reasonable thing to do.
Q. Sure. And that came back positive, correct?
A. Yes.
Q. Now, I noted that in her objective section she

says neck with shoddy anterior cervical LAD which is tender. What does that mean to you?

A. Neck with shoddy anterior cervical LAD.

My interpretation of that was shoddy nodes in the left anterior, we would normally refer to it as the triangle of the neck and maybe it was a mistype, I don't know, but, or she has a different meaning, but that's my interpretation was in the left anterior triangle of the neck.

Q. That there was swelling?

A. That there was shoddy nodes and shoddy nodes are, refer to a feel of a lymph node being shoddy as opposed to discrete.

Q. In English?

A. Well, actually, shoddy, a shoddy node we often will use in children who present often with lymph nodes that are of little meaning and say they aren't discrete nodes, they don't have, you can't identify their borders, they don't in their own right seem to be a problem but often may be associated with infection elsewhere in children. An ear infection is an example. In adults more commonly a sinus or a nasal or an oral infection.

Q. So some additional indication of an infectious process, would you agree with that?

A. Yes.
Q. Her assessment was that he had strep and then in parens fungal infection on the right hand which is not our concern but at that point she gave him intramuscular penicillin, correct?
A. Correct.
Q. She was assuming that he would be better, I would guess. Would you think that's what her deposition indicated, that she'd give him the shot and he would get well?
A. Yes. I think her experience had been probably that the vast majority would.
Q. Do people come to your office or did they come to your office directly if they had a sore throat?
A. Some did. I think that, you know, there are certain people who want to be treated by specialists for everything and so they would come with ENT complaints to me directly.
Q. He returned the next day, correct?
A. Yes.
Q. Now, he's back one day later after he has this injection of penicillin and his complaint is what? Do you remember?
A. Well, I'm going to refer to the record.
Q. That's absolutely fine.

A. Severe throat pain, what appears to be his chief complaint and difficulty swallowing.

Q. What does difficulty swallowing indicate to you as a person who's evaluating a person in light of a sore throat?

A. Well, you know, I guess it's always difficult to read off of a record because not being there, you can't really assess it; but I can't remember a strep throat patient that didn't have difficulty swallowing, so, you know, it's hard to go beyond that in interpreting this record.

He did indicate a laterality and that doesn't, I want to really comment on that because I noted that the other day when I was starting to prepare for this deposition and the laterality itself does not help us with the retropharyngeal or RPA.

In fact, it almost, it's almost suggestive of a viral infection and in fact if he had tenderness in the neck at the same time I would say he may have had a carotid odynia, a glosso-pharyngeal neuralgia because his pain ended up being so great or his complaints just continued to worsen.

I don't think that really happened here. I

think maybe part of his throat got better and part did not.

Q. Well, let's talk about that.

In the handwritten portion above the typed portion, it says hard to swallow saliva. He's not talking about a painful throat, is he?

MR. WALTERS: Which part? It says sore throat pain right above the it's hard to swallow saliva?

A. Right. It would not be uncommon in patients with a variety of conditions, not just RPA, but more commonly in adults supraglottitis, which involves inflammation of the lingual tonsils and tonsils and other areas, to say they can't swallow and that they have throat pain and they can't swallow their saliva.

I do think that this happening the day after the injection means less than it could have meant two days later because you expect the injection to have an effect within three days and I would be, so the timing is a critical issue here.

Q. You do not believe, it's your opinion to a reasonable degree of medical certainty or however you want me to phrase it, that laterality has no effect in assisting the practitioner to increase

their suspicion that there's something more than a strep throat going on?

A. I don't think laterality at this stage of the game, in other words we're talking a day after the first treatment, has any benefit in terms of diagnostic decision-making.

I think laterality later on could help focus one on alternatives since we have a persistent problem.

I can't tell you the number of times people have reported -- usually they don't come back the next day -- but with a strep throat that one side is better than the other. I mean it is a very common experience so I can't say that it really leads us to another pathway.

Q. Okay. So that I'm clear about what you said, initially I thought you said laterality a day after an initial injection with penicillin in the face of, you know, a positive strep doesn't help you but it might later?

A. Correct.

Q. How does laterality help you later in terms of making a diagnosis of RPA?

A. Well, if I didn't see, if I as an otolaryngologist did not see a response to my

initial treatment, which was the IM Bicillin, within three days or certainly if the patient was worsening, then laterality does lead me to other concerns and the next question is going to be what other concerns?

Q. Correct.

A. And they would include peritonsillar abscess, a viral glosso-pharyngeal neuralgia or ninth nerve neuralgia and possibly a retropharyngeal abscess, as well, although again those things are so uncommon that they don't jump right out at you.

Q. When a physician, and we can say ENT or anyone else, is having to make a decision between which possibility for a diagnosis exists, do we not have to eliminate the most, what word am I looking for, doesn't the standard of care require that we eliminate the one that will have the highest mortality?

A. I know what you're saying, you know, obviously you know the highest risk carries the greatest concern.

I think, I'm not sure that's how it really works. I mean, it sounds reasonable but I think what really works in a differential diagnosis is that it goes more by probabilities than it does

by severity of illness.

We can always say that a lymph node in the neck is lymphoma but the probability is it is not.

So, as an example, so I would not fault anyone for not having high on the differential diagnosis a life-threatening condition in this, in a patient who presented with a positive strep throat.

Q. And once again, it's your testimony that frequently people get relief on one side of their throat and don't get it on the other side of their throat?

A. Initially but you would expect that the other side would come along within a day or two.

Q. Is it clear to you that Dr. Noall gave Thomas Kidd a prescription for prednisone prn? In other words, if he wanted to use it, he could use it; if he didn't want to, he didn't have to?

A. I don't recall that. What I do recall is a prescription for prednisone. I believe it was ten milligrams four to five times a day. I don't know if it was prn or not.

Q. Do you see, doctor, pretty clearly in her assessment and plan section where it says he does

not have to use the prednisone if he chooses not to? Last sentence in the plan?

A. Yes, I do and that's correct.

Q. So Thomas Kidd's nonuse of prednisone isn't an issue in this case for you, is it?

A. No.

Q. Dr. Noall indicates, does she not, that she has a concern that he might have peritonsillar abscess?

A. I believe she does.

Q. Would you tell a client, I shouldn't call them clients. We get our professions mixed up.

Would you instruct a patient to watch for a uvular deviation?

A. I personally do not instruct a patient to look for uvular deviation. I certainly would say to them if you feel it worsening, then we may have to take another look at it and that there are other things that could be happening.

Q. How would a patient check for a uvular deviation?

A. Well, I think if he can see his uvula and he or she sees that it is moving to one side or the other with a flashlight or whatever, it's a possibility, depending on the individual; but many people cannot.

Q. Wouldn't that sort of, not sort of. Doesn't that

seem to you to be something of a skill that one would acquire in medical school, how to look in someone's throat and determine whether the uvula was deviating?

A. Well, or nursing school or a professional school.

Although I will say that I do, and I don't know that to be the case here at all, that I certainly have had patients who take an inordinate interest in every orafice that they can find and examine it.

If he felt, if he were conversing that he felt comfortable looking in his throat, that would be one thing. It's certainly not documented to that effect.

Q. No, because this uvular deviation, were it to have occurred, would have been indicative of what?

A. Uvular deviation is a hallmark of peritonsillar or, well, abscess.

Q. Do you believe based upon the autopsy or anything else that you've seen that Mr. Kidd had peritonsillar abscess at any point?

A. I didn't see any evidence of it.

Q. When do you believe he developed his RPA?

A. Boy.

Q. To the best of your ability based upon what is available?
A. I don't know exactly. My best guess is that it occurred after a couple of days of ongoing infection. My best guess is that it occurred because of a spread of the infection to a retropharyngeal lymph node and then that node became necrotic and infected.
Q. Just so I understand it, because I didn't ever get the privilege to go to medical school, even though I like to read it, you're in agreement at least to this extent: That it is the initial positive strep itself that then developed into this suppurative complication of RPA; is that right?
A. Yes.
Q. As long as we're on the same page on that one, I'm okay.

So he sees the doctor on the 27th, so the very next day.

Now, he also goes to the emergency room that day, correct?
A. That's my recollection, yes.
Q. And now that you've had an opportunity to look at the records and read all the depositions, is it

clear to you that he went to the emergency room after he saw Dr. Noall?

A. Yes.

Q. What is your belief, based upon deposition testimony, as to why he went to the emergency room after he had already seen Dr. Noall?

A. Again, without him able to testify, it's so difficult to exactly determine but my belief based on reviewing the information at hand is that he was not getting a response and was looking for additional treatment to enhance the response rate.

Q. I'm going to ask you, and I know it's crazy because I keep flipping back and forth, but a lot of the communication in this case was precipitated by telephone calls. Are you in agreement with that?

A. A lot of -- I'm sorry. Would you repeat that?

Q. That was a silly question because I said a lot of and that quantifies nothing.

You were aware that on the morning of November 27th that Mr. Kidd called Dr. Noall's office before he came in?

A. Yes. I recall that.

Q. Do you recall what their advice was in response

to his complaint at that point that one side of his throat was still sore?

MR. WALTERS: It's in the records.

A. Let me look it up just to be accurate.

So that was on the 27th?

Q. I think it was at 8:30 in the morning.

A. The response back to the patient?

Q. To the patient.

A. It says patient will come right down to office.

Q. I think we're looking at different notes.

A. Are we looking at different notes?

Q. Okay. I'm sorry.

A. I apologize. This is the later one, isn't it?

Q. Right. This is the note I'm looking at.

A. Maybe this is the early note. I'm sorry.

Q. This is the note I'm looking at.

A. Thank you.

The response --

Q. Does it say "Give it time. Just had an injection yesterday"?

A. It says, yes. "Give it time. Just had a penicillin injection or PCN injection yesterday evening. Call."

Q. So the patient sees her on the 26th. On the 27th in the morning, he's feeling poorly enough that

he calls in to say my throat is still sore but it's on one side and their advice initially was just give it time, right?

A. Yes.

Q. But Mr. Kidd in fact ends up coming to the doctor's office that day?

A. That day, yes.

Q. Because he calls back, right?

A. Yes.

Q. Because he says at that point "Going to ER. Can't breathe;" is that right?

A. Correct.

Q. So he's already developed some shortness of breath on the 27th. Would you agree with that, at least based upon what he reports to the office?

A. Based upon what is written on this report, yes.

Q. So then he does come back to her office, right?

A. Yes.

Q. It says, "Refuses to go to ER but he will come to their office"?

A. Correct.

Q. Does that mean to you or did you interpret that to mean that Mr. Kidd was comfortable with Dr. Noall as a physician?

A. I would believe so.
Q. So he comes down to her office. We've been through the exam. We know what she diagnosed or what she told him that day but then he goes on to an emergency room, correct?
MR. WALTERS: That night, yes.
A. That night.
MR. WALTERS: You want to go back to the ER?
Q. I'm just going to ask him and if he wants to look at the ER records, he can.
Was there anything in the emergency room record --
A. Let's look at that, then.
Q. -- which helps you to determine when he might have been developing his mediastinitis?
A. And this is dated, the record of Lake Hospital System emergency department, 11/27/01.
Q. Right.
A. He was essentially afebrile, although he complained of a sore throat and, I'm sorry, I should be answering your question.
Q. That's okay.
A. What is it specifically again?
Q. In other words, looking over the physical

findings that they had at the time, does that tell you whether or not he had already developed mediastinitis? Do you have any information --

A. According to this, I don't see any evidence that they would have picked up or that there would have been a suggestion of mediastinitis at this time.

Q. Do you have any criticisms with the emergency room confirming for Mr. Kidd that, you know, he's got pharyngitis, give it a couple days and call your doctor again?

A. Gosh, that's a good question. I hadn't really been oriented that way and thinking about that.

You know, I guess my concern at this point on the 27th is that in two days he has not, he has stated that he can't swallow water and that many emergency room physicians, and, again, being there, there's nothing like being there; so how, you know, certain patients can be histrionic and certain are not and you have to make a clinical judgment as to how accurate that statement is.

If in fact he was unable to swallow water at that time, then I would have been very careful about follow-up. I might, in my experience, the ER may have followed up itself to be certain the

next day that he was improving or not.

Q. Do you know what Dr. Noall's relationship is with the Lake East Hospital Systems?

A. No.

Q. Do you know whether the ER physicians knew who Dr. Noall was?

A. I don't know.

Q. Let's move on to the next contact that Mr. Kidd has with Dr. Noall's office and that's on the 30th, correct?

A. I believe so.

Q. Do you have an opinion, doctor, about a physician prescribing muscle relaxers for chest tightness over the telephone without physically examining a patient?

A. Well, I do have a rather complex opinion about this issue. I wish I could answer it in a single word which would be sufficient but I, it was clear that in this office and in many family practitioner offices that the information that one receives is via an LPN, RN, MA that one learns to trust their judgment and that that does affect one's conclusions.

One also gets to know one's patients and how they will respond to suggestions; so there are

some patients, as an example, whom I know will always want samples because they either can't afford or don't wish to pay or read some book that they said they can reduce their costs by having the doctors give them samples so, in looking at this, I would say that, I guess I would say this: It was clear that the doctor believed that the hunting, the weekend hunting episode had some effect on his musculoskeletal system. It seems clear to me that that was likely to have been conveyed to the people that talked to her and that she responded by ordering the drugs that she did.

As to whether or not one should see that person. I think a follow-up appointment would have been appropriate but I don't think it was absolutely necessary prior to prescribing it if he was pretty intent on getting treatment.

Q. Okay. Well, let's sort that out because that becomes one of the issues, I think that you fairly and clearly testified close to the beginning of this deposition that based upon the information available to you, this chest tightness that we see on November 30th at the time this phone call was made at 8:40 in the

morning more likely than not suggests that we have the beginnings of mediastinitis at some, that we're at some place with mediastinitis. Would you agree with that?

A. Yes.

Q. Now, you're the physician and you're talking with the patient, your patient who you've seen twice for his strep, knowing that you had a concern about this turning into something else, i.e. a peritonsillar abscess and all of a sudden you have this complaint of chest tightness, wouldn't that increase your suspicion that you may have something else going on relative to the infection in the throat?

MR. WALTERS: I'm just going to object because he didn't just complain of chest tightness; so for clarity of the record I will object.

Q. Well, for clarity of the record, Dr. Noall never spoke with Thomas Kidd again after the 27th. Would you agree with that?

MR. WALTERS: I'm not arguing with you.

A. I would agree with that.

MR. WALTERS: I just think when

you include a question about complaints of the question you should maybe include all of them.

Q. Well, let me do it this way:

Bob goes to Dr. Noall, right? Do you remember that?

A. Yes.

Q. Bob gets the phone call. Dr. Noall is in a meeting. Bob goes down there because this chest tightness is on Prime Health's hot list?

A. Yes.

Q. You've seen the hot list, right?

A. Well, no, I know about it, I guess.

Q. All right. You know about the hot list, all right.

So now it's Dr. Noall who is sitting in a meeting having a communication with Bob that now this patient who she is seeing and knows that he's infected and has been telling him to watch for this uvular deviation, now he calls in with a complaint of chest pain.

Wouldn't it be reasonable at that point to say we need to see this patient. This chest pain could be related to an infection?

A. Well, okay. I think, let's break that apart a

little bit in my response.

Q. Sure.

A. Firstly, when he called, according to the documents that I've been able to read, he complained of chest tightness and back pain and he wants a muscle relaxer. So the patient is conveying information to the doctor over the phone.

As I recall, Bob indicated that he knew and that the doctor knew, based on his testimony, that he was not one to want to come in; so she is working off of this information and then states follow up muscles in chest something causing to have trouble, something like that. Refused appointment and something else that I can't read, so the issue is, to get to the point that I think that you're going to be most interested in, should a family physician have at that point in time with a complaint now of chest tightness and even if the patient said back pain, which he apparently did, should she have had a high suspicion for an alternative illness and I think that is where in a sense I spent a lot of time in my own mind trying to construct a picture to be fair to both sides on this particular issue

because had he come in to see her, she may have been impressed that he is a sicker man than he lets on.

She probably would not have been able to make this diagnosis. I really think that a family physician in this situation would likely not have made the diagnosis but then again I'm testifying to a family physician and you can get one to maybe say otherwise.

Q. You have, to interrupt just the --

MR. WALTERS: He wasn't done yet. Would you let him finish his answer? Were you done?

THE WITNESS: No.

MR. WALTERS: Go on.

A. So, no, I would say that I thought it was reasonable for her to, under these circumstances where he was unwilling to be seen, to prescribe for his specific complaints.

Q. Is your predicate for approving of her behavior your belief that he refused to come in?

A. I believe it was a combination of that and the complaints that he related to the office staff.

Q. Okay. To be clear, if the jury believes that Mrs. Kidd advised Mr. Whelchel that they could

come in if they had to but that they would prefer not to and that they didn't refuse to come in, all right? Does that make sense so far?

A. Yes.

MR. WALTERS: Where is that coming from, though, is there some basis for that?

MS. KOLIS: Mr. Whelchel's testimony.

MR. WALTERS: Because Mrs. Kidd didn't say that, I don't believe.

Q. If the jury chooses to believe that, will you still think that Dr. Noall conformed to the standards of care in writing a prescription without seeing the patient?

A. I would say that under those circumstances where the patient was fully willing to be cooperative, that it is ideal to have seen the patient prior to prescribing for the patient.

Q. A muscle relaxer?

A. A muscle relaxer, yes.

Q. The Kidd family called the office yet again on the 27th later, correct?

A. As I recall, they did.

Q. And their indication at that point was that the medication was not working, correct?

A. Correct.
Q. At this point, Dr. Noall's response is to prescribe a narcotic, Vicodin, correct?
A. Correct.
Q. Doctor, do you believe that the standard of care is met when a physician who has not physically examined a patient relative to a new onset of chest pain writes a prescription for a narcotic over the telephone?
A. I think the specific answer to that, to chest pain is no.
Q. You wouldn't do it, would you?
A. No.
Q. Let me ask you a different question.

Based upon, and obviously it's clear to me based upon your written reports that you spent some time evaluating the autopsy and looking at the entire picture.

Do you believe that if Thomas Kidd had been seen in a medical facility or medical office on the morning of the 30th and properly diagnosed, whether it was vis-a-vis an emergency room doctor or sent to an ENT, would he have survived his RPA on the 30th, do you have an opinion?

A. On the 30th?

Q. Yes.
A. My opinion is that there was a very strong chance that he would not have even with intensive antibiotic therapy.
Q. What do you think the statistical probabilities were on that day?
A. I don't think I can give you statistics on that particular issue.
Q. And your basis for believing that he, well, I don't know if you said he probably wouldn't survive, you said a high probability that he wouldn't have, is based on what?
A. Well, by that time he had developed mediastinitis. I think by that time, when I look at the, of course, you know, a day can make a big difference but when you look at the autopsy reports, the pleural effusion, the potential high pneumonia, the general necrosis, even though he was a relatively young man of 40, you know, a little older because he smoked heavily but the, an attempt to try to salvage his life would require treatment of sepsis, which obviously, in my own theory is that he died of sepsis and septic shock.
Q. Complications, right?

A. Yes. Treatment of septic shock is still even today not highly successful. Had they gotten him there before he went into septic shock, he would have had somewhat better odds but we've got to remember that this septic shock, you know, occurred within 24 hours of this, his death or approximately thereof. I don't know, this is 1:42. I don't recall when he died. This, the next day?

Q. The following day.

A. Anyway, a day, that the ability to reverse a trend toward that is a lot more difficult than people might suspect so I would say that was my long answer.

Q. That's okay.

A. My short answer is I believe that if that had been diagnosed the day before, that he still would have had a very high chance of mortality.

Q. What do you believe or what in the chart indicates to you at that point that you for certain know he was in septic shock?

A. Well, really there is nothing. I mean I guess as a physician you piece together the logical trend of what occurs to a patient who has an overwhelming infection in specific areas and he

didn't seem to die of his pneumonia. In other words, it didn't seem to be extensive enough. He could have had an arrhythmia I suppose and died from that but the likelihood is he had an infection. Infections lead to sepsis and the body responds to sepsis very frequently in shock and that often is what causes a very quick demise in what seems like a person who shouldn't have experienced a quick demise. A perfect example of that is Jim Henson and his pneumococcal pneumonia. I mean it's a classic example, I suppose.

Q. When the Kidd family, Mrs. Kidd specifically, contacted Dr. Noall on December 1st, 2001 at 10:50 in the morning, she's relating to the office that Mr. Kidd is hallucinating. You see that --

A. Okay.

Q. -- telephone message?

A. Yes. Pain meds, up all night, regarding pain meds. Up all night and positive pain. Hallucinating. Yes.

Q. Given that that was the complaint, in addition to which when they return the call they find that he can't breathe through his nose, he's doing mouth

breathing at this point, was it appropriate for Dr. Noall to say go get your Vicodin filled? Did that meet the standard of care?

A. Did she say that?

Q. Yes.

A. I mean, where was that?

Q. If you read towards the bottom. I'm assuming you read her deposition; but it says per Dr. Noall, get Vicodin script. That will help with pain and sleep.

A. Yeah. One of the --

MR. WALTERS: I'll just object to the completeness of the hypothetical because it is incomplete.

A. One of the issues that I had a lot of difficulty with in ferreting out in this case was this hallucination issue which came up a couple of times in documents and, you know, when I think of hallucinations and, you know, not being a psychiatrist, I suppose I don't know if I have a classic definition but I usually think of a person who is seeing things, observing unusual behavior or unusual events as opposed to acting out and behaving unusually; so I really wasn't certain -- and obviously this is based on notes

and some testimony -- that he was truly hallucinating.

Irrespective of that, he did have complaints of pain and so working under the premise that she was, that he had back pain and not just chest pain, and that I think she was working, I believe she was working under the premise that that was related to some strenuous activity a few days before, she asked him to go ahead and take the medication that he had not taken.

I don't know that that in its own right is substandard. I guess that answers that specific question.

Q. I think that it does.

When you were practicing medicine, were you on call at Marymount or Hillcrest to provide emergency services?

A. Yes.

Q. I take it that you were able to, I don't take anything.

Was a part of your responsibility when you were on call to come in and help secure the airways of people who were badly infected perhaps with pneumonia or other things?

A. Yes.

Q. Would Mr. Kidd have benefited from being in a hospital setting on the 30th of November?

MR. WALTERS: You're asking this in light of his previous question where you asked him and he said in all probability he would have died even if he were admitted to the hospital?

MS. KOLIS: He didn't say he would have died. He said the high probability and he told me he can't give me a statistic.

MR. WALTERS: He didn't give you the exact number. He said in probability he would have died. I believe that was his answer. If I'm misstating it, the record will reflect it.

Q. If that is your answer, if you want to clarify it for me, that's fine.

A. You mean on the 30th?

Q. Yes.

A. On the 30th, I think that even had he presented to the hospital with all of the intensive care that he would have received, there is a high probability that he would not have survived.

Q. Is it greater than 51 percent in your own mind?

In other words is it more likely than not in your opinion that he would have died?

A. Yes, but then you had a second question for me just a moment ago.

Q. I probably forgot what it was.

MR. WALTERS: That's the part that didn't make sense to me because you said would he have benefited and I said in lieu of the fact that he gave testimony that in probability he was going to die --

Q. It wouldn't, right, that's okay.

Since you've authored your report, have you read the expert reports of Dr. Barnhart, Dr. Bagdasarian, Dr. Kelly?

A. I've read Dr. Barnhart and Dr. Bagdasarian. I don't remember reading Dr. Kelly.

Q. Dr. Kelly has also been retained to defend Dr. Noall.

MR. WALTERS: He's a family care physician. I don't know if I sent you Dr. Kelly.

A. I don't believe I've read that.

Q. Doctor, have I essentially covered all of the opinions that you'll be voicing at trial?

A. All of the opinions that I would offer short of

any additional questions by you.

Q. And just to make sure that I know what they are and I'll cover them briefly and that might prompt your memory that there is something I've left out.

You will be testifying that you think that it would have been -- I'm going to use the right word so you don't say he didn't say that -- that it would have been unlikely in your opinion for a primary care physician to have made the diagnosis of retropharyngeal abscess and mediastinitis?

A. Correct, in this case.

Q. In this case.

That if Mr. Kidd had presented to an emergency room or Dr. Noall's office on November 30th, 2001 to a reasonable degree of medical probability it would not have made a difference and he would have died anyway?

A. Yes, I believe that -- well, what I testified to, you asked me 51 percent or more.

Q. Right.

A. And I said that my opinion is that there was more than 51 percent chance that he would have died.

Q. Okay. That Dr. Noall did not deviate from the accepted standards of medical care in her care

and treatment of this patient?

A. Overall, my opinion was just that, barring of a couple of criticisms that you've elicited here, that that didn't lead to what I felt were substandard care but perhaps not approaches that I would have taken.

MS. KOLIS: Okay, doctor, I thank you and appreciate the time that you spent with me today and see you in September or October, whenever the trial is.

_____

MICHAEL J. PAPSIDERO, M.D., F.A.C.S.

C E R T I F I C A T E

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

I, Pamela S. Greenfield, a Notary Public within and for the State of Ohio, authorized to administer oaths and to take and certify depositions, do hereby certify that the above-named witness was by me, before the giving of their deposition, first duly sworn to testify the truth, the whole truth, and nothing but the truth; that the deposition as above-set forth was reduced to writing by me by means of stenotypy, and was later transcribed into typewriting under my direction; that this is a true record of the testimony given by the witness; that said deposition was taken at the aforementioned time, date and place, pursuant to notice or stipulation of counsel; and that I am not a relative or employee or attorney of any of the parties, or a relative or employee of such attorney, or financially interested in this action; that I am not, nor is the court reporting firm with which I am affiliated, under a contract as defined in Civil Rule 28(D).

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office, at Cleveland, Ohio, this 28th day of May A.D. 20 04.

Pamela Greenfield, Notary Public, State of Ohio
1750 Midland Building, Cleveland, Ohio 44115
My commission expires July 3, 2008

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1969-70	Vanderbilt University, Nashville, Tennessee
1970-73	Case Western Reserve University, Cleveland, Ohio B.A., Magna Cum Laude
1977	University of Michigan, Ann Arbor, Michigan, M.D.

POSTDOCTORAL STUDY

1996	Weatherhead School of Management/ School of Medicine of Case Western Reserve University Attendance at Physician Executive Institute Health Systems Management Center
1994-95	Weatherhead School of Management Professional Fellow Case Western Reserve University Cleveland, Ohio

INTERNSHIP

1977-78	William Beaumont Hospital, Royal Oak, Michigan Internship (straight surgical)

RESIDENCY

1978-82	University of Michigan Medical Center, Ann Arbor, Michigan Otolaryngology - Head and Neck Surgery
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Curriculum Vitae
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BOARD CERTIFICATION

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PROFESSIONAL AFFILIATIONS

1985-present	Fellow, American College of Surgeons
1986-present	Member, Fifth District Delegation of the Academy of Medicine to the Ohio State Medical Association
	Fellow,, American Academy of Facial Plastic and Reconstructive Surgery
	Fellow, American Academy of Otolaryngology-Head and Neck Surgery
1991-present	Member, American Sleep Disorders Association
	Member, Northeastern Ohio Otolaryngological-Head and Neck Surgery Society
	Member, Walter Work Society, Michigan
	Member, Academy of Medicine of Cleveland
	Member, Ohio State Medical Association
	Member, American Medical Association
	Member, American Academy of Medical Directors

1991-present	Member, American Association of Managed Care Executives
1996-1997	Member, Partnership in Hope Medical Mission
1997 - present	Member, Medical Leadership Council of Meridia Health Systems

POSITIONS

1998-present	Chairman, Cardiac Surgery Performance Improvement Team/Meridia Health Systems
1997-present	Interim Medical Director, Meridia Health Plan
1997-present	Co-Director, Meridia Airway Center
1997-1998	Medical Director/Clinical Resource & Quality Management Meridia Health System
1996-present	Program Director, Otolaryngology, Meridia Health Systems
1996-present	Program Director, Sleep Disorders Center, Meridia Health Systems
1996-present	Executive Manager, Development, Northern Ohio Otolaryngology Network
1995-present	President and Managing Physician, Cleveland Ear, Nose, Throat & Facial Surgery Group, Inc.
1993-present	Associate Managing Physician, Cleveland Ear, Nose, Throat & Facial Surgery Group, Inc.
1993-1996	Associate Director, The Center for Ear, Nose, Throat & Facial Surgery Group, Inc./Mt. Sinai Health Care System, Cleveland, Ohio
1993-present	Associate Director, Mt. Sinai Nasal-Sinus Center Mt. Sinai Health Care System, Cleveland, Ohio

POSITIONS (continued)

1989-present	Director, Division of Otolaryngology-Head and Neck Surgery/Marymount Hospital, Cleveland, Ohio
1988-91	Alternate Director, Department of Surgery Marymount Hospital, Cleveland, Ohio
1991-93	Coordinator, Residency Rotation University Hospitals of Cleveland/Marymount Hospital, Cleveland, Ohio
1990-present	Co-Director, Sleep Disorders Laboratory Marymount Hospital, Cleveland, Ohio
1990-91	Board of Directors, Emerald Health Network
1989-1995	President, Northern Ohio Health Providers Organization
1987-1995	Board of Directors, Northern Ohio Health Providers Organization
1986-1994	Delegate, Ohio State Medical Association

FACULTY APPOINTMENTS

Assistant Clinical Professor, Case Western Reserve University School of Medicine, Cleveland, Ohio

Clinical Instructor, Case Western Reserve University School of Dentistry, Department of Orthodontics, Cleveland, Ohio

Assistant Clinical Professor, Ohio University, College of Osteopathic Medicine, Athens, Ohio

GOVERNMENT APPOINTMENT

1996-present	Chairman, Public Health Council, State of Ohio
1995-96	Vice Chairman, Public Health Council, State of Ohio
1991-98	Member, Public Health Council, State of Ohio

TEACHING EXPERIENCE

September 1998	The Evaluation and Treatment of Patients with Sleep Apnea Syndromes and Snoring: An Algorithmic Approach American Academy of Otolaryngology-Head and Neck Surgery Annual Meeting, San Antonio, TX
February 1997	Lecture, Obstructive Sleep Apnea The Society of Weatherhead Professional Fellows Case Western Reserve University, Cleveland, Ohio
September 1997	The Evaluation and Treatment of Patients with Sleep Apnea Syndromes and Snoring: An Algorithmic Approach American Academy of Otolaryngology-Head and Neck Surgery Annual Meeting, San Francisco, CA
December, 1996	Course Director, Laser Applications In The Head & Neck Meridia South Pointe Hospital
October 15, 1996	Course Director, Symposium on Advances On The Diagnosis &Treatment of Asthma & Obstructive Sleep Apnea/Meridia Health System
September, 1996	The Evaluation and Treatment of Patients with Sleep Apnea Syndromes and Snoring: An Algorithmic Approach American Academy of Otolaryngology-Head and Neck Surgery Annual Meeting, Washington, D.C.
May 1996	Course Supervisor, Endoscopic Sinus Surgery, Laboratory, Case Western Reserve University
September 1996	The Evaluation and Treatment of Patients with Sleep Apnea Syndromes and Snoring: An Algorithic Approach American Academy of Otolaryngology-Head and Neck Surgery Annual Meeting
October 1995	Co-Director, Laser Course on Otolaryngology Review, Fortec Medical, Mt. Sinai Integrated Medical Campus, Cleveland, Ohio

September 1995	The Evaluation and Treatment of Patients with Sleep Apnea Syndromes and Snoring: An Algorithmic Approach American Academy of Otolaryngology-Head and Neck Surgery Annual Meeting
September 1995	American Academy of Otolaryngology-Head and Neck Surgery Annual Meeting, New Orleans, Louisiana
1992-93	Course Director, Endoscopic Sinus Surgery Course and Laboratory/Case Western Reserve University School of Medicine/Cleveland, Ohio
March, 1991	Cherry Blossom Conference, Moderator, Sleep Apnea Section/Washington, D.C.
1990	Rhinology Course Case Western Reserve University School of Dentistry, Cleveland, Ohio
December 1986	Instructor, Facial Plastic Anatomy Laboratory University of Michigan School of Medicine
Fall 1984	Instructor, Temporal Bone Laboratory University of Michigan School of Medicine
1983-present	Instructor, Case Western Reserve University School of Dentistry, Cleveland, Ohio
Fall 1980	Instructor, Oral Diagnosis 660 University of Michigan School of Dentistry

COMMITTEES

National

1996	Ambulatory Surgery Committee of the American Academy of Facial Plastic and Reconstructive Surgery
1993-present	Carrier Relations Task Force, American Academy of Otolaryngology-Head and Neck Surgery

January 1993	Functional Endoscopic Sinus Surgery Relative Value Committee, American Academy of Otolaryngology-Head and Neck Surgery
January 1993-present	Interprofessional Committee, American Academy of Otolaryngology-Head and Neck Surgery
1986-92	Manpower Committee, American Academy of Otolaryngology-Head and Neck Surgery
1986-92	Geriatric Committee, American Academy of Otolaryngology Head and Neck Surgery
1988-present	Legislative Committee, Academy of Medicine of Cleveland

COMMITTEES (continued)

Local

1995	PHO Medical Management Committee Mt. Sinai Medical Center
1995	Educational Peer Review Subcommittee Mt. Sinai Medical Center
1992-95	Chairperson, Medical Care Policy Committee Parma Community General Hospital, Cleveland, Ohio
1993-95	Strategic Planning Committee Parma Community General Hospital, Cleveland, Ohio
1991-92	Chairperson, Physician Practice Development Committee Marymount Hospital, Cleveland, Ohio
1990-present	Medical Education Committee, Marymount Hospital
1989-present	Surgical Policies and Procedures Committee Marymount Hospital, Cleveland, Ohio
1988	Member, Board Strategic Planning Committee Marymount Hospital, Cleveland, Ohio
1987-1991	Laser Committee, Marymount Hospital, Cleveland, Ohio

Curriculum Vitae
Michael J. Papsidero, M.D., 8

HOSPITAL AFFILIATIONS

Meridia Hillcrest Hospital, Courtesy Staff
Marymount Hospital, Active Staff
University Hospitals of Cleveland, Active Staff
Mt. Sinai Medical Center, Courtesty Staff
Parma Community General Hospital, Associate Staff
Meridia Huron Hospital, Courtesy Staff

Michael J. Papsidero, M.D., F.A.C.S.
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December 1, 2003

Mr. Stephen E. Walters
Reminger & Reminger
1400 Midland Building
Cleveland, OH 44115-1093

Re: Robin Kidd, E/O Thomas Kidd v. Carol Noall, M.D., et al.
Geauga County Common Pleas Court Case No. 03PT000216
File No. 4107-02-52205-03

Dear Mr. Walters:

I have recently received the expert report of Dr. William Barnhart, Dr. John R. Bogdasarian and John F. Burke Jr., Ph.D.

In reference to Dr. Barnhart's comments, I would say the following with respect his complaint that an inappropriate response to the complaint of back and chest pain was made by Dr. Noall, I would state that this patient was noncompliant and unwilling to go to an emergency room setting for further evaluation or to come to Dr. Noall's office for an examination. It appears that this is because the patient and his wife felt that he could not afford additional Dr. visits due to a lack of insurance.

In reference to Dr. Barnhart's complaint of the use of steroids, a potent anti-inflammatory medication, I completely disagree. The use of steroids in patients with severe pharyngitis and in particular with tonsillar and uvular swelling is common in combination with antibiotics.

Dr. John Bogdasarian's comments are interesting and point out some of the difficulties in this case in terms of the communications, which existed between Mrs. Kidd and Dr. Noall's office. However when piecing together the information from the deposed office staff, it appears that Mr. Kidd refused to be seen either by Dr. Noall or in an emergency room setting. Indeed Dr. Noall did prescribe a narcotic medication for worsening pain over the phone and this might be a source of criticism. However the rapid progression of this disease to death within 24 hours of this phone call suggests that had this patient been seen on the afternoon of 11-30-01, it is unlikely that even aggressive intervention would have resulted in survival.

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Consequently despite what might be termed an overaggressive over the phone treatment of symptomatology, it is ultimately the rarity of this condition, the virulence of the disease process and Mr. Kidd's reluctance to come to Dr. Noall's office or to the emergency room which led to his death.

I would be pleased to discuss the expert testimony of Dr. Barnhart, Dr. John Bogdasarian, or Dr. John Burke Jr., Ph.D. with you at anytime.

With best regards.

Sincerely,

Michael J. Papsidero, M.D., F.A.C.S.
Vice President for Surgical Services Development
Director Department of Surgery

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Cleveland Clinic Health System — Marymount Hospital

November 28, 2003

Mr. Stephen E. Walters
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1400 Midland Building
Cleveland, OH 44115-1093

Re: Robin Kidd, E/O Thomas Kidd v. Carol Noall, M.D., et al.
Geauga County Common Pleas Court Case No. 03PT000216
File No. 4107-02-52205-03

Dear Mr. Walters:

I am responding to your request for an expert opinion regarding the case of Robin Kidd v. Carol Noall, M.D. I have reviewed the office records of Prime Health, the Lake Hospital Emergency Room, the autopsy results, as well as the depositions of Carol Noall, M.D., Mr. Bob Whelehel, Cynthia Manley, Cindy Jo Moses and Cheryl Keller.

HISTORY

Mr. Kidd was a 41-year-old white male who presented initially to Dr. Noall on November 26, 2001 with complaints of a sore throat. At that time she obtained a positive strep test and a diagnosis of strep pharyngitis was made.

Mr. Kidd was treated with 1.2 IM. units of Bicillin administered intramuscularly. He was given Lotrisone for a rash on the hand. He had had a similar rash in the past, which was likewise treated with Lotrisone with success.

He was subsequently seen on November 27, 2001 at the Lake Hospital Emergency room. At that time it was noted that his throat pain was worsening, however there was a relative paucity of findings documented on the Emergency Room visit chart. There was in fact no reference in a drawing present within this chart, to enlarged tonsils, uvular deviation, or any evidence for a peritonsillar or retropharyngeal abscess.

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Mr. Kidd was advised by the Emergency room physician to follow up within two days with Dr. Noall. Apparently a telephone call was made on November 30, 2001 by Mr. Noall's wife Carol to the office in which she noted a complaint of chest tightness and back pain. It is unclear based on that note as to whether or not Mr. Kidd's throat pain had subsided at that point in time. No other significant symptoms were noted in the communication including any difficulty breathing.

The description by Robin Kidd to the MA and nurses within the office was consistent with a musculoskeletal complaint. Mr. Kidd was again offered the opportunity to present to the office and refused.

He called again on December 1, 2001 noting a persistence of complaints. These complaints at that time included some difficulty breathing, apparently through the nose, and sleeplessness for 48 hours do to pain. He was given Vicodin, a narcotic medication, for pain at that time. Mr. Kidd subsequently died later that same day.

A review of the autopsy note indicates that the primary cause of death was Pharyngeal abscess. However a careful examination of the autopsy report suggests that the cause of death would most likely be defined as a mediastinal infection occurring as a result of a perforation of retropharyngeal abscess. On autopsy Mr. Kidd demonstrated pleural thickening and confluent purulent fibrinous deposits in the lungs.

Also noted was necrotizing esophagitis and paraesophageal abscess with acute inflammation. Finally on the microscopic description it was noted that the posterior pharynx demonstrated evidence for abscess with perforation into the retropharyngeal space.

A careful review of the documents provided to date suggests that Mr. Kidd presented with a fairly typical picture of streptococcal pharyngitis a common condition. The deterioration in his medical condition was unusually rapid and the patient's pathology progressed quickly to mediastinitis and death.

Viewing the sworn testimony of the medical assistant's, and nurses within the office, it is clear that Robin and Thomas Kidd were resistant to returning to the office for an examination by Dr. Noall. He had been asked to do so on at least two occasions one by the Emergency room physician and at least once by the office staff within Dr. Noall's office.

While Dr. Noall might be faulted for having treated this patient with Soma and Vicodin over the telephone for proported musculoskeletal complaints, nevertheless Mr. Kidd had refused to come to the office for examination. Moreover this treatment did not affect the ultimate course of events.

Indeed had Mr. Kidd presented to the office as instructed it would have been difficult if not impossible for Dr. Noall, a primary care physician, to make the diagnosis of retropharyngeal abscess and mediastinitis. Even under those conditions, it is unlikely that at that point in time the course of events leading to death would have been altered.

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It is my opinion within a reasonable degree of medical certainty that Dr. Noall met the standard of care in the treatment of Mr. Kidd. Mr. Kidd's reluctance in complying with the requirement that he present to Dr. Noall in a timely fashion following his emergency room visit certainly contributed to his outcome. However, had the patient presented in a timely fashion to Dr. Noall, the diagnosis of this unusual condition would have been difficult at best, and indeed given the rapid course of events leading to Mr. Kidd's death, successful intervention would have been unlikely at best.

Sincerely,

Michael J. Papsidero, M.D., F.A.C.S.
Vice President for Surgical Services Development
Director Department of Surgery

MICHAEL J. PAPSIDERO, M.D.
Defense Expert

Deposition Summary

Taken: 05/14/04

PAGE	LINE	TESTIMONY
5	7-10	"I will review maybe four cases. End up doing a deposition on one or two. I've been at, in trial for a defendant or a plaintiff maybe four or five times."
6	6-7	"Relative to a medical malpractice issue, I don't know that I have."
8	17-24	He does not currently practice medicine as an ear, nose and throat physician. He's "vice president of Marymount Hospital for surgical services and director of the department of surgery, so it's all an administrative job."
9	5-7	It became his full time job about a year ago.
10	4-9	He's been sued for medical negligence "10 or 12" suits over the years.
13	1-6	He reviewed all the records, the autopsy report, depo transcripts of: Dr. Noall, Bob, Cynthia Manley, Cindy Jo Moses, and Cheryl Keller.

13	23-25	"This case appeared to me to be a little complex in terms of the order of the case and straightening out the communication issues of the case."
14	5-8	Question: "When you say straightening out the communication details, tell me what you're referring to." Answer: "Well, again, the communication between either Mr. Kidd or his wife with the office."
15	11-20	From Robin's deposition transcript, he "took that [the chronology and summation of communication] to mean that he [Bob Whelchel] instructed her to follow up at an urgent care center."
17	6-23	RE: issue of whether Dr. Noall had an obligation to speak with Tom/Robin directly (not through her MA and through Robin). Answer: "As the severity of the illness appeared to get worse, should Dr. Noall have spoken to Mr. Kidd and the issue that I had in deciding that in fact she probably didn't have an obligation to do that was that the information conveyed to her may not have been of a nature to make her think that he was having a worsening of some condition that was other than something like a muscular condition . . .I felt it was reasonable for her to not necessarily have talked to Mr. Kidd but certainly respond to his needs."

18	1-12	He is not a family practice medicine physician, he is not board certified in internal medicine, he has not taught family practice courses in a medical school setting.
18	19-20	"I don't believe I've been asked to testify to the standard of care of a family pracitioner."
19	7	To the best of his knowledge, he is NOT testifying on the standards of care of Dr. Noall.
20	7-12	Per his report: "Indeed had Mr. Kidd presented to the office as instructed, it would have been difficult if not impossible for Dr. Noall, a primary care physician, to make the diagnosis of retropharyngeal abcess and mediastinitis."
20	17-25	RE: Why would Dr. Noall not have been able to Dx the RP abcess? Answer: "Firstly, I think we have to distinguish b/w peritonsillar abscess and retropharyngeal abscess [which] is not quite as easy to diagnose. It's farther back. Involves retropharyngeal musculature. May be lateral. May involve the posterior tonsillar pillar."
21	15-20	"The typical presentation of a retropharyngeal abscess is through is through an ED and what happens, a patient has pharyngeal complaints, goes to an ED. They get a lateral x-ray and then they see and it then they call you. That is kind of 95 percent of the way these things happen."

21-22	24-2	"I felt that this was decompressing itself, maybe even as early as the 28th since he started complaining the 28th of November, since he started complaining of chest symptoms."
22	17-21	Question: "When you say that it might not be observable, you mean to the naked physician's eye if you're looking back in the throat you're not necessarily going to see a swelling or a bulge?" Answer: "Correct."
23	18-25	Question: "Do you disagree with Dr. Barnhart and Dr. Bogdasarian that when there is a suspicion in your differential diagnosis of a suppurative complication, a pharyngitis, that it is the standard of care to obtain an x-ray, a lateral x-ray?" Answer: "I think I disagree only to the degree that timing is an issue."
24	20-23	RE: beginning of mediastinitis. "I think probably it began when he started having chest pain and I don't have an absolute recollection of that, counselor, but I thought it might have been on the 28th."
25	16-17	Actually, "that was documented on the 30th, 11/30/01."

26	16-19	It is possible to make a diagnosis of RPA before it turns into a mediastinitis.
27	10-12	The goal in treating RPA is "to avoid any untoward consequences, one of which would be mediastinitis."
28	5-7	He has NOT reviewed any literature looking at the morbidity and mortality issues.
29	3-11	He has treated RPA. "Over a 20-year period, maybe seven or eight times."
29	12-19	He doesn't recall any deaths of those 7-8 patients he's treated w/ RPA.
30	5-13	Diagnosing RPA as an ENT: – "Depends on the mode by which it gets to you." Obviously if a good quality emergency room doctor calls you up and says he has a lateral x-ray that shows a mass in the pharynx and believes it is a RPA, then that is highly suspicious."
31	2	"I'd say the vast majority [of patients] are [delivered to him by] ED doctors."
33	22-25	re: note regarding "shoddy nodes" -> "In adults more commonly a sinus or a nasal or an oral infection."

36	17-21	"I do think that this happening the day after the injection means less than it could have meant two days later because you expect the injection to have an effect within three days and I would be, so the timing is a critical issue here."
37	7-9	"I think laterality later on could help focus one on alternatives since we have a persistent problem."
38	7-11	And what are the other concerns... "they would include peritonsillar abscess, a viral glosso-pharyngeal neuralgia or ninth nerve neuralgia and possibly a RTA, as well, although again those things are so uncommon that they don't jump right out at you."
38	24-25	"I think what really works in a differential diagnosis is that it goes more by probabilities than it does by severity of illness."
40	4-6	Question: "so Thomas Kidd's nonuse of prednisone isn't an issue in this case for you, is it?" Answer: "No."

40	19-24	Question: "How would a patient check for a uvular deviation?" Answer: "Well, I think if he can see his uvula and he or she sees that it is moving to one side or the other with a flashlight or whatever, it's a possibility, depending on the individual, but, many people cannot."
41	18-19	"Uvular deviation is a hallmark of peritonsillar or,well, abscess."
42	3-8	When did the RPA occur: "My best guess is that it occurred after a couple of days of ongoing infection. My best guess is that it occurred because of a spread of the infection to a retropharyngeal lymph node and then that node became necrotic and infected."
45	10-12	What do the records indicate the Kidds called in and told Dr. Noall's office: "Going to ER. Can't breathe."
47	4-7	"According to this [the ED records], I don't see any evidence that they would have picked up or that there would have been a suggestion of mediastinitis at this time."
47	22-24	"If in fact he was unable to swallow water at that time, then I would have been very careful about follow-up."

49	15-18	"I think a follow-up appointment would have been appropriate but I don't think it was absolutely necessary prior to prescribing it if he was pretty intent on getting treatment."
50	1-5	The 11/30/01 chest tightness relative the 8:40 a.m. phone call, it's fair to say that it was the beginnings of mediastinitis.
50	19-24	For the record, Dr. Noall never spoke with Thomas Kidd again after the 27th.
52	3-8	"Firstly, when he called, according to the documents that I've been able to read, he complained of chest tightness and back pain and he wants a muscle relaxer. So the patient is conveying information to the doctor over the phone."
52	9-14	"As I recall, Bob indicated that he knew and that the doctor knew, based on his testimony, that he was not one to want to come in; so she is working off of this information and then states follow up muscles in chest something causing to have trouble, something like that."
53	5-9	"I really think that a family physician in this situation would likely not have made the diagnosis but then again I'm testifying to a family physician and you can get one to maybe say otherwise."

53	16-19	"I would say that I thought it was reasonable for her to, under these circumstances where he was unwilling to be seen, to prescribe for his specific complaints."
54	15-18	"I would say that under those circumstances where the patient was fully willing to be cooperative, that it is ideal to have seen the patient prior to prescribing for the patient."
55	5-11	Question: "Doctor, do you believe that the standard of care is met when a physician who has not physically examined a patient relative to a new onset of chest pain writes a prescription for a narcotic over the telephone?" Answer: "I think the specific answer to that, to chest pain, is no."
56	2-4	On the 30th, if he had rec'd a Dx of RPA, he believes that Mr. Kidd "would not have [survived] even with intensive antibiotic therapy."
56	13-14	"By that time he had developed mediastinitis."
57	16-18	"My short answer is I believe that if that had been diagnosed the day before [his death], that he still would have had a very high chance of mortality."

61	21-24	"On the 30th, I think that even had he presented to the hospital with all of the intensive care that he would have received, there is a high probability that he would not have survived."
63	8-13	It would have been unlikely in his opinion for a primary care physician to have made the diagnosis of retropharyngeal abscess and mediastinitis.
63	14-21	More likely, than not, Mr. Kidd would have died even if he reported to an ED on 11/30/01.