

3 DIRECT EXAMINATION

4 BY MR. FIRM ATTORNEY:

5 Q Doctor, would you please tell the
6 jury your full name and your business address.

7 A William Christopher Foster, Box
8 980153 MCV Station, Richmond, Virginia.

9 Q Could you summarize for the jury your
10 educational background, with an emphasis on your
11 medical training.

12 A I received a medical doctor degree
13 from the medical college of Virginia in 1976; I then
14 did a surgical internship until 1977; I did an
15 orthopedic surgery residency from 1977 until 1981; I
16 did a fellowship in musculoskeletal tumor surgery
17 from 1981 to 1982; and I was certified by the
18 American Board of Orthopedic Surgeons in 1984.

19 Q And of course you're licensed to
20 practice medicine here in the Commonwealth of
21 Virginia?

22 A I am.

23 Q What does your specialty concern?

24 A Orthopedic surgery primarily concerns
25 the medical and surgical management of disorders of

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1 bones, joints, and surrounding connective tissue
2 structure such as muscles, ligaments and nerves.

3 Q And do you operate regularly
4 concerning that area?

5 A I do.

6 Q Is Mr. William Lewis a patient of
7 yours?

8 A He is.

9 Q Do you understand the term reasonable
10 degree of medical certainty?

11 A I do.

12 Q Will you so answer my questions?

13 A I will.

14 Q When did you first see Mr. Lewis?

15 A I first saw Mr. Lewis on May 5th,
16 1998.

17 Q How did you come to see him?

18 A Mr. Lewis was referred to me by one
19 of my partners, Dr. Vincent Dalton, who had been
20 treating him prior to my seeing him.

21 Q And why did he want you to see Mr.
22 Lewis?

23 A Mr. Lewis had pain in his right
24 shoulder and some pain running down his right arm.
25 Dr. Dalton had been treating him for his shoulder

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1 pain for an injury to the tendon of his shoulder.
2 Mr. Lewis also had evidence of degenerated and
3 bulging discs in his neck, which can also be a

4 source of shoulder pain, and Dr. Dalton wanted me to
5 evaluate him for his neck to see if treatment of
6 that might help alleviate his shoulder pain.

8 Q And what history did Mr. Lewis give
9 you when you first saw him?

10 A Mr. Lewis told me that he had injured
11 himself on December the 8th, 1997, while pulling on
12 some kind of a railroad switch; he told irle that Dr.
13 Dalton had been treating him for an injury to his
14 rotator cuff; and that he had had surgery in January
15 of 1998 for his rotator cuff disease; he had
16 continued to have pain in his right shoulder that
17 went down his right arm into his hand with nuffbness
18 into his long finger; he had been doing some
19 physical therapy for his shoulder but his symptoms
20 had gotten worse; he related to me that he hadn't
21 had any of the above symptoms prior to his injury in
22 December of 1997.

23 Q And did you perform an examination?

24 A I did.

25 Q And what did that reveal?

A I thought that motions of his neck

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1 were painful for him; I thought that he had weakness
2 of both the biceps and triceps muscles of his arm;
3 and I thought he had a diminished reflex of his
4 triceps muscle, which is the big muscle on the back
5 of the arm, which would be indicative of some type
6 of nerve problem; and I thought that he had some
7 diminished sensation in his long finger on the right
8 hand.

9 Q What was your diagnosis?

10 A I thought that he had degenerated and
11 bulging discs between his fifth and sixth cervical
12 vertebrae and between his sixth and seventh cervical
13 vertebrae.

14 Q Doctor, I'm going to hand you a
15 chart. Can you point out to the jury where those
16 areas are.

17 A This would be his fifth cervical
18 vertebra right here. The little blue line between
19 that and the bone below it would be the disc between
20 his fifth and sixth cervical vertebra. The next
21 little blue line down would be the disc between his
22 sixth and seventh cervical vertebra, those are neck
23 bones, and I thought those were the two degenerated
24 and bulging discs that he had.

25

Q Now I'm going to hand you another

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1 diagram and I'm going to ask if you can identify
2 that for the jury as to what that represents.

3 A This actually is a diagram of the
4 lumbar spine, not the cervical spine. Although
5 other than being larger the lumbar vertebrae are
6 reasonably similar. This area is a schematic
7 representation of a disc. A disc is composed mostly
8 of two structures: an outer area that is dense,
9 fibrous tissue like one would think of as sinew or a
10 ligament; the inner structure is a much softer
11 cartilaginous tissue, we often relate its
12 consistency to something like crabmeat. When the
13 disc bulges, as is showing here, some of the simple
14 portion of the disc bulges out into the ligamentous
15 portion of the disc, which can impinge on the nerve
16 root as it exits from the vertebral canal at that
17 level.

18 Q Thank you. We already marked that as
19 Exhibit No. 1 and we move to have that introduced.

20

21 NOTE: The above-referred-to
22 diagram of vertebrae was marked as
23 Plaintiff's Exhibit No. 1.

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1 BY MR. FIRM ATTORNEY (Continuing)

2 Q Now, based on this diagnosis of
3 degenerative and bulging discs at these two levels,
4 what treatment did you arrange for Mr. Lewis?

5 A Mr. Lewis and I discussed the
6 possibility of surgical removal of the disc and
7 fusion of those bones, which means putting bone in
8 between the bones where the disc was to get those
9 bones to grow together. I discussed with him the
10 procedure and the complications and left it with him
11 that he would call me if he wanted to schedule the
12 surgery.

13 Q And did you eventually schedule and
14 perform the surgery?

15 A Yes, I did.

16 Q And what is involved in that surgery?

17 A An incision is made on the front of
18 the neck. We go down beside the voice box and the
19 esophagus, which is a tube that goes from the mouth
20 to the stomach to the front of the spine. The discs

21 are marked with a marker and an X-ray obtained so
22 that we know what level we're at. We then remove
23 the disc and replace it with bone so that the bones
24 where the disc was will not be moving on each other
25 and it relieves the bulging portion of the disc

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1 where it abuts the nerve root.
2 Q And was this done at two levels for
3 Mr. Lewis?
4 A That was done at two levels.
5 Q Where do you obtain the bone that's
6 used for these fusion procedures?
7 A I obtain the bone from a bone bank.
8 Q And is the patient placed under a
9 general anesthetic?
10 A The patient is placed under a general
11 anesthetic.
12 Q How did Mr. Lewis handle the surgery?
13 A He seemed to tolerate the surgery
14 satisfactorily in terms of his acute course. In
15 terms of his chronic course, the surgery improved
16 some of his symptoms and didn't improve others of
17 his symptoms. The pain below his shoulder into his
18 arm and hand seemed to be improved, and the pain
19 around his shoulder was not significantly improved.
20 Q Did he require additional medication
21 after the surgery?
22 A He has been treated since the surgery
23 fairly regularly with pain medications.
24 Q What types of pain medication?
25 A The most recent medication that I saw

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1 was Tylenol No. 3 which is -- and soffiie Percocet,
2 which are narcotic pain medications.
3 Q Now, based on the history you
4 obtained, your examination, your findings, the
5 surgery, and your subsequent treatment, do you have
6 an opinion as to whether or not the problems that
7 you described for Mr. Lewis were related to his
8 railroad injury of December 8, 1997?
9 A I don't believe that the injury
10 itself injured his neck or caused his discs to
11 degenerate or bulge. I think though that the
12 shoulder pain, which is what he presented with, is
13 what eventually led him to having his neck operated
14 on to a large degree. I don't think that his neck
15 probably was the major source of his shoulder
16 symptoms and treating it didn't dramatically change
17 them, but I think had he not had the shoulder pain
18 he probably would not have had the neck surgery. To

19 that degree, they're related.
20 Q Now, have you continued to treat Mr.
21 Lewis?
22 A I have.
23 Q And have you focus3ed mainly on the
24 neck and hand problems?
25 A That's correct.

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I Q Now, have you discussed with Mr.
2 Lewis the possibility of him returning to work?
3 A I have.
4 Q And are you familiar with his prior
5 job as a conductor and his duties?
6 A I am as roughly familiar with it as a
7 person who doesn't do the job and hasn't been
8 involved in the job can reasonably be, I suppose.
9 Q And do you have an opinion as to
10 whether or not he can return to work?
11 A I don't believe that he can return.
12 Q What kind of limitations have you
13 placed upon Mr. Lewis?
14 A I have limited the amount of use of
15 his right arm that he can do, and that I don't
16 believe that he is going to be able to lift and
17 carry heavy objects or do things like pulling
18 switches like he was doing. I have limited his
19 walking and standing to some degree, although that's
20 not as related to his neck as it is his other
21 medical problems. I have limited him from bending,
22 stooping, twisting, and climbing, and reaching above
23 shoulder level.
24 Q Let me hand you a forrri, Doctor. Is
25 that a form that you completed?

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I A Yes. That's what I was looking for
2 and I found half of it.
3 Q Is that an accurate reflection of the
4 limitations that you've imposed upon Mr. Lewis?
5 A I think that it is.
6 Q And do you believe that he's able to
7 return to any kind of work?
8 A I think based on his neck problem,
9 shoulder problems, medical conditions and history of
10 a myocardial infarction, that he's not going to
11 return to work.
12 Q Now, you mentioned the myocardial
13 infarction, did you treat him for that problem?
14 A I did not.
15 Q Are you aware of his recovery?
16

17 MR. GREGORY: Object to the form
18 of the question as leading.

19
20 BY MR. FIRM ATTORNEY (Continuing)

21 Q You can go ahead and answer.

22 A I've seen him in my office on several
23 occasions since he had it, so I'm aware that he
24 recovered. I'm not specifically aware of the
25 medical implications of it.

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1 Q Now insofar as the limitations that
2 you just recited, is the myocardial infarction a
3 factor in those limitations that you've imposed?

4 A It is. Yes, I think it is.

5 Q And to what extent?

6 A I don't know how much, to be
7 perfectly honest. I mean, I think it limits
8 strenuous activities. I think his major limitation
9 is use of his right arm, and the myocardial
10 infarction contributes to his overall limitations.
11 But the major limitation that I've placed on him and
12 that I think is impacting him is his right arm.

13 Q What do you see as his future?

14 A I believe he's going to continue to
15 have right shoulder pain. I don't believe that that
16 is likely to significantly change in the future. I
17 don't have enough information to comment on his
18 medical future in terms of his diabetes and his
19 heart disease.

20 Q Do you think his shoulder will get
21 better or worse?

22 A I don't think it will change
23 dramatically.

24 Q How about his future insofar as pain
25 is concerned?

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1 A I think it's most likely to remain
2 stable at current levels.

3 Q Will he continue to require
4 medication?

5 A I think so.

6
7 MR. FIRM ATTORNEY: I will move to
8 introduce the form that the doctor's
9 identified, as Exhibit 2. And that's all
10 the questions I have.

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12 NOTE: The above-referred-to form
13 dated 11/3/98 was marked as Plaintiff's

14 Exhibit No. 2.

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CROSS-EXAMINATION

19 BY MR. GREGORY:

20 Q Dr. Foster, based on the history that
21 was given to you, do you have any history of Mr.
22 Lewis having shoulder pain before this accident?

23 A That sounded like two questions to
24 me, so let me be a little obtuse. Based on the
25 history given to me, no, but based on information

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2 that I have, yes.

2 Q All right. So as to the first where
3 you answered the history, based on what Mr. Lewis
4 told you, he never told you about shoulder pain, did
5 he?

6 A That is correct.

7 Q Now, you said but on -- independent
8 of Mr. Lewis you have seen some records that he did
9 have shoulder pain before this accident?

10 A That is correct.

11 Q Do you also see evidence based on the
12 records you've been able to look at that he had arm
13 pain, right arm pain before this accident?

14 A I do.

15 Q But Mr. Lewis didn't tell you of the
16 arm pain either, did he?

17 A He did not.

18 Q Is it important for a patient, any
19 patient, to be as accurate and as truthful with
20 their past history as they can be in terms of your
21 treatment and your diagnosis?

22 A It is.

23 Q For example, Doctor, your estimates
24 of what might happen to a patient in the future in
25 terms of having pain or disability or limitations is

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i determined in part by what they give you as a past

2 and present history of symptoms; is that correct?

3 A That's correct.

4 Q I guess to put it in layman's terms,
5 they have to be, I guess, sort of accurate and
6 truthful as to what pain they're reporting to you
7 and the duration and the nature of it; is that
8 correct?

9 A That's correct.

10 Q And I take it then from a scientific
11 standpoint, there's no way for you to determine
12 pain, per se, is there other than the -- I guess
you
13 can see someone grimace, but actually to measure
14 pain, you can't, can you?

15 A Pain is very multifactorial. And I
16 have a since deceased ex-partner who used to tell
17 people that he couldn't see pain. We can't see or
18 measure pain. Pain affects different people
19 differently and there's no way to quantitate it.

20 Q And, Dr. Foster, you mentioned, I
21 think you said quite candidly that the neck
problems
22 were not related to the accident, this accident,
but
23 you think that he, you think that he would not have
24 had the surgery had he not had the shoulder
problem?

25 A That's correct.

1 Q All right. Now, the degenerative
2 changes you saw, that was pre-existing, wouldn't you
3 say, of the accident?
4 A That's correct.
5 Q All right. And degenerative is where
6 a lay person would call it arthritis?
7 A Yes.
8 Q All right. So he had arthritic
9 changes that certainly they were there before
10 December the 8, 1997?
11 A Yes.
12 Q Now, in the schematic you gave us,
13 and you've just said it was of the lumbar section as
14 opposed to the cervical section of the spine but
15 very similar in terms of disc structure, you
16 mentioned in termg of the -- when you said that,
17 when you described sort of the viscous or crabmeat-
18 like interior of the disc, you said that can bulge
19 and it can impinge on a nerve, correct?
20 A That's correct.
21 Q But did you see impingement in this
22 case?
23 A I think so.
24 Q But you said you think so, you didn't
25 -- there was no clear indication of impingement in

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I this case, was there?
2 A Yes, I think there was.
3 Q You think there was?
4 A Yeah.
5 Q Okay.
6 A That's as definite as I can get. I'm
7 sorry, I'm a gray kind of a person. He had an MRI
8 scan which showed bulging disc out into the area of
9 the neural frame and where the nerve root goes. He
10 had symptoms of numbness that went into his hand
11 consistent with where one of those nerve roots that
12 would have been impinged goes. He had a diminished
13 reflex in his triceps which would indicate
14 impingement of the second one of those nerve roots
15 that I operated on. He got better from some of
16 those symptoais after his surgery.
17 Now, when I did his surgery, I left the
18 posterior ligament of his neck intact, so I didn't
19 actually see the nerve root itself, because to
20 remove that ligament and expose that nerve root
21 would have subjected him to the possibility of an
22 injury to the sleeve of the nerve root or something
23 for no benefit to him. So I didn't actually see the
24 nerve root. That's why I say I think so. Based on
25 the X-ray studies and the clinical findings and the

1 results of treatment, there is no question in my
2 rrtind that he had nerve root impingement, although I
3 never looked at his nerve root. So I think so.

4 Q Okay. So, Doctor, so your
5 qualification was you didn't see it, but based on,
6 as you said before, the symptoms given to you by Mr.
7 Lewis would lead you to believe that there was
8 impingement because he gave --

9 A No, he had physical examination
10 findings of diminished sensation in the finger and a
11 diffiinished reflex, and he had an MRI scan which
12 showed it.

13 Q All right. Now, for example, did you
14 do any nerve conductivity studies on him?

15 A No, I did not.

16 Q All right. Wouldn't you say, Doctor,
17 that's a definitive test that will give you
18 conductivity of nerve, it would be a lot more exact
19 in terms of --

20 A It's a test that is virtually never
21 done for this because it's an expensive, painful
22 test which adds very little to our knowledge of
23 what's going on. The physical examination findings
24 and the MRI scan is what would be used in the
25 overwhelming majority of cervical discectomy cases

I and in very few people would we actually get a nerve
2 conductivity test.

3 Q Now, you never had any consultation
4 with a neurologist, did you?

5 A No.

6 Q And what is the specialty of
7 neurology?

8 A Neurologists deal with diseases and
9 injuries of nerves.

10 Q Of nerves, that's their specialty,
11 correct?

12 A That's correct.

13 Q And Mr. Lewis never saw that
14 specialty?

15 A To the best of my knowledge he
16 didn't.

17 Q Also, he never had any consult with a
18 neurosurgeon either, did he?

19 A No, he didn't.

20 Q All right. What do neurosurgeons do?

21 A They operate on brains and spines and
22 nerves.

23 Q On spines. And many times they
24 operate in the cervical spine area, don't they?
25 A They do, but so do orthopedists who

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1 do spine surgery, and I do a lot of spine surgery
2 and do a lot of peripheral nerve surgery for tumors.
3 So I don't think that there was anymore expertise
4 available to him by having seen a neurosurgeon.

5 Q Do you ever CON3Ult with
6 neurologists?

7 A Occasionally.

8 Q But you didn't consult with a
9 neurologist in this case?

10 A Didn't think I needed one; don't to
11 this day think I needed one.

12 Q And you did surgery on this gentleman
13 after seeing him once?

14 A That's correct. He had seen one of
15 aLy partners, whols also an orthopedic surgeon, on a

16 number of occasions, and it is common in a referral

17 practice when you're having other specialist

18 surgeons sending you patients to get someone whols

19 already been evaluated, worked up, and is ready for

20 a procedure.

21 Q Now, in this case, he didn't have a
22 herniated disc, did he?

23 A No, he had a bulging disc.

24 Q All right. And would you describe

25 for the jury what a herniated disc is.

[Remainder of deposition omitted]