

IN THE COURT OF COMMON PLEAS
OF STARK COUNTY, OHIO

STEVEN FRANK, et al.,

Plaintiffs,

vs.

Case No. 1997 CV 0047:

JOHN VARGO, III, et al., Judge Reinbold, Jr.

Defendants.

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VIDEOTAPE DEPOSITION OF ROBERT K. DeVIES, Ph.D.

Tuesday, June 27, 2000

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Videotape deposition of ROBERT K.
DeVIES, Ph.D., called for direct examination
under the statute, taken before me, Elaine S.
FitzGerald, a Registered Professional Reporter
and Notary Public in and for the State of Ohio,
by agreement of counsel, at the office of Robert
K. DeVies, Ph.D., 4572 Dressler Road, Canton,
Ohio, on Tuesday, June 27, 2000, at 6:35 o'clock
p.m.

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1 APPEARANCES:

2
3 On behalf of the Plaintiffs:

4 Becker & Mishkind Co., L.P.A., by
5 HOWARD D. MISHKIND, ESQ.
6 Skylight Office Tower
7 1668 West 2nd Street, Suite 660
8 Cleveland, Ohio 44113
9 (216) 241-2600

10
11 On behalf of the Defendants:

12 Berlon & Timmel, by
13 PATRICK S. CORRIGAN, ESQ.
14 76 South Main Street
15 Suite 1604
16 Akron, Ohio 44308
17 (330) 376-1600

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20
21 ALSO PRESENT:

22 Barry D. Hersch, Videographer

23
24 ----

1 MR. HERSCH: We're on the record.

2 ROBERT K. DeVIES, Ph.D., of lawful age,
3 called for examination, as provided by the Ohio
4 Rules of Civil Procedure, being by me first duly
5 sworn, as hereinafter certified, deposed and said
6 as follows:

7 DIRECT EXAMINATION OF ROBERT K. DeVIES, Ph.D.
8 BY MR. CORRIGAN:

9 Q. Good evening, Doctor. Patrick
10 Corrigan here for Cincinnati Insurance Company.

11 Could you identify yourself to the
12 Panel, please?

13 A. Dr. Robert K. DeVies.

14 Q. And what do you -- what do you do as a
15 professional?

16 A. I have -- I work at the Altman
17 Hospital in the internal medicine residency
18 program as an associate professor in internal
19 medicine and psychology at the Northeastern Ohio
20 University College of Medicine and I'm the
21 president and chief executive officer of
22 Psychological and Family Consultants in Canton.

23 Q. I'm going to hand to you a copy of
24 what I believe is your curriculum vitae. It
25 looks a little old --

1 A. Yes.

2 Q. -- but would you please identify that
3 for the Panel?

4 A. Yes. This certainly was the vitae
5 that we were using at that time.

6 Q. Fair enough.

7 MR. MISHKIND: Could I see it,
8 please?

9 Q. Doctor, would you please describe your
10 practice specialty for the Panel?

11 A. My specialty is in rehabilitation
12 psychology. It -- I'm particularly interested
13 from a clinical and a research standpoint on
14 adjustment to illness and particularly neurologic
15 illness has been my biggest interest as well as
16 systemic disease. But I see patients in
17 rehabilitation units who have had strokes, who
18 have had head injuries and so on and teach
19 internal medicine residents on what are the
20 psychological aspects **of** that and how to evaluate
21 patients for these kinds of conditions from a
22 psychological standpoint.

23 Q. What portion of your practice here
24 involves testifying or serving as an expert
25 witness for either plaintiffs or defendants?

1 A. A very small part. I would say on --
2 in any given week, probably none, but maybe 5
3 to -- 5 hours a month on the average, maybe 60
4 hours to -- 60 to 100 hours per year.

5 Q. Okay. There came a time when you were
6 asked to review records and undertake an
7 examination of Steven Frank in this case. Can
8 you describe for the Panel the records that you
9 reviewed?

10 A. I was actually asked to review the
11 records on Steven Frank I believe by Attorney
12 Greg Beck from Baker, Dublikar, Beck, Wiley &
13 Matthews who represented I believe one of the
14 insurance companies, and that, I'm not sure who
15 Greg Beck represented, but he provided me with a
16 fairly lengthy set of materials having to do with
17 the police report and the different medical
18 reports on Steve Frank.

19 Q. Okay. Is it safe to say you reviewed
20 medical records from Dr. Afield and various
21 other --

22 A. Our -- I think in our initial --
23 Dr. Afield wasn't involved I don't think with the
24 initial materials that I had available, but later
25 I got to see something from Dr. Afield, yes.

1 Q. Okay. Can you tell the Panel about
2 your interview with Steve Frank and the time you
3 spent, the evaluation you performed?

4 A. Well, in -- in fact, I had reviewed
5 these records for Mr. Beck and had concluded that
6 there was certainly reason to pursue an
7 examination, you know, to do an independent
8 evaluation, and that was scheduled and that to be
9 conducted I believe on June 13th of 1998 and he
10 was to be here for two days of testing.

11 The -- he came in for the examination.
12 He had flown in from where he was living,
13 somewhere in the south. I don't know if it was
14 Florida or North Carolina or South Carolina. One
15 of the Carolinas or Florida. And he -- we
16 proceeded with an interview that lasted somewhere
17 over an hour, probably under two, and based on
18 what I had read of him, I wanted to do a fairly
19 extensive battery of tests that included the
20 House Rattan Neuropsychological Test Battery, the
21 Wechsler Adult Intelligence Scale, the Minnesota
22 Multiphasic Personality Inventory, the Memory
23 Scales, and we weren't able to do that.

24 Q. Can you tell the Panel why you weren't
25 able to do that?

1 A. The -- Mr. Frank indicated first of
2 all to me the morning of the second day that
3 his flight was scheduled to leave in the late
4 morning or around close to noon, he wouldn't be
5 able to stay, so instead of having two days, I
6 had one -- the best part of one day and only
7 about an hour or two on the second day.

8 The second reason was is that after we
9 had spent a couple hours doing the interview, we
10 set on out to do these tests, and the first test,
11 the MMPI or the -- I guess we gave him the Wide
12 Range Achievement Test and the Shipley Assertive
13 Living Test, he took forever to do them, and so,
14 you know, when I give him the MMPI and I went in
15 and would do a check on him regularly, he just
16 wasn't moving. He would do maybe 20 questions an
17 hour or 20 questions a minute, you know -- or,
18 I'm sorry, an hour. He took an excessively long
19 time to do it. And in fact, at the end of the
20 first day, he had in fact pretty much only
21 completed the MMPI. A test that should take an
22 hour, an hour and a half to take, he had taken
23 six hours to do.

24 Q. Did that pour into the next morning,
25 the MMPI?

1 **A.** He finished up that on the next
2 morning and I had to scrap our planned
3 examination and give a bunch of tests of far less
4 credence, far less validity, just a weaker set of
5 measures all together.

6 **Q.** **So** the basics of your time with Steve
7 Frank have just been testified to, is that
8 correct?

9 **A.** Yes.

10 **Q.** The tests administered, the
11 interview?

12 Were you able to achieve any diagnosis
13 based on your time with Steven Frank?

14 **A.** I didn't -- I was asked at one point
15 if -- if he had a head injury and I certainly
16 conceded that I, you know, I thought he did have
17 a head injury, but that was not based on my
18 testing. I couldn't get that from the testing.
19 I conceded that from -- and I say concede because
20 that was a word that was used in my deposition.

21 **Q.** What was it based on?

22 **A.** It was based on my observation and the
23 wreck and the emergency room records that I had
24 reviewed.

25 **Q.** Okay. Were you able to draw any other

1 conclusions about Steve Frank based on the time
2 that you spent with him?

3 **A.** The -- I believe that while there were
4 some -- there certainly was evidence of a head
5 injury, I felt that also there was evidence of a
6 very, very significant tendency for him to drag
7 his feet, to have -- that he was not giving me
8 his best effort. He certainly on -- I would not
9 use the word malingerer, you know. I -- I don't
10 believe that's the right term, and I don't know
11 that it's a particularly clinical term, but I
12 would use the term sandbag. I felt that he was
13 sandbagging me.

14 **Q.** Based on what you have said there,
15 is -- in this case there has been testimony that
16 Steve Frank, testimony from his medical
17 professionals, that he sustained a brain injury
18 that prohibits him from working and basically has
19 precluded him from being a salesman. **Is** it the
20 case in a mild brain injury that typically there
21 would be mild memory or cognitive changes that
22 are not necessarily disabling and such an
23 individual such as Steve Frank could return to
24 work and succeed in his prior job?

25 **MR. MISHKIND:** Let me just object to

1 the form of the question. It's leading in nature
2 as well, but certainly the Doctor, given that
3 this is to the Panel of Arbitrators, I will leave
4 it at that.

5 MR. CORRIGAN: Thank you, Howard. I
6 appreciate that.

7 A. I suspect the term what we used head
8 injury, I would use maybe a post concussion type
9 syndrome that includes this family of behaviors
10 and things, and it's in fact the case that most
11 people who sustain a mild head injury that has
12 residual or thought of as post concussion
13 syndrome does return to work. They do return to
14 work. Most return to the same job. Even if
15 you're an NFL quarterback, you return to the same
16 job. So yeah, I -- I -- I think it's very fair
17 to say that most people who sustain mild head
18 injury return back to the same job.

19 Q. If there was testimony presented in
20 this case from co-workers of Steve Frank and
21 other business associates that he returned to
22 work and achieved some success in sales
23 commensurate with or at least similar to his
24 prior performance, would you agree that that
25 would be an important evidence for a

1 neuropsychiatrist or a neuropsychologist to
2 consider in forming opinions regarding the
3 ability to perform?

4 A. Yes.

5 MR. MISHKIND: Let me -- objection
6 again --

7 THE WITNESS: I'm sorry.

8 MR. MISHKIND: -- but you have already
9 answered and the Panel's going to consider it
10 anyway, but my objection is noted.

11 Q. Okay. Let's assume that there has
12 been testimony in this case that Steve Frank
13 independently negotiated with an individual for
14 the opportunity to represent his company, in
15 other words, this other person's company, as an
16 independent sales rep and then proceeded to
17 achieve two significant sales in two months.
18 Would that be significant in determining the
19 ability of Steve Frank to return to his former
20 occupation?

21 MR. MISHKIND: Objection.

22 A. I believe it's a significant piece of
23 information, yes.

24 Q. And in the course of your practice as
25 an expert in this field -- apparently you're a

1 rehabilitation psychologist, is that correct?

2 A. Yes.

3 Q. Is it -- would I be correct in
4 assuming that when an individual returns to work
5 from some class of a minor concussion such as
6 occurred in this case, would I be correct in
7 assuming that post-accident performance
8 indicates -- which is testified to is a good
9 indicator of the ability to work?

10 MR. MISHKIND: Let me just object.

11 Again, this is an arbitration, but the
12 nature of your questions are so leading to an
13 expert witness that I would ask the Panel to
14 consider the content of the questions that are
15 being presented to the Doctor and give the
16 Doctor's testimony the weight that it deserves.

17 MR. CORRIGAN: Howard, I'm trying to
18 ask a hypothetical and I admit I'm rather
19 inartful at that, but --

20 MR. MISHKIND: I'll stipulate to
21 that.

22 MR. CORRIGAN: Okay.

23 A. I'm not sure that I -- I'm up on the
24 question now, but it -- I believe, if I
25 understood the question correctly, is that the

1 ability to conclude business that you were able
2 to do before is in fact a reasonably good
3 predictor of some degree of recovery.

4 Q. Okay. Just a minute, Doctor. I'm
5 trying to dispose of some other questions that
6 Mr. Mishkind might not like here and --

7 MR. MISHKIND: Don't dispose of them
8 on my account.

9 Q. Dr. Afield was asked on direct
10 examination by Mr. Kulwicki whether his opinion
11 of Steve Frank's condition would change assuming
12 that several witnesses that defense counsel
13 presents will opine that they've had dealings
14 with Mr. Frank both before and after his injury
15 and that they haven't noticed any change in his
16 cognitive function. Dr. Afield stated on page 38
17 of his transcript that it does not change his
18 opinions in any way, and he then went on to
19 testify that, quote, "That depends on the level
20 of witness. If it's me and the receptionist,
21 she's not going to notice a difference, if it's
22 me and my wife, she's going to notice a
23 difference, and if it's me and my business
24 manager and I can't make legitimate decisions, it
25 becomes very obvious to the people who are close

1 and involved in working with you that there's
2 something wrong."

3 Given that testimony, wouldn't the
4 converse situation also be significant from a
5 psychological evaluation point of view? In other
6 words, if five different co-workers, one of whom
7 was a supervisor, another of whom was an
8 independent businessman who had daily contact
9 with Steve, testified that Steve Frank was the
10 same sharp guy after his accident as he was
11 before, would that be important information for a
12 diagnostic purpose?

13 MR. MISHKIND: Objection.

14 A. Well, you know, I think the entire
15 situation there is pretty convoluted. I would
16 say this, that if in fact Dr. Afield believes
17 that the detection of a head injury requires such
18 subtle kinds of innuendoes from one level of
19 relationship to another, we must be talking about
20 a very subtle and mild head injury. You know,
21 that is not -- a person who has a head injury of
22 some significance doesn't disguise that from
23 anyone. That's an omnipresent condition, and
24 your wife, your receptionist, your business
25 manager, the garbage man can see that there are

1 significant changes.

2 If, in fact, the differences are so
3 subtle and so brief as Dr. Afield suggests, then
4 in fact the head injury's so minimal that it's
5 becomes essentially irrelevant with regard to
6 degree of injury.

7 Q. Okay. Well, given the -- and there
8 came a time when you interviewed Steve Frank and
9 can you tell the Panel how he presented to you in
10 the interview?

11 A. Steve Frank -- I have some notes here
12 from that. Let me just -- he came on time. He
13 was very casual. He had come from Florida. He
14 was friendly to me. My -- that's what I was
15 looking for. His overall appearance was mildly
16 disheveled although clean and coordinated; that
17 is, he wore pants and shirt that -- he was
18 disheveled though as I recall. Half of his shirt
19 tail was out and his hair was all amuss (sic),
20 but he didn't have any particular odor about
21 him. He had -- he had showered and he was -- he
22 was disheveled but he wasn't dirty.

23 Q. Okay. What about his affect or his
24 presentation otherwise in terms of cognitive
25 ability, his ability to converse? Did you make

1 any observations regarding that?

2 A. He came across very -- somewhat quite
3 dull. He -- we were in my partner's office for
4 the examination and he was seated on the couch
5 and he would dart his head back and forth and he,
6 you know, had a hard time making eye contact with
7 me. His mood, in other words, was very flat and
8 his speech was very flat and there was almost a
9 monotone in which he spoke, and I noticed that
10 his speech was somewhat dysarthric which is a
11 common speech characteristic noted by individuals
12 who have had a head injury.

13 Q. Would you define dysarthric for the
14 Panel, please?

15 A. Dysarthric is a term in aphasia
16 studies that in fact is short for central
17 dysarthria which suggests that there are problems
18 in the speech producing sound -- speech producing
19 areas of the brain that creates a flattening of
20 the T-H sound particularly. So there is a
21 tendency to hang on to the "th, th," T-H sound,
22 and you'll get a rather extension on that.

23 Q. Okay. I want you to assume that there
24 has been testimony by up to eight different
25 individuals who dealt with Steve Frank after his

1 accident, many who dealt on a daily basis in
2 either his sales contacts with various jobs or in
3 building a home in North Carolina, and each **of**
4 them testified that Steve Frank seemed sharp or
5 quick-witted and that his eye contact, his
6 ability to go in and make a presentation was the
7 same as it had ever been. Assume further that
8 many of these individuals testified that they
9 observed no difficulty in his ability to speak,
10 such as slurring or stuttering or difficulty
11 finding words or ability to express himself.

12 Given the above assumptions, is it
13 possible for an individual with a mild brain
14 injury as described by Steve Frank and his
15 doctors to essentially improve his speech or eye
16 contact or apparent focus or sharp-wittedness, or
17 should one be able to expect him -- in other
18 words, would he be unable to do that?

19 MR. MISHKIND: Let me object to the
20 question and I would ask the Arbitrators, even
21 though this is an arbitration, that any answer
22 given to this question should not be considered
23 based upon the form **of** the question, based upon
24 speculation, possibility, although assumes facts
25 which are not in evidence in the case and

1 probably for other reasons, but, Doctor, you can
2 go ahead and answer the question.

3 A. If I can recall what it was. I -- I
4 believe, and correct me, Mr. Corrigan, if I'm
5 wrong, because I need to see if I understand the
6 question correctly --

7 Q. Maybe I can try to simplify the
8 question.

9 A. -- it sounded to me like the question
10 was, is a person who has had a head injury able
11 to turn it up or turn it down.

12 Q. In other words, the question really
13 is, can a person who has a head injury with the
14 presentation that you described regarding
15 dullness, a flat affect, a speech difficulty, are
16 they able to turn that off and speak normally?

17 MR. MISHKIND: Objection.

18 A. My position is is that symptoms can be
19 added, symptoms can't be taken away. That is, if
20 a person has a head injury, they're at the mercy
21 of that head injury to the limitations imposed by
22 that head injury. If a person has a head injury
23 and they want to in fact make more of rather than
24 less of that head injury, they can in fact then
25 add symptoms to it, but they can't really take

1 symptoms away from it.

2 MR. CORRIGAN: Okay. Doctor, I don't
3 have anything further at this time. Thank you.

4 CROSS-EXAMINATION OF ROBERT K. DEVIES, Ph.D.
5 BY MR. MISHKIND:

6 Q. Good after -- good evening. Good
7 evening. Doctor, I introduced myself before the
8 deposition began. This is the first time that we
9 have met. I will slide around so you don't have
10 to get a stiff neck turning toward me. I am
11 Howard Mishkind and you had met Dave Kulwicki
12 from my office previously when your discovery
13 deposition was taken, correct?

14 A. I believe that was over the telephone
15 I think.

16 Q. Very possibly. Very possibly. There
17 has been a lot that's gone on in this case, some
18 of it less convenient than others. I do have
19 some questions for you this evening.

20 I've had an opportunity to review your
21 report and your notes that you provided at the
22 time of your discovery deposition. You have not
23 considered any further information since the time
24 of your discovery deposition?

25 A. Not to my knowledge, no.

1 Q. Your discovery deposition was taken
2 back in September of 1998?

3 A. Right.

4 Q. Okay. By the way, you indicated that
5 you had been retained by Mr. Beck from Baker,
6 Dublikar who is counsel for Erie Insurance
7 Company. I just -- I noticed that Erie Insurance
8 Company is directly across the street from your
9 office. Do you do many examinations at the
10 request of Erie Insurance Company?

11 A. No. Matter of fact, I -- I don't
12 think I -- I wouldn't have known that it was Erie
13 Insurance Company unless you told me. Mr. Beck
14 has -- I have done several examinations for him.

15 Q. Okay. I want to determine and sort of
16 clarify a few items. Number one, we can agree,
17 can we not, that Steve Frank in your opinion is
18 not malingering, correct?

19 A. I don't believe that he was
20 malingering in terms of the presence or absence
21 of a condition, no.

22 Q. And Steve is not a hypochondriac,
23 correct?

24 A. No. I do not believe that Steve is a
25 hypochondriac.

1 Q. Okay. And you don't believe that
2 Steve Frank is lazy either, do you?

3 A. Well, I -- I would say I can't say. I
4 don't have any reason to believe he's lazy.

5 Q. Okay. Doctor, the deposition will go
6 a lot faster if you can, when I ask you whether
7 we can agree that you don't think a particular
8 way, if it calls for a yes or a no, if you could
9 just say whether you -- whether that's a yes or
10 no and let me give the question to you again.

11 Can we agree that you do not think
12 that Steve Frank is lazy?

13 A. Let me just have one clarification so
14 we can go faster. If I can't say yes or no, I
15 need a -- my answer is I have no basis to know.

16 Q. Do you recall when your deposition was
17 taken -- and again, you were sworn to tell the
18 truth --

19 A. Yes.

20 Q. -- and at page 71 the following
21 question, I'll read the question and answer to
22 you --

23 A. Okay.

24 Q. -- the question began at line 4, "Are
25 you impressed by the fact that he tried to go

1 find work down in Florida?", Answer, "Yes."

2 Question, "Why?". Answer, "I don't believe that
3 Steve Frank is a malingerer. I don't think
4 that's true. I don't believe that Steve Frank is
5 a person who is lazy."

6 A. I'll stand by that.

7 Q. Okay. Now, Steve sustained a
8 traumatic brain injury, correct?

9 A. To my knowledge, yes. Yes.

10 Q. You have no basis to say otherwise, do
11 you?

12 A. That's right.

13 Q. You believe the traumatic brain injury
14 is mild, correct?

15 A. That's my opinion, yes.

16 Q. And for the benefit of the Panel, you
17 would certainly agree with me that a mild brain
18 injury can cause serious effects on a person's
19 ability to perform at a higher level in a job,
20 correct?

21 A. Correct.

22 Q. Let's review a couple things that you
23 talked about with Mr. Corrigan. Number one, at
24 the time of your exam, his speech demonstrated
25 some production difficulties, correct?

1 A. Yes.

2 Q. And that is consistent with someone
3 that has traumatic brain injury, correct?

4 A. Yes, yes.

5 Q. His affect was mildly dull and he had
6 a hard time keeping eye contact, correct?

7 A. That's right.

8 Q. He demonstrated this dysarhythmic --
9 dysarthric slurring which we talked about before?

10 A. That's right.

11 Q. Which is all consistent with someone
12 that has a traumatic brain injury, correct?

13 A. Correct.

14 Q. In fact, Doctor, I believe that you
15 indicated that you felt that part of Steve's
16 brain injury based upon the review of the facts
17 of the case and the tremendous collision that
18 occurred, the impact to the rear of the vehicle,
19 that you felt that part of his brain injury was
20 due to cervical difficulties involving the brain
21 stem causing a temporary anoxia, correct?

22 A. I recall we discussed that during the
23 deposition and I felt that that was a possible
24 explanation. I'm not sure that I said that
25 that's the reason, but I thought that that was

1 certainly possible.

2 Q. Doctor, again, at lines -- at page 69
3 line 9 of your deposition was the following
4 question and was the following answer given.
5 "The next paragraph -- and I'm going to skip over
6 the part about whether he was concussed at all
7 because I think we kind of covered that in a
8 different way -- I suspect that there may be some
9 relationship to his cervical difficulties and
10 disorientation moreso than an actual post
11 concussive event. Tell me what you mean there."
12 And your answer was, "My sense was that at least
13 from an exploratory standpoint, the things that I
14 wanted to examine was whether or not as you were
15 talking about axonal injuries, I felt that some
16 of the behaviors were more reflective of
17 temporary anoxia secondary to cervical injury
18 than in fact actual brain concussion
19 post-concussive syndrome."

20 A. That's right.

21 Q. Okay. Did I read that accurately?

22 A. The -- I think --

23 Q. Did I read that accurately?

24 A. Yes, you did.

25 Q. Okay. **So** certainly part of the injury

1 to the brain, certainly you considered and cannot
2 rule out a temporary anoxic event contributing to
3 some **of** his brain damage, correct?

4 A. I could not rule that out, no.

5 Q. And anoxia is a lack **of** oxygen which
6 will enhance someone's injury when they've had a
7 traumatic brain injury, correct?

8 A. Or be the source of the brain injury.

9 Q. Sure. Exactly. But in this
10 particular case, you do not believe that the
11 hyperextension, hyperflexion injury, the blow
12 that he took that caused the jarring of his head
13 was not contributory to the traumatic brain
14 injury, do you?

15 A. No.

16 Q. He was cooperative and friendly as you
17 said throughout the exam, correct?

18 A. Yes.

19 Q. And certainly you're more likely to
20 get truthful and accurate information from
21 someone such as a Steve Frank because he was
22 being cooperative and friendly as opposed to
23 hostile and noncooperative, correct?

24 A. That's right.

25 Q. It's always better to have someone

1 that's answering you and not trying to -- to
2 dodge the questions, correct?

3 A. That's right.

4 Q. You're not a medical doctor, correct?

5 A. That's right.

6 Q. You are not a neuropsychiatrist, are
7 you?

8 A. No, I'm not.

9 Q. And in fact, you are not a
10 neuropsychologist either, correct?

11 A. No.

12 Q. My statement's accurate?

13 A. That's right.

14 Q. Okay. Dr. Afield, one of Plaintiff's
15 treating doctors, is a neuropsychiatrist. You're
16 aware of that, correct?

17 A. I -- I -- I don't know.

18 Q. Are you aware or has Mr. Corrigan
19 advised you of some of the world class
20 credentials that Dr. Afield maintains as a
21 neuropsychiatrist?

22 MR. CORRIGAN: Objection.

23 A. No.

24 Q. You have a master's degree in
25 rehabilitation counseling which is as I

1 understand it from the Department of Education at
2 Bowling Green, correct?

3 A. That's right.

4 Q. Not the Department of Psychology?

5 A. That's right.

6 Q. And you have been retained as an
7 expert in well over 100 cases to provide expert
8 testimony, correct?

9 A. Yes, I have.

10 Q. Doctor, neuropsychology is a -- or a
11 doctor that is a neuropsychologist is a
12 specialist in brain behavior relationships,
13 correct?

14 A. Yes.

15 Q. And you have never testified as a
16 neuropsychologist, have you, because you are not
17 one, correct?

18 A. There is -- may I explain?

19 Q. First answer my question.

20 A. I have never held myself out to be a
21 neuropsychologist.

22 Q. Neuropsychology is a subspecialty
23 within psychology, correct?

24 A. That's right.

25 Q. You are a rehabilitation psychologist,

1 correct?

2 A. That's right.

3 Q. You know Dr. Toth, correct?

4 A. Yes.

5 Q. You would agree that she has
6 impressive credentials, correct?

7 A. Yes.

8 Q. You are aware, are you not, that Steve
9 Frank was referred to Dr. Toth not by one of the
10 lawyers b t by one of his treating physicians?

11 A. I don't know how he got there.

12 Q. Well, certainly you took a history and
13 were provided with a plethora of information so
14 you would certainly know, would you not, how --

15 A. I'm sure it's available, yes.

16 Q. Okay. But as you sit here right now,
17 you're not aware --

18 A. I don't recall it, no.

19 Q. Okay. Dr. Toth is a
20 neuropsychologist?

21 A. I don't -- what I'm saying, I am not
22 familiar with how he got to Dr. Toth.

23 Q. But it wouldn't surprise you if
24 Dr. Toth -- that Steve Frank was referred to
25 Dr. Toth by one of his treating doctors as

1 opposed to by Dave Kulwicki or by Howard
2 Mishkind?

3 A. No, that would not surprise me.

4 Q. Okay. And certainly in Dr. Afield as
5 well, the referral came not from one of the
6 lawyers, it came from one of the treating
7 doctors.

8 A. That wouldn't surprise me.

9 Q. And certainly Dr. Toth you would agree
10 arrives at opinions in an ethical and legitimate
11 format, correct?

12 MR. CORRIGAN: Objection.

13 A. I have no opinion.

14 Q. Well, you have been asked that
15 question before, Doctor, and do you recall --

16 A. I recall being asked that question
17 before and I believe that I answered that I have
18 a great deal of respect for Dr. Toth. I know
19 Dr. Toth. Her credentials are quite impressive,
20 but she has a distinct plaintiff's bias from my
21 experience.

22 Q. Doctor, let me ask you again the
23 question that I just asked you. I asked you
24 would you agree that she arrives at her opinions
25 in an ethical and legitimate format and I think

1 you said you have no opinion on that. Is
2 that --

3 A. That's true. That's true.

4 Q. Okay. Now, Doctor, do you remember
5 the Trussel versus Edelman case?

6 A. No, I do not.

7 Q. Just in January of 1997. You were
8 cross-examined by Richard Nickodemo.

9 A. Yes.

10 Q. And was this question and was this
11 answer provided when you were asked about
12 Dr. Toth? "You know Dr. Toth, don't you?".
13 Dr. DeVies, you actually at that time said, "Over
14 the telephone."

15 A. Yes.

16 Q. "You would agree that she has
17 impressive credentials?". Answer, "Yes, she
18 does." "You would agree that she is well -- a
19 well-intentioned psychologist?". "Yes, I would. I
20 "That she's well-trained?". "Yes, I would."
21 "You're confident I'm sure that she arrives at
22 her opinions in an ethical and legitimate
23 format?". Answer, "Yes, I would."

24 A. Yes.

25 Q. Okay. And that certainly you would

1 agree with that?

2 A. I agree with that, yes.

3 Q. Okay. That's fine.

4 Now, the -- on your direct testimony
5 you indicated, and maybe I heard you wrong but I
6 marked it down at the time, you said that your
7 exam was June 13 of 1998. According to --

8 A. My exam -- I have the notes right
9 here. Oh, right here. February 12, 1998.

10 Q. Okay. I think you may have said --

11 A. I may have -- yeah, I may have said
12 June 13, but it's February 12th. I'm sorry.

13 Q. Your exam was February 12th. Your
14 report was generated approximately four months
15 later, in June of 1998, correct?

16 A. That's right.

17 Q. And you did not have an opportunity to
18 do all of the testing that you wanted to do
19 because Steve Frank had to go back home, correct?

20 A. That's right.

21 Q. Did you ever request an opportunity to
22 do any additional testing on Steve Frank?

23 A. Yes.

24 Q. You would certainly have liked to have
25 done additional testing, correct?

1 A. That's right.

2 Q. Then or at any other time, correct?

3 A. That's right.

4 Q. Well, Steve Frank was back up in Ohio
5 two months later to see Dr. Sokolov, and did you
6 request of Mr. Corrigan at that time for an
7 opportunity when Mr. Frank was up in Ohio for him
8 to see you for any additional testing?

9 A. I don't believe that I knew
10 Mr. Corrigan at that point other than maybe he
11 sat in on the deposition that I had with
12 Mr. Beck. I -- I don't recall. Maybe he was
13 there, but until Mr. Corrigan contacted me
14 regarding this current situation, so I would have
15 had no reason to call Mr. Corrigan.

16 Q. But suffice it to say, you would have
17 liked to have done additional testing, correct?

18 A. I complained about that, yes.

19 Q. You -- there is nothing in any writing
20 that -- that indicates to any **of** the attorneys in
21 this case that bring me back Steve Frank, I want
22 to **do** additional testing, correct?

23 A. There is no writing to that effect,
24 no.

25 Q. Okay. And you never told Steve Frank,

1 "Come on back and visit me again for additional
2 testing," correct?

3 A. I -- I expressed to him my
4 dissatisfaction.

5 Q. That he had to go back and that you
6 weren't able to finish things?

7 A. That's right. That's right. I didn't
8 feel it was my call. I had him for that period
9 of time and I explained to the attorney that had
10 hired me that I couldn't get the information he
11 wanted.

12 Q. Okay. And for whatever reason, that
13 attorney or subsequently Mr. Corrigan when you
14 were contacted by him never made arrangements to
15 resubmit Steve to you for any additional testing,
16 correct?

17 A. No.

18 Q. And you didn't get the sense from any
19 of the communication that Steve Frank was
20 unwilling to cooperate with regard to any
21 additional testing at a later point, did you?

22 A. I did get the impression, yes.

23 Q. Well --

24 A. I was told that he wouldn't -- didn't
25 want to come back.

1 Q. Well, do you have any explanation for
2 why he came back in to Ohio just two months later
3 after you had submitted your report, was seen
4 just maybe a mile -- an hour or **so** south of where
5 you are by Dr. Sokolov, a well-regarded
6 psychiatrist, and arrangements weren't made for
7 you to see him at that point? Do you have any
8 explanation for that?

9 A. I don't know -- I don't know why that
10 was.

11 Q. Okay. By the way, the dysarthric
12 slurring, that's indicative **of** a person with a
13 head injury where the cranial nerves have been
14 jarred, correct?

15 A. That's -- dysarthric speech occurs,
16 you know, in a head injury if the cranial nerves
17 are jarred, but it can also occur if there is,
18 you know, cortical problems, not just cranial
19 nerves.

20 Q. **Is** there a validity scale that is
21 available in the **MMPI** to determine whether or not
22 someone is providing biased or unbiased
23 testimony?

24 A. Yes.

25 Q. And did you perform the validity

1 scale?

2 A. His testing was computer scored and on
3 that, his -- his F score on the MMPI was 70 and
4 the interpretation of that is that there is
5 minimal denial of common, ordinary faults and
6 imperfection, average overall defensive, and a
7 very high level of uncommon responses. This
8 pattern suggests an extreme tendency to overstate
9 problems, a tendency to overemphasize problems,
10 suggests the possibility of motivational
11 distortion to portray emotional disturbance.

12 Q. What was his -- the K scale

13 A. The K scale was 45. The -- which is
14 in the normal range.

15 Q. Are you aware of Dr. Toth's validity
16 scale?

17 A. I have not seen Dr. Toth's report to
18 my knowledge.

19 Q. Okay. That wasn't provided to you?

20 A. Not this, no.

21 Q. Well, certainly in arriving at
22 opinions, you'd like to have as much
23 information --

24 A. Well, oftentimes they do not provide
25 us raw data.

1 Q. Okay. Are you aware of what
2 Dr. Afield testified to concerning the validity
3 scale?

4 A. No.

5 Q. Would you agree with me that a
6 neuropsychologist is in a better position than a
7 psychologist to discuss damage to a person's
8 brain and how the injury to the brain has
9 resulted in emotional problems or a change in the
10 person's personality?

11 A. A plain old psychologist or a
12 rehabilitation psychologist?

13 Q. I'm talking about the difference
14 between a neuropsychologist and a psychologist.

15 A. The neuropsychologist would be
16 superior.

17 Q. When someone sustains a traumatic
18 brain injury, they typically experience some
19 alteration in behavior or cognition, don't they?

20 A. Yes, they do.

21 Q. And when a patient sustains a closed
22 head injury, there is damage to the brain
23 structures that lie within the skull, correct?

24 A. Occasionally.

25 Q. You don't need to see evidence of

1 injury to brain matter on an MRI for a patient to
2 have sustained a closed head injury, correct?

3 A. No, you don't.

4 Q. And when a closed head injury takes
5 place, the brain is actually mobilized and the
6 brain collides with the skull on the opposite
7 side, correct?

8 A. Yes, it is.

9 Q. And this is typically -- typically
10 called rotational acceleration, isn't it?

11 A. Yes.

12 Q. And you can have rotational
13 acceleration of the brain in a rear end
14 collision, correct?

15 A. Yes.

16 Q. Especially such a violent collision
17 like the one that Steve Frank was involved in,
18 correct?

19 A. Again, I had not -- I don't recall
20 his -- I don't know how violent it was. If there
21 was damage, certainly in that I would expect that
22 it's possible certainly.

23 Q. Tell me what your understanding is in
24 getting the history from him as to how much
25 damage, how hard he was hit and the structural

1 damage to the back of the vehicle.

2 A. Well, I saw -- I think I saw a picture
3 and the back end of his vehicle was pretty well
4 destroyed. That would say to me that he probably
5 took a big hit from behind. But as an accident
6 scene investigator, I don't know these things.

7 Q. Sure. That's fine.

8 When a patient sustains a post
9 concussive syndrome, would you agree that they
10 routinely have cognitive deficits such as
11 problems with attention, concentration,
12 short-term memory and general declines in level
13 of performance over short-term on their intellect
14 and achievement?

15 A. Yes.

16 Q. You may also see depression,
17 volatility, hostility and emotions that are
18 uncharacteristic -- easy for me to say --
19 uncharacteristic of the patient before the closed
20 head injury?

21 A. Yes.

22 Q. Would you also agree that sensory
23 losses, hearing and vision loss is also seen in
24 patients that have sustained a traumatic brain
25 injury?

1 A. They -- they may have that without any
2 reference to the brain because of the damage to
3 the sensory organs themselves.

4 Q. As a consequence of the rotational
5 acceleration?

6 A. Well, actually I'm talking about just
7 damage to the organ itself, you know, from --
8 from pressure, you know, pushing out on the ear
9 drums or internally it creates that.

10 Q. But associated with the traumatic
11 event?

12 A. Yeah, and it would be difficult to
13 distinguish from a neuropsychological test
14 standpoint. Because the vision's bad or the
15 hearing's bad, is it caused because of the brain
16 or is it caused because of the organ? I think
17 you need an eye specialist or an ear specialist
18 who could tell that.

19 Q. That's something that you not being an
20 M.D. you would defer to others?

21 A. That's right.

22 Q. You would agree, however, that
23 fatigue, soreness, coordination difficulties,
24 eye/hand coordination, as well as headaches are
25 some **of** the physical complaints recognized in

1 mild brain injury resulting from a closed head
2 injury?

3 A. Yes.

4 Q. And some of the symptoms that are
5 associated with traumatic brain injury and a
6 closed head injury include the decreased
7 information processing, correct?

8 A. Yes.

9 Q. Impaired attention and concentration?

10 A. Yes.

11 Q. Memory loss, difficulties in problem
12 solving?

13 A. Yes.

14 Q. Difficulties in reasoning or judgment?

15 A. Yes.

16 Q. Mental inflexibility?

17 A. Yes.

18 Q. Social inappropriateness?

19 A. Occasionally, yes.

20 Q. Depression?

21 A. Yes.

22 Q. Social withdrawal?

23 A. Occasionally.

24 Q. Disturbance of sleep or appetite?

25 A. Yes.

1 Q. And can we agree that an individual
2 can sustain a post-concussive syndrome closed
3 head injury without having a loss of
4 consciousness?

5 A. The debate is open. I don't -- I'm
6 open to that possibility and I believe that was
7 asked in my deposition. I have heard it argued
8 both ways and I think I have seen it won both
9 ways, but it was discussed at length in my
10 deposition and I had always taken the other
11 position, but in fact I had been to a trial and
12 lost because I took that -- that the neurologist
13 felt that it could and I --

14 Q. **So** you would certainly recognize that
15 a patient can sustain a brain injury without
16 having a loss of consciousness?

17 A. At this point I would say I would
18 concur on the basis of some light experience with
19 that opinion.

20 Q. You know Dr. Howard Sokolov, don't
21 you?

22 A. I don't know him. I have encountered
23 him. I mean I -- again --

24 Q. Do you know him by reputation?

25 A. -- I know him by reputation and I have

1 made a referral to him through another committee,
2 not related to this case at all.

3 Q. And you have considered him I believe
4 from other testimony that I have to be a very
5 competent and objective neuropsychologist, don't
6 you?

7 A. Yes, I do.

8 Q. Were you aware at any time prior to
9 the day that **Dr.** Sokolov had examined Steve and
10 wrote a report in this case?

11 A. Yes.

12 Q. And you would have learned that from
13 this gentleman seated to my left, Mr. Corrigan,
14 right?

15 A. No, no. I believe Mr. Beck made that
16 referral.

17 Q. You believe Mr. Beck made the referral
18 to Dr. --

19 A. I believe he did, yeah. I believe he
20 did.

21 Q. Fine. In any event, I have a report
22 written to Mr. Corrigan dated November 15, 1998
23 that Dr. Sokolov wrote to Mr. Corrigan. Have you
24 seen that report?

25 A. No, I haven't.

1 Q. Certainly you're not in a position to
2 disagree with Dr. Sokolov where he says that
3 Steve Frank in his professional opinion to a
4 reasonable degree of medical certainty has a
5 permanent cognitive disorder and has organic
6 brain damage mild in severity -- severity, are
7 you?

8 A. I think that's consistent with what I
9 said.

10 Q. Okay. Now, Steve Frank took longer
11 than you expected for him to have taken with the
12 test, correct?

13 A. Yes.

14 Q. When patient -- when patients have
15 mild traumatic brain injury and they have bouts
16 of depression, do they function worse at that --
17 during those periods of time?

18 A. Yes.

19 Q. Are you aware of what Steve Frank's
20 situation was with regard to his employment at or
21 around the time that he came up from Florida to
22 see you?

23 A. I think he had started to work for
24 another company down there.

25 Q. Are you -- are you aware of whether or

1 not he had recently had a failure with regard to
2 his employment down in Florida or whether he was
3 succeeding with his employment?

4 A. The -- I don't know if he was
5 succeeding or failing. I don't know.

6 Q. Okay. And certainly if he was
7 failing, based upon the level of the cognitive
8 deficits that he had experienced as a result of
9 the collision, would you expect that a patient
10 would have more difficulty handling changes in
11 life such as depressive episodes associated with
12 a failed employment situation?

13 A. Again, I -- it was a long question.
14 I -- I -- I -- if -- if I understand your -- your
15 question correct, do I understand him being
16 depressed both because he has a history of these
17 brain difficulties and he's having some social
18 stressors at the same time? Is that essentially
19 what you asked?

20 Q. Is someone less able to handle social
21 stresses when they have a mild traumatic brain
22 injury?

23 A. Yes, that's true.

24 Q. So that if someone has a failure in a
25 particular employment situation, they're less

1 able to handle those kind of stresses, correct?

2 A. I believe.

3 Q. And also the mild traumatic brain
4 injury and their cognitive abilities can also
5 contribute to their inability to function at
6 higher levels?

7 A. In all probability, yes.

8 Q. Okay. And certainly you would agree,
9 and I just have a few more questions for you,
10 Doctor, given the time that it is and I know the
11 Arbitrators are probably getting tired of
12 listening to my questioning, that a person that
13 suffers traumatic brain injury that has permanent
14 residuals from the injury, that person is at
15 increased risk of being unable to maintain
16 personal relationships, correct?

17 A. I believe that's true, yes.

18 Q. And would you also agree that it's
19 common for someone with traumatic brain injury to
20 have personality changes and emotional changes,
21 including depression?

22 A. Yes.

23 Q. Finally, Dr. DeVies, if a person has
24 traumatic brain injury such as Steve Frank and
25 it's permanent, the emotional and personality

1 problems that are common in this type of an
2 injury can have a very extreme effect in the
3 person's ability to have a healthy and enjoyable
4 life, correct?

5 A. Correct.

6 MR. MISHKIND: I have no further
7 questions. Thank you.

8 REDIRECT EXAMINATION OF ROBERT K. DeVIES, Ph.D.
9 BY MR. CORRIGAN:

10 Q. Dr. DeVies, you administered a number
11 of tests to Mr. Frank. How did he do on those
12 tests, the other tests in terms of IQ and other
13 results?

14 MR. MISHKIND: Let me just object
15 because this is beyond the scope of
16 cross-examination.

17 A. He -- he did -- he did very -- very
18 well. He had an estimated IQ of 109 which falls
19 very near the bright normal range. His visual
20 motor coordination was certainly quite adequate,
21 at least to -- up to the level of the test which
22 was a 12-year old. We were well past that.

23 I believe, if I look in the file, that
24 he was reading at the 93rd percentile, better
25 than 93 out of every 100 people, in word

1 recognition. His arithmetic was at the sixth
2 grade level or at the 10th percentile which is
3 much lower, and certainly the performance on
4 arithmetic was much lower, but reading -- reading
5 was very high. Arithmetic was very low.

6 Q. Okay. Doctor, Mr. Mishkind asked
7 about your not being a neuropsychologist. Was
8 there such a thing as a neuropsychologist when
9 you obtained your doctorate?

10 A. Well, there was, but they were
11 predominantly research. There weren't clinical
12 neuropsychologists. I -- rehabilitation
13 psychology, rehabilitation psychologists are
14 trained in neuropsychology. They don't limit
15 their practice because they deal with other kinds
16 of things.

17 Q. Do you have any memberships in
18 societies or academies related to
19 neuropsychology?

20 A. I'm in the Division of Neuropsychology
21 as well as the Division of Rehabilitation
22 Psychology of the American Psychological
23 Association. I was elected to membership in the
24 Ohio Academy of Neuropsychology.

--
25 MR. CORRIGAN: Thank you, Doctor. I

1 have nothing further at this time.

2 MR. MISHKIND: Nothing -- nothing
3 further. Thanks.

4 MR. CORRIGAN: Thanks. I m trying to
5 keep it brief.

6 Doctor, you have the right to review
7 your transcript or --

8 THE WITNESS: I'll waive.

9 - - - - -

10 (Videotape deposition was concluded a,
11 7:27 p.m.)

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