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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1 The videotaped deposition of THOMAS M. KOENIG,
2 M.D., taken by agreement of counsel, for any and all
3 purposes allowable under the Federal Rules of Civil
4 Procedure, before DENISE M. HOOD, Court Reporter and Notary
5 Public in and for the State of Tennessee at Large, on the
6 30th day of November, 2005, at the office of the witness,
7 11808 Kingston Pike, Knoxville, Tennessee.
8 It is agreed that the reporter may swear the
9 witness, take the deposition stenographically, and
10 afterwards reduce the same to typewritten form when the
11 completed deposition may be used in the above-styled cause.
12 The plaintiff does not waive any objections until
13 the time of the trial. All formalities are expressly
14 waived as to caption, certificate, transmission, and the
15 reading and signing of the deposition by the witness.
16 THOMAS M. KOENIG, M.D.,
17 having been first duly sworn, was examined and
18 deposed as follows:
19 DIRECT EXAMINATION
20 BY MR. ENGLISH:
21 Q Would you state your name for the
22 record?
23 A Sure. Thomas Martin Koenig, M.D.
24 Q Dr. Koenig, my name is Bob English, as
25 you know, and I'm here to ask you some questions about my

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1 client and Mr. Inman's client, Thomas Neely. And if you
2 would throughout this deposition, testify based on
3 reasonable medical certainty or probabilities. Will you do
4 that for us?
5 A I will.
6 Q Okay. Dr. Koenig, where do you practice
7 medicine?
8 A I practice in Knoxville, Tennessee, on
9 Kingston Pike.
10 Q What's your specialty?
11 A Orthopedic surgery.
12 Q Doctor, what does that mean, what does
13 that entail?
14 A It involves the study and treatment of
15 bones, muscles, tendons, ligaments, discs and nerves.
16 Q Okay. And where did you take your
17 medical training, sir?
18 A Most of my medical training was in
19 Philadelphia, Pennsylvania. I went to a medical school
20 there called Hahnemann Medical University, and then from
21 there I did a residency for five years at Hahnemann Medical
22 University, and then I did an optional one year in
23 Washington, D.C. with George Schonholtz in arthroscopy.
24 Q Okay. Doctor, where do you do your
25 surgeries here in Knoxville when you do surgery?

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1 A I've got privileges at a fair number of
2 facilities. Most of my surgery is done out west, the more
3 major cases at Parkwest. There are a bunch of surgery
4 centers like Parkwest Surgery Center Tower, Knoxville
5 Surgery Center, Fort Sanders West. It may be easier to
6 tell you where I don't have privileges, but primarily out
7 here in the west.
8 Q Okay. Is that for convenience sake?
9 A Yes. Whenever I first came here in
10 1992, I didn't mind the travel so much and thus I had
11 privileges at Children's, I'm sorry, East Tennessee
12 Children's, U.T., Regional, and as your practice matures,
13 you don't have the time to run around to the various
14 different places, so it's more or less stayed out here in
15 the west.
16 Q Doctor, as a matter of maturity, how
17 long have you practiced, been licensed to practice
18 orthopedic surgery in the state?
19 A In the state, since '92.
20 Q Okay. Are you Board certified, sir?
21 A Yes, sir. And recently recertified.
22 Q Okay. What does it mean to be Board
23 certified, Dr. Koenig?
24 A When you sit for your Boards the first
25 time, you undergo a rigorous written exam with several

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1 hundred questions. I no longer remember, but I'm sure it's
2 four or five hundred questions, and you have to pass those.
3 On the assumption that you've passed those, then the Board
4 queries you as to what you actually do as far as practice
5 goes, and you have to simulate for them and gather all the
6 x-rays, all the operative reports for about a six-month
7 period of your time and they have the ability to scrutinize
8 that. They ask you to come to Chicago and you carry a
9 bunch of bags with x-rays and all kinds of stuff, MRI's,
10 your operative reports, and then they grill you. You sit
11 for about eight hours and they ask you anything and
12 everything and hopefully you pass, and if you pass, then
13 you are, at that time, Board certified. I think ever since
14 1988, if you're certified, you're certified for a limited
15 time, ten years, then you had to re-sit for Boards again.
16 Q And you did so?
17 A Yes, sir. I think I'm good through the
18 year 2014, if I'm not mistaken. I have a CV, if you'd
19 like.
20 Q Doctor, we have a copy of your CV.
21 Would you hand that to the doctor and see if that's the
22 most recent CV he has, Ms. Court Reporter?
23 A Yes. That is correct. And I'm
24 recertified through the 31st of December, 2014.
25 MR. ENGLISH: Let's make your CV Exhibit

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1 No. 1 to your deposition, sir.
2 THE WITNESS: Sure.
3 (Exhibit No. 1 was filed.)
4 Q And, Doctor, at the request of my
5 partner, Michael Inman, did you see, examine and treat
6 Thomas Neely for injuries to his neck and his back that he
7 sustained on or about the 12th day of July of 2004, sir?
8 A Yes, sir, I did.
9 Q Okay. When did you initially see him,
10 sir?
11 A I saw him on the 12th of October, 2004.
12 Q And when you saw him, Doctor, I know
13 you've got very detailed notes, and I'm not going to ask
14 you to go over all the notes verbatim, but let's talk
15 specifically about what you found in his neck and what you
16 found in his low back that you think was either caused by
17 or aggravated by the wreck that we're here about today, the
18 wreck of July the 12th of 2004.
19 A Sure. And if I give you too much of an
20 abridged version, please -- I've got more detail to back up
21 my thoughts.
22 Q I understand that.
23 A He did come with a chief complaint of
24 low back pain, so his back pain hurt him more than his neck
25 pain. That was his secondary complaint.

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1 Q All right.
2 A After examining him as well as examining
3 multiple other medical records, those from Dr. Degnan's
4 office, emergency room records from Methodist Medical
5 Center, a bunch of CAT scans, x-rays and things of that
6 nature, basically he was given several diagnoses. Those
7 diagnoses -- and I should also tell you that at first we
8 saw him for his back, and then we were able to add on to
9 that because he's got a very complex case. We then added
10 on the neck thereafter.
11 Q Thank you.
12 A When we first saw him, we told him that
13 he had a lumbosacral strain, if you will. This is a
14 tearing of the ligaments much like you might do with a
15 severe ankle sprain of types. We also noted that he had
16 some degenerative disc disease. Without a doubt, the
17 sprain occurred secondary to the motor vehicle accident.
18 The degenerative disc disease is a little equivocal, could
19 be that there was a little bit that was preexisting, could
20 be that this was made worse. However, it should be
21 remembered that the patient specifically stated he had no
22 problems in regard to his back before. We did recognize
23 that he had some congenital problems. In other words, he
24 was born with some minor abnormalities. Fortunately, like
25 most congenital abnormalities, he didn't even know about

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1 it.
2 Q Okay.
3 A And those were that he had sacralization
4 of L5, and if I can over here, you should have five
5 nonribbed bearing lumbar vertebrae. Here's one, two,
6 three, four, five. This is, of course, normal. This is
7 not exactly what Mr. Neely has. Mr. Neely over here on the
8 fifth side, instead here in the back of having a discrete
9 transverse spinous process, it started to look more like
10 the sacrum down here, what we call sacralization, and it
11 started to be fused down here.
12 Q Was he born with that, Doctor?
13 A Yes, sir, almost certainly.
14 Q And the accident had nothing to do with
15 that?
16 A No, sir.
17 Q Does this skeleton that you're referring
18 to, does that fairly and accurately anatomically represent
19 Mr. Neely's skeleton?
20 A It represents a normal skeleton.
21 Q Okay.
22 A From which then I can tell you what's
23 not on Mr. Neely.
24 Q Okay. All right.
25 A If that's fair.

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1 Q Yes, that's what I meant.
2 A Okay.
3 Q Yeah, okay.
4 A He also had a congenital fusion, and
5 this is also not unusual. When you have someone that has
6 one congenital problem, often you find analogous, or
7 similar other structures, that are a little funny, and in
8 this regard, this vertebrae was also fused partially to the
9 sacrum, to the buttocks bone, if you will.
10 Q When you say congenital, what do you
11 mean, Doctor? What does that mean?
12 A The way you were born.
13 Q Okay. He was born --
14 A The way your genes made you.
15 Q Okay. What else did you find on that
16 initial visit?
17 A As far as orthopedically to his lumbar
18 spine, that was pretty much it. He had a few other
19 contributing medical problems. He's an overweight
20 gentleman, that's not going to do well on a back problem,
21 and he has a previous history of tobacco use and things of
22 that nature, which also are not great for having back pain,
23 but as far as actual additional mechanical problems, that
24 was what was discovered in the first office visit. In an
25 effort to answer your question fully, which you said please

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1 include the cervical spine, the neck, if you will, on a
2 subsequent visit, on a follow-up visit --
3 Q When?
4 A Let's see here. We followed him up
5 frequently. We saw him on the 2nd of November, we saw him
6 again on the 15th of December, and I think it was on that
7 visit, on the 15th of December that we actually took --
8 were able to take a harder look in regard to his neck.
9 Q Okay.
10 A To answer your question there, what we
11 felt was attributed to the motor vehicle accident was a
12 cervical strain, again analogous to a ligamentous tear much
13 like you would have with an ankle sprain. We also noted
14 that he had C4-5 and C6-7 preexisting degenerative disc
15 disease, meaning if we can over here on the model, I'll
16 turn this to the side so you can see both front and back,
17 there are seven cervical vertebrae, one, two, three, four,
18 five, six, seven, each of these have a vertebral body up in
19 front. There's gray or darker appearing discs in there,
20 and the discs that were between the fourth and fifth
21 vertebrae as well as between the sixth and seventh
22 vertebrae were degenerative. They weren't as thick and as
23 plump as normal, as one would hope a person of his age
24 would have.
25 Q Was that something that preexisted the

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1 accident, in your opinion?
2 A Yes, sir. I think that he had some
3 preexisting degeneration, but that this was made worse with
4 the accident.
5 Q Okay.
6 A So I'm trying to be fair to all parties.
7 I think he had some that was there, but it wasn't hurting
8 him and now through the accident, his preexisting disease
9 is made a little bit worse. He was also noted to have some
10 mild fascial trigger points. These are basically muscles
11 around the neck that get hard and spastic much like a
12 charley horse, and they would -- of course, this particular
13 skeleton doesn't have muscles on it, but they would be
14 located roughly one centimeter to the left of C3, which
15 would be right about here.
16 Q What did you do for that trigger point?
17 A Treated him with physical therapy, and I
18 believe a cortisone injection, if I'm not mistaken.
19 Q Okay. What is cortisone, Doctor, and
20 how do you inject it, how deep do you go to inject it?
21 A You go to the level that the muscle is,
22 and unfortunately on a gentleman who is six foot, one and
23 three hundred and thirty-eight pounds, there's a fair bit
24 of atapost tissue or a fat layer that you've got to go
25 through, so we probably went in about an inch and a half

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1 deep.
2 Q Would that be a painful procedure for
3 him, Doctor?
4 A I think it'd be moderately painful for
5 anybody.
6 Q All right.
7 A But usually short-lived. I mean the
8 shot hopefully in two or three days has more benefit than
9 it did negative.
10 Q Okay. And then when did you next see
11 him after that occasion?
12 A I saw him on the 12th of January. I
13 also saw him on the 6th of July, and I saw him on the 15th
14 of November, 2005.
15 Q Doctor, when you saw him on all these
16 occasions, did you see him for his neck and his back
17 injuries?
18 A Yes, sir.
19 Q Okay. The last time he was in in
20 November, this month, you also saw him for his knee, I
21 believe?
22 A Yes, sir.
23 Q That has nothing to do with this
24 accident, Doctor, to the best of our knowledge, so we don't
25 want to discuss the knee as far as you saw him, and if you

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1 would, I'm going to ask you about some bills in a few
2 minutes and if you could have your secretary or office
3 manager take out any bills from the knee, from your charge
4 for that date, that would be real helpful to us.
5 A Fine. I can send you an amended bill
6 that --
7 Q That'd be fine.
8 A -- that subtotals that.
9 MR. ENGLISH: That will be fine. We'll
10 have the court reporter contact you about getting
11 that.
12 THE WITNESS: Fine.
13 Q So from the time you first saw him on
14 October the 12th of '04 until you last saw him in November
15 the --
16 A 15th.
17 Q -- 15th of '05, it looks like he'd been
18 in to see you or your office on five or six different
19 occasions?
20 A That'd be a fair representation.
21 Q And just generally speaking, tell the
22 Court and jury how he was doing neckwise and low backwise
23 for injuries from this wreck whenever he came to see you
24 these five or six times, Doctor.
25 A For the most part, he was unchanged. He

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1 was actually pretty miserable. The exams were limited
2 because he said that he had substantial pain. We tried as
3 best as possible to accommodate him. However, you know,
4 you can only spend so much time with a patient catering to
5 his pain here in the office. You try two or three
6 different ways to get the data that you need, but I mean he
7 hurt. We tried a fair bit of conservative care and
8 semi-conservative or semi-invasive care. We tried physical
9 therapy, multiple nonsteroidal anti-inflammatories, what
10 they call tincture of time, some things just -- you know,
11 give them enough time and they go away, none of these
12 things seemed to work for him.
13 Q Okay. Doctor, I hand you a list of
14 medical expenses incurred, I think through the 15th of this
15 month when you last saw him, and I think your bill for
16 fourteen seventy-eight would be less than that amount or
17 maybe more than that amount, but if you would, do not
18 include anything in -- we need an updated bill from you for
19 this.
20 A Fine.
21 Q But look at those -- have you actually
22 looked at the underlying bills from that, Doctor?
23 A Yes, sir. You were kind enough to give
24 me those before the deposition, and I've had a chance to
25 leaf through those.

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1 Q Let me just briefly go over that.
2 Assume that, number one, on that bill he was taken by
3 ambulance from the scene of the wreck where he was
4 rear-ended and taken to Methodist Medical Center
5 complaining of headaches, low back pains, neck pains, and
6 he had three CT scans of the head, the neck and a
7 multi-planar or reconstruction CT, and he had x-rays of his
8 low back. Assume that all those tests were done at the
9 hospital. Does that bill at the hospital, forty-three
10 fifty-nine eighty-eight, is that reasonable and necessary
11 and related to the wreck, in your professional opinion?
12 A Yes, sir, as does the ambulance for five
13 hundred and thirty.
14 Q Okay. Well, do all of these bills, and
15 let me just go through them and tell you what the bills are
16 for based on what he will testify to, the emergency room
17 doctor, No. 3, was five seventy-nine; the radiology imaging
18 was four fifteen for interpreting the scans, and then his
19 family doctor he saw either three or four times complaining
20 of neck and low back pain from the wreck, the day after the
21 wreck, a hundred and eighty-eight dollars, and Dr. Jonathan
22 Degnan, an orthopedic surgeon, saw him three or four times,
23 and then he went to therapy at the request of his family
24 doctor, Dr. Martin, for right at three months, two and a
25 half months. That's No. 7.

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1 A Right.
2 Q And Dr. Degnan prescribed a TENS unit
3 that you later re-prescribed, I believe, for Mr. Neely.
4 No. 9, your bill of fourteen seventy-eight less whatever,
5 if there is a charge for the knee exam when you delete that
6 from your bill, and the Healthsouth Diagnostic Center for
7 an MRI of his low back on the 27th of October of '04,
8 twelve sixty-five, and an MRI of his neck on January the
9 10th of '05, and a referral to Dr. Jack Scariano for a
10 neurological consultation where he saw him about two or
11 three times in the amount of four hundred and nine dollars.
12 Do those figures appear to be reasonable and necessary and
13 related to what you know about this man's treatment for his
14 neck and back injuries from this wreck?
15 A Yes, sir, they do.
16 MR. ENGLISH: Let's introduce that as
17 the next numbered exhibit.
18 (Exhibit No. 2 was filed.)
19 Q And, Doctor, I'm not going to belabor
20 the point, but you've had some expenses here that you've
21 had this man incur at your direction and on your
22 prescription. Tell me what the TENS unit is that you
23 re-prescribed for him after it was initially prescribed by
24 Dr. Degnan.
25 A Yes, this is a transdermal electrical

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1 nerve stimulator. In short, these are electrical pads that
2 you put on a particular area. They look much like EKG
3 leads that you'd put on your chest, but you can put these
4 on your neck, you can put them on your back. They get
5 hooked up. These leads get hooked up to a unit about the
6 size of a large cigarette packet that's got a couple of
7 batteries in it. There are basically two controls, a
8 volume and intensity, and the patient is taught how to
9 maximize that as best as possible. You try to crank this
10 up as much as possible and then back it down just a hair,
11 and what it does is it will stimulate the underlying
12 muscles via stimulating the nerves, and sometimes patients
13 can feel contractures much like an eye twitch. You can
14 feel that sort of tingle in your back or in your neck and
15 often that gives relief of pain. Sometimes people complain
16 that that's just because you've fatigued the muscle, it no
17 longer has the ability to become spastic. It's pooped,
18 it's tired, so now it doesn't have to sit there and cramp
19 anymore. Sometimes you can also make muscles stronger that
20 way, and you can also decrease edema, the swollen, angry,
21 irritated tissues that are underlying there.
22 Q Doctor, whenever it shocks, is that a
23 painful shock, or is it just a mild shock?
24 A It can be if it's cranked up all the
25 way. The patient should be taught that he should go to

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1 that point of pain and back it down just a little bit so
2 it's not painful for him.
3 Q Is this helping him, according to what
4 he reported to you?
5 A Yes. He had reported that he had
6 benefits from it from when Dr. Degnan had prescribed it,
7 and thus we re-prescribed it.
8 Q Doctor, explain to the Court and jury
9 these two MRI's of his neck and his low back that you
10 ordered. Exactly what is that, and how does that work and
11 what does it show?
12 A Sure. I think probably the nicest way
13 to understand that would be the following: If you took a
14 look at a patient much like a baker might look at a loaf of
15 bread, and they don't teach you medical art work in medical
16 school, but I'll try here, that's a loaf of bread as best
17 as I can draw it here, you might -- by looking at the
18 outside, you can thump it, you can put your stethoscope on
19 it, you can squeeze it, and you might never learn that
20 there was a baked-in walnut that fell into this batter, yet
21 if I gave you a tool, like a knife, you could take several
22 slices. These slices, the ones I've drawn here, show
23 normal white bread, no problems. This slice, however,
24 would show you a little sliver of walnut, the problem, the
25 defect, the pathology. This slice here would show you a

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1 big chunk of walnut. This slice here would show you a
2 sliver of walnut, and then you'd be back to white bread.
3 And in short, out of this study, only this portion, these
4 three slices, would be abnormal, and the MRI does a similar
5 process with the neck or with the back. It takes this as a
6 loaf of bread, and it makes several slices, and it images
7 those. It's as if you took that slice out, took a black
8 and white picture of it, and then you could take a look at
9 those slices and see where is there a defect, where is
10 there a problem.
11 Q Did the MRI of his neck show any defects
12 that you feel are attributable to the wreck?
13 A Yes, sir. The MRI did verify that he
14 had a C4-5 degenerative disc disease with left sided disc
15 protrusion.
16 Q What is a protrusion, Doctor?
17 A Protrusion, this is if you think of
18 these discs over here, Mr. English, as if this were a jelly
19 donut.
20 Q Yes, sir.
21 A And if this were degenerative and
22 squished in height and you were to squish your jelly donut,
23 the jelly has to go somewhere and the jelly will go out the
24 weakest part. It will go out the hole that was used to
25 fill that donut. Well, that jelly coming out is going to

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1 go out the weakest part, which is, unfortunately in Mr.
2 Neely, towards the back, and that's where his nerve roots
3 are. The nerve roots are these little yellow structures
4 right over here and because the jelly went out and is
5 pushing on there, it can cause an irritation to the nerve.
6 What's fortunate, though, is that Mr. Neely does not suffer
7 what we call true radiculopathy to whereby he has a mash
8 defect whereby any one of these nerves has a decreased
9 reflex or decreased strength or he has numbness and
10 tingling just dedicated to that nerve. So it's not likely
11 that operating on these discs is going to substantially
12 make him better.
13 Q Have you ever done an operation on a
14 disc in someone's neck, Doctor?
15 A Yes, sir.
16 Q On how many occasions, roughly?
17 A Probably a hundred in the neck and a
18 hundred in the lumbar spine.
19 Q Is it your professional opinion that
20 surgery in his neck or his low back will not help him?
21 A I think he would have less than a fifty
22 percent chance of improvement.
23 Q Do you have an opinion, Doctor, as to
24 whether or not this man suffers any permanent impairment as
25 a result of the wreck that we're here about today to his

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1 neck first?
2 A Yes, sir. I utilized the A.M.A. Guides
3 to the Evaluation of Permanent Impairment, Fifth Edition,
4 to calculate his impairment. This is a Bible, if you will.
5 It's a gold standard, so it's not just the doctor's thumb
6 that says, oh, I think he deserves five percent here or
7 whatever. I carefully tried to delineate that and itemize
8 that for you and anybody else that was interested. In
9 regard to his cervical spine, he has some limited range of
10 motion. He can't bring his chin down all the way to his
11 chest. He can't bring his chin up all the way to the
12 ceiling. He can't rotate fully to the left and right. He
13 can't laterally bend this way, to the right and left
14 either, and when you take all that and you use the A.M.A.
15 Guides, he comes up with a sixteen percent impairment for
16 lack of range of motion.
17 Q Okay. To the neck?
18 A To the neck. Yes, sir, I'm sorry. I
19 believe that was your question, to the neck.
20 Q Okay.
21 A And I apologize if I was vague. You
22 also utilizing the A.M.A. Guides, can add additional
23 impairment because of actual spine pathology or what they
24 call spine disorders, and in that regard, when you take a
25 look at these sick discs that are there, he could have an

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1 additional seven percent impairment, and again, I'm
2 abridging this, I'm happy to go into how I got that seven,
3 but --
4 Q That's not necessary.
5 A But it was seven percent because of the
6 specific spine disorders. One might sit there and say,
7 well, look, just add the two of them, you've got a range of
8 motion impairment and a spine disorder impairment, seven
9 and sixteen should equal twenty-three. However, the A.M.A.
10 Guides is trying to be fair, and it realizes, look, if you
11 already have one impairment, adding another one is not
12 necessarily arithmetically accurate. You need to look at
13 this aggregate, put it together. It's kind of like if you
14 already have an amputation here and you receive another
15 amputation here, is that as much of a deficit to that
16 patient as if you just had amputated a person from here
17 once. This little bit doesn't add that much.
18 In short, these numbers aren't added, they're
19 combined. They use a special table called the combined
20 values chart, Page 604, and that totals a twenty-two
21 percent impairment to the cervical spine.
22 Q Would that be to the body as a whole?
23 A To the body as a whole, but for his
24 pathology of his neck.
25 Q Okay. Does he have any preexisting

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1 impairment to the cervical spine that you need to deduct
2 from that in order to be fair?
3 A Yes, sir. And that's what we tried to
4 do. We tried to actually anticipate that, and we said,
5 look, he's got some preexisting problems and because of the
6 congenital problems that also existed here that you didn't
7 specifically ask me about, but he's got some congenital
8 issues here as well. I doubt he had full range of motion
9 to begin with. I used my clinical judgment to figure out
10 what do I think based on his history and based on the
11 pathology on the x-rays and CT scan, what was it likely
12 that he had even though he said he had no problems,
13 probably he had some minor problems that he was unaware of,
14 and in that regard, I found that he had a -- an eight
15 percent impairment to the person as a whole in regard to
16 the cervical spine that was preexisting.
17 Q Okay. So when you subtract that from
18 the twenty-two percent impairment, what is his total
19 impairment to the person as a whole concerning his neck
20 injury as we sit here today, in your opinion?
21 A Yes, sir. Give me one second.
22 Q I'll refer you to Page 8, the second
23 paragraph, Doctor.
24 A Thank you. Yes, and that can be
25 arithmetically accomplished whereby it would be a straight

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1 subtraction. Twenty-two minus eight would yield a fourteen
2 percent impairment to the whole person, but that just
3 happens to be by luck the chart indicates that it can be
4 done arithmetically in that example.
5 Q And that's concerning the neck only?
6 A That's concerning the neck only, and
7 that would mean that in short, he currently has twenty-two
8 percent. He, before the accident, had eight percent. That
9 leaves you with fourteen percent that's attributed to the
10 motor vehicle accident.
11 Q Okay.
12 A To the neck only.
13 Q Of July of '04?
14 A The motor vehicle accident of July '04.
15 Yes, sir.
16 Q Now, let's talk about his low back. Do
17 you have an opinion as to whether or not he has any
18 permanent impairment to his low back as a result of the --
19 well, first of all, what did the MRI of his low back show?
20 A Yes, sir. The MRI of his lumbar spine
21 was performed on the 27th of October, 2004. It showed
22 these congenital anomalies that we talked about earlier, it
23 showed some minor disc bulges at L2-3. Now, forgive me for
24 one second because this is L1, so L2-3 would be here.
25 There'd be a little bit of a bulge. Again, it would stick

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1 out in the back, and it really would not irritate this
2 nerve very much. At L3-4, there was some minor disc bulges
3 and at L4-5 down here. It also indicated that at these
4 levels to the outside over here where the nerves exit, this
5 little hole, this bony hole right here that there was some
6 encroachment because of some pinching, that this did
7 slightly pinch these nerves in the hole coming out, what we
8 call normal foraminal stenosis, and those are also at all
9 three of those same levels.
10 Q Okay. Doctor, did you actually perform
11 the MRI of his neck and his back, or did you have it done
12 by another doctor?
13 A That was done by Healthsouth Diagnostic
14 Center, by a Board certified radiologist.
15 Q And what was his name?
16 A Glenn E. Jung. In fact, he has
17 additional expertise in musculoskeletal radiology.
18 Q And did you actually review the films
19 that he did?
20 A Yes, sir. I looked at both the films
21 and the report.
22 MR. ENGLISH: Let's make as the next
23 numbered exhibit, Exhibit No. 3, the MRI of the
24 lumbar spine, which was done on 10-27-04, and
25 Exhibit No. 4, the MRI of the cervical spine that

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1 was done on 1-10-05.
2 THE WITNESS: Thank you. Do you want me
3 to remove that from my chart?
4 MR. ENGLISH: No. We'll furnish it to
5 the court reporter.
6 (Exhibits No. 3 and 4 were filed.)
7 Q And, Doctor, do these MRI films that you
8 reviewed and the reports confirm your opinions that you're
9 giving today concerning this man?
10 A Yes, sir, to within that same reasonable
11 degree of medical certainty. Yes, sir.
12 Q Is that something you can actually see
13 that you saw on these two MRI films concerning this man?
14 A Oh, this is without a doubt objective.
15 He has disc bulges, and I doubt anybody would refute that.
16 The one thing that you can't definitively state, just based
17 on looking at the film, is was this old, was this new.
18 That requires judgment, it requires taking a history, and
19 that gets to be where the report itself might not say that
20 this is motor vehicle accident related. This is not --
21 that's why my report says that.
22 Q Okay. Assuming he was in a motor
23 vehicle accident, he was hit from the rear hard enough to
24 break his seat back, is that consistent with the protruding
25 discs and the bulging discs you found in his neck and his

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1 low back on the MRI's?
2 A Yes, sir. I should qualify that,
3 however, in stating that these disc protrusions I labeled
4 as being equivocally related whereby it gets to be very
5 tough to state that without a doubt he had no disc
6 pathology before and that it was all related to the motor
7 vehicle accident, and thus in regard to particularly his
8 cervical spine, I felt that you did need to dilute down
9 some of that impairment. I thought that that was fair and
10 appropriate. Yes, sir.
11 Q And you did. Okay. And we'll make
12 these the next numbered exhibits, Ms. Court Reporter, 3 and
13 4. And, Doctor, let's talk about his low back impairment
14 now. What impairment do you feel like he has to his low
15 back as a result of the wreck that we're here about today,
16 if any?
17 A As he stands or as he stood before me on
18 the 15th of November, utilizing the same A.M.A. Guides in a
19 short abridged form, he had an eight percent impairment.
20 Q Did he have any preexisting impairment
21 to his low back?
22 A And I felt that he had no preexisting
23 impairment in regard to his lumbar spine.
24 Q Okay. Would that be to the body as a
25 whole?

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1 A Again, to the body as a whole as it
2 relates to the lumbar spine.
3 Q Do you have an opinion, Doctor, as to
4 whether or not this man has reached maximum medical
5 improvement and if so, when?
6 A Yes, sir. I believe that he did reach
7 maximum medical improvement. I believe that he did so --
8 Q What was the date of that, sir?
9 A On -- I'm sorry, I apologize, I'm trying
10 to be as precise as I can be. That would be on the 15th of
11 November, 2005, whenever we calculated this impairment
12 rating.
13 Q When you say maximum medical
14 improvement, Doctor, what does that mean for the layman?
15 A Sure, that means that in our
16 professional opinion, it's not likely that he's going to
17 get much better. Also, it means that it's not likely he's
18 going to get much worse directly attributed to the motor
19 vehicle accident. I mean all of us are getting worse with
20 time because of age, et cetera, but in particular, with
21 regard to the motor vehicle accident, we think that he's
22 pretty much stabilized. We don't think he's going to get
23 much worse, we don't think he's going to get much better.
24 Q Did you refer this man to a pain clinic?
25 A Yes, sir, I did.

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1 Q Why?
2 A Because he still has pain and that is,
3 unfortunately, where you send patients who you can't get
4 better.
5 Q Have you done everything you can for
6 this man to alleviate his pain in his neck and his back
7 from this wreck?
8 A Yes, sir.
9 Q Okay. Who did you refer him to?
10 A I believe we sent him to Dr. Browder.
11 Q And is Dr. Browder a pain specialist
12 here in Knox County?
13 A Yes, sir.
14 Q Do you have an opinion, Doctor, as to
15 whether or not this man is capable of gainful employment at
16 this time as a psychiatric technician or working with
17 psychiatric patients?
18 MR. WOODFIN: Objection. That's beyond
19 the scope of his expertise, but go ahead and
20 answer the question.
21 MR. ENGLISH: Go ahead, please.
22 A I will state that I do feel comfortable
23 answering that question, and I've seen him multiple times,
24 and I believe that he does not have the ability to be
25 gainfully employed as a psychiatric technician, as I would

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

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

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

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

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

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1 Q No more or no less?
2 A No more, no less.
3 Q And as far as whether or not you've ever
4 actually performed a vocational analysis on someone, I
5 think that would be no?
6 A That is correct.
7 Q You mentioned his inability to do these
8 activities, and I'm thinking that's primarily based on the
9 complaints of pain that he's relating to you, correct?
10 A Based on the complaints of pain coupled
11 with the objective findings on MRI, CT scan and plain films
12 as well as a physical examination that's repetitively done.
13 Q There are no objective indications which
14 would lead you to conclude that if he tried to do anything,
15 he would hurt himself, are there?
16 A Not within the fifteen pounds that he
17 was allowed to do back in July. I don't think that the
18 fifteen pounds would hurt him. I just don't think that he
19 was able to do the fifteen pounds.
20 Q And that's still the same in November of
21 2005, when you last saw him? There's nothing objective
22 that you can point to that says if this man tries to do
23 something, he's going to hurt himself?
24 A I think if he tried to lift more than
25 fifteen pounds again, I think that he would fail again.

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

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

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

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

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

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

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1 Q Show the jury, if you would, what we're
2 talking about there.
3 A Sure. If you don't mind, I'm going to
4 turn this around this way. This is his tailbone. I'll
5 turn it to the side because I think that that's going to
6 show up better for the camera. The tailbone typically is
7 broken here at the junction of the sacrum -- I'll do it
8 this way. Here's where your sacrum ends. This is your
9 coccyx. Usually there's a fracture right here whereby this
10 then tips forward and comes up this way. That's what we're
11 talking about.
12 Q And you don't know how that happened?
13 A No, sir, nor did I really need to
14 evaluate that. That was taken as part of his history, and
15 that is if you will, sir, effectively an orthopedic mile
16 away from where his other pathology is. You can't be off
17 this much as an orthopedic surgeon and not get in trouble.
18 So in short, this ends up -- he could have told me he
19 fractured his great toe as well and it impacted his
20 impairment the same way. He received neither additional
21 nor a discount in his impairment rating because of that
22 1982 fracture down here.
23 Q If he had had some trauma which caused a
24 jarring of his spine, would that not be important to you?
25 A All history would be important. Yes,

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

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

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1 visit that he was treating with Dr. Degnan and that he was
2 giving complaints that, quote, "Went in one ear and out the
3 other"?
4 A Yes, sir. That's his history.
5 Q Did you also review the report from the
6 emergency medical technicians that saw him at the scene of
7 the accident?
8 A I know that I reviewed the emergency
9 room report per se. If you have a reference for me to --
10 Q Let's stick with that emergency room
11 report. I think that's what my notes said, and I just
12 misread it.
13 A Okay.
14 Q Again, looking at that with regard to
15 the lack of loss of consciousness, there was also a note
16 that there's minimal damage to his vehicle in that report
17 as well?
18 A Yes. That's what I noted in the
19 emergency room reports dated the 12th of July, 2004.
20 Q He then saw you ten days later on the
21 22nd of October of 2004, correct?
22 A Yes, sir.
23 Q You made a finding there that there was
24 a bruise on his back that you didn't see on the first
25 visit, if I read that correctly.

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

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

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

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

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1 A That's a fair way of saying it.
2 Q And that was occurring with Mr. Neely?
3 A Yes, sir, on the 12th of January, 2005.
4 Q I noticed in that record too you almost
5 put him at maximum medical improvement at that date, if I
6 saw that correctly.
7 A Yes, sir, there's a statement that says
8 because he's not accessing the additional recommended care
9 or doesn't have the funds to access additional care, that
10 he may -- I believe it said -- well, I'll just quote it
11 directly, the patient is made aware that at this time he
12 may well have reached maximum medical improvement in regard
13 to the above orthopedic diagnosis.
14 Q And you hadn't changed his restriction
15 from fifteen pounds to no duty after July of 2005, had you?
16 A No, sir.
17 Q I think you'd actually given him a
18 written restriction that said no lifting over fifteen
19 pounds, if I remember correctly?
20 A On which date? For instance, on the
21 12th of October 2004?
22 Q That was the very first time that you
23 saw him, correct?
24 A Yes, sir.
25 Q Correct?

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1 A Yes, sir.
2 Q Any others besides that?
3 A Yes, sir. There was -- give me one
4 second. On the 2nd of November, 2004, it basically says,
5 "Continue prior limited duty status." That's just a way of
6 shortcutting it so you don't fill out the paperwork so
7 much.
8 Q Sure.
9 A I apologize for the ton of paperwork
10 that this gentleman has.
11 Q Take your time.
12 A On the 21st of February, 2005, he was
13 placed again on continued prior limited duty with a
14 handwritten form, I should say with a form filled out by
15 hand. Similarly, on the 6th of June, 2005, and then on the
16 6th of July 2005, it was written in more detail to have no
17 repetitive bending, stooping, squatting, an allowance for
18 frequent changes of position, no lifting greater than
19 fifteen pounds. Does that answer your question?
20 Q It does, if those are the only written
21 restrictions that you've given him.
22 A And then on the 18th of November,
23 whenever I saw -- wait, on the 18th of November apparently
24 he may have wanted another form filled out or whatever.
25 That was three days after I last saw him. It said continue

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

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

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1 comfortable at work with attempts at weight loss, with
2 attempts of trials of epidural steroids, both to the
3 cervical spine and lumbar spine, physical therapy, tincture
4 of time despite -- and I've tried to be fair to everybody
5 and tried getting him to work to some level. Despite all
6 those attempts, he reports back to me on the 15th of
7 November that he has unchanged low back pain, unchanged
8 neck pain. In that regard, if I can't get him better and
9 get him back to the workplace, I'm in a little bit of a
10 dilemma. I can't keep pushing this gentleman. I can't
11 keep saying no, you've got to go back, you've got to go
12 back. I've got to say all right, fine, we've tried to do
13 everything we can, we've tried to gently persuade you to
14 get back to the workplace, we've tried to get you to
15 physical therapy, we've done everything we can, you're not
16 getting better. There comes a point where you have to fish
17 or cut bait, and in short, sir, I don't think that this
18 gentleman's going to be able to go back to the workplace
19 and be productive.
20 Q And you made that change on the day that
21 he was asked by his lawyer to come and see you and be
22 evaluated for this lawsuit?
23 A I made that change based on the fact
24 that enough time had elapsed from when his accident
25 occurred on July 2004 to November 2005, roughly a year and

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1 a half, call it a year and four months, whatever it works
2 out to be. There was plenty of time to allow this
3 gentleman to try to get better. He did not get better
4 despite appropriate conservative care and semi-invasive
5 care to where there comes a point and some would have said
6 that perhaps I should have come to this point earlier and
7 said you know what, you should have given him no duty much,
8 much earlier, some might have said as early as six months.
9 I tried harder to get him back to work. I tried -- this
10 gentleman is a very complicated person, very complicated
11 case. He's got congenital anomalies, he's not getting
12 better. I tried as hard as possible to get him back to the
13 workplace.
14 Q But on the day that he came in for his
15 evaluation is when you made the change?
16 A Because on --
17 Q That's yes or no. You can explain it
18 later, but yes or no, did you make the change to no duty on
19 the date he was sent in by his lawyer for an impairment
20 evaluation for this lawsuit?
21 A The answer to that question is yes.
22 MR. ENGLISH: Explain your answer,
23 Doctor, if you would.
24 THE WITNESS: Sure.
25 MR. WOODFIN: I'll let you do that on

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1 Redirect Examination. This man is also --
2 MR. ENGLISH: Well, no, excuse me, Mr.
3 Woodfin, for the sake of continuity so the jury
4 doesn't get confused, I would like for him to
5 explain it now and then you can delete it if the
6 judge wants you to.
7 MR. WOODFIN: Well, I'll object to it.
8 You can say what you want now --
9 MR. ENGLISH: Go ahead and explain it.
10 THE WITNESS: Well, I'm confused enough
11 as it is to whereby if you could repeat the
12 question so that I could answer it because I've
13 lost continuity.
14 MR. ENGLISH: Okay.
15 MR. WOODFIN: I didn't have a question.
16 MR. ENGLISH: Well, would you explain
17 your answer as to why the change in the
18 restrictions were made on the day he came in to
19 see you at my request, as you always see people
20 for different attorneys?
21 THE WITNESS: Sure. Please understand
22 the reason why was that a sufficient period of
23 time had taken place between when the injury
24 occurred and when I was seeing him. There was no
25 substantial improvement or no improvement

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1 whatsoever noted. It was unlikely he was going to
2 get better. It was unlikely despite our attempts
3 at getting him back to work at some limited basis
4 at fifteen pounds that he was going to be able to
5 do the work and feel good about it and, you know,
6 say, hey, look, I can do this without hurting.
7 In short, everything was right in the
8 fact that there was enough time had evolved,
9 enough studies had been done, enough physical
10 therapy had been given that a decision could be
11 made on a medical basis to say all right, it
12 doesn't look like we're going to be able to get
13 you back to work.
14 Q You hadn't done any objective tests for
15 him since the MRI of his cervical spine that was done,
16 correct, since November of 2005?
17 A If you're talking about radiographic
18 tests, that would be correct. However, of course, he
19 received an objective evaluation here in the office in
20 regard to muscle strength testing, reflexes, things of that
21 nature.
22 Q His chronic obesity obviously gives him
23 problems as well with his spine?
24 A Yes, sir. However, that should actually
25 be limited to his lumbar spine. It's unlikely that his

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1 obesity significantly alters his cervical spine. There's
2 not much weight that your head carries.
3 Q What did you call it, atapost tissue; is
4 that correct?
5 A Yes, sir.
6 Q Depending on how much is there, that
7 could affect his cervical range of motion, could it not?
8 A That could to a limited degree.
9 Q The jury's going to have a look at this
10 man so they'll be able to look at his neck and see how much
11 of that is there.
12 A Right. And please understand that that
13 also would be part and parcel of what you felt would be --
14 I did feel that he had some preexisting limited range of
15 motion.
16 Q I think you related that to the
17 congenital defect, though, did you not?
18 A Related it to preexisting conditions.
19 Of course, the largest component of which would be the
20 congenital defects. Yes, sir.
21 Q I didn't see anything in your record
22 that said you limited it because of fatty tissue in his
23 neck.
24 A No, sir. You know, you also try to sit
25 there and you try to be thorough, you try not to be wordy.

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1 Some people would state that I'm a wordy as it is, and in
2 short, I tried to give you as concise a plan as possible.
3 Also, sir, you try not to necessarily be cruel in a written
4 document that you know is going to be poured over by a
5 bunch of people to sit there and if there's a way you can
6 elegantly state that he's got a preexisting problem and not
7 sit there and say all right and part of it's because of the
8 layer of atapost tissue and just sit there and say he's got
9 a preexisting impairment of this and this much, and you can
10 do it elegantly as a gentleman. I would prefer to do it
11 that way.
12 Q You also understand you're being asked
13 to advocate a position for the plaintiff in this case, are
14 you not?
15 A No, sir, I don't know that I'm
16 necessarily being asked to advocate a position for the
17 patient. What I was asked to do was objectively -- at the
18 end, I was asked to objectively evaluate the patient, I was
19 asked to objectively take care of the patient, and I was
20 asked to objectively impair the patient if any existed, and
21 I think I did all three. Now, I will tell you this, I
22 certainly tried to do all three.
23 Q You were beginning to see Mr. Neely upon
24 referral of his attorney, correct?
25 A Mr. Inman, I think, was the person who

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1 set this up first. Yes.
2 Q One of his attorneys?
3 A Yes, sir, I believe so.
4 Q The history that we talked about
5 earlier, if there is some flaw in the history, that
6 obviously affects the way you're able to give your opinions
7 about causation as it relates to an accident, correct?
8 A It could. Yes, sir.
9 Q Okay. And whether or not he was being
10 truthful with you, you have no way of knowing; you, as a
11 doctor, just take what your patient tells you and believe
12 that to be the truth?
13 A Yes, sir. The patient was given the
14 benefit of the doubt in that regard, and I found him to be
15 truthful and if I have evidence to the contrary, that
16 certainly would be a big factor.
17 Q Now, you didn't have an occasion to look
18 at any medical records prior to this event of July 2004?
19 A No, sir.
20 Q Okay. I don't think I have all of your
21 notes, not through anyone's fault, probably through my own.
22 May I take a look at your chart?
23 A Sure. I'm sorry, that was the only
24 thing I think I added.
25 Q That's a good picture. Don't worry

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1 about it.
2 THE VIDEOGRAPHER: Would you like to go
3 off the video record?
4 MR. WOODFIN: I don't think I'll be that
5 long. Thank you.
6 Q Okay, sir. And, again, I didn't mean to
7 imply you were hiding anything or not sharing anything. I
8 just wanted to make sure I had everything --
9 A Sure.
10 Q -- that I asked you about when I needed
11 to. Thank you.
12 MR. ENGLISH: Is that it?
13 MR. WOODFIN: That's it.
14 REDIRECT EXAMINATION
15 BY MR. ENGLISH:
16 Q Doctor, is it probable that a fracture
17 of his coccyx, Mr. Neely's coccyx, about twenty-two years
18 ago would cause a disc problem that you found in his low
19 back on the MRI, would suddenly start hurting him
20 immediately after this wreck? Is that probable or not?
21 A Forgive me. I would hate to rephrase
22 your question, but I think what you're asking me is, is it
23 possible that just because he had a coccyx fracture in
24 1982, that because of that fracture in 1982, twenty years
25 later, with or without a motor vehicle accident, that

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1 because of that fracture he would have some of the symptoms
2 in his lumbar spine?
3 Q Yeah.
4 A Yeah. I would think that that would be
5 a protruding disc in particular. I think that that would
6 be improbable.
7 Q Okay. Doctor, when you last saw this
8 man on the 15th of November, did you do an impairment
9 evaluation so that you could give your best, most honest
10 opinion as to whether or not this man had any impairment
11 relative to the wreck that we're here about today?
12 A Yes, sir. I'm sure that the patient may
13 not have been happy with the fact that his history is such
14 that he said he wasn't hurting, he didn't have any decrease
15 in range of motion, yet I felt that there was probably
16 some, but again I tried to be fair to everybody. I tried
17 to do it as per the A.M.A. Guides, and I tried to do it as
18 objectively as possible.
19 Q Did you take the Waddell's test, the
20 positive Waddell's test into consideration in your
21 evaluation and impairment today, sir?
22 A Yes, sir. And when you say impairment
23 today, though, I apologize --
24 Q In your impairment rating that you've
25 given today.

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1 A Yes, sir.
2 Q Has all your testimony today been based
3 on reasonable medical certainty, both for myself and for
4 Mr. Woodfin, throughout this deposition?
5 A Yes, sir.
6 Q And did any of the questions that Mr.
7 Woodfin asked you on Cross Examination cause you to change
8 your opinions to any of the answers that you had previously
9 given me on my Direct Examination?
10 A No, sir.
11 MR. ENGLISH: Okay. That's all.
12 Thanks.
13 MR. WOODFIN: Nothing further.
14 AND FURTHER DEPONENT SAITH NOT.
15 THOMAS M. KOENIG, M.D.
16 By____________________
17 Court Reporter
18 Sworn to before me this 30th
19 day of November, 2005.
20 ____________________
21 Notary Public
22 My Commission Expires: December 19, 2006.
23
24
25

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