EXHIBIT D

IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

JOHNNY JONES,)
Plaintiff,)
vs.) Case No. 17 CV 8218
WEXFORD HEALTH SOURCES,)
INC. and DR. MARSHALL)
JAMES,)
Defendants.)

The deposition of DR. ANKHUR BEHL, called for examination pursuant to the Rules of Civil Procedure for the United States District Courts pertaining to the taking of depositions, taken before CHRISTINE M. PINA, a Certified Shorthand Reporter within and for the County of Cook and State of Illinois, at 1310 N. Main Street, Sandwich, Illinois, on July 12, 2019 at the hour of 2:25 o'clock p.m.

Reported by: CHRISTINE M. PINA, CSR, RPR
License No.: 084-003785

APPEARANCES:

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I N D E X

E X H I B I T S

NUMBER	MARKED FOR ID

NO EXHIBITS MARKED BY REPORTER

(Whereupon, the witness was duly sworn.)

MS. BYRD: Dr. Behl, I know I introduced myself before we went on the record, but my name is Sandy Byrd, and I am an attorney from Cassiday Schade --

THE WITNESS: Okay.

MS. BYRD: -- and we represent Wexford Health Sources, we represent Dr. James in this matter, okay?

THE WITNESS: Okay.

MS. BYRD: I'm assuming you've given a deposition before?

THE WITNESS: Yes.

MS. BYRD: And you know the rules then of making sure all of your answers are outloud?

THE WITNESS: Written, yes, or said, yes. Okay.

MS. BYRD: And that you'll wait for me to finish my question before you answer, and I will try and wait for you to finish your answer before I start my next question. If there's anything you have a question about, let me know, but you understand all the rules upfront?

THE WITNESS: Yes.

DR. ANKHUR BEHL,

having been first duly sworn, was examined and testified as follows:

EXAMINATION

BY MS. BYRD:

Q. What is your education, Doctor?

A. So, I did my undergraduate at the University of Oklahoma, did my medical school at the University of Oklahoma. I trained in orthopedic surgery, five years in Fort Worth at Fort Worth Affiliated Hospitals. I did a year of fellowship in sports medicine in Indiana University, I'm sports medicine trained, and I've been in practice here for the last -- this is going to be my sixth year.

Q. When you were -- I went to IU, so I have to ask IU questions. Were you in Bloomington or Indianapolis?

A. Indianapolis, yes.

Q. Your practice here is all orthopaedics?

A. It's orthopedic, yes. So, I have a general practice that's probably more catered towards sports medicine which is arthroscopies,

sports-related injuries, ligaments, tendons, you know, those are kind of my primary. The other 50 percent which is, again, more tailored towards sports. But I do a lot of general practice stuff as well, so total knees, fractures including anywhere from your bread-butter wrist-forearm, femur fractures, tibia fractures, ankle fractures.

Q. The case that we're here, Mr. Jones, he was an inmate at Sheridan?

A. Yes.

Q. How many inmates do you deal with here? Do you get a lot of inmates from --

A. I do. I get inmates from Wexford, I get inmates from Stateville, so both. I've probably operated on, what's a good estimate here, I would say maybe 15 inmates. I've probably seen 10 more than that, so maybe 25 inmates I would say from both facilities.

Q. That's over the last five or --

A. Five years, yes.

Q. The inmates that you treat when they come to your practice, they come obviously with guards, correct?

A. Yes.

Q. How familiar are you with the prison system and the medical care within the prison system?

A. So, you know, I would say I've gotten different experiences from different patients. It seems that the last few patients have more access to physical therapy on-site. You know, I know that there is a process for -- because most of the time the patients they send me are acute injuries, and so a lot of those patients do need surgical intervention. And so the process for getting that surgery approved seems to be more streamline, but, again, you know, I assume that they go through a general practice doctor there who decides that they need more subspecialty care and that's how I get the referrals.

Q. In your experience with that, you said it seems like things are more streamlined now. Are you getting that information from your conversations with the inmates or in your experience with dealing with getting the surgeries scheduled, et cetera?

A. In my experience with getting the surgery scheduled.

Q. So, you're not basing that opinion off of what you're told by the inmates?

A. I am not.

Q. The surgery we're dealing with here was a patella rupture, right?

A. Yes.

Q. How many of those surgeries have you done on inmates?

A. On inmates? Probably not very many. I would say less than five, yes.

Q. The ones that you have done on inmates, how quickly after the injury have you seen the inmate?

A. Typically within -- like any of those -- I mean not only inmates, but I guess typically with these injuries, I see them in the next -- in a few weeks, within a few weeks due to the fact that the patellar tendon is -- when you rupture your patellar tendon or you rupture your quad tendon, anywhere in your extensor mechanism that you rupture, you can't really walk with it very well because you have to be able to extend your knee to ambulate. And so most of the time patients are coming in quite early in the process just because

they can't walk.

Q. Is that always the case with a ruptured patellar tendon that you can't walk?

A. You can't walk well without a brace. That is always, yes. I mean there's -- without a patellar tendon, you can't extend your knee or without a -- well, without an intact patellar tendon, you can't extend your knee. And so if you can't extend your knee, you're going to be unstable. With a brace, you could get away with probably walking without a patellar tendon -- an intact patellar tendon. You're always going to have a patellar tendon, but an intact patellar tendon.

Q. So, someone who ruptures their patellar tendon, tell me exactly what that means. Does it detach, what does that mean?

A. Sure. So, the whole extensor mechanism -- so, the ability for you to straighten your knee which is the crucial component to walking, to holding yourself up as you take -- as a normal gait involves the quadriceps, the patella, the kneecap, the patella tendon, and the tibia tubercle where it attaches. So, any break in that mechanism being a

quadriceps tear, a patella fracture, a patella tendon rupture, or a fracture from the tibia will not allow you to extend your knee and allow you to have a normal gait. A patellar tendon rupture can refer to tearing the patella tendon in -- anywhere from the very top of it, so where it's torn from the top of the -- or the bottom of the patella to the midsubstance to it being torn right off the bone. Typically, these things when they rupture, they rupture to a point where there's not a good -- they rupture a lot of times midsubstance, so they rupture right in the middle. And they're not torn cleanly, they're torn severely on both sides. So, it's almost like a -- you would say almost like a mop end on both sides rather than a clean cut that you would imagine the way they tear. They're usually degenerative. They usually have some sort of tendinopathy involved in it because they're usually diseased. They typically occur under 40-year old patients opposed to quadriceps tendon ruptures that usually occur over 40, but I've seen both occur in both age groups.

Q. You said that they're usually degenerative?

A. So, what I mean -- I guess I would clarify that. I think there's usually disease within the tendon -- there's preexisting disease within the tendon for them to rupture. They don't -- you won't get a completely normal tendon before they rupture, but it does take a -- it takes a load for it to happen. Even if they have disease, they could have patellar -- just like Achilles tendonitis or other tendinopathies, they're quite frequent, it's only based on the mechanism. Eccentric -- usually it tears when there's an eccentric load to the tendon meaning that usually the knee is going the opposite direction that the quadriceps or patella tendon is supposed to go. So, usually the function of the extensor mechanism is to extend the leg so it's to straighten the leg. So, instead of doing that, the leg goes into a more bent position but it's still contracting, and that's where the most force is placed on the patella tendon.

Q. So, when you say the disease within the tendon, what do you mean?

A. So that there is I would call it more like tendinopathy, so there's inflammation within the

tendon. With inflammation, there may be partial intrasubstance tearing. You won't ever know about it. Patients may or may not ever complain about knee pain. It may just be inherent within the tendon itself.

Q. What causes that? What causes the --

A. So that -- you know, it's a variable. It's activity level. Sometimes you can -- if there's a genetic component to it, athletic activity. It can happen from, you know, overuse. It's very common -- I see it very commonly in patellar tendinopathy in basketball players, volleyball players. In athletic patients, you'll see that.

Q. Would someone having a rod in their femur, would that affect their --

A. The rod in the femur, there's no direct correlation between having a broken leg and a patellar tendon rupture; there's no direct correlation between the two. The only direct -- now, I don't remember if his was retrograde or antegrade. Let me see here. I have to look back and see what --

Q. Generally, before we --

A. It makes a difference, and the reason I say that is if the rod was placed from the hip, then there's no direct communication. If the rod was placed through the knee, then you do make a midline incision in the tendon so you can weaken it. I don't remember -- as far as I remember, I think his rod went the other direction. So, let me see. Femur fracture. Let me see. It will probably have it here. I wrote status post intramedullary nailing. I don't know if I wrote which way it was going. As far as I remember, I think it is -- his femur was fixed from the hip rather than from the knee. And I think, yeah, when he got it done in '91 is what I think I was reading -- yes. When he got it done in '91, we didn't do retrograde nails. So, that doesn't have a direct correlation.

Q. Retrograde meaning the one that is coming through --

A. Through the knee, yes. And you actually split the tendon, so there would be some relationship there. I've never seen it weaken, but you could theoretically say that it could weaken it, but not through the hip because it's the other

direction.

Q. I know you said you've done probably fewer than five surgeries on these inmates. Overall, how many have you done?

A. Probably 30 to 40. 30 to 40.

Q. Do you have independent recall of Mr. Jones?

A. I remember his clinical picture. I remember the timeframe from when he came in. I remember the surgery because of the timeframe from when the surgery occurred to when I operated on him. I remember the way I fixed it in terms of using the graft to do a reconstruction rather than a repair primarily. I don't remember, obviously, every visit, and I don't remember the last -- I did look back and review the last time that I saw him and how many times I saw him, to be honest, and kind of what his last rehab day was.

Q. You said there was a time between when you saw him and when the surgery --

A. The biggest timeframe is when the injury and when I saw him, yes.

Q. What is your understanding of that timeframe?

A. So, I have -- I remember it was at least a few months. And I'm looking back at my note. The injury occurred -- appeared to be November of 2015, and then, his first -- my first visit with him was February 8, 2016, so approximately three months.

Q. From November until February 8, 2016, you don't have any independent knowledge of the care that he received or anything else, correct?

A. I do not.

Q. You saw him on February 8, 2016 for the first time and then did the surgery on February 16, 2016, is that correct?

A. Let me check. Yes.

Q. And that timeframe from February 8 to February 16, is that a typical timeframe from the time you see a patient with this type of an injury until you do the surgery?

A. Yes, eight days. I don't remember if we had to get his MRI at the time or did he come with an MRI? So, that would be the question. It may have been a -- let me see here. The question I have is did we end up getting an MRI on him or just we basically knew the diagnosis. So, I will still occasionally get an MRI in those circumstances just

to see what the quality of the tendon is, where the tendon is torn. I'm just trying to see if I ended up getting -- oh, you know, he may have had an MRI that was -- he may have come with an MRI because I don't see -- it says here I did evaluate him on 2-8-16 at which point it was seen on X-ray, MRI, and exam that he had tore his patellar tendon. So, I think I did have an MRI, but it was brought with the patient.

Q. So, I can represent to you that he had an MRI in January of 2016.

A. Okay. Does it say if it was on a disk or hard copy? Because I don't see a disk or anything. Let me see if I have the report or anything in here because that I do not remember on what --

Q. I'm not sure if we do.

A. Here's radiology. Here we go.

Q. Do you have it?

A. Let's see here. It says comparison MRI of the left knee, so they had it somewhere. Here we go, MRI of the left knee. I do have the copy. 1-18-16, yes.

Q. So, you would have reviewed that --

A. Yes.

Q. -- at the time you met with Mr. Jones?
A. Yes.
Q. And that is what you base your diagnosis of a --
A. So, a combination -- yes. So, I think the diagnosis was made based on his history, his physical exam, and his imaging, all three.
Q. Your recommendation was for him to then have the surgery that you performed as soon as possible, correct?
A. Yes.
Q. And, again, you said that the timeframe between February 8 and February 16 was not concerning to you in any way in terms of the timeframe?
A. Eight days, no, is not concerning considering it was three months since when I saw him. So, an extra eight days does not change anything. I think you want to get to ruptures within -- the literature says less than four weeks. So, it was eight days from when I saw him, three months had already past, and I did know I was going to have to perform a reconstruction. So, no, the eight days was not concerning.

Q. Earlier you stated that when the patellar tendon ruptures, you can't walk. So, if a general practice physician saw a patient that was complaining of some knee pain and that person could still walk, it would not automatically be something that the doctor, general practice physician, should think is a ruptured patellar tendon, correct?
A. So, again, I don't know if he was braced. If he was braced, if he was placed in a knee -- when something -- you can ambulate with a brace. So, if he was put in a knee immobilizer and was able to bear some weight, that is possible because it's keeping your knee straight; you don't have to rely on your knee being straight. And the biggest thing he probably couldn't do, and I don't think he could do when I saw him, which I would be shocked if he could, is actually extend his knee against resistance. That's probably the most classic hallmark of a patellar tendon rupture is inability to extend his knee which it says -- yes, he could not hold his knee extended I think is when I did it. He couldn't -- the patient could not actively extend the knee and he couldn't hold it extended, so that's the biggest thing.

Q. But when you saw him, do you remember if he had a brace on his knee?
A. Let me see here. I do not know that. I'm not sure. I don't know if I indicated what he came in with, if he had come in with a knee immobilizer or not. I don't have any evidence either way. Let me see here. Yes. No, I don't think so because I put on there as a treatment option nonoperative management would include placing him in an immobilizer in extension and just trying to gradually activate the quadriceps. He would not really be able to extend his knee with his options. I can give him the option of that. So, as far as I know, I don't think he was in it at the time.
Q. So, as far as you know, he was not in a knee brace at the time?
A. As far as I know, yes, but I can't confer -- I have no evidence to say 100 percent that he was.
Q. So, February 16 you do the surgery?
A. Yes.
Q. You said that you knew that you did a graft I think is what you said?
A. Yes.

Q. Tell me about the surgery.
A. So, the surgery involved a midline incision. Let me pull up the op report so I'm on the same page. Okay. So, the surgery -- yes, the surgery involved a midline incision, usually a few centimeters above the kneecap going down to the front of the knee. You know, with a longer-standing rupture of the patellar tendon, typically the biggest -- I think the hardest thing about it is trying to get the kneecap back down because it chronically scars and it stays scarred more proximally because it's sitting more proximally. So, I think a lot of the time that we spent doing the surgery was releasing scar. I think I ended up getting -- I did get some X-rays of the other side just to get a sense of how far down we needed to pull the kneecap down. Let's see here. Yes. So, in order to immobilize the area, we released the area, extra synovial. We did remove an area around a centimeter of scar tissue from the tendon after we had kind of released all the scar so that we could get a good fresh edge. There was a lot of scar down to the femur, and so we used -- I remember we used a big Cob elevator

which is a device that could elevate the tissue. I remember we had to run it up the femur in order to release that kneecap and that quadriceps tendon from it being scarred down to the bone. Once that was done, we were able to get it to mobilize. We did kind of have to hold it down, I remember that. We had to hold it down with a device, a rake, in order to pull the kneecap down, but we were able to get it down which was good after we had done, again, multiple releases. At that point, we basically wove a semi-tendinosis graft which is a hamstring graft from a cadaver. This cadaver graft was thawed, placed on the stitches basically through that tendon. And the reason we use that tendon is to weave it through the patient's native patellar tendon in order to, again, reconstruct his patellar tendon. Because by the time we were able to get the kneecap down and freshen up the patella tendon, what he had left, it just wasn't as good quality due to the scar tissue around it. So, once we did that, we actually -- I think we ended up -- yes. We put two anchors in front of the kneecap, and then, we basically grafted that tendon through his own patellar tendon. Let's see here. Yes. We

due to the metal concerns.

Q. Okay.

A. And so I think initially the information that I had received from the guards at that time were that they recommended the cast because they were concerned about not being able to put him in a brace. It doesn't change management really that much because the first two weeks before we take out the staples, we leave him in -- straight anyway, we leave him in extension, so it doesn't change management.

Q. So, the decision between a cast and a brace doesn't affect the long-term results of the surgery?

A. It does not.

Q. Even if it did, you got that information from the IDOC guards, not from Dr. James or from Wexford, correct?

A. Yes.

Q. The process that you just described with the grafting and all of that, how common is that when you do these types of surgeries?

A. So, reconstructions are not that common. I probably would say less than ten percent of the

actually passed around 20 millimeters of the actual tendon into the kneecap itself, so we actually drilled a hole into the kneecap and pulled it down, and then, passed the tendon through -- kind of back and forth through the native patellar tendon, and then, we anchored it down with two anchors. So, we took the tendon, anchored it back down into two anchors, which are basically screws that have stitches in them, and we did that about 30 degrees of flexion. And once we did that, we were able to get about 70 degrees actually at the end of it. We were able to get about 70 degrees of flexion without really pulling a lot of tension in the repair, so we were happy with our repair. We then put him into -- we ended up closing the two side -- the retinaculum, and then, we had to put him in a cast at that time due to the concern with the knee brace so we ended up putting him in a cast. And that was it.

Q. When you say the concern with the brace, what do you mean by that?

A. Well, that's always a different conversation that I have with the guards at the time on what brace we can put him in after surgery

time, maybe -- yeah, less than ten percent. Typically, you can repair tendon-to-tendon in most circumstances acutely.

Q. The reason for having to do the reconstruction in this case was because of the scar tissue?

A. Timeframe and scar tissue. So, timeframe from onset of injury and surgical procedure; with that, becomes more scar tissue which makes it less likely for a side-to-side approximation of the tendon because of how much tissue we have to kind of remove from that area in order to mobilize the patella.

Q. Is there a way to tell specifically what caused the scar tissue?

A. Time. I mean there's no -- I mean that's -- scar I mean is a very normal progression of how things heal. And, you know, at certain timeframes you're going to get a certain amount of scar tissue, and I would say scarring or -- you know, inflammation or scarring is how you heal. So, as the time proceeds on, you're more likely to get that scar tissue there.

Q. So, could that scar tissue have been the

result of another injury?
A. Not in that area, no, because the only other injury he had was the femur fracture, and the femur fracture was more proximal to that area so it's unlikely that that were to occur.
Q. But you can't rule it out?
A. Yes, I couldn't -- I would never rule it in, but, yeah, anything is possible, but there's no precedent for that to form scar in the knee without directly injuring the knee. Now, on that note, if he broke his femur and he didn't really move his knee for -- since '91 and there's definitely a possibility -- not directly from the injury, but from him not moving the knee from the initial injury after the initial injury, then he could get scar tissue from that. But the scarring wasn't really in his knee as it was more the scar was because of the fact that the patella was superiorly migrated for three months because of the patellar tendon rupture.
Q. I guess my question is how do you know that for sure as opposed to something else? And assume that his injury that resulted in him having the rod in his leg was a gunshot wound.

A. The reason I would say that I know that is the rod doesn't cause the patella to be superiorly migrated, and that's the problem. The scarring is not -- we don't care about the scar within the knee as much we care about the patella being superiorly migrated and us not being able to bring the patella down without releasing that scar and releasing the scar tissue around the tendon that had already formed. And so that's the scar that forms. That scar wouldn't form from a femur fracture. The scar -- there could be scar in the knee, like he could have stiffness within the joint, but scar of the patella being superiorly migrated or scar from the end of the patella tendon would not occur in a femur fracture because there's no precedent for it to occur, there's no reason for that to happen. Him having a stiff knee after a femur fracture and having, quote-unquote, scar tissue in the knee joint is definitely a possibility after a femur fracture. But having a patella that's superiorly migrated and having scar tissue around the patellar tendon does not typically occur after a femur fracture. I've never seen that occur, I've never seen it reported to occur.

Q. And you said that you were happy with the repair that you did, correct?
A. Yes.
Q. You considered it to be a successful surgery?
A. Yes. And my judge of success was that clinically there appeared -- we were able to mobilize the patella distally. Again, it was high before we were able to bring it down, and it had good tension in the repair. Again, we were able to flex him around -- almost I think 90 degrees once we had closed the retinaculum without it looking like there was significant tension. So, almost 90 degrees acutely without any healing so far, obviously, because we just fixed it. And so, you know, with that, I did feel like it was successful.
Q. And 90 degrees acutely is a good outcome?
A. It is.
Q. That's on someone whether that person comes in with an acute injury or with a chronic injury?
A. Yes.
Q. The follow-up after the surgery --
A. Yes.

Q. -- did Mr. Jones follow-up as requested by you? I think your initial request was that he come back in 10 to 14 days?
A. Yes. He followed up on the 29th which was 13 days after surgery.
Q. At that time you examined him again, correct?
A. I did.
Q. You thought that he was progressing as you would expect?
A. I did.
Q. There was nothing about that examination on the 29th that was concerning or alarming to you, correct?
A. Yes.
Q. That was a bad question from me.
There was nothing that was concerning or alarming?
MR. FLAXMAN: Was there anything?
MS. BYRD: Yes.
THE WITNESS: There was not anything alarming when I saw him at two weeks. His staples were removed. His wound was well-healed. He had a little bit of swelling. I did remove his staples,

and I did have him see the physical therapist that day to show him some exercises.

BY MS. BYRD:

Q. And that happened, he saw the physical therapist, there was a recommendation of him doing exercises, correct?

A. Yes.

Q. Those were shown to him; he was shown what to do by the physical therapist?

A. Yes.

Q. And then at that time you asked, I think, for him to come back in four weeks?

A. Yes.

Q. And that happened as well, correct?

A. Yes.

Q. At the time, I think, that date was April 4 maybe?

A. So, I guess in hindsight, yes, so I was trying to do my math here. So, it would have been the end -- no. I guess that was right. It just said -- yes, 2-16, it would have been 2 -- yes, that's right. That makes sense, yes, because it was 2 and then 6, okay. Yes.

Q. When you saw him on April 4, he was still

doing well, is that correct?

A. Yes. His range of motion was -- so, he's six to seven weeks, so his range of motion was about 50 degrees which is, you know, a little bit on the tight side, you know, but he did have an intact extensor mechanism at that point so he was able to straighten his knee against resistance even. But he was very tight, and that unfortunately is a little bit part of the protocol or part of the -- not protocol, but part of the problem sometimes with extensor reconstructions. We're a little slower with rehab and they can get tighter. He also was doing therapy on his own. The difference unfortunately with, you know, some patients in the jail system versus a patient that is not in the jail system is access to therapy, and he did not have -- generally, the patients in these protocols will have therapy two times a week at least and they will be doing it on their own the other four to five days. He didn't have that access. He was doing only therapy on his own, so that also makes him more likely to be tight.

Q. Other than that, there was nothing unusual at that April 4 visit that you noted?

A. No, just stiffness.

Q. So, he was progressing as you would expect him to progress at that point?

A. Yes.

Q. And then, I think, you recommended he come back four to six weeks after that, correct?

A. Yes.

Q. And that was May 9?

A. Yes.

Q. When you saw him on May 9, he was continuing to progress?

A. He was. He had gained, I think, around 30 or 40 -- he gained around 40 degrees of range of motion. He could extend against resistance again. I think at that point he was also -- both times he saw the therapist while he was here in order to work on different exercises.

Q. There was nothing unusual at that May 9 visit?

A. There was not.

Q. When you say he had gained 40 degrees, is that from the date of the surgery or from the last time you had seen him in April?

A. From the last time I had seen him in

April.

Q. So, if I understand you correctly, he had 50 degrees range of motion when you saw him in April, and then, by May it would have been 90 degrees?

A. Yes.

Q. After May 9, you did not see him again, correct?

A. That is correct.

Q. You don't have any reason to know about the care that he received after May 9, correct?

A. The only thing that I did see is that I think he wanted to transfer care because, as far as I know -- and this, again -- I'm assuming that he was released from prison because I did get a correspondence from my assistant in July, it looks like July 5, 2016, that he wanted to -- yes, he said reason for calling, Johnny Jones refer ortho in Chicago. So, I had recommended Rush downtown, and my assistant had written a note from 7-7 spoke to patient, referred to Rush, patient is happy and understands this plan. And then it says here instructed to call Rush to schedule transfer of care. Patient states he will call back if there's

any issues. So, that's the last correspondence that I have.

Q. That was nearly two months after the last time you saw him, correct?

A. Yes.

Q. Your recommendation on April 9 is that you see him in four to six weeks, correct?

MR. FLAXMAN: April 9 or May 9?

THE WITNESS: May 9, yes.

MS. BYRD: Every time I say April 9, we'll assume I mean May 9.

THE WITNESS: Yes.

BY MS. BYRD:

Q. You did not see him in that four- to six-week period, correct?

A. I did not.

Q. Other than he called for a referral, you don't know anything about his care after May 9, 2016, correct?

A. I do not.

Q. When you last saw Mr. Jones on May 9, 2016, was there any expectation on your part that he would need to have further surgery?

A. There was no expectation, no.

Q. Did you have any indication that he would need further surgery?

A. I didn't have any expectation that he would need further surgery. In these circumstances when patients are very tight after surgery or still -- there's a tightness, especially with flexion, there is always a risk of needing an additional surgery which would include a manipulation under anesthesia and occasionally a lysis of scar tissue or lysis of adhesions arthroscopically. I have had one instance of a quadriceps repair where I had to do that where the patient was very tight even six or nine months after surgery and we did perform that. So, that's the -- when I talk about risks of surgery with the patient, stiffness is, of course, one of them, especially on a reconstruction. And that is a possible additional surgery that the patient may need if they're tight. The other possibility is if the patient re-ruptures and they need a repeat surgery. Those are the two possible surgeries afterwards, but that's variable depending on how the patient does afterwards.

Q. There was nothing that you observed at

that time that made you think that he was going to fall into that camp?

A. I mean at that point at three months in my opinion, it's too early to do that. I would not recommend any sort of manipulation or lysis of adhesions at three months. That was the last time I saw him.

Q. Okay.

A. So, you know, I've -- again, in my experience, I've had multiple patients be maybe not -- you know, I've had patients that tight at three months, and in four months and five months they get full motion. So, I would still recommend at that stage to not perform a repeat surgery -- or not a repeat, an additional surgery until more time had past.

Q. When you see people who are that tight at three months and by five months they have full range of motion, what steps do those patients take in that timeframe to reach that?

A. So, typically I'll put patients on either some sort of antiinflammatory, so a steroid, oral steroids, I'll put patients on NSAIDs, and then, they will be in very vigorous, dedicated physical

therapy. So, they are getting therapy a few days a week with a therapist, and then, multiple days a week by themselves gradually every day trying to get a little bit more range of motion and breaking up scar tissue.

Q. If someone is not doing physical therapy in that timeframe, would you expect there to be any improvement in their tightness?

A. So, I think that it depends on how motivated patients are doing therapy by themselves, but if they are not doing therapy by themselves -- even if they are, I still think it's difficult to gain more motion without an individual getting any sort of assistance with that in terms of getting the knee bent back farther and farther with assistance.

Q. Have you operated on other patients where it's been three months between the injury and the surgery?

A. The longest, I think, would be a month. The longest would be a month for what I've seen. Yes, I would say a month is the longest. Never -- I have not seen a three-month -- he would probably be my only patient with three months in-between

time from injury to time to surgery.

Q. The one time, that was a month?

A. Yes.

Q. What did you observe in that patient?

A. That patient, it was a quad rupture so it was a little bit different, it wasn't a patellar tendon rupture, it was a quad rupture, but it was the same mechanistically thing. And the patient really couldn't walk for almost three weeks but felt that he may have just strained his quad and was essentially hobbling during that timeframe before he came in and saw me. So, you know, the repair itself -- he was actually the one patient that I did end up having to perform a manipulation under and a lysis of adhesions. So, he was the one that got tighter because I think, in my opinion, the longer he had not been mobilizing his knee, the rehab was a little bit slower with him, and he was more likely to get tight after surgery. And so I did have to manipulate -- and he had really good therapy, but I did have to manipulate him. And I did, and I think at nine months I had to perform a manipulation and an arthroscopic lysis of adhesions and he gained another 15 to 20 degrees. So, he had

knee. You may have some weakness in extension, so you may not have the same strength you have in your other knee, and then, you have stiffness with range of motion. Those are the biggest risks. That being said, I would say that 90 percent of patients gain full extension. And the majority of patients, I don't know the exact percentage on this, are close in terms of strength to their other side. If you do an isometric test, they're probably not quite there on their other side, but they're close. It's not as perceptible to the patient. You could lose though up to 10 to 15 degrees of flexion compared to your other side, but, again, that's a -- I don't know what the -- to be honest, I don't know the exact numbers on the most recent study on what the comparison are. And there's so many variables from time of surgery to type of repair to rehab type to tissue quality to otherwise mobility. So, there's just so many variables that I don't know if they have exact numbers on that.

MS. BYRD: Give me one minute. That might be all I have.

THE WITNESS: Okay.

good strength, but was tight.

Q. Would you agree that the therapy is a really important part of recovering from this kind of surgery?

A. It's crucial, yes.

Q. And that's whether you're doing it on your own or doing it with a professional?

A. Yes.

Q. How often would you say that someone needs to do physical therapy to successfully recover?

A. Their usual recommendation is two to three times a week. There's no literature or science to say what's the exact number, but typically that timeframe allows the patient to do exercises on their own but have a feedback in enough of a timely manner so that they can modify or adjust what therapy exercises they are doing and how aggressive they're doing it. It also allows the therapist to contact me if there's a problem.

Q. With regular therapy, do you see great success from these surgeries?

A. Yes. I would say that the biggest risk we tell every patient is that you'll have an extensor lag meaning you won't be able to fully extend your

BY MS BYRD:

Q. Is it accurate for me to say that you would have needed the MRI before you knew what specifically had happened with Mr. Jones' knee?

A. I think it's confirmatory. I don't -- and I do it for every quadriceps and patellar tendon patient because I think it allows me to see where the tear -- it's good for surgical planning. Is it ultimately crucial for diagnosis? I believe that the physical -- the history, physical exam, and X-rays are enough, but the MRI is a very important aid in surgical planning and it can be confirmatory for the diagnosis.

Q. When you say the physical exam, what would the appropriate physical exam be?

A. So, a palpable defect -- well, physical exam. No. 1, it would be weakness in extension, inability to extend the knee, especially against resistance, especially against gravity; a palpable defect at the inferior aspect of the patella; a patella that is superiorly migrated. Looking for other possible diagnoses to rule out, so a palpable quadriceps tendon so you could feel the quadriceps tendon, no instability in other ligaments so

varus-valgus, ACL is okay, PCL is okay. Those probably would be the biggest thing on physical exam. And then diagnostic imaging, being able to evaluate the height of the patella and a patella that is superiorly migrated on X-ray, especially with the -- I think I measured iso valve ratio, those are all helpful in diagnosing a patella tendon rupture.

Q. Would you expect swelling on a patella tendon rupture?

A. I would expect a large affusion, yes.

Q. What about pain, what would you expect?

A. I would expect an immediate pain right after the injury and continual pain. If the knee is placed in -- again, in extension and it's not stressed, then the pain may decrease. But, yes, immediate pain, immediate swelling. There's a large, bloody affusion. The patients will get a large -- basically an accumulation of blood when the tendon ruptures.

Q. If a patient presented with mild pain, no swelling, and the X-ray came back saying that the patella was slightly high-riding, would that automatically trigger to you that it's a patellar

tendon rupture?

A. If I was given that history, that would not be the expectation, no.

MS. BYRD: I think that's all I have.

EXAMINATION

BY MR. FLAXMAN:

Q. Could you explain to us what you meant by range of motion?

A. So, range of motion refers to the ability to -- for the patient to bend and straighten the knee. It's measured -- at least I measure it in three numbers; the first number is how much they can extend. So, typically if patients can extend to neutral, it's zero. If they can higher extend, you add whatever that degree of hyperextension is, so one, two, three. Typically, patients are anywhere from zero, so ability to fully extend which is zero degrees to upwards of five if they have hyperlaxity. The second number is typically zero. It's typically if they can extend to zero, if they can extend to zero or past zero, it's zero. And then the third number is the ability to flex the knee. So, you measure it from straight, we see how much they can flex. So, we talk about

50 degrees of flexion, the patient if you were to take a straight line from straight to where it bends is about 50 degrees. Typically, patients can -- or normal people, I guess, can flex anywhere from 130 degrees to 140 degrees. You always compare it -- well, typically I'll compare it to the other side as a baseline, but that's what we talk about when we talk about range of motion.

Q. Is the type of injury that you saw in Mr. Jones a career-ending injury for a basketball player?

A. It is -- it can be. There are guys that have been able to return to playing. There's a few guys even in the NBA who have returned to playing. There's -- I have seen it in the NFL. I took care of an NFL team, I've seen guys return to the NFL, but it is a bad injury. It can be a career-ending injury.

Q. In the beginning of the deposition when you were talking about that physical therapy seems to have gotten easier -- there's more access to it in the prison now than there was when you first started. Could you explain what you meant by that, if I heard it correctly?

A. Yes. At least there was -- recently I performed an ACL reconstruction on a patient, and I was told by that inmate and patient that there was access to a therapist on-site that was able to do more consistent therapy with the patient.

Q. As far as you know, was there a physical therapist available to Mr. Jones back in 2016?

A. No, not that I know of.

MR. FLAXMAN: I have nothing further.

MS. BYRD: I think just two quick questions.

FURTHER EXAMINATION

BY MS. BYRD:

Q. The patient that you just talked about who said they had physical therapy available on-site, what prison was that person in?

A. As far as I know, it was Stateville prison, yes.

Q. You talked about range of motion. In your notes, you also have strength, you measure strength in here?

A. Yes.

Q. And you say that Mr. Jones has strength of five of five with extensor hallucis longus?

A. Yes.

Q. Did I get that?
A. Yes.
Q. What does that mean?
A. So, that really refers to his neurovascular status. And typically with an extensor tendon repair, we don't necessarily -- the nerves are very unlikely to get injured, but there's always a chance of them getting injured. So, the extensor hallucis longus refers to the big toe basically, and what nerve that refers to is the peritoneal nerve. So, I check all of their distal or all of my patients' distal extremities to make sure that everything distally is okay. So, the big toe is the extensor hallucis longus or EHL, and that just means that he's neurovascularly intact. I think there was an area that I had written, also, that he had five out of five strength against resistance as well which would have been, I think, the last time I saw him. Let me see here. I did put that he had good extensor strength.
Q. Yes.
A. Yes. So, I think I wrote in his last note on May 9, I said patient can extend against resistance with five out five strength. So, I

think he had good strength against resistance.
Q. So, that means that you had to put his leg out and you pushed down on it or what does that mean?
A. Yes. So, that means that he was able to extend his leg against me pushing against it.
Q. When you say five out of five, that's as good as --
A. Yes. That would imply in my opinion -- it's a subjective measure, there's no objectivity to it. But as a subjective measure, he was able to extend against resistance which makes, again, from a physical exam finding that he has an intact extensor mechanism.
Q. Which is what you would expect after a successful surgery?
A. Yes.
MS. BYRD: I think that's all I have.
MR. FLAXMAN: Signature?
MS. BYRD: We can send you a copy of the transcript so you can review it and make sure that what you said is what was written down.
THE WITNESS: Sure.
MS. BYRD: You can't change your answers. Or

you can trust that it was written down correctly and waive your signature.
THE WITNESS: Where does it get sent to? It gets sent to me directly to my e-mail or where does it get sent to?
(Whereupon, the record was read as requested.)
THE WITNESS: I think it's fine. You can waive.
(Whereupon, the deposition concluded at 3:20 o'clock p.m.)

STATE OF ILLINOIS)
) SS:
COUNTY OF C O O K)
I, CHRISTINE M. PINA, do hereby certify that heretofore, to-wit, on July 12, 2019 personally appeared before me, at 1310 N. Main Street, Sandwich, Illinois, DR. ANKHUR BEHL, in a cause now pending and undetermined in the United States District Court, Northern District of Illinois, wherein JOHNNY JONES is the Plaintiff, and WEXFORD HEALTH SOURCES, INC. and DR. MARSHALL JAMES are the Defendants.
I further certify that the said DR. ANKHUR BEHL was first duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by said witness was reported stenographically by me in the presence of the said witness, and afterwards reduced to typewriting by Computer-Aided Transcription, and the foregoing is a true and correct transcript of the testimony so given by said witness as aforesaid.
I further certify that the signature to the foregoing deposition was waived by counsel for

the respective parties.

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

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

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

Christine M. Dina

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49