STATE OF OHIO
COUNTY OF CUYAHOGA

KIMBERLY RICHLEY, Plaintiff	:	NO. CV-03-511510
vs.	:	
REICHENBACH FAMILY CHIROPRACTIC PROFESSIONAL CO., et al, Defendants	:	

VIDEOTAPE DEPOSITION OF GARY A. TAROLA, D.C.

Taken at the offices of Dr. Tarola, 17 North Route 100, Allentown, Pennsylvania, on Wednesday, September 29, 2004, commencing at 10:11 a.m., before Daniel R. Stout, Certified Court Reporter, Notary Public.

APPEARANCES:

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THE VIDEOGRAPHER: My name is Robert Stettner. I'm the Video Technician for this deposition. I'm employed by Gallagher Reporting and Video, LLC of 33 South Seventh Street, Suite 105, in Allentown, Pennsylvania.

Today's date is September 29th, 2004. The time is 10:11 a.m. We are located at the office of Dr. Gary Tarola, Chiropractic Associates, Route 100 and Schantz Road in Fogelsville, Pennsylvania.

The caption of this case is In The Court of Common Pleas of Cuyahoga County, Ohio, number CV-03-511510, Kimberly Richley, Plaintiff versus Reichenbach Family Chiropractic Professional, and others, Defendants.

The name of the witness is Dr. Gary Tarola. This deposition is being taken on behalf of the Plaintiff.

Present as counsel for the parties are Mark Ruf via telephone from Toledo, Ohio for the Plaintiff, --

MR. RUF: Cleveland, Ohio.

THE VIDEOGRAPHER: Cleveland, Ohio, and Michael Regnier for the Defendants.

The Court Reporter is Dan Stout and the Court Reporter will now swear in the witness.

* * *

GARY A. TAROLA, D.C., having been duly sworn, was examined and testified as follows:

MR. RUF: Before we get started I'd like to put on the record it's my understanding this deposition is being taken by agreement of counsel, is that correct?

MR. REGNIER: That's correct.

MR. RUF: There's no objection to the manner in which this deposition is being taken, is that correct?

MR. REGNIER: That's right.

BY MR. RUF:

Q. Okay. Doctor, could you state your name, please?

A. Gary Tarola.

Q. Do you agree that you have not published on the subject of facet fractures?

A. That's correct.

Q. Do you agree that you have not lectured professionally on the subject of facet fractures?

A. That's not correct.

Q. When have you given a lecture on facet

fractures?

A. Well, I've given lectures, numerous lectures on cervical spine problems and whiplash and that -- in the context of those lectures that would include information on cervical spine fractures, including facet type fractures.

Q. How many times have you specifically lectured on facet fractures?

A. I'd have to look at my CV to, you know, to be able to identify that, but it's been numerous times, at least twenty.

Q. Is it true that none of your publications relate to complications from Chiropractic manipulation?

A. Not directly, that's correct.

Q. Have you ever lectured on complications from Chiropractic manipulations?

A. Yes.

Q. How many times have you done that?

A. I don't know the exact number, but many.

Q. Did you ever give out written materials on complications from chiropractic manipulations?

A. I believe some of the materials that I would hand out included at least inferences in that regard.

Q. Do you still have any of those written materials?
A. I'm sure I do.
Q. Well, if I would request a copy of those, would you be willing to provide them?
A. Yes.
MR. RUF: Mr. Regnier, I'm requesting a copy of those materials.
MR. REGNIER: Okay. I assume you're going to reimburse the doctor for it?
MR. RUF: Sure.
BY MR. RUF:
Q. Doctor, if I wanted to review the Chiropractic literature for complications from cervical manipulations, what would be an accurate and reliable source to refer to?
A. Are you referring just to Chiropractic literature or any medical literature on the topic?
Q. Okay. Why don't we say any medical literature on the topic.
A. Probably the best source would be to look at the study that was published by the Rand Corporation. I believe that was back in the -- it was in the early '90's, I don't remember the exact year, and that pertained specifically to cervical

spine manipulation and complications related to that.

That study actually addressed complications of many different medical procedures that would be utilized for people with neck pain and treatment directed to the cervical spine, and that included manipulation.

Q. Do you know what the name of that study was?

A. The precise name I don't off the top of my head. I can certainly get it for you. But again, it was a study performed by the Rand Corporation, and I have it, I can get it for you. I just don't remember off the top of my head the precise title of the publication.

Q. Okay. I'd also request a copy of that. Is it published anywhere?

A. It's published in a -- as a text basically, a monograph.

Q. What's a monograph?

A. It's like a textbook, but it's not a hard cover textbook. It's published as an article, but a very extensive article.

Q. Do you know what the name of it was?

A. As I just mentioned, I don't recall

offhand the precise title.

Q. Okay. Thanks.

Do you have any books in your office?

A. Yes.

Q. What books do you have in your office?

A. Well, I have many books in my office.

Q. Do you have any books on Chiropractic manipulation?

A. I have --. Yes, I do.

Q. What are some of the books that you have in your office?

A. The primary book on Chiropractic manipulation would be a book entitled Principles and Practice of Chiropractic.

Q. Do you know who the author is?

A. The editor is Scott Haldeman. I've contributed chapters to two of the editions of that textbook.

Q. What are your chapters?

A. The second edition of the text my chapter was history and physical examination, the third edition which was just released was on documentation and record keeping.

Q. Do you consider that publication to be an accurate and reliable source of information?

A. Well, I don't know that any text is entirely reliable. It's certainly a very good reference source for Chiropractic and anybody who utilizes manual medicine.

Q. You wouldn't put your name on a publication that you thought was inaccurate and unreliable, would you?

A. No, I wouldn't.

Q. What other texts do you have in your office?

A. Well, I have many texts in my office. You'd have to -- I'd either have to spend an hour going through them or if you can be more specific with me with regard to what kind of texts you're looking for.

Q. Sure. What types do you have on Chiropractic manipulation of the cervical spine?

A. There are no specific texts specifically on Chiropractic manipulation of the cervical spine alone. There are texts that address many issues of the cervical spine and within the context of the texts there is information on Chiropractic manipulation, and I have several of those.

Q. Okay. What text would have a section that discusses cervical spine manipulation?

A. The one I just mentioned, Principles and Practice of Chiropractic. The Guidelines for Chiropractic Practice Parameters would have information with regard to manipulation as well as complications.

Q. Those are the Mercy Guidelines?

A. Yes. The Upper Cervical Spine is another text that also addresses issues of manipulation of the cervical spine.

Q. Do you know who the author is on Upper Cervical Spine?

A. Off the top of my head I can't recall, but I have it here.

Q. You were an editor or you were involved with the Mercy Guidelines, is that correct?

A. Yes, I was not an editor, I was a consultant.

Q. What was the purpose of the Mercy Guidelines?

A. The purpose was to review the literature to the point in time when these reviews were being done and try and formulate what would be termed the best practices document based on the current evidence, the scientific evidence at the time, and it addressed many, many issues with regard to

Chiropractic care in general.

Q. Do you consider the Mercy Guidelines to be an accurate and reliable source of information?

A. For the most part, yes.

Q. Any other books that you've got in your office on manipulation of the cervical spine?

A. Not that I can recall offhand, no.

Q. Do you subscribe to any publications?

A. Yes.

Q. Which ones do you subscribe to?

A. The Journal of Manipulative and Physiologic Therapeutics, the Journal of the Neuromusculoskeletal System, Spine Journal, The Back Letter, and Bone and Joint periodical.

Q. Why do you subscribe to those publications?

A. So that I can remain as current as possible with the published literature.

Q. Do you consider those to be quality publications?

A. Yes.

Q. Have you followed the local Rule in Cuyahoga County and put all of your opinions in your two reports?

MR. REGNIER: Objection. Go ahead,

Doctor.

THE WITNESS: Yes, I have.

BY MR. RUF:

Q. Are there any new materials that you've reviewed since you wrote your reports?

A. Yes.

Q. And what else have you reviewed?

A. Reviewed the deposition transcript of Charles DuVall.

Q. Anything else?

A. I don't believe so.

Q. Dr. Reichenbach performed an upper extremity pin test on Kim Richley, is that correct?

A. Let me go back into his record just to be sure.

Q. Sure, take a look at his records if you need to.

A. What date are you referring to?

Q. Well, he has a note that upper extremity pin and myo testing were negative C5 to T1.

A. Yes, that was on 10-17-02.

Q. What is upper extremity pin testing? What's that for?

A. I'm not sure where you see it. I see in his record pin bilateral C5 to T1 and muscle testing

bilateral upper extremity C5 to T1. Those are neurological tests. The pin test would be to test for sensation and the myo test or muscle test would be to test muscle strength in the upper extremities as they relate to the neurologic levels C5 to T1.

Q. So is the pin test to test for nerve function?

A. To test for sensory level function of the nerve, yes.

Q. And those were both normal?

A. Yes.

Q. What orthopedic testing did Dr. Reichenbach do?

A. He performed range of motion and provocative maneuvers. Those would involve maneuvers involving compression, distraction and stretching of the cervical spine.

Q. Okay. What do you perform foraminal compression for?

A. That test is a provocative maneuver that compresses certain structures of the cervical spine in various positions to try and identify whether or not that mechanism reproduces the patient's pain and then depending on how the pain is reproduced we can draw some conclusions from that with regard to the

tissue that might be involved in the production of that pain.

Q. If the nerve at C6-7 was damaged or injured would you expect the foraminal compression test to be positive?

A. Very frequently, yes.

Q. And when would it not be positive if you had a nerve injury at C6-7?

A. There are instances where depending on how the nerve is injured or depending on how the nerve is compressed where additional compression actually doesn't cause -- an external compressive load doesn't necessarily cause additional compression of the nerve itself. So it's not actually too uncommon for someone with a nerve root lesion in the cervical spine at C6-7, C5-6, for these tests to be either equivocal or negative.

Q. The foraminal compression test on Kim Richley was negative, is that correct?

A. Yes.

Q. What is the shoulder depressor test?

A. That's a test where the head is tilted to one side and the examiner depresses the shoulder stretching, which produces a stretch effect to the side of test.

Q. And what is that test used for?
A. Again, all of these tests are really just to see if any of these mechanisms of motion reproduces a patient's pain, the type of pain that they're complaining about in particular, and then depending on how the pain is produced or reproduced, we can draw some conclusions from that.
Q. What type of underlying pathology would cause a positive shoulder depression test?
A. A muscle injury to the trapezius or levator scapulae or other muscles on one side of the neck; a brachial plexus stretch type injury would -- that mechanism would generally reproduce that type of an injury.
Q. What about a nerve injury at C6-7?
A. Again, depends on how that nerve is irritated or compressed as to whether or not distraction or stretching that area would actually reproduce pain. It's possible it could, but in other instances it does not.
Q. Do you agree the shoulder depresser test for Kim Richley was negative?
A. Well, he reports it as negative, but then there's a written notation indicating that there was increase in muscle tension at least of the right

cervical and trapezius muscles.

Q. So how would you interpret that?

A. I would interpret that to suggest that there was some -- there was some muscle tension at the very least that the practitioner identified when he performed that test on the right as compared to the left.

Q. What's the Soto Hall test?

A. The Soto Hole test is performed with the patient in a supine or position lying on their back and the practitioner passively flexes the head on toward the chest, basically flexing the cervical spine passively.

Q. And what's the purpose of that test, what are you looking for?

A. There again, we're looking for any soft tissue response. For example, somebody who has some sort of soft tissue injury or muscle spasm in the back part of the neck, that test will often reproduce some of that discomfort. It's also used for vertebral fractures, spinous process fractures, or compression fractures of the body of the vertebrae; if somebody has that, that test will often times reproduce pain.

Q. What if somebody had a facet fracture?

A. It certainly is possible, probable that that would also reproduce pain.
Q. Would a nerve injury or nerve damage at C6-7 produce a positive Soto Hall test?
A. Not necessarily. It could, but not necessarily.
Q. You agree Kim Richley's Soto Hall test was negative?
A. Yes.
Q. And these tests were all done on 10-17-02?
A. Yes.
Q. What's the cervical distraction test?
A. It's a test where the patient is generally in a sitting position, could be in a supine position, but generally sitting, practitioner stands behind the patient or in front of the patient and lifts up on the base of the skull to distract or stretch the cervical spine, with --
Q. What are you looking for --
A. I'm sorry.
-- with the neck in an otherwise neutral position.
Q. What are you looking for with that test?
A. There again, we're looking for

reproduction of pain. If the pain is generally coming from muscles, ligaments or tendons, sometimes we'll get reproduction of pain by stretching those tissues. In other instances with nerve root lesions, for example, if the nerve root is being pinched, sometimes by distracting it basically that takes the pressure off the nerve, sometimes the patient will describe a decrease in the pain that they're experiencing, and that also then is significant for suspicion of a nerve root type problem.

Q. Dr. Reichenbach reported that it was positive on the right?

A. Yes. I'm sorry, the distraction --. Yes, positive on the right.

Q. According to Dr. Reichenbach's record Kimberly Richley had normal range of motion of the cervical spine in all directions, is that correct?

A. The range of motion was normal, yes, but there was some pain reproduction with those movements.

Q. Would you agree that based upon Dr. Reichenbach's record there was no evidence of a nerve injury or nerve damage at C6-7?

A. I would say based on these findings I

would conclude that to be the case, yes.
Q. Would you agree that based upon these findings Kim Richley did not have an abnormality at C6-7 on 10-17-02?
A. You'd have to be more specific in terms of what you're referring to as an abnormality.
Q. Well, do you think there was any type of abnormality at C6-7?
A. I couldn't draw any conclusion with regard to that based on these findings.
Q. Do you have any evidence of an abnormality at C6-7 on 10-17-02?
A. No.
Q. I'm sorry? I didn't catch the answer.
A. No.
Q. Would you characterize Kim Richley's cervical spinal on 10-17-02 as a normal cervical spine?
A. No.
Q. Why not?
A. Because there are findings here at the very least of a muscle condition of her cervical spine, there's abnormal muscle tension. Dr. Reichenbach also identified fixation, which is a mechanical lesion, at the C5-6 level, as well as the

T4 through T6 level, so that that wouldn't be characterized as a normal cervical spine. There are mechanical problems there.

Q. In your practice do you perform Chiropractic adjustments for the wrists?

A. For the wrists? Was that your question, for the wrists?

Q. Yes.

A. Yes, I do.

Q. What type of Chiropractic adjustments do you perform for a patient's wrists?

A. I perform primarily mobilization type techniques for the wrists, but there are some specific adjustments used for certain of the wrist bones, and that's done -- those types of procedures are performed in a high velocity/low amplitude method.

Q. Is there any adjustment that you use on the wrist for a wrist sprain/strain?

A. It depends on the nature of the strain/sprain, mainly whether it's acute, meaning a new strain or sprain, or if the patient still has symptoms from a chronic strain. In an acute nature generally we wouldn't do manipulation.

Excuse me, I'm sorry for that noise.

Q. That's all right. Please continue.
A. But for somebody who has chronic pain in the wrist as a result of an old strain or an old sprain, then we -- then there are manipulative procedures and mobilization procedures that we utilize.
Q. What about for a carpal tunnel syndrome, do you perform manipulations for carpal tunnel syndrome?
A. Yes.
Q. What type of manipulations?
A. The same as I just described.
Q. Would those manipulations be different from a modified rotary break?
A. Well, we're talking about two totally different body parts.
Q. Right. So that would be a completely different manipulation than a modified rotary break, correct?
A. Well, you can't even compare the two. The nature of the manipulation, the high velocity/low amplitude type manipulation would be the same or similar as what's performed with what you're describing as a rotary break type maneuver, because that's typically performed in a high

velocity/low amplitude fashion as well, but it's in a different body part so it's performed differently.

Q. So when you would treat either a wrist sprain/strain or carpal tunnel syndrome the adjustment would actually be to the wrist?

A. Yes.

Q. Do you ever perform a neck adjustment for a wrist sprain/strain or carpal tunnel syndrome?

A. Not -- not if all they have is a wrist sprain or a carpal tunnel syndrome. However, many people with carpal tunnel syndrome also have what's called a double crush syndrome whereby the symptoms they have in their hand could be partially coming from the carpal tunnel in the wrist but could also be partially emanating from something more proximal, even up into the neck area.

Q. Would you agree that the acceptable standard of Chiropractic medicine requires a Chiropractor only to perform manipulations that are indicated for the patient's condition?

A. Well, that's kind of a broad question. I'm not quite sure what you're referring to there. But when you say condition, are you talking about their symptoms at the time?

Q. Yes.

A. I would say that's not -- that's not really the standard of care. There are Chiropractors who will limit their treatment to a patient's immediate pain areas, but the vast majority of the profession tends to look at the entire spine as a whole unit, as a whole organ or mechanism, and even if a patient, for example, presents primarily with low back pain, there are many people in our profession who will evaluate the entire spine, and if they find mechanical problems in other parts of the spine will treat those areas along with the symptomatic area.

Q. Well, let me ask you this. In your practice do you only perform Chiropractic manipulations that are indicated for a patient's spine symptoms and the diagnosis you've made for the patient?

A. I would say yes to that, but in many instances that wouldn't still involve treatment in areas around the primary area of complaint. The treatment wouldn't necessarily be solely localized, for example, if somebody came in primarily with low back pain, the treatment wouldn't necessarily be specifically directed to the lower back. I would also assess the thoracic spine and many times even

the cervical spine. I would certainly assess those areas, and if I find there are biomechanical problems that could indirectly impact the lumbar spine or the lower back problem, then we will address those areas as well, even though they may not be symptomatic at the time.

Q. But even if it's not localized you're still performing manipulations that are indicated for the patient's signs, symptoms, and based upon the patient's diagnosis, correct?

A. Correct.

Q. And don't you agree that that's the reasonable and prudent thing to do as a Chiropractor?

A. I think that's a reasonable and prudent thing to do as any practitioner.

Q. And you don't want to perform manipulations for which there's no basis, do you?

A. As a broad question like that I would have to say that's right.

Q. Wouldn't you agree that it's unacceptable Chiropractic practice to perform manipulations where there's no indication for performing the manipulation?

A. I would agree with that.

Q. What were the treatment options for Kimberly Richley on 10-17-02?
A. Treatment options?
Q. Yes.
A. For what?
Q. The treatment of her cervical spine area?
A. From a Chiropractic perspective or any treatment options?
Q. Chiropractic perspective.
A. Treatment options would have been patient could have chosen not to have any treatment at all, but the treatment options would include anything from muscle therapy to modalities to mobilization techniques, manipulation techniques, exercise therapy, various types of home therapy that we could recommend for patients.
Q. Would you agree that Dr. Reichenbach had a duty to explain the treatment options to Kimberly Richley?
A. I'm not quite sure what you mean necessarily by duty, but yes, it's generally helpful for a practitioner to explain options to a patient, yes.
Q. Well, let me reword it then. Would the acceptable standard of Chiropractic practice require

Dr. Reichenbach to explain the potential treatment options for Kimberly Richley's cervical spine?

A. Well, I'm not quite sure -- I'm not sure really what you're getting at there. I think it was explained to the patient, but yes, it's helpful to -- it's always helpful to have a consult with a patient after they get examined and explain what your recommendations might be therapeutically.

Q. Well, don't you think a patient has the right to know the potential treatment for their condition?

A. Again, I'd have to ask are you referring to just the Chiropractic treatments or any other options that might be available.

Q. Well, any treatments. Don't you agree it's up to the patient to decide what treatment they want?

A. I think it's definitely the patient's choice to choose to accept treatment, yes.

Q. And a patient cannot make an intelligent decision unless they're informed by the Chiropractor of the potential treatment options?

A. That's true.

Q. What is your understanding of what must be explained in order to obtain informed consent

from a patient before performing a cervical manipulation?

A. I think it depends on the circumstance, the patient's basic knowledge of Chiropractic treatment generally, and any perceived risks involved with any procedures that are, you know, going to be recommended.

Q. Do you think that the Chiropractor should also explain whether or not a treatment is effective or has been proven effective?

A. You're asking really broad questions. These are not generally, you know, specific issues that would come up clinically. So I would say that that's just not a practical -- the way you're asking the question is not something that is practical in a clinical setting.

Q. Well, do you think if there's no proven effectiveness for a treatment that that should be explained to a patient?

A. What do you mean by proven effectiveness?

Q. Well, if there's no studies or medical literature proving that a treatment is effective, do you think that should be explained to a patient?

A. I think that would be reasonable to explain, but in most instances, both in medicine and

Chiropractic, if the treatment is a common practice, something that's performed on a regular basis that's routine for the type of practitioner the patient is seeing, it's generally not disclosed in that nature.

Q. Would you agree that in order to obtain informed consent not only do you have to obtain consent to perform a procedure but the patient also must be informed before making the decision?

MR. REGNIER: Objection. Go ahead, Doctor.

THE WITNESS: Informed of what?

BY MR. RUF:

Q. Informed of the treatment options and the potential risks and benefits of treatment.

A. I think that is -- depends on the type of treatment that's going to be applied, but in general I would say that's the prudent thing to do.

But in many instances from a clinical perspective, depending on the method of treatment that's being recommended, having an understanding of what the patient's understanding is of that treatment before it's even applied would determine the extent of any discussion that's held with the patient with regard to alternatives and risks and the procedures themselves.

Q. Have you been practicing Chiropractic medicine for twenty-eight years?
A. Yes.
Q. During that twenty-eight years have you ever treated a facet fracture --
A. No.
Q. -- of the cervical spine?
A. No.
Q. I'm sorry, you said no?
A. No.
Q. Have you ever diagnosed a facet fracture of the cervical spine?
A. Not that I recall. I have diagnosed pillar fractures, what are termed pillar fractures, which is an area just below the facet, but I don't recall if I've ever diagnosed a facet fracture.
Q. Have you ever diagnosed a subluxation of the cervical spine?
A. Can you define subluxation?
Q. Well, is it your understanding that subluxation and dislocation are the same thing or are they different?
A. They're different.
Q. How are they different?
A. Technically a subluxation is less than a

dislocation. It's an incomplete dislocation.

Q. Would a subluxation be where one vertebra slips over the top of another vertebra?

A. It depends on the extent. If it's not fully dislocated and there is shifting or measurable movement one vertebrae to the next, then that would be a subluxation.

Q. Okay. Then how would you define subluxation?

A. That is how I would define subluxation, from a purely radiographic or medical perspective.

We use the term subluxation in Chiropractic in a different fashion, as well, an entirely different -- it's an entirely different context when we use the term from a biomechanical standpoint, but we also use the term subluxation as it's used conventionally from a medical and radiographic perspective.

Q. Have you ever diagnosed a subluxation?

A. Yes.

Q. How many times have you done that?

A. All the time.

Q. How many times in your career have you diagnosed a subluxation?

A. I couldn't give you a number. Many, many

times.

Q. Could you give me an estimate?

A. Hundreds. The term subluxation from a Chiropractic -- from a purely mechanical perspective I diagnose on almost every patient that comes to me with some sort of complaint.

The term subluxation from a medical/radiographic perspective, the definition of incomplete dislocation I also diagnose on many occasions when there is vertebral shifting and we can identify that radiographically.

Q. Okay. Then let me clarify the question. How many times have you diagnosed subluxation based upon a medical/radiographic definition?

A. Probably hundreds.

Q. Have you treated hundreds of patients with a subluxation from the medical/radiographic definition?

A. Yes. That would be not just related to the cervical spine but the lumbar spine, as well.

Q. Would you agree that it's common with a facet fracture to see subluxation?

A. Is it common?

Q. Yes.

A. That can occur and frequently does occur.

Q. Is one of the functions of the facet to keep the vertebral bodies in place?
A. That's one of the functions, yes.
Q. So if you have a facet fracture, that can cause a subluxation?
A. It can, yes.
Q. Have you ever diagnosed a fracture of the transverse process?
A. I've identified transverse process fractures, yes, mostly in the lumbar spine. I can't recall if I've ever diagnosed one in the cervical spine.
Q. Have you ever been sued for malpractice?
MR. REGNIER: Objection. Go ahead, Doctor.
THE WITNESS: No.
BY MR. RUF:
Q. Who is your insurance company?
MR. REGNIER: Objection. Go ahead, Doctor.
THE WITNESS: National Chiropractic Mutual Insurance Company.
BY MR. RUF:
Q. So you have the same insurance company as Dr. Reichenbach, correct?

MR. REGNIER: Objection. Go ahead, Doctor.

THE WITNESS: Yes.

BY MR. RUF:

Q. Have you seen an increase in premiums over the years?

MR. REGNIER: Can I just have a continuing line of objections to insurance questions, Mark?

MR. RUF: Sure, that's fine.

MR. REGNIER: Go ahead, Doctor.

THE WITNESS: No. I've actually seen a decrease in premiums frequently.

BY MR. RUF:

Q. Would you agree that you have an interest in seeing that your premiums do not go up?

A. I certainly wouldn't -- don't like to see them go up.

Q. Do you agree that Dr. Reichenbach performed a modified rotary break on Kim Richley?

A. On what date?

Q. Did he perform a modified rotary break on three dates on Kim Richley?

A. Yes.

Q. What were those three dates?

A. 10-18-02, 10-19 and 10-21-02.
Q. Have you ever performed a modified rotary break?
A. Yes, I perform that regularly.
Q. How many times in your career have you done that?
A. Tens of thousands.
Q. I'm sorry, you said tens of thousands?
A. Yes.
Q. Have you ever had a complication from performing a modified rotary break?
A. No.
Q. What are the risks of performing a modified rotary break?
A. Any potential risk?
Q. Yes.
A. There's always a risk of soreness occurring, at least initially, for someone who has not had the procedure done before or depending on the acute characteristics of their condition, but other potential risks are --. Well, actually I don't know of any other really significant potential risks of performing that procedure. Again, it depends on the nature of the patient's condition at the time.

Q. Is a stroke a potential risk?
A. A stroke is a potential risk, a very low risk, but a potential risk.
Q. Is subluxation a potential risk?
A. In the absence of any underlying condition it's not a risk. If there is some other kind of underlying bone condition or other disease process related to the cervical spine, then that might be a risk.
Q. Are you aware of whether there are any reports in the literature of subluxation being a complication from a modified rotary break?
A. No, I'm not.
Q. Is a modified rotary break a high velocity manipulation?
A. It's typically a high velocity/low amplitude type manipulation, yes, although it can be performed in a variety of ways. The high velocity/low amplitude method is the most common; however, it can be applied in simply an oscillatory manner or simply in a mobilization type method.
Q. Can you describe the proper technique for performing a modified rotary break?
A. Generally the procedure is performed either in a sitting or supine position, which means

laying on their -- a patient laying on their back, and the provider stands behind the patient, with two hands stabilizes the head and neck, introduces distraction, mild flexion and mild lateral flexion positioning to the neck into the specific area of the spine that -- where the adjustment or manipulation is intended to take place, and if the high velocity method is completed, then a very controlled low amplitude, which means low depth, impulse is imparted into that section of the cervical spine.

Q. Would you agree that the acceptable standard of Chiropractic practice requires a Chiropractor to perform a cervical modified rotary break with proper technique?

A. Would you repeat that question, please?

MR. RUF: Sure. I'd ask the Court Reporter to read it back.

(The Reporter read the following:)

"Q. Would you agree that the acceptable standard of Chiropractic practice requires a Chiropractor to perform a cervical modified rotary break with proper technique?"

THE WITNESS: Certainly.

BY MR. RUF:

Q. Would performing a modified rotary break in the standing position be improper technique?
A. Performing that procedure in a standing position isn't even a technique. It's not a technique taught in any Chiropractic institution I'm aware of, I've never seen it performed by anybody in technique classes, I've never even saw it discussed by anybody or any colleagues of mine that I discussed these issues with.
Q. Okay. So would you agree that performing a modified rotary break in a standing position would be improper technique?
A. I would -- I don't know that I'd say it's improper technique. I would say it's not a practical, and it would be very difficult to perform.
Q. Well, if you've never heard of it in your career do you agree it's not proper technique to perform a modified rotary break in a standing position?
A. I would agree with that.
Q. If a Chiropractor performs a modified rotary break using rotational force, would that be improper technique?
A. No, not necessarily. There's often some

degree of rotation that is also imparted when performing these procedures. It's generally minimal, but there's always some rotation. I'm sorry, not necessarily always, but oftentimes there's rotation that's imparted into the movement that's required to perform the procedure.

Q. Would you agree that it would be improper technique to perform a modified rotary break on a cervical spine that exerts a significant amount of rotational force on the cervical spine?

A. You would have to define significant.

Q. Would you agree that it would be improper technique to perform a modified rotary break on the cervical spine which produces enough rotational force on the cervical spine to cause injury?

A. Certainly.

Q. Would you agree that if a Chiropractor performed a modified rotary break on the cervical spine which exerted enough force to cause injury to the cervical spine, that would be a deviation from acceptable Chiropractic practice?

A. Again, it would depend on the circumstances. When you say injury to the cervical spine, you would have to identify scenarios. There might be situations where injury could occur but it

couldn't be foreseen, even with a normal or what would be a customary amount of movement and force imparted with the procedure.

If there's some underlying condition that a patient might have that couldn't be foreseen and even a customary type of manipulation exerted enough force to cause damage, then I wouldn't say that would be a deviation from the standard of care, but in a normal spine, a normal healthy spine, for a manipulation to cause injury or a fracture, then excessive force would have to be imparted, yes.

Q. Would you agree that the acceptable standard of Chiropractic practice requires a Chiropractor to determine if there are contraindications to performing a modified rotary break on the cervical spine?

A. We certainly always try and assess for contraindications, yes.

Q. Do you agree that a facet fracture would be a contraindication to performing a modified rotary break on the cervical spine?

A. If someone had a facet fracture, then that would be a contraindication to manipulation, yes.

Q. Would you agree that if somebody had a

healed facet fracture, that would be a contraindication to performing a manipulation on the cervical spine?

A. No, I would not agree with that.

Q. Why wouldn't you agree with that?

A. Well, if the fracture were healed, there would be no -- there would be no condition there, the fracture is healed, there's no more fracture, so that would be not be a contraindication to manipulation.

Q. Based upon your experience if a fracture is healed is the condition of that bone weaker than if there never was a fracture?

A. No, it's stronger.

Q. Would you agree that if a modified rotary break is performed with proper technique it should not result in injury to a patient's cervical spine?

A. If a patient has a normal or relatively normal healthy cervical spine, then yes, I would agree with that.

Q. So would you agree hypothetically that if a Chiropractor performed a modified rotary break and caused a fracture in the patient's cervical spine, that would be a deviation from acceptable Chiropractic practice?

MR. REGNIER: Objection. Go ahead, Doctor.

THE WITNESS: If that particular cervical spine were a healthy cervical spine where there were no bone weakening diseases or other conditions that would weaken bone, that would normally fail under a fairly normal loads, then yes, I would say that would be a deviation from the standard of care.

BY MR. RUF:

Q. Did Kim Richley have any condition which would cause bone weakening?

A. Not that is in the record, no.

Q. What are the indications for performing a modified rotary break? What kind of conditions do you perform a modified rotary break for?

A. Many different types of cervical spine conditions, anything from mild strains to muscle spasm, people with chronic -- even acute or chronic neck pain for a variety of reasons, people with spondylosis, which is a degenerative condition that develops in some people over time, degenerative disk disease conditions we use the procedure, and even oftentimes for people with bulging and herniated disks the procedure can be utilized.

Q. What are you trying to accomplish in performing a modified rotary break of the cervical spine?

A. The same thing we try and accomplish with any spinal adjustment that we perform anywhere. The objective of an adjustment is to restore motion into a motor unit or two individual vertebra where motion has been lost, and oftentimes motion is lost in these vertebrae as a result of muscle imbalance, as a result of new or old injuries where scar tissue starts to form around the joints restricting the normal movement patterns of the joint.

It's a consequence almost invariably of degenerative changes to the vertebrae, the disks or the facet joints, and so the objective would be in those people that have pain syndromes from that or who simply have functional disturbances from that, the objective with the manipulation is to restore those normal movement patterns, and that generally then is a method of relieving pain.

Q. When you perform a modified rotary break do the bones in the cervical spine move?

A. Well, they can move to a minimal degree.

Q. Okay. And how are they moving?

A. I can't answer that question. It's just

too broad.

Q. In performing a modified rotary break of the cervical spine would there be any movement at C6-C7 if the technique is performed properly?

A. There can be.

Q. And what movement would you expect to see if it does occur?

A. Well, the movement would be normal movement between the vertebrae. We're taking the vertebrae into positions that are normal for those vertebrae to be moved into.

So in terms of what movements can occur, usually as I mentioned earlier with a cervical spine adjustment there are some distractive forces, which means a stretching or traction type force is imparted to the neck; there's usually some degree of flexion, some degree of lateral bending; and there could be an element of rotation.

Q. So in performing proper technique, the cervical spine should only move within its normal range of motion, is that correct?

A. Well, when we are setting a patient up for the adjustment the joint is moved into a normal range of motion.

When the impulse is created, the high

velocity/low amplitude impulse is created, it moves the joint into what's called the paraphysiological space. It's slightly beyond what would be termed the active range of motion, which is the range of motion that the patient can actually move voluntarily, into a more passive range of motion, but without exceeding the anatomic limits of movement.

Q. Would you agree that if you exceed the anatomic limits of movement, that could cause injury to a patient?

A. Yes.

Q. I'm sorry, did you give an answer?

A. Yes, I said yes.

Q. Oh, okay. Thanks. I missed that.

When you refer to a high velocity/low impulse manipulation, what do you mean by that?

A. High velocity/low amplitude, high velocity means it's done quickly; low amplitude means very low depth of thrust or impulse, it's a controlled amount of depth.

Q. Why do you want low depth?

A. Because if the depth isn't controlled, then it is possible to exceed the anatomic limits of motion.

Q. And if you exceed the anatomic limits of motion, could a fracture occur?
A. A fracture could possibly occur. It's much more likely that there would be soft tissue injury, overstretching of ligaments or tendons.
Q. Are you aware of any degenerative changes in Kim Richley's cervical spine on 10-17-02 or before?
A. Just give me one minute.
Yes.
Q. And what degenerative changes?
A. There were degenerative changes at C5-6 and C6-7.
Q. And what were those degenerative changes?
A. There was evidence of bone spurring at the posterior parts of the bodies of the vertebrae at both levels, and that is degeneration.
Q. Would you agree that her cervical spine films of 1-29-99 at Parma Community Hospital showed no evidence of fracture in the cervical spine?
A. Yes, I would agree.
Q. Would you agree that her cervical spine films of 1-29-99 showed no abnormality in the cervical spine?
A. If you can hold on a second, I'm not sure

if I personally reviewed those films.

No, I did not personally review those films, so I can only go based on the report that I read, and the report simply indicates that there was no fracture or dislocation.

Q. And no degenerative changes were reported, correct?

A. I'd have to look at the report again. I don't have that identified in my report, but that I don't recall, whether they identified that or not.

Q. Do you have that available?

A. I'm sure I do.

Q. Have you been able to locate it?

MR. REGNIER: He's looking, Mark.

THE WITNESS: Yes, I have an X-ray report of 1-21-99.

That may be a typo in my report. I had it listed as 1-29-99, but I see one of 1-21-99.

BY MR. RUF:

Q. Would you agree that based upon that report there was normal alignment and curvature, no fracture or dislocations seen, no degenerative changes were seen?

A. Yes, that's what it says.

Q. Would you agree that the impression would

be a normal cervical spine?
A. Yes.
Q. Let's go to 10-17-02. Have you reviewed that film, the film that was taken at Dr. Reichenbach's office?
A. Yes.
Q. Would you agree there's no evidence of fracture in the film of 10-17-02?
A. Yes.
Q. Would you agree there's no evidence of subluxation in the film of 10-17-02?
A. Yes.
Q. Would your interpretation of the film of 10-17-02 be normal cervical spine?
A. No.
Did you hear that?
Q. No, I didn't, I'm sorry.
A. No, I said no. As indicated earlier, when I reviewed those films there was evidence at that time of degenerative changes at C5-6 and C6-7.
Q. Did you notice any other abnormalities on the film of 10-17-02?
A. Just a flattening of the normal cervical lordosis which oftentimes is a normal event when the -- when the mid to lower cervical vertebrae

start to go through degenerative changes.
Q. Would you agree that there was no abnormality shown at C6-7 on the film of 10-17-02, other than degenerative changes?
A. Yes.
Q. Would you agree that Kimberly Richley's facet fracture occurred either on 10-17-02 or 10 --. I'm sorry. Strike that.
Would you agree that Kimberly Richley's facet fracture occurred either on 10-21-02 on 10-22-02?
A. I would agree that the separation occurred sometime within that time frame, yes. I'm not sure when the fracture actually occurred.
Q. Do you have an opinion based upon reasonable medical probability as to when Kimberly Richley's facet fracture occurred?
A. I do not. I have scenarios, possibilities, that I think are reasonable to presume, but based on all the records thus far we don't really know exactly when an actual fracture may have occurred.
Q. And those scenarios that you've come up with are just possibilities, correct?
A. Yes.

Q. Would you agree that there is no medical evidence that Kimberly Richley had a facet fracture at C6-7 before 10-17-02?

MR. REGNIER: Objection. Go ahead, Doctor.

THE WITNESS: There's no radiographic evidence of it, but her history indicates a number of falls that she had, at least one of which certainly could have caused a fracture of that nature.

BY MR. RUF:

Q. But none of the films before 10-17-02 or on 10-17-02 showed a facet fracture, correct?

MR. REGNIER: Objection. Go ahead, Doctor.

THE WITNESS: That's correct, but if a fracture did occur, it would be called an occult fracture; often times that will heal with a non-union effect which would not show up on conventional plain film X-rays.

BY MR. RUF:

Q. You've reviewed Kim Richley's medical records, correct?

MR. REGNIER: Objection, to the extent they've been produced. Go ahead, Doctor.

THE WITNESS: Yes, to the records that I've identified that I reviewed, yes.

BY MR. RUF:

Q. And based upon your review of those medical records, is there any mention in any of the records of a facet fracture at C6-7 before 10-17-02?

A. No.

Q. In your opinion did Dr. Reichenbach take a thorough history?

A. Yes, I thought his history was certainly adequate for the condition described.

Q. Do you think that the acceptable standard of Chiropractic practice requires a Chiropractor to take a thorough history?

A. I believe that the accepted standard of care is to take an adequate history. When you use the word thorough, that could mean anything. There's no such thing as a complete history or complete physical examination. It's important to gather the information necessary to assess the condition a patient has and then make recommendations from there.

Q. Would you agree that based upon his history there was no history of a neck fracture before 10-17-02?

A. There was no history of a neck fracture, but there -- he did indicate that she had had a history of many falls.

Q. Would you agree that based upon all the medical records you've reviewed none of the records mentions a history of a facet fracture before 10-17-02?

A. That's true.

MR. REGNIER: Objection. Go ahead.

BY MR. RUF:

Q. I'm sorry, did you give an answer?

A. I said that's true.

Q. What are the signs or symptoms of a facet fracture at C6-7?

A. A spontaneous facet fracture, an acute facet fracture?

Q. An acute facet fracture.

A. Well, the symptoms would certainly be significant pain in the area, at least initially; the character of the pain might change over a period of, you know, twenty-four to seventy-two hours or so, within that time frame the character of the symptoms could change; and the symptoms -- usually when a fracture occurs the feeling of a fracture to an individual where the fracture occurs is sort of a

dull, sort of a sickening, nauseating type sensation.

Q. Like a toothache type sensation?

A. Excuse me?

Q. Like a toothache type sensation?

A. No, not when it first occurs. When it first occurs it would be -- it would be -- a feel -- a significant feeling of pain and a feeling that something was, you know, something significant was done.

Q. What about after the passage of some time?

A. After the passage of time then it could transform into either a toothache type pain or if it's strictly pain from the fracture and not due to injury or an effect to any other surrounding tissue, then usually it is localized pain, an aching type, deep aching type pain that may spread to some immediate surrounding areas.

Q. And do you agree that based upon the medical records you've reviewed there were no signs or symptoms of a facet fracture before 10-17-02 in Kim Richley?

MR. REGNIER: Objection. Asked and answered. Go ahead.

THE WITNESS: I would agree with that.

BY MR. RUF:

Q. Doctor, would you agree that a facet fracture is very painful?

A. I would agree that it would be very painful, yes.

Q. And would you agree that a person who had sustained a facet fracture would probably have to go for medical treatment due to the pain?

A. Generally, yes.

Q. What was Dr. Reichenbach's diagnosis of Kimberly Richley's neck?

MR. REGNIER: On what date?

MR. RUF: I'm sorry?

MR. REGNIER: On what date?

MR. RUF: On 10-17-02.

THE WITNESS: The diagnosis he has listed on the diagnosis sheet are cervical thoracic segmental dysfunction.

BY MR. RUF:

Q. And what would your diagnosis be for Kim Richley?

A. It would have been similar to that. I may have included other diagnoses that were possible

based upon her symptoms and the physical signs. Cervical brachial syndrome is a potential diagnosis that could be utilized. But in this situation there was really no definitive diagnosis from an acute standpoint.

You couldn't diagnose it as a strain or a sprain because there was really no significant evidence or at least by the history that this was an acute condition. The history indicates that it was an ongoing, more of a chronic problem, and the physical findings are consistent with his diagnosis.

Q. And what was her prognosis on 10-17-02?

A. In terms of her neck problem?

Q. Yes.

A. Are you asking me based on review of the records or --

Q. Based upon your review of the records what was her prognosis on 10-17-02?

A. I think based on the symptoms she described and the physical findings that Dr. Reichenbach identified that she was a definite candidate for manipulative therapy and that that type of patient with those types of complaints and physical findings generally respond very favorably to manipulative therapy.

Q. So her prognosis was favorable?
A. Yes.
Q. She had no condition on 10-17-02 that affected her ability to work, correct?
MR. REGNIER: Objection. Is that what you're representing?
MR. RUF: I'm asking the Doctor.
BY MR. RUF:
Q. Do you agree that she didn't have any condition on 10-17-02 that affected her ability to work?
MR. REGNIER: Objection. Inaccurate recitation of the record.
BY MR. RUF:
Q. Go ahead, answer, Doctor.
A. Are you --. With regard to her cervical spine complaints or any of her complaints?
Q. Then let's limit it to the cervical spine. Do you agree that she did not have any condition of her cervical spine on 10-17-02 that would affect her ability to work?
MR. REGNIER: Objection. Go ahead, Doctor.
THE WITNESS: I guess that depends on the type of work, but I would say generally no.

BY MR. RUF:

Q. Would you agree that on 10-17-02 she did not have any condition of her cervical spine that would affect her ability to lift weight?

MR. REGNIER: Objection. Go ahead, Doctor.

THE WITNESS: You'd have to qualify the weight, but I would say to conduct normal activities of daily living, she was capable of doing that.

BY MR. RUF:

Q. Would you agree there was no condition of her cervical spine or 10-17-02 that would affect her ability to look up and down repetitively?

A. I would say she would have been able to do that. She may have had discomfort with it, but she would have been able to do it.

Q. And do you agree there was no condition of her cervical spine that would affect her ability to sit for long periods of time?

MR. REGNIER: Objection. Go ahead.

THE WITNESS: Based on the record I would say she probably should -- would have been able to sit for prolonged periods.

BY MR. RUF:

Q. Would you agree that it's more probable than not that Kimberly Richley's facet fracture occurred following the Chiropractic manipulation on 10-21-02?

A. It's very difficult to answer that question. There's no way really of knowing. I would say there's reasonable probability that it occurred some time following her visit with Dr. Reichenbach.

Q. Are you aware of any trauma to Kimberly Richley's cervical spine between 10-21 and 10-22-02, other than the Chiropractic manipulation?

MR. REGNIER: Objection. Go ahead, Doctor.

THE WITNESS: Well, I don't know that there was any trauma from the Chiropractic manipulation, and there's no record of any specific incident or event during that time period from the time she saw Dr. Reichenbach until the following morning when she awoke with symptoms.

The only thing I do know is that she has a seizure disorder and there is reasonable probability that something happened through the night, a seizure could have produced this kind of event; other than that, no, there's nothing else

that's disclosed.

BY MR. RUF:

Q. Are you aware of any medical literature that documents a facet fracture as the result of a seizure?

A. I do know fractures occur as a result of seizures, yes.

Q. I'm asking you are you aware of any specific medical literature that documents a facet fracture as a result of a seizure?

A. I couldn't give you any specific publication or text as I sit here, but I certainly do know that I've read information with regard to that in the past that seizures can cause significant spasm, muscle spasm, that could be intense enough to cause fracture.

Q. If you wanted to look for articles on facet fracture would using PubMed be a reasonable place to look?

A. Using what?

Q. PubMed or Medline?

A. Well, those are -- sure, those are sources for references for many medical conditions, yes.

Q. So if you were looking for documented

medical articles where there was a facet fracture from a seizure, PubMed or Medline would be a reasonable place to look?

A. I suppose it would be.

Q. And if there were articles out there, would you expect a search in Medline or PubMed to produce articles?

A. I would have no idea whether there are any articles that specifically address that issue.

Q. Are you aware of any Chiropractic or medical textbook that documents a facet fracture as a result of a seizure?

A. Not that I can recite to you at this point.

Q. Do you have any evidence that Kimberly Richly sustained a seizure on 10-21 or 10-22-02?

A. No.

Q. Do you know whether or not Kimberly Richley was being treated for epilepsy?

A. I don't know if she was actually under treatment at the time. Based on the medication she was taking, I don't believe she was on medication for a seizure disorder, although the Neurontin she was taking possibly could have been for her seizure disorder. I'm not really sure what the purpose of

the Neurontin was at the time, if it was for her chronic low back problem or for the epilepsy.

Q. So you don't know if she was on medication to control her seizures?

A. The Neurontin is an anti-seizure medication.

Q. Do you know how often Kimberly Richley had seizures in 2002?

A. No.

Q. Do you know the type of seizures she would have if she had a seizure?

A. I'm sorry, I don't -- I don't understand that question.

Q. Well, do you know what would happen with her body and her head if she had a seizure, can you describe for me what would happen?

A. If she had a Grand Mal seizure, it's fairly severe, significant spasms that occur, uncontrolled spasms, that can in fact hyperextend the neck and, you know, in a very forceful, violent fashion can cause tremors that can cause the body to move about and position themselves in ways that could be very dangerous for them. So that type of seizure is generally rather violent.

Q. Do you know if she had Grand Mal

seizures?
A. I don't know.
Q. You don't know the types of seizures she had?
A. No.
Q. You don't know whether if she had a seizure it exerted any kind of force on her neck, do you?
A. I wouldn't know that, no.
Q. Doctor, would you agree that Kimberly Richley's facet fracture extended to the transverse process?
A. Yes.
Q. Would you agree that it was a continuous fracture between the facet and the transverse process?
A. That's what the imaging studies implied, yes.
Q. So would you agree that it's more probable than not that the fracture started at the facet and continued over to the transverse process?
A. That seemed reasonable to me, yes.
Q. How many times have you been an expert in Chiropractic malpractice cases or medical malpractice cases?

A. How many times have I testified?
Q. How many times have you been an expert?
A. I don't know. I can't tell you the number. I don't know.
Q. Can you give me an estimate?
Well, why don't we start this way. How long have you been doing medical legal reviews?
A. For about fifteen years.
Q. And approximately how many cases have you done per year over those fifteen years?
A. Probably maybe five a year. That I've reviewed, not testified in.
Q. So around seventy-five cases or so would be a good approximation?
A. Probably.
Q. Have any of those cases involved a facet fracture?
A. No.
Q. Have any of them involved any type of cervical fracture?
A. Yes.
Q. What type of cervical fracture?
A. I've reviewed claims, one I know of, there may have been two, for an odontoid fracture, or what's called a os odontoidium. That's of the

second cervical vertebra.

Q. And what was the claim being made in that case? Was it due to the Chiropractic manipulation?

A. The --. Yeh, I'm sure that that was part of the claim. I really don't remember exactly what the claim was at the time -- or currently, but that was most likely part of the claim, which is probably why I was asked to review it.

Q. What was your opinion? Did you conclude that the fracture was due to the Chiropractic manipulation?

A. The only one I recall was a case with this os odontoidium, which is a -- another case of non-union basically of this odontoid process as it normally --. Normally it's osseously or firmly attached to the body of the second cervical vertebra. There are some people who have congenital non-unions of these processes where -- meaning they're born with -- where it is separated and it never fully forms or unionizes with the main part of the vertebra, and then with certain types of movements it could become dislodged, but even that usually requires significant force.

Q. So was your opinion that this was caused by the manipulation or not?

A. I really don't recall. I believe my opinion was that it was not caused by the manipulation, but I believe there were very significant other circumstances that were identified that could have caused the separation.

Q. How many times have you been an expert in a case where it is alleged that any type of fracture was caused by a Chiropractor?

A. Four or five times perhaps.

Q. Have you ever concluded that the fracture was caused by the Chiropractic manipulation?

A. There was one case involving the lumbar spine and pelvis where I made that conclusion, yes.

Q. What type of fracture was it?

A. It was a hip fracture, actually a femoral neck fracture.

Q. And what type of manipulation was used?

A. It was a lumbar spine called a side posture type manipulation and it was on an elderly individual, someone who, you know, definitely was osteoporotic, had bone weakening disease.

Q. Was it your opinion that the standard of care was met or was not met?

A. I don't really recall.

Q. Why did you conclude that the

manipulation caused the fracture?

A. Based on the --. I really don't recall all the details of this, this is just kind of, you know, just from remote memory, but I believe it was just because of all the other circumstances surrounding the case, and the onset of pain, the medical records subsequent to the treatment that was provided, but again, I really don't recall all the details of the case.

Q. Were you the Plaintiff's expert or defense expert?

A. I believe -- I was not the Plaintiff's expert. I believe I was asked to review the case as a defense expert and I do not believe that I was, you know, that -- I don't believe I was retained.

Q. I'm not sure I asked this question. Have you ever been an expert on a case involving any type of neck fracture, other than the odontoid process?

A. Not that I recall, no.

Q. Would you agree that Chiropractic manipulations are capable of fracturing bones in the human body if they're performed improperly?

A. Well, if a manipulation is performed improperly or too aggressively on the right person at the wrong time perhaps, yes, it could potentially

cause a fracture, but it is almost unheard of that it would cause a cervical spine fracture.

Q. And it's almost unheard of because it shouldn't happen, right?

A. Because it doesn't happen.

Q. It shouldn't happen, correct?

MR. REGNIER: Objection. Asked and answered.

BY MR. RUF:

Q. Doctor, would you agree that a cervical spine fracture should not happen?

A. Well, you asked me if it was unheard of because it shouldn't happen. It's unheard of because you don't hear of them because it doesn't happen, and yes, certainly it shouldn't happen.

Q. Have you ever studied the literature as to whether there's documentation of cervical spine fractures from Chiropractic manipulation?

A. I haven't personally done a literature review, but I have read this Rand study and based -- and they did a literature review, an extensive study, and concluded that the probability of fracture occurring is so small that it's barely -- barely warrants any kind of -- any kind of recommendation in terms of risk with regard to it.

Q. And do you agree there was an extensive literature review for the Mercy Guidelines?
A. Yes.
Q. Have you ever done an extensive literature review of complications from Chiropractic manipulation?
A. Not personally, no. I've simply read the reviews that are available.
Q. How many times have you been an expert for a Plaintiff or a patient in a Chiropractic malpractice case?
A. Again, I don't know the number, but a number of them; probably eight or ten maybe.
Q. And in those eight or ten cases, in how many of them did you conclude that the Chiropractor deviated from acceptable Chiropractic practice?
A. Any case that I accepted I, of those eight or ten, I would have rendered that opinion.
Q. So what percentage of the time have you been an expert for the Plaintiff versus expert for Defendant?
A. Probably ten to fifteen percent for the Plaintiff.
Q. What Plaintiffs' lawyers have you worked with? Do you recall any of their names?

A. No, I can't. I don't keep those in memory.
Q. When was the last time you were an expert for a Plaintiff in a Chiropractic malpractice case?
A. It might have been two or three years ago.
Q. What about before that?
A. It would have all been within the past fifteen or so years since I've been -- you know, since people have been sending me cases such as these.
Q. Did any of the cases involve a modified rotary break due to manipulation?
A. I don't recall.
Q. Have you ever rendered the opinion that a modified rotary break was performed improperly?
A. I don't recall if I have or not.
Q. Have you been an expert for Mr. Regnier in the past?
A. No.
Q. I'm sorry, what did you say?
A. No.
Q. How about the law firm of Eastman and Smith?
A. I don't believe so.

Q. Do you know where he got your name?
A. No.
Q. Have you been an expert in cases involving NCMIC, as the insurance company?
MR. REGNIER: Objection. Go ahead, Doctor.
THE WITNESS: I have, yes.
BY MR. RUF:
Q. And how many times have you done that?
MR. REGNIER: Continuing objection. Go ahead, Doctor.
THE WITNESS: That I don't know. I would say I review more cases for subscribers of Princeton Insurance Company than I do for NCMIC, but the numbers I couldn't tell you.
BY MR. RUF:
Q. Could you give me any kind of estimate?
A. I would say probably sixty to seventy percent of the cases I reviewed have been for subscribers of Princeton Insurance Company.
Q. Have you ever been an expert for the Plaintiff where NCMIC is the insurance company involved in the case?
A. I believe I have on one or two occasions.
Q. Do you remember what the cases were?

Could you tell me the issue or the facts in any of them?

A. No, I really couldn't. I believe one was a case of scoliosis in a child, but honestly I can't remember, and generally when I get these cases in I don't -- I usually don't even know which insurance company is involved until late in the case. It's not a question I ask.

Q. Do you know the city or State of any of those cases?

A. No.

Q. What are your charges for being an expert?

A. I charge $350 per hour for whatever time I, you know, I devote to these cases, whether it's for reading material or for deposition time or courtroom testimony.

Q. How much time have you spent on this case?

A. I don't know. Several hours.

Q. Do you know the amount of your total bill for this case?

A. No.

Q. Did you give all of your bills to Mr. Regnier?

A. I gave an initial statement I guess to them when I initially reviewed and prepared my report, but I have not provided an up-to-date bill -- an updated bill at this point.

Q. Okay.

MR. RUF: Mike, at this point I'd request copies of his bills.

MR. REGNIER: Sure.

BY MR. RUF:

Q. Could you tell me approximately how much money you make per year being an expert witness?

A. I really can't. It usually is about ten percent of my general income. Ninety percent of my income is from direct patient care from my practice.

Q. Well, approximately how much money do you make per year being an expert, if you do the math?

A. Oh, probably maybe 20,000, 30,000 maybe.

Q. Have you ever seen a patient with permanent residual problems as a result of a neck fracture?

A. I can't recall really specifically if it was specifically as a result of a neck fracture alone. I've certainly seen patients who have had neck fractures, but oftentimes the residual problems are not the result of the fracture at all, it's the

result of other underlying problems that usually, you know, relate to degenerative changes that might occur in the neck.

Q. Have you seen patients that have had permanent conditions as a result of damage to the nerves in the cervical spine?

A. Sure.

Q. And has it been your experience that when there's an injury involving damage to the nerve in the cervical spine that generally the healing occurs within a year of the injury?

A. Generally when there's nerve injury, nerve damage, it could take nine months to a year or so before a patient realizes the -- maximally improves as a result of that injury.

Q. Has it been your experience that if conditions persist beyond a year, that those conditions are permanent?

A. They're likely to be permanent, although they can still improve some over more time. There's likely to be some degree of permanency to it, although the way a patient feels within a year after an injury, if you give them another year or two, they certainly could be considerably better than they were after a year in terms of their functional

capabilities and their level of pain.

Q. Do you know what Kimberly Richley's current condition is?

A. Not specifically, no.

Q. Would you agree that it's more probable than not that her current condition is permanent?

A. I really couldn't address those issues, you know, without seeing either a report of a Functional Capacity Evaluation or a report from someone who has actually evaluated her from a disability perspective or by examining her myself, but from the records I've reviewed so far I really couldn't give a good answer to that question.

Q. Do you use a written consent in your practice?

A. No.

Q. I'm sorry, no?

A. No.

Q. Do you ever keep personal notes on patients outside of the patient's file?

A. Generally not. Occasionally, depending on various circumstances, we might, you know, use a sticky note on a patient's chart and then make an entry later, but I generally don't keep a separate file on a patient.

Q. That would be highly unusual to do that?
A. I don't know that it's highly unusual. I would say it's not typical.
Q. Would it be highly unusual in your practice to do that?
A. I'm sorry, go ahead, say that again.
Q. It would be highly unusual in your practice to keep notes on a patient outside of the patient's file?
A. Yes, I generally would not do that.
Q. And under what circumstances would you do that?
A. I don't think that I would.
Q. You went to the same Chiropractic school as Dr. Reichenbach, correct?
A. I don't recall what school he went to.
Q. What portion of the videotape of Dr. Reichenbach did you review?
A. It's been a while since I reviewed that videotape, but I believe it was a partial videotape of his deposition.
Q. What part did you review? Can you describe it for me?
A. To be honest with you, I'd have to review it again to be able to answer specific questions on

that videotape.

Q. Was there anything of significance in the tape that you reviewed to you?

A. You'd have to ask me specific questions. I really can't recall anything specific.

Q. Well, tell me what you recall about the tape you reviewed?

A. I believe it was -- there was an aspect of it where he was describing the type of manipulation he performed, and as of right now that's about all I remember.

Q. Are you aware of Dr. Reichenbach's doing any other cervical manipulation during any of his office visits, other than a modified rotary break?

A. During any of his prior office visits prior to 10-17?

Q. No, from 10-17 through 10-22-02.

A. Oh.

Q. Is there a way you could demonstrate how a modified rotary break is performed for the video --

MR. REGNIER: Mark, did you want him to answer your original question? He's looking at the record.

MR. RUF: I'm sorry, I thought he

gave an answer.

MR. REGNIER: No.

THE WITNESS: No.

As far as the cervical spine, he only identifies the modified rotary break.

BY MR. RUF:

Q. So you know of no other cervical manipulation that was performed, other than a modified rotary break, between 10-17-02 and 10-22-02?

A. That's correct.

Q. Is there a way you could demonstrate for the camera how a modified rotary break is performed?

A. There would be --. I would really need to perform that on somebody.

MR. RUF: Do you want to volunteer, Mike?

MR. REGNIER: No.

BY MR. RUF:

Q. Do you have any kind of skull model there or vertebral model?

A. I do, but it really doesn't do it justice. If you want, I can bring a spine up and make some demonstration.

Q. Well, could you show what hand motions

you use in performing a modified rotary break to the cervical spine?

A. The movement, if the patient is in a supine position, would be to cradle the head, distract it and side bend it, and then if the patient can tolerate that position, then an impulse is delivered from that position.

Q. Okay. Did you just demonstrate that on camera?

A. Yes.

Q. Okay, thank you, Doctor.

Would you agree you have no expertise in epilepsy?

A. Yes.

Q. And you have no expertise in seizures?

A. I'm certainly not an expert in those -- in that area, yes.

Q. Have you seen Dr. Mann's report? At the top of this report it says University Suburban Health Center. It's a letter of September 10th, 2004.

A. I don't believe I saw that report.

No, I have not.

Q. I'm just looking over my notes, Doctor.

What correspondence have you received

from Mr. Regnier?
A. When?
Q. I'm sorry?
A. When?
Q. Throughout this whole process?
A. What records have I reviewed?
Q. What correspondence have you received from him?
MR. REGNIER: What correspondence, he asked.
THE WITNESS: Letters that he may have written to me?
BY MR. RUF:
Q. Sure. Have you also received any E-mails?
A. No, no E-mails.
Q. Okay.
MR. RUF: I'd ask the Court Reporter to mark all the letters as exhibits to this deposition.
BY MR. RUF:
Q. Can you pull those letters aside so they can be marked as exhibits, Doctor?
A. Sure.
Q. Have you discarded any letters or

correspondence you received from Mr. Regnier?
A. I don't believe I have.
Q. I'm sorry?
A. I don't believe so, no.
Q. What about your report, did you issue any kind of draft to Mr. Regnier before the final?
A. I don't believe so.
Q. Did you discuss your findings with Mr. Regnier before you issued your report?
A. Yes, I did.
Q. Did he ask you to include anything in your report?
A. Not that I recall.
Q. Have you had any meetings with Mr. Regnier?
A. Just this morning, prior to --
Q. How long was your meeting?
A. About forty-five minutes.
Q. What did you discuss?
A. Discussed aspects of the case.
Q. Did you discuss seizure as a possible cause of the fracture?
A. That came up briefly.
Q. You did not put seizure as a possible cause of the fracture in your report, correct?

A. Correct.
Q. First time you talked about seizure was at this deposition today, correct?
A. No, I've discussed it in the past. You know, I knew she had a seizure disorder and that was something that was always in my mind as a possibility. I simply basically when I drafted my report I just included that under the I guess the general aspect of undisclosed events.
Q. But at the time of your report you put the most plausible scenarios that you thought in the report, correct?
A. Yes.
Q. Have you reviewed anything else that's not listed in your report?
A. No.
Q. Have you conducted any research for this case?
A. Reviewed a couple of textbooks with regard to facet fracture.
Q. Okay. What textbooks did you review?
A. Reviewed the Essentials of Skeletal Radiology by Yochum and Rowe, and Whiplash Acceleration/Deceleration Injuries by Foreman and Kroft.

Q. And what did you review in there?
A. Just looked up their -- any information that they had with regard to the type of fracture that Ms. Richley was ultimately diagnosed with.
Q. Would you agree that facet fractures are typically caused by flexion and rotation?
A. No, I wouldn't agree with that.
Q. Do either of those textbooks state that facet fractures are typically caused by flexion and rotation?
A. No.
Q. Would you agree that Kim Richley's facet fracture was probably caused by rotation?
A. No, I couldn't agree to that. I wouldn't know, you know, what mechanism caused her fracture.
Q. You don't have an opinion on that?
A. No. But pure rotation alone is not likely to fracture a facet joint.
Q. What about flexion plus rotation?
A. That's also a mechanism that would not likely fracture a facet joint. That actually takes pressure off the facet joint.
Q. Can you state any benefit that Kim Richley received from the rotary manipulation -- I'm sorry -- the modified rotary break of her cervical

spine?

A. Any benefit that she received?

Q. Yes.

A. On 10-19-02, which is the day after the first cervical spine adjustment, Dr. Reichenbach indicates that she was improved.

Q. Do you know how she was improved?

A. He doesn't really get into detail on that, no.

Q. Any other benefit you're aware of?

A. Not anything specific, no.

Q. In your opinion if the patient is not receiving benefit from cervical manipulation, should those manipulations be discontinued?

A. Well, in time, but, you know, it has to be over a reasonable time period.

Generally with manipulative therapy we don't always expect immediate improvement. Many times it requires a series of treatments to realize some improvement, but generally within a two to four week period with fairly regular manipulative sessions, if there's little to no improvement after that time frame, then either the method should be changed or it should be stopped and further investigation should be ensued.

Q. Do you know how Mr. Regnier found you as an expert?
A. No, I don't.
Q. Do you advertise at all for your expert services?
A. No, I don't.
Q. Do you testify for your own patients in personal injury cases?
A. I believe I've only had to do that once in my career.
Q. Do you know whether or not you testified that the patient's condition was permanent?
A. I don't recall. It was many years ago.
Q. Do you ever obtain police reports to try and get patients?
A. No.
Q. What type of Chiropractic practice do you have?
A. My practice is I treat primarily musculoskeletal conditions with non-surgical, non-drug techniques, mostly back and neck complaints, but I also treat other orthopedic type conditions involving the shoulders, elbows, wrists, hands and lower extremity conditions as well, but probably eighty percent of my practice revolves

around low back and mid-back and neck complaints.

Currently or for probably the last ten or fifteen years about seventy percent of any new patients that come into my practice are medical referrals referred from some form of medical doctor, either primary care physicians or some sort of specialist who specializes in neuromusculoskeletal conditions.

Q. So physician referrals to your practice are an important part of your practice?

A. That's been a fairly substantial part of my practice for a fair number of years now, yes.

Q. If a patient has any type of fracture, is that something you treat or do you refer the patient to a medical doctor for that?

A. If someone has an acute fracture, depending on the nature of the fracture, I will refer them to generally an orthopedic surgeon for that.

Q. Do you ever refer patients to neurosurgeons?

A. Yes.

Q. Approximately how many patients do you have in your practice?

A. How many total patients over twenty-eight

years or what kind of number are you looking for?

Q. Right now, per year, approximately how many patients do you see?

A. How many patients do I see per year? My practice sees about two-hundred-fifty to three hundred patient visits per week, so you can calculate that out.

Q. What hours do you have during the week?

A. My office is open from 8:30 a.m. until 7:30 p.m. Monday through Friday. I have an associate doctor who works part of those hours.

Q. How many patients do you see per day?

A. Personally myself? On a full day where -- if I'm seeing patients in a full day, which is usually about a ten hour day, I will see anywhere between fifty and seventy.

Q. Has your license ever been subject to disciplinary action?

A. No.

Q. Have you ever been arrested?

A. No.

Q. Have you ever been investigated professionally?

A. No.

MR. RUF: Okay, Doctor, that's all I

have. Thank you.

THE WITNESS: You're welcome.

MR. REGNIER: Doctor, you have the right to review the deposition for typographical errors or you can waive that right, it is up to you.

THE WITNESS: Okay.

MR. REGNIER: What would you like to do? You have to put it on the record.

THE WITNESS: I would like to review it.

MR. REGNIER: Okay.

THE VIDEOGRAPHER: This now concludes the videotape deposition of Dr. Gary Tarola. The time is 12:04 p.m.)

(Deposition concluded.)

* * *

10-11, 2004

I hereby certify that the evidence and proceedings are contained fully and accurately in the notes taken by me of the testimony of the within witness who was duly sworn by me, and that this is a correct transcript of the same.

Daniel R. Stout
Certified Court Reporter
Notary Public

E R R A T A

Page-Line:	From:	To:

_____, 2004

I hereby certify that I have read the foregoing transcript of my testimony taken at the within deposition and find it to be true and correct.

_____

GARY A. TAROLA, D.C.
Deponent

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October 19, 2004

Mark Ruf, Esq.
Hoyt Block
700 West St. Clair Avenue
Suite 300
Cleveland, OH 44113

RE: Richley vs. Reichenbach Family Chiropratic

Dear Mr. Ruf:

Enclosed please find the completed signature and errata pages as well as the original transcript of the deposition of Gary Tarola taken on September 29, 2004 in the above case.

Thank you for your cooperation. If you have any questions, please do not hesitate to contact me.

Very truly yours,

Kim Jones

Enclosure

cc Michael Regnier, Esq.

10/14, 2004

I hereby certify that I have read the foregoing transcript of my testimony taken at the within deposition and find it to be true and correct, except for the corrections noted on the errata page.

GARY A. TAROLA, D.C.
Deponent

E R R A T A

Page-Line:	From:	To:
24 - 18	wouldn't	would
~~49 - 1~~	~~T 6 7~~	~~C 6 7~~
59 - 16	PubMEd	I did not know what he was saying - I am unaware of PubMed.

CHIROPRACTIC ASSOCIATES
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GARY A. TAROLA, D.C., FACO
JOSEPH J. SMITH, D.C., FACO

FELLOWS - ACADEMY OF
CHIROPRACTIC ORTHOPEDICS

July 29, 2004

Michael W. Regnier, Esq.
Eastman & Smith, Ltd.
P.O. Box 10032
Toledo, OH 43699-0032

Re: Kimberly Richley vs. Reichenbach Family Chiropractic Professional, et. al.

Dear Mr. Regnier:

This is a follow-up to my report of July 17, 2004 to address the issue of informed consent regarding cervical spine fractures occurring as a result of cervical spine manipulation. In the absence of significant red flags, such as symptoms and signs of infection and cancer, significant recent trauma or moderate to severe bone weakening disorders, the risk of cervical spine fracture with chiropractic manipulative techniques is so remote that a risk estimate has never been established, nor has it ever been a focus of investigation. I am unaware of any case reports in the literature alleging that such a fracture occurred as a result of chiropractic cervical manipulation. And after 28 years of practice and almost 20 years of peer review and medical legal consulting this is the first such case I have seen.

It is my opinion therefore that a cervical spine fracture of this nature is not a material risk, and therefore informed consent, written or verbal, was not required. In this case, Ms. Richley was under treatment with manipulative therapy for her lower back and was aware of the nature of the treatment. Dr. Reichenbach discussed her cervical spine condition and informed her of his recommendation to perform manipulation to her cervical spine. Therefore, informed consent was implied.

If you have any additional questions please contact me personally.

Sincerely,

Gary A. Tarola, D.C., FACO

GAT/mkb