IN THE MATTER OF:

[redacted] *et al.*

-v-

[redacted]

KEVIN F. HANLEY, M.D.
APRIL 20, 2006

GORE REPORTING COMPANY
Maryland, D.C., & Northern Virginia
(410)269-0308

Condensed Transcript

IN THE CIRCUIT COURT FOR
ANNE ARUNDEL COUNTY, MARYLAND

[redacted], et al. *
*
Plaintiff, *
* CASE NO.
v. * [redacted]
*
[redacted] *
*
Defendant, *
*
* * * * * * * * *

Pursuant to Notice, the video deposition of KEVIN F HANLEY, M.D. was taken on Thursday, April 20, 2006, commencing at 10:50 a.m., at the offices of Bowie Health Center Conference Room, 15001 Health Center Drive, Bowie, Maryland, before Sylvia L. Jacobs, Notary Public.

Reported by: Sylvia L. Jacobs

APPEARANCES:

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WITNESS: Kevin Hanley, M.D.

EXAMINATION:

EXHIBITS: (Attached)

ALSO PRESENT:
Julie Souza, Videographer

PROCEEDINGS

VIDEOGRAPHER: Today is Thursday, April 20 year 2006. We are going on the record at 9:40. This is a video deposition of Dr. Kevin Hanley, taken by Jacqueline Bunty, Esquire with offices located at 10 North Calvert Street, Baltimore, Maryland. The caption of this case is [redacted] and William Miller versus [redacted] in the circuit court for Anne Arundel County, Case number 02-C-05-104523.

This video is being held in the office of Dr. Kevin Hanley, located at 15001 Health Center Drive, Bowie, Maryland.

My name is Julie Souza, videographer from the firm of Gore Reporting Company, located at 107 Ridgely Avenue, Suite 13A, Annapolis, Maryland. The court reporter's name is Sylvia Jacobs in association with Gore Reporting Company.

Will counsel please introduce themselves?

Jackie Bunty on behalf of defendant,

[redacted] Laura Zois, on behalf of the plaintiff.

Will the court reporter please swear the witness?

STIPULATION

It is stipulated and agreed by and between counsel for the respective parties that the reading and signing of this deposition by the witness be and the same are hereby waived.

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KEVIN HANLEY, M.D.,
called for examination, having been duly sworn to tell the truth, the whole truth and nothing but the truth, testified as follows:

EXAMINATION

BY MS. BUNTY:

Q Good morning, doctor.

A Good morning.

Q Kindly state your full name and business address.

A Kevin Francis Hanley, 1298 Cronson

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Boulevard, Crofton, Maryland.
Q And what is your occupation.
A I'm an orthopaedic surgeon.
Q And how long have you been involved in the area of orthopedics?
A I completed my residency training in orthopedics in 1981 and prior to that was a resident in orthopedics for three years.
Q And where did you do your internship and residency?
A I did my internship and residency training at Walter Reed Army Medical Center in Washington, D.C.
Q And from which, what medical school did you attend?
A I attended Georgetown University School of Medicine and graduated in 1977.
Q There, once you concluded your residency where did you move into?
A Well, I was just, I was in the Army at that time. I was assigned to the military hospital

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at Fort Ord, California where I served for four years as chief of the orthopaedic clinic and one of the staff orthopedic surgeons.
Q And then when did you leave the Army?
A In 1985 I left the Army and entered private practice in Maryland and I've been in private practice since 1985.
Q When did you obtain your license to practice medicine in Maryland?
A 1985.
Q Are you admitted to practice medicine in any other states?
A Yes. I have licenses in California, Pennsylvania, Delaware and Virginia.
Q Do you have memberships in any sort of professional societies?
A Yes. I'm a member or the American Academy of Orthopedic Surgeons. I'm a member of the American Medical Association, the Prince George's County Medical Society and the Maryland State Medical Society.

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Q Now in as much as you that you practice in the field of orthopedics, are there any special types of certifications that you can achieve in that area?
A Yes, there are.
Q And what if any of those do you have?
A Well, I'm board certified by the American Board of Orthopedic Surgery which is the specialty certification board that encompasses the whole field. But you can specialize in spine surgery, hand surgery, sports medicine, foot and ankle surgery, all of those different things.
I'm not subspecialized in any of those. I do have board certification from the American Board of Independent Medical Examiners. Part of my orthopedic practice over the years has included what can be referred to as forensic orthopedics or disability medicine and, and so I'm subspecialized in that area. And as a matter of fact, that's basically the part of my practice that I'm now specializing in, the forensic side.

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Q Do you still have your certification in orthopedics?
A Yes. Yes. I still have hospital privileges at Prince George's Hospital Center. I'm the medical director of the surgical ambulatory surgery center here at this facility. I'm still active in the clinical side of orthopedics but not at, you know, not at the level of actually seeing patients everyday and treating them.
Q Okay. And do you have any teaching experience, doctor?
A Yes. Ever since I was at Walter Reed, I've been on the faculty of the American, I mean, of the Uniformed Services University of the Health Sciences, which is the military medical school in Bethesda.
Over the years I'd had opportunity to teach residents, other doctors, physician's assistants, athletic trainers. At the present time I'm probably, the only teaching I've been doing lately is more in the other field, the forensic

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field.
Q All right.
MS. BUNTY: At this time I would offer Dr. Kevin Hanley as an expert in the field of orthopedics and submit him for any void dire you may have.
MS. ZOIS: No objections.
Q All right. Doctor, back in August of 2005 you were contacted by me to review the medical information on [redacted]
MS. BUNTY: Is that how you say it?
MS. ZOIS: Yes.
MS. BUNTY: Very good.
MS. ZOIS: I'll let him pronounce it.
Q What records were you able to review concerning his situation?
A You sent me several packets. One was from Bay Area Orthopedics, Dr. Fulton, I think Davis' group. Records from Dr. Jassi, who I believe was his internist, records from North Arundel Hospital. There were records from Dr.

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Asdourian. There was a emergency, ambulance record from the date of his accident and those, those are what I reviewed.
Q Did you,--
A Oh, I'm sorry. There was also records from the Multi-Specialty Healthcare Group, which is Dr. Misoul's group.
Q Okay. You were listing medical records, in addition to those those, did you have anything else to consider?
A Such as X-rays or MRI scans?
Q Well, such as legal filings.
A Well, I do have the answers to the interrogatories right here on the top, yes.
Q All right. Now to be clear, you did not see Mr. [redacted]
A Correct. I just had the opportunity to look at the records.
Q How can you as a physician not having seen the patient in the flesh come to determinations to a reasonable degree of medical

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probability as to what type of injuries this patient has solved and whether or not it's related to, in this case a specific occurrence, an automobile accident?
A Well, obviously if I had seen the patient I would have seen him, you know, on September 15, 2005. We're talking about an accident that occurred in April of 2003, so the opportunity to examine the patient gives you information on how he is today but all of the questions you asked about causation etc. really come from the record and the history. And the patient's history has to correlate with the record, so. And the record is something that's generated contemporaneously with the doctors that are seeing him, so it usually, a good analysis of the record is what you need to answer those types of questions. Now, if you were asking me what is his current condition, what is his current disability impairments whatever, without examining him myself I would be at a lost to, to comment in that regard.

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Q Okay. What information do you have concerning the accident that happened back in April of 2003?
A I have the ambulance report. I don't think I ever had an accident report. Oh, yes I do, I'm sorry. I have an accident report that indicates that this was a rear-end type collision at an intersection Mr. [redacted] was in the vehicle that was struck from the rear.
Q Does it, does the accident report reflect what type of vehicles were involved in the collision.
MS. ZOIS: Objection.
A Probably. Let me see here.
Q Well, let me ask you this.
A Yes, it does. It does. He was in a '92 Chevrolet truck. He was struck by a Nissan Maxima.
MS. ZOIS: Objection. Move to strike.
Q What if any facts about the collision itself assist you in reaching determinations regarding the appropriateness of treatment or that

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if any injuries may have been sustained?
MS. ZOIS: Objection. Move to strike.
Q Obviously, the type of accident and the force of the accident etc. can give you some, some insight into what to look for. You know, obviously that's most important to the emergency room doctor or the doctor that sees the patient first.
It's nice to know did the car roll over or was the patient thrown out of the car etc. all that kind of data. Once you get down the road like where I was at when I'm examining the records it's not as critical but, I mean, if you read a report that says this was a minor impact or this was not a not, you know, the patient hit a tree you can get an idea of what types of injuries might coincide with that type of an accident so it's good information to have. It's not necessarily something that you're going to base an opinion on because there's things that have happened after that, that you can also look at.
I mean, minor accidents can cause

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serious injuries and visa versa, so. But it's, in this particular case, you know, the ambulance driver wrote that it was,--
MS. ZOIS: Objection.
Q -- rather slight accident.
MS. ZOIS: Objection. Move to strike.
Q What if any complaints were documented by the ambulance personnel when they initially saw Mr. [redacted]
A The one thing I think that, that, that was important was that he suggested then he couldn't, he had no feeling in his legs or he had numbness in his legs. He also was complaining of some neck and, yeah, here it is. Patient found siting in his vehicle complaining of upper back and neck pain. He's had, it says here, a history of hip replacement, seated in the front. Those were the types of things that they were talking about and I saw somewhere that, yeah, states he can't feel his legs, so. And with the history of back surgery so that was kind of important to the

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ambulance people.
Q You know or we know from review of the records that Mr. [redacted] was then later seen at the emergency room.
A Correct.
Q What if any complaints were presented at that time?
A Yeah. He has seen at North Arundel and the complaints there I think were he had neck, upper back and some low back pain reported. I think he also had some sternal discomfort in his, you know, in his chest. Yeah, they show that he had some complaints of some chest pain, some lumbar tenderness and some upper back pain.
Q Were any X-rays done at that point?
A Yes, I think his neck was X-rayed.
Q Look at page 21 there when you're ready.
A Page 21? These aren't numbered this packet.
Let's see, he had the sternum X-rayed, that was negative. He had the neck X-rayed which

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showed some mild degenerative disease. He had the low back X-rayed, which showed that he had some internal fixation. He had some screws in his back from a prior surgery. He had evidence that he had, had what's called a laminectomy or removal of part the, of the back of the spine. And those where the X-rays that were reported in this packet.
Q It doesn't have a little page number at the bottom? All right, then. I'm going to hand you then so you have it the cervical X-ray report.
A Yes.
Q And what were the findings at that point?
A Like I said, they described the reversal of the cervical lordosis, which means some straightening of the neck. And they reported that he had some mild spondylosis, which is, you know, radiology speak for some arthritis or degeneration. And there was no fractures. He did have, it's interesting, he had, had prior X-rays at North Arundel May the 3, 2000 and they reported that,

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that there was no change from that date. So, these X-rays look the same they that had had two years, three years before. They were able to rule out any serious neck injury there.

Q Based upon your review of the emergency room record and the ambulance notes, are you able to determine what if any injuries Mr. [redacted] sustained as a result of the accident of April the 30, 2003?

A Yes. Yeah. The records would indicate that, that he had probably a cervical strain or neck strain, probably a lumbar strain. In other words, a soft tissue kind of sprain, strain to the lower back, a contusion of the chest probably from the seat belt and that's what they recorded there.

Q Now, what's a contusion?

A Contusion is an injury that occurs as a consequence of some type of blunt trauma. It's a bruise or if you get hit, you know, in the, in the leg with a softball that would be a contusion. If you get struck over the back with, you know, a

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baton by a policemen or something like that. That would be a contusion. It's a blunt kind of injury to the soft tissues although you can also contuse a bone.

Q Is a contusion something that you can see, is there objective evidence of a contusion?

A Someone that's had a contusion typically will have tenderness at that site, may well have some swelling at the site, some bruising at the site. Those are the, the, the hallmarks of a contusion. Now, tenderness is, is, is kind of objective because usually the patient, the patient does have to give you some information but usually you put your finger on the sore spot and they say it hurts and that's pretty objective.

Q All right. Mr. [redacted] then returned to seek additional medical treatment from physicians at Multi-Specialty Healthcare?

A Yes.

Q On the initial visit in May 2, of 2003 what complaints were presented at that point?

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A Correct. He saw Dr. Constantine Misoul that time. He reported that he had been involved in a motor vehicle accident. The, the history given by Dr. Misoul says that at, on May the 2, he was complaining of aching pain in the neck and upper back radiating into the shoulders and into the left arm with some numbness and tingling. He indicated that it hurt him while reaching or carrying or pulling with overhead maneuvers. He also reports some lower, mid and low back aches worse with standing. And he denied any pain down his legs or any radiating pain. He also said that his left knee hurt him with kneeling or squatting or climbing stairs. He also had aching in both shoulders which I think he said twice, but.

Q What did physical examination of the neck reveal?

A Okay. In the neck there was tenderness of what's called paracervical musculature which are these muscles that, that surround the neck, the back and side. There was tenderness of those

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muscles. There was tenderness down into the upper back area around the shoulder blade. He felt that there was some loss of motion in the neck.

He describes the six motions, flexion, extension, right and left rotation and right and left flexion. And he says there was about 20 degrees loss of motion, which is typical of someone who has a neck sprain.

He said there was some stiffness guarding. A patient with a sprained neck is not going to want to move it as normal because it hurts.

Q What if anything do you know about Mr. [redacted] prior neck treatment?

A Neck treatment. I don't, I didn't put anything in my report. I know he's had a host of treatment on the lower back.

Q Okay.

A But I don't have any evidence of any prior, or I don't have any,--

Q Did Dr. Misoul's report reflect any,--

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A Let's see.
Q -- post-surgical scarring?
A In the neck?
Q Yes.
A Not that I see in the neck, not, not in his report.
Q Okay.
A Am I missing something? Oh, I didn't see that, I'm sorry. He does describe a well-healed posterior scar in the cervicothoracic area.
Q Well, what kind of surgery would that be consistent with?
A Okay. Yeah, there's a past history, I missed that. Dr. Asdourian, and I did review those records. Dr. Asdourian had done a posterior surgery on his neck, a decompression which would be kind of a, you know, for a pinched nerve type thing.
Q What are the normal residua if any of that type of surgery?
A Normally it could no residual. In other

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words, it could work.
Q Okay.
A Surgery could work and the patient could be pain free and fully functional. It could be that there's some decreased range of motion of the neck could occur. A patient could have some, you know, there's like a spectrum. A well done surgery though can leave the patient asymptomatic. And according to this it states he was doing fine.
Q All right.
A I assume with regard to the neck.
Q What if any findings were revealed on examination of the shoulders by Dr. Misoul?
A Shoulders showed that had he had some tenderness in the, right here what's called subacromial space. He had some mild limitation of motion, 20 degrees loss of motion. That's about 10 percent. A little less loss of motion, a little more loss of motion on the left than on the right, no gross instability, positive impingement sign. He just had some signs of some, some decreased, some

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increased discomfort in the area of the shoulder.
Q Okay. What's the significance of, what did you say, positive impingement?
A Right. When the shoulder is ranged from down here on upward, the ball of the shoulder, the humeral head has to pass underneath something called the acromion which is a shelf of bone. And between that shelf of bone and the humeral head is where the rotator cuff is. And the rotator cuff and the bursitis, I mean the bursa in that the area sometimes can get impinged between the two bones. And if they get inflamed then that impingement will hurt when the patient moves it.
You can test for impingement. There are some tests you can do when you examine the patient. And in this particular case he suggests that the patient did have some pain when he tested for impingement, meaning that there, there might have been some aggravation of those soft tissues and I think his impression down the ball was that indeed he did have some tendonitis of those tissues.

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Q Okay.
A That's consistent.
Q What did Dr. Misoul's exam of the left knee reveal?
A It revealed that had he had, had a prior arthroscopic surgery because he says that there's well-healed arthroscopic portals, meaning that there were scars.
He also noted that there's a positive patellar compression test. When he pushed down on the kneecap and had the patient bend his knee back and forth, there was a complaint of discomfort. Range of motion was close to normal. There was no report of any swelling within the knee or effusion or fluid. There was no instability, nothing else going on in the knee other than this patellofemoral kind of finding.
Q Now this patellar finding, what are the likely causes of that?
A Well, I mean, the patellofemoral joint is prone to a lot of conditions. I mean, it can be

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mal-aligned from birth. And there's a certain group of people that have malalignment of the patellofemoral joint that over time develop pain and sometimes arthritis, okay. That's, that's called chondromalacia of the patella but it's also prone to degenerative arthritis. It's prone to damage and injury. I mean, occupational stresses can affect the patellar joint, the patellofemoral joint and if you kneel for a living, for example, do floors or carpets or something.

So, and just over time you can get an arthritic patellofemoral joint that hurts with provocative activities. You provoke the patellofemoral joint when you climb or descend stairs, when you kneel, when you squat down and come back up, when you sit with your knee bent, you pull that kneecap into the joint. So, those types of things are not uncommon in people as we get older.

Q And then what, if anything, did the physical exam of the, I guess, the mid to lower

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back reveal?

A As I said, there was no gross abnormalities. There was no scoliosis, no curvatures or, abnormal curvatures. He does, does describe the low back scar which, over which there was some tenderness. He did describe that the gentleman lacked some range of motion, 20 degrees, which is about 20 percent range of motion loss. He noted that there was some guarding. In other words, the gentleman was not anxious to show movement at the extremes, full flexion, full extension and that was about it. There was no neurological loss. In other words, he had a tender low back, mid and low back.

Q What if any information do you have about the prior surgeries to the lower back?

A He had, had prior surgery to the lower back in March of '97, May of '98 and at some point after that, the date of which I didn't have, when he had a fusion. So he had, had three surgeries in the mid to late 90's for degenerative disease.

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Q And what might be the expected residual of those, of those surgeries?

A Well, again some people that have back surgery and do fine and have no residuals. They have residuals only if you X-ray and you can see it.

But in this particular case, we did have evidence that, that he developed what we call junctional disease. He has fusions from 3, L3-4 to L5-S1. He had three levels fused and what happens then is you stabilize or you immobilize part of the spine and the level that remains mobile above, is overstressed and can begin to deteriorate and there was evidence in the records that he had that problem. He was having some deterioration of the junctional level and ultimately had to have more surgery for that. So, he has residuals in the sense that he had a stiff back and he had a progressive degenerative process.

Q And how if at all does that impact on range of motion?

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A Well, it, it's going lead to some loss of range of motion. That range of motion is a little difficult to test because people that have good flexible hips can get a lot of motion at the hips and bend over and touch the floor. But if you look at their spine as they're bending there's no motion at the spine. So you can adapt for that but clearly he's going to have loss of range of motion, he had three fused levels.

Q Dr. Misoul also did some X-ray of the shoulder and the left knee on May the 2. What were the pertinent findings?

A He reported them to be normal. He said, no acute osseous pathology.

Q All right. Now, based upon the review of the records that we talked about so far, the ambulance report, the emergency room records and the initial report of Dr. Misoul regarding his examination of Mr. [redacted] on May the 2, 2003, do you have an opinion to a reasonable degree of medical probability what if any injuries were

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caused by the accident of April the 30, 2003?
A **Yes.**
MS. ZOIS: Objection. Move the strike.
MS. BUNTY: Can we go off the record a second?
MS. ZOIS: Sure.
VIDEOGRAPHER: Off the record at 10:06.
VIDEOGRAPHER: On the record at 10:06.
Q Doctor, are you able to answer that question.
A **Yes.**
Q And what, what is your conclusion?
A **The medical records support a diagnosis of cervical strain, they support a diagnosis of thoracolumbar strain. They support the diagnosis of sprain strain of the trapezial slash shoulder region. All of those seem to be supported by what Dr. Misoul indicates and what's indicated in the emergency room records.**
Another, another way of putting it is, you know, soft tissue type of injuries to the

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spinal axis, the back, the neck and shoulder girdle area. The shoulder girdle is made up of a number of different muscles. It doesn't appear that any internal derangement of the shoulder occurred, in other words, a rotator cuff tear or anything like that. It doesn't appear that any significant internal derangement of the knee occurred. There's no evidence that he impacted the knee or anything like that. There's evidence that he had, had a prior knee problem as noted by Dr. Misoul's report about previous surgery. There's nothing going on there relative to the knee that I can pick up. So, it looks like a soft tissue spinal-type injury.
Q Okay. Did you have the opportunity to review the physical therapy notes from that facility?
A **Yes.**
Q Based upon your review in total of Dr., Mr. [redacted] medical records, what if any treatment is reasonably necessary to address the conditions that you just determined were causally

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related to the accident of April the 30?
A **Well, his visit to the emergency room clearly was reasonable, necessary and causally related. The determination in the emergency room was made that the patient had probably this soft tissue kind of injury. It's, it's, it's not unreasonable with someone who has that kind of an injury to simply observe them, not, not really treat them at all. But in today's society where, you know, we treat people for their symptoms it was totally reasonable to be referred to Dr. Misoul, to have an orthopedic evaluation because he does have some underlying problems that, you know, might be outside of the purview so to speak of the, of the emergency room doctor.**
So the first visit to Dr. Misoul is reasonable. I think then when you've identified these types of injuries and you know that you can, manage the patient's symptomatology by providing some therapy, some medication, it's not medically necessary to do all that because none of these

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things are going to not get better but it is totally reasonable to provide some, some treatment and I think sending him for a month or so of physical therapy that has a goal of ultimately getting him to a home program where he can rehab himself is reasonable. Putting him on some medication is reasonable if, if necessary. Limiting his activities, if he were working, you know, taking him off work depending on what he did for awhile. All of those things is, is I think in our day and age a reasonable way to treat these soft tissue injuries.
Q Great. Subsequent to the initial visit, Mr[redacted] was referred for electrodiagnostic studies which were performed in June, on June the 9, 2003. Did you have the opportunity to look at that?
A **Yes.**
Q What if any indication are there that would warrant that kind of test?
A **Well, that test, you know, just to be**

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real quick is a nerve test to try to determine how the transmission of nerve impulses are going, in this case, down the legs. We do that test looking for pinched nerves or looking for other problems with the nerve, muscle unit, muscular dystrophy, multiple sclerosis, those types of things.

In this case, Mr. [redacted] complained of numbness in the legs and so that would be a trigger for a doctor to think about electrodiagnostics. In this particular case, though, we know he's had two or three back surgeries. He's had a history of this problem before I would have, you know, I think you could have held off on ordering that test because when you order a test you have to ahead of time know what you're going to do with the result. So if the test comes back and the results going to be positive, in other words, it going to show signs of nerve impingement or nerve compression or something like that, are you going to do anything else different in a guy who you've already diagnosed a

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soft tissue injury. The answer is no, you're not. If it comes back normal, what are you going to do with that result? Are you going to say, well, gee he's got numbness and tingling, he's had three operations on his back, that test probably didn't pick up what it should have be so you're not going to do anything different with that. So, really in this particular case even though he did had complaint of numbness in the legs, there was really no good reason to do that test.

And as you can see from the report and from the record they didn't do anything with the result. The result is abnormal but they didn't change any course of treatment or anything like that.

Q Following the electrodiagnostic study, Dr. Reischer gave the impression of intrapelvic entrapment, what's that?

A The was talking about the superior gluteal nerve, which is a peripheral nerve that goes to the muscles around the pelvis. The gluteal

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nerve is, goes to the gluteus maximus, gluteus abductor and so what he was saying is there appears to be damage to that nerve. Most likely due to the fact that he's had fusion in the back and he's had bone graft harvested from his hip. So that's, that's what goes along with that. That was not an injury due to the car accident.

Q We also know from Mr. [redacted] information that he subsequently underwent knee surgery in August of 2003?

A Yes.

Q What are the pertinent findings upon that,--

A Well, at the time of his knee surgery he was, he was found to have degenerative changes in the kneecap joint. He was found to have a big, thickened lining tissue called a plica. He was found to also have a complex tear of his medial meniscus or cartilage and these were addressed by Dr. Misoul by trimming and shaving and things like that and those were the pertinent findings.

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Q Do you have an opinion to a reasonable degree of medical probability as to whether or not those findings are causally related to the accident of April 2003?

A Yes.

Q And what is that opinion?

A That those findings were not. Those were degenerative findings, findings that were not related, at least to an acute injury that had occurred a couple months before that, or three or four months before that.

The scarring of the plica, plica is a normal structure in the knee which can become abnormal over time or from damage or from prior surgery and it gets thicker and thicker and thicker as it scars up.

If that had occurred as a consequence of the accident in April, we would have seen evidence in April and subsequent to that of an acute injury to the knee. We would have seen swelling, limitation of motion, we would have seen the

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findings of acute edema etc. because that's what has to happen for the scar tissue to occur. So the findings of the plica problem had to be a preexisting thing.

The complex tear of the medial meniscus was also something that, that is not at all easily explained by the mechanism of injury in this accident. He was hit from the rear. Complex tears of the meniscus occur as a consequence of, when they're traumatically caused, a twisting injury or something that torques the knee.

In this age group we, the majority of meniscus problems are degenerative meniscus problems. This is a wear and tear finding that's described by Dr. Misoul and there's nothing in the, in the record to suggest a mechanism to place it as a cause by the motor vehicle accident.

Excuse me.

MS. BUNTY: Can we go off the record?

VIDEOGRAPHER: Off the record at 10:15.

VIDEOGRAPHER: On the record at 10:15.

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Q All right. To follow up then with the discussion of the surgery, do you have an opinion to a reasonable degree of medical probability as to whether or not the treatment rendered to the knee starting with the surgery in August of 2003 and the follow up visits and then there was some physical therapy are causally related to the accident of April of 2003.

MS. ZOIS: Objection for the reasons previously stated off the record.

A Yes.

Q What's the basis for, or what's your opinion first?

A Well, I don't think that, I believe, it's my opinion that the auto accident of April 30, 2003 did not cause injury to the knee that would have required surgery in August of 2003. I think that, you know, now that we can see what was found at the time of surgery and we have the whole picture, so to speak, it's clear that he did not tear a meniscus in this, in this accident. There's

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no evidence of that in the early management, even in the, even though he was having some discomfort when he saw Dr. Misoul it was patellofemoral discomfort, it wasn't medial meniscal discomfort. No evidence that the mechanism of that injury could have caused that, that finding and the findings around the kneecap of this scared up fibrotic plica clearly from a, you know, from an anatomic scientific basis couldn't have come from that accident either.

Nothing happened at the time of the accident that you can fill in the blanks. In other words, you've got to fill in the blanks between the accident and the finding at the time of surgery and there's no swelling, there's no edema, there's no effusion, there's nothing to suggest that the, enough damage to the plica occurred to lead to those kind of surgery. There is evidence of a prior surgical procedure though we don't have any other history about that, which most likely explains the findings at the time of surgery, in

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the plica region.

Q Okay.

MS. BUNTY: That's all the questions I have. Ms. Zois might have some follow up. Thank you.

THE WITNESS: Sure.

EXAMINATION BY MS. ZOIS

Q Dr. Hanley, you were hired by the defense to render an opinion in this case, is that correct?

A Yes, ma'am.

Q And in this particular case you never actually examined the person that you're giving opinions about today, is that right?

A That's correct.

Q So if you examined my client you would have had the benefit of asking him about his prior medical history, correct?

A Correct.

Q And in the particular case you didn't have the opportunity to ask the plaintiff whether

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or not he had a prior medical history of a surgery,--
A Correct.
Q -- is that right?
A Correct.
Q Okay. And you also didn't have the benefit of asking my client about the mechanism of injury in this case, is that right?
A Right.
Q So you've never asked Mr. [redacted] how this accident happened and what happened to him physically in the vehicle at the time of the accident?
A Correct.
Q Because you testified earlier that this is a rear-end accident and that in order to have the type of problem that he has there has to be some torquing of the knee, but you never had the opportunity to ask him what happened to him in the vehicle, is that right?
A Correct.

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Q And is it fair to say that you are basing your opinion that he had prior history on one note in Dr. Misoul's initial report of May the 2, 2003?
A On the knee you mean?
Q Yes.
A Yeah. That's the only place that we find anything, you know, Dr. Misoul says he has scars on his knees,--
Q Okay.
A So, you know.
Q And just so we're clear, you've reviewed subpoenaed records from North Arundel Hospital, you've reviewed subpoenaed, subpoenaed records from Dr. Jassi, you reviewed subpoenaed records from Paul Asdourian, you've reviewed subpoenaed records from Advanced Radiology, you have about a six-inch-stack of prior medical records sitting in front of,--
A Correct.
Q -- is that correct? Is it fair to say

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that nowhere in that six-inch-stack of medical records did you see any indication at all that he had a prior knee surgery before the date of this accident?
A No, other than what we've already talked.
Q Right.
A Just the one thing.
Q So in every occasion where he saw one of the doctors that you've got records before you and he gave a prior medical history, he never mentioned having a prior knee surgery,--
A Correct.
Q -- is that fair to say?
A Correct.
Q And in every physical examination done by every doctor for the records that you have in front of you there's no indication that he has healed arthroscopic scars on his knee, is that accurate?
A Correct.

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Q All right. So even with six inches of documents in front of you and no evidence in there of a prior knee surgery and none of those doctors put in their reports that he had scars healed on his knee you still believe he had a prior knee surgery?
A Sure. I mean it's entirely possible. These only go back to what, '95? We've been doing arthroscopic knee surgeries for 25 years.
I've had patients come in the office that had surgery in the military, for example, that forgot about it. I mean arthroscopic surgery is a pretty, almost a non-event for some people, it's possible. I mean, if Dr., if Dr. Misoul saw portal scars, truly did then they got there somehow.
Now, maybe, you know, you'd have to ask him but maybe this was a misinterpretation, maybe he put something in the report that wasn't there, I don't know. But, you know, I don't look at every patient that comes in the office for a back problem at their knee to see if they have portal scars.

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So, unless someone can suggest or prove, which I don't think will happen that they weren't there, then there has to be a reason for them being there and they're very specific findings. Portal scars are usually in the same spot, you know, you know what to look for. So if he claims they were there then I would think they were there.

Q I'd like to direct your attention to the past medical history that Dr. Misoul reported of Mr. [redacted] on that very same day that he saw the scars.

A Yes, I have it.

Q And in the prior medical history portion, is it fair to say that there is absolutely no mention of a prior knee surgery?

A There's no mention, correct.

Q Okay. Just so we can kind of pair down what the issues are for us in this case,--

A Sure.

Q You agree that he sustained a back injury in this accident?

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A Yeah.

Q You agree that he sustained a neck injury,--

A Yes.

Q -in this accident? You agree that he injured his shoulder in this accident?

A Yes.

Q And you agree that he had a contusion on his chest as a result of this accident?

A Correct.

Q Okay. So essentially we're here about the knee?

A Correct.

Q Is that fair to say?

A I think. I mean, yeah.

Q Okay.

A I mean, I think that's where my opinion diverges a bit.

Q Sure. And you, your opinion is based on the note in Dr. Misoul's record that says he observed scars?

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A Well, no. No. I think that even if he hadn't observed scars the findings at the time of surgery, see you don't, that's also important. I think what he records that he found on the gentleman. Even if he had not had a prior surgical procedure it still doesn't fit. In other words, the findings at the time of surgery don't fit the mechanism and the postop, the post-injury scars.

Q Just so we're clear, doctor, you don't know how the mechanism of injury occurred, correct because you don't have the benefit of asking,--

A Well, he was,--

Q -- the patient, is that right?

A He was hit from the rear so we do know that there's some basic physics that has to occur there. We know that if you're hit from the rear the first direction you go is backwards, okay? We know that, you know, Newton's law says that's which way you're going to go.

So we know that the first impact in the vehicle to no matter what position you're in or

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whatever is going to be backwards and you're going to impact the seat or whatever. We know that he was not thrown forward into the dashboard initially, that just doesn't happen in rear-end collisions. Whether or not he was looking over his shoulder or had his foot braced against the floorboard etc., etc., no I don't know any of that.

Q Okay. Now you were again coming back to how you were retained in this case, you were hired by Ms. Bunty to form opinions in this case at her request, correct?

A Correct.

Q And you've done work for Ms. Bunty's office before, is that right?

A Not very often by occasionally, yeah.

Q And on the particular date that you were retained to render opinions in this case, Ms. Bunty in her letter to you contends that the amount of property damage to my client's vehicle was $474.50, do you recall that?

A I don't,--

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MS. BUNTY: Object to the characterization.
A I don't remember that.
Q We can, we'll go ahead and mark,--
A But, you know,–
Q I can show you the records.
A I'm sure that when I reviewed the record I had just read the letter, so, yeah.
Q Okay. So let me, I'll just, just so it helps to refresh your recollection, when you were first retain to render opinions in this case Ms. Bunty provided you with information that indicated that there was $447.50 worth of property damage to my client's vehicle.
A Correct, that's, that's what her letter says.
Q And based on that, did you come to the conclusion this was a mild impact case?
A I didn't come to that conclusion. I think that it's, yeah, I guess you have to, I mean, you have to say that if there's only $400 worth of

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damage it wasn't a very heavy impact.
Q Okay. I'm going to show you what we're also going to mark for identification another repair estimate that I don't suppose you were provided with indicating that my client's vehicle, two days after the accident actually sustained over $1,600 in property damage.
A Okay.
Q Okay.
A It's a little more damage isn't it?
Q And is it, strike that question.
Now, you mentioned earlier that you are focussing your practice on forensic work, is that accurate?
A Yes.
Q And forensic work essentially when you're hired by an outside party to come in and review records and render opinions for people that you don't actually treat?
A Correct.
Q All right. And you've been doing this

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type of forensic legal work for quite some time?
A Correct.
Q Dating back to when?
A Well, '81, I mean, the very beginning of my career.
Q And currently 100 percent of your income is derived from doing medical legal work, is that right?
A Well, I have outside sources of income besides this but 100 percent of the income, almost 100 percent of the income from my practice comes from forensic work, yeah.
Q And that's been the case since January of 2004, is that right?
A Yeah. Yeah, December 16, 2003 I did a carpal tunnel release and that's the last surgery that I did.
Q And since January 2004 you haven't actually treated any patient that you received compensation for?
A Correct. I've treated patients but I've

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done it as, for patients that, people that I know and have special relationships, yes.
Q The friends and family discount?
A Yeah. Exactly. I mean, I last time I was here I drained a fellow's knee and gave him a shot.
Q And the majority of the work that you do evaluating people is at the request of the parties defending the claim, correct?
A Usually, yeah. The vast majority of that, over 95 percent of the time because a lot of this stuff I do, the majority of the people I see are injured workers, they're not injured in motor vehicle accidents etc.
Q And you're hired by the employer?
A The employer or the employer's representative or, you know, there's sometimes nurse case managers want a second medical opinion but, you know, they're being paid by the employer and the employer's representative. So, yeah, I think it falls into that, you can call it the

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defense side or the defendant's side, whatever you want to call it.

Q So locally 95 percent of the work that you do is for the defense side, is that fair?

A Yeah, I would say that's a good estimate maybe even a little touch more. I mean, there's two or three plaintiff attorneys that will send me their clients for this type of an exam and after that there's not many others.

Q Now you also do evaluations in California?

A Correct.

Q And you go out there about 10 to 12 times a year?

A Yeah, probably. This year it looks like it's going to be about 10 times. I just got back Sunday. That's where I initially started doing forensic work and, and I have a relationship with a group out there that does strictly workmen's compensation in California. Now in California it's a little different. Probably half of the patients

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I see, I see at the request of the patient. In other words, they have a system out there where the patient if they're unrepresented can get a list of three doctors from the state that are three qualified medical examiners and pick one. And so about half the patients I see pick me off of a three name panel.

Q And when you,--

A The other, about half of the other 50 percent are sent to me by what's called the applicant or plaintiff attorney and half are sent by the insurance company slash employer.

Q And when you go out there, do you usually go out for three days at a time and do about 55 evaluations per visit?

A Well, I just got back and only did 25 in three days, but,--

Q Is it fair to say that the average is between 45 and 55?

A Yeah, but I've been going for more, like five days now. So I would say over the course of

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the year I probably see about 500 patients up there.

Q And the fees out there for doing these types of evaluations are fixed fees, correct?

A Yes. There's a, there's a fee schedule. The majority of the ones I do I'll get paid $275.

Q Did you ever testify in the past there's fixed fees out there and the lowest fee is $500?

A Yeah, but I don't get all 500. I, I work for a, I'm an employee so, or a contractor. I get 55 percent so 55 percent of 500 is 275.

Q Okay. But as a contractor, I mean, the evaluation itself, the cost of the evaluation is $500?

A Correct.

Q And in the past you had, you grossed for the company that you've work for out there over a million dollars,--

A Yeah.

Q -- in one year?

A Yeah. That was back in the late '80's I

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guess. I believe, I mean, I never saw those records I estimated because I saw a thousand patients that year and this was, I guess it was just that year, I saw a thousand patients that year and the fee schedule back then was a thousand dollars plus were exam. So my guesstimate was that, that the guy I worked for pulled in a lot of money.

Q You got half of that?

A No, I didn't get half of that. I got about, I think I got, that year I probably made $270,000 in California.

Q In the late 80's?

A Yeah.

Q And you also do evaluations in Delaware, right?

A I haven't done any lately. I have done them, yes. I haven't done Delaware, a Delaware case in over a year.

Q And you were, you got your license to practice medicine in Delaware in 2002?

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A Yes, it should be on my,--
Q It's on your CV.
A Yeah.
Q Have you ever treated a patient in Delaware?
A Yes, but that was a long time ago when I was in residency. I did part of my training in Wilmington but I have not treated any patients since I got a license in 2002.
Q So is it fair to say that the reason you got the license in Delaware in 2002 was to allow you to do the forensic work,--
A Yes.
Q -- in Delaware?
A Exactly. I mean, there was, there was a, you know, the source of the forensic work is, there's a lot of different sources and one of the sources was desirous of having us, me and a couple of other doctors be available in Delaware and Pennsylvania and so we got licences in both Delaware and Pennsylvania strictly to practice

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forensics, not to treat patients, not to set up an office there for treatment.
Q And how many evaluations do you do a year in Delaware?
A Like I, like I said, I don't do any anymore. I do go to Philadelphia.
Q We'll get to Pennsylvania in a minute.
A Okay. So none in Delaware.
Q None in Delaware,--
A Right.
Q -- this year? Okay. When is the last time you did a forensic evaluation in Delaware?
A Probably in 2004 I would think.
Q All right. And onto Pennsylvania. You got your license in Pennsylvania in 2003?
A Yes.
Q And the purpose of getting your license in 2003 was as you just described was to do the forensic work over there?
A Correct. Correct.
Q When is the last time you did an

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evaluation in Pennsylvania?
A Last month. Well, what is this? Yeah, I don't, yeah, I haven't gone in April yet. I go once a month to Philadelphia.
Q Okay. And when you go once a month, how many days are you there?
A One day. Just, just, just up and back.
Q How many evaluations do you do in the one day?
A 10 to, 10 to 20. 10 to 18, something like that.
Q And what do you charge for the, what are the, what's the fixed fee for,--
A 225.
Q Is that the average or is that the,--
A No, each one is 225.
Q Is that your fee that you get?
A Yes.
Q So that's not the actual,--
A Correct.
Q -- evaluation cost?

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A Yeah, I don't,--
Q -- the actual evaluation cost?
A I don't know. Probably 350 I would think.
Q And have you ever provided medical treatment to anyone in Pennsylvania?
A No.
Q So generally, can you estimate for me about how many medical exams,-- well, let me before we there. Is there any other forensic work that you do outside of California, Maryland, Delaware and Pennsylvania that I don't,--
A Alexandria.
Q -- haven't asked you about?
A I go to Alexandria once a month as well.
Q Okay.
A About the same as, it's almost exactly the same as the Philadelphia numbers.
Q So just so we're clear, you,-- let me back track. You got your license to practice medicine in Virginia in 1995?

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A Right, I have that much longer. Right.
Q And have you treated patients in Virginia?
A I don't think I ever have.
Q Okay. So the purpose of getting the license in Virginia was to do the forensic work?
A Yes. I was working for a company that actually had an office in Virginia.
Q What's the name of the company?
A The company was called Professional Evaluation Group.
Q Are they, they're now defunked?
A I think they are, yeah. I don't work for them anymore, yeah.
Q So,--
A They're out of New York. They may still be funked up in New York but they're defunked down here.
Q So the purpose of getting the license in Virginia was to do the forensic work in Virginia?
A Yes. Actually I went to Richmond and

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Fairfax.
Q And you said that your trips to Virginia are about as frequent as your trips to Pennsylvania which is, you go about once a month?
A Correct.
Q You do about 10 to 20 evaluations while you're there?
A Yeah. Yeah, that's about right. And the, the fees there though are less. It's only 150.
Q And that's your fee?
A Correct, that's that I,--
Q Your fee is 150?
A That's what I get paid.
Q Okay. Is there any other forensic work that you do in any other jurisdiction that we have not discussed?
A No.
Q Do you participate as a principal in any type of organization that does forensic work?
A Yes.

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Q And you, that business is PPG?
A Yes.
Q And how long has PPG been in existence?
A 2001 maybe. I think it's probably going to be five years in December or November.
Q Are you a member or a principal of any other group that does forensic work other than PPG?
A No.
Q All right. Turning your attention to PPG for a minute. It is fair to say that PPG is essentially a match-making service where a person that needs a defense exam calls PPG and you line up the appropriate doctor to do the exam?
A I guess that's, that's one way of putting it. We have four or five doctors who are available at about, I don't know, 10 or 15 locations.
Q Who are the four or five doctors?
A Drs. Smith, Thompson,--
Q Dr. Robert Smith?
A Yes. Dilallo, Harries, Draper.

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Q Dr. Draper.
A And myself.
Q Okay. So, Dr.,--
A And so,--
Q -- Smith, Dr. Harries, Dr. Draper, Dr. Dilallo.
A Dilallo.
Q And yourself. Okay. So you actually match yourself up with people?
A Yeah. Well, I'm on that panel.
Q You're on the panel, okay.
A We send out a calendar that says that, you know, Dr. Smith is available in Landover on April 17. And someone will call and say, we want Dr. Smith in Landover.
Q Is it,--
A We match it up.
Q Is it fair to say that Dr. Robert Smith also no longer treats patients and does forensic work?
A I know he does a lot of forensic work.

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He may not be treating patients anymore.
Q How much does this business make a year?
A For who?
MS. BUNTY: Objection.
Q Well, your partners?
A For Smith or for me?
Q Let's put it this way, you're a partner in that business, correct?
A Correct.
Q And how much do you make a year from that business?
A A lot. It probably spins off about $300,000.
Q And as a partner you make $125,000?
A No, to each of us. 300 to each of us.
Q And your partner in this case, does he treat patients?
A No.
Q Why not?
MS. BUNTY: Objection. Relevancy.
A He's not a doctor. He's the

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administrator of the business.
Q How many medical exams do you estimate that you do a month including all the jurisdictions that you go to and PPG?
A Okay. I work five days a month for my own practice. I work six days a month for Principal Physician's Group. And I work about average three, let's say four days a month in California. So that's what, 15 days?
I would suggest that I average about 15 patients a day, so and I work I'd say about 10 months a year. I take about about six to eight weeks off, so I'd say I see almost 2000 patients a year through all of the various sources of what I do.
Q Okay. Now in addition to, and these are actual medical exams, correct?
A Yes. Every one, that's seeing the patient.
Q Now in this particular case you only did a records review?

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A Yes.
Q About how many records review to you do a year total for all the jurisdictions and PPD?
A Very few. Probably two or three a month I would think, 30 to 40.
Q So 30 or 40 a year?
A A year, yes.
Q Do you remember testifying back in October of 2005 that you were doing about a hundred records review a year?
A I don't remember that. but I don't think that that's,–
Q Let me show you your deposition.
A I don't think that's right, but I guess we could say a hundred. It's a guesstimate. I don't think I do more than three or four a month.
Q Okay. Let me show you your deposition transcript from October 13 of 2005 in the case of Tackett versus Anne Arundel County and it's the bottom of the page. And in that transcript you were asked essentially the same question about how

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many records review you did a year and in that particular case you said it was about a hundred.
A Well, let's see. It says, let me think. I would say maybe 100, maybe, maybe not that many it's hard to say. Yeah, probably less than a hundred. So, 40 is less than a hundred.
Q Okay.
A So I don't know how many it is, but.
Q Yes.
A Well, let me just say at that point in time I was doing more for PPG, I was doing more record reviews.
Q Okay. This was six months ago?
A Yeah. I'm doing much fewer now. Dr. Thompson is doing more of the record reviews. I've only done one or two in the last few months for PPG. So, that's why I came up with three or four a month. I probably get one like this from one of the firms like this once or twice a month. That's why I said, I think, let's say 40 to 50 a year would be probably the rate I'm seeing them at this

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time.
Q Okay. So you've cut your records reviews in half basically?
A Well, they're just not coming my way.
Q Okay.
A I mean, I'm perfectly happy to do them, but I'm just not getting them.
Q What did you charge for the records review in this particular case?
A $250.
Q Are you sure? Let me show you your,--
A This says, paid 250.
Q Yeah, this is unfair because I have your statements right here. What is your charge for the records review in this case, and I'll show you your bill to help refresh your recollection?
A Okay. Let's see here. It says here 450.
Q Okay.
A Oh, I see what happened. Okay. So a check for 250 came with the packet of records which

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was received on 8/19/05 and then after the records were reviewed and arrived it took longer than the typical amount, so we charged an extra 200. So we charged an hourly rate of 450 an hour.
Q And is that your typical hourly rate?
A Yes.
Q 450 an hour?
A Yes, ma'am.
Q Taking all of the types of evaluations, of evaluations that you do, is it fair to say that your average rate, including the ones in California, Delaware, Pennsylvania, Virginia, records reviews, PPG, is it fair to say that your average rate for doing an examination is $300 an hour?
A No, it would be less.
Q Okay. Is that less since October 13 of 2005?
A Well, I doubt if I included all of my, I don't think that was a global average, I don't think. Maybe it was. Let me see what I said then

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because most of the PPG evaluations are $150, so that's going to pull down the average. My average in my office of the ones I see in my office is about 325 but that's only those five days a month that I work for myself. Those are averaging about 325. The average of the ones at PPG are going to be, well the most I ever get paid for a PPG case is 225.
Q Okay. Well, I can show you your deposition transcript,--
A So that's going to pull it down.
Q Essentially in this, in this estimate you say the average is probably closer to 300 because there's a fair number that are charged around 150.
A Okay.
Q So you do include the lower number.
A All right.
Q And for deposition testimony you charge $450 an hour?
A Correct.

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Q But you always charge a two hour minimum, is that correct?
A One-and-half to two hours. I think lately its been two hours.
Q And so that's $900 per deposition?
A Correct.
Q And is it fair to say that in 2002 you did about 44 depositions?
A 2002?
Q Yes.
A That's probably right.
Q And in 2003 you did about 31 depositions?
A Yes.
Q How many depositions do you estimate that you've done so far in 2006?
A 2006. I have no idea. The problem is,--
Q How about 2005?
A I really don't know that either. The problem is that, you know, we schedule a lot of them. A lot of them don't go through and, for

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example, I think,--
Q Well, when was the last time?
A I had three or four this week. I had one yesterday.
Q Did you have one this morning?
A This one.
Q Okay. Was this the only one you had this morning?
A Yes.
Q And you had one yesterday also?
A I think so, but let me think.
Q John Valenti?
A Yes.
Q So,--
A There seems to be more lately.
Q Okay. And how many do you have scheduled this week?
A Let's see. I had one Monday, Tuesday, Wednesday. I had one yesterday. What did I do Tuesday? I don't think I had one Tuesday. I may have one scheduled for tomorrow. It may have been

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already cancelled but three or, two or three this week, two for sure maybe three.
Q So you had one Monday. You had one yesterday.
A Three, yeah.
Q You had one today.
A Three. And I may,--
Q You may or may not. You have one on your calendar for tomorrow though, right?
A I don't, yeah I think I do.
Q Okay. Do you have your calendar with you?
A No.
Q Is it fair to say that you've testified hundreds of times?
A More than a hundred, two hundred probably over the course of 25 years, sure. That would be only six times a year.
Q We know it's more than that, right?
A Absolutely.
Q You read, you read the MRI in this case?

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A I have the MRI of the knee, is that the one you're talking about?
Q Yeah.
A Yeah.
Q And according to the MRI, my client had a Grade IV tear?
A That's what it says, yes.
Q Okay. And during the course of his presentation with his doctors he described the problems with his left knee as being exquisite and tender and having difficulty ambulating and difficulty going up and down stairs, difficulty bending, difficulty squatting, difficulty walking. Do you recall,--
A Yeah. That is,--
Q -- these subjective complaints of pain?
A That was in the very first note of Dr. Misoul.
Q Right. And you have like we mentioned earlier six inches of medical records in front of you. It is fair to say that within this six inches

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of medical records there isn't a single doctor's note that indicates he ever complained of left knee pain before the day of this accident?
A None that I recall.
Q Is it fair to say that you have no records before you were he received any medical treatment for his left knee before the date of this accident?
A Correct.
MS. ZOIS: Nothing further.
FURTHER EXAMINATION BY MS. BUNTY
Q You were talking about these marks on the knee and you said they were very specific findings. What did you mean about that?
A Well, I mean, you know you put the portals for arthroscopic surgery at a very stereotyped location. I mean every doctor that does arthroscopic surgery is going to put an anteromedial portal, is going to put an anterolateral portal and then, those are the two main portals. And then depending on what you do

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you may put one medial to the patella, lateral to the patella. So, in other words you're not going to put one out here or out there, you're going to put them in specific spots within a, because that's where you get into the knee. And so an orthopedist or somebody that does orthopedic surgery,–

Q Would that include yourself?

A Yeah. Knows where to look for these things. You know, a primary care doctor is not going to do that necessarily. And, you know, they get pretty faint over time. But that's what I mean, they're specific, you know, specific locations.

Q Now, the records that you do have from other sources doctor, you listed that names, Asdourian, Jassi dah, tah, dah. When a patient comes in to you and their chief complaint is say, I have neck complaint, are you analyzing the knee or looking for knee complaints?

A No. I mean, again, we do a focused exam focusing on the location of the complaint. And so,

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you know, shoulder, ankle whatever it is, yeah.

Q So if Mr. [redacted] is showing up for the fifteenth time at Anne Arundel Hospital because he's got complaints of dizziness and shortness of breath, something related to his COPD or his lung condition, are you documenting or doing a physical examination of the knee?

A No. No.

Q We spent a great deal of time talking about your source of income and obviously this comes from your forensic dealings, isn't that true?

A Sure.

Q Now, back years ago when you decided to shift the focus of your practice into forensic, did you anticipate that you would be working in a legal context such as this, analyzing claims involved in litigation?

A Sure. I mean, that's what I had been doing for a long time. I just, you know, it's a lot easier on your family life etc. to do this type of orthopedics than it is to be going to the

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emergency room and doing surgery for eight hours a day etc. I mean, it's, it's, I'm getting older, it's a lifestyle change and I was fortunate enough to have the skills and the experience to be able to do this.

Q Thank you, doctor.

MS. BUNTY: I have no other questions.

FURTHER EXAMINATION BY MS. ZOIS

Q How much did you make in your 2005 tax returns doing forensic work?

A I don't know.

Q You don't have your tax returns?

A Not with me.

Q You don't review your tax returns before they're filed?

A My wife does.

Q When did you, you, you have to sign them though, correct?

A Sure.

Q Okay. Did you file recently, I mean, we're on April 20. They were due two days ago, did

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you file recently?

A Yes.

Q When did you file?

A Well, I made a lot more money on my tax returns that didn't have anything to do with forensic work.

Q Okay. How much, well then you know,--

A It's not broken out on my tax return.

Q Okay. But you know difference don't you?

A Sure. And I'm not going to tell you.

Q Okay. Doctor, I have a subpoena here,--

A Because it's my wife tax return as well.

Q No. I understand that.

A And, you know, she will not be,--

Q But you told me that you know how much you make in forensic work and you're not going to tell me.

A No, I don't know that. I said it's not broken out on my tax return. You asked me, okay, how much on my tax return is from forensic work and

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I don't know.
MS. BUNTY: Let's go off the record for a second.
Q Actually, I have a copy.
VIDEOGRAPHER: Off the record at 10:48.
VIDEOGRAPHER: On the record at 10:49.
Q We'll have this marked for identification. I guess it will be Deposition Exhibit Number 3. I'm going to hand you a subpoena for you to appear at trial to produce the requested documents that are attached to that list which include 1099 and your federal and state tax returns.
A Okay. Well, 1099s aren't maintained in my office.
MS. BUNTY: Doctor, there's not a question pending.
MS. ZOIS: That's it.
MS. BUNTY: That's it.
VIDEOGRAPHER: This concludes the video deposition. Off the record at 10:50, one tape.

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(Deposition Exhibits 1, 2 and 3 marked for identification and attached to the transcript.)
(Deposition concluded at 10:50 a.m.)

STATE OF MARYLAND, COUNTY OF BALTIMORE:

I, Sylvia L. Jacobs, a Notary Public in and for the State of Maryland, County of Baltimore, do hereby certify the within named KEVIN F. HANLEY, M.D. personally appeared before me at the time and place herein set out and, after having been duly sworn by me according to law, was interrogated by counsel.

I further certify that the examination was recorded stenographically by me and then transcribed from my stenographic notes to the within typewritten matter in a true and accurate manner. I further certify that the stipulations contained herein were entered into by counsel in my presence. I further certify that I am not of counsel to any of the parties, nor an employee of counsel, nor related to any of the parties, nor in any way interested in the outcome of this action.

AS WITNESS my hand and notarial seal this 27 day of April, 2006, at Baltimore, Maryland.

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Sylvia L. Jacobs, Notary Public