EXHIBIT F

November 12, 2019

Sandra L. Byrd
Cassiday Schade, LLP
222 W. Adams St., Suite 2900
Chicago, IL 60606

RE: Johnny Jones

Dear Ms. Byrd,

Below you will find my medical opinions regarding Mr. Johnny Jones. All of my opinions are rendered to a reasonable degree of medical certainty based on my review of the below-listed documents and my education, training and professional experience as a board-certified orthopedic surgeon. In forming these opinions, I have reviewed the following documents:

- Plaintiff's Complaint;
- Illinois Department of Corrections Medical Records;
- Wexford Health Sources, Inc.'s Utilization Management Notes;
- Medical Records from Midwest Orthopedic, Midwest Orthopedic at Rush, Rush Hospital, Valley West Hospital, Oak Park Hospital, Schwab Rehabilitation Center, Lawndale Christian Center and the Social Security Administration;
- Deposition testimony of Plaintiff;
- Deposition testimony of Dr. Marshall James;
- Deposition testimony of Dr. Neil Fisher;
- Deposition testimony of Dr. Ankhur Behl;
- Deposition testimony of Nikhil Verma;
- The report of Plaintiff's retained expert, Dr. Vincent Cannestra; and
- Deposition testimony of Plaintiff's retained expert, Dr. Vincent Cannestra.

Background

I have been a practicing orthopaedic surgeon for over thirty years. I obtained a Bachelor of Arts at Princeton University in 1975. In 1979, I obtained my Medical Doctorate at Johns Hopkins University Medical School and in 1980 I completed my surgical internship at the University of Chicago. I completed an orthopaedic residency at Rush Presbyterian St. Luke's Medical Center in 1984 and, in 1985 I completed an orthopaedic and sports medicine fellowship at Harvard Medical School/Massachusetts General Hospital.

I obtained my board-certification in orthopaedic surgery in 1987 and was recertified in 1997, 2007 and 2017. I served as an assistant professor at Rush University's Department of Orthopaedic Surgery for more than twenty five years and am currently the President of the Illinois Sportsmedicine and Orthopaedic Centers and Medical Director of the Illinois Orthopaedic Foundation. My *curriculum vitae* is attached hereto.

As a board-certified orthopaedic surgeon, I am familiar with the care and treatment of the orthopedic conditions involved in this matter.

Background

On November 14, 2015 Mr. Jones injured his left knee playing basketball. The same day he was examined by a nurse who noted that the patient characterized his pain as only a level of four on a scale of 1 to 10. The patient was also noted to have no tenderness swelling or bruising and was ambulatory under his own power.

The patient was then seen on November 16, 2015 by Dr. Marshall James. Dr. James considered the possibility of injury to his patellar tendon, ordered an x-ray to rule out a patellar tendon rupture and instructed Mr. Jones on home exercises. The x-ray showed a slightly upriding patella with a small knee joint effusion. Complete patellar tendon ruptures almost always have a large effusion. In general a complete rupture of the patellar tendon will also produce far more upriding than this. Based on the patient's presentation and the x-ray results, Dr. James appropriately told the patient to return on an as needed basis – *i.e.* if he were not doing well.

When the patient did return a few weeks later on December 8, 2015, Dr. James noted Mr. Jones had persistent left knee pain and swelling and that Mr. Jones' patella was notably displaced, in contradistinction to what he observed when the patient initially presented to him. Dr. James immediately ordered an MRI which is the standard of care for evaluation of knee injuries. The MRI was approved on December 15, 2015. Notably, on both December 26, 2015 and December 29, 2015, Mr. Jones refused medical care with the Sheridan Correctional Center medical staff.

Mr. Jones had an MRI on January 18, 2016. The radiologist did not urgently refer Mr. Jones for a surgical consult. Mr. Jones then saw the orthopedic surgeon on February 8, 2016. The surgeon discussed both operative and nonoperative options with Mr. Jones and Mr. Jones chose to undergo surgery. On February 16, 2016, Mr. Jones underwent successful surgery to repair his patellar tendon.

Following his surgery, Mr. Jones was housed in the prison infirmary until his release from prison in June 2016. Prior to his release from prison, Mr. Jones was seen for all recommended follow up appointments with his surgeon, and received physical therapy as recommended by the surgeon's office. Mr. Jones, however, admitted that he was not sufficiently self-motivated to diligently follow through with the recommended physical therapy on his own in the prison infirmary. As well, Mr. Jones was observed on occasion to not be wearing his brace as ordered by his surgeon.

Following his release from prison, Mr. Jones missed his follow-up appointment with his surgeon and in October 2016, Mr. Jones underwent elective surgery with a different surgeon, Dr. Verma, after complaining of moderate stiffness, which can occur after any primary repair or graft repair. Full flexion, that is full motion, was achieved during this surgery. Following the surgery, Dr. Verma referred Mr. Jones for an intensive course of physical therapy from which Mr. Jones was discharged for noncompliance. As well, Mr. Jones was noncompliant with Dr. Verma's recommendation to wear a brace on his knee.

In January 2017, Mr. Jones was noted to have a normal gait and walk without a limp and at his last appointment with Dr. Verma, Mr. Jones was noted to have 120° of knee flexion—a degree of knee flexion that would not produce restrictions on any activity—and Dr. Verma further noted that he could

not find any "anatomic reason" for Mr. Jones' subjective reports of pain. Mr. Jones' ultimate surgical result was good. At no time did Midwest Orthopaedics or Dr. Verma indicate that any delay in surgery affected the result.

Opinions

1. The medical care that Mr. Jones received from Dr. James was within the standard of care for a primary care doctor evaluating an acute knee injury.

Mr. Jones presented with little swelling, little pain, no bruising and an essentially normal x-ray. There was no reason for Dr. James or the nurse who initially triaged Mr. Jones to fear that a complete patellar tendon rupture had occurred. The clinical and radiologic presentations were quite atypical such that even an experienced orthopedic surgeon might not have diagnosed a complete patellar tendon rupture. Certainly I would not expect any non-orthopedic surgeon to come up with a diagnosis of complete patellar tendon rupture based on this patient's presentation.

Most injuries presenting in this fashion are acute and self-limited. They do not require a follow-up appointment be scheduled unless the patient is not doing well. For this reason Dr. James appropriately told the patient to return on an as needed basis if he were not doing well. When the patient did return a few weeks later Dr. James noted that the injury was presenting in a significantly different fashion than it had a few weeks earlier, and consistent with the standard of care, Dr. James ordered an MRI.

In a non-prison setting, insurance companies routinely refuse to approve MRIs for soft tissue injuries unless patients have first undergone a course of physical therapy or home exercise such as was prescribed by Dr. James. This is also true for companies that specialize in work-related injuries. The reasoning is that any non-fracture soft tissue injury will still be treatable after a delay of a few weeks and the great majority of these injuries will resolve during that timeframe, thus sparing the health system the unnecessary expense, and the patient the unnecessary discomfort, of unwarranted MRI scans. Thus Mr. Jones did not receive substandard care but rather exactly the care that is uniformly prescribed outside of the prison health system.

Additionally, complete tendon and ligament ruptures are frequently not diagnosed by the initial treating physician whether in the emergency room, in an urgent care clinic, a worker's compensation clinic or a primary care doctor's office. The initial treater is almost always a family practice doctor, internal medicine doctor or mid-level practitioner. They must be able to treat the full spectrum of medical problems and are not narrow subspecialists in the treatment of knee disorders. If an orthopedic surgeon performs the initial evaluation diagnostic accuracy is certainly higher. But in more than 30 years of practice as a knee specialist I have found that it is quite common for the initial diagnosis by the general practitioner to not be correct in this kind of case. It is the responsibility of the orthopedic surgeon to find the correct diagnosis in patients who are not progressing well as happened here. Surgery for ligament and tendon ruptures is quite commonly delayed for this reason.

Furthermore, a typical patellar tendon is roughly 50 mm long, however studies have shown significant variability in patellar tendon length. In fact, one study showed a difference of 7 mm in the average length of the tendon between patients with different probabilities of patellar dislocation. This longer patellar tendon is called patella alta and produces slight upriding but does not indicate injury. Dr.

Cannestra, Plaintiff's retained expert, indicated that a slight upriding patella would be considered to be roughly 2-6 mm. Thus slight upriding, as seen in Mr. Jones' x-ray, is not indicative of an abnormal state and not consistent with complete patellar tendon disruption. Dr. James was astute in even considering the possibility of some injury to the patellar tendon, especially since the patient had 5/5 strength. Dr. James' thorough examination did show some laxity of the affected patella, however when Dr. James compared it to Mr. Jones' other knee he noted the two knees were the same. By the time Mr. Jones did manifest a more typical patellar tendon presentation it was noted that he had 18 millimeters of upriding, vastly different than the slight upriding found by the radiologist and described by Dr. Cannestra.

As well, the fact that Mr. Jones was seen by a medical doctor as opposed to a mid-level practitioner, such as a physician's assistant, within 48 hours of his injury exceeds the standard of care in the community. It is typical for a patient presenting with symptoms consistent with those of Mr. Jones to first be seen by a mid-level practitioner, not a physician for weeks. Regardless, Mr. Jones' clinical and radiographic presentations were not typical for a complete patellar tendon rupture. It is unlikely that any primary care practitioner, including a primary care physician, would have recognized it as such given the normal x-ray and benign exam.

Finally, it is the standard of care to order an MRI only if the patient does not do well after several weeks of exercise. Insurance companies generally will not pay for MRI absent a course of physical therapy or prescribed exercise and patients do not pay for them out of pocket due to their expense. Thus, Dr. James' prescription for an MRI after Mr. Jones did not improve with rest and home exercise is exactly consistent with community norms and the standard of care.

2. Mr. Jones' tendon graft surgery was successful and restored function of his patellar tendon.

Mr. Jones underwent successful surgery to repair his patellar tendon in February 2016. Neither of Mr. Jones' surgeons has ever stated that any delay in surgery affected the outcome of the surgery. After Mr. Jones' surgery stability was restored, he developed moderate stiffness which can occur after any primary repair or graft surgery. Mr. Jones did achieve 90° of knee flexion which is quite consistent with painless walking and ascent of stairs but does require an altered gate for descent of stairs. The degree of stiffness Mr. Jones had would not produce pain or interfere with activities of daily living in the interval between his first and second surgery. Any stiffness experienced by Mr. Jones after his surgery was not due to any perceived delay in the surgery. Stiffness is seen following surgery performed both early and late and is actually more common in surgery performed earlier. It is more likely that any stiffness or failure to achieve full range of motion was the result of Mr. Jones's failure to successfully follow through on the ordered course of physical therapy. Restoration of satisfactory postoperative motion is the chief goal of this physical therapy. Failure to follow through on the recommended course of physical therapy most likely contributed to any sub-optimal outcome for Mr. Jones.

In fact, while Mr. Jones was awaiting his second surgery he had a full 90° of knee flexion which would allow him to perform all activities of daily living without pain. It should be noted that full flexion, that is full range of motion, was achieved during surgery. As well, following his second surgery Mr. Jones was able to maintain a very good range of motion, 120°, which would not restrict activities of any kind. There is no objective basis for Mr. Jones' continued subjective complaints of pain, which Dr. Verma confirmed when he stated that he could find no anatomic reason for Mr. Jones' continuing complaints of pain. As such, it is unlikely that Mr. Jones will require future medical treatment for his left knee.

Conclusion

Each of my opinions is rendered to a reasonable degree of medical certainty. I expressly reserve the right to supplement and/or revise my opinions should additional documentation develop. My current fee schedule and *curriculum vitae* are attached hereto.

Sincerely,

/s/ Chadwick Prodromos, M.D.