IN THE COURT OF COMMON PLEAS

CUYAHOGA COUNTY, OHIO

BEVERLY A. BELL, Plaintiff,	)	
vs.	)	Case No. 208407
	)	Judge Daniel O. Corrigan
KATHRYN ZETTL, Defendant,	)	

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Deposition of DR. MALCOLM A. BRAHMS, taken on direct examination before William J. Mahan, Registered Professional Reporter and Notary Public within and for the State of Ohio, at the Mt. Sinai Medical Office Building, 26900 Cedar Road, Beachwood, Ohio, at 6:15 p.m., Thursday, February 6, 1992, pursuant to notice and/or stipulations of counsel by the Defendant in this cause.

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APPEARANCES :

Joseph H. Wantz, Esq.
Meyers, Hentemann, Schneider & Rea
2100 Superior Building
Cleveland, Ohio 44114

on behalf of the Defendant.

ALSO PRESENT:

Mr. Randy Andrews, Videotape Operator.

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MR. WANTZ: For the record, we are here in Dr. Brahms' office for his videotape deposition on February 6th, 1992. I'm here for attorney Pat Roche who is representing the Defendant in this case.

Plaintiff's attorney, Donna Taylor-Kolis has not appeared for the deposition. It is now 6:15 p.m. Ms. Kolis was noticed of the deposition to begin at 5:30 p.m.

For the record, notice was sent to Ms. Kolis on December 9, 1991 by Mr. Roche advising her that a videotape deposition of Dr. Brahms had been scheduled and that it would take place this date, Thursday, February 6th, 1992 at 5-30 p.m., and that the deposition would take place at Dr. Brahms' office at 26900 Cedar Road, Beachwood, Ohio. Ms. Kolis has not appeared, Under the circumstances, I'm going to go forward with the deposition.

For the record, I would also state that I have attempted with Dr. Brahms to

reschedule the deposition in order to accommodate Ms. Kolis' failure to appear. However, the trial is scheduled for February 24, 1992.

Dr. Brahms has indicated that he has no time available to reschedule this deposition as he will be out of the state. Is that correct, doctor?

DR. BRAHMS: Yes, I will be out of the state.

MR. WANTZ: From February 8 until February 24th.

DR. BRAHMS: The 25th.

MR. WANTZ: The 25th. I'm sorry. And will not be returning is that correct, doctor?

DR. BRAHMS: That's correct.

MR. WANTZ: Thank you.

MR. ANDREWS: We are now ready to begin the deposition. Will the Reporter please swear in the witness?

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MALCOLM A. BRAHMS, M.D., called by the defendant for the purpose of direct examination, as provided by the

Ohio Rules of Civil Procedure, having been first duly sworn, as hereinafter certified, deposed and said as follows:

DIRECT EXAXINATION OF DR. MALCOLM A. BRAHMS

BY MR. WANTZ:

MR. WANTZ: Again, let the record show that we are here for the deposition of Dr. Malcolm Brahms which is being taken in this case and that this deposition is being taker? *to* preserve the doctor's testimony for the trial.

Q. Doctor, could you state your name for the record?

A. Dr. Malcolm A. Brahms.

Q. And where are we at the present time?

A. At my office, *26900* Cedar Road, Beachwood, Ohio,

Q. Doctor, are you a duly licensed physician in Ohio?

A. I am.

Q. When did you obtain your License?

A. 1950.

Q. Have you Seen practicing continuously since you obtained your license, ***doctor?***

A. I have been practicing since I completed my residency in 1955, and I Gave been practicing since that time continuously, yes.

Q. Doctor, could you tell us where you obtained your

education starting with your undergraduate background?

A Sure. I'm a graduate of Case Western Reserve University.

After graduating from the Ohio College of Chiropody in 1941, I completed a residency program, first year rotating internship at Cleveland City Hospital now known as Cleveland Metropolitan General Hospital, followed by another year of training at that institution, followed by a year at Mt. Sinai Medical Center in Cleveland, Ohio, and two years at Indiana University Medical Center in Indianapolis, Indiana.

Q Thank you, doctor. Doctor, do you specialize in any particular branch of medicine?

A Orthopedic surgery.

Q What is orthopedic surgery?

A Orthopedic surgery is that branch of medicine that deals with the investigation, preservation and restoration of the form and function of the musculoskeletal system by medical, surgical and rehabilitative means.

Q Would that include, doctor, the Sack, the spinal column, various parts of the back?

A. Yes.

Q. Doctor, would your practice also include what is known as neurological evaluations of patients?

A. Yes. Certainly when we examine any part of the upper extremities or lower extremities of the spine, it includes an evaluation of the neurological structures as well.

Q. Are you on the staff of any hospital or hospitals, doctor?

A. Yes, Mt. Sinai Medical Center and Suburban Community Hospital.

Q. Do you belong to any professional societies or organizations?

A. I do.

Q. And what are those, doctor?

A. I belong to the Cleveland Academy of Medic-ne; the Ohio State Medical Association; I'm a member of the American Medical Association and a Fellow of the American College of Surgeons; I'm a Diplomate of the American Academy of Orthopedic Surgeons; I belong to the Cleveland Orthopedic Society; the Ohio State Orthopedic Society; the Mid American Orthopedic Society; the Clinical Orthopedic Society; I'm a member of the American Academy of Orthopedic Surgeons for Sports Medicine;

I'm one of the founding members of the American Academy of Orthopedic Surgeons for the Foot and Ankle.

I belong to the International Society of Orthopedics and Traumatologists and some other minor groups as well.

Q. Doctor, you mentioned American Board of Orthopedic Surgeons. What is that exactly?

A. It's a body of men practicing orthopedic surgery who have succeeded ana completed training in orthopedic surgery and have qualified to practice orthopedic surgery.

Q. And you mentioned that you are a Diplomate in that organization?

A Yes.

Q. What does that mean to be a Diplomate?

A I'm certified to be in the American Academy of Orthopedic Surgeons which requires an AMA approved residency in orthopedic surgery and a completion of that residency followed by written and oral examinations, followed by the mandatory practice of orthopedic surgery for twc years, again followed by a written and oral examination. The successful completion of those requirements entitles one to become Board certified.

Q What does Board certified mean, is that something over and above having a license to practice medicine?

A Yes, that's correct.

Q Does that mean that you are additionally qualified to be an orthopedic surgeon?

A Yes

Q Doctor, when did you obtain your certification to be a Diplomate in the American Board of Orthopedic Surgery?

A 1958.

Q Doctor, during the course of your practice as an orthopedic surgeon, Go ycu treat people who have injuries of the neck and back?

A Sure. Yes.

Q Doctor, at the request of my office, specifically Mr. Fat Roche, did you have an occasion to examine the Plaintiff in this matter, Beverly Bell?

A I did.

Q And that, of course, was done at the request of Mr. Roche?

A That is correct,

Q And Mr. Roche has worked out an agreement to compensate you for your time spent on this matter?

A That is correct.

Q Doctor, do you recall when you first saw Miss Bell?

A. Yes, I saw her on the 1st of September of 1989.

Q. And, doctor, at the time that you saw her did you obtain a history from her?

A. I did,

Q. And could you tell us please what the history is?

A. She told me that she was involved in an automobile accident at the intersection of Drexmore and Van Aken Boulevard, and she said that she was the driver of her automobile, and that she was wearing a seat belt.

She said that her automobile was struck on the left side near the front door. The impact caused her to be, quotes, shook rap, end of quotes.

She denied unconsciousness,

She was unable to recall whether or not she struck any portion of the interior of the automobile.

She said she proceeded to go home and that evening was seen at Lutheran Hospital Emergency Room. She was examined, X-rays were taken and she was admitted to that hospital for a period of two days.

She did not identify the doctor who treated her.

When she was discharged, she was later

seen at Deaconess Hospital where she was examined on the 24th of July of 1989.

Q. 1989, doctor?

A 1987. I'm sorry. 1987.

The same year of her automobile accident she said she was sent there by her son. She was not admitted to that hospital. She was examined and x-rays were taken.

The emergency room record revealed that she was quote, a 54 year old white female in a motor vehicle accident two days ago and was admitted to Lutheran Hospital and received C spine x-rays and laminograms. Final diagnosis was no fracture of the cervical spine,

The patient told me that she did not like her doctor, that she had overheard some conversations about a possible disk injury which was seen on the laminograms.

She came to that hospital, Deaconess Hospital then, for a reevaluation.

She also had mild upper back and shoulder pain, And the note indicated that a Dr. Kirschner was notified.

She was referred by her attorney to Dr. Gabelman, She reported that he did, quotes, a

gauntlet of tests, end of quotes.

Re recommended therapy.

He provided hem: with a TENS unit, a TENS unit being a treatment of applying a small unit which projects an impulse which is felt through the skin which is supposed to modify pain symptoms.

She said that she had a lot more tests that was performed.

She was never hospitalized,

She said that an MRI examination was also obtained.

At the time of my examination on the lst of September of 1989, she said that she had pain on the right side of her neck which awakened her,

She said she had an ache in her right arm and that she drops objects,

She said the pain in her neck began the night of the accident and several days later she experienced the pain in her right upper extremity.

She said that occasionally she visits Dr. Gabelman and Dr. Mars, but has had no specific treatment far a year prior tu the time

I examined her,

She was able to comb her hair, however with some difficulty.

She was able to brush her teeth using her left hand.

She said she was able to drive, however she had difficulty turning her head and prefers others to drive.

She is able to drive herself, She has difficulty buttoning the clothes in the back.

She said she is right handed, She fastens her bra in front as she has always done,

When she reaches overhead, she does so with pain.

She reports no back pain.

It was her impression that she also ha an EMG examination but did not know the results of that test.

She said she does all her own household duties, but in some activities she gets help,

She is no longer able to bowl, which was her chief sporting activity.

She was working as a waitress.

Two months after her accident size did some work as a cashier and told me at the time of

the examination that she is now a manager of sane apartment buildings.

That was the history that she gave me.

Q. Thank you, doctor.

Doctor, you mentioned a couple of terms there and I just, if I could before we go on, you said the cervical spine. Could you tell us where the cervical spine is?

A. Yes, that is the neck portion, That is the part of the body from the base of the neck, base of the head, down to the shoulders.

Q. And you also mentioned the term laminograms. What are laminograms?

A. A laminogram is a special. form of an x-ray which takes *x-rays* in slices so that, for example, if a radiologist wants to examine a certain part, let's say it's a part perhaps two inches, he may cut slices every quarter of an inch or every half inch so that he can examine the front and the back or the side, either side in a more detailed manner.

Q. Doctor, another term you mentioned was an MRI. What is that?

A. An MRI is a sophisticated examination, It's a magnetic resonance imaging test. It's a test

done by the patient lying on the table and a magnetic field is established which produces a film of a three dimensional spectroscopic form which gives the radiologist the opportunity not only to see the parts but to get a thorough examination with different forms, different parts of the body, different tissues producing a different signal so that he can tell the difference between bone, between fascia, between muscle, between arteries, veins, ligaments, et cetera.

Q. Doctor, you mentioned fascia. What are fascia?

A. Fascia is a gristle. When you eat a steak and that part which is tough, the gristle, *that* is fascia.

Q. Doctor, the one last type of examination mentioned was an EMG.

A. An EMG is a test that will examine the speed in which a nerve transmits an impulse. It also is a test that discerns the activity of muscles, whether they act normally or abnormally.

Q. So that test *is* used to test for neurological and/or muscle problems?

A. That's correct.

Q. Doctor, did you then, after you obtained a history,

do an examination of Mrs. Bell?

A. I did.

Q. And what did that reveal, doctor?

A. That examination revealed that we are dealing with a 56 year old, 120 pound, five foot four inch female.

The examination of the neck and cervical spine was -- revealed that she was able to Send her head forward 50 degrees, a normal range, She was able to look up at the ceiling, which we call extension, 45 degrees, which is a normal range.

She was able to turn her head to either side and this was accomplished to 30 degrees, These movements were limited at the extremes of the motions on both sides.

The shoulder joint motions were measured and she was able to raise her arm up to the side, inside, outside, and all. those ranges were within normal limits.

She had no evidence of any muscle spasm in the area of her neck.

We checked the reflexes and found them to be normal.

She demonstrated no evidence of any muscle

soreness in the trapezious muscle which is that muscle that goes from the nape of the neck out to the shoulder,

And she had no scapular angle tenderness which is another site on the upper: back which we checked to see whether or not there is any pain or tenderness in that area,

She demonstrated then a form of sensory loss which we designate as glove type hyposthesia which means that no matter where the extremity is examined, on the inside or the outside, from the top to the bottom, there was a difference in the sensation between the right and left and this is ai? abnormal response, Glove type hyposthesias are manifestations of someone who may be either denying pain or is a hysterical type of component,

Q I'm not sure I understand what you're saying, doctor, Are you saying that it is not really there?

A That's -- it is not, it cannot, there cannot be a glove type hyposthesia because we know that there is a certain geography of distribution of the nerves from the brain and the brachial plexus that would designate every nerve in the

neck region which goes into the arm. When one has a circumferential or glove type hyposthesia that just doesn't work that way,

Q. How did Miss Bell demonstrate this glove type hyposthesia? Because I think you indicated a lot of tests there that you said were all normal,

A. Sure.

Q. How did she manifest or demonstrate it to you?

A. When she was checked with a pinpoint in her upper extremities, she, on the right side, would not be able to feei the pin, but was able to feel. it on the left side, whether we touched her on the inside of the arm or the outside of the arm, upper arm, lower arm, wrist, hand, all of this was as if it was covered with a glove, that she could not feel it. That is abnormal.

Q. And you're saying from an orthopedic or a neurological standpoint that that should not be happening if she was --

A. Yes, that's correct, It should not and cannot happen where all of the nerves in the upper extremity are completely senseless.

Q. I see, Thank you, doctor,

Could you -- was there any other examination that you performed?

A. Yes, a low back examination. The patient was able to stand on her heels and toes, and she was able to bend forward 90 degrees which is a normal range.

The straight leg raising sign, meaning raising her leg from the table measuring that arc, was found also to be within the normal limits.

She demonstrated no sensory loss, no motor loss or any reflex change.

She demonstrated no difficulty getting on and off the examining table.

She did not guard any movements of her neck when she went from a sitting to a lying position on the table, and it was noted that there was less guarding of her neck at the end of the examination as compared to that which was noted at the beginning of the examination.

It was also noted that she had no evidence of any glove type hyposthesia in the lower extremities.

Q. Doctor, what do you mean by guarding of her neck movements?

A. When a patient has a painful neck, when one asks them to lie down after sitting, most people who have acute pain in their neck, will hold on to

their neck and guard their movements in lying down and will want a certain Level of the pillow on the examining table so that the discomfort in the neck is minimized, That was noted,

Q. Hiss Bell did not ask for those things?

A. That's csrrect.

Q. I see. Doctor, did that complete your physical examination,

Q. Did you examine any records or any other material in connection with rendering your opinion?

A. I did.

Q. Ana what did *you* examine?

A. I examined the records that were submitted from Dr. Gabelman and from Dr. Mars,

I saw the emergency room record that was obtained as well.

Q. Doctor, did that complete everything that you examined in connection with rsndering your opinion in this matter?

A. Yes, that's correct.

Q. Before I get to your opinion, doctor, as I understand it, subsequent to rendering your initial opinion on September 5, 1989, you were provided with some additional information which you also have reviewed, is that correct?

A. That's correct.
Q. What other information were you provided, doctor?
A. The examination of the EMG and the MRI studies.
Q. Doctor, as a result of your examination of Miss Bell, the review of the records that you have received and your experience and training as an orthopedic surgeon, did you come to a -- did you reach an opinion to a reasonable degree of medical certainty as to whether Miss Bell suffered any injuries in this automobile accident?
A. Yes, I did.
Q. And what is that opinion, doctor?
A. Well, I thought that she sustained, at the time of the accident, some soft tissue injuries to her neck region, that the injuries that she sustained in a patient of this age group should respond favorably within a reasonable period of time, not to exceed 12 weeks and that the sophisticated tests that were taken and examined by the doctors who obtained those and the records that I reviewed, showed no evidence of any abnormal tests that were performed.
Q. Doctor, you mentioned the term soft tissue injury, What does that mean?
A. Soft tissue injury refers to anything in that part

of the body which is injured except for bone, meaning the skin, fascia, muscles, tendons, ligaments, et cetera.

Q. So you're saying that what you believe Miss Bell suffered was injuries to the muscles, skin and fascia of her neck?

A. No, I think what she had was an injury really to th ligamentous structures of the cervical spine which secondarily involves some degree of splinting of the muscles of the neck,

Q. And it's your opinion that based on your experience she should have recovered from that in a maximum period of about 12 weeks?

A. Yes, in this age group a person who otherwise is healthy, I would suspect that that period of time is sufficient for someone to recover fro:?? a soft tissue injury,

Q. And do I also understand you to say that the tests such as the EEG, EMG and the MRI all revealed no injury to her from this accident?

A. The radiologist, on her CT scan it was reported that she had a slight bulge of one of the disks. A CT scan of the cervical spine is not a very satisfactory examination.

The MRI is a better examination, which was

done.

The radiologist did not think that there was any abnormality and I agreed with that interpretation.

Q. Doctor, there has been some mention in this case by other doctors who have seen Miss Bell of a bulging disk approximately two or three millimeters in bulge. What does that mean?

A. Well, that was reported on the CT scan; (A) I don't think the CT scan is a good test in the cervical spine; (B) I don't think that two or three millimeters is of any significance; and (C) there is no evidence by a better test that there is any nerve root involvement that would imply that there is a disk injury,

Q. When you say nerve root involvement, what do you mean by that?

A. Well, in order for the patient to experience pain as a result of an injury to a disk, it implies that the disk must be irritating or pushing pressure on a nerve which is not demonstrated.

Q. There is no evidence of that in this case?

A. There is no evidence.

MR. WANTZ: Okay.

Thank you, doctor, I have no other

questions.

THE WITNESS: Thank you.

MR. ANDREWS: Doctor, you have a right to review this tape in its entirety or you may waive that right.

THE WITNESS: I waive it, I also waive signature on the transcript,

(Signature waived,)

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CERTIFICATE

The State of Ohio,
County of Cuyahoga, ss:

I, William J. Mahan, a Notary Public within and for the State of Ohio, authorized to administer oaths and to take and certify depositions, do hereby certify that the above-named DR. MALCOLM A. BRAHMS was by me, before the giving of his deposition, first duly sworn to testify the truth, the whole truth and nothing but the truth; that the deposition as above set forth was reduced to writing by me by means of stenotypy, and was later transcribed into typewriting under my direction; that this is a true record of the testimony given by the witness, and that the reading and signing of the deposition was expressly waived by the witness and by stipulation of counsel; that said deposition was taken at the aforementioned time, date and place, pursuant to notice and stipulations of counsel; and that I am not a relative or employee or attorney of any of the parties, or a relative or employee of such attorney, or financially interested in this action.

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office, at Cleveland, Ohio, this 12th day of February, A.D. 1992.

William J. Mahan

William J. Mahan, Notary Public, State of Ohio
1450 Midland Building, Cleveland, Ohio 44115
My commission expires January 19, 1995.

#498

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

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IN THE COURT OF COMMON PLEAS

- - -

ELMER JAMES ROTHMAN,)
)
Plaintiff,)
)
vs.) Case No. 119,621
)
CONSOLIDATED RAIL CORPORATION,) Judge Joseph McManaman
)
Defendant.)

- - -

DEPOSITION OF MALCOLM A. BRAHMS, M.D.

Thursday, April 21, 1988

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The Deposition of MALCOLM A. BRAHMS, M.D., a witness, called by counsel on behalf of the Defendant for examination under the Ohio Rules of Civil Procedure, taken before me, Janet M. Schlifer, a Notary Public in and for the State of Ohio, by agreement of counsel and without further notice or other legal formalities, at 26900 Cedar Road, Beachwood, Ohio, commencing at 6:15 p.m., the day and date above set forth.

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APPEARANCES:

On behalf of the Plaintiff:

Michael B. Michelson, Esq.
Michael J. Rogan, Esq.
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On behalf of the Defendant:

William F. Gibson, Esq.
Gallagher, Sharp, Fulton & Norman
6th Floor, Bulkley Building
Cleveland, Ohio 44115

ALSO PRESENT:

J. J. Sullivan
Tom Baker, Multi-Video

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STIPULATION

It was stipulated by and between counsel for the respective parties? and with the consent of the witness, that the reading and signing of the transcript of this deposition is expressly waived.

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MALCOLM A. BRAHMS, M.D.

a witness called by counsel on behalf of the Defendant for examination under the Rules, having been first duly sworn as hereinafter certified, was deposed and said as follows:

DIRECT EXAMINATION

BY MR. GIBSON:

Doctor, my name is Bill Gibson, and we're here today for your deposition.

Would you begin by giving us your full name, please?

A. Dr. Malcolm A. Brahms.

Q. And, Doctor, we're currently in your office. Would you indicate what the address is here?

A. 26900 Cedar Road, Beachwood, Ohio.

Q. And this is the Mount Sinai Medical Building; is that correct?

A. That is correct.

Q. All right.

Doctor, what is your profession?

A. Physician, orthopedic surgeon.

Q. And what is orthopedics?

A. Orthopedic surgery is that branch of medicine that deals with the investigation, preservation and restoration of the form and function of the

musculoskeletal system by medical, surgical and rehabilitative means.

Q. I notice, Doctor, that behind you are numerous sports pictures.

Do you have any connection with sports medicine?

A. Yes. I did at one time, yes.

Q. What was that, Doctor?

A, I was the orthopedic physician for the Cleveland Bulldogs, the Cleveland Indians and the Cleveland Browns.

Q. And that was during what time period?

A. A period of 15 years for the Cleveland Browns, 1965 through 1980.

Q. All right. And in regard to you educational background, Doctor, what is the educational background that you have had that got you up to this point?

A. I'm a graduate of the Ohio College of Chiropody, and then a graduate of Western Reserve University Medical School.

I served a year of internship at Cleveland City Hospital, now known as Cleveland Metropolitan General Hospital, a year of general surgical training at that same

institution, followed by three more years of orthopedic surgical training; one at Mount Sinai Medical Center, and two at the Indiana University Medical Center in Indianapolis, Indiana.

THE VIDEO OPERATOR: Excuse me, we're off the record.

(Whereupon, there was a discussion off the record.)

BY MR. GIBSON:

Q. Doctor, immediately prior to this deposition beginning, you had been sworn in by the Court Reporter. And you understand that in the course of your testimony you are remaining under oath, obviously.

A. Yes, that is correct.

Q. Can you indicate for us what the term Board certification means?

A. Yes. To be Board certified in orthopedic surgery, it requires that one complete a AMA approved orthopedic residency in an approved hospital setting. Following that, a written and oral examination is given, two years of orthopedic practice is required, followed by another written and oral examination.

Successful completion of all of those requirements entitles one to become certified.

Q. And, Doctor, are you Board certified?

A. I am.

Q. When did you receive that Board certification?

A. 1958.

Q. Are you a member of any medical associations or organizations?

A. I am.

Q. And what would that entail?

A. I belong to the Cleveland Academy of Medicine, to the Ohio State Medical Association, to the American Medical Association.

I am a Fellow of the American College of Surgeons. I am a Diplomate of the American Academy of Orthopedic Surgeons.

I am a member of the American Academy of Orthopedic Surgeons for Sports Medicine.

I'm a founding member of the American Academy of Orthopedic Surgeons for the foot and the ankle.

I am a member of the Cleveland Orthopedic Club, the Clinical Orthopedic Society, the Mid-America Orthopedic Society, the International Orthopedic Society, International

Orthopedist and Traumatology society, and some other minor groups, as well.

Q. Very well.

Now, Doctor, you have previously described orthopedics. In your role as an orthopedic surgeon -- by the way, are you affiliated with any hospitals?

A. I am.

Q. What hospitals would that include?

A. Mount Sinai Medical Center and Suburban Community Hospital.

Q. Now, in your role as an orthopedic surgeon, did you have an opportunity to see Elmer Rothman?

A. I did.

Q. Do you recall when you saw him?

A. On the 14th of December of 1987.

Q. And that was here in your office?

A. That is correct.

Q. And that was for purposes of an examination; is that correct?

A. That is correct.

Q. Did you take a history from Mr. Rothman at that time?

A. I did.

Q. And what was the result of that history taking?

A. He told me that on the 15th of January of 1985 that he was injured at work for the Conrail Corporation.

He said that he was installing a fuel line in an engine and he slipped on an icy surface, resulting in a back injury.

He reported that he did stay on the job, and was seen at Euclid General Hospital, either that day or shortly thereafter.

He was treated with medicine. He was not certain whether or not any X-rays were taken at that time. And he was referred to his local family doctor for continued treatment. He was seen by a doctor at the Euclid Clinic,

For two weeks he was assigned light duty. He reported to me that this meant that he was to report for work but stayed in the dispensary. He has not returned to work since March of 1985.

He states that surgery was recommended. He's uncertain who the doctor was that made that recommendation,

The patient reports that he has had an EMG, a CT scan and X-rays.

He's been told that he had, quotes, a

pinched nerve and needs surgery, end of quotes. He has thus far had no surgery.

He told me that he was referred to Dr. Gabelman by a friend, He was hospitalized at Hillcrest Hospital, traction was used, physical therapy was used, for approximately nine days.

At a later time, a myelogram was performed. He reported that he also had a thermogram and, at least, a second CT scan. He continued to have physical therapy, and takes medication.

He described his job to me that he does laborer's work, which includes fueling locomotives, servicing supplies of a janitorial nature.

He also has a second job, that of doing some light delivery for an advertising company. He has been working for them since April of 1987. This does not include any heavy lifting.

At the time that I examined him, he reported that he has a constant pain in his back, which is aggravated by long sitting or standing. Walking causes increasing difficulty. He is not troubled by driving, He lifts 35 pounds or less. Coughing and sneezing

aggravates his symptoms: however, bowel movements and intercourse do not.

He has paresthesias. He kneels and stoops keeping his back straight. The pain awakens him, and he has morning stiffness. That was the history that he gave me.

Q. All right.

By the way, was there a past history that he had indicated?

A. I asked him in the past if he had had any previous injuries, and he denied any previous back injuries.

He told me that he's been working for the Conrail System for 11 years.

He's never had any operations. The medicines that he takes are muscle relaxants, sleeping pills and pain pills. That was the past history.

Q. Now, after taking that history, did you have an opportunity to examine him?

A. I did.

Q. And is that examination something that is done here in the examination room?

A. That is correct.

Q. And you would examine him as you would examine

somebody else --

MR. MICHELSON: Objection.

Q. -- someone else who came in with a problem or a complaint: is that correct?

A. He had a routine, orthopedic physical examination.

Q. All right.

Doctor, what were the findings of that examination?

A. We were dealing with a 40-year old, 230 pound, five-foot eleven-inch male.

The patient demonstrated that he was able to stand on his heels and his toes. It was noted that he was wearing a TENS unit.

He is able to bend forward 60 degrees, and does flex his knees at the extremes. His reflexes were found to be physiological at the knees, and one plus at the ankles bilaterally.

His calf measurement on the right was 42 centimeters, and on the left 41 centimeters. There is a suggestion of some decreased sensory perception in his right lower extremity.

The patient was able to dress, get on and off the examining table and turn on the examining table without difficulty.

Q. Doctor, if I can stop you at that point, you had indicated he could stand on his heels and toes.

Is there a significance to that finding?

A. This is a measure of motor activity; tells us whether or not there's any motor weakness in the muscles of the leg and the foot.

And the fact that the patient is able to do so means that there is no obvious abnormal motor weakness.

Q. So, based on the findings that you, yourself made and observed, there was no evidence --

MR. MICHELSON: Objection.

Q. -- in that test, to indicate any kind of motor damage or nerve damage?

MR. MICHELSON: Objection.

A. That strictly is for muscle weakness, which would include muscle strength and the enervation of those muscles by nerves.

Q. And I believe you also indicated that he could bend forward to approximately 60 degrees?

A. That is correct.

Q. What is the significance of being able to bend to that extent?

A. Sixty degrees in a man weighing 230 pounds, in

my opinion, is a normal range.

Q. All right.

And, in regard to the reflexes that you tested, that's where he crosses his legs and you strike his knees: is that correct?

A. Yes, that is correct.

Q. And what is the significance of that finding which you made?

A. That the knee reflexes are physiological, and the fact that both ankles react, as I said, one plus, that equality and bilaterality makes it a normal finding.

Q. All right.

You also tested his ankles, I believe, for reflex: is that correct?

A. That's what I'm talking about.

Q. Oh, I'm sorry.

A. The latter was the ankle reflex.

Q. Now, you conducted some measurements of his leg; is that right?

A. I did.

Q. You've indicated the findings. I believe it was 42 centimeters right --

MR. MICHELSON: Objection.

Q. -- and 41 centimeters left; is that correct?

A. That is correct.

Q. All right.

Is there any significance to that finding?

A. One centimeter of difference is of no clinical significance.

Q. That would indicate nothing in terms of --

MR. MICHELSON: Objection.

Bill, you can't testify. This is his deposition: not yours.

MR. GIBSON: I understand, Mr. Michelson.

But he's already testified. I'm simply following up with a question.

MR. MICHELSON: You're following up with a statement.

I'm objecting to all of these statements. Not only are they leading, but they're your testimony.

And if you are not going to do it right, then you're going to have it all stricken later.

BY MR. GIBSON:

Q. Doctor, nothing that was said so far is because I've asked a question a particular way, is it?

MR. MICHELSON: Objection.

A. I read the physical examination and reported that there was a one centimeter difference in circumference of his legs, which is of no significance from a clinical standpoint.

Q. And I take it that -- well, clinically, would there be any correlation between that and a condition known as atrophy?

A. There is no reason to believe that this represents atrophy.

Q. Doctor, there has also been some scientific testing that was done on Mr. Rothman. Are you familiar with those tests?

A. I am.

Q. Which tests are you familiar with?

A. Well, he had a CT scan on February the 20th, 1985. There was evidence for that examination of a central L5-S1 disc.

And he had CT scan done at Hillcrest Hospital, which was interpreted to be within normal limits.

He had a myelogram study done: also within normal limits, with the evidence of a central protrusion.

He had an EMG examination, which was'

within normal limits.

Q. Doctor, I take it from -- based on what you've just said, are any of those findings consistent with any kind of objective evidence of a physical defect?

MR. MICHELSON: Objection.

A. Central disc seen on a CT scan or a central protrusion on the myelogram is of no clinical significance in a man who is 230 pounds.

Q. All right.

And so if I understand your testimony, not one of the scientific testing that you have just referred to is consistent --

MR. MICHELSON: Objection,

Q. -- is consistent with a disc herniation?

MR. MICHELSON: Objection,

A. The tests that were performed, the CT scans and the myelogram, are interpreted to be within the limits of normal.

MR. MICHELSON: Objection to the leading questions, objections to the statement, objection as being asked and answered and repetitious.

Q. All right.

Now, Doctor, were you aware that Mr.

Rothman also had had a thermogram performed?

MR. MICHELSON: Objection,

A. I am.

Q. In fact, what is your understanding of that test, as was done on Mr. Rothman?

MR. MICHELSON: Objection.

A. A thermogram is a test which, in my opinion, has no value whatsoever.

It is a gimmick procedure, useful in demonstrating to whoever wants to read that that there are some pretty pictures, but is not a test recognized by orthopedists, the College of Orthopedists, the College of Radiology, the College of Neurosurgeons as a test with any validity,

It is not an AMA recognized test.

MR. MICHELSON: Objection,

Q. Now, Doctor, at the time that I asked you to examine Mr, Rothman, I also provided you with medical records that pertain to Mr. Rothman; is that correct?

A. That is correct.

Q. All right. Can you list for us what medical records had been provided for your review?

A. Yes.

I reviewed some records from Hillcrest Hospital, from the Euclid Clinic Foundation, Euclid General Hospital, Suburban Rehabilitation Center, a report of Dr. Gabelman, records from the Upjohn Health Care Service, a report of Dr. Curran, of Dr. Mars, and also the Conrail medical files.

Q. Now, Doctor, I believe I asked you, did I not, to form certain opinions concerning, to form a diagnosis and a prognosis in this case?

A. Yes.

Q. All right. And were you able to form opinions concerning the diagnosis and prognosis as to Mr. Rothman?

A. Yes.

Q. Are all the opinions you formed in this case within the bounds of reasonable medical certainty?

Yes.

All right. Understanding that I am not going to ask you the term "reasonable medical certainty" with every question, can we follow through with that understanding, in terms of any opinion you offer?

A. Yes.

Q. All right.

Doctor, what opinion did you return in terms of diagnosis?

MR. MICHELSON: Objection.

A. I thought that Mr. Rothman sustained a soft tissue injury at the time of his fall.

I thought that he did not have any demonstrable objective evidences at the time that I examined him consistent with a herniated disc.

It's my impression that he has a lumbar myofascitis, and one in a patient of this size and weight, with overuse, repeated bending and lifting could have recurrence of low back discomfort.

Q. Doctor, you've referred a number of times to Mr. Rothman's weight, I believe you testified it was around 230 pounds.

A. That is correct.

Q. What is the significance of that?

A. Well, individuals who are of 200 pounds or more are big people, who have an increase in their lumbar lordosis.

And as one approaches middle age, the increase in the size and the weight bearing in

the lumbar spine may produce some facette changes and be a product for low back discomfort.

Now, a moment ago, Doctor, you referred to lumbar lordosis.

Starting with the word "lumbar," could you assist the jury with understanding what that term means?

Yes, The lumbar spine is that part of the back which is the low back region or the area of the waist and lower. It's that area from the lowest rib down to the sacrum.

All right.

It is a flexible, movable segment of the spine.

And there is a normal -- all of us have normal lordosis. As people get larger in size, and principally obese people, there is an increase in this lordotic posture, with an increased pressure on the facette joints in the lumbar spine.

This may lead to degenerative changes in the facette joints and produce low back pain.

All right.

Now, in regard to the term you referred to as "lordosis," or "lordotic," what does that

term mean?

A. In the lumbar spine, the curve has a convexity towards the abdomen.

In the dorsal spine, which is in the area of the ribs, from the neck to the lumbar area, there is a normal convexity in the opposite direction.

And in the cervical spine, the normal curvature is, again, a lordotic curve.

So we have normal curves, which, if accentuated, produces abnormal pressure on some of the small facette joints, which causes degenerative changes, now, of these articular facettes.

And as we get older, all of us, as we get older, demonstrate degenerative changes. But those who are obese or large have an increasing tendency to demonstrate these changes better.

Q. And in regard to the facette joint you have referred to, is there a way you could help us laymen understand what that's in reference to?

A. Yes.

Throughout the spine, from the cervical down to the lumbar, on each side of each vertebra there are two little joints called

facettes.

Those are small articular joints. And they help us in moving forward and backward and sideways.

And the lumbar spine is a movable segment, as is the cervical spine. More motion there than in the dorsal spine.

And those facette joints can wear out and produce pain.

Q. And that's on account of what, that would cause them to wear out?

A. Well, normally, they would wear out if there is any malalignment or injury; that would be the only reason.

And as I've said before, after we reach 39 years of age, we all demonstrate some degenerative changes in our lumbar spine.

Q. All right.

Now, earlier, in testifying as to your diagnosis, you referred to a soft tissue injury.

What did you mean by that term?

A. Well, I meant that the injuries that he sustained were to all of the parts which are soft tissue in nature, meaning the skin, the

muscles, the tendons, the ligaments, everything other than the bony structures.

And if the patient demonstrates arthritic changes prior to an injury, for a short period of time, that arthritic change may also be aggravated.

Q. Doctor, did you find any injury, then, to Mr. Rothman's facette joints from this accident?

A. I didn't X-ray Mr. Rothman. And I did not see any of his X-rays which were reported,

I am stating that on the basis of my personal experience and the likelihood for people who have low back discomfort.

Q. Understanding, then, the nature of your diagnosis pertaining to soft tissue injury, were you able to make a prognosis as to Mr. Rothman's condition?

MR. MICHELSON: Objection.

A. I think that I did mention already that he is likely, with overuse, and with excessive duties at work, to have some low back discomfort.

And these should respond favorably, as well, to the natural powers of recuperation and rest.

Q. With this type of injury that you've diagnosed, is there a period of time in which you would expect to see that injury last?

MR. MICHELSON: Objection.

A. Yes, I think that one would expect that a person who has an insult of this nature, which is greater than the normal activities of daily living, a fall being a formidable insult on the skeleton, that in a patient of this size, this age, that a minimum of six weeks would be necessary for him to recover.

Q. All right. Is there a maximum that you as a doctor would expect to see for recovery time?

MR. MICHELSON: Objection.

A. Yes, I think that a person would, again, principally because of his size, may take as long as 12 weeks.

MR. GIBSON: I have no further questions at this time.

MR. MICHELSON: Thank you.

- - -

CROSS-EXAMINATION

BY MR. MICHELSON:

Q. Dr. Brahms, we have been introduced. My name is Michelson, and I am representing Mr. Rothman

in this claim. Now it's my turn to ask you a few questions.

Doctor, your Board certification was in 1958; is that correct?

A. That is correct.

Q. And when was it that you completed your residency at Indiana and Mount Sinai?

A. 1955.

Q. And, Doctor, you would expect, I presume, that somebody who is a Board certified orthopedist, that alone would tell you that that person is certainly a qualified orthopedist, then, has qualified in the orthopedic skills and discipline.

A. Yes, that is right.

Q. All right.

Doctor, I certainly did not commit to memory the list of organizations and societies you are in.

That list, other than the Board certification, which I guess is one of the societies or organizations you listed, the others, do you have to qualify specially for those, other than being a Board certified and judged competent orthopedist?

A. Yes, in order to be in any of the societies that I have listed, one has to be Board certified.

Q. Right. But other than that.

I meant is there a special qualification test, for example, to get into the American Medical Association, to be a member, other than being a physician and a medical doctor?

A. One can be a member of the American Medical Association without being an orthopedist.

Q. Right.

A, Yes.

Q. And the Ohio State Medical Association?

A. One has to be a doctor to be in the American --

Q. That is right.

A, -- and the Ohio State Medical Association.

Q. Right.

Now, certainly, your opinion is that Mr. Rothman, nothing you have been shown indicates Mr. Rothman is a surgical candidate; is that correct?

A. In my opinion.

Q. In your opinion.

A. In my opinion, he is not a surgical candidate.

Q. And we understand that when I do ask questions

like that, of course, we're eliciting your opinion.

Now, you mentioned he was wearing a TENS unit. What is a TENS unit?

A. A TENS unit is a physical therapy modality instrument that emits a kind of a stimulus, submaximal in its character, a kind of a sensory impression that the patient gets.

It interferes with the normal -- or, the abnormal~not the normal. It interferes with the abnormal sensory reflex and attempts to minimize the discomfort that the patient is experiencing from this chronic form of pain.

Q. And that is a palliative technique, is it not? It's one that either masks or to some extent minimizes or eliminates pain. That's its purpose.

A. It ameliorates the pain. It doesn't eliminate it.

Q. Right.

And that is a prescription device, is it not?

A. Yes.

Q. All right.

Now, you indicated that Mr. Rothman was

able to bend to 60 degrees! which you consider to be normal! because of his size.

A. That is correct.

Q. All right.

Certainly, there are people of his size who can bend, in the natural course of things, more than 60 degrees.

A. Depends! if they are more flexible, yes.

A 230-pound person, that's pretty good range. But if he's flexible! he could go even more so.

Q. For example, yourself, what would be a natural -- somebody of your size; not you, personally, of course. But somebody of your size and age, would you be able to bend, for example, 90 degrees flexion?

A. No, I can't, because I have a certain amount of hamstring muscle tightness that doesn't permit me to do that.

Q. That is an abnormality.

A. It's not an abnormality.

Q. Okay.

A. That's part of the way I was born, put together.

Q. I see.

And, what would be a normal flexion for somebody of normal or average height and weight?

A. Sixty-five should be the least, and generally between 65 and 90 for most people.

Q. Now, you say a CAT scan that shows evidence of a central disc bulging, or whatever this showed, that is a normal sign?

You're not saying it's normal.

A. It's not normal, but it's not abnormal.

Q. Well, I heard you say before it's not clinically significant.

A. That is right.

Q. But it's still not normal.

A. Yes, but it's not abnormal.

Q. What do you mean by that?

A. Because we can see central discs in people who never had a backache.

Q. And you can see them in people who had a backache.

A. That is right, exactly,

Q. Okay.

And the EMG that you reviewed, the EMG test was normal, the result.

It was recorded normal. But in Dr. Gabelman's

report, he indicated that there was some evidence of some L5-S1 radiculopathy.

The formal report, as I recall, suggested that it was normal.

Q. Oh, I see.

You're thinking there was a single -- your understanding is there was a single EMG, electromyogram done.

A. Yes, that's what I'm thinking, yes.

Q. And in your recollection it was Dr. Gabelman's assessment that it indicated an L5 radiculopathy?

A. That is right.

Q. But, in fact, the EMG was reported itself to be within normal limits.

A. That's my recollection, yes.

Q. All right. Would there be significance if it was in fact indicating an L5 radiculopathy?

A. EMGs are probably the most useless test for lumbar spine problems of all the tests, other than thermography, which is useless.

MR. NICHELSON: We'll object to that, since it's non-responsive, and we have yet to establish that Dr. Brahms has any qualification or foundation to make that

statement.

Q. But be that as it may, you consider the EMG to be a useless --

A. Fairly unnecessary test.

Q. But you indicated in your testimony that it was negative.

A. Yes.

Q. I'm asking you if there is any significance at all to it being positive.

A. Yes, it would, if there was a significant reason for the patient -- for the test being positive.

EMGs, I'll repeat again, are not a very useful test in lumbar disease entities.

Q. Well, an EMG is an objective sign or examination, is it not?

A. Yes.

It's far better for the upper extremities than it is for the lower extremities.

Q. Doctor, please.

MR. MICHELSON: Objection. Move to strike. Simply unresponsive.

Q. I'm asking you a simple question. Please, just restrict your answers to the question.

A. Yes.

Q. Please.
A. Yes.
Q. An EMG is an objective test that is an objective sign, when it's given to you; is that fair?
A. Yes, an EMG is an objective test.
Q. That's all I'm asking.
A. Yes.
Q. And if, in fact, an EMG showed an L5 radiculopathy to a mild degree, as you indicate in your report, that itself would be an objective sign or an objective result of some examination.
A. Which requires interpretation.
Q. Of course.
A. Sure.
Q. But yet, nonetheless, objective.
A. Yes.
Q. All right.

And certainly not normal.

A. That is correct.
Q. Now, the lumbar myofascitis that you described, as I understand a myofascitis -- certainly, a lumbar myofascitis is a diagnosis, as you've stated. That is an orthopedic diagnosis.

A. It's a wastebasket orthopedic diagnosis.

Q. Meaning?

A. Meaning that it's some way of saying the patient has a backache.

Q. Oh, I see.

Myofascitis itself has no scientific significance or orthopedic significance?

A, It's another way of putting down that the patient has a backache.

Q. I see.

Are there other definitions in the text for myofascitis?

A. I think that that's about the way it's used, generally.

The term "myofascitis" means "myo" meaning muscle, "fascia" meaning fascia, and "itis" means inflammation,

And there is no indication that there's any inflammation of the muscle or the fascia. So it's a term that we use very loosely.

And as I said, it's a wastebasket diagnosis,

Q. I see.

A. It means that the patient has a backache.

Q. So when I look in the text, I'm going to find

them telling me that myofascitis is a syndrome and a condition which is a wastebasket and rather than them telling me that it is an inflammation of the fascia tissue surrounding the muscles; is that correct?

A. I think that you will find that the diagnosis of myofascitis has a number of interpretations by a number of different people.

Q. I see. Okay.

Now, does Mr, Rothman, in fact, have an increase in the lumbar lordosis?

A. I am sure he does.

Q. Do you know whether he does or not?

A. I'm positive he does.

He weighs 230 pounds. And he stands almost six feet tall. He must have,

Q. He must have an increase.

A. Yes, he must, unless he has --

Q. Do you know if he does?

A, He --

MR, GIBSON: Objection to cutting off the answer.

A, (continuing) The answer is that he must have, unless the man has a form of arthritis of the back, which makes him a spondylitis victim.'

Q. I see.

You have not examined any X-rays that indicate whether or not his lordosis is normal, abnormal, increased, decreased?

A. I think I stated that I did not see any of his X-rays.

Q. Okay.

Do you know if he has any facette changes?

A. I made that statement on the basis of my experience.

I did not see any X-rays, and I testified to the fact that I have not seen his X-rays.

I am bringing that out as a point of experience only.

MR. MICHELSON: Objection, as unresponsive.

Q. Doctor, so you don't know if he has any facette changes.

A. That is correct.

Q. And do you know if there are any -- well, this may be the same question.

That would include, of course, any degenerative changes in the facettes; you don't know that.

A, No, only on the basis of my experience.

Q. And any degenerative changes in the rest of the spine, do you know?

A, I have not seen any of his X-rays, and unless it's in the X-ray reports, I would have no other way of telling you that.

MR. MICHELSON: Off the record.

THE VIDEO OPERATOR: Off the record.

(Whereupon, there was a discussion off the record,)

BY MR. MICHELSON:

Q. Doctor, just a few more questions, if I may,

A. Sure.

Q. I want you to describe, if you would, for the jury, what is an epidural block?

A, An epidural block is a test, therapeutic or diagnostic, performed by, generally, an anesthesiologist: can be performed by an orthopedist or a neurosurgeon.

And it's the placement of a needle into what is known as the epidural space, and medicine is injected, medicine which includes substances like Xylocaine or drugs like Xylocaine and, frequently, steroids.

Q. My understanding is that this is done for a

chronic pain syndrome. If we're talking about lumbar or low back, particularly, we're talking about a chronic or on-going pain problem. That's the purpose for these blocks: is that correct?

A. I said it can be therapeutic or diagnostic.

And if it is for chronic pain, it's for the purpose of therapeutic nature.

It can also be done as a diagnostic test.

Q. In somebody who you -- in this, as we're discussing here with chronic pain, somebody who gets this injection -- which is an injection into the back, isn't it?

A. Yes.

Q. Near the spine?

A. Yes.

Q. And if it's done for therapeutic purposes, explain, would you, please, what you mean when you say therapeutic?

A. Therapeutic purposes means that it's done with the anticipation that the patient will benefit from the medications which are used.

Q. Okay. And that would be for pain relief, I suppose?

A. Pain relief, if it's done for that reason.

It can be done for other reasons, as well. But in this instance, if it's done for pain relief, it includes the use of drugs which have a numbing effect.

Q. All right, That would be the Xylocaine, and anesthetic-type material.

A. That is correct,

Q. And the steroids are used as anti-inflammatories?

A. That is correct.

Q. And their purpose, as I understand it - you correct me if I am wrong -- their purpose is to reduce the inflammation in the nearby -- or, in tissue in that area, so that there can be, perhaps, a longer standing benefit to somebody who is suffering from inflammation and pain in the area,

A, If indeed there is an inflammatory component, yes,

Q. Okay.

Now, as I understand it, Doctor, what you said, there is also a diagnostic purpose for these, or at least it can be used for a diagnostic purpose.

A, Yes, that is right.

Q. And so, if somebody is using it for therapeutic purposes, they can also gain some information diagnostically from this modality of treatment.

A. Yes, that is correct.

Q. All right.

Now, you would expect that if somebody was actually having a problem, a severe or a significant problem anatomically or pathologically or to the tissues of the body, you would expect, first, a report of immediate relief upon the injection of this material into their back; is that correct?

A. Yes. shortly thereafter, yes.

Q. And they would report truly relief of the pain that they had been reporting before.

A. Yes, that is correct.

Q. All right.

And then, you would further expect that there may be some continuing and on-going relief from the use of the steroids, even after the anesthetic, which is a short duration anesthetic, as I understand it, wore off; is that right?

A. Yes.

Even if one doesn't use steroids,

sometimes the anesthetic agent can break up an abnormal reflex, and the patient can benefit from that alone,

Q. All right.

And over a period of time, this type of technique or modality of treatment may very likely, and often is, temporary in nature: is that correct?

A. Generally speaking, it is temporary in nature, However, in some instances, it might be completely therapeutic,

Q. Now, in your -- I'll withdraw that.

Doctor, will you agree that a competent treating physician who treats a patient over an extended period of time and has the occasion to see that patient treat, see how that patient reacts, and deal with that patient over a period of time is best fit to render opinions concerning the care, treatment and condition of that patient?

A, Yes, that is true,

Q. Doctor, just a few more things.

Now, Doctor, you have done this examination at the request of Mr. Gibson; is that correct?

A. Yes, that is correct.

Q. And when he sent you all of the materials that you've described, in addition to that, he sent you a covering letter of some two pages and change, describing the case and describing what he understood the case to be and what he wanted: is that correct?

A. Yes, that is right.

Q. All right. And we've looked at that before this. I mean, there's no secret involved. We've marked it.

Would you please show us which letter that is?

Okay, Doctor, I'm going to just -- very temporarily,

MR. MICHELSON: Could we please mark this as Plaintiff's Exhibit 1 in the testimonial deposition of Dr. Brahms?

And we'll arrange for copies and markings afterwards.

BY MR. MICHELSON:

Q. Thank you.

A. Okay.

Q. Now, Doctor, you did this, as I said, at the request of Mr. Gibson and his firm; is that

correct?

A. Yes, that is correct.

Q. All right.

Now, Doctor, we can agree on certain things, I hope. And we've cleared them up before. But for the record, you do do these evaluations and reports on a fairly regular basis; is that correct?

A. Yes, that is correct.

Q. Now, in addition to any independent evaluations or evaluations such as you've done for Mr. Rothman, I understand you evaluate your own patients, certainly.

A. Yes, that is correct.

Q. And you write reports for people who are representing them in claims?

A. That is correct.

Q. And that would be claimant's work, work on behalf of a claimant.

A. Sure, that is right.

Q. But, in regard to the pure evaluation situations where it's simply for the purpose of an examination, evaluation and report, it's fair to say that the far greatest percentage that you do is for defendants, law firms, those

who are representing them, or employers; is that a fair statement?

A. I'd like to just remove one of your adverbs, the word "far," and the answer to that question is yes.

Q. And is there any way to tell me the percentage of those?

A, No, I don't have any knowledge of the percentage.

Q. Okay. And you do those, as I understand it, sometimes -- or, not sometimes. You do them approximately one or two per day in the office.

A, Yes, that is correct.

Q. And that would be, generally, four or five days a week?

A. Yes.

Q. For a normal work week.

A. That is correct.

Q. And is it fair to say that you work, your normal work weeks include at least 40 weeks a year?

A. Yes, that is correct.

Q. In the office.

A. Yes, that is correct.

Q. All right.

And your charges for these, for the time and for these examinations are how much for the examination?

A. $125,

Q. And for the report?

A. $150.

Q. In addition to that, Doctor, you are compensated for any time you spend in reviewing records --

A. That is correct.

Q. -- for those reports?

A. That is correct.

Q. And how much do you charge for that?

A. $150 per hour.

Q. Is there any way to approximate how much time it generally takes you to prepare for the examination and report, review records, on an average evaluation?

A. Anywhere from 20 minutes to three hours.

Q. Okay.

And, in addition to that, of course, you are compensated for your time in regard to consultations, as you have with Mr. Gibson, in preparation for depositions?

A. Yes.
Q. And at what rate are you paid for that?
A. $150.
Q. Per hour?
A. Per hour, that is correct.
Q. And in addition to that, of course, testimonial time, for depositions in the office is how much?
A. A deposition is $500 for the first hour, and $150 for every half hour thereafter.
Q. All right. And if you are required to go to Court and testify, which you do from time to time, are the rates the same for that --
A. No.
Q. Well, let me finish the question.
A. Sure.
Q. Are they the same for that, based upon time out of the office?
A. That is correct, that is correct.
MR. MICHELSON: One moment, please. Could we go off for one moment?
(Whereupon, there was a discussion off the record.)
BY MR. MICHELSON:
Q. Very briefly, Doctor, do you, yourself -- have

you ever discussed thermography with any of the physicians, orthopedists, radiologists and medical men who are using that technique?

A. Oh, yes, I know who those doctors are.

Q. Who do you know who uses it?

A. Dr. Gabelman, Yasowitz and Kaufman,

Q. In Cleveland.

A. In Cleveland.

Q. Right.

Do you know who uses them elsewhere? For example, at Johns Hopkins University, do you know who's using them there?

A. I receive across my desk, frequently, literature concerning thermography,

And I am aware that thermograms are done elsewhere, with the same criticisms that I gave before.

MR. MICHELSON: Objection.

Q. Doctor, are you aware of the physicians who are using them at Johns Hopkins?

A. I don't know the person, the doctors, personally, no.

Q. Are you familiar with those using them at Columbia University?

A. I do not know those physicians.

Q. How about in California, University of California? Are you aware of those?

A. It's very frequently in California. A lot of gimmick stuff is done in California.

Q. Right. UCLA and University of California Medical Schools, they are using this, Are you aware of who, and who is using them there?

A. All of the physicians at Columbia, Johns Hopkins, Cleveland, none of those are members of the societies that I mentioned who recognize them, in the radiology, neurological, neurosurgical or orthopedic societies, of any nature,

Q. You're sure they're not members?

A. I didn't say they weren't members.

I said it's not a recognized test by the individuals in, who are in charge of those particular societies.

The society does not look upon thermography in any of those societies with any validity whatsoever.

Q. I see.

Doctor, just so -- we'll say it again, then.

You said none of the doctors at those'

institutions who use thermography and have experience in thermography are members of the societies which you mentioned, the Orthopedic Society --

A. I did not --

Q. Is that what you're saying?

A. I did not say that at all.

Q. Then I was mistaken.

A. You are mistaken.

Q. Are those doctors members of those societies?

A. They certainly may well be, as the doctors here in Cleveland are.

That doesn't mean that the thermogram is looked upon by the societies that I mentioned as a valid test.

Q. You are a member of the American Medical Association?

A. I am.

Q. Do you know who the -- or, what the Council on Scientific Affairs is of the American Medical Association?

A. The most recent decision of the AMA referable to thermography is that they have not --

MR. MICHELSON: Objection.

Q. -- made any recognized authority for

thermography,

MR. MICHELSON: Objection, That is unresponsive.

Q. Doctor, do you know who the Council on Scientific Affairs of the American Medical Association is?

A, Obviously, I don't know everybody in the medical profession over the United States,

Q. Do you know who the American Medical Association's Council on Scientific Affairs is?

A. I think I answered that, I do not.

Q. You do not?

A. I do not know who that individual is, or the council.

Q. No, it's not an individual. It's a council.

A. I don't know any of the members of that council.

I mentioned a few minutes ago, AMA has avoided anything on thermography to this date.

Q. Are you telling me you're unfamiliar with the American Medical Association's Council on Scientific Affairs?

Do you know if there is such an organization?

A, I do not know that there is, There may well be, but I don't know that there is.

Q. I see.

So you certainly wouldn't be familiar with any reports they've recently come out with on thermography.

A. I have -- I do not know of any favorable reports for thermography by the AMA.

Q. Okay, fine.

And if there is one, would that change your mind?

A. Not a bit.

Q. Why is that?

A. Because it is a gimmick test.

Q. No, no. But if they proved that it wasn't, would that change your mind?

A. If it is proven to be a valid test, it will change my mind.

Q. And if one of the major committees on scientific study of the American Medical Association indicates that thermography may in fact have some very real value in diagnostic -- for diagnostic purposes as an adjunct to the other techniques which you've described for evaluating problems of a neuromuscular nature, would that change your mind?

MR. GIBSON: Objection, both --

A. I can --

MR. GIBSON: Wait, let me just put an objection before you answer.

Objection both to lack of foundation, as well as to the form of the question.

A. Thermography is a --

MR. MICHELSON: Objection.

A. (continuing) I will --

Q. Please answer the question.

A. I hope that the Judge and the jury will understand that the --

MR. MICHELSON: Object.

A. (continuing) -- position of thermography I can explain from a theoretical and an academic use.

Thermography is useful in research. It has no value in the diagnosis of a herniated disc.

Q. And you'll have that opinion, whether or not the American Medical Association, its societies and its councils report that it does.

A. Until --

Q. Is that the idea?

A. No, that's not the idea.

Q. Okay, thank you.

A. Until --

MR. MICHELSON: No further questions.

A. I will answer that. Until --

MR. MICHELSON: No further questions. There is no question posed.

A. I think the Judge will --

MR. MICHELSON: Please don't take down his statements and lectures.

A. I think the Judge and the jury will be glad to know that when it is recognized --

MR. MICHELSON: Objection.

A, -- as a test of validity, I, too, will agree that it has some value.

MR. MICHELSON: Oh, good.

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REDIRECT EXAMINATION

BY MR, GIBSON:

Q. . Doctor, I have a few questions on redirect.

We've talked a little bit about thermography and qualifications.

If a doctor or a technician -- do you have to be a doctor? by the way, to get a thermograph?

MR. MICHELSON: Objection.

Q. Do you know?

A. The thermograms are done by technicians in doctors' offices.

MR. MICHELSON: Objection.

A. (continuing) A doctor can do the test, as well as a technician do the test.

Q. Well, Doctor, if somebody goes out and purchases a thermograph, is there any licensing procedure that's necessary to start using that thermograph on a patient?

A, No, there is not.

Q. Is there any kind of certification process?

MR. MICHELSON: Objection.

A. No, there is not,

Q. You simply buy it and start using it?

A. It can be, can be a diagnostic tool used for pecuniary purposes to this point in time, except in research.

Q. All right.

MR. MICHELSON: Objection.

Q. Now, Mr. Michelson has asked you about a council that has done work for the AMA.

Regardless of what that council has done, are you aware of whatever opinions the AMA itself, the American Medical Association has rendered in terms of thermography?

A. Yes. The AMA has avoided any recognition or interpretation for thermography to this point in time.

MR. MICHELSON: Objection.

Q. By the way, does the Cleveland Clinic, with all of their scientific equipment, with all their --

MR. MICHELSON: Objection.

Bill, please don't make speeches. Now just ask the questions. Enough is enough.

MR. GIBSON: Mike, if you have an objection, you have every right to make it.

MR. MICHELSON: I'm making it.

MR. GIBSON: But I'm asking you not to run over the doctor's answers and my questions.

MR. MICHELSON: I'm making the objection. Stop testifying. Ask him questions.

BY MR. GIBSON:

Q. Doctor, with the facilities at the Cleveland Clinic that we're all familiar with, are you aware of whether they have a thermograph?

A. I am not aware that thermography is being used on a clinical basis at Cleveland

least by the orthopedists, and I think I know all their orthopedists.

Q. Are the hospitals that you're affiliated with using thermographs?

A, We do not have a thermogram at the hospitals that I work at.

Q. All right,

Now, Doctor, the opinions that you've rendered so far, is that based upon your expertise and your training?

MR. MICHELSON: which opinions? Objection.

Q. The opinions you've returned as to your diagnosis and your prognosis?

A. Would you ask the question again?

MR. MICHELSON: Objection.

A. (continuing) I didn't get it because of the --

Q. Are those opinions based upon your examination and your expertise?

MR. MICHELSON: Objection, leading: objection, asked and answered: objection, improper redirect.

Q. Go ahead, Doctor.

A. The opinions that I've rendered are based on my experience and my examination, and my

understanding of the records that I reviewed.

Q. All right.

Doctor, are you familiar with the term of secondary gain?

A. I am.

Q. All right.

MR. MICHELSON: Objection.

Q. (continuing) Mr. Michelson got into the effects that somebody can have with an epidural nerve block.

MR. MICHELSON: Objection.

Q. (continuing) Can secondary gain factor into those findings?

A. Yes.

Q. All right.

How would that be, Doctor?

A. Individuals, during physical examinations and/or sophisticated tests, may record results obviously different from that which is anticipated or expected or proven, and do so, principally, on the abnormal pathophysiological and psychiatric physiological aspects of their desires to get well or not to get well.

Q. All right.

Now, Doctor, you earlier had testified as

to the recovery rate for the kind of injury that Mr. Rothman had complained of.

A. Yes.

Q. When you examined him in December of 1987, almost three years after the accident, was he complaining to be symptomatic at that time?

A. I thought that the patient was cooperative. I thought that he was in no way demonstrating any abnormal psychological aspects.

I think that his inability to return to work from March of 1985, referable to that which I found on my examination, is abnormal.

Q. All right. Would that be consistent with secondary gain?

A. Yes, it would.

MR. GIBSON: I have no further questions,

MR. MICHELSON: One moment, please.

(Whereupon, there was a discussion off the record.)

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RECROSS-EXAMINATION

BY MR. MICHELSON:

Q. Doctor, just briefly, on what Mr. Gibson just asked you, and it's only about the very last

question and answer. Regarding this inability to return to work, explain that to me. I'm sorry, I don't understand what you meant to say.

A. In my opinion, there are individuals who are employed and sustained injuries of sometimes a major, sometimes of minor degree, and who fail to return to their normal occupational and work habits for reasons that they lack motivation.

Q. And how does that lack of motivation exhibit itself, in your experience?

A. Anyone who has an injury which in my opinion entitles him to return to work and doesn't do so for -- whether they are abnormal psychological responses or because the patient, for reasons of, perhaps, a secondary gain, may not desire to go back to work, and that to me is abnormal.

Q. So that when they have this, what you consider inappropriate response to a physical problem which cannot really be fully demonstrated by you, that is, they don't return to their occupation, but they, in fact, seem to be taking too much time off, as it were, that to you is the indication of their lack of

motivation and this, perhaps, reliance upon looking forward to a secondary gain?

A. Yes, I think that's right.

Q. And that somebody else is going to take care of them, so they don't have to work, and they stay out of work in order to make some dramatic gesture by showing how they're not able to do anything.

A. Yes, that's not an infrequent occurrence.

Q. All right.

And that's your opinion about Mr. Rothman, then.

A. No, I said that Mr. Rothman was a cooperative, intelligent, nice person. I failed to understand why a person of this nature, with this injury, could not return to work.

Q. And so, you don't understand why he has not returned to work.

A. That is correct.

Q. And why he isn't working at the present time.

A. That is correct.

MR. MICHELSON: I have nothing further. Thank you.

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FURTHER REDIRECT EXAMINATION

BY MR. GIBSON:

Q. Doctor, I have one final question.

There was a reference to a letter I'd written to you and what I wanted,

Is there anything in that letter where I asked you to make any specific finding?

A. No, you did not.

Q. All right. I simply asked for your opinion?

MR. MICHELSON: Objection. The letter will speak for itself.

A. Yes.

MR. GIBSON: Fine.

THE WITNESS: Fine.

MR. GIBSON: Doctor, you have an opportunity to waive signature. Do you do so?

THE WITNESS: I waive it,

MR. GIBSON: All right. No further questions.

THE VIDEO OPERATOR: Excuse me, Doctor, you also have the right to review this tape in its entirety, or you may wish to waive that right.

THE WITNESS: I waive it.

THE VIDEO OPERATOR: May we also have a

stipulation between counsel that Multi-Video remain custodian of the tape until the time of showing at trial or arbitration?

MR. GIBSON: Yes.

MR. MICHELSON: You better be a good custodian, too.

(Whereupon, Plaintiff's Exhibit No. 1 was marked for identification.)

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(Deposition concluded.)

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CERTIFICATE

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

I, Janet M. Schlifer, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within-named witness, MALCOLM A. BRAHMS, M.D., was by me first duly sworn to testify the truth, the whole truth and nothing but the truth in the case aforesaid; that the testimony then given by him was by me reduced to stenotypy in the presence of said witness? afterwards transcribed upon a typewriter? and that the foregoing is a true and correct transcript of the testimony so given by him 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, employee or attorney of either party, or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland? Ohio, on this 23rd day of April, 1988.

Janet M. Schlifer, Notary Public
in and for the State of Ohio.

My commission expires November 8, 1992.