

1998

Mark S. Dalebout v. Union Pacific Railroad Company, a corporation : Brief of Appellant

Utah Court of Appeals

Follow this and additional works at: https://digitalcommons.law.byu.edu/byu_ca2

 Part of the [Law Commons](#)

Original Brief Submitted to the Utah Court of Appeals; digitized by the Howard W. Hunter Law Library, J. Reuben Clark Law School, Brigham Young University, Provo, Utah; machine-generated OCR, may contain errors.

Richard I. Ashton; Ashton, Braunberger and Boud; John J. Rossi; Rossi, Cox, Kiker and Inderwish; Attorneys for Appellee.

Morris O Haggerty; Larry A. Gantenbein; Union Pacific Railroad Company; Attorneys for Appellant.

Recommended Citation

Brief of Appellant, *Dalebout v. Union Pacific Railroad Company*, No. 980163 (Utah Court of Appeals, 1998).
https://digitalcommons.law.byu.edu/byu_ca2/1451

This Brief of Appellant is brought to you for free and open access by BYU Law Digital Commons. It has been accepted for inclusion in Utah Court of Appeals Briefs by an authorized administrator of BYU Law Digital Commons. Policies regarding these Utah briefs are available at http://digitalcommons.law.byu.edu/utah_court_briefs/policies.html. Please contact the Repository Manager at hunterlawlibrary@byu.edu with questions or feedback.

UTAH COURT OF APPEALS
BRIEF

UTAH
DOCUMENT
KFU

IN THE UTAH COURT OF APPEALS

CKET NO. 980163-CA

MARK S. DALEBOUT,

Plaintiff and Appellee,

vs.

UNION PACIFIC RAILROAD COMPANY,
a corporation,

Defendant and Appellant.

) CASE NO. 980163-CA

)

)

)

) PRIORITY NO. 15

)

)

)

)

)

BRIEF OF APPELLANT

On Appeal from the Second Judicial District Court
of Weber County, State of Utah
The Honorable Roger S. Dutson

Richard I. Ashton
ASHTON, BRAUNBERGER & BOUD,
Professional Corporation
765 East 9000 South, Suite #A-1
Sandy, Utah 84094
Telephone: (801) 263-0300

And

John J. Rossi
ROSSI, COX, KIKER & INDERWISH,
Professional Corporation
12203 East Second Avenue
Aurora, CO 80011-8399
Telephone: (303) 366-3501

Attorneys for Appellee

ORAL ARGUMENT REQUESTED

Morris O Haggerty
Larry A. Gantenbein
UNION PACIFIC RAILROAD COMPANY
406 West 100 South
Salt Lake City, Utah 84101-1151
Telephone: (801) 595-3270

Attorneys for Appellant

FILED
Utah Court of Appeals

JUN - 1 1998

Julia D'Alesandro
Clerk of the Court

IN THE UTAH COURT OF APPEALS

MARK S. DALEBOUT,)	CASE NO. 980163-CA
)	
Plaintiff and Appellee,)	
)	
vs.)	PRIORITY NO. 15
)	
UNION PACIFIC RAILROAD COMPANY,)	
a corporation,)	
)	
Defendant and Appellant.)	

BRIEF OF APPELLANT

On Appeal from the Second Judicial District Court
of Weber County, State of Utah
The Honorable Roger S. Dutson

Richard I. Ashton
ASHTON, BRAUNBERGER & BOUD,
Professional Corporation
765 East 9000 South, Suite #A-1
Sandy, Utah 84094
Telephone: (801) 263-0300

And
John J. Rossi
ROSSI, COX, KIKER & INDERWISH,
Professional Corporation
12203 East Second Avenue
Aurora, CO 80011-8399
Telephone: (303) 366-3501

Attorneys for Appellee

Morris O Haggerty
Larry A. Gantenbein
UNION PACIFIC RAILROAD COMPANY
406 West 100 South
Salt Lake City, Utah 84101-1151
Telephone: (801) 595-3270

Attorneys for Appellant

ORAL ARGUMENT REQUESTED

TABLE OF CONTENTS

	<u>Page(s)</u>
JURISDICTION	1
ISSUES PRESENTED FOR REVIEW AND THE STANDARD OF APPELLATE REVIEW	1
I. Issue: Did the trial court err in allowing into evidence speculation regarding the possibility of future surgery?	1
II. Issue: Did the trial court err in instructing the jury, denying Union Pacific's motion for a directed verdict and denying Union Pacific's Motion for J.N.O.V./New Trial pursuant to Utah Rules of Civil Procedure 50(b) and 59, because there was not sufficient evidence that Dalebout would have to have a future surgery or that Dalebout would have future wage loss or an impairment of earning capacity?	2
III. Issue: Did the trial court err in failing to remit the verdict where it was excessive and not supported by the evidence.	3
IV. Issue: Did the trial court err in excluding testimony from Dalebout's treating physician regarding the effect of litigation on Dalebout's perceived pain and suffering while litigation was active and after the litigation ended	3
STATEMENT OF THE CASE	4
Nature of the Case	4
Course of Proceedings	5
Disposition in the Court Below	7
Statement of Facts Relevant to the Issues Presented	7
SUMMARY OF ARGUMENTS	20
ARGUMENT	22
I. THE TRIAL COURT ERRED IN ALLOWING INTO EVIDENCE SPECULATION REGARDING THE POSSIBILITY OF FUTURE SURGERY	22

II.	THE TRIAL COURT ERRED IN INSTRUCTING THE JURY WITH REGARD TO FUTURE SURGERY, FUTURE WAGE LOSS OR IMPAIRMENT OF EARNING CAPACITY; DENYING UNION PACIFIC’S MOTION FOR A DIRECTED VERDICT ON THESE ISSUES; AND DENYING ITS MOTION FOR J.N.O.V./NEW TRIAL AS THERE WAS NOT SUFFICIENT EVIDENCE THAT DALEBOUT WOULD HAVE TO HAVE A FUTURE SURGERY OR THAT DALEBOUT WOULD HAVE AN IMPAIRMENT OF FUTURE EARNING CAPACITY	28
III.	THE TRIAL COURT ERRED IN FAILING TO REMIT THE VERDICT BECAUSE IT WAS EXCESSIVE AND NOT SUPPORTED BY THE EVIDENCE	36
IV.	THE TRIAL COURT ERRED IN EXCLUDING TESTIMONY FROM DALEBOUT’S TREATING PHYSICIAN REGARDING THE EFFECT OF LITIGATION ON DALEBOUT’S PERCEIVED PAIN AND SUFFERING WHILE LITIGATION WAS ACTIVE AND AFTER THE LITIGATION ENDED	38
CONCLUSION		39

ADDENDUM

Exhibit 1	Memorandum Decision
Exhibit 2	Deposition of Dr. Donald W. Bryan

TABLE OF AUTHORITIES

	Page(s)
Cases	
<u>Claar v. Burlington Northern R. Co.</u> , 29 F.3d 499 (9th Cir. 1994)	23
<u>Corbett v. Seamons</u> , 904 P.2d 229 (Utah Ct. App. 1995)	30
<u>Cornia v. Wilcox</u> , 898 P.2d 1379 (Utah 1995)	2, 3
<u>Crookston v. Fire Ins. Exchange</u> , 817 P.2d 789 (Utah 1991)	2, 3
<u>DeChico v. Metro-North Commuter RR</u> , 758 F.2d 861 (2d Cir. 1985)	32, 33
<u>Erickson v. Wasatch Manor, Inc.</u> , 802 P.2d 1323 (Utah Ct. App. 1990)	1, 22, 24
<u>Fashauer v. New Jersey transit Rail Operations, Inc.</u> , 57 F.3d 1269 (3d Cir. 1995)	30, 32, 33
<u>Herber v. Johns-Manville Corp.</u> 785 F.2d 79 (3d Cir. 1986)	23, 29
<u>Howell v. Marmpegaso Compania Naviera, S.A.</u> , 536 F.2d 1032 (5th Cir. 1976)	37
<u>Mayhew v. Bell Steamship Co.</u> , 917 F.2d 961 964 (6th Cir. 1990)	23
<u>Nelson v. Trujillo</u> , 657 P.2d 730 (Utah 1982)	31, 32, 33, 35
<u>Robinson v. Hreinson</u> , 17 Utah 2d 261, 409 P.2d 121 (1965)	23, 29
<u>Seale v. Gowans</u> , 923 P.2d 1361 (Utah 1996)	2
<u>State v. Mickelson</u> , 848 P.2d 677 (Utah Ct. App. 1992)	1, 22
<u>Steffensen v. Smith’s Management Corp.</u> , 862 P.2d 1342 (Utah 1993)	4, 39
<u>Williams v. Martin Marietta Alumina, Inc.</u> , 817 F.2d 1030 (3d Cir. 1987)	37
<u>Williams v. Missouri Pacific R. Co.</u> , 11 F.3d 132 (10th Cir. 1993)	30
<u>Wood v. Day</u> , 859 F.2d 1490 (D.C. Cir. 1988)	23, 26, 27, 30, 34, 35

Statutes

Page(s)

Federal Employers' Liability Act 45 U.S.C. §51	4
Utah Code Ann. § 78-2-2(3)(j)	1
Utah Code Ann. § 78-2-2(4)	1
Utah Rules of Appellate Procedure, Rule 42	1
Utah Rules of Civil Procedure, Rule 50(b)	2
Utah Rules of Civil Procedure, Rule 59	2

JURISDICTION

This Court has jurisdiction in this matter pursuant to Utah Code Ann. §78-2-2(3)(j) and by assignment of this case to it by the Utah Supreme Court pursuant to Utah Code Ann. §78-2-2(4) and Rule 42, Utah Rules of Appellate Procedure.

ISSUES PRESENTED FOR REVIEW AND THE STANDARD OF APPELLATE REVIEW

I. Issue: Did the trial court err in allowing into evidence speculation regarding the possibility of future surgery?

The standard of appellate review: The admissibility of evidence is a question of law. Accordingly, the reviewing court generally grants no deference to a trial court's decision on that issue, but reviews it for correctness. State v. Mickelson, 848 P.2d 677, 684 (Utah Ct. App. 1992). This Court has also stated a different standard of appellate review--the appellate court reviews a trial court's determination on the admissibility of evidence for an abuse of discretion, affecting a party's substantial rights. A substantial right of a party is affected if, viewing the evidence as a whole, there is a reasonable likelihood a different result would have been reached absent the error. Erickson v. Wasatch Manor, Inc., 802 P.2d 1323, 1325 (Utah Ct. App. 1990).

This issue was preserved in the trial court when Union Pacific objected to the testimony of Dr. Donald Bryan that Mark S. Dalebout had a 30% chance of needing a future surgery by way of a Motion in Limine (R. 399, 402) and again at trial. (R. 590 Trial

Transcript p. 125 line 22- p. 126 line 9 objecting to Dr. Bryan's testimony that there was only a possibility of surgery and not a probability). The objections were denied by the trial court. (R. 590 Trial Transcript p.131 line 11-p. 132 line 18.)

II. Issue: Did the trial court err in instructing the jury, denying Union Pacific's motion for a directed verdict and denying Union Pacific's Motion for J.N.O.V./New Trial pursuant to Utah Rules of Civil Procedure 50(b) and 59, because there was not sufficient evidence that Dalebout would have to have a future surgery or that Dalebout would have future wage loss or an impairment of earning capacity?

The standard of appellate review: In reviewing a denial of a J.N.O.V. or motion for a new trial on the ground of insufficient evidence, the appellate court reverses only if, viewing the evidence in the light most favorable to the prevailing party, it concludes that the evidence is insufficient to support the verdict. Seale v. Gowans, 923 P.2d 1361, 1363 (Utah 1996); Crookston v. Fire Ins. Exchange, 817 P.2d 789, 799 (Utah 1991). See Cornia v. Wilcox, 898 P.2d 1379, 1383 (Utah 1995) (no competent evidence which would support the verdict). The challenging party must marshal all the evidence supporting the verdict and then show that the evidence cannot support the verdict. Seale, 923 P.2d at 1363. The standard of appellate review for a denial of a directed verdict is essentially the same--a directed verdict and a J.N.O.V. are justified only if the appellate court, after looking at the evidence and all reasonable inferences in a light most favorable to the nonmoving party, concludes that there is no competent evidence which would support a verdict in the nonmoving party's

favor. If reasonable persons could reach differing conclusions on the issue in controversy, then the motion should be denied and the denial affirmed. Thus, a motion for a directed verdict can be granted only when the moving party is entitled to judgment as a matter of law. Cornia, 898 P.2d at 1383.

This issue was preserved in the trial court when Union Pacific objected to the jury being instructed on and being able to award damages for Dalebout having to have a future surgery or that he would have a future wage loss or impairment of earning capacity. (R. 590 Trial Transcript p. 260 lines 12-15, p. 260 lines 16-19.) Union Pacific also moved for a directed verdict (R. 590 Trial Transcript p. 209 lines 6-19) and for a J.N.O.V. or New Trial based on these issues. (R. 482.)

III. Issue: Did the trial court err in failing to remit the verdict where it was excessive and not supported by the evidence.

The standard of appellate review: Where a damage verdict is attacked an appellate court will reverse a denial of a motion for a new trial on the grounds of excessiveness only if there is no reasonable basis for the trial court's decision. Crookston, 817 P.2d at 805.

This issue was preserved in the trial court when Union Pacific moved for a new trial on the ground of excessive damages. (R. 482.)

IV. Issue: Did the trial court err in excluding testimony from Dalebout's treating physician regarding the effect of litigation on Dalebout's perceived pain and suffering while litigation was active and after the litigation ended.

The standard of appellate review: Review of evidentiary rulings excluding expert testimony is abuse of discretion by the trial court. Steffensen v. Smith's Management Corp., 862 P.2d 1342, 1347 (Utah 1993). The burden is on the challenging party to prove that there is a reasonable likelihood that the verdict would have been different if the trial court had allowed the expert testimony. Id.

This issue was preserved in the trial court when Union Pacific sought to call Dr. Bryan on this issue and proffered the testimony of Dr. Bryan regarding his expert opinion on the effect of litigation on Dalebout's perceived pain and suffering and what would happen to Dalebout's future pain and suffering when the litigation was resolved. (R. 590 Trial Transcript p. 210 line 25-p. 213 line 5.) The trial court denied admission of this testimony. (R. 590 Trial Transcript p. 212 lines 17-24.)

STATEMENT OF THE CASE

Nature of the Case

This is a personal injury action brought by plaintiff/respondent Mark S. Dalebout ("Dalebout") who alleges he was injured in an on-duty accident on February 1, 1993 while working for defendant/appellant Union Pacific Railroad Company ("Union Pacific"). He sued Union Pacific pursuant to the Federal Employers' Liability Act, 45 U.S.C. §51, et. seq. The accident occurred when a locomotive seat on which Dalebout was sitting fell three inches. Union Pacific admitted that the locomotive seat on which Dalebout was seated at the time of the incident was defective but denied that Dalebout's injuries were caused as a result

of the defective seat or that Dalebout had any damages stemming from the defective seat. In a two day jury trial, Dalebout received a verdict finding causation of his injuries and awarding \$493,365.

Course of Proceedings

Dalebout's Complaint was filed on December 12, 1995, and requested a jury trial of his action. (R. 001.) Union Pacific's Answer was filed on December 26, 1995. (R. 012.) Various pretrial motions took place culminating in a Motion for Partial Summary Judgment filed by Union Pacific on May 9, 1997. (R. 195.) The Motion for Partial Summary Judgment was denied by the trial court without written opinion during a settlement conference on May 23, 1997. (R. 295.)

A Motion in Limine was brought by Union Pacific and filed on April 21, 1997. (R. 097.) A second Motion in Limine was filed by Union Pacific on August 20, 1997. (R. 399.) In a hearing on May 23, 1997, the trial court granted the first Motion in Limine in part and ordered Dalebout to submit the appropriate paper work to the trial court for signature. (R. 295.) Dalebout failed to do so. The second Motion in Limine was denied during pretrial proceedings. The important part of these motions was that Dr. Donald Bryan, Dalebout's treating physician and a trial witness via deposition, was allowed to testify that Dalebout had a 30% chance of needing a future surgery.

A jury trial was held on August 28 and 29, 1997. (R. 590, Trial Transcript.) On August 29 the jury returned a verdict finding that the defective seat was a cause of the

injuries sustained by Dalebout and awarding damages as follows:

A.	Past medical costs	\$ 825.00
B.	Future medical costs	5,040.00
C.	Past wage loss	0.00
D.	Future impairment of earning capacity	275,000.00
E.	Past pain, suffering, loss of enjoyment of life.	12,500.00
F.	Future pain, suffering, loss of enjoyment of life:	<u>200,000.00</u>
	TOTAL	\$493,365.00

(R. 475-76.)

On September 8, 1997, Union Pacific brought a Motion for J.N.O.V./New Trial. In a Memorandum Decision filed and dated December 18, 1997, the Motion was denied. (R. 541-549.) On January 16, 1998, Judgment was entered. (R. 550.) On January 16, 1998, the Order denying Union Pacific's Motion for J.N.O.V./New Trial was entered. (R. 553.) On January 16, 1998, Union Pacific's First Notice of Appeal was filed. (R. 556.)

The first Notice of Appeal was filed based on the trial court's Memorandum Decision denying Union Pacific's Motion for J.N.O.V./New Trial. As of that time the trial court had received Dalebout's proposed judgment (R. 508) but had taken no action. Due to the wording of the Memorandum Decision and its Certificate of Mailing ("I HEREBY certify I mailed a true and correct copy of the foregoing Order . . .) Union Pacific felt it was required to file a Notice of Appeal. After the Judgment and the Order denying the Motion for New Trial/J.N.O.V. were entered on January 16, 1998, Union Pacific filed its second Notice of Appeal on February 13, 1998. The second Notice of Appeal does not appear as part of the record in this matter for an unknown reason.

Both appeals were poured over to the Court of Appeals (R. 587 and 589) then consolidated by order of this Court. (This is in the record, Volume 5 preceding R. 531 but not stamped.)

Disposition in the Court Below

Union Pacific's Motion for Partial Summary Judgment was denied by the trial court at a settlement conference. (R. 295.) In a jury trial in this matter the jury rendered a verdict finding Union Pacific liable and awarding damages to Dalebout. See, supra.

Union Pacific's Motion for J.N.O.V./New Trial was denied by the trial court in a Memorandum Decision (R. 541), an Order was entered (R. 553) and Judgment was entered (R. 550). The trial court's Memorandum Decision is attached hereto in the Addendum.

Statement of Facts Relevant to the Issues Presented

1. In accordance with Union Pacific's duty to marshal the facts supporting the outcome of the jury verdict, Union Pacific sets forth the following facts:

Charles Julian testified to the following pertinent facts: He is a conductor for the Union Pacific Railroad, a friend and often a roommate of Dalebout. (R.590 Trial Transcript p. 117 line 5, p. 118 line 24-p.119 line 25.) Prior to Dalebout's accident, Julian knew of no restrictions on his activities. (R. 590 Trial Transcript p. 120 lines 11-14.) Dalebout was a workaholic, always doing things and fixing things around their apartment. (R. 590 Trial Transcript p.120 lines 14-19.) Since the accident Julian has noticed a marked difference in Dalebout including no longer fixing things up, sleeping constantly and "eating" aspirins. (R.

590 Trial Transcript p.120 line 22-p. 121 line 6.) Julian has not skied with Dalebout since the accident although they skied frequently before. (R. 590 Trial Transcript p. 121 lines 10-15.) Dalebout complains considerably about his back and Julian thinks he worries about his livelihood. (R. 590 Trial Transcript p.121 lines 18-22.) Dalebout's attitude has changed from a happy person with a positive outlook on life to someone who doesn't seem to have the zeal and lust for life that he had before. (R. 590 Trial Transcript p.121 line 20-p. 122 line 8.)

Dalebout testified to the following pertinent facts: Dalebout started with Union Pacific Railroad in August 1975. (R. 590 Trial Transcript p.148 lines 7-8.) He first was a switchman for three years then was laid off in 1985 and had to go back to Green River to work for another year as a switchman. (R. 590 Trial Transcript p.148 lines 22-25.) Dalebout became a brakeman after three years and started working from Ogden or Salt Lake to Green River. (R. 590 Trial Transcript p.149 lines 8-14.) Dalebout became a conductor in about 1993 or 1994 and was promoted shortly thereafter to engineer. (R. 590 Trial Transcript p.149 line 22-p. 150 line 3.) Dalebout testified about reductions in the size of the work force for Union Pacific where a crew of two brakeman, a conductor and an engineer was eventually reduced to a crew of only a conductor and an engineer. (R. 590 Trial Transcript p.150 lines 1-18.)

Dalebout was injured on February 1, 1993 while operating a locomotive when the seat on which he was sitting dropped down when he was trying to open a window. (R. 590 Trial

Transcript p.154 line 24-p. 156 line 8.) The seat fell three or four inches and jarred him. (R. 590 Trial Transcript p.157 lines 1-5.) He felt a sharp pain. (R. 590 Trial Transcript p.156 line 10.) Dalebout reported the injury and that his back was hurting but he did not want to fill out an accident report at that time because if it would go away everything would be fine. (R. 590 Trial Transcript p. 158 lines 4-7.) Dalebout later filled out an accident report because the pain did not go away. (R. 590 Trial Transcript p. 158 lines 9-13.) Dalebout had hurt his back on the Railroad two prior times in 1981 and 1985. Both times the problem cleared up within two or three weeks. (R. 590 Trial Transcript p. 152 line 14-p. 154 line 15.) From late 1985 through the time of his accident at issue in this trial, Dalebout saw no medical providers and had no problems with his back. (R. 590 Trial Transcript p. 154 lines 16-23.)

Dalebout was off for ten days after the accident then returned to work. (R. 590 Trial Transcript p. 161 lines 10-12.) Dalebout first went to see a doctor on February 8, 1993, the day after he first filled out his accident report. (R. 590 Trial Transcript p. 159 line 23- p. 161 line 1.) At that time he went to the Union Pacific Clinic and was given medication and referred to a Dr. Crossland. (R. 590 Trial Transcript p. 160 line 20-p. 161 line 11.) Dalebout's next medical visit was to Dr. Crossland's office where he was examined, x-rayed, diagnosed with a strain of the back and referred for physical therapy. (R. 590 Trial Transcript p. 161 line 13- p. 162 line 3.) Dr. Crossland's office also prescribed an anti-inflammatory for Dalebout. (R. 590 Trial Transcript p. 166 lines 4-5.) Dalebout participated in physical therapy while continuing to work. (R. 590 Trial Transcript p. 161 line 25-p. 162

line 6.) In physical therapy, Dalebout was given exercises to do which he continues to do to present. (R. 590 Trial Transcript p. 163 lines 6-20.) After seeing Dr. Crossland's office, Dalebout still had pain and the physical therapy did not help his pain. (R. 590 Trial Transcript p. 166 lines 2-13.)

Dalebout's next medical visit was to Dr. Donald Bryan about November 1993. (R. 590 Trial Transcript p. 166 lines 14-21.) In between the visits to Dr. Crossland's office and Dr. Bryan, Dalebout continued to have pain. (R. 590 Trial Transcript p. 166 line 22-p. 167 line 3.) Dalebout went to see Dr. Bryan because the pain was still there and he wanted to "cover things" to see if he was going to be okay. (R. 590 Trial Transcript p. 167 lines 10-15.) Dr. Bryan prescribed anti-inflammatories and Dalebout continues to take medication of one pill a day. (R. 590 Trial Transcript p. 167 line 22-p. 168 line 10.) Dalebout has seen Dr. Bryan four additional times. (R. 590 Trial Transcript p. 168 lines 12-13.)

Dalebout continues to have a lot of pain including pain in the right and left legs like an ace bandage that is way too tight on the leg. The pain in his back is always there. (R. 590 Trial Transcript p. 170 lines 4-9.) The pain affects his activities by making him be very careful how he does things. (R. 590 Trial Transcript p. 170 lines 12-14.) The pain and problems seem like they are slowly getting worse. (R. 590 Trial Transcript p. 170 lines 18-22.) He has pain every day. (R. 590 Trial Transcript p. 171 lines 8-9.) Dalebout also takes six aspirin, ibuprofen or Advil a day which is more than he was taking two or three years ago. (R. 590 Trial Transcript p. 171 lines 10-21.)

Before the accident Dalebout had no restrictions on his activities. (R. 590 Trial Transcript p. 171 lines 22-24.) Dalebout now has a lifting restriction of 50 pounds. (R. 590 Trial Transcript p. 173 line 12.)

Dalebout's injury does not affect his job except as to his comfort level. This makes him have to be careful, readjust and get up occasionally. (R. 590 Trial Transcript p. 172 lines 16-25.) Dalebout testified that he felt he could perform his job. (R. 590 Trial Transcript p. 174 lines 6-8.) He testified in response to a question as to whether he was worried or concerned about his low back and if he was going to be able to do his job as an engineer that "You always have to be concerned in life as far as your job because myself, I'm the provider for--for the wife and the kids and they depend on me and everything that they have. And so yeah, you're always concerned about--about your job and--and life. That in general." (R. 590 Trial Transcript p. 174 lines 18-24.)

Dalebout testified that the railroad no longer requires him to take general physical exams but he thought they had the right to call him in for a physical exam to determine if he was fit to do what the engineer's job description says he has to do. (R. 590 Trial Transcript p. 174 line 25-p. 175 line 17.)

At the time of trial Dalebout had annual earnings of about \$78,000 gross. (R. 590 Trial Transcript p. 175 lines 18-21.)

Dalebout's injury and pain has affected what he does with his children in that with his younger son he is able to only hit a few baseballs to him, he can shoot a few basketball hoops

but cannot play a game, he can throw a football back and forth but cannot play a game, he has missed hiking with family members, and in general he feels cheated out of activities with his children and feels this will continue with grandchildren. (R. 590 Trial Transcript p. 176 line 13-p. 177 line 16.) The injury affects his walking and by late afternoon he is limping and hobbling. (R. 590 Trial Transcript p. 177 lines 17-25.) He did not have these problems before. (R. 590 Trial Transcript p. 177 line 25-p. 178 line 7.) It has affected his relationship with his wife when she accuses him of not doing what he used to do and a lack of sexual intercourse. (R. 590 Trial Transcript p. 178 lines 12-18.) The pain affects his golfing and skiing which were major activities in his life before. (R. 590 Trial Transcript p. 178 line 19-179 line 10.) Because of the pain he has to be careful of what he does and restricts his activity to make sure “nothing blows out or goes wrong.” (R. 590 Trial Transcript p. 182 lines 16-21.) Dalebout restricts his recreational activities because he does not enjoy them and he wants to be careful. (R. 590 Trial Transcript p. 183 lines 4-12.)

Dalebout’s parents and brothers and sisters have not had any problems with their low backs. (R. 590 Trial Transcript p. 179 lines 21-p. 180 line 9.)

Dalebout plans on working until he is age 65. (R. 590 Trial Transcript p. 179 lines 11-14.) He thinks he is going to be able to work until he is age 65 and able to draw full retirement “But there’s always concern that you might not be able to.” (R. 590 Trial Transcript p. 182 line 22-p. 183 line 3.) Dalebout wants to work in the future and as to whether or not he can he has to go one day at a time and do his job. He wants to work in the

future but he sometimes worries about it. (R. 590 Trial Transcript p. 195 line 21-p. 196 line 1.)

Dalebout has gotten worse since he saw the first treating doctor. (R. 590 Trial Transcript p. 198 lines 3-6.)

Tim Holmes, Union Pacific Manager of Timekeeping, testified to the following pertinent facts: He was aware that the medical director of Union Pacific has the right to request a physical examination of an employee to determine if he is fit for duty. (R. 590 Trial Transcript p. 203 lines 20-22.) He testified that engineers' salaries are increasing (R. 590 Trial Transcript p. 206) and if Mr. Dalebout misses a year he would lose roughly \$78,000 a year. (R. 590 Trial Transcript p. 207 lines 1-3.)

Dr. Donald W. Bryan testified to the following pertinent facts: He treated Dalebout. (Bryan Deposition p. 7 lines 11-12.)¹ He first saw him on November 3, 1993, for the evaluation of back pain. (Bryan Deposition p. 7 lines 19-22.) To his knowledge Dalebout had first developed back trouble 12 years prior to his consultation, the trouble subsided over a period of two weeks, and since then Dalebout had been relatively pain free. (Bryan

¹Dr. Bryan testified at trial via a videotaped deposition. For some reason the trial transcript omits Dr. Bryan's testimony. See R. 590 Trial Transcript at p. 139 lines 2-3 "Whereupon the videotape deposition of Dr. Bryan was played." Union Pacific has moved to supplement the record in this matter to include Dr. Bryan's deposition which sets forth his trial testimony. Based upon the assumption that the Motion To Supplement will be granted and the trial transcript will be supplemented by adding the deposition of Dr. Bryan, Union Pacific will refer to that testimony by page and line number from the deposition. The deposition is also attached hereto in the Addendum as it plays a critical role in this appeal.

Deposition p. 9 lines 3-17.)

Dalebout told Dr. Bryan at that first visit that he had pain every day associated with prolonged sitting, bending, twisting, coughing, and sneezing. He usually slept through the night but occasionally would have pain that would wake him up. He did not have any pain down his left leg. (Bryan Deposition p. 37 line 20-p. 38 line 8.) Dr. Bryan had an MRI taken and that, together with x-ray films, showed that Dalebout had degenerative disc disease at the two lower levels of his spine with some bulging of the discs at L4-5 and L5-S1 into the spinal canal to a minimal degree. (Bryan Deposition p. 10 lines 17-25, p. 12 lines 13-17.) The bulges could also be called a minimal central herniation. (Bryan Deposition p. 41 lines 2-25.)

When Dr. Bryan saw Dalebout on November 7, 1994, he continued with back pain and had pain down his right leg towards the knee. (Bryan Deposition p. 43 line 24-p. 44 line 4.) When he saw him on August 14, 1995, Dalebout continued with back pain and leg pain on the right side and had a positive straight leg raising test on the right side at 45°. (Bryan Deposition p. 45 lines 1-10.) Dalebout also had a loss of sensation on the medial aspect of his right foot which is innervated by the L5 nerve root and this can be caused by the L4-5 or the L5-S1 disc pinching it. (Bryan Deposition p. 46 line 9-p. 47 line 10.)

In 1997, Dr. Bryan ordered a new MRI because he had been following Dalebout for three years, his pain had changed a little going from backache to leg symptoms and he wished to discover if the disc had herniated more. (Bryan Deposition p. 48 lines 10-22.) The

two MRIs did not show a dramatic change and were virtually the same. (Bryan Deposition p. 49 lines 1-11.)

Dr. Bryan testified that the cause of Dalebout's pain and problems was a degenerative process and, due to the fact that Dalebout had an injury and stated that his pain all started with his Railroad injury, the injury had to have been the contributing factor in his symptoms. (Bryan Deposition p. 19 line 25-p. 20 line 10.) He testified that the difference between an asymptomatic back and a symptomatic back may not be all that great but an injury makes it that way. (Bryan Deposition p. 20 lines 20-22.) Dr. Bryan testified that the injury played a role taking the degenerative back condition from a subclinical state to a clinical state with the total cause of the pain being a combination of preexisting degenerative changes plus the injury. (Bryan Deposition p. 21 lines 21-24.)

In Dr. Bryan's opinion Dalebout was having back pain due to degeneration of his discs with some mild tearing of the central disc allowing it to bulge. (Bryan Deposition p. 13 lines 8-10.) In Dr. Bryan's opinion 20% of Dalebout's pain was injury related and 80% was preexisting degenerative disease. (Bryan Deposition p. 17 lines 12-16; p. 18 lines 1-25.)

Dr. Bryan testified that to a reasonable degree of medical certainty Dalebout sustained an injury when the seat fell and twisted. (Bryan Deposition p. 29 line 24-p. 30 line 25.) His apportionment between the preexisting degenerative disc disease and the accident was difficult and it was impossible to point out the percentage within 1-5%. (Bryan Deposition p. 31 line 16-p. 32 line 24.)

Dr. Bryan testified the degenerative changes in Dalebout's back were progressive but that the pain would be totally unpredictable. (Bryan Deposition p. 33 lines 6-8.) Dr. Bryan expected Dalebout's degenerative change would get worse in the future but he did not know whether his pain would get worse. (Bryan Deposition p. 34 lines 1-6.) Absent the accident it was possible Dalebout could have gone the rest of his life without the degenerative changes causing him any problems and Dr. Bryan sees people with worse degenerative changes without symptoms or pain. (Bryan Deposition p. 33 lines 13-24.) Dr. Bryan testified that it would be very difficult to say that more likely than not Dalebout would have had pain due to his degenerative disc disease regardless of injury. (Bryan Deposition p. 22 lines 7-14.)

Dr. Bryan testified there was a 30% chance that Dalebout would require a back fusion. (Bryan Deposition p. 34 lines 7-13; p. 68 lines 6-19.) If surgery was needed he did not believe Dalebout would go back to work as an engineer. (Bryan Deposition p. 34 line 14-p. 25 line 4.)

Dr. Bryan testified that if a person were predisposed to problems because of degenerative disc disease it would be more difficult to get rid of pain. (Bryan Deposition p. 36 line 25-p. 38 line 5.)

Dr. Bryan testified that Dalebout would always need future medical treatment of an inflammatory drug and he may occasionally need an epidural steroid injection. (Bryan Deposition p. 51 line 23-p. 52 line 21.) Dr. Bryan felt that Dalebout would not go away and be perfectly normal, he would always have some chronic backache that will require medicine

and maybe injections. (Bryan Deposition p. 52 lines 14-18.)

If surgery were necessary, the cost of a fusion would be several thousand dollars. (Bryan Deposition p. 57 lines 12-22.) If a cage were used in such a surgery it would probably cost \$3,000 or \$4,000. (Bryan Deposition p. 58 lines 7-19.)

Dr. Bryan testified that the accident was an aggravation or a tearing of a sick disc that caused symptoms where Dalebout might not have had them if he had not had the accident, at least in the short term. (Bryan Deposition p. 62 lines 14-24.)

2. Union Pacific also sets forth the following facts in accordance with the standard of review for the admissibility of evidence being reversible error only if, viewing the evidence as a whole, there is a reasonable likelihood a different result would have been reached absent the error.

Dalebout testified that he finished high school and had two and one-half years of college. (R. 590 Trial Transcript p.147 line 13-14.)

Dalebout initially missed ten days of work after his accident. (R. 590 Trial Transcript p. 161 line 10-12.) While Dalebout was off for those ten days he continued to be paid by Union Pacific. (R. 590 Trial Transcript p. 162 line 25-p. 163 line 2.) Dalebout missed no other time from work because of his injury except he laid off sick once or twice. (R. 590 Trial Transcript p. 162 line 4-6, p. 174 lines 3-5, 189 line 19-190 line 8.)

Dalebout testified that his pain and problems do not have an effect on his job because he is working with his hands and the problems do not affect that. The only effect it has on

his job is his comfort level and he has to be careful, readjust and get up to take the pressure off. (R. 590 Trial Transcript p. 172 lines 16-25.) He testified that he felt like he could perform his job. (R. 590 Trial Transcript p. 174 lines 6-8.) Since the accident Dalebout has been able to work the type of engineer jobs he wants and has not cut back his work schedule because of the accident. (R. 590 Trial Transcript p. 195 lines 14-20.) He also testified in deposition that he thought he would be able to keep working into the future and confirmed this at trial. (R. 590 Trial Transcript p. 196 lines 5-9.)

Dalebout testified he is not working any less than he was before the accident and his wages have gone up continuously since the accident. (R. 590 Trial Transcript p. 190 lines 9-19.) At trial Dalebout confirmed that in interrogatory answers he never provided a figure for impairment of earning capacity, an amount was never calculated and an economist was never retained to calculate an amount. (R. 590 Trial Transcript p. 191 line 19-p. 193 line 4.)

Dalebout testified in response to a question whether he was worried or concerned about his low back as to whether he was going to be able to do his job as an engineer, that he had general concerns in life because he was the provider for his family, but identified no specific concerns that he would be unable to do his job. (R. 590 Trial Transcript p. 174 lines 18-24.) Dalebout testified that the requirement to take periodic general physical exams had been done away with and he is only required to take ear, eye and color blindness tests. (R. 590 Trial Transcript p. 174 lines 25-p. 175 line 13.) Dalebout testified that he was

released to return to work as an engineer with a 50 pound lifting restriction but that does not affect his job as an engineer. (R. 590 Trial Transcript p. 194 lines 14-24.)

Dalebout testified that he has been advised to not have surgery. (R. 590 Trial Transcript p. 176 lines 2-12.)

Dr. Bryan testified that he did not believe Dalebout had enough disc disease to warrant surgery. (Bryan Deposition p. 1 lines 19-22.) Dr. Bryan testified he did not think Dalebout had a pinched nerve or neurological loss, and he did not think he would benefit by an operation. (Bryan Deposition p. 14 lines 10-20.) Dr. Bryan testified that based on the standard of more likely than not, his feeling was that Dalebout would not need surgery in the future. (Bryan Deposition p. 59 lines 17-21.)

Dr. Bryan testified that eventually he would expect Dalebout to have some symptoms in his back because of the degenerative changes he had before the accident but maybe not for awhile, maybe not for a few years. (Bryan Deposition p. 21 lines 1-4.)

Dr. Bryan testified that the likely prognosis for Dalebout was low grade achy pain with no dramatic change and he should stay about the same as he is. (Bryan Deposition p. 22 line 17-p. 23 line 4.)

Dr. Bryan testified that he did not think there would be any contraindication for Dalebout to continue working, i.e., there was no reason why he could not continue to work as an engineer. (Bryan Deposition p. 23 lines 5-14; p. 24 lines 11-13.)

Dr. Bryan testified that there was no significant change between Dalebout's two MRIs

taken three years apart. (Bryan Deposition p. 49 lines 1-11; p. 54 lines 2-10; p. 55 lines 8-15.)

Dr. Bryan testified that he could not state what it cost for a fusion but he thought it was several thousand dollars. He bet that the cage used in such a surgery probably cost \$3,000 or \$4,000 but he could not tell what the total cost of the surgery would be. (Bryan Deposition p. 57 line 12-p. 58 line 19.)

Dr. Bryan testified that if Dalebout had problems in the future whether it be surgery, missed work or further restrictions, that the cause would be 20% due to the injury and 80% due to his preexisting degenerative changes. (Bryan Deposition p. 60 line 3-p. 61 line 8.)

SUMMARY OF ARGUMENTS

I. Dalebout's treating physician was allowed to testify that there was a 30% chance that Dalebout would need surgery in the future. This was error as the standard of proof is probability not possibility in an FELA case. This affected Union Pacific's substantial rights because this improper evidence likely influenced the jury's award of damages for future wage loss or impairment of earning capacity because absent this evidence there simply was no basis for them to find a future wage loss or impairment of earning capacity.

II. The trial court erred in instructing the jury with regard to future surgery and future wage loss or impairment of earning capacity, erred in denying Union Pacific's Motion for Directed Verdict on these points and erred in denying Union Pacific's Motion for

J.N.O.V./New Trial on these points. This was error because there was no competent evidence that would allow the trial court to instruct or the jury to find that Dalebout would probably need a future surgery or was reasonably certain to have a future wage loss or impairment of earning capacity. Viewed in the light most favorable to Dalebout, the evidence showed that he had a permanent injury, ongoing and worsening pain, and concerns about his future; however, no evidence was presented that he would have to have a future surgery as a probability, that he would be unable to work in the future as an engineer or at any job, or that his economic potential was limited in any way. The only evidence at all that could support such findings was the speculative surgery which was, of course, incompetent evidence.

III. The trial court erred in failing to remit the verdict because it was excessive and not supported by the evidence if the incompetent evidence as to a possible future surgery is excluded. The award included \$275,000 for loss of future earnings or impairment of earning capacity. There was no evidence to sustain this award. The award also included \$200,000 for future pain and suffering. This was far in excess of what the evidence would support. The trial court should have remitted the verdict to eliminate the future wage loss or impairment of earning capacity award and reduce the pain and suffering award.

IV. The trial court erred in excluding testimony of Dalebout's treating physician regarding the effect of litigation on Dalebout's perceived pain and suffering while litigation was active and after the litigation ended. Union Pacific proffered evidence from the doctor

that as long as litigation was going on Dalebout would be focused in on his pain and suffering and it would appear greater. Once the litigation ended his subjective perception would change and he would not have the same amount of pain and suffering. It is reasonably likely the verdict would have been different had the jury been allowed to consider this information due to the size of the pain and suffering award in light of a lack of objective evidence Dalebout would continue to suffer.

ARGUMENT

I. THE TRIAL COURT ERRED IN ALLOWING INTO EVIDENCE SPECULATION REGARDING THE POSSIBILITY OF FUTURE SURGERY.

The central issue in this appeal is whether the trial court erred in allowing into evidence testimony regarding a possibility that Dalebout would need a future surgery because of his accident. Dalebout's treating physician was allowed to testify that there was a 30% chance that Dalebout might need surgery in the future although it was probable he would not need surgery. See Statement of Facts, supra. This testimony was made over the objection of Union Pacific both in a Motion in Limine and at trial. Allowance of such testimony was clear legal error that affected Union Pacific's substantial rights.²

²This Court has articulated two different standards of appellate review regarding the admissibility of evidence. In State v. Mickelson, 848 P.2d 677, 684 (Utah Ct. App. 1992) this Court stated that it is a question of law and that no deference is granted to the trial court's decision on that issue although it is not unusual for the applicable legal standard of admissibility to vest a measure of discretion in the trial court by making the court's legal analysis contingent upon the resolution of certain predicate factual issues. In Erickson v. Wasatch Manor, Inc., 802 P.2d 1323, 1325 (Utah Ct. App. 1990) this Court set forth a different standard--the appellate court reviews a trial court's determination on the

Speculative medical testimony regarding possibilities rather than probabilities is not admissible even in an FELA case. See Claar v. Burlington Northern R. Co., 29 F.3d 499, 503 (9th Cir. 1994) (although the quantum of evidence sufficient to present a jury question of causation is less in an FELA case, it does not mean that no showing of causation need be made nor does it mean that in FELA cases courts must allow expert testimony that in other contexts would be inadmissible); Mayhew v. Bell Steamship Co., 917 F.2d 961, 963, 964 (6th Cir. 1990) (in FELA or Jones Act suits, medical experts must be able to articulate that it is likely or more than possible that the defendant's negligence had a causal relationship with the injury and disability for which the plaintiff seeks damages). See also, Wood v. Day, 859 F.2d 1490, 1493 (D.C. Cir. 1988) (damages for future consequences are recoverable only if a plaintiff establishes that it is more likely than not, a greater than 50% chance, that the projected consequence will occur); Herber v. Johns-Manville Corp. 785 F.2d 79, 82 (3d Cir. 1986) (a future injury, to be compensable, must be shown to be a reasonable medical probability); Robinson v. Hreinson, 17 Utah 2d 261, 409 P.2d 121, 125 (1965) (an award of damages may not be based on mere speculation or conjecture. There must be a firm foundation for any award by proof that is at least more probable than not that the damage will be suffered. For this reason a jury should not be allowed to assess future damages on

admissibility of evidence for an abuse of discretion, affecting a party's substantial rights. A substantial right of a party is affected if, viewing the evidence as a whole, there is a reasonable likelihood a different result would have been reached absent the error. Union Pacific will address the error under the more restrictive standard.

probability, but only such damages as it believes from the preponderance of the evidence a plaintiff will with reasonable certainty incur in the future).

The speculative medical testimony that Dalebout had a 30% chance of a future surgery--a possibility not a probability--should not have been admitted in this case. To do so was a clear error of law.

The error in letting in this testimony affected Union Pacific's substantial rights. The jury was allowed to consider this testimony in deciding if Dalebout would require a future surgery and would have a future wage loss or impairment of earning capacity due to such a surgery. Dalebout's attorney specifically referred in argument to the jury several times that there was a 30% chance of back surgery and that if that happened Dalebout would be unable to work. See R. 590 Trial Transcript p. 231 lines 5-14 and p. 234 lines 10-12 ("We know if he has the fusion, he's not going back to work as an engineer, that we know. And all we know is that there's a 30 percent likelihood that that would happen."). This argument was made in the context of Dalebout's potential future wage loss. See R. 590 Trial Transcript p. 233 line 9-p. 234 line 12.

Absent this testimony and viewing the evidence as a whole, there is a reasonable likelihood a different result would have been reached absent the error. See Erickson, 802 P.2d at 1325. Other than the incompetent evidence of a possible future surgery, there was no evidence from which a jury could reasonably find a future wage loss or impairment of earning capacity. Although Dalebout testified that he had pain, it was getting worse, his

recreational activities were affected, and he had concerns about being able to work in the future, there was no testimony that he would not actually work in the future as an engineer or in any other job. In fact, the testimony of his treating physician, and even of Dalebout, was that he could work in the future. Dr. Bryan testified that the likely prognosis for Dalebout was no dramatic change and there was no reason he could not work in the future. Dalebout testified that his pain and problems do not have an effect on his job because he is working with his hands, he felt like he could perform his job, since the accident he has been able to work the type of engineer jobs he wants, he has not cut back his work schedule because of the accident, his wages have gone up continuously since the accident and he thought he would be able to keep working into the future.

Absent the evidence of a possible future surgery there was also no evidence provided to the jury that would allow them to reasonably calculate a future wage loss or impairment of earning capacity. With a surgery they could at least estimate when the surgery might occur, the number of years of work Dalebout might miss, and then multiply that number by his annual wage of \$78,000. This is how the trial court in its Memorandum Decision justified upholding the jury's verdict--theorizing that a rational jury could have found a future wage loss by determining that if Dalebout lost 20% of his future wages in accord with Dr. Bryan's testimony on apportionment they could multiply this by his annual wage and reach the number they did. The unstated assumption in the Memorandum Decision though is that Dalebout would never work in the future which would happen only if he had the

speculative surgery the day after trial. Without the surgery the trial court could not find he would not work in the future, neither could the jury, and there was no basis to reasonably calculate future wage loss or impairment of earning capacity. Thus, if the speculation regarding a future surgery had not been admitted, likely a jury would have not found future wage loss or impairment of earning capacity.

Wood v. Day, 859 F.2d 1490 (D.C. Cir. 1988) is close to point and persuasive. There, plaintiff had an asymptomatic degenerative spinal condition, much like Dalebout. She was involved in an auto accident. She testified that after the accident she developed constant pain and her range of activities was considerably diminished. Evidence at trial established she had sustained permanent injury to her spine as a result of the accident causing further degeneration. Her doctor testified that while surgery would normally be the optimal course of action he did not believe it appropriate in her case due to heart and weight problems and he was very reluctant to recommend it. The trial court ruled that the doctor was not able to render an opinion as to the likelihood of surgery with the requisite degree of certainty. Despite this ruling the trial court allowed the issue of future wage loss to go to the jury.

In analyzing the case, the D.C. Circuit Court of Appeals held, in accord with the FELA and Utah law, that damages may not be based on mere speculation or guesswork:

... when recovery is sought for future consequences of a tort, damages are 'available only if such consequences are reasonably certain. Unless there is nonspeculative evidence demonstrating that future suffering, additional medical expense, and loss of income will occur, the question should not be submitted to the jury.' [Citation omitted.] This Circuit has previously stated

that damages for future consequences are recoverable only if plaintiff established that it is 'more likely than not (a greater than 50% chance) that the projected consequence will occur.'

859 F.2d at 1493 (citations omitted). The court held that once the testimony as to the possibility of surgery in that case was excluded there was no substantial evidence upon which the jury could extrapolate the plaintiff's future wage loss or medical expenses and the jury should not have been allowed to speculate. Id. at 1494. The court vacated the verdict and remanded for a new trial on the issue of damages. Id.

The instant case is very similar to Wood. Absent the erroneous testimony regarding a mere chance of surgery there was no substantial evidence regarding future wage loss or impairment of earning capacity. Like the plaintiff in Wood, Dalebout had slight past lost wages, pain, diminished activities and permanent injury but no evidence he could not work in the future or could not earn as much as or more than prior to his injury. Thus, Union Pacific's substantial rights were affected by erroneously allowing in that evidence.

As to Dalebout's likely argument that because the jury awarded no damages for a future surgery and therefore likely did not consider the speculative surgery in fixing future impairment, such a conclusion does not follow. The jury likely did not award damages for a future surgery because Dalebout never put on evidence of actual costs. He only elicited from his physician generalities that such a surgery would be "several thousand dollars" with possibly three or four thousand dollars more for a cage if one were used. It was also undisputed that the cause of such a future surgery would be due only 20% to the injury and

80% to the preexisting condition. Based on this testimony it was reasonable, if not required, for the jury to not award damages for a future surgery because they could not calculate 20% of “several thousand dollars” and maybe 20% of “three of four thousand” more. However, the jury could have reasoned that since there was a 30% chance of a future surgery and if it did occur the losses would be large that they should make an award for that possibility even without enough evidence to award the specific costs of such a surgery.

II. THE TRIAL COURT ERRED IN INSTRUCTING THE JURY WITH REGARD TO FUTURE SURGERY, FUTURE WAGE LOSS OR IMPAIRMENT OF EARNING CAPACITY; DENYING UNION PACIFIC’S MOTION FOR A DIRECTED VERDICT ON THESE ISSUES; AND DENYING ITS MOTION FOR J.N.O.V./NEW TRIAL AS THERE WAS NOT SUFFICIENT EVIDENCE THAT DALEBOUT WOULD HAVE TO HAVE A FUTURE SURGERY OR THAT DALEBOUT WOULD HAVE AN IMPAIRMENT OF FUTURE EARNING CAPACITY.

Closely related to the error in admitting the speculative evidence is the trial court’s compounding of that error by instructing the jury with regard to being able to award damages for a future surgery and future wage loss or impairment of earning capacity, denying Union Pacific’s Motion for a Directed Verdict on these points and denying its Motion for J.N.O.V./New Trial. This was all error as there was not sufficient evidence such damages would occur. As the standard of review is essentially the same, these issues will be discussed jointly.

First, with regard to a future surgery, the only evidence presented was that of Dr. Bryan who testified that there was only a 30% chance of a surgery. This was not enough

evidence to allow the jury to decide the issue and it should have been decided in Union Pacific's favor as a matter of law on directed verdict or J.N.O.V. "Of course, no award of damages should be based on mere speculation or conjecture. There must be a firm foundation for any award by proof that is at least more probable than not that the damage will be suffered. For this reason the jury should not be allowed to assess future damages on probability, but only such damages as it believes from the preponderance of the evidence the plaintiff will with reasonable certainty incur in the future." Robinson, 409 P.2d at 125 (footnotes omitted, emphasis in original); see Herber, 785 F.2d at 82 (a future injury, to be compensable, must be shown to be a reasonable medical probability). The objective of this approach is not only to provide compensation for harm that is likely to occur but also to ensure that an award of damages is not made for an injury that probably will not be suffered. Herber, 785 F.2d at 82.

The jury awarded no damages for a future surgery. While this finding might make this issue one that is not prejudicial error, it must be considered that the possibility for a future surgery which the jury was allowed to consider likely influenced the jury's calculations as to future pain and suffering which were considerable. A refusal to allow the jury to consider damages for the speculative future surgery or a directed verdict would likely have changed the complexion of the case for the jury on other issues.

Second, with regard to a future wage loss or impairment of earning capacity, even viewing the evidence most favorably to Dalebout there was no competent evidence that he

would suffer such damages.

An FELA plaintiff has the right to recover for future wage loss or impairment of earning capacity only if the loss is proven with reasonable certainty (although mathematical certainty is not required). See Williams v. Missouri Pacific R. Co., 11 F.3d 132, 135 (10th Cir. 1993) (a FELA plaintiff may recover damages for loss of earnings but the burden rests upon the plaintiff to establish by sufficient evidence a factual basis for the amount of such damages sought); Fashauer v. New Jersey Transit Rail Operations, Inc., 57 F.3d 1269, 1284 (3d Cir. 1995) (a FELA plaintiff may recover damages for lost earning capacity only where the plaintiff has produced competent evidence suggesting that his injuries have narrowed the range of economic opportunities available to him). See also, Wood v. Day, 859 F.2d at 1492-93 (loss of future earnings are recoverable if properly proved at trial, award must be supported by substantial evidence); Corbett v. Seamons, 904 P.2d 229, 232 (Utah Ct. App. 1995). There must be evidence demonstrating the reasonable value of the loss. Williams, 11 F.3d at 135. Medical testimony of permanent injury restricting physical activities only tangentially related to a plaintiff's economic horizons is not enough to sustain a verdict of future impairment of earning capacity. See Fashauer, 57 F.3d at 1284-85.

Union Pacific has marshaled the evidence in Dalebout's favor. In summary, the testimony of Charles Julian was that he was Dalebout's roommate and friend, saw that Dalebout had pain, was no longer active off the job, complained about his back and his attitude had changed. Dalebout himself testified he was pain free and active before the

accident, but after the accident he had considerable pain that is worsening and requires constant medication of anti-inflammatories. He has eliminated most recreational activities and the pain affects him by making him have to be careful with what he does continue to do. He has a lifting restriction of 50 pounds. He is concerned about whether or not he can do his job as an engineer and does not know whether he will be able to do it in the future because he has to take it one day at a time. Dr. Bryan testified that but for the injury Dalebout may not have had pain in the future, Dalebout has a degenerative condition in his back with pain, the degenerative change will get worse in the future, the state of the pain is unpredictable and Dalebout will continue to need medical treatment of anti-inflammatory drugs and perhaps an occasional epidural steroid injection.

This testimony did not show a future wage loss or impairment of earning capacity with any certainty at all, much less reasonable certainty, and was not sufficient to support the verdict. The testimony merely established that Dalebout had a permanent injury, he feared a future wage loss, that he didn't enjoy life as much and that he had pain. It did not establish that he would not be able to work at some point in the future as an engineer or in any other job, that his economic opportunities were narrowed, or that there was some calculable sum he would likely lose out on in the future. Most importantly, the evidence did not establish any basis for a jury to determine damages for a potential future impairment. All the jury could do was guess if he would be impaired and guess at an amount. This made instructing the jury on this issue improper and reversible error just like in Nelson v. Trujillo, 657 P.2d

730 (Utah 1982).

In Nelson, the Utah Supreme Court reversed and remanded for a new trial on the issue of damages because the jury should not have been instructed or allowed to consider a loss of future earnings. The court held:

Plaintiff has pointed to no evidence in the record upon which the jury could assess damages for future loss of earnings. A jury instruction on future loss of earnings is improper where there is no evidence upon which a jury could reasonably base such an award. [Citations omitted.] In the case at bar, “the jury had no basis, except pure guesswork, for estimating earnings reasonably certain to be lost in the future.” [Citation omitted.] The \$150,000 general damages in this case, and the trial court’s expressed surprise at the size of the verdict (in contrast to the \$12,000 awarded at the first trial) suggest that this erroneous instruction affected the size of the verdict to the detriment of the defendant. We must therefore remand this issue for a new trial.

Id. at 735. See also, DeChico v. Metro-North Commuter RR, 758 F.2d 856, 861 (2d Cir. 1985) and Fashauer, 57 F.3d at 1284-85.

In DeChico the court of appeals held that the trial court was justified in refusing to allow the jury to consider impairment of future earning capacity. DeChico was able to return to his job following his accident, eventually received a raise in salary so he was earning as much or more than he was at the time of the accident and he expected to continue in his job. In response to DeChico’s argument that he was still entitled to damages for impairment to his earning capacity because he had a permanent injury that might restrict his future employment possibilities and make it more difficult for him to compete in the open labor market, the court held that he was not entitled to such an instruction because “any suggestion

that appellant might be forced to leave his regular employment with the Railroad was too speculative to have supported a damage award on that theory.” 758 F.2d at 861. In Fashauer the court of appeals held that the trial court’s instruction on future lost earnings was proper. In discussing the issue the court agreed that the plaintiff had produced no competent evidence supporting his claim for lost earnings capacity. The testimony consisted of medical testimony only tangentially related to the plaintiff’s economic horizons--that the accident caused a permanent injury to his shoulder that restricted his physical activity, with a lifting restriction that prevented him from doing his railroad job but there was no testimony that the plaintiff would have difficulty obtaining work with a different employer or that jobs he could do after the injury were less lucrative than his railroad job. The court noted no witness even opined that plaintiff’s injury limited his economic potential. “The jury had no information from which to conclude that Fashauer’s economic horizons were limited. He essentially wanted the jury to take his counsel’s word for it.” Id. at 1285.

Due to the similar lack of evidence in this case, the jury should not have been instructed on the issue, the trial court should have directed a verdict, and/or the Motion for J.N.O.V./New Trial on the issue of damages should have been granted.

There is one difference between this case, Nelson, DeChico and Fashauer. In this case there was evidence admitted that if Dalebout had surgery at some point in the future then at that point he would be unable to work, a situation that was only possible, not probable. This is the only basis for the jury’s verdict regarding future impairment. Without this improperly

admitted evidence however, the jury could not reasonably find future wage loss or impairment of earning capacity. Of course the wrongful admission of the improper evidence cannot sustain the jury's verdict.

Again, Wood v. Day is on point and persuasive. In Wood, the plaintiff presented basically the same evidence as was presented by Dalebout--that she had an asymptomatic degenerative spinal condition, she was involved in an auto accident and developed constant pain, her range of activities was considerably diminished and she had sustained permanent injury to her spine as a result of the accident causing further degeneration. The plaintiff in Wood had also returned to work but had presented testimony that if a speculative surgery were to occur she would be off for six months following the surgery and not employed. Her doctor testified that while surgery would normally be the optimal course of action he did not believe it appropriate in her case due to heart and weight problems and he was very reluctant to recommend it. The court ruled that the doctor was not able to render an opinion as to the likelihood of surgery with the requisite degree of certainty.

In analyzing the case, the D.C. Circuit Court of Appeals ruled, in accord with the FELA and Utah law, that damages may not be based on mere speculation or guesswork. 859 F.2d at 1493.

Thus, "[w]hile damages are not required to be proven with mathematical certainty, there must be some reasonable basis on which to estimate damages."

And despite the jury's discretion, "[i]t is elementary that an instruction should not be given if there is no evidence to support it." [Citation omitted.]

The evidence presented must be more than a “scintilla,” [citation omitted] and, indeed, when recovery is sought for future consequences of a tort, damages are “available only if such consequences are reasonably certain. Unless there is nonspeculative evidence demonstrating that future suffering, additional medical expense, and loss of income will occur, the question should not be submitted to the jury.” [Citation omitted.] This Circuit has previously stated that damages for future consequences are recoverable only if plaintiff established that it is “more likely than not (a greater than 50% chance) that the projected consequence will occur.”

859 F.2d at 1493 (citations omitted).

The court held “As we have shown, once the testimony as to the possibility of surgery was excluded, there was no evidence in the record to support instructions as to loss of future earnings or future medical expenses. In such a case a jury may not be allowed to speculate, and this, under the instructions it was given, is what this jury was allowed to do.” Id. at 1494. The court vacated the verdict and remanded for a new trial on the issue of damages.

This was the exact situation in this case--there was no evidence, only speculation based upon only a possibility of surgery. As in Nelson and Wood, this Court should find similarly and reverse and remand for a new trial on the issue of damages.

Two additional points need to be addressed. First is the trial court’s rationalization of the verdict with regard to the damages for future wage loss or impairment of earning capacity in its Memorandum Decision denying Union Pacific’s Motion for a New Trial/J.N.O.V. There, the trial court did not address the erroneous admission of evidence or the legal standards for such evidence to be admitted. Rather, the trial court hypothesized a situation in which the jury could have properly awarded the future wage loss or impairment

of earning capacity it did. However, the trial court made an unstated assumption that was not supported by any competent evidence--that Dalebout likely would not be able to work in the future at all beginning the day after trial. Such an assumption had to rely on the speculative surgery occurring the day after trial. Other than the unstated assumption, the trial court cited no other evidence which would support the jury's verdict regarding its award as to future wage loss or impairment of earning capacity.

Second, the question arises as to whether a remand should be ordered for a new trial on all damages or if the jury's verdict as to future pain and suffering should stand. Union Pacific submits that the entire damage verdict was tainted by allowing the issue of future surgery and future wage loss or impairment of earning capacity to go to the jury. The trial court expressed surprise at the size of the verdict noting it made everyone's jaw drop. The award for future pain and suffering was completely out of proportion to the past award. It is likely the improper evidence and consideration of issues influenced the entire damage award. Union Pacific is entitled for a complete redetermination of damages without the improper evidence being in front of the jury.

III. THE TRIAL COURT ERRED IN FAILING TO REMIT THE VERDICT BECAUSE IT WAS EXCESSIVE AND NOT SUPPORTED BY THE EVIDENCE.

There was no reasonable basis for the trial court's refusal to remit the verdict or grant a new trial. First, as discussed supra, there was no competent evidence that Dalebout would have a future wage loss or impairment of earning capacity. The trial court's explanation in

its Memorandum Decision implicitly relied upon a future surgery. Removing this there is no reasonable basis left for such an award and the damage award should have at least been remitted in the amount of the \$275,000 awarded for future wage loss or impairment of earning capacity.

Second, the total verdict awarded “shocks the conscience.” Similar cases have been remitted to much less than the amount awarded by this jury for future pain and suffering and impairment of earning capacity. See, e.g., Howell v. Marmpegaso Compania Naviera, S.A., 536 F.2d 1032 (5th Cir. 1976) (similar back injury, treated by surgery, constant pain since then, plaintiff complained he could not play ball with his children, garden, dance, \$136,000 pain and loss of earning capacity award was “simply not in the universe of rational awards on the evidence in this record” remanded to trial court for remittitur); Williams v. Martin Marietta Alumina, Inc., 817 F.2d 1030, 1039-40 (3d Cir. 1987) (back injury with no surgery, minimal narrowing at L5-S1 due mainly to preexisting degenerative changes, return to work avoiding bending and heavy lifting, sexual dysfunction, plaintiff on muscle relaxants, complaints of pain in lower back, inability to sit through a movie, cannot dance, does exercise for his back, not found to be unable to work, jury award of more than \$300,000 for pain and suffering was excessive, “An award in this case in excess of \$100,000 for [plaintiff’s] pain and suffering extends beyond reasonable grounds”) (other cases involving similar remittiturs cited). Thus, a remittitur should be ordered or retrial should be granted on the issue of future damages on this ground.

IV. THE TRIAL COURT ERRED IN EXCLUDING TESTIMONY FROM DALEBOUT'S TREATING PHYSICIAN REGARDING THE EFFECT OF LITIGATION ON DALEBOUT'S PERCEIVED PAIN AND SUFFERING WHILE LITIGATION WAS ACTIVE AND AFTER THE LITIGATION ENDED.

Union Pacific proffered the testimony of Dr. Bryan regarding his expert opinion on the effect of litigation on Dalebout's perceived pain and suffering and what would happen to Dalebout's future pain and suffering when the litigation was resolved. (R. 590 Trial Transcript p.210 line 25-p. 212 line 12.) This is Dr. Bryan's testimony in the deposition p. 24 line 18 through p. 29 line 18. Union Pacific pointed out to the trial court that Dr. Bryan applied his general testimony specifically to Dalebout and that he said that litigation plays a role, he had to take that into consideration in trying to evaluate his patient and he had done that, in particular when he made an apportionment of Dalebout's pain and problems of 20% being due to the accident and 80% to preexisting conditions. (R. 590 Trial Transcript p. 211 line 16-p. 212 line 12.) The trial court excluded this testimony on the grounds that it did not feel Dr. Bryan was making an accurate statement that litigation is always a concern and that it was a "real prejudicial opinion of Dr. Bryan's, frankly, and I'm just not going to allow it in. I just -- I don't think the jury all ought to hear an opinion that a doctor has regarding litigiousness." (R. 590 Trial Transcript p. 212 line 17-24.) The testimony was formally proffered. (R. 590 Trial Transcript p. 212 line 25-p. 213 line 10.)

It was error to exclude the testimony. The trial court cited no legal grounds, it was relevant, well founded and went to the issue of future pain and suffering. There was a

reasonable likelihood that the verdict would have been different if the trial court had allowed the expert testimony. See Steffensen v. Smith's Management Corp., 862 P.2d at 1347. Dalebout was awarded \$200,000 for future pain and suffering. This was a large award especially when considered in light of the objective evidence of his problems which was minimal. See, for example, the MRIs which showed minimal bulging and no neurological compromise and the unchanging nature of the MRIs over the last three years. Dalebout's pain was basically subjective and had the jury been allowed to hear Dr. Bryan's testimony that it would change after trial, there would have been no basis for such a large award.

CONCLUSION

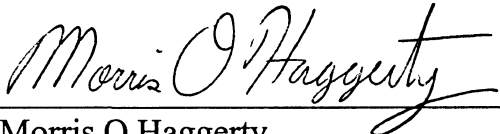
Union Pacific seeks a ruling that the speculative testimony of Dr. Bryan regarding a 30% chance of a future surgery should not have been admitted and that the admission affected Union Pacific's substantial rights. Thus, this was reversible error and the case should be remanded for a new trial on damages.

Union Pacific seeks reversal of the trial court's ruling on its Motion for Directed Verdict and Motion for J.N.O.V./New Trial with a holding that a directed verdict or J.N.O.V. should have been granted, that no damages should have been awarded for future surgery or future wage loss or impairment of earning capacity and a reversal of the jury award as to the award for future wage loss or impairment of earning capacity.

Union Pacific seeks a new trial as to the remainder of Dalebout's damages or remittitur of the future pain and suffering award.

Finally, Union Pacific seeks a ruling by this Court that Dr. Bryan's testimony regarding the effect of litigation on Dalebout's perceived pain and suffering should have been admitted and should be admitted at any future trial.

DATED this 1st day of June 1998.


Morris O Haggerty
Attorney for Union Pacific Railroad

CERTIFICATE OF SERVICE


I hereby certify that on the 1st day of June, 1998, a true, correct and complete copy of the foregoing was delivered upon the following attorneys in the following manner indicated below:

John J. Rossi, Esq.
Rossi, Cox, Kiker & Interwish
12203 East Second Avenue
Aurora, CO 80011-8399

<u>X</u>	U.S. Mail
<u> </u>	Hand Delivered
<u> </u>	Overnight
<u> </u>	Facsimile
<u> </u>	No Service

Richard I Ashton, Esq.
Ashton, Brauberger, Poulsen
& Boud, P.C.
302 West 5400 South, Suite 103
Murray, UT 84107

<u>X</u>	U.S. Mail
<u> </u>	Hand Delivered
<u> </u>	Overnight
<u> </u>	Facsimile
<u> </u>	No Service



Morris O Haggerty

A D D E N D U M

Addendum 1

IN THE SECOND JUDICIAL DISTRICT COURT, STATE OF UTAH
WEBER COUNTY, OGDEN DEPARTMENT

MARK S. DALEBOUT,

Plaintiff,

vs.

UNION PACIFIC RAILROAD COMPANY,
a Delaware corporation,

Defendant.

MEMORANDUM DECISION

Case No. 950900540 PI
Honorable Roger S. Dutson

This case was tried before a jury in late August and after judgment was entered in favor of Plaintiff the Defendant filed a Motion for Judgment Notwithstanding the Verdict (j.n.o.v.) or in the alternative, requested a new trial on the issue of damages. The court notes that the trial was primarily over the issue of damages rather than liability.

The attorneys conducted themselves very professionally throughout the trial. The court took notes during trial which have been reviewed.

The evidence included testimony that Mr. Dalebout suffered injuries on February 1, 1993, while working for Defendant as an railroad engineer when the seat he was sitting on fell a few inches while he was in a twisted position, hurting his back. He missed a few days work, eventually was treated by a Dr. Donald Bryan, an orthopedic surgeon, for back injuries and presently takes relatively mild pain medication for his back injuries, but has missed very little work since the injury. He complains of chronic pain and substantial changes in his life style as a result of the 1993 injury. However, he claims he has 'toughed' it out and worked regularly notwithstanding the continuous

pain, resulting in very little lost time from work since the injury. Dr. Bryan testified via a tape recorded video deposition. He has determined that the Plaintiff suffers from hereditary degenerative arthritis, and even though he apparently had no symptoms of that condition prior to the injury, it is a disease which even without this injury it would eventually progress on it's own to the point there would be similar symptom the Plaintiff now experiences. However, Dr. Bryan states that the accident apparently triggered the arthritic symptoms which would have naturally occurred eventually. Treatment was primarily arthritic medication, including pain relievers. The doctor indicated future surgery was unlikely, but acknowledged he had written at one time that there was a 30% chance of surgery. The Plaintiff has some limitations imposed on amounts lifted and physical activity because of the back problem. He stated that in the unlikely event surgery was required in the future, Plaintiff would probably not be able to continue working at the job he was presently doing. Dr. Bryan repeatedly stated that he believed Plaintiff's problems are 20% due to the injury and 80% due to the progressive genetic arthritic condition he inherited. It was also clear that in the unlikely event surgery were required in the future, it would result from the 80/20 relationship of genetic condition to injury. Substantial additional evidence was presented relating to income, mortality tables, anticipated normal work career prior to attaining retirement age, etc., and the court has carefully reviewed all the evidence.

The jury deliberated a substantial amount of time, clearly long enough to review the instructions and evidence and to discuss the case thoroughly. When they returned their verdict, this judge observed everyone's jaw drop, including the Plaintiff's attorneys, when the jury announced it's

verdict. The award included \$275,000 for future impairment of earning capacity, \$12,500 for past pain, suffering, and loss of enjoyment of life, and \$200,000 for future pain, suffering, and loss of enjoyment of life. Past and future medical costs awarded covered only an amount reasonable for the medications he takes. The court notes the jury was polled and based on their firm and emphatic 'No' votes it appeared to the court those dissenting jurors felt quite strongly the verdict was not a good one.

Defendant's Motion for j.n.o.v. asserts: (I) There was an error of law in allowing the issue of potential future surgery to go to the jury, (II) Damages were excessive and given under the influence of prejudice or passion, and, (III) There was insufficient evidence to justify the verdict awarding impairment of future earning capacity.

The court has carefully reviewed the evidence given at trial, observations of attorneys, witnesses and jurors, exhibits, and the notes taken by the court at trial. The court has also carefully reviewed the law and finds that Defendant has accurately stated the law in its memorandum supporting its motion. As stated above, the court felt the jury verdict was more than generous, based on the evidence.

ISSUE I- Concerning the alleged error of allowing the jury to consider the issue of potential future surgery, the court finds that there were adequate facts to allow that issue to go to the jury. Dr. Bryan, Defendant's expert, did not rule out such surgery, indicating at one point it was a 30% chance though he maintained surgery was unlikely. It would be an improper violation of the jury's

prerogative for the court to find facts where there is some substantial evidence given relating to a relevant fact which the jury could decide as a finding of fact. Even though the likelihood of surgery is not great, that fact should be considered by any fact finder along with possible relationship of the progressive nature of Plaintiff's arthritis as it might relate to need for future surgery, the worsening symptoms, the somewhat inconsistent statement by Dr. Bryan that there may be a 30% chance of future surgery sometime though he also stated he felt surgery was unlikely, and therefore, the court believes there was substantial evidence for the jury to consider regarding that issue and it would have been error for the court to not allow them to do so. It is noted that they did not award future medical expenses for future surgery and even if the court was in error, the error would likely be harmless and therefore not a reason to set aside, modify or retry that issue.

ISSUE II- Defendant requests the court enter judgment in it's favor, j.n.o.v. In order to do so the court must find Defendant is entitled to judgment as a matter of law. Basically, this means the court must find there were issues of law that would require setting aside the jury findings or verdict. For the court to find a 'law' reason in this it appears that would require a finding there was no substantial evidence in support of the jury's findings. The court admittedly was surprised at the amount awarded, but still, does not find reason to grant j.n.o.v. Even though the court finds the award extremely generous, as a matter of law, the court also finds there were substantial facts presented upon which the jury could reasonably reach such a verdict. The court has carefully considered Dr. Bryan's opinion that the injury caused only

20% of Plaintiff's present and future problems. The court has also examined the fact the jury apparently did not apportion the out of pocket medical expenses incurred in the past and projected pain medication expenses in the future, which raises the issue in the courts mind that they might have failed to apportion the other awards, based on the 80/20 split which the evidence appears to require. As to pain and suffering, the court cannot know what the jury did in that regard nor can it look at the award of past pain and suffering to get an indication of the process they pursued in reaching their decision. It is a somewhat subjective standard that must be applied. The court cannot set aside the jury finding with a j.n.o.v. unless there is no substantial evidence on the issue. As to the future lost wages award the court does have at least some objective mathematical approaches to use in determining whether the jury properly applied the facts and considered an 80/20 split in reaching their conclusions. One rationale is as follows: Plaintiff's salary is a fixed amount. If we take his present salary and multiply it by his normally remaining work years we come up with a dollar amount he would earn in the future. Plaintiff is about 48 years of age at the present and earns a low of \$78,000 or high of about \$82,000. If the court were to consider his salary at \$82,000 and add no future increases (even though presently he appears to get substantial annual increases in base pay) he has about 17 more years of work until he is 65 years old, a common age for retirement. He would, absent physical reasons to quit earlier, earn about \$1,394,000 until normal retirement age. If the court applies the 80/20 factor as a likelihood he will have his career cut short by that 20% because of the injury, the amount he would lose in lost wages would be \$278,000. If we used the low figure of \$78,000 it would be \$1,326,000 in his remaining normal career and 20% would be \$265,200.

Even though it is speculative for the court to attempt such a calculation to attempt to determine what the jury might have been thinking, it does present a rational review of the jury decision. Notwithstanding the fact that the court might not have used the above method had it been trying the case, and even recognizing the fact the jury might have used some other formula in reaching it's decision, and with the court considering several other methods a jury might reach the \$275,000 figure it awarded for lost wages, the court hereby determines, as a matter of law, it cannot set aside their verdict as a rational and reasonable explanation exists for their finding. Even on the issue of past and projected medical expenses, just because it appears the jury did not apply the 80/20 split on medications, the court is unable to determine they did not have a rational basis for reaching their decision, such as time and expenses to go to and from appointments, his time lost when he could have been doing other things, or a myriad of other possible explanations why they awarded all medication expenses in the past and projected the same rate for the future. Defendants motion for j.n.o.v. is denied

ISSUE III- This court can grant a new trial only if it finds there is insufficient evidence in support of the verdict or that the verdict is clearly against the weight of the evidence, or if the court finds the judgment for damages is excessive because of passion or prejudice or for any of the reasons it could grant j.n.o.v. The court does not find there is any evidence of a high award because of passion or prejudice. It is apparent there was conflict amongst the jurors in reaching a verdict as they were out for a substantial period of time deliberating before returning with a verdict and there were dissenting votes in the jury room, indicating they did discuss the methods in awarding damages and

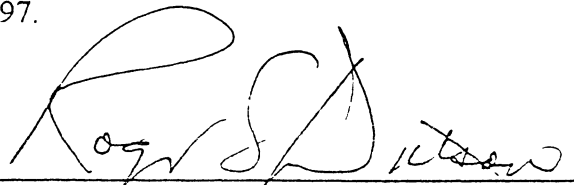
obtained the necessary votes to support the verdict. There was nothing in the conduct of the attorneys or witnesses during the court trial which gave indication of passion or prejudice, and therefore, the court does not find any facts supporting Defendant's claim of passion or prejudice. Even though the court has expressed its opinion that the jury award was extremely generous, the court cannot on that basis alone find there was no rational basis for the decisions reached by the jury. Our jury system stands as a positive bastion among legal systems by allowing a jury of peers to decide cases. Our constitution and the law protects this right by making jury trials readily available to its citizens. Justice can only be served if a judge gives the jury the proper legal instructions and if it appears they follow those instructions, great deference should be given their judgment. This court feel it would be improper to interfere with the jury verdict simply because there is a difference of opinion as to what a jury could decide, unless it finds they have disregarded the evidence or if an award is so clearly excessive that it shocks the conscience. As indicated in the rationale of the preceding paragraphs concerning j n.o.v , and even though the verdict was generous, that is permissible. Although the court cannot know the method the jury used in determining lost wages, it is certainly not clear that they did so without considering the evidence and the law, and frankly, the court can see a logic used in the calculation of damages awarded, even though the court may not agree that it would have awarded that same amount. The judge has not been asked to decide the case as it was a jury trial. In summary, there is nothing in the jury conduct or decision that would cause the court to disturb the jury verdict and grant a new trial on damages as requested by Defendant.

The court has also reviewed the potential of submitting a remittitur in this case, and based on

the rationale set forth above, the court does not do so. The court does not find the damages awarded so great as to enter into a permissive procedure that could lead to a disturbance of the jury prerogative when there is a rational basis for their decision and substantial evidence upon which they could reach their decision. It is noted, that this jury verdict only causes the 'jaw to drop', but does not clearly 'shock the conscience'.

The jury verdict is sustained and will stand as entered. Plaintiff has also submitted a Motion to Tax Bill of Costs. The court agrees that Plaintiff should not be allowed to claim costs of Dr. Bryan's deposition nor that of the Defendant as they were taken by Defendant and based on the rationale stated in Defendant's motion. The court will allow the costs of Steven Rapp's deposition as there was the potential of proving a defective seat in this case.

DATED this 18 day of December, 1997.



ROGER S. DUTSON
DISTRICT COURT JUDGE

Dalebout vs. UPRR
950900540 PI
Page Nine

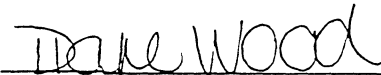
CERTIFICATE OF MAILING

I HEREBY certify that I mailed a true and correct copy of the foregoing Order by first class mail, postage pre-paid, to the following parties, this 12th day of December, 1997:

JOHN J. ROSSI
Attorney for Plaintiff
12203 East 2nd Avenue
Aurora, CO 80011-8399

RICHARD I ASHTON
Attorney for Plaintiff
302 West 5400 South, Suite 103
Murray, UT 84107

MORRIS O. HAGGERTY
LARRY /GANTENBEIN
Attorneys for Defendant
406 West 100 South
Salt Lake City, UT 84101



Deputy Court Clerk

Addendum 2

DEPOSITION OF DR. DONALD BRYAN

The following portions of the deposition were not entered into evidence at trial:

p. 18, lines 2-3, 7;
p. 21, line 25-p.22, line 6;
p. 24, line 18-p. 29 line 18.

<p>1 IN THE SECOND JUDICIAL DISTRICT COURT</p> <p>2 IN AND FOR WEBER COUNTY, STATE OF UTAH</p> <p>3 -ooOoo-</p> <p>4 MARK S. DALEBOUT, : CIVIL NO. 950900540 PI</p> <p>5 Plaintiff, : DEPOSITION OF:</p> <p>6 v. : DONALD W. BRYAN, M.D.</p> <p>7 : TAKEN: April 4, 1997</p> <p>8 UNION PACIFIC RAILROAD : </p> <p>9 COMPANY, a corporation, : </p> <p>10 Defendant. : </p> <p>11 -ooOoo-</p> <p>12 Deposition of DONALD W. BRYAN, M.D., taken</p> <p>13 on behalf of the Defendant, at 3903 Harrison</p> <p>14 Boulevard, Suite 400E, Salt Lake City, Utah, before</p> <p>15 ROCKIE E. DUSTIN, Certified Shorthand Reporter and</p> <p>16 Notary Public in and for the State of Utah, pursuant</p> <p>17 to Notice.</p> <p>18 -ooOoo-</p> <p>19</p> <p>20</p> <p>21</p> <p>22</p> <p>23</p> <p>24</p> <p>25</p>	<p>Page 3</p> <p>1 I N D E X</p> <p>2</p> <p>3 WITNESS PAGE</p> <p>4</p> <p>5 DONALD W. BRYAN, M.D.</p> <p>6</p> <p>7 Examination by Mr. Haggerty. 5</p> <p>8 Examination by Mr. Rossi. 29</p> <p>9 Further Exam by Mr. Haggerty. 58</p> <p>10 Further Exam by Mr. Rossi 67</p> <p>11</p> <p>12</p> <p>13 -ooOoo-</p> <p>14</p> <p>15</p> <p>16</p> <p>17</p> <p>18</p> <p>19</p> <p>20</p> <p>21</p> <p>22</p> <p>23</p> <p>24</p> <p>25</p>
<p>Page 2</p> <p>1 A P P E A R A N C E S</p> <p>2</p> <p>3 For the Plaintiff: John J. Rossi</p> <p>4 MORRISARD, ROSSI, COX,</p> <p>5 KIKER & INTERMISH</p> <p>6 12203 East Second Avenue</p> <p>7 Aurora, CO 80011-8399</p> <p>8</p> <p>9 Richard I. Ashton</p> <p>10 ASHTON, BRAUNBERGER & BOUD</p> <p>11 302 West 5400 South</p> <p>12 Suite 103</p> <p>13 Murray, UT 84107</p> <p>14</p> <p>15 For the Defendant: Morris O. Haggerty</p> <p>16 UNION PACIFIC RAILROAD</p> <p>17 406 West 100 South</p> <p>18 Salt Lake City, UT 84101</p> <p>19</p> <p>20</p> <p>21</p> <p>22</p> <p>23</p> <p>24</p> <p>25</p> <p>13 Also Present: Video Technician</p> <p>14 Charlie Persinger</p> <p>15 -ooOoo-</p> <p>16</p> <p>17</p> <p>18</p> <p>19</p> <p>20</p> <p>21</p> <p>22</p> <p>23</p> <p>24</p> <p>25</p>	<p>Page 4</p> <p>1 E X H I B I T S</p> <p>2 EXHIBITS PAGE</p> <p>3 No. 1 Medical Records 71</p> <p>4</p> <p>5</p> <p>6</p> <p>7</p> <p>8</p> <p>9</p> <p>10</p> <p>11</p> <p>12</p> <p>13</p> <p>14</p> <p>15</p> <p>16</p> <p>17</p> <p>18</p> <p>19</p> <p>20</p> <p>21</p> <p>22</p> <p>23</p> <p>24</p> <p>25</p>

Page 5

Page 7

1 April 4, 1997 2:40 p.m.
2 PROCEEDINGS
3
4 VIDEO TECHNICIAN: I am Lance Harrison, the
5 videographer. I represent Discovery Legal Video
6 Services in Salt Lake City. I am not financially
7 interested in this action nor am a relative of any
8 attorney or any of the parties. The date and time
9 indicated on the video screen is 2:41 p.m., April 4th,
10 1997.
11 The deposition is being taken at 3903
12 Harrison Boulevard in Ogden, Utah. The case number is
13 95-0900540. Entitled are Mark S. Dalebout, Plaintiff,
14 versus Union Pacific Railroad Company, a Delaware
15 corporation. The deposition is being taken on behalf
16 of the defendants. The deponent is Dr. Bryan, M.D.,
17 and the court reporter is Rockie Dustin. Counsel will
18 now introduce themselves, after then the court
19 reporter will swear in the witness.
20 MR. HAGGERTY: Morris Haggerty, counsel for
21 Union Pacific Railroad.
22 MR. ROSSI: John Rossi and Richard Ashton,
23 counsel for the plaintiff, Mark Dalebout.
24
25

1 Q.And are you certified by any professional
2 societies?
3 A.American Board of Orthopedic Surgeons.
4 Q.Doctor, as we talk today in the deposition,
5 I'd like to ask you to give us your opinions, and they
6 need to be based on what we call reasonable degree of
7 medical certainty or, in the FELA arena, more likely
8 than not. If you can remember that as we ask for your
9 opinions. All right?
10 A.Yes.
11 Q.Doctor, you've treated Mark Dalebout?
12 A.Yes.
13 Q.And when did you first see him?
14 A.I'll have to refer to my notes for all the
15 statements that I make in here.
16 Q.And let me interrupt you for just a second.
17 You have your chart in front of you?
18 A.I do.
19 The first time I ever saw Mark was on the
20 11th -- was on the 3rd of November 1993. He was 44
21 years old at the time and he came in to me for
22 evaluation of back pain.
23 Q.All right. And, Doctor, I'm going to hand
24 you what we're going to mark as Exhibit A, and I
25 believe you've looked through this earlier?

Page 6

Page 8

1 DONALD W. BRYAN, M.D.,
2 called as a witness and sworn to tell the truth was
3 examined and testified as follows:
4
5 EXAMINATION
6 BY MR. HAGGERTY:
7 Q.Doctor, can I get you to state your name for
8 the record, please.
9 A.Donald William Bryan.
10 Q.And what is your business address?
11 A.3903 Harrison Boulevard, Ogden, Utah, 84403.
12 Q.And what is your profession, Doctor?
13 A.Orthopedic surgeon.
14 Q.And can you give us a brief summary of your
15 educational background?
16 A.I graduated from the University of Utah in
17 1965, University of Maryland Medical School. In 1969,
18 I took my internship in orthopedic surgical residency
19 in Johns Hopkins Hospital in Baltimore. I was two
20 years in the Air Force, professor of orthopedics at
21 the University of Colorado for about a year and a half
22 and I have been here in private practice since around
23 1977.
24 Q.Here in Ogden, Utah?
25 A.In Ogden, Utah.

1 A.Yes. They look like they're copies of my
2 chart notes.
3 Q.All right.
4 MR. HAGGERTY: And we'd move for admission of
5 those chart notes at this time.
6 MR. ROSSI: I'll reserve objection until the
7 end of the deposition.
8 MR. HAGGERTY: All right.
9 Q.And, Doctor, let me ask you just some
10 foundational questions for these.
11 You've had a chance to look through. Are
12 they a copy of your chart notes dealing with your
13 treatment of Mark Dalebout?
14 A.Yes.
15 Q.And are these chart notes typically made at
16 or shortly after the time of the medical visit?
17 A.I dictate them immediately after seeing the
18 patient.
19 Q.And obviously, this is based upon your
20 examination and what you've found?
21 A.Yes.
22 Q.And are the chart notes then kept in the
23 regular course of business in files?
24 A.Yes.
25 Q.And it's your practice to keep these notes

Page 9

1 for your patients?
2 A. Yes.
3 Q. When did Mr. Dalebout first have any back
4 pain?
5 A. To my knowledge, he first developed back
6 trouble 12 years prior to my consultation. He stated
7 that he was working as a brakeman, he didn't describe
8 any specific injury at the time. I didn't get it
9 anyway, but that he had done something that resulted
10 in pain in his back. And that he was seen in the
11 railroad clinic 12 years before I saw him, eventually
12 referred to Dr. Carl Mattsson, another orthopedic
13 surgeon. And I don't know much about that evaluation
14 except that my understanding is that his symptoms
15 subsided over a period of a few weeks.
16 Q. And then he's relatively pain free?
17 A. It's my understanding, yes.
18 Q. And why did he come to see you this time with
19 back pain?
20 A. He stated that six months prior to my
21 consultation, he was in a train and he went to open up
22 a window and a seat that he was sitting on gave way,
23 resulting in twisting, pain in his back.
24 Q. Did you have him sent out for any tests?
25 A. I did. But at the time of that injury, I

Page 10

1 believe he was seen by Dr. Crosland, another
2 orthopedic surgeon, immediately after and not by me.
3 And then I think he was seen by a physical therapist
4 and continued with trouble, and then eventually came
5 in to see me.
6 And after examination, I obtained some x-rays
7 -- let's see, he had some x-rays that were taken at
8 Dr. Crosland's office. And I reviewed those x-rays
9 taken elsewhere and decided that he would best be
10 served at that time by getting a magnetic resonance
11 imaging of his back.
12 Q. Did you send him out for that?
13 A. I did.
14 Q. And did you get a report of the test?
15 A. Yes.
16 Q. And what did that show?
17 A. Well, for one thing, the initial x-rays that
18 I had from Dr. Crosland's office showed some narrowing
19 at the lowest disc down in his back. And the MRI that
20 was obtained at the McKay-Dee Hospital, which was
21 performed on 11-23-93, showed that he had degenerative
22 disc disease which is a narrowing degeneration of the
23 discs at the two lower levels, with some central
24 bulging of the disc at 4-5, which is the second one up
25 from the bottom, and at the bottom one, L5-S1. The

Page 11

1 discs above those two levels looked normal.
2 Q. And what is the significance of the bulging
3 disc? What does that mean?
4 A. Well, you have to go back to the anatomy of
5 the disc and a disc is composed of --
6 Q. Doctor, excuse me just a minute, your mike
7 seems to have jumped off you.
8 A. You have to go back to the anatomy of a
9 disc. And a disc, if you take a cross-sectional cut
10 through a disc, you find that it's composed of layers
11 of fibrous tissue that roll around like union rings on
12 the outside and on the inside is a fibrous nuclei
13 material. And over the years, just like skin begins
14 to change, discs undergo degenerative change, this
15 capsule begins to stretch out.
16 Many factors contribute to that, an injury
17 can contribute, genetic code, a lot of things we don't
18 understand. But in essence, the capsule stretches out
19 and gives way and that causes the disc to bulge.
20 Q. With regard to the MRI test that was done on
21 Mr. Dalebout, does that show how much the disc is
22 bulging --
23 A. Yes.
24 Q. -- or the different degrees? And what was --
25 how much were his discs bulging?

Page 12

1 A. Well, I would consider it minimal and the
2 radiologist who dictated it used the word "minimal
3 central disc" -- he classifies it as disc herniation.
4 It's a matter of semantics. Most of us nowadays, when
5 you see very minimal bulging, you classify it as
6 bulge.
7 Herniation normally is reserved for those who
8 have a bigger piece of disc material protruding back
9 in the spinal canal. But in essence, it still refers
10 to the fact that the capsule of the disc has some
11 tearing in it or some stretching in it and it just
12 bulges away from where it would normally be.
13 Q. And were Mr. Dalebout's discs bulging out
14 into the spinal canal?
15 A. Yes.
16 Q. And to what degree?
17 A. Well, minimal. I have a Xerox type copy of
18 the MRI on the lateral view that they send me in his
19 chart and it looks like a couple of millimeters.
20 Q. Did you come up with a diagnosis for Mr.
21 Dalebout, why he was having back pain?
22 A. Yes.
23 Q. And what was that diagnosis?
24 A. Well, first of all, there are not many of us
25 who are lucky enough to get through this world without

Page 13

1 back pain. Lots of us do. And most of the time, when
2 it occurs, it occurs as a result of degeneration of
3 the disc. And his case is -- his case is typical of
4 many others and that is, degeneration of the disc with
5 some central tearing of the fibers allowing it to
6 bulge into the canal, and that would be the cause.
7 It's like an arthritic condition, except this is a
8 specialized joint. So the cause of his pain would be
9 degeneration with some mild tearing of the central
10 disc allowing it to bulge.

11 Q.Is that also known as degenerative disc
12 disease?

13 A. Yes.

14 Q.Is he a surgical candidate to correct this?

15 A. Well, certainly at that time there wasn't a
16 very big herniation. And I followed him over the
17 years and I have not seen a big herniated disc. And I
18 don't believe the doctor determines whether a person
19 should have the operation. If he felt that he needed
20 an operation for this, I would defer him to somebody
21 else because I don't believe he has enough disease to
22 warrant surgery.

23 However, the indications for surgery are not
24 based upon what I think or necessarily entirely upon
25 the x-rays, they're based upon the patient's

Page 14

1 symptoms. If he had enough disease to account for
2 severe pain and he had severe pain, there are patients
3 that would benefit by surgery.

4 In his case, he did not have any pinched
5 nerve on this bulge. It doesn't go back that far. It
6 does not irritate the nerves. And when it comes to
7 surgery, the real indication to do it is to relieve
8 the pinched nerve pain. Surgery doesn't work that
9 well to relieve back pain.

10 He has no neurological loss, did not have
11 significant pinched nerve here, so I would not think
12 that he would benefit by an operation. I have talked
13 with him and seen him on several occasions since that
14 time about the cause of back pain, what's known to man
15 to try to help it, including various nonsurgical means
16 all the way through various types of surgical
17 procedures, but I have not felt that he would be best
18 served by surgery. And in his comments to me, after
19 understanding it, himself did not feel that that was
20 the way to go at this stage, anyway, in his life.

21 Q.Do you have an opinion as to the cause of why
22 Mr. Dalcabout is having pain and problems?

23 A.Well, I have -- absolutely. I think that we
24 have to recognize that, again, not very many of us are
25 lucky enough to get through this world without back

Page 15

1 pain. It's common. Degenerative disc disease is
2 probably the commonest cause. There are many factors
3 that play a role in the degeneration of discs. Injury
4 is by no means the only one. In fact, it is not the
5 dominant cause. If it were, Carl Malone and John
6 Stockton and a whole bunch of other people would be
7 basket cases.

8 There are multiples of people who have
9 multiple injuries all their life and don't seem to
10 have any trouble of a severe nature. And yet, I can
11 get somebody that's only 15 years old come into my
12 office with a big herniated disc and has never had an
13 injury, never participated in anything athletic,
14 they've got a huge herniated disc. And I believe that
15 genetic code is probably the most important factor,
16 maybe some things in our diet, activity level,
17 injuries. There may be viruses that get down in there
18 that cause some discs to degenerative. I don't think
19 we understand all why.

20 I can tell you, though, if we brought a
21 hundred people off the street, 20, 30, 40, 50 years of
22 age and got MRI's, we will see progressive
23 degeneration in everybody. And at least 50 percent of
24 patients 40 years of age have abnormal MRI's showing
25 disc disease. So as far as the cause of it, if a

Page 16

1 patient has no history of ever having any injury at
2 all, then you say, Well, it's a degenerative process.
3 If they have an injury and you get an MRI and it shows
4 that they've got degeneration, you know -- it take
5 years to develop this. So there's obviously
6 degeneration there long before the injury.

7 However, an injury may aggravate a
8 preexisting disc. It has the potential to produce
9 some weakening of the fibers of the disc. It may
10 contribute to some increased pain. Having not had an
11 MRI prior to his injury and determining how much of a
12 bulge was present before versus after, see, is not
13 possible. We don't have an MRI before his injury.

14 Certainly, the injury didn't produce the
15 abnormal degeneration, the chemical changes that you
16 see in the disc. That's not by injury. The minimal
17 central bulging of the disc possibly could be from the
18 injury, or it could have been there before. So one
19 thing is for sure, there's no big herniations, no
20 broken bone, there's no major pinched nerve. That's
21 all you can say.

22 MR. ROSSI: Move to strike as being
23 nonresponsive.

24 Q.Doctor, based upon your examination of
25 Mr. Dalcabout, that initial MRI that was done, can you

Page 17

1 apportion the problems and pain he's having now
2 between the injury, when the train seat fell, and his
3 degenerative disc disease?
4 A. One can make a guess about these things. And
5 if a person has an MRI that shows no narrowing of the
6 disc, doesn't have a lot of, oh, abnormal signal from
7 degeneration but has a big herniation, you'd say
8 injury plays a much bigger role in that patient.
9 Where you see some mild bulging and more abnormal
10 signal and degenerative changes, then degenerative
11 changes play a bigger role.
12 And in trying to come up with a figure in
13 regard to his case, his total amount of pain and
14 everything, I have felt that 20 percent of his pain is
15 injury related and 80 percent is preexisting
16 degenerative disc disease.
17 MR. ROSSI: Move to strike for failure to
18 form of the question, probability.
19 Q. All right. Doctor, you used the word
20 "guess." What we need to know is: Based upon your
21 medical training, the MRI, your experience and being a
22 doctor over the last 20-odd years, can you say that
23 you can apportion his problems 20 percent to his
24 injury on a basis of more likely than not?
25 MR. ROSSI: Objection as to leading.

Page 18

1 THE WITNESS: I haven't got any more to add.
2 I think if you went out and pooled all the orthopedic
3 surgeons, there are many things in this world we don't
4 know the answers to. I mean I can say two and two is
5 four. You can say with reasonable certainty and make
6 a fairly decent educated guess on experience and
7 opinions of multiple physicians. And my opinion is
8 exactly what I said, 20 percent injury and 80 percent
9 degenerative disc disease, and I think it would be
10 pretty hard to say anything different.
11 Q. Okay. Let me see if I'm hearing this
12 correct, Doctor.
13 Would it be fair to say, then, that your
14 opinion is to a reasonable degree of medical
15 certainty? We're not talking absolutely certain.
16 A. Absolutely. I'm not going to say anything
17 that I don't think is a fairly stable, supportive
18 statement on the basis of experience, not only mine,
19 but everything I've read about everybody else, talking
20 about disc disease and treating patients for many
21 years. I think that 20 percent and 80 percent is
22 right on target with regard to Mr. Dalebout.
23 Q. And so to a reasonable degree of medical
24 certainty, then?
25 A. Yes.

Page 19

1 Q. The degenerative disc disease that he had
2 before, that wasn't caused by the accident, was it?
3 A. No.
4 MR. ROSSI: Objection to the form of the
5 question.
6 Q. If you'll just --
7 A. No.
8 Q. How long had the -- well, strike that.
9 A. I mean, this is not just taking pie out of
10 the sky and making a statement. We've got MRI's on
11 lots and lots of people. We know that degenerative
12 disc disease occurs and it produces backache, and it's
13 not injury related in the vast majority of cases.
14 It's just one of those disease processes.
15 MR. ROSSI: Move to strike. Excuse me,
16 Doctor, we have to make objections contemporaneously
17 with the testimony because this is being taken for
18 trial purposes, so if I interrupt you, and I will from
19 time to time, you can go ahead and continue answering.
20 THE WITNESS: Should I answer the question if
21 it's asked regardless -- I'm supposed to answer the
22 question regardless of the objection; right?
23 MR. ROSSI: Yes, you do. I move to strike as
24 nonresponsive. There was no question pending.
25 Q. Doctor, were there two causes, then, for

Page 20

1 Mr. Dalebout's having pain and problems?
2 A. There may be multiple causes. But of those
3 that we can talk about, we would talk about the
4 degenerative process that occurs in every individual,
5 some more than others, because of genetic code and so
6 forth. And then they will also talk about the fact
7 that he had an injury and states that his pain all
8 started with that injury. So we have to say the
9 injury had to have been a contributing factor in his
10 symptoms.
11 Many of us are down, say, at this level, at a
12 lower level. We've got degenerative changes but we
13 don't have symptoms. But we don't have a normal back,
14 any more than my skin. That's not the same as when I
15 was 12 years of age and neither are a lot of other
16 structures inside my body, but they may not be causing
17 me any symptoms. They're in a low grade state. And
18 then all of a sudden, something happens that just
19 tilts it over where you start developing symptoms.
20 Now, the difference between asymptomatic and
21 symptomatic may not be all that great, but an injury
22 makes it that way. If the injury had not occurred,
23 maybe the patient could have gone along in this low
24 grade state without symptoms for who knows how long.
25 I think it would have been unusual to go forever.

Page 21

1 Eventually, I expect, Mr. Dalebout would have got some
2 symptoms in his back with the degenerative changes
3 that he's got there, but maybe not for awhile. Maybe
4 a few years. And then you have an injury and then it
5 produces symptoms.
6 Now, in some people, over a period of a few
7 months or weeks, even with the injury, symptoms will
8 die down. Their pain will go away and they will go
9 fine. Many patient with MRI's like this can become
10 asymptomatic, but his has persisted in this state. It
11 hasn't got up here where we would think about doing
12 any surgery. And certainly, the degree of disease
13 that he has here, I mean, I can't believe that any
14 orthopedic surgeon would recommend an operation on the
15 basis of the disease that he has here. If I were him,
16 I wouldn't let anybody touch me with a knife. Even
17 though he may have some symptoms, I would think that
18 the symptoms could be acceptably controlled with
19 antiinflammatory drugs and the things that I
20 prescribe.
21 But the injury played a role in taking it
22 from a subclinical state to a clinical state, but the
23 total cause of the pain is a combination of
24 preexisting degenerative changes plus the injury. And
25 as I said, I feel very comfortable and would be

Page 22

1 willing to take a poll of orthopedic surgeons
2 throughout the country evaluating this and expect that
3 it would be about a 20/80 percentage.
4 Q.Doctor --
5 MR. ROSSI: Move to strike the last sentence
6 in that regard, technical.
7 Q.Doctor, is it more likely than not
8 Mr. Dalebout would have had back pain regardless of
9 any injury due to the degenerative disc disease?
10 A.That's very difficult to say more likely.
11 There are patients who have these degenerative changes
12 that don't seem to have as much pain as others. Maybe
13 it's because of their activity level or how they
14 accept pain. However, I think that most people would
15 have developed some pain, maybe not to the degree that
16 he has described, regardless of injury or no injury.
17 Q.Do you have a prognosis for Mr. Dalebout,
18 what the future is likely to be like for him?
19 A.Well, I think if we took thousands of
20 patients just like him, the vast majority of them
21 would go along with some low grade achy pain in their
22 back, and other than that, spend the rest of their
23 life and not have anything more done. If he had -- I
24 mean, there are a lot of things that can happen.
25 If he has no other injury, if he doesn't go

Page 23

1 out and do a lot of heavy lifting, bending, twisting
2 or participate in some type of contact sport,
3 statistically, I think that he would not have any
4 dramatic change. He'd stay about the same as he is.
5 Q.Is there any reason he shouldn't work as a
6 locomotive engincer in the future?
7 A.Well, as best I understand, as to what a
8 locomotive engineer does, I don't think that there
9 would be any contraindication for him to continue
10 working, and I think that's what he's done.
11 Q.Contraindication, I don't mean to confuse
12 everybody.
13 A.Meaning there's no reason why he can't
14 continue to do that.
15 Q.All right.
16 A.And the indications for doing that are not
17 simply based upon the job. I have some farmers out
18 here that have far worse disc disease than Mr.
19 Dalebout. Far worse. And I have advised them, Gee,
20 you know, it would probably be better if ya'll sold
21 that farm and got into something light duty.
22 And they come back and say, Well, gee, you
23 know, that's fine, but I like this type of work. If I
24 went out and got another type of job sitting at a
25 desk, I'd be more painful, more agony, I'd hate that.

Page 24

1 I'd rather go out and put up with the pain and do this
2 heavy work farming.
3 So you say, Well, can he go work as a
4 railroad engineer? Well, of course he can. A lot of
5 us could do lots of things if we want. I think that
6 is more important, what he likes, what he enjoys, than
7 the job itself. If you've got a patient that cannot
8 stand the job, they don't have to have much pain,
9 they're not going to be able to work and they won't
10 work.
11 If you go strictly according to the pathology
12 in his back, all else considered, no question, he can
13 work. But if I get a patient that comes in and says
14 -- and I say there really isn't that much wrong, but
15 they say, Oh, I can't stand it, I don't like it, I'm
16 not going to push them.
17 MR. ROSSI: Move to strike as nonresponsive.
18 Q.Doctor, you've talked a couple of times about
19 some people with a lot of pathology in their back and
20 no pain, some people with a little pathology and a lot
21 of pain. Is it known in the orthopedic circles about
22 the effects of litigation, worker's comp claims, a
23 pending claim, on a patient's pain?
24 A.Yes.
25 MR. ROSSI: Objection as to form of the

Page 25

1 question and relevance.
2 Q.And what is that effect, Doctor?
3 MR. ROSSI: Objection as to relevancy.
4 THE WITNESS: Well, if -- to answer the
5 question, there are multiple articles in the
6 literature about litigation. And from the standpoint
7 of us as physicians, it would be far less -- it would
8 be far easier for us to treat our patients if
9 litigation were out, there were no litigation at all.
10 It always compromises our ability to try to make
11 patients better.
12 Q.And why is that?
13 A.I won't begin to speculate as to the cause
14 but I have to assume it has to do with some
15 psychosocial, economical values -- factors, unrelated
16 to the organic problem itself. You could -- anybody
17 can speculate any way they want.
18 If you go out and take a hundred patients
19 that have had an injury on the job and had an
20 operation on their back, you take another patient,
21 hundred, who have not had any injury on the job, maybe
22 an injury out in their backyard lifting a garbage can,
23 and you compare the two with regard to results, you'll
24 see about 20 percent of those seem to get better who
25 have the litigation and the workman's comp injury or

Page 26

1 the automobile accident or whatever it is, and you get
2 at least 80 or 90 percent of the other patients
3 getting better. How you interpret it is up for
4 grabs. It's just a fact of life and there have been
5 multiple studies done about it.
6 MR. ROSSI: Objection as nonresponsive and
7 not relevant.
8 Q.Doctor, you used the word "speculation" --
9 A.I think that also, when it comes to treating
10 patients -- and this is a bugaboo that we as
11 physicians have to consider, if you don't consider
12 litigation as a possible contributing factor to the
13 patient's pain, you're going to end up operating on
14 more people than should be touched and you will
15 totally miss how to get the patient better.
16 Q.Now, Doctor, you used the word speculation --
17 A.Our purpose is to try to get the patient
18 better, regardless of the cause. And if you focus in
19 on organic alone, you're going to have a lot of
20 patients that you will never get better until you can
21 make them come to grips with some of the other
22 factors, because we can't take care of -- pain is a
23 very subjective thing. It involves more than just the
24 orthopedic problem.
25 Even in my own case, if I came off the ski

Page 27

1 slope and broke my leg, I would be in pain because of
2 a broken leg and I'd be in pain because I couldn't
3 work here for the next little while. Bills would
4 build up, I'd be very unhappy and have a lot of stress
5 in my life. The total amount of pain that I would
6 have would be a combination of what comes from the
7 femur, plus psychosocial, economical factors. If I
8 can't come to grips with them, I may be consumed with
9 the whole thing. And it's no different for me than
10 anybody else, but it is more so when litigation is
11 involved.
12 MR. ROSSI: Objection as to relevancy and
13 move to strike as nonresponsive.
14 Q.Doctor, you used the word "speculation," but
15 haven't studies borne out litigation as being a
16 factor?
17 MR. ROSSI: Objection as to the form of the
18 question.
19 THE WITNESS: What was the question?
20 Q.Earlier, when we were talking about
21 litigation, you mentioned the word "you can speculate
22 any way you want," but isn't it the case that studies
23 in the medical journals have shown that litigation
24 seems to be a factor in pain?
25 MR. ROSSI: Objection as to the form of the

Page 28

1 question and relevancy.
2 THE WITNESS: No question about it.
3 Q.Now if you would answer.
4 A.No question, it always plays a role. And you
5 have to take that into consideration in trying to
6 evaluate the patient, trying to determine -- and I
7 have already done that. When I say there's 20/80,
8 I've already considered all of that.
9 Q.And that's known from journal articles
10 studied?
11 A.Yes. There are a lot of articles in the
12 literature about it.
13 Q.What happens when litigation is resolved?
14 What can --
15 MR. ROSSI: Objection as to the form of the
16 question.
17 THE WITNESS: That may vary from patient to
18 patient. However, once a person is not thinking about
19 litigation, anything that sort of lingers, that you
20 constantly think about, it perpetuates the stress
21 level. Once that is resolved, the patients then
22 accept their problem and get on with their life.
23 An individual who sustains a spinal cord
24 injury in which they're paralyzed, and they're not
25 going to get it back, if they keep constantly

Page 29

1 thinking, oh, if I do this, if I do that, I'm going to
2 get this back, they have more trouble rehabilitating
3 themselves and getting back to function than those who
4 recognize that this is a permanent injury, get it
5 behind you and get on with your life. Those people
6 rehabilitate 10 times better.

7 Same thing applies for here. If you get the
8 litigation and things out of the life, let the doctor
9 treat the patient, get the lawyers and everybody out,
10 then we could do better in our job.

11 MR. ROSSI: Move to strike as nonresponsive,
12 not relevant also.

13 Q.Of course, Doctor, you can't say this is
14 going to happen to Mr. Dalebout or that's going to
15 happen, but can you say it's more likely than not when
16 the litigation is resolved that we're going to -- that
17 he's going to see a lessening of pain?

18 A. In most patients.

19 MR. HAGGERTY: I don't have anything further,
20 Doctor. I think Mr. Rossi will have some questions.

21

22 EXAMINATION

23 BY MR. ROSSI:

24 Q.Doctor, in your opinion, based on a
25 reasonable degree of medical certainty, Mr. Dalebout

Page 30

1 sustained an injury on this date when this seat fell
2 and twisted, is that your understanding?

3 A.I can only base that on what has been told to
4 me. I have no objective findings to prove to me that
5 he had an injury. The only thing I've got is he came
6 in and told me that he had no back pain until this
7 occurred, except for that episode 12 years ago. And
8 that you have to take the patient at his word, that
9 that produced pain. And then he has changes here on
10 x-ray again, a lot of them are preexisting. But my
11 opinion, in regard to his case, has to be based on
12 what he tells me, the fact that his physical exam
13 doesn't show any neurological changes but he has pain
14 with motion and that he's got a disease process in his
15 lower back. That's where it's all entirely based.

16 Q.So based on his history, assuming that it is
17 credible and he's telling you the truth, he sustained
18 an injury on February 1st, 1990 --

19 A.That's correct. I have no idea whether he
20 did any other injuries, whether he had any problem
21 lifting a garbage can. I don't even consider it
22 because I don't have the history and I have to take
23 the patient at his word. And I assume that -- and I
24 believe that he is honest and I believe he told me
25 that his pain began then.

Page 31

1 Q.Have you been supplied with any other
2 information from any source, railroad or anyone else,
3 that he had any other problems before February 1st,
4 1993, let's say, for --

5 A.I don't have a record of it.

6 Q.Okay. Now, that injury, combined with, in
7 your opinion, this degenerative disc disease that we
8 all undergo as human being; is that correct?

9 A.That's correct.

10 Q.And what you're saying, and I think you
11 initially said, you're guessing that 20 percent of his
12 injury, 80 percent of it was degenerative, that
13 combined to cause the problems he's suffering from
14 now?

15 A.That's correct.

16 Q.And that have you previously indicated in a
17 letter I think to the railroad, or maybe in your
18 notes, that it's very difficult if not impossible to
19 make that type of apportionment or degree separation
20 between the two?

21 A.I think it's quite difficult and it all
22 depends upon -- I think it's quite difficult but it
23 depends on semantics. By saying "difficult," that
24 doesn't mean that that figure has no value
25 whatsoever. What it means is that some things are

Page 32

1 absolute scientific proven and others are more of a
2 guesstimate. But I don't consider that guesstimate to
3 be so off base that I would want to consider it of no
4 value. I think it's pretty much on target.

5 Q.Have you ever said in your notes or the
6 letter to the railroad that it's extremely difficult,
7 if not impossible, to make that apportionment?

8 A.That's very possible. But then I was talking
9 about -- if I said that there, and it's very possible
10 did, I was talking about nailing it right down to one
11 percent.

12 Q.I'm referring to a letter of March 8th, 1995
13 that you wrote to Mr. Persinger, the claims
14 representative who's here. And it says, and I'll show
15 you, "It's difficult or impossible to point out the
16 percentage of degeneration to the patient's disc which
17 can be attributed to the work related injury."

18 A.Yes, I agree with that. And what we're
19 saying here, in that statement, though, this person
20 wants me to say, is it five percent? Ten percent?
21 Fifteen? Twenty? Forty? Fifty? I don't believe I
22 can narrow it down to within five percent, but I think
23 that I can narrow it down certainly within a ten
24 percent range.

25 Q.Let me ask you this: In your opinion, right

Page 33

1 now, is this condition permanen' that he has in his
2 low back?
3 A. What do you refer to when you're saying
4 "condition"?
5 Q. His pain.
6 A. If you're talking about the degenerative
7 changes, no, they are progressive, they will
8 continue. His pain is totally unpredictable. And
9 here is where we have difficulty, because other
10 patients who have disease far worse may have almost no
11 pain, other people who have less degrees of disease
12 have worse pain. What can I say?
13 Q. Well, if other people who have worse
14 degenerative changes have little or no pain, then it's
15 likely that if there was no injury that ever occurred
16 to Mr. Dalbout, that he may have went the rest of his
17 life without the degenerative changes --
18 A. That is possible.
19 Q. Excuse me -- causing him any problems.
20 A. That is possible.
21 Q. And you see people with worse degenerative
22 changes without symptoms or pain, don't you?
23 A. I do. Most of them, though, that have
24 degenerative changes have an injury.
25 Q. Excuse me, Doctor.

Page 34

1 In the future, I believe you've said in your
2 records you think his condition will get worse; is
3 that correct?
4 A. Oh, I think his degenerative change will get
5 worse. Whether his pain gets worse, I don't know, but
6 his degenerative change definitely will.
7 Q. And you've said in your records that you feel
8 that there is a 30 percent likelihood that he will
9 require back fusion; is that correct?
10 A. On the basis of what he was telling me, I
11 think when I dictated that, his symptoms and so forth,
12 I felt that over the years that he would get to that
13 stage, and I put down a figure of around 30.
14 Q. And whether or not if this surgery goes
15 about, that he will be able to continue working as an
16 engineer is unknown?
17 A. That's very questionable. In fact, I believe
18 if he gets bad enough to the point that he needs a
19 surgical procedure -- again, going back to work is not
20 depending entirely upon the disease process. It
21 depends upon how much a patient wants to do the work.
22 I don't believe a person should be forced to do the
23 work when they've got objective changes. But some
24 people would want to do it. And if they came to me
25 and said, Can I do it, I'd let them do it. Even

Page 35

1 though they've got the disease, I'd let them do it,
2 and I think they could function okay. I don't believe
3 if he comes to the point of requiring an operation
4 that he will go back working as an engineer.
5 Q. When you say "disease," me, as a layman, I
6 always think of some infectious type of disease. Are
7 you talking about the problem, basically, that's
8 creating the symptoms, the pain in his back, as the
9 disease process?
10 A. Yes.
11 Q. Which is the combination of the injury and
12 the degenerative changes?
13 A. Disease we more refer to the degenerative
14 change, not the injury.
15 Q. Not the injury. Now, in this combination of
16 injury with the degenerative disease causing that, I
17 believe you -- in your feeling of 80 percent that you
18 said is degenerative disc disease, do you feel that
19 the major contributing factor to that 80 percent is
20 genetic code in a human being?
21 A. Yes, I do believe that the genetic code is
22 the main factor for disc disease.
23 Q. Is that what we would have individually, like
24 you, separate from me, is sort of a predisposition?
25 A. That's correct.

Page 36

1 Q. How can you tell that of an individual? Is
2 there any way?
3 A. There will be one of these days as we begin
4 to map out genes. The way you tell now is that
5 certain families have much more degenerative changes
6 than others. Certain families, they don't seem to
7 have disc disease that much. Others, they get it in
8 their lower back, they get it in their neck, their
9 brother and sister, many of them have had operative
10 procedures.
11 There are a lot of -- you know, just a
12 pattern of this type of thing, plus the changes that
13 occur there have taken many years to get to that
14 point. If it's not part of their genetic code, then
15 it has to be some type of virus or something that gets
16 in there, because it's not all mechanical. If it were
17 all mechanical, everyone that does all of these heavy
18 things in their life would all develop back trouble,
19 and it's not the case. We get just as many other
20 people who develop back trouble who don't do all of
21 these heavy, heavy things.
22 There's no question that once you get the
23 disease, if you have -- if you do heavy work, that may
24 bring the symptoms on more.
25 Q. And if you're predisposed, because of

Page 37

1 degenerative disc disease, to being effected by an
2 injury more, is it more difficult to get rid of your
3 pain, to get rid of and become asymptomatic or without
4 pain?

5 A. I think that's absolutely true.

6 Q. But I mean, how can -- you sort of have to
7 take the person as you find him insofar as the genetic
8 code, don't you?

9 A. That's right. There are some people that are
10 made to play in the NBA and there's others of us that
11 are just not. For many reasons, not just because of
12 your athletic ability, but because your body just
13 doesn't take it.

14 Q. The history that he gave you -- and I want to
15 go over some of the things on your records, Doctor.
16 If you could, you know, refer to those.

17 When you first saw him, November 3rd, I think
18 it was, 1993, do you have your record there?

19 A. Yes.

20 Q. Can you give us a history of the problems
21 that he was giving you that was bothering him at the
22 time?

23 A. That his -- you mean what brought his pain
24 on? After he'd seen Crosland and went on with his
25 physical therapy, then I got into a discussion of

Page 39

1 Q. Do you sometimes see that just in human
2 beings as a normal anatomical variant?

3 A. It depends on how the x-ray is taken. If the
4 x-ray beam is high, then the beam -- say the x-ray
5 beam is taken at a higher vertebra, then the beam, as
6 it comes down through the lower vertebra, may look --
7 may give the appearance that the L5-S1 is narrowed.

8 But to say that L5-S1 is narrowed in the normal
9 patient, if the beams are taken just right, it's a
10 relative thing. But I would say no, I would say no,
11 that it's not narrowed in the normal. It's narrowed
12 as a result of the degenerative changes that take
13 place.

14 It is probably more prone to undergo
15 degeneration than other discs because it is more
16 oblique and it takes --

17 Q. More at an angle; right?

18 A. It's more at an angle and it's the lowest
19 disc down and articulates with the sacrum where
20 there's no motion, so that's where the stresses are
21 going to be applied to the highest degree. The lower
22 two discs are the ones that degenerate the fastest.

23 Q. And you also point out that there is a
24 technique problem in taking those x-rays. If you're
25 studying the L5-S1 disc, the beam should be directed

Page 38

1 trying to describe his pain. He gets pain every day,
2 associated with prolonged sitting, bending, twisting,
3 coughing, sneezing. He usually slept through the
4 night. But occasionally, he would get pain that would
5 wake him up. He did not have any pain down his legs.
6 Walking on the straight and level didn't seem to
7 aggravate the pain, it was changing positions or
8 twisting.

9 Q. Now, on the x-rays that you reviewed, I think
10 these were from Dr. Crosland that he either brought or
11 were sent over to you; right?

12 A. That's correct.

13 Q. The anatomy in the low back, in the lumbar
14 section, has generally five vertebrae; is that right?

15 A. That's right.

16 Q. And the lowest vertebrae is called the lumbar
17 fifth?

18 A. L5-S1.

19 Q. And that separates from S, meaning sacrum,
20 and that disc in between them is L5-S1?

21 A. That's correct.

22 Q. Now, in those x-rays, I think you make note
23 in here that you felt there was some slight narrowing
24 between that -- on that L5-S1 disc; is that correct?

25 A. That's correct.

Page 40

1 right at that instead of at an angle; right?

2 A. That's correct.

3 Q. Or else you get a reading that would appear
4 to be narrowed when it shouldn't be narrowed?

5 A. That's correct.

6 Q. You didn't take those x-rays?

7 A. No, but the MRI, that will help resolve all
8 of those problems.

9 Q. And we're going to get -- I'm going to ask
10 you some questions about the MRI.

11 You put him on some medication, then,
12 apparently, and you saw him next December 1 of 1993.
13 Does that sound right?

14 A. After the 11-3-93 visit, I saw him 12-1-93.

15 Q. And still on some medication and then you
16 ordered the MRI; is that correct?

17 A. I ordered the MRI the first time I saw him.

18 Q. Okay.

19 A. And I saw him in 12-1-93 with the MRI.

20 Q. So you had the MRI available then on 12-1-93?

21 A. That's correct.

22 Q. Okay. And that MRI is dated 11-23-93?

23 A. That's correct.

24 Q. Do you have -- you've got a copy of it there,
25 the readout by the radiologist?

Page 41

1 A. Yes.
2 Q. Now, at the disc above that, L4-L5, it looks
3 like the third paragraph down, it says, "Minimal
4 signal intensity changes are noted at L4-5 level
5 consistent with mild degenerative changes;" is that
6 correct?
7 A. That's correct.
8 Q. Would you agree with that, that there were
9 some mild changes at that level?
10 A. Yes.
11 Q. At the disc below that is the one that you
12 had referred to previously, L5-S1, there is stated,
13 "Degenerative disc disease with narrowing of that
14 disc and a mild central bulging disc" --
15 A. Yes.
16 Q -- is that correct? Then when he talks about
17 it in the impression -- and I assume you know Dr.
18 Fuentes who's the radiologist?
19 A. Yes.
20 Q. He calls that a minimal central herniation?
21 A. Uh-huh.
22 Q. And he calls that a minimal central
23 herniation at the disc above this L5-S1, the L4-L5
24 level; right?
25 A. Right.

Page 42

1 Q. Let me ask you, have you talked to Dr.
2 Fuentes about his interpretation of this?
3 A. No. But I think that the words that you read
4 up in the first paragraph where it says, "Study of the
5 lumbar spine demonstrates findings consistent with
6 moderate central bulging of L4-5 and very minimal
7 central herniation," the words are essentially
8 describing the same. And that is, that he has some
9 degree of bulging disc. It doesn't produce
10 impingement of the nerve roots.
11 It would probably be better if every one of
12 these radiologists would point out the exact
13 millimeters of bulge rather than classifying it as
14 minimal, moderate, marked, because there is too much,
15 I think, leeway if you get into the legal aspects.
16 From the medical, it's not as crucial to us whether
17 it's minimal -- whether you classify it as a
18 herniation versus a bulge. We consider them all in a
19 ballpark figure of about the same.
20 Q. When you're talking -- and I'm looking at Dr.
21 Fuentes' interpretation -- impression, excuse me,
22 first paragraph and he says, "Producing a mild to
23 moderate mass effect upon the dural sack" --
24 A. Right.
25 Q. -- he's talking about this central herniation

Page 43

1 at L4-L5 that's pushing out on the sack that contains
2 the nerve roots that make up the remnants of the
3 spinal cord, the cauda equina, down low in the spinal
4 cord?
5 A. The cauda equina is a little -- yeah, the
6 nerve roots down in the bottom.
7 Q. And do those nerve roots go into the legs and
8 innervate the legs, muscles as well as sensation?
9 A. Yes.
10 Q. On the next time you saw him, February 21,
11 1994, apparently he was on some medication he said
12 that told -- he told you, I guess, that helps him
13 somewhat?
14 A. Yes.
15 Q. Voltaren?
16 A. Voltaren, is what I gave him. I believe
17 Q. Thank you. And I guess his symptoms were
18 waxing and waning with the use of that medication,
19 apparently?
20 A. Right.
21 Q. Then you changed his medication to DayPro at
22 that time?
23 A. That's correct.
24 Q. And then you seen him again November 7th of
25 1994?

Page 44

1 A. That's correct.
2 Q. And still back pain and now he's got pain
3 down his right leg towards the knee?
4 A. That's correct.
5 Q. At that time, you indicated that you
6 anticipated intermittent pain sometimes controllable
7 with drugs such as DayPro.
8 A. That's correct.
9 Q. And you state in the last paragraph, "It's
10 possible that his disc will just cause him low grade
11 intermittent symptoms indefinitely and may never come
12 to something more definite."
13 A. That's possible. There was a change on this
14 one compared to previous evaluations because in the
15 past he had never complained of any pain down his leg.
16 And this was the first time that he had ever said
17 anything about leg pain.
18 Q. Now, when that leg pain starts, is that --
19 can that occur because of the pressure being put
20 against the nerve roots that supply the leg?
21 A. It can. But remember, we're talking about a
22 central bulge. There's lots and lots of room in the
23 center of the canal for a bulge. It's when they
24 herniate out to the side that they start irritating
25 the nerve roots.

Page 45

1 Q. Well, when you next saw him, August 14th of
2 1995, he told you -- he continues again with back pain
3 and leg pain on the right side.
4 A. Right.
5 Q. Ten out of twelve days of the month,
6 apparently it's more severe. But more importantly,
7 what I want to get to, the first time, at least that
8 you have recorded, he has a straight leg raising test
9 on the right side that's positive at 45 degrees; right?
10 A. That's correct.
11 Q. Now, do you consider that an objective or
12 subjective measurement of whether he's got a nerve
13 impingement in his low back?
14 A. Because your -- the test is interpreted on
15 the basis of the patient's pain, it's a subjective
16 test. If you demonstrate that they seem to have a
17 restricted motion, you can't push it up easy on one
18 side versus the other, that's a little bit more
19 objective. But still, you're relying on the patient
20 to tell you pain and that's objective -- I mean
21 subjective.
22 Q. Now, he was okay on the left side. In other
23 words, his straight leg raising on his left leg was
24 fine.
25 A. Right.

Page 46

1 Q. And the right leg is where he was complaining
2 of the pain radiating down.
3 A. Yes. Straight leg raising is a test that has
4 more value than the patient just glibly saying, I
5 hurt. It's of some value, but you're still relying on
6 the patient to tell you that it hurts and so it's
7 still a subjective test.
8 Q. Now the other --
9 A. Loss of sensation -- loss of sensation is
10 still subjective.
11 Q. That's what I was going to ask you. Right
12 before that you say, "He has decreased sensation on
13 the medial aspect of his right foot."
14 A. That's still subjective. Loss of muscle
15 mass, measure the diameter of the calf, absent
16 reflexes, that's objective. Weakness, loss of
17 sensation, straight leg raise is still subjective. If
18 you put them altogether and then you find a big
19 herniation that pinches that nerve, then that gives
20 you some good information.
21 Q. Let me ask you this: Is the medial aspect on
22 the right foot an area that is supplied by the nerve
23 coming out of the low back area?
24 A. It is. All of them are.
25 Q. What nerve root would be that on the medial

Page 47

1 side?
2 A. It usually would be the L-5 nerve root and
3 usually it's the L4-5 disc that pinches it. But, you
4 know, sometimes it can be a 5-1 disc hitting the L-5
5 nerve root.
6 Q. So what you're saying is it could be either
7 L4-5 or L5-S1?
8 A. If a person develops an L-5 nerve root
9 problem, it could be either one of those discs that
10 causes them the trouble.
11 Q. Now, unless he knew a lot of medicine, how
12 would he know that just the medial aspect of his right
13 foot would be affected by that --
14 A. He wouldn't know a nerve root.
15 Q. So wouldn't that tend to be a little bit more
16 objective?
17 A. It's still subjective but it is -- there's
18 more credence -- well, unless someone had told him,
19 you know, that this is what you expect, you know, I
20 don't know. I really can't say that the patient, if
21 they have no knowledge -- I would not expect him to
22 tell me something he didn't feel. And I believe when
23 he had decreased sensation there that it's a real
24 thing. And it's related to some involvement of the
25 nerve root, regardless of the subjective or

Page 48

1 objective.
2 Q. Okay. I don't have your latest note, but I
3 think it's on the exhibit that Mr. Haggerty --
4 MR. ROSSI: May I see that, Mr. Haggerty?
5 Q. You also seen him November 6th of '96 and
6 then you saw him last, I believe, what, January of
7 '97, Doctor? January 13th of '97.
8 A. That's the last time I saw him, was January
9 13th of '97.
10 Q. Now, you ordered apparently another MRI; is
11 that correct?
12 A. I did.
13 Q. Why?
14 A. Well, because here I'd been following him
15 for, you know, almost three years, over three years,
16 and the original MRI was three years old and his pain
17 had changed a little. It originally was backache and
18 then he started having some symptoms in his leg, but
19 he wasn't doing better. And the question is, is there
20 something more? Is this disc herniated more? If it
21 is, then I've got something more objective that I can
22 start talking about as to why he's hurting.
23 Q. Do you have a copy of the radiology report
24 from the latest MRI in January of '97?
25 A. I do. Uh-huh.

Page 49

1 Q. Is there a change in your opinion between the
2 two MRI's?

3 A. There's not a dramatic change between the
4 two. In fact, I really don't believe there is any
5 significant change. I would have to get the two
6 x-rays and look at them side-by-side. But on the
7 basis of my memory, on the basis of the interpretation
8 of the radiologists, they're virtually the same. Both
9 of them describe, the last one, "Minimal findings on
10 computed tomography scan. Broad, narrowing
11 degeneration L4-5, L5-S1 disc," which we had before.

12 "Broad based bulging seen at 4-5 and 5-1,
13 slightly more pronounced at 4-5, causing only slight
14 mass affect upon the anterior aspect fecal sack.
15 Again, slightly prominent more at 4-5 compared to
16 S-1." And what they're saying is that there's no
17 focal protrusion of disc material.

18 Q. But, Doctor, on the first studies, there was
19 no narrowing of L4-L5.

20 A. Oh, I think so. If you -- he may not have
21 said it in his report, I'd have to review that again,
22 but I have a little copy here of the MRI and this disc
23 right here is narrowed compared to the normal disc.
24 You can see how narrow it is. It cannot undergo
25 degeneration to this degree without undergoing some

Page 50

1 degree of resorption.

2 Q. Well, there's no statement -- if you look at
3 the first MRI report that was done by Dr. Fuentes, the
4 only thing is that there is minimal signal intensity
5 changes at L4-L5, but he states nothing about
6 narrowing.

7 A. It's narrowed. Regardless of what he says,
8 the disc is narrowed. They don't write every single
9 thing down there. What they write is what they
10 consider most important and --

11 Q. Well, apparently, Doctor, this doctor, the
12 radiologist, did put these up side by side, because on
13 L4-L5 he says, "There is slightly more pronounced
14 bulging or possibly contained herniation of the L4-L5
15 disc." Do you see that?

16 A. You are talking about the --

17 Q. I'm talking about the --

18 A. -- original one or the second one?

19 Q. No. I'm talking about the later MRI, January
20 31, 1997, about the middle of the first page at L4-L5,
21 he says, "There is slightly more pronounced bulging or
22 possibly" disc -- "possibly contained herniation of
23 the L4-L5 disc." Wouldn't that indicate he had them
24 side-by-side and was looking at them?

25 A. No.

Page 51

1 Q. How does he know whether there's more
2 pronounced bulging or possibly herniation?

3 A. He's comparing L4-5 to L5-S1. I don't
4 believe he is comparing the x-ray done in '93 to the
5 one done now. He's saying that there is more
6 degeneration at the 4-5 disc than there is at the
7 L5-S1 disc, on the basis of the MRI done on 1-31-97.

8 Q. He's saying there's more herniation, isn't
9 he?

10 A. Again, it's semantics. He said, "There is
11 slightly more pronounced bulging or possibly contained
12 herniation." And again, I think the best way for the
13 legal standpoint is for people to talk in how many
14 millimeters the disc bulges. Because whether it's
15 herniated, whether it's bulging, the terms are used
16 interchangeably. But in many circles, particularly
17 maybe in the legal profession, herniation is more of a
18 severe thing than a bulging, but they're still the
19 same if they're mild.

20 Q. So the effect on the patient, is what you're
21 saying?

22 A. It's the same.

23 Q. Let me ask you this: In your opinion, is he
24 going to need future medical treatment?

25 A. I think he will always need some type of

Page 52

1 medical treatment. None of us develop these
2 degenerative arthritic things, get cured and go the
3 rest of our life without something. Whether it's a
4 torn meniscus in your knee and you go on and get some
5 degenerative arthritis, you need some treatment
6 forever.

7 Q. I want to talk about his back, this problem
8 that we're dealing with now. Do you think he's going
9 to need more treatment from you or anyone else?

10 A. Antiinflammatory drugs is what I expect he'll
11 need. He may need occasionally an epidural steroid or
12 something like that.

13 Q. Is that --

14 A. This is not going to go away and be perfectly
15 normal. He's always going to have some chronic
16 backache that will require some medicine and maybe a
17 little injection of some steroid or something like
18 that.

19 Q. So the epidural is more of an injection than
20 an oral medication?

21 A. Yes. It's one of the things that can be used
22 to help conservatively treat patients who have back
23 pain. Again, you try to treat them with the minimum
24 in order to get the mostest, and if you don't get
25 control, then you keep going up. The last thing you

Page 53

1 do is an operative procedure if you think it's going
2 to help. But one thing that can be tried, if he were
3 to get worse, is to put a needle down into the spinal
4 canal and inject a little steroid in the area.
5 Q. Do you have any idea what that costs?
6 A. I don't do them. I send them over and let
7 the neuroradiologist do them.
8 Q. Because the placement is real critical of the
9 needle?
10 A. Oh, I could do it but I just don't like -- I
11 don't have the interest in it.
12 Q. Okay.
13 A. They use an image intensification to put the
14 needle in. Anesthesiologists do the same type of
15 thing. And there's a place for those once in a while,
16 if they work. It's not something you're going to do
17 them every few months. And if you don't get a good
18 result, you don't keep doing it again. But that's
19 something that could be tried in him if he got worse
20 than he is.
21 MR. ROSSI: Thank you, Doctor, I have no
22 further questions. Excuse me, let's go off the record
23 for a second.
24 (Discussion off the record.)
25 MR. ROSSI: Back on.

Page 54

1 Q. Doctor, a couple of more questions.
2 If your interpretation of the two MRI's is
3 essentially the same, not much of a change, is that
4 the way I understand your testimony?
5 A. There's very little difference. And again,
6 for me to come out and say, boy, there's been no
7 change, I'd have to have both x-rays here in front of
8 me to look at. But on the basis of my memory and on
9 the basis of the interpretation here by these
10 radiologists, there is very little change.
11 There may be some mild further narrowing, if
12 we got out our measurement and measured the disc
13 height, the 4-5 and 5-1 compared to the way they were
14 before. But if anything, there may have been some
15 further resorption of the disc at the 4-5 and 5-1
16 level. The amount of bulging, central bulging, as
17 described by the radiologist, seems to me like it was
18 a little bit worse three years ago, and that is not
19 unusual. I mean, we have people that will herniate a
20 disc big time, decide they don't want an operation,
21 and three or four years later, see the disc undergo
22 resorption.
23 Q. Can you -- under situations like that, can
24 that disc reherniate just by sneezing?
25 A. By sneezing herniate?

Page 55

1 Q. Yes, or bending over to tie your shoes?
2 A. That is a very important question. And there
3 are people who have no symptoms whatsoever, reach over
4 to bend over and tie their shoe and herniate a disc,
5 right then. And to see that when they bent over it
6 that that caused the herniation is ridiculous. It was
7 a sick disc.
8 Q. So, Doctor, let me ask you this: Usually,
9 this -- two MRI's, one is done 11-23-93, the second is
10 1-31-97, so we're talking about not quite three and a
11 half years, but over three years; right?
12 A. Right.
13 Q. And the change and degenerative changes we
14 see are not significant, they're about the same?
15 A. Not dramatic.
16 Q. Wouldn't that indicate to you that the reason
17 for the symptoms and pain and problems is more likely
18 injury as opposed to this predisposition on the
19 degenerative changes?
20 A. I don't know why.
21 Q. Well --
22 A. It wouldn't indicate to me. People with
23 arthritis in the knee or anywhere else in the body,
24 and you have to compare it with other all other
25 musculoskeletal structures, is that arthritis and

Page 56

1 degeneration has a tendency to flare and come down and
2 flare and come down, regardless of injury. Now, if
3 you have an injury, if you're right at the point again
4 of starting to develop these type of symptoms with it,
5 where it comes and goes, and you have an injury and
6 you take it over the threshold, then that's going to
7 keep things going. But the symptoms are one thing and
8 then the objective findings are the other. And in the
9 end, the explanation for his symptoms is disc
10 degeneration without a big herniation and without
11 pinched nerve root.
12 Q. On February 1st, when he had this injury, of
13 1993, we don't know how close or far he was away from
14 this threshold you're talking about, do we?
15 A. No. You have to base that on the basis of
16 the -- if he came in here and had --
17 Q. Excuse me.
18 A. -- an MRI that was normal, then it would be a
19 little different. But the MRI is abnormal and it
20 takes a long time to develop those changes. Here we
21 go three years and we haven't seen that dramatic of a
22 change. It's not horrendous. That means that the
23 degenerative process has been going on for 10, 15
24 years.
25 Q. Well, the degenerative process starts in the

Page 57

1 early twenties, doesn't it?

2 A. It does.

3 Q. For all of us?

4 A. It does.

5 Q. But that's the price we pay to walking
6 upright, isn't it?

7 A. Unfortunately. It's just that some of us get
8 it a little more than others.

9 Q. Because of, in your opinion, more of a
10 predisposition from this genetic code?

11 A. I think that's the best explanation for it.

12 Q. What's the cost of a fusion that we've been
13 talking?

14 A. The price of a fusion?

15 Yeah.

16 MR. HAGGERTY: Excuse me, Doctor, I'm going
17 to object on relevance. It hasn't been established
18 he'll need one to a probability. Go ahead.

19 THE WITNESS: I diagnose and treat, I don't
20 manage the office and I can't tell you the figure of
21 what it costs for a fusion, but it's several thousand
22 dollars. You know, it's probably about four days or
23 so in the hospital. And we're finding newer and
24 better ways to try to do the fusion. Hopefully, if it
25 ever comes to doing a fusion in Mark, it wouldn't be

Page 58

1 as difficult as it has been in the past. I mean,
2 there's some new cages that have been -- that are
3 coming out, put the cage in.

4 Q. That's brand new, isn't it?

5 A. I think that the jury's not out as to how
6 well the patient is going to do long-term.

7 Q. Isn't this cage brand new?

8 A. It was just approved by the FDA around August
9 or September of last year. However, there was a few
10 years of experience and the results seem to be
11 promising for certain specific types of back trouble.
12 The standard way, obviously, is to put bone in there
13 and maybe even use some pedicle screw to help hold it
14 together so that it fuses well.

15 Some of the instruments, I bet that cage
16 probably costs three or four thousand dollars just for
17 the age, and then the surgeon's fee and
18 anesthesiologist. I can't tell you what the total
19 cost would be.

20 MR. ROSSI: Thank you, Doctor, I have no
21 further questions.

22

23 FURTHER EXAMINATION

24 BY MR. HAGGERTY:

25 Q. Doctor, I have just a few follow-up

Page 59

1 questions.

2 According to the chart notes I've looked at,
3 Mr. Dalcourt saw you, it looks like November 3rd of
4 '93, December 1st of '93 and February 21st of '94.
5 And then he didn't see you again until November of
6 '94, about nine months later?

7 A. Uh-huh.

8 Q. And then he saw you again August of '95,
9 again about nine months later?

10 A. Uh-huh.

11 Q. And then he didn't see you for a year, until
12 November of '96?

13 A. Right.

14 Q. And then he came back in in January of this
15 year; right?

16 A. That's correct.

17 Q. And, Doctor, is it likely Mr. Dalcourt is
18 going to need surgery in the future? More likely than
19 not, is the standard.

20 A. My feeling is that he will not need surgery
21 in the future.

22 Q. All right. Let's assume that he has further
23 problems, surgery, missed work, anything like that,
24 what would be the cause of those problems between the
25 injury and the degenerative disc disease?

Page 60

1 A. Let's see, what was that question again?

2 Q. It was a little complicated.

3 I want you to assume he has some kind of
4 problems in the future, whether it's surgery or missed
5 work or some further restrictions. Just assume that
6 generally, all right?

7 A. Assume that he's going to need the operation,
8 you say?

9 Q. Assume he'll have some kind of problem in the
10 future.

11 A. Okay.

12 Q. What would be the cause of that? Can you
13 differentiate between the accident that we've been
14 talking about and his degenerative disc disease? What
15 would cause him to have future problems or surgery?

16 A. All else equal, meaning, you know, he had an
17 episode here where he slipped on a chair and went
18 down, and a lot of us, we could have things like that
19 happen to us. Sometimes it flares things up and
20 sometime it doesn't cause any pain at all, you just go
21 about your business. All else equal, he has nothing
22 like that in the future, he's not lifting a garbage
23 can and develops some sudden trouble or whatever, my
24 feeling goes back to that 20/80.

25 I feel if he ends up with an operative

Page 61

1 procedure in the future, it will be 20 percent as a
2 result -- you have to hold things still. The injury
3 has already occurred, there it is, it will continue to
4 have its effect. The degenerative changes are there,
5 they continue to have their effect. If nothing else
6 occurs, I assume that if he needs an operation in the
7 future, it will be 20 percent related to injury and 80
8 percent related to preexisting disease.

9 Q.Now, this preexisting degenerative disc
10 disease we've talked about, you say primarily your
11 genetic code determines how much you have?

12 MR. ROSSI: Excuse me. Move to strike and
13 relevancy on the last question. Excuse me, Mr.
14 Haggerty.

15 THE WITNESS: Many factors again play a role
16 in degenerative disc disease of which I don't believe
17 we understand them all, but I think the evidence and
18 experience points towards genetic code being the
19 biggest. And it's going to be related to something as
20 to how the collagen fibers are made. And as we get
21 more into genetics, we are going to determine it. And
22 maybe one of these days, the treatment will be gene
23 transplant rather than surgical procedures or
24 antiinflammatories or anything else.

25 Q.But is there actual breakdown in the disc

Page 62

1 material?

2 A. Yes.

3 Q.And this is something you can see on MRI's?

4 A.Again, it goes back to the analogy that I
5 gave you before. It should not be so surprising. You
6 see your skin change. It is not the same as when
7 you're 12 years of age. That's a tissue. The same
8 tissue is in the back. It does not remain like you're
9 12 years of age, it begins to stretch, it tears it --
10 you look under a microscope and it's just not lined up
11 the way it's supposed to be. The capsule gets thin,
12 it gets weak. The next thing you know, in some of us,
13 with no injury at all, it will tear and herniate.

14 Q.Was this accident that we're talking about
15 then an aggravation of his degenerative disc disease?

16 MR. ROSSI: Objection to the form of the
17 question.

18 THE WITNESS: I think that's a way you could
19 describe it, an aggravation, or you could describe it
20 as having a disc in which the accident tore some
21 fibers in an already sick disc and then he started
22 having symptoms. Again, where he might not have had
23 them if he hadn't had the accident, at least in the
24 short term.

25 Q.Now, the MRI's we've talked about, do they

Page 63

1 show any impingement upon a nerve that might be
2 causing these right leg problems?

3 A.No. When it comes to impingement of the
4 nerve, he has a central bulge that puts some little
5 mass effect upon this dural sack. And you've got all
6 these nerves coming down through and they've got
7 plenty of room. If the disc herniates out to the
8 side, not right in the center, then it can start
9 irritating the nerve root. That was not the case.

10 Now, he has some symptoms in his leg and he
11 had some going down to his foot. You can get
12 irritation of a nerve root sometimes by chemistry.
13 Chemicals are leaked from these degenerative things.
14 They can irritate a nerve root. It's not entirely the
15 bulge of the mass of a disc material. That's the only
16 way I can explain any symptoms would be down his leg,
17 because on the basis of the studies, we don't have a
18 pinched nerve.

19 Now, there is one other factor about his leg
20 pain, and that was a visit on 11-6-96.

21 Q.What is that?

22 A.At that time, he came in complaining of some
23 pain in his groin. Groin pain is extremely unusual
24 from the standpoint of disc disease. The nerve that
25 supplies the groin comes up at a higher level. All

Page 64

1 his discs at a higher level are pristine normal, at
2 least normal as they can be. He didn't have any
3 degenerative changes that we could see up in those
4 discs.

5 Pain in the groin usually comes from the hip
6 joint. And when I examined him, I could reproduce
7 some pain by maximum internal rotation of his hip.
8 And at that time, the best explanation I'd give him
9 for the pain that he had in his groin -- now, this is
10 not pain that shoots down the leg -- would be the
11 beginnings of early arthritis of his right hip.

12 Now, that is not related to injury. That is
13 more related to the degenerative change that occurs in
14 some of us. The x-ray of his hip was normal. But a
15 lot of us can start getting inflammation and pain in a
16 joint, some stiffness in a finger, long before any
17 change occurs on an x-ray.

18 Q.Now, what about the right leg pain, he didn't
19 complain of that initially when you first saw him, did
20 he?

21 A.No.

22 Q.In fact, looking at the notes, it doesn't
23 seem to show up until '95, when he comes to see you?

24 A.I think it was around '94. November of '94
25 was the first time that he had any pain in his right

Page 65

1 leg. It went down toward his knee.

2 Q.Is the accident responsible for this right
3 leg pain then?

4 A.Well, I haven't determine yet a hundred
5 percent whether all of the pain in that right leg is
6 related to the beginnings of early degenerative
7 changes of his hip versus his leg. But at that time,
8 you know, I didn't have any problems with his hip
9 joint. He wasn't complaining of groin pain, he was
10 complaining of a pain that was more compatible with
11 irritation of nerves at the level of the back, even
12 though he didn't have neurological loss of dramatic
13 nature, it was more compatible with that.

14 And I thought, Well, maybe he's got some
15 leakage of some of the chemicals from the disc. Maybe
16 even a facet joint in the back, because there's a
17 whole gamut of things at a disc level. You've got the
18 disc up front and two little facet joints in the
19 back. And as the disc begins to settle down, these
20 two facets become stressed abnormally,
21 biomechanically, because they're not in their normal
22 position. These facets have to ride up a little bit,
23 and you start getting a little arthritis there also.
24 And the chemicals can be released that may irritate a
25 nerve root and cause some intermittent leg pain.

Page 66

1 So at the time, I felt it was maybe related
2 to some chemicals, not because of the herniation. And
3 that -- you treat him with antiinflammatory drugs and
4 it should help control that. It was only later that
5 he started having pain in his groin. And I don't know
6 what his groin is right now. I haven't really
7 examined, you know, his hip joint. But of all the
8 things that I did, it was motion of his hip joint that
9 produced the groin pain. And the groin pain, like I
10 mentioned, is not generally from the back.

11 So I believe that he has degenerative disc
12 disease, that he had an injury that tore some of the
13 some of the fibers of the disc producing a central
14 bulge. That 20 percent of the pain that he's got
15 relating to his back and leg was related to the
16 injury, that he probably is starting to get some
17 arthritic changes in his hip joint that may come and
18 go of a very mild nature and he may go through the
19 next five years and not have too much trouble. I
20 can't predict that.

21 I think that also that the degenerative
22 changes in his hip possibly could be tied in to the
23 tendency to degeneration of his lower back.

24 MR. HAGGERTY: I don't have anything
25 further. Thank you, Doctor.

Page 67

1 FURTHER EXAMINATION

2 BY MR. ROSSI:

3 Q.Doctor, on the report that you filed with the
4 Industrial Commission on December 8th, 1993, you
5 indicate in your diagnosis, "Pain is either related to
6 a central bulging disc with degeneration without
7 significant radiculopathy or it could be related to
8 his SI joint," SI meaning sacroiliac?

9 A.Uh-huh.

10 Q.And then you state on there that this was in
11 relationship to his injury on the railroad. Do you
12 have that report?

13 A.Was that March 8, '95?

14 Q.No. It was December 8, '93, and here is what
15 it looks like, Doctor. In fact, let me give you the
16 report.

17 A.If this was the case, then it would have been
18 the girls taking my chart notes and transferring
19 information from the chart notes to this.

20 Q.But you have --

21 A.So somewhere in my report of my medical
22 records, I have mentioned the central bulging disc,
23 the degenerative changes, or I have mentioned in there
24 that his symptoms could be SI joint related.

25 Q.But you did sign it?

Page 68

1 A.Yes.

2 Q.And you indicated is this -- you indicated
3 that this condition was a result of an industrial
4 injury at that time, Box No. 21?

5 A.That's correct.

6 Q.Now, Doctor, was it your opinion that there
7 was a 30 percent likelihood or probability that he
8 will require surgery, a fusion surgery, on his back in
9 sometime in the future?

10 A.At the time that I wrote that note, that's
11 what I indicated, and it may not be too far off.
12 Although, if I were to say right now, from what I
13 know, that would be on the high end. And the
14 indication, again,,for doing that operation is not
15 entirely what we see here. It's on the basis of what
16 he himself expects and wants out of it. If it were
17 me, it if it were me with these particular changes in
18 here, the chances of me ending up needing or having an
19 operation, I think would be less than 4 percent.

20 Q.Have you told him how you feel?

21 A.Absolutely.

22 Q.Is he the type of guy that says, Okay, I'm
23 going to put up with these problems and just bite the
24 bullet?

25 A.That he would just put up with it and bite

Page 69

1 the bullet?
2 Q. Yes, rather than going through surgery, he's
3 going to put up with what he's got and take the
4 medication based --
5 A. I think I would put up with more than he. I
6 think he's average.
7 Q. Okay. Apparently you can get these nerve
8 roots irritated by chemicals that are produced because
9 of the injury superimposed on the --
10 A. Because of the degenerative change, and
11 because of the injury, maybe initially, but then it
12 runs its course. The degeneration and the sickness of
13 the disc becomes the more involved. If you sprain
14 your ankle, you know, you get a lot of swelling and
15 inflammation. There's some chemicals released that
16 that swell the whole area. That can irritate. As
17 time goes by, all that begins to dissipate and it's
18 then the chronic degenerative thing that can flare
19 with chemical release intermittently.
20 Q. Are you saying it's the chemicals that are
21 being released from the torn disc?
22 A. The degenerative disc. The disc -- when you
23 tear something, we cut through these things or tear
24 something, you'll get some swelling and there are
25 chemicals that come in there that are part of the

Page 70

1 healing process, but they produce swelling. As time
2 goes by, the swelling begins to decrease, you have
3 less release of chemicals. But if you have an
4 arthritic change down there, that can cause
5 intermittent release of chemicals off and on a
6 person's entire life.
7 Q. So we have surrounding these disc an annulus
8 fibrosis, don't we, a heavy ligament?
9 A. Yes.
10 Q. And that is made up of different fibers?
11 A. Yes.
12 Q. And you're saying throughout our lifetime,
13 because of genetics, dominantly, we see changes in
14 there?
15 A. That's correct.
16 Q. And when we superimpose an injury on this
17 predisposed condition, it may become symptomatic?
18 A. That's correct.
19 Q. And that injury may tear or change other
20 fibers within that annulus fibrosis?
21 A. You might classify it as having a component
22 of acceleration of the normal degenerative process.
23 Q. Make you a lot older real quick?
24 A. That's correct.
25 MR. ROSSI. Thank you, Doctor, I have no

Page 71

1 further questions.
2 MR. HAGGERTY: Thank you, Doctor.
3 (Exhibit 1 marked.)
4 (Concluded at 4:10 p.m.)
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

Page 72

1 STATE OF UTAH } ss.
2 COUNTY OF SALT LAKE)
3 I, ROCKIE E. DUSTIN, Registered
4 Professional Reporter and Notary Public for the State
5 of Utah, certify:
6 That the foregoing deposition of DONALD W.
7 BRYAN, M.D. was taken before me pursuant to Notice at
8 the time and place therein set forth, at which time
9 the witness was put under oath by me;
10 That the testimony of the witness and all
11 objections made at the time of the examination were
12 recorded stenographically by me and were thereafter
13 transcribed under my direction;
14 I FURTHER CERTIFY that I am neither counsel
15 for nor related to any party to said action nor in
16 anywise interested in the outcome thereof.
17 IN WITNESS WHEREOF, I have subscribed my
18 name and affixed my seal this 8th day of April, 1997.
19
20 ROCKIE E. DUSTIN, CSR, RPR
21 Notary Public in and for the
County of Salt Lake, State of Utah
22 My Commission Expires:
23 July 5, 1997
24
25

Page 73

WITNESS SIGNATURE CERTIFICATION

STATE OF UTAH } ss.
COUNTY OF)

DONALD W. BRYAN, M.D. deposes and says: That
he is the witness referred to in the foregoing
deposition; that he has read the same and knows the
contents thereof; that the same are true of his own
knowledge.

DONALD W. BRYAN, M.D.

SUBSCRIBED and SWORN to before me this ____
day of _____, 19

Notary Public
Residing at

My commission expires:

Page 74

CORRECTIONS

Deposition of: DONALD W. BRYAN, M.D.
Taken: April 4, 1997

PAGE	LINE	CORRECTION	REASON
------	------	------------	--------

6	_____	_____	_____
7	_____	_____	_____
8	_____	_____	_____
9	_____	_____	_____
10	_____	_____	_____
11	_____	_____	_____
12	_____	_____	_____
13	_____	_____	_____
14	_____	_____	_____
15	_____	_____	_____
16	_____	_____	_____
17	_____	_____	_____
18	_____	_____	_____
19	_____	_____	_____
20	_____	_____	_____
21	_____	_____	_____
22	_____	_____	_____
23	_____	_____	_____
24	_____	_____	_____
25	SIGNATURE _____	DATE _____	