1 IN THE COURT OF COMMON PLEAS 1 LAKE COUNTY, OHIO 2 3 4 KATHLEEN SANTON, ) et al., 5 Plaintiffs, 6 Case No. 92 CV 000987 vs. 7 STATE FARM INSURANCE COMPANY, et al., 8 Defendants. 9 10 11 Deposition of ROBERT C. CORN, M.D., 12 taken as if under discovery examination before 13 Catherine Radie, a Notary Public within and for 14 the State of Ohio, and by videotape, at the offices of 15 Robert C. Corn, M.D., 850 Brainard Road, Highland 16 Heights, Ohio 44143, at 5:50 P.M., Monday, the 25th 17 18 day of October, 1993, pursuant to notice and stipulations of counsel, on behalf of Defendant 19 20 State Farm Insurance Company, to be read into evidence at the trial of the above-entitled cause. 21 22 23 KATHRYN KINNEY FOXX COURT REPORTERS 8547 HILLTOP DRIVE 24 MENTOR, OHIO 44060 (216) 257-5511 25

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prov.	APPEARANCES:
2	Nuranharg Dlavin Hallar 6
3	Nurenberg, Plevin, Heller & McCarthy Co., L.P.A., by Mr. David M. Paris,
4	On behalf of the Plaintiffs;
5	
6	Svete & McGee Co., L.P.A., by Mr. James P. Carrabine,
7	On behalf of Defendant
8	State Farm Insurance Company;
9	Davis & Young Co., L.P.A., by
10	Mr. David J. Fagnilli,
11	On behalf of Defendant Cincinnati Insurance Company.
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15	STIPULATIONS
16	
17	It was stipulated by and between counsel for
18	Plaintiffs and Defendants, that this deposition may
19	be taken in stenotypy by Catherine Radie; that said
20	stenotype notes may be subsequently transcribed into
2]	typewriting in the absence of the witness, and that
22	the reading and signing of the deposition by the
23	witness are waived.
24	
25	900 974 AAA 4000

## **OBJECTIONS INDEX**

**OBJECTIONS:** 

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By Mr, Paris:		
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]	MR. CARRABINE: Let the record
2	reflect that this is the videotape
3	deposition of Dr. Robert Corn, which
4	is being taken by the Defendant, and
5	for the purpose of playing it in
6	lieu of live testimony at trial.
7	
8	ROBERT CORN, M.D., of lawful
9	age, called by Defendant State Farm
10	Insurance Company for the purpose
11	of discovery examination, as provided
12	by the Ohio Rules of Civil Procedure,
13	being by me first duly sworn, as
14	hereinafter certified, deposed and
15	said as follows:
16	
17	DIRECT EXAMINATION OF ROBERT CORN, M.D.
18	BY MR. CARRABINE:
19	Q. Dr. Corn, would you be kind enough to tell the
20	ladies and gentlemen of the jury your full name
21	and address, please?
22	A. My name is Robert Curtis Corn, C-o-r-n. My
23	office address is 850 Brainard Road in Highland
24	Heights, Ohio.
25	Q. Are you a medical doctor?

7 Α. Yes, I am. 2 Q . How long have you been licensed to practice medicine in the State of Ohio, Doctor? 3 Since 1976. 4 Α. Do you specialize in any particular field? 5 0. I'm an orthopedic surgeon. 6 Α. 7 Could you tell the ladies and gentlemen of the 0. jury what it means to be an orthopedic surgeon? 8 Orthopedic surgery is that branch of medicine 9 Α. 10 which involves the medical and surgical treatment of diseases, disorders and injuries 11 12 of the musculoskeletal system. That includes the bones, muscles, tendons, joints and 13 14 ligaments, and also has a number of areas 15 ofsubspecialty -- surgery of the spine, surgery for total joint replacements, sports medicine 16 surgery, arthroscopic surgery, and surgery of 17 the hand. 18 Are you Board certified in your occupation, 19 Q. Doctor? 20 Yes, I am. 21 Α. 22 And what does it mean to be Board certified? Q. Board certification is a designation given by 23 Α. 24 the American Board of Orthopedic Surgery. The Board is a committee that is set up by each of 25

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1 the medical and surgical subspecialties for 2 standards of care, standards and gualification of training, as well as certain examinations. 3 4 And after fulfilling the obligations that were 5 deemed necessary by the Board, the Board certifies you. Α Doctor, could you briefly tell the jury what 7 Q. your education and training has been since 8 9 -- beginning with college, please? I received my Bachelor of Science in Biology 10 Α. 11 from the Albright College in Reading, 12Pennsylvania in 1971. I then moved to Philadelphia, Pennsylvania, 13 where I attended the Hahnemann University 14 School of Medicine from 1971 through 1975. 15 Τ graduated with my M.D. Degree from that 16 17 institution in June of 1975. I then moved out here to Cleveland, where 18 from 1975 through 1979, T completed the 19 20 orthopedic residency program at the Cleveland Clinic, and from August of 1979 to the present, 21 22 T've been in the private practice of orthopedic 23 surgery. Doctor, do you have staff privileges at any of 24 Q . the hospitals in this area? 25

		6
- Contraction of the second	λ.	Yes.
2	Q.	Which hospitals are those?
3	Α.	I'm an attending orthopedic surgeon at the
4		Meridia Huron Hospital, Meridia Euclid
5		Hospital, Meridia Hillcrest Hospital, Lake
Α		County Hospital System, Mt. Sinai Medical
7		Center, and Community Hospital of Bedford.
8	Q.	Are you a member of any medical associations,
9		and if so, tell the jury some of those
10		associations?
	Α.	Yes, I am. I am a Fellow in the American
12		Academy of Orthopedic Surgeons, a Fellow in the
13		American College of Surgeons, a member of the
14		American Medical Association, Ohio State
15		Medical Association, Cleveland Academy of
16		Medicine, Orthopedic Research Society, and a
17		number of other organizations.
18	Q.	Do you do any teaching, Dr. Corn?
19	Α.	Yes.
20	Q.	Where do you teach at and what do you teach?
21	Α.	I'm a clinical instructor in orthopedic surgery
22		at the Case Western University School of
23		Medicine, and I'm also an assistant professor
24		of orthopedic surgery at the Ohio College of
25		Podiatric Medicine, the podiatrist school here

7 in Cleveland. 1 2 Doctor, as part of your practice, I know you Q . mentioned that you do orthopedic surgery, do 3 you treat people who don't require surgery? 4 Α. Yes, I do. Do you treat people who have injuries to their 6 Q. 7 neck on a regular basis? Yes. 8 Α. 9 Q. Do you treat people who have neck problems, even without injuries, on a regular basis? 1011 Sure. Α. 12 Q. Do you treat people who have arthritis in their neck? 73 14 Α. Yes. And are those patients that you see on a 15 Q. 16 regular basis in your practice? I see the broad spectrum very usually every 17 Α. week. 18 19 Q. You've examined Kathleen Santon at my request; 20 do you recall doing that? 21 Yes. Α. 22 And as a practicing orthopedic doctor, do you Q. 23 frequently examine people who have the same or similar symptoms and complaints that she has? 24 Yes, I do. 25 Α.

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1	Q.	When did you examine Kathleen Santon, Doctor?
2	Α.	On January the 9th, 1992.
3	Q.	I see that you have a file there in front of
4		you. Feel free to look at that if you need to,
5		as I'm asking you questions.
6		Before you examined Kathleen Santon, did you
7		take a history from her?
8	Α.	Yes, I did.
9	Q.	What is it to take a history from a patient,
10		what does that mean?
11	Α.	Well, the history is essentially the history of
12		the present illness; that is, the complaints
13		what is the complaint and how did the complaint
14		start, what's happened since the complaint
15		began, what treatments had the patient had, any
16		hospitalizations, surgery, testing, scans,
17		leading up to the present time.
18		So it's a chronological recounting of all
19		the medical care that was rendered from the
20		time the symptom or problem started to the
21		present time.
22	Q.	So you actually sat down with Kathleen Santon
23		and got all this information from her as to
24		what had happened to her from the time of the
25		accident up to the present time; is that

		9
1		correct?
2	Α.	Right.
3	Q.	And you also did a hands-on physical
4		examination of her; is that correct?
5	Α.	That's correct.
6	Q.	And did you look at all of her records from her
7		doctors and the hospitals that she had been in?
8	Α.	After the examination, and when they arrived,
9		yes, T did.
10	Q.	And in addition to taking her history,
11		examining her, and looking at her records, did
12		you also look at her films, her MRI film, her
13		X-rays and so forth?
14	Α.	Yes, I did.
15	Q .	Without giving us the whole history from 1985
16		through the present, since the jury has already
17		heard that several times, can you tell us
18		basically what the history was that Kathleen
19		Santon gave you when she came in, mainly what
20		her present complaints were at that time, when
21		she saw you?
22	Α.	The complaints at the time of this evaluation
23		were really solely residuals from her neck
24		her alleged neck injury. She was on no
25		medications for her neck.

1 She was taking a medication, which I am sure 2 was discussed, which is Prednisone, which is a 3 very strong steroid anti-inflammatory medication that she was taking for her asthma, Δ and that seemed to help her neck and her arm 5 6 symptoms. 7 Ω. Did she tell you that? Α. 8 Yes. 9 She had an aching pain in the neck, which 10 she stated was there most of the time over the 11 course of the day. She had an occasional pain 12 radiating to the left arm to the top of the 13 wrist, the top part of the wrist area. This 14 seemed to be related to posture and position of 15 her head and neck. 16 Occasionally, she used heat to the neck and 17 back of her shoulder, which gave her what she considered a, quote, "soothing," end of quote, 18 19 relief. She had not used heat, however, for over the past year. She occasionally took 20 21 aspirin or Tylenol for her pain. 22 And those were essentially all the residual 23 symptoms that she had concerning her neck. 24 Ω. Doctor, did she tell you whether or not she had had any neck problems before this accident in 25

1985?

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2	Α.	She stated that she, quote, "may have injured,"
3		end of quote, her neck years ago. She had no
4		she was seen for her neck in 1982. I don't
5		recall what she said about that. I think
6		that was established also in the medical
7		records. She was never really X-rayed prior to
8		this accident.
9		And basically, that was her history. She
10		had some neck complaints. I think her treating
11		doctor, I think Dr. Wellman from MEDNET, saw
12		her and felt that this was either a strain or
13		arthritis, but never really pursued that to any
14		extent. But there was obvious signs on X-ray
15		that she had a chronic problem with her neck at
16		the time of this injury.
17	Q.	When you say "a chronic problem at the time of
18		this injury," do you mean a problem that
19		preceded the accident?
20	Α.	Well, by her X-rays, since her X-rays were not
21		normal, by definition, it had to have been
22		there before. And this was this degenerative
23		disk disease that I'm sure was discussed
24		before, and I'll be glad to discuss.
25	Q.	We're going to discuss it at length later on.

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use -- not anabolic steroids, like a 1 2 weight-lifter would use, these are catabolic steroids such as Prednisone that she was taking 3 4 for her asthma. 5 She also appeared somewhat older than her stated age, when I saw her. 6 Not to dwell on the respiratory aspect, but 7 she did have labored breathing -- not shortness 8 9 of breath, but labored breathing, short sentences, short breaths, just a few words in a 10 11 sentence, and that was basically how she 12 answered throughout the interview. From an orthopedic standpoint, she was able 13 14 to stand without difficulty. She walked without a limp, she was able to heel and toe 15walk without difficulty, she was able to arise 16 from a sitting position and climb up and down 17 the examining table. All those composite 18 motions that are using multiple body parts were 19 done completely normally, to my satisfaction. 20 Specific examination of the cervical spine, 21 the neck region, showed that there was no spasm 22 or abnormal or reflex muscle contraction. 23 There was no muscle guarding or tightening of 24 the muscles to movement, and there was no 25

dysmetria, which is uncoordinated motion. 1 2 Q. Excuse me, Doctor, pardon me for interrupting, but what is the significance of your finding 3 that there was no spasm? 4 Α. Spasm usually indicates an acute inflammation 5 or an acute flare-up of inflammation. 6 Spasm 7 has a very particular diagnosis, at least in an orthopedic standpoint. I think doctors in 8 9 general use spasm for anything from a charley horse to a muscle tightness, but spasm a O is a reflex muscle contraction, like a very 11 12 severe charley horse, that you can't break. It's an extremely painful condition and 13 never lasts a long time. And obviously, it was 14 not present at this time of this evaluation. 15 Go ahead, Doctor, I apologize. 16 0. Continuing with the examination, there was a a 7 Α. very minimal restriction of motion in her 18 ability to bend her head forward, putting her I9 chin on her chest, looking all the way up to 20 the ceiling, looking to the right, looking to 21 22 the left, and tilting right and tilting left. And this restriction was less than ten percent 23 restriction of motion, which is really pretty 24 normal for someone almost 60 years old and 25

considering her chronic degenerative condition in her neck.

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Q. Doctor, would you consider her range of motion to be good or bad?

A. I would consider it to be just shy of normal, even for a 58 year old, now 59 year old.

Her shoulder blade motion, that is, the shoulder blade -- she was asked to roll her shoulders forward, roll them backwards, shrug them up against resistance, and this was perfectly normal. There was no atrophy or muscle wasting noted in the shoulder musculature. There was a full range of motion of both shoulders, being able to move the shoulders forward in a frontal plane, in a side plane, rotate out, rotate in, and touch all the way above her bra line in the back.

The elbows, wrists and small joints of the 18 19 hand examined perfectly normally. I measured her arms with a tape measure at the armpit 20 level, at the mid-arm level, the forearm level, 21 at the wrist level, and they were equal and 22 symmetrical, indicating essentially normal 23 function, or certainly no -- not favoring one 24 side over the other side. 25

A neurological examination, including her 1 2 ability to detect sensation, motor examination against my resistance, as well as reflexes, 3 were entirely within normal limits for the 4 neck, upper back, as well as the upper 5 6 extremity. 7 Essentially, she had a normal physical examination, with the exception of a very 8 9 minimal restriction of motion, which is really the only quasi or partially objective sign that 10 11 was anything other than normal at the time of 12 this evaluation, which was a number of years after the accident. 13 Would that finding of slight restriction, of 14 Q. ten percent restriction, would that be 15consistent with a person who has arthritis as 16 17 she has on X-ray? Absolutely. Actually, it's better motion than 1.8 Α. I thought she would have had after looking at 19 20 the X-rays, which I did subsequent to her evaluation. 21 22 Do you attribute that ten percent restriction Q. 23 of motion to her arthritis, or to her motor

25 A. In that there was no muscle guarding, in other

vehicle accident, Doctor?

24

1		words, the muscle didn't contract, she just
2		stopped moving, she wouldn't go on beyond that
3		point, I would have to say, within reasonable
4		degrees of medical certainty, that it was
5		solely due to her progressive degenerative
6		deterioration at the mid-level of the neck.
7	Q .	When you say "degenerative deterioration," is
8		that the arthritis that you're speaking of?
9	Α	It's the disk disease and the concomitant
10		arthritis, which is essentially wear and tear
11		changes in the middle of the neck.
12	Q	Doctor, in your opinion, based on a reasonable
13	1	degree of medical certainty, is that
14		degenerative disk disease something that was
15		caused by the accident, or was it something she
16		had beforehand?
17	Α.	By definition, it was something that she had
18		beforehand, since it was present at the time of
19		her initial X-rays.
20	Q.	How long does something like that generally
21		take to form?
22	Α.	Nobody knows for sure exact dates, because it
23		obviously depends on the age that it's first
24		diagnosed, the type of occupation the people
25		have, and any other concomitant problems, but

		3 8
, and the second se		most people say anywhere from two to five years
2		for the condition to be diagnosable by X-ray.
3		So I would say somewhere within that time
4		frame, so 1980 to 1983, possibly even earlier,
5		but at least two to five years before.
6	Q.	You've reviewed the records of the Urgent Care
7		where she went in three or four or five days
8		after the accident, haven't you, Doctor?
9	Α.	Right.
10	Q.	Do you recall what her range of motion was
11		then, at that time?
12	Α.	Not offhand. But I don't think it was
13		dramatically reduced at that time.
14	Q.	Let me show you that these are part of the
15		MEDNET records, if I can show you that record,
16		Doctor. Does that indicate what her range of
17		motion was shortly after the accident?
18	Α.	It says good range of motion.
19	Q.	Is that consistent with your examination?
20	А.	Well, I would probably use a better word than
21		"good," but I would say good would be if
22		you're using good, fair, and poor, good would
23		be the best designation, and I would say that
24		would be compatible to what she had at this
25		time.

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1	Q.	Do you recall what her range of motion was when
2		Dr. Itani saw her, according to his records?
3	Α.	I believe he said it was pretty normal,
4		certainly not significantly restricted.
5	Q.	Dr. Nemunaitis testified in this case that her
6		range of motion was 50 percent of normal.
7		Have you seen anything in her records or did
8		you find anything on your examination that
9		would be consistent with Dr. Nemunaitis's
10		testimony?
11	Α.	No. I think in the review of the records, I
12		think he was the only one that found that there
13		was any abnormality in her range of motion.
14	Q.	Do you know Dr. Nemunaitis?
15	Α.	Sure.
16	Q.	Is he an orthopedic specialist, such as
17		yourself?
18	Α.	No, he's not.
19	Q.	Has Dr. Nemunaitis ever referred any patients
20		to you?
21	Α.	Yes.
22	Q.	Does he do so on a regular basis?
23	Α.	Well, he's part of an HMO, so it's not on that
24		regular a basis, because I am not a member of
25		that HMO.

But T did a total knee replacement on a 1 2 patient of his, actually just went home today from the hospital, so he does refer patients to 3 4 me for surgical treatment. Q. Doctor, I'd like to ask you some opinions that 5 you may or may not hold, and in the event that 6 7 I forget, I'd like you to express all your opinions to a reasonable degree of medical 8 9 certainty, if you would. 10 First of all, after you've had the opportunity to take her history from her, to 11 12 examine her records and her films and to do a hands-on physical examination of her, do you 13 have an opinion based on a reasonable degree of 14 medical certainty as to whether or not Kathleen 15Santon is permanently disabled as a result of 16 this automobile accident, with respect to her 17 neck injury? 18 Yes, I have an opinion. 19 Α. What is your opinion, Doctor? 20Ο. My opinion, based on my examination, she is not 21 Α. 22 permanently physically impaired enough to be 23 considered disabled, in my mind, as an orthopedic surgeon, due to the neck trauma 24 allegedly sustained in 1985. 25

1Q.Why do you say that she was not impaired,2Doctor?

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A. Well, T think the AMA has come up with guidelines for physical impairment, and the numbers of impairment -- the percentage of impairment for a region and for the whole person are based on a number of things, but it's primarily based on decreases in range of motion or motion abnormalities or -- obviously, not in the neck, but in other areas, amputations or losses or ankylosis or stiffness type of problems.

> But on the basis of the AMA guidelines, she has very minimal, if any, physical impairment that's measurable. And with a very low physical impairment that's measurable, I would have a hard time calling that a disabling condition.

Q. Tell us some of the things that you found in your examination that you feel indicate that she is not disabled with respect to her neck injury?

A. The fact that there was really no signs of
active inflammation, that there was an
excellent -- certainly minimally restricted

1 range of motion, she had good function of both 2 of her shoulders, she had excellent use of both of her extremities, and there was no atrophy, 3 4 there was no wasting of the muscles. She had a normal neurological examination. 5 I really was unable to find anything that 6 7 was dramatically or even significantly abnormal in the examination, and therefore, it would be 8 9 difficult to give her any degree of physical impairment. 10 Dr. Corn, Dr. Nemunaitis has testified that, in 11 Q. 12 his opinion, this woman has an injury to her 13 disks -- actually, an injury to several of her cervical disks, and a nerve injury. 14 15 Do you agree with that opinion? And again, base your opinion on a reasonable degree of 16 medical certainty, Doctor. 17 There was clearly no evidence, other than the 18 Α. EMG study, which was slightly abnormal, that 19 was done back in the early -- or early after 20 21 the accident, that there was any neurological 22 abnormalities. This was never repeated. 23 A neurosurgeon went over her, Dr. Itani, and found some questionable, very mild weakness, 24 which doesn't even correlate to the same 25

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		neurological level as the slight abnormality.
2	Q.	By the way, did you find that same questionable
3		left arm weakness?
4	Α.	No. Dr. Itani saw her in '85, and she was much
5		she was normal by the time I saw her. So
6		there must have been some improvement in that
7		mild very mild weakness which he described,
8		which I think is probably insignificant.
9	Q.	By the way, do you know the physician who
10		conducted the EMG?
11	Α.	Yes, Dr. Seo.
12	Q.	When you need a patient when you have a
13		patient who needs an EMG, do you ever refer
14		them to Dr. Seo for an EMG?
15	Α.	Never.
16	Q.	Is Dr. Seo a neurologist?
17	Α.	No. He's the same specialty actually, he's
18		a partner of Dr. Nemunaitis. He's a physical
19		medicine and rehabilitation specialist. Very
20		good at what he does, but that's where his
21		training is and that's where his expertise is.
22	Q.	What type of doctor do you have perform EMG's
23		on your patients?
24	Α.	Without question, I would have a neurologist
25		perform an EMG, a nerve conduction study, on a

patient of mine.

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2 Q. Do people with arthritis sometimes have some symptoms that would be consistent with the EMG 3 study that was done? 4 Not on the basis of arthritis. Arthritis Α. 5 doesn't cause nerve conduction problems. 6 7 If the arthritis was pinching on a nerve or a spur was resting on a nerve, then 8 9 theoretically, it could. But, you know, I'm 10 not really convinced that that was a significant neurological finding, at least it 11 12 was never repeated, and it was really done by -- not a Board certified specialist, who is 13 qualified to do that. 14 15In Ohio, anybody can do anything, as long as you don't hurt anybody, in the form of 16 treatment and diagnostic testing. That would 17 not have been my choice to pin a diagnosis that 18 sat on -- that's been sitting with this lady 19 20 for nine years now, eight years. You have reviewed her MRI film of the neck, 21 Q. 22 Doctor? 23 Α. Yes. And you have reviewed her CAT scan film that 24 Q. was taken in 1988? 25

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Ι	Α.	Yes. There were a number of them that weren't
2		available, but the one that was available, yes.
3	Q .	Is there any indication on those films, that
4		you reviewed personally, that this woman has a
5		herniated disk or an injury to her disk?
6	Α.	There is nothing on the scan that would show an
7		injury to the disk or a herniated disk.
8	Q.	Is there any indication on those scans that
9		there is an injury to her nerve, to any of her
10		nerves?
11	Α.	First of all, that wouldn't be how you tell,
12		but no, there is no indication that there would
13		be any impending neurological problem, based on
14		the scan.
15	Q.	Now, I've asked you what you saw personally,
16		with your own eyes, and now I will ask you if
17		you have reviewed the MRI report and the CAT
18		scan report that was authored by the
19		radiologist who reviewed those films; have you
20		reviewed those documents?
21	Α.	Yes, T have.
22	Q.	And those documents are authored by a Board
23		certified radiologist?
24	Α.	Yes, they are all Board certified radiologists,
25		and one of them was a neuroradiologist.

2 A Do you know them? 1 Q . Yes, I do know them, personally. 2 Α. And you know those radiologists to be competent 3 0. 4 in their field? I think they are. I trust them with my 5 Α. patients, so I do. I think they are very good. 6 7 Do any of the radiologists who authored any of Q. the CAT scans, the CAT scan reports or the MRI 8 report indicate that there is a disk injury or 9 a nerve injury on those reports? 10 There was not in their concluding remarks on 11 Α. 12 any of the -- by any of the Board certified radiologists, on review of their films. 13 Doctor, I would like you to assume that the 14 Q. 15history that Kathleen Santon gave you, with regards to her neck symptoms, is true. 16 Based on that and based on your examination 17 of her, what would your diagnosis of her be, to 18 a reasonable degree of medical certainty? 19 At the time of my evaluation, I would say that 20 Α. my clinical impression was, clinically, that 21 she had, by history, a resolved soft tissue 22 injury to her neck. 23 The bulk of the very minimal remaining 24 symptoms and remaining physical findings were 25

due to degenerative disk disease at multiple levels.

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3		And of course, her most disabling condition,
4		the asthma, I wasn't going to address
5		specifically, but I think that's her biggest
6		problem from a medical standpoint.
7	Q.	When you say degenerative disk disease, is that
8		getting back, is that the arthritis you
9		talked about earlier?
10	Α.	Well, there's two aspects of it, one is the
11		arthritis and one is the disk disease. Disk
12		disease and arthritis are different. You can
13		have one, or either, or both. And in this
14		case, Mrs. Santon has both.
15	Q.	Do you have any special interest in your
16		practice, Doctor, in treating people with
17		arthritis and with disk disease?
18	А.	Yes, I do.
19	Q.	And do you treat patients who have the same or
20		similar symptoms as Mrs. Santon, who have disk
21		disease, who have not been injured in an
22		automobile accident?
23	Α.	Sure.
24	Q.	Has there been any aggravation of her pre-
25		existing degenerative disk disease by this

accident?

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2	Α.	Well, there certainly was no evidence at the
3		time that I saw her. Certainly, it was quite a
4		number of years after the accident.
5		She may have had a transient aggravation,
6		which may have been the source of her symptoms
7		that persisted initially for the first six or
8		eight weeks afterwards. That would be the
9		normal time frame that these, quote, unquote,
10		aggravations usually persist.
11		But by the time I saw her, there was really
12		nothing that showed acute inflammation or
13		anything that could be directly attributed to a
14		direct, quote, unquote, aggravation.
15		There certainly wasn't any acceleration
16		faster than what would normally be expected for
17		this condition and this age group, considering
18		her steroid use and the activity level and the
19		asthma problems that she's had.
20	Q.	Would you expect there to be a change in her
21		condition, by X-ray, over a period of eight
22		years from 1985 to 1993, even if she had not
23		been in an accident?
24	Α.	Oh, absolutely.
25		The only X-rays we really do have for direct

**a** 8

1		comparison are her plane films. These give a
2		two-dimensional view of a three-dimensional
3		object. The three CT scans she had are, in my
4		opinion, somewhat useless from a diagnostic
5		standpoint. And the only other study she had
6		was the MR scan, which clearly, definitively,
7		shows the extent of the degenerative disk
8		disease, the levels of the degenerative disk
9		disease, and the fact there is no neurological
10		impingement or pushing, and that this is
11		basically a degenerative condition with minimal
12		bulging or minimal abnormality pushing toward
13		the spinal cord.
14	Q.	Doctor, do you expect what is the natural
15		progression of arthritis and degenerative disk
16		disease with age, what do you expect to see?
17	Α.	It always gets worse. Some people get worse
18		faster, some people get worse slower, but it
19		never stays the same and it never gets better.
20		The symptoms can get better, but the
21		condition always gets worse. It's a wearing
22		out, degenerative process that we haven't
23		really found out a way of stopping or halting
24	1 -	to any extent.
25	Q -	Doctor, are you familiar with what she did for

		30
]		a living, did you talk to her about that?
2	Α.	Yes. She was a bookkeeper.
3	Q.	Is there anything in her medical records or in
4		your examination of her that would indicate
5		that, based on her neck injury, that she's
6		unable to work at her job as a bookkeeper?
7	Α.	Based on my evaluation, T do not see why she
8		couldn't work. It was pretty obvious, and
9		pretty obvious to her, that her main reason she
10		wasn't working was and the reason she was on
11		her disability was because of her pulmonary
12		problem.
]3		MR. PARIS: Objection.
14		Move to strike.
15	Q.	Doctor, you had previously stated that you
16		thought she may have had a resolved cervical
17		strain from this accident
18	Α.	By her history, right.
19	Q.	by her history that she gave you, assuming
20		her history to be true.
21		You've treated many patients with that type
22		of injury before?
23	Α.	Yes.
24	Q.	Is that the type of injury that disables a
25		person from working at a bookkeeper job?

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1	Α.	Not on a permanent basis, for sure.
2		You know, it's always a degree of severity.
3		I mean, if you have a severe neck problem, it
4		may be difficult working over a desk. I have a
5		number of bookkeepers that have to use an easel
6		type of vertical type of desk, but that's
7		mainly people that have arthritis.
8		Usually, soft tissue components virtually
9		always improve over a short period of time,
10		certainly by three months. What people can
11		suffer from is from arthritic symptoms and from
12		decreased range of motion, soft tissue
13		inflammation, which clearly, there was no
14		objective evidence on at the time of my
15		evaluation.
16	Q.	Doctor, do you have patients with much more
17		severe injuries than Kathleen Santon, who work
18		full time?
19	Α.	Absolutely.
20	Q.	Can you tell us without giving us their
21		names, obviously, can you describe some of the
22		injuries that you treated people for who have
23		gone back to work full time?
24	Α.	Well, there are even a number of attorneys,
25		that I'm sure you know and the people in the

court know, who are basically quadriplegics or paraplegics, that have absolutely no hand -- or minimal hand motion and absolutely no leg motion, but drive and work. And they have to use motorized wheelchairs, but they're basically capable of earning a living in a sedentary type of job.

I have, probably, 40, 50, patients that I'm 8 just sort of scanning in my brain their faces 9 -- I don't think I can remember all their names 10 -- that have had basically devastating 11 12 injuries, that are quadriplegic or have some degree of spinal cord injury, who are able to 13 go and -- actually, one person does a pretty 14 15 repetitive manual factory type work.

16 So there are clearly people that have more 17 significant objective abnormalities and 18 injuries to their neck and spine that are able 19 to maintain gainful employment.

20 Q. Doctor, I wonder, do you have the MRI film21 there of her neck?

22 A. Yes.

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Q. Would you be kind enough to put that up on the
box there and we can maybe look at it and show
the jury some things?

33 1 Α. Sure. Dr. Nemunaitis has testified that this woman  $\mathbf{2}$ Q. has a disk injury and a nerve injury, and I'd 3 4 like to put the film up and see if we can see 5 whether or not there is any disk injury on that film, Doctor. 6 First of all, I'm not sure how, on the basis of 7 Α. a scan, you would be able to tell an injury 8 9 other than with bleeding in the area, and there is absolutely no sign of bleeding. 10 I'm not sure the jury has seen any of this 11 12 yet, but, basically, I'll show you two groups of MR scans. 13 14 Did we define MR scans? Why don't you tell the jury what an MRI scan 15Q. is? 16 There are a number of different imaging 17 Α. techniques available to physicians as 18 diagnostic studies. We're all pretty familiar 19 20 with an X-ray. An X-ray is basically a photograph that, instead of light, a burst of 21 radiation is actually shot through a patient 22 23 and it registers on a photographic film. That's where we get regular X-rays from. 24The CT scan, the computer tomography, is the 25

same type of study. In other words, it's done with X-rays with radiation, but it's -- the images are computer-generated.

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Well, the MR scan is the next step above 4 that, in which we don't use any radiation 5 whatsoever. What happens is the patients are 6 placed into a very large electromagnetic field 7 which pulsates, and that pulsation resonates or 8 causes the electrons in every single atom to 9 oscillate, to move slightly, and they're the 10 sensoring device that can pick up this 11 12 oscillation. And an image is created, and this image is a magnetic resonance imaging or MRI 13 picture. 14

Basically, by computer, you can tune out the fat, you can tune out the muscles, you can tune out everything to look at specific soft tissues. And that's the premiere imaging technique of the spine that we have available today.

This is a series of pictures. An MRT scan, if you can imagine somebody standing with their head sort of facing -- well, let's face the camera, it may be easier. The first view, what we're looking at, is what we call sagittal
pictures. If you can imagine somebody taking a meat slicer, putting one of those slicing machines in the deli, starting at one ear and working toward the other ear. And that's the first series we're going to look.

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The second one, we're putting the head first into the machine and we're making slices in this direction. These are called the transverse pictures. And I'll try to show the same structure.

11 What we're looking at is the vertebral 12 bodies, which are anterior or the front of the spine. We'll use this middle one, if you can 13 14 zoom in on the second row, middle picture. You may even be able to see the numbers, but 15basically, this is -- the first cervical 16 vertebrae is a ring, the second, third, fourth, 17 fifth, sixth, and seventh, and then the first 18 thoracic vertebrae. 19

If you look at the normal configuration, it's sort of like a square. The fourth vertebrae probably looks the most normal. But you can see, you get down here between the fourth and the fifth, and the fifth and the sixth, there is a big abnormality. And you

see the disk is no longer -- the disk is the 1 area between these bones -- is no longer 2 3 clearly delineated. There is a big spur 4 sticking out anteriorly, right where these numbers are. That's where the esophagus is, 5 that's where the swallowing tube is that goes 6 from the throat to the stomach. And this is on 7 one study, this is the T-l study. 8 What's a spur, Doctor? 9 Q. 10 A spur is the degenerative arthritis, it's part Α. of the degenerative condition. 11 12 And you can clearly see that there is no disk material that pushes out and impinges or 13 pinching on the spinal cord, so there is no 14 evidence of a herniated disk. Although, this 15is not the better study for the disks. 16 Doctor, are you going to get to the other study 17 Q. there? 18 Yes. We'll look at the other one, and you can 19 Α. actually see that -- the actual disks 20 themselves and their water content. 21 Before you go through that --22 Q. Basically, I'm just going to concentrate on 23 Α. the --24 25 Go ahead. Q.

1 Α. -- on the area, we're talking about C4-5 and C5-6.

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And this, you can clearly see the disks are white, water content is white. The stuff with a higher water content is the whitest. The spinal cord, which is this gray stuff in the middle, is not as white as the cerebrospinal fluid that's around it. The air in the trachea over here and the breathing tube is denser than the esophagus, which is the swallowing tube. And you can see the disks -- clearly, if there was a herniated disk, this white stuff

would be pushing out backwards. This is collapsed, essentially very severe degenerative disk at the C5-6 level. So that's the sagittal section.

17 We'll just look at one series on the cross section. It's labeled a tiny bit differently, 18 but in this area, this is mainly for the fluid 19 20 content one. The gray area is the spinal cord, and you can walk right -- this is the 5-6 21 22 level, and clearly, there is some white stuff in the front of it, clearly indicating there 23 is no impingement of the spinal cord. And you 24 can see sort of like a doughnut structure, like 25

a white ring around the spinal cord, all the 1 way along, so clearly, there is absolutely no 2 MRI evidence of any herniated disk or any nerve 3 4 root or spinal cord impingement. And 5 certainly, no injury observable on the basis of the MR scan. 6 7 This is nothing more than degenerative arthritis and degenerative disk disease, which 8 is most severe at the C5-6 level. 9 10 Dr. Corn, Dr. Nemunaitis has told us in his Q. deposition -- and I'm going to quote from Page 11 34 of his deposition transcript, while he's 12 showing us the film -- he says, quote, "You can 13 14 see a bulge pressing on the thecal sac of the 15 spinal cord." Do you see that on that film, Doctor? 16 No. There is no bulging disk. 17 Α. It's a bone spur that is causing some 18 indentation, but it's clearly not pushing on 19 it. You can see the white structure all the 20 way around the disk, clearly indicating that 21 there is no direct pressure on the spinal cord. 22 And based on a reasonable degree of medical 23 Q. certainty, Doctor, is that bone spur something 24 that was caused by this accident? 25

39 1 Α. No. 2 Q. Doctor, did you also look at the CAT scan of 1988? 3 4 Α. Yes, I did. 5 Is there any indication on that CAT scan film Ο. 6 that you saw, personally, of any bulging disk or herniated disk or any pressing on any nerves 7 8 or the spinal cord? 9 Α. Well, it's not the best study for the spine, 10 but I would interpret it as not being abnormal. 11 Q. Did Kathleen Santon say anything to you about 12 having any low back problems? 13 No. Α. Dr. Nemunaitis told us in his deposition that 14 Q. 15there are, quote, "hundreds of reasons --16 causes for low back pain." 17 Would you agree with that? Maybe a little high, but --18 Α. 19 0. Would you agree with the proposition that there 20 are multiple causes for low back pain? I was hoping you wouldn't ask me to list 21 Α. Yeah. 22 them. There are multiple causes, obviously, 23 Yes. 24 going anywhere from degenerative disease, to tumors, to fractures, to abdominal problems, 25

40 that would cause problems of the spine. 1 And 2 there is certainly an equal number that would cause neck pain that -- as would cause lower 3 4 back pain. 5 Q. Doctor, do you have patients that suffer from asthma? 6 7 Yes, I do. Α. My wife has asthma, so I have to live with 8 it on a fairly regular basis. 9 10 Is there any relationship between the continued Q. 11 steroid use that an asthmatic may encounter and 12 the cervical spine or any other part of the spine? 13 I think that it's pretty well documented in the 14 Α. 15orthopedic literature and also in the endocrinological -- I can't even say the word 16 17 -- endocrinological -- the glands, the people 1.8 that study the glands and the hormones. Endocrinological, there it goes. My 19 20 disfluency comes out sometimes. It clearly shows a direct correlation 21 between prolonged steroid use -- this is legal 22 steroid use -- and the development or the 23 progression of increased bone loss. 24 Some 25 people feel it's because the bone can't

reaccumulate the calcium, and some people feel that the Prednisone or the Cortisone stops the absorption from the intestines of dietary calcium.

It is well known that Caucasian females, white women, probably starting in their late 30's, start developing osteoporosis, they start losing calcium normally. If there is prolonged calcium loss and the use of steroids, this will accelerate the condition known as osteoporosis, or loss of bone matrix.

12This can lead to compression fractures, most13commonly seen -- not so much in the cervical14spine, but in the thoracic and lumbar spine,15the chest and low back spine, fractures of the16hip, fractures of the radius, fractures of the17arm bone.

18 Steroids will make this condition, this 19 osteoporosis condition, worse.

20 Q. Doctor, you know Mr. Paris, who represents21 Kathleen Santon?

22 A. Yes.

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Q. Does Mr. Paris and/or the partners in his firm
ever refer patients to you?

25 A. Sure.

42 7 MR. CARRABINE: Thank you, 2 Doctor. I have no more questions. MR. PARTS: Off the record. 3 4 5 (Thereupon, a discussion was had off the record.) 6 7 8 9 10 CROSS EXAMINATION OF ROBERT CORN, M.D. 11 BY MR. PARIS: 12Q . Doctor, my name is David Paris, and I represent Mr. and Mrs. Santon. 13 Now, I understand that you examined Kay 14 15Santon seven years after her accident? 16 Α. Yes. 17 Q. Is that right? And you examined her one time 18 and one time only? 19 Right. Α. And you examined her for State Farm in order to 20 Q. be in a position to let this jury know whether 21 there is a cause and effect relationship 22 between her complains and her accident of 23 24 February of '85; is that fair? 25 I think that's a thumbnail synopsis, yes. Α.

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1	Q.	You are not involved in her treatment?
2	Α.	Correct.
3	Q.	You have not talked to Dr. Nemunaitis about her
4		care?
5	Α.	No. I thought that would be inappropriate.
6	Q.	You have not talked to Dr. Itani about her
7		care?
8	Α.	No, I have not.
9	Q.	Dr. Seo?
10	Α.	No.
11	Q.	Or Dr. Wellman?
12	Α.	Correct.
13	Q.	Do I understand that you don't know whether Kay
14		Santon was a full-time employee before this
15		accident?
16	Α.	I don't remember.
17	Q.	You don't know if she was the main breadwinner
18		of her home?
19	Α.	I don't remember that, offhand.
20	Q.	You don't recall or know her duties at work
21		before the accident?
22	Α.	Specifically, no.
23	Q.	Do you know whether she had any orthopedic or
24		pulmonary limitations or restrictions affecting
25		her ability to work before the accident?

		44
1	Α.	I am not aware of any pulmonary or orthopedic
2		problems that restricted her from working prior
3		to the accident.
4	Q.	In 1985, T think you told the jury that, based
5		on the emergency room X-rays, she had some mild
6		arthritis, or mild degenerative disk disease,
7		which of the two?
8	Α.	It was probably easier to diagnose the disk
9		disease, but there was probably arthritis at
10		the same time.
11	Ω.	Well, what do the films show?
12	Α.	I don't remember, offhand.
13	Q.	Feel free to look at your records.
14	Α.	I don't know if I have that real close by.
15		It's the radiologist's interpretation, Dr.
16		Kline, that it was, quote, "mild degenerative
17		change," end of quote.
18	Q.	At what level?
19	λ.	It doesn't really say.
20	Q.	It doesn't say C2 or C3 or the fourth, fifth,
21		sixth or seventh level?
22	Α.	No. Lower cervical vertebrae, he doesn't
23		really put a number there.
24	Q.	And it's impossible, is it not, for you to know
25		if that mild degenerative process was present

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1		that was present in 1985 was present in 1982,
2		let's say?
3	λ.	I'm I wasn't sure
4	Q.	Do you know if that was present in 1982?
5	Α.	I don't know for sure. In other words, there
6		was nothing documented in 1982.
7	Q.	Do I understand that it did not worsen between
8		'85 and '88?
9	А	I'm sorry, what didn't worsen?
10	Q	The degenerative disk disease.
11	Α,	Well, there was different studies that were
12		done, so it's really hard to compare them all.
13	Q.	But you looked at the CAT scans of her neck of
14		'85.
15	Α.	But the CAT scan doesn't really the CAT
16		scans aren't really a good enough they don't
17		tell me what I want to know.
18	Q.	Well, I thought I asked you that question.
19		Do you remember I was out here in April of
20		'93 and I asked you some questions about this
21		case?
22	Α.	I know you were here, but I never got a chance
23		to re-review it prior to today's deposition.
24	Q.	You didn't read it over and make some changes?
25	Α.	I think that was maybe a week or two after the

46 deposition was taken, but I haven't looked at ] 2 it since that time. 3 Okay. You did read it over and make some Q. 4 corrections on the errata sheet? 5 Α. Whenever that was, last summer or spring. 6 Okay. Q. 7 MR. PARIS: On Page 11, Mr. Carrabine and Mr. Fagnilli. 8 I thought I had asked you, and I'll show this 9 Q. 10 to you when I'm done, "Has the amount of arthritis in her neck increased between '85 and 11 '92?" 12 13 And the answer was, "Well, there is no increase, at least by CAT scan, from '85 to 14 15 '88." So --16 Α. Okay. 17 My question to you --Q. 18 MR. FAGNILLI: Would you let 19 him read the entire answer? 20 MR. PARIS: I'm about ready 21 to hand it to him. THE WITNESS: Can I have one 22 23 of the copies of it? 24 Okay, that wasn't your question, first of all. Α. 25My question was --Q.

You said looking at the regular X-rays and the 1 Α. CT scans in 1988, and T said there was no 2 change between the 19 -- as a matter of fact, 3 there were three CAT scans, 1985, '86 and '88. 4 The '85 and '86, there was some abnormality 5 Then 1988 was determined as perfectly noted. 6 7 normal by Dr. Terrar. So my question to you is, is there a Right. 8 Q. worsening between '85 and '88? 9 10 According to -- if you were to look at the Α. radiologist's -- there was obviously no 11 significant worsening, at least according to 12 the radiologist. 13 But I'm not sure in the 1988 X-rays the 14 15radiologist said that he saw the 1985 X-rays. I think he just said it was a normal study. 16 I'm not sure there was any signs or things that 17 18 he mentioned that said comparing the 1985, 1986 and 1988 there was any significant change. I 19 think that there was no mention of the previous 20 21 scans. But you don't see any significant changes, do 22 Q. 23 you? I don't remember ever seeing the '85 or '86 24 Α. scans. I saw the '88 and I saw the '93. I 25

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1		can't remember specifically seeing the early
2		CAT scans. I think they were not available for
3		review.
4	Q.	How about the plane films?
5	Α.	The plane films there were plane films in
6		1985 and there were plane films in 1993, and
7		there were changes between 1985, from the
8		description.
9	Q.	I'm just saying '85 to '88, and you can't make
10		that determination; is that fair?
11	Α.	I would be giving an opinion on somebody else's
12		opinion, and I really don't know.
13		Probably not significantly worsened.
14	Q.	Thank you.
15		You have told the ladies and gentlemen of
16		the jury that soft tissue injuries, injuries to
17		the muscles, injuries to the ligaments, sprains
18		to the joints, those type of components will
19		improve within three months. Did I hear that
20		right?
21	Α.	I said there were usually improvements to the
22		point that you would no longer be disabled from
23		your injury within three months, in most cases.
24	Q -	Okay.
25	Α.	Provided there is no pre-existing problem.

		49
1		These are just from a purely soft tissue
2		standpoint.
3	Ω.	But certainly, Doctor, you have treated
4		patients in car accidents who have injured
5		their neck and suffered sprains and strains to
6		their neck, who you have treated with physical
7		therapy over a ten-month period of time, and
8		who you've had no problem coming up with an
9		opinion that they have suffered a permanent
10		injury; is that not true?
11	Α.	I don't know. I can't remember anybody
12		offhand.
13		Most people will
14	Q.	But I'll direct your attention to a specific
15		patient, as a matter of fact, a former client $\sim$
16		of my partner's, and if you'll take a look at
17		that.
18		Do you recall testifying in that case
19		involving Miss Gray in August of 1986?
20	Α.	No.
21		MR. CARRABINE: I'm going to
22		object to the use of this, unless
23		the entire transcript is provided to
24		us in the trial.
25		MR. FAGNILLI: Same objection.

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She hurt her neck, correct.	<b>.</b> A	51
She hurt her neck; is that right?	- Q	30
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same accident, but it was a work-related car		8 T
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MR. FAGNILLI: ODJection.		9
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Doctor, did you, on Page 17, diagnose Miss Gray	• 7	7
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MR. CARRABINE: So we can find		τ
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1		not?
2	Α.	At one time.
3	Q -	You prescribed therapy, physical therapy, if
4		you'll turn to Page 25?
5	Α.	You know, T'm not sure what the relevance is,
6		but, yes, there was physical therapy that was
7		prescribed over a prolonged period of time.
8	Q.	Did you render an opinion that she has a
9		permanent soft tissue injury to her neck?
10		MR. CARRABINE: Objection.
11		MR. FAGNILLI: Objection.
12	Α.	For your purposes and for that particular
13		individual, who had a much more complex story
14		than is getting out today, yes, that was my
15		opinion. But it was based on different, you
16		know, different findings, and a different
17		pathology, and a different injury and a
18		different person.
19	Q .	Did you, as it relates to this particular
20		patient, indicate with people with her, and
21		you can turn to Page 33, that one of her
22		hobbies was recreational reading?
23	Α.	Which patient are we talking about now?
24	Q.	Same patient, Pamela
25	А.	Pamela Gray?

		52
growi	Q.	Right.
2		Did you render an opinion that she would
3		have to give up recreational reading, because
4		keeping her head in one position, her
5		posturing, was affecting her pain syndrome?
6		MR. CARRABINE: Objection.
7		MR. FAGNILLI: Objection.
8	Α.	I don't remember.
9	Q.	Could you turn to Page 33 and tell the ladies
10		and gentlemen of the jury whether or not you
11		advised her to discontinue that type of
12		activity?
13		MR. CARRABINE: Objection.
14		MR. FAGNILLI: Objection.
15	Α	Well, it was providing if I can read the
16		whole thing this is my opinion, is that the
17		injury and the residuals of the injury are
18		preventing her from doing the horseback riding,
19		recreational reading and other sporting
20		activities that you mentioned. It was
21		specifically
22	Q.	And on 33, would you tell the jury why
23		recreational reading why you told her not to
24		do that?
25		MR. CARRABINE: Objection.

		53
1		MR. FAGNILLI: Objection.
2	Α.	Well, this is what I stated at that time. I
3		quote, "I think that the injuries, the
4		injuries that she sustained to her neck and of
5		her back" and this is not a back injury case
6		that we're talking about in this case
7		"unfortunately have compromised her to some
8		extent with posturing and positioning necessary
9		for both sitting activities as well as active
10		sports, such as sailing and target practice."
11		She was a semi-professional skeet shooter, an
12		excellent shotgun shooter at one time.
13		So but she had a back injury as well, not
14		just solely a neck injury, so you're comparing
15		apples to oranges.
16	Q.	And one of the reasons that you asked her not
17		to engage in the recreational reading anymore
18		was because of the posturing of her head?
19		MR. FAGNILLI: Objection.
20		MR. CARRABINE: Objection.
21	Α.	I didn't ask her not to do that. I said that
22		it was a problem, her doing that. She's, you
23		know, a professional accountant, and she's
24		always done recreational and non-recreational
25		reading.

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1		And I think that the jury is probably going
2		to get a poor representation of what
3		comparing these two individuals, two different
4		age groups, two different activity levels, with
5		the same subjective type of symptoms.
6	Q.	Doctor, certainly you have treated patients who
7		have had permanent decreased range of motion of
8		their neck and permanent pain from a whiplash
9		injury?
10	Α.	From a whiplash mechanism injury, sure.
11	Q.	And it's possible for one to have pain and
12		disability on a permanent basis with respect to
13		sprains and strains of the cervical spine?
14	Α.	Provided there are physical findings that would
15		correlate or corroborate objective findings,
16		that would corroborate the objective symptoms,
17		sure.
18	Q.	And muscle spasms can be objective evidence of
19		injuries to the muscles and ligaments, can they
20		not?
21	Α.	If there is muscle spasm present, then muscle
22		spasm can limit motion, correct.
23	Q.	If you turn to the records that Mr. Carrabine
24		and Mr. Fagnilli have provided you, starting
25		with the Urgent Care Center record on March 1st

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55 of 1985 --1 You probably have these in order, so it may 2 Α. take me longer. 3 Do you want to just ask me the questions, or 4 5 do you want to go over every single medical record? 6 7 Q. No, no, I'm not going to bore the jury with 8 that. 9 On March 1st of 1985 --10 Let me look at yours and then we can go quicker Α. 11 that way. On March 1st of '85, does the record indicate 12Q. 13 muscle spasm? This physician's opinion, quote, "neck dash 14 Α. 15 tender, left trapezius muscle with mild spasm." 16 That's what they said. We have an indication of spasm in that record; 17 Q. 18 is that right? You have an indication by that physician that 19 Α. 20 that was their opinion of what the physical finding was, yes. 21 And have you had an opportunity to go through 22 0. any other records to determine whether or not 23 there were other notations of muscle spasm? 24 Have you had occasion to do that in this case? 25

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1	Α.	I didn't do a spasm review, in other words,
2		review every single record to see if there was
3		spasm mentioned.
4		I'm sure, in Dr. Nemunaitis's records, there
5		may have been a mention, and there may have
6		been a mention in another physician's records.
7	Q.	But a spasm, as you've told us, is an objective
8		sign of injury?
9	Α.	When it's present and it's true spasm, is an
10		objective sign of inflammation, not necessarily
11		injury, but certainly acute or sub-acute muscle
12		inflammation.
13	Q.	And you would agree that spasms are an
14		extremely painful condition?
15	Α.	If a spasm exists, then while the patient is in
16		spasm, it is not a comfortable thing, and it's
17		quite uncomfortable.
18	Q.	It's worse than a charley horse, is it not?
19	Α.	Yes.
20	Q.	It can render a patient fairly nonfunctional?
21	Α.	It certainly can.
22	Q.	In other words, you can't do a whole heck of a
23		lot when you're having a muscle spasm?
24	Α.	No, you can't do a whole heck of a lot, and may
25		not be able to do anything.

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1	Q.	And a C7 radiculopathy, Doctor, that is an
2		irritation of the C7 nerve root; is that right?
3	Α.	As you mean by definition?
4	Q.	Yes.
5	Α.	It can be.
6	Q.	And the source
7	Α.	It can be also a subjective and objective
8		finding correlating with any inflammation of
9		any branch of that nerve root. It doesn't have
10		to be coming off the spinal cord.
11		It can come from the brachial plexus, it can
12		come from shoulder injury, it can come from an
13		elbow injury, but it would follow a specific
14		pattern, sensory and motor.
15	Q.	And an EMG, Doctor, is a valuable tool in
16		determining whether or not there is some nerve
17		denervation?
18	Α.	Well, I'm not an expert in EMG's.
19		If it's done appropriately and properly and
20		repetitively, and you get the same answer on
21		all types, and it does correlate with a
22		clinical finding, then T think it's an
23		objective finding.
24		And it's certainly objective no matter who
25		does it, it's just obviously, it has more

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1		weight if it corresponds with something
2		clinically.
3	Q -	Typically, you don't read the EMG
4		interpretations yourself, you rely on others;
5		is that right?
6	Α.	I don't read the oscilloscope, but I can look
7		at the numbers and draw my own conclusions.
8	Q.	Now, we spent a lot of time talking about
9		arthritis in this case.
10		Doctor, would it be fair to state that as
11		many as 90 percent of the people walking around
12		who have arthritis don't even know it, because
13		it's not necessarily painful?
14	Α.	Did I say that at one time?
15	Q.	You bet. Do you want the page?
16	Α.	No.
17		T would say that, depending, obviously, on
18		the age group it sounds like something you
19		would be quoting out of, something I may have
20		said, and it sounds like a very rhetorical type
21		of statement but I would say most people
22		that have arthritis, and it may be in excess of
23		90 percent, the only symptom that they may have
24		is stiffness, and they may not even realize it
25		as a painful condition. But obviously, that's

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1		depending on the age group.
2	Q.	Arthritis is not necessarily a painful
3		condition; is that right?
4	Α.	It is not necessarily. Pain is not the only
5		manifestation of arthritis, and some arthritis
6		ís not painful.
7	Q.	I take it you don't take issue with the EMG
8		findings of Kathleen Santon that they were
9		consistent with the C7 radiculopathy on the
10		left side?
11	Α.	I don't really have an opinion.
12	Q.	And the CAT scan of March 5th of '85 was not
13		inconsistent with the C7 radiculopathy on the
14		left side, was it?
15	Α.	Well, is it inconsistent? Well, it's not
16		specific.
17		The 1985 CT scan showed that there was
18		degenerative narrowing of the opening. This is
19		not related to the disk, but from spur
20		formation at the C7, Tl that's really the C8
21		nerve root. I mean, there is nothing that's
22		absolutely specific on this, that would be
23		specific for a left C7, although you could have
24		it with arthritis.
25	Q.	Let me reask the question, Doctor.

		6 0
		I take it there is nothing in the CAT scan
2		which would be inconsistent with the C7
3		radiculopathy; is that right?
4	Α.	I'm not sure how to answer that.
5	Q.	How about the way that you answered it on April
6		6th of '93, when T asked that same question.
7		MR. PARIS: On Page 36, Mr.
8		Carrabine.
9	Q.	At Line 16, the question was, "But there is
10		nothing in the CAT scan"
11	Α.	"Nothing in the CAT scan which would" I
12		would say there is nothing that is inconsistent
13		with it.
14	Q.	Okay, thank you.
15	λ.	To answer your the way you asked the
16		question.
17	Q.	Do you have an opinion as to whether Kathleen
18		was disabled from work in 1985?
19	Α.	No. Not at this point in time.
20	Q.	And I take it, it is your contention that
21		Kathleen's problems are arthritic in nature; is
22		that right?
23	Α.	Which problems?
24	Q.	Neck, orthopedic problems. You're not here
25		testifying as a pulmonologist.

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<b>1</b>	Α.	Her orthopedic problems are primarily
2		degenerative, I would say arthritis and disk
3		disease.
4	Q.	She had this disk disease before the accident?
5	Α.	It was present at the time of her maybe
6		mild, but she had it at the time of the
7		accident, so it had to pre-exist.
8	Q.	She had one instance of complaints to a doctor
9		in December of '82?
10	Α.	Right. But we know she had mild degenerative
11		changes in the 1985 X-ray from the Urgent Care
12		Center, so we knew they had to exist prior to
13		1985.
14	Q.	Right. And she has had constant, continual
15		neck pain since this accident; is that right?
16	Α.	Subjective neck pain.
17	Q.	Right.
18	Α.	Well, I don't know if it's been the entire
19		time, but it's been pretty consistent
20		throughout the entire course.
21	Q.	That's the history that you've been provided?
22	Α.	Right.
23	Q.	Are you telling the jury that her arthritis is
24		the source of her pain?
25	Α.	I think if she does have pain, it's probably on

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	1	the basis of her disk disease and arthritis.
	2	But there is certainly nothing on the physical
:	3	examination that would be compatible with a
2	1	painful degenerative condition of the spine.
55	5 Q.	Her pain is not related to the injuries to the
6	5	muscles and ligaments of her neck at the time
7		of the accident?
8	Α.	Not not in my opinion, based on the fact
9		that there was no signs of muscle guarding,
0		muscle irritation, or anything really abnormal
. 1		other than the fact that she couldn't move
2		beyond 90 percent of her normal motion, I would
3		say that would be probably it is not within
4		reasonable degrees of medical certainty that
1 55		any of her residual subjective symptoms or
166		objective findings were related directly to the
177		accident.
188	Q.	But we know, Doctor, do we not, that in certain
19)		types of accidents involving injuries to the
20)		neck and the supporting soft tissue structures,
21		one can have stretching, hemorrhaging and
22		bleeding of the soft tissues that heals with
23		scar tissue, which is not as elastic, which can
24		also result in a decreased range of motion; is
25		that right?
1		

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1	Α.	If there was no other basis objectively for
2		decreased motion, then I would say that has a
3		little bit more validity. But, yes, that is a
4		theory.
5	Q.	Sure, and that has been your opinion in other
6		cases and other patients of yours, that some of
7		their restriction of motion has been due to the
8		scar tissue?
9	Α.	It has been right. But those people
10		probably didn't have the degree of degenerative
11		arthritis and degenerative disk disease.
12	Ω.	Why can't people have two conditions going on
13		at the same time?
14	λ.	I think it's clinically, within reasonable
15		degrees of medical certainty, difficult, if not
16		impossible, to differentiate the two.
17	Q.	Are you telling me, then, that you can't
18		differentiate whether or not Kathleen Santon
19		has scar tissue on the soft tissues
20	Α.	I would say
21	Q.	and the degenerative changes going on in her
22		neck?
23	Α.	I would say the degree of scarring in these
24		type of injuries are minimal. I think that
25		they are not always valid as a diagnosis, and

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bannosi		they are usually used to describe subjective
2		symptoms when there is no objective findings.
3		Objectively, she had no real abnormality on
4		her examination. My opinion is that they are
5		coming the abnormality and the discomfort
6		are coming from her disk disease, which is
7		fairly substantial, much more so than any
8		potential scarring would have been.
9	Q.	When I asked you on April 6th of '93 the reason
10		that Kathleen was still having neck pain, neck
11		complaints, you told me you didn't know.
12		MR. CARRABINE: What page?
13		MR. PARIS: 52.
14	Q.	And today, six months later, six and a half
15		months later, you do know?
16	Α.	I don't know.
17		You're asking my medical opinion. Medical
18		opinion is a guess based on reasonable degrees
19		of medical information.
20		I don't even know if she is having neck
21		pain. If she is having neck pain, it would
22		certainly be compatible with the degenerative
23		findings, which are pretty substantial at a
24		couple of the levels of her neck.
25		But do I know if she's having pain? No, I

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<b>-</b>		don't know if she's having pain.
2	Q.	And if she's having pain, in April of '93, you
3		told me you didn't know why she was still
4		hurting.
5	Α.	Well, I still don't know why. I have a
6		reasonable an opinion within reasonable
7		degrees of medical certainty.
8	Q.	Here is the question I asked you at that time.
9		"Then do I understand, Doctor, you do not
10		have an opinion based upon a reasonable degree
11		of medical certainty as to the source or the
12		reason for the cause of her present neck
13		complaints?"
14		Answer: "I am at a loss from an orthopedic
15		standpoint, knowing the anatomic and
16		physiological basis for this condition that
17		she's claiming, to describe why she is still
18		having the level of discomfort that she has
19		with the positive findings and treatment that
20		she's had during the past five years. I don't
21		know why she is still hurting."
22	Α.	I'm sure I said it exactly that way, with that
23		type of inflection and intonation.
24	Q.	But I'm reading it slowly so that I don't make
25		a mistake.

66 And without any inflections in your voice, I'm ] Α. 2 sure. MR. FAGNILLI: Would you let 3 4 him answer the question, please? 5 А April 6th. Can I have that piece of paper back? 6 7 You know, I didn't really see all the X-rays until May 17th of 1993, which included all the 8 9 X-rays --10 That would be five months ago; is that right? Q 11 Yeah. One was in -- April of 1993, was when А 12 you took my deposition, and it wasn't until May 13 17th, '93, that I think I was able to review 14 everything. 15 MR. CARRABINE: X-rays were not 16 sent to you. In fact, we didn't 17 even know they existed --18 MR. PARTS: Let's not have 19 a discussion on the record. 20 The fact of the matter is, that you had --0 21 There was additional information that was A 22 presented since the time of the deposition, which changes my medical opinion. 23 24 That's fine. Q. 25 Then, Dr. Corn, after having reviewed that

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1		in May of 1993, did you dictate a report?
2	Α.	No.
3	Q.	Did you dictate any notes?
4	Α.	Yes.
5	Q.	Did you provide me with any of those notes?
6	λ.	No.
7		MR. CARRABINE: Objection.
8	Q -	Did you provide anybody else with any of those
9		notes
10	Α.	No.
11	Q.	that you changed your opinions?
12	Α.	No. Well, I wasn't
13	Q.	Thank you.
14	Α.	It wasn't to be kept a secret or anything, I
15		just you finally sent me the rest of the
16		information and I was able to generate a more
17		accurate diagnosis or medical opinion.
18	Q.	I didn't know you changed your opinion until
19		about 20 minutes ago.
20	Α.	I didn't know until you read my deposition
21		again to me.
22	Q.	Doctor, the complaints that Kathleen expressed
23		to you in January of 1992 are the same
24		complaints that she has expressed to the Urgent
25		Care doctors in March of '85 and to Dr.

		6.8
]		Nemunaitis over the past eight years; is that
2		correct?
3	Α.	I don't know if that's true.
4		I don't remember verbatim what her
5		complaints were, other than just neck pain. I
6		don't remember the details, I don't remember
7		her responses to the questions. I think that I
8		asked her a lot more questions than the Urgent
9		Care doctor did.
10		But if you're talking about pain in a
11		general area, yes, she has had neck pain and
12		neck complaints, subjective symptomatology in
13		her neck since the time of the accident.
14	Q.	And she has also had and complained of
15		intermittent left arm symptoms since the date
16		of this accident; is that right?
17	Α.	I believe that's well documented in the medical
18		records.
19	Q.	Do I understand, Doctor, that you did not find
20		Kathleen to be insincere or attempt to
21		exaggerate her complaints or findings when you
22		examined her?
23	Α.	She seemed to answer everything within I
24		don't really remember at this point in time. I
25		don't know if I noted that in my report, but

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1	she seemed to cooperate. But I really don't
2	remember her at all.
3	MR. PARIS: Thank you,
4	Doctor. I don't have anything
5	further.
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10	CROSS EXAMINATION OF ROBERT CORN, M.D.
11	BY MR. FAGNILLI:
12	Q. Dr. Corn, my name is Dave Fagnilli. I have a
13	few questions for you. I represent the
14	Cincinnati Insurance Company in this case.
15	You mentioned that Mrs. Santon's complaints
16	and that her complaints are inconsistent
17	with the physical findings. What do you mean
18	by that, could you explain that in more detail?
19	A. I think it's been pretty well established under
20	the last hour or so that she still is
21	complaining. But the physical findings at the
22	time of this evaluation did not reveal any
23	objective abnormality, and she had,
24	essentially, a normal physical examination,
25	with the exception of a very minimal

restriction of motion, which is somewhat subjective.

Her pain really wasn't that severe. When I saw her, that was not her -- she was not in any significant distress whatsoever. She had been on the steroids for her asthma, and she said the bulk of her symptoms were improved. And we do use Prednisone and steroids short-term for severe arthritic flare-ups as well, so that would certainly account for the diminution in her symptoms, since she's been on the steroids.

12 But really, there was no significant 13 correlation between the longevity of her neck symptoms and the physical findings at the time 14 15 of the evaluation in January of '92. Based on your review of the medical records, 16 Ο. the history that you took from her, and the 17 examination that you performed, is it your 18 opinion based on a reasonable degree of medical 19 certainty that she does not have a continuing 20 soft tissue injury from the 1985 automobile 21 22 accident?

23 A. Yes.

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Without any other explanation, "yes," I think, would suffice.
71 Doctor, Dr. Nemunaitis made some reference to a 1 Ο. 2 one millimeter bulge in her cervical spine in his deposition. 3 4 Could you explain to the ladies and 5 gentlemen of the jury what clinical significance, if any, there is to a one 6 7 millimeter bulge in the cervical spine? Just to give an example -- you may want to Α. 8 focus in on this -- the line between the top of 9 10 the card and the very first blue line is two millimeters. So one millimeter would be half 11 12 that distance. 13 There is nothing that I'm aware of in orthopedic surgery that that one millimeter 14 15would have any -- one half of that distance, which is really pretty small, would have any 16 clinical significance whatsoever, other than --17 18 and especially on a CT scan. A CT scan basically, you know, as we discussed, is not 19 the most accurate -- and it's certainly not 20accurate within five millimeters, let alone one 21 millimeter. I would say it's clinically 22 insignificant. 23 Mrs. Santon has had a number of CT scans at Dr. 24 Q. Nemunaitis's direction. Are they the type of

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| 72<br>admostic tool that would be used to diadmos  | <pre>1 diagnostic tool that would be used to diagnose</pre>  | 2 and treat either arthritis or a cervical injury   | 3 resulting from an automobile accident, in your  | 4 practice as an orthopedic surgeon?   | 5 A. First of all, the X-rays would not be anything   |  | agnostic tool that would be used to diagno   
   | agnostic tool that would be used to diagnos  |  | and treat either arthritis or a cervical inju   | ъ.  | resulting from an automobile accident, in yo  | resulting from an automobile accident, in yo  | resulting from an automobile accident, in yo  | resulting from an automobile accident, in yo
  |  |  | practice as an orthopedic surgeon  | mafine ornadourin un ar arcorad  |  |  |  | A. First of all, the X-rays would not be anythi   
  |   | · · · · · · · · · · · · · · · · · · ·  | ving  | T SHITAT AT A CONCEPTION OF THE ATTACK ATTACK  | **************************************  | more information of now to trea   |  | But I think I previously stated that   |  
   | only since late 1986, since when the MR  | 0 crans were available, that is the only tes  | A PORTA MARKA MARKARA LA MUA TA MUA ANA ANA ANA ANA ANA ANA ANA ANA ANA A  | t has any degree of accuracy in the cervic  | 1   | 12 spine for diagnosis and assessment of the  |   | 13 degree of disease due to disk disease,   
   | arthritis, or spinal cord abnormalities  |  | 15 Q. Do you use CT scans in your practice to  |  | diagnose patients that you are treating to  | 17 cervical injuries, injuries to the neck?  |   | t believe I have ordered on  | 0 CT cran of the cervical cnine and I don'   | A OI SCAN OF CHE CETATOR SPINE' AND T DON   | 20 remember how many of those I would have done        
  |  | 21 before that. They're just not that good,  |   | 22 they're not that accurate.  | 23 I do use it a lot in the lumbar spine,  |  | 24 because it does show arthritis in the lumbar   |   |   
   |            | A O A  | The second that would be used to diagno<br>treat either arthritis or a cervical inj<br>ulting from an automobile accident, in yo<br>ctice as an orthopedic surgeon?<br>st of all, the X-rays would not be anythi<br>do with treatment, other than giving you<br>e information of how to treat.<br>But I think I previously stated that the<br>Y since late 1986, since when the MRI<br>ns were available, that is the only test<br>thas any degree of accuracy in the cervi<br>ne for diagnosis and assessment of the<br>ree of disease due to disk disease,<br>britis, or spinal cord abnormalities.<br>You use CT scans in your practice to<br>gnose patients that you are treating for<br>vical injuries to the neck?<br>ce 1986, I don't believe I have ordered o<br>scan of the cervical spine, and I don't<br>ember how many of those I would have done<br>ore that. They're just not that good,<br>y're not that accurate.<br>I do use it a lot in the lumbar spine,<br>ause it does show arthritis in the lumbar<br>ne better than an MR scan shows. But in |
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and treat either arthritis or a cervical injur resulting from an automobile accident, in your practice as an orthopedic surgeon?	and treat either arthritis or a cervical injur resulting from an automobile accident, in your practice as an orthopedic surgeon?	resulting from an automobile accident, in yo practice as an orthopedic surgeon?	practice as an orthopedic surgeon? A First of all the Y-rave would not he anythi	A First of all the Y-rave would not he anythi	THE PERSON AT AND A COLORY AND ADD ADD ADD ADD ADD ADD ADD ADD ADD	<pre>aud treat etuner arturities of a cervicat in yo resulting from an automobile accident, in yo practice as an orthopedic surgeon? </pre>
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1		cervical spine, I think it's useless.
2	Q.	Just so we understand, you're an orthopedic
3		surgeon; is that correct?
4	Α.	Right.
5	Q .	And you operate on people with neck injuries?
6	Α.	I am qualified to operate. A number of years
7		ago, I stopped operating on the neck, simply
8		because I wasn't getting the amount of volume
9		that T felt was necessary to maintain a high
10		level of surgical skills.
1]		But I have had training for it and I have
12		done it in the past, although I don't do it
13		routinely at this point in time.
14	Q.	Do you treat patients with neck injuries?
15	Α.	Absolutely.
16	Q.	And is that on a regular basis?
17	Α.	Yes.
18	Q.	What is the significance of no spasm at the
19		time of your examination, what does that tell
20		you about Mrs. Santon?
21	Α.	It would tell me that there is no acute or
22		subacute active muscle inflammation or
23		protective inflammation present at the time of
24		my evaluation.
25	Q.	In your practice, have you seen patients who

74	have a soft tissue neck injury and have spasms	on a daily basis for a period of eight years?	A. No, never.	Q. And why is that, Doctor?	A. I don't think that entity really exists, and if	it does, it's exceedingly rare.	Q. If someone has a soft tissue injury of the	neck, and they do have spasms resulting from	that soft tissue injury, how long would you	expect that condition to last in the normal	course of things?	A. Well, I don't think if it was untreated that	the patient would want to continue living,	that's how severe I know from a personal	standpoint, from an old wrestling injury, I do	get intermittent spasms that reoccur with	stresses and things $l_{\uparrow}$ ke that, and you need	treatment very soon. You need to get some	medication in you and you need to have some	heat or physical therapy applied to you, or you	just can't you can't function, you can't	work, you can't walk, you can't think. You're	completely non-functional.	If you have this on a recurrent basis	that's why, when people say muscle spasm, they	
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]		usually mean muscle guarding, the muscles are
2		rigid. But true muscle spasm is an extremely
3		short-lived, very painful, painful condition.
4	Q.	How long would you expect it to last for?
5	Α.	Until some sort of treatment. Sometimes you
6		have to go to the emergency room and get a
7		Morphine or Demerol shot to try to break up the
8		spasm.
9		Most people would seek attention rather
10		quickly; you wouldn't try to live with muscle
11		spasm.
12	Q -	Did you note any treatment of Mrs. Santon's
13		cervical injuries since November of 1985 in
14		your review of the records?
15	λ.	I'm sorry?
16	Q.	Did you notice whether Mrs. Santon has had any
17		treatment for her cervical or orthopedic
18		injuries since November of '85, as opposed to
19		examinations?
20	Α.	I think she had some physical therapy early
21		on. I don't think she's had a lot recently.
22	Q.	We talked a little bit about the one millimeter
23		bulge and you said that T think that you
24		said that was of no clinical significance; is
25		that correct?

76 I think it's zero clinical significance. 1 Α. 2 Q. At what level would a bulge become symptomatic in the normal course of things? 3 4 Α. Well, it would depend on the anatomical 5 abnormality, but I would say most of the time that I see one, they are a minimum of five 6 7 millimeters and they're usually in excess of eight millimeters. 8 9 Most are symptomatic after ten millimeters 10 or one centimeter, which is about that big, about five of those -- about five of these 11 12 lines, probably the distance between two of the 13 big lines, you know -- that doesn't really make 14 a lot of sense. 15 That's -- this is about seven centimeters 16 -- I would say a little bit longer than a 17 regular line space, that would be usually symptomatic by that point in time. 18 And then they would have, if they had a true 19 20 radiculopathy, they would have sensory 21abnormalities following a particular pattern, 22 they would have motor abnormalities following that same pattern, and they would have reflex 23 24 abnormalities of that same pattern. You don't operate on X-rays; you operate on 25

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You, Doctor.		8 T
questions I have for you. Thank		LT
MR. FAGNILLI: That's all the		9 T
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And in your opinion, Doctor, based on a	۰. ۵	Oh
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<ul> <li>21.3 You and I were unaware that Mrs. Santon had had age helore that.</li> <li>22.4 Another X-ray a few days before that.</li> <li>23.5 A. Right.</li> <li>23.6 You did have additional information on that are that corrects.</li> <li>24. So you did have additional information on that are that corrects.</li> <li>25.7 A. Correct.</li> <li>26.8 That of arthritis; is that corrects?</li> <li>27.9 Correct.</li> <li>28.1 A. Correct.</li> <li>29.9 A. Correct.</li> <li>20.9 A. Correct.</li> <li>20.9 A. Correct.</li> <li>21.9 A. Correct.</li> <li>22.9 A. Correct.</li> <li>23.9 A. Correct.</li> <li>24.9 A. Correct.</li> <li>25.9 A. Correct.</li> <li>26.9 A. Correct.</li> <li>27.9 A. Correct.</li> <li>28.9 A. Correc</li></ul>
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<ul> <li>23 You and I were unaware that Mrs. Santon had had</li> <li>24 You and I were unaware that Mrs. Santon had had</li> <li>25 Now, you saw that X-ray subsequent to your</li> <li>26 deposition; is that correct?</li> <li>20. So you did have additional information on that</li> </ul>
<ul> <li>Xou and I were unaware that Mrs. Santon had had</li> <li>You and I were unaware that Mrs. Santon had had</li> <li>A another X-ray a few days before that.</li> <li>Mow, you saw that X-ray subsequent to your</li> <li>deposition; is that correct?</li> <li>A. Right.</li> </ul>
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13 You and I were unaware that Mrs. Santon had had 14 another X-ray a few days before that.
13 You and I were unaware that Mrs. Santon had had
April 6th of 1993. At that point in time, both
11 made in your deposition which was given on
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7 vas had off the record.)
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4 VIDEO OPERATOR: Off the record.
3 Q. Doctor, just to be clear on this one
S BY MR. CARRANIC:
1 REDIRECT EXAMINATION OF ROBERT CORN, M.D.
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-		RECROSS EXAMINATION OF ROBERT CORN, M.D.
2	<u>BY MR.</u>	PARIS:
3	Q.	Doctor, you were telling the ladies and
4		gentlemen of the jury that you can't hang your
5		hat on one EMG study and, basically, a bunch of
6		negative MRI's and CAT scans.
7		Did I misstate that?
8	λ.	I said I was basically directing that toward
9		treatment.
10		But I would not if someone would come to
11		me for treatment, and they would have one
12		abnormal EMG but no correlating neurological
13		findings, physical findings or scan findings, I
14		would think that that would be a somewhat
15		invalid examination to pin the whole diagnosis
16		and prognosis on.
17	Q.	See, I'm confused then, because I'm looking at
18		a report from a patient of yours. If you'll
19		take a moment and review your report.
20		Do you recall that patient?
21		MR. CARRABINE: Show an
22		objection.
23		MR. FAGNILLI: Same objection.
24	Q.	Do you recall Miss Medor?
25	А.	Yes.

80 And that's your report from November of '88, of 1 Q. a woman who had an accident in '86; is that 2 right? 3 4 MR. CARRABINE: Objection. 5 Α. April of '86, yes. Right. She had a car accident, she had some 6 Q. 7 neck and upper and lower back complaints? MR. CARRABINE: Objection. 8 MR. FAGNILLT: 9 Same objection. 10 I'm sorry, what? Α. She had some neck, upper back and lower back 11 0. 12 complaints? 13 I'm rereading this because I'm trying to --Α. yeah, neck and upper back complaints, as well 14 as low back, correct. 15You ordered an MRI on her cervical spine? 16 Q. 17 Right. Α. That was normal? 1.8 Q. Objection. MR. CARRABINE: 19 20 MR. FAGNTLLT: Objection. 21 The MRI was normal. Α. 22 She had a CT of her lumbar spine --Q . MR. CARRABINE: Objection. 23 24 -- which, I think, showed a bulge? Q. She had two levels that were abnormal. Two 25 Α.

81 abnormal -- L4 and L5 were both abnormal. 1 2 Q. But one was a bulge; is that right? MR. CARRABINE: 3 Objection. 4 Α. They were both central protrusions and bulges, both degenerative disk disease. 5 All right. But you didn't see any herniation 6 Q 7 or impingement on the spinal cord or --8 No. A 9 0. -- or anything like that? 10 MR. CARRABINE: Objection. Objection. 11 MR. FAGNILLI: 12 Q You ordered an EMG test to determine whether or 13 not there was any nerve involvement? 14 Correct. A 15 MR. CARRABINE: Objection. 16 And that failed to disclose, with reasonable Q . 17 medical certainty, any nerve denervation? MR. CARRABINE: Objection. 18 It said, quote, "possible CAT-1 cervical 19 A radiculopathy," end of quote. 20 So that's a questionable finding; is that 21 Q 22 right? MR. CARRABINE: Objection. 23 You know, that's what I said in the letter. Τ 24 A don't really remember those details at this 25

82 point in time. ] And you felt pretty confident, after two years 2 Q. of working with her, that you would be unable 3 to cure her, notwithstanding the involvement of 4 5 orthopedic surgeons, radiologists, neurologists and neurosurgeons; is that right? 6 7 MR. CARRABINE: Objection. MR. FAGNILLIT: Objection. 8 Essentially, she had a great deal of subjective 9 Α. 10 symptoms with very minimal subjective -- with very minimal objective findings. 11 Your prognosis for this woman was poor, and you 12 Q. opined at that time that her symptoms would 13 never resolve --14 15 MR. CARRABINE: Objection. 16 -- is that right? Q. 17 They hadn't resolved in two years, they Α. probably wouldn't resolve, right. 18 Did you further opine that she would need 19 Q. physical therapy for the rest of her life on an 20 intermittent basis? 21 22 MR. CARRABINE: Objection. Objection. 23 MR. FAGNILLT: 24 That was my opinion at that time, yes. Α. And to the cost of about \$2,500 per year? 25 Ο.

SZ58 3333Doctor. I have nothing further. 51 тоу Хои, SIAA9 .AM 30 . as that particular case, yes. 6 T ٠A stdpir tedt al ٠Õ 8 T MR. FAGNILLI: Objection. LI MR. CARRABINE: Objection. 9 T Snoitseup SΤ Wi trabions eloidev rotom edt to eoneupeanos 71 toerib e enew Yrului jo stuislymoo leubiser εt And of course, it was your opinion that these - Q TT.sey ,sew noinigo ym jedw s'jedT ٠A ΠI stdpir tedt al ٠Õ 0 T MR. FAGNILLI: Objection. 6 MR. CARRABINE: ODjection. 8 reach a pain-free status? L any significant recovery or that she will ever 9 that you doubted whether or not there will be G Did you further believe at that time, Doctor, ٠Õ Þ .aey, year the opinion at that time, yes. • ¥ ε MR. FAGNTLIT: Objection. Ľ MR. CARRABINE: ODjection. 1 83

84 1 FURTHER DIRECT EXAMINATION OF ROBERT CORN, M.D. 2 BY MR. CARRABINE: Doctor, I'm going to ask you a question. 3 Q . 4 Because there is no judge here to rule on our 5 objections, I may withdraw this question at a later date. 6 7 MR. PARIS: Move to strike. Is there any way that the ladies and gentlemen 8 0. 9 of the jury in this case, or me and Mr. 10 Fagnilli, for that matter -- we have not been 11 involved in these other cases that Mr. Paris 12 has brought up -- is there any way that we can 13 weigh or compare Mrs. Santon to those other individuals? 14 MR. PARIS: Objection. 15 16 I don't think there is any comparison Α. 17 whatsoever. 18 Why do you say that, Doctor? Ο. Both of them involve completely different areas 19 Α. 20 of the spine. I think Mr. Paris's points were that I have 21 22 made, for his clients or clients of his law 23 firm, definitive opinions based on soft tissue injury only, and I think he was just trying to 24 make a point that -- trying to, you know, say 25

that what I'm saying now is just the opposite of what I said then.

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Whereas, T don't think that just taking those statements out of context really clearly explains why I gave those opinions and how I felt on patients that I was treating -- not patients that I had seen after treatment was completed, essentially, that had ongoing symptoms that were difficult to describe on a physical basis.

And quite frankly, the last one, T essentially told her to go seek other medical attention because I had nothing else to offer her. And they have absolutely no pertinence to this case whatsoever. Neither one of them involved a purely neck injury.

One of them involved a back injury in a very obese young girl who was borderline mentally retarded, and I don't see the correlation between this particular case and either one of those two cases.

MR. PARIS: Move to strike. Q. Doctor, do we have in front of us any of the medical records, the deposition transcripts of the parties, the deposition transcripts of the

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86 doctors, or any of the other evidence in those ] 2 two cases of Mr. Paris so that the jury can review those items --3 4 MR. PARIS: Objection. 5 Q. -- and compare them to this case? Not on the record, no. Α. 6 7 MR. CARRABINE: Thank you, Doctor. I don't have any more 8 9 questions for you. MR. FAGNILLI: Nothing 10 further. 11 12 MR. PARIS: Thank you, Doctor. Nothing further. 13 VIDEO OPERATOR: Doctor, you 14 have the right to review this tape; 15you may waive that right. 16 THE WITNESS: I'll waive both 17 my right to review both the tape and 18 the transcript. 19 2021 (SignatiAre Waived.) 22 23 24 25

have CERTIFICATE The State of Ohio, 2 ) ) SS: 3 County of Lake. 1 I, Catherine Radie, a Notary Public within and 4 for the State aforesaid, duly commissioned and quali-5 fied, do hereby certify that the above-named ROBERT 6 C. CORN, M.D., was by me, before the giving of his 7 deposition, first duly sworn to testify the truth, the 8 Q whole truth, and nothing but the truth; that the 10 deposition as above set forth was reduced to writing 11 by me by means of stenotypy, and was later 12 transcribed into typewriting under my direction; that 13 the reading and signing of the deposition by the 14 witness were expressly waived by stipulation of 15 counsel and the witness; that said deposition was 16 taken pursuant to notice and the stipulations of 17 counsel herein contained, and was completed 1.8 without adjournment; that I am not a relative or 19 attorney of either party or otherwise interested in the event of this action. 20 21 IN WITNESS WHEREOF, I hereunto set my hand and seal of office, at Mentor, Ohio, this  $26^{r_0}$  day of 22 23 October, A.D. 1993. Catherine Radie, Notary Public 24 8547 Hilltop Drive, Mentor, Ohio 44060 My commission expires 10-19-94. 25

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