IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

DAVID BLISS,

Plaintiff,

vs.

BNSF RAILWAY COMPANY,

Defendant.

4:12CV3019

ORDER

IT IS ORDERED that the defendant's deposition objections, (Filing No. 190), are granted in part and denied in part as set forth in the attached transcripts.

May 16, 2014.

BY THE COURT:

s/ Cheryl R. Zwart
United States Magistrate Judge

DEPOSITION OF

DR. DANIEL RIPA

Condensed Transcript and Concordance
Prepared By:

LORI McGOWAN, RDR, CCR, CRR
Certified Realtime Reporter

LATIMER REPORTING
latimer-reporting.com
528 S. 13th St., Suite 1
Lincoln, NE 68508

Phone: (402) 476-1153
(877) 567-5669
Fax: (402) 476-3853

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF NEBRASKA

DAVID BLISS, Plaintiff, vs. BNSF RAILWAY COMPANY, Defendant.)CASE NO. 4:12CV 3019)DEPOSITION TAKEN IN)BEHALF OF PLAINTIFF

DEPOSITION OF: **DR. DANIEL R. RIPA**

DATE: February 24, 2014

TIME: 7:01 a.m.

PLACE: 575 South 70th Street, Suite 200, Lincoln, Nebraska

A P P E A R A N C E S.

APPEARING FOR THE PLAINTIFF:
(Appearing Telephonically)

Mr. William J. McMahon
Attorney at Law
542 South Dearborn
Suite 200
Chicago, IL 60605
wmcmahon@hoeyfarina.com

APPEARING FOR THE DEFENDANT:

Mr. Thomas C. Sattler
Attorney at Law
701 P Street
Suite 301
Lincoln, NE 68508
tcs@sattlerbogen.com

I-N-D-E-X

S-T-I-P-U-L-A-T-I-O-N-S

It is hereby stipulated and agreed by and between the parties that;

Notice of taking said deposition is waived; notice of delivery of said deposition is waived.

Presence of the witness during the transcription of the stenotype notes is waived.

Taken pursuant to the Federal Rules of Civil Procedure.

(Exhibit Nos. 78C and 78D marked for identification.)

DR. DANIEL R. RIPA,

Of lawful age, being first duly cautioned and solemnly sworn as hereinafter certified, was examined and testified as follows:

DIRECT EXAMINATION

BY MR. McMAHON:

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

A. Daniel Ray Ripa.

Q. And what's your profession or occupation?

A. I'm an orthopedic surgeon, a physician, orthopedic surgeon.

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Q. And showing you what's been marked as 78D, exhibit, is this a true and accurate copy of your curriculum vitae?
A. It is, correct.
Q. Would you tell the jury a little bit about your educational background and training to be an orthopedic surgeon?
A. Well, I went to the University of Nebraska Medical Center for my medical doctorate degree.
And then did a flexible internship and residency at Scott & White Memorial Hospital in Temple, Texas.
And after that, did a one-year spine fellowship that was split between New Orleans and Chicago, the latter part at Northwestern in Chicago on the regional spinal cord injury unit.
Q. And are you in private practice?
A. Correct.
Q. And could you give the jury an idea about the nature of your practice, what type of conditions you treat, how many surgeries or patients you treat on a weekly or monthly basis, that type of thing?

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A. Well, we're -- or I am a member of a 12- or 13-man orthopedic group. And we see patients all week long and do surgery all week long, a mixture of about half clinic, half surgery.
And I treat a variety of neck and low back disorders, scoliosis, fractures of the spine.
I also do a fair amount of work in artificial joint replacement.
Q. Okay. And do you regularly attend medical conferences or continuing medical education to keep up on the issues in your field?
A. I do.
Q. Okay. And are you published anywhere that we may have heard of in terms of articles or that type of peer-review journals?
A. Not for a long time. Did some back in the fellowship period. But not since then.
Q. All right. Doctor, at BNSF's request, did you perform a medical records review for this case, for Mr. Bliss?
A. That is correct.
Q. All right. And do you recall what

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materials that you reviewed in helping to formulate your opinions and conclusions in this matter?
A. Well, I looked at several MRI scans, a variety of medical records, some therapy notes, some evaluations that the patient had had for their fitness for work and those sorts of things.
Q. All right. And were these medical records -- they also predated the February incident that centraled this case; correct?
A. Yes. Some portions of them did.
Q. Okay. And are these the type of materials, documents that you and other orthopedic surgeons typically rely upon to assist them in formulating their opinions and conclusions as to a person's current medical condition?
A. Yes.
Q. And did you rely upon this information as well as your background and training as an orthopedic surgeon in formulating your own opinions and conclusions in this matter?
A. Yes.
Q. All right. And if we look at Exhibit

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78C.
A. I have it.
Q. Okay. There's listed here, I believe, seven numbered paragraphs. Do you see what I'm referring to?
A. Yes.
Q. All right. Are those the opinions and conclusions that you reached in this matter as far as relates to Mr. Bliss?
A. Yes.
Q. All right. And if we could, let's just go one by one through them. And we'll identify them. And if you could, just explain the basis for those opinions. All right?
A. Okay.
Q. All right. So No. 1, could you read it, please?
A. These are responses to the attorney that I believe represented the railroad previously.
The first response, I put, "Dr. Noble's release for Mr. Bliss to return to work without restrictions as per the request of Mr. Bliss in July 2010 was too liberal for someone with Mr. Bliss' degenerative spine condition."
Q. Okay. What's the basis for that

BNSF objects to the testimony as hearsay without an exception and as not relevant. Fed. R. Evid. 402, 403, 801, and 802.
Ruling: Overruled

opinion, Doctor?
A. Well, the patient did have some fairly significant abnormalities chronically in his low back. And in general, we would tend to imply or put upon the patient at least some degree of general restriction against excessive lifting or activities that might be considered likely to cause some degree of difficulty with his back in the future.
Q. Okay. Do you have any idea what those types of restrictions would be?
A. Well, our more generic restriction for someone with a low back condition is to try and avoid lifting in excess of 50 pounds at any time and, also, to keep repetitive lifting at or below about 25 pounds.
Other restrictions might be a bit more specific to the particular work activities.
Q. Okay. Were you asked to look at the particular work activities in this case or no?
A. Well, I don't recall a specific -- and I stand corrected.
I don't recall a specific delineation of the work activities in this person's employment.

Q. Okay. And then moving on to No. 2, I guess it's pretty self-explanatory, but just briefly go over the basis for opinion No. 2.
A. Well, this opinion was, "Mr. Bliss was clearly suffering from degenerative disk disease, particularly at the L3 slash 4, L4 slash 5 and L5 slash S1 levels prior to February 3rd, 2011."
Q. And the basis for that, was that just the prior medical records and the diagnostic films that you reviewed?
A. Correct. Specifically the MRI scan.
Q. Okay. And No. 3, could you read that and explain the basis for your opinion there?
A. This response was, "The change in Mr. Bliss' back condition between the MRI of April 27th, 2010, and March 18th, 2011, showed an increase in degenerative facet joints, foraminal narrowing and increased degenerative bone marrow at L4 slash 5 and L5 slash S1."
Q. Okay. What -- what -- what does that mean, and what's the basis for that opinion, sir?
A. Well, the basis for that opinion is looking at the two MRIs. One was prior to the

incident in question. The other was shortly after it.
And basically the MRI scan showed an increase in these degenerative changes rather than any clearcut evidence of an acute, sudden abnormality such as a broken bone or ruptured disk or something of that nature.
Q. Okay. And then No. 4?
A. No. 4, "The changes noted in the above response, paragraph No. 3, could be the result of the natural progression of a degenerative spinal condition."
Q. All right. Could the changes that appear in No. 3, could it be in part due to the February 3rd, 2009, incident?
A. Well, I would have to say that I did not see any sudden abnormality such as a ruptured disk, compression fracture or hyperintense zone in the spine that would indicate that there was some, you know, acute traumatic change.
Q. Okay.
A. So I would say that's less likely.
Q. Okay. And then No. 5?
A. "The Functional Capacity Evaluation of June 30th, 2011, appeared to be a valid

Functional Capacity Evaluation so as to reflect Mr. Bliss' physical capabilities as of that date."
Q. All right. And then No. 6?
A. No. 6, I responded, "Because of multiple back surgeries and continued natural progression of his degenerative spine condition and past history of knee and shoulder joint degeneration and surgery, it would be reasonable to restrict Mr. Bliss currently to lifting no more than 20 pounds and on occasion -- and only occasional bending, stooping and crawling."
Q. Okay. And what's the basis for that opinion?
A. Well, that was basically looking at the Functional Capacity Evaluation and the reflection of his physical abilities and basically endorsing that those recommendations were reasonable, based upon the medical record.
Q. Okay. And lastly, Doctor, No. 7 there.
A. I answered, "From a review of Mr. Bliss' medical history, MRIs and degenerative condition, it was likely that Mr. Bliss -- excuse me, Mr. Bliss' back would have continued

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to degenerate after 2004, regardless of his work environment."

Q. All right. And the basis for that opinion is what, sir?

A. Well, the natural progression of degenerative disk disease creates the appearance of the MRI scan that we saw. And essentially no matter what you're doing, that type of change in the spine does continue to occur over time.

Q. All right. And do you hold these opinions to a reasonable degree of orthopedic surgery, Doctor?

A. I -- reasonable degree of medical certainty, yes.

Q. Yes. Okay.

MR. McMAHON: Thank you, Doctor, that's all I have.

CROSS-EXAMINATION

BY MR. SATTLER:

Q. Dr. Noble --

A. Dr. Ripa.

Q. I'm sorry. Dr. Ripa. I'm sorry. With respect to the -- some of the medical records that you had available to you, that would have

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included an exhibit that had been marked previously as Exhibit No. 58, which is this statement of job awareness and general duties of a carman. This was dated and signed by Dr. Noble back in August of 2010. You would have had that available to you, would you not?

A. Yes. I believe looking now, that that was included in Dr. Noble's records rather than a specific entry in the files that I have.

Q. Right. And this would have covered basic activities, anticipated or expected, as general job duties of a carman?

A. Yes.

Q. Now, with respect to this broad category of degenerative disk disease, could you explain to the ladies and gentlemen of the jury what degenerative disk disease is?

There's been terms thrown around, like, spondylolisthesis, lumbar spondylosis and then this disk degeneration. Could you explain what these diseases are?

A. Well, certainly. Our natural tendency to age takes its toll on our spine. Generally most everyone is subject to losing moisture in their disk spaces. The disk spaces are the

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cushions between the vertebrae.

As this cushion material loses moisture, it becomes less elastic, less resilient to resisting shock. And our spine tends to settle somewhat. So that's why we naturally get a little shorter as we get older.

A degenerative disk does not have as good a support between the vertebrae, so it places more load or demand upon the little joints in the back of the spine.

And as these joints absorb more load and the cartilages ages in the joints, then those joints wear out.

So the term spondylosis, which is sort of a medical term for degenerative change or wear and tear change in the spine, that is a fairly accurate descriptor of what we saw on the MRI scans of the patient.

Disk degeneration, another way of describing it, some people will call it osteoarthritis of the spine, which is fairly accurate.

You mentioned a word spondylolisthesis. Spondylolisthesis is a term where one vertebra shifts slightly forward on the other. That is

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a situation where if the disk is degenerated and the facet joints wear out, then there may be some subtle shifting in the spine where either the vertebra goes forward or to the side.

And that is a term that was, I believe, mentioned once regarding the spine in this patient between lumbar 4 and lumbar 5.

Q. With respect to the imaging studies that were made available to you during your review, you had the benefit of seeing MRIs dating back to as early as 2002 and then moving up through and past the time of the February 2011 timeframe; isn't that correct?

A. That is correct.

Q. So you would have had an opportunity to see the changes that would have occurred as a result of this disease process that you've described?

A. That is correct.

Q. There is reference in the various MRI studies to facet hypertrophy. Can you explain to the ladies and gentlemen of the jury what the facets are and what that's really describing?

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A. The facet joints are the little connectors between each vertebra. So there is a left and a right joint that connects one vertebra to the other.

These are small little joints. They overlap each other, about the size of a fingernail. And as these joints wear out, the cartilage space decreases or thins. And then the patient's joints start to enlarge or thicken.

The most -- the most easily understood example is someone's knuckles. If you have a grandmother that has a lot of arthritis in her hands, you'll see that her knuckles have enlarged. And that's the same thing that's occurring in the spine. We just can't see it underneath the muscles.

The spinal joints enlarge and thicken and get irregular. And sometimes as those joints enlarge, then they pinch the nerve or narrow the openings for the nerves.

Q. And this facet joint deterioration, based upon the MRI studies that you were able to view, showed this degenerative process over time?

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A. That is correct.

Q. Doctor, you were asked some questions by counsel for plaintiff related to what type of generic restrictions that you would apply in this discussion of this first opinion related to Dr. Noble's release to return to work without restrictions.

I wanted to ask you, you're familiar with -- generally with the process of how employers obtain return to work restrictions from treating physicians? This is something that's common in your practice; is that true?

A. That is correct.

Q. When you say that the return to work without restrictions by Dr. Noble was too liberal, do you believe that it was reasonable and prudent for an employer in BNSF's position to reasonably rely upon work restrictions established by a treating physician?

A. Yes, I do.

Q. In this case, do you believe that it was reasonable and prudent for the BNSF Railway Company to rely upon this return to work restriction or work -- return to work without restriction that was issued by Dr. Noble?

18:2 --19:1 BNSF objects to the testimony as not relevant. Fed. R. Evid. 02 and 403.
Ruling: Overruled

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A. Yes.

MR. SATTLER: Those are all the questions I have, Doctor. Thank you.

MR. McMAHON: Nothing further. Thank you, Dr. Ripa, for your time this morning.

THE WITNESS: I will waive the right to read this.

(Deposition concluded at 7:19 a.m.)

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C-E-R-T-I-F-I-C-A-T-E

STATE OF NEBRASKA)
: ss.
COUNTY OF LANCASTER)

I, Lori J. McGowan, General Notary Public in and for the State of Nebraska and Registered Professional Reporter, hereby certify that DR. DANIEL RIPA was by me duly sworn to testify the truth, the whole truth and nothing but the truth, that the deposition by him as above set forth was reduced to writing by me.

That the within and foregoing deposition was taken by me at the time and place herein specified and in accordance with the within stipulations; the reading and signing of the deposition having been waived.

That the foregoing deposition is a true and accurate reflection of the proceedings taken in the above case.

That I am not counsel, attorney, or relative of either party or otherwise interested in the event of this suit.

IN TESTIMONY WHEREOF, I place my hand and notarial seal this 24th day of February, 2014.

NEBRASKA ORTHOPAEDIC AND SPORTS MEDICINE, PC

St. Elizabeth Medical Plaza
575 South 70th Street
Suite 200
Lincoln, NE 68510
Ph: (402) 488-3322
Fax: (402) 488-1172

October 4, 2012

James B. Luers
Wolfe, Snowden, Hurd, Luers & Ahl, LLP
1248 O Street
Lincoln, NE 68508-1424

RE: David Bliss V BNSF Railway Company
(Your File No. 961205.004)

Dear Mr. Luers:

This letter is in response to the review of records regarding David Bliss. The following are opinions based on a reasonable degree of medical certainty.

1. Dr. Noble's release for Mr. Bliss to return to work without restrictions as per the request of Mr. Bliss in July 2010 was too liberal for someone with Mr. Bliss' degenerative spine condition.

2. Mr. Bliss was clearly suffering from degenerative disk disease, particularly at L3/4, L4/5, and L5/S1, prior to February 3, 2011.

3. The change in Mr. Bliss' back condition between the MRI of April 27, 2010, and the MRI of March 18, 2011, showed an increase in degenerative facet joints, foraminal narrowing and increased degenerative bone marrow at L4/5 and L5/S1.

4. The changes noted in paragraph #3, could be the result of the natural progression of a degenerative spinal condition.

5. The Functional Capacity Evaluation (FCE) of June 30, 2011, appeared to be a valid FEC so as to reflect Mr. Bliss' physical capabilities as of that date.

6. Because of multiple back surgeries and continued natural progression of his degenerative spine condition and past history of knee and shoulder joint degeneration and surgery, it would be reasonable to restrict Mr. Bliss currently to lifting no more than 20 pounds and only occasional bending, stooping and crawling.

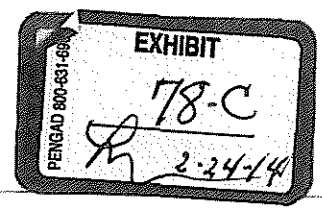

EXHIBIT
C

7. From a review of Mr. Bliss' medical history, either MRI's, and degenerative condition, it was likely that Mr. Bliss' back would have continued to degenerate after 2004 regardless of his work environment.

Please contact us if further information is required.

Sincerely,

Daniel R. Ripa, M.D.

DRR/mrr

Daniel R. Ripa, M.D.

Nebraska Orthopaedic and Sports Medicine, P.C.
575 South 70th Street, Suite 200
Lincoln, Nebraska 68510
402-488-3322

PERSONAL:

Date of Birth: August 1, 1958
Home Town: Wilber, Nebraska
Family: Wife – Geralyn
Children – Madeline & Elizabeth

EDUCATION AND MEDICAL TRAINING:

Undergraduate:
University of Nebraska – Lincoln 1976-1979

Medical School:
University of Nebraska College of Medicine 1979-1983
42nd & Dewey Avenue
Omaha, Nebraska 68105
Bachelor of Science in Medicine, May 1983
Doctor of Medicine, May 1983

Flexible Internship:
Scott & White Memorial Hospital
Temple, Texas 1983-1984

Orthopaedic Residency:
Scott & White Memorial Hospital
Temple, Texas 1984-1988

Fellowships:
Spinal Surgery Fellowship
Under the direction of Dr. S. Henry LaRocca
Elmwood Industrial Medical Center
Jefferson, Louisiana (New Orleans) July 1988 – December 1988

Fellowship in Spinal Cord Injury Treatment
Under the direction of Dr. Paul R. Meyer
Midwest Regional Spinal Cord Injury Unit
Northwestern Memorial Hospital
Chicago, Illinois January 1989 – June 1989

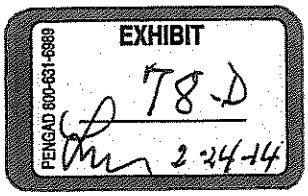

EXHIBIT
D

SPECIALIZED MEDICAL TRAINING

- Surgery of the Spine, Artificial Joint Replacement of the Knee and Hip
  BIRMINGHAM HIP Resurfacing System

CERTIFICATIONS:

- Board certification in Orthopaedic Surgery – July 1991
  Recertified in 2001
- Nebraska State Medical License - # 16549

HOSPITAL AFFILITATIONS:

St. Elizabeth Regional Medical Center
555 South 70th Street
Lincoln, Nebraska

BryanLGH-East
1600 South 48th Street
Lincoln, Nebraska

Lincoln Surgical Hospital
1710 South 70th Street
Lincoln, Nebraska

BryanLGH-West
2300 South 16th Street
Lincoln, Nebraska (courtesy staff)

Madonna Rehabilitation Hospital
5401 South Street
Lincoln, Nebraska 68506 (courtesy staff)

PROFESSIONAL AFFILITATIONS

- Member of Lancaster County Medical Society
- Nebraska Medical Association
- American Medical Association
- Member of the North American Spine Society
- American Academy of Orthopaedic Surgeons

PUBLICATIONS:

- "Series of 93 Cervical Spine Injuries treated by Anterior Spinal Plating", Spine, 1990 – Ripa, Meyer, Et Al.

Condensed Transcript

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

DAVID BLISS,	)	CASE NO. 4:12-CV-3019
Plaintiff,	)	
vs.	)	DEPOSITION OF DR. KEITH R. LODHIA
BNSF RAILWAY COMPANY,	)	TAKEN ON BEHALF OF THE DEFENDANT
Defendant.	)	

Taken at Midwest Neurosurgery & Spine Specialists, 8005 Farnam Drive, Suite 305, Omaha, Nebraska, October 16, 2012, at 1:18 p.m.

A P P E A R A N C E S

For the Plaintiff:
MR. WILLIAM J. McMAHON
HOEY & FARINA
542 South Dearborn
Suite 200
Chicago, Illinois 60605

For the Defendant:
MR. JAMES B. LUERS
WOLFE SNOWDEN HURD LUERS & AHL LLP
1248 "O" Street
Suite 800
Lincoln, Nebraska 68508

Job No. CS1540360

Sadhna

~~4 - 18~~ -

$4-3\neq 1$ $\quad (4-36)$

$3\neq \cancel{1} \neq 1-73 \quad (37\ 1-2)$

possibly soon re-direct - depends upon what of your class-date you want?

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STIPULATIONS

It is stipulated and agreed by and between the parties hereto:

1. That the deposition of DR. KEITH R. LODHIA may be taken before Lisa G. Grimminger, Registered Merit Reporter, Certified Realtime Reporter, General Notary Public, at the time and place set forth on the title page hereof.

2. That the deposition is taken pursuant to notice.

3. That the original deposition will be delivered to Mr. James B. Luers, Attorney for the Defendant.

4. That all objections except as to form and foundation shall be made at the time of the deposition.

5. That the testimony of the witness may be transcribed outside the presence of the witness.

6. That the signature of the witness to the transcribed copy of the deposition is waived.

* * * * * * * *

(Exhibit Nos. 56 through 60 were marked for identification.)

DR. KEITH R. LODHIA,
Being first duly cautioned and solemnly sworn as hereinafter certified, was examined and testified as follows:

(Witness's response to oath: "Yes.")

DIRECT EXAMINATION

BY MR. LUERS:

Q. Doctor, would you state your full name and spell your last, please.

A. Keith R., Raman, Lodhia, L-O-D-H-I-A.

Q. And your business address, Doctor?

A. It's 8005 Farnam, Suite 305, Omaha, Nebraska.

Q. You are a physician?

A. Yes.

Q. And you have a specialty, sir?

A. Yes, neurosurgery.

Q. Any subspecialties?

A. Spine, spinal neurosurgeries, neurosurgery of the brain, spine, peripheral nerve.

Q. And is -- I presume you're board

certified, is that the -- board certified as a neurosurgeon. Are you board certified in the subspecialty as well?

A. We don't have board certification in our spine specialty, and I'm board eligible. I still have to take the oral boards which are part of our secondary process. I've passed the written boards sometime at the end of residency, or actually at the beginning -- middle of residency, and then we take them, typically, in our fifth year out. I'm actually out beyond that, but I've applied over a year ago. It takes a long time for them to kind of get you on the list.

Q. I understand. How long have you been practicing a neurosurgeon, Doctor?

A. Six years.

Q. And you are licensed in the State of Nebraska?

A. Uh-huh.

Q. Anywhere else?

A. Iowa and Michigan.

Q. All right. Have you had your deposition taken before?

A. Well, I think so. I know I've been recorded before. I assume it was a deposition.

Q. All right. Are you acquainted as you sit here today -- well, strike that.

Are you acquainted with a patient by the name of David Bliss?

A. Yes.

Q. As you sit here today, do you have an independent recollection of that patient? In other words, can you picture him? Do you recall seeing him and talking to him?

A. Yes.

Q. All right. Do you recall who you were -- who referred Mr. Bliss to you or to your office?

A. No.

Q. Let's look at -- the first time you saw him, at least according to my records, would have been June 8th of 2011; is that right?

A. Probably right. I've got a note there, yes. That's the earliest note I have.

Q. I'm sorry?

A. That's the earliest note that I have.

Q. Okay. And it looks like on that particular date you saw him, and you then sent a letter to Dr. Kreshel, which is also dated June 8th

of 2011; correct?

A. Yes.

Q. All right. As of that first consultation, if you recall, Doctor, do you remember what sort of medical history, if any, you were provided, either prior or contemporaneously with that consultation?

A. He was a gentleman, I guess, who had previous surgery at a couple of disk levels.

Q. The information that's contained in that June 8th letter, is that the history, basically, that you were provided?

A. Yes.

Q. And would that have been a history that was provided by the patient as opposed to separate medical records?

A. Looks like we just heard from the patient. We did review an MRI scan, however.

Q. Okay. Do you remember which?

A. It says lumbar spine from 3-18, 2011, so there would have been a report there, but it was before his last surgery, I guess.

Q. All right. As of that particular first visit, Doctor, in June of 2011, were you aware that the patient had had both knee surgeries and

shoulder surgeries?

A. I don't have that printout. They usually have the patient's -- the full record that gets printed out here wasn't printed out. We have all the little stuff that they fill in, the patients fill in, themselves. They didn't print that out so --

Q. Like patient information?

A. Yeah.

Q. Would that --

A. Would that have affected --

Q. Yeah. I guess at this point you weren't directed to that particular -- or any of those problems; is that right?

A. No.

Q. You do reference that he had previous back surgery. Do you recall or do you know when those were?

A. Just what was stated. He had one done April of that year, which was only probably a couple months before I saw him, redo diskectomy at L3/4, and then it looked like he had some surgery before L3/4. He must have mentioned then there was one at L5/S1 and one at L2/3.

Q. Do you happen to know, Doctor, from

reviewing the MRI whether that information was accurate or not in terms of the location of those surgeries and what they did?

A. It doesn't say from here. It wasn't in the report, but it doesn't sometimes show up, depending on how small the bones were taken.

Q. When he reported to your office in June of 2011, what was the purpose of your consultation?

A. He came -- it says he came here with pain in his legs and back, and I guess he had some atrophy in his legs.

Q. And just seeking some relief, or what was the purpose of your visit?

A. Typically. Just says in consultation. It usually says why, but it's obviously for the symptoms. The next thing we talk about after his surgery is that he had pain in his legs and back before surgery. He was achy and stiff, limited lifting because of this.

Q. Did he tell you --

A. Correction. I think he had some difficulty on the job or so because of this.

Q. Did he tell you anything about his job or how he had gotten hurt?

A. If he did, I don't recall the specifics on that. I don't remember him saying anything about that. I knew he worked for the railroad because he knows a friend of mine from the railroad, just happenstance, because they work for the same company, and he was one of his supers at some point or something like that but -- so I knew that he had a very physical job. I guess that's about the extent of it.

Q. All right. Were you aware, Doctor, that the he had claimed an injury in February, February 3rd of 2011, on the railroad?

A. It's not listed on there so, no, I guess I wasn't aware of that, that he had previous surgery, so he must have complained to somebody about that.

Q. Okay. I take it, Doctor, since you didn't see him until at least four months after what he's claiming was his injury, you're not in a position to render an opinion in this case as to the cause of his injury or how it happened?

A. No.

Q. All right. When you examined the patient on June 8, 2011, what did you find?

A. At that time he had some incisions

on his back, it looks like. It looked like he was neurologically intact, meaning his strength and sensation were good. Reflexes were notable. Eyes were both equal, and he said he did have some atrophy in his left thigh compared to the right thigh, which I guess is what he had complained about, but other than that it didn't look like it was very remarkable exam.

Q. Okay. What did you recommend, if anything?

A. At that time he had just had a recent surgery, and because of that we ended up recommending an MRI to see what had been done and what was left over, whether any of that was contributing to his left leg symptoms, back pain, and so we recommended MRI, and then it says something about a functional capacity evaluation, 'cause he obviously felt limited in what he could do, and so we talked about possibly at some point down the line getting an FCE to evaluate what his limitations might be.

Q. And that's -- I read that under the letter of June 8, 2011, as part of the plan.

A. Uh-huh.

Q. Did you order an FCE at that time

or --

A. No, I don't think we did. I don't recall. I'd have to look down there, but I don't think that was ordered.

Q. If you'd had --

A. It would be in our computer orders somewhere if he did.

Q. What kind of back surgery did he have in April?

A. Well, it was mentioned as a redo diskectomy.

Q. And was there any -- did you have any medical records or anything to verify that, or was that just based on what he told you?

A. I suspect it was based on what he told us. I mean, until we got the MRI, which it looks like we got also on June 8th, so that was done on June 8th too, so we did get an MRI, but that wouldn't have been known that day, as we wouldn't have seen those results probably until later.

Q. What did you see on the MRI, if anything of significance?

A. The MRI showed changes, surgical changes, it looked like, at L5/S1, L4/5, and L3/4, as we talked about those levels, I think, being a

component. I think he said L2/3, but he may have meant L3/4. I don't know, because those levels that was dictated in here are different than what are showing up on the scan, those three levels.

Q. Okay. So he might have been off on what the levels of the diskectomies were?

A. Uh-huh.

Q. But, at any rate, the MRI, and that was dated June 8th of 2011 also. What other significant findings were on that particular report? Significant to you, Doctor.

A. Well, basically, he had a lot of marrow changes, meaning degenerative changes, at really three levels. All three of those levels were levels where he probably had his herniation, since he had surgery in those areas. He had what they call posterior retrospondylolisthesis, meaning a little bit of tipping back of the vertebrae at one of the levels. That typically indicates some level of instability, so basically we saw a lot of degenerative changes in the lower lumbar spine.

Q. Now, this gentleman was -- I'm sorry?

A. And postoperative changes.

Q. All right. This gentleman was

55 years old when you saw him. Were the degenerative changes that you saw in that particular spine of Mr. Bliss significantly different than other 55-year-olds?

A. Yeah.

Q. And in what regard, other than the surgeries?

A. There was more extensive degeneration of the discs. You typically don't see a spondylolisthesis or instability or that kind of alignment changes in a normal adult. You may see some mild degenerative changes in the joints or the discs with aging, but this would be what I'd consider beyond that.

Q. Okay. Were these degenerative changes the type of changes that, nevertheless, can be long term, ongoing, as opposed to traumatically induced?

A. Yes.

Q. Was there any way to know as you looked at either the individual, himself, or the MRI as to whether they were the result of trauma or just simple degenerative long term?

A. No. I don't think there was anything, at least from the MRI that we had seen

that we had ordered, that we could tell whether that was acute or a chronic type of --

Q. After that June 8th visit, did you order or prescribe any particular restrictions for the patient? In other words, did you place him on any restrictions activity wise?

A. I don't -- once again, if I had to -- if we did, we may have had a sheet we would have filled out for him. It's not referenced in the note --

Q. You don't recall any?

A. -- so I don't recall that. That's probably why we made the comments of the functional capacity evaluation. Typically, if we're going to give restrictions that aren't in the short term that we don't know how long they're going to go and we would tend to think it's a chronic condition, I would order a functional capacity evaluation.

Q. And that would be typically like before you impose restrictions?

A. Uh-huh.

Q. Is that a yes?

A. Especially if they're long term. On a chronic patient I've seen once, I'm not going to make restrictions on a patient like that unless they

came in with an acute problem that needed acutely fixing and I just needed to keep them out for a prescribed period of time.

Q. All right. I gotcha. Doctor, are you familiar with Dr. Noble from -- I guess he was in Lincoln.

A. I don't know him personally, but I've seen some of his patients.

Q. All right. Do you know if your clinic or you, personally, were ever provided with any records of Mr. Bliss from Dr. Noble's office from 2010?

A. I'm not aware of that. We don't have any reference that we did look at that, whether they were scanned in or not. We must not have seen them at the time of our visits.

Q. All right. I can tell you that he had had a surgery in 2010, and Dr. Noble was the surgeon, and I'm going to provide you what's been marked as Exhibit 56 and ask you just to review that briefly for me. That's a note from Dr. Noble regarding the surgery and then a release to return to work. Now, that's dated what, Doctor? Do you see that, top of the page?

A. June 24th, 2010.

Q. All right. I can show you, then, Exhibit 58, which is another note from Dr. Noble, ask you if you've seen this exhibit before? It's dated August 5th of 2010.

MR. McMAHON: Fifty-eight?

MR. LUERS: Yeah.

A. I don't recall seeing that.

Q. (BY MR. LUERS) All right. Doctor, Dr. Noble, after that surgery in 2010, released the patient to full duty with the railroad for the tasks that were set forth in that particular exhibit. If you'd peruse that very briefly or quickly and tell me, based upon your physical exam and the MRI that you did in 2011 of Mr. Bliss, if at that time he would have been capable of returning to that type of activity.

A. Yeah, I would suspect so.

Q. You would think he would?

A. Uh-huh.

Q. And that would have been even --

A. Basically, you're talking about after his diskectomy at the time when I would have seen him?

Q. Correct.

A. Yes, he had the functional abilities

to be able to do that. It was a matter of his description of pain.

Q. All right. So even though there was -- at least one of the tasks is may lift, carry, push, and pull objects weighing between 25 and 50 pounds --

A. 50 pounds some of the time.

Q. 25 pounds frequently, 50 pounds occasionally, those would not be unreasonable in terms of --

A. I don't think so.

Q. And even though --

A. Based on his size, muscle strength. His back MRI really didn't show anything, any gross instabilities, just that little base of trace retrospondylolisthesis, which usually isn't a high grade instability.

Q. Okay. So at least as of June of 2011, that would be the case too?

A. Yes, I believe he could have done that.

Q. After that June of 2011 visit, according to the records I have, Doctor, you saw him -- well, you spoke to him on June 13, 2011. Do you have that one?

A. Myself or my PA? I don't have June 13th.

Q. Well, this is the PA. I'm sorry. John Calabro?

A. Yes. No, I don't have that. I have July 13th. Did you say June or July?

Q. I said June.

A. I have a July 13th.

Q. Okay. I'm going to show you part of Exhibit 59, and actually it's on page --

A. Oh, I take it back. Here it is. Here's the June 13th. They were out of order. Yes, got it.

Q. Just read that briefly, and that's -- obviously, it's a note from John Calabro, which is your PA?

A. Yes.

Q. And by then you had suggested the FCE?

A. Uh-huh.

Q. Is that right?

A. Yes.

Q. All right. Then did you see the FCE when it came in?

A. Yes.

Q. All right. And at least as of the date when that arrived, you saw that they did his physical or functional testing, and they concluded that he could work at the demand level of a job categorized as heavy. Is that your understanding?

A. Yeah.

Q. Okay. Was there anything about that FCE that you found to be invalid?

A. Not necessarily. They just said he developed some pain.

Q. Right, but I'm talking about just the testing results, itself, at this point. Is there anything in there that jumped out at you?

A. Well, they didn't say anything about it being invalid or that he didn't pass any of the tests, so no. I would say no.

Q. Okay. So then you saw him on June 13th; is that right? Or, excuse me, July 13th.

A. Yes.

Q. And would you have actually seen him on that day, or would Mr. Calabro have?

A. We probably both saw him, I'm guessing.

Q. And that's when he came back complaining of additional pain after the FCE; is

that right?

A. Yes, or I don't know if it's because of the FCE but --

Q. No. I understand.

A. Yeah. Increasing pain, yes.

Q. What did you attribute that increased pain to, any particular thing?

A. No. Just the exacerbation of degenerative changes. You know, anything can flare that up, sometimes minor things. I wasn't sure what would cause that.

Q. All right. And you ordered another MRI at that time?

A. Right, and an EMG.

Q. And an EMG?

A. He had pain in a new distribution, I guess, is what he was complaining of.

Q. Okay. Tell me what you found with either of those test results.

A. Let's see. I don't know if I have those actual tests. I have a phone note based on our tests. I don't print up --

Q. I think that's the EMG.

A. That's the MRI. I've got that, so that didn't show anything essentially different than

the previous one. There's the EMG. Okay. And the EMG showed a chronic right L5 radiculopathy. That's what John was talking about in the July 15th note.

Q. So let me back up just a moment. So the repeat MRI that would have been done on July 13, 2011, basically, you didn't see anything significantly different from the MRI that you'd looked at when you first saw him in June?

A. Right.

Q. Correct?

A. Right, correct.

Q. So you couldn't attribute -- at least from the results of the MRI, you couldn't attribute the reason for the additional pain?

A. The additional pain, right, correct.

Q. Then, the EMG, what is the purpose of that?

A. The EMG is to look for acute nerve compression versus old nerve compression versus location, be it peripheral nerve or maybe pinched at the lumbar spine, so it's a way to help us quantify whether something's acute, chronic, and maybe what location, which nerve, et cetera.

Q. And what did you find again?

A. The EMG showed that right L5 chronic

radiculopathy, meaning it's -- that would be consistent with an old injury.

Q. Okay. "Old" meaning --

A. Not acute, something that's not healing further. It's nothing new that's ongoing or a new injury. There's no re-innervation occurring, meaning the nerve is not trying to heal or in the process of denervating. It's just stably or chronically impaired.

Q. Is there a -- what type of condition, injury or degeneration can result in those kinds of findings on the EMG?

A. You can have nerve damage from, say, a herniated disk or some other form of pinching of the nerve.

Q. Can that be degenerative in nature also, or does it have to be an acute injury?

A. Typically, it was a result of something that had injured it, so at some point it probably was an acute injury, but it could be anything from a stretch to a compressive phenomenon, meaning, you know, nerve stretch or actual physical compression on the nerve. Maybe it was a herniated disk, maybe it was a bone spur that he'd had previously from other operations that was taken off,

and the nerve may or may not heal.

Q. So that may have been a condition that was there from as early as 2003, when he was having these first back symptoms?

A. Possibly.

Q. Okay. No way to really know on that?

A. No, and we don't even know if the chronic EMG finding correlates even with his increased pain at the time.

Q. Okay.

A. May very well not.

Q. And how significant was the EMG finding? In other words --

A. It was mild.

Q. -- you said mild? Okay.

A. Which may or may not even cause symptoms in some people so --

Q. And then you or your physician's assistant spoke with David Bliss's wife on July 15; correct?

A. Yes.

Q. All right.

A. Got that.

Q. And then who sent the patient to

Madonna, was that you, for some rehab?

A. I don't know if he went to Madonna. We may have. I don't know if he did physical therapy or not.

Q. Let me show you a report that I got, Doctor. I think that's from Madonna.

A. It looks like we did.

Q. And that's dated what?

A. 7-26, 2011.

Q. Okay. So assuming that you guys sent him for rehab, do you recall what you were hoping to gain at that point in time through that rehab? If you want to look at this record, that's --

A. What date was that again?

Q. That was July 26th, is the date of service.

A. Okay. Was that before or after his functional capacity evaluation?

Q. Actually, it was after.

A. That was after his FCE?

Q. Yeah. The FCE was dated June 30th.

A. Okay. My guess is we were just trying something nonoperative as opposed to a three level fusion or something.

Q. Do you know offhand, Doctor, or do your records reflect any follow-up to that rehab? In other words, I can't recall at the conclusion of that report whether they recommended anything further or --

A. He believed he was at maximum medical improvement and deferred to either of us. He said, Use the information in the FCE as well as the physical exam to recommend future work restrictions, and he didn't recommend any work restrictions today with him, so he kind of basically said whatever we said.

Q. Then keep going in that. And you're looking at exhibit -- what's the number on the front of that exhibit, Doctor?

A. Exhibit 59.

Q. All right. And keep going, and I think there's -- the next, is it August 25th, 2011, either report or --

A. Uh-huh.

Q. What is that? Is that from Madonna again?

A. Yes.

Q. And at that point in time, were they recommending any further plan for Mr. Bliss?

A. No follow-up, just continue physical therapy is something he recommended. No narcotics, took the anti-inflammatories, nonnarcotic medicines.

Q. At some point in time, I thought I read in one of those Madonna reports work hardening or condition program. Do you know whether or not there was any follow-up in that regard or whether he engaged in any, Mr. Bliss?

A. I'm not aware of that.

Q. Let me take a quick look at it, Doctor. I'm sorry. I'm looking at page -- it's MRH5 of Exhibit 59 in the second-to-the-last paragraph. Do you know it references work hardening and some conditioning program?

A. Yes, yes. It says something about continuing to advance to more functional conditioning and work hardening, especially if there's no surgery planned.

Q. All right. And at that point in time, there was no surgery planned, I take it?

A. No.

Q. Do you know if there was any follow-up in that regard by either the rehab people or Mr. Bliss?

A. Not that I'm aware of.

Q. Okay. Put that exhibit back together. Then your next -- the next time you actually saw Mr. Bliss would have been when?

A. September 2nd.

Q. Okay. What was the purpose of that visit?

A. We saw him in consultation, reviewed his notes, I suppose, and re-review his complaints that he was having -- he was talking about when he got there.

Q. Now, at that point in time, your physical exam noted that basically it was unchanged except with some depressed reflexes and now some S1 radicular symptoms; correct?

A. Uh-huh.

Q. And that's yes?

A. Yes.

Q. Other than that, as far as his physical exam, was that pretty much the same as it was when you first saw him in June of 2011? And I realize his subjective complaints were different but --

A. Yes.

Q. Okay. You say down there on -- down at the last paragraph of that first page of that

September 2nd, 2011 report, it says he can't function at his job with his current pain level and would need to be in a light-duty situation. I take it, Doctor, and you correct me if I'm wrong, but basically what you're saying is if you could eliminate his pain or reduce it, then that -- then he could function at more than a light level; is that what you were saying?

A. Pain is what limited his functioning.

Q. All right. And the pain, obviously those -- not to diminish it, but those are subjective complaints. You can't measure that; correct?

A. Correct.

Q. Otherwise, his physical exam was virtually the same?

A. Correct.

Q. What did you recommend, if anything, at that point in time?

A. Still wasn't sure what was causing his pain based on our physical exam and our imaging and our EMG; so, therefore, we wanted to see if maybe his pain source was in the joints, the facet joints, themselves, in those three levels that had

that degeneration, and so we recommended maybe facet blocks or possibly facet rhizolysis. If facet blocks helped, they were a longer term solution.

Q. And the rhizotomy, is that different than the facet blocks?

A. No.

Q. Same thing?

A. Well, they actually are different. Usually, one's referred to as using medications. The rhizolysis is typically something they use a radiofrequency generator to actually create a lesion not chemically, but electrically.

Q. Okay. And you recommended that, and I take it, then, he followed through on that, as far as you know; correct?

A. Yes.

Q. Your next visit was when, Doctor?

A. Well, I guess we spoke to him on the phone, but we didn't see him until November 2011.

Q. That would be November 7th?

A. Yes.

Q. What did you do on that particular visit?

A. We discussed his MRI findings with him, we discussed what he had done since I'd seen

him, which at that time he had rhizolysis after having had his injections, still complained of some burning symptoms in the back of his heels and feet with walking.

Q. According to that November 7th letter you have, he actually had an excellent response to the rhizolysis with near complete resolution of his lumbar back pain; is that correct?

A. Right.

Q. And he had the heels and lateral foot pain if he walked for 20 minutes or more; correct?

A. He was complaining more from what I'd say is nerve-like symptoms as opposed to just the mechanical back symptoms.

Q. But those symptoms were located now in the feet; correct?

A. And the legs. He complained of some aching in the hips too, but, yes, it looks like they were in the feet and legs.

Q. At least from a physical standpoint, at that point in time -- or from a functional standpoint, it would have been improved, then, could you conclude, because of the lack of lumbar pain?

A. Yes. I think his back pain he was

suggesting had improved significantly, but his nerve-like symptoms that he had were still bothering him, and, as he said, were limiting him.

Q. And I think in that report, Doctor, you indicate that at that point in time you didn't think fusion would do any good for him?

A. Correct.

Q. You were not?

A. He didn't seem to have mechanical low back pain that he had had before, and I told him that a fusion is mainly for mechanical low back pain unless you have some nerves to decompress, which we did not based on our MRI or EMG studies.

Q. Do you know at that point in time what kind of pain prescription he was on, or had you prescribed pain medication? Was that -- was he getting that from somewhere else?

A. I suspect he would have gotten that from somebody else. Typically, we don't prescribe pain medications unless we've done surgery. We let their other doctors take care of that.

Q. Do you know if you ever have seen him since November of 2011?

A. I don't believe I have.

Q. Okay.

A. Not from my notes.

Q. So as you sit here today, you don't know what his condition is; correct?

A. Correct.

Q. I take it, then, you would agree with me, Doctor, that at least from the first time you saw him until the last time you saw him, if anything, his condition improved?

A. Correct.

Q. And you would agree with me that at least from a cursory examination of Exhibit 58, you still think he would be able to perform those types of tasks with his physical condition?

A. I'm not sure.

Q. Okay. Which one would cause you some hesitancy?

A. Well, to do a half a day of sitting or standing when he said he couldn't stand or couldn't walk for more than 20 minutes or so.

Q. Okay. But you don't -- do you know the reason that he couldn't walk for 20 minutes?

A. No. I had no objective evidence of why he couldn't do that.

Q. Okay. Doctor, do you agree that Mr. Bliss was clearly suffering from degenerative

disk disease at that L3/4 through L5/S1 as of the time you saw him first in June of 2011?

A. Yes.

Q. And any changes you noted in MRIs from the -- well, strike that.

Did you ever see any MRI results from anything before June of 2011?

A. Yes.

Q. Was there -- can you tell me what, if any, significant changes there were between those two MRIs and which -- let me back up. Which MRI did you see that was before 2000 and --

A. March 18th, 2011.

Q. Okay. And then, at least from March 18, 2011, through the last MRI you took, there wasn't any real significant changes; is that right?

A. Well, the March -- there was a change from the March 18th one from the MRIs that I saw, because he had surgery between these two.

Q. Okay. Which two are we talking about? I'm sorry. I'm confused.

A. You asked if I saw an MRI before June, and the answer is yes. We saw the March 18th one, which was done before his April surgery, and he had a recurrent disk herniation at L3/4 on that

study.

Q. Okay. I gotcha.

A. In June that wasn't mentioned there anymore so --

Q. Gotcha. That was repaired by the time the June MRI was taken care of?

A. Right, yes.

Q. Other than that change was there any significant change?

A. No.

Q. And did you see any MRIs taken prior to March of 2011?

A. No.

Q. Okay. Doctor, are you aware that you were identified as an expert witness because you were one of the treating physicians in this particular case that Mr. Bliss has against the railroad?

A. Yes.

Q. Okay. You're aware of that now, at any rate; right?

A. Yeah.

Q. You've not recommended any restrictions, either temporary or permanent, for Mr. Bliss; correct?

A. Correct.

Q. And you've not rendered any opinions or been asked to render any opinions as to any temporary or permanent restrictions for Mr. Bliss; correct?

A. Correct.

Q. And other than your physical exam and the MRI and EMG testing that you've done for Mr. Bliss, you don't know what his current condition is or his functional limitations or his medication requirements are?

A. No.

Q. And you have not been asked, nor have you rendered any opinion or have any opinion as to whether or not Mr. Bliss should return to any particular job or not return to any job; correct?

A. Correct.

Q. And as far as his conditions, whatever they are right now, you don't know whether they're temporary or permanent?

A. Correct.

Q. And, again, I think I already asked you this, but whatever his conditions are, you have no opinions, nor have you been asked as to what the cause of those conditions are?

A. No.

Q. Doctor, I have no further questions.

CROSS-EXAMINATION

BY MR. McMAHON:

Q. Doctor, just briefly, going back to the September 2nd, 2011, note, at the bottom there in Recommendations --

A. Uh-huh.

Q. -- it seems that you and David had a long discussion about the conditions, and at that time you stated that he certainly can't function at his job with the current pain level and he would need to be in a light-duty situation?

A. Yes, and that was related to his pain.

Q. Okay. And so, depending on his pain level, he may or may not still be at that light-duty situation that you thought he was that was appropriate in September 2nd, 2011?

A. Correct. I told him -- basically, he was telling me that the work was bothering him or repetitive type of twisting and movement and he couldn't function in his job. When he talked to me, he basically said he couldn't do these certain things and it was causing -- it was because of pain,

37:5 --39:9 BNSF objects to the testimony as hearsay without an exception and as not relevant. Fed. R. Evid. 402, 403, 801 and 802. Ruling: Overruled

and I said, "Well, if you can't do those things, you can't do those things," and so that was in reference to that, that maybe light duty might be more helpful because of his pain doing his current -- you know, his current job description, but I was not -- I did not prescribe him any light duty.

Q. Okay. And you weren't asked by the railroad?

A. I don't believe so.

Q. All right.

A. I don't have any forms that I recall filling out.

Q. All right. And then, in the November 7, 2011, note, you stated at the bottom that he would likely needed to continue on medications, at least in some form, as needed indefinitely unless he gets some relief with the spinal cord stimulator?

A. Uh-huh.

Q. What was this recommendation about?

A. Basically, he had been placed on anti-inflammatories and other medicines for his pain which was used to manage that, and I felt that his pain was probably chronic and he was likely going to need to be on medications if this didn't work for

his nerves, and we wouldn't know how long or what medicines those might be, but there may be nothing else, in other words, for him.

Q. And did you make the referral to Dr. Donovan at that time, do you know?

A. For the spinal cord stimulator?

Q. Right, for the consult.

A. Yes, we probably would have at that time. I don't know if he went or not.

Q. But from the November 7, 2011, note, it seems that you were making the referral to more of a pain management treatment plan; is that fair to say?

A. Yes. He was having nerve pain at that time, so sending him to a pain manager or somebody that could maybe identify whether he would even be a candidate for something like that spinal cord stimulator for some chronic nerve type of damage or pain, and that was my thought, is that that might be an option for him.

Q. And the procedure, I guess it was done by Dr. Devney, is that correct --

A. Uh-huh.

Q. -- in October of 2011, the rhizolysis?

A. Rhizolysis, yeah.

Q. Rhizolysis? Did that work in correcting some of the symptoms that Mr. Bliss had?

A. Yes. That's what he reported, that it helped him with his low back pain significantly.

Q. All right. And how? What's the -- how does that work? How does the rhizolysis function to alleviate the low back pain?

A. Basically, it's -- I would say it's a newer procedure, the idea being if you take away the painful innervation of the joints in the back, the facet joints, by basically destroying or disrupting one of the nerves through heat or some other type of injury that you can numb that joint innervation; therefore, if you have pain in that joint, you won't feel the pain in the back, and so it's a pain-relieving procedure by basically destroying part of the sensory portions of the nerves to those joints.

Q. And is it a permanent fix for patients like Mr. Bliss?

A. Most of the pain doctors consider it a semi permanent or longer term but not permanent, necessarily. Although some people supposedly get permanent relief, most of the doctors, I think,

suggest that it may be a year to two years, tops.

Q. And that's because the nerves regenerate themselves?

A. Yes, the sensory branches can regenerate.

Q. And if the sensory branches regenerate in that area where the rhizolysis was performed, is that the risk, is that the symptoms then will come back, the mechanical back pain symptoms will return?

A. Yes.

Q. Is that correct?

A. Yes.

Q. Okay. And then, in those patients where the nerve is regenerated and the symptoms of mechanical back pain have returned, if those patients return to see you, is there -- can you do another rhizolysis? What's the course of treatment at that time?

A. That, I typically would leave up to the pain doctors, but I have heard of patients going back and getting another rhizolysis if they have good relief, but it does reoccur. I don't know what the success rate of that is for a repeat procedure like that.

Q. All right. Now, there's been some mention in your records about a fusion, and in Mr. Bliss' case was it that he was a candidate for a three-level fusion?

A. That's what I offered him. If we were going to do a fusion, we were going to have to address all three of those degenerative levels, any one of or all of those three contributing to his pain, potentially.

Q. And fusion surgery, just by its own nature, is a permanent -- you're addressing a permanent type of fix for someone with mechanical back pain; correct?

A. Correct.

Q. And people that undergo the rhizolysis procedure, are they also candidates for fusion surgeries if the mechanical back pain symptoms return after the nerves regenerate?

A. Sometimes.

Q. All right. And is there anything about the rhizolysis procedure that excludes patients from future fusion surgery?

A. Not necessarily.

Q. Okay.

A. I'd say not from the procedure,

itself.

Q. That's what I meant. Is there something that would then sort of --

A. If the procedure were done and it gave no relief at a level that they did it, then I would suspect that I wouldn't fuse a level that didn't work from the other procedure either if I was using that as a diagnostic procedure, but typically those would be done with a block and not a rhizolysis.

Q. Okay, all right. 'Cause then fusion obviously wouldn't help those symptoms if the rhizolysis, or the block, didn't help those symptoms; correct?

A. Typically.

Q. So the thinking goes; right?

A. Yes, and in his case I think the joints were a big component of his pain. The other issue is the disk and the nerve, which isn't addressed by rhizolysis because that's -- we're talking about a little more anterior and different portions of the nerve, not the nerve innervation to the joint, so it gets a little complex using them to totally decide whether you're going to do that surgery or not.

Q. I understand. Thank you, Doctor.

REDIRECT EXAMINATION

BY MR. LUERS:

Q. But just so we're clear, Doctor, you didn't recommend and even told him in the November letter that the fusion would not make him any better, and you didn't recommend that procedure?

A. Based on his constellation of symptoms that he had at that time, which were almost all nerve related, which I couldn't pinpoint, I had no target. Before our target was back pain and generation back pain. The symptoms sounded like they got significantly better, and I couldn't improve upon that with fusion, at least when I saw him, and that's why I told him that.

Q. I gotcha. And you've not seen anything that changed your opinion in that regard?

A. No.

Q. And you're not aware of any medical doctor at this point advising him to get a fusion?

A. No.

Q. Doctor, I don't think I asked you, and I just very quickly will ask you if you ever saw this letter that Mr. Bliss wrote to Dr. Noble, and that is Exhibit 57. I'm doubting you've ever seen

it.

A. No.

Q. You've never seen it?

A. No.

Q. I take it that the language in here where he says, when I go to work as a carman even after January of 2011, it's not a heavy load, was that different than what he told you about his carman duties?

A. I was under the impression that he had some heavy physical labor involved in it. I don't know the specifics, but that was a physical job.

Q. Did you ever -- did he ever talk specifics with you in terms of how heavy or how physical?

A. I don't recall that conversation.

MR. LUERS: I have nothing further.

MR. McMAHON: I have nothing further.

MR. LUERS: Doctor, you have a right to read and review the transcribed deposition, or you can waive that right.

THE WITNESS: That's fine. Waive it.

(Deposition concluded at 2:07 p.m.)

CERTIFICATE

I, Lisa G. Grimminger, RMR, CRR, General Notary Public, duly commissioned, qualified, and acting under a general notarial commission within and for the State of Nebraska, do hereby certify that:

DR. KEITH R. LODHIA

was by me first duly sworn to tell the truth, the whole truth, and nothing but the truth; that the foregoing deposition was taken by me at the time and place herein specified and in accordance with the within stipulations; that I am not counsel, attorney, or relative of either party or otherwise interested in the event of this suit.

IN TESTIMONY WHEREOF, I have hereunto set my hand officially and attached my notarial seal at Lincoln, Nebraska, this 24th day of October, 2012.

_____

General Notary Public

Exhibits

NOBLE SPINE CENTRE

DANIEL P. NOBLE, MD
CHRISTOPHER M. MCWILLIAMS, PA-C

PATIENT: David Bliss
EXAM DATE: June 24, 2010
PRIMARY CARE PHYSICIAN: Charles Kreshel, M.D.

CHIEF COMPLAINT:

F/U left L3-4 microdiscectomy.

HISTORY OF PRESENT ILLNESS:

David returns today wishing to return to work. He feels better at this point than he has in a long time. He is doing better in all areas. He does feel he can return to work at this point without any heavy lifting.

REVIEW OF SYSTEMS:

Unremarkable for any recent illnesses or other complaints.

PHYSICAL EXAMINATION:

None today

DIAGNOSIS:

1. S/P left L3-4 microdiscectomy, DOS 5-6-10
2. S/P left L4 laminotomy with lateral recess decompression and discectomy, DOS 2-10-03

RECOMMENDATIONS:

1. Return to work. The patient may return to duty effective 6-25-10 with restrictions as outlined on his return to work form. Restrictions remain in place until 11-6-10.
2. MMI. I do expect he will be at MMI 11-6-10.
3. Return to clinic 8-12-10.

Daniel P. Noble, M.D./ap

EXHIBIT NO. 56
OCT 16 2012
LISA GRIMMINGER, RMR, CRR

DR. Noble :

David Bliss, regarding : Dr date today is the 4th of June. I stopped into my employer yesterday as regards to my status.

My Job is Carman relief write up. So here's what happens, 90% of the time I write up bills for the repair of rail cars. This is walking around cars and most the day at a desk and Computer. The relief part is to fill in for men on vacation or sick ect there are 8 of these guys and all have 5 weeks vac. and I is currently out due to an accident I am one of 2 men who know the different write up positions, for each does it different due To different types of Cars. Im needed rarely more than likley I won't see any carman work until at least Jan. of 2011 and then it's not a heavy load. BNSF has a med dept. They are sour on restrictions I safety rule is were not to lift anything over 50# without assistance. I won't have to go there anyway. Please could you give me a medical release to go back To work I am off all pain meds and feel good strength is back in my leg please call me. [illegible]

BNSF RAILWAY

Medical and Environmental Health Department

ATTENTION PROVIDER

Due to the work level of the position held by this employee and/or the nature of his condition, please complete this brief form and fax back to BNSF at 866-488-1260. Thank you.

Statement of Job Awareness
General Job Duties
Carman

EXHIBIT NO. 58
OCT 16 2012
LISA GRIMMINGER, RMR, CRR

TO PROVIDER: **Dr. Daniel Noble MD**
Re: **David Bliss 6/21/1955**

Some of the physical requirements of the position include:

- **Must be able to make quick hand and leg movements** – Due to the nature of the position, i.e. working around moving and heavy equipment, it is imperative that an individual is aware of the environment and able to respond quickly to any unsafe condition.
- Perform car and equipment inspections – Requires an individual to proficiently walk on uneven terrain and ballast to inspect for any unsafe conditions or mechanical defects.
- **Climb on/off equipment** – This involves lifting one foot approximately 3 ft. onto a ladder while reaching up to grasp the grab irons with both hands and pull their weight up onto the ladder.
- This carman maintains, replaces and/or repairs air brake pipes, valves or fittings, gaskets, air hoses, and other equipment as required to maintain a safe train.
- The carman must be able to exhibit **physical strength** sufficient to lift/carry push and pull objects weighing between 25 pounds (frequently) to 50 pounds (occasionally); pull, push, and position equipment or car components when making repairs; occasionally move rail car wheels; bend stoop occasionally as required when making repairs to freight cars; climbing onto and off of rail cars; maintain balance while climbing on stairs or ladders to repair rolling stock; perform occasional overhead work, remain standing or sitting for more than ½ of every work day with the opportunity to periodically change positions for comfort. Some work is performed in below ground workspaces to access undercarriage of rail car.
- The employee must be able to stoop, bend and twist low back on occasional to frequent basis; must be able to kneel, crawl and crouch on occasional to frequent basis; must be able to walk on angled and uneven ground; must be able to climb and work at elevations > 12 feet above ground level; must be able to remove and replace components on rolling stock (shoes, coupler assembles, air brake systems), use power tools and non power tools, and conduct inspections of rolling stock (railroad cars) in a yard or on a track.

I have considered the above job responsibilities in reaching my professional opinion regarding this employee's medical condition and capability to work.

DANIEL NOBLE, MD Daniel McLean 8/5/10

Physician's Printed Name and Degree Signature Date

MIDWEST NEUROSURGERY & SPINE SPECIALISTS
Adult & Pediatric

8006 Farnam Drive, Suite 306
Omaha, Nebraska 68114
ph: (402) 398-9243
fax: (402) 398-9263

Account #: 104768
Requesting MD: Charles L. Kreshel MD
Family MD: Charles Kreshel MD
Case Manager:

David R Bliss
1801 Preamble Lane
Lincoln, NE 68521
(402) 476-9107
06/21/1966

6/8/2011

Dear Dr. Kreshel:

David Bliss is here in the neurosurgery clinic in consultation. Mr. Bliss is a pleasant 55 -year-old who had recent surgery in April including redo diskectomy at L3-4. He has had previous diskectomy at L3-4 as well as what appears to be one at L5-S1, although he says he thought it was L2-3. He has had some pain in his legs and back before surgery. After his last surgery in April he has really had a hard time bouncing back. He has a lot of mechanical back pain. He has had atrophy in his left leg, although it is improving with physical therapy significantly. He has noticed a lot more pain in his back. He is achy and stiff and has limited lifting because of this. He has no numbness. He does have some quadriceps atrophy and weakness overall he says.

The patient is alert, oriented times three and appropriately dressed with normal affect. The neck is supple without masses. Casual gait is symmetrical, with normal heel-toe progression. Heart has regular rhythm, with no murmur. The lungs are grossly clear to auscultation. No carotid bruit is heard. The lower extremities demonstrate normal strength, reflexes, sensation and muscle tone bilaterally. He has mildly decreased muscle bulk when looking at his left thigh compared to his right thigh. No joint instability or crepitus is noted in the lower extremities exam. Patrick's maneuver bilaterally is negative. Straight leg raise is negative bilaterally. Dorsalis pedis and posterior tibialis pulses are regular and full bilaterally. There is no lower extremity edema. There is no clonus at the ankles bilaterally, and Babinski reflexes are absent bilaterally. Range of motion of the spine is full without increased pain. Palpation of the spine is nontender, although he has 2 well healed lumbar dorsal incisions in the midline from his spine surgery.

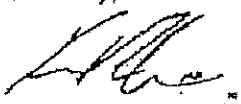
Imaging was reviewed including MRI of the lumbar spine from 3/18/11. This was preoperative before his last L3-4 diskectomy. There is evidence of recurrent disc herniation at L3-4 with compression to the L3 nerve root. There are modic endplate changes at L3-4 significantly. There are also some endplate changes and disc degeneration at L4-5. There is disc bulging, but no significant nerve root compression. At L5-S1 there appears to be a laminotomy on the right.

There is facet arthropathy severe at L5-S1 and some foraminal stenosis on that right side compared to the left, though both sides are having foraminal stenosis. There is also facet arthropathy at L3-4 and L4-5 that is more minimal. There is hypertrophy of the facets at L3-4. There is a slight posterior spondylolisthesis at L3-4. The remaining discs appear fairly normal.

ASSESSMENT:
1. Lumbar posterior spondylolisthesis L3-4.
2. Lumbar spondylosis L5-S1, L3-4 and L4-5.
3. Previous laminotomies, diskectomies.
4. Disc degeneration.

PLAN: David has continued mechanical back pain. I believe with his job on the railroad he is going to be somewhat limited given his multiple history of disc degenerations. He has not had any recent imaging. We will get an MRI of the lumbar spine. I discussed operations including diskectomy and fusion. We discussed limitations with and without surgery as well. At this point he would be a candidate for a functional capacity evaluation to see what his level of ability is. We will get him set up for his studies, and I will contact him with the results.

Sincerely,



Keith R. Lodhia, MD

Dictated but not proofread

Charles L. Kreshel MD
3100 N 14th St STE 201
Lincoln, NE 68521-2134

RE: David R Bliss
Account #: 104758
DOB: 06/21/1955
Exam Date: 06/08/11
Ordering Physician: Keith R. Lodhia, MD
Referring MD: Charles L. Kreshel MD
Family MD: Charles Kreshal MD

MIDWEST NEUROIMAGING

8005 Farnam Drive, Suite 202
Omaha, Nebraska 68114
402.390.4100
fax: 390-4103

Bruce Baron, DO
Christian Schlaepfer, MD
Erik Pedersen, MD
Don Evans, MD

Dear Dr. Kreshel:

MAGNETIC RESONANCE IMAGE OF THE LUMBAR SPINE WITH AND WITHOUT INTRAVENOUS CONTRAST

CLINICAL INDICATION: Low back pain, leg pain.

TECHNIQUE: Sagittal and axial pre and post contrast T1 weighted images and also T2 weighted FSE images of the lumbar spine were obtained. 20 cc of Magnevist contrast to the normal technique.

FINDINGS: Evaluation of the lumbar spine demonstrates a trace of retrospondylolisthesis of L3 on L4. There is noted to be end plate degenerative marrow signal changes at the level of L3-4, L4-5 and L5-S1. No evidence to indicate fracture. The conus medullaris ends at the level of L1-2 and demonstrates normal signal. The visualized sacrum and SI joints are noted to be normal.

At L5-S1 the disc space demonstrates postoperative changes of right hemilaminectomy change. There is a diffuse disc bulge. There is a mild end plate osteophytic ridge. The facet joints demonstrate moderate hypertrophic change. There is mild bilateral foraminal stenosis. No central canal stenosis.

At L4-5 the disc space demonstrates decompressive right and left laminectomy change. The disc space demonstrates mild to moderate loss of height. There are end plate erosions. There is vacuum phenomenon. There is a diffuse disc bulge with an end plate osteophytic ridge. Disc and osteophyte extend into both the right and left foramen. There is moderate left and mild to moderate right foraminal stenosis. No evidence for central canal stenosis. The facet joints demonstrate mild hypertrophic change.

At L3-4 the disc space demonstrates decompressive left laminectomy change. There is a diffuse disc bulge with an end plate osteophytic ridge. There is a focal area of disc protrusion extending to the left paracentral aspect of the canal. This is best viewed on sagittal image #9 and axial image #9. This is effacing the left side of the thecal sac. This is surrounded by areas of granulation tissue. There is no underlying central canal stenosis. No significant foraminal narrowing. The facet joints are mildly hypertrophic.

Account #: 104758
DOB: 06/21/1955
Exam Date: 06/08/11
Page 2 – Lumbar MRI

At L1-2 and L2-3 the disc spaces are normal. There is no central or foraminal stenosis.

IMPRESSION:

1) Small left paracentral disc protrusion at L3-4. Correlate clinically with symptoms.
2) Bilateral foraminal stenosis greater on the left than right at L4-5.
3) Mild bilateral foraminal stenosis at L5-S1.
4) No central canal stenosis.
5) Facet hypertrophic changes of the lower lumbar spine.

Thank you for the courtesy of this referral.

Sincerely,

Christian Schlaepfer, MD
CS/ mw
Dictated at Midwest NeuroImaging, 68114, 06/08/2011

Electronically approved by: Midwest NeuroImaging Date: 06/09/11 09:43

MIDWEST NEUROIMAGING

8005 Farnam Drive, Suite 202
Omaha, Nebraska 68114
402.390.4100
fax: 390-4103

Bruce Baron, DO
Christian Schlaepfer, MD
Erik Pedersen, MD
Don Evans, MD

Account #: 104758
Requesting MD: Charles L. Kreshel MD
Family MD:
Case Manager:

David R Bliss
1801 Preamble Lane
Lincoln, NE 68521
(402) 476-9107
06/21/1955

June 13, 2011

I spoke with Mr. Bliss in regards to his MRI scan showing multi-level degenerative facet changes. He has a disc herniation which was smaller than previous surgery in April. Dr. Lodhia did feel that he would be a surgical candidate consisting of a lumbar fusion L3-4, L4-5 and L5-S1.

At this point he seems to be getting by. Dr. Lodhia has recommended a functional capacity evaluation for further evaluation of his current work status. Mr. Bliss will give us a call once this has been completed.

John P. Calabro, PA-C

Keith R. Lodhia, MD
JC/KRL: mw
Dictated but not proofread

Electronically approved by: John Calabro Date: 06/16/11 15:33

MIDWEST NEUROSURGERY

8005 Farnam Drive, Suite 305
Omaha, Nebraska 68114
Phone: 402.398.9243
Fax: 402.398.9253
www.midwestneurosurgery.com

201 Ridge Street, Suite 305
Council Bluffs, IA 51503
Phone: 402-390-4115
Fax: 712-256-3059

Leslie C. Hellbusch, MD
Douglas J. Long, MD
Stephen E. Doran, MD
John S. Treves, MD
Mark J. Puccioni, MD
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Brittany Lanoha, PA-C
Kristin Hennessey, PA-C

John Dunn
Clinic Administrator

MIDWEST NEUROIMAGING

8005 Farnam Drive, Suite 202
Omaha, Nebraska 68114
Phone: 402.390.4100
Fax: 402-390-4103

MIDWEST NEUROSURGERY & SPINE Adult & Pediatric SPECIALISTS

8006 Farnam Drive, Suite 306
Omaha, Nebraska 68114
ph: (402) 398-9243
fax: (402) 398-9263

Account #: 104768
Requesting MD: Charles L. Kreshel MD
Family MD: Charles Kreshel MD
Case Manager:

David R Bliss
1801 Preamble Lane
Lincoln, NE 68521
(402) 476-9107
06/21/1966

07/13/2011

David Bliss is here today in followup and consultation after undergoing functional capacity evaluation. Mr. Bliss reports having increasing back and leg pain along with numbness into the balls of his feet. We had previously evaluated him and found his multi-level degenerative change along with multi-level previous surgeries. We had recommended the possibility of an L3 through S1 lumbar fusion. Due to his increasing pain, we are seeing him for further evaluation.

He is alert, oriented times 3, affect was appropriate. Gait was antalgic with a leaning wide based stance. He has mild decreased bulk into the left thigh as compared to the right. Motor strength is considered about a 5. Sensation is decreased in non dermatomal pattern. He has no clonus and Babinski reflexes are absent. Straight leg raise causes lumbar back pain. He has a well healed lumbar incisional site.

ASSESSMENT: 1) Bilateral lower extremity pain and lumbar back pain.

PLAN: David Bliss presents today with worsening symptoms. We have recommend proceeding with EMG studies of bilateral lower extremities along with a repeat MRI of the lumbar spine for further evaluation. Mr. Bliss now reports pain in the S1 distribution which is increased in intensity since previous examination. Therefore we will repeat his MRI scan. We did briefly discuss surgical intervention consisting of a lumbar fusion L3 through S1. We will plan on seeing him back once the studies have been completed to further discuss treatment options.

John P. Calabro, PAC

Keith R. Lodhia, MD

Dictated but not proofread

Charles L. Kreshel MD
3100 N 14th St STE 201
Lincoln, NE 68521-2134

RE: David R Bliss
Account #: 104758
DOB: 06/21/1955
Exam Date: 07/13/11
Ordering Physician: Keith R. Lodhia, MD
Referring MD: Charles L. Kreshel MD
Family MD: Charles Kreshel MD

MIDWEST NEUROIMAGING

8005 Farnam Drive, Suite 202
Omaha, Nebraska 68114
402.390.4100
fax: 390-4103

Bruce Baron, DO
Christian Schlaepfer, MD
Erik Pedersen, MD
Don Evans, MD

Dear Dr. Kreshel:

MAGNETIC RESONANCE IMAGE OF THE LUMBAR SPINE WITHOUT CONTRAST.

CLINICAL INDICATION: Bilateral leg pain, greater on the left than right, back pain.

TECHNIQUE: Sagittal and axial T1 and T2 weighted FSE images of the lumbar spine were obtained./

FINDINGS: Evaluation of the lumbar spine with comparison to prior examination from 06/08/11. The lumbar spine demonstrates the alignment to remain stable since prior examination. There is a trace of retrospondylolisthesis of L3 on L4. Vertebral body heights demonstrate no areas of new marrow signal abnormality to indicate tumor or infection. There is extensive end plate degenerative marrow signal changes at the level of L3-4, L4-5 and L5-S1. The sacrum remains stable in signal. No new abnormality of the SI joints.

At L5-S1 the disc space demonstrates postoperative changes of right hemilaminectomy change. The disc space demonstrates disc space desiccation. There is a diffuse disc bulge and end plate osteophytic ridge. The facet joints demonstrate moderate hypertrophic change. The appearance of the disc is noted to be similar to prior examination. There is mild bilateral foraminal stenosis. There is no new area of central canal stenosis.

At L4-5 the disc space demonstrates post surgical changes of bilateral laminectomy change. The disc is demonstrating moderate loss of height. There are end plate erosions. There is a diffuse disc bulge and end plate osteophytic ridge. This extends into both the right and left foramen. There is moderate left and mild to moderate right foraminal stenosis. The appearance remains stable. The facet joints are hypertrophic. No new area of central canal stenosis.

At L3-4 the disc space demonstrates postoperative changes of left hemilaminectomy change. There are elements of granulation tissue seen along the thecal sac. The disc is narrowed with a diffuse disc bulge. The small area of disc protrusion within the granulation tissue is noted to be similar to smaller than on prior examination.

RE: David R Bliss

Account #: 104758
DOB: 06/21/1955
Exam Date: 07/13/11
Page 2 – Lumbar MRI

Disc and osteophyte extend into both the right and left foramen. There is noted to be mild inferior foraminal stenosis, similar. There is no new central canal stenosis.

At L1-2 and L2-3 the disc spaces are noted to be normal. There is no underlying central or foraminal stenosis.

MIDWEST NEUROIMAGING

8005 Farnam Drive, Suite 202
Omaha, Nebraska 68114
402.390.4100
fax: 390-4103

Bruce Baron, DO
Christian Schlaepfer, MD
Erik Pedersen, MD
Don Evans, MD

IMPRESSION:

1) Bilateral foraminal stenosis greater on the left than right at L4-5, stable.
2) Mild bilateral foraminal stenosis at L5-S1, stable.
3) No new central canal stenosis.
4) Post surgical changes at L3-4, stable.

Thank you for the courtesy of this referral.

Sincerely,

Christian Schlaepfer, MD
CS/ mw
Dictated at Midwest NeuroImaging, 68114 07/13/2011

Electronically approved by: Midwest NeuroImaging Date: 07/14/11
09:29

JOHN C. GOLDNER, M.D.
RONALD A. COOPER, M.D.
JOEL T. COTTON, M.D.
ROBERT R. SUNDELL, M.D.
DAVID A. FRANCO, M.D.
T. SCOTT DIESING, M.D.

Neurology

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PHONE 402 354-2000
FAX 402 354-8645

INDIAN HILLS MEDICAL PLAZA • 8901 WEST DODGE ROAD, SUITE 210 • OMAHA, NEBRASKA 68114-3442

ELECTROMYOGRAPHY / NERVE CONDUCTION STUDY REPORT

NAME: David Bliss DOB: 6/21/1955 FILE #: 2011-2014

PHYSICIAN (S): Keith Lodhia, M.D. DATE: 7/13/2011

NERVE CONDUCTION STUDY:

MOTOR:

Nerve	Stimulating	Recording	Distal Latency (msec)	Proximal Latency (msec)	Amplitude (N=Normal)	Distance (cm)	Conduction Velocity (m/sec)	Normal (m/sec)
Lt. Peroneal	knee-ankle	ext. dig. brevis	5.3	14.5	N (3.9/3.4)	9/41	46	38-65
Rt. Peroneal	knee-ankle	ext. dig. brevis	5.7	14.3	N (4.0/4.5)	9/39	45	38-65
Lt. Tibial	knee-ankle	abd. hallucis	5.7	14.1	N (7.1/5.9)	9/42	50	38-65
Rt. Tibial	knee-ankle	abd. hallucis	5.6	15.0	N (8.3/8.1)	9/41	44	38-65

SENSORY:

Nerve	Stimulating	Recording	Latency	Amplitude (N=Normal)	Distance	Normal
Lt. Sural	posterior aspect lower leg	lateral malleolus	2.8	N	14	

ELECTROMYOGRAM:

Muscle	Fibrillation	Fasciculation	Motor Unit Potentials
Lt. tibialis anterior	0	0	Normal
Lt. medial gastrocnemius	0	0	Normal
Lt. peroneus longus	0	0	Normal
Lt. vastus medialis	0	0	Normal
Lt. tensor fasciae latae	0	0	Normal
Lt. abductor hallucis	0	0	-
Rt. tibialis anterior	0	0	Mildly large, polyphasic motor units
Rt. peroneus longus	0	0	Mildly large, polyphasic motor units
Rt. tensor fasciae latae	0	0	Mildly large, polyphasic motor units
Rt. medial gastrocnemius	0	0	Normal
Rt. vastus medialis	0	0	Normal

EMG with nerve conduction studies of the lower extremities was done at the request of Dr. Lodhia on a patient with left more than right lower extremity pain and prior back surgeries.

(CONTINUED)

SUMMARY: The peroneal compound muscle action potentials were normal and symmetric. The tibial compound muscle action potentials were normal and symmetric. The left sural sensory nerve action potential was normal. Needle examination of the left lower extremity was normal. Needle examination of the right lower extremity demonstrated mild chronic stable neuropathic motor unit changes within the right L5 myotome.

IMPRESSION: Abnormal EMG and nerve conduction studies of both lower extremities. There is electrophysiologic evidence of a mild chronic right L5 radiculopathy without evidence of uncompensated or ongoing denervation. No abnormalities were noted in the left lower extremity. Clinical correlation is needed.

T. Scott Diesing, M.D.
ELECTROMYOGRAPHER

TSD:pjf

Account #: 104758
Requesting MD: Charles L. Kreshel
Family MD: Charles Kreshel
Case Manager:

David R Bliss
1801 Preamble Lane
Lincoln, NE 68521
(402) 476-9107
06/21/1955

July 15, 2011

I spoke with David R Bliss's wife in regards to his EMG study showing chronic radiculopathy. No new or acute changes. In regards to the MRI scan this shows three-level lumbar disk degeneration as previously noted. No new disk herniations or listhesis.

John P. Calabro, PA-C

Keith R. Lodhia, MD
JPC/KRL/lmh
Dictated but not proofread

Electronically approved by: John Calabro Date: 07/22/11 08:36

MIDWEST NEUROSURGERY

8005 Farnam Drive, Suite 305
Omaha, Nebraska 68114
Phone: 402.398.9243
Fax: 402-398-9253
www.midwestneurosurgery.com

201 Ridge Street, Suite 305
Council Bluffs, IA 51503
Phone: 402-390-4115
Fax: 712-256-3059

Leslie C. Hellbusch, MD
Douglas J. Long, MD
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John Dunn
Clinic Administrator

MIDWEST NEUROIMAGING

8005 Farnam Drive, Suite 202
Omaha, Nebraska 68114
Phone: 402.390.4100
Fax: 402-390-4103

MADONNA REHABILITATION HOSPITAL

OUTPATIENT CLINIC NOTE ON: Bliss, David R

DATE OF SERVICE: 07/26/2011

REFERRING PHYSICIAN: Keith Lohdia, M.D.

REASON FOR REFERRAL: Rehabilitation evaluation and recommendations for chronic low back pain and left leg pain.

TIME IN: 2:00 TIME OUT: 3:15

Over 60 minutes were spent today with David and his wife, the majority of which was in evaluation, case discussion and management, and patient education.

HISTORY OF PRESENT ILLNESS: David Bliss is a pleasant 56-year-old gentleman who was referred here by Dr. Keith Lohdia for evaluation of low back pain. He has a fairly complicated history. In 2003, he underwent an L3-4 laminectomy due to a disk herniation that was causing a lot of left leg symptoms. It sounds like there was weakness in the left leg as well as possible footdrop and significant pain. He responded well to the surgery and had been working with the railroad since that time. This initial surgery was done by Dr. Noble. In the spring of last year, he started to develop similar symptoms going down the leg. He underwent a microdiskectomy in May with a follow-up exploration in April of this year. He still was having some ongoing symptoms and sought an opinion by Dr. Lohdia at Midwest Neurosurgery & Spine Specialists in Omaha. He reviewed the imaging studies and felt that it was primarily mechanical low back pain. They did repeat an MRI and discussed surgical options. He subsequently underwent functional capacity examination here in Lincoln around late June or the beginning of July. He tolerated the test pretty well but the following day was having an increase in his pain, not only the low back but also his left leg symptoms were worse. He saw Dr. Lohdia again who repeated the MRI and obtained electrodiagnostic studies that are discussed later.

After discussing the next surgical option which would essentially be a multilevel fusion, Dr. Lohdia referred David here for further evaluation and recommendations. Today he states that his pain is worse in the low back compared to the leg. He generally feels the best if he is lying flat on his back. Activity, especially frequent bending and lifting, bother him. He also has difficulty with lateral bending, especially to the left. He feels like he has general atrophy and weakness in the legs but that this has gotten somewhat better with physical therapy. He is working with Jeremiah Jurgensen here in town 2 times per week doing a variety of strengthening and stretches along with modalities. Currently for pain control he is primarily taking Tylenol frequently as well as some tramadol that is prescribed through his primary physician, Dr. Kreshel.

As this is work related, David is frustrated with the fact that his previous office job was no longer available after one of his surgeries and he has been doing more manual labor. He has not been back to work since his most recent surgery in April. Dr. Noble felt that it would take at least 3 months to get back to light to

medium duty work and 6 months for medium to heavy. David does not feel like he is anywhere near ready to go back to his previously highly physically demanding job.

David's other concern is that he does have quite a bit of fatigue. He thinks it has been worse since his most recent surgery and is unsure whether it is related to the pain or therapy that he has been undergoing. He has had to cut back on social activities as he used to fish quite a bit on his bass boat but is unable to do this. His sleep has been affected as well.

PAST MEDICAL HISTORY:

1. He has asthma that is well controlled and not requiring medications.
2. History of severe GI bleed requiring transfusion. This was thought to be related to aspirin and Mobic.
3. ACL repair in 1998.
4. Laminectomy in 2003.
5. Microdiskectomy in 2010.
6. Microdiskectomy revision in May of 2010 and April of 2011.
7. Multiple knee arthroscopies.
8. Left shoulder arthroscopy.

FAMILY HISTORY: Both parents are deceased, his father of a heart attack and mother of diabetes. He denies any history of diabetes.

SOCIAL HISTORY: David is single but has a significant other. He has occasional alcohol but no tobacco or alcohol exposure. He does not get any regular activity outside of work. He was previously a car man for the railroad.

CURRENT MEDICATIONS:

1. Tylenol max dose daily.
2. Tramadol 2 tabs every 4-6 hours p.r.n.

ALLERGIES: NEOSPORIN causes rash and THEOPHYLLINE causes GI reflux. He is also sensitive to adhesives.

REVIEW OF SYSTEMS: Twelve-point review of systems was obtained today and positive for fatigue, mild asthma, and those complaints listed in the HPI. The remainder was negative.

PHYSICAL EXAMINATION:

GENERAL: David is a pleasant, well-appearing, moderately obese gentleman in no distress. He does not exhibit any pain behaviors but is clearly frustrated with his current symptoms and especially as it relates to his occupation.

HEENT: Head is normocephalic, atraumatic. Facies are symmetric.

SKIN: Warm and dry throughout.

EXTREMITIES: No swelling, erythema, or ecchymoses.

BACK: Multiple midline incisions all well approximated and healed. He has some flattening of normal lumbar lordosis. He has fairly good flexion and extension, neither of which is particularly painful, but he is weak with extension and has some difficulty getting back to upright posture. He does not have any obvious list or scoliosis. He has pretty good lumbar rotation but sidebending to the left is restricted and quite painful. He has tenderness around the left SI joint as well as lower lumbar facets. This pain is exacerbated by sidebending but not too much by extension. He has no gluteal tenderness or pain around the trochanteric region. Examination of the legs shows symmetric muscle bulk without any obvious atrophy. He has at least 4+/5 strength throughout, and I have difficulty eliciting any obvious strength deficit. He can heel and toe walk without difficulty other than a little bit of balance trouble.

NEUROLOGIC: Absent reflex at the left patella but 2/4 at the right. He has 1+ reflexes at the Achilles, but it seems a bit more diminished on the left compared to the right. Sensory examination to light touch and pinprick is normal to all right lower extremity dermatomes. In the left lower extremity he basically has decreased sensation throughout the entire foot. This is mainly to pinprick which feels more dull compared to the right side, but light touch is preserved. There is no clonus or upper motor neuron signs noted.

IMPRESSION: David Bliss is a 56-year-old gentleman with chronic low back pain, primarily mechanical and axial, with history of multiple lumbar surgeries. He also has radiating symptoms in the left lower extremity that have improved with therapy but persist and are in a nondermatomal pattern. Imaging studies show diffuse degenerative arthritis in the lumbar spine as well as spondylosis at L3-4, L4-5, and L5-S1 with small posterior spondylolisthesis at L3-4. This is based upon the imaging reports as I do not have the images available. I did review the electrodiagnostic studies obtained on 07/13/11 which show some large polyphasic motor units in the right L5 myotome but no evidence of ongoing axonal loss. Also no evidence of peripheral neuropathy or focal neuropathy.

RECOMMENDATIONS: We had a long discussion about possible etiologies of his pain and that this is likely multifactorial. I would obviously defer to Dr. Lohdia as to whether or not he would be appropriate for a fusion, but this may not be a bad option, especially with what appears to be some mild facet-mediated pain, especially on the left which is where the majority of his pain seems to be coming from. Nevertheless, I think an adequate course of physical therapy and some medication management would be reasonable as there is certainly no rush to undergo surgery.

To help with pain control, I was hoping to use antiinflammatories; but with his history of GI bleed, I am a little hesitant to start an oral agent. I have had some luck with Flector patches which have much lower incidence of GI ulceration and therefore gave him a few samples to try; and if the adhesive does not bother him, he can get this script filled. He should apply it to the left low back where the majority of his pain is. Additionally I would like to start him on Lyrica to help with his leg symptoms as well as overall pain modulation in the hopes that he has better baseline control and can cut back on the amount of tramadol that

he is using.

I did write a prescription to obtain a vitamin D level as low levels have been associated with fatigue as well as pain. Furthermore, this is easy to correct if it is low.

I would like to see him back in 1 month. We will assess how he is responding to physical therapy as well as medication management. It does not appear as though he is going to pursue surgery but needs more intensive chronic pain management. I would recommend consultation with the pain management group here in town who are better equipped to follow long-term pain medication use. However, my thought is that he may not get a whole lot of benefit from chronic opioid use, and given the side effects and marginal efficacy of these in chronic low back pain, I would recommend avoiding them if possible.

I do appreciate this referral. If there are any questions regarding Mr. Bliss's visit, please feel free to contact me.

Adam T. Kafka, M.D.

DD: 07/26/2011
DT: 07/27/2011 8:42 A kp

Date 7/27/11 Time 1

cc: Charles L. Kreshel, M.D.
Keith Lohdja, M.D., 8005 Farnam Drive, Suite 305, Omaha, NE 68114

Thygesen
Physical Therapy

7/30/2011

Keith R. Lodhia, M.D.
Midwest Neurosurgery & Spine Specialists
8005 Farnham Drive, Suite 305
Omaha, NE 68114

Dr. Lodhia

RE: David Bliss

Mr. David Bliss presented to my clinic on 6/30/2011 for Functional Capacity Evaluation testing. A standard 1 day Core FCE was performed which involved a detailed musculoskeletal assessment followed by performance of standardized objective testing to determine his current physical abilites and safe lifting maximum recommendations. No specific job description was provided by the employer therefore determining a definitive job match was not fully possible. The only information that was communicated to me by his case worker (Eileen Warner) regarding physical job demand information was that the physical demand level of his job is categorized as HEAVY.

Therefore, given this information I have compared his performance on the FCE to physical demand characteristics of HEAVY as classified in the Dictionary of Occupational Titles (DOT). Please refer to the specifics of his performance on the FCE GRID for further details.

If you would have any further need to obtain information pertaining to specific tasks or physical demands testing pertaining to his job I would be more than happy to retest any items you would request. If you have any questions regarding any information on the FCE report please contact me directly at 402-423-7878.

Thank you again for this FCE referral

Paul Thygesen PT

Paul Thygesen PT

MADONNA REHABILITATION HOSPITAL

OUTPATIENT CLINIC NOTE ON: Bliss, David R

DATE OF SERVICE: 08/25/2011

TIME IN: 10:15 TIME OUT: 10:45

Greater than 25 minutes were spent today with Mr. Bliss, the majority of which was in case discussion and management as well as patient education.

INTERIM HISTORY: David returns today for followup regarding his low back pain. The initial visit I had with Mr. Bliss was on 07/26/11 upon referral from Dr. Keith Lohdia in Omaha. Briefly, he has a history of low back pain with several injuries that stem back to 2003, at which point he underwent laminectomy. He has subsequently had microdiskectomy and revision 3 times over the past year and a half or so. These were all done by Dr. Noble, but Dr. Lohdia was discussing possible lumbar fusion as a more definitive treatment. He came to me for any further rehabilitation recommendations that would be nonsurgical in nature. I did not feel that there was much indication for therapeutic injections given the diffuse nature of his axial pain that seemed primarily mechanical in nature. He does have some radicular symptoms with EMG evidence of mild chronic inactive right L5 radiculopathy.

I had recommended David continue with physical therapy and try a neuropathic pain agent. I wrote for Lyrica 50 mg t.i.d., and he is taking it about twice a day. It does help reasonably well with pain control, but it also makes him tired. He still takes tramadol as needed. There has not been a whole lot of change in his symptoms. He continues to work with physical therapy 2 days per week at the Center for Spine & Sport Rehab. It sounds like they are mainly doing some e-stim type activities using the ReBuilder system. He is looking to get this at home.

Most of our discussion today was David expressing his concerns and frustrations over this entire process. He feels as though his pain is significant enough that it is not allowing him to do any sort of physically demanding job. Even chores around the house cause quite a bit of pain. He also had a day at work when he spent most of the day in meetings in a chair and then the next day was having a flare-up of his pain, so sedentary activity also bothers him quite a bit. He has not returned to see Dr. Lohdia since his last visit but does have a scheduled appointment. It is still unclear whether or not he will pursue any further surgical interventions.

PHYSICAL EXAMINATION: On brief exam, David is well appearing and in no distress. He does not visibly appear to be in significant pain, and he walks with a symmetric and nonantalgic gait. No evidence of footdrop is present. Further examination was deferred in favor of case discussion.

IMPRESSION: David Bliss is a 56-year-old gentleman with chronic mechanical low back pain and mild right L5 radiculopathy. This was demonstrated electrodiagnostically, although the pain seems to be primarily on the left leg which was normal.

RECOMMENDATIONS: At this point I do not have a whole lot of further recommendations from a rehabilitation standpoint. If he is to pursue surgery, this will have to be decided between he and Dr. Lohdia; and with presumed segmental instability due to his prior surgeries, he may in fact get good benefit from this. I would obviously have to defer that decision to he and his surgeon.

From a medication standpoint, I would not use any stronger opioids than his tramadol. This is chronic in nature, and given his sensitivity to medications causing him sedation, I would try and escalate the Lyrica as tolerated and otherwise stick to antiinflammatories and other nonnarcotic pain medications.

I would continue with physical therapy. If the ReBuilder system is helping him with symptom relief, I would recommend it. I think it is reasonable to advance to more functional conditioning and work hardening, especially if there is no further surgery planned. This way we could get him at least as functional as possible, even if he does have ongoing pain.

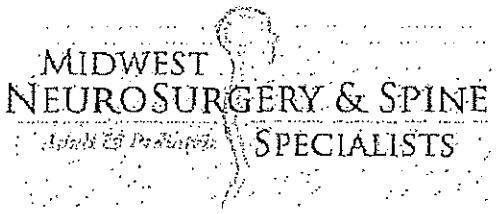
I did not schedule any formal followup. At some point, he will likely be at maximum medical improvement, assuming no surgery is performed. I would have to defer to either Dr. Lohdia or Dr. Noble as to when that point would be. Based on his recent history, he may in fact have already reached that point. Furthermore, since there has been an FCE performed, if this is everyone's opinion, then I would recommend using information from the FCE as well as his physical examination to recommend future work restrictions. I did not address any work restrictions today with Mr. Bliss.

Adam T. Kafka, M.D.

DD: 08/25/2011
DT: 08/30/2011 4:00 P kp

Date 9/1/11 Time 2

cc: Keith Lohdia, M.D., 8005 Farnam Drive, Suite 305, Omaha, NE 68114
Workers' Compensation



8005 Farnam Drive, Suite 305
Omaha, Nebraska 68114
ph: (402) 398-9243
fax (402) 398-9253

Account #: 104758
Requesting MD: Charles L. Kreshel MD
Family MD: Charles Kreshel MD
Case Manager:

David R Bliss
1801 Preamble Lane
Lincoln, NE 68521
(402) 476-9107
06/21/1955

09/02/2011

Dear Charles Kreshel:

David Bliss was seen today in consultation for forty-two minutes. I reviewed David's studies and discussed results with him. I reviewed his old notes and reviewed Dr. Kafka's notes for physiatry. I looked over his physical therapy notes as well as functional capacity evaluation. He was listed in a physical functional capacity as having no limitations on heavy demand, although he had a lot of pain that developed right after this and has limited him significantly. He has noted more SI radicular symptoms with numbness and some pain and particularly pain in the back with twisting or movements. If he sleeps he only gets a couple of hours of sleep and then wakes up and has to reposition because of the pain. Any kind of working in awkward positions bothers him as well. He takes Lyrica and Tramadol all the time. This is much more on the left side than the right side and follows an S1 distribution. He was found on EMG to have a chronic and active mild L5 radiculopathy likely related to his previous 3 surgeries.

His MRI showed laminectomy changes at the hemilaminotomy on the right L5-S1, bilateral laminectomy changes L4-5 and left sided L3 hemilaminectomy changes. He has degenerative disc at 3 levels as well as significant facet disease at those 3 levels. The other levels look fairly good in their condition. He has posterior spondylolisthesis Grade I at L3-4.

David's exam is unchanged with the exception of depressed reflexes and S1 radicular symptoms even a little numbness as he was sitting here. He has several well healed dorsal midline incisions and otherwise is not tender in the back. He transitions from sitting to standing with shocks of pain and walks with some mild antalgia.

1) Lumbar spondylolisthesis.
2) Lumbar spondylosis.
3) Lumbar disc degeneration.
4) Lumbar radiculitis.

Recommendations: David and I had a long discussion about his condition. He certainly can't function at his job with his current pain level and would need to be in a light duty situation. He has spondylolisthesis and spondylosis with facet degeneration as well as disc degeneration. I think most of his symptoms probably are facet mediated and may be even causing some of his radicular light complaints.

Page 2 - David R. Bliss

I would like for him to try some facet blocks both as a diagnostic and possible therapeutic effect and if this seems to help, maybe a facet rhyzolysis might be an option as opposed to a fusion at 3 levels. However I would recommend the posterolateral and interbody fusion at L3 to S1 if he continues to have refractory severe pain. His lifestyle is extremely limited in what he can even do when he's not working. David's questions were answered to his satisfaction and he's in agreement with our plan.

Sincerely,

Keith R. Lodhia, MD

Dictated but not proofread

MIDWEST NEUROSURGERY & SPINE
Adult & Pediatric SPECIALISTS

8005 Farnam Drive, Suite 305
Omaha, Nebraska 68114
ph: (402) 398-9243
fax (402) 398-9253

Account #: 104758
Requesting MD: Charles L. Kreshel MD
Family MD: Charles Kreshel MD
Case Manager:

David R Bliss
1801 Preamble Lane
Lincoln, NE 68521
(402) 476-9107
06/21/1955

11/07/2011

Dear Dr. Kreshel:

David Bliss is here in the neurosurgery clinic in followup. David was seen for 25 minutes in consultation, half of which was in counseling. We discussed findings on his MRI with him and his wife. He had rhyzolysis by Dr. Devney and actually had excellent response to this with near complete resolution of his lumbar back pain, only a little lower sacroiliac region discomfort at times and some occasional upper thoracic, mid-thoracic pain. He still has burning in the back of his heels and on the lateral foot if he walks for 20 minutes or more unless he takes Tramadol or hydrocodone. He gets some "aching" in his anterior hips and at the belt line and a little bit into his knees on occasion. He is worried because he doesn't think he can go back to work. He had a functional capacity evaluation on 07/30/11. He still has difficulty with walking. He can't walk more than 20 minutes which is bothering him the most. He feels like he's not very independent because of this. He would like to seek treatment for this.

I told him for chronic nerve issues I don't really have a good solution surgically with the exception of some possible spinal cord stimulator. He does have chronic mild L5 radiculopathy on the right although the left was normal. His symptoms seem to be more S1 mediated. I do think he would be a possible candidate for spinal cord stimulator and we will get him set up for an evaluation and possible trialing of the spinal cord stimulator. I did tell him that the fusion would not make him any better with regards to his lumbar spine as this seems to have already been improved significantly with his rhizotomy.

He will likely need to continue on medications at least in some form as needed indefinitely unless he gets some relief with the spinal cord stimulator.

Sincerely,

Keith R. Lodhia, MD

Dictated but not proofread

Thygesen
Physical Therapy

EXHIBIT NO. 60
OCT 16 2012
LISA GRIMMINGER, RMR, CRR

7/30/2011

Keith R. Lodhia, M.D.
Midwest Neurosurgery & Spine Specialists
8005 Farnham Drive, Suite 305
Omaha, NE 68114

Dr. Lodhia

RE: David Bliss

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Thank you again for this FCE referral

Paul Thygesen PT

Paul Thygesen PT

Client Name: David Bliss
FCE Dates: 06/30/2011
Therapist: Paul Thygesen
Thygesen Physical Therapy
5955 S 56th St Ste 1
Lincoln, NE 68510

WorkWell SYSTEMS, INC.
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WorkWell FCE History

Name: David Bliss
Dates of FCE Testing: 06/30/2011
Date of Birth: 06/21/1955
Date of Injury: 02/04/2011
Gender: M
Address: 1801 Preamble Ln.
City/State/Zip: Lincoln, Nebraska 68521
Primary Diagnosis: 722.73
Area of Injury: Low Back
Occupation: Railroad Carman
Dept of Labor Category of Work:
Heavy

Mechanism/Type of Injury:
Lifting injury of heavy/awkward piece of equipment.

Previous Treatment:
Conservative physical therapy, pain physician evaluatoin and treatment, lumbar surgery x 3,

Pertinent Surgery/Other Clinical Tests/Past Medical History:
Lumbar Surgery x 3, Knee surgeries, left RTC.

Current Medications:
Tylenol

Functional Status/ Activity Level:
Client indicates he is able to perform majority of day to day tasks independently "depending on how his back feels" Client indicates independence with ADL's. Client indicates intermittent disruption in sleep pattern due to back pain.

Chief Complaints/Symptoms:
Client reports that he has residual left LE weakness following injury and surgeries and continues to experience variable intermittent back pain but tolerates this and "gets on with his life".

Return to Work Information:
not working

Goals:
Client wishes to remain employed and return to work.

Signature Paul Thygesen PT

Date 7-30-11

Client Name: David Bliss
FCE Dates: 06/30/2011
Therapist: Paul Thygesen
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WorkWell FCE Physical Exam

Systems Review

Blood Pressure: 140/90
Height: 65"
Heart Rate (resting): 69
Weight: 220

Gait: WFL's
Posture: Client demonstrates sway back type posture with hips mildly shifted to the left and left shoulder girdle elevated.
Coordination: Client demonstrated functional coordinatoin with no observable deficits.
Movement Characteristics(speed, smoothness, posturing): Client demonstrated functional gait and movement between sitting, standing, and supine position changes with no specific deficit areas.
Atrophy/Edema: None observed in lumbar region
Integumentary: WNL's, well healed midline lumbar incisions observed.
Muscle Tone Spasms: Client demonstrated moderate increase in muscle tone through the bilateral lumbar and lower thoracic paraspinals and additionally at the left superior shoulder involving the muscles of shoulder girdle (scapular) elevation.

PAR-Q

Yes	No	Question
	X	1. Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?
	X	2. Do you feel pain in your chest when you do physical activity?
	X	3. In the past month, have you had chest pain when you weren't doing physical activity?
	X	4. Do you lose your balance because of dizziness or do you ever lose consciousness?
X		5. Do you have a bone or joint problem (for example, back, knee or hip) that could be made worse by a change in your physical activity?
	X	6. Is your doctor currently prescribing drugs (for example, water pills) for blood pressure or heart condition?
	X	7. Do you know any other reason why you should not do physical activity?

Musculoskeletal System

Neck	Normal	Range of Motion	Muscle Strength
Flexion	45	WNL	5
Extension	45	WNL	5
Right Lateral Flexion	45	WNL	5
Left Lateral Flexion	45	WNL	5
Right Rotation	90	WNL	5
Left Rotation	90	WNL	5

Trunk	Normal	Range of Motion	Muscle Strength
Flexion	80	55-60	4+/5
Extension	30	20-25	5
Right Lateral Flexion	35	25-30	4+/5
Left Lateral Flexion	35	25-30	4+/5

Client Name: David Bliss
FCE Dates: 06/30/2011
Therapist: Paul Thygesen

Thygesen Physical Therapy
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Lincoln, NE 68510

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Trunk	Normal	Range of Motion	Muscle Strength
Right Rotation	45	40-45	4+/5
Left Rotation	45	35	4+/5

Comments/Quality of Motion - Spine
Client demonstrates AROM decrease in planes of flexion, extension, right and left lateral flexion and rotation. Client demonstrates mild strength decrease in planes of flexion, right and left side flexion and rotation. Client c/o pain and stiffness at the limits of lower trunk extension and left rotation.

		Range of Motion		Muscle Strength	
Shoulder	Normal	Right	Left	Right	Left
Forward Flexion	180	WNL	WNL	5	5
Extension	60	WNL	WNL	5	5
Abduction	180	WNL	WNL	5	5
Internal Rotation	70	WNL	WNL	5	5
External Rotation	90	WNL	WNL	5	5

		Range of Motion		Muscle Strength	
Elbow	Normal	Right	Left	Right	Left
Flexion	150	WNL	WNL	5	5
Extension	0	WNL	WNL	5	5

		Range of Motion		Muscle Strength	
Forearm	Normal	Right	Left	Right	Left
Pronation	80	WNL	WNL	5	5
Supination	80	WNL	WNL	5	5

		Range of Motion		Muscle Strength	
Wrist	Normal	Right	Left	Right	Left
Flexion	80	WNL	WNL	5	5
Extension	70	WNL	WNL	5	5
Ulnar Deviation	30	WNL	WNL	5	5
Radial Deviation	20	WNL	WNL	5	5

		Range of Motion		Muscle Strength	
Gross Hand Motion	Normal	Right	Left	Right	Left
Composite Motion		WNL	WNL	5	5

		Range of Motion		Muscle Strength	
Hip	Normal	Right	Left	Right	Left
Flexion (knee extd)	90	WNL	WNL	5	4+/5
Flexion (knee fixd)	120	110-115	110-115	4+/5	4+/5
Abduction	45	WNL	WNL	4+/5	4+/5
Adduction	30	WNL	WNL	4+/5	4/5

Client Name: David Bliss
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		Range of Motion		Muscle Strength	
Hip	Normal	Right	Left	Right	Left
Extension	30	WNL	WNL	5	4+/5
Internal Rotation	45	WNL	WNL	5	5
External Rotation	45	WNL	WNL	5	5

		Range of Motion		Muscle Strength	
Knee	Normal	Right	Left	Right	Left
Flexion	135	WNL	WNL	5	4 - 4+/5
Extension	0	WNL	WNL	5	4 - 4+/5

		Range of Motion		Muscle Strength	
Ankle	Normal	Right	Left	Right	Left
Plantar Flexion	50	WNL	WNL	5	5
Dorsiflexion	20	WNL	WNL	5	4+/5
Inversion	35	WNL	WNL	5	5
Eversion	15	WNL	WNL	5	5

Other

Toe Rise Reps	Right	10	Left	10
Knee Squat	20			

Comments/Quality of Motion - Lower Quarter
Client demonstrated decreased hip ROM in planes of flexion bilaterally. Client demonstrated hip weakness in planes of flexion,extension,abduction,adduction. Client demonstrates muscle weakness to manual muscle testing with bilateral hip flexion, abduction/adduction, left hip extension. Client demonstrates muscles weakness of the left quadriceps and hamstrings. Client demonstrates left dorsiflexion weakness.

Neuromuscular System

Sensory Testing	Client reports chronic decreased sensation of left anteromedial leg (reported from medial malleolar regoin to medial knee/thigh.
Reflex Ankle Jerk	Absent left ankle jerk reflex
Reflex Knee Jerk	Absent left patellar reflex
Reflex Upper Extremities	WNL's

Screening for Gross Balance

Attribute	Trial 1(Times)	Trial 2(Times)
Standing on Floor, Eyes Open	30	30
Standing on Floor, Eyes Closed	30	30
Standing on Foam, Eyes Open	30	30
Standing on Foam, Eyes Closed	30	30

First Day Summary of Physical Assessment
Client demonstrated muscle tone increase in bilateral thoracolumbar paraspinal muscles, left schoulder girdle/scapular elevators. Client demonstrates postural assymetries. Client demonstrates decrease in AROM of trunk flexion, extension, lateral flexion and

Client Name: David Bliss
FCE Dates: 06/30/2011
Therapist: Paul Thygesen
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Lincoln, NE 68510

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rotation. Client demonstrates mild strength deficit in planes of flexion, right and left side flexion and rotation. Client c/o stiffness/pain at limits of lower trunk extension and left rotation. Client demonstrates decrease in hip ROM in the planes of flexion bilaterally and muscle weakness in plnaes of flexion, extension, abduction and adduction. Client demonstrates left quadriceps and hamstrings weakness and left dorsiflexion weakness. Please refer to the physical exam grid for specific tested ROM and strength values.

Signature Paul Thygesen PT
Date 7-30-11

Client Name: David Bliss
FCE Dates: 06/30/2011
Therapist: Paul Thygesen
Thygesen Physical Therapy
5955 S 56th St Ste 1
Lincoln, NE 68510

WorkWell SYSTEMS, INC.
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WorkWell FCE Test Results and Interpretation

The interpretation of WorkWell's standardized functional testing is based on assumptions including normal breaks, basic ergonomic conditions and that the tested functions are not required more than 2/3 of a normal working day. If a function is required continuously, job specific testing should be performed.

Client Name: David Bliss
Test Date: 06/30/2011

Interpretation of observed function regarding activity during a normal working day

Frequency	Weighted Activities Observed Effort Level	Position/Ambulation Quantitative + Qualitative Results	% of Workday
NEVER	Contraindicated	Not Possible	0%
RARELY	Maximum	Significant Limitation	1-5%
OCCASIONALLY	Heavy	Some Limitation	6-33%
FREQUENTLY	Low	Slight/No Limitation	34-66%
SELF LIMITED	Client stopped test; submaximum effort level		Submax percent

Lifting, Strength (lbs)	Never	Max Rare 1-5%	Heavy Occ 6-33%	Low Freq 34-66%	Limitations	Recommendations
Waist to Floor (11 in. from floor)		85	65	30		
Waist To Crown (Handles)		50	40	20		
Front Carry		85	50	35		

Posture, Flexibility, Ambulation	Never	Significant Limitation Rare 1-5%	Some Limitation Occ 6-33%	Slight/No Limitation Noted Freq 34-66%	Limitations	Recommendations
Elevated Work (Weighted - 2# cuff on both wrists)				X		
Forward Bending-Standing				X		
Standing Work				X		
Crouch				X		
Kneel - Half Kneel				X		
Stairs				X		
Walk - 6 Min Walk Test				X		
Sitting				X		

Push-Pull (Static)	Force Generated (pounds)	Limitations	Recommendations

Client Name: David Bliss
FCE Dates: 06/30/2011
Therapist: Paul Thygesen

Thygesen Physical Therapy
5955 S 56th St Ste 1
Lincoln, NE 68510

WorkWell SYSTEMS, INC.
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Push-Pull (Static)	Force Generated (pounds)	Limitations	Recommendations
Push Static	75		
Pull Static	83		

(Numerous variables impact Push/Pull force including load, equipment, surface, etc. These forces do not represent the amount of weight that is moved.)

Signature Paul Thygesen PT
Date 7-30-11

Client Name: David Bliss
FCE Dates: 06/30/2011
Therapist: Paul Thygesen
Thygesen Physical Therapy
5955 S 56th St Ste 1
Lincoln, NE 68510

WorkWell SYSTEMS, INC.
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WorkWell Functional Capacity Evaluation

Summary Report
Name: David Bliss
Test Date: 06/30/2011
Date of Birth: 06/21/1955
Gender: M
Address: 1801 Preamble Ln.
City: Lincoln
State: Nebraska
Zip Code: 68521
Phone: 402-525-6110
Physician: Dr. Keith R. Lodhia
Employer: BNSF Railroad
Primary Diagnosis: 722.73

Reason for Testing
Determine ability to return to previous job or other job.
Evaluation to determine functional abilities and limitations

Description of Test Done
One day Core WorkWell FCE

Cooperation and Effort
Client demonstrated cooperative behavior and was willing to work to maximum abilities in all test items

Consistency of Performance
Client gave maximal effort on all test items as evidenced by predictable patterns of movement including increased accessory muscle recruitment, counterbalancing and use of momentum, and physiological responses such as increased heart rate.

Pain Report
Client reported discomfort present in lumbar region and hamstrings toward the end of testing during static standing in forward trunk flexed positin, but there was no interference in safety.

Safety
Client demonstrated safe performance using appropriate body mechanics throughout all subtests.

Quality of Movement
Client demonstrated safe and appropriate changes in body mechanics, including use of accessory muscles, counterbalancing and momentum, as load/force increased. These changes are expected and consistent with maximal effort.

Abilities/Strengths
Client demonstrated significant abilities in grip strength, hand coordination, lifting, and carrying. Please refer to the FCE GRID for specific information.

Limitations
Client demonstated no specific physical limitations pertaining to the test items performed on this Core FCE.

Physical Return to Work Options Explored
The client's safe lifting maximums meet the PDL level HEAVY category. Please refer to the Job Match Grid for details.

Therapist's Recommendation Regarding Return to Work
Unable to obtain job description

US Department of Labor Physical Demand Level
Heavy

Signature Paul Thygesen PT

Client Name: David Bliss

FCE Dates: 06/30/2011

Therapist: Paul Thygesen

Thygesen Physical Therapy
5955 S 56th St Ste 1
Lincoln, NE 68510

Date 7-30-11

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

DAVID BLISS,	)	
	)	
Plaintiff,	)	CASE NO. 4:12CV3019
	)	
vs.	)	DEPOSITION TAKEN IN
	)	
BNSF RAILWAY COMPANY,	)	BEHALF OF DEFENDANT
	)	
Defendant.	)	

DEPOSITION OF: DR. LIANE E. DONOVAN
DATE: October 4, 2012
TIME: 1:05 p.m.
PLACE: 6940 Van Dorn Street, Suite 201,
Lincoln, Nebraska

APPEARANCES:

Mr. William J. McMahon
Attorney at Law
542 South Dearborn Street
Suite 200
Chicago, IL 60605 for Plaintiff

Mr. James B. Luers
Attorney at Law
1248 O Street
Suite 800
Lincoln, NE 68508 for Defendant

Job No. CS1336570

I-N-D-E-X

S-T-I-P-U-L-A-T-I-O-N-S

It is hereby stipulated and agreed by and between the parties that;

Notice of taking said deposition is waived; notice of delivery of said deposition is waived.

Presence of the witness during the transcription of the stenotype notes is waived.

All objections are reserved until the time of trial except as to form and foundation of the question.

DR. LIANE E. DONOVAN,

Of lawful age, being first duly cautioned and solemnly sworn as hereinafter certified, was examined and testified as follows:

DIRECT EXAMINATION

BY MR. LUERS:

Q. Good afternoon, Doctor. My name's Jim Luers.

Would you state your full name and spell your last name, please.

A. Liane Donovan, D-0-N-0-V-A-N.

Q. And your office address?

A. 6940 Van Dorn, Suite 201.

Q. Doctor, you are a physician; is that

correct?
A. Correct.
Q. Practicing here in Lincoln, Nebraska?
A. Correct.
Q. And what is your specialty?
A. Pain medicine.
Q. Are you board certified in that specialty?
A. Yes.
Q. And how long have you been practicing then?
A. Since '94.
Q. Okay. Is that with the same clinic here, the Pain -- Spine and -- or the Pain and --
A. I know. It keeps changing.
Q. What is it? Okay.
A. Yes. But that's -- this officially began I think in 2003.
Q. What's the name of it now?
A. Spine and Pain Centers of Nebraska.
Q. Okay. And you practice with some other specialists?
A. Yes.
Q. How many?

A. I practice with two other specialists.
Q. What are their names?
A. John Massey and Phil Essay.
Q. Okay. Is Dr. Devney then in your clinic?
A. No, he is not.
Q. Where does he practice?
A. Omaha.
Q. Okay. All right. So he's not associated with you in any way?
A. No.
Q. Doctor, have you had your deposition taken before?
A. Yes.
Q. All right. So you're familiar with the process?
A. Yes.
Q. Are you acquainted or do you know Mr. -- what's his first name?
A. David.
Q. David Bliss?
A. Yes.
Q. Yes. As we sit here today, do you have an independent recollection of Mr. Bliss?
A. Yes.

Q. All right. Can you tell me how you first met him?
A. I first met him in an evaluation for spinal cord stimulator.
Q. Okay. So he came to your office; is that right?
A. Yes.
Q. Had you ever done any treatment on Mr. Bliss prior to that?
A. No.
Q. And had you ever known any other members of his family or treated any other members of his family?
A. No.
Q. All right.
A. Not that I know of.
Q. Do you know who recommended you to him?
A. I think he came in referral from Dr. Lodhia.
Q. And is that -- do you typically get referrals from Dr. Lodhia?
A. Yes.
Q. For pain patients?
A. Yes.
Q. All right. Are you acquainted with

Mr. Bliss' attorney?
A. No.
Q. All right. Never spoken with him?
A. No.
Q. Are you aware, Ma'am, that there is a lawsuit pending in this case involving Mr. Bliss?
A. I'm aware now.
Q. Okay. You weren't at -- as of recent times?
A. No, I was not.
Q. Okay. Have you ever, to your knowledge, treated other railroad employees that are involved with pending lawsuits?
A. I assume I probably have. But I can't think of anybody.
Q. Not familiar?
A. Yes.
Q. Okay. As we sit here today, are you familiar with specific crafts or job duties of railroad workers?
A. No. The only thing that I am aware of in general is that unless they are 100 percent, it's hard to return to work, is how I understood it.

Q. Okay. But you know -- but as you sit here today, for example, you don't know what -- job requirements of a carman at the --
A. No.
Q. -- Lincoln shops?
A. I do not.
Q. Okay. And you are not a voc expert; is that correct?
A. Correct.
Q. So you don't typically render opinions as to whether an individual can return to work or what types of activities that individual can actually engage in in terms of work?
A. No, I do not.
Q. And you don't anticipate offering those kinds of opinions in this case, do you?
A. No, I do not.
Q. How about FCEs? Do you get involved in your practice in conducting functional capacity evaluations?
A. Rarely. More often we send them out.
Q. All right. Are you familiar with typically how they are run?
A. Yes.
Q. And when you send them out, do you

generally then look at the report and evaluate them yourself?
A. Yes.
Q. Okay. Have you ever seen one conducted on Mr. Bliss?
A. I have.
Q. All right. Do you have that one from WorkWell dated --
A. Yes.
Q. Looks like it's dated --
A. 6-30-11.
Q. Correct. You were provided with that?
A. Yes.
Q. Do you remember when or how?
A. Just before this deposition.
Q. Oh, really?
A. Yes.
Q. How did that come to you?
A. Just came in a form of just past records.
Q. Okay. Who provided it to you?
A. My work comp nurse.
Q. Okay. How did you -- did you make a request for that?
A. I, prior to depositions, request prior

records.
Q. All right. What other records were provided then just prior to this deposition?
A. I just -- I have Dr. Lodhia's notes. And I have an EMG study.
Q. And could you tell me, please, what date are the noted -- are the notes from Dr. Lodhia?
A. He has one -- and this may have been in the record. Although, I'm not sure. This one's from 11-7-11, just a letter to Dr. Kreshel.
Q. Okay.
A. And then I have another one of his that is from 9-2-11. And that is another letter to Dr. Kreshel.
Q. Okay.
A. And that's all the notes I have.
Q. And then you've got the --
A. I have the EMG.
Q. And when is that dated?
A. That is dated 7-13-11.
Q. From -- and who provided that to you?
A. Actually, I think I had that prior because I was aware of the EMG.
Q. Okay.

A. And then I have the functional capacity evaluation from 6-30-11.

And then I have an old op report. But I already had this prior from Dr. Noble from 2003.

Q. Very good. So all of those documents were provided to you -- when you say just prior, is that, like, within the last week?

A. Yes.

Q. Okay. Prior to that, prior to this past week --

A. Yes.

Q. -- did you have an opportunity to review old medical history of Mr. Bliss?

A. I was aware of his 2003 operation. And I was aware of Dr. Devney's notes regarding a radiofrequency he had done.

Q. And Dr. Devney actually got involved with this particular client in looks like September of 2011; is that right?

A. Yes.

Q. Okay. So other than those -- other than those medical records, you're not aware of any other medical history?

A. No, I'm not.

Q. All right. With regards to the WorkWell FCE, did you have an opportunity then in the past week to review that?
A. Yes, I have.
Q. Is there anything in there that jumps out at you that would suggest to you that it's not valid or it wasn't valid at the time it was taken?
A. No, I do not.
Q. All right. At least as of the date of June 30th, 2011, it appears to be a valid evaluation of his physical -- of Mr. Bliss' physical capabilities?
A. Yes.
Q. Okay. Dr. Devney saw the patient.
MR. LUERS: I'm going to mark this as an exhibit.
(Exhibit No. 51 marked for identification.)
Q. (BY MR. LUERS) Doctor, I've put together what I hope to be a fairly complete compilation of Dr. Devney and then your office notes. And it's marked as Exhibit 51.
It appears that Dr. Devney first saw Mr. Bliss on September 9th of 2011. Is that

your understanding?
A. Yes.
Q. When Dr. Devney sent the patient or -- no. Dr. -- I'm sorry. Dr. Devney didn't refer the patient to you. Was it -- well, wait a minute.
A. You know, that's --
Q. Strike that.
A. It's a good question. And I'm trying to remember how he came. I have it written as Dr. Lodhia. But I'm not sure whether it might have come through Devney.
Q. I think maybe I did see --
A. Did it come through him? It's possible.
Q. Well, it doesn't matter. But at any rate, let me -- let me -- when he -- when Mr. Bliss came to you, you had at least been provided with Dr. Devney's medical records; correct?
A. Yes.
Q. And as of 9-9 of 2011, if you could look at pages -- that initial report of Dr. Devney --
A. Uh-huh.
Q. -- on the second page, the objective --

looks like a -- sort of a general physical exam --

A. Yes.

Q. -- with the exception of some loss of -- slight loss of sensation on the left foot and some reflexes that are absent, would you agree with me, Doctor, that that physical exam was pretty normal?

A. Yes.

Q. And the impression then included a variety of these low back pain, mostly lumbar disc degeneration, facet and probably lumbar spinal stenosis. Are those -- can all of those be attributed to longstanding spine degeneration?

A. Yes.

Q. Okay. And is it -- was it your understanding that at least as of that initial report, Dr. Devney didn't impose any restrictions on Mr. Bliss?

A. Not that I am aware of.

Q. All right. 9-19 was his next report. And that begins on page 5.

Again, the condition was generally negative except for a few of the -- of the

original complaints; correct?
A. Yes.
Q. 9-26, they -- he proceeded with a -- is that a rhizotomy?
A. Yes.
Q. Tell me what that is, Doctor.
A. It is a -- it is a alternating current. It's actually a burn of the nerve to the joint, the facet joint in the back. So he --
Q. What is the purpose of that?
A. It is with the understanding that the pain in the back is related to facet pain or facet-mediated pain so arthritis in the spine and that the intent of the rhizotomy is to remove the sensory portion of what somebody feels with that range of motion in the joint and, therefore, decrease their pain.
Q. Is that -- and like you said, that's done on patients that are suffering from, like, multi-level degenerative spine?
A. Usually multi-level facet degeneration.
Q. Okay.
A. So it only works -- you do the medial branch or the diagnostic block to prove that a good portion of their back pain is related to

the joint.
Q. Okay.
A. And not a disc or anything else.
Q. So if the pain is alleviated, then it is, at least some of the pain that they're complaining of is related to the facet joint?
A. Yes.
Q. And is the facet joint something that, again, degenerates over time and that can be a normal process?
A. Yes.
Q. On November 7th, which is page 12, up above, mark the pages.
A. Uh-huh.
Q. Under subjective, I think it's the third sentence or fourth sentence, it says, "He reports 95 percent pain reduction."
A. Yes.
Q. So that's -- that's indicative of, like you said, if it's an arthritis-related condition?
A. Yes.
Q. And certainly with that kind of pain reduction, there's no indication that as of November 7th of 2011, there would be any reason

to impose additional -- or any restrictions; correct?
A. Correct.
Q. And as far as you know, there were no restrictions?
A. As far as I know.
Q. Okay. Under the objective portion on that page, 12 --
A. Uh-huh.
Q. -- it says, toward the bottom, "Lumbar range of motion is full in all directions with mild discomfort. His neurological assessment remains unchanged. No edema noted in the lower extremities." Pretty normal; correct?
A. Yes.
Q. All right. If we go to November 18th, which is page 14, this is the first time that you actually saw the patient; is that accurate?
A. That is correct.
Q. Okay. Talk to me a little bit about under the past, family, social, employment history. There is a line there that says, "Work history" --
A. Yes.
Q. -- "no changes required. He works at

BNSF as a carman." Obviously he would have told you -- he would have provided you that information?

A. Yes.

Q. When you -- says no changes required, I take it at that point in time, you're not imposing any restrictions or limitations?

A. It would -- when it says no changes required, it's been updated. That is how he described his work history. So it doesn't necessarily talk about restrictions.

It's how they say, like, I'm a secretary. Patient is a secretary. So it doesn't say currently disabled, currently -- I mean, they usually add that if I -- if I -- a change is required, they say currently disabled is a change, then you would remove the -- it would change that way so --

Q. Okay. So you would add -- if -- if for some reason either you believed it or the patient believed that he was unable to return to work as a carman, you would add disabled or --

A. Correct.

Q. -- restricted or --

A. Yeah.

MR. McMAHON: Objection. Foundation as to what Mr. Bliss thinks.

Q. (BY MR. LUERS) But that information would be provided to you then, and that might dictate a change?

A. Yes.

Q. Okay. In this instance, at least as of November 18th, it was still your understanding that he was working as a carman or would return to work as a carman?

A. Yes. I do have in his intake -- and I don't -- this is in his writing. He does say as last date of employment, February 3rd, 2011.

Q. Correct.

A. But --

Q. That's when his alleged injury occurred; correct?

A. Yes.

Q. At least that's your understanding?

A. Yes.

Q. Okay. And I think that's in your initial pain overview --

A. Yes.

Q. -- paragraph of your report.

Was there any indication in your initial visit here of November 18th, 2011, that Mr. Bliss was having shoulder problems or complaints of pain in his shoulders?

A. No.

Q. Go to 12-21, which I think is the next visit that you had with Mr. Bliss. That's on page 18?

A. Yes.

Q. Was that your next visit?

A. Yes.

Q. All right. Again, there's no reference to any change in work history there; correct?

A. Correct.

Q. Is there any indication in that report of any complaints of shoulder pain or shoulder problem?

A. On that date -- December 21st?

Q. Yes.

A. He doesn't say it in his intake with the nurse.

But on his picture, his pain diagram, he does draw just a mark across the shoulder there.

Q. Okay.

A. So at that point -- but he didn't -- usually what we discuss or address are the things they want to talk about. So a lot of times with the type of pain patients, we'll often see a whole body covered, but you have to focus on an area. So sometimes when other places are marked, it doesn't necessarily mean we address it unless a patient wishes to address it.

Q. Okay. Were you aware at that time that he was treating with any other physicians for shoulder problems?

A. No, I was not.

Q. He never brought that to your attention?

A. No.

Q. Were you aware that he had had surgery on December 5th for his shoulder?

A. No.

Q. Okay. Would -- did he make any -- give you any indication as of December 21st that he had gone through physical therapy at least four times or three times -- three or four times as of that date for the shoulder?

A. No, I don't have that.

Q. Okay.

A. I do see, though, that I have written multiple times that he is in litigation. I guess I just -- that doesn't tend to be something I focused on. So when you asked if I was aware he was in litigation, I must have known it.

Q. Oh, no. That's okay.

A. Yeah, but I never concentrate --

Q. That's fine. You didn't know he was treating for shoulder problems and had surgery and physical therapy?

A. I was not aware.

Q. Okay. As of that 12-21 visit, at least according to your history, it looks like his pain has improved?

A. Yes.

Q. And if you look on page 19, down on comments --

A. Yes.

Q. -- you say, "He's -- he's doing considerably better and pain is something he can live with."

And then you go on to say, "He is able to work but not likely at full capacity that he had been."

What changed -- what, if anything, if you recall, made you make that comment? First, let me ask you that.

A. Usually when -- that wouldn't necessarily -- the comments wouldn't necessarily be based upon a physical exam finding or a change that way. It's usually based upon their statement that they have some concern about whether they would be able to continue to work.

Q. Okay. So is it probable that that statement there is based upon what he told you?

A. Yes.

Q. And then what about, "He would likely be qualified for light or sedentary duty"? Is the same thing true there? Is that what he's telling you?

A. I don't recall. Sometimes -- sometimes when they -- they're unsure whether they would be able to work, we would still say -- my job, kind of my opinion of my job is to keep people going, to have them continue to work in some capacity.

When someone has chronic pain, the worst thing you can do is to disable them and let

them sit at home and not do anything.

So most of the time if they can't perform full capacity, such as with a railroad job, is my understanding, light duty or some sort of work to continue to work in some capacity tends to be in a pain patient's best interest and something that we'd recommend or we'd like them to continue.

Q. Okay. You weren't -- you weren't rendering an opinion there in that sentence based upon, like, the Social Security work categories as to whether he was eligible for light, medium --

A. No.

Q. -- or heavy duty?

A. No, no. It's not based on specific pounds that he can lift or time that -- no. It's more we believe he should be able to continue to work in some capacity.

Q. Okay. Whether it be light or medium?

A. Exactly.

Q. Okay. And you didn't at that time impose any restrictions on him?

A. No.

Q. All right. Next visit was March 20th;

is that correct?
A. I believe so.
Q. If you look on the -- page 22, under history, second paragraph, you say -- he says that, "Pain is exacerbated by walking long distance." Can -- do you recall, perchance, what he referenced as being long distance?
A. No, I don't recall.
Q. Would -- okay. You also say that he gets 80, 90 percent of relief from meds and that the pain is considerably better; correct?
A. Correct.
Q. Again, when you're doing your physical exam, you note, "No acute distress." So he's doing pretty well at that point?
A. Yes.
Q. Okay. Go to April 19th, which is the next visit. Same thing, physical exam is pretty much unchanged, relatively good; correct?
A. Yes.
Q. Exercise program, I think you're recommending under musculoskeletal on the second -- on page 26 --
A. Yes.

Q. -- you say, "Can undergo exercise testing and/or participate in exercise program." What did you have in mind there, Doctor?

A. That's an interesting thing because the electronic medical record, if you -- when you're going through the record, if you push the normal button, it will put that out. I'm not sure that's always an accurate statement. But if you look back probably through the record, it says that each time.

It's the assumption that -- I will change it if -- the best thing -- the more accurate thing would be normal gait and station, you know, whatever, no -- that sort of thing rather than what comes out on that form. But that's what it implies.

So I would say that he would be able to undergo normal exercise and activity, but that is not a new finding. That's probably how he's been the whole way through.

Q. Okay. And then what would -- what would normal exercise and activity be? I mean, in his case, as of April --

A. ADLs, whatever he normally does, his

activities of daily living. I didn't get the feeling that he was limited in his ability to do the things that he had been doing all along.

Q. Okay. And, again, he didn't indicate to you at that time anything changed with regards to his belief that he could -- that he was working as a BNSF carman or could work?

A. Yes, he did not.

Q. May 21st, 2012, which is the next visit, second paragraph under history -- and, quite frankly, on there you have the referral as Dr. Lodhia.

A. It is there?

Q. Yeah.

A. Okay.

Q. It's on page 28.

A. Uh-huh.

Q. Second paragraph under history.

A. Yes.

Q. He talks about, "Pain as stiff and sore first thing in the morning and by noon is feeling great. By evening the pain is starting to return." Is that uncommon in this kinds of -- in this kind of condition?

A. No, it is not.

Q. Okay. What -- what is the precipitating factor for someone that starts getting more pain as the day progresses?

A. When we ask about time of day that you have pain, just as a general rule, people who have pain in the morning tend to be more arthritis related, get up in the morning, they're stiff from lying in bed. And so that would be kind of -- when you're looking at facets or when you're looking at that sort of thing, you always kind of look toward morning pain.

Pain as the day progresses or more pain towards the end of the day suggests more disc mediated or other causes for pain.

So this would suggest he has some return of the arthritis pain but he may also have his -- the pain related to his spine and what he's had in the past.

Q. Okay. All right. It says, "Pain is exacerbated by no meds." I guess what? Did he take himself off the meds? Is that what he's saying?

A. I think he's saying when he's not taking medication, like, if he's saying -- yes, I

would say if he skips a dose, he notices more pain.

Q. All right. "Standing in one place or too much activity and long car rides," again, do you have any recollection of what he meant by long car rides there?

A. I do not.

Q. Okay. That's all right.

The pain on the VAS scale, 3 and -- out of 10, what -- tell me how you -- how you rate that and how you present that to the patient.

A. You know what I do have? Is this May 21st?

Q. Yes, Ma'am.

A. He does write on his intake, he says, he is "stiff and slow getting around in the morning and loosens during the day. Standing for more than 15 to 20 minutes is the limit I have."

Q. Okay.

A. "I have to sit down. Walking, I can go 30 minutes to an hour and then sit down. By midday, the back pain will leave, and I have no symptoms, but foot pain remains."

Q. Doctor, I didn't ever get those intake

pages.
A. I can get those to you. That's just -- what we tend to do is when a patient is sitting, about to come back, they'll write, you know, the information that we ask.
Q. I understand. Did he write anything about driving there?
A. He just mentions --
Q. Long car rides?
A. No. Just about having to sit down -- standing more than -- no, he does not.
Q. Okay. And then back to my question with regards to the pain, 3 on a scale of 10 --
A. Yes.
Q. -- tell me how that is presented to the patient and how do you analyze that?
A. Well, the more -- the more accurate way to analyze is a lot of times a visual analog scale, people learn it almost like they learn their Social Security number, what's your pain today, it's a 10. It's, like, that's the worst pain ever, it's a 10. You know, that's kind of how they are.
Really, the more accurate way is to use a scale such as this but, actually, it be, you

know, 10 inches or 10 centimeters and where they put their X on the scale should actually be measured. And then you have a measured reading based upon -- on a line where their pain tends to sit. And that can help you. And that's probably a little bit more accurate because where they put it, they don't memorize where they are on the line.

Q. Sure, sure.

A. And that's actually a little bit more accurate than using a number. But a three is pretty well-controlled pain as a whole.

Q. Okay. Then the next visit, if I've got this right, is August 22nd.

A. I have it as August 22nd as well.

Q. Okay. There he's reporting that his functionality has decreased. Did you do anything in terms of your evaluation that either confirmed or refuted that, or do you try to do that?

A. We use a lot of their report, their self-report as a means of figuring it out.

Sometimes when something changes considerably, we will kind of watch what they're doing or whatever. But we -- we use

actually functionality more than the VAS, the score, because, again, like you said, one's just a number. Whereas, I'm not doing -- I hurt more, I haven't been able to do as much, I can't go to the mailbox, I can only get around in the kitchen and I have to sit, that sort of thing. So a lot of times they'll give us more detailed report.

That's pretty vague except for he is now walking with a cane, which looks like that's something different.

Q. When he -- when he reported his functionality was -- has decreased, did he give you any more specifics than that?

A. He writes that he's same to worse, that "Tramadol use goes up with activities. Hand swelling in fingers hurt. Low back stiffness. Pain in both heels and balls of feet and grinding teeth," is what he wrote on his intake form.

Q. So you didn't conduct any evaluation or analysis yourself to determine if his functionality had, in fact, decreased?

A. No.

Q. Okay. And as far as why he was -- why

he had bought a cane, do you know what -- what specific physical problem led him to do that? In other words, was it the pain in his feet, do you know? Was it -- was it his balance? Was it meds?

A. It's more the foot pain, I believe is why he was using the cane.

Q. He -- you have it that he has a new complaint of bilateral hands and feet. What would that signify to you, if anything?

A. Well, I guess the one thing you always want to look for is, like, peripheral neuropathy, new onset diabetic, is there some sort of thing going on, is there a vitamin deficiency, you know, causes for peripheral neuropathy as that pain.

But other times, when we see pain that kind of is random, sometimes it can also be more related to depression or other changes as they -- again, that's the reason why I like getting them to work sooner or do something because when you sit around and dwell on your pain, you notice more pain.

Q. Were you -- throughout this period of time, do you counsel the patient to get out

and --
A. Yes.
Q. -- engage in exercise?
A. Always.
Q. And try to work?
A. Always.
Q. Did you -- were you having any success in Mr. Bliss' --
A. He -- he -- his problem and the problem pretty much from the beginning is that the medications always helped him, but the sexual side effects was causing a lot of problems in his house. So every time that he would come in, the main thing that he would be talking about is erectile dysfunction.

So we would counsel, you know, getting up and doing things and moving around and how big a deal is this because if it's a big enough deal, it is usually worth changing medication.

If a side effect is greater than its benefit, we should absolutely change a medication.

So his main focus -- I was never under the impression -- usually when somebody is not functional, he -- he described himself, I mean,

a 3 out of 10 pain, 80 to 90 percent improvement. That's a pretty functional person. So you're less likely to say, you know what, you need to get out of your chair and quit just watching TV. What do you do in the day. And I'll see that more with somebody who I feel is less functional. We will spend more time on that discussion.

In his particular case, he never really described decreased functionality until this visit. So he was mainly describing the side effects of the medication, although -- although, the medications were very helpful to him.

Q. Okay.

A. And it would be more counseling in that direction.

Q. So if I understand you correctly -- and you correct me if I'm wrong -- basically you felt that his activity level was probably high enough that you didn't have to spend a lot of time on encouraging him to work hardening and those kinds of things?

A. Yes.

Q. All right. There was no indication to

you, at least through your analysis over these months and your physical exams, that he was incapable of engaging in normal activities?

A. No, there was no indication.

Q. All right. On page 32, under assessment, you do reference encouraging him to attend the YMCA and to increase his activities. So at least there was some indication at that point in time maybe you felt he should increase his activity?

A. Yeah. And you can kind of see, he comes in. He says he's less functional. He's using a cane. Okay. How do we get him back, what happened between those three months or the last visit and how do we get him back to doing what he was.

There's not a big fall or something that changed significantly. Sometimes they just need a little push to say, you know what, if you're okay in the water, you're going to start to be okay in land and you get moving again.

And he looks like he expresses interest in trying to -- he recognizes it as well. And is actually saying going to the Y with his son. So he's proactively trying to do something,

which is also unusual with our patients so --
Q. Did you -- did you follow that up, or do you know if he joined the Y or if he did any aquatherapy?
A. I do not.
Q. Okay. As of that date of May -- or August 21st -- excuse me, August 22nd, 2012, you still had not imposed any specific restrictions on Mr. Bliss; is that correct?
A. That is correct.
Q. And that -- is that the last time you've seen him?
A. Yes, that I'm aware of.
Q. Okay. As of that date, what meds were you prescribing for Mr. Bliss?
A. Cymbalta and Lyrica.
Q. And what is Cymbalta for?
A. Cymbalta is -- what it does is it increases serotonin and norepinephrine, some neurotransmitters that get depleted with pain. It is an antidepressant, but we don't use it -- its indication is more for neuropathic pain. And most of the time people in pain also have some depression associated with it.
Q. He says he's taking up to six Tramadol a

day. Where is he getting that prescription?
A. That must be through his primary care.
Q. And what is Tramadol?
A. Tramadol is a -- it is a pain medication that works at a narcotic receptor. It is -- it's schedule -- I don't remember its schedule dosing.
But it doesn't -- it's not like hydrocodone. So people sometimes will have samples in their office or things like that. It's a lot less regulated. But all intents and purpose, it's a narcotic.
Q. Okay. And Lyrica?
A. Lyrica's an anticonvulsant. It works at something called an alpha 2 delta receptor. So what it's supposed to do is stabilize the way a nerve sends a pain signal.
If you -- if you block the calcium channel through there, you don't have pain. So, again, it's for neuropathic pain is what we use it for. Although, it's a anticonvulsant.
Q. How do you monitor his use of this narcotic drug in conjunction with what you're trying to do with your other drugs?
A. I -- I tend not -- I tend not to

prescribe narcotics very often for chronic pain. How -- the only way that we tend to monitor it is on an intake, asking the patient what are they taking.

I don't try to second guess necessarily their primary care unless I see a red flag or a reason that they should be a little more aware of something.

If I'm giving them a pain medication and I find out someone else is, that's a definite red flag. And that would be a reason.

But I've never given him as such a pain pill. And so what his primary care is doing is kind of between them.

Q. Okay. So this Tramadol, 100 milligrams, four to six tablets daily --

A. That's an outrageous amount in my personal opinion. But, again, I try not to judge. It almost makes me question whether that is the correct number or not. Because that is a really high dose.

Q. I understand. And I guess that was my question. Is -- is there any concern at this point --

A. Yes.

Q. Okay.
A. See, initially on my initial ones, he was on 100 milligrams. And this is another -- the way an extended-release medication works is it is supposed to be slowly released by whatever -- whatever substance that you want to use to cause it over a certain period, whether it be 12-hour, 24-hour.

I'm amazed by how often the medication is not prescribed correctly. As 100 milligram, that's an extended-release medication. Most people, you'd never give that person in a 50 milligram form, whatever -- 10, 15 of those. And, yet, you're somewhat doing that when you're giving them three a day of 100 milligrams or six a day of a 100-milligram pill.

Again, I question the judgment of that. But I -- I'll just leave it at that.

Q. Okay. I understand. All right. You didn't have any -- any -- you don't recall any specific visits that you had with Mr. Bliss concerning his narcotic medications?
A. No, I did not.
Q. Okay. All right.

A. The other thing that's really hard is that oftentimes when they come from a neurosurgeon or they come from a surgical consult or standpoint, we're not necessarily monitoring the primary care's care. So we're just handling that part of it. So Dr. Lodhia wasn't prescribing it, we're not prescribing it, it is of concern.

Q. I understand. Do you know who's prescribing it? I mean, for sure or --

A. I assume Dr. Kreshel because that's who his primary care is. But I don't -- I'm assuming. But I don't know.

Q. Okay. Any other medications that you're aware of that he's taking?

A. No, I'm not aware of any others.

Q. Now, at least as of November of 2011, he had -- he was on hydrocodone. That could have been through -- from the shoulder surgery or --

A. Yes, I would assume so.

Q. Okay.

A. I would assume so.

Q. All right. Next visit that you have is scheduled for, like, three months from August; is that right?

A. Yes.
Q. And why -- why do you have another visit scheduled, and how long is -- what are your plans? What is the prognosis and plans for Mr. Bliss?
A. As a whole, somebody with chronic pain needs to be seen at intervals -- and his interval, it would probably be further apart. If I saw him and he's still on Cymbalta at 60 or Lyrica at 100 three times a day or whatever he's on and he's been stable like that for a year or whatever, I'd probably extend those visits to six months because there's not a reason that we need to.

The -- the Tramadol use or things like that may -- may make it so that it would be valuable for him to come in sooner in a situation like that.
Q. Got you.

Do you -- strike that.

You didn't have an opportunity to review any MRIs or --
A. I have seen his MRIs before.
Q. Oh, have you?
A. Yes.

Q. Okay. The MRIs that reveal the lumbar disc degeneration, the facet arthropathy, the lumbar spinal stenosis, again, all of those things can be attributable to simply a degenerative process of the spine; correct?
A. Correct.
Q. And you saw those, I take it, on the MRIs prior to -- of those MRIs prior to February 3rd of 2011; correct?
A. Yes.
Q. That's a yes?
A. Yes.
Q. Okay. Doctor, you have been identified -- and I don't know if I'm telling you anything you don't know. But you've been identified as a possible expert for the plaintiffs in this case at trial. Were you aware of that?
A. No, I was not.
Q. All right. You -- it is -- it is suggested that you have some specific opinions relative to functional limitations, medication requirements and job restrictions. Is that -- is that -- based on what our earlier -- your earlier testimony was, I take it that's not

entirely accurate?
A. Yeah, that is not entirely accurate.
Q. Okay. For example, do you know or do you have opinions as to what his current functional limitations are?
A. No, I do not.
Q. All right. Do you have opinions relative to what his -- what, if any, job restrictions he has?
A. It would only be based upon his prior assessment.
Q. The FCE?
A. Uh-huh, yes.
Q. That FCE revealed a medium to heavy work?
A. Correct.
Q. Okay. What about opinions as to his pain? Do you have opinions as to whether that -- well, let me back up.
As we sit here today, do you know what specifically is causing Mr. Bliss' pain and where it's located?
A. I would say it's multifactorial.
Q. Okay.
A. I would say that by the response he had

from his rhizotomy, that there is definitely a facet or arthritis component to his pain.

I would say that based upon his EMG studies, he has some chronic L5 radicular -- radiculopathy. And there might have been S1, too. I'm not sure. But the EMG studies would suggest.

So he's got both lower extremity pain and back pain, which can be accounted for. And then the MRI findings suggest some chronic changes that way. Whether those are actually the cause of his current pain, I'm not sure.

Q. Do you know what -- to what extent he is having any pain, for example, in his knees and what's causing the knee pain?

A. I do not.

Q. Foot pain we talked about or the hand pain, we don't know if that is -- if there's a -- what's the word for it? Physiological reason --

A. We don't know.

Q. -- or if it's just -- okay.

What about shoulder pain? Do we know if any of his current conditions are related to his shoulder problems?

A. I do not know.
Q. Okay. I'm just about done, Doctor. Let me look for --
A. You're fine.
Q. You would agree with me that Mr. Bliss was clearly suffering from degenerative disc disease prior to February 3rd of 2011?
A. Yes.
Q. The -- I think you've already told me, the FCE appeared to be a valid FCE; correct?
A. Yes.
MR. LUERS: Doctor, thank you. That's all the questions I have.
THE WITNESS: Thank you.
CROSS-EXAMINATION
BY MR. McMAHON:
Q. Just a few, Doctor. Following up on some of the questions regarding any opinions that you might have, work restrictions or whatnot.
Since I'm his attorney and I'm the one that disclosed it, let me show you a document.
MR. McMAHON: I guess we should mark this as Exhibit 52.
///

(Exhibit No. 52 marked for identification.)

Q. (BY MR. McMAHON) Doctor, you recognize your signature is on this document?

A. Yes.

Q. Okay. Do you recall filling out this document for Mr. Bliss? I think it's dated January 27th, 2012.

A. Yes.

Q. Okay. And --

A. I did not -- I didn't fill it out, though.

Q. Okay. You didn't fill it out?

A. That is actually our work comp nurse that filled it out.

Q. Although your name is dated in the box No. 7?

A. Yes, yes.

Q. Your name is included in there?

A. I did -- I must have read over it to sign it.

Q. So you must have reviewed this when you signed the document?

A. Yes.

Q. Okay. And do you hold the opinions that

BNSF objects to the testimony as hearsay without an exception and as not relevant. Fed. R. Evid. 402, 403, 801 and 802.
Ruling: Overruled

are listed here that were submitted with this form on January 27th, 2012?
A. Yes.
Q. And on those forms, you both gave your diagnosis and the diagnosis -- working diagnosis that you had at the time; is that correct?
A. Yes.
Q. And you attached medical records that we just went over in great detail to this -- to this document; is that right?
A. Yes.
Q. And you indicated some of the past surgeries and medical history that Mr. Bliss had undergone; is that correct?
A. Correct.
Q. Box No. 3.
Box No. 5 was -- asked your opinion regarding his ability to return to work. And on that you said that he's not able to return to work but he needs light to sedentary work, which agrees with the opinions that were revealed in your medical records; correct?
A. Yes.
Q. And you stated on earlier questions that

it's your understanding just through your work experience, that the railroad carman position doesn't have a light or sedentary work assignment, but it was your opinion that he could return to work at the railroad in a light or sedentary position; correct?

A. Yes.

Q. And both -- you testified that, in fact, that is good for a patient like Mr. Bliss who has chronic pain to be out and doing some type of employment even if it's in a sedentary type of position?

A. Yes.

Q. And in your experience with -- in these type of work comp -- work injury type of situations, I should say, do you find that employers are typically receptive of accepting employees back with the -- with these types of restrictions?

A. Depends on the job. Depends on the employment. If it's not available, it's not available. I mean, a construction worker may not be able to go back to construction, and if they don't have a desk job available, they may need to find a different type of employment.

But as a whole, try to accommodate them.
Q. Okay. And so a reasonable employer would try to accommodate these types of restrictions?
A. Again, depends on the type of employment --
MR. LUERS: Object to form of the question.
A. -- they have.
~~Q. (BY MR. McMAHON) Right. Okay. Did you know that BNSF had terminated Mr. Bliss at or maybe a few days before he -- first seeing him?~~
~~A. No, I wasn't aware.~~
Q. Okay. And -- all right. And so Exhibit 52, do you still hold these opinions to a reasonable degree of medical certainty, that the -- the job restrictions that you would place upon Mr. Bliss would be a light or sedentary work assignment?
MR. LUERS: Object. Form and foundation.
A. How -- just -- how the -- how this comes about is we have a work comp nurse in the office to review the chart and then to fill in the lines.

BNSF objects to the question as to its improper form as to use of terms "reasonable employer" and "accommodate." Ruling: Sustained, especially since the witness never answered the question as to this plaintiff and his employment.

50:10-13 is stricken--See pretrial conference order and motion in limine ruling.

And I assume that she came to the light to sedentary work restriction based upon the note that was in the chart.

Do I think he is at 100 percent? No.

Do I really know where he falls on that? I do not. I don't know off the top of my head. I can look at a book and figure out what -- what the guidelines are for each of those categories.

But she -- the person who filled out this form does supposedly know both that and the railroad and their normal restrictions and the whole thing. So we tend to use their expertise oftentimes in some of this portion of it.

Q. (BY MR. McMAHON) Okay. So the -- so the typical procedure in your office when you have -- when you're called upon to -- in your -- in your capacity as a physician, when you're called upon to offer these types of opinions like you did in Exhibit 52, the way your office does it is you employ someone who --

A. Has work comp expertise.

Q. -- has work comp expertise?

50:10 --53:3 BNSF objects to the testimony as hearsay without an exception and as not relevant. Fed. R. Evid. 402, 403, 801 and 802. *See* subsequent testimony at 62:1 --63:8; 65:9-15. Ruling: Sustained. In light of 7:12-8:14, 24:9-21, 44:3-16, 62:1 --63:8, 65:9-15, this witness' testimony as to level of work the plaintiff can perform and his ability to return to work at the railroad is either wholly irrelevant for lack of sufficient foundation or, if relevant at all, more prejudicial than probative.

A. Uh-huh.
Q. They review your treating notes?
A. Yes.
Q. And any other records they might have --
A. Yes.
Q. And then --
A. They render kind of their understanding of it. And either we agree or disagree with things.

And in this particular case, as I understand -- well, as I understand secondhand how the railroad works is that he could not be a carman and that she's -- she's basically saying, so less than 100 percent, the next category from whatever full duty is is light and -- or sedentary. And that's how it came about.

Q. All right. And so when the -- this process that you just described took place, you endorsed that opinion?
A. Yes. Because, again, I didn't actually do a functional capacity. I didn't actually test him to figure that out.

But from how he presents in the office and how -- what I -- my understanding of his

job duties, I did not believe that he could go back to his current position. But I do think he should work.

Q. Right. Absolutely. So -- so this opinion that's reflected in Exhibit 52 where he should be on a light or sedentary job assignment, you still hold that opinion?

MR. LUERS: Object. Form and foundation, asked and answered.

Q. (BY MR. McMAHON) You still hold that to this day going forward?

MR. LUERS: Asked and answered.

A. As -- as of the last visit, I think it's reasonable.

Q. (BY MR. McMAHON) And in the beginning when Mr. Luers was talking about the documents you have in your chart, I believe you had some records from Dr. Lodhia?

A. Yes.

Q. And they're in the forms of letters to Dr. Kreshel?

A. Yes.

Q. Then that September note, Dr. Lodhia had both reviewed the FCE as well as the EMG as well as met with Mr. Bliss; is that correct?

53:4 --54:1 BNSF objects to question as to its improper form. BNSF objects to the testimony as there is no proper and sufficient foundation; it is hearsay without an exception and not relevant. Fed. R. Evid. 402, 403, 801 and 802. *See* subsequent testimony at 62:1 --63:8; 65:9-15. Ruling: Sustained as to 53:4-14 for the reasons stated as to 50:10-53:3; overruled as to 53:15-54:1

A. Yes.

MR. LUERS: Object on foundation, as far as what Dr. Lodhia did.

Q. (BY MR. McMAHON) Okay. That's contained in his records; correct?

A. Yes.

Q. And is nothing unusual for you to receive records from a neurosurgeon or a neurologist or other treating physician and you use those records as part of your care and treatment for patients; correct?

A. Yes.

Q. Okay. And that's what you did in this case with Dr. Lodhia's records; correct?

A. Yes.

Q. Who was a referral physician, of course; correct?

A. Yes.

Q. And it seems from that September 2011 note with Dr. Lodhia, that the FCE, as well as Mr. Bliss' condition over this -- this summer since the June 30th FCE, had worsened and his condition -- the -- had -- he still had the condition of back pain?

MR. LUERS: Object. Form and

foundation.
A. I lost track of your question.
Q. (BY MR. McMAHON) Sure. It seems the -- after the FCE and during the months when Mr. Bliss was getting the diagnostic tests that Dr. Lodhia had ordered, his back condition had -- didn't improve? It was still -- he was still symptomatic; correct?
MR. LUERS: Same objection, foundation, form.
A. Yes.
Q. (BY MR. McMAHON) And Dr. Lodhia, in fact, in that September 2011 visit recommended that Mr. Bliss be in a light and -- light-duty job assignment; correct?
A. Yes.
Q. In a permanent capacity?
MR. LUERS: Object. Foundation.
A. I don't know about that. But he does say --
Q. (BY MR. McMAHON) Okay. All right. Part of your -- part of the practice in pain management, I guess how -- what I want to phrase this more is there's a -- almost a -- the psychological and physiological response to

54:19 --55:18
BNSF objects to the question as to its improper form. BNSF objects to the testimony as there is no proper and sufficient foundation; it is hearsay without an exception and not relevant. Fed. R. Evid. 402, 403, 801 and 802. *See* subsequent testimony at 62:1 --63:8; 65:9-15
Ruling: Sustained for the reasons stated as to 50:10-53:3, plus the witness ultimately admitted she did not know what Dr. Lodhia recommended (55:12-20).

pain; is that correct?
A. Yes.
Q. All right. And while you were treating Mr. Bliss, obviously there was a psychological component to the chronic pain --
A. Pain condition.
Q. -- that he was treating; correct?
A. Correct.
Q. And that's -- although you're not a psychiatrist or psychologist or whatnot, that -- you incorporate those -- the mental impacts of chronic pain in your treatment; correct?
A. Yes.
Q. And you did that with Mr. Bliss?
A. Yes.
Q. All right. And part of that wasn't just the mental anguish of chronic pain with Mr. Bliss, but it was also affecting his personal life. And you mentioned a little bit about how that was impacting the medical care and treatment, the medicine --
A. Yes.
Q. -- side that you were treating him with; correct?

A. Yes.
Q. All right. And is that -- is that an unusual type of --
A. No.
Q. It comes with the territory of treating patients with chronic pain?
A. Yes.
Q. All right. And -- and that adjusting the medications and trying to find the right balance of the chronic pain medication that we saw that you went through with Mr. Bliss, that is -- that is what, I guess, the science and the medicine of pain management is all about; correct?
A. Yes.
Q. All right. And -- and fluctuating the medications to try to help the patient deal with the pain that's there on a permanent basis; is that right?
A. Yes.
Q. And is that what you did with Mr. Bliss?
A. Yes.
Q. All right. And just real small point that seemed to be made about the interesting software of electronic medical records.

A. Yeah, I know.
Q. So --
A. There will be typos in there, too, that will be, like, what in the world.
Q. This comes up a lot nowadays as EMR --
A. Unfortunately.
Q. Actually, I've been corrected. It's not EMR. It's --
A. EHR.
Q. EHR. Stand corrected.
A. Yes. It's a health record now.
Q. So this work history reviewed, no changes required, he works as a -- at BNSF as a carman, this no changes required, that's not a function of Mr. Bliss telling somebody, whether it's you or the nurse, that no changes are required from his perspective as a work ability?
A. The no changes required comes up. What happens is they are -- they're supposed to ask, is -- is -- you still on the same medications, has anything changed in terms of your social status or your work status. And they say, no, everything's the same from however they want to recall it.

And then you click a box. And it says, no change. And it fills that part out. And it says, no change is required.
Q. So it's automatic?
A. So it's not somebody saying don't change anything. It's just what it is.
Q. So if he came in and he got a job --
A. They should have taken that, and --
Q. Right.
A. -- it should have changed.
Q. Right.
A. He is now employed at blah, blah, blah.
Q. Blah, blah, blah. And that's when that no change required would have changed and would have --
A. Exactly. And it wouldn't be there then, yes.
Q. Right. Okay. And the same for -- there's a -- there's a part -- I don't even think it's a typo. It's more like a --
A. Unfortunately.
Q. It's a -- it's in the expectations line.
A. Uh-huh.
Q. And it seems to be more -- there must have been, like, an update to the software.

It states here, "David further states," like, for example, on the --

A. Like, expectations, focus on remedy and long-term effects or something?

Q. Yes.

A. Yes.

Q. So it seems like there's a second half that's sort of filled in, but that first half of the sentence is sort of -- is asked of the patient, and it's just a way of tracking where the patient is on that particular day?

A. It depends. Actually, sometimes it's how the nurse chooses to fill in that line. But we -- what -- what we require of them is that the expectations for the visit because sometimes patients will want to talk about medication, or sometimes patients have a new problem, I have a new pain complaint, my shoulder hurts or something, I want to address this instead of what -- what we expected them to come in for.

So -- or I want an injection today. So we know when we see them, this is what they want. And whether we can accommodate or not is another story. But that's what that line is.

Q. Good.
A. Is an expectation.
Q. Like another -- another way to flush out all of the patient's needs and --
A. Absolutely.
Q. -- for a --
A. Try to make them happy however -- what they want addressed.
Q. All right. Okay.

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

REDIRECT EXAMINATION

BY MR. LUERS:
Q. Doctor, I have a few more.
A. I thought you might.
Q. Surprise. Certainly by the time you signed Exhibit 52 --
A. Yes.
Q. -- you had seen the patient twice; correct?
A. Yes.
Q. And both of those times your general physical examination was virtually good, as you told me; correct?
A. Yes.

Q. All right. And you told me, I believe, that as of that December 21st visit, the language there where you said, he's able to work but not likely at full capacity and that he would likely be qualified for light and sedentary duty was likely the -- his words, Mr. Bliss' words reporting to you; is that accurate?
A. That is accurate.
Q. So the note that your -- that your nurse or whomever was filling out, Exhibit 52, was looking at is probably this note?
A. Based upon that.
Q. Okay. And I think you told me that your belief was, at least -- or is, is that he's not 100 percent so he -- so he may not be able to return to his normal employment; correct?
A. Yes.
Q. You're not analyzing based upon physical demands of a job and the categories that -- that identify light, medium or heavy work in your note of Exhibit 52; is that correct?
A. That's correct.
Q. And what you're saying is he -- he might be -- or he'd likely be qualified for light or

sedentary duty. You're not saying there that he would not necessarily be qualified for medium duty?

A. That's correct too.

Q. All right. And you're just not rendering opinions based upon functionality; is that right?

A. That's correct.

Q. And we're still -- you're still -- it's still your testimony that the only valid FCE that you're aware of is that WorkWell FCE and --

A. What -- but as an aside, when I get an FCE and I've seen a patient and I've evaluated him over time and I don't necessarily agree with the FCE, the best time to have that discussion or to state that is soon after it's occurred.

And in his particular case, I think after his FCE, he experienced more pain. And that is when Dr. Lodhia saw him and kind of assessed him and felt that maybe it's a little different than how he presented at his FCE, which is to say is that just a flare-up of his condition or is it something more -- hard to

say.

Mine is just another blip in time, quite a bit separate from the FCE. So, again, I'm rendering opinion based on something current at that moment.

So a functional capacity I always find is a very helpful thing because you can definitely -- most helpful when it's invalid because you can kind of say -- but when it's a valid FCE and the patient does their best and then they walk away and they have more pain, how long that pain lasts or what it is is -- sometimes it's reasonable to get or repeat if you feel like something's changed.

Over the course of his history or his physical exams, he -- when he came to us, he was in pretty good shape. He didn't want a spinal cord stimulator. He thought he could do pretty well.

He started off doing really well in terms of medication, despite the side effects and pretty -- seemed fairly functional.

And then in the last couple of visits, something kind of changed in terms of needing a cane, wanting to figure out if he's just not

physically active. There's definitely some depression and marital strife in all of that. Something changed a little bit there.

Whether that's enough to warrant another FCE, hard for me to say. But sometimes if there's a question as to its validity from prior to current, it may be reasonable to get another one.

Q. I fully understand. And as you sit here today, you're not going to render an opinion that he's capable of returning to heavy-duty. I understand that. But --

A. But the medium to light to sedentary category, that's -- I'm not rendering an opinion that way either.

Q. All right. And you don't know what it is that in the last three months or why it is in the last three months that maybe his condition or functionality may have deteriorated?

A. I don't. I don't.

Q. Okay. And you don't have any reason to attribute that deterioration to an incident that happened in February in 2011, do you?

A. No, that's not for me to say.

Q. Okay.
A. The one thing that is possible is that he had the rhizotomy. He was doing pretty well. Rhizotomy lasts on average six months to two years, eighteen months average. It might be the increased back pain or increased pain that he's having, if he's mainly describing back pain, may require another rhizotomy.
Q. Okay. But that wouldn't -- that wouldn't result in a -- further reduction of functionality, would it?
A. It should not.
Q. Okay. Right now his biggest limitation is pain, I assume?
A. As I understand it.
Q. Okay.
MR. LUERS: Thank you, Doctor. That's all I have.
THE WITNESS: Thank you.
MR. McMAHON: That's all I have. Thank you, Doctor.
THE WITNESS: Thank you.
MR. LUERS: Oh, you know what, can we get copies?
THE WITNESS: Yeah.

MR. LUERS: Could you make me a quick copy of those?
THE WITNESS: Yeah.
MR. McMAHON: I don't have them either.
THE WITNESS: Yeah, definitely.
MR. LUERS: Make two copies. Make three copies. And we'll mark it real quick so we know what we're talking about here.
THE WITNESS: These are these pain diagrams.
MR. LUERS: Yes.
MR. McMAHON: With the --
MR. LUERS: The intake, whatever.
(A short recess was taken.)
(Exhibit No. 53 marked for identification.)
Q. (BY MR. LUERS) We're back on the record. Doctor, I'm going to hand you what's been marked as Exhibit 53. It's my understanding that these were the -- sort of the intake notes and then the -- what do you call these? Clinical -- what do you call them?
A. It is a -- it is a patient intake and a

questionnaire.

Q. Okay. Fine. And that comes out of your file today; is that right?

A. Correct.

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

MR. McMAHON: Fifty-three.

MR. LUERS: Doctor, you have a right to read and review, or you can waive that.

THE WITNESS: Waive.

(Deposition concluded at 2:21 p.m.)

C-E-R-T-I-F-I-C-A-T-E

STATE OF NEBRASKA)
: ss.
COUNTY OF LANCASTER)

I, Lori J. McGowan, General Notary Public in and for the State of Nebraska and Registered Professional Reporter, hereby certify that DR. LIANE DONOVAN was by me duly sworn to testify the truth, the whole truth and nothing but the truth, that the deposition by her as above set forth was reduced to writing by me.

That the within and foregoing deposition was taken by me at the time and place herein specified and in accordance with the within stipulations; the reading and signing of the deposition having been waived.

That the foregoing deposition is a true and accurate reflection of the proceedings taken in the above case.

That I am not counsel, attorney, or relative of either party or otherwise interested in the event of this suit.

IN TESTIMONY WHEREOF, I place my hand and notarial seal this day of October, 2012.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

DAVID BLISS,) CASE NO. 4:12-CV3019
)
PLAINTIFF,) DEPOSITION OF
) MICHAEL H. MCGUIRE, M.D.
VS.)
) TAKEN ON BEHALF OF
BNSF RAILWAY COMPANY,) PLAINTIFF
)
DEFENDANT.)

VIDEOTAPED DEPOSITION OF MICHAEL H. MCGUIRE, M.D., taken before Gretchen Thomas, Certified Court Reporter, Registered Professional Reporter, Certified Realtime Reporter, General Notary Public within and for the State of Nebraska, beginning at 12:41 p.m., on June 18, 2013, at the Professional Offices of Thomas & Thomas Court Reporters, 1321 Jones Street, Omaha, Nebraska 68108, pursuant to the Federal Rules of Civil Procedure.

APPEARANCES

FOR THE PLAINTIFF:
MR. WILLIAM MCMAHON
HOEY & FARINA, P.C.
542 S. Dearborn Avenue, Suite 200
Chicago, Illinois 60605
(312)229-7581 FAX (312)939-7842
wmcmahon@hoeyfarina.com

FOR THE DEFENDANT:
MR. THOMAS C. SATTLER
MS. KATHERINE Q. MARTZ
SATTLER & BOGEN
701 P Street, Suite 301
Lincoln, Nebraska 68508
(402)475-9400
tcs@sattlerbogen.com

ALSO PRESENT

MR. JOHN J. THOMAS, JR., CLVS
Thomas & Thomas Court Reporters
and Certified Legal Video, L.L.C.
1321 Jones Street
Omaha, Nebraska 68102
(402)556-5000 FAX (402)556-2037

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(Whereupon, the following proceedings were had, to-wit:)

(Exhibit Nos. 80-81 marked for identification.)

VIDEOGRAPHER: Please stand by. Counsel, we are on the record.

This is Tape No. 1 to the Videotape Deposition of Michael McGuire, M.D., in a deposition qtaken by the plaintiff in a case entitled David Bliss versus BNSF Railway Company; Case No. 4:12-CV-3019.

This deposition is being held at the offices of Thomas & Thomas Court Reporters, 1321 Jones Street in Omaha, Nebraska.

Today's date is June 18th, 2013. The approximate time is 12:41 p.m.

My name is John Thomas, Videotape Specialist, from the office of Thomas and Thomas.

Our court reporter this afternoon is Gretchen Thomas.

Will counsel please identify themselves for the record.

MR. MCMAHON: William J. McMahon for the plaintiff, Mr. Bliss.

MR. SATTLER: Tom Sattler, BNSF

Railway Company.

MICHAEL H. MCGUIRE, M.D.
having been first duly sworn,
was examined and testified as follows:

DIRECT EXAMINATION

BY MR. MCMAHON:

Q. Good afternoon, Doctor.

A. Good afternoon.

Q. Could you please state your name for the members of the jury.

A. My name is Michael H. McGuire, M.D.

Q. And do you have a profession or occupation that you specialize in?

A. Yes. I'm an orthopedic surgeon.

Q. And what does it mean to be an "orthopedic surgeon"?

A. Orthopedic surgery is defined as the medical specialty that provides evaluation and treatment for conditions of the spine and extremities. Generally speaking, we're the bone and joint doctors.

Q. Okay. And could you tell the jury a little bit about your education and training to be an orthopedic surgeon.

A. Yes. I attended Creighton University here

in Omaha, and earned a bachelor of science in chemistry degree in 1971 -- May of 1971.

I continued at Creighton for my medical degree and earned an M.D. in May of 1975. I then served a five-year orthopedic surgery residency at St. Louis University in St. Louis, and completed that residency in -- on June 30th, 1980.

Q. And could you tell the jury a little bit about the current nature of your practice; what type of patients you see, what type of conditions you treat.

A. I'm a -- I practice as an orthopedic surgeon in Columbus, Nebraska, a town of 22,000 people about 90 miles from here. I practice a general orthopedic surgery with two other surgeons.

I do a number of joint replacements, do a number of fracture work. And my interest for many years in orthopedics -- or my special interest has been tumors of the musculoskeletal system, so I continue to see a number of patients referred for my treatment.

Q. And have you been on the staff of any hospitals, whether here in Omaha or Columbus?

A. Yes, I have. I'm currently -- I practice at the Columbus Community Hospital -- actually as a

full-time employee of that hospital for many years, about 25 years. I have headed the orthopedic service at the Creighton University Hospital here in Omaha, and I continue to hold privileges at Creighton.

Q. Okay. And are you board certified in that field?

A. Yes, I am. I'm certified by the American Board of Orthopedic Surgery.

Q. What does that mean, to be "board certified"?

A. It means that you've met the educational and training requirements as we just discussed. You've successfully mastered the fund of knowledge necessary to practice orthopedic surgery and have passed a written test for that. And then finally, you've demonstrated your abilities in the practice of orthopedic surgery, both by a review of your practice and by an oral examination of, um -- of that practice. If you meet all those things, you are granted certification by the American Board of Orthopedic Surgery.

Q. And I take it over the past -- over three decades of -- in your career, you've treated other patients with similar back conditions as Mr. Bliss?

A. That is true.

Q. And have you performed back surgeries on those types of patients?

A. In a very limited fashion.

My practice of orthopedics does not include routine discectomies or spinal fusions, but on the occasion when tumors have affected the spine, then I've worked with spine surgeons, either orthopedists or neurosurgeons, to do that type of surgery.

Q. Okay. And in the field of orthopedics, do you have to do continuing medical education courses to keep up with the certification in the field?

A. Yes.

Q. Okay. And do you regularly do that type of continuing education and attend conferences in the field?

A. Yes. Actually, the orthopedic community has developed a -- a whole range of opportunities for that, and I participate for a number of reasons, including the fact that in the state of Nebraska, we must demonstrate some level of continuing medical education to maintain our license.

Q. Okay. Doctor, at my request, did you perform a medical records review, as well as a -- an

examination of Mr. David Bliss?
A. Yes, I did.
Q. And, um, have you done this type of review before?
A. Yes, I have.
Q. Is it possible to estimate how many times, either per year or a period of time, that you perform this kind of medical/legal consultation?
A. Um, specific to a case like yours, it would be a handful of times per year. For many years, I -- I've done, um, similar work, perhaps 30 or 40 or 50 patients evaluated per year.
Q. Okay. And when you did this review, what materials did you review in helping you to formulate your opinions and conclusions in this matter?
A. Can I --
Q. Sure.
A. You or your office was good enough to send me this box of records. I haven't weighed it, but it's this box of records (indicating).
Q. Okay. And are those the medical records for Mr. Bliss?
A. Yes, they are.
Q. Both the medical records that exist after the February 2011 reported work-related injury, as

well as -- that predate that?
A. Yes, I believe that's true. I'd have to look -- on the predated ones, I'd have to look through. But yes, there's a complete set of records there.
Q. And you also had a chance to do a physical examination upon Mr. Bliss?
A. That is correct.
Q. And do you remember the date of that?
A. I saw Mr. Bliss on the 31st of May, 2012.
Q. All right. And is a review of these types of documents and -- as well as a physical examination of the patient, is that the type of information and documentation that you and other physicians and orthopedic surgeons typically rely upon to assist them in formulating opinions and conclusions as to the cause of a current medical condition of a person?
A. Yes.
Q. Okay. And, in fact, did you rely upon these medical records in your own review -- examination of Mr. Bliss in formulating your own opinions and conclusions in this matter?
A. Yes, I did.
Q. Before we get to those, what findings --

pertinent findings did you gather from your review of the medical records of Mr. Bliss's orthopedic history?
A. Well, in my report to you, I attached from that box of records a small collection of medical records that I found to be most pertinent to the case of Mr. Bliss. I can list those, if you'd like me to.
Q. If you could, yeah.
A. I hope to do this in the correct order.
So the first would be an office note, a note of the evaluation by Anthony Cox, PA-Certified, dated 4 February 2011, in reference to David Bliss.
So this would have been his office evaluation the day -- the day after the injury.
Q. Okay.
A. So that would be the first one.
Then there is a report of -- of MR imaging of Mr. David Bliss's lumbar spine, and the MR images were obtained on the 18th of March, 2011, so about six weeks later.
And the next is the -- the report of the operation -- the operative report of -- of surgery performed by Daniel Noble for the patient David Bliss, and that's dated 6 April 2011.

And then -- and then there -- and then there's a set of records for further evaluation of Mr. Bliss, and these records are authored by Keith Lodhia, L-O-D-H-I-A, M.D., of Midwest Neurosurgery and Spine Specialists, 8 June 2011, to September 2011, and 7 November 2011.
And then finally again attached to my report for you is a report of Mr. Bliss's operation by Daniel Noble, a lumbar spine operation, from the 6th of May, 2010, so prior to his injury.
And a report from the Lincoln Physical Therapy Associates date 3 October 2008 in the form of a letter to Dr. David Clare, C-L-A-R-E.
And finally the report of Mr. Bliss from the Spine and Pain Center of Nebraska from 21 December 2011. And this is authored by Dr. Liane Donovan.
Q. Thank you, Doctor.
Before we move on, maybe if we could define a few medical terms that might be helpful before we move on.
Doctor, what does the term radiculopathy mean?
A. In medical terms, it -- it refers to the way pain travels or radiates out through an

extremity.

So as an example, if one has a herniated disc in their low back, that disc may push against the -- a nerve root as it leaves the spine, and that nerve travels entirely down the extremity. Low back, it travels down the lower extremity, of course. And from neck, it travels through the upper extremity.

So we make reference to a radiculopathy, we're really referring to pain radiating out or traveling out through the length of an extremity.

Q. Okay. And what difference is there, if any, between the term disc extrusion and herniated disc?

A. Probably no -- no difference.

A disc extrusion may be a little bit more dramatic thing, that the disc -- a portion of the disc was actually squirted out. But -- but I think for purposes of this discussion, a herniation or extrusion of the disc would be the same.

Q. All right. And the medical procedure discectomy, what's that?

A. It's an operation, a form of surgery, and the goal is to remove the herniated or extruded portion of the disc and, therefore, take pressure

off the nerve root where it's being pinched.

Q. And another medical procedure, rhizotomy -- a fiset rhizotomy?

A. Yes.

Q. What's that?

A. Hard to know.

The spine -- we commonly think of the spine as a series of blocks; and, in fact, it is a series of blocks, separated in each way between a cushioning disc.

But, in fact, if we reach to -- any of us -- and feel our spine, feel our back, we're not feeling those blocks, but we're feeling the roof, um, of the spine that protects the spinal cord and the nerve roots. And there are joints back there to allow the spine to move and move.

And people are -- certainly a potential cause of back pain is wearing out those joints, much like an arthritis or something. And so one can destroy the nerves that supply those little joints and perhaps no pain would come from there. And that -- the procedure to destroy the nerves surrounding these little joints where the back of the spine hooks together is known as a rhizotomy.

Q. Okay. And then how is it that a

discectomy helps patients that have a disc extrusion?

A. Yeah. Well, it's simply by taking the pressure off the nerve root. So if you were to think about -- if my arm was to be the nerve root -- obviously much bigger than a true nerve root -- and a disc was pushing against it, any of us could stand that for a while, but after some length of time, we'd want the disc to be removed. So it's to take pressure off the nerve root or to remove the offending cause of the pinched nerve root.

Q. And, um, how is it that a fiset rhizotomy is used after a micro discectomy for patients that still have pain?

A. Well, I think the key phrase there in your question -- who still have pain.

So if a patient -- if a patient has undergone surgery to remove a herniated disc, and hopefully the pain that is radiating through their extremity, hopefully that's gone, but if they still have back pain, then a rhizotomy would be a reasonable attempt to relieve that part of the condition.

Q. Okay. And another term, what's a spinal cord stimulator?

A. Um, the -- it's an implantable device that discharges a -- small electric shocks, and I think the best way to probably think about is to perhaps confuse or -- confuse the brain or the pain receptors, and -- if you were to tap-tap-tap-tap-tap-tap-tap for- -- forever on something, maybe finally you just kind of wear out its ability to recognize pain. So it's a device, again, hope to relieve pain.

Q. All right. And then finally the last term that you use in your report is "failed back syndrome."

A. Yes.

Q. What is meant by that term?

A. It's kind of a catch-all I suppose, but Mr. Bliss here is a patient who's had -- I think at least three operations on his spine, and a number of other procedures. And despite everyone's best attempts, and despite appropriate indications for surgery, and despite time and everything else, the fact of the matter is he remains, um -- he continues to suffer back pain.

And so if you've kind of used up all of your reasonable choices and you still have pain, you gather that all together into one phrase, "failed

back syndrome."
Q. Okay. You were able to have a physical examination of Mr. Bliss; is that right?
A. Yes, I did.
Q. What were your findings on your physical examination?
A. I report those findings on the first paragraph of Page 3 of my letter to you, and for completeness sake, my letter's dated 31 May 2012.
I will read this short paragraph.
(Reading):
On exam, I noted a pleasant, healthy appearing male who moved about the office in a satisfactory fashion. The first step or two after arising from a seated position in our waiting room chair caused pain. He then ambulates for short distances in a normal fashion. Mr. Bliss was able to partially disrobe for the exam without difficulty. Visual examination of his lumbosacral spine is remarkable for healed surgical incisions consistent with his history. I noted a pain free, passive, full range of motion of both hips and knees. Mr. Bliss has bilateral pes planovalgus (flatfeet) deformities. The deep tendon reflexes were measured at the knee jerk and ankle jerk level.

On the right lower extremity, the reflexes were noted to be 2+/4 with provocation. On the left lower extremity, the reflexes were absent and could not be elicited, even with provocation. The function of the extensor hallucis longus muscle and tendon to each great toe is intact, brisk, and strong. His distal pulses at the posterior tibialis and dorsalis pedis levels are easily palpable bilaterally.
And then I add that Mr. Bliss is a nonsmoker.
Q. And then the following paragraph, you summarize some of your opinions in this matter; is that right?
A. Yes, I do.
Q. And is that based upon both the review of the medical records and documents that you had in this case, as well as your examination of Mr. Bliss?
A. And the history that I took from Mr. Bliss on that day. So that -- the records, the patient's history, and my physical examination, yeah.
Q. And what was that history that he provided to you on that day?
A. If we go back to Page 1, the second paragraph -- and I will again read.

(Reading):
Mr. David R. Bliss is a now 56-year-old male who has been an employee of the BNSF Railroad for the past 22 years. Mr. Bliss reports the onset of low back pain with radicular symptoms (especially through the left lower extremity) while on the job on 3 February 2011. Mr. Bliss was repairing the dented wall and bent door frame of a boxcar at that time. The project required the use of a hydraulic ram that, once maneuvered into place, can be used to jack the walls apart. This returns the frame of the door and wall of the boxcar to the original position. I reviewed photos of the device and how it works. The ram is estimated to weigh at least 150 pounds. Mr. Bliss reports that at the moment of the onset of the pain, he was not actually lifting any objects. Simply as he stood up, something popped in his low back. And the episode occurred following a two- or three-hour period of repeatedly maneuvering the ram into place and using that ram to repair the boxcar.
Q. And in the course of medical treatment that Mr. Bliss received after this incident on February 3rd, 2011, could you summarize that for the Ladies and Gentlemen of the Jury.

A. Yes. And this makes reference to the pertinent medical records that we already reviewed. But to summarize it, because of the severity of the symptoms, Mr. Bliss reported the event to his superiors at BNSF that day. He then sought evaluation on 4 February 2011 by Anthony Cox, PA-C. MR imaging of the lumbar spine was completed on 18 March 2011. Mr. Bliss underwent lumbar spine surgery on 6 April 2011. Unfortunately, his post-operative report has been unsatisfactory. He has been unable to return to work. Fasit rhizotomies were performed by James Devney, D.O., in October of 2011.
Q. Did you also gather from your review of the records, as well as your discussions with Mr. Bliss, his previous surgical history, previous to February 3rd, 2011?
A. Yes, I did.
Q. Could you summarize that for the jury as well?
A. I can do so in an expert fashion.
The next paragraph of my letter, Mr. Bliss's past surgical history is significant. He initially underwent a lumbar discectomy in 2003. He then underwent a lumber discectomy (at a more

proximal level) on 6 May 2010. Following that procedure, he was in an off-work status for approximately four months. He reports that he successfully returned to work in October of 2010. Mr. Bliss did well and apparently was working without restrictions until the morning of three -- until the morning of 3 February 2011. As noted above, he has not worked since that time.

Q. What -- what's your understanding of the surgery that Mr. Bliss had on the 6th of May, 2010?

A. As I understand the history from the records sent by Mr. Bliss's report, I state that as noted -- or excuse me. Strike --

I put down that the 6 May 2010 surgery was not the result of an injury at work. Rather, Mr. Bliss's back went out while lifting a bucket of water for his dog.

Q. And what type of surgery was that performed by Dr. Noble?

A. That was a lumbar discectomy, and we have a copy of the operative report from that date in these records.

Q. Okay. And what was the procedure after the work-related injury of February 3rd, 2011, that -- the surgical procedure that Dr. Noble

performed on Mr. Bliss on April 6, 2011?

A. I'll read from the operative report of that date, 6 April 2011.

The operation is listed as a left L3-4 micro discectomy, re-exploration. And No. 2, use of an operative microscope.

And the reason that it's listed as a re-exploration is because the 6 May 2010 discectomy had been at the same level, the left side of the Lumbar 3-Lumbar 4 disc.

Q. Okay. And what does it mean to be a recurrent left L3-4 disc extrusion?

A. Well, what it means is that Dr. Noble believes -- and certainly the history suggests that -- that the first time that the L3-4 disc extruded or pinched out against the nerve and the extruded portion -- the offending portion was removed and the patient got better, but now an additional extrusion, more of the disc has come out of the space and is pinching the nerve. You know, when we do a discectomy, we perhaps take -- most half of the disc out, which leaves people at some risk for recurrence or -- and Dr. Noble's listing here suggests that he believes that there was a -- a recurrence of that disc extrusion at that level.

And for that reason, required additional discectomy through a re-exploration of that same level.

Q. And when you say, "that level," could you indicate where on a person's spine is this -- the re-excrusion -- re-extrusion of the disc?

A. Sure.

So all of us -- or most of us, almost all of us, have 12 thoracic vertebrae or the blocks, and those are the vertebrae that our ribs are hooked to. And then almost all of us have five low back or lumbar vertebrae or blocks. And then finally we have the sacrum or the tailbone. So at the 3-4 disc, it would be halfway down the lumbar spine.

Q. And then on your examination -- I think it was continued on Page 3 of your report -- did Mr. Bliss present to you with any symptoms on that particular day?

A. Yes. If we go to the --

Q. Page 2, maybe?

A. Yeah. If we go to the bottom paragraph of Page 2 of my 31 May 2012 report.

(Reading):

At the time of my evaluation, Mr. David R. Bliss reported constant left lower extremity pain that radiates to his heel and is associated with

numbness over the lateral aspect of his left foot.

Q. And his current treatment at that time was what?

A. He was in a pain management program directed by -- by Dr. Donovan.

Q. And did he indicate what activities, if any, increased his level of pain?

A. He reports that he is relatively comfortable while seated or lying down. He has learned to stand and to bend in a slow and careful fashion. Prolonged standing and walking caused his lower extremity symptoms to increase.

Q. Okay. And Doctor, based upon your review of the medical records, and also your physical examination of Mr. Bliss, did you have an opinion, to a reasonable degree of orthopedic certainty, what the cause of the constant left lower extremity pain that radiated into Mr. Bliss's heel and associated numbness over the lateral aspect of his left foot, what that was caused from?

MR. SATTLER: I'll object to the form of the question as it relates to a history provided by the patient and not his physical exam. **Overruled**

BY MR. MCMAHON:

Q. Just based upon your physical exam and the

review of the records in this case, and background and training as an orthopedic surgeon, do you have an opinion as to what was causing the lower extremity radiating pain in Mr. Bliss as reported?

A. Yes, I do.

Q. And what is that?

A. I think I best tried to provide that by the statement that I would characterize his current status as a failed back syndrome. And certainly his reports of pain radiating to the heel of his foot and my findings suggest that there's ongoing irritation or pinching of some or one of the nerve roots exiting the lumbar sacral spine.

Q. Okay. And based upon your physical exam, your review of the records, as well as your examination of Mr. Bliss, did you formulate an opinion, to a reasonable degree of orthopedic certainty, whether Mr. Bliss had reached a point of maximum medical improvement as of May 31st, 2012?

A. Yes, I did. And I believe that Mr. Bliss had reached a point of maximum medical improvement effective the date of my examination, 31 May 2012.

Q. And based upon that opinion, did you formulate any restriction -- medical restrictions that you believe were appropriate for Mr. Bliss?

MR. SATTLER: Well, I'll object to the form of the question. Also, it goes beyond the disclosure made by the May 31, 2012, report. There is no such opinion or testimony.

MR. MCMAHON: Very good. I'll withdraw that, Mr. Sattler, and I'll rephrase it.

MR. SATTLER: I should have looked at your face, Doctor.

THE WITNESS: Oh, boy, they got me now. That's off...

MR. MCMAHON: I'll rephrase it.

BY MR. MCMAHON:

Q. Doctor, based upon your opinion that Mr. Bliss had reached maximum medical improvement, effective May 31, 2012, did you come to any opinion whether Mr. Bliss had reached any -- whether permanent or -- or impairment level of function, based upon your review of the records, your examination of Mr. Bliss, and your education and training and experience in orthopedic surgery?

MR. SATTLER: Hang on a second, Doctor.

I'll object to the form of the question.

If the question is did you rate him under the AMA guides to the evaluation of permanent

impairment, do you have an opinion in that regard, I don't have an objection to that. If that's what the doctor is going to address, that's fine.

MR. MCMAHON: Okay.

BY MR. MCMAHON:

Q. Doctor, I'll withdraw that previous question. Okay, Tom?

Doctor, did you rate Mr. Bliss based upon your review of the medical records, your examination of Mr. Bliss, as of May 31st, 2012?

A. Yes, I did.

Q. And what does that mean, first of all?

A. Um, well, based on everything that we've been discussing, and in these situations, the physician is asked to provide a rating of a permanent partial impairment of function. And to assist us in that task, the AMA has provided a text -- a large text that is named the AMA Guides to the Evaluation of Permanent Impairment.

At this time, I used the Fifth Edition of that textbook.

And in Table 15-3 of that text, the table provides criteria for rating impairment due to lumbar spine injury. And I am of the opinion that Mr. Bliss and his condition is best described in the

DRE lumbar category III. And for that reason, I would apply a 12 percent impairment of the whole person.

Q. And that phrase, "12 percent impairment of the whole person," it -- is it possible for you to translate that from orthopedic terminology to maybe what us laypeople might understand?

A. Well, I guess -- I hope this is appropriate, but I -- I often point out to patients that this is not a -- some sort of rating of disability.

If -- and I use myself as an example. I happen to be a surgeon, so if I were to for some reason suffer an amputation of my foot or lower leg, I could be rated, according to a table in the guides.

In fact, it would really not disable me in any way according to my profession. Other people, it would be more disabling.

So really I guess what this means is that 12 percent of all the things that we think a regular person like Mr. Bliss can do, he can no longer do. So he's lost -- or he's suffered a significant impairment of the normal function that we would expect of a 56-year-old man.

Q. All right. And then based upon that, did you come to any conclusions of whether Mr. Bliss could return to his prior position with the railroad as railroad carman?

MR. SATTLER: I'll object to the form of the question as no proper and sufficient foundation.

Overruled

BY MR. MCMAHON:

Q. Okay.

A. At the completion of -- at the completion of my letter, I offer the opinion, finally, I find it unlikely that Mr. Bliss can or will return to the duties required of his previous position at the BNSF Railroad.

MR. SATTLER: And again, I'll move to strike: Without sufficient foundation.

Overruled

BY MR. MCMAHON:

Q. Okay. And Doctor, what's the basis for your opinion regarding that he will not return to his previous position with the railroad?

A. Um, he -- it's my understanding that he did hard physical labor, such as jacking apart railroad cars to repair them. And his combination of clinical problems, as I've said, summarized as a failed back syndrome, make it particularly painful

for him to do heavy labor.

Q. All right. And lastly, Doctor, do you have an opinion, to a reasonable degree of medical certainty, as to whether the reported February 3rd, 2011, work incident was a cause in whole or in part to the -- to the injury to Mr. Bliss's spine and the subsequent medical treatment?

A. Yes, I do.

Q. And the basis for that opinion?

A. My -- the -- all the things that we've covered in this letter.

Q. Okay. And I guess I should close the loop there.

So you believe it was connected, to a reasonable degree of medical certainty, to the February 3rd, 2011, work injury?

A. Yes.

MR. SATTLER: Hang on a second Doctor.

I'll object: No proper, sufficient foundation. Also object to the form of the question.

Overruled

BY MR. MCMAHON:

Q. Okay.

A. I believe that the 3 February 2011 injury

is the cause of the treatment and outcome as we've described -- or reported in my letter.

Q. Okay. And the basis for that, again? Sorry.

A. The patient's history, my review of his medical records, and my findings at physical examination.

MR. SATTLER: Same objection. Move to strike.

Overruled

MR. MCMAHON: Thank you, Doctor. That's all.

CROSS-EXAMINATION

BY MR. SATTLER:

Q. Now, Dr. McGuire, you saw the patient, Mr. Bliss, at the request of his lawyer; is that right?

A. That is true.

Q. It was not a referral for another health-care provider?

A. That is correct.

Q. And it was not intended for purposes of examining Mr. Bliss as a patient for treatment?

A. That is correct.

Q. And in other words, this was a specific arrangement made so that you could offer opinions,

not unlike those that have just been provided by you in direct examination?

A. That is correct.

Q. Now, did this examination occur at your office, then?

A. Yes, it did.

Q. In Columbus?

A. Yes.

Q. Correct.

And this would have been on May 31st of 2012?

A. Correct.

Q. This would have been roughly 16 months after the incident alleged to have occurred on February 3rd of 2011, right?

A. Correct.

Q. In terms of the actual time that you would have spent with Mr. Bliss, how much time would that have taken?

A. With Mr. Bliss, about 30 minutes.

Q. In terms of the physical exam of Mr. Bliss, how much time was spent in the physical exam part? I'm talking about the clinical exam where you've got him in the room and you're looking at him.

A. Well, we were in a room -- the two of us in an exam room for those 30 minutes. The actual touching, checking, doing reflexes would be 5 or 7 or 8 minutes of that.

Q. And in terms of the records review in preparing your report, approximately how much time was involved there?

A. Um, probably 3 hours.

Q. Have you billed counsel for plaintiff in this case yet?

A. Yes, I have.

Q. And what amount was that?

A. Today, there's a bill for $1800 for this deposition. I'm sure there was a bill on -- for the May 31st, but I must admit I don't know what it is.

Q. All right. Now, was this done through the auspices of the hospital, or is this a business that's handled on the side or...

A. This is a side business.

Q. All right. And you had not seen the plaintiff, Mr. Bliss, before this visit on May 31st?

A. Correct.

Q. And you haven't seen him since?

A. Correct.

Q. And the only information that you would

have had regarding his past medical history or any history after you saw him would have been provided by his lawyer?

A. Yes. The box of records, yes.

Q. Right. I mean, you haven't consulted with any of his treating physicians, you haven't -- in other words, not being a health-care provider for Mr. Bliss, you're not in the loop discussing treatment plans or anything like that?

A. That is correct, I am not.

Q. Now, you refer in your report to your physical examination as a neuro-musculoskeletal exam focused on his lumbar spine and his lower extremities; is that right?

A. That is right.

Q. In terms of the interview that you had with Mr. Bliss, I take it that you're -- the only basis that you had as reflected in your report in terms of the -- his background with the railroad or the circumstances of the incident on February of 2011 would have been based solely on that information provided to you by Mr. Bliss?

A. Correct.

I suppose I should add the caveat, and I have the medical records, but Mr. Bliss re- -- that

reported to me.

Q. Right.

I noticed also, Doctor, we obtained copies of everything that was provided to you through a request to counsel for Mr. Bliss, and in the materials were included a number of photographs. Do you recall seeing photographs like this in the materials that you would have received?

A. Yes, I do recall.

(Exhibit No. 82
marked for identification.)

BY MR. SATTLER:

Q. For the record, I've asked, and the court reporter has marked as Exhibit 82, a series of four photographs. Also for the record these are Bates marked DID000759, -760, -761 and -762.

Doctor, if you could take a look at those photographs.

With respect to those four photos in Exhibit 82, do those look like the photos that were provided to you by counsel?

A. Yes, they're the same.

Q. Okay. I note in your report you said, "I reviewed photos of the device and how it works."

You were talking about this hydraulic ram?

A. Exactly.

Q. What you left off in your testimony, which appears in your report, is that it is maneuvered into place. And I want to make sure that you recognize that -- or accept that the photos here in Exhibit 82 -- was it your understanding that this was how it was maneuvered by Mr. Bliss at the time of the accident?

A. Yes.

Q. Okay. And you've had a chance to look at those? All right.

So these four photographs showing him leaning over, grabbing the device and maneuvering it, you understood that that was taking place on the date of the incident?

A. Correct.

Q. And that formed, at least in part, the basis for your opinions here today?

A. Yes.

Q. Now, interestingly, you note in your report that the episode occurred when he simply, as he stood up, something popped in his low back. Do you recall putting that in your report?

A. Yes, that's what he reported to me.

Q. Right. And for those of us who are not

physics majors, I'm going to use a term, but I'd like you to explain it to the jury. One can load the spine --

A. Correct.

Q. -- by lifting heavy objects or maneuvering heavy objects, et cetera.

Can you explain what the difference is between just standing up versus moving with some type of a heavy object in terms of loading of the spine?

A. Yeah. I'm not sure that I can.

Q. Okay.

A. But this -- the spine, as I have been demonstrating, is a series of bony blocks separated by cushions or -- that we call discs. And certainly going from a bent-over position to standing back up changes forces across the spine.

And as a physician, of course, I'm -- I start with what the patient tells me, and he says -- he reports, simply, as he stood up, something popped in his low back, which is -- it was actually not an unusual report.

Q. There are reports of people who just bend over to pick up the newspaper --

A. Exactly.

Q. -- and will have a disc problem, right?

A. Right. Or sneeze.

Q. Actually, if you look back at Dr. Noble's operative report -- or the reports around the time that he had the first discectomy, this is the one back in 2010, I think it's in May of 2010, you report the patient telling you that he was picking up a bucket of water for his dog.

You'll note in Noble's report, he got a history of just bending over to pick up a sock; do you remember that?

A. I didn't discover that.

Q. Okay.

A. Perhaps Dr. Noble was confused.

Q. Well, either that or the history has changed, right?

A. Yeah, or I'm -- or my report's confused. I'd be happy to look at that, if I can...

Q. Do you have the operative report from the May incident -- or the May surgery, I should say?

A. Yes, I do.

Q. Okay.

A. I have it.

Q. I've got one from -- and for the record, this is Bates marked NSC00020. This is from Noble's

spine center.

He says, "He bent over to pick up a socks -- a sock, when he felt a pop and felt a sharp stabbing in the left side of his low back and into his buttocks."

A. So that's different than what I learned.

Q. Right.

What I'm more interested in, rather than the disparity in the history, is the fact that events to the spine can occur as a result of just fairly minimal movement of the body; isn't that correct?

A. That's true.

Q. Now, I want to talk a little bit about your referral to this situation as a "failed back syndrome."

Now, this failed back syndrome is terminology that's used in your field. It's a term of art used in your field, is it not?

A. That's true.

Q. And it refers to chronic pain experienced after unsuccessful surgery for back pain; isn't that how it's typically defined?

A. That's very good, yes.

Q. Now, surgery for back pain is conducted

when there is an identifiable source of the pain, and I think you actually used language in your direct examination that the best attempts at fixing the problem through surgery were made and that there were appropriate indications for the surgery when the surgeries occurred. I think that's the language you used.

A. Correct.

Q. But back pain can also have a number of causes, and accurate identification of a source of pain is complicated. And I notice when you also gave your testimony about the failed back syndrome, I think you used the term he had "ongoing irritation over one or more of the nerve roots of the spine." I think that's the language you used.

A. Yeah. I think I -- toward the end -- counsel asked me why -- what was the source of -- of his continued complaints of pain, and based on Mr. Bliss's description of his pain and my findings at the time of my physical exam, it would suggest that he has ongoing problems or something causing pinched nerves.

Q. Right. And you're using the term plural, "nerves."

You're talking about -- he's got a -- when

we talk about a failed back syndrome, the real issue is trying to figure out where the pain source is, right?

A. That's true.

Q. And the difficulty is that when you try all these surgical approaches, you do the best you can, based upon the diagnostic tools that you typically would use, like MRIs, discography, whatever it might be, to isolate an area that may be the pain generator?

A. That's correct.

Q. But when you're in a failed back syndrome situation, what you have is a number of different levels that are deteriorating over time -- and by the way, this gentleman has degenerative disc disease; does he not?

A. That's correct.

Q. That's a progressive disease that's been ongoing for many years?

A. It can be a progressive disease.

Q. Have you compared his MRI studies from the 2010 time frame to the more recent ones?

A. I have not seen those.

Q. And then, of course, the symptoms that we're talking about, when we talk about complaints

of pain, that's a subjective symptom, right?

A. That is correct.

Q. And while we have these diagnostic tools to try to find out objectively where the pain generator is, it doesn't always work out that way?

A. That is true.

Q. Okay. Now, causes of failed back syndrome, um, that can be the original cause of pain, in terms of recurrence, it can even be complications that occur during surgery; isn't that true?

A. Correct.

Q. And when the surgery occurs, a nerve root causing the pain can be inadequately decompressed, right?

A. Correct.

Q. Joints or nerves may become irritated actually during the surgical procedure itself?

A. Correct.

Q. Scar tissue can form and cause recurring pain?

A. Correct.

Q. And also inadequate or incomplete rehabilitation or physical therapy, especially in patients whose back muscles are deconditioned, can

cause chronic pain?

A. Correct.

Q. Now, there was a point at which during direct examination you were reading from your report, and I'm assuming that was just the -- to refresh your memory as to your exam and your analysis.

But, um, this testimony that you gave about Mr. Bliss having pain radiating into his heel and associated with numbness over the lateral aspect of his foot, that was by his report to you?

A. Correct.

Q. Now, on your examination -- and again, I take it that this examination that you conducted, Dr. McGuire, is in the context of doing what you were asked to do, which was essentially put together an impairment rating for this guy?

A. Correct.

Q. Now, you understand we're not in a workers' compensation setting?

A. Correct.

Q. You also understand, and I think you actually testified, that when we talk about impairment, we're not -- that doesn't equate with disability under the AMA guides; that's a distinct

issue?

A. That is correct.

Q. Now, I want to talk a little bit about the approach that a physician in your position would take. Doing a rating under the AMA guides, and the type of physical examination that you would undertake -- and as a matter of fact, the AMA guides actually list and identify the type of physical examination for lumbar spine rating under the guides.

A. Correct.

Q. They talk about a standing position examination for posture, palpation, gait, range of motion, muscle strength screening. They talk about a sitting position, with neurological and nerve tension testing. These are all kind of a guideline under the AMA guides for how you do the lumbar exam, right?

A. Correct.

Q. Now, in looking at the -- at your report, you did a physical -- or excuse me, a visual examination of the lumbar spine, correct?

A. Correct.

Q. There's no mention here in terms of these various positions that one might have a patient

in --
A. Well, I --
Q. -- like, recumbent supine, recumbent prone, sitting position, or the exam's in a standing position?
A. I guess I could fill that in for you.
Q. Well, but it's not reported here is the point.
A. I can tell you that he was standing during the visual examination of the lumbosacral spine.
Q. All right. And there's no mention of posture in your report?
A. Well, that's not true.
On the first sentence of my paragraph of the report, I note that he moved about the office in a satisfactory fashion, and that -- that reflects his posture.
Q. Okay. There's no negative note regarding his posture?
A. Correct.
Q. In other words, there's no issue of lordosis, kyphosis, nothing like that?
A. Correct.
Q. So his posture was normal?
A. Correct.

Q. All right. Now, in terms of palpation of the spine, no mention of that?
A. Correct.
Q. Now, you didn't check for muscle spasm, guarding?
A. No.
Q. But if he had normal posture, that would tend to suggest that he didn't have muscle spasm or guarding?
A. Correct.
Q. Now, what is the significance of that in terms of the Ladies and Gentlemen of the Jury, the fact that there isn't a change in the posture caused by muscle spasm or guarding?
A. Well, you note that at the beginning, in my opening paragraph, I state that I performed a neuro-musculoskeletal exam, and you are making reference at this moment to muscle function -- or muscle findings.
Q. Well, but that's only because we're looking at the AMA guides as to how you do the impairment rating for the lumbar spine.
A. Right. And I'm not suggesting that there are any muscle problems.
Q. Okay. But what I to make sure is is --

let me ask you a different way.
Did you follow the AMA guides in terms of your physical examination?
A. I used a combination of my training, experience, and the Table 15-3 in the -- in the guides.
Q. Well, the Table 15-3 is just punching up the numbers. It's not the physical exam recommendations made by the AMA?
A. No. I do my physical exam.
Q. So you didn't follow those recommended?
A. Well, actually I did, but perhaps not the way you hoped I had.
Q. Okay. But in terms of posture, in terms of gait, range of motion, and whatever muscle strength screening that you did, there was nothing out of the ordinary?
A. Correct.
Q. All right.
VIDEOGRAPHER: Counsel, we are off the record.
The time is 1:39 p.m.
(1:39 p.m. - Recess taken.)

(At 1:42 p.m., with parties present as before, the following proceedings were had, to-wit:)
VIDEOGRAPHER: Please stand by.
Counsel, we are back on the record.
The time is 1:42 p.m.
BY MR. SATTLER:
Q. Doctor, when we broke, we were going over your physical examination of the plaintiff, Mr. Bliss, and I was going through the AMA guides in terms of the physical exam for the lumbar spine. We had just talked a little bit about this muscle issue.
Did you do any measurements of his lower extremities to determine if there was any atrophy of his lower extremity?
A. No, I did not.
Q. You didn't find any objective signs of loss of motor function or loss of innervation to the muscles?
A. No, I did not.
Q. Are you aware of whether or not at any time anyone has done any electromyographic diagnostic studies on this radiculopathy that has been discussed here today?

A. Not by memory. I guess I could not guarantee that there is or is not a report in that box.
Q. You didn't rely on any EMG studies --
A. No.
Q. -- or any other electrodiagnostic studies to come up with some objective evidence of the basis for the radiculopathy complaints?
A. No, I did not.
Q. Let's talk about this pain-free passive full range of motion of both hips and knees.
Could you describe for the jury what passive range of motion is, and what you're really looking at in terms of range of motion as it relates to the hips and knees?
A. Yes. So in this part of the exam, the patient is seated on an examining table. And, um, if -- we're trying to learn or rule out another cause for pain through the extremity. And certainly an arthritic hip and/or arthritic knee can cause radicular pain through the extremity.
In Mr. Bliss's part, I was able to demonstrate a full range of motion. And by passive, it means that the examiner is moving the joint rather than the -- in an active sense, the patient

is moving.
So to my movement of the extremity, to stimulate a range of motion, both of his hips and both of his knees, that was all done without causing any pain. Essentially, in a 56-year-old male, ruling out arthritis of the joint as a possible cause.
Q. All right. With respect to range of motion of the spine, can you test that? Can you measure it?
A. Yes, you can.
Q. Did you do that?
A. Well, I noted that he was able to partially disrobe for the exam without difficulty. That required some bending and twisting and moving, but I did not -- I did not list any direct measurements.
Q. There's actually a device called -- what is it, an inclinometer?
A. Yeah. I don't use that.
Q. And you understand the AMA guides, the difference between the approach you took for measuring impairment on the lumbar spine, there's another one where they use range of motion, right?
A. Yes.

Q. And you didn't use that methodology?
A. That is correct.
Q. Now, in terms of reflexes, you did note that reflexes were absent in the left lower extremity, and could not be elicited, even with provocation. "With provocation," we're talking about what, the little hammer, the mallet?
A. No.
Q. What are you talking about?
A. I was hoping you'd ask me.
The -- as it turns out, many of us, perhaps around this table, our reflexes would not fire even just with a tap of a hammer. But if patients are asked to grab their fingers like this (indicating), it kind of sets everything, and then the reflexes fire with a tap of a hammer.
So what I noted then in the right lower extremity, the reflexes were two-plus over four with this provocation. And by that, I mean they were normal.
On the left lower extremity, I could not elicit -- get any of the -- you know, you think of kick the leg out, excuse me, even with the -- this act of provocation.
Q. But you did note that the function of this

hallucis longus muscle and the tendon of each great toe was intact --
A. Yes.
Q. -- brisk and strong.
Now, in terms of radicular syndrome and the nerve roots, this extensor hallucis longus is related to lumbar disc level L4-5, right?
A. Correct.
Q. And that's the L5 nerve root?
A. Yes.
Q. And that was based on your -- your testing here would seem to be unimpaired?
A. Correct.
Q. Was any of your other findings on physical exam consistent with a specific -- or involvement of a specific nerve root?
A. Well, actually, yes, because the -- on the right lower -- excuse me. On the left lower exam -- left lower extremity, the absence of an ankle jerk is -- makes reference to the S1 nerve root.
Q. That's the ankle plantar flexors?
A. Correct.
And the absence of a knee jerk is more proximal, either the 3rd or 4th lumbar.
Q. So we're talking about involvement high --

relatively high in the spine and relatively low in the spine?
A. Correct.
Q. Okay.
A. Well, I suppose -- I don't know if -- I mean --
Q. Well, at 3-4 or L5, S1?
A. Yeah, of the lumbar spine.
Q. Yeah, we're just talking lumbar spine?
A. Correct.
Q. But as you mentioned, that's five different levels?
A. Correct.
Q. Now, you did mention this in your report, the fact that Mr. Bliss had preexisting lumbosacral spine degenerative disease. Can you describe for the jury what that is.
A. Well, he's a 56-year-old male, who in February of 2003, underwent surgery at the L5, S1 --
Q. It wasn't in February -- or February of 2003?
A. Correct.
Q. Okay. I'm with you.
A. At least on this op report.
Q. I'm with you.

A. All right.
So if we look at his op report from April of 2011, Dr. Noble was good enough to list as No. 4 diagnosis, "Status post right side L5-S1 micro discectomy, 2003."
So we know that for eight years prior to February of 2011, he's had an absence of at least part of the disc -- the cushioning between the fifth lumbar and first sacro segment, and that that can be connected. I don't know if it's absolutely so, but it certainly can be connected to the fact that his ankle jerk, deep tendon reflex, no longer works.
And then, as we know in 2010, he then went on -- a discectomy at the L3, L4 level. So again, he's had absence of normal cushioning effect.
And then he happens to be overweight, and he's worked for the railroad for 22 years, or whatever that means, and his spine is kind of wearing out.
Q. Okay. Also, if you're on the operative report for April 6 of 2011, I'm looking at the St. Elizabeth Regional Medical Center operative report for Dr. Noble, the surgery of --
A. Correct.
Q. Okay. I note in your -- in your report,

you say the diagnosis of a recurrent disc extrusion at the left side of the L3, L4 level was established.
Actually, Dr. Noble indicates that after the May 6, 2010, micro discectomy, he was advised to achieve more optimal body weight to decrease stress on the spine, as well as to help reduce his chance of recurrent herniation. Unfortunately, he was unable to lose any weight; and somewhat predictably, he is back as a result of recurrent herniation.
A. I see that.
Q. Okay. Is that generally consistent with the experience you've had over time?
A. Well, I know that I've not been able to lose any weight since 2010.
Q. Let's talk about your patients.
A. Well, I see. I thought perhaps you were being critical of me.
Well, you know, I mean, people -- I don't know the numbers, but obesity contributes to -- to low back problems, yeah.
Q. Now, finally, Doctor, in terms of what we're really referring to under these -- under the AMA guides, and this analysis that you undertook for the impairment rating -- by the way, before we move

off of that, I want to just tie up what I left off on the physical examination.
There was no evidence of -- of any loss of bowel or bladder with Mr. Bliss?
A. That is correct.
Q. Any function.
So we -- in terms of other sensory loss, other than his report, did you test for any sensory loss?
A. No, I did not.
Q. Now, going back to the AMA guides in terms of the impairment, this refers to a loss or decline of functional capacity as a result of a medical condition or a symptom, right?
A. Correct.
Q. Whereas a limitation is something that an individual cannot perform due to a medical condition. These limitations can be objectively measured, and tests have been devised to assess these limits of physical capacities. And I think the jury is going to hear about functional capacity evaluations. All right?
A. Okay.
Q. Now, a restriction is not what a patient cannot do it, it's what a patient should not do

because there is a substantial or immediate risk of harm to him or others, correct?
A. Correct.
Q. Now, with respect to this impairment rating that you've arrived at in this case, these guides from the AMA attempt to standardize an objective approach to evaluating medical impairments focused on perceived interference with activities of daily living.
I think you referred -- without using that terminology, I think you referred to these -- our normal activities in life?
A. Correct.
Q. Right. But again, the guide offers that just because a person may be assessed with an impairment that may interfere with these activities of daily living, there may be no corresponding diminution and ability to perform productive work?
A. Correct. In fact, I used myself as an example.
Q. As an example.
Determining whether a patient is impaired is a medical opinion, whereas whether or not someone is actually disabled is not a medical opinion?
A. That is correct.

Q. And the medical role is to determine functional limitations or medically reasonable restrictions, and not to make occupational determinations?
A. I'm sorry, say that again?
Q. The medical rule, your role --
A. Yes.
Q. -- is to determine functional limitations or medically reasonable restrictions and not to make occupational determinations?
A. That is correct.
Q. And you've not had any specific training in making occupational determinations?
A. That is correct.
Q. And the only information that you had available to you as to what he did at the BNSF Railway time -- at the BNSF Railway was his description of him maneuvering this -- this hydraulic jack, as depicted in these photographs in Exhibit 82, for a two- or three-hour period?
A. Correct.
Q. That's the only thing you know about his job?
A. I think that's fair.
Q. Okay.

MR. SATTLER: I think those are all the questions I have, Dr. McGuire. Thank you.
MR. MCMAHON: I have nothing. Thank you, Doctor.
VIDEOGRAPHER: Counsel, we are off the record.
The time is 1:56 p.m.
(1:56 p.m. - Recess taken.)

CERTIFICATE
STATE OF NEBRASKA)
) ss.
COUNTY OF DOUGLAS)
I, Gretchen Thomas, Registered Professional Reporter, General Notary Public within and for the State of Nebraska, do hereby certify that the foregoing testimony of Michael McGuire, M.D., was taken by me in shorthand and thereafter reduced to typewriting by use of Computer-Aided Transcription, and the foregoing fifty-nine (59) pages contain a full, true and correct transcription of all the testimony of said witness, to the best of my ability;
That I am not a kin or in any way associated with any of the parties to said cause of action, or their counsel, and that I am not interested in the event thereof.
IN WITNESS WHEREOF, I hereunto affix my signature and seal this 1st day of July, 2013.

GRETCHEN THOMAS, CCR, RPR, CRR
GENERAL NOTARY PUBLIC
Certified Court Reporter
Registered Professional Reporter
Certified Realtime Reporter

My Commission Expires: