

COPY

VIRGINIA: IN THE CIRCUIT COURT OF THE CITY OF SUFFOLK

CASE NO. CL09-154

BARBARA W. FRANCIS,

Plaintiff,

D-E-P-O-S-I-T-I-O-N

v.

OF

MARVIN RAY WISE, SR.,

and

MICHELLE RENE DAIL,

Defendants.

JOSIAH DUKE, M.D.

* * * * *

ON JUNE 24, 2010, AT THE OFFICES OF ORTHOPAEDICS EAST, INC.,
810 W.H. SMITH BOULEVARD, GREENVILLE, NORTH CAROLINA.

APPEARANCES OF COUNSEL:

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STIPULATIONS: PRIOR TO THE GIVING OF ANY TESTIMONY BY THE WITNESS, IT WAS EXPRESSLY STIPULATED AND AGREED BETWEEN THE PARTIES TO THIS ACTION, THROUGH THEIR RESPECTIVE COUNSEL, THAT:

1. BY NOTICE AND/OR CONSENT, THE DEPOSITION OF JOSIAH DUKE, M.D., WAS TAKEN ON THE 24TH DAY OF JUNE, 2010, BEGINNING AT 5:20 P.M., AT THE MEDICAL OFFICES OF ORTHOPAEDICS EAST, GREENVILLE, NORTH CAROLINA, BEFORE BOBBIE G. NEWMAN, A COURT REPORTER AND NOTARY PUBLIC IN AND FOR THE COUNTY OF PITT.

2. READING AND SIGNING OF THE TRANSCRIPT OF TESTIMONY BY THE WITNESS IS HEREBY WAIVED.

* * * * *

EXAMINATION OF THE WITNESS

MR. BENJAMIN P. LYNCH, JR.	PAGES 5 - 49
MR. GREG W. KLEIN	PAGES 49 - 62
MR. MICHAEL J. ANDERSON	PAGES 62 - 64

INDEX OF EXHIBITS

Defendant's
Exhibit [1] Barbara Williams Francis, Medical Record,
Surgicenter of Eastern Carolina, LLC.
1/22/2010.

Page 49

1 JOSIAH DUKE, M.D., BEING BY ME FIRST DULY SWORN
2 TO SPEAK THE TRUTH, DEPOSES AND SAYS:

3 ON EXAMINATION CONDUCTED BY MR. BENJAMIN P.
4 LYNCH, JR.:

5 Q. You're Dr. Josiah Duke?

6 A. Yes, sir.

7 Q. All right. Dr. Duke, I'm Ben Lynch. I
8 represent Mr. Wise, who's a defendant in this case. You've
9 been identified as an expert witness on behalf of Ms. Francis
10 and I have some questions I'd like to ask of you. Have you
11 ever qualified as an expert witness in the past?

12 A. No.

13 Q. And you've never given any testimony in court?

14 A. No.

15 Q. Tell me what your education is?

16 A. I trained in orthopaedics at Medical College of
17 Virginia, residency at Medical College of Virginia, and
18 fellowship in trauma at Vanderbilt.

19 Q. And when did you finish at MCV?

20 A. It was '99.

21 Q. And your residency was completed when?

22 A. In 2003. So I was in the military for four
23 years before I did the fellowship. So my --

24 Q. So --

25 A. -- so I did Air Force private practice for four

1 years from '99 to 2003.

2 Q. And you had a one-year residency then?

3 A. One-year fellowship.

4 Q. One-year fellowship.

5 A. Actually a six-month fellowship.

6 Q. Well, the fellowship was at Vanderbilt?

7 A. Uh-huh.

8 MR. MICHAEL ANDERSON: Yes.

9 Q. But when did you finish; when -- what was the
10 period of your residency?

11 A. Ended in '99, so that would be --

12 Q. So you finished your academic training when?

13 A. Okay, let's see here. High school, '86.

14 Q. I'm talking about the medical school.

15 A. Yeah, I'm trying -- I'm trying to remember.

16 Q. Okay.

17 A. '90 -- '94 was med school, '99 was residency.

18 Q. All right.

19 A. 2003 fellowship.

20 Q. And so you had a -- your residency was five
21 years?

22 A. Uh-huh.

23 Q. All right. And when did you -- when did you
24 join this practice?

25 A. 2003, January, I think.

1 Q. Is Ronald Bewick still a --

2 A. Yes, sir; he's a P.A.

3 Q. -- P.A. here?

4 A. Uh-huh.

5 Q. Do you -- do you work with him; does he work
6 under your supervision?

7 A. No, he's not my P.A., but we all work together
8 in different situations. There are times where he might see
9 some of my patients.

10 Q. All right. You sign for him?

11 A. Yes.

12 Q. Is he knowledgeable in --

13 A. Orthopaedics.

14 Q. -- orthopaedics?

15 A. All our P.A.'s are orthopaedic trained in that
16 most of that is clinical based.

17 Q. And do you know how long he has practiced as a
18 P.A.?

19 A. No, I don't.

20 Q. What is the procedure in this office with a P.A.
21 when a P -- when a P.A. sees a patient; is that in the
22 presence of the supervising physician?

23 A. Not usually. Usually a P.A.'s an independent
24 provider, so they'll see the patient, evaluate the patient,
25 and then their chart will be reviewed by the doctor.

1 Q. Is that a process that the doctor reviews at a
2 later time, or does the doctor review it with the patient?

3 A. There are times that we do both. There are
4 times we'll go see the patient with the -- with the P.A., and
5 there are other times we'll review the patient later -- I
6 mean the chart later.

7 Q. All right. Is there a Dr. Wilhelmsen --

8 A. Yes.

9 Q. -- in this practice?

10 A. Dr. Wilhelmsen is one of the orthopaedic
11 partners.

12 Q. How long has he been in practice? I know you
13 don't know that --

14 A. Fifteen years, I think.

15 Q. -- to the year, but --

16 A. It may be 15 years --

17 Q. Maybe 15?

18 A. -- it may be even longer than that.

19 Q. Does he have a particular area of orthopaedics
20 that he practices in or specializes in?

21 A. He's -- he does general orthopaedics and total
22 joints and hand.

23 Q. Do you have an area of specialty?

24 A. I do joint replacements, trauma, sports.

25 Q. You first saw Ms. Francis on March 17 of '08

1 according to the records I have. Is that your first
2 introduction to her?

3 A. Yes.

4 Q. When you saw her, did you have occasion to
5 review her prior records in this office?

6 A. I reviewed the note that -- the note before on
7 April 23, 2007, and I reviewed most of the -- most of the
8 records that she had had.

9 Q. Did you have the radiographic studies that had
10 been done elsewhere?

11 A. I think I had the report.

12 Q. How about the -- would that include the CT scan
13 that was done?

14 A. Yes. I think I looked at the report --

15 Q. All right.

16 A. -- because it was a year -- it was a year later.

17 Q. And would -- had that been sent to you, or did
18 you retrieve it from the radiologist; do you know?

19 A. I think it was in the chart. It may have been
20 in the chart -- the actual report. I honestly don't
21 remember.

22 Q. All right. Would that have been the one that
23 was read by Dr. Arcara, or Arcara?

24 A. Yes.

25 Q. Where -- when she, in that report, spoke of

1 tricompartmental, what -- what was she referring to?

2 A. The word "tricompartmental" is basically trying
3 to label different locations in the knee. The first
4 compartment is the inside compartment where you stand, the
5 second compartment's around the kneecap when you bend, and
6 then the third compartment's on the outside of your knee when
7 you stand. So there is a CT scan showing, I guess, some
8 changes that they interpreted as tricompartmental
9 osteoarthritic changes.

10 Q. All right. And the osteophytes that they found
11 there would be calcification or are of long standing?

12 A. Osteophytes are when a bone responds to
13 arthritis, they'll start to form little spurs.

14 Q. Right.

15 A. Some people have them really advanced. But you
16 know, again, CT scans are designed to look at fractures; it's
17 really hard to comment on someone's arthritis.

18 Q. But apparently there was arthritis present --

19 A. That's according --

20 Q. -- in this woman's knee?

21 A. -- according to the reading of that, that's what
22 that radiologist said.

23 Q. And the chondrocalcinosis --

24 A. Uh-huh. Chondrocalcinosis is --

25 Q. -- is, is what?

1 A. It's a little tiny calcium deposit in the -- in
2 the menisci or sometimes in the cartilage, and it's just
3 crystals that form that are age related.

4 Q. And that would be in the -- it says in the
5 lateral compartment. You say that would be of the meniscus?

6 A. Well, they said -- let's see here. Lateral
7 compartment; right. And they're talking about, you know
8 again, chondrocalcinosis seen in bilateral menisci. It says
9 here there's --

10 Q. That would have been on the right knee, would it
11 not?

12 A. Also -- what do you mean? This is a CT scan
13 left knee report. I'm just reading what the radiologist
14 said. So it says chondrocalcinosis is seen involving the
15 bilateral menisci. That's in paragraph one. In paragraph
16 two, it says minimal chondrocalcinosis in the lateral
17 compartment.

18 Q. Let me ask you to look -- well, where's the
19 lateral compartment?

20 A. The outside.

21 Q. Is that -- is that of the meniscus?

22 A. I think -- when they're mentioned in that
23 report, I think what they're trying to say is that there's
24 probably some chondrocalcinosis involving the cartilage
25 that's on the end of the femur.

1 Q. The cartilage?

2 A. Yup.

3 Q. All right. Now, I'll ask you to look at that
4 first paragraph again.

5 A. Uh-huh.

6 Q. That is speaking to the right knee; was it not?

7 A. Good point; I didn't see that. Yeah, it's
8 confusing because the CT is of the left knee, so they must
9 have maybe cross-referenced this. This is very confusing.

10 Q. Well --

11 A. So, unfortunately, there's really no way to know
12 what they're saying there.

13 Q. All right.

14 A. But I guess what they're saying is
15 chondrocalcinosis is seen on the -- yeah, you'd have to talk
16 to Lynn Arcara to find out what they meant.

17 Q. All right.

18 A. I don't know if that whole first paragraph is
19 all the right knee; it sounds like it.

20 Q. It does. And it would appear that the second
21 paragraph is referencing the left knee.

22 A. Yup.

23 Q. But this is what you had to go with --

24 A. Uh-huh.

25 Q. -- to work with; right?

1 A. Actually, what I went with when I saw her a year
2 later was we went with her history and physical exam, and we
3 went with her, you know, we -- we cross-referenced some of
4 the things that happened in the past trying to figure out
5 what's going on at this time.

6 Q. So you really didn't consider this CT scan when
7 you saw her a year later; is that what I should understand?

8 A. I consider everything.

9 Q. All right. In this, also, it was talking about
10 a Baker's cyst was present. What would that be?

11 A. A Baker's cyst is a normal communication. The
12 back of the knee can have a small hole where there can be
13 some fluid that accumulates, and they can be common in, I
14 don't know the data, but it's -- it's not an uncommon
15 variant.

16 Q. This would indicate that there were significant
17 arthritic changes in this woman's knee --

18 A. No.

19 Q. -- at that time?

20 A. That's not true.

21 Q. That it --

22 A. A Baker's cyst has no meaning of -- has no
23 relation to arthritis.

24 Q. All right, but the chondrocalcinosis of the --

25 A. Has no -- no relation to arthritis.

1 Q. And the arthritic changes with osteophytes
2 present --

3 A. That does indicate some arthritis.

4 Q. -- would -- would be arthritic; correct?

5 A. Some arthritis.

6 Q. All right. Now, what would be the significance
7 of the nondisplaced fracture fragment that is mentioned
8 there?

9 A. I mean, to me, that indicates that there was
10 some trauma, and that the -- and that there was a fracture
11 involving the tibial plateau.

12 Q. All right. And of what significance is that;
13 how -- what -- what problem does that present?

14 A. It's tough to say because usually a fracture a
15 year later would be healed, and then it would indicate that
16 the patient had traumatic -- a traumatic injury. It can be a
17 source of pain; it can be just a sign that the patient did
18 have a severe injury.

19 Q. All right. It would appear in looking at this
20 note that was made by Mr. Bewick; right --

21 A. Yes.

22 Q. -- in this office, that there was no treatment
23 prescribed on that initial visit. Do I read that correctly?

24 A. Let's see here. It says she's seen on April 2
25 and she had her accident on March 10.

1 Q. Right.

2 A. So, I think, at the time he mentioned that,
3 there was a fracture there, but it did not need surgery and
4 he wanted to limit her weightbearing and continue to allow
5 her to move her knee. So, he mentioned -- so he treated her
6 in a -- in a way of saying that she needs to limit her
7 weight.

8 Q. All right. Well, the treatment that was
9 offered --

10 A. So, he's treating the fracture.

11 Q. -- at that time was to, to limit your weight to
12 try --

13 A. Right, he's treating the fracture.

14 Q. -- to try to stay off it as much as you can?

15 A. Yeah, he's just -- he's saying, Look you have a
16 fracture, we're going to treat you by limiting your
17 weightbearing.

18 Q. All right. And to return in three weeks?

19 A. Right.

20 Q. All right. And then when you look at the visit
21 of March 23 --

22 A. Uh-huh.

23 Q. -- she was seen by one of the partners here, Dr.
24 Wilhelmsen; right?

25 A. Right; uh-huh.

1 Q. And at that time, it -- it would appear that he
2 reports that there's no effusion in the knee, that he -- he
3 thought she had a contusion that was resolving, and -- well,
4 she was discharged; right?

5 A. He said follow up as needed, which just
6 indicates that if it continues to hurt or gives you problems,
7 come on back.

8 Q. All right. And the next time that you had any
9 contact with her would be when she came to see you 11 months
10 later; right?

11 A. Correct.

12 Q. No -- no indication or evidence that there was
13 any complaint, that she came back, any report of any problem,
14 any difficulty for the 11-month period?

15 A. Let's see here. She and I saw each other and
16 she said that the pain crept back into her knee, and then
17 began to bother her at night, during the day with aching. So
18 it sounds like she was having some symptoms and that's why
19 she came to see me.

20 Q. All right. If there were a traumatic injury --

21 A. Uh-huh.

22 Q. -- you would have some symptomatology following
23 that trauma; would you not?

24 A. Yeah, it said that she did. She said that she
25 had pain in her knee after a month or two and it began to

1 bother her at night. So she was having --

2 Q. Right.

3 A. -- some symptoms.

4 Q. But she indicated that it was a month or two
5 after the accident that it slowly crept --

6 A. Correct.

7 Q. -- up?

8 A. Right. Right, because, you know again, you
9 know, who knows what happens in terms of this. But she was
10 on crutches, so she limited her weightbearing and then she
11 said it started hurting when she started going back to her
12 activities.

13 Q. Now, tell me where you get it -- get the
14 information that she was on crutches?

15 A. She was limiting her weightbearing, so there's
16 really not many ways of limiting your weightbearing. That
17 note is written by Ron Bewick.

18 Q. Were there -- was there a prescription given for
19 crutches? I mean, it's a matter of just --

20 A. Well, like I say, I'm not a -- I'm not a lawyer,
21 I don't know. It's -- not every time is written down. But
22 when you say someone has a broken knee, a tibial plateau
23 fracture, and you want them to limit their weightbearing, you
24 know, you can either give them a walker or crutches. It
25 could have been given in the ER or not, but it's just hard to

1 know.

2 Q. All right. Now, were you aware of what her
3 employment had been during that 11-month period?

4 A. No.

5 Q. What her activities had been?

6 A. Nope.

7 Q. You noticed on your physical examination that
8 there were palpable osteophytes present?

9 A. Yes.

10 Q. And those osteophytes would be indication of a
11 arthritic condition?

12 A. Correct.

13 Q. You indicate that there was some mild
14 tenderness. That would be an object -- a subjective finding;
15 would it not?

16 A. Tenderness is an objective finding.

17 Q. Is objective?

18 A. Correct. When you push on them and they say it
19 hurts, they flinch, it's an object -- it's part of a physical
20 exam. Subjective is what the patient tells you; objective is
21 what you examine.

22 Q. All right.

23 A. So...

24 Q. Well, if it's a matter that you push on it and
25 the patient responds, gives you a response, then you're

1 dependent upon what the patient tells you --

2 A. No.

3 Q. -- isn't that true?

4 A. No.

5 Q. No?

6 A. You examine someone in orthopaedics and they're
7 tender, and you see them and you feel their tenderness, I
8 mean, it's an objective finding. If they break a bone and
9 you touch it and it hurts, I don't know.

10 Q. All right.

11 A. I mean you don't know.

12 Q. Now it appears --

13 A. It's tough to say.

14 Q. -- in -- in -- in your note you indicate that
15 you did a straight leg raising test --

16 A. Uh-huh.

17 Q. -- right? A straight leg raising test is not a
18 test that would be utilized for examining a knee; would it?

19 A. Sure. You always examine the joint above and
20 below. You examine the back and I always examine the whole
21 patient.

22 Q. All right. The straight leg raising test would
23 indicate some problem in the nerve distribution coming from
24 the spine; would it not, Doctor?

25 A. It can do that, or it can be tender if you have

1 something pinching in the front of your knee. Or it can hurt
2 if you have a bad hip joint. So, yeah, there's plenty of
3 different reasons why you'd have it.

4 Q. All right.

5 A. But I don't think we said that the patient had a
6 positive straight leg raise; we said you have an equivocal.

7 Q. Equivocal.

8 A. So it's almost more of a documentation trying to
9 say whether she may or may not have had some nerve tension
10 signs.

11 Q. And you had recorded tenderness over the sciatic
12 nerve; that would be of the low back --

13 A. Right.

14 Q. -- would it not?

15 A. Right.

16 Q. That would not be associated with a knee
17 problem; would it?

18 A. No, we're just, we're just examining her.

19 Q. Correct.

20 A. She's got complaints, we're trying to examine
21 her, so...

22 Q. And you found tenderness on the L5 spinous
23 process?

24 A. Correct.

25 Q. That also would not have anything to do with the

1 knee; would it?

2 A. No.

3 Q. You indicated that she was to return in six to
4 eight weeks. And at the bottom, there's an August 18 stamp.
5 What is that date?

6 A. I don't know. I think it looks like it's --
7 August 18 is stamped probably because that was the day of the
8 next visit.

9 Q. Of the next visit?

10 A. Uh-huh.

11 Q. So that that was a record keeping matter?

12 A. I have no idea.

13 Q. All right. Now, apparently you sent her for
14 therapy following this visit; is that right?

15 A. We did a injection of her knee and wanted to see
16 if that would help, and we recommended studies of her back.

17 Q. Well, when I have seen records from Select
18 Physical Therapy that have been submitted, the indication is
19 that the referring physician was Josiah Duke; would that have
20 been you?

21 A. Yes, obviously.

22 Q. And you don't have a record of having referred
23 her for therapy then; is that it?

24 A. I think that might be the record then.

25 Q. All right.

1 A. So --

2 Q. And when --

3 A. -- sometimes there's a prescription written in
4 here. (Looks at another section of his file.)

5 Q. All right.

6 A. So, you know, there's all sorts of different
7 ways of documenting things in the chart. But I don't know;
8 it wasn't written in that note.

9 Q. It would appear, and I hand you a record here
10 from Select Physical Therapy of March 24, and it would appear
11 that her complaints were of the lumbar area. And that's --
12 is that what you sent her for therapy for?

13 A. I don't have my request for therapy, but, you
14 know, all my documentation's right here.

15 Q. Right.

16 A. So, this is what I saw as an orthopaedic
17 surgeon; this is what's written down by a physical therapist.
18 So I don't know.

19 Q. Do you get the physical therapy records; are
20 they sent to you?

21 A. Yeah, but --

22 Q. Do you review them in connection with your
23 treatment?

24 A. Yup.

25 Q. And when it came back to you and you saw that

1 they were treating the lumbar area, did you agree with that?

2 A. Well, I already injected -- I already injected
3 her knee, so --

4 Q. Right.

5 A. -- we treated her knee and then obviously we
6 must have wanted them to address her back.

7 Q. But you were not ordering therapy for her knee,
8 you were treating her back?

9 A. We -- we said recommend studies of her back.

10 Q. Right.

11 A. In other words, we're concerned that she may
12 have a pinched nerve. We also are treating her for knee
13 pain. So we're addressing two problems. We did therapy for
14 her back, clearly, and we did an injection for her knee. So
15 that's what we did that day, March 17.

16 Q. All right. You indicate that you saw her again
17 on August 18, according to these notes. At that time, your
18 direction was again focused to the sciatic area in her low
19 back; true?

20 A. Correct.

21 Q. And it talks -- you speak about having her spine
22 evaluated by Dr. Reeg or Dr. Voos. Who are they?

23 A. Spine doctors.

24 Q. Are they a part of this practice?

25 A. No.

1 Q. Are they orthopedists?

2 A. Yes.

3 Q. But they specialize in the spine?

4 A. Spine surgery.

5 Q. And you don't have spine surgeons here in this
6 practice?

7 A. We -- we did; his name is Dr. Harvell. And at
8 the time, I don't think he got involved in her care. So I
9 think we sent her, as a second opinion, to these -- to this
10 clinic.

11 Q. Did she go?

12 MR. ANDERSON: I'm sorry, did she go where?

13 Q. To Dr. Reeg or Dr. Voos.

14 A. I don't know. I don't think I have that
15 documented in here. She ended up getting pain management,
16 but I don't have Dr. Reeg and Dr. Voos' notes here, so that
17 might be something that you guys can look into and see if
18 there's a consult with Dr. Reeg and Voos.

19 Q. Well --

20 A. Because it's not here in this chart.

21 Q. -- if -- if it were a consult, you didn't
22 utilize it in your treatment of her; true?

23 A. Well, as a -- as a surgeon treating her knee and
24 trying to make sure she doesn't have a pinched nerve, my
25 interest is -- is to get her treated for her knee, and then

1 to make sure that there's no involvement of her back. In
2 other words, I'm trying to figure out what is causing her
3 pain is clearly what's happening in this chart.

4 Q. Uh-huh.

5 A. So if you read the notes, you can see that
6 there's treatment of the knee with the injection, and a
7 workup of the back, and -- and even treatment of the back
8 that we've been doing during this time.

9 Q. Well, in the -- the physical therapy records,
10 they speak about radiation from the back to the left -- to
11 the yeah, left lower extremity.

12 A. Right.

13 Q. So that the treatment of the lumbosacral area
14 would be a natural treatment when there is radiating problems
15 that go into the extremity; wouldn't it?

16 A. Like I said, I'm -- I'm -- we're doing, you know
17 -- we're evaluating a patient who has knee pain from a prior
18 tibial plateau fracture, who has knee pain and some symptoms
19 of -- of radiation. So, we are trying to figure out is this
20 from the knee or is this from the nerve. And the only way to
21 do that is to evaluate both --

22 Q. All right.

23 A. -- and then to treat both and try to figure out
24 what makes her better. So when we inject her knee, we're
25 trying to see if that helps. And then when we send her to

1 physical therapy for her back and have her evaluated by the
2 spine doctors, again, we're trying to address both.

3 Q. All right. On the next visit that you had,
4 which was April 24, I believe, according to the note that you
5 furnished -- well, let me back up. On the December 8, where
6 there was a question of referring her to Doctors Reeg and
7 Voos, a question of obtaining a myelogram of her lumbar
8 spine, it seems as though that that was by Mr. Satterfield.
9 Did you actually see her on that visit?

10 A. No. That was seen by the P.A., Bart
11 Satterfield.

12 Q. All right. You then did see her on April the
13 24th then of '09?

14 A. Right.

15 Q. And this was only the second time that you had
16 seen her. You had seen her a year earlier in March of '08;
17 correct?

18 A. Correct.

19 Q. And at the time that you saw her on April the
20 24th, it appears that you were still trying to figure out
21 whether it was from the back --

22 A. Uh-huh.

23 Q. -- or whether it was from the knee?

24 A. Correct.

25 Q. Correct. And so you suggested an arthroscopic

1 examination.

2 A. Correct, because the injections for her back did
3 not help her knee pain.

4 Q. All right.

5 A. So her knee continued to hurt even after the
6 injections and the therapy, and that became again kind of
7 drawing, you know, kind of working along the path trying to
8 figure out is this the knee or is this the back. Well,
9 clearly, it's not the back, so then we went ahead and decided
10 it's best to take a look in the knee. And all this happens
11 because she cannot have an MRI. So you know the -- the CT
12 scan again is designed to find fractures; the MRI is designed
13 to find meniscal tears and damage to the cartilage, bone
14 bruises. And so, unfortunately, because of that we had a
15 very convoluted workup. So it took a while to figure out
16 that it was coming from her knee.

17 Q. Well, if it's somebody that really is having
18 difficulty, do you find that they will stretch it out over a
19 year before they really do anything about it?

20 A. I think when you have someone who can't get an
21 MRI it becomes challenging because that person -- that person
22 ends up seeing providers and trying to get better, and it
23 just is challenging.

24 Q. Well, the --

25 A. The knee hurts and you can't make it better. It

1 -- it's a challenge.

2 Q. The only provider is your office; wasn't it,
3 other than the physical therapy that you sent her to?

4 A. Correct. And -- and it's documented that we had
5 a challenging time figuring out what was hurting and we did
6 things to try and make her problems better, but it didn't
7 work. So then, we had to resort to the arthroscopy.

8 Q. Well, when you suggested the arthroscopy in
9 April of '09, is it not sort of unusual that you don't
10 actually do it until January of '10?

11 A. You have to ask the patient that; I'm not sure.

12 Q. Well, it's --

13 A. You know, I didn't schedule it. You could -- I
14 don't know, you know, how that works. I -- I submit a
15 request, it gets scheduled, you know, just challenging to
16 know why things get scheduled on certain days; it's hard to
17 know.

18 Q. All right. Well, but from April, that would be
19 like nine months later after you recommended it that --

20 A. Well, you know --

21 Q. -- you actually did it; wouldn't it?

22 A. -- her knee pain's been going on since 2007.

23 Q. Now --

24 A. So that, again, it's hard to understand, but
25 it's not really what I'm looking at. I'm trying to make a

1 person's knee pain go away.

2 Q. All right. And when you decided to do that in
3 April of '09, the purpose of doing it was to determine
4 diagnostically if it was the meniscus or if she had patella
5 femoral arthritic condition; correct?

6 A. Correct.

7 Q. And then on January 22, 2010, you did the
8 arthroscopic examination; right?

9 A. Correct.

10 Q. And handing you your operative procedure, your
11 note here, you concluded that there were no meniscal tears
12 seen and that there was nothing abnormal about the meniscus;
13 correct?

14 A. We found a large bucket handle tear that was
15 displaced in the intercondylar notch with significant
16 secondary arthritic changes that were Grade III and diffuse
17 on the femoral condyle. So, no, that's -- that's the --
18 that's the tear right there.

19 Q. Doctor, am I misreading your note that says
20 "overall no meniscal tears were seen and nothing seemed to be
21 abnormal"?

22 A. Well, the way -- the way these notes work and
23 you have to kind of unfortunately get used to it. So if you
24 look at the progress of the note, what happens is, you talk
25 about the order of examination. Remember we talked about

1 tricompartmental arthritis, the three different compartments?
2 So, what we do is we put the scope in and we start with the
3 kneecap. We mention what we see there. So, we found that
4 there is some arthritis in the kneecap. Then we go down to
5 the medial compartment and we see a large bucket handle tear
6 that was displaced in the intercondylar notch with secondary
7 arthritic changes. And then, we get to the lateral joint
8 line and we did not see -- you know, we saw a central lesion
9 and then we did not see an obvious lateral meniscal tear.
10 So, I think, you know, again, it's just hard --

11 Q. Well --

12 A. -- because you're not used to these reports.
13 But if you read it, it's pretty clear and I got a picture
14 right here of it, so --

15 Q. Doctor, is -- is this your operative report?

16 A. Uh-huh.

17 Q. Do I misread it here that says overall --

18 A. You're reading out of context.

19 Q. Well, I mean --

20 A. Because we're in the paragraph on the -- we're
21 in the section on the lateral joint line and then you're
22 reading this. So, you know, I just think you're --

23 Q. Whether I'm reading it out of context, whether
24 I'm --

25 A. You're just reading it wrong. It's just hard to

1 understand.

2 Q. Well, tell -- tell me, would you read for me
3 what's highlighted there?

4 A. Yeah. This is in the section of the lateral
5 joint line; we're talking about the lateral compartment which
6 is on the outside of the knee. And, it says, "lateral joint
7 line had a central lesion that extended from the anterior to
8 posterior and the lateral femoral condyle."

9 Q. I asked you, if you don't mind, Doctor --

10 A. Wait, wait, wait, let me --

11 Q. Well, you can -- excuse me, Doctor.

12 A. Right.

13 Q. And you'll have an --

14 MR. ANDERSON: No, no, no, no.

15 Q. -- opportunity to respond.

16 A. You're asking me to read this; I'm trying to
17 read it.

18 Q. I asked you to read what was highlighted.

19 MR. ANDERSON: I'm going to interpose an
20 objection. I've been trying to be very, very courteous and
21 professional towards you. You've asked some leading
22 questions, you've been argumentative. You're going to allow
23 the physician to answer the questions. Okay.

24 MR. LYNCH: I'm happy for him to answer the
25 question, but I would ask that he answer the question that

1 was asked.

2 MR. ANDERSON: Well, that's fine and after he's
3 done --

4 MR. LYNCH: And I asked --

5 MR. ANDERSON: -- after he's done answering, you
6 can explain that you'd like it answered a different way, or
7 you can reiterate your question. But you will allow him to
8 answer the questions.

9 MR. LYNCH: You go right ahead, Doctor.

10 A. So -- so anyway -- so within the lateral
11 compartment there was a central lesion extended from the
12 anterior to posterior, which is again described in the
13 contents of the lateral side of the knee. She was found to
14 have a relatively stable lesion except for some mild fraying.
15 Meniscus had some generalized fraying that was debrided back
16 to a stable rim. Overall, no meniscal tears were seen and
17 nothing seemed to be abnormal. So, again, you know, it's
18 just out of context. It's all right --

19 Q. It's lifted -- it's lifted out of what you have
20 written.

21 A. No, it's not lifted out of it; you lifted it out
22 of it highlighting.

23 Q. Yes, sir; that is correct.

24 A. But if you read the entire report and you had
25 some operative experience and understood operative reports,

1 you would know that that's the order that surgeons dictate,
2 and that's how they do it, and that's what it says. And
3 also, again, pictures are here. So, you know, it's just --
4 it's tough because there are so many different parts of the
5 knee and we're describing each part.

6 Q. But you have written in this --

7 A. No, I dictated it.

8 Q. You dictated --

9 A. Uh-huh.

10 Q. -- that the meniscus had some generalized
11 fraying which was debrided back to a stable rim --

12 A. Uh-huh.

13 Q. -- period.

14 A. Right.

15 Q. Overall, no meniscal tears were seen and nothing
16 seems to be abnormal.

17 A. Right; yeah.

18 Q. Right?

19 A. In the lateral compartment.

20 Q. All right.

21 A. So --

22 Q. Now --

23 A. It's amazing.

24 Q. -- in the -- if you'll help me out -- is that a
25 photograph, or is this a picture that somewhat displays what

1 the knee is like?

2 A. Right.

3 Q. All right. Now, when -- when you started off in
4 this, you indicated that there was a mild lateral lesion on
5 the lateral side of the patella.

6 A. Uh-huh.

7 Q. Now, admitted this is a right knee and you were
8 working on a left knee.

9 A. Uh-huh.

10 Q. So -- but the similarities are there. Where
11 that -- the lateral side of the patella would be on the left
12 knee in -- in this area?

13 A. Well, on this picture, the lateral side is
14 there. (Indicates.)

15 Q. Okay, it would be over here; all right. That
16 was the -- an arthritic condition; was it not?

17 A. Correct.

18 Q. All right. Now, the cartilage would be under
19 the patella?

20 A. Correct.

21 Q. All right. And that was found to be unstable.
22 That, again, would be an arthritic or a deteriorating
23 degenerative condition; would it not?

24 A. Yes. Yeah, we document her arthritic changes
25 pretty --

1 Q. All right.

2 A. -- clear.

3 Q. Now, it says that the trochlea had a lesion.

4 A. Uh-huh.

5 Q. It was symmetric on both sides. And the
6 trochlea is the area that is between the patella and where
7 the femur goes around; is that right?

8 A. Correct.

9 Q. And when you went down further, it said that you
10 then brought the scope down into the medial joint line which
11 would be where?

12 A. Well, this is lateral and this is medial.
13 (Indicating.)

14 Q. And the joint line would be what?

15 A. It's between the two bones, so it's inside here
16 between the -- the femur and the tibia.

17 Q. All right. And you say you found a large bucket
18 handle that was displaced in the intercondylar notch.

19 A. Correct.

20 Q. Well, the intercondylar notch would be up in
21 this area at above the patella; would it not?

22 A. No.

23 Q. Where is the intercondylar?

24 A. Intercondylar. (Indicates on photograph.) So
25 this is a condyle and that's a condyle, so the condylar notch

1 is between the two condyles; it's basically deep inside the
2 center of the knee.

3 Q. Deep inside the center of the knee?

4 A. Uh-huh; right.

5 Q. All right.

6 A. So what happened is the bucket handles gets
7 caught.

8 Q. And that's cartilage in there?

9 A. It's the meniscus. The meniscus was torn and it
10 displaced and got caught into the center of the knee. That's
11 what a bucket handle tear is.

12 Q. And yet, when you conclude it all, you say that
13 there were no tears to the meniscus?

14 A. No, that's not true.

15 Q. When you open up the knee, what is -- what is
16 that -- where are you going then?

17 A. Well, the knee is -- is basically a potential
18 space, so there's normally no space between the femur and the
19 tibia. You have to actually open it to get the scope in.
20 The scope's about the size of a pencil. And in order to get
21 to the front and back part of the knee, you have to open it
22 up a little bit, so you're actually maneuvering and pushing
23 the bones apart and back together.

24 Q. Well, did you -- I thought you had opened it up
25 to get into the area. You said it was --

1 A. No, no.

2 Q. -- back into the knee.

3 A. Arthroscopy is a series of pictures taken from
4 sticking a device into the knee --

5 Q. All right.

6 A. -- so you can actually get to the front and
7 back, sides, under the kneecap. That's -- that's the point
8 of an arthroscopy.

9 Q. You've found that there was arthritic changes
10 around the femoral condyle?

11 A. Correct.

12 Q. And that is the area where?

13 A. Right there; right on that condyle.
14 (Indicates.) So it goes all the way to the back.

15 Q. The top, the top of the condyle?

16 A. No, that's through the front, that's --

17 Q. The front?

18 A. -- not through the joint. It's inside. It's
19 underneath.

20 Q. All right. When you were debriding the meniscus
21 from the back and from the front, that was what, just a
22 fraying?

23 A. No. The bucket handle, which on this image is
24 between the -- between the bones, you can't really -- can't
25 really open up the joint. You have to get rid of this

1 because it's caught. So what happened was is that it used to
2 be here and was torn and displaced into the joint,
3 essentially blocking our access. Once we saw the meniscus,
4 we had to remove it because it had been torn for a long time.
5 It had to be resected and was essentially pinching between
6 the bones.

7 Q. Did you verify then that there was patella
8 femoral arthritic conditions of the knee?

9 A. Let's see. We document -- in each compartment
10 we documented the arthritic changes. We documented that she
11 had some arthritic changes under the kneecap, and also when
12 we saw the large bucket handle tear, there was some secondary
13 changes on the end of the distal femur. I mean, it's all
14 documented right here, so --

15 Q. Okay. Now, since then, have you been requested
16 to develop or express an opinion relative to the relationship
17 of the conditions that you found in an incident that occurred
18 on March 10, 2007?

19 A. Yes.

20 Q. Can you tell me what those opinions are that
21 you've developed?

22 A. In general, or you want to read the report?

23 Q. I haven't seen a report.

24 A. Okay.

25 Q. Have you written a report?

1 A. I think there was some documentation; wasn't
2 there?

3 MR. ANDERSON: Are you referring to that
4 supplement to the --

5 A. Supplement here?

6 MR. ANDERSON: He's referring to that
7 supplemental Discovery response that you all asked for
8 following the telephone conference.

9 Q. This is -- this is a -- a pleading signed by
10 Doctor -- by attorney John Cooper. Have you written
11 anything?

12 A. I don't know; did we? No, I haven't written
13 anything.

14 Q. All right.

15 A. He had called me and we --

16 Q. Can you tell me what opinions -- what opinions
17 have you developed?

18 A. About specifically like what?

19 Q. About Ms. Francis and her conditions and their
20 relationship to an incident that occurred in March of 2007?

21 A. Okay. So you're asking me what caused her
22 injury?

23 Q. I'm asking you what opinions you have developed.

24 A. I mean, I don't have opinions. I'm just a
25 surgeon and I treat patients' needs and I try to make them

1 better. So if you want to ask me a specific opinion about
2 something, then I can tell you that. But I don't have an
3 overall opinion about this. I just think this woman had an
4 injury and I tried to treat it to make her better.

5 Q. Well, and I -- I understand that, and that's
6 what most doctors do.

7 A. Right.

8 Q. So, is it fair to say then that you have not
9 developed an opinion with reasonable medical probability of
10 any correlation between the conditions you found and any
11 incident that occurred in March of 2007?

12 A. Okay. So what -- what I would say is that -- is
13 that she had a fracture of her -- of her knee that was
14 diagnosed by the CT scan, and that happened back in 2007.
15 And -- and then, she had persistent knee pain.
16 Unfortunately, because she did not get an MRI, the meniscal
17 tear was never identified. It stayed locked in the front of
18 her knee, and then when we scoped it, we found it. And I
19 think that the back pain and the preexisting arthritis were
20 aggravated by the injury. So I think the meniscal tear was
21 traumatic and it happened from the accident.

22 Q. What do you base that upon?

23 A. Well, having a bucket handle tear is a traumatic
24 injury. The bucket handle tear is incurred from a traumatic
25 injury where the meniscus is torn and displaced into the

1 joint and it essentially locks the knee. Sometimes the
2 patient will come in walking on it and then gradually he'll
3 push it out of the way, and then they'll just have some
4 intermittent pain. In her case, you know, she also developed
5 symptoms down her leg, in her back, and in her knee. So we
6 treated -- we tried to treat all of her problems.
7 Eventually, the only way we really were able to help her was
8 to scope her knee.

9 Q. Well, what causes you to say that -- that she
10 had a prior condition of her back?

11 A. Well, she had back pain and we treated her with
12 injections. And she had symptoms going down her leg that we
13 tried to make better by doing physical therapy. So, I do
14 think she had prior arthritis in her knee. I think that she
15 had some irritation of her back, and that those conditions to
16 me were probably aggravated by the injury. I think that the
17 --

18 Q. Is that --

19 A. -- bucket handle tear was traumatic.

20 Q. -- is that with a reasonable degree of medical
21 probability?

22 A. Yes.

23 Q. Or is it just possible that that was what the
24 situation was?

25 A. I don't think there's any chance that she

1 developed a bucket handle tear before.

2 Q. Do you have any idea what occurred to her or
3 what she did in the intervening year before she came to you?

4 A. You know, I don't have her -- every day that
5 she's walked and done things, I don't have that documented.
6 I mean, because I don't --

7 Q. People --

8 A. -- live with her.

9 Q. -- people tear meniscus falling, picking up
10 things, and other activities; don't -- do they not?

11 A. Yeah, certainly that's true. But in this case
12 we have a documented injury. We have the CT scan, we have
13 the fracture, and we have the fact that she's had continued
14 pain. And the fact that she has had a difficult time and we
15 found the tear and it -- and it was displaced bucket handle;
16 those are traumatic injuries.

17 Q. All right.

18 A. If it was just an arthritic problem, then I
19 would say that she just aggravated her preexisting arthritis.
20 But because we found the bucket handle tear, it's traumatic.
21 That's how they're caused.

22 Q. Have you -- tell me what you base your opinion
23 that she had a fracture of the tibial plateau on?

24 A. I base my opinion on the reading by Dr. Lynn
25 Arcara that showed that she had a lateral left plateau

1 fracture with concern for unstable small fracture fragment
2 that is nondisplaced.

3 Q. All right. And where is the -- the lateral
4 plateau of the tibia?

5 A. On the lateral side of the joint, in the back.

6 Q. In the back?

7 A. Uh-huh.

8 Q. All right. And that's a solid bone; is it not?

9 A. Correct.

10 Q. And the fracture of it would be that there was
11 -- it was nondisplaced, as I read it, so that there -- is
12 there a crack there or is it just that there's a chip out of
13 it; what was it?

14 A. A chip.

15 Q. A chip out of it?

16 A. Uh-huh.

17 Q. And if it was nondisplaced, then the chip was
18 still in place; right?

19 A. Correct.

20 Q. And so, how would that affect the patient?

21 A. Typically, tibial plateau fractures are -- some
22 of them have to be treated because they are clearly displaced
23 and they need to be put together, otherwise, you can't walk.
24 When there are small tibial plateau fractures, it indicates a
25 higher energy of injury; it indicates that there's a risk for

1 cartilage damage; that there's a risk for meniscal tears;
2 that there's a risk for ACL or PCL injuries. So, you know,
3 the -- the fact that she had the fracture is what to me
4 indicates that she had a pretty significant injury.

5 Q. Dr. Wilhelmsen didn't seem to find that when he
6 saw her; did he?

7 A. You would have to talk to him about that.

8 Q. According to your records.

9 A. I mean, I just don't know anything about why he
10 said what he said. But -- sorry.

11 Q. If the low back, or the sciatica, the sciatic
12 nerve in the lower part of the spine had been damaged
13 traumatically, would you not expect to have immediate onset
14 of discomfort and complaints before a year had passed?

15 A. In terms of -- I think that there's just not a
16 lot of documentation of her back injury at the beginning of
17 the first visit, and I don't see any studies where it showed
18 that she had had a back injury. You know, in terms of us
19 looking at her, trying to figure out, you know, why she was
20 still having knee pain, we wanted to look at her back to see
21 if there was a reason why she might still be having it. So.

22 Q. But if -- if it were traumatically induced,
23 would you not expect to have symptomatology before a year had
24 passed?

25 A. You mean in terms of her back?

1 Q. Yes, sir.

2 A. You know, it's just like I said. I don't know
3 if, you know, when you're talking about car accidents and
4 you're talking about pain later in the -- in the course, I
5 think that I tend to focus more on the knee because that's
6 what was documented as being injured. I think if there was
7 documentation that she had had a back injury from the get-go,
8 or that we were the ones being consulted to see her for her
9 back, then I probably would -- I probably would say her back
10 injury was somehow related and we would have studies and we
11 would be looking at it. I think in terms of what we're
12 talking about here, this is all about her knee. We're
13 talking about why she kept having knee pain after she had
14 broken it and why it kept hurting. And -- and I think that
15 you're wondering about the discrepancy between Bruce
16 Wilhelmsen's report and mine and wondering about, you know,
17 whether this meniscal tear is there and then not there. So
18 -- but I'm not really talking much about her back because I'm
19 not a spine surgeon. The reason why I worried about her back
20 was because I didn't want her to have a pinched nerve, end up
21 getting her knee scoped and finding nothing. I wanted to
22 make sure. So.

23 Q. Dr. Duke, to ask you the question again. If
24 there was traumatic injury to her low back, would you not
25 expect her to have some symptomatology or complaint before a

1 year had passed?

2 A. I don't -- I don't base my opinion on that. I
3 base my opinion on what the patient presents as their
4 examination, their prior studies. So, you know, I don't
5 speculate about different parts of this like you do, because,
6 obviously, it's your job. My job is just to talk to her,
7 understand what's going on. And I think that if you break
8 your knee and you're having a hard time, that you can
9 aggravate your back. I think that it would be tough to say
10 she injured her back in the car accident. I would say that
11 the accident may have aggravated her back, but I don't think
12 we have any documentation that her car accident caused a
13 spinal injury.

14 Q. And when you say "may have," that's a different
15 standard than with reasonable certainty or reasonable medical
16 probability, isn't it?

17 A. I never -- I never -- I never said anything
18 about that. We were talking about her knee. Talking about
19 the fact that she injured her knee, she tore her meniscus,
20 she had a bucket handle tear, and it happened from the car
21 accident, and that's what I'm saying.

22 Q. And so you do not have an opinion then that
23 there was an aggravation of her -- of a sciatic condition as
24 a result of this accident; correct?

25 A. We don't have any documentation that she had a

1 herniated disk or a pinched nerve. So, there's not any
2 documentation. What I think happened was that she aggravated
3 her preexisting arthritis and she may have aggravated her
4 back. But, again, you know, I was seeing her for her knee.
5 So.

6 Q. And I can appreciate that.

7 A. Right.

8 Q. And I understand that -- that you would see me
9 as perhaps argumentative because you haven't testified
10 before. But the standard -- there's a standard that has to
11 be met, and that's why I continue to question you along this
12 line. As far as I understand it, you are confident and
13 definite about the meniscus.

14 A. Correct.

15 Q. But that, as to the aggravation, the suggestion
16 that there was an aggravation of a preexisting condition of
17 the sciatic nerve or the low back is not something that you
18 are strong on like you are the knee, and that that is a "may"
19 and not medically certain or medically probable; correct?

20 A. I think it's -- no, I think it's medically
21 probable that she aggravated her back and she aggravated her
22 knee arthritis. So, you know, but again, what are we talking
23 about? Do you want to know about her back? Well, again,
24 there's very little documentation of a true injury to her
25 spine. There's no documentation she had a fracture or

1 dislocation. Her back has been documented to have been
2 hurting, and she has responded to therapy and she's had
3 injections. So, she has had aggravation of her back from the
4 accident.

5 Q. All right. Now, have you opined that with
6 reasonable medical probability she must have a knee
7 replacement?

8 A. In terms of this person's chronic knee pain,
9 what's -- what the -- the real question is -- is that if
10 she --

11 Q. Excuse me. Let me -- you -- you can answer my
12 question yes or no because it's a yes or no question. And
13 then you can explain.

14 A. No, it's not a very good question because --

15 Q. All right.

16 A. -- you know, you need to explain this thing
17 about opined and you got to be a little more clear. So what
18 do you want to know?

19 Q. Have -- have you reached an opinion with medical
20 probability --

21 A. Correct.

22 Q. -- that she must have a knee replacement?

23 A. My -- my opinion is that her knee may continue
24 to hurt. She may need a knee replacement in the future.

25 Q. All right.

1 A. That's my opinion.

2 MR. LYNCH: I don't have any further questions.

3 MR. ANDERSON: Do we want to give the Doctor a
4 break? Doctor, do you need to take five or ten minutes --

5 DR. DUKE: No, let's --

6 MR. ANDERSON: -- or do you just want to just --

7 DR. DUKE: -- go on. Come on.

8 COURT REPORTER: Are you going to enter the
9 exhibit?

10 MR. LYNCH: Yes, I want to. The -- thank you.

11 MR. ANDERSON: Ben, let's swap seats before we
12 go on.

13 MR. LYNCH: Yeah. The operative report that
14 he's referred to, I would offer as Defendant's Exhibit [1].

15 COURT REPORTER'S NOTE: There was an off-the-
16 record break beginning at 6:20 p.m. and ending at 6:21 p.m.

17 ON EXAMINATION CONDUCTED BY MR. GREG W. KLEIN:

18 Q. Dr. Duke, my name is Greg Klein. I'm
19 introducing myself for the record; we've obviously met
20 before. I represent Michelle Dail in this case; she's a co-
21 defendant in the case, and we're here obviously to take your
22 deposition. And, I just want to lay out a couple of quick
23 ground rules for you and hopefully we can avoid some -- some
24 issues. I'm not here to question whether the medical
25 treatment you provided was competent, I'm not here to

1 question the authenticity of the records. I just have a lot
2 of questions about what some of these terms mean.

3 A. Okay.

4 Q. And I'm hoping that you can hopefully just
5 provide some explanation as far as that's concerned.

6 A. No problem.

7 Q. For the court reporter's benefit too, if we can,
8 let's try not to talk over one another. It's probably hard
9 enough to understand a doctor and a lawyer speaking
10 alternately as opposed to over atop of one another. If you
11 could turn to the medical record for Barbara Francis that's
12 dated April 2, 2007. And I am going to apologize in advance;
13 I believe some of these questions may have already been
14 answered, but I just want to make sure that I have a clear
15 understanding. If you go to the second paragraph under
16 "Physical Examination," and it states, "X-rays were obtained
17 today of her knee. They do show evidence of degenerative
18 changes." Can you explain in lay person's terms what are
19 degenerative changes?

20 A. When someone has arthritis, their joint on x-ray
21 becomes more narrow and there are spurs. And -- and it's
22 sometimes related to your age. I mean, it's -- it's just
23 something that we see, so we do talk about that.

24 Q. Would you consider degenerative changes mainly
25 age related then?

1 A. It can be both. There are some people that just
2 have a predisposition for arthritis. It can be
3 posttraumatic, it can be -- it can be caused from damage. It
4 can -- it can -- it can just be age related.

5 Q. Okay. And if you continue to go through on that
6 report, it states that "no specific fracture is seen." But
7 then the next sentence, it addresses the tricompartmental
8 osteoarthritis with possible evidence of a lateral tibial
9 plateau fracture on the left.

10 A. Correct.

11 Q. I know you didn't write this report, but my
12 question is can you explain, is it possible, why it says no
13 specific fracture is seen, and then it addresses possible
14 evidence; is that a standard?

15 A. I think it's the same question that he had
16 earlier. What you have to understand is there's a -- there's
17 an order to the note. If you read the note it says "x-rays
18 were obtained today of her knee." These are just plain
19 films.

20 Q. Uh-huh.

21 A. These are not 3-dimensional CT scans. So when
22 you look at an x-ray, you don't see a fracture. And then, it
23 says the CT scan was reviewed. It does show a possible
24 evidence of a lateral tibial plateau fracture. So, again, a
25 CT is a 3-dimensional x-ray.

1 Q. Uh-huh.

2 A. And you are actually slicing the bone, looking
3 at the front and back side. And the x-ray is more of a 2-
4 dimensional image where you're just looking at the front of
5 the bone and kind of seeing through.

6 Q. Okay. If you continue to read through, it says
7 that he looked at the CT scan and could not appreciate any
8 type of gross depression --

9 A. Right.

10 Q. -- to the tibial plateau. What is a gross
11 depression in this context?

12 A. If there's a fracture of the tibial plateau,
13 it's a -- the tibial plateau is flat.

14 Q. Okay.

15 A. So, sometimes what happens is, is that when
16 someone's knee is injured, the knee can hyperextend, or
17 hyperflex, or be translated so the femur will take the
18 plateau and drive it down; okay? So it's a -- it's a
19 compression type of mechanism, and the plateau becomes
20 depressed. Or it can just pop back up, stay depressed, stay
21 -- just kind of stay pulled off like it's been ripped off
22 with ligaments. So, there are just different types of
23 fractures.

24 Q. Okay. So the gross depression is a -- is just a
25 type of fracture?

1 A. Right. And, that's what he was looking for was
2 to make sure it did not need surgical intervention.

3 Q. Okay. If you could turn to the note of April
4 23, 2007, it indicates, on the second line, it says "repeat
5 views were taken of her knee today and no fracture is seen."
6 In your records does it indicate whether those views were
7 again just the plain film, or were -- was it the CAT scan; do
8 you have any idea?

9 A. Plain film.

10 Q. Okay. And it indicates on there that "she's
11 feeling much better and there's no evidence of permanent
12 impairment."

13 A. Correct.

14 Q. Okay. I don't want to delve too deeply into the
15 back for reasons that you've obviously already articulated.
16 The question is this, did she complain to you of back pain?

17 A. You know, honestly, it's just not documented
18 well enough, but she complained of pain in her knee that
19 radiated up her leg. So, what we thought was that she might
20 have a pinched nerve.

21 Q. Okay.

22 A. I mean, you know, that kind of where we -- you
23 know, what -- what we looked at was that she's got a knee
24 injury and she's got this pain that's shooting up her leg and
25 down her leg and it's also in her knee. And it's just -- is

1 it a pinched nerve or is it a meniscal tear, or is it
2 arthritis. And, you know, you just kind of go through this
3 long ordeal. Obviously, it's longer due to the fact that
4 there's PA's seeing her in the middle. They're not always as
5 focused on just solving the problem quickly. Sometimes they
6 might say well we'll try a therapy and we'll try injections,
7 but -- and that's really the -- if you look at the chart,
8 it's the big picture.

9 Q. And, Doctor, the reason why I was asking is
10 because I'll represent to you that in her deposition, she
11 manifested that she never complained of back pain, never
12 received any treatment for her back, and so I was just trying
13 to get some clarification as to that. But I -- I think what
14 you said makes perfect sense.

15 A. Right.

16 Q. Okay. If we go to August 18, 2008, we turn to
17 that record. In the first paragraph, it says she's been
18 worked up for the knee with a CAT scan which did show some
19 medial compartmental arthritis and possible fracture of the
20 tibial plateau. This will sound like a stupid question, but
21 can you describe to me what a "possible fracture" means?

22 A. That's a good question. I mean, you know, I
23 think that the -- I think the main question with this
24 fracture is in terms of looking at these cracks that these
25 radiologists say, "Is that crack symptomatic?" You know, "Is

1 it what's hurting her." And I think that's really the big
2 picture is that we're saying do you, you know, did this
3 fracture still hurt you. Is that part of what's happened
4 because it's, it's not a big fracture. It's not an obvious
5 surgical lesion and clearly was not depressed. It was a
6 small little crack. So what we thought was that, yeah, she
7 had energy, she had an injury, there's definitely something
8 going on in this knee. We need to be careful and make sure
9 that there's nothing. The problem is, I hate to say it, if
10 we had gotten an MRI, it would have been done; the problem
11 would have been solved. So, unfortunately, we couldn't get
12 an MRI and it kind of haunted us throughout this visit.

13 Q. And again, you'll have to forgive me for asking
14 lay person questions, but how is the fracture related to the
15 meniscal tear?

16 A. To me, it's more related to the fact that there
17 was an energy, that -- that she had an injury in that a -- a
18 fair amount of energy was transmitted to the knee. It's just
19 that whether the knee was hyperflexed, hyperrotated,
20 compressed, driven in. Again, it's so hard a year out to --
21 to speculate exactly how she got a bucket handle tear. I can
22 tell you that they are big-time injuries.

23 Q. Bucket handle tears are?

24 A. Handle tears; yeah.

25 Q. Are they the type of injury that typically

1 result from a -- from a high energy incident?

2 A. Yeah. We see them a lot in sports injuries, and
3 we see them a lot in car accidents. And, you know, to have
4 it displaced completely in your intercondylar notch, it means
5 that it literally flipped all the way into the joint and got
6 stuck like a rock or a pebble. And that's what I think is so
7 unique about her -- her entire course.

8 Q. If someone were to suffer a bucket handle
9 fracture --

10 A. Bucket handle tear.

11 Q. -- bucket handle tear, excuse me. I said again
12 you're dealing with a lay person.

13 A. With a fracture.

14 Q. If you're dealing with a bucket handle tear, how
15 long, based on your experience, not speaking about Ms.
16 Francis, but based on your experience, how long does it take
17 for symptoms to become evident?

18 A. It's -- it's -- it's confusing. I think that if
19 you are, if you are seen right away and you're evaluated
20 right away, you're going to know it immediately and you're
21 going to get an MRI and you're going to have pain pretty darn
22 quick. I would say that that's, you know, again, an unusual
23 part of her history. However, it's so hard to speculate
24 because I don't know what they did with her. Was she on
25 crutches, was she on a walker, you know, how was she limiting

1 her weightbearing. You know, that -- that's tough.

2 Q. Do bucket handle tears ever heal themselves?

3 A. No.

4 Q. Do bucket handle tears ever just begin to become
5 asymptomatic?

6 A. They can become less symptomatic over time,
7 because what happens is you just push them out of the way.
8 And what happens is that your femur normally sits in a -- in
9 a concavity that's made by the meniscus.

10 Q. Uh-huh.

11 A. And it has room for it. Now, imagine that that
12 concavity is now flipped to the other side; the femur now has
13 to make itself a new happy place. So this gets pushed out of
14 the way further and further, but it still hurts because
15 you're still straightening out your knee and you're hitting
16 the front, and bending your knee and hitting the back. So
17 it's like she's now walking on a disk.

18 Q. Okay.

19 A. Like a split frisbee or something like that.
20 And -- and so it does give you persistent pain, and it can
21 make you limp and walk differently and --

22 Q. Are you familiar with the -- the details of the
23 accident that occurred?

24 A. No.

25 Q. Okay. Would you say that it's typical for a

1 patient with a bucket handle tear to come in with pain, have
2 the pain get better, and then have the pain get worse?

3 A. Yeah. I think that's the tough part of this
4 argument, is again, yes, it could happen. I mean, that's --
5 that's a problem. And -- and, again, I don't know what
6 happened from here to here.

7 Q. And when you say here to here, what do you mean
8 by that?

9 A. Well, you're talking about the interval. You
10 know, I think your big concern is that she had this injury in
11 March 10, is managed with limited weightbearing in April with
12 a presumed fracture, told by a doctor that she's normal on
13 April 21, and said go away, you're fine. So if she comes
14 back, well, she comes back -- we're talking seven, eight,
15 nine months later, but she's been having pain.

16 Q. Sure.

17 A. I don't know who she's seen, I don't know what
18 she's been doing.

19 Q. Sure.

20 A. I can just tell you that when we saw her and we
21 examined her, that's what we found.

22 Q. Sure. And -- and certainly, so that you
23 understand, I'm not suggesting that any of the injuries are
24 -- are faked or anything of that effect. I just -- I'm no
25 doctor and I'm just trying to figure it out as best as I can.

1 What is, in your opinion, her -- well, strike that. Does she
2 have a current disability in your opinion?

3 A. Her -- I haven't done a disability evaluation of
4 her. The last time I saw her was in June of 2010 and she was
5 still having pain. She had lost some extension and lost some
6 function. By definition, she would have some disability.
7 I'm not sure what rating I would give her but she's had
8 surgery, she's had a fracture, she's had a displaced bucket
9 handle tear, and she's clearly aggravated her arthritis.

10 Q. But at this point, you haven't?

11 A. I have not. I -- I don't -- I don't know why,
12 but I have not given her an MMI rating as of yet.

13 Q. Okay.

14 A. So --

15 Q. Were you -- were you asked to provide one by her
16 counsel?

17 A. I don't remember. If I did, I hadn't documented
18 it in the chart.

19 Q. Okay. Do you recall ever telling her counsel
20 that she was permanently disabled?

21 A. I can only remember what I write in the chart.

22 Q. I understand.

23 A. It's hard to remember.

24 MR. KLEIN: I've just a couple of more points
25 and then I'm -- I'm done and I'm assuming, Mr. Anderson, you

1 probably won't have anything.

2 MR. ANDERSON: I'll ask a couple of questions,
3 but we won't be here long.

4 Q. Is it possible that there was some intervening
5 event that occurred between this car accident and the time
6 that you saw her which caused the injury?

7 A. I don't know. I don't know much about those
8 things.

9 Q. Certainly, would you say it's within the realm
10 of possibility?

11 A. I'm an orthopaedic surgeon, I'm not a lawyer; I
12 don't -- I can't comment on those things.

13 Q. And I'm not -- I'm just asking. I mean, I --

14 A. You know, I just say what I say and I do --

15 Q. Sure.

16 A. -- what I do.

17 Q. And, and here's the reason why I'm asking, and
18 this kind of goes back to the basis as to some of the
19 questions that Mr. Lynch was asking you. You've been
20 identified as an expert --

21 A. Correct.

22 Q. -- in this case. And so, as an expert, you're
23 expected to provide an opinion to a reasonable degree of
24 medical certainty --

25 A. Correct.

1 Q. -- and not just to the diagnosis or the
2 condition's permanency, things of that nature, but also the
3 very causation of the injury.

4 A. Right.

5 Q. And that is what you're responsible for. Now, I
6 think we all agree that there is some injury here.

7 A. Correct.

8 Q. The question becomes, you know, what caused it.
9 And so, what we want to know is, to a reasonable medical
10 certainty, can you say that this car accident, which you said
11 you don't know any of the details of, caused this bucket
12 handle tear?

13 A. Yes.

14 Q. Okay.

15 A. I -- I believe it caused the -- the tear.

16 Q. Okay. And, very quickly, just walk me through
17 why do you think that the car accident caused the tear?

18 A. Well, you know, there's different reasons. But
19 I think that the big reasons are that she had a fracture, she
20 had energy, she had a mechanism, she had knee pain, she had
21 tenderness. We diagnosed it through the scope and it was a
22 traumatic injury. And, you know, putting all that together,
23 you know, again that's your job, not mine. I think that you
24 were asking my opinion. My opinion is that it was caused by
25 the accident. So.

1 Q. Do you have any idea how fast the cars were
2 traveling?

3 A. No.

4 MR. KLEIN: Okay. I don't think I have any
5 further questions. Thank you, Doctor.

6 A. Okay.

7 MR. ANDERSON: You want to tell him?

8 DR. DUKE: Yeah, you know, I -- I'm sorry, but
9 it's just --

10 MR. KLEIN: Let's go off the record for a
11 second.

12 COURT REPORTER'S NOTE: There was an off-the-
13 record break beginning at 6:40 p.m. and ending at 6:42 p.m.

14 ON EXAMINATION CONDUCTED BY MR. MICHAEL J.

15 ANDERSON:

16 Q. These may be some things that -- just
17 housekeeping things that I missed, but, you know, we've got
18 you scheduled for a trial deposition coming up here, so just,
19 for my clarification. Are -- are you Board certified in
20 orthopaedics?

21 A. Yes.

22 Q. Okay. Do you know Dr. Hinson, H-I-N-S-O-N?

23 A. Yes.

24 Q. Okay. And I'm going to try to sum this up into
25 one question. No, I don't think I can do it. Can a -- can a

1 pinched nerve in a person's back manifest itself in
2 radiculopathy or lower extremity symptoms without causing
3 significant back symptoms?

4 A. Yes.

5 Q. Okay. If you had been able to, or Dr.
6 Wilhelmsen had been able to obtain an MRI back in April of
7 2007, do you think all of the evaluation and treatment of
8 Barbara's back would have been necessary to determine the
9 etiology of her knee symptoms?

10 A. MRI would have been very helpful.

11 Q. Okay. Is that why you evaluated and -- and
12 treated her -- her back to determine if that was a
13 significant cause of -- of her knee symptoms?

14 A. We -- we went more toward the nerve because of
15 the pattern of her pain. We -- you know, in general, I just
16 felt that, you know, it -- I just feel that you need to
17 exclude something that might be a problem. I did not want to
18 scope her until I was sure she didn't have a pinched nerve.

19 Q. Okay. One thing I guess I will ask, it seems
20 pretty clear to me that you're not attaching a lot of
21 significance to it, but in your operative report, I noticed
22 an indication of partial MCL tear?

23 A. Yes.

24 Q. Okay. Do you find that to be a significant
25 finding?

1 A. Not really at a -- not really at a year out, I
2 didn't.

3 Q. Okay.

4 A. Because the meniscus -- the cruciate ligaments
5 hold the joint together and they heal and they don't cause
6 chronic pain.

7 MR. ANDERSON: Okay; okay. I don't have any
8 other questions.

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*****THE DEPOSITION CONCLUDED AT 6:43 P.M.*****

129446

Hospital Encounter

Barbara Williams Francis (MRN 128711)

Note Report

Author	Service	Author Type	Filed	Note Time
Josiah W Duke, MD	(none)	Physician	01/25/2010 0752	01/22/2010 1513

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SURGICENTER OF EASTERN CAROLINA, LLC
102 Bethesda Drive
Greenville, N.C. 27834

Name: FRANCIS, BARBARA WILLIAMS	MR No: 000000128711
Date of Admission: 01/22/2010	EDP No: 000020020644
Date of Discharge: 01/22/2010	Date of Birth: 12/30/1941
Room No: SUR	

DATE OF OPERATION: January 22, 2010

PREOPERATIVE DIAGNOSIS: Left knee pain with possible lateral meniscal tear

POSTOPERATIVE DIAGNOSIS: Same

OPERATION:

- (1) Left knee arthroscopy
- (2) Partial medial meniscectomy
- (3) Chondroplasty of the patella
- (4) Chondroplasty of the lateral femoral condyle

DESCRIPTION OF OPERATION: After informed consent had been obtained, the patient was taken to the operating room where she underwent general anesthesia. A time out was taken. She was prepped and draped in the usual sterile fashion. The right leg was placed in the lithotomy position and well padded. We proceeded to place a superior lateral portal in the left knee after a time out was taken and she was prepped and draped. We did not place a tourniquet. We left it down. We then made a small incision in the superior patellar pouch and put in a superior lateral outflow portal with an 11 blade and an anterior lateral inflow portal with an 11 blade just off of the patella tendon. Then, a medial portal was established just above the medial meniscus. We proceeded to bring the arthroscope into the suprapatellar pouch. We found that there was a mid lateral lesion on the lateral side of the patella, grade III. It measured 2 by 2 cm. The superior pole was intact. The inferior pole was slightly intact. The cartilage was found to be mildly unstable and debrided back to a full radius resector. The trochlea had a large grade III lesion that was symmetric on both the medial and lateral sides. It extended down to the mid trochlea and was at least 2.5 x 3 cm in size. We then found that these edges were also mildly unstable and debrided back to a stable rim. We then brought the scope down into the medial joint line. We found a large bucket handle that was displaced in the intercondylar notch with significant secondary arthritic changes that were grade III and diffuse on the femoral condyle. The edges were found to be unstable. These were debrided. The meniscus was also debrided first from the back and then from the front. We then had to open up the knee. There were some difficulties to get to the very back of the posterior horn of the knee to get a full debridement. We did feel a small opening as we pushed the knee into valgus force which suggested a small

DEFENDANT'S EXHIBIT

Irritation to the deep medial cruciate ligament which we felt was a partial tear. Once we were able to do this, we could more easily get into the knee. We found the anterior cruciate ligament to be intact and the posterior cruciate ligament to be intact. There were no loose bodies in the back of the knee. The tibial plateau was intact with some mild grade II changes on the medial side. The lateral joint line had a central lesion that extended from the anterior to posterior and the lateral femoral condyle. She was found to have a relatively stable lesion except on the posterior aspect which was debrided back to a more stable rim. The meniscus had some generalized fraying which was debrided back to a stable rim. Overall, no meniscal tears were seen and nothing seemed to be abnormal. The very posterior horn and posterior aspect of the bone was not significantly involved. There was no evidence of the step off or fracture which would require any surgery. At this point and time, we felt that we had appropriately reduced the knee. The knee was well aligned. The medial cruciate ligament was intact but had the mild increase in laxity and no more than 3-4 mm of increased laxity. We did not consider this a true medial cruciate ligament tear but just partial injury. We proceeded to close the portals with 3-0 Nylon sutures. The patient was sent to the Post Anesthesia Care Unit in stable condition.

Unreviewed

Josiah Duke, M.D.

D: 01/22/2010
T: 01/25/2010
JWD/ewv
000867429/1604199

cc: Josiah Duke, M.D.