IN THE COURT OF COMMON PLEAS
SUMMIT COUNTY, OHIO

LAWRENCE PIETRO, Ind. and as Father and Natural Parent of Anthony Pietro and Gina Pietro, Minors, et al.,

Plaintiffs,

vs.

GENERAL EMERGENCY MEDICAL SPECIALISTS, INC., et al.,

Defendants.

Case No. CV98-05-1804
JUDGE BOND

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

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

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

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

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JAMES G. BEEGAN, M.D.
of lawful age, a Witness herein, having been first duly sworn, as hereinalter certified, deposed and said as follows:
CROSS-EXAMINATION
BY MS. MOORE:
Q. Doctor, for the record would you please state your name.
A. James G. Beegan, M.D.
Q. And what is your business address here?
A. Business address here? Well, my actual -- see, I come here and see patients once a week. My formal more proper business address would be 1261 Flickinger Road, Akron, Ohio 44312.
Q. And is that a professional office --
A. Yes, it is.
Q. -- space?
Is there any group associated with that space'?
A. Yes, Summit Rehabilitation Medicine, Incorporated.
Q. And what's your occupation?
A. I'm a physical medicine and rehabilitation specialist.
Q. And you are an M.D.?

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A. Yes.
MS. MOORE. Off the record.
(Defendant's Dr. Beegan Exhibit A was marked for identification.)
BY MS. MOORE:
Q. Doctor, I'm going to hand you what's been marked as Defendant's Exhibit A. Is that a current copy of your CV?
A. Yes, it is.
Q. And just briefly for the benefit of everyone else here, since we have no copies, could you just give us a little bit about your educational background beginning with medical school.
A. I attended medical school at the Ohio State University. I attended physical medicine and rehabilitation residency there, Ohio State University. I was chief resident my senior year.
And do you need me to go into --
Q. What year did you graduate?
A. -- CMEs or continuing education conferences, or just what's here?
Q. What year did you graduate from medical school?
A. I graduated from medical school in June

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of 1991.
Q. And when did you become licensed to practice medicine in the State of Ohio?
A. June of 1990 -- June of 1995.
Q. And are you Board certified?
A. I am.
Q. In what areas?
A. American Board of Physical Medicine and Rehabilitation.
Q. And what year did you receive that certification?
A. In 1996.
Q. Did you pass your Boards the first time?
A. Yes, I did.
Q. Do you have any other Board certifications?
A. I do not.
Q. Are you Board eligible in any other areas?
A. I'm Board eligible in electrodiagnostic medicine.
Q. Do you plan to take the Boards in that area'?
A. 1took them in May of this year.
Q. Okay. And is that just the first part

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of that Board examination?
A. No, we took the entire examination then.
Q. Have you received any results from that yet?
A. I havenot.
Q. When do you expect results?
A. June 4th.
Q. Do you have staff privileges at any hospitals in the area?
A. Yes.
Q. And which hospitals?
A. Edwin Shaw Hospital, Akron General Medical Center, Summa System, Cuyahoga Falls General Hospital.
Q. Have any of your privileges ever been revoked or suspended?
A. No.
Q. Has your license ever been revoked or suspended?
A. No.
Q. And have you ever been sued for medical negligence?
A. No.
Q. Have you given depositions in the past?
A. Yes.

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Q. And about how many occasions?
A. Three or four I'd estimate.
Q. And were those for testimony such as we're here today, for patients that you've treated?
A. As I recall there were two that were specifically referred to me by attorneys stating "Can you please evaluate this person, tell me their extent of disability"; and the other two or three were patients I had seen in the office or at the hospital previous.
Q. Of those two cases where you evaluated them by request for other attorneys, were those both for plaintiffs attorneys or defense attorneys? Do you know?
A. I believe both were for plaintiffs.
Q. Do you know Dr. Thomas Elson over at Akron General?
A. No, I do not.
Q. How about Dr. Susan Tout?
A. I do not.
Q. Dr. Kevin Markowski?
A. No.
Q. How about Dr. Lynn Mason?
A. No.

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

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

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

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

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

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

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

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

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

A. Um-m --

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

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

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

A. I havenot, no.

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

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

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

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

A. Yes.

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

A. Uh-huh --

Q. -- at Akron General Medical Center?

A. -- yes.

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

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

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

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

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

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

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

THE WITNESS: Yea, one G.

BY MS. MOORE:

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

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

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

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

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

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

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

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

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

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

A. An estimate.

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

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

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

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

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

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

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

Q. Okay. When Mr. Pietro came to Edwin

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

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

Q. Is there anything else?

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

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

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

A. Let me double-check that, please.

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

I see a note from the days of his

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

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

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

Okay. He denies lower limb edema or leg or *arm* pain as of 12120196 is what he told me when I reviewed his systems.

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

A. Yes.

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

A. Yes.

Q. How many have you seen?

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

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

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terms of what you see in rehab patients?

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

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

MR. SCOTT: I'm *sow*, Doctor, what did you just say? Will you repeat what you just said?

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

MR. SCOTT: After that.

MR. BONEZZI: The checkbook.

MR. HIRSHMAN: About the checkbook.

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

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trouble concentrating.
MR. SCOTT: Thank you.
THE WITNESS: So I think there are things that a healthy person his age would -- would be expected to do, and would want to do, that he can't do, so -- even with equipment or extra time -- so I'd say mild to moderate deficits.
In terms of handicap, meaning his ability to perform in a social role, I'd say it's moderately severe, his impairments, because from his -- again from his report of -- of the way he did things with his family before, and the way he worked before, he was working full time and -- and had no difficulty with that, he was actively involved caring for the children, involved with, you know, their sport activities and things like that, and those are things he feels he can't do anymore.
And also vocationally, you know, one of his roles is to, you know, provide for the family, he felt, and I agree that he seems very impaired in that regard as well.
BY MS. MOORE:
Q. Okay. And what you just testified to is

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based upon Mr. Pietro's condition now, today, based upon your last visit?
A. As of -- as of, yes, January.
Q. We will come back to that. I was trying to get an indication in general how people at that age, you know, may function. So Mr. Pietro falls into that mild to moderate category?
MR. HIRSHMAN: Well --
THE WITNESS: I think the level of impairment and --
BY MS. MOORE:
Q. Right.
A. -- in tenns of disability, in terms of handicap, how much those impairments and disabilities impact his ability to keep his normal social roles --
Q. All right.
A. -- care giver to the home, moderate to severe.
Sort of a long answer, but when we think about how much of a physical condition affects somebody we tend to break it down into those categories because they're -- they're not always the same in terms of extent of severity.
Q. Okay. Are these the same kinds of

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problems you would see with other people who have had a brainstem injury? I mean, is this a fairly typical pattern?
For example, you indicated Mi. Pietro was having vertigo and impaired vision, for a period of time some balance problems. Is that the fair -- I mean, is that a fair statement of what -- what you see with these brainstem injuries? Or can --
A. It --
Q. -- can there be more I guess is what I'm trying to find out?
A. Can there be other tlungs --
Q. Right.
A. --related?
Q. In addition to that.
A. Dys- -- other additional problems can be dysphagia, or trouble swallowing; dysarthria, or difficulty with annunciation of words so that they can be intelligible; dysphonia, or quietness of voice if -- if a person has trouble getting the volume loud enough for people to understand. Vision problems, difficulty with balance.
There -- there are reports in the medical literature of high level cognitive

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impairments caused by cerebellar infarcts alone. Cer- -- I believe the -- it's well substantiated in the literature cerebella infarcts can cause high level cognitive or reasoning or intellectual problems.
Q. Is there any literature that comes to mind that you just referenced?
A. Yes, there is. There is a study -- I can get you a copy if you like, which I don't have it with ine in this office today, but there was a study from -- from the early '90s that looked into just that question from the rehabilitation literature.
Q. If you do have a copy of that I would like to take a look at it.
Is it fair to say though that as far as what you may see in terms of both physical and medical impairment you can run the gamut to a much more severe level of dysfunction than what we're seeing here with Mr. Pietro'?
A. Oh, yes, certainly you can, I would agree with that. There are some people who might have a brainstem infarct or hemorrhage who would have complete paralysis on one side, or severe lose of sensation or --

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Q. That was my next question.
A. -- any of these things. It's a matter of degree. Any of these things can be more severe.
Q. Sure.
Going back to Mr. Pietro's stay at Edwin Shaw beginning on December 20th --
A. Uh-huh.
Q. -- what types of therap es did you have planned for him to get him back home?
A. He underwent balance training with the physical therapist. That would include walking on level and uneven surface:;, working on climbing steps, one leg stance balance activities, trying to make quick turns or quick change in the directions to coinpensate for the problems he had.
He also underwent occupational therapy where he would work with arm coordination, transfers, bathing and dressing activities. He was in role and speech therapy.
They cleared him for swallowing problems. He was safe to swallow on normal diet, and taught him oral motor exercise to try to strengthen his -- his oropharynx for better communication skills, and they taught him a

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program with that, and he was performing that on his own.
Q. Is there anything else that was included in that initial program at Edwin Shaw?
A. That was the -- the therapy program as I recall it when he was an inpatient.
Q. During the time that he was at Edwin Sbaw from the 20th until his discharge on the 24th did you actually see M-. Pietro?
A. Uh-huh.
MR. HIRSHMAN: Yes?
THE WITNESS: Yes, I did. Sorry, yes, I did.
BY MS. MOORE:
Q. And on what occasions?
A. I saw him 12/20/96 upon admission, 12/21, 12/23 and 12/24.
Q. If you could briefly tell us what Mr. Pietro was -- Mr. Pietro's coiidition was on 12/21 when you saw him?
A. 12/21? I would have to rely on **my** notes from that hospital day --
Q. 'fiat's fine.
A. -- to give you any kind of indication because I can't recall from -- froin my own

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recollection.
Q. And specifically what's -- was he showing any improvement?
A. Yes, he was demonstrating improved balance while walking in the room. He said he was walking with a gate belt. That's a belt that goes around their waist, we hold onto someone if they have problems of balance, for safety basically.
I said he was doing that with contact guard assistance. And I thought he was stable for continuing his therapies.
Q. And you said you saw him again on 12/23?

remaining that you saw?
A. Minimal impairments of insight, continued problems with walking such that -- especially he needed standby assistance for walking. Difficulty with transfers and dynamic walking such that he needed supervision.
Difficulty climbing steps such -- such that he needed contact guard assistance. Contact guard assistance means there needs to be another person with their hand on the patient, but that person providing the help is providing less than 25 percent of the help. So it's -- so it's a way of -- shorthand way of saying **a little** bit of help is required with actual hands on, but

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

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

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

Q. Okay.

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

And I reported that he had passed his swallowing screen. So those were the problems that 1 documented at that time.

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

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

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

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

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

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

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

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

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

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

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

In general there would be a

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

Q. Okay.

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

Q. Okay. That's fair.

Were you also involved in Mr. Pietro's care when he wa:; involved with physical therapy at Akron General?

A. As an outpatient?

Q. Yes.

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

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

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

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appropriate. So he was taking care of himself, he wasn't willfully neglecting his health care. He was doing the right things and getting checked up on. He didn't have any signs of problems from the Coumadin from excess bleeding.
His gait was slightly ataxic, which I thought was an improvement. He was walking on level surfaces without any device, no cane, which is an improvement.
Shoulder had remained -- I'm sorry, his strength had remained good. And on that basis I had said that he was making good improvement.
Q. You also noted that his strength was at fiveifive?
A. Uh-huh.
Q. What does that mean in lay terms?
A. Sure. There is -- several years ago -- well, actually decades ago there was a gathering of professionals called the Muscle Research Council, they got together to try to come up with a standard format for grading strength. So it goes from zero to five, and five is normal strength.
So with five out of five strength I would say his strength was -- was normal on testing.
Q. Did you feel Mr. Pietro was making more rapid progress than the average patient, or was he about where you expected him to be given his stroke?
A. Um-m, I -- I think about average. He was improving. He still wasn't totally independent, and was still having problems with ataxia. So I would say it was -- it was as expected or average. You know, good in my mind.
Q. Did you have a prognosis at that point in time? And I real- -- I heard your answer to the last question, I'm not trying to be unfair --
A. Yes.
Q. -- but I'm just trying to find out if at that time, in January of 1997, whether things had changed enough where you could come to a determination as to what to expect with Mr. Pietro?
A. Well, at that point he would have been -- he would have been several weeks out from the onset of the stroke and he was still having problems with ataxia, for example.
In general, if someone has gotten to

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

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unusual nature.
Plus if a person has impaired muscle control for whatever reason, this case ataxia, then the -- the normal rhythm of the rotator cuff can be altered. So we see a lot of patients who have shoulder pain after a stroke.
I thought that the pain was due to rotator cuff arthopathy, meaning an inflammation of *the* rotator cuff tendons. That's not a direct result of the stroke.
I'm trying to think if 1 could say definitely it was a result of -- an indirect result. I'm not -- I'm not certain I can say --
Q. That's fair.
A. -- an indirect result. I ***think*** it's possible that it's an indirect result because he had the stroke, he's doing therapies, he has some alterations of his motor control, he's doing things with his shoulder he wouldn't normally have done. Say then he develops rotator cuff tendinitis, so you could argue it's an indirect result but --
Q. Rut there is no -- I'm sorry.
A. -- but I think to say that with any kind of medical certainty wouldn't be possible. But

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rotator cuff problems are very common in anybody our age, his age, doing an exercise program as well. So to say it's definitely froin the stroke I think is unfair.
Q. And you did order some rehabilitation therapy for the rotator cuff problem?
A. Yes.
Q. And that was successful about a month later? I think your note indicates it had improved.
A. Yes.
Q. And that would be the next time that you saw Mi-. Pietro, on 2/20/97?
A. Yes.
Q. And how was he doing at that point?
A. At that time he reported improvement in his shoulder. He felt that the -- the pain was significantly decreased, which was a good sign that the inflammation from the rotator cuff problem had decreased.
He felt his right arm strength was approximately 90 percent of normal. Now, when a patient reports their strength is better or worse, that has -- has to do with a lot of factors.

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If someone's shoulder is painful, but has normal strength, a lot of times a patient will report that as weakness. It's not true muscle weakness, it hurts so they can't do what they normally do with it, so it's, quote, weak. See what I mean?
So he thought it was about 90 percent of his normal strength, which 1 thought was a good sign.
He was doing his regular exercise program, which is also a good sign. Again, he was taking care of himself, he wasn't neglecting his health.
His balance is better, no falls. He felt his ataxia and vertigo had improved.
His wife was present, and she -- I'll often ask spouses or family, you know, "What's" -- "What's your opinion," because what a patient reports, of course, is subjective.
And his wife reports that he was doing better with endurance and concentration. But she did give more information. She stated that he was having difficulty reading, and he had difficulty with concentrating and blurring of his vision.

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1 said he was helping more with the family business, "much more" I said, but had difficulty with the endurance and stamina to perform that for long periods of time as he did before the stroke.
I said -- stated that he had no problems with unusual bleeding.
On a quick mental status examination he was oriented. I reported his gait was slightly ataxic.
We had mild impairments of left upper limb coordination compa-ed to right. His leg coordination was smooth to brush his heels on the front of his shins, a standard maneuver to check how the coordination in the legs were doing. Strength was normal throughout I -- I reported.
Q. Okay.
A. I noted a very mild right facial droop. I didn't see any visual field cuts or double vision. And then that's grossly that I examined him, of course, so that's how I felt he was doing at that time.
Q. And he was improved from the visit before?
A. Yes.

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Q. You mentioned that his wife had said he was helping more with the family business?
A. Uh-huh.
Q. Did she elaborate as to what extent he was involved with the business, or what he was doing specifically?
A. Um-m, I'm sorry, I can't recall from the time. I -- I would have to rely on what the note says. I didn't -- I didn't go into details on my note at the time, so I can't give you any more specifics than what I've documented there.
Q. You also mentioned there was some problems with endurance as far as working with the family business. Is that something that you would expect to improve over time again?
A. It would. Generally I counsel my patients who have had strokes that they'll have a relatively long period of -- of impaired endurance of fatigue longer than they think, you know.
It usually -- oh, in my experience the people with other types of strokes it can last for two to three months. What I normally tell people is "Expect your endurance to be poor for that long but gradually improving all during

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that time."
I can't give specific recommendations about a young person with a brainstem stroke just because it's relatively a more unusual stroke than what I typically see day by day, but I think it's fair to say he could expect some problems with endurance that should get better gradually over the course of several months.
Q. As far as the type of therapies that Mr. Pietro was involved in on an outpatient basis at Akron General, what kinds of things was he doing? Is that something you would set up as his physician, or is that something that was set up by the physical therapists there?
A. Generally how it works is we will Write orders stating what -- the problem the patient's having and any medical restrictions --
Q. Okay.
A. -- that -- that they should honor. And then we'll give general guidelines saying "We want you to work on high level balance, and we want you to work on his strength, and we want you to work on his ability to walk in the community," for example.
And the physical therapist will

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tailor the program based on their evaluation of the patient. So to answer your question a little bit of both. We give --
Q. Oh.
A. -- generally we give general guidelines, follow the program, and I think generally my -- my -- my requests for physical therapy will state "Please call with questions," meaning "If you're having problems give me a call and we can talk about other ways you might approach this and such." And I think that's -- that may be on his consultation request as well.
So that's generally, but that's -- that's a fairly typical practice. I didn't see any need to go into more specifics with him.
Q. Do you get reports from Akron General concerning the patient's progress?
A. Yes.
Q. And did you receive them in this case as well?
A. Sorry for the delay. I'll have to look back through the notes.
Q. That's okay, take your time.
A. Yes, there are notes from his -- there are notes froin his therapies from late December

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and early January of '97. Those notes are primarily froin Edwin Shaw Hospital, the ones I have in my record.
Oh, and here are some from Akron General Medical Center as well, reporting his progress. So yes, I have indications of his progress in therapy from both Edwin Shaw's outpatient program, and also Akron General Medical Center's department.
Q. My notes reflect that he underwent therapy for several months at Akron General Medical Center. Do you know when he stopped therapy there, when he was discharged from therapy?
A. I don't know off the top of my head. I I'd have to look through the records here. It's like occupational therapy was stopped on 1/22/97. I don't see a specific note from the physical therapist reporting when his outpatient physical therapy had stopped.
So no, I don't -- I don't have any specific days when I can tell you it stopped.
Q. Would you typically see a patient prior to their discharge from therapy?
A. Typically. It depends on the patient.

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

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

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

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

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abilities, where you saw him headed at that time?

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

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

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

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

Q. Okay.

A. -- almost unheard of to see improvcments beyond then, so I think it's important to talk to families and satients about, vou know. "We expect

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

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

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

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

A. *Yes.*

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

A. That's correct. That was a request from -- from Ivfr. Hirshman for me to see the patient and get a sense of how he was doing at that time, since 1had not seen him in several months.

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

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

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

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THE WITNESS: Sorry about that.

45 year old, right-handed. Independent and healthy prior to 12/8/96.

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

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

BY MS. MOORE:

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

A. Sure.

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

A. Correct.

Q. Okay.

A. By the patient's report.

Q. Okay, that's fine.

A, 1didn't -- it would be of no -- of no

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

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

Q. Okay.

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

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

Q. That would be fine.

A. Okay.

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

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

Q. Sue.

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

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

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

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

Q. Okay.

A. He was in the ICU for one week.

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

He reports improvement for nine to twelve months.

And I went to a section where I asked him what his -- I asked him to list his current complaints. 1'11 put that under the "Now" section.

Q. Before you go on to that --

A. Go ahead.

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

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A. Uh-hub.

Q. Is that some type of home therapy program?

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

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

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

Q. Okay.

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

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

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

Q. Okay.

A. This is a --

Q. This --

A. -- is a list of his current €unction,

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

Q. Okay.

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

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

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

Numbness of the right side of his face. Decreased hearing [sic] of his right eye, for which he sees Dr. Rates, one of our neurophthalmologists, and receives Natural Tears. Diminished depth perception, diminished visioii in the right eye. Variable throughout the day, worse with stress.

Fatigue, decreased concentration. Fatigue with attempts to concentrate. Sleeping more often, and naps through the day.

Impaired cognition and confusion. Right facial burning and discomfort. And I -- where that, in the past it had been treated with Tegretol, Elavil, Neurontin and a certain type of

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

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

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

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

Q. If you don'tmind.

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

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

Stiffness in his left leg and arm.

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

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

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

Those are the complaints he presented

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with.

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

Q. Did he indicate how he fell?

A. He did not.

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

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

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

A. He told me --

Q. In other words --

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

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safely, with our driving program at Edwin Shaw Hospital.

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

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

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

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

bladder function were intact, as before.
And we -- as part of my review of systems I asked him about sexual function, and he had given me information about that.
Q. What did he tell you about that?
A. He toldine that his sexual function was abnormal. He said he had numbness affecting the left side of his groin. He -- he was able to obtain only a partial erection, and had orgasms only occasionally. Had decreased frequency of sexual contacts, and decreased intensity of the -- the sexual contacts with his wife.
Q. As far as Mr. Pietro's complaints though that he has expressed to you in January of 1999, do you have any reason, in your mind, as to why certain things have seemed to progress in a negative fashion, instead of getting better they've become worse?
A. Uh-huh.
Q. Is there anything that he told you that would enlighten you to why that happened?
A. Well, in terms of his -- if you go back to breaking it down into impairments, and disabilities, and handicaps, looking at his -- his impairments there was no indication of why he

would be having more trouble. He didn't relate to me a history of any traumas except for the fall a week before. But --
Q. Okay.
A. -- it seemed as if that was a self-limiting problem. He didn't relate any history of new strokes or traumatic brain injuries or other problems of that type.
The -- the complaints he was listing in terms of diminished balance, particularly with quick head movements, and slowness of his gait I think could be reasonably attributed to the ataxia we were seeing even two years previous.
He told me he was walking without a device fifty yards at a time before he needed to rest, so it sounded to me, compared to when I had seen him before, his gait was somewhat improved, if anything, although still impaired due to this ataxia.
So at the physical impairment level my impression was he was having long-term problems with continued ataxia which would have been expected, but that his -- his walking and such had improved somewhat since I had seen him last.

Q. If I can stop you there with respect to those physical problems, is there anything that he can do in terms of therapy now, physical therapy, that would help those problems? Or as you stated before, after that nine to twelve month period is this pretty much what he should expect now?
A. It -- it is pretty much what he should expect now.
Q. So in other words --
A. Like any of us -- I guess I should qualify that like any of us, if he were to continue with his home exercise program he may see some gradual improvements to -- to a certain extent, though I think he'll have some limitations long-term though this far out.
Q. Okay.
A. Particularly given that the reports from the therapist, and his reports, and those of the other people that had seen him was he was continuing -- he was taking care of himself and he was trying to -- to exercise and do the right thing by -- by way of taking care of his medical problems and physical problems.
Q. So it would be fair to say any type of

structured rehabilitation with a physical therapist really wouldn't do much good at this point?
A. No, I wouldn't recommend it at this time in general.
Q. Is there any type of equipment that you would recommend for Mr. Pietro, or are we pretty much that's it?
A. There -- no, there was nothing I really could recommend to him at that time.
Q. Okay.
A. He was walking without a device. A cane would only slow him down further.
Changing his environment was a thing he had already done himself. In other words, he was complaining about difficulty concentrating, and difficulty reading, and difficulty tolerating being in a busy environment or being around his kids for more than a few hours, and he had already made adjustments to avoid those type of situations. In other words, he had applied for disability. He was not coaching, he was --
Q. And --
A. -- doing the things to avoid situations that were difficult for him.

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Q. Did he mention to you -- I mean, he said he couldn't do his checkbook. Did he mention anything about working on his business, or doing things with the business?
A. Not as I recall. Not that I documented. So I -- I don't think so.
Q. Okay. If you would continue then you -- you said that these were his physical impairments.
A. Oh, yes. And then in terms of his disabilities -- well, we've covered those actually. You know, he's having trouble doing -- he tells me he's having trouble doing his checkbook, he's having trouble keeping up with his sexual/marital relationships, he's having difficulty keeping up with his family obligations as a father because of his difficulty with -- with concentration, and presumably pain, and also his balance problems.
Q. Again, are these things that are permanent in nature, or is there something more in terms of treatment or therapies or medication that could be used to help Mr. Pietro with any one of those issues?
A. In terms of solving the actual problems

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I -- there is nothing I could recommend to him to -- to fix the underlying problems he's having doing those tasks.
I mentioned that he wasn't receiving any psychological counseling sessions. You know, I think it would be very reasonable given -- telling me he's frustrated and depressed from his problems that he pursues counseling to try to maybe find some peace with these type things, or try to feel better within himself with his limitations.
Q. Do you know if he ever did receive counseling based --
A. Following our visit?
Q. Following your recommendation.
A. No, I do not know. I didn't have any contact with him that way.
Q. As far as the pain that he experiences, and facial burning and things like that, is there any medication that would help him with that, or reduce some of that?
A. He had -- he had tried several. Pain following stroke is not very well understood first of all, so I can't -- it's unlike -- you know, a broken leg causes these neurotransmitters

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to fire. Given this heals up, it goes away.
It's less well understood. Pain following nerve injuries is well described in -- in the medical literature, it responds in general not well to typical analgesics. So in general the Tylenols of the world, even the narcotic analgesics like Darvocet and Vicodin, don't treat this kind of pain very well. He said he was getting partial relief with Tylenol.
Generally physicians consider pain following stroke, or nerve injury, or spinal cord injury to be a category of pain caused by abnormal firing of irritated nerves, and so typically medicines that aren't used as pain pills in other people we try in these people to try to calm down the firing of nerve endings.
There has been some literature that diabetic neuropathy can be helped with Neurontin, that's been shown in some of the medical literature, and we think this kind of pain is related to that in that they're both nerve type pains, pains caused by abnormal nerve firing. He did have a trial of Neurontin.
Elavil is an older antidepressant agent which is felt to have some ability to

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decrease this abnormal nerve firing, so Elavil is often used in patients with, you know, facial pain from tic douloureux, or from diabetic neuropathy or spinal cord injury.
So he had had a trial of that which is very reasonable, as well Tegretol. Similarly that's an anti-seizure medication thought to be -- you can calm down the nerve endings with anti-seizure medication. He told me he tried that, it didn't help.
He was on a fifth medication he couldn't recall the name of from Dr. Rafecas, but probably in that same family of -- of non-typical analgesic agents used in an attempt to calm down nerve injury pain.
Q. Earlier I believe you were -- earlier you -- you indicated som: -- I think you were reading from some of your notes about his current functional disability?
A. Uh-huh.
Q. Did you read that in its entirety?
A. Yeah, I believe so, yes.
Q. Okay.
A. I think so. Do you guys -- if you -- if you saw anything I missed, or have a question,

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

MR. HIRSHMAN: I kind of lost you after you went froin the right side of the page to the left.

BY MS. MOORE:

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

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

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

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

Driving, did okay for short

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distances.

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

Walks without a device fifty yards before he must rest.

Bowel and bladder function are okay.

Diminished sexual function as we elaborated previously.

Q. In this middle section --

A. Uh-hub.

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

A Yes, "No psychological counseling sessions."

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

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

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So under that category of disability I said he had -- he had been evaluated by the Bureau of Vocational Rehabilitation.

Q. Okay.

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

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

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

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

Q. Okay --

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A. -- dash "Granted disability.'!

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

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

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

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

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

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

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

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

Q. Okay.

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

His physical -- the actual physical

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

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

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

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

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

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

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

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

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more gains after that time?

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

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

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

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

A. Not that I'm aware.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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that wasn't reported to me.

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

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

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

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

From that he -- he gave some overall

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levels of functioning comments. These are as follows: The claimant's ability to relate to others is below average. He is irritable and in frequent pain. He minimizes socialization, does not interact with the public on a regular basis, does not like to be around -- doesn't like to be around crowds or noises.

Ability to understand and follow instructions, that he is at a seventh grade reading level. He has trouble concentrating and understanding what he has read. He does not read independently during the day or for leisure. His ability to maintain attention to perforni simple receptive tasks is deferred to proper medical authorities who are treating him.

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

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

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

Q. Doctor, without going through the --

A. That's basically it.

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

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

THE WITNESS: Uh-huh.

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

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

(Discussion had off the record.)

MR. BONEZZI: Back on the record.

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BY MR. BONEZZI:

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

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

A. Yes.

Q. In what capacity?

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

Q. Have you referred patients to her?

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

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

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

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rehabilitation.

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

A. Not that I recall, no.

MR. BONEZZI: Okay, thank you.

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BY MR. SCOTT:

Q. Doctor, my name is John Scott.

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

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

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

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

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

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

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

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

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

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

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

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

The other -- another indication of functional overlay might be a lack of motivation. You know, reports from the therapist, "Hey," you how, "doctor, this patient just isn't trying," you know, "trying to do these things, they're just not giving any effort."

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And I had never seen that with Mr. -- Mr. Pietro. So from my point of view as a rehabilitative specialist 1 didn't see any evidence of functional psychological overlay. I didn't see any evidence he was trying to fool me, or fool other professionals that were seeing him, or he was a criminal in that regard trying to commit fraud.

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

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

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

A. Yes, partially. And also --

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Q. Okay.

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

MR. SCOTT: Okay. Thank you, Doctor.

MS. FEHN: I have no questions.

MR. HIRSHMAN: Ma'am?

MS. MOORE: Nothing.

MR. HIRSHMAN. All right.

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

MR. HIRSHMAN: I'll get them. I can wait for them if -- if you want and 1'11 --

THE WITNESS: I don't need them now.

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

THE WITNESS: I suppose just to keep it clean we probably should have the authorization.

MR. BONEZZI: Thank you, Doctor.

THE WITNESS: Okay. Thank you.

(Discussion had off the record.)

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(Deposition concluded at 12:11 o'clock p.m.)

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

_____

JAMES G BEEGAN, M D

Sworn to before me, _____, a Notary Public in and for the State of _____, this ____ day of _____, 19__.

Notary Public in and for the State of _____

My commission expires _____

CERTIFICATE

STATE OF OHIO, } SS:
SUMMIT COUNTY.)

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

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

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

IN WITNESS HEREOF, I have hereunto 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 Oho.

My Commission expires Novembe 4,1999.

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