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IN THE COURT OF COMMON PLEAS

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JACK ALBANO,
Plaintiff,
vs.
HAMMOND CONSTRUCTION CO. ET AL.,
Defendant.

Case No. 153043
Judge Daniel O. Corrigan

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DEPOSITION OF MELVIN SHAFRON, M.D.
Wednesday, February 5, 1992

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Deposition of MELVIN SHAFRON, M.D., called by the Defendants for examination under the Ohio Rules of Civil Procedure, taken before me, the undersigned, Phyllis L. Englehart, Notary Public in and for the State of Ohio, at the offices of Dr. Melvin Shafron, 26900 Cedar Road, Beachwood, Ohio, commencing at 6:05 p.m. the day and date above set forth.

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APPEARANCES:

On behalf of the Plaintiff:

Eric Kennedy
Henry Chamberlain
Weisman, Goldberg, Weisman & Kaufman
1600 Midland Building
Cleveland, Ohio 44115

On behalf of Defendant Hammond Construction Company:

Thomas J. Cabral
Gallagher, Sharp, Fulton & Norman
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Cleveland, Ohio 44115

On Behalf of Defendant Salvaggi & Sons:

John S. Rea
Myers, Hentemann, Schneider & Rea
21st Fl. Superior Building
Cleveland, Ohio 44114

Also Present:

Dale Swazer, Video Technician

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MELVIN SHAFRON, M.D.

called by the Defendants for examination under the Ohio Rules of Civil Procedure, after having been first duly sworn, as hereinafter certified, was examined and testified as follows:

MR. CABRAL: It's 5:05 p.m. on February 5th, 1992, and we're here to take the deposition of Dr. Melvin Shafron.

DIRECT EXAMINATION

BY MR. CABRAL:

Q Good evening, Doctor.

A Good evening, sir.

Q Doctor, could you state your full name for the record, please.

A Melvin Shafron.

Q Doctor, are you a medical doctor?

A Yes.

Q I'd like to begin by going a little bit into your medical background and education. Can you tell us, please, where you obtained your undergraduate degree?

A What was then called Western Reserve University.

Q What year was that, sir?

A 1952, long time ago.

Q Thereupon did you go on to attend medical school?

A Yes, sir, I did.
Q And where was?
A That was at Harvard Medical School.
Q And when did you graduate from Harvard?
A 1956.
Q Did you undergo any specialized training or general training upon graduation from Harvard?
A I had a year -- I had general training first, like most everyone who did neurosurgery. I had a year of what was called an internship at University of Michigan Hospitals at Ann Arbor, went to service for two years, and I returned from the Navy in 1959.

I had a year of training in general surgery, which was a requirement to be fulfilled before beginning neurosurgery training in 1960. And I trained in neurosurgery from 1960 to 1964 at the University Hospitals of Cleveland. And I've been in practice since that time.

Q Doctor, do you have a specialty?
A Neurosurgery or neurological surgery.
Q And can you explain for the jury, please, exactly what that is.
A Neurosurgery is that specialty of medicine that deals with the diagnosis and either the surgical or

nonsurgical treatment of a variety of conditions which can affect the brain, the skull, the bony spine, the disks of the spine and the various nerves of the body.

Doctor, are you board certified?

Yes.

In what field?

Neurosurgery.

And when did you become board certified?

1966.

Doctor, are you licensed to practice in the state of Ohio?

A Yes, sir.

Q Do you hold privileges at any local hospitals?

A Yes.

Q Can you describe those for us, please.

A I'm on the staff of University Hospitals, Mt. Sinai Medical Center, St. Luke's, Hillcrest and Suburban Hospitals.

Q Do you hold any positions at any of these hospitals?

A Yeah. I'm director of neurosurgery at Mt. Sinai.

Q Doctor, have you authored any publications?

A Yes.

Q Can you describe some of these for us?

A I've authored -- authored publications on various diagnostic techniques used to study brain tumors, treatment of certain disorders of childhood, use of certain types of skull -- use of portions of the skull to repress certain defenses of the body.

What else? There have been so many, I can't recall them all specifically.

Q Thank you. Doctor, do you belong to any professional organizations?

A Yes.

Q And can you describe some of these for us, please.

A I'm a member of the Ohio State Neurosurgical Association, the American Association of Neurological Surgeons, the Neurosurgical Society of America, which I've been president of, the Ohio State Medical Association, the American Medical Association and the Cuyahoga County Medical Society or the Academy of Medicine of Cleveland.

Q Thank you very much, Doctor. Doctor, have you had an opportunity to examine Mr. Jack Albano?

A Yes, sir, I did.

Q Did you take a history at that time, Doctor?

A Yes.

Q Can you give us a brief rundown of what the history was at that time?

A May I just read from my notes?

Q Certainly.

A Okay. He related to me that he was involved in an accident on October of 1986. He said that he was carrying some duct work into a building, and he slipped on some cardboard and that his foot caught on something, and he tripped and fell on the left side of his body. He said he was covered with mud. Apparently he fell in a construction site.

He got up immediately, told his foreman -- turned out it was his father, those were his words -- that he had gotten hurt and that his complaints of pain got progressively worse. And he went to what I suspect is probably an urgent care center on Rockside Road where he had X-rays performed, was examined and allowed to go home.

He told me he was given medications, and he said that about a week later his soreness felt a bit better, and he tried to go back to work, but he said that in November his back pain worsened, took himself off the job, and he said that shortly afterwards he developed pain primarily on the right side, which is over the right buttock and went down the outside of the right thigh into the calf. He said that he had pain in the foot as well. He was

told that he had a slipped disk by a physician.

I asked him if he had any pain in any other part of his lower extremities, and he said yeah, he had some pain on the left side, but it was worse on the right side. He described that he had a cold feeling or a numb feeling in the same area of the toes and foot, that he had pain and numbness on the outside of his foot, the sole of the foot and on the instep of the foot.

He saw a physician at Brentwood Hospital who treated him with exercises, heat, cold, traction for two years, and then he had a myelogram and an operation in March of '89. He said the operation did not help him except that it took his immobilizing back pain away, but it didn't do anything for the leg pain. He said that his leg pain is still there.

He told me that he saw an orthopedic surgeon, saw several physicians other than Dr. Krahe prior to his surgery, including a doctor in Akron and an orthopedist in this community, actually in this building. He told me that he had seen no other physicians since his surgery except for the operating surgeons.

He denied other problems with his back

prior to the accident in question. He said that he may have had a couple of back strains in the early 1980's but required no specific treatment. He told me that he had had an operation on his left knee about a week after a motorcycle accident in 1972 or 1973 and apparently tore some ligaments or cartilage in that knee. He denied other operations, other accidents, told me that he took no medications except for a prescription medication called Darvocet, which he used occasionally for his pain.

When I asked him if he could equate the severity of his leg pain with his back pain, he said that certainly before the operation his back pain was his primary complaint. Now, the operation seemed to help his backache and that his primary complaint now is leg pain.

He also told me that prior to his surgery he had several scans, including an MRI scan and a CT scan. He also told me that he wore what may have been a foot drop appliance after the operation for about three months.

And that was the sum and substance of the history that I got from the patient.

Q Doctor, with respect to the prior back injuries

that he suffered before 1986, did he describe these as having any significance?

A My own interpretation of what he told me is that they were not of any particular significance.

Q Have you since had an opportunity to review any records with respect to these injuries?

A Just today for the first time.

Q Did any of these records indicate how long these injuries put him out of commission?

A I'm going to have to look at them very carefully because I've not seen them. I guess about -- I'm not sure whether these are estimated or true dates, but this note that, for example, with respect to an incident which occurred in 1980, that he stopped working on 11-23-80 and returned to work on 12-30-80, so about five weeks.

Q Thank you, Doctor. Doctor, did you conduct an examination of Mr. Albano?

A Yes, sir, I did.

Q Can you describe for us, please, your physical findings.

A When I examined the gentleman, I noticed that he had a low scar -- low midline scar on the back. I tried to evaluate his strength. In other words, there are a number of ways you can evaluate the

presence or absence of abnormalities in the muscles of the lower extremities that relate to a problem of a herniated disk. One of these is by asking the patient to stand on their heels and toes. In other words, you can get an evaluation, true functional evaluation of the strength of these muscle groups, and it was very difficult because the patient could hardly stand on his feet or toes. In other words, there was no way I could do that.

I did measure the calves of his lower extremities, and I noticed that the right calf was two centimeters, which is a little less than an inch, less in circumference than the one on the right. I looked at his buttocks very carefully. Sometimes with a herniated disk or a problem with the nerve you can see that one buttock may droop compared to the other buttock. The buttock may actually be atrophic, or thin, and I didn't notice any of this.

I then looked at his back. The patient's -- the site of the patient's scar was very tender, and I didn't really go terribly far in testing his movements because he said that every movement of his low back caused him to have pain. And the purpose of my examination is not, you know,

not to make a patient feel uncomfortable, and I wouldn't do that with any patient. But he said every movement of his back caused him to have pain.

I then tested his sensation in three different ways, first by moving the patient's toes up or down with his eyes closed, which tests a certain modality of sensation or a certain type of sensation. I then tested that same type of sensation with the tuning fork, and I noticed that this was normal. I then tested sensation with using what we call a painful stimulus, it really isn't painful but it's with a pin, or a device called a pin wheel, and I noticed that when I did that that he had decreased appreciation of pin involving the entire right buttock and the entire right lower extremity from the groin down.

And that was -- in other words, you ask the patient do you feel this and compare right to left, and he said no, it's different for the entire right lower extremity from the groin down.

I then tested his straight leg raising to 90 degrees, and I noticed that this maneuver did not produce leg pain; it produced back pain. I then tested his reflexes, and I noticed that I was able to test the reflexes with a rubber hammer at

the knees, and the reflexes there were symmetrical, and they were present. The reflexes in the ankles were absent bilaterally. I'm not sure what the significance of that was. And that there were no abnormal or pathological reflexes.

And that was the sum and substance of my examination.

Q Doctor, you indicated that the straight leg raising test caused pain in the back.

A Yeah.

Q But not pain in the legs.

A That is correct.

Q What significance is that?

A Well, to me it means that the patient probably doesn't have active compression of the nerve. This is what it means to me.

Q Doctor, over the years, have you had opportunity to examine patients complaining of back and leg pain?

A That's probably the most common thing I see patients for in the office.

Q Over the years, give me have a rough estimate of how many of these people you've had come through your office.

A I'll give you a conservative estimate and say about two or three thousand.

Q Having seen two or three thousand people with this kind of problem, can you tell me whether there was anything unusual about Mr. Albano?

A I think that when you examine or evaluate a patient, you try to relate the things that a patient tells you with what you find on an examination and with what you see on any studies that you may have with reference to that patient at the time you see the patient.

The unusual features about his examination were his either unwillingness, and I'm not going to say inability because I don't think -- I think he should have been able to stand on his feet or toes, which to me is unusual in my experience.

The loss of sensation of pin from the groin down is another unusual thing to see on an examination in a patient with a herniated disk whether he's had surgery or not. It's just not a physical finding that one can relate to an injured nerve. Even if that nerve were -- if I were to have cut that nerve purposefully, it would not produce a loss of sensation in the groin down, from the groin down the entire leg.

So that this is his response to his problem and his response to my examination.

Q Doctor, have you had an opportunity to review CT scans which were taken in November of 1986?

A Yes. I did so, and I noted this in my note to you, which I wrote on the 9th of May of 1991, that there's some bulging of the disk at L4-5, but I said I basically agreed with the report of the radiologist. There's nothing that suggests a herniated disk at all.

Q Doctor, what is a herniated disk?

a A disk -- a herniated disk is a disk which escapes the normal confines of the space in which it is located to the point where, as it escapes its normal confines, it very often will press upon a nerve to produce a very characteristic painful disorder that we call sciatica.

Q And again, was there anything on the CT scans to indicate that there was a herniated disk?

A No.

Q Doctor, have you had an opportunity to look at an MRI test which was taken in 1987?

A Yes, I did.

a Doctor, what is an MRI?

n An MRI is a special type of examination which is presented to a doctor on an X-ray film, but it's not really an X-ray; it's an examination performed

by the use of -- by placing a patient in a magnetic field, very complicated, and I don't begin to -- I can't begin to explain it, because I really don't understand it.

But a patient is placed in a magnetic field, and this magnetic field is altered by a technician, and the alterations that produces, the alterations of the magnetic field produce changes in the way certain atoms spin in our bodies. And when the magnetic field is removed, the changes and the spinning characteristic of these structures can be recorded after they're analyzed by a computer in some very mysterious way. They can be portrayed on an X-ray film, and one can get a picture of various structures, many structures, bones, nerves, disks.

I mean, the things that can be studied is sort of almost infinite. I mean every day there's new technology which allows us to do more and more with this device.

Q It sounds like this is light years ahead of an X-ray machine.

A Oh, yeah. It's eons ahead, yes.

Q Is this kind of test helpful in diagnosing a potential herniated disk?

A Oh, sure, absolutely. It's probably the most

commonly used examination today.

Q Doctor, when you reviewed the film from the MRI taken in August of 1987, did you note any indication of a herniated disk?

A No, I did not personally.

Q Have you reviewed the report of the radiologist who interpreted it at the time?

A Yes.

Q And did he note a herniated disk?

A I don't think he did. I have to look at that report again. The radiologist described with probable associated central disk protrusion.

Q Is that the same as a herniated disk?

A No, it is not.

Q What is a disk protrusion?

A Exactly what he says. See, it says -- and he's fudging a little bit. He says "there appears to be," and you would have to ask him what he means by that. To me, it's either there or it isn't there.

There appears to be, in addition to the bulging anulus, a small central disk protrusion, which means that the disk was bulging, in the midline, in the middle.

Q Is there anything either in that radiologist's report or your own observations in evaluating the

MRI film, anything which would explain Mr. Albano's leg difficulties that he's claiming?

A I think the spinal stenosis of in itself can produce leg pain, no question.

Q What is spinal stenosis, Doctor?

A Spinal stenosis for the most part is an acquired disorder. There are rare patients who are born with narrow spinal canals. But spinal stenosis is a change which occurs in the low back, for reasons which are sort of mysterious, which can produce anatomical abnormalities which, in turn, will press upon a nerve. This of in itself can produce pain that's sciatic in nature, no question about it.

Q Doctor, stenosis, can that be a narrowing of the bony structure?

A That's what it really is, yes. It's a narrowing of either the spinal canal itself, or it's a narrowing of the hole or the space, that's called a foramen, through which the nerve leaves the spine to enter a certain complex structure to make up the sciatic nerve, for example, the fifth vertebra.

Q Doctor, is this ordinarily, this stenosis, is this ordinarily caused by trauma?

A In my own mind, a single episode of trauma does not cause this, no, no.

Q Do you have an opinion as to a reasonable degree of medical certainty as to whether the stenosis you noted in Mr. Albano was caused by the accident of October -- or the slip and fall of October 13th, 1986?

A No. I just think it happens to people because they're alive. I don't have a better answer for you.

Q In other words, as far as you know, or as far as you're concerned, it was not caused by the fall in October of '86?

A I don't believe so.

Q Do you have an opinion as to whether or not the stenosis as you observed it would have pre-existed October 1986?

A I think -- well, it was there on the CT scan that he had in November, I think, so one would presume it existed beforehand, but I can't tell you when it started. I have no idea.

Q Thank you, Doctor. Doctor, some time ago you've had an opportunity to review some myelogram films which were taken of Mr. Albano?

A Yes, I did.

Q And these were taken when, do you recall?

A I'd have to look. I think a myelogram was done on

9-26-88, and I saw those films on or about November 13th, 1991. At least that's the time I sent a report to you.

Q Do these demonstrate an abnormality?

A Yes.

Q Where is the abnormality within the bony structure of Mr. Albano's spine?

A I believe the abnormality is at L4-5. That is the disk area between the fourth and fifth bones of the low back.

Q Is it located centrally or to the right or to the left?

A The X-rays I reviewed, and I don't have them here and I've not seen them since that time, to me, the X-rays were basically not interpretable. I only saw one X-ray that had a right and a left label on it that I could identify, and when I looked at this X-ray, this was an X-ray taken in the upright position, the patient not moving, I could see a marker of left, right. And that film showed an abnormality on the left side at L4-5.

There was one other X-ray that was taken with a label on it which showed a lesion at L4-5. And this is -- I think an X-ray was taken -- it looked to me that the table that the patient was

lying on was being tilted at the time the X-ray was being taken, and that also showed an abnormality at L4-5. I haven't looked at those X-rays since that time, and I really can't tell you.

Q Now, Doctor, when you say X-ray, you're referring to the film that was produced as a result of the myelogram?

A That is correct, sir.

Q Doctor, briefly explain for the jury what a myelogram is.

A A myelogram is a test that's done usually by radiology specialists, although years ago neurosurgeons did them and orthopedists did them. Certainly today the person most often doing this is an X-ray specialist.

And what they do is place a fine needle in the back and inject a special type of material called a dye. The needle is removed and a series of X-rays are taken with the dye being manipulated around by the radiologist. And the dye is such now that it doesn't have to be removed; it sort of goes away by itself.

Q Doctor, are you aware that plaintiff eventually underwent an operation?

A Yes, sir, I am.

Q Have you reviewed the report of Dr. Krahe, the surgeon who performed the operation?

A Yes, I did.

Q Have you had an opportunity to briefly review Dr. Krahe's testimony with respect to this operation?

A In all candid honesty, I looked at that today. I received the deposition, I don't know who delivered it, today in my office, and I sort of glanced at it between patients. I must have seen 20 or 25 patients today, and I sort of looked at it in between patients to see what the substance of it was, only because I had some difficulty interpreting the operative report that I read when I first saw it.

And I think that the nature of his operation was a little more clarified to me after looking through his deposition. There, you know, there's some inconsistencies in these that aren't quite true about what he said -- quite right, I shouldn't say true. But his deposition I think clarified a bit in my own mind as to what he found at the time of surgery.

Q Can you describe for the jury what the procedure was that Mr. Albano underwent.

A He -- this gentleman underwent a very standard

operation called a lumbar laminectomy, which is just a medical name given to the surgical procedure that's utilized to expose the abnormal areas that one sees on diagnostic tests to remove a herniated disk or a ruptured disk or, in some cases, to do nothing more than just do a decompression of the spine. That is, you don't take disks out, but you remove the bone around the nerves that are being compressed. This is just a standard name given to this type of procedure.

Q For the sake of the jury, could you briefly describe the anatomy of the spine at L5-L4 level.

A Well, it's pretty -- I mean there are certain bony structures which are present that have to be removed or enlarged in order to get exposure, there are certain ligaments which have to be removed in order to directly visualize the nerves themselves and to visualize the abnormalities of disk or bone that you're trying to treat. And these things all have to be removed. And this is done, you know, by an experienced surgeon with relative ease, depending on certain circumstances. And as far as I can tell from looking at the records and reports, this is what the doctor did at the time of his surgery.

But what I don't quite understand is that he described removing a ruptured disk on the left side and finding nothing basically on the right side, as far as I can tell from looking at his record.

Q What did Dr. Krahe find during the operation with respect to the nerve roots?

A Well, I'll have to look at his description again, some of which I find a little bit difficult to understand, at least on the basis of my own experience.

He found that the root was trapped in adhesions, which I find a little bit difficult to understand in the absence of a previous operation. He found a freely herniated disk, which I would take to be a ruptured disk, that's a disk which has totally escaped the confines of the disk space, on the left side, and he removed that. Then he looked at the right side and saw nothing, and then he closed the incision.

Q What is the significance of his indication that there was some impingement on the nerve on the left side?

A Well -- say that once more.

Q In your mind, what is the significance of the fact

that he apparently found some impingement or entrapment or however he describes on the left side on the nerve root?

A It's hard to say. The patient, according to his pathology, this is a note that he says, although I didn't see this looking through the records, in the past he had predominantly left leg pain. At the time of surgery he was found to have a large, freely herniated L4 disk on the left side. This certainly could relate to his left leg pain, but it's something that went on in the past, but in no way can the finding on the left side explain his right-sided pain. It just doesn't work that way.

Q Was his right-sided pain a significant complaint?

A That was his only complaint at the time he had his surgery.

Q You indicated that there were no findings with respect to the right nerve.

A That's what he said.

Q What significance is this?

A That I would have great difficulty explaining his right leg pain.

Q Doctor, I want you to assume for the moment that Dr. Krahe testified that his explanation as to the right leg pain had to do with scarring or

impingement of the spinal cord that he noted during this operation.

A It's totally incorrect. It can't be.

Q Can you explain for the jury why?

A There's no spinal cord in this part of the spine. The spinal cord, the structure that we call the spinal cord, ends at a significant distance away from L4-5. In other words, the spinal cord ends usually at the bottom of the L1 bone in the spine, between the first and second bones in the spine, so there's no spinal cord down here.

Q Is it true, Doctor, that a centrally herniated disk can cause pain on either the right or the left?

A I suppose it could. I suppose it could, if it's big enough. I mean, it's not common for things to protrude exactly in the middle. It's just not. They're almost always asymmetrical, one side or the other.

Even with what we call big midline protrusions or big midline ruptures or big midline herniated disks, they're almost never exactly in the midline; they're almost always off to one side or the other.

Q For a centrally herniated disk to cause radiculopathy, or pain going down one side or the

other, would there have to be some kind of impingement?

A Oh, sure, sure, sure.

Q Would a centrally herniated disk explain right-sided leg pain where there is no impingement on the right nerve?

A No.

Doctor, have you done these surgeries yourself?

A Several thousand I think.

Q You're still doing them?

A Yes.

P How many would you say you did in 1991, approximately?

A A hundred, 150.

Q Doctor, does Dr. Krahe's operative note reflect spinal cord involvement at any level?

A No, can't.

Q Doctor, do you believe, to a reasonable degree of medical probability, that the scarring of the spinal cord as described by Dr. Krahe in his deposition testimony could account for Mr. Albano's symptoms?

A Well, first of all, you mean the scarring that existed before the operation?

Q Any scarring of the spinal cord whatsoever.

A Well, there's no scarring of the spinal cord involved in this situation at all under any circumstance. There may be scarring now because he's had surgery. That'o a normal accompaniment of surgery. There's always scarring.

To be quite candid with you, I just don't think that one sees scarring in what we call a virgin back, a virgin disk space, something that hasn't been violated by a surgeon before. I just don't think we see scarring. And I don't know what -- I can't tell you what he interpreted to be scarring. It's just something that I don't think I've ever seen.

Q In other words, assuming Mr. Albano had never undergone a back surgery in the past?

A Yes.

Q Do you have an opinion as to whether scarring could be present?

A I don't think so. I do have an opinion. The answer is no.

Q Thank you, Doctor. Doctor, what does it mean to say that a patient's symptoms are hysterical?

A They're hysterical, functional, tnose are symptoms which cannot be explained on the basis of a physical abnormality.

Q Can you describe for the jury, please, Doctor, what is meant by a conversion reaction?
A Same thing. That's I think a -- conversion reaction is more of a psychiatric term. But, you know, we use that term, the patient has conversion symptoms, which a physician would know that these, you know, these are symptoms that can't be real.
Q Doctor, you described sensory changes in Mr. Albano's right leg --
A Yes.
Q -- when you examined him.
A Yes.
Q Do you have an opinion to a reasonable degree of medical certainty as to whether Mr. Albano's right leg sensory changes are hysterical?
A I do have an opinion.
Q And what is that opinion?
A That at the time I examined him, those findings were hysterical, were not organic in nature.
Q Again briefly, can you go through why, for the jury, this is?
A I think I mentioned before that even if I were to have cut that nerve purposefully, one would produce loss of sensation in a very specific or given area of the leg. That area would be probably on the

outside of the calf across the top of the foot, top of the great toe. It would not produce what we call a loss of sensation of buttock or loss of sensation of thigh, loss of sensation on the inner calf.

In other words, the areas of the body that relate to specific nerves, abnormalities of those specific nerves, whether they be caused by a doctor or they be caused by disease, those areas of altered sensation would be very specific and fairly regular given the differences among human beings. We're all different creatures. But the changes that one sees are really fairly regular from patient to patient to patient to patient to patient.

Q Do you have an opinion to a reasonable degree of medical certainty, Doctor, as to whether Mr. Albano is suffering from a conversion reaction?

A At the time I saw him, with respect to his sensation, I really thought he was.

Q And again, what does this mean in real terms, Doctor?

A It means that -- I can't define this in psychiatric terms because I don't know how, but it means --

Q As it applies to Mr. Albano.

A It means that the claimed loss of sensation that he has, or had when I examined him, isn't real. It's as simple as that. You know, I can't say it any other way.

Q Do you have an opinion, Doctor, as to how these hysterical sensory changes in this conversion reaction may affect his prognosis or potential for recovery to a reasonable degree of medical certainty?

A That's very hard for me to say on the basis of one visit. It might give some insight into the patient, it might give a physician some insight into, you know, the makeup or the character of the patient, but it's not the kind of thing that I would be able to say, you know, how significant is this in terms of his overall rehabilitative potential. I just can't answer that. I just haven't seen this patient enough.

Q Doctor, assume that Dr. Krahe has testified that he believes there is absolutely no potential that this man will get better. Would you agree or disagree with that contention?

A I don't know whether anything has ever been tried. I don't know whether he's tried, whether he's put in any kind of rehabilitation program. This was an

industrial injury. The state has an excellent program and an excellent center down here in Cleveland I send patients to, the Walker Center. Nothing ventured, nothing gained.

It may be futile, I don't know. But, you know, he's a young man. You certainly have to try. I mean I don't know whether he'll ever be able to go back to doing construction work again. There's no way I can say that. I would doubt it personally just because of, you know, experience with patients who have had problems like this.

But to totally write off a young man who is probably no more than 40 years old, to me that would be a dreadful thing, at least, you know, personally I think it would be a dreadful thing. I'd make every attempt to try to rehabilitate this man in some way that he could get along reasonably, maybe not necessarily returning to the kind of work he did before, but certainly to try to rehabilitate him both in terms of his, you know, his problems and in terms of his vocational abilities.

Q Doctor, in your experience with patients you've seen over the years, have you had an opportunity to observe a correlation between patients with hysterical symptoms and those who may be undergoing

litigation, prosecuting cases?

A I can't say that for certain, because I've seen patients who were not involved in litigation with hysterical symptoms. I wouldn't necessarily relate one to the other.

Q Okay.

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

MR. REA: No questions.

CROSS-EXAMINATION

BY MR. KENNEDY:

Q Doctor, my name is Eric Kennedy, and I represent Jack Albano. Let's start -- I'm most interested to discuss with you this thought that Jack Albano is hysterical or his symptoms are psychological or he suffered --

A No, I --

Q -- from this conversion reaction.

A Okay.

Q I haven't asked a question.

A Okay, okay.

Q Doctor, first of all, with regard to this, the jury should understand your role here in light of this thought that possibly this gentleman is hysterical. You saw him on one occasion; is that correct?

A That is correct, sir.
Q And that would have been about ten months ago?
A Sure. No, just about a year ago.
Q Okay. Have you seen him since?
A No.
Q Would I be correct; in saying that the first time you saw Jack Albano was May 9, 1991?
A According to my note, 2-15-91.
Q Okay, 2-15-91.
A Yeah.
Q Almost five and a half years after this fall?
A Correct.
Q And injury?
A Correct.
Q Based upon this one meeting with Jack Albano, you are concluding here that this is a hysterical conversion reaction; is that what you're saying?
A No, I didn't say that. No, I didn't say that.
Q All right.
A I said that at the time I examined him, the time I saw him in the office, that the sensory examination was not organic or hysterical -- it was hysterical in nature. I didn't say --
Q It was hysterical.
A At the time I saw him. I don't know what he was

like the day before, I don't know what he would have been like the day before had I examined him, nor do I know what he would have been like --

Q You thought it was psychological in nature?

A I can't -- I don't know the mechanisms by which -- when we describe this as happening. This is the way he responded to the way I examined him.

Q Doctor, would I be correct in saying that you were not brought into this case for the care and treatment of Jack Albano?

A That is correct, sir.

Q Your sole purpose in examining him and seeing him was because that was requested by the defense?

A Yeah, sure, sure.

Q They called you up; is that true?

A I don't know who called whom, but an appointment was arranged for me to see him.

a They communicated with you and asked you to see Jack Albano?

A They probably communicated with my secretary.

Q The purpose of that was to have you evaluate him so you could testify?

A I suppose the end result would be testifying, right sure, sure.

Q And you did evaluate him, then, at the request of

the defense?

A Yes, sir.

Q And then you wrote a report?

A Yes.

Q And now you're here today at their request because they hired you to do so to testify?

A Sure, sure, sure.

Q You never treated Jack Albano in any regard?

A No, sir.

Q And would I be correct in saying from past testimony that I've seen that you're being compensated at at least $200 an hour for your time?

A Absolutely. I'm going to certainly submit a bill for it, absolutely.

Q Would I be correct in saying, Doctor, that approximately once a week you will see a patient in some sort of legal sense?

A I think that's -- that's probably an average, probably a little less than that, but for the sake of this, once a week is fine.

Q You give testimony about 10 to 15 times a year?

A Maybe.

Q In similar settings?

A Maybe, sure.

Q You've testified for Mr. Cabral's law firm in the

past?

A I'm sure I have.

Q That would be the Gallagher Sharp law firm?

A Yes, yes.

Q Weston Hurd law firm?

A Yeah, I'm sure I've done that in the past.

Q Jacobson, Maynard, Tuschman & Kalur law firm?

A I have in the past, sure.

Q Squire, Sanders & Dempsey law firm?

A Not recently, not for a long, long time, but I have.

Q All right. Arter & Hadden law firm?

A Once maybe, twice maybe, I don't know.

Q The Reminger & Reminger law firm?

A I have, yes.

Q Would I be correct in saying, Doctor, that your testimony with regard to injured persons has been utilized in state court in Cuyahoga County?

A If you mean the Court of Common Pleas, yes, yes.

Q Lake County?

A Yes.

Q Lorain County?

A Once, yes.

Q Geauga County?

A Once that I can recall.

Q And your testimony has even appeared in the Federal Court system?

A Yes. It was a maritime case, so it had to be in Federal Court. I'd never forget that.

Q Doctor, without a question this man had a herniated disk; would that be true?

A Well, I have to assume that from the note of the surgeon.

Q Well, you looked at the myelogram, did you not?

A Well, I can't -- you can't tell that for sure. You can't tell, in all honesty. As I recall the myelogram, and I haven't seen it since the time I wrote my note --

Q So you're saying you can't even tell from the myelogram?

A No, you can't really tell. At least I could not tell. There's no question that he had an abnormality at L4-5. To me there was no question of that. It is difficult sometimes in a myelogram to tell whether or not there is a herniated disk involved, and that's why oftentimes, most often, at least always when I have a myelogram performed on a patient --

Q Doctor, let me --

A May I finish?

Q Let me -- I think that you answered --
A I have not. I haven't.
Q -- my question.
MR. CABRAL: Objection.
A I haven't answered the question.
Q Go ahead.
A That we do a myelogram -- do a CAT scan after the myelogram because the combination of the two studies enables us to much easier tell precisely what we're dealing with, that is whether we're dealing with a herniated disk or whether or not we're dealing with bony disease.

And so there's no question that the myelogram was absolutely abnormal. There's no question of that in my mind.

Q And there's absolutely no question it showed a lesion to the left at L4-L5?
A Absolutely.
Q Now, let's talk about what caused this herniated disk. You have told us that you do not believe or you can't say that the October 13, 1986 fall caused the herniated disk; is that your testimony?
A I don't think so. I think -- because of the --
Q One second. Is that --
A That's what I said, yes.

Q All right. You are aware, I think you said today, that Mr. Albano had a prior muscular back injury in the past prior to the fall in October?

A Sure, sure.

Q You said today that today was the first opportunity you had to review those records.

A Sure.

Q You had those records before today, though, did you not?

A No, no, no.

Q Doctor, the records reviewed were those of Dr. Harnden. I believe he treated him for this.

A Hernden?

Q Harnden, H-a-r-d-e-n.

A I never saw those. I never anything with reference to anything that I recall noting in my own notes or in my report with respect to the document.

Q Okay. Doctor, if you look at paragraph 1 of your report, it says I reviewed copies of records from Brentwood, Dr. Stewart and Dr. Harndon.

A Okay.

Q Now, would I be correct in saying that with regard to this prior back injury, it resolved, did it not?

A As far as I know it did, yes.

Q In fact, he had basically no problems for a period

of five and a half years prior to his fall in October of '86, correct?

A To the best of my knowledge, that is correct.

Q Would I be correct in saying from listening that this prior fall -- this prior muscle back injury probably plays no role in this case at all?

a That is correct.

Q Now, in determining whether or not a certain incident, such as a fall, causes symptoms or causes a herniated disk, I think you explained to us it's important to look at the temporal relationship. Is that true?

4 Sure.

a What you mean by that is it's important to look at how quickly you have the development of a symptomatology?

A Correct.

Q Now, Mr. Albano fell on October 13, 1986; is that true?

A Yes.

Q And, Doctor, from your review of the records, are you aware that within one hour, less than one hour, Mr. Albano was in an emergency room and had pain in his back radiating into his right leg? Are you aware of that?

A This may well be so, and I honestly can't -- don't know, because I don't have the records of that emergent care center -- or urgent care center available, in all honesty.

Q So that would have been radiating pain within an hour, correct?

A Yes, sir. If that's what it says, absolutely.

Q And would I be correct in saying that after that he consistently continuously had low back pain radiating into the right leg?

A That's what he says, but again, his doctor said something differently, so, you know, it's hard for me to understand. Because his doctor said in a note dictated prior to the operation, prior to the operative note, that when this first began he had pain in the left leg.

Q Well, you reviewed the records in this case.

A Sure. I mean, you know, and there are different things being said at different times.

Q Well, let's talk about your review, Doctor?

A Sure.

Q If we look at your report, the second paragraph --

A Yes, sir.

Q -- on the first page, you state, "It is not clear from the records when the right leg pain began."

A Correct.

Q "But his primary complaint during the course of his entire recorded history seems to be pain in the right lower extremity."

A Uh-huh.

a Is that correct?

X Absolutely.

Q So in your review of these records he consistently has pain in the right lower extremity?

A Absolutely.

Q Okay. And that's from within an hour of his injury?

A Right.

Q Up to today, five and a half years later?

A Right, right.

Q Now, this pain, Doctor, that he has described to you and what you've seen in the records in his right leg is typical sciatic pain?

A To me it is.

Q And sciatic pain is pain, Doctor, that can be caused by a herniated disk?

A Absolutely.

Q And the first complaint that we have of sciatic pain, which you told us earlier is commonly caused by a herniated disk, the first instance of that is

one hour after his fall?

A Correct.

Q In fact, Doctor, leg pain radiating into the leg is the typical symptom of a herniated disk?

A Absolutely.

Q And this man had the typical symptom of a herniated disk within one hour of his fall?

A That's what he said.

Q And complained of it constantly throughout?

A Yes.

Q In fact, Doctor, a doctor really can't make the diagnosis of a herniated disk unless there is leg pain?

A Correct.

Q And again, this man had it from within an hour?

A Absolutely.

Q Right on out to up to today?

A Absolutely, yes.

Q And again you told us in relating this herniated disk to the fall, how closely he developed symptoms is important?

A Yes.

Q That's the key determination?

A Absolutely.

Q Now, the Lasegue's sign, or the straight leg

raising test, is a test that is done by laying the patient on his back?

A I almost never -- I usually have the patient sitting, but you can do it that way, sure.

Q Okay. And you ask the patient to raise their leg? No, no. You do it for the patient.

Q Keeping the leg straight?

a Yeah.

Q All right. And this is a test that's done to look for a herniated disk or a possible herniated disk?

A Sure, sure.

Q Would I be correct, Doctor, from your review of the records that this gentleman, within three weeks of his injury, within three weeks of his fall, had a positive straight leg raising test?

A Again, I don't know what the doctor who recorded that means by that. I know what I mean by it. If this patient had leg pain produced by this test, indeed I would agree with that. If he had back pain produced by this maneuver, I would not agree with it. I don't know.

Q Can we assume that the doctors who did this test did it in an appropriate manner?

A Oh, I'm sure they did the test in an appropriate manner.

Q Okay. If Dr. Gordon found straight leg raising tests to be positive within three weeks of the injury, can we assume that he did it appropriate?

A I'm sure he did the test appropriately, but doctors, different doctors interpret that test differently, as I said. I'm not fudging with you. I'm just telling you what's true.

Q All right.

A If it meant -- if the doctor -- if the doctor meant that this patient's leg pain was worsened by this maneuver, then I totally agree that he had a positive straight leg raising test. If he had a backache that was made worse, the answer to that would be no.

Q Okay. Now, Dr. Krahe, when he did the straight leg raising test, he did it for the first time three weeks after the fall, and it was positive when he did it.

A Again, you'd have to ask him exactly what he means. I always write down when I do that maneuver what the patient complains of. I just don't say test positive or test negative. I don't know what he means by that.

But if it did mean that this patient had his leg pain worsened by the maneuver, then I would

agree, of course, that the test was positive, but I don't know that.

Q Okay. He found this test to be positive and indicative of a herniated disk three weeks after the fall.

A Which side was that? I don't have --

Q The right and the left.

A Both sides?

Q Both sides.

A I find that a little bit unusual.

Q Okay. And this continued, positive straight leg raising test that Dr. Krahe did, every time that he did it through the five-year period it was positive; is that correct?

A That's what he said then.

Q And when Dr. Gordon did it two weeks, two and a half weeks after, he found it positive also.

A I don't have those records in front of me, but if you say that, I certainly would assume that it's true.

Q In fact, the physicians in this case, Dr. Gordon, three weeks after the fall, he already was talking about the possiblity of a herniated disk; is that true?

A Well, we know that he didn't have one.

Q Well, that's your statement here today.
A Of course it's my statement.
Q All right.
A The CT scan of the spine showed that he didn't have one.
Q Well, the CT scan of the spine, Doctor, isn't that of poor quality and very difficult for you to interpret?
A No, it's not a great quality examination, it's not a great quality examination, but there's no evidence of a herniated disk on that examination.
Q Doctor, again, you wrote a report that you --
A I said that, yeah.
Q -- provided to us?
A Right.
Q Okay. With regard to the CT scan, do you state, "The CT scan copies which I reviewed are not of good quality"?
A Correct.
Q And X-ray gantry does not make slices parallel to the disk space so that accurate interpretation is not really possible?
A It is true for --
Q Is that your statement?
A That's what I said.

Q All right.
A May I finish, or may I not finish?
Q No, I just -- is that your statement in your report?
A Fine, okay. I can't dispute the statement in my report.
Q Okay. And in addition, did you tell us earlier with respect to this second type CT scan, it's not a CT scan that you normally do and utilize?
A No, but I can see -- well, there are some slices or views that I can see where there's no evidence of a herniated disk, and I said that there's some bony changes at L4-5, but there's no evidence of a herniaced disk.
Q All right. But what is found on those CT scans is a bulging disk at L4-L5; is that true?
A I'd have to look at them again. Are you talking about the second CT scan?
Q Well, I'm just -- from your report anyways. Did you write in your report, Doctor, "There seems to be some bulging of the disk at L4-L5"?
A Yeah.
Q Is that what you wrote?
A It's very mild.
Q Now, Doctor, there doesn't seem to be much question

here that you find it to be very important, that being the time between the development of symptoms of a herniated disk and the time of the fall, that is very important in determining whether the fall caused the herniated disk?

A Oh, I think so, sure.

Q And, Doctor, from our review of these records, will you agree with me there's not much question that there was an immediate development of symptomatology in this case?

A Correct, absolutely, correct.

Q Doctor, you talked a little bit about your writings with Mr. Cabral. Would I be correct in saying that you've only really written four published papers since 1965?

A Oh, I think there are about eight or ten. I can't recall the specific number, but there are more than that.

Q Is there a reason why those would not appear on your bibliography?

A They should if they're there, I think. I think they're there.

Q Would I be correct in saying, Doctor, that you have never written anything about surgery on herniated disks?

A No, I've never written anything on surgery for herniated disks.
Q Would I be correct in saying that you've never written anything about herniated disks in general?
A Absolutely correct.
Q Would I be correct in saying that you have never written anything about any type injury to the low back?
A You would be absolutely correct in saying that, absolutely correct.
Q Do you know Dr. Frank Boumphrey at the Cleveland Clinic?
A I don't know him at all.
Q Have you heard of him?
A No, I don't know him.
Q With respect to the right-sided pain that Mr. Albano is experiencing, has experienced, centrally herniated disk can cause pain on the right side, can it not?
A That's a very difficult question to answer, to be quite candid with you. I suppose it could.
Q And the surgeon who did the operation, the man who actually removed the disk, said that it was a centrally herniated disk, did he not?
A Well, he really can't make any comment about that,

in all honesty, because if one were to have a centrally herniated disk producing right leg pain, you do the operation from the right side, not the left side.

And I can't understand or explain anything that was done to this gentleman, to be very candid with you. I don't know. Very hard for me to figure this.

Q Doctor, are you saying that Dr. Krahe, who was under oath and gave us his deposition, is not telling the truth when he says he found a centrally herniated disk?

A Well, I think it's very difficult to tell when you've taken a disk out. I think it's very hard to tell, personally, in my own experience. I wouldn't doubt him one bit, but it's something that's very difficult to tell.

Q Was an MRI study done? I think you mentioned it.

A Sure, sure.

Q That was done before the surgery, was it not?

A Yes. That was done a year and a half or two years before the surgery.

Q And did that MRI, Doctor, show a centrally herniated disk?

a Well, no, it did not show a centrally herniated

disk. It showed small central disk protrusion, which is a totally different thing.

Q What's the difference between a protrusion and a herniation?

A A herniation is a frank escape of the disk from the confines of the disk space. A small central protrusion is exactly what this says, a small central protrusion. It's a little bulging of the disk. That's not the major abnormality with this patient. The major abnormality is the bony disease that he has.

Q Doctor, this bony disease, you're talking about stenosis; is that right?

A That's right.

Q This stenosis was in existence prior to his fall on October 13th?

A I assume it was. I think it probably was.

Q And it wasn't causing him any problems prior to that --

A May not have been, correct, not as far as I know.

MR. KENNEDY: I have nothing further at this time.

REDIRECT EXAMINATION

BY MR. CABRAL:

Q Doctor, I've got a few more questions for you.

Doctor, Mr. Kennedy has felt it necessary or important to go into the fact that you're being paid for having seen Mr. Albano and for giving your testimony.

A Any expert who testifies in a case like this is being paid, whether his expert or your expert. I mean he's being paid for his time, and I'm sure that whoever his expert is is going to also charge. It's a standard practice.

Q Do you have a stake, financially or otherwise, one way or another, in whether or not Mr. Albano was injured?

A Absolutely not.

Q You get paid the same rate whether he's injured or not injured?

A I assume so, sure.

Q Doctor, in response to Mr. Kennedy's questioning, you indicated that sciatic pain can be caused by a herniated disk. Are there other possible causes as well?

A Spinal stenosis can cause the same kind of pain. Sure it can.

Q Do you have an opinion to a reasonable degree of medical certainty as to whether a herniated disk made it necessary for Mr. Albano to go to the

urgent care center on October 13th, 1986?

A Let me -- I'm going to have to answer your question obliquely, because after he made that initial visit, he had studies which did not show a herniated disk. He had at least two studies done within a month or two months after the accident in question, and ten months later I guess, ten or 11 months later he had another study, the MRI scan, which did not show any evidence of a herniated disk.

So that certainly within a month after the accident, I think he had a CT scan done on the 5th of November and another one done on the 10th of November, there was no evidence of a herniated disk.

Then if you're going to ask me well, how can you explain this pain, I can give you my own reasonable answer: I'm not quite sure how to explain this pain. I don't know.

Q Do you believe it was due to a herniated disk?

A Not then, no, absolutely I do not believe it was.

Q Doctor, you indicated that the myelogram which was done in 1988 showed an abnormality.

A No question.

Q Assume for a moment that that abnormality is a

herniated disk --

A Sure.

Q -- just for the sake of argument. Do you have an opinion to a reasonable degree of medical certainty that a single episode of trauma will cause a herniation two years after the fact?

A I would find it difficult to believe that personally. I think there's no question that a single episode of trauma can cause a herniated disk, there's no question of that in my mind, but for that event to occur that far along in time, I would find it, in all honesty, a bit unusual in my experience.

Q Doctor, in response to Mr. Kennedy's questioning, you made the comment that the fact that Dr. Krahe found positive straight leg raising on both sides was unusual. Can you explain why?

A Well, you don't often see this as a physical finding, particularly in patients with complaints in one lower extremity. And again, I don't know what Dr. Krahe means by positive straight leg raising.

There are a number of doctors, in all honesty, who will say that if you raise the leg up to 90 degrees, the patient complains of a backache,

that that's a positive straight leg raising test. To me it isn't.

So that, you know, I said this before and I just say it now, you know, you'd have to ask Dr. Krahe what he means by it. I can't tell you what he means by it. I know what I mean by it, and that's all.

Q Doctor, you were questioned about the CT scan and what you wrote in your report about the CT scan. You indicated in your report that there was some difficulty in interpreting some of these films. You weren't allowed to finish your response. Would you like at this point --

A Yeah.

Q -- to clarify that point?

A It is not a technically great CT scan. Would you ask me if it's adequate, I suppose it's adequate; it's not a good one. There's nothing that I could identify as a herniated disk, and there's nothing that the radiologist could identify as a herniated disk. You know, this is true of the scan that was done five days later.

Q Doctor, is a mild bulge the same as a herniated disk?

A No.

Q What is the difference?

A The differences are great differences of degree. Bulging is very common. It's a very common thing seen in normal people, and there's no character -- there may be no symptoms, often there are no symptoms associated with a bulging disk or a mild protrusion.

A herniated disk is an entirely different thing. Of course, one can see herniated disks in patients who have no symptoms at all either. There's no great mystery about that. It's just an event that's been observed for years. But if you see a disk that has escaped the confines of the disk space, which is a true herniated disk, in a patient that has appropriate symptoms, you say that's a symptomatic herniated disk, very characteristic, totally different from bulging or protrusions.

You know, these are words that radiologists use to describe a finding, and you really have to ask the radiologist what he means. I mean, a little bulging, but that's all it means. It doesn't mean anything else.

Q You've seen these films yourself?

A Yes.

Q In your opinion, to a reasonable degree of medical certainty, could these bulges or protrusions which were demonstrated by the CT scans or the MRI account for Mr. Albano's symptoms?

A Personally, I don't think so. Personally, I don't think so. I think that initially his symptoms are really very difficult to explain on the basis of the CT scans that he had.

Certainly when he had the MRI scan in 1987, that's a pretty impressive study, and to me there was a very characteristic abnormality of a very focal abnormality in the lumbar spine at L4 and L5 that was not due to a herniated disk. It was due to lumbar stenosis, which is a very common problem that I deal with surgically 50 to 75 times a year.

Q Doctor, lastly, in response to Mr. Kennedy's questioning, you indicated that sure, a centrally herniated disk could cause pain on either side?

A Sure.

Q Could it cause pain without impinging on the nerve?

A A single nerve, no, I don't think so.

MR. CABRAL: Thank you, Doctor.

EXAMINATION

BY MR. REA:

Q Doctor, did I understand you to say that --

MR. KENNEDY: Objection. I'm going to object to your questioning at this point in time. I don't think you're entitled to begin your direct examination after there's been a direct and a cross.

MR. REA: Let the record show your objection. Let's proceed.

Q Doctor, do I understand that you've done about 150 of these low back procedures in this past year or so?

MR. KENNEDY: Objection.

A Yes.

Q And can you tell us, please, over the years, your many years of practice, about how many times have you performed low back surgery of the type that Mr. Albano had in this case?

MR. KENNEDY: Objection, asked and answered.

A I would guess at least 1500 times.

Q At least 1500 times?

A Yeah.

MR. REA: Thank you. I have

nothing further.

RECROSS-EXAMINATION

BY MR. KENNEDY:

Q Doctor, can a bulge or a protrusion cause symptomatology, bulge or protrusion of the disk?

A Per se, no, I don't think so. This is a very difficult question to answer because, you know, when you see a patient with certain types of complaints of a backache and you do a scan and have a scan performed on a patient like that, oftentimes I won't order scans on patients like that, but patients are sent to me by other doctors scans in hand with complaints of backache, and they have a little bulging of a disk.

I don't do anything very aggressive with patients like this, because it's very difficult in my own mind to relate this X-ray finding or MRI scan finding to a specific symptom or complaint because you can see this in normal people who have no complaints.

Q Doctor, Mr. Albano immediately following this had symptoms --

A Correct.

Q -- consistent with a herniated disk?

A Yes, he certainly did.

Q And when the symptomatology occurs, that's consistent with a herniated disk, occurs immediately after an event, doesn't that allow you to conclude that the event caused the symptoms and the herniated disk?

A There would be no question in my mind but that the event caused the symptoms, but there is a great deal of question in my mind as the fact that he didn't have a herniated disk on the right side.

MR. KENNEDY: I have nothing further.

REDIRECT EXAMINATION

BY MR. CABRAL:

Q Very briefly, Doctor. You indicated that the event caused the symptoms.

A No question.

Q Do you have an opinion as to whether, to a reasonable degree of medical certainty, this could have represented an aggravation of a pre-existing condition, that being the stenosis?

A I think it's possible. I think it's possible.

Q Do you think it's probable?

A I'd have to think a lot about that. It's a difficult question to answer, but I think it's possible.

MR. CABRAL: Thank you very much.

RECROSS-EXANINATION

BY MR. KENNEDY:

Q Just finally, Doctor, this issue of stenosis, again, this is something he had prior to this fall?

A I think he did.

Q And we have no evidence and no record that it ever caused this man any pain or any disability or problem; is that true?

A To the best of my knowledge, that is so.

Q Doctor, in the past, with your own patients, would I be correct in saying that when the back symptomatology has occurred close in time to the event, the accident or the fall, you have been able to conclude with reasonable probability and reasonable certainty that the symptoms and then a later diagnosed herniated disk were caused by that fall or that incident?

A Obviously, if the symptoms began afterwards, one would relate the symptoms to the event. When you say later, it's almost too broad a term. When you say later, do you mean --

Q If the herniated disk wasn't diagnosed for a year and a half to two --

A That would be very unusual in my own experience. I

mean, if I had a patient with right sciatic pain and I could not identify a herniated lumbar disk, I would sort of scratch my head and wonder why the patient had right sciatic pain, to be quite candidly honest with you.

MR. KENNEDY: I have nothing.

MR. CABRAL: Thank you, Doctor.

MR. REA: Thank you, Doctor.

MR. CABRAL: Ask counsel -- first of all, Doctor, do you agree to waive signature?

THE WITNESS: Oh, indeed, yes.

MR. CABRAL: And would counsel agree to waive the filing requirements? Let the record reflect he nodded yes.

(Deposition concluded at 7:15 p.m.)

(Signature waived)

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

I, Phyllis L. Englehart, CM and Notary Public in and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named witness, Melvin Shafron, M.D., was by me first duly sworn to testify the truth, the whole truth, and nothing but the truth in the cause aforesaid; that the testimony then given by him was by me reduced to computerized stenotypy in the presence of said witness, afterward transcribed, 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 and completed without adjournment.

I do further certify that I am not a relative, counsel, 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 7th day of February, 1992.

Phyllis L. Englehart

Phyllis L. Englehart, CM and Notary Public
in and for the State of Ohio.
My commission expires June 23, 1996.