THE STATE of OHIO,)
COUNTY of CUYAHOGA.) SS:

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IN THE COURT OF COMMON PLEAS

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JAMES YARBROUGH, et al.,)
plaintiffs,)
vs.) Case No.
) 356193
MAX QUINTON, et al.,)
defendants.)

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Videotaped deposition of JOHN G. OAS, M.D., a witness herein, called by the plaintiffs as if upon direct examination, and taken before David J. Collier, RPR, Notary Public within and for the State of Ohio, pursuant to agreement of counsel and pursuant to the further stipulations of counsel herein contained, on Tuesday, the 11th day of June, 2002 at 2:31 p.m., at the Cleveland Clinic Foundation, 9500 Euclid Avenue, City of Cleveland, County of Cuyahoga and the State of Ohio.

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I N D E X

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INDEX OF OBJECTIONS

- - - - -

BY MR. JEPPE:	PAGE/LINE	PAGE/LINE
	5/3	52/9
	31/14	52/15
	32/9	52/17
	33/6	55/13
	33/13	56/8
	45/18	56/24
	47/14	58/1
	47/18	62/3
	50/16	119/5

BY MR. SIGMIER:	PAGE/LINE
	33/5
	45/16
	46/10

BY MR. MESTER:	PAGE/LINE
	90/17

P R O C E E D I N G S

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MR. MESTER: Just a couple formalities, same formalities we've had for the other depositions. I assume that you guys will waive the one day filing requirement of the transcript?

MR. SIGMIER: Yes.

MR. JEPPE: Yes.

MR. MESTER: And it's okay that the videotape is just brought to court and played rather than filed with the court?

MR. SIGMIER: Yes.

MR. JEPPE: Yes.

MR. MESTER: And we'll stipulate, of course, to the qualifications of the officers we have today?

MR. SIGMIER: Yes.

MR. JEPPE: Yes.

MR. MESTER: And waive any defects in the notice of the deposition? I know that this was changed around a little bit so you could have Dr. Oas' discovery deposition last week.

MR. SIGMIER: That's right. No

objection.

MR. JEPPE: Yes.

MR. SIGMIER: I do want to note a potential objection on the record. When we were here the last time, the doctor had some medical records which he hadn't reviewed yet, and it's -- my sense was that he was going to be reviewing them and perhaps offering some new opinions today that weren't expressed in his report dated May 25th, 2001. And so to the extent that he has any new opinions, I'm going to object to those.

MR. MESTER: I don't think there will be any new opinions.

MR. JEPPE: I'll join in that also, and if there is, I think maybe a motion in limine might be in order or a remedy with the Court somehow before the trial.

MR. MESTER: And again I would just say that of course I reviewed that deposition and I don't think there will be any new opinions. He was perhaps asked one question about those records and he said he hadn't had a chance to fully review them and I don't think any of his opinions will be

changed here today.

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JOHN G. OAS, M.D.

being first duly sworn, as hereinafter certified, was examined and testified as follows:

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DIRECT EXAMINATION

BY MR. MESTER:

Q Okay. Doctor, would you state your name for the record, please.

A John G. Oas, M.D.

Q Okay. And we're coming -- taking your deposition here today at the Cleveland Clinic Foundation?

A That is correct.

Q Okay. And, Doctor, what kind of doctor are you?

A An otoneurologist. That's a neurologist with special additional training in disorders of the ear and vestibular system.

Q Okay. And where do you practice?

A Here at the Cleveland Clinic Foundation, exclusively.

Q Okay. Now, with regard to your -- you

have a specialty within the field of neurology?
A Yes, that's true
Q Okay Could you just explain in a little bit more detail for the jury exactly what -- I think you said the vestibular system, what that entails?
A Ae An otoneurologist is someone who is an expert in the vestibular system, which is our sense of balance, from the sensory organ, the ear, to the parts of the brain that help take that information that the ear supplies and make sense of up and down and side to side, how fast we're moving, and keep our vision clear and keep us from falling
Q Okay And, doctor, as part of that specialty, do you have a -- a specific and specialized knowledge in areas of the spine?
A Only as much as it relates to a specific diagnosis called cervicogenic dizziness, that is -- specifically means that the neck itself and only a particular part of the next can generate a source of dizziness, which is a symptom of abnormality or pathology in the -- in the vestibular system.

Q Okay. I think we may have a model there of the spine at your disposal.

A Yes.

Q Could you just show the jury with respect to the spine which portions you really focus your practice on and in what fashion?

A The vestibular system concentrates on the upper cervical spine, because the spine below C3 is all essentially the part of the spine that most of us know about with disk spaces filled with a disk material, this is when you have a slipped disk, so to speak, it's happening in this area of the spine. In the upper area of the spine, C1, C2, it's specifically left by nature to be much more mobile, to be able to move in essentially six degrees of freedom, so that we can walk like an ostrich and keep our head level to the ground; we can also turn our head without even using the lower part of our spine, and that's of critical importance because this kind of freedom and movement is what the inner ear and neck muscles and neck muscle feedback to where your head actually is is

important for the basic science understanding of how these areas of the neck and the muscles that hold things together here can actually cause dizziness, if there's an abnormality in the way these muscles and vertebrae work.

Q Okay. Thank you, Doctor.

Moving on, can you tell the jury a little bit about your educational background beginning with college?

A In college I studied aerospace engineering and specifically the space part of aerospace engineering. It was in the 1970's and space was an interesting thing, plus it was a great premedical training in terms of systems engineering, how systems work together in control systems, much like the vestibular system does; and it did involve several years of training, both for premed and completing engineering studies as well as a internship-like experience at NASA Johnson Space Center in Houston with space medicine as a focus and the engineering of designing experiments and performing experiments and designing equipment for human

being research and treatment in space

Q Okay And where did you receive your medical degree?

A From the University of Texas Medical Branch, which is right next door to NASA Johnson Space Center, because NASA is in the southern part of Houston, about 25 miles away is Galveston island

Q Okay And is that why you chose that area, because of the NASA connection?

A So that I could continue my work at NASA while I was still going to medical school, yes

Q All right Can you tell the jury, Doctor, a little bit about your post-doctoral training?

A After medicine you're required to do several years of training in hospitals and clinics to gain a specialty certification, mine being neurology I chose to do that again in Galveston Prior to beginning a neurology residency I was required to do a year of internal medicine, so I left to go to Boston for a year to get away from the hurricanes and hot weather of Galveston.

Q Okay.
A And then after completing my neurology training, when I became Board eligible for neurology, I chose to take two more years of training post-residency at UCLA Medical Center in neurootology, as it was called then, which is my subspecialty of neurology.
Q Okay. Thank you, Doctor.
Doctor, are you Board certified in any specialty within the medical field?
A Yes, neurology.
Q Okay. And how long have you been Board certified, Doctor?
A Since 1994.
Q All right. Doctor, a basic question, are you licensed to practice medicine in the State of Ohio?
A Yes, I am.
Q And how long have you been so licensed?
A Since 1998.
Q All right. Doctor, are you currently involved in the teaching of medicine at all?
A Yes, I am.
Q Can you tell the jury a little bit about that?

A I teach ENT residents, medical students from OSU and Case Western Reserve University, and neurology residents in the practice of dizziness, otoneurology.

Q Okay. Now, Doctor, I have a copy of your CV here. You have -- am I correct that you've been published several times over the years in this field?

A That's correct.

Q Okay. And have you been published in this area of otoneurology?

A Yes, I have.

Q Okay. How many publications have you had, Doctor?

A Oh, roughly about 24, I think.

Q All right. And what about research projects, have you engaged in any research projects over the years in this field?

A 1 have been in academic medicine my entire practicing life, so every year I'm doing research, including research more recently with NASA again on the influence of gravity on astronauts and the influence of gravity-sensing organs on my patients.

Q That's something you're doing at the

current time?
A That is correct.
Q Okay. I asked you earlier about teaching. Before you came to the Cleveland area, did you do any teaching in any other places?
A Yes, I was an instructor of neurology and otology at Harvard Medical School in Boston from 1992 to 1997, where I had a similar job, to instruct residents in neurology and otolaryngology as well as medical students at Harvard Medical School in the same discipline.
Q Okay. Doctor, now, before we get into the specifics of James Yarbrough, just a few more clean-up questions.
Doctor, there is a cost for your time here today for the deposition, correct?
A That is correct.
Q How much of that are you receiving?
A None.
Q And why is that?
A The Cleveland Clinic has a policy that all of its physicians that testify do so and the monies garnished from that go back to pay

the Cleveland Clinic for the basic facilities here. None of it is personally awarded to the physicians.

Q Okay. Thank you, Doctor.

Now, Doctor, I'm going to ask you some questions about James Yarbrough, and in the course of my examination some of those questions will be questions about your opinions with regard to his condition, and I'd like if you would today to limit all of your opinions to those you hold to a reasonable degree of medical probability, okay, Doctor?

A Yes.

Q Great.

Okay. Let's go ahead then and talk about James Yarbrough. I know you had a chance to see him on numerous occasions. In addition to your visits, did you have a chance to review numerous other medical records?

A Yes, I have been furnished medical records that were not available to me at the time of my opinions from 12-3-99 until the last time I saw him on 11-10-2000. These

records, you saw Mr. Yarbrough again, I believe, on January 28th of 2000?
A Yes.
Q Okay. And why -- why did you see him on that day?
A Let's see if it's -- I saw him on that day because I had to essentially discuss the fluoroscopy of the cervical spine.
Q Okay. And before we talk about that, what is a fluoroscopy, Doctor?
A It's literally a movie of how bones move, so that you shoot the x-ray at the bone you want to see how it moves and then move the joints and see how they move as a movie and -- so that the radiologist and myself, who is present for the study, can watch how the movement of the neck is and compare that with what we'd expect for a normal neck to do.
Q Okay. Doctor, do you know from your recollection or from your notes why the fluoroscopy was done?
A Because Frank Gargano called me and said this is a -- this is a neck that I don't feel safe proceeding with unless I know what's

happening, that he with his hands found an inordinate -- inordinate amount of movement in the spine that he would not anticipate. In trying to get at fixing a patient, he's trying to eliminate any chance of him not being able to fix it, and he felt that this spine was unstable in the way he feels unstability is, not in a medical term but basically he didn't like the way the neck felt when he was working it.

Q So if I understand what you re saying, if the neck has a certain degree of instability, Mr. Gargano essentially would not be able to heal him through rehabilitation; is that correct?

A Well, no. He wouldn't want to proceed without knowing ahead of time that he's not going to get into trouble. He is not a chiropractor --

Q Okay.

A -- but he still needs to have some explanation to -- before he begins to do his work.

MR. MESTER: Okay. Let's go off the record for a second.

(Discussion had off the record.)

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BY MR. MESTER:

Q Okay. Doctor, I've gone ahead then and put the fluoroscopy films from January of 2000 up for you. Could you explain to the jury what you saw?

A Okay. These are actually shots that are still shots. What we're doing between this shot and that shot is having him move his head from as far back as he can put it to as far forward as he can put it, much like the model will show, to demonstrate this.

So in this view, for instance, he's trying to tip his head back as far as he can, and the reason for doing this is to see what happens to the way in which these bones move in conjunction with each other, because it's how lax or how much these can move back and forth that the film is trying to pick up.

So basically we -- we say, okay, James, bend back as far as you can, and he can't bend back as far as the model because this is not human, and then he comes to neutral, and then he goes as far forward as

he can. and we're jud ging on the basis of what's happening in here and what's happening as far as how these particular line up

Now, this is where my expertise stops and the radiologist who is present is -- their job is to measure what happens, because it -- you know, to a neurologist, we don't have the eye to pick that up

Q Okay.

A But nonetheless I was there making certain that he was doing appropriate flexion/extension, because that's what Frank wanted me to see, how unstable he was in that movement

Q And what did the radiologist find with respect to these films?

A I'm going to quote from the radiological report of January 25th, 2000 by Mr Bradford Richmond

The fluoroscopy was projected for Mr Bas to have the patient go through a range of flexion and extension, lateral rotation, lateral bending motions, demonstrating approximately two millimeters

of posterior subluxation. That means that the vertebrae moved backwards on top of each other. And it's impossible to demonstrate this on the model because the model is too rigid. It's not up here where it's happening, that would be called retrolisthesis or -- retro, this would be antero. So that's the radiologist's terms. So that would move back -- I'm trying to see -- C3 over C4. And on the pictures over here --

Q Hang on one second, Doctor.

A This is the best one to demonstrate the --

Q Yeah, why don't we get that and then I'm going to ask you if you would to point out for the jury exactly where the subluxation is on those films.

A Right. I will.

This is C1, C2. These are the two parts of the spine that are the most important for dizziness, okay? This is C3, 4, 5, 6 and 7.

Q Okay.

A The radiologist found that 2 -- excuse

me, 3, that's 1, 2, 3, was moving backward on 4. That was in the reduction in movement result of stabilization at that level. Let me see. "Which is limited with manipulation of the C3 spinous process and reduced in motion as a result of stabilization." That means we put our hands in there and have them stabilize it and -- to see if we could reduce that. Frank was with me at the time, the physical therapist.

Q Okay.

A Additionally, there was two millimeters of C4, that's the next v rtebrae down, on relationship to this vertebrae, again, moving backward this way two millimeters, so that would be a total of four, which was also stabilized at approximately one millimeters posterior subluxation.

Q Okay. Thank you, Doctor.

MR. MESTER: Let's go off the record for a second.

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(Discussion had off the record.)

BY MR. MESTER:

Q Okay. Doctor, just a couple of

questions then about those films.

What is -- what is the significance of the subluxation finding on these films?

A Quite simply put, it means he's got a spine that tends to move in ways it was not designed to move, which indicates that it -- that the usual elements that keep the spine together are looser. The only way to get looser in that area is to either lose disk material or to stretch the ligaments that hold the spine together.

Q Okay. Now, is there a point, Doctor, with regard to subluxation, a measurement, where the patient is rushed to surgery?

A Absolutely. Over 3 to 4 millimeters of subluxation or any subluxation of C1 and C2 are considered un -- in -- unstable spines and are required to be essentially put in a rigid head brace awaiting neurosurgery. It's not necessarily an emergency, but they have to be put in a rigid brace. This is why every car accident the patient is basically immobilized until it can be proven that there's not instability in C1 and C2, because if either of those two are unstable, a simple

flexion of the neck will result in total paralysis and even death.

Q Okay. So Mr. Yarbrough wasn't quite at that stage of 3 to 4 millimeters, he was at 2 millimeters, correct?

A He was at 2 millimeters, which would be called moderate.

Q Okay.

A Not severe, requiring stabilization to prevent death.

Q That is an abnormal finding though, Doctor?

A Yes, it is.

Q Okay.

A Clearly abnormal.

Q Okay. Now, Doctor, about subluxation, does -- based upon your experience, education and background, does a subluxation in general -- can it be caused from trauma?

A Subluxations, as I stated before, can either result from losses of material that spread the spine apart called the -- the intervertebral disks, or from a lengthening of the ligaments that are normally designed in size naturally as our spine grows to be

correct to hold things together. The trauma would be able to clearly show whether or not there was any disk loss, and there wasn't, so the only thing we're left with is a stretching of the ligaments.

Q Okay. And does that occur then from trauma?

A Absolutely. Especially in terms of, at least how he tells me he was -- his first -- his accident of July 30th, 1999, where he was seatbelted and had a forward/backward movement of his head, which is commonly called whiplash, and that can lengthen ligaments that are normally the correct size.

Q Okay. Now, Doctor, based upon all the records that you have reviewed of Mr. Yarbrough's condition, and based upon the films you have seen, and based upon your education and training, was the subrogation -- subluxation, excuse me, that we're seeing on these cervical spine films caused by these motor vehicle accidents?

A The problem with answering that question is at the time, 12-3-99, I had no prior knowledge of what had happened to him or what

symptoms he had had prior to the second accident, and only after reviewing and pointed out by other sources that it came to my knowledge that he had symptoms of both pain and dizziness prior to the second accident Inasmuch as what I knew at the time after his second accident, it would be impossible for me to tell how much was only two, but I assume it was number two at the time of my consultation because I had no prior knowledge of symptoms after --

Q Okay.

A -- accident number one

MR JEPPS: Objection. I ask the answer be stricken and the question.

Q Okay Let me ask -- let me ask it this way, Doctor

A Okay

Q Have you seen any records to indicate that Mr Yarbrough was having any difficulties with his cervical spine prior to the first accident in March of 1994?

A Yes.

Q Have you seen -- you've seen records that he was having problems with his cervical

spine?
A Prior to 1997?
Q Correct.
A No. No.
Q Okay. And based upon that, Doctor, do you have an opinion whether the accident of 1997 was a cause of the subluxation that he has on his cervical spine?
MR. JEPPE: Objection.
A The accident, as I now know it and understand it to be in 1997, would result in the same kind of whiplash or traumatic lengthening of the spinal ligaments to cause the subluxations noted by January 25th of 2000.
Q Okay. Let me ask it this way, Doctor. Based upon everything you've reviewed in this case, do you have any reason to believe that the subluxation that you've seen in these films existed prior to the first accident of March, 1997?
A No, I have no evidence to support that contention.
Q All right. So based upon that, Doctor, do you have an opinion of whether that first

accident and the second accident together, I guess, were the causes of this subluxation that we're seeing on these cervical spine films?

MR. SIGMIER: Objection.

MR. JEPPE: Objection.

A It's reasonable to conclude that accidents of the type of number 1 and number 2 would cause a subluxation.

Q Okay. And that's your opinion to a reasonable degree of medical probability, I take it?

MR. JEPPE: Objection.

A Yes.

Q Okay. Thank you, Doctor.

Okay. Now, what was your recommendation then, based upon your films -- again going back to the January visit, what was your recommendation for Jim at that point in time?

A That we refrain from any further neck physiotherapy with Frank Gargano until I could have a neurosurgeon look at the instability of his spine and make recommendations regarding the safety to

proceed.
Q Okay. And was he looked at by a neurosurgeon?
A Yes, he was.
Q And --
A Edward Benzel.
Q Okay. Dr. Benzel is here at the Cleveland Clinic as well?
A Yes. He's specifically a spinal neurosurgeon whose specialty is in biomechanical abnormalities and treatments to the spine in any location.
Q Okay. And based upon -- did Dr. Benzel report back to you in the chart, I assume?
A That is correct.
Q And what did -- what was Dr. Benzel's view in terms of surgery?
A He did not feel and mentioned to me in the hallway and certainly talked to my patient that any spinal surgery he would do would do anything to help his headaches or dizziness, but that the instabilities noted as subluxations on the fluoroscopy could be amenable to either one or -- a nonsurgical or surgical method, and being the conservative

surgeon he was, he wanted to try a nonsurgical approach, which was more physiotherapy, and then decide at the end of a conservative approach whether or not spinal fixation surgery as he identified would be done.

He was very, how can I say it, cautious to suggest the degree and extent of spinal fixation surgery was quite involved and therefore would have risks involved in terms of chronic pain, to the point that the patient really decided after seeing the surgeon that he did not want a surgical option at all at that point.

Q Okay. Now, what -- if I could have you maybe on the model just explain to the jury, if the surgical option were followed as indicated by Dr. Benzel, what exactly would we be talking about here?

A I'm going to give you --

Q I think you mentioned a cervical fixation surgery?

A Right. A fixation surgery, and I'm turning to the March 13, 2000 letter to me from Dr. Benzel --

Q All right.
A -- would involve, as he said, a fusion operation from C4 to C7, that is from this vertebrae -- one, two, three, this vertebrae, 5, 6, 7, there would be essentially a fusion of all four of these vertebrae together as a single unit.
Q Okay. Can the jury see that? Okay.
A Okay? And the way he does that is a -- various and sundry ways. The old style way is to put bone across these areas. The new style is to put hardware that is screwed in at these different levels and the spinal height is adjusted so that there is no chance of subluxation and yet you can -- you can essentially rebuild the spine structure using this hardware and technology.
Q Okay. And how would that type of procedure benefit Jim?
A It would stabilize the subluxation so that Frank Gargano could start working on the spine above those levels of fusion to see if we could reduce his headache and dizziness at that point.
Q Okay. Doctor, I think you had a chance

to see Mr Yarbrough again, if my records are correct, in April of 2000?
A That is correct We decided to go ahead with the kind of physiotherapy that Dr Denzel was more familiar with here at the Cleveland Clinic Foundation with Michelle Fornadel, and she's a much more conservative and less trained in the upper cervical spine. Because he wanted to stabilize the lower cervical spine, and therefore I concentrated to have Michelle see him.
Q Okay.
A And she began treatment after Dr Denzel -- actually before and after, to work closely with the team to do what she could do I believe her first visit to see him was on 4-10 Was that the first time? I'm pretty sure that was her first visit -- no. 3-24-2000 was the first visit; 3-31 was her second visit; the t ird visit she had with Mr Yarbrough was on 4-10-2000
Q Okay And that's the way that you saw him as well?
A I was requested by a page from Michelle Fornadel that her patient was suicidal and

she was frightened by his report of his suicidal -- at which point I said immediately transport him to me for me to see the patient, and discuss with the patient what we were going to do. It's there where I took a history and literally fit him into my schedule that day because I was concerned about his ability to act on his suicidal thoughts.

Q Okay. And did you examine him then on that day?

A Yes, but to a minimal degree, just to convince me that there was enough to justif a stat consultation with my psychiatry colleagues to see him in my clinic room, they came over from the psychiatry hospital to evaluate him for possible admission or triage him back to home for follow-up as an outpatient.

Q Okay. Now, based upon the presentation he gave you on that day, did you make any additional impressions regarding his condition?

A Yes. There were two things. In formulating my suspicion of why he was

suicidal, I suspected that he might have what we call posttraumatic stress disorder, which was confirmed by my colleagues in psychiatry on that day. So my formulated impression was on the basis of consultation with psychiatry that it was an adjustment disorder with depressed mood and there was a posttraumatic stress disorder which was complicating his physical therapy.

Q Okay. Doctor, just briefly could you explain to the jury what posttraumatic stress disorder is?

A Posttraumatic stress disorder is going on right now in the -- those who suffered near-death experiences in September 11th in New York and elsewhere, it's a sense that you're on the verge of dying and preparing to die physically and are convinced of the possibility that you may die. It is a very physical condition and it's hard to remove from your memory of the actual threat to you, whether or not it is actually justified.

In other words, people who walk away from near-death experiences have this disorder; people who don't walk away don't

have this disorder because they're dead; and people don't -- who don't come close to a near-death experience can't have a posttraumatic stress disorder at all.

Q Okay.

A It's a very specific -- tied to a specific event where the patient, not those who observe the patient, the patient decides for whatever reason that he is close to death.

Q Okay. Okay. And based upon the histories you took from Mr. Yarbrough about his accidents, again, based upon your experience, are those the type of accidents that can provoke a posttraumatic stress disorder?

A Usually not, but again, it's from the perspective of the patient. If the patient thinks in an accident he's going to die, you know, that's their perspective, and it could be a bumper bump --

Q Okay.

A -- and you could still feel that way.

Q All right.

A So it doesn't -- how can I say it? Any

accident can create a posttraumatic stress disorder and it all depends on what the patient is feeling while pinned or the patient is feeling in the car while they're waiting for the EMS to arrive.

Q Okay. And, Doctor, what were your recommendations then, again, for Jim on April 10th of 2000?

A I was convinced that without a combined approach using psychology and physical therapy, that his prognosis for improvement during this physical therapy was very grim, that he could not do it alone with Michelle. He went back to Michelle to discuss that with her one more time and was actually -- to Michelle, she did not want to proceed either, called me on that day, unless Mr. Yarbrough committed to the co-treatment with cognitive behavioral therapy with Dr. Bea here at the Clinic.

Q Okay. Dr. Bea is -- is in the psychiatry department?

A Yes. He's a licensed psychologist who deals with posttraumatic stress disorder and the cognitive behavioral therapy of that, not

medication.
Q Okay. All right. So, Doctor, is it fair to say at this point that your -- your view in terms of his treatment needs was that it was broadened, he was going to need psychiatric intervention as well?
A And that's why I say I will be following his progress in both cognitive and disability rehab, expecting both would occur concurrently.
Q Okay. Thank you, Doctor.
Doctor, let's go ahead then to what I believe was your final visit with Mr. Yarbrough in November of 2000, if you have that note in front of you.
A Yes, I do.
Q Why did Mr. Yarbrough return to you on that day?
A Because he still wasn't getting any better. It was his last check with me about what he should do and we revisited all of his options at that time.
Q All right.
A And the key was he wanted to be told what was in -- what was ahead for him. He

had expected to be better by this time and clearly wasn't, by his own self-report and he wanted to know what he was facing in terms of where he's going to go from there.

I also had information between the 4-10 and 11-10-2000 visits of a thing called a functional capacity evaluation where they did not feel that he could return to work as he knew it before, and we had to address where do we go from here in that regard.

He was starting to show us that he wasn't getting any better and he was not interested in -- in things that we had wanted him to do, and he basically came back and wanted to talk turkey with me about what -- what could happen in his future.

Q Okay. Doctor, let me just ask you a few questions about some of that and that visit.

I notice in your note there's a reference to a Horner's sign.

A Yes.

Q Could you explain what that is to the jury, please?

A Horner's sign is where a pupil changes. Instead of -- a bit like going to the eye

doctor and having your pupil dilated, in that Horner's sign, which is a pupilary change -- it's really more than just pupil, it's also a lack of sweating and temperature on one side of the face, and it's usually a sign of a thoracic root, T1 usually -- T1 usually, that is being entrapped by a spinal element, if and only if it can be produced by moving those spinal elements, as Frank Gargano clearly demonstrated. And pointing that out basically told us that without further spine stabilization, that he should expect one of his symptoms, which was blurriness in his eye.

Q Okay. So the blurriness in his eye that Mr. Yarbrough was complaining of, Doctor, is that consistent with the Horner's sign?

A Yes.

Q Okay.

A I was not willing to provoke it because I didn't feel comfortable doing it.

Q Okay. Okay. Now, Doctor, you also mentioned the functional capacity exam --

A Yes.

Q -- that was done.

A Urn-hum.
Q And were you the one that ordered that, Doctor?
A I was requested to order that to try to certify or quantitize what he could and could not do physically at that point.
Q Okay.
A And I am not capable of doing one of these reports and so I tasked the Cleveland Clinic physical therapy department to do that and they did on 7-26-01.
Q All right. And as I read that note, the indication, I believe, says "Difficult for patient to hold any job being on his feet secondary to his balance issue"?
MR. SIGMIER: Objection. Leading.
MR. JEPPE: Objection.
Q Am I reading that correctly?
MR. SIGMIER: Leading.
Q Did I read that document correctly, Doctor?
A It says intolerance -- well, "Based on the information gathered, it would seem difficult for this patient to hold any job

that involved him being on his feet secondary to his balance issues."

Q Now, let me ask it again, Doctor, just to make sure that we've got it properly in the record.

Doctor, that record that you have in front of you, the functional capacity exam, can you tell me what the findings were?

A Basically --

MR. SIGMIER: Objection.

A -- he could not tolerate prolonged standing, sitting, walking because he report -- reported a sense of imbalance and a fear of falling.

Q Okay. And did that exam make any statements with respect to whether the patient would be able to hold an occupation as a result of that?

A Yes. It said that based on what they found during the examination, the amount of fear, dizziness, imbalance and pain behaviors would suggest that it would do harm to him to do the kinds of testing -- the kinds of things with his body that the testing was trying to see how much he could tolerate.

Q Okay. And would that make it difficult then, Doctor, for him to do his job as an auto mechanic?

A In terms of falling --

Q Yes.

A -- and harming himself or others as a consequence, absolutely

Q Okay

A The other thing is the heavy exertion that oftentimes mechanics have to do overhead in front of increasing clearly in the functional evaluation.

Q Okay

MR JAMES: Objection. Ask it to be stricken.

Q And, doctor, are you in agreement with these findings?

MR JAMES: Objection.

A Yes, I am. I was surprised to the extent to which fear was identified by the physical therapist

Q Okay.

A And that's why I really saw him in giving, to address the chronic pain management program, which the physical therapists

thought might be a good thing to do at this point.

Q Okay. Now, Doctor, I want to ask you about a few records that you may have reviewed -- I believe you have reviewed in this case.

First of all, did you review records from the Cleveland Clinic Foundation dating back to 1976 for Mr. -- with Mr. Yarbrough?

A Yes, I did, at the time of his initial visit on 12-3-99.

Q Okay. And you've had a chance to review those in details, I take it, before today?

A Yes.

Q Doctor, my question there is: Can you tell me, is there a relationship between the problems he was having in 1976 and the current problems that you've diagnosed today?

A Based on -- on the fact that he did not complain of pain in the back of his neck or the kind of dizziness that was promoted by changes in the way he moved his neck, I would have to conclude that the dizziness he reported back then was not consistent with

the same kind of cervicogenic or neck source of dizziness.

Q Okay. So you -- do you relate in any way the problems that he's -- that you've diagnosed then with the stuff back in 1976?

A Because the symptom complexes identified by the patient and recorded by the physicians in 1976 were more consistent with an ear problem --

Q Okay.

A -- more consistent with a blood pressure problem, and different from the symptom complex presenting to me as of 12-3-99, I would only conclude that they are separate causes of dizziness.

Q Okay. Doctor, what is orthostatic hypotension?

A That's when you stand up, your blood pressure drops, you become nauseated and lightheaded.

Q Okay. And, Doctor, based upon the records you've reviewed from 1976, I know you weren't at the Clinic at that time, is the condition that Mr. Yarbrough had at that time consistent with orthostatic hypotension?

A Yes, just as much as it's consistent with almost any other kind of dizziness, because the tools of which they were diagnosing at the time had to do clinical and not as specific as are available to me today

Q I see. Okay.

Now, doctor, just a couple more records I want to ask you about

did you have an opportunity -- I think you mentioned earlier you had an opportunity to review records from Dr. Harold Mars pertaining to treatment that he rendered to Mr. Yarbrough back in 1987 following the first accident?

A That is correct.

MR. JEPPE: Objection to anything relating to the records of Dr. Harold Mars.

Q Okay. And, doctor, based upon that review, did you find that Mr Yarbrough was having any problems of a cervicogenic nature after the first accident?

A Yes He was complaining of both dizziness and neck pain, diagnosed by Dr Mars as cervical myofascial -- or, excuse

me, cervical myositis and tension-type headache at that point.

Q Okay. Now, that's a slightly different diagnosis than you've given here, Doctor. I think Dr. Mars' records indicate cervical myofascitis.

A Um-hum.

Q How does that relate to what you've diagnosed? I think what you've told us is cervicogenic dizziness.

A Well, the more specific diagnoses are what this -- the subspecialty of neurology is attempting to do, and so it's kind of relating to an old-timey kind of diagnosis of cervical, whatever he calls it, myofasc -- fascitis or something. Now we would call that specifically cervicogenic headache, not specifically a, how can I say it, neck pain or headache. And we confirmed that diagnosis with a colleague of mine in the headache center who actually did an injection and proved beyond a shadow of our doubt at this present time that it's a cervicogenic source of pain as well.

Q Was that Dr. Stillman?

A Dr. Stillman, yes.
Q Okay. All right. So, Doctor, if I'm understanding correctly then, are the symptoms that you've read in Dr. Mars' record -- records that Mr. Yarbrough was expressing after the first accident, are those consistent then with a -- with cervicogenic dizziness?
MR. JEPPE: Objection.
A Milder -- milder but similar, yes.
Q Okay. And based upon that, Doctor, do you have an opinion as to whether Mr. Yarbrough's cervicogenic dizziness condition began after that first accident --
MR. JEPPE: Objection.
Q -- of March, 1997?
MR. JEPPE: Objection.
A I can't -- I can't measure how much. I can just --
Q All right.
A -- say that symptoms are there of a similar nature as the ones that are present when I did have a chance to examine him.
Q Okay. Now, Doctor, I want you to comment on something else, if you would.

Have you read in the records regarding the problems Mr Yarbrough was having with -- urologically, with erection and so forth?

A Yes.

Q Okay.

A I discovered that last week in discussions concerning this case, that he reported importance and that he reported, how can I say -- not reported, that it was reported to me that a urologist had made a diagnosis of neurogenic bladder

Q And, doctor, how does -- from a neurological standpoint, from your viewpoint as a neurologist, how does that fit in with this picture of James Yarbrough?

A That makes it much more critical, that the pathways, that is the nerves connecting the brain to the bladder that are running through these areas of cervical instability, that those pathways are being damaged by a process that's consistent with spinal instability and that just a minor increase in the amount of subluxation is enough to cause permanent spinal cord damage

Q Okay. Thank you, Doctor.

Now, Doctor, we have already talked about the fact that Mr Yarbrough -- you've diagnosed him with posttraumatic stress disorder. How does this type of symptomatology, in other words, having difficulty with erections and other urological problems, how does that fit in with a posttraumatic stress disorder?

A Posttraumatic stress disorder from the patient's standpoint is a loss of control or that if put in certain situations he has no control over his actions or that -- has an over-expression of distressing -- kind of an agony greater than the medical condition, so that if he was not able to achieve an erection before and now he's not able to move around after that that could create a situation where he's not in control of his body from a greater -- in other words, magnify the loss of control he has in terms of getting his body to do what he wants to do, like move his neck around without pain or dizziness.

Q Okay. Doctor, I just have a few more

questions for you regarding your opinions in this case. And again, I'd just like to remind you to limit your opinions to those that you hold to a reasonable degree of medical probability, okay, Doctor?

First of all, Doctor, from a neurological vestibular standpoint, based upon your education, training and background, what injuries does Jim Yarbrough have that were caused from these motor vehicle accidents?

A A laxity of the cervical spine --

MR. JEPPE: Objection.

A -- at elements below C3, resulting in a change in the biomechanics of the upper cervical spine, resulting in a conflict between what his neck is saying about what his head is doing and his ears are saying, so-called cervicogenic dizziness.

Q Okay. And, Doctor, did you also diagnose Mr. Yarbrough as having a posttraumatic stress disorder?

A I did that only after the psychiatrist's consultation pointed that out as the reason for him to become suicidal during the

treatment, the physical therapy treatments.
Q Okay. And, Doctor, again, based upon a reasonable degree of medical probability, do you have an opinion whether Mr. Yarbrough -- whether these injuries that you've diagnosed in Mr. Yarbrough were caused by the motor vehicle accident of March 29th, 1997?
MR. JEPPE: Objection.
A I must admit that the degree at which that accident caused the total is unanswerable, that I can't say how much was he set up by the first accident to obtain greater injuries from the second accident from looking at the second accident in isolation, it's impossible for me to compare or predict that, but in terms of the sum total of the types of accidents both caused, I can conclude without any doubt in my mind that the condition he is presently in today is as a result of those accidents.
Q Okay. And just so the jury is clear, Doctor, as a result of both accidents, is that what you're saying?
MR. JEPPE: Objection.
A From my perspective, I can't separate

out one from the other, and I'm only privy to what has occurred as a consequence of both of those accidents, yes.

Q Okay. Okay. Doctor, now, also, again, based upon a reasonable degree of medical probability, do you have an opinion regarding whether all the medical care he's received here at the Cleveland Clinic Foundation as well as at Rehabilitex during your treatment phase, whether that was all reasonable and made necessary by the motor vehicle accidents -- well, by the motor vehicle accident of July 30, 1999?

A Yes.

Q And what is your opinion?

A It is reasonable. Actually it's less than I would expect of treatment that he should receive, so it's -- if anything, it's less than I would expect that would be required by that kind of accident.

Q Okay. And again, Doctor, based on your previous opinions then, would you -- do you have an opinion whether that was also then necessitated in part by the first accident of March, 1997?

MR. JEPPE: Objection.

A Again, it's impossible for me to be able to judge because both accidents were of a similar nature in terms of whiplash and I only can conclude that as a sum total of both he is the way he is today.

Q Okay. Now, Doctor, at this point in time for Mr. Yarbrough, can you tell the jury what are his options? I mean, where can Mr. Yarbrough go from here?

A Quite simply, unless he gets his head put back on his shoulders from a psychiatric standpoint, he's going to be too frightened to try to participate in his medical plan. The fact that just by evaluating what he can do physically provoking fear, the fact that the psychiatric consultation said that he has a posttraumatic stress disorder component to his illness, means that anything he does that provokes dizziness or pain might provoke a sense that his neck will be irreparably harmed by our treatment. So until he gets it out of his head that our treatment is intended to improve him, I don't see that he's going to improve at all in the state

that he is presently.
Q All right. Now, what about -- what types of specifics treatments would you advocate for Mr. Yarbrough at this time? What are his options?
A Until he accepts his psychiatric diagnosis and works toward that in concert with his medical diagnosis and the physical therapy necessary to prove to Dr. Benzel that conservative treatment is not effective, it s not going to work, he's not going to get where he needs to be. He's going to remain the same way he is today.
Q Okay. Doctor, we talked about surgery earlier, the cervical fixation surgery. Again, Doctor, based upon a reasonable degree of medical probability, if Mr. Yarbrough is ready to enter into that, is that something you would advocate for him at this time?
A I would only couch that by asking him to review that with Dr. Benzel and defer to Dr. Benzel's decision in that regard. I would never want to supersede Dr. Benzel's opinion at all.
Q Okay. Okay. And, Doctor, with respect

to the more conservative approach, I think in your report to me you made indications of a necessity for, I think you said, palliative care with ongoing physiotherapy, psychiatry and psychotherapy interventions?

A That is correct. The treatment for posttraumatic stress disorder requires a more long-term psychiatric plan. The treatment for spinal stabilization, which is an attempt to keep him strong and keep him doing his exercises as he strains and uses his neck in the activities of daily living, those kinds of, how can I say it, ongoing -- the station-keeping comes to mind, but that's a space term. Ongoing maintenance, therapy, is essential.

I can't comment on how much psychotherapy or what kind of psychiatry, I can only say that posttraumatic stress disorder does not get better without intervention and his spine will not get stiffer without some form of intervention, be it physical therapy on a long-term basis because he's frightened of surgery or surgical intervention like Dr. Benzel details

plus physical therapy afterwards.
Q Okay. Doctor, with regard to his daily activities of living, are those going to be impaired due to the injuries you've diagnosed?
A According to the functional capacity evaluation's assessment of what he could do in their very strictly developed called a laboratory and what he can and cannot do, even his activities of daily living outside of the job will cause him pain and dizziness --
Q Okay.
A -- and fear.
Q Okay. And what about within the job? As we talked before, he's an auto mechanic; that's going to cause him problems?
A That was clearly discussed in the recommendations and -- summary and recommendations part of the work evaluation rehab clinic as of 7-26-01.
Q Okay. Doctor, one final question, I guess, to -- that I have for you.
As a result of these motor vehicle accidents and where Mr. Yarbrough is today,

what is the condition of James Yarbrough's cervical spine today?

MR. JEPPE: Objection.

A I would say that it is just as bad as when we saw it back in 2000. There -- he hasn't had any further accidents, to my knowledge. The spine doesn't recover on its own once these ligaments are stretched. Pain has an ability to fester and actually worsen and become more chronic the more -- more days that go by that he's not pain-free. Muscles tend to atrophy when they're not used. Posttraumatic stress disorder.tends to worsen the less out and about he is in the community. I would expect him to be worse today than he was when I last saw him.

Q Doctor, you've seen a lot of patients, I take it, over the years for these types of conditions?

A Yes.

Q How does Mr. Yarbrough compare?

A It's one of the most difficult cases in terms of biomechanics in a case of cervicogenic dizziness both Frank Gargano and myself have had to work with, and it -- it

points out really the seriousness, at least in my clinic, of the use of fluoroscopy and neurosurgical consultation. It is less than one percent of my cases do I wear do that extent, because most of my cases do not have these kinds of lower signal instabilities to have to deal with

So it's a frustration for me because it's hard for me to gauge his prognosis on the basis of how seriously wrong his lower spine is, and from my perspective, it's very hard to gauge even what I think should happen, which is if he had a better neck he should be less dizzy with the appropriate therapy And -- and with the further complication that we discovered of the posttraumatic stress disorder, it makes it even more difficult a process to achieve what I would call treatment success, which is move his neck around without being dizzy, being able to do whatever he wants to do without getting dizzy.

MR. MESTER: Okay. Doctor, that's all I have Thank you.

THE WITNESS: Thank you.

correct?
A That is correct.
Q The records indicate that he gave a history of having been hit over the head five years before he came to the Cleveland Clinic, correct?
A That is correct.
Q And he said that since then, since he had been hit over the head five years ago, he had had dizzy spells, correct?
A Spells, yes, that -- that have a beginning and an end.
Q All right.
A They would begin and then they'd end and so he described them as spells.
Q Right. And he said that he had those spells as often as three to four times a day --
A That is correct.
Q -- is that correct?
A Um-hum.
Q All right. Now, when you saw Mr. Yarbrough for the first time in December of 1999, do you know whether he was working?
A I -- I think I usually say that in the

social history, detailed elsewhere significant for the fact he's a mechanic and self-employed without insurance What I'm going to do now is go to the 'detailed elsewhere' part of the chart to find out

In his handwritten note at that time, his last work part was left empty and he's -- where it says 'Are you disabled from work?' it says 'partially '

Q All right I'd like to refer your attention to the psychological therapist's note of March 24, 2000

A Okay That's Michelle Forcheel; is that correct?

Q Correct.

A Okay That looks like her first visit, is it? No, I think her second visit Second visit.

Q Now, about five lines down, Michelle stated that the patient is self-employed as a supervisor/mechanic, correct?

A Um-hum.

Q And then she went on to say that he is working six to eight hours a day; is that right?

A That is correct.
Q All right. Now, Doctor, you have talked about the testing that you had done, and first of all, before you saw Mr. Yarbrough, he had been seen by Dr. Dinner here at the Cleveland Clinic; is that correct?
A That is correct, yes.
Q And Dr. Dinner referred him to you, correct?
A Yes. At the time and it still is true today that dizziness can present to any of our neurologists at the Cleveland Clinic, and he did what most of them do, which is schedule them for testing and consultation with me after testing.
Q Dr. Dinner noted that the patient had been treated with medications for his dizziness; is that correct?
A That is correct.
Q Now, when you saw -- did you see Mr. Yarbrough on January 28th, 2000?
A That is correct.
Q And did you note on that date that Mr. Yarbrough had a mild posterior subluxation at C4-C5?

A Yes. That's to a neurologist "mild."
Q Okay Now --
A I've since learned from a neurosurgery standpoint, and not as of this week, but as -- other cases like this, that what we call mild is not necessarily what neurosurgeons call mild, and that was part of my education in this case, that -- that was my opinion as of that date After he saw Wenzel that was no longer my opinion, Dr Wenzel pointed out to me that it's not -- it's not considered mild So I did learn something in this case in between that time
Q Do you have Dr Wenzel's March 13, 2000 letter?
A Yes, I do
Q And Dr. Wenzel referred to the subluxation as minimal; is that correct?
A Yep
Q All right Now, Doctor, you were talking about -- I think you made some comments that the subluxation was not present in a neutral position?
A That is correct The only way to make a spine subluxes is -- when it's all filed up

together on itself. there's no way to know if there's any movement, which is essentially the x-rays that are done now and were done in this case at the time of the accident. they'll just file them and make sure that there is one that's not misplaced, because if they're not -- there's one that is misaligned. they will assess at that point it's so unstable that it's out of place

In the flexion/extension standpoint. that's when you start to put forces that are on the side. much like a stack of tires, and you're asking yourself what are those elements of the spine that can push back and keep aligned That's the only way to case a subluxation that is not seen in neutral. is to prowide that force

Q Would you expect Mr Yarbrough to be dizzy when the spine is in a neutral position?

A Yes.

Q Why is that?

A Because in the neutral position. in the -- in the flexed position and the extended position, the part -- the elements

of the neck that have to do with dizziness are really not changed at all. In other words, if you tend to put your head forward, you still have a conflict between where your head appears to be to your ear -- to your brain from an ear standpoint as well as from the neck. So in any position you would still feel dizzy, but you could feel more dizzy or less dizzy if you could seek a position that had more or' less conflict between the two.

Q All right. Now, as you've explained, after you had Dr. Benzel examine. Mr. Yarbrough -- first of all, Dr. Benzel did not recommend surgery; is that a fair statement?

A But it's also fair to say that Dr. Benzel never recommends surgery after the first visit unless he is required to from the standpoint of harming the patient by not doing, which is really the purpose of this visit, is to get his heads-up on is this such a dangerous case I don't need to have my physical therapist touch him or not. And his answer was no, it's a minimal subluxation kind of case, certainly it is an unstable

spine in the standpoint of moving around a lot, and the only fix I would have for that kind of sloppy spine would be a fixation that is so extensive that it's a rather drastic step in his mind. So he was hoping that with some physiotherapy stabilization we'd be able to obviate the need, even with this degree of subluxation, which I've already said is more than I usually see in such cases.

Q All right. And the object of the physical therapy that you were recommending and that Dr. Benzel was recommending was to strengthen the muscles in the neck to improve the stability of his spine; is that correct?

A We actually divided and conquered in this case. I said, gee, Dr. Benzel, deliver me a lower spine so I can build the upper cervical spine with Frank. And he said, well, give me some time in the lower spine with Michelle and we'll see what we can do with the upper spine. So in a sense we split. I said you take care of the lower part, I'll take care of the higher part. The higher part is the only thing that can cause dizziness anyway.

Q All right.
A So it's really get this out of the way, is my feeling, so that I can concentrate on my treatment. And I'm hearing back from my neck physiotherapist that treats cervicogenic dizziness that he can't proceed without a more stable basis from which to proceed; and Dr. Benzel agreed, he said let's stabilize the lower spine. None of the physical therapy that he recommended has anything to do with dizziness or the upper cervical spine.
Q All right. So he recommended therapy to the lower part of the neck, correct?
A To replace the need for surgery by using the muscles to strengthen around the lax ligaments to provide the kind of structure necessary to make up for that laxity in the tendons.
Q All right. And your plan and Dr. Benzel's plan was that you would improve the stability of the neck --
A And then proceed with the upper cervical spine cervicogenic reordering that Frank would do.

Q And that would hopefully correct Mr. Yarbrough's dizziness, correct?
A That's correct, because I -- how can I say it? Inasmuch as the lower cervical spine would impact my treatment for the upper cervical spine. I could care less about his lower cervical spine health, per se, because it has no relevance at all to his dizziness.
Q All right. And tell me -- tell us about the type of physical therapy that he was having through Michelle.
A Michelle did exactly what Benzel wanted her to do, which I need to quote his note because it's -- it's a very precise note, and he says, basically: Aggressively employ strengthening and stretching exercise to increase the strength and stability of his intrinsic, that is the muscles that are there, muscular support system. Have physical therapy help him with the -- these things and treat his muscle spasm while he's being treated with a medicine called Flexeril, which is just -- not for dizziness, just for the spasm that may interrupt the process of physiotherapy.

Q All right. What type of exercises are we talking about?
A Literally parts where -- 1'11 give an example. One of the spine stabilization exercises is actually what I'm doing right now, okay? It doesn't seem like much but it's applying a force and then having you push against. It's called isometrics. Other things are stretches that only she can do, stretch like this and strengthen. And what you'll find is these little tiny exercises that don't seem like much force actually build these intrinsic muscles stronger and stronger and stronger.

To my patients I try to explain to them it's like being a wrestler. Wrestlers have big thick necks, and they get those thick necks not because they're wrestlers but because they're doing the kinds of exercises that strengthen those intrinsic muscles to a degree that they have thick necks. In a sense that's what we were hoping that we could do with Mr. Yarbrough, is build him a -- kind of a wrestler's neck so we wouldn't have to do surgery.

Q I saw some references to horizontal -- horizontal head turning. Is that the type of exercises?

A Those are the stretches, okay? And then say pushing this way and that way, that's a different muscle group than here in the middle.

The problem with that from a dizzy standpoint is this may make him so dizzy that he won't want to do that, and so you can't strengthen him because he doesn't want to do the dizzy part necessary to strengthen, which in turn won't ever get his dizzy part fixed, so it's a -- it's a confusing mess, so to speak.

Q All right. Anyway, Mr Yarbrough saw Michelle several times?

A Until --

Q April 10th, 2000, correct?

A Until she frightened him and he frightened her. It was becoming increasingly evident on my review of her notes that she was getting frustrated that as she tried to push him further and further towards what Dr Benzel wanted to have done, his reports

of fear, anxiety and dizziness precluded her treatment of that area, insomuch as to the point in retrospect maybe she did push him a little too hard, but her boss in this regard was Dr. Benzel, not me. It just so happens that she works with me on dizzy cases and so she knew to call me and say, rather urgently, we need to do something.

Q Let's look at Michelle's note of April 10, 2000.

A The day I saw him also?

Q Right.

A Go ahead.

Q She noted that Mr. Yarbrough said he was seeing things that weren't there, such as shadows, correct?

A Um-hum.

Q And then he also said he was concerned about the fear of getting in someone's way, correct?

A Um-hum.

Q And he reported that last night he dreamed that he would die, correct?

A That's correct.

Q And he complained about feeling

worthless, correct?
A That is correct.
Q He did not say that he was considering suicide when he -- according to Michelle's note, did he?
A No, but she said -- reading in between the lines -- the only thing keeping him going is his son.
Q All right. But he didn't say that he was actually contemplating suicide, did he?
A How can I say this? She would not have referred him to me urgently unless she suspected, and I -- I mean, I can't recall exactly our conversation by phone, because we did talk, but I came to the conclusion that he was very dysphoric, which is this foreboding sense of doom and feeling ill, which is a big tip-off for -- even if they voice suicidal ideation or not, that suicide, which is death, which is, how can I say it, a rather lethal form of dizziness, was a risk here, and I had to stop my day and address a rather -- usually I don't have dizziness causing any death at all, address that urgent issue to make certain.

I wasn't certain after my interview with him and wanted a formal psychiatric interview because I did not trust my training as a -- my psychiatric training as a neurologist enough to feel comfortable letting him out of my sight.

Q All right. And you referred him to a psychiatrist here at the Clinic?

A Actually, the psychiatrist came over to him.

Q All right.

A I asked the psychiatry service, come to my clinic room to examine him and so-called, quote, safe him, unquotation, let him out of the Cleveland Clinic Foundation in a situation where he would not harm himself or others.

Q What was the name of that doctor?

A Dr. Mallone.

Q Malard?

A No, Pozeulo, P-O-Z-E-U-L-O, Pozeulo.

Q All right. Now, we have Dr. Pozeulo's notes, correct?

A That is correct.

Q And Dr. Pozeulo determined that

Mr. Yarbrough was not suicidal, correct?
A He was safe to go. That doesn't -- what was he saying? I con -- let me see. That's not the reason the consultation was -- it was basically can he go home without killing himself, and the answer was yes.
Q I mean, Dr. Pozeulo indicated that there was no active --
A Suicidal ideation.
Q -- suicidal ideation. So he wasn't actively thinking about suicide?
A That is correct.
Q And therefore he was safe to go home, correct?
A Yes. Yes.
Q And it also came out during Dr. -- that doctor's interview that Mr. Yarbrough had seen a psychiatrist back in 1996, correct?
A That is correct.
Q And the doctor noted that at that time Mr. Yarbrough had some talk therapy but that he never fully recovered; is that right?
A That is correct.
Q All right. Now, where is -- on this note from the psychiatrist, where is the

diagnosis portion?
A It's an A slash.
Q All right.
A Assessment: Vestibular disorder, that's an Axis 3 or a medical condition. Spinal trauma status post MVA, that's another medical condition. And then there's an adjustment disorder, depressed and anxious, And then rule out posttraumatic stress disorder with concurrent anxiety. And PFAPC, which means psychological factors affecting his physical condition.

So that Dr. Pozeulo could not separate out the psychiatric and the organic in terms of the total picture, that they were interacting with each other and that there was a component of posttraumatic stress disorder that needed to be addressed in his physiotherapy total treatment program.
Q Well, Dr. Pozeulo said rule out posttraumatic stress disorder. Did he ever diagnose posttraumatic stress disorder?
A When you're thinking of the differential diagnosis, the "rule out" allows you to keep it on the differential diagnosis until

further exploration of the causes, which requires, how can I say it, more psychiatric intervention than just one interview. The key is that he identified at that point that he had -- didn't have enough evidence to exclude it. If he had evidence to exclude it, he would never have put it on the differential.

Q All right.

A He didn't have enough evidence to exclude it, and after discussion with me about -- from a dizzy doctor standpoint, is that did -- or did the possibility exist that he interpreted dizziness as a threatening loss of control situation that was somehow linked to that sense that he was going to die. The only requirement from my perspective is that both occur in a temporal relationship that the patient can't separate; and according to his interview with Dr. Pozeulo, not with mine, he had to say that he was going to die for him to even address that. And I'm trying to find the exact -- exact reference to that in terms of how he, the patient, interpreted it was as

though he was about to die

Q Now, my question has to do with Dr. Pezeulo's diagnosis He -- he did not diagnose posttraumatic stress disorder.

A That's right, he did not, but he did not exclude it either

Q That s all I -- that's all I was asking how about

A And he wouldn't put it on the differential diagnosis unless it would require further psychiatric intervention to rule it out completely

Q All right And at this April 10 visit with the psychiatrist he recommended that Mr. Yarbrough follow up with a psychologist, Dr. Bea, correct?

A Dr. Bea is a psychologist that with regard to interviewing would get to the bottom of things and be able to report back to Dr. Pezulo yes or no there is an element of posttraumatic stress disorder, and at that point the two of them would have to have a discussion about how much medication be required, how much cognitive behavioral th. rapy

Q All right.
A But the hope was by Dr. Pozeulo that if he sent him to a good diagnostician and therapeutician, that as James would improve in his level of depression and anxiety, these other things would come out to be able to exclude or include them.
Q And they actually scheduled an appointment with Dr. Bea for April the 26th, 2000?
A That's correct. But he wanted to meet with Michelle, who saw him, I think, on the 13th and the 14th to discuss the physiotherapy aspects of the combined approach that Dr. Pozeulo said, look, unless you do both at the same time, I don't recommend it.
Q And you were sufficiently concerned that you wrote Mr. Yarbrough a letter dated April 10, 2000, correct?
A The reason I wrote that letter is because I didn't get to see him after the psychiatrist met with him and I wanted to close the loop in terms of what discussion I had with the psychiatrist and put it in a

framework so that James would understand it I always try to write my letters to James to kind of close the loop, as if I was in the room with him, discussing it with him, and that was the purpose of writing the letter, because I have no other letters I wrote to him except that one after he saw the psychiatrist, because I didn't think I had a chance to discuss it with him. I was concerned that he would be mad at me for sending him to a psychiatrist in the first place.

Q But after you saw him, you learned that he was referred to Dr Bess from --

A No, I knew at the time I saw -- that psychiatry -- they called me up and said we are referring him to Dr. Bess as our treatment plan, and I said I support that So I knew at the time that was part of the treatment plan

Q All right And you encouraged Mr. Yarbrough in his letter to make sure he followed up with Dr Bess and Michelle, correct?

A That is correct

Q You stated in your letter that it is essential that you keep that appointment and I will let Michelle know that you will be working together with him and her on this problem, correct?
A That is correct.
Q Now, Mr. Yarbrough did not keep the appointment with Dr. Bea; is that correct?
A That is correct.
Q All right. He never followed up with Dr. Bea as you suggested, as the other doctor, the other psychiatrist at the Cleveland Clinic suggested?
A And as Michelle was trying to encourage him on her visits with him.
Q All right. And the idea was that through working with the psychiatrists and the psychologists at the Cleveland Clinic, you would get Mr. Yarbrough to a point where he would be sufficiently motivated to follow through with the physical therapy to strengthen the muscles in his neck with the hope of correcting the dizziness?
A I don't think the word "motivated" correctly describes this, because Michelle

was finding that the therapeutic relationship, the physiotherapy, was interfering with this fear thing, that as she tried to help him less dizzy, which by the way is what the physiotherapy she was doing was trying to do, he was getting more anxious, and so she knew that the therapy that she was trying to do was just making things worse in terms of anxiety

In terms of him not keeping his appointment, it could be as though he didn't want to face this issue, he just wanted to go away, he didn't want Michelle to make him dizzy anymore, he didn't want to have to deal with being dizzy anymore, he was -- he admitted to Michelle, not to me, that it was frightening for him to get dizzy

Q I --

A And so inasmuch as wanting to do something -- he had a lot of motivation not to do something because being dizzy and frightened is not a pleasurable experience for anyone, much less Mr Yarbrough

Q All right doctor, I used the word 'motivated' because that was a word that you

used when I took your deposition just recently.

A Right.

Q You indicated that the ther -- that the psychological therapy was designed to get Mr. Yarbrough motivated to return to the physical therapy, correct?

A That's right. And motivation in that respect would be not as a casual motivation but as more of a clinical psychiatric motivation, which would be face your fears, develop coping strategies so you can face that and move forward with Michelle, not treat it as something to avoid.

Q All right. But the whole idea was that you would hopefully get Mr. Yarbrough to a point where he would participate in the physical therapy to strengthen the muscles in his neck --

A That is correct.

Q -- which would correct his dizziness?

A That's correct. If we --

Q And he never followed through on that --

A No.

Q -- correct?

Even to this day he has not followed through on that, correct?
A That is correct.
Q Now, he returned to the Cleveland Clinic in November of 2000, right?
A Um-hum.
Q And at that time he complained to you about still having dizziness?
A Right. Came to me, said why am I still dizzy, why am I still dizzy.
Q Right.
A And I went -- pointed out to him basically you're still dizzy because we haven't proceeded with any treatment.
Q Right. And you don't know what he was doing between April of 2000 and November of 2000 when he came back, right?
A I knew something was happening because I was required to furnish a functional capacity evaluation of what he could and could not do as of July 26th, '01. So I knew something was up in terms of his symptoms of dizziness and how it was impairing his ability to do what he thought he could do at that time.
Q All right. Did you order the functional

test in response to requests from the attorneys for a report?

A Somebody requested it I don't recall exactly who wanted me to quantitate and at what time It could be the letter from Jonathan

Q And what is the date on that letter?

A It's March 7th, and then I wrote in the record, so it tells me through -- when I actually saw it, is basically, sorry, when was this done? 5-21-01

So as of 5-21-01 I initiated my office to proceed with a functional capacity evaluation to answer his questions

Q All right So that -- that test was in response to Mr Mester's request?

MR MESTER: Objection

A As far as I can tell, yes

Q All right Now, when Mr Yarbrough came back, you told him, of course you're still dizzy because you haven't followed up on the treatment -- I asked you to follow up on, right?

A Absolutely Only I wouldn't couch in those terms because I already have a

psychiatrist telling me how delicate this guy is, so I don't want to blow him up and make him suicidal and -- you know. So I'm trying to talk turkey with him about what do you expect? Duh. You know, and at the same time try to motivate him to my way of thinking, which is if you want to be less dizzy, you've got to do this way, not because this is what he thinks he should do but because this is what I -- this is what he asked me for, is an opinion of what should I do.

Q All right. And at that point you suggested that he see another -- a psychiatrist at the Cleveland Clinic, Dr. Covington; is that correct?

A No, that was my way of getting around his, how can I say it, fear of having to deal with psychiatry. I basically -- in the functional capacity evaluation, the physical therapists pointed this out to me, that because pain was an issue at that point and because psychological issues were part of that, that perhaps the combination of psychiatric and pain issues that's so well-handled in the chronic pain ward, run by

a psychiatrist, in a way that any psychologically maintained or exacerbated pain could be taken care of in their combined or their dual diagnosis approach. They treat pain and they treat the psychiatric aspects at the same time. So I'd get him in the door for pain and fix his psychiatric as well, the pain issues would drop down, I'd get him back for more physical therapy, then go to the dizzy physical therapy and avoid surgery.

Q All right. And you know from the records that an appointment was made with Dr. Covington?

A That is correct.

Q And Mr. Yarbrough did not show up for that appointment; is that correct?

A That is correct. It is the findings of the chronic pain ward as well as my psychiatric colleagues that unless a patient is motivated to want to get help in those departments, that they do not want him to be seen as a patient, that they only want to see patients who are motivated, because their data shows that only motivated patients respond to their kind of treatment.

Q All right. Doctor, I -- I want to ask just a few questions about medications.

When you first saw Mr. Yarbrough back in December, 1999 he was taking a number of medications, correct?

A That is correct.

Q And some of those medications have the side effect of dizziness; is that right?

A That is correct.

Q And you encouraged Mr. Yarbrough to go off those medications?

A That is true, but only in the setting of his physiotherapy. In other words, if you say just discontinue your medications, just the withdrawal from those medications could cause dizziness as well.

Q All right. And which medications did you encourage him to go off of?

A Valium, cyclobenzaprine or Flexeril, Tranxene, which is another form of Valium, and butalbital, which is a barbiturate-like calming medicine.

Q And Mr. Yarbrough wanted to stay on the medications; is that right?

A He felt especially enamored of the use

of Tranxene for the treatment of his dizziness, which should work in dizziness to suppress it as well as cause it, and it's very hard to sort out which is causing and which is suppressing, and I pointed that out to him, that unless we start to do something with your medications, these medications can contribute as much to if not cause his constant dizziness and certainly impair his ability to eventually render the ear says one thing, neck says another problem.

Q But -- so you encouraged him to go off the meds but he decided he wanted to stay on the meds; is that right?

A No, he was asked to go to physical therapy and then we'll address that later basically.

Q All right.

A But the treatment course was that end -- open-ended so that I could get feedback from Frank on his current medications, and then we kind of lost track because we couldn't even start up or couldn't even begin with Frank enough to taper him off those medications.

Q All right. So he never did taper off

the medications while he was under your care, correct?

A That is correct

Q Except when he returned in November of 2000 --

A He was off everything

Q So -- and you don't know who took him off or why he went off all of those medications, right?

A Everything that I've looked at is a mystery to me I suspect, because my recollection of the thing is he was on no insurance at the time, so he probably made the decision himself, saying I can't afford these medications, and took himself off in that regard.

Q And you -- and you have not seen Mr. Yarbrough since November of 2000?

A Not at all.

Q And your only involvement since then is in connection with this lawsuit; is that fair?

A That is correct.

MR SIGMIER: All right that's all I have Thank you.

MR. JEPPE: Doctor, my name is Gerry Jeppe and I represent Max Quinton, he was the individual involved in the accident on March the 29th of 1997.

Off the record. Wait a sec. All right. Back on the record.

All right. Doctor, during my course of my cross-examination I may make a few statements; if any of the statements I make are incorrect, stop me and tell me where I'm incorrect, all right?

THE WITNESS: Okay.

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CROSS-EXAMINATION

BY MR. JEPPE:

Q Would you again tell the jury the first time that you ever examined or saw Mr. Yarbrough?

A December 3rd, 1999.

Q All right. So December 3rd, 1999, I think we've all agreed that that was after both of the accidents had already occurred; is that correct?

A That is correct.

Q Now, did you take a history from

Mr. Yarbrough at the time you first saw him?
A Yes, I did.
Q Did he give you any history of being involved in a motor vehicle accident on March 29th of 1997?
A I am referring to the handwritten records that we ask our patients to supply, and there is no reference to that nor is there reference to my typewritten notes of my visit on that time of his -- his prior accident.
Q Now, when he came to see you on that date and he gave you the history, what history did he give you, sir?
A As it's stated clearly in my note, because my recollection is never as good this distant as it is written down, the history was that he had been dizzy on and off over the years, because he was addressing what I pointed out to him in the chart, but that he had been pretty free of that or clear of that prior to his July 3rd, which is a typo in the record, July 30th, 1999, at that point, and then I talk about the accident.
Q All right. So in his history he

directly related his problem for which he came to see you to the July 30th, 1999 accident; is that correct?

A He stated basically that he -- he's been free of dizziness generally until that date and that his chief complaint to me is fix the dizziness that has occurred after that date.

Q All right. Now, Doctor, were there any diagnostic studies done, to your knowledge, or have you reviewed between the time of the first accident and the second accident that would diagnose a subluxation in the neck as you described in the -- in the -- in the -- on your direct examination?

A No. The studies that I've reviewed between the first and the second accident as supplied to me today, if we want we can show them, are insufficient to compare the views that we've demonstrated here, that they weren't specifically flexion and extension views, therefore without that evidence I literally have no baseline.

Q All right. So the first time that diagnostic studies were performed, and also the first time the subluxation then was

diagnosed, was after the fluoroscopy?
A That is correct.
Q And that was done when, sir?
A January 25th, 2000.
Q All right. Now, Doctor, with respect to the records -- you do have the Clinic records in front of you, do you not?
A Yes, I do, sir.
Q I want to call your attention to -- I don't -- I think my pages are marked, yours may not be marked.
A That's okay.
Q All right?
A I'll find them.
Q All right. What's been marked on my copy as page number 6, that would be --
A What date do you think that is?
Q Well, looks like -- this says performed 3 April 2000. This is a --
A 4-3-2000 --
Q Um-hum.
A -- is the date you want me to look at?
Q It's --
A By whom?
Q This is interpreted by Dileep R. Nair,

N-A-I-R
A Nair
Q Nair?
A That sounds like a diagnostic study he had done in neurology to look at the nervous tract between his legs and his brain; is that correct?
Q Right. All I'm --
A Non-sensory evoked potentials
Q All right
A What was an attempt to provide objective evidence between his feet and his brain of something affecting the transmission of nerve function between those two areas
Q Well, then -- let me just show how my copy
A Okay
Q It might be faster. If you can pass it back to me when you're done
A Yes This is actually a computer printout of the actual -- this is in the computer, basically
Q Would you then read for t e jury the history that was taken at that time?
A 4[illegible]-year-old man with neck pain, constant

dizziness, right face paralysis, leg pain, arm numbness, blurred vision, status post MVA 7-99. MRI shows C4-5 and C5-6 subluxations.

Q So he refers to, what, the 7-99 accident; is that correct?

A That is correct.

Q All right. Can I have those records back, sir?

A Okay. I further note that that was requested by a Harold Mars, not by myself, which is the first knowledge that I had that Dr. Mars was even seeing him during that time period.

Q All right. And this was back then in 2000; is that correct?

A That's clearly after I had already seen him, yes.

Q All right. Now, Doctor, there's a clinic note on initial visit dated April 24th, 2000.

A By Dr. Stillman?

Q Dr. Stillman, that's correct.

A Okay.

Q Do you have that one?

A Yep.

Q If you look at the second paragraph, on the first -- first -- it's a two page report.
A Okay.
Q On the first page.
A Okay. So that's page number what, for your records?
Q Page number 9 on my records.
A Okay. I have 81. So that would be page number 3 -- I have that record in question. Page 1 of 2.
Q All right. In the history then given under Present Illness, could you read for the jury what that says?
A Yes. It says Mr. Yarbrough is a 46-year-old right-handed mechanic who was in a motor vehicle accident in July, 1999 and before that a year or two earlier. He was rear-ended by a car he claims was going 60 miles an hour.
Q Was that the second accident?
A I don't know. It's not stated.
Q Didn't you take a history from him as to which -- what happened in both these accidents?
A But both of them -- but the only

accident that I had no -- the only accident I had knowledge of was this July of '99 accident at the time of my history where I knew he was rear-ended. I don't know enough to say anything about the first accident except from my review of Dr. Mars' records.

Q Do you know if he was rear-ended in the -- in the second accident?

A Absolutely.

Q All right. And did you know if he was rear-ended in the first accident?

A No, I didn't have knowledge until last week of exactly the kind of accident he had.

Q All right. He said he was rear-ended by a car that he claims was going 60 miles an hour. Would you go on from there then, please?

A Okay. But again, it's indistinct. I don't know which accident --

Q Well, the jury will know, sir.

A Okay. Fine.

Q Go ahead.

A He was found to have dizziness and imbalance due to cervicogenic causes. He was seen by Dr. Dinner and then referred to

Dr Oas.

Q Okay Thank you. Let's go to page -- ich is my page 65.

Okay.

Q This is --

A The first visit to Dr Dinner. I think. Yes

Q All right You said clinical note. initial visit What's the first paragraph. sir? Starts off with this 45-year-old --

A This 46-year-old married man presents for evaluation. Complains of dizziness He describes that he has experienced this since he was involved in a motor vehicle accident July 30th, 1999.

Q Okay. And then he says he describes that he was hit -- well, no While he was driving, was hit in the rear, with a resulting concussion.

A That is correct.

Q Now, he refers here to the July 30th, 1999 accident.

A That is correct.

Q Does he refer anywhere to the March 29th, 1987 accident?

A Not at all.
Q All right. I'll draw your attention to page 69,. which that's for me. For you that would be --
A My first consultation.
Q Otoneurology consultation?
A That is correct.
Q All right. Let's go down, if we could, to -- I think you read this into the record earlier, but let's go down to that first large paragraph that starts off with patient was seen today, et cetera, et cetera. So --
A And --
Q Okay?
A Although he has had dizziness on and off over the years, he had been free of any dizziness for months and years prior to July 3rd, again, typo, 30th, 1999.
Q Okay. All right. Then he goes ahead and des --
A At that point he was stopped and was rear-ended while belted, resulting in breaking of the seat. He ended up looking at the ceiling of the car after the accident.
Q All right. Thank you.

Now, if we go down a little ways farther, let's skip down about four or five lines, the sentence that starts out: He has also had a couple.

A He has also had a couple of other accidents over the years, also resulting in whiplash injuries, which he has found mostly have affected his lower back but not his upper neck.

Q Thank you.

I -- let's go to page 73. That's my page 73.

A Okay.

Q And we've discussed this before. Down at the bottom.

A Yes. It's hard to read.

Q I know it's hard to read, but we can make out a few things here.

A Okay.

Q S/P 3-29-97.

A I'll be there.

Q What's S -- what does S/P mean?

A Status post. That's after the accident of 3-29-97.

Q Anywhere there does he mention any type

of injury to his neck or dizziness?
A It says MVA, arrow, causing lumbar pain, diagnosed with lumbar herniated cyclous ulposus No surgery He improved Remain with right lower extremity parasthesias, which is a tingling kind of sensation
Q Okay Now, also that there's another S/P
A Yes Status post the accident of July 29th Must be a typo there too
Q That there
A MVA, caused neck pain and bilateral lower extremity parasthesias and decrease in right eye vision, immediate onset No prior neck pain. Pain is right suboccipital and sharp.
Q Let's go to page -- what's my 91, I believe.
A Okay What's a dr. Stillman note of April 24th, 2000, handwritten.
Q All right I believe this --
A Are we on the same page?
Q Y s, we are
A O ay.
Q H refers to the motor vehicle accident

of 7-99; is that correct?
A That is correct.
Q Rear-end collision?
A Yep.
Q What does it say there, sir?
A After seeing Dr. Oas, saw physical therapy, Frank Gargano, and headaches went away. At Spine -- at Spine Center for dizziness, that made headaches worse. After MVA, right eye, also C4-5, 5-6 instability, stair-stepping subluxation. Headaches started after accident. Vision improves when headache goes away.
Q And by "started after accident,'' he's referring to the accident of 7-99?
A I can only conclude, as that's the only accident he refers to, he's referring to that 7-99 accident.
Q All right. Then let's go to page 97.
A That's the Clinic note. That's the typed record from the same handwritten note by Dr. Stillman.
Q All right. And --
MR. JEPPE: Off the record a second, please.

(Discussion had off the record.)

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BY MR. JEPPE:

Q On page 97 --

A Yes.

Q -- there is a medical -- a past medical history; is that correct?

A That is correct.

Q And what does that say, sir?

A It says significant for an accident three to four years ago, as mentioned above, which led to low back pain. He had nerve blocks to his back.

Q Any mention there of any neck injury in that accident, the one three to four years prior?

A I have to go to where he's referencing "as mentioned above,'' so I have to go up to the higher-up paragraphs.

Q Why don't we start up there slightly -- second sentence: He was in a motor vehicle accident in July of '99. Do you see that, sir?

A Yep. And that -- and before that, a year or two earlier, he was rear -- and then

it gets -- it -- so the only reference to the accident before, a year or two earlier, is just in reference to that.

Q All right.

A There's no other references made about anything other than his low back and et cetera.

Q Okay. Now --

MR. JEPPE: Off the record a second.

- - - - -

(Discussion had off the record.)

- - - - -

BY MR. JEPPE:

Q Doctor, have you had a chance to review the Rehabilitex, Inc. records?

A Yes. Those are reviewed by me as they come in. I need to find mine in the chart, however, because they're outside correspondence and that often gets misplaced in the Cleveland Clinic archives.

Q Okay.

A So I may need you to hand that over to me to reference to.

Q Now, again, can you -- on the first page

of that record --
A Um-hum.
Q -- I think it's dated --
A Do you have a number on it?
Q No. This is like --
A A different one, yeah.
Q Just the very first page. I think it's dated 12-20-99; would that be correct?
A That is correct. That's when I signed it.
Q Okay. Can you look at the first part of the first paragraph?
A The first part of the first paragraph: The patient was referred for physical therapy to diagnose a cervicogenic dizziness and cervicalgia. Patient states his first motor vehicle accident was approximately two and a half years ago at which he had severe injuries to his lumbar spine for which he's still having difficulty; however, on July 30th, 1999 he was rear-ended. This caused a concussion, right side of his head. He has had poor vision on the right side, difficulty reading, memory loss, nausea, dizziness and balance loss as a result.

Q Now, with that history, he relates the dizziness, the other injuries other than the low back, to the accident of July 30th, 1999?
A It is clear that the chief complaint he had as a consequence of the second accident was dizziness, whereas the chief complaint he had as to the first accident was pain. So at the time of the history taken by Frank Gargano it's clear that the symptoms after the two accidents were completely different.

MR. JEPPE: All right. Thank you, Doctor. I have nothing further.

MR. MESTER: Off the record.

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(Recess had.)

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MR. MESTER: Doctor, just a couple more questions for you, I promise.

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REDIRECT EXAMINATION

BY MR. MESTER:

Q First of all, with regard to your diagnosis of posttraumatic stress disorder, you were asked by Mr. Sigmier, I believe, about a notation in the records that he had

had previous -- a previous psychological consultation prior to any of these motor vehicle accidents, and my question for you, Doctor: With respect to posttraumatic stress disorder, is there a pre-existing component to it?

A No.

Q Can you explain that to the jury, please?

A Anyone with any past medical history, psychiatric or otherwise, can still have a posttraumatic stress disorder as a consequence of a single life event. In other words, all of us are vulnerable for the same regardless of what kind of psychiatric illnesses we might all have had. It just requires a situation in which you are placed at a point where your body feels as though it's preparing for death, that you are near death, and that there's no way out, no control over the process that is killing you.

Q All right. So based on your review of the records that Mr. Sigmier pointed out to you, that he consulted with perhaps a psychiatrist in '96, based upon that record

and everything you've seen in this case, Doctor, is there any connection between that notation in the record and the posttraumatic stress disorder that you've diagnosed in this case?

A Not only should there not be on the grounds I just said, but it would be immaterial at the -- from the standpoint of the specific diagnosis. From a greater standpoint in terms of an adjustment disorder with depressed anxious mood, that would be more contributing, because typically a response to stresses of the past predict the future, but not in the situation of a posttraumatic stress disorder.

Q Okay. Thank you, Doctor.

Now, you were also asked a lot of questions by Mr. Sigmier regarding Mr. Yarbrough's follow-up at the Cleveland Clinic, and I'd like you, if you would, to tell me, is that consistent -- I think you've -- you talked a lot with Mr. Sigmier about him missing appointments; do you recall that?

A (Nodding head.)

Q And you've talked about him not being able to follow through with some of the treatments you would have liked. Is that behavior consistent with somebody who has a posttraumatic stress disorder such as Mr. Yarbrough?

A Only if there is something traumatic in attending to those things. I mean, to be negligent for a reason that is avoidant from a psychiatric standpoint is different from being negligent because you're just too lazy or not motivated in a sense of too much travel, how much you have to pay for parking, how much it will cost you, that's the difference.

And -- and from a posttraumatic stress disorder, if Michelle was right, that as she was working with him she was making him more psychiatrically worse, and if Dr. Pozeulo was right by saying he might have a posttraumatic stress disorder, then it's pretty simple to conclude that this man, every time anybody sees him they give him bad news or make him painful or make him dizzy, all of which brings up this old kind of

posttraumatic stress that that's the way I felt when I thought I was going to die, dizzy and painful.

Q Okay.

A So I think that it's reasonable to suggest that a -- how can I say it? A less than compliant patient may be seeking to do that at the lowest cost to him in terms of, not money, but in terms of agony, that it is reasonable to suspect that if it's -- it makes him feel sick to be dizzy and painful, then he's not going to participate in anything that makes him sick or painful.

Q Okay. Thank you, Doctor.

Now, Doctor, you were also asked by Mr. Sigmier a few questions regarding medications that he would -- what he was taking, and I just want to make sure I understood this.

When you saw him for the last time in November of 2000 he was off those medications, correct?

A My recollection is he didn't have any money to pay for them and that's why he was off of them.

Q All right. And on that visit was he still expressing dizziness?
A Absolutely.
Q Okay.
A Only this time I was able to talk to him about dizziness without being on the medications, and so I had a clearer idea of his symptoms not covered up by these medications at all.
Q Okay. And, Doctor, would that be an indicator, by virtue of the fact that he was off the medications and still having dizziness, that the medications were not a cause of his dizziness?
A Not only that, but I remember, as I always do with my patients when given the chance, see, I told you the medications aren't helping your dizziness either.
Q Okay.
A And it's true because he was just as dizzy off them as he was on them. Why be on them?
Q So essentially your examination, if I'm not mistaken, was it didn't have an affect on his dizziness?

A (Shaking head) Even though he was convinced of it. I wasn't

Q I see. Okay

Finally, doctor, there's been a lot of talk in your testimony here today about the two accidents and -- and the conversation of the problems you diagnosed here today I'd like to just make sure that I understand and the jury understands your testimony

doctor, first of all, the second motor vehicle accident of July, '99, the one that precipitated him coming to you at the Cleveland Clinic, was that motor vehicle accident a cause of the injuries that you have diagnosed and treated in James Yarbrough?

A Yes.

Q Okay Now, doctor, based upon your review of the records from after the first accident, specifically the records of Harold Mars, did the first accident of March 19 -- March, 1997 also cause cervicogenic problems in James Yarbrough?

A Yes.

Q Okay And, doctor, again, based upon

the last time you saw Mr. Yarbrough and the condition that he was in, can you apportion the disability that Mr. Yarbrough has between accidents one and two?

MR. JEPPE: Objection.

A Absolutely not. I cannot. There's no way I can.

MR. MESTER: Okay. Doctor, I thank you.

MR. SIGMIER: I don't have any questions.

MR. JEPPE: We're done.

MR. MESTER: Okay.

MR. TACKLA: Off the record.

THE WITNESS: Thank you for your patience.

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(Deposition concluded at 4:26 p.m.

Signature not waived.)

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JOHN G. OAS, M.D.

C E R T I F I C A T E

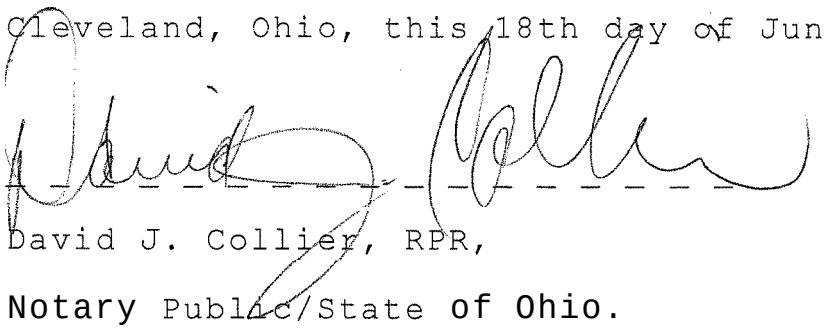
The State of Ohio,)
County of Cuyahoga.) SS:

I, David J. Collier, Registered Professional Reporter, Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named witness, JOHN G. OAS, M.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 the above-referenced witness was by me reduced to stenotypy in the presence of said witness; afterwards transcribed, and that the foregoing is a true and correct transcription of the testimony so given by the above-referenced witness.

I do further certify that this deposition was taken at the time and place as in the foregoing caption specified, and was completed without adjournment.

I do further certify that I am not a relative, counsel or attorney for either party, or otherwise interested in the outcome of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, this 18th day of June, 2002.



David J. Collier, RPR,
Notary Public/State of Ohio.
Commission expiration: April 26, 2006.