Doc. 435

STATE OF OHIO)
) SS: IN THE COURT OF COMMON PLEAS
MAHONING COUNTY)

CASE NO. 86 CV 1419

SHARON K. FELLOWS

Plaintiff

VS.

JACK A. BRUNO, JR.

Defendant

DEPOSITION

OF

DR. E. HERBERT THOMPSON

DEPOSITION taken before me, Lisa C. Nagy-Baker, a Notary Public within and for the State of Ohio on the 12th Day of October, A.D., 1988, pursuant to agreement and at the time and place therein specified, to be used pursuant to the Rules of Civil Procedure or by agreement of counsel in the aforesaid cause of action, pending in the Court of Common Pleas, within and for the County of Mahoning, State of Ohio.

APPEARANCES

Atty. Alan J. Matavich
On Behalf of Plaintiff

Atty. Marshall D. Fuck
On Behalf of Defendant

STIPULATIONS

It is stipulated and agreed by and between counsel for the parties hereto that this deposition may be taken at this time, 9:30 a.m., October 12, 1988, in the office of Dr. E. Herbert Thompson, 75 Arch Street, Akron, Ohio.

It is further stipulated and agreed by and between counsel that the deposition may be taken in shorthand by Lisa C. Nagy-Baker, a Notary Public within and for the State of Ohio, and may be by her transcribed with the use of computer-assisted transcription; that the witness' signature to the finished transcript of his deposition may be and is hereby waived under agreement of the parties; and that the deposition may be thereupon used on behalf of the parties in the aforesaid cause of action as fully and to the same extent as if written in the presence of the witness and subscribed by the witness in the presence of the Notary Public.

WHEREUPON,

DR. E. HERBERT THOMPSON,

of lawful age, being by me first duly sworn to testify the truth, the whole truth, and nothing but the truth, as hereinafter certified, deposes and says as follows:

DIRECT EXAMINATION:

By Mr. Buck

(Whereupon Defendant's Exhibits A and B were marked.)

Q Dr. Thompson, as you know I represent Jack Bruno in a lawsuit that's been filed by Sharon Fellows in the Mahoning County Common Pleas Court. I'd like to ask you some questions about your examination of Miss Fellows, and if at any time I ask a question that you don't completely understand, please stop me and ask me to explain or rephrase the question.

For the record, would you please tell the Court and jury your full name and your present business address?

A My name is Edward Herbert Thompson; my business address is 75 Arch Street, Suite 501, Akron, Ohio.

Q What is your profession?

A I'm an orthopedic surgeon.

Q Doctor, would you tell us what your educational background is?

A I attended the University of Kentucky, graduating with a degree in chemistry. I then attended and graduated from the West Virginia University School of Medicine. I served a one-year internship at Akron City and Akron Children's Hospital and following that a four-year residency training program in orthopedic surgery at the same hospitals.

Q Would you explain to the jury what a residency training program is?

A It's a training program for specialization in the field of medicine.

Q And what was the area of specialization that you studied?

A Orthopedic surgery.

Q Would you explain to the jury what orthopedic surgery encompasses?

A It's basically the treatment of diseases of and surgery of the musculoskeletal system; that's the bones, joints, muscles, tendons, ligaments.

Q Following completion of your four-year residency program, what was the next phase of your career?

A I served two years in the U.S. Army practicing as an orthopedic surgeon. And after that, I entered private practice in Akron, Ohio, and have been there since.

Q Doctor, are you licensed to practice medicine in the State of Ohio?
A I am.
Q Are you Board Certified?
A I am.
Q And would you explain to the jury what Board Certification is?
A After having successfully completed a residency training program, you take a certifying examination given by the American Board of Orthopedic Surgery which consists of both a written and oral examination.
Q And, Doctor, are you on the staff of any hospitals?
A I am.
Q And would you tell us what hospitals you have privileges at?
A Akron City Hospital, Akron General Medical Center, and Akron Children's Hospital.
Q Do you have any sports medicine participation?
A I do.
Q What areas are those?
A I, along with one of my partners, Dr. George Mallo, am team physician for all varsity sports at the University of Akron. I'm also head of the sports division of

Akron Hospital.

Q Doctor, in your private practice and in the area that you practice in sports medicine, do you see a lot of soft tissue injury?

A I do.

Q Do you have considerable experience in treating those particular types of injuries?

A I do.

Q Doctor, are you on the staff of any medical schools?

A I am.

Q Would you tell the jury what your affiliations are?

A I am an assistant Professor of Orthopedics at the Northeastern Ohio University College of Medicine.

Q Doctor, did you have an opportunity to examine Sharon Fellows?

A I did.

Q Were you attempting to become her treating physician?

A I was not.

Q And would you explain to the jury the purpose of your examination?

A It was for the purpose of performing an independent medical evaluation of Sharon Fellows.

Q And at whose request did you perform that examination?

A Yours.

Q Did you take a history from Miss Fellows?

A I did.

Q Would you tell the jury what the history consisted of?

A I saw Sharon Fellows and examined her on the 18th of July of 1988. At that time she reported that on the 29th of August of 19 --

MR. MATAVICH: I'm going to object for the record. If the doctor is using his report to refresh his recollection, I don't think proper foundation has been laid for him to just read from the report.

Q Doctor, you can use whatever notes you have that you took at the time of your report to help refresh your recollection, and please feel free to do so. He's noted his objection for the record.

A At the time of my examination, she reported on 29 August, 1984, she was driving a car when a pickup truck ran a stop sign and struck her car broadside on the driver's side. Said the impact spun her car approximately 180 degrees. She noticed immediately that her whole body was numb, and she was very upset and nervous. She was taken by ambulance to Salem City Hospital emergency room in Salem, Ohio, where she

was examined. X-rays were made of her neck.

She said that she had reported at that time that she had had back surgery on the 8th of November, 1983. They told her that her neck was reversed, and she had muscle spasms. They advised her to go home and relax and take aspirin. She had been under the care of Dr. Brocker for her back problem and was seeing him at the hospital in Salem. She saw him again in September and related to him about the accident. Said she started noticing a problem with her low back approximately one to two weeks after the accident. She had also noticed a tightness in her right leg. She said that Dr. Brocker really laughed about her accident and said she did not return to see him any more. She came under the care of of Dr. Sansone, a chiropractor, in October 1984; was under his care until December 1984.

Said she saw him approximately three times a week for chiropractic treatments and noticed no improvement.

In January of 1985, she came under the care of Dr. Pannozzo, a physiatrist in Youngstown, Ohio, remained under his care until August of 1985. She saw him approximately twice a week in this period of time. He initially made X-rays; told her she had damage to the ligaments in her neck with inflammation. Treated her with physical therapy and injections in her neck and back.

She did notice improvement in her symptoms but still had

problems with tightness in the entire right side of her body. She has not seen anyone since or had any forms of treatment since August of 1985. She feels that her symptoms have gotten worse since August of 1985.

At the time of my examination she complained that she had difficulty with a soreness in the right posterior aspect of her neck which was present constantly. That would be the back side of her neck on the right side. She said that nothing helped this, including rest. She also had a pain in this region of her neck which she said was present constantly. When asked to describe this pain she would only describe it as a funny-type feeling. In other words, I asked her if it was a sharp, dull, aching, cramping kind of pain; she would just say it was a funny kind of feeling. She also complained of tenderness in that area and said that turning her head to either side produced pain in the neck but it was worse when she turned it to the left. She said any exercises caused an increase in the pain, and she had noticed a cracking sensation on certain movements of her neck. She complained of a tightness and pain in the right arm which she described as tingling of the entire arm and said it constantly felt that way. Activity increased it, as did writing.

She also felt that she had a weakness in the arm and was unable to hold things. She said electromyograms were done by Dr. Pannozzo, but she doesn't think they showed any

abnormalities but wasn't sure.

A She complained of a tightness down the entire side of her right back and said the entire right side; "feels like there is 50 pounds of weight on her right side and 10 pounds on the left side." Said that this was always present and did not subside. She complained of a tightness in the back of her right leg and a tingling of the entire leg. She also complained that her back cracked with movement. She says her leg pain was completely resolved following her initial back surgery and did not have any problems with the back or leg prior to the accident. She was on exercises for her neck and back after the accident which were prescribed both by Dr. Sansone and Dr. Pannozzo. She said it was hard for her to do her daily activities, and she got very tired at the end of the day.

Q Doctor, after obtaining the history from Miss Fellows, did you perform a physical examination?

A I did.

Q And would you explain to the jury how the physical examination was performed and what your findings were?

A First of all, I examined her cervical spine, her neck area. I asked her to move it through the normal range of motion, and I found that she had a full range of motion except she had a very minimal loss of extension: that

is tilting the head back, straight back. She had no evidence of any parvertebral muscle spasm or deformity present; that is on palpating or feeling the muscles long her neck in the back there was no spasm noted at the time of my. Examination on observing her, there was no tilting of the neck to one side or the other or any deformity of the neck that I could detect.

Q Now, Doctor, in the history, you mentioned that she complained of some cracking when she would move her neck. In your physical examination, were you able to find any such cracking?

A No, but really cracking in the neck has no real significance. Probably more people than not that you examine have some, certainly if they're past the age of 30, will have some cracking in their neck; and this really means nothing.

Q Please continue with your examination.

A She had a full range of motion of all joints of her upper extremities; that is her shoulders, elbows, wrists, hands, fingers, all moved fully without any limitation. Her muscle testing or motor exam revealed that she had an almost cogwheel type weakness of the biceps, triceps and shoulder abductors of both arms, but not the internal rotators or external rotators of her shoulders. Okay? What I mean by this is when I was asking her to resist my movements, she would give way in just a jerky-type motion

which we call a cogwheel resistance. And this included the biceps, or the muscles that flex the elbow or bend the elbow, the triceps, muscles that straighten the elbow out, and the shoulder abductors, the ones that raise the shoulder up to the side. The muscles which are really part of the same muscles that turn the shoulders in and out, she did not have this.

Q How can you explain that then, Doctor?

A It is very difficult to explain. A cogwheel type giving way is generally associated with more or less a hysterical-type reaction. It's not a valid -- people who have true muscle weakness do not give way in a jerky fashion. They give way in general resisting, just a gradual fashion. It's not a jerky-type thing. If you had significant weakness of the shoulder abductors, you would also expect, most likely, to have some in either the internal or external rotators of the shoulder also. So it really does not fit into a well explainable pattern.

Q Does that type of resistance, or can that type of resistance be explained on a voluntary basis?

A It could, yes, very well.

Q When you're talking about testing her resistance, Doctor, are you talking about holding her forearms parallel to the floor and then doing a curling motion up toward the shoulder?

A What you do is you bend, if you're checking

the elbow flexors or biceps, you have them pull their arms up in tight and then you pull against them and see how, you know, if there is just -- if there is a difference between the two sides or if there is more than you would expect, weakness; it's usually just a gradual thing. But when you pull against in this fashion, they would give way in a jerky-type fashion.

Q Okay. Did you notice any loss of strength or weakness in those muscles?

A Well, this, you know, would be considered a weakness but not an explainable weakness.

Q Okay. Please continue.

A Measurement of circumference of both the upper arm and the forearm at equal distance from the elbow joint revealed that the right arm was approximately one quarter-inch larger than the left in both the upper arm and forearm area. She is right-handed and so this would be a normal finding in the dominant arm with the dominant arm being slightly larger than the nondominant arm. There was certainly no evidence of any muscular atrophy or muscle wasting of the arm.

Q Okay.

A The deep tendon reflexes were equal and reactive, checking her reflexes in her arm. Sensory exam revealed that she complained of decreased sensation to pinprick over the entire right side of her body, including the

right side of her face.

Q Doctor, is there any significance with regard to her complaints of loss of sensation over the entire right side of her body, including the face?

A There is.

Q And could you explain to the jury why that is significant?

A Okay. There is really no organic lesion which will explain this.

Q What do you mean by a lesion?

A Okay. In an abnormality that will explain why the whole half of the body would be numb or have a decreased sensation, the fact of the matter is, the true anatomy, if you had a lesion high enough up in the brain which would cause this sort of thing, such as like having a stroke, it doesn't involve the same side. The face is the opposite side from the body that's involved. So like when people have a stroke, they will have problems with facial paralysis on one side and paralysis of the arm and leg on the other side of the body. So there is no organic -- in other words, this can't be explained on an organic anatomical basis.

Q The nerve patterns in the body would not permit the type of injury where it would be the face and the same side of the body?

A No.

Q Please continue, then, Doctor. Well, let me ask one more question. Doctor, do you have any way of explaining why someone would have complaints of numbness on the same side of the face as they would have on the body on the same side as the face?

A Well, it's either one of two things. It's either a hysterical reaction, conversion hysteria, or it's just that they're not being honest with their bodies.

Q Okay. Please continue.

A Examination of her dorsal and lumbosacral spines revealed no obvious deformities. There was a two and a half centimeter well-healed surgical scar over the right side of the low back area. She had a moderate limitation of motion in all directions of her low back area with flexion, forward bending or flexion, with her hands only coming to the level of her knees. In other words, when I asked her to bend forward like she was going to touch her toes, instead of being able to come down around her ankles or feet, she could only bend to the level of her knee.

Q Doctor, is this something that is controlled solely by the patient?

A Yes.

Q You don't force her to try and bend?

A No.

Q So she bends until she tells you she can't

go any farther?

A Yes.

Q Okay.

A I could not detect any parvertebral muscle spasm in her dorsal and lumbosacral spine area; that is like I explained in the neck on feeling the muscles at the time of my examination, I did not detect any spasm. Pelvis was level. Her deep tendon reflexes in the lower extremities were equal and reactive. There is no gross motor weakness there. She again complained of decreased sensation of pinprick over the entire right leg. Straight leg raising exam was negative.

Q Now, Doctor, would you explain to the jury the significance or what you're looking for when you find the deep tendon reflexes were equal and reactive?

A You're looking to see if there is an increase or decrease of a reflex and what you're trying to do is see if you can find any evidence of a nerve irritation or nerve weakness or paralysis in the leg that would give you an abnormality such as this.

Q And do you compare the reflexes from one leg with the other?

A Oh, yes.

Q And in her case, were there any abnormalities?

A No.

Q What is the purpose of the straight leg raising exam?

A That's an exam with the knee straight where I bend the hip to 90 degrees, and that puts the sciatic nerve on stretch; so if you have any element of active sciatic nerve irritation, you would expect to get a reproduction of pain radiating down the sciatic nerve when you do this.

Q Doctor, were you able to make any objective findings that would explain her claim of decreased sensation in the right leg?

A No.

Q Does that conclude your examination, Doctor?

A Yes.

Q Did you take any X-rays?

A I did.

Q Would you explain to the jury what X-rays were taken?

A I took X-rays of the neck or cervical spine area, which included lateral flexing and extending; that is bending forward and back. Oblique is between front to back and the side. I did not notice any significant abnormalities on these X-rays.

Q Doctor, did you have an opportunity to examine any other X-rays besides the ones taken in your office?

A I did.

Q What X-rays did you have an opportunity to examine?

A I had X-rays from the Neurologic Diagnostic Clinic dated November the 7th, 1983, which were lumbosacral spine films. I had films from a discogram. There were numerous X-rays from Columbus Community Hospital in Salem, and these consisted of cervical spine films on the first of November, 1983; X-rays of the lumbosacral spine, I think, which were the same date. There was two lateral views of the lumbar spine dated 19 January 1984; a full series of lumbosacral spine films dated 3 April, 1984; lumbosacral spine films from 5 June 1984; X-rays of the cervical spine dated 29 August, 1984; and these would have been the one made, I believe, on the day of her accident. And then four X-rays from Dr. Pannozzo's office, one in 1983 and the others in January of 1985.

Q Doctor, you were talking about the X-ray you made of the cervical spine?

A Yes.

Q And I believe we've marked that as Defendant's Exhibit B; is that correct?

A Yes.

Q Could you identify that document and explain to the jury what it is?

A Okay. This is a lateral view of the

cervical spine made on the 18th of July, 1988 in my office.

Q Tell us what your findings are from reviewing that document?

A This is a, really there is no abnormalities noted on this film. Now, there is kind of a straightening of the cervical spine which some people would tend to interpret as showing muscle spasm or something, but that is not anything that you can determine from an X-ray because it's been well documented in some of the radiologic literature and orthopedic literature that just really tilting the chin will cause the normal curve in the cervical spine to straighten out.

Q Doctor, did you have a chance to compare the X-ray of the cervical spine taken in your office with an X-ray taken 10 November, 1983, prior to the automobile accident?

A I did.

Q Okay. And could you tell us what your findings were when you compared those two X-rays?

A These were very similar, other than there was a little more flexion in the upper cervical spine on the film made in my office and this was because of the tilting. You can see that her chin's down on the X-ray, and it's purely due to the position of the chin.

Q From the time of the 1983 X-ray until the X-ray taken in your office in 1988, were there any noted changes in her cervical spine?

A No.

Q Doctor, please go back and explain to us then what your other X-ray findings were?

A Okay. I made X-rays of the upper back or dorsal spine, an AP and lateral, or front and side view; these did not show any abnormalities. An upright X-ray or standing X-ray was made from front to back of the dorsal lumbar spine or the upper and lower spine. This showed a very minimal thoracolumbar scoliosis, and this means a side-to-side curvature of the spine.

Q What causes that, Doctor?

A It's a condition that is usually something that develops in adolescence as you grow.

Q Okay. Does that cause any type of problem for the patient?

A Not likely unless it's a severe curve.

Q Did she have a severe curve?

A No, she had a very minimal curve. Her X-rays of the lumbosacral spine, this did show some narrowing of the L5-S1 interspace or the disk space between the fifth lumbar vertebra and the first sacral segment. There was evidence of a couple droplets of myelographic dye being present. This was the liquid placed to do the myelogram prior to her back surgery, and the impression would be mild degenerative disk disease at L5-S1.

Q Doctor, do you know what the cause of the degenerative disk disease was in the low back?

A Well, she had had a ruptured disk and had had surgery for it in the past, and certainly this is part of the process of the disk, you know, being, part of it being taken out and the collapse of the disk.

Q Would that explain the narrowing of the interspace?

A Yes.

Q And that back surgery was prior to the automobile accident in 1985?

A Yes.

Q Doctor, in addition to the examination, did you also have records of the plaintiff's prior medical treatment to review?

A I did.

Q Would you explain to the jury what records you had available?

A Okay. First of all there was a radiology report from the Salem Community Hospital dated 29 August, 1984, X-ray of the cervical spine. The interpretation was reversal of the curvature most likely secondary to muscle spasm, negative for fracture. As I stated before, that's really not a conclusion you can draw off an X-ray. That's been well documented in the literature. There was also a

report from 10 January 1984 of the lumbar spine film with flexion extension; and it said there was a little motion in the lower lumbar vertebra. There was a chest X-ray in July of 1983 which was reported normal. I had some records which I believe were from Dr. Sansone's treatment which were really not legible. There was an Emergency outpatient report from Northern Columbiana Community Hospital which I believe is the date of the accident. Said that the patient was in an automobile accident short time ago. Denies any injuries, although her right leg was tingling. That she'd had back surgery more than two years ago. Denied lack of consciousness or hitting head or body. Was moving all extremities, and I believe that this was a nurse's triage history; and I could not read the remainder of this report.

Q Doctor, is there any significance to you as a treating physician where the patient relates in the emergency room that she didn't strike her head or any part of her body in the accident and that she had no injury?

A Well, it certainly is -- what she was relating had happened to her at the time has something to do with the amount of trauma from the accident.

Q Any other records you have available?

A There was a copy of the same cervical spine report that we had before. There was a report of a CT scan of the lumbosacral spine dated October 19, 1984, which apparently

was orderedby Dr. Sansone; and this was reported as showing a laminectomy defect at L5-S1 on the right side. There was no evidence of any definite disk herniation seen from the L3-4 level to the L5-S1 level in the areas that were scanned, and no other abnormalities were reported on this CT scan.

Q Would you explain to the jury what a CT scan is?

A Well, what it really stands for, the CT is computerized tomography. What tomograms originally were were just an X-ray that makes a single cut or like a slice through the body, and it just takes this one slice and looks at that area. This with the CT scan; there are multiple slices taken and the computer reconstructs these. So it's like you can cut at each level or what interval you've taken these, you can cut the body just in, if you're looking at the lumbar spine or abdomen or what, you can just slice the body in half at that area and look right down on that; and this is what this does. It shows soft tissues and things much better than a routine X-ray does. So whereas with a routine X-ray you can just basically see bone and not a whole lot else, this shows the disk and other soft tissue planes and things that you can see.

Q Now, is that a state-of-the art type of technology for noninvasive observation of the body parts?

A It's one of two major state of the arts.

Q Now, you talked about a laminectomy defect; would that be surgery that she had on her low back prior to the accident?

A Yes, that would be the bone that had been resected from the back of her spine in order to take the disk out.

Q And, Doctor, if there were any damage to the facets of the vertebrae, would they show up on the CT scan?

A Yes, a CT scan visualizes the facets very well.

Q Would you tell the jury what facets are?

A They're the small joints in the back of the spine. There is one on each side at each level.

Q Is that the joints between the different, the vertebrae as they sit on top of each other?

A In the back?

Q Yes.

A Yes.

Q Did the CT scan find any damage at all to the facets?

A Let me review this to make absolutely sure. My recollection is they did not report any. No, there is no mention of this.

Q Any other records that you were able to review, Doctor?

A Okay. There was an Emergency outpatient report from Salem Community Hospital which was dated 9/1/84, and I think this is where Dr. Brocker saw her for a checkup, and it says has intermittent tightness in the back, return on 9/27/84; said patient called, she was having tingling sensation on left side, top of the leg; said RJB advised. I don't know, maybe that refers to Dr. Brocker; I'm not sure. Said that it was most likely the muscle around the disk still healing.

Another report from 7/10/84 said to see Dr. Brocker for checkup, intermittent left calf spasm, otherwise doing well. And 3/13/84, return two months, doing well. There were other reports that really didn't have anything to do with the current problem.

Q Doctor, the types of complaints that were presented in those records, were they consistent with the healing process following a laminectomy?

A Most likely, that or persistent problems from a laminectomy. It's not unusual to still have back and leg problems after a laminectomy.

Q Okay.

A Those are reports from her back surgery. Dr. Brocker's report. X-ray reports from Columbiana Community Hospital. This was in November 1983 of a cervical spinal flexion-extension; lumbar spinal flexion-extension was

reported normal. Then there is one on the 7th of November, 1983 of a lumbar spine which says there is degenerating spondylotic disk disease at multiple interspaces to minimal extent. Scoliosis of the lumbar spine. There was apophyseal sclerosis; that's the same thing as facet films described on these films bilaterally at 4-5, decreasing as it progresses cephalically. That means toward the head.

Q What does that mean?

A That means the radiologist at that point had interpreted some degenerative changes in the facet joints.

Q What was the date of that?

A That was the 7th of November, 1983.

Q Prior to the automobile accident?

A Yes.

Q What type of problems does a patient have with that type of condition?

A Usually some intermittent low back pain. There was a report of a lumbar myelogram that revealed there was asymmetry in S1 level on the left and L5 level on the right. Said a lumbar discogram showed that the patient's symptoms were reproduced with the discogram at L5 on the left side.

Q Doctor, were these the studies that were performed prior to her back surgery?

A Yes.

Q Okay.

A There was a report of an electromyogram, nerve conduction test dated 3/2/83 done by Dr. Pannozzo. This was in the lower extremities and was within normal limits. There was then a report of the lumbar spine with flexion-extension done on 3 April 1984, which showed a slight limitation of motion without any other abnormality. There was a letter written by Dr. Pannozzo dated August 19, 1985.

Q Let me go back one minute, Doctor; the flexion-extension in the lumbar spine with the limitation of motion, was that essentially your finding in 1988?

A Well, flexion-extension was 3 April 1984, which says it showed a slight limitation of motion without any abnormality. My finding could have been more than a slight.

Q But prior to the accident, she did have a limitation of motion in the back?

A According to this X-ray study. The letter of Dr. Pannozzo, he writes his treatments and findings; he said he did an electromyographic exam, nerve conduction of the right upper extremities and right peripheral median and ulnar nerves, which were all within normal limits. There were then the records; the rest were the X-rays that I reviewed.

Q Doctor, what are electromyographic studies and nerve conduction studies for?

A To see if you can determine any problems

with the nerves in the area that's tested.

Q And based on Dr. Pannozzo's findings, was there any nerve damage at all?

A Not according to the report.

Q Doctor, I'd also like you to identify the document that's been identified as Defendant's Exhibit A.

A That is a front-to-back or AP X-ray of the lumbosacral spine area.

MR. MATAVICH: Excuse me, I thought the other one was Defendant's Exhibit A.

MR. BUCK: No, that was B.

A B.

MR. MATAVICH: Oh, okay.

Q Doctor, that was an X-ray that was taken in your office at the time you examined her?

A Yes, an X-ray made on the 18th of July --

MR. MATAVICH: I'm sorry; what was that again?

A It's an AP view of the lumbosacral spine.

Q And that is of Sharon Fellows?

A It is.

Q And, Doctor, can you tell the jury what the X-ray shows?

A Well, basically all this shows is that there are, I believe on this you can see one droplet of myelographic

dye.

Q Can you circle that so the jury will know what it is?

Q What is that from?

A (Complying.)

Q That's from where she had her myelogram. Prior to the automobile accident?

A Yes.

A And the only other thing you can notice is there is some bone that's been resected, a laminectomy defect from the laminectomy which is really pretty hard to see. I can kind of outline it, but it's more if you look. I'll put a 4 over the fourth lumbar vertebra and a 5 over the fifth, and on the 4 I'll just kind of outline this little area in here where there has not been any bone resected; and then when you look at the fifth, this is much bigger because it's where she had her surgery and there was bone taken out. That's really all you can say from that X-ray. There is no other abnormalities noted on that.

Q Other than the area where they've removed the bone that you've outlined, it's a normal study?

A Yes.

Q Okay. Doctor, based upon your review of the medical records of Sharon Fellows, the history that you took from Sharon Fellows and the examination that you performed,

were you able to draw any conclusions with regard to her present status?

A I was.

Q And would you explain to the jury what your opinions are?

MR. MATAVICH: Object.

A Basically at the time of my examination I could not find any objective findings on Sharon Fellows to explain her numerous subjective complaints. Certainly the finding of the decreased sensation of the entire right side of her body including her face is not on any organic basis.

Q Doctor, would you explain to the jury the difference between subjective complaints and objective findings?

A Subjective complaints are things that the patient complains of, that they tell you, I hurt, or I'm numb here. Objective findings are things that you can document that really have no control from the patient's response.

Q And were you able to make any objective findings of any problems with Sharon Fellows related to the automobile accident?

A No.

Q Doctor, you'd indicated that the plaintiff had treated with a chiropractor for some period of time. Is

there any medical benefit to chiropractic treatment for the type of complaints she presented?

MR. MATAVICH: Object.

A Well, certainly if -- we have some question about chiropractic treatment, but certainly if she did not respond within a six or eight-week period of time and was not noticing improvement, I could not see any medical reason to justify continuing this treatment.

Q Doctor, the treatment that she was receiving from Dr. Pannozzo, was this treatment any different than what you would expect for someone with post-laminectomy type problems?

MR. MATAVICH: Object.

A Not really. Like I stated before, it's not unusual for people to have difficulty with post-laminectomy problems.

MR. BUCK: Doctor, thank you very much.

CROSS EXAMINATION:

By Mr. Matavich

Q Doctor, before I start my questioning, can I see everything in your file pertaining to Sharon Fellows, please?

A (Complying.)

Q And the X-rays, too, if you will, please?

A (Complying.)
Q And that one too if you will, please?
A (Complying.)
Q Doctor, let me give you your file back. I'm going to hold onto this for just a minute. When I refer to it, we'll send it back to you; okay?
A Okay.
Q First of all, Doctor, so that the jury will understand your role here, will you tell us again when it was that you first saw Sharon Fellows?
A The one and only time I saw Sharon Fellows was on the 18th of July, 1988.
Q And that was almost four years after the automobile accident?
A Yes.
Q Your purpose, the purpose of your examination was not for treating her, was it?
A As I previously testified, it was to perform an independent medical evaluation.
Q It was not to treat her was it?
A Yes, it was to perform an independent medical evaluation. It was not to treat her.
Q And the purpose was to examine her, make a report and then if necessary, testify in this case; isn't that correct?

A Yes.
Q And you have no responsibility for the care and treatment of Sharon Fellows?
A No.
Q You hadn't seen her before July 18, of 88; is that correct?
A I just previously testified, sir, I saw her the one and only time on the 18th of July, 1988. I think that was clear.
Q Doctor, if you'll just answer my question, please.
MR. BUCK: He's answered your question. I don't know how many times you have to ask it.
Q You haven't seen her since that date, have you?
A I previously testified I saw her for the one and only time on the 18th of July, 1988.
Q Doctor, you seemed to cooperate when Mr. Buck was asking you questions, and if you'll just answer my question.
A I answered your question.
Q You never consulted with Dr. Pannozzo about Sharon Fellows, did you?
A No, I did not.
Q You never consulted with Dr. Sansone about

her, did you?

A No, I did not.

Q Now, Doctor, your office is here in Akron; is that correct?

A That's correct.

Q Sharon came to Akron for this examination?

A That's correct.

Q Do you have an office at any other location other than the one here in Akron?

A No, I do not.

Q Does your practice occasion you to be in the Youngstown area at any time to treat patients?

A No.

Q Are you afilliated with any of the local hospitals in Youngstown?

A No, I am not.

Q Do you have many patients who travel from Youngstown to treat for soft tissue injuries with you?

A I have a few, yes.

Q Do they attend school at Akron?

A No, sir.

Q And Mr. Buck hired you to do this examination?

A Yes.

Q Have you conducted similar examinations of

other plaintiffs at the request of Mr. Buck's law firm, Comstock, Springer & Wilson?

A I have.

Q How frequently do you examine plaintiffs at the request of Comstock, Springer and Wilson law firm?

A I do not keep any record of these. I just do one examination of this sort a week, and there are numerous times of the year that I don't, including vacation times; so I probably end up doing, oh, 30, 35 of these type examinations a year at the most.

Q When did you begin to examine plaintiffs for the law firm of Comstock, Springer and Wilson?

A I again have no record of that. Several years ago.

Q Five years ago?

A Anything I did would honestly be strictly a guess. I don't know.

Q You can't tell us how many years you've been examining people for this law firm?

A No, I cannot.

Q Can you tell us how many people you've examined at the request of this law firm?

A As I just previously testified, I do not keep any records of that.

Q Do you examine plaintiffs for other defense

law firms?

A Yes.

Q How many other law firms?

A I don't keep any records of it, sir. I told you I do 30, 35 of these exams a year at the most.

Q I see. Can't tell us how many different law firms, though?

A I have no idea.

Q When did you start begin doing defense examinations?

A I've done this sort of examination, independent medical evaluations, almost since I started practice.

Q Which was when?

A 1972.

Q Do you examine claimants for insurance companies?

A I do.

Q How long have you been doing that?

A Same length of time.

Q Since '72. And, Doctor, were you paid for your examination and report?

A Absolutely.

Q And how much were you paid for the examination?

A For the examination and report it was $550.
Q And who paid you?
A I don't know. I assume Attorney Buck did.
Q And are you being paid for the testimony today?
A I'm paid for my time, yes, sir.
Q What is your charge for that?
A I think our current charge is 500 an hour, sir.
Q And you had a conference with Mr. Buck before the deposition this morning; is that correct?
A Correct.
Q And did you charge for that also?
A Absolutely.
Q And what was the charge for that?
A My charge for that is $75.
Q Now, Doctor, during the deposition by Mr. Buck, you were reading almost verbatim from the report that you prepared; is that correct?
A That's correct.
Q Is it fair to say that you have little independent recollection of this examination?
A That's fair.
Q And do you remember about what time of day the examination took place?

A These are normally scheduled first thing in the morning, so it would be about 9:00 or 9:15 in the morning.
Q And this was during normal working hours?
A Yes.
Q And did you see your own patients that day as usual?
A Yes, sir.
Q How long did the examination of Sharon Fellows take?
A I did not keep any record. We do not punch a time clock in and out when people come in and out. Whatever the time to do the adequate evaluation required.
Q Okay. Ten, 15 minutes for the actual exam itself?
A That's about reasonable, yes.
Q And then maybe 20 minutes taking the history?
A That or longer, yes.
Q Did Sharon arrive on time for the examination?
A I would assume, sir. I don't keep --
Q Was she cooperative?
A I have no reason to believe that she wasn't.
Q Doctor, in the file that you let me look at before I started my questioning, I didn't see any original notes from your examination; do you have those?

A I just jot notes down, and once I dictate my report, those are discarded.

Q So if someone wanted to check the accuracy of your report against the original notes, that couldn't be done?

A That's correct.

Q All right. Now, before Sharon Fellows even came in here, you had received a letter from Mr. Buck dated July 13 of 1988; isn't that correct?

A That's correct.

Q And in that letter from Mr. Buck, essentially outlines Sharon's history, medical history, complaints, history of the accident; isn't that correct?

A I would assume. The only thing I do with these letters is just glance at the problem that the patient's being sent to me for. That's as far as I read that letter.

Q I see. How many pages does that letter consist of, Doctor?

A Three.

Q Okay. So you were told that Sharon was involved in an auto accident; is that correct?

A Yes.

Q And she was hit broadside by a pickup truck; is that correct?

A That's what she told me, yes.

Q And that's in Mr. Buck's letter, too, isn't it?

A I'll have to read it to see. It says the front of a truck. It does not say pickup truck.

Q If you could set the letter aside, please, and we'll get back to what Sharon told you. And you were told that her vehicle was spun 180 degrees?

A That's what she said.

Q And you took a complete history from her?

A I asked her questions, yes.

Q And history is important to get the overall picture of a person, isn't it, Doctor?

A That's correct.

Q It's important to see how the injury that the person claims affects their lifestyle; isn't that correct?

A Can you repeat that, please, sir?

Q Well, the history is important to see how the injury that the person is claiming affects that person's lifestyle, isn't it?

A The history is important to determine the medical background and problems the patient is having to try to make a diagnosis. I don't know that it has anything much to do with the lifestyle.

Q Do you know what Sharon's work duties are?

A No.

Q Do you even know if she's employed?
A No.
Q You didn't ask her that?
A No.
Q Do you know what her recreational pursuits are?
A No.
Q Do you know what her activities with her children are?
A No.
Q Now, the letter from Mr. Buck says that Sharon's children were not examined in any medical facility; is that correct?
A Sir, as I previously said, I'll have to read the letter to see.
Q Well, Doctor, the letter's part of your file, isn't it?
A Yes.
Q Okay.
A It says her two children were riding with her at the time of the accident, were not injured; and they were not examined at any medical facility, nor do they voice any complaints of injury.
Q Do you know whether that's a fact or not?
A No, sir.

Q Okay. Doctor, would you agree that the cervical spine or the neck has great flexibility?
A Yes.
Q Supports the head, doesn't it?
A Yes, sir.
Q How much does the head weigh?
A I don't have any idea.
Q Well, generally speaking, what's the weight of the human head, adult human head?
A I don't have any idea, sir.
Q How many joints does the cervical spine consist of?
A How many joints?
Q Joints, yes. Doctor, if you want to get the X-ray and count them, feel free to do so.
A I don't think you can count them very well off the X-ray, sir.
Q How many does it consist of?
A There are six intervertebral disks in the cervical spine; there are two facets joints at each level. That's 14 and 6. It depends on whether you're talking about the cervical spine itself or it joins in the skull and the thoracic spine below, but 6 and 14 is 20; and if you want to include the other joints, then you get more.
Q How many muscle groups in the makeup of the

cervical spine?

A There are no muscle groups. The cervical spine is -- spine meaning the --

Q The bone?

A -- the bone.

Q I stand corrected, Doctor. How many muscle groups are there in the neck?

A There are numerous muscle groups in the neck.

Q What are the names of some of the muscle groups?

A The paravertebral muscles run along the back of the spine; there are numerous ones there. The trapezius muscle runs over the back of the head, down across the top of the shoulders; sternocleidomastoid muscles in front.

Q How many ligaments are there in the neck, Doctor?

A Sir, I couldn't begin to count the ligaments in the neck.

Q Okay. How about tendons?

MR. BUCK: I'm going to object to this line of questioning as being inappropriate for cross examination.

A How about tendons?

Q Yes, how many tendons are there in the neck?

A I couldn't begin to count those.
Q Joint capsules, how many joint capsules are in the neck, Doctor?
A One for each joint, sir.
Q And would you agree, Doctor, that the flexibility of the cervical spine predisposes it to acute injury from sudden motions?
A Yes.
Q What is an acute injury?
A It's an injury that just happened.
Q And would you agree that an impact from a truck that spins a car 180 degrees is a sudden motion that would exert a force on the cervical spine?
A It's possible.
Q And that type of force is going to throw the head around, won't it, Doctor?
A It's possible.
Q And the head's attached to the neck, isn't it, Doctor?
A Yes.
Q And that head has weight; isn't that correct?
A I certainly hope so.
Q Now, Doctor, you're not saying that Sharon Fellows wasn't injured in this accident, are you?

A No.
Q As a matter of fact, your report says that she suffered what was most likely a mild cervical strain at that time; isn't that correct?
A Yes.
Q Doctor, this is a soft tissue injury, isn't it?
A Yes, it is.
Q And would you agree that any soft tissue injury is a stretching and tearing of the tissues, muscles or ligaments in that area of the body?
A To some extent.
Q And a strain, Doctor, technically involves a stretching and tearing of muscles, doesn't it?
A Yes.
Q And a sprain, again, technically involves a stretching and tearing of ligaments?
A That's correct.
Q And, Doctor, what is a ligament?
A A ligament is a fibrous tissue structure that goes across a joint, one side of the joint to the other, that helps to stablize the joint.
Q And trauma such as that from an automobile collision can cause a strain or a sprain, can't it?
A Certainly.

Q The soft tissues that we're talking about, the muscles, the ligaments, those aren't going to show up on an X-ray, are they, Doctor?

A No. If there is significant damage to them, you can see indirect evidence of that.

Q That takes some time to develop, doesn't it, Doctor?

A No.

Q The muscles of the neck aren't going to show up on X-ray, are they?

A No.

Q The ligaments aren't going to show up on X-ray, are they?

A No.

Q The tendons won't show up on X-ray, will they?

A No.

Q What other soft tissue is there in the neck, other than the muscles and ligaments?

A Fat, skin, nerve.

Q Joint capsules?

A That's primarily a ligamentous structure.

Q And these can be stretched and torn also, can't they?

A Yes.

Q And there can be stretching and tearing of this soft tissue without any damage to the bone; isn't that correct?

A Yes.

Q When you get a tearing of the soft tissue, the muscles and the ligaments, you're going to get bleeding, aren't you?

A If it's a significant tear.

Q Well, Doctor, do you remember testifying in another case on behalf of Mr. Buck's law firm, the name of the case was Sauce versus Zinns, and you testified May 16 of 1988; do you remember that?

A No, I don't.

Q Do you remember making this statement: "Well, because any soft tissue injury is a stretching and tearing of tissues, muscles or ligaments." Do you agree with that statement?

A Yes.

Q And do you recall making this statement, Doctor: "And with that you get bleeding. If you put heat on it, you are going to make it bleed more and you are going to make it worse. You want to put ice on it to try to constrict the vessels, keep down the swelling"?

A What I said was you get bleeding to some extent. And it depends on the amount of tear. It may be a

drop from a very minimal tear to a very significant amount.

Q I see. And you don't know what degree of bleeding Sharon Fellows may have had, do you, Doctor?

A No, I did not see Sharon Fellows at that time. If she had any.

Q Is this what they call a petechial hemorrhage?

A No, sir.

Q What's a petechial hemorrhage?

A A petechial hemorrhage are little, tiny hemorrhagic spots, little, tiny dots you see in the skin.

Q Let me get back to the bleeding that you had talked about in Gauce versus Zinns with a soft tissue injury. That bleeding isn't going to show up on on X-ray, will it, Doctor?

A No. Maybe indirectly.

Q This tear then of the soft tissue, it will heal itself, mend itself by the body's natural processes, won't it?

A Absolutely.

Q And it grows back together, won't it?

A Yes.

Q And when it grows back together, there will be a formation of some scar tissue there, won't there, Doctor?

A Everything but bone in the body heals by

scar.

Q And the scar tissue isn't as elastic as normal tissue, is it?

A Not quite.

Q And scar tissue in a case like that is a permanent condition, isn't it, Doctor?

A Yes.

Q And would that scar tissue show up on an X-ray?

A No.

Q What is myofascitis?

A Technically myofascitis would mean an inflammation of the muscles and the fascia that covers the muscles. It is really a wastebasket term. It means nothing.

Q I see. Can myofascitis irritate nerves in the area where it is?

A Possible.

Q Doctor, would you agree that scar tissue is more prone to damage than normal tissue?

A Well, to a slight extent. It really depends on the amount of scar tissue you have. If you have a very minimal amount of scar tissue, then it's not even going to be noticeable.

Q I see. Doctor, your familiarity with sports medicine, the way I would relate to this is a boxer, he gets

punched in the eye and there is a cut and he's stitched up; and the next time he comes back to fight, that cut opens up a little more easily. Then the next time he fights, it opens up again, and then the next time he fights it opens up again more easily; is that a pretty good analogy?

A Not if it's well healed, it shouldn't.

Q Now, Doctor, what's the cervical curve?

A The cervical curve?

Q Yes.

A There is normally a little curve, and if you look from the side in the cervical spine --

Q And that's also called a lordotic curve?

A Yes.

Q And the straightening of the lordotic curve or the cervical curve on an X-ray is an objective finding, isn't it?

A No, sir. Well, it is an objective finding, yes, sir.

Q And that is something that can be caused by muscle spasm, isn't it, Doctor?

A It can be.

Q And the X-rays that were taken of Sharon on August the 29th of 1984, after this collision, were reported as being a straightening of the lordotic curve secondary to muscle spasm; isn't that correct?

A That was the report. As I previously testified, that's not a statement you can make from an X-ray. A radiologist is out of line when he makes that statement.

Q I see. What is muscle spasm?

A It's a tightening, involuntary tightening of the muscle.

Q And that's an objective finding, isn't it?

A Yes.

Q Now, a patient doesn't have control over his muscles to get a straightening of the lordotic curve, does he?

A If the muscles cause it, he or she does not.

Q And the muscle spasm itself isn't going to show up on X-ray, is it?

A No.

Q Now, the X-ray that is referred to in that report from the date of the accident at Salem Hospital, that X-ray was read by a radiologist, wasn't it?

A It was.

Q What is a radiologist?

A He's a doctor who specializes in reading X-rays.

Q He's a specialist in that like you're a specialist in orthopedics; is that correct?

A Yes.

Q And all that doctor does as a radiologist

is read X-rays?

A That's correct.

Q And isn't it a fact that a radiologist's intrepretations are often relied upon by treating doctors in their treatment plans?

A Certainly.

Q And this radiologist happened to be at Salem Hospital when Sharon Fellows went there?

A Apparently.

Q And when a person goes to a hospital, to the emergency room of a hospital for X-rays, they don't select the doctor who's going to interpret those X-rays, do they?

A No.

Q And that doctor isn't hired by anybody in a lawsuit to interpret the X-rays, is he?

A No, he isn't.

Q If you look at that X-ray report, Doctor, and I'll give you a chance to find it.

A Okay.

Q Got it?

A Yes.

Q Okay. There were five views taken from different angles before this X-ray report was prepared, weren't there?

A Yes.

Q And the report says that there was a reversal of the curvature, most likely secondary to muscle spasm?
A Yes.
Q And it's negative for fracture?
A Yes.
Q And, Doctor, when a patient is X-rayed, the patient doesn't position himself for the X-ray, does he?
A Patient does. You do not hold their head. If you're doing a cervical spine, the patient is there and they are asked to place their head in position. They do position themselves.
Q Well, doesn't the doctor or the X-ray technician put the patient in the position?
A They tell them where they want them to hold it, yes.
Q And the X-ray technicians are trained to position patients for X-rays or to tell them?
A Yes.
Q And, Doctor, you have to assume that the people doing the test are familiar with the testing procedures, do you not?
A I would hope so.
Q And in forming a diagnosis or relying on a medical test, doesn't the physician have to depend on the

integrity of the test?

A I'm not sure I understand your question.

Q Well, let me ask it again. In forming a diagnosis based on an X-ray or a test, or in relying on a medical test, the physician has to depend on the integrity of that test, doesn't he?

A I am still not sure what you mean by that, sir.

Q Well, for instance, if you send a patient to a hospital for a blood test, whatever it is that you're looking for, the doctor himself oftentimes doesn't draw the blood and run it through the different procedures; correct?

A Correct.

Q So when the patient comes back and the report of the blood test comes back, the patient or the doctor has to assume that that test was competently done, doesn't he?

A Yes.

Q And the X-rays that were done of Sharon Fellows in your office, she was positioned by your technician, wasn't she?

A Correct.

Q And you didn't take those X-rays yourself, did you?

A Absolutely not.

Q As a matter of fact, did you have to repeat

any series of the X-rays?

A I don't recall. It's possible. And that is what you, very frequently the X-ray text will not have the projections properly; and you have to look at the X-rays and ask them to redo a certain view or something because it is not the proper view.

Q Now, you've examined other plaintiffs before who have been told that the vertebrae in their neck were straight instead of curved, haven't you?

A Yes.

Q That's a common finding in a cervical injury, isn't it?

A It can be.

Q Now, you had Dr. Brocker's records and you referred to an X-ray report of Sharon's neck November 1 of 1983?

A Yes.

Q And, again, that report was prepared by a radiologist?

A Yes.

Q And there is no mention of a reversal of the cervical curve in that report, is there?

A That's correct.

Q And the report goes on to say no fracture, no dislocation, no bone destruction, no bone production; isn't

that correct?
A That's correct.
Q Normal X-ray?
A Yes.
Q And in your report to Mr. Buck, Doctor, you say that there is little, if any, difference between the X-ray taken on August 29 of '84 of Sharon's neck and this one taken November 1 of '83 of her neck, isn't that correct?
A That's correct.
Q Now, part of your examination of Sharon was to put her neck through a range of motion?
A Yes.
Q Would you tell the jury what that is, please?
A That's asking her to put her chin on her chest, to bend her head back as far as she can, to turn to each side as far as she can.
Q Your report notes that Sharon had a very minimal loss of extension?
A Yes.
Q Would you tell us what extension is?
A That is, as testified before, bending the head back.
Q And how is the amount of extension measured?
A By observing the patient, how far they move.
Q Can't it be quantified?

A It's very difficult. It's not like taking an elbow where you can put a goniometer, angle measuring device, on and do it. It's very difficult to do that to the neck. It's not commonly done by measuring it directly.

Q It is measured in degrees, though, isn't it?

A It can be, yes.

Q Did you measure what her loss of extension was?

A I just testified I did not. This is by observing her, how much she bent; and it's very uncommon to get a goniometer and measure something in degrees on the neck.

Q Well, Doctor, you were doing an independent medical evaluation, weren't you?

A Yes, sir.

Q And you knew that you were going to be called upon to testify perhaps in this case?

A Possible.

Q And you didn't -- do you have a goniometer in the office?

A I carry one in my pocket all the time, sir.

Q You didn't measure what the loss of extension was?

A I examine these people exactly like I would examine someone in my practice who I'm treating. I don't know of anyone who routinely, to my knowledge, that goes around

trying to measure the exact degrees in a neck. To accurately do, it's almost impossible.

Q I asked you if you did, Doctor?

A I told you I didn't.

Q And that would not be reflected in the notes that you discarded?

A No.

Q Doctor, what do you consider to be very minimal?

A Probably less than 10, 15 degrees.

Q Ten, 15 degrees. Well, have you testified in another case that a loss of extension of 10 degrees was very minimal?

A I don't know, sir.

Q Would you agree with that statement?

A Yes.

Q What is normal extension, Doctor?

A Normal extension, probably 30 or 40 degrees.

Q That loss of motion is a positive finding, isn't it?

A What do you mean by positive finding, sir?

Q Well, --

MR. BUCK: Do you mean objective or subjective?

MR. MATAVICH: I mean positive.

A You'll have to tell me what you mean by positive finding.

Q Well, Doctor, when you say that a test is negative, what does that mean to a doctor?

A It means there are no abnormalities.

Q When a test is positive, what does that mean to a doctor?

A It means for what degree.

Q So if the amount of extension of Sharon Fellows was, of her neck, was limited, that would be a positive finding, wouldn't it?

A Yes.

Q And if there were contractures of the muscle in the neck or tightness in the neck, that would limit motion, wouldn't it?

A It could.

Q Doctor, you found no evidence of muscle atrophy in Sharon's arms?

A That's correct.

Q And atrophy is caused by disuse of the muscle; isn't that correct?

A Disuse or paralysis.

Q Did she give any history of disuse of her arms?

A She said she was having difficulty using her arm.

Q My question was, did she give you any disuse of the arms?
A No.
Q And atrophy, if you put somebody's arm or leg in a cast for a period of time, they're not going to be able to use that particular part of the body that's casted, are they?
A That's correct.
Q The radial pulses that you examined, isn't it a fact that sometimes you'll get a diminishing of the pulse from spasm or pressure on the nerves and vessels as they come out of the shoulder?
A Correct.
Q That's not going to happen all the time?
A No.
Q Now, this cogwheel type of weakness that you found in the biceps, triceps and shoulder abductors, that was a positive finding, wasn't it?
A Yes.
Q That wasn't a normal finding, was it?
A No.
Q What are the biceps?
A The muscles that flex the elbow.
Q When somebody tells you make a muscle, that's what the wrestlers show off; is that correct?

A Yes.
Q How about the triceps, what are those?
A As testified before, they're the muscles on the back of the arm that straighten the elbows out.
Q And the shoulder abductors?
A They're the muscles on the shoulder that raise the shoulder up.
Q Isn't it a fact that a weakness in the biceps indicates injury to the C6 nerve root?
A Can.
Q What is the C6 nerve root, Doctor?
A That's the sixth cervical root.
Q And a weakness in the triceps indicates injury to the C7 nerve root, doesn't it?
A Correct.
Q What is a nerve root?
A What is a nerve root?
Q Yes.
A That's a nerve that comes off of the spinal cord.
Q And if a person has an injury to the C5-6 or 7 level, it's not unusual for that person to have referred pain to the shoulders or shoulder blades, is it?
A From C5 it isn't. Six, possible, 7, C7 unlikely.

Q Physicians can disagree on issues in medicine; is that a fair statement?
A I think so.
Q And matter of fact, there's been a difference of opinion in the interpretation of Sharon's neck X-rays?
A Absolutely.
Q And there are other tests you could do to check neck pain, aren't there?
A Such as?
Q Well, did you do a compression test?
A Compression test?
Q Yes.
A You'll have to explain to me what you mean by that.
Q When you push on the patient's head.
A No, I didn't do that.
Q Doctor, wouldn't pressure on a vertebral joint cause pain upon compression?
A The compression is thought by some to be a reliable test for when you have a ruptured disk, and you can compress a neck to put pressure on the disk and cause it to bulge out more. It really doesn't have much to do with vertebral joint.
Q Well, Doctor, Sharon didn't make any

complaint about a ruptured disk in her neck, did she?
A A ruptured disk in the neck could explain arm weakness and arm pain and things like this if there was anything to go along with it to explain it.
Q Mr. Buck's letter to you didn't say anything about a ruptured disk in the neck, did it?
A I don't know what Mr. Buck's letter said.
Q Doctor, did you do a Valsalva test on Sharon?
A No.
Q And isn't it a fact that if there is a space-occupying lesion such as a herniated disk in the cervical canal, the patient may develop pain in the spine secondary to increased pressure as would come in a Valsalva test?
A That is a test that --
Q Well, Doctor, would you answer my question, please?
A I'm trying to answer your question, if you'll allow me.
Q Okay. I'm sorry.
A That could possibly reproduce radicular pain if there were a ruptured disk because of that, but it's not a very reliable thing that most people use routinely.
Q It's a test you had available to you as an orthopedic surgeon, isn't it?

A I use the tests that I feel comfortable with, sir, in evaluating the problem. There are certainly some that you could use. The return is not really justified.

Q Well, Doctor, I don't know if you answered my question. My question was that was a test that you had available to you, wasn't it?

A I could have done that, yes, sir.

Q It's not any kind of a unique test, is it?

A No.

Q Now, your report doesn't indicate whether or not there was any tenderness in Sharon's neck upon palpation, does it?

A No, which means that I didn't find that.

Q I see. Well, you pointed out in your report rather emphatically that there was no evidence of muscle spasm?

A Yes.

Q But you didn't say there wasn't any tenderness?

A I just didn't dictate it, sir.

Q Doctor, is it characteristic of a soft tissue injury to have periods of remission and exacerbation?

A Only if they're reinjured.

Q Tell us what remission is?

A Remission means that symptoms go away.

Q And exacerbation means they come back?
A They return.
Q It doesn't really have to be an injury, though, does it, Doctor? I mean, could it come from stress on the injured body part?
A What do you mean by stress?
Q Overuse, overexertion?
A That's in the form of an injury.
Q Okay. Maybe we're using the term injury a little loosely?
A I think we're making two different -- I think the assumption is that you may be assuming that soft tissue injuries don't heal, and then these things come back. I don't agree with that. I think they do heal, and if they do come back it's because they're reinjured, whether it be by stress from overuse or whatever.
Q Well, let's confine it to stress from overuse. If there was an exacerbation, would there be muscle spasm in that area?
A There could be.
Q Okay. And what kind of things would cause an exacerbation of a soft tissue injury?
A Reinjury.
Q Okay. Housework?
A Well, if you're doing something vigorous

enough to reinjure it. Not likely that housework, soft tissue injury had healed unless there was really a very severe soft tissue injury with joint instability and things, it's very unlikely that something of that nature would cause a recurrence of this injury.

Q Physical activity?

A Depends on the extent of the physical activity.

Q And you examined Sharon first thing in the morning, didn't you?

A Yes.

Q Presumably she was well rested from the night before?

A I assume so.

Q Now, she's also complained of low back pain; isn't that correct?

A Yes, sir.

Q And she had a lumbar laminectomy disk surgery about nine months before the automobile collision; isn't that correct?

A If you want me to look up the exact date, I'll be glad to. I don't recall the exact. 11/8/83; that's correct.

Q Would you tell us what an intervertebral disk is?

A It's a cartilaginous material that is present between two vertebral bodies.
Q Kind of the inside of it is kind of gelatinous?
A Nucleus pulposis.
Q Nucleus pulposis. And when that disk ruptures, the nucleus pulposis is kind of squeezed out between the cartilaginous material, isn't it?
A Yes.
Q And this nucleus pulposis is going to press on the nerves in that area, isn't it?
A It can.
Q And that's what causes the pain, isn't it, Doctor?
A Yes.
Q And when surgery is done on a disk, the neurosurgeon goes in and he removes the nucleus pulposis and the disk material between bones, doesn't he?
A He removes some of it.
Q Well, he can remove all of it, too, can't he?
A If he does an anterior discectomy in which he operates from the front, he can remove all of it. If he operates from the back on the posterior aspect, it's usually an attempt is made to remove as much as you can; but usually

what happens is it's in the range of 20, 30, 40 percent, not even half of the disk material.

Q Okay. And when the disk material is removed, presumably that solves the patient's problem?

A It would be nice to think that.

Q That's the objective of the surgery, isn't it?

A Unfortunately it doesn't work out that way often.

Q Well, you had Dr. Brocker's records to review, didn't you?

A Yes.

Q And I assume that you reviewed them?

A Yes.

Q And it appeared Sharon was making a good recovery from that surgery, didn't it?

A She was -- she was recovering, yes. That doesn't mean she's not going have problems.

Q Would you take a look at Dr. Brocker's records, please?

A (Complying.)

Q If you'll turn to the visit by Sharon to Dr. Brocker of December 6 of 1983?

A Okay.

Q And if you look at his records for that

visit, it says Sharon's doing well, doesn't it?

A Yes.

Q And if you'll go to the next visit?

A That's all it says. Doing well. Return two weeks. Does not say anything about what an exam showed.

Q December 20, if you'll look at that examination?

A Okay.

Q He says she could return to work, return to light work, excuse me, should not lift over 40 pounds; is that correct?

A Yes.

Q Then if you go to the February 14 examination, it says doing well, doesn't it?

A Okay. He skipped --

Q I skipped that one. That was going to be my next. Well, let's go to the January 10. Apparently these aren't in order. The January 10, '84, exam, intermittent numbness in left leg; is that correct?

A Yeah, apparently that's a nurse's note.

Q Okay. And Dr. Brocker told her to return in two months?

A Yes.

Q So she went back February the 14th?

A Okay. It says doing well with generalized

muscle aching.

Q Okay. You don't know where the muscle aching was, though?

A No, these are really very brief notes.

Q And you don't know what her activities may have been; is that correct?

A That's correct.

Q Okay. Doctor, if you'll go to the next visit, March 13 of '84, doing well, return two months; isn't that correct?

A Yes.

Q Doctor, how about the next visit to Dr. Brocker; well, there is one May the 8th of '84, where it says intercostal neuralgia; do you see that?

A No, not offhand.

MR. BUCK: Perhaps that's one you haven't given us, Mr. Matavich. Because I don't have it in my records either.

MR. MATAVICH: Well, you subpoenaed Dr. Brocker's records, so I didn't give you these.

MR. BUCK: Perhaps Dr. Brocker did not give it to us then.

MR. MATAVICH: Well, here, take a look at mine.

Q Intercostal neuralgia?

A Yes.
Q That means rib pain, doesn't it, Doctor?
A Yes.
Q Now, if you'll look at the next visit, May the 15th, of 1984, the chart shows much improved, doesn't it?
MR. BUCK: Dr. Brocker did not provide us with those records.
MR. MATAVICH: Well, again, Mr. Buck subpoenaed those records.
MR. BUCK: Well, we can only give Dr. Thompson the records that are provided to us.
A It says improved; return two weeks.
Q Would you turn to the next visit, June 5 of '84?
A Says complaints of right calf knotting. Again, this is the nurse's notes. Really his notes are almost none.
Q Doesn't it saying doing well also?
A 6/5/84, doing well, yeah; nurse's note says doing well but complains the right calf knotting. That doesn't quite add up, does it? And he's got X-ray lumbosacral spine.
Q Doctor, would you look at the July 10, '84 visit?
A Again he says doing well.

Q Okay. Fine. Could I have that, please? And that's to be expected after a successful surgery; that the patient comes along, isn't it, Doctor?

A Hopefully.

Q Now, Dr. Brocker's records don't show any complaints of back pain after the surgery before August 29 of '84, do they?

A They really don't show much at all, to be very honest with you.

Q Well, they don't show any complaints of back pain, do they, Doctor?

A No, they show complaints of leg pain. It's interesting that he ordered X-rays. I'm curious why if there were no complaints of back pain and all, why you would order X-rays after a laminectomy, and he ordered numerous sets of X-rays.

Q Well, maybe he wanted to monitor her condition; that is one reason?

A I can't give you a good medical reason in the absence of difficulty after a laminectomy, why you would be doing repeat X-rays.

Q Another reason could be to charge for the service, huh, Doctor?

A I don't know, sir. I just can't give you a good medical reason, that's what I said, unless there was

difficulties that you wanted to evaluate.

Q It appears from that record she was coming along fine, doesn't it?

A From what little you can tell from the record, yes. There is no record of any sort of physical exam or findings, what her motion was; it's really very poor documentation of a postop care.

Q You're not saying Dr. Brocker committed malpractice in this, are you?

A No, sir, no, sir. I'm just saying it's not good documentation.

Q She returned to work?

A Apparently.

Q Nothing to indicate that Dr. Brocker's surgery was not successful?

A No.

Q Then we have the automobile accident on August the 29th of 1984; is that correct?

A Yes.

Q And Sharon's next visit to Dr. Brocker is September the 11th of '84; would you take a look at that, please, Doctor?

A (Complying.)

Q What's Sharon's complaint on September 11 of '84, to Dr. Brocker after the auto accident?

A Again, you're relying on what the nurse apparently has written down; it says burning in calf better. Has intermittent tightness in back.

Q And she was to return in two months?

A Yes. That's all he wrote. The nurse wrote the rest. He just wrote return two months. He doesn't say anything about physical findings, anything else.

Q Do you know if she returned to him after that visit?

A Well, at least she called. There is a note here that says on the 27th, patient called; she's having tingling sensations on left side top of leg. That's the one we talked about before. RJB. I guess that's Dr. Brocker. Said the the muscle around the disks still in healing process.

Q No indication from this chart that I've handed you that she ever returned to Dr. Brocker?

A No.

Q And after the collision on August 29 of '84, she was complaining of low back pain again?

A Some weeks later, I believe, sir.

Q Doctor, would you agree that collision probably had some affect on her low back?

A I would think it may likely have had some temporary effect on her low back, yes.

Q And within a reasonable degree of medical probability, that collision of August 29, '84, probably aggravated her low back condition, didn't it?
A Most likely, yes.
Q And aggravation means that an existing condition was made worse, doesn't it?
A Yes, for some degree of time.
Q And after neck or back surgery, a patient is advised not to ride in a car for a while; isn't that correct?
A Maybe for a few weeks or months. Not for years.
Q Fine. And that's to avoid reinjury of an area in the event of a collision, isn't it?
A Yes.
Q What level was that laminectomy done at?
A As I remember, I'll have to go to the operative report to be sure. Says lumbar discectomy, foraminal decompression, L5, right.
Q What level of Sharon's back did Dr. Pannozzo treat?
A Who knows.
Q Well, you have his report, don't you?
A Dr. Pannozzo said that he felt that her pain was most common at the L3-4 intervertebral joint and L2-3 intervertebral joint on the right side.

Q That's a different area of the spine than where the laminectomy was, isn't it?
A That is higher, yes, sir.
Q And you can have injuries at different levels of the spine, can't you?
A Absolutely.
Q So it's conceivable that she sustained a new injury at that level in this accident, isn't it?
A It's conceivable.
Q Well, you've treated patients who have sustained low back injuries in automobile accidents, haven't you?
A Yes, sir.
Q Person can hurt more than just his neck, can't he?
A Absolutely.
Q Now, you did a straight leg raising test for Sharon during your examination?
A Yes, sir.
Q And I think you said that if that test was positive, it would produce pain or show sciatic nerve irritation?
A Correct.
Q And, Doctor, isn't a straight leg raising test one that's done to see if there is a disk herniation in

the lumbar spine?

A That's one thing that can produce irritation on the sciatic nerve. The straight leg raising test itself is for sciatic nerve irritation. The disk is one thing that can cause that.

Q All right. Sharon made no complaint about having another herniated disk in her low back, did she?

A No.

Q Okay. And you would expect the straight leg raising test to be negative, wouldn't you?

A If there were no nerve irritation present, I would, yes.

Q The myelographic dye that you pointed out in the Defendant's Exhibit A, that won't cause pain, will it?

A Unlikely.

Q Okay. That's something that's left over from the surgery of '83?

A You can get an arachnoiditis, an irritation of the lining that can cause pain from this.

Q Did she have that?

A I have no way of knowing that. You can't see that on an X-ray. You'd need another myelogram to determine that.

Q Doctor, would you take one of your X-rays, any one. I don't want to mark up Mr. Buck's exhibits.

A X-ray of what?
Q X-ray of the neck, please.
A Any particular view you want?
Q Let me look at one of the lateral views. That would be a good one. Let's mark this as Plaintiff's Exhibit A.
(Whereupon Plaintiff's Exhibit A was marked.)
Q Okay. Doctor, you've been handed Plaintiff's Exhibit A. Is that one of the X-rays that you took of Sharon here?
A Yes.
Q Could you get your grease pencil and draw in the anterior longitudinal ligament, please?
A You can't see the anterior longitudinal ligament on an X-ray. You just know it's the ligament that runs down, connects the front of the vertebrae.
Q Okay. And you're using your yellow pencil for that?
A Yes.
Q Okay. I'm going to give you a red one, and if you'll draw in the posterior longitudinal ligament. I'll give you a blue pencil and ask you to shade in the sternocleidomastoid muscle, Doctor?
A You cannot see the sternocleidomastoid muscle on this, sir.

Q I know. That's why I'm asking you if you would shade it in where it's supposed to be?

A It would be much easier to draw that on a front to back view that on a lateral view.

Q Would you do it for us, please, get one of the proper views?

MR. HATAVICH: Let's mark that one first as Plaintiff's Exhibit B, Doctor.

(Whereupon Plaintiff's Exhibit B was marked.)

A It would be a muscle that has rather a broad base off of the clavicle and the sternum down in this area which would run up.

Q Doctor, if you'll get that pencil on there and just mark it up for us, if you would, please?

A There it is.

Q Can you kind of shade that in a little bit in the area that you've outlined?

A (Complying.)

Q There you go. Where is the trapezius muscle?

A That's a broad muscle that comes off the scapula in the back and again you can't see the scapula well; and it comes up along the back of the neck.

Q Okay. And the joint capsules, where are those at, Doctor? Here I'll give you a green pencil. You can

mark up some joint capsules for us.

A Joint capsules are the ligaments crossing the joint. All the ligaments are is thickening in the joint capsules, and they just go all across every joint you see here. Intervertebral joints.

Q What view of the neck is that, Doctor?

A That's an anterior-posterior view, AP, front to back.

Q Okay. Thank you. Now, your report says that Sharon had decreased sensation on her right side?

A That's correct.

Q You don't say that she didn't have any sensation; is that correct, too?

A No. I said she had decreased sensation.

Q Okay. So she has some sensation, at least she reported it to you?

A Yes.

Q And there is no way of quantifying what that loss of sensation is?

A No.

Q Okay. You're not a neurologist, are you, Doctor?

A No.

Q Or a neurosurgeon?

A No.

Q Now, your report goes on to say that the X-rays you took of her dorsal spine, that being the mid-back, could not show any abnormalities?

A That's correct.

Q And you also took some X-rays of the neck, which we've talked about, and your report says that they do not show any significant abnormalities; is that correct, too?

A Yes.

Q What abnormalities were there on the cervical X-ray that you did not consider to be significant?

A That's just semantics, sir.

Q Pardon me?

A That's just semantics where you say there were no. I say there are no abnormalities or no significant abnormalities. I mean the same thing.

Q Oh, I see. Now, you've testified that according to Dr. Pannozzo's EMG, electromyograph reports, that those were reported as normal?

A Yes.

Q And isn't it a fact that an electromyograph will often be reported normal even in patients with known intervertebral disk protrusions?

A Can be.

Q And you can have a negative EMG and still have a nerve problem, can't you?

A Yes.
Q In fact, Dr. Brocker's records show that the EMG taken of Sharon on November 2 of '83, before her surgery, when she was in for that back surgery, when we know she had a herniated disk, the EMG was reported as normal, wasn't it?
A Yes.
Q And the nerves that emanated from her low back were the ones that were tested, weren't they?
A Yes.
Q Now, the emergency room report that you read from August 29 of '84, said at the emergency room that she complained of her right leg tingling?
A Yes, I believe so.
Q What would that be indicative of?
A Could be that she had some nerve injury of the right leg or irritated something that was there.
Q Okay. Now, the numbness over the whole body, can that be explained by the flight or fright mechanism?
A Certainly.
Q And would you tell the jury what the flight or fright mechanism is?
A Well, it's just fear.
Q It's a jolt of adrenalin that one encounters in a frightening situation, automobile accident, armed robbery, something like that; is that correct?

A Correct.
Q And that jolt of adrenalin is going to stay with the patient for a while; isn't that correct?
A Well, usually 15, 20, 30 minutes, something like that.
Q And that jolt of adrenalin when everything's over with and things return to normal; sometimes then the patient will feel some pains in places that he hadn't before; isn't that correct?
A Yes.
Q The X-rays of Sharon's neck then you reported as essentially negative?
A Correct.
Q No changes in the neck from when they were first taken in November of '83 pursuant to Dr. Brocker's orders until you took them?
A In my opinion, yes.
Q No arthritis or anything like that?
A Not that I can detect.
Q Now, Doctor, you kept saying on your direct examination, or at least I heard it, that you could find no objective findings at the time of the examination; is that correct?
A Correct.
Q And you've limiting your findings to the one

time that you examined her; isn't that correct?
A Yes, sir.
Q And on that day at that time you found nothing?
A That's correct.
Q You can't say that she didn't have pain or muscle spasm before your exam, can you?
A No.
Q And you can't say that she didn't have pain or muscle spasm after your exam, can you?
A No.
Q And from your testimony you don't know what her condition was like two months, three months, six months after the collision, do you?
A No.
Q And she treated with Dr. Sansone in December of '84?
A I believe that's correct.
Q And she started treatment with Dr. Fannozzo in January of '85?
A That's correct.
Q The limitation of motion that you found in her low back, that would be expected with a person who had a lumbar laminectomy; isn't that correct?
A Very frequently, yes.

Q And I think you testified that the motion that you found on your examination was more than what the X-ray showed before the accident but after the laminectomy?
A I don't think that's correct. I think I said that -- what I testified was, the question was that there was a report from a flexion-extension X-ray, and that's not a good way to determine motion, but again that's where the technician asked them to bend; but what I believe I said was at least according to that X-ray, she had more motion then than when I examined her. She had less motion when I examined her.
Q Oh, okay. Thanks for correcting me because that was the point I wanted to bring out. Thanks. Doctor, would you agree that a strain and sprain of muscles results in a weakening and usually some tightening of those structures?
A On a temporary basis, yes, sir.
Q And you want to prescribe exercises to help those muscles regain the strength, don't you?
A Absolutely.
Q Generally that helps to resolve the problem?
A It should.
Q Not always?
A Makes you nervous if it doesn't.
Q Well, as a doctor, as an orthopedic surgeon, do you always get the medical result with a patient that

you're hoping for?
A No, sir.
Q This degenerative disk that Dr. Brocker operated on back in 1983, Sharon was only 27 then; correct?
A Yes. I assume.
Q Is that kind of young?
A I'll take your word for it.
Q Is that kind of young for a degenerated disk?
A It can be seen. It's on a younger age than you usually see it, but you certainly can see it then.
Q Well, she had a traumatic episode right before that problem surfaced, didn't she?
A I'm not really sure.
Q Well, you said you looked at Dr. Brocker's --
A I did not commit them to memory, sir. I'll be glad to go back and look at it.
Q I think you'll find it in Dr. Brocker's letter to Dr. Bookwalter. And it will be in the first paragraph, the last sentence.
A When she fell, yes.
Q She had a fall on August 18 of '83, and at that time the symptoms progressively got worse?
A Yes.
Q Doctor, is it true that a traumatic episode could be followed by a development of degenerative changes at

a single disk space rather than multiple levels of the spine?
A Certainly.
Q What I'm saying is, if you have a degenerated disk at one level, that doesn't mean every disk in your back is bad?
A Unlikely, not every disk in your back.
Q And the narrowing of the L5-S1 disk space where Dr. Brocker did the surgery, you would expect to see that, wouldn't you?
A Yes.
Q The CAT scan report that was done at the request of Dr. Sansone, what did you say the facets were?
A The facets are the small joints in the back of the spine.
Q Okay. What are those made of?
A What are they made of?
Q Yeah.
A They're just like any joint where two bones come together, and they're covered with thick cartilage; and they have a joint capsule and they have a synovial lining.
Q And the report says there is no hypertrophy?
A Yes.
Q And what's hypertrophy?
A It means increase in size.
Q And, Doctor, I must have put this note that

I asked you about earlier, that on your finding, Sharon's low back movement, the limitation was more than it was back in April of '84 when the X-ray after surgery was taken?

A Okay. Again, according to the X-ray report, the limitation was more. The X-ray is a poor way to judge motion. Dr. Brocker has no records of motion or anything in his notes.

Q You didn't find any evidence of degenerative disk disease in Sharon's neck?

A No.

Q And, Doctor, you testified that at the outset that you treated patients on a regular basis for soft tissue injuries?

A Correct.

Q And in those patients, what do they tell you is bothering them or gives them pain?

A It varies.

Q Okay. Generally speaking, from what to what?

A Well, first of all, you got to tell me what type of soft tissue injury you're talking about.

Q Neck and low back.

A Usually it's stiffness and pain with motion. It's usually a condition that's relieved by rest and is worse with activity.

Q And in such patients, have you taken X-rays

which don't show any fractures of the vertebrae, the bones?
A Absolutely.
Q And have you ever treated a patient with muscle injuries to the neck and low back where there aren't any broken bones, but the pain and discomfort that the patient has continues for a long period of time?
A Yes.
Q And have you ever treated a patient with soft tissue injuries to the neck and low back that have not responded to your treatment?
A Yes.
Q And have you ever treated a patient over a long period of time for soft tissue injuries to the neck and low back where you've concluded those injuries to be permanent?
A Yes.
Q And have you ever treated a patient who suffered a soft tissue injury to the muscles, nerves, ligaments, of the neck or low back who have suffered pain over a period of years?
A Yes.
Q And when you treat your own patients with those soft tissue injuries to the neck and low back, do you require seeing them over a period of time before you arrive at a conclusion as to how serious or permanent that patient's

injuries are or were?

A It depends on the frame of time when I see him. If I see him immediately after the accident or the injury, whatever it was, then it requires a frame of time to see how they respond and all. If I see someone a year or two years later, then usually you can tell with one evaluation. You don't need repeated evaluations.

Q And have you ever disagreed with another doctor's opinion about permanency of a patient's injuries?

A Absolutely.

Q Medicine is not an exact science, is it?

A No, it is not.

Q Have you ever made a prognosis of a patient's medical future and then changed it after you've had further opportunity to see the patient in your office?

A Certainly.

Q And have you ever seen a patient you're treating for soft tissue injury to the neck or low back who has muscle spasm on one visit to your office, has no muscle spasm on a second visit, and then has muscle spasm again on a third visit and later visits?

A That usually only occurs if they've had reinjury or reaggravation of a problem.

Q And what are generally accepted procedures that a physician uses on a patient who's suffered a soft

tissue injury to the neck or low back?

A The initial phase is a phase to allow the acute injury to subside, or phase one, in which you would treat with rest or limited activity, ice, to prevent swelling. After that then you should go into a form of rehabilitation and which you're placing him on an exercise program, first of all to stretch, general stretching of the tissues back out to regain normal motion, and gradually adding on first an isometric then an isotonic type exercise program to strengthen the affected muscles around the area and regain the normal motion and strength present.

Q How about physiotherapy?

A That's usually how you do it.

Q Okay. Hot packs?

A Well, the hot packs don't hurt anything, but they may help him loosen up a little bit at the time; but that's not the important thing. The important thing is the exercises and the stretching-type things.

Q Doctor, you occasionally use hot packs in your care and treatment of soft tissue injuries, don't you?

A Yeah, but you've got to realize what you're doing. It's just like telling somebody to put a heating pad on at home. It feels good while you do it, but it really does nothing for the overall solution of the problem.

Q How about ultrasound?

A Same type thing. It's just a way of deep heat.
Q Injections?
A Occasionally.
Q You use ultrasound sometime in your care and treatment of soft tissue injuries, don't you?
A Rarely.
Q You use it sometimes, don't you?
A I said rarely.
Q Doctor, if Sharon came to see you on the very first occasion for her treatment, would you want to see her more than once or twice before you made up your mind as to the permanency of her injuries?
A If I saw her right after the injury, yes.
Q And do you always make up your mind that your patients are telling you the truth about their pain after the first visit?
A I think you have to put everything in perspective, sir, and you have to see what they say, how this correlates with the findings you have, and also, you know, how it fits into how they're responding to treatment.
Q Pain to a patient is real, isn't it?
A Sure.
Q Can't see the pain, can you?
A No.

Q Doctor, are you suggesting that Sharon Fellows was untruthful with you?
A I did not say, that sir.
Q Is it true that a conscientious person will try to carry out his normal duties despite the fact that he may have a soft tissue injury to the low back or neck?
A Yes.
Q It's not uncommon for a patient to present himself to a doctor with a condition that's supported only by subjective complaints, is it?
A No.
Q And it isn't unusual for a doctor to base a medical diagnosis solely on subjective complaints, is it?
A Not over a prolonged period of time.
Q As a matter of fact, the first thing that you as a doctor do when you see a patient in the examining room is ask what happened and how do you feel?
A Certainly.
Q That's where you guys have it over veterinarians and pediatricians; those patients can't talk to you?
A Certainly.
Q Doctor, someone who sustains a cervical strain or sprain or a low back strain or sprain, they're more vulnerable to reinjury in those areas, aren't they?

A Not if they're properly rehabilitated.
Q Did you suggest to Sharon that she see any sort of other doctor for what you've called a conversion hysteria?
A No, sir; my purpose to see her was not to advise treatment.
Q Conversion hysteria, if it exists, that's real to the patient, isn't it?
A Yes.
Q The structures that we've been talking about, the neck, the muscles, the tendons, in a child they're more supple, more flexible than in an adult, aren't they?
A Certainly.
Q A kid could take a better wallop than an adult?
A Certainly.
Q And in an automobile accident, there is different forces involved, aren't there?
A Certainly.
Q As a matter of fact, you've probably seen people who have crawled out of cars that have rolled over and smashed without an injury and other people who were injured in accidents with less damage?
A Certainly.
Q And the way that one is sitting in a seat

can play a role in the type of an injury?
A Certainly.
Q And one's body size in relation to the seat, how the seat envelopes that body, plays a role, doesn't it?
A Certainly.
Q And, Doctor, to make it clear, you're not testifying that Sharon was not injured in any way in this collision?
A No.
Q And it's not your testimony that she should not have sought treatment for those injuries after the collision?
A No.
Q And you don't claim to be infallible in any of the opinions you've expressed here today, do you?
A Absolutely not.
Q You make mistakes?
A Absolutely.
Q Just like all doctors and lawyers, too?
A Like everyone.
Q Would you agree that a doctor who sees a patient over a period of time charts that patient's progress, treats that patient, is in a pretty good position to assess that patient's injury?
A Yes.

MR. MATAVICH: Thanks, Doctor. I don't have any more questions at this time.

REDIRECT EXAMINATION:

By Mr. Buck

Q Doctor, I have just a couple questions I'd like to follow up. In response to Mr. Matavich's questions, you said you examined or performed 30 to 35 independent examinations per year. Do you perform all of those for me or my office?

A No, absolutely not.

Q Do you have any -- I don't have a guess, but do you have any idea how many you might perform in a year at my request?

A No.

Q Would it be more than three or four?

A You know, I really don't know.

Q Doctor, do you also treat patients who are plaintiffs in lawsuits?

A Yes.

Q Do you testify on their behalf?

A I do.

Q And is the testimony that you render on behalf of your patients who are plaintiffs or in cases where you have performed an independent medical examination any different?

MR. MATAVICH: Object.

A No.

Q How do you testify in the two types of cases where your patients are plaintiffs or where you've done an independent medical examination; what is your purpose in testifying?

MR. MATAVICH: Object.

A I just try to give my honest opinion on what's there, whether it's my patient or whether it's someone I did an independent evaluation on. It's no different in my mind. I'm just trying to tell honestly what I felt.

Q Thank you, Doctor. Now, Mr. Matavich asked you about some notes that you might take during the course of the examination. Do you dictate your report from those notes immediately after the examination is completed?

A Fairly soon after yes.

Q When it's still fresh in your mind?

A Yes. Actually I can assure you those notes would mean nothing to anyone. It's my form of shorthand.

Q Doctor, Mr. Matavich asked you about mild cervical strain and talked about stretching and tearing of muscles and ligaments. You indicated that you can see indirectly evidence on X-rays where muscles and ligaments have been torn. Would you explain to the jury what you meant by that?

A Well, if there is a significant tear of the ligaments, then it's going to lead to a joint instability. And when you take the X-ray, you're going to see shifting of the joints.

Q That would be the bones?

A Yes. In relation to one another.

Q In the X-rays that you reviewed, the ones taken at the emergency room right after the accident, the ones taken prior to the accident, and the ones that you took in your office, did you find any evidence of any stretching, tearing, of the muscles, ligaments or tendons?

A Not that you could see on X-rays. The other thing you could see on an X-ray is, the ones made right after the injury, is a soft tissue swelling which leads to a displacement of the trachea, the windpipe, pushes it away from the bones.

Q And in reviewing the X-ray of the cervical spine taken at the emergency room, was there any evidence of soft tissue swelling?

A No.

Q What's the significance of lack of soft tissue swelling?

A Well, the severity of the injury.

Q And where there is no swelling, what does that mean?

A Well, you know, it means it's less severe.
Q Doctor, these mild cervical sprain and strains, do they heal?
A Yes.
Q Can you explain to the jury, give some type of analogy in your experience?
A Well, it's a stretching and tearing of soft tissues and ligaments and things. It's just like having a sprained ankle. I think we've all seen the athlete on TV, the football player or the basketball player who sprains his ankle. If we assume this didn't heal, we would expect never to see him back playing, he or she or whoever it might be. However, we know that routinely they are back in some period of time depending on the severity of the injury. So if you assume that these don't heal and they do heal with scar tissue, but this is in most instances is not a significant thing that causes permanent problems.
Q Okay. Doctor, was there any evidence of any significant formation of scar tissue in Sharon Follows?
A Not that I could detect.
Q Any evidence of any significant tearing of muscles, ligaments or tendons?
A Not that I could detect.
Q Is there any evidence that she had any bleeding from torn muscles, ligaments or tendons?

A There is no way I could tell that.
Q Is there anyway anybody could tell that?
A Well, they could if it was severe enough at the time of injury that it, again, went to swelling, soft tissue displacement on the X-ray or swelling on exam or ecchymoses or bruising of the skin, where it spread out to the, the bleeding spread out to where it was in the tissue planes underneath the skin. That's what a bruising is.
Q All right. And from reviewing the emergency room report, was there any evidence of bleeding, swelling, bruising?
A I really can't read that, the doctor's writing well enough there to be sure what they're saying from that emergency room report. I don't know. I can only read part of this. The first part, you know, what this is, what doctor's writing. He says no LOC, which is loss of consciousness. Parallel means the pupil are okay. Heart's okay; lungs okay. I think the abdomen soft not tender. Something else. The bowel sounds; I don't know what it says there. Then there is a thing says cervical spine negative.
Q That's under the X-rays?
A Yeah, under X-ray findings. I can't read what he says under treatment. I think the diagnosis is rule out head injury, but it's really not legible enough to me that I can be sure what they're saying, to be very honest with you.

Q But based on the X-ray findings; and what you can read here, is there anything to indicate that there is any swelling of the soft tissues in the neck, or bruising?

A There is no indication of what I can read.

Q And would that also be true of your review of the emergency room X-rays of the neck?

A Yes.

Q Doctor, when you interpret the X-rays, is the most effective way to do an interpretation to compare one X-ray with another X-ray of the same anatomical part of the body taken at another time?

MR. MATAVICH: Object to the leading question.

Q Doctor, can you tell us what is the most effective way to interpret X-rays?

MR. MATAVICH: After Mr. Buck gave you the answer, Doctor, feel free to do so.

A Well, the interpretation of the X-ray is really based on what you see on that X-ray. Certainly if there had been a series of X-rays and you're looking for progressive changes, then it's beneficial to put those beside each other and see if there is a change or not, if you have those available. That's the only beneficial thing.

Q And would the radiologist in an emergency room have that opportunity to look at X-rays taken in other

doctor's offices?

A Not unless he requested them.

Q And is there any evidence in the emergency room X-ray that the radiologist in the emergency room compared --

A No, usually the radiologist will dictate, not always, but usually if they compare with previous films they will indicate that in their report.

Q And did you have an opportunity to compare X-rays prior to the accident, at the time of the accident, and X-rays taken three years later?

A I did.

Q And was there any change in the cervical spine in those three X-rays?

A Not in my opinion.

Q Now, you talked about a minimal limitation of motion in extension of her cervical spine. Is that something that's controlled by the patient?

A Yes.

Q What do you do; do you ask her to look up?

A Yes.

Q Do you force her or position her head in any respect?

A Absolutely not.

Q Is that what you would call a subjective

symptom?

A Certainly.

Q Now, Doctor, Mr. Matavich asked you about the arm weakness. You talked about the biceps having the cogwheel effect. Did you test Sharon Fellows using, testing the same types of muscles with other tests, asking her to perform other functions using the same muscles?

A Not against resistance, no.

Q But did she perform other tests using the same muscles; were all your tests consistent with the weakness in those muscles?

A I'm not sure you understood. Maybe you didn't understand what I testified. The cogwheel type weakness is not recognized as an organic type weakness. By that I mean if there is a true weakness in the muscle as I previously testified, you should expect a gradual give way of the muscle and not in a jerky fashion. A cogwheel type weakness is either associated with a hysterical type reaction or a, just a voluntary response by the patient.

Q Did you tell us in response to, I believe it was Mr. Matavich's question, that there were some other either abduction, aduction or abduction tests that would use the same muscles that did not show this same type of weakness?

A Yes, that was in response to yours.

Q Okay. So were there other tests that she

was able to perform without any weakness or deficit using the same muscle groups?

A Yes.

Q What conclusions can you draw where she gives inconsistent responses using the same muscle groups?

A Again, it's lack of a voluntary response on the patient or a hysterical type reaction.

Q Doctor, why would you not perform Valsalva tests or cervical compression tests?

A Well, Mr. Buck, there is literally hundreds or maybe thousands of different tests you can perform. When you learn to do your examinations and things you pick the tests that you feel in your hands give you the most information. You certainly, it's just not practical to try to do every test that's possible. You try to do tests that in the great majority of the time will yield a positive response if there is a problem there; and each person has to, each physician has to develop the things that they're comfortable with and the things that they feel are beneficial in doing this. And this is primarily things that you learn throughout your medical school training and your residency training and then you refine during your years of practice. And some people consider tests more beneficial than others, and it's just things that you consider beneficial in your practice and what you use day-to-day.

Q Now, Doctor, in the period following the laminectomy surgery up until the time of the accident, did Sharon Fellows have consistent complaints of problems with her legs?

A She had, I don't know whether they were consistent. The documentation is so poor there I don't know how you can make any statements about really what was going on and what wasn't going on. You know, I'm sure in all fairness to Dr. Brocker, he probably did do these examinations when he was doing it. He just didn't record it. He didn't take the time. He is probably a busy guy who didn't take the time to record it.

But more and more, especially in the present climate, we're learning you better record, better keep better records and keep things; but there are things that you do and, you know, usually take down. Just the movements of the low back after a lumbar laminectomy, and I can testify from personal experience about this since I've had one, that it's usually very limited at first and gradually gets better but it doesn't usually get full; and it's things that you might as an examining physician

you say, well, the motion's a little better than last time; you know, you just don't even record that.

But there is really no way that I can make any conclusions about what was going on in this post-op period

from the information I have available.

Q Doctor, orthopedic surgeons also perform lumbar laminectomies, don't they?

A Yes.

Q What is the purpose of taking lumbosacral spine X-rays as a follow-up to a lumbar laminectomy?

A As I previously testified, the only reason you would really do this is if a patient in my mind, to my knowledge, if the patient were having some difficulty. There is no real purpose to get a routine study of the lumbosacral spine post-op unless you were looking for something wrong.

Q And from your review of the records, did Dr. Brocker order several lumbosacral spine films between the time of the surgery up until the time of the auto accident?

A Yes.

Q Mr. Matavich asked you about the EMG and having a normal finding when there is a disk herniation. Can you explain to the jury how that occurs?

A Well, the EMG measures basically motor activity of the nerve where there is any involvement that would involve the muscles; in other words, the motor activities is a part of the nerve that supplies the muscles and makes the muscles contract; whereas the sensory part of it is what gives you your sensation or feeling. An EMG is really just measuring the motor activity of it. So you can have the

nerve involved, if it is involved, purely just disturbing the sensory part of the nerve and not the motor part, you could have a normal EMG. You could also, you know, have the whole scenario and nerve really isn't involved. You could also have that it's involving the motor a little bit but not enough to give a significant EMG finding.

Q Now, Mr. Matavich also asked you about the flight or fright syndrome and talked about the surge of adrenalin. I think you said it would last for 20 to 30 minutes possibly?

A It's usually not much longer than that. It's just like giving somebody a shot of adrenalin. This is a very-transient-type thing. It's not something that goes on for hours and hours.

Q Doctor, would you expect someone who was involved in an automobile accident that once the accident was over, the police investigation was completed, and they traveled to the emergency room where they were examined by a physician in the emergency room, would you expect the effect of the surge of adrenalin to have worn off by that time?

A I would certainly think so.

Q Doctor, if there were to be any changes or degenerative conditions develop as a result of the accident in August 1984, would you expect those changes to have started so you would be able to observe them on X-rays by July of 1988

when you examined her?

MR. MATAVICH: Object.

A Certainly.

Q And did you observe any degenerative changes in Sharon Fellows?

A Just the degenerative disk disease at L5-S1 on the lumbosacral spine.

Q That's where she had the surgery?

A Yes.

Q Anything related to the automobile accident?

A Not that I could really relate.

Q Doctor, you told Mr. Matavich you have treated people for soft tissue injuries who have not responded to treatment and you felt were injured permanently. Could you explain to the jury what it is you would find where the patient does not respond to the treatment?

A Well, it's usually you have a, you have objective findings to go along with the subjective complaints on a consistent basis and you know that are just going to be there, you know; you have, let's take the -- you have a significant, severe ligamentous injury to the cervical spine where you actually tear the ligaments and joint capsules; you get a subluxation of one vertebra on the other and you have a chronic instability.

Q Have you had patients --
A We can demonstrate this on X-ray.
Q Do you have patients where there is no objective findings that you can substantiate the complaints that you feel are injured permanently?
A Most of these turn out to have some secondary influence on them, and you can tell this by their response to therapy.
Q Doctor, if you saw a patient one time three years after the accident, would you feel comfortable in making a diagnosis at that time after you got a complete history, reviewed the medical records and performed a thorough examination and X-rays of the patient, could you form an opinion as to their status at that time and condition with regard to an accident that occurred three years earlier?
A Certainly.
Q Doctor, can a person who was involved in ongoing litigation for an extended period of time where there is compensation motivation, convince themselves of problems where there is no anatomical basis or objective evidence of injury?
MR. MATAVICH: Object.
A Absolutely.
Q That is something you observed in your practice?

MR. MATAVICH: Object.

A This is documented in the medical literature. There were 20 years ago articles in the Journal of the American Medical Association dealing with the accident process well documenting this.

Q Doctor, as far as Sharon Fellows is concerned, if you had seen her immediately after the accident, what would her course of treatment have been, if you had been her treating physician?

A Assuming that she had had a mild cervical sprain based upon the accident, I would, like I said, initially for the first week or so just primarily rest this, use ice initially, maybe some anti-inflammatory medication if she could tolerate it; then start therapy; again, the same thing that I outlined with stretching, range of motion, adding increasing strengthening exercises.

Q What is the expected course of recovery with regard to the amount of time it would take in this type of injury?

MR. MATAVICH: Object.

A I would say that 90 percent of people with no other problems will essentially be asymptomatic in six to eight weeks.

RECROSS EXAMINATION:

By Mr. Matavich

Q Doctor, you've testified in other cases that this type of an injury will generally heal in three to four months; a person will fully recover then, haven't you?

A It depends on the degree of the involvement, sir. I probably have. I think I prefaced this with saying this was a mild --

Q This was a hyperflexion-extension injury, wasn't it, to the neck? That's another way of saying cervical injury, hyperextension, hyperflexion?

A That's a way of doing it, yes.

Q Do you remember testifying in Sauce versus Zinns back on May 16 of '88 --

A No, sir.

Q And you were asked this question: "Now, you said earlier of course that does not follow in all of these cases where there is a hyperflexion-extension injury that in three or four months they should be all right?"

MR. BUCK: I'm going to object unless you establish the degree of injury of this hyperflexion-extension injury.

Q Do you remember your answer Doctor: "I talked about probabilities, sir, and I talk in the majority, great majority of cases she should be unless they show up on long-term things with post-traumatic changes, which she has not."

A I told you, sir, I don't remember that. I'm sure I said that's a reasonable thing, and it depends on degree of severity in which case you're talking about in the problem and if you want to say with her, if you want to stretch it out to three or four months, I would doubt that, but certainly by three or four months I would say you'd reach a 99 percent probability that it would be gone.

Q Now, Doctor, the X-ray from the emergency room of Salem Hospital on August 29 of '84, it says negative for fracture, doesn't it?

A Yes, sir.

Q And a person doesn't have to have swelling immediately after the trauma, does he?

A The significant -- the onset of the swelling is related directly to the significance of the trauma.

Q Well, Doctor, have you ever bumped your thigh on a table or a desk and not seen anything then, and then the next morning you have swelling and a bruise?

A Just what I said, it's totally related to the significance of the trauma. If it's just a real minor trauma and the less the degree of trauma, then the more likely it is that you would notice this at a later date. The more severe the trauma, the more tearing and things and the more you're going to see this right away. Just like in the knee joint, maybe I can explain it to you this way; if you see swelling in

the knee joint within two hours, that's bleeding. You tore something that bled or you chipped a piece of bone off. If something swells two hours or later, then it can just be the reaction of the joint fluid there. So the bleeding is how much you're bleeding, and so it's how much you're going to notice it right away. So it's directly related to severity of injury.

Q When was Sharon fellow seen in the emergency room after the accident?

A The time looks like 1350, which I would assume is the time that the accident occurred. The time in the emergency room here is 11:56: I really don't know what time her accident occurred.

Q What time did she go to the emergency room?

A I believe, if I can read this right, time in is 11:56, and I believe time out was 1350, which would be 1:50.

Q Take a look at the copy of the police report. You'll see the accident time was 10:40.

A Okay.

Q Fair enough? Now, Doctor, would you agree that sometimes a medical examination in itself is stressful?

A Certainly.

Q Person's going to fear what the doctor might find; isn't that correct?

A Certainly.
Q And that in itself -- well, hospitals aren't pleasant places, are they?
A To some people. Some people like them.
Q Doctors probably like them?
A Not necessarily.
Q Well, be that as it may, a person who's just been in an accident and is awaiting treatment in an emergency room, diagnostic treatment, that would exert some stress on that person, wouldn't it?
A It could.
Q And you could still have adrenalin pumping, couldn't you?
A You could.
Q Now, the series of X-rays that Dr. Brocker took, those could serve multiple purposes, couldn't they?
A I guess. I can't tell you why he took them.
Q He could be charting the progress of the patient, couldn't he?
A I don't know what progress he would be charting.
Q To see what kind of changes there are in the area of the surgery?
A Okay. Over a short period of time you would not expect to see any changes.

Q Dr. Brocker could have been practicing defensive medicine, couldn't he?
A I guess. I don't know what he would be defending against with an X-ray.
Q The entries of his examinations after the surgery in his records say doing well, don't they?
A Yes.
Q Doctor, you mentioned in response to Mr. Buck's redirect examination that there were some other orthopedic tests other than the compression test and the Valsalva test that you could have performed but didn't; is that correct?
A I didn't say orthopedic. I said there are other tests. I didn't say specifically orthopedic tests.
Q Well, were there other orthopedic tests that you could have done but didn't, other than the Valsalva and compression?
A Sir, there are literally hundreds of thousands of test you could do.
Q So there were more available to you?
A Yes. I thought I very thoroughly explained that.
Q You compared a neck sprain with a sprained ankle. Doctor, how many joints are there in an ankle?
A Oh, there is probably 7 or 8 around the ankle

joint.

Q How many joints in the neck?

A We went over, what did I say? Depending what you're talking about, probably around 20.

Q Now, the range of motion tests that you put Sharon Fellows through, you say that she had control over that?

A Yes.

Q Flexion was normal; she was able to do that within normal limits?

A Yes.

Q Then there is also lateral bending, isn't there?

A Yes.

Q That would be when the person places his right ear on his right shoulder?

A Rotation is essentially the same thing.

Q Oh, okay. Fine. You did rotation?

A Yes.

Q She rotated to the right?

A Yes.

Q That was within normal limits?

A Yes.

Q And she rotated to the left when you asked her, didn't she?

A Yes.
Q And that was within normal limits?
A Yes.
Q It was only when she extended her neck and put it back that there was what you call minimal loss of extension?
A Correct.

MR. MATAVICH: Thanks, Doctor. I don't have any more questions.

MR. BUCK: Nothing further. Doctor, will you waive signature?

THE WITNESS: Yes.

MR. MATAVICH: Wait a minute, I do have another question. Let me ask a couple more questions here.

FURTHER RECROSS EXAMINATION:

By Mr. Matavich

Q Doctor, would you agree that it takes a considerable period of time for bone to be produced, and I'm talking about osteophyte spurring?

MR. BUCK: I'm going to object to any further cross-examination unless it is, in fact, cross-examination. If you're going into new areas now, I'm going to --

MR. MATAVICH: You were the one

who asked him about this.

MR. BUCK: I never asked him about that.

MR. MATAVICH: You asked him about degenerative changes in the neck that he would see on X-ray, and that's what degenerative changes are, osteophytes and spurs.

A What was your question?

Q Takes a considerable period of time for osteophytes and spurs to form on a person, doesn't it?

A Yes.

Q You can't tell us what Sharon Fellows' X-ray is going to look like a year or two from now, can you?

A No.

MR. MATAVICH: No further questions.

MR. BUCK: Waive signature, Doctor?

THE WITNESS: Yes.

REPORTER'S CERTIFICATE

I HEREBY CERTIFY that the above and foregoing is true and correct transcript of all the testimony introduced and proceedings had in the taking of the testimony in the above-entitled matter, as shown by my stenotype notes, taken by me at the time said deposition was held.

Lisa C. Nagy-Baker
Lisa C. Nagy-Baker
Registered Professional Reporter

STATE OF OHIO)
) SS: CERTIFICATE
MAHONING COUNTY)

I, Lisa C. Nagy-Baker, Notary Public within the State and County aforesaid, duly commissioned and qualified, do hereby certify that the above-named, DR. E. HERBERT THOMPSON was by me first duly sworn to testify the truth, the whole truth, and nothing but the truth, and that the foregoing deposition was written by me in stenotype in the presence of the witness; that by agrement of counsel, signature was waived.

I do further certify that I am not of counsel, attorney or relative to either party, or otherwise interested in the event of this action or proceeding.

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office at Youngstown, Ohio, this 19th Day of October, A.D., 1988.

Lisa C. Nagy-Baker
Lisa C. Nagy-Baker, Notary Public
My Commission Expires 12/14/88