#583

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

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IN THE COURT OF COMMON PLEAS

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JAPES L. McKNIGHT, et al., )
)
Plaintiffs, )
) Case No. 65691
vs. )
) Judge Frederick Coleman
DAVID A. SMITH, )
)
Defendant. )

- - -

DEPOSITIOZJ OF DEFNIS B. BROOKS, M.D.

THURSDAY, APRIL 10, 1986

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The deposition of Dennis B. Brooks, M.D., a witness called for examination by the defendant under the Ohio Rules of Civil Procedure, taken before me, Robert A. Cangemi, a Notary Public in and for the State of Ohio, by agreement of counsel and without further notice or other legal formalities, at the offices of Dennis B. Brooks, M.D., 26900 Cedar Road, Cleveland, Ohio, commencing at 2:00 P.M., on-the day and date above set fort'?.

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APPEARANCES:

On behalf of the Plaintiffs:

Nurenberg, Plevin, Heller & McCarthy
David M. Paris, Esq.
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Cleveland, Ohio 44114

On behalf of the Defendant:

Davis and Young Co., L.P.A.
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816 Engineers Building
Cleveland, Ohio 44114

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ALSO PRESENT:

Multi-Video

- - -

MR. MURPHY: Let's go on the stenographi, record first.

We can let the record reflect that this deposition is on videotape and stenographic recording of Dr. Dennis Brooks, a witness called on behalf *of* the defendant on direct examination, for purposes of reading and/or showing the videotape to the jury in Cuyahoga County Common Pleas Case No. 65691, captioned James L. McKnight versus David Smith.

The deposition of Dr. Brooks is being taken at this time and place pursuant to an agreement between counsel as to the taking of the deposition, and any of the requirements of notice or service of notice are expressly waived.

It is also my understanding that the requirement of filing the videotape and/or the transcript of the reporter are expressly waived.

MR. PARIS: That is correct.

MR. MURPHY: Okay, then we can go on the record.

THE VIDEO OPERATOR: Stand by, we are on the record.

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DENNIS B. BROOKS, M.D.

a witness herein called for examination by the defendant, under the Rules, having been first duly sworn, as hereinafter certified, was examined and deposed as follows:

DIRECT EXAMINATION

BY MR. MURPHY:

Q. Doctor, would you state your full name for the court and jury?

A. Dennis Bruce Brooks.

Q. And Doctor, your deposition €or testimony at trial is being taken where?

A. In my office.

Q. And Doctor, can you tell us, if you would, where you began your medical training?

A. Yes. I went to Western Reserve University School of Medicine and graduated from there in 1963.

Q. After you concluded your study at Western Reserve University Medical School, what did you do?

A. I served as a rotating intern at the Mt. Sinai Medical Center for one year.

Then I served as a general surgery resident also at Mt. Sinai.

Following that I took a two year orthopedic residency at Mt. Sinai Hospital.

My fifth year of postgraduate training was as a

research associate in the Biomechanics Laboratory of Case Western Reserve University.

And my sixth year of postgraduate training was in children's orthopedics at the Indiana University Medical Center.

Q. And after you finished the six years of training after medical school, Doctor, what did you do?

A. I served in the United States Air Force as a Major and the last -- for two years, and during the last year, I was chief of the orthopedic services at Davis Monthan Air Force Base.

Q. And afteryou concluded your service in the military, what did you do?

A. I returned to Cleveland and joined three other orthopedists in the private practice of orthopedic surgery?

Q. And when was that, then, that you returned to Cleveland?

A. 1971.

Q. And have you been involved in the practice of orthopedic surgery ever since?

A. Yes, I have.

Q. And have you been involved as a matter of fact with the same fellows?

A. Yes.

Q. Now Doctor, in regard to your practice in Cleveland,

do you have any associations with any hospitals?

A. Yes, I do.

Q. And would you tell the Court and jury what hospitals you have associations with, and what those associations are?

A. I am on the active staffs of the Mt. Sinai Medical Center, Hillcrest Hospital, and Suburban Community Hospital.

And the consulting staff of Woodruff Hospital.

Q. And do any of your staff responsibilities at any of the hospitals or elsewhere involve any teaching responsibilities?

A. Yes, they do.

Q. And will you tell us about those?

A. I am an assistant clinical professor of orthopedic surgery at Case Western Reserve University School of Medicine

I am active in the orthopedic residency teaching program at the Mt. Sinai Medical Center.

And I also lecture in the field of biomechanics.

Q. And Doctor, have you confined your practice to orthopedic surgery?

A. Yes.

Q. And could you tell the Court and jury what orthopedic surgery is?

A. Yes. Orthopedic surgery is that branch of medicine that deals with the musculoskeletal system.

That is today, as an orthopedist, I treat patients

who have diseases and injuries to that part of their body that is made up of their bones, joints, soft tissues, that cover those areas, the muscles, ligaments and tendons; as well as patients who have problems with their spine and the contents of the spine, which include the interveterbral discs and the nerve roots.

As an orthopedic surgeon I treat patients who have a variety of problems. There are those that are present at birth that are called congenital in nature.

There are the category of illnesses that occur as one is growing. Those are referred to as developmental.

There is the large part of our practice that deals with people who have sustained injuries, be they in automobile accidents, sports activities, work activities. Those are referred to as traumatic.

And the last category are the patients who present with problems that arise as part of the aging process, and that is referred to as a degenerative problem.

As an orthopedic surgeon, I treat my patients both with and without surgery, depending on their condition.

Q. Do other physicians who treat these types of problems in human beings -- do they join together in associations, or boards in your specialty?

A. Yes, they do.

Q. And what's that called, Doctor?

A. Well, there are the associations, for example, the American Academy of Orthopedic Surgeons is an association that is comprised of orthopedic surgeons.

The American Board of Orthopedic Surgery is the board which certifies orthopedic surgeons as being competent to practice their specialty.

Q. And in that regard, are you a member of this board?

A. Yes, I am.

Q. And can you tell me when you became a member of the board?

A. I became certified by the American Board of Orthopedic Surgery in 1971.

Q. And do you have to pass a test of some kind, or how does that occur, that you become certified?

A. Yes, and yes.

It occurs by first taking a prescribed training course, much like I outlined. Then practicing only orthopedics to the exclusion of all other branches of medicine for one year in one location.

And then, in my situation, I had to take an examination which was a full day written examination and a half day oral examination.

As a matter of fact, this July, I am going to be an examiner for the American Board of Orthopedic Surgery.

Q. Doctor, to return then to the practice of orthopedic

surgery, in treating patients for orthopedic problems, what diagnostic tools did you have to use?

A. In general, the diagnostic tools that we use are history, physical examination. Depending on the diagnosis that comes out of that portion of the process, we will -- or I will -- oftentimes order radiographs and then depending on the patient's condition and the obscurity, or if you will, of their problem, we will go to more specialized procedures, for example, we utilize CATscans, myelograms, magnetic residence imaging, electrodiagnostic studies, to name a few.

Q. Okay. In that regard, is your clinical practice then intimately involved on certain occasions with that of radiology?

A. It is so intiminately involved that we have a door between our office and the radiologists next door, and I probably spend half of my day over in the x-ray office.

Q. You mentioned a CT scan, and do you have occasion then to read CT scans?

A. Yes, I do.

Q. How often would you do that in your practice?

A. I read -- well, I read essentially every CT scan that I order, and I would say that with patients in the hospital, and with patients in the office, I am probably reading CT scans several times a month.

Q. And with regard to these types of tools, the CT scan, x-ray films, the myelogram that you talked about, do you ever have an opportunity to correlate those with real patients in terms of what you find, for instance, when you peform surgery?

A. Well, absolutely. Every diagnostic tool or every diagnostic test that I order is not considered in a vacuum. It only has meaning when I correlate it with the patient whom I have examined.

And I certainly do not operate on every patient on whom I order a CATscan, for example, but I have had opportunities in the past to correlate the findings, clinical examination, the CATscan, the myelogram, with the actual findings at surgery.

Q. And you do operate then on the human spine- in your practice?

A. Yes, that is correct.

Q. Doctor, could you just generally tell us what the basic anatomy of the human spine is?

Could you just generally describe that, or is that too broad for you?

A. Well, let me try to be general, and then if it is not specific enough, you will ask me some more questions.

Q. Okay.

A. The spine is essentially broken into various segments.

I don't mean fractured, when I say broken, but it can be classified or grouped into various segments.

There is the cervical spine, which is the portion that we refer to as our neck.

There is the thoracic spine, which is that portion of the spine which extends below the neck to about waist level and is directly behind the chest.

There is the lumbar spine, which is referred to commonly as the low back area.

There is the sacrum or the sacral spine and the coccyx.

So there are those segments.

Each portion of the spine is comprised of a number of vertebra, and the number of vertebra, which in essence are the building blocks of that segment, different from one portion of the spine to the other.

Between each of the vertebral bodies there is a material or a structure which is referred to as the intervertebral disc, and that's a donut shaped structure, if you will, that's between each of the two vertebral bodies.

In addition, the spine is a tubular structure, if you will. The back part of the spine is a tubular structure, and through that tube in the upper portions of the spine runs the spinal cord, and the spinal cord ends after the level of L-1, the first lumbar vertebra.

After that the various nerve roots which are present throughout the spine continue in the coverings of the spine, which is called the dura, another tubular structure within this bony tube.

The spine itself is covered by muscles and certain ligaments.

Q. Are there standard methods that orthopedic surgeons use in examining the spine to determine abnormalities of any of the segments now that you have told us about in describing the anatomy of the spine?

A. Yes.

Q. And do you regularly perform those types of examinations?

A. Yes.

Q. In that regard, did I engage you, Doctor,-to examine Mr. James McKnight in this case?

A. Yes, you did.

Q. And did I agree to pay for your time, for your services, as an examiner and perhaps even as a witness in this case?

A. Yes.

Q. And after the engagement, Doctor, did you actually see Mr. McKnight?

A. I did.

Q. And was that in this very office?

A. Yes, it was.

Q. And can you tell the Court and jury when you saw Mr. McKnight?

A. I believe it was on December 4th, 1984.

Q. Now Doctor, in addition to the examination that I am going to ask you about, did you also receive from me certain records relative to Mr. McKnight?

A. Yes, I did.

Q. And at one time or another, did we eventually get to you all of Mr. McKnight's films?

A. Yes.

Q. And have you had an opportunity to review all of those?

A. Yes, I have.

Q. Well, let's go back and start with the day-Mr. McKnigh came here, if we could, Doctor, and you can refer to your notes.

A. Thank you.

Q. All right.

Did Mr. McKnight appear alone here?

A. No, he did not.

Q. And was someone with him?

A. Yes, there was.

Q. Do you recall who was with Mr. McKnight?

A. I know that it was a representative of his attorney,

and if my memory serves me correctly, I think it was Mr. Rosen, but I may have been wrong.

Q. And can you tell us, then, when the patient came in, did you take a history from him?

A. I did.

Q. Is that the initial step or one of the initial steps when you conduct an examination of a person?

A. Yes.

Q. All right.

And tell us what history you ook from this patient?

A. Mr. McKnight informed me that he had been injured on April 29th, 1983, when he was driving an automobile whicn was involved in a head-on collision with a second car.

He was not wearing seat belts at the time of the accident and told me that he had been -- using his words -- "Thrown around the car," as his car went backwards.

He was aware of immediate pain in his neck following the accident.

He told me that he went to Lakewood Hospital the following morning for evaluation of the symptoms which he had with respect to his neck and low back.

He was given a prescription for pain medication and released.

Approximately three days after the accident he came under the care of Dr. Mulligan and was treated with muscle

relaxants and Valium.

He was referred to Dr. Katzenmeyer and received outpatient physical therapy for approximately one month.

Mr. McKnight indicated that he was placed in the Hubbard tank, received ultrasound, traction and hot packs to his neck and low back.

He told me that each treatment took approximately four to five hours, and that he received treatment approximately three times a week.

He recalled that during physical therapy he was improved.

He indicated that sometime thereafter his back became more symptomatic, and in the latter part of September of 1983, he went to the emergency room of Lakewood Hospital. He was examined and referred to Dr. Yurick.

He told me that initially Dr. Yurick prescribed a back brace and medication and that later a bone scan and a CT scan were ordered.

By that time, he had continuing low back pain and what he referred to as a little pain in his neck.

He was told that the CT scanshowed a slipped disc, using his words.

He continued with this back brace and remained home on bed rest for approximately a week.

He was then given medication to do, as he told me,

"Shrink down the fatty tissue."

During 1984, he continued under Dr. Yurick's care and was last examined by him in August of 1984.

He told me that he had not been hospitalized, nor had he been treated by other physicians.

He was aware of the fact that he was scheduled to be re-evaluated by Dr. Yurick in January of 1985.

I then inquired as to his condition, or his symptoms, at the time of my examination, and he told me that his neck was, using his words, "Almost sometimes completely better," but at other times he had symptoms with respect to his neck.

He told me those occurred approximately every two months, and he would be symptomatic for approximately one month. He indicated that he had been symptomatic for the two weeks preceding my examination and described pain in the left side of his neck which radiated into the superior aspects of his shoulders.

He had no associated arm radiation. He was unable to describe those activities which increased his neck symptoms. He further indicated that his low back was symptomatic, as he put it, "all the time," primarily to the left side.

If he sat for what he referred to as an extended period of time, or if he sat in the soft chair, he would develop pain radiating into his buttocks.

His symptoms were also increased by bending, putting or

his shoes -- I am sorry, putting on his pants, or tying his shoes.

He had no true leg radiation.

Coughing and sneezing produced left low back pain.

I then inquired into his past medical history, and he indicated that in 1980 or 1981 he was involved in an automobile accident and sustained what he referred to as a whiplash. He was treated by Doctors Mulligan and Katzenmeyer and recovered.

He sustained no low back injuries in the accident of 1980 or 1981.

He had no prior symptoms referrable to his low back, and he had sustained no new injuries since his accident of April 29th,1983.

At the time of my examination, in Decenber of 1984, he was taking no medication, and he was working as a salesman

Q. Okay. Did that complete then your history taking from the patient?

A. Yes, it did.

Q. And the next stage of your engagement involved the examination, is that correct?

A. That is correct.

Q. Would you tell the jury then what examination you made of Mr. McKnight?

A. I performed a standard orthopedic examination, which

cervical spine and his lumbosacral spine and examined those areas by observing them, by having him perform various ranges of motion, by doing various neurologic testing, and by palpating various areas.

Q. Doctor, do I understand that this was done in an examining room?

A. That is correct.

Q. As the patient disrobed, so you can see the spine?

A. Yes. For example, when I am examining a male patient, such as Mr. McKnight, I ask him to remove all his clothes except his undershirt.

Q. All right. Can you then, Doctor, in a step by step progression, if you would, tell us what examination you performed?

A. Yes. The examination began with observation and I noted that Mr. McKnight was a male of approximately his state age. He was of average proportions.

I noted that he was able to get out of the chair without difficulty, that he was able to walk without limping, and that he was able to climb onto and off of the examining table in a normal fashion.

Q. Do those findings, or those observations that you made, are they part of the examination?

A. Yes, they are.

Q. And of what importance are those?

A. Those are all normal findings. They are important in that they are normal.

They would also be important if they are abnormal.

For example, if he had limped when he walked, that would have been a clue that there may have been -- excuse me -- something wrong with either a leg or something of that nature.

Q. I am sorry to interrupt you, Doctor, then go ahead with your answer.

A. I then examined his cervical spine and noted that he had normal cervical lordosis without evidence of paracervical or trapezius spasm.

Q. Can you break that down into ordinary language for the jury?

A. Certainly. That's the ordinary language I use all the time, but it is medical terminology.

I suspect -- you want to know several things. Cervical refers to the neck, okay?

Lordosis is the configuration of the cervical spine. If you look at somebody from the side, you will see that in the normal situation their neck assumes sort of a C-shaped configuration.

Paracervical is the area on either side, para, of the cervical spine.

Trapezius is the large muscle that covers the top of your shoulder and extends down your back.

Q. What is spasm?

A. Spasm is a sustained contraction of a muscle, much like a charley horse.

Q. Okay. You can continue then, Doctor.

A. I found that there was tenderness to palpation in the left trapezius. There was approximately 75 percent of normal cervical flexion, extension and lateral rotation, and approximately 50 percent of normal lateral bending.

Q. Can you explain those findings?

A. Certainly. Flexion is nodding your head forward.

Extension is looking backwards.

Lateral rotation is turning your head from side to side.

And lateral bending is tilting your head from side to side.

Q. All right.

And in regard to the findings of limitation, what does that represent?

A. It represents that Mr. McKnight did not demonstrate a normal range of cervical motion.

He had approximately three-quarters of normal flexion, extension and lateral rotation, and approximately half of normal lateral bending.

Q. Does he do that himself, or do you turn his head?

A. No, he does that himself.

Q. Thank you, Doctor.

What else was involved in the examination then?

A. I found that when he performed lateral rotation and lateral bending, he complained of pain in each side of his neck. I performed a neurological examination of the upper extremities and found that he had normal deep tendon reflexes, muscle strength and sensory perception.

Q. I will have to stop you again and ask you what the significance of those findings are, and if you can explain them a little bit so the jury can understand them, and I can understand them.

A. Let me explain what they are, and then we will discuss their significance.

Deep tendon reflexes, those are your reflexes, the thing that the doctor checks with a little red rubber handle.

Muscle strength is really an evaluation of the strength of various groups of muscle, and sensory perception is the patient's ability to perceive, to feel, to experience either light touch or pinprick.

This is done to determine if there is a problem. For example, in this case, with the nerves that supply the various muscles, and the various skin portions.

These nerves originate in this particular situation

in the cervical spine.

These are all normal findings.

Q. All right.

Did you then do further examination?

A. Yes. I then examined his lumbosacral spine or his low back.

Q. And what was your examination and findings concerning the low back?

A. That he had normal lumbar lordosis, without evidence of paraspinal spasm.

He had no areas of localized tenderness on palpation in the lumbosacral area, sacroiliac joints or the sciatic notches.

Q. What is localized tenderness as opposed to just general tenderness?

A. Localized tenderness means when I palpate the various areas I am only touching a local area. In other words, I can't, even though I have reasonably big hands, I can't touch your whole hack at one point, so that I will touch the lumbosacral spine, touch the sacroiliac joint or touch the sciatic notch.

So the palpation is localized to those areas.

Q. What is the significance of no areas of localized tenderness, then?

A. That's a normal finding.

Q. Okay. Thank you.

What else occurred then?

A. I found that forward flexion could be accomplished, such that his fingertips reached his knees.

Extension and lateral bending were performed fully, and he complained of pain with extension and pain with left lateral bending.

Q. Can I stop you there, Doctor?

A. Certainly.

Q. What is the significance of pain with left lateral bending, as opposed to right lateral bending, or is there any difference?

A. When there is one abnormal finding, I can't really attach a lot of significance to that particular finding, in isolation. Mr. McKnight, for example, complained of pain in the left low back.

When he bent toward that side on examination, he complained of pain on that area.

Q. All right. Then what happened next in your examinatior

A. I found that the Burns Test was positive.

Q. Can I stop you there, Doctor?

I would like to know what the Burns Test is, if you can explain that to us?

A. Yes. The Burns Test is one of the tests that is used to evaluate the lumbar spine.

The patient is asked to kneel onto a wooden chair that has no arms, and his body is parallel with the back of the chair.

If I am not being clear, let me know.

Q. Okay.

A. So he is parallel with the back of the chair.

While he is in the kneeling position, I then ask him to sit back so that his buttocks touches his heels, to hunker down.

From that kneeling position, he is asked to bend forward as Ear as he can, to touch the floor, if he can.

In Mr. McKnight's case, after he assumed the position, sat back onto his heels and bent over, he did not touch the floor.

Q. What's the significance of that?

A. The significance of that is that that test demonstrate that Mr. McKnight was not performing to his full capacity.

Q. Why do you use that type of test?

A. That type of test is a confirmatory test for some of the other tests that we use.

For example, when Mr. McKnight was in the standing position, I asked him to bend over, and he only bent over as far as being able to have his fingertips reach his knees.

That's a marked limitation of motion.

Very unusual. By having him perform the Burns Test,

several things occur.

When he gets into the kneeling position and sits back onto his heels, he relaxes his hamstring muscles. He also relaxes the muscles that go from his spine down to his pelvis and he also flattens out his lumbar lordosis.

In that position he is putting his spine and his extremities in the most relaxed position that there can be, and unless he had the condition, which I will explain in a minute, he ought to be able to bend forward and touch the floor.

Now, the conditions, none of which Mr. McKnight had, would be a fused spine, or a rigid spine, fused hip joints, or solid hip joints, total hip replacement, whatever.

So in essence what I am saying is that Mr. McKnight had the capacity to perform the 'BurnsTest such that he could have,touched the floor if he wanted to.

Q. Well, did you then conduct other tests, Doctor, on the patient?

A. Yes, I did.

Q. And what else did you do?

A. I found that heel walking and toe walking were Fer-formed without evidence of weakness or of pain.

I found that sitting straight leg raising could be accomplished to the horizontal bilaterally, and that each maneuver was accompanied by left low back pain.

Q. Is there any significance to those findings?

A. The fact that sitting straight leg raising could be accomplished to the horizontal bilaterally is significant in that it is a normal finding.

The fact that he complained of low back pain on both the right side and the left side again is a finding that needs to be considered with respect to the other findings.

He had some pain, and I noted that.

Q. Okay. And what else then was done?

A. I found that supine straight leg raising could be accomplished to 45 degrees on the right and to 60 degrees on the left, and that each maneuver was accompanied by left low back pain.

Q. Can I stop you there?

What is the difference between sitting straight leg raising and this supine straight leg raising,?

A. Sitting straight leg raising is performed with the patient initially sitting over the edge of the examining table, and initially his knees are Sent.

I asked him to raise one leg and then the other leg, so that his knee is extended.

In that position, his leg is parallel with the floor, and then the test could be performed to the horizontal. What I mean by that is, his leg is now parallel with the floor and forming a right angle or a 90 degree angle with his

body.

The supine straight leg raising test is performed by asking the patient to lie down, and then I assist him in raising up one leg and then the other leg.

Then when he indicates either he is having pain, or there is resistance to this maneuver, we stop.

So in Mr. McKnight's situation, sitting straight leq raising could be accomplished such that he formed a 90 degree angle between his legs and his body. That's a normal finding

When we turned -- when he turned over, 90 degrees so that he was lying down, he only performed this to 60 degrees on the right, and to 45 degrees -- I am sorry -- 45 degrees on the right and to 60 degrees on the left, about a half to two-thirds what he did in the sitting position.

Q. Should there be any difference between those two tests

A. No, there shouldn't be. There is no anatomic basis for this.

Q. Does this correlate back with the Burns Test, this type of finding?

A. Yes, it does.

Q. All right. And what else did you do with regard to Mr. McKnight, then?

A. I found that the Lasegue's maneuver was negative.

Q. What's that?

A. The Lasegue's maneuver is a test that is designed to

put stress on the sciatic nerve.

The test is performed during the supine straight leg raising test, and it is done just at the limit where the patient complains of pain.

I then dorsiflex his ankle or bring his toes into the upward position.

That maneuver causes tension or stretch on the sciatic nerve.

When the test is negative, the patient has no complains of pain in his leg and in particular in his calf.

Q. And what other examinations did you perform?

A. I performed a neurological examination of the lower extremities and found that he had hyperactive deep tendon reflexes, no ankle clonus, normal sensory perception, a giving way type of weakness of each extensor hallúcis longus and normal strength of the other muscle groups.

Q. Can I ask you about the type -- this giving way type of weakness and the extensor hallucis longus?

A. Yes. The extensor hallucis longus is the long extensor of the great toe, and that particular muscle is ennervated or supplied by a specific nerve.

When I asked him to bring his toes up and to hold them against my resistance, they collapsed very quickly. Again, that's not a finding that has any anatomical basis.

When somebody has weakness, they will bring, for

example, their toe up, and they will resist my pushing and ultimately fatigue, and the muscle or the toe actually will begin to drop.

This was the type of weakness that we refer to as giving way; with the slightest of pressure, his toe fell down

Q. Is this the same type of finding, then, going back to the Burns Test and the findings in the supine and the sitting straight leg raising?

A. It falls into the same category, yes.

Q. All right.

Was there any other examination, physical examination performed by you?

A. No, there was not.

Q. Does that conclude all of the standard orthopedic examinations that you needed for purposes of your' engagement in this case?

A. It included all the standard orthopedic examinations that I would use on any patient, not just particularly for you, Mr. Murphy.

Q. Okay. Did you do anything else then, Doctor, concerning this patient?

A. Yes. I sent -- referred. him to the radiologist next door, asked that radiographs of the cervical spine and lumbosacral spine be obtained, and personally went over and reviewed those radiographs after they had been taken.

Q. And can you tell us, Doctor, what the findings were with regard to the radiographs that you took on December 4th?

A. Yes. The radiographs of the cervical spine showed no evidence of fracture, dislocation or disc space narrowing.

Q. And how about the x-rays of the lumbosacral spine, low back?

A. They showed no evidence of fracture or dislocation. There was narrowing of the lumbosacral interspace with associates spurring.

Q. And where precisely was that located?

A. The narrowing was at the lumbosacral interspace or the interspace that is between the fifth lumbar and first sacral vertebra.

Q. Okay. Now with regard to anything else you did on the 4tk of December, did you'do anything else concerning the patient, first of all?

A. Physically?

Q. Physically?

A. No, I did not.

Q. Did that conclude your physical examination and your x-ray examination of Mr. McKnight?

A. Yes.

Q. And then he left your office, I take it?

A. Yes.

Q. In the company of his lawyer?

A. No, in the company of Mr. Rosen.

Q. Okay. And did you read any additional, or did you have any additional records or documents at that time?

A. I did.

Q. And did you review those?

A. I did.

Q. Did you have any films, other films at that time?

A. Yes.

Q. And did you review those?

A. Yes.

Q. Did you have everything you needed in terms of other films and records and documents at that time?

A. No, I did not.

Q. And what documents and records or films did you find you were lacking?

A. I had -- the documents that were lacking were the emergency room record from April 30th, 1983 at Lakewood Hospital.

The reports of Doctors Mulligan, Katzenmeyer and Yurick; and the radiologist's interpretation of the CT scan of the lumbar spine.

Q. So did you formulate any opinions at that time, or did you defer that until you had all of your -- all of these documents and records?

A. I deferred it until I had the remainder of the

documents and records.

Q. Okay. And then did there come a time when I later got those materials for you?

A. There did.

Q. And did you receive those then sometime thereafter?

A. Yes, I did.

Q. And then you reviewed those, I take it?

A. That is correct.

Q. To go back just for a moment, did you review the x-ray film that was taken at Lakewood Hospital on April 30th, 1983 --

A. I did.

Q. -- emergency room?

A. I did.

Q. And did you compare that with the film you took here?

A. Yes.

Q. And what were your findings in terms of reading that film and the films you took on December 4th?

A. I found that the radiographs of the cervical spine, which were obtained on April 30th, 1383, were the same as the films of the cervical spine that were obtained on December 4th, 1984.

In essence, they were normal.

I also found that the radiographs of the lumbosacral spine that were obtained on April 30th, 1983, were the same

as the radiographs that were obtained on December 4th, 1984.

That is to say, it was the same degree of narrowing of the lumbosacral interspace with the same degree of spurring the day after the accident as there was when I examined him in 1984.

I was trying to -- a year and seven months later.

Q. Can you tell the jury what you mean by narrowing and spurring?

A. Yes. Spurring refers to an additional bony proliferation or bony growth, much like a spur or a barb, or an additional projection on the bone. This is as a result of arthritis or degenerative changes.

Narrowing refers to the fact that the space between each vertebra has a normal height. And in addition, each vertebral interspace has a normal relationship to the remaining interspaces.

For example, the widest interspace is the L4-L5 interspace. The lumbosacral interspace, the L5-S1 interspace is about the same height or width as the L3-L4 interspace, the one above it.

Narrowing is a condition where, when I look at the x-rays, I can see that the height of that space between the two vertebra is less than it should be.

It is smaller or narrower.

Q. And what are the causes of narrowing?

A. The most common cause of narrowing is a condition referred to as degenerative disc disease.

The other causes of narrowing can be infection, can be post-surgical changes: for example, as a result of a laminectomy.

There is a congenital narrowing, in other words, a narrowing that an individual is born with.

I was just trying to think of if I had seen any narrowing immediately following trauma, or if that condition exists. It really doesn't exist immediately after trauma, so those are the basic causes.

Q. Doctor, with regard to Mr. McKnight, specifically, did you have an occasion, in addition to reading his plane films, to look at the CT scan that was performed?

A. Yes, I did.

Q. Now, before we get to that, Doctor, can I ask you this:

Is there degrees or -- strike that.

In terms of the disc, and its relationship with the vertebrae, and its relationship with the nerves and the dur , do discs bulge, extrude, protrude, or herniate?

A. Yes, all four.

Q. Can you sort of explain that for me?

A. Sure. The disc, when it is looked at in cross-section, is like a disc, like a donut without a hole.

It has a covering around it that is referred to as the anulus.

In addition, it is reinforced in the front by the anterior longitudinal ligament, and in the back by the posterior longitudinal ligament.

In its normal configuration, the disc is oval in its geometry.

The earliest form, or the most minimal degree of abnormality or pathology would be a bulging disc, and what occurs when you look at the disc, instead of being oval and symmetrical within the confines of the anulus, it has a bulge.

It is beginning to push on the anulus and stretch the anulus in a certain area.

The next degree would'be a protrusion, which is a larger bulge, if you will.

The next degree would be an extrusion. I would think of -- when people commonly think about -- when they talk about extruding things, if you had a pasta maker, for example, and you were making some pasta, for example if you were making the slices of pasta, you were-extruding it out of the pasta maker, so with an extrusion there is now a hole in the anulus or a tear in the anulus, and a portion of the disc material is now extruded or pushing out of this.

And a herniation is the other end of the spectrum, the

highest grade of the spectrum, wherein this extruded piece has completely come out of the confines and is lying free and separate from the disc.

Q. Do you treat people with these various disorders in your everyday practice?

A. Yes, I do.

Q. Is this one of the common problems that you treat in your practice?

A. Yes.

Q. Are there classic then symptoms to a person who would have a herniated disc or an extruded disc?

A. Yes.

Q. And what are the classic symptoms and findings?

A. The classic symptoms and findings of a herniated disc would be an individual who has back pain, and more important1 who has leg pain.

Oftentimes, patients who have an extruded or herniated disc will tell you that they had back and leg pain sometime in the past, and all of a sudden their back pain went away, but their leg pain got worse.

Now, we will confine things to the Lumbar spine, otherwise we will be here for quite a while, and we will confine it to three specific levels, because those specific levels are the most common levels of a herniated disc.

There's the disc between the third and fourth lumbar

lumbar vertebrae, the L4-L5 interspace, and between the fifth and the first sacrum, the lumbosacral interspace.

Each of those areas has a specific pattern. And perhaps to simply it even more, let's just look at the lumbosacral interspace, the lowest interspace.

With an individual who has a herniated disc, an extruded disc, at the lumbosacral interspace, his leg pain would be unilateral. It would be on one side or the other.

Let's assume it is on the left side, he would complain of pain in his back, radiating into his buttocks, down the posterior aspect of his thigh, or the back of his thigh, into the posterior or posterial lateral, into the back or the back and outer side of his calf, into his foot and the lateral aspect of his foot, the little toe and the fourth toe, the one right next to it.

Those would be his complaints of pain.

Depending upon the length of the time that the disc had been herniated, he would also, or may also, have numbness, and the distribution of his numbness would follow the same distribution that I talked about, and would probably be more pronounced in the little toe and next to it.

There are a whole variety of activities that would increase his symptoms. There are a whole variety of activities that would make his symptoms better.

In terms of his physical findings, he would have some, if not all, of the following things: He would have limitation of straight leg raising, both sitting and supine, to the same degree.

He may have a positive Lasegue's test, with pain radiating into his calf.

Classically, he would have loss of his ankle reflex. He would have weakness of his calf musculature.

He would have difficulty or inability to walk on his toes, and he would have decreased perception of light touch along the lateral border of his foot.

Q. Now, can I ask you then to consider Mr. McKnight in terms of your examination, specifically regarding, let's say the potential for a diagnosis of extrusion or herniated disc at L5-S1 on Mr. McKnight.

Did he have any of those findings that you just elicited?

A. He had none of these symptoms. He had no neurological findings, and he had limitation only of supine straight leg raising, without limitation of sitting straight leg raising, and that was on both sides, rather than one side.

So in the pure sense, I would say, no, he had none of the classical findings of a herniated disc at the lumbosacral interspace.

Q. With regard to the unilateral left side finding or

pain symptom, did you find that Kr. McKnight had unilateral pain?

A. He complained of pain unilaterally in the left side of his back.

I don't recall that he complained of left leg pain at the time that I examined him.

Q. Well, left -- I will ask you to assume, Doctor, that there has been a diagnosis of a disorder on -- causing an impingement of the nerve on the right side at L5-S1. What unilateral symptomatology should there be for that type of finding?

A. For the diagnosis of an extruded, or --

Q. Or herniated disc?

A. -- or herniated disc, the right side at L5-S1, it would be all the same symptoms that I talked about on the left side, but on the right side. He would experience them down his right leg in the distribution that I talked about.

Q. And was there any of that in Mr. McKnight's case?

A. No, there was not. In fact, I just reviewed his history again, and he had no leg radiation when I examined him.

Q. Now Doctor, if we could get into the CATscan, maybe you could put it up on the shadow box there behind your desk.

THE VIDEO OPERATOR: We are off the record.

(Off the record.)

THE VIDEO OPERATOR: Stand by, we are on the record.

BY MR. MURPHY:

Q. Doctor, you now have on the shadow box some of the films taken of Mr. McKnight at Lakewood General Hospital, as I understand it.

These are the types of films that you talked about before that you deal with on a regular basis in your practice?

A. Yes.

Q. And with regard to the films of Mr. McKnight, can you tell me from looking at those films if you have reached a diagnosis or a finding relative to the films?

A. Yes.

Q. And can you tell me what your interpretation of the films is?

A. This is the Scout film.

This is the film that is taken for the radiologist as a reference, so that when he takes the remaining films of the CATscan, he can localize things in space, and in particular in the patient's -- with respect to the patient's anatomy.

This film shows narrowing of the lumbosacral interspace, the L5-S1 interspace.

In the remaining films, and I am referring to Defendant's Exhibit A through D, as well as E through G,

I reached the conclusion that there is no evidence of a herniated disc.

Q. Okay. Now, with regard to the protrusion of discs or the extrusion of disc material, or the bulging beyond the normal boundaries of the disc, are there classic measurements that can be made from films such as a CATscan?

A. Yes.

Q. And is there a rule of thumb that is followed in terms of what type of protrusion, extrusion, herniation, or bulge, you must have before it becomes pathologic?

A. Yes.

Q. And what measurements are those?

A. Well, the radiologist can measure the degree of bulge or protrusion, and it is considered that when there is a protrusion that is five millimeters or larger, that is considered to be pathologic.

Q. And by pathologic, what do we mean, Doctor?

A. Abnormal.

Q. And less than that would then be within the normal range?

A. That would be considered within the normal range.

Q. And is it -- what is your opinion with reasonable medical certainty as to the measurement of the protrusion in this case, in terms of normal or abnormal?

A. I believe with a reasonable degree of medical certainty that there is no abnormal protrusion in this situation.

Q. Thank you very much, Doctor.

THE VIDEO OPERATOR: We are off the record.

(Off the record.)

THE VIDEO OPERATOR: Stand by. We are on the record.

BY MR. MURPHY:

Q. Doctor, based on your review of all of the films and all of the records of Mr. McKnight, together with your examination, and based on your experience as an orthopedic surgeon in treating conditions of the human spine, did you arrive at an opinion, based on a reasonable degree of medical certainty, as to your findings as to whether or not Mr.McKnight suffered any orthopedic condition as a result of the accident

April 29th, 1983, Mr. McKnight sustained a cervical and lumbosacral strain.

Q. And Doctor, I will ask you to assume for purposes of this question that Mr. McKnight was involved in an automobile accident on the 30th of April, 1983, and that he went the

next day to Lakewood Hospital and had emergency room treatnent for symptoms to his neck and low back, and that he followed up with Dr. Mulligan on the 2nd of May, 1983, and that he was referred to Dr. Katzenmeyer at Lakewood Hospital for therapy, and received therapy until June 3rd, 1983;

And at that time the discharge note stated that the only pain now is in the middle of the back of his neck, burning sensation after sitting a while, and that he returned to work at that time and had no medical treatment whatsoever for June, July, August, and most of September, 1983, until he returned from Pennsylvania on a car trip near the end of September of 1983 and went to Dr. Mulligan for this low back symptomatology, and then was referred to Dr. Yurick and had a CATscan that you saw.

I will ask you if you have an opinion, based upon reasonable medical certainty, if the findings by Dr. Yurick and the treatment by Dr. Yurick that occurred after September of 1983, and any subsequent treatment he may have had from any physician after September, 1953, related with reasonable medical certainty to the accident of April 29th, 1983.

MR. PARIS: Objection.

A. I have an opinion, but may I ask you if I have to assume all the things that you said, even though I know that

one of those things is not true?

Q. Doctor, what did I tell you that is not true?

The accident was April 29th, 1983, and the beginning of your question indicated that it occurred on April 30th, 1983.

MR. MURPHY: Okay.

MR. PARIS: Want to reask that, Marty?

BY MR. MURPHY:

Q With that correction, Doctor, do you have an opinion as to whether the treatment after September of 1983 was related to the accident?

MR. PARIS: Objection.

A. Yes.

MR. PARIS: Objection.

A. Yes, I have an opinion.

MR. PARIS: Objection.

Q. And what is your opinion?

A. My opinion is that the treatment which he received in September of 1983 was not related to the accident which occurred on April 29th, 1983.

THE VIDEO OPERATOR: Excuse me. We are off the record.

(Off the record.)

THE VIDEO OPERATOR: Stand by. We are on the

record.

BY MR. MURPHY:

Q. And Doctor, with regard to the bulge that was noted in this particular case, do you have an opinion, based upon a reasonable degree of medical certainty, as to whether that bulge is related to the accident of April 29th, 1983?

MR. PARIS: Objection.

A. Yes, I have an opinion.

Q. And what is that opinion?

MR. PARIS: Objection.

A. That it is not related to the bulge -- the accident of April 29th, 1983.

Q. In the history taking from this patient, by the way, Doctor, did Mr. McKnight tell you that he was a weightlifter?

A. No, he did not.

Q. Well, I will ask you to assume that from 1976, when Mr. McKnight graduated from Kent State -- or I believe he finished two years at Kent State University -- until an accident that occurred in 1981, he was involved in weightlifting, continuously and regularly on a weekly basis, I believe, three times a week.

I will ask you to assume that.

And with the exception of the hiatus of six months in 1981, until the time of this accident, was a weightlifter; do you have an opinion, based upon reasonable medical

certainty, that that type of activity causes -- caused abnormal wear and tear on the spine of this particular individual?

A. Yes, I have an opinion.

Q. And what is that opinion?

MR. PARIS: Objection.

A. Certainly weightlifting three times a week for a prolonged period of time does cause the spine to experience excessive loads nd as a result would cause, and I believe caused, abnormal wear and tear on Mr. McKnight's spine.

Q. When you saw him, he was, I believe, 31 years of age?

A. That is correct.

Q. And you noted some narrowing and some degenerative changes in this young man.

A. That's correct.

Q. Was that usual for his age group?

A. Not for a 31-year old.

Q. Okay. And taking into consideration the history of weightlifting that I gave you, would that provide an explanation?

MR. PARIS: Objection.

A. Yes.

Q. With reasonable medical certainty?

A. Yes, it could.

Q. Now, with regard to a bulge -- just one final question about the bulge, Doctor.

Is it significant if the bulge is central, as opposed to lateral?

In a disc between L5 and S1, in an anterior extradural bulge?

A. Yes. The location of the bulge is always significant.

Q. And what's the significance of the bulge, the location of the bulge?

A. The significance of the location of the bulge is that if the bulge is central, then it does not press on the two nerve roots which are peripheral or lateral to that, and the central bulge therefore cannot be productive of any leg radiation, and cannot fall into the category that's described as a herniated disc.

Q. And with regard to central bulges, if they were related hypothetically, if a bulge was related to trauma, would there be a finding regarding the ligaments attached to the disc?

MR. PARIS: Objection.

A. Yes.

Q. And can the disruption of those ligaments be clinically diagnosed by an orthopedic surgeon?

MR. PARIS: Objection.

A. Not per se, no.

Q. Okay. How are they diagnosed?

A. Well, actually I didn't answer your last question

Yes, they can be diagnosed by an orthopedic surgeon when he operates on the patient and looks and sees that the patient's ligaments are ruptured. Barring an operation, any diagnosis that he makes is inferential, although accurate.

In other words, if he were to get a myelogram or a CT scan and see a herniated disc, the far end of the spectrum he would infer, and accurately so, that the ligament had been torn or ruptured, because that's the only way the disc material could have extruded or become herniated.

Q. For instance, in Mr. McKnight's case, do we know, without taking a repeat CATscan, or without a myelogram, or without surgery, if in fact, the bulge is there today?

A. No, we don't.

I would suspect that it is there today, because it was back there in September of '83.

Q. Okay. Was it there, in your opinion, to a reasonable degree of medical certainty, at the time of this accident?

A. On the day of the accident, for example?

Q. Yes.

A. Considering the fact that he had degenerative disc disease on the day of the accident, I would say, yes.

MR. MURPHY: Thank you very much, Doctor. I have no further questions.

CROSS EXAMINATION

BY MR. PARIS:

Q. Doctor, my name is David Paris. I repr sent Tim McKnight.

Just to follow up on that last question, Doctor, if Mr. McKnight didn't have any degenerative disc disease, as you call it, at the time of this accident, would ycur opinion be different?

In other words, that there probably was no bulge there at the time of the accident?

A. It would be different, but I wouldn't be able to say whether or not there had been a bulge at the time of the accident.

Q. Then your opinion would be different, and that you would have no opinion one way or the other?

A. That's correct.

Q. Okay. In any event, there was a bulge as depicted in the CAT scans taken in October of 1983, is that correct?

a. That is not my opinion.

0. Let me rephrase the question.

A. Yes.

0. Do you suspect that there is still a bulge there today?

A. No.

Q. That was your last opinion to Mr. Murphy.

A. That's right. You are absolutely right. That's what I said.

Q. All right.

Now, can I take a look at your file very briefly, before we start?

A. Certainly.

THE VIDEO OPERATOR: We are off the record.

(Off the record.)

THE VIDEO OPERATOR: Standby.

We are on the record.

BY MR. PARIS:

Q. Doctor, on what date were you first retained by Mr. Murphy to examine Mr. McKnight?

A. August 7th of 1984.

Q. And your defense medical examintaion was December 4, 1984?

A. That's correct.

Q. And that was about four months before the actual exam?

A That's correct.

Q. And, Doctor, at that time was that how long you were booked up in advance for defense medical examinations?

A I suspect that that probably was the case.

Q. And is that about how long you are currently booked

up in advance?

A. Yes.

Q. You do charge a fee for reviewing Mr. McKnight's records, the films, conducting the defense medical examination and preparing the report, I take it?

A. Yes.

Q. What was your fee in this particular case?

A. I have no independent recollection.

Q. Is your customary fee still in the range of $175 to $250?

A. Yes.

Q. Okay. And just to clarify, the purpose of your defense medical exam was not for the purpose of treating Mr. McKnight, but rather solely to render an opinion and prepare a report for Mr. Murphy on his behalf; is that correct

A. Yes.

Q. Okay. You are charging a fee for your testimony today?

A. I never charge a fee for my testimony, Mr. Paris. Nobody buys my testimony.

I am charging a fee today to compensate me for the time away from my practice.

Q. And your customary fee is what, $500 for the first two hours?

A. That is correct.

Q. And additional charges thereafter?

A. Correct..

Q. I take it you did charge for your time that you set aside in early March of this year, when this was supposed to be tried, but the trial was cancelled?

A. I don't recall whether I was notified far enough in advance.

if I was, then I didn't charge for that time. If the cancellation occurred reasonably close to that time, yes, I did charge.

Q. And you wouldn't charge if you were notified how long in advance?

48 hours.

That's close.

You met with Mr. Murphy again immediately prior to our last trial date of March 6, 1986, I take it?

A. Yes.

And you reviewed the CAT scans and films at that time?

A. Yes

Q. Did you also charge him an additional fee for that?

A. Yes.

Q. And what would have been your customary fee for that?

A. I don't recall how much time Mr. Murphy and I spent,

but I would have charged on an hourly basis at the rate of $200 an hour.

Q. Okay.

Now, this is not the first time that you have been retained by defense to examine a plaintiff in order to render a report and opinions and if necessary testimony in Court, is that correct?

A. That is correct.

Q. And would it be fair to say, in fact, that you perform about four defense medical examinations on plaintiffs per week on behalf of defendants?

A No, it is really only three.

Q. And when did it change from four to three?

A. Sometime between the last time you asked me the question and today.

I don't keep track of that. It is generally three a week, and with cancellations and other kinds of changes, it is probably averaging out less than three, but we schedule three a week.

Q. All right.

But you certainly recall the last time I was here, which was only a matter of probably four weeks ago, in regard to your testimony on behalf of Buckeye Union Insurance Company and Eleanor Latkovich, you indicated that you were still doing about four defense medicals a week; do

you recall that?

MR. MURPHY: I object to that. I will object to that.

A I remember you being here. I don't remember what I said. You just said, "about four"?

Q Yes.

A Believe me, we schedule three a week on the average, which I think was your question.

MR. NURPHY: Well, I want to object for the record. If you have a transcript from before, I think that would be appropriate to impeach what he said.

MR. PARIS: All right.

BY MR. PARIS:

Q As a matter of fact, Doctor, you ordered a copy of that video tape.

MR. MURPHY: If you don't have a transcript so that the witness can see it -- let's go off the record.

THE VIDEO OPERATOR: We are off the record.

(Off the record.)

THE VIDEO OPERATOR: Standby.

We are on the record.

BY MR. PARIS:

Q At least, Doctor, between yourself and I, we can

agree that you do between three and four defense medical examinations a week?

A Yes.

Q. Okay. That would be somewhere shy of a about 200 a year, taking into consideration that you take some time off from your practice?

A. It would be closer to 150 than it would be to 200.

Q. Okay.

A. Out of thousands of patients that I see a year.

Q. And that would be true in 1985?

A. 1985, yes.

Q. 1984?

A. Yes, probably.

Q. And 1983?

A. You know, I am getting old. I don't remember back to 1983.

Q. Okay. And, Doctor, would it be fair to say that your physical examination of Mr. McKnight upon which you are basing your testimony here today in part, only lasted ten minutes?

A. I have no independent recollection of the amount of time that I spent examining Mr. McKnight. That is not an important issue to me.

I took as much time as was necessary to completely examine Mr. McKnight.

Q. Certainly you wouldn't dispute the fact that it probably took only about ten minutes?

MR. MURPHY: Objection. He just answered the question.

Q. Are you saying you don't know, or is ten minutes a reasonable calculation of time?

MR. MURphy: Objection.

A. What I am saying is that I don't have a recollection, that Mr. Rosen was there, and I assume that Mr. Rosen is honest, so whatever he told you I spent is what I spent.

Q. Okay. Now, I take it you consider the history as related by the patient and his records to be of importance to you in drawing conclusions about the patient's diagnosis and perhaps the cause and effect relationship between the car accident and whatever findings and/or complaints he had.

A. Yes.

Q. And I presume that one of the significant factors that would be of importance in the history is whether in fact this accident presented significant trauma, is that a fair statement?

A. I am not sure I understand your question.

Q. Well, would it be important to know whether or not the accident presented a significant trauma?

A. Yes. The only problem I have with that question is

that we have to define what significant trauma is.

Q. I mean, a significant collision between two moving forces.

A. Okay.

Q. Would that be significant to you?

A. Yes. That would be a factor I would consider.

Q. Okay. In connection with that history, Mr. McKnight did advise you that on April 29, 1983 he was in a car traveling down a road, and was struck head on in a head on accident by another car.

A. Yes, he did.

Q. Apparently by way of history, the impact was significant enough to push his car backwards?

A. That's what he told me.

Q. Doctor, I am sure you had many patients that have been involved in significant trauma where the history indicates what is commonly known as an extension flexion type trauma to the head, neck and lower back.

A. That is correct.

Q. And I suspect that you are highly skilled in biomechanics, having spent a year at the Case Western Reserve Biomechanics Lab, and I am not skilled in that area, but my understanding would be that if your auto was hit head on and comes to an abrupt halt or something to that effect, what happens to your body in the car?

A. You just said to me: My understand is, and you ended it with a question.

Q. I decided not to give you my understanding for fear that I may be totally wrong.

A. You want my understanding?

Q. What is your understanding?

A. My understanding is that if you have an individual who is riding in a car, and the car comes to an abrupt halt as a result of a collision, he continues to move for a short period of time.

Q. And is he put in a rather acute phase of flexion?

A. Yes.

Q. Okay. And does the body ever move backwards in extension?

A Yes. Then it will move backward in extension.

Q. That follows immediately after the acute phase of flexion?

A That is correct.

Q. And is that a fair summary of what happens to an individual, such as Mr. McKnight, in a head on collision?

A. I would say so, yes.

Q. Drawing from your knowledge of biomechanics as applied to orthopedics, that is pretty much what you imagined would have happened to Mr. McKnight as a result of this accident?

MR. MURPHY: Objection to imagination.

A. Yes.

Q. And in fact that's what you inferred happened when Mr. McKnight gave you a history that he was thrown around the car in the accident; would that be fair?

A. I didn't make any inferences at the time.

Q. Okay. Now, it would of course also be significant to you, and you did make inquiry as to whether Mr. McKnight had any problems or complaints prior to this car accident, regarding his neck and low back?

A. Yes.

Q. And that in this particular case, the history that was given to you was that he did not have any prior or subsequent injury to his low back?

A. That's correct.

Q. In that -- by way of history and all the records you have reviewed in April of 1981 he had a car accident injuring his neck and shoulders, which he did make a complete recovery from before his accident of April of '83; is that correct?

A. Yes.

Q. Okay. And that immediately prior to this accident of April, 1983, he had no significant neck or low back pain, and as far as he could describe it, he considered that he had an essentially normal functioning neck and low

back, for all practical purposes?

A. That's what he related to me, that's correct.

Q. And you have no reason to believe from anything that has been submitted to you, including the voluminous medical records which you have examined, your own history, which is usually very thorough, to believe otherwise than the fact that he was essentially functioning in a normal manner prior to this accident, as far as his neck and low back are concerned; isn't that true?

A. No, that isn't true.

Q. Okay. Why is that not true?

A Because I know that Mr. McKnight had evidence of degenerative disc disease in his lumbosacral spine on the day of the accident. There was narrowing and spurring.

I also have learned today that Mr. McKnight was a weight lifter prior to this accident, and therefore I believe that Mr. McKnight was not totally asymptomatic or without symptoms with respect to his low back before this accident.

Q. And you felt that he was lying to you?

A At the present time, I wculd say that, yes, he was lying to me.

Q. Okay. Now, Mr. Murphy asked you to assume that Mr. McKnight was a weight lifter. Now, that is a very general term.

Mr. Murphy did ask you the amount of weight lifting. He didn t ask you the type of weight lifting he was doing, the amount of the weights on the dumbbells, or if they are dumbbells or barbells, if they're bench presses, curls, leg lifts, what have you: is that significan to you in any regard?

If he is working out with three pound weights as opposed to 60 pounds, if he is doing curls as opposed to bench presses?

A Yes.

Q. If he is doing curls sitting as opposed to standing up?

A. Yes.

Q. Okay. So your opinions could be altered in that regard as it relates to weight lifting?

A. Yes.

Q. Depending on the type of weight lifting Mr. McKnight was doing prior to this accident?

A Yes.

Q. And would it be fair to say that if Mr. McKnight on a three times a week basis, like many of us try to do what we call repetitions with a small amount of weights, like I myself do at home with 20 pounds to do curls or something of that nature, would that affect your opinions as it relates to the stresses on the spine?

MR. MURPHY: I am going to object: is that what he is going to testify to?

MR. PARIS: I don't know what he is going to testify to, Marty. You didn't inquire and you asked the doctor what his opinions are.

MR. MURPHY: All I know is that he is a weight lifter.

MR. PARIS: I just want to know what the doctor's opinions are.

MR. MURPHY: All right.

But I just want to sure that you are giving hypotheticals that will be supported in the evidence.

MR. PARIS: All I want to know is what the doctor's opinions are.

MR. MURPHY: All right.

If that's what he did -- if you are representing that's what he did, you can ask him.

A I couldn't make an opinion about the effect of your weight lifting on Mr. McKnight's back, so I don't understand your question.

Q Okay. Certainly the amount of stress put on a spine by doing bench pressing with weights of 60, 70, 80, 90, 100 pounds, is much different than doing curls with dumbbells at 15 or 20 pounds, would you not agree with that?

A. Yes.

Q. Okay. And you would not expect, I take it, that an individual who does such things as curls with dumbbells 20 pounds or 25 pounds or less than that, would be putting the amount of stress on the spine to cause the type of degenerative disc disease in a young man in his late 20's, that you claim you saw of Mr. McKnight's spine.

A. The answer to the first part of your question is yes, and I guess the second part is where I claim. I mean, I did see it. Maybe we are hassling over words, but I agree with what you just said.

Q. Now, the other thing that you claim that you are basing your opinion that Mr. McKnight was symptomatic before April 29, 1983, is that you found evidence of narrowing in his L-5, S-1 disc space on the April 30, 1983 films, is that correct?

A. In addition to spurring, yes, that's correct.

Q. You did have a chance to review all of the medical records that Mr. Murphy provided you regarding Mr. McKnight?

A. Yes.

Q. You've had an opportunity to review Dr. Mae Urso's interpretation, the radiologist at Lakewood Hospital who read the films of April 30th, 1983.

A. I suspect that I did. I don't remember the

doctor's name. But I will for the sake of time, assume that you are correct

Q. Did the radiologist who read those films immediately after they were taken on April 30, 1983, interpret them as showing any narrowing of the L-5, S-1 disc space?

A. Do you have the report handy?

If not, I will try to find it.

Q. Yes. That will be marked at trial, the second page of Plaintiff's Exhibit 2-A.

A. I don't remember the question. But the answer is that Dr Urso's impression of the radiographs obtained on April 30, 1983 was, and I quote, "Normal lumbosacral spine."

I don't agree with that

Q. Fine.

Is there anything else, aside from those two items, which lead you to believe that Mr McKnight s symptomatic prior to his accident of April 29, 1983?

A. No

Q. Okay You certainly haven't reviewed any medical records indicating that he was into any hospitals or doctors or chiropractors or ort opedic surgeons for any complaints of pain or any treatment between the fall of 1981 and April 29, 1983?

A. That is correct

Q. Now, there were some plane X-ray films of Mr. McKnight's neck and low back taken at the emergency room, April 30, 1983, which we just discussed, and you examined those and found narrowing of the L-5, S-1 interspace with associated spurring.

And leaving the discrepancy between your interpretation and the radiologist's interpretation aside for the moment, what degree of narrowing did you find when you looked at those films?

A. The same degree of narrowing as was present when I examined him in December of 1984.

Q. Well, I guess what I am asking is, was it severe narrowing, moderate narrowing, slight narrowing?

A. I would say that it was mild to moderate, judging from the lack of other adjectives in describing it.

Q. Now, where does it say mild to moderate in your report?

A. That's what I said. It does not say that, and i said that because of the lack of other adjectives.

In other words if it had been severe, I would have said severe.

So therefore I assume that it was mild to moderate.

Q. Okay. So I am just trying to understand. If it would have been slight, you would have put slight, or is that a term you don't use?

A. That's not a term that I use.

Q. If it would have been severe, you would have put severe; if it wasn't severe, you wouldn't put anything?

A. That is correct.

Q. Okay. And if it is not severe, it could be mild or it could be moderate?

A. Correct. That's why I said mild to moderate.

Q. And it would be your opinion that that degree of narrowing existed for a substantial period of time prior to April 30, 1983?

A. Yes.

Q. And you compared those films of April 30, 1983 to the ones that you took on the day of your defense medical exam, December 4, 1984, and found there to be no change in the films over that 17 month period of time?

A. Correct.

Q. Doctor, isn't it true that there are many people walking around in the world today with mild to moderate narrowing of a vertebral interspace, who are capable of performing normal daily functions without pain and disability?

A. Let's go back to your last question.

April of '83 to April of '84 is 12 months.

Q. I am sorry.

A. April to December is 20 months. It is 20 months.

Q. I am sorry.

A 20 month differential.

A. All right. So the answer is still yes, but no, or whatever I said.

Q. There hasn't been any change in 20 months?

A. That's correct.

Q. Your next question was?

A. My next question is aren't there many people walking around today in the world with narrowing of a vertebral interspace who are capable of performing normal daily

the normal daily functions, right.

Q. And isn't it also true if an individual has some underlying lumbosacral interspace narrowing, and they get subjected to the type of flexion and extension injury that Mr. McKnight was involved in, that they frequently develop symptoms and disabilities that were not present previously?

A. Yes, that is certainly true, and peopie who have had no pre-existent disease also can develop symptoms after an accident, such as Mr. McXnight had.

Q. Exactly.

So that if somebody has a problem in their back, such as arthritis, but they don't experience symptoms, what

do we call that, a quiescent condition, is that what doctors call it, or is that what lawyers call it?

A. That's probably what lawyers call it, because doctors don't see patients when they are quiescent.

In other words, somebody comes to you because they have complaints. We'll call it quiescent.

Q. Okay.

And certainly you would agree that somebody who is subjected to the type of trauma as described to you by -- in this particular case, which that trauma is superimposed on a quiescent, pre-existing narrowed L-5 disc space, that such a trauma may precipitate or at least aggravate this quiescent condition to become actively symptomatic; would you agree with that?

A If you say may, then I would agree with you.

I believe that's what you said.

Q. And, Doctor, let me ask you to assume certain facts to be true for the purpose of my next question.

Assume that whatever degree of narrowing at the L -- lumbosacral interspace Mr. McKnight had in his low back before this accident, which you claim the April 30, 1983 X-rays show, it was not at least not bothersome enough to require that he seek relief from a hospital, doctor, chiropractor, osteopath or orthopedic surgeon prior to this accident: assume that to be true.

And regardless of the years that this alleged condition may have existed before this accident, it didn't interfere with his driving long distances, putting on his pants, tying his shoes, athletics and household chores.

Assume that to be true.

Now along comes this car accident where his car is totaled after being hit head on, that he is subjected to an extension flexion injury where he immediately feels pain in his neck and later that evening pain in his low back, that the next day he goes to tne emergency room to seek relief, and thereafter seeks relief from a series of physicians of various medical specialties, as well as physical therapists.

Assume further that lumbar X-rays taken in the emergency room on April 30, 1983, are read by you and interpreted by you as showing some narrowing and spurring at the L-5, S-1 level, and once again the films taken by you about a year and a half or so later show the same degree of narrowing, that is there has been no progression of the alleged lumbar arthritis.

Now assuming those facts to be true, would you at least agree that Mr. McKnight's medical care and treatment which followed this accident is directly related to and made necessary by the trauma to his neck and low back when he was hit head on by the other car on April 29, 1983?

MR. MURPHY: Objection.

And one of the reasons for my objection, in addition to a misstatement of some of the evidence that I believe is going to be in this case is that the car wasn't totaled.

Both front fenders were hit.

You said the car was totaled.

MR. PARIS: I am sorry. I meant to say that both front fenders were totaled.

MR. MURPHY: Okay. All right. You made it sound like --

BY MR. PARIS:

Q. To the extent there was like $2500 or over $2000 of damage.

MR. MURPHY: Two fenders were dented in, okay.

A. Just as I said to Mr. Murphy, when he gave me as almost a convoluted a question as that, if I know for a fact that some of the things you asked me to assume are not true, do I have to assume them to be true?

Q. What do you know not to be true?

A. You said he sustained an extension flexion injury to his lumbar spine.

A half an hour ago we just had a long discussion about why this particular accident was a flexion extension

injury.

Q. Okay. Did I say extension flexion?

A. This time, yes. Which one do you want me to assume?

Q Let's do flexion extension.

A. That's what occurred.

Q. Okay.

A. The answer is that I would believe that a certain portion of his medical treatment was necessitated by this accident.

Q. Okay. And just to back up, I think Mr. Murphy covered this with you, it is your opinion that everything up until the time of Dr. -- up until the time of the Lakewood Hospital emergency room of October 3, 1983, up until that time, is related to the accident, and everything thereafter is not related to the accident?

A. Again, yes and no, because what I would like to say is that I believe that the treatment that he received through May or June was related because there was a hiatus in where he had no treatment.

I believe that for the first eight to ten weeks after the accident, that any treatment which he received during that period of time, was related to the accident.

Q. And that would be up until June 2nd, 1983, which was his last physical therapy visit.

A. All right.

Q. Is that correct?

A. Yes.

Q. And it is your further opinion that because there was a hiatus between -- from --

A. June 2nd.

Q. -- June 2nd through the end of September, a four month hiatus, that everything -- all the treatment thereafte is unrelated to this accident?

A. Yes.

Q. And it is also your opinion that the care and treatment prescribed by Dr. Yurick was unnecessary treatment?

MR. MURPHY: Objection.

A. I didn't say that. I said that's not *my* opinion.

Q. Oh.

A. I said it was unrelated to the accident.

I didn't say that it was unnecessary.

I don't want anyone to think that I believe that Dr. Yurick provided unnecessary care.

Q. At least we can agree that the probabilities are that Mr. McKnight needed the treatment that Dr. Yurick prescribed him.

MR. MURPHY: Objection.

A The probabilities are that in Dr. Yurick's opinion Mr

McKnight needed the treatment that Dr. Yurick prescribed.

Q. Do you know Dr. Robert Yurick?

A. Yes.

Q. Do you know him to be -- to have a good reputation in this medical community as a physician?

A Yes.

Q. And as an orthopedic surgeon?

A Yes.

Q. Okay. And would it be your opinion, Doctor, that Mr. McKnight needed this treatment, which Dr. Yurick prescribed for him, before his accident of April 29, 1983?

A I have no opinion.

Q. You don't have an opinion one way or another?

A The question doesn't make sense to me, if I understa your question, so I can't answer it.

It doesn't make sense.

Q. Okay. Let me rephrase it.

In all probability, would you agree that Mr. McKnight needed the treatment that Dr. Yurick prescribed for him; is that correct?

A Yes.

Q. Subsequent to his coming under Dr. Yurick's care.

Can we also agree that Mr. McKnight didn't need this treatment prior to his car accident of April 29, 1983?

A. Yes.

Q. Is it your opinion that the narrowing of Mr. McKnight's L-5, S-l intervertebral space is presently causing him problems, or at least at the time of your defense medical examination?

A No.

Q. But it was your opinion that the narrowing in his low back -- correct me if I am wrong, but 15 minutes ago I thought you said that it was your opinion that he was symptomatic before his car accident, because of his weight lifting, and because of the narrowing of his interspace in his low back.

A What I said was that I believe that he had some symptoms with respect to his low back before his automobile accident of April 29, 1983, even though he said to me he had no symptoms and I said to you that I believe that to be true because he had narrowing of the lumbosacral interspace on the day of the accident.

Your last question, as I understood it, was did I believe that the symptoms that he was having at the time of my examination in December of 1984, were as a result of the narrowed lumbosacral interspace, and my opinion was no.

And the reason for my opinion is that after having examined Mr. McKnight, I am not sure what symptoms he really has.

Q. Okay.

A. Okay?

Q. Now, just let me brush up on one last thing.

It was not your opinion that -- let me rephrase that.

Prior to this accident, it is your opinion and it is still your opinion that Mr. McXnight was symptomatic with regard to his low back?

A That is correct.

Q. And that would have been why, because of the narrowing of the L-5, S-1 interspace?

A Yes. That's the basis for my opinion.

In other words, maybe I can clarify it one last time, okay.

The narrowing of the L-5, S-1 interspace, with associated spurring, is a degenerative condition:

That condition is associated with symptoms, be they persistent or occasional.

Q. Okay.

A. That condition develops over time; therefore, because I see that condition, i believe that Mr. McKnight had symptoms sometime in the past before the accident.

Q. But you don't believe that those symptoms existed after the accident, or -- I am sorry, you don't believe that the narrowng and the associated spurring of the L-5, S-1 interspace still produce symptoms today?

A. I believe that the narrowing of the L-5, S-1 interspace can produce symptoms today.

As I recall your last question, it had to do with the time I examined Mr. McKnight.

Q. That was my next question.

A. Okay.

Q. You believe that they can produce symptoms as of today, and you also believe that narrowing and associated spurring caused symptoms on December 4, 1984, with regard to Mr. McKnight?

A. And I answewred you before, and I will answer again, I am not sure what symptoms Mr. McKnight really had, because I did not believe that Mr. McKnight was totally truthful with me on the date that I examined him.

Q. Okay.

Well, would it make sense to you that he would be asymptomatic on December 4, 1984, at the time you examined him?

A. I don't believe that Mr. McKnight would be asymptomatic or without symptoms at the time I examined him, absolutely not.

Q. All right.

And you don't have an opinion, based upon reasonable medical certainty, as to what the basis of those symptoms that Mr. McKnight displayed on December 4, 1984, are the

result of, is that correct?

A. Yes, that is correct.

Q. Okay. Certainly, Doctor, he had symptoms December 4, 1984.

MR. MURPHY: Objection.

Asked and answered.

A. That's correct.

Q. Doctor, I am sure you have had many patients that you treat for orthopedic problems, related to trauma, and more often that not, such patients come to you with these kinds of problems -- I am sorry, the patients who do come to you with these type *of* problems, see you on more than one occasion, is that correct?

A. Yes.

Q. And you have the opportunity to follow through with their progress when you prescribe therapy or other treatment you feel their condition justifies?

A. Yes.

Q. And would you agree as a general proposition, that the particular doctor who has had an opportunity to follow the patient and examine the patient over a period of time, is in the best position to evaluate that particular patient's condition and the progress of that patient's condition?

A. In contrast to what?

Q. A single examination.

A. No. Not if the single examiner has all the information which the physician who treated the patient over a long period of time compiled.

Q. Doctor --

MR. MURPHY: Off the record.

THE VIDEO OPERATOR: We are off the record.

(Off the record.)

THE VIDEO OPERATOR: Standby.

We are on the record.

BY MR. PARIS:

Q. Doctor, it is true, and I am sure you have had experiences on many occasions where -- that when you do have the advantage of following your patients over a period of time, they present different findings on different occasions, they are not always the same; have you had that experience?

A. Absolutely. Life would be rather boring and unrewarding, if it were.

Q. It seems they would have days of exacervation, or what we call bad days, or some days of remission or good days; is that correct?

A. That's true.

Q. And to follow a patient's progress over a period of time in that fashion is one of the advantages that you

get in evaluating the total picture as distinguished from a single examination, would you agree with that?

A. Again, I would not agree with that because if I am provided with all of the information that the individual has compiled, who has followed the patient over a period of time, I am in the same position to evaluate the total picture as he is.

Q. And on the day that you examined Mr. McKnight, one and a half years after the accident, he was still complaining of the same parts of his body that he complaine about to Dr. Mulligan and Dr. Katzenmyer in 1983, and to Dr. Yurick in 1983 and '84, is that not correct?

A. If you will just refresh my recollection, so I don't have to go through all this stuff, did he have complaints referable to his neck when he saw Dr. Yurick?

Q. Neck to Dr. Mulligan.

Dr. Katzenmyer, physical theraphy.

And Dr. Yurick notes only record neck complaints near the end of his treatment, I believe, in January of 1985.

A. Okay. Then if that is the case, then yes.

Q. Okay.

So the jury doesn't lose this, he complained to you on the defense medical examination about the same parts of his body that he complained to Dr. Mulligan,

Katzenmyer and Yurick, *is* that correct?

A Yes.

Q. And the areas that -- or strike that.

Do you agree that Mr. McKnight certainly sustained some injuries in this accident?

A Yes.

from work as a traveling salesman, was reasonable and made necessary by virtue of the injuries he sustained in this accident?

A. Yes.

MR. PARIS: Move to strike that.

BY MR. PARIS:

Q. And is it not a fact, Doctor, that true muscle spasms of the cervical spine and/or the lumbar spine can be objective evidence of damage to the muscles, ligaments and other supporting structures?

A Yes.

Q. Would you also agree that true muscle spasms which are due to ligamentus and muscular damage can be productive of pain and disability?

A. Yes.

Q. And isn't it true that ligaments and injuries to

the ligaments and muscles can be productive of pain and disability, even without accompanying muscle spasms?

A. Yes

Q. You would also agree, Doctor, that true muscle spasms can go into periods of remissions, where they don't appear, and then suddenly they appear at subsequent times?

A. True muscle spasm is yes

Q. And you have patients who come in one day who appear improved and the next visit are exhibiting spasms, is that not correct?

A. I think I have seen it once or twice.

Q. Doctor, can one have a normal neurological examination and still have pain and disability to injuries of the ligaments and muscles?

A. Yes.

Q. So then one can have an injury to the ligaments and muscles of the neck and the low back with associated pain, spasm and disability and still have a normal neurological examination?

A. Yes.

Q. Doctor, can you explain the term c ronic from a medical standpoint for the jury?

Don't say it is like my cross examination, it goes on and on and on.

A. At least you remember from time to time to time.

Chronic refers to a condition that lasts for a long time, and that long time is beyond the time that a condition would normally be expected to last.

For example, let's take an injury to the lumbar spine.

We would diagnose the condition initially as an acute lumbosacral strain. It happened right now.

That condition usually takes six, eight weeks or so to resolve itself.

If in fact there were actual findings upon which a diagnosis could be made a year later, that would be a chronic strain.

Q. Okay.

So, then, chronic really -- the definition of chronic from a medical standpoint, could that include the terminology into the indefinite future?

A. Not really, because what you are doing now is looking into a little round ball.

Q. Does chronic have the connotation of having a definite beginning and a definite ending as it relates to an injury?

A Not necessarily.

Q. Okay. It can include the connotation of into the indefinite future?

A No. What I am trying to say, Mr. Paris, is that

injuries to a *disc?*

A. Yes.

Q. And, Doctor, even you yourself have treated patients for cervical strains resulting from car accidents, as long as seven months to a year after an accident, where on physical examination you found normal neurological findings, no true spasms, normal cervical lordosis, no areas of localized tenderness to palpation, full range of motion of the cervical spine except for perhaps 25 percent decrease in the right lateral bending, and as long as eight months after the accident, even you have prescribed rehabilitative exercises and medication consisting of Darvocet, is that not a fact?

A. That was a very long question, and the answer is that yes, I have seen people as long as seven to eight months after an accident who have had complaints, who have had the findings as you describe them in that one particular situation, unless you have got another one, and have referred them for rehabilitation exercises.

The only objection I have with the question is that the findings and the treatment may or may not be related to the accident.

Q. Well, if there were no findings, except for 25 percent decrese in right lateral bending, and everything else was merely subjective complaints, nonetheless, there

when I make the diagnosis of chronic, I am seeing patient at point B. At point A he sustained the injury.

The time interval between point A and point B is extraordinarily long, therefore it is chronic.

Hopefully he is going to come under my care and get better, therefore he is no longer going to have the chronic condition.

You are asking -- the definition as I use it for chronic is retrospective in nature, as opposed to prospective.

Q. Certainly one can be in a position after two or three years after an accident of an injury of a soft nature, to be in a position to say whether that condition has become chronic or not.

A The physician?

Q. Yes, right.

A Okay.

Q. And, Doctor, would you agree that one can have pain and disability of a chronic nature from injuries to the muscles, ligaments and soft tissues of the neck and low back?

A Yes, in the confines of my definition of chronic.

Q. Okay. And you would also agree, Doctor, that one can have pain and disability of a chronic nature of

have been at least one instance where you have referred that person for rehabilitative exercises and medication?

A. Yes.

Q. Okay. Doctor, would you agree that one who has some narrowing at the L-5, S-1 disc space is more susceptible to a low back injury from a car accident, than one with a normal type of interspace?

A. Yes.

Q. And the more susceptibility to injury we are talking about, includes injuries to the muscles and ligaments?

A. Yes.

Q. Does that also include susceptibility to injuries to the disc?

A. Yes.

Q. And, Doctor, there are some kinds of tests that help us to refine or help physicians to refine or distinguish diagnoses between lumbar sprains and herniated lumbar disc: such as myelograms and CAT scans, is that correct?

A. Yes.

Q. And you can see things on those type of films that you can't see on the ordinary X-ray pictures?

A. Yes.

Q. Now, do you know Dr. Wilfrid Gill of Puc Jan & Gill:

A. No.

Q. Do you know Dr. Charlie Doyle?

A. No.

Q. You don't know Charles Doyle?

A If I knew Charles Doyle, I would tell you I knew Charles Doyle. Does Dr. Doyle know me?

Q. Sure, I am surprised.

Dr. Doyle is on the Board of Directors of the P.I.E. I mention that because Mr. Murphy examined Dr. Doyle in that regard, and you yourself are a member of the P.I.E. Insurance Company.

A. No.

Q. Okay?

MR. MURPHY: They can both be insured by Nationwide, and I am not sure that I know somebody.

BY MR. PARIS:

Q. Doctor, you never undertook a residency program in radiology, is that correct?

A. That is ,correct.

Q. You don't partake in a 50 hour per year continuing education course in radiology, is that correct?

A. That's correct.

Q. In fact, you don't have radiological equipment here in your office, but rather, you rely on your neighbors, Dr. Krause & Lubert for that?

A. That's correct.

Q. You don't have any type *of* board certification in radiology?

A. That's correct.

Q. You are not a member of any radiological associations or societies?

A. That's correct.

Q. You don't have any staff or courtesy privileges at any hospitals in regards to their radiology department?

A. That is **also** correct.

**P** You don't hold yourself out to the public as having a specialty in radiology, correct?

A. No, I don't.

Q. And certainly it is fair to say that your peers, other physicians in the community, do not look to you as an authority in radiology?

4. That's not necessarily true.

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Q. Okay. The PIE has peer reviews, for instance; have you ever participated in any peer reviews?

A. Yes.

Q. Have you ever participated in any peer reviews as it relates to radiology?

A. Yes.

Q. Okay. Now finally Doctor, you do acknowledge that your interpretation of the lumbosacral films of Mr. McKnight taken on April 30th, 1983, differ from that of the radiologis Dr. Mae Urso, and that he or she read them as normal, and you read them as showing narrowing and spurring at the L5-S1 interspace?

A. Absolutely.

Q. And of course, I take it you had an opportunity to read Dr. Doyle's deposition?

A. Yes.

Q. And to review his report?

A. No.

Q. Mr. Murphy didn't --

A. If I did, I have no independent recollection of his report.

Q. And of course, Doctor, you do acknowledge that your interpretation of the lumbar CT scan of Mr. McKnight differs from that of Dr. Doyle?

A. Yes.

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Q. And did you have a chance to read Dr. Wilfred Hill's x-ray interpretation of that CATscan?

A. A long time ago, yes.

Q. And do you remember what his diagnosis was, and interpretation?

A. No, but I can find it, or you can find it.

Q. I have it here for you, Plaintiff's Exhibit 5.

A. Yes, I see what it is.

Q. And, of course, you disagree with this radiologist's interpretation, as well as Dr. Doyle's?

A. Yes.

Q. And did you have a chance to read Dr. Yurick's report and/or deposition?

A. I certainly read Dr. Yurick's report, but I don't recall whether I read his deposition or not.

Q. In any event, Dr. Yurick, besides Dr. Hill and Dr. Doyle, looked at the scan and interpreted it as a herniated disc, do you recall that in his report?

MR. MURPHY: Objection.

Q. Do you recall that in his report?

A. No, I don't have an independent recollection of that.

MR. MURPHY: It is not herniated.

Q. On your own defense medical report, I think you characterized Dr. Yurick's notes.

A. What I said in my own defense medical report --

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Q. At the top of page two.

A. And it was a quote from Dr. Yurick, and I quote, CATscan does definitely show some evidence of a herniated disc. Of interest, he has improved.

Q. Okay, and you definitely disagree with Dr. Yurick's interpretation of the CT scan?

A. Yes.

Q. Okay.

A. I stand alone.

MR. PARIS: Off the record a moment.

THE VIDEO OPERATOR: We are off the record.

(Off the record.)

THE VIDEO OPERATOR: Stand by. We are on the record.

BY MR. PARIS:

Q. Doctor, earlier you were talking about -- to Mr. Murph about your Burns Test and how it was positive, and in describing that, I believe you indicated that you have an individual kneel on a chair without arms, and his body is parallel to the chair.

A. To the back of the chair, that's correct.

Q. Parallel to the back of the chair, or perpendicular to the back of the chair?

A. You are sitting in the same chair that the Burns Test is performed on.

Q. Okay.

A. Now you are sitting in it with your back against the chair, okay?

Now, imagine rotating your body 90 degrees, so that your head is facing where there would be arms, if there were arms, and your buttocks where there would be feet.

Q. Now, my understanding of your description of the Burns Test is that a person leans back with their buttocks to their heels?

A. That's correct.

Q. Then you ask them to lean forward, and if they can touch the floor, without falling, still remaining in the chair, then they probably have back problems, but if they can't touch the floor, then they don't have back problems?

A. No. You don't understand the test.

Q. Okay.

A. I have seen people in my office who have back problems including myself, who can perform the Burns Test such that they can touch the floor.

What I was saying in trying to explain the Burns Test is that Mr. McKnight's inability to touch the floor, or more importantly, his unwillingness to touch the floor, indicated to me that he was not demonstrating the complete range of lumbosacral motion that he was capable of performing.

Q. Have you ever had patients tell you, I am afraid to

do this test, and I am unwilling to do it?

A. I have never had a patient verbalize that to me, nor did Mr. McKnight verbalize that to me.

Q. Have you ever supposed a psychological aspect to that test, that individuals who have had low back pain for a few years, are protective of their back and tend not to put themselves in positions of instability, perhaps, where they could reinjure or aggravate that low back pain?

MR. MURPHY: Objection.

A. That test is designed to bring out psychological aspects of low back pain.

In fact, there is an article that I can refer you to, that has to do with the historical aspects of low back pain and the use of the Burns Test in evaluating that.

Q. Okay. At least that is a consideration.

I take it you have considered that some individuals, who are overprotective of some low back pain, do not perform the Burns Test in such a manner so that it is negative?

A. No, that was not what I was saying, and I have no recollection of seeing a patient who was indicating to me that they were being protective of their back.

Q. All I am asking is if you ever supposed that in your own mind?

No, I don't suppose it. If you are asking me what suppose, when I see an individual who has a positive Burns

Test, I suppose either they are trying to put me on, they are trying to exaggerate their disability, or they have a certain degree of unconscious emotional overlay.

Q. Okay. Either they are consciously or unconsciously trying to protect their back, or they are consciously or unconsciously trying to fool you; is it the former, *or* the latter?

A. It is the latter.

Q. Now on this Burns Test, when you are kneeling on a chair, and *you* are leaning over in an attempt to touch the floor -- I am trying to understand what your expectation is; do you expect, or are you looking for individuals to touch their fingertips to the floor, or rest their palms against the floor?

A. Touch their fingertips to the floor.

Q. And do you use the same chair on all your patients?

A. Well, I have a comparable chair in one room.

Q. Same sized chair?

A. Same sized chair.

*3* Do you take in consideration the size of the patient?

A. It really doesn't matter, okay?

Q. The size of their arms, the length of their arms?

A. Look. Mr. McKnight was an average patient, okay? And I don't remember his exact height, but that should not have been a consideration.

If he were a dwarf, then I might have got him a shorter chair.

Q. Okay. I didn't mean to upset you, Doctor.

MR. MURPHY: Object.

Move that comment be stricken.

BY MR. PARIS:

Q. Now, one can kneel in the chair and touch their fingertips to the floor, and still remain in a stable position on the chair during this Burns Test?

A. Yes.

Q. Now you indicated there was a discrepancy in the straight leg raising --

A. Yes.

Q. -- between laying down and sitting?

A. Yes.

Q. When, of course, somebody is lying down, their back is straight against the -- what do you call that, the table, the examining table?

A. Yes.

Q. And you are able to measure the angle that the person is raising their leg, is that correct?

A. Yes.

Q. And so if somebody is lying down and you can raise their leg to 90 degrees, you can see that it is 90 degrees, because their back is resting against the examining table?

A. That is correct.

Q. Okay. If somebody is sitting down doing the straight leg raising, are they sitting on the edge of your examining table?

A. Yes.

Q. Is their back against the wall?

A. No.

Q. Their back can't be against the wall, otherwise their legs couldn't hang over the edge of the table, is that correct?

A. Unless they have very long legs, that's correct.

Q. And what you are interested in in a straight leg raising test is a true angle, correct?

A. That is correct.

Q. And if the back is bent, or a person is bent at the pelvis area with their back -- if they are leaning back, you may not get a true angle of 90 degrees, if the leg is brought up level to the floor, is that correct?

A. That's not correct.

Let me explain it this way, so that maybe we can all go home.

The angle that is being measured is not the angle between their back and their legs.

The angle that is being measured is the angle between their dorsal, the front of their chest and their leg, so that

angle can be measured whether they are sitting or whether they are lying down. It makes no difference, okay?

If an individual is sitting on the edge of the examining table, and they lean backwards, okay, therefore the angle can still be measured, all right? To obviate or to prevent any errors in this kind of measurement, I specifically ask the individual when he is sitting on the edge of the examining table to rest his hands on the examining table, so that he is sitting upright.

Therefore, I could measure the angle between his thighs and his body.

If you were to lean back, I could still make the same measurement.

Q. You indicated that the most common cause of problems -- strike that.

You indicated that, I think, the most common causes of narrowing is degenerative disc disease, infection, post-surgical changes after a laminectomy, or congenital narrowing; and we are talking about narrowing of such as the L5-S1 disc space?

A. Yes.

Q. What about if a disc is compromised, could that lead to narrowing of a disc space?

A. What do you mean *by* compromised?

Q. Compromised being either herniated, extruded -- either

herniated or extruded?

A. No. I don't believe that with a herniated disc, per se, that the disc narrows, the disc space narrows.

Q. You qualified that by saying herniated per se.

A. Yes.

Q. Are there other circumstances in a herniation, in a bulge cr something of that nature, where the disc is compromised and narrowing can occur?

A. Well, that's why I asked you to define compromised. A degenerated disc is compromised. It is not normal.

Q. I take it that there is room for disagreement between orthopedic surgeons in that regard?

A. No, I don't believe in that regard that there is any disagreement.

Q. Now, you defined discs -- as the least deformity being a bulge, the next one being a protrusion, next up the ladder, extrusion, and lastly a herniation?

A. That's correct.

Q. You read Dr. Doyle's deposition; do you find that he used the same type of terminology and definitions?

I believe Dr. Doyle intermixed the words protrusion and extrusion, or interchanged.

Q. I thought he indicated that a herniation was a categorical term tc be used for protrusion and extuusior; extrusion being the worst, and protrusion beinq less so,

but both being herniation.

A. Well -- ,

Q. I wonder if we are just getting into a semantic difference here?

A. I think many of the differences we've had today are semantic, but I will be glad to refresh my recollection and reread Dr. Doyle's deposition.

I think it is vitally inportant to understand the difference between a bulge, a protrusion and extrusion and a herniation, in terms of what is going on anatomically with respect to the patient in his resultant symptoms.

Q. Azd Dr. Gill's interpretation as an extrusion is definitely wrong, according to you?

A. Yes.

E Dr. Doyle's definition of a herniation is definitely wrong, according to you?

MR. MURPHY: Objection.

A. Yes.

Q. Okay. Did you measure the abnormality of the disc that you saw on the CATscan?

A. No.

Q. Why is that?

A. Because that would not be a real measurement.

There is magnification, when you produce these films, so I have PO idea of what the real measurement is.

Q. You indicated that a protrusion is five millimeters or larger, and -that is abnormal, correct?

a Yes.

e And did you measure the abnornality or? this film?

a No, I said I did not.

Q. Finally Doctor, I think you indicated that one of the prinary reasons that you don't believe that any of Dr. Yurick's care and treatment that occurred to Mr. McKnight is unrelated to this accident is because there was a gap in treatment, medical treatnent by Mr. McKnight over the summer of 1983, is that true?

A. Yes.

Q. Would it change your opirion to any extent whether or not Mr. McKnight was still symptomatic, still had pain and problems, but only treated himself at home over the summer; would that alter your opinions to any degree?

A. No, it would not.

Q. The fact that -- if I asked you to assume that Mr. McKnight was still experiencing low back pain over the course of the summer of 1983, and he was still experiencing intermittent neck pain, and he would. utilize heat at hone, his wife at the time would massage his low back and that he would restrict his activities, and that he would. occasionally engage in swimming and some type of stretching or Williams' type flexion exercises that he was instructed upon at

physical therapy, that would not alter your opinions in any regard?

A. That's correct, it would not.

Q. Why is that, Doctor?

A. Because I believe, considering what I feel are the injuries that Mr. McKnight sustained, cervical and lumbo-sacral strain, that he had recovered from those specific injuries within the eight to ten week time frame that we were talking about earlier.

Q. Notwithstanding the history that Dr. Yurick had, that he was still symptomatic over the course of the summer, is that correct?

A. Notwithstanding that history, that is correct.

MR. PARIS: Okay. Thank you, Doctor. I have nothing further.

THE WITNESS: You are welcome.

MR. MURPHY: Can we go off the record just for a moment?

THE VIDEO OPERATOR: We are off the record.

(Off the record.)

THE VIDEO OPERATOR: Stand by. We are on the record.

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REDIRECT EXAMINATION

BY MR. MURPHY:'

Q. Doctor, is it still your opinion that the CT scans that you reviewed in this case did not disclose any disc abnormality at the level of L5-S1, in this patient?

A. Do not disclose any disc abnornalty, *yes,* that is still my opinion.

Q. All right.

And could you show us the film marked Plaintiff's Exhibit 17, is it, David?

MR. PARIS: Yes.

Q. All right.

'The finding that Dr. Doyle and Dr. Gill refer to as an extrusion or a bulge or **a** protrusion --

A. Yes.

Q. -- can you show us that?

A. This very white area represents the top of the sacrum, the S1.

They are referring to this cloudy, if you will, material in through right here, and that is what they are referring *to* as an abnormality.

Q. All right.

And do you have an opinion, based upon reasonable medical certainty, as to what that condition that's portrayed only on slice four is?

A. Yes.

Q. What is that?

A. I believe that that condition that is portrayed on that slice is what we refer to as an artifact, or is as a result of the procedure, and rather than a real anatomical abnormality of any clinical significance.

Q. All right.

And is that abnormality -- strike that.

Is that projection indicated on any of the other films?

A. No.

Q. Other than four?

A. No, it is not.

Q. It only appears then on one slice?

A. That is correct.

Q. And so to clarify everything regarding your opinion in this case, do you have an opinior, based upon reasonable medical certainty as to whether or not Mr. McKnight has first of all a herniated disc?

A. Yes, I have an opinion.

Q. What is the opinion?

A. He does not have a herniated disc.

Q. 30 you have an opinion based upon reasonable medical certainty as to whether Mr. McKnight has an extruded disc?

A. Yes, I nave an opinior..

Q. What is your opinion?

A. He does not have an extruded disc.

Q. And do you have an opinion, based upon reasonable medical certainty, as to whether Mr. McKnight has a protrude6 disc?

A. Yes, I have an opinion.

Q. And what is your opinion?

A. That he does not have a protruded disc.

Q. Do you have an opinior, based upon reasonable medical certainty as to whether Mr. McKnight has a bulge?

A. Yes, I have an opinion.

Q. An6 what is your opinion regarding that?

A. That is he has a bulge, it is of no clinical significance.

Q. Okay. Thank you, Doctor.

You can turn off the shadow box. I just have a few more questions.

Now, with regard to chronic conditions, did you find that Mr. McKnight, based upon reasonable medical certainty, had any chronic condition whatsoever as a result of the accident of April 29th, 1983?

A. No, I did not.

Q. And with regard to your examination, I understand that the test that you performed, called the Burns Test, is something that you usually use in examinations of this

nature?

A. I use it in exaninations of all nature.

Q. Of all nature, okay, whether you are treating the patient or whether you are examining the patient of another physician?

A. That is correct, or examining for the plaintiff.

Q. All right.

Do you do some of that?

A. Yes.

Q. As a matter of fact, have you ever done any examinations for the Nurenberg, Plevin firm, Mr. Paris' office?

A. Yes.

Q. oh, you have.

Somebody there has engaged you to do some work there?

A. Yes.

Q. Oh, I see.

And with regard to this type of examination, the Burns Test, this is something that is routine and a part of every examination you do?

A. Well, it is routine --

Q. Almost every?

A. -- it is routine in a part of the examinations that I do with respect to the lumbosacral spine, and in particular when I suspect that the individual is not demonstrating his full range of capacity.

For example, if you came into my office, or even Mr. Paris, complaining of back pain and I asked you to bend forward and touch your toes, there would be no reason to perform the Burns Test, because that shows that you have normal motion in the back.

Q. I see.

So the Burns Test, which tells you if there is an emotional or psychological reason, or if the patient is actually malingering and faking, is something that you have to know as an examiner in every case where that comes up?

A. That is correct.

Q. And the other test you talked about, the straight leg raising, the difference in the supine and the sitting straight leg raising also goes along in that fashion, when the findings are such as in the McKnight case?

A. Yes.

Q. And in addition, I think in the McKnight case, there was a weakness in the toe. I forget how you described that now, without going back through the record, but weakness to resistance, did not give gradually, it gave instantly, I think.

A. That's correct.

Q. And that's also the sane general type of finding?

A. Yes.

Q. That leads you to believe that the patient is not

giving you --

MR. PARIS: Objection to the leading nature of the question.

MR. MURPHY: You are right, I am leading. I take that back.

BY MR. MURPHY:

Q. What is your finding when you have those types of results?

A. Either that the individual is attempting to exaggerate or that there is an unconscious emotional component with illness which can be akin to hysteria.

Q. And that's the reason why you stated, I believe, in cross-examinatioc, that you are unsure what symptoms --

MR. PARIS: Objection. Leading.

Q. (Continuing) -- that this patient had?

A. Yes, that is correct.

MR. MURPHY: Thank you very much, Doctor I have no further questions.

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RECROSS-EXAMIMATION

BY MR. PARIS:

Q. Just to clear it up, Doctor, it is -- you are certainly not saying -- calling Mr. McKnight a malingerer, are you?

A. I don't believe that Mr. McKnight is being truthful.

To me, malingering is a conscious attempt on an individual to fool someone else.

What I am saying to you is, I don't know whether Mr. McKnight's behavior is conscious or unconscious.

Q. Okay. Is that to say that you believe he is a malingerer, or you just don't know?

A. I believe I don't know whether he is doing this consciously, ergo, I don't know whether he is a malingerer.

I do know that he presents with a number of physical findings that have no anatomic basis, which makes me believe that eitner he is a malingerer or he has some kind of psychiatric problem that's causing him to perform as he is.

Q. But he also has a symptoms, which he described to you, which is consistent with the type of accident he had, is that riot correct?

A. That is certainly correct, that the symptoms that he described are consistent with the accident that he had a .long tine ago.

MR. PARIS: Okay. That's all I wanted to know.

Thanks, Doctor. I don't have anything else.

MR. MURPHY: I don't have anything further, Doctor.

Can I ask you, though, this one final thing; You have a right, as you know, to review the

tape and transcript when they are done, and sign the transcript and approve the videotape; do you waive your right to do those?

THE WITNESS: Yes, I will waive that.

MR. MURPHY: Thank you, Doctor.

THE VIDEO OPERATOR: Can we have an agreement by counsel to waive the filing requirement of the videotape?

MR. PARIS: Yes.

MR. MURPHY: I think we did that at the beginning.

THE VIDEO OPERATOR: We are off the record.

- - -

(DEPOSITION CONCLUDED)

(SIGNATURE WAIVED)

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CERTIFICATE

State of Ohio:, )
) §§:
County of Cuyahoqa. )

I, Robert A. Cangemi, a Notary Public within and for the State of Ohio, duly commissioned and qualified, 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 by him was by me reduced to stenotype 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 tine and place in the foregoing caption specified, and was completed without adjournment.

I do further certify that I am not a relative, employe 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 16th day of April, 1986.

Robert Cangemi

Robert A. Cangemi, Notary Public
in and for the State of Ohio.

My commission expires March 5, 1991.