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STATE OF OHIO)
COUNTY OF CUYAHOGA)

ORIGINAL

COURT OF COMMON PLEAS

KIMBERLY RICHLEY,)
Plaintiff,)
vs.) Case No. CV-03-511510
REICHENBACH FAMILY) Judge Carolyn Friedland
CHIROPRACTIC PROFESSIONAL)
COMPANY, et al.,)
Defendants.)

- - -

DEPOSITION OF PATRICK W. McCORMICK, M.D.

DATE: September 24, 2004 at 5:00 p.m.
PLACE: St. Luke's Hospital
5901 Monclova Road
Maumee, Ohio
REPORTER: Robert W. Scheid, Jr., RPR
Notary Public

- - -

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1 PATRICK W. McCORMICK, M.D.,
2 a Witness herein, called by the Plaintiff as if upon
3 Examination, was by me first duly sworn, as
4 hereinafter certified, deposed and said as follows:

5 EXAMINATION

6 BY MR. RUF:

7 Q. Could you state your name, please?

8 A. Patrick William McCormick.

9 Q. Dr. McCormick, my name is Mark Ruf. I
10 represent Kim Richley. If at any time during this
11 deposition you do not understand a question, please
12 tell me. If you give me an answer, I'll assume you
13 understood the question. Okay?

14 A. Fine.

15 Q. Also, when I ask you a question, please
16 give me a direct answer to the question. If you give
17 me an evasive answer or a nonresponsive question, I'm
18 going to ask my question again. Okay?

19 A. Sounds fair.

20 Q. So this will go faster if you give me
21 direct answers to my questions. Okay?

22 A. Sounds fine.

23 Q. It appears from your CV that your
24 concentration is in vascular neurosurgery?

1 A. It is.

2 0. Is that your specialty?

3 A. Well, my specialty is neurological
4 surgery. I did subspecialty training in
5 cerebrovascular neurological surgery.

6 Q. What percentage of your practice is
7 vascular neurosurgery?

8 A. Well, I'm in the general practice of
9 neurosurgery. And I'd say perhaps 10 percent of my
10 practice is vascular work.

11 Q. And what's the remainder of your
12 practice?

13 A. General neurosurgery, such as cervical
14 spine, lumbar spine, trauma, brain tumors,
15 hydrocephalus.

16 Q. Would you agree that none of your
17 publications relate to the issues in the Richley case?

18 A. I haven't thumbed through a list of
19 publications, but none of them, to my recollection,
20 would touch on those issues.

21 Q. You have not published or lectured on the
22 injury that Kim Richley sustained, correct?

23 A. Again, to the best of my recollection,
24 there's nothing in my CV regarding these issues.

1 Q. And you've not published or lectured on
2 the surgery that was performed on Kim Richley,
3 correct?

4 A. Same answer.

5 Q. So the answer would be yes? I mean, if
6 you want, you can look through your CV.

7 A. What I'm saying is, when you ask me if
8 I've ever lectured on the topic, let's say, of spine
9 trauma, I'm sure I have. Whether there's anything
10 captured in my CV, I don't recollect anything there
11 that would reflect on that.

12 Q. Well, have you published on the surgery
13 that was performed on Kim Richley?

14 A. No, I have not published on the surgery
15 performed on Kim Richley.

16 Q. And have you lectured on the surgery that
17 was performed on Kim Richley?

18 A. Well, I'm involved in a teaching program
19 with the residents at St. Vincent's Mercy Medical
20 Center and I give a number of lectures on trauma and
21 cervical spine trauma. So I'm certain that I've
22 lectured on it many times, but nothing that I've
23 included in my CV.

24 Q. I noticed in the records that you have,

1 that you had a meeting at 5:00 p.m. June 24th with
2 Attorney Regnier; is that correct?

3 A. I certainly had a meeting with him. I
4 couldn't testify to the date.

5 Q. Let me show you, there's a letter of June
6 8, 2004. It's the second page. Would you agree it
7 refers to a meeting at 5:00 p.m. June 24?

8 A. It does.

9 Q. Do you know how long that meeting was?

10 A. Half hour to an hour.

11 Q. Do you know what the purpose of the
12 meeting was?

13 A. We discussed the case.

14 Q. Did you review any materials at that
15 time? Did you have the meeting before you reviewed
16 materials or after you reviewed materials?

17 A. After I reviewed materials. And I don't
18 know that we reviewed anything specifically. I don't
19 have any recollection of that.

20 Q. Do you remember what you discussed in
21 that meeting specifically?

22 A. I think we discussed the nature of the
23 facts in the case and the type of injury that Mrs.
24 Richley was found to have and what its relationship

1 would be to chiropractic treatment, issues like that.

2 Q. Did you render any opinions at that time?

3 A. I don't know that I did. I created a
4 series of opinions that are in my letter, but I don't
5 know that I created any at that time.

6 Q. Do you know how much time you spent total
7 reviewing this case and meeting with defense counsel?

8 A. I don't.

9 Q. Do you know what your total bill has been
10 on this case?

11 A. I do not.

12 Q. Could you give me an estimate of what
13 it's been?

14 A. I would be purely guessing. I honestly
15 don't know.

16 Q. What do you charge for being involved in
17 medical-legal matters?

18 A. I have a fee schedule.

19 Q. Could I see that, please?

20 A. (Witness complies.)

21 (Court Reporter marked
22 Plaintiff's Exhibit 1.)

23 BY MR. RUF:

24 Q. Okay. Your fee schedule's been marked as

1 Plaintiff's Exhibit 1, correct?

2 A. Correct.

3 Q. Can you give me an estimate as to the
4 amount of time you've spent reviewing this case and
5 forming your opinions?

6 A. I think you asked me that already. I
7 don't have a recollection of the exact time.

8 Q. Well, I asked if you could give me an
9 estimate. I know you said you didn't know the exact
10 amount of time. I'm asking if you could give me an
11 estimate.

12 A. I really would be purely guessing.

13 Q. Do you have your time written in bills
14 that you've sent to Mr. Regnier?

15 A. We certainly have sent invoices along the
16 way.

17 MR. RUF: Would you have a
18 problem producing those, Mike?

19 MR. REGNIER: No.

20 BY MR. RUF:

21 Q. How many years have you been licensed to
22 practice medicine?

23 A. Since 1984.

24 Q. 20 years?

1 A. 20 years.

2 Q. Has your license ever been subject to any
3 type of disciplinary action?

4 A. No.

5 Q. Have you ever been subject to any type of
6 disciplinary action by a hospital?

7 A. No.

8 Q. Have your privileges ever been revoked at
9 any hospital?

10 A. No.

11 Q. Have your privileges ever been suspended
12 at any hospital?

13 A. No.

14 Q. Did you comply with the local rule in
15 Cuyahoga County and put all of the opinions that you
16 have in the report that was produced in this case?

17 A. As far as I know, I have.

18 Q. Are any of the hospitals that you work at
19 a Level 1 trauma center?

20 A. Yes.

21 Q. What hospitals?

22 A. St. Vincent's Mercy Medical Center and
23 the Toledo Hospital.

24 Q. How many times have you been an expert

1 witness in legal cases?

2 A. I don't have an exact answer to that.
3 It'd be my guess that over the past five years or so,
4 I've reviewed somewhere between five and ten cases a
5 year.

6 Q. And that's medical malpractice cases?

7 A. Yes.

8 Q. So how many have you done in total,
9 approximately?

10 A. Well, I've done them prior to the last
11 five years. Prior to that, it would just be, you
12 know, one or two a year that would come along.

13 Q. And how long had you done one or two a
14 year?

15 A. Probably started that about '95.

16 Q. So in the last five years, you've
17 reviewed between 25 and 50 medical malpractice cases?

18 A. Sounds like a lot, but I think that's a
19 reasonable range.

20 Q. And before that, you probably had
21 reviewed less than 10?

22 A. Probably.

23 Q. Have you also served as an expert in
24 automobile accident cases, or other types of auto

1 accident cases?

2 A. When they've involved my patients.

3 Q. How many times have you done that?

4 A. Oh, gosh, I really don't know.

5 Q. Can you give me an estimate?

6 A. You know, it comes up a few times a year,
7 slip injuries, automobile accidents, Workers' Comp
8 issues. Probably a half dozen of those kinds of cases
9 a year that I end up being deposed or something.

10 Q. So about a half dozen injury cases per
11 year that you serve as an expert for patients?

12 A. Only if they're my patients.

13 Q. Have you ever served as an expert for a
14 plaintiff in a medical malpractice case?

15 A. I have.

16 Q. How many times have you done that?

17 A. I've reviewed about six records.

18 Q. And did you actually render an opinion in
19 those six cases that a physician deviated from
20 accepted medical practice?

21 A. One of them is up in the air. I've just
22 started to review it. Out of the other five, I
23 thought two were meritorious. Out of those two, one
24 was settled in arbitration. And one, I never heard

1 another word about.

2 Q. Did you ever write a report?

3 A. No.

4 Q. The other one that you thought was
5 meritorious, were you reviewing it for defense
6 counsel?

7 A. No. For plaintiff's counsel.

8 Q. And you told them you thought the case
9 was meritorious and then you heard nothing else?

10 A. Right. I presumed that maybe it settled
11 somewhere, but I never heard anything more about it.

12 Q. Do you advertise your services as an
13 expert in any way?

14 A. No.

15 Q. So approximately what percentage of your
16 expert review has been for the defense?

17 A. Oh, 95 percent or something. Just to
18 qualify that, that's referring to the medical-legal
19 work. You know, obviously if you threw in the cases
20 where you had auto accidents and things that involve
21 my patients, that's typically plaintiff's counsel.

22 Q. Okay. Let me ask a more precise
23 question. For medical malpractice cases,
24 approximately 95 percent of the reviews have been for

1 the defense?

2 A. I think that's a fair estimate, yes.

3 Q. Have you ever served as an expert for
4 Attorney Regnier before?

5 A. I believe we have had a prior case
6 together.

7 Q. Do you know what type of case that was?

8 A. My recollection is that it involved a
9 subarachnoid hemorrhage.

10 Q. How about his firm, Eastman & Smith? Do
11 you know any other attorneys at that firm?

12 A. I do know other attorneys there, yes, but
13 I haven't been involved in any other situations where
14 I was an expert witness for them.

15 Q. So you think you've only been an expert
16 for Mr. Regnier at that firm?

17 A. I believe that's true. Yes.

18 Q. Have you ever been represented by the law
19 firm of Eastman & Smith?

20 A. I have not.

21 Q. Have you been sued for practice?

22 A. I have not.

23 Q. As part of your practice, do you hand out
24 any literature on medical malpractice to your

1 patients? Some doctors are doing that these days.

2 Are you one of them?

3 A. I'm not sure I know what you mean. But I
4 don't have any specific literature that I hand out to
5 patients.

6 Q. Have you attended any anti-medical
7 malpractice doctor rallies?

8 A. No, I have not.

9 Q. Have you ever done anything socially with
10 Mr. Regnier?

11 A. No, I have not.

12 Q. Have you ever gone out to dinner or lunch
13 with him?

14 A. No, I haven't.

15 Q. Have you ever done any work before for
16 NCMIC? Are you familiar with that? It's a
17 chiropractic malpractice insurer.

18 MR. REGNIER: Objection.

19 Go ahead and answer.

20 THE WITNESS: No, I never have.

21 BY MR. RUF:

22 Q. Have you ever served as an expert on a
23 chiropractic malpractice case before?

24 A. I don't believe so.

1 Q. Can you tell me approximately how much
2 money you've made per year serving as an expert
3 witness?

4 A. Gosh, I really don't know the answer to
5 that. I mean, I don't think we accounted separately.

6 Q. You can't give me some type of estimate?

7 A. Maybe something like \$20,000 or
8 something. I really don't know. I'm kind of
9 guessing.

10 Q. Could you describe for me the
11 manipulation that was performed by Dr. Reichenbach on
12 Kim Richley on 10/21/02?

13 A. Well, obviously there's different
14 versions of that story. Dr. Reichenbach has testified
15 that Kimberly was laying on a bed or a treatment table
16 of some type and that he was supporting her head and
17 applied some pressure at the C5-6 level in a modified
18 break-type maneuver.

19 I believe it's Ms. Richley's testimony
20 that she was sitting in a chair upright, as we are
21 sitting now, facing Dr. Reichenbach, and that he sort
22 of held her head between his hands and moved it
23 forward, backwards, and side to side.

24 Q. Is it your understanding that she

1 testified that there was a rotary component to his
2 manipulation?

3 A. When I said, "side to side," yes, I
4 meant -- I think what she testified to is that he
5 moved her head forward, then moved her head backwards,
6 then moved her head in a rotational manner to one side
7 and then a rotational manner to the other side.

8 Q. Are you familiar with what a modified
9 rotary break is?

10 A. I first heard of it on this case.

11 Q. So you had no independent knowledge of
12 what a modified rotary break was before this case?

13 A. That's correct.

14 Q. Have you done any research to determine
15 what a modified rotary break is?

16 A. No. I just relied on the explanation
17 given by Dr. Reichenbach in his testimony.

18 Q. To your knowledge, is that a
19 high-velocity manipulation?

20 A. Well, it seems to me that you can do that
21 maneuver with different types of velocity, but the
22 testimony is that it was done with low velocity.

23 Q. Didn't Dr. Reichenbach testify that it is
24 a quick-impulse manipulation?

1 A. Well, I think velocity is one issue and
2 quick impulse is another issue. I believe what he
3 testified to is that he gave a low-velocity force in a
4 short period of time, or on a quick basis, not a
5 sustained basis. But I don't think he describes using
6 velocity.

7 Q. Do you know if a modified break is
8 referred to as a high-velocity manipulation in the
9 literature?

10 A. That, I wouldn't be aware of.

11 Q. You haven't reviewed any literature on
12 modified rotary break, correct?

13 A. Right. And I'm not holding myself out as
14 an expert witness in chiropractic medicine.

15 Q. As we sit here today, can you tell me the
16 amount of force that the manipulation exerted on
17 Kimberly Richley's cervical spine, or don't you know?

18 A. I think I could say that it was a low
19 amount of force consistent with the type of forces
20 that we all experience in our daily life.

21 Q. Did Ms. Richley feel pain after this
22 manipulation?

23 A. I believe she actually described minimal
24 pain and I think she may have even left the

1 chiropractic office feeling better. Although, in
2 retrospect, in her deposition, she describes having
3 some deep achy sensation.

4 Q. If she heard or felt a shattering
5 sensation in her neck, would that be consistent with a
6 facet fracture at that time?

7 A. It would be kind of unusual. I certainly
8 have taken care of many patients with fractured bones.
9 I never heard anybody say that they actually heard the
10 bone fracture. So it seems a little odd.

11 Q. Well, if she had a sensation of a shatter
12 occurring in her neck, would that be consistent with a
13 facet fracture occurring?

14 A. I think it's the same answer. All I can
15 say is that when you ask me if it's consistent, I'm
16 somebody who sees people with fractured facets and
17 fractured necks all the time. And I just have never
18 had a patient describe hearing shattering noises in
19 their neck when the bone broke.

20 It's a very small bone and it's very deep
21 in the neck, surrounded by capsular ligaments and
22 heavy muscles. It's kind of implausible that you
23 would hear it break.

24 Q. So would a deep soreness or a deep pain

1 in the neck be consistent with a facet fracture?

2 A. I think that's certainly -- most facet
3 fractures are acutely painful. One could feel pain.

4 Q. Would a toothache-type pain extending
5 into the shoulder be consistent with a facet fracture?

6 A. Well, most people with fractured necks
7 have significant pain, typically right over the area
8 where the fracture is. Toothache pain would seem kind
9 of minimalistic for this type of a fracture.

10 And pain can radiate, although most
11 people do not describe radiation as much as they
12 describe pain right over the broken bone, very similar
13 to a broken bone in the extremity.

14 Q. Based upon your experience, what
15 sensation do patients have when they sustain a facet
16 fracture?

17 A. Oh, usually they have onset of acute
18 severe pain. And, you know, they complain bitterly of
19 it. They typically refuse to move their neck, hold it
20 very rigid and stiff.

21 Q. Has it been your experience that the pain
22 can increase over time?

23 A. No. Actually, the pain, in my
24 experience, tends to be maximally severe at the time

1 of the fracture and then taper off over time.

2 Q. Well, have you ever read or heard of a
3 patient's pain increasing over time?

4 A. From an acute fracture of a facet?

5 Q. Yes.

6 A. No. I'd say it would be the opposite.

7 Q. What do you mean by "opposite"? The pain
8 would be the worst at first and then become less?

9 A. That's correct.

10 Q. Why do you think that's the situation?

11 A. Why do I think? Well, first of all, it's
12 my experience in treating these people on a frequent
13 basis. But secondly, it's like any other fractured
14 bone. It's a painful event and it's acutely painful
15 at the time it happens.

16 For whatever reason, as time goes by,
17 even before the fracture is repaired, the symptom does
18 settle down a little bit, the symptom of pain.

19 Although many people do have the stiffness of the neck
20 and they refuse to move it, they hold their heads
21 typically in an awkward posture, they realize
22 something dramatic has happened and typically are
23 seeking care at the time it happens.

24 Q. Are you aware Kim Richley first saw Dr.

1 Reichenbach on 10/16/02?

2 A. I'd have to check that.

3 MR. REGNIER: Are you
4 representing that's when she first saw
5 him?

6 BY MR. RUF:

7 Q. Well, let me ask this question: Do you
8 agree Dr. Reichenbach took a cervical x-ray of Kim
9 Richley on 10/17/02?

10 A. I'm going to have to check, so just a
11 second. Yes. He has a radiology report in his file
12 dated 10/17/02 on Kim Richley.

13 Q. And you've actually reviewed that x-ray,
14 correct?

15 A. I believe I have, yes.

16 Q. Do you agree that the x-ray of 10/17/02
17 does not show a fracture of Kim Richley's neck?

18 A. Yes, I agree, I do not see a fracture.

19 Q. You do not see any fracture in the x-ray
20 of 10/17/02 at the C6-C7 level, correct?

21 A. Yes. I have an AP and a lateral plain
22 film. These two films do not show an obvious
23 fracture.

24 Q. Would you also agree that neither of the

1 films of 10/17/02 show a subluxation at C6-C7?

2 A. That is correct.

3 Q. Is it your understanding that subluxation
4 is the same as dislocation?

5 A. I think, in a general sense, that's a
6 true statement.

7 Q. So subluxation of C6-C7 and dislocation
8 of C6-C7 can be used synonymously?

9 A. Well, "dislocation" would not be a word
10 that's typical in allopathic medicine, but I think
11 they convey the same concept.

12 When we use the word, we're speaking of
13 one of the cervical vertebrae being shifted out of its
14 normal alignment with the bone next to it, and that we
15 refer to as a subluxation. "Dislocation" would be a
16 term that probably conveys the same thing but would
17 not be used in typical medical parlance for the neck.

18 Q. Do you agree that on 10/17/02, Kim
19 Richley had normal range of motion for cervical
20 flexion?

21 A. Could you repeat the question?

22 Q. Sure. Dr. Reichenbach has a chart on
23 10/17 where he recorded range of motion. Are you
24 aware of that?

1 A. I'll have to look at it. I do see an
2 office note dated 10/17/02 on a patient Kim Richley
3 with a section called "range of motion."

4 Q. Do you agree that she had full range of
5 motion for cervical flexion?

6 A. If I'm understanding his notations
7 properly, he has a reference number to the left in
8 parentheses. For example, for flexion, it says 60.
9 And then he's recorded in his own handwriting the
10 number 60 next to it.

11 So being unfamiliar with this type of
12 format -- I believe it's a chiropractor format -- if I
13 understand it correctly, those two numbers being the
14 same would imply that it's a normal range of motion
15 and flexion.

16 Q. Would you agree that Kim Richley had
17 normal range of motion for cervical extension?

18 A. Well, given the same set of issues, I
19 would say yes, because he's got 75 in parentheses and
20 records next to it 75.

21 Q. And she had normal range of motion for
22 right rotation?

23 A. Again, the same issues. Yes. Both are
24 listed as 45.

1 Q. Normal range of motion for left rotation?

2 A. I would say the same set of issues, he
3 has 45 written in parentheses and handwritten.

4 Q. And she had normal range of motion of
5 right lateral flexion.

6 A. Correct.

7 Q. And normal range of motion of left
8 lateral flexion.

9 A. Assuming I'm interpreting this correctly,
10 that would be correct.

11 Q. So would you agree that, based upon his
12 records, she had normal range of motion in her
13 cervical spine in all directions on 10/17/02?

14 A. If I'm interpreting this notation
15 properly, yes, I would agree with that.

16 Q. Would you agree that a person with a
17 facet fracture would not have normal range of motion
18 in all directions of their cervical spine?

19 A. An acute fracture, they would not.

20 Q. Would you agree that Kimberly Richley had
21 a normal cervical spine on 10/17/02?

22 MR. REGNIER: Objection. Go
23 ahead, Doctor.

24 THE WITNESS: Well, I mean,

1 she's seeing a chiropractor for her
2 cervical spine. When you say "normal," I
3 presume you mean the radiographs did not
4 show a fracture and the range of motion,
5 if we're interpreting it correctly, is
6 normal. But obviously she's having some
7 condition that's causing her discomfort.

8 BY MR. RUF:

9 Q. Well, she actually went to see the
10 chiropractor for low back problems, correct?

11 A. That was what initiated their treating
12 relationship.

13 Q. That's why she was referred there,
14 correct?

15 A. That is correct.

16 Q. She was not referred there for cervical
17 treatment, correct?

18 A. Correct.

19 Q. Do you agree that there is no medical
20 evidence that Kimberly Richley had a neck fracture at
21 C6-7 on 10/17/02?

22 A. None that I'm aware of.

23 Q. So would you agree that, based upon
24 reasonable medical certainty, she did not have a neck

1 fracture on 10/17/02?

2 A. I think I would agree with that.

3 Q. Was there any diagnosis for her neck on
4 10/17/02?

5 A. Well, again, the chiropractor began
6 treating her neck, because she developed complaints
7 referencing her neck after their relationship began,
8 although it did initiate regarding a lumbar spine
9 problem. I think he was considering the possibility
10 of a disk problem.

11 Q. Based upon your review of the records,
12 would you have a diagnosis for the condition of her
13 neck on 10/17/02, or would you characterize her neck
14 as being normal?

15 A. I think she has a diagnosis.

16 Q. What's the diagnosis?

17 A. Well, the diagnosis is, at the minimum,
18 neck pain. And I think he has a working diagnosis of
19 a possible disk problem. On that radiology report
20 that we discussed earlier, he's talking about her
21 having osteophytes and a flattening of the cervical
22 lordosis and he's considering an MRI.

23 His third impression was a vertebral
24 malposition. So I would say she has, at a minimum, a

1 diagnosis of neck pain. At a maximum, she has three
2 or four diagnoses, including these chiropractic
3 diagnoses, and there's probably a working diagnosis of
4 a disk problem.

5 Q. What would your diagnosis be, as a
6 neurosurgeon reviewing the records?

7 A. If I was working this patient up, I think
8 I would probably have a leading diagnosis of neck pain
9 and a working diagnosis of probable disk disease.

10 Q. Did she have any radicular symptoms at
11 that time?

12 A. Well, she did not present with
13 radiculopathy, no. She had some pain that was midline
14 with paraspinal radiation.

15 Q. And if you were seriously considering a
16 disk problem, wouldn't you be looking for
17 radiculopathy?

18 A. Well, if you were talking about a lateral
19 disk herniation, typically you do get radiculopathy
20 with that. But there's obviously many forms of disk
21 disease in the cervical spine.

22 Q. Are you aware of any film before 10/17/02
23 that shows a fracture at C6-7 of Kimberly Richley's
24 spine?

1 A. I'm not aware of such a film.

2 Q. Would you agree that, based upon a
3 reasonable medical certainty, Kim Richley did not have
4 a fracture at C6-7 before 10/17/02?

5 A. Did you not already ask me that question?

6 Q. No. I asked you on 10/17. I'm now
7 asking you before 10/17.

8 MR. REGNIER: Is this based on
9 the records you won't produce in this
10 case?

11 THE WITNESS: I would only
12 qualify my answer by saying in the end,
13 she shows up with a fracture. And it's
14 my opinion that the only way she could
15 obtain a fracture from chiropractic
16 manipulation is if she had a preexisting
17 injury or abnormality of her bone.

18 So that would be the only line
19 of evidence that would support a fracture
20 or an abnormality prior to 10/17/02.

21 BY MR. RUF:

22 Q. Doctor, are you aware of any medical
23 evidence that supports a fracture prior to 10/17/02 in
24 Kim Richley?

1 MR. REGNIER: Objection. You
2 refused to produce records prior to that
3 date.

4 Go ahead, Doctor.

5 BY MR. RUF:

6 Q. Doctor, are you aware of any medical
7 evidence? I'm not talking about speculation.

8 A. I presume by "medical evidence," you mean
9 an x-ray?

10 Q. X-ray, medical record, anything that
11 would document a preexisting fracture.

12 A. I've not reviewed any such record.

13 Q. You're not aware of any history
14 documenting a neck fracture prior to 10/17/02,
15 correct?

16 MR. REGNIER: Same objection.
17 Go ahead.

18 THE WITNESS: I think I just
19 testified to that fact.

20 BY MR. RUF:

21 Q. So you would agree you're not aware of
22 any medical record documenting a fracture prior to
23 10/17/02, correct?

24 MR. REGNIER: Same objection,

1 based on failure to produce preexisting
2 records.

3 Go ahead, Doctor.

4 THE WITNESS: I'm not aware of
5 it, nor have I reviewed it.

6 BY MR. RUF:

7 Q. And you're not aware, in any of the
8 medical records that you've reviewed, of a history of
9 a neck fracture prior to 10/17/02, correct?

10 A. In these records, there is no mention of
11 a fracture prior to 10/17/02.

12 Q. And are you aware of any trauma prior to
13 10/17/02 that occurred with respect to Kim Richley
14 that could have caused a neck fracture?

15 MR. REGNIER: Same objection.

16 Go ahead, Doctor.

17 THE WITNESS: I know that she's
18 had a seizure disorder, but I'm not aware
19 of any specific episode of trauma, like a
20 car accident or anything of that nature.

21 BY MR. RUF:

22 Q. So you're not aware of any trauma prior
23 to 10/17/02 that could have caused a neck fracture in
24 Kim Richley, correct?

1 A. Well, what I'm saying is that trauma
2 comes in many forms. I don't know of any car
3 accidents or falling out of trees or anything like
4 that. You can, of course, fracture a cervical
5 vertebrae during a seizure or something, and we know
6 she had seizures.

7 So there are episodes that could have
8 given rise to a fracture that perhaps would not fall
9 into your definition of "trauma" or perhaps it would.

10 Q. So, Doctor, would you agree that the
11 answer is no, you're not aware of any trauma prior to
12 10/17/02 that could have caused a neck fracture in Kim
13 Richley?

14 MR. REGNIER: Same objection.

15 Go ahead, Doctor.

16 THE WITNESS: I've answered your
17 question. But if you'd like a more
18 specific answer, she's not had a
19 high-velocity automobile accident or
20 traumatic episode that typically causes
21 these fractures, that I'm aware of, prior
22 to 10/17/02.

23 However, her medical history
24 does contain events that could lead to

1 these types of fractures prior to
2 10/17/02.

3 BY MR. RUF:

4 Q. If a person sustains a fracture of the
5 facet, would you expect to see arthritic changes where
6 the fracture occurred more than a year after the
7 fracture occurs?

8 A. It depends.

9 Q. Is one of the arthritic changes that you
10 could see a thickening of the bone where the fracture
11 occurs?

12 A. You could see that.

13 Q. Do you agree that, based upon Dr.
14 Likavec's operative report, no arthritic changes were
15 noted at the location of the facet fracture?

16 A. Let me just look at the report. Is there
17 a particular part of the report that you're
18 referencing?

19 Q. I'm just asking you that, based upon the
20 report, there's no notation of any changes where the
21 facet fracture is?

22 A. Well, it's a lengthy report and he does
23 describe abnormality of the bone. I guess when you
24 say "arthritis," that's a rather nonspecific term.

1 You know, if you had a specific observation here, I
2 could address it. But my best answer is that he does
3 note abnormality of the bone.

4 Q. Well, what type of arthritic changes
5 would you expect to see for a person that has
6 sustained a facet fracture?

7 A. Well, you asked me could they have them
8 and I said it's possible. They also may not have
9 them. So I don't know that I'd expect to see any
10 quote, unquote, arthritic changes from a facet
11 fracture.

12 Q. Okay. If you did see arthritic changes,
13 what would you expect to see?

14 A. Well, they could have some broad range.
15 You could have some minimal thickening of a ligament.
16 You could have hypertrophy of bone, as you mentioned.
17 You could have some exophytic bone spurs.

18 You could have narrowing of the facet
19 joint. You could have gapping of the facet joint.
20 You could have irregularity of the facet surfaces. I
21 mean, there's a broad range of changes that one could
22 throw into the category of arthritic.

23 Q. Would you agree that Dr. Likavec, as a
24 surgeon, is in a better position than you to determine

1 the condition of her bones intraoperatively?

2 A. Well, I would suppose. He's the only one
3 that saw the bones intraoperatively.

4 Q. If he has testified that, based upon his
5 performing this surgery, he was of the opinion that
6 this was an acute fracture, would you disagree with
7 that opinion?

8 A. I don't see any reason to dispute it.

9 Q. Would you agree that a neck fracture is a
10 contraindication to cervical manipulation?

11 MR. REGNIER: Objection. Not a
12 standard of care expert.

13 Go ahead, Doctor.

14 THE WITNESS: I would presume it
15 is, yes.

16 BY MR. RUF:

17 Q. To put it another way, it would be a
18 deviation from acceptable, medical, or chiropractic
19 practice to manipulate somebody's neck where they had
20 a neck fracture, wouldn't it?

21 MR. REGNIER: Objection. Go
22 ahead, Doctor.

23 THE WITNESS: Well, I can't hold
24 myself out as an expert on the standards

1 of care in chiropractic medicine.

2 If you're talking about a
3 patient who has an acute fracture that's
4 unstable and is known to the treating
5 chiropractic, it would seem prudent that
6 that would be a standard.

7 BY MR. RUF:

8 Q. Would you agree it would be unreasonable
9 and imprudent to manipulate somebody's neck where that
10 person had a neck fracture?

11 MR. REGNIER: Objection. Go
12 ahead, Doctor.

13 THE WITNESS: I think I just
14 said that if it was an acute fracture and
15 it was unstable and the treating
16 physician was aware of it, I think it
17 would be imprudent to treat it with
18 manipulation unless the manipulation was
19 done to reduce the fracture with x-ray
20 guidance and other well-known techniques.

21 BY MR. RUF:

22 Q. Are you aware of "Campbell's Operative
23 Orthopedics"?

24 A. Am I aware of it?

1 Q. Yes.

2 A. I'm aware that it's a general textbook of
3 orthopedics.

4 Q. Have you reviewed that text and studied
5 that text?

6 A. No.

7 Q. Would you agree with the statement in
8 "Campbell's Operative Orthopedics" that unilateral
9 facet dislocation usually results from flexion and
10 rotation of the cervical spine?

11 MR. REGNIER: Objection.

12 Go ahead, Doctor.

13 THE WITNESS: I would only say
14 that that's an incomplete description.
15 It does not -- you know, we all flex and
16 rotate our spines every day. We've
17 probably done it during the course of
18 this discussion.

19 It takes far more than that to
20 cause a unilateral facet fracture.

21 MR. REGNIER: Pardon me, Mark.
22 Could you identify the edition for me?

23 MR. RUF: Sure. Eighth edition.

24 BY MR. RUF:

1 Q. Well, would you agree that a facet
2 fracture is typically caused by rotational force?

3 A. No, no. Facet fractures are not caused
4 by rotational force. There are different types of
5 facet fracture. The fracture described here in Kim
6 Richley is a combination of simultaneous forces.

7 Q. Okay. In your opinion, what simultaneous
8 forces caused her neck fracture?

9 A. You would have to get a simultaneous
10 hyperflexion and rotational component to result in the
11 type of injury you see here. That accounts only,
12 however, for the facet fracture. Her transverse
13 process fracture would not fall into that set of
14 forces.

15 Q. If Kim Richley's subluxation was such
16 that one vertebra was not directly over the other one,
17 there was partial slipping, would that be consistent
18 with a rotational force causing her facet fracture?

19 A. No, no. That's just a natural logical
20 consequence of a jumped facet, which is what she ends
21 up with in the end.

22 Q. Would you agree that if a chiropractor
23 performs a neck manipulation that results in a facet
24 fracture at C6-7, that would be a deviation from

1 acceptable medical practice?

2 MR. REGNIER: Object. Can't
3 testify as to chiropractic standard. Go
4 ahead.

5 THE WITNESS: I think I've
6 mentioned already that I can't testify to
7 the chiropractic standard of care. So I
8 don't think that I would have an answer
9 to your question.

10 BY MR. RUF:

11 Q. Well, Doctor, do you think it's
12 acceptable to break a patient's neck with a
13 manipulation?

14 MR. REGNIER: Objection.

15 THE WITNESS: Well, obviously,
16 if you're talking about a patient who has
17 a normal neck and you do something to
18 fracture it, that would seem
19 unreasonable.

20 However, it also is quite
21 implausible that you could fracture a
22 patient's neck with routine manipulation.

23 BY MR. RUF:

24 Q. I mean, you would agree if enough force

1 was exerted on a patient's spine to fracture the
2 facet, that that would be unacceptable medical care?

3 MR. REGNIER: Objection.

4 Go ahead, Doctor.

5 THE WITNESS: We're talking
6 about forces that occur in high-speed
7 automobile accidents. These are not the
8 kind of forces that one would encounter
9 in medical care.

10 BY MR. RUF:

11 Q. Well, do you know exactly how much force
12 is exerted on a patient's spine with a modified rotary
13 break? Have you ever studied that?

14 A. I've already testified to the fact that I
15 have not studied modified rotary break. But I would
16 just say that you cannot, with human force, fracture
17 the cervical vertebrae in this manner.

18 Q. Have you treated patients that have
19 gotten in fights with other people?

20 A. Altercations?

21 Q. Yes.

22 A. Sure.

23 Q. And have those patients sustained
24 fractures of bones as a result of those altercations?

1 A. We're speaking now of a unilateral facet
2 fracture, and --

3 Q. I'm first asking you: Have you treated
4 patients who have sustained fractures as a result of
5 blows or hits from other human beings?

6 A. Well, for example, an orbital rim
7 fracture or a broken jaw from a punch, yes, I've seen
8 that.

9 Q. So you would agree that a human being has
10 a potential to cause fractures in another human being?

11 A. If you're talking about fracturing a thin
12 bone with a focal impact of a fist, yes. That's
13 certainly not applicable to this case.

14 Q. Doctor, could you tell me the amount of
15 foot pounds of force that were exerted on Kim
16 Richley's spine by this modified rotary break
17 technique?

18 A. Nobody could tell you that.

19 Q. You don't know.

20 A. Nobody knows.

21 Q. Do you know the amount of foot pounds it
22 takes to fracture a facet in a person's spine?

23 A. Depends on the quality of the bone. If
24 they have normal, healthy bone, it would be much

1 higher than if they have, for example, soft bone.

2 Q. Okay. What about for either one? Do you
3 know the amount of foot pounds of force it would take?

4 A. I would only know in a rough category
5 that it would be significantly high for normal healthy
6 bone. In reality, we see these fractures only in
7 high-speed, high-velocity, high-force-type
8 deceleration trauma. So I know they'd be high forces.

9 Q. Have you ever treated patients who have
10 had injuries caused by a chiropractor?

11 A. When I was a resident at Henry Ford
12 Hospital, we had a patient who had a vertebral
13 dissection after chiropractic manipulation. That's
14 the only one I've ever seen.

15 Q. Have you read about injuries caused by
16 chiropractors in the medical literature?

17 A. The only topic I've ever seen discussed
18 relative to that would be vertebral dissections.

19 Q. And what do you mean by "vertebral
20 dissections"?

21 A. The vertebral artery is a blood vessel
22 that supplies blood flow to a portion of the brain.
23 And it runs through the bones of the neck. And there
24 are isolated case reports of that blood vessel being

1 injured during manipulation by chiropractors and
2 osteopathic physicians.

3 Q. Have you ever done a literature search to
4 determine what the literature documents as
5 complications caused by chiropractors?

6 A. No, I haven't.

7 Q. And you aren't aware of the potential
8 complications caused by chiropractic manipulation,
9 correct?

10 A. Well, you had asked me my experience, and
11 my experience is I've seen vertebral dissection and
12 I'm aware of vertebral dissection. And in my years of
13 general practice in neurosurgery, I've not seen any
14 other type of injury from chiropractic treatments.

15 Q. But you've never specifically researched
16 or studied the potential complication from
17 chiropractic manipulation, correct?

18 A. Correct.

19 Q. So you don't know what the potential
20 complications are from chiropractic manipulation,
21 correct?

22 A. Other than from my own experience.

23 Q. Right. Other than from your own
24 experience, you don't know what the documented

1 complications are from chiropractic manipulation,
2 correct?

3 A. I think that's a fair statement.

4 Q. Doctor, in your practice, you use a
5 written consent form, correct?

6 A. Yes.

7 Q. As a matter of fact, that's available
8 on-line, is it not?

9 A. Yes.

10 Q. And you have a rather extensive written
11 consent form, correct?

12 A. I believe it's comprehensive.

13 Q. That's the standard that you use in your
14 practice, a written consent form, correct?

15 A. For invasive procedures, yes.

16 Q. Would you agree that in treating a
17 patient's spine, you have to inform a patient of all
18 the potential risks of the treatment?

19 A. In our practice, for example, when you're
20 doing surgery and invasive procedures, yes.

21 Q. Do you ever manipulate a patient's spine?

22 A. Only in attempting to reduce fractures
23 and things under x-ray guidance.

24 Q. Well, do you agree with any type of

1 medical treatment, a patient should be informed and
2 consent to the risks of that treatment?

3 MR. REGNIER: Objection. Go
4 ahead, Doctor.

5 THE WITNESS: Well, I think
6 that, you know, it would be a little hard
7 to say. I mean, for example, if --

8 BY MR. RUF:

9 Q. Well, isn't that the way that you
10 practice medicine, Doctor?

11 A. I'd like to finish my answer.

12 Q. All right.

13 A. I was going to say, you know, in
14 medicine, many times we do things like swab the back
15 of a throat, look into an ear canal, et cetera.

16 They're not considered to be issues one
17 would obtain informed consent over or have lengthy
18 discussions regarding the risk benefits of. When you
19 get down to something like an invasive procedure,
20 doing surgery, then, yes, it would be typical and I
21 would say prudent to have those types of discussions.

22 Q. So would you agree that if there's a risk
23 of injury to the patient, that risk should be
24 discussed with the patient?

1 MR. REGNIER: Objection.

2 Go ahead, Doctor.

3 THE WITNESS: Well, I just
4 answered that. I mean, of course, when
5 you're swabbing the back of a throat, you
6 could ostensibly injure somebody. Of
7 course, there's a risk of injury in any
8 of the things we do.

9 But I'm not suggesting that all
10 of those issues are subject to formal
11 discussions regarding the risks and
12 benefits.

13 BY MR. RUF:

14 Q. Well, are you telling me it's acceptable
15 to treat a patient where there's a risk of injuring
16 that patient without obtaining that patient's consent?

17 MR. REGNIER: Objection.

18 Go ahead, Doctor.

19 THE WITNESS: I think I'm
20 answering your question and I think I've
21 been very clear and I'll say it again.

22 BY MR. RUF:

23 Q. Well, I think you're giving me an evasive
24 answer. Do you think it's acceptable to treat a

1 patient where there's a risk of injuring the patient
2 and the patient has not consented to that risk?

3 MR. REGNIER: Objection.

4 THE WITNESS: There's nothing
5 evasive about my answer, and I will
6 repeat it.

7 Many times, we perform
8 investigations, observations,
9 manipulations. Even during the course of
10 an examination, I do straight leg
11 raising. I do an external rotation of
12 the hip to check range of motion. I have
13 people stand on their toes.

14 They could fall. I could
15 fracture a hip. I could pull a muscle.
16 Of course these things aren't subject to
17 consent discussions.

18 So when you ask if we do
19 something that has the potential to harm,
20 isn't it necessary to have a consent
21 discussion beforehand, I think I've
22 answered clearly no.

23 When you then turn around and
24 say, well, are you telling me it's okay

1 to do things that can harm patients
2 without telling them about it, I'm
3 saying, you know, in practical reality,
4 that is true, that there are things like
5 swabbing the back of a throat that could
6 harm somebody and, in fact, we don't have
7 lengthy consent discussions about it.

8 I'll bet you the last time you
9 had your teeth cleaned, you didn't have a
10 lengthy consent discussion with your
11 dentist before he cleaned your teeth.
12 But can teeth cleaning harm you? Sure.

13 When your barber cuts your hair,
14 I'm sure you didn't have a lengthy
15 consent discussion. But could he harm
16 you with those shears? I'm sure he
17 could.

18 BY MR. RUF:

19 Q. A barber's not a doctor, correct?

20 A. I think what I'm doing is using analogies
21 to help you understand my point on this issue.

22 Q. I think you're the only doctor I've ever
23 talked to that doesn't think you need to obtain
24 informed consent from a patient.

1 MR. REGNIER: Objection.

2 BY MR. RUF:

3 Q. Doctor, if there's a risk of fracturing a
4 patient's neck from treatment, would you agree that's
5 something that has to be explained to the patient and
6 the patient has to consent to the treatment?

7 MR. REGNIER: Objection. Your
8 question's not consistent with Ohio law.

9 Go ahead, Doctor.

10 THE WITNESS: I don't think that
11 there is necessarily any strong body of
12 evidence or literature to support
13 fracturing a neck during manipulation.

14 And if it's the type of thing
15 that would occur one in a million times,
16 I think that you would not need to have a
17 discussion regarding that. It just
18 doesn't seem reasonable.

19 If it's something that occurs
20 with frequency, 5 percent of the time, I
21 think, yes, you should have a discussion
22 regarding that.

23 BY MR. RUF:

24 Q. Do you agree there's no evidence of any

1 event or occurrence which could have caused Kim
2 Richley's facet fracture between 10/17 and 10/21 other
3 than the chiropractic manipulation?

4 A. I don't agree with that.

5 Q. You don't agree with that. Well, are you
6 aware of any trauma to Kimberly Richley's cervical
7 spine between 10/17 and 10/21/02?

8 A. I'm not aware of any.

9 Q. So you're not aware of any other
10 potential cause for Kimberly Richley's neck fracture
11 other than the cervical manipulation of 10/21/02?

12 A. I didn't say that. I distinctly believe
13 there has to be some other explanation. It's just not
14 plausible that her neck was fractured by manipulation,
15 either by the description she gives or the one that
16 Dr. Reichenbach gives.

17 She's a seizure patient, and my best
18 guess is that she had a seizure that caused it. But
19 maybe there's some type of trauma that she suffered
20 that I'm not aware of. Because certainly the
21 transverse process fracture is a telltale sign that
22 whatever caused the fracture was beyond what one would
23 expect with flexing and rotating the head.

24 Q. But you have no other plausible

1 explanation for why she sustained a fracture which
2 appeared on the films on 10/22/02?

3 A. No. I think my plausible explanation, my
4 best explanation, is that it must have been a seizure.
5 She awoke out of sleep with it, common history for a
6 seizure. That type of fracture would fit with a
7 seizure. And I don't think it's plausible that she
8 suffered a fracture from the manipulation.

9 Q. Are you aware of any evidence that she
10 actually had a seizure between 10/21 and 10/22?

11 A. Other than she's a patient that's treated
12 for epilepsy and that she ended up with a fracture
13 that's consistent with a seizure. That's my best
14 evidence for that.

15 Q. So you would agree you have no evidence
16 that she actually had a seizure between 10/21 and
17 10/22?

18 MR. REGNIER: Objection. Asked
19 and answered.

20 THE WITNESS: I think I gave you
21 my best answer to that question.

22 BY MR. RUF:

23 Q. Do you have any evidence or don't you,
24 Doctor?

1 MR. REGNIER: Objection. He
2 just gave it to you.

3 Go ahead, Doctor.

4 THE WITNESS: She has a fracture
5 that I believe is consistent with a
6 seizure, and the only plausible
7 explanation for her to have this fracture
8 is a seizure or some event that we're not
9 aware of.

10 She has a history of seizures.
11 And she also woke out of sleep with this
12 problem, which would fit the pattern of
13 seizures. That's what I would offer to
14 you as evidence that there's a reasonable
15 and perhaps best explanation of her
16 fracture.

17 BY MR. RUF:

18 Q. Do you know if she had had seizures
19 before 10/21/02?

20 A. I'm sure she had.

21 Q. Do you know for sure whether or not she
22 had seizures?

23 A. She had been treated for them.

24 Q. Do you know the frequency of the

1 seizures?

2 MR. REGNIER: Same objection,
3 based on your failure to produce records.
4 Go ahead.

5 THE WITNESS: It wouldn't matter
6 what the frequency was.

7 BY MR. RUF:

8 Q. Do you know how long before 10/21/02 she
9 had a seizure?

10 A. Again, it wouldn't matter. If a person
11 has one seizure every day or one seizure every 20
12 years, they could still fracture their neck during
13 seizure. The frequency doesn't have any impact on
14 that.

15 Q. Can you cite one medical article or one
16 medical textbook that documents a facet fracture in
17 the neck as a result of a seizure?

18 A. I don't know that it's written in any
19 textbooks, but it's certainly quite plausible and I
20 think the best explanation for this situation.

21 Q. So as we sit here today, you can't tell
22 me any medical literature that would document a facet
23 fracture being caused by a seizure, correct?

24 A. Well, I don't claim to have memorized the

1 world's medical literature, nor do I believe that
2 appearing in literature is something that is necessary
3 to state that something is a reasonable and
4 appropriate conclusion.

5 And I'm certain that if we did search the
6 literature, we'd probably find that reported. But if
7 you're asking me have I memorized literature and can
8 cite it chapter and verse, of course not.

9 Q. I'm asking you are you aware of any
10 literature as we sit here today that documents any
11 facet fractures being caused by a seizure? The answer
12 is no, correct?

13 A. The answer is the answer I just gave you.

14 Q. Why can't you just give me a simple
15 answer, Doctor, instead of these circular answers?

16 MR. REGNIER: Objection.

17 THE WITNESS: Because the answer
18 is not simple. The answer is not simple
19 at all.

20 BY MR. RUF:

21 Q. Can you cite an article as we sit here
22 today?

23 A. Well, that, I did answer quite directly.
24 I said I do not have the world's literature memorized.

1 I cannot give you a citation off the top of my head.
2 I said that if we searched the literature, we may well
3 find it.

4 And I also pointed out that because
5 something is documented in literature is not the
6 litmus test for whether it's reasonable, unreasonable,
7 true, or untrue.

8 Q. Have you ever treated a patient that
9 sustained a cervical facet fracture as a result of a
10 seizure?

11 A. I can't recall that set of circumstances.

12 Q. How many people have you treated with
13 facet fractures in the cervical spine?

14 A. Oh, I'm sure it's probably, if not 100,
15 very close to it.

16 Q. Would you agree that, based upon a
17 reasonable medical certainty, the facet fracture to
18 Kimberly Richley's cervical spine occurred between
19 10/21 and 10/22/02?

20 A. I'm not sure I would. I don't think that
21 you would have to tie it down to that time frame.

22 Q. Well, you've already testified that,
23 based upon reasonable medical certainty, she did not
24 have a fracture on 10/17/02, correct?

1 A. Yes.

2 Q. So would you agree that the cervical
3 fracture had to be caused sometime between 10/17/02
4 and 10/22/02 when the film showed the fracture?

5 A. Well, that's a different set of dates
6 that you just stated. I was confused as to why you
7 were trying to narrow the dates earlier.

8 Q. Well, since you wouldn't agree with my
9 question, I'm changing it.

10 A. I see. I think, you know, based on the
11 medical records that I've been allowed to review, I do
12 not see evidence of a fracture before 10/17. And we
13 have those x-rays. And then I think the first time we
14 see evidence of a fracture, if I'm correct, is 10/22.
15 I'll check that and make sure I've got it right.
16 Yeah, I think 10/22 is the date.

17 Q. So you would agree that the fracture
18 occurred sometime between 10/17/02 and 10/22/02?

19 A. I believe that's a reasonable conclusion.

20 Q. Would you also agree that the subluxation
21 at C6-7 occurred sometime between 10/17/02 and
22 10/22/02?

23 A. Yes.

24 Q. Have you performed surgery on patients

1 that have sustained facet fractures of the cervical
2 spine with subluxation?

3 A. I have.

4 Q. Was the type of surgery performed by Dr.
5 Likavec appropriate to treat Kim Richley's condition?

6 A. Yes.

7 Q. Would you agree that the treatment by
8 Deaconess Hospital, Metro Hospital, and Precision
9 Orthopedics was all reasonable and necessary
10 treatment?

11 A. I'm okay with the hospital and with the
12 surgery. I'm not so sure what Precision
13 Orthopedics --

14 Q. It's Dr. Chauhan.

15 A. You know, I don't really know what Dr.
16 Chauhan is doing for her. The problem was treated
17 surgically, and I don't know what an orthopedic
18 surgeon is offering that's of value. But I agree that
19 the hospitalization and the surgery were necessary and
20 reasonable treatment.

21 Q. Based upon your experience, would
22 approximately 34,000 in medical bills be the
23 approximate cost to treat a facet fracture surgically,
24 with subsequent follow-up treatment?

1 A. Well, including the hospitalization and
2 all ancillaries.

3 Q. Yes?

4 A. Yes, including the hospitalization and
5 all ancillaries.

6 Q. Doctor, can you identify for me any
7 medical article or any medical textbook that supports
8 the opinions you set forth in your letter?

9 A. Do you have a specific opinion that
10 you're referring to?

11 Q. Any of your opinions.

12 MR. REGNIER: Objection.

13 Vague.

14 THE WITNESS: For example,
15 Opinion 1, which states the description
16 of the chiropractic treatment rendered to
17 Kimberly Richley does not correspond to
18 the forces involved in a unilateral jump
19 facet injury and that such injuries are
20 usually associated with high-velocity
21 deceleration injuries, you could find
22 virtually in any textbook that discusses
23 this type of issue, and I'm certain
24 innumerable articles.

1 BY MR. RUF:

2 Q. Can you cite to one?

3 A. Well, I didn't come here prepared with
4 citations and I don't keep citations memorized in my
5 head.

6 Q. I'm just asking if you can cite one. If
7 you can't, tell me you can't.

8 A. I would just say that any general
9 textbook that discusses cervical spine trauma.

10 Q. Okay. Why don't you name a textbook?

11 A. Gosh, there's a number of general texts
12 in neurosurgery. I'm sure they must cover the topic.

13 Q. Name one.

14 A. Yeoman's would be a textbook in general
15 surgery that may cover this topic.

16 Q. Have you found Yeoman's to be accurate
17 and reliable?

18 A. I use textbooks for general reference.

19 Q. That's a peer-review textbook, is it not?

20 A. Peer review usually refers to articles
21 and literature. Textbooks are typically not peer
22 review.

23 Q. Well, what's written in Yeoman's is
24 reviewed by a whole group of doctors, is it not?

1 A. Well, my general understanding of the
2 process, having been a contributor to general
3 textbooks, is that usually contributing authors write
4 a chapter and it's the editor of a text who will
5 generally review it and sign off on it, but it's not
6 reviewed by any panel of experts or anything like that
7 for a textbook.

8 Textbooks are just basically representing
9 the chapter's author's experiences. And the
10 experiences that are included in the chapter are
11 usually defined by the instructions given by the
12 managing editor.

13 And you may well find textbooks like that
14 that have multiple contributing physicians that you'll
15 find conflicts, even, in what they write in one
16 chapter versus the next. But that just reflects the
17 nature of the medicine. It's not something that can
18 be pinned down to exact precise science. A lot of it
19 is judgments and opinions and biases.

20 Q. Are you aware of any other textbooks that
21 would support the statement you made in Paragraph 1?

22 A. Well, I said just about any general
23 textbook would support it.

24 Q. Can you cite any others other than

1 Yeoman's?

2 A. Another general textbook of neurosurgery
3 would be Wilkins & Rengachary. That's a very similar
4 book. I'm sure you'll probably even find it in your
5 "Campbell's Operative Orthopedics."

6 Well, it's an operative book. That
7 probably wouldn't be germane. You'd probably want to
8 see something in a more generalized text. But there
9 are certainly many of these textbooks out there. I
10 just don't have a whole list of them in my mind right
11 now.

12 Q. Any other ones you can think of that
13 would support the statement you made in Paragraph 1?

14 A. I think I'm just going to stop. I just
15 can't think of any other general textbooks to offer
16 you.

17 Q. What about for Paragraph 2, either
18 articles or general textbooks?

19 A. I'd say the same answer. You could find
20 that in any general text on the topics. If you need
21 specifics, I'll just stick with the two I've already
22 been able to think of off the top of my head.

23 Q. The same with Campbell's?

24 A. No, I can't include Campbell's. It's an

1 operative book, so it wouldn't really discuss these
2 issues, at least not in any depth.

3 Q. What about Paragraph 3?

4 A. Delayed onset of pain recorded by the
5 patient? Well, of course, it's a very common piece of
6 information that would probably, again, be covered in
7 any general textbook. When you fracture a facet, you
8 have pain at the time of the fracture.

9 I mean, it might be so widely accepted,
10 it's assumed in the chapter. I don't think you would
11 find a book that would suggest otherwise.

12 Q. Would you stick with the same two
13 textbooks you've named for Paragraph 3?

14 A. Since they're the only ones I can think
15 of off the top of my head right now, I'll go with
16 them.

17 Q. What about Paragraph 4?

18 A. Well, Opinion No. 4 states that the jump
19 facet injury could only be caused by low-velocity
20 forces if there's a significant preexisting injury of
21 the facet joint.

22 I doubt that a topic like that would be
23 covered in a general textbook of any type. I think
24 that this is based on the fact that I have expertise

1 in treating these, and I've treated, as I've said,
2 hundreds of neck fractures and certainly a great deal
3 of facet fractures.

4 You just don't see them in low-velocity
5 injuries. You see them as a result of high-velocity
6 injuries, significant forces like you find in
7 high-velocity car accidents, that type of thing.

8 Q. What about Paragraph 5?

9 A. Well, now, in Paragraph 5, C7 nerve root
10 compression is a common clinical case, that many
11 patients with symptoms similar to Kimberly Richley's
12 are seen in my practice. And it goes on to say that
13 in my experience, these injuries do not result in
14 debilitating lifelong symptoms.

15 Now, I doubt my experience is captured in
16 anybody's textbook, but certainly I treat C7
17 radiculopathy on a daily basis, and I find it
18 incredulous that anybody would claim permanent
19 disability from a C7 nerve root injury. It just
20 doesn't fit at all with my experience.

21 Q. Have you ever had a patient who has had
22 permanent sequelae from a facet fracture where a piece
23 of the fracture is impinging on the nerve?

24 A. Well, yeah. That's common, to find a

1 piece of -- in these types of fractures, if the facet
2 jumps and fractures off the tip of the bone as it did
3 here, you can find a piece of bone lodged in the
4 neural foramina of the nerve root. That's not
5 exceptional. And it would be similar to rupturing a
6 disk and having the ruptured disk sit in the neural
7 foramina with the nerve root. Nothing more, nothing
8 less.

9 Q. Have you had patients that have had
10 permanent sequelae from that?

11 A. Well, you could certainly have permanent
12 numbness, permanent weakness of all varying degrees.
13 But what I'm saying is that it's not something that
14 would cause a person to be disabled.

15 Q. Based upon your experience in general,
16 does the healing to the cervical spine occur within a
17 year of the injury?

18 A. Well, the bony healing, of course, is
19 quicker than that. Nerve root healing, if it involves
20 regeneration, you know, we usually use a time frame of
21 9 to 12 months for nerve root regeneration.

22 Q. So has it been your experience that if a
23 patient has problems past one year, that those are
24 permanent problems?

1 A. Well, it depends on what the problem is.
2 When we're talking about nerve root degeneration,
3 we're talking about numbness and weakness. So if you
4 have weakness and it doesn't get better in a year's
5 time, then we usually say whatever portion of that
6 weakness you have is probably permanent. And the same
7 with numbness.

8 Q. What about pain?

9 A. Pain, you couldn't say that. Pain is a
10 very subjective thing. It can come and go. People
11 who walk into my office who have had pain for years
12 and years and years can be relieved of their pain.

13 Q. Have you ever testified in an automobile
14 accident case that a patient was going to have
15 permanent pain for the rest of their life?

16 A. I don't recall testifying to that, but I
17 guess it would depend on the nature of the case facts.

18 Q. Well, would you agree that the conditions
19 that Kimberly Richley is currently suffering from are
20 permanent conditions?

21 A. I don't know that she's suffering from
22 any condition.

23 Q. Okay. Could you tell me what her current
24 condition is?

1 MR. REGNIER: Objection.

2 THE WITNESS: I would say that I
3 think the record leaves off with her
4 surgeon finding her to be in normal
5 health without any neurologic residual.
6 And that's what I would expect.

7 BY MR. RUF:

8 Q. Are you aware that Dr. Likavec, her
9 surgeon, and Dr. Chauhan, her pain management
10 orthopedic doctor, have both rendered the opinions
11 that her current condition is permanent?

12 MR. REGNIER: Objection.

13 THE WITNESS: I don't know what
14 condition you're speaking of. But we can
15 review Dr. Likavec's office notes. And
16 as far as I could tell, I think his
17 office notes said she was doing fine.

18 BY MR. RUF:

19 Q. First let's start with Dr. Chauhan. Have
20 you reviewed his report? I think I saw it in your
21 materials (indicating).

22 A. Do you want to hang on to that? I'll try
23 and find my copy.

24 Q. Sure.

1 A. Okay.

2 Q. Would you agree that in his report of
3 April 15th, 2004, he documents that presently, the
4 primary complaint is that of neck pain?

5 A. I see in Paragraph 3, it says regarding
6 her current condition, she continues with substantial
7 neck pain.

8 Q. You have not examined Kimberly Richley,
9 correct?

10 A. That's correct.

11 Q. So do you have any basis to dispute that
12 she suffers from neck pain on a daily basis?

13 A. Well, I guess I was earlier looking for
14 the office records of Dr. Likavec. I just wanted to
15 cross-reference this with what he wrote about her
16 postoperative condition.

17 MR. REGNIER: Which report are
18 you looking for?

19 THE WITNESS: I was looking for
20 the office notes from Dr. Likavec, his
21 follow-up visits.

22 BY MR. RUF:

23 Q. Well, let me ask you this: Would you
24 agree that Dr. Chauhan is in a better position than

1 you are to know what Kimberly Richley's current
2 condition is?

3 A. Well, in the fact that you've represented
4 that he's treating her, I'm sure he is.

5 Q. Are you aware that the defense had an
6 examination done by a neurologist, Dr. Mann?

7 A. I don't know that I'm aware of that.

8 Q. If Dr. Mann, as a witness for the
9 defense, conducted a neurological examination on
10 September 9th, 2004, and stated that Kimberly Richley
11 is troubled with burning, tightness, and pain in the
12 neck radiating down the arm into the fingers, and
13 headaches originating in the neck, do you have any
14 basis to dispute that?

15 A. No.

16 Q. Would you agree that if she is suffering
17 from those conditions almost two years from the date
18 of the fracture that, based on reasonable medical
19 certainty, those conditions are permanent?

20 A. Well, I find that harder to agree to. I
21 would just say that, in my experience, these types of
22 injuries, when you treat them, use them, patients may
23 have some complaints of achy pain, stiff neck. But
24 nothing quite that dramatic.

1 And whether it would be permanent would
2 be hard to say. Because as I've mentioned, you know,
3 I'll see people that come in years after a problem and
4 we can treat them and get them better.

5 Q. Would you agree that the healing and
6 improvement for an injury to the cervical spine
7 usually occurs within the first year after the injury?

8 A. What I testified to the last time you
9 asked me that question was that if the injury is to
10 the nerve and it requires nerve regeneration, a
11 9-to-12-month time frame is about right.

12 For bone healing, it's a little bit
13 quicker than that. But that's about how long it takes
14 for these tissues to heal and/or regenerate.

15 But when you speak of healing in the
16 sense that they become symptom-free, that's a little
17 bit different. Because symptoms can linger on for
18 longer than a year and longer than two years. And
19 that doesn't mean that they'll be permanent.

20 Q. If Dr. Chauhan has testified that
21 Kimberly Richley cannot sit for long periods of time
22 due to her condition, do you have any basis to dispute
23 that?

24 A. It seems implausible.

1 Q. Do you know whether or not she can look
2 up and down repetitively?

3 A. No, I don't know whether she can look up
4 and down repetitively. I presume she can, because if
5 you have a single level of your neck fused, you lose
6 probably 7 degrees of total motion out of a range
7 that's probably 40 to 50 degrees flexion-extension, so
8 it would only be a small percentage that she would
9 lose.

10 Q. Do you know if she can lift more than
11 2-1/2 pounds?

12 A. She can lift more than 2-1/2 pounds.

13 Q. Do you know if she's been tested for
14 that?

15 A. I don't know that she's been tested. But
16 you can function without your C7 root altogether and
17 lift more than 2-1/2 pounds.

18 Q. Doctor, would you agree that if Kimberly
19 Richley is troubled with burning tightness, pain in
20 the neck radiating down the right arm to the fingers,
21 headaches originating in the neck, that she can't lift
22 more than 2.5 pounds, she can't sit for long periods
23 of time, she can't look up or down repetitively, she
24 has daily neck pain, that those things would disable

1 her from working?

2 MR. REGNIER: Objection. Go
3 ahead, Doctor.

4 THE WITNESS: I would say those
5 things are not consistent with the injury
6 she had. It would only seem to me that
7 that's an extraordinary pattern of
8 symptomatology for a person with a C7
9 root injury, and there must be some other
10 explanation.

11 BY MR. RUF:

12 Q. Well, assuming those problems are
13 documented both by Dr. Chauhan by Dr. Mann, if she has
14 those conditions, don't you think it would be
15 difficult for her to get a job?

16 A. Well, I think that -- you know, I
17 wouldn't want to hold myself out as a rehabilitation
18 expert, but I would think that she could be
19 rehabilitated to meaningful remunerative employment.

20 Q. Doing what? What do you think she can
21 get a job doing?

22 A. Well, can she talk on the phone? She
23 could get a job as a telephone operator, as a phone
24 solicitor, as a receptionist. I mean, there's a lot

1 of light-duty work. People with really, truly
2 dramatic injuries to their neck who are paralyzed and
3 things work in those capacities all the time.

4 Q. Do you know if any of those jobs would
5 require lifting more than 2.5 pounds?

6 A. I doubt they would.

7 Q. Do you know of an employer that would
8 hire her with all these restrictions?

9 MR. REGNIER: Objection.

10 THE WITNESS: Do I know of an
11 employer personally?

12 BY MR. RUF:

13 Q. Yes.

14 A. I don't know that many employers, but I
15 know disabled people are hired all the time. I go to
16 the checkout line in the store and I've had groceries
17 bagged by people with cerebral palsy. I've had people
18 in wheelchairs ring up my orders.

19 I mean, in the courthouses around, I've
20 seen people who are blind preparing and serving meals.
21 Yes, disabled people are fully able to return to work.

22 Q. Would you agree that you don't know
23 whether or not she's employable, because you don't
24 know her current condition?

1 A. I wouldn't agree to that, no. You've
2 described her current condition as you believe it is,
3 and I'd say I still think that, you know, in this day
4 and age, people with much worse injuries than she
5 sustained go back to remunerative employment, and that
6 people with disabilities are employed in many
7 different walks of life.

8 Q. So what jobs is she qualified for?

9 A. We've talked about that.

10 Q. Any other jobs you can think of she's
11 qualified for?

12 A. Filing logistics. I'm sure, you know, if
13 I was a rehab specialist, I could probably come up
14 with a whole litany of them.

15 Q. I'm asking you. You've talked about
16 employability in your report.

17 A. And I'm answering you.

18 Q. Okay. Any other jobs you can think of
19 that she's qualified to do?

20 A. I said radio dispatch logistics in
21 trucking companies, fire departments, police
22 departments. She could be some type of a school aide
23 to help teach kids how to read. She could probably
24 work in any one of a number of capacities, and I think

1 a rehab specialist could probably rattle off a whole
2 litany.

3 Q. Do you know if any of those jobs require
4 lifting more than 2.5 pounds?

5 MR. REGNIER: Objection.

6 THE WITNESS: I doubt they
7 would.

8 BY MR. RUF:

9 Q. You don't know one way or the other,
10 though, right?

11 A. Well, I would say that there are
12 definitely jobs out there that do not require lifting
13 2-1/2 pounds that she would qualify for.

14 Q. And do any of those jobs that you named
15 require sitting for long periods of time?

16 A. Well, it depends. Perhaps. Perhaps you
17 could take frequent breaks.

18 Q. Do you know if any of those jobs require
19 looking up and down repetitively?

20 A. I would say it's unlikely they would.

21 Q. Are you aware that the defense expert,
22 Dr. Mann, has rendered the opinion that her cervical
23 facet fracture appears to him to have been caused by
24 the manipulation of October 21st, 2002?

1 A. I don't believe I'm familiar with his
2 report. I see the highlighted sentence here in the
3 report you've handed me, this appears to me to be
4 caused by the manipulation of October 21st, 2002.

5 Q. Do you agree that, based on the Metro
6 Health medical records, the doctors at that facility
7 attributed Kimberly Richley's neck fracture to the
8 cervical manipulation?

9 A. I see an encounter form from the
10 emergency department that says a 39-year old, status,
11 post-manipulation by report. In patient's
12 chiropractor's office yesterday with exquisite pain,
13 sharp, shooting down right arm.

14 Now, your question is am I aware they
15 attributed it to manipulation? I don't know that
16 would be an attribution, but there might be somewhere
17 else you want to point me in the record.

18 Q. Sure. Do you agree that the radiology
19 report for the CT states under "History": "C6-7
20 dislocation with numbness in upper extremities,
21 chiropractor dislocation"?

22 A. Do I agree that's what it says? Yes,
23 that's what it says. Do I agree that that means the
24 treating doctors have gone on record stating that they

1 believe that the chiropractic manipulation caused the
2 fracture? I don't think that that would....

3 Q. Well, are you aware that Dr. Likavec, the
4 neurosurgeon, has written a report in which his
5 opinion is that the chiropractic manipulation caused
6 the fracture and the condition he observed at the time
7 of surgery?

8 A. I'm aware of Dr. Likavec's report.

9 Q. Don't you agree that that's a reasonable
10 conclusion?

11 A. Well, I think I've given you my
12 conclusion, is that it's implausible that the
13 low-velocity forces involved in chiropractic
14 manipulation on this patient, either by the
15 plaintiff's description or Dr. Reichenbach's
16 description, would result in this type of fracture.
17 It's just not biologically plausible.

18 Q. What I'm asking you is: Do you think Dr.
19 Likavec's conclusion and Dr. Mann's conclusion that
20 the chiropractic manipulation caused Kimberly
21 Richley's facet fracture is an unreasonable
22 conclusion?

23 A. Yes, I think it's an unreasonable
24 conclusion.

1 Q. Even though you're not aware of any other
2 trauma that could have caused this facet fracture?

3 A. We've gone over that extensively and I
4 think I've offered my explanation, which I think is a
5 better explanation for her facet fracture.

6 Q. Do you know whether or not an EMG of
7 March 2nd, 2004, documented ongoing evidence of
8 chronic nerve damage in Kimberly Richley?

9 A. Well, I think that we're going back now
10 to precision orthopedics. I've never seen an EMG. I
11 think he references that there was an EMG done in his
12 report dated April 15th, 2004. And in that report, he
13 states an EMG was repeated on March 2nd, 2004, and she
14 had ongoing evidence of chronic nerve damage, but with
15 some recovery of nerves noted.

16 Now, taken at face value, that sentence
17 is not reasonable and is self-contradictory. What I
18 think he means to imply is that the EMG shows evidence
19 of a prior or a chronic nerve injury. To say it's
20 ongoing, I think he doesn't mean to imply that she has
21 ongoing nerve damage.

22 Q. You haven't even seen the results of the
23 EMG, correct?

24 A. No, I have not seen the results of this

1 particular EMG.

2 Q. So you're commenting on the results of
3 the EMG without even seeing it, right?

4 A. No. I think you have to give me a chance
5 to finish my answer here. Basically, this patient has
6 had an injury, and this EMG is being done well after
7 the injury is completed.

8 The sentence does not have internal
9 consistency. And I think that what he means to say is
10 not necessarily conveyed in the words he used.
11 Typically after a patient has had a nerve root injury
12 and you get an EMG, it won't be normal.

13 It will show evidence of the prior
14 injury, and we usually refer to that as a chronic
15 change that's related to a prior injury. What it
16 doesn't imply is that there's some kind of ongoing
17 injury to the nerve.

18 And the reason we know that's not the
19 case is because he goes on to say that the same EMG
20 shows some recovery of the nerves noted.

21 Now, an EMG can't show recovery of
22 nerves. What I think he's intending to mean there is
23 that there was an injury. The acute phase is over.
24 You don't see any acute phase changes on EMG. All you

1 see is chronic phase changes indicative of the prior
2 injury.

3 That would be found virtually in anybody.
4 I mean, if you had a ruptured disk and had a surgery
5 done and your EMG was positive, if you got an EMG ten
6 years later when this was all over with, you would see
7 this pattern of chronic phase changes consistent with
8 a prior injury. I think that's what he's referring
9 to.

10 Q. Have you reviewed any studies in the
11 medical literature on neurological sequelae from facet
12 fractures?

13 A. I mean, I've read extensively on facet
14 fractures.

15 Q. I'm asking you: Have you reviewed any
16 specific article that addresses the subject of
17 neurological sequelae from facet fractures?

18 A. The answer is I've read extensively on
19 facet fractures. I've read a number of articles and
20 reports and things over the course of my training and
21 career that have addressed neurological injury from
22 facet fractures.

23 Q. Would "The Journal of Neurosurgery" be a
24 good place to look for information on neurological

1 sequelae from facet fractures?

2 A. "The Journal of Neurosurgery" is just one
3 of many journals that has publications on that type of
4 topic. The publications, of course, range. Some
5 would be a higher grade of evidence than others.

6 Q. You've published in "Neurosurgery,"
7 correct?

8 A. I have.

9 Q. Do you consider it to be a quality
10 journal?

11 A. Well, I consider it to be a quality
12 journal. But please remember that quality journals
13 carry a variety of pieces of information.

14 And I'm sure you're well aware of the
15 fact that scientific reports can be Grade A evidence,
16 double-blind, randomized, controlled study; or it can
17 be Grade D evidence, which is anecdotal case reports.

18 So we don't claim that these journals are
19 authoritative references. They're simply reflections
20 of people's experiences.

21 Q. Well, have you found the articles in
22 "Neurosurgery" to be accurate and reliable?

23 A. I have found them to be reasonably
24 reliable. I can't say that's universally true, but

1 certainly the majority that I've read have been pretty
2 reasonable.

3 Q. What about "The Journal of Neurosurgery"?
4 You've published in that, correct?

5 A. I have.

6 Q. Have you found the articles in "The
7 Journal of Neurosurgery" to be accurate and reliable?

8 A. Well, when you say, "accurate and
9 reliable," you know, if somebody's reporting their
10 anecdotal case series, I mean, you know, there's no
11 way to say whether it's accurate and reliable.

12 It may be interesting reading. It may
13 resonate with something that you've seen or
14 experienced as a physician. It may offer a new way of
15 looking at an old problem or a new technique for
16 treating an old problem.

17 I think when you're asking me is it
18 reliable, you're implying that there's some scientific
19 presentation that I would agree to or sign off on, and
20 those types of articles are few and far between.

21 Those are the types of articles that are
22 double-blind, randomized, and set standards of care,
23 you know, because the evidence is irrefutable. Those
24 types of articles appear only rarely in our

1 discipline.

2 Q. You have never conducted a study on the
3 neurological sequelae from facet fractures, correct?

4 A. How would you study it? Go and fracture
5 a --

6 Q. Have you ever written a paper on that?

7 A. No. I think we started off by reviewing
8 my CV and whether any of the publications directly
9 impacted the issues, and I didn't believe it did.

10 Q. Have you ever been involved in a study
11 where doctors are studying the neurological sequelae
12 from facet fractures?

13 A. I don't know what you mean by your
14 question, but I think that'd be an awfully hard thing
15 to study. But, again, we've gone over my CV and I
16 don't claim to have published or been involved in
17 research that has to do with specific topic.

18 Q. Based upon your experience, have you
19 found the articles in "The Journal of Neurosurgery" to
20 be accurate and reliable?

21 MR. REGNIER: Objection. Asked
22 and answered.

23 MR. RUF: He's given me circular
24 answers. It's a simple question.

1 BY MR. RUF:

2 Q. Have you found it to be accurate and
3 reliable or not?

4 MR. REGNIER: Objection. Asked
5 and answered.

6 THE WITNESS: It's not a simple
7 answer and it's not a binary answer.
8 It's not a yes/no answer. The articles
9 that appear in "The Journal of
10 Neurosurgery," as in any scientific
11 journal, are articles that range from
12 anecdotal reports, single-case reports,
13 all the way up to double-blind,
14 randomized trials.

15 And "accurate and reliable"
16 would be terminology that I would apply
17 to a double-blind, randomized trial. It
18 would not be something that I would apply
19 to a report in the literature of
20 somebody's experience with ten facet
21 fractures or something.

22 BY MR. RUF:

23 Q. How about "The Journal of Spine"? Are
24 you familiar with that journal?

1 A. Same answer.

2 Q. Have you read it?

3 A. "The Journal of Spine"?

4 Q. Yes.

5 A. I'm familiar with it and I have read it.

6 Q. What journals do you subscribe to?

7 A. "The Journal of Neurosurgery",
8 "Neurosurgery", "The Journal of Spine", "Surgical
9 Neurology." That pretty much covers the ones that I
10 read.

11 Q. And you subscribe to those journals to
12 stay current on the medical literature and what's
13 going on in medicine?

14 A. Not really. They come automatically with
15 my membership in the society. I think that, you know,
16 reading the journals does, you know, keep you informed
17 as to what other people's experiences are and what
18 issues are being, you know, highly contested amongst
19 the people who have expertise in one area of
20 neurosurgery or another.

21 And I think that's pretty much why I read
22 them. But I don't necessarily subscribe to them so
23 that I remain current in my field. There are many
24 ways in which one does that.

1 Q. Would you agree that there's articles in
2 medical literature that document permanent nerve
3 damage as a result of the facet fracture?

4 MR. REGNIER: Objection.

5 THE WITNESS: Well, you can have
6 permanent nerve damage as a result of
7 many things, ruptured disks, facet
8 fractures, et cetera, that wouldn't
9 surprise me at all.

10 I don't know of such an article,
11 but it would be one of those things that
12 you would certainly find if you searched
13 the literature, I'm sure.

14 BY MR. RUF:

15 Q. How much time would have to pass before
16 you would be willing to say that Kimberly Richley's
17 condition is permanent?

18 A. Well, you know, I think if you're talking
19 about healing the bone, six months. A nerve
20 regeneration takes place, like we said, 9 to 12
21 months.

22 When you're talking about this sort of
23 vast -- and in my mind, implausible -- pain disorder,
24 I think that's something that would be -- wouldn't

1 have any time limits. I just wouldn't want to bracket
2 that and say it's permanent after some point in time.

3 Q. Do you know what Kimberly Richley's pain
4 in her neck is from?

5 A. Well, as I said earlier in the
6 deposition, I do hundreds of fusions. And those
7 patients with single-level fusion -- I mean, people
8 are born with congenital fusion. They don't complain
9 of loss of motion in their neck.

10 People with congenital fusions don't even
11 know they have them until somebody gets an x-ray. So
12 single-level fusions, they don't tend to complain too
13 much of loss of motion in the neck.

14 They may complain of a stiff, achy
15 sensation, and it may get aggravated when they're
16 particularly active. Those types of complaints are
17 kind of routine.

18 The kind of complaints she's offering is
19 so extraordinary, it would be hard to say what they're
20 due to. But what you could say with some reliability
21 is that they don't reflect the typical patient with
22 the injuries that she's sustained.

23 Q. You have not examined her, have you?

24 A. I think we've gone over that.

1 Q. Have you heard of Dr. Likavec?

2 A. No, I haven't.

3 Q. Do you ever keep personal notes on a
4 patient outside of the patient file?

5 A. Do I?

6 Q. Yes.

7 A. Not that I'm aware of.

8 Q. That's not something you've ever done in
9 your practice?

10 A. No.

11 Q. Have you ever referred a patient for
12 chiropractic treatment for carpal tunnel syndrome?

13 A. I can't imagine that I would refer a
14 patient for chiropractic treatment for carpal tunnel
15 syndrome.

16 Q. Why not?

17 A. Well, because I think there's better
18 treatments for carpal tunnel syndrome.

19 Q. Would you agree there's no proven benefit
20 for manipulating the neck for carpal tunnel syndrome?

21 MR. REGNIER: Objection.

22 THE WITNESS: There's no benefit
23 for manipulating the neck for carpal
24 tunnel syndrome?

1 BY MR. RUF:

2 Q. No proven method.

3 A. None that I'm aware of.

4 Q. Are you aware of any proven benefit for
5 manipulating the neck for a sprain/strain?

6 MR. REGNIER: For what?

7 THE WITNESS: Sprain/strain of
8 the neck?

9 BY MR. RUF:

10 Q. Yes.

11 A. Well, you know, obviously, that's
12 probably the most common diagnosis supporting
13 treatment, including chiropractic treatment. I mean,
14 I'm sure that that would be perhaps the most common
15 reason to manipulate the neck.

16 Q. You're saying perhaps. You don't know?

17 A. Well, let me put it this way: I used to
18 chair the quality assurance committee at Workers' Comp
19 in Columbus, and we would do all types of
20 comprehensive reviews.

21 And I think, of allowed conditions in
22 Workers' Comp systems, sprain/strain was always ranked
23 among the highest. And virtually, I'd say 50 percent
24 or more of those patients would have been treated at

1 some point in their course with manipulation therapy.

2 Q. Doctor, have you ever referred one of
3 your patients to a chiropractor for manipulation for a
4 cervical strain/sprain?

5 A. Well, I don't use that word. To me,
6 that's not a diagnosis I would make. But, yes, there
7 are certainly patients in my practice who come to me
8 with that diagnosis, oftentimes in the Workers' Comp
9 system.

10 I don't find anything surgically curable.
11 I give them a range of options. If they choose
12 chiropractic treatment and they haven't got an
13 established relationship and wanted a referral, I'm
14 happy to offer one.

15 Q. Are you aware of any proven benefit to
16 cervical manipulation for a wrist strain/sprain?

17 A. No. I have never heard of that.

18 Q. If a manipulation has no proven benefit,
19 is that something that should be explained to a
20 patient before it's done?

21 MR. REGNIER: Objection.

22 THE WITNESS: Well, if you're
23 saying that a manipulation has no proven
24 benefit, the patient should be informed

1 of that.

2 I guess my only question is:
3 What would be a proven benefit? For
4 example, is manipulation proven to cure
5 anything? I don't know.

6 I guess if you're suggesting
7 that you're using manipulation for some
8 indication which would be unrecognizable
9 to your chiropractic peers, that might be
10 something you want to discuss with your
11 patient.

12 But I would say that if you
13 demanded double-blind, randomized,
14 absolute proof before you did
15 manipulation, there probably would be
16 very little in chiropractics that you
17 could do without sitting down and telling
18 your patient that it hasn't been proven
19 by a double-blind, randomized scientific
20 trial.

21 BY MR. RUF:

22 Q. Have you done any research for this case?

23 A. No.

24 Q. Doctor, would you agree, bottom line,

1 it's unacceptable to break a patient's neck due to any
2 type of medical treatment?

3 MR. REGNIER: Objection. Go
4 ahead.

5 THE WITNESS: I guess it would
6 be unacceptable to break a patient's
7 neck.

8 BY MR. RUF:

9 Q. I mean, that's not something you want to
10 do, right?

11 A. That's correct.

12 MR. RUF: Why don't we finish on
13 that note.

14 MR. REGNIER: Do you want to
15 review it?

16 THE WITNESS: I'll review it.

17 (Deposition concluded and
18 witness excused at 6:50 p.m.)

19 (Signature reserved.)

20 - - -

21

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23

24

SIGNATURE PAGE

Date of Deposition: September 24, 2004

Correction page(s) enclosed? Yes___ No___

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PATRICK W. McCORMICK, M.D. Date

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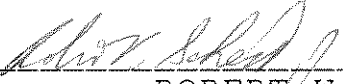
1
2 I, Robert W. Scheid, Jr., a Notary Public
3 in and for the State of Ohio, duly commissioned and
4 qualified, do hereby certify that the within-named
5 witness was by me first duly sworn to tell the truth,
6 the whole truth, and nothing but the truth in the
7 cause aforesaid; that the testimony then given was by
8 me reduced to stenotype in the presence of said
9 witness and afterwards transcribed; that the foregoing
10 is a true and correct transcription of the testimony
11 so given as aforesaid.

12 I do further certify that this deposition was
13 taken at the time and place in the foregoing caption
14 specified.

15 I do further certify that I am not a
16 relative, employee of or attorney for any of the
17 parties in this action; that I am not a relative or
18 employee of an attorney of any of the parties in this
19 action; that I am not financially interested in this
20 action, nor am I or the court reporting firm with
21 which I am affiliated under a contract as defined in
22 the applicable civil rule.

23
24

1
2 IN WITNESS WHEREOF, I have hereunto set
3 my hand and affixed my seal of office at Toledo, Ohio
4 on this 12th day of October, 2004.

5
6 
7 ROBERT W. SCHEID, JR.
8 Notary Public
9 in and for the State of Ohio

10 My Commission expires May 29, 2008.
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