Doc. 193

STATE OF OHIO)
) SS: IN THE COURT OF COMMON PLEAS
CUYAHOGA COUNTY)

CASE NO. 106333

DONALD B. MILLIGAN,	)	
PLAINTIFF,	)	VIDEOTAPE DEPOSITION
VS.	)	OF
CSX,	)	DR. BYRON HOFFMAN
DEFENDANT.	)	JUDGE

VIDEOTAPE DEPOSITION taken before Tim Palcho, a Notary Public within and for the State of Ohio, pursuant to Notice, and as taken on April 20, 1988 in the office of Dr. Byron Hoffman, Huron Road Hospital, 2nd Floor, Cleveland, Ohio. Said deposition taken of Dr. Byron Hoffman is to be used as evidence on behalf of the Defendant in the aforesaid cause of action, pending in the Court of Common Pleas, within and for the County of Cuyahoga, for the State of Ohio.

APPEARANCES:

MR. MICHAEL B. MICHELSON,

On Behalf of the Plaintiff,

MR. HARLEY MCNEAL,

On Behalf of the Defendant.

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OPERATOR: We're on the record. Doctor, raise your right hand. Do you swear the testimony you are about to give to be the truth, the whole truth, and nothing but the truth, so help you God?

DR. **HOFFMAN:** I do.

DURING DIRECT EXAMINATION BY MR. HARLEY MCNEAL:

Q Dr. Hoffman, I am going to hand you what has been marked as Defendant's Exhibit "A", Defendant's Exhibit "B", and "C". Would you advise us as to what the three documents are?

A Exhibit "A" is a copy of my curriculum vitae. Exhibit "B" is a copy of...or the original of my written report covering the examination of Donald B. Milligan on December 15th, 1987,

Q The back portion.

A And I guess Exhibit "C" is the X-ray report rendered by Hill and Thomas covering areas of the body that I ordered to be X-rayed on 12/15/87.

Q And did you receive the X-rays that are interpreted by Drs. Hill and Thomas or just the report?

A No, I review all....I look at all X-rays that I order. I have the X-rays that we ordered here today.

Q Very well, If I may, I will then ask you what is

a curriculum vitae?

A Oh, I guess it is a summary of your past training and activities of a professional nature.

Q And would Defendant's Exhibit "A" which you have identified as the curriculum vitae, is this an accurate listing of your education, your board certification, and the activities in which you would have been involved in over the period of the time from graduation from medical school up to the present time?

A Yes. It also includes the educational background leading to the practice of orthopaedics,

Q And what is board certification?

A In orthopaedics, after the conclusion of the prescribed required training period, you take a written and oral examination. Then two years following that written and oral examination you take a second written and oral. If you pass both then you are certified by The American Board of Orthopaedic Surgery.

Q And certified to do what?

A Orthopaedic surgery.

Q And generally, in two or three sentences, what is orthopaedic surgery?

A It is that branch of surgery that specializes in problems, injuries, diseases, and the maintenance of health in what we call the skeletal muscular system and

its associated structures; that is bones, joints, ligament: tendons, muscles, blood vessels, nerves, et cetera.

Q And Defendant's Exhibit "C" relate the findings of roentgenologist relative to the X-rays which were taken, is that correct?

A That is correct, yes.

Q And do you have a copy of that?

A I do.

Q And going to the areas which were X-rayed relative to both the right knee and the left knee, the conclusions as to those X-ray findings were what?

A May we go off the record for a moment?

Q Yes.

OPERATOR: We're off the record.

OPERATOR: We're on the record.

A Would you repeat your question, Mr. McNeal?

Q Yes. As to the information which is listed or contained in the X-ray reports from Dr. Hill and Thomas, and particularly I believe.. ..I'm not familiar with the.. . (Phonic) yes, it was by a Dr. Crudy who apparently is a roentgenologist either employed by or a member of Drs. Hill and Thomas who have done X-ray interpretations and undertaking....undertaken X-ray diagnoses over a period of years, is that correct?

A Yes.

Q What were the findings as to Dr. Crudy's X-rays relative to the right and left knees?

A Well, the conclusions of Dr. Crudy are also my conclusions, having reviewed the X-rays at the time they were taken, and so that they are both of our conclusions. On the left knee we found...he found... we found aging changes in the knee; that is the left knee. On the right knee, again there were aging changes in the knee and on the right knee there was a density that suggested the possibility of a loose body in the right knee. That is a "joint mouse" I think is the lay term for it. So he had aging changes in both knees, of pretty much comparable degree, and he had a joint mouse possibly in the left knee. The X-ray couldn't make that diagnosis exactly.

Q Is that what....aging changes, is that what is referred to as degenerative?

A Yes.

Q And how does degenerative differ from traumatic?

A There can be post traumatic degenerative changes in a joint if that joint has been subjected to an appropriate type of injury that leads to that. Aging degenerative changes are a part of the biochemical process that we are all trying to fight.

Q That would be unrelated to trauma, is that correct?

9:00:03 - MR. MICHELSON: Objection. Objection. It is leading.

A There are....as we already stated, there are post traumatic degenerative changes if the trauma to a joint is appropriate. The vast majority, statistically population-wise, of degenerative changes in a joint are due to the aging process because 100 percent of human beings undergo them.

Q And in your examination, which was both a physical examination and also an interpretation of the X-rays, did you find any evidence in so far as Dr. Milligan was....or Donald Milligan was concerned relative to a difference between degenerative and traumatic?

9:00:51 - MR. MICHELSON: Objection.

Are we talking about the knees?

That is correct.

Your question is a long one. I think the answer would be that I found no evidence of post traumatic degenerative changes in either knee.

Q And that would be in connection with not only the examination you made, but also the history which was secured?

9:01:24 - MR. MICHELSON: Objection

MR. MCNEAL: Well, if we want to,..

MR. MICHELSON: Withdraw the objection.

MR. MCNEAL: Very well. Fine. Because we can do it the hard way if we have to, but I am trying to save time.

Okay. Go ahead, Doctor-

Well, I am not quite sure what the question was.

Would you go back to what you were describing as to your findings on examination of Mr. Milligan relative to the relation of his complaints to your findings?

Well, his complaints in the left knee were pain in the front of knee in the area of the kneecap. The findings in the knee, in the left knee, were, as I have stated, aging changes in the knee, in the left knee, but alsoagingchanges in the right knee in which he didn't have symptoms. I don't know whether that answers your question or not.

Very well. When you did examine him under the heading of "Present Illness," I believe Mr. Milligan described what had occurred I believe by the date of September 13th, 1984. Would you look at that and refresh your recollection as to what his complaints were with that. ..respecting the date of September 13th, 1984?

A Well, the description of the mechanism and circumstances of the injury of 9/13/84 was gained through two sources. One; review of a deposition that the patient gave on 11/3/87 and a corroboration of the patient at the time I examined him of.. .for wed-- ~~one~~ of a better word....corroboration of the previous deposition. The combination indicated that, "I was walking on the east side of the air compressor room. I stepped in a hole." He did not fall. The patient indicated, "I stepped in the hole and I felt severe pain in my left knee and kind of wrenched myself with my back." The deposition itself indicated that he walked away from the accident in ~~counter~~ contra distinction to having to be carried away on the stretcher. That he first had medical attention...well, I don't know whether the deposition said this or the patient said this, but anyway a combination of the patient and the records indicated that the first medical attention following the episode of 9/13/84 was on 9/17/84, 4 days later; this being rendered by his private physician.

Q And your examination of both knees were as you have previously related to us?

A Yes.

Q And what part, if any, did the description of the accident of 9/13/84 play in so far as injury to the knee,.

...left knee is concerned?

A I can only testify to the patient's condition at the time that I examined him on 12/15/87, At the time of that examination I found no evidence of. an orthopaedic abnormality that I could attribute back to the episode of 9/13/84 ,

Q And that would all be reported in your report of December 15th, 1987, is that correct?

A I believe it....(VO)

9:05:35 - MR. MICHELSON: Objection.

A I believe it is reported in that report, yes,

Q Well, now also in your examination...physical e: amination of Mr. Milligan in your office on I believe it was December 15th, 1987, what did you observe in so far as not only your examination was concerned, but what Mr. Milligan did on presenting himself to you in his cffice....in your office?

A The physical examination in orthopaedics, as in any field of medicine, but probably more so in orthopaedics because it is a mechanical specialty; that is it is how the patients works and how the patient functions, there are two equally major portions of the physical examination. One is conducted in the consulting room. As you are taking your history on 'the patient.....(VO)

(VO)

9:06:40 - MR. MICHELSON: Objection.

Q Go ahead.

A ....you watch how the patient walks from the waiting room into your consulting room, how he sits in a chair, the posture in the chair, how he gets up out of the chair, how he walks from the consulting room to the examining room, how he dresses or how he undresses, and so forth, so that you are watching the patient's mechanical movements during that phase....that major phase of the physical examination. Part two of the physical examination, which is equally important, is conducted in the examining room and is what the lay public interprets as the only part of the physical examination. In this particular patient's case the examination was of the low back, the flanks, the kidney areas, the sacroiliac joints, both of his shoulders, his buttocks, both of his hips, and both of his upper and lower extremities from a bone, joint, ligament, tendon, muscle, blood vessel, and nerve standpoint. He was examined in the standing, sitting, and lying positions wearing only his shorts. His wife was present for the examination. In that examination all maneuvers were done by the patient. There was no passive. ...I didn't move him. He did all the moving. We found his temperature and pulse to be normal, The patient indicated that he was right handed. There were surgical scars involving

the areas of both knees. There was a scar in the midline in the low back...down in the low back from the site of a previous spine fusion. There was a small circular scar over the front of the left shoulder in this area.

Q Pointing to your left shoulder?

A In this area of the left shoulder. It was a punctate scar.

Q What is a punctate scar?

A It is a circular scar. It was about the size I think of maybe your fingernail. All the scars were well healed, they were non-tender, and they were stable. There was slight flexor tendon crepitus at the "MP" joints of the thumb bilaterally of equal degree, but no triggering.

Q What is that?

A What we mean by that is that each thumb in this area when he moved them you could feel a little grating in these two joints. This physical finding was substantiated on the X-rays by the finding of aging changes in those two joints. There was no triggering of the thumbs at that time. What we mean by that is that you...many people have this...that you bring your thumb down and it gets caught and you can't bring it out, and then out it will come. What it is due to is it is due to swelling of the flexor tendon at the introitus of

the fiberosseous tunnel. of the thumb. To make that in lay terms, the tendon beginning at about this point in the hand that brings down the thumb runs or enters a tunnel, an encasement so to speak, through which that tendon runs. Because of the particular architecture and vascular supply of the tendon at that area, it is prone to undergo what we call degenerative changes and this forms a little bubble on the tendon. So that as the tendon enters the tunnel the bubble gets caught and it will click back and forth. Usually a couple of shots...in the majority of cases a couple of shots or cortisone solves that problem. If cortisone doesn't solve it, which is fairly rare, I would say maybe 25 percent of the time, then the patient has the choice of living with it or having surgical correction of it.

Q Is that again an aging process?

Yes, It is very common. Let's see.

Q You are on six.

He had grating of the kneecaps on motion of the knees of equal degree on both sides. That means that when he flexed and extended his knee, if this is his knee and his kneecap is here, you could feel a grinding of the kneecap on the femur. 100 percent of people get this as we age. Otherwise the examination as I have described it was normal. The...he had had a spine fusion

in the past, but the spine fusion was not of the degree that limited clinically, that is through observation, limited the motion of the spinal column on physical examination. It is very similar to say you have a chain of, well, let's say 24 links and you fuse two of the links together. It really doesn't interfere with the motion or the flexibility of the chain to that degree.

Q The ability to bend, twist, turn, or pull would still be there?

A Yes. It would still be there with just one segment fusion. By physical examination it was there. Let's see. That was the extent of the findings; the objective findings on physical examination.

Q Now, what did you also observe other than the physical findings when he was in your consulting room?

A You mean, in the consulting room or in the examination room?

Q Well, when he entered the consulting room you have a....

A Oh, all right.

Q ....apparently you were present at that time?

A Yes.

Q That is in your section listed as "Number 10-A" on page 6.

A Well, I have a series of things listed under

item 10-A. Upon entering the consulting room the patient (Phonic) was carrying a Loftstrand Crutch. That is a crutch that has a handle on it and a band that goes around the back of the arm. It is not up into the armpit and so we call that an axillary crutch. He was carrying a Loftstrand Crutch in his right hand, but was not relying on it for ambulation and exhibited no evidence of a limp. So he was carrying it, but not using it. During direct range of motion examination, that is asking him to move the back back and forth, and through the range of motion examination he exhibited marked limitation of motion to the point where he held his back, low back, in the neutral position in almost rigidity. Then during other portions of the examination, when we were not looking for range of motion particularly, he exhibited a normal range of motion of the back. Straight leg raising in the sitting position bilaterally was negative to 90 degrees while in the supine position it was bilaterally positive at 30 degrees,

Q What would account for that difference?

A Well, it would not be organic orthopaedic pathology.

Q You mean that is not due to some injury or.....

9:14:23 - MR. MICHELSON: Objection.

Q ....problem?

9:14:24 - MR. MICHELSON: Objection.

A Well, it is....

Q What would be the difference between straight leg raising bilaterally negative to 90 degrees and then when flat I am assuming it was positive bilaterally to 30 degrees? What brought about that difference in degrees?

A Well, I can't tell you what brought about it in the sense that it is an inconsistent finding. They should either be negative in both positions or positive in both positions because they are exactly the same examination as ar as the mechanics of the bo y are concerned. So it indicated to me that his...since under two circ sta es there were variances in that test you would have to conclude that he had a negative straight leg raising examination.

Q Is that something that is controlled by the individual or it is controlled by the circumstances of the physical condition of the patient?

A Well, since the response on a straight leg raising examination is a subjective response then it is controlled by the patient. That is his response is controlled by him.

Q Which would compare with the rigidity of the spine?

A Yes. Again, the patient has control over his motion of his spine.

Q All right. What other findings?

During direct examination of the left shoulder, that is, my attention and the patient's attention was directed to an examination of the left shoulder, he exhibited marked limitation of motion due to the subjective response of pain. That is when we were both focusing on the left shoulder and moving it through various motions he exhibited marked limitation of motion of it,... marked restriction of motion of it and indicated that that was painful. However, then during other portions of the examination he exhibited a normal range of motion to the left shoulder when neither he or my attention was specifically directed to the left shoulder, and this being without apparent pain. He had good muscle function of the left shoulder. I used the illustration in the report that during part of the examination you have the patient lying on his face on the table and you are examining his spine with him lying down on his face. That is the final part of the examination that I have alluded to. Then in the process of having the patient say, now, get off the table and stand up, he did a push up with both arms in the process of rolling over to get off the table without apparent difficulty. I think

that concludes the section of the report on the physical examination.

Q All right. And your diagnosis included what?

A Well, the items under diagnosis were four. No evidence of orthopaedic pathology to the episode of 9/13/84.

Q That is the episode with the hole, is that correct?

A Yes, it was. This is the episode that we are considering here this morning. He was status post operative from his spine fusion at L4 to L5. That is down low in the back they fused two of his vertebrae together.

Q For what purpose?

A I'll have to go back. Can we go off the record for a moment. It will take me a few minutes to find it.

OPERATOR: We're off the record.

OPERATOR: We're on the record.

Q Go ahead.

A Could you repeat the question, Mr. McNeal?

Q In so far as the spine fusion was concerned, what did you find relative to the spine fusion which would be related to any complaints that Mr. Milligan made during your examination of him?

A I don't think the spine fusion that was done, let's see, in 1965 was contributing to the complaints that

he voiced at the time that I saw him. By physical examination and by X-ray at that point at the time that we examined him he had had a good spine fusion, the spine was good and solid in the area of the fusion, and I don't think the spine fusion in itself was contributing to any of his back complaints at the time I saw him. I think that the fact that he had a spine fusion in the past was indicative that he had had previous low back problems that necessitated the spine fusion.

Q Would that again be an aging process?

A I wasn't there at the time of the spine fusion in 1965 and I really can't testify to the nuances of it. Apparently, however, that following the spine fusion of 1965, according to past history that was obtained from the records reviewed, at least in 1973 he had low back pain. So that one would have to assume that...and I think rightly so...in my patients when I did a spine fusion I always tell them that this isn't going to relieve the backache for the rest of your life if you have any causes of backache. He had subsequent episodes of backache as is expected. So he has a past history of low back pain and low Sack surgery.

Q And continuing you aiso had a diagnosis relative to both knees and what were your conclusions relative to your diagnosis?

A He had aging changes in both knees pretty much of comparable degree; maybe a little greater on the left than on the right. He had degenerative changes, aging changes, in these joints of both thumbs.

Q Would that be your conclusions as to your examination of Mr. Milligan, not only physical examination, but the examination which you made relative to his complaints which were made to you concerning his claim of stepping in a hole on September 13th, 1984?

A Well, those diagnoses are a combination of the tools I had available, so to speak, to evaluate the patient. Those tools were medical records, history from the patient, a deposition from the patient, physical examination of the patient at the time I saw him, and an X-ray examination. So we have five tools to use to arrive at those conclusions.

But he either ignored or resisted or failed to perform the tools.

Then Doctor, finally assuming the statements of Mr. Milligan that on September 13th, 1984 he was walking on the east side of an air compressor room when he stepped in a hole and that from what he told you he did not fall; he was able to stop his fall and did not fall down. That as a result of stepping in the hole he felt severe pain in his left knee and also in some manner he indicated that he wrenched himself with his back. Now, assuming those facts and assuming again the statements which I

have related and which are also set forth in your December 15th, 1987 report, based upon your examination which was undertaken on December 15th, 1987, what were your conclusions as to your examination and the relation of your examination and your findings to the incident which Mr. Milligan related to you and described to you which occurred on September 13th, 1984?

A That is a long question, Mr. McNeal. I think the bottom line to your question as far as what conclusions did I reach is that at the time that I examined the patient on 12/15/87, I could find nothing that I could....I could find no abnormality or disability that I could attribute to the episode of 9/13/84.

MR. MCNEAL: I would lastly like to introduce as part of the defense of this case the original report of Dr. Hoffman....

9:25:18 - MR. MICKELSON: Objection

MR. MCNEAL: ....dated December 15th 1987....

9:25:20 - MR. MICKELSON: Objection

MR. MCNEAL: ....together with the X-ray interpretations which have been discussed by Dr. Hoffman, attached to the report of December

15th, 1987, and the curriculum vitae account which has been marked as Defendant s Exhibit "A" about which Dr. Hoffman discussed as to his experience in training in orthopaedics. I ask the court to admit Defendant's Exhibits "A", "B", and "C".

9:26:01 - MR. MICHELSON: I .have no objection to the curriculum vitae and I certainly have no objection to the X-ray record which we have....which we will stipulate as being authentic. However, we have a strong objection to the report of Dr. Hoffman. It is not admissible, it is not appropriate to be admissible, and he has testified in full about his examination and conclusions.

MR. MCNEAL: We will leave that up to the court to interpret. Fine.

Q I have nothing further.

DURING CROSS EXAMINATION BY MR. MICHAEL MICHELSON:

Q Dr. Hoffman, we have met. My name is Michelson

as you know, and I am here representing the claimant in this case, Mr. Milligan. If any of the questions I ask you aren't clear, or you don't understan them, or you don't hear me, let me know please and I'll repeat or explain it. Doctor, let's....on your curriculum vitae, just some preliminary things, which hospitals are you now presently affiliated with? I notice there is a list here.

A Yes. Those are the ones over the course of the last 30 years.

Q Right.

A Currently it is Euclid General, Hillcrest, and at Huron Road I am the emeritus Chief of Orthopaedics and Director of Quality Assurance.

Q So Huron Road, Euclid, and Hillcrest, right?

A Correct.

Q Okay. Now Doctor, first I want to go through a few things that you have testified to to see if I understand them or I can clarify them. In regard to your testimony about the X-rays that you had taken.... you ordered them from Drs. Hill and Thomas?

A I ordered them and Dr. Hill and Thomas took them. yes.

Q Right. And that is not unusual that physicians or orthopaedic men will have the X-ray people take the X-rays?

A Some Orthopaedic surgeons have an X-ray facility in their office and they bill for the X-rays. I have never done that because I don't want to be accused of taking unnecessary X-rays, and so I don't want any financial gain from the taking of X-rays and so I have always referred them to a radiologist.

Q Well, I never even hinted that you wanted any extra financial gain.

A No, I just..,.

Q I said that is appropriate.

A I just wanted to indicate why I don't particularly take X-rays at my own facility.

Q Oh, no. That is all right. Well, certainly Drs. Hill and Thomas are at least competent if not expert radiologists and in their operation?

A Yes. I understand they are the largest group of radiologists either in Ohio or The United States, I don't know which.

MR. MCNEAL: In Ohio, I think.

DR. HOFFMAN: Is it Ohio?

MR. MCNEAL: I believe.

Q And they certainly take many, many X-rays and review them?

A Yes.

Q All right. Including orthopaedic X-rays, I presume?

A Yes.

Q And that is why you use them?

A Well, no. I use them because they are in the office building and it is convenient.

Q Okay. You have also read their X-rays?

A I read all the X-rays that I order.

Q Okay. So you have read these X-rays?

A Yes.

Q All right. In your opinion,. ..by the way, are you qualified to read X-rays?

A I am qualified to read orthopaedic X-rays that fall into my realm of expertise, yes, That is part of the training.

Q That is based upon your orthopaedic training?

A Yes. That is true of any orthopaedic surgeon.

Q All right. You haven't taken an internship or a residency certainly in radiology?

No, but in the process of your orthopaedic residency you rotate through radiology from an orthopaedic standpoint.

Q I see. How long is that rotation generally?

The last 5 years because you are required..,.

Q No, no. The rotation through the.. ...

A The department of radiology?

Q Yes.

A Can we go off the record?

OPERATOR: We're off the record.

(OFF THE RECORD DUE TO INTERRUPTION AT THE DOOR,)

OPERATOR: We're on the record.

Q Okay. I think the question was ~~that~~ I understand during the course of your residency in orthopaedics and your training you have occasion to look at orthopaedic X-rays on a regular and continuing basis?

A That is right, yes.

Q I understand.

A Throughout the 5 years.

Q You mentioned a rotation through radiology during the course of the residency and I just wanted to know briefly how long that residency rotation itself was?

A It occupies the entire time that you are in your orthopaedic training.

Q Oh, okay.

A Because you are responsible for the X-rays that are obtained by the particular service you are on; the private service, the out patient service, the trauma service, et cetera.

Q And your policy is, as I understand it, to read all of your own X-rays?

A I do.

Q That you order?

That I order, yes.

And you make your independent evaluation?

Yes.

And you have done that in this case?

I have.

And you have told us that you and Drs. Hill and Thomas...or I'm sorry....Dr. Crudy agree?

Agree, yes.

Okay. Now, I noticed that in the....now, it is your opinion after reading the X-rays that Mr. Milligan's left knee X-ray and Mr. Milligan's right knee X-ray describe basically equivalent knees from an orthopaedic perspective, is that correct?

Yes, that is correct. There are minor nuances of difference, but I think they are both equivalent pretty much.

Okay. So you agree that his left knee showed a moderately advanced degenerative change including both lateral and medial joint spaces and the retro-patellar region with joint space narrowing?

I agree with what it says in the X-ray report with regard to the knees, yes.

Q All right. Now Doctor, in the X-ray report of the lumbosacral spine, I notice ~~that~~ you indicate that you felt the X-ray of the spine showed a stable and strong

fusion, is that correct? Good and solid I think were your words?

A Yes. My opinion was that it was good and solid.

Q Dr. Crudy indicates that the fusion perhaps is not complete at the L4-5 level and it shows a motion of L4-5. Is that correct?

A Yes.

Q Is that different than being stable and solid?

A Basically not because he says, suggesting. He doesn't say it is.

Q But that is a possibility that it is unstable?

A Anything under the sun is possible. It is possible that both Dr. Crudy and I both are wrong.

Q Well, in this case Dr. Crudy is saying, is he not, that a review of the X-rays, because of motion in flexion and extension on lateral views of L4-5 that there is a less than solid fusion, is that what he is suggesting?

A *Yes*, he is suggesting that possibility, but he is not making that a diagnosis.

That is correct. So...and you are saying there is no possibility of that?

A No, I said anything under the sun is possible.

Q All right.

A In reviewing the X-rays and reviewing Dr. Crudy's

comments, it is my opinion that the spine fusion is solid and in fact there is no motion existing at the spine fusion.

Q Oh, okay. So you disagree that there is motion?

A No, I don't disagree. Dr. Crudy does not say that there is absolutely motion. He is suggesting that possibility. There is a certain art left in medicine that is not quite in, you know, such finite terms.

Q He is suggesting, is he not, that the X-ray finding, because it describes some slight motion between L4-5 in flexion and extension lateral views, may suggest a non-union or an unstable fusion, isn't that what he is suggesting?

A And it may not suggest it.

Q I'm asking what he is suggesting.

A Well, you can read what he says.

Q That is all I am asking. Do you agree with that?

A I am agreeing with the X-ray report as it is stated.

Q Okay. Now, there was some discussion with Mr. McNeal concerning the difference between degenerative changes and traumatic changes. There certainly is no way to tell whether or not something is a degenerative change in a joint caused by aging or a degenerative change caused by trauma, assuming a distance of time between the

trauma and the time you are looking at the X-ray, is that correct?

A No.

Q All right. Tell me how you can tell the difference?

A By the findings on the X-ray and by the history.

Q I'm just talking about X-rays now. Forget the history for a moment.

A Well, that is like forgetting part of the tools that you use in medicine. You don't do an operation if you forget the scalpel.

Q So the history is critical in making conclusions?

A No, but it is certainly a value.

Q A significant value?

A Yes, if it is obtainable.

Q Okay. So the person who has the significant history.....the physician who has a obtained or can obtain a very definitive history and a complete history, as well as all of the other tests and observations, certainly is in the best position to make an evaluation. of a patient, is that correct?

A Well, you say best. Best relative to what?

Q Somebody who does not have a complete history or a complete record and somebody who has not had the opportunity to personally treat, observe, and examine the patient over a period of many years.

9:39:39 - MR. MCNEAL: I would object to that.

Q As compared to that person.

A Well, the answer to your question is yes and no.

Q Okay. Tell me why no?

A Well, no in the sense that your question implies that adequate treatment can not be rendered in the absence of a history.

Q No, I didn't ask you that. Excuse me, Doctor. I certainly don't mean to imply that you can't adequately treat. I asked a different question all together.

A Well, you'll have to tell me what question you asked because that was my interpretation of the question.

Q I'm sorry then if I wasn't clear. The physician, for example in this case, Dr. Stiles (Phonic), who has treated Mr. Milligan for a series of orthopaedic problems and had him...and treated him with surgery...including surgery over a period of well over 20 to 25 years has had the opportunity to take a complete history over that 25 years, examine all of his records, and himself note the transitions and the changes in Mr. Milligan's body, and has had the opportunity to go in and actually observe and feel the underlying tissues, both bony and soft, even within his body, for example in the knee joints, in his back, and in his shoulder. That physician would have

the best opportunity of making....and assuming that he is a qualified physician; a board certified orthopaedic physician....he will have the best opportunity for evaluating that patient, would he not?

A Over the course of those number of years, yes.

Q Okay. And drawing conclusions?

9:41:50 - MR. MCNEAL: Well, I object.

MR. MICHELSON: Withdraw the last....

MR. MCNEAL: That is your opinion.

MR. MICHELSON: I said I'll withdraw it.

MR. MCNEAL: Okay. Fine.

Q Now, let's get back to degenerative changes. Degenerative changes you said can certainly be the result of trauma?

A There can be, yes.

Q And so when you observe a degenerative change in a joint and there is a history of trauma at sometime before, it can be very possible that that degenerative change may be contributed to by the trauma....

9:42:00 - MR. MCNEAL: Objection. (VO)

Q ....is that correct? (VO)

9:42:01 - MR. MCNEAL: Objection.

A Well, again you use possible and anything under the sun is possible. So to your question I think I would

have to say, yes, but it is not probable.

Q Why is that?

A Because it depends upon the tools that you have to evaluate the patient.....

Q What tools?

A ...at the time that you are making the evaluation. It is possible....it is probable.. ..it is a fact that given an appropriate examination one can differentiate between aging degenerative changes and post traumatic degenerative changes.

Q And what would that examination consist of?

A Well, it depends upon, one, what trauma or what degenerative change you are looking for, what joints you are looking for, the history of the patient, et cetera.

Q Well, we want to look about an examination of the knees in this case obviously.

A All right. Let's do a facetious, but simple illustration. That if the history indicates that the patient has had trauma to the knee, the diagnosis, for example, is a depressed fracture of the lateral plateau of the knee, The X-rays 20 years later show residual evidence of a fracture of the lateral plateau of the knee which is healed, and in that area there are degenerative changes, then you come to the conclusion that

those degenerative changes are due to the previous fracture. So that is the way you arrive at degenerative,...

Q I see,

A ...post traumatic degenerative changes.

Q And so if....

MR. MCNEAL: Had you finished your answers, Doctor?

Q I'm sorry.

A Yes, I think I....

MR. MCNEAL: All right, fine.

A I just used that as an illustration.

Q Okay. So if you have a history of trauma and subsequent to the trauma of the knee, in this case the left knee, and there are...there is evidence of damage to the knee as a result of that trauma or some damage and surgery results which involves partial meniscectomies, arthroplasties, scraping, removal of tissue, removal of bones, osteophytes, or bony masses, on at least two occasions. That there is evidence of effusion on a regular or continuing basis over a three year period subsequent to that trauma and before, during, and after the surgeries, removal of fluid during that time by aspiration, the need for injections of cortisone or other type materials in the knee as anti-inflammatories, and a continued pain, instability, locking, and giving way

of the knee, and then three or three and a half years later you observe that knee with some degenerative change, could that be the result of that trauma or traumas?

9:46:02 - MR. MCNEAL: Show an objection. That isn't an accurate recitation of what happened in so far as this particular accident of September 13th, 1983 is concerned.

MR. MICHELSON: That will be up to the jury to decide.

MR. MCNEAL: '84. '84.

A Is the scenario that you have given me the scenario of this patient?

Q I just want you to assume that scenario

A Well, I need more information.

Q What other information?

A I need to know what the kind of trauma to the knee was.

Q It was as Mr. Milligan did stepping in a hole....

A No, no. I mean the diagnosis of the trauma at the time of the trauma.

Q By the examining physician at that time?

A Yes. In other words, what was he diagnosed at that time.

Q I see. You would have to know that?
A I wouldn't have to know it.
Q You would want to know that?
A It would help me if I knew it, yes.
Q Okay. What else would you want to know?
A I think really based on the scenario that you have given me that that would be the only thing that I would want to know. If the scenario applies to this patient and the findings on this patient that I found at the time of my examination, then I wouldn't particularly need the diagnosis at the time of the episode of injury.
Q Oh, I see. Well, assume that Mr. Mill.. ..that is a substantial part of.. ..I mean, I don't have it committed to memory, but assume that that is a substantial part of the history of the patient from September 13th, 1984. That he injured his knee by stepping in the hole, twisting and wrenching, feeling immediate pain, had effusion, instability, and locking very shortly thereafter on a graduated basis, That within three days required aspiration of the knee and injection of some anti-inflammatory, and....by the orthopaedic surgeon, and had subsequent episodes and continuous episodes of swelling, effusion, locking....I know effusion may be the same as swelling.. ..locking and giving way through October 22nd which was approximately a little over 5 weeks from the

incident. Then you have had a fair review of all the other things after that, but it included two further surgeries on that knee, multiple aspirations of the knee by the physician, and multiple injections of the similar material. I assume it is a cortisone type of material for anti-inflammatory and pain relief. We are just talking about the knee now.

A Uh-huh.

Q And a general increase in symptomatology over the period of time despite the surgeries. Can you say then that the degenerative changes you observed may have been the result of trauma. ....

9:48:13 - MR. MCNEAL: Show an objection. Again, it has not been accurately described,

Q ....as opposed to simply aging?

A Well, fortunately in this case, and you pretty well have outlined them, that we did have voluminous records on the patient which were of great assistance. Based on your question we were fortunate in this case that I think I can state that the findings, both by physical examination and by X-ray at the time that I examined him, were not degenerative changes caused by trauma.

Q Is that your conclusion?

MR. MCNEAL: He has just stated it.

Q Please. That is your conclusion?
A I guess you would call it a conclusion.
Q Okay. Now, you indicate that in your review of the situation that you took a description of the incident of September 13th, 1984 when he stepped in the hole and twisted, and that you noted the first medical attention was on the 17th of September; some 3 or 4 days later?
A Yes.
Q All right. Now, do you know what his condition was or did you elicit from him what his condition was on the 14th of September; the day after?
A No, because....
Q I just want to know if you asked him.
A Well, don't you want to know why?
Q Not yet.
A Not yet, all right. No, I did not ask him.
Q Okay. And did you find out whether or not he had spoken with a physician before the 17th at all?
A No, I did not.
Q Nor whether he received any instructions from a physician?
A No, I did not, but there were reasons for all of those.
Q I assume there are. There are always reasons.

Now, you can now tell me the reason why you didn't ask him.

A Well, number one, we examined him in 1987 and the injury was 3 years previous. I don't think that you or the patient could remember what our symptoms were 4 years ago at the time of an injury specifically and with any degree of accuracy as far as the first 24 hours versus the second 24 hours. Secondly, it is relatively unimportant whether he called a physician or not during that interim of time because obviously a physician can't treat you over the telephone nor can he make a diagnosis. When patients call me I say, well, hold your knee up to the telephone and I'll make a diagnosis. So really that doesn't have any influence on the accuracy of the evaluation of the patient during that 4 day interval.

Q Well, certainly it is important to know what his condition was during that 3 or 4 days, is it not?

A Well, I imagine that at the time....

Q Excuse me. I am only asking you, Doctor. Not what you think happened, but I am asking you whether or not it is important to know his condition from the time of the accident until the time he first received medical attention?

A Yes, but that didn't fall under my preview. That

would fall under the doctor that treated him at that time. I wasn't there.

Q I understand you weren't there and I understand that Dr. Stiles was, but you are drawing conclusions about the damage caused on September 13th. I am simply asking you isn't it important to know the condition of, in this case, the knee immediately after and during the next couple of days after the injury?

A Yes and no.

Q Okay. Now, did you ascertain what was done and what Dr. Stiles found on September 17th when he examined him?

A Yes. He...the patient indicated that initially on an ambulatory basis he was treated with oral medication, aspiration of the left knee, and steroid injections.

Q That is from the doctor...that is from the patient?

A I have it recorded as being obtained,...that information being obtained from the patient.

Q Okay. Now, you mentioned in your examination that the examination was conducted all in a passive mode. I assume that is in distinction then to active manipulation by you, is that right?

A That is right. I didn't manipulate the patient.

He did.. ..

At all?

No. Other than for testing ligamentous stability.

Well, tell me what that is?

Well, let's take, for example, you have been concentrating on his knee....

I am only talking about the knee right at this moment.

Okay. There are certain physical examination tests which are accomplished by the doctor to evaluate the integrity of the ligaments of the knee,

And that would include, as I understand it now, holding onto the leg and holding onto the knee and moving the knee yourself so that you can test whether or not the knee is stable, or has movement, or those things, is that right?

That is correct, *yes.*

Okay. Did you do that?

Yes. I have indicated that under my physical examination.

And that, of course, is not passive, that is active, correct?

That is correct.

All right. So your statement that all examination was passive with no manip....you say being no.. ..see, I

am confused on what you said here. You said....

A It says, "All maneuvers in the examination were performed actively by the patient and there being no passive manipulation by this examiner."

Q All right. So I have misstating it then. In fact, you said there was no passive manipulation which would mean doctor manipulation; passive manipulation, right?

A The passive manipulation applies to applying force or applying my endeavors to the patient other than for the ligaments.

Q All right. You didn't say other than for.... but....

A You don't have to. We didn't say the.....

MR. MCNEAL: Let him finish his answer.

Q I'm sorry.

A Really you don't have to because everybody assumes that when you are....it is an assumption and a logical medical assumption, and all doctors do it, that if you are going to examine for ligamentous integrity that you have to examine the ligaments and this is passively. We didn't include in the report that the patient was breathing. You know, some things are obvious that you forget to do some of these....

Q You forget to dictate it?

A No, you don't forget to dictate them. You just forget to, oh, I would say in the process of being a doctor to indicate that the lay public is going to interpret your record.

Q Well, this was prepared for the purpose of this litigation and so I assume that you understood that Mr. McNeal and counsel were going to be reading it at least, and that there would be the possibility of a finder of fact; be it a jury or a judge, would have to evaluate this, is that...you knew that?

A I knew that, yes.

Q Okay. All I am suggesting to you is then this statement that it was entirely active motion by the patient as opposed to any passive manipulation by the physician, it is just not entirely accurate, is it?

A It is entirely accurate in the context that it is used.

Q Except for the fact that you did do active..... you did do manipulation of the knee to test the stability?

A I think we are tilting windmills, but....

Q I don't want to...

MR. MCNEAL: Go ahead and answer that question, Doctor.

Q Answer the question if you can.

A That in the first part...the first paragraph

under the paragraph of physical examination, we indicated that we examined him for one of other things, from a skeletal standpoint. A skeletal standpoint includes examination of joints. Examination of joints include testing ligamentous stability.

Q Okay.

A So that that indicates that the ligaments...well, you don't have to go back and say that we manually tested. the ligaments. That is the only way you can evaluate ligaments.

Q Okay.

A But, in the process of dictating the item number 2 that you are talking about, passive manipulation, that indicated that there was no other manipulation of the patient.

OPERATOR: Excuse me. We're off the record,

END OF TAPE ONE.

START OF TAPE TWO.

OPERATOR: We're on the record.

DURING CROSS EXAMINATION BY MR. MICHAEL MICHELSON CONTINUED:

Q Okay, Doctor, I think we have done that one enough. Now, when you did do the manipulation of the knee for stability, what did you find?

A That all the ligaments of the knee by the various

maneuvers you are testing ligamentous stability of the knee, the ligaments were all stable.

Did you elicit any symptomatic complaints by Mr. Milligan when you conducted that examination?

No.

Do you remember?

No.

Are you saying no because you didn't write any down?

No, I didn't elicit any subjective complaints during the examination or I would have written them down.

Okay. Let's go off for a second.

OPERATOR: We're off the record.

OPERATOR: We're on the record.

A couple of questions, Doctor, and then I will go on to some other things. You mentioned particularly to Mr. McNeal that upon several of the, as you call them, discrepancies in the examination you said that he didn't rely on the crutch when he came into the examining room..,, into the consulting room, is that right?

A That is correct.

Q All right. How far did he go when he came into the consulting room?

A You mean how far was the distance of the walk?

Q Yes.

A Oh, about 10 feet.

Q Okay. Now, you also mentioned the straight leg raising which in your view became a negative test because it was inconsistent?

A That is correct.

Q Okay. The straight leg raising...correct me if I am wrong,..I am sure you will,...is a test that relates to nerve damage or impingement generally in the back and spine? Is that really what it is about?

A You are wrong.

Q Okay. So tell me what is wrong- What is that for?

A The straight leg raising test is one part of a Combination of tests; the straight leg raising and Laseque's Sign., The straight leg raising test when done indicates one of two possibilities; a hamstring muscle tightness or sciatic nerve irritation. So to differentiate which of those two is the case with a positive straight leg raising you add the Laseque's Test during the time the leg is raised., If the patient voices appropriate subjective responses to the.. .or depending upon what the patient's subjective response is to the Laseque's Test it permits you to hopefully, but not absolutely, differentiate between a hamstring muscle tightness and a lumbar nerve irritation.

Q So the tests in conjunction with the Laseque Test is to examine to see if, A, there is any nerve involvement in the lumbar area or, B, hamstring tightening?

A That is correct.

Q Which is.. ..what causes that generally? What are we looking for?

A You and I both have it sitting at a desk all day.

Q Why is that?

A It is very common in people who lead sedentary existences and particularly common in women because they are wearing high heels.

Q Just the muscle tightens up?

A It is the muscles behind the back of your knee. If you try to bend over and touch your toes and can't, why, it is due to hamstring muscle tightness.

Q So your conclusion was that he had no nerve problem at all in the lumbar area, is that.. ..

A Well. ...

...at least the sign didn't indicate any or this test didn't indicate any?

A We did multiple tests in our examination to evaluate nerve function emanating from the lumbar spine. We found no abnormalities of that nerve function by multiple tests.

Q Okay. So we agree on that that there is no nerve involvement. N , doctor....if I may, doctor, I would just like to go over a couple of these records just to ask you some questions, if I can. I am going to ask you if you would....off the record. Excuse me.

OPERATOR: We're off the record.

OPERATOR: We're on the record.

Q Would you take a look if you could please, at the....we have previously marked this...is this "B"?

MR. MCNEAL: Mhe depo previous to this deposition.

Q Yeah, this is "A". It has previously been marked as Plaintiff's Deposition "B".....Deposition Exhibit "B" in another....on another date, but in the record there is an admission and discharge....I guess this is a discharge summary briefly. In there I note that Dr. Stiles states that the patient had a fall with a twisting rotation type injury....he is talking about.... it says right knee, but we agree that it is the left knee and t at that appears to be an error. I think you mentioned that in your review of this record too if you recall.

A He makes typo's too.

Q We all do. We all do. But, he describes the twisting rotational type injury relating to that knee

with pain and locking since that time. Removal of loose bodies. A torn medial meniscus. Then he goes on to talk about recurrence of back pain. Now, that is information that is important to know when you are trying to evaluate what happened to him in 1984, isn't it?

MR. MCNEAL: What is the date of that report?

MR. NICHELSON: 10/22. That is in the hospital admission of 10/22/84.

MR. MCNEAL: Go ahead.

A Give my response...go ahead.

Q *Yes.*

A The answer to your question I think is that...I think the answer to your question would be, no, because there are discrepancies between the comments made in the discharge summary covering his admission of 10/22/84 to 10/29/84. Those discrepancies exist between this discharge summary.

Q And his operative....

A ...and the operative report.

Q Okay. But, if there aren't any discrepancies then....I mean...okay....That is the reason why it is not important to know this?

A Oh no, I didn't say that.

MR. MCNEAL: One or the other is not correct.

MR. MICHELSQN: Hold it, please, Mr. McNeal. You'll have your chance.

Q I am only asking you, Doctor, if you are looking at that discharge summary, the information that he fell with a twisting rotational type injury to his knee, hac? pain and locking since that event, had removal of loose bodies, and had a torn medial meniscus, that is important to know in evaluating what happend to him on September 13th, 1984, isn't it?

A That would be,. ..if this were the only record I had.. .

Q That would be significant?

A ...that would be significant, yes.

Q May I have that one? Now, in the same record on October 18th, 1984 there is a note from Dr. Stiles which was included in that record which describes a severe problem,. ..

A Now, this was before the admission to the hospital?

Q That is right. It is a note that he admitted into the hospital record or that he attached to the hospital record saying.. ..again, I assume it'is relating

to the knee....very unstable, quite painful, loose bodies, and there is a possibility that one of those loose bodies moved in and gotten hung up, and they will plan the arthroscopy which later took place. Now, what does it mean when he says loose bodies may have moved in and gotten hung up? What does that mean?

A Well, he is indicating the possibility that the patient had a loose body in a position of the knee that did not interfere with motion to the knee. Then....

Q Excuse me. Okay, go ahead.

A Then subsequently the loose body...it is his.... the possibility again, he doesn't say probability....he says it is the possibility that the loose body had moved from the previous position into a position that would have prevented normal motion of the knee. For example, if you had a ball on the floor over there in the middle of the floor, it wouldn't interfere with motion of the door. But, if you rolled the marble over to into the door jam you couldn't close the door.

Q It would interfere?

A It would interfere with the motion of the door.

Q Right. And so certainly if there was a traumatic event creating a loose body and that loose body itself at that point or very shortly thereafter moved into the joint, that could be a description of what we have here,

isn't it?

A description of what we have where?

Of what this is describing. That event....that sequence that I just described to you is consistent with this?

I'm sorry. I don't know what.....

A traumatic event causing....in the knee joint..,. or a trauma to the knee which causes a body, a loose body, causes abody to break loose and become a loose body and that moves in and gets hung up, as he is describing here that possibility, that is consistent with his statement, is it not?

A Well, you have asked me to assume a lot. You have asked me to assume that he had no loose body previously. You have asked me to assume that a piece of bone in the knee joint is broken off. And, you asked me to assume that that piece of bone in the knee joint has migrated to a position that is interfering with motion of the knee.

Q I am not asking you to assume that that happened. I am asking you to assume that that is a possibility given this report.

10:08:38 - MR. MCNEAL: Show an objection of possibility again.

MR. MICHELSON: I'll withdraw the

question.

A All right.

Q Doctor, the loose bodies that he speaks of that have migrated in and have gotten hung up, there is nothing here that tells you how long that loose body may have been in the knee, is there?

A No.

Q Okay. Can I have that? Now, in the same hospital record, Doctor, you have....I'll ask you to look on 10/22/84, the history that was in that record. This is again the history that Dr. Stiles I assume took of Mr. Milligan. In that history he describes stepping in a hole with a valgus twisting injury to his knee, What is a valgus twisting injury?

A Let me read this first. All right. I think I can demonstrate it better than describe it. If.... let's assume that we are talking about the right knee. That it is an injury with the knee being rotated in that position.

Q Okay. And he goes on to say that he has had severe pain and difficulty at that time, He was seen in the office and aspirated. What does aspirated mean?

A It means sucking fluid out of the knee with a syringe.

Q Given crutches and that despite the swelling going

down he has continued with constant locking, severe medial pain, and inability to bear weight on his knee. Now, all of that statement there, including the twisting injury, that is consistent with a torn....if a torn meniscus is found, is it not?

A No, because he has left out one vital piece of information,

Q What is that?

A He hasn't describe2 the character of the fluid that he has aspirated.

Q This is the history. This is just the history. I am only asking you about the history.

A Well, it is indicated. That should be included in his history. That he aspirated the knee for how many cc's, of what kind of fluid, and how many times. That is the historical. facts.

Q Well, how many cc's would you want to aspirate?

A I'm not particularly concerned about the cc's, I would want to know on an historical basis the character of the fluid that he aspirated,

Q Okay.

A Because it would tell you whether the possibility of a torn cartilage exists.

Q Why is that?

A If it was bloody and this soon after an injury it

would indicate a torn cartilage....the possibility..... the probability of a torn cartilage based on and in addition to other physical findings. If it was normal colored synovial fluid then it would probably indicate the lack of a tear of the medial meniscus.

Q What if you find a torn meniscus though when you go in?

A What if you find a torn meniscus.,..

Q In other words, you have this history....

A Yeah.

Q ...and then you do surgery within a month after the history, or within a few days after the history, and you find a torn meniscus,...

A Well, your question. ...

Q ...isn't that all consistent with a torn meniscus coming from the injury of the twisting and the fall?

A Well, basically you are asking me two things. You are asking me to evaluate just that one piece of paper and now you are throwing in....

Q No, I didn't ask you to evaluate it. If you will remember I asked you isn't this important to know this history? Isn't that consistent, this history all by itself, with a torn meniscus injury? That is all I asked. I didn't ask you if it was complete or anything. Is there anything inconsistent with this relating to a torn

meniscus injury?

I could not make a diagnosis of a torn medial meniscus based on the piece of paper which you just showed me.

10:12:31 - MR. MICHELSON: I'm going to object. I am going to say it is not responsive and I am going to ask you the question one more time.

Q Doctor, please, is there anything in that history that is inconsistent with a finding of a torn meniscus?

MR. MCNEAL: I think he has answered it twice.

A Yes.

Q What is it?

A The lack of the description of the fluid that was aspirated.

Q But, the information in there certainly is consistent, right?

10:12:53 - MR. MCNEAL: Show an objection to that. It is not consistent.

A Well, we can't....

MR. MICHELSON: Objection to your discussion.

Q Your answer stands?

A I think so.

Q Okay. Now Doctor, I would like to go for a moment, if I could please, to the operative report which has been referred to and that you described, if you would. Doctor, the operation that is described there is an arthroscopy with removal of loose bodies, debridement of a torn meniscus, and abrasion arthroplasty, is that right?

A That is correct, yes.

Q Okay. And so in Dr. Stiles' view that was a torn meniscus, is that right?

A Let me refresh my memory with regard to the operative note for just a moment.

Q No. Excuse me, Doctor, before you do that, all I want to know is that headline says, "Torn meniscus," doesn't it?

A At the top of the page under operation: it does, yes.

Q Okay. And you included that in your recitation. of what was there?

A I did, yes.

Q Yes. Okay. Now.,,.

MR. MCNEAL: Now, let him review the record. He just asked....

MR. MICHELSON: How do you know that I am going to ask him anymore questions about this.

MR. MCNEAL: Well, you are not being fair to him.

MR. MICHELSON: Excuse me. Mr. McNeal, let me ask the questions please. The judge can determine whether I am fair or not. If you have an objection, please make it on the record.

10:14:42 - MR. MCNEAL: I am, That is what I am doing.

MR. MICHELSON: Your objection is taken,

MR. MCNEAL: The doctor said let me review the record for a moment and you said I'll come back to that or....

MR. MICHELSON: That is right.

MR. MCNEAL: Well, then give him a chance now.

MR. MICHELSON: I'm going to give him a chance....all the chance he needs. Don't worry about him,

He is reviewing it even as you speak, Mr. McNeal. Well done.

Q Now Doctor, are you reviewing the record? Do you want to read the whole thing first, is that the idea?

A Yes.

Q Okay. Why don't you.

A All right.

Q Now Doctor, the surgeon's report of the operation describes a torn meniscus....debridement of a torn meniscus, is that correct? Isn't that correct?

A It says, "The lateral meniscus," that is the one on the outside of the knee joint, "which had previously been excised.' he had had previous surgery there....

Q Yeah.

A ..."but had a small area of tearing along its remaining border. It was also debrided."

Q That describes a torn meniscus, does it not?

A It does, yes.

Q All right. And this operative report further describes a partial avulsion of a rather large loose body, isn't that correct?

A It does, yes.

Q And it describes marked condylar flattening, does it not?

A Yes.

Q All right. Now, certainly a torn meniscus is consistent with a traumatic injury, is it not?

A A torn meniscus can be caused by trauma or it can be caused by not trauma.

Q And a loose body that is the result of an avulsion can be traumatic in origin, can it not?

A From the description of that particular aspect of this operation I would say that is a non-traumatic finding based on my experience.

Q Based on your experience?

A Yes. I was one of the first doctors in Cleveland to do arthroscopy and so I have had some experience with it.

Q Doctor, you have described the word and the term avulsion to mean a tearing away and that you said before, if I recall, it is certainly compatible with trauma?

A Right.

Q Right?

A Right to the....

Q That is all I am asking you. Okay?

A I think maybe we ought to get some guidelines. If you...I'll let you ask your questions and not tell you how to ask them if you would let me answer without

telling me how to answer.

Q No, the guideline is going to be, please, just respond to the questions I ask you.

A I would be happy....

Q Now, if there are other things to say, if it is appropriate, I am sure . McNeal can ask the appropriate question to elicit that.

MR. MCNEAL: If we ever get time to do it.

A Who determines whether my answers are appropriate?

Q The court. Can...it is true, is it not, that a description of marked cornular flattening and also some of that disruption can be caused by trauma, sn't that true....possible?

A Anything under the sun is possible.

Q Okay. Now, where in the X-ray report....

A Could we go off the record for a moment?

OPERATOR: We're off the record.

OPERATOR: 're on the record.

Q Is there anything in Dr. Stiles' operative report.... is there anyplace where he says that any of the injury or any of the materials in this knee is frayed? Does he use the word frayed anywhere?

A As I remember, yes. Can you point it out without me having to read it all over again since you asked the

question?

Q Well, I don't know. I don't think there is any in there.

A Oh, okay.

Q I am just wondering.

A Oh, okay. Let me read this again then. Well, the term chondromalacia indicates fraying. In other words fraying is a finding that permits the diagnosis of chondromalacia and! so one follows the other.

Q What does chondromalacia mean?

A "Chondro" means cartilage and "malacia" means softening. So a softening of the cartilage.

Q It is a softening of the cartilage?

A Yes.

Q All right. That is what that means.

A Well, it also means fraying because when a cartilage becomes soft it frays.

Q At what point does it fray?

A At what point does it fray?

MR. MCNEAL: When it becomes soft.

A When it becomes soft.

Q Or where the material is torn for some reason?

A No. Fraying is not tearing. Fraying is a wearing away.

Q I understand.

A So, you know, you fray the collar on your shirt from wear and tear,

Q Or a tear if it is loose or not strong anymore?

A When you speak...he speaks about "The lateral compartment showed moderate degenerative changes without exposed bone." Now, to make that diagnosis, in all probability he saw fraying of the cartilage because that is the sign or that is the finding that permits you to make that diagnosis.

Q He didn't say that though?

A Well, he didn't say it, but he implied it. That is the only way you can make that diagnosis.

Q And what does that imply; fraying of what? I'm sorry. Where is that? I apologize, but I....

A In approximately the middle of the paragraph it says, "Lateral compartment showed moderate degenerative changes without exposed bone." By definition in my 30 years in orthopaedics and having done arthroscopy, moderate degenerative changes are indicated by the finding of fraying of cartilage during an arthroscopy.

Q I see. And which cartilage is that, do we know?

A Well, it is called the lateral compartment. He doesn't indicate...that is on the outside of the knee between the tibia and femur, but he doesn't indicate where the degenerative changes were occurring; whether

on the surface of the tibia or on the surface on the femur.

Q I see.

A He doesn't indicate that.

Q All right. And is that the meniscus?

A No.

Q No, okay.

A It is the articular surface where the two bones come together.

Q All right.

A The rubbing surfaces of the bone.

Q So in that operative report there is some information that you feel is really another way of saying that there was some fraying of the area you just described, and that is what you mean when you say fraying?

A In my reading of the operative note, I believe he found fraying of the articular cartilage within the interior of the knee joint in some areas,

Q Okay. Well, the area you just described because that is where he said he was degenerative?

Well, there are other degenerative changes in that operative note,

Q Yes, but you just pointed out that there were moderate degenerative changes without exposed bone and

that leads you to the conclusion that that is frayed material?

A In that area.

Q Okay.

A There were others,

Q Where else is there a frayed area?

A Well, he has never used the term fray....

Q Where else?

A ....in his operative note. I don't need the operative note. He also indicates from the context of the operative note, an orthopaedic surgeon would come to the conclusion that there was also fraying of the cartilage behind the kneecap on the articular surface of the kneecap.

Q Of the patella?

A Yes.

Q Okay. Anyplace else?

A No. He had such severe wear and tear changes in the medial compartment of the knee joint that he had complete loss of the cartilage over the medial femoral condyle. So rather than fraying, the early stage of chondromalacia, he had worn the cartilage clear off the medial femoral condyle which takes years to do.

Q All right. Okay. I'm sorry, Doctor. It is a little awkward here and I apologize for the hang up.

I'll try not to be too long. Now Doctor, again I want to go, if we can, and this will be I think more brief, concerning the May 22nd admission.. ..May 21st admission which you have described in there. If you would, would you take a look at this? This is part of it. This is again the physical examination....I'm sorry.,.. that is not the physical examination. That is the history, right?

A Well, it is the admission history, yes.

Q Right. And the doctor describes an X-ray view of a calcified mass which you have referred to in your report in the medial border of the tibia which appears to be fractured. in its mid portion, correct?

A Correct.

Q Okay. Now, is that calcified mass, is that the same as an osteophyte or a bony mass?

A I can't tell by that description.

Q Okay. So.,..

A It could be either,

Q It could be either. Okay. Either what?

A It could be a calcified mass, it could be a loose body, and it could be calcification within the ligament, From that standpoint I would have to say that I don't know what it was. I would have to see the X-rays,

Q Okay.

A That is I think the best I can do.

Q That is fair. And Doctor, also we have here in the same hospital admission a physical where the doctor came to a conclusion that there was a fracture of the bony projection of the medial tibial plateau beneath the tendons and internal derangement of the knee. We can assume that the fracture.. ..the conclusion of the fracture was from the X-ray report?

A Well, first of all, you asked me about the physical examination and then you quote the diagnosis or impression. Which are you asking me....

Q I'm sorry.

A ....about the physical examination or the impression?

Q I meant...I only used the physical as an identifier because on the top you will notice there is an "X" where it says physical,

A Uh-huh ,

Q And that is all I meant. I didn't say it is the physical examination, But, his impression was of a fracture of the bony projection of the medial tibial plateau?

A That was his diagnosis based on the history and physical examination, yes.

Q Okay, And can we then....is it fair to say that

that bony projection is the calcified mass that he referred to in the medial border of the tibia?

A *Yes*, I would have to assume that by not being there.

Q That I understand. Now, I just want to briefly go to the operative report, Doctor, again. Now, the post operative diagnosis. .which means that that is the conclusions that Dr. Stiles or any orthopaedic surgeon draws after the operation I presume?

A The post operative diagnosis, yes.

Q Right. And in there he talks about the fracture of the bony projection from the tibial condyle, right?

A Right.

Q Okay. And within the procedure aspect itself, down towards the lower third, he talks about a fracture in the osteophyte which I am assuming is the bony projection, is that fair?

A Do you have a copy of the X-ray report and we won't have to do any assumptions?

Q No, I don't. i have what I have, I don't have one, I'm sorry.

A Well, we are making, I think at least in my medical opinion, assumptions that don't have to be made because a review of the X-rays might change them from,. .. change it from an assumption to a fact.

Q Okay. Well, we know that Mr. Stiles....

A So we have to say as far as this operative note is concerned that Mr. Stiles says what he says.

Q And he says there is a fracture in the osteophyte which he refers to... there was a fracture in the osteophyte extending from the tibia down into the pes anserina and the fractured portion was removed, right?

A He says that, yes.

Q Okay. And so his post operative diagnosis, his impression from the physical examination, the history of his present illness, describing the X-rays, his impression based upon his physical examination, and the operative note with which he was... where he actually saw the tissue, describes a fracture, is that correct?

A That is correct. That is what the records indicate.

Q Okay. Thank you. Off the record one second, please?

OPERATOR: We're off the record.

OPERATOR: We're on the record.

Q I have nothing further at this time. Thank you.

DURING REDIRECT EXAMINATION BY MR. HARLEY MCNEAL:

Q Just two questions. What is an osteophyte?

A An osteophyte is a projection of...it is a little horn on a bone. They generally occur around joints,

although they can occur along the shaft of the bone. There are multiple causes of osteophytes. They can be, one, a process of aging, Two, they can result from previous trauma of a particular type around varying joints. They can be developmental. The patient can be born with this predisposition of their formation during the growth years prior to the bony maturation at the age of puberty. But, an osteophyte is a projection from the bone.

Q Is that disabling in any manner?

A It depends on where the osteophyte occurs,

Q In this case.. ..

A It can produce symptoms.

Q In this case would it be the cause of any disability?

10:31:46 - MR. MICHELSON: Objection

A From the description of the osteophyte as I know it from reviewing the records, it would not be one that would cause dysfunction of the knee joint.

Q Fine. Now, the last question. The statement has been made by counsel that the hole episode is consistent with a valgus twisting of the foot or ankle, I would assume. The plaintiff has testified that the hole was approximately 8 to 10 inches deep. That he had his foot in the hole 6 to 8 seconds and he took

his left foot out quickly. As you know he did not fall down. He broke his fall with his hands. Under those circumstances, does that....the testimony of the plaintiff, is that consistent with a valgus twisting as described and repeated by Dr. Sipes?

10:32:56 - MR, **MICHELSON:** Objection. You can answer.

A I think you are asking me what is the significance of a valgus twisting injury with.....

Q Related to the history as he has....

A ,,.related to the history and related to the subsequent pathology found within the knee, is that the question?

Q Exactly. Exactly that,

10:33:23 - MR. MICHELSON: Objection.

Q Exactly that.

A All right. Let's stand up for a moment. There are two mechanisms of injury that cause damage tears to cartilages of the knee. The one is a valgus twisting injury to the knee in that fashion, This could occur under the circumstance....in other words, a valgus twist of **a** knee stepping into a hole can occur, There **is** another mechanism of injury in which....(VO)

10:34:04 - MR. MICHELSON: Objection. **1** think the question **has** been

answered.

MR. MCNEAL: No, he has not.

He said there are two situations.

MR. MICHELSON: But, the question has been answered and the question was,..

MR. MCNEAL: Well, that is your opinion.

MR. MICHELSON: The question was, was the history as given by Mr. Milligan in his deposition consistent with a valgus twisting injury as described.

MR. MCNEAL: He hasn't answered....

MR. MICHELSON: And the answer was, yes.

MR. MCNEAL: No, he hasn't answered that.

DR. HOFFMAN: There was one other item that I put in as it relates to the pathology found in his knee,

MR. MICHELSON: That wasn't the question, You put it in.

DR. HOFFMAN: Yes, I did. I added that as a final.

MR. MICHELSUN: I agree.

DR. HOFFMAN: That was....there were three items.

MR. MICHELSON: Therefore, I am objecting. The question has been answered.

Q That goes with the history that I gave you, isn't that correct?

A That is correct. Now, that kind of an injury or that kind *of* a mechanism of injury causes a tear of the medial meniscus. It does not cause a tear of the lateral meniscus. In the operative note with regard to a torn meniscus the tear was found in the lateral meniscus. A valgus rotational strain to the knee causes a tear *of* the medial meniscus and not the lateral **meniscus**. A tear of the lateral meniscus is produced by a varus rotational strain, So that the patient's description **of** the mechanism **of** injury of his knee does not fit the pathologic findings that were found at the time **of** the arthroscopy inside the knee.

END

Q And are hot consistent with his description as the.. ..

10:36:38

Q ....the length of time the f ot was in the hole, withdrawn, and without any fall down?

10:36:48 - MR. MICHELSON: Objection.

Q Is that correct?

10:36:49-MR. MICHELSON: Objection.

A The length of time in the hole has nothing to do with what might have gone on with the knee. My comment is is that the description of injury by the patient does not fit the description of findings at the time of the arthroscopy when the torn lateral meniscus was found.

Q Fine. Thank you very much.

MR. MICHELSON: Now, before we go off the record I would like the X-rays marked, please, and made a part of the deposition.

DR. HOFFMAN: Okay.

MR. MICHELSON: I would like to take them because I may want to have them looked at. Can we mark these please?

OPERATOR: Sure. Doctor, you have the right to review this tape or you may waive that right?

DR. HOFFMAN: I waive the right.

OPERATOR: And will counsel waive filling allowing us to be custodian

until the time of trial?

MR. MICHELSON: Sure.

MR. MCNEAL: I do.

OPERATOR: We're off the record.

END OF THE TESTIMONY AS GIVEN BY DR. BYRON HOFFMAN.

STATE OF OHIO)
) SS: IN THE COURT OF COMMON PLEAS
CUYAHBGA COUNTY)

DONALD B. MILLIGAN,) CASE NO. 1 6333
)
PLAINTIFF,) VIDEOTAPE DEPOSITION
)
VS.) OF
)
CSX,) DR. BYRON HOFFMAN
)
DEFENDANT.) JUDGE

C E R T I F I C A T I O N

I, Tim Palcho, a Notary Public within and for the State of Ohio, do hereby certify that the within named witness, Dr. Byron Hoffman, was by me first duly sworn to testify to the truth, the whoie truth, and nothing but the truth, in the cause aforesaid.

I further certify that the testimony then given by him was transcribed to typewritten form and that the foregoing is a true and correct transcription of the testimony so given by him as aforesaid.

I do further certify that I am not counsel for or related to any of the parties involved in this action nor am I interested in the outcome of this matter. Also I am an independent videotape reporter employed on an as needed basis and not in the employ on a regular or full time basis of any of the parties involved in the aforesaid litigation.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office to attest these fact to be true at Kent, Ohio on this _____day of April, 1988.

My Commission Expires:
August 23, 1990.

Tim Palcho Notary Public
and Videotape Reporter