In The Matter Of:

BONNIE PIKKEL, ET AL v.
MARK ZANNETTI, D.C., ET AL

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IN THE DISTRICT COURT OF CUYAHOGA COUNTY, OHIO
COMMON PLEAS COURT

BONNIE PIKKEL, ET AL.,)
Plaintiffs,)
vs.) No. 326207
MARK ZANNETTI, D.C., ET AL.,)
Defendants.)

The deposition of HERBERT H. ENGELHARD, M.D., called for examination, taken pursuant to the provisions of the Code of Civil Procedure and the Rules of the Supreme Court of the State of Illinois pertaining to the taking of depositions for the purpose of discovery, taken before LORIANNE McGUIRE, CSR No. 84-4269, a Notary Public within and for the County of Cook, State of Illinois, and a Certified Shorthand Reporter of said state, at Suite 1000, 155 North Wacker Drive, Chicago, Illinois, on the 25th day of April, A.D. 2001, at 1:45 p.m.

PRESENT:

LINTON & HIRSHMAN,
(700 West Saint Clair Street, Suite 300,
Cleveland, Ohio 44113), by:
MR. ROBERT LINTON,
appeared on behalf of Plaintiffs;

LAW OFFICE OF MARK RUFF,
(700 West Saint Clair Street, Suite 300,
Cleveland, Ohio 44112), by:
MR. MARK RUFF,
appeared on behalf of Plaintiffs;

WESTON HURD FALLON PAISLEY & HOWLEY,
(2500 Terminal Tower, 50 Public Square,
Cleveland, Ohio 44113), by:
MR. KENNETH A. TORGERSON,
appeared on behalf of Defendants;

PRESENT: (continued)

REMINGER & REMINGER,
(113 Saint Clair Street, Suite 700,
Cleveland, Ohio 44113), by:
MS. LINDA GORCNNSKI,
appeared on behalf of Defendants.

REPORTED BY: LORIANNE McGUIRE, CSR NO. 84-4269.

(WHEREUPON, certain documents were marked Deposition Exhibit Nos. A-C, for identification, as of 4-25-01.)

(WHEREUPON, the witness was duly sworn.)

HERBERTH. ENGELHARD, M.D., called as a witness herein, having been first duly sworn, was examined and testified as follows:

EXAMINATION
BY MR. LINTON:

Q: Doctor, good afternoon. My name is Bob Linton. We met just a minute ago. Mark Ruff is on the line as well. The two of us represent Bonnie Pikkel and her husband in a lawsuit in which you've been retained by the emergency room doctor and his professional corporation as an expert in this case specifically in neurosurgery.

I assume you've been deposed before?

A: Yes, sir.

Q: Have you produced for us and do we

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have in front of us your entire file in this case?
A: Yes.
Q: Has there been anything removed at any time from this file?
A: No.
Q: Aside from the literature that is contained in Dr. Bell's deposition, have you independently reviewed or researched the literature in connection with this case?
A: A Little bit. To answer the question more fully, I'd say that, you know, I've had patients with this condition so I've been aware of the literature. When I was fist contacted about this case, I looked at some of the literature.
Over the past few weeks, especially since literature was in one of the depositions, I looked at some literature, various papers and book chapters. As I sit here today, I couldn't tell you all the authors of those.
Q: Did you keep a file either a hard file or a computer file of the research that you've done in connection with this case?

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MR. RUFF: Excuse me, this is Mark Ruff. I cannot hear the doctor at all.
THE WITNESS: I'll sit a little closer, sorry about that. Is this better?
MS. GQRCNNSKI: That's much better.
MR. RUFF: Bob, if you could try and keep your voice up, that would be helpful as well.
MR. TORGERSON: They're too polite at this point and too soft spoken.
MR. RUFF: I completely missed the answe I didn't want to interrupt his answer. Go ahead.
BY MR. LINTON:
Q: Just so we're clear the question is. have you retained a file of the research that you've done in connection with this case?
A: I don't have — I have a file in my office that has a few articles on cauda equina or lumbar disks and an abstract or two I might have thrown in there. But as far as a file specifically for this case with cauda equina articles for instance or other relevant articles, no.
Q: Can you identify any of the articles

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that are in your current cauda equina file?
A: No, although there was some overlap with what was in the one deposition and article by Dr. Shapiro, for instance, from 1993.
MR. RUFF: I'm still having problems hearing.
(WHEREUPON, discussion was had off the record.)
MR. LINTON: We'll have to do the best we can because we can't be screaming and the phone is close as it can get.
BY MR. LINTON:
Q: Just so we can get back on track, you were identifying for us what articles ate in your cauda equina file. You mentioned some overlap with Shapiro including an article from 1993.
Any other articles or abstracts in your file that you can recall?
A: There are other articles and abstracts in the file. I know that there was an article from surgical neurology now that I think about it in 1998 from a Japanese group. But really as far as the specific authors and so forth, I

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can't remember.
Q: Would you be willing to provide to us at our expense a copy of your file as it now exists?
A: If that's okay with Mr. Torgerson.
MR. LINTON: Do you have any objection to that, Ken?
MR. TORGERSON: I don't know. I'll just make an objection for the record, but I suspect we'll be glad to do so.
BY MR. LINTON:
Q: Doctor, aside from what's in that file, can you recall any articles you'd have looked at in connection with this case?
A: Well, what I did on a couple of occasions was just to scan through abstracts and articles using an Internet search just to refresh my memory and make sure I hadn't omitted any critical articles.
I didn't really print all those out. I just sort of read them because there's hundreds of articles as you know, if not thousands, on this and related subjects. So I didn't want to print them all out, but I just

did do a search through an Internet through med line.
Q: What did you use as your search term?
A: Oh, let's see, I did a search cauda equina, I looked through some articles on lumbar disk herniation.
MR. RUFF: Hello.
MS. GORCNNSKI: It just got a lot worse.
MR. RUFF: I can't hear at all,
BY THE WITNESS:
A: I looked through some articles on lumbar disk herniation. I looked through some articles on urinary problems. I can't think of anything else as a sit here right now.
BY MR. LINTON:
Q: Are you able to identify any other. specific articles you looked at besides the ones we've just identified and those contained in Dr. Bell's deposition?
A: No.
Q: Would there be any way to reconstruct that at this point without —
A: I could do more searches but that might not tell exactly which articles I was

looking at, but I could do some more searches.
Q: Did you do a search of the literature before you prepared your report in this case specifically for this case?
A: As I sit here today, I do not recall. It's more likely than not that I did, but these topics are something I deal with if not everyday every week. So you know, I may have just looke into it a month before. I really can't say.
Q: You have no record that you can look to now that would show the jury for sure that you had done a literature search specifically for this case before preparing your report, can you?
MR. TORGERSON: Note an objection. But yo may answer.
BY THE WITNESS:
A: Correct.
BY MR. LINTON:
Q: *Your* report is identified as Exhibit A. That's dated September 17, 1999?
A: Yes.
Q: Is that the only report you prepared in this case?

A: Yes.
Q: I note the handwritten word bladder on the second page. What's the significance of that?
A: Well, the significance of this is, of course, I was contacted back in 1999 to review some records, and I agreed to do so. I generated this letter or report to Ms. Chrisafi. As the case developed and I was sent more information and more depositions, I made a couple little designations on this letter which is certainly sort of as you can see a preliminary short page and a half report or letter.
I put the word bladder over nerve roots because at the beginning of Page 2 it says, "My opinion is that Ms. Pikkel's nerve roots were damage prior to her presentation," and I wanted to clarify in my known mind what I meant by that. Nerve roots is a pretty general term, and what I meant by that is that the nerve roots going to her bladder and for the control of her bladder.
Then I put C.E.S. at the bottom. As

you know, this has sort of developed into a big discussion about cauda equina syndrome, and that's what that stands for. Those are the *two* little notations I made on it.
Q: What were the specific nerve roots in the bladder that were damaged?
A: Well, we usually think of the sacral roots I guess through S5 going to the bladder, and we may not be able to tell exactly which one of those was damaged. Usually it's going to occur bilaterally in order to cause that sort of a problem. So I would say because we know that her bladder was having malfunction, those sacral nerve roots. That's what I meant.
Q: Those sacral nerve roots being some or all of the nerve roots most likely bilaterally from S2 to S5?
A: Correct.
Q: Did you actually review the films themselves?
A: Yes.
Q: Do you have those with you or do you have those back in your office?
A: I don't have a copy of those right

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now. My recollection is that I mailed them to someone, but I did look at the actual films.
Q: Was your interpretation consistent — strike that.
Was your interpretation the same as Dr. Bell's and the radiologist that reviewed them?
A When I looked at the films, my recollection is that as far as what the radiology report said about them, I was pretty much in agreement with that.
THE WITNESS: Are you hearing me better?
MR. RUFF: I'm having a lot of trouble here. I'm wondering if when you guys picked the phone up you did something with the speaker volume.
(WHEREUPON, discussion was had off the record.)
BY MR. LINTON:
Q: Does your report identify the items you would have reviewed before preparing the report?
A: Yes.
Q: What is your understanding of

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Ms. Pikkel's current condition?
A: I don't have one.
Q: Let me rephrase that. That was a bad question.
What is your most recent account of her medical condition as it relates to the issues you'll be testifying to in this case?
A: Well, the most recent account that I can recall, and I probably have to check through the records to be exactly sure, but she was continuing to have bladder problems, possibly some bowel problems and numbness in her perineal region. So that sometimes was a continuing chronic problem. Now whether she still has that today, I don't know.
Q: Can you identify specifically what record you're referring to?
A: Let's see.
MR. RUFF: You guys have completely cut off.
MR. LINTON: We're not talking. He's reviewing records.
WHEREUPON, discussion was had off the record.)
BY THE WITNESS:

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A: I would say that that opinion comes from Dr. Bell's records and probably his deposition as well, and it might come from what Ms. Pikkel related in her deposition. Again, I don't know if that is true as far as what injuries she still has, if any, today.
BY MR. LINTON:
Q: Are all of her bowel, bladder, and perineal numbness problems a direct cause of the cauda equina syndrome?
A: I would say, no. We would have to break those down if you wanted my opinion about each individual thing.
Q: What is the cause of her bladder problem?
A The bladder problem according to my review of the records started with the manipulation by the chiropractor Dr. Zannetti.
I would say the — just to finish up the answer of the question, the bowel problems and the numbness problems really became apparent and continued, of course, after her presentation to the emergency room on I believe it was the 5th; in other words, the second time she came

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back to the emergency room. So I think that answers your question. Despite the surgery, those three things continued.
Q: Can we agree that all three of her problems, bladder, bowel, and numbness are due to the disk herniation?
A: Yes.
Q: Would you agree this is a case of acute cauda equina syndrome?
A: Well, we'd have to define cauda equina syndrome. And really according to the definition of cauda equina syndrome, this was acute, yes, as far as if we think about her presentation to the emergency room on the 5th; in other words, the second time back. It was certainly an acute problem at that time.
Really to characterize it better at its worst I'd say it was a partial cauda equina syndrome. It was not a full cauda equina syndrome.
Q: How do you define partial as compared to full?
A: Well, the full syndrome you could look at Dr. Shapiro's article for instance, there is

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pain, there is numbness, there is weakness, and there is bowel, bladder involvement. Those things constitute the cauda equina syndrome.
She never Rad much in the way of numbness going down her legs or weakness of her legs to make it the *full* syndrome. *So* I would say she had a partial cauda equina syndrome at best — or at most I should say.
Q: From your perspective.
A: Maybe worst. That's what she had immediately prior to the surgical intervention on the 5th.
Q: Let me see if I'm understanding you correctly. You would define a full cauda equina syndrome to include pain, numbness, weakness, and bowel and bladder disfunction?
A: Correct.
Q: Because she did not have numbness into her legs or weakness in her legs, it would be an incomplete cauda equina syndrome?
MR. TORGERSON: I'm just going to interpose an objection, I think it's vague. Go ahead.
BY MR. LINTON:
Q: Am I understanding you correctly?

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A: It wasn't a complete cauda equina syndrome. It wasn't the cauda equina syndrome, for instance, that is dealt with in the Shapiro articles because it doesn't have all the features of the syndrome. Syndrome means symptoms or findings running together.
Q: So I'm clear, the symptoms that were lacking from the full syndrome were numbness in the legs and weakness of the legs?
MR. TORGERSON: Objection. You may answer.
BY THE WITNESS:
A: I think those are the main findings. The syndrome may also have positive straight leg raising, but yes.
BY MR. LINTON:
Q: Take as much time as you need. I don't need to try to trip you up or misconstrue what you're saying. I want to understand what your working definition of a full syndrome is.
A full syndrome would include pain, numbness in the legs, weakness of the legs, bowel and bladder disfunction, and possibly straight leg raise?
A: Yes, and the pain would be expected to

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be severe and in the **back** and that **may** be radiating down the legs as well.
Q: Now, from a mechanical standpoint the reason why you have a full syndrome is that more of the nerve roots in the cauda equina would be compressed as opposed to only some of those nerve roots being compressed?
MR. TORGERSON: Objection.
BY MR. LINTON:
Q: Is that mechanically what happens?
A: Yes.
Q: In terms of whether it's acute or chronic or subacute, how do you define acute in terms of a time frame?
A: Well, you kind of answered the question right. It's in terms of the time frame. You know, different articles have said 24 or 48 hours, maybe some people put it at 72 as far as acute. Other authors have put a 72-hour time period or maybe a little bit longer in the subacute category. Chronic is definitely being there for several days, weeks, months.
But I think for all practical intense and purposes we could say the acute would be in

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that 24, 48 hour time range.
Q: Now, the actual disk herniation in your opinion occurred at the time of the chiropractic manipulation?
A: I think that's when it started, yes.
Q: Can we agree that it is reported in the literature that chiropractic manipulation can, in fact, cause a cauda equina syndrome?
MR. TORGERSON: Objection. But go ahead.
BY THE WITNESS:
A: Yes.
BY MR. LINTON:
Q: That was something that you were aware of as your experience and training as a neurosurgeon before you reviewed this case; isn't that right?
MR. TORGERSON: Objection. But go ahead.
BY THE WITNESS:
A: Yes, if you look for them, you could find a couple of articles on that. Now, weather that's, I mean, everyone's general fund of knowledge, you know, I can't say that. But I was able to find in my literature searches a couple of articles relating cauda equina

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syndrome to chiropractic manipulation, yes.
BY MR. LINTON:
Q: Can you explain exactly how that occurs, what mechanically actually happens?
A: Well, I might not be able to explain it exactly. I think that, number one, someone is going to the chiropractor if they're having back pain because they may have a problem in the fist place. The disk has two different components; there's an outer annulus and an inner nucleus. If the annulus has a crack in it for instance, that could be a cause of pain.
Then if that area is moved thinking of it, that crack could widen or there could be more pressure on the disk that would cause some of that inner material to come out more. So it has been reported and it does make sense to me if the disk is being manipulated in some way.
Q: Does the mere fact that someone like Bonnie Pikkel gets cauda equina syndrome from chiropractic manipulation meaning the chiropractor made a mistake or deviated from the standard of care in terms of how he did the manipulation?

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MR. TORGERSON: Objection. I think you're asking him a standard of care question on the chiropractor for which — *is* that what you're doing? He's not really testifying about that.
BY MR. LINTON:
Q: Let me ask it this way, whether it was a chiropractor or whether it was a physical therapist or whether it as an orthopedic surgeon or a neurosurgeon for that matter, simply because we have cauda equina syndrome resulting from manipulation does not mean that the manipulation was done improperly?
MR. RUFF: Objection.
BY MR. LINTON
Q: Is that true?
MR. TORGERSON: Objection.
BY THE WITNESS:
A: I think that's true. I can agree with that. I'm not necessarily saying correct, that a manipulation was done improperly. People have back pain all the time, and they get manipulated, and I couldn't say that their — again, I'm not a chiropractor, but I can't say that the manipulation was done improperly to cause it, that is true.

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BY MR. LINTON:
Q: Now, is it your belief that there was partial herniation that then led to a more complete herniation between the time of the manipulation and the time of Bonnie Pikkel's second presentation to the ER?
A: Could you read that back. I lost it.
BY MR. LINTON:
Q: Let me rephrase it, sure. Maybe I should ask it this way.
MR. RUFF: Bob, I'm going to hang up. I can't hear. This is not useful to me to listen in.
(WHEREUPON, discussion was had off the record.)
BY MR. LINTON:
Q: You believe, Doctor, that there was fist interference with bladder function and then at a later point in time the numbness with interference with bowel function?
A: Right.
Q: Did I say that correctly?
A: Yes, there was interference with

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bladder function and at a later time there was inference with bowel function. There was some temporary numbness that cleared up and then numbness returned at or right before the time she went back into the emergency room the second time.
Q: You're basing that conclusion on the medical records, specifically the ER records?
A: *Yes,* but I also have read depositions so.
Q: Let me ask it this way.
A: But primarily I'm basing it on the medical records, that is correct.
I'm just going to try to talk into phone.
Q: Specifically the fact that the second ER record noted there was a problem with bowel function and the first ER record noted that there was numbness which has since resolved, correct?
A: Yes, that's part of it; yes, sir.
Q: What else can you point to in the materials that you've reviewed that support your view that those were new symptoms that arose

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between the first ER and the second ER visit?
A: In term of the bowel function?
Q: Bowel and numbness, yes.
A: Just the records that I reviewed, the medical records, and the account of the history and the findings in the two different ER visits.
Q: Does it matter in terms of your opinions on causation whether those were problems that developed immediately after the manipulation or whether those were new problems that developed between the first visit and the second visit to the ER?
A: To a certain extent, yes, it would matter.
Q: How would it matter?
A: If the problem started with the manipulation — and I'll try to get out my opinions here more than are on this little report. The problems starting with the manipulation, for instance the bladder.
By the time she came into the emergency room and could have gotten into surgery, it was basically too late. The damage to the delicate nerves going to the bladder had

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already occurred. Even if surgical decompression had been done earlier, it's my opinion that she would have had a very high chance of permanent or long-term damage.
Numbness, take the issue of numbness, that actually is similar. I think that when you have a disk compressing nerve roots in the cauda equina region, once you get bladder difficulty and numbness as a surgeon you should certainly not guarantee your patient or even lead them to believe that you're probably going to be able to reverse that. They're very delicate nerves, permanent damage is very likely.
But by the same token, the doctors really did not have a cauda equina syndrome. They never had a full cauda equina syndrome presenting to them. They had a partial cauda equina syndrome and reason to look at the cauda equina closely when she came into the emergenc room the second time, and she definitely had bowel findings at that time. So her picture was that of a progressive one.
Q: Let me get back to the question I asked previously and that is, does it matter in

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terms of causation; and that is, would there have been an increased likelihood of successful surgery if the symptoms all occurred immediately at the time of manipulation versus some of those symptoms occurring between, in your opinion, the fist visit and the second visit?
MR. TORGERSON: Objection. But go ahead.
BY THE WITNESS:
A: Now I think I understand your question a little better. I would say that right after the manipulation if Ms. Pikkel had developed a more characteristic cauda equina syndrome, if that had happened, it might have made a difference because — well, I won't say because. I'll wait for you to ask me.
BY MR. LINTOM:
Q: Why is that so?
A: If she presented to the emergency room the first time with a full cauda equina syndrome, I have every reason to believe that would have been picked up like it was when she came back in the second time. It wouldn't have been as difficult to diagnose at that point. I think the surgeon would have been called in

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earlier.
Q: Assuming that the surgeon is called in during the fist visit and further assuming that her symptoms existed at the time of the first visit, that is perineal numbness, interference with bowel function, interference with bladder function, there would have been a higher chanc of a successful surgery than if it was done the second time — wait, let me back up.
MR. TORGERSON: Let me interpose an objection. But go ahead.
BY MR. LINTON:
Q: Let me back up to make sure we're not mixing apples and oranges here. I want to talk about two points in time for surgery; Number 1, after the first visit, and Number 2, after the second visit.
A: Okay.
Q: Now, under your scenario in which this was a partial syndrome because the bowel disfunction and the numbness did not begin unt the second presentation, you're saying there was a high chance that there would be no difference with the surgery; is that in essence your

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opinion?
MR. TORGERSON: I'm going to object, and I'm going to ask that you read the question back so I can hear it again.
MR. LINTON: Withdrawn.
BY MR. LINTON:
Q: Doctor, have you testified in other cauda equina syndrome cases?
A: Yes.
Q: How many other cases?
A: One that I recall.
Q: Did you do that for the patient or for the doctor or hospital?
A That was for a doctor.
Q: What was the issue in that case?
A: The issue — again, this was a few years ago so I have to apologize. I don't really have all the details of *the* case, but it was —
MR. TORGERSQN: Let me just interpose an objection. But go ahead.
BY THE WITNESS:
A: It was something to the effect that an epidural injection or epidural catheter had

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caused a cauda equina syndrome and that that should have been recognized earlier.
BY MR. LINTON:
Q: Was there likewise an issue in that case if it had been recognized earlier that there could have been surgical intervention that would or would not have made a difference?
MR. TORGERSON: Objection to the foundation of the question. Go ahead.
BY THE WITNESS:
A: Well, it was a complicated case but that was probably part of that. They thought that there should have been earlier surgical intervention, yes. That was the hypothesis that the plaintiff had.
BY MR. LINTON:
Q: In that case you had both an issue as to standard of care as well as causation?
MR. TORGERSON: Objection.
BY THE WITNESS:
A: I would say so.
BY MR. LINTON:
Q: Would hired you in that case?
A: I don't recall. I could probably find it in my records.
Q: What record would you look to?
A: What I do is I look back through my tax records for the billing. I think it was in Wheaton County or in Wheaton, Illinois. You'd think I'd know the attorney's name or the patient's name, but I just don't. I'd have to go through my tax records and find a bill.
Q: Would you go in and do that and provide a copy to Mr. Torgerson?
MR. TORGERSON: Note an objection. But go ahead, Doctor.
BY MR. LINTON:
Q: I'll be happy to pay your professional time, you or your staff.
A: I have a lot of tax records. If Mr. Torgerson says I should do that, I will do that.
Q: When was that case approximately?
A: Again, I think it was about — it was probably about three years ago, could have been as long as five years ago.
Q: Did you give trial testimony in that case?

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A: Yes.
Q: Did that result in a verdict?
A: Yes.
Q: Was the verdict in favor of the doctor?
A: Yes.
Q: What was the time involved in that case in term of the alleged delay?
A: I don't recall.
Q: Do you recall if it was *24* hows or *48* hours?
A: Don't recall.
Q: When was the last time that you personally treated a patient surgically with cauda equina syndrome?
A: I've treated two this year.
Q: Surgically?
A: Yes.
Q: How long after onset of symptoms did you perform the surgery?
A: One was several days so it would be in the subacute or chronic category, and one was after several months. You know what, I don't think I did a surgery on that one. I had a

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patient with cauda equina syndrome that was so severe and so long-standing and she had such medical risks, I don't think I did a surgery.

Q: The one with several months?

A: Yes. But those are the two patients that come to mind this year.

Q: Are you far enough out to see if there's been any improvement in bowel or bladder function on the patient you performed surgery

A: I tell them it's an individual matter, that we hope that there will be a recovery as a

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matter of fact, but we can't guarantee recovery. In other words, recovery — and let me clarify, I'm sorry.

Do we want me to focus on bowel and bladder? Focusing on bowel and bladder I tell them there may be some recovery. I hope there is some recovery. I would think it would be more likely that the recovery would take place within a year or less, but I think it Would be possible for a recovery to occur over a longer period.

I also tell them that it may be possible that despite intervention and even rapid intervention they may continue to have that permanent problem with their bowel and their bladder. So I think that answers it.

Q: If I understand you correctly then, you tell them that there would be probable improvement within one year and possible improvement thereafter, am I understanding you correctly?

MR. TORGERSON: Note the objection. I think he testified to what he said, and I would let the record stand.

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BY THE WITNESS:

A: You know for bowel and bladder, I don't use the word probable. If I used that in my answer, I shouldn't have. I hope that they would get better, but I'm very —

BY MR. LINTON:

Q: Let me just stop you.

A: It's not —

Q: We're on two different waive lengths here. I understand that you're not talking about a probability of recovery from the surgery.

What I'm actually talking about if there is improvement, you would expect that improvement to probably occur within one year, and there is still a chance of possible improvement thereafter?

MR. TORGERSON: Objection. But go ahead.

BY THE WITNESS:

A: I think that would be a fair characterization, yes.

BY MR. LINTON:

Q: You would not tell the patient that if they had not recovered within one year that

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there would be probable improvement thereafter?

MR. TORGERSON: Objection.

BY THE WITNESS:

A: Correct.

BY MR. LINTON:

Q: What is the longest from surgery that you have seen improvement of bowel or bladder function in a case of acute cauda equina syndrome?

A: Well, I'd have to say that after a year or two I'm usually not following the patient because the patient is usually being followed in a rehabilitation facility as an outpatient or by a urologist or a neurologist. So me as the neurosurgeon several years out, I'm probably not continuing to see the patient.

So I don't know if that plays into your question. You may want to ask it again. I'm not sure that I answered it. I'm usually not telling people at one year or later as a neurosurgeon. What I'm telling them in their more — in their period that is closer to the time of surgery what I'm telling them is based on the literature, based on wh at I've been told,

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you know, by urologists and so forth. But their care at that time is usually not by me as the neurosurgeon.
Q: Can you say how long after surgery there can be bowel or bladder improvement based on any specific literature?
A: I couldn't give a specific time frame, no.
Q: Is it fair to say that at this point in time with Bonnie Pikkel being this long after surgery that she's probably as good as she's going to get in terms of bowel and bladder function?
MR. TORGERSON: Objection.
BY THE WITNESS:
A: Well, I couldn't say. That's why to clarify in the letter I put in the last sentence of the first paragraph, as you know a more current report from a urologist as not been received.
So to answer that question as precisely as possible, I think that if we needed or wanted or be desirable to assess her bowel and bladder function by a urologist or someone

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who is trained to do that. I think as a general principle the longer the time is without recovery, the less likely it is to get it, but I'm not ruling out the possibility. It could happen.
BY MR. LINTON:
Q: You certainly can't say with reasonable medical certainty that it will happen in Bonnie Pikkel's case, can you?
MR. TORGERSON: Objection.
BY THE WITNESS:
A: Just let me see if I understand the question, as far as where she's at today with her bowel and bladder function, I would not say that in a year from now, say the year 2002 or something, that she would be better than the way she is 2001, that is correct. I'm just not real sure where she is at currently as I've answered before.
BY MR. LINTON:
Q: I understand. The patient with acute cauda equina syndrome you treated this year, you used the word several days after onset. Do you recall if it was beyond 48 hours?

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A: It was so I didn't mean to say that patient had acute cauda equina syndrome. He was subacute to chronic area.
Q: Is there any difference in likelihood of successful surgery if it is a subacute case as opposed to an acute case of cauda equina syndrome?
A: Well, that depends on what you mean by successful. I think, for instance, in that person or if someone has a subacute cauda equina syndrome you weigh the risks and the benefits, but in general it's worth doing the surgery.
But if you're talking about successful meaning absolutely normal in terms of normal strength, normal sensation, normal bowel function, normal bladder function, I think that would be very, very — I wouldn't say very, very m e ; but I think it could happen, but it would not usually be the case.
Q: Let me see if I could phrase it differently. You've answered the question.
Do you keep records on the number of procedures you do and the type of procedures you've done?

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A: No, the records go into the hospital files.
Q: There would be no way now to go back to your office and reconstruct how many acute cauda equina syndrome cases you've handled, would there?
A: Correct.
Q: When was the last cauda equina syndrome case you handled before this year?
A: Well, I'd say in a general way either myself or someone in our group or in past groups sees one every year or two. It's fairly rare. It's maybe one or two percent of lumbar disk herniation, something in that range.
Q: You're speaking now of acute cauda equina syndrome?
A: Yes.
Q: Can you recall as you sit here the last case of acute cauda equina syndrome you personally handled?
A: I think there was one due to an infection a couple of years ago so it wasn't a lumbar disk case; but otherwise, no.
Q: Would you be able to say with any

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degree of probability the number of cases that you personally have done surgery on for acute cauda equina syndrome?
MR. TORGERSON: Objection.
BY THE WITNESS:
A: Certainly less than ten, maybe — probably closer to five. Again, they're pretty rare.
BY MR. LINTON:
Q: Can you recall as you sit here the circumstance of any specific acute cauda equina syndrome case you've handled?
A: No.
Q: If you were called in like Dr. Bell was, would you have recommended surgery on this patient?
A: Yes.
Q: Do you have any criticisms of Dr. Bell in terms of the procedure he performed or the way he performed it?
A: In reviewing the operative report, I thought it was unusual that he used the laser. I think that was an option. I don't think most people are using the laser at this point. I

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wouldn't call that a criticism. It was just something I noted reading his operative report.
I also noted that he had the dural tear. Again, that is certainly something that could happen in this kind of a surgery. It could also have caused a nerve root injury. I'm not saying that it did. I'm saying it's possible.
If the dural tear was made by the laser, it could have caused a nerve root injury. I just don't know. I'm not going to be critical of him in saying that that was negligent, but these are things I noted and I think you want to know in this discovery deposition.
Q: I appreciate that. Let me just make sure that I'm hearing you correctly. You're not suggesting that Dr. Bell committed malpractice, was negligent, or failed in the standard of care, are you?
MR. TORGERSON: Objection.
BY MR. LINTON:
Q: Is that correct?
A: That is correct.

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Q: You likewise can't say with a reasonable degree of medical probability that the dural tear, in fact, caused the bowel or bladder problems in this patient, can you?
MR. TORGERSON: Objection.
BY THE WITNESS:
A: That is correct.
BY MR. LINTON:
Q: Can you say that if you had performed the surgery you would not have caused a dural tear as well?
MR. TORGERSON: Objection.
BY THE WITNESS:
A: I'd say probably not, but 100 percent, I couldn't say that.
BY MR. LINTON:
Q: Do you understand in a case like this with a herniation that is that close to the dura that that is a normal risk and complication of the procedure?
MR. TORGERSON: Objection.
BY MR. LINTON:
Q: Correct?
MR. TORGERSON: Objection.

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BY THE WITNESS:
A: Yes.
BY MR. LINTON:
Q: Aside from not using a laser, would you have performed the same type of surgery?
A: Yes.
Q: At what point — strike that. How long after onset would you say — strike that.
At what point in time from the surgery would you no longer — at what point in time after the onset of cauda equina would you no longer recommend surgery because the chance of recovery or improvement would be too slight to justify the surgery?
A: I can't give you an exact time frame, but the patient I had referred to had had it for years. So certainly after several years I think the chance of neurologic recovery from a cauda equina syndrome is low.
But whether — I don't think you could say that there's a definite time frame such as three months, six months, one year, two weeks. I think you have to make that decision. This

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whole area has been controversial in the literature in terms of cauda equina syndrome. So I wouldn't give you a specific time frame for nonintervening.
Q: One could still recommend surgery even weeks or months after the onset of cauda equina syndrome?
A: It would depend on the patient but that **might** happen, yes.
Q: Again, from your **own knowledge** base you can't say how long after onset of cauda equina you've performed surgery?
MR. TORGERSON: I'm going to object.
BY THE WITNESS:
A: I've certainly done it a few weeks after the onset. Now whether it's — exactly how many weeks, I just don't recall.
BY MR. LINTON:
Q: I assume you have not published yourself on cauda equina syndrome?
A: I have not.
Q: Have you done any reliable research on the subject?
MR. TORGERSON: What was that modifier, what

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kind?
MR. LINTON: Reliable research.
MR. TORGERSON: Has he done any reliable research?
MR. LINTON: On cauda equina syndrome.
MR. TORGERSON: Note an objection.
BY THE WITNESS:
A: Yes, I've researched it. I've researched it for the my patients, and I've researched it in conjunction with this case and the previous case I mentioned.
BY MR. LINTON:
Q: Badquestion. I don't mean did you search the literature. Have you yourself done a research project into outcomes as it relates to cauda equina syndrome?
A No.
Q: Has anybody in your practice group?
A: No.
Q: Do you personally know Dr. Shapiro?
A: Not personally.
Q: Do you know of him?
A: Yes.
Q: In fact, one of his articles you say

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was in your file, your cauda equina syndrome file?
A: Correct.
Q: That was the file that you kept not solely for this case but for your general medical knowledge?
A: Correct.
Q: Do you consider that article to be a reliable authority in your field?
A: No, I think it's part of a literature on a controversial topic.
Q: In your opinion is there any reliable medical authority on this topic?
MR. TORGERSON: I'm going to object. I think the question is a little flaccid by what you mean by reliable.
But if you can answer, go ahead.
MR. LINTON: I haven't heard a flaccid objection before. I'll add that to my repertoire.
MR. TORGERSON: That's a thin objection to a flaccid question, loose I meant.
BY THE WITNESS:
A: I don't think there is a reliable

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literature or a paper or a collection of papers that gives us the definitive answer for cauda equina syndrome. I think that most of the **studies,** if not all of them, are done retrospectively.
I think that this is a controversial area. I think different papers and different people have come up with different conclusions. I think that sometimes the conclusions are trying to be forced. I think that time frames such as 24 hours, 48 hours are basically artificial. So it's a long answer to tell you that I don't think there is an authoritative or reliable paper on cauda equina syndrome.
And **of** course, as I pointed out many times, this lady did not have the *full*blown cauda equina syndrome that even — or that is even covered in these kind of papers, so no.
BY MR. LINTON:
Q: If I can just summarize in a short fashion here, you just told us in your judgment there's no reliable or authoritative article or publication in the area of cauda equina syndrome, correct?

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MR. TORGERSON: Objection.
BY THE WITNESS:
A: Yes, I think what a neurosurgeon or orthopedic surgeon if they're doing this surgery what they have to do is be aware of — I'm speaking from the point of view of a neurosurgeon — has to be aware of this entity and be aware of how it presents, what the intervention could be, what the causes are, file that into one's memory bank, and then, you know, make individual decisions for patients based on that individual patient.
BY MR. LINTON:
Q: Are you relying on any specific medical literature or publication in giving your opinions?
A: In giving my opinions about Ms. Pikkel and the whole situation, I'm relying on my 20 years of work as a neurosurgeon and neurosurgical resident and my fund of knowledge from papers, talking to colleagues, patients, books, articles, abstracts, meetings, everything put together, the experience and things that I've learned over a long time frame.

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Q: But there's not a specific article that you are relying on to give your opinions; is that correct?
A: That is correct.
Q: Is there a specific article that you've found in your literature search that you feel supports your opinion in this case?
A: Yes, I think most of the articles support them. Now, if you're asking me to give a specific author's name, I mean, going back to the beginning of the deposition I can't do that as I sit here right now.
Q: Again so I'm clear, you can't give us a specific article that supports your position as you sit here, correct?
MR. TORGERSON: Objection.
BY THE WITNESS:
A: I could if I was required to do so. But as I sit here today, I wouldn't. I don't have any articles even with me so I couldn't give them to you. But there are articles out there if I wanted to find them, but it would depend on the specific question that you're asking me.

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BY MR. LINTON:
Q: Well, have you found any specific article that supports your opinions in this case?
MR. TORGERSON: Objection. That's the second, possibly third time you've asked that. But go ahead.
BY THE WITNESS:
A: I would say the literature in general taken together supports it.
BY MR. LINTON:
Q: Is there a specific article, though, that you can refer me to that supports your opinion in this case?
MR. TORGERSON: Objection; asked and answered.
BY THE WITNESS:
A: I could find articles, yes, to support my opinions if I needed to.
BY MR. LINTON:
Q: But you can't tell me as sit here what articles support that?
MR. TORGERSON: Objection.
BY THE WITNESS:

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A: Not by specific author's name, no, sir.
BY MR. LINTON:
Q: Can you refer to a specific journal or specific year or a specific institution or any way in which you can identify as we sit here today an article or articles that support your opinions?
MR. TORGERSON: Objection.
BY THE WITNESS:
A: I could if I needed to, but I don't have any article here with me today.
BY MR. LINTON:
Q: Not to beat a dead horse, right now I'm asking you can't refer me to a specific article or tell me there's a study out of this institution or check this particular journal as we sit here today, correct?
MR. TORGERSON: Objection.
BY MR. LINTON:
Q: Is that correct?
MR. TORGERSON: Asked and answered.
BY THE WITNESS:
A: What I would refer you to do is do a

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search like I have done and look at all these articles and think about specific questions that need to be answered. So yes, I would refer you to do a search of the literature, absolutely.

BY MR. LINTON:

Q: I understand that a generic search. I'm talking about a specific article that you can say as you sit here that supports your position, and you don't have one, correct?

MR. TORGERSON: Objection; asked and answered.

BY THE WITNESS:

A: I'm sorry, could you read that back.

(WHEREUPON, the record was read by the reporter.)

BY THE WITNESS:

A: I don't have any specific articles here in this room today other than the articles that are already attached to the depositions.

BY MR. LINTON:

Q: You're not suggesting that one of those specific articles supports your position in this case, are you?

A: It may.

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MR. TORGERSON: Objection.

BY THE WITNESS:

A: It may. We'd have to go through the articles and see the specific question that we wanted to ask. But they may, sure.

BY MR. LINTON:

Q: Have you done that?

A: I've looked at the articles, yes.

Q: Do any of those support your opinions in this case?

A: Yes.

MR. TORGERSON: Objection.

BY MR. LINTON

Q: Which articles?

MR. TORGERSON: Objection. Go ahead.

BY MR. LINTON:

Q: Which articles support your opinion?

A: Well, let's fiid them. Is that okay?

Q: Sure.

(WHEREUPON, discussion was had off the record.>

BY THE WITNESS:

A: So I'm trying to answer the question or I am answering the question about articles

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that supported my opinions about this case. By answering it in this way, I in no way mean to imply that these with would be the only articles supporting my position.

For instance in Defendant's Exhibit G, the first article at the end of Dr. Bell's deposition, it's written by Dr. A-h-n of Baltimore. It says, quote, Timing of Surgical Decompression for Cauda Equina Syndrome Secondary to Lumbar Disk Herniation is Controversial. That supports my position.

Let's just skim through these articles here. There's an article Defendant's Exhibit H, Cauda Equina Syndrome Due to Sequestrated Disk Herniation After Chiropractic Manipulation by Markowitz and Dolshoy (phonetic) that supports what I said about the fact that it can occur after a chiropractic manipulation.

We come to Dr. Shapiro's article which was written in 1993 and published in neurosurgery. Let me put on my glasses. He has a little table here. Again, I've given a lot of different opinions. I'm just picking out a couple of things. It's kind of a broad

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question.

These are people, again, that have cauda equina syndrome. These are not necessarily people like Ms. Pikkel, but you're asking me about this issue of cauda equina syndrome. So for instance Patient Number 2 in his Table 1 had five days. The surgery was done at five days after the appearance of the cauda equina syndrome and the outcome was normal. There was a Patient Number 11 that had surgery less than 24 hours after the onset of the syndrome but continued to have a problem, namely pain. This article will also talk about the controversy of cauda equina syndrome and the fact that even if surgery is done right away, a permanent problem can exist. The comments of the article are important.

For instance, Dr. Miller on Page 747 after that article says, quote, the study, of course, suffers from being retrospective and antidotal. So I agree with that, that supports my opinion.

I'm looking at another exhibit here Exhibit J, an article by Demming and Shaffer

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(phonetic). It's called, Discogentic Compression that Cause Cauda Equina, a Surgical Emergency. It's the type of article that would contribute to my understanding of cauda equina syndrome, the presenting symptoms, the surgical interventions. the operative technique. For instance, in the discussion of that article on Page 931 it says, quote, the surgical literature on this condition is somewhat scanty and for the most part consists of case reports or brief references.

I can go on and on. Let's look at one more thing from the back of Dr. Bell's deposition. It's an article called, Cauda Equina Syndrome and Lumbar Disk Herniation. The first author is Dr. Kostuik. I don't know if I pronounced that correctly, K-o-s-t-u-i-k. At the end of the abstract it says, quote, there was no correlation of these times with return of function.

So you know, definitely there are lots of articles in the literature that support the various positions and opinions I have in this case.

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BY MR. LINTON:

Q: Are you through with your answer?

A: Well, again, by answering with those, I don't mean to imply that those are the only articles that would support my position. But I'll stop there, yes.

Q: Does the literature not generally suggest that the earlier the intervention the better?

MR. TORGERSON: Objection. You may answer.

BY THE WITNESS:

A: I would say so.

BY MR. LINTON:

Q: And that the longer one waits to do surgery, in general the worse the outcome?

MR. TORGERSON: Objection.

BY THE WITNESS:

A: I think it's an individual matter. It depends on the individual patient, what they've got, what's causing the cauda equina syndrome. So while the literature may generally have a suggestion of the timing, you could never use that as a neurosurgeon as far as what to tell an individual patient.

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You should never tell a patient, for instance, if you're operating right away on a cauda equina syndrome that her bladder or his bladder will be normal. That would be a mistake. So there's what's in the literature and then there's what you use to relate to an individual patient.

BY MR. LINTON:

Q: Well, Doctor, would you ever wait for, let's say, 12 hours or longer to do a surgery on a patient who presents with a acute cauda equina syndrome?

A: As a neurosurgeon, no, I would not wait. That is correct.

Q: Why is that?

A: Because as soon as the diagnosis was made which usually means obtaining the lumbar MRI scan or sometimes the CT myelogram, if you have a cauda equina syndrome, as soon as the patient is medically ready I think it would be wise as Dr. Bell did in this case to go ahead and do the decompression.

Q: Now, if you were the patient — strike that.

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If a patient presented to you with a 26-hour history of being unable to void following chiropractic manipulation with perineal numbness that may or may not have resolved, would you not have made the diagnosis or at least included in your differential the diagnosis of cauda equina syndrome?

MR. TORGERSON: I'm assuming that's a hypothetical. I'm going to object. Those are not the facts in this case.

BY THE WITNESS:

A: I think I understand the question. Of course I'm a neurosurgeon. I'm going to look at it from the view of the neurosurgeon. Usually as neurosurgeon I'm already going to have the MRI scan done.

I started my answer, but I lost the rest of your question. Could you either repeat it.

BY MR. LINTON: —

Q: Let me rephrase it so we're clear. You're familiar with the emergency room record from the first visit?

A: I am.

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Q: You're familiar with the history that was presented by Bonnie to the emergency room?
A: I am.
Q: Based on that history would you have suspected cauda equina syndrome?
A: I would not have.
Q: You would not have suspected cauda equina syndrome or disk herniation with a 26-hour history of being unable to void with perineal numbness that may or may not have resolved following chiropractic manipulation?
A: Let's clarify that. It's not a matter of suspecting cauda equina syndrome or not. When she came in that day to the emergency room the first time, she did not have cauda equina syndrome.
Q: Would you —
A: So it's not a matter of suspecting it or not.
Q: The reason for that is because of how you defiie cauda equina syndrome?
A: No, not the way that I've defined it. The way that it's been defined in the literature. When she came into the emergency

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room the first time, she did not have cauda equina syndrome. She had urinary retention.
So as a neurosurgeon with a patient having urinary retention, would I have done an MRI, probably not.
Q: Would you have done a neurological examination?
A: Well, that would be a decision that's made by the emergency room doctor.
Q: I'm talking about you.
A: As a neurosurgeon, that's what I do. If someone calls me to see a patient, of course I as a neurosurgeon have to do a neurologic examination. That's what I do.
Q: You don't do a neurologic examination on every patient you see, do you?
A: That's correct.
Q: Regardless of the symptoms, the signs or symptoms?
A: Right, you have to — well, the neurological examination is a big tool. It has many parts. There's a lot that could go into it. What you do is you selectively do an examination or you focus on the things that

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could be a problem or that are appropriate. If someone has — well, I'll just stop there. The bottom line is that you do a neurological examination depending on the individual patient.
Q: Assuming that the patient presented to you with a 26-hour history of not being able to void after chiropractic manipulation and had perineal numbness that may or may not have resolved, what would have been on your differential diagnosis?
MR. TORGERSON: Interpose an objection. I'm assuming this is a hypothetical.
BY THE WITNESS:
A: So you're adding — I'm sorry to clarify this. You're adding numbness that may or may not have resolved with urinary retention?
BY MR. LINTON:
Q: Following chiropractic manipulation.
A: And the question what would I have had in my differential. Well, I think you'd have a large differential. I think that the primary problem in that kind of a patient is going to be the urinary retention. You're going to want to

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address that. I'm not a urologist, but there's dozens of things that could cause that.
Now, adding onto that the numbness and manipulation. If the numbness had resolved, I might tell her to go either to the emergency room or to a urologist. It would depend on the patient. If the numbness was persistent, I don't know. Again, I'm a neurosurgeon. I know about lumbar disk herniations.
So from the point of view of the neurosurgeon, I might have gotten on MRI. I don't know. But cauda equina syndrome does not describe that person: I would not have made that diagnosis.
Q: Would you have —
A: No one can because that's not the diagnosis at that time.
Q: We can agree that you could have done an examination of the perineal area?
MR. TORGERSON: Objection.
BY MR. LINTON:
Q: Including testing for sensation?
MR. TORGERSON: I'm somewhat confused as to symptoms for which he would have done that.

Since I know in general that you started but it's changed as to resolved perineal hypesthesia or continued. I just want to — I would ask you to clarify what you're asking in that question.

BY MR. LINTON:

Q: I'm asking, Doctor, if this patient presented to you during her first visit to the ER, you would have done a neurological examination, correct?

MR. TORGERSQN: Which patient are we talking about?

MR. LINTON: Bonnie Pikkel, the only patient that we're talking about in this case.

MR. TORGERSON: As reflected in the 9-4-96 ER review.

MR. LINTON: That's correct,

BY MR. LINTON:

Q: You would have done a neurological examination, correct?

A: I'm a neurosurgeon. I already answered that, what I do is a neurologic examination. If a patient just came in with urinary retention, I would say, look, I'm a neurosurgeon. Go to the emergency room doctor,

go to urologist. It wouldn't be appropriate for me to come in and start poking that woman's perineal, no.

Q: Would you expect that an emergency room doctor was qualified to diagnosis cauda equina or a problem with a disk herniation to be able to do a proper examination, correct?

MR. TORGERSON: I'll note an objection.

BY MR. LINTON:

Q: Don't you have to rely on emergency room doctors to do that?

MR. TORGERSON: Objection.

BY THE WITNESS:

A: I'm going to try to answer now. In other words, in someone who has urinary retention would I rely on the emergency room doctor to do the appropriate examination, I would say, yes.

BY MR. LINTON:

Q: In fact, aren't doctors trained in medical school how to do physical examinations?

A: Yes.

Q: They're trained in medical school how to test, for example, for rectal tone?

A: Yes.

Q: And how to test for sensation in the perineal area?

A: Correct.

Q: So an emergency room doctor would have received that training as any doctor when they went to medical school, correct?

A: Yes.

Q: That training to be further reinforced during their residency, correct?

MR. TORGERSON: Objection.

BY THE WITNESS:

A: Yes.

BY MR. LINTON:

Q: Is there any way to reliably rule out perineal numbness without doing an examination of the perineal area?

MR. TORGERSON: Objection.

BY THE WITNESS:

A: Well, practically speaking I think that the first thing to go on is what the patient tells you. If the patient says that, I'm having numbness, then you may need to examine that and pursue it. If they say, I'm

fine down there, I had some but now it's gone or resolved, then I probably would not have examined it because numbness in itself is subjective. You're relying on what the patient tells you.

Actually, the patient can — and sometimes it's more advisable. The patient can feel that particular area and give you information as to whether or not it's numb. I don't think — this may be anticipating a question — in someone with urinary retention you should poke someone with a pin. I think it's an individual decision that is made. You may have nothing to gain by poking someone if they're telling you that I can feel there now.

Q: Why would you ever do a pinprick sensation then? Why not just rely on what the patient tells you all the time?

A: Well, one reason is because the patient may not know the distribution of the dermatomes. For instance, actually it's less important now when we get an MRI that will include that whole area. But in the past you wanted to identify which dermatomes were

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involved with the numbness or in the pain or the weakness because that was what you used to localize the lesion that was causing the nerve root problem. So in this day of MRI, it's actually less important to do such a detailed exam.

Q: Why is it important to check for rectal tone in a patient who has an inability to void 26 hours after chiropractic manipulation?

A: Would be looking for cause. In other words,,you're asking me a general question I think. In a person that has an inability to void if the rectal tone is being checked by a doctor, that doctor is trying to find out if the nerves going to the rectum are also being affected. That would help discriminate between, say, a mechanical bladder problem and something else.

Q: You would you agree that a change in bowel or bladder function or incontinence suggests cauda equina syndrome?

MR. TORGERSON: Objection.

BY THE WITNESS:

A: Urinary retention or fecal

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incontinence are part of the cauda equina syndrome, yes.

BY MR. LINTON:

Q: So they would suggest a cauda equina syndrome?

A: They're part of it; in other words, for the cauda equina syndrome as we've gone through, you have to think that plus other things.

Q: So it's one factor or one sign that would suggest cauda equina syndrome?

MR. TORGERSON: Objection.

MS. GORCZYNSKI: Objection.

BY THE WITNESS:

A: The word suggestion or suggest I cannot accept because it's like the corner is part of this room. If you have a corner, it doesn't suggest a room. Those things that you're asking me about are part of the syndrome.

Now. I don't know how I can make that clearer, just look at Dr. Shapiro's article, for instance, and what he says cauda equina syndrome is.

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BY MR. LINTON:

Q: Do you agree that it's crucial to do a rectal exam and test the perineal sensation if cauda equina syndrome is suspected?

MR. TQWGERSON: I'll object.

BY THE WITNESS:

A: I think it would be advisable. I think practically what happens if it's suspected is that an MRI is done.

BY MR. LINTON:

Q: Even without a rectal exam or a test for perineal sensation?

MR. TORGERSON: Objection.

BY THE WITNESS:

A: I'm sorry, that wasn't a complete question.

BY MR. LINTON:

Q: Let me just ask you the statement and tell me if you agree with it or disagree. Do you agree that it is crucial to do a rectal exam and test for perineal sensation if cauda equina syndrome is suspected?

MR. TORGERSON: Objection.

BY THE WITNESS:

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A: No, I think you can go by the information that the patient gives you. If you've made the decision to do the MRI. I wouldn't say that that absolutely is crucial to be done, no.

BY MR. LINTOM:

Q: Let me ask it this way. Would you agree that it's crucial to do a rectal exam and test for perineal sensation or proceed with an MRI if cauda equina syndrome is suspected?

MR. TORGERSON: Objection.

BY THE WITNESS:

A: It would depend on the individual case, how strong the suspicion was, what else was gong on, if there was other reasonable explanations. I can't give you a blanket answer.

BY MR. LINTON:

Q: What other reasonable explanation could there have been in Bonnie Pikkel's case for urinary retention?

A: Well, you have — again, I'm not a urologist, I'm not an emergency room doctor, but there are lot of things that could cause urinary

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retention in a woman.
Q: We know that she had cauda equina.
She had a disk herniation at L5-S1, correct?
MR. TORGERSON: Objection. I think there are two questions in there, and I'm not sure what we know.
BY MR. LINTON:
Q: Doctor, Bonnie Pikkel, in fact, had a disk herniation at L5-S1, did she not?
A: She did.
Q: In fact, you believe that was caused by chiropractic manipulation, correct?
MR. TORGERSON: Objection.
BY THE WITNESS:
A: That's what started it.
BY MR. LINTON:
Q: That was what, in fact, was causing her inability to void for 26 hours when she presented to the ER for the first time, wasn't it?
A: Yes.
MR. TORGERSON: Objection.
BY MR. LINTON:
Q: That, in fact, was what was causing

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her perineal numbness?
MR. TORGERSON: Objection.
BY MR. LINTON:
Q: Correct?
A: It did cause it later, yes. In other words, I don't want to imply by my answer that she had perineal numbness when she came in and saw Dr. Spanner because she didn't.
Q: Even if you believe what Dr. Spanner put in his records, she had it at some point before her first visit and according to Dr. Spanner's record it was resolved?
MR. TORGERSON: Objection.
BY MR. LINTON:
Q: Let me phrase it this way, Doctor. Regardless of whether the perineal numbness continued or stopped, the perineal numbness whenever it occurred was due to the disk herniation, correct?
MR. TORGERSON: Objection.
BY THE WITNESS:
A: In my opinion I would say, yes.
BY MR. LINTON:
Q: Likewise the bowel incontinence was

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due to the disk herniation, correct?
A: At a later time, yes.
Q: You said at a later time, doesn't the record state that she had been unable to have a BM for two days?
MR. TORGERSON: Objection, point in time.
BY MR. LINTON:
Q: The second ER record.
A: That's different than incontinence. Inability to have one is different than loss of control of holding it in.
Q: Do you have the second ER record handy?
A: Sure. Do you want me to just show you this?
Q: Let me ask this, based on the record from the second ER visit, what was Bonnie's — the status of Bonnie's bowel control based on this record?
A: So I'm reading from 9-5-96, it's the ER record on Bonnie Pikkel. The nurse says, in emergency department for urinary retention, et cetera. It says, urge to have BM. Is that what you're asking about?

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Q: Correct. It also reports she was unable to have a BM for the past two days, doesn't it, in the physician's history?
A: Yes, without bowel movement for two days. Yes, I see it.
Q: Now, are you suggesting by that note that that meant her bowel problems only developed between the first and second visit to the ER?
MR. TORGERSON: Objection.
BY THE WITNESS:
A: Well, what I'm suggesting actually is this, an urge to have a bowel movement and unable to have it for two days, that in itself does not mean that someone is incontinent of stool. It could be someone, for instance, who's very constipated. They need to go.
BY MR. LINTON:
Q: I'm not —
MR. TORGERSON: Wait.
BY MR. LINTON:
Q: I want to just focus on the question. I'm not talking about what could have happened. I'm talking about this particular patient.

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She was unable to have a BM for two days, that was reported during her second visit to the ER, right?
MR. TORGERSON: Objection.
BY THE WITNESS:
A: That it true. That's what she reported.
BY MR. LINTON:
Q: Likewise on physical exam there was no rectal tone?
A: Correct.
Q: The first ER visit says nothing one way or the other about rectal tone, does it?
A: Could I go back and look at that?
Q: Sure.
A: True.
Q: Now, isn't it more likely based on the record that, in fact, the problem with the bowel goes back to before the first visit to the ER?
MR. TORGERSON: Objection.
BY MR. LINTON:
Q: Let me rephrase it this way, bad question. Assuming that what is reported here is accurate, that is that there was a two-day

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history of not being able to have bowel movements, there was no rectal tone, that would suggest that, in fact, the disk herniation was causing problems with the bowel correct?
MR. TORGERSON: I'll object. But go head.
BY THE WITNESS:
A: I think the disk herniation was started with the chiropractor. It started to cause some symptoms first with her bladder and then I think her condition progressed. By the time she came into the ER the second time, she was having the bowel problems. You can't just say because she didn't have bowel a movement for two days that she was incontinent of bowel and had a flaccid rectal sphincter when she came in the first time to the emergency room, absolutely not.
Q: We don't know because there is nothing in the record the first time that can show one way or the other whether she was having — whether she had rectal tone or not?
MR. TORGERSON: Objection.
BY MR. LINTON:
Q: Right?

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MR. TORGERSON: It sounds to me like you're arguing with the witness, but you did put a right in there. In any event, objection. Why don't you have the question read back so you can hear it again.
BY MR. LINTON:
Q: Let me rephrase, If you assume that what is *in* the second ER record is, in fact, accurate, doesn't that suggest that the disk herniation had caused problems with the bowel that existed at the time of the first ER visit?
MR. TORGERSON: Objection.
BY THE WITNESS:
A: No, and let me explain. If someone loses rectal tone, they will usually defecate on themselves. If you have no rectal tone, you can't hold in your bowel movement. If that were in this case true, if she didn't have any rectal tone, I think she would have had the problem. She would have reported that she was losing control of her bowel. So exactly on the contrary I think that the bowel problem developed right before she came into the emergency room the second time.

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Q: If she hadn't had a bowel movement in two days and presents the second time with no rectal tone, why isn't she defecating all over the ER?
A: She might. It can happen with a full blown cauda equina syndrome. You could be in the cart in the emergency room and you could have — you could defecate in the ER.
Q: If you get no rectal tone, you haven't had a bowel movement for two days, the movement has to go somewhere, doesn't it?
MR. TORGERSON: Objection.
BY THE WITNESS:
A: That's exactly my point.
BY MR. LINTON:
Q: So where did it go? If she's got no rectal tone when she presented to the ER the second time, she would have had to have had a bowel movement that occurred in an uncontrolled fashion at some point either at the ER or before the ER, wouldn't she?
MR. TORGERSON: Objection; argumentative.
BY THE WITNESS:
A: Well, it can depend on a lot of

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things, how much you're eating. If you've eaten a lot in those intervening days, I think it would be more likely. If she hasn't eaten very much, she wouldn't necessarily had to have had one. Everyone's bowel habits honestly are a little different. Some people go everyday regularly, some people go every third day. It really depends.

BY MR. LINTON:

Q: Let's assume that she has regular bowel habits, that she has a BM regularly every morning, that she's eating a regular diet, that she's gone two days without a BM, and now she's shown to have no rectal tone when she presents the second time, wouldn't you exact that either at the time she presents or sometime before then she's going to defecate uncontrollably?

MR. TORGERSON: Objection. If you can answer.

BY THE WITNESS:

A: Not necessarily, it could be after that: for instance, if she lost her rectal tone an hour before coming into the emergency room the second time, you know. As that tone becomes

Page a3

MR. TORGERSON: Objection. Go ahead,

BY THE WITNESS:

A: No, practically speaking we can't record everything that we do on the chart. If I see a patient, I may do a lot of things, and I'll just kind of stick to the relevant or important things or sometimes you can't even put those on. So the medical record is incomplete.

BY MR. LINTON:

Q: Would you agree that cauda equina syndrome represents a true neurologic emergency?

A: I don't think it's an emergency as much as, you know, a massive brain hemorrhage; but I think that it should be dealt with in an urgent matter, yes.

MR. RUFF: I'm going to hang up. I can't hear.

MR. LINTON: That's fine.

MR. RUFF: Bye.

(WHEREUPON, Mark Ruff telephonically left the deposition proceedings.)

BY MR. LINTON:

Q: From a timing standpoint should it be

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likely
's

iat she probably did have
: was in the emergency room

BY MR. LINTON:

e don't know because it wasn't
sed on the record, was it?

GERSON: Objection; asked and answered, and the record is different from your

BY MR. LINTON:

s there any reference
l to the rectal tone being checked?

MR. TORGERSON: Objection.

BY THE WITNESS:

A: I already answered that it wasn't recorded on the ER chart.

BY MR. LINTON:

Q: Doesn't the standard of care require a doctor to note on his chart the results of his examination?

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handled any less urgently than a brain hemorrhage?

A: Yes. For a brain hemorrhage you're immediately putting the person in the CT scan and immediately taking them up to the operating room after the diagnosis is made. Again, I don't mean to minimize a full blown cauda equina syndrome, but it's not as life threatening. The fact is that it's in a little different category.

Q: Did Bonnie Pikkel ever have back pain from her disk herniation?

A: Well, we know she had pain before going to the chiropractor, and I think it was about at that time that she was having the onset of this particular disk herniation progressing shall we say.

Q: Do you a feel with cauda equina
re's usually a weak Fishberg tone on rectal examine on associated urinary retention?

A: Yes.

Q: Do you agree that an MRI should be used on an urgent basis when cauda equina syndrome is suspected?

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MR. TORGERSON: Objection.
BY THE WITNESS:
A: I think if you have a patient that you strongly suspect has cauda equina syndrome, you should get some sort of imagining of the spine, yes.
BY MR. LINTON:
Q: Would you expect that this massive of a herniation would likewise have to be disclosed on a CT scan?
MR. TORGERSON: Objection to your characterization.
BY THE WITNESS:
A: It probably would have showed up on a CT scan. The MRI shows it better.
BY MR. LINTON:
Q: Is there any window of opportunity that you, yourself, recognized as a neurosurgeon based on your review of the literature, based on your own clinical experience, based on your general knowledge, is there a window of opportunity from which recovery of bowel and bladder function is more likely than not to occur?

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A: I don't say that there's a window of opportunity, no. I think any such proposed time frame like *24* hours or *48* hours is really artificial. So I would not say to anyone, a patient or another doctor, that there's a window of opportunity, no, sir.
Q: Is it your opinion that when you have acute disk herniation like Bonnie Pikkel has that leads to urinary retention that surgery will not ever to a reasonable degree of medical probability reverse the damage done to the nerve roots sufficient to regain bladder control?
MR. TORGERSON: Objection.
BY THE WITNESS:
A: I have an opinion about that; that is that if you have a herniated disk that injures the nerve roots going to the bladder even if surgery is done immediately, there are certainly cases — and, again, it depends on exactly how much injury has been done. But even with immediate surgical decompression, it can be possible that the patient won't recover bladder function or they'll have at least some difficulty with their bladder as a residual

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problem after the decompression.
BY MR. LINTON:
Q: I understand that it could possibly occur. But isn't it more probable that there will be recovery of some if not all bladder function if surgery is promptly done?
MR. TORGERSON: Objection.
BY THE WITNESS:
A: I think it depends in all honesty on the degree of damage done to the nerve roots. I think if there's pressure on them and they are partially not working shall we say, that surgical decompression can help the situation. But if they've been severely damaged, then sometimes no surgery is going to be able to help that particular situation. You'd still want to do it to try.
BY MR. LINTON:
Q: How do you determine if they're partially damaged or if they're completely damaged?
A: Well, I think that's in the realm of a neurologist — excuse me, a urologist. A urologist may be able to determine that in terms

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of how much bladder function there is with a cystometrogram.
Q: You can't say based on anything you've reviewed the extent to which there was complete, almost complete, or only partial damage to the nerve roots to Bonnie Pikkel's bladder, can you?
MR. TORGERSON: I'm going to object. Are you asking him for an opinion or you are — is it a factual question. I'm not sure I understand.
BY MR. LINTON:
Q: Just that you can't — there's nothing you're talking about the way to look — there's nothing you can look to in the records that shows the extent of that damage to the nerve root?
A: What I can look at is her course and the record and knowing that the disk herniation was large and in knowing that at least for many months, maybe a year she continued to have a problem. It's my belief that the damage to the nerve roots going to the bladder was severe. When this occurred was right after the time of the chiropractic manipulation because by the

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time she came into the emergency room the fist time, she had been unable to void for 26 hours.
Q: Does that mean there was complete damage to all the nerve roots controlling the bladder at the time of the herniation?
A: Most likely, either complete or shall we say severe.
Q: Once there's complete or severe damage to the nerve roots, one cannot recover function with prompt surgery?
A: Possible but unlikely. I've seen many cases where a person did not recover.
Q: In an acute case?
A Yes.
Q: How many of those cases?
A: You know where are you, can I just take one second. This is beeping.
(WHEREUPON, a recess was had.)
BY MR. LINTON:
Q: Doctor, can you tell just on — during surgery itself can you look at nerve roots and determine the extent of the damage?
A: Well, usually in this kind of surgery you don't open up the dura so, no. Sometimes

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you can see a nerve root and see if it's damaged and if there's a tumor in the cauda equina for instance or it's involved with tumor. But in this sort of situation, you're not going to be directly examining the nerve roots, that's correct.
Q: Doesn't the literature, in fact, show — the overwhelming amount of literature show when you look at the patient population, you don't look at an individual patient; but you look a patient population if you do this surgery promptly more likely than not, that is greater than 50 percent chance, are you going to get a recovery of function if not complete at least substantial recovery if you do prompt surgery?
MR. TORGERSON: Objection; asked and answered.
BY THE WITNESS:
A: Well, again, you're taking the individual patient out of the equation; but I've said this before, the interpretation of the literature is that you should do the surgery sooner as opposed to later. There's no doubt about that. I said that many times, but you

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have to think of each individual patient.
BY MR. LINTON:
Q: Of course you can never decide what an individual patient is going to do, but if you look at the patient population as studied in most of the literature, doesn't it suggest that the majority of patients who receive prompt surgery will have a return of full or substantial bladder function?
MR. TORGERSON: Objection; asked and answered, indefinite and vague as to what you mean by prompt.
BY THE WITNESS:
A: Actually that's not my interpretation of the literature, no.
BY MR. LINTON:
Q: Likewise is that true with respect to bowel function?
MR. TORGERSON: Same objection.
BY THE WITNESS:
A: I'm pausing because I'm trying to think of papers and so forth and my fund of knowledge about this, but I think regarding bowel function the literature would support

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doing surgery earlier as opposed to later. But that's, again, looking at antidotal retrospective groups of patients.
BY MR. LINTON:
Q: When one looks at the literature, does not the majority of the literature support that if you have prompt surgery there will be in the majority of patients return of bowel function?
MR. TORGERSON: Objection; asked and answered.
BY THE WITNESS:
A: The literature looking at groups of patients would support doing prompt surgery, yes, I've said.
BY MR. LINTON:
Q: It would show that if prompt surgery is done the majority of those patients will have a return of bowel function, correct?
MR. TORGERSON: Objection; asked and answered.
BY THE WITNESS:
A: I think that depends on the individual patient as far as how bad their bowel was, the other things that were going on, other medical

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conditions. So I just don't want to agree to that word majority, and it's really not fair to ask me about a majority because we have to total up all the numbers from all those patients. I don't have, you know, those figures all together to say whether it would be greater or less than 50 percent.

BY MR. LINTON:

Q: You haven't tried to do that as of this point?

A: I haven't done that, and I don't know if it would be reasonable to do it because we're talking about an individual patient, not groups.

Q: But don't we have to look at the literature in order to see as a patient population what most likely will occur?

MR. TORGERSON: Objection; asked and answered.

BY THE WITNESS:

A We look at the literature to get as much information as we can as a neurosurgeon treating this kind of patient.

BY MR. LINTON:

Q: Isn't that the best predictor is

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what's reported in terms of case studies and the literature?

MR. TORGERSON: Objection,

BY THE WITNESS:

A: I think that's part of what you put together with your own personal experience and what you've learned. So the literature is part of the equation.

BY MR. LINTON:

Q: You're just essentially saying you'll never know with this patient because she never had a chance to have the surgery; so, therefore, one can't predict on a case by case basis how a particular patient will respond to surgery?

MR. TORGERSON: Objection,

BY THE WITNESS:

A: No, that's not what I'm saying.

BY MR. LINTON:

Q: How am I misunderstanding you then?

A: What I'm saying with Bonnie Pikkel is that she had a lumbar disk herniation which either started or was exacerbated by the chiropractic manipulation. This damaged the nerve roots going to her bladder, It's my

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opinion that even by the time she got to the emergency room that first time that her — it is more probable than not that her nerve roots were irreversibly damaged going to her bladder, and she was going to have even with surgical decompression a continuing problem with her bladder.

Furthermore, her clinical condition deteriorated. She represented to the emergency room the next day. She had more of the features of cauda equina syndrome. She still did not have all of the features of cauda equina syndrome, and then the MRI was appropriately done. The surgery was performed, you know, in a fairly quick manner; and she recovered to a certain extent, but she had some residual neurologic problems.

Some of those went back to 26 hours before she presented to the emergency room the first time. Others of those may have been produced by when the cauda equina syndrome is worse. I'm saying that she presented to the emergency room with urinary retention.

I think what they did to work up the

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urinary retention was appropriate. If I had been in that spot at the same time and I think most reasonable physicians, of course that would have been an emergency physician, would have done the same thing. I don't think Dr. Spanner was negligent and that certainly it's unfortunate that she has some problem. If she does still have it today, I don't know.

But this is the nature of damaging your nerve roots going to your bladder, your sexual area. They are sensitive. Even with — I don't think that catching it earlier would have made any difference.

Q: Not a bit?

A: Now, if it was possible to catch it — now, it's possible that within the first 6 or 12 hours of that manipulation if somehow someone had been able to know that she had a large extruded disk, maybe an intervention could have been carried out at that time, but she did not have cauda equina syndrome —

Q: Let me see what you're saying.

A: — until later.

Q: Are you saying now that with

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reasonable medical probability if it had been operated on within 6 or 12 hours after onset that more likely than not there would have been return or at least improvement in bladder function?

A: No, I'm just giving you the example that even if it had been diagnosed earlier — okay, I'll stop there.

Q: So you're saying with reasonable medical probability if she had gone right from the chiropractor's office to the operating table and had surgery done at that time with reasonable medical probability there would not have been return or substantial improvement in bladder, is that your opinion?

A: No, that's not what I'm saying.

Q: So then there would have been with reasonable medical probability as of that point substantial improvement or return of bladder function?

MR. TORGERSON: Objection.

BY THE WITNESS:

A: Where I was going with that to answer your question is that if immediately after the

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chiropractic manipulation it had been possible — and I'm not saying that it would have been because she didn't have a cauda equina syndrome. She just had some urinary retention. But if had been possible to go back much, much earlier, the likelihood would have been greater to a point.

BY MR. LINTON:

Q: At least it would have been to a reasonable degree of probability 50 percent — better than 50 percent likelihood?

A: I still can't say 50 percent likelihood.

Q: Again, getting back to the original hypothetical, she went from the chiropractor's office to the operating table, surgery was done. Even then in your judgment there was not a probability of return of bladder function?

MR. TORGERSON: By probability you're using the legal term of probability, the greater or less than 50 percent.

BY MR. LINTON:

Q: Isn't that what you understand probability to mean, Doctor?

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A Well, what I would say in answer to that is the chance would have been higher if the intervention would have been done earlier. But the problem is you can't make the diagnosis until the other things occur.

In other words, it's not appropriate or the standard of care or necessary to get an MRI scan just with someone having urinary retention even if they have back pain chronically. It doesn't become appropriate until there are other neurological findings. By that time it was too late.

BY MR. LINTON:

Q: Let me ask it this way, just assume hypothetically that you could have had her on the operating table within two hours after leaving the chiropractor's office and had done the decompression at that point. Even then are you saying there is not a probability that is more likely than not that she would have had return of bladder function?

A: I think her chance would have been better, but I still couldn't say that her bladder function would be normal because the

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nerve roots would have been damaged.

Q: So there would have been with reasonable medical probability improvement if the surgery had been done within two hours of the manipulation?

MR. TORGERSON: Objection.

BY MR. LINTON:

Q: Is that what you're saying?

A: I think the chance of improvement would have been higher.

Q: Would it have been beyond — would it have been to a reasonable degree of medical probability; that is, a better 50 percent chance it would have improved?

A: I don't know because we have no medical studies that have been published, and I personally don't have an experience in that area so it would be speculating.

Q: What about your personal experience — do you have personal experience at six hours?

A: Probably, but not just with an isolated urinary retention, no, because usually there are more symptoms and signs and findings

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involved when this happens you see.
Q: Help me out with this, Doctor. She has surgery after her second presentation?
A: Correct.
Q: Let's assume Dr. Bell or yourself had been called in after the first presentation.
A: You mean to the emergency room when she came in the fiist time on the 4th?
Q: Correct.
A: Okay, I'm with you.
Q: Assuming that the surgery was done following her first visit to the ER. Wouldn't there have been a better chance of some recovery than waiting until after the second presentation?
MR. TORGERSON: _ m going to object. You should answer it, but you're implying that we're assuming something about a recovery better or worse than — I just don't know the status of her recovery. If you do, Doctor, answer the question.
MS. GORCNNSKI: Objection.
BY THE WITNESS:
A: Could you read that back.

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(WHEREUPON, the record was read by the reporter.)
BY THE WITNESS:
A: Well, see, with her first presentation to the ER.
MS. GORCZYNSKI: Did something happen to the phone?
MR. TORGERSON: Can you hear us.
(WHEREUPON, discussion was had off the record.)
BY THE WITNESS:
A: With her first presentation to the ER at that time she was just having the urinary retention. It wasn't appropriate to get an MRI scan so there would be no way to trigger the event that would have lead to the surgery.
In your hypothetical are you asking me if just at, say, 30 hours with a disk pushing on the nerve roots going to the bladder that it would be more likely than not that the person would have recovered? Is that what you're asking me?
Q: Yes.
A: I can't say, but I think it's very

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likely that the person would have had in — this particular person would have had continuing neurologic problems as I've already answered.
Q: Exactly the same? An earlier surgery would not have effected in any way her residual problems from the disk herniation?
MR. TORGERSON: Well, objection; asked and answered.
BY THE WITNESS:
A: I don't know. We don't have any studies specifically looking at that to tell us.
BY MR. LINTON:
Q: Would we have any studies at all that even address the issue in this case in terms of earlier surgery?
A: I do not think there are any specific studies, no. I think what we have to use is our clinical experience and our opinion about that.
Q: Your clinical experience, you can only remember probably five patients, and you can't even remember the details of more than one patient.
A: This is a rare entity. This is going

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to be true of everyone involved in this case.
Q: Let's not speak — you haven't talked to Dr. Shapiro yet?
A: Right.
Q: In your experience you've got five cases. The only one you can remember any details about as you sit here is the one you operated on this year. We're not far enough out to determine involvement.
So in terms of your clinical experience, you can't tell us any specifics that would apply to this case?
MR. TORGERSON: Objection; asked and answered. Don't answer the question. We've been over this before. It's in the record. Let's go on to a question that can be asked.
BY MR. LINTON:
Q: Please answer the question, Doctor.
MR. TORGERSON: The question is complex, it's ambiguous, it needs definition.
MR. LINTON: Just say the objection.
MR. TORGERSON: I'm entitled to say the basis for the objection.
MR. LINTON: You're not entitled to give a

speech to try to coach the doctor.
MR. TORGERSON: I'm not coaching anybody,
MR. LINTON: Let the doctor please answer
the question as it's posed.
MR. TORGERSON: The doctor has answered the
question.
MR. LINTON: Not that question.
MR. TORGERSON: Objection.
MR. LINTON: Please read back that question.
(WHEREUPON, the record was
read by the reporter.)
MR. TORGERSON: Objection.
BY THE WITNESS:
A: Incorrect.
BY MR. LINTON:
Q: Okay, Doctor, let me try to go over
that. I thought we did.
Can you please tell us the details of
any other acute cauda equina syndrome cases that
you've treated other than the one you told us
about this year.
MR. TORGERSON: Note an objection.
BY THE WITNESS:
A: What happens when you have contact

with these cases you talk to people, you learn
about the situation at the meetings, you read
papers, you read textbooks. What you use for
your clinical experience or for making a
clinical judgment isn't just based on the people
that you've operated on. That's part of it, but
there's more than that.
So I don't have a photographic
memory. I guess a few people do. If I learn
about a person, a patient of mine or some other
patient in the literature that has cauda equina
syndrome, which is really not what this patient
had any way, that goes into ones memory.
So although I'm an expert on cauda
syndrome, that doesn't mean necessarily I could
tell you the exact age, time course,
intervention that was done for specific people
in the past, no.
BY MR. LINTON:
Q: I just want to make sure you haven't
recalled more now than you did at the start of
this deposition. Can you recall any mora
details about any other cases that were probably
about five in number that presented with acute

cauda equina syndrome other than what you've
told us?
MR. TORGERSON: Objection.
BY THE WITNESS:
A: No, I've been focused on answering
your questions, not thinking back about other
patients. The best way for me to do that is for
me to try to get some old records or something.
BY MR. LINTON:
Q: You have not attempted to do that as
of this point, correct?
A: No, I don't think that would be
helpful for Ms. Pikkel anyway.
Q: Would that be feasible at this point?
A: No.
Q: We don't want to call this — strike
that.
How would you define Bonnie Pikkel's
condition?
If you don't want to call it an acute
cauda equina, how would you describe it?
A: Thanks, that's a good question. When
she came into the emergency room, her diagnosis
and condition was that of urinary retention.

That's on the first time, 9-4-96. When she came
in the second time, her diagnosis was L5-S1 disk
herniation.
Q: Now, Doctor, what was the — strike
that.
Was anything done during her first
visit to the ER to diagnosis the cause of the
urinary retention?
A: What was done was taking a history,
performing a relevant exam, and placing the
foley catheter which was more therapy than a
diagnosis. So that's what was done.
Q: First of all, the exam we don't know
if rectal tone was checked and we don't know if
perineal — if the perineal area was checked for
sensation, correct?
MR. TORGERSON: Objection to form. Object
to it's repetitive nature. The records speak
for themselves as to what is known.
BY MR. LINTON:
Q: To lay my foundation for my next
question, we can agree that there is nothing in
the first visit — the record of the first visit
that shows either rectal tone was checked or

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that perineal area was checked for sensation, correct?
MR. TORGERSQN: Objection; asked and answered. The continuing asking of the question which has been previously asked on several occasions is coming close to being harassment of this witness,
BY THE WITNESS:
A: My answer is that we've gone through that. I guess the best thing to rely upon is Dr. Spanner's deposition under oath and if he could recall what was done. Because as I've said many times, right, it was not recorded in the emergency room chart; but it is not possible to record everything that one does unless you have a court reporter sitting right here.
BY MR. LINTON:
Q: Would you expect that Dr. Spanner would have an independent memory of what he did on this patient this many years later or when his deposition was taken?
MR. TORGERSON: Objection. You may answer.
BY THE WITNESS:
A: I'm not going to answer for

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Dr. Spanner, but there is something about having a lawsuit that does help to refresh ones memory sometimes. So you could ask him.
BY MR. LINTON:
Q: Would you then favor what Dr. Spanner has to say as opposed to what Bonnie Pikkel has to say about that point?
MR. TORGERSON: Objection.
BY MR. LINTON
Q: Or are you not picking sides?
MR. TORGERSON: Objection.
BY THE WITNESS:
A: I'd rather not pick sides. I think the opinions I'm giving here today are — I mean, I am an expert for the defense, but I try to be objective and honest in my opinions. So I think that I'm not going to try to resolve a difference of opinions between Dr. Spanner and Ms. Pikkel. I think that's for the jury to do.
BY MR. LINTON:
Q: I appreciate that. But one of the purposes to do a proper examination of a patient like Bonnie Pikkel when she presents as she did during the first visit is to try to find a cause

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for the urinary retention; is that correct?
A: No, sometimes we treat something and then we find the cause later as a practical matter.
Q: Isn't one of the reasons you do a clinical exam is to try to come to a diagnosis?
MR. TORGERSON: Objection.
BY THE WITNESS:
A: Yes.
BY MR. LINTON:
Q: Isn't the purpose for a diagnosis to try to find out the cause of the problem. what's wrong with the patient?
A: No, a diagnosis is really different than a cause, and this is a perfect example. The diagnosis was urinary retention, but since there are so many different causes, it wasn't feasible to really know what the cause was at that time.
Q: You would agree knowing everything you know about Bonnie Pikkel that if an MRI was done that, in fact, would have showed the cause of the urinary retention being an L5-S1 disk herniation?

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MR. TORGERSON: I'll object to everything we know about Bonnie Pikkel. But you may answer.
BY THE WITNESS:
A: I think that if an MRI would have been done at that time, and again I'm not saying it should have been, but it might have shown some of the disk herniation. But I think it is likely that it would have been smaller than the disk herniation later which was causing even more problems.
I base my opinion on the fact that her clinical course deteriorated; in other words, she was worse the next time coming back into the ER than this time. This time she had urinary retention. I think if MRI had been done, it might have shown a small disk. Again, that's a totally different issue whether or not it would have been operated on at that time, but I'm speculating.
Q: I understand. But based on what you're impression is of the medical records and what you believe her clinical course to have been, you believe if an MRI was taken during her first visit it would have most likely have shown

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a smaller disk herniation than what was actually shown after her second presentation?
MR. TORGERSON: Objection; asked and answered. Go ahead.
BY MR. LINTON:
Q: Is that correct?
A: Probably, yes.
Q: Assuming that it showed a disk herniation although a smaller one, would it have been a appropriate at that time to call in a specialist like Dr. Bell?
MR. TORGERSON: Objection. You may answer.
BY THE WITNESS:
A: I think that would have — that might have been an option for the emergency room doctor.
BY MR. LINTON:
Q: Do you think it would have been equally appropriate for him to simply send her home with a catheter if the MRI showed a disk herniation even though it was smaller?
A: I don't know.
Q: Assuming it was a smaller disk herniation than was presented during the second

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time and assuming if a neurosurgeon was called in to operate, more likely than not there would have been a better outcome in Bonnie Pikkel had the MRI been taken and had the surgery been done after the first visit, correct?
MR. TORGERSON: Objection; asked and answered.
MS. GORCZYNSKI: Objection.
BY THE WITNESS:
A: The problem is there's so many parts to that question that I kind of lost track of it.
BY MR. LINTON:
Q: I'll break it down. I don't want you to be confused.
Assuming the following facts, an MRI was taken after the first visit, that it showed a smaller disk herniation, that a neurosurgeon was called in after the first visit, that he did the surgery.
When you compare that outcome as opposed to what happened in this case, more likely than not Bonnie would have had a better outcome, correct?

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MR. TORGERSON: Objection.
BY THE WITNESS:
A: Well, I think that if somehow a neurosurgeon had been called in just based on urinary retention and a small disk herniation, I don't think neurosurgery would have been done. So I have to disagree with that. If I was called in on this day —
BY MR. LINTON:
Q: Day one?
A: On day one as a neurosurgeon, I can't say that I would have recommended surgery because even in there was a disk herniation — that's a good other opinion to bring out because I wouldn't have thought with 36 hours of urinary retention, Number 1, that I was sure that the small disk herniation caused it or a smaller disk herniation.
Number 3, by operating on it I wouldn't expect that her bladder problem would resolve. I would be worried about other things causing the bladder problem.
Number 3, I'd be confused because there was no leg pain, there was no severe back

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pain, the other symptoms were not there. So that's an important question that I think a neurosurgeon seeing her at that time probably would not have operated.
Q: Doctor, please tell me whether the following in your opinion is appropriate or inappropriate.
Would it be below the standard of care if a physician who is qualified to diagnosis cauda equina syndrome who sees a patient with a 26-hour urinary retention who has perineal numbness that may have resolved to simply place a catheter in that patient, diagnosis the patient as having urinary retention, and sent her home with no further diagnostic tests or studies?
MR. TORGERSON: Objection.
MS. GORCZYNSKI: Objection.
BY THE WITNESS:
A: No.
BY MR. LINTON:
Q: You believe that would have been entirely appropriate?
MR. TORGERSON: Objection.

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BY THE WITNESS:
A: I think it would depend on the circumstance. In looking at the Pikkel case, I think what Dr. Spanner did was appropriate considering what she told me and other factors. So I'm not critical of that, no. That's from the point of view of a neurosurgeon who's going to be more attune to the problem with the nerve roots than an emergency room physician would normally be.
BY MR. LINTON:
Q: If you were there during the first visit, you would not have ordered an MRI even if the MRI — strike that.
You would not have ordered an MRI if you, yourself, were in Dr. Spanner's shoes, that's what you're saying, correct?
A: I wouldn't be in his shoes. I'm not an emergency room physician.
Q: If the patient had come into your office with this exact same presentation as presented on the first ER visit, would you have ordered an MRI scan?
A: I might have, but I probably would not

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ordered it emergent. In other words, I might have ordered it, but I can't imagine that I would have ordered it as an emergency, no, because I'm a neurosurgeon, that's what I do, I order MRIs.
Q: Wouldn't there be at least some suspicion in your mind, however slight, that it could possibly be due to a problem with the disk compressing the nerve as a result of chiropractic manipulation?
MR. TORGERSON: Objection.
MS. GORCZYNSKI: Objection.
BY THE WITNESS:
A: Well, I think that was a suspicion in Dr. Spanner's mind.
BY MR. LINTON:
Q: If that's the case that it's a suspicion in Dr. Spanner's mind or in a neurosurgeon like yourself, doesn't the standard of care require that you first rule out any potential treatable causes?
MR. TORGERSON: Objection.
MS. GORCZYNSKI: Objection.
BY THE WITNESS:

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A: No, I think an emergency room doctor who deals with people with urinary retention from all kinds of reasons is going to behave exactly like he did. He put in a Foley and said, follow up with your doctor. There was nothing else about her neurologic exam that indicated that she was having a cauda equina syndrome.
In fact, she did not have cauda equina syndrome. I can't stress that enough. That didn't happen until later when it was partial at best.
BY MR. LINTON:
Q: She at least had an L5-S1 disk herniation following chiropractic manipulation, correct?
A: True.
Q: She had a L5-S1 disk herniation at the time she presented to the ER the first time?
A: She probably did.
Q: That diagnosis was never made during her first presentation to the ER?
MR. TORGERSON: Objection.
BY THE WITNESS:

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A: You say never, it was made when she got worse.
BY MR. LINTON:
Q: Let me repeat the question so I'm clear. Did Dr. Spanner diagnose an L5-S1 disk herniation you believe was present at the time Bonnie Pikkel went to the emergency room?
A: Remember, I have the benefit of hindsight. So the answer is, no
(WHEREUPON, certain documents were marked Deposition Exhibit Nos. D, D1-D3, for identification, as of 4-25-01.)
BY MR. LINTON:
Q: Just for the record, Doctor, I'm going to mark as D your manila file. That contains all your correspondence in the case?
A: Yes.
Q: D 1 being the first note or your first contact in this case. I'm looking at a message slits to you dated 10-16-98 from Ms. Chrisafi who is the original attorney on this case?
A: Yes.

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Q: D 2 is a letter that followed on November 25, 1998, correct?
A: Yes.
Q: And D 3, are those your billing records in this case?
A: These are recent ones from 2001. There were some previous bills generated at about the time that it was first sent to me as well, but those are, you know, previous tax years. I don't really keep those. They were paid.
Q: Where can we get those bills?
A: I would have to print them out from my computer or maybe Westin Hurt (phonetic) could give them to you.
Q: Would you be so kind as to do that Mr. Torgerson in turn will give them to me. I'd just like to have a complete copy of your billing records if we could for this case.
A: It's okay with me if it's okay with him.
Q: You came over here, when was it, 1998 to University of Illinois?
A: Well, by over here, I came to

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Chicago — I did my residency in Chicago.
Q: Just to speed things up, at the time you got involved in this case, you originally were at Northwestern. You are now at University of Illinois; is that right?
A: That is true.
Q: When did you make that change?
A: I started at the University of Illinois in February of '99.
Q: I assume that was a better opportunity for you than at Northwestern?
A: Sure was.
Q: How was it better for your own career advancement?
A: My salary was more. I was assigned to be the director of neuro-oncology as part of my responsibilities. I was an associate professor and got a promotion or academically I was an associate professor instead of an assistant professor. I was given research money, and I like the people that I worked with. So all in all it was a better opportunity for me.
Q: Tell me the different academic positions that were in place at Northwestern as

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well as the ones that are in place at the University of Illinois.
A: Those are pretty much just on the CV.
Q: You were an assistant professor at Northwestern?
A: Yes.
Q: The next step up from that, is that an associate professor?
A: Yes, sir.
Q: After that is a full professor?
A: Yes.
Q: Do you have tenure currently?
A: I'm on what's called the tenure track, but tenure has not yet been awarded.
Q: What is required for you to complete your track and get tenure?
A: I don't think you can even be considered for it when you come in as an associate professor for two or three years or something like that. So I don't have tenure yet, that's correct.
Q: I don't want to know the specific numbers, but what was the percentage increase in salary coming over here?

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MR. TORGERSON: Objection.
BY THE WITNESS:
A: 50 percent.
BY MR. LINTON:
Q: In terms of research money, were you getting research money at Northwestern, you specifically?
A: I had to get grants, some of which are listed in the CV. So I wasn't given research money just, say, on a month-to-month or a year-to-year basis. I had to apply for grants. In coming to the University of Illinois, they did give me start-up research money.
Q: How much do they give you in start-up research money?
A: $315,000.
Q: 315 or 350?
A: 3, 1, 5. That was not to me but it's to my lab.
Q: Not salary to you, it's money you use to fund your research projects?
A: Exactly.
Q: Is your research interest still brain tumor cell biology?

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A: Yes.
Q: Glioblastoma, is that still your baby?
A: That and other things.
Q: What other areas of brain tumor cell biology?
A: Anything involving neuro-oncology which would be the way that tumors or cancer or benign tumors effect the nervous system. Any of that would be in my research area.
Q: What percentage of your neuro-oncology responsibilities would relate to brain tumors versus other parts of the nervous system?
A: Most of it is brain tumor, maybe 75 to sometimes 90 percent over the past two years.
Q: Have the number of surgeries you performed changed since you came over here just in terms of numbers?
A: They may have increased a little bit. You know, it's something that's going to vary from month to month, year to year; but it's been pretty consistent I'd say over the past ten years.
Q: How many surgical procedures do you do on average per year?

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A: I would say 200 to 300.
Q: What percentage of those would be brain versus spine?
A: Well, currently I'd say it's about 50/50. Earlier when I was at Northwestern I'd say it was 75 to 85 percent spine.
Q: So even though you are a director of spine surgery where, you're still doing spine surgery yourself?
A: Yes, sir, that is — really neurosurgeons do in general more spine surgery than brain surgery just because of the number of patients that have problems with the spine as opposed to brain problems. So I still do a lot of spine surgery, yes.
Q: Could you just break out for me in term of percentage of your professional time what you do generically do in your current position?
A: I'd say the vast majority of it is seeing and taking care of patients and performing their surgeries, probably 75, 85 percent of it. Then there's the research which is the bulk of the rest of it. There's some

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administrative work. There's some legal work like this which is maybe, you know, 2 percent of my time, something like that. Well, there's some other committee work and so forth, but I would lump that into administrative duties.
So the vast majority is clinical and that overlaps with teaching. In other words, I give a few lectures a month, some of those are in the CV. But my teaching overlaps with the clinical work. So for instance, if I'm doing a surgery or seeing patients, a student or a resident is with me so I spend a good amount of time teaching as well, but that's kind of going along with my clinical work.
Q: Do you teach formal classes at the medical school?
A: Yes, I teach on neurosurgical topics. For instance, the medical students will have lectures on neurosurgery, and I and the other faculty members would give those. I'm also in the bioengineering department and give seminars according to that. So there are some formal teaching responsibilities, yes.
Q: Have you specifically lectured on

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cauda equina syndrome?
A: I have mentioned it if I've been talking about disk surgery, specifically lumbar disk surgery. It's been something that has come up.
Q: Do you have any course materials or written materials from any of those lectures?
A: No.
Q: Have you specifically lectured on the anticipated outcome of surgery or the timing of when surgery should occur with cauda equina syndrome either complete or partial?
A: I probably have, and the opinion that I would give in that lecture would be similar to the one I've been giving today which is that this is something that — cauda equina syndrome is something that is better to be dealt with urgently, but even with immediate or very rapid surgical decompression, there can be continuing neurologic problems.
You can't guarantee that operating within a certain time frame, for instances as we've gone over, is magical or that is the window of opportunity. I have not ever lead

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students to believe that there is such a window of opportunity.
Q: Of course there's no guarantee in your business, but isn't the whole reason for urgent surgery is because you expect that there will be some improvement after surgery?
A: That's why you do surgery is you hope to make the patient better or prevent the patient from getting worse.
Q: Again, I assume you don't have any written materials that would contain any information on that topic from your lectures?
A: I don't, not the topic of cauda equina syndrome.
Q: Is there a different policy in place at the University of Illinois compared to Northwestern in terms of your involvement as an expert in legal cases?
A: I wouldn't say it's different. I think it's prudent to keep it to a very limited amount of time and not let it interfere with any of your responsibilities with your real job, and usually the amount of time that we spend doing this is reported. So there's no change I would

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say that would be significant.
Q: Is there any written policies or procedures or guidelines concerning that topic?
A: No.
Q: The fees that are paid for your work as an expert witness in legal cases, is that money that goes directly to you or does it go to the university?
A: Well, it's discretionary. I think it could go to you. You could use it in that way, but you could also do it through the university billing system if that was your desire.
Q: In this case it's gone through your own personal funds as opposed to billing through the university?
A: To the state, it has, that's correct.
Q: Do you anticipate changing that?
MR. TORGERSON: Objection. Go ahead and answer.
BY THE WITNESS:
A: I don't know. I'll have to see what my academic and laboratory needs are. For instance — well, I haven't made — if I come to Cleveland to testify if and when, I really

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haven't made a determination as to how that will work,
BY MR. LINTON:
Q: Have you calculated a charge for doing that?
A: No.
Q: Have you ever had to travel out of town to testify at a trial?
A: I've traveled out of town but never traveled out of state.
Q: What do you charge — do you have a current fee schedule for testifying at trial?
A: What I had charged in the past for testifying at trial is $800 per hour plus travel expenses. Usually those have been very limited. So I'm going to have to think about that. I haven't really thought about it for coming to Cleveland if I need to do that.
Q: What do you charge an hour to review records?
A: $400.
Q: To give a deposition?
A: $600.
Q: Have you ever worked before for

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Ms. Chrisafi or the law firm of Jacobs, Manard Tushwin, and Caler (phonetic)? That was firm in Ohio that basically defended a company called PIE which is the largest malpractice insurer of physicians in Ohio. Did you do any work for that firm?
A: I don't think so. I think this is my first contact with them, but I think I might have been sent one other PIE case a long time ago. I certainly never had to go to Ohio. I think it just sort of disappeared, and I don't remember the details of that. But I don't recall any previous work with Ms. Chrisafi or this law firm or the other one that you mentioned.
Q: Or Mr. Torgerson I assume?
A: No, this is definitely the first case I've worked on with Mr. Torgerson.
Q: Are you doing less legal work now that than you did when you were at Northwestern?
A: Yes.
Q: You have less time?
A: Yes.
Q: Are you accepting new cases?

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A: Yes, selectively.
Q: Tell me in whatever way you can quantify how it's different now than it was at Northwestern.
A: It's quantitatively less, maybe 50, 75 percent less, something like that.
Q: How many cases do you currently have?
A: I don't know. I keep a little office that just holds records on cases, and most of those cases are from quite a long time ago, 1995, 1996.
Q: Your previous life?
A: My previous life. And I would say — as this one actually started in my previous life. I would say there's probably something like a dozen cases sitting there, and I don't know at the present time if those are just done or if they're going to go to trial or what. I think there may actively be one or two other cases that I'm working on. When I give a deposition, it's usually because I've been a treater.
Q: Let me make sure I'm clear. The number of cases that you have you said is like a

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dozen and then you said one to two other cases. I was confused.
A: What I meant by that is I have on file maybe a dozen cases. Other than this one there's maybe one or two others —
Q: Active?
A: — that, you know, I have received communication about, say, this year.
Q: I see. So the others are there if and when, but in terms of active cases, there would be just one or two?
A: I think that's an accurate characterization, yes.
Q: Are you accepting new cases for review in term of case a month, a case every six months? Have you set any sort of goal or limi for yourself in that area?
A: I haven't any sort of goal. I would limit it to only an occasional selective case, yes.
Q: If we look at in term the course of a year, are we talking a couple a year?
A: Right, a couple cases a year.
Q: Separate from any work you've done as

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a treating physician where you were asked to give deposition testimony in an auto accident case or Workers' Comp. case or something like that?
A: This is correct.
Q: The 2 percent or so of your practice that involves legal work, would that include those cases as well?
A: I wouldn't say it's of my practice, I would say it's of —
Q: Professional time?
A: — my working time.
Q: Which is how many hours a week approximately on a good week?
A: Depending if I'm looking at it or if my wife is looking at it I would say probably I am working probably more than 80 hours a week.
Q: When was the last time you gave a deposition in a case where a patient — excuse me, for a plaintiff in a medical malpractice case?
A: Usually it becomes a little fuzzy to me because what's happened in the past is a lawyer has sent me a patient and then I become a

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treater, but I also get involved as an expert.
So that has probably happened this year, maybe last month where I was a treater, slash, expert.
Q: Is that in a malpractice case?
A: Oh, in a malpractice case. Yeah, within the last five or six months I was probably deposed as a treater and then they used me as the expert in a malpractice case which has subsequently settled.
Q: For the patient?
A: Yes.
Q: What was the issue in that case, sentence or less?
A: The issue was head trauma.
Q: When before that did you last give a deposition for a plaintiff in a malpractice case?
A: I don't recall.
Q: Have you ever testified at trial for a plaintiff in a medical malpractice case?
A: No.
Q: How many times have you testified at trial in a medical malpractice case for a doctor or hospital?

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A: I'd say about half a dozen times, probably less than ten, in that kind of range.
Q: Have any of those aside from the one cauda equina case we talked about involve the issues in this case or relate to the issues in this case?
A: No.
Q: In terms of the number of cases, it's still the overwhelming majority that would be for the defense in a malpractice case as opposed to the plaintiff? If you look —
A: If terms of testimony, yes. In my previous life I've been sent cases to analyze by plaintiff's attorneys, an occasional case. So in terms of case volume forgetting about depositions, at one time it was more like 50/50 or maybe in terms of the plaintiffs; but a lot of those settled, and I never had to give a deposition and never testified at trial for them.
Q: What do you expect — tax time is just completed. What did you make last year from your legal work approximately?
MR. TORGERSON: Objection.

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BY THE WITNESS:
A: In terms of total money or in terms of percentage or what?
BY MR. LINTON:
Q: Let's start with both.
MR. TORGERSON: If can you segregate it, please do so.
BY THE WITNESS:
A: Well, I think total revenues from legal cases were about in the year 2000 somewhere between $60,000 and $70,000.
BY MR. LINTON:
Q: In terms of percentage?
A: It all depends on net income or gross income, things like that. It would be about 20, 25 percent.
Q: Of net or gross?
A: Gross. I should have my accountant in here.
MR. TORGERSON: Don't suggest it.
MR. LINTON: He'll be next.
BY MR. LINTON:
Q: Are you still doing any insurance examinations or examinations for any

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governmental entity?
A: No.
Q: When was the last time you were involved in that sort of work?
A: Unless, of course, you consider the University of Illinois a governmental entity.
Q: Well, separate from that. I mean in terms of insurance exams or Workers' Comp, Social Security, anything of that sort?
A: Anything that I do along those lines, anything that involves seeing a patient is clinical work, and it all goes through the University of Illinois. I don't do anything independently other than looking at some records.
Q: In case reviews like this case?
A: Right.
Q: Has there been anything else you've been asked to do between now and trial in this case?
A: No.
Q: Kind of going backwards, as you may or may not know our local court rules require that you give notice of all of the opinions that you

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hold in a case in your report and in deposition. I want to make sure I leave here today with all of your opinions.
Do you have any other opinions in this case that we've not covered either in your report or in your deposition here today?
A: Well, it's a little bit of a hard question to answer. I know you need to get the opinions, but for instance, look at all these flags on these depositions. I flagged them because either I had a little opinion or thought something about each little point.
Q: Let's start.
A: I'd have to say that I think most of the gist of things I've been able to get out here. I think I've made it very clear that the preliminary report that I gave did not express all of my opinion — I had a lot more opinions about, for instance, the definition of cauda equina syndrome and how Ms. Pikkel's condition related to that.
So I think I've given most of my opinions, but for instance, if I'm asked, do agree with Dr. So-so about this particular

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issue, it might trigger another opinion.
Q: I want to make sure I know all those opinions. I'm happy to go through these depositions with the tabs and tell us what the significance of the tabs are and what additional opinions, if any, you have.
A: Okay. Can I take a little break.
(WHEREUPON, a recess was had.)
BY MR. LINTON:
Q: I don't want to be surprised at trial.
A: We want to give all the opinions.
Q: If there's anything else you have, I want to know about now because it's the last time we talk before trial. If it means going line by line every piece of record, I'll stay as long as you want to or come back. If it's just a matter of focus —
MR. TORGERSON: It isn't a matter of staying as long as you want to. He's indicated that he has annotated his depositions which we've now been looking at, we've looking over for the last three hours.
MR. LINTON: I haven't looked at any

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depositions.
MR. TORGERSON: You certainly had the opportunity.
MR. LINTON: They're here.
MR. TORGERSON: He had — and you chose to proceed the way you do. I'm not criticizing.
(WHEREUPON, a recess was had.)
BY MR. LINTON:
Q: I'll try to speed this up, but I believe I've covered the opinions that you have given. I understand that obviously the opinions that you have today conflict to some extent with the deposition testimony of other witnesses in this case, in particular Dr. Bell and Dr. Yates, our emergency room expert.
But if there are any new additional opinions that you have based on these tabs, I want to cover those. If it's simply that you disagree because you've given the opinion why already, we don't need to get into that.
A: I think I understand the question is to get out my opinions, and I think that if I just kind of skim through these, it will refresh my memory about other opinions I may have that

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you may want to know about.
Q: Lee's start if we can with Dr. Spanner's deposition and just note the page you have tabbed, and tell us the significance, if any, of any of those pages in terms of your opinions.
MS. GORCZYNSKI: What deposition are we startingwith?
MR. LINTON: Dr. Spanner.
MR. TORGERSON: Every page or every page that —
MR. LINTON: Every page that matters in terms of any of his opinions.
BY THE WITNESS:
A: Well, I would say — I'm going to move closer the speaker. Looking at Dr. Spanner's deposition, I mean, most of it if not all of it — I'm going to go through it kind of quickly — but I agree with him. So in most of these tags they were key points in which I was in agreement with him.
BY MR. LINTON:
Q: Could you just for the record identify the pages that you've tabbed.

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A: Yeah. I tagged 31 and 32 and 33 and 35 and 38. A lot of these tags, though, are just for important points in the case such as it may be an L5-S1 herniated disk, something like that, and a witness or someone that was deposed might have said that so I may have tagged that. It doesn't really reflect on a major opinion of mine.
But to continue 39, 43, 44, 47, 56, 57, 60, 63, 74, 77, 79, 83, 85, 87. I was noticing things like his knowledge of neurology and so forth which was good. I was agreeing with most of his opinions, for instance, about cauda equina. A particular thing was that I was aware that he was knowledgeable about the things that could possibly cause urinary retention which was the diagnosis obviously of Ms. Pikkel in this case when she presented to him.
He confirmed in his deposition the 26-hour time frame of the urinary retention. Me did appropriately on Page 56 include cauda equina syndrome is part of the differential diagnosis for Ms. Pikkel. I don't know if this is the kind of information you want.

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Q: That's okay, yes.
A: I thought that his knowledge of what the cauda equina was and his understanding of the time frame was good. I think his treatment of putting the Foley in obviously was appropriate. He said he did a neurologic examination.
There was this issue of tweaking of the nerve roots. It's an op agree that can occur. As a might also be called to use a medical term instead of the more understandable laymen's term it might be called a neuropraxia.
Q: Bruising of the nerve?
A: No, praxia means a temporary nerve or nerve root injury.
Q: How can one determine whether it's a neuropraxia versus external damage of the nerve?
A: Neuropraxia is going to resolve more quickly.
Q: But there is no way to know at the time she presents to the ER whether it is a condition that will resolve or a condition that will become permanent, correct, because as of

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that point of time absent an MRI?
A: As far as the bladder problem, true, but I think he could also use that in terms of the numbness. The numbness when he saw her in the emergency room, meaning Spanner which would be the first emergency room visit, the numbness had resolved.
Q: If you believe Dr. Spanner?
A: Correct. So my opinion that I'm conveying to you today is that the explanation of tweaking or a neuropraxia for a transient numbness I believe is valid.
Q: But you know he's now wrong?
A: I'm sorry?
Q: You know he's wrong, it wasn't just a tweaking of the nerve?
A: Well, you have to discriminate — no, I can't agree with that. To explain my answer you have to discriminate what nerve is being tweaked. Now, the nerve or the nerve root going to the bladder was permanently damaged, and that's what I said in my report.
Q: So there was no tweaking of the nerve as it relates to the bladder?

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A: I wouldn't say that was tweaked. I would say that was permanently damaged.
Q: So Dr. Spanner was wrong to say that it was simply a tweaking of the nerve that lead to her urinary retention?
A: Let me look at what he said.
MR. TORGERSON: Let me interpose an objection.
BY MR. LINTON:
Q: You don't need to look at the exact time. Assume that if one was of the opinion during the first presentation that it was merely a tweaking of the nerve that caused the urinary tension, that would be incorrect?
A: You have to put yourself back into 1996 in the emergency room.
Q: No. We know that that was wrong, correct?
MR. TORGERSON: I'm going to —
BY MR. LINTON:
Q: I'm not talking about what he knew —
MR. TORGERSON: — interpose an a objection.
BY MR. LINTON:

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Q: — or should have known. I'm talking about the facts.
The reality is it was not a tweaking of the nerve that caused the urinary retention, correct?
A: I think it was valid as part of the differential diagnosis. I think it was — I think at this time it was a very real possibility. But now with hindsight and in my opinion, as you know I have said, I believe that the damage to the nerve roots going to the bladder was not a tweak but was permanent and that it had been going on for 26 hours.
Q: Likewise, if the numbness had not resolved, then that, too, was not due to a tweaking of the nerve but due to the disk herniation?
A: Now, it could be both. In other words, a disk herniation could cause a tweak or a neuropraxia. So I think for the numbness that was present and then resolved, tweaking or neuropraxia was correct.
Q: Assume it does not resolve, assuming the time she presented to the ER visit number 1

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she, in fact, had perineal kneel numbness still. If that's the case, could that still be at that point simply a neuropraxia or is that due to more serious damage to the nerve roots caused by disk herniation following chiropractic manipulation?
A: It still could be a neuropraxia at that time.
Q: If it is neuropraxia at that time, isn't that all the more reason to get in there and do surgery to relieve the pressure off the nerve root?
MR. TORGERSON: Objection.
BY THE WITNESS:
A: No, that doesn't really follow logically because a neuropraxia is a transient deficit. By definition the neuropraxia is going to resolve without surgery. Do you see what I mean? So no.
BY MR. LINTON:
Q: Doctor, if the tweaking of the nerve was part of differential and the cauda equina syndrome was also part of their differential, isn't a doctor required first to rule out the

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more serious condition that can be treated surgically before he goes and makes the conclusion it's simply a tweaking of the nerve?
MR. TORGERSON: Objection.
BY THE WITNESS:
A: It depends on the individual situation, and keeping it on this case, no, I don't think he was obligated to do an MRI. I already answered that.
BY MR. LINTON:
Q: what did he do to rule out cauda equina syndrome from his differential? How did he rule that out?
MR. TORGERSON: Objection.
MS. GORCZYNSKI: Objection.
BY THE WITNESS:
A: Cauda equina syndrome, I'll go through this again. I hate tu beat a dead horse too.
BY MR. LINTON:
Q: He used that term, Doctor. What did Dr. Spanner do to rule out the cauda equina syndrome that he had on his differential?
MR. TORGERSON: Objection; this has been asked and answered. But since it's been asked

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once again, go ahead and answer.
BY THE WITNESS:
A: What he did was his history and neurologic exam, and the patient did not have the manifestations of cauda equina syndrome.
BY MR. LINTON:
Q: You would agree that if he did not do a neurological exam, that that, in fact, would have been below the standard of care because he could then not have ruled out cauda equina?
MR. TORGERSON: Objection.
MS. GORCZYNSKI: Objection.
BY MR. LINTON:
Q: Would it have been appropriate?
MR. TORGERSON: Objection.
BY THE WITNESS:
A: He did a neurologic exam.
BY MR. LINTON:
Q: How do you know that, Doctor? I'm not going to ask you to take sides. Assume that he did not.
A: I'm waiting for a question.
Q: Assume that he did not do a neurologic exam, what did he do to rule out cauda equina

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syndrome?
MR. TORGERSON: Note an objection.
BY THE WITNESS:
A: I've asked this many times, cauda equina syndrome is a clinical presentation. She did not have cauda equina syndrome.
BY MR. LINTON:
Q: So he was wrong to put that on his differential, which one is it, Doctor? You said you agree it should have been on his differential. Now you're saying it shouldn't be on his differential.
MR. TORGERSON: Objection.
BY THE WITNESS
A: I think the differential you could make very broad. I mean, in your differential you could include infection, leprosy. The differential is big.
BY MR. LINTON:
Q: Would you include leprosy here, Doctor?
A: Well, I think leprosy might be a possible cause of cauda equina syndrome.
Q: Would that be on your differential?

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A: I was trying to answer a question by making a point. In a differential diagnosis, you keep it — you keep it broad and you think about all these different things, but what you treat is the patient. The treatment that was given putting in the catheter I think was the appropriate treatment.

BY MR. LINTON:

Q: How did putting in a catheter — assuming he did not do a neuro exam, how did putting in a catheter rule out cauda equina syndrome from his differential diagnosis?

MR. TORGERSON: Objection.

MS. GORCNNSKI: Objection.

BY THE WITNESS:

A: You're asking me a question that doesn't make any sense.

BY MR. LINTON:

Q: Because what he did doesn't make any sense, Doctor.

MR. RUFF: Objection.

BY MR. LINTON:

Q: If it's on his differential and he doesn't do a neurologic examination, he hasn't

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ruled it out. If he doesn't do an MRI, he hasn't ruled it out; isn't that right?

MR. TORGERSON: Objection.

BY THE WITNESS:

A: No —

BY MR. LINTON:

Q: Let me ask it this way.

A: — he can rule out cauda equina —

MR. TORGERSON: Wait a minute, the doctor is trying to answer one of your last several questions.

BY THE WITNESS:

A: ~~He can~~ rule out cauda equina syndrome simply with a question. Let me illustrate this, cauda equina syndrome as we've gone through the very beginning is a collection of different findings, okay. If those findings are absent, if a person does not have pain — really if you come right down to it if you're talking about cauda equina syndrome in the strictest sense, if you ask the patient, are you in pain, and they say, no, you could make an argument for the fact that the person doesn't have cauda equina syndrome.

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That doesn't say anything about the lumbar disk, but it says — it speaks to the fact of someone having cauda equina syndrome or not.

BY MR. LINTON:

Q: Well, I think we're arguing over semantics I understand they are very important to you. Hear me out, I understand that you're using a medical, technical definition of cauda equina syndrome. Let's call it lumbar disk herniation.

What did Dr. Spanner do to rule out a lumbar disk herniation during the first visit to the ER?

MR. TORGERSON: Objection.

MS. GORCZYNSKI: Objection.

BY THE WITNESS:

A: Same answer, he took the history of the patient and did the examination focused on the problem that the patient came in with.

BY MR. LINTON:

Q: Now, assuming he did not do a neurologic examination, did not check with pinprick sensation, did not do a rectal

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examination, what then did he do to rule out a lumbar disk herniation?

MR. TORGERSON: Object to the hypothetical assumptions.

BY THE WITNESS:

A: Same answer, he took the history and examined the patients extremities and did an examination that he thought was appropriate.

BY MR. LINTON:

Q: But the appropriate examination for a patient in whom you suspect a lumbar disk herniation as a possible cause of urinary retention is to do a rectal exam and to check for perineal numbness, right? Isn't that what's required to do a proper exam?

MR. TORGERSON: Objection.

BY THE WITNESS:

A: No, this patient was not even having back pain, was not having leg pain. He would have had to have been psychic to —

Q: To do a simple examination?

A: — think she had a lumbar radiculopathy or a lumbar disk herniation. This was an unusual presentation for you want to call

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it a cauda equina syndrome. He did what was appropriate. With hindsight we know that she had to have disk surgery the next day.
Q: Would it have been unreasonable for him to do a rectal exam and for him to do a pinprick examination for sensation of the perineal area?
MR. TORGERSON: Objection.
BY THE WITNESS:
A: Would it have been unreasonable? I don't think the patient necessarily would have liked it, but —
BY MR. LINTON:
Q: I think she would have liked it very much, Doctor, if it had led to the diagnosis of her disk herniation and led her to have an earlier surgery that Dr. Bell, her treating surgeon, said would have made a difference in her outcome. I think she would have appreciated that very much.
A That's a statement. I need a question.
MR. TORGERSON: I don't think you can respond to that.

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BY MR. LINTON:
Q: Would it have been unreasonable for him to do an MRI?
MR. TORGERSON: Objection; asked and answered.
MS. GORCZYNSKI: Objection.
BY THE WITNESS:
A: I don't think an MRI was indicated based on the presentation that day with Dr. Spanner.
BY MR. LINTON:
Q: Would it have been unreasonable?
MR. TORGERSON: Objection.
BY THE WITNESS:
A: I think in most — I don't know if it would have even been approved because there was not an indication to do an MRI.
BY MR. LINTON:
Q: Approved by whom, by an insurance company?
A: Yeah.
Q: Assume that the patient would pay for it anyway, would it be unreasonable for a doctor to order it?

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MR. TORGERSON: Objection.
BY THE WITNESS:
A: I don't think it was indicated to order it,
BY MR. LINTON:
Q: Assuming a doctor suspected a disk herniation in a patient that has a 26-hour history of being unable to void, what should be done to rule that out from the differential diagnosis?
MR. TORGERSON: Objection.
BY MR. LINTON:
Q: Full history, a full examination, and assuming the examination shows persistent perineal numbness and a lack of rectal tone, at that point would an MRI be appropriate?
MR. TORGERSON: Objection.
BY THE WITNESS:
A: Yes.
BY MR. LINTON:
Q: If at that point the MRI showed a disk herniation even if it was smaller than what was shown on the second ER visit, would a neurosurgical consultation be appropriate?

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MR. TORGERSON: Objection,
MS. GORCZYNSKI: Objection.
MR. TORGERSON: Asked and answered.
THE WITNESS: Could you read that question again.
BY MR. LINTON:
Q: I'll withdraw the question. Assume that the MRI was performed during the first ER visit and showed the same size disk herniation, we can agree then a neurosurgical consultation should have been done?
MR. TORGERSON: Objection.
BY THE WITNESS:
A: Let met make sure I understand the question. So what you're saying is that if a patient comes into the ER with all these problems including the urinary retention, including the history of back pain, including the chirogmctic manipulation.
BY MR. LINTON:
Q: Let me just be clear so I can lay it out for you.
A: Thanks.
Q: Presents in the ER with a 26 — strike

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that.
Presents in the ER with a 26-hour history of being unable to void following chiropractic manipulation, the physical examination is performed and shows no rectal tone, shows perineal numbness, and MRI is then order which shows the same disk herniation that was shown when the MRI in this case was taken.
Assuming all of that occurred during the first ER visit, then a neurosurgical consultation should have been obtained —
MR. TORGERSON: Objection
BY MR. LINTON:
Q: — correct?
MR. TORGERSON: Objection.
BY THE WITNESS:
A: If we see all those things, I would say, yes.
BY MR. LINTON:
Q: I interrupted you when you were going through Dr. Spanner's deposition. Could you pick up when where you left off.
A: I think I was done with it.
Q: How about Dr. Bell's deposition?

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A: Well, I've marked about probably 100 pages on this. In prefacing going through these depositions, you said that you assumes opinions different than —
Q: That's all I want to know about.
A: — Dr. Bell. So I would agree —
Q: I just want to make sure that there's nothing in these tabs that is going to trigger in you a new opinion that we haven't covered during the deposition today.
A: Give me a few minutes to scan through this. Let me just see if there's going to be any new opinions.
MR. LINTON: Linda, I'm assuming you don't have any questions or do you?
MS. GORCZYNSKI: I do not.
BY THE WITNESS:
A: For instance, this could be an important point. This opinion that if she had been operated on 9-4-96 her chances of having recovered without residual bowel and bladder problems with have improved to approximately 80 percent. In my opinion and I don't think the medical literature and our knowledge as

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neurosurgeons would support coming up with a figure such as 80 percent, 55 percent.
BY MR. LINTON:
Q: Would support any figure?
A: It would not support a specific figure, that is correct. So that's an important opinion to come out.
Q: You've made a distinction in your report and in your testimony today between the return of function or full function versus the return of any function. With reasonable medical probability wouldn't you expect there to be with prompt surgery and, let's say, 35 hours versus 48 hours there to be the return of some function?
MR. TORGERSON: Objection.
BY THE WITNESS:
A: Well, with the bladder it's pretty much either working or it's not. You'd have to ask a urologist exactly about trying to quantitate it and if some medicines may be able to help. For instance, you know, if Ms. Pikkel is still having some bladder problems today, I don't know if she's on medicine for that. I

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don't know if she's been evaluated for that. I recommend she be evaluated for that to see if there are some medicines that could help her situation. That's another opinion, that's true.
BY MR. LINTON:
Q: You didn't know that she was still self-catheterizing 10 to 15 times a day in order to urinate? Do you recall seeing that in her deposition?
MR. TORGERSON: That deposition goes back to 1999 or 2000. We'd like to take her deposition again, but I think you've resisted that.
MR. LINTON: I think the doctor also said that after 1999 he would not have expected any further improvement.
MR. TORGERSON: I'm not sure he did.
MR. LINTON: With reasonable medical certainty.
BY THE WITNESS:
A: If that, in fact, is happening that she is having to catheterize herself, you know, I would really hope that she is under the care of a urologist so that if there is anything that

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can be done to help that that would be done. That's my opinion about that.
Dr. Bell on Page 75 answered that he had no problem with Dr. Spanner, I agree with that.

BY MR. LINTON:

Q: I believe that's a mischaracterization of his testimony.
A: Well, you guys can figure that out. I'm just giving my opinions.
Q: Did you continue reading on page — strike that.
Go ahead, Doctor.
A: Well, I want to draw attention to this time frame on Page 111 of Dr. Bell's deposition, and this is something we haven't covered. When she showed up in the emergency room on September 5,1996, that would be the second time, it was about a seven-hour time period between when she came in and when the surgery was started.
So I'm not being critical of that seven hour delay because as, you know, it's my opinion that if this surgery had been done at three hours, four hours it wouldn't have made

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any difference in her long-term outcome.
But we have to realize that if it took seven hours in the middle of the day on the 5th, I think it is very likely if you're coming up with a theory in terms of any alleged injury, that you would have to add that time period or even more because it was late at night if you're going to be thinking about when the surgical intervention was done if it was done the day earlier.

BY MR. LINTON:

Q: It's not going to be done when she walks in the ER. You would, of course, defer to Dr. Bell who was a 40-year — had a 40-year history of being a neurosurgeon in Cleveland and was the former head of the department there, you would defer to Dr. Bell in terms of when he thought he could come in and do the surgery had he been called after the ER visit, would you not?
MR. TORGERSON: Let me object.

BY MR. LINTON:

Q: You don't profess the workings of Meridia Hospital and Dr. Bell's group in terms

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of their availability to come and do the surgery had they been called after her fist visit?
MR. TORGERSON: Objection.

BY THE WITNESS:

A: Well, I wouldn't give a blanker answer that I would defer to Dr. Bell. I'm just only pointing out an opinion that additional time which you've recognized would have to be added to any possible intervention. Would I defer to Dr. Bell, that would depend. You would have to ask me specifically what I would defer to him about. I've already admitted in this deposition the way he did the procedure, I'm not critical that.

BY MR. LINTON:

Q: He says he could be there within five hours or certainly within seven hours, the same time period as after the first surgery. You would not disagree with that?
MR. TORGERSON: Objection.

BY MR. LINTON:

Q: You don't have any factual basis, would you?
A: Well, in Illinois you should really be

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available to the ER in about an hour as a neurosurgeon if you're on call. So if he was saying I would get there in five hours, I don't know if I could defer to that. That might not be appropriate. It might depend on the patient.
Q: If you were the one covering this ER on the night of the first ER, you would have been there in an hour if it was at one of your local hospitals or at your university?
A: No, I said that that's the time frame in which we need to be available.
Q: To respond to a call?
A: Right. So if someone had urinary retention, I probably wouldn't have been called at all.
Q: Let me ask this way, just based on your own clinical experience. best case scenario you're called in covering for neurosurgery that night, what would be the quickest you could get in and do surgery assuming it was indicated?
MR. TORGERSON: Note an objection. But go ahead and answer.

BY THE WITNESS:

A: If the MRI had already been done. less

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than an hour.

BY MR. LINTON:

Q: Less than hour you could actually be in the hospital or in the OR?

A: In the hospital and in OR.

Looking at Dr. Zannetti,

Q: Actually, I don't care about Dr. Zannetti. You're not offering opinions on Dr. Zannetti.

A: We'll leave him out. I did review Pikkel's deposition, and I found just a few things. Really the fact that the pain was different over any particular time, my opinion is that clinically that didn't really have a lot of significance.

Q: The pain being the severity of the backpain?

A: Yes.

Q: Why would that not have clinical significance in a case of disk herniation?

A: Well, I think if back pain was present enough to be a complaint, that could have significance. But if back pain is a little better a little worse, different in character

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But on the other hand, if someone says, I'm defecating on myself or my whole region is numb, I think that would have made it into the record so I'm giving that opinion.

Q: The standard of care required that if there was complaint of numbness made by a patient that should have been recorded in the record and you would expect that that would have been recorded in the record, correct?

MR. TORGERSON: Objection.

BY THE WITNESS:

A: If it was clinically significant. In other words —

BY MR. LINTON:

Q: You're saying it would have been clinically significant in this case. I'm saying if, in fact, it was made —

A: There's a difference between a little numbness and, for instance, spinal anesthesia. I think you can appreciate that.

If someone says, I'm a little numb back here, that might not be clinically significant. If one says, my entire genital area has no feeling and I can poke it with a pin

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provided that that difference isn't radiating down the leg for instance or may be associated with another neurologic deficit, that didn't have a lot of meaning to me.

Q: Assume that she actually has excruciating pain and also numbness through her mid section even before she goes to the chiropractic, would that suggest that she's starting the disk herniation or starting the compression of the nerve roots even before the manipulation occurs?

A: That would be more suggestive of that, yes.

Another thing is if she had — I don't remember exactly where this is in her deposition, but if she did have a very significant complaint of numbness, if that were true, I think it would have been recorded by th nurses and doctors seeing her in the emergency room.

Q: You hope it would be recorded?

A: I gave you an opinion saying that a doctor can't put everything that he does into the opinion — or into the record, excuse me.

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and there's nothing there, that's different. That would have made it into the medical record and that should have been in the medical record.

Q: Standard of care would require that?

MR. TORGERSON: Objection.

MS. GORCZYNSKI: Objection.

BY THE WITNESS:

A: I'm not an emergency doctor, but as a neurosurgeon, I would have been interested in that, yes.

I note in her deposition, and this is important, that she has not had as of the time that this was done a repeat cystoscopy or urodynamic study. I think if she's going to say she's permanently injured or to what extent she's injured, I think that should be done. That's an opinion. Now whether it will get done, I don't know.

The only two things I've got left is Villarosa who really I had no criticism of what he did, and I don't think anyone else did either. The plaintiff's ER doctor, I'm not an ER doctor. I'm looking at these opinions through the eyes of a neurosurgeon obviously. I

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disagree with some things.
Q: In all fairness then you're not in a position to say whether or not Dr. Spanner met or deviated from the standard of care, are you?
MR. TORGERSON: Objection.
MS. GORCZYNSKI: Objection.
BY MR. LINTON:
Q: You're talking about this as a neurosurgeon?
MR. TORGERSON: Objection.
BY THE WITNESS:
A: There's no doubt that I'm talking about it as a neurosurgeon, and the clinical issue in this case is neurosurgical or causation, that's another medical term — I mean a legal term, excuse me.
BY MR. LINTON:
Q: Let me ask it this way.
MR. TORGERSON: You're interrupting him.
MR. LINTON: I will interrupt him.
MR. TORGERSON: You will interrupt him.
MR. LINTON: I will.
BY MR. LINTON:
Q: I want very simply do you or do you

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not know the standard of care that applies to an emergency room doctor like Dr. Spanner under those circumstances when he saw Bonnie Pikkel?
MR. TORGERSON: Note an objection.
BY THE WITNESS:
A: I do for this problem because as a neurosurgeon I'm called into the emergency room all the time. If a patient has a neurologic problem, in my career I have to go in there and interact with the emergency room physicians, absolutely. So in a situation like this, I can give an opinion
BY MR. LINTON:
Q: I see.
A: But there's no doubt that I'm not an emergency room doctor, and there's other experts that are talking about that.
So I do have some criticisms of the plaintiff's emergency room expert.
Q: Tell me what experience and training you have with respect to the standards of the care of an emergency room doctor.
A: Sure, I mean, emergency room medicine and emergency situations are covered in medical

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school. In my internship I spent I think it was two months in the emergency room just working in the emergency room. I actually moonlit or moonlighted in the emergency room during my mining working in the emergency room.
Then as I mentioned as a neurosurgeon myself or my residents get called about emergency problems frequently. Saturday night is a primary example.
Q: So you are able to testify then about all issues as it relates to the standards of care provided by Dr. Spanner to Bonnie Pikkel; is that your testimony?
MR. TORGERSON: Note an objection.
BY MR. LINTON:
Q: You've gone back and forth, Doctor, in all fairness. You said, I can't defer to the doctor because I'm not an ER doctor; but when you want to give an opinion favorable to Dr. Spanner, then you say you are qualified.
I want to know, are you qualified —
MR. TORGERSON: Argumentative,
BY MR. LINTON:
Q: — across the board unequivocally to

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the standard of care by Dr. Spanner or are you not?
MR. TORGERSON: Argumentative, asked and answer, mis leading.
BY THE WITNESS:
A: I think as it relates to this case I can give an opinion.
BY MR. LINTON:
Q: On all issues as it relates to Dr. Spanner's treatment to Bonnie Pikkel during the ER during her first visit?
MR. TORGERSON: Objection; asked and answered.
BY THE WITNESS:
A: Can I ask a point of clarification, what do you mean by all issues? Do you mean the emergency room physician call schedule for that day?
BY MR. LINTON:
Q: I'm talking about anything that he did in his history, examination, diagnosis or misdiagnosis, and treatment of Bonnie Bikkel during this first visit.
A: I'm qualified.

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Q: You're **qualified** and you're confident that you know the standard of care that applied to an ER doctor like Dr. Spanner under those circumstances?

MR. TORGERSON: Objection; asked and answered.

BY THE WITNESS:

A: I can be an expert about that, of course.

BY MR. LINTON:

Q: Have you ever been qualified in any court to give expert testimony on the standard of care as that applies to an emergency room physician?

MR. TORGERSON: Objection.

BY THE WITNESS:

A: What does that mean being qualified in a court?

BY MR. LINTON:

Q: Has the court allowed you to testified on that **issue** on the standard of care that applies to an emergency room doctor?

MR. TORGERSON: Objection.

BY THE WITNESS:

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A: I have given testimony, yes, in court about emergency room issues as they relate to neurological surgery, yes.

BY MF?.LINTON:

Q: Specifically whether an ER doctor met [si or violated the standard of care of an ER doctor under those circumstances?

A: Yes.

Q: I'm *sorry* I interrupted you when you were going through the deposition.

MR. LINTON: You forgot your flaccid objection by the way.

MR. TORGERSON: Once is enough.

BY THE WITNESS:

A: You know, do you want me PO read the pages where I tagged Yate's deposition?

BY MR. LINTON:

Q: Yes?

A: 7.

Q: And if those represent any new opinions, please let us know.

A: 7, 10, 15, 34, 49, 56, 73, 76. Let's look at 76 because I disagree with this, and we might as well just get it out here. Dr. Yates

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alleges that perhaps Dr. Spanner had fallen into the trap of finding a possible explanation that was benign and talked himself out of ruling out a more dangerous cause of the symptoms. He continues. I want to point out that I disagree with that.

Q: Why do you disagree?

A: Because from my looking at the record and understanding what was going on with Ms. **Pikkel** at that time even separate from the issue of what Dr. Spanner said in his deposition, I don't think it was a matter of him talking himself, for instance, out of the possibility of cauda equina syndrome. She didn't have cauda equina syndrome.

Q: I think Dr. Yates —

A: No talking out was necessary.

Q: I think Dr. Yates was saying there that on the differential was a temporary condition versus a permanent condition that could have been or would have been corrected by surgery and that it was a mistake for the doctor PO go with the temporary condition **as** opposed to the ruling out the more serious correctable

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condition; i.e., the lumbar disk herniation as opposed to a merely tweaking of the nerve.

A: And in general if you're just try to get my opinion, I disagree with his line of thinking.

Q: Why is that?

A: Mostly because she just had the urinary retention without the other things that would make — but you've gotten this opinion out of me already, that part of it.

The emergency room doctor here mentions on Page 91 — you know, I may have skipped a couple of flagged pages. Let me see, let me put those into the record, 86, 77. I think that covers it.

It's talking about the neurosurgeon. This is an emergency room doctor expert talking about the issue of the neurosurgeon dealing with causation. So I want to point that out, that's why I can be involved here.

Q: So you can criticize him but he can't criticize you?

A: He can criticize me. That's for the jury to decide I guess and the court system.

Really that's all I have.
MR. LINTON: Thank you. That's all the questions I have at this time.
MR. TORGERSON: Is that it?
MR. RUFF: Linda, nothing at your end?
MS. GORCZYNSKI: No questions.
THE WITNESS: I better read.
MR. TORGERSON: We'll order it and read it.
MR. LINTON: A is the reports. B was your old CV. October '98 CV. C your current CV. D is your file. I marked D 1, D 2 and D 3 individual records from that file. I think that covers it.
FURTHER DEPONENT SAITH NOT.

IN THE DISTRICT COURT OF CUYAHOGA COUNTY, OHIO
COMMON PLEAS COURT
BONNIE PIKKEL, ET AL.,)
Plaintiffs)
vs.) No. 326207
MARK ZANNETTI, D.C., ET AL.,)
Defendants.)
I hereby certify that I have read the foregoing transcript of my deposition given at the time and place aforesaid, consisting of Pages 1 to 181 inclusive, and I do again subscribe and make oath that the same is a true, correct and complete transcript of my deposition so given as aforesaid, and includes changes, if any, so made by me.

HERBERT H. ENGELHARD, M.D.
SUBSCRIBED AND SWORN TO
before me this day
of , A.D. 200 .
Notary Public

STATE OF ILLINOIS)
) SS:
COUNTY OF COOK)
I, LORIANNE McGUIRE, a Notary Public within and for the County of Cook, State of Illinois, and a Certified Shorthand Reporter of the State of Illinois, do hereby certify:
That previous to the commencement of the examination of the witness herein, the witness was duly sworn to testify the whole truth concerning the matters herein;
That the foregoing deposition transcript was reported stenographically by me, was thereafter transcribed under my personal direction and constitutes a true, complete and correct record of the testimony given and the proceedings had;
That the said deposition was taken before me at the time and place specified;
That I am not a relative or employee or attorney or counsel, nor a relative or employee of such attorney or counsel for any of the parties hereto, nor interested directly or indirectly in the outcome of this action.

IN WITNESS WHEREOF, I do hereunto set my hand and affix my seal of office at Chicago, Illinois, this 30th day of April, 2001.

Notary Public, Cook County, Illinois.
My commission expires 2-16-05.

C.S.R. Certificate No. 84-4269.

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