IN THE UNITED STATES DISTRICT COURT FOR THE
EASTERN DISTRICT OF TENNESSEE
AT KNOXVILLE

THOMAS NEELY,
Plaintiff

V. NO. 3:05-CV-304
PHILLIP/GUYTON

FOX OF OAK RIDGE, INC.
and BENJAMIN H. CURD,
Defendants

APPEARANCES:

ROBERT J. ENGLISH,
MICHAEL C. INMAN,
Attorneys for the Plaintiff,
Thomas Neely

CLINT J. WOODFIN,
Attorney for the Defendant,
Fox of Oak Ridge, Inc. and
Benjamin H. Curd

DEPOSITION
OF
THOMAS M. KOENIG, M.D.
November 30, 2005

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EXHIBITS

The videotaped deposition of THOMAS M. KOENIG, M.D., taken by agreement of counsel, for any and all purposes allowable under the Federal Rules of Civil Procedure, before DENISE M. HOOD, Court Reporter and Notary Public in and for the State of Tennessee at Large, on the 30th day of November, 2005, at the office of the witness, 11808 Kingston Pike, Knoxville, Tennessee.

It is agreed that the reporter may swear the witness, take the deposition stenographically, and afterwards reduce the same to typewritten form when the completed deposition may be used in the above-styled cause.

The plaintiff does not waive any objections until the time of the trial. All formalities are expressly waived as to caption, certificate, transmission, and the reading and signing of the deposition by the witness.

THOMAS M. KOENIG, M.D.,
having been first duly sworn, was examined and deposed as follows:

DIRECT EXAMINATION

BY MR. ENGLISH:

Q Would you state your name for the record?

A Sure. Thomas Martin Koenig, M.D.

Q Dr. Koenig, my name is Bob English, as you know, and I'm here to ask you some questions about my client and Mr. Inman's client, Thomas Neely. And if you would throughout this deposition, testify based on reasonable medical certainty or probabilities. Will you do that for us?

A I will.

Q Okay. Dr. Koenig, where do you practice medicine?

A I practice in Knoxville, Tennessee, on Kingston Pike.

Q What's your specialty?

A Orthopedic surgery.

Q Doctor, what does that mean, what does that entail?

A It involves the study and treatment of bones, muscles, tendons, ligaments, discs and nerves.

Q Okay. And where did you take your medical training, sir?

A Most of my medical training was in Philadelphia, Pennsylvania. I went to a medical school there called Hahnemann Medical University, and then from there I did a residency for five years at Hahnemann Medical University, and then I did an optional one year in Washington, D.C. with George Schonholtz in arthroscopy.

Q Okay. Doctor, where do you do your surgeries here in Knoxville when you do surgery?

A I've got privileges at a fair number of facilities. Most of my surgery is done out west, the more major cases at Parkwest. There are a bunch of surgery centers like Parkwest Surgery Center Tower, Knoxville Surgery Center, Fort Sanders West. It may be easier to tell you where I don't have privileges, but primarily out here in the west.

Q Okay. Is that for convenience sake?

A Yes. Whenever I first came here in 1992, I didn't mind the travel so much and thus I had privileges at Children's, I'm sorry, East Tennessee Children's, U.T., Regional, and as your practice matures, you don't have the time to run around to the various different places, so it's more or less stayed out here in the west.

Q Doctor, as a matter of maturity, how long have you practiced, been licensed to practice orthopedic surgery in the state?

A In the state, since '92.

Q Okay. Are you Board certified, sir?

A Yes, sir. And recently recertified.

Q Okay. What does it mean to be Board certified, Dr. Koenig?

A When you sit for your Boards the first time, you undergo a rigorous written exam with several

hundred questions. I no longer remember, but I'm sure it's four or five hundred questions, and you have to pass those. On the assumption that you've passed those, then the Board queries you as to what you actually do as far as practice goes, and you have to simulate for them and gather all the x-rays, all the operative reports for about a six-month period of your time and they have the ability to scrutinize that. They ask you to come to Chicago and you carry a bunch of bags with x-rays and all kinds of stuff, MRI's, your operative reports, and then they grill you. You sit for about eight hours and they ask you anything and everything and hopefully you pass, and if you pass, then you are, at that time, Board certified. I think ever since 1988, if you're certified, you're certified for a limited time, ten years, then you had to re-sit for Boards again.

Q And you did so?

A Yes, sir. I think I'm good through the year 2014, if I'm not mistaken. I have a CV, if you'd like.

Q Doctor, we have a copy of your CV. Would you hand that to the doctor and see if that's the most recent CV he has, Ms. Court Reporter?

A Yes. That is correct. And I'm recertified through the 31st of December, 2014.

MR. ENGLISH: Let's make your CV Exhibit

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understand a psychiatric technician would need to potentially have to subdue potentially unruly psychiatric patients, would have to assist them in feeding, have to assist them in lifting them on occasions to beds and commodes and/or move them from one place to another for CAT scans and things of that nature.
Q Doctor, when you last saw him the 15th of November, did you give him a permanent no duty, no work status with certain impairments?
A Yes, sir.
Q Restrictions?
A Yes, sir.
Q What were those restrictions? And I'll ask you to refer back to your July 6 note, the specifics of that, sir.
A On July 6th, it was written for no repetitive bending, stooping, squatting, or lifting greater than fifteen pounds. He should be allowed frequent changes in position.
Q Are those still the restrictions that you had him on permanently at this time, sir?
A If I can, sir, allow me just a few seconds to check my notes.
Q Okay.
A No. In effort -- I should state that

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those were amended further to whereby he was placed on no duty on the 15th of November, 2005.
Q What does that mean, sir, in your opinion?
A Meaning that I really don't think he could do anything. When I saw him in the office, let's say, on the 15th of November, I saw him for forty-five minutes to an hour and during that time the man just could not sit or lay still or stand still. He was constantly having to change positions. I don't think that he would have been employable in that regard. He would have been a distraction to any workplace with as frequently as he had to move to try to keep himself in some semblance of comfort.
Q Doctor, do you have an opinion as to whether or not this man will suffer pain in the future as a result of these injuries?
A Yes, sir. I think that that unfortunately also is permanent, and that's the reason why we sent him to a pain management consultation through Dr. Browder.
Q Will he require medications to alleviate the pain of this wreck and injuries in the future?
A Most likely.
Q Have you done everything that you can

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for him at this time from an orthopedic standpoint, Doctor?
A Yes, sir.
MR. ENGLISH: I believe that's all.
CROSS EXAMINATION
BY MR. WOODFIN:
Q Dr. Koenig, my name's Clint Woodfin, and I represent Mr. Curd and Fox of Oak Ridge in this lawsuit. Mr. Curd was driving the vehicle that rear-ended Mr. Neely's vehicle. If I understood your testimony correctly about his restriction, you have changed the restriction that you had him on since July of 2004 as of 11-15-05; is that correct?
A That was correct. I just want to make sure I heard the dates correctly. He was -- we attempted to put him back to work on a limited duty basis, very limited, in July, and I responded as such to Mr. English's question. He said as of July, what was his duty status, and then on the 15th of November, 2005, he was placed on no duty.
Q And that original restriction didn't change until November 15th, 2005, correct?
A That's correct. Please understand that this gentleman has never had a Functional Capacity Evaluation, which would objectively describe exactly what this gentleman can and cannot do. When you don't have the

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benefits of that study, the physician can use his thumb and try various limited duty attempts. Sometimes he undershoots, sometimes he overshoots. It was my opinion that he could not tolerate the fifteen pounds of repetitive lifting that we attempted to get him to do in July, so I overshot the mark in July; I asked him to do too much.
Q So you think he should have been restricted from doing anything from the first time that you saw him up until the time that you last saw him here in November?
A No, sir. I think it was appropriate to try it in July. I don't think that there was an error in medical decision making. I think that I just was overly hopeful that he would be able to do that.
Q When you say he is not able to do anything, are you saying he needs to sit in a bed for a complete day and not do any activity at all?
A What I'm saying is that this gentleman probably can't even tolerate sitting in bed for eight hours. He's going to have to sit, stand. He's going to have to move his self to a recliner. He's going to have to walk, he's going to have to pace. In that regard, no to your question, simply, and similarly at the workplace do I think he could sit and just answer a phone, I don't think so. He's going to have to stand, he's going to have to

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sit, he's going to have to lie down for a short period of time. I know that I couldn't employ him in a clerical position in my office, and I certainly couldn't employ him to do any manual labor in my office.
Q Do you have any training as a vocational assessor?
A Indirect training in the fact that I have substantial -- how can we put it, in the fact that I deal with a lot of vocational reports. I discuss with vocational rehabilitation counselors various options and how they orthopedically or mechanically can be potentially adjusted or improved, so I have a fair bit of experience, but, no, sir, I'm not a vocational rehabilitation counselor.
Q Do you have any training in what jobs are available for disabled people in this area?
A I have a good general idea. Do I have the ability to know that at this particular time that one company "X" has a job that's opened, no, sir.
Q Is that general ability similar to what any of us who have an understanding as to what work involves has?
A I would think it would be similar to what any other Board certified orthopedic surgeon has in the area.

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Q No more or no less?
A No more, no less.
Q And as far as whether or not you've ever actually performed a vocational analysis on someone, I think that would be no?
A That is correct.
Q You mentioned his inability to do these activities, and I'm thinking that's primarily based on the complaints of pain that he's relating to you, correct?
A Based on the complaints of pain coupled with the objective findings on MRI, CT scan and plain films as well as a physical examination that's repetitively done.
Q There are no objective indications which would lead you to conclude that if he tried to do anything, he would hurt himself, are there?
A Not within the fifteen pounds that he was allowed to do back in July. I don't think that the fifteen pounds would hurt him. I just don't think that he was able to do the fifteen pounds.
Q And that's still the same in November of 2005, when you last saw him? There's nothing objective that you can point to that says if this man tries to do something, he's going to hurt himself?
A I think if he tried to lift more than fifteen pounds again, I think that he would fail again.

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You're correct, I don't have a Functional Capacity Evaluation, which I think you're alluding to, which is an objective test to state no, he can lift eleven pounds but he can't lift twelve pounds. There are studies that are out there that can do that.
Q His complaints of pain and the pain behaviors that he exhibits to you are, to a certain degree, subjective based on what he's revealing to you by his actions, correct?
A To a certain degree. Yes, sir.
Q And you couple that with what you see on the test and come up with your opinions?
A Yes, sir.
Q And I think you stated to Mr. English the tests by themselves don't give a complete picture; you have to tie that in with what he tells you about his condition?
A Without a doubt, history is important, as is the physical exam. They teach you in medical school you don't treat an MRI, you don't treat a chart, you treat a patient.
Q So what the patient is telling you about his condition and about what he's feeling is an import to you in giving an opinion about the causation, is it not?
A It is certainly a factor. Yes, sir.

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Q In this case, given the findings on the test which don't show any broken bones or any acute abnormalities, the history is what allows you to tie it into this accident; is that correct?
A It does show some equivocal acute abnormalities, and those are clearly labeled as equivocal.
Q In your report, you say they're equivocal because they might be related to degenerative changes, they might be related to the accident?
A Yes, sir.
Q And then you listen to the patient telling you I was not hurting before this accident, I'm hurting now, and that's how you tie it in?
A Yes, sir. That is a key factor. However, please understand despite the fact that he told me he did not hurt in regard to his neck, I tried to be fair to the patient as well as fair to your client, as fair to Mr. English, as fair to the system. I've got to meet my maker somewhere down the pike, and I try to be fair to him, too. And in short, I said to myself, you know what, I don't think that he, the patient, can accurately assess this in regard to his neck as well as I can. I know for a fact, or I should state within a reasonable degree of medical certainty, this is your field, not mine, that he probably did not have full range of motion of his neck

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given the pathology that was there before, and what I tried to do was discount what he told me appropriately and validly and do it in concordance with the A.M.A. Guides as they direct and come up with a number that hopefully does adequately represent this gentleman's impairment as he stands on that day with numbers that specifically state how much is attributed to what was preexisting and with numbers that could then be figured out as to what happened through the motor vehicle accident.
Q Speaking about his neck, and I think you mentioned it, you say as he's standing here this day --
A On the 15th of November. I apologize.
Q I understand what you're saying. The range of motion, though, can differ from day to day, can it not?
A It can.
Q And I think you're looking at your chart, and you can correct me if I'm wrong, his range of motion was actually greater on the visit previous than it was on the visit of November 15, 2005, in his neck.
A In certain areas, you're correct. In certain areas, you're incorrect. For instance, thirty degrees of rotation to the left of midline is maintained on both days. Please also understand the following: Whenever a patient is seen on days other than an impairment rating

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day, the surgeon is going to use his thumb. I'm going to sit there and say that's approximately thirty degrees worth of flexion. I'm not going to use other instruments like inclinometers and goniometers to test. Whenever I'm actually asked to tabulate, to calculate what an impairment is, I'm going to do it by the book and I'm going to sit there and say, look, let's do it with an actual measuring stick, not my thumb. That also would account for the minor differences because we're talking primarily about ten degrees plus or minus, and that would probably be either due to some slight change in the patient or the difference between my thumb and an actual ruler or what we call a goniometer or inclinometer.
Q How much degree motion does he lack in his neck?
A Well, on which day, sir?
Q Let's say on the last day.
A On the last day. All right, fine. I would be glad to do that for you. Allow me to just look at my notes. All right. On the 15th of November, the patient was able to tolerate twenty degrees of flexion. I'll try to show you what roughly twenty degrees of flexion is. I do have to tell you that I can't put an inclinometer and read it on myself, so I'm giving you a rough approximation, but in short, and I'm going to turn myself to the side so

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you can see this, this is roughly twenty degrees of flexion, this would be thirty and this would be forty and this would be fifty, fifty would be full. So in short, he's missing the terminal or the last thirty degrees of flexion. In regard to extension, this is neutral. He tolerates about twenty degrees of extension. That means he's missing thirty, forty, fifty and sixty degrees of normal extension, so he's missing that amount.
Q And in performing these tests, I think you've referenced it in your notes, you're asking the patient to move his neck, and he's doing it according to his effort as much as he can.
A He's doing it to the best of his ability. He's doing it multiple times, and the maximum amount of movement is registered.
Q And I think you put in your notes that he was making complaints to you of, "Oh, no, that's it, I can't do any more"?
A Yes, sir. And, of course, that means that you push within a certain level, and I mean I'm not here to crack a whip on the gentleman. I'm going to try to report this as accurately as possible, and you are correct in the fact that he did verbalize that he didn't want to go further than it hurt.
Q And that's a day he knows he's being

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evaluated for impairment that you're doing that obviously?
A That is correct. I do believe he knew that he was being evaluated that day.
Q His effort is not something that you can measure objectively, can you?
A A Functional Capacity Evaluation does a pretty good job of measuring that.
Q When you're asking him to move his neck up and back, there's no way you can objectively measure how much effort he's giving?
A No way that I can on that limited exam in the office. That's correct. However, again, in an effort to give you the most complete answer, a Functional Capacity Evaluation does have the ability to determine effort, validity of effort and thus also validate the score.
Q Some of the other measures of validity are history that's given to you and its consistency with other history as well as his effort and tests that you give him from an orthopedic standpoint, correct?
A Yes, sir.
Q In his first visit with you, he talked about the accident. I believe he told you that he'd broken his tailbone back in 1982; is that right?
A I do remember a reference to that.

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Q Show the jury, if you would, what we're talking about there.
A Sure. If you don't mind, I'm going to turn this around this way. This is his tailbone. I'll turn it to the side because I think that that's going to show up better for the camera. The tailbone typically is broken here at the junction of the sacrum -- I'll do it this way. Here's where your sacrum ends. This is your coccyx. Usually there's a fracture right here whereby this then tips forward and comes up this way. That's what we're talking about.
Q And you don't know how that happened?
A No, sir, nor did I really need to evaluate that. That was taken as part of his history, and that is if you will, sir, effectively an orthopedic mile away from where his other pathology is. You can't be off this much as an orthopedic surgeon and not get in trouble. So in short, this ends up -- he could have told me he fractured his great toe as well and it impacted his impairment the same way. He received neither additional nor a discount in his impairment rating because of that 1982 fracture down here.
Q If he had had some trauma which caused a jarring of his spine, would that not be important to you?
A All history would be important. Yes,

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sir.
Q And that could possibly impact the status of his discs or the level of degeneration that was present that you saw?
MR. ENGLISH: I'm going to object to possibly. Many things could possibly impact it.
Q Assuming that to be correct that he had some trauma to his tailbone, you would expect that there would be some trauma on the discs, would you not?
A Not necessarily. I think I could tell you that there would be a fair number of patients that could have a coccyx fracture and have no other spinal pathology, but you are correct in the fact that if you had enough trauma to break a bone here, it's possible to have enough trauma elsewhere to do damage elsewhere. Yes, sir.
Q Especially a man this size?
A Yes, sir.
Q Someone who's three hundred and thirty, three hundred and fifty pounds, if there was trauma sufficient to crack their tailbone, that would also have an impact on their lower lumbar spine, would it not?
A If you could use the word possible, I could say yes.
Q And you just don't know because you didn't find out one way or the other?

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A That's correct.
Q Were you shown pictures of the vehicles in this accident?
A I believe I was, and if I did, I would have referenced that. If you'll give me thirty seconds --
Q I believe you were -- okay.
A I apologize that I don't have the immediate recall to say yea or nay. I do believe I was shown pictures. However, if I was shown pictures, I do believe I would have recorded them as such. I've looked through the first two notes that I had where you would think that he would have presented them on the first or second office visit, and I don't have that recorded. So I'm sorry that my memory cannot definitively state whether or not I was shown pictures of the motor vehicle accident.
Q Okay. Back again to that first visit, he also told you that he lost consciousness at that time, did he not?
A Yes, sir.
Q You have reviewed the emergency room record either from receiving it from the attorney or from Mr. Neely himself that noted in that record that he did not lose consciousness?
A That's also correct.
Q He was reporting to you on that first

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visit that he was treating with Dr. Degnan and that he was giving complaints that, quote, "Went in one ear and out the other"?
A Yes, sir. That's his history.
Q Did you also review the report from the emergency medical technicians that saw him at the scene of the accident?
A I know that I reviewed the emergency room report per se. If you have a reference for me to --
Q Let's stick with that emergency room report. I think that's what my notes said, and I just misread it.
A Okay.
Q Again, looking at that with regard to the lack of loss of consciousness, there was also a note that there's minimal damage to his vehicle in that report as well?
A Yes. That's what I noted in the emergency room reports dated the 12th of July, 2004.
Q He then saw you ten days later on the 22nd of October of 2004, correct?
A Yes, sir.
Q You made a finding there that there was a bruise on his back that you didn't see on the first visit, if I read that correctly.

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A Yes, sir.
Q Okay. Any explanation for that?
A Sometimes it will take a little bit longer for bruising to occur, especially on a gentleman this large. If the bruising occurred at a muscle that was, let's say, an inch and a half deep, sometimes it takes awhile for the bloody pigment, the biliverdin and the hemoglobin to penetrate up to the skin. That's one possibility.
Q Three months and ten days?
A I agree with you. That's probably pushing it.
Q So there's really no explanation why that bruise is there?
A No, sir.
Q Okay. I think you had wanted to start treating him for his neck in November of 2004, and I think you explained that you did one part at a time and finally then the neck came available, but it looked like November was when you first wanted to do that?
A Yes, sir. That would be typical that we would add one body part per visit.
Q In looking at your notes, it looks like for whatever reason that day, there was a child accompanying him that was running around in the examining

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room, and you didn't get to work on his neck that day?
A Yes, sir.
Q He had had his MRI for his low back at that time, and that's when you noted he had this congenital defect in his lumbar spine?
A Yes, sir.
Q And that was there before the accident, as you've told us?
A Yes, sir.
Q Whether or not that was giving him a problem, you only know based on the history that he gave you that it was not problematic, and that's what you're basing that on?
A Yes, sir.
Q You started focusing on the neck in December of 2004, and you said you doubted there was any cervical radiculopathy present, correct?
A Yes, sir.
Q And that means there wasn't anything pressing on the nerves from what you saw on the MRI which would cause him pain and numbness in his arms?
A Yes, sir.
Q But he was making complaints of pain and numbness in his arms?
A Yes, sir. That would be what we were --

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or what the A.M.A. Guides would call nonverifiable radicular pain.
Q He says it hurts or in this case, it's numb, but you have no way to identify that by test?
A Yes, sir, or that the test that you've done don't adequately describe what he has.
Q I think you made a note there in December of 2004 that he was turning his neck to the left and having numbness in his right arm?
A Yes, sir.
Q And that that's not clinically a finding in which you could match up, is it?
A Please forgive me for not understanding the term --
Q It's probably a bad question. If a man says I'm turning my head to the left and he says that my right arm is numb, that doesn't make any sense, does it?
A There could be a whole constellation. You're correct in the fact that that's not the typical presentation. However, to state that it couldn't happen is not correct.
Q Anything could happen?
A Yes, sir.
Q But in this case, it wasn't happening on Mr. Neely?

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A I don't know that I can state that nothing was happening with Mr. Neely. What I can state was that there was no classic presentation that was happening.
Q That's the nice doctor way of saying that it just didn't make any sense.
A I'm not trying to be a nice doctor. I'm just trying to be a fair doctor. I apologize --
Q Well, that's the fair doctor way of saying it just doesn't make any sense?
A I don't believe that was a question, so I'll just let that go.
Q Would you agree with that statement?
A I have no ability to disagree with that statement.
Q When you saw him in January, it didn't seem like anything you were offering this man or telling him was helping him in any way?
A That's correct.
Q He had a positive Waddell test in January?
A Yes, sir.
Q Waddell tests are what doctors like yourself use to see if someone is giving you a symptom that they shouldn't be giving you based on a test that you're doing; is that a fair way to say that?

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A That's a fair way of saying it.
Q And that was occurring with Mr. Neely?
A Yes, sir, on the 12th of January, 2005.
Q I noticed in that record too you almost put him at maximum medical improvement at that date, if I saw that correctly.
A Yes, sir, there's a statement that says because he's not accessing the additional recommended care or doesn't have the funds to access additional care, that he may -- I believe it said -- well, I'll just quote it directly, the patient is made aware that at this time he may well have reached maximum medical improvement in regard to the above orthopedic diagnosis.
Q And you hadn't changed his restriction from fifteen pounds to no duty after July of 2005, had you?
A No, sir.
Q I think you'd actually given him a written restriction that said no lifting over fifteen pounds, if I remember correctly?
A On which date? For instance, on the 12th of October 2004?
Q That was the very first time that you saw him, correct?
A Yes, sir.
Q Correct?

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A Yes, sir.
Q Any others besides that?
A Yes, sir. There was -- give me one second. On the 2nd of November, 2004, it basically says, "Continue prior limited duty status." That's just a way of shortcutting it so you don't fill out the paperwork so much.
Q Sure.
A I apologize for the ton of paperwork that this gentleman has.
Q Take your time.
A On the 21st of February, 2005, he was placed again on continued prior limited duty with a handwritten form, I should say with a form filled out by hand. Similarly, on the 6th of June, 2005, and then on the 6th of July 2005, it was written in more detail to have no repetitive bending, stooping, squatting, an allowance for frequent changes of position, no lifting greater than fifteen pounds. Does that answer your question?
Q It does, if those are the only written restrictions that you've given him.
A And then on the 18th of November, whenever I saw -- wait, on the 18th of November apparently he may have wanted another form filled out or whatever. That was three days after I last saw him. It said continue

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the prior limited duty status as referenced to the 15th of November.
Q So are you continuing what you had always continued, or are you changing him in July of -- I mean November? I understood your testimony to be you were changing it.
A It would be based on what was last written and last noted and what was last written and last noted was on the 15th of November, 2005, that he was placed on no duty and that that was going to be continued.
Q But you didn't write a change for him where it changed from fifteen pounds with no repetitive bending, stooping, et cetera?
A On the 15th of November, 2005, you're correct in the fact that I don't have a document showing that there was a specific change that was done on that date on that form. However, I do have a document in more detail than just handwritten. I have a typewritten report that shows that it was changed.
Q So do you give this man that report and these records when he tries to go get a job?
A Typically what's done is -- well, yes and no. Both are available to him. He can have whatever he wants. What's typically done is there's a short form that's filled out by hand and then days later a typewritten

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report gets generated. Typically what happens, workplaces demand something quicker. If this had been a workmans' comp injury, they would want something that day, and we'd handwrite something. This was not a workmans' comp injury and thus the staff may have felt, look, there's no urgency to writing such a form again for him on that date that he left, because we knew in a few days that it would be produced on a typewritten record.
Q Your staff knew what you were going to say?
A Well, hold on for a second. Often they can from my handwritten notes. However, I don't know how they would be able to get that from my handwritten notes on that particular day.
Q I guess what we need to know, Doctor, is are you telling the Court and jury that there was some change from July of 2005 to November of 2005, which made you take this man off of any possible activity that he would want to engage in?
A Allow me just a moment to try to --
Q Sure.
A -- find a documented answer for that. What I have, sir, is a patient that I have tried to get back to work multiple times. I've tried to get him to be comfortable at work. I've tried to get him to be