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

* * * * * * * * *

DEPONENT: DR. RICK WICKSTROM

DATE: AUGUST 3, 2016

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Tina M. Barlow, CCR

Certified Court Reporter

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The deposition of Dr. Rick Wickstrom, taken for the purpose of discovery and/or use as evidence in the within action, pursuant to notice, heretofore taken at the office of Dr. Rick Wickstrom, 7665 Monarch Court, Suite 109, West Chester, Ohio 45069, on August 3, 2016, at 9:00 a.m., upon oral examination, and to be used in accordance with the Ohio Rules of Civil Procedure.

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APPEARANCES

REPRESENTING THE PLAINTIFF:
Blake R. Maislin, Esq.

REPRESENTING THE DEFENDANT:
Bradley A. Powell, Esq.

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DR. RICK WICKSTROM, called on behalf of the Defendants, after having been first duly sworn, was examined and deposed as follows:

CROSS-EXAMINATION

BY MR. MAISLIN:

Q. How do you do? My name is Blake Maislin. I represent McKenzie Davis and her mom regarding a fall at a haunted house. My understanding is that you were retained by the haunted house's camp to evaluate McKenzie Davis. And that's what we're here to talk about, okay?

A. Yes.

Q. Okay. Have you ever had your deposition taken before?

A. Yes, I have.

Q. All right. About how many times?

A. I don't know exactly, more than 20, less than 50, ballpark.

Q. Have you ever testified in court?

A. Yes, I have.

Q. Okay. And how many times?

A. Probably around ten times.

Q. And when you -- the 20 plus times that you mentioned before, did that include the ten times in court, or no?

A. Well, it probably included those times, because I had a deposition most likely, like a discovery deposition, before the times in court. So I don't know exactly.

Q. Okay.

A. I don't specifically track that.

Q. Do you ever do any federal work, or ever testify in federal case?

A. I have.

Q. Okay. Do you happen to have a list that's required under the federal rules?

A. I do maintain a list of the last, I think four years or so, live testimony occurrences. I brought that with me today.

Q. Okay. What have you been asked to do in this case?

A. To evaluate Ms. Davis' extent of physical disability in relation to -- also in relationship to her occupational goals.

Q. Okay. Are you giving any opinions regarding her diagnoses?

A. No, not specifically, not her medical diagnoses.

Q. Right. So let me break that down a little bit. I mean, are you being asked, or do you think

that you're qualified in this case to give a medical diagnosis regarding McKenzie Davis?

A. I'm qualified to give a physical therapy diagnosis.

Q. Correct. I'm just saying medical diagnosis.

A. It depends on what you mean by a medical diagnosis. But part of -- and one of the things that we do as physical therapists is we attribute and make connections between their diagnoses that maybe have been established by other professionals with their functional limitations. So when I talk about the physical therapy diagnosis, really I'm speaking to the types of impairments that relate to her function.

Q. Okay. In other words, you're not going to be giving an opinion, within a reasonable degree of certainty, regarding whether or not Ms. Davis has RSD or not?

A. No.

Q. Or what's the other one, it's not RSD, it's CRPS --

MR. POWELL: CRPS, Complex Regional Pain Syndrome.

Q. Will you be giving any testimony in this

case whether or not she has CRPS?

A. I don't plan to.

Q. Do you think you're qualified to?

A. I do.

Q. Okay. And what qualifies you to diagnose whether or not she has CRPS?

A. My background as a licensed physical therapist.

Q. Okay. Have you ever diagnosed anybody in your practice with CRPS?

A. As far as establishing the initial diagnosis for CRPS? No.

Q. Have you ever diagnosed someone, as far as having CRPS, after an initial diagnosis?

A. Well --

Q. In your practice?

A. Well, in our practice as physical therapists, we always have to determine what their diagnoses are and how it relates to their functional limitations. So, in terms of formally establishing a diagnosis for some purpose, I don't do that.

MR. POWELL: I am not going to ask Dr. Wickstrom whether or not McKenzie has a particular medical diagnosis, such as RSD. However, what I would reserve the right to do,

depending on the evidence, is whether or not when he examined her, she exhibited any of the signs or symptoms consistent with RSD; is that fair?

MR. MAISLIN: Sure.

MR. POWELL: So he will not be giving medical diagnoses opinions in this case.

MR. MAISLIN: Got it. Okay.

Q. And you did perform a comprehensive functional capacity evaluation?

A. I did.

Q. Okay. And tell me what did you do to perform that?

A. Well, I took an extensive history, performed a physical exam, and put her through a whole series of functional capacity tests. And then went back and reviewed additional records that were sent to me on the case and provided a report.

Q. I see you have Dr. Steinman's narrative report.

A. I do.

Q. Okay. Have you ever talked to Dr. Steinman?

A. I have.

Q. Okay. Regarding --

A. Very briefly.

Q. I'm sorry. Regarding this case?
A. No, not regarding -- not directly regarding this case.
Q. Okay. Did you talk to him about a separate person, not McKenzie Davis, I mean?
A. Yes. I just happened -- I happened to talk to him about a separate person.
Q. As long as it's not related to this case. Is there anything that you wish you would have been able to see or do regarding this case that would have aided in your ability to provide your opinions?
A. No.
Q. As part of your report you have listed -- well, you tell me what this is. I'm looking at Pages -- starts on Page 5, and it's Page 6, Page 7, Page 8 and it finishes up on Page 9 of your report. It just looks like a list of medical records in a somewhat chronological order.
A. That's correct.
Q. Do these identify all of the records that you received?
A. Yes -- well, not necessarily. When I go through records, I tend to cite the ones that seem to be of most interest or most relevance to me in the case. I noted in this case, I didn't receive a

bunch of records to review. Sometimes I'll get six boxes. I got maybe a couple inches -- an extra inch or so of records. So this represents some of the relevant things that I noted as I went through the records that I was provided.

Q. Okay. I don't think I provided you any records, you mean defense counsel?

A. Yeah. That's correct.

Q. I'm sort of going out of order, just because I know where I want to go. I'm trying to keep it short.

A. That's all right.

Q. In front of you is, it looks like a chart, it looks like some records. Is that all the materials you have regarding this file on this table?

A. Again, except for a summary of the records that was sent to me by -- a summary of records that was sent to me by Mr. Powell.

Q. Okay. Is that summary of records -- where is that summary?

A. Where is it?

Q. Yes.

A. It's sitting on my desk in my office.

Q. Okay.

A. It was like an attorney work product kind of thing, so I didn't think that I needed to disclose it.

Q. Can you go get that for me?

THE WITNESS: Can I get it for him?

MR. POWELL: Yeah. I'm going to object. I really don't know how this works anymore because back in the old days it was discoverable. Now, I do think it's -- whether I agree or disagree, I think it's not discoverable. But in this case here, that's fine. Just show him and we'll --

THE WITNESS: Sure.

(OFF THE RECORD)

BY MR. MAISLIN:

Q. You just handed me a clipped stack of papers that defense counsel has been kind enough to identify as the, sort of medical outline, for the post accident medical treatment of McKenzie Davis?

A. Uh-huh.

Q. Yes?

A. Yes, I did.

Q. Did you rely on this in performing your work and ultimately your opinions?

A. I did reference some materials from that.

Q. Okay.

A. In my review of records.
Q. Okay. In your review of records, are you saying that you relied on this clipped packet that defense counsel gave you, in addition to the actual medical record copies that you have?
A. Yes, I did. I did, I believe, reference some of the diagnostic results that were contained here that may not have been contained in what I was provided by counsel.
Q. Okay. So counsel provided you an inch of records, plus the clipped pages that we're referring to?
A. Correct.
Q. And then you used the combination of the two of them to create your --
A. Summary.
Q. -- relevant diagnostic/records findings in your report?
A. That's correct.
Q. Did you find anything in the clipped packet that wasn't accurate, based on the actual medical records that defense counsel gave you?
A. Not that I can recall.
Q. Did you look to see if it was accurate?
A. Well, when I had the original records, I

took that information from the original records that I was provided. For example, Dr. Amis had a letter to you, I don't know, in 2014.

Q. Okay.

A. And I -- where I had the written record, I referred to it exactly. If there was some references to other diagnostic reports that were in there, then I may have referenced the findings for those diagnostic reports in my summary.

Q. But as far as if you didn't have the records, then you would be relying on defense counsel's statements contained in this packet here?

A. That's correct.

Q. You did an examination of McKenzie Davis on May 13, 2016?

A. That's correct.

Q. And how long was the exam, the actual physical exam?

A. It lasted about four hours.

Q. Did that include taking the history or was that all --

A. That included taking the history.

Q. Okay. And can you sort of break down what the four hours then represented? Does it start with paperwork and then taking a history and then -- you

tell me. I'm making that up.

A. Sure. I mean, it starts out with her completing some intake surveys --

Q. Okay.

A. -- typically sitting in the waiting room. That takes her about a half hour. Then the history portion, as you can imagine, can vary widely, but in her case, probably took an hour and a half.

Q. Okay.

A. Physical exam part, half hour, 45 minutes, and the rest of the time was functional capacity tests. About half the time performing functional activities and half the time doing a combination of history and physical exam.

Q. It's mentioned, I believe in your report, that McKenzie Davis was pleasant when she came in?

A. She was.

Q. And other than at one point I think you performed a test on her leg and then her mom consoled her, but leaving that aside, was there anything regarding her behavior or demeanor or tone that you thought was out of order or inappropriate?

A. No.

Q. Did she seem honest?

A. Generally, yes.

Q. Is there an exception to the general rule of honesty during that appointment?

A. Well --

Q. Let me ask it a different way. Do you think she lied to you?

A. I don't know.

Q. Are you an expert at all in determining whether people are telling the truth?

A. I don't know how to answer that question. I certainly -- my approach is to give the person the benefit of the doubt. Let them tell me their history and story. And then cross-validate that multiple different ways, whether it's -- I don't generally look at the records, for example, before I see the person for an exam. I'll see the person, kind of form my own impressions, my own diagnoses, physical therapy diagnoses per se. Then I'll look at the records and see how my impressions concur with the impressions of other experts or other opinions in the case.

So what my impression of McKenzie Davis was, is that she -- she presented her history and also -- and generally speaking was cooperative and provided, what I would characterize for the most part, as a consistent performance throughout much of

the exam. So I try not to get into so much the honesty type of issue one way or the other, but just whether there's consistencies in what she's reporting versus what I see in the records, what she's demonstrating on physical exam versus what she's demonstrating functioning. So I look for those consistencies to see if it all makes sense.

And if it kind of makes sense and I'm getting a good consistent performance, then the -- you know, usually the records are really a secondary concern at that point in time. If I feel like they've come in, laid down and give me a bunch of garbage throughout the whole evaluation, then I have to almost disregard everything they say and everything they do and I have to rely more on the records. In this case, I felt like I had a good read on her capabilities just almost based on just the exam alone.

Q. Okay. So, in certain cases you get people in here that are clearly magnifying their symptoms. You just know they're faking it; is that fair?

A. Well, they've -- yes. I do have people that are magnifying their symptoms. I also have people that are being intentionally deceptive to me. To me, those are sometimes two different --

Q. Right.
A. -- presentations, I mean, so...
Q. Well, did you find -- just during the exam, forget about the records. You said you didn't look at the records, you met with McKenzie. Did it appear to you at all during the course of your exam that she was being intentionally deceptive?
A. No. It didn't feel like she was being intentionally deceptive to me.
Q. And I thought it read as if she really was trying hard during your exam to do what you wanted her to do, fair?
A. Yes. I felt that she was providing a good effort for the most part throughout the evaluation, yes.
Q. And I saw some pictures in the back where she's squatting and doing some other stuff, right?
A. That's correct.
Q. Okay. And it looks like she was really trying to do what you had her do.
A. Yes.
Q. Okay. Have you ever had people that have come in here and it's clear they're not trying to do what you're asking them to do?
A. Yes.

Q. Okay. So it's not that you wouldn't recognize it. It's just that in this case it was clear that she was giving you full effort?

A. Yes. For the most part I think I was getting a pretty full effort from her throughout the evaluation. There was a lot of attention on her symptoms, as far as -- you know, but when I actually say, you know, do these activities and let's see how you're functioning, I felt her effort was appropriate.

Q. And I'm going to come back, I'm jumping ahead. Based on your evaluation of her, did you find that she has any functional limitations?

A. That's a big jump ahead. She does have some functional limitations.

Q. Okay. Why don't you tell me what you have.

A. Sure.

Q. These opinions are within a reasonable degree --

A. Yes.

Q. -- of certainty?

A. Reasonable degree of physical therapy and ergonomic certainty. Those are my two --

Q. Okay.

A. So, in terms of her functional limitation, her main functional limitation was low -- what I would describe as low agility. And that's -- that can be a residual from her left ankle surgeries, or it could be -- it could be related to her morbid obesity.

Q. Okay.

A. Other than that, she's -- she really is demonstrating pretty normal functional abilities for her age and sex.

Q. Did McKenzie tell you that she's not able to do certain things?

A. Well, I went through what she can and can't do quite a bit, yes.

Q. Did you find that any of her claims in what she can or can't do was inconsistent with your ultimate opinion regarding her functional limitation?

A. I would have to look specifically at her -- her report of limitations to comment about that. So, in terms of her most recent job activities, she told me that she successfully completed all her clinical rotations for her RN program. And that she was working 12-hour shifts and she graduated in the top of her class. She told

me that she had to wear a boot for a period of time around 2013, when she was going through lower leg pain and ankle surgeries. So that was her job functioning. With respect to her --

Q. Okay. Let's just stop right there. So given that portion of her history regarding work, is there anything that you found to be inconsistent between what she reported and what you found?

A. For her job, no.

Q. Okay. Go on.

A. Okay. There's a section in my report on Page 10 that talks about recent lifestyle activities. She reported some lifestyle limitations that -- such as experiencing sensitivity in her leg when she's taking a shower.

Q. Do you have any reason to disbelieve that?

A. I don't know. It's a subjective sensation that she's reporting.

Q. All right. So is that a no?

A. I don't know.

Q. Well, I asked do you have any reason to disbelieve that?

A. That she's experiencing sensitivity?

Q. Correct.

A. No.

Q. Okay.
A. She reports that her low back gets uncomfortable when she's sitting and driving. And that if she's on her feet too long like during shopping and housekeeping chores that her left foot gets uncomfortable.
Q. Do you have any reason to disbelieve either of those subjective complaints?
A. No.
Q. Okay.
A. She reported that she can't run, or that she had severe difficulty with running for two blocks at a time, because it bothers her left foot.
Q. Any reason to disbelieve that?
A. No.
Q. Okay.
A. I mean, all of her activity limitations kind of relate to things like climbing steps, climbing a ladder, kneeling down, lifting and carrying. She's just reporting these subjective areas of pain, either in the left foot or the lower back.
Q. Okay. And all of those subjective -- the last ones that you mentioned, do you have any reason to believe that she's not telling the truth there?

A. Well, in terms of the truth, she's relaying how difficult it is to her. And the degree of difficulty that she's reporting is greater than I would expect, based upon the functional capacities that she's demonstrating for me. So her perceived disability seems to be higher than her demonstrated impairment and functional limitations.

Q. Okay. And you're saying perceived disability, meaning she appears to be more concerned about it than what's really there?

A. Yes. I think there's a heightened level of concern compared to what is actually -- what she perceives and how much she perceives herself to be limited seems to be higher than what she's actually demonstrating or I'm measuring on physical exam.

Q. Now, are you qualified to give that opinion, or are you just a fact witness saying, hey, what she's telling me doesn't exactly match up to what I saw on my exam?

A. Well, I think I'm qualified to give that opinion.

Q. Well, no, what I just said is not an opinion. Well, I guess it is, right?

A. You asked me if I was qualified, and I think I am, yes.

Q. Well, let me break that down because there's really two things there, right? She's telling you -- I'll use an example. If I say, oh, I can't lift 50 pounds and then you see me lift 50 pounds, there's really not an expert opinion in there. It's just anybody could say, hey, what you say you can do and what you can do are two different things, right? And obviously you're qualified to do that. The question is, are you qualified to say that she perceives her injury as being greater?

A. That's a really subtle point.

Q. You're not a psychologist, right?

A. No. I'm not a psychologist.

Q. You have no history in psychiatric care whatsoever, correct?

A. Correct.

Q. You can't read minds.

A. No, I can't.

Q. Okay. So the question is, you can't give a diagnosis of why she gave, and what you saw, a different history than what you saw on your exam, correct? In other words, you can't take it any farther than it's just a mismatch?

A. I would agree.

Q. Okay. And tell me specifically what the

mismatch is that you saw.

A. Well, for example, she said she couldn't carry 50 pounds for 30 feet. She was unable to do that, and I tested her carrying ability --

Q. Okay.

A. -- and lifting ability, and she lifted 50 pounds.

Q. Did she carry it 30 feet?

A. I don't know if I specifically tested her on a 30-foot carry. I primarily tested her lifting abilities in a job specific type of way compared to her nursing abilities.

Q. Well, we know she didn't have anything other than maybe complaints as opposed to disability with her nursing abilities, right? I mean, she graduated from nursing care, that's not the issue -- strike that. So, is that a mismatch or not, in your opinion?

A. Is what a mismatch?

Q. Well, you've said that she said she can't -- she doesn't believe that she can carry 50 pounds 30 feet, and you had her pick up 50 pounds.

A. Well, it's harder to pick up 50 pounds from a lower level, in general, than to carry 50 pounds for 30 feet. Because you have to -- it's a

more strenuous activity on the knees, the ankles and the lower back.

Q. If you pick up 50 pounds, you went through the stress of all of that, correct, picking it up that you just mentioned?

A. Uh-huh, correct.

Q. And then is there not additional loading on all those joints you mentioned over the course of 30 feet as you're carrying it and stepping?

A. Not -- if I was to test ten people on a carry test and a lower lift test, I would have -- whatever the person could carry, in general, unless there's some really unusual balance problem, which she has low agility, but that's not a problem. But it's a lot easier to carry 50 pounds for 30 feet than it is to pick up 50 pounds from below knee level.

Q. I mean, I can tell you that my ten-year-old can pick up 50 pounds but he sure as heck can't carry it 30 feet.

A. Well, I would -- if I tested your ten-year-old, I would be very surprised to have that outcome because you have to squat and flex. That's the hardest position to --

Q. Obviously --

A. -- pick an item up from the floor below knee level. And she's fully squatting to do that movement. So she also reported to me that she had -- would have severe difficulty lifting 20 pounds off the floor, and she lifted 50 pounds for me. So there's a gap between what she's representing to me as her perceived abilities and what I'm actually testing with her.

Q. Okay. So we have a, can't carry 50 pounds times 30 feet. We have her saying that she can't pick up 20 pounds off the floor, which she, in fact, does, right?

A. Correct.

Q. What else?

A. Well, I mean, these are just lifestyle activities that she's giving me perception of difficulty on, so...

Q. Well, I want to know every instance where you think there's a mismatch between what she told you and what you actually observed.

A. Okay. She told me that she had moderate difficulty sitting for 30 minutes at a time, and severe difficulty sitting for two hours at a time. And I didn't observe any significant fidgeting or pain behavior during the entire time that I

interviewed her.

Q. How long was she sitting when you were interviewing her?

A. Well, she was sitting in my waiting room for half an hour. She was sitting and doing those forms, you know, I kind of stroll through and kind of keep an eye on how a person is doing there. And she was -- it probably took every bit of an hour and a half during the intake interview.

Q. Was she sitting?

A. She was sitting during that whole time.

Q. Did you say that she got up and stretched her back due to the pain in the lumbar region?

A. Yes, she did. She did get up periodically, and she did fidget periodically during the sitting. So --

Q. So would that --

A. I did note that at the bottom of Page 10.

Q. So you're saying that it's a mismatch between what she reported and what you observed?

A. Well, the degree of difficulty that she's reporting I think is a mismatch, yes.

Q. Because you would -- your definition of moderate and severe differ, maybe than what hers are?

A. Well, it's just very -- again, perceived disability is exactly what it is. It's what the person perceives it to be. So just like beauty is in the eye of the beholder, the degree of difficulty is in the eye of the beholder. But that she performs so well on activities that stress the same areas tended to give me an impression of there being a mismatch.

Q. Well, I'm talking about specifically the moderate difficulty, the 30 minutes severe difficulty for two hours, and her getting -- when you observed her, she got up and stretched and she was fidgeting.

A. Yeah. Once in a while she did, yes.

Q. Did you mark how often she did it?

A. Not specifically.

Q. So based on your memory, she didn't get up or fidget enough to -- for you to think that she's either in moderate or severe pain or discomfort?

A. That's my impression.

Q. Did you give her a definition of what moderate or severe was?

A. Not necessarily. It's really -- the ends of the scale are, you know, is it -- if it's not a problem it's a four and if you're completely unable

it's a zero. And if you feel like it's a mild degree of difficulty it's a three. And if you feel like it's a moderate difficulty it's a two, and if it's severe it's a one. So it just kind of rates those areas. And then we're -- whenever there's an area that's rated above a mild degree of difficulty, I always ask for a clarifying comment to help explain why they perceive it to be difficult.

Q. Okay.

A. So it's just perception of disability is just one -- one, I guess, consideration when arriving at the overall opinion of how a person can function.

Q. Okay. What else did you find to be a mismatch?

A. Well, she's reporting that standing for two hours at a time is severely difficult. I found that to be a mismatch.

Q. Did she say severely difficult?

A. For two hours at a time she said severely difficult.

Q. Did you observe her standing for two hours?

A. No. Not for a full two hours, I did not. But she did report to me that she was employed or

was entering employment to do 12-hour shifts and commonly did 12-hour shifts in a variety of different nursing situations. So standing for a prolonged time is a key factor for that job.

Q. Is it possible that somebody is having severe difficulty or even moderate difficulty and they're willing to work through it?

A. Absolutely.

Q. Okay.

A. Yeah. How someone deals with their pain or symptoms is very individualistic.

Q. So you didn't see her standing for two hours at a time. What you're saying is, the mismatch isn't from what her history is versus what you saw, it's -- on this item it's the history that she gave you versus another part of the history that she gave you?

A. I found some inconsistency -- yes, I did see an inconsistency there, and also --

Q. Well, let's just -- I just want to -- I'm sorry, go ahead.

A. Well, I also found this report of difficulty for these activities to be inconsistent with other abilities that she demonstrated. I mean, the lower lifting is a big ability as far as it's a

key factor with a lot of nursing positions. And so that she could lift 50 pounds, which is above what I would expect for most women of her age and sex, demonstrates a pretty good level of functional capacities.

Q. How big is she?

A. How big is she? You mean in terms of her weight?

Q. Height/weight.

A. I can tell you exactly what her height and weight is. She's 5'6-1/2" and she's 267 pounds.

Q. Would you expect somebody that heavy to have an easier or harder time lifting weights?

A. It depends on the activity. She's going to have a harder time lifting weights from a lower level because of her weight, because she's carrying her body weight in addition to the weight that she's lifting.

Q. Did she know it was 50 pounds?

A. I started and then I gradually increased the weight. My process is I basically ask the person to kind of rate how difficult they perceive the load to be.

Q. Okay. And how difficult did she say the 50 pounds was, if at all?

A. She rated it as 7 on a -- and 7 on a rating of perceived exertion scale is between somewhat hard and hard.

Q. Okay. During any of the carrying or the lifting, did she complain at all about -- or excuse me, or the standing or sitting, did she complain at all of any discomfort?

A. Are you asking with about lifting?

Q. We can start with lifting.

A. Okay. So, on the lifting test I asked if she had pain with that and she said no.

Q. Okay.

A. On the lower lifting, and she said no on the chest lift, and she said no on the high lifting. So she reported no pain with the lifting activities. She did report pain with the two square agility test that I administered to her, she reported pain in her left calf.

Q. What is that test?

A. It's basically a person stands in front of a marked line on the floor and they step back and forth across the line. So right foot, left foot, right foot, then you time them for a sequence of activity. So it's a measure of kind of forward-back agility.

Q. Okay.
A. So time them for five complete cycles of doing that.
Q. Okay. And she complained of pain in her left lower leg?
A. In her calf.
Q. Left calf.
A. And ankle, I believe. Let me just double-check that. So on every functional activity, it's common for me to ask after the activity, did pain limit your function. And if the answer is yes, then I usually write down in this comment what the source or what the area of pain is. I don't -- so in her case, my comments for that were that she had left calf pain. And I observed that she turned her left foot out to, what appeared to be, compensate for left calf tightness.
Q. Did you evaluate her calf, physically touch her calf to see if it was spasming or anything like that?
A. Well, I did evaluate her calf, and I also --
Q. I just mean after the two square, five cycle test, did you make any objective findings regarding her calf?

A. No. I just noted the source of her pain.
Q. Okay. And then you also made a notation that she actually -- you saw her turn her left calf out, which would have indicated to you that she was compensated for some discomfort?
A. My interpretation was that she was turning her calf out to compensate for tightness.
Q. Okay.
A. It could have been discomfort, but I thought it was more likely due to tightness.
Q. Okay. Did you find that there was a mismatch between her history and what she related to you and her ability on the two square test?
A. Can you clarify what you mean by that?
Q. Well, you said before in her history it would appear that her perceived discomfort -- well, for example, when you did the 50-pound carry for 30 feet, she said she wouldn't be able to do that. However, you think that that mismatched your findings because she was actually able to pick 50 pounds up off the ground.
A. Uh-huh.
Q. Correct?
A. Right. So you're referring to her perception of activities of daily living.

Q. Okay.
A. Okay.
Q. And I'm saying, is there anything that she told you in her history that mismatched what you perceived on a two square test?
A. Well, I measured some limitation or a low level of agility on the two square test. And she represented, I would say, higher perceptions of limitations on the -- on activities of daily living that involved agility. So, for example, she said running was severely difficult --
Q. Okay.
A. -- on measuring that agility is somewhat impaired.
Q. Do you disbelieve that her running is severely difficult for her?
A. It's her perception of her -- I'm just pointing out that her perception and her actual performance, there seems to be a gap there. Whether -- I'm not casting any judgment on her perception, you know, that's her perception. I'm just saying, the actual functional abilities appear to reflect a higher degree of functioning than what she's saying that she's able to do. So if that was the baseline restriction entirely of what her

perception of disability was, then that might be a different profile of work restrictions. I actually look at that and look at the diagnostic results and look at the actual test performance. So I'm using all three to arrive at my professional judgment of a physical functioning.

Q. Okay. Anything else where there was a mismatch between what she told you and what you observed?

A. No, I think that covers it.

Q. Just so we're clear, and I have it all in one paragraph on the transcript. The first one was where she said she didn't think that she'd be able to carry 50 pounds times 30 feet, and yet you saw her lift 50 pounds from the ground, that's number one. That she didn't believe she could lift 20 pounds off the floor, but she was able to lift 50. And then we have moderate difficulty after 30 minutes, severe difficulty after two hours while sitting. And then we have she has severe difficulty standing for two hours at a time, and we have the two square test, correct?

A. That, and also her reported history of successfully completing those clinical affiliations that can involve both prolonged sitting and

prolonged standing at times.

Q. Okay. So based on what we just talked about, does this appear to be a woman to you who -- she describes limitations greater than what you were able to perceive, but regardless it's not holding her back from really doing anything either at work or anywhere else?

A. That's correct.

Q. Did she ever tell you that she was limited at her job or anything else?

A. Well --

Q. As a result of physical limitations -- did she ever say that she had trouble completing school because of physical limitations?

A. Actually, I did review that issue. I didn't -- she didn't necessarily volunteer it with me, but we had a discussion about how things went during her schooling process.

Q. Okay.

A. Some of that I documented on the first page of the report under her education. I asked her which of the nursing assignments were most difficult for her. And she reported to me that she had to do a different variety of different assignments, so I was interested in seeing how her injury impacted her

to do the full range of nursing assignments. So that she indicated that the med surgery floor of the hospital, like on the renal floor and the ICU, were probably the most difficult assignments for her. And that the easiest ones for her were the OB and the pediatric assignments.

Q. And why is that?

A. I didn't specifically write why they were there, but my impression was that those assignments perhaps involved more standing and walking. Whereas, she had maybe more opportunity to sit a bit during the other assignments.

Q. Is that consistent with the report that she gave you, as far as when she has more difficulty or less regarding standing and sitting?

A. Well, it's certainly consistent with report of difficulty with prolonged standing. The sitting kind of thing, who knows. You know, people -- unless you are in a job like a truck driver where you're constrained and can't get up from sitting, sitting is generally not as much of a barrier, or as limiting from a disability standpoint, as standing tasks can be.

Q. I noticed in your report there's a finding where -- did you like do the hammer and check her

reflexes?

A. I did.

Q. And her right leg had a normal reflex, what -- I'm looking on Page 11 in your report, spine and pelvis exam.

A. Right.

Q. And it says under reflexes abnormal.

A. That's correct.

Q. Correct?

A. So she didn't have a normal ankle jerk reflex on the left side.

Q. But did on the right?

A. But did on the right.

Q. What does that mean to you?

A. Well, in my mind it was directly related to the surgery. She had some type of heel cord lengthening type of procedure. So I think it was related to her actual surgery.

Q. Okay.

A. And the tightness in that.

Q. How would you know that, is that a guess?

MR. POWELL: How would he know what?

MR. MAISLIN: How would he know why she has no ankle jerk reflex.

A. How would I know why?

Q. Yeah, well --
A. I mean, I don't know exactly the reason why, but she had a surgery, a localized surgery, to that area.
Q. Okay.
A. And she also had nerve blocks as well for treatment. Either the nerve blocks can affect that, as well as it could also be a residual from the surgery. So there's a couple of logical explanations that -- those are the two most logical explanations.
Q. Well, let me -- maybe I'm getting away from why we're here. But are you qualified to give an opinion as to why there was no ankle jerk reflex on the left?
A. Well, I don't -- I'm not -- I don't know exactly why there was no ankle jerk reflex.
Q. My question is, are you qualified to give that opinion of why. I know you don't know why, are you qualified to give an opinion why, within a reasonable degree of certainty?
A. I think so.
Q. Okay. And what training qualifies you to give an opinion as to why a patient would have no ankle jerk reflex?

A. Well, my training as a physical therapist in anatomy and physiology and pathology. We are taught in physical therapy school what the signs and symptoms are for various types of abnormal findings.

Q. We're only talking about diagnosis, right?

A. That's correct.

Q. A medical diagnosis?

A. Well, as a physical therapist I make a diagnosis.

Q. Have you ever made a medical diagnosis like that in your practice ever?

A. Yes.

Q. You --

A. Yes. And whenever I -- whenever I do a physical therapy evaluation, I am doing a -- I am determining what are the underlying problems that I'm addressing in my physical therapy clinic here.

Q. Does anybody come to you first before seeing a medical doctor?

A. Yes.

Q. In your practice?

A. Yes.

Q. And you make a diagnosis and you treat them per your diagnosis?

A. Yes.

Q. And does health insurance pay for that?

A. Some health insurances do. I don't take most of the traditional health insurances, but I have -- I've been practicing in a direct access mode for physical therapy for over ten years. So people do come to me all the time without established diagnoses and, yes, I have to determine what is wrong with them, what is appropriate that I can address within my scope of practice as a physical therapist and when there are red flags where you just simply see someone else for issues that are outside my scope of practice. So, yes, I assert my qualifications to make a diagnosis as it relates to my plan of care for physical therapy.

Q. Do you think you're as qualified in this case as Dr. Amis would be to provide a diagnosis as to why there's no ankle jerk reflex in this case?

A. That's a great question. I have great respect for Dr. Amis. I knew him when he was a resident, and really think that he is very qualified in terms of establishing her diagnoses and how, you know -- so, in terms of as qualified, he establishes that diagnosis for purpose of his medical treatment and surgical management for the care. I establish a

diagnosis for the purpose of my physical therapy plan of care. I'm sure he does a great physical exam for her leg and ankle, as I do a pretty darn good physical exam as well. So I think he does a great job. I respect Dr. Amis highly, and that, and value his opinion. I thought his letter to you was a very well -- very good opinion.

Q. Based on your examination, do you agree with the opinions in Dr. Amis' letter?

A. I agree with a number of his opinions, yes.

Q. Is there anything in his letter that you don't agree with?

A. I would have to -- you'd have to provide that letter for my inspection, if you want me to address that question.

Q. Is it not a part of your file?

A. I do probably have it in the file if you want me to look for it. I might have it right here. And I also cited the sections in his -- in this letter in my review of relevant diagnostic records as well.

MR. POWELL: Are you waiting for a question or are you waiting for an answer?

MR. MAISLIN: I'm waiting for an answer.

A. Sorry. I thought perhaps you were --
Q. Is there anything that you see in Dr. Amis' report that you don't agree with?
A. That I don't agree with? Well, I agree --
MR. POWELL: Hold on a second. I just want to note an objection to the extent that Dr. Wickstrom was retained for the purpose of functional capacity evaluation and his related opinions. To the extent that your question calls for him to go beyond that, I'd object. But since this is a discovery deposition, you can answer.
A. Well, his opinion about diagnosis listed the os trigonum, the lateral ankle stability and then the third one he listed was reflex sympathetic dystrophy. And I certainly agreed with his two diagnoses that related to the os trigonum and lateral instability for which he, I felt, treated her very appropriately for. And also agreed that she had recovered normal joint motion as an outcome from that surgery. He doesn't opine about her degree of impairment. He doesn't really address the whole issue of reflex sympathetic dystrophy and how that will impact her future ability. So I -- well, he associates all three of those diagnoses with her injury. I see a good rationale for the first two,

and question the third.

Q. What makes you question the third?

A. Well, because -- and, again, I'm measuring her at my point in time. I'm not measuring her earlier in the process. I would defer to someone like Dr. Steinman, who is more of an expert in reflex sympathetic dystrophy in terms of whether she does or does not have that particular diagnosis.

Q. Have you ever treated people with RSD or CRPS?

A. I have evaluated people with CRPS. I haven't specifically treated anyone in clinical practice with CRPS.

Q. And when you have evaluated them, you mean do like legal work, testimony type work?

A. Could be legal work, it could just be kind of like one of the regional evaluators for Opportunities for Ohioans with Disabilities. So I see all kinds of consumers that have a whole host of different diagnoses. It could be legal work, it could not be.

Q. How many times have you evaluated somebody with CRPS?

A. Well, I probably evaluated people with CRPS, I don't know, twenty times or so that have

been diagnosed with CRPS. Whether they -- CRPS is not a well understood syndrome, and there's quite a range of problems associated with it. So whether they actually have CRPS versus a local nerve injury type of mechanism remains to be determined.

Q. What have you noticed, objectively, in your evaluations in those twenty cases regarding CRPS?

A. Well, the presentation is quite different in each one. Some people have hypersensitivity, some people have atrophy, some people have skin color changes. You know, what I observed in this young lady was some mild calf atrophy and a loss of a reflex, or not being able to get a ankle jerk reflex, which again, could be a residual from her treatment for that condition, the blocks. And I think I also observed that she had some calf tightness in her ankles.

Q. And this is all on the left as compared to the right, correct?

A. Correct. For example, dorsiflexion on the left she was zero degrees versus on the right she was 15 degrees. But that was with the knee extended when that measurement was taken. When I actually looked at her dorsiflexion in squatting, like in the

picture that I took, she's got pretty normal dorsiflexion in that movement. And then I had some very -- I noted very mild swelling. Those are my main findings, basically disuse atrophy, calf tightness, mild swelling and, you know, tightness -- you know, tightness in the calf. So these are physical exam findings that are certainly consistent with a joint -- they're certainly consistent for a history of surgeries, and also the blocks that she was receiving for CRPS.

Q. And also consistent with somebody with CRPS?

MR. POWELL: Objection.

A. Well, some --

Q. That was how we started the conversation.

A. Well, some of those findings could be present in CRPS, and they could be present in other -- just as a residual from the surgeries and treatment that she had.

Q. All right. Is it fair to say that there's no doubt that there's objective findings that something's going wrong with her left leg ankle?

A. She does have some objective findings of -- for the left ankle that are not normal compared to the right ankle.

Q. In your notes, like on February 13, 2014, it shows that there's generalized loss of bone marrow density around the foot and ankle.

A. Correct.

Q. What's that mean?

A. Well, that is a finding that can be associated with CRPS, and it can also be associated with not weight bearing normally through that ankle.

Q. Look on 9/11/2013, so five months before there's an MRI finding, it says subtle marrow reaction within the distal tibia as standard view related to chronic fibrovascular reaction.

A. Uh-huh.

Q. What does that mean?

A. Well, fibrovascular is certainly a combination of scar tissue and associated vascular changes in that area. It's abnormal tissue, essentially is what they're saying.

Q. And then same note, it says no marrow reaction or marrow changes, medication station, RSD is demonstrated. What does that mean?

A. Well, it's basically saying that there is no -- that they're looking to see -- with RSD, sometimes you will see a bone marrow reaction or some type of marrow change, they're saying that's

not present.

Q. Okay. So it's not present on 9/11/2013, but it is present, at least according to these scans, on February 13, 2014, which is five months, right?

A. Correct.

Q. Is there any treating physicians -- treating physicians -- that rule out the RSD diagnosis?

A. That rule it out for her?

Q. Yeah, treating physicians?

A. No. I don't think there's any that rule it out from what I saw in the records.

Q. Okay. So from what you saw in the records, I'm talking Dr. Amis --

A. Right.

Q. -- who you have very high regard for.

A. I do.

Q. Okay. Gave a diagnosis of RSD, yes?

A. He --

Q. That's number three.

A. He did give a -- he did provide that as one of his diagnoses.

Q. Okay. We have Dr. Stanton Hicks. You're familiar with his work at the Cleveland Clinic?

A. I am.
Q. And what do you think of Dr. Stanton Hicks?
A. What do I think of Dr. Stanton Hicks?
Q. Yeah.
A. I'm not a big fan of Dr. Stanton Hicks.
Q. Okay. Why is that?
A. Because I -- I think that the way that -- I guess because I've just seen too dang many cases with complications from overzealous treatment of what he calls reflex sympathetic dystrophy, so I'm just not a fan.
Q. When you say overzealous treatment, what do you mean?
A. Well, I'm saying when you start putting in indwelling morphine pumps and spinal cord stimulators in the back and in the neck. And I've seen quite a few of the individuals after that treatment where, you know, I think if they had to go do it all over again, they wouldn't have gone down that path. I'm not a fan of Dr. Stanton Hicks.
Q. Okay. When you say you're not a fan, are you talking at all about his recognition of diagnosis of RSD or CRPS, or you're talking about his aggressive nature of attacking that problem?

A. I think RSD and complex regional pain syndrome are -- while you can't rule that out, I think it's -- I think it tends to be overdiagnosed and I think it tends to be overtreated. And I think as a result of that, there are many disabling consequences to that.

Q. Is that ever the patient's fault?

A. Well, I think the patient and the doctor -- well, you got a patient/doctor relationship there. And the person has inappropriate surgery, some of that blame goes to the patient, some of that goes to the doctor, some goes to the patient's willingness to just kind of do anything the doctor suggests to do, but without realizing the bad consequences from that. So there's ownership on both sides of that relationship as far as that goes.

Q. Do you think that McKenzie Davis was one of those people that falls in that category? And, I mean, in a category of somebody that treated with Dr. Stanton Hicks and had too aggressive treatment?

A. I would be very concerned about someone like McKenzie Davis being treated for RSD by someone -- by Dr. Stanton Hicks because of -- because McKenzie Davis, my perception or

observation, is that she tends to overreact to things. And that she's got, I think, a pretty long history of very considerable healthcare utilization even before this injury happened. So if you take an individual like that, that -- and then you hook them up with someone that's a pain interventional management kind of person, it's just not a good combination in my mind. It's -- I think the way that McKenzie Davis is functioning right now with having employment in front of her and focusing on her nursing career and those motivations is where she needs to be. Not in that medical model where she's that patient and she's getting all that attention. Because I don't think that she -- I think I would be concerned about McKenzie Davis being Dr. Stanton Hick's patient on an ongoing basis.

Q. Are you saying that McKenzie Davis is -- I'm not asking if it's a cause, I'm asking you if she's at fault for it. Do you blame McKenzie Davis for receiving any of the treatment that she had received?

A. I think if there are any treatments that McKenzie Davis received, that are -- whenever there's a treatment process, it's a decision between

the person and the doctor. So I hold them jointly accountable. But I do think that there's a tendency to just let the doctor kind of like run the whole show and do -- and make all those decisions and just to go along with them, be the cooperative patient. But if you've got a person that goes to the -- that's, what I would characterize, as a frequent flyer into the healthcare system for everything that happens to them, and that person hooked up with the wrong doctor that is going to just keep treating and treating and treating is a bad combination. So is there accountability? There's accountability to McKenzie, there's accountability to her parents, there's accountability to the healthcare team that's working with her to do no harm.

Q. How old is McKenzie Davis?

A. She's 21 years old.

Q. And when did she have the stimulator put in her back?

A. How old was she?

Q. Yeah.

A. I'd have to look at my record to know exactly. You're asking me a question you probably already know the answer to.

Q. I'm going to say she was 19, but that's a

guess. Let's just say it's 19 or 20 or even 21, do you think that McKenzie is in a better position to tell the doctors what she needs? I mean, I wouldn't want my son not doing what the doctors told him to do. Would you have recommended that to McKenzie in this case?

A. Are you kidding me? I mean, if I had a 19-year-old son and let's assume that McKenzie was -- spinal cord stimulator, when was it put in? Let's just assume it was -- she was 19 years old. No, I don't think my kids -- my big kids, I don't think my kids are that great at making healthcare decisions and choices at that young age. So, as a parent, I would hold not only McKenzie Davis responsible but her parents for helping to guide her and work with the healthcare team.

Q. Totally different answer. You said you wouldn't trust your children to take the decision-making away from the doctor, correct?

A. No, I didn't.

Q. Okay. Forget about the mom. Do you think that McKenzie Davis was in a position -- was in a position to not do what the doctors are telling her to do? Do you think that would have been a good idea for her?

A. I think McKenzie Davis' history reveals that -- I mean, she had the spinal cord stimulator put in, had the spinal cord stimulator taken out, right?

Q. Okay.

A. So having that spinal cord stimulator wasn't an appropriate or an effective treatment for her.

MR. POWELL: Dr. Wickstrom, I think Blake's question is, you know, directed specifically at whether -- regardless of whether you think it was a good decision to have the spinal cord stimulator or -- in or out, what I think Blake is asking is, in terms of McKenzie's accountability, would you want her to not proceed with medical treatment directed by her doctors.

MR. MAISLIN: Correct.

MR. POWELL: At that age.

Q. Whether Dr. Amis or Stanton Hicks or a physical therapist.

A. I think it -- I would hope that McKenzie Davis would treat her doctors as consultants, not parents, not you do this and you have to do this. You consider what their input is, what their recommendation is, then you make your healthcare

choices. So I would expect her to make the best healthcare choices after consulting with -- and if they're recommending something extreme like that, you know, I would be consulting with other doctors. You know, I think she did have Dr. Amis, who I respect, available to her. I don't know whether he encouraged her to have that spinal cord stimulator or not have that. But I think -- the bottom line, I think it's a terrible thing that she underwent that at such a young age.

Q. There's two portions of your medical record review notes that are highlighted by way of all capital letters. You know what I'm referring to?

A. Yes, I think I do.

Q. And why did you highlight those two sections? For your reference, on Page 8.

A. Okay.

Q. Why only highlight those two?

A. Well, one of the reasons I highlighted that one on 10/1 was that before this injury happened, McKenzie was -- well, this was actually after her injury happened. But the doctor mentioned in his history that she tends to overreact or gets a little stiff and sometimes tends to have

hypersensitivity reactions and they're basically saying she was at risk, based on how she was behaving in the past to other injuries. So I thought that was a relevant statement.

Q. Risk of what?

A. At risk of getting -- what they say is getting any kind of RSD. So that was the first thing.

Q. Why did you highlight that, though? Why does that have anything to do with your evaluation in this case?

A. Because she's predisposed to overreacting to injury types of situations. So their only treating doctors are mentioning that as a concern. The whole RSD kind of syndrome, it's not just -- it's a chronic pain type syndrome. So you got the psychology, you got the physical injuries and you got the whole social kind of interaction, too, which I observed with her mother.

Q. But why highlight it? How does that statement help you at all regarding her functional capacity exam?

A. Because it points out to me that she tends to overreact to her circumstances.

Q. But you said that -- okay.

A. But that's why I highlighted it, short and sweet.

Q. And then why did you highlight the one on 5/7/2012 -- or excuse me, it was 1/18/12 where it says probable complaint of RDS in past.

A. Because it reflected that she had a preexisting component of that in prior care before this injury even happened.

Q. And how does that affect your functional capacity exam?

A. Well, it tells -- from a predisposition standpoint, it tells me that she tends to overreact or react in a way that is more -- different than expected when she has injury circumstances. So, to me, it reflects on her kind of prior level of functioning before the functional capacity evaluation.

Q. And that doesn't necessarily mean she's being dishonest, it's just saying that she's hypersensitive; is that fair?

A. Yes, that's fair.

Q. I mean, because at least in this case, I mean, nobody wants to be in pain all the time. I mean, as far as you can tell.

A. As far as I can tell.

Q. All right. And these doctors are saying -- I mean, is this your read that the doctors are saying, hold on, this is someone who has the psychological component that can couple with the physical component that can create a real mess here, right?

A. Yes.

Q. And the real mess is sort of what you're seeing during your functional capacity exam to some degree?

A. Yes. Yes, I'm seeing -- I'm seeing what her willingness and ability is to function, and it could reflect a lot of complex influences.

Q. Tell me about what happened when you performed the ankle reflex test.

A. Okay. Like anything I do, I explain the activity and then I ask the person to perform it. In that ankle reflex test, we -- first we did the knee jerk ones while she was sitting. And then I basically had her stand and kind of like put one leg on the chair, so that her leg is kind of like in a -- sort of a relaxed position and I tapped the back of the heel cord. So we showed her how -- I did the unaffected side first. Then I had her do it with the affected side. And then she had -- so I

literally demonstrated it before she did it. And then when I tapped it, she just kind of went ballistic, really, just really lost it emotionally and then her mother's reaction was even more remarkable.

Q. Before we get to the mom. You said she lost it emotionally, tell me exactly how she behaved that you can recall.

A. She just started crying.

Q. Was that -- sorry. Go ahead. So she just started crying. Did she say anything out loud?

A. I don't -- there's almost -- from my recall, it was like -- almost like I tapped the back of her heel cord and there was like a -- like a brief pause from what I recall, and then all of a sudden she started to well up with tears, and her mother saw her starting to cry and then got this whole emotional interaction with her and her mother.

Q. Had she just teared up and started crying, would that have been unusual to you?

A. Well, I wasn't expecting that reaction.

Q. Okay.

A. So it was an unusual reaction for just tapping the back of her heel cord.

Q. What about tapping people's heel cord if

they have RSD or CRPS?

A. Well, I mean, that's a hypersensitivity type of response. Hypersensitivity is one of the -- is -- but she also had localized surgery, right, in that area, so --

Q. Well, hold on. We're getting off topic. I'm only talking about, let's assume she has RSD or CRPS, she could have hyper -- you started to say hypersensitivity is one of the symptoms from that. And the heel tapping that you described resulting in her crying, is it fair to say that that could be a very legitimate response? I'm not talking about the mom coming in here.

A. It's a really -- it was a really unusual response. I mean, it's a stretch reflex, you know, tapping with that. And when you squat down and you lift 50 pounds from a lower level, you also stretch that same area, so there's -- but it is a hypersensitivity type of response. It wasn't anything that I really expected from the physical exam I had already done on the ankle.

Q. Do you have any reason to believe that she was faking her symptoms, of hypersensitivity?

A. No.

Q. Okay. So tell me about what happens when

the mom comes in the picture.

A. Her mom was right with her during the evaluation. I mean, she just like -- I mean, the best way to describe it is she literally -- Mom literally got down on her hands and knees in front of her and just started like just cradling her and rocking her like a baby. So, Ms. -- McKenzie was sitting in a chair, Mom's on her knees, you know, and just -- and this went on for like probably five minutes before she got herself together and was willing to proceed.

Q. When you say -- I mean, tell me what happened within the five minutes. You're telling me they're sitting there rocking for five minutes, or it was, we're going to take a break, and we don't know if we're going to continue or what?

A. No, just rocking, holding, hugging, you know, just -- it was just a -- I mean, it's like all of her overreaction was being essentially, I'm going to say enabled, by her parents. I mean, this whole thing with chronic pain is all about, you know, motivational rewards and that kind of thing. And she was definitely being almost like in a way rewarded and nurtured for exhibiting these overreactive behaviors. That's one of the reasons

why one of the most effective treatments for CRPS is cognitive behavioral therapy, which she's had very little of.

Q. So you recommend -- do you recommend that for McKenzie in this case?

A. McKenzie is marching into a pretty positive path, so, you know, my philosophy is not to overmedicalize and overtreat stuff, unless there's a barrier that needs to be addressed. So I felt like her attitude towards school and beginning of career was so good, that that's the piece that needs to be supported more so than further medicalizing or psychologizing, you know, her problems. But that's a very unusual family dynamic.

Q. I'm looking at the active movement screen. And specifically I'm looking at the number 9 on Page 11, active movement screen, number nine, toe walk in place. It says right fair, left poor.

A. Uh-huh.

Q. What does that mean, is that the box you were referring to?

A. No. Toe walking is like -- toe walking is a pretty common movement. They walk on their heels, they walk on their toes. But basically it reflects a combination of calf strain, calf muscle strain,

and ankle flexibility.

Q. Okay.

A. So, if it's impaired, it could be because of tightness, which that wasn't really the case because I measured her flexibility, but it's more from a weakness standpoint.

Q. Okay.

A. Or pain.

Q. And it's worse on the left than the right?

A. Yes, it was. But it was somewhat limited on the right which, again, that's -- toe walking is also more difficult for people that are morbidly obese, and that's one of her big problems. People who are morbidly obese are low -- tend to have low agility and they take some -- almost ten times as long to recover.

Q. Your consistency of performance on Page 16. Now, consistency of performance, does that mean that they were -- it's within their performance during your testing? So, in other words, if you say raise your hand in the sky and I raise and you say how does that feel and I say, it's fine. And then five minutes later you say, raise your hand to the sky and I raise my hand and say, oh, my God, right?

A. Correct.

Q. As opposed to consistency with the medical records and things?

A. Yeah. I'm -- in this section I'm primarily addressing consistency of performance related to her physical exam and functional capacity testing. It is possible to discover other information in the medical records after the fact that might point out -- that might point to inconsistencies during that performance, for example, you know, surveillance.

Q. Okay. You have checked magnified pain ratings?

A. Yes.

Q. And did we already discuss that?

A. I don't know that we discussed her pain ratings. I did -- I always ask the person what their pain is, like during the seated interview --

Q. Okay.

A. -- versus last 30 days. And I think that's on -- it's going to be right around the first part of the exam, bottom of Page 10. So she's telling me that she's had a 10 out of 10. And I qualify that with, a 10 is call the emergency room. You know, if you tell me a 10 during the exam, you know, that tells me that we need to call the

emergency room. So she's reporting a 10 out of 10 within the past month, and pre-interview 6. And she's telling me at times she has no pain whatsoever. But pre-exam she was reporting pain primarily on the bottom of her left foot. That was her source of pain during that intake interview process when she was getting up and moving about.

Q. Okay. And why is that an inconsistent -- why is that an inconsistency?

A. Well, 10 out of 10 is the top end of the scale.

Q. Okay.

A. And I don't think she reported any history of emergency care within the past month. So she's just the person that tends to report very high levels of pain. The fact that I'm seeing these ratings here rated from zero to 10 tells me that when she does have pain, she gets -- she feels anxious about it and reports higher pain levels. So that's -- that's just a high pain rating for someone to report, a 10 out of 10. I get real worried when they say 20 out of 10, and the scale only goes to 10. But she's capping out the pain scale, so that's why I checked that.

Q. Do you know whether McKenzie Davis was in

and out of the emergency room for pain? Maybe not in the last month but --

A. Well, I am -- in looking through her records, I saw records of -- I mean, she's been in and out of the emergency room many, many times over her young life, even before this injury even happens. So, yes, I saw multiple indications, I guess I'm kind of thankful I didn't get the whole box of records for her pre-existing stuff to review.

Q. Is that an assumption?

A. Well, I -- I have the summary from Mr. Powell. And I'm sure there are boxes of records that relate to that summary. The good thing for me is, I got a pretty good effort out of her during the evaluation, so the records became less -- I could rely more on my actual findings.

Q. So, I guess, what is the actual inconsistency you're referring to when you say magnified pain ratings?

A. Her rating of 10 out of 10.

Q. Is inconsistent with what?

A. Well, it's just the top end of that scale without any evidence of -- it's just a very extreme pain rating considering her level of demonstrative functioning for me. It just seemed like it's a very

extreme --

Q. Did she relate to you that sometimes she has zero pain?

A. Yes, she did.

Q. Would that also be inconsistent then with her level of functioning that you saw?

A. No. I don't think it was inconsistent at all that sometimes that she's rating a zero.

Q. So you think that it doesn't make sense to you that someone on one day can have extreme pain and on another day can have zero pain?

A. Well, it can make sense. I just felt that that was a magnified rating.

Q. Do you think that it can make sense in this case, that on one day she can have very extreme pain, and one day she can have zero pain?

A. Again, pain is what she is perceiving.

Q. But you're saying that it's inconsistent, and I'm saying a different question. Do you think that she can have very severe pain on one day as related to the conditions that she has and yet a zero on another day?

A. Yes. Because that's her perception. I'm not questioning her perception. I'm just saying that it's inconsistent with her functioning.

Q. Is her perception her reality?
A. Yes. I think that is.
Q. So, if her perception is severe, then to her it's severe and intolerable.
A. That's her perception.
Q. Right. Which is her reality, right?
A. I don't disagree.
Q. Okay. What do you mean by not anatomic or superficial tenderness?
A. Just jumpy behavior with light touch, things that --
Q. And what would that be inconsistent with?
A. It's an indication of overreaction, because you're not really putting much mechanical pressure on the tissue structure. So it's an indication of overreaction. And when you have overreaction, then you tend to have inconsistencies.
Q. If her reality is that she's having severe pain, then when you talk about excessive pain behavior for non-anatomic or superficial tenderness, that would be a direct -- that would be inconsistent with her actual reality, right?
A. When I see those behaviors, I interpret that as a source of inconsistency during the exam process. And I think it's much more likely when you

see those present, that I'm going to observe different functions, maybe at different circumstances. So, it represents an -- how we respond to stimuli is different under different circumstances, okay? So if she's doing something that she is -- that interests her, she may be less -- her function may be better during that time when she's doing something that doesn't interest her, so she's more focused in on her symptoms. So I'm just saying, it's a source of performance inconsistency when I see that present.

Q. Okay. The reason why I'm hammering on it so hard is, because I don't want people going into court and saying that this girl is a liar. This girl is a faker. So am I right to say -- to assume that when you go into court, you're not going to testify that she's a liar or a faker?

A. Yes, you are right.

Q. Okay. That these symptoms that she feels, they're real to her?

A. They likely are real to her.

Q. And you said that a component in RSD is the psychological factors, right, that can combine with the physical component that results in that reality, which results in those behaviors, right?

A. RSD is a chronic pain syndrome that is affected by how -- by both the psychological and the physical limitations, and they do interact with one another.

Q. And that's exactly what we have here, right? We have the psychological and the physical combining together to result in magnified pain ratings, non-anatomical or superficial tenderness and excessive pain behaviors or overreaction?

A. Yes.

Q. Are you familiar with Dr. Lee, who has been her pain management?

A. Yes.

Q. What's his reputation in the community, as far as you know?

A. Well, he's a pain intervention management specialist. He's referred patients to me for evaluation.

Q. Is he a good doctor, as far as you know?

A. Well, I'm not -- you know, I'm just aware of the people that he sent to me for evaluations. And, unfortunately, those people that he sent to me are people that aren't getting on with their lives, you know, so they need some type of functional evaluation, some type of recommendations to kind of

get them moving into vocational rehabilitation. So I really can't comment too much on his direct practice and, you know, but seems like a nice -- and, of course, I tend to deal with his ancillary people a little bit more. But I know he sends people to me.

Q. Have you ever referred anybody to Dr. Lee?

A. No.

Q. Have you ever referred anyone to Dr. Amis?

A. Yes.

Q. How often or how many times, if you recall?

A. I don't recall. He's on my short list of one or two. I like him a lot. Of course, I knew him when he was a resident. He's just a -- he's outstanding in his field of foot and ankle surgery.

Q. When you've seen patients who have been diagnosed with RSD, do they always show all of the symptoms of RSD all the time?

A. No.

Q. Okay. Just so I'm clear, if someone has atrophy and swelling, they may not have discoloration all the time, it may come and go, right?

A. I mean, it's possible. I mean, they have

their own little diagnostic criteria, which I'm sure Dr. Steinman can lecture to you on more extensively but, yeah -- no, it's a syndrome of problems. So nothing is ever -- sometimes you have a perfect picture and people have everything that you would expect, and it's just a God awful presentation, but there's a wide variation on just having some peripheral nerve complication kinds of things versus the full spectrum of RSD.

Q. With McKenzie do you know about her prescriptions, or not really?

A. I went through her prescriptions with her. Something I always ask, because it can affect their behavior.

Q. Within the 30 days leading up to your examination, do you know if McKenzie took any morphine? By prescription, I don't mean in the emergency room.

A. So I asked about recent medications. And I asked about them within the past month.

Q. Okay.

A. So, on the bottom of Page 4 in my report she told me that Dr. Lee prescribes her with morphine that she takes anywhere from zero to one time a day, and she last took a few days ago.

Q. And why would she take that?
A. Her pain.
Q. If I told you that she does that so she does not have to go to the emergency room when she's a 10 out of 10, is that reflected anywhere in your notes, or does that sound familiar at all?
A. Well, I mean, I didn't specifically -- I'm always interested in knowing what she'd been taking and what the frequency is. So, on a good day are you taking it, on a bad day, and how much are you taking it? So I just want to know, you know, whether she's taking it or not. Because it has -- it can have an effect on her function. And in particular it can have an effect on her performance during my evaluation. If let's say that -- let's say that she didn't take it -- she took it on a regular basis, she stopped taking it for three days before my exam so that I knew how she really felt when she wasn't on her medications. Well, that would have a big impact on her functioning during my exam than when she's taking it. My instruction is always take your medication, according to the way that allows you to function best. So that's why it's relevant for me to know it, so that I can gauge how that relates to her responses during the exam.

Q. Did you tell McKenzie that -- your exact words, did you say you are very credible?

A. Pardon me?

Q. Did you tell McKenzie "you are very credible"?

A. Do I have that documented in my report?

Q. No. I'm asking if you said that to her? Did you tell her she's credible?

A. I don't recall specifically. I wasn't negative with her in any way in terms of I was complimenting -- complimentary to her on her functional behavior during my exam. But I don't recall specifically about whether -- whether I said that or not.

Q. It wouldn't be inconsistent with her functional behavior?

A. No. I don't think so. I think I got a credible presentation of her functional abilities during the evaluation when I actually had her doing tasks.

MR. MAISLIN: Okay. Why don't we go off the record. I'll take a look at your stuff.

THE WITNESS: All right.

(OFF THE RECORD)

BY MR. MAISLIN:

Q. It says in here that you reviewed Marianne Boeing's Life Care Plan. Did you have a chance to review that?

A. Did that go on the records that are on there?

Q. I don't know, it was -- I just saw this and then you -- it wasn't really addressed in your report.

A. Those look like just the records that Mr. Powell provided to me. They weren't so much specific to your inquiry.

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

A. When you ask about prognosis with respect to what, with respect to her functioning or with respect to her restrictions?

Q. Her --

A. I'm not --

Q. Just her actual medical condition. Do you know whether she will heal or not heal or get worse to any degree? Do you have an opinion, within a reasonable degree of medical certainty, or are you not providing one?

MR. POWELL: No.

MR. MAISLIN: So he's not providing one?
MR. POWELL: Not from a medical standpoint.
Q. I think the record is clear, but that was only referring to the medical prognosis, whether her condition will heal or not to any degree, or get worse or not to any degree, fair?
A. Yes.
Q. Okay. Have you reviewed -- I think I just asked this, Marianne Boeing's Life Care Plan?
A. What's the date of that one? Because if I did review it, then it should be listed as one of my records under relevant diagnostics or record findings. I don't --
Q. I didn't see it in there.
A. I don't think I did, so...
Q. Do you have an opinion, within a reasonable degree of certainty, as to the type of future care that McKenzie Davis will require as a result of the injuries she sustained in the fall from the haunted house, Delhi Haunted House?
A. Do I have an opinion?
Q. Yes.
A. I mean, do I have an opinion that I will offer up in trial?

Q. Yes.
A. No. I don't think so.
MR. POWELL: Not from a medical standpoint. What he will be rendering testimony on are functional aspects of McKenzie's condition.
Q. Okay. So I see this, this is part of your chart, it's a Life Care Plan.
A. Okay. So I did look at it. What's the date on it?
Q. April 16, 2015.
A. Okay. I did cite it in my list of records, so I do have it.
Q. Do you have any, or do you plan to criticize this report in any way in court?
A. I don't know.
Q. Do you have any criticisms of the report?
A. I mean, as -- I don't recall.
Q. Okay. Do you have an opinion, to a reasonable degree of certainty, as to what type of future medical care McKenzie Davis will require?
A. Yes. I have an opinion.
Q. Okay. What's that opinion?
A. Well, my opinion is that she needs to be weaned off of her narcotic pain medications.
Q. Okay.

A. And needs to engage in an appropriate self-management program that is directed at weight loss, low impact aerobic exercise.

Q. Anything else?

A. That's just my opinion.

Q. Okay.

A. It may require cognitive behavioral therapy to get that done in a limited manner.

Q. Do you have an opinion, to a reasonable degree of certainty, as to whether any of the treatment contained in VoCare's Life Care Plan will not be necessary?

A. I may, yes.

Q. I need to know, so when I go to trial, I know what your opinion is.

A. Right. Well, I mean, I didn't -- I wasn't asked initially -- I was asked -- my initial charge from Mr. Powell was to look at her functional capacities, and look at her impact on that. I did review that Life Care Plan. I did see things in there that I do not agree with, but I'd have to go through it and provide you with a more detailed analysis, if you want me to do so.

MR. MAISLIN: Is he going to be attacking the Life Care Plan?

MR. POWELL: Quite frankly, I'd have to look at it. I mean, the Life Care Plan itself, no. But I'd have to look to see if the components of it in terms of -- I mean, I think he's addressed a lot of this, but I don't want to limit you in your questions. I don't want to limit him in his. For instance, like the medications, I mean, you've answered --

MR. MAISLIN: Right.

MR. POWELL: -- that. I think with the future care, he's kind of answered that. He is -- maybe this will help you, Blake. He is not going to attack the Life Care Plan or what Ms. Boeing did in terms of her protocol or what she ended up with in terms of her numbers and how she went about obtaining those numbers. I don't know the answer to this question as to --

THE WITNESS: Or I might endorse it.

MR. POWELL: Well, whether he will respond to questions pertaining to information that's contained here, which I believe is probably nothing to do with -- the genesis has nothing to do with what Ms. Boeing did, versus the information she got from the doctors. So I think that answers -- he's not going to give Life Care Plan

opinions.

MR. MAISLIN: Okay.

MR. POWELL: He may address some of the components of the Life Care Plan as it pertains to the treatment or information she obtained from the doctors.

BY MR. MAISLIN:

Q. So, if, in other words, if Stanton Hicks, for example, says, well, I think she needs to be taking 30 Percocet a day instead of weaning off. Then you may take issue with that?

A. I do. I think it's a big problem --

Q. Well, I made that up as an example.

MR. POWELL: He's just asking if that's the type --

A. No. But her -- I have a big problem with the amount of narcotic pain medication that she's being prescribed at such a young age.

MR. POWELL: But hold on. Hold on. You've already answered that. All Mr. Maislin is asking is the type of issues you would address that are contained in that Life Care Plan. One of which, he used as an example, is pain medication. And your answer was, yes, that would be something that you potentially could comment on at trial.

THE WITNESS: Yes.

MR. POWELL: Okay.

Q. Are you in a position to ever prescribe whether someone has surgery or not?

A. No. The prescription of surgery would be made by the surgeon. I would certainly refer someone to a surgeon that I thought would likely be a candidate for surgery.

Q. Okay. So you aren't -- and I don't want to keep saying you're not qualified. I don't mean to demean you by any stretch, that's not what I mean when I say that. You know, I don't want to start trouble. But you're not qualified to prescribe or not prescribe surgery. You may see symptoms and refer someone, correct?

A. Correct. I would refer that person to a surgeon for consult.

Q. Okay.

MR. POWELL: He is not going to either agree or disagree with Dr. Amis' decisions to operate.

MR. MAISLIN: Okay.

Q. Are you going to give an opinion as to whether a future spinal cord stimulator may or may not be appropriate for McKenzie Davis in the future?

A. Wow, that's a -- I don't know what the future holds with her with regard to future surgeries.

Q. This Life Care Plan was generally and essentially signed off on by Dr. Stanton Hicks related to the condition of RSD or CRPS, okay? In here is a list of treatments and the probability of such treatments over the course of her lifetime related to that condition. Do you think -- well, can you take a look at this report and tell me if there's any treatments in here that you think are -- that you're going to take issue with at trial outside of --

A. The way that I would like to respond to that is, I would defer to Dr. Steinman on those matters, on medical issues at trial.

Q. Got it. I'm just trying --

A. Yeah. I have an opinion that I think I'm qualified to say, but I would defer to his expertise with regard to those medical treatment related things. Now, if there's something in there that relates to needing physical therapy, something that is within more of my zone of practice related to physical therapy, job accommodations, home modifications, assistive devices, you know, those

are things that I, you know, feel very -- would feel comfortable commenting about, if those issues came up. But it looks to me like most of the information in there was more medical treatment centered in terms of that Life Care Plan.

Q. Okay. And because you're not able or not giving an opinion regarding McKenzie Davis' prognosis, if we're talking about the number of future physical therapy appointments, you're not able to speculate on that?

A. I don't think anybody can speculate on the number of future physical therapy appointments.

THE WITNESS: Can we go through your list maybe, so I can kind of give -- make sure I have it?

MR. POWELL: Here we go.

A. So you should already have one of these, but I did make a copy of it. Did I give it to you?

Q. I don't have it.

A. Okay.

Q. What I'm going to do is I'm going to take your whole chart and I'm just going to make it an exhibit.

A. I made a copy of my chart, parts of my chart already that's relevant.

Q. Well, I want the whole chart.
A. You asked me to do that, and that's what I did. Do you mean you want to make a copy of the records that were provided in my chart --
Q. Yeah.
A. -- by Mr. Powell?
Q. Yes.
A. Okay. I did not anticipate that request.
Q. Well, I don't mean right this minute. I mean, I'm comfortable with you making a copy and sending it to Mr. Powell and -- I mean, I'm not a stickler of how I get it. I trust that you'll make a good copy.
A. Right.
Q. Can I take a look at your file, please?
A. Oh, sure.
Q. It will just go a lot faster that way. I just want to make sure there's no surprises in here. I see, what you're saying is what you just handed me is the copy.
A. Yeah.
Q. I'm sorry, I thought --
A. I wanted to just check it off and make sure it's organized.
Q. This is what's in here.

A. Well, okay, so here's my -- going through your list, here is my resume, an extra copy.

Q. Okay.

A. Mr. Powell already has that. Here are my invoices for work that's been done to date including the -- here is my fee schedule, these are the -- I made a copy of the intake form in my chart that Ms. -- that McKenzie filled out. And then essentially everything on this side is what is here talking about the subpoena. This is the page from the other side, for example. So I kind of made a copy of that already. And then these other items are records that were provided to me by Mr. Powell, which I did not make a copy of. And then you asked -- it was a pretty broad request for publications that I have. All of my references, in terms of how I interpret the functional capacity results and stuff like that, are cited actually in my report. There's a list of references in the report.

Q. Okay.

A. I didn't reproduce those copyrighted documents or anything like that. But I did make copies of a couple of things related to publications I was involved with. I was the lead editor for the

American Physical Therapy Association Guideline of Functional Capacity Evaluations, I made a copy of that. I also made a copy of the article that I wrote on job specific functional capacity testing. And that's really more of a context for how I performed this evaluation, because she was entering a specific vocation. And then I put in a couple articles that related to her -- the effect her obesity will likely have on her utilization of healthcare and her injury risk.

Q. Okay.

A. That's what those are.

Q. Are these my copies?

A. Yes, they are. And this is your copy, too. This is the health questionnaire that I had her complete.

Q. Okay.

A. I've got it kind of organized on either side of my chart.

Q. And these are all mine?

A. Yes.

Q. And this is mine?

A. Yes.

Q. And I already have this. But is this mine?

A. Those are medical records that are provided by Mr. Powell, so I didn't make copies of those.

Q. Real quick, I'm just looking at these. This is Obesity and Worker's Compensation. This is essentially heavier people go to the doctor more?

A. Heavier people get hurt more. They're more predisposed to falls. When they do get hurt, it's -- there's a lot more cost associated with those injuries, and that relates to mobility. How obesity relates to mobility impairments. It's more for older adults, but the same principles kind of apply to whatever age you are.

Q. It all seems pretty intuitive, right?

A. I think it is, but it's -- it explains some of her low agility.

Q. Okay. What is this one?

A. This is an article I wrote in the -- for the American Medical Association on the -- in a book that they wrote on guide to functional ability and it's on job specific functional capacity testing. But it kind of reflects the approach you might take when someone -- when matching a person's abilities to a specific job.

Q. What's this one?

A. And that's the American Physical Therapy Association Guidelines for performing functional capacity evaluations. I served as the lead editor of that document. Just describing the process. I thought those were the most relevant to your requests.

Q. All right. So the only thing that I don't have copies of is this, the medical records.

MR. POWELL: Hold on. These two go together.

THE WITNESS: Is that something we provide to him?

MR. POWELL: Well, no, we have to make copies of that, because I -- I can print it out but he needs to have what's in your file since you testified that you did rely on some of the information contained in this summary versus the information contained in the records, he's entitled to it.

THE WITNESS: Okay.

MR. POWELL: And there's no thought process, other than retyping of the information contained in the records. We didn't paraphrase it, those are -- those notes come directly out of the medical records, so we just need to make copies of

those.

THE WITNESS: Okay. I can have my assistant do that while you're here if you want.

MR. MAISLIN: Sure. I'm done, unless you have any questions?

MR. POWELL: I don't.

(Witness excused)

(The deposition ended at approximately 12:05 p.m.)

(PLAINTIFF'S EXHIBIT 1 WAS MARKED FOR THE RECORD)

_____ _____

Dr. Rick Wickstrom Date

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STATE OF OHIO)

)

I, Tina M. Barlow, Notary Public for the State of Ohio, do hereby certify:

That the witness named in the deposition, prior to being examined, was by me, first 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 12th day of August, 2016.

TINA M. BARLOW
Notary Public
State at Large
My Commission expires: 5/16/19