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Deposition of KIM JOHNSTON, M.D., taken

on behalf of the Plaintiff, pursuant to

Notice, in accordance with the Georgia Civil

Practice Act, before Dorothy T. Shutt,

Certified Court Reporter and Notary Public

at 840 Pine Street, Macon, Georgia, on

August 24, 2010, commencing at the hour

of 7:53 a.m.

IN THE SUPERIOR COURT OF FULTON COUNTY  
STATE OF GEORGIA

JOHNNY C. WILCOX,

Plaintiff,

vs.

Civil Action No. 2008-CV-151063

CSX TRANSPORTATION, INC.,

Defendant.

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APPEARANCES:

On behalf of the Plaintiff, JOHNNY C. WILCOX:

SHAPIRO, COOPER, LEWIS & APPLETON, P.C.

By: John M. Cooper, Esquire

1294 Diamond Springs Road

Virginia Beach, Virginia 23455

On behalf of the Defendant, CSX TRANSPORTATION,  
INC.:

CASEY GILSON, P.C.

By: Glenn Tornillo, Esquire

Six Concourse Parkway

Suite 2200

Atlanta, Georgia 30328

Also present:  
Johnny Wilcox

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INDEX TO EXAMINATIONS

WITNESS: KIM JOHNSTON, M.D.

EXAMINATION

By Mr. Cooper.....Pg.05  
By Mr. Tornillo.....Pg.24  
By Mr. Cooper.....Pg.52  
By Mr. Tornillo.....Pg.55

- - -

INDEX TO EXHIBITS

Exhibit No. Description Marked

PX 1.. Board portraying normal disk..Pg.58  
anatomy

PX 2.. Board portraying disk.....Pg.58  
herniation

DX 1.. Medical record for Wilcox.....Pg.56  
dated 7/11/05

DX 2.. Letter from Dr. Meeks to.....Pg.57  
Otis Forbes, Esquire dated  
July 17, 1992

DX 3.. Dorminy Medical Center records.Pg.57  
for Wilcox dated 2/9/05

1 THE VIDEOGRAPHER: One second. We're now  
2 on the record with Videotape No. 1 in the  
3 deposition of Dr. Kim Johnston taken in the  
4 matter of Johnny C. Wilcox versus CSX  
5 Transportation. This is filed in the Superior  
6 Court of Fulton County, Georgia, Civil Action  
7 File No. 2008-CV-151063.  
8 This deposition is being held at 840 Pine  
9 Street, Macon, Georgia. Today's date is  
10 August 24, 2010 and the time is 7:53 a.m. My  
11 name is Harris Bitman. I'm the video  
12 technician.  
13 Will counsel please identify yourselves  
14 for the record.  
15 MR. COOPER: My name is John Cooper, and I  
16 represent Johnny Wilcox.  
17 MR. TORNILLO: I'm Glenn Tornillo on  
18 behalf of CSX Transportation, Inc.  
19 THE VIDEOGRAPHER: The court reporter  
20 today is Dorothy Shutt with Esteb & Associates  
21 and will now swear in the witness.  
22 (The court reporter administered the oath  
23 to the witness.)  
24 MR. TORNILLO: And, John, before we start,

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1 if I could just go ahead and put on the record

2 that CSX is objecting to any testimony regarding

3 medical causation in this case based on the

4 grounds that we believe Dr. Johnston's medical

5 causation opinions were disclosed after the

6 close of the discovery period. If I may have a

7 standing objection to those questions, I won't

8 need to interrupt you during your questioning.

9 Is that fair enough?

10 MR. COOPER: That's fine.

11 MR. TORNILLO: Go ahead.

12 KIM WALDEN JOHNSTON, M.D.

13 having been first duly sworn, was examined and testified as

14 follows:

15 DIRECT EXAMINATION

16 BY MR. COOPER:

17 Q. Dr. Johnston, are you licensed to practice

18 medicine?

19 A. Yes, sir, I am.

20 Q. Please state your full name for the record, by

21 the way?

22 A. Kim Walden Johnston.

23 Q. What's your specialty?

24 A. Neurosurgery.

25 Q. And what is neurosurgery?

1 A. Neurosurgery is the medical and surgical

2 practice of the central and peripheral nervous system which  
3 includes the brain, the spinal cord, the peripheral nerves

4 and the structures supporting it.

5 Q. Where is your office?

6 A. 840 Pine Street, Suite 880, in Macon.

7 Q. That's where we are today?

8 A. Yes, sir, it is.

9 Q. Please tell us about your medical education.

10 A. I began my medical education in, let's see, in

11 1977 at the Medical College of Georgia, completed that in

12 1981, did a year of general surgery internship at the

13 medical college and then five years of neurosurgical

14 training there and completed my training in 1987.

15 Q. And what is an internship?

16 A. Internship is for us it was a general surgery

17 internship where we basically took histories and physicals

18 and treated patients on the floor and did some surgery, but

19 it was mainly the first year of training out of medical

20 school.

21 Q. How about residency for the jury and for me to

22 understand just what the nature of that is.

23 A. For residency you start -- we sort of laugh --

24 you start off at the bottom and you work your way up until

25 the last year or next to the last year you work at what's

1 called the chief resident where you are in charge of taking  
 2 care of patients, you're in charge of surgery. Of course,  
 3 all of this is with supervision with professors that teach  
 4 you how to treat patients and to do neurosurgery.  
 5 Q. Have you had the honor of doing some teaching  
 6 of medicine yourself in your career?  
 7 A. Yes, sir, I have.  
 8 Q. Tell us about that briefly.  
 9 A. I am currently an associate professor of  
 10 surgery at Mercer University and assistant professor at the  
 11 Medical College of Georgia.  
 12 Q. What is board certification?  
 13 A. Board certification means that you have gone  
 14 through the process that you have to do to consider to be  
 15 competent within your field. And this involves taking a  
 16 written test, doing your residency, and then following your  
 17 residency for two years, you have to collect cases that you  
 18 have performed with the cause, the outcome, and this is  
 19 sent to the board which reviews this. And you then sit for  
 20 oral presentation for three different parts.  
 21 Q. You are board certified?  
 22 A. Yes, sir, I am.  
 23 Q. When did you receive that?  
 24 A. 1991 or '92.  
 25 Q. And by whom are you certified?

1 A. The American Board of Neurosurgical --

2 Neurosurgery.

3 Q. And you're in private practice?

4 A. Yes, sir, I am.

5 Q. When did you start in private practice?

6 A. Let's see, when I completed, 1987.

7 Q. You have hospital privileges?

8 A. Yes, sir, I do.

9 Q. Which hospitals?

10 A. The Medical Center of Central Georgia and

11 Coliseum Medical Center.

12 Q. Tell us what kinds of neurosurgical problems

13 you treat on a regular basis.

14 A. I really treat from the brain to the spine.

15 We're a Level I trauma center at the medical center so we

16 have a lot of traumatic injuries involving the brain and

17 spinal cord and the lumbar spine. We do brain tumors. I

18 have gotten away and do not do as much as far as aneurysms

19 because we have a specialist here that has done a

20 fellowship in that and feels -- and I feel that he is more

21 qualified, so he does more of this, but we treat spinal

22 conditions as well as brain conditions.

23 Q. And have some of the traumatic patient people

24 who were injured been injured at work?

25 A. Yes, sir.

1 Q. And have you treated some railroad folks,

2 people who work on the railroad?

3 A. Yes, sir.

4 Q. How often do you do surgery?

5 A. I operate three days a week.

6 Q. And what kind of surgery do you tend to do the

7 most of?

8 A. Most of this is spinal.

9 Q. And by spinal we mean the neck and back?

10 A. Neck and back, yes, sir.

11 Q. And have you published articles in peer review

12 journals about spine surgery?

13 A. Yes, sir, we have. I'd have to get my CV to

14 see that, but, yes, sir, we have. Especially one of the

15 partners is very, very keen and we have an active research

16 program going on within the practice. He oversees most of

17 this, but, yes, sir, we do publish.

18 MR. COOPER: At this point we would offer

19 you as a fully qualified expert in the field of

20 neurosurgery and general medicine and ask if

21 adverse counsel has any questions about those

22 qualifications at this time.

23 MR. TORNILLO: No, no objection as to

24 qualifications.

25 Q. (By Mr. Cooper) When a person comes to your

1 office, they fill out a form for you, telling you why  
 2 they're there?  
 3 A. Yes, sir.  
 4 Q. What sorts of questions does it tend to cover?  
 5 A. Go to my -- okay. Well, of course, everything  
 6 from who referred them, to their name, address, age,  
 7 height, weight, their employer, their chief complaint, and  
 8 then after the chief complaint, any current medications  
 9 that they might be on, any adverse reactions, previous  
 10 hospitalizations, family history that they may have had at  
 11 that time and any medical condition, including social  
 12 history, which we include marital status, habits such as  
 13 alcohol and tobacco.  
 14 Q. And you then take a history also from the  
 15 patient asking them more questions about their condition?  
 16 A. Yes, sir.  
 17 Q. And you examine them, do a physical  
 18 examination?  
 19 A. Yes, sir.  
 20 Q. And do you evaluate diagnostic tests like  
 21 x-rays?  
 22 A. Yes, sir.  
 23 Q. And you try to figure out what's wrong with the  
 24 person?  
 25 A. Yes, sir.

1 Q. And that's called a diagnosis?

2 A. Yes, sir.

3 Q. And do you try to rule out different

4 possibilities about what might be wrong with the person?

5 A. Yes, sir.

6 Q. Is that called differential diagnosis?

7 A. Yes, sir, it is.

8 Q. And do you usually form opinions as to what was

9 causing the problem?

10 A. Yes, sir.

11 Q. Let's talk about Mr. Wilcox. When did you

12 first meet him?

13 A. Let's see, March 1st, 2005.

14 Q. And he filled out the forms?

15 A. Yes, sir, he did.

16 Q. And who did he indicate was his employer?

17 A. CSX Railroad.

18 Q. And what did he indicate was his main medical

19 complaint?

20 A. Neck pain.

21 Q. And in terms of discussing what you found when

22 you do your physical examination, what's the medical

23 significance of the bilateral arm pain and left-hand

24 numbness that he reported?

25 A. This is -- well, you can have this -- this

1 usually is coming from the neck most of the time. And this  
2 is indicative of a -- what we call radiculopathy, which is  
3 a pinched nerve or it can be -- numbness in the hand can be  
4 due to myelopathy, which is pressure on the spinal cord  
5 itself or compression of the spinal cord.  
6 Q. And you did a physical examination when you  
7 first saw Mr. Wilcox on March 1, 2005?  
8 A. I did, yes, sir.  
9 Q. What did you find when you did the Spurling's  
10 maneuver on him?  
11 A. He had a positive Spurling's maneuver to the  
12 left. And this is a pressure loading test. By this what  
13 we mean is his head was turned to the left and the pressure  
14 was exerted on the top of the head. And when we did this,  
15 it causes pain or numbness to radiate down the arm. We're  
16 reproducing this symptom.  
17 Q. And what kinds of diagnostic imaging was done  
18 on his neck?  
19 A. It was recommended that he undergo an MR scan.  
20 Q. And what did those MR scans show? What did the  
21 picture of his neck show?  
22 A. We'll go back --  
23 Q. And --  
24 A. Now I will -- I will mention that Dr. Tom  
25 Terry, a cardiologist, had referred him. And when he did,

1 he had already completed a CT scan. And from the CT scan  
2 that Dr. Terry sent there was multi-level cervical  
3 spondylosis with the C3-4 and C6-7 levels being most  
4 affected with moderately severe spinal stenosis and  
5 possible cord impingement at those levels.  
6 Q. And what did you find that was abnormal as far  
7 as the neck on the MRS or the MRI scans?  
8 A. Okay. On the MR scan itself.  
9 Q. What was the major symptom, major --  
10 A. March 15th, it was done on March 15th. At the  
11 C6-7 there was a disk extrusion slightly asymmetric to the  
12 right resulting in flattening of the interior sac which  
13 touched the cord. There was moderate to mild bony  
14 foraminal encroachment. There was some bony ridging at the  
15 C5-6 level with bony narrowing on the right. There was  
16 some minimal central disk bulging at C3-4.  
17 Q. As far as the C6-7 disk extrusion which way --  
18 it was asymmetrical to which side?  
19 A. The right.  
20 Q. Was it right or left?  
21 A. On the report it's got right.  
22 Q. And in terms of a disk extrusion what does that  
23 mean?  
24 A. Disk extrusion means the disk is made of two  
25 parts. It's made of what we call an outer part and I think

1 -- actually

2 Q. Perhaps you can show us --

3 A. If you don't mind, I will --

4 Q. Do you have a pen?

5 A. Yes, I do. We have the annulus fibrosus, and

6 this is basically -- what we're talking about here is a

7 fibrous tissue that holds in what's called the nucleus

8 pulposus. The technical term of a ruptured disk is a

9 herniated nucleus pulposus. And what that means is that

10 the inside -- you will have a break in the annulus, and the

11 inside of the disk will rupture out.

12 I think actually the drawings we can see right

13 here, this is the annulus that comes out, this is the

14 nucleus pulposus. And what happens it breaks through.

15 This is the nerve that's coming here and we can see.

16 That's the reason sometimes it's called a pinched nerve.

17 Q. So that board that you have in your hand titled

18 disk herniation, is that a reasonably accurate portrayal of

19 the kind of disk herniation in the neck of Mr. Wilcox?

20 A. Yes, sir, but in addition to this, besides the

21 herniated disk, it also mentioned spondylosis. And what

22 this means is that in this area right here, you can also

23 have bone formation, which is called an osteophyte or bone

24 spurting. We can see that that can -- if you have a bone

25 spur that forms right here, likewise it can press on the

1 nerve as well, so, yes, sir.

2 Q. And so the disk herniation or extruded disk is

3 -- when we talk about cervical, that means neck; right?

4 A. Yes, sir.

5 Q. And what part of the neck -- maybe you can use

6 the model to show us where that would be on the human

7 anatomy?

8 A. Okay. This is the base of the skull at the

9 very top. This is what we call C1, C2, 3, 4, 5, 6, 7.

10 This one here becomes the thoracic, so we are talking about

11 -- the levels that we are talking about are 5-6 and 6-7

12 levels, so we are talking in the base of the neck.

13 Q. And so these are disks that are the shock

14 absorbers between the bones which are called vertebrae?

15 A. Yes, sir, that is correct.

16 Q. All right. Do you believe you had enough

17 information to form a diagnosis of -- an analysis of the

18 causation, treatment, prognosis and so on for Mr. Wilcox?

19 A. Yes, sir.

20 Q. What was your diagnosis?

21 A. Let's see. I think at that time -- at that

22 time he was felt to have the cervical spondylosis with

23 impingement on the canal or stenosis, which just means

24 narrowing of the canal. And it was felt that at that time

25 he was probably going to need surgical intervention. There

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were several levels involved. And I think it was recommended he undergo a myelogram and CT scan to follow. And did you ultimately do a surgery on his neck?

A. Yes, sir, we did.

Q. What was the nature of that surgery?

A. Let's see. At that time -- let's see, he was taken to the operating room on May 23rd, 2005, and at that time he had a C5-6, C6-7, which again is this level. He had, I think, at this level there had been previous surgery. It had not fused. He had what was called a pseudarthrosis, which means a non-union of the fusion. And then he had the 6-7 level, he had the herniated or ruptured disk. We re-fused this level and then went in from anterior, from the front, took the disk out, went back to the level of where the spinal cord is, took the ligament out, freed up -- take the bone spur and disk from each side.

When that was finished, we then had Dr. Rich, an orthopedic surgeon, take two pieces of the bone from the anterior iliac crest, the front of the hip, and we placed that in each one of the levels. After that was completed, we then went forward and put a plate on the front of that from C5 to C7, which goes on the front of the spine. That extends -- would extend from here to here.

1 Q. And what's the purpose of the plate?  
 2 A. The purpose of the plate is two-fold. One is  
 3 it holds everything in place and it helps with stability.  
 4 The whole thing, as we mentioned, is in place, but it also  
 5 helps with trying to get a solid fusion.  
 6 Q. What are the downsides of having a plate in  
 7 your neck?  
 8 A. The biggest downsides are if you have movement  
 9 of the plate, you have to do slightly more retraction to  
 10 put the plate on the front of the spine, so after surgery  
 11 there may be a little more sore throat than if you didn't  
 12 put a plate in position.  
 13 Q. And does it potentially limit mobility in the  
 14 future?  
 15 A. The plate does not. The fusion will, yes. The  
 16 plate itself really after the fusion takes place, really  
 17 has no purpose. It's to hold things in place until the  
 18 fusion has taken place.  
 19 Q. And I really should have asked. What I meant  
 20 is the fusion itself, what effect does that have on the  
 21 person's ability to move that segment of their neck?  
 22 A. It will cause a decreased range of motion, yes,  
 23 sir.  
 24 Q. What warnings do you give a patient like Johnny  
 25 Wilcox before you perform the surgery?

1 A. Well, there is -- I've got a page, it's about  
 2 five pages long, but any -- basically, you know, the big  
 3 things that we -- with any surgery are, you know,  
 4 infection, blood loss. We are operating on the spinal  
 5 canal, so there is the chance of paralysis of one, both or  
 6 all limbs, anything until possibly a patient having a heart  
 7 attack on the table and death.  
 8 Q. And in terms of the surgery, how did he do  
 9 postsurgically?  
 10 A. He did very well.  
 11 Q. Did there come a time that you ended up  
 12 referring him on to someone else?  
 13 A. Yes, sir, I did. For the first while I think  
 14 Mr. Wilcox did better, but then he began to develop pain in  
 15 his left arm again. I think we -- his myelogram was -- he  
 16 had other studies and including an EMG. And we did not see  
 17 evidence of a definite problem with the EMG and -- at that  
 18 time, and he was subsequently referred to Emory for a  
 19 second opinion.  
 20 Q. He was still symptomatic, has some radicular  
 21 symptoms at that time?  
 22 A. Yes, sir, he did.  
 23 Q. And the nature of radicular symptoms that you  
 24 mentioned before, what is the relationship between having  
 25 those symptoms in your upper extremities and arm and the

1 impingement of the disk extruding on to structures of the  
 2 nerve and the spine?  
 3 A. Normally when a disk does compress the nerve,  
 4 it will cause -- you will -- you will have the sensation of  
 5 pain where that nerve travels even if it's in the -- a lot  
 6 of times it's hard to understand why a pinched nerve in the  
 7 neck will cause arm pain. That's where the nerve goes and  
 8 that's where the brain perceives that the pain is  
 9 originating from. So, yes, sir, if you have a nerve that's  
 10 being impinged upon in the neck by a disk, by a bone spur,  
 11 it can certainly cause the symptoms to go in the extremity.  
 12 Q. And was that all consistent in Johnny Wilcox's  
 13 case, did it make sense medically what you found as far as  
 14 the extruded disk, your surgery and the response?  
 15 A. Yes, sir.  
 16 Q. And did you at any time find any facts that  
 17 would lead you to believe that Mr. Wilcox was malingering  
 18 or exaggerating his symptoms?  
 19 A. No, sir.  
 20 Q. And you held Mr. Wilcox out of work from when  
 21 you first started treating him. When did you first take  
 22 him out of his railroad work?  
 23 A. I think I recommended with the first time that  
 24 I saw him after his CT scan.  
 25 Q. Would it have been right from when you first

1 started treating him?

2 A. Yes, sir, it should have been -- yes, sir, it

3 should have been which would have been March 1st, 2005.

4 Q. And you held him out of work the entire time

5 that you were treating him?

6 A. Yes, sir.

7 Q. In terms of opinions I'm going to ask you some

8 questions about your opinions. I'll ask you to answer them

9 each to a reasonable degree of medical certainty. Unless

10 you tell me otherwise, I will assume that's the level to

11 which you are answering. Okay?

12 A. Yes, sir.

13 Q. Based upon your medical education and

14 experience and your treatment of Johnny Wilcox, did you

15 form an opinion to a reasonable degree of medical certainty

16 as to the cause of his herniated cervical disk?

17 A. As far as the cause I mean there is multiple

18 causes, but certainly it was -- there was an event that had

19 caused protrusion onto a nerve root that was compressing

20 the nerve root.

21 Q. And based upon all the information available to

22 you today, do you have an assessment of what that likely

23 cause is?

24 MR. TORNILLO: I'm going to -- yes, I'm

25 just going to object, lack of foundation. You

1 can --

2 THE WITNESS: From that he worked with the

3 railroad and said that, you know, that this was

4 -- began with the movement and different

5 positions that he had -- was placed in.

6 Q. (By Mr. Cooper) And so what aspects of his

7 railroad work do you think would be primarily responsible

8 for causing a cumulative trauma injury like he had?

9 MR. TORNILLO: Object on lack of

10 foundation, also leading.

11 MR. COOPER: Let me rephrase that,

12 counsel.

13 Q. (By Mr. Cooper) Do you have an opinion as to

14 what aspects of his work would be involved in causing the

15 kind of injury that he had?

16 A. Certainly I'm not an expert neurosurgical

17 railroad person, but certainly, you know, knowing that they

18 do have positions that they have to get into, look outside

19 the window, repetitive positions to look -- to look out. I

20 know from my fascination with railroads earlier that, you

21 know, there is the -- when cars are linked or connected or

22 coupled there is the bumping and the jerking that is --

23 occurs, and I think those were the main events.

24 Q. Did you receive some photographs from my office

25 which were exemplars of the kinds of postures that would be

1 involved in certain aspects of engineer work?  
 2 A. I did.  
 3 Q. And did you get a chance to review those?  
 4 A. Yes, sir, I did.  
 5 Q. And do those pictures reasonably accurately  
 6 portray the kind of awkward postures that you were just  
 7 referring to?  
 8 A. Yes, sir.  
 9 Q. And did you also receive from my office a copy  
 10 of Johnny Wilcox's deposition and a summary of some of the  
 11 aspects of the case from me?  
 12 A. Yes, sir, I think that's right.  
 13 Q. And so I take it that in terms of what you are  
 14 relying upon for your opinion that his work and these  
 15 things caused his injury, I take it that you're basing that  
 16 on the history you took, the information you had, your  
 17 experience as a neurosurgeon and what you understand  
 18 occurred in his work?  
 19 MR. TORNILLO: Objection, leading.  
 20 MR. COOPER: Okay. Let me rephrase it for  
 21 you. Let me rephrase it.  
 22 Q. (By Mr. Cooper) Let's talk about the seating.  
 23 What did you -- what is your understanding from those  
 24 materials about aspects of how the chairs in the locomotive  
 25 cabin might have affected his neck?

1 A. Well, the seating, I know that at one time

2 there was what was the stool type, they had the pedestal

3 that they sat on that was small. Then an event was -- I

4 think that was improved. But my understanding there are

5 some seats that are not the most -- in the best repair, I

6 guess, as far as being a straight seat. You know, I know

7 in the pictures these were leaning back and there was not

8 very much support on the back.

9 Q. And would that be the kind of thing if you were

10 on a seat like that for six hours a day, for a career, for

11 decades, it might cause problems with your neck?

12 A. Yes, sir.

13 Q. As of the time when you treated Mr. Wilcox did

14 you have an opinion as to whether his smoking would be the

15 cause of a herniated disk?

16 A. The cause of a herniated disk, no, sir, I did

17 not feel that smoking would cause a herniated disk.

18 Q. And do you have an opinion to a reasonable

19 degree of medical certainty as to whether the neck injury

20 that you treated disabled Mr. Wilcox from his work as a

21 locomotive engineer at least during the time that you were

22 treating him?

23 A. Yes, that is correct. Yes, sir.

24 Q. Have all the opinions you have given here today

25 been to a reasonable degree of medical certainty?

1 A. Yes, sir.

2 MR. COOPER: That's all I've got.

3 CROSS-EXAMINATION

4 BY MR. TORNILLO:

5 Q. Good morning, Dr. Johnston.

6 A. Good morning.

7 Q. I'm Glenn Tornillo here on behalf of CSX, and

8 thank you for your time this morning.

9 A. Yes, sir.

10 Q. And I have a few questions for you as well.

11 A. Sure.

12 Q. Dr. Johnston, you first saw Mr. Wilcox on March

13 1st of 2005; is that correct?

14 A. Yes, sir, it is.

15 Q. And at that time Mr. Wilcox according to your

16 registration form was five foot eight inches tall?

17 A. Correct, yes, sir.

18 Q. And weighed 218 pounds; correct?

19 A. Yes, sir.

20 Q. And he was 50 years old at the time?

21 A. Yes, sir.

22 Q. And when he came to see you in March of 2005,

23 had been referred by his cardiologist, Dr. Terry; correct?

24 A. That's correct, yes, sir.

25 Q. And when he saw you on March 1st, 2005, he

1 complained of neck pain that he said he had for years;

2 correct?

3 A. Yes, sir.

4 Q. Did he say how many years?

5 A. No, sir, I think it was just for years.

6 Q. He also at that time complained that he was

7 having bilateral arm and leg pain; is that correct?

8 A. Yes, sir.

9 Q. And the way I read your notes it's my

10 understanding that that was a new symptom for him; is that

11 correct?

12 A. Now I'm sorry, what is, the arm and legs or --

13 Q. The arm and leg pain.

14 A. He had said that he had had it, as we said, for

15 years, I think in my history and testimony -- I must rely

16 on that --

17 Q. Sure.

18 A. He just said it was progressively worsening.

19 Q. If I can direct your patient -- your attention

20 --

21 A. Please.

22 Q. -- to the new patient consultation --

23 A. Uh-huh.

24 Q. -- dated 3/1/05 --

25 A. Yes, sir.

1 Q. -- the second sentence: It says the patient's  
2 chief complaint is that of severe neck pain, which he has  
3 had for years, but he states he now -- he is now having  
4 bilateral arm pain and pain in his leg as well. Did I read  
5 that correctly?

6 A. Yes, sir.

7 Q. And that would be fair to say that that was a  
8 new symptom; correct?

9 A. Yes, sir.

10 Q. As opposed to the neck pain for years?

11 A. Yes, sir. Yes, sir. Okay.

12 Q. And the bilateral arm and leg pain was  
13 something that had only begun bothering him shortly before  
14 he saw you in March 1st of 2005 based on your notes.

15 A. All I can -- he just says it was progressively  
16 worsening. That would tell me that he has had it for, you  
17 know, exact period of time I do not know, but it had seemed  
18 to progress.

19 Q. And with your examination and diagnostic  
20 studies you eventually determined that Mr. Wilcox had  
21 problems in his cervical spine that were, one, causing his  
22 neck pain; correct?

23 A. Yes, sir.

24 Q. And you discussed those with Mr. Cooper?

25 A. Yes, sir.

1 Q. And there was also problems on -- those same  
2 problems were also what was causing his bilateral arm and  
3 leg pain that had recently started to bother him; correct?  
4 A. Arm pain.  
5 Q. Okay.  
6 A. You know, I think I see more with the arm pain  
7 than possibly with the legs.  
8 Q. But the arm pain.  
9 A. Yes, sir.  
10 Q. And specifically you found -- one finding was  
11 that Mr. Wilcox had degenerative disk disease at C5-6, C6-7  
12 and C4-5; correct?  
13 A. And 3-4.  
14 Q. And 3-4.  
15 A. Yes, sir.  
16 Q. And what is degenerative disk disease?  
17 A. Degenerative disk disease is sort of a broad  
18 term but basically what it is when we're -- I guess when  
19 we're 18 year old, our disks that we talked about is at  
20 least 70 percent water. As we get older, we sort of  
21 evaporate as far as the disk is concerned. We lose the  
22 water content in the disk in what we call desiccation.  
23 This is the reason why the disk will become smaller and  
24 that's why we shrink as we get older, it's because we have  
25 degeneration of the disk.

1 Q. And it's a progressive condition; correct?

2 A. Correct.

3 Q. Progressive naturally.

4 A. Yes, sir.

5 Q. And eventually we are all going to get it; aren't we?

6 A. We hope so.

7 MR. COOPER: Objection, speculation.

8 Q. (By Mr. Tornillo) If we live long enough.

9 A. If we live long enough, yes, sir.

10 Q. And at the time you saw Mr. Wilcox he was 50 years old?

11 A. Yes, sir.

12 Q. And would you agree with me, Dr. Johnston, that a gentleman of 50 years old, it's not unusual to find that individual with degenerative disk disease in their cervical spine at that age?

13 A. Certainly, yes, sir, we certainly see that.

14 Q. And that would be true even if Mr. Wilcox was a doctor, a lawyer, an accountant?

15 A. Yes, sir.

16 Q. You also mention that Mr. Wilcox had multi-level cervical spondylosis?

17 A. Yes, sir, spondylosis.

18 Q. Can you tell me again what that is?

1 A. Okay. This is -- this is basically what it is,

2 we say we have disk degeneration. And I think you

3 mentioned that the disk acts as a shock in between the

4 bones and a spacer. And when the disk degenerates, becomes

5 smaller, what happens is you will have bone that will sort

6 of touch against bone and it stimulates the formation of an

7 osteophyte, which is a bone spur.

8 This bone spur many times will form off what we

9 call the facet joint, where is right by the hole where the

10 nerve comes out, so it compresses it, it can compress the

11 nerve root. We sometimes call a soft disk and a hard disk.

12 A hard disk, of course, is a piece of bone. Soft disk is

13 the herniated disk that we talked about.

14 Q. And -- and of the bone spur is that a

15 degenerative process, the development of a bone spur?

16 A. Yes, sir.

17 Q. Is that akin to what may be generally called

18 arthritis?

19 A. Yes, sir. Sometimes we call it osteoarthritis,

20 a bony arthritis.

21 Q. And you also found that Mr. Wilcox had

22 multi-level cervical stenosis?

23 A. Yes, sir.

24 Q. And if I understand right, that is just

25 basically the narrowing of the canal where the nerve roots

1 go through?

2 A. It can be the central canal where the spinal

3 cord goes or it can be, yes, sir, what we call the

4 neuroforamin and that just means the hole where the nerve

5 goes out. So it can be -- you can have stenosis of both

6 levels, just means narrowing.

7 Q. And is the stenosis generally caused by the

8 degenerative process we've been talking about?

9 A. Yes, sir.

10 Q. The degeneration of the disk and the formation

11 of the bone spurs closes the opening basically?

12 A. Yes.

13 Q. Narrows it?

14 A. Yes, sir, narrows it, yes, sir.

15 Q. And you performed a spinal fusion on Mr. Wilcox

16 at level C5-6 and C6-7; correct?

17 A. Yes, sir.

18 Q. And the purpose of that surgery was to relieve

19 his neck pain; correct? One of the purposes.

20 A. Well, more so the arm difficulties that he was

21 having, but yes, you hope it's going to help with the neck

22 pain. But I mean the main reason you do the surgery is

23 because it's to relieve the stenosis and to relieve the

24 radiating pain.

25 Q. And when you were treating Mr. Wilcox in 2005,

1 did he inform you that he had previously injured his neck  
2 and back in 1991?  
3 A. I think in his history he had mentioned that he  
4 had had surgery on his neck previously under  
5 hospitalizations and type of surgery. And I think we  
6 talked about it, and he was not sure exactly which level it  
7 was.  
8 Q. Did you eventually come to learn that he had a  
9 cervical fusion at C5-6 in 1991?  
10 A. Yes, sir.  
11 Q. And that surgery at C5-6 in 1991 was somewhat  
12 similar to the surgery you performed in 2005?  
13 A. Yes, sir. Yes, sir.  
14 Q. And basically in 1991 the fusion in basic terms  
15 they removed the disk -- Mr. Wilcox's disk at C5-6 and  
16 inserted a bone?  
17 A. Correct, yes, sir. That's my understanding.  
18 Q. And the idea was that the bone would fuse to  
19 the vertebrae above and below?  
20 A. Yes, sir.  
21 Q. And therefore relieve pressure on the joint?  
22 A. On the nerve.  
23 Q. On the nerve.  
24 A. I'm assuming the nerve is what they would --  
25 Q. Did Mr. Wilcox tell that you that he was

1 diagnosed -- diagnosed with degenerative disk disease in  
2 his cervical spine in 1991 by Dr. Meeks in Augusta?  
3 A. I don't recall that, no, sir, I don't recall.  
4 Q. Did at some point you become aware that he had  
5 degenerative disk disease or was diagnosed with  
6 degenerative disk in 1991?  
7 MR. COOPER: Objection to things in other  
8 people's medical records which is hearsay and no  
9 proper foundation.  
10 THE WITNESS: I didn't -- I didn't have  
11 Dr. Meeks' records so --  
12 Q. (By Mr. Tornillo) You were not provided with  
13 Dr. Meeks' records by plaintiff's counsel?  
14 A. Oh, you mean since then? I thought you meant  
15 -- you mean you're talking about 2005 or are you talking  
16 about --  
17 Q. I'm talking at any time have you become -- and  
18 if I didn't articulate my question, I apologize. At any  
19 time have you learned that Mr. Wilcox was diagnosed with  
20 degenerative disk disease in 1991?  
21 A. I knew he had surgery in Augusta, you know,  
22 from that; I didn't know who -- it was Dr. Meeks or who he  
23 saw or -- at that time.  
24 Q. Understood. As we're sitting here today  
25 though, is it your understanding that he was diagnosed with

1 degenerative disk disease in 1991?

2 MR. COOPER: Same objection.

3 THE WITNESS: I don't want to say what Dr.

4 Meeks -- I mean not having seen these things and

5 not knowing, you know, what his -- I hate to say

6 what Dr. Meeks thought at that time because,

7 like I say, I didn't even know who treated

8 Mr. Wilcox.

9 Q. (By Mr. Tornillo) That's fair enough. I want

10 to help you out there.

11 A. Okay.

12 Q. I'm going to hand you a letter from Dr. Meeks

13 dated July 17, 1992 and ask you to take a look at it.

14 First let me know if you've ever seen it before.

15 MR. COOPER: Glenn, can you pass it to me

16 first? Do you have an extra copy?

17 MR. TORNILLO: I'm sorry, I don't.

18 MR. COOPER: Give me just a moment please.

19 MR. TORNILLO: I apologize, John. I don't

20 have an extra copy of that.

21 MR. COOPER: Thank you.

22 Q. (By Mr. Tornillo) Dr. Johnston, feel free to

23 read the whole letter. I have highlighted and marked --

24 MR. COOPER: Can I have a continuing

25 objection to use of another doctor's records

1 under the circumstances and just make it a  
2 continuing objection?  
3 MR. TORNILLO: Yes.  
4 MR. COOPER: Thank you.  
5 THE WITNESS: Okay. In reading this  
6 letter, I think it was from Neurological  
7 Associates, it was -- this was a letter that I  
8 mentioned. It was to Attorney Otis Forbes, III,  
9 and in this letter Dr. Meeks mentioned that the  
10 patient had an MR scan, a myelogram and a CT,  
11 which revealed degenerative disk disease at C5,  
12 C6, central and to the left, and that he was  
13 having neck and radicular pain, and that he  
14 underwent surgery on December 9, 1991 with an  
15 anterior diskectomy and interbody fusion at  
16 C5-6.  
17 Q. (By Mr. Tornillo) And can we agree, Dr.  
18 Johnston, that in 1991 he was diagnosed -- Mr. Wilcox was  
19 diagnosed by Dr. Meeks with generative disk disease at  
20 C5-6?  
21 A. Yes, sir.  
22 Q. Thank you.  
23 A. Yes, sir.  
24 Q. And, Dr. Johnston, would it be fair to say that  
25 the degenerative disk disease that Mr. Wilcox had in 1991,

1 that was a preexisting condition when you saw him in 2005?  
 2 A. The degenerative disk disease at C5-6?  
 3 Q. Yes, sir.  
 4 A. Yes, sir.  
 5 Q. And I think we've already talked about you  
 6 would agree that degenerative disk disease is a progressive  
 7 condition; correct?  
 8 A. Yes, sir.  
 9 Q. It can worsen over time?  
 10 A. Yes, sir.  
 11 Q. And it actually does usually get worse as the  
 12 years go by and the individual gets older; correct?  
 13 A. Yes, sir.  
 14 Q. And would you agree with me, Dr. Johnston, that  
 15 the natural progression of Mr. Wilcox's preexisting  
 16 degenerative disk disease that he had at least since 1991  
 17 at C5-6 would be a likely cause or contributing factor to  
 18 the conditions you treated him for in 2005?  
 19 A. I'm sorry?  
 20 Q. Would you like me to repeat that?  
 21 A. Repeat that, I'm sorry.  
 22 Q. Dr. Johnston, would you agree with me that the  
 23 natural progression of Mr. Wilcox's preexisting  
 24 degenerative disk disease that was diagnosed in 1991 at  
 25 C5-6 would likely be a contributing cause of the conditions



1 less level so you are going to put more wear and tear on  
 2 the level above and below.  
 3 Q. And am I correct, Dr. Johnston, that in your  
 4 diagnostic studies and exams the two areas where there was  
 5 significant degeneration in Mr. Wilcox's cervical spine was  
 6 at C4-5 and C6-7 the levels --  
 7 A. C6-7? I think it was C3-4. Let me go back and  
 8 -- there was disk bulge on the myelogram. I think it  
 9 showed there was disk bulging at C4-5 slightly more. Now  
 10 on the -- I think it was on the MR scan it showed 3-4 but  
 11 yes, sir. Yes, sir, I mean certainly the myelogram showed  
 12 that there was at -- let's see. I think mostly it was at  
 13 C6-7.  
 14 Q. And if I can direct your attention to your  
 15 office visit of 3/15/05 --  
 16 A. 3/15? I've got a 3/16.  
 17 Q. It's right -- right above it it says return  
 18 office visit.  
 19 A. Yes, sir. I'm sorry. That was 4/1. Okay,  
 20 yes, sir.  
 21 Q. And starting with the third sentence, let me  
 22 read that to you and at least tell me if I'm reading this  
 23 correctly. "The patient does have some mild degenerative  
 24 changes and spondylosis in the lumbar spine but in the  
 25 cervical area the patient does have significant stenosis of

1 multiple levels. It appears that C4-5 and C6-7 are the

2 most affected." Did I read that correctly?

3 A. Yes, sir.

4 MR. COOPER: Let me --

5 THE WITNESS: Let me mention, this is by

6 the myelogram.

7 Q. (By Mr. Tornillo) Understood.

8 A. The myelogram. What I was referring to was, I

9 think, our CT scan before and how it was interpreted is the

10 MR scan.

11 Q. Okay.

12 MR. COOPER: Let me interpose an objection

13 to the form of that last question and answer.

14 Q. (By Mr. Tornillo) But, Dr. Johnston, can we --

15 can we agree that Mr. Wilcox has significant degenerative

16 disk disease at both levels, C4-4 and C6-7?

17 A. Yes, sir.

18 Q. And, Dr. Johnston, would you agree with me that

19 the fusion that Mr. Wilcox had at the C5-6 level in 1991,

20 14 years before you saw him, was a likely cause or

21 contributing factor of the degenerative disk disease that

22 you treated Mr. Wilcox for in 2005?

23 A. There is -- well, it certainly can, but there

24 is one caveat here. This was not a solid fusion, so

25 actually what we have here, you know, it's very, very

1 difficult to determine how much motion we really had of the  
2 5-6 level because it was not a solid fusion. He had a  
3 pseudoarthrosis. But certainly, you know, this is what we  
4 would expect is that once you have one level over years and  
5 especially this time, you are going to get more  
6 degeneration.

7 Q. And you had mentioned the term pseudoarthrosis.  
8 A. Yes, sir.  
9 Q. I understand that to mean that there was not a  
10 solid fusion from the 1991 surgery?

11 A. That's correct, yes, sir.  
12 Q. And was that one of the contributing factors to  
13 why you had to go in and perform another fusion in 2005?

14 A. One of the factors, yes, sir. I mean certainly  
15 the neck pain that you can have certainly pseudoarthrosis  
16 we know can cause neck pain. The radicular pain is more  
17 related to the problem that he had at 6-7.

18 Q. But the neck pain at least in part can be  
19 related to the pseudo -- pseudoarthrosis?

20 A. Yes, sir.  
21 Q. I think Mr. Wilcox indicated to you that he is  
22 a smoker?

23 A. Yes, sir.  
24 Q. And that he smoked approximately one pack of  
25 cigarettes per day?

1 A. Yes, sir.

2 Q. I know Mr. Cooper asked you about smoking

3 related to the herniated disk, and we got your opinion on

4 that. Let me ask you are there studies out there that show

5 that smoking can contribute to the development of

6 degenerative disk disease?

7 MR. COOPER: Let me object to the form of

8 the question. These are studies that haven't

9 been identified but --

10 Q. (By Mr. Tornillo) I'm asking are you aware --

11 A. I'm not aware of any that concern the

12 degeneration of the disk, no, sir.

13 Q. Are you aware of any studies out there that

14 relate smoking to the healing process and cervical fusion?

15 A. Yes, sir.

16 Q. And what do those studies from your

17 understanding indicate?

18 MR. COOPER: Can I have a continuing

19 objection to studies, unnamed studies?

20 THE WITNESS: It's felt that smoking does

21 decrease or hinder bone fusion.

22 Q. (By Mr. Tornillo) And in this case at least we

23 know the 1991 -- 1991 fusion didn't heal fully; correct?

24 A. That is correct, yes, sir.

25 Q. The fusion you performed in 2005 did that

1 become a solid fusion or did Mr. Wilcox have to go back for  
 2 a second surgery?  
 3 A. I can't answer that.  
 4 Q. What's that?  
 5 A. I can't answer it.  
 6 Q. That's fine, but just why can't you answer?  
 7 A. He came -- Mr. Wilcox came back and as we  
 8 mentioned I think we did some studies. We did an EMG. Did  
 9 not show any abnormalities. He continued to have  
 10 discomfort in his arm and in his neck. I referred him -- I  
 11 think he saw Dr. Yun at Emory, and I never saw Mr. Wilcox  
 12 back. And I never got a letter from Emory or anything  
 13 about his care.  
 14 Q. Okay. So the last time you saw him was in  
 15 August of 2005?  
 16 A. Yes, sir.  
 17 Q. And that is the last information you had about  
 18 him?  
 19 A. Yes, sir.  
 20 Q. Fair enough. We've already talked about  
 21 Mr. Wilcox's symptoms, the neck pain and bilateral arm pain  
 22 that you saw him for in March of 2005. First, when you  
 23 first saw him in March of 2005, did Mr. Wilcox inform you  
 24 that he had fallen in the shower less than a month previous  
 25 to you visiting him on February 9th of 2005?

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A. No, sir.

Q. At some point between when you first saw Mr.

Wilcox and now have you been made aware that he reportedly fell in the shower on February 9th, 2005?

MR. COOPER: Let me interpose the

objection of facts not in evidence. Go ahead.

You can go ahead and answer it to the best of

your ability.

THE WITNESS: No, sir.

Q. (By Mr. Tornillo) And you had no knowledge of

that?

A. No, sir.

Q. Okay.

MR. COOPER: Let me -- if I can just have

the same continuing objection to other doctors

and people's records that are hearsay without

Foundation. That's continuing, counsel?

MR. TORNILLO: Yes, that's continuing.

MR. COOPER: Thank you.

Q. (By Mr. Tornillo) Dr. Johnston, I'm going to

hand you a medical record from Dorminy Medical Center dated 2/9/05 from Dr. Thomas Mann. I've highlighted an area on

the back, but please feel free to look at the whole record.

A. Okay.

Q. Is that a record you have ever seen before?

25 Q. (By Mr. Tornillo) I would like you to assume

24 improper form.

23 word pain. I think it says discomfort.

22 MR. COOPER: Objection to the use of the

21 A. Low back pain, yes, sir.

20 that he reported low back pain after that fall; correct?

19 Q. And it's the first time you have been aware

18 A. Yes, sir.

17 February 9th of 2005; correct?

16 the possibility Mr. Wilcox may have fallen in the shower on

15 Q. And the first time you have been made aware of

14 A. Yes, sir.

13 first time you have seen this record; correct?

12 Q. Okay. And in fairness to you, this is the

11 A. Yes, sir.

10 correctly?

9 report some lower back discomfort." Did I read that

8 floor. He was unaware of any injury but did subsequently

7 remembers being in the shower and subsequently being on the

6 He actually does not remember falling but states that he

5 "Possible syncope. Patient is very unclear in his regard.

4 Wilcox had a history of -- and I'll read it to you:

3 you agree with me that according to Dr. Mann's record Mr.

2 Q. Dr. Johnston, in fairness to you, first will

1 A. No, sir, I haven't seen it.

1 for me, Dr. Johnston, that Mr. Wilcox had a history of

2 falling in the shower on February 9th of 2005 for the

3 purpose of these following questions. First, would you

4 agree with me that an acute trauma such as falling in the

5 shower can aggravate a preexisting degenerative condition

6 in the cervical spine?

7 A. I don't think we talked -- he didn't -- I mean

8 that's possible, but I mean we didn't say anything about

9 cervical spine if we're basing it on that. I mean I think

10 it said low back. Cervical is the neck.

11 Q. Sure.

12 A. So I'm --

13 Q. Fair enough. Would you agree with me though

14 that if someone falls in the shower, there is the

15 possibility they can hit their head, hit their neck?

16 A. Oh, certainly, yes, sir.

17 MR. COOPER: Calls for speculation.

18 Objection.

19 Q. (By Mr. Tornillo) And would you agree with me

20 if someone fell in the shower and did hit their neck or

21 twist their head, that that could aggravate a preexisting

22 degenerative disk disease condition?

23 A. Yes, sir.

24 Q. Would you also agree with me that if someone

25 fell in the shower and hit their head or twisted their

1 neck, that that could cause a disk to herniate, especially

2 in someone who's had -- has degenerative disk disease?

3 MR. COOPER: Let me interpose -- if I can

4 make it a continuing objection to this line of

5 questioning --

6 MR. TORNILLO: Sure.

7 MR. COOPER: Lack of foundation,

8 speculative, et cetera. Objection to form but

9 just continue. I won't say it again.

10 MR. TORNILLO: You can have that

11 objection.

12 Q. (By Mr. Tornillo) Do you need me to repeat the

13 question there?

14 A. No, sir, I think I --

15 Q. And would you agree with me that if someone

16 fell in the shower -- let me rephrase that. Would you

17 agree with me that if Mr. Wilcox fell in the shower and hit

18 his head or twisted his head, and that aggravated his

19 preexisting degenerative disk disease, could cause the

20 herniated disk you saw him for, that that would be an

21 explanation for the arm pain that he reported to you in

22 March of 2005?

23 A. It's possible, yes, sir.

24 Q. Did Mr. Wilcox ever give you a history of

25 playing football in high school?

1 A. No, sir.

2 Q. Okay. Did he ever give you a history that he

3 suffered a concussion while playing football in high

4 school?

5 A. No, sir, I don't think so.

6 Q. Would you agree with me that someone who played

7 football and suffers blows to the head, that can also

8 constitute blows to the neck as well?

9 A. Yes, sir.

10 Q. When Mr. John -- when Mr. Wilcox first saw you,

11 Dr. Johnston, were there also some complaints -- let me

12 rephrase that because it might have been your first

13 evaluation -- at some point did Mr. Wilcox have some

14 complaints of low back pain?

15 A. Yes, sir.

16 Q. And you did some diagnostic studies of

17 Mr. Wilcox's lumbar spine?

18 A. Yes, sir.

19 Q. And was one of those an MR scan?

20 A. Yes, sir.

21 Q. And what was the finding of your MR scan we've

22 already -- the lumbar spine of Mr. Wilcox?

23 A. The MRI scan of March 15, 2005 he had a mild

24 left bony foraminal encroachment at L5-S1.

25 Q. Were the findings you had with -- findings in

1 his lumbar spine, did you consider those significant,

2 significant enough to require any kind of surgery

3 intervention at that time?

4 A. At that time, no, sir.

5 Q. Okay. Dr. Johnston, I have a few questions

6 regarding some of the opinions regarding work causing Mr.

7 Wilcox's cervical spine problem that you have given. First

8 I'd like to ask you if I have read your records correctly,

9 there was nothing in your records that describes Mr.

10 Wilcox's job duties; correct?

11 A. That's correct.

12 Q. There was nothing in your records that Mr.

13 Wilcox indicated to you that he -- or complained to you

14 that coupling rail cars at work was causing him any

15 problems; correct?

16 A. Correct.

17 Q. There was also nothing in your records that

18 stated that Mr. Wilcox complained to you about the postures

19 he was experiencing at work; correct?

20 A. That's correct, yes, sir.

21 Q. And I didn't note in your records that even

22 listed that he was a locomotive engineer; is that correct?

23 A. No, sir, I think we just had that he worked for

24 CSX.

25 Q. Okay. But he didn't indicate that he was an

1 engineer for CSX; correct?

2

A. No, sir.

3

Q. Now have you ever watched or observed Mr.

4

Wilcox perform his job?

5

A. No, sir.

6

Q. Have you ever in your professional capacity

7

observed a locomotive engineer perform their job?

8

A. Yes, sir.

9

Q. Have you ever ridden on a freight train?

10

A. On a freight train?

11

Q. Yes, sir.

12

A. No, sir.

13

Q. Have you examined any of the seats that Mr.

14

Wilcox used in his job as a locomotive engineer?

15

A. No, sir.

16

Q. Have you ever -- have you seen any studies,

17

medical studies, that demonstrated that locomotive

18

engineers have a higher risk to develop degenerative disk

19

disease than the general population?

20

A. I have not.

21

Q. Do you know how often Mr. Wilcox had to couple

22

rail cars on a daily basis?

23

A. No, sir, I mean --

24

Q. Do you know how frequently or what duration Mr.

25

Wilcox had to maintain the postures you claim were awkward

1 on a daily basis? A. I do know that an engineer has to know where  
 2 the train is going and has to see and look out. Now how  
 3 many times he has to turn his neck a day, no, sir, I can't  
 4 tell you how many times a day he turns his neck.  
 5 Q. I take it you have not measured any of the  
 6 forces that the plaintiff, Mr. Wilcox, experienced while  
 7 working as a locomotive engineer?  
 8 A. No, sir.  
 9 Q. Have you seen any studies or data showing the  
 10 forces that either Mr. Wilcox or any locomotive engineer  
 11 may experience while operating a locomotive?  
 12 A. I have not.  
 13 Q. I take it you've never been on a locomotive  
 14 engine when it's been coupling?  
 15 A. When it's coupling, not on it.  
 16 Q. You have probably seen it.  
 17 A. Yes, sir.  
 18 Q. Are you aware that CSX Transportation has a  
 19 rule that a coupling speed is not to exceed four miles per  
 20 hour?  
 21 A. No, sir.  
 22 Q. If I understand your testimony correctly, Dr.  
 23 Johnston, one of the awkward postures you believe was a  
 24 risk factor for Mr. Wilcox was turning his head and looking  
 25

1 back out of the locomotive; is that correct?  
 2 A. Looking back, having to look out to the side,  
 3 look forwards, to the side, yes, sir, in all directions to  
 4 -- he's -- I guess he's the conductor. I mean he's the  
 5 conductor of the train and responsible for it, so he has to  
 6 look after everything to make sure that it's functioning  
 7 properly.  
 8 Q. Would it be similar to if I was looking out of  
 9 my car backing up, that kind of posture, like turning my  
 10 head to the side and look backwards?  
 11 A. Yes, sir.  
 12 Q. Okay. Have you done any analysis or asked Mr.  
 13 Wilcox how often he turns his head to look back when he's  
 14 -- when he's driving?  
 15 A. No, sir.  
 16 Q. How much he's done that in his life?  
 17 A. No, sir.  
 18 Q. Have you done any kind of analysis to determine  
 19 what kind of postures Mr. Wilcox maintains or maintained  
 20 throughout his life outside of working for the railroad?  
 21 A. No, sir.  
 22 Q. You know what his hobbies are?  
 23 A. No, sir.  
 24 Q. Do you know what kind of postures he assumes  
 25 when he's performing household chores or when he work jobs

1 other than the railroad?

2 A. No, sir.

3 Q. I know that you have some pictures that were

4 provided by plaintiff's counsel; correct?

5 A. Yes, sir.

6 Q. And apparently you also were provided with the

7 deposition of Mr. Wilcox?

8 A. I was provided, yes, sir, I was provided.

9 Q. When were you provided that information?

10 A. I think maybe -- I'm trying to -- today is the

11 23rd, 18 -- maybe a week ago.

12 Q. Had you -- had you seen Mr. Wilcox's deposition

13 before a week ago?

14 A. No, sir.

15 Q. Had you seen the photographs before a week ago?

16 A. No, sir.

17 Q. I know you had a brief meeting with Mr. Cooper

18 before the deposition. Have you spoken to Mr. Cooper

19 before today?

20 A. Yes, sir.

21 Q. When was the first time you spoke with

22 Mr. Cooper?

23 A. I'm unaware. It's probably been a year ago.

24 Q. Okay.

25 A. I'm guessing it's probably somewhere in the

1 neighborhood of a year probably, I would say.

2 Q. If I recall, you filled out an affidavit for --

3 A. I did, yes, sir.

4 Q. Was it around the time you filled out the

5 affidavit or was it before --

6 A. Yes, sir. Yes, sir. It was around that time.

7 Q. Okay. So if the affidavit was signed by you in

8 February of 2010, would that be --

9 A. Yes, sir, that's certainly --

10 Q. And would that have been the first time you

11 shared your opinions regarding work causing Mr. Wilcox's

12 opinions with Mr. Cooper?

13 A. From what I recall, yes, sir.

14 Q. Had you spoke to any of Mr. Wilcox's attorneys

15 other than Mr. Cooper?

16 A. No, sir.

17 Q. Have you spoke to Mr. Wilcox since you last saw

18 him in August of 2005?

19 A. Personally, no, sir, I don't think I have.

20 Q. Dr. Johnston, that's all the questions I have

21 for you. Thank you very much for your time today.

22 REDIRECT EXAMINATION

23 BY MR. COOPER:

24 Q. Just a couple of followups, Dr. Johnston --

25 A. Sure.

1 Q. -- to make sure we are clear about some things.

2 I take it that you're -- although you are not an expert in

3 railroading, you are an expert in neurosurgery?

4 A. I hope so, yes, sir.

5 Q. And I take it that the cause of a particular

6 injury is often secondary to try to treat the patient and

7 get them well?

8 A. Certainly, yes, sir.

9 Q. In terms of the extruded disk that you saw in

10 Mr. Wilcox's neck, that was an abnormal finding that's

11 different than any degenerative disk disease, right?

12 A. Yes, sir. I mean it certainly is a soft disk

13 herniation. Now degeneration can help, I guess, exaggerate

14 it or cause this to happen, but, no, sir, this is

15 usually more of an acute.

16 Q. And by acute we mean something new.

17 A. New. New and recent.

18 Q. And so not everybody who happens to have some

19 osteoarthritis is going to have an extruded disk or a

20 pinched nerve, right?

21 A. Correct.

22 Q. And the reason you did the surgery and

23 recommended the surgery on Mr. Wilcox was because of the

24 extruded disk impinging on nerve tissue?

25 A. Correct.

1 Q. And that was at a different level than wherever

2 his old surgery was?

3 A. Correct.

4 Q. Do you have an opinion as to what the medical

5 significance would be of the fact that Mr. Wilcox had

6 worked for 13 years on the railroad without receiving any

7 medical treatment for his neck from 1992 until 2005 when

8 you saw him? What does that tell you?

9 A. That he was doing well, not having major

10 difficulty.

11 Q. When you went and did the surgery, you saw the

12 extruded disk with your own eyes; correct?

13 A. Yes, sir. Let me look at the op note to tell

14 you. Yes, sir. There was -- there was a bone spur that

15 was present. This was moved. There was also a disk

16 protrusion which was moved with a nerve hook and the

17 pituitary rangier. When this was removed, there was

18 expansion of the dura, which is the covering of the spinal

19 cord that has the spinal fluid.

20 Q. And do you have an opinion to a reasonable

21 degree of medical certainty whether degenerative disk

22 disease can be made symptomatic or made worse by cumulative

23 trauma such as what we have talked about during his

24 railroad work?

25 A. Yes, sir.

1 Q. And that's certainly -- is that in essence what

2 you think likely occurred in this case, you have a new

3 extruded disk and worsening of the degenerative disk

4 disease?

5 A. Yes, sir. Certainly, yes, sir.

6 Q. That's all the questions I have for you. Thank

7 you.

8 RE-CROSS-EXAMINATION

9 BY MR. FORNITTO:

10 Q. A few short followups --

11 A. Sure.

12 Q. -- and we'll be done. Mr. Cooper asked you the

13 significance of Mr. Wilcox not having medical treatment

14 since he recovered from his 1991 surgery, I guess, until he

15 saw you in March of 2005.

16 A. Yes, sir.

17 Q. Let me ask this question, Dr. Johnston: If you

18 can presume Mr. Wilcox fell in the shower on February 9th

19 of 2005 and within a month sought treatment from a

20 neurosurgeon, what of significance would that be to you?

21 MR. COOPER: Objection. Same objection as

22 made before.

23 THE WITNESS: Well, I mean if there was --

24 if he stated that he began having, you know, the

25 neck discomfort, then it's quite significant,

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prescription for physical therapy we would like for him to  
Fitzgerald, Georgia, so yes, I probably gave him a  
prescription because I think Mr. Wilcox lived in  
A. Well, I think what this -- probably gave him a  
Wilcox to?  
Q. And was this a physical therapist you sent Mr.  
This is from July 11, 2005.  
A. This appears to be from a physical therapist.  
you tell me what that form is?  
Q. It looks like it came from your records. Can  
A. Uh-huh.  
bottom.  
Exhibit 1. I believe it's got your signature at the  
Q. (By Mr. Tornillo) I hand you Defendant's  
patients waiting for him.  
on records, and the doctor probably has got  
the redirect and therefore shouldn't be allowed  
interpose the objection that this goes beyond  
objection -- I'm sorry. I'm also going to  
MR. COOPER: I'll also interpose the  
marked for identification.)  
(Defendant's Exhibit No. 1 was  
and mark this. I'll show you Exhibit 1.  
Q. (By Mr. Tornillo) I hand you -- let's go ahead  
you know, after that.

1 have.

2 Q. Okay. And you note at the top of the form  
3 there is a date that says onset date. Top right.

4 A. Onset date, yes, sir.

5 MR. COOPER: Same objection, counsel. I

6 assume that the problem with this going beyond  
7 not only the redirect, beyond your cross,

8 totally new information is continuing and as to  
9 the fact this is somebody else's record. Can I  
10 have that as continuing --

11 MR. TORNILLO: Yes, you may.

12 MR. COOPER: Thank you.

13 Q. (By Mr. Tornillo) Dr. Johnston, what's the  
14 onset date noted by the physical therapist?

15 A. I think on the physical therapy it says 2/9/05.  
16 MR. TORNILLO: Just for recordkeeping,

17 John, I'm going to -- so we have everything, I'm  
18 going to mark the letter from Dr. Meeks as

19 Exhibit No. 2 and the Dorminy Medical Center

20 records as No. 3 and just attach it so we have

21 that in the record.

22 (Defendant's Exhibit Nos. 2-3 were

23 marked for identification.

24 And I have no further questions.

25 MR. COOPER: Doctor, if you could pass

1 that piece of paper to me, I think I'm about

2 done. Let's just for identification purposes

3 mark these two boards. If I could ask the court

4 reporter to mark on the back of the normal disk

5 anatomy the doctor has in his hand Exhibit 1,

6 Plaintiff's Exhibit 1 or however you want to say

7 that, Johnston Plaintiff 1, and Johnson

8 Plaintiff 2 would be the board of the disk

9 herniation, please

10 (Plaintiff's Exhibit Nos. 1-2 were

11 marked for identification.)

12 (Off the record.)

13 MR. COOPER: I think we're done. Thank

14 you, doctor.

15 THE VIDEOGRAPHER: The time is now

16 8:58 a.m. This concludes Videotape No. 1. OFF

17 the record.

18 (Signature was waived by the witness.)

19 (Deposition concluded at 8:58 a.m.)

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C E R T I F I C A T E

STATE OF GEORGIA:  
COUNTY OF COWETA:

I hereby certify that the foregoing transcript

was taken down, as stated in the caption, and the questions and answers thereto were reduced to typewriting under my

direction; that the foregoing pages 1 through 58

represent a true and correct transcript of the evidence

given upon said hearing, and I further certify that I am

not of kin or counsel to the parties in the case; am not in

the regular employ of counsel for any of said parties; nor

am I in anywise interested in the result of said case.

This, the 25th day of August, 2010.

*Dorothy Shuff*  
DOROTHY SHUFF, CCR-B1121  
ESTER & ASSOCIATES, LLC

ESTEB & ASSOCIATES, LLC

COURT REPORTER DISCLOSURE STATEMENT

STATE OF GEORGIA  
COUNTY OF \_\_\_\_\_

Deposition of Kim Johnson, M.D.

Pursuant to Article 10.B. of the Rules and Regulations of the Board of Court Reporting of the Judicial Council of Georgia, I make the following disclosure:

I am a Georgia Certified Court Reporter. I am here as a representative of Esteb & Associates, LLC.

I am not disqualified for a relationship of interest under the provisions of O.C.G.A. §9-11-28(c).

Esteb & Associates was contacted by the offices of John Cooper to provide court reporting services for this deposition. Neither I nor Esteb & Associates will be taking this deposition under any contract that is prohibited by O.C.G.A. §15-14-37 (a) and (b).

Neither I nor Esteb & Associates have a prohibited contract/agreement to provide reporting services with any party to the case, or any reporter or reporting agency from whom a referral might have been made to cover this deposition.

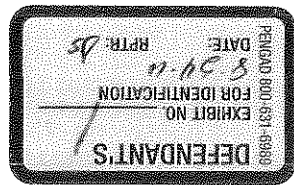
Esteb & Associates will charge its usual and customary rates to all parties in the case, and a financial discount will not be given to any party to this litigation.

David J. Black  
Certified Court Reporter  
CCR# 61121 DATE: 8-24-10

John Cooper  
Signature of Attorney for Plaintiff  
DATE: u

[Signature]  
Signature of Attorney for Defendant  
DATE: 8/24/10

PLEASE RETURN THIS FORM AFTER REVIEW AND/OR SIGNATURES TO THE COURT REPORTER FOR INCLUSION IN THE RECORD.



Physician's Signature: [Signature] Date: 7/20/05

I certify that the above Physical Therapy Treatment is medically necessary and is approved by me.

Therapist's Signature: [Signature] Date: 7-11-05

Rehabilitation Potential: Good Duration: 4 wks Family Involvement: [Blank] Expected Duration of Treatment: 4 wks

Suggested Treatment Plan: M/T/F-SK @ 10:00 AM, US 1.5 w/2 x 2 @ 10:00 AM, SKL Shy's, IF SKL, program @ 10:00 AM

Short Term Goals (2 wks): Cervical range 50%, ROM 10%, 2 sprms. Long Term Goals (4 wks): US Anticollaps, 5 @ 5 @

Assessment: Cervical range 50%, ROM 10%, 2 sprms. Long Term Goals (4 wks): US Anticollaps, 5 @ 5 @

121 psi	102 psi	150	145	145	155	155	155
↑	↑	↑	↑	↑	↑	↑	↑
121 psi	102 psi	150	145	145	155	155	155

Objective Findings: pt presented 3 coll. PSHX: gill bladder PMHX: HTN Allergies: Aspirin

Subjective Findings: SI g/o made referred to PT Eval of chest MOI: turned head - head pain DOS: 5-23-05

Primary Diagnosis: s/p ACF Cervical spondylosis Patient Name: JOHNSON Wilcox Date: 7-11-05 Onset Date: 2-9-05 DOS: 5-23-05

H-180

NEUROSURGICAL ASSOCIATES, P.A.

UNIVERSITY MEDICAL CENTER, SUITE 4-C

820 ST. SEBASTIAN WAY, (10)

ALGUSTA, GEORGIA 30910

TELEPHONE (706) 724-9607

FAX (706) 722-1999

NEUROLOGICAL SURGERY  
E.E.G. LAB

- POMEROY NICHOLS, M.D.
- JOHN T. WILLIAMS, M.D.
- JOHN D. REYNOLDS, III, M.D.
- BEN N. ESTES, M.D.
- WILLIAM H. WEEKS, M.D.

July 17, 1992

Otis K. Forbes, III

Attorney at Law

P.O. Box 5369

Virginia Beach, VA 23455

RE: J.C. Wilcox

Dear Mr. Forbes:

This 37 year old male was first seen by me on 8/7/91. He was working on the brakes. He noted a burning pain in his low back which progressed in intensity. He was seen by several physicians and referred here for evaluation of the low back pain.

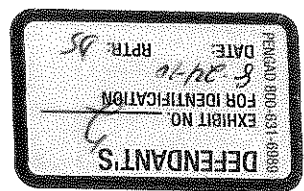
When seen, he was complaining of low back pain with activity, occasional left leg pain, as well as some neck pain without radiculopathy.

He was admitted to the University Hospital, Augusta, GA 8/12/91 through 8/14/91. A myelogram with emphasis on the lumbar region was within normal limits. Myelogram in the dorsal region as well as the cervical region was considered normal. Xrays of the cervical spine did reveal a small amount of cervical osteoarthritis C5-6. CT scan of the lumbar spine revealed no paraspinal abnormality. Vertebral body pedicles were intact and the posterior elements were unremarkable. Bone scan showed mild osteoarthritic changes in the mid dorsal and upper lumbar region with no definite evidence of any significant acute post traumatic osseous change such as compression fracture or an osteoblastic lesion. Blood work was normal. He was discharged with the diagnosis of (1) lumbar sprain, (2) cervical osteoarthritis C5-6 and (3) radiculopathy left leg etiology undetermined and (4) hypertension.

After being discharged from the hospital he was seen back in the office on 8/23/91. The patient was better and he was put on some exercises.

Office visit 9/19/91 still on exercises doing normal activity at home.

Office visit 10/8/91 doing well. he was to return to work on 10/14/91 however on 10/11/91 he called indicating that he would not return to work due to onset of neck pain and was staying off work.



William H. Meeks, M.D.

*W.H. Meeks*

With regards,

Permanent disability in regards to cervical problem consist of 7% to the whole person. Partial disability would extend from the time of being seen on 8/7/91 through 4/30/92.

- (1) Cervical spondylochorondrosis C5-6
- (2) Radiculopathy, left arm, secondary to #1
- (3) Hypertension

Office visit 4/30/92 - EMG was normal. Left arm numbness was better. Patient was asked to return to work on 5/4/92.

Office visit 3/24/92 - left arm still goes to sleep at times. Dr. Hudson has scheduled him for EMG. Patient was having no neck pain.

Office visit two and half months postop (2/25/92) xrays showed early fusion. Patient was out of his collar and remained off work.

Office visit 1/28/92, six weeks postop, patient was doing well. Repeat xrays of the cervical spine revealed bone plug in good position.

He was taken to the operating room on 12/9/91 at which time he had anterior disectomy and interbody fusion at C5-6. Postop he had no radicular left arm pain and did well.

Patient was discharged from the hospital and followed in the office.

consultation by Dr. Hudson (orthopedist) who concurred with the diagnosis.

left arm pain and in fact it would be dangerous for him to do so. He was seen in

and radicular left arm pain. EMG and nerve conduction study of the left upper extremity revealed a C6 radiculopathy. Patient did not feel that could work with this neck and

and CT revealed degenerative disc at C5-6, central and left. Patient was having neck

myelogram revealed central defect at C5-6 (disc vs. ligament). MRI scan, myelogram

Omnipaque myelogram at this time revealed a small central defect at C5-6. CT post

He was readmitted to the University Hospital, Augusta, GA on 12/2/91 through 12/12/91.

was unable to return to work in regards to his neck and arm.

of the neural foramina and nerve roots. When seen the patient was of the opinion he

and left posterior lateral herniation of the disc at C5-6 level without encroachment

Hulsey who did a MRI scan of the cervical region which revealed a small central

After this he was referred by workmans' compensation to Atlanta to Dr. J. Max  
shoulder and a questionable bursitis. He was placed on a Decadron dose pack.  
Office 10/17/91 the neck pain was better. Ten days before this visit he started  
having left arm pain however. Examination revealed some tenderness of the left

H-181



EKG: No acute changes. Hematocrit was 48.9, white count 6000. CK was 48 with MB of 1.4. His Troponin was 0.03. BUN was 12, Creatinine was 1.2.

PHYSICAL: T- 98.9, P- 106, R- 22, BP- 141/92  
GENERAL: Patient is pleasant. He is slow to answer questions and in no acute distress.  
NECK: Supple. There is no bruit.  
CARDIO: Regular without murmurs, gallops or rubs. There is no chest wall tenderness.  
LUNGS: Clear bilaterally.  
ABDOMEN: Soft and non tender to deep palpation. There is no guarding or rebound.  
EXTREMITIES: No edema.

FAMILY HISTORY: Mother died of cancer. Patient has three children and four siblings.

SOCIAL HISTORY: Patient is employed by the railroad. He has a prior history of tobacco use. He does not drink alcohol.

CURRENT MEDS: Prilivil 20 mg per day, Zocor, Prilosec and Dyazide.

ALLERGIES: NKDA.

PSH: None.

PMH: Remarkable for hypertension, hyperlipidemia, stenosis of his right coronary artery in 1999.

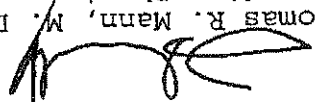
HPI: Patient is a 50 year old black male with PMH significant for atherosclerotic cardiovascular disease, status post stenosis of his right coronary artery in 1999. Prior to that, he did not have a MI and subsequent to his stent he had a cardiolyte scan performed in 2000 which showed a small, fixed apical defect suggestive of congenital thinning with ejection fraction of 69%. Patient reports that for the past three months, he has had chest discomfort which is described as a burning and tends to come and go without response to exertion. He denies aggravating or relieving factors. On the evening of admission, patient was getting up to go to work and was taking a shower. He felt some substernal chest burning. He apparently fell in the shower and may have lost consciousness. He got up and lay down on the bed and continued to have chest pain and actually felt that the chest discomfort was getting worse and subsequently presented to the ER for evaluation. He complained of left sided chest pain and was given sublingual Nitroglycerin, followed by Morphine and Phenergan. He did not clearly get a response to the Nitroglycerin. He was subsequently admitted to rule out myocardial infarction. He also denies aggravation of the symptoms with food.

Name: WILCOX, JOHNNY C  
Address: P O BOX 5161  
Doctor: MANN, TOM R  
Hosp#: 32358 / 360776 Adm: 02/09/05  
DOB: 03-18-1954

DORMINY MEDICAL CENTER  
HISTORY AND PHYSICAL

IMPRESSION:

1. Chest pain in a patient with known atherosclerotic cardiovascular disease. He does not have aggravating or relieving factors and his description is somewhat atypical as it is a burning type discomfort. Due to his history, he is admitted and placed on Lovenox with serial isoenzymes.
2. Possible syncope. Patient is very unclear in his regard. He actually does not remember falling but states that he remembers being in the shower and subsequently being on the floor. He was unaware of any injury but did subsequently report some lower back discomfort.
3. Hyperlipidemia.
4. Current tobacco use.

  
Thomas R. Mann, M.D.  
Attending Physician

DC: 2-10-05 09:29  
TS: February 10, 2005 9:40  
11157