IN THE COURT OF COMMON PLEAS

CUYAHOGA COUNTY, OHIO

RODNEY L. McCLENDON,

Plaintiff,

-vs-

JUDGE McGINTY
CASE NO. 374136

KAISER FOUNDATION HEALTH PLAN OF OHIO, et al.,

Defendants.

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Deposition of STEPHEN LAI-TIEN CHENG, M.D., taken as if upon cross-examination before Laura L. Ware, a Notary Public within and for the State of Ohio, at the offices of Mazanec, Raskin & Ryder, 100 Franklin's Row, 34305 Solon Road, Solon, Ohio, at 1:50 p.m. on Thursday, June 24, 1999, pursuant to notice and/or stipulations of counsel, on behalf of the Plaintiff in this cause.

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On behalf of the Defendant
The Cleveland Clinic Foundation.

W I T N E S S I N D E X

E X H I B I T I N D E X

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(Thereupon, Plaintiff's Exhibits 1 through 26 were mark'd for purposes of identification.)

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STEPHEN LAI-TIEN CHENG, M.D., of lawful age, called by the Plaintiff 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 STEPHEN LAI-TIEN CHENG, M.D.

BY MR. RUF:

Q. Could you state your name and spell your name.

A. Steven Lai-Tien Cheng, S-T-E-P-H-E-N, L-A-I, dash, T-I-E-N, C-H-E-N-G.

Q. What is your professional address, Dr. Cheng?

A. 12301 Snow Road in Parma, Ohio, I believe. I have to check my card. That's right, Parma, Ohio.

Q. Doctor, my name is Mark Ruf. I'm representing Rodney McClendon in a lawsuit that's been brought against Kaiser and the Cleveland Clinic.

If at any time I ask you a question and you do not understand my question, please tell me. If you give me an answer to a question, I'll assume that you have understood the question. Okay?

A. Fine.
Q. Are you currently licensed to practice medicine in the State of Ohio?
A. I am.
Q. When were you licensed?
A. I believe I was licensed in 1996. I would have to check the records.
Q. Has your license ever been subject to any type of disciplinary action?
A. No.
Q. Do you specialize in any area of medicine?
A. I specialize in orthopedic surgery.
Q. Did you do an internship and residency in orthopedic surgery?
A. I did a general comprehensive internship, I did an orthopedic surgery residency.
Q. Where did you do both of those?
A. The internship was done at Toronto Hospital, the residency was at the University of Toronto Orthopedic Program.
Q. When did you finish your residency?
A. 1994.
Q. Who were you employed by after your residency?
A. After my residency I spent a year at the University of Toronto, Sunnybrook Science Center, I followed an

additional year at the Mayo Clinic and subsequent to that I've been employed by the Ohio Permanente Medical Group here in Cleveland.

Q. What were your fellowships in?

A. The first fellowship was in upper extremity surgery and trauma surgery, the second fellowship was in adult reconstructive surgery with emphasis on the upper extremity.

Q. And you've been employed by Ohio Permanente Medical Group?

A. Medical group.

Q. Since 1996?

A. Yes.

Q. Do you only have one employer or more than one?

A. Currently?

Q. Yes.

A. Yes, one.

Q. From 1996 to the present have you only had one employer?

A. Yes.

Q. What is your position with Ohio Permanente Medical Group?

A. I'm an orthopedic surgeon.

Q. Do you receive a salary from Ohio Permanente Medical Group?

A. Yes.
Q. How many times did you see Rodney McClendon as a patient?
MR. LEAK: We'll work off of that one.
THE WITNESS: Why don't you double check your note. I haven't tallied it myself.
A. I've got five, I think.
MR. RUF: Let's go off the record one minute.
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(Thereupon, a discussion was had off the record.)
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MR. RUF: Let's go back on the record.
Q. How many times did you see Rodney McClendon as a patient?
A. According to my records in front of me, five times.
Q. I have marked Plaintiff's Exhibits 16 through 26. Are those the records that reflect the times you saw Mr. McClendon?
A. They do appear to be.
Q. Are there any additional records that would reflect the times that you saw Mr. McClendon?
A. I'm not aware of any.
Q. What was the first date that you saw Mr. McClendon?

A. I have a clinic office note from the 8th of April of 1998. I believe that reflects my first visit.
Q. On April 8th did you perform a detailed history and physical examination?
A. Mr. McClendon presented for a problem with his elbows and I asked him about his elbows, examined him and made an assessment.
Q. Could you take a look at Plaintiff's Exhibit 17. Down at the bottom do you agree that history detailed is checked, exam detailed is checked and decision moderate complexity is checked?
A. They are checked.
Q. Do you know who marked in history, exam and decision?
A. I did.
Q. Why did you mark detailed under history, detailed under exam and moderate complexity under decision?
A. These are bubble sheets that we use for purposes of internal coding of complexity of examination, history and decision making.
Q. Why did you mark moderate complexity for decision making?
A. That was my decision on the complexity of the decision making.
Q. Why was that opinion -- what was your thinking?

A. My thinking is this gentleman had a problem with his radial head fractures and required my treatment, and I felt that was a situation of not high complexity nor low complexity, nor was it straightforward, so I checked the moderate complexity.

Q. Was the decision as how to treat him of moderate complexity?

A. In the scheme of decisions I make in the course of my practice in the office, this would be one of the more moderate complexity decisions.

Q. Why was it of moderate complexity as opposed to straightforward?

A. Because it is not the most straightforward decision I make in an office.

Q. Is that because some healing had occurred for his fractures by April 8th?

A. That's because, taking the entire situation, the entire problem that he had, my judgment was that it was a moderate complexity situation. This is not a black or white, pregnant versus nonpregnant decision making algorithm. This is a subjective decision.

Q. What were the factors that made it of moderate complexity as opposed to straightforward?

A. The factors involve the limb, the joint, the natural history of problems of this joint, the age of the

patient, the dominance of the patient, the occupation of the patient, the findings on examination, the radiographic findings. I may have missed one.

Q. Let me ask you first about Plaintiff's Exhibit 16. Who wrote at the top constant complaint bilateral elbows, date of injury 2-6-98?

A. Let me correct you. The C-O-N-S, the first word is the abbreviation we use in the office for consultation, which implies first visit. To answer your question directly, this is written by the nurse that works with me that day or the LPN.

Q. What history did you obtain from Rodney McClendon?

A. A review of my notes from April the 8th, he reported to me that he was a 43-year-old gentleman who was injured on the 6th of February of 1998. He stated that he had jumped over a railing and he tripped and he fell on both of his outstretched hands. He had pain in the elbow and was seeing me for that. He was initially seen and treated in the emergency room, was diagnosed as having strains and treated with splints. And at the point he was seeing me, his pain had settled down, he had very little night pain. And that's it.

Q. When you first saw him on April 8th, did you

retrieve any of the previous Kaiser records?
A. I would have reviewed those records.
Q. Did you review those on the Kaiser computer or did you obtain hard copies of the records?
A. At this point in time it's difficult for me to remember a single case that I saw over a year ago to report specifically to you. Both of those are available to me. I would have used one or both of those methods to obtain the information I needed.
Q. Is it your regular practice to review the past medical records of the patient?
A. I review the past medical records as I feel it's indicated in relevance to the patient's problems.
Q. Was the reference to the emergency room visit made based on your discussion with Rodney McClendon or your review of the previous medical records?
A. That I do not recall.
Q. To your knowledge had he had constant bilateral elbow pain since February 6th, 1998?
A. My impression was that he had pain from the time of injury until the time I saw him and that the pain had decreased somewhat at the time that I saw him on the 8th of April.
Q. Could you characterize the type of pain he was having; was it shooting pain, dull ache?

A. I don't have any notes that comment on the character of the pain in my notes, so I would not be able to do that.
Q. In what specific area was he having pain?
A. In the elbows.
Q. Did the pain radiate from some area to another area?
A. Not that I have documented.
Q. Based on your history, did you take a physical exam?
A. I did examine him. It wasn't based on the history though.
Q. What did your physical exam reveal?
A. Again, reviewing and reporting from my notes of the 8th of April, I found that he did not have any tenderness on the medial aspect of his elbow, he had slight tenderness laterally, that would be the outer part of the elbow, there was no effusion or fluid in the joint. I documented his range of motion of both elbows.
Q. And what was the range of motion?
A. The right elbow flexed from 30 degrees on to 105 degrees. The left elbow flexed from 30 degrees to 105 degrees and the form rotation, which we call pronation, supination, was nearly full. I have in

my notes that it was a few degrees less than full.
Q. Was the range of motion of both the right and left elbows a full range of motion or a reduced range of motion?
A. This is less than a full range of motion.
Q. What is a full range of motion for each elbow?
A. A full range of motion depends on the individual. There are people who have more motion and less motion, just like there are short and tall individuals.
Q. But generally what is the normal range?
A. In general, people can nearly straighten their arm or can hyperextend or straighten their arm more. That would be a range of motion that would be close to zero with some variation, and typically people can flex to at least 130 to 135 degrees, but again, it depends on the individual, the body habitus, the age, a number of factors.
Q. Did Rodney McClendon have pain during the range of motion examination?
A. He did have pain.
Q. What else did your physical examination reveal?
A. My notes reflect I examined his wrist. His left wrist was not tender. His right wrist was tender in the volar aspect of the wrist but not the dorsal

aspect, nor the distal radial ulnar joint. The joint itself was stable. There was a slight click with a radial deviation, no pain with ulnar deviation. There was some bilateral laxity of the wrist joints and the neurologic examination and the vascular examination was intact, meaning normal.

Q. Did you just read into the record all of the information before the line starting with X-R?

A. Yes.

Q. Above that what's the notation?

A. The line directly above X-R?

Q. Yes.

A. That's N-V-I, which stands for neurovascular intact.

Q. What about the line above that?

A. That's his mid carpal versus radial carpal laxity bilaterally.

Q. Could you read into the record the rest of your note for 4-8?

A. Sure. The x-rays, I reviewed the x-rays and the ones from February the 6th from the emergency room were bilateral and wrist x-rays were negative for fracture and there was no -- negative fat pads on the forearm views and noted the left forearm was an ulnar positive variance.

The x-rays from 3-31 were reviewed and these were elbow x-rays of the right. There was minimally displaced fracture with two millimeter step Mason, M-A-S-O-N, one fracture is the classification system that is sometimes used for these types of fractures.

Left elbow x-ray showed a buckle or very minimally displaced Mason one fracture. Wrist right and left is unclear if they were neutral rotations, which is a specific x-ray view we obtain sometimes. The left was ulnar positive variance, otherwise the x-rays were negative. Would you like me to carry on with impression?

Q. Yes, please.

A. Impression, bilateral radial head fractures times 2/12, which is my abbreviation for two months. Needs range of motion. Taught and discussed range of motion exam. Will also send to physical therapy. A note was written for that. Right wrist unclear regarding the subtle injury to ligaments. No evidence today for an Essex-Lopresti, E-S-S-E-X, dash, capital L-O-P-R-E-S-T-I, or TFCC injury. Given prescription for Vicodin. Continue Naprosyn. Discussed natural history and sequelae of radial head fractures, possible stiffness, and discussed

turnbuckle orthoses.

Q. What was it about the history, physical examination and review of the x-rays that led you to the impression of bilateral radial head fractures?

A. Primarily the x-rays demonstrated there was fractures in the radial heads on both right and left elbows.

Q. Did he have any symptoms that were consistent with bilateral head fractures?

A. Yes, he did.

Q. What symptoms did he have that were consistent with bilateral radial head fractures?

A. He had pain in the elbow, he had a limited range of motion of his elbow. Those are not specific symptoms for radial head fractures, but they are symptoms of them.

Q. Based on your review of the February 6th, 1998 records, had his symptoms or range of motion changed from February 6th to the time you saw him?

A. I can't comment on that based on my records of April 8th.

Q. Do you remember if you reviewed the symptoms and finding of the doctor on February 6th?

A. I probably did. I don't recall exactly what they were.

Q. What was your prognosis for Rodney McClendon at that point?
A. I explained to all individuals with radial head fractures that it's a significant injury and that there are frequently, in fact the majority of patients with this injury, have some sequelae from this fracture that is permanent.

And sequelae may include pain, stiffness, that is a limitation or an inability to fully move the arm, occasionally clicking and swelling. And these are all common problems or sequelae of radial head fractures. And I explain this to the patients when I see them so that they understand what it is they have and what to expect.

Q. Did you tell Rodney McClendon on April 8th that too much time had passed for the right elbow to heal properly?
A. No.
Q. Did you tell Rodney McClendon that at any time --
A. No.
Q. -- you saw him?
A. No.
Q. Did you consider putting a cast on Rodney McClendon's elbows on April 8th?
A. No.

Q. Why not?
A. This fracture didn't require a cast. It wasn't medically necessary.
Q. Do you know whether it was medically necessary at any point prior to April 8th, 1998, or did you not perform that assessment?
MR. LEAK: Objection. Go ahead and answer.
A. Ask the question again.
MR. RUF: Sure. Could you please read back the question.

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(Thereupon, the requested portion of the record was read by the Notary.)

- - - -

MR. LEAK: Objection. You're talking about prior to April 8th when he saw him, correct?
MR. RUF: Correct.
A. That's all right. Do I know -- sorry.
MR. RUF: Read it back again, please.
A. You asked about putting casts on?
Q. Correct.
A. I don't know that it was medically necessary to do that, no.

Q. Were your treatment options hindered at all or made more difficult because Rodney McClendon had not been treated for elbow fractures before March 31st, 1998?
A. I'm not sure what you mean by was not treated for elbow fractures. Can you clarify that?
Q. Well, do you agree that the diagnosis was not made of bilateral elbow fractures until March 31st, 1998?
A. I believe, according to the notes from the other physicians, that it was made on March 31st.
Q. Was your treatment hindered at all or made more difficult because of the fact that the diagnosis was not made until March 31st?
A. My treatment was not made any more difficult. I prescribed physical therapy to him and I demonstrated the exercises myself in the office to him.
Q. If you had seen him on February 6th, 1998 and made the diagnosis of bilateral elbow fractures, would your treatment have been different at that time than it was on April 8th?
A. You're asking a lot of speculation in that question. Based on the data that we have, I'm not sure I can answer that question.

Q. What are the potential types of treatment for bilateral elbow fractures?
A. The treatments depend on the severity of the fracture and the amount of displacement of the fracture, and a number of other factors, patient age, patient dominance, a number of conditions. So I'll answer that question broadly, given all those parameters understood.

The treatments may range from telling the patient to actively move the arm, to treating with a sling and then actively moving the arm, or some kind of a splint and then moving the arm, to cast treatment, to surgical treatment.

Q. Did you review the x-rays of February 6th, 1998?
A. I did.
Q. What views were taken on February 6th, 1998?
A. AP and lateral views of the forearm, both forearms, were taken, and PA views of both wrists were taken.
Q. Did you observe any fracture in the films of February 6th, 1998?
A. No.
Q. Have the x-rays been marked as Plaintiff's Exhibits 1 through 3 for the films of February 6th, 1998?
A. This film here is dated February 6th. It's the right forearm view, two views of the right forearm.

Q. That's Plaintiff's Exhibit 3. Excuse me, Doctor.
A. No problem.
Q. Doctor, was that Plaintiff's Exhibit 3 that you just described?
A. Oh, you're asking me? Yes, it was. This one is Plaintiff's Exhibit 2, again, the date is February the 6th, 1998. These are two views of the left forearm.

And then Plaintiff's Exhibit 1, February 6th, 1998, and these are presumably PA views, right and left wrist.

Q. Did you order films on April 8th, 1998?
A. No, I don't believe I did.
Q. Did you review the films from March 31st?
A. My notes reflect that I reviewed those films.
Q. What did you observe in the films of March 31st?
A. The films of March 31st, the elbow and right side showed there was a minimally displaced fracture of the right radial head and the left side there was also a minimally displaced fracture of the left radial head.
Q. Which view did you see the fractures on?
A. Well, that I did not note in my note. I usually don't. I usually report a composite of my review of the entire x-rays.

Q. Do you know what views were taken on March 31st?
A. I do not from my note.
MR. RUF: Let's go off the record one second.
- - - -
(Thereupon, a discussion was had off the record.)
- - - -
(Thereupon, Plaintiff's Exhibit 27 was mark'd for purposes of identification.)
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Q. I'm handing you what's been marked as Plaintiff's Exhibit 27. Could you please identify that document.
A. This document from the Radiology Information System at Kaiser Permanente of Ohio is the report of the examination of a right elbow. That would be an x-ray of the right elbow that was performed on the 31st of March, 1998.
Q. Do you actually read your own films or do you rely on the radiologist's interpretation?
A. I typically prefer to read the films myself.
Q. Does Plaintiff's Exhibit 27 help you state what views were taken on the 31st?
A. It does not. He reports his findings. This is the

doctor that did the -- dictated the report. He reports the findings but not the specific views.

Q. Were his findings consistent with your findings?

A. I'll move to his impression. His impression is there's a definite fracture of the right radius, which I agree with, and the second bullet point is the possible fracture of the head of the left radius, a follow-up film is suggested.

And my interpretation, based on my notes of April 8th, was that I felt there was evidence of a fracture, however minimally displaced, of the left side, although I can see how he would think it would be a subtle fracture.

Q. Do you remember the discussions that you had with Rodney McClendon on April 8th?

A. I remember meeting him. I know what he looks like. I don't recall the exact content of the discussion. I would have to refer to my notes to help me refresh my memory.

Q. Do you have an independent recollection of your discussions, other than reviewing your notes? In other words, do you have an independent recollection without looking at your notes?

A. That's the purpose I write notes, so I try not to rely on recollections. I don't specifically recall

any other conversation to the point that I would be able to enter it into testimony for you.

Q. Do you recollect any conversation that you had that is not recorded in your notes?

A. No.

Q. Did you have any discussions with any Kaiser personnel or physicians on April 8th about Rodney McClendon?

A. I don't recall that I did. I work with a nurse, an orthopedic technician, and I have a physician assistant and we frequently discuss our patients and discuss the findings, so I may have talked it over with them, but again, not that I can recall a year later.

Q. Did you prescribe a brace for Rodney McClendon?

A. Not at this visit. I did eventually.

Q. What were you trying to accomplish through your treatment?

A. Well, I wanted Mr. McClendon to regain as full function with his arms as possible after a fracture.

Q. So the goal was to regain full range of motion?

A. You're paraphrasing me. As I said, my goal is to try and -- well, you can read from the testimony. I answered the question already.

Q. Did you order Rodney McClendon to stay out of work?

MR. LEAK: On April 8th?

Q. Yeah, at any time.

A. I don't have the records that would substantiate that. There's an additional initial form that we sometimes fill out for that and I don't have it in front of me.

Q. Okay. Let's go to the next visit.

A. Uh-huh.

Q. When was the next time that you saw him?

A. I arranged to follow him up on the 29th of April, 1998.

Q. Could you read into the record your notes from that visit, please.

A. Sure. Doing physical therapy three times a week, home exercise one times a week. Pain, bilateral elbows, right greater/equal to left, click in the bilateral elbows, painful. Very little pain in the mid arc, pain at the extremes of motion mostly with extension. Range of motion to the right was 25 to 125 degrees in flexion, on the left was 25 to 130 degrees flexion. Pronation and supination were full. No click or crepitus. Pain to the radial head bilaterally was negative. Sorry. He had pain of the radial head bilaterally but not at the medial

collateral ligament area. No effusion, no wrist tenderness or click.

X-rays showed bilateral healed fractures. Wrist views, according to the patient, were not done in neutral rotation. And I discussed, number one, home range of motion exercises need to be done three times a day. Number two, I prescribed him Feldene, which is an antiinflammatory medicine, Cytotec if he had gastrointestinal upset. He had problems with Naprosyn but was unclear if it was the Naprosyn or other cold medicines he was taking at the same time.

I discussed and demonstrated Mayo type elbow splints and would like the patient to discuss with Yankee Bionics and wrote a prescription for this. Follow up until three weeks or when braces are made.

Q. What are Mayo type elbow splints?

A. These are progressive static type splints for the elbow, that is splints that are applied to increase the range of motion of the elbow.

Q. And how is the range of motion increased with those splints?

A. The splint involves a cuff that fits around the forearm, these are custom splints, and a cuff that

fits around the upper arm, and it's hinged at the elbow joint. The patient applies it with Velcro fasteners so it fits snugly, and there's the type that I use has a dial here that one turns and it's attached to a worm gear or some kind of gear that then moves the two cuff pieces relative to each other.

So what a patient would do is he would dial that splint to the point where it applied a stretch to the arm. I'm demonstrating a stretch in terminal flexion. And it can be used to stretch -- I demonstrated extension. It can be used to stretch terminal flexion. And the patient sets the splint with some tension, some stretch on the arm, and then spends a variable amount of time, hours, in the splint so that the tissues of the joint involved, in this case the elbow joint, are allowed to stretch in a plastic deformation kind of fashion, and this is a technique that is used, one of the techniques, that one applies to try to increase the range of motion of a patient's joint.

Q. To what point is the patient to stretch using the brace?

A. I instruct the patient to stretch it to the point where it hurts a significant amount but not

excruciating pain, but they need to stretch it to the point where it's going to be worthwhile for them to wear it for several hours. So if they just turn it so that it's slightly uncomfortable, after the tissues start to stretch the brace becomes actually loose.

Q. And how many hours is the patient to wear the brace?

A. The program that I devise is customed for each patient. I have in my notes of the 20th of May the program that I mapped out for Mr. McClendon.

Q. Why don't you tell me what that program was on --

A. I mapped out -- sorry.

Q. I'm sorry, Doctor. On the 29th.

A. Yeah.

Q. You just prescribed the brace?

A. Right, on the 29th I made the prescription for the patient to be fitted with the brace. It's a custom-made brace, so there's some work involved in fitting the patient by an independent company that does this for us.

Q. And then he got the brace and returned May 20th?

A. Let's see my notes. Right, on May 20th he had the brace in his possession.

Q. And what was the plan for May 20th?

A. Well, I mapped out a 24-hour time line for him and explained to him that I would want him to be in the splint from 11:00 p.m. until 7:00 a.m. in the extension mode and then from 7:00 to 8:00 to not be in the splint, to be moving the elbow freely, then from 8:00 a.m. to 12:00 noon to be in the splint with it dialed in the flexion mode, 12:00 to 1:00, noon to 1:00 he would be out of the splint, from 1:00 to 4:00 he would be in the splint in extension mode, 4:00 to 5:00 p.m. he would be out of the splint, then from 5:00 to 9:00 p.m. he would be in the splint in flexion mode, then from 9:00 to 11:00 p.m. he would be out of the splint, and then the cycle would resume.

Q. So what was the total number of hours per day he was supposed to be wearing the brace?

A. 8, 12, 15 -- 19 hours a day.

Q. And what was the plan for how long he was supposed to use the splint?

A. The plan is a flexible plan and I monitor the patients closely to see how they're progressing. And depending on how well they're achieving their range of motion, how well they tolerate the brace, what their goals and desires are, we decide in the future as, you know, as progress is being made how

long the eventual total brace time will be.
Q. I want to go back to April 29th. Did you order x-rays on that date?
A. Yes.
Q. Are those x-rays marked as Plaintiff's Exhibits 4 through 7?
A. Plaintiff's Exhibit 4 is dated 4-28-98, and I'm not sure on this copy if I can read the marking on this one. Exhibit 5 is dated 4-28-98. This is an x-ray of the right elbow. Plaintiff's Exhibit 6, 4-28-1998, x-rays of the left elbow. And Plaintiff's Exhibit 7, 4-28-1998, these are x-rays of the right elbow.
Q. Could you tell me which exhibits show the fractures?
A. Okay. X-rays of the right elbow, Plaintiff's Exhibit 7 and Plaintiff's Exhibit 5, do demonstrate the fractures.
Q. Could you please show me where the fractures are, Doctor?
A. There's a break in the cortex here which represents a fracture on the lateral view. On the anteroposterior view it's more subtle. One wouldn't really be able to confirm a fracture on that view. And on this other view, the fracture is demonstrated

as this cortical break here on the right radial head.
Q. Were the views taken on Plaintiff's Exhibit 5 and 7 different from the views taken on February 6th?
A. Yes.
Q. Would the information shown in Plaintiff's Exhibit 5 and 7 show up on the views that were taken on February 6th?
A. Would they show up, is that your question?
Q. Yes.
MR. LEAK: Or do they show up?
Q. Do they show up?
A. No, I don't appreciate the fractures on the x-rays of February 6th.
Q. And that's because of the type of view that was taken?
MS. VANCE: Objection.
A. You're asking me to make an assumption, and I don't know. I don't see the fractures on these x-rays.
Q. But in the records you had stated that the fractures had been present since February 6th, correct?
A. Demonstrate to me where I said that.
Q. Then let me ask you this. Based on reasonable medical probability were the fractures present on February 6th?

A. They probably were.
Q. Thank you, Doctor.
Let's go to the handwritten note of May 20th. Could you read into the record your note?
A. Yes. May 20th, 1998, I'll read my handwritten notes. Three and a half months, some pain with heavy lifting and physical therapy, right greater than left side. Occasional clicks bilaterally, may be painful. The range of motion on the right side is 25 degrees to 132 degrees, on the left side is 15 degrees to 132 degrees. He had full pronation and supination.
He has the Mayo type splints. I confirmed the fit. The notation on the left with the numbers and the Fs and the Es is my abbreviation, diagram, detailing what we discussed before about the time frame, the program in which this man was to wear his splints over a 24-hour time period.
I discussed the splinting principle and continue range of motion exercises. I wrote that he would be off work from June the 9th times two months to the 10th of August. I wrote a prescription for 80 Percocets and arranged follow-up in a month's time.
Q. The Percocet was for pain?

A. Right.
Q. And his range of motion was increasing using the braces?
A. At this visit he had just obtained the braces, and while he may have put them on himself to try them this is the visit where I teach him how to use the brace and when to use the brace.
Q. What was the next visit?
A. The next visit would be on the 6th. Sorry, on the 24th of June, 1998.
Q. Could you read into the record your notes from that visit?
A. Okay. Obtained Mayo type splints and has been following the protocol I gave him on May 20th and on both arms since the 9th of June and on the right arm for the past three weeks. The Percocet gave him some gastrointestinal upset and the Vicodin gave him dizziness.

He had a slight click with rotation on the right radial head that was mildly painful. The range of motion on the right side was less than 15 degrees to 135 degrees of flexion. On the left side was 10 to 130 degrees flexion.

I discussed continued splint use bilaterally per our 24-hour schedule, gave him a prescription

for some Feldene, I gave him a prescription for some Darvocet and I emphasized to him the rationale for using the analgesics because the splinting can be an uncomfortable process.

Will obtain bilateral x-rays of elbows this week and will call me when the x-rays are done. And asked to re-refer him to PT, to physical therapy, and I did.

Q. So you prescribed pain medication to help him in using the splint?

A. Yes.

Q. And I believe you said he was following your protocol?

A. Right. As I remember, he wasn't taking the painkillers, and my intent is that people do take the painkillers so that pain is not what limits them from using the protocol correctly.

Q. Was his range of motion increasing using the braces?

A. Comparing his range of motion from 5-20 to 6-24 on the right elbow, he had improved his range of motion, both flexion and extension. On the left elbow he had improved his range of motion as well.

Q. When was the next time that you saw him?

A. Next time I saw him was July 29th, 1998.

Q. Could you read into the record your notes from July 29th?
A. My handwritten notes are as follows, occasional pain with terminal flexion/extension. Darvocet made him sick, on Feldene and doing well with that. Range of motion on the left side was five degrees to 135 degrees of flexion with full pronation/supination. Range of motion on the right side was 10 to 130 degrees of flexion, full pronation/supination. He was tender at the radial head in extension but not the olecranon. Pain at extremes. X-ray shows satisfactory healing of bilateral fracture. He felt ready to return to work and was returning to work. He felt ready to return to full duty, and I wrote that he could do that as of 8-3-98. We discussed the nighttime use of the splints with extension, and follow-up at that point was a PRN basis.
Q. And that's as needed?
A. That is as needed. It's patient driven.
Q. So it was his decision whether or not to return?
A. I'm sorry, to what?
Q. It is Rodney McClendon's decision whether or not to return for a follow-up visit?
A. Yes.
Q. Why did you make a return visit PRN at that point?

A. At that point he had been using the splints and I had seen him several times and discussed the splint use with him, so he was quite comfortable in how to apply them and the mechanics and the protocol and how to use them.

He had gained considerable motion in both elbows. His symptoms had subsided. He himself had reported that he felt well enough to return to work at full duty, so my role in this is to try and return a patient to as full a function as possible, and I felt at that point that we were nearing that goal or we had achieved that goal.

The final discussion that I have with patients who use splints is that they need to continue to use the splints for an extended period of time at nighttime, and we had that discussion so I didn't have anything further to add to the care. And he didn't feel that there was anything that he needed from me to add to his care.

He felt comfortable and his result was satisfactory, certainly satisfactory enough for him to go to work. And so if he had further problems, new or the same problems, I would be happy to see him but there wasn't any real point in arranging a follow-up when neither he nor I felt there was

anything further to add to his care at that point.
Q. Did you give him any instruction as to how long he was to use the braces?
A. I typically do.
Q. And what was your instruction?
A. My instructions are to continue using the splints at nighttime for several months.
Q. And then after several months was he to discontinue using the splints?
A. After several months he discontinues using the splints and he makes his own judgment as to whether or not his motion is maintaining stable. If there's a problem with the motion becoming decreased again, then he needs to get back in the splints and then to contact me and discuss why that's occurring. That's a rare occurrence.
Q. So he's only to use the splints if he's losing range of motion?
A. After the initial period of using the splints at nighttime alone, yes. It's a program where you start off using the splints quite intensively and then you gradually wean out of using the splints, and as you're weaning if you see that you're slipping back in terms of losing more -- losing your motion again, then naturally you need to step up the

use of the splints again.
Q. Did he have full range of motion on July 29th when you last saw him?
A. No, I wouldn't say this was a full range of motion.
Q. Did he have full range of motion of either the right or the left elbows?
A. No, his left elbow was very close, but neither of them I think you could characterize as full. These were a functional range of motion but not a full range.
Q. Did Rodney McClendon follow your prescribed treatment while he was under your care and treatment?
A. To an extent he did. My treatment is complex, as you gather, and there's a number of areas where Rodney did not adhere to it the way that perhaps if I broke my arms myself would have done it. He adhered to many of the principles of the treatment.
Q. Overall was he following your prescribed treatment?
A. I think I've answered that question already.
Q. Did you take any other x-rays that we have not discussed?
MR. LEAK: I think we discussed some but we didn't look at some, correct?
THE WITNESS: Right. We discussed a

number of films.

MR. LEAK: But we didn't actually look at them.

Q. What are Plaintiff's Exhibits 12 through 15? I'm sorry, Doctor, let's go back first.

A. Okay.

Q. Why don't you go through Exhibits 8 through 15.

A. Okay. Starting with 8, this is a Cleveland Clinic radiology x-ray dated the 2nd of June, 1998 of his right elbow. Plaintiff's Exhibit 9, again, Cleveland Clinic radiology film of the left elbow, 2nd of June, 1998.

Plaintiff's Exhibit 10, 2nd of June, 1998, x-ray of the left elbow from the Cleveland Clinic. Plaintiff's Exhibit 11, same date, same location, right elbow. Plaintiff's Exhibit 12 is an x-ray from the Kaiser Foundation Hospital. I can't tell the date on this one. It's a left elbow film.

Plaintiff's Exhibit 13, Kaiser Foundation Hospital, the date -- this is a copy, the date I can't read clearly, right elbow x-ray. Plaintiff's Exhibit 14, films from the Kaiser Foundation Hospital, no date on the copy, right elbow and left elbow film. And Plaintiff's Exhibit 15 is June -- sorry, July 17th, 1998 from the Kaiser Foundation,

which is an x-ray of the right end of the left elbow.

Q. I believe you said on the 24th you ordered additional x-rays?

A. The 24th I examined him to obtain bilateral x-rays of the elbow this week and call me when the films are done. That implies that he probably couldn't stay for the x-rays that particular visit. He had other things to do, perhaps.

Q. Were those x-rays eventually taken?

A. What's the date on those? 4-28. That's April. I believe the next set of x-rays from the Kaiser Permanente offices were the 17th of July, so, yes, he did eventually take those x-rays, but there was a delay from 6-24 to 7-17. He didn't get them done until about almost three weeks after the visit rather than having them done that week.

Q. What was the purpose of the follow-up of x-rays?

A. To evaluate the healing process and to look at the appearance of the joint.

Q. Based on your review of the July 17th x-rays --

A. Uh-huh.

Q. -- what do those x-rays show?

A. From July 17th I have a single lateral view of the right elbow and a single lateral view of the left

elbow. This particular x-ray I have a hard time actually seeing the fracture because of the projection on the x-ray on the right side.

And the left side I also have a hard time seeing the fracture. It has to do with the projection of the fracture and the position that the x-rays are taken.

Q. Would it help you if you reviewed the original film?

A. No, this is the original film, I believe. No, it isn't.

MR. LEAK: No.

A. It might. We could try. I don't know.

MR. RUF: Let's go off the record.

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(Thereupon, a discussion was had off the record.)

- - - -

Q. Doctor, do you have the original films at this point?

A. Yeah, I have the original films from July 17th here.

Q. What do those films show?

MR. LEAK: Doctor, before we start, do you want to compare Exhibits 12, 13 and 14 with

the original to see if those are the ones where you couldn't read the dates that correspond with those?

MR. RUF: Why don't we put a stipulation on the record. Can we enter into a stipulation as to the date of the x-rays --

MR. LEAK: We have to confirm that.

MR. RUF: -- that are undated?

MS. VANCE: That's what he's going to do right now.

MR. LEAK: Yeah, that's what he's going to do right now.

A. Okay. Plaintiff's Exhibit 14, didn't we talk about that already?

Q. What's the date of Plaintiff's Exhibit 14?

A. Plaintiff's Exhibit 14, comparing it to this original which is dated July 17th, 1998, this appears to me to be the same film, to be a copy of the same film.

MR. LEAK: How about number 13?

A. I don't have an original. Oh, yeah, here we go. All right. So this is Plaintiff's Exhibit 13 and this compares favorably to the x-ray dated July 17th, 1998. That's of the right elbow. That goes over there.

And then Plaintiff's Exhibit 12 compares favorably to this original that's dated July 17th, 1998.

MR. LEAK: Just for the record, I don't know what we would have done without Dr. Cheng here to coordinate this.

Q. What did the films show for July 17th with respect to the fracture?

A. This x-ray from July 17th is an anteroposterior view of the right elbow and one of the left elbow. The one of the left elbow really -- I don't discern the fracture on this view very clearly. On the right elbow one can see it -- a very slight depression in the joint that reflects a fracture there.

This other view of the right elbow from the 17th of July, 1998, there's a cortical interruption here that represents a fracture. It's pretty subtle. These are not -- these are slightly oblique x-rays, same date, July 17, 1998, x-rays of the left elbow. I don't discern a fracture on this x-ray.

Q. Was there an improvement in the condition of the fracture for both the right and left elbow compared to the prior films?

A. I think there was an improvement. I think the films demonstrated the fracture is healed, was healing.

Q. Do you have any independent recollection of any conversations with Rodney McClendon that are not recorded in your medical records for any visit?
A. No.
Q. Do you have a recollection of discussing Rodney McClendon with any physician or Kaiser employee?
A. Again, I think we talked about this earlier. I discuss all my patients with my team. I don't have a specific recollection of a conversation, per se.
Q. But at this point I'm asking you about for all visits. Before I just asked about one specific visit.
A. Oh, I see. My answer is the same, it applies to all other visits.

MR. RUF: Let's just go off the record for one minute.

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(Thereupon, a discussion was had off the record.)

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A. There is a form that's used. Not everyone requests a form. If the patient says I don't need a note, I don't write them a note. But there is a form that we can obtain off the computer and print it out. That's what it looks like.

Q. Did you give a doctor's order to Rodney McClendon to be off work for a period of time?
A. Yes, I did. I have in front of me a return to work note which is an off work note dated the 20th of May, 1998 that carries from the 9th of June to the 10th of August that he's not to work.
Q. What was the reason for that order?
A. Because he would be using the splints full time at that point.
Q. Do you have any independent recollection of your care and treatment of Rodney McClendon that we have not yet discussed?
A. No, I think we've pretty thoroughly discussed our notes.
Q. Okay. Thank you, Doctor, that's all I have.

MR. LEAK: There may be some questions over here.

THE WITNESS: Okay.

MS. VANCE: Doctor, my name is Vicki Vance. I represent the Cleveland Clinic. I would like to ask you a couple of questions just to clarify my understanding of how you assess the patient.

THE WITNESS: Okay.

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CROSS-EXAMINATION OF STEPHEN LAI-TIEN CHENG, M.D.

BY MS. VANCE:

Q. You told us that when you first saw the patient on April 8, 1998 that he had symptoms of pain and limitations in his range of motion; is that true?

A. He had signs of pain and symptoms of limited range of motion, that's true.

Q. And you were asked the question by Mr. Ruf whether those symptoms are consistent with a patient having bilateral radial head fractures, and you said that they were consistent?

A. Right. I also said they were not specific for that injury but they are a feature of the symptom that would accompany an injury, such as a radial head fracture.

Q. Doctor, have you seen in your practice patients that have presented with complaints of pain and limited range of motion and not have bilateral radial head fractures?

A. Oh, absolutely. The majority of patients that have pain do not have a fracture.

Q. So the majority of the patients who complain of pain in both elbows and even limited range of motion in both elbows do not turn out to have fractures of their radial heads?

A. That's a completely tenable assumption, yes.
Q. You also indicated that when you saw the patient for the first time your prognosis you said you explained to your patient, a majority of patients will have sequelae from this type of an injury which may include pain, stiffness, clicking and swelling; is that true?
A. Yes.
Q. Doctor, do patients who have bilateral radial head fractures that are diagnosed and found within 24 hours of injury, do those patients also go on to have sequelae that includes pain, stiffness, clicking and swelling?
MR. RUF: Objection.
A. Yeah, absolutely. The injury is a significant injury that does not lead to a perfect result in the majority of cases.
Q. So even if the injury is diagnosed within 24 hours of onset --
A. Yes.
Q. -- will those patients, even with an early diagnosis by an institution of what is deemed to be an appropriate management, do those patients also have the risk of pain, stiffness, clicking and swelling and other sequelae from their injury?

MR. RUF: Objection.

A. I would say the majority of patients, even given your assumptions, would have some of those symptoms if not all those symptoms.

Q. Doctor, you testified that you did not place a cast on the patient at the time of the first visit, April 8 of 1998, because you saw no medical necessity for it at that time; is that true?

A. Yes.

Q. Are there any risks that are presented to patients when they are casted for bilateral radial head fractures? Or perhaps a better way to ask the question is what would be sort of either the considerations or indications for instituting casting as a treatment method for a patient presenting with bilateral radial head fractures?

A. The factors that one would consider are fracture based and patient based, and by that I mean that the fracture based considerations would be the pattern of the fractures, the size, angulation, any associated injuries as well.

The patient based reasons would be depending on the age, the sex, the dominance, the occupation of the patient, concurrent medical problems. So there's a number of factors that synthesize -- that

we synthesize as physicians to decide whether or not a cast treatment is appropriate for an injury like this.

Q. Doctor, if you see a patient and make a diagnosis of bilateral radial head fractures within 24 hours of the onset of injury, is casting the most likely form of treatment at that point?

MR. RUF: Objection.

A. Again, it depends on the fractures. By and large the problem with immobilization, that is casting of injuries for a period of time, is that it promotes stiffness because the patient does not move that limb that is in the cast for a period of time.

And we know that one of the problems that people face after rehabilitation from an injury is that they may have some stiffness in the joint that may be permanent, that is they may not have full range of motion in that joint. So one tries to minimize the time in a cast or if possible not treat in a cast any injury because of that reason.

Q. Assuming that a patient with bilateral radial head fractures is placed in a cast, what would be the patient's arm position if a cast is applied?

A. That would be doctor dependent. I think one of the accepted positions would be to have the cast applied

with the elbow bent at a 90-degree position.
Q. Are casts ever applied with a patient having their arm in full extension for bilateral radial head fractures?
A. That wouldn't be my choice. I'm not aware if anyone does that. That wouldn't be how I would do it.
Q. If you were to apply a cast on a patient with bilateral radial head fractures, generally a 90-degree angle would be preferred?
A. If I were applying a cast, I would apply it in a 90-degree flexion.
Q. And if you apply a cast in a 90-degree flexion does that carry the risk that after the cast is removed the patient may have limitation on their range of motion or stiffness in being able to ultimately achieve full extension and flexion of that joint?
A. Right. As we said before, the cast is a double-edged sword. The advantage is it then limits the patient from using his arm and hopefully allows the fracture to heal. The down side is that you are enforcing immobilization on a patient and running the risk of stiffness which already is a risk having had an injury.
Q. Has it ever been the case in your practice that after applying casts to a patient with a radial head

fracture that after the cast is removed they've gone on to require the type of Mayo splints program that you applied to Mr. McClendon?

A. That does happen. That does happen.

Q. So is it fair to say that the use of a cast on a patient with a bilateral radial head fracture does not rule out or eliminate the potential need that that person may still go on to require Mayo bracing or splinting?

A. Not at all. In fact, probably the opposite. People who are immobilized for a long period of time or people who are immobilized in general have a high risk of stiffness than people who are not immobilized, than those people who are allowed to move the arm freely earlier, requiring this kind of extensive treatment.

Q. When we went through your notes you showed us that on May 20, 1998 the patient came in with the Mayo splints, he already had them custom-made at that point, and you mapped out the schedule for time periods which he would wear those splints; is that correct?

A. Correct.

Q. Now, you then at that visit gave him the notice that he could be off work for two months to allow for

this bracing program; is that right?
A. That's right.
Q. The time that he was going to be off work was going to begin on June 9 of 1998; is that true?
A. Yes.
Q. Why did he or you elect to delay the start of the splinting program from May 20 for approximately three weeks to begin on June 9? In other words, why not start the bracing program right away if you had the splints in hand and he had been shown or instructed on how to use them?
A. That's a very good question. As I recall, there were some patient based factors on why -- we're talking about taking time off of work for a guy who's already been off work for some time, I believe at this point. So there were some patient based factors as to why he did not want to or could not take the time off until that point.

We're talking about a guy who's going to be off work for a full two-month block. So I think there's a lot of considerations from his workplace and from his personal situation that go into deciding when he's going to start this time period off work in addition to the goal that we have of, obviously, of trying to get him on the splints as soon as we can.

Q. Ultimately you allowed him to return to work on August 3, 1998?
A. Let me review my notes from the 29th of July. We discussed together when he would return to work. He felt that he was ready for full duty as of August the 3rd, and that's when I wrote here that he could go back to work.
Q. So he felt he was ready to return to work on August 3, which was one week less than the original prescription for how much time he would be off of work?
A. He asked to go back to work. He said he was ready to go back to work, and he asked to go back to full duty.
Q. During the time that you were treating the patient do you recall that he ever complained to you that he had any concerns that he could go back to work and perform his job functions as a Cleveland police officer?

THE WITNESS: I'm sorry, could you read that one back to me again?

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(Thereupon, the requested portion of the record was read by the Notary.)

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A. Yes, when I explained to him what one might expect from having broken his elbows, from having radial head fractures, and we talked about the risks of stiffness and all those sequela that we discussed previously, he was concerned how this would impact on his job performance.

Q. What about at the end of the bracing program when he was asking to return to work a week ahead of schedule?

A. At that point he volunteered that he wanted to go back to work. And so I don't recall, again it's been a year, what our exact conversation was, but clearly from my notes and from the fact that he wanted to go back to work the impression he conveyed to me was that he felt that he was ready to return to not just part-time work or limited work but he felt that he was ready to go to full duty, so I let him.

Q. I wanted to ask a question just to make sure I understand the grading system or notations that you used to note both flexion and extension of the elbows. If a patient is opening up their arm to its full length, this is referred to as extension; is that right?

A. Yes.

Q. And if they take the hand and put it up by the shoulder and close their elbow, that would be flexion?
A. Flexion.
Q. And when you make the notations in your records as you observe this on the patient, you said that the normal range generally is zero to approximately 135; is that correct?
A. Well, let me try and explain this a little better. This, the motion, the bending of the elbow, which is the major motion of the elbow, is referred to as the flexion of the elbow as you arc from that position to that position.

Now, having said that, when you straighten the elbow that's termed extension, although the act of straightening is termed extension, but one may only extend to that point. And then bending it all the way would be termed flexion.

When we record these numbers that I report in my notes, the range is measured with zero. This is just the customary method. It's universally used so we can communicate in forms like this. Fully straight, as in the arm, the humerus bone here and the ulna bone here are co-linear or parallel. That would be referred to as zero degrees. So this would

be 90 and this would be more than 90 degrees of flexion.

Q. Did it appear that Mr. McClendon was regaining some of his range of motion of his right and left arms even before the bracing program began?

A. When I first saw him his range of motion of the right was 30 to 105 and his left was 30 to 115. And the day we talked about the 24-hour program using the splints his right motion was 25 to 132, which is an improvement, a definite improvement from his visit from April 8th. And his left arm range of flexion was from 15 to 132, which is also a significant improvement from the numbers of February 8th. So I would have to answer yes to that.

Q. When you look at these last series of films taken on July 17, 1998, do you see evidence of good bony healing of the radial head fractures?

A. Yes.

Q. Even though you can still appreciate the fracture line on those films, do you, nevertheless, can you state that the fractures are either healing or completely healed as of July 17, 1998?

A. Healing, as you know, is a process, and one can -- it's difficult to actually draw a line as to which day the healing stopped because it really doesn't.

Initially the fractures are in two pieces and it's mobile, and as time goes on it becomes more and more and more solid. So you can't really apply a black and while to healing, unlike pregnancy or not being pregnant.

But these x-rays of July were taken five months after the time of the initial injury, and for that period of time we're seeing an appropriate amount of healing. I didn't feel that that was either slow or faster than normal, and it seemed appropriate. And it seemed unlikely that given the fact the fractures had attained this stage of healing the process would reverse and become unhealed. They looked like they were moving in the right direction at this point.

Q. Is it expected that for some period of time in Mr. McClendon's life if he has elbow x-rays taken you'll continue to see the fracture line or the old fracture line will continue to appear for at least some period of time on x-rays?

A. That's variable. It's difficult to predict, but I would have to answer in the affirmative. Fractures in general you can appreciate the fracture line even if the patient's fractures heal and even if they feel perfectly fine, sometimes forever.

Q. So the fact that you can look at a film and say I

can see the fracture site is not equivalent to saying this is an unhealed fracture?

A. No.

Q. When you look back at x-rays that were obtained on February 6th, 1998, those that were marked as Exhibits 1, 2 and 3 taken in the radiology department at the Cleveland Clinic in connection with the patient's original emergency department visit, do you conclude that those three films, Exhibits 1, 2 and 3, were correctly interpreted as negative for fracture?

A. Yes.

MS. VANCE: Thank you. I don't have any other questions.

MR. RUF: I have a follow-up question.

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RECROSS-EXAMINATION OF STEPHEN LAI-TIEN CHENG, M.D.

BY MR. RUF:

Q. For a patient with bilateral elbow pain and loss of range of motion would a fracture be part of the differential diagnosis?

A. Yes.

MR. RUF: That's all I have. Thanks.

MR. LEAK: He'll read. Just so you know, you have the right to read this to make

sure everything was taken down. We have a lot of medical terms so I'm going to make sure everything was accurate. Okay?

THE WITNESS: You want me to read?

MR. LEAK: You're going to read.

THE WITNESS: Okay.

MR. LEAK: And I guess you'll waive any time constraints?

MR. RUF: Sure.

_____

STEPHEN LAI-TIEN CHENG, M.D.

C E R T I F I C A T E

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

I, Laura L. Ware, a Notary Public within and for the State of Ohio, do hereby certify that the within named witness, STEPHEN LAI-TIEN CHENG, M.D., was by me first duly sworn to testify the truth, the whole truth, and nothing but the truth in the cause aforesaid; that the testimony then given was reduced by me to stenotypy in the presence of said witness, subsequently transcribed into typewriting under my direction, and that the foregoing is a true and correct transcript of the testimony so given as aforesaid.

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

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, this 14th day of July, 1999.

Laura L. Ware, Ware Reporting Service
3860 Wooster Road, Rocky River, Ohio 44116
My commission expires May 17, 2003.

Case Title: _____

Case Number: 374136 Deposition Date: _____

I, STEPHEN CROSS, wish to make the following changes:

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I have read my deposition, and having made the corrections that I wish to make hereby affix my signature.

Signature: _____ Date: 7/19/55