UNINSURED MOTORIST CLAIM

IN RE:

Doc 248

Robert McPherson,

vs.

Westfield Insurance Company.

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Deposition of DENNIS B. BROOKS, M.D., a witness herein, called for cross-examination by Robert McPherson, taken before Michelle A. Bishilany, a Registered Professional Reporter and Notary Public within and for the State of Ohio, at the offices of Dennis B. Brooks, M.D., 26900 Cedar Road, Beachwood, Ohio, on Thursday, the 13th day of August, **1992**, at 4:22 p.m.

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APPEARANCES:

Willis & Linnen, by
Mr. Jerome T. Linnen, Jr.,

On behalf of Robert McPherson;

Davis & Young, by
Ms. Jan L. Roller,

On behalf of Westfield Insurance Company.

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(Exhibit 1 was marked for identification purposes.)

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DENNIS B. BROOKS, M.D., of lawful age, a witness herein, called for cross-examination by Robert McPherson, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

CROSS-EXAMINATION

BY MR. LINNEN:

Q. Doctor, I'm Jay Linnen. I represent Bob McPherson in this action which we have against Westfield Insurance Company.

I'm sure you've been through this process many times. I'm going to ask you a few questions about your background very briefly and then I'm going to conduct a discovery deposition about your examination of Bob McPherson.

If I ask you a question and you don't understand, of course, let me know. Give a verbal response for the court reporter.

How long have you been an orthopedic surgeon?

A. Good afternoon.

How long have I been an orthopedic surgeon? 21 years -- well, actually that's not true. I

finished my residency in 1968. 24 years.
Q. 24 years you've been an orthopedic surgeon?
A. Yes.
Q. Have you been engaged in a specific specialty in those 24 years?
A. No. I practice general orthopedics.
Q. Do you do surgery currently?
A. Yes.
Q. What types of surgeries do you do?
A. General orthopedic surgery.
Q. So you're not limited to any specific areas of the body?
A. If I were I would have told you.
Q. Okay. Approximately how many medical examinations do you perform a week for attorneys?
A. I don't really keep track of it so I can't tell you how many I perform per week for attorneys.
Q. All right. I'm not asking for a specific number, but approximately how many times a week do you find yourself examining patients for insurance companies or attorneys?
A. Again, I don't keep track of it so I can't tell you.
The only thing I can tell you is that 1 limit myself to three examinations on behalf of

defendants.

I also examine on behalf of plaintiffs, and I don't know how many of those, I don't have any limit on the number of those.

Q. So that's three examinations a week?

A. On behalf of the defendant, yes.

Q. Have you ever performed an examination for Mr. Eklund or his firm prior to Mr. McPherson?

A. Yes.

Q. Do you have a file concerning Mr. McPherson?

A. Yes.

Q. May I take a look at it?

A. Sure.

Q. Thank you.

What do you generally charge for a so-called independent medical examination?

A. I don't have a general charge.

Q. Well what do you charge for that service; do you know? I assume that you're getting paid?

A. I certainly hope that I'm being compensated for my time.

When I do an independent medical I don't have a flat rate fee for an independent medical.

Q. Well then do you charge an hourly basis?

A. Yes.

Q. What would your hourly basis be then?
A. At the present time?
Q. Yes.
A. $325 an hour.
Q. And you indicated that on occasion you perform examinations for plaintiffs?
A. Yes.
Q. I assume that's some type of independent examination at the request of the plaintiff's attorney?
A. Yes.
Q. Do you also -- on some of these independent medical examinations for attorneys do you also sometimes provide treatment?
A. Yes.
Q. So you examined Bob McPherson on May 28th of '92?
A. Yes.
Q. Approximately how long did the examination take, are you aware?
A. I don't know.
Q. No idea? All right.
Why don't we go through, we've previously marked as exhibit 1 your report which I believe you generated dated May 29th, '92.

I assume you've got, there was a copy I guess in your file, why don't you pull that out? We're going to skip over the history itself and let's go right to the physical examination that you performed and what complaints Mr. McPherson had on that date.

A. Whatever you'd like.

Q. Okay. What physical examination did you perform at the time of the IME?

A. Examined the cervical spine, his shoulders, his thoracic spine and his lumbosacral spine.

Q. Did you find any abnormalities with any of those areas of his body?

A. No, I did not find any abnormal objective findings with respect to any of those areas.

Q. Was there any indication of abnormal subjective findings?

A. Yes.

Q. What abnormal subjective findings did you discover?

A. There was limitation of cervical motion. There were complaints of pain with external rotation of the right shoulder.

There was decreased perception of pinprick in the left upper extremity. There was decreased perception of pinprick which extended from the

midline of the chest into the left upper extremity.

Extension was performed by walking up his thighs.

There was limitation of supine straight leg raising.

There was decreased perception of pinprick in the left lower extremity.

Q. Based on those subjective abnormalities did you draw any conclusions with respect to Mr. McPherson's condition? And from those findings did you make any conclusions that he had any abnormal condition?

A. I would never make any kind of conclusions based only on a physical examination.

Q. Okay. What other records did you take a look at?

A. I reviewed the emergency room record from Women's and Children's Hospital from March 24th, 1989; the radiographs that were obtained on March 24th, 1989; Chiropractor Shimmel's letter of March 3rd, 1990; Dr. Sveda's records, the period between May 18th, 1989 and May 25th, 1989; Dr. Lefkovitz's letter of August 14th, 1989; Dr. Lefkovitz's letter of June 13th, 1989; Chiropractor Fakhoury's, F-a-k-h-o-u-r-y, handwritten records; Dr. Smith's

letter of August 30th, 1990; Dr. Burke's letter of August 31st, 1990; Dr. Mann's letter of March 16th, 1992; and radiographs of the cervical spine obtained on January 8th, 1992.

Q. All right. Referring you to page four of your report. On the first paragraph you make an indication: Neurologic examination of the upper extremities reveal symmetrically depressed deep tendon reflexes. Can you explain that in laymen terms?

A. It meant that his reflexes were not active but they were depressed or not as active as the "average" is, but that decreased activity was present in each arm so that it was symmetrical.

Q. All right. If it's symmetrical does it cause any, does it raise any concern neurologically?

A. No. If it's symmetrical it does not raise any neurologic concern.

Q. Under any circumstances would that raise neurologic concern?

A. That's like asking me to define the universe and give examples.

Q. Then it ought to be easy.

A. It ought to be easy. I can't define the universe and give examples.

Are there any conditions where somebody could have symmetrically depressed deep tendon reflexes and that would be of concern neurologically?

I can't think of any.

Q. All right. How do you actually go about doing that; can you show me?

A. You want to come into the examining room? I mean, I can't believe you're asking these questions.

Take a little red rubber hammer and I put my finger over the biceps tendon and I palpate that. I also palpate the triceps tendon where it inserts into the ulna. And I also tap over the brachial radialis and the forearm.

Q. And from that you determined he had depressed tendon reflexes?

A. Yes.

Q. You also indicate that the left upper extremity had decreased perception to pinprick. And I think you're indicating because he's the one that tells you how it feels that that would be subjective?

A. That's correct.

Q. As a doctor does a doctor from time to time use subjective tests to make a diagnosis; yes or no?

A. No.

Q. Does he use that as one of the things in making a diagnosis?
A. Yes.
Q. And you also found symmetrically decreased deep tendon reflexes with the lower extremities and you didn't find that to be of any consequence; is that correct?
A. I can't answer that yes or no.
Q. And on your fourth page of your report the third paragraph down you could explain to me, you indicate that there was decreased perception of pinprick in the left lower extremity in a nonanatomic pattern. What do you mean by that?
A. May I answer it other than yes or no?
Q. Yes.
A. Thank you.
Each nerve root that leaves the area of the spine, and here we're talking about the lower part of the spine, the lumbosacral plexus, supplies a particular area of the body, and that's referred to as a dermatome or a myotome.
When an individual has a true problem or a true pathology with a particular nerve root as, for example, compression from a herniated disk or a tumor, and because of that compression there is lack

of conductivity down that nerve root, an examiner will pick up loss or decrease in perception of pinprick in a specific area.

Contrast that with Mr. McPherson's examination where he had a generalized decrease in perception of pinprick in his left lower extremity which was in a nonanatomic pattern. It didn't follow any nerve root distribution.

Q. Okay. There are more definitive neurological tests performed, I assume, such as the NCT and an EMG; would that be a correct statement?

THE WITNESS: Would you read back the question, please?

(Record read.)

A. There are additional neurologic tests other than those performed during a physical examination. I don't know whether they're necessarily more definitive or not.

Q. Would an NCT be more objective than your pinprick examination in your test of strength and so forth?

A. An NCT, a nerve conduction test, is more objective in that it measures certain parameters. But it is not the same test as my pinprick test which is the same as all doctors use, or my muscle

strength test.
Q. If a person complained of cervical pain in the cervical region and he was negative on an NCT and negative on EMG, is it still possible that he could have a disk problem of some kind?
A. I can't answer your question.
Q. What are the ways to make a diagnosis of a disk problem?
A. Where?
Q. In the neck.
A. Okay. Taking the patient's history, performing the physical examination. And then we've got to define what is a disk problem, I mean, I don't know what that means.
Q. How about if you have a patient that comes in and says he has a pain in the neck, how would you go about making that diagnosis as to what might cause that problem?
A. Okay. Somebody came in to see me and told me that they had pain in the neck, I would take their history, I would examine them and I would get some routine radiographs.
Q. What's a radiograph, an x-ray? Just a regular x-ray? Yes or no.
A. I can't answer that yes or no. Oh, yes, I

can answer that yes or no. The answer is no.
Q. What would be a radiograph?
A. Okay. A radiograph is the film that's produced when you have a machine generate some x-rays. It's like the stuff that you get back from Fotomat when you take your film in for developing, okay? Those are called radiographs.
And I'd obtained some routine radiographs.
Q. What would be a routine radiograph?
A. The radiographs that I order routinely. I mean, I don't understand your questions.
Q. Are you talking about a regular -- are you talking about an x-ray that shows density of the bone?
A. I just explained to you that an x-ray is the thing that the x-ray machine generates, okay? A radiograph, hell, we'll pull out 8,000 of them, that's the picture you look at.
Q. That's the actual film?
A. That's right, and those are called radiographs.
Q. And that could be an MRI?
A. No, that's a radiograph.
Q. All right.
A. It's a regular, routine radiograph, okay?

Q. All right.
A. And you look at those. And there are standard ones of the cervical spine.
Now, if the patient says that they've got a pain in the neck and they've got a normal physical exam and their routine radiographs are normal, then I would have no explanation for what their pain in the neck would be from. And then you take all the various permutations from there on.
Q. Which would be what?
A. Well, let's assume they have a complaint of pain in the neck and they have nothing on physical examination but they have some degenerative disk disease on the routine radiograph, some narrowing of one of the disk spaces. Then I could say well, their pain in the neck is probably coming from their degenerative disk disease. That's a disk problem.
Q. What other methods do you use to make that diagnosis of a disk problem?
A. You use the methods that you need --
Q. Doctor, 1 understand this is very elementary to you, okay, but I'm going to pay you for this --
A. I don't care whether you pay me or not, and I'm not trying to give you a hard time. But you're asking me questions that I can't possibly answer.

Because a disk problem is *so* nonspecific, there's everything from degenerative disk disease through herniated disk.

Now if you ask me a specific problem I'm happy to give you a specific answer.

Q. All right. How would you make a diagnosis of a herniated disk in the cervical spine?

A. Okay. I would make the diagnosis of a herniated disk in the cervical spine by obtaining a history and specifically looking in the history for complaints of pain radiating down one arm or the other arm in a dermatomal pattern.

I would perform a physical examination. And during the physical examination I would look for findings which would indicate that there was a problem with one of the nerve roots specifically supplying one of the dermatomes.

Then I'd get some routine cervical radiographs. And those, in fact, might look normal. They might, on the other hand, show some evidence of degenerative disk disease. But the routine films wouldn't demonstrate whether or not the patient had a herniated disk.

Q. What would demonstrate that?

**a.** Well, wait, I haven't finished. Finally gave

me a question I could answer and then you cut me short. That's not fair.

And then I'd treat the patient nonoperatively, okay? And after a period of time if they didn't get worse then I'd start exploring whether, in fact, they had a herniated disk.

And in 1992 I would order an MRI of the cervical spine.

Q. Has Mr. McPherson had an MRI of the cervical spine?

A. Not that I'm aware of.

Q. Have you recommended that an MRI be performed?

A. No.

Q. Do you think that would lead us to any, I mean, do you think that would assist in making a proper diagnosis of the condition that he's experiencing with his cervical spine?

A. No.

Q. Why do you say that?

A. Because I don't believe that his complaints are on the basis of a herniated disk.

Q. What do you base that on?

A. The history that I obtained from him, the examination that I performed, the review of the

radiographs taken at the time of the accident and the review of the radiographs that were taken some three years later as well as the material that I reviewed.

Q. What's the difference between a herniated disk and a bulging disk?

A. A herniated disk in 1992 has almost become a wastebasket term. That is to say it is a term that is used with very little specificity.

There really is a spectrum of disk abnormalities that range from a bulge, which is akin to, best example -- which is akin to a tire that's got a little bubble on it.

The next more significant problem would be a protrusion where part of the nuclear material has left its confines within the center of the disk and is causing a little more protrusion of the posterior longitudinal ligament in the annulus.

The next more severe situation is an extrusion, whether it's an actual tear in the posterior longitudinal ligament and the annulus, but the nuclear material is still in contact with the nucleus.

And finally there's a sequestered piece of disk which is just like when you sequester a jury,

it's separated from the disk itself. And even with those findings the condition cannot be called a herniated disk unless the patient's symptoms and physical findings correlate with whatever's seen on the MRI.

Q. Can a bulging disk create a painful condition in the cervical spine?

A. Generally not.

Q. So generally a person would be symptom free if they had a bulging disk in the cervical spine?

A. Generally, yes.

Q. Because it's not coming in contact generally with the nerve ending or any nerves?

A. That's correct.

Q. What does it mean when a bulging disk, when you find bulging disk with tenting? Have you ever heard that terminology before?

A. I was going to say most bulging disks don't go out camping, but I don't know.

Q. Have you ever heard that phrase before?

A. No, I really haven't.

Q. Do you know Dr. Zelch?

A. Dr. Zelch is a radiologist. I know of him.

I'd be happy to read Dr. Zelch's report of the MRI that apparently has been obtained since I

examined Mr. McPherson.

MS. ROLLER: I was going to ask you, and this can be on the record, do you have an MRI or even a CT scan that I'm --

MR. LINNEN: I do. I assume you had it.

MS. ROLLER: I don't think -- you examined him in May of this year, correct?

THE WITNESS: Right.

MS. ROLLER: This was July 1992.

THE WITNESS: I examined him in May of '92.

MS. ROLLER: Well, I have to tell you, Mr. Lemon --

MR. LINNEN: Linnen.

MS. ROLLER: Lennon, as in John.

MR. LINNEN: No, not as in John. As in cloth.

MS. ROLLER: Linnen?

MR. LINNEN: L-i-n-n-e-n.

MS. ROLLER: I should talk with a name like Roller.

In any event, Mr. Linnen, I'm here on behalf of Paul Eklund.

MR. LINNEN: I'm here on behalf of Mark Willis.

MS. ROLLER: And I can tell you that I'm aware that Paul Eklund does not have this, a report from the CT that -- oh, an MR of the cervical spine that was done at the Regional MRI Diagnostic Center on July 27th, 1992.

MR. LINNEN: What's your point?

MS. ROLLER: My point is that I would object to its use at the arbitration hearing. When is the hearing?

MR. LINNEN: I have no idea.

MS. ROLLER: Neither do I.

MR. LINNEN: I think it's first week in September.

MS. ROLLER: We have not --

MR. LINNEN: It might not have any significance, let's just give it to the doctor and see.

MS. ROLLER: Fine, let's give it to the doctor.

THE WITNESS: Off the record.

(Discussion had off record.)

MS. ROLLER: Do you have a report from this doctor or anybody --

MR. LINNEN: No.

MS. ROLLER: -- who ordered the MR; do you know?

MR. LINNEN: I'm not sure. I think maybe Lefkovitz did. They had trouble getting him in the tube originally.

MS. ROLLER: Yes, I saw that.

A. Okay.

MR. LINNEN: Can we mark this as an exhibit, 2?

MS. ROLLER: You wouldn't happen to have another copy, would you, so I can follow along?

(Exhibit 2 was marked for identification purposes.)

Q. Doctor, you've been handed what's been marked as Plaintiff's exhibit 2 --

A. Yes.

Q. -- which is or appears to be an MRI of the cervical spine of Bob McPherson. Is that what you have in front of you?

A. Yes, sir.
Q. All right. Dr. Zelch's conclusion: Bulging disks with tenting of the posterior longitudinal ligament at three levels. What significance, if any, does that have?
A. Before 1 answer your question I'd like to preserve the record and read what Dr. Zelch said in its entirety.

And he said: Bulging disks (2.0 mm) with tenting of the posterior longitudinal ligament at three levels.

The reason I do that is that a two millimeter bulge has no clinical significance, it does not cause any clinical symptoms. And there are a number of articles that refer to that point.

What he is saying, and I don't know why he's using the word tenting, but the posterior longitudinal ligament is a structure that is at the most peripheral portion of the disk. And what he's saying is that there's a little bulge that's causing the posterior longitudinal ligament to stick out, look more like a tent.
Q. Okay. I take it that you've never seen that type of conclusion before?
A. Not with that word, that's correct.

Q. Neither have I.

Well, would it be accurate to conclude that Dr. Zelch believes that a disk is coming in contact with the posterior longitudinal ligament? I mean, what conclusion would you draw?

A. It is fair to say that Dr. Zelch is making the conclusion that the disk is coming in contact with the posterior longitudinal ligament. In fact, all disks come in contact with the posterior longitudinal ligament.

Q. All right. But we're not quite sure what he means by tenting?

A. No. Maybe we ought to ask him.

Q. Looking at the rest of the MRI of July 27th. Do you see any other abnormalities in the report or anything that you would conclude to be an abnormality?

A. I want to be perfectly clear that I've not had the opportunity to review this myself so I'm just reviewing his description of this.

But in the second paragraph he says on T-2 analysis there is ridge-like indentation of the subarachnoid fluid column at C-3, C-4 and C-5, and that's probably abnormal.

Q. If that's probably abnormal, has it been your

experience that that type of condition would create any type of painful condition for a patient?

A. Not necessarily. That's an indicator of some arthritis. And the ridge that he's talking about is just a little bit of bony proliferation.

You notice that he says indentation of the subarachnoid fluid column and doesn't even say indentation of the cord. So this ridge is so small that all it's doing is causing a little, if you will, scalloping of the fluid column.

Q. All right. Would this MRI finding be consistent with any of the symptoms or complaints that Mr. McPherson had when he presented himself to you for examination?

A. No.

Q. Doctor, what does -- if you could explain to me what myofascial pain syndrome is. I'm not trying to be facetious, I'm not sure what it is.

A. Right. And I'm not sure what it is either, and that's why I was hesitating, okay? It's another one of those wastebasket type of diagnoses.

I mean, you can dissect it all out. Myo refers to muscle. Fascia refers to the covering of the muscle. So myofascial pain syndrome.

So what in essence it says is that somebody

has a set of symptoms for which there are really no physical findings and we've got to give it a name so we call it a myofascial pain syndrome.

Q. Is it referring to some sort of a membrane or covering of the muscle itself?

A. Well, you're absolutely right in that the fascia is the membrane or the covering over the muscle. But when you talk about myofascial you're talking about the muscle and the fascia. I mean, in the old days it used to be called myofascitis, but now we've gotten more sophisticated and called it myofascial pain syndrome.

MS. ROLLER: I must be getting old.

THE WITNESS: That's right.

Q. Let me ask you: When somebody experiences a routine, what is referred to as like a soft tissue injury of the neck, a sprain or a strain of the neck, in a situation like that many times it seems like the patient complains of pain and yet nothing shows up on radiograph or any other diagnostic test, but yet they're still experiencing pain.

A. That's true.

Q. In a situation like that if you had a patient in a situation like that, what type of diagnosis

would you make, just a sprain, strain of the soft tissues and they're expected to recover?

A. For the most part, yes.

Q. Have you seen situations or have you seen cases, have you treated patients where they had a so-called soft tissue injury and continue to have chronic pain without objective symptoms that you believed to be real?

I mean, many times it seems like people question a patient where nothing shows up objectively but they continue to complain of chronic pain.

Are there situations in your opinion that this could actually occur without any objective disk problem or neurological problem where the patient actually does experience pain as a result of some disorder?

A. I'm not trying to be facetious either, but you've asked me three questions, okay? Now which one do you want me to answer, the last one?

Q. Why don't you answer the last one.

A. Okay. I can't remember what it was.

The bottom line is have I treated patients who have complaints of pain and have no objective findings --

Q. Right.
A. -- following some kind of soft tissue injury.
Q. That's it.
A. And the answer is yes, I will treat them for a short period of time and that short period of time maybe four weeks, maybe six weeks.
And if they continue to have complaints of pain and there's nothing that I can find after doing routine studies, maybe even some more sophisticated studies, then I would say to them there's nothing more I can do for you and suggest if necessary they see a psychiatrist to help them manage whatever kind of nonorganic problems they're having.
Q. What do you mean by nonorganic problems?
A. Well, nonorganic means that the cause of their pain is really not in their body structures. I mean, this may have been a very -- it may have had a large psychological impact on somebody for whatever reason, okay? And so what they're doing is they are, what's called somatocizing, they're taking emotional feelings that they have, anger because they were in this accident, anger because they've lost their job, you know, whatever, and converting that into physical symptoms for which there are no physical findings. So they need to be able to first

recognize that and then deal with these things in the appropriate forum.

Q. Well is it possible that the soft tissues have been damaged such as ligaments or possibly muscles that injury itself would not show up on an objective test of any kind?

A. It is possible that ligaments and muscles can be damaged and that damage not show up on any objective test.

Q. I had a physician down in Akron, I won't give you his name, but he indicated that every time you had some type of a strain on the cervical spine or any part of the back for that matter that your body never fully recovered, that you would be, you can be more susceptible to injury but that it was never going to be completely the same before the accident even though you might not have symptoms. Would that be, I mean, is that an accurate statement? Is that an accurate philosophy?

A. I think it's true that once you're injured you never are again normal because you've always, you have some even microscopic remnant of that injury. But that doesn't necessarily mean that you're more susceptible to injury. And it certainly doesn't mean that you can go back -- that you cannot

go back and do what you were doing before the injury.

I mean, I tore my quadriceps so look at my thigh, it's not normal; and yet I can do all the things that I did beforehand.

Q. Well these types of soft tissue injuries that nothing objective can be found to make a diagnosis and sometimes they're labeled, you know, myofascial pain syndrome; do you believe that that type of syndrome actually exists? Have you ever made that type of diagnosis, I guess?

A. No, I've never made that type of diagnosis.

Q. I guess what I'm trying to get at is: Can a person experience a real pain without there being some objective neurological or orthopedic finding?

A. We're going to limit your question to injuries to the musculoskeletal system, right?

Q. Right.

A. People can voice pain or make complaints of pain when there are no objective findings either on neurologic examination or orthopedic examination.

Q. I understand that. But in situations like that even though I think you said people can voice pain --

A. Make complaints of pain.

Q. __ are you saying make it up?
A. No. No. It hurts. Walk in and say I hurt, that's voicing or making a complaint of pain.
Q. But I guess what I'm trying to find out is whether there could be a real physical problem without some objective determination either neurologically or otherwise.
A. Well, again, what I tried to say earlier is that I believe that initially there may be a real physical problem without any objective findings, but sprains and strains heal, they get better.
Q. They always heal?
A. The kinds of injuries that we're talking about that are limited to the soft tissues, okay, always heal.
Q. Without any residual problems or pain?
A. I believe so.

MR. LINNEN: I have no further questions.

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

CERTIFICATE

I, Michelle A. Bishilany, a Registered Professional Reporter and Notary Public within and for the State of Ohio, do hereby certify that the within named witness, DENNIS B. BROOKS, 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 was reduced by me to stenotypy in the presence of said witness, subsequently transcribed into typewriting under my direction, and that the foregoing is a true and correct transcript of the testimony so given as aforesaid.

I do further certify that this deposition was taken at the time and place as specified in the foregoing caption, and that I am not a relative, counsel or attorney of either party or otherwise interested in the outcome of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, this 20th day of August, 1992.

Michelle A. Bishilany, Holland & Associates, Inc.
520 National City - E. 6th Bldg., Cleveland, Ohio
My commission expires 1-11-96.

UNINSURED MOTORIST CLAIM

IN RE:

DOC. 248
(V)
(video)

Robert McPherson,

**vs.**

Westfield Insurance Company.

- - - -

Video deposition of DENNIS B. BROOKS, M.D., a witness herein, called for direct examination by Westfield Insurance Company, taken before Michelle A. Bishilany, a Regfatered Professional Reporter and Notary Public within and for the State of Ohio, at the offices of Dennis B. Brooks, M.D., 26900 Cedar Road, Beachwood, Ohio, on Thursday, the 13th day of August, 1992, at 5:12 p.m.

- - - -

HOLLAND & ASSOCIATES
(216)621-7786

APPEARANCES:

Willis & Linnen, by
Mr. Jerome T. Linnen, Jr.,

On behalf of Robert McPherson;

Davis & Young, by
Ms. Jan L. Roller,

On behalf of Westfield Insurance Company.

- - - -

EXAMINATION OF DENNIS B. BROOKS, M.D.



- - - -

DENNIS B. BROOKS, M.D.,

of lawful age, a witness herein, called for direct examination by Westfield Insurance Company, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

DIRECT-EXAMINATION

BY MS. ROLLER:

Q. Doctor, my name is Jan Roller and I'm here on behalf of Paul Eklund from the law firm of Davis & Young. And we are here to take your deposition for purposes of an arbitration hearing in the case of Robert McPherson and his claim against the Westfield Insurance Company.

Doctor, first of all, will you give us your name?

A. Dennis Bruce Brooks.

Q. And we are here in your office; is that correct?

A. Yes.

Q. And your office is located where?

A. 26900 Cedar Road in Beachwood, Ohio.

Q. Doctor, because this is an arbitration I will try to move through your credentials in a rather summary fashion.

You are a board certified orthopedic surgeon;

is that correct?
A. Yes.
Q. When did you receive your board certification?
A. 1971.
Q. Would you please tell the panel where you went to college and to medical school and when you graduated?
A. Graduated from Harvard University in 1959; and I graduated from Western Reserve University School of Medicine in 1963.
Q. When did you begin your practice as an orthopedic surgeon?
A. I guess it depends how you define practice.
I had six years of postgraduate training and then I served in the military for two years at which time I served as an orthopedic surgeon.
So between 1969 and 1971 I was practicing orthopedic surgery. And then in 1971 1 returned to Cleveland and have been in the continuous practice of orthopedic surgery since that time.
Q. Would you describe for the panel the nature of your practice?
A. I practice general orthopedic surgery.
Q. All right. And as an orthopedic surgeon you

have hospital privileges?
A. Yes.
Q. And where is that, what hospitals?
A. Mt. Sinai Medical Center of Cleveland.
Q. All right. And do you do teaching?
A. Yes.
Q. And where is that?
A. I'm an assistant clinical professor of orthopedic surgery at Case Western Reserve University School of Medicine. And I'm also on the orthopedic residency teaching faculty at the Mt. Sinai Medical Center.
Q. You have also authored articles?
A. Yes.
Q. And where have they appeared?
A. Majority of them have been in the Journal of Bone and Joint Surgery, one is in Clinical Orthopedics and Related Research and another is in the Journal of Orthopedic Trauma.
Q. All right. Doctor, did Paul Eklund of my office ask you to perform an independent medical examination of Mr. McPherson?
A. Yes.
Q. And did you do that?
A. I did.

Q. And on what date, sir?
A. I believe that was in May of this year, 1992. Specifically May 28th of 1992.
Q. And when you conducted that examination was there anyone else present in the room?
A. There was.
Q. And who was that?
A. I believe it was Mr. Willis.
Q. Did you understand him to be Mr. McPherson's attorney?
A. Yes.
Q. Doctor, did you take a history from Robert McPherson?
A. I did.
Q. Why don't you relate to the panel what that history was?
A. Certainly.

Mr. McPherson indicated to me that he was injured on approximately March 23rd, 1989 when he was lying on a bed in a van which was moving when the van was involved in an accident with a car.

The front end and both sides of the van were damaged. Mr. McPherson indicated they totaled it.

Although he did not remember his movements following the impact he did recall that when he

awoke the left side of his body was shaking. He was unable to find his dentures.

He told me that he had pain in his head and left shoulder for he had struck the back of the bench seat in the van.

He told me the accident occurred in Charleston, West Virginia. And he went to Charleston Women's and Children's Hospital soon after the accident.

There he was examined, treated and released with a cervical collar and a sling. He was given prescriptions.

He recalled that by the time he had pain in his neck, superior aspect of his left shoulder, in his jaw, and what he referred to as knee; he could not recall which knee was painful.

He told me that he and his family then proceeded to Crystal River, Florida.

Approximately four days after the accident the family returned back to Akron, Ohio. He told me his son did the majority of the driving on the way home.

Told me that within a week of the accident he came under the care of Chiropractor Shimmel.

Chiropractor Shimmel performed what Mr.

McPherson referred to as spinal manipulation and treated Mr. McPherson with hot packs, cold packs and so forth. Mr. McPherson indicated that the majority of the treatment was to what he referred to as the cervical area.

He received treatment approximately six to seven months. Initially he received treatment every other day and eventually received treatment every two weeks. He did recall that the treatments, as he put it, did relieve the pain temporarily.

Approximately six months after the accident he was examined by Dr. Sveda. A bone scan was performed and this revealed, as Mr. McPherson told me, there were no bone chips.

Dr. Sveda then referred Mr. McPherson to physical therapy. Mr. McPherson received treatments for approximately three to six months approximately two times a week.

Mr. McPherson recalled that the therapist, as he put it, did craniosacral readjustment. He also received rubs with what he referred to as a machine on my back. He was re-examined by Dr. Sveda on two or three occasions.

Mr. McPherson told me that approximately a year after the accident he came under the care of

Dr. Lefkovitz at Akron General. Mr. McPherson referred what he referred to as pain management and this included the use of a TENS unit and drugs. Mr. McPherson was re-examined by Dr. Lefkovitz approximately every month.

During **1991** as well as **1992** he was re-examined by Mr., Dr. Lefkovitz rather, approximately once a month. He was last examined on April. 20th, 1990.

At that point in the history Mr. Willis indicated that Mr. McPherson had come under the care of Dr. Lefkovitz in August of **1989** and the care of Dr. Sveda in May of **1989**.

Mr. McPherson told me that during **1990** he also received chiropractic treatment from Chir practor Fakhoury in Crystal River, Florida.

Mr. McPherson indicated that he had been examined by five physicians for the Railroad Retirement Board.

He indicated that at the time of the accident he had been working as an engineer on the railroad. He had not returned to work.

He also indicated that an MRI had been ordered, but that he couldn't fit into the tube.

Cinefluoroscopy was done. It showed

stretched or torn ligaments by the movement of my spine, he told me. The cinefluoroscopy had been performed by Chiropractor Fakhoury.

Mr. McPherson also had undergone two nerve conductance tests. These studies reveal some problems with C-3, C-4, C-5 and the brain stem he told me.

After these tests had been performed his physicians gave him some suggestions for relief of pain.

I then inquired into Mr. McPherson's condition at the time of my examination of May of 1982 and he indicated, and I quote, "if I touch any part of my cervical spine it's still sore to touch and it's swollen."

He experienced headaches which began in the posterior aspect of his cervical spine and radiated into his head. His headaches were, as he put it, directly related to my activity.

His left jaw was more symptomatic than his right jaw. He would have jaw symptoms, he told me, if I lift something heavier than I should lift. He also had jaw symptoms, as he put it, with motion of my left arm. I can't open my mouth all the way, he told me.

When he performed activities above shoulder level he would develop arm pain. He indicated that the pain in the lateral aspect of his right arm was, as he put it, not near as severe as the pain in his left arm. On occasion it radiated into his little finger.

He had pain at the lateral aspect of the left acromion which would radiate down the posterior aspect as far as the elbow.

Q. Doctor, let me just interrupt and ask you to explain where the left acromion is, or the lateral aspect of the left acromion.

A. The acromion is the outer most part of your shoulder girdle, Part of it attaches to your collarbone. So the lateral aspect of the left acromion would be where I'm pointing with my finger; sort of the point of your shoulder, if you will.

Q. Thank you.

What else did he say?

A. So he told me that he had pain there that radiated down to the posterior aspect as far as his elbow and he told me from there it goes straight down.

He had numbness in the hypothenar, or little finger area of his hand.

Told me that he was symptomatic with respect to his midback which was, as he put it, tired. He experienced what he referred to as a burning in his midback.

During the year preceding my examination, that is during 1991, he developed low back pain. Told me that he had what he referred to as mobility problems.

I asked him if he had sustained a specific injury to his low back in the accident which had occurred in 1989 and he indicated, and I quote, "everything that happens I blame on that," that is the accident.

His low back symptoms were increased if he sat or stood, as he put it, too long. He had pain which radiated into his legs, more so on the left than the right. The radiation was down the posterior aspect of the thigh to the knee.

Coughing, sneezing and bowel movements produced no leg radiation.

Q. When he says the posterior aspect of the thigh, is that the -- which side is that?

A. That's the back side.

Q. Okay.

A. He told me that he was taking Midrin,

Stelazine and Klonopin. He had not taken any of these medications on the the day of the accident and he was not taking any other medications.

Q. Was that on the day of the accident or on the day of the examination?

A. The day of the examination. Thank you.

So those were the medications he was taking.

I then inquired into his past medical history and he told me that he had sustained an injury to his upper back in approximately 1987. This had occurred at work.

He was treated by Chiropractor Shimmel for approximately one month. He told me that he had no symptoms referable to his upper back after that treatment by Chiropractor Shimmel.

He had had no neck symptoms and he had had no low back symptoms before the accident of March 24th, 1989.

When I asked him if he had sustained any injuries or he had been involved in any accidents after March 24th, 1989, he indicated, and I quote, "I'm going to have to say no."

I then left the examining room while Mr. McPherson removed his clothing and put on an examining gown.

When I returned he indicated that on the way to my examination in May of 1992 his van had been struck from behind by a car. He told me he was not injured.

Q. Doctor, did Mr. McPherson tell you that he had been injured and had an injury to his lower neck and upper back when playing racquetball, that when playing racquetball he felt a sharp pain in his neck when he ran into a wall; did he tell you about that?

A. No.

Q. He didn't indicate to you that he had treatment with the Chiropractor Shimmel after injuring himself playing racquetball then?

MR. LINNEN: Objection.

A. No, he did not.

Q. Doctor, did you then conduct a physical examination after taking the history from Mr. McPherson?

A. I did.

Q. And tell us what your examination consisted of.

A. It was a routine orthopedic examination which focused on those parts of his body about which he was complaining: His cervical spine, his lumbosacral spine and his thoracic spine.

Q. Would you tell us what your findings were?
A. Certainly.
First I noted that he was a male of approximately his stated age who was considerably overweight. He told me that he was six foot tall and that he weighed approximately 280 pounds.
I noted that he rose from a sitting position without difficulty, that he walked without limping and that he was able to climb on to and off of the examining table in a normal fashion.
I examined his cervical spine, or his neck, and noted that he had normal cervical lordosis without evidence of paracervical or trapezius spasm. There was normal cervical flexion and extension with complaints of pain at the extreme of extension.
There was approximately 75 percent of normal lateral rotation bilaterally and approximately 80 percent of normal lateral bending bilaterally. He complained of pain from the mid range of these motions to the extremes. Lateral rotation and lateral bending were performed in a ratchet-like fashion.
Q. Doctor, I have a few questions regarding your examination and the findings you made of Mr. McPherson's cervical spinal.

First of all, can you tell the panel what you did or what you asked Mr. McPherson to do in order that you could examine his cervical spine?

A. Yes.

Initially I said to him I'm going to be touching various areas of your cervical spine and if my touching causes you any pain I apologize, but you need to tell me, because I can't interrupt facial grimaces and things of that nature.

After I completed palpation I then asked him to bend his head forward, which was flexion.

Asked him to bend his head backwards, I didn't do it myself, which bending it backwards is extension.

Asked him to look at one side and then the other side, which is lateral rotation.

And then asked him to tip his ear toward his shoulder, which is lateral bending.

Q. First of all, you state in your report that with respect to his cervical spine he had normal cervical lordosis without evidence of paracervical or trapezius spasm. Were you able to determine that, first of all, when you palpated his neck, when you felt his neck?

A. I was able to determine it first of all when

I looked at his neck.
Q. Right.
A. And then secondly when I palpated his neck, yes.
Q. All right. And you did not feel any spasms in his cervical spine?
A. If I had I would have told you.
Q. Okay. Now with respect to his movements as you've just described --
A. Right.
Q. -- flexion, extension and lateral movement, he did indicate that he couldn't move his neck to the extremes?
A. That's correct.
Q. All right. And what did he say when he attempted to do that?
A. I don't remember his specific words, but he went as far as I recorded and he said something that I interpreted as a complaint of pain. Whether he said it hurts or he said ouch or, I don't know, but, I mean, he made complaints of pain.
Q. All right. And with respect to his lateral rotation and bending, you have indicated that he performed it in a ratchet-like fashion. Can you describe what you mean by that?

A. Yes.

I suspect most people have tried to tighten down, vise grips or ratchet wrench, and as you tighten something down it has very definite stops as you tighten it down. Well, that's the way he moved his neck, in a ratchet-like fashion. There's no anatomic basis for that.

People who have injuries to their neck and have subsequent limitation of motion, people who have arthritis in their neck and subsequent limitation of motion go as far as they can in a very smooth fashion and then they stop. They don't ratchet down one way or another.

Q. For the findings that you made of his cervical spine where he indicated he had pain on the flexion and extension and on the rotation and bending, were those objective findings or subjective findings?

A. These were subjective findings.

Q. And why don't you just describe for the panel how you interrupt, what you would -- or how you define subjective findings?

A. Subjective findings are those which require input from the subject or the patient.

For example, if Mr. McPherson has pain when

he does something, I couldn't tell that by looking at him. He would have to tell me that he had pain. So that's a subjective finding that requires his input.

Q. As opposed to an objective finding?

A. An objective finding is one that does not require input from the subject or is one that I can see, measure without any help on his part.

I looked at Mr. McPherson; he was overweight. He didn't have to tell me that, I could see that. That was an objective finding.

Q. All right. Now moving to the examination you conducted of Mr. McPherson's shoulders.

A. Yes.

Q. What were your findings on your examination?

A. I noted that there was no evidence of atrophy, deformity or localized tenderness.

There was a full range of shoulder motion bilaterally. He complained of pain with external rotation of the shoulder and impingment signs were negative.

Q. Doctor, when you -- what movement did Mr. McPherson do when he complained of the external rotation? Did you ask him to move the arm himself? Or can you just describe that?

A. Yes. External rotation is the movement away from or from your body in a fashion like this.

He said on the right side that when he moved it away it hurt, he had pain.

Q. Of your examination of his shoulder then, was the only abnormal finding, that external rotation when he's complained he had some pain in doing that?

A. That's correct.

Q. And that finding, was that objective or subjective?

A. That was a subjective finding.

Q. All right. Then with respect to the thoracic spine or the midback, would you tell us what your findings were?

A. I noted that he had an increase in the thoracic kyphosis or increase in the normal curvature of the thoracic spine. There was no evidence of spasm. There was no evidence of tenderness. And essentially those are the only things that you could do when you examine the thoracic spine.

Q. Okay. What if any significance is it that you found that he had an increase in the thoracic kyphosis?

A. In and of itself it's of no significance.

Q. Okay. Did you examine his upper extremities?
A. I did.
Q. And what did you find?
A. I found, first of all, he had symmetrically depressed deep tendon reflexes. I noted that his muscle strength was normal.

I found that there was decreased perception of pinprick in the left upper extremity in a nonanatomic pattern.

When I noted that I proceeded further and found that there was decreased perception of pinprick which extended from the midline of the chest into the left upper extremity.

When I tested his perception of pinprick over the left and right sides of his forehead, he said in those areas the sensation on one side was much like that on the other side or was close, whereas on the chest he said there was a definite difference.

Q. Let's take your findings with respect to the upper extremities one at a time.

First of all, you said they revealed symmetrically depressed deep tendon reflexes?
A. Yes.
Q. What is that? What do you mean when you state that?

A. The deep tendon reflexes are those things that you test with a little red rubber hammer people's reflexes.

Symmetry is what's important. All biologic parameters, or all findings, if you will, have a range. No two people are alike. So that we look at a certain finding and say that's normal, but at one extreme, for example, with reflexes, they could be more active in one person than in another and at the other extreme they could be less active or depressed in one person than another.

But if they are symmetrically depressed, less active, on the right side and the left side, that's a finding that has no significance or clinical significance or doesn't imply that there's any pathology.

Q. That's what I wanted to ask you. Was the fact that they were symmetrically depressed indicate any physical abnormality?

A. No, it does not.

Q. If one side was depressed rather than the other, may that indicate some pathology?

A. Yes.

Q. Okay. And what would that indicate to you if that had been present?

A. All it would say is Dr. Brooks, you've got to look further to find out what's wrong. I mean, it's a red flag, but you don't -- rarely do you make a diagnosis on one isolated finding.

Q. But because the upper extremity in Mr. McPherson's upper extremities, when you tested his deep tendon reflexes they were symmetrical, you felt that that was, there was no problem?

A. Yes.

Q. Okay. Now you go on to say or to examine that his muscle strength was normal but that you noticed a decreased perception of pinprick on the left in a nonanatomic pattern. Could you define that or explain that?

A. Certainly.

The nerves that supply the upper extremities, the arms, originate in the cervical spine, in the spinal cord. And at each level in the cervical spine a nerve root leaves the cord and passes out of the cord. They then join together and ultimately supply what we refer to as a dermatome or a specific area of the skin.

Now, when I say that it's in a nonanatomic pattern I'm saying that he has decrease in his ability to perceive a pin that does not follow a

dermatome map.

In contrast to someone who has a definite specific problem with one nerve root or even two nerve roots, you can map that out and the individual have decreased perception in a specific area.

But when it's, it's called glove like, when it's circumferential or it's spotty and makes no sense it's nonanatomic.

Q. Can you just describe that for the panel when you're doing the pinpricking in the left upper extremity, are you picking in a dermatomal pattern to see if the dermatome, any particular dermatome is involved and then do you pick around the arm to see whether or not the sensation is in any anatomic pattern?

MR. LINNEN: Objection.

Q. Can you just explain your pattern of picking, I guess?

A. I have a little thing, a little instrument that's called a pinwheel, okay? And it's got slightly sharp little points and it rolls.

And so you roll it in one of the dermatomes, ask the patient how does it feel, is it sharp or dull, then you roll it in the same dermatome in the other arm and you say is it the same or different.

Well, you go over all the dermatomes one by one and compare one side with the other side.

And what I found was that Mr. McPherson's perception of pinprick, which is what this pinwheel causes, was decreased on the left side in a nondermatomal pattern.

Q. Okay. What, if any, significance is it that you found that he stated that the pinprick sensation when you were doing that on his forehead was close, but that there was a definite difference on his chest?

A. You put the whole thing together and this is an indication that the symptoms and physical findings which Mr. McPherson is exhibiting have no basis. They are the symptoms and physical findings which are oftentimes noted in hysteria.

You don't have a midline lesion, that is to say you don't have decreased sensation to pinprick on one side of your body and not the other side of your body unless you have a lesion in your cervical spinal cord. But if you have that, and that's a condition known as Brown-Sequard syndrome, you have increased tone on one side and more importantly you have loss of muscle strength on the opposite side.

That is to say, if Mr. McPherson really had

some kind of problem, lesion, that caused decreased perception of pinprick in his left arm, he should have had decreased weakness in his right arm. And his muscle strength in both upper extremities was normal.

Now it's conceivable that he had a lesion in his brain. But if he had a lesion in his brain it would also be causing problems with anesthesia in his face.

Q. Meaning when you conducted the pinprick testing in his forehead then he wouldn't have indicated it was close, instead it would have been a difference?

A. That's correct.

Q. Okay. Doctor, you then examined his lumbar spine or his low back; is that correct?

A. Correct.

Q. What findings did you make on that examination?

A. Essentially there again were no objective abnormal findings.

There was normal lumbar lordosis. There was no spasm. There wre no areas of localized tenderness. Forward flexion could be accomplished such that his fingertips reached his ankles. He did

extend from the flexed position by placing his hands on his thighs, walking up his thighs.

Q. What significance do you place on that, Doctor?

A. That's another finding that indicates to me that he's attempting to exaggerate. I treat a lot of people with back pain and I see a lot of people with acute back pain. I see people that have had an injury some time after their back injury. And the people that are really hurting and have really been hurt don't walk up their thighs after they've bent over.

Q. When you say walk up his thighs, what do you mean he was doing?

A. As I explained initially, he bent over, got all the way down such that his fingertips reached his ankles and then he put his hands on his thighs as he extended as if he was walking up his thighs helping himself to get himself extended.

Q. All right.

A. Extension and lateral bending were normal and he was able to walk on his heels and toes without difficulty.

Q. All right. Did you do a pinprick testing of his lumbar spine?

A. Not of his lumbar spine.
Q. What did you do a pinprick testing of?
A. His lower extremities.
Q. Thank you, Doctor. And what did you find?
A. Interestingly enough, he had decreased perception of pinprick in his left lower extremity in a nonanatomic pattern.
Q. Doctor, did you examine any other part of his body that we haven't reviewed at this point?
A. No.
Q. Okay. Did you examine records of treatment for Mr. McPherson?
A. I did.
Q. Can you first just tell us what they were, just a listing so we can get some idea of the amount of material that you reviewed?
A. Certainly. As a matter of fact, I referred to them as voluminous.

I examined the emergency room record of Woman and Children's Hospital for March 24th, 1989.

I actually personally reviewed the radiographs that were obtained on March 24th, 1989.

I reviewed Chiropractor Shimmel's letter of March 3rd, 1990.

I reviewed Dr. Sveda's records for the period

between May 18th, 1989 and May 25th, 1989.

Dr. Lefkovitz's letter of August 14th, 1989.

Dr. Lefkovitz's letter of June 13th, 1990.

I tried to review Dr. Lefkovitz's records, but I couldn't decipher his record, his handwriting.

Nor could I decipher Chiropractor Fakhoury's handwritten records.

I reviewed Dr. Smith's letter of August 30th, 1990.

I reviewed Dr. Burke's letter of August 31st, 1990.

1 reviewed Dr. Mann's letter of March 16th, 1992.

And I reviewed radiographs of the cervical spine on January 8th, 1992.

That was the information.

Q. Doctor, just prior to this videotaped deposition were you handed a MR report of Mr. McPherson's cervical spine?

A. Yes.

Q. Did you read it just prior to this video here today?

A. I did.

MS. ROLLER: Okay. And I'll just state for the record that the date of

that examination was, or of that MR was July 27th, 1992.

Q. Doctor, let's *go* back now and talk about some of the records that you reviewed and what if anything significant you found in them.

First of all, with respect to the emergency room records from the hospital in West Virginia, what if anything did you note about those records?

A. I noted, first of all, that Mr. McPherson was treated there shortly after midnight on March 24th, 1989.

He was examined by the emergency room physician who made the diagnosis contusion/cervical strain.

Radiographs were obtained. And those demonstrated upon my review no evidence of fracture, dislocation or disk space narrowing. There was a small spur at C-5.

Q. Does that small spur at C-5 account for any of the complaints that Mr. McPherson made to you during your examination of him?

A. No.

Q. What else did you review then that you found of significance in forming your opinion in this matter?

A. What other records? Well, there was Chiropractor Shimmel's letter which indicated or actually summarized his treatment of Mr. McPherson between April 5th, 1989 and February 20th, 1990.

It was significant to me that Mr. McPherson first obtained treatment from Chiropractor Shimmel two weeks after the accident and at that time he had complaints referable to his neck, left shoulder and midback.

There were some subjective findings referable to the cervical, thoracic spine and left shoulder.

It was also significant to me that Chiropractor Shimmel did not report in his letter any further findings or complaints that may have necessitated the treatment which Mr. McPherson received.

And lastly with respect to Chiropractor Shimmel, there was nothing in his letter that indicated Mr. McPherson had symptoms or physical findings referable to his low back during the period that he treated him between April 5th of 1989, February 20th of 1990, 10 months.

Q. All right. Now, Doctor, first of all, why is it important to you that he saw Chiropractor Shimmel for the first time two weeks after the accident?

A. Well, I think that, I don't think, I believe, that that's an indicator of the severity of his injury.

That is to say, if he had sustained a significant injury or an injury of major severity to his cervical spine, I don't think that he would have proceeded on to Florida. And I believe that he would have sought treatment when he returned to the Akron area.

He returned to -- he proceeded on to Florida and then he returned to Cleveland and then received treatment.

Q. All right. And with respect to his low back, the fact that there was nothing in Chiropractor Shimmel's records for his initial treatment that there was any complaint of pain in the low back, that, I take it, is also significant to you regarding the severity of the -- well, why don't you tell us: Why is that significant?

A. When I obtained Mr. McPherson's history in May of 1992 he indicated to me that he had low back pain. He also indicated to me that his low back pain began about a year prior to the time that I was, I examined him.

Chiropractor Shimmel saw him within two weeks

of the accident which occurred in 1989. The lack of low back complaints in the 10 month period between April of 1989 and -- lost it, March of -- or February of 1990 is a further indication that he did not injure his low back in the automobile accident.

Q. If he had would you expect there to be complaints during that period, that 10 month period?

A. Yes.

MR. LINNEN: Objection.

Q. What other notations did you find significant in the other records that you reviewed, Doctor?

A. Ds. Lefkovitz wrote a letter of August 14th, 1989, five months after the accident, there were no symptoms or physical findings referable to the low back, thera were no focal neurologic deficits, that's again important because it indicates another source to whom Mr. McPherson does not complain of low back problems.

In the letter of June 13th, 1990 Dr. Lefkovitz refers to the cinefluoroscopy, but he doesn't indicate whether he has actually examined that himself.

Q. Let me ask you: What is a cinefluoroscopy? I'm not familiar with that type of test myself so can you describe that?

A. Well, that's all right. I mean, you know, you've gone to the cinema, okay?
Q. Yeah.
A. The movies, okay? So a fluoroscopy is a temporary radiograph. That is to say -- it's something that's hardly done any more. You turn the x-ray machine on and you generate some x-rays for a brief period of time and while the person is in the machine you have them move back and forth.
Now you do have the ability to obtain hard copy radiographs, but the idea is that while you're x-raying somebody's neck you're watching their neck move.
Q. Do you use cinefluoroscopy?
A. No.
Q. Now, was a hard copy or a film developed as a result of the cinefluoroscopy that you could examine?
A. Yes.
Q. Did you have the film yourself to examine?
A. Yes.
Q. Okay. Do you agree with Dr. Lefkovitz when he states that the cinefluoroscopy demonstrated listhesis of C-4, or C-3 on 4 and C-4 on 5?
A. No, I don't agree with him.

Q. First of all, what is that, listhesis?
A. Listhesis. In fact, what he saw was retrolisthesis. Okay.
Listhesis is a slipping, okay? Retro-listhesis means that it's slipping backward,
Now, when I looked at the two radiographs the flexion/extension views of the cervical spine that were obtained on April 3rd of 1990 these was, indeed, a very mild retrolisthesis of **C-4** on C-5.
That is to say that the posterior border of C-4 was slightly behind the posterior border of **C-5**. But that's a very common finding on flexion and extension views and is not indicative of any laxity.
Dr. Lefkovitz had indicated that Mr. McPherson had cervical spinal laxity. Now first of all, if you had cervical spinal laxity as a result of damage to the soft tissues, one vertebra wouldn't fall backwards on another. In fact, it would fall off frontwards.
Q. Well first of all, do you agree that Mr. McPherson has cervical laxity?
A. No.
Q. And this listhesis, C-3 on C-4 or 4 on 5, first of all, do you agree that he has that condition?

A. I felt that he had a mild retrolisthesis of C-4 on 5.
Q. And does that condition account for the complaints he is making in his cervical spine?
A. No.
Q. All right. Now, what other documents or records that are in Mr. McPherson's file did you find significant in coming to your opinion in this case, Doctor?
A. Well, Mr. McPherson was examined by three additional physicians, Dr. Smith, Dr. Burke and Dr. Mann.

What was significant to me was that both Dr. Smith and Dr. Burke described on the right side, not the left side, the right side, decreased sensation in a nondermatomal pattern.
Q. Is that consistent with what you found on your examination, findings in a nondermatomal manner?
A. Yes.
Q. Okay. Now, with respect to the right versus the left, in the history you were given by Mr. McPherson what side did he say he was having trouble with?
A. So long ago I forgot.

Q. Maybe if I can help you, Doctor.
A. Actually he said it was his left arm that was more symptomatic than his right arm, okay?
Q. Okay. And what did Dr. Smith and Dr. Burke find in their examinations?
A. They found this nonanatomic numbness on the right side of his body, not the left side of his body.

Dr. Mann, when he examined him, also found no physical process present, certainly not one that can account for as many symptoms in apparent total disability.
Q. Well then, Doctor, let me ask you: Based upon the history you were given, the physical examination you conducted, the review of the radiographs, the review of the records, do you have an opinion based upon a reasonable degree of medical probability as to whether or not Robert McPherson sustained any injury in the automobile accident of March 24th, 19891
A. I have an opinion.
Q. What is your opinion?
A. I believe he sustained a cervical strain as a result of the automobile accident of March 24th, 1989.

Q. Do you have an opinion to a reasonable degree of medical probability as to whether or not he still suffers from any pain or problems from the cervical strain?
A. I have an opinion.
Q. And what is that opinion?
A. I believe that at the time that I examined him and thus at the present time he had recovered from the cervical strain and does not suffer from that injury.
Q. By your testimony you indicated that the only problem he had was to his neck or his cervical area. What about the low back, did he suffer an injury in his low back from this accident in your opinion, Doctor?
A. He did not.
Q. All right. Now, the tests that were taken of Mr. McPherson, first of all, some nerve conduction studies were taken; is that correct?
A. Yes.
Q. And do you know the results of them?
A. Yes.
Q. And what were they?
A. The nerve conduction and the EMG, or electromyographic studies of the left upper

extremity that are contained in Dr. Lefkovitz's records were normal.

Q. What about the bone scan? First of all, what was that, a bone scan of what portion of his body?

A. Bone scans are of the entire body. That was also normal.

Q. All right. And the MR, you just had a chance to review, I'd like to go over that with you for a moment.

First of all, the conclusion of, or the impression of Dr. James Zelch, the radiologist, states bulging disk two millimeters with tenting of the posterior longitudinal ligament at three levels. Did I correctly state what his conclusion was, Doctor?

A. You read that very well.

Q. Thank you.

A. It's all right.

Q. Does that in any -- first of all, is that an abnormal finding?

A. Is that an abnormal finding? No, it's not an abnormal finding.

Q. The doctor says, Dr. Zelch says he has a bulging disk, two millimeters. You say it's not abnormal. Why do you say that's not abnormal?

A. Because as an orthopedic surgeon who treats patients and not radiographs, not MR, I am aware of studies which indicate that asymptomatic patients, for example, can have these kinds of findings.

So from a radiologist's standpoint, yes, they are considered an abnormality.

But from somebody who treats patients, they are not considered abnormal and they are not productive of symptoms, they don't cause symptoms.

Q. Does the two millimeter bulge that was, that's discussed here in the report of the MR, explain in any way to you the ongoing complaints that Mr. McPherson is making, made during his examination with you in May of this year?

A. No, it does not.

Q. Did he also -- did Mr. McPherson sustain some contusions in this accident as far as you know?

A. I believe so.

Q. Okay. Is the findings or the reports of Dr. Burke and Dr. Smith, are they consistent with your opinion in this matter?

A. Some of my opinions, yes.

Q. All right. With respect to the findings that Mr. McPherson's symptoms were in a nonanatomic pattern, is that consistent with your findings?

A. Yes.
Q. And with your opinion here today?
A. Yes.
Q. Likewise Dr. Mann, his report, did you find that that was consistent with your opinion here?
A. Yes.
Q. When did you review the records that you received of Mr. McPherson?
A. After I took the history and after I performed the physical examination.
Q. All right. Is there a reason that you review the records after you do those things?
A. Yes.
Q. And what is that?
A. I don't like to review records. I also feel that I like to go in and I like to take a history from the individual like I do from any other patient. I want him to tell me his story. I don't want to rely on a set of records as to what's going on. I want him to tell me what parts of his body he believes to be symptomatic and so I can examine those and then I review the records which tell me what has gone on in the past.
Q. Doctor, based upon your opinion that Mr. McPherson sustained a cervical strain in this

accident, and based upon your review of the other diagnostic tests and the records, do you have an opinion as to how long he would have incurred any discomfort or pain from that cervical strain?

A. Yes.

Q. What is your opinion?

A. I believe that he would have been symptomatic with respect to this particular injury for a period from six to eight weeks.

Q. And what is the reason you say that? What's the basis of that opinion?

A. When I look at the events that occurred in the immediate post-accident period, I note, for example, his ability to proceed on his vacation. The fact that he returned back to the Akron city area; sought chiropractic treatment rather than medical treatment; that there was, it was two weeks after the accident that he had first treatment; that in his letter to Mr. McPherson's attorney the chiropractor did not delineate any additional symptoms or delineate any additional physical findings after the description of what was present two weeks after the accident.

And so 1 feel that his ability to do the things that he did in the manner in which he did

them indicates that he had a mild cervical strain and I think that those kinds of injuries take about six to eight weeks to heal themselves.

Q. All right. After that six to eight week period is there anything in your examination or any of the records or any of the tests that would indicate to you that Mr. McPherson was not able to return to work at that time?

A. NO.

Q. Now he was an engineer at a railroad. Does that make any difference to you that that may be perhaps a more active job than sitting behind a desk?

A. Well, it's certainly a more active job than sitting behind a desk. But the bottom line is although I don't know each and every specific activity that he did in that job he was doing the job before the accident and so I have no reason to believe that he could not do the job after the accident.

Q. Even in light of the strain he received to his cervical spine?

A. Once that strain healed even in light of the strain, yes.

Q. Is there anything in your review of the

records or your examination that indicated to you that that strain to his cervical spine wouldn't have healed in the period that you've just described, six to, what, 12 weeks is what you said?

A. You're being too generous, I only gave him six to eight weeks.

Q. Okay, whatever.

A. I said when you asked me that a little bit ago, I said no, he got better.

MS. ROLLER: Okay. I have nothing further, Doctor. Thank you.

THE WITNESS: You're welcome.

MS. ROLLER: Off the record for a moment.

(Discussion had off record,)

CROSS-EXAMINATION

BY MR. LINNEN:

Q. Doctor, I'm Jay Linnen. I represent Bob McPherson in this case. We briefly met this afternoon. I have a couple questions for you.

A. Good evening.

Q. When you and I talked earlier this afternoon I think you indicated that you did not recognize the diagnosis of myofascial pain syndrome; is that a correct statement?

A. Yes.
Q. All right. Do you call that type of syndrome or do you have a different word for that type of diagnosis?
A. No, I've not used that and I really don't have a different word, I don't have a different word for it.
Q. All right. Is it your opinion that that type of syndrome is nonexistent?
A. I have never made that diagnosis. Obviously other people feel that it's existent and have made that diagnosis.
Q. Okay. For instance, in this case I believe one or two of the physicians have made a diagnosis of myofascial pain syndrome; and would you specifically disagree with that diagnosis in the case of Mr. McPherson?
A. Yes.
Q. All right. And I think you also indicated that, this was earlier this afternoon when you and I talked, that you believed in all cases of soft tissue injuries that at some point the patient would recover completely; is that a correct statement?
A. Yes.
Q. All right.

A. Well, let me just explain that a little if I may because, you know, when we talk about all, I mean, I can think of a lot of things. In cases of soft tissue injuries to the cervical spine involving the muscles and the ligaments, yes.

Q. Okay. I don't know whether this has been marked during the course of this deposition, but it was previously marked as Plaintiff's exhibit number 2, the MRI which was taken of my client back on July 27th of 1992.

And you had the opportunity to review that MRI earlier this afternoon; is that correct?

A. The MRI report, yes.

Q. Okay. And looking at that report you made a determination that there were some abnormalities; is that correct?

A. Yes.

Q. Okay. You also, I believe, looked at a report during the course of your review of this case that was made by a Dr. Witek down in Sarasota, Florida?

A. May I refresh my recollection?

Q. I think Dr. Witek was the physician that did the cinefluoroscopy.

A. The cinefluososcopy?

Q. Yes.
A. I don't recall that I saw the report. I think what I saw was Dr. Lefkovitz's reference to that report.
Q. Okay. So you have --
A. But I'd be happy to look at it.
Q. Okay. I'm going to hand it to you then and I think then we can have an agreement, we can mark that as exhibit 1 today.
MS. ROLLER: Fine.
Q. First of all --
MR. LINNEN: Thanks.
Q. -- I think you indicated in the direct examination that you do not utilize fluoroscopy?
A. That's correct.
Q. All right. What is the -- is there a type of diagnostic procedure that you would utilize instead of fluoroscopy?
A. Yes. For example, if I was concerned that somebody had cervical spinal instability following a soft tissue injury to their cervical spine, first thing I would do would be get views in flexion, extension and in neutral. And by comparing those three views I could determine whether an individual had instability.

Q. All right. And that would just be a regular x-ray?
A. They would be routine radiographs but in three specific positions. Normally radiographs are taken in flexion and extension. But you want to include the neutral to see the degree of change between the flexion to the neutral, from the neutral to the extension and that would give you an indication of whether or not there is instability.
Q. All right. Now have those type of radiographs been performed for Robert McPherson?
A. No.
Q. All right. So all we have to go on is the fluoroscopy, the -- is it cinefluoroscopy?
A. Cine, correct.
Q. -- that was performed down in Florida?
A. That's correct.
Q. And does that report indicate any abnormality?
A. It was the impression of Dr. Witek that there was a listhesis of C-4 on 5 anteriorally consistent with posterior longitudinal ligament laxity or damage in this area.
Q. What does that mean to you?
A. What the verbiage means is that that C-4 slid

forward on C-5, he says in the flexion views.
Q. Is that an abnormal condition in your opinion?
A. If what he -- I'm sorry. I can't answer that without determining the degree of listhesis. In other words, just like bulging disks, there's a range. So that if there is some sliding forward or backward of a couple millimeters, that's going to be within the range of normal or it's going to be abnormal but not indicative.
Q. So it's based on the degree of the listhesis?
A. That's right.
Q. All right.
A. You wanted to mark this, I believe?
Q. We could mark it when we're done. I think we'll mark it as exhibit 1.
Q. What is laxity? What would that mean in terms of the cervical spine?
A. And let's confine it to the cervical spine.
There are a number of supporting structures or a number of structures that help to maintain the alignment and integrity of the cervical spine. So if someone has laxity, I don't want to sound facetious, but the only thing that comes to mind is that they're lax.

Q. Things are loose up there?
A. Loose, that's a great word, loose, okay, that they're not as stable as they should be.
Q. All right. Is laxity -- have you had occasion to treat people that you made that type of diagnosis, that they had a loose condition or laxity in the cervical spine?
A. In the 22 years that I've been treating people 1 have never treated anybody and I've only seen one report in the orthopedic literature of one case. Maybe there are two now.
Q. You also indicated that there's a set period of time to recover from a soft tissue injury and I was wondering: How did you come up with that period?
A. No, I said for the kind of condition that I felt Mr. McPherson had.
Q. Oh, okay,
A. Certainly if somebody had a more significant injury than Mr. McPherson had it would take him longer to recover.
Q. Well unless you originally treated Mr. McPherson how would you know the degree of his injury at the actual time or close to the time of the actual injury; how would you be able to make

that determination?
A. By reviewing the records that I reviewed.
Q. All right. All right. It would have been much easier or more definitive if you had been the original treating physician to make that conclusion, if you had been in the position to review him or to examine him shortly after the collision I think you would have had a better idea of his actual condition; would that be correct?
A. If I had been the original treating physician you wouldn't be asking me the questions that you're asking me today.

If those people who treated him in the immediate post-accident period were accurate observers and accurate recorders of their observations, then 1 have the same information that they have and it really makes no difference whether I'm reviewing their records in retrospect or whether I'm right there hands-on.
Q. All right. Doctor, I didn't see anything in your report to indicate the speed of the motor vehicles involved. Is that something that would be important to you in making a diagnosis in this case?
A. It really wouldn't, because speed is a factor but it's the end result that you make the diagnosis

from. I mean, what actually happened to the person -- I have some pictures of some pretty horrendous looking automobile accidents where people had no injuries.

Q. All right. And for that matter the amount of property damage would not be an important factor to you in making a diagnosis of Mr. McPherson; is that correct?

A. No, that's correct.

Q. I believe if I'm correct that in the direct examination you indicated that a person can be asymptomatic, meaning having no symptoms, and have a bulging disk; is that correct?

A. That's correct.

Q. Have you ever seen a patient in the -- was it 24 years?

A. Roughly, right.

a* -- 24 years that you've been practicing that did have symptoms that could be correlated to a bulging disk?

A. The answer is yes. And I recall operating on a patient who had symptoms that correlated to a bulging disk which was 17 millimeters of bulge, not two millimeters, but 17 millimeters.

Q. All right.

A. So again the degree is important.
Q. Have you ever seen a patient that had symptoms that could be related to a bulging disk of two millimeters?
A. No.
Q. Never?
A. Never.
Q. Okay. You also indicated that, I can't remember exactly what it was, Doctor, but it seemed to me that you were negative in some way towards chiropractors; is that true?
A. Am I negative towards chiropractors?
Q. The type of treatment that they provide.
A. Yes, I don't think it's appropriate.
Q. All right. Do chiropractors, some chiropractors, some chiropractors that you migh be familiar with, do they provide the same services as a physical therapist on some occasions?
A. There are some chiropractors, and I was trying to think if I was familiar with any of them, who do only modalities and don't do manipulation, yes.
Q. So that would be, in that case it would be very similar to what the physical therapist, the type of treatment they would provide?

A. A certain portion of the treatment a therapist would provide, yes.
Q. Now, as part of your review of this case, you are aware that the Railroad Retirement Board has ruled that this individual is occupationally disabled; are you aware of that determination?
A. I don't think *so.* I know that he was -- he told me he had been examined by people for the Railroad Retirement Board, but I'm not aware of what their ruling was.
Q. All right. Well they have ruled that he's occupationally disabled. And my question to you is whether you are familiar with the physical requirements that, of the type of position that Mr. McPherson had prior to his injury; do you have any information concerning those?
A. As I indicated earlier, I'm not familiar with all the requirements of an engineer.
Q. Okay. Are you familiar with any of the requirements of an engineer?
A. I think if I'm correct an engineer does have to throw some switches and things of that nature.
Q. All right. So you're not in a position to evaluate whether Mr. McPherson would be capable of performing his regular job functions because you

don't know what those functions are?
A. That's right, except as I answered the question earlier.
Q. All right. And when you and I met earlier this afternoon you indicated that you weren't sure how many defense medicals you perform in a week but your rule is that you don't do any more than three; is that correct?
A. No. When we met earlier today you asked me how many examinations I did in a week and I said I don't know how many I do in a week, I said, but I limit myself to the average of three on behalf of the defense. That is I may do a couple plaintiffs, I may do more plaintiffs, I don't know.
Q. But do you do mostly defense?
A. I don't know what mostly, you know, what mostly is. If mostly is 51 percent, then --
Q. That's mostly.
A. -- that's mostly. So in a year's time I suspect I do more defense medicals than I do plaintiff's medicals.
Q. And you charge, what was it, 375 an hour for a defense medical; is that what it was?
A. You must be from the IRS. No, I said three and a quarter.

Q. Oh, okay, three and a quarter.

MR. LINNEN: Doctor, I have no further questions. Thank you.

MS. ROLLER: Doctor, I just have a few follow up.

REDIRECT-EXAMINATION

BY MS. ROLLER:

Q. You indicated you don't know what the functions are of a railroad engineer; is that correct?

A. That's correct.

Q. Whatever the functions were that Mr. McPherson was doing before the automobile accident in March of 1989 do you have an opinion as to whether or not he is capable of performing those same functions after, say, let's say two months after this accident; do you have an opinion?

MR. LINNEN: Objection.

A. Yes, I have an opinion.

Q. And what is your opinion?

A. That after two months after the accident he was capable of returning to the same occupation that he had before the accident.

Q. All right. You also indicated in response to Mr. Linnen's question that you feel that in all

cases where there is injury to the soft tissues of the cervical spine eventually those patients, those people will recover?

A. Yes.

Q. What's your reason for stating that?

A. 21 years of practice, 24 years of practice.

Q. Okay. In addition to that the anatomical or medical reasons for why they do recover?

A. We're talking about injuries to the muscles and to the ligaments, okay? We're excluding injuries to the bone. We're excluding injuries to the disks. And things heal, they get better.

I mean, I can't, you know, one of the things I guess that we don't have the advantage of is that we really don't go out and dissect out, you know, our patients' necks, you know, and look at them at varying times afterwards to see the status of the healing. But I guess you know from laboratory experiments with animals and stuff these things heal.

Q. And that's your experience, Doctor?

A. Yes.

MS. ROLLER: I have nothing further.

MR. LINNEN: I just have a

couple additional questions and I'll be real quick.

RECROSS-EXAMINATION

BY MR. LINNEN:

Q. There is a physician down in Akron, I'm not going to give you his name, he's also a Harvard graduate, and he indicated to me when someone injures their neck, cervical spine, it never completely recovers. They may be asymptomatic, meaning not having any symptoms, I'm sure you know what that means, Doctor, but he indicated that the person would be more susceptible to injury and that the person actually never completely recovers from that injury.

And I was just wondering if you've ever -- is this a difference in opinion between physicians? Have you heard other physicians with a similar point of view?

A. Wow, that's sure one long question. The bottom line is that yes, it's a difference of opinion. His opinion is that once you've had a soft tissue injury to your cervical spine you never recover. I don't believe that's true. I believe you do recover.

Q. Are there orthopedists here in the Cleveland

area that recognize myofascial pain syndrome to your knowledge?

A. I'm trying to think.

I've not seen anybody use it in the Cleveland area.

Q. Have you seen physicians other than the physicians involved in this case utilize that type of diagnosis, myofascial pain syndrome?

A. Fortunately it hasn't spread up from Akron to Cleveland yet.

MR. LINNEN: I have no further questions. Thank you.

THE WITNESS: Thank you.

MS. ROLLER: Nothing further.

THE WITNESS: 1'11 waive.

(Plaintiff's exhibit 1 was marked for identification purposes.)

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

I, Michelle A. Bishilany, a Registered Professional Reporter and Notary Public within and for the State of Ohio, do hereby certify that the within named witness, **DENNIS** B. BROOKS, **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 was reduced by me to stenotypy in the presence of said witness, subsequently transcribed into typewriting under my direction, and that the foregoing is a true and correct transcript of the testimony so given as aforesaid.

**I** do further certify that this deposition was taken at the time and place as specified in the foregoing caption, and that I am not a relative, counsel or attorney of either party or otherwise interested in the outcome of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, this 18th day of August, 1992.

Michelle A. Bishilany, Holland & Associates, Inc.
520 National City - E. 6th Bldg., Cleveland, Ohio
My commission expires **1-11-96.**