

EXHIBIT D

1	IN THE UNITED STATES DISTRICT COURT	1	I N D E X
2	NORTHERN DISTRICT OF ILLINOIS	2	
3	EASTERN DIVISION	3	
4	JOHNNY JONES,)	4	WITNESS EXAMINATION
5	Plaintiff,)	5	
6	vs.) Case No. 17 CV 8218	6	DR. ANKHUR BEHL
7	WEXFORD HEALTH SOURCES,)	7	By Ms. Byrd 5
8	INC. and DR. MARSHALL)	8	By Mr. Flaxman 42
9	JAMES,)	9	Further By Ms. Byrd 44
10	Defendants.)	10	
11		11	
12	The deposition of DR. ANKHUR BEHL, called	12	
13	for examination pursuant to the Rules of Civil	13	
14	Procedure for the United States District Courts	14	
15	pertaining to the taking of depositions, taken	15	E X H I B I T S
16	before CHRISTINE M. PINA, a Certified Shorthand	16	
17	Reporter within and for the County of Cook and	17	NUMBER MARKED FOR ID
18	State of Illinois, at 1310 N. Main Street,	18	
19	Sandwich, Illinois, on July 12, 2019 at the hour of	19	
20	2:25 o'clock p.m.	20	NO EXHIBITS MARKED BY REPORTER
21		21	
22		22	
23	Reported by: CHRISTINE M. PINA, CSR, RPR	23	
24	License No.: 084-003785	24	
	1		3
1	APPEARANCES:	1	(whereupon, the witness was
2	KENNETH N. FLAXMAN, P.C.	2	duly sworn.)
3	BY: MR. KENNETH N. FLAXMAN	3	MS. BYRD: Dr. Behl, I know I introduced
4	200 South Michigan Avenue, Suite 201	4	myself before we went on the record, but my name is
5	Chicago, Illinois 60604	5	Sandy Byrd, and I am an attorney from Cassiday
6	(312) 427-3200	6	Schade --
7	knf@kenlaw.com	7	THE WITNESS: Okay.
8	on behalf of the Plaintiff;	8	MS. BYRD: -- and we represent Wexford Health
9		9	Sources, we represent Dr. James in this matter,
10	CASSIDAY SCHADE	10	okay?
11	BY: MS. SANDRA BYRD	11	THE WITNESS: Okay.
12	222 West Adams Street, Suite 2900	12	MS. BYRD: I'm assuming you've given a
13	Chicago, Illinois 60606	13	deposition before?
14	(312) 641-3100	14	THE WITNESS: Yes.
15	sbyrd@cassiday.com	15	MS. BYRD: And you know the rules then of
16	on behalf of the Defendants.	16	making sure all of your answers are outloud?
17		17	THE WITNESS: Written, yes, or said, yes.
18		18	Okay.
19		19	MS. BYRD: And that you'll wait for me to
20		20	finish my question before you answer, and I will
21		21	try and wait for you to finish your answer before I
22		22	start my next question. If there's anything you
23		23	have a question about, let me know, but you
24		24	understand all the rules upfront?
	2		4



<p>1 THE WITNESS: Yes.</p> <p>2 DR. ANKHUR BEHL,</p> <p>3 having been first duly sworn, was examined and</p> <p>4 testified as follows:</p> <p>5 EXAMINATION</p> <p>6 BY MS. BYRD:</p> <p>7 Q. What is your education, Doctor?</p> <p>8 A. So, I did my undergraduate at the</p> <p>9 University of Oklahoma, did my medical school at</p> <p>10 the University of Oklahoma. I trained in</p> <p>11 orthopedic surgery, five years in Fort Worth at</p> <p>12 Fort Worth Affiliated Hospitals. I did a year of</p> <p>13 fellowship in sports medicine in Indiana</p> <p>14 University, I'm sports medicine trained, and I've</p> <p>15 been in practice here for the last -- this is going</p> <p>16 to be my sixth year.</p> <p>17 Q. When you were -- I went to IU, so I have</p> <p>18 to ask IU questions. Were you in Bloomington or</p> <p>19 Indianapolis?</p> <p>20 A. Indianapolis, yes.</p> <p>21 Q. Your practice here is all orthopaedics?</p> <p>22 A. It's orthopedic, yes. So, I have a</p> <p>23 general practice that's probably more catered</p> <p>24 towards sports medicine which is arthroscopies,</p> <p style="text-align: right;">5</p>	<p>1 Q. How familiar are you with the prison</p> <p>2 system and the medical care within the prison</p> <p>3 system?</p> <p>4 A. So, you know, I would say I've gotten</p> <p>5 different experiences from different patients. It</p> <p>6 seems that the last few patients have more access</p> <p>7 to physical therapy on-site. You know, I know that</p> <p>8 there is a process for -- because most of the time</p> <p>9 the patients they send me are acute injuries, and</p> <p>10 so a lot of those patients do need surgical</p> <p>11 intervention. And so the process for getting that</p> <p>12 surgery approved seems to be more streamline, but,</p> <p>13 again, you know, I assume that they go through a</p> <p>14 general practice doctor there who decides that they</p> <p>15 need more subspecialty care and that's how I get</p> <p>16 the referrals.</p> <p>17 Q. In your experience with that, you said it</p> <p>18 seems like things are more streamlined now. Are</p> <p>19 you getting that information from your</p> <p>20 conversations with the inmates or in your</p> <p>21 experience with dealing with getting the surgeries</p> <p>22 scheduled, et cetera?</p> <p>23 A. In my experience with getting the surgery</p> <p>24 scheduled.</p> <p style="text-align: right;">7</p>
<p>1 sports-related injuries, ligaments, tendons, you</p> <p>2 know, those are kind of my primary. The other 50</p> <p>3 percent which is, again, more tailored towards</p> <p>4 sports. But I do a lot of general practice stuff</p> <p>5 as well, so total knees, fractures including</p> <p>6 anywhere from your bread-butter wrist-forearm,</p> <p>7 femur fractures, tibia fractures, ankle fractures.</p> <p>8 Q. The case that we're here, Mr. Jones, he</p> <p>9 was an inmate at Sheridan?</p> <p>10 A. Yes.</p> <p>11 Q. How many inmates do you deal with here?</p> <p>12 Do you get a lot of inmates from --</p> <p>13 A. I do. I get inmates from Wexford, I get</p> <p>14 inmates from Stateville, so both. I've probably</p> <p>15 operated on, what's a good estimate here, I would</p> <p>16 say maybe 15 inmates. I've probably seen 10 more</p> <p>17 than that, so maybe 25 inmates I would say from</p> <p>18 both facilities.</p> <p>19 Q. That's over the last five or --</p> <p>20 A. Five years, yes.</p> <p>21 Q. The inmates that you treat when they come</p> <p>22 to your practice, they come obviously with guards,</p> <p>23 correct?</p> <p>24 A. Yes.</p> <p style="text-align: right;">6</p>	<p>1 Q. So, you're not basing that opinion off of</p> <p>2 what you're told by the inmates?</p> <p>3 A. I am not.</p> <p>4 Q. The surgery we're dealing with here was a</p> <p>5 patella rupture, right?</p> <p>6 A. Yes.</p> <p>7 Q. How many of those surgeries have you done</p> <p>8 on inmates?</p> <p>9 A. On inmates? Probably not very many. I</p> <p>10 would say less than five, yes.</p> <p>11 Q. The ones that you have done on inmates,</p> <p>12 how quickly after the injury have you seen the</p> <p>13 inmate?</p> <p>14 A. Typically within -- like any of those -- I</p> <p>15 mean not only inmates, but I guess typically with</p> <p>16 these injuries, I see them in the next -- in a few</p> <p>17 weeks, within a few weeks due to the fact that the</p> <p>18 patellar tendon is -- when you rupture your</p> <p>19 patellar tendon or you rupture your quad tendon,</p> <p>20 anywhere in your extensor mechanism that you</p> <p>21 rupture, you can't really walk with it very well</p> <p>22 because you have to be able to extend your knee to</p> <p>23 ambulate. And so most of the time patients are</p> <p>24 coming in quite early in the process just because</p> <p style="text-align: right;">8</p>



<p>1 they can't walk.</p> <p>2 Q. Is that always the case with a ruptured</p> <p>3 patellar tendon that you can't walk?</p> <p>4 A. You can't walk well without a brace. That</p> <p>5 is always, yes. I mean there's -- without a</p> <p>6 patellar tendon, you can't extend your knee or</p> <p>7 without a -- well, without an intact patellar</p> <p>8 tendon, you can't extend your knee. And so if you</p> <p>9 can't extend your knee, you're going to be</p> <p>10 unstable. With a brace, you could get away with</p> <p>11 probably walking without a patellar tendon -- an</p> <p>12 intact patellar tendon. You're always going to</p> <p>13 have a patellar tendon, but an intact patellar</p> <p>14 tendon.</p> <p>15 Q. So, someone who ruptures their patellar</p> <p>16 tendon, tell me exactly what that means. Does it</p> <p>17 detach, what does that mean?</p> <p>18 A. Sure. So, the whole extensor mechanism --</p> <p>19 so, the ability for you to straighten your knee</p> <p>20 which is the crucial component to walking, to</p> <p>21 holding yourself up as you take -- as a normal gait</p> <p>22 involves the quadriceps, the patella, the kneecap,</p> <p>23 the patella tendon, and the tibia tubercle where it</p> <p>24 attaches. So, any break in that mechanism being a</p> <p style="text-align: right;">9</p>	<p>1 A. So, what I mean -- I guess I would clarify</p> <p>2 that. I think there's usually disease within the</p> <p>3 tendon -- there's preexisting disease within the</p> <p>4 tendon for them to rupture. They don't -- you</p> <p>5 won't get a completely normal tendon before they</p> <p>6 rupture, but it does take a -- it takes a load for</p> <p>7 it to happen. Even if they have disease, they</p> <p>8 could have patellar -- just like Achilles</p> <p>9 tendonitis or other tendinopathies, they're quite</p> <p>10 frequent, it's only based on the mechanism.</p> <p>11 Eccentric -- usually it tears when there's an</p> <p>12 eccentric load to the tendon meaning that usually</p> <p>13 the knee is going the opposite direction that the</p> <p>14 quadriceps or patella tendon is supposed to go.</p> <p>15 So, usually the function of the extensor mechanism</p> <p>16 is to extend the leg so it's to straighten the leg.</p> <p>17 So, instead of doing that, the leg goes into a more</p> <p>18 bent position but it's still contracting, and</p> <p>19 that's where the most force is placed on the</p> <p>20 patella tendon.</p> <p>21 Q. So, when you say the disease within the</p> <p>22 tendon, what do you mean?</p> <p>23 A. So that there is I would call it more like</p> <p>24 tendinopathy, so there's inflammation within the</p> <p style="text-align: right;">11</p>
<p>1 quadriceps tear, a patella fracture, a patella</p> <p>2 tendon rupture, or a fracture from the tibia will</p> <p>3 not allow you to extend your knee and allow you to</p> <p>4 have a normal gait. A patellar tendon rupture can</p> <p>5 refer to tearing the patella tendon in -- anywhere</p> <p>6 from the very top of it, so where it's torn from</p> <p>7 the top of the -- or the bottom of the patella to</p> <p>8 the midsubstance to it being torn right off the</p> <p>9 bone. Typically, these things when they rupture,</p> <p>10 they rupture to a point where there's not a good --</p> <p>11 they rupture a lot of times midsubstance, so they</p> <p>12 rupture right in the middle. And they're not torn</p> <p>13 cleanly, they're torn severely on both sides. So,</p> <p>14 it's almost like a -- you would say almost like a</p> <p>15 mop end on both sides rather than a clean cut that</p> <p>16 you would imagine the way they tear. They're</p> <p>17 usually degenerative. They usually have some sort</p> <p>18 of tendinopathy involved in it because they're</p> <p>19 usually diseased. They typically occur under</p> <p>20 40-year old patients opposed to quadriceps tendon</p> <p>21 ruptures that usually occur over 40, but I've seen</p> <p>22 both occur in both age groups.</p> <p>23 Q. You said that they're usually</p> <p>24 degenerative?</p> <p style="text-align: right;">10</p>	<p>1 tendon. With inflammation, there may be partial</p> <p>2 intrasubstance tearing. You won't ever know about</p> <p>3 it. Patients may or may not ever complain about</p> <p>4 knee pain. It may just be inherent within the</p> <p>5 tendon itself.</p> <p>6 Q. What causes that? What causes the --</p> <p>7 A. So that -- you know, it's a variable.</p> <p>8 It's activity level. Sometimes you can -- if</p> <p>9 there's a genetic component to it, athletic</p> <p>10 activity. It can happen from, you know, overuse.</p> <p>11 It's very common -- I see it very commonly in</p> <p>12 patellar tendinopathy in basketball players,</p> <p>13 volleyball players. In athletic patients, you'll</p> <p>14 see that.</p> <p>15 Q. Would someone having a rod in their femur,</p> <p>16 would that affect their --</p> <p>17 A. The rod in the femur, there's no direct</p> <p>18 correlation between having a broken leg and a</p> <p>19 patellar tendon rupture; there's no direct</p> <p>20 correlation between the two. The only direct --</p> <p>21 now, I don't remember if his was retrograde or</p> <p>22 antegrade. Let me see here. I have to look back</p> <p>23 and see what --</p> <p>24 Q. Generally, before we --</p> <p style="text-align: right;">12</p>



<p>1 A. It makes a difference, and the reason I 2 say that is if the rod was placed from the hip, 3 then there's no direct communication. If the rod 4 was placed through the knee, then you do make a 5 midline incision in the tendon so you can weaken 6 it. I don't remember -- as far as I remember, I 7 think his rod went the other direction. So, let me 8 see. Femur fracture. Let me see. It will 9 probably have it here. I wrote status post 10 intramedullary nailing. I don't know if I wrote 11 which way it was going. As far as I remember, I 12 think it is -- his femur was fixed from the hip 13 rather than from the knee. And I think, yeah, when 14 he got it done in '91 is what I think I was 15 reading -- yes. When he got it done in '91, we 16 didn't do retrograde nails. So, that doesn't have 17 a direct correlation.</p> <p>18 Q. Retrograde meaning the one that is coming 19 through --</p> <p>20 A. Through the knee, yes. And you actually 21 split the tendon, so there would be some 22 relationship there. I've never seen it weaken, but 23 you could theoretically say that it could weaken 24 it, but not through the hip because it's the other</p> <p style="text-align: right;">13</p>	<p>1 A. So, I have -- I remember it was at least a 2 few months. And I'm looking back at my note. The 3 injury occurred -- appeared to be November of 2015, 4 and then, his first -- my first visit with him was 5 February 8, 2016, so approximately three months.</p> <p>6 Q. From November until February 8, 2016, you 7 don't have any independent knowledge of the care 8 that he received or anything else, correct?</p> <p>9 A. I do not.</p> <p>10 Q. You saw him on February 8, 2016 for the 11 first time and then did the surgery on February 16, 12 2016, is that correct?</p> <p>13 A. Let me check. Yes.</p> <p>14 Q. And that timeframe from February 8 to 15 February 16, is that a typical timeframe from the 16 time you see a patient with this type of an injury 17 until you do the surgery?</p> <p>18 A. Yes, eight days. I don't remember if we 19 had to get his MRI at the time or did he come with 20 an MRI? So, that would be the question. It may 21 have been a -- let me see here. The question I 22 have is did we end up getting an MRI on him or just 23 we basically knew the diagnosis. So, I will still 24 occasionally get an MRI in those circumstances just</p> <p style="text-align: right;">15</p>
<p>1 direction.</p> <p>2 Q. I know you said you've done probably fewer 3 than five surgeries on these inmates. Overall, how 4 many have you done?</p> <p>5 A. Probably 30 to 40. 30 to 40.</p> <p>6 Q. Do you have independent recall of 7 Mr. Jones?</p> <p>8 A. I remember his clinical picture. I 9 remember the timeframe from when he came in. I 10 remember the surgery because of the timeframe from 11 when the surgery occurred to when I operated on 12 him. I remember the way I fixed it in terms of 13 using the graft to do a reconstruction rather than 14 a repair primarily. I don't remember, obviously, 15 every visit, and I don't remember the last -- I did 16 look back and review the last time that I saw him 17 and how many times I saw him, to be honest, and 18 kind of what his last rehab day was.</p> <p>19 Q. You said there was a time between when you 20 saw him and when the surgery --</p> <p>21 A. The biggest timeframe is when the injury 22 and when I saw him, yes.</p> <p>23 Q. What is your understanding of that 24 timeframe?</p> <p style="text-align: right;">14</p>	<p>1 to see what the quality of the tendon is, where the 2 tendon is torn. I'm just trying to see if I ended 3 up getting -- oh, you know, he may have had an MRI 4 that was -- he may have come with an MRI because I 5 don't see -- it says here I did evaluate him on 6 2-8-16 at which point it was seen on X-ray, MRI, 7 and exam that he had tore his patellar tendon. So, 8 I think I did have an MRI, but it was brought with 9 the patient.</p> <p>10 Q. So, I can represent to you that he had an 11 MRI in January of 2016.</p> <p>12 A. Okay. Does it say if it was on a disk or 13 hard copy? Because I don't see a disk or anything. 14 Let me see if I have the report or anything in here 15 because that I do not remember on what --</p> <p>16 Q. I'm not sure if we do.</p> <p>17 A. Here's radiology. Here we go.</p> <p>18 Q. Do you have it?</p> <p>19 A. Let's see here. It says comparison MRI of 20 the left knee, so they had it somewhere. Here we 21 go, MRI of the left knee. I do have the copy. 22 1-18-16, yes.</p> <p>23 Q. So, you would have reviewed that --</p> <p>24 A. Yes.</p> <p style="text-align: right;">16</p>



<p>1 Q. -- at the time you met with Mr. Jones?</p> <p>2 A. Yes.</p> <p>3 Q. And that is what you base your diagnosis</p> <p>4 of a --</p> <p>5 A. So, a combination -- yes. So, I think the</p> <p>6 diagnosis was made based on his history, his</p> <p>7 physical exam, and his imaging, all three.</p> <p>8 Q. Your recommendation was for him to then</p> <p>9 have the surgery that you performed as soon as</p> <p>10 possible, correct?</p> <p>11 A. Yes.</p> <p>12 Q. And, again, you said that the timeframe</p> <p>13 between February 8 and February 16 was not</p> <p>14 concerning to you in any way in terms of the</p> <p>15 timeframe?</p> <p>16 A. Eight days, no, is not concerning</p> <p>17 considering it was three months since when I saw</p> <p>18 him. So, an extra eight days does not change</p> <p>19 anything. I think you want to get to ruptures</p> <p>20 within -- the literature says less than four weeks.</p> <p>21 So, it was eight days from when I saw him, three</p> <p>22 months had already past, and I did know I was going</p> <p>23 to have to perform a reconstruction. So, no, the</p> <p>24 eight days was not concerning.</p> <p style="text-align: right;">17</p>	<p>1 Q. But when you saw him, do you remember if</p> <p>2 he had a brace on his knee?</p> <p>3 A. Let me see here. I do not know that. I'm</p> <p>4 not sure. I don't know if I indicated what he came</p> <p>5 in with, if he had come in with a knee immobilizer</p> <p>6 or not. I don't have any evidence either way. Let</p> <p>7 me see here. Yes. No, I don't think so because I</p> <p>8 put on there as a treatment option nonoperative</p> <p>9 management would include placing him in an</p> <p>10 immobilizer in extension and just trying to</p> <p>11 gradually activate the quadriceps. He would not</p> <p>12 really be able to extend his knee with his options.</p> <p>13 I can give him the option of that. So, as far as I</p> <p>14 know, I don't think he was in it at the time.</p> <p>15 Q. So, as far as you know, he was not in a</p> <p>16 knee brace at the time?</p> <p>17 A. As far as I know, yes, but I can't</p> <p>18 confer -- I have no evidence to say 100 percent</p> <p>19 that he was.</p> <p>20 Q. So, February 16 you do the surgery?</p> <p>21 A. Yes.</p> <p>22 Q. You said that you knew that you did a</p> <p>23 graft I think is what you said?</p> <p>24 A. Yes.</p> <p style="text-align: right;">19</p>
<p>1 Q. Earlier you stated that when the patellar</p> <p>2 tendon ruptures, you can't walk. So, if a general</p> <p>3 practice physician saw a patient that was</p> <p>4 complaining of some knee pain and that person could</p> <p>5 still walk, it would not automatically be something</p> <p>6 that the doctor, general practice physician, should</p> <p>7 think is a ruptured patellar tendon, correct?</p> <p>8 A. So, again, I don't know if he was braced.</p> <p>9 If he was braced, if he was placed in a knee --</p> <p>10 when something -- you can ambulate with a brace.</p> <p>11 So, if he was put in a knee immobilizer and was</p> <p>12 able to bear some weight, that is possible because</p> <p>13 it's keeping your knee straight; you don't have to</p> <p>14 rely on your knee being straight. And the biggest</p> <p>15 thing he probably couldn't do, and I don't think he</p> <p>16 could do when I saw him, which I would be shocked</p> <p>17 if he could, is actually extend his knee against</p> <p>18 resistance. That's probably the most classic</p> <p>19 hallmark of a patellar tendon rupture is inability</p> <p>20 to extend his knee which it says -- yes, he could</p> <p>21 not hold his knee extended I think is when I did</p> <p>22 it. He couldn't -- the patient could not actively</p> <p>23 extend the knee and he couldn't hold it extended,</p> <p>24 so that's the biggest thing.</p> <p style="text-align: right;">18</p>	<p>1 Q. Tell me about the surgery.</p> <p>2 A. So, the surgery involved a midline</p> <p>3 incision. Let me pull up the op report so I'm on</p> <p>4 the same page. Okay. So, the surgery -- yes, the</p> <p>5 surgery involved a midline incision, usually a few</p> <p>6 centimeters above the kneecap going down to the</p> <p>7 front of the knee. You know, with a</p> <p>8 longer-standing rupture of the patellar tendon,</p> <p>9 typically the biggest -- I think the hardest thing</p> <p>10 about it is trying to get the kneecap back down</p> <p>11 because it chronically scars and it stays scarred</p> <p>12 more proximally because it's sitting more</p> <p>13 proximally. So, I think a lot of the time that we</p> <p>14 spent doing the surgery was releasing scar. I</p> <p>15 think I ended up getting -- I did get some X-rays</p> <p>16 of the other side just to get a sense of how far</p> <p>17 down we needed to pull the kneecap down. Let's see</p> <p>18 here. Yes. So, in order to immobilize the area,</p> <p>19 we released the area, extra synovial. We did</p> <p>20 remove an area around a centimeter of scar tissue</p> <p>21 from the tendon after we had kind of released all</p> <p>22 the scar so that we could get a good fresh edge.</p> <p>23 There was a lot of scar down to the femur, and so</p> <p>24 we used -- I remember we used a big Cob elevator</p> <p style="text-align: right;">20</p>



<p>1 which is a device that could elevate the tissue. I 2 remember we had to run it up the femur in order to 3 release that kneecap and that quadriceps tendon 4 from it being scarred down to the bone. Once that 5 was done, we were able to get it to mobilize. We 6 did kind of have to hold it down, I remember that. 7 we had to hold it down with a device, a rake, in 8 order to pull the kneecap down, but we were able to 9 get it down which was good after we had done, 10 again, multiple releases. At that point, we 11 basically wove a semi-tendinosis graft which is a 12 hamstring graft from a cadaver. This cadaver graft 13 was thawed, placed on the stitches basically 14 through that tendon. And the reason we use that 15 tendon is to weave it through the patient's native 16 patellar tendon in order to, again, reconstruct his 17 patellar tendon. Because by the time we were able 18 to get the kneecap down and freshen up the patella 19 tendon, what he had left, it just wasn't as good 20 quality due to the scar tissue around it. So, once 21 we did that, we actually -- I think we ended up -- 22 yes. We put two anchors in front of the kneecap, 23 and then, we basically grafted that tendon through 24 his own patellar tendon. Let's see here. Yes. we</p> <p style="text-align: right;">21</p>	<p>1 due to the metal concerns. 2 Q. Okay. 3 A. And so I think initially the information 4 that I had received from the guards at that time 5 were that they recommended the cast because they 6 were concerned about not being able to put him in a 7 brace. It doesn't change management really that 8 much because the first two weeks before we take out 9 the staples, we leave him in -- straight anyway, we 10 leave him in extension, so it doesn't change 11 management. 12 Q. So, the decision between a cast and a 13 brace doesn't affect the long-term results of the 14 surgery? 15 A. It does not. 16 Q. Even if it did, you got that information 17 from the IDOC guards, not from Dr. James or from 18 Wexford, correct? 19 A. Yes. 20 Q. The process that you just described with 21 the grafting and all of that, how common is that 22 when you do these types of surgeries? 23 A. So, reconstructions are not that common. 24 I probably would say less than ten percent of the</p> <p style="text-align: right;">23</p>
<p>1 actually passed around 20 millimeters of the actual 2 tendon into the kneecap itself, so we actually 3 drilled a hole into the kneecap and pulled it down, 4 and then, passed the tendon through -- kind of back 5 and forth through the native patellar tendon, and 6 then, we anchored it down with two anchors. So, we 7 took the tendon, anchored it back down into two 8 anchors, which are basically screws that have 9 stitches in them, and we did that about 30 degrees 10 of flexion. And once we did that, we were able to 11 get about 70 degrees actually at the end of it. We 12 were able to get about 70 degrees of flexion 13 without really pulling a lot of tension in the 14 repair, so we were happy with our repair. We then 15 put him into -- we ended up closing the two side -- 16 the retinaculum, and then, we had to put him in a 17 cast at that time due to the concern with the knee 18 brace so we ended up putting him in a cast. And 19 that was it. 20 Q. When you say the concern with the brace, 21 what do you mean by that? 22 A. Well, that's always a different 23 conversation that I have with the guards at the 24 time on what brace we can put him in after surgery</p> <p style="text-align: right;">22</p>	<p>1 time, maybe -- yeah, less than ten percent. 2 Typically, you can repair tendon-to-tendon in most 3 circumstances acutely. 4 Q. The reason for having to do the 5 reconstruction in this case was because of the scar 6 tissue? 7 A. Timeframe and scar tissue. So, timeframe 8 from onset of injury and surgical procedure; with 9 that, becomes more scar tissue which makes it less 10 likely for a side-to-side approximation of the 11 tendon because of how much tissue we have to kind 12 of remove from that area in order to mobilize the 13 patella. 14 Q. Is there a way to tell specifically what 15 caused the scar tissue? 16 A. Time. I mean there's no -- I mean 17 that's -- scar I mean is a very normal progression 18 of how things heal. And, you know, at certain 19 timeframes you're going to get a certain amount of 20 scar tissue, and I would say scarring or -- you 21 know, inflammation or scarring is how you heal. 22 So, as the time proceeds on, you're more likely to 23 get that scar tissue there. 24 Q. So, could that scar tissue have been the</p> <p style="text-align: right;">24</p>



<p>1 result of another injury?</p> <p>2 A. Not in that area, no, because the only</p> <p>3 other injury he had was the femur fracture, and the</p> <p>4 femur fracture was more proximal to that area so</p> <p>5 it's unlikely that that were to occur.</p> <p>6 Q. But you can't rule it out?</p> <p>7 A. Yes, I couldn't -- I would never rule it</p> <p>8 in, but, yeah, anything is possible, but there's no</p> <p>9 precedent for that to form scar in the knee without</p> <p>10 directly injuring the knee. Now, on that note, if</p> <p>11 he broke his femur and he didn't really move his</p> <p>12 knee for -- since '91 and there's definitely a</p> <p>13 possibility -- not directly from the injury, but</p> <p>14 from him not moving the knee from the initial</p> <p>15 injury after the initial injury, then he could get</p> <p>16 scar tissue from that. But the scarring wasn't</p> <p>17 really in his knee as it was more the scar was</p> <p>18 because of the fact that the patella was superiorly</p> <p>19 migrated for three months because of the patellar</p> <p>20 tendon rupture.</p> <p>21 Q. I guess my question is how do you know</p> <p>22 that for sure as opposed to something else? And</p> <p>23 assume that his injury that resulted in him having</p> <p>24 the rod in his leg was a gunshot wound.</p> <p style="text-align: right;">25</p>	<p>1 Q. And you said that you were happy with the</p> <p>2 repair that you did, correct?</p> <p>3 A. Yes.</p> <p>4 Q. You considered it to be a successful</p> <p>5 surgery?</p> <p>6 A. Yes. And my judge of success was that</p> <p>7 clinically there appeared -- we were able to</p> <p>8 mobilize the patella distally. Again, it was high</p> <p>9 before we were able to bring it down, and it had</p> <p>10 good tension in the repair. Again, we were able to</p> <p>11 flex him around -- almost I think 90 degrees once</p> <p>12 we had closed the retinaculum without it looking</p> <p>13 like there was significant tension. So, almost</p> <p>14 90 degrees acutely without any healing so far,</p> <p>15 obviously, because we just fixed it. And so, you</p> <p>16 know, with that, I did feel like it was successful.</p> <p>17 Q. And 90 degrees acutely is a good outcome?</p> <p>18 A. It is.</p> <p>19 Q. That's on someone whether that person</p> <p>20 comes in with an acute injury or with a chronic</p> <p>21 injury?</p> <p>22 A. Yes.</p> <p>23 Q. The follow-up after the surgery --</p> <p>24 A. Yes.</p> <p style="text-align: right;">27</p>
<p>1 A. The reason I would say that I know that is</p> <p>2 the rod doesn't cause the patella to be superiorly</p> <p>3 migrated, and that's the problem. The scarring is</p> <p>4 not -- we don't care about the scar within the knee</p> <p>5 as much we care about the patella being superiorly</p> <p>6 migrated and us not being able to bring the patella</p> <p>7 down without releasing that scar and releasing the</p> <p>8 scar tissue around the tendon that had already</p> <p>9 formed. And so that's the scar that forms. That</p> <p>10 scar wouldn't form from a femur fracture. The</p> <p>11 scar -- there could be scar in the knee, like he</p> <p>12 could have stiffness within the joint, but scar of</p> <p>13 the patella being superiorly migrated or scar from</p> <p>14 the end of the patella tendon would not occur in a</p> <p>15 femur fracture because there's no precedent for it</p> <p>16 to occur, there's no reason for that to happen.</p> <p>17 Him having a stiff knee after a femur fracture and</p> <p>18 having, quote-unquote, scar tissue in the knee</p> <p>19 joint is definitely a possibility after a femur</p> <p>20 fracture. But having a patella that's superiorly</p> <p>21 migrated and having scar tissue around the patellar</p> <p>22 tendon does not typically occur after a femur</p> <p>23 fracture. I've never seen that occur, I've never</p> <p>24 seen it reported to occur.</p> <p style="text-align: right;">26</p>	<p>1 Q. -- did Mr. Jones follow-up as requested by</p> <p>2 you? I think your initial request was that he come</p> <p>3 back in 10 to 14 days?</p> <p>4 A. Yes. He followed up on the 29th which was</p> <p>5 13 days after surgery.</p> <p>6 Q. At that time you examined him again,</p> <p>7 correct?</p> <p>8 A. I did.</p> <p>9 Q. You thought that he was progressing as you</p> <p>10 would expect?</p> <p>11 A. I did.</p> <p>12 Q. There was nothing about that examination</p> <p>13 on the 29th that was concerning or alarming to you,</p> <p>14 correct?</p> <p>15 A. Yes.</p> <p>16 Q. That was a bad question from me.</p> <p>17 There was nothing that was concerning or</p> <p>18 alarming?</p> <p>19 MR. FLAXMAN: Was there anything?</p> <p>20 MS. BYRD: Yes.</p> <p>21 THE WITNESS: There was not anything alarming</p> <p>22 when I saw him at two weeks. His staples were</p> <p>23 removed. His wound was well-healed. He had a</p> <p>24 little bit of swelling. I did remove his staples,</p> <p style="text-align: right;">28</p>



<p>1 and I did have him see the physical therapist that</p> <p>2 day to show him some exercises.</p> <p>3 BY MS. BYRD:</p> <p>4 Q. And that happened, he saw the physical</p> <p>5 therapist, there was a recommendation of him doing</p> <p>6 exercises, correct?</p> <p>7 A. Yes.</p> <p>8 Q. Those were shown to him; he was shown what</p> <p>9 to do by the physical therapist?</p> <p>10 A. Yes.</p> <p>11 Q. And then at that time you asked, I think,</p> <p>12 for him to come back in four weeks?</p> <p>13 A. Yes.</p> <p>14 Q. And that happened as well, correct?</p> <p>15 A. Yes.</p> <p>16 Q. At the time, I think, that date was</p> <p>17 April 4 maybe?</p> <p>18 A. So, I guess in hindsight, yes, so I was</p> <p>19 trying to do my math here. So, it would have been</p> <p>20 the end -- no. I guess that was right. It just</p> <p>21 said -- yes, 2-16, it would have been 2 -- yes,</p> <p>22 that's right. That makes sense, yes, because it</p> <p>23 was 2 and then 6, okay. Yes.</p> <p>24 Q. When you saw him on April 4, he was still</p> <p style="text-align: right;">29</p>	<p>1 A. No, just stiffness.</p> <p>2 Q. So, he was progressing as you would expect</p> <p>3 him to progress at that point?</p> <p>4 A. Yes.</p> <p>5 Q. And then, I think, you recommended he come</p> <p>6 back four to six weeks after that, correct?</p> <p>7 A. Yes.</p> <p>8 Q. And that was May 9?</p> <p>9 A. Yes.</p> <p>10 Q. When you saw him on May 9, he was</p> <p>11 continuing to progress?</p> <p>12 A. He was. He had gained, I think, around 30</p> <p>13 or 40 -- he gained around 40 degrees of range of</p> <p>14 motion. He could extend against resistance again.</p> <p>15 I think at that point he was also -- both times he</p> <p>16 saw the therapist while he was here in order to</p> <p>17 work on different exercises.</p> <p>18 Q. There was nothing unusual at that May 9</p> <p>19 visit?</p> <p>20 A. There was not.</p> <p>21 Q. When you say he had gained 40 degrees, is</p> <p>22 that from the date of the surgery or from the last</p> <p>23 time you had seen him in April?</p> <p>24 A. From the last time I had seen him in</p> <p style="text-align: right;">31</p>
<p>1 doing well, is that correct?</p> <p>2 A. Yes. His range of motion was -- so, he's</p> <p>3 six to seven weeks, so his range of motion was</p> <p>4 about 50 degrees which is, you know, a little bit</p> <p>5 on the tight side, you know, but he did have an</p> <p>6 intact extensor mechanism at that point so he was</p> <p>7 able to straighten his knee against resistance</p> <p>8 even. But he was very tight, and that</p> <p>9 unfortunately is a little bit part of the protocol</p> <p>10 or part of the -- not protocol, but part of the</p> <p>11 problem sometimes with extensor reconstructions.</p> <p>12 We're a little slower with rehab and they can get</p> <p>13 tighter. He also was doing therapy on his own.</p> <p>14 The difference unfortunately with, you know, some</p> <p>15 patients in the jail system versus a patient that</p> <p>16 is not in the jail system is access to therapy, and</p> <p>17 he did not have -- generally, the patients in these</p> <p>18 protocols will have therapy two times a week at</p> <p>19 least and they will be doing it on their own the</p> <p>20 other four to five days. He didn't have that</p> <p>21 access. He was doing only therapy on his own, so</p> <p>22 that also makes him more likely to be tight.</p> <p>23 Q. Other than that, there was nothing unusual</p> <p>24 at that April 4 visit that you noted?</p> <p style="text-align: right;">30</p>	<p>1 April.</p> <p>2 Q. So, if I understand you correctly, he had</p> <p>3 50 degrees range of motion when you saw him in</p> <p>4 April, and then, by May it would have been</p> <p>5 90 degrees?</p> <p>6 A. Yes.</p> <p>7 Q. After May 9, you did not see him again,</p> <p>8 correct?</p> <p>9 A. That is correct.</p> <p>10 Q. You don't have any reason to know about</p> <p>11 the care that he received after May 9, correct?</p> <p>12 A. The only thing that I did see is that I</p> <p>13 think he wanted to transfer care because, as far as</p> <p>14 I know -- and this, again -- I'm assuming that he</p> <p>15 was released from prison because I did get a</p> <p>16 correspondence from my assistant in July, it looks</p> <p>17 like July 5, 2016, that he wanted to -- yes, he</p> <p>18 said reason for calling, Johnny Jones refer ortho</p> <p>19 in Chicago. So, I had recommended Rush downtown,</p> <p>20 and my assistant had written a note from 7-7 spoke</p> <p>21 to patient, referred to Rush, patient is happy and</p> <p>22 understands this plan. And then it says here</p> <p>23 instructed to call Rush to schedule transfer of</p> <p>24 care. Patient states he will call back if there's</p> <p style="text-align: right;">32</p>



<p>1 any issues. So, that's the last correspondence</p> <p>2 that I have.</p> <p>3 Q. That was nearly two months after the last</p> <p>4 time you saw him, correct?</p> <p>5 A. Yes.</p> <p>6 Q. Your recommendation on April 9 is that you</p> <p>7 see him in four to six weeks, correct?</p> <p>8 MR. FLAXMAN: April 9 or May 9?</p> <p>9 THE WITNESS: May 9, yes.</p> <p>10 MS. BYRD: Every time I say April 9, we'll</p> <p>11 assume I mean May 9.</p> <p>12 THE WITNESS: Yes.</p> <p>13 BY MS. BYRD:</p> <p>14 Q. You did not see him in that four- to</p> <p>15 six-week period, correct?</p> <p>16 A. I did not.</p> <p>17 Q. Other than he called for a referral, you</p> <p>18 don't know anything about his care after May 9,</p> <p>19 2016, correct?</p> <p>20 A. I do not.</p> <p>21 Q. When you last saw Mr. Jones on May 9,</p> <p>22 2016, was there any expectation on your part that</p> <p>23 he would need to have further surgery?</p> <p>24 A. There was no expectation, no.</p> <p style="text-align: right;">33</p>	<p>1 that time that made you think that he was going to</p> <p>2 fall into that camp?</p> <p>3 A. I mean at that point at three months in my</p> <p>4 opinion, it's too early to do that. I would not</p> <p>5 recommend any sort of manipulation or lysis of</p> <p>6 adhesions at three months. That was the last time</p> <p>7 I saw him.</p> <p>8 Q. Okay.</p> <p>9 A. So, you know, I've -- again, in my</p> <p>10 experience, I've had multiple patients be maybe</p> <p>11 not -- you know, I've had patients that tight at</p> <p>12 three months, and in four months and five months</p> <p>13 they get full motion. So, I would still recommend</p> <p>14 at that stage to not perform a repeat surgery -- or</p> <p>15 not a repeat, an additional surgery until more time</p> <p>16 had past.</p> <p>17 Q. When you see people who are that tight at</p> <p>18 three months and by five months they have full</p> <p>19 range of motion, what steps do those patients take</p> <p>20 in that timeframe to reach that?</p> <p>21 A. So, typically I'll put patients on either</p> <p>22 some sort of antiinflammatory, so a steroid, oral</p> <p>23 steroids, I'll put patients on NSAIDs, and then,</p> <p>24 they will be in very vigorous, dedicated physical</p> <p style="text-align: right;">35</p>
<p>1 Q. Did you have any indication that he would</p> <p>2 need further surgery?</p> <p>3 A. I didn't have any expectation that he</p> <p>4 would need further surgery. In these circumstances</p> <p>5 when patients are very tight after surgery or</p> <p>6 still -- there's a tightness, especially with</p> <p>7 flexion, there is always a risk of needing an</p> <p>8 additional surgery which would include a</p> <p>9 manipulation under anesthesia and occasionally a</p> <p>10 lysis of scar tissue or lysis of adhesions</p> <p>11 arthroscopically. I have had one instance of a</p> <p>12 quadriceps repair where I had to do that where the</p> <p>13 patient was very tight even six or nine months</p> <p>14 after surgery and we did perform that. So, that's</p> <p>15 the -- when I talk about risks of surgery with the</p> <p>16 patient, stiffness is, of course, one of them,</p> <p>17 especially on a reconstruction. And that is a</p> <p>18 possible additional surgery that the patient may</p> <p>19 need if they're tight. The other possibility is if</p> <p>20 the patient re-ruptures and they need a repeat</p> <p>21 surgery. Those are the two possible surgeries</p> <p>22 afterwards, but that's variable depending on how</p> <p>23 the patient does afterwards.</p> <p>24 Q. There was nothing that you observed at</p> <p style="text-align: right;">34</p>	<p>1 therapy. So, they are getting therapy a few days a</p> <p>2 week with a therapist, and then, multiple days a</p> <p>3 week by themselves gradually every day trying to</p> <p>4 get a little bit more range of motion and breaking</p> <p>5 up scar tissue.</p> <p>6 Q. If someone is not doing physical therapy</p> <p>7 in that timeframe, would you expect there to be any</p> <p>8 improvement in their tightness?</p> <p>9 A. So, I think that it depends on how</p> <p>10 motivated patients are doing therapy by themselves,</p> <p>11 but if they are not doing therapy by themselves --</p> <p>12 even if they are, I still think it's difficult to</p> <p>13 gain more motion without an individual getting any</p> <p>14 sort of assistance with that in terms of getting</p> <p>15 the knee bent back farther and farther with</p> <p>16 assistance.</p> <p>17 Q. Have you operated on other patients where</p> <p>18 it's been three months between the injury and the</p> <p>19 surgery?</p> <p>20 A. The longest, I think, would be a month.</p> <p>21 The longest would be a month for what I've seen.</p> <p>22 Yes, I would say a month is the longest. Never --</p> <p>23 I have not seen a three-month -- he would probably</p> <p>24 be my only patient with three months in-between</p> <p style="text-align: right;">36</p>



<p>1 time from injury to time to surgery.</p> <p>2 Q. The one time, that was a month?</p> <p>3 A. Yes.</p> <p>4 Q. What did you observe in that patient?</p> <p>5 A. That patient, it was a quad rupture so it</p> <p>6 was a little bit different, it wasn't a patellar</p> <p>7 tendon rupture, it was a quad rupture, but it was</p> <p>8 the same mechanistically thing. And the patient</p> <p>9 really couldn't walk for almost three weeks but</p> <p>10 felt that he may have just strained his quad and</p> <p>11 was essentially hobbling during that timeframe</p> <p>12 before he came in and saw me. So, you know, the</p> <p>13 repair itself -- he was actually the one patient</p> <p>14 that I did end up having to perform a manipulation</p> <p>15 under and a lysis of adhesions. So, he was the one</p> <p>16 that got tighter because I think, in my opinion,</p> <p>17 the longer he had not been mobilizing his knee, the</p> <p>18 rehab was a little bit slower with him, and he was</p> <p>19 more likely to get tight after surgery. And so I</p> <p>20 did have to manipulate -- and he had really good</p> <p>21 therapy, but I did have to manipulate him. And I</p> <p>22 did, and I think at nine months I had to perform a</p> <p>23 manipulation and an arthroscopic lysis of adhesions</p> <p>24 and he gained another 15 to 20 degrees. So, he had</p> <p style="text-align: right;">37</p>	<p>1 knee. You may have some weakness in extension, so</p> <p>2 you may not have the same strength you have in your</p> <p>3 other knee, and then, you have stiffness with range</p> <p>4 of motion. Those are the biggest risks. That</p> <p>5 being said, I would say that 90 percent of patients</p> <p>6 gain full extension. And the majority of patients,</p> <p>7 I don't know the exact percentage on this, are</p> <p>8 close in terms of strength to their other side. If</p> <p>9 you do an isometric test, they're probably not</p> <p>10 quite there on their other side, but they're close.</p> <p>11 It's not as perceptible to the patient. You could</p> <p>12 lose though up to 10 to 15 degrees of flexion</p> <p>13 compared to your other side, but, again, that's</p> <p>14 a -- I don't know what the -- to be honest, I don't</p> <p>15 know the exact numbers on the most recent study on</p> <p>16 what the comparison are. And there's so many</p> <p>17 variables from time of surgery to type of repair to</p> <p>18 rehab type to tissue quality to otherwise mobility.</p> <p>19 So, there's just so many variables that I don't</p> <p>20 know if they have exact numbers on that.</p> <p>21 MS. BYRD: Give me one minute. That might be</p> <p>22 all I have.</p> <p>23 THE WITNESS: Okay.</p> <p>24</p> <p style="text-align: right;">39</p>
<p>1 good strength, but was tight.</p> <p>2 Q. Would you agree that the therapy is a</p> <p>3 really important part of recovering from this kind</p> <p>4 of surgery?</p> <p>5 A. It's crucial, yes.</p> <p>6 Q. And that's whether you're doing it on your</p> <p>7 own or doing it with a professional?</p> <p>8 A. Yes.</p> <p>9 Q. How often would you say that someone needs</p> <p>10 to do physical therapy to successfully recover?</p> <p>11 A. Their usual recommendation is two to three</p> <p>12 times a week. There's no literature or science to</p> <p>13 say what's the exact number, but typically that</p> <p>14 timeframe allows the patient to do exercises on</p> <p>15 their own but have a feedback in enough of a timely</p> <p>16 manner so that they can modify or adjust what</p> <p>17 therapy exercises they are doing and how aggressive</p> <p>18 they're doing it. It also allows the therapist to</p> <p>19 contact me if there's a problem.</p> <p>20 Q. With regular therapy, do you see great</p> <p>21 success from these surgeries?</p> <p>22 A. Yes. I would say that the biggest risk we</p> <p>23 tell every patient is that you'll have an extensor</p> <p>24 lag meaning you won't be able to fully extend your</p> <p style="text-align: right;">38</p>	<p>1 BY MS BYRD:</p> <p>2 Q. Is it accurate for me to say that you</p> <p>3 would have needed the MRI before you knew what</p> <p>4 specifically had happened with Mr. Jones' knee?</p> <p>5 A. I think it's confirmatory. I don't -- and</p> <p>6 I do it for every quadriceps and patellar tendon</p> <p>7 patient because I think it allows me to see where</p> <p>8 the tear -- it's good for surgical planning. Is it</p> <p>9 ultimately crucial for diagnosis? I believe that</p> <p>10 the physical -- the history, physical exam, and</p> <p>11 X-rays are enough, but the MRI is a very important</p> <p>12 aid in surgical planning and it can be confirmatory</p> <p>13 for the diagnosis.</p> <p>14 Q. When you say the physical exam, what would</p> <p>15 the appropriate physical exam be?</p> <p>16 A. So, a palpable defect -- well, physical</p> <p>17 exam. No. 1, it would be weakness in extension,</p> <p>18 inability to extend the knee, especially against</p> <p>19 resistance, especially against gravity; a palpable</p> <p>20 defect at the inferior aspect of the patella; a</p> <p>21 patella that is superiorly migrated. Looking for</p> <p>22 other possible diagnoses to rule out, so a palpable</p> <p>23 quadriceps tendon so you could feel the quadriceps</p> <p>24 tendon, no instability in other ligaments so</p> <p style="text-align: right;">40</p>



<p>1 varus-valgus, ACL is okay, PCL is okay. Those 2 probably would be the biggest thing on physical 3 exam. And then diagnostic imaging, being able to 4 evaluate the height of the patella and a patella 5 that is superiorly migrated on X-ray, especially 6 with the -- I think I measured iso valve ratio, 7 those are all helpful in diagnosing a patella 8 tendon rupture.</p> <p>9 Q. Would you expect swelling on a patella 10 tendon rupture?</p> <p>11 A. I would expect a large effusion, yes.</p> <p>12 Q. What about pain, what would you expect?</p> <p>13 A. I would expect an immediate pain right 14 after the injury and continual pain. If the knee 15 is placed in -- again, in extension and it's not 16 stressed, then the pain may decrease. But, yes, 17 immediate pain, immediate swelling. There's a 18 large, bloody effusion. The patients will get a 19 large -- basically an accumulation of blood when 20 the tendon ruptures.</p> <p>21 Q. If a patient presented with mild pain, no 22 swelling, and the X-ray came back saying that the 23 patella was slightly high-riding, would that 24 automatically trigger to you that it's a patellar</p> <p style="text-align: right;">41</p>	<p>1 50 degrees of flexion, the patient if you were to 2 take a straight line from straight to where it 3 bends is about 50 degrees. Typically, patients 4 can -- or normal people, I guess, can flex anywhere 5 from 130 degrees to 140 degrees. You always 6 compare it -- well, typically I'll compare it to 7 the other side as a baseline, but that's what we 8 talk about when we talk about range of motion.</p> <p>9 Q. Is the type of injury that you saw in 10 Mr. Jones a career-ending injury for a basketball 11 player?</p> <p>12 A. It is -- it can be. There are guys that 13 have been able to return to playing. There's a few 14 guys even in the NBA who have returned to playing. 15 There's -- I have seen it in the NFL. I took care 16 of an NFL team, I've seen guys return to the NFL, 17 but it is a bad injury. It can be a career-ending 18 injury.</p> <p>19 Q. In the beginning of the deposition when 20 you were talking about that physical therapy seems 21 to have gotten easier -- there's more access to it 22 in the prison now than there was when you first 23 started. Could you explain what you meant by that, 24 if I heard it correctly?</p> <p style="text-align: right;">43</p>
<p>1 tendon rupture?</p> <p>2 A. If I was given that history, that would 3 not be the expectation, no.</p> <p>4 MS. BYRD: I think that's all I have.</p> <p>5 EXAMINATION</p> <p>6 BY MR. FLAXMAN:</p> <p>7 Q. Could you explain to us what you meant by 8 range of motion?</p> <p>9 A. So, range of motion refers to the ability 10 to -- for the patient to bend and straighten the 11 knee. It's measured -- at least I measure it in 12 three numbers; the first number is how much they 13 can extend. So, typically if patients can extend 14 to neutral, it's zero. If they can higher extend, 15 you add whatever that degree of hyperextension is, 16 so one, two, three. Typically, patients are 17 anywhere from zero, so ability to fully extend 18 which is zero degrees to upwards of five if they 19 have hyperlaxity. The second number is typically 20 zero. It's typically if they can extend to zero, 21 if they can extend to zero or past zero, it's zero. 22 And then the third number is the ability to flex 23 the knee. So, you measure it from straight, we see 24 how much they can flex. So, we talk about</p> <p style="text-align: right;">42</p>	<p>1 A. Yes. At least there was -- recently I 2 performed an ACL reconstruction on a patient, and I 3 was told by that inmate and patient that there was 4 access to a therapist on-site that was able to do 5 more consistent therapy with the patient.</p> <p>6 Q. As far as you know, was there a physical 7 therapist available to Mr. Jones back in 2016?</p> <p>8 A. No, not that I know of.</p> <p>9 MR. FLAXMAN: I have nothing further.</p> <p>10 MS. BYRD: I think just two quick questions.</p> <p>11 FURTHER EXAMINATION</p> <p>12 BY MS. BYRD:</p> <p>13 Q. The patient that you just talked about who 14 said they had physical therapy available on-site, 15 what prison was that person in?</p> <p>16 A. As far as I know, it was Stateville 17 prison, yes.</p> <p>18 Q. You talked about range of motion. In your 19 notes, you also have strength, you measure strength 20 in here?</p> <p>21 A. Yes.</p> <p>22 Q. And you say that Mr. Jones has strength of 23 five of five with extensor hallucis longus?</p> <p>24 A. Yes.</p> <p style="text-align: right;">44</p>



<p>1 Q. Did I get that?</p> <p>2 A. Yes.</p> <p>3 Q. What does that mean?</p> <p>4 A. So, that really refers to his</p> <p>5 neurovascular status. And typically with an</p> <p>6 extensor tendon repair, we don't necessarily -- the</p> <p>7 nerves are very unlikely to get injured, but</p> <p>8 there's always a chance of them getting injured.</p> <p>9 So, the extensor hallucis longus refers to the big</p> <p>10 toe basically, and what nerve that refers to is the</p> <p>11 peritoneal nerve. So, I check all of their distal</p> <p>12 or all of my patients' distal extremities to make</p> <p>13 sure that everything distally is okay. So, the big</p> <p>14 toe is the extensor hallucis longus or EHL, and</p> <p>15 that just means that he's neurovascularly intact.</p> <p>16 I think there was an area that I had written, also,</p> <p>17 that he had five out of five strength against</p> <p>18 resistance as well which would have been, I think,</p> <p>19 the last time I saw him. Let me see here. I did</p> <p>20 put that he had good extensor strength.</p> <p>21 Q. Yes.</p> <p>22 A. Yes. So, I think I wrote in his last note</p> <p>23 on May 9, I said patient can extend against</p> <p>24 resistance with five out five strength. So, I</p> <p style="text-align: right;">45</p>	<p>1 you can trust that it was written down correctly</p> <p>2 and waive your signature.</p> <p>3 THE WITNESS: Where does it get sent to? It</p> <p>4 gets sent to me directly to my e-mail or where does</p> <p>5 it get sent to?</p> <p>6 (Whereupon, the record was</p> <p>7 read as requested.)</p> <p>8 THE WITNESS: I think it's fine. You can</p> <p>9 waive.</p> <p>10 (Whereupon, the deposition</p> <p>11 concluded at 3:20 o'clock p.m.)</p> <p style="text-align: right;">47</p>
<p>1 think he had good strength against resistance.</p> <p>2 Q. So, that means that you had to put his leg</p> <p>3 out and you pushed down on it or what does that</p> <p>4 mean?</p> <p>5 A. Yes. So, that means that he was able to</p> <p>6 extend his leg against me pushing against it.</p> <p>7 Q. When you say five out of five, that's as</p> <p>8 good as --</p> <p>9 A. Yes. That would imply in my opinion --</p> <p>10 it's a subjective measure, there's no objectivity</p> <p>11 to it. But as a subjective measure, he was able to</p> <p>12 extend against resistance which makes, again, from</p> <p>13 a physical exam finding that he has an intact</p> <p>14 extensor mechanism.</p> <p>15 Q. Which is what you would expect after a</p> <p>16 successful surgery?</p> <p>17 A. Yes.</p> <p>18 MS. BYRD: I think that's all I have.</p> <p>19 MR. FLAXMAN: Signature?</p> <p>20 MS. BYRD: We can send you a copy of the</p> <p>21 transcript so you can review it and make sure that</p> <p>22 what you said is what was written down.</p> <p>23 THE WITNESS: Sure.</p> <p>24 MS. BYRD: You can't change your answers. Or</p> <p style="text-align: right;">46</p>	<p>1 STATE OF ILLINOIS)</p> <p>2) SS:</p> <p>3 COUNTY OF COOK)</p> <p>4 I, CHRISTINE M. PINA, do hereby certify</p> <p>5 that heretofore, to-wit, on July 12, 2019</p> <p>6 personally appeared before me, at 1310 N. Main</p> <p>7 Street, Sandwich, Illinois, DR. ANKHUR BEHL, in a</p> <p>8 cause now pending and undetermined in the United</p> <p>9 States District Court, Northern District of</p> <p>10 Illinois, wherein JOHNNY JONES is the Plaintiff,</p> <p>11 and WEXFORD HEALTH SOURCES, INC. and DR. MARSHALL</p> <p>12 JAMES are the Defendants.</p> <p>13 I further certify that the said DR. ANKHUR</p> <p>14 BEHL was first duly sworn to testify the truth, the</p> <p>15 whole truth and nothing but the truth in the cause</p> <p>16 aforesaid; that the testimony then given by said</p> <p>17 witness was reported stenographically by me in the</p> <p>18 presence of the said witness, and afterwards</p> <p>19 reduced to typewriting by Computer-Aided</p> <p>20 Transcription, and the foregoing is a true and</p> <p>21 correct transcript of the testimony so given by</p> <p>22 said witness as aforesaid.</p> <p>23 I further certify that the signature to</p> <p>24 the foregoing deposition was waived by counsel for</p> <p style="text-align: right;">48</p>



1 the respective parties.

2 I further certify that the taking of this
3 deposition was pursuant to subpoena and that there
4 were present at the deposition the attorneys
5 hereinbefore mentioned.

6 I further certify that I am not counsel
7 for nor in any way related to the parties to this
8 suit, nor am I in any way interested in the outcome
9 thereof.

10

11 IN TESTIMONY WHEREOF: I have hereunto set
12 my hand this 1st day of August, 2019.

13

14

15

Christine M. Rina

16

CERTIFIED SHORTHAND REPORTER

17

LICENSE NO. 084-003785

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