STATE OF OHIO)
) SS: IN THE COURT OF COMMON PLEAS
MAHONING COUNTY)

CASE NO. 95 CV 499

WILLIE BLUE, ET AL Plaintiffs VS. CHESTER BROWN Defendant	DEPOSITION OF DENNIS B. BROOKS, M.D.

DEPOSITION taken before me, Mary J. Carney, a Notary Public within and for the State of Ohio, on the 15th Day of January, A.D., 1997, pursuant to agreement and at the time and place therein specified, to be used pursuant to the Rules of Civil Procedure or by agreement of counsel in the above cause of action, pending in the Court of Common Pleas, within and for the County of Mahoning State of Ohio.

APPEARANCES

On Behalf of Plaintiffs:

Matthew T. Fekete, Attorney at Law
725 Boardman-Canfield Road, Unit L-1
Youngstown, OH 44512

On Behalf of Defendant:

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BY MR. SPRINGER: PAGE(S) 83, 84, 85

EXHIBITS INTRODUCED: (NONE)

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STIPULATIONS

It is stipulated and agreed by and between counse for the parties hereto that this deposition may be taken at this time, 4:00 p.m., January 15, *1997,* in the offices of Dennis B. Brooks, M.D., Mt. Sinai Integrated Medical Campus 26900 Cedar Road, Suite 325, Beachwood, Ohio.

It is further stipulated and agreed by and betwee counsel that the deposition may be taken in shorthand by Mary J. Carney, a Notary Public within and for the State of Ohio, and may be by her transcribed with the use of computer-assisted transcription; that the witness's signature to the finished transcript of his deposition may be and is hereby waived by agreement of the parties; and that the deposition may be thereupon used on behalf of the parties in the aforesaid cause of action as fully and to the same extent as if written in the presence of the witness and subscribed by the witness in the presence of the Notary Public.

WHEREUPON,

DENNIS B. BROOKS, M.D.,

of lawful age, being by me first duly sworn to testify the truth, the whole truth, and nothing but the truth, as hereinafter certified, deposes and says as follows:

DIRECT EXAMINATION:

By Mr. Springer

Q Dr. Brooks, would you state your name and professional address for our jury, please?

A Yes. My name is Dennis Bruce Brooks, and my address is 26900 Cedar Road in Beachwood, Ohio.

Q What is the nature of your profession, Doctor?

A I'm an orthopedic surgeon.

Q And orthopedic surgery is a specialty of the practice of medicine, I take it?

A Yes.

Q Would you just briefly tell the jury what the practice of orthopedic surgery encompasses?

A Yes. As an orthopedic surgeon, I treat patients who have problems with their musculoskeletal system. By that I mean, I take care of patients who have problems with their bones, joints, the soft tissues that

cover those areas, the muscles, ligaments and tendons, as well as taking care of patients who have problems with their spine and its contents, the intervertebral disks and the nerve roots.

Q Now, in order to reach this level, Doctor, obviously you had to have had an educational background. Let's begin with college, and tell us when and where, where you attended, when you graduated, what degree you achieved?

A I attended Harvard University from 1955 tc 1959, and I graduated from there with a Bachelor of Arts degree in 1959.

Q And from there?

A From there I attended Western Reserve University School of Medicine, and I graduated from there in 1963 with the degree of Doctor of Medicine.

Q And following obtaining that degree, Doctor, is it necessary for you to go into what is called a residency and internship program?

A Yes.

Q And did you do that?

A I did.

Q Okay. And tell us when you did that and what years that was done.

A Yes. I was a rotating intern at the Mt. Sinai Hospital of Cleveland for one year, and that was in,

between 1963 and 1964. I then spent a year as a general surgery resident at Mt. Sinai for one year; and my third and fourth years of postgraduate training were as an orthopedic surgery resident. During my fifth year, I was a National Institute of Health research associate in the biomechanics laboratory of Case Western Reserve University.

Q And what does that mean, Doctor; what specifically did you do, and it seems a little bit different than the usual type of training?

A It is. Biomechanics, in essence, is the application of engineering principles to biological systems. So while I served as a fellow in the biomechanics laboratory, I actually took courses in engineering at what then was Case Institute of Technology; and I performed independent research in three areas on various projects.

Those projects included the biomechanics of knee injuries; another project dealt with the development of a new device for the treatment of femur fractures; and a third project dealt with the biomechanics of cervical spine injuries.

Q So that would take us up into about what, 1968?

A 1968.

Q Okay. And following the completion of that five years of residency and your study in biomechanics,

what did you do then?

A Took another year of residency.

Q Okay. And that --

A And that was a year of children's orthopedics at the Indiana University Medical Center. So that took us up to 1969.

Q All right. By that time were you finally ready to start practice?

A Well, I was ready years before; but that, yes, I was. And then between 1969 and 1971, I was in the United States Air Force. I had the rank of Major, and I served as an orthopedic surgeon during that two-year period of time.

Q Okay. When you completed your obligation to Uncle Sam, then what was your next step in your career?

A I returned to Cleveland, and I entered the private practice of orthopedic surgery.

Q And have you been engaged in the private practice of orthopedic surgery since that time?

A Yes, I have.

Q Doctor, are you on the staff of any hospitals in the Cleveland area?

A Yes.

Q And what are those hospitals?

A Mt. Sinai Medical Center of Cleveland.

Q Doctor, do you also belong to any number of organizations particularly associated with medicine and your specialty?

A Yes.

Q Could you give us an example of some of those?

A Certainly. I'm a member of the American Academy of Orthopedic Surgeons, the International Society of Orthopedics and Traumatology, and the Clinical Orthopedics Society.

Q Okay. And then I assume you belong to the usual organizations, such as the local medical society, the Ohio State Medical Society and so forth?

A Yes.

Q Okay. You are, of course, licensed to practice medicine in the State of Ohio?

A Yes.

Q And how long have you been so licensed?

A I was licensed in 1963, and this **is** now 1997. My gosh, 34 years.

Q Doctor, in addition to your active practice of orthopedic surgery, do you have any teaching responsibilities anywhere?

A Yes.

Q And would you tell us about those?

A I'm presently an assistant clinical professor of orthopedic surgery at Case Western Reserve University. I participate in the orthopedic residency teaching program at the Mt. Sinai Medical Center. And I lecture in the Cleveland Area-Wide Biomechanics Course.

Q Okay. And finally I guess, Doctor, is there an organization that certifies physicians in your specialty?

A Yes.

Q And what is that certifying organization?

A It's called the American Board of Orthopedic Surgery.

Q And have you obtained certification from that organization?

A Yes.

Q Does that mean then that you're what is normally referred to as board certified?

A Yes, that's correct.

Q Doctor, what was necessary for you to do to obtain that board certification?

A In order to become board certified, I had to complete a postgraduate training program that was prescribed by the American Board of Orthopedic Surgery. I had to practice only orthopedics, to the exclusion of other branches of medicine, in one location for one year. And

then I had to take an examination which in my case was a full-day written examination and a half-day oral examination. And having completed those requirements, I was considered to be board certified.

Q And when did you receive that certification, Dr. Brooks?

A I was initially board certified in 1971.

Q Okay. You say initially. Have you been recertified?

A Yes.

Q And when was that?

A I was recertified in 1994.

Q Okay. Is there a reason why you did that, or was that required or --

A Yes, there was a reason. Beginning in 1986, any individual who became board certified was issued a time-limited certificate; and that meant that, at the end of ten years, they had to take another examination or go through the recertification process. Because I was board certified in 1971, I was actually grandfathered in.

But I have the privilege of being an examiner for the American Board of Orthopedic Surgery. And it was felt by the board, rightfully so, that if we're going to examine people, then we'd better take the exam as well. And so in 1994 I voluntarily took the recertification examination and

passed that.

Q I see. So in addition, not only did you pass it and become recertified, but you are an examiner?

A Yes.

Q Who examines others for board certification?

A That's correct.

Q I see. Okay. All right. Dr. Brooks, then at the request of our office, did you have occasion to examine both Eleanor Blue and Willie Blue, Jr., who are plaintiffs in the lawsuit that we are now -- we're going to be trying?

A Yes.

Q I believe if -- you examined Eleanor Blue first; is that correct?

A Yes.

Q And what day did you examine her?

A I examined her on July 29th, 1996.

Q And then Mr. Willie Blue you saw when?

A I examined Willie Blue on August 1st of 1996.

Q Okay. Doctor, I think for clarity's sake, what we will do, since you examined Eleanor Blue first, is, we will start with her, and I will ask you about her; and then if Mr. Fekete so desires, he may cross-examine or defer

as he wishes.

Doctor, first of all, let me ask you this: When someone such as myself or our office asks you to examine an individual or individuals such as Eleanor Blue and Willie Blue, Jr., do you go about that examination any differently than any other patient that you would see in your office?

A No, I don't.

Q And of course, it is true that you're seeing them just for an examination, not for treatment purposes; is that right?

A That's correct.

Q Okay. And, Doctor, have you had occasion to examine other people at my request in the past?

A Yes, I believe so.

Q Okay. Now, starting with Eleanor Blue, you said that you saw her on July 29th of **1996**. When you see someone like, like Mrs. Blue, what is -- or Ms. Blue -- what is the first thing that you do?

A I introduce myself and make sure that they're the individual that I am to examine, and then I obtain a history from them.

Q All right. And, Dr. Brooks, what is the reason for obtaining a history?

A A history is the beginning of the diagnostic process. Without obtaining a history, I wouldn't

know what happened to the individual, what their complaints are at the time that I examined them, and I wouldn't know if they had any -- had had any symptoms in the past that are similar to the ones that they have at the present time.

Q Now, Dr. Brooks, it is a fact, is it not, that before you saw these people, our office forwarded to you medical records pertaining to each one of them?

A Yes.

Q Now, did you examine those records before seeing and examining Ms. Blue and Mr. Blue?

A No, I did not.

Q And is there a reason for that, Doctor?

A Yes.

Q And what is that reason?

A As I indicated earlier, I proceed with an examination such as the one I did on Miss Blue and Mr. Blue in the same manner that I would if you came to me as a patient. And that is to take your history, to do a physical examination, to order any radiographs or X-rays that I feel are pertinent; and then, after I have an idea of your problem as you've stated it and as I've identified it on physical examination, I then go to the medical records to find out what they contain with respect to your present problem.

If I did it in the reverse order, I would really I

think be biased or have some preconceived notions about what's gone on. This way I let you tell your story; I examine you, and then I look at your records.

Q I see. All right. Well, then let's begi with Eleanor Blue, Doctor, and if you would relay to us the history that she gave to you? I guess I should ask you first, you did, following your examination of both of these people, prepare and submit a report to me; did you not?

A Yes.

Q And of course, I have shared that with Mr. Fekete. You have that in front of you?

A Yes, I do.

Q And of course, you may feel free to refer to it or any records or notes that you made.

A Thank you.

Q Okay. Doctor, then would you tell us the history that Eleanor Blue relayed to you?

A Yes. She told me that she was injured on approximately March 9th of 1993 when she was riding as a front-seat passenger in an automobile that was stopped when it was struck from behind by a second car. She was restrained at the time of the accident and, as she indicated, jerked forward. "My knees went into the dashboard; my head hit the windshield."

Q You're quoting her at this point?

A That's correct.

Q Okay.

A She told me that she was not unconscious. She also told me that she was aware of pain in her neck, midback, low back and right knee. She was taken by ambulance to Sharon Regional Hospital, where she was examined, treated and released to her home. She went on to tell me that she was given a prescription for medication and what she referred to as a neck brace.

Approximately one to two weeks after the accident, she told me, she came under the care of Dr. Baker at the recommendation of her family. She had not received any interval treatment during the period between the accident and the time that she first saw Dr. Baker. Dr. Baker prescribed medication, a back brace, and physical therapy.

She told me that she received treatment three times a week for approximately three months and that she received this treatment in his office. Treatment was applied to her neck and back. She was re-examined by Dr. Baker after she completed physical therapy. He then referred her for an additional two months of therapy. Again she received treatment to her neck and back three times a week.

She went on to explain that Dr. Baker re-examined her, and in approximately September of 1993, she returned to work on what she described as a light-duty basis. She indicated

that at the time of the accident, she had been working as a Bank One teller and also had been working at Red Lobster. When she returned to work at Red Lobster, she did so as a hostess with decreased hours.

She told me that she continued under Dr. Baker's care and that he obtained an MRI of her back. This revealed what she described as scoliosis.

MR. FEKETE: Objection.

A She also said it didn't show a slipped disk.

MR. FEKETE: Objection.

Q Now, we've used some medical terms here, Doctor. The term scoliosis, what does that mean?

A Scoliosis is a curvature of the spine that is developmental in nature. It develops during adolescence and puberty.

Q Okay. And the term slipped disk I guess is not really an accurate medical term. Is that something people usually talk about when they mean a herniated disk?

A Yes.

Q And a herniated disk is what, Doctor?

A A herniated disk is a disk that is out of its normal location between the two vertebral bodies and is pressing on one of the nerve roots.

Q Okay. And here that did not -- was not

shown on the MRI?

MR. FEKETE: Objection.

A That's correct.

MR. FEKETE: Move to strike.

MR. SPRINGER: Basis of your objection?

MR. FEKETE: He never saw the MRI.

MR. SPRINGER: I'm sorry?

MR. FEKETE: He never saw the MRI.

MR. SPRINGER: This is a history, okay, she's relating to him.

MR. FEKETE: She's not a doctor.

MR. SPRINGER: Okay.

Q Incidentally, Doctor, what is an MRI?

A MRI stands for magnetic resonance imaging, and an MRI is a diagnostic procedure used to image both the soft tissues and the bone of a particular part of the body. Here she underwent an MRI of her lumbar spine, her low back, and she also under --

MR. FEKETE: Objection.

Q Okay.

A Underwent an MRI of her cervical spine, her neck.

Q All right. Okay. Picking up the history, tell us what else she relayed to you.

A She told me that she had an MRI of her neck, her cervical spine, and she told me, quote, "I guess it came back normal."

MR. FEKETE: Objection. Move to strike.

A Lastly, Dr. Baker obtained an MRI of her right knee, and Miss Blue told me, "I guess it was also normal."

MR. FEKETE: Same objection. Move to strike.

Q Okay. Go ahead. These -- this is the history she's relating to you?

A Right; this is what she told me.

Q Very good. Continue.

A During 1994 she was evaluated by Dr. Baker four or five times. During 1995 she was examined by him approximately two times. During 1996 she was examined by him two to three times. She told me that she was last examined by him in June of 1996. She had not been treated by any other physicians.

Q Okay. Did that complete the history, or was there more, Doctor?

A There was more. That completed the first part of the history, what she told me had occurred between the time of her accident in '93 and the time that I examined

her in '96.

I then asked her how she was feeling at the time that I examined her, and she told me, quote, "I still have back pain," unquote. She was symptomatic with respect to her middle and lower back and had pain, quote, "all across," unquote, these areas. She described her pain as being sharp. Excuse me. She would have symptoms three to four times a week. There were no specific activities that were associated with her pain. She told me that her symptoms were decreased by taking medication two to three times day. She did not recall the name of the medication. She had no associated leg radiation.

Q That means what, Doctor?

A She had no pain going down her legs.

Q Okay.

A She also complained that she had what she described as moderate pain in the back of her cervical spine that was present, quote, "all the time. It's constant; it's aching." There were no specific activities that were associated with her neck pain. Pain medication did decrease her symptoms, and she had no associated arm radiation.

Lastly, she complained that on, quote, "certain days," unquote, her right knee was, quote, "bad," unquote. It swelled approximately once a week but could remain swollen one and a half to two weeks after that. She experienced

what she described as aching all over the knee, as well as tenderness along the anterolateral aspect of her knee.

She was unable to bend down and kneel. She climbs steps one at a time. She had not had any locking or buckling, and there were no specific modalities that decreased her knee pain.

Q Okay. Now, you've described two parts of the history process. Was there an additional history process that you obtained?

A Yes, it was her past history.

Q Okay. And that would be what, prior to the accident?

A That's correct.

Q Okay. And would you tell us what she relayed to you as far as that was concerned, Doctor?

A Yes. She told me that she did not have any symptoms referable to her neck, midback, low back, or right knee before the accident of March of 1993. She had not sustained any prior on-the-job **or** off-the-job injuries. She also told me that she had not been injured since March 9th of 1993. She had no long-term medical problems. She was not taking any other medication beside the one that she took several times a day. She had had a cesarean section. And that completed her history.

Q Okay. Incidentally, Doctor -- and I think

maybe to some extent you may already have answered this -- but in taking the history, did this consist both of her relaying the history to you as well as you asking questions?

A Well, yes. Just as you're asking questions of me, I have to ask questions of a patient in order to elicit their history and to inquire about the areas that they have complaints.

Q Okay. Now, was there any other portion of the history, particularly as regards to her working history, that you obtained?

A Yes. She told me at the time of the accident she was working as a part-time bank teller and was also what she referred to as an ally -- an alley, rather -- coordinator at Red Lobster. She indicated that in her Red Lobster job, she acted as a, quote, "middleman between the kitchen and the servers." She did not return to her Red Lobster job after she delivered her child. She did return to her job as a part-time bank teller.

Q Okay. And did that then conclude the history?

A Yes.

Q Okay. Then, Doctor, if I understood your earlier testimony, following the history, you go in; you do examine the patient?

A That's correct.

Q Now, is this examination limited to some extent, Doctor, or is it a general physical examination?

A Well, it's an orthopedic examination that is essentially limited to her areas of complaint. Here it would be her spine and her right knee.

Q All right. Doctor, would you tell us then, describe the examination you performed and your findings on examination; and I may interrupt you from time to time to explain something.

A All right. I noticed that Miss Blue was a female of approximately her stated age who told me that she was five foot five and a half inches and that she weighed 170 pounds. I noted that she got out of a chair without difficulty; that she walked without limping; and that she was able to climb onto and off of the examining table in a normal fashion. I examined her cervical spine and noted that there was normal cervical lordosis without evidence o paracervical or trapezius spasm.

Q Okay. Let me stop you right there. First of all, when you refer to the cervical spine area, what area is that, Dr. Brooks?

A That's her neck.

Q Okay. And you used the term spasm and particularly paracervical and trapezius spasm. First, what is spasm?

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

Q Okay. And is that indicative of anything to the physician when you either find it or find it absent, as in this situation?

A Well, the absence of spasm is a normal finding.

Q Okay. And the paracervical and trapezius areas are where?

A Para means on the sides of, so the paracervical muscles are the muscles on either side of the midline of your spine.

Q Okay.

A And the trapezius **is** the big muscle that goes from the side of your neck, over the top of your shoulder, covering your shoulder blade. It's much like a shawl, if you will.

Q Is that that big muscle that we can feel as we -- the top of our shoulder?

A Yes, depend how -- depending on how much weight lifting you do.

Q Okay. All right. Go ahead with your examination and findings, Doctor.

A I noted that she had no tenderness when **I** palpated any areas of her neck or these muscles.

Q Palpation meaning?
A Applying light pressure.
Q Okay.
A There was a full range of cervical flexion, extension, lateral rotation and lateral bending
Q That means what, Doctor?
A That she was able to move her neck freely forward and back and side to side.
Q Okay. Is that a normal finding?
A Yes.
Q Okay. Please continue.
A I then examined her thoracic spine or her midback and noticed that there was no evidence of deformity or localized tenderness, and there was no spasm. I performed a neurological examination of her upper extremities and noted that she had normal deep tendon reflexes, normal muscle strength and normal sensory perception.

While I was examining her, I noted a healed scar on the back of her little finger. She indicated that on July 4th, 1996, she had cut her finger with glass, and this had been repaired with sutures.

Q Okay. This was just an incidental finding as you were examining her?
A That's correct.

Q Okay.

A I then went on and examined her lumbosacral spine or her low back and noted that she had an increase in her lumbar lordosis without evidence of spasm. There were no areas of localized tenderness with palpation of the spinous processes, sacroiliac joints, sciatic notches.

Forward flexion could be accomplished such that her fingers reached her distal tibias. Extension and lateral bending were performed normally. Heel walking and toe walking were performed without evidence of weakness or of pain. And Burn's test could not be performed because she indicated that she was unable to kneel on her right knee.

Q Incidentally, you talked about an increase in the lumbar lordosis. *Any* significance in that finding, Doctor?

A No, there's actually a wide range of lordosis or the curvature of your spine; and generally when people are short and overweight, they do have an increase in their lumbar spine or some swayback.

Q Okay. All right. Then you continued to examine her?

A Yes. I noted that sitting straight leg raising could be accomplished to 90 degrees bilaterally. The tripod sign was negative. Supine straight leg raising

was restricted to 60 degrees on the right and was accompanied by hamstring pain. Simultaneous hip and knee flexion decreased the right hamstring pain; and with contralateral hip and knee flexion, supine straight leg raising could be accomplished to 90 degrees on the right.

On the left, supine straight leg raising was restricted to 45 degrees and accompanied by anterior knee pain. Simultaneous hip and knee flexion decreased this pain, and with contralateral hip and knee flexion, supine straight leg raising could be accomplished to 60 degrees. Lasegue's maneuver was negative bilaterally.

Q Let me ask you a couple of questions about what you've just told us, Doctor. There seems to be a difference between the degrees that she was able to -- was restricted; and then you spoke of a contralateral hip and knee flexion, and we got to a 90 degree or what I believe to be as a normal extension?

MR. FEKETE: Objection.

A Yes.

Q What is the significance of any of the difference that we have there?

A Well, the significance of all those tests put together is that it indicates that Miss Blue has tight hamstrings. When she was in the sitting position and I asked her to straighten out one leg, she was able to do so

such that she formed a 90-degree angle between her leg and her body.

Then I asked her to lie down on the examining table, and initially I asked her to raise up her leg, and there was some limitation. She couldn't form a 90-degree angle. She complained of pain in her hamstrings. When I had her flex her opposite or contralateral knee and her hip, that allows her to flatten out the curvature of her spine, her lumbar lordosis, and actually relaxes her hamstrings. And so on the right side she was able to do it to normal.

On the left side, initially when she did supine straight leg raising, she only did so to 45 degrees, and she complained of pain in the front of her knee. Now, that doesn't make any medical sense. When you are in a supine position and you lift up a leg, if that causes you any discomfort, it doesn't cause pain in your knee; it should, as it did on the other side, if it's going to do anything, cause pain in the back of your knee, like in your hamstrings. So that made no medical sense.

Q Okay. Well, you anticipated a question I was going to ask you, so you can't explain that medically?

A That's correct.

Q Okay. Go ahead. Is there anything else?

A No, that completed that portion of the exam.

Q The tight hamstrings, based upon a reasonable degree of medical probability, Doctor, do you relate that to this accident that she described to you?

A No, I do not.

Q Okay. All right. You had further examination then of this young lady?

A Yes. I just performed the neurological examination of her lower extremities, and I noted that on the right her patellar tendon reflex was absent, and on the left it was slightly positive. Both achilles tendon reflexes were absent. Her muscle strength and her sensory perception was normal.

Q Okay. And was there further examination, Doctor?

A Yes. I then went on to examine her right knee, the knee about which she complained. Previously I had noted that, when she was standing, her alignment was normal. She performed a half squat and complained of right knee pain when she did that. There was no measurable quadriceps atrophy or palpable effusion.

While she was lying on the examining table, she kept her knee bent to 25 degrees. She indicated that she experienced pain when she attempted to straighten out her knee fully. There was 95 degrees of flexion. There was no crepitus, and there was no tenderness with palpation of her

patella, either femoral condyle, either joint line, or either tibial plateau. And there was no evidence of collateral or cruciate ligament laxity.

Q Okay. Basically, Doctor, without asking you to explain all these various terms you've used, such as crepitus and atrophy and effusion and so forth, were these findings normal?

A No, they weren't.

Q Okay. What was abnormal?

A Well, what was apparently abnormal -- and I'll explain why I use the word apparently -- is that, when she was lying on the examining table, she kept her knee bent to about 25 degrees. And then she only bent it further to about 95 degrees. So that would be an indicator that she has a limitation of knee motion.

The reason why I doubted whether that was actually the case was that I had watched her walk previously. She walked normally. And during the gait cycle, while you're walking, you have to straighten out your knee completely before you bring it down at heel strike; and she was able to do that.

Also, in the standing position, before she got onto the examining table, she stood with her knees fully extended or fully straight. So again, there was no medical explanation why, when she was on the examining table, she lay there with her knee bent 25 degrees.

Q I see. Was there anything else then about what you've just described to us in your examination other than the flex of the knee that was abnormal?

A No.

Q Okay. Did that then essentially, Doctor, except for tests, complete your examination?

A Yes.

Q Okay. And then did you do some specific types of tests?

A Yes, I referred her to the radiologist and asked that radiographs of her thoracic spine, cervical spine, lumbar spine and right knee be obtained.

Q Okay. And did you also personally review these X-rays?

A Yes.

Q Okay. And was there any -- were there any abnormal findings on any of these X-rays?

A The only abnormal finding on the radiographs were in those of the right knee, where they demonstrated the residual of what's called Osgood-Schlatter's disease.

Q Okay. I'm going to have to ask you what that is, Doctor, and whether, with a reasonable degree of medical probability, you relate that to the accident?

A With a reasonable degree of medical

probability, I do not relate that to the accident.

Q And why is that?

A Osgood-Schlatter's disease is again a developmental condition. It's a condition that you're not born with but appears during adolescence and puberty. And as the condition develops, there is some fragmentation of a structure that's called the tibial tubercle. The tibial tubercle is the bony prominence in the front of your knee to which the patellar tendon attaches. By the look on your face, I guess I got to explain that, too. The patella is your kneecap.

Q Do you have a model here, Doctor, that you might be able to use?

A Yes, if somebody could just hand it to me, why -- thank you very much.

This, this is a model of the knee. It happens to be a model of the right knee. And this structure is the kneecap. The kneecap is attached to the thigh muscle by the quadriceps tendon. And then it is attached to the tibia or the shinbone at the level of the tibial tubercle by the patellar tendon or the patellar ligament. And when an individual develops Osgood-Schlatter's disease, they develop fragmentation of the tibial tubercle.

Q I see. Okay. And that was the only abnormal finding then on the radiographs?

A Yes.

Q Okay. All right. Well, then, Doctor, by this time, having taken a history, examined this young lady, and done the radiographs, were you at a point where you were ready to review the medical records that we had submitted to you?

A Yes.

Q Did you do so?

A I did.

Q Okay. And would you tell us what you found in those records that particularly was of significance to you?

A Yes. The first record that I reviewed was the emergency room record of Sharon Regional Hospital, and that indicated that Miss Blue was in the emergency room on March 9th, 1993. The emergency room physician noted that she complained of neck pain, lower back pain, and left knee pain.

Q Now; throughout she complained to you of right knee pain?

A That's correct.

Q Okay.

A The emergency room physician also noted that she had had no apparent head trauma. After he examined her and reviewed some radiographs, he made the diagnosis

strain, cervical; strain, back; contusion, knee.

Q Okay.

A The next bit of information that I reviewed was Dr. Baker's letter of December 15th, 1993, and in that letter he summarized his treatment of Miss Blue between March 28th, 1993, and November 4th, 1993.

MR. FEKETE: Objection.

A From his letter, it appeared that he first examined her in the emergency room of Greenville Hospital three weeks after the accident.

MR. FEKETE: Objection. Move to strike.

A He went on to describe the tests that he ordered, including the MRI of her cervical spine and her lumbar spine. He --

MR. FEKETE: Objection. Move to strike.

A -- re-examined her at various intervals thereafter, eight weeks later in his office and then five months after that.

MR. FEKETE: Objection. Move to strike.

A His final diagnosis was, quote, "Chronic cervical, dorsal and lumbar sprain." He did not make any diagnoses referable to her left knee or her right knee.

Q Okay.

A I also reviewed his letter of January 18th, 1995. Again he summarized the treatment between March 28th, 1993, and April 19th, 1994. Reviewed a report of an MRI of the cervical spine that was obtained on April 14th, 1993, and that MRI was normal.

MR. FEKETE: Objection. Move to strike.

A There was an MRI of the lumbar spine that was performed on April 14th, 1993, and that also was normal.

MR. FEKETE: Objection. Move to strike.

A And that concluded my review of the records.

Q Okay. All right. Well, now, Doctor, ther based upon the history relayed to you by Ms. Blue, your examination of her, the tests that you performed, and also based upon your review of the records that you have just relayed to us, and also, of course, based upon your background, training and years of experience, did you form an opinion based upon a reasonable degree of medical probability as to what injuries, if any, Miss Blue sustained in the automobile accident of March 9, 1993?

A Yes, I did.

Q And what is that opinion, Doctor?

A I believe that she sustained a mild cervical and lumbosacral strain and a mild contusion of her left knee as a result of the accident of March 9th, 1993.

Q Okay. And when you say mild, Doctor, medically, can we define that term in any way that our jury would understand?

A Well, I use the term mild to contrast it with a severe condition. A mild cervical strain is, is a mild injury to the muscles of the neck that heals generally in a four- to six-week period of time.

Q Well, Doctor, you have -- you spent quite a bit of time at the beginning of the deposition outlining to us the complaints that Miss Blue relayed to you regarding the cervical, thoracic, lumbar spine, as well as her right knee. First of all, let me ask you, Doctor, did you find anything on your examination to substantiate these complaints?

A No, I did not.

Q Okay. Do you have any medical explanation for those complaints at this particular time?

A No, I do not.

Q Do you have an opinion, Doctor, based upon a reasonable degree of medical probability as to whether those complaints she relayed to you are related to the accident of March 9, 1993?

A Yes, I have an opinion.
Q And what is that opinion?
A My opinion is that her complaints were no: related to the accident of March 9th, 1993.
Q And does that include the right knee complaints as well?
MR. FEKETE: Objection.
A Absolutely.
Q Doctor, do you have an opinion based upon a reasonable degree of medical probability as to whether Miss Blue has recovered from the injuries that, at least in your opinion, she sustained in the accident of March 9, 1993?
A Yes, I have an opinion.
Q And what is that opinion?
A That she has recovered from the mild cervical and lumbosacral strain and the mild contusion of her left knee that she sustained.
Q Doctor, are these types of injuries that you have described generally what we might call self-limiting?
A Yes.
Q And again, based upon a reasonable degree of medical probability, how long would you anticipate it would take someone to recover from the injuries that you

diagnosed in Miss Blue?

A Three to six weeks, as I mentioned earlier.

Q Finally, Doctor, do you have an opinion based upon a reasonable degree of medical certainty as to whether Miss Blue sustained any type of permanent disability attributable to the accident of March 9, 1993?

A Yes, I have an opinion.

Q And what is that opinion?

A That she did not sustain any degree of permanent disability directly attributable **to** these accident -- to this accident.

Q Dr. Brooks, that concludes my examination of you as it pertains to Eleanor Blue.

MR. SPRINGER: Mr. Fekete, whatever you wish at this point. If you wish to examine, cross-examine at this point, please feel free to do so.

MR. FEKETE: I would prefer to cross-examine at the conclusion of your direct examination, so please proceed with Mr. Blue and --

MR. SPRINGER: Okay.

MR. FEKETE: -- at that time I'll cross-examine Dr. Brooks.

Q All right. Doctor, then let's turn to Willie Blue. We can shorten this somewhat; I won't have to

go through all that I did preliminarily to Miss Blue. And just again, to set the stage, you examined him on what date, Doctor?

A On August lst, 1996.

Q All right. And you also took a history from him?

A Yes.

Q Okay. Would you relay the history that you obtained from Mr. Blue? And incidentally, this was done in the same sequence as was with Miss Blue?

A That's correct.

Q Okay. Please relay the history.

A He told me that he had been injured on March 9th, 1993, when he was driving an automobile that was stopped when it was struck from behind by a second car. As a result, he said, quote, "It buckled all four doors." He told me that he was not restrained at the time of the accident.

MR. FEKETE: Objection. Move to strike.

A He struck his head on the window and his chest on the steering wheel. He was not rendered unconscious. Following the accident, he was aware of pain in his back and right knee. He stated that his right knee was straight with his foot placed on the brake at the time

of the accident.

He was taken by ambulance to Sharon General Hospital, where he was admitted for two days for observation. He told me that he had a history of, quote, "cardiomyopathy." He was treated by Dr. Lazar, a cardiologist, who, quote, "monitored me," unquote. He was discharged ambulating without crutches.

Approximately a month after the accident he came under the care of Dr. Baker. He had not received any interval treatment during the period between the accident and the time he was first examined by Dr. Baker. He had not been involved in any additional accidents. By the time he came under Dr. Baker's care, he told me, he had symptoms referable to his neck, midback, low back, and pain radiating down the posterior aspect of his left leg.

Q Posterior being back?

A Yes, sir. He recalled that his left leg, quote, "throbbed all the way down," unquote. He could not recall when that symptom began. He also had symptoms referable to his right knee. He indicated that it was the first time that he could be evaluated by Dr. Baker.

He went on to tell me that Dr. Baker obtained radiographs and referred him for physical therapy. Mr. Blue chose to treat with Chiropractor Detelich, I think it is. He received treatment three times a week for, quote, "a year

at least," unquote. These treatments included, quote, "massage, heat treatment, electrical stim and adjusting," unquote.

When he was under Chiropractor Detelich's care, he was re-evaluated by Dr. Baker. Initially he was examined every month and then, quote, "as needed." After he completed his treatment with the chiropractor, he returned to Dr. Baker. During 1994 he was re-examined by him, quote, "a few times, two to three times." During 1995 he was re-examined, quote, "about the same," unquote. And during 1996, he was examined on approximately two occasions, with the last examination, quote, "a couple of months ago," unquote.

He told me that he has not been treated by any other physicians. In 1993 an MRI of his lumbar spine was performed. He told me that this was, quote, "negative," unquote.

MR. FEKETE: Objection. Move to strike.

A He indicated, quote, "I should have had an MRI of my knee," unquote. During 1993 he also underwent an MRI *of* his midback which was, quote, "negative," unquote.

MR. FEKETE: Objection. Move to strike.

A During 1993 he -- excuse me.

During 1993 he was examined by Dr. Ogunro, a

neurologist, at the recommendation of Dr. Baker. He was evaluated for his headaches on one or two occasions. Dr. Ogunro, quote, "ran some tests." He also ordered an MRI which, quote, "didn't turn up anything," unquote.

MR. FEKETE: Objection. Move to strike.

A Excuse me one second. That can wait. Sorry about that.

Now, at the time of this examination when I examined Mr. Blue, he indicated that he experienced what he called a "throbbing," unquote, in his low back that was present, quote, "every day." His symptoms were increased by bending and sitting for longer than an hour. His symptoms were decreased by lying on the floor and using heat.

His low back pain radiated into each buttock and into the posterior aspect of his left thigh. He told me that he did not pay any attention to the extent of this radiation. His leg pain occurred when he attempted to wash his car. He also indicated that his left leg, quote, "tingles some," unquote. He experienced this sensation in the entire leg.

Coughing, sneezing and bowel movements did not cause any leg radiation. He had not noted any change in his bowel or bladder symptoms. He indicated that he had more back pain than leg pain.

He went on to complain that he experienced what he

called a stiff neck from time to time. His symptoms, quote, "come and go." He had no associated arm radiation. And he had no other symptoms referable to the accident.

Q Okay. All right. Then as with Miss Blue, I take it you then went into his past history, that is, pre-accident?

A Yes.

Q Yes. And what did you learn from Mr. Blue about that?

A He told me that he had no symptoms referable to his neck, low back or left leg before the accident. He had sustained a rotator cuff tear at work in the '80's, and Dr. Baker had performed right shoulder surgery. At the time he was working in the mill, and in November of '92 he retired when the mill closed.

He told me that he had not been involved in any subsequent accidents since March of 1993. I asked about his past medical history, and he inquired -- he indicated to me, rather, that he had what he called cardiomyopathy.

Q Did you understand what that was, Doctor, or what that was supposed to be?

A Oh, yes.

Q Okay. Briefly, what is that?

A Right. Cardio refers to the heart. Myo refers to the muscle. And opathy or -- refers to a

condition of. *So* in essence, cardiomyopathy is an inflammation and/or weakness of the heart muscle.

Q All right. And he indicated to you that he was diagnosed for that in when?

A 1994.

Q Okay. *Go* ahead.

A He was presently taking Tenormin, 50 milligrams each day, and another medication. He had no other long-term medical problems. He told me that he took Advil, quote, "from time to time," and that was for his neck and low back complaints. Had not undergone any other surgery beside his right shoulder surgery. And that completed the history.

Q Okay. Then, Doctor, I assume that you performed the examination similar to the type of examination you performed with Eleanor Blue?

A Yes.

Q Okay. And would you tell us about that examination and your findings with regard to Willie Blue?

A Yes. The examination of Willie Blue revealed that he was a male of approximately his stated age who was somewhat overweight. He said that his height was five foot six inches and his weight 170 pounds. I noted that he got out of a chair without difficulty; that he walked without limping; and that he was able to climb onto

and off of the examining table in a normal fashion.

I examined his cervical spine or his neck and noted that he had normal cervical lordosis without evidence of spasm. There was no tenderness with palpation. There was normal cervical flexion, extension, and left lateral rotation. There was 75 percent of right lateral rotation and of lateral bending bilaterally.

Q Now, that is a somewhat abnormal finding?

A Yes.

Q What significance, if any, Doctor, did you attribute to that?

A It was an observation, and at that time I made a note of it. I didn't put any particular significance on one isolated finding; just indicated that, when I asked him to move his neck, he did so not completely but about 75 percent of normal.

Q Doctor, in medicine, are there what we call objective and subjective complaints?

A No.

Q Okay. Well, subjective complaints and objective findings perhaps is more accurate?

A Right. All complaints have to be subjective because those are the complaints that the subject or the patient tells me about. Findings can be objective or they can be subjective.

Q Okay. And what is the difference between subjective and objective?

A A subjective finding is a finding that requires the input from the patient. An objective finding is one that I can observe or measure or determine without the patient. For example, I can look at you and note the objective finding that you're wearing a tan shirt. I don't know whether your collar is too tight. You would have to tell me. And if you said, "My collar is too tight," that would be a subjective complaint.

If I asked you to move your shoulder, for example, that would be a subjective finding because you are doing it. I'm not moving your shoulder. You're the one that's controlling that motion.

Q Okay. Into what category would you place the notation that you made of the 75 percent of right lateral rotation and lateral bending bilaterally?

A That's a subjective finding. It's something that I could not determine without asking Mr. Blue to do that, and it was completely under his control as to how much he moved his neck.

Q Okay. All right. If you would continue then with your findings on examination.

A I then examined his right shoulder and noted that he had a barely discernible scars. There was no

evidence of atrophy, deformity or localized tenderness. He had a full range of right shoulder motion except for slight limitation of internal rotation.

Q Did that mean anything to you at that point?

A No. Well, yeah, I guess it did mean something. It meant that that was a residual of his prior right shoulder injury and surgery.

Q This is the one he'd had the surgery back in the '80's?

A Correct.

Q Okay. Please continue.

A I then examined his thoracic spine or midback and noted that was normal. I performed a neurological examination of his upper extremities; that was normal. I examined his low back and noted that he had decrease in his lumbar lordosis without evidence of spasm. There was tenderness with the lightest of palpation of the spinous processes and of each buttock.

Forward flexion was restricted such that his fingertips reached his proximal tibias. There was 50 percent of normal extension. Lateral bending was performed normally. He had no complaints of pain with cervical compression and torso rotation. Heel walking and toe walking were performed normally, and Burn's test was considerably positive.

Q Okay. Let me interrupt here for a moment. You said there was tenderness with the lightest of palpatior of the spinous process and each buttock. What do you mean by the lightest of palpation?

A Palpation is the application of pressure. It's touching various areas. So the lightest of palpation is actually just stroking the skin.

Q The -- when you speak of tenderness, this is something then that the patient complains to you about when you were stroking him?

A Yes.

Q Did this finding make any medical sense tc you, Doctor?

A No. Tenderness with the lightest of palpation really has no medical explanation, per se.

Q Did this mean anything to you as an examiner?

A Yes.

Q And.what was that?

A It meant to me that Mr. Blue --

MR. FEKETE: Objection.

A -- was attempting to exaggerate his complaints.

MR. FEKETE: Objection. Move to strike.

Q Now, Doctor, you spoke of the Burn's test What is the Burn's test?

A The Burn's test is a confirmatory test, and it's utilized to confirm whether or not the patient is demonstrating a true range of motion of his spine when he's asked to bend forward and when he's asked to bend backwards

Q Well, you said he complained of low back pain as he attempted to do this. Is that the type of result that would have been expected in Mr. Blue's situation?

MR. FEKETE: Objection.

A No. One should not complain of low back pain when you are in the kneeling position and then you attempt to sit back onto your heels.

Q Why, Doctor?

A As you kneel down, as you do during the Burn's test, you relax your hamstrings. And as you sit back onto your heels, you reverse your lumbar lordosis. And those two maneuvers together take all the pressure off of your lumbar spine. Therefore, you should not complain of low back pain. In fact, that's the kind of position that people who have low back pain put themselves in to relieve their discomfort.

A good example of that is this secretarial or desk chair that became popular several years ago where, instead of sitting on the seat, you kneel on the seat and you sit

back onto your heels. Sitting back onto your heels from the kneeling position does not cause back pain.

Q All right. Continue with your examination, Doctor, and your findings.

A Then found that sitting straight leg raising could be accomplished to 90 degrees bilaterally. The tripod sign was negative. Supine straight leg raising could be accomplished to 80 degrees on the right and to 60 degrees on the left. Lasegue's sign was negative bilaterally. On the left, with contralateral hip and knee flexion, spine straight leg raising could be accomplished to 80 degrees.

The neurological examination of the lower extremities revealed absent patellar tendon reflexes bilaterally, a 2+ achilles tendon reflex on the right and a 1+ on the left; and muscle strength and sensory perception were normal.

Q Straight leg raising in your findings and then the contractual hip and knee flexion, is this the same type of exercise that we went through when we were talking about Eleanor Blue and the tests that you ran?

A Yes.

Q Okay. And basically then, are we looking at another situation where we have -- there are tight hamstrings?

A Yes.

MR. FEKETE: Objection. Move *to* strike.

Q Well, let me phrase the question this way I was trying simply to shorten things a little bit. But what did the findings that you made upon the straight leg raising test and the contractual lateral hip and left knee flexion tell you about Mr. Blue?

A That he had tight hamstrings.

Q Okay. Based upon a reasonable degree of medical probability, Doctor, do you relate those tight hamstrings to the accident of March 9, 1993?

A Based on a reasonable degree of medical probability, I do not relate the tight hamstrings to the accident of March 9th, 1993.

Q Okay. Basically then, Doctor, at that point had you completed your examination of Mr. Blue?

A Yes.

Q As with Miss Blue, did you then take some radiographs or X-rays?

A I referred him to the radiologist, who did obtain radiographs of the cervical spine and his lumbar spine.

Q And again, did you review those X-rays yourself?

A Yes.

Q Doctor, what were the findings on X-ray?
A There was no evidence **of** fracture or dislocation. There was evidence of moderate intervertebral disk degeneration at the C5-6 interspace, and there was alsc spurring at the C4-5 interspace.
Q And when we speak of degeneration and spurring, Doctor, what does that mean?
A That's part of the normal wear-and-tear process. The conditions together are what people often refer to as arthritis of the neck.
Q Were these findings compatible with, as we'll get into in a little bit, findings in the emergency room X-rays taken right after the accident?
A Yes.
Q Do you, with a reasonable degree of medical probability, relate these findings at all to the accident of March 9, 1993?
A No, I do not.
Q All right. Were there any findings referable to the lumbosacral spine, pelvis?
A There was some minimal arthritic change in the last lumbar vertebra.
Q Again, is this a developmental type of thing?

MR. FEKETE: Objection.

Q All right. Let me phrase the question this way: What is -- what is the significance of this spurring at L5?

A It has no significance. It's part of the normal aging process, unrelated to the accident.

Q Based upon a reasonable degree of medical probability, is it related to the accident of March 9th, 1993?

A Based on a reasonable degree of medical probability, it is not related to the accident of March 9th, 1993.

Q Okay. Doctor, were you then ready to review the medical records as to Mr. Blue?

A Yes.

Q Okay. And would you tell us what records you reviewed and what you learned in reviewing those?

A Yes. I reviewed the records from Sharon Regional Medical Center for the period between March 9th, 1993, and March 11th, 1993. I reviewed Dr. Baker's records, which included his letter of December 28th, 1993. I reviewed reports of the MRI of the lumbar spine obtained on April 14th, 1993; a CT scan of the head obtained on April 9th, 1993. I reviewed Dr. Ogunro's records -- is that how you pronounce that -- and a report of an MRI of the brain that was performed on May 26th, 1993; and, lastly,

Chiropractor Detelich's records.

Q Okay. And what did you learn in reviewing these records, Doctor; what was revealed?

A I learned that Mr. Blue was admitted to the hospital between March 9th, 1993, and March 11th, 1993. After he had been hospitalized for two days, he was discharged with the diagnosis cardiac contusion, motor vehicle accident. I learned also that, while he was in the hospital, he had some complaints of neck pain. Radiographs of his neck were obtained, and on the day of the accident, they demonstrated the same findings that I noted on the radiographs that were obtained three and a half years later.

Q Okay. Doctor, based upon a reasonable degree of medical probability, would the findings --

MR. FEKETE: I'm sorry. Objection. Move to strike your previous question -- previous response. Sorry. Go ahead.

Q Would the findings of the X-rays in the hospital be, with a reasonable degree of medical probability, related to the accident of March 9, 1993?

MR. FEKETE: Objection.

A No, they would not.

MR. FEKETE: Move to strike.

Q And why is that, Dr. Brooks?

A The radiographs that were obtained while

Mr. Blue was hospitalized on the day of the accident showed advanced arthritis of his cervical spine.

MR. FEKETE: Objection. Move to strike.

Q Continue.

THE WITNESS: Do you think it would be polite to at least let me finish my response before you object? You know, it's rather bothersome -- and maybe that's why you're doing it -- to interrupt me in the middle of a sentence. I tend to lose my train of thought.

MR. FEKETE: I have to object and move to strike.

THE WITNESS: Do whatever you have to do.

A The question before me was what, please?

Q Yeah. The question, Doctor, was why you have -- you had rendered your opinion based upon a reasonable degree of medical probability that the X-ray findings as reported in the emergency room were not related to the accident. My question was, why are they not?

MR. FEKETE: Objection.

A The radiographic findings that were noted on the day of the accident were the findings of advanced arthritis in the cervical spine. That condition did not develop in the several hours between the time of the

accident and the time that the radiographs were obtained. That condition developed over a period of years and had beer present for a period of years before the accident.

Q Okay.

MR. FEKETE: Objection and move to strike.

Q All right. Okay. Was there anything else then that you learned in reviewing the emergency room records?

A No.

Q Okay. Please, if you would then, go on tc Dr. Baker's letter and what you learned from that.

A I learned that he examined Mr. Blue for the first time approximately three weeks after the accident. At the time of his last examination in October of '93, Mr. Blue complained of low back pain.

MR. FEKETE: Objection. Move to strike.

A There was no indication in Dr. Baker's records that Mr. Blue had symptoms referable to his neck --

MR. FEKETE: Object.

THE WITNESS: I'm not through.

MR. FEKETE: Doctor --

THE WITNESS: Why can't you give me the courtesy of at least finishing a sentence before you

interrupt me?

MR. FEKETE: I'll tell you why.

THE WITNESS: Okay.

MR. FEKETE: The reason is because I am under a duty to protect the record, okay. The Court reviews your testimony, reviews Mr. Springer's questions and my objection. If I don't object immediately to your response, I may waive that objection. So there is a good reason for me objecting.

MR. SPRINGER: You can protect the record, however, by waiting until he completes his answer --

MR. FEKETE: I am, but --

MR. SPRINGER: -- and then making your objection at that point.

MR. FEKETE: You'll have to note, in all fairness --

MR. SPRINGER: I think -- I think the Doctor's objection is well-taken.

MR. FEKETE: I have waited until you've completed your sentence --

THE WITNESS: I --

MR. FEKETE: -- at which point I have -- I have objected.

THE WITNESS: I wasn't even through with that sentence when you objected.

MR. FEKETE: You did. Ask the reporter.

MR. SPRINGER: Well --

THE WITNESS: I paused. That's a comma.

MR. FEKETE No, sh put d wn -- hat was the end of your sentence, and I objected.

THE WITNESS: I object to your reading my mind. I wasn't through with the sentence. Now, doggone it, let me finish what I have to say; then you can object.

MR. FEKETE: Okay. But right now I have to object to your narrative, see.

MR. SPRINGER: You don't have to object in the middle of what he's saying. You can wait until he's finished and then protect the record.

MR. FEKETE: I'll do so. Go ahead. Please proceed.

A At any rate, what I was trying to say was that there was no indication in Dr. Baker's records that Mr. Blue had symptoms referable to his neck or his right knee while he was under Dr. Baker's care, end of sentence.

THE WITNESS: Your objection?

MR. FEKETE: Yes. Objection. Move to strike.

THE WITNESS: Thank you.

Q Continue.
A I also learned that an MRI that was obtained on April 14th, 1993, was normal.
MR. FEKETE: Objection. Move to strike.
A I learned that an M -- a CAT scan that was obtained on April 9th, 1993, was normal.
MR. FEKETE: Objection. Move to strike.
A I reviewed Dr. Ogunro's records. Mr. Blue had no leg radiation as evidenced by the notations that Dr. Ogunro made. I noted that his diagnosis was, quote, "post-traumatic headache, sprain of cervical and thoracolumbar spine."
MR. FEKETE: Objection. Move to strike.
A I noted that an MRI of the brain on May 26, 1993, was normal.
MR. FEKETE: Objection. Move to strike.
A I noted that Chiropractor Detelich records indicated that he apparently examined Mr. Blue on May 2nd, 1993, and he made diagnoses referable to the head, neck, low back and left knee. And those were the records that I reviewed.

Q Okay. All right. Now, Doctor, then again, based upon the history you obtained, your examination, the tests you performed, your review of the medical records, and again, of course, your own background, training, experience, did you form, with a reasonable degree of medical probability, an opinion as to what injuries, if any, Mr. Blue sustained as a result of the motor vehicle accident -- excuse me -- of March 9, 1993?

A Yes, I did.

Q And what is that opinion, Doctor?

A My opinion is that he sustained a cervical and lumbosacral strain and a cardiac contusion as a result of this accident.

Q Doctor, again, as with Miss Blue, Mr. Blue complained to you upon examination and history of symptoms referable to his neck and low back. Again, in your examination, did you find anything to substantiate these complaints?

A I did not.

Q Do you have an opinion, Doctor, based upon a reasonable degree of medical probability as to whether Mr. Blue recovered from the injuries that you believe he sustained in the accident?

A Yes, I have an opinion.

Q And what is that opinion?

A That he did completely recover from those injuries.

Q Do you have an opinion based upon a reasonable degree of medical probability as to how long it took him to recover from those injuries?

A Yes, I have an opinion.

Q And that opinion is what, Doctor?

A It took him approximately six weeks to recover from those injuries.

Q Doctor, do you have an opinion based upon a reasonable degree of medical certainty as to whether Mr. Blue sustained any injuries that are permanent as a result of the automobile accident of March 9, 1993?

A Yes, I have an opinion.

Q And that opinion, Doctor?

A Is that he had no injuries that were permanent.

Q Doctor, based again upon your examination, the history, your experience, did you form an opinion based upon a reasonable degree of medical certainty as to whether Mr. Blue's complaints were compatible with -- strike that and let me try that over again.

Do you have an opinion based upon a reasonable degree of medical certainty as to whether the findings of Mr. Blue -- or the complaints of Mr. Blue are medically

legitimate?

MR. FEKETE: Objection.

A I'm sorry; I don't really understand your question.

Q All right. Let me phrase it this way: Do you have an opinion based upon a reasonable degree *of* medical certainty as to whether Mr. Blue was being completely honest with you in the complaints he related?

MR. FEKETE: Objection.

A Yes, I have an opinion.

Q And what is that opinion?

A My opinion is that he was not being completely honest with me at the time that I examined him.

MR. FEKETE: Objection. Move to strike.

Q Doctor, based upon a reasonable degree *of* medical probability, do you think -- medical certainty -- do you think he was exaggerating his opinions --

MR. FEKETE: Objection.

Q -- his symptoms, complaints?

MR. FEKETE: Objection.

A I believe that he was, based on a reasonable degree *of* medical certainty, I believe that Mr. Blue was attempting to exaggerate his claimed disability, yes.

Q And why do you believe that, Doctor?

MR. FEKETE: Move to strike.

A Why do I believe that?

Q Yes.

A Based on the manner in which he presented his history, his performance during the physical examination, including the inappropriate responses of tenderness with the lightest of palpation and the markedly positive Burn's test, and based on my review of the records and my years of practice as an orthopedic surgeon, I believe that he was attempting to exaggerate his claimed disability

MR. FEKETE: Move to strike.

MR. SPRINGER: Thank you. That's all I have. You may inquire.

THE WITNESS: If it's not objectionable, I would like to ask for a break at this time

MR. SPRINGER: Sure.

(Whereupon a brief recess was taken.)

CROSS EXAMINATION:

By Mr. Fekete

Q Hello, Doctor. I'm Matt Fekete, and I represent the plaintiffs in this action, Mr. Willie Blue and Miss Eleanor Blue.

A Good evening.

Q Thank you. Same to you.

A Thank you.
Q You've given me the liberty of looking at your file, and I thank you for allowing me to do that, both concerning Mr. Blue and Eleanor Blue. And I do have some questions first concerning when you examined both Mr. Blue and Eleanor Blue. First, when did you see Mr. Willie Blue?
A I examined Mr. Blue in August of 1996.
Q You didn't see him right after the accident then?
A That's correct.
Q Or even during the first few weeks or months after the accident, did you?
A That's correct.
Q The first time you saw him was almost three and a half years after the accident; isn't that true?
A Yes.
Q And the same holds true for Eleanor Blue; true?
A Yes.
Q You didn't see her until late July 1996; correct?
A Correct.
Q And that was the first and last time you've seen either Mr. Blue or Eleanor Blue; correct?
A Yes.

Q And at the time you saw Mr. Blue in August of 1996, he wasn't really getting medical treatment for his injuries anymore, at least not on a regular basis, was he?

A That's correct.

Q And the same is true for Eleanor Blue?

A Correct.

Q So that the jury will fully understand your role in this case, Doctor, would you tell us again who contacted you to examine Mr. Blue and Eleanor Blue?

A Mr. Springer.

Q And that would be Mr. Brown's lawyer?

A I don't know who Mr. Brown is.

Q That would be the other driver.

A Oh, all right. Then that's his lawyer, yes.

Q Neither Mr. Blue nor Eleanor saw you for treatment, did they?

A I believe you've asked me that about eight times, and the answer is no.

Q I don't think I asked you that, but the purpose of your examination was not for treating Mr. Blue or Eleanor Blue or providing any sort of care for them, was it?

A Your statement is correct.

Q Your purpose was to examine them, make a report if necessary, and if necessary testify on behalf of

the other driver in this case; isn't that true?

A Yes.

Q Basically you're a witness that's being called by the defendant; isn't that true?

A Yes.

Q You have no responsibility for either Mr. Blue's care or Eleanor Blue's care, do you?

A No.

Q And you hadn't seen either, either one, before your one-time examination in late summer of 1996, did you?

A No.

Q Okay. And you haven't seen either of them since?

A No.

Q Now, your office is here in the Cleveland area, in Beachwood; that would be considered as a suburb of Cleveland, wouldn't it?

A Yes.

Q Do you have an office or practice at any location other than Beachwood?

A No.

Q Does your practice ever occasion you to be in Sharon, Pennsylvania, where Mr. Blue and Eleanor Blue reside?

A No.

Q Doctor, you didn't conduct these examinations for free, did you?

A No.

Q And you're not here today testifying on the deposition for free either?

A No.

Q Would you tell us who hired you to do these examinations and to testify?

A I believe I've told you already, Mr. Springer.

Q You didn't tell me.

A Yes, sir, I did. You asked me, who contacted you to perform these examinations. Obviously the same person who contacted me is the same person who asked me to examine them.

Q Well, that may or may not be the case. Have you conducted similar examinations of other persons at the request of either Mr. Springer or his law firm, Comstock, Springer & Wilson, before?

A Yes.

Q And have you testified before at their request?

A Yes.

Q When would you say you started doing

examinations for either Mr. Springer or members of his law firm?

A I don't know.

Q Would it have been more than a year ago?

A Yes.

Q More than two years?

A Yes.

Q More than three years?

A I don't know that far back.

Q How many other persons would you say you have examined and/or testified about at Mr. Springer's request or at the request of his law firm?

A I don't know.

Q Now, do you examine people for other defense law firms as well?

A Yes.

Q Or at the request of insurance companies?

A Yes.

Q And out of those examinations and/or testimony, is there a certain percentage of time that you would devote to defense examinations, for instance, as opposed to examinations on behalf of an injured person?

A I don't keep track of that particular item, so I can't answer your question.

Q All right. How long was Mr. Blue at your

office for that one and only time?

A That one and only time, when I saw him for evaluation, not for treatment, I don't know.

Q Approximately how long does your examination take in your own clinical practice?

A There's no approximate time, Mr. Fekete. I take as much time as necessary to do a comprehensive, thorough examination.

Q Would it be fair to say that you spent perhaps 15 to 20 minutes in examining Mr. Blue?

A I don't know.

Q And the same for Eleanor Blue?

A I don't know. Time is not the parameter that's important There was a comprehensive examination done, and I took as much time as I needed.

Q Fair enough. You didn't take the time then? You didn't note the time?

A No.

Q Now, during that visit you took a history, and you asked Mr. Blue how he was feeling and what was bothering him, didn't you?

A Yes.

Q And he responded to your questions, didn't you?

A Yes.

Q He cooperated in coming up here to Cleveland and allowing you to examine him and responding to your questions; true?

A Yes.

Q And you were asked some questions about well, you stated that your opinions were in part based upo some of the medical records that were provided to you; correct?

A Yes.

Q And you've allowed me to look in your files to see what records the files contain. And my question is, do the files contain all the records which Mr Springer's office provided to you?

A I believe they do with respect to Mr. Blue. And --

Q You don't have any recollection of disposing of any of the records that Mr. Springer's office provided to you, do you?

A No, I wouldn't have disposed *of* them. If they're not in my file, I would have returned them to him.

Q Okay. And how about for Eleanor Blue, does the --

A The same holds true.

Q And your file contains all the records that you reviewed for Eleanor view that were -- Eleanor Blu

which were provided by Mr. Springer's office, don't they?
A Yes, they do. I didn't return them to him.
Q Okay. Now, specifically, I'd like to go over some of those records. Mr. Springer provided you with the emergency room records from Sharon Hospital for both Mr Blue and Eleanor Blue; is that correct?
A Yes.
Q But he did not provide you with the records from Sharon General Hospital for the physical therapy which Eleanor Blue had received there, did he?
A If they're not in my records, he didn't provide them to me.
Q Okay. Do you think that a review of those records might be helpful in the evaluation of the case?
A No.
Q And you rendered some, made some comments concerning CAT scans which were -- might have been taken. You did not, however, review the CAT scan films yourself, did you?
A Yes; I did not review them.
Q You did not review the CAT scan films?
A That's correct. Yes; I did not review them.
Q And that would also apply to the MRI's

that you made comments on; correct?

A Correct.

Q The MRI scans, you didn't review the scans yourself, did you?

A That's correct.

Q All right. And concerning Dr. Ogunro's records, in fact, you were provided with a letter from his office, weren't you?

A No, I was provided with his office record.

Q Does what you have before you include all of Dr. Ogunro's office record or just a letter?

A Mr. Fekete, I have --

Q It's Fekete, Doctor.

A I'm sorry. I really do apologize. Fekete?

Q Fekete.

A Fekete.

Q Fekete; right.

A I really apologize. Mr. Fekete, I have in front of me a piece of paper. It is not addressed as a letter. It looks to me as a record from Dr. Ogunro. It's not addressed to anyone. It's signed by him. But it prevents -- it includes a history, an examination, a diagnosis and recommendations.

Q Isn't it a letter addressed to Dr. Baker?

A I don't believe that it's a letter addressed to Dr. Baker. It doesn't say, "Dear Dr. Baker." It doesn't have Dr. Baker's address on it. It looks like a record.

Q Okay. May I just see it for a moment?

A Absolutely.

Q Thank you.

A Thank you.

Q That's one page then?

A That's one page.

Q All right. Now, as you made some comments about Dr. Baker's records, and in fact, in reviewing your file, the only thing I saw that you had from Dr. Baker's office was a report?

A Yes, that's true. That is a letter addressed to a Mr. McConnell, and I would consider that a report.

Q All right. You were not provided with Dr. Baker's office records themselves then, were you?

A No.

Q All right. And X-rays, you made some comments about X-ray findings. Of course, you took your own or had both Mr. Blue and Eleanor Blue X-rayed by a radiologist at this clinic or complex; but you also made some remarks about X-rays at Sharon Hospital and other

treating physicians. You, yourself, did not review the X-ray films that were taken at Sharon Hospital on the date of the accident, did you?

A That's correct; I did not.

Q Okay. And you didn't review any X-ray films that were -- that might have been taken by Dr. Baker's office when he first saw them, did you?

A No, I did not.

Q And the same would be true for X-ray films that were taken early on by Dr. Detelich's office; correct?

A That's also true.

Q And when you evaluate patients for neck pain who give a history of being involved in a motor vehicle accident, you've spoken about objective findings and subjective findings. But one of the objective findings, if a patient complains of neck pain, is that the cervical lordosis is straightened; isn't that true?

A Straightening of the cervical lordosis is an objective finding.

Q And you would make that objective finding by looking at the X-ray films that were taken on the date of the accident; true?

A No. I would not make a finding of looking at radiographs -- well, excuse me. That's not correct. By looking at radiographs, I could make a finding of

straightening of the cervical lordosis. I could not make a finding as to the cause of that straightening.

Q But if, for instance, the cervical lordosis did appear to be straightened on X-ray film taken in Dr. Detelich's office, that would be consistent with an objective finding of a cervical spine injury sustained in the accident, wouldn't it?

A I would not hazard to answer that questior without actually looking at the radiographs to which you are referring.

Q Is that a yes or a no then?

A That is a no.

Q Okay. Now, the -- in the Sharon Hospital records that you did review, it was noted that the patient, Mr. Blue, complained of left chest pain and chest discomfort; correct?

A Yes.

Q Left arm stiffness?

A Yes.

Q Neck pain?

A Yes.

Q Back soreness?

A Yes.

Q And that he sustained a heart contusion?

A That was the diagnosis, yes.

Q Were you, Doctor, provided with Dr. Detelich's records? I noticed in reviewing the file, I saw what I -- seems to be a report. My question being, were you provided with his actual office records?

A No, I was just provided with the report that he wrote to Mr. McConnell.

Q And Dr. Detelich's office treated Mr. Blue for some period of time; true?

A True.

Q Wouldn't it be useful in your evaluation to note what Dr. Detelich's findings were if, in fact, he examined and saw the patient for a relatively longer period of time?

A I would have to believe that the results of that treatment were explained in his letter. Therefore, reviewing Dr. Baker's letter that describes the treatment, reviewing Chiropractor Detelich's letter that describes his treatment, would be sufficient.

Q Okay. Basically you did review the records which were provided with you; but the fact is, you were not provided with all of the records for these particular patients, were you?

A That's a correct statement.

Q Dr. Brooks, not all doctors, would you agree, are good records keepers; is that correct?

A That's probably true.
Q Some are certainly better records keepers than others?
A That's the other side of the coin, which is true.
Q And there's a big range of practice between physicians and the way records are kept, isn't there?
A Yes.
Q All right. And the fact that one doctor does not note all of his findings doesn't necessarily mean he's not providing treatment that's benefiting a patient, does it?
A I can't answer that with a yes or no.
Q Now, Doctor, did you consult personally with any of the physicians that actually treated either Mr. Blue or Eleanor Blue?
A No.
Q You never consulted with Dr. Baker, Dr. Ogunro, Dr. Detelich or any of them, did you?
A You ask me a question. I answer it honestly. And then you ask me the same question again. The answer is still no.
Q Now, if you, in your own clinical practice, Doctor, if you have a patient who was treated by

another physician, if that physician referred the patient tc your office and you had a question about that treatment, you would have no hesitation about consulting with that physician, would you?

A If I had a question about the treatment, I would have no hesitation. I had no questions here.

Q Because the physician there can give you his firsthand impression of the patient, can't he?

A He can give me his firsthand impression; but if I have his records, that's sufficient.

Q Would you agree, Doctor, in your own clinical practice, that it's generally true that the more often you see a patient, the more knowledgeable you are about that particular patient's condition; isn't that true?

A Yes.

Q And here you examined these individuals only once, for 15 to 20 minutes each; right?

A I examined these people on one occasion. I don't recall the amount of time that I spent with them, however.

Q Doctor, in your own clinical practice, you see and treat patients for injuries to the soft tissue structures of the neck and lower back, don't you?

A Yes.

Q And when we say soft tissue structures of

the lower back and neck, we're talking about muscles, nerves, ligaments and tendons, aren't we?

A Yes.

Q Ligaments are the attachments which hold bones together; is that true?

A Yes.

Q And tendons are the attachments which hold muscle to bone?

A Yes.

Q And they're referred to as soft tissues, as opposed to bony or bone, bony tissue or bones and organs; right?

A Yes.

Q Now, soft tissue structures can and are often injured in trauma such as the trauma a patient sustains in a motor vehicle accident?

A Yes.

Q And often these types of injuries, would you say, are not immediately visible on the scene?

A I'm sorry; I don't understand your question.

Q Well, for instance, if there's no laceration but bruising and contusions, those may not be visible until a period of time has passed?

A That's correct.

Q All right. Generally, Doctor, the heavier the impact, the more severe the injury to the soft tissue structures injured; would you agree?

A No.

Q You wouldn't agree that a heavier impact is more likely to cause more serious injuries than a fender-bender?

A The second question was not the same as the first question.

Q All right.

A Okay?

Q Again, the first --

A The first --

Q Go ahead. Go ahead. Answer the first.

MR. SPRINGER: Let him answer, please

A Okay. The degree of energy that's dissipated in an automobile accident is not directly correlative of the injuries that the patient sustains. Automobiles today are made -- living in the Youngstown area, I think you should know about automobile making -- the cars are made to absorb energy. So when you see a car that has severe damage to it, that has happened because the bumper has collapsed because it's supposed to; the side panels have crumbled because they're supposed to.

The only way that you can truly tell about the injuries

to the patient is either examining the patient at the time of their injury or reviewing the records of competent individuals who have examined the patient at that time. Looking at a picture of a car doesn't tell me how the occupant's been injured.

Q Well, I wasn't going to show you a picture of a car. My question is simply -- perhaps you didn't understand it -- is generally, as a general rule, the heavier the impact, the more severe the injury to the soft tissues injured; isn't that true?

A No.

Q Did you receive any information about the severity of the impact in this case?

A No.

Q So you don't know the extent of physical damages caused to either vehicle?

A No.

Q Now, in motor vehicle accidents, particularly if one car is at a complete stop, Doctor, when it is hit from behind, we can agree that that creates sudden forces on the occupants inside, in particular, to their neck and back; isn't that true?

A Yes.

Q And force results to the neck because the head is suddenly snapped forward and backward?

A No.
Q Snapped backward and then forward?
A It moves backward and may move forward, yes.
Q And then it may snap backward yet again; right?
A Anything is possible.
Q Okay. And these types of injuries are known as hyperflexion or hyperextension injuries, aren't they? Or acceleration-deceleration injuries?
A They're known as acceleration injuries; that's correct.
Q And there are soft tissue structures in the neck, muscles, nerves, ligaments and tendons, which have elastic limits like a rubber band, don't they?
A Yes.
Q And if they are stretched beyond that elastic limit like a, just like a rubber band, they can be damaged; they can be broken, and they can tear; right?
A Yes.
Q And as a result of sudden force, sudden impact on soft tissue structures such as in the neck and in the back, muscles, nerves, ligaments and tendons are stretched and twisted?
A They can be, yes.

Q And a strain technically is a stretching and twisting of the ligaments, isn't it?

A Yes.

MR. SPRINGER: Are you asking him in this case, or are you just asking generally?

MR. FEKETE: I think the question was pretty clear.

MR. SPRINGER: Well, I -- maybe it was to the Doctor. It isn't to me.

Q And if the soft tissue structures tear, that can occur -- that can occur on a microscopic level, can't it?

MR. SPRINGER: Well, I'm going to object to these questions unless you begin to apply them to Miss -- Mr. and Miss Blue. Just to generally ask these questions I don't think has relevance to this particular lawsuit on a general basis.

Q Isn't that true, Doctor?

A I'm sorry; I forgot the question.

Q The tearing of tissue can occur on a microscopic leve as well as on a larger level?

A Yes, anything's possible.

Q And soft tissue structures each have their own blood supply, don't they?

A Yes.

Q So if they're cut or torn, they bleed?
MR. SPRINGER: Objection.
A Yes.
MR. SPRINGER: Same basis.
Q And in this case we have the diagnosis of cervical strain and sprain and lumbar strain and sprain for both Mr. Blue and Eleanor Blue?
A No.
Q What was the diagnosis, Doctor?
A Diagnosis was cervical and lumbar strain for both Mr. Blue and Eleanor Blue.
Q All right. And there was a lumbar -- you've just said there was a lumbar strain for both patients; correct?
A Yes.
Q And when those tissues are torn or twisted in a strain, they bleed, don't they?
MR. SPRINGER: Objection.
A Yes.
Q Okay. And the difficulty sometimes is, in recovering, the tissue just doesn't regenerate itself back to its old self, does it?
MR. SPRINGER: Objection.
Q It heals with the formation of scar tissue?

MR. SPRINGER: Objection.

Q Isn't that true?

A Again, anything is possible; and it can or it cannot.

Q All right. But when soft tissue structures, Doctor, are injured, torn and stretched, they heal with the formation of scar tissue, don't they?

MR. SPRINGER: Again, objection. It's not being applied specifically to this case, and there's no evidence or no testimony at this point that this is what happened.

A They can or they cannot.

Q And when scar tissue forms, internal scar tissue, that can sometimes bind and constrict the nerves --

MR. SPRINGER: Objection.

Q -- that are adjacent to the scar tissue; isn't that true?

MR. SPRINGER: Objection.

A I am not aware of that being reported in the medical literature. Maybe in the legal literature, but not in the medical literature.

Q Well, scar tissue isn't the same as the old tissue; it's tougher and denser, isn't it?

A It can be.

Q Now, Doctor, you see patients who have

chronic low back pain in yourself in your own clinical practice, don't you?

A I -- I see patients who have pain over a number of years, yes.

Q You would characterize those patients as being chronic, as opposed to acute, wouldn't you?

A Yes.

Q And when you see those patients, who makes the decision on that patient's treatment, you or the patient?

A I do.

Q And that's your role as the treating doctor, isn't it?

A Yes.

Q So when a patient comes to a doctor for help and the doctor decides what the treatment -- the doctor is the one that decides what treatment may or may not be necessary for his or her care?

A The doctor makes a treatment plan, and the patient can either agree or disagree with that plan.

Q And in this case, you have no evidence that the patients were noncompliant with their physicians' instructions, do you?

A Well --

Q These patients complied with the treatment

plan of their treating doctors, didn't they?

A I can't answer that question because, as you've pointed out, I haven't seen their treating physician doctors' records; so I don't know whether there was compliance or not.

Q Do you have any information, Doctor, to indicate that either Mr. Blue or Eleanor Blue were noncompliant patients?

A I don't have any information that they were noncompliant patients nor any information that they were compliant patients.

Q Now, the, much of the treatment plan that the treating doctor comes to is within his or her clinical judgment; isn't that the case?

A Yes.

Q You prescribe medication to alleviate pain; you prescribe medication to stop inflammation and relax the muscles and so forth; and that's all part of treatment, isn't it?

A Yes.

Q And what I'm getting to, Doctor, is a patient has a right to be treated for pain, doesn't he?

A Right.

Q And alleviation of pain is one of a physician's roles?

A Correct.
Q And if the pain is long-term or chronic, with some patients, as in your own clinical practice, they have a right to get treatment over the long term to alleviate that pain, don't they?
A Yes.
Q I wanted to go over some of your medical findings. You were asked whether or not the X-rays, what the X-ray findings were, and first I wanted to clarify to the jury, X-ray, X-rays really don't image soft tissue injuries very well, do they?
A Routine radiographs do not.
Q And those were the plain X-rays, the type of X-rays that were taken in this case; isn't that true?
A That's correct.
Q So people who have sustained soft tissue -- injuries to the soft tissue structures, you wouldn't expect those injuries to show up on their plain X-ray studies, would you?
A I would not expect the type of mild soft tissue injuries that Mr. Blue and Miss Blue sustained in this particular case to show up on radiographs that I obtained some three and a half years after the accident, no.
Q Okay. You wouldn't expect people who've sustained just injuries to the soft tissue structures, for

those injuries to show up on X-ray studies; correct?

A Depends upon the type of soft tissue injury.

Q But strains and sprains, you wouldn't expect those to show up on X-ray study, would you?

A As a matter of fact, sprains can be diagnosed on X-ray.

Q I didn't ask whether they can. I asked whether you would expect those to show up on plain X-ray?

A I would expect a sprain to show up on a routine X-ray.

Q Okay. Is that how a sprain is diagnosed then?

A No injury is diagnosed merely on an X-ray. An injury is diagnosed by obtaining a history, performing a physical examination, and reviewing X-rays and putting the whole package together.

Q And then by your testimony, if, in fact, you would expect a strain to show up on an X-ray study --

MR. SPRINGER: He didn't say that.

THE WITNESS: You stole my thunder.

MR. SPRINGER: I'm sorry.

Q You didn't look at the X-rays, did you?

A Wait a minute. You asked me a question; you never finished the question, so we'll forget that one

and go on to the next one. I did not review the radiographs that were obtained at the time of these injuries; no, I did not.

Q And MRI's, Doctor, typically are taken to rule out disk herniation or nerve root compression; isn't that true?

A No, MRI's are taken for a variety of reasons.

Q And you can have chronic low back strain and pain in the presence of a normal MRI, can't you?

A I don't believe that anybody has a chronic low back strain. But their MRI certainly would be normal.

MR. FEKETE: Off the record for a moment.

(Whereupon an off-the-record discussion was had.)

Q Doctor, you, in your examination of Mr. Blue and Eleanor Blue, *you* examined range of motion in both the lumbar and cervical and thoracic spine, didn't you?

A Yes.

Q And in Mr. Blue's case, you found that the forward bending or flexion was restricted; correct?

A No.

Q All right. In his lumbar spine?

A Oh, in his lumbar spine, yes.

Q Yes. All right. How much should normal

range of motion be in the lumbar spine --

A Normal --

Q -- for forward bending or flexion?

A Normal range of motion of the lumbar spine is the ability to touch the tops of your feet or to touch your toes.

Q Ninety degrees?

A It's not really measured in, in degrees. It's the functional aspect of what an individual does.

Q And in his case, that was restricted?

A Yes.

Q And you also measured his lateral or side-to-side range of motion?

A Correct.

Q You found that to be normal?

A Correct.

Q But the backward bending or extension of the lumbar spine you found to be restricted, didn't you?

A Yes.

Q In fact, you found it to be restricted to 50 percent of what's normal?

A Correct.

Q And Dr. Baker also reported limitation in back motion, didn't he?

A In his letter.

Q So Mr. Blue had abnormal range of motion of the lumbar spine, didn't he?

A He demonstrated abnormal motion of the lumbar spine, yes.

Q And with Eleanor Blue's case, you examined the range of motion of her cervical, thoracic and lumbar spine and found her range of motion to be normal in those planes?

A Yes.

Q But you didn't look at the, or you were not provided with the physical therapy records from Sharon Regional Hospital, so you -- I assume you were not aware that the records there indicate abnormal range of motion?

A That's correct; I did not review those records.

Q And you also examined Eleanor Blue's trunk flexion, didn't you?

A I'm not familiar with that term; I'm sorry.

Q Forward, bending forward of the lumbar spine.

A Of her lumbar spine?

Q Yes.

A Yes. We talked about that already.

Q You found it to be normal?

A Yes.

Q But you were not aware that at Sharon Regional Hospital she only had 30 degrees with pain on both sides, were you?

A That's correct.

Q And as far as lumbar spine extension is concerned, backward bending, you found it to be normal?

A Yes.

Q But you did not know that at Sharon Hospital it was noted to be only 10 percent?

A That's correct. In fact, I don't even know when you're talking about. The day after the accident:

Q No, June of 1993, over three months later.

A I see.

Q And lateral flexion with Eleanor Blue, side bending, you found to be normal?

A Of what part of her body, please?

Q Lumbar spine.

A Yes.

Q And were unaware that at Sharon Regional Hospital the records note that she had only 20 degrees with pulling sensation?

A That's correct.

Q That would be an abnormal finding, wouldn't it?

A It is, yes, an abnormal subjective finding.

Q Doctor, you also tested reflexes of both Mr. Blue and Eleanor Blue, didn't you?

A Yes.

Q And you do that as a matter of course in evaluating a patient for low back pain, don't you?

A Yes.

Q And would you -- excuse me -- would you agree that the purpose generally is to determine if there's any neurological deficit, any nerve involvement?

A Yes.

Q The presence of abnormal reflexes, you would agree, may indicate nerve root involvement; isn't that true?

A May indicate nerve root involvement. Does not necessarily indicate nerve root involvement.

Q That was my question. Now, normal --

A I just wanted to reinforce it.

Q Normal reflexes are usually symmetrical, aren't they?

A Correct.

Q And in this case you noted Mr. Blue's reflexes for his upper extremities, relating to his cervical spine, as normal and symmetrical, didn't you?

A Yes.
Q And that would tend to rule out nerve root involvement in his neck; true?
A True.
Q But you did find abnormality in the deep tendon reflexes of the lower extremities, didn't you?
A Yes.
Q His achilles tendon reflexes were 2+ on one side and only 1+ on the other; right?
A Correct.
Q And achilles tendon reflexes are checked with a percussion hammer, aren't they?
A Yes.
Q And that's considered a more or less involuntary response, isn't it?
A Yes.
Q So it's considered an objective finding true?
A Yes.
Q All right. So Mr. Blue then had abnormal deep tendon reflexes, didn't he?
A I think we discussed that. He did.
Q Now, abnormal reflexes, Doctor, of the lower extremities, coupled with pain reported to be radiating into the legs, would you agree, is consistent with

nerve root involvement, isn't it?

A It is consistent with but not diagnostic of.

Q I agree. It is not conclusive or diagnostic, but it is consistent with?

A Absolutely.

Q And to your knowledge, Mr. Blue never had radiating back pain, that is, pain radiating into the legs, before the accident of March 9, 1993, did he?

A That's correct.

Q Doctor, you also talked about evaluating tenderness, point tenderness, spasms and trigger points. You do that as a matter of course in evaluating a patient for low back pain and pain in -- and pain in the neck region, don't you?

A Yes.

Q Would you agree that muscle spasms are more or less involuntary contracting of the muscles?

A True muscle spasm is, yes.

Q And what are trigger points?

A I don't know. That's not something I routinely describe.

Q Trigger points is an accepted condition by some physicians who deal with rehabilitation medicine, isn't it?

A There are always some physicians who will accept some things. The majority of orthopedic surgeons do not accept the term trigger points.

Q But the presence of both indications, muscle spasms, true muscle spasms, as you've stated, and focal points of tenderness, would be consistent with soft tissue injuries to the muscles, to the musculature, and specifically the paraspinal muscles of the neck and the back --

A Yes.

Q -- wouldn't they? Now, in your examination of Willie Blue, you did find tenderness upon palpation of the lumbar spine and in each buttock, didn't you?

A I found tenderness with the lightest of palpation of the spinous processes and in each buttock.

Q You've already testified several times that this was the first and only time that you saw Mr. Blue; true?

A I haven't changed my opinion in the last 45 minutes or half hour that you've asked, since you last asked me that question.

Q I'm not making a big point about it. All I mean --

A You're not? You keep asking the same

question over and over again. Sounds to me like you're making a big point about it. I examined him one time.

Q Okay.

A For the record, for the jury.

Q My point being, he may have been somewhat uncomfortable when you saw him; right?

A He may have been.

Q Your hands may have been cold; correct?

A They may have been.

Q And that can cause tenderness, those two factors combined?

A The fact that he --

Q Isn't that one possibility?

A The fact that he's uncomfortable and my hands are cold can cause tenderness? I don't think cold hands cause tenderness. The point is that I applied the lightest of palpation. I stroked his skin. I didn't apply any pressure.

Q All right.

A There's no explanation for that.

Q And but you've never treated him at any point in time, and so it's fair to say he was not used to being examined by you; and neither was Eleanor Blue, for that matter; would you agree?

A I would agree they were not used to being

examined by me.

Q You didn't examine Dr. Detelich's records, so you wouldn't be aware as to whether or not they reflected true muscle spasms and trigger points, would you?

A Correct.

Q You didn't examine the physical therapy records from Sharon Hospital, so you wouldn't be aware whether or not those showed true muscle spasms from the T12 level down to the third level of the lumbar spine, would you?

A Correct.

Q You also tested for straight leg raising; correct?

A Yes.

Q And that's considered an objective orthopedic test, isn't it?

A No. It's still a subjective test.

Q And in that test, the patient lies down supine on the examining table; true?

A True.

Q And you put one hand under the heel and the other one over the knee to prevent the knee from being flexed, don't you?

A Correct.

Q And then you raise up the leg to see if

you can raise it up to the normal degree of 90 degrees or whether you encounter pain; true?

A With all due respect, it doesn't hurt me to do it, so I wouldn't encounter pain.

Q Well, when I say encounter pain, I mean encounter a pain response from the patient?

A If the patient resists what I'm doing or complains of pain, then I stop.

Q All right. And you noted, I think, norma: straight leg raising, didn't you?

A Sitting straight leg raising was normal for both people, yes.

Q For Mr. Blue, supine straight leg raising was abnormal, wasn't it?

A Yes.

Q And since you didn't review the physical therapy records from Sharon Hospital, you wouldn't know whether or not Eleanor Blue had positive straight leg raising recorded in those records, would you?

A No. Or yes, I wouldn't know.

Q Did you do a lumbar extension test?

A You haven't been listening.

Q Oh, I have been listening.

A Well, we talked about the fact that Mr. Blue demonstrated 50 percent of normal lumbar extension.

You asked me about that. We talked about Eleanor Blue. We said that her motion was normal. So we've already discusse that.

Q All right I stand corrected. Did you d a Yeoman's test?

A I'm not a sailor. I didn't do a Yeoman's test.

Q Do you know what a Yeoman's test is?

A It's a chiropractic test and not one that I do.

Q All right. Now, you've talked about subjectivity of tests versus objectivity of tests. And you indicated that range of motion tests for the cervical spine and the lumbar spine are subjective?

A Correct.

Q You've indicated that palpation for tenderness is subjective?

A Correct.

Q Calling for a subjective response from the patient?

A Yes.

Q But notwithstanding that, the subjectivity of those tests, you did them all, didn't you?

A Say again?

Q Notwithstanding the fact that you consider

all those tests subjective, you did all of those tests on both of these patients, didn't you?

A Oh, yes.

Q And you do all of those tests, all of those subjective tests, in your own clinical practice as a routine basis, don't you?

A Yes.

Q Now, would you agree, Doctor, that when injuries are acute, the involved tissues are usually inflamed and swollen, so it is generally easier with soft tissue injuries to elicit objective physical signs when they're acute, isn't it?

A Yes.

Q But when the injuries become chronic, the inflammation and swelling has usually subsided?

A Yes.

Q And you saw these patients in a chronic state, as opposed to an acute stage; right?

A No.

Q Well, you saw them three and a half years after the accident?

A Right. But your use of the term chronic implies that I agree with you that there was still something wrong with them when I saw them. There wasn't anything wrong with them when I saw them, so I didn't see them in a

chronic stage; I saw them in a healed stage.

Q You took a history about Mr. Blue's previous health and about Eleanor Blue's previous health, didn't you?

A Yes.

Q And he was never involved in an accident before, was he?

A That's what he told me.

Q She was never involved in an accident before?

A That's what she told me.

Q And you don't have any information to the contrary, do you?

A No, I don't.

Q And had that been the case, certainly that information would have been provided to you by Mr. Springer's office; wouldn't it have?

A With all due respect to Mr. Springer, I don't know what he would have provided or what he wouldn't have provided. I took a history, and that's what the people told me.

Q Fair enough. Neither Mr. Blue or Eleanor Blue had any neck or back surgery before, did they?

A No.

Q To your knowledge, neither ever injured

either neck or back before, did they?
A That's correct.
Q And they had no pre-existing neck or back injuries, to your knowledge, and never been treated by a doctor for any neck or back injuries before either; correct:
A Were -- I'm not sure I understand the question because there is the --
Q I'll rephrase it.
A Okay.
Q I'll rephrase it. Neither Mr. Blue nor Eleanor Blue ever saw a doctor or received any medical treatment for any neck or back pain before the motor vehicle accident of March 9, 1993, did they?
A To my knowledge, they did not.
Q And in your own clinical practice, you have patients who have chronic low back pain years after an accident, don't you?
A No.
Q Doctor, may I ask, what is your fee or what was your fee for having examined Mr. Blue?
A I don't have a recollection of what I charged for obtaining the history, performing the physical examination, reviewing the records and preparing the report.
Q Well, surely you must know what you customarily charge for those services, don't you?

A I don't have a customary charge for that service.

Q You don't have a customary hourly charge of --

A That wasn't your question.

Q -- three or four hundred dollars an hour?

A That wasn't your question. I have an hourly charge; but each examination that I do varies in the amount of time that it takes me to do that. So I don't have any knowledge of what I charged in toto for that exam. I can tell you what I charged on an hourly basis.

Q Would your files have the -- excuse me -- would your files have the amount of the total charges that were billed for your examination?

A You've looked through my file. It doesn't contain the charge.

Q Okay.

A It's not part of the medical record.

Q Okay. What then is your standard hourly charge for examining a patient at the request of a defense law firm?

A My standard charge for examining a patient, regardless, is $350 an hour.

Q All right. And you would have charged that for both, for each, Mr. Blue and Eleanor Blue; right?

A Yes.
Q Do you also have an additional charge for reviewing records?
A Yes.
Q And what would that charge be?
A The charge for this service, as i is for any service that I provide, one that you might request of me, another patient, reviewing patient records, is $350 an hour.
Q All right. Do you also have an additional charge for consultation? You met with Mr. Springer, I assume, before this deposition for some period of time. Do you also have a charge for that?
A Yes.
Q And what is that charge?
A That charge is the same as the charge for the deposition this evening.
Q That's included with that charge?
A Yes.
Q Did you meet with Mr. Springer on more than one occasion?
A No.
Q Did you have a telephone conference with him?
A No.

Q And you have a separate charge then for depositions?
A Yes.
Q What you're doing right now?
A Correct.
Q And what is that particular charge?
A $450 an hour.
Q All right.
MR. SPRINGER: So you're costing me money.
Q You never have to see these, either of these patients again, either Mr. Blue or Eleanor Blue, do you?
A I don't have to, but I would be more than happy to.
Q Okay. But you don't intend to?
A It's entirely up to them. If they want to schedule an appointment, I'll be happy to see them and treat them, if they need treatment.
MR. FEKETE: I have no further questions. Thank you.
THE WITNESS: You're welcome.
REDIRECT EXAMINATION:
By Mr. Springer
Q Doctor, I just have a few questions on

redirect. First of all, you have an active practice in which you see patients, I take it, on a daily basis?

A Yes.

Q Are some *of* those patients involved in accidents of various types that lead to litigation?

A Yes.

Q Have you over the years testified for your patients?

A Yes.

Q So you don't testify or examine exclusively for defendants?

A That's correct.

Q Your examination, history-taking and so forth of these people, was it any different than any patient you see that you treat?

A No.

Q Now, Doctor, you were questioned extensively about the fact that you have not seen the X-rays or the MRI films. Doctor, did you assume that the physicians who interpreted those films, be they MRI's, CAT scans or X-rays, were competent and reported the findings -- that those findings that they reported were accurate?

A I assume that the radiologist, radiologists who interpreted the radiographs *of* the cervical spine of Mr. Blue and the other radiographs that were

obtained of both Miss Blue and Mr. Blue in the hospital were competent. I assume that the radiologists who reviewed the various MRI's and CT scans were competent.

Q Okay. And the doctors' reports that you reviewed from Dr. Baker, the chiropractor, Dr. Detelich, did you again assume, as you do in your reports, assume that' these were accurate and comprehensive reports of what they considered important of their records?

MR. FEKETE: Objection.

A I assumed that the reports that **I** reviewec were an actual and accurate reflection of their office records that they maintained, yes.

MR. FEKETE: Move to strike.

Q Now, Doctor, I don't know how many times you were asked about seeing these people just one time.

A More than once.

Q We'll agree with that. In your practice as an orthopedic surgeon, are you frequently called upon by other physicians as a consultant?

A Yes, from time to time.

Q And in many of those instances where you are called upon as a consultant, do you see and examine the patient just one time?

A Yes.

Q And based upon that one examination, do

you render opinions and suggestions for treatment of those particular patients?

A Yes.

Q Is there anything at all unusual about that in the medical profession?

A No.

Q You were asked about the abnormal range of motion in the lumbar spine of Mr. Blue, the findings of deep tendon reflexes of Mr. Blue. Is there anything about those findings inconsistent with the opinions you rendered?

A No. I took those findings into consideration when I rendered my opinions, so they are consistent with my opinions.

Q Are -- and why -- why are they consistent? I mean, you say, we find abnormal range of motion; we find deep tendon reflex, reflex abnormal findings. These sound inconsistent. Why are they not, Doctor?

A Well, okay. I understand the -- the question. First of all, my opinion is that, when I saw Mr. Blue, he had recovered from his injuries and had no residuals.

MR. FEKETE: Objection. Move to strike.

A Therefore, how is it that that opinion can be consistent with those abnormal findings? Well, first of

all, I think we spent considerable amount of time explainin that the subjective findings that I look for on all my patients of Mr. Blue's limitation of flexion and extension was not consistent with his performance of the Burn's test; and, therefore, I believe that he was not being truthful when he performed those two maneuvers.

MR. FEKETE: Objection and move to strike.

A The absence or lack of symmetry of the deep tendon reflexes is one finding. One does not make a finding of nerve root compression, injury to an intervertebral disk, injury to the soft tissues of the back or really any injury based on a single, isolated finding. There were no other findings on examination that indicated that that minimal asymmetry in Mr. Blue's deep tendon reflexes was of any clinical significance.

MR. FEKETE: Objection. Move to strike.

MR. SPRINGER: Thank you very much, Doctor. Nothing further.

THE WITNESS: You're welcome.

RECROSS EXAMINATION:

By Mr. Fekete

Q You also found abnormal deep tendon reflexes for Eleanor Blue, didn't you?

A Yes.
Q All right. And again, that's considered an objective finding, isn't it?
A Yes.
Q And -- thank you. Did you do a Hoover's test?
A No.
Q That's a test for malingering, isn't it?
A Yes.
Q You didn't do that test?
A You just asked me.
Q Did you do a --
A I said I didn't.
Q Did you do a -- sorry. Did you do a Magnuson's test?
A Let's make this a learning experience. What's a Magnuson s test?
Q It's another test, an orthopedic test, I believe, for malingering.
A Could you explain it to me, please?
Q Well, I will.
MR. FEKETE: Let's go off the record for a minute.
(Whereupon an off-the-record discussion was had.)
Q Doctor, you were asking me about if I knew

what a Magnuson's test is; and as I understand the procedure, assuming that the patient with alleged low back pain is asked to point to the site of the pain, and the examiner marks that site; the examiner then distracts the patient by performing any relevant examination away from the marked site of the pain; then, resuming the examination of the low back, the test is positive with any significant change of the site of the pain. You didn't perform that test, did you?

A That's correct; I did not.

Q All right. So we've talked about three tests for malingering, only one of which you performed; right?

A Correct.

MR. FEKETE: Thank you.

THE WITNESS: You're welcome. Thank you. That was informative.

MR. SPRINGER: Nothing further.

THE WITNESS: I'll waive my signature to the reading of the deposition and viewing of the videotape.

MR. SPRINGER: Thank you.

SIGNATURE WAIVED

REPORTER'S CERTIFICATE

I HEREBY CERTIFY that the above and foregoing is a true and correct transcript of all the testimony introduced and proceedings had in the taking of the testimony in the above-entitled matter, as shown by my stenotype notes taken by me at the time said testimony was taken.

Mary J. Carney
Registered Merit Reporter

STATE OF OHIO)
) SS: CERTIFICATE
CUYAHOGA COUNTY)

I, Mary J. Carney, Notary Public within the State and County aforesaid, duly commissioned and qualified, do hereby certify that the above-named, DENNIS B. BROOKS, M.D., was by me first duly sworn to testify the truth, the whole truth, and nothing but the truth, and that the foregoing deposition was written by me in stenotype in the presence of the witness; that by agreement of counsel, signature was waived.

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

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office at Youngstown, Ohio, this 22nd Day of January, A.D., 1997.

Mary J. Carney

Mary J. Carney, Notary Public
My Commission Expires 7/24/00