#631

ORIGINAL

UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF OHIO

WESTERN DIVISION

BOBBIE CLARK, et al., :

Plaintiffs,

vs. : Case No. 3:91 CV 7704

QUALITY STORES, INC., : Hon. John W. Potter

Defendant.

- - -

Deposition of CHRISTOPHER C. LAYNE, Ph.D., a Witness herein, called by the Plaintiff upon Cross Examination under the Federal Rules of Civil Procedure, taken before Kenneth P. Gallaher, Registered Professional Reporter and Notary Public in and for the State of Ohio, pursuant to Notice and stipulations of Counsel at 3450 West Central Avenue, Toledo, Ohio, on Tuesday, November 17, 1992, commencing at 10:05 a.m.

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Deposition of Christopher C. Layne. Ph.D.

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CHRISTOPHER C. LAYNE, Ph.D.,

was by me first duly sworn, as hereinafter certified, testified and said as follows:

CROSS EXAMINATION

BY MR. LEESEBERG:

Q Could you say state your full name for the record please?

A Christopher Layne, L-a-y-n-e.

Q Is it Dr. Layne?

A Yes.

Q You have a Ph.D.?

A Yes.

Q In psychology?

A Correct.

Q Dr. Layne, I represent Bobbie Clark and I'm here to

ask you a few questions about yourself and about your involvement in this case and any opinions that you may hold.

If I ask you any questions which aren't clear and that don't make sense, please let me know and I'll be happy to rephrase or clarify them so you understand exactly what it is I'm asking, okay?

A All right.

Q Have you been deposed before?

A Yes.

Q How many occasions?

A About 40, say.

Q And in connection with what, or what under circumstances have you been deposed?

A Mostly civil claims and few criminal claims as well.

Q The criminal claims involving what; claims of insanity or something along that line?

A Right, right.

Q All of them were involving insanity pleas or --

A Some insanity, some, essentially character references. The ones where I do an analysis to determine, for example, whether a person has the personality of a rapist or --

Q Okay. Civil claims. You say that's the vast

majority of the cases in which you've been deposed?
A That's correct.
Q What kind of civil claims have you been involved in? Are these all personal injury claims?
A Some of, most are personal injury claims, that's right. A few divorce proceedings, but the vast majority are personal injury. Psychological damages.
Q Okay. Breaking down the personal injury, are we, does that include Workers' Comp, Social Security Disability or is this strictly civil litigation between private parties?
A Workers' Comp and civil litigation between parties.
Q When you've been involved in Workers' Comp cases, how did you get involved?
A The companies will call and ask me to do an independent medical exam. Occasionally I will have a patient who has a difficulty and attempts to get Workers' Compensation, and in this case I testify for the plaintiff, or the claimant.
Q The vast majority of the Workers' Comp claims that you've testified in have been at the request of companies?
A Correct.
Q And in essence, you're offering testimony on behalf

of a company which is seeking to deny that a person has an injury or that their injuries weren't related?

A That could be argued. The company wants a second opinion about the person's injuries.

Q The rest of your personal injury involves what, outside of Workers' Comp?

A The scope of auto accidents, work related injuries, and other claims of infliction of distress. About one-third of those claims are plaintiff oriented; I'm asked by a plaintiffs' attorneys to examine. And about two-thirds are defense attorneys making the same request.

Q Okay. Out of the 40 times or so you've been deposed, how many times have been related to personal injury claims in civil litigation?

A I would guess 34 of those 40 times.

Q That's a pretty specific figure. Do you keep records of all the times you testify?

A No, I'm -- no. I'm simply pulling the best estimate I can out of my head, but I'll bet it's wrong.

Q Okay. But you do not keep records, some kind of index or listing of cases in which you've served as a consultant? Do you have it on your computer?

A No, I don't have it on my computer, but actually I do have a sheet that lists some of the attorneys that I've worked with, both on plaintiff and defense side.

Q Okay. Why do you maintain that list?

A Right outside the door, as a matter of fact. Would you like a copy?

Q Okay, go ahead. Why don't you get a copy. My question was, though, why do you maintain that list?

A Because of questions just like this that occur.

Q Why don't you go ahead and grab a copy of that?

(Discussion held off the record.)

Q Dr. Layne, before we move on into other areas, you've indicated that you've testified approximately 40 different occasions. How many times -- you've been deposed on approximately 40 occasions. How many times in addition to that have you testified in court?

A Maybe 15 or 20 times.

Q When was the last time prior to today that you gave a deposition?

A Approximately two months ago, three months ago. I really don't remember which one that would be.

Q Do you recall when the last time you testified in

court was?
A Yes. That was by videotape, about a month ago.
Q Was that for a plaintiff or a defendant?
A Defense.
Q Who was the attorney, either for the plaintiff or the defendant?
A The attorney for the defense was in the firm of Savoy, Bilancini, Kenneally and Flanagan. I probably have those names messed up. But they're from Elyria, I believe. And I believe that the attorney was Terry Kenneally, but I may be wrong about that too.
Q Do you happen to know who the plaintiff's attorney was?
A No.
Q Was he from Elyria as well?
A I don't know.
Q Have there been -- I assume there have been occasions in which you've reviewed cases in which you've not been called for a deposition or trial testimony?
A Yes.
Q Over and above the 40 cases, how many additional case have you served as a consultant in which you did not offer testimony for whatever reason?

A Probably another 50 or 60 or 70. Those would all be civil litigation. In addition to that, in my Workers' Compensation work, I never get called. Those go to the Workers' Comp Board, so I never testify in those.

Q These are the ones you referred to earlier where primarily you're being consulted by companies?

A In the Workers' Compensation work, that's correct.

Q And about how many Workers' Comp deals have you done?

A Say 30 or 40.

Q Okay. Over what time frame are we talking about? When of all things we've been talking about in terms of deposition, court testimony, Workers' Comp consults or other medical/legal consultation, when did that first get started?

A 1980.

Q And has that practice component increased since 1980?

A Yes.

Q Has it ever been a larger part of your practice as a component than it is at the present time?

A Presently it is -- the answer is no, it is larger now as a component of my practice than it has ever been.

Q And how do you charge for your time spent in connection with these activities?
A $100 an hour, $150 an hour for testimony.
Q Is that exclusive of expenses? What about, do you travel outside of Toledo?
A Yes.
Q What if you travel to say Elyria, Ohio?
A I charge for time, but not for travel, not for gas, not for meals.
Q What percentage of your practice is, on a percentage basis or otherwise, is spent on this component of your practice?
A About a fourth, maybe a third. And I should add that that is a component of my practice. In addition to that I am a tenured professor over at the University of Toledo, so that's another part of my professional functioning, not included in that percentage.
Q And what percentage of your time is spent in academics?
A About 20 percent.
Q So we're talking about 50 percent of your time is spent away from other than the active clinical practice of psychology?
A Yes, if by that you mean direct patient contact for

the purpose of curing the sick, yes.

Q By percentage or some other calculation, what percentage of your income is derived in your medical/legal consulting?

A About the same percentage, a fourth to a third of my practice income. In terms of overall income it would be substantially less; 10, 15 percent.

Q Income from all sources whatever, you mean?

A Pardon me?

Q Income from all sources whatsoever, you mean?

A Correct.

Q But in terms of your profession as a psychologist, it would make up 25 to 33 percent of your income?

A Right, correct.

Q Have you ever been a party to a malpractice claim yourself?

A No.

Q How do you know Mr. Clayton?

A I don't. I have reviewed records with the name Mr. Clayton on them.

MR. CLAYTON: You mean Clark or Clayton?

A I'm sorry?

MR. CLAYTON: I think he's talking about Clark.

A You're asking how I know him, Mr. Clayton, and I thought you said Clark.
Q Okay.
A My apologies. Mr. Clayton called me to ask me to review these records. And I don't know him in any other respect other than that professional contact.
Q That was the first time you ever had any contact with him was in connection with this case?
A It seems to me we have worked together on one other case. Is that correct?
MR. CLAYTON: Correct.
Q And when was that?
A Roughly nine months ago.
Q Okay. What happened nine months ago; did he consult you on something nine months ago or did you give testimony nine months ago; what are we talking about?
A He consulted me on a case.
Q And what did that case involve?
A I don't remember.
Q What was your role; what did you do?
A It was civil litigation; it was not criminal. It was a case that is, therefore, somewhat similar to this one in the sense of it being civil litigation. Beyond that, I don't remember.

Q Are you still serving as a medical/legal consultant in connection with that case to your knowledge?
A No, I don't believe so. I believe that was settled or something.
Q What did the claims involve in that case?
A I don't remember.
Q You've worked with other members of Mr. Clayton's law firm?
A Yes.
Q On how many occasions?
A Roughly two other times.
Q You're Boarded; is that correct?
A That's correct.
Q Are there any other Boards available other than clinical psychology?
A There are none available other than the American Board of Professional Psychology.
Q So you have the only Board certification available as a psychologist?
A There are other certifications available from that Board. There's, for example, one in neuropsychology. But that's the only board.
Q You say there is a board in neuropsychology?
A No, I'm saying there's one board recognized, and that is the American Board of Professional

Psychology. And in turn, it grants several different kinds of certifications or boarding. One is in clinical psychology, I have that one. Another is in neurological psychology; I do not have that one.

Q I see.

A They both come from the same board.

Q When were you Board certified?

A 1980.

Q And did you successfully complete your examinations on your first attempt?

A Yes.

Q You've got two publications as far as books are concerned. One is called "Know Your Psychological' Experts". What's that about?

A It's a treatise on psychological evidence and testimony in the courtroom.

Q Who was that authored for; who is your intended readership?

A Attorneys and clinical psychologists.

Q Clinical psychologists who are serving or anticipate serving as psychological experts in court?

A That's right.

You have a second book published called

"Psychological Torts Manual". What is that about?
A That book -- now, I hope I listed that as being in press.
Q In press.
A So it's not yet published. It is a book that reviews psychological cases across the country, mainly ones dealing with infliction of emotional distress. Reviews them from a psychological perspective and then follows up with a brief treatise on what in the eyes of a psychologist is right and wrong with the legal system's view of mental illness.
Q And your intended readership of that is who?
A Psychologists and attorneys.
Q Same basic readership as the other one?
A Yes.
Q Do you speak at legal seminars or at psychological seminars -- psychology seminars or medical seminars concerning legal issues?
A Yes, I have. I speak on other topics as well, but I have spoken to groups about legal issues.
Q With what frequency do you do that?
A Once every six months.
Q Where are those lectures at, or where have they been?

A I've done a lecture for OACTA; does that sound right? The Ohio --

Q Criminal defense association or civil trial attorneys?

A Ohio Association of --

MR. CLAYTON: Civil Trial?

A -- Civil Trial Attorneys, right. That was in Toledo, several years ago.

Q Who contacted you or invited you to speak at that?

A It was not someone from Mr. Clayton's firm. It was, I think Gerry Kowalski from Manahan, Pietrykowski.

Q Okay, any other seminars that you've spoken at?

A In Cleveland I did one about six months or so ago. This was a seminar put on by Gallagher, Sharp in Cleveland.

Q Defense firm?

A Right. They do a lot *of* defense work as, it's my understanding.

Q Who was that seminar put on for?

A Insurance claims adjusters and essentially their customers.

Q And what was the gist *of* your talk; what was the subject of your talk?

A The, as is true in almost all of my talks, it is

the notion that psychology is much more objective than people think it is. It's much more of a science and that therefore the legal profession ought to pay more attention to the objective sources of information in psychology.

Q Do you find that your speaking at these seminars generates consulting business for you?

A Not a lot. Some, but not much.

Q Why do you do it?

A Well, it's an area that I'm very interested in. I like it. My father was a lawyer and maybe I just have a natural affinity for the area.

Q What kind of lawyer was your dad?

A Mostly real estate and general practice.

Q Where are you from?

A Virginia.

Q Do you have any particular specialty or subspecialty within the area of clinical psychology?

A Yes.

Q What is that?

A Anxiety and depression and, of course, psychological evaluations.

Q Who is the governing board; is that the American Board of Professional Psychology?

A Right.
Q Is there a State Board of psychology?
A No -- oh, yes there is State Board of Psychology, yes.
Q And what are they charged with in terms of responsibility; are they strictly a licensing or do they set standards of practice?
A Both. Their main charge is to license psychologists, but in the process they set you up some standards for practice.
Q Where else other than the State Board, where else do your standards of practice come from?
A The American Psychological Association's code of ethics.
Q You have a private practice in which you see patients?
A Correct.
Q With the entire spectrum of psychological problems?
A Right.
Q Are there any psychological problems that you will not treat?
A The blunt answer is no. There are no problems that I will not treat. By that I mean, anybody that wants to come in to see me, I certainly will allow that. There are many psychological disorders that

I immediately refer out somewhere else. And examples of those would be rehabilitation for brain damage. While I feel that I'm good at diagnosing it, the rehabilitation of a brain damaged individual is pretty highly specialized.

Q Is that what is referred to as an organic injury?

A Right.

Q Okay.

A Secondly, I would be reluctant to treat by myself a person who is actively psychotic with severe schizophrenia or mania. I would immediately want that person evaluated for medication which has a, probably a higher likelihood of being effective than I could be verbally. So those are examples.

Q What about split personalities, or multiple personalities?

A I would treat those, but they're a challenge for anyone. There are very few specialists that are interested in treating that very rare set of disorders.

Q When does a psychological problem become a psychiatric problem?

A I don't think that distinction is valid. Psychological as opposed to psychiatric in this context, I believe they're synonymous. Maybe I'm

missing your question.

Q No. No, you're not. Why is it necessary for a psychiatrist to be involved as opposed to a psychologist?

A When medication is warranted.

Q Patients who are depressed often require medication?

A Patients who are depressed can often be helped with medication, yeah. They may not require it, but that can be helpful.

Q You cannot prescribe medication?

A Correct.

Q If you're diagnosing and treating a patient with depression within your area of specialty and the patient needs depression -- or needs medication, what do you do?

A If the patient needed medication, I would send them to a psychiatrist.

Q Okay. Do you have a particular psychiatrist that you refer to?

A There are several in town. One of them is Haley, another one is Tom Sherman, and there are a few others.

I also would consider referring to the person who works in this office, her name is Melanie

Thombre; she's a psychiatrist.

Q What percentage of clinically depressed patients, or psychologically depressed patients require medication?

A Put that way, it would be zero. None require it. The research suggests that the verbal techniques, certain verbal techniques are either as effective as antidepressant medication or more effective. So the first line of treatment ought to be the verbal therapies.

Q What percentage of patients nevertheless then go on to require some medication regimen in your experience?

A The failure rate for verbal therapies in depression is about 15 percent. And it would be wise with those 15 percent certainly to send them off for medication. *So* 15 percent might be a reasonable answer.

Q Okay. When were you first contacted about this case?

A Oh, maybe two months ago.

Q How were you contacted?

A By phone.

Q Did you receive any written confirmation of your willingness to get involved? I'm trying to pin

that down a little more specific as to when you --
A I certainly received the records and in the course of that I may have received a letter.
Q When did you receive the letter? I mean when did you receive the records?
A Perhaps a month and a half ago.
Q What were you asked to do?
A Review the records in order to render opinions, not so much about this particular individual, but about psychological issues that may, that relate to this case.
Q That's what you were asked to do?
A Yeah, that is fair.
Q Mr. Clayton asked you to review the records for the purpose of rendering opinions not about this individual, but about psychological issues related to this case?
A Well, that may be a bit overstated. Mr. Clayton asked me to review the records.
Q For what purpose?
A To comment on the, or perhaps render an opinion on the psychological issues revolving around the case. I guess that is a fair description of the task that he set out to have me do.
Q Okay. I sort of feel like we're having a euphemism

Clark v. Quality Stores 11/17/82

4 ✓ Deposed 40X

6 ✓ 34/40 R.I.

7 ✓ 15-20 court testimony

9 ✓ first stated testifying - 1980

✓ consulted w/o testimony - 50-70 P2
+ 30 a 40 w/c.

10 - $150 hr testimony

11 ✓ 1/4 - 1/3 income from medical/legal consulting

14 - known your Psychological Expert - for AT&T
& other Expts

16 - ✓ Spoke at Seminar Put on by Hollaska
for Insurance Claims Adjusters.

36-37 - Highlighted in medical Records. each
color has meaning.

44 - Didn't Examine it.

40 - Secretaries do highlighting.

45 - Didn't read each & every line
& every Page.

A Yes.
Q And comment on this patient?
A Yes.
Q And your response was, well, I will be willing to look at the records and comment on the psychological issues that are raised by those records, however, I'm not willing to render any opinions concerning what this particular individual's psychological condition may be?
A That's correct.
Q Okay. So we're clear for the record, you do not intend to express any opinions concerning what Bobbie Clark's psychological condition or diagnosis is?
A That's correct.
MR. CLAYTON: Except based upon the records.
A I have many opinions about issues revolving around this case.
Q Okay. We're going to have to kind of wade through that then.
A Okay.
Q What were you provided to review?
A About 1500 pages of records; mostly medical records, some psychological records. Bobbie

used here. An evaluation of psychological issues revolving around this case; what does that mean?

A Right. Let me put it to you another way; maybe that will help.

Q That's not the way lawyers generally talk, so I guess I'm trying to find out, did Bob call up and say I want you to take a look at the records to find out whether this guy has, you know, got psychological problems, or what exactly did he ask you?

A You know, I can't remember the specific words. But what I'm getting at is that in our early conversations, I made it clear that I can't express opinions about this particular person. So his request -- and I don't think he really required that or necessarily wanted that. He wanted me to react to various psychological issues underlying this case. And again, I don't remember how he put it. You are right, he didn't put it the way I'm putting it; that's my language. But I believe that's what he wanted me to do.

Q Okay. So if I understand what you're saying -- and correct me if I'm wrong; I don't want to put words in your mouth -- Bob said I'd like you to look at some records?

Clark's diary. Those are the major things.

Q Okay. I need the minor things as well. I don't need you to go through every page or medical report, but if there's something other than medical records, we'll talk about the medical records.

A No, I --

Q You talked about medical records, psychological records, diary of the plaintiff. In terms of categories or generic representations what else, what other kind of materials have you reviewed?

A I can think of nothing else besides those. Those would include, those are the major and minor things.

I also reviewed some psychological literature relating to what I received. In addition, I also re-scored the MMPI as best I could. The MMPI that this person took, in order to get a better grasp for what the MMPI meant. I believe that it's fair to say that they are almost all medical records.

MR. CLAYTON: I think it's fair to say that I sent you a letter summarizing deposition testimony and how the accident happened and so forth.

A Right. Okay.

Q Do we have a copy of that available?

A Let's look. I too remember the letter. I must have gotten it by fax. And I believe that there's another letter as well; one that dates back a little farther and one that is longer.

MR. CLAYTON: Here's a copy of it. You want to show this to Dr. Layne to refresh his memory.

A Yeah, this is it.

Q Do you think that's hidden somewhere in these materials?

A It could be. Or in the process of ripping these apart and analyzing them, the letter was set aside, somewhere. That is also possible.

Q This is an index of medical records that was prepared by you or somebody else?

A By somebody else.

Q Okay. Mr. Clayton also indicated that he provided you with a copy of Dr. Wade's report?

A I don't believe that I've gotten that report, have I?

MR. CLAYTON: I, maybe I just mentioned it in my letter to you. I don't remember.

Q Do you know who Dr. Wade is?

A Yes. He's a physician in town.

Q How do you know him?
A I don't know him. I never met him. But I have heard his name.
Q In connection with what, do you know?
A In connection with this case.
Q But prior to this case, did you have any familiarity with Dr. Wade?
A Occasionally reports that he writes will make their way to me involving other cases or patients that I'm treating.
Q What is your understanding of the operative facts as relate to the injury that Mr. Clark suffered? What are you assumed as -- what have you assumed to be the case in that regard for purposes of your evaluation?
A The details of the accident are not entirely clear to me. But in general, he was hit on the top of his head by a door, a heavy door, which stunned him and didn't knock him down, but knocked him forward and he grabbed hold of a car to steady himself.
Q Anything else that you consider to be pertinent facts or information about the mechanics of the injury?
A No. Those are, the other thing is that he continued to function, did not lose consciousness

and later on that day began to complain of a variety of difficulties.

Q So it's your understanding that he did not lose consciousness?

A That's correct.

Q What understanding did you take with you for your evaluation with respect to the severity of the force that hit him?

A That seems ambiguous. It did not knock him off his feet, did not knock him unconscious, so that again he didn't lay down because of the blow. On the other hand, it was hard enough to knock him off his balance.

Q How heavy was the door that hit him?

A Some records say several hundred pounds.

Q What did you interpret that to mean?

A Well, I took it at face value. My problem is that sometimes these kinds of estimates of weight are inaccurate. But I take it into account.

Q I guess all I'm asking you is did you have an understanding or an assumption as to how heavy this door was?

A No.

Q That was of no significance to you at all in terms of your evaluation?

A It was somewhat significant. I would like to know the actual weight of the door. But the more important factor is whether or not it knocked him down, whether or not it incapacitated him on the spot, whether or not it rendered him unconscious, or on the other hand, whether he eventually walked away from it. That seems more important.

Q And it's your understanding that was not knocked to the ground and that he was not "knocked unconscious"?

A Correct. It's my understanding that later he would say that he lost memory, but that's not the same thing as being knocked unconscious.

Q We're talking about amnesia?

A Correct.

Q Was that anterograde or retrograde?

A I believe that it was both, although not for -- mostly retrograde.

Q And --

A You know, I may be getting my terms confused. By retrograde, I mean amnesia after the accident.

Q Right. Amnestic for events following the accident, and anterograde is amnestic for events prior to the accident.

A Right.

Q And your understanding is that he at some point in time was experiencing both anterograde and retrograde?
A Mostly he reported amnesia for events after the blow.
Q Altered states of consciousness are a spectrum, are they not?
A Sure.
Q Where on that spectrum, if any, did you feel that Bobbie Clark fit for purposes of your assumptions in terms of altered states of consciousness?
A I believe that the evidence points towards a person who had little if any alteration in their state of consciousness after the blow.
Q Okay. Did you read this letter from Mr. Clayton?
A Yes.
Q You read it in its entirety?
A Yes.
Q And did you assume the validity of the information in here for purposes of your evaluation?
A No.
Q You did not?
A No, I did not.
Q Why did you read it then?
A Because it, often such letters help to steer me

towards the important information. If there are quotes or records cited in the letter, I can go and verify the quote and it therefore makes my job easier.

Q The following statements appear on Page 5: "Clark contends that the accident has caused him to suffer from just about all the 'ills that man is heir to.' His previous medical history indicates otherwise. Clark is a chronic complainer. We have no doubt that he believes he is totally disabled. We have little doubt that is he quite content with being totally disabled. We have no doubt that he will never be gainfully employed in the future. He is a rather pathetic person."

Did you understand those to be quotes out of medical records?

A No.

Q Did you understand those to be attempts to steer you to the important issues in this case?

A Quite possibly.

(Plaintiff's Exhibit 1 marked for identification.)

Q The letter that I was just inquiring about has been marked as Plaintiff's Exhibit 1; is that correct?

A That is correct.

Q Okay. *Off* the record we were having a discussion about some, what appears to be computer generated sheets. For the record, what are those?
A Those are sheets generated by my computer when I computer scored the MMPI answer sheet labeled with Mr. Clark's name.
Q What's this stack of information here?
A This is just a neater copy of the computer generated report; one that's a little more easily understood by folks that are not in the business of psychology. ***So*** this is according to that. This is a list of the complaints that Mr. Clark made, physical complaints that he made both before and after his accident. And we thought that might be helpful in terms of understanding this man's complaints.
Q We who?
A Me and the people here who help me to organize the records for purposes of analyzing them.
Q Who helped you to organize the records?
A Probably all of my secretaries.
Q Anyone besides secretaries?
A No.
Q Has anybody other than yourself been involved in your consult with Mr. Clayton, other than your

secretaries?
A No.
Q Okay.
A This is the third paper that you were asking about. And these are his hospitalizations, both before and after the 1989 accident, and a brief and perhaps at times inadequate summary of the reason for his hospitalization.
Q Who prepared that?
A I did.
Q 7-27-89 you have a reference to drinking?
A Yes; I believe that the -- I'll have to go back and check my records on that, because that was a peculiar situation. After the accident, records indicated that he had a previous history of drinking. But I'm not sure whether or not that word comes from the 7-27 records or whether some other records reached back and pointed out that that was a time when he was drinking. I'll have to check on that.
Q Well, what does the 7-27-89 reference to drinking reflect?
A That one of the problems he was enduring at the time of that hospitalization was drinking.
Q So he had a drinking problem in July of '89?

A Well, what I'm saying is that is what the records indicated.

Q Okay. Just so we're clear, for the record, your understanding is that the records for July of '89 reflect that Mr. Clark had a drinking problem as part of the basis for his hospitalization in July of '89?

A What I'm telling you it could be. I'll need to check on that because that may be a mistake. These are rough drafts and they're not in their final form. So I'm not sure. I do recall that that was an odd situation where some other records reached back to that hospitalization or that period of time.

Q When you say these are rough drafts, do you know whether or not any of these references are accurate at this point in time?

A Yeah, I believe that they are for the most part accurate.

Q For the most part?

A Yes. We are, of course, going to need to go back and check to make sure. But, yeah, you have picked out probably our biggest problem.

Q When do you plan on going back to find out whether or not these are accurate?

A Within a matter of days.
Q And are you saying that regardless -- well, you've already formed your opinions I would take it?
A Yes.
Q And if I understand what you're saying, your opinions are based upon the assumptions reflected in these summaries?
A That's correct.
Q And so if I understand what you're saying, your opinions may very well be based upon inaccurate summarizations of medical information?
A Not exactly. I stand behind the majority of these references. I have some trouble with this reference here, the reference to drinking. I was aware of that as a potential problem, a potentially inaccurate word, and wanted to go back and check on it. The rest of the stuff I'm quite --

MR. CLAYTON: Just let him look at the record.

MR. LEESEBERG: I don't want to talk about the records now.

Q Go ahead.
A So you have focused in on probably the biggest single weakness in the, that particular chart. Something that I intended to check on. We printed

these out this morning because we thought you might be interested in seeing them. But there, they may have some flaws in them.

Q I noticed in going through these, there are a lot of highlighted materials or information?

A Right.

Q Is that correct?

A That's correct.

Q Several different colors of highlighters. Does every different color of highlighting have any significance?

A They do, yes.

Q What's the significance?

A Blue is psychological problems.

Q What do you mean psychological problems?

A Anything that you see in blue is going to be a psychological aspect to the person; whereas purple is specifically test results, psychological test results.

Q Okay.

A The pinkish color is medical difficulties, or medical tests. Orange is medications.

Q Show me an orange color.

A That's one right there, for example.

Q Now, you've got two colors of yellow?

A And yellow, regardless of its shading, is other interesting things with no particular category.
Q Now you referred to the blue as referencing psychological problems?
A Or psychological characteristics. Not necessarily problems. Most of the time they're problems, but sometimes they're positive statements.
Q These reviewed Dr. Shamberg's report?
A That's correct.
Q Am I correct in my assumption that you disagree with Dr. Shamberg's evaluation and conclusions?
A Yes.
Q Do you know Dr. Shamberg?
A No.
Q Do you find with -- what do you take issue with Dr. Shamberg, or in what respects?
A It is a little difficult for me to recall, but in general I believe that he makes a couple of significant errors.
Q Those are?
A One, he shows little awareness of this man's health complaints before this particular accident. And number 2, I don't believe that he interprets this man's MMPI correctly. The interpretive error is significant, because once again he doesn't

recognize the fact that this man's highest scales are scales labeled hypochondriasis and schizophrenia; thereby showing that this man is prone to delusions of illness. I mean serious hypochondriacal delusions of illness.

He just doesn't seem to recognize that. He also doesn't recognize the fact that in addition this man's MMPI reveals a conscious attempt to exaggerate his physical and his mental ills. I mean he's got the data there, he just seems to ignore it.

Q You don't dispute his data?

A No. That's a difficult question to answer with an unambiguous no in the sense that I have before me a MMPI and not a human being. I have, I am assuming that that MMPI was taken by Mr. Clark.

Q Okay. You have the data of Dr. Shamberg which is purportedly related to Mr. Clark's test?

A Correct, yeah.

Q And you don't have any criticism, or take any issue with that data, the validity of that data?

A That's correct. I really am unable to do that in the sense that I have re-scored the raw test data. I've re-scored it. Shamberg's scores seem to be accurate. He seems to have scored it accurately.

So, yeah, I do not take issue with the scoring. It's the interpretation of the profiles that I take strong issue with.

Q Well, is the interpretation a question of professional judgment or is there some kind of a book to which one turns *to* interpret?

A There are plenty of books. And that's what the professional ought to do is take the profile and go to the books and ask himself, well, what do the books say?

Q So if I understand you, you're saying Dr. Shamberg's interpretation is not supported by authoritative psychological testing standards?

A That is correct.

Q And so his interpretation is basically incompetent?

A It's in error.

Q Well, it's incompetent?

A It's a nasty word.

Q Well, I didn't say he's incompetent, **I** just said his interpretation is incompetent.

A I would prefer to say that it's wrong.

Q Does it deviate from acceptable standards of psychological interpretation?

A I don't think so.

Q It does not?

A Acceptable standards of psychological interpretation? If by that you mean is it a violation of ethics --

Q No, no, I'm not talking ethics. I'm talking about professional standards of interpretation, whether they're from any of these books that you referred to or other objective standards for interpretation, does his interpretation fall within any accepted standards of interpretation that you're aware of?

A No, his interpretation does not.

Q Who highlighted these records?

A The secretaries.

Q How did they know what to highlight and how did they know what color pens to use?

A That's a standard procedure we've agreed a long time ago to.

Q So this isn't the first time they've done this?

A That's correct.

Q And they do this in connection with all of your consulting?

A Most of it.

Q Have you reviewed those medical records to determine whether or not they performed their task accurately?

A Yes.

Q What is the necessity or need €or highlighting the records?

A To begin the process of categorizing the information so that in turn we can focus on it and make lists, such as the ones I've showed you.

Q Okay. Let's try to plow through. They're in some order. Some of this stuff I'm going to want to get copies of before I leave.

We'll go through this later. Is that sort of the end there?

A Those are.

Q Where we're headed?

A Yeah, that's pretty important.

Q Mr. Clayton, interjected a comment that I guess I need to sort of tease out here. Do you intend to express any opinions concerning Bobbie Clark's psychological condition, either before the accident or after the accident?

A No.

Q Help me out to focus, you know, shorten this up. What do you intend to testify about?

A Opinions, clear opinions I have about these records and about the psychological issues raised by those who have seen him and that have rendered opinions about him.

Q Okay tell me -- okay.
A And opinions about the, for example, the experts' interpretation of test data.
Q Shamberg?
A For example, yes.
Q Are there others that you take issue with?
A Yes, the psychologist Gordon, I take issue with some of what he had said.
Q What do you take issue with as far as his opinions?
A His diagnosis is, I don't think in many ways fits the facts of the case. He diagnosed a mental health problem that is by definition temporary. It just seems unlikely with this long history that this man has of mental health difficulties, it seems unlikely that he suffered from a disorder that only can last six months. And that's what, as I recall, Gordon said.
Q Well, for you to be able to dispute Dr. Gordon's opinion that this is a "temporary duration psychological condition," you would have to hold an opinion yourself to the contrary?
A Well, I could also do it on the basis of, for example, the medical records and the, and this person's diagnosis and what it says. What his diagnosis means according to the psychological

literature.

Q Okay. So again, if I understand what you're saying, is you're going to testify about what his records reflect?

A And --

Q And compare that information to some given point in time such as Dr. Gordon's evaluation or Dr. Shamberg's evaluation?

A Well, maybe an analogy would help. If they diagnosed -- if, if psychologist Gordon said that this man shows crying suicidal ideas and lack of interest in anything, and then he says that the proper diagnosis is anorexia, I can't accept that and I would then express an opinion that those two things just don't jive.

Regardless of Mr. Clark, there's a lack of correspondence between the facts that he lays out on one hand and the diagnosis he comes up with on the other.

Q So correct me if I'm wrong, but if I understand your analogy, and I think I do, you intend to testify about the validity of the conclusions that his treating psychologists have arrived at and whether or not they are valid in light of all the medical information that's available to you on

Bobbie Clark?

A That may be expressing it a little too strongly. I don't mean to quibble with words here, but commenting on the diagnoses that they've made and how they fit in with the literature or do not fit in with the literature is one of the things I intend to do.

Q The reason you have no opinion about Bobbie Clark's psychological condition independent of what is reflected in the medical records is because you haven't examined him?

A That is correct.

Q And you would not undertake to render an opinion of somebody's psychological condition without having examined them?

A Correct.

Q Just out of curiosity, what's the significance of the yellow highlighting with the check marks in the diary? It just has dates and check marks.

A I don't know. This could be someone pursuing a certain organization of the records. I don't know.

Q Well, did you actually review all of the records or did you only review the highlighted portions?

A I reviewed all of the records in the sense of quickly reading through, spot checking and looking

for anything that was missed.

Q I'm not sure I understand your answer. Did you read each and every line of each and every page of the materials that were provided to you?

A Read, no; skim, yes.

Q How much time have you spent on this case so far?

A I've spent maybe 15 hours.

Q How much of that was spent skimming the records?

A Four hours, five hours.

Q What was the rest of the time spent doing?

A Supervising the making up of these tables and the scoring of the MMPI using our computer printout. Delving into some of the records in detail; for example, the psychological reports. That's all I can think of.

Maybe doing some, doing some literature searches that pertain to this case; for example, finding out what the MMPI experts say about his profile.

Q You do not consider yourself an expert on the MMPI profile?

A Yes, I do.

Q Then why did you find it necessary to consult literature as to what other experts say?

A Well, that is the proper technique. The other

experts base their opinions on research studies. And so all I'm doing is really going to those references to find out what their research reveals about particular profiles. That's what a good psychologist does in a case like this.

Q So you're saying that in any case where an MMPI is performed, the psychologist should then consult published experts on how to score it?

A Not on how to score it, but how to interpret it. We don't all have the time to do that, but that's the best possible way to do it.

Q And do you **do** that with respect to every one of your patients?

A Yes.

Q Just so I'm clear for the record, every time you perform an MMPI, you score the results and then you consult the psychology literature to consult with what the experts, published experts say with respect to how to interpret that scoring?

A That's right. And the way I do that is that we've built up over the years a computer bank of research information on the different MMPI profiles.

Q What literature did you consult in this case?

A There were three books. In fact, I have them right here. Graham.

Q The Lachar?
A Uh-huh, L-a-c-h-a-r.
Q "The MMPI: Clinical Assessment and Automated Interpretation"?
A That's right.
Q "The Actuarial Use of the MMPI", Marks?
A Right.
Q And "The MMPI, a Practical Guide", Graham?
A Correct.
Q Okay. This case, this first one is Clinical Assessment and Automated Interpretation. What does that mean?
A The automated interpretation means that this fellow proposed a scheme for interpretation of the MMPI via computer. Actually that part of the book only takes up about 20 pages at the end of the book. The major portion of the book is on that first part of the title, clinical assessment.
Q Okay. Do you use automated interpretation?
A Not automated interpretation, no. Automated scoring, but we interpret using the literature as opposed to some computer programmer's opinions.
Q What is the role of clinical assessment? By clinical assessment, what are we talking about?
A The Lachar book, what it means is assessment of a

patient's **MMPI** based on research.

Q It doesn't have anything to do with the clinical assessment of the patient himself or herself?

A **No,** it is purely an interpretation of the test results. It's like a cookbook.

Q So there's no discussion whatsoever in this book about how to correlate MMPI findings with the clinical symptoms **or** presentation **of** the patient?

A Well, I suppose you're correct about that. That's not the purpose of the book. The purpose **of** the book is to interpret the test, so.

Q Okay.

A These books are similar, or analogous to a book that's filled with different kinds of x-rays, and then a little written description that shows what the x-ray means.

(Recess taken.)

Q Back to the books. The one book, "The Actuarial use of the MMPI", that's a **1974** book?

A Right.

Q Why are you referring to a **1974** book?

A Well, research is research. This is research done on the accuracy of people's profiles back during that time. There's no substantial evidence that the personalities of the entire culture have

changed in any way.

A And finally, it's one of three books; there are two others.

Q The Graham book is a 1977 copyright?

A That ought to be an '87.

Q There's a 1977 and 1987.

A Right. But I believe this is an '87.

Q Okay. And the Lachar?

A Uh-huh.

Q Is an '87 book as well?

A No, I believe that that was written much earlier.

Q It's the tenth edition of the same book which was originally published in '74.

A Right. Yes. Okay.

Q Any other literature that you referred to or reviewed other than these three books?

A Yes. And I'm going to have trouble naming this literature because I don't have it with me. But there is literature on the motivations behind people who suffer from what are called somatoform disorders.

Somatoform disorder is a hypochondriacal disorder. And as I say, there are researchers who have investigated what causes this particular difficulty. And so I reviewed that literature.

Q You reviewed that literature in connection with this case?
A Correct.
Q Now when you say that literature, you referred to some articles about somatoform disorders?
A That's right.
Q But you don't recall what those were?
A That's right. We have them in a file of articles that we are building up. They're in our article library.
Q And you are building up that library in connection with your medical/legal consulting?
A That's correct. And my clinical practice.
Q So you have it here in the office someplace?
A Correct.
Q I don't want to go through that now, but do you recall how many articles are in that file?
A Maybe seven or eight.
Q And you reviewed all of those?
A Yes.
Q And I can get copies of those from you --
A Yes.
Q -- later on? Okay. Why did you review that literature?
A Because it seems to me there is substantial

evidence from the testing and from this man's history that he suffers from a somatoform disorder. That is to say a exaggeration of physical ills.

Q You say from his history. Did anybody diagnose him as having a somatoform disorder?

A No.

Q That's your diagnosis?

A I'm not diagnosing him.

Q That's what I'm trying to get at.

A His records are consistent with the diagnosis and so is his testing.

Q So, your, it's your opinion that he has a somatoform disorder based on the information in his medical records?

A Again, I don't want to quibble too much with the verbiage here, but having not expressed an opinion about this man, it's more accurate and appropriate to say the medical records that I reviewed are consistent with the somatoform disorder diagnosis.

Q In your opinion?

A Correct.

Q So your opinion is that the medical records reflect a condition of somatoform disorder?

A Yes. When I say the medical records, I mean all the records that were reviewed, including his

psychological testing.

Q So you are concluding that this patient has a somatoform disorder on the basis of his medical records?

A No. Again, I hate to quibble, but I am expressing no opinion about Mr. Clark's diagnosis. I am expressing an opinion about what the medical records that were set before me, what they point towards. And that's a little different. Because I haven't seen him. So all I can express an opinion about is what the medical records imply.

Q Do you have an opinion as to whether or not Bobbie Clark has a somatoform disorder?

A No.

Q And yet out of all the psychological conditions which exist, that's the one condition or disorder that you went and reviewed medical literature on?

A That's right, because the records that I had before me suggest that, suggest that psychological problem.

Q Suggest that to you?

A Correct.

Q Nowhere did they state that this patient has a somatoform disorder or any condition of hypochondriasis?

A Right. Other than the case could be made if you take his test, if you take the **MMPI** --

Q I don't want to talk about the MMPI. Just talking about medical records other than the psychological testing.

A All right.

Q No place is there ever any mention of, by any physician or psychologist or psychiatrist that's ever seen this patient, of a somatoform disorder or hypochondriasis?

A Correct.

Q **Is** your wife in practice with you?

A No. She does manage the office.

Q She's not a psychologist?

A That's correct.

Q Tell me what do you perceive to be the difference between diagnosing Bobbie Clark's psychological condition from reviewing his records, which you've indicated you're not doing, and doing that which you are saying you're doing?

A Okay. Perhaps another analogy. A physician could look at an x-ray and never, the physician has never seen the person before, never seen the patient, and he looks at an x-ray and says this x-ray is most compatible with tuberculosis. He doesn't want to

go any farther than; he doesn't want to say I believe that person has tuberculosis because there could be other things going on he's not aware of, and because his profession tells him that he can't go around diagnosing people based on nothing but records.

But he can certainly say with absolute firmness, look, this x-ray looks exactly like a picture of tuberculosis. That he can say with adamant forcefulness. That's the analogy.

I'm looking at records rather than a person. I could draw many conclusions about what those records are compatible with. And that's what I'm doing. And the records include a test in this case.

Q And just so we're clear, your interpretation of what those records show is not supported by anybody else that's seen this patient?

A That's correct.

Q And your interpretation is without the benefit of ever having met Bobbie Clark?

A That's correct.

Q And you do not under any circumstances ever diagnose any of your patients for any psychological condition without having first met them?

A That's right.
Q That would be unethical and unprofessional?
A Right.
Q And yet you feel perfectly comfortable coming to court and rendering a diagnosis that you feel is consistent with the records of Bobbie Clark without ever having seen him and which has not been supported or borne out by any other person that's ever seen him?
A That's right.
Q Okay. I'm going to go through the records a little bit. They're sort of broken down into groups; is that accurate?
A Yes.
Q This one starts out all stapled together, self-evaluation, adult, and then it's got a bunch of other records; looks to be primarily psychology and psychiatry records?
A Right.
Q Why are those grouped together?
A They appear to be records associated with psychologist Gordon's evaluation.
Q Okay. There is also a Masser and another psychiatrist in there as well, is there not?
A Let's check. Yes, here *is* somebody named Masser.

Q Okay. Is he a psychologist?
A I don't know what Masser's degrees are.
Q Demosthene?
A Right.
Q Psychiatrist?
A He's a psychiatrist, right, uh-huh.
Q Going back to my original question; why are those records all grouped together, stapled together?
A I believe they're all from roughly the same time period.
Q Okay. They are also by, generated by mental health specialists; is that your understanding?
A Some are, uh-huh.
Q What do you understand to be in here that's not generated by mental health specialists?
A Reports by psychologist Gordon. Perhaps you mean to include him as a mental health specialist?
Q Yes.
A Okay. In that case, I agree with you. They are all mental health workers of some kind, yeah.
Q That's the only reason they're all grouped together, because of temporal proximity and the specialty of mental health?
A Right.
Q Do you have any particular conclusions or opinions

that you draw based on this stack of records?

A Let me look them over just for a second and see if there are any noteworthy things in the records.

There are a few things that are important. One is that the Page 1 is labeled a self-evaluation by Bobbie Clark. And his age is listed as 53 years old, which suggests that this is an evaluation after his 1989 accident. And then on Page 2 of the record, it says that he was referred by his attorney. And it says, "Have you ever been under psychiatric care?" And his answer is no. And, "Have you ever been hospitalized in a mental hospital?" His answer is no.

Q Of what significant to you are those two responses?

A This is a guy that well before the accident tried to kill himself with both Valium and carbon monoxide. He might be able to argue that he never got psychiatric care for that.

Q Did he ever get psychiatric care for that?

A He was hospitalized, specifically for the suicide attempt, as I recall. And it's hard to imagine that he got no psychiatric care for that.

Q You're not aware of any psychiatric care that he received?

A Well, I can repeat that he was hospitalized for a

suicide attempt. And while I could be wrong, it could be that they simply treated him for his physical symptoms and released him. It's highly likely that it would be appropriate to categorize that as psychiatric care.

Q Well, you've read his records?

A Uh-huh.

Q Yes?

A I have read his records.

Q Did you see any treatment for psychiatric care during that hospitalization?

A No. In that hospitalization, it is fair to say that I note that he was hospitalized for a serious suicide attempt.

Q Well, let's try to be specific with our question and answer. You did not see any treatment or -- you did not see any psychiatric treatment or care of this patient during that hospitalization?

A I would interpret the records of that time as indicating psychiatric care. Also psychiatric diagnoses.

Q What psychiatric care did he receive?

A Well, by virtue of being put in the hospital, he is being protected, he's being protected from himself. He's going to receive some conversational

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therapies.

Q Well, do you see any conversational therapies reflected in the records?

A No. I don't believe so. Now I can't, it's hard for me to remember that specific set of records so' I probably should refresh my memory on those.

Q How long was he hospitalized?

A I don't recall.

Q The records reflect that he was admitted 9-16 and discharged 9-17; do you recall that?

A No, I don't. But I will take your word for it.

Q Do you recall from your review of those records for his one-day admission related to possible carbon monoxide poisoning this patient receiving any psychiatric care?

A No. If by that you mean, for example, he was billed for an hour of psychotherapy or something like that, then the answer is no. Although, in the more general question of psychiatric care would lead me to ask also, did he take any tranquilizing medication, any psychiatric medication before the accident? And I believe he did, but I would have to look that up. If that is true, if he took Xanax, for example, and I believe that he did --

Q You're talking about prior to the accident?

A Prior to the accident. Then that would be psychiatric care.
Q But that's the only psychiatric care that you're aware of?
A That's right. Now again, I don't have records in front of me so it's difficult for me to recall.
Q And you indicated that his psychiatric care response answer to that no is being untruthful?
A That's right. There's a cloud of suspicion when he has a history of psychological difficulties.
Q It doesn't ask if he had psychological difficulty.
A I understand that.
Q It has, "Have you ever been under psychiatric care?" His answer is no, and you take that to be untruthful because you seem to recall some prescription of Xanax?
A And a hospitalization for an attempted suicide and multiple psychiatric diagnoses; that's right. It just strikes me as somewhat misleading on his part.
Q But you've also acknowledged that you don't recall him receiving any psychiatric care while he was in the hospital that one day?
A Not while he was in the hospital that one day, that's right.
Q Now you also indicate that his response to, "Have

you ever been hospitalized in a mental hospital," to have been an untruthful or misleading answer. Why do you interpret that as being untruthful or misleading?

A Well, that is a less misleading statement. On the other hand, it seems like as though he should elaborate. If I were filling out a medical form and somebody, and I had his history, and somebody said have you ever been under psychiatric care, have you ever been hospitalized in a mental hospital, I think I would -- I don't think I would just put no. I think I might go ahead and mention that I had multiple psychological problems. No is just a little too clean, a little too absolute in this case. And it gets that -- what I'm implying here is there seems to be a --

Let's go through the rest of the records. The very next page, Page 3, again the date here is 8-5-91. The very next page shows him to be taking among other things Xanax.

Q This is all after the accident?

A Right. But the point is the question is have you ever been under psychiatric care? He says no. And on the next page he lists a tranquilizer.

Q So you think he's not honest and forthright with

respect to medication he's taking?

A That is correct.

Q And you're implying that he is attempting to lie to whoever is seeking this information by denying he's ever been under psychiatric care when he immediately turns around and reports he is taking Xanax?

A Right. I think he's minimizing his psychiatric problems, yeah.

Q Okay, go ahead.

A All right. Moving along, he mentions on item number five of the third page of my packet, he mentions under item number five that his father and mother and brother have had trouble, heart trouble and trouble with high blood pressure.

That's relevant because the histories of people with hypochondriacal disorders usually include an ill relative that they focus on and model. So that's what relevance there is; it's predictable that he would have relatives with fairly serious --

Q So you're saying this is not just Bobbie Clark's problem, it's his entire family's problem?

A Well, no. I'd -- I'm saying that his history is consistent with that of a somatoform disorder.

Q And it's consistent because you find evidence of somatoform disorder not only in Bobbie Clark, but in his family?

A No. I find evidence of somatoform disorder in Bobbie Clark because his parents and brother suffer from long-term chronic, what appear to be long-term chronic health problems. Theirs may be real. So I'm not accusing them of being psychologically disturbed.

Q Okay. Their health problems may be real, but Bobbie's are not, is what you're saying?

A According to the tests, his tests are not compatible with the notion of real health problems.

Q Okay, go ahead.

A Again, I hate to keep using this verbiage to indicate that I'm note expressing an opinion; I'm not expressing an opinion about Bobbie Clark.

"Check of any of the following that you have had," and he's checked a fair number of them. And what is striking about the physical symptoms that he checks is that they are of such wide scope. In one in the same person we have headaches, eye trouble, dizzy spells, shortness of breath, chest pain, asthma, rheumatic fever, aching painful joints, insomnia and, of course, high blood

pressure. It's a wide range of physical ills.
Q What's so unusual about any of those problems in a man his age and with his prior medical history?
A Well, in one sense it's not unusual. In the sense that he had an equally wide scope of physical health problems before the accident and after. I mean he's always complained of multiple complaints.
Q The question asks which of those medical problems have you ever had during your entire life.
A Right.
Q It's not just asking what problems have you had since the accident.
A Right. And I didn't mean to imply that. I'm simply saying he has a wide range of problems that he complains about and has complained about.
Q None of those problems are unusual for a man his stated age?
A I believe they are. If I understand what you're saying, I would not be willing to agree that every 53-year-old complains of this list of problems.
Q What about the average 53-year-old man that's been struck on the head with a 300-pound door; does that tend to result in frequent headaches in a person such as that?
A If a door hit -- if there were significant head

injury.

Q Are you assuming that Bobbie Clark does not have a significant head injury?

A That appears to be the case to me.

Q *So* your --

A Based on records.

Q *So* you're diagnosing him also as not having a significant head injury?

A No. As I said, I'm not diagnosing him with anything, but implicating that the records show little evidence of, little or no evidence of neurological problems.

Q And what records are you referring to?

A It's difficult for me to sort through the 1500 pages and tell you exactly the names of those records. But I believe that we will find MRIs, maybe CT scans, and x-rays of his head showing no physical damage. The one exception to that is going to be the notion of atrophy, which is a difficulty that can emerge out of aging. *So* what I should say is beyond the natural course of aging.

Q So it's normal for a 53-year-old man to have brain atrophy, but it's not normal for a 53-year-old man to have complaints of high blood pressure, aching joints, frequent headaches, asthma, rheumatic

fever, especially after being hit on the head with a 300-pound door; is that what you're saying?

A Yeah, I believe that's a fair statement.

Q You're not aware of recent MRIs or CT scans which show brain lesions?

A *No,* that doesn't, does not sound familiar, lesions, no.

Q Are you aware of the fact this gentleman has had surgery on his back?

A Yes.

Q Subsequent to this injury?

A Yes.

Q What is your opinion as to whether or not those are related to this injury?

A I don't know. I just don't know. It is not unusual for a person with a hypochondriacal disorder to go through multiple surgeries and lots of medication; comes with the disorder.

Q So you're saying that surgeons perform unnecessary surgery on patients without any indications for surgery because they are a hypochondriacal patient?

A I didn't say that. That's kind of going far afield.

Q Well, you just suggested that patients have numerous surgeries because they have somatic

disorders; is that what you said?
A Yes, some patients have frequent surgeries because of their somatoform disorders, that's right.
Q And I take it from what you're saying those surgeries are not indicated; they're only having the surgery because they are somatoform disorder patients?
A That's right.
Q So the surgeon who performs the surgery on the patient would not only be unprofessional, but an unethical surgeon?
A No, the surgeon is not unprofessional or unethical, but rather is fooled by the hypochondriacal complaints.
Q A narrowing of disk space; that's something a surgeon can be fooled by a somatoform disorder patient?
A If I understand your question correctly, somatoform patients can't feign a narrowing of the disk space, no.
Q Do you know why the surgery was performed on this patient?
A There was some evidence of spinal abnormalities on MRI or x-ray.
Q Was Bobbie Clark feigning those?

A No. By definition you can't feign those particular problems, no.

Q And what is your assumption as to whether or not those spinal abnormalities were related to his being struck on the head or not?

A I'm really not quite sure. I, you know, I don't have medical opinions about this guy. I don't have psychological opinions either, but I certainly don't have medical opinions about him.

Q You indicated you consider him a person who is consistent with a somatoform disorder, although you're not willing to make a diagnosis yourself?

A Correct.

Q Based on the fact he complains about aching joints, yet this is a patient who has had spinal surgeries because of spinal abnormalities following a traumatic blow to the head with a 300-pound garage door?

A I don't think you've characterized what I said well.

Q You recharacterize it for me in a way you want to recharacterize it, because that's what I heard you say.

A Okay. I'm not saying that I'm diagnosing him; I'm only suggesting that his difficulties are

compatible with somatoform disorder based on the aching joints; it's based on a large range of evidence. Primarily the testing done by Dr. Shamberg.

Q You're getting away from a whole different topic.

MR. CLAYTON: No, wait a minute. He's trying to answer the question. You're just arguing. I object.

MR. LEESEBERG: No, he's --

MR. CLAYTON: Don't answer anything.

MR. LEESEBERG: He's not trying to answer my question.

MR. CLAYTON: If you're going to argue with him --

MR. LEESEBERG: I don't want him to take up my transcript and my time talking about Dr. Shamberg's report; we're talking about this patient.

MR. CLAYTON: I'm not going to let him answer the question unless you let him complete his answer. Give him a fair chance.

Q Doctor, I don't want to talk about the MRI. You interpreted the information reported by Bobbie

Clark on this sheet, this second page of this sheet, third page of this sheet, to be reflective of a patient with a somatoform disorder, in that he reported a wide variety of symptoms which you consider to be reflective of a somatoform patient. Did I understand you to say that?

A Yes. But let me make sure you understand that this wide range of complaints is one piece of evidence. There are other pieces of evidence as well.

Q I'm taking your one piece of evidence at a time.

A Let's look at this one point.

Q I'm talking about your interpretation of this data as reflective of a somatoform disorder patient in a patient who has been hit on the head by a 300-pound door, who has vertebral surgery because of spinal abnormalities, as you understand them to be, and who is 53 years of age and who has been diagnosed as someone with rheumatic fever, which he clearly didn't feign, correct?

A I suppose you're right about that.

Q And asthma?

A Okay.

Q Did he feign that?

A I suspect not.

Q Which of these is he feigning?

A Well --
Q Is he feigning high blood pressure?
A No.
Q Okay, let's go through this list then.
A Okay.
Q Frequent headaches; is he feigning that?
A He could be.
Q Trouble with eyes or vision?
A Could be.
Q Dizzy spells?
A Could be.
Q Shortness of breath?
A Could be.
Q Recurrent chest pain?
A Could be.
Q Do you recall all of those things being reflected in his medical records prior to the day of this injury?
A Yes.
Q Rheumatic fever?
A Probably not.
Q Asthma?
A Probably not.
Q Aching or painful joints?
A Could very well be.

Q High blood pressure?
A Probably not.
Q Insomnia?
A Could be. Now understand, I take the word feigning to be exaggeration, hypochondriacal. I mean saying a hypochondriac is feigning in this case it sounds like he's a liar. I don't mean to say that. I mean to say his difficulty is a difficulty of exaggerating the physical ills.

Notice how many of those complaints are subjective.

Q We just eliminated the subjective -- the objective. You ruled out him feigning asthma, rheumatic fever and high blood pressure.

MR. CLAYTON: Show an objection to that. There's been no evidence that there's been a diagnosis; that's his words.

MR. LEESEBERG: I just asked him whether or not he considered asthma, high blood pressure and rheumatic fever to be a condition he could feign, and your answer was no?

A No, I don't think so.
Q And do you have any other evidence that he was

feigning any of those complaints or that he was falsely reporting those conditions?

A Yes.

Q You do?

A Yes. And the evidence is the larger mosaic of evidence that I have referred to over and over again that include Shamberg's MMPI and his history and these data here.

Q No, wait a minute. I want to make sure we are clear here. You're saying you think he was feigning asthma, rheumatic fever and high blood pressure?

MR. CLAYTON: He said he could be.

Q No, I want to know whether or not you think in in this case this patient was feigning or falsely reporting complaints of asthma, rheumatic fever and high blood pressure?

A Again, you keep using the word feign, and I'm a little uncomfortable with that. But setting that aside for the moment, it is unlikely that a person can feign or exaggerate high blood pressure, rheumatic fever and --

Q Asthma?

A -- asthma. But it is not impossible to feign those.

Q Well, my question now is do you believe that Bobbie Clark was feigning those conditions or falsely reporting those conditions at the time this thing was filled out?

A No. I believe those are the least likely to be exaggerated or feigned.

Q I'm not asking least likely, most likely; my question is do you interpret those reports as being feigning or false reports of medical conditions?

A No.

Q Okay. Now let's talk about frequent headaches, trouble with eyes or vision, dizzy spells, shortness of breath, recurrent chest pain, and aching or painful joints.

A Okay.

Q In a person who is 53 years old, who's been through the war, who has been --

MR. CLAYTON: Hold it. Been through what?

MR. LEESEBERG: A war.

MR. CLAYTON: Come on. He hasn't been through any war.

MR. LEESEBERG: Who's been --

MR. CLAYTON: In the military service.

Q Who's been struck on the head with a 300-pound garage door and who's had surgery for spinal abnormalities including narrowing of the vertebral spaces; do you in light of that history, do you interpret those symptoms or conditions which he's checked to be evidence of a somatic disorder?

A Yes. A somatoform disorder, yes.

Q On what basis?

A Well, most of the stuff you just listed he had before he got hit with a 300-pound door. And so again, we're left with, your question emphasizes maybe this guy was hit on the head with a 300-pound door. My response is well, let's look at what he complained about before he was hit with a 300-pound door.

And the symptoms just go on and on and on and on. I don't see any difference between his complaints before he was hit with the 300-pound door as opposed to afterwards, except for the fact that the before list is slightly longer.

When it comes to his hospitalizations, we really come to the same conclusion. There was a revolving door on this man's, in front of this man's hospital. And he went through it many times before he was hit with a 300-pound door. After he

was hit with the 300-pound door he continued to revolve through the door. It seems to me that the number of times that he went through was no higher.

So the emphasis in your questions on a 300-pound door, it seems to me are kind of misplaced. The question is how come this guy complains about stuff since 1954? That's the question. And the answer is he's either got a physical problem that's, or a series of physical problems that are incredible, or it's some kind of psychological disorder that leads him to complain.

And then finally we've got to just keep in mind, before this door came down on this guy, he had tried to commit suicide, he had been diagnosed as a neurotic, as depressed, as anxious. He has shown multiple symptoms of mental health difficulties. That's what we have before he was hit by the door.

So and then finally, Shamberg's MMPI is unambiguous. This somatic delusions, meaning he's at a stage where the physical health problems he complains of are almost bizarre. And that's what all of the experts will say when they interpret this profile. So that's some of my bases.

Q Doctor, with reference to the list of symptoms that,

you've categorized before his accident as evidence to you of a somatoform disorder, indicative of feigning or exaggeration, do you believe that this patient feigned having a tonsillectomy and adnoidectomy?

A No.

Q What about mumps?

A No.

Q Rheumatic fever?

A No.

Q Measles?

A No.

Q Meningitis?

A Probably not.

Q Right ankle fracture?

A Probably not.

Q Chorea?

MR. CLAYTON: Cholera?

A Probably not.

Q Nephritis?

A Not sure.

Q Head injury?

A Quite possible that that was an exaggeration.

Q The fact that the head injury itself?

A No, the symptoms that he complained about.

Q Do you recall what the symptoms were that he complained about related to his head injury before the accident?

A No. I do recall that the physicians were convinced it was a concussion.

Q Well, are you inferring from that he's exaggerating the symptoms related to the head injury?

A It's compatible and he's doing it again; same old thing.

Q You're not answering my question.

A Okay.

Q Are you inferring from his prior head injury that he in some way exaggerated or feigned symptoms associated with that head injury?

A Yes. It is in the sense that there is a wide, wide, spectrum of problems. The ones that you've listed that are objectively diagnosable, certainly to be expected in the course of a person's life. It's all the others.

Q We're not talking the same line. I'm asking you whether or not you think he feigned a head injury?

A And my answer is that it is quite likely. I cannot say with certainty, but it is quite likely.

Q Do you know how he got his head injured?

A I don't recall.

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Q Do you recall what the symptoms were that he complained about?

A Vaguely; memory loss, dizziness. It's difficult for me to recall.

Q Well, if you don't recall how he was injured and you don't recall what the symptoms are, how are you inferring he exaggerated the symptoms or feigned the injury itself?

A Okay. It is no one medical problem. It is the wide range of medical problems.

Q I don't want to talk about anything else other than the head injury. Do you know whether or not he got hit in the head with a baseball bat?

A I don't know.

Q Are you saying even though he got hit in the head with a baseball bat, the mere fact that it appears in this list of extensive medical problems, that it is therefore a feigned injury; is that what you're saying?

A Not quite.

Q Well, what are you saying then? If you don't know how he was injured and you don't know what the symptoms are, how are you inferring from that that he feigned that injury?

A Because it is in the context of a wide range of

physical health problems.
Q A bullet wound to the head is a head injury, is it is not?
A Yes.
Q Do you know if he got shot?
A I don't recall.
Q But the mere fact it appears in this list of excessive medical problems, you would infer that he feigned that injury, even though he had been shot?
A Once again, no. That's an extreme mischaracterization of what I'm saying. I'm saying that in terms of the list that you're looking at, there are an unusually wide range of medical complaints.
Q I understand that. But I don't want to talk about all the other problems. I want to take each one of them one at a time.
MR. CLAYTON: Note an objection. Each one of those were taken from medical records. If you want to question him about each one, let him look at the medical record to refresh his recollection then he'll be able to answer.
MR. LEESEBERG: He's got listed here as being a symptom before the accident and

he's already testified that without knowing what the injury was or what the symptoms were, he is concluding that this patient feigned that injury.

MR. CLAYTON: Based upon --

MR. **LEESEBERG:** I'm not asking him about anything that is in the records; I'm simply asking him the basis for his opinion that he feigned this injury.

MR. CLAYTON: Well, his testimony has got to be based upon the medical records.

Q Okay. You don't even recall what the medical records show with respect to the head injury?

A No.

Q But yet you're still willing to opine that it is reflective of a patient with a somatoform disorder?

A Yeah. Maybe I could --

Q No, that's all I need to know. Pneumonia; is that evidence of somatoform disorder?

A If could be.

Q Did he feign his pneumonia?

A Not sure.

Q What **do** you need to know to be sure?

A What kind of symptoms he was complaining about,

what level of care he sought.
Q And you don't know any of that?
A I don't recall it. You are -- once again, one of things that you're doing at this point is asking me to recall specifics --
Q Over --
A I haven't finished quite yet.
Q Okay.
A -- of over 1500 pages of records.
Q Doctor, you've listed it as a symptom or a condition or an illness before his accident from which you are deducing and concluding that this patient has a somatoform disorder?
A Correct.
Q I'm asking you why you have pneumonia in that category when you don't know what his symptoms were, you don't know what his tests were, and you don't know what his care was? How without that information do you conclude, or are you comfortable saying that that is reflective of a somatoform disorder as opposed to a perfectly valid and identifiable disease process?
A I assume you do want me to answer that question?
Q Yes, I do.
A Okay, here it comes.

Q Okay.
A One of the major symptoms of somatoform disorder is a long list of widely different physical health complaints, okay. One of the criteria for diagnosis of somatoform disorder is that the persons have a wide variety of physical health complaints.
Q I understand all that. I just want to talk about pneumonia.
A Now I'm in the middle of my answer at this point. But that's my point one, and I just wanted to make sure to nail that down.
Q We've already taken that many times and I don't need to hear that anymore.
A Point number two is you are looking at a wide variety of physical health complaints; he therefore witnesses the criteria.
Q And therefore, regardless -- what about cancer? If cancer was on that list, would that be evidence of somatoform disorder?
A It depends.
Q Okay.
A But it would certainly, it certainly wouldn't take away from it.
Q Do you know whether this was a viral or bacterial

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pneumonia?

A I don't know.

Q If it was a bacterial pneumonia, would **you** believe that he feigned bacterial pneumonia?

A No.

Q If it was bacterial pneumonia, would that still be some evidence of a somatoform disorder?

A It could be.

Q Okay.

A You want me to tell you why?

Q No. Dog bite is evidence of somatoform disorder?

A It could be.

Q Gets bit by a dog and feigned the fact you've got a dog bite?

A Would you like for me to explain my answer?

Q Yeah.

A It depends on the level of care that fellow sought. For example, if he were to have experienced a very minor dog bite and he ran to the emergency room and demanded to be hospitalized for a week, that would be evidence of a somatoform disorder.

Q How much treatment did Mr. Clark seek?

A **I** don't know.

Q Why don't I see this listed among this list of conditions from which you are concluding that he is

a somatoform disorder patient?

A My answer is the somatoform disorder has as one of its criteria a wide range of physical health problems; that's what you're looking at. I really don't know quite else how to say it.

It would be odd, wouldn't it, if I accused him of being a somatoform disorder and we couldn't find any health complaints, no physical health complaints whatsoever in his past. That wouldn't fit very well.

Q If he got bit by a dog and had 50 stitches in his arm, went to the emergency room and was treated and followed up with his family physician to have the stitches removed, is that evidence of a somatoform disorder?

A By itself, it is not.

Q You're saying that in conjunction with chorea, rheumatic fever, measles, meningitis and a tonsillectomy and adnoidectomy and mumps it would be indicative of a somatoform disorder simply because it's a part of a long list of medical problems?

A That has to be seen with the other criteria.

Q What's the other criteria?

A That the long list of physical health problems

include problems for which there are no, there's no medical support, and this will be included in the list.

Q What about cardiomyopathy?

A Your question is?

Q Is that evidence of a somatoform disorder?

A No.

Q What about peptic esophagitis?

A That I'm not sure about.

Q Do you know what the symptoms associated with cardiomyopathy are?

A No. I don't believe I do.

Q Well, you don't know whether or not any of these symptoms that are listed of subjective complaints are related to cardiomyopathy or not, do you?

A No, I'm not sure about that.

Q For example, easy fatigability, tingling in the extremities, lips being numb, nausea, dizziness, aching joints, sweating, vertigo, numbness, left arm pain, short of breath, you don't know whether any of those are symptoms associated with cardiomyopathy, do you?

A That's correct.

Q And yet you're taking all of those subjective complaints in the presence of a condition of

cardiomyopathy as an indication that this patient is feigning?

A It is consistent also with -- again, the word feigning is a bit extreme.

Q You're the one that used it.

A Well, this is the second or third time I've told you I was uncomfortable with your word feigning. But it is consistent with the diagnosis of somatoform disorder.

Q Diabetes, was he faking that?

A I don't think so.

Q Why not?

A Well, I assume, and perhaps even recall, the -- I assume that his blood sugar was taken and the blood sugar was high. But understand, minor elevations in blood sugar are taken very seriously if the patient is complaining of multiple problems.

Many physicians start becoming desperate when their threshold of diagnosis drops.

Q The patient was feigning seizures?

A It's quite likely.

Q Why is that? Have you ever seen him have a seizure?

A I've never seen him.

Q How would you know if he's feigning a seizure if

you've never seen one of his seizure episodes?
A Well, because, number one, it is a typical symptom of people with certain kinds of somatoform disorders. It corresponds very nicely with Shamberg's testing. In other words, that that testing would predict psychologically oriented seizures for example.
Q When you say seizures, as though you're referring to it in quotation marks, as though it's not real a seizure, are you suggesting he's not having seizures, he's just reporting seizures?
A I'm saying that's quite likely.
Q But you don't know that unless you've seen the seizure occur? You don't need to see the seizure occur or not occur to know things like that?
A No, I don't think that's necessary.
Q Now wait a minute now. You're assuming that he's not really having seizures, that he's just reporting seizures, correct?
A It is likely.
Q And you're saying it's likely that he's just reporting seizures and not actually having them, even though you've never seen his seizure?
A That is compatible with the testing. Yeah. And then I'm adding that for a physician to diagnose,

for example, for a physician to diagnose a seizure disorder, the physician doesn't have to be present when the patient has the seizure. In fact, that's rarely the case.

Q And for a patient who is feigning seizures, what is the appropriate treatment?

A If a person were feigning seizures, what would be the appropriate treatment? If he were feigning, meaning lying about it, you tell him to knock it off.

Q Would you prescribe, or is Dilantin appropriate treatment for a feigned seizure?

A No.

Q So you're saying that a physician that has prescribed Dilantin for Bobbie Clark is making an inappropriate treatment?

A Well, I don't know. I mean, it is -- I am saying to you that somatoform disorders have as one of their symptoms seizures.

Q Reports of seizures?

A Reports of seizures, that's right.

Q They don't actually have seizures?

A Correct.

Q And since they're not actually having seizures, it's not appropriate to give them Dilantin, right?

A That's right.

Q But you're aware Bobbie Clark has been given seizure?

MR. CLAYTON: Dilantin.

Q I'm sorry, been given Dilantin?

A Yes.

Q And so therefore it's your opinion that this Dilantin is inappropriate treatment?

A Well, it has a, given his psychological testing, it has a likelihood of that, that's right. The more general point which I can make over and over again is this: hypochondriacs get a lot of medical treatment. Lots of medical treatment and very little of it is appropriate. I mean it's well-known; it's in every piece of literature that you can find on hypochondriacs. They go from doctor to doctor. They believe in theirself. They report symptoms that mimic illness; and physicians, good physicians, will be duped into treating them. There is unnecessary surgery, unnecessary medication that goes on and so on.

I don't think it shows that the physicians are immoral or incompetent; it shows that hypochondriacs can be mighty good at exaggerating ills.

Q Does Bobbie have a lot of stressors in his life?
A Yes.
Q What's your understanding of Bobbie's work history in the five years prior to being hit on the head by this door?
A As I recall, he was a truck driver for many years and then a few years before he was hit on the head with the door, he began to work as a corrections officer.
Q He's got a good employment history?
A I think he's got, as I recall, it's a reasonable employment history of driving truck consistently and then moving into this field.
Q What do you mean reasonable employment history?
A Well, driving a truck is not a highly complicated task. It fits his profile for him to enjoy being alone driving a truck with no ordinary pressures of day-to-day life and social interaction.
Q I'm just talking about his consistent employment. Did you find him to be consistently employed in remunerative employment for a period of time, significant period of time prior to this accident?
A Well, as I recall, it deteriorated immediately before. The word is before the accident.
Q Okay. Let's talk about about before. It

deteriorated before the accident.
A Okay.
Q We'll get into that in a minute. Prior to that period, how would you characterize his employment history?
A As I recall, his -- he drove trucks regularly.
Q How would you characterize his employment history? I didn't ask you what he did.
A I believe I already -- what was the word I used? It was all right. It was reasonable.
Q What does that mean, reasonable?
A Mediocre.
Q What's mediocre about it? Did he go to work every day?
A Most days. If he wasn't in the hospital. I believe that he did.
Q Did his somatoform disorder in any way, shape or form interfere with his employment history prior to this period of deterioration which you've referred to prior to the accident?
A Occasionally. I mean I have listed here before the accident about 17 or 18 hospitalizations. During the time that he was in the hospital, he wouldn't be working. And so my answer is yeah, there would be some interference before the accident.

Q Well, it didn't interfere with his ability to hold a job; he wasn't fired, he didn't quit, wasn't unemployed.
A He wasn't fired and he wasn't unemployed and he didn't quit, that's right.
Q He was employed?
A That's right.
Q Throughout this entire period of time?
A Right.
Q In productive, income earning employment?
A Correct.
Q And do you have any knowledge about his job evaluations?
A I believe that his job evaluations were okay. I believe that he got reasonable job evaluations.
Q Where did you get that information from?
A I don't recall. I've got 1500 pages of records here.
Q So you recall his job performances, you recall reviewing something about job performances?
A Something somewhere. Something he said, something that a record said, yeah.
Q Something he said or something the records said, and all you recall is that you recall it being average; is that what you said?

A I think I said that his job evaluations were pretty good.
Q Pretty good now?
A Uh-huh.
Q What do the experts say about somatoform disorders in terms of disrupting a person's ability to hold and maintain jobs?
A They say that somatoform disorders interfere with job performance.
Q Do you have any indication that the somatoform disorders which you feel that Mr. Clark has interfered with his job performance?
A Yes.
Q And what's your opinion?
A In the, I mean he was off work for disability at the time of the accident.
Q Well, that doesn't affect his job performance. I'm talking about his on-the-job performance.
A No, no, no, no. When somebody is off of the job because of a disability, by golly that has some impact on their job performance because they ain't there. I mean it's a pretty significant impact.
Q Let's not talk about the fact that they're not on the job because they're getting medical care. What do the experts say about somatoform disorders in

terms of affecting a person's ability to hold a job or to seek employment?

A They get no more specific than to say that it interferes with occupational functioning. And a person who is not going to work certainly has a problem with occupational functioning.

Let me put it another way. The primary symptom or sign of interference with occupation is not going to work. Getting disability, saying I'm too sick to work, that's what they do.

Q You're not aware of any statements in published psychological literature to the effect that persons with somatoform disorder find it difficult to find and retain jobs or employment?

A I believe that you can find that in the literature.

Q I thought you said they didn't get any more specific other than to say that it interferes with job performance?

A I did say that. The major criteria for the disorder talks about interference with job functioning.

Q But now you acknowledge that published psychological literature does in fact say more specifically that people with somatoform disorders often find it difficult to find and maintain

employment?

A Not exactly. My statement is that somatoform disorders cause interference with occupational functioning. Severe somatoform disorders would interfere so greatly with job performance that the person may either quit work or be fired or stop work and never go back, be totally disabled. Others have a lesser interference with their occupational functioning because they continue them.

Q So how are you describing your opinion as to Bobbie Clark's somatoform disorder; is it severe or is it mild?

A I'd call it moderate. In between the two, yeah.

Q And even though it's moderate, there is no evidence that Bobbie has had a difficult time finding a job or maintaining employment?

A Since he was off on disability when the accident occurred --

Q I'm talking about, we're talking about before that time.

A If you maybe could get a little more specific.

Q Well, again, I Prefaced all my questions on the period of time prior to accident that you've referred to as a deterioration in physical

condition.

A Okay. So the time period you're talking about is basically birth until the day of the accident?

Q Right. No, no, I'm talking about before his condition deteriorated to the extent that he was off work immediately preceding the accident. I want to talk about from birth up until the point in time when he went off work for a short period of disability prior to the accident.

A Okay. And my answer to you is that he was in the hospital roughly 16 times.

Q Do you know how long he was hospitalized on any of those occasions?

A In one specific instance, it was a day. You and I talked about that. The others I don't recall the specific days.

Q What about the laceration?

A If -- I don't know. And I will say that with all of the different entries.

Q Okay. My question, though, now you're changing the question. My question specifically is from the time of his birth until the time when he was disabled shortly before this accident in which he was injured by the falling door, do you find that his somatoform disorder which you consider to be

moderate in any way interfered with his ability to find a job or to maintain employment?

A If you restrict the question to A, finding a job, the answer to that is no. He found a job.

Q And did he maintain a job throughout that entire period of time?

A He maintained a job, meaning that he didn't quit the job and he wasn't fired. He did not maintain the job in the sense that he was absent at least on these days of hospitalization.

Q And you're not aware of what if any effect this moderate somatoform disorder had on him in terms of his job performance while he was at work?

A I don't know how he acted when he was at work.

Q And in fact, the only information that you do have is that he was evaluated as reasonably good as an emp1oyee?

A That's my recollection. That's right, yeah. Keeping in mind that he was driving a truck, he was sitting alone in the cab of a truck.

Q What about the five years working as a correctional officer? Have you seen any of the letters of recommendation that have been provided to Mr. Clayton?

A No, I don't recall those.

Q He didn't show you those?
A I don't think so.
Q If a person is suffering from some psychological problems before a traumatic physical injury, does the traumatic physical injury present a risk of exacerbation of the pre-existing psychological problems?
A Yes.
Q And does pain and disability associated with a traumatic physical injury have a risk of exacerbating any prior psychological conditions?
A Yes.
Q Do you have an opinion as to whether or not Bobbie Clark is suffering from pain or discomfort as a result of the physical injury he suffered in November of '89?
A With cautions about my opinions about Clark, his testing and his history suggest the source of his complaints are psychological.
Q So you're saying that he doesn't have any pain or discomfort as a result of being hit on the head with a 300-pound garage door?
A That is quite possible.
Q And do you have an opinion as to whether or not his spinal surgeries were the result of being struck on

the head with a 300-pound door?
A I don't know. But I do know that his psychological profile and his history leading to suspicion of somatoform disorder would in turn be compatible with a wide range of medical treatments, surgeries, heavy medication.
Q So you're saying he had his surgeries because he has a somatoform disorder?
A It's compatible with the diagnosis, yeah.
Q Well, please answer my question. Are you saying that he had these surgeries on his spinal area because of his somatoform disorder?
A I'm saying that that's quite possible.
Q If a person has numerous significant stressors in their life and they suffer from depression or anxiety or stress as a result of that, does that fit them, or put them in the category of a somatoform disorder?
A It is compatible. And the reason for that is that our diagnostic manual, the one that's used by Shamberg and Gordon and others, our diagnostic manual says that one of the primary characteristics of a somatoform disorder is reports of depression and anxiety. It comes with the territory.
Q Well, if your grandchildren are raped and you

suffer anxiety or stress as a result of that, does that make you a person with a somatoform disorder?

A No.

Q And yet, stress and anxiety and depression as a result of the incident are perfectly normal expected consequences, correct?

A Oh, sure, yes. It's just that in this case we have a history of complaints of depression and anxiety and depression that go back a decade. It didn't take a rape of the grandkids for this man to complain of anxiety and depression. He did that long before anybody, long before they were born.

Q There's reference here to a frontal parietal brain lesion. What do you know about that?

A Well, the frontal lobes are in the front of the head and parietal lobes are in the back top. And I know what a lesion is.

Q I mean with respect to Bobbie Clark, what do you know about his having a frontal parietal brain lesion?

A I recall no medical evidence that he has such a lesion.

Q What are the symptoms or conditions or complaints that a patient might be expected to evidence psychologically or physically as a result of a

frontal parietal brain lesion secondary to trauma?

A The major one for the purpose of this discussion would be a sudden onset of complaints. By sudden,. I mean at least within six months. There are times when a head blow has a delayed onset of symptoms associated with it. But whatever the person, whatever I list, should be something that the person is now complaining of, but they didn't complain of it before the blow. That's pretty obvious.

Having said that, the complaints would be recent onset dizziness, recent onset headaches, recent onset concentration problems, memory problems, emotional lability, that sort of thing; all of recent onset and not conditions that go back a decade before the blow.

Q All of the things that Bobbie complains about are consistent with a frontal parietal lesion, are they not?

A No. Because I wanted to emphasize recent onset.

Q I'm not talking about in terms of when they're being reported, I'm simply asking you whether or not all of the symptoms that he reports subsequent to the accident are consistent with a frontal parietal lesion?

A And I have to answer by saying, no. Because you simply cannot sweep aside the duration of the complaints. And this man complained of most of those things that I've just listed. He complained about them before the blow. And as I understood your question, your question was are his complaints consistent with the garage door hitting him? And my answer is no, they are not. His complaints supersede the garage door.

Q If we can set aside for the moment the fact that he, according to you, may have complained of some of these symptoms before being struck on the head with this door, I want you to put that aside for a moment.

A All right.

Q Apart from that, all of the symptoms and conditions which he complains about following the accident are consistent with being hit on the head with a 300-pound door and suffering a frontal parietal brain lesion?

A Are you saying all his complaints?

Q Yeah.

A No, they are not.

Q Which ones are not?

A Pain in his collar bone; that's not caused by a

frontal parietal lesion.
Q Okay.
A Pain in his two top ribs.
Q Okay?
A Numbness in his feet, upset stomach; bronchitis is not caused by a frontal parietal lesion. But I can go on and on, but you get the point.

So, see, the problem we're having, the problem we're having is that, let's go through the dozens of diseases that this man's complaints are compatible with. He has such wide variety of physical complaints, that he'll fit into the physical disease category of just about anything you can come up with.

And I guess the complaints are probably consistent with appendicitis, vomiting, pain in his side and so on. So that's my whole point.

Q I want to know whether not the following symptoms are consistent with a diagnosis of frontal parietal brain lesion secondary to traumatic injury, okay?
A Okay.
Q With me? Headache, vision and hearing trouble?
A I believe that the answer is yes to headache, and that the answer is no to vision trouble.
Q What about hearing?

A I don't think so. That's probably temporal lobe.
Q Loss of consciousness?
A Possible.
Q Dizziness?
A Yes.
Q Nausea?
A Unlikely.
Q Light headed?
A Probably.
Q Heat feeling from arms to wrist?
A I don't think so, no, huh-uh.
Q Breakouts or blackouts?
A Possible, yes.
Q Syncope?
A Possible.
Q Seizures?
A Possible, yeah.
Q What did I just ask you about; seizures?
A Seizures, uh-huh.
Q Apnea?
A No.
Q Why is apnea not consistent with a frontal parietal brain lesion?
A I believe they're talking there about his sleep apnea, caused by obesity and extra folds of skin in

the back of the throat.
Q I'm not talking about Bobbie Clark, I'm just asking about frontal parietal brain lesion. In a patient with frontal parietal brain lesion, is apnea or apneic spells a consistent symptom?
A I don't believe so, huh-uh.
Q Why not?
A Because as I was saying, apnea is a sleep disorder consisting of failure to breath and caused typically by obesity and extra folds of skin in the back of the throat. It has nothing to do with the head blow.
Q You're not aware of apneic spells being associated with neurological disorders or injuries?
A No. It is possible, but the vast majority of sleep apnea difficulties are as I've described.
Q In a patient such as Bobbie Clark, whom you feel has a moderate somatic disorder pre-existing this accident, am I correct so far?
A Right, somatoform, uh-huh.
Q Somatoform disorder, who gets hit on the head with a 300-pound door, what would you expect to be the effect of that incident on the patient?
A There is no doubt that if the patient were a somatoform disorder sufferer, he would latch onto

any sort of obvious and objective accident and would begin to blame all of his problems on that event. He would conveniently forget or minimize the problems that he had prior to that event and would go around telling physicians that this particular event is responsible now for all of his problems. That's what they do.

Q And what effect does that have on the psychological condition of the patient?

A It has no effect on the psychological condition. It simply is the patient's grabbing onto a very, a perfectly normal event, a kind of event that any reasonable person would ignore. But it's a way of the person coming up with an excuse or an explanation as to why they are having the difficulties they're having.

Q Are you saying that the only thing that changes is the patient's assignment of causation for all of the problems they had both before and after the accident?

A Yes. There is that primarily.

Q Okay. Are you saying that Bobbie's condition has not in any way, shape or form changed following this injury; that his complaints following the accident are identical to his complaints before the

accident?

A No. The frequency and intensity are the same. The character changes; and this is always the case. It changes as a function of the specific accident involved. But the trick is that it is the person's psychological disorder that leads them to latch onto the event and to blame it. It is that pre-existing tendency that leads them then to subtly change some of their complaints.

Q You said that the intensity and frequency remain the same?

A Yes, I believe.

Q Referring to what?

A The records of Bobbie Clark.

Q *So* you're saying that the intensity and frequency of his physical complaints is the same prior to the accident as it is after the accident?

A Yes.

Q Are you aware of the fact that he's got over $125,000 in medical treatment following this accident?

A That would -- I can believe that. And would simply hold this back up and say, gee, he had a lot of expenses before the accident too.

Q Over what time period?

A Well, from 1954.
Q From 1954. And you have already stated that you're not aware of how long any of those hospitalizations were?
A That's true.
Q And so you are speculating entirely that the cost of the medical care and frequency of the medical care and duration of the medical care is in no way, shape or form similar to the medical care that he's received since this accident?
A I've got a list of his hospitalizations I'm showing --
Q And that's all you have?
A Well, I also have a list of his complaints.
Q But you don't have a list of how long he was hospitalized, how many doctors he was seeing, what the medical bills were?
A True.
Q Or for how long he treated for those conditions after discharge?
A Yeah, I'm simply arguing that the statement that I made is not entirely due to speculation. I have some data here.
Q You have some data?
A Uh-huh.

Q And over a 35-year period of time before the accident?
A Yes.
Q And you're comparing that to all of the hospitalizations and all of the doctor care and all the psychological care that he's had since this accident and you're saying those are roughly equivalent in terms of intensity and duration?
A Yes.
Q And frequency?
A Yes. Yes. Keep in mind he was disabled before he was hit with the door.
Q For how long?
A A month as I recall.
Q And why?
A I believe that he complained of stress.
Q And are you aware of the fact that his doctors released him to return to work the day of the accident?
A Yes.
Q Of what significance is that to you?
A Well, it is that we have a fellow here who is now beginning to leave work, and I believe that it was the beginning of his deterioration.
Q What does that mean; beginning to leave work? Why

was he off work?

A Well, I think I just answered that question. He had claimed disability due to stress at work. The door becomes a perfect excuse to not complain of stress anymore, and now he's physically disabled, he's going to tell us.

My point is really a very simple one. Before the accident, this man was disabled and off work, he told us. Now, nothing has changed in that regard. That's all.

Q Do you know whether or not Bobbie Clark wanted to return to work prior to this injury?

A Well, he will say that he wanted to return to work. That's the whole key. Your somatoform disorders say, oh, if it wasn't for my injury, I'd be back at work, and that's -- it's not true. They have every motivation to find an injury to keep them off work. So but, no, he will say, he would have said, I want to go back to work. Please, Doctor, get me back to work. But I don't think he really wanted to.

Q That's your opinion, you don't think he wanted to?

A It is my opinion based on my knowledge of the category, yeah.

Q Without ever having met Bobbie Clark?

A Correct. That's right.

Q Are you aware of whether or not he asked to be disabled from work or whether his doctor advised him to take time off from work?
A I'm not sure, but I think I can vaguely piece that together.
Q Why don't you vaguely piece it together for me?
A All right. It is that he complained repeatedly of a wide range of physical health problems and left the physicians with little choice as to whether or not he should or shouldn't go back to work.
Q Should or shouldn't go back to work?
A Right. If you complain enough, then eventually you're going to get the advice of physicians to stay off work. It's just a matter of pounding away at the complaints and going to them a lot and calling them a lot. They'll eventually let you off work.
Q My question is do you know whether or not Bobbie Clark asked to be disabled from work or whether his physicians recommended it to him?
A I don't recall that.
Q And do you know whether or not Bobbie Clark at any time sought the permission from his physicians to return to work prior to the accident date or whether it was his doctors that recommended that he

try to go back to work?
A I don't recall that either.
Q And neither one of those scenarios would make any difference to you in your opinion?
A While they would have a tiny impact, of all the things that we've recently talked about, the most important thing is quite simple, and I think relevant. That is, he was disabled before he was hit with the door. If my doctor right now told me not to go to work, I'd go to work. I'd ignore him. Because I, I don't feel bad.
Q Is it your testimony that his apneic spells were a result of obesity?
A It is -- not exactly. It is that apnea is associated with obesity and the extra skin folds at the back of the throat.
Q Do you have an opinion as to what the cause of Bobbie Clark's apneic episodes was?
A No, I can only comment on the general cause of apnea.
Q Do you know of any other causes of apnea other than obesity and the folds of skin?
A No. And that is because the medical literature is quite vague on the causation of the problem.
Q So that's the only condition or cause for apneic

spells that you're aware of based on the reported 1iterature?

A It's the only one that I'm aware of, yeah.

Q Did you get all of the medical records from his prior medical care, or just excerpts?

A I believe I got them all.

Q This is it right here?

A That's right.

Q That's all you've got?

A Well, we often eliminate, going into it, eliminate things that are illegible, medical test data that we can't explain or understand and which we have no reason to opine about. *So* we cull through them pretty carefully. The stack was larger when we started.

Q So you've thrown out some records?

A Correct.

Q And you can't tell me as you sit here today what you've thrown out and ignored and disregarded?

A Right. And even worse, I believe that some of the records that we got were, we didn't make copies of them, we simply reviewed them and gave them back to Mr. Clayton.

Q So what did you keep?

A I believe that what we retained --

Q I don't need you to tell me; I'm just trying to find out what did you keep as opposed to saying why did you give them back? Why did you give back some and keep some?

A Because some of the records came late and were, I guess nobody had a chance to make copies of them.

Q And some of the records were illegible?

A Yes.

Q Meaning you couldn't read them?

A That's right.

Q So you don't know what they said?

A By definition.

Q Tell me of what significance the diary of Bobbie Clark is to you?

A Well, couple of things. One is it is a reflection of a wide, wide range of health complaints. It is difficult as a medical layman for me to understand how this wide variety of complaints could result from a blow to the head. And so that's the first thing the breadth.

Another interesting comment is that getting along with the wide range of problems, he complains of blackouts, neck pain, he says his teeth hurt. That's a pretty classic somatoform comment, my teeth hurt. Head pain, chest pain and so on. I

mean it's a wide variety.

On Saturday, November 18, he says he's unable to cut wood or haul wood home for winter heat. All right. I guess that's not that relevant. Hang on, there are some other things.

Blackouts, therapy all over the place, constantly using heating pads and so on. On Saturday, January 27 of 1990 he says he's disgusted because I don't feel like working anywhere. Well, I suspect that's true, just talking about pain all the time. Again the pain that he's referring to is back and his head and his shoulders and his arms. All this from a blow on the head.

Q Well, do people suffer pain on a permanent basis from traumatic head injuries?

A It's possible.

Q What do you mean, it's possible? It happens all the time, doesn't it?

A No.

Q It doesn't happen all the time that people get traumatic heads injuries and suffer permanent pain as a result? That's not a regular everyday occurrence?

A No, it's not a regular everyday occurrence. I mean it does happen.

Q It happens every day across the country, around the world, people get hit on the head traumatically and suffer permanent pain as a result.

A I really don't agree with that. I mean they're more likely to suffer from symptoms if they are seriously damaged, symptoms of concussion or brain injury, but the --

Number one, most brain injuries clear up; and number two, if they don't clear up, then the person reports difficulty concentrating, difficulty with memory. But they do not -- I mean I could emphatic about that -- they do not report wide ranges of bodily pain. They report brain damage symptoms; concentration and so on.

So again to summarize --

Q Well, in addition to being hit on the head and suffering brain injury, in a patient suffering an injury to their musculoskeletal system, that can and does on a regular basis result in permanent pain in a person, does it not?

A I disagree with that statement. It does not regularly result in chronic permanent pain. On the other hand, it is possible most of the people that have back injuries get well, get over it. I've hurt my back before. I don't suffer permanent

pain.

Q Have you had back surgery?

A No.

Q Have you ever been struck on the head by a 300-pound door?

A No.

Q Are you 53 years of age?

A No.

Q Have you had a complicated prior medical history?

A No.

Q It's not unusual for patients with significant injuries to their musculoskeletal system to have residual pain and discomfort on a permanent basis, is it?

A I believe that that is unusual. And understand what we're saying here. You're asking me if it is common for a person who has a musculoskeletal injury to suffer pain on a permanent basis; and my answer is no, that is not common. That is rare.

Q It's rare?

A Uh-huh.

Q What do you mean by rare?

A Well, under 50 percent of people who have musculoskeletal injuries have pain on a permanent basis.

Q And that makes it rare?
A Uh-huh.
Q Pardon me?
A I said well under 50 percent, yes.
Q And that makes it rare in your opinion?
A Uh-huh, yeah. To put it a different way, I don't believe that I can agree with you when you say it is common.
Q So you consider yourself an expert in orthopedics as well?

MR. CLAYTON: He didn't say that and you're arguing with him again. I object. We're talking generalities here. I mean, geez, musculoskeletal, what does that mean?

MR. LEESEBERG: We're talking more than generalities, Bob.

MR. CLAYTON: No, you're not.

Q Do you consider yourself an expert in orthopedics?
A No.
Q Do you consider yourself an experts in neurology?
A I'm sorry?
Q Do you consider yourself an expert in neurology?
A No.
Q Do you consider yourself an expert in

psychoneurology?
A The answer is no, I don't consider myself an expert, but I know something about it.
Q Now, I want to make sure I understand your opinion correctly. You're saying that Bobbie Clark's medical condition, psychological condition and physical condition and emotional condition in no way, shape or form changed from before the accident to after the accident; that the only thing that this accident did was to have Bobbie focus all of his problems, both before and after the accident, as being related to that traumatic injury?
A My answer is yes with one additional qualification. And that is that while the intensity and frequency of his complaining did not change, the qualities of it changed. He began to focus now with a myriad number of complaints he had before the accident, now he is focusing on the ones that are most compatible with a head injury or back injury. He began to emphasize those. Beyond that, there was no change.
Q And as a result of that emphasis change, did that result in him psychologically experiencing more frequent and intense symptomatology and conditions than he had previous?

A Overall, I don't think so. I believe that his complaints remained just about the same. I believe he sought more treatment. I believe the case could be made that he has amassed more time off work since the accident, in spite of the fact he was disabled before the accident.

Q Did he complain about seizures before the accident?

A If I could look at my little thing, I might able to recall a little better.

Q Do you recall without looking at your little thing whether or not he complained about seizures before the accident?

A No, I don't.

Q Do you recall whether or not he complained of headaches before the accident?

A Let me make sure I understand your question correctly. You're going to ask me a series of questions about whether I remember something on a sheet of paper that you now hold in your hand?

Q No, I'm asking you about --

A But you don't want me to look at it; is that what you're saying?

Q No, that's not at all what I'm saying. You've opined that his symptoms, both in terms of intensity and frequency and duration changed in no

material significant way whatsoever from before this accident to following the accident. That's what you just got done testifying to.

A That's incorrect.

Q Tell me what is incorrect?

A That after the accident, the quality of his complaints changed.

Q I didn't use the word quality; I said intensity, frequency and duration. I left out quality because you testified to a quality change.

A Got you. All right.

Q Now, are we together?

A Yes.

Q Now, I'm going to ask about the basis for your opinion.

A Okay.

Q Since you've testified that his symptoms, other than quality reporting, in no way, shape or form changed.

A Okay.

Q Okay.

A You understand the quality means the specific kind of complaints? That's what I mean.

Q Did he complain of headache before the accident?

A I don't remember. It would refresh my memory if I

could see the paper that you've got sitting in front of you. But if you want to test my memory, I guess you're going to be --

Q Did he complain --

A -- disappointed.

Q Did he complain of vision and hearing trouble before the accident?

A I don't recall.

Q Did he complain of pain in the collar bone, top twa ribs before the accident?

A I don't recall.

Q Did he complain of numb legs and feet before the accident?

A I don't recall.

Q Did he complain of upset stomach at any time before the accident?

A I don't recall. I need to see my sheet.

Q Did he complain of left upper arm pain before the accident?

A I don't recall because I need to see the sheet of paper that you are holding.

Q Did he complain of lightheadedness before the accident?

A I believe that he complained of difficulties that are compatible with that, like vertigo, yeah.

Q Did he complain of a heat feeling from the arms to the wrists?
A Again, not having the records in front of me, I don't recall.
Q What does that mean to you when a patient reports to you a feeling of heat from the arms to the wrists?
A Well, it's a peculiar symptom. It's aligned with things like reflex sympathetic dystrophy, which he's not complaining of.
Q What is reflex sympathetic dystrophy?
A A medical disorder first discover during the civil war, caused often by bullet wounds that hit nerves.
Q What's the present state-of-the-art definition of reflex sympathetic dystrophy?
A I don't know.
Q I didn't think so. What does apart from -- go ahead, finish your definition, whatever your understanding, what a heat feeling from the arms to the wrists reflects.
A It's pretty much finished by saying it's an unusual symptom and that I believe that --
Q Is that a neurologic sign or symptom?
A Not to my knowledge.
Q Finger numbness; is that a neurological sign?

A That can be.
Q Did the patient complain of seizures before the accident?
A No, I don't believe he used the word seizure before the accident. He complained of various kinds of dizziness, a vertigo and so on, but I don't believe he used the word seizure.
Q Are you saying that your understanding is that those are synonymous; dizziness and seizure are synonymous?
A No, they're simply related.
Q Is your understanding of Mr. Clark's employment prior to his injury that of a physically demanding occupation or a sedentary nonphysical enterprise?
A If you're talking about the truck driving, that would be generally not very physically demanding.
Q Really? You don't think being an over-the-road trucker is a physically demanding activity?
A I don't believe so.
Q Okay. Have you ever driven a truck?
A No.
Q I didn't think so. What about being a police officer or correctional officer in a prison; is that sedentary or physical?
A I suppose, I think that it's moderately physically

demanding, certainly at times.
Q Why?
A Well, you can gets into fights.
Q Do you know whether or not he gets into fights?
A I believe that he has had to subdue some rowdy inmates.
Q Where do you get that belief from?
A I don't recall.
Q Do you recall what the symptoms that Mr. Clark complained of were when he went to the emergency room?
MR. CLAYTON: When?
A Which time?
Q The date of the accident.
A Okay, then ask your question again.
Q Yeah. Let me get my -- do you recall what the symptoms were that Bobbie Clark complained of on the day of the accident at the emergency room?
A Vaguely. Again, if you're asking me to search my memory without looking at records --
Q I want to know what you recall his symptoms being?
A Okay. I recall that he went to the emergency room with his wife, and his wife complaining that he seemed disoriented.
Q Is disorientation an alteration of consciousness?

A Yeah.
Q Okay, go ahead.
A That sounds familiar. Maybe some sort of agitation and difficulty remembering.
Q Anything else?
A That's all I remember. But I believe there were a few other complaints at that time.
Q That's not significant to you what his symptoms were? I mean you don't even remember what his symptoms were as a result of the traumatic blow to the head; that's not significant to you?
A I didn't say it was insignificant.
(Discussion held off the record.)
A No, I never said his symptoms on the day of the accident were not relevant or were insignificant. I didn't say that. I did say that I couldn't recall it. And will continue when, you know, to point out whenever you ask me a question about the 1500 pages of records and I can't recall something, I will continue to --
Q That's a pretty critical event, isn't it? I mean that's all of the detail you remember here about November 4, 1989, and you've arrived at these opinions, if you will, about whether or not he suffered any injury or any psychological or

emotional problems as a result of the blow that he suffered to his head on November 4 of 1989, correct?

A Correct.

Q And yet as you sit here today testifying about the opinions that you are going to express at the time of trial, you don't even recall what the symptoms or the complaints of the patient were when he went to the emergency room?

A That's not correct. I have, I believe, accurately recalled some of them.

Q But you don't remember what they all are, is that correct?

A They are on record and at court we can certainly bring out the records and see exactly what symptoms he suffered and whether or not he had ever complained of those symptoms before the accident. That will be quite possible at trial.

Q Do you recall when the next time the patient was, the next time the patient sought out medical care was after November 4?

A I believe that the next day he went back in.

Q And what were his complaints on that occasion?

A Generally difficulties with his memory and orientation and also complaints of pain.

Q Pain where?
A That's what I recall.
Q Pain where?
A I don't remember. But once again, it's the kind of thing we can look at and get the specifics on.
Q So the specifics of what he was complaining about the day following the accident are not significant to you, such that you recall what they are?
A That, of course, is not what I said. What I said is that I don't recall. You could also, for example, ask me what his raw score was on the MMPI Scale 8, I will tell you that I do not recall that. It's very important. I don't recall it, but I don't need to; it's sitting right in front of me. All I've got to do is look.

Now you hold in your hands a large stack of records. Should you want to go ahead and disclose those and show them to me, I'd be happy to look at them. But if you're going to quiz me on their dates and color of the ink and whether or not he crossed the T's, I'm going to tell you I don't remember.

Q You remember altered mental state and general complaints of pain, you don't recall where. Is there anything else you remember?

A No. No, there's nothing else I'd remember, but the information is significant and accessible.

(Discussion held off the record.)

Q Doctor, what's your understanding of Bobbie Clark's cardiac status before the injury?

A That he complained of a wide variety of heart problems before the garage door injury. And that physicians suspected a wide variety of heart problems before the injury.

Q Did he in your, to your understanding have any heart conditions or not?

A It appears that he did.

Q And what's your understanding of what card ac conditions he had?

A I just don't know.

Q Do you have a recollection or an understanding as to whether they were mild, moderate or severe cardiac conditions?

A Only that I would assume that they were mild from the standpoint that he continued to work after he made his first heart complaints.

Q Your assumption is that it's mild?

A Yes, but --

Q Did you have an understanding as to whether or not Bobbie Clark had a condition of right carpal tunnel

syndrome?

A I don't recall that.

Q Do you recall looking at the records that were provided to you that were highlighted by your staff in red and yellow magic marker oh, eight, nine, ten pages worth, referring to right carpal tunnel syndrome?

A Huh-uh.

Q You don't recall that?

A No, I don't. I do recall complaints that he had about pain in his arms or extremities or whatever.

Q Was he feigning those?

A Again, once again that word feign. It is my belief based on his testing and breadth of his complaints that he was prone to exaggerate and very well could have been exaggerating those.

Q Exaggerating those what?

A Complaints of pain in his arm and wrists. I recall, for example, no medical evidence that he in fact had that disorder. But I may be wrong about that.

Q Do you recall whether or not there was any treatment rendered for that condition?

A There may have been.

Q You don't recall?

A No, I don't. There is such wide variety of physical complaints that it's very difficult to remember which ones he received treatment on. Generally when a person complains he gets treatment.

Q Whether he needs it or not?

A Correct, yes.

Q Do you know what an EMG is?

A Yes.

Q Can a patient feign an EMG finding?

A I don't believe so.

Q Why don't you go ahead and run through that; tell me what that's all about.

A He has, there are two things that are important on this profile. The first is the validity scales. There are on the MMPI a wide number roughly 7 or 8 validity scales. Those scales don't tell you about the personality of the test taker, but rather than the spirit with which he took the test.

On this profile, that was purportedly generated by Shamberg, Mr. Clark's validity scales show that he's grossly exaggerating his illnesses, both physical and mental.

Q Now when you say he's grossly exaggerating them, that doesn't mean that he doesn't have them; he's

simply exaggerating the extent to which they are affecting him?

A I mean the word exaggeration to mean that he has some problems which he exaggerates, but I also mean it from the standpoint that this suggests that he may even complain of problems that he doesn't have at all. An exaggeration in a sense of the word.

Q For example, carpal tunnel syndrome?

A No. Depending on the data involved with that difficulty, that may not be one. But there are plenty of others; dizziness, numbness, tingling fatigability, so on.

Q So all the subjective ones you're willing to say he's exaggerating, or is making up, but the objective ones you're willing to concede may be real?

A Just because, just because you're a hypochondriac doesn't mean you're immune to illness. Hypochondriacs do get sick.

Q So since there's no way for Bobbie Clark to prove the subjective complaints he has, you're willing and able to say those are a product of his somatic --

A Somatoform.

Q -- somatoform disorder?

A Not at all. I'm holding in my hands a test that was reportedly taken by Bobbie Clark. It shows him to be an exaggerator. If he were a legitimate medical patient, he would not show this pattern.

The pattern is shown by people who exaggerate; it is not shown by people who do not exaggerate.

Q Let's assume Bobbie Clark had, hypothetically, carpal tunnel syndrome, okay. What would that test reveal about Bobbie Clark with respect to his carpal syndrome?

A That he would exaggerate the symptoms grossly, would complain about the carpal tunnel repeatedly. You and I might tend to alter our lifestyle a little bit and just go on with it. This guy is going to go back to the physician numerous times and claim that he can't work and so on.

Q So it does not eliminate the validity of the underlying disease process, or the injury, or condition, it is simply a reflection to the extent to which it is affecting that particular patient in his **own** mind?

A Well, the extent to which -- not the extent to which the disease is affecting the patient, but rather the patient's misinterpretation of the intensity of the disease. Yeah, which is a little

different way of looking at it.
Q Okay.
A And understand, by definition hypochondriacal disorders also include complaints of problems with no medical basis whatsoever, So he can also have those, but -- well go ahead. I do want to get back to the test.
Q You have two patients with carpal tunnel syndrome; one is hypochondriacal, or somatoform disorder patient. What you're saying is the injury may, or the condition may be identical in both patients from a physical standpoint, and yet the effects on the patients is going to be entirely different?
A Well --
Q In terms of their ability to cope with the problem?
A There's a fair way to put it.
Q So if you have two different people, one of whom is hypochondriacal, or a somatoform disorder patient, and the other is an otherwise normal adjusted, emotionally strong person, and you drop a 300-pound door on each of those two people, the physical injuries may be identical and yet the effect that that injury is going to have on those individual people may be dramatically different?
A My problem is that word effect. It is the person's

interpretation of the events. That is the key.
Q However you want to describe it.
A I'd rather describe it that way. The one guy is going to interpret the events.
Q Rather than call it effect, the consequences to those two people is going to be dramatically different?
A Yeah, because of the way they interpret it, yeah.
Q Okay, go ahead.
A Okay. What we have here is a person who is grossly -- to get back to the MMPI here -- these validity scales show that Mr. Clark exaggerates his physical ills and his mental ills. He does that both consciously and unconsciously. The unconscious part is the somatoform disorder, the conscious part is just --
Q Why don't you bring that over here and let's work through this one at a time. I want to know exactly what you're saying. Let's start with lie; what does that mean. He's in the normal range?
A That's correct.
Q Meaning what, you didn't find him to be a liar?
A Not on that scale.
Q Fake, bad; meaning what?
A That is a scale that measures a person's tendencies

to exaggerate physical and mental ills.
Q And he's outside the normal range on that?
A That's correct.
Q Defensiveness; he's within the normal range?
A That is correct.
Q Hypochondriasis, he's outside the normal in the high range?
A Way out. Way out of the normal range.
Q Depression, he's high?
A Right.
Q Hysteria, he's high?
A Right.
Q Psychopathic, meaning what?
A The tendency to behave in a criminal and deceptive way.
Q Okay.
A That's high.
Q Masculinity-femininity, he's in the normal?
A Correct.
Q Paranoia, he's in the normal?
A Uh-huh.
Q Yes?
A That is correct.
Q Worry, he's high?
A Uh-huh.

Q Meaning he worries a lot?
A Yeah, much more than average.
Q Schizophrenia, meaning what?
A Tendency to form bizarre conclusions, to perceive things that aren't there.
Q You don't know whether that's the result of a psychological problem or an organic problem, do you?
A Yes, I do. Because while you are doing -- what often is done, and that is going down the line saying normal, abnormal. The much more profitable way and standard way to interpret the MMPI is to take the two highest peaks and to ask what kind of person generates peaks on hypochondriasis and schizophrenia, all right? And the answer is -- it's in lots of books -- the people who generate that kind of profile are grossly, grossly hypochondriacal.
Q Mania, he's just high normal?
A Right.
Q Introversion --
A Well, he's significantly above average in mania. He's in the high normal. He's significantly above normal.
Q He's just outside the range of normal?

A That's right. He's out of the range of normal.
Q Just outside the range of normal?
A Correct.
Q Introversion, he's within normal?
A Right.
Q Now, what you're saying is that -- well, you're saying that this MMPI profile is after the accident, correct?
A Uh-huh.
Q Yes?
A Yes.
Q Is in no way, shape or form subject to effect as a result of a traumatic head injury?
A I'm sorry, I didn't follow that.
Q Let me rephrase my question.

Do MMPI results -- strike that. Are the results of MMPI tests subject to interpretation depending on whether or not the tester has had or suffered a traumatic head injury?

A The answer is, if I understand your question correctly, the answer is yes. That a person's MMPI can be affected by a head injury, yes.
Q And how does one determine whether or not a person's MMPI has been affected by a head injury?
A Well, you look at the person's profile and you go

to your authorities on the subject and you find out whether or not the authorities believe that that profile derives from a head injury.

Now, elevations on scales nine -- let me rephrase that. Peaks on scales nine, one and three raise that probability. This guy does not have peaks on scales nine, one and three.

Q He's got four and eight?

A One and eight.

Q One and eight?

A Uh-huh. And that is associated with somatic delusions. A guy who is so hypochondriacal that he is that close to claiming physical ills that are just downright crazy.

Q Okay.

A That's what the experts say. That's not really my thing. That's what the books say.

Q And somebody who is suffering a traumatic injury can trigger those kinds *of* bizarre complaints?

A No. No. Injury doesn't cause people to become hypochondriacal.

Q I'm not suggesting it does; I'm saying somebody who is hypochondriacal who suffers a traumatic injury that can then cause them to perceive or feel these physical ailments or problems?

A No. Again that turns it on its head. When a person is a hypochondriac, every little thing that happens to him, he overinterprets it. The event doesn't cause him to overinterpret it; his inner pathology causes him to overinterpret.

And again, it's a, I suspect I made that point clear, but just an example to make the point. When John Hinkley watches a movie with Jody Foster in it and then he shoots, tries to shoot President Reagan, we don't say that Jody Foster caused him to shoot President Reagan. We say Hinkley was a little mentally ill and that he overreacted to Jody Foster.

So the point I'm trying to make is when people react funny, that's not the symptom's fault, that is the inner person's fault.

Q Seeing Jody Foster was the trigger that set off Hinkley?

A Right. But we don't put Jody Foster in jail, we don't charge her with murder, we don't hold her liable. What she did is perfectly normal. She's an actress. Hinkley reacted to her in a funny way. And so you could say Foster triggered him, but you don't hold her responsible. You don't really say she caused it. Hinkley's mental illness caused it.

Q In this particular case, being struck on the head with a garage door triggered some somatoform disorder complaints in Mr. Clark?
A He had it before he was hit.
Q Had it? It what?
A Somatoform symptoms.
Q Well, he had a somatoform disorder?
A He had symptoms of somatoform disorder, yeah. It's again, I don't want to diagnose him. Signs everywhere.
Q He didn't have head and neck pains from being hit with a garage door before he got hit with a garage door?
A That is true.
Q That's true, that happened when he got hit with a garage door, right?
A Well, the quality of his symptoms changed to fit the event.
Q Well, are you saying --
A The intensity remained the same.
Q Are you willing to acknowledge that Mr. Clark probably got hurt when he got hit with the garage door?
A You know, probably a little.
Q Probably a little?

A Uh-huh.
Q Now you can say probably a little, even though you don't know how heavy the door was, you don't know whether or not he lost consciousness, you don't know whether he got knocked to the ground, you don't know anything about the mechanics of the injury, and yet you're willing to say he probably got hurt a little?
A That's an, almost entirely a mischaracterization of my statement.
Q Good. You characterize it correctly then, because I'm going to tell the jury what your opinion is and I want you to be very clear on the record what your opinion is now.
A Good, okay. Do **I** know how much the door weighed? You've used the term 300 pounds here almost a dozen times. I know the door was heavy.
Q Does that make a difference in whether or not, whether or not a person is injured when they get hit by that door, the weight of the door?
MR. CLAYTON: I object. You have to know all the facts.
MR. LEESEBERG: I'm justing asking almost about that fact in isolation.
Q Does that make any difference to you how heavy the

object was that hits somebody in the head as to whether or not you think the injury may be significant or insignificant?

A It makes a little bit of difference.

Q Just a little bit of difference?

A That's right. Because what makes more difference is the person's reaction to the injury. What did the person do once he got hit?

If you told me that he got hit by a Mack truck and then walked off, I would say that the Mack truck, which weighs tons, but if it just tapped you, you know, and you didn't fall down and you just kept walking and went on shopping, I'd say you weren't injured. I'd be looking at your behavior.

I don't think that's a bizarre viewpoint on my part. That would be a couple pounds hitting you, but if you weren't even knocked down.

Q Would you agree then that a person that gets hit with a 10-pound door is not as likely to suffer injury as somebody who gets hit with a 300-pound door?

A Again, I don't mean to be facetious, but if a 10-pound door is dropped off the top of a 40-story building.

Q Let's not play --

MR. CLAYTON: Object. We are playing games, because 300 pounds is meaningless unless you know how fast it was coming down and a variety of other things.

Q That's my point. If all things being equal whether the door that hits him is 10 pounds or 300 pounds is going to make a difference in terms of the likelihood of injury.

A And for the third time, it is relevant in a minor way. The more important consideration is the person's reaction to the accident.

Q Sir, how does a person's reaction to being hit on the door reflect on the likelihood that that instrument that hits him is going to cause him injury? I mean what difference --

A It's fundamental.

Q What difference does a person's reaction to being shot in the head have to do with the likelihood he's been injured by bullets that go through his head?

A Fundamental; absolutely fundamental.

Q So if a person acts normal after he's been hit by a bullet, you don't think he's hurt?

MR. CLAYTON: I'll object to a that

analogy; it's ridiculous.

MR. LEESEBERG: His statement is ridiculous.

MR. CLAYTON: No, it's not.

MR. LEESEBERG: Yes, it is.

MR. CLAYTON: I object to that.

MR. LEESEBERG: Go ahead, object to it.

MR. CLAYTON: Well, I am. Because just because you don't like it or don't understand it --

MR. CLAYTON: I don't dislike it; I think it's great.

MR. CLAYTON: -- doesn't make it ridiculous.

MR. LEESEBERG: I love it. Go ahead.

A If --

Q Go ahead.

A If you want to get off on the hypothetical about people being shot in the head, fine.

Let's assume somebody is out hunting and he gets shot in the head with bullets. Let's assume his behavior doesn't change at all. Three months later, four months later, five months later, he absolutely hasn't changed at all. I'd say the

injury is a minor injury. What we might find, for example, is the bullet grazed his skin, barely punctured the top of his head and it was a very trivial injury. He was shot in the head all right.

On the other hand, let's take another example. A movie star takes a gun that shoots blanks and jokingly puts it to his head and pulls the trigger. It's a blank gun, it doesn't even have bullets in it. And after he pulls the trigger his brain waves are altered, he's no longer responsive, he's laying on the floor unconscious, never returns to their normal personality; it's a serious injury, in spite of the fact it was a blank.

Q Thank you very much. That's exactly --

A Right, you've got it.

Q Let's get back to the 300-pound door.

A Yeah, go ahead. We know somebody was hit with a 300-pound door and went shopping; that's what we know.

Q What information do you have that he went shopping?

A Oh, dear, here we go again. He either did or didn't. If I'm wrong, let me know. I believe I'm right it's in some records. 1500 pages of records.

Q Your understanding is he got hit in the head with the door and went shopping?

A Correct.
Q Now, besides, I don't want to talk about the particulars of this particular case at the moment.
A Okay.
Q All other things being equal, do you know what the concept of mechanics of force, mechanics *of* trauma mean? Are you aware of physics?
A Well, I've taken a few physics courses. You may be quickly getting in over my head; I don't know. I'm not an expert in physics.
Q Do you concede that you as a normal human being are more likely to sustain an injury if you are struck in the head by a 300-pound door rather than if you are struck in the head by a door weighing only 10 pounds if both those doors are identical and traveling at the same rates of speed and all of the other circumstances are identical?
A Obviously, the answer to that is yes, all other things being equal.
Q Thank you.
A Right.
Q Now, Bobbie Clark gets hit in the head with a 300-pound door, and you are of the opinion that he's a somatoform disorder, and we assume that Bobbie Clark suffered some injury to his head,

whether it's a bruise or a contusion or a laceration or a mild concussion, you with me so far?

A Yes. I am also not going to be with you in about two minutes, I'm afraid, okay.

Q Is Bobbie Clark's -- Bobbie Clark's injury is not going to be any worse simply by virtue of the fact he is a somatoform disorder?

A That's correct.

Q Bobbie Clark's reaction to that injury and that event, as I understand your testimony, is going to be worse than would your or my reaction to that same blow, or that same force, or that same injury because of his somatoform disorder?

A That is fair, yes.

Q That's all the questions I have. Well, no. Bobbie Clark is not a dishonest person?

A That's a difficult question to answer. He exaggerates, there's no question from the profile. This is a profile of somebody who exaggerates physical and mental ills.

Q That's one of the earmarks of a somatoform disorder, right?

A Right.

Q I'm talking about is Bobbie Clark somebody who

intentionally lies to people?

A Unfortunately the profile suggests that on top of the tendency to exaggerate physical ills, he is in addition someone who is consciously exaggerating. Again that's what the profile says.

Q So it's your opinion that he is a liar?

A No, I didn't say that. I don't have any opinion about Bobbie Clark.

Q Well, look, what does your profile reflect as to whether or not Bobbie Clark is a liar?

A This is, the profile that I've got in front of me is a profile of someone who exaggerates both conscious and unconsciously. Malingering may be a more appropriate term.

Q Is Bobbie Clark a liar?

A No, I think that is a pejorative term. I'd rather use the term malingering.

Q Means the same thing, though?

A By virtue of wanting to use another term that's a little less pejorative, I don't think they have the same shade of meaning. You keep something else in mind, too, about the two forms of exaggeration, malingering versus somatoform.

Q Is somatoform disorder something that somebody brings on themselves or is that a psychological

illness or psychological condition like schizophrenia or any other psychological --

A Somatoform disorder is a psychological condition.

Q That what -- why does it occur?

A Because of a history of the person observing illness in the family and modeling those disability behaviors. Also being associated with people who have a long history of routinized work, the highly routinized work. And so those seem to be causal factors.

And what it leads to is a situation of where a person is scanning for any event and when the event occurs, he's going to latch onto it. If that event doesn't occur, then another one will down the road in short order.

So in this case, I just want to make clear, it's not true that but for the garage door Clark would be okay. It is clearer to say that this profile suggests somebody that was going to find something, in fact had already found something before the garage door, and was due to find something after the garage door, just as surely as Hinkley was going to find some excuse to do something violent.

Q My question, though, is somatoform disorder the

same as --

A It's an illness.

Q It's an illness?

A That malingering is not. Malingering is a willful and not a mental illness. And what I'm looking at in this profile suggests he is both somatoform and a malingerer.

Q Is malingering a function of his somatoform disorder?

A It's a separate problem.

Q What kind of association do you find in terms of people developing a propensity for malingering after the development of somatoform disorder?

A They are not that related. Some people are just pure clean hypochondriacs; they just believe they're ill and that causes them troubles; they're just simply mentally ill.

Others have both problems; they are somatoform disorder, and in addition to that they see the rewards and they make darn sure that everybody knows that they are having problems.

Let me give you -- you're not asking for this, but I might as well mention it. This guy took a profile years ago, and something like ten years before the accident, and on that MMPI profile he

had validity scales that were exactly the opposite. He was faking good, according to Shamberg.

Q What does that mean?

A Well, that means he was doing exactly the opposite of what he's doing here. Instead of faking bad, putting his worst foot forward, he was putting his best foot forward. But it was because he was being evaluated personally to adopt a child, so he wants to look good. So when he wants to look good, he fakes good and the MMPI catches him. And when he wants to look bad, he fakes bad and the MMPI catches him. The MMPI responds to whatever impression he wants to make.

Q I have just one more question. I'm trying to remember what it was. Oh, I know what it is.

Apart from these two tests scores, do you have any evidence of events, prior events in which Bobbie Clark was lying? I know I recall you referred to his responses to the questionnaire about have you ever been under psychiatric care and his answer was no, you interpreted that as evidence of lying.

A Well, again, lying is not my word. It's a strong, pejorative, ugly word. But, no, I can't right off the bat think of any other evidence of fabrication

other than the invalid testing of ten years ago.

Q Okay. Thanks.

(Deposition concluded at 1:55 p.m.)

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CHRISTOPHER C. LAYNE, Ph.D.

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C E R T I F I C A T E

STATE OF OHIO)
) SS.
COUNTY OF LUCAS)

I, Kenneth P. Gallaher, Registered Professional Reporter and Notary Public in and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within-named CHRISTOPHER C. LAYNE, Ph.D., was by me first duly sworn to testify the truth, the whole truth, and nothing but the truth in the cause aforesaid; that the testimony then given by him was by me reduced to stenotypy in the presence of said witness, afterwards transcribed upon a computer; that the foregoing is a true and correct transcript of the testimony so given by him as aforesaid; that this deposition was taken at the time and place in the foregoing caption specified; that the signature of the said witness to the transcribed copy of his deposition was reserved.

I do further certify that I am not a relative, employee, or attorney of any of the parties hereto; further, that I am not a relative or employee of any attorney or counsel employed by the parties hereto or financially interested in this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my notarial seal of office at Toledo, Ohio, on this 30th day of December, 1992.

Kenneth P. Gallaher

KENNETH P. GALLAHER, RPR
Notary Public in and for the State of Ohio

My Commission expires January 10, 1997.