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State of Ohio,)
)
County of Cuyahoga.)

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IN THE COURT OF COMMON PLEAS

- - -

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CHAROLOTTE HEINE, et al.,)
)
Plaintiffs,)
) Case No. 309,666
vs.)
) Judge Gail R. Kane
DAVID WILSON, et al.,)
)
Defendants.)

- - -

DEPOSITION OF ROBERT C. CORN, M.D.
Thursday, December 18, 1997

- - -

The deposition of ROBERT C. CORN, M.D., a witness, called for examination by the Defendant, David Wilson, under the Ohio Rules of Civil Procedure, taken before me, Diane M. Stevenson, a Registered Merit Reporter and Notary Public in and for the state of Ohio, by agreement of counsel, at the offices of Robert C. Corn, M.D., 850 Brainard Road, Highland Heights, Ohio, commencing at 5:30 p.m., the day and date above set forth.

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APPEARANCES:

On behalf of the Plaintiffs:

Ellen M. McCarthy, Esq.
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1st Floor Standard Building
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and

John P. Berena, Esq.
10633 Pearl Road
Strongsville, Ohio 44136

On behalf of the Defendant, David Wilson:

Walter H. Xrohngold, Esq.
Keller & Curtin Co., LPA
330 Hanna Building
Cleveland, Ohio 44115

On behalf of the Defendant,
State Auto Insurance Company:

Robert G. Hurt, Esq.
7029 Pearl Road, Suite 310
Middleburg Heights, Ohio 44130

ALSO PRESENT:

Kenneth M. Simon, Videographer

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MR. KROHNGOLD: Let the record reflect that this is the trial deposition of Dr. Robert Corn, which is being taken pursuant to notice, and I am going to ask for a waiver of any defects in service, notice, or the filing of the deposition, Counsel.

MS. McCARTHY: Sure.

MR. KROHNGOLD: Let the record further reflect that this is the trial deposition of Dr. Robert Corn, which is being taken to preserve his testimony for use at the time of the trial in the action brought by Charlotte Heine and her husband against my client, Mr. David Wilson. This action has Case No. 309,666 in the Cuyahoga County Court of Common Pleas.

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ROBERT C. CORN, M.D.

A witness, called for examination by the Defendant, David Wilson, under the Rules, having been first duly sworn, as hereinafter certified, was examined and testified as follows:

DIRECT EXAMINATION

BY MR. KROHNGOLD:

Q My name is Walter Krohngold, and I represent the defendant in this case, Dave Wilson.

Doctor, could you please tell us your full name.

A. My name is Robert Curtis Corn, C o R N.

Q. Doctor, what is your current professional address?

A. My main office address is at 850 Brainard Road in Highland Heights, Ohio.

Q. Are we at that address today?

A. Yes.

Q. Doctor, what is your profession?

A. I am an orthopedic surgeon.

Q. Are you licensed to practice medicine in the state of Ohio?

A. Yes.

Q. How long have you been so licensed?

A. Since 1976.

Q. Are you Board certified in orthopedic surgery?

A. Yes, I am.

Q. Could you please tell us a little bit about what orthopedic surgery involves and what Board certification means.

A. Well, orthopedic surgery is the branch of medicine which involves the medical and surgical treatment of diseases, disorders, injuries, and some tumors of the musculoskeletal system. That

includes problems of the bones, muscles, tendons, joints and ligaments.

It also involves a number of subspecialties, which may be a little bit more familiar, such as hand surgery, surgery of the spine, sports medicine, and arthroscopic surgery. Surgery for total joint replacements, problems with rehabilitations, problems with nerves and muscle injuries

Orthopedic surgery is a surgical subspecialty, and it has its own board or committee which sets certain educational and testing standards, as all medical and surgical subspecialties do

What happens and how you become an orthopedic surgeon is that sometime in your second or third year in medical school when you decide what you want to be when you grow up, you seek what the boar stipulates as the necessary accomplishments that you have to go through in order to qualify.

In the mid and late 1970s, when I went through this process, I had to have completed a residency program, that is a postgraduate, post-medical school apprenticeship program, which basically allows you to do more and more as your educational experience and your talent improves

You have to take certain in-training examinations each year and pass those exams, or at least have a satisfactory grade in them to show that you are learning something. Then you have to be in the clinical practice of the specialty for one calendar year and one geographical location.

During that time period, a peer review would take place. Questionnaires would go out in the community, doctors would appear in surgery and watch how you work, they would basically judge how you have performed during that particular year, and then you become eligible to take a certifying series of examinations.

The exams were a two-day series of oral exams and written exams. And after fulfilling all of those requirements, you would be certified by the American Board of Orthopedic Surgery.

Q Is that one of the highest, if not the highest, achievement obtainable in your specialty?

A Yes.

Q Doctor, could you please tell the ladies and gentlemen of the jury a little bit about your professional background, including college, medical school, and your post-medical school

training.

A. I received my Bachelor of Science in biology from the Albright College in Reading, Pennsylvania in 1971. I then moved back to my hometown in Philadelphia, Pennsylvania, where I attended the Hahneman University School of Medicine from 1971 to the middle of 1975. I graduated and received my MD degree in 1975.

I then moved out here to Cleveland where I started my orthopedic training. I did all my training at The Cleveland Clinic. I was at The Clinic from 1975 until the middle of 1979, when I graduated from the program.

I then entered the private practice of orthopedic surgery in August of 1979. And for the past 18 and a half years I have been a private practice orthopedic surgeon, primarily on the east side of Cleveland.

Q. Do you have any hospital privileges at the local hospitals?

A. Yes.

Q. Could you tell us about some of those?

A. I am on the active staff at the Meridia Hillcrest Hospital, the Meridia Euclid Hospital, and the Meridia Huron Hospital, the Lake County Hospital

Systems, the PHS Mt. Sinai Hospital System, a
the University Hospitals Bedford Medical Cent

By "active staff" I mean I have emergenc
room, hospital, and operating room privileges
those hospitals.

Q Have you had any administrative posts in any o
these hospitals?

A Yes.

Q What are those?

A Well, I was Chief of the Orthopedic Surgery
Service at the Meridia Huron Hospital from
January of 1984 through November *of* 1992.

Q Have *you* been involved in teaching at all o er
the years?

A Yes.

Q Please tell us about that.

Since 1980 or '81 I have been a clinical
instructor in orthopedic surgery at the Case
Western Reserve University School of Medicine.

And from the early '80s on, I have been an
Associate Professor of Orthopedic Surgery at the
Ohio College of Podiatric Medicine. That is the
podiatry school here in Cleveland.

Thank you, Doctor, Doctor, on occasion, do you
examine individuals who are not your patients fo

purposes of medical-legal matters or Social Security or Workers' Compensation proceedings and the like?

A Yes.

Q Did you have an occasion to examine the plaintiff in this case, a Ms. Charlotte Heine, at the request of the defense?

A I did.

Q Doctor, could you please tell us when and where that examination took place?

A The examination took place here in my office on April the 7th of 1997

Q Either before or after the examination, did you have an opportunity to review a variety of medical records which were also sent to you?

A Yes.

Q As well as some photographs taken of Ms Heine's knees during surgery?

A Yes, on both of her knees

Q And also some x-ray films, as well?

A Yes.

Q Doctor, have you prepared a report regarding your examination, which is dated April 9, 1997?

A. Yes.

Q. Please feel free to refer to your report or any

of the medical records in answering my questions today, Doctor. And I would ask that any opinions you do give us be to a reasonable degree of medical certainty. Okay?

A. Sure.

Q. Doctor, would you please tell us when you initially saw Ms. Heine, was that on April 7 of this year?

A. It was.

Q. At that time, did she give you a description of the accident itself?

A. Yes.

Q. What did she tell you?

A. Basically, it was a front end impact when a vehicle turned. And she basically stated that she had both feet on the brake, that she felt that both of her knees, but primarily -- well, actually, primarily the left knee was injured. The right knee subsequently became painful a number of months later.

She also was thrown forward and backwards and injured her neck and upper back, as well.

Q. Was there any loss of consciousness in this accident in which you are aware?

A. No, there was no loss of consciousness.

Q. And then she was taken to Fairview General Hospital for a couple of days?

A. Well, she was admitted -- she was appropriately evaluated and admitted for observation. I think the primary reason was because there was some abnormality noted on the initial neck x-rays, and they wanted to get additional films, that they subsequently did.

They did not find any traumatic abnormalities, that is nothing, no fractures, no bones slipped out of position, what we call a dislocation or subluxation. And she was subsequently discharged from the hospital.

Q. While she was in the hospital, there was an MRI of her neck, correct?

A. Yes.

Q. What kind of findings were on that MRI?

A. Well, the findings, basically, despite her fairly young chronological age -- "fairly young" means anybody younger than I am -- it basically showed that, really, the whole middle portion of her cervical spine was involved with a rather pronounced premature aging process or loss of water content within the actual disks, the intervertebral disks. This is called

degenerative disk disease.

We know this by MR scan, because the MR basically sees or detects the different levels of water concentration. And with this type of disk problem, you lose water content.

This is not an acute process, "acute" meaning quick process to start, it is usually a rather lengthy process that can go on for months, years, or decades.

The standard x-rays showed some abnormalities, but the MRI really gave the details. It allowed the doctors to actually physically see the disk tissues and the small bone spurs that were present, clearly indicating a long-term process, not a newly-started process.

Q. From your review of the records, was there any injury to her right knee at the time of the initial accident, Doctor?

A. No, there was no mention of her right knee at all as part of the original injury.

Q. I believe your report mentions that she saw a Dr. Mervart on one occasion regarding some problems with her left knee?

A. Well, actually Mervart is a neurosurgeon. And I think that was just basically a follow-up from --

I think he was consulted in the hospital, and she followed up with him on one additional visit. But there was really nothing that he elected to do. It certainly wasn't a surgical problem in her neck.

Q. She eventually began treating at Beachwood Orthopedics. Are you aware of that?

A. Yes.

Q. And initially, we have already -- the jury will have already heard Dr. Morris's rather lengthy testimony by this time, so I don't want to dwell on it too much.

But could you tell us, from your understanding of the records, what her initial complaints were to Beachwood orthopedics?

A. Well, her initial complaints were spinal. They were in the neck and upper back. I believe in the second visit, which was a couple weeks later, I can't remember whether it was two on three weeks, that is when she first started having some left knee complaints.

They basically for the first block of time ignored her knee complaints, although it was mentioned in the medical records. Their primary concern was treating her spinal condition.

The left knee ultimately underwent, and this was about three months later in September, she underwent some further neurological evaluation in that interim with Dr. Myers and Dr Leizman, I believe.

And then she had her MRI of her left knee And the left knee MRI was radiologically abnormal, and it was elected to proceed with a surgical procedure on the abnormality that was noted on the MR scan.

Q Now, you mentioned there was an M R done by Beachwood Orthopedics

A Yes, by Dr. Leizman, who is one of Dr Morris's associates

Q What parts of the body would an EMG test for?

A Well, the E G stands for electromyogram. It essentially examines a portion of the peripheral nervous system involving the ability of a nerve to conduct a motor impulse to a muscle, and that is essentially what an EMG tests, it tests the conductivity of a nerve and the functional behavior, so to speak, of the nerve and its connecting muscle.

Q. Was this done to her upper body, her neck area?

A. This was really part of the spinal evaluation

with her, the initial complaints that were treated out at Beachwood.

Q. Would there be a sound reason for performing the EMG if there was an MRI previously done at the hospital of her neck area which showed the condition of her neck?

MS. McCARTHY: Objection.

A. The MRI really would give a better structural picture. The EMG basically gives you a functional picture.

Without any neurological deficits, I am not sure what the exact indications there were and exactly clear why the EMG was performed. But from a surgeon's standpoint, even if the EMG was positive and there was a very -- or negative, rather, it was normal, and the MRI was very positive, you tend to ignore the EMG results if there was something that was critical from an anatomical, that is a physical, standpoint.

I don't have any specific indications that I can recall that made the EMG necessary. But then, again, I didn't see her at that time.

Q. Now, she had two surgeries from Beachwood Orthopedics while under their care, correct?

A. Yes.

Q. The first one was on her left knee, and that was in October of 1994.

A. Correct, about a month after the scan.

Q. Now, did you have a chance to look at any of the photographs that were taken during that procedure?

A. Yes.

Q. And can you tell us a little bit about why that is done and how it is done?

A. The surgery, I assume you are talking about?

Q. Yes.

A. The surgery is an ambulatory procedure. It is right now my most common operation that I perform other than fracture and trauma surgery. It is done on an in an out basis, typically under general anesthetic. I always make pictures of a similar quality. Actually, I tend to make a video of the actual surgery, so I can instruct my patients exactly what we do.

Essentially, the procedure is done through a closed circuit TV system where you basically do the operation by watching a TV screen. Through one little incision is placed the arthroscopic telescope, which also has an irrigation system in it to fill the knee up with fluid. And through

separate incisions, I typically only use one, but there are surgeons who use two or three, depending on what their preference is, in order to fully evaluate and to remove damaged or abnormal tissue.

The goal of the surgery is to make normal the knee as well as possible, removing anything that may cause future damage, remove any loose pieces or loose fragments that may be floating around the knee, and also to quantify what the MRI shows.

The MRI basically is a snapshot. It tells you if something is there or it is not there. The details are really a lot more apparent when you are physically looking at the tissues.

Q. When you make these incisions to put these various instruments through, generally how big are the incisions?

A. The incisions are about a quarter of an inch long, about that wide.

Q. And there may be either one, two or three on someone's knee?

A. I almost universally use two. There are some surgeons, and I think Dr. Gabelman, who did the surgery, typically uses three. One extra one is

for irrigation purposes only

But typically most doctors use two Some use four I mean, whatever the preference It depends on how you learned how to do the technique, and how complicated it gets and whether you can see what you want to see through the two incisions that you originally planned

Q You said this is ambulatory? Does that mean the go home the same day?

A Correct.

Q Now, you don't do the surgery. Is you see photographs taken during the procedure?

A Yes.

Q What do those tell you about Ms Heine's left knee, at least at the time what the surgery was performed? If you want to feel free to look at the photographs or even show them to is if that will help.

MS. McCARTHY: Objection.

A Again, and these are somewhat -- they don't mean anything unless you have seen lots and lots of these, and I will try to hold this up and use a pointer.

Q Just by way of background, I had supplied these to you?

A. Correct.
Q. And these were from Dr. Gabelman's chart, his office?
A. Correct. I will use a little laser pointer. This is the end of the thigh bone, or what we call the femur. This area over here is the top of the leg bone, or the tibia. And this raggedy looking tissue here is the complex tear that was in the medial meniscus.

Now, the complexity of the tear and the somewhat raggedy appearance, it looks like a frayed piece of cloth. And, essentially, this is the appearance of a chronic, long-term, meniscal tear.

I think that if you look down here, the next picture you can see is a metal probe going over here. And you can see that this is not a tear like you would split your -- rip a piece of paper in half or punch a hole, or a button hole type of appearance. This is a very raggedy looking tear. And you can see it in this one, too. Again, not a real clean appearance.

Unfortunately, these are reversed, so I will need to flip these over. The other thing that was noted, on the undersurface of the femoral

condyle on the end of the thigh bone, the cartilage appeared to be also very, very raggedy in appearance; that is, when you break open a chicken bone that nice pearly white, smooth substance, this was not pearly white and smooth, it had a lot of dents and furrows in it.

And what Dr. Gabelman ended up doing, if you look down here, is used a little shaving device and he removed the cartilage, the torn parts of the meniscus, removed the frayed parts of the arthritis that was making up the end of the thigh bone, and basically she is left with a pretty clean appearance. This looks much, much better than the original one that we looked at.

And this is the lateral meniscus, or the outside cartilage, And we notice that it is absolutely pristine surfaces on the top and bottom with a normal appearing cartilage.

This was the intra-articular, the inside of the joint, photographs that were made at the time of the first surgery. And they clearly indicate an extremely long-standing degenerative type of meniscal tear. This is not the appearance of an acute, certainly two months old, three months old, type of tear. This is something that looks

years old, if not longer.

Q. If it was a very recent or had just occurred as a result of the accident, what would you expect to see different?

MS. McCARTHY: Objection.

A. You wouldn't see the articular cartilage damage typically what happens -- the bad thing about these injuries, and why the doctors tend to want to remove that tissue, is that it acts like a pebble in the shoe. If you step on a pebble and you step on it, it is not only painful, but it can actually give you a blister.

Well, what happens, when that blister type damage from this tear affects the end of the thigh bone, what happens is that it destroys the cartilage. And this is a tissue that the body cannot repair itself.

And once that is damaged, you can always see damage, it may work fine, but you can always see the damage.

This is not the type of thing you would see with a direct impact type of trauma. This is a grinding away type of situation that looks years old. It looks like it is ancient.

Q. Now, a month later she had right knee arthroscopic

surgery. And I had supplied you with photographs taken of her right knee, although, admittedly, I guess they came out fairly poor when they were taken during the procedure.

Again, this is probably because the light source was a little tiny bit different. I think with very little imagination, if I can figure out how to use this thing, again, this is the end of the thigh bone, and the same type of raggedy looking tear is located along the back side of the inner cartilage, the one that is on the inside of the right knee. And this was a knee that wasn't eve injured.

This was not the knee that would bother her. And we have virtually the identical appearance of a meniscal injury, something that looks identical to the one that was hurt.

In other words, the cartilage was chewed u to the same degree. And absolutely the identic procedure was performed on the uninjured knee a month later.

This clearly indicates to me that she had the same process going on in both of her knees, premature arthritic process, similar to the arthritic process going on in the mid-portion c

her neck and neither one of these damages, so to speak, were from a singular incident of trauma, especially the right one. And there was no identical appearance on the left one to the right one.

MS. McCARTHY: Objection. Move to strike.

Q Was there anything on your review of either of these sets of photographs which appeared to be caused by the automobile accident of June of 1994?

MS. McCARTHY: Objection.

A In my opinion, the chronic meniscal tears would not have been caused by the motor vehicular accident, as it was described, and with the short period of time that transpired between the car accident and the time of the arthroscopic surgeries were performed.

Q Doctor, at the time you first saw Ms. Heim -- or you saw her on just one occasion, is that correct?

A. Yes.

Q. And um per the rules of the Court that are set up, are you only allowed to see and examine her on one occasion?

MS. McCARTHY: Objection.

A. I am not a lawyer, so I don't know what the rules are. But typically I am not allowed, unless both counsel need or want an update, I am usually only allowed to see them once.

Are you familiar with the arrangements between the local Bar Association and the local Medical Association regarding these examinations?

A. Yes, I am very well aware of that.

MS. McCARTHY: Objection.

Q. Under those rules, are you permitted to see a litigant in a personal injury case more than one time --

MS. McCARTHY: Objection.

Q. -- for an action examination?

A. Typically I am not, unless both parties agree to a second examination. I can't ask for a second examination, and the patient can't ask me for a second examination.

Q. Are you allowed to offer any medical advice to the patient?

MS. McCARTHY: Objection.

A. No, I am not.

Q. Are you allowed to treat the patient at all?

MS. McCARTHY: Objection.

A. I am not allowed to give the patient any recommendations or any treatment. It is strictly an evaluation, a second opinion, so to speak, for whoever asked me to see the patient. I am not allowed to really share that information with them, or give them any advice or recommendations of what they could do in the future.

Q. At the time that you saw Ms. Heine, what were her complaints to you in April of '97?

A. The complaints at that time, she still had a lot of complaints. She still had problems with her neck. She had difficulty lifting. She had a tingling sensation in both shoulders. She had a great deal of -- do you want me to just read what I have in my report, because I have no physical recollection of it.

She basically had problems with her neck. She had less problems with the low back. Her knees at that point in time were off and on, they weren't as consistent as her neck and upper back symptoms were.

Q. Did you conduct a physical examination of Ms. Heine?

A. Yes.

Q. Was anyone present during the physical

examination and the time spent with her?
A. Yes.
Q. Who was that?
A. Her attorney was there.
Q. Was that Mr. Berena?
A. Yes.
Q. Please tell us what you examined, what parts of her body you examined, and what you found upon your examination.
A. The examination that was performed was a complete orthopedic examination on the areas that she had complaints. This is the same exam that I do 40 to 60 times a week on the neck, the low back, and on both of her knees. So I did a thorough, comprehensive orthopedic examination on those areas.
Q. Tell us about your exam of her neck area, which is called the cervical spine?
A. Correct.
Q. Tell us about that.
A. Well, first I tend to watch how people walk. She was able to walk on her heels and toes. She didn't have any gross limping. She did not have any atrophy or gross wasting of her leg muscles when she was observed walking in and out and

during the history portion of the examination.

The neck exam revealed no objective signs, "objective" meaning abnormalities that I can see, touch, feel or measure. She had some complaints which only she feels, and then there are objective findings, if they are present, which is a manifestation, a physical manifestation, of complaints, so to speak.

Q. Are complaints what we call subjective complaints?

A. Yes, they are feelings that one has that no one else really has other than the person making the complaints.

Q. And the objective findings would be your measurements or your examination which would verify or confirm some physical problem with her?

A. They may or may not confirm a physical abnormality, or something else may show up that she was unaware of, he or she would be unaware of.

Q. I am sorry for --

A. So, in other words, what I am looking for is she had a bunch of complaints, and I am looking for any physical abnormalities. I knew she had some MR abnormalities, but I was looking for: Is there

anything on physical examination that I could see?

So, in general, what I look for is the posture, the position, how people hold themselves, how they move, how they change positions.

I felt and touched the major muscle groups in the front, side, and back of the neck, upper back, shoulders. I watched how she moved her neck, her upper back, her scapula, which are the shoulder blades.

There seemed to be a voluntary restriction of motion. In other words, she said she couldn't move any farther, but I could not see any tightness of the muscle or any spasm or any guarding of the muscle. And these would be objective signs of the muscle not functioning normally, or a muscle overprotecting.

The movement of the shoulder blade she claimed to be painful, but essentially the movement was normal. The muscle development in the neck, upper back and shoulder area appeared to be proportional, that *is* the left and right, and appeared to be well developed. There were no signs of a single or a group of muscles that

appeared to be being favored. She had a fairly normal appearance for someone 47 years old of her height and weight.

The examination also included exam of the shoulders, the elbows, the wrists, and the small joints of the hand. I looked and felt and tried testing the strength of these muscle groups. I looked at them, and I also physically measured them with a tape measure, measuring the circumference of her arms at the armpit, the mid-arm and forearm, as well at the wrist levels. There was no atrophy or size difference between the left and the right side noted.

And in neurological examination, that is her ability to detect sensation, the motor exam and reflex exam was performed, and I was unable to determine any lesion, any abnormality that would be affecting a particular nerve root or part of the nervous system.

Q. When you say this neurological examination was normal, what are you looking for in terms of some of the complaints or the degenerative problems that were seen on the MRI films?

A. Well, again, when I had seen her I had not looked at the medical records. So I was unaware at that

time what the diagnostic testing had uncovered other than what she told me her understanding was.

In other words, I don't look at the medical records, I didn't look at the x-rays, prior to the examination. So, at that time I just go in cold, so to speak, and I just look for any abnormalities I can find.

She did claim to have some stiffness. But typically when there is stiffness related to irritation of muscle there would be some guarding, some factor of the muscle either protecting the individual or protecting one group of muscles in certain movements. So that is what I look for.

I look for an abnormality of a nerve root. That is a part of a branch of the nerve that leaves the spinal cord and goes to a particular area of the arm. And I did the same thing in the legs, too, but we are talking about the arms right now.

I looked for any ability to detect -- abnormality in sensation. Now, although sensation, or the ability to feel, is subjective, the pattern is objective.

In other words, if they are numb within a

certain area, although they feel it and I can't feel it, it can be objective in its distribution.

In other words, does it follow a particular nerve root? Does it match with any other symptoms the individual may have? So even though I can't tell it is numb, if the numbness follows a certain distribution, that can also add up into a possible abnormality.

Q. And that part of your examination was normal?

A. Correct. So even though she had all of these very unusual neck pictures on the MRI scan, there was really no physical abnormality that shows any neurological impingement, that is a squeezing, a pressure or irritation of any of the nerves in her spinal cord or leaving her spinal cord.

Q. Did you also examine her low back?

A. Yes.

Q. And that is called a lumbar spine?

A. Correct.

Q. Tell us about that.

A. Again, a similar type of examination was done in her low back. I asked her to move in certain directions, and she had approximately 90 percent of what I expected her to have. So there was a minor degree of stiffness, but really she had

fairly normal motion.

Again, certain provocative testing was done in order to test whether there was any irritation of the nerves of the low back, the nerves that go from the back to the legs. And these tests were all normal. The hip joint also examined normally.

So other than a little stiffness in the low back, really no objective abnormality was noted. And she had over 90 percent of her predicted movement.

Q. Did you examine her knees?

A. I did.

Q. What did you find there?

A. I examined the knee, and I will basically go over my findings, and probably easier to go through what I look for in examination.

What I first look for is I look for alignment. Is there an angulation, what we call a varus or valgus deformity, that is a knock-kneed or bowlegged deformity. And she had none, the knees were straight.

I then look if there is any effusion, or water on the knee. This can be seen and it can be felt. Neither of that was felt. Effusion, or

water on the knee, usually comes if the body remains inflamed, the knee is inflamed, and the body tends to form fluid to sort of protect itself, or to cushion the structures within the knee.

I then look at range of motion, how flexible, how mobile is the knee? And she had a normal range of motion of both knees.

I then test the ligaments, both the inside ligaments and the outside ligaments. This is done with manual stressing. That is holding one area and wedging or trying to push the knee open.

I then do the same thing with the front and back ligaments of the knee. I then test rotational instability, which, basically, I am looking at the cuff of ligaments that run around the knee, and the two ligaments that run in the middle of the knee. This is a typical sports knee evaluation was done.

The only abnormalities that were noted is under both kneecaps. When she bent and straightened the knees, there was a slight grinding sensation, a rubbing sensation, and this was undoubtedly part of this minor degenerative

abnormality underneath the kneecap. But it was not significant, and it was not severe, and it was not painful. It was just an objective abnormality. And this was very minimal.

I see this universally in people over the age of 50, and I may see 30 or 40 of these a week. I felt that these findings were there, but they were minimal, and they certainly were not painful.

I then looked at the circumference of the knees, actually took a physical tape measure and measured at the bend of the knee to see if one knee was larger than the other knee, and both knees were the same size.

I then did the same for the measurements of the muscles of the thigh and the muscles of the calf, and they feel equal and symmetrical, that is that both sides were the same.

The only other objective finding was the healed arthroscopic incisions. And I believe that there were four incisions on each of the knees.

Q. Did that complete your physical examination of her?

A. Yes.

Doctor, did you also happen to review a variety of medical records sent to you?

A I did.

Q Could you list those records, please.

A The records that were reviewed included those from the Fairview General Hospital, the records form Beachwood Orthopedics, including the MRI scan results, and basically from the West Side imaging unit, the records from Dr. Morris, Leizman and Gabelman.

There was the actual x-ray films that were done in the hospital. But I did not see the actual MRI films both at the hospital or the ones of her knees. I also did evaluate the actual arthroscopic pictures that were taken at the time of the surgery.

Q Doctor, based on your examination of the plaintiff, and any of the records which you reviewed, were you able to form an opinion based on a reasonable degree of medical certainty as to Ms. Heine's condition at the time of your examination?

A Yes.

Q Could you please tell us that.

A At the time that I saw her, she had some

subjective residuals of a cervical, that is a neck, and low back strain or sprain, a stretching muscular injury.

Q. What do you mean by "subjective residuals"?

A. In other words, the way the accident occurred, and the way the mechanism which was suspected would have caused this type of injury, that is a stretching or pulling injury to the neck, if it was more severe, then there could have been a more severe bony injury or disk injury sustained. But there was really none that was ever noted.

So my opinion was that was, essentially, the injury that she had, a stretching or pulling injury of the muscles or ligaments of the neck and the low back. And there was also a probable contusion to the left knee, although this was not a contusion that produced a black and blue mark.

Q. Did any of your diagnoses regarding the knee relate to the automobile accident itself, as far as your findings on examination?

A. Well, the findings were normal, other than the arthroscopic incisions and the slight degree of patellar grinding. And none of those were part of the accident.

Q. Regarding your examination and your review of the

records, do you have an opinion as to whether the knee surgeries which she had were due to the automobile accident?

MS. McCARTHY: Objection.

Q. And if you want to separate out the left and the right knee, please do so.

A. I do have an opinion.

Q. What is that, please?

A. The surgery on the right knee, in my opinion, was unrelated to the accident. There was never an injury. There was never a problem. Although I believe it was Dr. Morris's opinion she may have been limping and favoring it, she wouldn't have torn a meniscus doing that.

Initially when I reviewed the case, before I saw the arthroscopic pictures which came somewhat later, it sounded like, according to what she said, that the left knee injury may have been caused and the surgery may have been necessary on the basis of the history she presented to me and the time of my evaluation.

However, when I looked at the intra-operative pictures, that is the pictures taken during the surgery, the same type of tearing was noted in both of the knees, virtually identical. And the

right knee wasn't injured and had that. Then I really questioned how the left knee injury could have torn the meniscus in that chronic manner.

The actual surgery was done for the torn cartilage, and I don't believe that the torn cartilages were due to the motor vehicular accident. And I guess that probably summarizes it. The actual need for the surgery was the tears. And the tears, in my opinion, were not caused by the accident.

Q. Would they have predated the accident, in other words, occurred before the accident?

MS. McCARTHY: Objection.

A. By their appearance, in my opinion, they probably preexisted the injury by a substantial period of time, months if not years.

Q. Doctor, you said that you do some of these arthroscopic procedures, as well, correct?

A. Yes.

Q. When you do a procedure of this kind, what is your general fee for the procedure?

MS. McCARTHY: Objection.

A. I am assuming, reading the operative note, it was for a partial meniscectomy and chondroplasty, which would be anywhere from $2,000 to $2,200.

Q Yes. And if I can just use the words that are on the bill from Beachwood Orthopedics, "Arthroscopy of the knee with debridement and shaving as well as a meniscectomy."

A It would be about $2,000, $2,200.

MS. McCARTHY: Objection.

Q And that would be for the entire procedure?

A Correct, the surgeon's fees. And most insurances wouldn't pay anywhere near that.

Q All right. I believe the records would indicate the bill charged by Beachwood Orthopedics was approximately $5,200. Would your fees in any circumstance approach those for a single operation?

MS. McCARTHY: Objection.

A My fees for a total knee replacement would not exceed that amount. So I think that is a little high.

Q And after you perform a similar surgery on one of your patients, would it be typical that you order some type of rehabilitation of your patients to get their knee back in shape?

A Yes.

Q Would that include a certain amount of physical therapy?

A It usually includes some degree, yes.
Q And approximately how many physical therapy treatments would you generally order to rehabilitate, say, a middle-aged woman with this type of procedure?
A Five to ten treatments, with home exercises.
Q Doctor, do you have a prognosis for Ms. Heine as far as what the future holds?
A Yes.
Q Could you please tell us what that is.
MS. McCARTHY: Objection.
A The prognosis for soft tissue injuries I believe is good. Soft tissue injuries typically heal. And, really, on the basis of the evaluation, I was unsure as to where her severe symptoms were still coming from.

Now, she does have some degenerative problems. Now, there is no clear indication in the records or in the test that was done that there was any acceleration of these problems or permanent aggravation of these problems.

Typically, these problems will always get worse with age. So I would expect that if she is normal, and most people fall into this type of category, degenerative changes always get worse

as you get older.

But there did not appear to be any physical injury to these tissues that would have accelerated this process. So, from a prognostic standpoint, I would say it would be guarded solely on her degenerative problems.

But on her acute injuries, on any injuries she may have attained or received as part of the car accident, I believe those have healed and would have healed long before I saw her.

Q. Could you tell us, finally, Doctor, exactly what you believe, to a reasonable degree of medical certainty, were the injuries to Ms. Heine as a result of this automobile accident.

MS. McCARTHY: Objection.

A. In my opinion, the injuries sustained were a soft tissue strain or sprain of the neck and low back, and possibly a contusion of the left knee, although that was not documented for two weeks. And typically when people bruise themselves, it comes about rather rapidly. By her history, this may have occurred.

Q. Have the opinions you have given us today, Doctor, been to a reasonable degree of medical certainty?

Yes.

MR. KROHNGOLD: Can we go off the record for just a minute, please.

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

MR. KROHNGOLD: Doctor, at this time I don't have anything further. Thank you very much.

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CROSS-EXAMINATION

BY MS. McCARTHY:

Q. Dr. Corn, my name is Ellen McCarthy. And I, along with Leon Plevin and Mr. Berena, represent Charlotte Heine.

As I understand it from the conversation earlier, Mr. Krokngold did send you some correspondence with respect to this case?

A. You know, I don't keep any correspondence with any attorneys for any reason. So I don't know if I have received anything,

I think it was Mr. Hurt who hurt contacted my office for this exam. I believe the only communication we had was a fax notice of the deposition time from Mr. Xrohngold's office. I didn't even know he was involved initially.

Q. So any correspondence that might have come through is not here for us to review today; is that fair?
A. I don't keep it, and I don't even know if I got it or what it contained.
Q. Dr. Corn, what do you charge for your deposition testimony?
MR. KROHNGOLD: Objection.
A. The charge is basically a charge for the service, and it is based on an hourly basis, and it is $900 an hour.
Q. Did you charge for your report, your examination, and your review of the records?
A. There was a global fee that was submitted for the actual examination, review of medical records, and the production of a medical report. And that was one fee that was probably sent in back last April.
Q. What was that fee?
A. I have no idea.
Q. About what would you expect it to be, given the nature of this case?
A. Probably in a range between $900 and $1,700.
MR. BERENA: I am sorry, I didn't hear you, Doctor.

THE WITNESS: Between $900 and $1,700 for the whole service.

MR. BERENA: For the report?

THE WITNESS: For everything.

MR. KROHNGOLD: If we can just have one attorney asking questions at a time. I mean, when Ellen is done, Mr. Berena, if you want to ask questions, but I prefer we not go back and forth and back and forth like this.

MS. McCARTHY: Okay.

Q (Continuing.) Doctor, in terms of the records that you did review after your examination, did you have an opportunity to review Dr. Mervart's records?

A. No.

Q. Have you ever seen those records?

A. No.

Q. I think you said earlier that Mrs. Heine sustained a sprain or strain to her neck, upper back, and lower back; is that correct?

A. I said neck and lower back. But that was my opinion.

Q. Is a sprain or strain of the neck or low back productive of pain?

A. For a period of time, sure.

Q. Why is that?
A. That is a good question. Most people don't have a scientific explanation for that. But it usually involves irritation of the muscles in response to an injury.

We have all had the feeling of a pulled muscle or an overused muscle, and that is essentially varying degrees of uncomfortable.

There may be some local irritation of some of the nerves that supply the muscles. I am not really sure of the exact etiology of where the pain comes from.

Q. In your report on page eight, top paragraph, you indicate she was objectively recovered from her neck, upper back, and lower back injuries.

Do you see that?

A. Yes.
Q. When did she recover?
A. An exact date she recovered? I really don't know the exact date. I know she had not sought any medical care or attention for quite some time. I would imagine it was sometime in 1995.
Q. You can't say with a reasonable degree of medical certainty when, precisely, this woman recovered from her neck and back injuries which you

attribute to this accident; is that a fair statement?

A. I have no idea.

Q. Have you ever diagnosed a patient of your own with permanent injuries to his or her neck and back from strains and sprains?

A. I may have at one point in time in the past, yes. They usually have some other component to it. But I do believe there can be permanent objective injuries from soft tissue that have been torn or chronically inflamed.

Q. Can a person have a degenerative condition and never know it?

A. Absolutely.

Q. Can a person have a degenerative condition and never have any pain or any problem associated with that condition?

A. Well, realistically I am sure people would say yes to that answer, but they probably have some stiffness or some weather change feelings. They may have something they may not be aware of as needing to see a doctor.

But I think there are many people that do not seek medical attention for nuisance complaints that may be degenerative in nature.

Q. When you asked Mrs. Heine if she ever, prior to this accident, experienced stiffness or weather type changes in any of the affected areas that you have talked about, in particular her knees, what did she tell you?

A. I don't remember if I asked that particular question.

Q. Can a person have a degenerative condition which doesn't produce any pain and get involved in a motor vehicle accident and suddenly have pain?

A. Is it possible? Sure, it is possible.

Q. Why is it possible?

A. If there has been a significant enough stretching injury to the joint, if it is a joint, or if there is a disk that goes beyond its normal degree of movement, or a ligament that goes beyond its normal degree of stretchability or strength, sure, you could injure a degenerative condition. I don't think you are more susceptible, but I think that, sure, you could injure it.

Q. There is no evidence that this woman had any prior problems with her knees, is there?

MS. McCARTHY: Objection.

A. Again, I really didn't see any records that

that, in your opinion, the injury, at worst, created a minor tear or aggravated a previously torn medial meniscus.

You will stand by that statement today, won't you?

A. Sure. That is a probability, yes.

Q. When you took her history, she told you that in addition to hitting both knees either on the steering column or the dashboard, she also had a twisting type injury to her knee? She told you that?

A. She may have told me that. It is difficult to picture, but she did tell me that.

Q. It is noted on the second page of your report.

A. That is because she told me that, yes.

Q. Would you agree that a twisting motion of the leg can produce a tear to the medial meniscus?

A. A twisting movement with certain other parameters, not just a twisting movement, that it is part of a mechanism for a tear.

Q. Doctor, is the nature and extent of property damage significant in terms of the extent of injury?

A. No, not in my opinion.

MS. McCARTHY: I don't have any

more questions. Thank you.

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CROSS-EXAMINATION

BY MR. BERENA:

Q. Doctor, I would like to ask you a number of questions.

I need to get this microphone.

MS. McCARTHY: Oh, sorry.

Q. Do you have the records that were submitted to you by Mr. Krohngold or Mr. Hurt in front of you, Doctor?

A. I don't have all of them. We sent them back. I have some of the records still here.

Q. I am going to direct your attention to the nursing progress notes which are dated June 10, 1994.

A. From which source?

Q. This would be from Fairview General Hospital.

A. Okay.

Q. I don't know if you found the same.

A. I do. Page 42?

Q. Well, up at the left-hand corner it says 6/10/94.

A. Unfortunately this doesn't have the 6 -- the first number is off of it. But it says "1700" in the top margin.

Q It starts out reading, "Patient admitted to 227-2 for observation.

A I do not have that.

MR. XROHNGOLD: It might be up here on the top line.

A Oh, yes, I do have that. Yes, okay.

Q You do have that?

A Yes. That is not the first thing that it says.

Q All right. Doctor, first of all, June 10, 1994, that was the very day that this accident occurred; is that correct?

A Correct.

Q And you have mentioned you understood that Mrs. Heine came in by ambulance to the emergency room at Fairview General. And reading toward the end of the second line on my sheet, please follow along with me on your copy, it says, "Complains of left shoulder, arm, and knee pain.''

Is that correct?

A Yes.

Q So that we can understand that a person at Fairview General, perhaps a nurse, spoke with Mrs. Heine, and these are the things that that nurse recorded that Mrs. Heine told that individual; is that correct?

A. I assume that is how it happened, sure.
Q. So that is a statement by Mrs. Heine that her left knee is bothering her on the very same day that she first comes into Fairview Hospital, the very same day of the accident; is that correct?
A. It does mention that, yes.
Q. If you would go down about six or seven lines, toward the right-hand side it says, "C/O," with a slash in between, "general soreness."
What does that "C/O" mean?
A. Complains of.
Q. So she told the person that wrote this down that she had soreness in a generalized way; is that correct? How do you understand that, Doctor? What does that mean?
MR. KROHNGOLD: Objection.
A. I don't have any idea what that means.
Q. General soreness would mean throughout various parts of her body; wouldn't that be correct?
A. I don't know.
Q. Do you know if that person asked her, "Mrs. Heine, do you have any pain in your right knee?"
A. Again, I don't know what questions were asked, and neither does anybody. All we know are some of the responses that she may have made and that

were recorded by a licensed practical nurse on that particular point in time at 1700 hours.

Q. Would you please follow it down there a little bit further there, Doctor. A few more lines below that it says, "Complains of generalized pain." Then it says -- would you read those words? It starts out with the word "very," "Very slight --"

A. It looks like, "Very slight edema noted, left knee."

Q. What does the word "edema" mean, Doctor?

A. It means swelling.

Q. And the person then looked at Mrs. Heine's knee?

A. We don't know that.

Q. And then wrote this?

A. I don't know.

Q. What is the normal course of your experience -- you have hospital privileges, you said, at all these various hospitals.

A. Correct.

Q. How are the nurses trained, to your understanding?

A. I have no idea.

Q. What are the nurses called upon to do in writing these records?

A. Basically, they have to chart what transpired

during various time periods of their nursing shift.

Q. Do they write down what they see with their own eyes?

A. I have no idea what they are told at Fairview General Hospital.

Q. It says, "Very slight edema noted, left knee"; is that correct, Doctor?

A. That is what it reads.

Q. So someone wrote that down --

A. Obviously.

Q. -- from observing or looking with their eyes at Mrs. Heine's left knee.

A. I can't say that for sure.

Q. What does the word "edema" mean, again? I didn't understand what you said.

A. Edema is actually a subcutaneous collection of fluid.

Q. And you stated earlier in your testimony that a twisting and a medial meniscus tear would result in fluid being accumulated in the knee, didn't you?

A. I never said that, no. The question was: Can a twisting injury injure a meniscus?

Q. I thought earlier in your testimony, excuse me, I

thought you said that fluid would accumulate where there was a torn medial meniscus.

A. No, it doesn't always do that.

Q. Okay. But does it do it sometimes, Doctor?

A. Well, it accumulates in a very specific pattern, and I can't say that that is the one that is being described here.

Q. But my question to you, sir, was: Does fluid accumulate on occasions when there is a torn medial meniscus?

A. Sometimes, about 25, 30 percent of the time.

Q. All right. Perhaps on this particular day, then, you are aware Mrs. Heine was bedridden, that she stayed in a bed for four days while she was at Fairview Hospital?

MR. XROHNGOLD: Objection.

A. Again, I don't know what her mobility status was. It is not real clear from reading the medical records.

Q. If we go down a few more lines, please, Doctor, if you would follow me, it says -- this is now on June 11th, this is the next day, it says, "0800."

Do you see that line, Doctor?

A. Yes.

Q. It says, "Complains of generalized pain, mainly

on the left side. Sore back." And what are the next words there? I can't quite read that.

A. "Lying in bed. Has a history of back problems."

Q. So she is lying in bed when this note is made.

A. No, we don't know if she is lying in bed. We know that at 800 hours this was the recording. It recorded that is 8:00 in the morning the day after the accident.

This is what the first nurse is noting at some point in time on that shift.

Q. This is the next day that we are talking about.

A. The next morning.

Q. Please go down about six lines. I see an "L" with a circle, and it says, "L knee." Could you read that for us, please.

A. I am sorry, I have no idea where you are talking about now.

Q. About four lines down further.

A. From where?

Q. From where we just read where it says "Mainly on the left. Sore back." Go down five lines.

A. "Left knee hurts when ambulates to bathroom." So she is clearly not in bed.

Q. What does that indicate, Doctor?

A. That means she is complaining of left knee pain

when she is walking to the bathroom.

Q. When she got out of bed to go to the bathroom --

A. The morning after the accident she was walking to the bathroom, and she complained her left knee hurt.

Q. And a nurse wrote that down in this chart; is that correct?

A. That is what it says.

Q. You have no idea what caused the pain to her left knee?

A. I don't think anybody does.

Q. In common sense, when she had just been in an accident the day before, what do you conclude from common sense, Doctor?

MR. KROHNGOLD: Objection.

A. I found that common sense has very little relevance in medicine, especially trying to interpret someone else's opinions and what they are putting down. Common sense plays no role in this whatsoever.

Q. Would you go down about -- let me count the lines, please.

A. Maybe we can start at the bottom and count up.

Q. Well, *yes,* we could do that. Five up from the bottom. This is in a different handwriting,

isn't it, Dr. Corn?

A. Well, I am not a handwriting specialist, but it look pretty similar to the one that was written the night before.

Q. Let's look at the part where it says, "Left knee hurts when ambulates to bathroom."

A. That is definitely a different --

Q. That handwriting is definitely different than this handwriting, isn't it?

A. Yes, that is absolutely true. This is 1630, which is 4:30 in the afternoon.

Q. Can you read what it says there, Dr. Corn.

A. "Skin warm and intact. Denies pain."

Q. No, where it says, "Complains of," a little bit lower.

A. "Denies pain at present. Complains of left knee, ankle, shoulder soreness, left knee slightly edematous."

Q. What does that mean, Dr. Corn?

A. I have no idea. "C-collar remains on. Patient wishes to go home."

Q. Mrs. Heine was observed by another person who has different handwriting at this time that you have indicated. That person wrote down in this chart, "Complains of left knee, ankle, shoulder

soreness, left knee slightly edematous." I don't understand, what is "edematous"?

MR. KROHNGOLD: Objection. He said that didn't know. Asked and answered.

A. "Edematous" is the adjective for "edema."

Q. And edema means collection of fluid; is that correct?

A. Yes.

Q. So we now have another person observing Mrs. Heine's left knee and writing down "edematous."

A. We don't know that.

Q. Well, it is two different handwritings.

A. We know that there are two different persons entering that. We don't know if it is the patient saying that. We don't know if it is the nurse saying that. We know it is the nurse recording that.

Q. From your experience and your admissions at all these various hospitals, you don't understand that the nurses are supposed to write down the objective findings that they see in the chart?

A. I have no idea what the nurses are instructed to do. I spend very little time reading the nurses' notes to determine physical findings because they

are usually very unqualified to give expert findings medically, especially from an orthopedic standpoint, which is a lot more confusing than the typical medical findings.

Q. But don't you, as a treating physician, don't you read the nurses' notes before you further treat a patient? Don't you use that information?

A. No, not typically. I scan the nurses' notes. I usually, typically, make rounds with the nurses, so I don't usually read their notes until I sign off on the chart. So I do not use the nurses' notes as a practical means of patient management.

Quite frankly, their assessments are not always accurate when it comes to complex diagnostic areas. I think it is important that --

Q. Is observing --

MR. XROHNGOLD: Objection. Let him finish his answer.

Q. Excuse me, Doctor. Is observing a swollen knee, is that a complex diagnosis?

A. If you don't know -- well, we don't know who is saying that. We don't know what that means. It is not quantitated in any way, shape, or form.

It doesn't say what position the knee appeared to be swollen in. It didn't say where

the knee appeared to be swollen. So it really gives me no clinical information whatsoever except that somebody wrote it down.

Q. Somebody that happens to be a registered nurse, and another person that happens to be a registered nurse.

A. Again, it says LPN. These are licensed practical nurses.

Q. And they have years of training, don't they, Doctor?

A. I don't know what their training is. I am sure it is not as long as medical training.

Q. Let me ask this question: Mrs. Heine explained to you how this accident happened; is that correct?

A. Yes.

Q. She told you she had both of her feet on the brake pedal at the time of the impact?

A. Correct.

Q. She told you that the impact caused her feet to slip off of that brake pedal?

A. She said that it slipped off after the impact.

Q. And she told you --

A. I did not understand that the impact caused the knee, caused the legs, the feet to come off of

the brake pedal. That is not what I understood.

Q. Mrs. Heine further explained how close she was to the steering wheel and the dashboard in her vehicle, didn't she?

A. She may have.

Q. Now, you mentioned that you saw Mrs. Heine for the first time, and you first saw her on April 7, 1997; is that correct, Doctor?

A. Correct.

Q. And that is about two years and ten months after this collision occurred; is that correct?

A. That is probably true. I didn't do the arithmetic, but I would have no problems with that.

Q. How many physical therapy treatments had Mrs. Heine had before you saw her?

A. I have no idea. Probably over 70.

Q. How do you come up with the number 70?

A. I think that is what they did at Beachwood Orthopedics.

Q. Did Mr. Xrohngold write you that number in one of his letters?

MS. McCARTHY: Krongold I counted them up and I told the doctor.

A. He told me 73 or something like that.

Q. So you hadn't counted them yourself, right?
A. I don't the waste my time doing things like that.
MR. KROHNGOLD: I waste my time doing things like that.
Q. Mr. Krohngold counted them and he brought it to your attention; is that correct?
A. Mr. Krohngold mentioned to me that -- he mentioned the care and treatment, and that is what he told me.
Q. How many prescriptions had Mrs. Heine had for pain medication before she saw you?
A. I have no idea.
Q. How many prescriptions for other types of medications, muscle relaxers, et cetera, had she had before she saw you?
A. I have no idea.
Q. How much time had passed after this accident before Mrs. Heine was first seen by Dr. Morris?
A. I think it was a couple weeks.
Q. So he saw her within 14 days of when this accident occurred; is that correct, Doctor?
A. I think that is what the records indicate.
Q. How many times did he see Mrs. Heine over that two years and ten months before you saw her?

A. I have no idea. I haven't counted the number. I am sure you have that number.

Q. Doctor, would it be fair to say -- you are a physician -- if you had seen a patient over a protracted period of time yourself, one of your patients, and you had performed various tests and various office examinations on more than one occasion over a period of two years and ten months, would you be in a better position to give opinions about your patient than Dr. Morris if he saw your patient one time two years and ten months after an incident?

A. Well, in fact Dr. Morris has seen some of my patients and has come to similar conclusions that I have.

The thing is that I cannot tell you how she was at all those various times. I rely on the medical records, their validity, their truth, their honesty, and their completeness. That is not what my job was here.

My job was to evaluate her at one particular point in time a number of years after the accident to ascertain what any degree of permanence was, what her current injuries are, what her current problems are.

I am sure that I have no idea, and I am sure that Dr. Morris, other than his notes, may have no idea what each and every one of his visits were. You are talking about apples and oranges. That is not my job.

My job was to look at her one particular time, to look at her present condition at that point in time, to review the medical records and give opinions of how she was at that particular point in time. That does not necessitate me being there at every single visit to see how she was at one point in time.

Q. Dr. Corn, on page four of your report at the bottom, it says, "Past medical history."

Do you see that portion, sir?

A. Yes.

Q. Would you read just the first four or five words after "Past medical history."

A. It says, "Past medical history revealed absolutely no prior knee problems."

Q. Mrs. Heine was able to go about her daily life and she was pain free, she had no problems with her knees before this collision; isn't that true?

A. That is what she said.

Q. Do you have any reason not to believe Mrs. Heine?

A. I don't have any opinion one way or the other.
Q. Well, when you saw her, did she appear to you that she was trying to deceive you or mislead you or lie to you?
A. You know, I didn't give her that opportunity because I didn't really look at the medical records and try to quiz her on what she may have said or didn't say. That was not the purpose of it.
Q. Well, neither defense counsel has ever given you Dr. Mervart's records even up to today; is that correct? You haven't seen them?
A I haven't seen them.
Q. Thank you. Now, you mention in your report that your opinion about this degenerative condition is based upon the films that you took, the films that you looked at from Dr. Gabelman's surgery; is that correct?
A. The arthroscopic pictures, yes.
Q. And you are aware that Dr. Morris has a different opinion; is that correct?
A. I have no idea what his opinion was. He wasn't even there at the time of surgery.
Q. Is it fair to say that physicians have different opinions regarding the treatment of different

patients?
A. I think when you lock at objective findings, such as pictures of an abnormality, I don't know how you can have a great deal of individual opinion.
Q. That wasn't my question, Dr. Corn. Your approach treating a patient may be different than a different physician; is that correct?
A. My approach to treatment?
Q. Yes.
A. Sure, absolutely.
Q. Have you treated patients on subjective complaints?
A. Not for very long. Until I start getting diagnostic testing, until I find something else to treat, I do not feel comfortable treating subjective symptoms. Because people with subjective symptoms only don't get better.
Q. Is an MRI test an objective finding?
A. No. An MRI test is not an objective finding. An MRI test generates objective x-ray abnormalities.
Q. In this case you indicated Mrs. Heine's MRI of her left knee clearly showed abnormal findings?
A. It clearly showed abnormal findings.
Q. And then later on, a short while after that, Mrs. Heine had an MRI on her right knee, and that

also showed abnormal findings?
A. It showed the identical abnormal findings. As a matter of fact, the reports were absolutely identical.
Q. Mow, when Mrs. Heine had the first surgery on the left knee, are you aware she had to try to use crutches afterward during her rehabilitation?
A. That would have been the appropriate thing to do.
Q. Are you aware -- and I showed you her complaints of left shoulder injury from the hospital records of June 10.
A. Well, it doesn't say left shoulder injury. It says she has left shoulder pain.
Q. When we use crutches, we put the crutch underneath our armpit; is that correct?
A. If you do, you are doing it incorrectly. These are not crutches that rest in your armpits. These are crutches that you basically walk on with your forearms and your hands. You should not rest them in your armpits. You should not put any stress on your shoulder that way.
Q. Can a person who is favoring one leg, like the left leg or left knee, can they put extra strain on their right leg or right knee?
A. Well, that is the purpose of the crutches, to

equalize it. I don't really believe there is excessive strain put on the opposite leg if you are using your crutches appropriately.

Q. I will finish up very briefly, Doctor.

Doctor, you said you had this standard fee for your services which included both the deposition and the report.

A. No, that is not what I said.

Q. The deposition cost today was $900; is that correct?

MR. KROHNGOLD: Objection.

A. Well, the deposition charges by my corporation for my services as an employee is $900 an hour.

Q. $900 an hour?

MR. KROHNGOLD: Objection.

A. Correct.

Q. And then the report cost was something different?

A. Well, there is no separate report cost. It was the global fee for the time it took to do the examination, review the medical records and x-rays, and the production of a nine-page report -- ten-page report -- nine and a little bit more page report.

Q. Now, when you saw Mrs. Heine, which was two years and ten months after this accident, she had told

you that she had had to use a TENS unit; is that correct?

A. That is what she told me she used, yes.

Q. Would you tell us what a TENS unit is, please.

A. A TENS unit stands for transcutaneous nerve stimulator.

Q. What is the purpose of having those TENS unit being used, Doctor, please?

MR. KROHNGOLD: Objection.

A. Well, typically, I don't recommend them, and I don't distribute them in my practice. But it is supposedly to relieve pain.

Q. Also, Mrs. Heine indicated to you that she had tried to do, and along with her physical therapy treatments, treating herself at home; is that correct, Doctor?

A. Well, that is all she had done for quite sometime because she didn't see her treating doctors for quite sometime before she saw me.

Q. No, I am talking about in the early course of her treatment. She was actively trying to get better. She was using the TENS unit; is that correct?

A. Well, a TENS unit doesn't get you better. A TENS unit is a method of supposedly relieving pain.

Q. She also used home cervical traction equipment; is that correct?
A. Correct. That was another unit, I think, that was distributed by Dr. Morris's office.
Q. She also indicated to you that she was using a stationary bicycle?
A. Yes.
Q. So those were efforts Mrs. Heine was doing in order to try to strengthen her legs and make her movements better, and so forth; is that correct, Doctor?
A. Well, some of them were. At least the stationary bicycle was.

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

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REDIRECT EXAMINATION

BY MR. KROHNGOLD:

Q. Doctor, I have now just a few questions, and I will hope to be brief so we can let you go, and hopefully we haven't put the jury to sleep too much so far today.

Why don't we go off the record for just a moment, please.

(Thereupon, a discussion was had off the

record.)

Q. (Continuing.) Doctor, I just want to try to review a couple of things that were raised by Mr. Berena upon his questioning of you.

I just showed you two pages of records from Mr. Mervart, which I will represent to you are the only records from Dr. Mervart I have ever seen in this case.

Could you please tell us what date are from those pages, please.

A. Basically, one is handwritten and one is typed from June 28 of 1994.

Q. And that is about two weeks after the accident, or so, two and a half weeks after the accident?

A. More or less, yes.

Q. What are her complaints at that time?

A. Basically --

MR. BERENA: Object. I object.

A. She basically had some neck aches, and she had some pain going from her neck to her shoulders. She had some tingling of both upper extremities. So she had a bunch of subjective symptoms at that time.

Q. Any complaints of knee problems at that time to that doctor?

A. No. He is a neurosurgeon. I am not sure how he would even handle a knee complaint.

Q. But at least there is none in those records?

A. No.

Q. Now, Ms. McCarthy actually had asked you a question about aggravating a dormant preexisting condition. Assuming for the moment that Ms. Heine struck her knees on the dashboard, as she is suggesting, would that type of trauma cause the kind of stretching or twisting injury which you had talked about earlier in aggravating one of these degenerative conditions?

A. Not typically.

Q. And was there evidence, from your review of the photographs, again, that if this happened this caused any kind of tear of the meniscus?

MS. McCARTHY: Objection.

A. You know, I really was racking my brain on this issue. And this was probably one of the hardest things to review is something that happened two years ago and trying to fill in blanks which the own treating doctor really could not explain.

I have never seen a torn meniscus tear -- or a meniscus, I should say, tear the way that these pictures appear with the way the injury was

described, in that there didn't appear to be any acute or fresh component to it. This just looked like a chewed up meniscus.

Could one of those little tears have occurred? Sure. But it certainly wouldn't have necessitated the need for the removal of the cartilage and removal of the end of the thigh bone cartilage.

I just can't see how that would happen from a physical standpoint. I just don't understand the mechanism that that would have happened.

Q. While we were off the record, I asked you to take a look at the records from the EMS and the typewritten initial intake records from the emergency room. And I will just hand those to you once again.

First of all, the EMS report, is that identified somehow at the top?

A. I recognize it. It says, "Cuyahoga County EMS Run Report Form."

Q. All right. Is there anything in the description of her complaints about her knees striking the dashboard?

A. No. They typically show a little schematic of the human body and where they assess the injuries

to be. You can clearly see that the injuries that she was concerned with at that time -- they have a little stick figure of the back of a person and the front of a person -- and they shaded the areas in the left shoulder and the left side and abdomen region. There is absolutely no shaded regions in the lower extremities at all.

Q. Next to there are some boxes which talk about normal and abnormal parts of her body.

A. Yes. This is, simple checklist, as well as a head injury sheet.

Q. What part of the body would the blank be for her knees under that?

A. It says normal.

Q. For what part?

A. Back and spine, lower extremities normal. Upper extremities, she had pain.

Q. So lower extremities would include the knees.

A. Yes.

Q. And that was checked off as normal?

A. Correct.

Q. Now, I asked you also to review some of the typewritten intake notes from the hospital. And have you had a chance to review those?

A. Yes.
Q. Now, is there anything in those intake records about her striking her knees anywhere?
A. No.
Q. Now, on the side there I put a little yellow tag on the side of the pages there, and I believe you just read that to the jury. If you could read that one line about previous history.
A. I think we discussed that before. It is that particular line that is on page 42 of my records, dated 6/11/94 at 8:00 in the morning, "Complains of generalized pain in the left side. Sore back. Lying in bed. Has had history of back problems."
Q. So these records which Mr. Berena had been discussing at length with you do contain an admission by her of a history of back problems.
A. That is what it says.
Q. Did she acknowledge that to you at the time that she came and saw you?
A. No.
Q. Now, Mr. Berena had also asked you about your knowledge about medication that she was taking. Do you recall that?
A. Yes. He asked me how many prescriptions.

Q. I would like to show you a listing of prescriptions that is going to be submitted to the jury in this case from Beachwood Orthopedics, and ask you if you are familiar with some of these medications there, because they are kind of long names.

A. Yes, sure.

Q. Could you tell us, generally, are they generic terms for what may be more commonly known as some of the drugs that people may take for pain?

A. Yes. They dispense these medicines themselves. There is a medicine called Relafen and Naprosyn. Those are both anti-inflammatory medications. Darvocet, which is basically a Darvon, mild to moderate pain killer. Ibuprofen, which is Motrin. Cyclobenzaprine, that is a Flexeril, that is another muscle relaxant. And those are the medicines.

So basically an anti-inflammatory, three anti-inflammatory medications, and one mild to moderate pain medication.

Q. All right. Now, you said ibuprofen. Is that --

A. Ibuprofen is Motrin. It is the same stuff you get over the counter, only it is a little stronger.

Q. What is the charge for the ibuprofen there?
A. Ibuprofen was $29.16.
Q. And is there a charge for acetaminophen?
A. That is Tylenol. Well, it is actually Darvon and Tylenol.
Q. What is the charge for that?
A. $34.65.
Q. Are there some prescriptions there as much as $70 there?
A. Yes, the Flexeril, the muscle relaxants, were $88.03.
Q. Do you know how these compare to drug prices if you were to go to Revco and buy them?
MS. McCARTHY: Objection.
Q. If you know.
A. You know, I don't know the precise things. They seem a little on the high side, but I don't have the exact fees. These are probably generics. Generics don't typically cost as much as the name brand.
Q. All right. Mr. Berena has also asked you a couple questions about your abilities to or your qualification to comment on some of these injuries that Mrs. Heine had.
You are aware that although Dr. Morris is

the only one that is testifying in the case, he is not the one that performed the actual surgeries?

A. Correct. Dr. Gabelman performed the surgeries.

Q. Do you know whether Dr. Morris ever even looked at the photographs that you showed to the jury of how her knee looked at the time of the surgery?

MS. McCARTHY: Objection.

A. I have no idea what he reviewed and what he didn't review.

Q. Assuming that he never looked at those photographs, would you be in as good or better position to comment on the condition of Ms. Heine's knee at the time of surgery?

MS. McCARTHY: Objection.

A. I think if you looked at the pictures, you would know exactly what the condition was. If you didn't look at the pictures, I am not sure how you would have any idea what the condition was.

Q. From your review of the pictures, does this appear to be a degenerative process that is going on inside Ms. Heine's knee?

MR. BERENA: Objection.

A. Yes.

MR. KROHNGOLD: Doctor, that is

all I have. Thank you.

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RECROSS-EXAMINATION

BY MS. McCARTHY:

Q. Dr. Corn, I think you indicated in response to one of Wally's questions that there was a nursing note from June 11 that said she made a history of back complaints or made a complaint of back problems.

A. She had a history of back problems.

Q. Thank you. And I think you said that she didn't reveal that to you. Is that what your comment was? Or you didn't know about it?

A. I wasn't aware of that.

Q. To be fair, Doctor, on page five of your report, top paragraph, it says, "She did briefly discuss the 1980 injury. This was a somewhat substantial impact, with an injury to her neck and low back. She did state that she had objectively recovered from these injuries prior to the car accident in question." Did I read that correctly?

A. Correct, you did.

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

MR. BERENA: I just have one.

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CROSS-EXAMINATION

BY MR. BERENA:

Q. Dr. Corn, when Mrs. Heine told you about the 1980 accident, didn't she indicate to you that she had a lot of serious dental problems and teeth that were cracked and broken, and she had to have a significant amount of dental work from that accident?

MR. KROHNGOLD: Objection.

A. You know, if she did, I would not have recorded it because I don't have any particular knowledge or interest in dental injuries.

Q. But it is clear that she did tell you about that accident; is that correct?

A. She did tell me that she was in it, and she had completely recovered from it.

Q. And that accident was 14 years before this accident; isn't that true?

A. Correct. I was not aware that she had a current back problem.

MR. BERENA: Thank you. No further questions.

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FURTHER REDIRECT EXAMINATION

BY MR. KROHNGOLD:

Q. Doctor, if someone had recovered a long time ago from a back injury, do you think it would be likely that they would mention a history of back problems to a nurse in a hospital if they had recovered from that long ago --

MS. McCARTHY: Objection.

Q. -- that would appear in a daily nurse's note?

MS. McCARTHY: Objection.

A. Again, I would say typically you would only give a problem to the nurse of a current situation. Again, this probably *goes* into the level of detail of these nurses' notes, and that they are not real complete, and they are not meant to be comprehensive.

I have no idea what she told them, if she tried to explain that this was a recent back problem, or something that was 20 years earlier, that is really not clear, which goes to the lack of specificity of all nurses' notes. They don't particularly have doctor issues in mind. They have nursing issues in mind.

MR. KROHNGOLD: Thanks, Doctor, that is all.

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FURTHER RECROSS-EXAMINATION

BY MR. BERENA:

Q. Just one question, Doctor. If Mrs. Heine wanted to be forthright with a nurse who asked her, "Have you ever hurt your back before,'' then she answered honestly and truthfully; is that correct?

A. The fact is --

MR. KROHNGOLD: Objection.

A. The fact is that you don't know what question was asked, how the question was phrased, or what the response was. So I don't know, and I don't have an opinion on any of those type of questions.

Q. She clearly told the nurse she had a prior back problem.

MR. KROHNGOLD: Objection.

A. Again, all I know is that they had a history of back problems. I have no idea what else was explained, or what the question was that elicited that, or whether it was a voluntary remark. I have no idea.

Q. Just the same way that you don't know about the rest of the nursing notes that we went through in detail; is that correct?

A. Again, if you are making some sort of derogatory inference, that really frosts me because I tried to explain nurses' notes are nurses' notes. They deal with nursing care issues. They do not typically address orthopedic issues.

I don't know what questions were asked that produced these answers. I don't know if it is the patient's own interpretation that the nurse is recording. I don't know. And you don't know.

All we know is that there are certain statements, and if you want to isolate out a statement, you can isolate out a statement. But it really means nothing to me without looking at the entire picture or seeing what the doctors thought at that time. And the doctors didn't even mention any problem with her knee during that hospitalization.

MR. KROHNGOLD: Anything else?

MR. BERENA: Thank you. Doctor.

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

MR. SIMON: Doctor, you have the right to view the videotape and/or read the transcript, or you can waive such rights.

THE WITNESS: I will waive my right to review both.

MR. SIMON: Counsel, do you want to waive the filing of the videotape?

MR. KROHNGOLD: Yes.

MS. McCARTHY: Yes.

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(DEPOSITION CONCLUDED.)

(SIGNATURE WAIVED.)

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CERTIFICATE

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

I, Diane M. Stevenson, a Registered Professional Reporter and Notary Public in and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within-named witness, ROBERT C. CORN, M.D., was by me first duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by him was by me reduced to stenotypy in the presence of said witness, afterwards transcribed by means of computer-aided transcription, and that the foregoing is a true and correct transcript of the testimony as given by him as aforesaid.

I do further certify that this deposition was taken at the time and place in the foregoing caption specified, and was completed without adjournment.

I do further certify that I am not a relative, employee or attorney of any party, or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland Ohio, on this 16th day of JANUARY, 1998.

Diane M. Stevenson

Diane M. Stevenson, RMR
Notary Public in and for
The State of Ohio.

My Commission expires October 31, 2000.