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

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IN THE COURT OF COMMON FLEAS

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FETES A. FRCTE, et al.,)
)
Plaintiffs,)
)
vs.) Case No. 104081
)
PAUL G. BEGNAUD,) Judge Robert Lawther
)
Defendant.)

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DEPOSITION OF ROBERT CORN, M.D.
Thursday, April 30, 1987

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The deposition of ROBERT CORN, K.C., a witness, called for examination by the Defendant under the Ohio Rules of Civil Procedure, taken before me, Diane M. Stevenson, a Registered Professional Reporter and Notary Public in and for the State of Ohio, by agreement of counsel, at the offices of Robert Corn, M.D., 850 Brainard Road, Highland Heights, Ohio, commencing at 5:25 p.m., the day and date above set forth.

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APPEARANCES:

On behalf of the Plaintiffs:

Steven L. Gardner, Esq.
McDonald, Hopkins & Hardy Co., L.P.A.
1100 East Ohio Building
Cleveland, Ohio 44114

On behalf of the Defendant:

Roger Williams, Esq.
Keller, Scully & Williams Co., L.P.A.
330 Hanna Building
Cleveland, Ohio 44114

ALSO PRESENT:

Tim Palcho, Video Operator

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MR. WILLIAMS: Before we begin the examination of Dr. Corn, initially let the record reflect that this is the deposition of Dr. Robert Corn which is being taken pursuant to notice, and it would be my understanding that notice would be waived; is that ccrrect?

MR. GARDNER: That's correct.

MR. WILLIAMS: And it is also my understanding that you will waive the requirement of the filing of the transcript as

MR. GARDNER: That is correct.

MR. WILLIAMS: Further let the deposition reflect or let the record reflect that this deposition is being taken upon direct examination in order to preserve the doctor's testimony for use at that time of the trial of this action which has been brought by Mr. Peter Prete and his wife Vera Prete against my clients, Paul and Edward Begnaud, said action bearing case number 104081 before the Honorable Judge Robert Lawther in the Court of Common

Fleas for Cuyahoya County, Ohio.

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ROBERT CORN, M.D.

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

DIRECT EXAMINATION

BY MR. WILLIAMS:

Q. Doctor, you have been sworn, and I would ask you to please state your full name for the record?

A. Robert Curtis Corn.

Q Doctor, what is your current professioanl address?

A 850 Brainard Road in Highland Heights, Ohio.

Q. Are we at that address here today?

A. Yes.

Q. Doctor, what is your profession?

A. I am an orthopedic surgeon.

Q. When were you first licensed to practice medicine in the State of Ohio?

A. 1976.

Q. Again, your specialty in the field of medicine is orthopedic surgery; is that correct?

A. That is correct.

Q. Doctor, would you please explain to the ladies and gentlemen of the jury what is involved with that specific specialty?

A. Orthopedic surgery is that branch of medicine which deals with the medical and surgical management of disorders and injuries to the musculoskeletal system.

joints, ligaments. It includes the subspecialties of spinal surgery, arthritis surgery, sports medicine and hand surgery.

Q. Doctor, are you Board certified in orthopedic surgery?

A. Yes, I am.

Q. When did you become so Board certified?

A. In 1980.

Q. In 1980, Doctor, what was involved in the Board certification of an orthopedic surgeon?

A. To become Board certified, the candidate had to complete an approved residency approved by the American Board of Orthopedic Surgery.

After the completion of the residency requirements, there was a requirement that the candidate had to be in practice for one calendar year, and after that year the candidate sat for

an examination which included both oral and written examination over a two-day period.

After satisfactorily completing the requirements and passing the examination, then the candidate was deemed Eoard certified.

Q. Doctor, would Board certification be one of the highest, if not the highest, achievement attainable in your specialty?

A. Yes, it is.

Q. Doctor, if you would, would you please give the ladies and gentlemen of the jury a little of your educational background including college through medical school as well as your internships, residencies, etc. up to the present time?

A. I received my Eachelor of Science in biology from the Albright College in Reading, Pennsylvania. I received that degree in 1971.

Then I attended the Hahneman University School of Medicine from 1971 through 1975 and received my MD degree from that institution in June of 1975.

I then came out to the Cleveland, Ohio area and completed my residency in orthopedic surgery at the Cleveland Clinic Hospital in June of

1979, and from August of 1979 to the present I have been in the private practice of orthopedic surgery.

Q. So you have been in private practice approaching now about eight years?

A. That's correct.

Q. Doctor, are you a member of any medical

A. Yes, I am.

Q. Of what organizations or societies are you a member?

A. I am a fellow in the American College of Surgeons, a member of the American Academy of Orthopedic Surgeons, the American Coard of Orthopedic Surgery, the American Medical Association, Ohio State Medical Association, the Cleveland Academy of Medicine, the Orthopedic Research Society, as well as a variety of other smaller national and international Organizations.

Q. Do you have staff or courtesy privileges at any Greater Cleveland area hospitals?

A. Yes, I do.

Q. At which hospitals, Doctor?

A. I am chief of orthopedic surgery at the Huron

Road Hospital. I have staff privileges at Euclid General hospital, Hillcrest Hospital and at the Mt. Sinai Medical Center. I also have courtesy privileges at the St. Vincent Charity Hospital.

Q. Are you involved in teaching at all in your field?

A. Yes, I am.

Q. In what capacity?

A. I am a clinical instructor in orthopedic surgery at the Case Western Reserve University, and an assistant professor of orthopedic surcjery at the Ohio College of Podiatric Medicine.

Q. Are you involved in any publications in your field?

A. Yes.

Q. What publications have you been involved with?

A. I have a variety of publications encompassing the fields of arthritis, trauma, and metabolic bone disease.

Q. Doctor, would you please tell the ladies and gentlemen of the jury whether you had an occasion to examine the Plaintiff in this particular matter, Peter Prete, at my request?

A. Yes.

Q. When did that examination take place?
A. The examination was on March 11, 1987.
Q. Where did that examination take place?
A. Here in my office.
Q. Doctor, as part of your office records, do you have a copy of your repcrt which you prepared and which is dated April 6, 1387 with regard to your examination of the Plaintiff, Peter Prete?
A. Yes, I have the report.
Q. Does that report document your findings upon that examination?
A. Yes, it does.
Q. Doctor, feel free to refer to that report and any other records you have available during your testimony in answering any of my questions as well as those of counsel for the Plaintiff.

Doctor, upon your first meeting with Mr. Prete, did you obtain a history?
A. Yes, I did.
Q. Was Mr. Prete accompanied by his attorney at the tine of the examination?
A. Yes, Mr. Gardner was present throughout the entire examination.
Q. Doctor, what was the history which was provided? I realize it is a little lengthy, but

if you could tell us the history which was provided?

A. I will be glad to. I'm going to be teking this mostly directly reading from my report.

Mr. Prete presented with a history that he was a driver of an AMC Spirit motor vehicle that was stopped in a line of traffic approxinately the third car back at an intersection.

He was not wearing a seat belt or shoulder restraint device. A rear-end collision occurred. At the moment of impact he attempted to grab the steering wheel in order to quote! "brace," end of quote, himself.

At the moment of impact he was thrown forward and, quote, "actually lifted up," erid of quote. He struck the metal above the windshield with the bridge of his nose and sustained an abrasion to his forehead.

As his car was thrown forward, it struck the car in front of him. This caused him to be thrown backwerds, and it felt like, quote, "someone hit me with a slab of steel in my neck," end of quote.

Initially he, quote, "stayed put and didn't try to move," end of quote. His neck was

painful but he was not quits sure what to do at that time.

A son who was approximately six or seven years old in the back seat was not wearing a seat belt and apparently the child was crying and he was concerned about the child.

The child bruised one of his legs, but Mr. Prete could not recall which leg was injured. Mr. Prete's wife was a passenger in the front seat of the car and she allegedly, quote, "cracked the windshield with the right side of her head," end of quote.

MR. GARDNER: Objection move to strike.

A. She was not wearing a seat belt, either.

He was taken by ambulance with a back brace and a shoulder strap to the emergency room at the Lakewood Hospital.

At that time he was x-rayed and an evaluation was performed. He was released from the hospital after the evaluation and was not admitted.

The primary evaluation was for his neck and his, quote, "painful right wrist." He was given a list of instructions.

His first medical contact was with Dr. Culley, his family practitioner, who ha6 treated him for previous problems.

He was seen approximately one week after the accident. He also stated that he lost approximately one day of work after the accident.

During the first week, quote, "things were difficult," end of quote. He stated there was a, quote, "loss of feeling,'' end of quote, in the right side of his neck and shoulder region as well as a, again, quote, "loss of feeling.," end of quote, in both of his upper extremities as well as the anterior aspect of his thigh.

He was given some medicine which he thinks was a muscle relaxant and this was by Dr. Culley. Because of failure to improve with the medicine, he was referred to Dr. Russell Elmer who is an orthopedic surgeon at Lakewood Hospital approximately one week later. No new x-rays were taken.

Dr. Elmer examined him and felt physical therapy was recommended primarily in the form of heat and traction, Mr. Prete also stated that he received a, quote, "Cortisone shot or

lubricant," end of *quote*.

The headaches that he started experiencing shortly after the accident began tc worsen. The traction and physical therapy were unsuccessful in relieving his problems and, in fact, the traction worsened his headache.

The accident occurred on 5/12/84, and he continued with Dr. Elmer for about a year before he was first hospitalized at Lakewood Hospital on May 7, 1985.

He was hospitalized from May 7 through May 20, 1985. During this first year he also tried a-number of home remedies to relieve the pain in his hand--this is his right hand--and he wore gloves or taped the hands to protect then or taped the thumbs, actually, to protect them.

I asked him why he was admitted in 1985 and he said that this was because of a, quote, "extreme loss of sensation on the right side of my body," end of quote. He was not sure how long he was out of work.

Dr. Elmer's diagnostic workup included a CT scan as well as a myelogram, which were apparently--and there was no improvement. I don't recall whether Mr. Prete stated what the

results were.

On September 23, 1985 he sought a second orthopedic opinion with Dr. Henry Bohlman,

millimeters of room in a slightly narrowed C5-6 disk space," and that is Dr. Bohlman's quote.

He recommended an anterior spinal fusion.

operating room the following day on 11/12/85. The surgery performed was an anterior cervical diskectomy. That is a removal of the disk and a fusion at the C5-6 level. Apparently the post-operative course was fairly smooth and he was discharged on November 16, 1985.

Immediately after the surgery, Mr. Frete reported a definite relief in his headache and neck pain, although he continue6 to have a significant amount of pain in his right arm, specifically in his right thumb.

He had continuing pain and Dr. Bohlman

referred him to one of his associates, Dr. Michael Keith, who is an orthopedic surgeon that specializes in hand surgery at University Hospitals.

Dr. Keith felt that his diagnosis was a, quote, "grade two sprain, collateral ligament sprain, of his thumb as well as a contusion to the metacarpal phalyngeal joints."

Dr. Keith also, according to his report, felt that there was no instability or arthritis present and that it would, quote, "probably remain a low grade problem," end of quote.

At this time I noted in the course of the interview that--or up to this time, I should say, the patient, Mr. Prete, had a somewhat secure--

MR. GARDNER: Objection.

A. --attitudetoward the residuals of injury.

MR. GARCNER: Move to strike.

Q. Well, why don't we ask--let me just ask you, then, Doctor: You have given us the history then as portrayed by Mr. Prete up until the point of his seeing Dr. Keith; is that correct?

A. After he saw Dr. Keith.

Q. After he saw Dr. Keith, okay. And all of what

you have now testified to would have been statements given to you by Mr. Prete; is that correct?

MR. GARDNER: Objection.

A. Yes, with the exception of the description that Dr. Bohlman and Dr. Keith used in their medical reports.

Q. So when you talked about the fairly narrow spinal canal at C5-6 level with 13 millimeters of room and a slightly narrowed C5-6 disk space, that would have been from Dr. Bohlman's report?

A. That's correct.

Q. And when you talked about Dr. Keith indicating, "Probably remain a low grade problem," that. would also be a quotation from Dr. Keith?

A. From his report, that's correct.

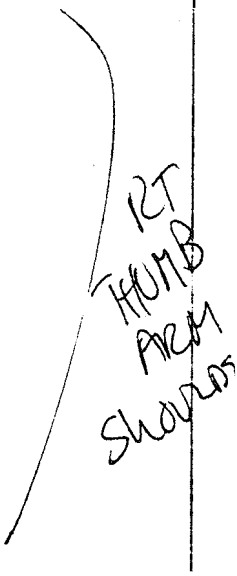
Q. As well as the quotation you gave about a grade two collateral strain, right and left thumbs with contusion to the metacarpal phalyngeal joint. That would have been a quote from Dr. Keith?

A. Yes, that's correct.

Q. As far as the other quotes that you have noted in recounting your history as given by Mr. Prete, those would have been direct quotes,

A.

Q.



A.

Q.

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Q.

observed at that point as far as Mr. Prete's demeanor in his recounting of the history?

MR. GARDNER: Objection. Move to strike.

A. At this point in the course of the interview, I was trying to assess basically where he was right now.

We started talking and I was concerned about the adjectives and the way that Mr. Prete was describing his current medical condition, and it was at this point when I started uncovering from his history that he was involved in a chronic pain management program.

He seemed to be initially reluctant to talk about this, but once he understood that I understood what his problem was with it, he began to be a little bit more free in explaining to me what was being done, what the game plan was, so to speak, of the pain management center.

And he was very cooperative, it is just that there was a change in his attitude when I started talking about the chronic pain syndrome, the psychological aspect of it.

MR. GARDNER: Move to strike.

Q. Doctor, you are familiar with the chronic pain management program; is that correct?
A. Yes.
Q. How are you familiar with that program?
A. I am the orthopedic consultant and one of the three members of the Pain Panel at the Huron Road Chronic Fain Management Program.
Q. To the best of your knowledge, would that be a similar program as that that is instituted at the University Hospital?

MR. GARDNER: Objection.

A. It is a little tighter group. I am familiar with the University program. I have sent patients over to that particular program prior to the establishment of our own program, and I am familiar with it, and it is a similarly based program, multi-faceted type of approach which uses a great deal of medical and surgical specialties including orthopedics, neurology, neurosurgery, psychology, psychiatry, and physical therapy.

I think that all quality pain management programs are involved with this approach. It is the only way to handle a problem such as this.

Q. Then at that point then did Mr. Prete continue

with his history with regard to the pain management program?

A. Yes. I'm not meaning to say that he was uncooperative with this. I think that he acted almost embarrassed about this, which I don't think is appropriate. It is something that obviously he had or he has, and I was trying to approach it as a medical problem as I would a broken bone.

I have a lot of respect for people who are going through chronic pain type of syndrome. I deal with them on a daily basis. I see very, very complex cases, and I recognized certain characteristics in his descriptive pattern, and I just basically wanted to find out why, you know, why he used the adjectives he did.

And then we got into a little discussion, which is basically the next part of the history, primarily about the chronic pain aspect, not so much about the neck injury anti not so much about the surgery and not so much about the thumb, so much as to find out exactly how extensive this chronic pain syndrome he had was.

He also stated that he was quite new in the program and had only been in it a month, but

with the medications prescribed, there was already some improvement, and I thought this was significant.

Q. Did he then go on and give you a little history of what the course of treatment was or what his problems were that led him-- .

A. Yes.

Q. Okay. What did he relate to you?

A. Now, I can't remember exactly--5.1: cf this is not all from his history. To make the report readable and more organized, some of this was taken from the hospital records from University Hospital, including Dr. Kriegler and the psychologist's reports as well as Dr. Bohlman's reports.

So this is all not specifically verbatim from him, but it will flow a little bit better because the whole story comes together a little better in my mind.

Q. Okay, well, why don't you go ahead, then?

A. Basically because of the failure to completely improve the way Dr. Bohlman had expected, Mr. Prete was referred to Dr. Jennifer Kriegler, who is a neurologist and the director of the Chronic Pain Management Program at University

Hospitals.

According to the medical records, there was no question in Dr. Kriegler's mind that this was, in fact, what Mr. Prete was suffering from. not getting Better as Boldman expected

To confirm this, I basically set some guidelines to determine exactly where his level of pain was at the time of my examination in March of 1987.

One of the problems or one of the complex problems of chronic pain patients is that the way they describe levels of pain and extremes of pain have to be quantitated, and it is this quantitation of pain or that is the amount of pain which can be followed, because basically pain is subjective. There is no way that an examiner can rate pain, it is how pain is rated by the chronic pain patient.

Chronic pain patients always have somewhat unusual ways of describing pain, in their levels of intensity, and it is these levels of intensity that are not well correlated to objective signs, but to the patients they are quite real.

I basically set some guidelines with

Mr. Frote at this time to learn what he felt, what his level of pain or what his subjective level of discomfort was, and I set some guidelines where I described the pain at a level one being a pein that was just barely perceptible, just sort cf like a tickle, just Sitting in the background, and a pain level on the saie of ten as a level of pain that is such an intense, excruciating p; in that no human being can stand that pain for more than five seconds.

Most patients with normal, and I say quote, unquote, "normal" orthopedic pain very rarely get above a seven or eight. Ten is never used in a patient who does not have a cronic pair, syndrome, or very rarely, if ever, and it is usually substantiated by a rather significant problem such as pain post-operatively, but this was not a post-operative situation at this point.

He described his headaches as those exactly as felt prior to his surgery. They were diffuse and aching in nature and they were primarily in the occipital region in the back of the scull and radiated anteriorly across the skull.

At the time of the interview, his level of pain was at a one, but at times, or usually, the pain level was between, quote, "five and six."

Occasionally it was a nine or a ten.

Concerning his neck pein, there was persistant right-sided pain which he described as diffuse and aching, in other words, poorly localized, as well as a radiating pain into the right upper back region.

This he described as a pain center. This is obviously a description that was given to him by the pain program, chronic pain management program, to help keep the vocabulary similar. This is the same thing that we use in our program.

There was a diffuse burning pain or a quote, "sharp pain," end of quote, which he felt virtually every day in the posterior right upper back and shoulder region.

He would rete it as a three on a good day, but usually on the five or six level. These were his descriptive numbers.

The pain seemed to be aggravated by physical tension, or by the use of a telephone, that is keeping the head tilted using a

telephone so both hands were free.

So there was a second type of pain, which was diffuse, aching neck pain which seemed to be improved with some of the medications.

The Naprosyn, which is an anti-inflammatory medication, that was prescribed by one of the physicians at the University. The pain was felt usually in the one to two range, but as bad as four, a level four. Naprosyn seemed to, quote, "give him more movement," or "give me more movement," end of quote.

The last area of concern were his thumbs. He stated that he felt there was absolutely no use of his thumbs whatsoever. He said that, quote, "the use of it," meaning his right thumb, "died three years ago," end of quote.

The pair, at the time of the evaluation was a two or three, but the pain was, quote, "usually a ten or more," end of quote.

Q. Did you review with him at that time, Doctor, as part of the history, the current medications he was taking?

A. Yes, I did.

Q. What did he advise you as to those medications?

A. At that time he was taking a drug called

Pamelor, which is a major tranquilizer. He wasn't taking it as a tranquilizer. It is used in people with major psychiatric diseases, but not at the low level that he was using it, or at the time of the evaluation.

I'm not sure what he was using later on, but he was just using it for sleep, in other words, to assist him in sleep. There is evidence in the pain literature, chronic pain literature, that the conhination of a nonsteroid anti-inflammatory medication such as Naprosyn and the major tranquilizer, such as Pamelor, act together, and this was somewhat successful and he felt that there was improvement in his pain just simply being on these two medications.

He said that there was a distinct improvement on his overall symptoms on the medicine, and his ability to sleep was also improved. He was wearing no neck brace at the time of the evaluation.

Q. Did you review his past medical history with him, also?

A. Yes, I did.

Q. What did that reveal?

MR. GARDNER: Objection.

A. Well, the past medical history, which is part of a normal history and physical evaluation revealed--he stated there were no previous injuries to his spine, but he did say he injured his right thumb while playing football, quote, "back in high school," end of quote.

Q. Did you then perform a physical examination, Doctor?

A. Yes, I did.

Q. What did that reveal upon physical examination?

A. On physical examination of the portion of the interview during the evaiuation, he appeared a somewhat apprehensive male who had, in my opinion, a typical affect of a chronic pain. patient, that is, being somewhat reticent and over protective.

MR. GARDNER: Object. Move to strike.

A. His gait pattern was normal, that is, he had no limp. He was able to arise from a sitting position as well as ascend and descend the examining table in normal a fashion.

Examination of his neck and upper back revealed no spasm, no dysmetria. In other words, the muscular movement was coordinated.

There was one area of soreness to palpation in the right rhomboid, which is just to the inner side of the shoulder blade, the wing bone on the right side, and this is the area that he described as the, quote, "pain center."

Q. Did you then examine more fully the cervical spine?

A. Yes, I did.

Q. What did that reveal, that examination?

A. The range of motion of the cervical spine showed very minimal limitations in forward flexion and extension, left rotation and right lateral tilt.

Right rotation and left lateral tilt caused some discomfort in the right upper back as well as in the trapezius muscle, which is a big muscle along the side of the neck.

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

BY MR. WILLIAMS:

Q. Doctor, at the point where you indicated about the right rotation and left lateral tilt causing some discomfort, then what else did you examine him with or for?

A. There was a four-inch motion of both shoulders, and this was in all directions.

There was a well-healed scar on the left side of his neck compatible with the surgical history.

His scapular area, that is the shoulder blades, had a normal amount of motion, and on neurologic examination including sensation, motor and reflex testing in both upper extremities was normal.

I also measured cireumferentially both arms and forearms at precise distances from the elbow, and the right arm was slightly larger by approximately one centimeter, which was compatible with his right-handedness.

Tnere was a full range of motion of his elbows, wrists, and small joints of the hand.

Q. Doctor, if we could go back into the cervical spine examination, you indicated that there was very minimal limitations in forward flextion, extension, left rotation and right lateral tilt.

Can you show the ladies and gentlemen of the jury how you test for that?

Doctor Gantverq 2/18 10

A. Okay. Basically what I ask the patient to do, and I observe from the side for the front/back motions, and from the back for the side/side

motions, the flexion, that is bending forward putting the chin maximally to the chest, he was just about able to do that.

Hyperextension or extension would be back, looking upward toward the ceiling. Right rotation is turning the head to the right, left rotation is turning the head to the left.

Right lateral tilt, trying to put the right ear on the right shoulder, left lateral tilt, trying to put the left ear on the left shoulder.

Q. You indicated, I believe in your report, that there was no dysmetria noted. What is dysmetria.

Q. Dysmetria is another word for coordination. In other words, the movement was ccordiriated. It wasn't staccato or favoring or one muscle group not working. The motions were essentially normal. The excursions and the muscle contractions appeared to he normal.

Q. You also indicate a full range of motion of both shoulders. How would you test for range of motion in the shoulder?

A. Well, basically I do the shoulder both actively and passively. Actively, meaning asking the patient to move the arm to its fullest extent,

such as this is forward flection, this is abduction, that is going to the side, external rotation is going this way, internal rotation is going this way, and extension is bringing the arm behind.

I also have my hand on the individual to assist them In seeing how much or if there is a difference between active and passive motion.

Q. And you also indicated that protraction and retraction of the scapula were performed normally.

A. In other words, I ask them to roll the shoulders forward and roll the shoulders backwards. If there is paralysis or a problem with any particular muscle group, the motion is not coordinated.

Q. You were able to perform a neurological examination?

A. *Yes.*

Q. To the best of your ability, that was normal; is that right?

A. Yes.

Q. Now, you indicated there was also full rang of motion with both elbows, wrists and small joints of the hand. How do you test for that?

A. Well, basically the elbow has a number of the set motions. It has elbow flexion, which is bending the elbow. Extension is a palm-up motion called supination, a palm-down motion called pronation.

The wrist flexes and extends, moves the radial side or thumb side, which is the ulnar side, and basically the motion I use in the hand is watching the patient grip, and the ability to have coordinated motion in the thumb, the thumb and fingers.

Q. And there was full range of motion for both hands?

A. Yes.

Q. Doctor, did you then go on and examine the thumbs specifically?

A. Yes. Now, when I first asked him to use the thumb, use the hand, he was holding the thumb out like sort of like in a protected fashion, but on specific motions he was able to move the thumb.

There was a deformity at the base of the thumb, down at the carpel/metacarpal joint-- I'm sorry, the metacarpel/phalyngeal joint, this joint basically at this level, which appeared to

DR Report Forms Defendants

be an old--sort of like an old stoving injury, sort of like I see probably 10 or 15 of these a week from old injuries that occurred ages ago, usually most commonly when the bones are still forming or the joints are still forming.

He was able to move the thumb fully, although when asked to use his hand in a composit fashion, that is, making a fist, he sort of curled the thumb up to try to protect it.

Most people when they make a fist, they don't curl their thumb under the fingers. They do it like this, in other words, they do this to try to protect their thumb. That is what he did when asked to use the composit motion.

I also examined the ligaments, that is testing--stressing the ligaments in the different ways, and there was no instability detected in the thumb-side direction, little finger-side directi'on cr rotationally, that is twisting and rotating them.

Q. Did you then go on and examine the lumbosacral spine?

A. Yes.

Q. What did that examination reveal?

A. Basically the back examined perfectly normally. He was able to flex down to the ankle level, and neurologically both lower extremities were normal by neurologic examination.

Q. Doctor, have you detailed all the tests which you performed upon your examination of Mr. Frete on that die?

Q. Are all those tests approved and accepted within your field and performed by other orthopedic surgeons?

A. Yes.

Q. Doctor, did you have sufficient time in which to perform a full and complete orthopedic evaluation of this particular patient?

A. Yes.

Q. Obviously the history portion of the examination took quite a bit of time. Would that be a fair statemcnt?

A. It is a feir statement, yes.

Q. Doctor, did you also have an opportunity to review additional medical records available to you either prior or subsequent to your examination which I forwarded to you?

A Yes. There was no review of information prior

to the history and physical, and all the medical records were reviewed prior to the preparation

Q. Did you indicate what records that you had available to you to review?

A. I don't know what the sequence of their arrival was. I know that there was not the reports from

from Dr. Ashenburg, who is the assistant professor, Department of Psychiatry and Neurology. This is directed to the pain clinic. Reports from Dr. Jennifer Kriegler who is the director of the pain clinic, a letter to Dr. Gardner from Dr. Eohlman--

MR. GARDNER: That you, Doctor, I take that as a compliment.

A. Oh, did I say doctor? Mr. Gardner, I'm sorry. Well, it is a compliment, then I won't retract it.

A letter between Dr. Kriegler--there is a variety of letters, correspondences between the treating physicians, a letter from Michael Keith, office records from Lakewood Hospital. I assume these are Dr. Elmer's records. I didn't review those prior to the deposition.

Emergency room reports from Lakewood Hospital, admission reports from Lakewood Hospital, and the chart record from University Hospitals from Mr. Prete's inpatient stay.

Q. Doctor, based upon your examination of Mr. Prete and from the oral history provided by him and from the records which you reviewed, are you able to make a diagnosis within a reasonable degree of medical certainty as to the injury that he allegedly sustained at the time of the accident?

A. Yes.

MR. GARDNER: I'm going to object.

Q. What is your opinion, Doctor?

A. The basis of my exemination and history, I believe that Mr. Frete sustained a flexion/rotation injury to his cervical spine, that is his neck, a herniated C5-6 disk, the status post anterior diskectomy and fusion.

I think he sprained both of his--my opinion is that he sprained both of his thumbs, the right thumb at the most was injured in the grade two collateral ligament injury, and that he had a chronic pain syndrome.

Q. Doctor, what is a grade two collateral ligament

injury?

A. A grade two collateral ligament injury is basically a mild stretching of the capsule and supportive structures about a join. It doesn't have to be necessarily the thumb, it could be any joint.

Q. And Doctor, based upon your examination, the oral history and the records which you reviewed, were you able to make a diagnosis as to Mr. Prete's condition at the time of your examination?

A. Those were my--the examination, was that your question?

Q. Well, the original question was the type of injury, but I take it then that is a compilation of both the injury that he originally sustained and his current condition?

A. That's correct.

Q. And Doctor, would this diagnosis be based upon the assumption that all the medical records which you reviewed as well as the oral history provided by Mr. Prete were true and complete statements?

A. Yes.

Q. Doctor, as a result of your examination and

again as a review of all the records as well as the oral history provided by him, are you able to express an opinion within a reasonable decree of medical certainty as to the prognosis for this individual a8 it exists at that time of your examination?

A. Yes, I have an opinion.

Q. What is your opinion?

A. My opinion was--

MR. GARDNER: Objection. Go ahead.

A. My opinion was that the prognosis was excellent for a good releif of his residual pain, a good relief from the symptoms of the chronic pain syndrome, just on the basis of the patient's complaints, his apparent personality, his psychological approach to his problem, and the early good results with the medication. I felt the prognosis was excellent.

Q. Doctor--

MR. GARDNER: Move to strike.

Q. I had provided you with some records, but I believe you also requested from Mr. Gardner additional records; is that correct?

A. Yes, those are primarily the records from the Chronic Pain Management Program.

Q. And Mr. Gardner did, in fact, provide those records and you did have an opportunity to review those?

A. The records that I state6 before were those provided by Mr. Gardner.

Q. And obviously then that all became part of your report which you' have testified about today?

A. Yes.

Q. Did you find any objective evidence of any ongoing orthopedic problems or orthopedic disease?

A. NO.

Q.

MR. GARDNER: Objection. Move to strike.

Q. As far as the right hand or the right thumb, did you find any objective evidence of any ongoing significant problem there?

MR. GARDNER: Objection.

A. No.

Q. As far as specifically the right thumb is concerned, Doctor, do you have an opinion within a reasonable degree of medical certainty as to the prognosis for the right thumb?

MR. GARDNER: Objection.

A. The prognosis and my opinion would be that the right thumb should be perfectly fine. There was absolutely no evidence of any instability, arthritis, or any objective evidence of any treatable orthopedic conditions.

So it was my opinion that the pain from there was primarily due to the chronic pain syndrome, and having a good overall long-term prognosis, I felt that that was also a good prognosis.

Q. You also had an opportunity, I believe, Doctor, to review Dr. Keith's report; is that correct?

A. Yes.

Q. I believe that you agree with Dr. Keith that this is a low grade injury?

A. Absolutely.

Q. You also, I believe, indicated that according to Dr. Keith's interpretation, there was no arthritis or instability noted; is that correct?

A. Yes. Well, Dr. Keith, I believe, had x-rays and he stated the results of those x-rays, and that was the basis of my opinion.

Q. And that would conform with your physical examination of Mr. Prete's right thumb and hand?

A. Absolutely, yes.

Q. Doctor, have you had to take out time from your busy orthopedic practice in order to present testimony this afternoon?

A. Yes.

Q. You will charge my office for the time that you have had to take out from your practice and obviously not see any patients to present this testimony; is that correct?

A. Yes, that is correct.

MR. WILLIAKS: Thank you, Doctor. I don't have anything further.

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CROSS EXAMINATION

BY MR. GARDNER:

Q. Doctor, my name is Steve Gardner, and I'm Peter and Vera Prete's attorney, and at this time I would like to just take a look at your office file which is in front of you and I would suggest we go off the record while I take a look at this.

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

Q. (Continuing.) Thank you. Dr. Corn, I have reviewed your file, and I'm holding it in my lap and there is probably 12 feet between us and I'm

off camera.

If at any time in order to answer any of my questions you need your file back to review it, I'll hand it back to you, will try and minimize the inconvenience.

Doctor, you examined Mr. Prete at the request of Mr. Williams and his office, correct?

A. Yes.

Q. When the initial arrangement was made for you to see Mr. Prete for Mr. William' office, how was that handled because I don't find any letter of reference arranging the appointment in your file? Is there such a letter?

A. I don't recall. I don't remember.

Q. Is there typically in the cases which ycu examine--

A. Some of the time. Some of the times. Usually they will call the office and then will send the medical records.

I think there was some hold up for the records in this case. I don't remember. There was a vacation or something that happened. I really don't recall why all the information wasn't sent.

Q. So there was no letter from Mr. Williams'

office?

A. I don't have a letter. I may--1 don't recall seeing a letter, and my secretary would take care of that.

Q. If you had it, would that ordinarily be in the file, if there was one?

A. No. If it was not part of the communication for medical record, it would not be part of the medical record'.

Q. Is there then another file that pertains to Mr. Frete?

A. No, that is it.

Q. Doctor, you examined Mr. Prete on one and only one occasion; is that correct?

A. Yes.

Q. Mr. Prete, you are not his treating physician; is that correct?

A. No, I have never been his treating physician.

Q. Doctor, how many examinations have you done, would you say, for Mr. Williams' office, that being the law office of Keller, Scully and Williams?

FIR. WILLIAMS: Objection. Go ahead.

A. I would say probably over the last two years, probably 30, 35.

Q. So that is more than one a month, on an average?
A. Yes.
Q. Doctor, what are your fees for providing the examination of a party to an injury lawsuit?
A. Well, it is not only standard for an injury lawsuit, the standard fee is for independent medical evaluation, and the base fee is $500 for the evaluation and report.

If there were extensive medical records or if there were--I don't do it by the inches, but if there was extensive medical, then it would be more just on the basis of how much time it took to complete the report, but there is a standard base fee which is $500.

Q. Do you recall whether this was a standard base fee exam?
A. Standard base fee exam, yes.
Q. Doctor, you have indicated that you would be charging for the time involved, for the time involved in taking this testimony as the doctors charged for their time in the depositions that I took of Dr. Kriegler, Dr. Bohlman and Dr. Keith.

What are your charges per hour of deposition testimony?

A. Deposition testimony is $450 for the first hour and $100 an hour or any part of that hour after that.

Q. That starts from the time that you first meet with Mr. Williams or whoever the attorney is before you commence the deposition?

A. It usually starts at the tine of the beginning cf the deposition.

Q. And, in fact, you had an opportunity to meet with Mr. Williams and go over this file before we began the deposition; is that not correct?

h. Well, actually we met ahead of tine. It was mostly anecdotal and not about this case, but we did have an opportunity to go over a couple. aspects of this case prior to the commencement of the deposition.

Q. Doctor, are you in any disagreement with the diagnosis made by Mr. Prete's treating physicians based upon your review of the records and your examination?

A. No.

Q. So there is no dispute about his medical condition, it is what it is?

A. As stated before, using the diagnosis that I made, yes. If there is anything else that is

new that I'm not aware of, it would be difficult to comment on, but on the basis of what I said in my report I will stand by what I said in my report.

Q. So then either your diagnosis confirms what his doctor said his diagnosis was, or vice versa, whichever came first, the chicken or the egg?

A. I came to my diagnosis independently of their opinions, and our opinions are quite similar.

Q. And for the record, Doctor, based upon the history that Mr. Frete gave to you in his course of treatment and his medical records, it is uncontroverted that the injuries which you found as your diagnosis were sustained in the automobile accident of May 12, 1984?

MR. WILLIAMS: Objection.

Q. Is that not correct?

MR. WILLIAMS: Objection.

A. I'm not quite sure I understand what you mean.

Q. Doctor, is there any doubt in your mind that his injuries, his C5-C6 disk which was repaired by anterior diskectomy and fusion and his grade two collateral ligament strains in his thumbs and the chronic pain syndrome were directly and proximally caused by the automobile collision of

May 12, 1984?

MR. WILLIAMS: Objection.

A. I believe his neck injury--he injured his neck at the time of the collision. I am not totally convinced that the C5 disk problem was totally related to the accident.

I have nothing to--it is just that it is unusual for a disk not to be more symptomatic or picked up. After all, he did have a negative CT scan and a negative myelogram in the area at the Lakewood Hospital.

Q. Doctor, would you please review the medical records and find, if you will for us, please, a negative myelogram from the Lakewood Hospital?

A Can we go off the record, because it may take a while?

Q. Well, Doctor, let me give you my professional representation that a myelogram was done at the Lakewood Hospital which found a bulging C5-C6 disk.

A. Oh, did it? Okay.

MR. WILLIAMS: Why don't we go off the record and if that is the case then we will--

(Thereupon, a discussion was had off

the record.)

A. I stand corrected that there was, in fact, a positive myelogram with an extra dural defect at the C5-6 level.

I think to answer your question, I'm not sure, although I have no way of proving otherwise, that the actual herniated disk was directly related to the accident, although the accident was competent to produce it.

Q. Without anything else that would suggest that it came from another cause, you would have no reason to dispute that it came from the automobile collision?

A. No, what I'm saying is that it may have been made symptomatic. At the least, it was made symptomatic. In other words, at least it would have aggravated a preexisting disk disease.

At the most, it was caused by the accident. I don't know. I don't think anybody knows, but it became symptomatic from the accident.

Q. In other words, when you say "symptomatic," it began to cause him problems which ultimately led to his having to have the surgery?

A. I believe so, yes.

Q. And you are not aware of any trauma to his neck which caused or aggravated whnt his neck was between the time of the accident and the time he had surgery?

A. I'm not aware of anything else, no.

Q. Doctor, you didn't make any tape recording of your examination of Mr. Prete when you did your examination, did you?

A. No.

Q. So when you rely on--when you include direct quotes in your report, you are taking those from some handwritten notes, I take it, that you made at the time of the examination?

A. That's correct.

Q. And Doctor, you don't take shorthand; is that also correct?

A. Yes.

Q. You don't take down everything the man says word for word; is that correct?

A. No, not everything the man says. If there is a specific interesting quotation, I will take that down word for word, yes.

Q. And you are interested in descriptions of symptoms and pain. Is that part of your relationship with--being consultant to the pain

clinic at Huron Road Hospital?

A. I'm sorry, I'm not quite sure I understand.

that you paid particular attention to the adjectives that Mr. Prete used.

Q. Is that because of your association with the pain clinic and that has something to do with diagnosis or treatment in the pain clinic?

A. Well, I think I'm a little bit more sensitive to specific adjectives simply because of the volume and the variety of cases that we do see, so it. is easier for me to recognize symptoms of a condition when you see a lot of it.

I don't portend to be an expert in management of chronic pain, but I think I see enough of it, and certainly more than the average physician sees in his practice, to he able to identify this condition without *any* difficulty and be very secure with that diagnosis.

Q. Doctor, when you say "typical affect" of a chronic pain' patient, what exactly are you describing?

A. The affect is the way someone--the way you see

someone, whether he is high-strung, relaxed, confident, insecure, keeps a straight face, doesn't use any facial expressions, doesn't smile, didn't laugh, that all goes in affect, so it is a subjective observation of the observer, of the trained observer.

So usually it is a reflection of the patient's comfort in a certain situation, the patient's relationship to himself and to you, as a physician.

I'm not saying that all chronic pain patients have this. I'm just saying that there are normal patients that have the same effect to and affect is the way a patient come across,

Q. Eo in other words, that affect which you wrote in your report, typical affect of a chronic pain patient, that is subjective, that is your, opinion, so to speak?

A. Yes, it is always my opinion. The diagnosis is my opinion and what I observe is my opinion.

Q. Much in the same way that patients relate to you when you are doing an examination whether they have pain or don't pain, that is subjective to them.

By the same token, you don't hesitate to

use subjective kinds of observations in your examination and your reports?

A. No, my observations are objective. My interpretation are subjective. What I observe, I observe. How I interpret that observation is subjective.

But all physicians and all attorneys have to be subjective. You have to draw conclusions based upon your own fund of knowledge and your own experience in the field.

Q. Doctor, in your notes don't you also make a reference that Mr. Prete is a chronic pain syndrome personality type? It is on a different piece of paper. It is also typed notes.

A. Yes.

Q. What is a chronic pain syndrome personality type?

A. Basically the same type of affect. Somewhat reticent to discuss things initially, but then opens up when he sees sympathy toward the cause or toward, you know, his cause so to speak or his pain, the type of adjectives that are used as I think I testified on already.

There are a variety. If you want me to make a list of them, I probably could, but I

dictated that note immediately after walking out of the room with him that day.

That connotes to me, sort of in shorthand, so to speak, about what he came across as, just to give me--because I didn't know how long it was going to take me to get all the records and when I was going to write the report, so I had to heve something that was sort of a buzz word to remind me of what the whole situation was.

Q. So you found him to be sort of withdrawn into himself?

A. I think after we started talking about the drugs and the chronic pain medicine, I think he began to be, but I satisfied myself in my ability to get him out of that mind set to able to talk about it, because I basically try to be fair.

Q. He cooperated fully with you?

A. Oh, absolutely. I had no problems with his level of cooperation. I think be was a very nice gentleman and very honest and I think he was really sincere in how he was describing what he felt.

Q. Doctor, were you aware that Mr. Prete had only started--I'm going to call it inpatient treatment at the Pain Center at University

Hospitals, but what I'm actually describing is when he want there and spent like five hours at a shot there the first time that he had done that was I think the day before you had seen him.

A. Yes, I think I testified that; and I was very impressed. I don't think it was that. I think he had seen them once. I don't remember precisely because I didn't think that was that significant to remember, but he had seen them, started on the medication, but had first started the counseling aspect of it very, very shortly prior to my evaluation, and I felt this was significant that, you know, he was very, very positive that this was going to be the thing and this really gave him--they understood what his problem was, and I felt that his attitude toward it was superb.

I wish most of our patients had his attitude toward alleviating it with this chronic pain management approach. I think it was very positive.

Q. Doctor, one of the criteria for categorizing a patient as a chronic pain syndrome is pain that persists longer than six months where there is

no underlying orthopedic or medical thing that an orthopedic surgeon or medical doctor can do for the patient; is that correct?

A. I don't think that is particularly true. I think you have to differentiate between chronic pain anti a chronic pain syndrome.

Chronic pain is pain that persists greater than six to eight weeks that can or cannot be explained on the basis of, in my particular specialty, an orthopedic problem or neurological problem.

A chronic pain syndrome is a psychological or psychiatric disorder in which there is pain described by the patient that is above and beyond that which is found by objective testing or by what a standard patient with that particular abnormality would complain of.

I'm not sure that is coming across right, but usually they describe pain in a specific sort of--what some doctors would consider an exaggerated fashion, but in essence that is what they are really feeling.

In other words, what they are saying doesn't correlate with what they should feel on the basis of their objective disease.

I think Dr. Bohlman caught this soon after he expected complete resolution, and they started having pain again. He had Mr. Prete go to Dr. Kriegler, which is what I would do in a similar type of situation.

So what I'm trying to say in my answer is that there is a difference between chronic pain and the chronic pain syndrome.

Q. All right. Doctor, is changing the medication as Dr. Kriegler did from Motrin to Naprosyn appropriate treatment for a patient beginning a pain center program?

A. In general, I think--I don't particularly use either one of those medications.

Q. That is a metter of choice among physicians?

A. What I think is important was the combination, that is the use of a non-steroidal anti-inflammatory medication and a major tranquilizer has a potentiated affect. In other words, one potentiates the other one in the actual brain receptors, the actual chemical receptors in the brain.

I particularly use Trilisate, which is an aspirin-like product. It has less side effects than Motrin and Naprosyn. I don't use Naprosyn

simply because it has some toxic effects when used for long periods of time at high levels. So it is just a matter of choice, but I think they were appropriate choices.

Q. Is a side effect of Naprosyn internal bleeding?

A. A side effect, a complication of all anti-inflammatory medication can be intestinal bleeding. Although hemorrhage is unusual, minor bleeding is fairly common.

Q. And that shows up as blood in the stool?

A. It may, yes. They have many other things that can cause blood in the stool, but it is not uncommon to see it just with the use of anti-inflammatory medications.

Q. Doctor, I was paying particular attention to your direct testimony, as I'm sure the members of the jury were, and when you were reading from page three of your report you had stated--and I trust that the record will bear me out on this, but I'm not going to ask the court reporter to go back and find it--in the third small paragraph, the top paragraph carries over from the page before and the third paragraph after that you wrote, "Past medical history failed to reveal previous trauma to his neck and upper

back region." That is what your report says.

Now, Doctor, while you were testifying I wrote down the word "spine" because I think you said "spine" when you were talking rather than neck.

A. I don't iecall lut I stand by my report, neck and upper back. That's where the major portion of his symptoms are.

Q. So the low back problem that. the guy had years before was immaterial as far as this case is concerned?

A. I don't: think it has milch relevance, no.

Q. Because you have Dr. Elmer's office records in front of you and that does, in fact, talk about a low back problem.

A. I was not concerned with that.

Q. Okay. My point is that,. had you asked him about low back, he would htve told you about it, but when you said "spine," spine goes from top to bottom and I just want to clear up any misconception that there may be.

A. Well, the major if not all of his symptoms were confined to the upper aspect of his spine and not the lower aspect of his spine. I simply examined the lower aspect of the spine just to

get an idea of what normal for him was.

Doctor, you treat your own patients on the basis of rheir subjective complaints; do you not?

No. I treat patients on the basis of their complaints, my findings during physical examination, and x-rays when appropriate.

Q. Well, Doctor, you do, do you not, treat your patients when you do an examination and they tell you it hurts, that is a subjective tl ing.

I think you testified that that kind of symptom, part of an examination when someone tells you it hurts, that's a subjective finding or subjective complaint.

You ask your patients when it hurts, don't you?

A. Is that the question?

Q. Yes.

A. Yes, I ask the patients where it hurts.

Q. When they tell you if it hurts or doesn't hurt, that's a subjective kind of thing because ycu can't see or feel it?

A. That's correct, but I don't base my treatment just on what they say.

Q. Certainly not totally on that, it is part of everything else.

A. That's cor-rect.

MR. GARDNER: Off the record.

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

BY MR. GARDNER:

Q. Doctor, would you tell the jury what the side effects are of a cervical myelogram?

MR. WILLIAMS: Objection. Go ahead.

A. I'm not a radiologist, but--

Q. Eave you ordered myelograms for your patients?

A. Yes.

Q. When you see your patients after myelograms, what are some of the common side effects?

MR. WILLIAMS: Objection.

A. Common side effects would include post-operative nausea, maybe some post-operative headaches.

With the current material that they are using now, all of the material is absorbed, so they are water soluable. I'm not sure what variety he had.

There can be seizures with the medication, due to the medication, but that is about all.

Q. Severe post-myelogram headache would not be that uncommon, would it, Doctor?

MR. WILLIAMS: Objection.

A. You know, I don't see the headache that often, but it is reported in the literature.

Q. Doctor, it is significant, isn't it, and I think you testified on direct examination that it was significant, that Mr. Prete appeared to improve after just a short time on the new medication in the pain program; is that correct?

A. Yes.

Q. What do you mean by that? Why is that significant?

A. Well, that helped to let me know that the prognosis was favorable. Usually, and to understand this, and I will try to keep it simple, to understand how the brain pain receptors work, it is sort of like a socket. Only one plug can fit in a socket at a time. If you had a bigger plug in a bigger socket where there would be more of an effect, then that would be the same equivilant of combined medicaticns having an additive effect together.

I think that after being on the medication for a fairly short period of time, which I believe was about a month--1 can't recall the exact dates. I think it is my report. I'm not sure.

You probably have found it, but it was on a minimal time. There was a good early result with the medication just by chemically changing the brain's ability to handle pain or to handle these chemical mediators that cause pain or that is interpreted as pain.

It was a very good prognostic sign. In other words, without any psychological therapy, without really working on a psychiatric or psychological basis or working on a personality basis, there was already an improvement.

One of the theories about this is that the reason that people have different pain thresholds is because the brain--everybody's brain or central nervous system secretes different concentrations in different amounts of chemicals that are grouped called endorphins which are endogenous inside-produced opium-like medication.

People with higher pain thresholds secrete more of these, and there is some evidence, although it is purely experimental and it is in animals, it is not in humans because there are not too many human volunteers of this. They take biopsies of the brain and study the aspect

that the combination of these drugs enhance the endorphin production or make the endorphins work for efficiently, so to speak.

These can cause less pain and are interpreted as improvement in the patient's subjective complaints.

Q. Did Mr. Prete appear to you to be motivated to concur his pain?

A. Absolutely, no question about that. As I testified previously, I wish most of our chronic pain patients had that kind of attitude because it is an excellent attitude.

MR. GARDNER: Off the record.

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

BY MR. GARDNER:

Q. Doctor, did you have Mr. Prete take his shirt off, remove his neck tie for your examination?

A. I believe so, yes.

Q. Were you present in the room when Mr. Prete put his neck tie back on and shirt back on?

A. I doubt it. I really don't remember.

Q. Well, I will represent to you professionally that you were during part of the time that he put his tie back on.

Did you happen to notice how he used his fingers to put his tie back on or button his shirt.

MR. WILLIAMS: Objection.

A. No, I didn't.

Q. If Mr. Prete didn't really use his thumbs but just use? his forefingers to put his neck tie on and button his shirt, you failed to observe that as part of your examination?

MR. WILLIAMS: Objection.

A. I was finished with the examination at that point. I did observe that he was using--I think I stated that previously, that he was not using his thumbs appropriately. I think I stated that previously.

Q. Did you discuss with Mr. Prete what kinds of work he has to do and what kinds of equipment he has to use?

A. Yes.

MR. GARDNER: Okay, Doctor, I think that is all I have. Mr. Williams may have some additional questions. Thank you very much.

MR. WILLIAMS: No, I have no further questions, either. Doctor, would you waive your right to review the videotape and also waive

your right to read the transcript of this deposition.

THE WITNESS: Yes.

MR. WILLIAMS: Thank you, Doctor, I have nothing further.

MR. PALCHO: Will Counsel waive filing of the tape?

MR. GARDNER: Yes.

MR. WILLIAMS: Yes.

- - -

(DEPOSITION CONCLUDED.)

(SIGNATURE WAIVED.)

- - -

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 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 4th day of May, 1987.

Diane M. Stevenson

Diane M. Stevenson, RPR
Notary Public in and far
The State of Ohio.

My Commission expires October 26, 1990.

Page	Line	

NAME: COOK, Rosalee **DATE:** 8/20/90

ADDRESS: **D.O.I.:**

PHONE: **EMPLOYER:**

REFERRED BY: **IC#**

Patient evaluated for an IME. DOI 4/98/88. Essentially she was rearended. The details ar in the enlosed chart note.

PHYSICAL EXAMINATION was entirely within normal limits. There was no spasm or dysmetria Full ROM in both her neck and upper back, shoulders, elbows, wrists and hands. No signs o any neurological impingement. SLR to 90° in both the sitting and supine positions.

Most of her low b c k discomfort was just to the left center of midline, radiating into th sacroiliac joint. This is what she called her buttocks. She has had no medical car recently. She was pregnant until approximately June 8, 1990 when she delivered her secon child. She also was in a previous MVA injuring her neck and low back in 1983. She state there has been no problems for the last 5 years.

Will complete an IME after I review the additional medical records. (RCC/bn)

B