2-1-2000

Dr. Robert White Deposition

Cuyahoga County Court of Common Pleas

State of Ohio,)
County of Cuyahoga.)

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IN THE COURT OF COMMON PLEAS

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ALAN DAVIS, et al.,)
Plaintiffs,)
v.) Case No. 312322
) Judge Ronald Suster
STATE OF OHIO,)
Defendant.)

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THE DEPOSITION OF ROBERT J. WHITE, M.D.

MONDAY, FEBRUARY 1, 2000

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The deposition of ROBERT J. WHITE, M.D., a witness herein, called for examination by the Plaintiffs, under the Ohio Rules of Civil Procedure, taken before me, Lauren I. Zigmont-Miller, Registered Professional Reporter and Notary Public in and for the State of Ohio, pursuant to notice, at MetroHealth Medical Center, 2500 MetroHealth Drive, Cleveland, Ohio, commencing at 10:15 a.m., the day and date above set forth.

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APPEARANCES:

On behalf of the Plaintiffs:

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On behalf of the Defendant:

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(Thereupon, Plaintiffs' Exhibits 1 and 2 to the deposition of Robert J. White, M.D., were marked for purposes of identification.)

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ROBERT J. WHITE, M.D.,

a witness herein, called for examination by the Plaintiffs, under the Rules, having been first duly sworn, as hereinafter certified, deposed and said as follows:

CROSS-EXAMINATION

BY MR. GILBERT:

Q. Good morning, Dr. White. My name is Terry Gilbert as you know and we're going to be conducting your deposition today in connection with this case.

Would you please state your full name for the record?

A. Dr. Robert J. White.

Q. Where do you currently reside, Dr. White?

A. Well, my home address is 2895 Lee Road, Shaker Heights, Ohio.

Q. Are you currently employed?

A. No.

Q. Have you formerly been employed?

A. Yes.

Q. And where was that?

A. Well, I was employed by Case Western Reserve University Medical School and the MetroHealth Medical Center.

Q. What is your occupation?

A. I'm a neurosurgeon.

Q. Are you retired at the present time, Dr. White?

A. From practice, yes.

Q. When did you retire?

A. July of 1998.

Q. That was from both positions, at Metro and Case Western Reserve University?

A. No, just from Case, as the director of neurosurgery at this institution.

Q. Your last position was director of neurosurgery?

A. Director of neurosurgery at MetroHealth Medical Center and director of the brain research laboratory.

Q. How long did you hold that position?

A. Since 1961.

Q. So the director of neurosurgery was since 1961?

A. Yes, sir.

Q. And the brain research laboratory, that position --

A. Same length of time.

Q. All right. So there were no changes in your title from 1961 until your retirement in 1998?

A. Not at this institution.

Q. What other positions did you hold?

A. Well, I was the co-chairman of neurosurgery at Case Western Reserve for a number of years.

Q. What years was that?

A. Well, I don't know exactly. I would suspect that was probably in the 1970s for about probably ten years.

Q. Now, showing you what's been marked as Plaintiffs' Exhibit 2. This is a professional biographical sketch that was provided to me regarding your background; is that correct?

A. Yes, sir.

Q. Are there any changes that you would like to add or any corrections in that document at this time?

A. Well, I don't want to read the entire thing. As it sets out and looking at the paragraphs and scanning them, no, sir.

Q. You have been listed as an expert witness in connection with this case; is that correct?

A. That's my understanding.

Q. Can you tell me how it came about that you were contacted in regard to your role in this case?

A. I think the prosecutor's office inquired, I think by phone, my availability.

Q. What was it that they asked you?

A. Well, they may have been aware that I have spent a good deal of my career caring for people with head injuries and spinal cord injuries, and I can only presume that they thought in consideration of Dr. Sheppard's problems that perhaps it might be well to have somebody who has concentrated in these areas in their career to at least review the records.

Q. What did they specifically ask you to address?

A. Well, it was the hospital record of his admission and the consultations, in other words, to focus on the medical aspects of the case.

Q. Were you asked to look at anything else in connection with this matter other than the injuries as reflected in Dr. Sheppard's admission after July 4th of 1954? Were you asked to look at anything else?

A. Yes. I was asked to look at the testimony

contained in the court records that reflected the details that had to do with the 4th of July and the interviews that were taken with the various physicians and so forth who were involved, some, but not all of them, who had actually examined Dr. Sheppard in the hospital.

Q. Were you asked to look at the injuries of anyone else connected to this case?

A. No.

Q. I just want to make sure what the subject areas of your work on this case is confined to, the injuries or lack of injuries sustained by Dr. Sheppard from July 4th, 1954; is that correct?

A. Yes, and then, of course, what followed.

Q. Exactly. So July 4th and beyond?

A. Yes, sir.

Q. But connected to the injuries supposedly sustained by him in connection with the events surrounding the murder of his wife?

A. Yes, sir.

Q. You were not called upon to look at Marilyn Sheppard's injuries that caused her death?

A. No, sir.

Q. Now, since July 1998 how have you been spending your time in retirement?

A. Consultations, teaching, lecturing and doing what we call visiting professorships.

Q. Is there any particular area of concentration in the overall discipline of neurosurgery that you are interested in concentrating on at the present time?

A. Well, there's a continuation of my interest in central nervous system trauma.

Q. I assume you've authored articles, written extensively in the area of neurosurgery; is that correct?

A. At the present -- I think this single page doesn't reflect it -- there are about 800 articles that have been written.

Q. Have you ever served as an expert witness before?

A. Yes.

Q. In litigation?

A. Yes.

Q. When was the last time you did that?

A. I'm not totally sure, Mr. Gilbert. I don't do it very often. I'm involved in a case now, but it has to do with a physician's curriculum vitae, it has to do with a physician, it has nothing to do with expertise. The reason I'm an expert is simply

because of the years that I've done academic medicine, but it has nothing to do with the injury side of things.

But there have been situations in which I was brought in as the expert witness on cases, for example, spinal problems. One I recall was for the Mayfield Clinic and the University of Cincinnati some years ago. As a matter of fact, I represented Dr. Mayfield himself.

Q. What was that case about?

A. It was about a physician who had been operated on by a member of the Mayfield Clinic staff, and Dr. Mayfield himself came late to the operation, and the case had to do with whether or not some harm had been caused as a result of the operation.

Q. Was it a medical malpractice situation?

A. Yes.

Q. And it was a case that was in litigation?

A. Yes.

Q. And you were called upon as an expert for which side?

A. For the physician's, the doctor.

Q. In other words, the defense of the standard of care by the physicians that were being sued?

A. Yes.

Q. Any other cases that you can remember in recent years that you've provided expert testimony?

A. Yes. I've reviewed cases for the Cleveland Clinic, but in those cases I think they were of the head and had to do with surgery for tumors and things of that order. I think I was involved for a patient that had a gunshot wound, and I think -- we're talking about a three decade span here. I think I was involved for a disk problem where I was supporting the patient who turned out to be a patient of mine.

My activities -- then there's one more recent one -- have had to do with injury cases in which I've operated on, patients of mine. So they're not strictly malpractice, they were basically for insurance purposes and so forth.

Q. Have you ever testified in a criminal case?

A. No.

Q. Have you ever been an expert witness in a lawsuit or court case involving the mechanism of head trauma?

A. Yes.

Q. Can you recall what that case was?

A. Well, this was the bullet wound to the

head.

Q. And that was when?

A. Actually, your Congressman Sweeney who later became a commissioner was the lawyer on the case for the young man. Gosh, we're talking about probably the '70s.

Q. That was Bob Sweeney, right?

A. Yes. His father, I think, was also a congressman. Didn't he finish out his father's seat in congress, I think?

Q. I don't know. That's an interesting question. We could talk about that later, I suppose.

A. Well, at any rate, he was the attorney who was defending this patient of mine.

Q. All right. And what were the issues in that case, generally speaking?

A. I think that the young man had gone in to make a purchase at a small store and there was some disagreement between the son who was manning the store as to some small purchase, and at that time I think the patient was a high school student, quite an athlete, and his father came down and was discussing it with his son, the young man had left, and then, as I remember the details, shot the boy.

Q. And what was the medical issue in that

case?

A. Well, the medical issue was that they had an insurance policy, and the attempt here was to obtain for the young man, my patient who had been shot, the financing from that particular insurance policy that I presume covered the grocery store. I don't know the details of how it was written and so forth, but Sweeney had taken this case for the young man.

Q. But what was the medical question?

A. Well, the medical question for me was merely to present to the jury what the details were in regard to the injuries, what surgical techniques had to be carried out and so forth. So I was just, you know, physician of record.

Q. So this had to do with what surgical procedures were done in order to provide treatment to this --

A. And the extent of his injuries.

Q. This was a wound to the head?

A. Yes.

Q. Do you ever recall testifying in any matter or providing expert witness report in any matter regarding the mechanism or cause of blunt force head injuries?

A. Yes. I had a relatively recent case where

a limb of a tree fell on a young man who was again my patient and required multiple surgeries and survived. Under those circumstances I became involved in testifying as to the extent of injuries, the surgical details and what the expected results would be.

Q. Do you remember the name of the case?

A. Oh, I can get that for you.

Q. It was in court?

A. Yes, it was. It was in court and I gave my deposition.

Q. Any other --

A. Reed was -- the last name was Reed.

Q. Reed?

A. R-E-E-D.

Q. Can you remember who the lawyer was?

A. No. I have a bad memory for lawyers.

Q. When was this case?

A. This was within the last few years.

Q. Do you remember what court it was?

A. No, sir, I don't. I just gave my deposition, which was relatively extensive.

Q. Have you ever been called upon to look at historic cases and reflect on and offer an opinion regarding the nature of injuries?

A. I don't think so. At least not to my

knowledge.

Q. In regard to the case of Dr. Sam Sheppard, prior to being contacted in this case had you been familiar with the Sheppard case?

A. Not really. I came with my family here in '61, and, as I understand the dates, this was something that took place in the '50s. But there were a number of neurosurgeons in the community who would certainly have knowledge of the case, but this wasn't, as I recall, something that was cocktail fare. The issue was over and done with.

Then when the second trial came along, once again I don't recall there was all that much interest. Now, I did read and have reread most, if not all, of the books that are available that have been written.

Q. What books have you read?

A. I'm trying to think. The one which is -- his son was involved. Most of these had to do with, I think, reporters, people that came through -- there was one by Dorothy Kilgallen. I can't remember exactly. The three or four that are now in pocket paperback edition, I read them.

Q. And did you read these books before you were contacted?

A. Yes. I just read them when I was here in Cleveland. My wife is interested in the case, she's very much interested in the court and lawyers and all that.

Q. Is she offering an opinion on this case?

MR. DEVER: I object.

A. I don't think so.

Q. She hasn't?

A. No.

Q. Have you ever offered an opinion on this case other than your expert --

A. No.

Q. -- as to the guilt or innocence of Dr. Sheppard?

A. Well, I never felt I knew enough about the case. I didn't know much more after I read these books.

Q. Have you ever met any of the members of the Sheppard family?

A. No, sir.

Q. Do you have an opinion regarding osteopathic medicine?

A. Do I have an opinion? Can we go off the record?

Q. Well, I think --

MR. DEVER: I'm going to object --

A. What I'm saying is is that a proper question?

MR. DEVER: There's an objection to it.

BY MR. GILBERT:

Q. Here are the ground rules here. The lawyers can object, but you have to answer the question, and then a judge will rule later whether it's admissible.

A. Well, the question was do I have an opinion on osteopathic medicine, and I suppose an answer to that is yes.

Q. And what is your opinion?

A. Well, osteopathic medicine is a form of medical practice that appears to be well-established here in the United States and, as I view it, has become more and more like allopathic medicine.

Q. Which is what?

A. Allopathic medicine is the traditional form of medicine that's practiced here by people receiving medical degrees.

So I guess what I'm saying is over the years it seems to me that more and more of the young

men and women trained in osteopathic medicine have become part of organized medicine in this country and practice in allopathic institutes.

Q. Have you ever expressed a negative opinion regarding osteopathic medicine?

A. Yes, I have.

Q. And what was that?

A. Well, I don't think that the osteopathic institutions that train young men and women in osteopathic medicine or osteopathic institutes since they have their own hospitals and clinics are really the equal of what I choose to call American medicine, which is allopathic.

Q. Did you know Dr. Sam Gerber?

A. I've met Dr. Gerber, but I don't think I could really argue, Counselor, that I knew him.

Q. Do you remember --

A. I knew of him. I think I was introduced to him on several occasions at social functions.

Q. So you never had any kind of a professional interaction with Dr. Gerber?

A. No, sir.

Q. Did you ever talk to Dr. Gerber about the Sheppard case?

A. No, sir. I had no professional contact

with him.

Q. But I mean --

A. Even socially, no.

Q. Even socially did you ever talk about the case?

A. No, sir.

Q. In connection with your services in this case have you been paid a fee?

A. I have not submitted a bill.

Q. Do you intend to submit a bill?

A. Yes, I do.

Q. And how is it that you charge for your service?

A. Well, in some cases I don't charge anything and in some cases I charge considerably.

Q. Well, what is your intent in this case, if you've decided that yet?

A. No, I haven't decided.

Q. So you're not sure what you're going to do in terms of charging a fee?

A. Well, I've acquainted them what my nominal charges are. Whether or not I've invoked those or not I haven't decided.

Q. What are your charges?

A. Nominally for a review of records,

consultations and so forth and the work that I have to do in charting these and comparing them is $1,000 an hour.

Q. And how many hours have you spent already on this case up to this point?

A. Quite a few. 17. No, I'm sorry, Counselor, 17 until I began the second review, which is not totally complete. The basic review of the type we're talking about was 17.

Q. What do you mean by the second review?

A. Well, I was asked to look more carefully and even more specifically at the hospital chart and the consultations that were part of the chart as well as the extended testimony of those physicians under deposition or testimony in the courtroom. I was asked to look at the situation as far as Dr. Sheppard was concerned at the time of his injury, specifically at the time of injury, what the records reflected in the most detail of Dr. Sheppard's condition.

Q. Did you review any records after you prepared your report, which is Exhibit 1?

A. You mean new ones?

Q. Yes, additional records since the time that you wrote your report.

A. I may have received after this report was

prepared a consultation dealing with hypnosis and an extensive phone conversation that a Mr. Mahod took of Dr. Elkins. There was a phone -- I remember -- here, I think I received that afterwards, and this was a phone call I presume from a lawyer, McMann.

Q. What was the business with this hypnosis that you're talking about?

A. Well, as I understand it, Dr. Sheppard underwent hypnosis, and under that form of therapy or treatment or diagnostic procedure was an attempt to have him recall the details of that particular tragedy.

Q. And what was your response to that?

A. Well, two things, Counselor. First of all, I'm not an expert in medical hypnosis, and, second, as by far the majority of practicing American physicians, we do not approve of it.

Q. What document did you receive that reflects that Dr. Sheppard underwent hypnosis?

A. Well, I had hoped that it was here amongst the papers, but I may have to search.

THE WITNESS: As I recall, Steve, your office, the prosecutor's office sent me a document which represented a consultation on the part of the physician who had placed Sam under

hypnosis, as I recall.

BY MR. GILBERT:

Q. And you don't remember what that document was, who authored it, whether it was an official report, whether it was a magazine article or anything like that?

A. No. I got the impression it was done in somebody's office. It was professional, that was my understanding.

Q. So other than that and this memo regarding Dr. Elkins was there anything else that you received since you did your report?

A. Well, I got a letter that you had sent to Dean which listed some other people's background you wanted in regard to tapes and transcripts, then I was sent another copy of nurse's notes, which I already had, and then I was given the front sheet for temperature and pulse and so forth, which I already had, then this interview phone call with Charles W. Elkins.

I did receive a copy of a consultation done on August 6th by a Dr. Bashline from Grove City, Pennsylvania, but there was no information as to why he was being brought in to examine Dr. Sheppard. Then there was another repeat consultation of Dr. Foster,

which we already had. Finally, the spinal fluid report, all of which were basically attached to the record. But I don't know why I don't have the hypnosis.

Q. Well, we'll talk about that later. Don't worry about it.

Let me ask you this, Plaintiff's Exhibit 1, is that your report in this case?

A. Yes.

Q. Are there any opinions generally speaking -- I know you'll be able to elaborate on it, but are there any opinions that you intend to talk about or offer not included in this report?

A. Well, Counselor, it seems to me that, as I indicated, there appears to be ample evidence in the hospital record that on Dr. Sheppard's appearance at the hospital he did have changes in the face, but on my review of the hospital records -- which to me are the gold standard and the bible of this particular case, are to reflect Dr. Sheppard's injuries -- I have not been able to build a substantial clinical diagnosis for either concussion or for spinal cord contusion, and it seemed to me that the issue for your experts is to provide you with the data.

See, I can't find the data in the chart

to sustain those two diagnoses, both of which do need a neurosurgeon as an expert in these particular areas. I can't find the data to sustain those.

I will mention this, however, as you well know, even Dr. Elkins, who is a neurosurgeon, reversed himself on the diagnosis of spinal cord contusion and changed it to spinal cord concussion stating that he had to feel now that the injury was much less than he originally thought. So even the original diagnosis which appears constantly in the hospital record in a sense has been downgraded even by the specialist who made the diagnosis.

Q. Okay. I appreciate your answer, but I wanted -- what I was getting at was, is there anything beyond this report that you're going to be testifying to as far as you know at this time in this case?

A. Well, all I can testify to is the neurological examinations and the physical examinations that Sam received when he came to the hospital and during the period that he was in the hospital from the 4th through the 8th. I mean, this is the consultations and the hospital record.

Q. So your opinions are going to be confined to those issues; is that correct?

A. To those issues and also in regard to what

the principals have stated in their records, and also -- I keep concentrating on the physicians, but I was asked to make an assessment utilizing the testimonies of others as to how seriously injured Dr. Sheppard had been at the time of the tragedy as reflected in the remarks of himself, his brothers and a few others. I was not -- for example, I was not asked to review the testimony of many of the people that are involved, it was mostly the Sheppard family.

Q. And you've expressed the essential opinion that you're going to make in this case -- you were elaborating earlier -- that you have not been able to build a substantial clinical diagnosis for concussion or spinal cord contusion, correct?

A. Yes.

Q. That is your fundamental opinion in this case; is that correct?

A. Yes.

Q. Now, showing you what's been marked as Plaintiffs' Exhibit 1, is there any reason why there's no date on that report?

A. Well, there should be a date on it.

Q. Do you know what the date is that you wrote that report?

A. I'll have to check my records. You

probably know down there.

Q. Well, I'm asking if you know.

A. Well, the thing is that we can certainly tell you when this was submitted to the prosecutor's office.

Q. Tell me when it was submitted.

A. Well, that I don't know, but I think we should be able to tell you that, find out.

Q. Well, I wanted to know from you, but that's okay.

Is there any reason why you did not sign that report?

A. No, there isn't. I have a copy of it here with me and I don't know why I didn't sign it. It's sort of like Dr. Elkins who forgot to date his first consultation in the hospital record.

Q. Well, that's fine. I didn't ask you about Dr. Elkins, I asked you about you.

A. Well, but neurosurgeons have these problems, we're so busy.

Q. Now, let's go over -- you brought a file with you, right?

A. A file.

Q. Or you brought some documents with you?

A. Well, I brought the hospital record.

Q. But you have other things in there, right?
A. Yes.
Q. Why don't we take a look at everything that's in your file. I see some newspaper clippings in your file?
A. Yes, I've cut out some of these. I think some of these mention you from time to time. I've taken the clippings out of the --
Q. Well, why don't we --
A. Do you want those?
Q. Sure. I want to know everything that you looked at.
MR. DEVER: Doctor, are there any confidential documents, work product documents in your --
THE WITNESS: Confidential?
MR. DEVER: Yes.
THE WITNESS: Well, I can only say that all we have here are extracts, but there are commentaries.
BY MR. GILBERT:
Q. Well, let's look at all the newspaper clippings.
A. I'm looking because I even have one for you from I think the New York Times. Here we go.

Q. Doctor, let me ask the questions, okay, and you try to answer to the best of your ability.

A. I'll try the best I can. Harvard graduates have problems with questions, we usually ask them.

Q. Let me just ask you, you do have a number of articles and opinion pieces and that kind of thing that you clipped out regarding this case; is that correct?

A. That's right.

Q. Is it customary that an expert witness like yourself would review articles about the case as part of your opinion on a medical matter?

A. I have no idea. As you know, I write for legal journals. I have no idea what other people do. I advise physicians on how to conduct themselves.

Q. I see here that you have clipped out an article by Brent Larkin. Do you know Brent Larkin?

A. Vaguely.

Q. Vaguely?

A. Vaguely.

Q. Did you ever meet him in person?

A. Yes. He's a nice person. I don't think he knows who I am, but he's a nice person.

Q. And he wrote a piece that you cut out

called "Evidence Will Swamp Sheppard's Defenders," right?

A. Yes.

Q. And you underlined something in that article, correct? Do you want to look at it?

A. He's the editorial director for the Plain Dealer. It says July 5, 1954 was a staged domestic homicide committed by Dr. Sam Sheppard. The date is wrong.

Q. That's why you underlined it?

A. Yes, wondering how in the newspaper those errors can crop up.

I'm doing nothing different in this particular case, Counselor, than I always do. As a non-member of the jury I feel that it's important for me to get as much information as I can.

Q. How does that information help you as a retained expert by the prosecutor's office to offer medical opinions in this case?

A. Well, it gives me some idea as to how the wind is blowing, what is being done out there. I'm not a member of the jury, and as a consequence I take advantage to read any and all materials that I can.

Q. What else do you have in there?

A. There is the hypnotic report. It's a

little hypnotic in and of itself.

Q. Are you referring to a document that says, "How a medical hypnotist unlocked Sam Sheppard's memory of violence by Joseph N. Bell"? Is that the document you're referring to?

A. That's the document that was given to me.

Q. You would agree this is not a report by a hypnotist, don't you?

A. A hypnotist?

Q. Is it? Doctor, can you look at that report and try to answer that question, please?

A. No. As I've already stated, Counselor, I'm not an expert, nor somebody that's even interested in the field of hypnosis.

Q. Can you just answer, you'd agree that that is not a report from a hypnotist?

A. Well, I suppose in all honesty I don't know who Joseph N. Bell is, and, therefore, whether he's a reporter or an associate or not, I don't know, but the document had no bearing on my activities in this case.

Q. Let's see what else you've got in your file there.

MR. DEVER: Why don't you ask him, Terry, and then he'll tell you.

I have no intention of pilfering through your various experts' files. You can ask him questions about it.

MR. GILBERT: The record should reflect that the rules require if asked that the expert witness provide all the data and source material that he reviewed in connection with the case. I mean, it's standard.

MR. DEVER: I understand that, but there's a way to go about doing it. Ask him the questions.

BY MR. GILBERT:

Q. I want you to identify all the documents that you have in your file, and we'll make copies of them and have them photographed, made part of the record at some point during the deposition.

Can you go over all the stuff that you looked at?

A. Well, what we're looking at here are materials that -- here we go, these materials were submitted to me from the prosecutor's office.

Q. What do you have there?

A. What I have here is the first copy of my deposition, which had just a few editorial changes.

Q. Can I see that, please?

A. Sure.

Q. What else?

A. Here you are (indicating). Here's some questions that I submitted to the office. Here's a letter from you. Here's your copy of Dr. Fallon's consultation. Here's a rundown on the books that I told you about. This is another working copy of my deposition copy. Here's an online search for the famous fracture, which incidentally as you know did not exist. Here's some more of it if you want. Here's a very interesting article here on current issues in the management of sports-related concussion.

Q. What else do you have there?

A. I have notes here of mine. I don't know whether you want these are not.

Q. Just notes that you took?

A. Yes, these are just notes. Then we're down to the hospital record of which you've got millions of copies. You've got this thing here, which is an examination of neurological examinations that have been done by the various consultants and where they differ and where they agree, what the summary is. That will cost you a bit of money.

Q. Oh, really?

A. That's a lot of work. These are some of the things you and I discussed already. They're either part of the record or those things I talked about, the phone call and so forth.

Q. Why don't we have some of these things marked.

(Thereupon, Plaintiffs' Exhibit 3 and 4 to the deposition of Robert J. White, M.D., were marked for purposes of identification.)

A. Most of what we're left with here are, as I've said, my own personal notes. And we do have the hospital record. You obviously have an open book as far as my materials are concerned, but they're really prepared for me, Counselor. In going through these records I felt it was necessary to compare these.

Q. You're using that --

A. Consultations.

Q. You're using that as part of your testimony in this case?

A. Well, I don't know if it will absolutely be necessary or not.

Q. You may be called upon?

A. Yes, you may call upon me to indicate what my opinions are of the consultations that were done.

Q. This chart will form the basis of the opinions you will express in this case, correct?

A. No. All I've done is put it together so I'll remember them, that's all. They're just a better shorthand. They're from the record.

MR. GILBERT: Are you going to produce that, Steve?

MR. DEVER: Yes, we'll produce it. I would like for him to be able to get it typed up as opposed to --

MR. GILBERT: Well, I need to refer to it in the deposition.

MR. DEVER: Okay, you can do that.

(Thereupon, Plaintiffs' Exhibit 5 and 6 to the deposition of Robert J. White, M.D., were marked for purposes of identification.)

BY MR. GILBERT:

Q. Showing you what's been marked as Plaintiffs' Exhibit 3, is this a document that you prepared, excluding the fax sheet?

A. Yes.

Q. What's the date of that document?

A. It doesn't carry a date. It was submitted

at the same time that the --

Q. You were asked to help the prosecutors formulate areas of questioning of Dr. Steve Sheppard; is that correct?

A. Well, it seemed to me that --

Q. Is that correct, Doctor?

A. That's not correct, no.

Q. Okay. What were you asked?

A. Well, in my conversations with the prosecutor's office and in bringing them up-to-date with what my analysis had been -- and I think we're talking about November, I'm not a hundred percent sure -- it was suggested perhaps on the basis of what I had told them, my analysis to that point, would it be possible for me to dictate some areas and/or even questions that I had concerns about and might be part of their activities as far as Dr. Steve Sheppard was concerned.

Q. This document was a transcription of tape from Dr. White dated January 12, 2000; is that correct?

A. Then that would be the date, yes. What's the date on that?

Q. January 12, 2000, the upper left-hand corner. I thought this was submitted back in November. Maybe that's when this came through.

MR. DEVER: Maybe that's when it was typed up.

BY MR. GILBERT:

Q. You prepared a tape and at some time later it was transcribed; is that right?

A. I guess, yes.

Q. You talk about the pre-murder time period in this document, do you not?

A. I'm not sure what you mean.

Q. You talk about motive in this case?

A. Is that what it states?

Q. Yes. Do you talk about motive in this case, that you really think it's a sexual one?

A. I'll have to see that document to refresh my memory.

Q. First look at the first paragraph.

A. Yes. I think what I indicate by a sexual one is that I didn't tell you, it was brought out in repeated testimony, including with Dr. Sam himself about infidelity here, that's what I'm referring to.

Q. Dr. White, are those matters part of the profession of neurosurgery?

A. I'm not sure I understand the question.

Q. Regarding criminal motive, is that a matter of expertise of a neurosurgeon?

A. No, I don't think we claim that a neurosurgeon is necessarily an expert on the criminal motive.

Q. Showing you what's marked as Plaintiffs' Exhibit No. 4, bibliography, what was the purpose of running this search on October 6th, 1999?

A. About what?

Q. All the books relating to the Sam Sheppard case.

A. Well, I thought as long as I was going to have to review the hospital records, or perhaps even after I reviewed the hospital records, I thought it might be appropriate what other people thought that were much closer to the case at the time.

Q. You thought it was important to read some of these books in connection with your expert opinions in this case?

A. Not necessarily for my expert opinion, but simply to fill myself in to what was the going opinions at that particular time.

Q. Let's talk about the specifics of your opinion. By the way, are you familiar with the trauma services unit at Metro Hospital?

A. Yes.

Q. Are they the primary unit in initial

treatment of head injuries from trauma or accidents or violence and that kind of thing?

A. I don't believe I understand the question.

Q. When somebody suffers an injury to their head and they are brought to Metro Hospital where you were affiliated with for 30-some years, would the trauma unit be the first unit to look at the injuries?

A. They would look at all injuries and they would call us immediately, the neurosurgical service, because it's our responsibility to cover for the head injuries.

Q. But they would be the first to see --

A. No, the emergency medical people.

Q. And then they would be the second one?

A. Either trauma or emergency medicine would be the first responders.

Q. Now, you reviewed the medical records in this case regarding the admission of Dr. Sheppard from July 4th I believe all the way through August 6th; is that correct?

A. No. He was in the hospital until the 8th of July and then he was discharged.

Q. And then there were other records that you looked at beyond that date, correct?

A. Very skimpy. These were not hospital

admissions.

Q. What were your findings regarding the facial injuries?

A. Well, of course I made no findings myself, I had to rely on the testimony of others.

Q. Well, you're offering an opinion on that?

A. Yes. I said that it appeared that all of the physicians and dentists who had examined Dr. Sam Sheppard on 7-4 had described considerable variation injuries related to the right side of the face.

Q. Do you agree that was trauma injuries?

A. Well, certainly that would appear to be the most likely cause. Since I did not interrogate Sam myself and had to go by the records, from what was described they certainly seemed to be of a traumatic nature.

Q. And you don't dispute those findings?

A. Well, I do dispute some of the findings since apparently the examiners dispute each other.

Q. Okay. Tell me what your opinion is regarding that.

A. Well, Dr. Carver, who wrote one of the admitting notes, noted a laceration on the right side of the jaw and under the right eye, and now I quote him, no other contusions noted. Now, Dr. Sam

Sheppard's brother, Steve, who was the physician of record, stated on his initial workup on 7-4, large ecchymosis entire face, laceration right cheek, contusion, spasm at base of skull.

Then Dr. Sheppard, Steve Sheppard, sees Sam on the same day with Dr. Foster, and Dr. Foster is an ENT doctor, and together they note contusion with extensive edema seen at base of skull posteriorly. Neck discolored in front on the left, which, if you remember, bears no relationship to what Dr. Carver told us.

Then we go on to Dr. Elkins himself who examined Sam on 7-4, but the neck brace is not removed, and Dr. Elkins could not remember examining him on 7-5, but does his examination, which turns out to be the key exam here, on 7-6, and he says in regard to the head and neck, neck tenderness, spasmodic contraction. He doesn't describe anything.

Finally -- now, remember, that was 7-6 -- 7-4 Dr. Hexter, as you recall, was brought in by Dr. Gerber and is the only M.D. other than Elkins in this group, he is the only person that seen Sam up to this time and has no interest. He's not a family member, he's not a staff member, he has no relationship to Bay Village. This is what he says, no contusions or

abrasions of the throat. Back of neck, no abrasions or contusions, thick but edema. But he does agree that Sam has abrasions.

In fact, in some ways he's more worried about fractures than the others, which all prove to be negative. But he does describe -- I can't find the thing -- he does describe that Sam has discoloration and so forth in and about the right face at an eye level and at a cheek level on the right side.

Well, Counselor, that's a rather interesting series of opinions I would say.

Q. What did you conclude from that?

A. Well, first of all, that those most related and interested in Sam found a lot more, how should we call it, physical damage, whereas the individual that had no relationship professionally or familywise to Dr. Sam Sheppard did not describe very much.

Q. And you make opinions based on relationships, is that what you do, as a reviewer of medical records?

A. No. I ask myself -- of course I don't. I ask myself this question, why is the fact that the most -- how shall I put it -- deleterious injuries are set forth by the individuals here who are most closely

related to Sam? One could argue, well, they're concerned about Sam, they're very concerned about him. Why is it that the individual who has no relationship doesn't really find very much wrong here at all?

Q. How do you define relationship?

A. Well, in two ways, either family, by blood, or else professional. You're a member of the staff at Bay Village -- I'm sorry, Bay View, you consult there, you have some relationship in a professional sense to the Sheppard family.

Q. You find it interesting, that's all?

A. I find it very interesting.

Q. But you're not able to conclude based on reasonable medical certainty that anyone lied or exaggerated or distorted their observations, can you? Are you prepared to make that opinion, Doctor?

A. Would you repeat the question?

THE NOTARY: Question:

"But you're not able to conclude based on reasonable medical certainty that anyone lied or exaggerated or distorted their observations, can you? Are you prepared to make that opinion, Doctor?"

A. I must have an explanation. There must be an explanation. Under those circumstances I certainly

don't want to accuse somebody of professional dishonesty, but at the moment I'm unable to explain the incredible variations and contradictions that appear in this record.

Q. Do you know whether Dr. Gerber had a bias in this case?

MR. DEVER: Object.

BY MR. GILBERT:

Q. If you're looking at the relationship between Dr. Sheppard and people who treated him from Bay View or his family, did you also examine the relationship between Dr. Hexter and Dr. Gerber in this matter?

A. I have no idea what their relationship was.

Q. Wouldn't that be a good idea?

A. No, I don't think so.

Q. You're assuming that Dr. Hexter was neutral?

A. Yes. He was very reluctant as I read the records. He had to be requested twice to go to examine, he did not want to become involved in this case.

Q. What were the incredible variations in these diagnoses as you've called them?

A. Well, as you know, there was the issue of the C-2 fracture.

Q. Well, the original question that I asked you was about the face, the facial injuries. Do you remember we were talking about that, then you went on to the other areas. I really want to hold off on that for a moment. Let's just talk about the facial injuries.

What are the incredible variations that you notice from doctor to doctor?

A. Well, those are your words, incredible.

Q. No, you said --

A. There are variations within the description of the findings in and about the face and neck. Now, if we read Dr. Hexter's review of Sam's cephalic and cervical situation at the time it paints a much more benign picture than the record shows as far as Dr. Steve Sheppard is concerned and Dr. Foster who examined Dr. Sam Sheppard with him.

The issue is very simple. Dr. Hexter does indeed sustain the fact that Sam has had injuries in and around the orbit and the jaw and the mouth, and I have no reason to argue those were physically present at the time, it's just that as I read the records and consultations of each of the physicians that saw him

there's considerable variation, and perhaps far more important in my judgment in and about the neck.

Q. But as far as the face, the variations are not that significant, are they?

A. I don't think so.

Q. I just want to, you know, understand where you're coming from because I know there are different issues in this case and I want to deal with them separately. Is that fine?

A. Fine.

Q. Was there not a finding that there was ecchymosis to the right eye in one of the reports?

A. Well, I think that would be the right orbit. Every single neurological examination done as far as Dr. Sam Sheppard's eye was concerned fortunately was normal. And when I speak of the eye I'm speaking of the eye, per se. If you're talking about the lids and the orbital structures, there were reports in which basically there was ecchymosis and contusions in and around the right orbit.

Q. So when you say it did not involve the eye apparatus, what are you saying?

A. I'm talking about the eye apparatus.

Q. In terms of the actual eye itself?

A. The eye movement, vision, so on and so

forth. All the examinations were normal.

Q. And the teeth area, do you recognize that there was some damage to the teeth?

A. Well, it's not a matter of my recognizing it. All I can tell you is that there are consultations that specifically state that there was damage to Dr. Sam Sheppard's teeth; however, this was not confirmed by Dr. Hexter, and even within that the degree and extent of the number of teeth that were loosened, the number that were chipped and so forth varies. You know, that's understandable, but one certainly has to accept the fact that some damage was rendered to the orobuccal area under the circumstances.

Q. And the facial injuries, is that consistent with an assault?

A. Yes, but it would be only one of many causes.

Q. What is a concussion?

A. Well, a concussion is rather difficult to define. Generally speaking if you look up in the textbooks of neurology and neurosurgery you will find that it's an incident in which the brain has been disturbed but in such a way that it will return to being perfectly normal. So we think of it primarily built around a blow to the head, that is, to the skull

if you like or the tissues which eventually is transmitted to brain. We also feel that with a concussion that generally there's an issue of unconsciousness, and this period may vary depending on the degree of the concussion which soon sort of fades into what we call a minor head injury.

Q. When you say minor head injury, what do you mean by minor?

A. Well, by minor as opposed to moderate or severe. It would be my argument in this case that if the conditions that surround Dr. Sam Sheppard's alleged involvement with an intruder are correct that they should be more correctly arguing --

Q. What's the word?

A. -- they should be more correctly arguing that this was a head injury.

Q. Now, what are the symptoms of a concussion?

A. The symptoms of a concussion are generally considered in the negative range except for the problem of unconsciousness. Now, the difficulty is that when you talk about the symptoms you're talking about a patient who has had a concussion and, therefore, in the period after the concussion may have a series of symptoms, like problems with memory, headache,

cognitive disturbances and so forth. All of these are issues that occur after the concussion has taken place.

Q. Do you want to say something else?

A. No.

Q. Why is it that you cannot diagnose a concussion in this case?

A. Well, I need a database, I need evidence.

Q. You need a database?

A. I need some information. I don't have a skull fracture.

Q. You're not saying that it didn't happen in this case, you're just saying that you in reviewing these records do not have enough information; is that correct?

A. That's all I can say.

Q. When a patient comes in for treatment with a head injury, much of what is learned is through the patient himself; is that correct?

A. Providing he's awake, yes.

Q. And back in 1954 we did not have MRIs; is that correct?

A. That's correct.

Q. So there was no real way of doing an x-ray?

A. We had x-rays.

Q. What's that?
A. You had x-rays.
Q. But an x-ray wouldn't show a concussion; is that right?
A. No. I'm not sure -- certainly a CT wouldn't, and I'm not sure an MR necessarily would.
Q. So basically when you have diagnosed concussions before your diagnosis, in part at least, is based on the symptomatology as expressed by the patient himself; is that correct?
A. Well, the patient or witnesses sometimes.
Q. What were the symptoms that Dr. Sheppard presented with on July 4, 1954?
A. Symptoms in regard to what part of his anatomy or physiology?
Q. Well, with respect to what he presented with in terms of the notes and the observations from the physicians that you reviewed. What were the symptoms that he presented himself with?
A. Well, now where -- you mean --
Q. At the hospital.
A. At the hospital?
Q. Bay View Hospital.
A. At the hospital or at the home?
Q. Well, he wasn't officially diagnosed at

the home, was he?

A. Well, actually his brother raised the issue, Steve raised the issue in testimony that he had a concussion. In fact, he thought he was dead.

Q. Well, we have no medical records on a diagnosis at the house, do we?

A. No, that's in testimony.

Q. I want to confine you to the medical records in this case, okay?

A. Of course. Well, I could only read --

Q. What were the symptoms that Dr. Sheppard presented himself with when he was admitted to the hospital, Bay View Hospital, do you know?

A. Well, I can only read from what is recorded within the consultations and the workup.

Q. What were the symptoms?

A. Well, there weren't very many symptoms at all. I'm trying to find them at the moment. That's the difficulty here.

One of the very first workups that we have they just don't raise those issues. Now and then they come up with the idea he's mildly confused. When we go to the neurosurgeon who comes to see him, other than Dr. Elkins who sees him on the afternoon of his admission -- let me look at the master sheet here -- it

says it very calmly that he is alert and lucidly answers questions. He speaks -- and this is a neurosurgeon speaking. He says nothing about confusion, says nothing about amnesia. He states very frankly that he's alert and answers questions lucidly, quoting directly from his consultation.

Q. Have you ever seen concussion cases where anywhere from five to six hours after the concussion people have regained some measure of lucidity even though they had earlier suffered the typical symptoms of a concussion?

A. Well, see, I wouldn't classify it as a concussion. To me he had a head injury. And you're now talking about somebody and that would very well be appropriate in this case.

Q. So the fact that somebody was lucid --

A. The fact that somebody was lucid and alert, Counselor, and could answer questions by a neurosurgeon and the neurosurgeon made no commentary here even though he made the diagnosis and when challenged on that he said, well, you have to make a diagnosis about concussion and that's what you've been working at subjectively, which means, and he stated that, have you to believe the patient.

Q. And you don't agree with that?

A. No, I don't agree with that for the simple reason the patient can tell you anything that he wants, there's no witnesses here.

Q. 11:00 in the morning was when the note talked about patient lucid and talking to police officers, correct?

A. No, I think that's a little later. I think that Elkins shows up after his golf game in the afternoon. He does not -- he has the same problem I do, he did not date his consultation, but I'm pretty sure it was in the afternoon.

Q. So the fact that perhaps 10 to 12 hours had lapsed since the injury, the alleged injury, that doesn't necessarily negate the injury because one is lucid at that point; is that correct?

A. Well, with concussion, and as we study it in its various classes, the lucidity and the alertness could certainly be blunted even for a period of even a day or two, and when you get down to retrograde amnesia that can persist for even a longer period of time.

MR. GILBERT: Can you read the question back?

THE NOTARY: Question: "So the fact that perhaps 10 to 12 hours had lapsed since the injury, the alleged

injury, that doesn't necessarily negate the injury because one is lucid at that point; is that correct?"

A. The answer to that question is that a person who's had a very minor concussion could in that period of time be perfectly normal.

Q. Thank you.

Was there a physician that noted mild shock to Dr. Sheppard?

A. Yes.

Q. Just answer that question.

A. Well, I answered it, yes.

Q. Is mild shock a symptom that could be associated with a head injury?

A. I've written on this, and in a very special type. This is an area of my special interest, and it's what we call brain stem shock. Shock as a central system is much more associated with the spine, and I've just written an article on spinal shock.

Q. Well, could you answer the question?

A. I answered the question. I said it can be.

Q. I'm sorry.

A. But a very special type, not applicable to this case.

Q. Now, what is a muscle spasm?

A. Well, it's sort of a contraction of the muscles where there's almost an irregular -- it comes in various forms. Some of them there could actually be continuous activity, but generally speaking the muscle tightens and in the process the form often becomes relatively hard so that you can feel it. It can be painful.

Q. If a physician in this case noted a muscle spasm at the base of the skull and at the back of the neck, do you have any reason to dispute that that physician noted that and saw that?

A. Well, if that was his professional judgment, no.

Q. Is a muscle spasm consistent with a neck injury?

A. Yes.

Q. Is it an objective finding?

A. No. It can be pretended.

Q. On July 6th --

A. The neurosurgeon comes.

Q. The report, yes. His report dated July 6th, you're familiar with that; is that right?

A. Yes.

Q. The patient complained of urgency on

urination and this morning when attempting to pass gas soiled his sheet with fecal material. Does that mean anything to you?

A. No.

Q. That could be fake, too?

A. No, no, no. The thing is, first of all, you put a young man Sam Sheppard's age to bed the first thing that's going to happen is he's going to develop a problem in terms of urination, that's only common. You'll remember if you refer back -- you want to remember with spinal cord injuries, even though Elkins -- I don't know where he got these ideas, this is not so much a progressive thing.

If you have a spinal cord injury you're going to see the worst of the worst generally speaking at the time. You'll note that when he interrogated him on the 4th there are no problems with urination, now he says there are, but only in the form of urgency.

Now, the issue as far as the bowels are concerned -- and incidentally, he did not do an anal reflex on the 6th, he did not test the anal reflex -- there's nothing in the nurse's notes to support that particular entry on the part of Dr. Elkins. In other words, the nurses made no note that the sheets were soiled, there's nothing in the nurse's notes. But even

if this is a fact -- and I have to take what Dr. Elkins says -- it does not concern me.

Q. In the diagnosis section of the -- there's a printed copy of that report, do you have that?

A. Well, I can read his writing.

Q. He noticed a numbness of the ulnar sensory distribution left -- ulnar sensory distribution left. Do you note that?

A. Yes.

Q. What is that?

A. Well, what he's saying is that in an area very close to the left hand here involving the thumb and probably the fourth finger on the inside that Sam complains of some numbness in this particular area, and this is served by a branch of the ulnar nerve. He also goes on to say that he feels that some of the small muscles of the fingers, the interossei, are weak.

Q. Is that a finding consistent with a head injury? Could it be?

A. I would say no. But he was using that as a spinal cord injury, and it is not a spinal cord injury.

Q. Is that something that could be faked?

A. Yes. Dr. Elkins admits that.

Q. A local examination that he found

tenderness over spinous process of C-2 with spasmodic contractions of cervical muscles to pressure, is that a finding that is consistent with a head injury?

A. I'd say more consistent with something like a neck injury.

Q. Are you saying that there was no neck injury in this case?

A. That's correct.

Q. There was not a blow to the back of the neck?

A. Well, I can't do that. All I'm saying is he did not have a fracture, nor was this transmitted in any way to his spinal cord. Now, if you want to tell me that in the process of what's happened here -- and I've already admitted that it's traumatic as far as the right face is concerned, and this extended as far as the neck is concerned, fine, but there's no evidence there. There's no discoloration, there's no swelling there, there is some tenderness, but that can all basically be on the part of the patient, Counselor. He can say this is tender back here where you're pushing.

Q. But that is to a large extent the only way that physicians can examine for a head injury, like a mild concussion where there is no necessarily physical objective evidence; is that correct?

A. Well, he has some evidence. He's got swelling and soreness on the right side of the face, and even in Hexter's writeup he's so concerned he wanted pictures of the skull, he wanted x-rays of the skull.

Q. One can get hit in the back of the neck and there's no discoloration; is that correct?

A. Yes.

Q. And they could have a head injury, correct?

A. Right.

Q. Basically what a concussion is from my understanding is that some kind of trauma causes the brain to move inside the skull and causes the things that we've talked about, right?

A. Well, generally speaking, it's not so much the movement of the brain for a concussion, there has to be something to interfere with the metabolic activity of the brain, the blood has got to stop momentarily or where there's an impaction on the brain. Now your movement that the brain floats is absolutely correct. All these physical examples you give are correct.

Q. The physical examination that Dr. Elkins did with respect to reflexes, were those proper

examinations that were in line with the standard of care in diagnosing head injuries back in the '50s?

A. No, I would say no, it's incomplete.

Q. Maybe it's incomplete, but doing examinations on reflexes is part of it at least, is it not?

A. Yes, sir, it is.

Q. And he noted some absences in reflexes?

A. Yes, he did.

Q. Is that consistent with a head injury?

A. No.

Q. It's not, why is that?

A. Well, the situation here is that even Dr. Elkins is looking at these absent reflexes in relation to the spinal cord, he is not attributing these in any way to the concussion. The concussion is such a minor event for the brain it doesn't leave any fingerprints in the way of reflexes. The issue here is do these reflexes that Dr. Elkins argues are not present reflect damage to the spinal cord.

Q. As I understand what you're saying is that Dr. Elkins was looking at reflexes and things like that in connection with the spinal cord, alleged spinal cord injury?

A. Yes, sir.

Q. Is that correct?

A. Yes, sir.

Q. And those would be proper tests to do or examinations to do in connection with that issue; is that correct?

A. They would be appropriate to both, but in his examination he has granted him a concussion, and, as I say, generally speaking we don't see neurological findings with a concussion, nor does Dr. Elkins report them. What he's reporting here are changes in his opinion in the form of absence of reflexes, numbness and even some weakness in his hand that has driven him to the diagnosis of spinal cord contusion.

Q. And you did read the testimony of Elkins and he claimed that he detected abnormalities?

A. Well, the absences are his abnormality.

Q. You have no reason to believe that he's lying about those, do you?

A. Well, as he indicates, the most important one would be the weakness in the hand, and he's arguing under testimony that, yes, Sam could actually pretend that situation. And, remember, if I recall, it was Sam who brought to his attention the numbness.

Q. What about the abdominal muscle reflex absent?

A. Well, the difficulty with all of this is that even if we -- well, the first thing that Dr. Elkins noted, going back to the left extremity, is that there was a reflex that was absent in the left extremity, that was the triceps. Now, for the very first time in all the examinations that were done on the 4th and presumably on the 5th nobody had described an absence of the triceps reflex, which is of course up in the arm. As a matter of fact, Dr. Hexter was able to obtain a triceps reflex.

Dr. Elkins says the one on the right side is fine, the one on the left side on the 6th is absent. Dr. Hexter examining Sam on the 4th found a triceps on both sides. Another example of the difference in the examinations.

Now, going to your abdominals. The first person that found the left abdominal reflex was actually Hexter. Hexter was the only one that reports on the 4th an absent left abdominal. Dr. Elkins on the 6th reports the absence of a left abdominal. The problem with all of this is even Dr. -- they don't know how to do abdominal examinations. These are relatively unimportant as the testimony was brought out. These you cannot take as isolated events, and I'll tell you why.

First of all, if you're overweight you won't get abdominals, if your stomach is distended you won't get abdominals, if you've had surgery on it you won't get abdominals. Granted, all of these are not the case with Sam. Emotional stress, you won't get abdominal reflexes. They're actually just not in the same ballpark as, say, your triceps and, above all, your Babinski.

The Babinski is a pathological reflex, and it was never, never found to be abnormal in Sam, which would go back to both your head injury and your spinal cord injury. So my problem -- well, then on top of that he has a lumbar puncture which is perfectly normal. I just don't have any evidence, Counselor, to make these diagnoses.

Q. Well, let me ask you, the x-ray that Dr. Flick, the radiologist, took on the 4th, give me your rundown on that.

MR. DEVER: Which one?

MR. GILBERT: The first one.

A. Of course I've never seen these.

Q. The C-2 fracture?

A. I've never seen those.

Q. I understand. We don't have those.

If you had the x-ray would that be

helpful?

A. Of course. I've read thousands of these.

Q. So there was a report, though, correct?

A. Well, we don't know when it was typed. We had some difficulty in working through the testimony as to when it was typed.

You're also told something interesting, Dr. Flick doesn't know quite who put or how the x-rays got on his desk, those of the 4th. There seems to be some confusion about that set of x-rays for the 4th. He writes in the chart himself that the skull films are perfectly normal.

Now, he did describe -- and it is in his report -- that he identified a chip fracture at the posterior inferior area of the spinous process of C-2, you're absolutely correct, but all of that is eventually taken back in formal testimony because the sets of films are done over and over again. Dr. Flick of course was dead for the second, but in the first he admitted that this was an artifact and not a fracture.

Not only that, what's very disturbing here, Counselor, is that that particular film which allegedly had a dark streak on it -- the film is this little thing that Dr. Flick went backwards and forwards with and then with additional films decided it was not

a fracture there.

There's another interesting finding at C5-C6, there's a great big hunk of hypertrophic bone which we don't know how it got there. There's a big piece of hypertrophic bone, which is much more obvious on those films than the fracture which wasn't even there, we never see that again. And that raises the issue -- and even Dr. Flick addressed that -- what happened, where did those films go? Were we looking at a different set of films the first time around? You cannot wipe out that piece of calcium. So the films number two and number three sets at 72, that does not appear.

Q. The hypertrophic bone?

A. Right. Where did that go, one of the great mysteries.

Q. So based on --

A. I have no evidence, Counselor, that I can make the diagnosis that I stated in my opinion piece. I do not have the data to make a diagnosis that I used to make every day day in and day out.

Q. You did review the report of Dr. Bashline on August 6th; is that correct?

A. Yes. May I ask, who is he and how did he become involved in this case?

Q. Well, that's something you can ask your lawyers in the prosecutor's office. But you do recognize that there was a Dr. Woodrow Bashline who examined Dr. Sheppard on August 6th, 1954?

A. Yes. May I have his report, Counselor?

Q. Here. See if you have it.

A. Yes, I've got it.

Q. Do you know if he was a neurologist or neurosurgeon?

A. No, I have no idea what his specialty is. I suspect he is a general practitioner.

Q. Do you have any problems with his findings in this case?

A. Only in that they don't square with any of the findings.

Q. In what way?

A. First of all, now he's speaking of slight muscular atrophy of the entire left arm, whereas Dr. Elkins spoke only of weakness of the interossei, the muscles in the hand.

Q. What else did you find?

A. Well, he does speak here, there was weakness of the adductors of the left hand, which would be an ulnar nerve finding, but his workup is so fragmentary that it's very difficult to compare it

above all with Dr. Elkins' exam. And, remember, he's conducting this thing at least sometime later.

Q. He did find the left arm presented demonstrable weakness of grip of hand; is that correct?

A. That's correct.

Q. You're saying that's inconsistent with the report of Dr. Elkins?

A. Dr. Elkins indicates that only the interossei -- and if it's of the ulnar nerve it's only several of the digits, it does not involve the entire hand. In other words, he's reporting more damage here.

Q. Well, he doesn't say -- he just says demonstrable weakness of grip of hand, right? He doesn't talk about how many fingers.

A. He says there was weakness of the adductors of the left hand. Those are specific interossei muscle.

Q. Where does the word adductors appear?

A. It appears on the page where he gives his impression.

Q. I'm sorry. And the adductors are what?

A. Those are the ones that move the fingers in together.

Q. He didn't say all the adductors of the left hand?

A. No, he just said adductors of the left hand.

Q. He did find a traumatic hyperflexion injury of the cervical spine?

A. I repeat, of the spine. He says nothing about the spinal cord here.

Q. Is that consistent with an injury to the head?

A. No.

Q. Is it consistent --

A. It's a different diagnosis completely.

Q. Is it consistent with an injury to the neck?

A. Yes. Listen, don't miss what he said here, and this is very important, with radiculitis of the left arm.

Q. You cut me off before I was able to read the whole thing.

A. I would never cut you off.

Q. When I stopped at cervical spine you --

A. You asked me --

Q. You jumped in before I read the whole sentence.

What does the radiculitis of the left arm mean? What does that mean?

A. Radiculitis, we never heard this word before.

Q. You never heard of that word before?

A. I've heard of that word before, but I haven't seen it anywhere in this entire multi-medical workup.

Q. What is it?

A. It has to do with the roots, the little roots that bring up the nerves and everything. It's back and very consistent in what these people have been talking about if there was damage to the little nerves that leave the spinal cord, come together to form nerves like the ulnar nerve. It's like when you have a disk, you know when you have a disk.

Q. Is it consistent with a neck injury?

A. Yes.

Q. And is it consistent with an assault to the neck?

A. Yes.

Q. Is it consistent with someone with a concussion?

A. No, it's totally different. It's a totally different diagnosis.

Q. What is it consistent with?

A. It's consistent, as you said, with a form

of injury.

Q. And it's a nerve injury?

A. It's a nerve injury. But also remember --

Q. That's all I asked.

A. All right.

Q. Now, what is a contusion?

A. Well, a contusion is something in which there is physical evidence that damage has been done. We're talking about contusion to the nervous system and specifically contusion to the spinal cord. Under those circumstances there's physical evidence of damage.

Q. What are the physical --

A. Some hemorrhage.

Q. You have to have hemorrhage?

A. Well, you don't have to, but hemorrhage would be one of the possibilities.

Q. Let me just get it straight now.

A. I'm going to list --

Q. Are you saying there has to be physical damage seen?

A. Well, that's how we make the diagnosis. A contusion, whether it's in your skin or whether it's in your spinal cord, is a recognizable visual lesion.

Q. How do you see a contusion in the spinal cord?

A. Well, you see hemorrhage.
Q. Okay, that's one thing.
A. You see bruising, tissue damage.
Q. Where do you see the bruising?
A. You see the bruising right where the impact was.
Q. Because of the hemorrhage?
A. Hemorrhage, breakdown of cells and tissue damage.
Q. What breakdown of what cells?
A. Well, you can break down the neurons if you want, the astrocytes.
Q. How do you see that?
A. Well, it's very often physical, or I suppose if it was small enough you'd see it microscopically.
Q. How do you get to see those cells?
A. One of the things you can do is you can do a lumbar puncture. What you see on a lumbar puncture is, number one, you usually see some hemorrhage and you may see some increase in protein.
Q. What is it that you cannot -- well, let me just ask you this, do you need to have a fracture for a contusion of the spinal cord?
A. No.

Q. And can you tell me why is it that a diagnosis of spinal cord contusion cannot be sustained in this case?

A. Well, first of all, Dr. Elkins doesn't sustain it, the man who made the diagnosis reversed himself. How can I do better than that?

Q. Okay.

A. The reason he did was there was not enough evidence.

Q. So he was honest about that, right?

MR. DEVER: Objection.

A. I don't know whether he's honest or not, all I can tell you is that he reversed himself.

Q. Is that necessarily a bad thing?

A. Well, it's not necessarily a bad thing, but what I challenge Dr. Elkins on is I can't put together an injury of the spinal cord in any form on the basis of his examination or his writeup, that's my problem.

Q. And he agreed with that, right?

A. Well, he agreed that there was no contusion, eventually he agrees there's no contusion. Whether or not he now flipped over to a concussion, which I think he did, he's now saying that it was a cerebral concussion and there was a spinal cord

concussion, that he had overread the symptoms, findings, complaints, examination, whatever it was, and made a wrong diagnosis of contusion.

Q. Isn't it, though, an ongoing evaluation sometimes in these injuries, that the patients do see the physician over time and look at the improvement or lack of improvement of symptoms and then adjust their original opinion, is that abnormal?

A. I think what's abnormal here is that Dr. Elkins has testified that in all probability Sam's neurological situation was perfectly normal on the 4th and the 5th and was abnormal on the 6th and then he gets better. He's talking about something like this (indicating), which in my judgment has no relationship to a spinal cord.

Q. He did not do a thorough examination as he explained on the 4th?

A. Well, he did not do a thorough examination on the 4th.

Q. He admitted that?

A. But he's been quoted in testimony here that in his judgment in all probability Sam's neurological status was normal for the first 48 hours.

Q. In answer to my question why a diagnosis of spinal cord contusion cannot be sustained in this

case was, number one, Dr. Elkins reversed himself?

A. No. I just can't make the diagnosis on the basis of the information that is in his hospital chart, including Dr. Elkins' two notes.

Q. And the lack of hemorrhaging or bruising, does that necessarily rule out a contusion of the spinal cord?

A. Would you repeat that?

THE NOTARY: Question: "And the lack of hemorrhaging or bruising, does that necessarily rule out a contusion of the spinal cord?"

BY MR. GILBERT:

Q. Does the absence of hemorrhaging or bruising visible to an examination necessarily rule out the existence of a spinal cord contusion?

A. Not a hundred percent. But it would be the major consideration to make the diagnosis.

Q. I mean if you had that --

A. I mean, you can't make a diagnosis of a contusion, which is synonymous with bruising, because you could write in your report patient has a bruise of the spinal cord.

Q. But the fact that one does not have visible signs of hemorrhaging doesn't mean they don't

have a contusion, correct?

A. Well, but you would expect that reflected in the spinal fluid, which was negative.

Q. All right. The fact that there is a spinal tap and no fluid, does that --

A. Well, there is fluid.

Q. Well, whatever. The negative findings of a lumbar puncture does not mean that there is no spinal cord contusion, does it?

A. Well, it makes it very, very iffy. It can't completely eliminate it. But we keep going around, Counselor, when Dr. Elkins himself has finally agreed that this patient did not have a bruise or a contusion of the spinal cord.

Q. Do you know of a spinal cord injury without objective radiograph abnormality? Have you ever heard the term sciwor, S-C-I-W-O-R?

A. It happens all the time.

Q. So there can be a spinal cord injury without objective radiograph abnormality?

A. Well, for 1954 that's true, but it's very difficult now if you want to throw in MRI, and even CT, but particularly MRI.

Q. The fact of the matter, isn't it true that spinal taps or lumbar punctures aren't done today?

A. They're still done.
Q. But not very frequently?
A. Because you now have these imaging things.
Q. Isn't a spinal tap a serious procedure?
A. I don't think so.
Q. Isn't it true that a doctor would not do a spinal tap without proper symptomatology?
A. No. He might do it for the very reasons that Dr. Elkins did it, on the basis of what he found on his studies and his belief he was probably expecting to find some hemorrhage and some high protein, which he didn't.

He also did a test, though, which was called a Queckenstedt test, which I think was very dangerous to do under those circumstances.

Q. And a doctor wouldn't do a test like that --
A. Certainly I wouldn't, even in '54.
Q. Let me finish the question. A doctor would not do a test like that unless they thought that there was a serious injury that needed to be looked at; is that correct?
A. No. That wouldn't be the reason they did the test, no, sir.
Q. What would be the reason to do the test?

A. They would do the test if they thought there was what we call a spinal block. If there was so much swelling and there was a tumor or something of that order, which is not applicable here, they would do the test, which is done rarely now, to see if there was a spinal block.

Q. It's a dangerous procedure?

A. In this case, in a spinal cord injury it's a dangerous procedure.

Q. Are you aware of the Advanced Trauma Life Support for Doctors Manual?

A. Yes.

Q. Have you seen this manual before?

A. Well, at one time I helped compose it. I don't have much to do with it anymore.

Q. You know Dr. Fallon is here, do you not?

A. Yes, I do.

Q. He is a trauma expert?

A. Yes.

Q. In that manual it briefly describes what a mild concussion is. I'm going to ask you if you just agree with this. A mild concussion is an injury which consciousness is preserved but there is a noticeable degree of temporary neurological dysfunction. These injuries are exceedingly common and, because of their

mild degree, often go unnoticed. The mildest form of concussion results in confusion and disorientation without amnesia. This syndrome is completely reversible and is not associated with any major sequelae. A slightly greater injury causes confusion with both retrograde and antegrade amnesia.

Do you have any problem with that definition?

A. I may have written it for them, I'm not sure.

Q. So you have no problem with that?

A. No. What I would tell you is we're entering an area that is very argumentative because you've got neurologists. This section was undoubtedly written by a neurosurgeon for them carried over for many years. As to how long, how many systems, it's a very, very complex case.

As I told you, if the alleged situation happened to Dr. Sam Sheppard I would have classified him as having had a major head injury under these circumstances. The second feature is that he allegedly was unconscious for a second time, because, remember, unlike the thing that's been read here you're proposing that Dr. Sam was unconscious. In the two that you've read here for me there's nothing about unconsciousness,

so you have to move his alleged concussion up the scale.

Q. So let's look at the classic cerebral concussion. The classic cerebral concussion is an injury that results in a loss of consciousness.

A. What was the one you read before?

Q. That was mild.

A. Yes. See what I mean?

Q. Do you disagree that the classic cerebral concussion is an injury that results in a loss of consciousness, the condition always is accompanied by some degree of post-traumatic amnesia, and the length of amnesia is a good measure of the severity of the injury?

A. I don't agree with the very last part. When we opened our little session you --

Q. The loss of consciousness is transient and reversible?

A. That's right.

Q. And in a somewhat arbitrary definition, the patient returns to full consciousness by six hours, although this may occur earlier. Many patients with classic cerebral concussion have no sequelae other than amnesia for the events relating to the injury, but some patients may have more long lasting neurologic

deficits. These include memory difficulties, dizziness and nausea, anosmia and depression amongst others. This is referred to as a post-concussion syndrome and may be quite disabling.

Is there anything that Dr. Sheppard describes -- you read his statements -- that is inconsistent with that definition?

A. Yes.

Q. What is that?

A. Almost everything.

Q. What is it?

A. Well, first of all, I don't see any retrograde amnesia here. I don't see -- Sam, as you recall, was described as lucid and able to answer questions.

Q. That was how many hours?

A. Well, whenever -- you'll have to tell me. All I know is that was done in the afternoon. All I can tell you in these writeups that I reviewed -- I didn't examine Dr. Sheppard -- there may be an occasional one who quotes some confusion, but as I listened to what Sam was able to do after all of this and when I looked at his own testimony I don't see an awful lot of amnesia, I don't see a lot of confusion, I don't even hear the word dizziness anywhere in this

presentation. All I can say is as I read all of the testimony I cannot find that it fits very well within the framework of the post-concussive syndrome as far as Dr. Sheppard is concerned. You'll never see the term post-concussive syndrome in any of these reports.

Not only that, Sam was never subjected to an EEG, Sam never had psychometric tests done. He's back on the wards on the 12th, he's back making rounds at the hospital on the 12th. He's had no checkups in these areas. The standard things that could have been done in '54 to document the degree of post-concussive syndrome were not done. So I don't have the evidence.

Q. I guess we have to stop. I could probably spend another hour with you.

Just one other question. Looking at whatever wounds that you were able to determine exist in this case do you have an opinion as to whether they could be self-inflicted or not?

A. I believe they could be self-inflicted, but I don't put them down as a major possibility. I like the concept that this could be the victim attempting to protect herself under these circumstances or they could be brought about by falls. I would put those two one, two and three, self-inflicted I would put down as the third. But, Counselor, I would also

argue that also I would have to submit and believe that the extent in this particular situation, the degree has been heavily influenced here.

Q. What do you mean by that?

A. Well, by Sam's own testimony, I was unconscious, I was hit from behind. All these sorts of things, I don't see the evidence for it. He doesn't even have a fracture of the spine.

Q. You need a fracture of the spine to --

A. No, but it helps, it helps. It really does help. I need a neurological examination that says you've got spinal cord injury, I don't see that.

MR. GILBERT: Thank you. I have no further questions.

MR. DEVER: You have an opportunity to read this transcript.

THE WITNESS: Oh, yes, I will want to read it before I sign it.

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(DEPOSITION CONCLUDED.)

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ROBERT J. WHITE, M.D. (Date)

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STATE OF OHIO,) CERTIFICATE

COUNTY OF CUYAHOGA.) SS:

I, LAUREN I. ZIGMONT-MILLER, Registered Professional Reporter and Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within-named witness, ROBERT J. WHITE, M.D., was by me first duly sworn to tell the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by him was reduced to stenotypy in the presence of said witness, and afterwards transcribed by me through the process of computer-aided transcription, and that the foregoing is a true and correct transcript of the testimony so given by him as aforesaid.

I do further certify that this deposition was taken at the time and place in the foregoing caption specified.

I do further certify that I am not a relative, employee or attorney of either party, or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this 12th day of February 2000.

Lauren I. Zigmont-Miller, RPR and Notary Public in and for the State of Ohio.
My commission expires December 3, 2000.