IN THE COURT OF COMMON PLEAS

HAMILTON COUNTY, OHIO

CASE NUMBER: A1402190

JUDGE STEVEN E. MARTIN

MCKENZIE DAVIS	PLAINTIFF
vs.	
DELHI TOWNSHIP OHIO DBA DUNGEONS OF DELHI, ET AL.	DEFENDANTS

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DEPONENT: DR. GERALD STEIMAN

DATE: AUGUST 23, 2016

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Mindy Davis

Certified Court Reporter

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Covington, Kentucky 41011
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EXHIBITS

The deposition of DR. GERALD STEIMAN, taken for the purpose of discovery and/or use as evidence in the within action, pursuant to notice, heretofore taken at the office of Steiman Neurology Group, 5150 East Main Street, Suite 100, Columbus, Ohio, on August 23, 2016, at 10:00 a.m., upon oral examination, and to be used in accordance with the Ohio Rules of Civil Procedure.

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APPEARANCES

ATTORNEY FOR PLAINTIFF:

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DR. GERALD STEIMAN,

called on behalf of the Plaintiff, after having been first duly sworn, was examined and deposed as follows:

CROSS-EXAMINATION

BY MR. MAISLIN:

Q. Dr. Steiman, let me ask you to just state your name for the record, please.

A. Gerald Steiman.

Q. And you were hired by whom in this case?

A. By Mr. Brad Powell.

Q. All right. And do you know who he represents?

A. No.

Q. Do you know that he's defending a civil case that's been brought by McKenzie Davis and her mom?

A. Yes, I do.

Q. And how were you told that information?

A. By Mr. Powell.

Q. Did you have a chance to see McKenzie Davis?

A. Yes.

Q. And did you also review her records?

A. Yes.

Q. And there's a huge stack of records that's in front of us. Tell me, is that your entire chart?

A. Correct. And all of it was received by Mr. Powell -- was from Mr. Powell.

Q. Okay. Other than the medical records that are in this big stack with a rubber band, looks like it's about 13 inches, maybe 12, have you reviewed anything else?

A. No.

Q. So the extent of your evaluation in this case included review of all the medical records of McKenzie Davis and an independent medical examination that you, yourself, conducted?

A. Yes, sir.

Q. Anything else that you relied on in this case?

A. No.

Q. There was a medical records summary that was provided to a different defense expert in this case that was created by defense counsel. Have you seen that?

A. Not that I'm aware of. We don't use -- I would never use that.

Q. Okay. And why not?

A. Because that's defense counsel's work

product, not mine.

Q. Okay. Are there any records in particular that you notated or you tabbed that you find to be more important than others when you are relying on your opinion?

A. No, everything about a patient is important. I mean, what's more important depends on the question you ask me.

Q. All right. And how long did you spend with McKenzie Davis?

A. Oh, the time slot is 45 minutes and probably pretty close to a full 45 minutes. I can't remember specifically, but it was probably pretty close.

Q. Where did you perform your examination?

A. I think it was here in the office.

Q. In Columbus?

A. I think so.

Q. Okay. And I'm only saying that for the record because we're down in Cincinnati. What is your office address?

A. 5150 East Main in Columbus.

Q. Do you have any other offices?

A. I do independent medical exams in an office just south of Dayton. I go there about once

a month to do IMEs typically for the state, but I don't see patients or anything there.

Q. So you have an office dedicated just to independent medical --

A. In the Dayton area, in the Miamisburg area.

Q. And how much time do you spend down there?

A. About one day a month. Usually it's like I would see anywhere from two to five claimants or IMEs or what have you.

Q. And you said mostly by the state. Who else would be hiring you for those?

A. I mean, I do IMEs for many entities, whether it's Social Security, Department of Labor, Postal Service, Bureau of Workers' Comp, medical malpractice, personal injuries, things like that. So whatever is scheduled there, I see.

Q. I understand, but who are the entities that are actually hiring you? I mean, the government's obviously one of them. In this case you were hired by --

A. Oh, it could be government, it could be attorney, it could be Workers' Compensation through a third-party administrator or anything of that nature.

Q. You ever do any work for plaintiffs' lawyers?

A. Sure. Sure.

Q. What's the percentage --

A. Well --

Q. -- breakdown?

A. -- of all the IMEs I do, about three-quarters, two-thirds, three-quarters are actually government related, so there's no defense or plaintiff. It's strictly from the Bureau or what have you or from Social Security. About a third have an attorney involved, and probably nine out of 10 would be for defense and one out of 10 would be for plaintiff. Typically plaintiff uses treating physicians, defense uses IMEs, and that's why the skew in the numbers.

Q. Why don't we rely on plaintiff's physicians, are they just not as good as you?

A. No, that's a trick question so let's get beyond that.

Q. No, I like my question. Why --

A. I think it's a silly question.

Q. Okay. Why do people hire defense experts like you?

A. Oh, probably because I'm experienced, I'm

knowledgeable and trained. I've got expertise. That's why people hire me. Why would defense? Because typically, as far as I am aware, defense is not able to use treating physicians.

Q. Why do you say that?

A. That's just only my thought. I don't have expertise in that area.

Q. Have you talked with the treating physicians in this case?

A. No, that would be, in my mind, a breach of ethics.

Q. What if we gave you authorizations and you had the opportunity to talk with the treating physicians in this case, do you think that would help you with your opinions?

A. No, I don't think it would help me in this case because this, to me, is no different than a second opinion. If a patient came to see me, I would give them an opinion as to whether I think -- what my thoughts are. And if the treating physician has the same -- let's say another physician has the same thoughts or has a different thought, I'm not there to, you know, enter into an argument where I think it's green and they think it's blue. I'll give you my opinion.

Q. Just so I get the numbers right, you said two-thirds to three-quarters, roughly in that area, you're representing the government?

A. Yeah. Well, I'm asked to see them on behalf -- from a government. I don't look upon it as representing the government.

Q. And what is the government looking into, are they looking into whether or not somebody should receive treatment to be paid for by the government or what are we talking about?

A. Well, it varies. It could be whether they deserve Social Security benefits, whether they have a bus driver employed by the state, whether they're able to go back to work as a bus driver, whether a teacher who has MS is able to go back to work as a teacher, whether a fellow who is injured at work, what injury did he sustain, what is the recommended treatment, so it varies.

Q. And this is when -- they're asking you to do this instead of the treating physicians?

A. Well, there may be a -- there may be a conflict as to what the right thing to do is or whether it's appropriate, whether it's related, whether it's not related. So they would determine -- I don't know on the basis of why they

would determine it, but they ask me to see a claimant and give an opinion.

Q. There are other physicians in this case that have reviewed McKenzie Davis' medical records and provided opinions, correct?

A. Correct.

Q. You're aware of some of the other opinions in the medical records?

A. Correct.

Q. Are you familiar with the physicians that provided those opinions?

A. No, I do not know them.

Q. Okay. You don't have an opinion one way or the other whether their opinion was properly formulated or not?

A. Well, I don't know the basis of their opinions. I mean, if a doctor says -- like in this case some doctor makes a diagnosis. I don't know the basis they use to make that diagnosis. I know what they diagnosed.

Q. Do you know how many doctors in this case diagnosed McKenzie Davis with either RSD or CRPS?

A. No. I think she saw a number of different pain managers and they all agreed with themselves, but I don't know the exact number.

Q. Any orthopaedic doctors?
A. I think she saw Dr. Amis and I know initially she saw a Dr. Burger, but I can't remember offhand if she saw another orthopaedic surgeon. I'd have to go through the specific notes of the chart.
Q. Okay. And are you able to say that your opinion holds more weight than any of the other physicians in this case?
A. No, I'm not claiming one holds more weight. I'll give you my opinion. I'll give you the basis of that opinion. I'll give you the science behind my opinion. So I can -- my role, I view my role as -- not just to formulate an opinion. So it's a discussion as, quote, unquote, who's stronger or who's taller or who's shorter, but I'll give the scientific basis and the science of this entire area and set forth the basis of my opinion.
Q. What percentage of your practice deals with either RSD or CRPS?
A. Patients who actually have the illness or patients who are referred to me to assess whether or not they might have?
Q. Well, let's break it down.
A. Well, I can't. You see, you use the term

RSD and I respect that you're using the term, but please be aware the current term is a little different name. But for the sake of discussion, why don't we agree we'll use the terms interchangeably?

Q. Okay.

A. So RSD is a diagnosis which is often made but seldom meets diagnostic criteria. So in my experience, a number of patients that I might see who are referred to assess whether or not they might have RSD, in fact, have an alternative explanation as to why they have their system complex. It's not RSD, but it's something else. The number of patients with RSD, it's hard to -- probably in a year I would see hundreds of patients who are thought to have RSD. In a year I might see a dozen patients who meet the criteria of RSD.

Q. And how are these 100 patients coming to you throughout the year?

A. Treating physicians, emergency rooms, government, attorneys who want an opinion as to whether they have it.

Q. Really I'm looking for a breakdown. I mean, how many of these are you actually being hired to treat and diagnose?

A. You mean that are my patients?

Q. Yes.
A. Probably 50 a year, plus or minus, of which, let's say, half come from independent medical exams, half comes from referring physicians. And of both groups, as I said, maybe 10 percent actually have the diagnosis.
Q. In the 45 minutes that McKenzie Davis was in your office, did she spend the entire 45 minutes in your presence?
A. Pretty well. I know my nurse would go in there at the beginning and get some history and then I would spend time with her reviewing it, so the majority of time, yes.
Q. Do you think that she was lying to you during her interview?
A. No.
Q. Do you think that she was fudging anything or intentionally magnifying symptoms; do you know?
A. Intentionally magnify, I didn't assess her for that. If you're asking me did I assess her to see if she was giving heightened responses, no, I did not. You raise an interesting point. I know she has a history of depression and anxiety, and those patients tend to have heightened symptomatic complaints. She was on narcotics. And as you're on

narcotics for a long period of time, they become less effective so you have more pain so you need more narcotics. In that group of patients, you often determine their impairment, if I can use that word, based on objective physical findings rather than subjective complaints. But I didn't find and I didn't look into whether she was exaggerating, embellishing, magnifying, I'm just aware of that.

Q. Aware of what?

A. That patients may do that, but I didn't assess her for that possibility.

Q. Okay. Just so we're clear, because sometimes we go into court and there's these hints that maybe a client or a patient is intentionally fabricating symptoms, you're not going to present any opinions in this case that she did that?

A. No.

Q. I'm going to -- I have your report here.

A. Sure.

Q. It's a discovery deposition. I'm going to keep it easy. It looks like it's a 23-page report; is that correct?

A. Correct. And just to save time, the first part is the history that she gives me directly, all right? I obtain that from her.

Q. Anything in the history that she gave you, do you find any of that inconsistent with any of the other findings that you made either during your exam or the record review?

A. No. I mean, you asked me, as I look, she saw Dr. Sammarco, an orthopaedic surgeon, so it's here. It talks about who she saw, what they did, the response she had, things of that nature. Her past history is obtained from her job activities. As you can see, she wrote down, and I expounded on that, what her complaints are. Activities of daily living and pain perception are standardized forms. Social history is directly from her. Medical record review is a -- what I consider to be a pertinent summary of her medical records. Then the discussion is basically a discussion who she saw, what they did, and then I discuss in part the diagnostic criteria of CRPS, both the AMA Guide diagnostic criteria, the diagnostic criteria of the International Association for the Study of Pain and then the so-called Budapest criteria which are really just a proposal to amend the IASP criteria published by Harden, et al, where basically the difference between the two, I highlight the difference between AMA criteria, which are highly

objective, ISAP criteria, which are minimally objective, and I applied her physical findings to both criteria to see if she met the diagnosis and reached my conclusion.

Q. When you talk about her physical findings, are you talking about the ones that you personally were able to notice during your exam?

A. Correct.

Q. Are you referring at all to any of the physical findings that may have been objectively seen by any other physician in the medical records?

A. Correct. I reviewed all of that. I look to see if she met the criteria for me and I look to see if she met the criteria identified by any other physician. Now, be aware sometimes she'll see a physician and she'll complain of -- she'll present a subjective complaint.

Q. That's subjective. I'm just talking about objective findings.

A. Oh, objective. No, I did not see objective findings by her treating physicians that she met the ISAP or the AMA or the proposed Budapest criteria for CRPS.

Q. If I look at your report, and specifically I'm looking at page 21 of 23 and it's the last

paragraph before the opinion.

A. Correct.

Q. About halfway down it starts with she does not, however, have any objective evidence of complex regional pain syndrome.

A. Correct.

Q. There was no objective evidence of temperature asymmetry and/or skin color changes/asymmetry. There is no evidence of edema or sweating changes. There is no motor dysfunction except that secondary to pain. There is no intrinsic muscle weakness, tremor, or dystonia. There are no dystrophic changes of the skin, nails, or hair. In addition, there is an alternative diagnosis which better explains Ms. Davis' current symptoms. Did I read that correctly?

A. Yes, sir. If you go to the beginning --

Q. Hold on a second. I'm going to ask a question.

A. Okay.

Q. When you say there's no objective evidence of these things, are you referring to in your exam?

A. Yes.

Q. Okay. You're not referring to the exams by the other physicians in the medical records?

A. Correct, sir.

Q. All right. Because if I look through the medical records, I mean, there is objective evidence by other physicians of asymmetry and skin color changes and edema, correct? I'm just asking if there are those objective findings.

A. Well, that's a difficult question to answer, and I'll tell you why. You see, somebody may say there's edema, but they don't provide a measurement and they don't provide an observation to support that. Someone may say there's a temperature change, but they don't supply objective information to substantiate that. So you're left wondering on what basis do you decide there was edema, on what basis are you assessing a temperature change. You can't do it by skin touch. You can't just put your hand on someone's skin and say that's a viable temperature assessment because all that measures is a difference between my skin temperature and the patient's skin temperature.

Q. What if it's asymmetric?

A. Then give me a measurement.

Q. I'm saying, can you not tell if you touch one thing and it's colder than when you touch another thing?

A. No. You can't tell by touch. And that's a major, major criticism of a lot of the diagnoses. If I touch your right leg and I touch your left leg and let's say I perceive a difference in temperature, A, is that temperature difference significant and, B, what am I testing? I'm only testing the difference between my skin temperature and your skin temperature, all right, and how fast the temperature moves through the medium. In other words, if I put a piece of metal in this room, it's room temperature. It's room temperature. Yet if I touch it, it feels cold. Why? My skin is room temperature.

Q. But what if you touch one end of the metal and it's cold and you touch the other end of the metal and it's warm?

A. It's not the way you do it. You do --

Q. Why --

A. Because that's not scientifically valid. It's not scientifically valid.

Q. What about skin color changes, any physician notice skin color changes?

A. Yeah, a lot of physicians did.

Q. Okay. So would you test that in your office if you noticed skin color changes?

A. Take a picture.
Q. Have you seen any pictures in this case?
A. Not of her, no. I'd take a picture and see if there's skin color changes. I would take --
Q. So you can't rely on a doctor saying it, they would have to take a picture and give it to you?
A. Oh, when you provide a second opinion, you don't rely on anything that anybody says. In other words, if I'm seeing this individual and I document the temperature, you may say it feels warm or it feels cold or one is different than the other. I'm going to give you temperatures to assess whether there is, in fact, a difference. One is objective verification. The other is just an opinion based on anecdotal or unscientific measurements.
Q. Let's talk about viewing mottling of the skin or what is that, allodynia?
A. No, those are two different things completely.
Q. I'm sorry, that's feels different --
A. No, allodynia doesn't mean feels different. Allodynia doesn't mean feeling different.
Q. Well, what about -- let's just talk about

skin color changes.

A. All right. Show me a picture.

Q. If a doctor says there's skin color changes, you're going to dismiss that, you need to see a picture?

A. No, if a doctor says there's skin color changes, I'll accept that he opined there was skin color changes.

Q. But will you use that at all in formulating your opinion?

A. No, because that's his finding, not my finding. So if you ask me, I need to see the skin color changes. Just because that doc saw them -- you see, if a patient has a skin color change, has the same illness ongoing and they have a skin color change a week ago, I'm going to see it now because the skin color changes don't come and go. They don't disappear and come and go and come. They're there. So if you say there's skin color changes and you see her at the first of the month, I see her at the end of the month, I'm going to see skin color changes.

Q. So you're saying that it's a constant skin color change?

A. Not a hundred degree constant where it's

there, but you will always see a skin color change. It does not come and go and disappear depending on who sees the individual.

Q. And what about edema or swelling, does it come and go?

A. No.

Q. So you're saying that if somebody has -- again, we're calling it RSD for the purpose of this deposition.

A. Sure.

Q. You're saying if they have symptoms, the symptoms are static?

A. They wax and wane. I don't want to use the word static, it's the same color red or the same mottling every time you see them. It will wax and wane like every illness waxes and wanes, but you see the symptoms.

Q. I'm going to go through -- if you look at the IASP Guides, it proposes 11 objective characteristics divided into subcategories, page 19 of 23 of your report.

A. No, for correction, you're talking about the AMA Guides. The AMA Guides have eight out of 11 concurrent diagnostic criteria which means, you see, CRPS isn't a diagnosis where you have a lab valve if

it's greater than 10, you have it, if it's less than 10, you don't.

Q. I understand.

A. So, therefore, CRPS is a diagnosis made basically on a statistical analysis. And I'll give you what I mean. If you have a cough, no doc is going to look at you, oh, you have a cough, God forbid you have lung cancer. No one is going to say that. That's silly. But suppose you have a cough, you're a heavy smoker, you've got a lung mass, you're spitting up blood, you're losing weight, suddenly that scenario sounds a little bit more like lung cancer. Now, you have chest pain. No one's going to say simply because you have chest pain you've had a heart attack. It could be gallbladder. It could be ulcer. But you've got chest pain with exertion, it's like an elephant sitting on your chest, it's going into your left arm, it's going in your face, you're feeling your heart pound erratically, that's a little bit more indicative of a heart attack. CRPS is the same type of diagnosis. If you go to your -- I don't know how old you are. Let's say you go to your -- I'm old enough, you go to your son's wedding. You wear a new pair of tuxedo shoes and you're dancing all night and you

come home and your feet are swollen and your feet are red and your feet are sweaty and they hurt and they're mottled. That doesn't mean you have RSD. Doesn't mean you have RSD. So you want to look at the objective criteria. And the more objective criteria you have, the greater the sensitivity is that you're correct in making the diagnosis.

Now, won't get into the reasons, AMA has eight out of 11 criteria for much greater sensitivity. IASP has only one objective criteria, so their sensitivity is far less. The Budapest criteria was a move by Harden to increase the number of objective criteria from one to three to make it a little bit more sensitive and specific. The Budapest criteria haven't been voted upon, so they're not official criteria of the IASP as of yet. But you can see that the diagnosis of this entity is based on the number of physical findings you have supporting the criteria. IASP has basically -- well, they have three sets of criteria. They have one set if you're doing research, they have a second set if you're doing clinical, and have a third set if you're basically not smart enough to figure out the answer, which is you have no physical findings but I can't think of anything else except RSD so I'm

going to call it RSD. But let's take away that one because no one really considers that to be a valid criteria. But IASP has a research criteria and a clinical criteria. Their research criteria are a little bit more objective, a little bit more sensitive.

Q. Okay. I'm just going to ask you, when you look through the medical records -- let's go through these that's on page 19 of 23.

A. Okay.

Q. Have you seen any doctors note changes in skin color which could be considered mottled or cyanotic skin color? I'm just asking a question.

A. I'd have to look specifically to see whether they noticed it or whether they rely on the patient who told them that, but let me try to -- it's such a complex case. Let me -- rather than talk off the top of my head --

Q. How about Dr. Stanton-Hicks on August 20th of 2013?

A. Before that, September 3rd, she sees Dr. Smith who noted mild swelling with erythema.

Q. What's erythema?

A. Redness.

Q. Okay. Only on the one side?

A. It doesn't say. He just says -- he just examines the left ankle, doesn't say if there's anything on the right ankle.

Q. What's erythema?

A. Erythema, redness. It's red.

Q. So August 9, 2013 Dr. Smith, a physiatrist, said the exam revealed mild swelling, erythema?

A. August 5th or August --

Q. August 9th.

A. August 9th. Mild swelling, erythema, reduced range of motion, and increased pain compared to the stimuli with normal sensation, reduced strength.

Q. She also saw that on September 9th?

A. September 9th, same things on the exam. Dr. Smith is a physiatrist, but she functions as a pain manager. She's a pain manager. Dr. Caneris, another pain manager, identifies allodynia, a purplish discoloration and swelling.

Q. What about Stanton -- are you familiar with Stanton-Hicks' work?

A. I'm familiar with Stanton-Hicks. He's at Cleveland Clinic, I believe.

Q. On August 20, 2014 she went to

Stanton-Hicks?

A. Let me get there. On exam, there was tenderness over the spinal cord stimulator site. No edema. Slight reddish discoloration of the left foot on the dorsum of the foot.

Q. So just even with those examples, it's fair to say that there are doctors who are seeing mottled or -- in any event, it would satisfy 1A?

A. Of the IASP criteria?

Q. Well, I thought you said the AMA Guidelines?

A. Oh, I just want to make sure the one -- the -- in 1A of continuing pain which is disproportionate, are you talking about that?

Q. No, I'm looking at the vasomotor criteria, page 19 of 23 of your report.

A. The vasomotor criteria, that's -- you're on page 19?

Q. Yes.

A. That is -- one of the doctors or several of the doctors talk about mottled or cyanotic skin. They talk about mottling.

Q. Okay. And then have you noticed that any of the doctors talked about cool skin temperature?

A. Yes.

Q. I know you don't rely on their opinion?
A. Well, they did that, but none of the doctors took measurements. So I can't accept that as being a valid assessment, not without measurements.
Q. Okay. So you don't accept it, but they talk about it?
A. They talk about it, yes.
Q. Do you know if they took measurements and it doesn't say it in the record, or you don't know?
A. Well, if it doesn't say in the record, typically they didn't do it.
Q. Edema, we see that all over the place, right?
A. Correct, they talk about edema.
Q. Okay. So for the vasomotor criteria, we have doctors talking about A, B and C, correct?
A. Yeah, different doctors at different times, yes, sir.
Q. Okay. The Sudomotor criteria, have you seen anything where it was overly dry or overly moist skin? If I can help you out, somebody says that the skin looks slick. Do you recall reading that in the records?
A. No, but I'll assume they say that. I'm

just not sure what slick means.

Q. Okay. So you're not incorporating that as having any value, in your opinion?

A. I don't know what slick -- slick, as far as I know, isn't a medical descriptive term.

Q. Okay. Trophic criteria, did you see anything in the records regarding smooth, nonelastic skin texture?

A. Not that I'm aware of.

Q. Soft tissue atrophy?

A. No.

Q. Did you see any issues of atrophy at all regarding her leg?

A. I'm not aware she showed atrophy by anybody's measurements or observations.

Q. Okay. You measured her legs?

A. Yes, sir.

Q. You didn't notice any atrophy?

A. No.

Q. And you don't recall any other doctor mentioning atrophy?

A. No, I don't. I wouldn't be surprised if she did, having the surgeries she's had, but I don't recall anybody specifically measuring or documenting the trophic changes.

Q. What about joint stiffness with decreased passive range of motion?

A. The joint stiffness with passive range of motion she didn't have. She has joint stiffness because of the surgery she's had. And the joint stiffness is both purely orthopaedic in nature and also there's reduced movement of the joint secondary to pain, but it's not intrinsic joint stiffness.

Q. Well, it says passive range of motion joint stiffness?

A. Correct.

Q. What does that mean, actually?

A. Well, the -- it's an intrinsic decrease in movement. You see, the joint is stiff intrinsically. So it's not you're not moving because of pain and it's not you can't move it because you had surgery, that the joint becomes -- think of it as scarred or fused, that it can't move. So you passively move the joint. It's not the patient actively moves it, you passively move it. And you find it has reduced movement or stiffness in motion not explained by pain and not explained by an orthopaedic mechanical issue.

Q. Just so I'm clear, when they say no better alternative diagnosis, do you apply no better

alternative diagnosis to each one of these characteristics on their own?

A. No, that's not -- when you're referring to the IASP criteria, one of the criticisms of IASP is it has an out. It has an out. So it's no better alternative diagnosis, which is another way of saying are you smart enough to come up with the right diagnosis because when it says no alternative diagnosis, it means --

Q. That's not my question.

A. Oh, you don't apply it to each one individually, you apply it to the entire process. So in a patient who presents with -- you want to assess them doing the IASP criteria. And their feet are swollen, red, hot, edematous, sweaty, slick, you name it, but they were dancing at a wedding with a new pair of shoes. Well, an alternative diagnosis better explains your symptom complex. So you're not going to diagnose RSD, you're going to give it another diagnosis.

Q. Moving onto the radiographic criteria, do you see any x-rays with evidence of trophic bone changes or osteoporosis?

A. No.

Q. No?

A. I don't believe she had.

Q. Would that be important to your opinion if she had that?

A. No. No. I mean, of course it's important to the opinion if indeed it's due to the diagnosis of CRPS. If you have a patient with three orthopaedic procedures or two orthopaedic procedures and they now show bone changes, that's important -- that's an important finding, but you need to determine is the bone changes due to the orthopaedic or are the bone changes due to CRPS.

Q. That was what I was asking you, is you're finding alternative diagnoses for each criteria --

A. No, not for each, for the diagnosis, for the diagnosis. It's not can you find an alternative explanation for A and B and C. You will -- as you go through the steps in the diagnosis, you put all the things in favor of the diagnosis, you put them in a list, and then you ask yourself is there an alternative diagnosis that better explains all these symptoms, not can I find a different excuse for symptom A, B, C and D, but put them all together, is there a better explanation.

Q. Okay. So let's talk about osteopenia around her ankle in the left tibia and fibula on

March 22, 2014. You have it noted on page 10 of your report.

A. Let's look.

Q. That was with Dr. Braun, family physician?

A. Yes, there is osteopenia around the ankle on an x-ray.

Q. Okay. So is that what they're talking about in 4A?

A. Yes.

Q. And then have you seen a bone scan? Now, when they say a bone scan, do they mean an actual bone scan or can you use an MRI or an x-ray? Does it have to be an actual bone scan?

A. It has to be an actual bone scan.

Q. Had she had any bone scans?

A. Something tells me she did, but I can't remember offhand.

Q. Well, let me ask you this: There was an MRI on September 11, 2013?

A. Yes.

Q. And there was Achilles hypertrophic tendinopathy and peritendinitis?

A. Yes.

Q. Now, my understanding is hypertrophic tendinopathy means a non-tumorous enlargement of

tissue, right?

A. Okay.

Q. Yes, no?

A. Yeah, that's --

Q. Well, you tell me what it means.

A. Hypertrophic tendinopathy?

Q. Yeah.

A. Okay. Pathy means a problem. There's a problem in your tendon and it's hypertrophic, meaning it's enlarged, so you have an enlarged tendon. As to why you have it, it doesn't tell you but the tendon's enlarged.

Q. At the end of your paragraph there, which actually continued on to page 9, it says there was no marrow reaction or marrow changes as a manifestation of reflex sympathetic dystrophy?

A. Correct.

Q. And that was on September 11, 2013, correct?

A. Correct.

Q. And then on February 13, 2014, Ms. Davis went to Good Samaritan Hospital emergency room?

A. Yes.

Q. And it showed a generalized loss of bone marrow density around the foot and ankle as well as

the distal leg consistent with disuse osteopenia or RSD?

A. Yes, either one.

Q. And then it was a month later where there was swelling in an x-ray, showed the osteopenia around the ankle?

A. You're referring to the MRI of March 26th of '15 or the x-ray of March 22nd?

Q. No, March 22 --

A. Osteopenia around the ankle.

Q. Right?

A. Yes, sir.

Q. And I have osteopenia is when the body doesn't make new bone as quickly as it reabsorbs old bone?

A. Correct.

Q. So what is your explanation of the difference in objective findings between the no marrow reaction, marrow changes of September 11, 2013 and then seeing these x-rays with the osteopenia on March 20, 2014? Why would that happen?

A. Well, because they're looking at different processes. The first is the x-ray shows a thinning of bone but you don't know why. It could be because

of disuse. It could be because of RSD. The MRI looks at the marrow change itself and is it the type of marrow change that you would see in RSD. Didn't see that. So if you put all those x-rays and the MRI together, it's saying that the atrophy -- that the osteopenia she has is disuse osteopenia. There's no good evidence that it's RSD type osteopenia.

Q. What's the degree of temperature change that would be required to satisfy the objective finding of temperature change?

A. According to the International Association of the Study of Pain, you want a one-degree centigrade difference.

Q. Did you see that anywhere in the records, because I just saw it?

A. Did I see it anywhere in the records?

Q. Well, if you look at Dr. Lee who evaluated her on April 11th, he said the left foot temperature was 86 degrees compared to 85 degrees on the right?

A. Okay. That's a one-degree Fahrenheit, so he didn't find it.

Q. How do you know it -- well, I guess it would have to be Fahrenheit, otherwise it would be in the 20s or --

A. Yeah, it's a one-degree. Now, that figure was from the IASP itself. They published that as to what temperature asymmetry was significant. AMA doesn't stipulate the temperature asymmetry. IASP stipulates it has to be more than one-degree centigrade.

Q. What is low-grade medial tibial stress syndrome?

A. Low-grade medial tibial syndrome, syndrome refers to the signs and symptoms you have and tibial stress is -- it's referring to the tibial part of the ankle, that there is inflammation in the tibial tendons, and as a result of that, you've got discomfort.

Q. There was a bone scan done, it looks like, right? I'm referring to Dr. Amis' records, references a bone scan which demonstrated uptake in the third and fifth metatarsals and around the lateral pole of the navicular. In addition, it sudden uptake in the subtle talar joint.

A. Now, you're referring to --

Q. Page 13 of your report.

A. Okay. I just want to get on the same page as you. Yes, he references a bone scan which demonstrated increased uptake in the third to the

fifth metatarsals. Now, that's not a triple phase bone scan, so that bone scan is not used for RSD determination. It's a triple phase bone scan which we use in RSD. This --

Q. Who uses the triple bone scan for RSD, everyone, or just you?

A. No. I mean, some doctors do, some doctors don't.

Q. Okay. But you don't like it because it's not the highfalutin triple bone scan that you like?

A. No. No. No. No. Okay. I'm mistaken. In the criteria for RSD put forward by the AMA Guides, they specifically use triple phase bone scan findings. And that's because a routine bone scan doesn't have the ability to assess for RSD. You can't get that information.

Q. Is that a universally-accepted proposition, what you just said, that you have to use a triple phase bone scan?

A. Well, I'm not aware of anybody using a routine bone scan for RSD. I can't say whether it's universally accepted, but in almost 40 years of practice I've never heard of anybody diagnosing RSD off of a routine bone scan.

Q. Well, nobody would just diagnose RSD off a

bone scan, right?

A. I've never seen anybody use a regular bone scan as a diagnostic criteria helping them to reach it. It's always been a triple phase bone scan. In fact, when someone does a bone scan and they're thinking about RSD, you then got to waste the patient's money and do the triple phase bone scan because that's a test they should have ordered in the first place. So to answer your question, I'm going to say universally, I'm not going to say you're stupid if you do it, I'm just going to say I am not aware of anybody using the results of a routine bone scan as informative for RSD. The bone scan that Dr. Amis looks -- refers to, it says there's increased uptake in the third to fifth metatarsals. You'd wonder whether there was -- that tells you there's an increase in blood flow in that area. And if there's an increase in blood flow, could there be a fracture or a stress fracture in that area. Very often you'll do a routine bone scan if you fracture your elbow or you fracture, let's say, your wrist and you do an x-ray and it's perfectly normal, a bone scan is one method of telling you whether there has been a fracture. But you can't see it on x-ray because there will be

increased blood flow in that area because fractures have increased blood flow. An MRI --

Q. Is that what it means by uptake?

A. Yes, uptake -- you see when you have a bone scan, you put radioactive material in your blood.

Q. Okay.

A. If there's an increased blood flow to an area, it will show more radioactivity.

Q. What do you expect to see on your triple bone scan if there's RSD?

A. Well, typically it's a delay in the third phase.

Q. I'm sorry, it's a delay in the third phase?

A. Delayed third phase.

Q. Which means what?

A. Altered blood flow in the third phase. It's got to be done if so much time -- it's a radioactive assessment so much time after the administration of the dye. You test it about an hour later.

Q. And what are you looking for?

A. Well, what is -- well, you're looking for an increased uptake.

Q. All right. So the same thing as this one except this one is just not the fancy --

A. Yeah.

Q. You don't like it?

A. It's not that I don't like it, it's not used. I mean, it doesn't matter if I like it or not like it, it's not used.

Q. Well, if there's an increased uptake --

A. Totally different.

Q. If there's an increased uptake in the bone scan that they're referring to here -- and do we know if it's a triple -- what did we call it, a triple bone scan?

A. Triple phase.

Q. Do we know if this was a triple phase bone scan or not?

A. No.

Q. So it could be, you're just assuming that it wasn't?

A. Well, it says bone scan. It doesn't say triple phase bone scan.

Q. Well, this is your summary of the --

A. Yeah, it did not say -- we don't have that -- I never received that report. I only say Dr. Amis referenced a bone scan. So that the --

when I say reference, that means Dr. Amis in a letter spoke about a bone scan. He didn't speak about a triple phase bone scan, he spoke about a bone scan. The two are quite different.

Q. And the uptake in the triple phase is what you're looking for in a diagnostic criteria for the RSD?

A. It's helpful. The problem is bone scans have such a poor sensitivity and a poor specificity.

Q. It's only one diagnostic criteria that you may be looking for?

A. Correct.

Q. I understand it's not completely --

A. And it's not a good diagnostic criteria. But having said that, if you see increased uptake in the third phase of a triple phase bone scan, you will use that as one of your eight out of 11 diagnostic criteria which will support that diagnosis.

Q. Right. Sort of like mottling in the skin and edema and the other stuff that all these other doctors are seeing, correct?

A. Correct. Well, let's not go that far. Let's say the other criteria.

Q. Well, let's talk about -- how many doctors

saw edema with this young lady's leg?

A. Some did, some didn't.

Q. How many saw it, more than five?

A. I can't answer that. I can't tell you. A number of doctors quoted edema. A number of doctors quoted skin color changes. A number of doctors quoted other changes that they saw.

Q. Right.

A. Okay.

Q. And we have a bone scan that shows uptake. You don't think the bone -- maybe or maybe not the bone scan is the triple bone scan that you like or that you feel is necessary to be diagnostically relevant?

A. Okay.

Q. Fair?

A. Fair. Okay.

Q. I mean, I noticed that as we go through all these, you know, I mention what other doctors see and you have a reason to dismiss every one of them as either a finding or something that you're not going to rely on, right, because you don't either like the test or you can't rely on the type of exam that they did or you didn't see it yourself?

A. No, I think that's a mischaracterization.

Q. I mean, that seems to be how the testimony is going.

A. Well, that's perhaps how you're leading the testimony, but that's not how I looked upon it. The question I asked myself was do I find Ms. Davis to have reflex sympathic dystrophy. The answer is no.

Q. Yeah, I know that's your answer.

A. Then I said I looked at the various reports of all the doctors. Do I find that based on objective findings of those doctors they had findings of RSD? I don't believe they did. I am aware that one doctor may find this, one doctor may find that, some find this and this. I looked at all that. Applying the diagnostic criteria for RSD to what they did on that exam, I don't think she has it.

Q. Where does it say in the literature that you need to do the triple phase bone scan?

A. It doesn't say you need to do the triple phase bone scan. It --

Q. That's your opinion?

A. No, you asked me -- I pay close attention to the question. If you look at the AMA Guides, the AMA Guides talk about a triple phase bone scan. You

don't have to do it. You can reach the diagnosis without a triple phase bone scan. In fact, the IASP don't even mention the triple phase bone scan.

Q. So where did you get the triple phase bone scan from?

A. AMA Guides talk about a triple phase bone scan as one of the criteria you may use to help you reach a diagnosis of CRPS.

Q. Do they specifically dismiss the use of a non-triple bone scan instead of using a bone scan?

A. They don't specifically dismiss the use. They don't dismiss the use of tests. They tell you the tests that is used as a criteria. They don't dismiss x-ray, bone scan, you name it. This is what you need. Now, you may want to question can I use an alternative method, and that's a fair question. But if you're going to use a bone scan, it's a triple phase bone scan, not a single phase or routine bone scan.

Q. Yeah, but is there anything that says that you have to use the triple phase bone scan as opposed to a regular bone scan?

A. There's no literature that talks about the use, that I am aware of, that talks about the diagnostic specificity, sensitivity or use of a

single bone scan in CRPS diagnosis. I'm not aware that that even exists.

Q. Okay. Can we say that there's bone scan findings consistent with CRPS?

A. No, you can't.

Q. But when we're looking for a bone scan finding consistent with CRPS, we're looking at uptake?

A. You can't use it. If you're asking me can you use, the answer is no. If you would like to argue on it, I'm perfectly willing to argue, but the answer is no.

Q. What are bone scan findings that would be consistent with CRPS?

A. Zero. There are no bone scan findings that are consistent with CRPS because it's --

Q. But that's in your AMA Guidelines?

A. Triple phase bone scan.

Q. No, it doesn't say that here. It says bone scan findings consistent with CRPS.

A. Yeah, that's a triple phase bone scan. It's a triple phase bone scan. If you look at the -- there are no findings of CRPS on a routine bone scan, they're only triple phase bone scans.

Q. And that's reuptake?

A. That's delayed phase three. That's an altered update on phase three of a triple phase bone scan.

Q. So if it was, in fact, a delayed phase --

A. Well, if it was -- if it was a triple phase bone scan and it was a delayed phase three, then fine, it's indicative.

Q. Okay. So if it was in this case, then you would say she has CRPS?

A. No. No, not at all. I'd say that that's -- if I was applying the AMA Guidelines, that's one of the criteria I would use in trying to find eight out of 11.

Q. Well, we would have x-ray evidence of trophic bone changes or osteoporosis. We would have the bone scan finding consistent with CRPS. We would have mottle skin color, reports of cool skin temperature, edema, right? I mean, those are all things in the records. Anything else? I mean, we have soft -- and you saw no soft tissue atrophy anywhere in the records?

A. No skin changes. No hair changes. No nail changes.

Q. And --

A. And also if you apply the AMA Guides,

you'll see the word concurrent. So they have to be there at one time in one evaluation, and at no point does any doctor give you eight concurrent objective physical findings.

Q. So you're saying all eight have to present at exactly the same time?

A. I'm not saying that. The AMA Guides say that.

Q. Well, it's your opinion that I'm concerned about.

A. Well, based on the -- yes, the interpretation of the AMA Guides says specifically all eight has to be present concurrently. I guess one of the differences that we're finding, I try -- I'm trying to give you the basis of my opinion. My opinion is that you need eight out of 11 concurrent physical objective findings. The basis of that is the AMA Guides. IASP does not have that basis.

Q. Okay. Well, let's go through the IASP. Continuing pain which is disproportionate to any inciting event. I think we have that, right?

A. Correct.

Q. Then we talk about the presence of subjective complaints and symptoms. Reports of hyperesthesia. What is that?

A. An increased sensitivity to touch.
Q. Okay. So we have that?
A. Correct.
Q. Reports of temperature asymmetry and/or skin color changes and/or skin color asymmetry?
A. She complains of that.
Q. Okay. Reports of edema and/or sweating changes and/or sweating asymmetry. We have edema, correct?
A. She complains of that.
Q. All right. Motor/trophic, reports of decreased range of motion and/or motor dysfunction like weakness. We have that?
A. Correct.
Q. Okay. So that's all of one and all of two. And then the presence of objective physical findings. A, evidence of hyperalgesia, to pinprick, and/or allodynia, to light touch. We have that?
A. Well, but that's a problem. You see, that's not objective. That's subjective. So that's one of the criticisms of the IASP criteria, so --
Q. Well, hold on a second. I'm just asking if we have that in the record?
A. Correct. But you see --
Q. No, just hold on a second. I'll let you

explain that in a minute, okay?

A. Sure.

Q. But we have that, right?

A. You have complaints of allodynia and complaints of hyperalgesia.

Q. Okay. Evidence of temperature asymmetry and/or skin color changes and/or asymmetry. We have that, right?

A. No, you don't have that.

Q. Skin color changes, we don't have that?

A. No, not that I've seen. You have people talking about that, but not objective documentation.

Q. Well, these doctors are writing it down in their records.

A. That's fine.

Q. You don't like it because you didn't see it, but it's in the record, yes?

A. Okay. It's in the record.

Q. All right. So we have record of that?

A. Yeah.

Q. Evidence of edema and/or sweating. So let's see, evidence of edema, do we have that?

A. Yeah, you have doctors talking about that.

Q. And then D is evidence of decreased range of motion and/or motor dysfunction?

A. You have people talking about that.
Q. All right. So we have all of three. And the only thing left is no other diagnosis better explains the patient signs and symptoms, correct?
A. Correct, and you have a better diagnosis.
Q. What other doctor has given what they believe to be a better diagnosis in this case other than possibly you?
A. No. I see most of the pain managers have given the diagnosis of CRPS.
Q. Correct. So my question is, is there any doctor who treated this patient --
A. No.
Q. -- who has a better explanation than either RSD or CRPS?
A. I don't see that.
Q. Okay. So you're the only one in this case?
A. I see I'm the only one who applied the criteria and find the better answer.
Q. And what is your better explanation?
A. That this is a result of someone who injured her ankle on multiple occasions, has had two surgeries, and has not done well.
Q. And you believe that that leads to all of

these symptoms?

A. Yes.

Q. Does that happen a lot to people who injure their ankle and don't do well, all of these symptoms, or is it kind of rare?

A. No.

Q. We get clients, maybe 40 a week, that injure their ankles and I don't notice all these symptoms with these people. They don't come up.

A. And that proves what?

Q. It proves that it must be a very rare condition that this young lady is suffering from --

A. Well, I think that when you injure your ankle and you do ankle surgery, the majority of people get better, a minority of people stay the same, and even a smaller minority get worse. And those who get worse may have all of the symptoms that this young lady is complaining of.

Q. So what's your diagnosis, within a reasonable degree of medical certainty, as to what's going on with this ankle?

A. She has a bad ankle. She has the results of having multiple injuries to her ankle, two surgeries, a spinal cord stimulator inserted, a spinal cord stimulator removed. All of those things

taken together have ended up -- has made this woman the way she is.

Q. Okay. And is that her fault?

A. No, I'm not saying it's anybody's fault, that just is.

Q. What you represented that there's multiple ankle injuries, when you say ankle injuries, are we talking trauma -- included are the traumas from the surgeries or are you saying multiple ankle injuries --

A. Well, I think she has this initial injury. She gets surgery --

Q. What's the initial injury, the fall at the haunted house, you mean?

A. Correct. She has that injury. She has surgery. She gets better, released from care, then a month or so later she starts twisting her ankle and retwists it and retwists it and retwists it. Ultimately she has another surgery. She continues to have ankle problems. Let's just take away all the pain management stuff, which goes to treat pain as opposed to make a diagnosis of the underlying cause of the pain, but I think as a result of the initial injury and the subsequent instability, if I can use that term, weakness of her ankle, she

retwists it, retwists it, retwists it. You look at the MRI studies that show the progressive changes. She has surgery, which unfortunately doesn't help her.

Q. Right.

A. Or initially helped her and now this is what's left. I don't think it's -- I find no evidence that she's got CRPS. She has a poor ankle.

Q. Did you review McKenzie Davis' life care plan?

A. I think so.

Q. Created by Bowing from Vocare Services up in Cleveland?

A. I don't recall offhand.

Q. Then do you have an opinion, within a reasonable degree of medical certainty, as to whether that life care plan is just as sufficient for the diagnosis that you think is a better alternative to RSD?

A. No, I can't comment on the life -- that's not within my level of expertise to comment on someone's life care plan. I didn't do one.

Q. All right. So do you have a more scientific or more medical term for bad ankle that she's suffering with?

A. A lot of doctors will use something like failed surgical syndrome in that you have -- in the neck and back we sometimes call it Post-laminectomy Syndrome. I think you might be familiar with that term.

Q. Sure.

A. Someone injures their back, you do surgery on them, and they end up being much worse. And you try to think of a name. Well, Post-laminectomy Syndrome, that's the symptoms you have after surgery. Now, obviously the symptoms are worse in that case. Well, you can say post ankle surgery syndrome, and that is someone who has ankle surgery, has not done well, and these are the signs and symptoms. There's not really a good descriptive term.

Q. I understand. Do you have an opinion, within a reasonable degree of medical certainty, as to whether the surgery that Dr. Amis performed or the surgeries that Dr. Amis performed was reasonable and necessary or not?

A. No, I wasn't asked to do that and I'm not an orthopaedic surgeon.

Q. So would you be qualified to give that orthopaedic opinion?

A. Well, I'm not an orthopaedic surgeon.
Q. I know. I'm looking for a yes or no.
A. Well, no, I don't have -- I can't answer that and I'm not offering an opinion as to the need for surgery or not.
Q. Was the question that you were asked by defense -- actually, do you have your file here that I can take a look at?
A. Yeah, over here.
Q. That's this big stack right here?
A. Yes.
MR. MAISLIN: Go off the record for a second.
(OFF THE RECORD)
BY MR. MAISLIN:
Q. I'm looking here at two letters from Defense Counsel Brad Powell going to you. One's dated April 12, 2016, one's July 1, 2016. It looks like the July 1st, the second letter, refers to the functional capacity evaluation performed by Rick Wickstrom. Did you rely on his report to any degree in your --
A. No, because Mr. Wickstrom did a functional capacity. He didn't address whether or not she has this diagnosis or not.

Q. Did you read his report?
A. A summary of the -- the financial conclusions of that report. I didn't have time to go through all of it in detail.
Q. It asks -- this letter, the end of the first paragraph says, as a result of plaintiff's alleged fall, she alleges that she sustained the following injury/conditions; left ankle sprain, reflex sympathetic dystrophy, RSD/complex regional pain syndrome, CRPS. The third one is OS trig --
A. Trigonum.
Q. Trigonum Syndrome. It says that they provided you with a copy of the life care plan. They wanted you to review that as well. They gave you a chronology. It doesn't actually state what questions you were asked to answer and the opinions that you're going to be providing at trial. Have we reviewed all of the opinions that you intend to provide?
A. Well, I would answer it in the following fashion. I view an opinion as a response to your question, all right? So if you ask me another time a question you didn't ask me today, I may have an opinion on that. Now, having said that, in no way am I trying to sneak anything around you or

misconstrue or hold back opinions to surprise, et cetera. I've tried to be as forthcoming as I can as to my reasons. But just be aware if you ask me a question at a later date which you did not ask me today, I may have an opinion on that answer.

Q. Let me ask it a different way. Why were you hired in this case?

A. Well, I view myself as hired to assess whether or not this woman had evidence of complex regional pain syndrome, RSD. Os trigonum ankle sprain, I think those are orthopaedic diagnoses. I'll leave that to the orthopaedic people involved. Complex regional pain syndrome is a neurologic diagnosis. It's a nervous system problem. Today we look upon it as a central brain problem, not a peripheral nerve problem. We know it's not sympathetic. We know it's not a reflex. We know it's not a dystrophy. And there's mounting evidence that it's a central brain problem as opposed to a peripheral nerve problem.

Q. And how does one get CRPS?

A. You can get it from any number of reasons. You can get it from trauma. You can get it from strokes. You can get it from immobility. You can get it from other diseases. It's a response to. Of

the trauma, it could be any type of trauma. It's typically peripheral.

Q. Meaning?

A. Hands and feet. Less likely, but you can get it in knees. You can get it in ankles. Much rarer, you can get it in chest, abdomen.

Q. And if it's coming from the brain, is there a psychological component to it?

A. Well, don't use the word -- you used the word psychological as a, quote, unquote, craziness type thing.

Q. Well, I don't mean it like that. I mean, more like a psychosomatic?

A. Well, you can have psychosomatic symptoms looking like reflex sympathetic dystrophy. However, be aware that psychological diagnoses basically have a foundation in organicity, whether or not they're nerve transmitter problems, whether or not they're biochemical problems, whether or not they're electrical problems. But as you can tell with the diagnosis of -- like schizophrenia which used to be thought of as a pure psychological diagnosis, now have a clear-cut metabolic basis, a clear-cut genetic basis.

Q. Psychological is a symptom of many things?

A. Yeah. So psychological -- you can with a psychological diagnosis manifest complaints that for all the world look like complex regional pain syndrome. You can have the physical findings, all the objective physical findings of complex regional pain syndrome of a purely psychosomatic basis that we know long-standingly. However, having said that, that's just one of the causes of this apparent CRPS presentation. It can occur as a result of peripheral nerve injuries. It can occur in strokes. It can occur from a psychological basis of an illness which has a psychological code which has some biochemical basis, so there's many, many causes.

Q. Do you have an opinion, within a reasonable degree of medical certainty, as to McKenzie Davis' psychological or psychiatric condition?

A. Well, I didn't diagnose her. I didn't look at her to make that. I know that she's been diagnosed in the past as suffering from depression and anxiety, which she tells me I believe at one point she was hospitalized with suicidal ideation. But having said that, I'm not saying her problem is or is not based on anxiety or based on depression or

what have you. I'm not making that claim.

Q. I understand. Not relevant one way or the other to your diagnosis?

A. Well, if you ask me is that relevant to the diagnosis of CRPS, no. May it be relevant to explain some of her symptoms? Sure, it may be relevant. As I said before, patients with depression and anxiety often have heightened complaints. It doesn't mean she does, but you need to be aware of that. Patients on chronic narcotics often have heightened complaints because they need more narcotics because that's the inherent problem. So you've got to be aware of that. So you may look at the patient's complaints and then you have to marry it or merge it with the objective physical findings because in this subset of population, complaints may not be a good measuring gauge of the severity of their illness.

Q. And that doesn't make them bad people or liars or anything like that?

A. No, not at all, not at all. You as a physician need to be aware of that. It's the old saying there may be people chasing paranoid individuals. I mean, you can't disregard -- you can't simply say, well, she's depressed, throw

everything out. You've got to say she's depressed. It may be influencing what she says, take that into consideration, but do the workup, do the evaluation. You're more than welcome to review all those records.

Q. Yeah, that's not my intention. I just want to make sure -- so we have medical records in here?

A. There's another letter from the attorney. And I think this one may answer more of your questions.

MR. POWELL: There it is. I thought I sent him something.

Q. Okay. This is a letter dated May 10th from defense counsel. And we may have covered this, but one of the questions is what condition -- excuse me, strike that. What injury or condition did McKenzie Davis sustain as a direct result of this accident?

A. I don't know if I can answer that question because I think that question, and I don't think you'll see an answer in my report, I don't believe --

Q. It just says there's an alternative better diagnosis.

A. Well, if you -- that's with respect to the entity of CRPS, RSD. Now, as a result of the injury, Dr. Amis talked about an aggravation of an os trigonum and an ankle sprain. Now, I don't have an opinion as to whether he's right or he's wrong. That's not my area of expertise. But having said that, whatever orthopaedic injury she had, whatever orthopaedic injury she had, Dr. Amis did surgery, she seemed to get better, she seemed to reinjure, she seemed to go on and have more problems, more problems. And now at the end of all that, someone says she has CRPS. Now, I can't tell you -- I think you'll need to speak to the orthopaedic surgeon as to what injuries she sustained at the onset. Clearly she doesn't sustain CRPS at the onset. Even if she did -- even if you believe she did have it, at some point in the process that developed. So you -- so I don't think I answered the question as to what injuries she had at the beginning. That would have been an orthopaedic question to answer. It looked like she got better from whatever injury it was, evidenced by Dr. Amis' reports and such, and then she reinjured and had further problems.

Q. You say that's what it looks like from his reports. Is that your opinion that she healed from

the fall at the haunted house and then reinjured it or you're just repeating --

A. Well, no, when I look over Dr. Amis' reports, my opinion is that the information tells me she got better, she was released from care a month or two later, she goes back to see him and she says I think I was walking on platform heels or I twisted my ankle shopping or something like that, and she developed pain again.

Q. But is that your -- I mean, you repeat -- what you're saying is, your opinion is this what you saw, but I'm saying do you have an opinion or are you relying on Dr. Amis to provide the opinion withing a reasonable degree of --

A. Oh, I didn't see her at that time, so I'm saying the medical records -- my opinion is the medical records of Dr. Amis provide me with that information.

Q. Right.

A. I hope that clarifies it for you because I didn't see her at the time to make an independent observation of that.

Q. So you would rely on Dr. Amis?

A. Correct. If he says -- I would rely on him to -- if I'm mistaken in understanding his

opinion, he'll say so.

Q. And then it says, do you agree with the assessment and evaluation regarding the future treatment and care that Davis may require as set forth in the life care plan?

A. I can't comment on life care plans. I'm not here to talk about life care plans.

MR. MAISLIN: Okay. Fair enough. Let me take a little bit break and talk with my associate here.

(OFF THE RECORD)

BY MR. MAISLIN:

Q. I'm finished asking questions. The only thing I ask, I don't need copies of any of the medical records, the medical records summary. If I can just get a copy of everything else like these letters --

A. Let me -- what about I give you copies of the letters? Do you want the forms that the patient filled out?

Q. Yes, please.

A. Okay. And I think that's everything other than my report, and you have my report.

Q. Yeah, and I've got the report. Perfect.

A. I'll do that. And usually --

MR. POWELL: Are you going to identify the report for the record? You don't have to, but --

MR. MAISLIN: Well, why don't we just include that in everything else.

THE WITNESS: Can we go off the record?

MR. MAISLIN: Sure.

(OFF THE RECORD)

(Deposition Exhibit 1 was marked for identification.)

BY MR. MAISLIN:

Q. You said that you don't rely on stuff that attorneys say because subconsciously it's slanted and it's not anybody's fault, it doesn't matter if they're plaintiff --

A. No, the comment I'm making, a chronological report of someone -- a nonphysician's review of medical records is not acceptable to me as a review of medical records. So when a layperson reviews medical records, I can't accept it as being valid because that layperson may subconsciously or consciously choose records that may or may not favor or disfavor their opinion. So, I always do my own medical record review. I never rely on a medical record review done by anybody else.

Q. Where does the subconscious part come in, how does that work?

A. That's just my explanation as to why a nonmedical person who has a -- may influence records.

Q. But why would they subconsciously influence the record --

A. They may not give me every piece of information that I find to be necessary.

Q. Yeah, but if they do a review, I mean, the idea is because subconsciously, right, correct me if I'm wrong, subconsciously they know where they want to go with a case like a lawyer, and they may present it in a light --

A. I can't trust -- I can't exclude that possibility, so I just don't feel comfortable. And it's never been my practice to accept on face value someone else's medical record review whether it's --

Q. Yeah, but you went farther than that when we were talking before. You said you can't rely on anything that an attorney sends you because why?

A. Okay. We were talking off the record and I was saying that when a defense or plaintiff attorney sends me records, I cannot -- I am concerned that they might slant the records to favor

their opinion.

Q. And that happens sometimes even if they're not trying to do that, correct?

A. That may happen.

Q. Subconsciously --

A. I'm not saying they're doing it on purpose. They may just -- they may say that this information is more important than that information and I'm just giving you the important information. However, as a physician, what someone else considers important may not be what I consider important or I may consider things important that they do not. And if you're asking me to review a file, I'm going to review the file. I'm not trusting what you do or you do or anybody else does.

Q. I understand. And in this case, you feel that you are not subject to the subconscious issues that --

A. Well, the way I get around that, you see, the way I get around that is when I give you an opinion, you're perfectly correct to challenge that opinion. But I go a step further. I give you the scientific medical basis of that opinion. When I do that, I no longer have the luxury of picking and choosing. This is a science behind my opinion. You

may not agree with the science, that's your right, but at least I'm giving you the science behind my opinion. So I prevent myself from having a subconscious bias one way or the other because --

Q. Well, subconscious, you believe that you're --

A. Well, I believe I protect myself from a subconscious bias by giving you the medical basis of that opinion. And if my opinion doesn't hold up to the medical basis, you're right in disregarding it.

Q. Everybody's got an opinion, right?

A. Well, everybody has an opinion. But you see, I don't view this -- when you asked me -- I look upon it as more than just my opinion. I look upon it as the standard of care, the consensus medical opinion, the majority of doctors follow this type of recommendations or what have you. I mean, you can find in the medical literature proof of almost anything you want. There's always -- you know, using bee venom to treat coughs or what have you. But the majority consensus and medical opinion, I try to stick to that. And by giving you the scientific basis of my opinion, I divorce myself from potential bias.

Q. Are you able to exclude RSD as we're

calling it in this case, are you able to exclude that diagnosis totally regarding McKenzie Davis or you don't have enough information so that other things may prove to be --

A. No, I can exclude the diagnosis. I don't find evidence she has RSD at all. I mean, I'm fully aware that others have made the diagnosis. They're entitled to their opinion. But if you're asking me when I apply criteria, she doesn't have it. She's got an alternative explanation. And Lord knows she's been seen by every different doctor who's given her multitudes of treatments. And if you talk to this woman, not one of them has worked. She gets a honeymoon effect, a placebo effect and then everything wears off and she's back to square one and they do the same things, same things. You just talk to this woman and she'll -- nothing has worked. Nothing has worked.

Q. Have you ever found RSD patients, it's very difficult to treat them?

A. Oh, it's a very difficult treatment.

Q. Is there any RSD patients where it appears that nothing works?

A. There's always something that works, always something that gets you better. It may not

get you as better as much as you want because, of course, you want to be 100 percent better. So it's an illness where inherently the patient's going to be dissatisfied because patients want to be totally better. With RSD, the mainstay of treatment, the mainstay of treatment is aggressive mobilization. It goes back to what Mr. Nike said, use it, lose it. Aggressive mobilization, not physical therapy three types a week, physical therapy and home therapy and exercises six hours a day. I mean, aggressive, with appropriate use of medications. Some information on some -- some medications will help reduce some of the symptoms, but be aware there is no -- there is no treatment for curing you of RSD. Not like you have pneumonia, I'll give you antibiotics, I can cure you. Everything that is done for a patient with RSD is symptomatic treatment.

MR. MAISLIN: All right. I'm finished. Thanks.

EXAMINATION

BY MR. POWELL:

Q. There was a chronology sent to you by my office, correct?

A. Right.

Q. Did you read it?

A. No.
Q. So you didn't rely on it in forming any of your opinions in this case?
A. None, whatsoever. I didn't read it at all. In fact, to be honest with you, I didn't look at it.
Q. Did you and I even talk before you issued your report?
A. Did we talk?
Q. Did you and I talk before you issued your report?
A. I think we spoke at the very beginning, not about whether I issued my report or anything like that. I talked to you about -- I mean, you called the office, you scheduled, but at no point did we talk about the substance of the report or what my opinion is. I mean, I said she didn't have RSD.
Q. I spoke to your office, correct?
A. I guess you did, yeah.
Q. I didn't speak to you before you issued your report?
A. Probably not, yeah. But the office, you called the office and spoke probably to --
Q. Right. I spoke to the office, but I

didn't speak to you, is that correct, before you issued your report?

A. Correct.

MR. POWELL: All right.

(Witness excused.)

(Deposition concluded at 11:50 a.m.)

Signature expressly waived

DR. GERALD STEIMAN DATE

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STATE OF OHIO)

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I, Mindy Davis, Notary Public for the State of Ohio, do hereby certify:

That the witness named in the deposition, prior to being examined, was by me duly sworn;

That said deposition was taken before me at the time and place therein set forth and was taken down by me in shorthand and thereafter transcribed into typewriting under my direction and supervision;

That said deposition is a true record of the testimony given by the witness and of all objections made at the time of the examination.

I further certify that I am neither counsel for nor related to any party to said action, nor in any way interested in the outcome thereof.

IN WITNESS WHEREOF I have subscribed my name and affixed my seal this 6th day of September, 2016.

MINDY DAVIS

Notary Public

My Commission expires: 04/03/21