IN THE COURT OF COMMON PLEAS

CUYAHOGA COUNTY, OHIO

JOANN JUHN,

Plaintiff,

-vs-

JUDGE LAWTHER
CASE NO. 99465

REGIONAL TRANSIT AUTHORITY,

Defendant.

Doc. 374

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Videotaped deposition of RALPH A. REILLY, M.D., taken as if upon direct examination before Linda A. Astuto, a Registered Professional Reporter and Notary Public within and for the State of Ohio, at the offices of Ralph A. Reilly, M.D., 14601 Detroit Avenue, Lakewood, Ohio, at 2:30 p.m. on Wednesday, December 16, 1987, pursuant to notice and/or stipulations of counsel, on behalf of the Plaintiff in this cause.

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On behalf of the Defendant

ALSO PRESENT:

Shirlie Morton, Videotape Operator

RALPH A. REILLY, M.D., of lawful age, called by the Plaintiff for the purpose of direct examination, as provided by the Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

DIRECT EXAMINATION OF RALPH A. REILLY, M.D.

BY MR. SPERO:

MR. SPERO: This is a deposition of Dr. Ralph Reilly, one of Joann Juhn's treating physicians.

I am Keith Spero, Joann Juhn's attorney and Mr. Taddeo is here representing RTA.

At this time I will ask some questions of Dr. Reilly and I would appreciate it if you swear in the witness.

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(Thereupon, the witness was sworn.)

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A. This isn't being recorded?

Q. Yes, it is.

A. Do we need mikes?

Q. No. It ought to be able to be picked up. We will try to keep our voices up.

Doctor, can you tell us what your name is?

A. Ralph Arthur Reilly.

Q. What is your office address?

A. 14601 Detroit Avenue, Lakewood, Ohio.

Q. What is your occupation or profession?

A. I am a physician specializing in orthopedic surgery.

Q. Doctor, how long have you been licensed to practice medicine in the State of Ohio?

A. I was licensed in 1949.

Q. And you indicated you were a specialist in a particular branch of medicine, Doctor?

A. Yes, orthopedic surgery.

Q. What is orthopedic surgery, Doctor?

A. In general it is just treating of injuries and diseases of the musculoskeletal system which comprises the spine and its attachments and the arms and legs, all the structures therein.

Q. Can you tell us what education and training you have had for the practice of your profession, Doctor, beginning with undergraduate school?

A. Graduated from Adelbert College, 1943.

Q. Is that at Western Reserve University?

A. Yes. Hahnemann University School of Medicine 1947. Served an internship at St. Luke's Hospital in Cleveland for one year. One year

general surgical residency, which is a prerequisite to orthopedic residency training, that was at Lakewood Hospital.

And started my orthopedic training at the combined program of the Graduate School of Medicine, University of Pennsylvania and Akron City Hospital.

After a year and a half of that I was interrupted by two years of service as an orthopedic surgeon in the United States Air Force where I was chief of orthopedics in the Air Force Regional Hospital.

I returned and finished my adult training in the Cleveland Clinic. Had a year of children's orthopedic training in Kernan Orthopedic Children's Hospital in Baltimore.

Q. Are you a Board Certified specialist in orthopedic surgery?

A. I am.

Q. What requirements are necessary in order for a physician to become Board Certified as a specialist in orthopedic surgery? Are there tests or requirements or is that an automatic designation?

A. First of all the American Board of Orthopedic

Surgery has designated certain training programs as being approved by the board.

And you must then complete the training requirements of the board and there are two examinations given by the board, one can be taken after your first two years of training or at any time thereafter.

And the second examination is given two years after you have been in practice or at any time thereafter. And you must pass both of those examinations. And at the completion of all of this, you are certified as being competent to practice orthopedic surgery.

Q. As a specialty?

A. Yes.

Q. And when did you become a Board Certified orthopedic specialist, Doctor?

A. 1957.

Q. Doctor, at what hospitals do you regularly practice?

A. I am chairman of the Department of Orthopedic Surgery at Lakewood Hospital and I have privileges at Fairview General and Lutheran Medical Center.

Q. So what professional organizations or societies

do you belong?

A. I am a fellow of the American College of Surgeons. Fellow of the American Academy of Orthopedic Surgeons and I have been on the board of counselors of that group.

I am a past president of the Cleveland Orthopedic Club, member of the Ohio State Medical Association and Ohio State Orthopedic Society and American Medical Association and so on. Mid America Orthopedic Society, charter member of that group.

Q. Fine. When and where did you first see Joann Juhn as a patient, Doctor?

A. I first saw her here in my office on August 21, 1984.

Q. Doctor, did you take a history for purposes of treatments?

A. Yes, I did.

Q. What history did you obtain, Doctor?

A. My history consisted first of eliciting her complaints. Secondly how these complaints arose. Any other medical history that might be pertinent.

Q. Could you indicate, you know, how did she -- did she come to you saying that she was hurting or

injured or something?

MR. TADDEO: Objection.

Q. Can you tell us what history you took for purposes of treatment?

A. Some of her history is written in her own hand on an admission form we have. And listed under her chief complaint, pain in the right leg and back, shoulders, neck, right arm and hand and pain in the fingers. No feeling in the fingers accompanied by tingling sensations. I presume that all relates to the right hand and the complaints about the hand and fingers.

She described the pain as constant, moderate degree but intermittently severe in the leg and back.

She further, on further questioning she described the pain in her right leg as being from the heel up to the anterior thigh and the groin. Told me that it was worse on weightbearing, that she dragged the right leg on walking.

Q. Did she indicate when all of these complaints started?

A. They were somewhat changable over a period of time but her initial complaints started on the

8th of February, 1984 when she was injured while a passenger on an RTA train which was derailed. This threw her somewhat off her seat and resulted in the injuries. She related to me that she was thrown, she grabbed the back of the seat in front of her. She was sliding off.

I am not certain whether she grabbed the one in front of her or her own seat. This caused a stretching injury of the right arm and she was thrown somewhat forward and received, of course, quite a jerking type of injury to her body.

Q. And did she describe any medical treatment that she received prior to seeing you --

A. She related --

Q. -- as part of that history?

A. She related she went to the emergency room at Lutheran Medical Center where she was x-rayed and examined and they provided her with a cervical collar and medication. And she was referred then for follow-up care. I understand she saw Dr. Bohl the following day.

Q. Was she admitted to your knowledge to Lutheran Medical Center? I believe she was admitted for three or four days or a week. Saw Dr. Bohl in

the hospital, is that consistent with what you have got?

A. I don't have that in my record.

Q. And to your knowledge did she see other doctors from time to time prior to seeing you?

A. She did not relate any other medical attention.

Q. What if anything did she tell you about pain in her lower left abdomen?

A. Initially she didn't have any of those complaints. Later on she had complaints of that nature.

Q. Did she tell you that she had had pain in her lower left abdomen?

MR. TADDEO: Objection.

A. Not at the time of my initial examination, no.

Q. Are you aware of what medical and hospital treatment she did receive since the derailment and before first coming into your care?

A. She had some physical therapy which she said had been helpful in reducing her neck and arm complaints. She said that her last treatment had been on July the 30th of 1984.

Q. What were her complaints when you first saw her in August of '84, what were her chief complaints?

A. I just related all of those complaints. You want me to go over those again?
Q. Just so that we make sure what it is that you are seeing her for.
MR. TADDEO: Note my objection to the repetitious nature of the testimony.
Q. Well, did you make an examination thereafter of her with regard to these complaints?
A. Yes, I did.
Q. Would the use of an anatomically correct model of the human spine aid you in explaining the findings that you made on examination, Doctor?
A. I don't think at this time.
Q. Can you tell us what findings you did make?
A. In regard to the neck, she exhibited moderate spasm of the muscles in the back of the neck and the upper trapezious muscle. Those are the broad muscles up here on top of the shoulder that extend up into the neck.
She also demonstrated some limitation of motion, movement and rotation and on lateral bending of the neck. There was marked tenderness over the third, fourth and fifth interspinous ligaments in the back of the neck. There was marked tenderness in the muscles about

both shoulder blades.

I could not find any abnormalities of a neurological nature or no circulatory abnormalities in the upper extremities.

In relation to her lower back, she exhibited moderate lumbar spasm and limitation of motion in all directions. Straight leg raising was painful in the lower back at 60 degrees on each leg.

There was marked tenderness over the lumbosacral area and over the right post iliac spine, the lumbosacral area of course being the lowest portion of the spine and the post iliac region is the back portion of the pelvis.

She had moderate tenderness over the right greater trochanter which is the prominent portion of your hip which you feel over on the side. Once again there were no neurologic or circulatory changes.

In relation to the right arm, she did show some clinical evidence of compression of the median nerve and the carpal tunnel.

Q. Now Doctor, you mentioned something about muscle spasm. Can you explain what that is?

A. Muscle spasm is a continuous contraction of a

muscle. This is a condition that is beyond the patient's control. It is an involuntary activity.

It has somewhat of a protective nature but at the same time it usually produces pain of its own and therefore it is often a source of continual pain on a vicious cycle basis of spasm producing more pain and pain producing more spasm. But it is an involuntary situation.

Q. In other words the patient -- can the patient intentionally cause this to occur?

A. The patient has no control over it.

Q. What does it do to the muscle? Does it make it hard or soft or what does it do?

A" Well, the muscle is very tight. It is contracted and very tight.

Q. Would you be able to point out on an anatomically correct model where you found the muscle spasm in her body?

A. Well, basically yes.

Q. Is this model anatomically correct, Doctor?

A. Basically, yes.

Q. Can you tell us -- what does that show? Could you explain that for the jury?

A. This is a plastic model. It is not real bone.

It is a plastic model of the spine and pelvis and it has a portion of the base of the skull attached up here.

The upper seven segments here are the cervical spine or the neck area. And these are the spinous processes to which I referred. There are of course ligaments between these spinous processes and on top of them as well as on the sides.

Q. Is the part that you are holding right now the neck?

A. This is the neck area. Of course, these are muscles that go up and down the spine on each side and in these areas on each side of the spine in the back that the spasm was detected and of course in the lower back it is down in this area.

Q. All right. Now what is the difference between an objective finding as opposed to a subjective complaint?

A. An objective finding is a finding, that is the examiner detects entirely and one over which the patient has no control. It is a response to a specific test or any other finding over which the patient has no control.

Q. How would you classify muscle spasm?
A. Well, as I indicated earlier, this is an objective finding over which the patient has no control.
Q. Now is muscle spasm a constant thing as opposed to sometimes being present and sometimes not even if there is real injury?
A. It can be intermittent depending on the degree of stimulation that might produce it. It might be present at one time and not another.
Q. Why would that be?
A. But when it occurs it is not just a momentary thing ordinarily. It can be momentary but it is always involuntary when that happens.

But ordinarily once it starts, it lasts for a period of time, anywhere from minutes to hours to days or weeks even.

Q. And that is true that it can come and go even if there is real injury?
A. Oh, yes.
Q. What is the relationship between muscle spasm and injury? Does the presence of muscle spasm indicate anything one way or the other so far as whether or not there is an underlying injury?
A. Independent muscle spasm is either a response to

a pain reflex alone or as a protective measure to prevent the production of pain by certain movements or positions that one might obtain.

Q. Can you explain what limitation of motion is in the medical sense, Doctor, as far as whether that is objective or subjective and whether or not, how that is used by you?

A. There is an average range of motion of the various parts of the body and in testing the range of motion of a given individual, it is compared to that average.

In the case of the extremities, if one extremity is injured and the other one isn't, we have a direct comparison. But normally it is compared against an average and we determine whether the motion approaches the average or whether it is limited.

And if it is less than average, it is described as limited motion of course.

Q. Is limitation of motion an objective sign of injury to an experienced medical specialist in your field, Doctor?

A. Well, it is kind of iffy. An experienced examiner should be able to detect any voluntary attempts to inhibit motion. There can be some

voluntary control over that.

Q. When you examined Joann Juhn, you said you found limitation of motion?

A. Yes.

Q. Was that voluntary or involuntary?

MR. TADDEO: Objection.

Q. What is your opinion?

A. My opinion it was involuntary, particularly in view of the demonstrated muscle spasm which is strictly an involuntary situation.

MR. TADDEO: Objection.

Q. What about marked tenderness, Doctor? You said you found it. Is that an objective sign of injury?

A. That is subjective. That requires a response on the part of the patient. It is not directly observed by the examiner either by sight or touch or response to a test.

Q. Based on your experience are you able to tell whether or not the patient is feigning marked tenderness or actually has marked tenderness, Doctor, in your experience as an orthopedic surgeon?

MR. TADDEO: Objection.

A. Well, there are degrees involved here. Somebody

that obviously is over-reacting is easily detectable and there are probably lesser degrees that you might be deceived in that instance.

Q. What was your opinion with regard to Joann Juhn so far as your physical examination of her in that regard?

A. I saw no evidence that she was over-reacting at that point.

Q. And where did you find both this limitation of motion and marked tenderness on August 21st when you first examined Joann Juhn?

MR. TADDEO: Objection. It has been asked and answered.

MR. SPERO: This is just preliminary to the next question.

A. The areas of tenderness were in the back of the neck, three different levels, over the lower back, over the muscle attachments to the back of the pelvis that we referred to, the right post iliac region.

Q. Would you pull that up a little higher?

A. Right by this area.

Q. Is that by the hip?

A. That go down into the lower part of the back. And also over the side of the right hip.

Q. Doctor, you indicated -- excuse me.
A. And around both shoulder blades.
Q. All right. You indicated you performed a straight leg raising test on the patient on August 21, 1984.
A. Yes.
Q. Can you explain to us what that test is and how it is performed and what it is supposed to show?
A. It is performed with the patient lying on the back and one leg at a time is lifted to the point at which that produces pain either in the back or down in the leg is noted.

And the point at which the leg cannot be lifted any higher either because of muscle tightness or because of inhibition due to pain is noted and the area where the pain is produced is noted.

Q. Was that significant in Joann Juhn's case, Doctor, that test?
A. She was painful in the lower back at 60 degrees on each side. Normally a flexible individual can go up to 90 degrees which is right angle, but some people have tight muscles normally and wouldn't go quite as far.

But 90 degrees is considered an obtainable

normal. In this case as I indicated at 60 degrees on each side she developed increased pain in her lower back.

Q. All right. Doctor, is the spine a single bone or is it more than one bone?

A. No. It is -- as you can see on this model, it is a series of boney segments that are of course intimately related.

Q. Can you briefly explain the anatomy of the spine, Doctor?

A. I don't know if I can do it briefly.

Q. Do the best you can.

A. In detail it would take the rest of the day. But basically the first seven segments are the neck area.

Q. Are those separate bones?

A. We are looking at it from the side now. The first seven segments are the neck area and the next 12 are the thoracic or dorsal area and the bottom five are the lumbar area in a normal spine.

And of course the bottom lumbar vertebrae articulates with the sacrum which is this portion between the wings of the pelvis here.

Q. What is between the individual bones or

segments?
A. In between the bones are intervertebral discs.
Q. What is the function of those?
A. Between the vertebral body portions of the bone which are the heavier portions in the front. And these clear plastic areas in here are the intervertebral discs.

As you can see in the neck the bones are much finer and the discs are smaller. The bones and the discs themselves become increasingly large as we go lower in the spine. The load of course on these areas becomes greater so that the structure has to be bigger and stronger.
Q. Are there nerves -- is the spinal column associated near the areas that you are talking about?
A. Well, let's turn this around. Well, let's turn it around and look at it from the back. The spinous processes, the laminae and transverse processes here --
Q. Are those parts of the bone?
A. And looking at it from the side there is a continuation of bone from the body back to these areas and there are also some small joints between the segments.

All of this forms an arch over a canal which is called the spinal canal through which the nerve elements of the spine travel.

At each level between vertebrae a nerve root emerges on each side represented by these yellow plastic pieces here. You may be able to see in through here the spinal cord and of course the roots that come off on each side here.

Q. Those yellow things are supposed to be nerves?

A. Those represent nerve roots, yes.

Q. Do those nerves go to different parts of the body?

A. They innervate the different parts of the body of course starting with the level where they emerge. In the neck region, these nerves, these roots coalesce to form the nerves that go into the arm and in the lumbar area, they coalesce to form the nerves that go into your leg.

Q. Are all of those nerves attached to the spinal cord, Doctor?

A. Yes, they all travel from the spinal cord.

Q. Is the spinal cord attached to the brain, Doctor?

A. That has its origin at the base of the brain,

yes.

Q. Now, what is the function of these discs that you referred to?

A. Well, the discs have two functions. One of course is to provide stability by virtue of their attachments to the bony portions of the spine and the other basic function is to allow motion and to cushion the forces that occur in movement.

Q. Sort of like a shock absorber or something?

A. So these discs are tough but they are elastic to a degree and they do allow some movement.

Q. Is it something like a shock absorber in function?

A. You could describe it as a shock absorber, yes.

Q. Now, can you explain what a herniated disc is?

A. Well, a herniated disc occurs when a portion of the disc becomes displaced. It can displace anywhere but most significantly, of course, would be if, say down here, if it displaced backward and pinches this nerve back behind the bone behind it, see. In the neck a similar situation.

Q. What would happen if that happened, if it impinged on a nerve?

A. It would produce at least some abnormal sensations, numbness, tingling, pain. If the pressure increased, it would lead to paralysis.

Q. I will go back to that in a little bit.

I would like to -- first of all, would it necessarily produce the pain right there at the site of the herniation?

A. It could produce the pain anywhere in the distribution of that nerve root. So it could, in the case of the neck, it could produce pain all the way into the fingers.

In the case of the lower back it could produce pain all the way into the foot.

Q. I see. Doctor, do you have an opinion to a reasonable medical probability as to whether or not Joann Juhn suffered one or more herniated discs or damage to the discs in that fashion as a result of the derailment and crash of the RTA rapid transit of February 8, 1984?

Do you have an opinion?

A. Yes, I do.

Q. What is that opinion?

A. My opinion is that she did definitely suffer injury to at least one disc in the neck and also to a disc in her lower back as a result of that

injury.

Q. Now, did you come to that conclusion on August 21, 1984 on the first day that you met her?

A. No, I did not.

Q. What -- when did you come to that conclusion? I don't need the exact date. Did you work with her for a period of time?

A. It was several years later actually that I finally came to the conclusion that she had some probable disc pathology and at that time I referred her for a magnetic resonance imaging study, both the neck and the lumbar spine and at that point my suspicions were verified. This was in May of 1987.

Q. All right. We are going to come back to that. Let's go back first to August 21, 1984.

What was your working diagnosis at that time?

A. My initial diagnosis were, number one, remote sprain of the cervical spine with residual periscapular fibromyalgia. Two, lumbosacral strain.

Q. Could you explain what that meant in ordinary language?

A. Let's go back to the neck. The sprain of the

cervical spine I think is more or less self-explanatory.

Q. What is a sprain?

A. It indicates she had some tearing of the muscular and ligamentous support in the neck.

The term fibromyalgia periscapular means that she had a painful nodular condition of the muscles about the shoulder blades and this of course is indirectly related to the injury to her neck.

Q. And what is lumbosacral strain?

A. Lumbosacral of course is the lower part of the spine as indicated on that model and at that point I diagnosed that as a strain rather than a sprain, meaning that there was a lesser degree of injury, that the ligaments and muscles down there appeared to have just been stretched and not actually torn.

Q. But you thought she had torn muscles and ligaments in her neck?

A. Yes.

Q. Now then are those torn muscles and ligaments, would they be -- how close would they be to nerves that are in the neck?

A. Well, they wouldn't have any direct relationship

to the nerves.
Q. But are they near them?
A. They are near them certainly.
Q. Now what is radiating pain, Doctor?
A. Okay. Radiating pain, radicular pain is pain that is along the course of a specific nerve and caused by a condition directly affecting that nerve.
Q. Where is that pain felt?
A. It is felt in the distribution of the nerve.
Q. If there is an injury in one part of the body, can it be felt in another because of this radiating pain?
A. Yes. As I indicated earlier, an injury in the upper portion of the body and in the cervical area of the neck can produce pain into the hand.
Q. What causes radiating pain?
A. Well, I just answered that. Some sort of injury or abnormal condition of the nerve supplying the area where this pain is felt.
Q. Did you find that Joann Juhn had radiating pain, Doctor?
A. Not on my initial examination, no.
Q. Did you eventually find that she had radiating pain? Did she have complaints of having any

pain in parts of her body where you found injury elsewhere?

A I have to go through many notes here.

Q It was my impression I thought you said she was complaining of pain down one leg and down one arm in your medical report.

A Actually it was difficult I think at any time to differentiate in her case whether her pain was true radiating pain or whether it was what is called referred pain.

And the distinction there is that referred pain is pain into an area remote from the origin of the diseased or injured part of the body which does not travel down a specific nerve pathway from the point of injury.

There has to be some sort of transfer of the pain impulses either through the spinal cord or maybe even through the lower portions of the brain.

Q Did you find that Joann Juhn had referred pain?

A Well, as I just indicated, it was difficult to determine at any point whether it was referred or radiating pain. It basically didn't have all the elements of true radiating pain at any time which is one reason why it took so long to

establish a definitive diagnosis in this case.
Q. Where was her either referred or radiating pain as you say it, whichever it was?
A. Where was it?
Q. Yes.
A. Well, it was in all these areas that we went over way back in the beginning of her complaints, pain down and tingling and numbness and so on in her hand and arm and pain down her right leg.
Q. In light of your findings throughout the entire course of your treatment of her over several years, was that in your opinion to a reasonable certainty real pain, Doctor, that she in real life had that pain?
A. Yes. It certainly was real pain.
Q. Doctor, did you take x-rays of her body on August 21, 1984?
A. Yes, I did.
Q. And what portions of her body did you x-ray?
A. X-rays of the neck area, bony structures showed some malalignment due to muscle spasm.
Q. What does that mean?
A. Well, it means that the normal curvatures in the spine were altered. Looking from the side, you

can see that there is, they are balanced curves in the spine.

In the neck area the curve is somewhat forward. In the dorsal area it is somewhat backward.

Q. Is the dorsal area where your shoulder blades are in the middle of your back?

A. The shoulder blades are in the upper portion.

Q. Is that the low back and the belt line and below?

A. Yes. It curves back inward again. In the presence of muscle spasm, on the x-ray, this normal so-called lordotic curve will straighten out and look stiff like a poker instead of having a graceful curve to it.

Q. You actually found that on these x-rays?

A. Yes.

Q. You have the x-rays here. In a few minutes I will ask you to get them, not quite yet.

You have those x-rays, is that right?

A. Yes.

Q. Did you also have the opportunity, Doctor, before today to look at other x-rays that had been taken of Joann Juhn's back from time to time?

A. Yes.
Q. Do you have those here too?
A. Yes.
Q. All right. Can you put some of these x-rays up on the view box and compare them and tell us what significance they are in a few moments.

I wanted to ask you what x-rays show. Do x-rays show anything more than bone, do they show soft tissue?

A. They don't show soft tissue hardly at all.
Q. Okay. What do they show?
A. They show basically the bony structures. The soft tissues are very vague shadows.
Q. All right. And you told us what the cervical x-rays showed.

Why don't you show us the x-rays? You can read them for us on the view box, first the ones that you took on August 21, 1984.

A. Now this is a side view of the neck bending backward and the findings on that film are essentially normal.

This is the erect view and you can see that this is not a graceful symmetrical gentle curve. We start up here and from this level up in here there is a straightening, an asymmetry

of the spine and that is felt to be due to muscle spasm.

I do not see any evidence of any bony injury and the disc spaces, this is where the intervertebral discs are. They all appear to be pretty normal.

Q. Would malalignment due to muscle spasm be painful, Doctor?

A. Yes.

Q. And what about the lumbar spine, did you also have any films taken of those?

A. I did. Essentially that was normal. I think it would be a waste of time to sort through all these films to demonstrate it, unless you have --

Q. Earlier you had mentioned that you thought that she had had a herniated disc in the lower part of her spine.

How could the x-rays be normal if that were true?

A Well, we already indicated the x-rays don't show the soft tissue and the intervertebral disc is the soft tissue.

Q. I see. So x-rays would not be able to detect a herniated disc by themselves?

A. No. They would show if the disc had gotten degenerated and flattened out. That is not the initial condition of it normally.
Q. Okay. Now can you compare any x-rays, any other x-rays that you have of Joann Juhn with the x-rays that you took on August 24, 1984?
A. Well, I took further films in June of '85 of both the neck and lower back and in neither instance did they provide any real new or significant information.
Q. Once again because it is really basically soft tissue?
A. Yes.
Q. What about previous x-rays that were taken before she saw you? Have you looked at those or can you show us those?
A. I have seen x-rays taken at Lutheran Hospital on the day of injury.
Q. Can you put those up and show us those.
A. Now this is again that side view of the neck.
Q. Is it much difference from what you had?
A. Well, on this view I would probably call that pretty much a normal appearing cervical spine. They didn't take any motion views, however, to demonstrate what happens when she bends forward

or bends backwards. This is merely a straight lateral view and motion views might have revealed some restriction.

It appears as though she was probably wearing the cervical collar at the time this was taken because you can see these faint streaks that you see across here which I assume to be from some sort of collar about her neck to splint the area.

Q. All right. Have you seen any other x-rays besides the ones that you took and the ones at Lakewood Hospital and the ones that were taken at Lutheran Hospital on the day of the accident?

A. Not plain films, no.

Q. Were any of these films that you did see from Lutheran alter your view in this case in any way?

A. No, not at all.

Q. Now as you sit here today, Doctor, do you have any doubt that the straightening of the lordotic curve in her neck and the muscle spasm and the pain that you found were in fact caused by damage to Joann Juhn's disc in her neck from the crash of the RTA train that derailed?

MR. TADDEO: Objection.

A. No, I don't have any doubt.
Q. And did you in fact eventually diagnose that particular disc in her neck as being herniated and pressing on the spinal cord and nerves, Doctor?
A. Yes.
MR. TADDEO: Objection.
Q. Is a herniated disc painful, Doctor?
MR. TADDEO: Objection.
A. Painful to varying degrees, yes.
Q. Could you turn off the light.
Can you please describe the type of pain herniated discs typically cause, Doctor, in relation to what you found in Joann Juhn?
A. It depends of course on what parts it presses. If the disc is just stretching the ligaments behind the disc, the pain would tend to be dull and confined pretty much to the area of the neck or lower back where it may occur.
In the neck area where the spinal cord of course exists, if it presses against the spinal cord, it is apt to cause rather diffuse symptoms which are going to go into the extremities and they may go into both the upper and lower extremities because of course the spinal cord

has the nerve tracts which supply the entire body and even at the neck level of course the tracts that go into the lower part of the body and into the legs exist and press on the cord and the neck can produce symptoms in the legs as well as in the upper extremities.

If the herniation is out to the side further, then it is going -- I may illustrate this here a little bit. This of course is the spinal cord. And the discs are in the front here and they can rupture straight back in the middle and press against the spinal cord or just slightly to one side and still catch the cord.

If they rupture out more laterally here, then they are going to pinch these nerves. Then you get what we referred to earlier as a true radicular pain.

Q. Did Joann Juhn have that?

A. No. And then you get the real true radicular pain where you can pretty much trace the course of the pain. You can trace the course of the pain and frequently there will be some numbness in the course of that nerve and you can test that and test the specific areas of the extremity where a specific nerve root supplies

and localize the lesion quite accurately. This she did not have.

Q. It would have been easier to diagnose?

A. Yes, that would have been much easier to diagnose. She had the more diffuse type of pain with sort of a combination of radiating and referred pain into the upper extremities and possibly even the lower extremities.

Q. Well, for what period of time have you been Joann Juhn's treating orthopedist?

A. Well, ever since August of '84.

Q. To the present?

A. Yes.

Q. Well, if you did not decide at the outset that she had these herniated discs, when did you come to that conclusion?

A. Well, it would have been I think May of 1987 when I sent her for the MRI.

Q. Now, what kind of treatment had she had between August 21, 1984 and May of 1987 when you decided to send her to the MRI?

A. Well, she had intermittent physical therapy and she treated herself at home of course with heat and she was advised on some exercises.

In the interval she also had some

psychotherapy because all of this began to tell on her emotions and I understand that she also had some treatment by her family physician, Dr. Mulligan, for a period of time during this overall period because she could not get away from work to see me, he had office hours at a more convenient time. She of course had medication.

Q. You had even hospitalized her in '86, didn't you?

A. At one point she was hospitalized because she had an acute increase in her pain which wasn't responding to outpatient treatment.

Q. So you finally referred her to MRI?

A. Yes.

Q. And what is MRI?

A. Well, it is, stands for magnetic resonance imaging.

Q. Is it a test of some sort?

A. It is a study in which the body is subjected to high force magnetic fields. Without getting into a lot of scientific jargon, it demonstrates soft tissues quite nicely in contrast to x-rays. And it is one of the more recently developed investigative tools to look for

disease.

Q. What were the results of these MRI tests?

A. Well, without reading from it directly --

Q. Just whatever.

A. It did show a central disc rupture in the neck area between five and six. It would be down at this level pressing against the spinal cord.

It also showed a small disc rupture at the lowest level in the spine, the lumbosacral level down here.

Q. Now Doctor, were those test results consistent with your personal clinical evaluation of the patient in May of 1987?

A Yes.

Q Now on the basis of your hands-on clinical evaluation of this patient in May of 1987, and the results of the MRI tests that you sent her for, what was your diagnosis of the patient at that point?

A. After the MRI?

Q. Yes.

A. Obviously she had the ruptured disc and the cervical spine pressing on the spinal cord.

Q. What problems did that cause?

A. This leads to a diagnosis of cervical myelopathy

secondary to ruptured disc.
Q. What does that mean?
A. It means that there is -- the strict definition, the term myelopathy, it means there is a pathological condition in the spinal cord itself.
Q. In your opinion to a reasonable medical certainty or probability was that responsible for the problems of pain and numbness she was having in her arms and wrist and hand?
A. Yes.
Q. In your opinion to a reasonable medical probability is this the reason why she was having problems with dropping things and with typing?
A. Yes.
Q. Had she complained of these things to you over a period of years?
A. Yes.
Q. And what was your diagnosis as far as her low back was concerned by May of 1987 after the magnetic resonance imaging tests were completed and you completed your clinical evaluation of the patient as far as the low back is concerned?
A. Well, it did demonstrate a ruptured disc on the

MRI study. I am still not willing to feel that this is a surgical condition at this time.

Q. Yet? Have you in fact advised her with regard to surgery on both her neck and her low back?

A. She already had surgery on her neck of course.

Q. You did that?

A. Yes.

Q. We have not come to that in this deposition.

Did there come a time when you advised her in May of '87 or at some point thereafter about surgery to her neck and low back? What have you advised her back then at that point?

A. Well, at that point I advised that, feeling that her biggest problem was in her neck, we should go ahead and remove the offending disc and replace it with a bone graft.

Q. Doctor, do you have the MRI films which you could show where the disc is on the film?

A. I don't know if there will be anything that would be really visible or not here. Let's see.

Okay. We can see something here. This again -- excuse me. This is probably the best one here.

This is a side view of the neck area and

the base of the skull. This is the lower portions of the brain coming in here. This is the spinal cord, this white area down here. The darker areas are the segments, the bony segments of the spine. The lighter areas in between are the discs.

At this level you can see an indentation into the spinal cord where this disc is ruptured and pressing on the cord. You can see it again over here.

Q. All right. And you also have similar findings with regard to the low back?

A. Now this is going to be difficult for you to see. It is difficult for me even to see. But this of course is the lower back. Once again the dark areas are the bony segments of the spine. The lighter areas are the discs which are much bigger here.

You can see even the difference in the lightness or darkness of these discs as compared to this disc. This indicates degenerative changes in this disc.

You can even see some of that, the central part of that disc protruding in a little tongue like area and producing a little pressure out

here on the nerve elements. Now this is not cord down here.

Starting at the first lumbar, remember I told you there were five lumbar vertebrae, between the first and second lumbar the spinal cord ends. From there down it is just a number of nerve roots all latched together in what is called the cauda equina which interprets to mean horse's tail, which means that there are a number of filaments in it.

So these are nerve roots coming down through here, not the cord. There is a little pressure coming down here.

We would have to go through all of these and look at them and you would have to be an expert to make the interpretation. That is why we have radiologists that do that. I don't think I can really demonstrate that too well to you.

Q. In your opinion to a reasonable medical probability, does she have damage to her lumbar disc in the lower part of her spine as a result of the February 8, 1984 derailment?

A. Yes.

Q. In your opinion to a reasonable medical

probability was the herniated disc that you found in her neck related and caused, related to and caused by the derailment of February 8, 1984?

MR. TADDEO: Objection.

A. I certainly believe so, yes.

Q. Now at any time during the course of your treatment of Joann Juhn from August of 1984 to the time that you came to the conclusion that her discs were herniated, did Joann Juhn present with any symptoms or conditions that were inconsistent with a herniated disc diagnosis?

A. No.

Q. Can you explain why then you did not come to a conclusion it was a herniated disc at the outset? I know you touched on it before but could you be more clear on that?

A. I indicated she never had any definite neurological changes that would be objective evidence or no changes in reflexes. There were no definite sensory patterns that followed anatomical designs.

There was no evidence of any muscle atrophy even though she was complaining of dropping things and weakness and what not, there still

was no evidence of muscle atrophy to indicate any significant paralysis. So you had really nothing to really hang your hat to make a diagnosis.

Q. Of course you didn't have the MRI at that time back in '84?

A. Correct.

Q. What kind of treatment did you prescribe back in '84?

A. I indicated she had physical therapy.

Q. Did it seem to do her some good?

A. Exercises, medications, traction, neck tractions. Yes, she went through periods where she did fairly well.

In fact when I first saw her the treatment she had been receiving to date had helped her neck symptoms to improve and then they became worsened as time went on.

Q. Why would --

A. Initially her back symptoms were not prominent but at the time of her first visit and the thing that brought her in initially to see me was a flare-up of back and leg pain.

So her major complaint when I first saw her was actually her lower back and her leg, not her

neck.
Q. When did you first see her after August 21, 1984?
A. Pardon me?
Q. When did you see her next after August 21, 1984?
A. It was September 4th of 1984.
Q. And what did you find then?
A. Well, she seemed to be improved and I just recommended she continue on symptomatic use of heat and continue with her exercises.
Q. Can you explain what exacerbations and remissions mean as related to the herniated disc?
A. An exacerbation just means the symptoms become worse and the remission it becomes better.
Q. How does the pain get produced in the case of a herniated disc?
A. This is not -- when a disc is ruptured or herniated, it is not always herniated to the same degree. It depends on the position that one gets in, the amount of pressure that is exerted on the disc which may squeeze it out a little further.
Q. By herniated you mean it bulges out beyond where it was supposed to go?

A. Bulges or it may be a completely free fragment even.
Q. Is there any free space that is next to where it comes out or are the nerves --
A. Yes, there is some space obviously. There has to be some room for the nerve elements to accomodate to changes in position.
Q. What happens with swelling in that area, if anything, Doctor, where there is a herniated disc as far as the associated tissues are concerned?
A. Ask that again, would you?
Q. Is there swelling in the associated areas where the herniated disc is produced?
MR. TADDEO: Objection.
A. That would vary. I don't think you could say specifically. There would be swelling if it was pressing on a nerve. That would make the nerve swell probably.
The other soft tissues in the area might react in chemical irritation even and produce some swelling of the tissues around the disc.
Q. Is that painful, Doctor?
MR. TADDEO: Objection.
A. Not significantly unless it is producing

pressure on the nerve.

Q. If it is producing pressure on a nerve, is that painful?

MR. TADDEO: Objection.

A. That is painful.

Q. Doctor, why sometimes are there symptoms when you have a herniated disc and other times there aren't?

A. We are just getting into that. Sometimes the disc is bulged out further at certain times. In certain positions you put more pressure on the disc which makes it bulge and also narrows the space through which nerves might emerge and make it more vulnerable to pressure.

Q. Does that mean that the symptoms that a patient experiences if they have a herniated disc are not always the same?

A. Yes, they are not necessarily the same from day-to-day or even hour-to-hour.

Q. If a person does have herniated discs, can physical therapy and medicine sometimes mask these symptoms?

A. It will alleviate them. Of course analgesics if they are powerful enough can definitely mask them.

Q. Will that give permanent relief if the disc is actually herniated?

MR. TADDEO: Objection. Are we talking Joann Juhn or are we talking some generalized person.

Q. In general and if a person has a herniated disc and gets medicine, will that permanently take care of the problem?

MR. TADDEO: Objection.

A. Medicine alone will not take care of it, no.

Q. Did it in Joann Juhn's case?

A. No.

Q. Is that why surgery was eventually required?

A. Yes.

Q. Now in your opinion to a reasonable medical certainty, did Joann Juhn have these injured discs in her neck and low back which you eventually diagnosed to be ruptured when you first saw her on August 21, 1984 and on September 4, 1984?

A. I think the overall history and progression of this case would indicate to me that she definitely had the injury to the disc at that time. Whether at what point the disc actually ruptured into the spinal canal and put pressure

on the spinal cord, I am unable to say.
Q. Except that it was as a result of the train wreck?
A. Direct result of the injury, yes.
Q. Now when --
MR. TADDEO: Objection. Move to strike.
Q. -- did you next see Joann Juhn?
A. Pardon me?
Q. When did you next see Joann Juhn?
A. I did not see her again until the 9th of May, 1985.
Q. Now, had you determined why she had not come back to see you between September of '84 and May of '85?
A. No. That refers back to what I mentioned earlier. She had been seeing Dr. Mulligan at that time because she could not get off work to see me when I had office hours.
Q. Why did she come in to see you on May 9, 1985?
A. She said she was having some increasing problems particularly with her right leg. Said she had fallen several times because it had become difficult to move the right leg.
She did say she was dropping things with

her right hand. She was complaining about pain in the medial side of her right thigh on walking and also into the left groin.

Q. Are these complaints consistent with herniated discs in the cervical and lumbar spine?

A. Yes, they certainly are. They certainly fit into the overall picture that she presented over that period of time.

Q. What did you diagnose on May 9, 1985?

A. My diagnosis was still cervical sprain and lumbosacral strain, chronic.

Q. What does chronic mean?

A. Longstanding.

Q. All right. Now you mentioned before that you did not find any neurological findings.

Is that terribly unusual even if there is a herniated disc or is that --

A. Not unusual, no. But to make a really definitive diagnosis clinically, one certainly wants to find some neurological changes.

Q. But can a person have a herniated disc and not, in your experience, not have these neurological changes?

A. Definitely.

Q. Is that what happened in this case?

A. Yes.
Q. What did you recommend to her at that point, back in May of 1985?
A. There is no specific mention made here in the notes. But I presume she had some physical therapy because I saw her again a week later and she was not improving.
Q. Did she have further pain?
A. She had the same complaints plus she was complaining about pain in the left lower abdomen and also pain in the medial side of her right knee and on the dorsum of the right forearm.
Q. What was the right knee pain from?
A. I could not determine anything unusual with the knee itself. I assume it was referred pain from her lower back.
Q. Now when did you next see her?
A. June 14th of '85.
Q. And what was her problem then? Was it about the same?
A. The notes only reflect she had further x-rays taken at that time.
Q. Well, did you see her after that?
A. On July 11th.
Q. And tell us about that appointment? What were

her complaints?

A. She was improving at that point. She had been on physical therapy. She did relate on the fourth of July her right ankle had given out on the stairwell. But she fortunately was holding onto the handrail and didn't fall.

But as a result of that she did go to Lakewood Hospital emergency room and they did an x-ray of her ankle. It was negative, normal.

Q. That wasn't -- was that the first time she told you she fell when she was trying to walk or going downstairs?

A. No. She told me she had fallen a number of times prior to that.

Q. In your opinion, Doctor, was that fall on July 4th as well as the others she told you about related to the RTA derailment to a reasonable medical probability because of the injury to her low back that you told us about?

MR. TADDEO: Object.

A. I would say yes, and to amplify it by saying that I believe in light of later developments, that it was quite probably due to the cervical cord pathology from the ruptured disc.

Q. Now what were her other complaints on July 11,

1985, Doctor?

A. Well, pain in the right knee into the toes. Some numbness in the fingers, the right hand and also in the left hand.

Q. Doctor, would that make it difficult for her to type? She is a typist by occupation.

A. She complained to me that she was having trouble with typing and estimated that this was present about 25 percent of the time.

Q. In your opinion to a reasonable medical probability what was causing those difficulties with regard to the fingers and the hands and the numbness?

A. I think this can all be related to the disc rupture in the neck.

Q. What did you recommend to her so far as treatment was concerned that day?

A. At that time I just advised her to continue on her exercises since she was improving.

Q. Did you continue to see and treat this woman during 1986?

A. January 13th of '86.

Q. And on other dates as well?

A. 4/29/86; 5/8/86.

Q. What happened on 5/8/86?

A. She complained of awakening with severe pain in the lower back that morning shooting into the front of both thighs. Marked difficulty walking.
Q. Did she appear in your office that day?
A. Yes.
Q. What did you do?
A. I examined her and it was at that point that I admitted her to the hospital for traction and therapy to her lower back.
Q. How long was she in the hospital, Doctor? I have between May 8th and May 23rd. Does that square with your records?
A. I have to get the discharge summary here. It doesn't come readily to hand. But that seems reasonable.
Q. What is her pelvic traction that you mentioned you had her on?
A. Pardon me?
Q. Did you say you had her in pelvic traction?
A. Yes.
Q. What is that?
A. It is a belt that is fastened around the waist and there are two straps, one on each side from this belt that go down to a spreader bar which

is fastened to a rope over a pulley with weights on it to help stretch out the lower back.

Q. A stretching machine of some sort?

A. Yes.

Q. And when did you see her after -- did you treat her during the course of the hospitalization?

A. Yes, I saw her daily when she was in there.

Q. And did you see her further after that during 1986?

A. Not until December 9th.

Q. I have June 14th and July 11, '86.

Did you see her at either of those times?

A. Excuse me. I don't have any notes in '86 to those dates. June 14th of '85 and July 11th of '85.

Q. I see. I may have misunderstood that.

A. Not '86.

Q. During this time that you did see her in '86, what were her principal complaints? Was it the same thing?

A. Pain in the low back to the right knee, increased in October while -- at which time she developed severe swelling in both legs.

She saw Dr. McGinnis at that time who started her on diuretics. She also complained

that her right knee was swelling at times.
Q. At any time did she tell you she had hit her right knee when she was thrown from the chair or the seats in the derailment?
A. Not specifically, no.
Q. While she was in the hospital in 1986 when you had her hospitalized, was that Lakewood Hospital, Doctor?
A. Yes.
Q. Did she display objective signs of injury such as muscle spasm during that time to your memory?
A. Oh, yes. She had marked spasm in her lower back and marked limitation of motion.
Q. Did you also see this lady and treat her in 1987?
A. I apparently didn't see her until May of '87, May 21st.
Q What dates, first of all, did you see her in 1987?
A. I saw her May 21st, June 16th.
Q. What did you tell her, what occurred at that time? Is that when you had the MRI?
A. That was an outgrowth of my exam on the 21st of May, yes.
Q. What did you find on the 21st of May, what did

you do?

A. Well, she had three major complaints at that time, what she described as migraine headaches several days each week accompanying pain on the right side of her neck.

Q. What did you diagnose that as being, what did you diagnose that as being?

A. I didn't diagnose the headaches specifically. I felt they were probably not migraine but related to her neck injury.

Q. Because of the pressure on the nerve?

A. Migraine is a specific type of headache and what she described did not fit that pattern. She also was complaining again of tingling in the fingers of both hands.

Secondly, she had sharp shooting pains in her lower back and she related this went into her stomach aggravated by being jarred on a bus and riding in taxis.

She had an ultrasound study of her abdomen by Dr. Shu, Shu I guess you would pronounce that, which was negative. I think that was done at Fairview.

Also pain in the medial side of the right thigh and her third complaint which was somewhat

unrelated was of increased weight gain and retention of fluids.

Q. What was her personality like during this period of time that you were treating her between '84 and '87?

MR. TADDEO: Objection.

Q. What were you able to observe about her reaction emotionally to her injury?

A. I would say overall she appeared moderately depressed. She also displayed some symptoms of anxiety that didn't appear too marked to me. But she definitely was obviously under stress and throughout the whole period of time.

Q. Did you make any recommendations to her in May or in June of 1987 with regard to surgery?

A. After the MRI reports came back, yes, on the basis of her findings and long continued failure to alleviate her symptoms I recommended she have surgery on her neck.

Q. What was the reaction to this recommendation?

A. She was afraid of it and wanted to put it off as long as she could.

Q. Doctor, what kind of an operation were you recommending? Could you describe the kind of operation where you would go in and what you

would do?

A. The operation involves going in through the front of the neck and removing the disc and taking a piece of bone from down here on the pelvis and wedging that into the disc space to fuse those vertebrae together.

You take out the entire disc here which of course removes the area which is actually protruding on the other side, which you go clear through that inner space there and go clear down onto the front surface of where the spinal cord is.

Q. So you go in from the front of the neck right out to the back?

A. You go through the front of the neck.

Q. Now Doctor, is there a risk of paralysis from the neck down from this type of surgery, is that one of the risks?

A. Well, it could happen. It has happened on occasion.

Q. Was she made aware of that risk as well as the others of surgery?

A. Yes.

Q. Now did she in fact delay your recommendation, delay having the surgery despite your

recommendation in May of 1987?

A. Yes. She put it off until actually in October.

Q. And then did she in fact finally agree to the surgery?

A. She had agreed to the surgery actually at the end of August but wished to have it scheduled in October.

Q. When you went in and did the surgery, did you in fact find a herniated disc that you had suspected you would find?

A. The way the surgery is performed, one can't actually visualize the herniation. The entire disc is taken out from the front and of course the herniation is in the back. So by the time you get down there you have pulled out the herniated portion of the disc.

So it was never actually visualized but her response to the treatment of course is good proof that that was the area of her difficulty.

Q. What happened as a result of your removing the disc?

A. She got very rapid relief of her arm complaints. She is still in a convalescent stage. The bone graft probably at this point has not healed yet, although we don't have any

recent x-rays.

She is due to come in here within the next month to get further x-rays to judge the degree of healing. But --

Q. Would you say that was great improvement, a little bit of improvement?

A. No. Great, significant, almost total relief of her arm complaints.

Q. Now prior to that the arm complaints were that she had the pain in both arms and wrists and hands?

A. Pain, numbness and tingling and the dropping of objects, the weakness of her grip.

Q. Was her relief when you removed the herniated disc and the pressure on her spinal column gradual or immediate?

A. Very rapid. Within a few days.

Q. Is there any doubt at all in your mind, Doctor, as an experienced orthopedic surgeon that that disc that you removed was in fact actually herniated?

A. There is no doubt in my mind, no.

Q. Is there any doubt in your mind that this was caused by the derailment of the rapid transit train in 1984 that you talked about before?

A. No doubt whatsoever.

Q. Now Doctor, I would like you to assume that back in February of 1980 Joann Juhn had had an auto accident in which she had a neck injury which caused her to have some pain in her neck and also in one arm which cleared up after about a week; and thereafter she had a single episode of numbness in that right arm and tingling; in April of 1980, several months later, at the same time that her mother had a similar episode of numbness in her arm and she had taken her mother for treatment. And this was four years before the RTA derailment.

I want you to further assume there was no treatment or complaints of this again as far as any pain in the neck or any pain in that arm until after the RTA derailment in February of 1984, and that she was able to work and carry out her normal activities between that 1980 incident and the derailment in 1984.

Would the fact that she had that auto accident with that complaint in February of 1980 change your opinion that her herniated discs in her neck and back were caused by the RTA accident in February of 1984?

A. No, that would not change my opinion.

MR. TADDEO: Objection.

Q. Now, how long was Joann Juhn in the hospital for her surgery to her neck and the fusion using the bone you took from her pelvis or hip?

A. She was in nine days.

Q. Did she experience any complications in the hospital so far as that neck was concerned?

A. She did have problems with an extensive skin rash which we felt was an allergic reaction to the plastic in the immobilizing collar that was placed on her after the surgery.

Q. Did that cause swelling and discomfort, Doctor?

A. It caused considerable discomfort to the skin, yes.

Q. Doctor, would the taking of the bone from Joann Juhn's hip or pelvis be a painful procedure?

A. It is painful temporarily, yes, for a period of usually several weeks.

Q. How would you compare that pain with the surgical pain from the surgical site in the neck?

A. Worse.

Q. The pain in the hip was worse?

A. Yes.

Q Why would that be?
A Usually always is. It is stripping some muscles off the side of the pelvis to get to the bone, attempts to move are quite painful until that heals.
Q When did you do the surgery?
A On the 6th of October, 1987.
Q How long do you anticipate she will be off work recuperating from this surgery, Doctor?
A Well, until I determine that the disc is fused, and this may be anywhere from the middle of this coming January to any period thereafter, when I would expect that in general she probably can go back to work in late January or early February.
Q Now what advice have you given her with regard to the surgery for the herniated disc in her low back?
A I am going to wait and see how that condition responds. I don't believe it is serious enough at this time to justify any surgical procedure.
Q Now in the event that her symptoms regarding her low back and the radiating leg pain which has caused her to fall, et cetera, as you described, do not improve, in your opinion to a reasonable medical certainty will it be necessary to

eventually do surgery on her low back?

MR. TADDEO: Objection.

Q. I am talking about if it continues in the future as it has in the past.

MR. TADDEO: Same objection.

A. I cannot make any specific response to that question. It depends entirely on what her condition appears to be. I can't say that there is any probability she is going to need any surgery there.

I am just going to have to wait and see what develops, if she develops some objective neurological changes or something further along the line, it may well be that she may need some surgery. I cannot say that at this time.

Q. Do you have any doubt in your mind that she does in fact have a herniated disc in her low back however from this crash?

MR. TADDEO: Objection.

A. It has been well demonstrated on the MRI.

Q. And is that your opinion at this point?

A. Yes.

MR. TADDEO: Objection.

Q. Even if you are not willing to recommend surgery at this time, do you have an opinion as to

whether or not Joann Juhn will continue to require medical treatment with regard to her low back even if it is not surgery because of the herniated disc which is there?

A. I think I would have to defer judgment on that until I see what her progress is. It may be that this is all going to respond to the neck surgery.

Q. If it doesn't respond, what sorts of treatment will be expected?

MR. TADDEO: Object.

A. It depends on what the clinical picture is at that time. I can't answer specifically right now. It might only be physical therapy and continued exercise program.

She certainly needs to lose weight. The next step of course if she doesn't respond to that would be surgery if the findings justified it.

Q. Doctor, handing you what has been marked Exhibit 1 to this deposition, which is your bill in the amount of $3,995, I ask you whether or not that represents the reasonable value of your services to Joann Juhn to date, including the surgery for injuries caused by the RTA derailment?

A. Yes, this is an accumulated bill.
Q. How much was the fee just for the surgery that you performed for the disc in her neck?
A. The fee for the disc surgery was $3,000.
Q. All right. And in your opinion was that reasonable and necessary because of the accident that she was in?
A. Yes.
Q. All right. And handing you what has been marked as Plaintiff's Exhibit No. 2, the bill of Lakewood Hospital in the amount of $7,141.50 covering the admission of May 8, 1986 to May 23, 1986, and Exhibit No. 3 to this deposition, another bill from Lakewood Hospital in the amount of $6,128.17 covering the admission of October 6, '87 to October 15th, and the third for $169 from Lakewood Hospital for the day before that admission covering the preadmission testing done before you admitted her, I think that is shown on Exhibit 4, I ask you whether or not these hospital services were necessary for the treatment of Joann Juhn for the injuries that she sustained in the RTA derailment and crash of February of 1984 and were reasonable?
A. Yes, they are.

Q. And handing you Exhibits 5 and 6, Doctor, of Lakewood Hospital in the amount of $86.00 and $99.25 respectively for outpatient July 4, 1985 when she fell because her leg gave out as you told us and on January 5, 1986 for the wrist pain, I ask you if these were necessary and reasonable for the treatment for injuries she sustained in the derailment from RTA?

MR. TADDEO: Objection.

A. Yes, I think they are.

Q. And I hand you Exhibit 7, which I believe is A, B, C and D from -- and also Exhibit 8 which these are physical therapy bills, Exhibit 7A, B, C, A did $1,018 from Sports Medicine, and was for physical therapy I believe recommended by a different doctor before she originally saw you, as you can see by the dates, also from McCoy Physical Therapy in the $1,146, were these bills for treatment of that sort reasonable and was physical therapy reasonable and necessary treatment for the injuries sustained in the RTA derailment in your opinion?

MR. TADDEO: Objection.

A. Yes, I think so.

Q. All right. And you indicated, let's see, with

respect -- I would like to show you this bill from Lutheran Hospital covering an inpatient admission for her from February 8, 1984, the date of the crash, to February 12, 1984, which I guess is four days later, for an inpatient admission at Lutheran for Joann Juhn in the amount of $2,400 and I ask you whether or not you think that is a reasonable bill for that period of hospitalization following the crash?

MR. TADDEO: I will object.

A. It appears to be.

Q. And would it be reasonable to admit her to the hospital after a crash of this nature where the train derailed?

MR. TADDEO: Objection.

A. That is within the judgment of whoever examined her of course. If he felt her injuries were severe enough, it certainly is justified.

Q. And handing you a bill from a consulting orthopedist that was called in during that period from Dr. Bohl, do you know him, William Bohl, in the amount of $110, Exhibit 10, for seeing her on three occasions which you say that was reasonable, that amount?

A. Yes.

MR. TADDEO: Note my objection.

Q. And would it be reasonable for a person who had the surgeries which she described to you to be seen by an orthopedic surgeon at that time following the crash?

A. Certainly.

Q. And wouldn't that be a reasonable medical treatment then for injuries following the crash?

A. Yes, I would say so.

Q. Now handing you what has been marked Exhibit 11, a bill from Westside Imaging for the MRI which you recommended, in the amount of $1,900, is that a reasonable and necessary bill for that service caused by injuries from the RTA crash?

A. Yes.

Q. And in connection with your surgery, Doctor, I hand you Exhibit 12.

Did you have an anesthesiologist take care of her during the surgery and is this bill in the amount of $800 as shown by Exhibit 12, I guess that is Exhibit 12, reasonable and necessary for the treatment of injuries from the RTA crash?

A. Yes.

Q. Doctor, do you have an opinion to a reasonable

medical certainty as to whether or not Joann Juhn will suffer in the future from injuries she received in the RTA derailment and crash? Do you have an opinion?

A. Yes, I have an opinion.

Q. What is that opinion?

A. My opinion is that she probably will have some residual, one rarely has 100 percent recovery Even though we have alleviated the problems with the ruptured disc, there is still residual problems of the torn ligaments and musculature which normally heal by scar and frequently produce ongoing symptoms over lengthy periods of time.

Q Now when you say scar, are you talking about the muscles and ligaments that are inside the body?

A. Yes.

Q. Is scar tissue as resilient as regular tissue?

A. No. It does not stretch like normal tissue

Q. As a result of having removed that disc, is that a permanent removal?

A. Yes.

Q. Will she ever have a normal spine now that you have in fact fused it?

A. She will lose what element of flexibility occurs

at that level because that level is fused now.

Q. What about the surgical scar in front of her neck where you went? Is that permanent?

A. Permanent.

Q. Is that your opinion to a reasonable medical certainty?

A. No, it is definite.

MR. SPERO: You may inquire.

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CROSS-EXAMINATION OF RALPH A. REILLY, M.D.

BY MR. TADDEO:

MR. TADDEO: I would like to take a break and look at the Doctor's records first.

- - - -

(Thereupon, a discussion was had off the record.)

- - - -

MR. SPERO: We can go back on the record.

VIDEOTAPE OPERATOR: You can begin now.

- - - -

(Whereupon, Defendant's Exhibits Nos. 1-6 were marked for purposes of identification.)

- - - -

Q. My name is Joseph Taddeo, Regional Transit Authority. You understand we have a right to conduct some cross-examination in order to assess the validity of the statements heretofore made.

A. Certainly.

Q. You have heard of people spraining their ankles or falling or almost falling for reasons other than having any problems with their spine, haven't you?

A. Well, certainly.

Q. You didn't treat Joann Juhn following any of the incidents that she has claimed where she turned her ankle, have you?

A. Not immediately, no.

Q. Only remotely?

A. Right.

Q. And so far as you know the means by which she fell may have been simply turning her ankle just as anyone else turns their ankle, is that a fair statement?

A. Something to consider, yes.

Q. So I mean on a medical, strictly medical basis, she may have made complaints about weakness of

her leg and dragging her leg or that, but on the specific instances when she fell, it is fair to say that you don't have a medical basis to know whether or not each one of those sprained ankles that she claims or complains about were in any way related to RTA, is that correct?

A. I can't make a direct connection on the basis of examination other than --

Q. I know you can't. That is why I am bringing it out.

A. Other than the fact that she apparently didn't suffer any direct or significant injury to either the knee or the ankle in any of these episodes, anything that I could detect.

Q. But my statement is a fair statement and a true statement, isn't it, that from a medical standpoint, from your medical expertise as an orthopod, excuse me, orthopedic surgeon, you cannot say with any degree of certainty that any one of those events is directly attributable to the RTA accident some years before or whether or not they are, she just simply turned her ankle just like anybody else would do?

A. Not those isolated instances, no.

Q. Okay. That is what I wanted to hear.

Now confining your attention to Joann Juhn's cervical spine, that area is what we commonly refer to as the neck area of the spine, is that correct?

A. Yes, that is right.

Q. That would be some place right where the shoulders are up to where the head is, that generally would be the confines of the cervical spine, is that correct?

A. Yes.

Q. You have testified that the plaintiff in this case had a herniated disc in the area of her cervical spine, correct?

A. Yes.

Q. And you have claimed that that was directly attributable to an RTA accident which happened approximately three years before your diagnosis, is that true?

A. That is correct.

Q. Now when this accident happened, we thank God that she was not cut or bleeding, was she?

A. Not to my knowledge, no.

Q. And once again, we thank the lord she did not suffer any broken bones so far as you know, did she?

A. Correct.
Q. So she was not cut or bleeding, suffered no broken bones, right?
A. That is correct.
Q. Now what you claim did happen to her is that as a result of this accident somehow or another she injured soft tissue areas which are not bone of her neck, is that right?
A. That is correct.
Q. Now this injury to the soft tissue is something that you have never seen, is that right? I mean you have never visualized directly a herniated disc in the area of her cervical spine, have you?
A. That is correct.
Q. The means whereby you have testified that she had a herniated disc in her cervical spine, and that it was caused by the RTA accident is an interpretation from other signs or signals that you have received from other areas instead of seeing it directly?
A. That is correct.
Q. So say, for instance, God forbid if she had suffered a broken arm, that would be something you can visualize directly on an x-ray?

A. Yes.
Q. And the injury that we have discussed here all afternoon is something that simply could not be visualized on the x-ray, is that right?
A. On plain x-rays, that is correct.
Q. On plain x-ray. We will get to the MRI in a minute.

The means, correct me if I am wrong, but I believe the means whereby you concluded first of all that she had the existence of this condition was by means of an MRI study as well as the complaints that the plaintiff or patient herself had?
A. Yes.
Q. And among those complaints which I believe it is mentioned in the reports were indicated to be very significant, were that in her hands she felt a tingling and occasionally a numbness?
A. Yes.
Q. And that she indicated a loss of grip in her hands or a weakness, is that correct?
A. That is correct.
Q. And additional signs would have been numbness, additional signs would have been numbness of her arms, is that correct?

A. Yes.
Q. This arm numbness and tingling of hands would have been mostly located on the right, is that correct?
A. That is correct, although on one occasion she related that it was also affecting the left hand.
Q. Now the nerves that radiate out from the neck and go down into the arms, that is called the brachial plexus complex?
A. There are roots that come from the neck that form the brachial plexus.
Q. The brachial plexus is a group of nerves that we refer to that radiate out in this particular area, would that be right?
A. It is an interconnection of nerve roots that again split to form specific nerves that enter the arm.
Q. Is it true that those nerve roots do not extend down into the legs?
A. The roots from the neck -- the roots do not, no.
Q. Right. Sorry. Let me rephrase the question.
Is it true that the nerves from the brachial plexus area that radiate out from the cervical area of the spine go into the arms as

opposed to the lower extremities, the legs?
A. That is correct.
Q. The nerves that radiate out into the legs, those are much lower in the lumbar area, is that correct?
A. That is correct.
Q. So whatever happened to Joann Juhn with regard to her neck, that in no way could be attributed to anything that happened to her with regard to her legs or ankles, is that correct, sir?
A. Incorrect, sir. Incorrect.
Q. All right. Now with regard to the fact that you claim she had a herniated disc in her cervical spine, is it your testimony that when this accident happened she immediately had a herniated disc in her neck or is it your testimony that over a period of time it developed?
A. I am unable to say specifically. It may have existed right from that time and the condition worsened or it may have just been a matter of injury to the disc at that time with a natural history of progressive leading to further herniation at a later date.
Q. Do you equate bulging disc with a herniated

disc?
A. Not semantically if you are being extremely correct, no. But most people talk about them in the same breath.
Q. We have talked about impingement of the disc upon the spine.
However that is something that can also occur with just a bulging disc, is that not true?
A. Yes.
Q. Well, if you believe, and I believe you do, that there was impingement of this fifth cervical disc upon this woman's spine, then is it fair to say that you are not certain that the impingement was a result of simple bulging of the disc, or in the alternative, if it was the result of a complete herniation of the disc?
A. I can't say specifically, no.
Q. So the answer is it is fair to say that you don't know which one of the two it was?
A. That is correct.
Q. Now, you have testified that there was -- you have testified that within medical certainty, a reasonable degree of medical certainty that there actually was a herniated disc in this

instance but that statement now appears to be, have some doubt along with it, isn't that a fair statement?

A. No, I don't see that is inconsistent at all.

Q. Well, what you have said is you are not sure if we had a bulging disc here or if we had a completely herniated disc here.

The only thing we know for sure is that we had impingment on this woman's spine?

A. That is correct.

Q. And it is also correct that you are not sure if it was bulging or herniated?

A. Well, it doesn't matter whether it was bulging or herniated. To bulge it has to be pathological. It is an injury, an abnormal disc whether it is bulging or whether it is actually herniated and for all practical purposes the distinction is not really significant.

Q. All right. Let's go into that a little bit.

A bulging disc, a disc is a spongy material that has walls and is mostly like sponge on the inside, is that a fair description of it?

A. I would not call it sponge. It is resilient.

Q. Would it be almost as though it was filled with a liquid?

A. Not in an adult, no. No. In an infant, in a very young child the center part of the disc, the so-called nucleus of the disc is gelatinous.

With aging that dries out and it becomes more fibrous and the center part of the disc then becomes, in the lumbar area particularly, it becomes a tougher substance which to me looks more like cooked crab meat when you see it.

In the cervical spine because of the smallness of the disc, that so-called nucleus is rather insignificant in structure by itself.

And so what we are left with for all practical purposes in the neck region is the outer so-called annulus of the disc which is an interlacing of tough fibers and these fibers have to be torn to allow the disc to bulge or to allow anything to rupture.

In particular in the cervical spine to draw the distinction between a bulging disc and a ruptured disc where the nuclear portion of the herniated disc, a true definition of it, which most people don't even distinguish in their minds, a true herniation is the nuclear portion being extruded through the outer wall, the

so-called annulus.
Q. I was getting to that.
A. In the cervical spine, I don't think that has any practical significance.
Q. So if we had a ruptured disc, however, we would be certain that it was ruptured if the material were actually extruded from the interior of the disc, would that be fair?
A. Yes.
Q. And if we had a bulging disc, then we would have a disc that were simply distorted but no interior material being extruded to the outside, correct?
A. Not truly extruded, yes. But it is still --
Q. It may be just out of shape or out of form?
A. Yes.
Q. But no interior material being extruded?
A. Yes, it may be even ruptured through the outer layers of the annulus and still be confined by overlying ligaments and this is particularly true in the center portion of the disc where the majority of this disc problem lay.
So you can have it actually herniated through the wall of the disc and still confined by the ligament behind it and therefore you are

only creating a bulge.

The nuclear and disc fragments would not be lying free within the spinal canal where they could be picked out, but they still would be creating pressure against the spinal cord.

Q. I understand that. My purpose in asking the question was to bring out the difference between bulging and herniated.

And I believe that generally speaking we have established that herniated would mean that the material inside had been extruded, although maybe it didn't move out of the area because of surrounding ligamentous material, correct?

A. Yes, that is true. But as I said in the cervical spine, this distinction loses its significance.

Q. Getting back to the symptoms, you said after the surgery she had a great deal of relief?

A. Yes.

Q. And that relief was from pain, numbness, tingling of the arm and dropping things, correct?

A. Yes.

Q. Now besides the MRI, correct me if I am wrong, those are the major symptoms that we have here

indicating the problem existing with her cervical spine, is that right?

A. That is correct.

Q. Now in order to relate this back to the RTA accident now, you would have to believe with a certain degree of medical certainty and actually without a doubt as the attorney asked you to testify, that those conditions did not exist before the RTA accident?

A. That is correct.

Q. They could only have existed after the RTA accident?

A. That is correct.

Q. Now when Joann Juhn came in and gave you her history of injury, she told you about a mild whiplash accident and you have written that up in your report.

That occurred during 1971, is that about right?

A. I recall an earlier accident.

Q. What year did she say that it occurred? 1980, '79?

A. 1979 question mark is what she wrote on the admission form.

Q. So that would have been an automobile accident,

it would have been the origin or source for that problem which she experienced at that time?

A. Yes.

Q. Now did she ever tell you about a much more severe automobile accident that she had earlier than that?

A. No. That is the only knowledge I have of any other accidents.

Q. Did she ever tell you she had an automobile accident where the impact was so severe that her head had been thrown through the windshield?

A. No.

Q. Did she tell you that the impact of the accident was so severe that after her head was thrown through the windshield that she broke her nose?

A. No.

Q. Doctor, I am going to show you what has been marked as Defendant's Exhibit No. 1 --

MR. SPERO: Would you show that to me first?

MR. TADDEO: Yes.

Q. It is rather difficult to read.

Can you see at the upper right it says St. John's Hospital?

A. Yes.

Q. Now the patient's name is -- you can see the date, can't you, 6/23/71?
A. Yes.
Q. And you can see the patient's name as Joann Frederick?
A. Yes.
Q. You don't happen to know, do you, whether or not that was Joann Juhn's former name or do you know that for a fact?
A. I don't know that.
Q. Now on that document it says "chief complaint", and you see it says "head injury"?
A. Yes.
Q. In the first line?
A. Yes.
Q. And then skipping down, today, "the condition started today when the patient had a car accident and she lost consciousness", can you see that?
A. Yes.
Q. It says, "the patient has severe laceration of the forehead and face especially the nose with severe bleeding"?
A. Yes, that is what it says.
Q. Now, a large part of your diagnosis is based

upon the history given to you by the patient, isn't it?
A. A portion of it, yes.
Q. Well, the history given by the patient is an important diagnostic tool, is it not?
A. It certainly is.
Q. So when the patient comes in and tells you that the only thing she has had in the past is a mild whiplash injury when in fact she had an automobile accident and had a severe facial and nose injury where her head was thrown through the windshield, that would be a distortion of some magnitude, wouldn't it?
A. I think it should have been mentioned. I don't know that you can call it a distortion.
Q. And you have no way of knowing, do you, whether or not that impact threw her head back with such an impact that it caused or commenced the problem that you ultimately diagnosed with regard to her cervical spine, do you?
A. I have no way of knowing in particular. However I think with an injury of any magnitude that would occur to a disc in 1971, by 1984 would certainly show evidence on plain x-rays of some degenerative changes in that disc and her plain

x-rays do not show that condition.
Q. X-rays don't show discs, do they?
A. They show the disc space and any degenerative conditions of the disc are manifested by either and/or narrowing of the disc space as well as the production of bony spurs around the margin of the disc where the disc attaches to the bony vertebral bodies and as I say, any significant injury to a disc that long prior should certainly be manifested by some changes over that period of time.
Q. Let's go into that. I mean this lady was almost three years between date of accident which she claims caused all her problems and the date she was ultimately diagnosed for herniated disc?
A. That is correct.
Q. In that period of time there was no changes in the disc spaces, was there?
A. No, not in three years.
Q. So I mean what you are saying is that three years, no changes in disc space, although you diagnosed a herniated disc?
A. Yes.
Q. Now going back to the numbness in the right arm, tingling in fingertips and loss of grip in the

right arm, you have already testified that that is one of the major bases whereby you determine your conclusion that her herniated disc was indeed related to the RTA accident?

A. Yes.

Q. And that those symptoms could not have pre-existed, otherwise the disc pathology would have pre-existed the RTA accident?

A. That is correct.

Q. I am going to show you Defendant's Exhibit No. 2 as soon as the attorney Keith Spero has looked at it.

Doctor, this is Defendant's Exhibit No. 2 which I am going to hand to you. That is a Lakewood Hospital record, isn't it?

A. Yes, emergency department record.

Q. And is that dated April 22, 1980?

A. That is correct.

Q. And that is a date before the date on which Joann Juhn was involved with the RTA incident, is that correct?

A. Yes.

Q. And on that document does it indicate her complaint that she had numbness in her right arm, tingling in her left fingers?

A. It does.
Q. And in the diagnosis it says "numbness of hands to be investigated", doesn't it?
A. Yes.
e. And that is an indication that this major symptom of herniated disc was a complaint of this patient made in writing at a hospital sometime prior to the RTA event, isn't it?
A. That is correct.
Q. You were not aware of that, were you?
A. No, I have not seen this record.
Q. Now I want to go back to without a doubt.

These records certainly cast some doubt upon the issue of whether or not she had cervical disc pathology prior to February 8, 1984, don't they?

A. They might cast some doubt on the fact --
Q. Thank you.
A. -- that the disc was entirely normal prior to that time, yes.
a. Thank you. I agree with that. Now, when you first saw this patient, if there had been a sufficient belief that she had a significant cervical disc problem, there would have been an opportunity to conduct a myelogram, wouldn't

there?
A. If it had been significant, yes.
Q. Okay.
A. You don't just do myelograms for no good reason though.
Q. You could have also done a CT scan, is that right?
A. Once again, only on indication.
Q. A CT scan is not invasive in any way?
A. It involves a lot of radiation.
Q. They don't have to put any needles in your body?
A. It is expensive. It is not done without indication.
Q. But an MRI is expensive too, isn't it?
A. It certainly is. Once again not done without indication.
Q. What I am getting at is, I mean we went along here for a period of three years and we are talking, saying with some degree of certainty or at least your testimony is this is all related to the RTA event, but there was sufficient opportunity within three years to do a CT scan, myelogram.

How about an EMG, that could have been done, that would have been informative, wouldn't

it?
A. I didn't see any reason to do one.
Q. Let me ask you, what is an EMG?
A. That is an electromyogram is what it stands for. It is an electrical testing procedure of the muscle.
Q. Is another word for that a nerve conduction study?
A. No. Nerve conduction study is a different electrical testing.
Q. Explain the EMG? Exactly how does that work or what is your understanding of it?
A. The EMG is a testing of the response of the muscle to an electrical stimulation and depending on this is recorded graphically and interpreted by a physiatrist or a neurologist and it indicates whether the nerve elements of the muscle and the muscle itself are normal or not.
Q. All right. Now what would that indicate if the muscles, say, of the arm are not normal, if somebody is dropping things, what would that indicate?
A. That would indicate some nerve pathology.
Q. Some nerve pathology?

A. Or muscle pathology, either one.
Q. I am going to show you what has been marked Defendant's Exhibit 3, I believe that is.
Doctor, now that you have finished reading Exhibit No. 3, would you tell the court and jury what that document is?
A. This is a report of an electromyographic study done on 6/13/84 at Lutheran Medical Center.
Q. Can you see the name of the physician at the top for whom that was done?
A. Dr. Bohl.
Q. Is he an orthopedic doctor?
A. Yes, he is.
Q. And is he a good orthopedic physician?
A. I have no idea.
Q. You are not acquainted with him?
A. I am not familiar with his work.
Q. Now, the name of the patient was Joann Juhn, was it not?
A. Yes.
Q. So this is an electromyographic study of Joann Juhn done at Lutheran Medical Center for Dr. Bohl, is that correct?
A. That is correct, yes.
Q. And at the bottom there is an impression listed

there at the very bottom of the form. I think it is the fourth line from the bottom.

What is the impression that was obtained?

MR. SPERO: Objection on the grounds of not being allowed to read from the document. The document would have to speak for itself.

Q. Do you note that it says "bilateral carpal tunnel syndrome"?

A. Yes.

Q. "Moderately severe right side"?

A. That is what it says.

Q. Now a carpel tunnel syndrome --

MR. SPERO: Move to strike.

Q. -- would the existence of that cause somebody to have or could it cause somebody to have numbness, tingling, loss of grip?

A. It certainly can.

Q. And the carpal tunnel syndrome is something that originates in one's wrist, is that correct?

A. In the wrist or upper forearm. The carpel tunnel syndrome of course originates at the wrist but the same findings pretty much can originate from conditions as high as the elbow.

Q. But my point is if this examiner were correct

and she had carpal tunnel syndrome, that has nothing to do with any pathology in the neck, is that a fair statement?

A. Not necessarily.

Q. All right. And it says that there is, the next line says "there is no evidence of radiculopathy on this examination"?

A. Yes.

Q. Cervical radiculopathy?

A. That is right.

Q. So this examiner felt that this problem had, this patient by means of this study showed no pathology with respect to the area of her cervical spine, is that correct?

MR. SPERO: Objection.

A. The study cannot rule out pathology in the cervical spine. It only can rule out -- not even rule out, it is an indication certainly that there isn't any proximal nerve root involvement.

However, it is the clinical experience of anybody that treats these conditions, specifically the carpal tunnel syndrome, that it frequently is associated with some sort, form of pathology in the neck.

What the connection is has not ever been directly explained but it is a common clinical observance and frequently the two conditions go together.

Q. All right. But in this case where the examiner has said there is no evidence of cervical radiculopathy on this examination, certainly that would indicate that the risk condition of carpal tunnel syndrome exists without cervical pathology, wouldn't it, at least to this examiner?

A. To this examiner, yes.

Q. Yes.

A. This examiner only did an electrical study. This examiner did not do a physical examination. This examiner did not see any x-rays or any other studies.

Q. We will get on to the one who did do a physical examination.

But my point is that this Exhibit No. 3, the electromyographic study done on behalf of Dr. Bohl, is a contraindication to the testimony that you have given us concerning the fact that this woman's tingling and numbness and loss of grip were only attributable to her cervical

pathology, is that right?
A. I would not say it is a contraindication or contradiction of it.
Q. Let me put it this way, it is inconsistent with what you have testified with, isn't it?
A. No.
Q. You mean when he says there is no evidence of cervical radiculopathy, that is not inconsistent with what you testified to?
A. I never said there was cervical radiculopathy, never in any of my testimony did I say there was cervical radiculopathy.
Q. However, the problems that she experienced with her arm, the dropping of things and the numbness and tingling, you have directly attributed to a nerve that radiates from her neck all the way down to her hand, is that correct?
A. No, I never said that either. I said I attributed it to pressure on her spinal cord.
Q. What you are saying is that pressure results in these symptoms all the way down to her hand?
A. That is correct.
Q. And this examiner would indicate, wouldn't he, that the dropping of things would be a result of something that exists more proximally to her

hand, that being her wrist, isn't that right?
A. It may or may not.
Q. All right. To the extent that it may indicate that, then it is inconsistent with your testimony, isn't it?
A. I would have to amplify this quite extensively to answer your question.
Q. Well, you can't say yes or no then, can you?
A. I can't say yes or no.
Q. Now Doctor, on your own case history that you wrote on July the 11th, and I obtained -- July 11, 1985, and I obtained from your file, you said there is some numbness in the fingers, "exclude ulnar 3 plus base of thumb right hand"?
A. Yes.
Q. Now that finding is completely consistent with carpel tunnel syndrome, isn't it?
A. No. No. I at one time myself considered the possibility of a carpel tunnel syndrome early in the course of this. But the physical findings were not consistent with the diagnosis.

It is also obvious that Dr. Bohl never followed through and never felt that as a basis of this report that the condition was serious enough to require any surgery.

So I have a hard time relating the conclusions from this electrical study with her clinical condition.

Q. Doctor, during the course of your treatment of Joann Juhn, you suggested that she be consulted by a Dr. K. Weaver?

A. Yes.

Q. Who I presume is another physician at Lakewood Hospital, is that correct?

A. That is correct.

Q. And that consulting physician took another history and did another physical on your behalf and come out with an impression and diagnostic impression, is that correct?

A. Yes.

Q. I will hand you what has been marked Exhibit 4. Tell the court and jury if that is indeed the report that was prepared on your behalf by Dr. Weaver?

A. Yes.

Q. Now and by the way, this report is part of your own file, isn't it, this report of Dr. Weaver?

A. Yes, this is a copy from the hospital record, yes.

Q. I mean it can be found in your own file in your

own records concerning Joann Juhn?
A. Yes.
Q. And it says there that she "has continued to complain of pain intermittently", under the impression on page two, "with no definite physical findings".
Do you agree with that statement?
A. No.
Q. All right. It says, "she has continued to work in spite of her complaints. However, pending lawsuit against RTA makes it likely on statistical basis that her pain complaints will not cease until the lawsuit is settled, which often takes years to occur."
Do you agree with that statement?
A. Do I agree with that statement?
Q. Yes.
A. No, I think that is a statement, it has no business being in there. He is talking about a statistical basis. He is not talking about this individual. The patient, I think it is a statement that never should have been made.
Q. You don't agree that perhaps Joann Juhn was continuing her complaints or conducting any exaggeration or blaming this whole thing on RTA

simply for the potential of financial recovery?
A. I never saw any evidence of that whatsoever.
Q. You have seen now though, you have seen evidence that while she may have had pathology with her neck, there is some indication it may not have been entirely due to RTA, you have seen that now, haven't you, in the form of the documents I have handed you?
A. Well, as I mentioned earlier, I have a big problem relating this electrical study to the clinical picture.

If you are trying to make the point that she had some condition other than the injury, why did it occur at this date, what was the etiology of it, did it respond to treatment, what was the treatment, you have left us with a very incomplete picture.

I cannot draw conclusions from that incomplete picture.
Q. That is right. All I want to indicate to the court and the jury is that there is some doubt as to whether or not the pathology with regard to this woman's cervical spine for which you operated to remove a disc, there is some doubt as to whether or not that was entirely caused by

the RTA incident, and you have indicated there is doubt as to that?

A. There is no doubt in my mind. There may be doubt in yours but not in mine. We proved the cervical pathology and we found that we relieved her symptoms by treating the cervical pathology. We did not treat her wrist.

Q. That is right. But I am talking about the existence of the symptoms back in 1980 indicates that the pathology to her neck may have pre-existed the RTA accident and you said yourself that there was some doubt as to whether or not it was entirely caused on February 8, '84 or whether or not it pre-existed, you testified to that just awhile ago.

A. I would not say that. I would have to agree that there may possibly have been some pre-existing cervical pathology.

However, I would maintain very strongly that the accident, was it February of 1984, is the precipitating cause of her symptoms and of the development of an obvious herniated or protruding cervical disc.

Whether or not any pre-existing injury to that disc had occurred, it certainly, either the

accident in February of 1984 was either the direct cause of the pathology, or a severely aggravating and precipitating cause of the pathology.

Q. All right. So what you are saying by means of aggravating and precipitating is that this condition may have existed before, you are not certain, and it may have been aggravated by the RTA incident, you are not sure?

A. No, I am not 100 percent certain.

Q. I know that. Now out of your own files I obtained Dr. Glenn Sykora's report from Westside Imaging. And this is the MRI study itself that we have discussed heretofore, is that right?

A. Yes.

Q. Excuse me one second. Let me show it to your attorney if he wants to see that.

MR. SPERO: Yes. I am Joann Juhn's attorney, not the Doctor's.

MR. TADDEO: Yes. Sorry.

Q. In this report isn't it true -- now you have just testified that this was clearly a herniated disc, you just said that on your testimony?

A. Yes.

Q. And I want you to tell the court and the jury,

isn't it true that this MRI study was interpreted by the neuroradiologist, Dr. Glenn Sykora, and that he said these words in his conclusion, "there is a ventral epidural mass at C-5/C-6", that is the level of the cervical spine where you operated, right?

A. Yes.

Q. "Which deforms the spinal cord to the right of midline. This most likely represents an osteophyte but a disc herniation cannot be excluded."

A. That is what he said. He did not have the plain films to view. There was no evidence of spurs on the plain films.

Q. Tell us what is an osteophyte?

A. Osteophyte is a boney spur.

Q. Is that developmental in origin or is that traumatic in origin generally speaking?

A. Certainly not developmental in the strict sense.

Q. Let me ask the question.

A. Spurs are frequently found in people as an aging process, as -- actually what causes the spurring are repetitive minor trauma, pulling of the attachments of the fibers that attach the ligaments and discs to the fiber of the bone.

Q. Dr. Reilly, I want to inform the jury here about osteophyte and spurring.

Quite frankly these things are generally formed over a period of time with the normal aging process, correct?

A. That is what I just stated.

Q. And your own MRI examiner has said that what he saw on the MRI film was more likely an osteophyte, that is something that generally occurs with the normal aging process as opposed to a herniated disc, that is what he has said, correct?

A. That is what he said. I just got through telling you he did not ever see an osteophyte though.

Q. But you never saw a herniated disc either, did you, Doctor?

A. No, I never saw it directly, no.

Q. Thank you.

A. But on the x-ray there is no osteophyte.

Q. I have another report here.

A. As you can see from the pictures of the MRI, it only shows soft tissue. It does not show bone in the way of any bone detail.

Q. I am going to hand you what has been marked

Exhibit No. -- is that 5, Docor?

A. Yes, it is Defendant's Exhibit 5, yes.

Q. That is a report by Dr. Bohl who, if it is necessary, we can bring him in to testify.

And I want to ask you to read that over and review it if you would, please.

A. You want me to read the whole report?

Q. If you would briefly, yes, sir.

A. Okay.

Q. I just want to go back and make reference to something we already discussed before we go into that report.

If this woman's pathology with regard to her cervical spine were indeed caused by osteophytes, and the osteophytes were impinging on either the spinal cord or nerves, et cetera, that would result then in the same type of pathology that you have diagnosed as a herniated disc, is that a fair statement?

A. Yes.

Q. So your own examiner, Dr. Sykora interpreted the MRI to mean that there was existence of osteophytes which are other organic or developmental in nature generally speaking, but you have interpreted the very same MRI study to

mean that it was a herniated disc, and not only that it was a herniated disc, but that it was traumatically induced, is that correct?

You are misquoting Dr. Sykora somewhat.

Well, the record will speak for itself.

I well read this directly. His conclusion is "there is a ventral epidural mass at the C5-6 level which deforms the spinal cord to the right of the midline. This most likely represents an osteophyte but a disc herniation cannot be excluded."

A. That is right.
Q. And he says that what we have here is an osteophyte?
A. He did not say that. Let's read the English language correctly.
Q. What he says it is most likely an osteophyte?
A. Most likely. But a disc cannot be excluded.
Q. Most likely means more likely and less likely it is a disc, correct, that is what he said?
A. That is what he said, yes.
Q. Now you have read -- the main point with regard to osteophytes though is that they are organic and developmental, correct, generally speaking?
A. They are slow to develop. Let's say they are slow to develop.
Q. They can also be congenital, a person can be born with some osteophyte formation in their spine?
A. Never saw it in my life.
Q. It is only part of the aging process then?
A. Or response to trauma.
Q. Or response to trauma?
A. Yes.
Q. And you can't pinpoint the existence when that osteophyte, if it was an osteophyte, when it

started to exist?

A. What osteophyte are we talking about?

Q. The osteophyte that Dr. Sykora believes is more likely to be in existence and causing the pathology of this lady's cervical spine and less likely it was a herniated disc?

A. I think you must misunderstand me. I am maintaining very definitely that no osteophyte existed. I don't care what way you want to interpret Dr. Sykora's words, I do not interpret them the same way as you do as I made very clear.

And you are talking about an osteophyte that may or may not exist and it certainly does not show on any films and Dr. Sykora never saw an osteophyte. He merely said it was more likely an osteophyte because of the type of reflection off these tissues that the magnetic field produced.

This is quite vague and I think you are trying to make something out of nothing.

Q. Doctor, I will hand you an Exhibit No. 6, a copy of your own medical report you submitted.

What is the date on that one, December 18, '84?

A. December 18, '84, yes.
Q. Now at the bottom of the second paragraph you have indicated yourself, "clinical evidence of carpal tunnel compression", at the bottom of the second paragraph?
A. I have already testified to that, yes.
Q. And you have already testified that the existence of carpel tunnel syndrome may be responsible for numbness and tingling of the hand and loss of grip of the hand, is that a fair statement?
A. Yes, we have already concluded that the symptoms between the cervical myelopathy and carpal tunnel compression can be quite similar.
Q. You believe they can be quite similar?
A. Absolutely.
Q. Now you also --
A. They can be quite confusing to differentiate the two.
Q. -- indicated on this report there was no evidence of -- excuse me, "no neurological abnormality in the upper extremity"?
A. That is correct, no objective gross neurological changes, that is correct.
Q. Would that be consistent with the existence of a

herniated disc or would that be inconsistent with it?

A. It would not be either. There is not -- it does not help establish the diagnosis but it does not rule it out either.

Q. And then you made a prognosis, "forecast is good for complete recovery".

A. Yes. Her symptoms had alleviated and at that time I thought she would recover. Certainly without any significant findings at that time I felt she would go on to recover.

Q. And over a period of three years then her condition deteriorated to an extent where surgery was necessary?

A. That is absolutely correct.

Q. But you claim that whatever abnormality she had with regard to her neck was caused by one single event on one single day as opposed to a developmental condition?

A. Yes, I do, and I think the natural history of this thing has been quite typical and certainly supported that conclusion.

Q. That is even in spite of the fact that over a period of three years you saw her develop or degenerate, her condition that is of her neck

degenerate almost right before your eyes, you witnessed that developmental stages of deterioration?

A. Yes. In fact the condition undoubtedly had existed for some time before the definitive diagnosis was made on the MRI.

Q. And as a matter of fact it may have existed before the RTA accident too?

A. I don't know that there is any evidence at all to support that observation. She certainly had no complaints and was never treated prior to that.

Q. But you previously testified there was doubt on that and it was an open question for the reason that she did exhibit the symptoms and they are down in writing, she exhibited the symptoms and complained of weakness in her arm, tingling, numbness in her arm prior to the RTA event, you indicated that cast doubt and you could not be certain, that is a fair statement?

A. Not for a period of four years? That was 1980, was it not?

Q. I believe so.

A. So for a period of four years ostensibly she had no problems.

Q. But she had the symptom before and that would indicate the existence of the neck pathology before too?
A. As I have indicated that there is a possibility that she had had a disc injury four years previously and possibly even before that.
Q. Before that?
A. But in the absence of degenerative changes, it certainly wasn't significant and the fact that there was at least four years between the last evidence of any complaints and the presence of an accident with immediate symptoms which were progressive and sometimes intermittent but overall progressive leading to a culmination of a definite condition which was treatable, I still have to maintain that the injury of February, 1984 was the precipitating cause, if not the sole direct cause of the problem.
Q. But looking back at the history and the entire progression and the fact that you have in writing that she exhibited the very same symptoms before the RTA accident, from an objective standpoint couldn't you just as well say that the entire progression started some time earlier before the RTA event, wouldn't that

be a fair statement objectively speaking?
A. That might well be part of the progression, yes.
Q. Thank you.
A. As I say there was a precipitating event which caused a dramatic change.
Q. That is all I wanted to develop all afternoon, some part of the progression started before the RTA event --
A. And that is only possible. Not probable or --
Q. You are telling me in view of the fact that you have it in writing before you that she exhibited the same symptoms before, that it is not fair to say that the progression started before the RTA event, that is the deterioration leading to an ultimate pathology of her neck requiring surgery, you are saying it is not fair to say that that progression started before the RTA event?
A. We have already established though those same symptoms could be caused by several different conditions.
Q. It could also be caused by the cervical progression for which you --
A. Yes.

Q. -- ultimately operated on this woman?
A. Yes, I will not argue with that.
MR. TADDEO: That is all.
...
REDIRECT EXAMINATION OF RALPH A. REILLY, M.D.
BY MR. SPERO:
Q. In your opinion did she have a herniated disc back in 1980?
MR. TADDEO: Objection.
A. Certainly no evidence.
Q. In your opinion, Doctor, in the event she had no inability to work between 1980 and 1984 and was doing well between 1980 and 1984, would that be significant with regard to your opinion that her herniated disc was caused by the '84 accident?
MR. TADDEO: Object.
A. It is certainly significant. I already made that point.
Q. Doctor, in your opinion did this lady have a carpal tunnel symptom that caused any of her problems for which you treated her?
A. I don't believe so. At this point, no.
Q. In the event, Doctor, that Dr. Bohl's tests which you read talking about carpal tunnel syndrome were something that you would agree

with -- do you agree with the fact that she had a carpal tunnel syndrome?

A. On the basis of an electrical test?

Q. Yes.

A. No.

Q. On the basis of your clinical hands-on face-to-face in the same room examination of this patient, did she have a carpal tunnel syndrome?

A. I do not believe so. As I say, I considered that diagnosis myself at one time and discarded it because the physical findings did not support the diagnosis over time and I no longer considered it a viable diagnosis.

Q. In your experience as an orthopedic surgeon, can a carpal tunnel syndrome be caused or aggravated by a crash such as the one she was in in February of 1984?

MR. TADDEO: Objection.

A. I already testified there is frequently a connection between cervical pathology and the development of carpal tunnel syndrome.

Carpal tunnel syndrome can develop from a number of different conditions, some local, some endocrine, some traumatic, some inflammatory,

some neurological and one has to be careful though what they are talking about when they come up with this waste basket diagnosis of carpal tunnel syndrome.

It is a syndrome. It does not describe specific pathological condition. By syndrome we just mean it is a collection of complaints.

Q. In your opinion to a reasonable medical certainty did Joann Juhn suffer the complaints for which you treated her as a result of the accident of February 8, 1984?

MR. TADDEO: Objection.

A. I believe she did.

Q. Now you looked at the x-rays of Joann Juhn prior to operating on her, is that correct?

A. Yes.

Q. Did she have an osteophyte in her neck?

A. She did not.

Q. When you operated on her, did you remove any osteophyte from her neck?

A. I did not.

Q. In the event that she had an osteophyte in her neck, Doctor, I know you have already told us she does not, in the event that she had an osteophyte in her neck and you removed the disc

but not the osteophyte, wouldn't she still have the same symptoms if it was the osteophyte that was causing the problems in the first place?

A. Probably would, yes.

Q. Now, you never removed an osteophyte, did you?

A. I did not.

Q. You did remove a disc, is that correct?

A. That is correct.

Q. And did her symptoms improve?

A. Dramatically.

Q. Is there any question in your mind, Doctor, having actually gone in and operated on this woman that her problem was caused by a herniated disc and not by an osteophyte?

A. No question in my mind.

MR. SPERO: No further questions.

- - - -

RE-CROSS EXAMINATION OF RALPH A. REILLY, M.D.

BY MR. TADDEO:

Q. An osteophyte consists of a calcium deposit, is that right?

A. Not just calcium. A true osteophyte is actually boney. The term osteo means bone.

Q. If there were an osteophyte in existence in the area of this lady's disc, you took out a lot of

tissue there in the area of the disc, is that right?

A. I took out just disc material.

Q. You are saying there was no fibrous material that was in with the disc material that could be interpreted to be an osteophyte or calcium deposit or boney formation?

A. I didn't use any instruments that would cut bone.

Q. No, not cut bone. I am talking about spur material.

A. The spur is attached to bone. It would have to be resected with an instrument capable of cutting bone, a curette or a plunger, motorized burr or something of that kind.

Q. You didn't use anything like that?

A. No. I used curettes in the disc space but not -- and of course the pathology specimen did not show any evidence of any bone within it.

Q. Are there many people walking around with bulging discs?

A. Oh, sure.

Q. Great many people, aren't there?

A. Sure.

Q. And probably some of those discs should deserve

or should be removed?
A. Not unless they are symptomatic, no.
Q. Let's say that they are mildly symptomatic or developing into symptomatic, are you saying they should wait until they become entirely symptomatic before they remove them, have their disc removed?
A. They have to be producing sufficient disability to justify the surgery, certainly.
Q. It should be somewhat debilitating?
A. Yes.
Q. What I am getting at is, I know you don't agree, but there is in writing some indication that Joann Juhn had symptoms of either a bulging or herniated disc by means of the fact that she had this arm, these arm symptoms before the RTA accident, and she could have been amongst one of these many people that were walking around with pathology of her cervical spine called either a bulging disc or herniated disc before this RTA accident, correct?
A. I would say that that is a possibility, yes.
Q. And isn't it more than a possibility because we have in writing confirmation that she was experiencing these very same symptoms that you

have testified are directly attributable to the cervical pathology, that is the numbness, tingling and loss of grip?

A. She had similar symptoms, not necessarily the very same symptoms four years before.

Q. Before the RTA accident?

A. Four years before.

Q. And that gives some indication, some indication?

A. Some indication.

Q. Of neck pathology before the RTA accident?

A. Not necessarily the neck. You tried to make a big point about her carpal tunnel. It could have been the same thing then, you know.

We are speculating, we are really stretching. I have to agree with the possibility if you want to talk in terms of probability, I would have to say you can't say that.

Q. You did not examine her at that time so you could not say it was probable?

A. I would not have been able to tell at the time anyway.

Q. It would have taken a longer period of time for it to become sufficiently debilitating or ripened so to speak?

A. Yes.
Q. That happened over the three year period of time, that ripeness occurred over the three year period of time that you treated this woman, it became sufficiently debilitating so that you removed it?
A. Well, as I indicated, we were probably slow in making the diagnosis. I imagine if that MRI had been done quite some time prior it would have shown the same thing.
Q. What are the factors --
A. The fact that she didn't have any objective neurological findings and the fact that of course, which had not been brought out too much, that we do know that she had considerable emotional problems, certainly made me go slowly and treat her very conservatively for a long period of time until I became convinced that in fact this woman had some real problems.
Q. What are the factors upon which you state with certainty that this thing originated on February 8, '84?
A. The history of the accident, the immediate onset of symptoms, the whole natural history of this thing as it went forward.

Q. The history and progression?
A. Yes.
Q. Anything more definite than that?
A. I don't know how definite you can be.
Q. Something more definite is the fact that she had the symptoms before the RTA accident and you have it in writing?
A. I don't think there is any point in me even responding to that question. Again I responded about six times already.

MR. TADDEO: That is the end. That is all I have.

- - - -

REDIRECT EXAMINATION OF RALPH A. REILLY, M.D.

BY MR. SPERO:

Q. Doctor, do you attach very much weight to the fact that on one time in April of 1980 on one occasion she had a complaint of numbness in her right arm?
A. Very little. Very little significance in my mind.
Q. In any event if she were able to work and carry on her normal activities between 1980 and 1984, without this continuous symptom or without pain in the neck, would that weigh heavily in your

decision?

A. I think that is significant.

Q. You have had many many questions, Doctor.

Has any question that was asked of you today caused you to alter your opinion as to the herniated disc being caused by the RTA derailment?

A. No.

Q. That is still your opinion?

A. That is my opinion.

MR. SPERO: Doctor, will you waive signature and the viewing of this tape?

THE WITNESS: Yes, certainly.

MR. SPERO: You indicated we could keep the deposition in our hands and you waive the filing of it, we can play it in court at the appropriate time?

MR. TADDEO: That is correct. That is all right with me.

MR. SPERO: That is fine. Thank you very much. The deposition is completed at this time.

(Signature waived.)

C E R T I F I C A T E

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

I, Linda A. Astuto, a Notary Public within and for the State of Ohio, authorized to administer oaths and to take and certify depositions, do hereby certify that the above-named RALPH A. REILLY, M.D. Was by me, before the giving of his deposition, first duly sworn to testify the truth, the whole truth, and nothing but the truth; that the deposition as above-set forth was reduced to writing by me by means of stenotypy, and was later transcribed into typewriting under my direction; that this is a true record of the testimony given by the witness, and the reading and signing of the deposition was expressly waived by the witness and by stipulation of counsel; that said deposition was taken at the aforementioned time, date and place, pursuant to notice or stipulation of counsel; and that I am not a relative or employee or attorney of any of the parties, or a relative or employee of such attorney, or financially interested in this action.

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office, at Cleveland, Ohio, this 22 day of DECEMBER A.D. 19 87.

Linda A. Astuto

Linda A. Astuto, Notary Public, State of Ohio
650 Engineers Building, Cleveland, Ohio 44114
My commission expires October 24, 1992

EXHIBIT 1

JUHN, JO ANN — STATEMENT — 476-4717

RALPH A. REILLY, M.D., INC.
Orthopaedic Surgery
14601 DETROIT AVENUE - SUITE 330
LAKEWOOD, OHIO 44107
TELEPHONE: 521-2217

Jo Ann Juhn
3249 West 130th
Cleveland, Ohio 44111

DATE	REFERENCE	DESCRIPTION	CHARGE	CREDITS Payments	CREDITS Adj.	CURRENT BALANCE
		BALANCE FORWARD →				
21-84	IOV	Exam back	50 00			50 00
9-4	OVF	"	35 00	35 00		50 00
-9-85	OVF	"	35 00	85 00		-0-
-16-85	OVF	"	50 00			50 00
-1485	OVF	Exam-X-ray	170 00	50 00		170 00
-1485	OVF	Exam back	50 00			220 00
1-13-86	OVF	Exam hand	40 00	40 00		220 00
4-29-86	OVF	Exam cervical lumbar	75 00	40 00		255 00
5/8/86	OVF	Exam spine	50 00			305 00
5/8-86	HV	Hosp. care 5/23	400 00			705 00
2-9-86	OVF	Exam-X-ray	115 00			820 00
5-21-87	OVF	Exam	75 00			895 00
-16-87	OVF	Exam	50 00			945 00
3-27-87	OVF	Exam	50 00			995 -
10-687	Surg	Surgery cervical	3000 00			3995 00
0-19-87	OVF	Exam-Post op.	N/C			3995 00

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2-OVF—Office Visit Follow-up
3-INJ—Injection
4-AI—Aspiration
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6-C—Cast
7-CR—Cast Removal
8-B—Bandage, Sling, Strapping
9-CON—Consultation
10-R—Report (s)
11-ROA—Received on Account
12-HVI—Hospital Visit, Initial
13-HVF—Hospital Visit, Follow-up
14-F—Fracture
15-ER—Emergency Room
16-O—OTHER

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EXHIBIT 2

APPROVED OMB NO. 0938-0279

SEND REMITTANCE TO:
LAKE-[illegible] HOSPITAL
P.O. BOX [illegible]
CLEVELAND, OHIO 44143
T [illegible] 216/[illegible]-7331

2	3 PATIENT CONTROL NUMBER	4 TYPE OF BILL
[illegible]	2991636	111

5 BC/BS PROV NO.	6 FEDERAL TAX NO.	7 MEDICARE NO.	8 MEDICAID NO.	9
31	34 6001633	36 0212	4923682	

10 PATIENT'S LAST NAME	FIRST NAME	INITIAL	11 PATIENT'S ADDRESS	CITY	STATE	ZIP
JOHN	JO ANN		3249 W. 130	CLEVELAND	OH	44111

12 BIRTH DATE	13 SEX	14 MS	ADMISSION 15 DATE	16 HR	17 TYPE	18 SRC	19 A-H	20 D-H	21 STAT	22 STATEMENT COVERS PERIOD FROM	THROUGH	23 COV. D.	24 N-C-D.	25 C-I-D	26 I-A-D	27
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28 OCCURRENCE CD	DATE	29 OCCURRENCE CD	DATE	30 OCCURRENCE CD	DATE	31 OCCURRENCE CD	DATE	32 OCCURRENCE CD	DATE	33 OCCURRENCE SPAN CD	FROM	THROUGH

34

JOHN JO ANN
3249 W. 130
CLEVELAND OH 44111

CONDITION CODES 35	36	37	38	39	BLOOD RECORD (PINTS) 40 FURN	41 REPL.	42 NOT REP.	43 DED.	44 SP PROG	45
									81	

46 VALUE CD	AMT	47 VALUE CD	AMT	48 VALUE CD	AMT	49 VALUE CD	AMT
01	45000						

50 DESCRIPTION		51 R CODE	52 S UNITS	53 TOTAL CHARGES	54	55	56
ROOM + BOARD (SP)	425.00	121	15	637500			
CENTRAL STERILE SUPPLIES		270		4000			
PHARMACY		250		1050			
PHYSICAL THERAPY		420		66000			
ADMISSION COST		221		5500			
TELEPHONE		993		1500			
TOTALS		001	15	714150			

57 PAYER	58 REL INFO	58 ASG BEN	60 DEDUCTIBLE	61 CO-INSURANCE	62 EST. RESPONSIBILITY	63 PRIOR PAYMENTS	64 EST. AMOUNT DUE
DUE FROM PATIENT ▶							7141.50

65 INSURED'S NAME	66 SEX	67 P.REL.	68 CERT.-SSN-HIC-ID. NO.	69 GROUP NAME	70 INSURANCE GROUP NO.

71 EID	72 ESC	73 EMPLOYER NAME	74 EMPLOYEE ID.	75 EMPLOYER LOCATION

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EXHIBIT 3

APPROVED OMB NO. 0938-0279

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P O BOX 73341
CLEVELAND, OH 44193
TEL: 216/529-7031

2	3 PATIENT CONTROL NUMBER	4 TYPE OF BILL
36[illegible] 08	6071765	111

5 BC/BS PROV. NO.	6 FEDERAL TAX NO.	7 MEDICARE NO	8 MEDICAID NO	9
31	34-6001633	36 0212	4923352	722.0

10	5 LAST NAME	FIRST NAME	INITIAL	11 PATIENT'S ADDRESS	CITY	STATE	ZIP
	JUHR,	JO ANN		3249 WEST 130	CLEVELAND,	OH	44111

12 BIRTH DATE	13 SEX	14 MS	ADMISSION 15 DATE	16 HR	17 TYPE	18 SRC	19 A-H	20 D-H	21 STAT	22 STATEMENT COVERS PERIOD FROM	THROUGH	23 COV D	24 N-C D	25 C-I D	26 L-R D	27
08 11 44	F	9	10 03 87	11	3	1		13	01	10 06 87	10 15 87	9				102287

28 OCCURRENCE CD	DATE	29 OCCURRENCE CD	DATE	30 OCCURRENCE CD	DATE	31 OCCURRENCE CD	DATE	32 OCCURRENCE CD	DATE	33 OCCURRENCE SPAN CD	FROM	THROUGH

JUHR, JO ANN
3249 WEST 130
CLEVELAND, OH 441111

CONDITION CODES 35	36	37	38	39	BLOOD RECORD (PINTS) 40 FURN	41 REPL	42 NOT RP	43 DED	44 SP PROG	45

46 VALUE CD	AMT	47 VALUE CD	AMT	48 VALUE CD	AMT	49 VALUE CD	AMT
01	4[illegible]						

50 DESCRIPTION		51 R. CODE	52 S. UNITS	53 TOTAL CHARGES	54	55	56
MED-SUR-GY/2 BED	442.00	121	9	397800	397800		
ADMISSION COST		221		5700	5700		
PHARMACY		250		10450	10450		
IV THERAPY		260		6800	6800		
MED-SUR SUPPLIES		270		34567	34567		
LABORATORY		300		8800	8800		
PATHOLOGY LAB		310		4300	4300		
RADIOLOGY		320		7800	7800		
OR SERVICES		360		11468	11468		
ANESTHESIA		370		11300	11300		
RECOVERY ROOM		710		10700	10700		
TELEPHONE		993		900			900
TOTAL		001	9	613717	612817		900

57 PAYER	58 REL INFO	59 ASG BEN	60 DEDUCTIBLE	61 CO-INSURANCE	62 EST. RESPONSIBILITY	63 PRIOR PAYMENTS	64 EST. AMOUNT DUE
A					612817		612817
B							
C							
DUE FROM PATIENT ▶					900		900

65 INSURED'S NAME	66 SEX	67 P.REL.	68 CERT.-SSN-HIC.-ID. NO.	69 GROUP NAME	70 INSURANCE GROUP NO.
A.					
B					
C					

71 EID	72 ESC	73 EMPLOYER NAME	74 EMPLOYEE ID.	75 EMPLOYER LOCATION

EXHIBIT H

APPROVED OMB NO. 0938-0279

SEND REMITTANCE TO:
LAKEWOOD HOSPITAL
P O BOX 73341 N
CLEVELAND, OH 44193
TEL: 216/529-7033

2 360 03

3 PATIENT CONTROL NUMBER 4071765

4 TYPE OF BILL 131

5 SC/GS PROV. NO. 31

6 FEDERAL TAX NO. 34-6001533

7 MEDICARE NO. 36 0212

8 MEDICAID NO. 4923332

9 722.0

10 PATIENT'S LAST NAME JOHN FIRST NAME JO ANN INITIAL

11 PATIENT'S ADDRESS 3249 WEST 130 CITY CLEVELAND STATE OH ZIP 44111

12 DATE 03 11 44 | 13 SEX F | 14 MS | ADMISSION 15 DATE 10 06 87 | 16 HR 11 | 17 TYPE 3 | 18 SRC 1 | 19 A.H. | 20 O.H. | 21 STAT | 22 STATEMENT COVERS PERIOD FROM 10 05 87 THROUGH 10 05 87 | 23 COV.D. | 24 N-C.D. | 25 C-I.D. | 26 I-R.D. | 27 102287

28 OCCURRENCE CD	DATE	29 OCCURRENCE CD	DATE	30 OCCURRENCE CD	DATE	31 OCCURRENCE CD	DATE	32 OCCURRENCE CD	DATE	33 OCCURRENCE SPAN CD	FROM	THROUGH

34 JOHN, JO ANN
3249 WEST 130
CLEVELAND, OH 441111

CONDITION CODES 35 36 37 38 39

BLOOD RECORD (PINTS) 40 FURN 41 REPL 42 NOT RP. 43 DED. 1 44 SP. PROG. 80

45

46 VALUE CD	AMT	47 VALUE CD	AMT	48 VALUE CD	AMT	49 VALUE CD	AMT
a							
b							

50 DESCRIPTION	51 R. CODE	52 S. UNITS	53 TOTAL CHARGES	54	56	58
XXXXXXXXXXXX	XXXXXXX	XXXX	XX	XXXXXX	XXXXXX	
RADIOLOGY	100587	320	1	6000	6000	
XXXXXXXXXXXXXXXXXX	XXXXXX	XXXXXXXX		XXXXXX	XXXXXX	
PULMONARY FUNC	100587	460	1	900	900	
EEG	100587	730	1	240	240	
LABORATORY	100587	300	4	7600	7600	
TOTAL		101		16940	16940	

57 PAYER	58 REL INFO	59 ASG BEN	60 DEDUCTIBLE	61 CO-INSURANCE	62 EST. RESPONSIBILITY	63 PRIOR PAYMENTS	64 EST. AMOUNT DUE
A					1694.00		15246.00
B							
C							.00

DUE FROM PATIENT ▶

65 INSURED'S NAME	66 SEX	67 P REL.	68 CERT. -SSN - HIC. - ID. NO.	69 GROUP NAME	70 INSURANCE GROUP NO.
A					
B					
C					

71 ESD	72 SSC	73 EMPLOYER NAME	74 EMPLOYEE ID.	75 EMPLOYER LOCATION

NOTICE TO THE PATIENT

The hospital is acting solely as an agent for the patient in filing for insurance benefits assigned to it, however, the hospital can assume no responsibility for guaranteeing payment of covered charges as shown on the face of the bill. Credit is shown only when the hospital has actually received payment. Should an overpayment be made, a refund check will be sent to the authorized party that is due the overpayment.

UB-82 HCFA-1450

PATIENT COPY

EXHIBIT 5

APPROVED OMB NO. 0938-0279

END REMITTANCE TO:
AKEWOOD HOSPITAL
.O. BOX 73341-N
LEV. IND. OHIO 44193
EL: 216/529-7037

2	3 PATIENT CONTROL NUMBER	4 TYPE OF BILL
360 08	E443659	131

5 SIC/BIS PROV NO	6 FEDERAL TAX NO	7 MEDICARE NO	8 MEDICAID NO	9
31	34 6001633	36 0292	4923827	

PATIENT'S LAST NAME	FIRST NAME	INITIAL	11 PATIENT'S ADDRESS	CITY	STATE	ZIP
UHN	JO ANN		3249 WEST 130 ST	CLEVELAND	OH	44111

12 BIRTH DATE	13 SEX	14 MS	ADMISSION 15 DATE	16 HR	17 TYPE	18 SRC	19 A.H	20 D.H	21 STAT	STATEMENT COVERS PERIOD FROM	THROUGH	23 COV.D	24 N-C D.	25 C-I.D	26 I-R.D	27
8 11 44	F	S	07 06 85	19			17			07 04 85	07 04 85					07 15 85

28 OCCURRENCE CD	DATE	29 OCCURRENCE CD	DATE	30 OCCURRENCE CD	DATE	31 OCCURRENCE CD	DATE	32 OCCURRENCE CD	DATE	33 OCCURRENCE SPAN CD	FROM	THROUGH
15 07 04 85												

CONDITION CODES 35	36	37	38	39	BLOOD RECORD (PINTS) 40 PURN	41 REPL	42 NOT RP	43 DED	44 SP PROG	45

46 VALUE CD	AMT	47 VALUE CD	AMT	48 VALUE CD	AMT	49 VALUE CD	AMT

UHN JO ANN
3249 WEST 130 ST
CLEVELAND OH 44111

8 DESCRIPTION		51 R CODE	52 S UNITS	53 TOTAL CHARGES	54	55	56
EMERGENCY ROOM	070485	450	1	1000			
PROFESSIONAL FEE	070485	960	1	4500			
RADIOLOGY DIAGNOSTIC	070485	320	1	3100			
TOTALS		001	3	8600			

57 PAYER	58 REL INFO	59 ASG BEN	60 DEDUCTIBLE	61 CO-INSURANCE	62 EST RESPONSIBILITY	63 PRIOR PAYMENTS	64 EST AMOUNT DUE
							86.00

DUE FROM PATIENT ▶

65 INSURED'S NAME	66 SEX	67 P.REL	68 CERT -SSN - HIC - ID NO	69 GROUP NAME	70 INSURANCE GROUP NO

71 ESD	72 ESC	73 EMPLOYER NAME	74 EMPLOYEE ID.	75 EMPLOYER LOCATION

NOTICE TO THE PATIENT

The hospital is acting solely as an agent for the patient in filing for insurance benefits assigned to it, however, the hospital can assume no responsibility for guaranteeing payment of covered charges as shown on the face of the bill. Credit is shown only when the hospital has actually received payment. Should an overpayment be made, a refund check will be sent to the authorized party that is due the overpayment.

EXHIBIT 6

SEND REMITTANCE TO: LAKEWOOD HOSPITAL
P.O. BOX 73341-N
CLEVELAND, OHIO 44193

TYPE BILL			
XXX		FINAL	
P/T	BILLING TO	BILL DATE	LV. D
E/P		010786	

PATIENT NUMBER: E038730

HOSPITAL PHONE: 216/521-4200

FEDERAL I.D. NUMBER: 34-6001633

PATIENT NAME	REL	M/S	AGE	ADMISSION DATE AND TIME	GUARANTOR PHONE	GUARANTOR SOC. SEC. NO
JU JOANN	1	9	41	01 05 86	F 000000	

PATIENT SOC. SEC. NO.	HOSP. SER.	DOCTOR NO.	PATIENT'S BIRTH	DISCHARGE DATE AND TIME	DAYS STAY	SERV. CODE	F/C	AVG. SEMI-PRIVATE R
	3111	99999	08 11 44	010586	0	CB1	31	

INSURANCE INFORMATION C.O.B.

INSURANCE COMPANY	EMPLOYER'S NAME	CERT/CONT NUMBER	GROUP POLICY NO.	EMP. NO.
BLUE CROSS	ARTER & HADDEN LAW FIRM	286389619	26660A	

DAILY BENEFIT PERCENTAGE

GUARANTOR NAME AND ADDRESS
JOHN JOANN
3249 W. 130TH ST.
CLEVELAND OH 44111

IS SPOUSE EMPLOYED? YES ☐ NO ☐

IF YES NAME AND ADDRESS OF THAT EMPLOYER

DATE MO/DAY	DESCRIPTION OF SERVICES	TOTAL CHARGES	INSURANCE AMOUNT DUE 1	2	3	PATIENT AMOUNT
/05/6	060 WRIST SPLINT	[illegible]				
/05/6	060 EMERGENCY ROOM	1000				
/05/6	060 PROFESSIONAL FEE	4500				
/05/6	075 XRAY WRIST	3100				
	TOTALS ▶	9925				

PLEASE PAY THIS AMOUN

Ex 1

a

STATEMENT

SPORTS MEDICINE ASSOC.
2609 FRANKLIN BLVD.
CLEVELAND, OH. 44113

FOR ANY QUESTIONS CALL
1-216-696-3391

WHEN CALLING OR WRITING ABOUT YOUR ACCOUNT,
PLEASE REFER TO YOUR ACCOUNT NUMBER

ACCOUNT NO. AND BALANCE	RESPONSIBLE PARTY NAME AND ADDRESS	BILLING DATE
9990976	JOANN JUHN 3209 WEST 130TH STREET	Ob130184 A
$443.00	CLEVELAND , OHIO 44111	

PLEASE RETURN TOP OF STATEMENT WITH PAYMENT.
INSERT IN THE ENCLOSED ENVELOPE. DETACH HERE

ENTER PAYMENT AMOUNT

DATE	DESCRIPTION	PATIENT	DOCTOR OR PROVIDER	CHARGES OR CREDITS (CR)
06/08/84	EVALUATION I	JOAYX	3	t3.00
06/08/84	CERVICAL TRACTION	JOANY	3	23.00
06/08/84	MOIST HEAT	JOANN	3	13.00
06/12/84	ULTRASOUND	JOANN	3	13.00
06/12/84	CERVICAL TRACTION	JOAYN	3	23.00
06/12/84	MOIST HEAT	JOANN	3	13.00
06/14/84	ULTRASOUND	JOAYH	3	13.00
06/14/84	CERVICAL TRACTION	JOANH	3	23.00
06/14/84	MOIST HEAT	JOANN	3	13.00
06/18/84	ULTRASOUND	JOANN	3	13.00
06/18/84	PELVIC TRACTION	JOANN	3	23.00
06/18/84	MOIST HEAT	JOANN	3	13.00
06/20/84	ULTRASOUND	JOANN	3	13.00
06/20/84	CERVICAL TRACTION	JOANN	3	23.00
06/20/84	MOIST HEAT	JOAYH	3	13.00
06/22/84	UtTRASDUND	JOAYY	3	13.00
06/22/84	CERVICAL TRACTION	JOANN	3	23.00
06/22/84	MOIST HEAT	JOANN	3	13.00
06/25/84	ULTRASOUND	JOANN	3	13.00
06/25/84	CERVICAL TRACTION	JOAYN	3	23.00
06/25/84	MOIST HEAT	JOANN	3	13.00
06/27/84	ULTRASOUND	JOANN	3	13.00

CURRENT	30 DAYS	60 DAYS	90 DAYS	120 DAYS OR OVER	NEW BALANCE

ACCOUNT NO.	BILLING DATE	RESPONSIBLE PARTY	PAY THIS AMOUNT
9990976	06/30/84	** STATEMENT CONTINUED **	

CHARGES AND PAYMENTS MADE AFTER BILLING DATE WILL APPEAR ON NEXT STATEMENT.

SPORTS MEDICINE ASSOC.

7b

STATEMENT

SPORTS MEDICINE ASSOC.
2609 FRANKLIN BLVD.
CLEVELAND, OH. 46113

FOR ANY QUESTIONS CALL
1-216-696-3391

WHEN CALLING OR WRITING ABOUT YOUR ACCOUNT,
PLEASE REFER TO YOUR ACCOUNT NUMBER

ACCOUNT NO. AND BALANCE	RESPONSIBLE PARTY NAME AND ADDRESS	BILLING DATE
9990976 $443.00	JOANY JUHN 3249 WEST 130TH STREET CLEVELAND o OHIO 44111	06/30/84 A

PLEASE RETURN TOP OF STATEMENT WITH PAYMENT;
INSERT IN THE ENCLOSED ENVELOPE. DETACH HERE

ENTER PAYMENT AMOUNT

DATE	DESCRIPTION	PATIENT	DOCTOR OR PROVIDER	CHARGES OR CREDITS (CR)
06/27/84	CERVICAL TRACTION	JOANN	3	23.00
06/27/84	MOIST HEAT	JOANN	3	13.00
06/29/84	Ut TRASOUND	JOANN	3	13.00
06129194	CERVICAL TRACTION	JOANN	3	23.00
06/29/84	MOIST HEAT	JOANN	3	13.00

CURRENT	30 DAYS	60 DAYS	90 DAYS	120 DAYS OR OVER	NEW BALANCE
443.00	.00	.00	.00	.00	$443.00

ACCOUNT NO.	BILLING DATE	RESPONSIBLE PARTY
9990976	06/30/84	JOANN JUHN

CHARGES AND PAYMENTS MADE AFTER BILLING DATE WILL APPEAR ON NEXT STATEMENT.

PAY THIS AMOUNT

SPORTS MEDICINE ASSOC.

7c

STATEMENT

SPORTS MEDICINE ASSOCo
2609 FRANKLIN BLVD.
CLEVELAND, OH. 44113

FOR ANY QUESTIONS CALL
1-216-696-3391

ACCOUNT NO. AND BALANCE	RESPONSIBLEPARTY NAME AND ADDRESS	BILLING DATE

PLEASE RETURN TOP OF STATEMENT WITH PAYMENT.
INSERT IN THE ENCLOSED ENVELOPE. DETACH HERE

ENTER PAYMENT AMOUNT

DATE	DESCRIPTION	PATIENT	DOCTOR OR PROVIDER	CHARGES OR CREDITS (CR)
	BALANCE FORWARD			443.00
07/02/84	ULTRASOUND	JOANN		13.00
07/02/84	CERVICAL TRACTION	JOANN		23.00
07/02/84	MOIST HEAT	JOANN		13.00
07/05/84	ULTRASOUND	JOANN		13.00
07/05/84	CERVICAL TRACTION	JOANN		23.00
07/05/84	HOIST HEAT	JOANN		13.00
07/09/84	ULTRASOUND	JOANN	SPORTS	13.00
07/09/84	CERVICAL TRACTION	JOANN	SPORTS	23.00
07/09/84	MOIST HEAT	JOANN	SPORTS	13.00
07/11/84	ULTRASOUND	JOANN		13.00
07/11/84	CERVICAL TRACTION	JOANN		23.00
07/11/84	MOIST HEAT	JOANN		13.00
07/13/84	ULTRASOUND	JOANN		13.00
07/13/84	CERVICAL TRACTION	JOANN		23.00
07/13/84	HOIST HEAT	JOANN		13.00
07/16/84	ULTRASOUND	JOANN		13.00
07/16/84	CERVICAL TRACTION	JOANN		23.00
07/16/84	MOIST HEAT	JOANN		13.00
07/17/84			SPORTS	39.00
07/17/84			SPORTS	108.00

CURRENT	30 DAYS	60 DAYS	90 DAYS	120 DAYS OR OVER	NEW BALANCE

ACCOUNT NO.	BILLING DATE	RESPONSIBLE PARTY	
9990976	07/31/84	** STATEMENT CONTINUED **	PAY THIS AMOUNT

CHARGES AND PAYMENTS MADE AFTER BILLING DATE WILL APPEAR ON NEXT STATEMENT.

SPORTS MEDICINE ASSOC.

1d

STATEMENT

SPORTS MEDICINE ASSOC.
2609 FRANKLIN BLVD.
CLEVELAND, OH. 44113

FOR ANY QUESTIONS CALL
1-216-696-3391

WHEN CALLING OR WRITING ABOUT YOUR ACCOUNT, PLEASE REFER TO YOUR ACCOUNT NUMBER

ACCOUNT NO. AND BALANCE	RESPONSIBLE PARTY NAME ANL ADDRESS	BILLING DATE
9990976	JOANN JUHN P.O. BOX 11157	07/31/04 A
$822.00	CLEVELAND , OHIO 44111	

PLEASE RETURN TOP OF STATEMENT WITH PAYMENT.
INSERT IN THE ENCLOSED ENVELOPE. DETACH HERE

ENTER PAYMENT AMOUNT

DATE	DESCRIPTION	PATIENT	DOCTOR OR PROVIDER	CHARGES OR CREDITS (CR)
07/18/84	ULTRASOUND	JOANN		13.00
07/18/84	CERVICAL TRACTION	JOANN		23.00
07/18/84	HOIST HEAT	JOANN		13.00
07/20/84	CERVICAL TRACTION	JOANN		23.00
07/20/84	MOIST HEAT	JOANN		13.00
07/23/84	ULTRASOUND	JOANN		13.00
07/23/84	CERVICAL TRACTION	JOANN		23.00
07/23/84	MOIST HEAT	JOANN		13.00
07/25/84				13.00
07/25/84				36.00
07/25/84	ULTRASOUND	JOANN		13.00
07/25/84	CERVICAL TRACTION	JOANN		23.00
07/25/84	MOIST HEAT	JOANN		13.00
07/27/84	ULTRASOUND	JOANN		13.00
07/27/84	CERVICAL TRACTION	JOANN		23.00
07/27/84	MOIST HEAT	JOANN		13.00
07/30/84	ULTRASOUND	JOANN		13.00
07/30/84	CERVICAL TRACTION	JOANN		23.00
07/30/84	MOIST HEAT	JOANN		13.00

CURRENT	30 DAYS	60 DAYS	90 DAYS	120 DAYS OR OVER	NEW BALANCE
575.00	443.00	.00	.00	.00	$1,018.00

ACCOUNT NO.	BILLING DATE	RESPONSIBLE PARTY
9990976	07/31/84	JOANN JUHN

CHARGES AND PAYMENTS MADE AFTER BILLING DATE WILL APPEAR ON NEXT STATEMENT.

PAY THIS AMOUNT

SPORTS MEDICINE ASSOC.

Ex 8

cCOY PHYSICAL THERAPY ASSOCIATES

Raymond L. McCoy, L.P.T.
Douglas E. Majko, L.P.T.

irma Medical Arts Center, 66111 Ridge Road
irma, Ohio 44129 842-4444

Lakewood Center Professional Building, 14601 Detroit Avenue
Lakewood, Ohio 44107 221-4161

Middleburg Heights Medical Arts Center, 18660 Bagley Road
Middleburg Heights, Ohio 44130 234-8100

East Brunswick Professional Building, 3864 Center Rood
Brunswick, Ohio 44211 225-0553

r

JUHN, JOANN
3249 W.130 Street
Cleveland, Ohio 44111

L

ND PAYMENT TO ML/ ~~UCR~~

TE	PROFESSIONAL SERVICE	CHARGES	CREDITS	BALANCE
-27-84	(HPUSMESE.)2	48.00		48.00
-28-84	"	48.00		96.00
-29-84	"	48.00		144.00
3-30-84	"	48.00		142.00
-31-84	"	48.00	1984	240.00
-1-84	"	48.00		288.00
-25-84				
-13-85	(HP US ES M EX)2	56.00		344.00
14-85	"	56.00		400.00
-15-85	"	56.00		456.00
-16-85	"	56.00	1985	512.00
-17-85	"	56.00		568.00
-18-85	"	56.00		624.00
-21-85	"	56.00		680.00
-22-85	"	56.00		736.00
-23-85	"	56.00		792.00
-24-85	"	56.00		848.00
-28-85	"	56.00		904.00
-29-85	"	56.00		960.00
-1-86	HPUSESME-cerv.	39.00		999.00
-1-86	HPUSESME-lumbar	23.00		1,022.00
6-8	HPUSESMEX-cerv.	39.00	1986	1,061.00
6-86	HPUSESMEX-lumbar	23.00		1,084.00
8-86	HPUSESME-cerv.	39.00		1,123.00
8-86	HPUSESME-lumbar	23.00		1,146.00

HP - HOT PACKS PTR - PELVIC TRACTION

EXHIBIT 9

STATEMENT OF ACCOUNT

If Address Or Insurance Information Shown Below Is Incorrect. Please Enter Changes On Back And Check This Box ☐

LUTHERAN MEDICAL CENTER
2609 FRANKLIN BLVD
CLEVELAND, OHIO 44113

ADDRESS CORRECTION REQUESTED

Amount Paid ▶	
$ 5.00	04/28/84
Pay This Amount	Payment Due By
84006782	0303
Refer to Above Pt. No. on All Inq.	

For Information Regarding this Statement. Telephone ▶363-2042

SELF PAY UNIT

02/21/84-04/13/84

[redacted]

Patient Name JUHN , JOANN 08/11/44 216-476-1717

▼ Send Payment To ▼

LUTHERAN MEDICAL CENTER
P.O. BOX 92693-T
CLEVELAND, OHIO 44190

▼ Guarantor ▼

84006782
JOANN JUHN
3249 W 130 ST
CLEVELAND,OH 44111

TO INSURE PROPER CREDIT TO YOUR ACCOUNT DETACH ALONG DOTTED LINE - AND RETURN TOP PORTION WITH YOUR PAYMENT.

Patient Name JUHN , JOANN Last Stmt. 02/21/84 Prev. Bal. $ 2,289.00

TRANSACTION DATES	DESCRIPTION	AMOUNTS
		191.00

Hospital: LUTHERAN MEDICAL CENTER BRO Stmt. Date 04/13/84

Patient No.: 84006782

Adm. Date	Discharge Date		Account Balance		Err. Insurance Due*		Pay This Amount
02/08/84	02/12/84	$	5.00	E	.00	$	5.00

*Insurance Is Estimated For Billing. Any Balance Unpaid Will Be Billed To The Patient.

Payments And Charges Received After The Date Of This Statement Will Be Reflected On The Next Statement.

Ex 10

STATEMENT

OHIO CITY ORTHOPAEDICS, INC.
ORTHOPAEDIC SURGERY
MEDICAL ARTS BLDG. OF LUTHERAN MEDICAL CENTER
SUITE 3200 - 2600 VESTRY AVE.
CLEVELAND, OHIO 44113

TELEPHONE (216) 621-4060

ACCOUNT NO.	STATEMENT DATE	PAGE	AMOUNT REMITTED
658321	6/28/84		

YOU ARE RESPONSIBLE FOR PAYMENT IN FULL OF THIS BILL. QUESTIONS CONCERNING INSURANCE COVERAGE FOR SERVICES ARE BETWEEN YOU AND YOUR INSURANCE COMPANY. WE WILL BE HAPPY TO ASSIST!

Joann Juhn
P.O. Box 11157
Cleveland, Ohio 44111

PLEASE DETACH AND RETURN THIS STUB WITH YOUR REMITTANCE

DATE	PROCEDURE CODE	DESCRIPTION	ICDA	PATIENT	DR.	LOC.	AMOUNT
2/9/84		In Hospital Consultation requested by Dr. Markakis					$ 60.00
_, 18/84		Office Examination					$ 25.00
6/8/84		Office Examination					$ 25.00
				TOTAL BALANCE			$ 110.00

WILLIAM R. BOHL, M.D.

ACCOUNT NO.	CURRENT	OVER 30 DAYS	OVER 60 DAYS	OVER 90 DAYS	OVER 120 DAYS	LAST PAYMENT DATE	BALANCE DUE

EXHIBIT 11

PATIENT: JUHN, JC

ACCOUNT NO.: 20-65-C0003612 | STATEMENT DATE: 7-30-87

WESTSIDE IMAGING ONCOLOGY
34055 SOLON ROAD SUITE 107
SOLON OH 44139-2620

IRS NO.: 34-1493613

BILLING OFFICE PHONE: 216/349-2455

DATE	*	EXAM CODE	DESCRIPTION	DX CODE	AMOUNT
5-26-87	3	72141	MRI SPINAL CORD-CERV C4-C8	724.5	950.00
5-26-87	3	72144	MRI SPINAL CANAL LUMBAR	724.5	950.00

REFERRING PHYSICIAN	DATE ADMITTED	DATE DISCHARGED	PATIENT PHONE NO.	BALANCE DUE
REILLY, R. MD			476-4717	1,900.00

PLACE OF SERVICE: WESTSIDE IMAGING ONCOLOGY 5260 SMITH ROAD BROCKPARK OH

NOTE

* PLACE OF SERVICE: 1 INPATIENT HOSPITAL, 2 OUTPATIENT HOSPITAL, 3 DOCTOR'S OFFICE, 4 EMERGENCY ROOM

EMPLOYER ▶

PRIMARY INSURANCE ▶

SECONDARY INSURANCE ▶

ATTENDING PHYSICIAN ▶ SYKORA, GLENN, MD

DATE OF BIRTH: 8-11-44

INJURY DATE:

236389619

EXHIBIT 12

JAMES R. COY, M. D.
PRACTICE LIMITED TO ANESTHESIOLOGY

LAKEWOOD, OHIO 44107

221-1564

DATE 10/17/87

Anesthesia services rendered 10/6/87
for Jo Ann Juhn $ 800.00

Place: Lakewood Hospital IH
Surgeon: R. Reilly, MD
Procedure: 63020 Anterior Cervical Fusion C5-6
with Bone Graft from Anterior Superior Iliac Crest

Duration: 2:15 - 5:45 PM 210'

Rel. Value: 10 + 14 + 1* = 25

71048680

6000000

ST. JOHN'S HOSPITAL

CLEVELAND, OHIO

FREDERICK,JO ANN ACC
C.OBERT SUR ICU
71048680 062371 BC
14220 TRISKET[illegible]

INTENSIVE [redacted]

ADULT PERSONAL HISTORY

OCCUPATION _____ DATE 6 23 71 M S W D

CHIEF COMPLAINT Head injury

PRESENT ILLNESS

The pt was last seen today when she had a car accident and she lost consciousness. The pt had severe lacerations to the forehead & was especially the mouth was bleeding. The pt is unconscious. She also complains of severe dyspnea & pain in upper part of the sternum. Nausea & bowel disturbances.

PAST HISTORY (Illnesses, Operations, Injuries and prior Hospitalization):

No previous operations or hospitalizations.

PENGAD-Bayonne, N.J.

DEFENDANT'S EXHIBIT

1

MED-13-(1)-P

LAKEWOOD HOSPITAL — LAKEWOOD, OHIO

EMERGENCY DEPARTMENT

EMX - - 176

ADMISSION NUMBER: E310882

DISCHARGED: DATE 4/22/80 TIME 8:30

ADMISSION: DATE [redacted] TIME

ARRIVED BY: SELF CP

LAST	FIRST	MIDDLE (MAIDEN)	AGE	BIRTH DATE	SEX	RACE	MARITAL STATUS
[redacted]	JOANN	M	35	8-11-44	F	W	DIV

ADDRESS: 3249 WEST 130TH ST | CITY: CLEV | STATE: 11 | ZIP CODE | PHONE: 476 2437 | SOCIAL SECURITY NO.: 286 38 9619

NEAREST RELATIVE | RELATIONSHIP | PHONE | PATIENT SERV CODE | PREVIOUS ADMISSION YES ☐ NO ☐ | YR | FIRE CLASS

CITY | STATE | ZIP CODE | PHONE

POLICY HOLDER OR GUARANTOR: SELF | RELATIONSHIP | ADDRESS | PHONE | GUARANTOR'S SOCIAL SECURITY NO.

EMPLOYER NAME: STEEL SERVICE CENTER INSTITUTE | ADDRESS: TERMINAL TOWER

BC SERVICE CODE	BC GROUP NO.	BC CONTRACT/CERTIFICATE NO	MEDICARE NO	PART B	WELFARE I.D./OTHER I.D. NO.
DR7 CEK	10662	286389619			

OTHER INSURANCE: BC PLAN CODE 333 | OTHER INSURANCE: HB GIVEN

I hereby authorize the physician or physicians in charge of the emergency room, or their assistants or designees, to diagnose and treat my condition(s). I understand that unforeseen conditions may be revealed during the course of the examination or procedure. I authorize and request said physicians to perform such procedures as are necessary in the exercise of professional judgment. I acknowledge that no warranty or guarantee has been made by anyone concerning the results of the emergency procedure or treatment. I consent to the administration of such anesthetics as may be considered advisable. I further understand that subsequent to this emergency treatment x-rays may be read or review may be made regarding my condition which may cause a revision to be made thereto. I understand that the medical care furnished is limited solely to emergency treatment and that it will be necessary to select another physician and make immediate arrangements with him for a continuation of treatment.

The undersigned jointly and severally unconditionally guarantees payments of all such hospital's charges or balances when due.

SIGNATURE OF PATIENT: Jo Ann Joann | SIGNATURE OF GUARANTOR

IF ACCIDENT, SPECIFY LOCATION, DATE AND TIME: PT STS NUMBNESS IN RIGHT ARM - TINGLING IN LEFT FINGER TIPS. NO HX OF INJ. 4-22-80

PERSONAL PHYSICIAN: GUIAO

REFERRED TO(DOCTOR'S FULL NAME):

X-RAY REQUEST: Chest C Spine

HISTORY & PHYSICAL: T 98.3 P 80 R 16 BP 120/80

X RAY RESULTS: Chest neg C-S spine

DIAGNOSIS: Numbness of hands to be investigated

TREATMENT – HOME GOING INSTRUCTIONS

Referred to Dr Guiao for follow up

ALLERGIES: penicillin

DOCTORS ORDERS | TIME | GIVEN BY

TETANUS

RECEIVED 03 AM '80 MED

DISPOSITION

DOCTOR'S SIGNATURE: [signature]

SIGNATURE OF NURSE: B Dennenmeyer RN

ADMITTED: DATE | TIME | UNIT | ROOM | BED | FINANCIAL CLASS

ACTION NUMBER: 0134

CHECK OTHER SERVICES WHICH PATIENT RECEIVES: X RAY, LAB, EKG, OB

DOCTOR'S FEE	P.C.	
BASIC EMERG. FEE ILLNESS	0378	4000
BASIC EMERG. FEE ACCIDENT	0379	

RECORD ROOM COPY

FORM 66 REV. 8-79

DEFENDANT'S EXHIBIT 2

PENGAD-Bayonne, N.J.

DEFENDANT'S EXHIBIT 3
PENGAD-Bayonne, N.J.

LUTHERAN MEDICAL CENTER
Cleveland, Ohio 44113

ELECTROMYOGRAPHIC STUDIES

PATIENT Mrs. Joann Juhn AGE 39 DATE 6/13/84

REFERRING PHYSICIAN Dr. W. Bohl ROOM NO. O.P. HOSPITAL NO.

PROBLEM pt is c/o pain in the Rt. shoulder, tingling of the Rt. & left fingers. She had an accident in Feb 1984 when fell out of RTA rapid fell on the track. A few days later she had tingling in her hands.

ELECTROMYOGRAPHY

MUSCLE	INNERVATION	INSERTIONAL ACTIVITY	POSITIVE WAVES	FIBRILLATIONS	FASCICULATIONS	MOTOR UNIT ACTION POTENTIALS			
						%Voluntary Motor Units	Amplitude (Micro Volts)	Duration (ms)	% of Polyphasics
Rt. APB		N↓	-0-	-0-	-0-	80%	2-3K	<10	
1st DI		N	-0-	-0-	-0-	N	N	N	
Biceps		N	-0-	-0-	-0-	N	N	N	
Triceps		N	-0-	-0-	-0-	N	N	N	
ECRL		N	-0-	-0-	-0-	N	N	N	
FDS		N	-0-	-0-	-0-	N	N	N	

NERVE CONDUCTION STUDIES

NERVE	RECORDING MUSCLE	LATENCY (ms) Dist.	LATENCY (ms) Prox.	DISTANCE (cm)	STIM. DUR. (ms) Dist.	STIM. DUR. (ms) Prox.	MOTOR OR SEN. RESPONSE Dist.	MOTOR OR SEN. RESPONSE Prox.	CONDUCTION VEL. (meter/sec.)
Rt. median (S)			no response						
N (M)	APB	6.1	10.5	22.5	0.05	0.1	10K	10K	51
ulnar (M)	Thenar	2.2							
ulnar	ADM	2.2	5.6	17.5	0.1	0.2	10K	10K	51
			8.4	16.5		0.1		10K	66
F	N		26.0						

COMMENT:

Nerve Conduction Studies: The Rt. median sensory response was not obtainable. The left median sensory distal latency was mildly prolonged. The Rt. median motor distal latency was moderately prolonged & the left median ~~motor~~ distal latency was mildly prolonged. The conduction velocities were normal. The Rt & left ulnar nerves were nl distally. The conduction velocity was nl along the Rt ulnar nerve.

MG studies of the muscles of the Rt. upper extremity was nl.

Impression: Bilateral Carpal tunnel syndrome, moderately severe on the Rt. side, mild on the left.

There is no evidence of cervical radiculopathy on this examination. The F response along the ulnar nerve was nl.

EXAMINER: Shanai Lashgari, M.D.

617657

JUHN, JO ANN 299163 (Findings, Diagnosis, Recommendations) E469-01

DEFENDANT'S EXHIBIT 4
PENGAD-Bayonne, N.J.

CONSULTING SERVICE OR PHYSICIAN: K. Weaver, M.D.

REASON FOR CONSULTATION:

Referring physician requests:

- ☐ Emergency Consultation
- ☐ Within 24 hours
- ☐ At your convenience
- ☐ History & Physical
- ☐ Diagnosis
- ☐ Recomnendations only
- ☐ Outline treatment
- ☐ Follow with Attending
- ☐ Transfer to your service

Signed
R. Reilly, M.D. Requesting Physician
Date of Request

This 41 year old divorced white female is admitted with complaints of left shoulder and neck pain, numbness and tingling in the fingers of both hands with some pain, weakness of the arms, and sharp lumbar pains, radiating down the right leg. Psychiatric consultation is requested for evaluation of depression and psychosomatic complaints. She saw Dr. Gordillo yesterday who left a consultation report, but she stated that she did not wish to see him any further since the two of them did not get along very well. She also has seen a psychologist, Dr. Ritz for about 3-4 sessions under the referal of her attorney and she does get along well with him and plans to continue to see him after discharge. She saw Dr. Savinsky for one visit back several years ago after hysterectomy and was treated with Ludiomil 50 mg t.i.d. for about 3 wks which she felt helped her quite a bit, but had no further psychiatric followup at that time. She has had no past psychiatric hospitalizations. As you know, she had an injury on the RTA in February of '84 in train collision. She was thrown on the floor and landed on her right arm and right leg, described as being twisted behind her. Initially, the pain was worse in the right hand and arm and sounds as though she had some nerve injury in the right brachial plexus or arm, producing this pain. She apparently has never had a myelography and does not remember if she had a CT s . of the back but continues to have the upper and lower back pains, arm pain, leg pain and neck pain ever since this injury. She was hospitalized at Lutheran Medical Center and treated with Fiorinol , Darvocet and Valium. Other treatments have included Robaxol, Motrin, Talwin, SOMA Compound, Demerol, Vicodin, and most recently Elavil. She felt the Fiorinol helped her and she does not feel that the Vicodin and SOMA Compound helps. She was a secretary at the time of her injury. She was not able to go back for two months and then was placed in lower position when she did return. From that time on she had difficulties with her boss, because of missing work for doctor's appointments and finally she quit that job and started her current job in word processing for an attorney's firm 1½ years ago. At that job she missed 9 days last year and about 14 days this year due to her back pain. She does have a suit pending against RTA for her injury, otherwise, she has no other source of income, other than from employment.

FAMILY & SOCIAL HISTORY: Parents separated when she was in the 8th grade, father was an alcoholic who used to be physically abusive to the wife and children, he died in '72 of stroke and diabetes, mother is still living at 75 and she gets along well with "the mother; she has two older sisters and one younger brother and gets along pretty well with all of them. They are all in the greater Cleveland area. She has been married 3 times, first marriage to an alcoholic husband who was also abusive to her, much like her father was to her mother; she asked for a divorce from that husband after 7 yrs of marriage; second husband married to twice for a total of 7 yrs and divorced the second time in '80, he also was an alcoholic and apparently bisexual. She had one abortion in '80. She had a hysterectomy for what was described as severe endometriosis a few years ago (nine months prior to her injury at the RTA). She has two daughters, 22 and 23, one is married; she has two grandchildren and both daughters lives in Cleveland area and she gets along well with them. She has no current boyfriend and now finds that she has too much pain to be able to handle sical relationships and her libido has been low

Signed
Consultant
Date of Consultation

CONSULTING SERVICE OR PHYSICIAN: _____

REASON FOR CONSULTATION: _____

Referring physician requests:

- ☐ Emergency Consultation
- ☐ Within 24 hours
- ☐ At your convenience
- ☐ History & Physical
- ☐ Diagnosis
- ☐ Recommendations only
- ☐ Outline treatment
- ☐ Follow with Attending
- ☐ Transfer to your service

Signed _____ Requesting Physician

Date of Request _____

PAGE 11:

She sleeps fairly well with the exception of nightmares about 3 times a week, eminent car crash or train going around a mountain and on the verge of falling off the mountain. She also states that muscle spasms in her sleep awaken her at night. Appetite is fair and weight is apparently has been stable. She denies any suicidal thoughts.

MENTAL STATUS EXAM: Alert, well-oriented, 41 year old white female, just slightly above ideal weight, she walks stiffly and slowly with some facial expressions of pain, speech is clear and coherent, somewhat diminished volume and productivity and somewhat slow in rate. She appears mildly depressed and angry at RTA for what she feels is uncaring treatment of her and also angry at her ex-employer and somewhat angry at past physicians. Insight and judgment fair. Intellect is average. Recent and remote memory are intact.

IMPRESSION:

I believe this woman may have had a nerve injury initially with her RTA accident. Since that t she has obviously continued to complain of pain intermittently with no definite physical findings. She has continued to work in spite of her complaints, however, pending law suit against RTA makes it likely on statistical basis that her pain complaints will not cease unti law suit is settled, which often takes years to occur. Therefore goals of treatment have to be somewhat minimized to keep her working with the minimal possible degree of pain complaints

I would recommend attempting to keep her off narcotic medication and she might manage to do satisfactorily with Fiorinol or nonsteroidal anti-inflammatory drug for pain along with continuing the Elavil and increasing the bed time dose of Elavil which may help to decrease her nightmares and muscle spasms as well as improve her sleep and decrease the main complaints of pain. Antidepressant medication such as Elavil has been helpful as adjuctive agents for chronic pain syndromes with both physical and psychological. components. There appears to be definite emotional factors in this patient's background relating to abusive father and ex-husbands which make the issue of physical pain and injury an emotionally sensitive issue for her and I believe, contributes to her current ongoing complaints of pain.

DIAGNOSTIC IMPRESSION:

(1) Chronic pain disorder
(2) Psychogenic and/or organic etiology
(3) Mild chronic depression (dysthymic disorder)

RECOMMENDATIONS:

(1) As above, attempt to increase the Elavil at night and continue with small dose of 25 mg several times during the daytime in addition to using non-narcotic analgesics and physical therapy with whirlpool for her pain complaints.

Signed _____ MD Consultant

Date of Consultation _____

617657

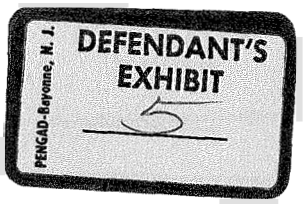
OHIO CITY ORTHOPAEDICS, INC.
SPORTS MEDICINE ASSOCIATES
ORTHOPAEDIC SURGERY
MEDICAL ARTS BLDG OF LUTHERAN MEDICAL CENTER
SUITE 3200 2600 VESTRY AVE
CLEVELAND OHIO 44113

TELEPHONE 621-4060

EARL A BRIGHTMAN M D
WILLIAM R BOHL M D
MARK S BERKOWITZ M D

June 28, 1984

David I, Sindell
Attorney at Law
Sindell, Sindell & Rubenstein
Second Floor
National City East Sixth Building
Cleveland, Ohio 44114



Re: Joann Juhn
3249 West 130th St.
Cleveland, Ohio 44111
Date of Accident: 2/8/84

Dear Mr. Sindell:

I saw Joann Juhn as a consult in Lutheran Hospital on February 9, 1984. Miss Juhn is a 30 year old female who had been involved in an accident on a RTA train which derailed the day prior to my seeing her. She stated that at the time of the derailment she was thrown sideways and then forward. She thinks that she landed on her right shoulder. She stated that she had initial right arm numbness which resolved and at the time I saw her was complaining of pain in the neck, frontal headaches, pain in the right shoulder and anterior chest, both posterior knees and right ankle. She stated that she additionally had intermittent numbness in the right hand and forearm. She had a history of a whiplash injury to the neck approximately fifteen years ago and again approximately five years ago.

On physical examination of her neck there was some tenderness over the right upper trapezius area. She had 60° forward flexion, 30° backward bending with pain. She had 40° right lateral bend and 20° of left lateral bend.

Examination her her chest revealed some tenderness over the lower sterno costo-junctions.

Examination of the right shoulder revealed tenderness of the right acromio-clavicular joint without laxity. There was also tenderness over the brachial plexus at the base of the neck on the right.

Examination of the knees revealed painful medial joint lines and metaphyseal areas bilaterally and tender lateral joint line on the right. There was no laxity present and no effusions. There was a bruise on the posterior medial aspect of the left thigh.

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Right ankle examination revealed tenderness over the medial malleolus just above the joint.

Motor exam in the upper extremities was normal. Sensory exam revealed some decreased touch sensation of the right forearm only. Hands were equal. Reflexes were equal and normal.

As that time the diagnoses were 1) Cervical sprain with whiplash type injury; 2) Mild brachial plexus stretch injury on the right; 3) First degree sprain of the right acromioclavicular joint; 4) Contusion of the left knee and right ankle; 5) Chest contusion.

A soft cervical collar was recommended.

I did not see her again until May 18, 1984 at which time she appeared in the office complaining primarily of numbness in both hands and some pain in the back of the neck for approximately one week period with pain in the anterior scapular region. She also complained of some right anterior thigh pain with ambulation.

On physical examination, gait examination revealed that she walked in a hunched over gait. Examination of her back revealed jumping with apparent or simulated discomfort on light touch to the skin from the mid-thoracic area down. There was no palpable spasm present and there was tenderness in both sacroiliac joints and both sciatic notches and the posterior aspect of the greater trochanter bilaterally. Forward bend to 90° and backward bend to 30°, again without any spasm. Motor examination revealed weakness of the grip on the right side and weakness of the right foot flexors and extensors. She was unable to touch her right thumb to her small fingers. She complained of decreased touch sensation **of** the right hand. Reflex exam again were equal and normal bilaterally. Examination of her shoulders revealed full range of motion There was an area of mild spasm in the right upper trapezius. She complained of tenderness over all joints of the right shoulder, including the sternoclavicular joint, acromioclavicular joint and along the entire clavicle shaft. Range of motion of her neck was 75" forward flexion, 45° backward bend with 40" right-and left lateral bend. She complained of diffuse posterior neck tenderness to light touch.

Muscle relaxants and a soft collar were prescribed.

She returned to see me on June 8, 1984. At that time she was not wearing the cervical collar. She was complaining **of** right hand stiffness in the morning and neck pain with motion. She complained that she'had had low back pain for the last week with pain to her right leg. This kept her from doing her typing job at work. **I** referred her to the physical therapist for cervical traction and electromyograms were ordered.

My diagnoses attributable to the accident are: 1) Cervical sprain; 2) Mild brachial plexus stretch injury; 3) First degree sprain of the acromioclavicular joint; 4) Contusion of the left knee and right ankle; 5) Chest contusion.

RECEIVED

David I, Sindell
Attorney at Law

Re: Joann Juhn

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It appears to me that with the possible exception of mild cervical sprain these conditions have all resolved. I feel that the symptoms on the last examination were grossly exaggerated as there was no objective basis for the patient's complaints as there was no way some of the portions of the examination would have caused the symptoms expressed.

With the numbness in the hand and the findings of the electromyogram it is apparent that the patient does have a moderately severe carpal tunnel syndrome on the right hand which would explain the numbness and pain in the right hand and forearm, this is not in any way related to her injuries sustained on February 8, 1984.

If I can be of any further aid, please get in touch.

Respectfully,

William R. Bohl, M.D.

WRB/pak

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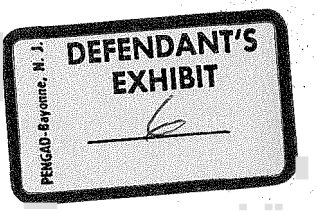
RALPH A. REILLY, M.D., INC.
14601 DETROIT AVE., SUITE 330
LAKEWOOD, OHIO 44107

521-2217

ORTHOPAEDIC SURGERY
AN OHIO PROFESSIONAL COWORATION

617657

December 18, 1984



Sidney M. Cornrich Co., L.P.A.
Suite 1016 - 75 Public Square Bldg.
Cleveland, Ohio 44113

Attention: Mr. Scott I. Levey

Re: JoAnn Juhn
Date of Acc.: 2-8-84

Dear Mr. Levey:

JoAnn Juhn was examined in my office on 8-21-84. At that time her chief complaint was a pain in the right leg, lower back, shoulders, neck and right arm into the right hand and fingers accompanied by a tingling sensation and numbness in the fingers of the right hand. She stated she had been injured on 2-28-84 wnile a passenger on an R.T.A. train which derailed, at which time she grabbed the back of the seat in front of her with her right hand as she was sliding off the seat and tried to brace her feet against a partition. She received emergency treatment at Lutheran Medical Center emergency room largely for pain in her right hand and fingers and less for her back. Her back pain became more severe in July 1984. Initial symptoms of pain in her neck and right arm were somewhat alleviated by physical tnerapy treatments. She also complains of some left lower abdominal pain for which she has undergone an ultrasound examination at Fairview General Hospital without any unusual findings. Her past history is significant in that she had a "mild whiplash" in an automobile accident in 1979. No residual symptoms. She has also had a hysterectomy and bladder repair in May, 1983, and March 1984 exploratory laparoscopy.

Examination revealed moderate spasm posterior cervical muscles and upper trapezius muscles. Limitation on rotation and lateral bending of cervical spine. Marked tenderness over C-3, 4, and 5, interspinous ligaments. Marked tenderness periscapular muscles. No neurologic or circulatory abnormalities in the upper extremities. Lower back moderate lumbar spasm, limitation of motion. Straight leg raising painful in the lower back at 70° bilaterally. Marked tenderness lumbosacral and over the right posterior iliac crest. Moderate tenderness over the right greater trochanter. No neurologic or circulatory changes, clinical evidence of carpal tunnel compression.

X-rays cervical spine show some malalignment due to muscle spasm. No evidence of bony or intervertebral disc injury. Lumbosacral spine normal. Diagnosis: Remote sprain cervical spine with residual fibromyalgia periscapular. 2. Lumbosacral strain start physical therapy, Soma Comp, the physical therapy to include resistive exercises for the cervical spine and postural exercises

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FEB 28 3 PM
CLAIMS DEPT.

December 18, 1984

Page two

617657

Orthopaedic report - JoAnn Juhn

for cervical and lower back.

Miss Juhn was re-examined on 9-4-84 at which time she had no neck complaints and minor low back complaints. Examination at that time was unremarkable. She was advised to continue on her exercises and use symptomatic heat for treatment.

The prognosis is good for complete recovery, no permanent physical impairment is anticipated as a result of these injuries.

Very truly yours,

Ralph A. Reilly, M.D.

Ralph A. Reilly, M.D.

RAR:da
Enclosures

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