

1 IN THE COURT OF COMMON PLEAS  
2 SUMMIT COUNTY, OHIO  
3 LAWRENCE PIETRO, Ind. and  
4 as Father and Natural Parent  
5 of Anthony Pietro and Gina  
6 Pietro, Minors, et al.,  
7 Plaintiffs,  
8 vs.  
9 ) Case No. CV98-05-1804  
10 ) JUDGE BOND  
11 )  
12 )  
13 )  
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25 )

COPY

11 Deposition of JAMES G. BEEGAN, M.D., a  
12 Witness herein, called by the Defendants for  
13 cross-examination pursuant to the Rules of Civil  
14 Procedure, taken before me, the undersigned,  
15 William S. Bish, an RDR/CRR and Notary Public in  
16 and for the State of Ohio, at the offices of  
17 Summit Rehabilitation Medicine, Inc., 3275  
18 Embassy Parkway, Akron, Ohio, on Wednesday, the  
19 2nd day of June, 1999, at 10:37 o'clock a.m.

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23  
24  
25  
COMPUTERIZED TRANSCRIPTION BY  
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1 On Behalf of the Defendants Radiology  
2 and Imaging Services, Inc., and Victor  
3 J. Louisin, M.D.:  
4 Messrs. Reminger & Reminger Co.,  
5 L.P.A.

6 By: John R. Scott, Attorney at Law  
7 Seventh Floor  
8 113 St. Clair Building  
9 Cleveland, Ohio 44114

10 On Behalf of the Defendant David M.  
11 Cola, M.D.:

12 Messrs. Buckingham, Doolittle &  
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15 4518 Fulton Drive N.W.  
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## 1 APPEARANCES:

Page 2

## On Behalf of the Plaintiffs:

Messrs. Linton &amp; Hirshman

By: Tobias J. Hirshman, Attorney at Law  
Hoyt Block Suite 300  
700 West St. Clair Avenue  
Cleveland, Ohio 44113-1230

On Behalf of the Defendants General  
Emergency Medical Specialists, Inc.,  
S. E. Tout, M.D., and Thomas J. Elson,  
M.D.

Messrs. Roetzel &amp; Andress, A L.P.A.

By: Juliana S. Moore, Attorney at Law  
Suite 400  
222 South Main Street  
Akron, Ohio 44308

On Behalf of the Defendants Lynn Mason,  
M.D., Kevin Markowski, M.D., Montrose  
Diagnostics, and Akron General Medical  
Center

Messrs. Roetzel &amp; Andress, A L.P.A.

By: Amy Fehn, Attorney at Law  
Suite 400  
222 South Main Street  
Akron, Ohio 44308

On Behalf of the Defendants Karla J.  
Madalin, M.D., and Karla J. Madalin,  
M.D., Inc.:

Messrs. Bonezzi, Switzer, Murphy &amp; Polito Co., L.P.A.

By: William D. Bonezzi, Attorney at Law  
1400 Leader Building  
Cleveland, Ohio 44114-1491

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1 JAMES G. BEEGAN, M.D.  
 2 of lawful age, a Witness herein, having been  
 3 first duly sworn, as hereinafter certified,  
 4 deposed and said as follows:  
 5 CROSS-EXAMINATION  
 6 BY MS. MOORE:  
 7 Q. Doctor, for the record would you please  
 8 state your name.  
 9 A. James G. Beegan, M.D.  
 10 Q. And what is your business address here?  
 11 A. Business address here? Well, my actual  
 12 -- see, I come here and see patients once a  
 13 week. My formal more proper business address  
 14 would be 1261 Flickinger Road, Akron, Ohio 44312.  
 15 Q. And is that a professional office --  
 16 A. Yes, it is.  
 17 Q. -- space?  
 18 Is there any group associated with  
 19 that space?  
 20 A. Yes, Summit Rehabilitation Medicine,  
 21 Incorporated.  
 22 Q. And what's your occupation?  
 23 A. I'm a physical medicine and  
 24 rehabilitation specialist.  
 25 Q. And you are an M.D.?

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1 A. Yes.  
 2 MS. MOORE. Off the record.  
 3 (Defendant's Dr. Beegan Exhibit A  
 4 was marked for identification.)  
 5 BY MS. MOORE:  
 6 Q. Doctor, I'm going to hand you what's  
 7 been marked as Defendant's Exhibit A. Is that a  
 8 current copy of your CV?  
 9 A. Yes, it is.  
 10 Q. And just briefly for the benefit of  
 11 everyone else here, since we have no copies,  
 12 could you just give us a little bit about your  
 13 educational background beginning with medical  
 14 school.  
 15 A. I attended medical school at the Ohio  
 16 State University. I attended physical medicine  
 17 and rehabilitation residency there, Ohio State  
 18 University. I was chief resident my senior year.  
 19 And do you need me to go into --  
 20 Q. What year did you graduate?  
 21 A. -- CMES or continuing education  
 22 conferences, or just what's here?  
 23 Q. What year did you graduate from medical  
 24 school?  
 25 A. I graduated from medical school in June

1 of 1991.  
 2 Q. And when did you become licensed to  
 3 practice medicine in the State of Ohio?  
 4 A. June of 1990 -- June of 1995.  
 5 Q. And are you Board certified?  
 6 A. I am.  
 7 Q. In what areas?  
 8 A. American Board of Physical Medicine and  
 9 Rehabilitation.  
 10 Q. And what year did you receive that  
 11 certification?  
 12 A. In 1996.  
 13 Q. Did you pass your Boards the first time?  
 14 A. Yes, I did.  
 15 Q. Do you have any other Board  
 16 certifications?  
 17 A. I do not.  
 18 Q. Are you Board eligible in any other  
 19 areas?  
 20 A. I'm Board eligible in electrodiagnostic  
 21 medicine.  
 22 Q. Do you plan to take the Boards in that  
 23 area?  
 24 A. I took them in May of this year.  
 25 Q. Okay. And is that just the first part

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1 of that Board examination?  
 2 A. No, we took the entire examination then.  
 3 Q. Have you received any results from that  
 4 yet?  
 5 A. I havenot.  
 6 Q. When do you expect results?  
 7 A. June 4th.  
 8 Q. Do you have staff privileges at any  
 9 hospitals in the area?  
 10 A. Yes.  
 11 Q. And which hospitals?  
 12 A. Edwin Shaw Hospital, Akron General  
 13 Medical Center, Summa System, Cuyahoga Falls  
 14 General Hospital.  
 15 Q. Have any of your privileges ever been  
 16 revoked or suspended?  
 17 A. No.  
 18 Q. Has your license ever been revoked or  
 19 suspended?  
 20 A. No.  
 21 Q. And have you ever been sued for medical  
 22 negligence?  
 23 A. No.  
 24 Q. Have you given depositions in the past?  
 25 A. Yes.

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1 Q. And about how many occasions?  
 2 A. **Three** or four I'd estimate.  
 3 Q. And were those for testimony such as  
 4 we're here today, for patients that you've  
 5 treated?  
 6 A. As I recall there were two that were  
 7 specifically referred to me by attorneys stating  
 8 "Can you please evaluate this person, tell me  
 9 their extent of disability"; and the other two or  
 10 three were patients I had seen in the office or  
 11 at the hospital previous.  
 12 Q. Of those two cases where you evaluated  
 13 them by request for other attorneys, were those  
 14 both for plaintiffs attorneys or defense  
 15 attorneys? Do you know?  
 16 A. I believe both were for plaintiffs.  
 17 Q. Do you know Dr. Thomas Elson over at  
 18 Akron General?  
 19 A. No, I do not.  
 20 Q. How about Dr. Susan Tout?  
 21 A. I do not.  
 22 Q. Dr. Kevin Markowski?  
 23 A. No.  
 24 Q. How about Dr. Lynn Mason?  
 25 A. No.

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1 Q. What percentage of your professional  
 2 time is devoted to rehabilitation medicine?  
 3 A. One hundred percent.  
 4 Q. Do you do any outside consulting other  
 5 than case reviews?  
 6 A. Could you be more specific? I don't --  
 7 I don't think so if I understand your question --  
 8 your question correctly.  
 9 Q. In other words, apart from medical/legal  
 10 reviews, or looking at patient files for whatever  
 11 other purposes, do you do any other type of  
 12 consulting? For example, for sports facilities,  
 13 setting up their equipment or anything like that.  
 14 A. Oh, I am the Rehabilitation Medicine  
 15 Director at Akron Manor Care. That's a skilled  
 16 nursing facility. And I work with the therapy  
 17 staff there and do in-services, continuing  
 18 education, help set up and monitor their  
 19 rehabilitation program.  
 20 Q. Well --  
 21 A. I don't do any chart reviews in general,  
 22 or file reviews for the Bureau of Disability  
 23 Determination or other bodies like that.  
 24 Q. Okay. Do you do any teaching at medical  
 25 schools any -- anywhere in the area?

1 A. I give lectures approximately once a  
 2 year at the Ohio State University, usually in  
 3 electrodiagnostic medicine.  
 4 I give occasional lectures to local  
 5 resident groups, orthopedic -- orthopedic surgery  
 6 residents or other groups of that type.  
 7 And I've given a yearly lecture at  
 8 Kent State University to the vocational  
 9 rehabilitation counseling Master's level class.  
 10 Q. Okay. As far as serving in an expert  
 11 capacity you said that you gave two depositions  
 12 previously?  
 13 A. Uh-huh, I believe that's about  
 14 approximately right.  
 15 Q. How many cases have you actually  
 16 reviewed though for plaintiffs or defendants?  
 17 Was it only those two that you mentioned?  
 18 A. I've reviewed no others except for the  
 19 ones mentioned.  
 20 Q. Okay. Have you ever testified at trial  
 21 as a witness?  
 22 A. Never at trial. I've done the video  
 23 depositions twice --  
 24 Q. Okay.  
 25 A. -- but never in an actual trial setting.

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1 Q. What is your rate for giving deposition  
 2 testimony such as we're doing here today?  
 3 A. I would need to check with my  
 4 secretary. The group sort of has a going rate  
 5 they charge. I'm not sure roughly how much that  
 6 is. I believe it's in the neighborhood -- well,  
 7 I'd be -- it's purely speculating. I could check  
 8 if you like, if you need that information.  
 9 Q. If you need that information is it on a  
 10 sheet that's typed up?  
 11 A. Uh-huh.  
 12 Q. Could you just give us that after the  
 13 deposition?  
 14 A. Yes.  
 15 Q. And that would include whatever your  
 16 fees are for testifying at trial?  
 17 A. Yes. Okay, we can get that for you.  
 18 Q. Okay. When did Mr. Hirshman first  
 19 contact you to testify in this case on behalf of  
 20 Mr. Pietro?  
 21 A. I don't have that information written  
 22 down in my medical chart specifically. My  
 23 recollection is that it was sometime in January  
 24 of 1999.  
 25 Q. In reviewing your chart I saw that there

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1 was a note from a person named Giana. Is that  
 2 one of your secretaries here?  
 3 A. That would probably be Gina, who is my  
 4 secretary, yes.  
 5 Q. Gina? That was dated January 11th of  
 6 '99?  
 7 A. Okay. Would you need me to find that  
 8 and review it for you?  
 9 Q. No. I was just going to ask you if that  
 0 would refresh your recollection as to when Mr.  
 1 Hirshman may have contacted you?  
 2 A. It may. Let me see if I can find it.  
 3 Do you recall where you saw it in the chart?  
 4 Q. Actually I think it's on the other side.  
 5 A. Okay.  
 6 Q. It may be one of those tabbed notes.  
 7 A. Okay, here. Yeah, there is a note  
 8 1/11/99 from Gina, she's one of our office staff,  
 9 stating that Toby Hirshman called and wanted to  
 0 speak to me about Mr. Pietro.  
 1 And I left a note that I called his  
 2 office on the 14th of January, left -- left a  
 3 message, That means I didn't talk to him  
 4 directly. And then --  
 5 Q. What --

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1 A. Go ahead.  
 2 Q. I was going to say there is also another  
 3 note of January 14th of 1999.  
 4 A. Yes.  
 5 Q. And you're to see Mr. Pietro?  
 6 A. One hour evaluation, and call the  
 7 attorney after the visit, correct.  
 8 Q. That evaluation was at Mr. Hirshman's  
 9 request?  
 0 A. Yes.  
 1 Q. Is that also what generated your report  
 2 of 1/27/97 [sic]?  
 3 A. The Written note from 1/27/99, yes.  
 4 Q. I'm sorry, '99.  
 5 A. That's okay.  
 6 Q. Have you ever done any testimony for Mr.  
 7 Hirshman in the past?  
 8 A. No.  
 9 Q. Other than your involvement with Mr.  
 0 Pietro as a patient, did you know him personally  
 1 at all --  
 2 A. Never before.  
 3 Q. -- socially?  
 4 A. No, I first met him in consult- -- when  
 5 I first saw him in consultation.

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1 MR. HIRSHMAN: Talking about me or  
 2 Mr. Pietro?  
 3 MS. MOORE. I'm talking about Mr.  
 4 Pietro.  
 5 MR. SCOTT: Not you, Toby.  
 6 THE WITNESS: No to both.  
 7 Let me find my consultation in here.  
 8 Sorry for the delay. These charts  
 9 really get a life of their own. Here it is.  
 0 I first met Mr. Pietro on 12/8/96 --  
 1 I'm sorry, 12/17/96 rather, 12/17/96 when I was  
 2 -- when I saw him in consultation at Akron  
 3 General Medical Center.  
 4 BY MS. MOORE:  
 5 Q. I'll come back to that in a minute.  
 6 A. Uh-huh.  
 7 Q. As far as your deposition today, what  
 8 materials did you review in preparation for it?  
 9 A. I reviewed our office chart. I also  
 0 reviewed the chart from Edwin Shaw Hospital, both  
 1 the inpatient and outpatient therapy notes, the  
 2 nurse's notes.  
 3 Within the medical chart that I have  
 4 are his outpatient notes where I saw him in  
 5 follow-up, copies of some of the hospital notes,

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1 but not a complete set.  
 2 Copies of therapy notes from  
 3 different facilities when he was going through  
 4 therapy as an outpatient, and also a copy of my  
 5 initial consultation, and a copy of a  
 6 psychological evaluation.  
 7 Q. What was the date on the psychological  
 8 evaluation?  
 9 A. 6/30/97.  
 0 Q. And who requested that?  
 1 A. The Bureau of Disability Determination.  
 2 That's the -- that's the report on -- the reason  
 3 for referral on that report.  
 4 Q. Did you review any depositions that have  
 5 been taken in this case?  
 6 A. No.  
 7 Q. How about any summaries of records?  
 8 A. No.  
 9 Q. Any reports from any of the other  
 0 experts?  
 1 A. No.  
 2 Q. Did you author a report for Mr. Hirshman  
 3 with this case, independent of your chart?  
 4 A. No. My understanding was he wanted me  
 5 to meet with Mr. Pietro and get an understanding

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1 of how he had progressed or not progressed as the  
2 case may be, get an understanding of his current  
3 symptoms as of the 27th of January of this year,  
4 and be available to answer questions about his  
5 problems.

6 Q. Did you spend any time reviewing this  
7 case other than what you may have done today,  
8 meeting with Mr. Hirshman?

9 A. Um-m --

0 Q. In other words, did you -- did you spend  
1 any time reviewing the case for Mr. Hirshman to  
2 give him information?

3 A. We had had contact on the telephone  
4 perhaps a week or two ago to discuss the written  
5 notes here, to make sure he could understand what  
6 I had written and such. That's been the extent  
7 of it as I recall.

8 Q. Okay. Have you been asked to render any  
9 opinions with respect to the standard of care of  
0 any of the other physicians in this case?

1 A. I havenot, no.

2 Q. Is it your intention to render any such  
3 opinions either now or in the future if asked at  
4 trial?

5 A. It is not. I -- I don't feel qualified,

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1 frankly, to do so. I'm trained in rehabilitation  
2 medicine, so I feel qualified to give information  
3 about extent and severity of disability, and ways  
4 to help compensate for that. But I don't have  
5 enough training in neurology, emergency room  
6 medicine, radiology, or the other specialties  
7 involved, to render an opinion.

8 Q. So it's fair to say your testimony today  
9 will surround your care and treatment of Mr.  
0 Pietro and how he's progressed and so forth?

1 A. Yes.

2 Q. Okay. You just mentioned a while ago  
3 that you first saw Mr. Pietro on December 17th of  
4 1996 on consult --

5 A. Uh-huh --

6 Q. -- at Akron General Medical Center?

7 A. -- yes.

8 Q. When you first saw him what was his  
9 condition at that time?

0 A. Let me look at the consultation. I  
1 can't recall, of course, from -- from memory  
2 alone, but I can tell you what I wrote at that  
3 time.

4 My conclusions in terms of what his  
5 problems were is that he had had -- sustained a

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1 brainstem infarct occlusion of the right p-i-c-a  
2 of uncertain etiology, onset approximately  
3 12/8/96.

4 Now, that information I would have  
5 gathered from the patient's report, and also from  
6 review of the hospital chart there.

7 And I said that he had impaired  
8 balance, mild dysarthria, vertigo, nausea and  
9 vomiting, impaired vision and dysphagia. And I  
0 also reported he had good social support from his  
1 family.

2 MR. HIRSHMAN: For the court  
3 reporter, dysphagia is spelled with a G; is that  
4 correct?

5 THE WITNESS: Yea, one G.

6 BY MS. MOORE:

7 Q. What was your plan for Mr. Pietro on  
8 that date?

9 A. I recommended that he should undergo  
0 inpatient rehabilitation short-term at Edwin Shaw  
1 Hospital or Barberton Citizens Hospital  
2 rehabilitation unit to include physical therapy,  
3 occupational therapy and speech therapy.

4 I recommended that the length of stay  
5 would be approximately five to six days, and that

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1 he have follow-up outpatient therapies after his  
2 hospital rehabilitation stay.

3 Q. Okay. After the 17th did you have  
4 occasion to see Mr. Pietro again?

5 A. Yes, and I followed him at Edwin Shaw  
6 Hospital for rehabilitation.

7 Q. That would have been on December 20th  
8 when he was admitted?

9 A. Let me double-check that date if you  
0 would.

1 Yes, according to my history and  
2 physical that I admitted on -- dictated on that  
3 date he was admitted 12/20/96.

4 Q. You mentioned he had a five to six day  
5 stay. That was your recommendation?

6 A. An estimate.

7 Q. Was that due to the fact that he wasn't  
8 that badly injured from the stroke?

9 A. The goal of inpatient rehabilitation is  
0 to improve the patient enough to be safe for  
1 discharge home, so it was my estimate that he  
2 would be safe for discharge home after five to  
3 six days.

4 Q. What's entailed in being safe for  
5 discharge home, what factors are involved?

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1 A. You need to understand the social  
2 factors. For example, if the patient lives by  
3 themselves, then if they have any cognitive  
4 impairment they may never be able to be safe for  
5 discharge at home. They may not be able to walk  
6 a mile.

7 If their thinking is not good they  
8 may need permanent placement in a nursing home.  
9 You need social support.

0 In the physical environment, how many  
1 steps, how many -- how much distance is involved  
2 walking from one end of the house to another, and  
3 you have to have some appreciation of the  
4 person's physical abilities and mental  
5 abilities. So discharge home isn't necessarily  
6 -- or length of stay, that's not -- doesn't  
7 necessarily reflect severity of disability.

8 For example, I work at Edwin Shaw  
9 Hospital as the director of the spinal cord  
0 injury clinic, and those patients are  
1 outpatients, and many of them had two and three  
2 week hospital stays; but they're severely  
3 disabled, they have complete paralysis, so there  
4 is no direct correlation.

5 Q. Okay. When Mr. Pietro came to Edwin

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1 Shaw on December 20th what, in your view, were  
2 his chief problems that he needed to overcome?

3 A. Impaired balance; dysarthria, which I  
4 thought was mild; vertigo; impaired vision;  
5 nausea.

6 Q. Is there anything else?

7 A. He had alterations to sensation with  
8 numbness reported. He reported vision problems  
9 which were, he said, improved. Generalized  
0 weakness.

1 And his dysphagia had improved, by  
2 his report, from the time I had initially seen  
3 him at Akron General Medical Center, so I didn't  
4 list that as a main rehabilitation issue at the  
5 time of admission to Edwin Shaw.

6 Q. It was also indicated, I believe, in one  
7 of your notes that he no longer had any leg pain  
8 or arm pain on that particular date. Does that  
9 sound correct to you?

10 A. Let me double-check that, please.

11 The last time I saw him in the  
12 hospital is on the 24th of December. At that  
13 time he was taking Tylenol occasionally,  
14 presumably for discomfort.

15 I see a note from the days of his

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1 hospital stay, but not one indicating resolution  
2 of pain as you described. Do you have a date on  
3 that, perhaps, or do you have one referenced?

4 Q. Actually I took it from your history and  
5 physical from Edwin Shaw, I believe.

6 A. The history and physical, okay. History  
7 and physical from 12/20 I'll review then.

8 Okay. He denies lower limb edema or  
9 leg or arm pain as of 12/20/96 is what he told me  
10 when I reviewed his systems.

11 Q. And he was also alert and oriented times  
12 three?

13 A. Yes.

14 Q. Have you reviewed patients like this  
15 before as young as Mr. Pietro with this kind of  
16 brainstem injury?

17 A. Yes.

18 Q. How many have you seen?

19 A. It's a relatively unusual injury, but I  
20 have -- I'm following one currently who was  
21 injured in a similar fashion three years ago, and  
22 I've had one other who I no longer follow.

23 Q. In terms of Mr. Pietro, how would you  
24 characterize the outcome of this stroke if you --  
25 if you can give me mild, moderate, severe in

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1 terms of what you see in rehab patients?

2 A. In terms of the -- the impairment level,  
3 the actual how much physical damage he's had, I  
4 think mild to moderate would be a reasonable way  
5 to characterize it in that he does have physical  
6 limitations.

7 There are things he wanted to do he  
8 can't do, even with equipment or at a slower pace  
9 than normal. In terms of disability, meaning his  
10 ability to do things he wanted to do for himself,  
11 like bathing, and dressing, and driving, also  
12 mild to moderate. He tells me he can drive only  
13 short distances. He wishes to do the checkbook  
14 but has difficulty with that because of  
15 concentration problems. He wants --

16 MR. SCOTT: I'm sorry, Doctor, what  
17 did you just say? Will you repeat what you just  
18 said?

19 THE WITNESS: Yes. He tells me he  
20 can drive short distances, obviously, but --

21 MR. SCOTT: After that.

22 MR. BONEZZI: The checkbook.

23 MR. HIRSHMAN: About the checkbook.

24 THE WITNESS: He reports to me he has  
25 trouble doing the checkbook because of he has

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1 trouble concentrating.

2 MR. SCOTT: Thank you.

3 THE WITNESS: So I **think** there are  
4 things that a healthy person his age would --  
5 would be expected to do, and would want to do,  
6 that he can't do, so -- even with equipment or  
7 extra time -- so I'd say mild to moderate  
8 deficits.

9 In terms of handicap, meaning his  
10 ability to perform in a social role, I'd say it's  
11 moderately severe, his impairments, because from  
12 his -- again from his report of -- of the way he  
13 did things with his family before, and the way he  
14 worked before, he was working full time and --  
15 and had no difficulty with that, he was actively  
16 involved caring for the children, involved with,  
17 you know, their sport activities and things like  
18 that, and those are things he feels he can't do  
19 anymore.

20 And also vocationally, you know, one  
21 of his roles is to, you know, provide for the  
22 family, he felt, and I agree that he seems very  
23 impaired in that regard as well.

24 BY MS. MOORE:

25 Q. Okay. And what you just testified to is

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1 based upon **Mr. Pietro's** condition now, today,  
2 based upon your last visit?

3 A. **As** of -- as of, yes, January.

4 Q. We will come back to that. I was trying  
5 to get an indication in general how people at  
6 that age, you know, may function. So Mr. Pietro  
7 falls into that mild to moderate category?

8 MR. HIRSHMAN: Well --

9 THE WITNESS: I think the level of  
10 impairment and --

11 BY MS. MOORE:

12 Q. Right.

13 A. -- in terms of disability, in terms of  
14 handicap, how much those **impairments** and  
15 disabilities impact his ability to **keep** his  
16 normal social roles --

17 Q. All right.

18 A. -- care giver to the home, moderate to  
19 severe.

20 Sort of a long answer, but when we  
21 think about how much of a physical condition  
22 affects somebody we tend to break it down into  
23 those categories because they're -- they're not  
24 always the same in terms of extent of severity.

25 Q. Okay. Are these the same kinds of

1 problems you would see with other people who have  
2 had a brainstem **injury**? I mean, is this a fairly  
3 typical pattern?

4 For example, you indicated Mi. Pietro  
5 was having vertigo and impaired vision, for a  
6 period of time some balance problems. Is that  
7 the fair -- I mean, is that a fair statement of  
8 what -- what you see with these brainstem  
9 injuries? Or can --

0 A. It --

1 Q. -- can there be more I guess is what I'm  
2 trying to find out?

3 A. Can there be other things --

4 Q. Right.

5 A. --related?

6 Q. In addition to that.

7 A. Dys- -- other additional problems can be  
8 dysphagia, or trouble swallowing; dysarthria, or  
9 difficulty with annunciation of words so that  
10 they can be intelligible; dysphonia, or quietness  
11 of voice if -- if a person has trouble getting  
12 the volume loud enough for people to understand.  
13 Vision problems, difficulty with balance.

14 There -- there are reports in the  
15 medical literature of high level cognitive

1 impairments caused by cerebellar infarcts alone.  
2 Cer- -- I believe the -- it's well substantiated  
3 in the literature cerebella infarcts can cause  
4 high level cognitive or reasoning or intellectual  
5 problems.

6 Q. Is there any literature that comes to  
7 mind that you just referenced?

8 A. Yes, there is. There is a study -- I  
9 can get you a copy if you like, which I don't  
10 have it with me in this office today, but there  
11 was a study from -- from the early '90s that  
12 looked into just that question from the  
13 rehabilitation literature.

14 Q. If you do have a copy of that I would  
15 like to take a look at it.

16 Is it fair to say though that as far  
17 as what you may see in terms of both physical and  
18 medical **impairment** you can run the gamut to a  
19 much more severe level of dysfunction than what  
20 we're seeing here with Mr. Pietro?

21 A. Oh, yes, certainly you can, I would  
22 agree with that. There are some people who might  
23 have a brainstem infarct or hemorrhage who would  
24 have complete paralysis on one side, or severe  
25 loss of sensation or --

1 Q. That was my next question.

2 A. -- any of these things. It's a matter  
3 of degree. Any of these things can be more  
4 severe.

5 Q. Sure.

6 Going back to Mr. Pietro's stay at  
7 Edwin Shaw beginning on December 20th --

8 A. Uh-huh.

9 Q. -- what types of therapies did you have  
10 planned for him to get him back home?

11 A. He underwent balance training with the  
12 physical therapist. That would include walking  
13 on level and uneven surface;;, working on climbing  
14 steps, one leg stance balance activities, trying  
15 to make quick turns or quick change in the  
16 directions to compensate for the problems he had.

17 He also underwent occupational  
18 therapy where he would work with arm  
19 coordination, transfers, bathing and dressing  
20 activities. He was in role and speech therapy.

21 They cleared him for swallowing  
22 problems. He was safe to swallow on normal diet,  
23 and taught him oral motor exercise to try to  
24 strengthen his -- his oropharynx for better  
25 communication skills, and they taught him a

1 program with that, and he was performing that on  
2 his own.

3 Q. Is there anything else that was included  
4 in that initial program at Edwin Shaw?

5 A. That was the -- the therapy program as I  
6 recall it when he was an inpatient.

7 Q. During the time that he was at Edwin  
8 Shaw from the 20th until his discharge on the  
9 24th did you actually see Mr. Pietro?

10 A. Uh-huh.

11 MR. HIRSHMAN: Yes?

12 THE WITNESS: Yes, I did. Sorry,  
13 yes, I did.

14 BY MS. MOORE:

15 Q. And on what occasions?

16 A. I saw him 12/20/96 upon admission,  
17 12/21, 12/23 and 12/24.

18 Q. If you could briefly tell us what Mr.  
19 Pietro was -- Mr. Pietro's condition was on 12/21  
20 when you saw him?

21 A. 12/21? I would have to rely on my notes  
22 from that hospital day --

23 Q. 'fiat's fine.

24 A. -- to give you any kind of indication  
25 because I can't recall from -- from my own

1 recollection.

2 Q. And specifically what's -- was he  
3 showing any improvement?

4 A. Yes, he was demonstrating improved  
5 balance while walking in the room. He said he  
6 was walking with a gate belt. That's a belt that  
7 goes around their waist, we hold onto someone if  
8 they have problems of balance, for safety  
9 basically.

10 I said he was doing that with contact  
11 guard assistance. And I thought he was stable  
12 for continuing his therapies.

13 Q. And you said you saw him again on 12/23?

12 remaining that you saw?

13 A. Minimal impairments of insight,  
14 continued problems with walking such that --  
15 especially he needed standby assistance for  
16 walking. Difficulty with transfers and dynamic  
17 walking such that he needed supervision.

18 Difficulty climbing steps such --  
19 such that he needed contact guard assistance.  
20 Contact guard assistance means there needs to be  
21 another person with their hand on the patient,  
22 but that person providing the help is providing  
23 less than 25 percent of the help. So it's -- so  
24 it's a way of -- shorthand way of saying a little  
25 bit of help is required with actual hands on, but



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1 no -- no heavy lifting required on the part of  
2 the helper.

3 I said he had balance problems that  
4 continued, so he still needed contact guard  
5 assistance for most dynamic activities.

6 A dynamic activity, as opposed to a  
7 non-dynamic activity, would be, for example, a  
8 transfer from a bed to a commode, or standing up  
9 walking to a door and opening it --

10 Q. Okay.

11 A. -- as opposed to sitting in your bed and  
12 shaving or -- or dressing from a seated position.

13 And I reported that he had passed his  
14 swallowing screen. So those were the problems  
15 that I documented at that time.

16 Q. With respect to the therapy that goes on  
17 at Edwin Shaw would a patient be tested for  
18 dressing and doing daily activities of living to  
19 make sure that he or she could do that upon  
20 discharge?

21 A. Yes. Or -- or to make sure that if they  
22 can't do it themselves completely independently  
23 the family has been trained and understands the  
24 extent of help required and knows how to do it  
25 properly.

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1 Q. Do you know from looking at your  
2 records, or from your memory, whether Mr. Pietro  
3 was able to do that upon discharge?

4 A. From my records he still needed help  
5 with those things. He was not able to be totally  
6 independent.

7 Q. Okay. Did you expect at that time that  
8 Mr. Pietro would eventually become totally  
9 independent with respect to the daily living  
10 activities such as dressing, walking, using the  
11 -- the bathroom, the commode?

12 A. That's a question that comes up a lot in  
13 my job, and the thing I have to always tell  
14 people is that in the best of studies that are  
15 trying to predict stroke outcome there is only --  
16 there is -- there is still about a two-thirds  
17 variance in how well we can predict.

18 In other words, there have been  
19 studies -- one larger one comes to mind using  
20 multivariate analysis, a very statistical tool  
21 where every variable that can be considered was  
22 considered to predict outcome from a stroke.

23 And -- and even considering, you  
24 know, literally dozens of different factors, and  
25 putting that into a statistical analysis with a

1 computer that was very sophisticated, the  
2 researchers could only predict about two-thirds  
3 of the variance in outcome. So it's a  
4 long-winded way of saying physicians still aren't  
5 very good about predicting long-term outcome.

6 The best predictors of long-term  
7 outcome in a stroke setting is how severe was the  
8 initial stroke. So the fact he had well  
9 preserved strength, was walking with contact  
10 guard assistance which, in my mind, is a small  
11 amount of assistance to require, and the fact  
12 that he had improved his swallowing, and had been  
13 doing much of his bathing and dressing with a  
14 small amount of help, supervision, or only  
15 contact guard assistance for -- for dynamic  
16 activities, that would indicate to me a good  
17 prognosis.

18 So in general if I were seeing a  
19 patient like this, and I had this information, I  
20 would say, "Well, your prognosis for independent  
21 function is relatively good," but I -- I can't  
22 put a -- you know, I can be two-thirds -- you  
23 know, I can be two-thirds? sure of that and -- but  
24 in general the outcome would be good.

25 In general there would be a

1 progressive improvement over the course of nine  
2 to twelve months after a stroke.

3 Q. Okay.

4 A. And then after about one year no further  
5 improvement expected from spontaneous neurologic  
6 recovery. Like any of us, if someone takes up a  
7 heavy weightlifting program, for example, they  
8 can increase their strength a small amount, but  
9 there would be expected to be no further  
10 neurologic improvement, just from spontaneous  
11 healing.

12 Q. Okay. That's fair.

13 Were you also involved in Mr.  
14 Pietro's care when he was; involved with physical  
15 therapy at Akron General?

16 A. As an outpatient?

17 Q. Yes.

18 A. Yes, I was following him in  
19 consultation, specialty service, as a consulting  
20 physician. Let me check my notes from that time,  
21 please.

22 Q. Could you tell us then when the first  
23 time was that you would have written a note  
24 concerning Mr. Pietro's physical therapy at Akron  
25 General?

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1 A. Yes. I saw him January 27th, 1997 in  
 2 follow-up.  
 3 Q. Is -- is that about the average time you  
 4 see a patient for follow-up?  
 5 A. It is, yeah. Generally a patient with  
 6 stroke I'll see four to six weeks afterwards,  
 7 unless there are unusual or more complex issues  
 8 involved.  
 9 Q. I believe your note also characterizes  
 0 him as making good progress at that time. Do you  
 1 see that in there?  
 2 A. Yes. I think -- phew, phew, phew, phew,  
 3 phew. Yes, he's making good gains, uh-huh.  
 4 Q. My question is what was the basis for  
 5 that comment that he was making good gains?  
 6 Could you tell us how he had improved by that  
 7 point in time?  
 8 A. Yes. He had had no falls at home, or  
 9 other difficulties, so it appeared he was  
 0 adjusting to being back at home well. That was  
 1 the most important thing.  
 2 He was continent. That's important.  
 3 He was following with his primary  
 4 care physician to get his Coumadin level -- his  
 5 INR level, to make sure his Coumadin was

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1 appropriate. So he was taking care of himself,  
 2 he wasn't willfully neglecting his health care.  
 3 He was doing the right things and getting checked  
 4 up on. He didn't have any signs of problems from  
 5 the Coumadin from excess bleeding.  
 6 His gait was slightly ataxic, which I  
 7 thought was an improvement. He was walking on  
 8 level surfaces without any device, no cane, which  
 9 is an improvement.  
 0 Shoulder had remained -- I'm sorry,  
 1 his strength had remained good. And on that  
 2 basis I had said that he was making good  
 3 improvement.  
 4 Q. You also noted that his strength was at  
 5 fivefive?  
 6 A. Uh-huh.  
 7 Q. What does that mean in lay terms?  
 8 A. Sure. There is -- several years ago --  
 9 well, actually decades ago there was a gathering  
 0 of professionals called the Muscle Research  
 1 Council, they got together to try to come up with  
 2 a standard format for grading strength. So it  
 3 goes from zero to five, and five is normal  
 4 strength.  
 5 So with five out of five strength I

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1 would say his strength was -- was normal on  
 2 testing.  
 3 Q. Did you feel Mr. Pietro was making more  
 4 rapid progress than the average patient, or was  
 5 he about where you expected him to be given his  
 6 stroke?  
 7 A. Um-m, I -- I think about average. He  
 8 was improving. He still wasn't totally  
 9 independent, and was still having problems with  
 0 ataxia. So I would say it was -- it was as  
 1 expected or average. You know, good in my mind.  
 2 Q. Did you have a prognosis at that point  
 3 in time? And I real- -- I heard your answer to  
 4 the last question, I'm not trying to be unfair --  
 5 A. Yes.  
 6 Q. -- but I'm just trying to find out if at  
 7 that time, in January of 1997, whether things had  
 8 changed enough where you could come to a  
 9 determination as to what to expect with Mr.  
 0 Pietro?  
 1 A. Well, at that point he would have been  
 2 -- he would have been several weeks out from the  
 3 onset of the stroke and he was still having  
 4 problems with ataxia, for example.  
 5 In general, if someone has gotten to

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1 that point, they're still having some -- some  
 2 significant problems with getting around, or  
 3 needing help, or having weakness, or numbness, or  
 4 problems with balance, generally you expect some  
 5 long-term problems.  
 6 So I guess at that point you could  
 7 more accurately state his problem object- -- this  
 8 person would probably have some long-term  
 9 deficits related to this, although those would be  
 0 expected to be much less severe up to a point in  
 1 time up to a year after the stroke.  
 2 Q. There were also noted some problems with  
 3 his right shoulder as far as range of motion?  
 4 A. Yes.  
 5 Q. Was that attributed to the stroke as  
 6 well?  
 7 A. I did not think so. I thought that he  
 8 probably had some degree of rotator cuff  
 9 problems.  
 0 Q. Do you have any idea what the etiology  
 1 of those problems were?  
 2 A. Rotator cuff tendinitis is relatively  
 3 common in people trying to recover from stroke  
 4 problems because they're doing a lot of exercises  
 5 many of which they've not done before. or of an

1 unusual nature.

2 Plus if a person has impaired muscle  
3 control for whatever reason, this case ataxia,  
4 then the -- the normal rhythm of the rotator cuff  
5 can be altered. So we see a lot of patients who  
6 have shoulder pain after a stroke.

7 I thought that the pain was due to  
8 rotator cuff arthropathy, meaning an inflammation  
9 of the rotator cuff tendons. That's not a direct  
0 result of the stroke.

1 I'm trying to think if I could say  
2 definitely it was a result of -- an indirect  
3 result. I'm not -- I'm not certain I can say --

4 Q. That's fair.

5 A. -- an indirect result. I *think* it's  
6 possible that it's an indirect result because he  
7 had the stroke, he's doing therapies, he has some  
8 alterations of his motor control, he's doing  
9 things with his shoulder he wouldn't normally  
10 have done. Say then he develops rotator cuff  
11 tendinitis, so you could argue it's an indirect  
12 result but --

13 Q. Rut there is no -- I'm sorry.

14 A. -- but I think to say that with any kind  
15 of medical certainty wouldn't be possible. But

1 rotator cuff problems are very common in anybody  
2 our age, his age, doing an exercise program as  
3 well. So to say it's definitely from the stroke  
4 I think is unfair.

5 Q. And you did order some rehabilitation  
6 therapy for the rotator cuff problem?

7 A. Yes.

8 Q. And that was successful about a month  
9 later? I think your note indicates it had  
0 improved.

1 A. Yes.

2 Q. And that would be the next time that you  
3 saw Mr. Pietro, on 2/20/97?

4 A. Yes.

5 Q. And how was he doing at that point?

6 A. At that time he reported improvement in  
7 his shoulder. He felt that the -- the pain was  
8 significantly decreased, which was a good sign  
9 that the inflammation from the rotator cuff  
10 problem had decreased.

11 He felt his right arm strength was  
12 approximately 90 percent of normal. Now, when a  
13 patient reports their strength is better or  
14 worse, that has -- has to do with a lot of  
15 factors.

1 If someone's shoulder is painful, but  
2 has normal strength, a lot of times a patient  
3 will report that as weakness. It's not true  
4 muscle weakness, it hurts so they can't do what  
5 they normally do with it, so it's, quote, weak.  
6 See what I mean?

7 So he thought it was about 90 percent  
8 of his normal strength, which I thought was a  
9 good sign.

0 He was doing his regular exercise  
1 program, which is also a good sign. Again, he  
2 was taking care of himself, he wasn't neglecting  
3 his health.

4 His balance is better, no falls. He  
5 felt his ataxia and vertigo had improved.

6 His wife was present, and she -- I'll  
7 often ask spouses or family, you know, "What's"  
8 -- "What's your opinion," because what a patient  
9 reports, of course, is subjective.

0 And his wife reports that he was  
1 doing better with endurance and concentration.  
2 But she did give more information. She stated  
3 that he was having difficulty reading, and he had  
4 difficulty with concentrating and blurring of his  
5 vision.

1 I said he was helping more with the  
2 family business, "much more" I said, but had  
3 difficulty with the endurance and stamina to  
4 perform that for long periods of time as he did  
5 before the stroke.

6 I said -- stated that he had no  
7 problems with unusual bleeding.

8 On a quick mental status examination  
9 he was oriented. I reported his gait was  
0 slightly ataxic.

1 We had mild impairments of left upper  
2 limb coordination compared to right. His leg  
3 coordination was smooth to brush his heels on the  
4 front of his shins, a standard maneuver to check  
5 how the coordination in the legs were doing.  
6 Strength was normal throughout I -- I reported.

7 Q. Okay.

8 A. I noted a very mild right facial droop.  
9 I didn't see any visual field cuts or double  
10 vision. And then that's grossly that I examined  
11 him, of course, so that's how I felt he was doing  
12 at that time.

13 Q. And he was improved from the visit  
14 before?

15 A. Yes.

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1 Q. You mentioned that his wife had said he  
2 was helping more with the family business?

3 A. Uh-huh.

4 Q. Did she elaborate as to what extent he  
5 was involved with the business, or what he was  
6 doing specifically?

7 A. Um-m, I'm sorry, I can't recall from the  
8 time. I -- I would have to rely on what the note  
9 says. I didn't -- I didn't go into details on my  
10 note at the time, so I can't give you any more  
11 specifics than what I've documented there.

12 Q. You also mentioned there was some  
13 problems with endurance as far as working with  
14 the family business. Is that something that you  
15 would expect to improve over time again?

16 A. It would. Generally I counsel my  
17 patients who have had strokes that they'll have a  
18 relatively long period of -- of impaired  
19 endurance of fatigue longer than they think, you  
20 know.

21 It usually -- oh, in my experience  
22 the people with other types of strokes it can  
23 last for two to three months. What I normally  
24 tell people is "Expect your endurance to be poor  
25 for that long but gradually improving all during

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1 that time."

2 I can't give specific recommendations  
3 about a young person with a brainstem stroke just  
4 because it's relatively a more unusual stroke  
5 than what I typically see day by day, but I think  
6 it's fair to say he could expect some problems  
7 with endurance that should get better gradually  
8 over the course of several months.

9 Q. As far as the type of therapies that Mr.  
10 Pietro was involved in on an outpatient basis at  
11 Akron General, what kinds of things was he  
12 doing? Is that something you would set up as his  
13 physician, or is that something that was set up  
14 by the physical therapists there?

15 A. Generally how it works is we will write  
16 orders stating what -- the problem the patient's  
17 having and any medical restrictions --

18 Q. Okay.

19 A. -- that -- that they should honor. And  
20 then we'll give general guidelines saying "We  
21 want you to work on high level balance, and we  
22 want you to work on his strength, and we want you  
23 to work on his ability to walk in the community,"  
24 for example.

25 And the physical therapist will

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1 tailor the program based on their evaluation of  
2 the patient. So to answer your question a little  
3 bit of both. We give --

4 Q. Oh.

5 A. -- generally we give general guidelines,  
6 follow the program, and I think generally my --  
7 my -- my requests for physical therapy will state  
8 "Please call with questions," meaning "If you're  
9 having problems give me a call and we can talk  
10 about other ways you might approach this and  
11 such." And I think that's -- that may be on his  
12 consultation request as well.

13 So that's generally, but that's --  
14 that's a fairly typical practice. I didn't see  
15 any need to go into more specifics with him.

16 Q. Do you get reports from Akron General  
17 concerning the patient's progress?

18 A. Yes.

19 Q. And did you receive them in this case as  
20 well?

21 A. Sorry for the delay. I'll have to look  
22 back through the notes.

23 Q. That's okay, take your time.

24 A. Yes, there are notes from his -- there  
25 are notes from his therapies from late December

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1 and early January of '97. Those notes are  
2 primarily from Edwin Shaw Hospital, the ones I  
3 have in my record.

4 Oh, and here are some from Akron  
5 General Medical Center as well, reporting his  
6 progress. So yes, I have indications of his  
7 progress in therapy from both Edwin Shaw's  
8 outpatient program, and also Akron General  
9 Medical Center's department.

10 Q. My notes reflect that he underwent  
11 therapy for several months at Akron General  
12 Medical Center. Do you know when he stopped  
13 therapy there, when he was discharged from  
14 therapy?

15 A. I don't know off the top of my head. I  
16 I'd have to look through the records here. It's  
17 like occupational therapy was stopped on  
18 1/22/97. I don't see a specific note from the  
19 physical therapist reporting when his outpatient  
20 physical therapy had stopped.

21 So no, I don't -- I don't have any  
22 specific days when I can tell you it stopped.

23 Q. Would you typically see a patient prior  
24 to their discharge from therapy?

25 A. Typically. It depends on the patient.

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1 Someone is doing well, and progressing as  
2 expected, and there is no specific problems that  
3 are hampering their progress, then I might see  
4 them once or twice in follow-up, perhaps four to  
5 five weeks, and then again two to three months  
6 after discharge from Edwin Shaw Hospital. And if  
7 a patient is doing well, or functioning well, for  
8 example, I would not necessarily see them again.

9 Q. Is that -- is that why we don't have any  
10 more notes, at least I don't have any more notes  
11 from your office concerning Mr. Pietro after  
12 February 20th of '97 until your most recent note  
13 from January of '99?

14 A. My recommendation to him at that time  
15 was that he follow up with me again in three  
16 months to see how he was doing. As expected, you  
17 know, I wanted to make -- there are problems that  
18 can crop up down the road, and I wanted to make  
19 sure that things were going well for him, so I  
20 had hoped to see him again in three months, but  
21 it appears he didn't follow up with me then, as  
22 recommended, until January of '99.

23 Q. Okay. Did you have a prognosis again  
24 back in February of 1997 for Mr. Pietro as to  
25 both his functional abilities. his mental

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1 abilities, where you saw him headed at that time?

2 A. I think -- I think that he had made  
3 continued improvement, and he would still be  
4 expected to have another eight to ten months of  
5 continued improvement based on the initial  
6 recovery from stroke syndromes. So assuming no  
7 complicating factors, my anticipation was he  
8 would continue to improve.

9 Since he still had significant  
10 impairments, you know, at the approximate two  
11 month period, I -- I would have anticipated he  
12 would have had some long-term problems, but I  
13 would have expected him to be more -- or I would  
14 have expected them to be less severe than when I  
15 saw him on the 20th of February.

16 Q. When you speak of long-term problems are  
17 you talking of problems that can resolve over  
18 time, or are you talking permanency of problems?

19 A. Perm- -- permanency of problems. After  
20 -- after that -- you know, typically like that  
21 one year period it's --

22 Q. Okay.

23 A. -- almost unheard of to see improvements  
24 beyond then, so I think it's important to talk to  
25 families and patients about, you know. "We expect

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1 to see improvements till this period. After that  
2 period where you're at is probably where you'll  
3 be long-term."

4 And that's one way of giving the  
5 family some expectation since we're not able to  
6 give specific clear long-term data about "Well,  
7 you've had this kind of stroke, therefore in  
8 twelve months you'll be right here."

9 We can at least tell them when we  
10 expect the improvements to tail off or stop.

11 Q. Doctor, finally you did see Mr. Pietro  
12 on January 27th of 1999.

13 A. Yes.

14 Q. And that was at Mr. Hirshman's request'!

15 A. That's correct. That was a request from  
16 -- from Ivfr. Hirshman for me to see the patient  
17 and get a sense of how he was doing at that time,  
18 since I had not seen him in several months.

19 Q. Doctor, if you would read that last note  
20 into the record I'm sure we would all appreciate  
21 it.

22 A. Sure. Lawrence Pietro, 1/27/99,  
23 recheck.

24 MR. HIRSHMAN: Doctor, read slow so  
25 that he can get it all.

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1 THE WITNESS: Sorry about that.

2 45 year old, right-handed.

3 Independent and healthy prior to 12/8/96.

4 I gave a list of his -- his  
5 complaints at that time. Numbness right side of  
6 face, diminished ability to open bilateral eyes,  
7 vertigo and nausea.

8 No CT in emergency room, per  
9 patient. At this time I was collecting his  
10 report, so whenever I could I put, you know, "by  
11 the patient". In other words, I didn't go back  
12 and review the notes back then because it's not  
13 an area of expertise for me, so I'm saying this  
14 is what he said to me.

15 BY MS. MOORE:

16 Q. If I could ask you something, I don't  
17 mean to interrupt.

18 A. Sure.

19 Q. What do you mean "No CT in E.R.," is  
20 that going back to December of '96?

21 A. Correct.

22 Q. Okay.

23 A. By the patient's report.

24 Q. Okay, that's fine.

25 A, I didn't -- it would be of no -- of no

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1 benefit for me to go back and read that or review  
2 that, so I didn't pursue that any further with  
3 him. This is what he reported.

4 I put things like that in the record  
5 and -- and try to state if it's a patient's  
6 recollection, because it does sometime reflect on  
7 the patient's understanding of their illness.

8 Q. Okay.

9 A. He was seen in the emergency room on two  
0 occasions via 911 calls. He was sent home to  
1 follow up with his primary care physician.

2 Is it acceptable for me, where I've  
3 got a dash or an mow, to state that that  
4 indicates sent to, or an up arrow means better,  
5 or down arrow means worse?

6 Q. That would be fine.

7 A. Okay.

8 Q. I'm trying to read what you have here.

9 A. Right. That will help you understand  
0 what --

1 Q. Sue.

2 A. -- what -- what I'm writing. When a  
3 person is talking I use a shorthand.

4 Sent home to follow up with primary  
5 care physician. Two to three days later saw Dr.

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1 Cola. Diagnosis of inner ear disorder was made.  
2 Diagnosed inner ear infection treated with  
3 antibiotics.

4 Two to three days later back to  
5 emergency room. After one day, due to difficult  
6 -- due to no relief with the antibiotics, he  
7 went via 911 call at that time, was admitted to  
8 the hospital. MRI showed infarcts times three.  
9 Again, that would be patient recollection. This  
0 is -- I'm gathering history.

11 Q. Okay.

12 A. He was in the ICU for one week.

13 Then he was at Edwin Shaw Hospital  
14 four days, that's E-S-H, that little scribble,  
15 E-S-H. Then outpatient therapy for nine months.  
16 Currently on a home program.

17 He reports improvement for nine to  
18 twelve months.

19 And I went to a section where I asked  
20 him what his -- I asked him to list his current  
21 complaints. I'll put that under the "Now"  
22 section.

23 Q. Before you go on to that --

24 A. Go ahead.

25 Q. -- you said he was on a home program.

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1 A. Uh-hub.

2 Q. Is that some type of home therapy  
3 program?

4 A. That would indicate he had been given  
5 instructions, and usually -- I can't confirm this  
6 now because I don't recall -- I would have  
7 involved written and drawn out diagrams saying  
8 "Do this exercise, do that exercise."

9 Q. Okay. The next section is for past  
0 surgical history. Am I reading that right or --

1 A. Yeah. Well, the next section would be  
2 past medical history, which I indicated none.

3 Q. Okay.

4 A. And then the next section I made was for  
5 now, meaning his current problems, and this is  
6 his list of -- of current complaints.

7 Q. Okay. What is the stuff in the margin,  
8 before you start reading? Is that all current  
9 complaints or --

10 A. This was the list of current complaints  
11 as I understood them.

12 Q. Okay.

13 A. This is a --

14 Q. This --

15 A. -- is a list of his current function,

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1 and this is more -- more information about his  
2 current function.

3 Q. Okay.

4 A. More details about what he was doing  
5 under current function.

6 Q. Why don't we start off with, I guess,  
7 the current complaints then.

8 A. Okay. Under "Now" I wrote that current  
9 complaints were as follows, numbness left side,  
10 involving arm and leg, from his head down or  
11 distally.

12 Numbness of the right side of his  
13 face. Decreased hearing [sic] of his right eye,  
14 for which he sees Dr. Rates, one of our  
15 neuroophthalmologists, and receives Natural  
16 Tears. Diminished depth perception, diminished  
17 vision in the right eye. Variable throughout the  
18 day, worse with stress.

19 Fatigue, decreased concentration.

20 Fatigue with attempts to concentrate. Sleeping  
21 more often, and naps through the day.

22 Impaired cognition and confusion.

23 Right facial burning and discomfort. And I --  
24 where that, in the past it had been treated with

25 Tegretol, Elavil, Neurontin and a certain type of

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1 medication provided by his neurologist, Dr.  
2 Rafecas, at the time I saw him 1/27, but he  
3 couldn't recall.

4 I described the pain more as -- he  
5 described it more as being a sharp spiking right  
6 head pain, can last 15 to 30 seconds. He  
7 described it as a frozen palate sensation. As I  
8 recall, he was talking if you eat ice cream or a  
9 popsicle, I think we've all had that sharp pain.  
0 He described that -- said it occurs two or three  
1 times a day, had started over the past year, and  
2 that the pain was unpredictable but often  
3 occurred with -- often occurred with attempts to  
4 concentrate.

5 Continuing on with other complaints  
6 he had at that time, diminished balance which was  
7 worse with quick head movements or sudden changes  
8 in direction. Slow gait. Left leg dysesthesias  
9 24 hours a day. Stiffness in his left leg and  
0 arm.

1 Do I need -- do you need me to define  
2 dysesthesias? Is that a term --

3 Q. If you don't mind.

4 A. Dysesthesia is an abnormal pain or  
5 sensation typically described as a tingling

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1 numbness, but also painful sensation. Some  
2 patients describe coldness, excess heat, that  
3 type of thing, typically associated with nerve  
4 injury. But there can be other causes too to  
5 dysesthesias.

6 Stiffness in his left leg and arm.

7 He reported being very frustrated and  
8 depressed. He reported diminished ability to  
9 discriminate -- to discriminate stimuli. For  
0 example, walking in a store he said he felt like  
1 his head -- he said, quote, "Like my head will  
2 explode," unquote, and that he must nap after  
3 these periods of being in an environment like  
4 that.

5 Going off the social roles, he told  
6 me he cannot coach little league or soccer  
7 because of diminished concentration and problems  
8 with balance.

9 He told me he couldn't -- couldn't  
0 watch his kids for more than a few hours. He  
1 complained of neck pain. He complained of  
2 continued difficulty with reading due to right  
3 eye impaired vision. And he told me that he  
4 covered his right eye if he needs to read.

5 Those are the complaints he presented

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1 with.

2 I got a review of systems also where  
3 I asked him, you know, "How is your heart, how is  
4 your lungs," that kind of thing, and he told me  
5 that he had low back pain because he had fallen  
6 one week before, and he had had diminished  
7 extension of his lumbar spine, he thought because  
8 of pain from the fall.

9 Q. Did he indicate how he fell?

0 A. He did not.

1 Q. With respect to these complaints, it  
2 would appear that these are new and different in  
3 some cases from what Mr. Pietro experienced at  
4 your last visit in February of 1997?

5 A. Yes. Some -- some do seem different,  
6 and inore -- and others seem more severe than he  
7 had complained to me previously.

8 Q. Did he indicate to you what his  
9 activities were during this last roughly two year  
0 period?

1 A. He told me --

2 Q. In other words --

3 A. -- he had been driving for short  
4 distances, and he had gone through driving  
5 evaluation which had cleared him to do that

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1 safely, with our driving program at Edwin Shaw  
2 Hospital.

3 He told me that he had difficulty  
4 doing his checkbook because of diminished --  
5 diminished concentration. He told me he had been  
6 evaluated by the Bureau of Vocational  
7 Rehabilitation.

8 He also related that he had had  
9 neuropsychological testing done approximately one  
0 year ago by someone he described as a State  
1 M.D.. By that I think he -- by that I'm sure he  
2 meant a person -- physician or a psychologist  
3 authorized by the State Disability Determination  
4 Bureau to determine if he had disability. He  
5 told me he had been granted disability.

6 He told me that he was taking  
7 occasional Tylenol for his pain with only partial  
8 relief, and that he was taking an uncertain type  
9 of medication to try to control the face pain,  
0 and also had switched from Coumadin to Plavix  
1 under the care of his primary neurologist and  
2 primary care physicians.

3 He told me he had been able to walk  
4 without a device up to fifty yards at a time, but  
5 needed to rest after that. Told me bowel and

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1 bladder function were intact, as before.

2 And we -- as part of my review of  
3 systems I asked him about sexual function, and he  
4 had given me information about that.

5 Q. What did he tell you about that?

6 A. He told me that his sexual function was  
7 abnormal. He said he had numbness affecting the  
8 left side of his groin. He -- he was able to  
9 obtain only a partial erection, and had orgasms  
10 only occasionally. Had decreased frequency of  
11 sexual contacts, and decreased intensity of the  
12 -- the sexual contacts with his wife.

13 Q. As far as Mr. Pietro's complaints though  
14 that he has expressed to you in January of 1999,  
15 do you have any reason, in your mind, as to why  
16 certain things have seemed to progress in a  
17 negative fashion, instead of getting better  
18 they've become worse?

19 A. Uh-huh.

20 Q. Is there anything that he told you that  
21 would enlighten you to why that happened?

22 A. Well, in terms of his -- if you go back  
23 to breaking it down into impairments, and  
24 disabilities, and handicaps, looking at his --  
25 his impairments there was no indication of why he

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1 would be having more trouble. He didn't relate  
2 to me a history of any traumas except for the  
3 fall a week before. But --

4 Q. Okay.

5 A. -- it seemed as if that was a  
6 self-limiting problem. He didn't relate any  
7 history of new strokes or traumatic brain  
8 injuries or other problems of that type.

9 The -- the complaints he was listing  
10 in terms of diminished balance, particularly with  
11 quick head movements, and slowness of his gait I  
12 think could be reasonably attributed to the  
13 ataxia we were seeing even two years previous.

14 He told me he was walking without a  
15 device fifty yards at a time before he needed to  
16 rest, so it sounded to me, compared to when I had  
17 seen him before, his gait was somewhat improved,  
18 if anything, although still impaired due to this  
19 ataxia.

20 So at the physical impairment level  
21 my impression was he was having long-term  
22 problems with continued ataxia which would have  
23 been expected, but that his -- his walking and  
24 such had improved somewhat since I had seen him  
25 last.

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1 Q. If I can stop you there with respect to

2 those physical problems, is there anything that  
3 he can do in terms of therapy now, physical  
4 therapy, that would help those problems? Or as  
5 you stated before, after that nine to twelve  
6 month period is this pretty much what he should  
7 expect now?

8 A. It -- it is pretty much what he should  
9 expect now.

10 Q. So in other words --

11 A. Like any of us -- I guess I should  
12 qualify that like any of us, if he were to  
13 continue with his home exercise program he may  
14 see some gradual improvements to -- to a certain  
15 extent, though I think he'll have some  
16 limitations long-term though this far out.

17 Q. Okay.

18 A. Particularly given that the reports from  
19 the therapist, and his reports, and those of the  
20 other people that had seen him was he was  
21 continuing -- he was taking care of himself and  
22 he was trying to -- to exercise and do the right  
23 thing by -- by way of taking care of his medical  
24 problems and physical problems.

25 Q. So it would be fair to say any type of

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1 structured rehabilitation with a physical  
2 therapist really wouldn't do much good at this  
3 point?

4 A. No, I wouldn't recommend it at this time  
5 in general.

6 Q. Is there any type of equipment that you  
7 would recommend for Mr. Pietro, or are we pretty  
8 much that's it?

9 A. There -- no, there was nothing I really  
10 could recommend to him at that time.

11 Q. Okay.

12 A. He was walking without a device. A cane  
13 would only slow him down further.

14 Changing his environment was a thing  
15 he had already done himself. In other words, he  
16 was complaining about difficulty concentrating,  
17 and difficulty reading, and difficulty tolerating  
18 being in a busy environment or being around his  
19 kids for more than a few hours, and he had  
20 already made adjustments to avoid those type of  
21 situations. In other words, he had applied for  
22 disability. He was not coaching, he was --

23 Q. And --

24 A. -- doing the things to avoid situations  
25 that were difficult for him.



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1 Q. Did he mention to you -- I mean, he said  
2 he couldn't do his checkbook. Did he mention  
3 anything about working on his business, or doing  
4 things with the business?

5 A. Not as I recall. Not that I  
6 documented. So I -- I don't think so.

7 Q. Okay. If you would continue then you --  
8 you said that these were his physical  
9 impairments.

10 A. Oh, yes. And then in terms of his  
11 disabilities -- well, we've covered those  
12 actually. You know, he's having trouble doing --  
13 he tells me he's having trouble doing his  
14 checkbook, he's having trouble keeping up with  
15 his sexual/marital relationships, he's having  
16 difficulty keeping up with his family obligations  
17 as a father because of his difficulty with --  
18 with concentration, and presumably pain, and also  
19 his balance problems.

20 Q. Again, are these things that are  
21 permanent in nature, or is there something more  
22 in **terms** of treatment or therapies or medication  
23 that could be used to help Mr. Pietro with any  
24 one of those issues?

25 A. In terms of solving the actual problems

1 to fire. Given this heals up, it goes away.

2 It's less well understood. Pain  
3 following nerve injuries is well described in --  
4 in the medical literature, it responds in general  
5 not well to typical analgesics. So in general  
6 the Tylenols of the world, even the narcotic  
7 analgesics like Darvocet and Vicodin, don't treat  
8 **this** kind of pain very well. He said he was  
9 getting partial relief with Tylenol.

10 Generally physicians consider pain  
11 following stroke, or nerve injury, or spinal cord  
12 injury to be a category of pain caused by  
13 abnormal firing of irritated nerves, and so  
14 typically medicines that aren't used as pain  
15 pills in other people we try in these people to  
16 try to calm down the firing of nerve endings.

17 There has been some literature that  
18 diabetic neuropathy can be helped with Neurontin,  
19 that's been shown in some of the medical  
20 literature, and we **think** this kind of pain is  
21 related to that in that they're both nerve type  
22 pains, pains caused by abnormal nerve firing. He  
23 did have a trial of Neurontin.

24 Elavil is an older antidepressant  
25 agent which is felt to have some ability to

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1 I -- there is nothing I could recommend to him to  
2 -- to fix the underlying problems he's having  
3 doing those tasks.

4 I mentioned that he wasn't receiving  
5 any psychological counseling sessions. You know,  
6 I think it would be very reasonable given --  
7 telling me he's frustrated and depressed from his  
8 problems that he pursues counseling to try to  
9 maybe find some peace with these type things, or  
10 try to feel better within himself with his  
11 limitations.

12 Q. Do you know if he ever did receive  
13 counseling based --

14 A. Following our visit?

15 Q. Following your recommendation.

16 A. No, I do not know. I didn't have any  
17 contact with him that way.

18 Q. As far as the pain that he experiences,  
19 and facial burning and things like that, is there  
20 any medication that would help him with that, or  
21 reduce some of that?

22 A. He had -- he had tried several. Pain  
23 following stroke is not very well understood  
24 first of all, so I can't -- it's unlike -- you  
25 know, a broken leg causes these neurotransmitters

1 decrease this abnormal nerve firing, so Elavil is  
2 often used in patients with, you know, facial  
3 pain from tic douloureux, or from diabetic  
4 neuropathy or spinal cord injury.

5 So he had had a trial of that which  
6 is very reasonable, as well Tegretol. Similarly  
7 that's an anti-seizure medication thought to be  
8 -- you can calm down the nerve endings with  
9 anti-seizure medication. He told me he tried  
10 that, it didn't help.

11 He was on a fifth medication he  
12 couldn't recall the name of from Dr. Rafecas, but  
13 probably in that same family of -- of non-typical  
14 analgesic agents used in an attempt to calm down  
15 nerve injury pain.

16 Q. Earlier I believe you were -- earlier  
17 you -- you indicated some -- I think you were  
18 reading **from** some of your notes about his current  
19 functional disability?

20 A. Uh-huh.

21 Q. Did you read that in its entirety?

22 A. Yeah, I believe so, yes.

23 Q. Okay.

24 A. I think so. Do you guys -- if you -- if  
25 you saw **anything** I missed, or have a question,

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1 I'd be happy to address that, but I think I read  
2 everything.

3 MR. HIRSHMAN: I kind of lost you  
4 after you went from the right side of the page to  
5 the left.

6 BY MS. MOORE:

7 Q. Just for the record's clarity would you  
8 mind reading "Current Functional" just in its  
9 entirety so we have that? With all due respect,  
10 your handwriting is hard to read.

11 A. No, that's okay. That's why I normally  
12 dictate everything unless there is -- unless it's  
13 some reason not to.

14 Current function, bathing and  
15 dressing, I put under dressing, which is D,  
16 "Slowly due to loss of balance but  
17 independent."

18 Bathing likewise slowly due to loss  
19 of balance. Must hold onto the rail when closing  
20 his eyes. In other words, when he's taking a  
21 bath, or taking a shower, or washing up at the  
22 sink, he closes his eyes to wash his face, he has  
23 to hold onto the sink otherwise he loses his  
24 balance.

25 Driving, did okay for short

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1 distances.

2 Can't take care of the checkbook due  
3 to diminished concentration.

4 Walks without a device fifty yards  
5 before he must rest.

6 Bowel and bladder function are okay.

7 Diminished sexual function as we  
8 elaborated previously.

9 Q. In this middle section --

10 A. Uh-huh.

11 Q. -- of the page after it says -- I think  
12 it says "No counseling sessions"?

13 A. Yes, "No psychological counseling  
14 sessions."

15 Q. What does that text read at the -- after  
16 that?

17 A. Disability, dash. By that I mean when I  
18 -- when I talk to a patient who has -- who  
19 alleges disability, or has physical problems, one  
20 important aspect to understand is how are they  
21 interacting with society, be -- are they on  
22 disability, have they applied, are they angry  
23 with their employers, are they involved in  
24 litigation, because all of that influences a  
25 person's function in the world as well.

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1 So under that category of disability

2 I said he had -- he had been evaluated by the  
3 Bureau of Vocational Rehabilitation.

4 Q. Okay.

5 A. And that's something I recommend that  
6 people who are disabled, unable to go back to a  
7 previous type of work, always being a part of  
8 being a 45 year old man is working -- or woman is  
9 working, and so -- or at least having the  
10 opportunity if you want to, so I think it's  
11 important that he was doing that. And that's why  
12 I asked about it.

13 I asked about if he was receiving  
14 disability payments. He told me he was granted  
15 disability after being -- after going through  
16 neuropsychological testing. And again that was  
17 his -- his report to me, not something I checked  
18 up on myself after talking to him.

19 Q. That -- could you read that one line  
20 right above "Granted disability"? Part of mine  
21 is cut off.

22 A. "Had neuropsychological test at Edwin  
23 Shaw Hospital, also State physician one year  
24 ago" --

25 Q. Okay --

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1 A. -- dash "Granted disability."!

2 Q. -- okay. Do you have any opinions as to  
3 whether Mr. Pietro's able to find some kind of  
4 employment?

5 A. Two -- two thoughts on that. One is  
6 pain and fatigue, those are subjective complaints  
7 unfortunately, there is no way for us to  
8 objectively measure the extent of pain someone  
9 has, and the extent of disability due to pain.

10 So -- and then that's -- that's been  
11 well-documented in -- in the A.M.A. guides,  
12 permanent impairments. You may be familiar with  
13 those. There is a big paragraph that sums up  
14 very nicely how it's really impossible to state  
15 how impaired someone is from pain.

16 You have to take in, you know, what  
17 is the underlying cause of the pain, what's a  
18 patient's report, what are the observations of  
19 the patient's abilities to -- to come up with  
20 some kind of even reasonable guess. But even at  
21 best it's still just an estimation.

22 How much his pain interferes with his  
23 ability to do daily tasks is hard to state. He  
24 says that it interferes significantly, so I see  
25 no reason to -- to doubt him in that.

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1 And **there** was no -- there was no  
2 history of antisocial behavior that I had seen  
3 before, and there was never an indication when I  
4 was working with him in the past that he was  
5 trying to mislead me, or was a criminal trying to  
6 obtain disability, you know, fraudulently.

7 In terms of difficulty concentrating,  
8 high level cognitive abilities are best  
9 understood in the context of  
0 psychological/neuropsychological testing because,  
1 you know, a big battery of that kind of testing  
2 could pick out very specific deficits you might  
3 not see with just routine office visits or  
4 observation of a patient or their own reports.

5 Based on what he had told me in my  
6 interaction with the patient it appeared there  
7 had been some problems with his cognition. We  
8 saw that from the beginning.

9 Q. Okay.

0 A. And he was telling me that -- that  
1 further psychological testing had shown problems  
2 with concentration and attention and that sort of  
3 thing. So I would estimate that those would --  
4 would impose a barrier to returning to work.

5 His physical -- the actual physical

1 and slurring. Well, that combination was  
2 devastating to his career. He couldn't work. It  
3 was impossible for him to sell.

4 He sold furniture, and like bathroom  
5 cabinets, expensive things, and people just  
6 didn't trust him. If you walk into the store and  
7 met this guy you -- even if you didn't -- even if  
8 the people didn't recognize what it was about him  
9 that made them feel uncomfortable, there was  
0 something about that guy that was different, so  
11 he couldn't sell, he had to go through vocational  
12 rehabilitation to find a non-people contact kind  
13 of work.

14 So I *think* a similar thing would  
15 happen with Mr. Pietro. If we were to say, "Oh,  
16 go back to working with *the* public and selling,"  
17 he probably would have a hard time with that in  
18 any kind of work that would involve, you know,  
19 that nonverbal "Hey, I just" -- "I just shook  
20 your hand, you got to trust me," that kind of  
21 work, he'd have a hard time doing that type of  
22 thing.

23 Q. With respect to cognition, is that the  
24 same type of recovery period, the nine to twelve  
25 months, and then you wouldn't expect to see any

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1 impairments otherwise, I would think, would make  
2 it difficult for him to be a salesperson, to  
3 return to his old type of job.

4 In my four years or so of practice  
5 I've learned a better understanding of how that  
6 affects, having any kind of physical impairments,  
7 because of being a salesman. I didn't understand  
8 that at first, but I've had a couple of patients  
9 now who had strokes and were relatively young and  
0 worked as salespeople. They tell me they just  
1 can't sell cars or sell furniture because people  
2 assume they're drunk or are mentally retarded.

3 Or even if they're -- even if they  
4 don't say so there is -- there is a lot of  
5 nonverbal communication that occurs with selling,  
6 and I -- I have a patient who I'd like to  
7 reference just by way of comparison, but a  
8 gentleman who had had a stroke, young, and his  
9 only problem was very mild balance impairment,  
10 and very mild slurring of his words, and he was  
11 otherwise independent and felt well.

12 And I had written him "Can return to  
13 sales, no restrictions" because I didn't see  
14 any. There was nothing wrong with the guy  
15 basically except for very mild balance problems

1 more gains after that time?

2 A. Yes. In general after a stroke, that's  
3 right. So I *think* in terms of doing the type of  
4 work he was doing before, I -- I think it's very  
5 unlikely he could be successful at that.

6 But in terms of some other kind of  
7 work, from just a purely physical impairment  
8 level I think there would be other types of work  
9 he could pursue if he were very motivated, and if  
10 his problems with concentration, fatigue, and  
11 pain weren't limiting to him.

12 And I say that because there is --  
13 you know, there is a psychologist who works full  
14 time at Edwin Shaw Hospital who is quadriplegic,  
15 has no function at all of the arms or legs. So  
16 being able to return to some type of work is --  
17 you know, there are mentally retarded people who  
18 work in structured workshops and make some small  
19 income, so there is a whole range of -- of  
20 occupation for people with mental and physical  
21 impairments if they're able to tolerate it and  
22 are motivated to do so.

23 Q. Doctor, have you been asked to appear at  
24 trial for testimony in this case?

25 A. Not that I'm aware.

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1 Q. Okay. One last question. There is a  
 2 report there from, I believe, June 30th toward  
 3 the back of your file that was a psychological  
 4 evaluation. Could you just tell us what the  
 5 results of that were?

6 A. Okay, yeah. 6/30/97 -- this is from a  
 7 Dr. E. M. Bard, Ph.D.. This is from the report  
 8 requested by the Bureau of Disability  
 9 Determination according to the records here.

10 Let's see. As is typical for the  
 11 kind of report Dr. Bard summarized the patient's  
 12 interview, what his reports of his problems were  
 13 and his past history, family relations, et  
 14 cetera.

15 I don't *think* you want me to review  
 16 all that, do you?

17 Q. No. I just want to know what the  
 18 general outcome was, if it's there somewhere?

19 A. He went through a battery of tests.  
 20 General interpretation, the results indicate the  
 21 claimant -- claimant is currently performing  
 22 within the low average classification range in  
 23 regard to his overall intellectual ability. No  
 24 significant difference was noted between his  
 25 verbal and nonverbal reasoning abilities.

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1 His full scale intellectual quotient  
 2 fell 1.33 standard deviations below the mean, and  
 3 was at the 9th percentile. Results of the WAIS-R  
 4 -- that's a specific kind of psychological test  
 5 -- intellectual are felt to be a valid estimate  
 6 of the claimant's cognitive functioning at the  
 7 time of examination.

8 The reason he says that is, I believe  
 9 -- I'm not a Ph.D. who does these kind of  
 10 things, but there is almost always something in  
 11 there relating to that, because it is possible to  
 12 pick out someone who -- if they're someone who is  
 13 attempting to fool the examiner in other words.

14 This says that the testing revealed a  
 15 valid estimate of his function, although below  
 16 his pre-morbid level of functioning. Put forth  
 17 efforts and materials presented.

18 He did have problems with his eye,  
 19 and toward the end of the testing session was  
 20 quite fatigued.

21 It appears that Mr. Pietro was  
 22 functioning within the above average range prior  
 23 to his stroke. His current levels of cognitive  
 24 functioning give evidence of significant  
 25 weaknesses in the areas of short term mental

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1 recall involving manual dexterity and social  
 2 situations, involving nonverbal reasoning and  
 3 planning ability. No significant strengths were  
 4 noted.

5 He did some memory testing, showed  
 6 that he was functioning in the low average range  
 7 -- low average range, sorry, in regard to  
 8 overall memory skills.

9 He was -- he was unable to count  
 10 successively by serial threes. Fairly poor, I'm  
 11 surprised it was that bad actually. He fell at  
 12 the tenth percentile, 1.26 standard deviations  
 13 below the mean.

14 Under reading comprehension test said  
 15 he was able to read with comprehension at the mid  
 16 seventh grade level. And again he stated appears  
 17 to be a decrease in regard to pre-morbid status.  
 18 He stated there was a sixth percentile one  
 19 standard deviation below the mean.

20 There was a section where he asked  
 21 about questions that can be related to traumatic  
 22 brain injury. He summarized the patient's many  
 23 complaints. Let me read through that paragraph.  
 24 Pardon me for the delay. I -- I want to see if  
 25 there is anything he reported to the psychologist

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1 that wasn't reported to me.

2 In addition to the things that the  
 3 patient had mentioned to me, he also mentioned to  
 4 the psychologist problems with vision and taste,  
 5 personality changes with irritability and short  
 6 tempered behavior. The patient did tell me he  
 7 was depressed and ir- -- and frustrated, so I  
 8 guess that's similar.

9 Changes in sleep pattern were noted  
 10 on that date. A loss of interest in hobbies and  
 11 interests, decreased interest in sex, decreased  
 12 motivation. Pain is mentioned here. He suffers  
 13 severe daily -- he suffers severe daily from  
 14 pain. That's from his wife.

15 And those were the -- the things that  
 16 he mentioned.

17 And he goes on to summary, conclusion  
 18 and comments, and under this section he writes --  
 19 he states that formal testing indicates the  
 20 claimant is functioning below his estimated  
 21 pre-morbid states in areas of general  
 22 intellectual ability, verbal and abstract  
 23 reasoning ability, auditory and visual ability,  
 24 and general reading comprehension,

25 From that he -- he gave some overall

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1 levels of functioning comments. These are as  
 2 follows: The claimant's ability to relate to  
 3 others is below average. He is irritable and in  
 4 frequent pain. He minimizes socialization, does  
 5 not interact with the public on a regular basis,  
 6 does not like to be around -- doesn't like to be  
 7 around crowds or noises.  
 8 Ability to understand and follow  
 9 instructions, that he is at a seventh grade  
 10 reading level. He has trouble concentrating and  
 11 understanding what he has read. He does not read  
 12 independently during the day or for leisure. His  
 13 ability to maintain attention to perform simple  
 14 receptive tasks is deferred to proper medical  
 15 authorities who are treating him.

16 Because of numbness his ability to  
 17 work in his position as a salesman is  
 18 significantly impaired. He has trouble with  
 19 extended speech, and he stated that he is easily  
 20 fatigued. He has trouble with mobility and  
 21 depends on his wife for transportation.

22 The psychologist felt that in the  
 23 event that the patient was found to be disabled  
 24 he would need his -- a competent adult, such as  
 25 his wife, to handle granted benefits that might

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1 be awarded. He stated again the patient was not  
 2 handling financial -- was not handling family  
 3 finances at the time, his wife had taken over  
 4 those responsibilities.

5 Q. Doctor, without going through the --

6 A. That's basically it.

7 MS. MOORE: Okay. I don't have  
 8 anything else, but I -- before I leave I would  
 9 like a complete copy of your chart because I  
 10 don't have a complete copy.

11 And I -- I will keep the deposition  
 12 open in the unlikely event that there is  
 13 something in there I need to question you about.

14 THE WITNESS: Uh-huh.

15 MS. MOORE: These other people may  
 16 have some questions also.

17 MR. BONEZZI: Let's go off the record  
 18 for a moment.

19 (Discussion had off the record.)

20 MR. BONEZZI: Back on the record.

21 ---

22 BY MR. BONEZZI:

23 Q. Doctor, you were asked at the beginning  
 24 of the deposition if you knew a number of  
 25 physicians involved. The one name I have for you

1 is Karla Madalin. She's a neurologist. Are you  
 2 familiar with her?

3 A. Yes.

4 Q. In what capacity?

5 A. I have met her at an occasional  
 6 meeting. We're not -- we -- we exchange a few  
 7 words, and we've had, oh, less than a half a  
 8 dozen, I believe, patients in common, and so I've  
 9 corresponded with her about patients. I've never  
 10 had a social relationship or other contact with  
 11 her.

12 Q. Have you referred patients to her?

13 A. I don't recall any specific instances,  
 14 but I very well may have because, you know, we --  
 15 we see a similar type of patients, and I may have  
 16 sent her patients with headache problems or  
 17 neurologic problems. I would certainly have no  
 18 -- no difficulty in doing that. My  
 19 understanding is Dr. Madalin does good work.

20 Q. And in turn do you know if she has  
 21 referred any patients to you for rehab purposes  
 22 following stroke?

23 A. I do recall seeing her name on the  
 24 charts of patients that have been sent to Edwin  
 25 Shaw Hospital or other facilities for

1 rehabilitation.

2 Q. Have you had any discussions with her,  
 3 if you recall, relative to Mr. Pietro?

4 A. Not that I recall, no.

5 MR. BONEZZI: Okay, thank you.

6 ---

7 BY MR. SCOTT:

8 Q. Doctor, my name is John Scott.

9 I wonder if you have any opinion as  
 10 to whether any of the patient's condition is due  
 11 to a functional overlay, or whether you would  
 12 defer that to a counselor, that determination to  
 13 a counselor?

14 A. Um-m, I see a lot of patients with  
 15 different disabling illnesses and pain  
 16 complaints, and I do as part of my day-to-day  
 17 office practice see patients for independent  
 18 medical evaluations where, for example, the --  
 19 the Bureau of Workers' Compensation will say  
 20 "This patient with low back pain, do you think  
 21 they are disabled? Can you give us an opinion  
 22 about their extent of disability?"

23 So I have clinical experience with  
 24 people with different degrees of functional  
 25 overlay.

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1 The -- the overall feeling I have --  
2 or I have had with Mr. Pietro throughout is no,  
3 not significant amounts of functional overlay to  
4 his complaints.

5 Typically reliable signs that you can  
6 see or feel for functional overlay would be  
7 things like overreaction in the office, crying,  
8 yelling, sweating, changing positions, moaning,  
9 grabbing parts of the body. I've never had  
0 experiences to see him behave that way.

1 Another sign of functional overlay  
2 can be non-neurologic -- non-neurologically  
3 explained symptoms like, well, the entire -- you  
4 know, both legs from the knee on down is numb.  
5 You know, it's difficult to explain that in terms  
6 of a stroke syndrome.

7 Or, you know, this finger, but not  
8 this finger is numb, that sort of thing. And I  
9 never experienced that with the patient.

0 Another sign is distraction, meaning  
1 you watch the patient walk out to their car, or  
2 watch them -- you know, you check them in the  
3 room and ask them to do a specific thing. You go  
4 down later to therapies and watch how they're  
5 doing, they're doing better.

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1 I had never seen that in him, and I  
2 can't recall specific -- like incidents where I  
3 had done those things, but I didn't see that in  
4 the office.

5 Diffuse tenderness is another sign of  
6 functional overlay, you know, touching an arm  
7 people yell with pain, or do a general typical  
8 physical examination maneuver like testing a  
9 reflex and they complain of severe pain from the  
0 tapping. He never exhibited that behavior.

1 Another sign of functional overlay is  
2 inconsistent functional abilities, in other words  
3 "I can't do this, but I can do this."

4 You know, "I" -- "Doc, I can't sit  
5 for fifteen minutes, it hurts too much, but I  
6 drove in to see you here at the office," you  
7 know, "I drove a half hour to come to see you  
8 today," you know, things like that that are  
9 inconsistent, and I had not seen that with --  
10 with Mr. Pietro.

11 The other -- another indication of  
12 functional overlay might be a lack of  
13 motivation. You know, reports from the  
14 therapist, "Hey," you know, "doctor, this patient  
15 just isn't trying," you know, "trying to do these

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1 things, they're just not giving any effort."

2 And I had never seen that with Mr. --  
3 Mr. Pietro. So from my point of view as a  
4 rehabilitative specialist I didn't see any  
5 evidence of functional psychological overlay. I  
6 didn't see any evidence he was trying to fool me,  
7 or fool other professionals that were seeing him,  
8 or he was a criminal in that regard trying to  
9 commit fraud.

10 Certainly frustration, depression,  
11 anxiety, all of these negative emotions, will  
12 definitely impact on anybody's function even  
13 without a physical impairment. You know, those  
14 things alone can be enough to make somebody be  
15 unable to function in the world properly.

16 To the extent to which the depression  
17 and frustration are limiting his abilities would  
18 be best determined by a counselor, like you say,  
19 but I anticipate it would -- it would have to  
20 affect him at least somewhat, like it would any  
21 of us.

22 Q. Those are the reasons why you  
23 recommended to him, if I understand correctly,  
24 that he see a -- a therapist?

25 A. Yes, partially. And also --

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1 Q. Okay.

2 A. -- because he seems to be suffering, you  
3 know, the -- the -- what I gather from -- from  
4 talking to him in January, and -- and from the  
5 reports I've had from his wife, and from  
6 reviewing the information in the chart, he -- he  
7 is suffering -- he's -- he's lost a lot and he  
8 feels bad about it, so perhaps some counseling  
9 can help him come to better terms with that so  
10 he's not so much depressed and frustrated.

11 MR. SCOTT: Okay. Thank you, Doctor.

12 MS. FEHN: I have no questions.

13 MR. HIRSHMAN: Ma'am?

14 MS. MOORE: Nothing.

15 MR. HIRSHMAN: All right.

16 MR. BONEZZI: What are you going to  
17 do then about the records?

18 MR. HIRSHMAN: I'll get them. I can  
19 wait for them if -- if you want and I'll --

20 THE WITNESS: I don't need them now.

21 MR. HIRSHMAN: If you want a copy --  
22 if that's not convenient you can send them to  
23 me. If you want an authorization before we do  
24 it, I can get that for you too. If you need that  
25 I'll get that in the mail to you today.

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1 THE WITNESS: I suppose just to keep  
 2 it clean we probably should have the  
 3 authorization.  
 4 MR. BONEZZI: Thank you, Doctor.  
 5 THE WITNESS: Okay. Thank you.  
 6 (Discussion had off the record.)  
 7 - - -  
 8 (Deposition concluded at 12:11 o'clock p.m.)  
 9 - - -

## 1 CERTIFICATE

2 STATE OF OHIO, }  
 3 SUMMIT COUNTY, } SS:

4 I, William S. Bish, RDR/CRR and  
 5 Notary Public within and for the State of Ohio,  
 6 duly commissioned and qualified, do hereby  
 7 certify that the within named witness, JAMES G.  
 8 BEEGAN, M.D., was by me first duly sworn to  
 9 testify the truth, the whole truth and nothing  
 10 but the truth in the cause aforesaid; that the  
 11 testimony then given by the witness was by me  
 12 reduced to Stenotypy in the presence of said  
 13 witness, afterwards transcribed upon a computer;  
 14 and that the foregoing is a true and correct  
 15 transcription of the testimony so given by the  
 16 witness as aforesaid.

17 I do further certify that this  
 18 deposition was taken at the time and place in the  
 19 foregoing caption specified, and was completed  
 20 without adjournment.

21 I do further certify that I am not a  
 22 relative, counsel or attorney of either party, or  
 23 otherwise interested in the event of this action.

24 IN WITNESS WHEREOF, I have hereunto  
 25 set my hand and affixed my seal of office at  
 Akron, Ohio on this 4th day of June, 1999.

William S. Bish, RDR/CRR and Notary  
 Public in and for the State of Ohio.

My Commission expires November 4, 1999.

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1 I, JAMES G. BEEGAN, M.D., do verify  
 2 that I have read this transcript consisting of  
 3 ninety (90) pages and that the questions and  
 4 answers herein are true and correct with  
 5 corrections as noted on the errata sheet.

6  
 7 JAMES G. BEEGAN, M.D.

8  
 9 Sworn to before me, \_\_\_\_\_,  
 0 a Notary Public in and for the State of \_\_\_\_\_,  
 1 this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_.

2  
 3 Notary Public in and for the

4 State of \_\_\_\_\_  
 5 My commission expires \_\_\_\_\_

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