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IN THE COURT OF COMMON PLEAS
CUYAHOGA COUNTY, OHIO
MARIE LIAPIS, et al.,
Plaintiffs,
-vs- JUDGE GALLAGHER CASE NO. 254818
ADELE CARAVELLA, et al.,
Defendants.
- - - -

Deposition of KENNETH R. CALLAHAN, D.D.S., taken as if upon cross-examination before Sandra L. Mazzola, a Registered Professional Reporter and Notary Public within and for the State of Ohio, at the offices of Kenneth R. Callahan, D.D.S., 21100 Southgate Park Boulevard, Suite 212, Maple Heights, Ohio, at 4:05 p.m. on Monday, January 19,1998, pursuant to notice and/or stipulations of counsel, on behalf of the Plaintiffs in this cause.

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On behalf of the Plaintiffs;

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On behalf of the Defendant Adele Caravella.

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(Thereupon, Plaintiff's Exhibit 1 Notice of Deposition Duces Tecum, was mark'd for purposes of identification.)

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MS. McCARTHY Put on record that a notice of deposition with duces tecum was issued to Dr. Callahan through counsel, Bill Rider, which requested the doctor to produce a number of items, 1 through 6, attached to the notice, including all 1099's for a variety of insurance companies, journals, calendars and that kind of thing, and that they weren't produced today and they are not going to be produced and that no other reason was given for their non-production. Would that be fair?

MR. RIDER: I'll give the reason that they are not being produced. They're not being produced for several reasons. One reason is some records requested do not exist. Another reason is some of the records requested can not be located because they're comingled with other records of the same nature.

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Another reason is that they can not readily be produced and certainly, if they were available, they couldn't have been produced within the time frame of the discovery deposition since I got the notice of deposition duces tecum on Thursday and I was in trial on Friday and we are here taking the doctor's discovery deposition on Monday.

And finally, perhaps most importantly, had I had the opportunity, I would have filed a motion for protective order anyway because I believe the request is really simply for the purposes of annoyance, oppression --

MS. McCARTHY: And harassment?

MR. RIDER: And harassment, thank you. And I was unable to file the motion for protective order because I was in fact in trial on Friday and the Courts were closed on Monday.

MS. McCARTHY Which ones are not available and which ones do not exist?

MR. RIDER: 1099's may exist, but are comingled with other 1099's for patients

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who may have had insurance with the carriers who you request. Those that don't exist at all -- No. 1, and 2, are comingled with all other payments from insurance companies for patients that the doctor sees and treats.

The doctor's library is available if you want to look at the medical texts that are contained therein. Office calendars do not exist. They are destroyed at the end of the year. There are no copies of reports or depositions from medical examinations requested in No. 5. The doctor has no list of other cases in which he's testified, which you requested in No. 6.

MS. McCARTHY Okay. Will you swear the doctor?

KENNETH R. CALLAHAN, D.D.S., of lawful age, called by the Plaintiffs for the purpose of cross-examination, as provided by the Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

CROSS-EXAMINATION OF KENNETH R. CALLAHAN, D.D.S.

BY MS. McCARTHY

Q. Doctor, my name is Ellen McCarthy, and I along

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with Leon Plevin represent Mrs. Liapis in this case. I'm here for the purposes of determining what your opinions are with respect to Mrs. Liapis and the basis of each of those opinions, especially the ones you intend on discussing at the time of trial.

If I ask you a question which you don't understand, stop me, tell me, and I'll rephrase the question so that is clear to you. Okay?

A. Yes.

Q. If you answer one of my questions, I will assume you understood it and I will rely on the answer that you provided in the trial of this case, is that clear to you?

A. Yes.

Q. Where do you practice your profession?

A. Southgate Medical Arts Building in Maple Heights, Ohio.

Q. And what is your profession?

A. Oral and maxillofacial surgery.

Q. How long have you been engaged in that practice?

A. Forty years.

Q. How do patients find you for treatment or evaluation outside of the medicolegal context?

A. Well, I have a referral base among physicians and

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dentists who send me patients.

Q. Any other way they find you outside of the medicolegal context?

A. Patients speak well of our treatments and they refer other friends or relatives or other patients to the office.

Q. Do you diagnose patients with disorders of the temporomandibular joint?

A. I do.

Q. Do you treat those patients whom you diagnose with TMJ disorders?

A. On occasion I will treat patients. Otherwise I will direct treatment.

Q. What does direct treatment mean?

A. That means I will send them to a doctor close by here in the same building for a bite splint, or if they require surgery, I will take them to University Hospital where I practice and have that surgery done by the head of the department there.

Q. And who is that?

A. Dr. Goldberg.

Q. And what is his first name?

A. Gerald.

Q. When you do treat patients on occasion whom you

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diagnose with temporomandibular joint disorders, under what circumstances do you provide them treatment?

A. If it's a mild disorder that can be treated with medicines and habit control and diet control.

Q. Do you send your patients who need surgical management strictly to Dr. Goldberg or do you send them to any other place?

A. Oh, occasionally Dr. Hauser.

Q. Dr. Michael Hauser?

A. Uh-huh.

Q. And he is at Mt. Sinai?

A. Uh-huh.

Q. Is that ayes?

A. Yes.

Q. So would it be fair to say that you personally know Dr. Hauser?

A. Yes.

Q. And do you know him by way of his involvement in various organizations which you participate in?

A. Yes.

Q. What is his reputation as an oral and maxillofacial surgeon in this community?

A. I think he has a fine reputation, Ms. McCarthy.

Q. Is he qualified to diagnose and treat

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temporomandibular joint disorders?
A. Yes.
Q. And in the past he has performed surgery on patients of yours, is that fair?
A. He has operated on patients of mine, perhaps not through direct referral by me, but perhaps by my partner.
Q. And that's Dr. Bell?
A. Dr. Bell.
Q. Do you perform surgeryon temporomandibular joints?
A. Not any longer, Ms. McCarthy. Although I did for many years. I was one of the primary pioneers in TMJ surgery in the late '50's.
Q. When was the last time before May 1993 that you performed surgery on the temporomandibular joints as the lead surgeon as opposed to as an assistant physician?
A. Oh, it's been many years. I don't know how long.
Q. Would that be in the 1960's?
A. Perhaps.
Q. Can you think of anytime in the 1970's when you performed surgery on the temporomandibular joints as anything other than an assistant surgeon?
A. No.

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Q. Do you teach in a classroom setting about the surgical management of temporomandibular joint disorders?
A. I teach in a clinic setting about temporomandibular joint disorders.
Q. So would that be the surgical management?
A. Surgical management.
Q. And when you say --
A. Management generally. Not specifically surgical, no.
Q. Would it be fair to say that there are two ways to manage it, clinically and surgically?
A. Yes.
Q. All right. So you don't get involved in the classroom teaching of the surgical management of temporomandibular joint disorders?
A. That is correct.
Q. But you do get involved in a clinical setting with the management of TMJ disorders, is that correct?
A. Yes, with students when I'm asked.
Q. How does that work?
A. We have discussions in the clinic in the morning when I teach and the students come and bring questions about a varied number of things, one of

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which is temporomandibular joint disorder.
Q. And when you say the clinic, you are referring to what?
A. The Oral and Maxillofacial Surgery Clinic at Case Western Reserve University School of Dentistry.
Q. Do you have privileges at any of the other hospitals?
A. I do.
Q. Okay. Where is that?
A. Privileges at University. I bring a primary number of cases there. Also at Marymount where I see trauma cases. At South Pointe I have privileges and occasionally at Bedford.
Q. Do you lecture to any other individuals outside of medical students about temporomandibular joint management?
A. No, but I don't know who else would be interested in that.
Q. Well, I suppose insurance representatives and defense lawyers may be interested in that type of thing. Have you had occasion to lecture to those individuals?
A. I put on a seminar out at Colorado Springs. I was one -- excuse me. I didn't put on a seminar. I was one of the participants in a

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seminar. And that was for attorneys.
Q. And when was that?
A. That was in July of 1992 at the Broadmoor.
Q. And was that at the invitation of some individual or company?
A. Invitation from a group of attorneys, but I'm sorry, I can not remember what they are -- it had an acronym. I could probably go look it up if you want.
Q. Have you ever published in the area *of* TMD diagnosis?
A. Well, to that group I did. Otherwise, no.
Q. When you say to that group, would that be an outline that you published in a textbook that was used or some sort of handout that was used for purposes of that seminar?
A. Syllabus, yes.
Q. And I don't want to mix up terms when I'm referring to TMJ and TMD, but for my purposes when I say TMD, I mean temporomandibular joint dysfunction.
A. Yes.
Q. As opposed to TMJ which is just the joint itself, correct?
A. Same thing as saying like, The patient has knee.

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Yes, of course, it's TMD. TMD is what I'd rather it be called.
Q. All right. Have you ever diagnosed a patient of yours with traumatically-induced internal derangement of the temporomandibular joint in the absence of direct trauma to the head, face or jaw?
A. I can not think of having ever done so.
Q. Can a person sustain a whiplash type of injury without direct trauma to the head, face or jaw and develop temporomandibular joint disorder as a result?
A. My view is in the lack of very high speed collision, no.
Q. And very high speed means what?
A. More than 70 miles an hour. More than 60 miles an hour perhaps.
Q. Have you reviewed some articles or some data or materials that indicate that a speed lower than 60 with no direct trauma will not produce any kind of internal derangement or dysfunction to the temporomandibular joint?
A. I have.
Q. Can you refer me to a text that published such a statement or such a view?

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A. I will refer you to the March 1995 Journal of Oral and Maxillofacial Surgery, authors Howard, et al., who ran a number of experiments using live dummies -- and that is really the correct term --who were involved in moving vehicle accidents and they measured the impact at the joint.
Q. And determined what?
A. That that impact is less than the stress put on the joint in the normal act of chewing.
Q. The impact at what speed?
A. Produced in the absence of cuts, lacerations, bruising, in the absence of a direct injury.
Q. Well, I'm talking about, you made a statement that you needed a very high speed in order to produce an internal derangement. Is that your statement?
A. Yes, because at high speed you are bound to strike something on the inside of the automobile.
Q. Would that be true in the presence of an air bag?
A. Well, I don't know. I don't have any experience with air bags. I don't know of any reading materials on air bags. I don't know.
Q. I just want to understand what your opinion is in terms of a whiplash type injury where there's no

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direct trauma. And when I say direct trauma, I'm talking about the head, the jaw and the face.
A. It is my view that in the absence of direct trauma, whiplash injuries, while they may produce cervical, flexion-extension injuries do not produce temporomandibular joint injuries.
Q. So to phrase it another way, an individual who sustains a whiplash type injury without direct trauma to the head, jaw or face can not develop traumatically-induced internal derangement of the temporomandibular joint?
A. That is correct.
Q. Have you ever seen literature to the contrary?
A. I have.
Q. Tell me where you've seen it.
A. Only place where I have seen such literature is in articles which I suspect are advocational, literature by an advocate.
Q. Advocate of what?
A. Of a particular view.
Q. Okay. Have you ever seen any of those articles appear in the Journal of Oral and Maxillofacial Surgery?
A. I can not remember one.
Q. Do you subscribe to that journal?

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A. I do.
Q. And would it be fair to say that for a number of years you have been a subscriber and reader of that journal?
A. Yes. There is one that was by LaPointe. That was in the August 1986 or '87, I'm not sure. I think in the 1987 journal. In which it cited 28 whiplash injuries that produced flexion-extension injury. LaPointe and Weinberg. However, they were all reported within a short period of time after the report at the emergency room.
Q. Well, when you say flexion-extension injury, I assume you are talking about the neck, or are you talking about something else?
A. Whiplash which produces jaw injury.
Q. Now, did Mrs. Liapis have TMD prior to the first automobile accident that is at issue in this case?
A. I believe she did.
Q. Did she have internal derangement of the disks prior to the first accident that is the subject of that lawsuit?
A. We don't know that, Ms. McCarthy, because nobody examined her for TMD.
Q. When did the TMD develop?

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A. Well, I suspect that developed back in 1986 after her first accident.
Q. And why do you say that?
A. Because she had maxillary pain at that time.
Q. And maxillary pain is what?
A. Pain in the maxilla, the upper jaw.
Q. Is it your belief that the cause of her TMD in 1986 was the automobile accident on, I think it was -- I don't know what date. Some time in *'86.*
MR. DOWNS: Labor Day of *'86,* I think it was.
Q. Okay.
A. I don't know what caused it. I think --
Q. Does it have any -- excuse me. I don't want to interrupt you.
A. I think it had -- it also has to do with, as Dr. Betor pointed out, the osteoarthritic changes. But as to what caused it, I don't know.
Q. Did the 1986 automobile accident have any relationship to the development of TMD at that time?
A. I suspect it did.
Q. And why do you say that?
A. Because she struck her face.

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Q. What did she strike her face on?
A. I don't know. It's in the record.
Q. What happened in that collision?
MR. RIDER: If you recall.
A. I don't.
Q. What speeds were the vehicles going at that time?
A. I don't know.
Q. Was it a rear-end collision?
A. I'm sorry. Ms. McCarthy, I've only seen this report very recently. I don't know whether it was a rear-end collision or not.
Q. When did you see the report?
A. Today.
Q. Would it be fair to say that you reviewed those records within a half hour or an hour of my appearing here today for your deposition?
A. That's correct.
Q. And in spite of that, you can't recall on what she struck her face, what caused the accident or the speeds of the vehicles involved?
MR. RIDER: Objection. It's not in spite of that. It's because of that.
Q. What treatment did she have as a result of her maxillary pain at that time?
A. I have no idea.

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Q. Have you seen any dental records that were generated prior to May of 1993 which indicated she was making any complaints of TMD?
A. No.
Q. Are there generally recognized causes of TMD?
A. Thereare.
Q. What are they?
A. There is a common belief among authors and lecturers on the subject that TMD arises primarilyfrom stress, external stresses and social stresses, which produce a parafunctional habit of bruxing and clenching.
Q. Is that it?
A. Oh, there are a number of other habits that can produces chronic temporomandibular disorder.
Q. And what are those?
A. Gum chewing, hand -- chin to shoulder telephone conversations, singing, violin playing, and occasionally sudden uncontrolled traumatic injuries such as a sneeze or a sudden uncontrolled yawn, a number of things, opening too wide to eat a sub sandwich are some of the things that set it off.
Q. Anything else that causes TMD?
A. Direct injuries to the jaws.

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Q. Anything else?
A. No.
Q. Are there generally recognized symptoms of TMD?
A. There are.
Q. And what are those?
A. It hurts to open. It hurts in the ear. Patients have headaches. They have pain to chew. Facial pain. Tinnitus.
Q. Is that ringing in the ears?
A. Yes.
Q Anything else?
A There are subset symptoms, hurts to yawn, hurts to laugh, not always present. Hurts to open very wide.
Q. Anything else?
A. In the cluster of symptoms, if the other symptoms or a number of those others that belong in the cluster are present, clicking can be an added symptom, but clicking by itself is not pathognomonic for TMD.
Q. Anything else?
A. No.
Q. How about popping?
A. I think clicking and popping fall under the same aegis, Ms. McCarthy.

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Q. I'm sorry? Fall under the same aegis, is that what you said?
A. Yes.
Q. So you can have popping, but you can have the other symptoms that you have listed, including facial pain, complaints of pain in the ears, headaches pain on chewing or tinnitus?
A. Or a significant number of those. Not everyone has all the symptoms.
Q. Sure. Could a person have clicking and one of the six cluster symptoms that you gave me and have TMD?
A. That's too nebulous a question to answer. I don't know.
Q. Let me ask you this way, doctor. Can a person have clicking, audible clicking and, say, ear pain and be symptomatic of TMD?
A. Clicking and ear pain?
Q. Right.
A. Yes.
Q. Can a person have clicking and facial pain and have TMD?
A. Yes.
Q. Have you reviewed Dr. Betor's records?
A. Yes. There wasn't much in there.

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Q. Okay. So can you and I agree that there's no reference in Dr. Betor's prior records, at least those generated before May 1993, that indicate that she had any of the generally recognized symptoms of TMD?
A. Yes.
Q. Did Dr. Betor misdiagnose Mrs. Liapis?
A. No.
Q. If you believe Mrs. Liapis had TMD prior to May of 1993 and Dr. Betor treated her for the three years prior to that, how did he fail to recognize this disease entity?
A. Perhaps she did not complain about those symptoms at that time to him.
Q. Are you an expert in disorders of the temporomandibular joint?
A. Ms. McCarthy, there are no experts in this area. There are those of us who read a lot and study a lot, but I doubt if anyone is really an expert because there's so much still to be learned.
Q. Would it be fair to say that you do not consider yourself to be an expert in the surgical management of temporomandibular joint disorders?
A. I have been, but I no longer am. I simply don't want to stand at a table for seven, six hours at a time.

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Q. Do you know Dr. James Moodt?
A. I do.
Q. And how do you know him?
A. I have met him on occasion and I know of his work, and he doubtless knows of my work.
Q. What is his reputation in the dental community?
A. Fine reputation.
Q. Is he qualified to diagnose and conservatively manage temporomandibular joint dysfunction?
A. Yes.
Q. You wrote a report in this case dated November 7?
A. That is correct.
Q. Did you write any other reports?
A. No.
Q. And that is a seven-page report, is that correct?
A. That is correct.
Q. What records did you have prior to writing this report or at the time you wrote this report?
A. I had a voluminous set of charts, progress notes, narrative letters and dental records, all of which pertained to Miss Liapis, including my own panorex x-rays.
Q. Well, specifically, what records did you have at the time or just before you wrote this report?

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A. The records and narrative reports of Dr. James Moodt, the Fairview General Hospital emergency room report.
Q. Dated when?
A. 5-9-93. The medical charts of physician Fitch, the personality assessment of psychologist Robert Goldberg.
Q. When is that dated?
A. 7-2-87. Charts of St. John's West Shore Hospital, 7-24-87; more charts that come from St. John West Shore which are partially illegible.
Q. Can you tell the date from those?
A. I can not. Physical therapist report from Fairview Hospital, including myriad numbers of visit entries.
Q. Over what period of time?
A. I believe it's the middle of '93 through '94. A narrative letter from Richard Betor, B-E-T-O-R, D.D.S.
Q. What's the date of that?
A. August 16, 1993. And the dental records from Dr. Betor dated from 3-22-90 until 5-20-94; reports from a weight loss clinic.
Q. Dated when?
A. I'm sorry. I don't have the date for those. St.

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John's West Shore.
Q. That would be the weight loss clinic from St. John West Shore?
A. Yes. A report of Michael Hauser.
Q. Datedwhen?
A. 11-10-94.
Q. I'mjust interested in what you had before you wrote your November 7, 1994 report.
A. There is no reports since that time except the one which we previously touched on.
Q. You mean the Southwest General records?
A. Yes.
Q. Well, Dr. Hauser's report is dated November 10th of '94. Your report is dated November 7th of '94.
A. Well, that is a fax copy so perhaps that was sent to me prior to my letter, but perhaps it was sent after my letter, neither one of which I know.
Then there are some radiologic interpretations from Plaza South One.
Q. Datedwhen?
A. 11-19-93. Reports from Health South, which believe is also physical therapy.
Q. Over what period of time?
A. It appears to be in the middle of 1994.

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Q. Is that it?
A. It may not be, Ms. McCarthy, if you can wait for a minute. And an MRI report April 1994 for the TM joints. That is it as far as I can tell.
Q. So you did not have the office notes of Dr. Hauser, is that correct?
A. I did not have the office notes of Dr. Hauser.
Q. Have you ever received the office notes of Dr. Hauser?
A. I don't know. I don't recall. I don't see them in here.
Q. All right. Have you ever received the operative note from the Mt. Sinai Hospital with respect to the arthroscopic surgery performed by Dr. Hauser?
A. No.
Q. Have you ever seen office notes from Dr. Thomas Murphy?
A. No.
Q. Do you know Dr. Thomas Murphy?
A. I know him.
Q. How do you know him?
A. I used to do some surgery at Metro and he was training there at that time.
Q. What's his reputation?
A. He has a fine reputation.

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Q. Did you ever see any of the operative notes dictated by Dr. Murphywith respectto the surgeries he performed?
A. No.
Q. Have you seen any emergency room records with respect to any other automobile accidents in which Mrs. Liapis was involved after May 9, 1993?
A. I'm sorry. I'm going to have to go off the record. Look, I don't know whether I have those or not. Do I have those?
MR. RIDER: I don't believe you do. I believe all the records that you reviewed prior to rendering your report are the records that you referred to today. And I don't believe I forwarded you any additional materials, nor do I think anyone else has.
A. The answer is I don't believe I have them here. If you have a copy, you might show me a copy and I would recognize it.
Q. Sure, but the stack that you have sitting in front of you right now which you've looked through, you have not read *off* any emergency room treatment other than the Fairview Hospital emergency room treatment of May 9, 1993, and I'm wondering simply in terms of what records were

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provided to you --
MS. McCARTHY And maybe we can stipulate that he was not provided those records and then I can move on.
MR. RIDER: I didn't bring that part of the file with me, but I don't believe any other records were sent to the doctor other than what he's testified to today.
Q. All right. And the records that you reviewed in anticipation of your discovery deposition included Southwest General Hospital records dated in 1986with respect to an automobile accident that same year?
A. Repeat the question, please.
MS. McCARTHY Would you read back the question for him, Sandy?
A. No.
Q. Did you review any other records in terms of your testimony today that we haven't talked about?
A. No.
MR. RIDER: How did the doctor answer that question about the review of his records today?
A. It was in preparation for the discovery dep. So therefore, I saw those records from Southwest.

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MR. RIDER: And those records, just for the record, were records supplied by Dr. Randt. However, those records contain more than just his office notes. They contain records from Southwest -- I'm sorry --from St. John West Shore, and I'm not sure what else they may contain, but they were records supplied by Dr. Randt.

Q. Have you since the time of your report reviewed any records, office notes or operative notes or hospital records, generated with respect to the treatment of Drs. Hauser and Murphy?

A. Other than the narrative written by Dr. Hauser to which we have already referred, no.

Q. Have you reviewed any records of Dr. Robert Zaas?

A. No.

Q. How about Dr. Sheehan?

A. Was he a physical therapist? If he is a physical therapist, I probably have, but otherwise, no.

Q. I believe is endocrinologist at the Cleveland Clinic.

A. No, then I did not.

Q. Now, do you have your report in front of you dated November 7, 1994, is that correct?

A. Yes, I have.

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Q. And you saw Mrs. Liapis only one time on October 7, 1994, is that correct?

A. That's correct.

Q. Now, in your report under history, Roman Numeral No. I, first paragraph --

A. Yes.

Q. --you have the first accident she was involved in was May 9, 1991. Is that an error?

A. That is a typo made by the secretarial service, a typographical error. That should be 1993.

Q. It's your understanding based on your review of the records that Mrs. Liapis did not make any complaints of jaw pain or discomfort or jaw symptoms until she was seen by Dr. Moodt a couple of months after the accident, is that correct?

A. That is not correct.

Q. All right. Is that what is contained in your report?

A. *Yes.*

Q. All right. And so the report is in error in that regard?

A. Actually, she did complain earlier than two months.

Q. All right. So the report is in error on that point?

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A. Just on that point, yes.

Q. Okay. Clear up the error for me then, doctor.

A. I think the first mention of jaw discomfort occurs on June 16, five weeks after the accident.

Q. All right. And where do you get that information?

A. This is contained in a series of progress notes, I believe belonging to Dr. Fitch, which on June 16 say, When patient opens mouth, jaw pops.

Now, perhaps my report -- in that case my report is not in error because I did not consider that as diagnostic of temporomandibular joint disorder.

Q. Does that note mention anything else that would be significant in terms of the symptomatology associated with TMD?

A. Left-sided face pain, but of course, she's had face pain many other times prior to this.

Q. Does your report talk about that, doctor?

A. No.

Q. Whynot?

A. Well, inasmuch as the report was made more than three years ago, I don't recall why not. It either was because I did not see that entry, A; or B, because I did not consider that as

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diagnostic of temporomandibular joint disorder.

Q. Incidentally, do you know what has happened to this woman since you wrote this report in terms of her medical care?

A. I do not.

Q. So you have no idea about subsequent surgeries?

A. I do not. Mr. Rider has indicated to me prior to the time he met you today that she has had secondary surgeries.

Q. Well, let me ask you this then. You're not going to render any opinions in terms of any care she received after you saw her in October of 1994, is that fair?

MR. RIDER In regard to what?

MS. McCARTHY: Anything. Any opinions he may have on that stuff.

A. I think I maintain opinions vis-a-vis nonspecific temporomandibular joint disorder. Specific to some incident that Mrs. Liapis had -- specific experiences she has had, no, I will not, but otherwise, I would still make generalities about temporomandibular joint disorder.

Q. Well, let me ask you this. Is it your opinion that the care and treatment that she had up to the point in time when you saw her in October of

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1 1994 was medically necessary?
2 A. Yes.
3 Q. All right. #at you understand in terms of her
4 treatment since you saw her in October 1994 is
5 that Dr. Murphy has performed surgery on both
6 sides of her temporomandibular joint and removed
7 the disks, is that your understanding?
8 A. That was not my understanding, but that may well
9 be the case.
10 Q. All right. You don't take issue with the
11 necessity of that treatment, do you?
12 A. No. I was not there for that treatment.
13 Q. Your sort of -- I don't want to characterize it
14 a5 a dispute, but where you part company with the
15 treating physicians is with the causation issue,
16 is that fair?
17 A. That is fair.
18 Q. All right. Your opinion is that all of the care
19 and treatment to the temporomandibular joints
20 that she has had since May 19, 1993 is related in
21 some fashion to the 1986 automobile accident,
22 correct?
23 A. Or to the longstanding osteoarthritic changes to
24 which Dr. Moodt referred.
25 Q. Can you think of any other cause?

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1 A. I know she has had considerable stress in her
2 life and this she has mentioned a number of
3 times.
4 Q. What is the stress that she has had in her life
5 that you consider to be considerable?
6 A. I will quote Dr. Goldberg's report first.
7 Q. All right.
8 A. Patient has had --this is dated 3-2-87. The
9 patient has had two significant stressors in past
10 months. Her daughter has been treated at
11 Glenbeigh for drug and alcohol use and there has
12 been family counseling. The patient stated that
13 family factors were -- not significant.
14 Paragraph.
15 The patient's adult son went into personal
16 therapy and Mrs. Liapis said that she lost weight
17 secondary to worry initially. And the second
18 stressor is the car accident a few months ago in
19 which she was injured when they were hit by a
20 drunk driver. This is 3-2-87. Continuing on.
21 The patient also has had a sister ill with a
22 brain tumor and this has been a constant stress
23 to the patient over some months.
24 There is another mention of stress in
25 another St. John's West Shore report. I doubt if

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1 111 find it right now. I did find it. This is
2 dated 9-14-86. This is poorly copied and it's
3 very difficult to read. It's just that she had a
4 sensation, dot, dot, dot, of numbness, and I can
5 not read the rest.
6 Q. Why is that significant?
7 A. Because she talks of numbness later many times.
8 Q. Well, where was the numbness that you are
9 referring to in the September 14, 1986 St. John
10 West Shore record?
11 A. I can't read where it is.
12 Q. So it can be numbness in her toe for all we know,
13 correct?
14 A. Yes.
15 Q. And that would have nothing to do with the
16 temporomandibular joints, is that fair?
17 A. I think numbness has nothing to do with
18 temporomandibular joints at any time.
19 Q. So that note wouldn't be important in terms of
20 our discussion, would it?
21 A. No.
22 Q. All right. Any other stressors after 1987 that
23 you are aware of, doctor?
24 A. None to which I can specifically refer at this
25 time.

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1 Q. And I'd like to make it clear that it is your
2 opinion that stress causes temporomandibular
3 joint dysfunction?
4 A. It is generally accepted as one of the primary
5 causes from which TMD arises, yes.
6 Q. As opposed to an aggravating event with
7 underlying conditions?
8 A. Yes.
9 Q. Do you know how these stresses resolved after
10 1987?
11 A. I do not.
12 Q. Have you ever diagnosed sinusitis?
13 A. Yes.
14 Q. What are the signs and symptoms of sinusitis?
15 A. Pain and swelling over the infraorbital area.
16 Q. And where is that located?
17 A. It's right underneath the eye. Tenderness to tap
18 underneath the eye, pain in the anterior teeth, a
19 feeling of heaviness on that side of the face and
20 headaches which tend to be frontal only.
21 Q. Not temporal?
22 A. No.
23 Q. How about dizziness?
24 A. Dizziness is one, too.
25 Q. How about pain in the ears?

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A. No. I looked that up in the Merck Manual last night, M-E-R-C-K, and they do not list pain in the ears as being one.
Q. Is the Merck manual authoritative on sinusitis?
A. I believe so.
Q. Is the diagnosis of sinusitis and treatment of sinusitis something that you do in your practice on a routine basis?
A. I make the diagnosis of it on occasion. I don't treat it unless it's dentally caused as, for example, a root tip in the sinus.
Q. How about drainage, is that also a symptom of sinusitis?
A. Yes.
Q. When were Mrs. Liapis's osteoarthritic changes first picked up?
A. July 27, 1994.
Q. By way of what study?
A. Corrected tomograms. In July of 1993. I'm sorry. The letter is written July 27. In July of 1993 according to Dr. Moodt.
Q. All right. Had Mrs. Liapis ever had panorex x-rays done before May of '93?
A. These are not panorex x-rays. These are tomograms.

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Q. I understand that. I'm asking you if she ever had panorex x-rays done before May of '93.
A. I have no record of any.
Q. You took x-rays of her, is that fair?
A. Yes, I did.
Q. For what purpose?
A. For my independent medical examination, Ms. McCarthy.
Q. Well, the x-rays that you took are not going to tell you anything about the interior of the joint, is that fair?
A. They don't tell you about the interior of the joint. They tell you about the bone.
Q. Was there some suspicion that she had a fracture of any of the bone around the TMJ?
A. No.
Q. You understood that the issue was whether the disks were internally deranged, is that right?
A. There was also the issue of whether she has osteoarthritic changes, whether she has a closed bite, because that can produce the temporomandibular joint disorder. Certain chewing discrepancies produce that. X-ray shows whether the person has a closed bite or not.
Q. Which are a better diagnostic tool, the tomograms

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or the panorex x-rays?
A. Tomograms.
MR. RIDER: For what diagnosis?
MS. McCARTHY Temporomandibular joint dysfunction.
MR. RIDER: Okay.
Q. Doctor, when did you learn that Mrs. Liapis had made complaints consistent with symptoms of temporomandibular joint disorder before today?
A. I learned that on November 7,1994, when I took her history.
Q. Why didn't you put that in her report then?
A. I'msorry. Put what?
Q. Well, as I understand it, there is an error in your report where on at least three or four occasions you mention that she made no complaints of symptomatologyassociated with TMD for two and a half months, and we know today that that is incorrect.
A. It was one and a half months.
Q. When did you learn that that was incorrect is my question.
A. Oh, I see.
Q. Did you learn that today?
A. Oh, perhaps reviewing the chart, yes, recently,

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but it's of very little importance, one and a half or two and a half.
Q. Well, as I understand it, in reading page 5 of your report, the last full paragraph, last sentence where it says, My doubts vis-a-vis causality arise from two separate and distinct areas. And then your report goes on to talk about the two separate and distinct areas, one being the lack of complaints for a two and a half month period of time --
A. I'm sorry. What page?
Q. Page 5.
A. Whatparagraph?
Q. The last full paragraph starting with Drs. Moodt, Murphy and Hauser.
A. All right.
Q. All right. The last sentence that says, My doubts vis-a-vis causality arise from two separate and distinct areas.
A. Yes.
Q. And as I read your report, the first being the lack of complaints within the first two and a half months of the accident, and the second being the lack of direct trauma?
A. Right.

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Q. So when you wrote this report, your view was that it was important she did not make any complaints of symptoms associated with TMD for two and a half months, is that a fair statement?
A. No, but that is not germane. One and a half months, if you read the rest of the report, still is too long to make a complaint.
Q. Where in this report do you say one and a half months is too long?
A. I don't say.
Q. Okay.
A. I say that injury to the jaw joint is rather like interior injury to any other joint. When you're injured it hurts right away. Whether it's one and a half months or two and a half months is not germane.
Q. In retrospect, doctor, did Mrs. Liapis have a permanent injury to the temporomandibular joints?
MR. RIDER: At what point in time?
MS. McCARTHY At any point in time.
A. I believe she had permanent changes in her temporomandibular joints. Those are the osteoarthritic changes.
Q. And the motor vehicle accident of 1986 --

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A. I'm sure that was -- I believe that was a contributor.
Q. All right. Your statement on page 7 of your report second paragraph, paragraph that begins, As for Mrs. Liapis' prognosis. Do you see that paragraph?
A. I do.
Q. Midsection of the paragraph, where you say, I do not believe her injuries are permanent. Then you make a statement, TMD is a self-limiting disorder?
A. Yes.
Q. What does that mean?
A. That with or without treatment it eventually dissipates.
Q. Is that true in her case?
A. No. She had treatment so we don't know.
Q. We don't know if it dissipated in her case?
A. No. Because she had treatment for it. The jaws remodel, generally speaking.
Q. What does that mean?
A. They remodel to accommodate dysfunctions of the TM joint.
Q. Is that true in a hundred percent of the cases?
A. Ms. McCarthy, I don't know if anything is true in a hundred percent of the cases. I can't answer that.
Q. So --
A. I just -- the statistics tell us that old people no longer have --whether they had them before or not, they do not have it. A number of people have temporomandibular joint disorder, and older people, for example, in nursing homes do not have complaints vis-a-vis temporomandibular joint disorder. Indicating that at the end people would go out and commit suicide but that rather, they get better.
Q. In terms of jaw remodeling, doctor, let's get back to that. How does that happen anatomically?
A. I think there's bone organization and bone change, and occasionally patients will learn not to do certain things, and over a period of time pain seems to --the symptoms seem to dissipate.
Q. So it's not just anatomical; it's also functional in terms of patient input?
A. Yes.
Q. So the patient has to learn to adapt with the dysfunction?
A. Yes.
Q. All right. In other words, if one has an anterior displaced disk that causes a number of painful symptoms, a person has to stay away from chewing hard foods, from putting things in their mouth, those type of things that will limit the amount of pain they're going to have because of that displacement?
A. Ms. McCarthy, it is not my role to lecture to you about temporomandibular joint disorder. However, let me say that about 38 percent of the adult population who are totally asymptomatic, have no previous injury, no symptoms of any sort, when they are examined with an MRI, anterior displaced disks. So anterior displaced disks does not dictate that the patient has pain. People, probably you and I, one of us, 38 percent, has anterior displaced disks and without symptoms.
Q. Well, let's talk about the people who do have symptoms. Okay? Those people have to modify their behavior and conduct to accommodate those symptoms, is that right?
A. If they have symptoms, yes.
Q. Okay. And there are times or occasions when those modifications are of a permanent nature, right?
A. Perhaps you could give me an analogy or a

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specific instance.
Q Well, if a person has signs and symptoms of temporomandibular joint disorder and they have popping and clicking and jaw pain, they have trouble opening their mouth fully without a great deal of pain, they have problems chewing hard foods without a great deal of pain, and they continue to get medical treatment directly related to temporomandibular joint disorder, they never get any better, and ultimately that person needs surgery, would that person fall under the category of self-limiting?
A. No, because they've had surgery.
Q All right. Thank you. Did Mrs. Liapis have malocclusion?
A Yes.
Q. Was that a contributing factor to her TMD?
A I don't believe *so.* We used to believe that bu we don't anymore.
Q The medical community used to believe that malocclusion was a contributing cause of TMD and it is no longer the case?
A. That is true of me, yes, and I think it's true generally of the researchers on the subject, too. With the exception of, as I told you,

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missing posterior teeth and closed bite.
Q. Did she have any of those problems?
A. No
Q Is it true that a person can have arthritic changes and not be plagued with any problems associated with arthritic changes?
A. It's a difficult question. I would think that if you have arthritic changes, you would have some -- some pain in the moving of a joint. I think if you have arthritic changes, you must have symptoms with that.
Q. So the same wouldn't be true of, say, a patient, the 38 percent of population that you talked about who have displaced disks and no symptomatology associated with that, it's not true of people who have osteoarthritic changes who don't know it but have no symptoms. The same analogy can not be drawn in terms of arthritis?
A. No, no.
Q. Is that a generally accepted principle of medicine as far as you know?
A. I can not speak for the general medical opinion. I don't know.
Q. Doctor, what other opinions do you intend on rendering at the time of trial in this case?

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A. Well, I think that's all contained in my report.
Q. So you don't intend on rendering any other opinions that are not contained in your report dated November 7, 1994, is that correct?
A. With the exception of what little --what material I will have to --that still came from the Southwest Community Hospital.
Q. So you do not intend on reviewing any records generated after, say, November of 1994 before you testify, is that right?
A. That's correct.
Q. Doctor, how many times per month do you examine patients on what you call an independent medical evaluation?
A. That's a perjorative remark and I will accept it as such. What I call independent medical exams are indeed independent medical exams.
Q. Yes.
A. I have done it for the plaintiff and I've done it for the defendant many times. The answer is probably about -- in a month, is that your question?
Q. That was my question.
A. About three.
Q. And how long has it been the case that you do

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three per month?
A. Since about 1985.
Q. Had you been doing independent medical evaluations prior to 1985?
A. I might have done a few, but not very many. Maybe in the '83, '84 area I did one or two a year but I started getting more and more involved in doing them in '85.
Q. In terms of doing an independent medical examination, would you agree that it is important to be thorough in your review of the medical records that you are presented with?
A. Yes.
Q. Is it fair to say that in terms of doing an IME, it is important for you to be objective in your evaluation of the medical data and the complaints made by the person when they come to see you?
A. Yes.
Q. Is it fair to say that it is important to be accurate in terms of the facts contained in the medical records?
A. Yes.
Q. Why is it important to be accurate in terms of the facts in the medical records?
A. I think that is evident to both of us,

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Ms. McCarthy.
Q. Will you answer my question anyway?
A. No.
Q. You won't answer that question, doctor?
A. No.
Q. Whynot?
A. Because it's evident to both of us, to everyone here in the room, why it's important to be accurate.
Q. It's not evident to me. So I would appreciate it if you would answer my question. Educate me, if youwould.
A. Accuracy is a fundamental virtue.
Q. A fundamental virtue? All right. And is that your answer?
A. Yes.
Q. Is it important in terms of citing and quoting authors of medical literature to be accurate?
A. Yes.
Q. Have you in the past been accused of not being accurate in your quotation of authors and various publications?
MR. RIDER: Objection. You can answer.
A. On one occasion when I first started out doing

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this work.
Q. And what were the circumstances?
MR. RIDER: Note my continuing objection. You can answer.
A. I don't recall the specific one to which you refer, Ms. McCarthy. If you're referring to one involving your office, that is correct.
Q. Oh, actually I'm unaware of that one. So there's been more than one?
A. Well, I don't know of any other one. There was one in --with a Mr. Spero in 1981.
Q. 1981, is that what you said?
A. '81, '82, yes. About one of the first ones I ever did.
Q. So you have been doing IME's at least back to '81 as opposed to '83 and '84?
A. Every practitioner does some. Every practitioner writes reports at one time or another. I think I probably started, yes, in the '80s.
Q. On an independent basis, is that what we are talking about?
A. Yes, yes.
Q. So what were the circumstances of the 1981 misquotation involving Mr. Spero?
A. It had to do with interpretation of a paragraph

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and the two separate editions of a book, and I had one but I didn't --the second edition of the book had exactly what I had said, but I cited the page number in the first page of the book in the first edition.
Q. And how was the misquotation brought to your attention?
A. By plaintiff's counsel.
Q. Did you ever receive correspondence from the author about the misquotation?
A. You are referring to another -- another case which involved Mr. Paris in your office in which there was a dispute over an article which says in very plain language exactly what I had quoted it as saying. And I had not misquoted the article, but the author says that is not what he meant.
Q. Okay. What is your charge for the independent medical evaluation?
A. They vary. If I spend several nights writing a paper, and I suppose it's around $100 an hour, so that would come to about $500. But then there is the cost of the examination and the panorex x-ray and then there is the typing costs.
Q. Well, what is the cost of the examination then?
A. I think the examinations, counting the panorex

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x-ray are around $100 is standard in the Northern Ohio area, yes.
Q. And the panorex x-ray is what? How much?
A. That's included in the $100.
Q. The exam and the x-ray is $100?
A. Yes.
Q. Are the x-rays performed here in your office?
A. Yes.
Q. Then there is a separate charge for writing the report, is that right?
A. Yes.
Q. All right. And on average what is your cost for writing a report? You mentioned a figure, if it takes five hours, $500. Would that be the average figure?
A. Yes, but then the typing is fairly expensive. I don't do it myself. I take it out to a typing service.
Q. So you would dictate it and take the tape to some service?
A. Yes.
Q. And what does that typically cost?
A. I used to make longer reports that cost more. It costs someplace between one fifty and two twenty-five.

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Q. How many times per month do you testify by way of videotape?
A. Not very often. Six times a year perhaps, if that.
Q. How about live appearances at trial per month?
A. No Not very often A few times a year.
Q. Would that be two or three?
A. Two, yes.
Q. Two times per year?
A. Yes.
Q. And how long has it been the case that you have testified by videotape six times per year?
A. Well, six is high. I don't think -- I think -- videotape, gosh, really, it's more like four times a year, Ms. McCarthy. And how long have I been doing that? I suppose since 1990 or so. I never did many videotapes before that.
Q. And what is your charge for videotape testimony per hour?
A. I don't charge per hour. I don't charge -- I only charge if I'm missing office time. I have to clear out my office for however long it takes, so I charge for what office time I've missed, same as I'm doing today. I'm missing office time.

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Q. Well, what would the charge be then?
A. But you weren't on time.
Q. The letter I got from Bill said 4:00.
A. The letter I got said 3:30.
MR. RIDER: I thought it was 3:30.
A. Well, the bill started at 3:30.
Q. That's no problem. I'll handle it. Well, tell me what the charge is for clearing out your office for however long it takes for you to testify.
A. I suppose a couple hundred dollars an hour.
Q. $200 per hour?
A. $225.
Q. I'msorry. $225?
A. $225.
Q. Okay. And is your live trial testimony more expensive than $200 or $225 an hour?
A. No.
Q. It's the same cost?
A. Yes.
Q. Incidentally, are you going to be in town next week?
A. No.
Q. Where are you going?
MR. RIDER Objection. That's not

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really relevant.
A. All right. If you want to know, I'm on the board of trustees of a university and we have a presentation of our president in Vero Beach, Florida, which I've been asked to be presenting. So I'll go down on Thursday and present him and give an introduction and talk.
Q. Thursday of this week or --
A. Yes.
Q. -- Thursday of next week?
A. Thursday I will leave and I come back Tuesday.
Q. Thursday of this week or Thursday of next week?
A. Yes.
Q. So you will be in town next week?
A. No. I come back Tuesday night of next week.
Q. So you will be here Wednesday, Thursday, Friday, Saturday, is that correct? During this trial you be you will be in town?
A. I don't know when the trial is, Ms. McCarthy.
Q. But you will be in town Wednesday, Thursday and Friday of the week of the 26th, is that a fair statement, doctor?
A. Yes.
Q. So that I understand, you're billing me $200 or $225 an hour?

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A. Yes, $225 an hour, yes.
Q. Okay. Starting from 3:30?
A. That's right.
Q. Is there a textbook that you consider to be authoritative in the area of temporomandibular joint dysfunction?
A. Let me think about that. Right now I'd have to say no because it's a constantly churning field. New research is always being brought to the literature. So textbooks are not as valuable as periodicals. There is one by a man named Victor Gelb, G-E-L-B, but that came out in the middle '80's. I still refer to that once in a while.
Q. Do you have a textbook to which you refer that was edited or revised since say 1990?
A. No, I don't. I'm sure there are such, but I don't.
Q. If I were a medical student and wanted to know from you what textbook I could buy to educate myself on temporomandibular joint dysfunction, where would you send me and what would the book be?
A. Honestly, I don't think -- I don't know of one that is really up to date because things change, just like this article in 1995.

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Q. Is the Journal of Oral and Maxillofacial Surgery the journal or periodical that you would refer me to to educate myself on temporomandibular joint dysfunction?
A. Yes, yes.
Q. Is there any other dental periodical besides that journal?
A. Well, there is a small summarycalled TM Update, and that has synopses of all of the new articles that come out. So they quote the Journal of Craniomandibular Orthopedics and the Journal of Orthodontics and one that I think is a very good one called the Journal of Oral Medicine, Oral Pathology and Oral Surgery.
Q. Is that it?
A. Yes, I think so.

MS. McCARTHY I don't have any more questions for you. Thanks.

MR. RIDER: Questions, Tom?

MR. DOWNS: No.

MR. RIDER: Thanks, doctor. Do you waive signature?

A. Yes.

(Signature waived.)

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CERTIFICATE

The State of Ohio ) SS:
County of Cuyahdga.)

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

INWITNESS WHEREOF, I have hereunto set my hand and seal of office, at Cleveland, Ohio, this ____ day of _____ A.D. 19____.

Sandra L. Mazzola, Notary Public, State of Ohio
14237 Detroit Avenue, Cleveland, Ohio 44107
My commission expires January 27,2002

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## S

# DEPOSITION OF KENNETH R. CALLAHAN, DDS

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**CONDENSED TRANSCRIPT AND CONCORDANCE**

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COURT OF COMMON PLEAS
CUYAHOGA COUNTY

- - -

MARIE LIAPIS, )
et al., )
)
Plaintiffs, )
)
vs. ) Case No. 254818
) Judge Gallagher
ADELE CARAVELLA, )
et al., )
)
Defendants. )

- - -

Transcript of deposition of KENNETH R. CALLAHAN, D.D.S., Expert Witness herein, called by the Defendants as upon examination, pursuant to Subpoena and Agreement of Counsel, pursuant to the Ohio Rules of Civil Procedure, before Denise M. Andreotti, a Court Reporter and Notary Public within and for the State of Ohio on Wednesday, January 21, 1998, at the office of Kenneth R. Callahan, D.D.S., Southgate Medical Arts Building, Maple Heights, Ohio, commencing at 4:25 p.m. and concluding at 6:00 p.m.



APPEARANCES:

Ellen McCarthy, Esq.
Nurenberg, Plevin, Heller & McCarthy
on behalf of the Plaintiffs;

Stephen C. Merriam, Esq.
Williams & Sennett Co., L.P.A.
on behalf of Richard Harkins;

Thomas J. Downs, Esq.
Attorney-at-Law
on behalf of Adele Caravella;

Christopher J. Russ, Esq.
Mazanec, Raskin & Ryder Co., L.P.A.
on behalf of Sam Elkadi.

- - -

Also present:
George Tackla, Videographer
Tackla &Associates

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(Marked previous to the deposition commencement)

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(Signature waived)



OBJECTIONS PAGE LINE





OBJECTION PAGE LINE



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PROCEEDINGS

KENNETH R. CALLAHAN, D.D.S.
Expert Witness herein, called by the
Defendants as upon cross-examination, having
been first duly sworn, as hereinafter
certified, was examined and testified as
follows:

---

DIRECT EXAMINATION OF KENNETH R. CALLAHAN. D.D.S

BY MR. MERRIAM:
Q. Good afternoon, Doctor. Could you state
your full name for the record and spell your last
name, please.
**A. My name is Kenneth Robert Callahan,**
**C-A-L-L-A-H-A-N.**
MR. MERRIAM: Thank you,
Doctor. My name is Steve Merriam. I'm an
attorney with Williams & Sennett. I'm working
with Roger Williams on this matter. Our firm
represents Richard Harkins, one of the Defendants
in a case brought by Marie Liapis, et al. against
Adele Caravella and the other Defendants. This
matter is pending in a Cuyahoga County Court of
Common Pleas before Judge Eileen Gallagher.

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BY MR. MERRIAM:
Q. Doctor, you've told us your name, could you tell us your business location and the nature of your business?
A. I'm located at the Southgate Medical Arts Building in Maple Heights. I do oral and maxillofacial surgery.
Q. Thank you, Doctor.
How long have you been located at this address?
A. I've been here for twenty-five years.
Q. All right. Doctor, if you would, could you summarize for the jury your educational and dental training background, please.
A. Yes. I am a graduate of St. Ignatius High School, of John Carol University. I graduated from Case Western Reserve University School of Dentistry and then to the Graduate School of Medicine at the University of Pennsylvania. Internship and residency at Cleveland Metro General Hospital, now called - at that time called Cleveland City Hospital. After that time I went into practice at West 25th and Lorain where I remained until 1972 when I came out here to Southgate.

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Q. Doctor, how long have you been in the private practice of dentistry?
A. I've been oral and maxillofacial surgery since - for thirty-nine years.
Q. All right. And, of course, you're licensed in the State of Ohio?
A. I am, Mr. Merriam.
Q. Do you have any hospital affiliations or privileges?
A. Yes. I teach at University Hospitals, I teach the resident staff in oral and maxillofacial surgery. I also do surgery at University Hospitals. I'm former Chief of the Oral and Maxillofacial Surgery Department at Marymount Hospital and I occasionally go to Bedford and to South Pointe Hospitals as well.
Q. Thank you, Doctor.
Could you tell us some of the more significant professional associations that you belong to?
A. I'm a diplomat of the American Board of the Oral and Maxillofacial Surgeons. I'm a member of our parent society which is the American Society of Oral and Maxillofacial Surgeons. I also am a member and past president of the Northeast Ohio

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Society of Oral and Maxillofacial Surgeons. I belong to the Ohio and Great Lakes Societies of the same and the American Dental Association. I also have some honorary degrees. I'm a fellow of the American College of Dentists, a fellow of the International College of Dentists and I've been teaching at Case Western Reserve University and there's an honor associated with that, certain teachers, which is called "Okay You," which indicates that I must teach well or long. One or the other.
Q. Doctor, could you explain to the jury what oral and maxillofacial surgery is all about? In other words, in lay person's language, what that means?
A. Well, oral and maxillofacial surgery is that branch of dentistry which deals with diseases and injuries of their mouth, the jaws and their associated structures.
Q. And that would include problems with the temporomandibular joint?
A. That is correct; yes. It does, Mr. Merriam.
Q. Could you tell us about your experience and background with that particular area of the jaw

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and the joint – the joint associated with the jaw and tell us where that is.
A. Well, I'll show you in a minute. Where's my skull?
MR. MERRIAM: I think we left the model in the other room. Perhaps, we could go off the record just for a moment and retrieve it for a second. Thank you.
(A short break was taken)
MR. MERRIAM: Back on the record, please.
A. The temporomandibular joint is a ball and socket joint which all of you can feel. It's in front of your ear and when you open and close, you will feel it rotating, and about 62 percent of you will feel it clicking because that's the percentage of adults who have clicking or popping in the temporomandibular joint. The ball and socket looks like this. This is the ball. It's in the lower joint, the socket is the upper joint. The ball rotates in the socket like this and when you open very wide it also slides down the little ramp. Between the ball and the socket is a disc called a meniscus which is a little cushion between the ball and the

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socket. It's the joint which we move every time we speak, every time we yawn and every time why chew, but also every time we breathe so the joint mechanism is in motion a great deal of our adult - of all of our lives. You had asked me about surgery, my experience with surgery on it. I was one of the pioneers in the area with Dr. Spilcovackonee, (phonetic) middle fifties, one of the first people to do surgical procedures on the ball and socket joint in order to remove the meniscus or to repair the meniscus. I did that at Lutheran Hospital many years ago.

BY MR. MERRIAM:

Q. Do you presently do surgery in that area?

A. I do not any longer, Mr. Merriam. I do not care to stand at an operating table that long.

Q. In recent years, Doctor, what has been the focus of your practice then?

A. I do some exterior facial trauma, a lot of jaw fractures and avulsed teeth and people that are in bar fights who are talking when they should be listening; but I do have some, do some facial trauma, I do impacted wisdom teeth and diagnosis of temporomandibular joint disorder.

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Q. All right. What is TMD?

A. It's an acronym which stands for temporomandibular disorder. The TMJ that everybody refers to is the joint, that's the anatomic spot. So temporomandibular joint is TMJ. The disease, and the disorder is called TMD.

Q. Okay. So rather than try to say that long name, I'm going to be referring to TMD -

A. All right.

Q. - throughout the rest of your deposition. Can you define what TMD is, how that shows up; the type of symptoms you see?

A. Temporomandibular disorder manifests itself in a cluster of symptoms. They include pain in the ear, ringing in the ear, pain to open and close, pain in - facial pain, frequently facial pain, and pain sometimes to yawn, sometimes pain to laugh, sometimes in all those cluster of symptoms are other symptoms which by themselves do not designate the disorder like clicking or popping. It affects a number of people. It affects females in a ratio of 9 to 1 over males for some reason which nobody is apparently aware.

Q. Doctor, what about sinus discomfort; is that associated with TMD?

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A. No. Sinus discomfort is manifested usually as pain underneath the eye and feeling of fullness under the eye and above the upper teeth, upper front teeth particularly, that's where sinus is most unnoticeably symptomatic. Sometimes frontal headaches, too.

Q. Doctor, in your experience does it occur that instead of diagnosing TMD that a sinus problem is diagnosed?

MS. McCARTHY: Objection.

A. Yes. That is a frequent misdiagnosis because TMD is really one of the most frequently misdiagnosed or misaccentuated diagnosis. Often, you're not thinking of TMD and you're thinking of something else. It's a great imposter disorder because you could overlook it so often. What may appear to be a sinus infection is actually a TMD disorder.

Q. Doctor, is TMD caused by direct trauma to the area?

A. It can be caused by direct trauma; yes.

Q. In your experience does it occur without direct trauma to the facial area?

A. No. It doesn't, Mr. Merriam, and it's been - there's so many new articles and new

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research in the area in our literature about the causes of TMD and there's kind of a wide spread consensus among the new authors. It suggests that in the absence of direct trauma you do not get temporomandibular joint disorder. In the absence of being struck on the face or in the face or on the chin or in the mouth you do not develop TMD. There's one recent article published in 1995 by Dr. Howard, et al. which suggests that in a low velocity moving vehicle accident the trauma to the temporomandibular joints is less than what you'd ordinarily experience in chewing a tough steak so we don't think that that trauma, in the absence of direct injury, is any worse than a sudden sneeze, uncontrolled yawn. I don't think trauma causes it unless there's direct trauma.

MS. McCARTHY: Objection.

BY MR. MERRIAM:

Q. Well then, Doctor, a motor vehicle accident resulting in simple whiplashes, it's caused, as it's ordinarily called, would not be the type of thing that would cause TMD; is that correct?

MS. McCARTHY: Objection.

A. That is correct, Mr. Merriam. And as a matter of fact there's a guy by the name of

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Laskin, who is one of our international heroes who published an article a couple years ago. He's the editor of the journal, the Oral and Maxillofacial Surgeon Journal. He examined the cervical flexing/extension injury, the whiplash, of one-hundred and fifty three patients and his conclusions were that, no, well, there's obvious whiplash and so annotated in the emergency room they did not produce temporomandibular joint disorder.
MS. McCARTHY: Objection.
A. It doesn't do it.
Q. Doctor, in your experience when someone is involved if an accident would problems with the joint, specifically TMD, would those problems arise immediately or would you except somebody to be reporting those problems weeks or months later?
MS. McCARTHY: Objection.
A. In my experience of almost forty years of dealing with patients in the emergency room, patients who have suffered direct injuries to their jaw joints, they have pain right away. The reason for this, and I think you can all understand this is this, if you hurt one of your joints it hurts right away. If you've ever see a

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football player on your football screen who injures one of his joints maybe the elbow the knee or the ankle, he does not report that a month and a half later. He rolls around the field and everybody, the coaches, the viewers, the players know that he has hurt one of his joints. This is true of temporomandibular joint, as well. If you hurt it in an accident, it hurts right away and basically in the emergency room you say, oh, I can't open my mouth. It should hurt right away, but not – within the first seventy-two hours anyway.
Q. All right. Doctor, you've mentioned various symptoms or signs of TMD such as the headaches, sometimes sinus, sometimes ear pain and ringing, facial pain; is there any correlation between personal external stressors, parts of the patient's personal life, and people getting this type of disorder?
MS. McCARTHY: Objection.
A. There is a strong consensus again among authors and lectures on the subject that do a lot of research suggesting that stress is a primary source from which temporomandibular joint arises. Stress produces a lot of parafunctional habits

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which do stretch the tendons and the ligaments, and, yeah –
Q. Doctor –
A. – and psychosocial stresses have more to do with it than anything.
Q. Doctor, you mentioned certain habits para?
A. Parafunctional habits. When people are under stress they sometimes clench their teeth and their jaws not knowing it and doing that you stretch the tendons and ligaments beyond their elastic limits.
Q. Doctor, when you take a history from a patient complaining of symptoms that suggest TMD do you ask about their personal life and the types of things that may cause them to have that sort of array of external stressors affecting them?
A. Sometimes I will; yes, Mr. Merriam.
Q. Did you examine the Plaintiff, Marie Liapis, in this case?
A. I did, Mr. Merriam.
Q. And when did that examination take place?
A. That took place in my office on October the 7th of 1994.
Q. And did you produce a written report regarding your examination including your

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conclusions and opinions?
A. I did, Mr. Merriam; yes.
Q. And what is the date of that report, Doctor?
A. November 7th, 1994.
Q. Now, you're holding a copy of that report marked as Exhibit A; is that correct, Doctor?
A. Yes. That's correct.
Q. All right. And it's certainly permissible for you to refer to that report or any of your file while I continue to question you about this particular case, Doctor.
A. Okay.
Q. Where did you examine the Plaintiff in this case?
A. It was in my office.
Q. Okay. Was that prior to her having any surgery?
A. Yes, yes.
Q. Okay. Doctor, did you begin your session with her on October 7, 1994 by taking a history?
A. I did.
Q. And referring to your records as well as your report marked as Exhibit A, what did the history you took reveal regarding this particular

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individual?
A. Ms. Liapis stated that she was involved in a moving vehicle accident which took place on May 9, 1993. She was the driver. She was restrained with both lap and shoulder seat belts. At the time of my examination – excuse me – she stated that she suffered injuries to her neck, shoulder and back. She denies having suffered any cuts, lacerations or bruises, and she did not strike any object on the inside of the automobile. She had no direct trauma. I said did you strike your face or jaw and she said, oh, no, I had a seat belt on. She drove home.
Later she presented herself to the emergency room at Fairview Hospital and her chief complaints at that time were those of pain and discomfort in the back, shoulder, neck and lower back. I asked her if she had any discomfort with her jaw joint when she went to the emergency room and she said no; and this is corroborated by the emergency room report which says there's no – she made no complaint of jaw or facial or pain, facial or jaw injury. She later on went to the office of her personal physician, Dr. Fitch, who recommended
physical therapy.

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Two and a half months later she made her first presentation to Dentist James Moodt, in regard to jaw complaints. She states she went there because, quote, my jaws were clicking when I opened wide. I pointed out to Ms. Liapis that indeed jaw clicking is not really very important. It is as much as 62 percent of us have it at any given time. She says that Dr. Moodt made a bite splint for her which she wore during sleep hours thereafter. She said it was made a little bit better, but she said by that time her complaint was not just clicking but numbness. The numbness was on the left face. I do not know the source of the numbness because numbness is not and never has
been a symptom of TMD. I don't know why she has the numbness, but...
Q. Doctor, before you get on to the second accident, let me ask you a question or two about what you have said so far.
The first page of your report refers to the first accident being in 1991, but you mentioned 1993; is there a typographical error in your report?
A. Yes. It's the other way around. I said it was in 1991, it was 1993. It's a typo that the

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secretarial service made, a typographical error.
1993; yes.
Q. That May 9th, 1993 accident, I'll refer to as the first accident on some of my subsequent questions.
On the second page there's a reference to two and a half months before she presented any complaints of TMD problems, in further reviewing the records is that two and a half months reference accurate?
A. She made some reference to jaw discomfort one and a half months later. She first presented for treatment to Dr. James Moodt two and a half months later.
Q. Well, Doctor, is there any significance as to whether it was six weeks or two and a half months after the accident before she first made any complaints about TMD problems?
MS. McCARTHY: Objection.
A. No. No; there's no significance, Mr. Merriam, but the important thing is that if she didn't report complaints within the first seventy-two hours then I do not believe it's accident-related. As I told you about the football players, when you hurt your elbow you

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know the moment you hurt it; when you hurt your knee you know the moment you hurt it. So whether you report it six weeks later or two and a half months later, ten weeks later, it doesn't make any difference; no.
Q. Okay. Doctor, getting back to your history I think you were at the point where you were going to go into the paragraph about the November 19th, 1993 accident involving my client.
A. This is an accident which Ms. Liapis reported to me which happened indeed on November
the 19, of '93. Once again she was completely restrained with the seat and with a seat belt shoulder harness. Again she denies having struck any object of the inside of the automobile and she did not suffer any cuts, lacerations or bruises. Dr. Moodt told her and Dr. Fitch told her that she had somehow aggravated the injury, and she believes that her jaw symptoms expanded to include pain upon the act of chewing and headaches which had expanded before that had now deteriorated; and she finished by saying in her history that as long as she's able to wear the bite splint that the jaw is stable, but she was planning on having arthroscopic surgery done on

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the both temporomandibular joints and it's my understanding that Dr. Michael Hauser did, indeed, do arthroscopic surgery after my examination.
Q. Doctor, did she report to you any direct trauma to her face as a result of either the first accident on May 9th, 1993 or the second accident on November 19th, 1993?
MS. McCARTHY: Objection.
A. She did not report any direct trauma and she specifically denied any direct trauma to any part of her face or neck - or, excuse me - face or head in either one of the accidents, Mr. Merriam.
Q. All right. Doctor, did she, in giving you the history about her condition prior to the first accident, mention anything about prior headaches?
A. I don't think she did, but it is in her history that she has had headaches in the past.
Q. Well, maybe I'm getting ahead to the records that you reviewed.
A. All right.
Q. So I'll save you those questions for a little bit later. I guess that leads me to the part of your report on page two that is about the records and charts that you reviewed as part of

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your examination, could you summarize for the jury what records and films and so forth you looked at?
A. I looked at all the charts of Dr. Fitch, her personal physician and the charts from St. John's West Shore Hospital dealing with an accident in which she was involved in September of 1986 and her charts, Dr. Moodt's charts, her prior dentist charts and -
Q. Did you also look at the emergency room?
A. And the emergency room report.
Q. Okay. Did you look at - did the information you looked at include information on MRI?
A. She has an MRI report which was taken in April of 1994.
Q. Okay. And also Dr. Moodt's commentary on the tomogrorne - excuse me - tomograms?
A. Yes. That's in Dr. Moodt's letters; yes.
Q. Doctor, now referring to your report as well as your recollection, what was significant about the records you reviewed pertaining to this individual?
A. Ms. Liapis was involved in a previous MVA which I mentioned took place in September of 1986, well before.

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Q. By MVA do you -
A. A motor vehicle accident; yes.
Q. Okay.
A. That was she suffered direct injury to her face in that accident. She struck her face against the inside of the automobile, and as a result of that she was left with a residual and persistent, dull ache in the right shoulder, shooting pain in the left cervical area, the neck area and chronic neck pain. She was being treated as late as July of '87 for that disorder. It also - at that time she complained of shoulder numbness, chronic neck pain and difficulty driving the automobile and that was back in '86.
Q. Okay. Did those records indicate anything about headaches or sinus problems? And I'm referring to Section B on top of page three of your report?
A. In her prior charts from St. John's West Shore Hospital she listed headaches going back to 1987. She had complained - she had been to a weight control clinic and she complained of persistent headaches at that time, and in fact headaches are listed as one of her physical problems on virtually every one of her charts

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throughout the spring of 1987. She listed the headaches at one time as being sinus-related, and she eventually had headaches so severe, this was back in '87, that they were awakening her at night. She described her headaches to a physician, Dr. Howard Levine, as being in the right face and cheek area.
Again, I think - I had first thought these belonged to the paranasal sinus - these were sinus headaches, but that didn't turn out to be the case. Dr. Levine's examination and x-rays of paranasal sinuses on 1-6-93 show that she had normal sinuses.
Q. Do those records indicate any complaint of facial pain or ear pain prior to either of the two accidents that I mentioned?
A. Yes, Mr. Merriam. Dr. Fitch noted on March 20th, '92, a year before the three accidents that the patient had pain in her face and on 12-8-92 she complained of, quote, her ears hurt and again in January of '93, she complained she had facial pain and ears hurting. She complained of facial pain after her two accidents, but she had complaint of facial pain many times before her accidents. She attributed the pain before her

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accidents to sinus problems, but there is good evidence that she didn't have sinus problems because Howard Levine examined her and she had didn't have sinusitis.

MS. McCARTHY: Objection.

A. So I think the pain in the ears is strongly suggestive of chronic temporomandibular joint disorder going back to the, until 1987 at least. I think she has this disorder well before any of the moving vehicle accidents.

Q. Doctor, do the records reflect that she had complained about clicking in her jaw prior to the accidents we're talking about?

A. I don't know that there's any mention of clicking prior to these.

Q. Well, on page three, Section C you were mentioning Dr. Fitch's reports or – excuse me – documents from 1993. I guess in June of 1993; do you see where I'm referring to in your report?

A. Yeah. Clicking was noted in June, but no other symptoms.

Q. So this would be prior to the accidents that we're talking about in this case?

A. No. This would be after the first of the three accidents so May of '93.

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Q. All right. But prior to the one involving my client?

A. Yes.

Q. Doctor, further on in your discussion of what you reviewed, you refer to an MRI examination in April of 1994. Before I asked you about that could you tell the jury what an MRI is so we know what you're referring to here.

A. MRI is again an acronym which stands for magnetic resonance imaging. It is a non-evasive peak at some area in your body. In this case the temporomandibular joint which produces an image, but when I say non-evasive it's not like cutting in there to look in there. And it's not like you're using x-rays which you don't like to use x-rays because they could be destructive to cells. An MRI is not destructive at all, but it's a look at some internal portion of the body. In this case the MRI was done on Ms. Liapis's temporomandibular joints and they showed normal temporomandibular joints on both sides. That was in April of 1994.

Q. So that was after the accident. You've also referred to tomograms taken by Dr. Moodt in July of 1993?

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A. Yes.

Q. What did the documentation pertaining to those and any letters or reports by Dr. Moodt indicate?

A. Dr. Moodt took tomograms of Ms. Liapis's temporomandibular joints in July of '93, and these are significant. This is important because he said in a letter to Dr. Murphy, he comments on his own tomograms. He says, quote, there is no question that these radiographs, that means these x-rays, do suggest the development of some arthritic change within the temporomandibular joints certainly would have predated her initial accident. See, could have predated the accident of May of 1993. Arthritic changes which Dr. Moodt has seen in his tomogram take years to develop, take years to develop, so I presume they have been that – arthritic change has been there for a long time. My own x-rays show arthritic changes as well in the left temporomandibular joint so again I have to presume that those arthritic changes predated all three of the accidents by years.

Q. Thank you, Doctor. Comparing tomograms to MRIs, which would say is a better way to evaluate a potential TMD problem?

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A. They're both pretty good. I think MRI is better, but both of them are pretty accurate. They're better than trying to just take a regular x-ray. Yeah, I think MRI is probably considered the gold standard, the best you could do.

Q. But tomogram is certainly accepted –

A. A tomogram is very good.

Q. – in your field of specialty as a proper way for evaluating and diagnosing TMD problems?

A. Yes.

Q. Okay. Doctor, the next section of your report refers to oral regional and radiographic examination, could you explain just in general terms for the jury the type of examination you give and specifically gave this individual kind of braking it down by those three areas and also explaining what the results were.

A. My examination ordinarily consists looking at the bite, looking at the occlusion, then asking the patient to open to see if the jaw deviates to the right or the left and then palpating the muscles of mastication, that is the chewing muscles to see whether those are tended. There's four of those muscles. Then you measure the

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opening with a little measuring stick, you know, how wide can you open. Normal is on females is maybe thirty to forty-five millimeters. Then you measure how far they could go to the left, to the right and out to the front and can they do that without pain, can they reach normal limits without pain, then you listen for clicks, then you palpate for popping with your fingers and then you palpate the areas around the external joint and you've made a pretty good physical examination.
Q. Doctor, you've mentioned previously that you tookx-rays. I believe they were Panorex x-rays at the time –
A. Yes.
Q – you examined this individual.
A. Yes. I have that Panorex here.
Q. Do those x-rays confirm what Dr. Moodt had indicated in his letter to Dr. Murphy that being the existence of osteoarthritic changes in both joints?
A. Absolutely. And Ms. Liapis has osteoarthritic changes particularly in the left and it's evident on my x-ray; yes.
Q. Okay
A. And they take long years for any arthritis

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to develop as you know.
Q. Doctor, if you could just summarize for the jury what your examination of this Plaintiff indicated.
A. When she opened she was able to reach thirty-eight millimeters which is within normal limits, but she did a lot of guarding, that is moving, so that she didn't want to open very much; and the muscles of mastication, she had some tenderness in the left muscles and I listened for clicks. I didn't hear any because she didn't open really wide enough to hear a click, but that isn't significant. Clicks aren't significant anyway unless they're associated with a lot of other cluster symptoms. She was having, summarily she was having some temporomandibular joint discomfort and pain on the left side when I examined her.
Q. Okay. Doctor, in your discussion section of your report you mention that some TMD patients cope well and some do not; did I accurately quote your report?
A. Yes. I think some patients tolerate minor discomfort and the little ups and downs of life better than others; yes.
Q. Doctor, based on the history you took from

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this individual, the review of the reports, your examination, how is this particular individual coping –
MS. McCARTHY: Objection.
Q. – with the symptoms that she's complained of?
MS. McCARTHY: Objection.
A. I think she visited doctors more frequently than other patients might have done. I think her numbers of treatments were considered to be more than others might have done. I think that even prior to her MVAs she saw Dr. Fitch for a number of things, numbness in the shoulders, numbness in the hand, numbness – pain in the ankle, pain in the shoulder, but things that are – she had a lot of somatic complaints over a period of years.
Q. What do you mean by somatic?
MS. McCARTHY: Objection.
A. Bodily complaints of...
Q. Doctor, you indicate in your report that you would put her in the category of a chronic pain patient, could you explain that to us.
A. She had a number of anatomic areas in which she complained frequently as some people do.
Q. Okay. Doctor, I'm going to ask you a

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series of questions all of which I'd like you to answer with a reasonable degree of medical certainty and based on your education, your training, your experience, the history you took from this individual as well as the records that you have reviewed.
First of all, I want to ask you to a reasonable degree of medical certainty based on all those things whether this individual had chronic temporomandibular disorder prior to either the May 9th, '93 accident or the November 19th, '93 accident involving my client?
MS. McCARTHY: Objection.
A. Mr. Merriam, I believe strongly that Ms. Liapis has had chronic temporomandibular joint disorder for many years prior to any of the three motor vehicle accidents. The three recent ones.
Q. Doctor, would you summarize for the jury the basis of that opinion.
MS. McCARTHY: Objection.
A. She had a number of symptoms prior to 1993 including episodes of facial pain, ear pain, pain behind the eyes and headaches all of which suggest a cluster of symptoms which would suggest temporomandibular joint and they're all in her

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charts going back to the late '80s and early '90s. Q. Do you also base your opinion on the fact that the radiographic evidence shows osteoarthritic changes? MS. McCARTHY: Objection, A. Both by Dr. Moodt and by my own x-rays shows she has osteoarthritic changes which take a long timing to develop which would suggest that she has temporomandibular joint disorder for many years prior to 1993. Perhaps beginning with her auto accident in 1986 or perhaps because of the various stresses of her life, but she's had it for a long time prior to the accident. MS. McCARTHY: Objection. Q. Based on that, your last comment there, I would assume the prior accident in 1986 where there was direct contact with the face is also part of the basis of your opinion? MS. McCARTHY: Objection, A. That is right, Mr. Merriam. You need to strike your face in order to produce temporomandibular joint disorder as a result of trauma. She has not in any of the three subsequent accidents, in the '93,'94 time, she did not strike her face any time.

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In 1986, in that accident, she did strike her face and thereafter she starts talking about jaw pain – excuse me – about facial pain, about ear pain and about headaches and then I imagine that's when she began to have the osteoarthritic changes in the joint, which are evident in both Dr. Moodt's x-rays and in my x-rays. Q. Thank you, Doctor. Again to a reasonable degree of medical certainty do you have an opinion as to the reasonableness of the treatment she had received up until the point you saw her? MS. McCARTHY: Objection, A. Yes. I think all of her treatment was reasonable. Dr. Moodt made a bite splint for her which is the ordinary treatment. Sometimes makes – most frequently makes patients improve. If that doesn't make patients improve then you have arthroscopic surgery which it is my understanding she had done by Dr. Hauser. Yeah; treatment is within normal limits; yes. Q. Doctor, do you have an opinion as to whether the treatment was proximately caused by either of the two motor vehicle accidents or the need for that treatment was proximately caused by

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either of the two motor vehicle accidents that we've mentioned? MS. McCARTHY: Objection. A. Yes; I have such an opinion, Mr. Merriam. The need for treatments arose from her longstanding temporomandibular joint disorder, her longstanding joint disorder as I've just explained. Not from any of the motor vehicle accidents. Q. All right. Doctor, do you have an opinion again to a reasonable degree of medical certainty and based on all the things that I previously listed as to her prognosis for the future? MS. McCARTHY: Objection. A. Understand that I have not seen her from 1994. It's hard for me to make a definitive prognosis, but based on from what I've been told I would think that after she's had jaw joint surgeries and treatment, I think her prognosis in my experience is pretty good. You have patients who get better, that do not continue to have temporomandibular joint all their lives, the joint disorder. They get better after such treatment. It's the reason for such treatment really. Q. Okay. And, finally, Doctor, do you have an

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opinion regarding any claim of permanent problems that she may be relating to the accident involving my client or the one before that? MS. McCARTHY: Objection. A. My own view and that is after proper bite splint therapy and arthroscopic and/or open surgery patients get better, but we do know that they do not have longstanding, permanent disability because the jaw remodels. Eventually, jaws remodel and as I've mentioned before you have patients – a lot of studies were done on patients in nursing homes, for example, who complain about everything, but not temporomandibular disorders; so where did it go? They had it, an awful lot of people had it when they are young, and it eventually does dissipates. And this had been brought out by a number of articles to see that eventually it is a self-limiting disorder. MR. MERRIAM: Thank you, Doctor. I don't have any further questions for you right now. MS. McCARTHY: Off the record. (A short break was taken)

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CROSS-EXAMINATION OF KENNETH R. CALLAHAN, D.D.S

BY MS. McCARTHY:

Q. Doctor, my name is Ellen McCarthy, and I along with Leon Plevin represent the Liapis's in this action. I have some questions for you. And I suppose, first of all, Doctor, is it your opinion that when you saw this woman at the request of one of the Defendants in October of 1994 she had dysfunction of the temporomandibular joint?

**A. It is; yes.**

Q. All right. No doubt in your mind about that when you saw her she was in dysfunction?

**A. Yes. That's true.**

Q. All right. Now, could you and I agree that dysfunction of the temporomandibular joints can be a very painful condition?

**A. Oh, yes.**

Q. Is it a functionally, limiting condition?

**A. Well, there's all different gradiencies to it, but full-blown temporomandibular joint disorder is functionally limiting, yes; and painful.**

Q. It can be a permanent injury, can it not,

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or permanent problem?

**A. Well, again, this is a kind of disputed point. Without treatment it may be a longstanding disorder.**

Q. Can it be a longstanding disorder even with treatment?

**A. Yes.**

Q. That was your opinion in October of 1994; is that right?

**A. What was?**

Q. All of those things? You had that opinion or those ideas in mind in October of 1994?

**A. Yes.**

Q. All right. As I understand it, Doctor, you base the opinion that Ms. Liapis had temporomandibular joint dysfunction on, I believe, three things. The first one being that in sometime in the late '80s she had a variety of symptoms that you associate with temporomandibular joint dysfunction; is that correct?

**A. Yes.**

Q. All right. Now, you also base that opinion on the fact that she shows osteoarthritic changes in her x-rays; is that correct?

**A. Yes.**

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Q. All right. Now, in terms of the first part of your opinion that she had symptoms in 1986, '88 or thereabouts associated with temporomandibular joint dysfunction.

**A. Yes.**

Q. Where did you get that information and when did you get it?

**A. Well, I got the information from her charts and I received that sometime either prior to or after my independent medical examination. I never look at charts until I do the examination.**

Q. Did you receive the medical records associated with her 1986 automobile accident two days ago?

**A. I have prior records from St. John's West Shore in this chart. I received the full set two days ago, but I had – it turned out I read prior to that.**

Q. Doctor, you would agree that facial pain, pain behind the eyes and headaches are complaints consistent with a sinus problem or sinus infection; would you not?

**A. Yes.**

Q. All right. Now, your function in this case was just to see this woman one time, review some

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records, arrive at some conclusions and if necessary testify about those conclusions; is that correct?

**A. That is correct.**

Q. All right. And in doing that task it's important for you to thoroughly review the records that you were provided; correct?

**A. That is correct.**

Q. It's important to be accurate with respect to the facts that you were not only familiar with the patient, but from your review of all the medical records you were provided; correct?

**A. Yes. That is correct.**

Q. And it's important to be fair in terms of your opinions; correct?

**A. Oh, sure.**

Q. Now, you didn't have any intention *of* providing this woman with dental care; did you?

**A. No.**

Q. How many times a year do you see people like Ms. Liapis for this one-time evaluation and records review?

**A. As you know I see patients both – on both sides, Plaintiffs as well as Defense patients. Perhaps twenty per year.**

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Q. Maybe I didn't phrase my question correctly. On how many occasions do you do these independent medical examinations per year?
A. Well, I think whatever - I don't keep close track of that, Ms. McCarthy, but I think on the Discovery deposition I said around twenty or twenty four; something like that.
MS. McCARTHY: Let's go off the record for a minute.
(A short break was taken)
BY MS. McCARTHY:
Q. Okay. Doctor, I think in the time I took your Discovery deposition on Monday, you told me you do about three a month which by my math is thirty six a year; would you quibble with that?
A. Probably a little high, but again I don't keep accurate records on that.
Q. What do you charge, Doctor, for the examination of the patient as distinct from sitting down and analyzing the medical records and actually writing a report?
A. The charge for the examination is pretty much standard assigned by which considered usually customary and reasonable in Northeast Ohio and

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that is someplace around $50 for the examination and someplace around $50 for the Panorex x-ray.
Q. And how much do you charge, Doctor, for the review of the records and generating a report setting forth your opinions?
A. It depends. If it's a very short chart, I charge I suppose by the hour, it's a very short letter of one page or two pages, I suppose then it would take you a half hour or forty-five minutes, an hour maybe, that would be maybe $200. A longer report would be maybe more like $400.
Q. $400 for the report or $400 an hour?
A. No, no. $400 for the report plus the typing costs, plus the exam costs.
Q. So you wrote a seven-page report on Ms. Liapis in your review of what you call voluminous records, what did that cost?
A. I'm sorry. I don't have that record, Ms. McCarthy.
Q. Well, based on -
A. That was back in 1994. I don't keep records.
Q. Well, based on your experience, Doctor, what would you except for that type of work to have cost?

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A. It's a long report, it took me two nights. I suppose $400 or $500 total.
Q. And your charge for testifying by the hour is what, Doctor?
A. $225.
Q. You don't treat disorders of the temporomandibular joint beyond medication and diet advice; is that right?
A. That is true. If they need bite splints I send them to a colleague in the building here. If they need surgery then I send them down to the University Hospitals to Dr. Goldberg.
Q. You have not operated as an attending surgeon on the temporomandibular joint since the 1960s; is that correct?
A. As the first operator, that is correct; no, I haven't.
Q. If you have a patient with a temporomandibular joint problem who needs treatment, you send that patient out to specialists so that patient gets the very best care for their temporomandibular joint; is that right?
A. Yes. I explained that I don't want to stand at a table that long anymore.

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Q. Sure. In the past, Doctor, you have referred patients of your own to Dr. Michael Hauser at Mt. Sinai Medical Center; haven't you?
A. Yes.
Q. And you were aware that Ms. Liapis was a patient of Dr. Hauser's; right?
A. Yes.
Q. Now, Dr. Hauser not only has a dental degree but has a medical degree as well; is that correct?
A. That is correct.
Q. All right. You would acknowledge that he is a highly skilled and highly regarded temporomandibular joint surgeon in this community; wouldn't you?
A. Yes.
Q. All right. And because he is so highly regarded and so highly skilled you send patients of your own to him for evaluation and treatment if necessary; correct?
A. I just said that; yes.
Q. Now, you don't consider yourself an expert in the surgical management of temporomandibular joints at this point; do you?
A. No.

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Q. Would you defer to Dr. Hauser as to whether Ms. Liapis developed temporomandibular joint disorder as the result of the May 1993 accident?
MR. DOWNS: Objection.
MR. MERRIAM: Objection.
**A. No. I wouldn't because we're talking about causation. You're talking about surgical technique.**
BY MS. McCARTHY:
Q. All right. Well, you understand Dr. Hauser's opinion to be that the accidents that issue in this case caused the problems he diagnosed and treated her for; right?
MR. DOWNS: Objection.
MR. MERRIAM: Objection.
**A. That may be his opinion. That is not my opinion.**
BY MS. McCARTHY:
Q. When I was here on Monday, Doctor, you gave me a number of items that caused temporomandibular joint dysfunction and I'd like to run through those with you so that I'm correct.
You talked about bruxing or grinding as being a cause?
**A. Yes.**

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Q. Clenching?
**A. Yes.**
Q. Gum chewing?
**A. Yes.**
Q. Chin-to-shoulder telephone use?
**A. These are - you asked for all the list of all of, yes, the causes.**
Q. Okay. I'd like to go through them.
**A. All right.**
Q. Singing?
**A. Singing, vocals.**
Q. Violin playing?
**A. Uh-huh.**
Q. Is that a "yes"?
**A. That's a yes.**
Q. Sudden uncontrolled sneezing or yawning?
**A. Yes.**
Q. Opening too wide to eat a sub sandwich?
**A. Yes.**
Q. And direct injury to the jaw; is that right?
**A. And stress.**
Q. Well, actually I think you didn't really say stress was causative. You said stress leads to bruxing and clicking?

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**A. Stress itself is causative.**
Q. Is that something different than causative *of* bruxing and clenching?
**A. Yes.**
Q. All right. Explain how that is different.
**A. I think stress causes muscle tension and the muscle tension then produces temporomandibular joint disorder.**
Q. Well, the muscle tension would lead to what anatomic function that would produce disorders?
**A. Well, that might be to bruxing or clenching.**
Q. All right. You also talked about a cluster of symptoms associated with temporomandibular joint dysfunction –
**A. Uh-huh.**
Q. – as being pain on opening; correct?
**A. Yes.**
Q. Ear pain?
**A. Yes.**
Q. Headaches?
**A. Yes.**
Q. Pain while chewing?
**A. Uh-huh.**
Q. Facial pain?

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**A. Facial pain; yes.**
Q. Ringing in the ears?
**A. Tinnitus, ringing in the ears; yes.**
Q. And in the presence of one or several of those symptoms, clicking or popping would be indicative of the temporomandibular joint dysfunction; is that correct?
**A. In association with other symptoms; yes.**
Q. In one of the symptoms I just read off?
**A. Yes.**
Q. All right. Now, at the time you wrote your report on November 7th, 1994 you had Dr. Fitch's records, Dr. Beater's records and Dr. Moodt's records; is that right?
**A. Yes.**
MR. DOWNS: Objection.
BY MS. McCARTHY:
Q. After you examined Ms. Liapis and reviewed the records you wrote a seven-page report setting forth your summary of all those things and your opinions; is that right?
**A. Yes.**
Q. And you said in that report you believed her temporomandibular joint dysfunction is related to a longstanding bout with temporomandibular

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joint disorder; is that right?
A. Yes.
Q. Could you please show me in your file what
records you have or had at the time you wrote this
report that documented this woman ever made
complaints of pain while opening her mouth, pain
chewing foods, pain yawning, pain while laughing
or pain opening real wide?
A. That is not documented in the records nor
did I say it was. She had -
Q. All right. Thank you.
A. - the other symptoms, pain in the ears and
headaches and ringing in the ears, however.
MS. McCARTHY: Move to strike
the last comment as non-responsive to the
question.
BY MS. McCARTHY:
Q. Now, could you show me in your records,
Doctor, where it's indicated that this woman
struck her face in the 1986 accident?
A. We may as well go off the record because
I'm going to have to find it.
(A short break was taken.)
BY MS. McCARTHY:
Q. Could you tell me what you're looking at

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specifically, Doctor?
A. I'm looking at a narrative letter written
by George Randt, R-A-N-D-T, M.D., internal
medicine. He writes June 13th, 1988, forty-two
year old involved in auto accident 8-31-86 when
another car struck the front of the passenger's
side of the car which she was riding. Ms. Liapis
stated that she struck the right side of her head,
the right side of her thorax and abdomen and
twisted her head. She suffered tinnitus of the
left ear.
Q. I'm asking for an record that indicates she
struck her face, Doctor.
A. Well, I think when you strike your head and
your thorax face is right in between those and it
sticks out further. I think when you strike your
head and your thorax, you can't help but strike
your face. Unless she has a caved-in face which
she doesn't.
Q. Can you and I agree that there isn't any
record that indicates Ms. Liapis struck her face
in the 1986 automobile accident?
MR. MERRIAM: Objection.
A. I've just explained to you, Ms. McCarthy,
that if you strike your head that includes your

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face. Isn't face part of the head?
Q. Doctor, I would imagine that people in this
profession would be more specific. If that were
the case, if she struck her face, Dr. Randt would
have put that in there.
MR. MERRIAM: Objection.
Q. Now, it could have been the back of her
head for all we know; is that right?
A. No; it isn't. It says the right side of
her head. It doesn't say the back of her head.
The right side of her head.
Q. It could be the right, top side of her
head; right? It has nothing to do with her face;
right?
MR. MERRIAM: Objection.
A. And thorax. If you get the thorax and the
head, then you'd have to get the face. I think
that's reasonable.
Q. That is your interruption of her head?
A. That's correct.
BY MS. McCARTHY:
Q. All right. Incidentally, at that time did
Ms. Liapis make any complaints at all about jaw
pain?
A. 11-6-86, it states on the record maxillary,

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that means the upper jaw, maxil is the upper jaw,
maxillary facial pain. History, several days of
facial pain. Maxillary is the upper jaw.
Q. Why don't we just read the notice that
exists, Doctor. Would you do that for us?
11-6-86, read the entire first, underlined
sentence. Out of abundance of fairness.
A. Maxillary facial pain with nasal
congestion.
Q. Then the next sentence reads history,
several days of -
A. Several days of facial pain with nasal
congestion and some postnasal drip. No period
with drainage fever or chills findings.
Q. All right. Now, in summary, the doctor
diagnoses or puts down, maxillary facial pain and
congestion, will treat with decongestant and he
prescribes Drixoral and a nasal spray; is that
correct?
A. Yes.
Q. And the next note after that dated 12-19-86
says absolutely nothing about her congestion or
her nasal problem; is that right?
A. Yes; that's right.
Q. Now, in terms of the November '86 note,

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when was that note generated in relation to the automobile accident?
A. That was prior to the auto accident of '86.
Q. I thought the automobile accident that you just talked about when quoted Dr. Randt's report was 8-31-86?
A. All right. So that was after the auto accident. Both were after the auto accident.
Q. So it's at least three months after the automobile accident, or about three months after the automobile accident; is that right?
A. Yes.
Q. So if we accept what you said on direct that if a patient injures their temporomandibular joint in an automobile accident they will have symptoms immediately; right?
A. Yes.
Q. All right. So can we -
A. They should have symptoms, but they don't necessarily report the symptoms and she didn't.
Q. All right. So can we eliminated the 1986 accident as being causative of any injury to her jaw?
MR. MERRIAM: Objection.
A. I think it's speculative what is causative

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in 1986. She had it for a long time.
Q. Since it's speculative can we eliminate the 1986 accident as causative of temporomandibular joint dysfunction?
MR. MERRIAM: Objection.
A. No. We can not, Ms. McCarthy, because she struck her face at that time.
Q. But you told us earlier, Doctor, that a person has to have immediate complaints of jaw pain if there's a jaw injury.
A. That is correct.
Q. This woman has no documented complaints of jaw pain at that time; is that right?
A. It's not documented, but she should have had some symptoms at the time.
Q. Why should she have had some symptoms at that time?
A. Because she struck her face.
Q. No, no. She struck the right side of her head. Let's stick with Dr. Randt's description of it.
MR. MERRIAM: Objection,
A. The auto accident was 8-31-86. On 9-2-86 she sees Dr. Randt and she was complaining of tinnitus in the ear and that would be a symptom

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then that she was starting to get some TMJ symptoms.
Q. But you told me you need to have more than one symptom in that constellation of symptoms in order to have temporomandibular joint dysfunction; didn't you tell me that earlier?
A. I did, but she reported only one.
Q. Right. So she couldn't possibly have had temporomandibular joint dysfunction at that time?
A. That's not true.
MR. MERRIAM: Objection.
Move to strike.
A. She only reported one.
Q. Are you saying she had symptoms and didn't report them?
A. Yes.
Q. Okay. What symptoms did she have that she failed to report, Doctor?
A. Well, I don't know. I know that she had one at least, ringing in the ear.
Q. All right. But that's insufficient to arrive at a diagnosis of TMJ; is that true?
A. It is certainly suggestive of...
Q. Is it sufficient in and of itself to arrive at a diagnosis of temporomandibular joint

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dysfunction? "Yes" or "no"?
A. No.
Q. All right. Thank you.
Now, you said on direct examination that this woman, and I can't recall your phrase for it, but as I understand it the gist of it was that she is in and out of the doctors' office with a myriad of complaints, Doctor, from head to toe; right?
MR. MERRIAM: Objection.
Q. Would that be a fair characterization of what you said?
A. I don't think from head to toe. She had a number of somatic, bodily complaints.
Q. Okay. And prior to May 9th, 1993 she never made any complaints of jaw pain; true?
A. She had signs of TMJ pain. She did not make a complaint of jaw pain except the note of maxillary pain.
Q. Well, that could be associated with sinus; right?
A. Except we found out from Dr. Levine's examination that she didn't have sinus.
Q. We didn't find anything out from Dr. Levine.
MR. MERRIAM: Objection.

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Move to strike.
BY MS. McCARTHY:
Q. We can assume, can we not, that she did not complain - because she did not explain on the next visit of any more sinus trouble or nasal drip, that the medication she was given was sufficient to take care of that problem; can't we?
MR. MERRIAM: Objection.
A. No. We can't. Temporomandibular joint also is a disease of exacerbation and remission, it comes and goes, it has bad days and good days.
Q. So for seven years between the 1986 accident and the May '93 accident was her TMJ problem in a dormant condition?
A. I don't think it was dormant. I think every once in awhile she would have some symptoms.
It was not discovered.
Q. Did Dr. Randt misdiagnose her?
A. No. I think an awful lot of people, I think TMD is hard to diagnose because it mimics so many other disorders and this has been published again very frequently that sometimes it's overlooked, unless you're specifically looking for it; because it mimics so many others.
Q. So Dr. Randt missed it?

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A. He reports that she had soft tissue injury, strains and sprains to the neck, shoulders, chest wall resulting from a motor vehicle accident. It doesn't, no. He didn't diagnose temporomandibular joint disorder, but it would be probably hard to find at that time, too.
Q. So he missed it?
A. All right.
Q. All right. And in the seven years that transpired between that accident and the first accident at issue here, Dr. Beater, her treating dentist missed it; is that right?
A. He did not specifically ever exam her for it.
Q. How do you know that?
A. Because he would have written it down. Did a TMJ exam.
Q. Did she ever make any complaints to him of jaw pain?
A. No.
Q. Pain on opening?
A. No.
Q. Popping, clicking?
A. No.
Q. All right. Did she ever make any

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complaints to Dr. Fitch during the period of time Dr. Fitch treated her before the May '93 accident of pain in the jaw, popping, clicking, pain on opening, pain while chewing, pain while yawning and pain while laughing?
A. No.
Q. All right. Did Dr. Fitch miss the diagnosis, as well?
A. Dr. Fitch notices some other symptoms. She does not diagnose this as temporomandibular joint, but again that's hard to diagnose.
Q. Sure. Now, did Ms. Liapis sustain any injury in these accidents?
MR. DOWNS: Objection.
A. I am not an expert in the areas of shoulders and neck injuries so I don't know. It is reported that she complained of shoulder, back and ankle injuries.
Q. She also complained of a neck injury?
A. That's what she said when she went to the emergency room, I believe.
Q. Okay. Can a person have --- strike that. Can cervical whiplash cause temporomandibular joint dysfunction specifically internal derangement?

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A. No. That's what we've discussed talking about Dr. Howard.
Q. Who?
A. Dr. Howard who published the article in 1995, an excellent article saying that cervical whiplash, the flexion/extension injury does not cause internal derangement. That's in my letter when I mentioned Dr. Puliger (phonetic) said, no, it does not cause displacement or derangements; and that's what Dr. Laskin found out in his one-hundred and fifty three examples of patients who had cervical extension/flexion, that is whiplash. He did not notice any significant temporomandibular joint disorder.
MS. McCARTHY: Move to strike as non-responsive to the question.
BY MS. McCARTHY:
Q. Doctor, have you ever questioned to the contrary, that cervical whiplash trauma can and will cause temporomandibular joint dysfunction specifically internal derangement?
A. (No response)
Q. Maybe I can help you out.
A. Please help me out because I don't recall that.

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Q. Wendy Perin, P-E-R-I-N, versus Bella Leybovich, L-E-Y-B-0-V-I-C-H, case number 153064, pending in Cuyahoga County before Judge James J. Carol, cross-examination of Dr. Kenneth Callahan, you were being represented by David Borland and Thomas O. Callahan was cross-examining you and he asked you the following question: As a – strike that.

"Question: And fact is cervical whiplash trauma can and will cause temporomandibular joint dysfunction specifically internal derangement?" Your answer was yes.

MR. MERRIAM: Objection. Move to strike.

Q. Do you dispute that?

A. Pardon?

Q. Do you dispute that that was your testimony?

A. I don't – will you give us the date of that testimony, please?

Q. I don't have the date of it, Doctor, but I can certainly get it to you?

A. I believe you could find that date. It's someplace on there, and I'll bet you it was in **1985;** in the middle **'80s.**

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Q. Okay. So now you recall this testimony?

A. And everyone – since so much new material has come out in the **'90s** about specifically whiplash injuries vis-a-vis temporomandibular joint disorder, of course, I've changed my opinion on that. People who don't change their opinions, they're foolish people.

Q. Can a person have arthritis and never be troubled by it, Doctor?

A. I think you could have low-grade arthritis that's starting to show up and not have symptoms.

Q. All right. In terms of MRI that was done in April, I believe it was April 19, 1994 and you have a copy of that report in your records there. It was ordered by Dr. Moodt.

A. Yes.

Q. And that MRI showed no significant arthritic changes; is that true? I believe it might be one of the pages I turned.

A. Menisci, that MRI shows menisci. That is the discs normal position on the right and left side. There's normal range of motion. There's no evidence of subluxation, condyle appears normal and no significant arthritic changes, that's true.

Q. And that was after this accident?

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A. Yes.

Q. Or after the first two accidents; is that right?

A. That's right. But Dr. Moodt's found it in **1993.**

MS. McCARTHY: Objection. As non-responsive to the question. Move to strike.

BY MS. McCARTHY:

Q. Now, in your report, at least as I could count, five times you indicate that Ms. Liapis never made any complaints consistent with TMD for two half months following the first accident and that is incorrect; isn't that right?

A. Just a minute. Sorry, just a minute.

Q. I could give you the page and reference if that will help.

A. I say in my report at one time it was not until two and a half months later that she first sought treatment, and that is, of course, correct. Two and a half months later, first sought treatment.

Q. Page three, paragraph C?

A. But she first complained of treatment on a month – six weeks after the MVA.

Q. But you didn't put that in your report; did

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you?

A. No. But remember it is, as we've said, a very voluminous set of charts.

Q. Well, certainly that's an important point, Doctor, isn't it? When she was first making any complaints that you would associate with the diagnosis of TMD?

A. I think I already answered that. I said that the difference between six weeks and two and a half months is insignificant. If you don't make it within the first three or four days then I find that significant. Six weeks or eight weeks doesn't make much difference.

Q. So then we go back to the 1986 accidents where there are no complaints associated with TMD within the first two or three or four days; right?

A. There was a complaint the third day in the **1986** accident according to Dr. Randt that she had tinnitus, ringing in her ears.

Q. But told me that in the absence of any other complaint that you gave me –

A. That amounts to at least a temporomandibular joint symptoms.

Q. But that's not that what you told me earlier.

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MR. MERRIAM: Objection.
A. I said she didn't report any others.
It didn't mean there weren't any others.
Q. Right, okay. She didn't report them.
A. All right.
Q. You also told me earlier on it was
important to be accurate in terms of defense;
right? So you were inaccurate here; right?
MR. MERRIAM: Objection.
A. In that - I've listed a number of times
where I was. I said that she didn't seek
treatment for two and a half months and that one
instance it said she didn't have symptoms for two
and a half months, that is inaccurate.
Q. Okay. Well, let's then go through it.
Four lines down, paragraph C, page three, first
sentence on line four: Clicking was noted in June
but with no other symptoms, that's wrong; isn't
it?
A. That's wrong, but -
Q. All right.
A. Yes, for a reason. It's very hard to read
Dr. Fitch's chart. I finally found it the other
night going back through it, again I can't read
that. It doesn't look like TMJ to me, but it is,

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apparently, if you look down at it very closely.
Q. Well, I guess a jury will be able to
determine whether it's legible or not. I
certainly had no trouble reading it.
MR. MERRIAM. Objection.
Move to strike.
BY MS. McCARTHY:
Q. She does write in the June 16, 1993 note
where she writes jaw popping, left side face pain;
isn't that correct?
A. Yes. In June 16th, low back pain, jaw
pops, still pain in neck and shoulder.
Q. Has had seven therapy sessions, nasal
congestion -
A. Yes.
Q. Postnasal drip.
A. Postnasal drip.
Q. Dizziness.
A. Dizziness.
Q. Left side of face pain -
A. Left side of face pain, congestion.
Q. All right. Your sentence later on in
paragraph C, which is seven lines down: And she
was not having any TMJ symptoms. She was having
TMJ symptoms on June 16,1993; wasn't she?

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A. Are you referring to face pain? It would
have been the congestion, too.
Q. I'm referring to popping and face pain.
Well, you've dismissed the face pain earlier as
being sinus-related.
MR. MERRIAM: Objection.
Move to strike.
Q. She was having symptoms on June 16,1993 of
temporomandibular joint dysfunction; right?
A. That's right. That is six weeks after the
MVA for the first time.
Q. Then on page six, top paragraph, third
sentence down you say she had no symptoms during
those two and one half months; again, that's
incorrect?
A. Yes.
Q. All right.
A. I said she didn't seek treatment for two
and a half months.
Q. I'm sorry, maybe I misread it. I'rn
reading, she had no symptoms during those two and
one half months.
A. That's what it says in that sentence;
that's right.
Q. All right And in your last paragraph,

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page seven entitled summary, last full sentence:
Finally the time hiatus between her first MVA and
her first seeking treatment two and a half months
during which time she had no TMJ symptoms makes a
causal relationship somewhat unlikely, did I read
that correctly?
A. Yes.
Q. All right.
A. First seeking treatment two and a half
months.
Q. And the absence of complaints; right?
A. Yes.
Q. All right. Now, you haven't read any of
the records generated on Ms. Liapis since you saw
her in October of 1994; is that right?
A. I think I just have Dr. Hauser's report.
Q. All right. So you don't really know
anything about her subsequent surgical care and
how she progressed or failed to progress after you
saw her in October of '94; is that correct?
A. That's correct.
Q. Are you at all curious about how she
progressed7
A. Well, of course, I'm curious about all
patients at all times. It's what our business is.

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Q. And did you request the records that were generated on her from the time you last saw her up to the present time?
MR. DOWNS: Objection.
**A. No.**
MS. McCARTHY: I don't have any questions for you. Thank you.
- - -
DIRECT EXAMINATION OF

KENNETH R. CALLAHAN, D.D.S.

BY MR. DOWNS:
Q. Doctor, my name is Tom Downs and I represent Adele Caravella. She was one involved –
MR. DOWNS: Let's go off the record for a minute.
(A short break was taken)
MS. McCARTHY: I'm just going to interpose that any objection to anybody else cross-examining or doing any kind of rehabilitation with this doctor beyond Steve Merriam; any questions that you and Chris might have so... I didn't want to put that on the videotape, but with that go ahead.
MR. DOWNS: Thank you. I

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have the right to cross-examine a Witness that's expressed opinions regarding an accident my client's in.
BY MR. DOWNS:
Q. Doctor, my name is Tom Downs and I represent Adele Caravella. She's a Defendant in this lawsuit. She was involved in the May 9, 1993 accident.
If a patient has skull x-rays following an accident does that imply that you're having pain or a problem in that area in an emergency room?
MS. McCARTHY: Objection.
**A. Yes. Yes; certainly it does.**
Q. And the skull includes the part of the head and face that includes the temporomandibular joints; correct?
**A. It showed the whole thing; yes.**
Q. So would it be fair for me to understand if Marie Liapis in August of 1986 following her motor vehicle accident is in the emergency room at Southwest General Hospital and has x-ray to her skull that that would imply she's having pain in that area?
**A. It would to me; yes.**
Q. Okay. And then three days later she's

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complaining of tinnitus in one of her ears. The pain one day and tinnitus a couple days later, those are both indicia of the TMJ dysfunction that you've been describing here today; correct?
**A. Yes.**
MR. DOWNS: Thank you, Doctor. I don't have any more questions.
MR. RUSS: I don't have any questions.
- - -
FURTHER EXAMINATION OF

KENNETH R. CALLAHAN, D.D.S.

BY MR. MERRIAM:
Q. Doctor, very briefly. You were asked about Dr. Randt and Dr. Fitch and what they diagnosed or didn't diagnose.
**A. Yes.**
Q. Let me refer back to Dr. Randt's June 1988 report, if you could take a look at that document.
**A. Maybe you better show it to me.**
Q. Okay. Let me just pull it up so you could just kind of read it at a distance. Could you read to the jury the specialty or nature of Dr. Randt's practice as indicated by his letterhead in 1986?

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**A. He does internal medicine, preventive medicine, sports medicine, fitness testing, injury rehabilitation; that was Dr. Randt M.D.'s letterhead listing his specialties.**
Q. So obviously he does not list as his practice or specialties any of the types of things that you do on a regular basis; isn't that correct?
**A. No.**
Q. So would you agree it's not surprising that he did not properly diagnose a TMD situation based on the focus of his ordinary practice?
MS. McCARTHY: objection.
**A. I would agree to that.**
Q. And in the same way Dr. Fitch, I believe, is a general practitioner, a family doctor?
**A. Yes.**
Q. And she would also would not necessarily be someone expected to have any expertise or special background such as you have in TMD problems; is that correct?
MS. McCARTHY: Objection.
**A. That is also correct.**
MR. MERRIAM: Doctor, I don't have any further questions for you at this

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(1) time. Thank you very much.
(2) THE WITNESS: Okay.
(3) - - -
(4) RECROSS-EXAMINATION OF

(5) KENNETH R. CALLAHAN, D.D.S.

(6) BY MS. McCARTHY:
(7) Q. Doctor, are you aware that Dr. Fitch was
(8) one of the people that referred Ms. Liapis to
(9) Dr. Moodt?
(10) **A. I'm not aware of that nor is it**
(11) **significant.**
(12) Q. Well, you've commented on her not being
(13) able to recognize or diagnose TMJ, but after she
(14) learned that Ms. Liapis was making complaints of
(15) popping in her jaw and left-sided face pain she
(16) sent her off to a specialist in the treatment of
(17) temporomandibular joint disorder, that being
(18) Dr. Moodt; is that right?
(19) MR. MERRIAM: Objection.
(20) **A. Yes.**
(21) Q. So apparently –
(22) **A. Six weeks.**
(23) Q. – she had some recognition of the problem;
(24) right?
(25) **A. The patient started to complain at that**

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(1) **time.**
(2) Q. And she understood what the complaints
(3) were; right?
(4) **A. Well, yes.**
(5) Q. And she put them her into the hands of
(6) somebody that does nothing other than treats
(7) temporomandibular joint situations on a
(8) conservative basis; is that right?
(9) **A. That's right.**
(10) MS. McCARTHY: I don't have
(11) any more questions for you. Thanks.
(12) MR. MERRIAM: Thank you,
(13) Doctor. We don't have any further questions for
(14) you today.
(15) Doctor, do you waive your right of
(16) signature? And will everybody waive, well, we
(17) waived the filing requirement of the transcript
(18) and of the tape, itself; correct?
(19) MS. McCARTHY: Right.
(20) THEWITNESS: Yes. I'll
(21) waive.
(22) - - -
(23)
(24)
(25)

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(1) CERTIFICATE
(2)
(3) The State of Ohio, )
(4) ) SS:
(5) County of Cuyahoga. )
(6)
(7) I, Denise M. Andreotti, a Notary Public
(8) within and for the State of Ohio, duly
(9) commissioned and qualified, do hereby certify that
(10) the within-named witness, KENNETH R. CALLAHAN,
(11) D.D.S., was by me first duly sworn to testify the
(12) truth, the whole truth, and nothing but the truth
(13) in the cause aforesaid; that the testimony then
(14) given by the above-referenced witness was by me
(15) reduced to stenotype in the presence of said
(16) witness, afterward transcribed, and that the
(17) foregoing is a true and correct transcription of
(18) the testimony so given by the above-referenced
(19) witness.
(20) I do further certify that this deposition
(21) was taken at the time and place in the foregoing
(22) caption specified and was completed without
(23) adjournment.
(24) I do further certify that I am not a
(25) relative, counsel, or attorney of either party, or

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(1) otherwise interested in the event of this action.
(2) IN WITNESS WHEREOF, I have hereunto set my
(3) hand and affixed my seal of office at Cleveland,
(4) Ohio, on this 23rd day of January, A.D., 1998.
(5)
(6)
(7)
(8) Denise Andreotti, Notary Public in and
(9) for the State of Ohio.
(10) My commission expires August 18, 2001.
(11) - - - - -
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**Look-See Concordance Report**

- - -

UNIQUE WORDS: **1,382**
TOTAL OCCURRENCES: **4,661**
NOISE WORDS: **385**
TOTAL WORDS IN FILE: **12,383**

- - -

SINGLE FILE CONCORDANCE

- - -

CASE SENSITIVE

- - -

NOISE WORD LIST(S): **NOISE.NOI**

- - -

INCLUDES ALL TEXT OCCURRENCES

- - -

DATES OFF

- - -

IGNORES PURE NUMBERS

- - -

POSSESSIVE FORMS **OFF**

- - -

MAXIMUM TRACKED OCCURRENCE THRESHOLD: **50**

- - -

NUMBER OF WORDS SURPASSING OCCURRENCE THRESHOLD: 7

- - -

LIST OF THRESHOLD WORDS:

- - -

**accident** [57]
**Doctor** [75]
**Dr** [69]
**joint** [69]
**pain** [79]
**right** [101]
**temporomandibular** [64]

## – $ –

**$200** III
*44:10*
**$225** [1]
*45:5*
**$400** [5]
*44:11, 12, 13; 45:2*
**$50** [2]
*44:1, 2*
**$500** [1]
*45:2*

## – 1 –

**1-6-93** [1]
*26:12*
**11-6-86** [2]
*53:25; 54:6*
**12-19-86** [1]
*54:21*
**12-8-92** [1]
*26:19*
**13th** [1]
*52:4*
**16th** [1]
*68:11*
**1960s** [1]
*45:15*
**19th** [3]
*22:8; 23:7; 34:11*

## – 2 –

**20th** [1]
*26:18*
**23rd** [1]
*78:4*
**25th** [1]
*7:23*

## – 4 –

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*1:22*

## – 6 –

**6:00** [1]
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## – 7 –

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**8-31-86** [3]
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*31:21*
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*8:21, 23; 9:3, 5*
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*2:16*
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**associations** [1]
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*45:13*
**attorney** [2]

## – D –

## - E -



## – F –

## – G –



## – H –



## – I –

## – N –



## – O –

## - P -



## - Q -



## - R -

## – S –

## – X –



## – Y –

Drs. Bell and Callahan
ORAL AND MAXILLOFACIAL SURGERY

Dr. Ronald H. Bell
Dr. Kenneth R. Callahan

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Cleveland, Ohio 44137-3099
(216) 475-2122

DOC 101

February 3, 1995

Rerninger & Reminger Co., L.P.A.
Attorneys at Law
The 113 St. Clair Building
Cleveland, Oho 44114

Attention: John R. Scott

Re: Meredith Bragg v. Family Dental Centers, et at.
Your File No. 4200-12-26437-94

Dear Mr. Scott:

Please be advised that I have had adequate opportunity for review and perusal of a number of charts and records which pertain to medical and dental treatments received by patient Meredith Bragg beginning on July 3, 1993. Specifically, I have reviewed these charts in regard to claims made by patient Meredith Bragg that dentist Igor Skalsky, D.D.S., performed treatments on her which were below the acceptable standard of care for the national community. The records which I reviewed include, but are not limited to, the following: dental records of Dr. Skalsky including one panorex x-ray, certain medical records of the Cuyahoga Falls General Hospital, miscellaneous records of Suncoast Medical Family Practice, deposition af the plaintiff, and deposition of Dr. Skalsky. Please be further advised of the following information which I believe to be germane to these claim allegations.

I. Brief synopsis of the salient facts in this case.

Ms. Bragg is a 25-year old female who presented to Dr. Skalsky at the Family Dental Centers on July 3, 1993. She presented with an impacted lower right wisdom tooth (No. 32) which had a pericoronal infection. Such infections do not go away. They require dental extraction. She also had two maxillary (upper) wisdom teeth, Nos. 1 and 15, which were malposed, out of occlusion, and non-functional. Dr. Skalsky proposed removing the three wisdom teeth, a decision which I believe is prudent, and he placed the patient on amoxicillin 500 milligrams, four times a day, he gave her enough amoxicillin tablets to last her seven days, which would have been through July 10th. This is, in my opinion, excellent prophylactic antibiotic coverage.

On July 6, the patient presented again to Dr. Skalsky's office where he removed the three wisdom teeth, Nos. 1, 76, and 32, epparently uneventfully. On July 8th, accarding to Dr. Skalsky's records, the patient reappeared in his office, complaining of inability to swallow. She had some slight cheek swelling, and

trismus (inability to open). Actually, according to the charts, her trismus was not groat, She was able to open 14 millimeters on admission to the ER, and she was able to open 20 millimeters when she was seen in consultation by Dr. Winston. Let me quickly disabuse the reader of any notion that this sort of trismus is unusual on the second postoperative day. It is not. Further, trismus does not preclude the act of swallowing. I treat patients with jaw fractures wherein their teeth are wired together for six weeks. However, they can still swallow anytime they feel like it. Dr. Skalsky changed the oral antibiotic to Augmentin, a penicillin variant.

On the morning of July 9th, the patient presented to the ER of Cuyahoga Falls General Hospital with a complaint of trismus and inability *to* swallow. She told the ER doctor that she was unable to swallow her oral antibiotics- She was thereafter hospitalized for seven days at Cuyahoga Falls General Hospital, she was treated with an intervenous antibiotic, Unasyn, another penicillin variant, and got better, No surgery was ever performed. She was discharged on July 16th. She has, to my knowledge, no residual defects.

II. Review of tho complaints,

It is my understanding that there are two separate and distinct areas of contention contained heroin, Both of these involve plaintiff Bragg's allegations that Dr. Skalsky's dental treatments were below acceptable standards of the community. The first of these putative complaints arises from Ms. Bragg's perception that the extraction of teeth Nos. 1 and 16 (the two upper wisdom teeth) were not indicated at the time of her surgical procedure. The second claim against Dr. Skalsky by Ms. Bragg arises from her contention that, had Dr. Skalsky placed her on liquid antibiotics rather than oral antibiotics, she would not have developed the postoperative cellulitis which led her to her hospital admiuion. Let me discuss each of these allegations in order.

III. Based on the preoperative panorex x-ray which I have before me, taken 7/3/93, it is my firm dental opinion that all three wisdom tooth required removal. Of this, I am absolutely certain.

The Invidious suggestion that the removal of all three wisdom teeth at one time enhances the possibility of infection is counter-factual. It does not, Let me explain the reason why tho three wisdom teeth required extraction. The lower right, No. 32, had an active infection or pericoronitis. You may treat such a tooth with antibiotics for a brief period of time, but the pericoronitis comes back whnn you stop using the antibiotics. Therefore, the only treatment of merit is to remove tooth No, 32. Thereafter, the tooth above it, No. 1, has no opposing tooth. No. 16, the upper left wisdom tooth, already had no opposing tooth. In such cases, teeth which are surely going to be non-functional for the remainder of *the* patient's life ought to be removed. The reason for this arises from the fact that such teeth, 100 percent of the *tims*, begin to extrude, In a very brief period of time, they cut into the cheek, because they do nor have an opposing tooth. Then they must be removed. Ms. Bragg needed all three wisdom teeth removed. The question of whether to do all three at once, or to do it in three sittings, is an arbitrary one, generally agreed upon by the patient and the dentist. In this case, according to the consent form signed by Ms. Bragg, she agreed with Dr. Skalsky's suggestion that all three should be done at once. I believe this is a salutary procedure. We routinely recommend *to* our

patients that all three or four wisdom teeth be dnne in one sitting. The reason for this isobvious. You only have one night of suffering, because you don't suffer more with three than with one, and you don't have to undergo three separate nights of suffering and pacing the floor. Physicians do not take out your child's tonsil one tonsil at a time. It is, in my opinion, reasonable and logical for Dr. Skalsky to have done all three wisdom teeth at once. Apparently, Ms. Bragg agreed, because she signed the operative permit. And, in fact, her two uppar wisdom teeth had absolutely nothing to do with her postoperative infection anyway.

IV. The question vis-a-visthe proper route of postoperative antibiotic therapy.

Three days before her surgery, Dr. Skalsky prescribed for Ms. Bragg 28 extra strength penicillin tablets. This is the precise and correct antibiotic regimen suggested by the manufacturer. Had she sa taken the pills as directed, It is quite possible that the incipient postoperative infection which she began *to* develop would have dissipated In several days, and without any further intervention. This is, ofcourse, speculative, because the patient did not Lake them as directed. So the point is moot.

On her third pastaperative day, July 8th, Ms. Bragg stopped taking any antibiotics at all. The reason she gives is either that she could not swallow, or that she hed a sore throat. I do not believe that either of these explanations is either reasonable nor valid. The fact is, she could swallow. She states in her deposition that, indeed, she swallowed the water but the pill wouldn't go down. And inasmuch as the swelling was only on one side, all of us who have ever had a sore throat on one side know that you swallow the pill on the opposite side, What's more, it has been my experience over many years to see an occasional patient who genuinely could not swallow. In such cases, the patient carries a cup around with them so that they can spit out the saliva, because the mouth continues to produce saliva, and if it doesn't go down, then it must be spit out. Intho case of Ms. Bragg, we have no evidentiary material that suggests that she was carrying any saliva bowl around with her. No. she could swallow saliva, and she could swallow water, And, *of* course, she could have swallowed the pill, had she cut it up.

Common wisdom tells me, as itought to tell the reader, that if you can't swallow a pill. you cut It up Into pieces and then swallow it. I believe I have known this fact since I was about six. Above and beyond that, Ms. Bragg admits in her deposition that a suggestion was made that she should mash up the pills. That seems pretty reasonable to me, You take two spoons and you mash up the pill and you take it with gelatin, or with orange juice, or with anything. Under no circumstance would a reasonable person who had reason to suspect that they were developing an Infection, discontinue antibiotic therapy. There is, I believe, an implied contract between doctor and patient which requires that the doctor prescribe the correct medicine, and that the patient take the medicine. Dr. Skalsky provided the correct medicine, Ms. Bragg did not take the medicine after the morning of July 8th.

Ms. Bragg alleges that after she saw Dr. Skalsky on July 8th, he prescribed a different pill (another form of penicillin) called Augmentin. She complained that these pills were even larger than the penicillin pills, so, of course, she couldn't swallow them. Nevertheless, she maintains that she went to the pharmacy and got the pills, let me quote from the Physician's Desk Reference,

40th edition, page 660. Therein, the dosages of Augmentin are outlined. It stater that Augmentin may be given as chewable tablets, and it is also given in an oral suspension. It is called Augmentin-250, and it is in an orange-flavored syrup. Now, then, common wisdom tells me that if Ms. Bragg did, indeed, pick up the pills at the pharmacy and they were too big, all she needed to do was to inform the pharmacist that she could not swallow the pills, and, of course, he would have given her the oral suspension. That is an everyday occurrence. Or, for that matter, she could have called Dr. Skalsky, and he would have ordered the oral suspension in the orange syrup. However, she did not do either one. She just stopped taking them. That is hardly the fault of Dr. Skalsky.

Finally, Dr. Skalsky states under oath in his deposition (page 46) that at no time when he talked to Ms. Bragg on July 8th in his postoperative visit, did she report to him that she was having difficulty swallowing the antibiotic pills which he had prescribed. She didn't tell him. Mind reading is not one of the attributes generally attributed to dental surgeons. Given the evidentiary material presented to me, it is difficult for me to find fault with Dr. Skalsky's care and treatment. He performed his surgery adequately, he prescribed the correct antibiotic regimen, and he followed the patient postoperatively for two and one-half days, until the patient abandoned him. And as a tangential observation, let me point out, speaking as one who has performed oral and maxillofacial surgery for almost 40 years, that all of us, regardless of our care and our diligence, occasionally get postoperative wisdom tooth patients who develop infections. The reasons for these are obscure and nebulous. After all, every time you make an opening into the mucosa in the mouth, you have produced a catchbasin in which can accumulate myriad colonies made up of the millions of bacteria which inhabit our mouths at all times. In the presence of antibiotics, these instances are rare.

According to an article in the Journal of Oral and Maxillofacial Surgery, Volume 53, No. 1 January 1955, page 59, the authors state that the overall rate of maxillary infections is less than 0.27 percent. A subset article on page 63, notes that the overall incidence of postoperative infection for wisdom teeth ranges from a low of 1 percent. It has been my experience to know that virtually all of those infections dissipate in the presence of continuous oral antibiotic therapy. However, there is an occasional episode wherein a patient requires hospitalization, and in the case of Ms. Bragg, I believe the use of intravenous Unasyn was solubrious and efficacious. She got better, she was discharged, her prognosis is excellent, and she has no residual deficit. Nevertheless, at no time, in my opinion, did Dr. Igor Skalsky practice in a manner which was below the standard of acceptability in the national community.

V. Summary.

For all of the above reasons, it is my firm and trenchant professional opinion that the treatment rendered by Dr. Igor Skalsky beginning on July 3, 1993, to patient Meredith Bragg was correct, reasonable, and did in no way fall beneath the level of acceptable standard of care as practiced in the national community.

If you have further need of information, please so advise me.

Sincerely,

Kenneth R. Callahan, D.D.S.
F.I.C.D., F.A.C.D., O.K.U.
Associate Clinical Professor of
Oral and Maxillofacial Surgery
Case Western Reserve University
School of Dentistry
Diplomate, American Board of
Oral and Maxillofacial Surgeons

KRC:as

#568

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

McMonagle, G., J.

IN THE COURT OF COMMON PLEAS
(CIVIL BRANCH)

DONNA MAYER, )
Plaintiff, )
vs. ) Case No. 107571
)
MARILYN KAVALEC, )
Defendant. )

- - - - -

TRANSCRIPT OF PROCEEDINGS

- - - - -

APPEARANCES:

On behalf of the Plaintiff:

Dale S. Economus, Esq.
James Watson, Esq.

On behalf of the Defendant:

John D. Campbell, Esq.

- - - - -

Janice M. Lowe
Official Court Reporter
Cuyahoga County, Ohio

**WEDNESDAY MORNING SESSION, MARCH 22, 1989**

THEREUPON, the Plaintiff, to maintain the issues on her part to be maintained, called as a witness **KENNETH ROBERT CALLAHAN,** who, having been sworn, was examined and testified as follows:

**CROSS-EXAMINATION OF KENNETH R. CALLAHAN**

**BY MR.** ECONOMUS:

Q Doctor Callahan, your credentials are quite impressive.

A Thank you.

Q We have met before on other cases, haven't we, Doctor?

A I believe ***so***, Mr. Economus.

Q We have quite a number of questions to ask you in this case, ***so*** I hope you will be patient with me, because, obviously, I am not a dentist.

Before testifying today in court did you review any of your notes or office records, sir, your file?

A I did.

Q Did you bring it with you?

A I did.

Q May I please see it? Your Honor, may **I have a**

moment?

Doctor, are these all the records that you have relative to Donna Mayer's case?

A. Yes, Mr. Economus.

Q They are a copy or original of your report, dated October 13, 1987, on the subject of Donna Mayer, a letter from Mr. Campbell, a letter from Mr. Hopkins, a copy there of Miss Mayer's previous attorney, and some emergency room records from Parma Community General Hospital, some records from Dr. Kulick, and another report from Dr. Michael Kulick. Is that accurate?

A Yes.

Q Now, just so we can clear a few things up quickly, at no time prior to today did you ever see Donna Mayer?

A. That is correct.

Q And that means, by definition, that prior to writing the report you did not conduct an examination of her physically, what we call clinically, did you?

A That is true.

Q And, therefore, you were really unable to, based upon any clinical evaluation, draw a diagnosis of her condition, is that true?

A I could draw a diagnosis, Mr. Economus, but not

based on clinical evidence.

Q. I understand that, but my question is since you did not see her clinically you could not draw a diagnosis based upon any clinical evaluation?

A. That is true.

Q. You did no tests on her teeth. You could not draw a diagnosis based upon any tests that you did?

A That is correct.

Q. Your opinion given here today is solely based upon a review of records, and a letter sent to you by Mr. Campbell, is that accurate?

A Plus thirty years of experience.

Q. I understand, but thirty years of experience that you have is yours, and then you apply that, do you not, to whatever information you get?

A Yes.

Q. And that is what you did in this case?

A. Yes.

Q. Now, Doctor, you are acquainted with Dr. John Kulick, are you not?

A. I am acquainted with Dr. John Kulick,

Q. As a matter of fact, didn't the two of you go to dental school together?

A Yes.

Q. Or during the same period of time?

A He was a couple years behind me, yes.

Q Wouldn't you agree with me that Dr. Kulick's reputation i the community as a fine dentist is beyond reproach?

A Absolutely.

Q As a matter of fact, you are personally acquainted with Dr. Michael Kulick as well, aren't you?

A Yes.

Q And you think he is a fine dentist?

A Oh, I know Mike Senior. He and I interned together. I do not know Mike Junior.

Q Well, in your report didn't you indicate that you knew Mike Kulick?

A Yes. I was thinking of his father, Mike Kulick.

Q So you were mistaken?

A Yes.

Q Now, Doctor, you are not Board-certified in endodontics, are you?

A No.

Q And I think endodontics , just to clear another thing up -- Mr. Campbell said something to you about your taking your time away from your practice to be here in court.

You regularly take your time away from your practice to review cases, don't you?

A. If I am asked to do an examination I do, yes.

Q. And you have been in court before?

A Yes.

Q. You have never been nor are you now a treating dentist for Donna Mayer?

A That is correct.

Q. Now, Doctor, you made some reference to the emergency room records, and I think that you in part based your conclusions that you gave us here today on the Parma Emergency Room records, is that a fact?

A Partly, yes, that's true.

Q. Now, certainly you weren't there at the hospital when Donna Mayer made any complaints at Parma Community Hospital on the 31st of March of 1984?

A. No.

Q. Nor was I, of course?

A. Uh-huh.

Q. You don't know what was excluded from those records, do you?

A. Yes, I do.

Q. You know what wasn't put in?

A Yes, Mr. Economus, because in this litiginous age every one of us knows you write down every single thing that the patient says verbatim. You don't exclude anything unless it wasn't said, so I

do know what was not said, was not there.

Q. You are assuming the detail and exactness of the person taking the information, are you not, when you make that statement?

A. Yes, but emergency room people are so inclined.

Q. The emergency room records do indicate a trauma to the back of the neck, don't they?

A. Yes, a strain of the cervical and lumbar spinal muscles.

Q. And on the subject of occlusal trauma you are not saying that occlusal trauma never occurs because of a car accident, are you?

A. Oh, no.

Q. And you are also not saying that occlusal trauma is not a cause of the fracture of teeth, are you?

A. I am saying that in this case occlusal trauma is not a cause of the fractured teeth.

Q. That is not what I asked you, Doctor. My question was --

A. Repeat the question.

Q. Are you saying that occlusal trauma caused by car accidents is never the cause of the fracture of teeth?

A. No.

Q. And are you saying that occlusal trauma caused

by car accidents is never the cause or is never known to be the cause of the fracture of anterior or front teeth?

A I am saying that that is extraordinarily unlikely, Mr. Economus.

Q My word was never, Doctor. Can you tell us with any degree of dental probability that occlusal trauma never caused the anterior teeth to fracture as a result --

MR. CAMPBELL: I will object to the question, how he can testify probably, something is never.

THE COURT: I don't know whether he is going into dental literature or what it is you are inquiring about. I take it really your question is -- he testified that this anterior occlusion never damaged teeth. Is that what you are asking?

MR. ECONOMUS: The front teeth, Judge.

THE COURT: Anterior, you are talking?

MR. ECONOMUS: Yes, sir.

THE WITNESS: In my experience I have never seen anterior teeth sheared by

occlusal trauma. They could be evulsed or knocked up and out, but not sheared, in my experience.

Q. In your experience?

A That is correct.

Q. Which is, of caurse, limited to you?

A. Yes.

Q. Now, Doctor, your practice is limited to oral surgery, correct?

A Yes.

Q. And you are familiar, of course, because of your review of this case, with the type of treatment that Donna received from Dr. Kulick, are you not?

A Yes.

Q. And that was root canal therapy, wasn't it?

A Yes.

Q. Would you agree with me that root canal therapy is painful at least part of the time?

A I think putting the novocaine in is painful. We all know that, but after that, no, it ought not to be very painful, Mr. Economus.

Q. You mentioned pulp vitality.

A Yes.

Q. The pulp is that inner chamber of the tooth that you referred to?

A Right.

Q Now, when a fracture of a tooth occurs first of all the dentin is not sensitive to pain usually, is it?

A Oh, yes, it is.

Q I am sorry. I meant enamel?

A Is not, no.

Q Dentin is the next section?

A Yes.

Q Then we have the pulp?

A Right.

Q Once the pulps are exposed to air or saliva or some other foreign matter they hurt, don't they?

A Yes.

Q And from your review of Donna's case do you know that on the 27th of June, 1984, her teeth cracked off?

A Yes.

Q And are you aware that on the 31st of March, 1984 she was in an automobile accident?

A Yes.

Q And can you tell the ladies and gentlemen of the jury based upon your personal knowledge of anything that you know of between, aside from the accident, between March 31, 1984 and June 27, 1984 that would

have caused her teeth to crack off, based upon what you know, any event?

A. Based on what I know I do not have any notion, no. I know what didn't cause it.

Q. But you don't know what did?

A That's correct.

Q. And if there had been, Doctor, a recent traumatic event to Donna's mouth, around the 27th, when these teeth cracked off, a blow to the face, a fall down, anything like that, would you agree with me that it would have been likely that her treating dentists, Drs. Kulick, would have recognized some evidence of that in her face when they treated her for the root canal therapy?

A. Not necessarily, Mr. Economus. You can just injure teeth without injuring any soft tissue.

Q. So it is possible that teeth can be injured, fractured, cracked, without any evidence of trauma, you know, a bloody lip, a cracked lip, something like that? Would you agree with that?

A. Yes.

Q. So that we get this established would you agree with me that because of the nature of Donna's tooth injury that at some point in time after these teeth cracked off she had some pain?

A. Oh, yes.

Q. And if I told you that they cracked off on the evening of the 27th o June, 1984, and that she didn't see the doctor, or dentist, until the morning of the 28th, and that those pulps were vital, would you agree that she would have had pain during that period of time?

A. Yes.

Q. Would you also agree with me that emotional disturbance from pain in the face is generally far more intense than that associated with occurrence of pain in most other parts of the body?

I don't know the answer to that. It depends on what other parts we are talking about, but generally speaking, I think that it is an emotional experience, yes.

Q. Would this be so because of the importance, for example, in our society of our faces, things people look at first when they meet us?

A Yes.

Q. Would you agree that a dentist who is dealing with facial pain should realize he is dealing with an effective disorder that is of a special nature, especially intensive?

A I don't quite follow the question.

THE COURT: Restate your question.

BY MR. ECONOMUS:

Q. Do you think that a dentist who is treating a patient who has facial pain, like vital pulps, should be particularly attuned to that in the way he treats a person?

A. Well, yes, Mr. Economus, we should be attuned to everything, every patient who has any pain, yes.

Q. Would you agree with me that the emotional upheaval, based upon facial pain, probably is more intense in women than in men?

A. I think all of us are about the same as far as our appearance is concerned, our cosmetic defects, or lack of them, about the same.

Q. Doctor Callahan, there are sub-specialties in dentistry, are there not and yours is oral and maxillo-facial surgery?

A. Right.

Q. How did I do?

A. Very good.

Q. Endodontics is another sub-specialty?

A. It is.

Q. And endodontics is the sub-specialty that deals with tooth restoration. Would you agree with that?

A. Well, no. Tooth restoration means putting in

fillings, removal of pulps, and taking out, doing root canal.

Q You are not an endodontist?

A No.

Q. Based upon your study of this case and the pictures that you have seen and I think I heard you testify that Donna's teeth are fractured off about what, half-way, two-thirds? Do you want to see the pictures again?

A. I think Dr. Kulick stated between a half and one-third.

Q What would you say based upon the pictures that are Plaintiff's Exhibit Nos. 11 through 14?

A Well, in these pictures it looks like it is about half, just about half-way up the middle of the tooth.

The tooth is shaped like a little chicklet, and about half a chicklet is sheared off in each picture.

Q The dentin, you testified that the dentin is hard, kind of like ivory?

A Yes, but also somewhat -- remember, it has collagen in it.

Q Doesn't that make it resilient?

A That is a good question. I don't know. I guess

it does, yes.

Q. What is collagen?

A. It's a protein.

Q. And it gives dentin some elasticity, doesn't it?

A. Yes.

Q. Now, in the early formative stages of the tooth the pulp is the portion that kind of builds the tooth, isn't it?

A. Yes.

Q. And the pulp has the nerve and the blood supply and the like?

A Right.

Q. And it, for lack of a better term, lays down the dentin?

A. Yes.

Q. And this occurs for the most part throughout life, but more often than not, in a normal tooth, at the earlier stages of life; in other words, the pulp is much larger the younger you are?

A. Yes.

Q. It reduces in size as we get older?

A. Uh-huh.

Q. Now, when the root canal therapy was done on Donna by Dr. Kulick he extirpated, his word, the pulp?

A Right, yes.

Q With some sort of a burr instrument, to pull it out?

A A little thing that looks, has got little burrs on the side, looks like a little hat pin.

Q A fish tooth barb?

A Right. Then you pull the pulp out.

Q Once those pulps come out of the teeth, for all intents and purposes for us, as laymen, the teeth are dead, aren't they?

A That is correct.

Q The pulp is what gives the tooth life?

A Yes.

Q So we can't dispute, and I don't think you would disagree with me, that as Donna sits here now her two front teeth are dead?

A Yes.

Q And they are going to stay that way, aren't they?

A Absolutely.

Q Now, Doctor, in your thirty years' experience as a dentist, and I take it you don't do that many root canals these days, correct?

A Not many.

Q Can you tell us, do those caps last forever?

A No, Mr. Economus. You can allow for one change

at least throughout life.

Q One throughout life?

A One, maybe two. It is always a difficult point.

Q It depends on the individual, of course?

A. Yes. The dentist thinks he makes crowns forever and always tells the patient that, in fact, they don't last forever.

Q Isn't it a fact that it is generally recognized in your business that crowns will last about ten years and then should be replaced?

A. It's a difficult point. Some say fifteen, some say twenty, on an average.

Q But they do have to be replaced?

A Yes.

Q Because they wear down?

A Something happens to them. They get loose.

Q If you can answer this I would appreciate it. If you can't, just tell me.

In your experience have the charges that dentists have for recapping teeth increased over the years?

A. Sure.

Q And would it be likely that for the forseeable future that will continue to occur, that charges will increase?

A That is a nebulous question. I don't know the

answer to that.

Q. You can't answer?

A It has to do with economics.

Q. Well, based upon past history they have increased?

A That's true but, you know, things *go* down too.

Q. I understand. Based upon your review of Dr. Kulick's records, Doctor Callahan, you can give the jury no indication that before March 31, 1984 she ever had any serious problems with her two front teeth, is that correct?

A That is correct.

Q. No indication or evidence of fracture?

A No.

Q. No indication or evidence of tooth decay?

A. No.

Q. No indication or evidence of any unusual circumstance except, you know, the usual cleaning and dental hygiene, correct?

A Right.

Q. Are you aware that Dr. John Kulick has been Donna's dentist since she was about five years old?

A Yes.

Q. It's good dental practice to keep a running history and chart of your patient over the years, is it not?

A Of course,

Q **And you generally do that, don't you?**

A Yes.

Q So would you agree with me that Dr. John Kulick is a person who is more familiar with the general conditon of Donna's teeth than you are?

A. Yes,

Q. And certainly on the 27th of June, 1984, when Dr. Michael Kulick did the root canal you would agree that anything associated with the root canal that happened on that day Dr, Michael Kulick would be a person who has far greater knowledge than you do of that set of circumstances, wouldn't you?

MR. CAMPBELL: Object.

THE WITNESS: I don't know.

MR. ECONOMUS: I will rephrase the question, Judge.

Q With regard to what her teeth looked like on the 28th, since you weren't there, Dr. Kulick was, he knows more about it than you do? Would you agree with me?

A In regard to the clinical evidence before him he knows more than I. Other than that I don't **know** that he knows more than I. Nobody knows more than I.

Q With regard to your report, Doctor, and you have

it there in front of you, this is not the first report that you have written for a defense lawyer, is it?

A No.

Q As a matter of fact, Doctor, in addition to Mr. Campbell's firm, you have been hired to give your opinions by many other defense firms in this city, have you not?

A. I have, Mr. Economus. I do plaintiffs' work too, if they ask me.

Q. I understand that. In fact, you also do reviews of cases and give opinions for companies, don't you?

A. Yes.

Q. You do between forty to fifty-two of these a year, don't you?

A Perhaps.

Q. And in every one of these you charge for your services, don't you?

A. Yes.

Q. And you charge for writing the report, correct?

A Pardon?

A You charge for your review and writing of your report?

A Yes.

Q. And then you charge separately for coming to

court to testify?

A If I miss office time I do, yes.

Q The largest percentage of cases that you review, Doctor, are for defense lawyers, aren't they?

A Probably, yes.

Q This accident happened, Doctor, as you know, on March 31st, 1984, is that true?

A Yes.

Q And your report is dated, if I am not mistaken, October 13, 1987, about three and half years later, is that right?

A Well, yes. The facts haven't changed in those years.

Q Doctor, what is the typical length of one of your reports?

A They are pretty long. They are usually about --

Q Eight, nine pages?

A Yes.

Q And you have a habit, don't you, of using a lot of similar language in your reports. Do you agree with that?

A I like not to think so, but it is possible that I may.

Q Well, let me give you some examples. You like to use the words forthright, trenchant, sincere,

firm, and sincere when describing your dental opinions, don't you?

A Yes.

Q You did that in Donna's case, didn't you?

A Yes.

Q And you have done it in a number of other cases using the same language, haven't you?

A It is better than saying insincere, non-forth-right, yes.

Q So your answer is yes?

A Yes.

Q And in many of the cases that you review, Doctor, you conclude that there is no direct causal connection between the incident and the claimed injury, don't you?

A Yes, Mr. Economus, In some I find there is. You don't see those.

Q No, I don't, and in writing your reports, Doctor Callahan, you frequently call on authors of dental literature and cite other dental books as being authoritative, don't you?

A Well, I think that adds substance to a report on occasion. I did not in this case.

Q I know that, but you have done it in the past?

A Yes.

Q. And you will use it a quote oftentimes from some authoritative source and put it in your reports in an attempt to underscore your conclusions or support your conclusions, would you not?

A. Yes.

Q. Now, Doctor, let me ask you this. Have you quoted Dr. Daniel Laskin in any of your reports?

A. I don't believe I have quoted Daniel Laskin since 1980 or 1981. I don't use him anymore.

Q. Well, I don't want to get bogged down in details, but I have some reports here in which you have quoted him. Would you like to see them?

h What year?

Q. '85, '86.

A. Laskin in '86?

Q. Uh-huh.

A I am surprised. I don't think he is an authoritative person. That only deals with temporal mandibular joints. It has nothing to do with this case.

Q. You have quoted him, haven't you?

A. Yes.

Q. And there have been times, Doctor, when you have quoted him out of context in your reports, haven't there?

A Out of context?

Q Uh-huh, taking something from this place and putting it in this place where it really doesn't belong? Have you done that with Dr. Laskin's works?

A I don't think so. I think you may think so, but I don't.

Q Do you recall giving a deposition on January 21, 1987, Doctor?

THE COURT: In this case?

MR. ECONOMUS: No, Your Honor, in a different case.

MR. CAMPBELL: Mr. Economus, in fairness, I mean, pick a date. How about a little more information?

THE COURT: He has got a date in January, 1987, at Southgate, at 4:30, before a court reporter, Kathleen A. Wheeler, taken on behalf of Howard Mishkin, and Mr. Lybrand, defense lawyer, was there. Do you remember that?

THE WITNESS: Not right offhand, no.

BY MR. ECONOMUS:

Q Would you like to look at it to refresh your recollection?

THE COURT: Counsel, are you

suggesting there is something that he stated on deposition in another case at some other time that apparently impeaches what he says here?

MR. ECONOMUS: Yes, Your Honor,

THE COURT: Come over here. Bring that with you. Bring it with you.

(Thereupon, a discussion was had between Court and counsel at the side bar, off the record.)

THE COURT: May I have it, please, Doctor? Just a minute. Don't answer, Doctor. You might not have to answer the question. Hand it to him, Doctor.

(Thereupon, the following proceedings were resumed in the presence of the jury and parties as follows:)

THE COURT: You may not inquire about it.

MR. CAMPBELL: Thank you, Judge.

BY MR. ECONOMUS:

Q Do you know how many x-rays were taken of Donna at Parma Hospital, Doctor?

A I do not know the exact number. I do know an

x-ray was taken of the cervical spine and the lumbo-sacral spine.

Q. You don't know whether there are any x-rays taken of any other part of her body, do you?

A. I know there were not any taken of any other parts of the body, because she should have -- I would think they would have been included in the chart. I should think they would.

Q. The teeth that have pulps in them are living structures, aren't they?

A. Yes.

Q. And they are suspended in the mouth by ligaments, in a socket?

A. Yes.

Q. And there is a certain give to them upon impact, isn't there, generally?

A. Generally they loosen a little bit upon impact, yes.

Q. And they are generally resilient to damage, aren't they?

A. That's a nebulous question as well. They are not resilient to caries, to decay. They shear off. They can be broken. They can be evulsed, so they are not resilient to damage.

Q. One last question or, two, really. So I

understand you can't deny Donna's teeth sheared off on the 27th of June, 1984, can you?

A No.

Q And you can't give us a reason why they did specifically, can you?

A No.

MR. ECONOMUS: No further questions.

THE COURT: Anything further?

MR. CAMPBELL: One or two, Your Honor.

THE COURT: All right.

REDIRECT EXAMINATION OF KENNETH R. CALLAHAN

BY MR. CAMPBELL:

Q Doctor, you just, in answer to a question by Mr. Economus, said that when teeth are impacted they will loosen, is that correct generally?

A Usually if they are hit from an angle they will loosen.

Q Even minutely they will loosen?

A Yes.

Q And if a person has even minutely loose teeth are they likely to detect that?

A Yes. You know, immediately you are sitting there and saying, that isn't right, yes.

Q. Can you feel your tongue?

A. Yes.

Q. You feel differences existing to talk. I am not hitting the right place with my tongue?

A. Yes.

Q. So if there was an impact you would expect the person to be able to feel something different with their mouth?

A. Absolutely.

Q. Now, let's take that the next step. You say the average person could detect something wrong. What about a person who really loved their teeth, somebody who thought she had fabulous teeth, who took great care of her teeth, was very conscious of their teeth? Is that person going to be even more likely than you or I or any member of the jury to see if there is something wrong with their teeth?

A. Yes.

Q. You told Mr Edmonds that teeth can be fractured sheared off, without trauma to the lips, or to the gums, or to any other signs of trauma other than the fractured teeth Do you remember saying that?

A. Yes, without any soft tissue injury

Q. Have you seen that occur?

A Oh, yes.

Q. Can you give a couple examples of what you have seen happen?

A I had a kid just a little while ago who plays shorts-top. The ball comes up and hits the teeth. The teeth are gone. He has no cut in his lip or anything, but the teeth are sheared off.

Q. When that happened he had pain, didn't he?

A. Oh, yes. The poor guy.

Q. And his mouth hurt?

A. Yes.

Q. And he felt those fractures?

A. Yes.

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

THE COURT: Is everybody all finished? Are you?

MR. ECONOMUS: I think so, Judge.

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# C E R T I F I C A T E

I, Janice M. Lowe, Official Court Reporter for the Court of Common Pleas, Cuyahoga County, Ohio, do hereby certify that as such reporter I took down in stenotypy all of the proceedings had in said Court of Common Pleas in the above-mentioned cause; that I have transcribed my said stenotype notes into typewritten form, as appears in the foregoing Transcript of Proceedings; that said transcript is a partial record of the proceedings had in the trial of said cause and constitutes a true and correct Transcript of Proceedings had therein.

Janice M. Lowe
Official Court Reporter
Cuyahoga County, Ohio

#569

THE STATE OF OHIO, )
) SS: JAMES J. CARROLL, J.
COUNTY OF CUYAHOGA: )

IN THE COURT OF COMMON PLEAS

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Plaintiff,

vs. Case No. 153064

BELLA LEYBOVICH,

Defendant.

--- 000 ---

EXCERPT OF PROCEEDINGS
(Cross-examination of Dr. Kenneth Callahan)

--- 000 ---

**APPEARANCES:**

On Behalf of the Plaintiff:

THOMAS O. CALLAGHAN, ESQ.

On Behalf of Defendant:

DAVID G. BORLAND, ESQ.

Thomas C. Walters
Official Court Reporter
Cuyahoga County, Ohio

WEDNESDAY AFTERNOON SESSION, OCTOBER 18, 1989

* * * *

THE COURT: Mr. Callaghan?

MR. CALLAGHAN: Thank you, your Honor.

CROSS-EXAMINATION OF KENNETH CALLAHAN

BY MR. CALLAGHAN:

Q Good afternoon, Doctor. My name is Tom Callaghan?

A Hi, Mr. Callaghan. How are you?

Q I spell my name with a G and you don't?

A Right. Your parents could spell better than nine.

Q You had at one time?

A That's right.

Q Doctor, you and I first met in your office January 7th of 1987 on the time of your exam of Wendy Perin, right?

A Right. That's correct, Mr. Callaghan.

Q Do you recall my being present at that time?

A I do.

Q And I was present during the time type of your recording of notes of the history that Wendy gave,

was I not?

A That is correct, Mr. Callaghan.

Q And, Doctor, you didn't tape-record that session, did you?

A NO,

Q Do you remember, we were both taking notes? As I remember, my yellow pad and your yellow pad?

A Yes.

Q I see you're looking at your notes?

A Yes.

MR. CALLAGHNA: Your Honor, may I have a moment to look at Dr. Callahan's notes?

And, Doctor, have you brought your complete chart with you today?

THE WITNESS: I have, indeed, Mr. Callaghan.

THE COURT: Mr. Borland?

MR. BORLAND: That's fine.

MR. CALLAGHAN: May I approach the witness?

THE COURT: Surely.

MR. CALLAGHAN: If the Court please, this may take a minute for me to review,

THE COURT: All right.

Q Thank you, Doctor?

A Thank you, Mr. Callaghan.

Q And those are the only notes of that meeting that *you* have, *is* *that* correct, Doctor?

A That is correct, Mr. Callaghan.

Q And I take it it's your practice, Doctor, not to ever tape-record those sessions, *is* that true?

A That is true.

Q All right, And you don't tape-record those sessions *to* this day, do you?

A No.

Q Defense medicals, what we call defense medicals?

A I call them independent medical examinations.

Q All right. Were you satisfied, Doctor, and are you now satisfied that the notes that you took that day included all that you thought was relevant about what Wendy told you?

A Yes.

Q All right. And you were aware then, were you not, that an arthrogram procedure had been performed a month and a half earlier?

A Yes.

Q Had that been performed to one or both sides of her jaw?

A I never saw the copy of *the* arthrogram, but I believe it was done o both sides.

Q And Wendy told you at that visit, January *6*, 1987, in fact, that she had just had the arthrograms perf ormed, didn't she?

A *Yes,* I have it here,

Q And did she tell you that they were positive findings on the arthrogram at the time?

A I don't recall that she had, but I would look at the arthrogram ordinarily anyway.

Q That is not included in your notes as to what she might have said about the results of the arthrogram, is it?

A It's implied. Dr. Lewis sent ne to University Hospitals for arthrograms. The next sentence, Lewis said I need surgery.

If it was a negative arthrogram she wouldn't need surgery.

Q When she told you that Dr. Lewis had talked about surgery, if you, in fact, believed her, given your regard for Dr. Lewis, you would nave believed that she probably would have surgery at that time, is that not true?

A Pes.

Q Okay. Doctor, tell me if you will, why at

that *tine* you ordered a panorex X-ray?

A Well, a panorex X-ray, Mr. Callaghan, will show the ball and socket. It will show whether there's any erosion or nibbling away, osteonecrosis of the bone.

It will show a considerable amount *of* the bone.

Q But it won't show anything about the inside of the temporomandibular, would it?

A No.

Q And you knew at that time, based upon your exam and based upon Wendy's report, again if you believed her, that the arthrogram had been performed and Dr. Donald Lewis was considering surgery, isn't that true?

A *Yes.*

Q Were you looking for something else from a treatment standpoint, having done those panorex X-rays?

A From a diagnostic standpoint, Mr. Callaghan, if there is arthritic changes or if there are bone changes a flattening of *the* condyle, you can learn a lot from a panorex.

Q You knew at that time that the panorex X-rays were not going to show you anything with respect to

her internal derangement of the temporomandibular joint itself, correct?

A That it does not show soft tissue.

Q Right. Now, October 12, 1987 you wrote that letter to Mr. Borland's law firm as you testified?

A Yes.

Q And the purpose of that report is to evaluate Mrs. Perin in terms of one, her injury, and whether or not her injury was caused by the accident, fair to say?

A That is correct.

Q And that report, including the signature page, consisted of ten typewritten pages?

A That is correct, Mr. Callaghan.

Q That report as you testified was written ten months after that one visit Wendy and I made to your office in January of 1987?

A Partly on that and also all of the other reports I have before me.

Q As far as the history is concerned, you had to look back into your notes there and reconstruct what Wendy had told you based upon your notes?

A That's correct.

Q Because you didn't have any tape-recording device at the time?

A No.

Q Doctor, isn't it fact when Wendy and I visited you, and we were both there taking notes, that Wendy told you that she could -- she could eat, but that she had -- she couldn't bite, couldn't open her mouth for something big, but that she was eating soft foods at that time?

A Well, I don't -- I don't take notes, Mr. Callaghan. If you notice these are all long hand sentences. It's a narrative form. It's not just notes, so I don't have that in my notes.

I knew she could not open very wide, so I think it's implies. It only opened 35 millimeters at that time.

Q In your report of October 12, 1987, who is this Dr. Gelb? Is he well known as an authority?

A I have his textbook here, Yes, I believe he's well known as an authority.

Q And this is the third addition or second addition?

A Second addition.

Q Has he been he recognized for sometime as an authority on the subject of temporomandibular joint dysfunction?

A Yes, he is one authority, yes.

Q And there are other authorities upon whom you rely? Of course, you testified?

A That is correct.

Q And how long has he been recognized as an authority in your view, Doctor?

A I don't know specifically, Mr. Callaghan. I would think in the '80's. He published tne book in '85, so we certainly recognized it since then.

Q Had he published before that time?

A I don't know.

Q As a matter of fact, up until three and a half years ago you had never heard of Dr. Gelb, isn't that right, Doctor?

A I have to think about that. I don't know whether I had or not. When his book came out I bought it, and that was in '85. I certainly heard of it then.

Q Dr. Gelb has been recognized as an author, at least and writing textbooks for a long time before 1985, isn't that true?

A I said I don't know, Mr. Callaghan.

Q So you didn't know him until recently, is that correct, Doctor?

A I still don't know him.

Q You just knew him as of three years?

A I don't know him now. I just know what he writes.

Q Now, Doctor, on page seven of your report, and could you pull that out, dated October 12th? Are you on page seven?

A Yes.

Q Under discussion, I wonder if you would read along with me? "Trauma is rarely listed as one of the prime ~~ideological~~ etiological factors involved in long standing and chronic temporomandibular joint dysfunction.

This applies particularly to trauma in which the patient did not strike any object at the time of the traumatic incident with her jaws, face or teeth."

And you made that statement then?

A Yes.

Q October of --

A Trauma is meant to understand in this context, external trauma.

Q As opposed to internal trauma which you discussed --

A Yes.

Q -- on direct?

A Yes.

Q Right. Is that still your view today?
A That it is rare?
Q It's rarely a factor etio ideologically in the cause of TMJ dysfunction?
A I believe that it is a factor, but it's well down on the list.
Q Well down on the list?
A Yes.
Q And that is in terms of being and etio ideological factor with temporomandibular joint dysfunction?
A Yes.
Q That is opposed to myofascial pain dysfunction?
A No, not as opposed to -- as opposed to the other causes of temporomandibular joint.
Q Let's get our definitions straight, shall we?
A Please do.
Q I'm going to try. Myofascial pain dysfunction is something separate and apart, is it not, from internal derangement?
A Absolutely.
Q Okay. And both of those disorders, if you will, can be subheadings of the general category of TTMJ dysfunction, fair enough?
A That's correct.
Q Now, you would agree, of course, that trauma is

rarely an ideological factor in the cause of myofascial pain dysfunction, correct?

A Well, I'll have to think about that, I didn't say that in the report.

Q I'm asking to you breakdown the statement, because it's a general statement, is it *not,* Doctor?

A *Yes,*

Q And it includes both myofascial pain dysfunction and internal derangement and I want to break it up.

Are you referring in that statement more to myofascial pain dysfunction which Wendy did not have, or are you are referring just as much and with just as much force to internal derangement?

A in this statement I'm saying that the overall causes of temporomandibular disoraer, whether it's MPD or internal derangement, that of the overall causes, I believe that trauma is well down on the list of common causes.

Q All right. And you would further agree that that statement insofar as it relates to MPD is irrelevant to Wendy's case because at the time, at the time of the writing of the report you already knew she had internal derangement and that was the subject of the report and the subject of this case,

isn't that true?

A I don't break down between MPD and internal derangement, In this particular case she has internal derangement.

Q Do you agree it might not have been a bad idea when you wrote this, because it was specifically about this young woman that we night have couched the phrase in *terms* of what she actually had, not another dysfunction, MPD?

A I don't really know what you are getting to, but --

Q All right. Well, admittedly, Doctor, I'm a little clumsy. This is my first TMJ case and please bear with ne.

What if the statement read like this, trauma is rarely fisted as one of the prime etes ideological factors involved in internal derangement of the temporomandibular joint?

Would you agree with that statement?

A I probably would agree *to* that, Mr. Callaghan, yes.

Q You would agree also that trauma is rarely related to causing internal derangement, intrinsic trauma?

A *Yes,* that's correct.

Q And understand that Dr. Lewis and Dr. Goldberg completely disagree with you on that topic?

A *Yes.*

Q And there are many, many others that, in fact, disagree with you, isn't that so, on that subject?

A No.

Q They are two of the only people that you know of in this community, in your field of oral and maxillofacial surgery that disagree with you on that topic?

A Well, I haven't asked everybody, Mr. Callaghan, but the ones I asked pretty much agree with me.

I added an appendage to *that* statement.

Q Please *feel* free --

A If internal trauma did cause it, then why don't all the Brown's football players have it? Why don't boxers have *it,* and why is it it's restricted so much to young female sales representatives?

Q I'll answer the question for you, but we'll *get* to that in a minute. Ligaments. The ligaments contained inside the fntracapsuleinside the joint of the jaw, they are considerably smaller than the ligaments in the knee and the elbow.

*You* would agree with that, would you not?

A

Q And you said that you have done some surgery, some TMJ surgery in the past?

A *Yes.*

Q That wasn't by any means a major component of your practice, was it, Doctor?

A No, not in recent years.

Q Now, you answered Mr. Borland's question that, yes, indeed, you have written reports for his law firm, Meyers, Hentemann, Stevens, and Rea, and you have written a number of reports for them over the years?

And could you estimate approximately how many *reports* you have written for Mr. Eorland's law firm, say in the year 1988, and I'm saying with respect to personal injury cases of this type, TMJ, alleged TMJ injuries, if you will?

I'll use the word allege, ana accidents?

A I have a chart. I could go home and tell *you,* but I don't have that accurate of a number here.

Q Would it be more than 20 in the last year?

A Probably might be a close estimate -- around there.

Q And those reports were principally concerned

with he people who allegedly suffered injuries to the TMJ joint as a result of accidents, correct?

A Yes.

Q And, likewise, do you also write reports for the law firm of Gallagher, Sharp, Fulton and Norman?

A Infrequently, but some.

Q And, in addition to writing reports for that law firm and Mr. Borland's law firm, you write reports to the clients directly, do you not, before the matter gets to court -- so to speak, before a lawsuit is filed?

A I don't write letters to clients, no.

Q Clients of Mr. Borland's law firm, you do not write letters to them?

A No, I write -- no, I write then to the law firms when they ask me, but a number of these, I have. Yes, there is a causal relationship ana I so report that,

And others I report no, there is not a causal relationship, I'm sorry. Go ahead.

Q You have already told us that you are no stranger to the courtroom?

A That is true.

Q And *you* are comfortable in this surrounding, would that be fair to say?

A Yes.

Q You are quite obviously appearing here live today, right?

A Yes, it's me.

Q Quits obviously I said?

A Yes.

Q And you're not on videotape?

A No. Nope, you and ne.

Q Like Dr. Lewis and King, in fact, you make it your practice to appear live for courtroom testimony, don't you?

A Yes.

Q Fair to say you enjoy this experience?

A Yes, I think so.

Q You get a kick out of it?

A Better than being home watching television, yes.

Q When you have to come and testify live, Doctor, does that pose a problem with your schedule with patients?

A Well, it does and it doesn't, I'll answer that. I have a partner and he's really a neat guy, but he's gone. He takes long vacations, like being in practice with Marco Polo. He's dressed and he's gone.

But when he's there we have an arrangement whereby he takes over the practic and I come to court.

Q He's there now?

A Yes.

Q He's there today?

A Yes.

Q You are pretty much on call if Mr. Borland's law firm or other defense law firms for whom you work, if they call you, you can pretty much make arrangements to be at the courthouse at a certain time, is that fair?

A Yes, or plaintiffs' attorneys just as well.

Q Doctor, come on. What percentage of your testimony is for plaintiffs' lawyers?

A I write many letters which I don't testify for.

Q You don't testify for, though?

A NO.

Q You write plenty of letters for plaintiffs' lawyers, is that what you are telling us?

A Yes.

Q How many is plenty, Doctor, in the last year?

A I would say in the last month, I have written three and one will go to court with Paul Kaufman.

Q Doctor, you admitted on direct, did you not,

that cervical whiplash injury can cause internal derangement?

A *Yes.*

You did say that?

A Yes.

Q And that's been known for sometime, has it not?

A

Q I mean, you won't find a treatise either by an author that Dr. Goldberg recognizes or that you recognize as an authoritative source that is going to say the opposite, that cervical whiplash trauma does not cause internal derangement of the temporomandibular joint. That is fair to say, *too*, isn't it?

A

Q Something that you have read widely?

A *Yes,*

Q And fact is, cervical whiplash trauma can and will cause temporomandibular joint dysfunction specifically internal derangement?

A *Yes.*

Q And that's been recognized by Dr. Gelb going back *to* 1985, *isn't* that true?

A Yes.

Q And frankly, it's been recognize by the authorities for sometime predating 1985, isn't that right?

A That may well be,

Q Yeah. So when did you change your mind, Doctor? When did you finally come to the conclusion and start *to* agree with the rest of the experts that cervical whiplash trauma can, in fact, cause internal derangement, because that didn't used to be your opinion, Doctor?

A I suppose around 1985 or so.

Q Oh, I'll help you on that. Ana, again forgive me. With all do respect, I'm here to do justice for a young lady, and please --

THE COURT: Please, Mr. Callaghan, just questions.

MR. CALLAGHAN: I'm sorry, your Honor.

THE COURT: And the jury will disregard counsel's purpose for being here,

Strike it from your mind. It's stricken from the record.

MR. CALLAGRAN: Thank you, your Honor. Your Honor. I apologize.

Q I beg the Court's indulgence.

Didn't you at one tine in the last few years, Doctor, testify to the affect that a patient can no sooner suffer a whiplash trauma in the TMJ than you can have a whiplash of a tooth.

That was a clever play on words. Do you remember saying that?

A I may have.

Q So you aid change your mind?

A *Yes*, back in -- there's an article that came out in the Journal of Oral Surgery in August of '87.

Q I'm aware of that article, Doctor, and we'll get *to* that in a minute. That is also not quoted in Wendy's report.

You wrote that report, Wendy's report October 12, *1987*, and as I heard you say on direct, you read these journals every night ana that journal came out in early August and that is the Journal of Oral and Maxillofacial Surgery, correct?

A Yes, there's lot of things I didn't quote in Wendy's report.

Q That's pretty much the bible to your profession, just as the New England Journal of Medicine is to the field of medicine, isn't that right?

A No, that is not right, Mr. Callaghan. A bible

has words which are guaranteed *to* be true, A journal has words that are sometimes controversial.

Q It is as the name implies, it's the Journal of Oral and Maxillofacial Surgery. It's quite respected by members of your profession?

A *Yes,* absolutely.

Q Okay. And that was the first time when this article came out, I take *it,* this case study of 25 patients who had suffered cervical whiplash trauma and then developed internal derangement.

That was the first time that you swung over to the other side that yes, in fact, cervical whiplash trauma extension/flexion injuries can cause TMJ internal derangement, is that fair to say?

A I don't think it -- Mr. Callaghan, *I* don't know. This remark about whiplash of the tooth -- you are quoting me out *of* context, and if I could see the rest of the letter maybe I would say fine.

Q It's not a letter, it's live testimony.

A Okay. Well, then to answer your question, I think -- I don't know when I was more amenable to cervical whiplash. I'm saying now --

Q Now, *you* are more amenable to --

MR. BORLAND: Let him finish his answer.

A Yeah. I don't that I was ever directly opposed to it. I don't know.

Q *You* certainly don't mention anything about recognizing the fact that a cervical whiplash injury can cause internal derangement in Wendy's report and that was written October 12th of 1987, isn't that true?

A Mr. Callaghan --

Q Isn't that true, you did not mention anything about whiplash trauma?

A That's true, because she didn't report it for four and a half months.

Q I'm asking when she reported it, Doctor. I'm talking about the mechanism that caused the injury, the type of *accident that* she was involved with.

What you do say in your report, though?

A The mechanism that you say caused the injury, I say doesn't,

Q I'm not talking about causing the injury necessarily, talking about the accident itself. And certainly by implication in that report you are suggesting to the evaluator of your opinion and the reader of your report that you must suffer a direct blow to the mandible, to the jaw, to the head, to the face, because you did say that in your report, did

you not --

A No.

Q Let's take out your report. Doctor, we'll come back to that.

Doctor, can you tell the jury, if you would, how long it's been that you have been giving expert testimony of this type?

A I don't know really. Eight years, maybe ten years.

Q And I believe you testified that you and Dr. Goldberg are good friends?

A Yes.

Q All right. And that you and Dr. Lewis are good friends?

A Yes.

Q And that both you and Dr. Goldberg are on the faculty at Case Western Reserve?

A Yes.

Q As a matter of fact, Doctor, you don't really teach at Case Western Reserve University Dental School, isn't that true?

A That is true.

Q You don't teach in the classroom?

A I teach in the clinic, Clinical Assistant Professor. I teach in the clinic, but we give the

lecture at --

Q You are a Clinical Assistant Professsor?

A Yes.

Q And Dr. Goldberg is an Assistant Professor on the faculty, the teaching faculty?

A He gives lectures. *Yes,* he's head of the department.

Q When did you become an Assistant Professor?

A Associate Professor.

Q You are an Associate professor?

A I think 1978.

Q And Associate Professor is one step blow an Assistant Professor, isn't that right?

A I don't know.

Q You know that, Doctor, do you not. You have a title?

A I got one *title. It's* an Associate Clinical Professor and I have that since '78.

Q How often do you teach at *Case* Western Reserve University in the clinic, Doctor?

A Tuesday mornings, once a week.

Q Every Tuesday?

A Yes.

Q And what types of surgery do you teach?

A Primarily dental --

Q What?

A Dental, extractions and bone trims and biopsies, that sort of thing.

Q Extractions of wisdom teeth and how about the bones? I don't quite --

A Bone trim.

Q Bone trim?

A Yes.

Q You do some jaw surgery, too?

A *Yes.*

Q And that would involve wiring the jaws?

A Talking about the clinic or my practice?

Q In your practice?

A I do jaw surgery, of course, and jaw fractures and jaw fractures involves wiring the jaws, *yes.*

Q And you did say that you hold Dr. Lewis and Dr. Goldberg in very high esteem?

A *Yes.*

Q You would agree that both Dr. Goldberg and Dr. Lewis do an extensive amount of TMJ surgery?

A I don't know that Dr. Lewis does temporomandibular joint surgery. I know Dr. Goldberg does.

Q Dr. Goldberg does *extensive* arthroscopic surgery as well?

A Yes.

Q And you said Dr. Donald Lewis is a good friend of yours. Don't you, in fact, know that he does a very tremedous amount of open jaw internal derangement -- repair of the meniscus, repair of --

A I don't know that -- where the primary areas are done. They are done at Metro and University.

Q Would you also agree that Dr. Goldberg's talents as an oral and maxillofacial surgeon, and his expertise in the area of the TMJ and temporomandibular joint disorders, is recognized not only in Ohio, but outside of Ohio, as well?

A Yes.

Q Because Dr. Goldberg treats or teaches the main course, courses in temporomandibular joint dysfunction at Case Western Reserve Dental School, doesn't he?

A Yes.

Q When was the last time you taught in a classroom at Case Western Reserve?

A When I give -- I give a talk every Tuesday morning at the end of the session, and it's essentially a small classroom.

We talk on office emergencies and what to do in the case of a patient with a fast pulse,

slow pulse, various things tnat happen in the office. So I give little seminars each Tuesday.

Q Doctor, have you published on the subject of TMJ?

A No, I haven't, Mr. Callaghan, although I have one in tne process of.

Q The answer is that you have not?

A No.

Q Save you published in any other areas of surgery, Doctor?

A Yes.

Q Where would that have been?

A I published on Pagett's Disease. I published on Pentrane anesthesia, on a disease of the kidney wnich causes jaw lesions. I have had four publications mentioned.

Q Those have been published in the last ten years?

A No.

Q You haven't published anything in the last ten years?

A No.

Q And as a matter of fact, Doctor, you don't treat and manage temporomandibular joint patients, do you?

A I diagnose them and I see them --

Q Apart from diagnosing them, though, you don't actually treat them from the standpoint of their coming back on regular basis to see you?

A No. No, I would refer them if they need surgery.

Q To a dentist -- if they didn't -- I didn't mean to interrupt your testimony, but to a periodontist or dentist, isn't that true?

A *Yes.*

Q Now, Doctor, you testified I believe that you're *chief of* the department of oral and maxillofacial surgery at Mary Mount?

A That is correct, division of.

Q I'm sorry?

A I think it's a division.

Q I think you said that. Does anyone, in fact, perform TMJ surgery at Marymount?

A I don't believe so, nor do I believe it ought to be done --

Q I didn't ask that. *It's* a simple yes or no.

THE COURT: Please let the witness finish his answer.

A I don't know that. To my knowledge, I don't think anyone does temporomandibular joint surgery at

Marymcunt, no.

Q When you have a patient who requires TMJ surgery, to whom do you refer that patient, because as you testified, you don't do that surgery yourself?

A I have a feeling that not very many people need temporomandibular joint open surgery.

Q Let me rephrase that. For those patients whom you deem to need surgery of the temporomandibular joint, to whom do you send those patients?

A I'll answer that again, Mr. Callaghan. I don't believe that anyone needs temporomandibular joint surgery unless we are talking about arthroscopic surgery.

Arthroscopic, I would refer them to Dr. Thomas Henderson at Cleveland Metro.

Q Cleveland Metro?

A Yes.

Q So, apart from diagnosis, you do not treat medically any of your, any TMJ patients at the present time?

A At the present time, no.

Q As a matter of fact, you haven't in the last ten years, isn't that fair to say?

A Last seven years.

Q And you don't treat these patients surgically

either?

A No.

Q Have you at any time, doctor, treated patients with TMJ dysfunction from a medical standpoint as opposed to surgery?

A Yes, I used to.

Q And that was prior to seven or eight years ago, is that right?

A Yeah.

Q Do you have in your practice currently, patients referred to you by others, other physicians or treating specialists for treating TMJ dysfunction?

A Yes.

Q What is that for, diagnosis?

A Diagnosis, yes.

Q Doctor, have you at any time ever done any surgery on a patient with internal derangement of the temporomandibular joint?

A Yes.

Q You have actually performed surgery?

A Yes.

Q Where would that have been?

A Lutheran Hospital.

Q That was many, many years ago, wasn't it?

A Yes.

Q How many years, approximately?

A It would be bef re '73, but we did a lot of surgery in the '60's.

Q So it's fair to say, is it not, that the state of the art with respect to the understanding of the temporomandibular joint, its workings, the way it functions, the ideology or causes of damage to it, that that's changed quite a bit since the late '60's?

Is that true?

A That's correct.

Q Did you ever act as a lead surgeon in those cases?

A Yes.

Q And that was open jaw surgery?

A Yes,

Q Am I correct in understanding, Doctor, that your qualifications as an expert in this case, have primarily to do with your wide reading, your attendance at seminars and your attendance at lectures, is that right?

A No, I see a lot of TMJ patients in the office as I just explained to you, Mr. Callaghan, and we talk at great length, yes, talk about treatment, planning diagnosis, X-rays.

Q You diagnose TMJ patients clinically and --

A And radiographically.

Q Radiographically?

A *Yes.*

Q *You* don't perform arthrograms?

A No.

Q By the way, that is a painful procedure, isn't it?

A *Yes.*

Q So, let me rephrase it. Given the fact as we know now, you don't surgically treat and manage TMJ patients with internaf derangement?

You don't medically treat them. You don't see them on a regular and continuing basis. All rignt. Notwithstanding, and I understand your qualifications to testify in this case nave to do with your wide reading, your attendance at lectures, attendance at seminars and seeing patients that have TMJ?

A Diagnosing them, *yes.*

Q Okay. But you don't diagnose them through arthrograms?

A No.

Q Have you ever lectured on *the* TMJ, other than to lawyers?

A Not recently.

Q You have, in fact, lectured to defense lawyers, lawyers who represent defendants in these type of cases, on the subject of TMJ, haven't you?

A I may have. I have been at seminars. Whether they are all laywers or not --

Q Okay. Your Honor, I beg the Court's indulgence. (Pause.) I'm trying to find the correct report and I just found it.

Now, when you did an examination of Wendy on January 6th of '87, you found Wendy to be a person with normal dentition, isn't that correct?

A *Yes.*

Q You didn't find any wear facets that night be indicative of grinding?

A I didn't find any wear facets A, but, B, I don't think they are terribly significant.

Q I'm just asking if you found them?

A No.

Q Did you at the tine of your examination note any parafunctional jaw habits of any kind upon your physical examination of Wendy?

A I don't see how you could note parafunctional jaw habits during an examination, no.

Q One way would be to see the wear facet. I suppose another way would be to *see* or perceive a

malocclusion, a bite problem, isn't that true?

A That's not a parafunctional habit, Mr. Callaghan,

Q I'm sorry. It's caused by a parafunctional habit sometimes, is it not?

In any case, Doctor, you didn't find any malocclusions in Wendy's teeth either, did you?

A No.

Q Was there anything in her history that she gave you that suggests that she was a stressful or stressed-out person?

A NO.

Q Now, Doctor, you talked about microtrauma before, I tnink, and that is internal --

A Yes.

Q That is internally induced trauma?

A That's correct,

Q As opposed to extrinsic trauma?

A Yes.

Q And as a matter of fact, those microtraumas, that would be as a result of parafunctional jaw habits, I suppose, that involves the stretching of the ligaments inside of the interior capsule of the joint, doesn't it?

A Yes.

Q And I think I understood you to say with that situation as opposed to direct extrinsic trauma that they will stretch to a point where eventually pain will occur?

A *Yes.*

Q And there is no telling, is there, when the pain will occur with those microtraumas internally?

A That's correct. I think Dr. Goldberg says it or Lewis says it very well. It goes from a click to a louder click to a click and pop that doesn't hurt, to a pop that does hurt.

Q And as a matter of fact, you said, I believe on direct, that when the jaw is opened too wide you can stretch tne ligaments inside the capsule.

Isn't that true, whether *you* said it cr not, is it [redacted]

A Probably true, sure it is.

Q And, likewise, with a cervical whiplash injury, can you not stretch the ligaments inside the capsule without causing immediate pain?

A No.

Q Couldn't they *be* -- could they, in fact, be stretched minutely by a whiplash trauma?

A Yes, the same way that it could with an uncontrolled yawn, same way with a sneeze and the

same way it could with eating a Big Mac Burger.

Q And let's say that it takes, for example, and this might sound silly to you, Doctor, but bear with me.

A Okay.

Q We talked about these little microtraumas gradually building up where the ligaments are stretched far enough, I take it to the point where they lose their elasticity, their grip, and the disk would move anteriorly forward, right?

A Yes.

Q And it takes so many of those microtraumas to add up to a big trauma?

A Yes.

Q To enough stretching to accomplish that?

A Yes.

Q Now, is it not possible, Doctor -- am I boring you? I'm sorry?

A No, keep talking --

Q Is it not possible to have stretching as a result of cervical whiplash that doesn't tear off the meniscus, it doesn't rip it apart, but it stretches it just enough, it stretches those avascular ligaments on both sides such that you wouldn't experience pain at the time of the accident or

immediately thereafter?

A If you're talking specifically in this individual's case or generally --

Q We are talking about -- let's talk about generally first, then we'll talk about Wendy.

A Generally, it is possible for one act to give internal derangement.

Q Is it possible for one act not to create internal derangement, but to create a stretching of the ligaments such that maybe we skipped over about eight microtraumas, but we will needed another eight to get to the final trauma, the final slip?

A In the case of Wendy she already had internal derangement, as I explained to you, in 1984. And to answer your other question, can it skip over, if it skips over chat far it's a pretty painful injury.

That is like opening too wide or that is like doing something, oh, my gosh, what did I do to my jaw? It hurts.

Q Let's go ahead, You said that Wendy had internal derangement because she had clicking back in '84?

A Crepitus, yes.

Q Let's go back to that prior clicking before the accident, and, Doctor, take a look at your notes

because I couldn't understand it myself in reading the report why you also report a click in '82 if Wendy told you not only did she have a click in '84, but she had a click in '82?

A Because it says in my notes in '82, but then I read Dr. King's report and it was in '84.

Q Then you, in fact, you include in the report she had a slight click in '82 and '84?

A Yes.

Q So you made a mistakes?

A He may be incorrect. Probably '84. It's still the one episode. She reported it and --

Q And you have read through Dr. Ring's deposition, haven't you?

A I have.

Q The transcript?

A Yes.

Q And you know, as a matter of fact, that his testimony was that crepitus to him is that the general dentist meant any form of clicking, and further, that there were varying degrees of quote, crepitus to Dr. King,

You read that, You reviewed that with Mr. Borland?

A *Yes.*

Q But I take it that you are still standing by your reliance on what you saw in Dr. King's chart,

A *Yes.*

Q Would that clicking without pain, does that indicate internal derangement?

A *Yes.*

Q And that internal derangement is a TMJ dysfunction?

A If you got clicking you have internal derangement. That is the reason it clicks. It's sliding up and running over that little band on that displaced meniscus.

Q So a lot of people, I take it, in the general populous, generally without any other problems with their jaws, they have, in fact, have internal derangement if they have any clicking?

A That is correct. As a matter of fact, I just attended a seminar where they took *42* normal joints with people with no history of trauma, no history *of* clicking, no history of symptoms, and did an MRI and said they had 30 years of internal derangement -- it's a very complicated subject.

Q That *is* a TMJ dysfunction. But if you have an internal derangement that, doesn't necessarily cause

pain?

A That's correct.

Q It's when the derangement becomes more anteriorly displaced that it starts to cause pain, right?

A I'm sorry. I'm note sure about. I don't know wnat causes the pain, Other people have it for years and *don't* have pain,

Q Some people that have internal derangement versus others who have their discs farther forward, isn't that true?

A Right, but I don't know that there's a correlation between the further forward it gets ana the more it hurts. I'm not sure of that.

Q Doctor, I don't remember if you would remember writing this letter, December *5th of* 1988. It doesn't involve this case, but it's another case, opinion letter that you wrote to the firm of Gallagher, Sharp, Fulton and Norman.

And it's written under your heading there, Doctors Bell and Callahan, December 5th, 1988, and written to Mr. Singletary. Do you know him?

A Like a pen pale. I have written to him.

Q He's one of *the* lawyers at Gallagher's office?

A Okay.

Q You make a statement on page 11 of that report, Doctor, and I quote, opposite paragraph number three, 'and the conclusion --

MR, BORLAND: Excuse me. Has ne been provided a copy of this?

MR. CALLAGHAN: I'm not sure.

MR. BORLAND: Would you provide him a copy?

Q And there it says, and I quote, "I'm not convinced that the TMJ disorder includes popping and clicking alone." You said that, right?

A That's right.

Q Can you explain how that statement is consistent with your previous statement?

A An awful lot of people, as I explained, have popping and clicking and I think Dr. Goldberg and Lewis explained that to you, too.

If you have popping and clicking it's not necessarily TMJ disorder even though it's an internal derangement. Even though it's a, it's an anatomic finding, that has no significance,

If you don't have any pain you don't -- it's a pathologic existence which does not need treatment.

Q What you are saying, I gather, is internal

derangement is not always a TMJ disorder?

A That's right.

Q I asked you before wnether it was a TMJ dysfunction -- same thing?

A Okay.

Q So what you are saying, is that people can have a slight click as Dr. Goldberg and Dr, Lewis both testified -- in many, many people there is a perfect synchronization of the TMJ, right?

A That's right.

Q And many of us, literally speaking, we have internal derangement. In fact, I suppose internal derangement so slight *that* you wouldn't even have a click. Is that fair to say?

A I don't know. I don't know.

Q Wendy had -- would you now acknowledge, based upon the charts that you reviewed, the arthrogram, and the University Hospitals surgery, she had a very serious internal derangement, did she not?

A *Yes.*

Q Yeah. I believe your testimony was earlier that you don't know what causes pain after a patient gets -- gets the discs sufficiently anteriorly displaced -- you know what it's caused by?

A I know what causes the pains. I didn't say I

don't know what causes the pain. I don't believe that any more anteriorly or any more lateral extension of a disc dislocation necessarily puts one patient in great pain and another patient goes along and pays no attention to it,

What causes the pain is the retrodisc.

Q The nerves and the blood vessels are exposed?

A Yes.

Q That is not the only pain tnat you can feel in the inside of the joint as result of internal derangement, is it? That is part of the pain?

A NO.

Q isn't it a fact that there is, in addition to that inflammation, that sensitivity that I think you are talking about, tne retrodiscal pad, that their can be often, with internal derangement, bleeding into the joint spaces, and that in turn, along with the inflamation, can produce scar tissue?

A Yes, that's correct.

Q And the scar tissue itself isn't painful and neither is the process of the formation of the scar painful, isn't that right?

A Yes.

Q The scar tissue becomes painful, sufficiently painful, when enough scar tissue develops such that

movement of the jaw, microtears, if you will, tear up the adhesions and cause pain in the case of an internal derangement?

A But the disc is still coming from the disc area.

Q But that takes some time to develop after the disc has gone forward in some cases, doesn't it?

A Correct, but it starts with the click as I stated,

Q Let's go back to --

THE COURT: Let's take a recess, Ladies and gentlemen, you are not to aiscuss this case among yourselves. Do not permit anyone to discuss it with you or in your presence, nor form any opinion concerning this case.

(Thereupon, a short recess was had.)

Q Doctor, do you have your report in hand, October 12, 1987?

A I do.

Q I direct your attention to the top of the page, actually about a quarter of the way down, at the end of the first paragraph?

A What page?

Q Page four. I'm sorry if I didn't mention that. The last sentence -- well, let's go to the previous, so we can put it in context.

You're commenting here, are you not, about Dr. Brooks' orthopedic evaluation of Wendy, Dr. Brooks' being the defendant's expert in this case, isn't that true?

A Yes.

Q And at that time you were reviewing his chart or his report as part of your ability to evaluate Wendy's TMJ problem, isn't that right?

A Yes.

Q All right. And read along with me, Doctor, if you would, and we are referring now, are we not, to Dr. Brooks' opinion letter such as this opinion you wrote.

Now, in his letter to Mr. Borland, Dr. Brooks has a one paragraph summary in his letter in which he states in the early part of 1986 -- we know it was 1985, December, that in the early part of 1986 Mrs. Perin consulted Dr. King the dentist because of continuing jaw pain.

He concludes that paragraph by stating that she was referred to Dr. Lewis and he discussed

surgery with her.

These are Dr. Brooks' words that you are paraphrasing, I take it, right?

A That's correct.

Q "He makes no other comment about her alleged TMJ complaints, nor apparently did Mrs. Perin bring any complaint to Dr. Brooks' at the tine of her examination on April 13, 1987 of TMJ dysfunction or complaint."

Now, Doctor, this, as we know, this report was written October 12 of '87, at a time wnen you knew the surgery had already been performed on Wendy, right?

A Yes.

Q And she had a serious enough internal derangement problem to necessitate surgery and that surgery gave her relief certainly by the time you had written this report?

A *Yes.*

Q You knew that because the surgery was accomplished in June of 1987?

A ***Yes.***

Q There are two things that concern me, Doctor. "He makes no other comment about her alleged TMJ complaints."

Why did you say "alleged," Doctor? At that point, Doctor, you knew as well as we know today they weren't "alleged." She had complaints and it was her real injuries that necessitated surgery,

Why did you say allege?

A I don't know why I said alleged in that particular instance. She had symptoms when I saw her.

Q Do you think that statement might help the defendant?

A No.

Q You didn't think it was going to help the plaintiff. You didn't put it in there for that reason.

Why did you think it was significant, Doctor, that Dr, Brooks or that Wendy didn't bring any complaint of TMJ disorder to Dr. Brooks in April of 1987 when, in fact, she was going there for the sole purpose of being examined orthopedically by a doctor she never expected to see again and by a doctor who was hired by the other side in this case?

A Because, Mr, Callaghan, if you see an orthopedic surgeon you would talk about temporomandibular joints. The orthopedic surgeon deal with joints, and I don't know --

Q But she had --

THE COURT: Just a moment, complete your answer.

THE WITNESS: They will with joints, and very frequently if you have a joint disturbance I would tell a joint doctor about it.

Q Doctor, she had, as you paraphrase it here, she had, indeed discussed it with Dr. Brooks and told him about the history, but that she didn't complain to him at that tine and apparently you thought that was significant, isn't that so?

A Can I answer that by finding Dr. Brooks' letter? I think the second -- she did not apparently bring any complaint to Dr. Brooks at the time of her examination in April 13, 1987.

Q Yeah?

A It's not particularly significant. It's just part of the report. This is one of the things I found from reading the report.

There is no other basic underlying significance.

Q Because it's reasonable to assume now, appreciating Wendy's history, that in April of '87, just a month and a half or month and three quarters

before the surgery that she was having problems with her internal derangement, with her TMJ at that time, That would be a fair statement?

A Yes, but what I find unusual about that, most TMJ patients I see will tell everybody; tell the cleaning lady running the vacuum sweeper. It's attached a great deal of --

Q Maybe she's not a complainer and she knew she was going to have surgery?

A That may well be.

Q And didn't necessarily trust an orthopedic surgeon whom she never met and only there for one occasion ana going there for advice on her TMJ when she was treating with Dr. Lewis --

MR. BORLAND: Are you testifying or is that a question?

THE COURT: The objection is sustained,

A It's not a --

THE COURT: The objection is sustained, Doctor.

Q Do you believe Dr. King now when he says, as he did in his testimony, that Wendy had a slight click in February of 1984 and not that grating and grinding which you interpreted that crepitus notation to mean?

A I simply don't know the answer to that. Dr. King writes such sparse notes. I don't say that in a pejorative manner. He said crepitus.

If I take that in context really only I meant a slight click. Then you ought to have written that down but, in fact, he didn't.

Q But you had an opportunity to review his testimony, right?

A *Yes.*

Q As a *matter* of fact, that is one of the advantages of testifying live here today rather than on videotape, because these transcripts have been available since August and you have had a lot of opportunity to review then with Mr. Borland, isn't that a fact?

A I don't think I saw the transcripts until last Wednesday or last Thursday.

Q Normally --

A They may have been available --

Q Normally, of course, had they been testifying live, there would have been a separation *of* witnesses and you would not have been able to view their testimony had they been?

MR. BORLAND: Objection. What is the point of all this?

THE COURT: The objection is sustained.

Q Now, on that same page, Doctor, in page four, last paragraph, I would appreciate it if you would read along with me.

"However, there is one other finding which is significant on Dr. King's chart. I have before me a chart that indicates Dr. King did a routine dental examination of Wendy's teeth and existing fillings on that chart.

In very easy to read writing, is the following notation, that you referred to, crepitus, 2-84, in quotation marks. Where did -- the word crepitus is used frequently by dentists to indicate TMJ clicking or popping which you also testified to.

No problem yet. Dr. King indicates that Mrs. Williams-Perin, had crepitus, cracking grating, in February of 1984. This is one and a half years before her moving vehicle collision and almost two years before she sought help from Dr. King about her TMJ.

Then you go onto say on the same page, and in the same writing, and apparently with the same pen, Dr. King indicates bite plane. I must infer from this that the patient had crepitus, TMJ

symtomatology, and need for a bite plane approximately one and a half years prior to her moving vehicle collision?"

A Yes.

Q Right. Do you have a copy of Dr. Ring's chart in your file, Doctor, and if you do --

A *Yes.*

Q May I see it? May we approach the bench?

(Thereupon, Plaintiff's Exhibits 11 and 12 were marked for identification.)

Q Doctor, handing you what's beer, marked for identification as Plaintiff's Exhibit Number 11, can you identify that?

A *Yes,* that is the same -- I have the photocopy. This is a photocopy. It is -- shall I explain to the jury what it his?

Q Is that Dr. King's chart?

A Yes.

Q May I see your copy? These copies seem to be different, Doctor. In fact, on my copy crepitus is very light. Isn't it marked, 2-84 and bite plane is very dark, isn't it?

A *Yes.*

Q But on yours, crepitus appears to be quite a bit more bold, doesn't it?

A Yes, correct, but since those are the only two notations on this one side of the page I presume they were done at the same time.

I have found since that they were done with a different pen. I can't tell.

Q Handing you now what's been marked as Plaintiff's Exhibit Number 12, can you identify that for us?

A Why sure. One is done in red, and this, of course, I can't tell that. I'm just given a copy and it looks like the same handwriting and same type of pen and since they are only two notations it's logical to asume bite plane and crepitus have something to do with one another.

Q I see. Yours came out darker than mine, Let me refer you to the front page of that report, Doctor. That is the clinical record?

A Yes,

Q And does yours look the same as mine other than there were a few extra visits? I'm handing you the original now.

A Yes,

Q Yours cuts off there?

A Yes.

Q And I refer you to about line number seven where it says one, 4-85,

A Yes.

Q Bite plane seated?

A Yes.

Q Look at my original, if you would, Plaintiff's Exhibit Number 12?

A Okay,

Q All right. Is there any other writing, and that is opposite January of '86. Is there any other writing on that, the front of the chart in black, I think, similar to this --

A Yes,

Q Isn't that a felt tip pen? Does it appear to be?

A It's really not my field of expertise. I don't know. I think it's a felt tip.

Q Let me stop the inquiry, I'm not trying to jump on you. We see bite plane on the chart on the diagrammatic, do we not?

A Yes.

Q And with the same pen, January of '86, bite plane seated, right?

A Yes.

Q So we can conclude, logically, I think, you would agree with me, that the bite plane was written here at the same time that the bite plane was seated in '86?

A Yes.

Q Not in February of '84?

A That is true.

Q So your inference to the fact that you said that you must infer from that hat Dr. King detect a need for a bite plane, you would back off on that statement now, wouldn't you?

A Well, *yes.* I already explained that to you, Mr. Callaghan, that I see it in only *two* entries on one page. And I presume they would have made them the same day. It's reasonable.

Q And, Doctor, going back to your visit of January of '87, at that time were you concerned how minor or slight the click that Dr. Ring talks about, how that had progressed from the time of February of '84 to the time of her automobile accident in August of '85?

A Was I concerned?

Q Were you interested *to* know the progression or lack of progression of that click between the time it was noted by Dr. King in February of '84 to how it

was doing by the time of the accident in August of '85?

A Not specifically. I'm not, Mr. Callaghan, and I'll tell you, because Dr. King told Miss Williams -- she told us she had a click. He said, quote, don't worry about it. So I presume it would been redundant for her to tell him again about it.

Q I'm asking whether you thought it was important for you to know, in assessing the causation, evaluating the causation or lack of causation of this accident to Wendy's internal derangement, and by that, wouldn't it have been important for you to inquire at tne time of the examination, hey, Wendy, has that click been getting *worse* or is it the sane or is it not present at all since the time it was noted by Dr, King in 1984?

A *Yes,* that might have been worthwhile.

Q As a matter of fact, you never did ask tnat question?

A Well, I asked as many questions as I could, Mr. Callaghan. I don't know wnether I asked that one or not.

MR. CALLAGHAN: Thank you, Doctor. I have nothing further.

--- *000* ---

# CERTIFICATE

I, Thomas C. Walters, Official Court Reporter for the Court of Common Pleas, Cuyahoga County, Ohio, do hereby certify that as such reporter, I took down in stenotypy all of the proceedings had in said Court of Common Pleas in the above-entitled cause; that I have transcribed my said stenotype notes into typewritten form as appears in the foregoing Excerpt of Proceedings, that said transcript is a partial record of the proceedings had in the hearing of said cause, and constitutes a true and correct Excerpt of Proceedings had therein.

THOMAS C. WALTERS,
Official Court Reporter
Cuyahoga County, Ohio

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Doc 100

November 7, 1994

Law Offices of
Richard J. Hartman
The 113 St. Clair Building
Suite 525
Cleveland, Ohio 44114

Attention: Mr. William H. Rider

Re: Marie A. Liapis

Dear Mr. Rider:

Please be advised that I have had adequate opportunity for oral, regional, radiographic, and historical examination on the above-named patient, Mrs. Marie Liapis, a 50-year-old homemaker. The examination took place in my office on 10/7/94. The examination was in regard to alleged injuries suffered by Mrs. Liapis to her temporomandibular joints as the result of a moving vehicle accident. Please be further advised of the following information which I believe to be germane to these alleged injuries.

I. *History* as related by the patient, with some marginal input provided by her husband who accompanied her *to* the office examination.

Mrs. Liapis states that she *was* involved in an MVA which took place on May 9, 1991. She was the driver, and she was restrained with both a lap and a shoulder harness. At the time of the examination, according to Mrs. Liapis, she suffered injuries to her neck, shoulder, and back. She denies having suffered any cuts, lacerations, or bruises. She denies having struck any object on the inside of the car. She stated, "Oh, no, I didn't strike anything because I had a *seat* belt on."

She drove home, but later presented herself to the Emergency Room at Fairview Park Hospital. Her chief complaints at that facility were those of "back, shoulder, neck, and lower back." I asked Mrs. Liapis at that juncture if she was having any jaw discomfort or jaw symptoms. She stated that she was not. This observation is corroborated by the Emergency Room Report, wherein there is absolutely no mention

made of any jaw or facial pain or jaw injury. Later she went to the office of her physician, Dr. Fitch, M.D. *She* recommended physical therapy. Her TMJs were asymptomatic at that time.

More than *two* and one-haif months later, according to the patient, she made her first presentation *to* Dentist James Moodt vis-a-vis putative TMJ complaints. Mrs. Liapis states that she went there because "My jaws were clicking when I opened wide." I pointed out to Mrs. Liapis that clicking in the TM joints, by itself, does not constitute a pathologic condition. This is because it occurs in approximately 62% of the adult population at any given time, Nevertheless, she states that Dr. Moodt made a bite splint for her which she wore during sleeping hours thereafter. I asked if it gave her any relief. She stated that she was getting somewhat better gradually, and that the clicking began to improve. However, she adds at that juncture, he problem was not only clicking but "numbness." The numbness was, apparently, of the left face. Inasmuch as numbness is not, and has never been, either a sign or a symptom of temporomandibular joint disorder, I remain somewhat uncertain vis-a-vis the provenance of this alleged numbness.

On November 19, 1993 Mrs. Liapis was involved in a second MVA. Once again she was restrained with a seat belt and a chest and lap harness. Once again she denies having struck any object on the inside of the automobile, nor did she suffer any cuts, lacerations, or bruises. However, she returned to Dr. Fitch, who told her that she had aggravated her injury. Dr. Moodt told her *the* same thing. She believes that from that time to the present she has had no evidence of progress, but rather that her jaw symptoms, now expanded to include pain upon the act of chewing and headaches, has deteriorated. She adds that her jaw is stable as long as she is able *to* wear the bite splint. At the time of my examination, Mrs. Liapis was planning to have arthroscopic jaw surgery, Since my examination of Mrs. Liapis, she has had bilateral arthroscopic surgery done on her temporomandibular joints.

II. Review of the Charts and Records.

Inasmuch as this is a voluminous portfolio, let me present a brief distillate of salient products from the portfolio which I believe to be germane.

A. Mrs. Liapis was involved in a previous MVA which took place in September, 1986. It left her with a residual and persistent dull ache of the right shoulder, sharp shooting pain in the left cervical area, and chronic neck pain, She was being treated as late as 7/87 for *this* disorder. The MVA also produced right shoulder numbness, chronic neck pain, and difficulty in driving an automobile,

She also lists in a medical history questionnaire, "joint pain related to car accident" in March, 1987. The site of the joint is not disclosed.

B. The patient has had headaches since at least 1987, and in her prior charts at St. John and West Shore Hospital at a weight control clinic, headaches are *Listed* as one of her physical problems on virtually every one *of* her charts throughout the Spring of 1987. She listed the headaches at one time as being sinus related, and she eventually had headaches which were so severe that they were awakening her at night. She described the headaches to ENT Physician, Dr. Howard Levine, as being in the right face and right cheek area. Again, I believe that these arose from the paranasal sinuses, but that did not turn out to be the case. The examination by Dr. Levine and x-rays of the paranasal sinuses on 1/6/93 showed normal sinus architecture.

Dr. Fitch noted on March 20, 1992 that the patient had pain in her face, and on 12/8/92, she complained of "ears hurt" and on 1/6/93, the patient complained that she had "facial pain and ears hurting." The patient complained of facial pain frequently after her two MVAs. However, it *is* evident that: the patient complained of facial pain many times before her MVAs. She attributed her pain before the MVAs to sinusitis. However, there is good evidence that she did not have sinusitis. Further, pain in the ears *is* not diagnostic nor suggestive of sinusitis. Rather, pain in the ears is strongly suggestive of chronic temporomandibular joint disorder. It is my suspicion that Mrs. Liapis had this disorder prior to her MVAs.

C. At the time of her presentation to the Emergency Room at Fairview Park Hospital, Mrs. Liapis made no complaints vis-a-vis temporomandibular joint dysfunction or pain. Nor, in fact, did she do so for another two and one-half months after her MVA. Clicking was noted in June, but with no other symptoms. A diagnosis made by attending physician, Dr. Fitch, on 6/18/93, notes specifically That her two diagnoses were only those of acute cervical strain and back pain. that was more than one month after her MVA, and she was not having any TMJ symptoms, Further, the entire volume of charts from her physical therapists, Health South and Fairview Park Physical Therapy, makes a great number of entries in regard to back, shoulder, and neck problems. There was virtually no mention of jaw or TMJ disorder throughout the entire charting.

noted 6/18

D. An MRI examination taken in April, 1994, shows normal TM discs, and normal temporomandibular joint apparatus, This finding is supported by tomograms taken by Dr. Moodt in July of 1993.

Equally significant, I believe, is an observation made by Dr. Moodt in a letter to Dr. Murphy on 7/27/94. Therein he comments on his own tomograms. He states, "There is no question that these radiographs do suggest the development of some arthritic change within the temporomandibular joints which certainly would have predated her initial accident." I believe that observation is accurate. I believe that she had osteoarthritic changes and TMJ symptoms which predated her initial MVA by a tong time.

III. Oral, Regional, and Radiographic Examination.

As was previously mentioned, this took place in my office on 10/7/94. I believe the following observations *are* germane to Mrs. Liapis' current jaw status.

A. Her panorex x-rays show a suggestion of osteoarthritic changes in both TM joints. Panorex x-rays are not definitive, however, and I believe that Dr. Moodt's tomograms are more significant. They also show osteoarthritic changes which predated her first MVA.

B. When she opened, Mrs. Liapis was able to reach an interincisive aperture of 38 millimeters. This is within normal limits for females. Nevertheless, she presented so muck guarding that I was unable to record any other measurements.

C. When I palpated her muscles of mastication, she had slight tenderness in the left masseter, but no other notable palpable muscle tenderness.

D. When I listened for clicks, I was unable to hear any. However, she declined to open again wide enough so that I could hear any clicks.

E. Nevertheless, although I was unable to complete my examination satisfactorily, it is my opinion that Mrs. Liapis was, indeed, having same TMJ pain on the left side at the time of the examination.

F. Two weeks after my examination was completed, Mrs. Liapis underwent surgery performed by Dr. Michael Hauser at Mount Sinai Hospital. His findings at the time of surgery were definitive. He discovered that *the* patient had significant anatomic internal derangements of both TMJs, including displaced discs and adhesions within the superior joint space, It was his view that the medical history indicates that the history and progression of her symptoms are consistent with traumatically induced TMJ internal derangement.

N. Discussion.

Temporomandibular disorder (TMD) is a rather common disease. It occurs in females in a ratio of nine to one over males. Dr. Samuel Dworkin, writing in the Journal of Prosthetic Dentistry, 72:29-38, 1994, agrees that TMD is a chronic pain condition, sharing major characteristics of other common chronic pain conditions. He adds that these patients can be differentiated, not on the basis of observable organic pathology, but according to their ability to cope adequately with their condition. He states, "The majority of chronic TMD patients cope well, but a small proportion, the psychosocially dysfunction segment, shows a higher rate of depression and health care use." I believe this is true, and further that Mrs. Liapis fails under the aegis of a chronic pain patient. I believe Mrs. Liapis has had TMD symptoms and signs for a long time prior to either one of her MVAs, and that they went undiagnosed. She has had facial pain, ear pain, headaches, and pain behind the eyes, all of which are suggestive of TMD, dating back to her charts at least six years prior to either one of her MVAs,

I believe further that the primary Source of injury and irritation to her discs and to her internal joint structures, including the production of adhesions, arises primarily and exclusively from her longstanding degenerative joint disease. This degenerative joint disease, which I note in concert with Dr. Moodt, is noted on his tomograms, and is a matter which he specified in his letter to Dr. Murphy in which he states, "There is nu question that these radiographs do suggest the development of arthritic change within the temporomandibular joints which certainly would have predated her initial accident." I believe that is true as well. I believe the degenerative joint disease was the result of arthritic changes within the joint, and these arthritic bond edges irritated and damaged the internal structure of the TM joint and produced disc displacement. All of this took place long before either one of her MVAs.

Drs. Moodt, Murphy, and Hauser all believe that there is a causal relationship which exists between Mrs. Liapis' two MVAs and her eventual treatments for TMD. I believe, on the other hand, that there is no compelling support for such a cause-and-effect relationship, My doubts vis-a-vis causality arise from two separate and distinct areas.

There is good evidentiary material before me which suggests that Mrs. Liapis had chronic TMD prior to either one of her MVAs. She had a great number of symptoms which strongly suggest, as a cluster, a diagnosis of TMD. These include previously mentioned episodes of facial pain, ear pain, pain behind the eyes, and headaches. However, after her first MVA, she did not report any TMD problems. It was not until two and one-half months later that she first sought treatment. Specifically, one

month afterwards, her physician, Dr. Fitch, did not list jaw problems in her summary of symptoms. Two and one-half months is a long time between an episode of trauma and the first seeking of treatment. She had no symptoms during those two and one-half months. After all, injury to a jaw joint is rather like injury to any other joint. When you hurt it, it hurts right away and it hurts very badly, When we see football players on our TV screens who injure one of their joints, perhaps the elbow, or the knee, or the ankle, they roil about on the field in a great deal of distress. They do not report it or seek treatment two and one-half months later. I believe the time hiatus makes a causal relationship somewhat unlikely.

A bigger problem, in my dental opinion, in making a causal relationship arises from the fact that neither of Mrs. Liapis' MVAs produced any direct trauma. She was restrained in both instances, and she struck nothing on the inside of the car. Common wisdom tells me that you cannot injure temporomandibular joints in the absence of direct trauma. There is a plethora of research articles which have been published in the last few years which supports this avenue of common wisdom. I will only cite a few.

An internationally known expert, Dr. Daniel Laskin, writing in the Journal of Oral and Maxillofacial Surgery, Vol. 50, pp. 825-828, in an article entitled "Incidence of TMJ Symptoms Following Whiplash Injury" that he designed a series including 155 patients to analyze the development, if any, of TMJ pain and dysfunction following cervical musculoskeletal injury (whiplash). The study revealed, "No clinical evidence of a significant relationship between cervical musculoskeletal injury and the development of TMJ dysfunction."

p. 827 "Although our data . . . same article says "Trauma may be both an important cumulative + precipitating event in TMDs"

tearing of the posterior attachment shown on arthrogram

Pullinger, writing in Oral Surgery, Oral Medicine, Oral Pathology, 71:529-34, 1991, in an article entitled "Trauma History in Diagnostic Groups" states that "It's been suggested that whiplash can produce disc and disc ligament trauma from indirect hyper-propulsion injury (jawlash)." However, the authors have found "traumatic tearing of the attachment in direct injuries to be exceptionally rare." The authors add, "We find it difficult to accept trauma-induced disc tears . . . in the absence of direct trauma to the jaws, and suspect a preexisting problem when . . . "

from another study

Finally, without belaboring the subject, Goldberg writing in the Journal of Cranial Mandibular Disorder, 4:131, 1990, states that his studies indicate that anterior disc displacement is an unlikely consequence of a motor vehicle accident without a preexisting history of dysfunction.

Not based on his studies' opinion - rev

However . . .

* Finish paragraph

Finally, as a tangential observation, let me point out that the article by Dr. Laskin which states that indirect injury in the absence direct injury does not cause TMD was published by Dr. Moodt in his office newsletter and mailed to me.

As for Mrs. Liapis' prognosis, I believe that it is favorable. I base this opinion on Dr. Hauser's preliminary report. Arthroscopic surgeries on TMJs have a very high rate of success, however. I would lightly disagree with Dr. Hauser in two other minor areas. I do not believe that Mrs. Liapis' injuries are permanent. TMD is a self-limiting disorder, Jaw joints have a favorable quality of remodeling, and it has been my experience that most patients become symptom free after arthroscopy and sufficient physical therapy. Finally, I believe that under no circumstance will Mrs. Liapis ever need orthodontic treatment to correct her longstanding malocclusion. Orthodontics is not a treatment for temporomandibular joint disorder.

V. Summary.

Based on the evidentiary material before me, it is my dental opinion that it is difficult to *make* a reasonable cause-and-effect relationship between Mrs. Liapis' two MVAs and her longstanding bout with temporomandibular joint disorder, I believe her long-standing osteoarthritic changes which predated her first MVA caused her internal derangement. Further, I believe that in the absence of direct trauma, the likelihood of either one of the two MVAs producing internal derangements is slight. Finally, the time hiatus between her first MVA and her first seeking treatment, two and one-half months, during which time she had no TMJ symptoms, makes a causal relationship somewhat unlikely.

If you have further need of information, please so advise me.

Sincerely,

Kenneth R. Callahan, D.D.S.

Kenneth R. Callahan, D.D.S.
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December 5, 1988

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Sixth Floor - Bulkley Building
1501 Euclid Avenue
Playhouse Square
Cleveland, Ohio 44115

Attention: Mr. Gary Singletary

Re: Kathleen A. Rowan v. David Kermode
Your File No. 900-88557

Dear Mr. Singletary:

Please be advised that I have had adequate opportunity for oral, regional, radiographic, and historical examination on the above-named patient, Ms. Kathleen Rowan, a 22-year-old female bookkeeper. The examination took place in my office on December 2, 1988. The examination was in regard to alleged injuries suffer?.? by Ms. Rowan to her temporomandibular joints and to her upper front tooth as the result of a moving vehicle collision. Please be further advised of the following information which I believe to be germane to these alleged injuries.

I. History as presented by the patient.

Ms. Rowan presented herself to my office for examination together with her attorney, David Mast, Esq., an attorney with the firm of Spangenberg. Mr. Mast tape recorded our conversation. Ms. Rowan states that she was in apparent good health until June 1, 1986, on which date she was involved in a moving vehicle collision which took place on Ford Road in Madison, Ohio. Ms. Rowan states that she was the front seat passenger, and she was not wearing a seat belt. In regard to direct injuries to her person at the time of the MVA, Ms. Rowan states that "I struck the side of my left face with the dashboard." She denies having suffered any lacerations to her jaws or to her teeth. She alleges rather that she had a corneal laceration. She states further that she was conveyed by ambulance to the Emergency Room at the Northeast Ohio Hospital. In the Emergency Room of that facility, she had multiple X-rays taken. I asked Ms. Rowan specifically which X-rays were taken, and she stated, "Practically my whole body." She was discharged thereafter to her home.

Upon arriving at her home, Ms. Rowan realized that she chipped her left upper central incisor tooth. The chip is on the incisal angle, and it is not very extensive. Ms. Rowan alleges that she had jaw complaints at the time of her presentation to the Emergency Room, and that she informed the Emergency Room doctor about it. She also alleges that jaw X-rays were taken (she thinks) at the time of her presentation to the Emergency Room. For the record, let me point out that the Emergency Room report for the Northeast Ohio General Hospital does not bear out these allegations. Rather, that document states only that Ms. Rowan complained of pain in the shoulders, neck, face, right eye, and right side of the forehead. The Emergency Room physician made a final diagnosis of corneal abrasion, and multiple contusions. There is no recorded evidence of any complaints vis-a-vis temporomandibular joint pain nor jaw pain. The radiologist's report from that same hospital on the same day indicates that, indeed, multiple X-rays were taken which included bilateral ribs, skull, cervical spine, clavicles, and knee. However, the radiology request states that the patient's clinical history "complains of pain in the shoulders, neck, eye, and knee." Again, there is no evidence of complaints vis-a-vis TMJ problems, nor was any X-ray taken of the jaws nor were there any X-rays taken of the temporomandibular joints.

Ms. Rowan continues in her history, stating that it was suggested by the Emergency Room doctor that she see her dentist, and that she put eye cream in her left eye. The following Monday, according to Ms. Rowan, she went to her dentist, Dr. William Koenig, DDS. Ms. Rowan alleges that Dr. Koenig filed down the sharp edges of the chipped front tooth but did not place a filling in it. She gives as his reason the fact that she did not have up front money to pay for it. Apparently, Ms. Rowan made no complaints to Dr. Koenig in regard to her temporomandibular joint problem.

Next, Ms. Rowan states that she saw her family physician, Dr. Smith, MD. She states that she saw him only for her neck and for her back. She quotes him as telling her that "the neck could hurt for a year." However, he did not treat her. Ms. Rowan continues in her history, stating that she eventually went to see another dentist, Dr. Kenneth Kosovich, DDS. She states that she saw Dr. Kosovich in February of 1987. She states quite specifically that the reason she saw Dr. Kosovich in February of 1987 was "because

I wanted my tooth fixed." However, instead of fixing her tooth, Dr. Kosovich told her, in his view, she had temporomandibular joint problems. At this juncture, I asked Ms. Rowan specifically if, indeed, she had gone to see Dr. Kosovich in regard to any temporomandibular joint complaints. She answered, "No. . . I didn't think I had temporomandibular joint problems." She adds that he only discovered this malady by doing an examination. Inasmuch as it has been my experience over many years to note the fact that patients usually discover temporomandibular joint pain and discomfiture well before they go to a dentist to tell about it, I was, of course, baffled by Dr. Kosovich's unusual discovery *of* TMJ symptoms in a patient who did not complain of any TMJ symptoms. I, therefore, asked Ms. Rowan what it was that Dr. Kosovich discovered. She stated, "I had a popping noise . . . I told him about the popping. . . he did something with my neck . . . he could tell where it was hurting." She adds that her neck was still hurting and her shoulders were still hurting at that time (February of 1987). Ms. Rowan adds that Dr. Kosovich then made her a bite splint or bite guard. He also referred her *to* an osteopathic physician, Dr. Thomas, D.O. Dr. Thomas, according to Ms. Rowan, "put electrodes and wires and hot packs on my back and shoulders." Again I asked Ms. Rowan if she had told Dr. Koenig about the clicking of her jaw, at the time of her appointment with him. She answered, "No, that was only two days after the accident."

Ms. Rowan continued in her history, alleging that "Dr. Kosovich made the splint for me because I was chewing more on one side than the other, and it would switch back and forth." This observation appears to me to be incorrect. On her first visit to Dr. Kosovich, February 28, 1987, in answer to an interrogatory which Ms. Rowan filled out herself, she answered the question, "Do you chew on only one side of your mouth?" by indicating "No." Apparently, however, at her first visit to Dr. Kosovich, Ms. Rowan was not having TMJ pain symptoms. She adds, "It was screwing up my ears . . . it popped my ears shut." However, when I asked Ms. Rowan when the popping began "to pop her ears shut," she stated, "I'd have to say after the splint had been made and put in my mouth." Nevertheless, even though it apparently caused popping, Ms. Rowan alleges that she wore the bite splint twenty-four hours a day. She states that she chewed through three of them. She adds, "I chewed right through them." Inasmuch as this indicates some degree

of clenching, a parafunctional habit which is very common, and frequently a causative factor in temporomandibular joint dysfunction, I asked Ms. Rowan if she, indeed, was a clencher. She denied doing so. She adds that sometime thereafter, when the popping and clicking were continuing, she was referred by Dr. Kosovich to an oral surgeon, Dr. Karl Schneider, DDS. This was not until March of 1988, however. The time lag was explained by Ms. Rowan, "I had a kid in between." Ms. Rowan adds that Dr. Schneider also made a hard plastic bite splint for her, and then another one after that, the reason being "I chewed right through it."

In regard to current symptoms, Ms. Rowan states only that she has headaches, jaw aches (only on the left), her ears pop, but she is able to eat a normal diet. She adds, "certain foods give me a problem . . . when you're wearing a splint, you can't chew gum and you can't eat a steak."

II. Review of the Charts and Records.

1. The Emergency Room report from Northeast Ohio General Hospital dated 6/1/86 indicates, indeed, that Ms. Rowan did visit that facility on that date. Her chief complaint, however, as previously noted, was that of "pain shoulders, neck, face, and right eye." There is no mention of temporomandibular joint nor jaw discomfort. There is a note that she had a redness of the right side of the forehead, and an abrasion of the upper right eyelid. She also had tenderness of the muscle on the right neck, and tenderness over the shoulders and the clavicle. Her final diagnosis was that of corneal abrasion and multiple contusions. Again, the X-ray report indicates that her chief complaints to the radiologist were those of pain in the shoulders, neck, right eye, and right knee. No X-rays were taken of the jaw or of the temporomandibular joint, nor is there any mention made of temporomandibular joint or jaw distress.

2. Letters and Chart from Dr. William Koenig, DDS. Dr. Koenig's chart indicates that his office only saw Ms. Rowan on two occasions in 1983, and not at all in 1984 and 1985. Two days after her MVA, on 6/3/86, Dr. Koenig notes on his chart that Tooth #9 (the upper left central incisor) had an incisal angle fracture. Dr. Koenig

suggested bonding the tooth in order to repair it. He did not do the bonding procedure, which he quotes as between $65 and $75, because, as Ms. Rowan had suggested in her history, she did not have the money up front. However, the chart makes no mention of any injury to the jaws or the temporomandibular joints.

A letter from Dr. Koenig dated February 6, 1987 restructures his statements on the chart, and negates the notion of putting a crown on the tooth. Dr. Koenig also believes that permanent nerve damage to the tooth is highly unlikely because of the small amount of external damage to the tooth. Again, Dr. Koenig makes no mention of any temporomandibular joint injury, nor any temporomandibular joint discomfiture, two days after her MVA. Instead, he talks only about the tooth. I presume this is because Ms. Rowan talked only about the tooth. However, Dr. Koenig suggested to Ms. Rowan that she was informed to return to his office if she suffered any more discomfort, which she did not do.

3. Charts and Letter from Dr. E David Thomas, D.O., dated November 9, 1987. Herein, Dr. Thomas indicates in his chart that he did not see Ms. Rowan for the first time until March 7, 1987. That is more than nine months after her MVA. Dr. Thomas treated Ms. Rowan with various physical therapies. In his letter, Dr. Thomas states that Ms. Rowan's chief complaints consisted in neck and back pain throughout the entire spine, headaches, and pain when chewing her food, with the center of her pain being in the neck region. Dr. Thomas notes that Ms. Rowan had headaches after the accident, but he also notes that she had headaches prior to the accident. Dr. Thomas' treatments were on an interim basis, and they extended for approximately fifteen months.

4. Charts and Letters of Dr. Kenneth Kosovich, D.D.S. The charts indicate that Dr. Kosovich did not see Ms. Rowan until February 28, 1987. Again, that is nine months after her MVA. In her interrogatories, which she filled out herself, she states that she was having pain in and around the ears. She does not agree that she had popping or clicking or snapping noises in her jaws. In answer to the question about discomfort about the time of the examination, Ms. Rowan stated that it was only "occasionally."

Hereafter, Dr. Kosovich's charts turn into a murky cryptogram. It is, in my opinion, an attempt to dissemble. To begin with, Dr. Kosovich states in the same paragraph that the patient is "four months pregnant" and at the same time, and on the same day, he took a full series of dental X-rays. It is my understanding that taking a full set of dental X-rays, subjecting the patient to a great deal of radiation exposure when the patient is four months pregnant, is considered by most of us to be unacceptable practice. It is my belief that a full set of dental X-rays on a patient who is four months pregnant is a dental oxymoron. Furthermore, Dr. Kosovich presents the same chart twice. The original chart is legible enough to be understood. Nevertheless, he has transcribed the second chart, in which he has added a great deal of after-the-fact information. It is my belief that that process is called '"doctoring up a chart" and I believe it is not acceptable in any way. What he has done is add some perjorative and advocational comments to a chart which has already been finished. The comments were put in on March 8, 1988, and they refer to a charting which has already been completed on March 17, 1987. I simply reject that misuse of a patient's chart, not because I believe it to be inappropriate, but rather because I believe it to be unlawful. One cannot doctor up a chart after the fact. You can't erase from it, you can't scratch things out, and you can't add on to it. I should, therefore, 1ike to approach the original chart as it stands.

In the original chart as it stands, Dr. Kosovich notes that he saw the patient for the first time on February 28, 1987. He did a number of silver fillings and temporary fillings on Ms. Rowan between February 28, 1987 and October 8, 1987. He notes that the patient was having pain, presumably in a tooth because he did a pulp capping on the tooth (Tooth #14), and then he noted that the patient had a possible sinus infection. He did not note that the patient had any tempormandibular joint complaints, nor does he make any observations in regard to jaw or TMJ discomfiture or injury. In fact, he does not mention TMJ in his chart until October 8, 1987. At this time he notes that there is TMJ, left symptoms. But the reader should be mindful of the fact that in all the eight months that Dr. Kosovich treated Ms.

Rowan, he had her mouth open on a great number of occasions very widely in order to fill the teeth. She did not complain of TMJ symptoms at that time. She only complained of sinusitis. It was not until October 1987, sixteen months after her MVA, that he notes any TMJ symptoms. On 3/8/88, in his addendum, Dr. Kosovich states that he now believes that the pain that the patient suffered was due to a malocclusion from the TMJ. I mean, give me a break! Charts are charts, and we will take them as they are written.

4. A letter from Dr. Kosovich dated January 22, 1988 tells us among other things, that Dr. Kosovich does "Gentle Family Dentistry." This is in apparent contra-distinction to the rest of us, who either do "Brutal Family Dentistry" or perhaps do "Gentle Orphans, Widows, Illegitimate Children Dentistry." The rest of the letter is made up of, in my belief, mostly hyperbole. Dr. Kosovich states that it is not feasible to determine a definitive diagnosis at this time. . ."due to the complexity of the damage." He states that he cannot even determine the type of TMJ damage until he restores all the teeth. Yes, that's what it says. He has to restore the teeth in order to tell what kind of TMJ damage the patient has. Then he will "use additional techniques to hone in on a specific diagnosis." As a tangential comment, it is my belief that Dr. Kosovich also ought to "hone in" on what's wrong with taking a full set of dental X-rays on a patient who is four months pregnant, and what's wrong with doctoring up one's charts after the facts.

III. Oral, Regional, and Radiographic Examination.

As was previously mentioned, this examination took place in my office on December 2, 1988. I believe the following physical findings are germane to Ms. Rowan's current oral and temporomandibular joint status.

1. Ms. Rowan's panorex X-rays exhibit a normal jaw with normal dentition. She has seven dental restorations, which appear to be well done. Her temporomandibular joints appear to be normal in every way, at least on this panorex X-ray. There is no evidence of mottling of the bone in either the ball or the socket, and there is no evidence of arthritic changes or bone spurs.

2. Ms. Rowan's upper left central incisor still has the incisal edge shirred off. In 2-1/2 years, after a long series of dental treatments, she has still not had the incisive bonding placed on the tooth. The chip fracture of the upper left central incisor is, of course, accident related.

3. Ms. Rowan, who, incidentally, presented herself as most cooperative and pleasant throughout our examination, is able to open her mouth to an interincisive aperture of 40 millimeters. This is considered to be within the normal limits of incisive aperture. Further, she does so with no pain whatsoever. However, she adds that "it bothers my jaw when I have to open it for a long time."

4. She is able to move her jaws into lateral excursion from side to side to a width of approximately 10 millimeters, with no difficulty and with no pain.

5. On my first examination with a stethoscope, I could hear no click on either the right or the left temporomandibular joints. However, when I listened again, I could hear a click on the closing phase on the left side.

6. Ms. Rowan has a remarkable dental malocclusion. While I realize that she has completed three years of orthodontic treatment, the treatment has apparently produced a certain degree of failure. She has what is called a Class II bite, with an overjet of 3 millimeters. She has, in addition to that, an anterior overbite.

7. These dental malocclusions, or dental occlusal disharmonies, are frequent producers of temporomandibular joint dysfunction.

8. At the time of my examination at least, and with the exception of sometime clicking on the opening phase on the left side, Ms. Rowan presents no acute signs or symptoms of temporomandibular joint disease whatever. I believe that she has had it in the past but, right now, she is relatively symptom free.

IV. Discussion.

1. Temporomandibular joint disease, more recently termed temporomandibular disorder or TMD, othertimes referred to by a subset of acronyms such MPD (myofacial pain dysfunction), or PDS (pain dysfunction syndrome) is a remarkably common disease. It affects approximately 30% of all Americans, according to some reports, but according to a new report issued by the ADA Workshop on TM Disorders, November 1, 1988 recently published, it occurs in up to 84% of all adult Americans. It affects females to the ratio of 9 to 1 over males, and it affects young females to a ratio of 5 to 1 over older females. While there is still some controversy over the exact etiology and causative factors involved in TMD, there is a general consensus among authors and lecturers on the subject that the primary causes are dental disharmonies and dental malocclusions, and the parafunctional habit of biting. Cathy Rowan fits the perfect silhouette of the chronic TMD sufferer. She has a remarkable dental malocclusion, consisting in an anterior Class II relationship, overjet, and overbite. She is in the right age group, the right sex group, and of course, while Ms. Rowan denies clenching, Dr. Kosovich's records refer not only to her malocclusion on his entry for 3/8/88, but on 2/19/88 he notes (his words) "Cathy had chewed and ground through the soft splint." So I must presume that, indeed, she does clench and grind her teeth. She stated in her history that she chewed through Dr. Carl Schneider's splint as well. It is my sincere dental opinion that if, indeed, Ms. Rowan has TMJ disease, it arises from these two factors.

2. While it is occasionally possible to suffer an injury to the temporomandibular joint as the result of a moving vehicle collision or other external trauma, it has been my experience over the past thirty-three years of treating patients with TMD, that it is a rare instance. However, when it does happen, it has also been my experience to observe the fact that when a patient injures him/herself via external traumatic injury, the patient suffers pain and discomfort immediately. He or she sits on the bench in the Emergency Room, and is in exquisite pain. This observation of mine is reinforced by an excellent author, Dr. Harold Gelb, D.M.D., in his

textbook Clinical Management of Head, Neck, and TMJ Pain and Dysfunction (1985), page 376. Dr. Gelb states in regard to acute trauma to the TMJ, the following, "These conditions (TMJ injuries) may be diagnosed clinically by noting severe tenderness or exquisite pain in the area of the joint with minimal pressure on chin, and severe to complete limitation in mandibular opening." Of course, after all, TMJ injury is very much like any other joint injury, perhaps the elbow or the ankle. That is, if you injure it, it hurts very badly and it hurts right away. We have all seen the scenario on our television screens where a football player injures one of his joints, perhaps the elbow, or the knee, or the ankle (Bernie Kosar is a good example several months ago when he injured his elbow.) Such a player does not report the injury nine months later. No, rather, he lies down on the turf in a great deal of pain, and he rolls about, and the viewing audience, and the coaches, and the trainer all know that this man has hurt one of his joints. This is true of TMJ injuries as well. If you hurt it, it hurts right away and it hurts very badly.

Now then, consider that Ms. Rowan did not report to the Emergency Room of any TMJ injury or any TMJ pain. What's more, when she had plenty of time to consider it, she reported to Dr. Koenig's office in 48 hours. She reported to him only the injury to her tooth. She did not make any complaints vis-a-vis TMJ injury.

In an article in the Journal ~~of Oral and~~ Maxillofacial Surgery, which is frequently quoted, cervical extension-flexion injury (whiplash) and internal derangement of the temporomandibular joint, Weinberg, et al., page 653, February 1987, the authors state that it is possible to have a whiplash type of injury to the muscles of tne temporomandibular joint. However, they state rather definitively that when they discovered this whiplash type of injury, "the onset of symptoms occurred immediately after the accident, on the day of the accident, or within one or two days. . . ." To me, nine months later is simply out of the question.

More significantly, to me, is the fact that, indeed, when Ms. Rowan went to Dr. Kosovich February 28, 1987, she did not go because of any TMJ complaints. Rather, she went to talk about her fractured tooth. In the previously cited recent text TMJ Update, A Special Report, the ADA Workshop on TM Disorders, November 1, 1988, the authors state that a definition of TMD ought to exclude specifically certain types of TMJ disorders. Specifically excluded according to Dr. Mohl in this paper is "single signs such as joint clicking, which have not been identified by the patient as a symptom." That exclusion, it is my belief, includes Kathleen Rowan. After all, she did not discover the TMJ, Dr. Kosovich discovered it for her.

3. I am not convinced that TMJ d sease or TMJ disorder includes popping and clicking alone. It is my understanding that that is all Ms. Rowan presented when she went to see Dr. Kosovich. In fact, in her history, Ms. Rowan states specifically tha "the popping of her ears shut" began sometime after the bite splint treatment by Dr. Kosovich. Surely then, that symptom cannot be attributed to the MVA.

4. In regard to Ms. Rowan's fractured anterior tooth, it remains fractured. It is not going to turn dark or discolor or die, but it needs to be repaired. The cost of such is approximately $75.00. I believe this is accident related.

5. In regard to Ms. Rowan's current and future status, it is my belief that, at least on the day of my examination, she did not present any remarkable TMJ symptoms. I feel sorry for Ms. Rowan inasmuch as her orthodontic treatment has, indeed, relapsed, and it would be nice if she had new orthodontic bands placed. This, of course, is not going to happen, but I believe that if she could wear the bite splint on occasion, she will have normal TMJ function.