

1 IN THE COURT OF COMMON PLEAS

2 GEAUGA COUNTY, OHIO

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

5 Plaintiffs,

6 -vs-

JUDGE FORREST BURT
 CASE NO. 03 PT 000216

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

9 Defendants.

10 - - - -

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

21 - - - -

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On behalf of the Plaintiffs;

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On behalf of the Defendants.

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

CROSS-EXAMINATION
MICHAEL J. PAPSIDERO, M.D., F.A.C.S.
BY MS. KOLIS

4

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

Plaintiffs' Exhibit 1,
Papsidero CV

8

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

7 CROSS-EXAMINATION OF

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

9 BY MS. KOLIS:

10 Q. Good morning, Dr. Papsidero.

11 A. Good morning.

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

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

21 A. That's correct.

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

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

1 A. Yes.

2 Q. Currently what amount of time do you spend on an
3 annual basis say in the past two to three years?

4 A. Just a couple percent of my time. It's a very
5 low percent. I usually do -- well, you know,
6 there's the review of the case, depositions, all
7 this stuff. I will review maybe four cases. End
8 up doing a deposition on one or two. I've been
9 at, in trial for a defendant or a plaintiff maybe
10 four or five times.

11 Q. Doctor, when is the last time that you authored
12 an expert report on behalf of a patient?

13 A. I think in the fall.

14 Q. Was that here locally?

15 A. No. That was a case that was a Texas case. That
16 was actually for a plaintiff.

17 Q. Do you know how the attorney from Texas located
18 you as an expert witness?

19 A. You know, I really don't know how he located me,
20 to be quite honest. I, in terms of services and
21 things like that, I did have my name on the SEAK,
22 S-E-A-K, service, after I took a, kind of a
23 disability management course once and I don't
24 think it's on there anymore, so he may have
25 gotten it off of that.

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

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

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

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

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

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

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

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

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

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

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

8 Q. You worked with Mr. Walters before?

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

13 Q. Are you acquainted with Dr. Noall?

14 A. No.

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

18 A. No.

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

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

25 Q. Good enough.

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

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

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

10 - - - -
11 (Thereupon, Plaintiffs' Exhibit 1, Papsidero
12 CV, was marked for purposes of
13 identification.)

14 - - - -
15 Q. I think that your education is pretty
16 self-explanatory to the degree that I understand
17 things. You currently practice medicine as an
18 ear, nose and throat physician?

19 A. I do not.

20 Q. You do not?

21 Tell me what you're doing currently.

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

1 predominantly like Medical Mutual, Blue Cross.

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

4 A. About a year ago.

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

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

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

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

21 A. About a year ago.

22 Q. Was that located in Garfield Heights?

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

25 Q. Doctor, have you ever been sued for medical

1 negligence?

2 A. Yes.

3 Q. How many occasions?

4 A. I don't recall exactly. I mean, I would guess
5 I've been named on 10 or 12 suits over the years.

6 Q. To make this simple for you, to the best of your
7 recollection, in any of those 10 to 12 suits,
8 first of all, were any payments made on your
9 behalf?

10 A. There were two payments made on my behalf that I
11 recall over ten years ago. One was about \$30,000
12 and the other 60,000.

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

16 Q. I'm going to gather based upon what you just told
17 me about the settlements that neither of those
18 particular situations resulted in anyone's death?

19 A. No, and I would like to say that, you know, that
20 was a time when PIE was --

21 Q. Go ahead.

22 A. -- you know, proffering settlements very openly.
23 We didn't really defend the case too much, or the
24 cases.

25 Q. When you were practicing medicine, what was your

1 specialty, doctor?

2 A. Otolaryngology or ENT.

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

5 A. Yes. Please.

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

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

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

18 A. Approximately 40 percent.

19 Q. And what kind of surgeries were you performing?

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

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

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

1 I also did surgery at Hillcrest.

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

4 A. The majority was.

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

7 A. Oh, that's a good question.

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

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

15 Do you have a correspondence file?

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

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

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

5 A. Whelchel.

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

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

9 Q. Okay.

10 A. I'm just kidding.

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

13 A. That's correct.

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

16 A. This report, yes.

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

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

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

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

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

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

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

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

15 A. Yes.

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

18 A. Yes.

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

23 A. I don't have a direct recollection of that.

24 Maybe if we could look at that area.

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

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

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

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

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

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

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

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

24 A. I'm probably not interpreting you correctly.

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

1 they?

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

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

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

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

23 Q. That's all right. Go ahead.

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

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

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

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

25 A. Correct.

1 Q. You are not board certified in internal medicine?

2 A. Correct.

3 Q. You have not taught family practice courses in a
4 medical school setting, correct?

5 A. Correct.

6 Q. Do you currently still teach? I notice at one
7 point you were an assistant clinical professor.

8 A. Yes, I am still an assistant clinical professor.
9 I am not actively engaged in teaching right now.

10 Q. And when you taught, Dr. Papsidero, what were you
11 teaching?

12 A. ENT related issues to a variety of types of
13 students, everything from family practice to ER
14 to ENT specialists to other types of specialists
15 who might have, plastic surgeons and so forth.

16 Q. In this particular case, are you going to be
17 offering testimony as to the standard of care
18 that needed to be followed by Dr. Carol Noall?

19 A. I don't believe I've been asked to testify to the
20 standard of care of a family practitioner.

21 Q. Okay. That kind of helps me. Sometimes it's me.
22 I read too many expert reports a month but as I
23 had an opportunity to reflect upon this last
24 night, it was unclear to me as to whether or not
25 you were retained as a causation expert or

1 causation and standard of care.

2 A. I see what you're saying.

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

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

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

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

21 MS. KOLIS: That's fair enough.

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

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

1 \$2,000, I think, but we'll give it our best shot.

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

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

12 A. Yes.

13 Q. Please tell me how you reached that conclusion.

14 MR. WALTERS: I object to the form

15 of the question but go ahead.

16 A. Why I feel that way?

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

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

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

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

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

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

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

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

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

12 A. Tear it apart.

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

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

21 A. Correct.

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

1 A. Yes.

2 Q. I'm with you so far.

3 Interestingly you're indicating that -- and
4 I'm taking it you're going based on your life
5 experience not something you've read in a
6 textbook -- that the typical presentation occurs
7 through an ED?

8 A. That's been my life experience, yes.

9 Q. And in this instance, this person had a family
10 physician and went to the family physician with
11 their complaints, correct?

12 A. Yes.

13 Q. And I wasn't surprised to hear that you're
14 telling me that the diagnosis frequently is made
15 because a lateral x-ray is performed and then
16 they can see the abscess, correct?

17 A. Yes.

18 Q. Do you disagree with Dr. Barnhart and
19 Dr. Bagdasarian that when there is a suspicion in
20 your differential diagnosis of a suppurative
21 complication, a pharyngitis, that it is the
22 standard of care to obtain an x-ray, a lateral
23 x-ray?

24 A. I think I disagree only to the degree that timing
25 is an issue. That in fact if the diagnosis of

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

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

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

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

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

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

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

24 Q. Did you bring your --

25 A. -- or 29th.

1 Q. I'm sorry to interrupt.

2 A. That's all right.

3 Q. Did you bring the medical records that you
4 reviewed?

5 A. I brought, yes, I think I brought everything that
6 I, well, maybe I didn't bring everything that I
7 had.

8 MR. WALTERS: Do you want him to
9 look at something?

10 Q. Just so that he could be certain as to the date.

11 A. The date he complained of chest pain?

12 Q. Chest pain, right.

13 A. I guess I'd like to review the records to
14 determine that.

15 Q. Absolutely.

16 A. Okay. So that was documented on the 30th,
17 11/30/01. Is that the first time?

18 Q. Correct. And that's why when you said the 28th,
19 I thought I had missed something, so I just
20 wanted to be sure.

21 A. I'm sorry. I wasn't exactly certain and that
22 clarifies it for me.

23 Q. Okay. So when you say probably, and I don't like
24 to pick at things but just because the law
25 requires us attorneys to be this way, is that

1 your opinion more likely than not --

2 A. Yes.

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

6 A. That is my opinion.

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

9 A. Yes.

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

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

19 A. Yes.

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

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

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

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

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

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

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

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

25 If one were to catch it early and intubate,

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

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

7 A. No.

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

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

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

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

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

1 diagnosed?

2 A. No.

3 Q. Have you treated RPA?

4 A. Yes.

5 Q. I do understand that it is clinically a rare
6 entity; so in your personal career, how many
7 times have you seen this?

8 A. Oh, I would say, I'm obviously guessing.

9 Q. That's all right.

10 A. But over a 20-year period, maybe seven or eight
11 times.

12 Q. Do you have a recollection of how your seven or
13 eight patients did?

14 A. How they did?

15 Q. Yes.

16 A. Not for each of them, obviously. I think that
17 most of them did pretty well.

18 Q. None of your patients died?

19 A. I can't recall any deaths.

20 Q. And so it was a matter of making the diagnosis
21 and then surgically draining the abscess,
22 correct?

23 A. Yes. Draining the abscess.

24 Q. And following your drainage and probably some
25 sort of antibiotic regimen, I'm going to guess?

1 A. Yes.

2 Q. Did your patients go on to do well?

3 A. As far as I can recall, they did. It may have
4 been an extended course of treatment, but --

5 Q. Doctor, how does one make the diagnosis of RPA?

6 A. You mean an otolaryngologist?

7 Q. Yes.

8 A. The, well, I guess it depends on the mode by
9 which it gets to you. Obviously if a good
10 quality emergency room doctor calls you up and
11 says he has a lateral x-ray that shows a mass in
12 the pharynx and believes it is a retropharyngeal
13 abscess, then that is highly suspicious.

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

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

1 doctors?

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

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

6 A. Yes.

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

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

15 Q. Okay.

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

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

1 Q. Okay. Well, you probably gave me a good answer.

2 A person presents with a sore throat, isn't
3 that what Thomas Kidd presented with?

4 A. I believe that that was his primary complaint.

5 Q. His initial complaint on the 26th, correct? Do
6 you remember that examination with Dr. Noall?

7 A. Yes.

8 Q. If you wouldn't mind looking at the medical
9 records so you and I can go through them
10 together, I just want to see where we are going
11 to end up differing with each other.

12 You of course had an opportunity to read her
13 deposition testimony?

14 A. Yes, I have.

15 Q. And then look at the medical records to see how
16 they fit with one another.

17 He presents with, her typed version, with a
18 sore throat since yesterday and she appropriately
19 does a rapid strep test. Would you agree that
20 was the appropriate thing to do?

21 A. Yes. I believe that's well within a reasonable
22 thing to do.

23 Q. Sure. And that came back positive, correct?

24 A. Yes.

25 Q. Now, I noted that in her objective section she

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

3 A. Neck with shoddy anterior cervical LAD.

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

10 Q. That there was swelling?

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

14 Q. In English?

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

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

1 A. Yes.

2 Q. Her assessment was that he had strep and then in
3 parens fungal infection on the right hand which
4 is not our concern but at that point she gave him
5 intramuscular penicillin, correct?

6 A. Correct.

7 Q. She was assuming that he would be better, I would
8 guess. Would you think that's what her
9 deposition indicated, that she'd give him the
10 shot and he would get well?

11 A. Yes. I think her experience had been probably
12 that the vast majority would.

13 Q. Do people come to your office or did they come to
14 your office directly if they had a sore throat?

15 A. Some did. I think that, you know, there are
16 certain people who want to be treated by
17 specialists for everything and so they would come
18 with ENT complaints to me directly.

19 Q. He returned the next day, correct?

20 A. Yes.

21 Q. Now, he's back one day later after he has this
22 injection of penicillin and his complaint is
23 what? Do you remember?

24 A. Well, I'm going to refer to the record.

25 Q. That's absolutely fine.

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

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

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

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

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

25 I don't think that really happened here. I

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

3 Q. Well, let's talk about that.

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

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

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

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

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

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

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

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

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

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

21 A. Correct.

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

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

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

6 Q. Correct.

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

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

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

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

1 by severity of illness.

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

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

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

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

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

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

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

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

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

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

6 A. No.

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

9 A. I believe she does.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

24 Q. When do you believe he developed his RPA?

25 A. Boy.

1 Q. To the best of your ability based upon what is
2 available?

3 A. I don't know exactly. My best guess is that it
4 occurred after a couple of days of ongoing
5 infection. My best guess is that it occurred
6 because of a spread of the infection to a
7 retropharyngeal lymph node and then that node
8 became necrotic and infected.

9 Q. Just so I understand it, because I didn't ever
10 get the privilege to go to medical school, even
11 though I like to read it, you're in agreement at
12 least to this extent: That it is the initial
13 positive strep itself that then developed into
14 this suppurative complication of RPA; is that
15 right?

16 A. Yes.

17 Q. As long as we're on the same page on that one,
18 I'm okay.

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

21 Now, he also goes to the emergency room that
22 day, correct?

23 A. That's my recollection, yes.

24 Q. And now that you've had an opportunity to look at
25 the records and read all the depositions, is it

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

3 A. Yes.

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

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

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

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

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

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

24 A. Yes. I recall that.

25 Q. Do you recall what their advice was in response

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

3 MR. WALTERS: It's in the records.

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

5 So that was on the 27th?

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

7 A. The response back to the patient?

8 Q. To the patient.

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

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

11 A. Are we looking at different notes?

12 Q. Okay. I'm sorry.

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

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

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

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

17 A. Thank you.

18 The response --

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

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

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

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

4 A. Yes.

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

7 A. That day, yes.

8 Q. Because he calls back, right?

9 A. Yes.

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

12 A. Correct.

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

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

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

19 A. Yes.

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

22 A. Correct.

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

1 A. I would believe so.

2 Q. So he comes down to her office. We've been
3 through the exam. We know what she diagnosed or
4 what she told him that day but then he goes on to
5 an emergency room, correct?

6 MR. WALTERS: That night, yes.

7 A. That night.

8 MR. WALTERS: You want to go back
9 to the ER?

10 Q. I'm just going to ask him and if he wants to look
11 at the ER records, he can.

12 Was there anything in the emergency room
13 record --

14 A. Let's look at that, then.

15 Q. -- which helps you to determine when he might
16 have been developing his mediastinitis?

17 A. And this is dated, the record of Lake Hospital
18 System emergency department, 11/27/01.

19 Q. Right.

20 A. He was essentially afebrile, although he
21 complained of a sore throat and, I'm sorry, I
22 should be answering your question.

23 Q. That's okay.

24 A. What is it specifically again?

25 Q. In other words, looking over the physical

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

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

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

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

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

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

1 next day that he was improving or not.

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

4 A. No.

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

7 A. I don't know.

8 Q. Let's move on to the next contact that Mr. Kidd
9 has with Dr. Noall's office and that's on the
10 30th, correct?

11 A. I believe so.

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

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

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

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

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

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

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

5 A. Yes.

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

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

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

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

24 A. I would agree with that.

25 MR. WALTERS: I just think when

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

4 Q. Well, let me do it this way:

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

7 A. Yes.

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

11 A. Yes.

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

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

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

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

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

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

1 little bit in my response.

2 Q. Sure.

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

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

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

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

10 Q. You have, to interrupt just the --

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

14 THE WITNESS: No.

15 MR. WALTERS: Go on.

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

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

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

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

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

4 A. Yes.

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

7 MS. KOLIS: Mr. Whelchel's
8 testimony.

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

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

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

19 Q. A muscle relaxer?

20 A. A muscle relaxer, yes.

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

23 A. As I recall, they did.

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

1 A. Correct.

2 Q. At this point, Dr. Noall's response is to
3 prescribe a narcotic, Vicodin, correct?

4 A. Correct.

5 Q. Doctor, do you believe that the standard of care
6 is met when a physician who has not physically
7 examined a patient relative to a new onset of
8 chest pain writes a prescription for a narcotic
9 over the telephone?

10 A. I think the specific answer to that, to chest
11 pain is no.

12 Q. You wouldn't do it, would you?

13 A. No.

14 Q. Let me ask you a different question.

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

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

25 A. On the 30th?

1 Q. Yes.

2 A. My opinion is that there was a very strong chance
3 that he would not have even with intensive
4 antibiotic therapy.

5 Q. What do you think the statistical probabilities
6 were on that day?

7 A. I don't think I can give you statistics on that
8 particular issue.

9 Q. And your basis for believing that he, well, I
10 don't know if you said he probably wouldn't
11 survive, you said a high probability that he
12 wouldn't have, is based on what?

13 A. Well, by that time he had developed
14 mediastinitis. I think by that time, when I look
15 at the, of course, you know, a day can make a big
16 difference but when you look at the autopsy
17 reports, the pleural effusion, the potential high
18 pneumonia, the general necrosis, even though he
19 was a relatively young man of 40, you know, a
20 little older because he smoked heavily but the,
21 an attempt to try to salvage his life would
22 require treatment of sepsis, which obviously, in
23 my own theory is that he died of sepsis and
24 septic shock.

25 Q. Complications, right?

1 A. Yes. Treatment of septic shock is still even
2 today not highly successful. Had they gotten him
3 there before he went into septic shock, he would
4 have had somewhat better odds but we've got to
5 remember that this septic shock, you know,
6 occurred within 24 hours of this, his death or
7 approximately thereof. I don't know, this is
8 1:42. I don't recall when he died. This, the
9 next day?

10 Q. The following day.

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

15 Q. That's okay.

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

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

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

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

13 Q. When the Kidd family, Mrs. Kidd specifically,
14 contacted Dr. Noall on December 1st, 2001 at
15 10:50 in the morning, she's relating to the
16 office that Mr. Kidd is hallucinating. You see
17 that --

18 A. Okay.

19 Q. -- telephone message?

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

22 Hallucinating. Yes.

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

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

4 A. Did she say that?

5 Q. Yes.

6 A. I mean, where was that?

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

11 A. Yeah. One of the --

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

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

1 and some testimony -- that he was truly
2 hallucinating.

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

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

14 Q. I think that it does.

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

18 A. Yes.

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

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

25 A. Yes.

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

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

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

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

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

19 A. You mean on the 30th?

20 Q. Yes.

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

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

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

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

5 Q. I probably forgot what it was.

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

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

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

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

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

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

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

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

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

1 any additional questions by you.

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

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

12 A. Correct, in this case.

13 Q. In this case.

14 That if Mr. Kidd had presented to an
15 emergency room or Dr. Noall's office on November
16 30th, 2001 to a reasonable degree of medical
17 probability it would not have made a difference
18 and he would have died anyway?

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

21 Q. Right.

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

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

1 and treatment of this patient?

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

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

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

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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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CURRICULUM VITAE

Michael J. Papsidero, M.D., F.A.C.S.

PERSONAL HISTORY

Business Address: 12000 McCracken Road, Suite 550
Garfield Heights, Ohio 44125

Telephone: (216) 662-3373

EDUCATION

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

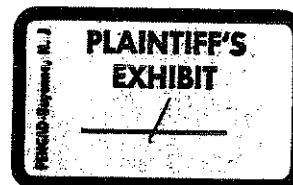
1996 Weatherhead School of Management/
School of Medicine of Case Western Reserve University
Attendance at Physician Executive Institute Health Systems
Management Center
1994-95 Weatherhead School of Management
Professional Fellow
Case Western Reserve University
Cleveland, Ohio

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
1981-82 Chief Resident



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BOARD CERTIFICATION

1982 American Board of Otolaryngology - Head and Neck
Surgery

MEDICAL LICENSURE

State of Michigan (40423) November 1977
State of Ohio (47395) June 1982
State of California (G50065) June 1983

MEDICAL SPECIALTY

1978-present Otolaryngology-Head and Neck Surgery

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

Curriculum Vitae

Michael J. Papsidero, M.D., 3

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

Curriculum Vitae (continued)
Michael J. Papsidero, M.D., 5

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 Algorithmic 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

Curriculum Vitae
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- 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

Curriculum Vitae

Michael J. Papsidero, M.D., 7

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

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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, Courtesy Staff

Parma Community General Hospital, Associate Staff

Meridia Huron Hospital, Courtesy Staff

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



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Marymount Hospital

November 28, 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 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 due 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 purported 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.

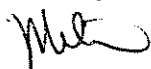
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It is my opinion within a reasonable degree of medical certainty that Dr. Noall met the standard of care in the treatment of Mr. Kidd. Mr. Kidd's reluctance in complying with the requirement that he present to Dr. Noall in a timely fashion following 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 practitioner."

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 abscess and mediastinitis."

20 17-25 RE: Why would Dr. Noall not have been able to Dx the RP abscess?

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 glossopharyngeal 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.