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

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IN THE COURT OF COMMON PLEAS

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KEVIN BECKER, et al.,)
)
Plaintiffs,)
)
v.) Case No. 307384
)
RALPH HOLLANDER, et al.,)
)
Defendants.)

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THE VIDEOTAPED DEPOSITION OF JEFFREY J. ROBERTS, M.D.

THURSDAY, APRIL 23, 1998

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The videotaped deposition of JEFFREY J. ROBERTS, M.D., a witness, called for examination by the Plaintiffs, under the Ohio Rules of Civil Procedure, taken before me, Cynthia A. Sullivan, Notary Public in and for the State of Ohio, pursuant to notice, at the offices of Orthopedics Associates, Inc., 14601 Detroit Avenue, Suite 700, Lakewood, Ohio, commencing at 8:30 a.m., the day and date above set forth.

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(Thereupon, Plaintiff's Exhibits Nos. 1, 2 and 3 to the deposition of JEFFREY J. ROBERTS, M.D. were marked for identification.)

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JEFFREY J. ROBERTS, M.D.

a witness, called for examination by the Plaintiffs, under the Rules, having been first duly sworn, as hereinafter certified, deposed and said as follows:

DIRECT-EXAMINATION

BY MR. RUF:

Q. Good morning, Doctor, my name is Mark Ruf. I'm assisting David Malik in the represent tion of Kevin Becker.

Could you please tell the jury your name?

A. My name is Jeff Roberts.

Q. And what is your business address, Doctor?

A. 18099 Lorain Road, Suite 525, Cleveland, Ohio, 44111.

Q. What is your profession?

A. I'm an orthopedic surgeon.

Q. Are you licensed to practice medicine in the State of Ohio?

A. Yes, I am.

Q. When were you licensed to practice medicine in

the State of Ohio?
A. **1985.**
Q. Do you specialize in any area of medicine?
A. Yes, orthopedic surgery.
Q. Are you Board Certified in orthopedic surgery?
A. Yes, I am.
Q. What does it mean to be Board Certified?
A. To be Board Certified you have to complete an accredited residency program and, obviously, medical school before that, and then you have to take a written examination, pass the written examination, then you have to practice for two years and then take an oral examination based on some of the cases and patients that you've operated on and pass that.
Q. Is that the highest level of certification for orthopedic surgery?
A. Yes, it is.
Q. Where do you have hospital privileges?
A. I have hospital privileges at Fairview General Hospital, Lakewood Hospital, St. John West Shore Hospital and Cleveland MetroHealth Medical Center.
Q. Have you been involved in teaching other doctors orthopedic surgery?
A. Yes, I have.
Q. Could you briefly tell us about your education

starting with college?

A. Certainly. I went to the University of Miami in Florida and graduated with a B.S. Degree.

Then I proceeded to medical school in 1980. I went to Case Western Reserve University School of Medicine, and from there I did a residency training program. The first year was an internship of surgery at University Hospitals in Cleveland, then I did a research year, then I did another year of surgery and four years of orthopedic surgery, that was at St. Luke's Hospital in Cleveland, and then I did an additional year called a fellowship, and that was in spine surgery and scoliosis surgery.

Q. How long have you limited your medical practice to orthopedic surgery?

A. Approximately five years.

Q. How many patients do you see per week, approximately?

A. Approximately between 100 and 150 patients a week.

Q. And how many orthopedic surgeries do you do per week, approximately?

A. It really is variable depending on whether you're on call or not, but on average probably seven to ten surgeries a week.

Q. Do you regularly treat people who have suffered injuries as a result of an accident?

A. Yes, I do.

Q. That's a regular part of your medical practice?

A. Yes, it is.

Q. Doctor, could you explain to us the anatomy of the spine? Perhaps you could use an illustration to show the jury.

A. I could try to do that.

This is a -- this is a model of the spinal column, and the upper part of the spinal column is called the cervical spine or your neck part of the spine. This middle section is called the thoracic spine or the chest part of your spine, that is where the ribcage hooks into the back bones. And then there's the lumbar spine which is the next lowest segment, and then the sacrum.

And it's made up of several individual back bones, and between each back bone is a disk which is a gelatinous cartilage-type material. And within this column which is protected by bone on all sides runs the spinal cord.

And if you look at something like this, the spinal cord would be running through this circular area which is the canal, with this being the back bone in

front equivalent to this, and this is the back of the spine, this is actually the part of the spine that you can feel on yourself called the spinous process, and then these are called the lamina.

The nerve roots that go to your legs come out through these little areas here, and, if I may, this is a picture or diagram of somebody who is face down, and this is the spinal -- the spine, here, these are what are called the spinous process that you can feel on yourself, and these are the nerves that come out and go to your legs and skin and such, bladder.

Q. What part of the spine was involved with Mr. Becker?

A. His was the lumbar spine which is -- and in particular it was the fifth lumbar vertebral body which is the lowest vertebral body just adjacent to the sacrum,

Q. Was there any nerve involvement with Mr. Becker?

A. Well, Mr. Becker presented with complaints of pain radiating down his leg, and when someone presents with that sort of complaint, one certainly considers nerve root pinching, if you will, or impingement as a possible source for that pain.

I think that in his situation the pain -- if pain is just in the thigh area, it can be from pinched

nerves, it could be from a fracture, it could be from arthritis, but when somebody has pain that radiates below the level of the knee, then we certainly become a little bit more concerned about it being pinched nerve-type pain.

Q. Could you use the other chart to explain how you could have pain in your leg or pain down your leg from a condition of the spine?

A. Okay. I'll start on this one actually.

If you -- if you can imagine these nerves coming out through this little teardrop-shaped thing, sort of straight out like this, and I'll show that on the next diagram, but this is looking at the spine from the side, and if a nerve comes out through here and then sort of tracks down and goes into the leg, if there is something that's pinching the nerve as it comes out through this area, the nerve, even though it's going down the leg, the pain gets referred from here to some area down the leg.

And in his situation, Mr. Becker that is, his back bone actually slipped, this back bone slipped forward a little bit on this one, and it caused pinching or kinking of the nerve right in this area called the neural foramen. And I'll try to show that again on this.

This is called the sciatic nerve, and the sciatic nerve is a large nerve. It's actually made up of two nerves, the peroneal nerve and the tibial nerve, and there are several nerve roots with each one -- at each level of the spine there is a nerve root, and several nerve roots come together to form the sciatic nerve.

Q. Doctor, the nerves are shown in yellow --

A. Yes, they are.

Q. -- on the diagram?

A. Yes. So these nerve roots if they're pinched or if there's impingement on them, then pain can be referred down the leg.

And I don't know, I don't know if this shows on the video, but this is what's called a dermatomal diagram, and each one of these nerves we know from electrical studies goes to a certain area of skin and also to a certain group of muscles, and these sort of bulbous endings on the little nerve roots here are actually trying to show that these are going to various muscles that actually aren't drawn into this diagram. But the point being here is that if a certain nerve is pinched we can many times tell from our physical exam which nerve it is that's being pinched just on the basis of loss of sensation or weakness of a certain muscle group or the pattern of pain that the patient is

experiencing.

By that I mean if the pattern is the back of the thigh or the side of the thigh or the front of the thigh, and same thing with the calf.

Q. Do you have an actual picture of a human spine?

A. There is, we do have one.

This is a cadaver model of the spine. Again, this is looking at somebody from the back, and what has been done is that the roof, if you will, of the spinal canal has been lifted off so that the lamina and the spinous processes, which I showed you on the other pictures, are gone, and what you have is the spinal canal running down here.

And within the spinal canal is this sac, and that's called the dural sac, and within that sac are nerves. And these nerves come out at various levels, and they go to our legs, to our bladder and to our skin to affect the sensation and motor strength of our legs.

Q. And the view on the side is a -- is what, Doctor, on the right side?

A. This view?

Q. Yes.

A. This view looks to me as though what they've done is they've injected the vein system so that they're showing various veins and --

Q. Where are the disks in the vertebra on that?
A. Well, on this the disk is the yellow -- I'm sorry, the whitish area which would be labeled No. 9, and the back bone is the reddish area because it contains bone marrow.
Q. And where is the spinal column and the nerves on that diagram?
A. On this? The spinal -- well, the spinal column would be the back bones that you were referring to, and that's sort of in the front of this sac of nerves, and the nerves are in this. This is 7, it's the sac, and it contains the nerves such as No. 6, and it's within this sac.
Q. Thank you, Doctor.
Now, I'd like to talk specifically about Kevin Becker. When did you first see Mr. Becker?
A. I first became involved with Mr. Becker in 1996. It was August 9th of 1996.
Q. Do you know why he came to see you?
A. Well, the reason that he came to see me is that he was having problems or back pain.
Q. Did you take a history from Mr. Becker?
A. Yes, I did.
Q. What was the history that you took from Mr. Becker?

A. The history was that Mr. Becker at the time I saw him was 35 years of age, he was a motorcycle policeman or patrolman, and he had been involved in two accidents in the past year. The first accident he stated was on January 8th, and he was directing traffic, and he was struck by a car and knocked onto the hood of the car, and he then rolled off the front of the car or rolled off the car and landed on the right side of his body on the pavement.

He said that he did not lose consciousness, so he was aware of what was going on the whole time. And he was taken to Charity Hospital where he had complaints of right elbow pain, knee pain, and he was treated for an elbow condition.

About three days after that accident he was standing from the couch when he developed severe pain shooting from his back, lower back, into his right leg, both in the thigh and into the side of his calf. It lasted a few seconds, and from that point on he has had constant lower backache.

He was off work for about two and a half months. He was placed in some physical therapy, and he attempted -- excuse me, he returned to work with a low backache which he stated was worse when he had to stand for any great length of time.

Then on May 23rd of 1996 he was in a second accident. On this occasion he was on his motorcycle, and he said he was traveling about 15 miles an hour when he was hit -- when he hit a car broadside. And in describing what happened he said he had to lay the motorcycle down, and he was pinned beneath the motorcycle, again, with his right leg down.

He recalled having a huge bruise over his right hip. I obviously didn't see that because I'm seeing him sometime later than the time of the accident. And at the time he reported having increasing low back pain and increasing right hip pain. He also complained of some numbness on the right leg.

On that particular occasion he was taken to MetroHealth Medical Center and X-rays, again, were done of his hip and ribs. And from that point on he continued to have constant low back pain which walking made it worse or standing made it worse, and the more he walked, the more pain he would have. The pain radiated into his right buttock and the side of his thigh and side of his calf, and at that time he was complaining of no numbness in his legs.

At one point he described having difficulty clearing his foot from the ground as he was walking, and I think the implication is that he had a partial

foot drop, and what that means is that there was a significant nerve irritation such that the strength in the lower leg muscles to pull your toes up towards the ceiling was not present when he was swinging his leg through the normal gait process.

Q. Based on the history that you took when did his problems begin with his low back and referred leg pain?

A. Well, Mr. Becker, from my history gathering, never had a problem, never complained of a problem with his back until the first accident, or three days after the first accident.

Q. And that was the accident in January of 1996?

A. January of 1996.

Q. Based on the history that you took did Mr. Becker have any difficulty with work between 1993 and 1996?

A. Based on my medical notes and history gathering there was no mention of any problems between 1993 and 1996.

Q. Based upon the history that you took did Mr. Becker have any difficulty in physical functioning between 1993 and 1996?

A. Not to my knowledge.

Q. How many times did you see Mr. Becker?

A. Well, it's kind of interesting. The first time that I saw him he failed to tell me that he was

actually scheduled for surgery by another surgeon the day after 1 think I was seeing him, or certainly within the immediate time frame that I was seeing him, and as we discussed his situation he then led on to the fact that he was contemplating surgery the next day or shortly thereafter.

But 1 saw him -- I saw him three times before we actually did surgery, and then I've seen him it looks like about six or seven times since his surgery.

Q. Could you tell the jury the symptoms that Mr. Becker was having prior to the surgery?

A. Mr. Becker was having very significant lower back pain. I mean, the easiest way to say it, it was an incapacitating back pain in that he couldn't do everyday things, so sitting was uncomfortable, walking was uncomfortable, standing for any length of time was uncomfortable, and he had pain radiating into his leg.

He was not having any difficulty passing his urine, but it was all leg problems.

Q. Were those symptoms consistent during the three office visits that you had prior to performing surgery on Mr. Becker?

A. I think he had some lessening of the symptoms, that he was able to get back to work and do some partial duties with a constant daily ache in his back.

He also complained that he had great difficulty playing with his children because of his backache, but the leg pain seemed to have diminished. He had some occasional pain in his right buttock.

Q. Had Mr. Becker undergone conservative treatment before he came under your care?

A. Yes.

Q. What is conservative treatment?

A. Well, I think that -- that's a good question.

Sometimes -- well, most people think of conservative treatment as nonoperative treatment which is what I like to say, operative treatment or nonoperative treatment. Sometimes operative treatment is really the conservative treatment, so I don't use those other words that you were using. But anyway, conservative treatment in this particular case was physical therapy, anti-inflammatory medications, a period of rest, maybe a period of some muscle relaxants, those sorts of modalities.

Q. Did the conservative treatment cure or eliminate the condition of his low back and leg?

A. No.

Q. Did you perform any diagnostic tests on Mr. Becker?

A. I believe that Mr. Becker had all his diagnostic

tests completed at the time that he came to see me. He had had X-rays, he had had, I believe, an MRI, and he was as I mentioned scheduled for surgery, so pretty much all the diagnostic testing was done. And I think he was kind of searching for answers and came really as a second opinion, although that didn't come out until later.

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

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

BY MR. RUF:

Q. Doctor, did you conduct a physical examination of Mr. Becker?

A. Yes, I did.

Q. What did your physical examination show?

A. Physical examination showed that he was a tall, thin gentleman, and he was quite flexible, able to bend forward without really increasing his back symptoms and also to lean backwards somewhat. His strength in his legs was good, his sensation was good, as were the reflexes in his legs. He was not having tenderness to palpation, if you will, of his lower back.

Q. Based upon the history you took, the physical examination and the diagnostic tests that were

performed, did you reach a diagnosis of Mr. Becker?
A. Yes, I did.
Q. What was your diagnosis?
A. My diagnosis was that he had what's called a spondylolisthesis of the fifth lumbar vertebral body on the first sacral vertebral body, and it was pinching the fifth lumbar nerve.
Q. What is a spondylolisthesis?
A. Well, a spondylolisthesis is -- in essence it's a fracture. It can happen in early adolescence as a stress fracture, but it can also happen traumatically later on in life from some sort of injury, but it's generally thought of as a stress fracture that occurs sometime during early adolescence.
Q. Could you use the anatomical diagram to show the jury what there was a fracture of on Mr. Becker?
A. Yes. You can get a spondylolisthesis from degeneration of the disk as well. That is usually seen in an older person, but that can occur, and it's more typical for that to occur between L-4 and L-5. What happens is that, this is not going to help a whole lot, but it might help somewhat, if we can focus or center over here, this is a diagram of a lumbar vertebral body, and there's an arrow pointing to this piece of bone here. It's called the lamina. And at

the top, at the top of this lamina is where one gets a stress fracture, and that, it's called a Pars defect, and it occurs usually on both sides.

And if you can imagine this back piece, this piece of bone here connected to the front or vertebral body through this piece of bone called the pedicle, there's no longer that attachment. So if the back is no longer connected to the front, it can allow for this, for this to slip forward on this.

And what happens is that the disk in here wears out from that constant motion, back and forth, and it can give you the impression of a disk herniation as well on an MRI which causes pinching of the nerve in this nerve channel called the neural foramen.

Q. Doctor, what do you mean by disk herniation or disk bulge?

A. Well, we talked earlier about the disk being this space in here. We talked about it being a cartilaginous cushion, or shock absorber maybe, between the two bones, and with aging this outer lining of the disk called the annulus can wear out and the material inside can bulge out.

Normally the disk ends at the back margin of the back bone, and if it bulges out into the canal, that's what will be called a disk herniation. And that can

happen from trauma, or it can happen just from the normal wear and tear aging process.

Q. What's the significance of a herniation or a bulge, what kind of problems can it cause?

A. Well, it can cause -- it runs the whole spectrum from no problems to pinched nerve symptoms such as sciatic-type pain.

Q. Given that Mr. Becker had spondylolisthesis did he have instability of his lumbar or lower spine?

A. Well, there are different kinds of instability. There's mechanical instability, and then there's what is called dynamic instability. And dynamic instability would be that we would be able to demonstrate the instability with various X-rays; that is, if you were to bend forward we would take an X-ray and show that this slips forward more, and when he bends back it reduces back into position.

And I don't think that we were able to demonstrate that on his X-rays, but when the disk is worn out and you have this stress fracture, it causes more of a mechanical instability which can give you constant backache and also lead to wear and tear of the disk.

Q. Did Mr. Becker have the spondylolisthesis prior to the automobile accidents of 1996?

A. Well, that's a good question. I don't know the answer to that. I don't have the X-rays, you know, any other time except from his accidents forward.

At the time of his accident it was there, and I don't think you could say for certain that it wasn't something that was present earlier.

Q. Did Mr. Becker have spinal surgery prior to **1996** on his lumbar or lower spine?

A. No.

Q. Why was surgery indicated?

A. Well, because he failed all, as you mentioned, non-operative or conservative treatments to get better.

Q. Based on medical probability did the automobile accidents of **1996** necessitate the surgery that you performed on Mr. Becker?

A. Yes.

Q. What surgery did you perform on Mr. Becker?

A. There was -- the procedure is called a Gill procedure, and that essentially is what's called a laminectomy, but we remove the lamina part of the bone through the fracture or stress fracture, and --

Q. Doctor, could you explain to us what that means in laymen's terms, please?

A. What it means in laymen's terms is that we're unroofing the spinal canal so that there is -- so that

the nerves are freed up.

If we went back to this, this early picture that we showed, if you just disregard the part up top but look say just at this level, we unroofed, we took bone off the back of the canal here so that essentially we were looking at this sac and these nerves as they go out into the leg to be certain there were no pressure -- there was no pressure on the nerves or pinching of the nerves.

Q. Doctor, how long does that surgery take?

A. It takes four and a half, five hours.

Q. Do you fuse the spine during that surgery?

A. Yes.

Q. What does that mean, fuse the spine?

A. Fusing the spine means that we're connecting one -- one back bone to the next so that there is -- so we take this motion and mechanical instability out of -- out of the back as a source of pain.

Q. What do you use to fuse the lumbar spine?

A. Well, in his situation we used some screws and rods.

Q. Do you use a piece of the iliac crest to fuse the spine?

A. Yes. The screws and rods are used to hold the spine in the position that we want it to be in while

the bone that we've taken from his hip is actually doing the fusing part. The screws and rods are sort of a temporary fix, and the goal is to get his own bone to fuse to bone for a successful operation.

Q. Okay. I'm handing you what has been marked as Plaintiff's Exhibit 1.

What does Plaintiff's Exhibit 1 show us, Doctor?

A. This is a -- this is a surgical techniques book from one particular company that makes spinal implants.

Q. Does Plaintiff's Exhibit 1 accurately show the surgery that Mr. Becker underwent?

A. Relatively speaking, yes. I think that it shows actually a little more surgery than what we did. This shows that at least in the step-by-step book in the back that three levels were fused, and we only fused two levels.

Q. Doctor, could you hold that up and show the jury? Why don't you bring it closer. It will be easier to see.

A. This is what the screws and rods -- or screws would look like in the back bone, this is the spinal canal, and what we would have done as part of the operation was the laminectomy, and that is we would have removed this through the fracture here, fracture here, would have taken this piece of bone out so this

canal is then wide open. There's nothing over the top of it.

And then we put the screws in above into L-5 which is the fifth lumbar vertebra and the first sacral vertebra, and we connect them with a rod and -- I think that this shows the step-by-step technique of doing it. If we look at the X-rays I think that these kind of pictures will speak much better than that techniques book.

Q. Are the X-rays that you pointed to the actual X-rays for Mr. Becker?

A. These are X-rays of Mr. Becker from January of 1997, and --

Q. Would those be prior to the surgery or after the surgery?

A. These would be after the surgery.

Q. Could you explain to us what the X-rays show, Doctor?

A. The X-rays show that the two things that I mentioned; one is that he has had a laminectomy or Gill procedure, that is we removed bone from the center here. If you look at the -- just the level above there's still bone over the canal. Here the canal is wide open with the edges of the canal being here and here.

And then it shows that the screws are in the bone, and the screws are connected with a rod, and this, too, shows the screws and the bone from the side and they're connected to a rod that holds things in place.

Q. Did you make any observations about Mr. Becker's anatomy during the surgery?

A. Yes. His -- this lamina -- or the lamina was loose. It was -- you could just wiggle it anywhere you wanted to wiggle it which is very characteristic of a spondylolysis or stress fracture through the Pars.

Q. Did that substantiate the necessity for the surgery?

A. Well, I think the necessity --

MR. ROCHE: Objection.

A. -- for the surgery was substantiated before we did the surgery.

Q. Based on medical probability was that surgery necessary due to both the accidents of January 8th, 1996 and May 23rd, 1996?

MR. ROCHE: Objection.

MR. SCHENK: Objection.

BY MR. RUF:

Q. Go ahead, Doctor.

A. I don't know that you could say it was -- I mean,

his symptoms resulted from the accidents of those two dates that you mentioned, and he failed to get better following those accidents and conservative treatment which led to surgery.

Q. So based on medical probability was -- were the accidents of January 8th, **1996** and May 23rd, **1996** the cause of the need for surgery?

A. Yes.

MR. ROCHE: Objection.

MR. SCHENK: Objection.

BY MR. RUF:

Q. Doctor, does scar tissue form when surgery is performed?

A. Yes.

Q. What is scar tissue?

A. Scar tissue is a normal response to body healing. Any time one cuts themself or scratches themself it heals with scar tissue.

Q. Is scar tissue permanent?

A. It's permanent, and it may at times replace normal tissue.

Q. Doctor, I'm handing you what has been marked as Plaintiff's Exhibit 2. Could you hold that up and identify that for the jury?

Could you bring it closer, Doctor?

A. Well, this is a picture of an incision on somebody's back with some -- with the incision being this part here. The reason I can tell it's somebody's back is because you can see the gluteus or the buttock fold right in the middle, and there are some staples in the incision.

Q. How long is the incision for the surgery that you performed?

A. The incision that I performed, somewhere between 10 centimeters and 12 centimeters.

Q. Are you aware that Mr. Becker missed work prior to surgery?

MR. ROCHE: Objection.

A. Yes.

Q. Based on medical probability would Mr. Becker's condition interfere with his ability to work as a police officer?

MR. ROCHE: Objection.

MR. SCHENK: Objection.

A. That, too, is a very difficult question. I don't know what it takes to -- what his job entails as policeman and what it takes to be a policeman.

Q. Would his condition prior to surgery affect his physical functioning?

A. Could you repeat that?

Q. Yes. Would his condition prior to surgery affect his physical functioning?
A. Yes.
Q. How would it affect his physical functioning?
A. Well, I mentioned earlier that he had difficulty standing, he had difficulty walking, he had difficulty sitting, he wasn't able to do enjoyable activities of daily life such as playing with his children because of his back pain.
Q. So if he had to walk and sit as part of his job, his condition would affect his ability to walk and sit?
A. Yes.
Q. Based on medical probability was the effect on his ability to walk and sit caused by the automobile accidents of January 8th, 1996 and May 23rd, 1996?
MR. ROCHE: Objection.
A. It was -- I think with all due medical probability it was caused by an aggravation of a condition that he had had previously unbeknownst to him that was aggravated by the accidents of those two dates that you mentioned.
Q. Is there any basis for the conclusion that Mr. Becker had a lumbar back strain?
A. No.
Q. What's the difference between a lumbar back

strain and your diagnosis?

A. There's a huge difference. First off, on a lumbar strain one doesn't have a fracture that's seen on X-ray, and, well, you could almost write a textbook on the difference, I think, but a strain is a pulled muscle, and pulled muscles generally get better, and they get better usually in a short course of time.

Probably everyone in this room here has had a strain of some sort. The difference is that in his condition he had a fracture, a stress fracture of his spine, and he had irritation of the nerve exiting the spine which gave him pain down his legs.

And when somebody has a strain, you don't get leg pain certainly below the level of your knee. You can get pain radiating to your buttock or to your thigh area, but not below the knee. You don't get a foot drop, you don't get numbness and tingling in your leg, and you certainly don't have the X-ray changes that he had on his X-rays.

Q. Do you perform surgery on patients that only have a lumbar strain?

A. No.

Q. Why wouldn't you perform surgery on a patient with only a lumbar strain?

A. There is no surgery indicated for such a problem.

Q. Can surgery alleviate a lumbar strain?
A. Having never done an operation for a lumbar strain, no.
Q. Would there be any basis for concluding that Mr. Becker only had a lumbar spine strain?
A. No.
Q. Doctor, I'm handing you what has been marked as Plaintiff's Exhibit 3. It's an itemization of medical expenses.
Have you reviewed Plaintiff's Exhibit 3?
A. I have.
Q. Doctor, based on medical probability is it more probable than not that those medical expenses were incurred as a result of the automobile accidents of January 8th, 1996 and May 23rd, 1996?
A. Yes.
MR. ROCHE: Objection.
MR. SCHENK: Objection.
BY MR. RUF:
Q. Doctor, are the expenses listed in Plaintiff's Exhibit 3 fair, reasonable and necessary expenses?
A. Yes, they are.
MR. SCHENK: Objection.
MR. RUF: Thank you, Doctor. That's all I have.

MR. ROCHE: Are we off the record?

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

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CROSS-EXAMINATION

BY MR. ROCHE:

Q. Dr. Roberts, good morning. My name is Pat Roche, and I represent Scott Schwartz in this same lawsuit.

You indicated that you first saw Mr. Becker on August the 9th of **1996**, and I think you have before you your office notes regarding that visit, right?

A. Yes.

Q. And these are notes that you made as you spoke to and as you examined Mr. Becker?

A. After I spoke with him I dictated the note, yes.

Q. First, apparently he didn't tell you at all until you were finished that he had apparently scheduled surgery with another physician; is that right?

A. That's correct.

Q. All right. Now, one thing that you do note under the X-ray section on the following page of your notes there is that the MRI -- and that was taken in June of **'96;** was it not?

A. I don't have -- I'd have to -- June of **'96.**

Q. All right. The MRI confirms the grade one spondylolisthesis, correct, that's your note?
A. Yes.
Q. He has a pseudo disk herniation due to the grade one spondylolisthesis, correct?
A. Correct.
Q. Does that mean what it says, the disk herniation is due to spondylolisthesis?
A. That's correct.
Q. All right. And that's the herniation or the pseudo herniation that you described on the film here where the bone slips and the disk goes out and pinches the nerve, right?
A. Yes, it gives the impression of a disk herniation. And the reason that I use the word pseudo is because it's not truly a disk herniation, it's the disk is left in place but the bone has slipped forward and so it looks on picture that there is a disk herniation.
Q. All right. Now, you indicated in your next section of the report, the patient is at high risk of pseudoarthritis as he is a smoker, right?
A. Correct.
Q. Now, the fact that he's a smoker was important to you in the treatment of the patient particularly when

you're going to perform this kind of surgery; am I right?

A. Absolutely.

Q. And the final sentence of that same paragraph indicates instrumentation has been clearly shown to increase the success rate of fusion particularly in smokers.

A. Correct.

Q. Would you have not have used the same instrumentations here, the same hardware, had Mr. Becker not been a smoker?

A. I think that's a good point. I probably would not have used the same instrumentation.

Q. All right. You would have done perhaps a less, can we say, invasive procedure if he wasn't a smoker?

A. I would have done a fusion without instrumentation.

Q. Meaning without all that hardware in it.

A. I would have given him the option of that, yes.

Q. All right. Now, the final paragraph of that same section in your note after the first visit is, as the patient never had an acute severe low back pain following either injury, and that's the two car accidents you're talking about, right, it is unlikely that his spondylolisthesis is secondary to an acute

fracture, right?

A. I did say that.

Q. All right. Well, it's true then; it's true now, right?

A. Yes.

Q. And then you *go* on, more likely is the picture of adolescent spondylolysis. Spondylolysis, that's another word, huh, spondylolysis?

A. Spondylolysis.

Q. Spondylolysis and spondylolisthesis at the L-5, S-1 level which now has become symptomatic or exacerbated by these trauma, right?

A. Yes.

Q. All right. Now, what you're saying there, and you correct me if I'm wrong, is he had the spondylolisthesis before either one of these car accidents ever occurred.

A. That is the assumption that I'm making, yes.

Q. Well, that's what you wrote in your report, correct?

A. Yes.

Q. All right. And what your opinion is in this record here is that, as you testified before, these car accidents aggravated that situation.

A. That's correct.

Q. All right. Now, you don't have any X-ray or MRI evidence that either one of these accidents physically changed the condition of his low back, do you?
A. No.
Q. Meaning that the disk was slipped out, the bone was overlapping the other bone before either one of these accidents happened.
A. I don't have any X-rays prior to that, no.
Q. You don't have any evidence to the contrary, right?
A. Correct.
Q. Okay. Did he tell you -- did he tell you whether or not he had been involved in any other accidents before January of 1996?
A. As I mentioned earlier he mentioned no problems, but no, specifically accidents, no.
Q. Did he tell you that in August of 1993 he was in an accident on his motorcycle and he broke seven ribs, one of which didn't heal?
A. No.
Q. He didn't tell you that at all?
A. No.
Q. Do you know that even today?
A. I know that he had -- there was a report somewhere that showed one rib that had not healed.

Q. Would it be helpful for you to know that kind of background, that kind of history when you're asked to give opinions about patients like this?
A. It would be helpful, I guess.
Q. In your note of March 3rd, **1997,** if you flip to that in your office notes, March 3, **1997.**
A. Okay.
Q. This is now about four months, I think, after he had the surgery which was in November of **1996,** right?
A. Three months, yes.
Q. Three months, **90** days. Under impression there you indicate, healing posterior spinal fusion, etc., the patient is presently asymptomatic.
Am I correct that asymptomatic means he doesn't have any symptoms anymore?
A. Symptoms with respect to what he saw me for.
Q. Right, which was the surgery you performed for the problems of the low back.
A. Correct.
Q. All right. So would I be fair to you if I said you did a very good job here and you got an excellent result?
A. Up to that point in time, but I think it's early.
Q. Okay. Now, did he every tell you about any accidents he was involved in after his surgery, and

I'll refer to your notes of May 1, 1997.
A. He did on 04-26-97. He mentioned that he was driving his family minivan, and it was struck by another vehicle on the driver's side quarter panel.
Q. Okay. And on the following day he developed increasing left-side low back pain; is that right?
A. Yes.
Q. Okay. Excuse me just a moment.
So is it correct to say that based on your notes here now that you've reviewed them that the spondylolisthesis or the stress fracture, as you called it, probably in this patient occurred in his adolescence?
A. Probably, and if I could just go back to that for one minute --
Q. Yes, sir.
A. The statement that I made about he wasn't having any pain, the note August 9th, exactly the statement that I made was the patient has never had any acute severe low backache following either injury.
The inference that I was trying to make from that was that an acute fracture would cause more pain than the pain that he had been experiencing, in my experience.
Q. So if he had sustained a fracture, either in the

accident in January of '96 or in the accident of May of '96, you would have known it or he would have known it right away?

A. I would think so, yes.

Q. So that would certainly support the proposition that his fracture occurred long before?

A. Probably so.

Q. And then after that there were degeneration in the back, correct? Or is that unfair to say?

A. I think it's unfair to say.

Q. All right. But he also had this problem with the disk in the low back in addition to the fracture.

A. Right.

Q. Before either one of these car accidents.

A. I don't know. I don't have any evidence to support that, I don't have any X-rays before his accident so I -- I mean, he wasn't having to my knowledge any problems with his back prior to that particular accident.

Q. Well, just to make it clear, your note of August 9th indicates that the spondylolisthesis is likely from an adolescent fracture.

A. Correct.

Q. And your same note also indicates that the pseudo herniation is from the spondylolisthesis.

A. Correct.
Q. All right. So we can agree that both of those -- neither one of those conditions are caused by either one of these car crashes.
A. That would be correct.
Q. All right. Now, there's a letter in your file dated, I think, January 23rd, 1998. I have folded over a page.
And I'm interested in your earlier testimony when you indicated you couldn't tell whether the condition was aggravated by the accident in May or the accident in January. I think the letter you have in front of you is dated January 23rd, 1998?
A. Yes.
Q. It's written by you?
A. Yes.
Q. And it's written to Attorney David Malik who is handling this case?
A. Yes.
Q. What does that indicate about which if either of these accidents aggravated this condition?
MR. SCHENK: Objection.
A. 1 indicated that I thought it was the first accident that aggravated his condition.
Q. Could I ask you to read exactly what you wrote?

MR. SCHENK: Objection.

A. Sure. I'm in receipt of your letter of January 14th, 1998, and re-reviewing Mr. Becker's notes it seems as though the first accident was the accident which led to his aggravation of a pre-existing condition. It does not seem as though he ever fully recuperated from that injury and that he returned to work with low backache. He was then involved in a second accident which seemingly worsened or added further insult to his injury.

Q. That was true then and it's true now?

A. Yes.

MR. ROCHE: Okay. That's all I have. Thank you very much.

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

BY MR. SCHENK:

Q. Doctor, my name is Jeff Schenk, and I represent the estate of Ralph Hollander in this lawsuit. I do have just a few questions for you.

First off, you testified that you regularly treat patients who have been involved in accidents, correct?

A. Correct.

Q. And am I to assume also that you regularly treat

patients who have problems relating to their orthopedic needs who haven't been involved in accidents?

A. Absolutely.

Q. And do you perform surgery on patients who have not been involved in accidents?

A. Absolutely.

Q. And would that include surgery involving the lumbar spine?

A. Yes, it would.

Q. And would that also include individuals who have suffered from spondylolisthesis?

A. Yes, it would.

Q. You first saw Mr. Becker on August 9th, 1996, correct?

A. Yes.

Q. And that would have been after the second accident, correct?

A. Yes.

Q. You understood that the first accident occurred in January of 1996.

A. January 8th of 1996 is what I have.

Q. And he related that to you by way of the history that you obtained.

A. Yes.

Q. Did you review any medical records from any of

his prior treating doctors?
A. No.
Q. Would that have been helpful in reviewing the symptoms that he related to those doctors as far as making a determination on giving opinions regarding the causation of his problems?
A. It certainly could be helpful.
Q. It wasn't necessary for you to have that information as far as your treatment of him was concerned, correct?
A. Correct.
Q. From the history that you did obtain from Mr. Becker you understood that following the accident with -- in January of 1996 he was treated in the emergency room for complaints relating to his elbows and his knees, correct?
A. Yes.
Q. And he related to you that the first time he had any back complaints was approximately three days after the accident?
A. Yes.
Q. And on that occasion there was one incident of pain radiating into his thigh, and I bel eve you indicated into his calf.
A. Yes.

Q. And, Doctor, your note of August 9th, **1996 I** believe indicates that that was a singular occurrence.

A. Yes.

Q. And that means that it only occurred that one time?

A. Yes.

Q. Are you aware of when he first made any complaints to a doctor regarding his lower back after the accident of January 1996?

A. Well, he was seen in the emergency room on the same day.

Q. Okay, but did you review any of those records from the emergency room?

A. No.

Q. He told you that he was treated only for his elbows and his knees in the emergency room.

A. Yes.

Q. Would that mean based upon what he told you that he did not complain about his lower back in the emergency room?

A. Yes.

Q. And you understood that he did have physical therapy after the January 1996 accident.

A. Yes.

Q. And that the physical therapy was primarily for

his elbow; is that correct?
A. My notes indicate that it was for his elbow and some low back exercises.
Q. Okay. Your notes specifically state that the physical therapy was for primarily his elbow but also some low back exercises?
A. That's correct.
Q. Okay. So from that I could understand that it would be -- the main problem that he was seeking physical therapy for was the elbow?
A. Presumably *so.* I wouldn't order physical therapy for his back if he wasn't having symptoms for his back, but I didn't order the physical therapy.
Q. Okay. But I'm going solely based upon your use of the word primarily.
A. Right.
Q. Now, just so I'm clear, your understanding of Mr. Becker's condition following that first accident only included one episode of any radiating pain.
A. Yes.
Q. He did not have any episodes of the foot drop syndrome that you mentioned; is that correct?
A. That's correct.
MR. SCHENK: Let's go off the record.

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

BY MR. SCHENK:

Q. Doctor, was it your understanding that Mr. Becker had returned to full-time full active duty following the January 1996 accident?

A. He returned to -- he did return to duty as a police officer.

Q. Whether or not it was light duty or full duty you don't know?

A. I'm not certain.

Q. If he was a motorcycle officer and he was injured in a motorcycle accident whi e in the course and scope of his employment in May of 1996, would that seem to indicate that he had returned back to his motorcycle duties?

A. Yes.

MR. RUF: Objection.

Q. Now, you last saw Mr. Becker in January of 1997, is that correct, or actually was that in March of 1997?

A. June of '97 is the last record I have, June 2nd, 1997.

Q. Okay, thank you.

Doctor, I want to, if I can, ask you to refer to the report that you wrote to Mr. Becker's attorney.

It's dated September 5th, 1997. Do you have that in front of you?

A. Yes.

Q. On page 2 of that report you wrote to Mr. Becker's attorney and stated in the second to the last paragraph, he has done extremely well, his back pain as well as leg pain has been greatly resolved; is that correct?

It's in the paragraph that begins November 21st.

A. He is -- yes.

Q. Okay. And then in the very last paragraph, the last sentence, you've indicated that his prognosis should be excellent; is that correct?

A. Yes.

Q. And the prognosis is what the future would hold for him, correct?

A. Yes.

MR. SCHENK: Thank you. I have nothing further.

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REDIRECT EXAMINATION

BY MR. RUF:

Q. Doctor, I have a couple of questions for you to follow up.

Mr. Becker did very well following surgery,

correct?
A. Yes.
Q. Now, when somebody has spondylolisthesis are you always going to perform surgery on that patient?
A. No.
Q. When would you perform surgery on a patient with spondylolisthesis and when would you not perform surgery?
A. I would perform surgery on somebody with spondylolisthesis when, first off, the diagnosis has been made; number two, they are symptomatic from the spondylolisthesis; the third thing would be that they didn't respond to nonoperative treatment for their spondylolisthesis; and fourth is that they want to undergo such an operation as there is -- his spine condition is not a life-threatening condition.
Q. So if Mr. Becker was asymptomatic but had spondylolisthesis prior to January of 1996, there would be no indication for surgery prior to that time, correct?
A. That's correct.
Q. So it's the development of medical symptoms that was the indication for performing the surgery?
A. Yes.
Q. How would the pain from a rib fracture differ

from pain due to an exacerbation of spondylolisthesis?
A. Well, the pain from a rib fracture would be in a totally different area of the back. Pain from a rib fracture would not radiate into the legs, and generally speaking, pain from an acute rib fracture is localized to the area where it's fractured, being the chest.
Q. Doctor, and it's your opinion based on medical probability that these two automobile accidents in 1996 caused the symptoms to start in Mr. Becker?
A. Yes.

MR. ROCHE: Objection.

MR. SCHENK: Objection.

MR. RUF: Thank you, Doctor. That's all I have.

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RECROSS-EXAMINATION

BY MR. ROCHE:

Q. Doctor, spondylolisthesis can be a degenerative ongoing condition; can it not?
A. It can be a degenerative ongoing problem. When it's a degenerative problem it usually is at the L-4-5 level and one doesn't usually have the spondylolysis, that is, the fracture, that stress fracture that I was referring to.
A. M-hm.

Q. They usually don't have that when it's a degenerative process.

Q. Well, in the case of Kevin Becker this condition got worse since it originally started in his adolescence; did it not?

A. I'm not certain **I** can answer that.

Q. You don't know.

All right. Doctor, the letter I referred to in January of **1998**, is that part of your medical file in this case?

A. Yes, it is.

MR. ROCHE: Okay. I'll request that we mark this Schwartz Exhibit A, and I have no further questions for you.

(Thereupon, Schwartz Exhibit A to the deposition **of** JEFFREY **J**. ROBERTS, **M.D**. was marked for identification.)

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BY MR. SCHENK:

Q. Doctor, just so **I** understand correctly, do 1 understand that the primary reason that you felt surgery was necessary was a result of the radiating symptoms that went down into the leg?

A. It was his constant backache and his inability to

function and the pain into his leg.
Q. And was that -- is that evidenced by the foot drop syndrome that you mentioned?
A. Well, the foot drop symptom when I actually examined him was not clinically present; that was more of a subjective assessment that I made from what -- the story he was giving me.
Q. When you say subjective, that was based solely upon what he had told you?
A. What he had told me.
Q. And your understanding of his problems before you ever saw him were, again, based solely upon what he had told you, correct?
A. Correct.
MR. SCHENK: Thank you. I have no further questions.
THE VIDEO REPORTER: Doctor, you have the right to view the video in its entirety or you may waive that right?
THE WITNESS: I'm waiving it.
THE VIDEO REPORTER: May I have a stipulation between counsel that Mirror Image remains custodian of the video until its time of playback?
MR. RUFF: Yes.

THE VIDEO REPORTER: Agreed?

MR. ROCHE: Yes.

MR. SCHENK: Yes.

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(DEPOSITION CONCLUDED.)

(SIGNATURE WAIVED.)

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CERTIFICATE

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

I, Cynthia A. Sullivan, Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within-named witness, JEFFREY J. ROBERTS, was by me first duly sworn to tell the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by him was reduced to stenotypy in the presence of said witness, and afterwards transcribed by me through the process of computer-aided transcription, and that the foregoing is a true and correct transcript of the testimony so given by him as aforesaid.

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

1 do further certify that I am not a relative, employee or attorney of either party, or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this 29th day of April 1998.

Cynthia A. Sullivan

Cynthia A. Sullivan, Notary Public
in and for the State of Ohio.
My commission expires October 6, 2001.