In The Matter Of:

Patricia Lindamood-Tamler v.
State Farm Insurance Company

Robert C. Corn, M.D.
Vol. 1, May 14, 1996

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IN THE COURT OF COMMON PLEAS
CUYAHOGA COUNTY, OHIO

PATRICIA LINDAMOOD-TAMLER,)
)
Plaintiff,)
)
-vs-) CASE NO. 287952
)
STATE FARM INSURANCE COMPANY,)
Defendant.)

Deposition of ROBERT C. CORN, M.D., taken as if upon direct examination before Susan M. Cebron, a Registered Professional Reporter and Notary Public within and for the State of Ohio, at the offices of Robert C. Corn, M.D., 850 Brainard Road, Highland Helghls, Ohio, at 9:38 a.m. on Tuesday, May 14,1996, pursuant lo notice and/or stipulations of counsel, on behall of the Defendant in this cause.

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On behall of the Defendant.
ALSO PRESENT:
Dan Williams, Multivideo Service

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ROBERT C. CORN, M.D., of lawful age, called by the Defendant for the purpose of direct examination, as provided by the Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

DIRECT EXAMINATION OF ROBERT C. CORN, M.D.

BY MR. WANTZ:

Q: Doctor, could you tell **us** your complete name for the record, please?

A: My name is Robert Curtis Corn, C-o-r-n.

Q: And I have referred to you as doctor. Are you a licensed physician in the State of Ohio?

A: Yes, I am.

Q: When did you obtain your license, doctor?

A: In 1976.

Q: And do you presently have an office in the Ohio or Cleveland area?

A: I do.

Q: **And** we are at that office right now, correct?

A: Right. That's my primary office.

Q: Could you tell the jury, please, the address here?

A: We are at 850 Brainard Road in Highland Heights, Ohio.

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Q: Now, you mentioned that you obtained your license in 1976. How long have you been actually practicing medicine?

A: Well, I have been practicing orthopedic surgery since August of 1979. So I am in my seventeenth year.

Q: Doctor, where did you obtain your medical education and training?

A: I received my bachelor of science in biology from the Albrecht College in Redding, Pennsylvania. I moved back to my hometown, Philadelphia, Pennsylvania, where I attended the Hahnemann University School of Medicine from 1971 through 1975. I received my M.D. degree in June of 1975.

Q: And did you receive any clinical training or practice or residency after that, doctor?

A: Yes.

Q: And where did you obtain that?

A: Well, in June of 1975 I moved out here to Cleveland and I started the orthopedic residency program at the Cleveland Clinic. I was at the Clinic from 1975 through 1979, completing the orthopedic residency program at the Clinic.

Q: And at that time you went into practice as an

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orthopedic surgeon?
A: Correct. As of August of that year, yes.
Q: And have you been continuously practicing orthopedic surgery since that lime?
A: Yes.
Q: Doctor, could you tell us, please, what is orthopedic surgery?
A: Orthopedic surgery is a subspecialty in the field of surgery. It involves the medical or nonsurgical as well as surgical treatment of diseases, disorders and injuries and tumors of the musculoskeletal system.
That includes the bones, the muscles, tendons, joints, ligaments, their muscles, associated nerve problems as well as certain subspecialties, surgery of the spine, surgery of the hand, sports medicine and arthroscopic surgery, trauma and fracture surgery, surgery for musculoskeletal tumors as well as joint replacements and surgery for arthritis.
Q: Doctor, you made reference *to* musculoskeletal problems. Could you explain for us a little bit more in detail what musculoskeletal problems are?
A: Well, musculoskeletal problems, really, is sort

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of a wastebasket term to mean basically anything that is involved, the bones, the joints, their connecting soft tissue, which are the ligaments, their muscles, the nerves that supply those muscles, the developmental problems, that is congenital problems that babies are horn with, developmental problems, stuff that the aging process adds, degenerative problems, as the population ages dealing with those problems, and any injuries that occur in any of those age groups are basically under the field of orthopedic surgery.
So it is a fairly broad area of medical care.
Q: Now, doctor, you mentioned you deal with nerve injuries to some degree in your field, is that correct?
A: To some extent. Usually as it involves certain regions of the body, such as the wrists, the elbow, the shoulder, the spine, but we don't deal with the diseases of the nerves.
In other words, if you have a problem of the nervous system, that's more in the field of neurology, whereas we deal with compression of the nerves, that is a pinching of the nerves or

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due to anatomical pressures on the nerves. We don't deal with brain disorders or nerve disorders unless they affect the muscles, the joints or one of the other orthopedic areas.
Q: Doctor, the jury will have heard from Dr. Jennifer Kriegler by the time they will be hearing your testimony. She has indicated she is a neurologist.
What is your understanding of the difference between a neurologist and an orthopedic surgeon such as yourself?
A: Well, we already defined orthopedic surgery. Neurology is a medical subspecialty which involves the care antl treatment of diseases or problems of the central nervous system, which is the brain antl spinal cord, and the peripheral nervous system, which is the nerves that go to all the other places in the body.
They are not surgeons. They are diagnosticians and they offer treatment and help with a number of the surgical specialties to figure out where the problem is, where the nerve may be damaged and if there is any surgery that can correct that problem.
Q: Thank you, doctor. Now, are you on staff at any

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hospital or hospitals?
A: Yes.
Q: Anti could you tell tis, please, which hospitals?
A: I ani an attending orthopedic siirgeon at the Meridia Hillcrest Hospital, the Meridia Euclid Hospital, the Meridia Huron Hospital, the University Hospitals Bedford Medical Center, the Mount Sinai Medical Center anti the Lake Hospital Systems.
Q: And, doctor, do you or have you in the past held any positions other than as an attending physician at any of these facilities?
A: Yes.
Q: Could you tell us, please, about that?
A: I was chief of orthopedic surgery at the Meridia Huron Hospital and I ran the orthopedic teaching service from January of 1984 to November of 1992.
Q: Doctor, do you do any teaching?
A: Yes, I do.
Q: Where do you teach?
A: Currently I am a clinical instructor in orthopedic surgeon at the Case Western Reserve University School of Medicine and I am an assistant professor of orthopedic surgery at the

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Ohio College of Podiatric Medicine.
Q: Do you belong to any professional societies or groups in the field of orthopedic surgery or in medicine in general?
A: Yes, I do.
Q: And could you, again, please tell us a little bit about that?
A: I am a fellow in the American Academy of Orthopedic Surgeons. I am a fellow in the American College of Surgeons. I am a fellow in The Orthopedic Research Society.
I am a member of the American Medical Association, Ohio State Medical Association, Cleveland Academy of Medicine, Cleveland Orthopedic Society and a number of other organizations.
Q: Now, doctor, the first societies which were basically orthopedic societies you mentioned you were a fellow as opposed to being a member. Is there a difference?
A: Well, the second one I mentioned, the American College of Surgeons, is basically a surgical group. The other two are orthopedic, and there is a difference between fellowship and membership.

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Membership, there are certain organizations where you basically if you fall into that category such as if you are a doctor you can join the medical society, and as long as you maintain their criteria for continuing medical education and you stay out of trouble you are a member forever.
Whereas a fellow you have to be elected by that organization. You have to be board certified, you have to jump through certain hoops, so to speak, for the organization.
For The Orthopedic Research Society you have to have had a major orthopedic presentation at the national meeting to even be considered for membership.
The American Academy of Orthopedic Surgeons you have to have been board certified in that and actually elected in by your peers, in other words, there is a constant peer review process. During the application process doctors come in to the operating rooms spontaneously, they come into your office, they appear on rounds when you are going to see your hospital patients and trying to observe what your level of quality is.

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So that's the basic difference between the two, a fellowship and a membership.
Q: Doctor, you mentioned several times that one has to be board certified. I take it then you are board certified?
A: Yes.
Q: And what is being board certified mean?
A: Well, every medical and surgical specialty and subspecialty has a board or a committee which sets the etlucational requirements and testing requirements for that particular specialty.
In other words, the American Board of Orthopedic Surgery, they approve every single residency or teaching program in North America. In other words, somebody goes out and makes sure everything is being followed just the way the board wants it to to standardize the education. They provide a written examination every year of your training. They also provide a so-called Anal exam, part of the board certification examination, which is two, three hour written exams.
They also provide the oral exams and the criteria for which a young doctor can be a member or a fellow in that group, and there are

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basically certain steps you had to follow.
In 1980 I had to have completed a residency, approved residency and completed it in good standing, had passed the exams each year, had to have been in clinical practice for one calendar year in one location and that's the time the peer review takes place, and then you have to take a series of exams, and after passing that examine you were ultimately certified by the board and then qualified for the other organizations.
Q: When did you become board certified, doctor?
A: September of 1980.
Q: Thank you. And, doctor, let me also ask you this. Have you done any writing or been published in your field as an orthopedic surgeon?
A: *Yes.*
Q: And could you please tell us some of the articles you have had published?
A: Well, orthopedic research has been one of my interests ever since my college days. I worked at my medical school every summer with animal research.
The first paper I actually had published

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was in The International Journal of Surgery antl that was between my junior and senior year in college.

During my medical school years I continued with my research work anti also in my residency where we did some of the preliminary work on biological fixation of joint replacements, that is the porous coating, how big the pours should be, what they should do, and that is now in clinical application.

Since I finished my training most of my interest has been in basic diseases antl disorders that affect the general population, osteomyelitis, which is a bone infection. I have done some work and published papers on osteoporosis, including the surgical and orthopedic complications of osteoporosis, as well as a number of articles over the years.

Q: Thank you, doctor. Now, during the course of your practice and just so we are all clear, do you have occasion personally to treat people who have injuries and problems with the back?

A: Sure, on a fairly routine basis.

Q: And, doctor, turning to Patricia Lindamood-Tamler, at my request did you have an

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occasion to examine her?

A: Yes.

Q: And before we get into the specifics of that examination, doctor, generally speaking, do you perform what we call as lawyers independent medical examinations for others, for people on a general basis?

A: I have a certain allotted time during the week that I will schedule independent exams. They aren't always defense exams. I have two slots a week that I reserve for nontreatment evaluations. This is basically scheduled on a first come first serve basis and it's for a nontreating exam, in other words, an evaluation and no treatment. In other words, just a letter to be written to someone. It can be an employee, it can be the State of Ohio, Bureau of Worker's Comp, it could be a plaintiff's lawyer, it could be a defense lawyer.

In other words, these are certain time slots that I have that are for nontreatment and I do do that on a regular basis.

Q: Doctor, you said you do that about two times a week?

A: Correct. That's the typical schedule over the

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years has been twice a week.

Q: And do you have any knowledge as you sit here as to the breakdown of how many you might do for a defense lawyer as opposed to a plaintiff's lawyer or for the State of Ohio or an employer?

A: Over the years I believe it's been, those particular exams have been about 55 or 60 percent for defense, quote, unquote, and that could be for a personal injury such as this or an employer or Bureau of Workers' Compensation or the Attorney General's Office about a contested Workman's Comp claim, that would be that segment.

The others would be one time evaluations for personal injury, product liability, medical malpractice, other things that I would do for either defense or plaintiffs, depending on the first come first serve basis. Obviously I have limited an amount of time so it doesn't interfere with my patient care time, and that's what I usually devote toward medico/legal aspect of orthopedics.

My patients being in orthopedics, you can't avoid medical/legal issues, anti a lot of my patients have been injured with different claims

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and, obviously, I would spend time working up their medical/legal problems as well from my standpoint and doing the same thing we are doing here, depositions and medical reports for them as well.

So this is something you really can't avoid in an orthopedic surgeon's practice and I sort of enjoy the mental aspect of it.

Q: Doctor, let me ask you this. You are compensated for doing these one time examinations, correct?

A: Yes.

Q: And your compensation for these examinations, does it change in terms of what your basic charges are regardless of who you do the examination for?

A: Well, the charges are on the basis of the complexity and the amount of time it takes. It doesn't matter what the source of the reference is. It basically is not precisely a minute by minute type of charge, but it's based on the complexity and it would be the same for whoever is reserving that slot of my time.

Q: And, doctor, when you do these examinations, these one time examinations, you have mentioned

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that they are obviously iiontreating examinations.

Apart from being nontreatiiig examinations, is there any other difference between these one time examinations and your examination of a regular patient?

A: The only difference is usually the complexity of the records and the complexity of the problem I am asked to try to sort out or give an opinion on, but the examination itself and the history that I, the questions I ask and the information I try to obtain is virtually the same as I would do for my own patients who are coming to me for treatment.

The exception is that by agreement between the county and local Bar Association and the Academy of Medicine of Cleveland I am not allowed to talk about treatment, I can't offer these individuals any recommendations, I basically can evaluate them and that's it.

So there are agreements and stipulations about these exams, and I have my limitations, even if I want to say listen, you should really do this or do that, I am not allowed to say that or not allowed to give those recommendations,

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whether there are plaintiff attorneys present or defense attorneys present or not. These are just agreements that are strictly for an evaluation and I am limited in what I can do with them.

So it is not something doctors feel real comfortable with. You like to help patients, you like to manage patients, you like to give them an idea what they could be doing differently, but that's not the purpose for this type of exam.

Q: Thank you. Now, doctor, let's turn to Patricia Lindamood-Tamler. Can you tell us, please, when you saw her?

A: The evaluation was on January 26th of 1996.

Q: And at the time that you saw Miss Tamler could you tell us what the specific parts of your examination were, what you did as part of your examination and rendering of an opinion here?

A: Well, she was present and she appeared with a lawyer from her plaintiff's law firm.

I provided, I did a history and physical, a typical orthopedic history and physical, that is I tried to establish when she felt her problems began, some of the details about the accident,

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although that is really out of the - the details are really anecdotal or just of interest and are not necessarily necessary for establishing what the injuries were, trying to chronologically put together what happened from the time the problem began to the present time, all the doctors they havr seen, all the tests that they can remember, what institutions they were seen at or evaluated at, what their current state is, what kind of medications they are on, was there any previous injuries or previous problems, and basically the history, the same as you would go to a doctor's office and the doctor would try to establish all the facts that he or she could.

Q: Doctor, let me interrupt you for just a second. Just so we are clear, what is a history when you refer to that term?

A: The history is the give and take conversation between a physician and a patient in which this chronology or this series of events is being put into order. It consists of the chief complaint, that is, what brings the patient to the office, the history of the present illness, any past medical history, current symptoms, employment

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history, what medications they are on, those type of segments.

Q: And did you go through all of those parts of a history with Miss Lindamood-Taniler?

A: I did

Q: And was there anything unusual or significant about the history that she gave you?

A: The only thing that was a little bit challenging for me was to figure out what was really bothering her at the time that I saw her. I really had to ask a lot of questions trying to establish, you know, what her current condition is, you know, where does she hurt, what's going on now.

Most people are very capable of doing that, whether they are here for treatment or they are here for evaluation, most people know what brings them into the doctor's office or know what their current situation is.

It was difficult to assess when I evaluated her, it took a lot of questions and a lot of effort on my part. It usually doesn't take that long.

Q: By the way, doctor, do you have an independent recollection as you sit here today of the

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examination arid the history that you obtained from Miss Lindamood-Tamler?
A: No, I do not.
Q: You have records in front of you that you are referring to to refresh your recollection, is that correct?
A: Primarily the letter that I sent to you, yes.
Q: Now, doctor, after you obtained her history, what is the next step of your examination?
A: Well, the next step in the evaluation is to do a physical exam.
Q: And could you tell us, please, the details of the physical examination that you performed?
A: The physical examination revealed a 51-year old female who appeared older than her stated age. Her general body habitus, that is the shape of her body, showed that she was of somewhat short stature with the chest area or the trunk area of her body seeming a little shorter than it should have been as coniparison to her arms and legs, and noting subsequently the medical records with her history of severe osteoporosis this would certainly account for that general appearance.
Some of the basic movements and motions observed that she was able to walk normally,

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although she was somewhat hesitant when she first stood up. She was able to stand on her heels and toes showing in general a normal neurological function.
She did claim to have some balance problems. She felt she had to hold onto the exam table as part of the, which is not terribly unusual, most people aren't used to walking around on their heels and toes.
She was able to get up from a sitting position without any trouble. She was able to climb up and down from the exam table without any difficulty.
In general the actual hands-on physical examination was divided into anatomical areas, the neck and tipper back, and that includes the shoulders and upper extremities, that is the arms, and then the lower back and then the lower extremities and the neurological evaluation of those areas. So it's sort of a regional evaluation.
Going to the neck area, what a doctor tries to do in any evaluation is he tries to sort out what the patient is saying, that is take the patient's symptoms and try to match a treatable

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known anatomical abnormality.
In other words, you look for objective symptoms. Subjective complaints, that is something that only the individual can experience, and objective findings which someone who knows what to look for can find them. So there is really uncontested actual physical problems, and that's what a doctor looks for.
Doctors like to treat physical problems or anatomical problems, and they don't like to treat syniptoms in general, unless you go to a pain center which all they do is treat syniptoms.
The neck area revealed no signs of what we call spasm, which is an uncontrolled muscle contraction. It showed no evidence of dysmetria, abnormal muscle coordination and no guarding, which is the reflex tightening of a muscle. That's the feeling that a day after you, a day or two after you have done the gardening or the housekeeping you get that stiff muscle that sort of grabs you.
That's called guarding. That is objective when it is present, but it wasn't present at the time of this exam.
The range of motion of the neck was

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unrestricted. In other words, she had a full motion, being able to bend her chin on her chest, look up to the ceiling, look right, look left and tilt right, tilt left.
The examination of her shoulder blades, upper back and neck area again failed to show any signs of this muscle irritation. It was full unrestricted motion of her shoulders, her shoulder blades, her elbows, wrists and small joints of the hand.
She had a subjective weakness when I asked her to grip my fingers during the examination. However, there was no objective signs of muscle wasting, no physical observable atrophy or wasting of the muscles, and I physically took a tape measure and measured around the armpit, the upper arm, the forearm and wrist and, in fact, even around the hand, and both sides were equal.
So there was a subjective weakness. In other words, she was claiming she was weak and she was not squeezing hard on that hand, but there was no objective finding that would give me a reason why she couldn't do that. In other words, there was no motor abnormality, no

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sensory or inability to detect sensation and there was no reflex abnormality and there was no muscle atrophy, but despite this she still had a weaker grip, and there is really no orthopedic explanation for that.

Even the intrinsic muscles, which are the little muscles that move and wriggle the fingers, taking a tape measure and measuring around the hand and having them make a tight fist showed that there was really no significant difference. I mean, there was less than a millimeter of difference between the left and right hand, which showed essentially normal usage despite the subjective weakness that she demonstrated, and the only objective finding in the neck/upper back exam was this mildly positive Phalen's sign.

The Phalen's sign was originally described by a doctor in the mid Fifties at the Cleveland Clinic, Dr. Phalen, who noted that if you force flex the wrists, that is, if the doctor does this and holds this for a period of time, usually 20 to 30 seconds, you may develop some numbness, tingling in the median nerve distribution, and this is commonly known as

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carpal tunnel syndrome.

There was mild response to that. In other words, with that hand bending down there was some tingling in her fingers.

Q: Doctor, if I could interrupt you for just a second here. You have indicated that there may have been some evidence of carpal tunnel syndrome. Is that something that she complained of or that she related to this accident in any way?

A: No. I mean, it was something that she didn't even know she had. Obviously by reading the records that was never any of the considerations by Dr. Kriegler or the doctors at the Cleveland Clinic, that was not even a diagnosis that was entertained.

Q: Thank you. I apologize for interrupting. Could you go on with your examination?

A: Well, a similar type of exam was done of her lower back area. Again, the only area that she really truly complained of some discomfort was in the left sacroiliac joint area. That is where the pelvis meets the midportion of the backbone, and this was just tenderness. There was no objective finding associated with this.

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There was unrestricted motion of her lumbar spine, that is, she had full range of motion, her hips examined normally, her knees, her ankles, her straight leg raising, that is looking for sciatic nerve irritation, there was no abnormal signs.

There was no atrophy or muscle wasting in the upper or lower thigh or upper or lower calf area. Her deep tendon reflexes were intact and there was some discomfort in a Patrick Figure Four, that's when you cross the legs and roll them outward, she complained of some discomfort with that maneuver, but, again, no objective abnormality was associated with that, and her neurologic examination was normal.

In other words, there was no evidence of any neurological disease or neurological injury, anti that essentially completed the actual hands-on physical exam.

Q: Thank you, doctor. Now, doctor, during the course of the exam you mentioned the fact that you noted, I believe, that Mrs. Lindamood-Tamler suffers from osteoporosis?

A: Well, that really was my clinical suspicion looking at her. I had not reviewed the records

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or looked at the x-rays prior to the exam, but, yes, that was diagnosed by a number of, at least one other doctor prior to this evaluation.

Q: Could yori tell us, please, what is osteoporosis?

A: Osteoporosis is a metabolic bone condition, which involves all people eventually, but primarily causation females in which when they either go through menopause, which can be anywhere from the 40's to 50's to early 60's, or if they have a surgical menopause, that is the ovaries are removed in one way, shape or form they start losing bone mass, they actually physically lose the calcium matrix.

It is in some studies felt that women in their 30's start losing bone, and that's why a lot of Concentration from prophylaxis and appropriate diet, taking appropriate calcium and vitamins to help prevent this disease is so common and we hear about it on the news virtually everyday.

But what happens is there is unrelenting loss of bone matrix, that is the actual stuff that makes the bone hard, and when you lose that, over a period of years rhe bones actually physically become weak to the point that women

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can develop what we call atmumatic fractures, that is fractures that occur, collapses of the bone that occur that are not traumatic. In other words, you don't need a fall or car accident or someone pushing you down the steps or anything to cause the bone to break. It just breaks on its own through the normal stretches and pushes and pulls of the muscles.

This is what the condition was that was in this particular patient. In other words, there had already been atraumatic spinal fmctures. If you can think of a Ping-Pong ball and you dent the Ping-Pong ball, there is no way of getting that dent out, and that is essentially what the fracture abnormalities were localized in her spine.

The fractures themselves mean nothing other than the fact that it may be a source of pain, but what happens when you have more than one fracture is that the spine starts to collapse, and when the spine starts to collapse it throws the body off, and if you have one spinal fracture, the chance of getting the second one is about 30 percent; if you have two, the chance of a third is about 60 percent, antl when you

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have three the chance of a further fracture is a hundred percent.

So once this thing starts it's unrelenting and there is no way of treating it. There is no way of physically operating on it to straighten out the spine, arid what this causes, it causes a mechanical abnormality and this is seen very commonly, not so much in the early 50's, but usually in the 60's and 70's when women's osteoporosis develops and worsens.

In other words, that's when it becomes symptomatic. That's when people start presenting with symptoms, other than the fact that their clothes don't fit them right or they notice they are bent over a little bit more.

Q: Doctor, now Mrs. Lintiamood-Tamler, as I understand it, suffered from severe osteoporosis at the time of this accident, is that correct?

A: That was prior to the accident, yes.

Q: And she had already suffered multiple compression fractures of the vertebral spine by the time of the accident?

A: They were present on the initial evaluation. So, yes, they had probably occurred before that.

Q: Did **she** suffer any types of fractures or bone

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injury as a result of this automobile accident based on your review of the records?

A: I don't think that was anybody's opinion. I think that they assumed that it was part of the complications of osteoporosis, and the fractures were certainly by history not traumatic in that it would feel like you break your spine if it was from trauma.

I don't think anybody's suggestion was that these were at all related to the accident antl were merely a preexisting condition.

Q: Doctor, now you commented that a person with osteoporosis such as this is subject to atmumatic fractures of the bone, correct?

A: Correct.

Q: Does that also make such a person more subject to fractures even with simple trauma?

A: Well, if the bone structure is weakened to the point that it doesn't take an injury to break it, then certainly an injury would have a tendency - it would certainly be more vulnerable to injury. It would take less of a trauma to continue the fracture process if it had already happened without trauma.

Q: Doctor, osteoporosis, can that also cause pain

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and problems in the back?

A: Well, osteoporosis, if you look at a hundred women with diagnosable osteoporosis, that is you **know** that they have it, 80 some percent will be totally pain free. They won't hurt at all and they won't even know they have it. They may notice their dresses fit a little funny or they may be rounded over a little bit or one of their grandchildren may say something to them, but they really don't hurt.

The pain from osteoporosis comes from two primary reasons. The first is the fracture that can occur, and the second is mechanical. In other words, as the center of gravity is being forced forward, it takes more of an effort of the mid and upper back muscles to hold the body up. Otherwise, you would fall flat on your face, and this causes a diffuse muscle type of aching pain which is indistinguishable from a fibromyalgia type of picture in this age group.

In other words, it's purely mechanical. They are much better when they are sitting, they are much better when they are lying, but the more they are on their feet or the more they are over a desk or **the** more **they** are bending and

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lifting and doing their regular daily chores, that's the other common pain associated with osteoporosis.
The actual condition doesn't hurt. It's the complications of the condition that hurt.
Q: Thank you, doctor. And I got a little bit away from your specific evaluation here.
After you completed your examination of Miss Lindamood-Tamler did you have an opportunity to review medical records regarding her care and treatment?
A: Yes, I did.
Q: And could you tell us, please, what records you reviewed?
A: The records were from the Parma Community Hospital, which was essentially the emergency room visit, Dr. Matthew Fronz, Dr. Daniel Mazanec and the Cleveland Clinic records, Dr. Jennifer Kriegler and the Mount Sinai Pain Management records, some records from Therapeutic Touch Massage or Massotherapy, Dr. Chad Deal, who was the rheunlatologist that diagnosed the osteoporosis, as well as a series of x-rays from the Cleveland Clinic and the Mount Sinai Medical Center.

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Q: And, doctor, after having - by the way, did that complete your evaluation and examination of, in connection with Miss Lindamood-Tamler?
A: Yes.
Q: And, doctor, having reviewed those records and examined Miss Tamler, did you come to an opinion to a reasonable degree of medical certainty as to whether or not she suffered any injury as a result of the automobile accident of October 11, 1993?
A: I did develop a clinical impression, yes.
Q: And, doctor, could you please tell us what that impression was?
A: My impression was that she had a subjective pain syndrome without any substantial objective findings. Most of her ongoing pain subjectively seemed to be coming from the left sacroiliac joint, at least on the exam.
There was no treatable orthopedic or neurosurgical or neurological process and that she probably had mechanical pain from the osteoporosis.
Q: Doctor, you said that your opinion she had subjective symptoms as opposed to objective findings, is that correct?

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A: Yes.
Q: Could you explain, you nlay have done this already anti I apologize, but could you explain the difference between subjective symptoms anti objective findings?
A: The way I simplistically look at that, subjective is something that only the individual can ascertain, and there is no way anybody else would know that is true or not. It's a pain. If you touch someplace, it can include tenderness, it can include trigger points, it can include headaches, how the pain bothers them, whether there is weather changes that affect their pain picture.
These are all subjective complaints, whereas something that is an objective finding, it's something that someone other than the individual can determine is abnormal. It can be something on a physical finding, it can be the body habitus, it can be a finding on x-ray, those are irrefutable type of facts, and it's just separating which facts have to deal with the subjective symptoms, that's the challenge that the physicians have in prospectively managing a problem.

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That is a patient coming into the office and what do you do next to try to make the person feel better or make the person better.
Q: Doctor, you also mentioned that - strike that. Let me ask it a little different.
Did you find anything based on your examination and your review of the medical records that would support an objective finding of injury as a result of this automobile accident?
A: In my opinion, there was none. I know that some of the opinions registered and some of the doctors feel that when they do certain physical findings where they have tenderness in an area, that can constitute an objective finding, but in my opinion there was none that I found that was documented.
Q: So, doctor, at least as I understand your opinion, you are basing any opinion that she was injured on what she told you?
A: Well, I think that's what all of her doctors did. Certainly the doctors at the Clinic that saw her five months later, Dr. Kriegler who saw her 15 months later, they base their patient's symptoms on what the patient tells you.

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Q: Doctor, Dr. Kriegler has rendered an opinion already that Miss Lindamood-Tamler suffers from fibromyalgia. Could you tell us, please, what is fibromyalgia or what is your understanding of the diagnosis of fibromyalgia?

A: Fibromyalgia is a condition that is an exclusion diagnosis. In other words, after you have ruled out everything else and the patients still have pain that appears to be coming from their muscles or the lining of the muscles, it is given a diagnosis of fibromyalgia.

There are certain characteristics that can be associated with fibromyalgia. You can have objective muscle spasm, muscle tightness. They are characterized by tenderness in certain muscle groups. They can be associated with so called trigger points. That is, if you push on an area and it gives them subjective pain, that, again, is a subjective finding. It rarely, it rarely has an objective abnormality associated with it.

So it's basically muscle pain or pain stemming from the muscles or the lining of the muscles.

Q: Doctor, Dr. Kriegler has mentioned or has

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testified that she found various trigger points which she indicated supported her diagnosis of fibromyalgia.

Do you have an understanding as to what she is referring to when she talks about trigger points?

A: I know what a trigger point is. I assume that we are both using the same diagnosis.

Q: Could you tell us, please?

A: A trigger point, I guess the best way a regular person, nondoctor person understanding it is if on examination I touch a spot that reproduces the pain that an individual subjectively feels that, or it triggers the same symptom, that is called a trigger point.

It is a subjective finding. It can be associated with an objective abnormality. There can be a tight muscle bundle, and I have seen this in patients, so it can be associated, but it doesn't have to be associated with a objective finding, and it is usually not associated with an objective finding, but it is simply a point at which when you apply pressure you can elicit the same symptoms that the patient complains of.

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So it triggers the symptom.

Q: Doctor, if, in fact, Miss Lindaniood-Tamler is suffering from the complaints of ongoing pain that she has told you about, do you have an opinion to a reasonable degree of medical certainty as to what is the cause of that ongoing pain?

MR. SUCHER: Objection.

A: I have an opinion, yes.

Q: And what is that opinion, doctor?

A: My opinion is that the pain as it is described, she subjectively relates it to the automobile accident, but the diffuse nature of her pain is commonly seen in individuals that have hail spinal fixtures, spinal collapse, and the fibromyalgia symptoms, in my opinion, are probably coming froni mechanical imbalance of her spine.

MR. SUCHER: Objection. Move to strike. Not contained in the doctor's report.

Q: Is that the osteoporosis that we've talked about earlier, doctor?

MR. SUCHER: Same objection.

A: In my opinion, it is related to the

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osteoporosis, yes.

MR. SUCHER: Objection. Move to strike. Not contained in the doctor's report.

MR. WANTZ: Doctor, I have no other questions. Thank you very much.

CROSS-EXAMINATION OF ROBERT C. CORN, M.D.

BY MR. SUCHER:

Q: Good afternoon, doctor. Doctor, my name is Daniel Sucher. I don't think we've ever met before.

A: No.

Q: I see you have your file in front of you. Can I take an opportunity to look at that?

A: Sure.

MR. SUCHER: Off the record, please.

VIDEOTAPE OPERATOR: We're off the record

(Off the record.)

MR. SUCHER: Back on the record.

VIDEOTAPE OPERATOR: Stand by.

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We're on the record.
Q: Doctor, thank you for letting me have the opportunity to review your file.
Now, doctor, you refer to your examination of my client as independent, don't you?
A: Yes.
Q: Now, doctor, you knew that this matter was in litigation prior to the examination, didn't you?
A: I don't know. I knew there may have been issues. I don't know what the status of it was. I don't usually pay attention to that.
Q: Well, doctor, if you look at your report, you have that in front of you, you refer to a case number there, don't you, doctor?
A: I do, and I did when I wrote the report, but you asked me at the time of the examination and then I said I didn't know,
Q: Okay. Doctor, do you know where you got that case number from?
A: Probably from the medical records after I reviewed them.
Q: The Cuyahoga County Common Pleas Court case number would be on the medical records, doctor?
A: It frequently is on the medical records, yes.
Q: Okay. Mr. Wantz asked you to conduct this

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examination, didn't he, doctor?
A: Yes.
Q: And he asked you to conduct it on behalf of his client, State Farm Insurance Company, didn't he, doctor?
A: I am not sure who his client was.
Q: Doctor, you understand that there is two sides to a case, there is a plaintiff and there is a defendant, don't you?
A: Yes.
Q: And you understand Mr. Wantz is representing the defendant in this case, don't you, doctor?
A: Yes.
Q: And, doctor, you did receive some of the medical records and don't they have a case caption on it that has Patricia Lindamood-Tamler versus State Farm?
A: Well, I didn't really notice that. They may.
Yes, as a matter of fact, it does.
Q: Okay. So you understand that the defendant in this case is State Farm Insurance Company, don't you, doctor?
A: I do now, yes.
Q: And you rendered opinions for State Farm Insurance Company, doctor, didn't you?

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A: I rendered my opinions.
Q: For Mr. Wantz representing State Farm, is that correct?
A: Correct.
Q: Now, no one from my office asked you to perform this examination, did they, doctor?
A: No.
Q: And no one from the court asked you to perform this examination, did they, doctor?
A: That is not my understanding, no.
Q: That's correct, the judge didn't ask you to perform this, did he?
A: No. I didn't understand what you meant. No. This was clone for Mr. Wantz.
Q: Solely for Mr. Wantz, is that correct, doctor?
A: Yes.
MR. WANTZ: I will stipulate to that.
Q: Mr. Wantz is the one that has paid your fees in rendering your opinions and doing your report and your examination, isn't that correct, doctor?
A: I have no idea if we have been paid yet for it.
Q: Who would you have billed, doctor?
A: Probably Mr. Wantz.

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Q: And I assume you expect to be paid by Mr. Wantz, is that correct, doctor?
A: I don't care who the check, who signs the check.
Q: You prepared a report in this case, correct, doctor?
A: Yes.
Q: And the only person you sent that report to was Mr. Wantz, isn't that a fact, doctor?
A: The letter was sent to him, yes.
Q: You never sent it to me, did you, doctor?
A: No. He usually sends it to the opposing attorneys.
Q: Just answer my question. Did you send the report to me?
A: No. I didn't even know who you were.
Q: Did you send the report to the judge?
A: No.
Q: Did you send the report to Dr. Kriegler?
A: No.
Q: Have you ever talked to Dr. Kriegler about Miss Tamler?
A: No.
Q: Doctor, do you still feel that your examination was independent?
A: Absolutely.

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Q: Doctor, also, in fact, today's deposition is going to be shown during the defense of this case, isn't that a fact?
A: Yes.
Q: Doctor, you stated to Mr. Wantz that you are being compensated for your time today, that is correct?
A: I am sorry?
Q: You are being compensated for your time today, is that correct?
A: Today, yes, I am.
Q: And you are being compensated for your time for the report?
A: Or I will be.
Q: And the exam?
A: Right.
Q: And your review of the records, is that correct?
A: Yes.
Q: Doctor, my understanding – strike that.
Doctor, my understanding is that you are compensated anywhere from 400 to $1,200 per exam, report and review of medical records, is that correct?
MR. WANTZ: Objection. ok
A: That's approximately correct.

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Q: Doctor, do you disagree with that number?
A: Not in general, no.
Q: And you perform two of these exams a week, is that correct?
A: Well, I think I already testified that I do two nontreating exams a week. They are not necessarily defense exams.
Q: Okay. But this was a defense exam, wasn't it, doctor?
A: Yes.
Q: Your two independent or your two legal, we'll call them legal exams, nontreating exams, would that be a better term to use?
A: That's what I call them, yes.
Q: You do two nontreating exams per week, is that correct, doctor?
A: Yes.
Q: And for those exams you charge between 400 and $1,200, is that correct?
MR. WANTZ: Objection. ok.
A: Usually.
Q: Doctor, you are also being compensated for your time today for deposition, is that correct?
A: Yes.
Q: And my understanding is your normal fee for deposition time is $900.00, is that correct?
MR. WANTZ: Objection. ok
A: Yes.
Q: Doctor, how many of these depositions do you do a week?
A: I do depositions whenever I am asked to do depositions. I don't have a regular time. I can do zero or I can do three.
Q: Doctor, would it be safe to say that you do one a week, maybe two a week?
A: I would say on the average probably one a week for snre, over the 40 some weeks, probably 38 to 40 weeks a year, anti they are not obviously always for the defense. They are for whoever needs the deposition. They can be for Workman's Comp or plaintiff or defense, but I usually do them at the end of the day unless I am going to go on vacation, which is why we are here today on a Tuesday morning.
MR. SUCHER: Move to strike the answer as nonresponsive. 3 wo
Q: Doctor, the depositions that you do, they average what, with preparation time, actual testimony time about two hours?
A: I don't know. I think 1testified that somewhere in tlie past, but it can be shorter or it can be longer.
Q: But that would be a safe ballpark, doctor, approximately two hours?
A: Yes.
Q: Now, doctor, isn't it a fact that the majority of your testimony is for defendants in lawsuits?
A: I am sorry?
Q: The majority of your testimony is for defendants in lawsuits?
A: The majority? Probably at this point in my life, yes.
Q: And doctor, you have testified for Mr. Wantz in the past, haven't you?
A: Yes.
Q: And you have testified for other attorneys in Mr. Wanm' office?
A: Yes.
Q: Arid you are aware of, doctor, that their primary work is in defense of personal injury cases for insurance companies?
MR. WANTZ: Objection. ok.
A: I would say most of the cases that I review for them are defense oriented, yes.
Q: And, doctor, you are aware that their primary

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client is the State Farm Insurance Company, aren't you?
MR. WANTZ: Objection.
A: I have no idea who they do all their business with. It is not any of my business and I have never asked.
Q: Well, doctor, would it surprise you to know that their number one client is the State Farm Insurance Company?
MR. WANTZ: Objection.
A: I don't know.
Q: Would it surprise you, doctor, that they list themselves in Martindale-Hubbell - are you familiar with Martindale-Hubbell, doctor?
A: I never heard that name before.
Q: It's a listing of attorneys and they list their primary client as State Farm Insurance Company, would that surprise you, doctor?
A: I arn not surprised by anything.
MR. WANTZ: For the record, I am going to move to object and strike all of this testimony regarding who my clients are or my firm's clients are.
Q: Doctor, do you know what percent of the cases that you look at on a legal standpoint end up

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going to trial?
A: I have no idea.
Q: Doctor, would you agree with me that not all the cases go to trial?
A: I have no idea what goes to trial. I don't usually know what settles or what goes to trial or what gets thrown out. I don't have time to keep track of that.
Q: Okay. Doctor, would it surprise you if I have reviewed The Verdict Reporter for cases in Ohio since *1770* and it has you testifying in trials of actions 35 times?
MR. WANTZ: Objection.
A: Since 1990?
Q: Since 1990.
A: Would it surprise me? No, it wouldn't surprise me.
Q: Doctor, would it surprise you if that publication revealed that 31 of those occasions you testified for the defendant?
MR. WANTZ: Objection.
A: I am not surprised by that figure, no.
Q: And that would be four times that you testified for the plaintiff?
A: In that particular listing, I guess. I have no

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opinion of what that is or what counties that is, you know, I don't know what that means.
Q: Do you want to take a look at it, doctor?
A: I ani not sure I will even understand it.
Q: Okay. Doctor, it wouldn't surprise you that 13 of those 31 cases that you testified for were on behalf of State Farm Insuiance Company?
MR. WANTZ: Objection.
Q: Would that surprise you, doctor?
A: I don't really have an opinion.
Q: And would it also surprise, doctor, that you testified eight times for Mr. Wantz' law firm?
MR. WANTZ: Objection.
A: During that five year period of time?
Q: Yes.
A: That wouldn't surprise me.
Q: And three of those times for Mr. Wantz particularly, would that surprise you, doctor?
A: No. Not in five years, six years.
Q: Doctor, do you remember testifying for Mr. Wantz in the past?
A: Do I remember?
Q: Yes.
A: Sure.
Q: Do you remember any of the particular cases that

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you testified for Mr. Wantz?
A: Not off the top of my head.
Q: Do you remember a case by the name of Johnstone versus Lockgreen, doctor, where you testified for Mr. Wantz in Cuyahoga County in August of '93?
A: I don't remember that at all.
MR. WANTZ: Again, I am going to make a continuing objection.
Q: Doctor, do you remember testifying for Mr. Wantz in a case entitled Reed versus Kiss in March of 1994?
A: No.
Q: Doctor, do you remember testifying for a case Barkensizk - I am mispronouncing that - versus Horner, Case Number *246004* in Cuyahoga County in January of 1994 for Mr. Wantz, do you remember that case, doctor?
A: I have no independent recollection of it.
Q: Doctor, do you remember testifying again on 13 other times that went to trial for State Farm Insurance Company?
A: You asked me that before and I said I don't recall the number nor does it matter to me.
Q: You also testify for other defense firms in

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town, don't you, doctor?
A: Whoever, it is first come first serve. I don't have a particular law firm that I work with or like to work with more than another. It's basically luck of the draw.
Q: Would it surprise you, doctor, that a review of The Verdict Reporter indicates that you testify primarily for Meyers, Hentemann, Williams & Sennet, Keller & Curtain and Nationwide Insurance Company attorneys, would that surprise you, doctor?
A: It doesn't surprise me, no.
Q: Doctor, in fact, recently you just testified in a matter for Mr. Roman of Mr. Wantz' office in a case that just went to trial, do you remember that?
A: Not off the top of my head.
Q: Do you remember testifying videotape on May 7th, doctor?
A: Particularly on that date, I have no recollection of what I did on May 7, 1996.
Q: Okay. Doctor, you don't remember testifying in the case of Mixon versus State Farm Insurance Company?
A: I remember the Mixon case, yes, but I don't

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remember what date it was or who was the attorneys involved.
Q: Do you remember that would have been this month that you did a video deposition?
A: You have to realize, this is a very small portion of my time, and I really don't keep that kind of log or keep or have an interest in maintaining the statistics like you are reciting.
So, you know, I have no qualms and I have no opinions whether it's true or not true.
MR. SUCHER: Objection. Move to strike as nonresponsive.
Q: Now, doctor, you remember testifying in the Mixon matter, don't you?
A: I vaguely remember it, yes.
Q: So if I told you that the deposition was taken here on May 7, 1996, would you have any reason to disagree with that?
A: No,
Q: You testified for Mr. Roman in Mr. Wantz' office in that deposition?
A: That's what you tell me, yes.
Q: And his client was State Farm Insurance Company in that deposition?

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A: I have no idea.
Q: Doctor, are you familiar with Dr. Kriegler?
A: Yes.
Q: Do you have an opinion of Dr. Kriegler?
A: Specifically, yes.
Q: What is that opinion, doctor?
A: I have respect for what she does in the segment of the population that she tries to help.
Q: Doctor, would you agree with me that she is a very competent physician?
A: I don't really know her that well, but I just know her reputation and I do use her for referrals.
Q: And you sent patients to her in the past, haven't you?
A: Yes.
Q: And you are associated with Mount Sinai and so is she?
A: Well, I am very, very peripherally associated with Mount Sinai at this point in time and I know that that's her primary area. She was previously with University Hospitals and that's where most of my contacts with her were.
Q: And you are associated with University Hospital, correct?

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A: Yes.
Q: Doctor, have yon referred patients in the past to pain centers at Mount Sinai?
A: I probably have.
Q: And I'm sure -
A: Although quite frankly she has joined their staff fairly recently and I am not sure when that was. I don't know how many people I have referred to her since she has left. That has probably been probably under five.
Q: I take it, doctor, you refer people to the pain center at University Hospital?
A: Very rarely. I don't really see that many people that would qualify for that, probably less than 10 patients a year that are not treatable from a standard standpoint and they need to have some sort of pain management. So it's not a large segment since I see about a hundred patients a week.
Q: But you do send people to pain centers, doctor?
A: I do use pain centers when I feel it is appropriate, sure.
Q: And you have used University Hospital, is that correct, doctor?
A: I have.

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Q: And you have also probably used the Cleveland Clinic, is that correct, doctor?
A: I don't know if I specifically remember referring anybody to the Cleveland Clinic, but I am familiar with their program.
Q: Doctor, you have had an opportunity to review the Cleveland Clinic records, is that correct?
A: Yes.
Q: And you reviewed the report from I believe it's doctor–
A: Mazanec.
Q: Mazanec. Are you familiar with Dr. Mazanec?
A: I know of him. I don't know him personally.
Q: Doctor, would you agree with me that he ha5 a good reputation in the community?
A: I have no idea.
Q: Doctor, does the Cleveland Clinic have a good reputation in the community?
A: Sure.
Q: And, actually, you served your residency there, is that true?
A: Yes, that's true.
Q: Have you reviewed his report, doctor?
A: I did.
Q: And, doctor, what was his diagnosis and opinion

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in this case?
MR. WANTZ: Objection.
A: I don't really remember at this point in time.
Q: Doctor, would you like to take a moment and look at his report? I believe it's in front of you.
A: Sure. If you want to go off the record I'll be glad to.
VIDEOTAPE OPERATOR: Off the record.

(Off the record.)

MR. SUCHER: Back on the record.
VIDEOTAPE OPERATOR: Stand by.
We're on the record.
Q: Doctor, you have had an opportunity to review Dr. Mazanec's findings, haven't you?
A: Yes.
Q: And what was his impression in this matter?
MR. WANTZ: Objection.
A: Mechanical back pain.
Q: And what does that mean, doctor?
A: Back pain due to abnormal spinal mechanics.
Q: And, doctor, he related it to her accident of October 11, 1993, didn't he?

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MR. WANTZ: Objection.
A: He relates it by her history to the accident, correct.
Q: Doctor, would you read the, I believe it's the fourth full paragraph, "it is my impression"?
MR. WANTZ: I am going to object.
A: Which – I ani sorry?
Q: Page one.
A: Page one. You want me to read the whole paragraph?
Q: Just the first Sentence of the paragraph.
A: "It was my impression that Miss Lindamood had a myofacial pain syndronie as a consequence of her injury and I recommended a trial of Trilisate twice a day and physical therapy".
Q: And, doctor, do you agree with that opinion?
A: What opinion?
Q: Dr. Mazanec's opinion.
A: No.
Q: When did he see Miss Lindamood, doctor?
A: He saw her about
Q: Doctor, would you
Lindamood sustained some injury in her automobile accident?
A: Probably.

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Q: Doctor, now you are not a psychologist, are you?
A: No.
Q: You are not a psychiatrist?
A: No.
Q: You are not a neurologist?
A: I ani not a neurologist.
Q: You are not a neurosurgeon?
A: No. That's correct.
Q: You are not a rheumatologist?
A: No.
Q: Doctor, you, also, when I review your report you state that there were no Cleveland Clinic records of epidural blocks, spinal blocks?
A: I didn't say that. I said it **was** really difficult to establish when the exact dates were. That's what I said.
Q: Doctor, can you refer to those records for me, please?
A: Sure.
Q: Would you go to Page 41? They are marked at the bottom, doctor.
A: Okay.
Q: Did you have trouble finding this when you were looking for your report?
A: No. This was the history and physical done by

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actually one of the residents.
Q: What does the procedure note say at the bottom, doctor?
A: Well, I ani not going to read the whole paragraph. Basically they stuck a needle in her back and they gave her a shot.
Q: That is an epidural block, isn't it, doctor?
A: It sounds like an epidural block, yes.
Q: Okay. But you didn't notice that when you were preparing your report?
A: No. I just said she had a number of blocks and I just couldn't find all of them.
Q: Okay. Doctor, would you go to *43* and through *44.* Do you see on Page *43,* doctor, where there was a visit of *3/6/94?*
A: Yes.
Q: And on the second page continuing on that visit do you see trigger point injections under impressions?
A: No. It says, it's under plan.
Q: Doctor, if you look ai the bottom of Page *44.*
A: Yes. It says trigger point injection, it's under -
Q: Impression.
A: It is not under impression. It's a separate

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series of numbers. Impression, he has two impressions and then he has five things underneath that. So it's not under impression.
Q: Okay. Thank you for correcting me, doctor. So trigger point was part of the plan on that date, is that correct?
A: It was part of the plan on that date, that's the way it looks.
Q: And then we look at procediire on Page *45,* was a trigger point performed on that day, doctor?
A: It's difficult for me to say what was given her. I have a hard time reading this, whether it was an attempted epidural block or what. I am not really sure what this says.
Q: You can't read under number two, doctor, where it says patient sitting for lumbar epidural, sterile prep and drape?
A: Right.
Q: Would that indicate to you that an epidural was going to be performed?
A: It looks like that's what their intention was.
Q: And then, doctor, if we go to Page *46* at the *9/15* visit, that appears to be similar in nature, too, doesn't it, doctor, with the procedure that was performed, if you look at

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Page *47,* procedure notes?
A: Right.
Q: And if we look also, doctor, on 10/4/94, pain management, Cleveland Clinic, Page *47,* if we go on to Page *48,* procedure, it also looks like a block was performed on that date, too, doesn't it, doctor?
A: Certainly an injection, yes.
Q: Doctor, what are epidural blocks?
A: Epidural blocks are injections of chemicals into the epidural space.
Q: And why would a patient have an epidural block?
A: It is felt by some people that it tends to break the pain cycle and it's useful as part of pain management, and it's also the same location where anesthesia is given for surgery.
Q: Doctor, is it painful for a person to get an epidural block?
A: I have seen blocks that are very painful and blocks that - when my wife had her babies we had no problem with her epidural. So I think it varies on the technique and the ability of the individual physician.
Q: And it would also, doctor, take into account the individual patient, is that correct?

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A: Whether they complain of pain or not? Sure. Obviously pain is subjective. So there is no way of verifying that.
Q: Pain is always subjective, isn't it, doctor?
A: Always.
Q: Doctor, your opinions are subjective in a sense, aren't they?
A: All opinions are subjective, but it's what they are based on that is not always subjective.
Q: Now, doctor, you talked about Miss Lindamood's osteoporosis. Was that causing her any complaints prior to the accident?
A: I don't remeniber. She obviously had it diagnosed. I don't remember what her complaints were at that time, though.
Q: Doctor, would it be safe to say that it was asymptomatic prior to the accident?
A: I don't remember.
Q: Do you have anything to indicate otherwise, doctor?
A: I don't remember.
Q: The same thing with the fractures, doctor, were they asymptomatic before the accident?

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problems, were they?
A: Not that I saw in the records.
Q: And she was under no treatment for those, was she, doctor?
A: For the osteoporosis or - ,
Q: For the osteoporosis and the fractures.
A: I don't remember.
Q: Doctor, you stated earlier during direct examination that 80 percent of women with osteoporosis are pain free, is that correct?
A: Well, they are asymptomatic. They don't know they have it.
Q: Meaning that they are pain free?
A: Well, it could mean that they are pain free.
Q: What else does it mean?
A: It means they do not know they have osteoporosis. They could have pain and not know it's osteoporosis. What I am saying is that the diagnosis of osteoporosis was not correlated with their pain in those people.
Q: Doctor, was there any evidence that Miss Lindamood was suffering any pain from her osteoporosis prior to the accident from the medical records you reviewed?
A: I really don't recall. I don't remember.

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Q: Now, doctor, you saw Miss Lindamood one time, is that correct?
A: Yes.
Q: And that was over *two* years after the accident, is that also true?
A: Yes, that's also true.
Q: And you didn't see her to treat you?
A: Yes.
Q: And you didn't see her at anyone's request other than Mr. Wantz'?
A: Again, yes, that's true.
Q: And you saw her for about a half an hour for the history, is that correct, doctor?
A: I don't know how long it took.
Q: Would that be a safe estimate, doctor, that it took a half an hour?
A: I have no idea. I usually leave *45* minutes for the examination. So it could be a half hour, it could have been 15 minutes.
Q: And the exam itself would have taken 15 minutes, is that correct, doctor?
A: Probably.
Q: So some sort of combination between a half an hour to 15 minutes, ***45*** minutes total, is that correct, doctor?

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A: That's what I usually leave. Now I am not sure how much of that time or if I used more time.
Q: If Miss Lebit's notes from my office reflected a half hour history and 15 minute exam, you have no reason to disagree with that, wouid you, doctor?
A: I really don't have an opinion.
Q: Now, doctor, you haven't had the benefit of Dr. Kriegler of seeing my client everyday for a month during the pain management, did you?
A: I am sorry?
Q: You haven't -
A: You talk very quickly and I am not sure I get **all** of your words.
Q: I am sorry, doctor. You didn't have the benefit, let's say, that Dr. Kriegler had in examining Miss Lindamood, did you, doctor?
A: I **did** not examine her frequently and I was not asked to comment on how she was on each of those individual time periods.
Q: But, doctor, wouldn't you agree with me that Dr. Kriegler had the benefit of seeing Miss Lindamood on numerous occasions and, actually, she saw her for a continuous month during the pain management, wouldn't you agree with that,

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doctor?
A: I am not sure how many times she saw her during that month, but I think if that is what you are reflecting to me I have no problem with that. That would be actually very good medical care.
Q: In reviewing the medical care that she received at the pain management, doctor, do you disagree with any of that medical care?
A: I don't really have an opinion. I think that Dr. Kriegler's approach to chronic pain is better than most of the pain centers in the area. However, I have a problem, a subjective problem, that treating someone solely on the basis of their symptoms has some fraught with failure **and** inaccuracies, but I think if anybody does it, Dr. Kriegler probably does it the best.
MR. SUCHER: Objection. Move to strike as nonresponsive.
Q: Doctor, and it is also a fact that you saw Miss Lindamood after she successfully completed her pain management with Dr. Kriegler, isn't that the fact?
A: I am not sure successfully is an appropriate word, but I did see her a while after she completed her pain management.

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MR. SUCHER: I have no further questions at this time.

REDIRECT EXAMINATION OF ROBERT C. CORN, M.D.

BY MR. WANTZ:

Q: Doctor, just to follow-up. Mr. Sucher was asking you several questions about the epidural blocks. Do you dispute the fact that she had epidural blocks?

A: No. Usually most medical records have the blocks as a procedure, as a separate operative procedure. I have never seen them and I had trouble with the Cleveland Clinic's records of trying to figure out exactly what is done.

In other words, they don't have a set sheet like a procedure like other hospitals have that is easily attainable. I had no problem with the fact that she had the blocks. I just could not figure out what she had each individual time.

Q: Doctor, the other question I have, Mr. Sucher asked you about Dr. Mazanec's report and he also asked you whether you agree with the opinion and you said no.

Could you explain to us why you do not agree with Dr. Mazanec?

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A: Dr. Mazanec really didn't address anything other - he called it mechanical back pain, but he really didn't go into why he called it mechanical. He felt it was related to the injury because the patient said it was related to the injury. There was really no explanation as to why it was mechanical, in other words, why the pain would be caused by a mechanical means.

What he failed to address was why she was having mechanical pain. So I felt that his letter and evaluation was somewhat incomplete. But he is not an orthopedic surgeon, he a pain management physician similar to Dr. Kriegler. So I didn't really, he came out with a diagnosis of mechanical back pain, but he really didn't say how it was mechanical or what was mechanical, what was causing the mechanical quality.

Q: What do you mean when you say mechanical back pain?

A: When an orthopedic surgeon or spinal specialists, including neurosurgeons, talk about mechanical they mean that something was biomechanically off. In other words, there is an imbalance or there is some: sort of mechanical means or physical means of why the back is painful.

It can mean a kyphotic deformity like the plaintiff has with her body forward flexed slightly off of midline or it could be related to other spinal abnormalities.

Q: And you indicated Miss Lindamood-Tamler has a body flex forward, correct?

A: Correct. She is a little out of balance.

Q: And that's caused by the osteoporosis in your opinion, doctor?

A: Solely due to the osteoporosis.

MR. WANTZ: Thank you, doctor. I have no other questions.

MR. SUCHER: I have no further questions.

VIDEOTAPE OPERATOR: Doctor, you have the right to review this videotape or you can waive that right.

THE WITNESS: I will waive my right.

VIDEOTAPE OPERATOR: Will the attorneys from both sides waive the filing of this videotape?

MR. SUCHER: Yes.

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THE WITNESS: I waive signature.

MR. WANTZ: I assume Dan will waive any filing of the transcript prior to trial?

MR. SUCHER: Exactly. Same stipulations we had for Kriegler, Joe.

MR. WANTZ: Thanks.

(Signature waived.)

CERTIFICATE

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

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

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

Susan M. Cebron, Notary Public, State of Ohio
1750 Midland Building, Cleveland, Ohio 44115
My commission expires August 17, 1998

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Highland
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Robert C. Corn, M.D., F.A.C.S.
Timothy L. Gordon, M.D.
Orthopaedic Surgeons

March 25, 1996

Joseph H. Wantz
Attorney at Law
The Superior r Building, 21st Floor
815 Superior Avenue, NE
Cleveland, OH 44115-2701

RE: Patricia Lindamood-Tamler
Case #287952
File #1700-12862

Dear Mr. Wantz:

I evaluated Patricia Lindamood-Tamler in my office on January 26, 1996, in reference to alleged residuals of injury sustained in a motor vehicular accident which occurred on October 11, 1993. Throughout the history and physical she was accompanied by lier attorney, Linda Hardacre.

The history presented was that she was the driver and solo occupant, at approximately seven o'clock in the morning, of a 1989 Barretta heading in a southbound direction on Tidemann Road on the westside of Cleveland. She was on her way to work as a school teacher for tlie Brooklyn School District. She stated she was not stationary, but moving in traffic when she was suddenly rear-ended. At the moment of impact she was jolted forwards and backwards. Slie felt "stunned" but was able to make tlie appropriate reports and went on to work. Slie is employed as a reading specialist. She liad slow development of upper back and lower back pain, reported it to her boss who recommended that she go to the hospital.

Initially she was evaluated at the Parma Community Hospital Emergency Room on the day of injury, primarily with left paracervical neck pain arid cliest pain from a contusion. She present with a history at that time to the doctor that she was rear-ended by another car traveling perhaps 25 miles per hour. She stated that despite this impact there was "minimal damage to her car". Diagnostic studies were performed wliich were essentially normal. These were chest x-rays arid neck x-rays. Slie was essentially treated and released.

She subsequently came under tlie care of Dr. Mathew Frantz, an osteopathic physician, with pains on both sides of her neck, headaches, blurred vision, and general soreness and weakness. This initial evaluation was on October 14, 1993, as a follow-up from the emergency room. Dr. Frantz saw her on three occasions in October of 1993, one occasion at the end of November 1993, and one on February 24, 1994. Osteopathic manipulations was tried on these occasions. It was felt that, at worst, she had a strain or sprain of the neck, upper back and left sacroiliac joint. Manipulations did not help.

She subsequently tried massotherapy at the Therapeutic Touch. These were done in early 1994, having four treatments. She stated that there was not much improvement with this type of approacti. In fact, tlie massotherapy tended to make her worse.

Ultimately she was referred to the Cleveland Clinic where she was initially evaluated by Dr. Daniel Mazanec, approximately five months post-injury, on May 18, 1994. At this time her primarily complaints were low back pain and left sided posterior chest **pain.** On examination tlier-e was full lumbar spinal motion, but some decreased extension. Essentially it was a normal neurological examination. It was felt at that time she had a "myofascial pain syndrome" arid was started on a series of physical therapy treatments. The therapy was carried out through May, June, and early July of 1994.

Ultimately an MRI scan was performed of lier lumbar spine. This was done on August 16, 1994, and revealed an old compression fracture with some wedging of T9 and T10.

Therefore, the T9-T10, and T1 1 were involved probably with osteoporosis. No disc herniations were noted, but there was arthritis noted bilaterally at the L3-4 and L4-5 level, as well as L5-S1 level. There was absolutely no signs of a herniated disc or any neurological abnormality to explain her arm and leg pain.

She stated she went through a series of spinal blocks and trigger injections. The exact dates could not be recalled nor were they readily ascertainable from review of the medical records provided. She stated that she may have had five injections total, as well as a variety of medications including anti-inflammatories, as well as pain medication.

She concluded her treatment at the Cleveland Clinic in December of 1994 and then transferred her medical care to the Mt. Sinai Medical Center. She was seeing an internist, Dr. Scott Feudo, and he referred her to Dr. Jennifer Kreigler for pain management..

On January 16, 1995, she was evaluated by Dr. Jennifer Kreigler, Director of the Center for Pain Management at Mt. Sinai. This was 15 months post-injury. She presented a history of pain since the time of the accident. She was evaluated at that point in time with their fiill pain management program, including a series of exercises and examinations. No further scans were done. Slie was treated for "fibromyalgia", that is, fibrous and muscular pain without any other anatomical abnormalities. She went through a physical therapy program for a month through tlie Wellness Center on South Woodland in Beachwood, including physical therapy, occupational therapy, exercises, low back school, as well as biofeedback. She was also tried on a niunber of medications and is currently still on Prozac and Xanax when she cannot sleep at night. She continues to be imder the care of Dr. Kriegler, although according to the medical records the Pain Management Program went from February 20, 1995 to March 10 of 1995.

EMPLOYMENT HISTORY: She remains employed by the Brooklyn School District. She lias some restrictions that were given by Dr. Kreigler which include the ability to change and move her position, limit the amount of time sitting or standing, and also the number of children she would teach at one time. This was riot reviewed. It is her understanding that she has "fibromyalgia" which affects her from working.

PAST MEDICAL HISTORY was somewhat sketchy. Tlie patient would not volunteer any tremendous details. She was, however, involved in previous trauma, three prior automobile accidents in wliicli she had no long-term treatment. She also fell in 1990 breaking her ribs. Apparently she lias also been under observation and diagnosed with osteoporosis which would account for her spinal compression abnormalities, and the somewhat short stature of lier body.

CURRENT SYMPTOMS: Even with the careful questioning that I do to musculoskeletal complaining patients, I had difficulty eliciting lier pain complaints. She was extremely evasive iii trying to explain them, which I think is done on a routine basis with a fair degree of accuracy by the average individual. The bulk of her pain, to my understanding, is localized in the left low back sacroiliac joint area. Tlie other area is about the left scapula. She is under the impression that her sacroiliac joint was "dislocated" at the time of tlie injury despite the fact tliat there was no inability to walk or move about initially. In fact, she was able to go on to work initially. This pain seems to radiate into the buttock and down to tlie lower extremity. After careful questioning, it appears that she has lost some sensation in her left leg which involves "part of the leg for part of the time". Some activities tend to relieve it such as swimming, stretching over a large rubber ball, as well as working on her flexibility exercises.

In reference to her upper back and shoulder, she has pain described as diffuse aching and burning pain about the left shoulder blade, but it's not as intense. Her left upper extremities "feels weak" although no precise neurological deficits ever were established. Slie never had any EMG and Nerve Conduction Studies to further delineate this. She is right handed. Slie feels that she has pins arid needles along a

non-physiological pattern in her left upper extremity (a similar type of nondescript pattern was noted in her description of her left lower extremity). "Part of my arm is numb and part of it feels pins arid needly".

PHYSICAL EXAMINATION revealed a 51 year old female who appeared much older than her stated age. Her body habitus appeared that she was of somewhat short stature, having the chest area of lier spine somewhat disproportionally short. Retrospectively, this may have been due to the osteoporosis arid the spinal compression.

Her gait pattern was normal, although she was somewhat hesitant. She was able to heel and toe stand, showing normal neurological function although there was some "balance problem". She was able to arise from a sitting position without difficulty. Ascending arid descending the examining table was performed normally. There was, as will be noted below, a great deal of subjective symptoms without a great deal of objective findings.

Examination of her cervical spine revealed no spasm, dysmetria or muscular guarding. There was unrestricted range of motion in forward flexion being able to bend forward to put her chin on her chest. Hyperextension, side bending, arid rotation, which showed no objective limitations of predicted normal. Examination of her shoulder blades, upper back, and neck area failed to show any no spasm, dysmetria or muscular guarding, or any objective signs of injury. There was a full range of motion of her elbows, wrists, and small joints of the hand. Despite the diffuse weakness that she demonstrated to me when asking her to grip, there was no difference in circumferential measurements at the axillary, midarm, forearm, or wrist level. There was no atrophy noted to gross observation of the intrinsic muscles of her left hand nor noted on circumferential measurements of her hand. The balance of the neurologic examination was normal, although there was a very slight positive Phalen sign which may indicate subclinical mild left carpal tunnel syndrome.

Examination of her lumbar spine again revealed no spasm, dysmetria, or muscular guarding. She seemed to be very tender in the area of the left sacroiliac joint.

Forward flexion was performed in an unrestricted fashion, bending forward to the ankle level. Hyperextension, side bending, and rotation were performed without any significant limitations of normal. Her straight leg raising both in the sitting and supine positions were performed to 90° bilaterally. No atrophy was noted on circumferential measurements of left upper thigh, lower thigh, mid-calf, or ankle levels. The deep tendon reflexes were intact. There seemed to be some irritation in the left sacroiliac joint on Patrick Figure-of-4 sign. Neurologic exam was normal.

IMPRESSION: Subjective pain syndrome without substantial objective hidings. Chronic subjective pain stemming from the left sacroiliac joint. No objective ongoing treatable orthopaedic or neurological abnormalities.

DISCUSSION: I have liad the opportunity to review a number of medical records associated with her care and treatment. These include records from the Parma Community Hospital, Drs. Mathew Frantz, Daniel Mazanec and the Cleveland Clinic, Jennifer Kreigler and the Mt. Sinai Pain Management Program, Therapeutic Touch Massotherapy, Dr. Chad Deal (doctor who evaluated lier for osteoporosis), and a series of x-rays. These x-rays were reviewed from three sources, Cleveland Clinic Radiology (two envelopes), and the Mt. Sinai Medical Center.

After careful questioning of the patient's history and physical limitations, as well as after a careful physical examination and review of medical records, I have come to some conclusions concerning lier ongoing level of physical impairment.

There was never any documented significant objective orthopaedic abnormality. She has had a substantial amount of treatment for subjective pain which has been diagnosed as "fibromyalgia". This is a tenn that poorly describes an organic patliology and is a descriptive term to explain an individual's subjective symptoms. Her symptoms did not improve with any of the invasive studies including the epidural blocks. It seems that the physical therapy and "pain management" with antidepressant medication seems to have relieved a fair amount of her symptoms and has made her

much more functional. There is no indication that the epidural blocks had any benefit. There is no abnormalities noted on the MRI scan that would be related to trauma.

At the time of this evaluation, it was my conclusion that this is a woman who alleges a soft tissue strain or sprain of the upper and lower back, but never had any substantial objective findings. She has been treated by a niunber of physician sources, including Dr. Frantz, Dr. Mazanec and the Cleveland Clinic, as well as Dr. Kreigler solely on the basis of her ongoing subjective symptoms. Although I have seen individuals like this in my practice, there is clearly a functional non-physiological component to her claims of **pain.** There is no true way of verifying whether or not this pain exists. As stated above, there are no objective findings to support her ongoing complaints of pain arid there does not appear to be have been any substantial abnormalities ever noted by any of her treating physicians or health care providers.

The long-term prognosis is good. At the time of this evaluation, despite her symptoms, there are no objective findings. On the basis of this evaluation, no further orthopaedic care or treatment is necessary or appropriate for her alleged conditions. She has objectively recovered. The only symptoms noted were that of a subjective response to certain body positioning. These could not be verified or confirmed by abnormal physical fmdings. She has objectively recovered.

Sincerely,

Robert C. Corn, M.D., F.A.C.S

RCC/bn

cc: File