

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM SPARTANBURG COUNTY
Court of Common Pleas

R. Keith Kelly, Circuit Court Judge

Appellate Case No. 2017-002522
Case No. 2010-CP-5743

RECEIVED
OCT 18 2018
SC Court of Appeals

Gregory J. Feldman, MD, Joseph A. Boscia, III, MD, and
Upstate Lung & Critical Care Specialists, PC,

Appellants,

v.

Ray E. "Chuck" Thompson, and Charles M. Fogarty, MD,

Respondents.

**RECORD ON APPEAL
VOLUME IX**

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STATE OF SOUTH CAROLINA) IN THE COURT OF COMMON PLEAS
)
COUNTY OF SPARTANBURG) C.A. NO. 2010-CP-42-05743

Gregory J. Feldman, MD, Joseph A.)
Boscia, III, MD, and Upstate)
Lung & Critical Care Specialists, PC,)
)
Plaintiffs,)

Versus)

William Mark Casey, Ray E. "Chuck")
Thompson, and Charles M. Fogarty, MD,)
)
Defendants.)

VIDEOTAPE DEPOSITION OF
L. RANDOLPH WAID, PH.D.

Pursuant to Notice of Deposition and/or agreement
in the above-entitled case, the videotape deposition of L.
RANDOLPH WAID, PH.D. was taken on the 2nd day of May,
2017, commencing at the hour of 9:07 a.m. in the offices of
L. Randolph Waid, Ph.D., 1458 Stuart Engals Boulevard,
Suite 204-A, Mount Pleasant, South Carolina.

REPORTED BY: Rosalind Poole Walters,
Certified Verbatim Reporter-Master

VIDEOTAPED BY: Kevin O'Quinn
Certified Legal Video Specialist

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*Note: Only cover page of exhibit attached to copies.

(THIS TRANSCRIPT MAY CONTAIN QUOTED MATERIAL. SUCH
MATERIAL IS REPRODUCED AS READ OR QUOTED BY THE SPEAKER.)

1 STIPULATIONS:

2 It is agreed by and between the counsel for the parties as
3 follows:

- 4 1. That this deposition is being taken pursuant to Rule 30
5 of the South Carolina Rules of Civil Procedure;
6 2. That this deposition is being videotaped;
7 3. That the deponent waives the right to read and sign the
8 deposition transcript.

9 VIDEOGRAPHER:

10 We're now on the record at 9:07 a.m. on May 2,
11 2015. This is the video deposition of Dr. Randolph
12 Waid. Counsel has waived the reading of the caption.
13 Counsel, please introduce yourselves for the record.

14 MR. MANN:

15 Yes. My name is Milton Mann. Dr. Waid, I have
16 subpoenaed you here for your deposition today. I
17 represent Dr. Feldman, Dr. Boscia, Upstate Lung and
18 Critical Care. There were previously other plaintiffs
19 who have been dismissed or are in the process. They
20 have been dismissed. Excuse me.

21 MR. HENRIKSON:

22 My name is Matt Henrikson. I represent Chuck
23 Thompson.

24 MS. CHEEK:

25 This is Ellen Cheek for Dr. Charles Fogarty.

1 EXAMINATION BY MR. MILTON:

2 Q. And Dr. Waid, would you please state your name for the
3 record?

4 A. Sure.

5 VIDEOGRAPHER:

6 We have to swear the witness.

7 MR. MANN:

8 I'm sorry. I'm jumping ahead.

9 *****

10 L. RANDOLPH WAID, PH.D., being duly sworn to tell the truth,
11 the whole truth, and nothing but the truth of his own
12 knowledge concerning the matter herein, testified as
13 follows:

14 *****

15 EXAMINATION BY MR. MILTON:

16 Q. would you please state your name for the---

17 A. My name is Lewis Randolph Waid.

18 Q. And Dr. Waid, what do you do for a profession?

19 A. I am a licensed clinical psychologist, and I have a
20 specialty in clinical neuropsychology.

21 Q. With those qualifications, what do you primarily do for
22 your vocation?

23 A. My vocation primarily involves really general practice
24 where I evaluate, treat, and provide intervention to
25 clients who have psychiatric or psychological

1 difficulties. About 40 percent of my work is forensic
2 neuropsychological or psychology which involves
3 evaluations that are directed toward psycho-legal
4 issues. That can range from competency issues to
5 issues of personal injury and damages due to a personal
6 injury and other sorts of, you know, courtroom and
7 forensic work.

8 Q. Do you do any teaching, also, Dr. Waid?

9 A. Well, for about 30 years I was a clinical associate
10 professor in psychiatry and neurology at the Medical
11 University of South Carolina, regularly teaching. I'm
12 adjunct professor at The Citadel where I also taught a
13 course on substance abuse counseling. And my teaching
14 activities at the Medical University of South Carolina
15 ceased about a year ago when I finally disengaged from
16 the university.

17 Q. Thank you. You were noticed today, I believe a notice
18 with also a subpoena as well as a request for medical
19 records, for today's deposition?

20 A. That is correct.

21 Q. And did you -- were you able to locate your chart
22 respecting the patient at issue, who is William Mark
23 Casey?

24 A. We did a thorough search both here, but because of the
25 dates of seeing Mr. Casey, we believed it would be in

1 the storage. We have thoroughly, thoroughly checked
2 that out, and I -- we did not come up with Mr. Casey's
3 chart. So I do not have my personal chart on him.

4 Q. I believe you have Mr. Henrikson's contact information?

5 A. I do.

6 Q. Who represented Mr. Thompson.

7 A. Yes.

8 Q. Chuck Thompson. Who worked with you in the medical
9 malpractice case that the chart that we were just
10 referencing would have evolved from, from that
11 litigation?

12 A. Yes, sir, it would have.

13 Q. Now that I've just butchered that question, let me see
14 if I can ask it a little bit better. Do you recall
15 William Mark Casey?

16 A. I do recall Mr. Casey having seen him in 2005 for the
17 initial evaluation. I did an updated evaluation on
18 2009. In the interim period between those two time
19 periods there was a deposition about -- taken for my
20 opinions based on the 2005. I did the updated
21 evaluation because it had been some years, and -- and
22 in order to provide better opinions in the legal case
23 or literally courtroom testimony, we did an updated
24 evaluation just to see if the opinions, you know, about
25 him would persist, and so that evaluation was done in

1 2009. And I do have recall for driving to Spartanburg
2 and testifying in this particular case.

3 Q. Thank you, Dr. Waid. What was your understanding as to
4 why you were involved with Mr. Casey?

5 A. The understanding was because there was concern that
6 Mr. Casey was experiencing some neurocognitive or brain
7 behavior and emotional difficulties that seemingly
8 commenced following his engagement in a surgical
9 procedure where there may have been complications. And
10 so ultimately my understanding was that they wanted an
11 evaluation of his brain behavior functioning and
12 emotional functioning as it related to the temporal
13 relationship to those incidents and -- and assessing
14 Mr. Casey regarding those kinds of difficulties.

15 Q. Before we got started I believe that I showed you two
16 notebooks. Do you recall that?

17 A. Yes, I do.

18 Q. I'm going to request the court reporter mark the first
19 one. And we are keeping exhibit numbers running one
20 through however many in the case just in sequential
21 number. We're not doing one through however many with
22 each individual deponent.

23 A. Okay.

24 Q. So this one is going to be number 114. So I'm going to
25 ask --

1 A. Gotcha.

2 Q. -- that it be marked.

3 (Plaintiff's Exhibit Number 114 marked)

4 EXAMINATION RESUMED BY MR. MANN:

5 Q. Dr. Waid, would you please look at this and tell me or
6 if you can identify what it is.

7 A. Yes. It is indeed the transcript of the deposition
8 that was conducted in May of 2009 of me regarding the
9 evaluations that I had done on Mr. Casey.

10 Q. I'm not sure that I'm going to have particular
11 questions, but if you feel that it would benefit you to
12 help answer my questions to refer to it, please feel
13 free to do so.

14 A. Okay.

15 Q. Further, if you feel that it would benefit you to
16 answer any of my questions, if you'd just tell me what
17 it would to -- excuse me -- assist you in answering my
18 questions, please advise me.

19 A. Will do.

20 Q. I didn't go over the boiler plate information simply
21 because you've given a deposition before?

22 A. Yes, I have.

23 Q. And you're well-versed in the procedures of taking a
24 deposition?

25 A. Yes, I am.

1 Q. And anything, of course, that I can do to benefit or
2 help you, please let me know.

3 A. Will do.

4 Q. Thank you, Dr. Waid.

5 (Plaintiff's Exhibit Number 115 marked)

6 EXAMINATION RESUMED BY MR. MILTON:

7 Q. I have now requested this document that I previously
8 showed you before we get started -- got started. Can
9 you help me identify what has been marked as Exhibit
10 115?

11 A. Yes. That's a copy of the transcript of my testimony
12 that took place in the William Mark Casey versus
13 Gregory J. Feldman case on May 19, 2010 in Spartanburg.

14 Q. And I think before we got started you mentioned that
15 you did have an opportunity to review your trial
16 testimony before today's deposition?

17 A. I did.

18 Q. In your review of your trial testimony, did you notice
19 any inaccuracies or anything that you felt -- no longer
20 felt were accurate?

21 A. No, I didn't see anything that particularly changed my
22 thinking about this case.

23 Q. And, again, I'm primarily providing that to you just in
24 case you did not have it and in case you desired to
25 refer to it during your deposition.

1 A. Okay.

2 Q. This has previously been marked an Exhibit 112 in this
3 litigation. Can you see if you can identify what that
4 document is?

5 A. Yes. That's the report of the neuropsychological
6 evaluation that I conducted on Mr. William Mark Casey.
7 The dates of that evaluation are August 30th and
8 September 10th of 2005.

9 Q. Okay. And did you have an opportunity to review that
10 prior to our sitting for the deposition today?

11 A. Yes, I did.

12 Q. Did you notice any inaccuracies or anything in it that
13 you would want to correct or point out at this time?

14 A. No, I did not see anything that I would want to
15 correct.

16 Q. Let me ask you to keep that handy.

17 A. Okay.

18 Q. And if you would, please, that is a Bates-stamped
19 number document, and it's actually Bates stamped two
20 different ways.

21 A. Right.

22 Q. Down at the bottom for this litigation the Bates
23 stamping is Thompson 059913 as the starting page?

24 A. Yes, sir.

25 Q. Would you please turn to 059914, which should be the

1 second page, please?

2 A. Yes, sir.

3 Q. would you reference the fourth paragraph for me, and do
4 you see that fourth paragraph?

5 A. Yes, sir, I do.

6 Q. I'm going to ask you some questions regarding that
7 paragraph.

8 A. Yes, sir.

9 Q. Before we get started let me show you another exhibit.

10 A. Yes, sir.

11 Q. Because I want you to ultimately do a comparison for
12 me, Dr. Waid.

13 A. Sure.

14 Q. This is previously marked as Defendant's Exhibit Number
15 7.

16 A. Yes.

17 Q. would you take a moment and take a look at that and
18 tell me whether or not you feel that you have seen that
19 before.

20 A. I have seen this recently. Yesterday that was provided
21 me by counsel. This is a copy of a report dated July
22 21, 2005. It's an office note, and it is authored by
23 Charles M. Fogarty, M.D., and that's -- that's my
24 understanding of what it is.

25 Q. Let me ask if you would be so kind as to turn to the

1 last page.

2 A. Yes, sir.

3 Q. And the third paragraph down, the first sentence, would
4 you please read that first sentence to yourself?

5 A. "With reference to the patient's difficulty
6 concentrating, air emboli have been reported as a
7 complication of laser bronchoscopy even without
8 preparation of the endotracheal tree with resultant
9 leakage of air into extrapleural vascular and
10 mediastinal spaces. Although he is fortunate not to
11 have any gross motor deficit, he may well have
12 permanent neurologic deficit, in which case the
13 indication for taking medication such as Strattera may
14 be moot. The patient may simply need to recognize that
15 although he would like to go back to work, he may be
16 chronically disabled by his neurologic impairment-
17 slash-permanent brain damage."

18 Q. And Doctor, before we go further, looking at the top of
19 page 3, there appears to be a patient name on Exhibit
20 Number 7?

21 A. Yes.

22 Q. And what is that patient name, please?

23 A. I have the name William Casey.

24 Q. Okay. And what is the proposed or the date reflected
25 at the top?

1 A. July 21, 2005.

2 Q. And let's please look on the first page again.

3 A. Yes, sir.

4 Q. And I believe you had said that your understanding is
5 that this is an office note?

6 A. That's how he has titled it.

7 Q. Okay. And the date of the office note is 7/21/05?

8 A. Yes, sir.

9 Q. Okay. I can't remember if I asked you that before, so
10 I apologize --

11 A. Okay.

12 Q. -- if I'm being repetitious. So let's look at toward
13 the latter part of the one, two, three, fourth
14 paragraph --

15 A. Yes, sir.

16 Q. -- in your report. Do you see where there is some
17 quoted language attributed to Dr. Fogarty?

18 A. There is, yes.

19 Q. All right. Now, looking back at Number 7, again third
20 page, one, two, three, third paragraph down, does that
21 quotation seem to track this version of the 7/21/05
22 note?

23 A. In my opinion, yes, that would be the version that I
24 would have quoted from.

25 Q. Okay. So you feel pretty confident you had previously

1 seen this note?

2 A. Yes, because, again, in my report it has quotes, which
3 would mean I'm taking it directly from another source.

4 Q. Let me show you a document that previously in this
5 litigation has been marked as Exhibit Number 6.

6 A. Yes, sir.

7 Q. Can you look at it and tell me what it appears to be,
8 please?

9 A. It is an office note on July 21, 2005 from Dr. Fogarty
10 regarding William Casey.

11 Q. And can you look at the third page? Is there a
12 signature?

13 A. Yes.

14 Q. And would -- would it appear that that would be
15 something that Dr. Fogarty authored?

16 A. Yes. There's a signature, and -- and it does have his
17 name listed at the base of the correspondence.

18 Q. Let's go back to that same paragraph that we were
19 referencing earlier, which is on the third page of what
20 has been marked Exhibit Number 6, and we're talking
21 about the third paragraph down on page 3.

22 A. Yes, sir.

23 Q. Just looking at the very first sentence, is there a
24 difference between these two first sentences that you
25 notice?

1 A. The first---

2 Q. Comparing -- excuse me -- comparing Number 6 with
3 Exhibit Number 7.

4 A. Yes. Let's see. Yes, it's -- it's a similar sentence,
5 but it is a little different. Yeah, it is a little
6 different, I mean, in terms of basically he said there
7 complication when there is laser perforation of the
8 endotracheal tree with resultant leakage of air into
9 extrapleural vascular and mediastinal spaces, and the -
10 - the first one I read, it had it phrased in a way
11 where it says even without perforation. On this one it
12 basically says with, you know, when there is laser
13 perforation. So he just subtle changed there in terms
14 of even without or on this case when there is
15 perforation.

16 Q. Looking and comparing again note Number 6, do you see
17 the term common complication --

18 A. I do see---

19 Q. -- in note Number 6?

20 A. Yes, I do.

21 Q. And would you agree with me note Number 7 no longer
22 contains the word common?

23 A. That is correct.

24 Q. And, again, these are both dated 7/21/05?

25 A. They are.

1 Q. Did you know that there were at least two notes dated
2 the same day respecting William Mark Casey regarding
3 Dr. Fogarty prior to being advised that recently either
4 through this deposition or with your meetings with Dr.
5 Henrik---

6 A. No.

7 Q. Excuse me. Mr. Henrikson?

8 A. No, I did not.

9 Q. So in the underlying medical malpractice case you did
10 not know that?

11 A. That is correct.

12 Q. If you had become aware of it, would you have made
13 inquiry as to why there appears to be two notes dated
14 the same date?

15 A. I would have tried to draw -- I would have tried to
16 resolve that, you know, that finding in some form or
17 fashion.

18 Q. Do you feel that the physicians in the underlying
19 medical malpractice case, do you feel that they were
20 zealously defended?

21 A. Say again? I'm sorry.

22 Q. Do you feel that they were zealously defended, the
23 physicians in the underlying case? Do you -- do you
24 feel that the attorneys in the underlying litigation
25 were doing their jobs providing a zealous defense to

1 the physicians in the medical malpractice case?

2 A. I do believe they were.

3 MR. HENRIKSON:

4 object to the form.

5 EXAMINATION RESUMED BY MR. MILTON:

6 Q. Okay. Do you feel that if -- and do you recall who the
7 -- do you recall who the defense attorneys were in the
8 underlying medical malpractice case?

9 A. Yes, I do, and I recognize, but I think in terms of
10 questioning, I think Mr. Gunn questioned me the most
11 personally. So I recognize him, but I was aware that
12 you and Mr. King was part of that.

13 Q. Did either of the three of us question you about what
14 has been marked Exhibit 6 and Exhibit 7 in the
15 underlying medical practice case?

16 A. No, I do not believe so.

17 Q. In your---

18 A. I mean, you questioned me about causal factors, but not
19 there being different reports. I'm not aware of
20 different reports until recently.

21 Q. In your interaction with the defense attorneys involved
22 in this case, if they would have realized that there
23 were multiple notes representing to be the 7/21/05
24 note, do you feel that you more likely than not would
25 have been questioned about that?

1 A. Generally---

2 MR. HENRIKSON:

3 Let me object for --

4 MS. CHEEK:

5 Objection.

6 MR. HENRIKSON:

7 -- a couple of grounds. One, you're asking him to
8 speculate.

9 MR. MANN:

10 That's fine.

11 MR. HENRIKSON:

12 And two, when you say defense lawyers in this
13 case, are you talking about me and Ellen, or are you
14 talking about---

15 MR. MANN:

16 Matt, as Ellen told me once before, I've got your
17 objection, and I'll try -- I'll try to rephrase my
18 question.

19 MR. HENRIKSON:

20 Okay. I'm sorry.

21 MR. MANN:

22 No, that's fine. That's fine. And I appreciate
23 the help. And, trust me, I may hold my hand up and ask
24 you to help in the future. Okay? So can I reserve
25 that right?

1 MR. HENRIKSON:

2 Sure.

3 MR. MANN:

4 Thank you.

5 EXAMINATION RESUMED BY MR. MILTON:

6 Q. As you heard, I think Mr. Henrikson did make a good
7 point. So respecting the questioning in the underlying
8 medical malpractice case of myself, Mr. Billy Gunn, and
9 Mr. Spencer King --

10 A. Right.

11 Q. -- did anything in our questioning in the underlying
12 medical malpractice case indicate to you that we were
13 aware that there were multiple copies of the 7/21/05
14 note?

15 A. My recollection is no, that there wasn't any awareness
16 on your part and there wasn't any awareness on my part.

17 Q. And now I am going to ask you to speculate, because you
18 have given a multitude of depositions --

19 A. Sure.

20 Q. -- in your career. Correct, Dr. Waid?

21 A. Yes.

22 Q. Do you think more likely than not, based upon your
23 experience giving testimony and -- and working with
24 lawyers, do you feel that that would have been an area
25 of inquiry by Mr. Gunn, Mr. King, or myself?

1 MR. HENRIKSON:

2 Object to the form.

3 EXAMINATION RESUMED BY MR. MILTON:

4 A. Yes, I believe that you would have inquired about these
5 multiple reports only in the sense that even in my
6 testimony the temporal relationship to causal factor
7 was questioned a lot, and this is certainly having some
8 bearing on that.

9 Q. And I appreciate that. What do you think that bearing
10 would be that you're referencing?

11 A. The bearing would be basically exactly what took place
12 during the surgical procedure that may have resulted in
13 changes in Mr. Casey's emotional and psychological and,
14 you know, neurocognitive, brain behavior functioning,
15 the concern really about air emboli and whether that
16 air emboli occurred or did not occur as an aspect of a
17 complication related to this procedure.

18 Q. Thank you. I'm going to show you -- give me one
19 second. This has previously been marked as Exhibit 5
20 in this litigation.

21 A. Yes, sir.

22 Q. Would you take a look at that for me, Dr. Waid, and see
23 if you can identify what that is.

24 A. Yes. This is an office note from Mr. -- regarding Mr.
25 William Casey again dated July 21, 2005 from Dr.

1 Fogarty.

2 Q. And this contains the same dates as Exhibit 6 and
3 Exhibit 7 did, also?

4 A. Yes, sir, it is the same date.

5 Q. Do you notice on the front that there's an exhibit
6 sticker?

7 A. Yes.

8 Q. As part of the copy?

9 A. Yes.

10 Q. Can you tell me what the exhibit number is?

11 A. Number 20.

12 Q. Do you see a name on that exhibit sticker?

13 A. Dr. Fogarty.

14 Q. And do you see a date on that exhibit sticker?

15 A. Yes. 12/22/2008.

16 Q. Thank you, sir. Let's go back to the third page of
17 this note, please.

18 A. Yes.

19 Q. And let me ask you to look at the first sentence of the
20 third paragraph, the paragraph that we've been looking
21 at before.

22 A. Yes, sir. Yes, I've read that sentence.

23 Q. Is there a difference between this 7/21/05 note and the
24 Exhibit 6 and Exhibit 7 in what you're seeing?

25 A. Yes, there is a difference in terms of some wording.

1 As the -- after the stem of "with reference to the
2 patient's difficulty concentrating," on this occasion
3 the statement reads, "he undoubtedly had air emboli
4 given his lengthy duration of anesthesia and laser
5 perforation of the endotracheal tree with resultant
6 leakage of air into the extrapleural and vascular
7 extrapleural mediastinal and vascular spaces." So,
8 again, mainly the undoubtedly kind of stem is
9 different, kind of the same thing after that.

10 Q. And so you would agree those three notes are not the
11 same?

12 A. They are not exactly the same, that is correct.

13 Q. And, again, we talked about Exhibit 6 and 7, and you
14 previously said that you were not aware that there were
15 multiple notes. Does that also apply to what I've
16 shown you as Exhibit 5?

17 A. That is correct.

18 Q. Okay. We can get off of that for a minute. Do you
19 recall Mr. Thompson -- now, who is Mr. Thompson? Did
20 you have interaction with Mr. Thompson in the
21 underlying medical malpractice case?

22 A. Basically, I think I did. I'm certainly aware of Ken
23 Anthony, also interfacing with him. I think
24 potentially Mr. Anthony was more of the front person
25 that I interfaced with, but I was aware that both of

1 them were making the referral to this office.

2 Q. Yes, sir. Do you recall Mr. Thompson requesting around
3 the time that you finalized your first report, do you
4 recall him requesting your file?

5 A. Yes. I think I do have recall that he wanted a copy of
6 my records.

7 Q. Let me -- I'm going to mark this as -- are we to 15, I
8 believe? Let me mark this 16. I'm sorry. 16.

9 MR. HENRIKSON:

10 116.

11 MR. MANN:

12 116. Thank you, Matt. I need all the help I can
13 get.

14 (Plaintiff's Exhibit Number 116 marked)

15 EXAMINATION RESUMED BY MR. MANN:

16 Q. All right. I'm going to ask you to look at that, Dr.
17 waid, while I put a number on this one and I pass out
18 copies to the other attorneys. Dr. Waid, I will
19 represent to you that I do not believe that you've seen
20 this document before. Would you take a look at it and
21 read the two pages for yourself, and then I've got a
22 few questions.

23 A. Sure.

24 Q. Okay. Tell me when you're ready.

25 A. I am ready.

1 Q. Okay. At the top left-hand corner there appears to be
2 a 10-slash-20?

3 A. Yes.

4 Q. I believe that that is referencing 10/20/2005.

5 A. That would be a reasonable speculation, in my opinion,
6 but I'll leave it to your---

7 Q. That's fine. Respecting your report, does the date
8 10/20 have any reference as to your report?

9 A. In my opinion, it would be more than likely after my
10 report was completed. I must say that. 10/20, that's
11 literally a month and a half, and I usually am done
12 within three or four weeks afterwards at the latest.
13 So I would assume my report was completed.

14 Q. Let me ask you to look up at the very top of the first
15 page of your report, which has previously been marked
16 Exhibit 112.

17 A. Yes.

18 Q. Do you see that fax information at the very, very top
19 of the page? And let me ask you if you can attempt to
20 read the date that is at the far top left-hand corner?
21 Left --

22 A. Okay.

23 Q. -- Dr. Waid.

24 A. It does look like 10/20/2005 up there.

25 Q. So looking at what we've marked as 116 and looking at

1 112, there does seem to be a correlation respecting the
2 date of September [ph] 20th?

3 A. Yes.

4 Q. And I'm just trying to get things in chronological
5 order here. So you more likely than not sometime
6 around 10/20 your report was finished, and I believe
7 that purports that it was faxed to Mr. Anthony's
8 office?

9 A. It's quite likely that it was faxed on that date if
10 that's...

11 Q. Okay. Let's -- let's go over what we've marked 116.
12 At the top we've talked about the 10/20. Correct?

13 A. Sure.

14 Q. And this is the handwritten note, 116. Down, it looks
15 like your name?

16 A. That is correct.

17 Q. Do you recognize that phone number, sir?

18 A. I do recognize that phone number. That is my business
19 number.

20 Q. Thank you, Dr. Waid. Do you remember a Kathryn being
21 involved?

22 A. Kathryn was indeed our -- the primary assistant to
23 myself and Dr. Teichner at that time.

24 Q. Okay. Can you read that next paragraph?

25 A. Yes. It says, "Medical notebook, FedEx overnight to us

1 for corrections and updates."

2 Q. Do you remember what those corrections and updates
3 were?

4 A. No. I'm not sure I ever -- I'm not sure I ever
5 received such, but all I would see is that they are
6 requesting that medical notebook, which would be a
7 notebook container, to be FedEx'd back.

8 Q. Do we see the date down at -- or, excuse me -- the
9 address at the bottom?

10 A. Yes.

11 Q. Do you -- does that address have any relevance to you,
12 Dr. Waid?

13 A. It was a long time ago, and that's where I was officed,
14 that's correct.

15 Q. And let's look on the back page, at the top it again
16 looks like 8/26 is the date?

17 A. Yes.

18 Q. would you agree?

19 A. Yes.

20 Q. Read that to yourself, and I think you've already
21 indicated, does that have any relevance to you, that
22 language on the second page?

23 A. I've read it to myself. I can't imagine it has any
24 relevance to me, to our office.

25 Q. They were together, so that's why I just included them

1 together --

2 A. Sure.

3 Q. -- in the discovery that we were provided. Do you
4 recall whether or not that chart or records were sent
5 back to Mr. Thompson?

6 A. I don't have conscious recall for that one way or
7 another. Obviously it would have been helped if I
8 could have found the chart, but I do not have conscious
9 recall for that.

10 Q. I'm going to request this be marked as Exhibit 116 --
11 17. Excuse me. 117.

12 (Plaintiff's Exhibit Number 117 marked)

13 EXAMINATION RESUMED BY MR. MILTON:

14 Q. Dr. Waid, let me ask you to take a look at this, and
15 please tell me when you've had a chance to review it.

16 A. Sure. I've reviewed it.

17 Q. Okay. What does this appear to be to you?

18 A. It looks to me to be a FedEx Express airbill, and
19 ultimately it's made from me, Randolph Waid. That is
20 not my handwriting, but it sure does look to be the
21 handwriting of my assistant at that time, as I recall.
22 It does seem to have a match. And it's being -- we're
23 sending to Karen Greer at Burts Law Firm it looks like
24 on North Church Street in Spartanburg.

25 Q. Okay. How many packages were sent?

1 A. It does appear to be three packages.

2 Q. Let me ask you, here.

3 A. Oh, I'm sorry. I'm looking up here at the top. You're
4 right. One total package with a total weight of four.

5 Q. And I believe that says -- would you have any inkling
6 if that's four ounces or four pounds?

7 A. Yeah, I really don't know, but I -- I suspect four
8 ounces is too light for the records. So I would
9 probably lean toward four pounds.

10 Q. Thank you. So it would appear that you complied with
11 that request?

12 A. Sure, you know, again, with my assistant doing the work
13 undoubtedly, but yes, it looks like we did send a
14 package back to that address in Spartanburg.

15 Q. Is it a common practice to send the medical records and
16 things of that nature back to the engaging attorney
17 after you have completed your report?

18 A. No. I would say it's not common that it's requested.
19 Times when it has is when I'm often given a huge volume
20 where people don't want to spend the money to copy it
21 in that case, but I would say that happens more often
22 in criminal cases for me. But bottom line is, you
23 know, there might be -- I might have records in a
24 record form like that where I'm reviewing them and know
25 they're going back, but most of the time, no, I'm given

1 my own copy of the records.

2 Q. And, again, you don't recall what the corrections and
3 updates were?

4 A. No, I do not have any recall for what the corrections
5 or updates, what that might mean, and I don't have
6 recall for, you know, looking at anything later on that
7 was corrected, you know, in terms of anything in my
8 reports that indicates that's what I did. I'm aware of
9 the records that I did review, and then it looks to me
10 that we sent it back.

11 Q. Do you recall if you ever got your records back?

12 A. No, I don't have recall for that, again, and I can't
13 tell you that I have recall for the size of this chart,
14 which would help me, tell me that. So, I mean, I did
15 see him again, but I don't have recall for whether or
16 not I received them back. I just don't have that
17 recall.

18 Q. You're aware that a ream of paper, copy paper is 500
19 pages?

20 A. Yes.

21 Q. I will represent to you that 350 pages weighs
22 approximately four pounds. Does that help in any way?

23 A. Yeah. I believe, you know, when I look at the -- what
24 I reviewed, I think it was a sizable amount of
25 information that came in paper form back then. I think

1 we do disks a lot more now. And I would have no
2 trouble believing this was a rather large pocket --
3 packet of information or paper.

4 Q. Let me take a quick break, Dr. Waid.

5 A. Sure.

6 Q. That may very well be the conclusion of my questions.
7 So let me -- let me take five minutes and think.

8 A. Sure.

9 VIDEOGRAPHER:

10 off the record, 9:40 a.m.

11 (Off the Record)

12 VIDEOGRAPHER:

13 Back on the record, 9:45.

14 EXAMINATION RESUMED BY MR. MILTON:

15 Q. Dr. Waid, can you give me an approximation of how many
16 cases that you have been involved with of a nature
17 where you were giving deposition and opinion testimony?

18 A. Sure. I can even provide you my list of cases, but I
19 would tell you uppermost would be in the 30 or 40
20 depositions a year. This year a little bit -- I think
21 in the last three or four years a little bit less, but
22 generally my list since the federal government started
23 wanting us to keep those lists, it ranges from anywhere
24 from 20 to 40 in a given year.

25 Q. And total number, can you tell me approximate over your

1 career?

2 A. You know, you'd really have to multiply -- you know,
3 easily you could multiply 30 by, you know, almost 30
4 years, because once it started happening it's always
5 been around 20 to 30 or 40 in a year.

6 Q. It -- excuse me.

7 A. So I would basically say probably easily I've done 900
8 depositions over my career.

9 Q. Have you experienced another case where there has been
10 an office visit note dated the same date with
11 differences contained within the note before?

12 MS. CHEEK:

13 Object to form.

14 EXAMINATION RESUMED BY MR. MILTON:

15 A. I'm not aware of seeing such in terms of the same date,
16 same office note, no, I'm not aware of such. In my
17 experience, that's not very -- I have not seen it.

18 Q. And given Ms. Cheek's objection, but you do feel that
19 you understood my question. Correct?

20 A. Yes. I think ultimately in terms of reviewing medical
21 records, it's -- there are sometimes inconsistencies
22 that I'll pick up on or I'll find some information that
23 hasn't been conveyed to me that I will check on, like
24 maybe a previous involvement in the emergency room,
25 where's that data, but that would be keeping some

1 information from me, but I haven't really seen
2 multiplicity of one report that would have different
3 constructs. I would tend to -- you know, I tend to
4 avoid them, because I think ultimately they're -- you
5 know, when you change a report -- I rarely do that -- I
6 will provide an addendum just so there's not multiple
7 copies of what I'm saying, you know, if I'm changing
8 it. If an attorney wants a change, I generally don't.
9 I'll send an addendum. I'll just add another
10 completely different piece of paper.

11 Q. Thank you, Dr. Waid. And, again, I want to make sure
12 that I clean this up to overcome any potential
13 objection.

14 A. Sure.

15 Q. We previously looked at what was marked Exhibits 5, 6,
16 and 7.

17 A. Yes.

18 Q. And those appear to be office visits -- visit notes all
19 dated the same day, all authored by Dr. Fogarty, all
20 respecting the same patient, William Mark Casey.
21 Correct?

22 A. That is correct.

23 Q. And, as we have discussed, there are internally
24 differences between those three notes?

25 A. There are.

1 Q. And have you seen a similar situation of this nature
2 where there are multiple such as visible by the review
3 of Exhibits 5, 6, and 7?

4 MS. CHEEK:

5 Object to the form.

6 MR. HENRIKSON:

7 Same objection.

8 EXAMINATION RESUMED BY MR. MILTON:

9 A. No, I haven't. I've certainly seen in secondary
10 reports variations of how they say something, but not
11 in the same report. So, you know, if you have a report
12 July 21st, but then you have a report July 23rd or, you
13 know, July 30th that changes a little bit the causal
14 factor or how the causal factor is worded, I've seen
15 that, but I've not seen it in the same dated report.

16 A. Dr. Waid, I have no further questions. Thank you.

17 EXAMINATION BY MR. HENRIKSON:

18 Q. Dr. Waid, my name is Matt Henrikson. I represent Chuck
19 Thompson. Have you ever read and revised a draft
20 report?

21 A. Yes.

22 Q. And changed it?

23 A. Yes.

24 Q. So you would have a -- the original draft and then a
25 final draft until you may sign it, you may make changes

1 thereafter?

2 A. That is correct.

3 Q. Now, Mr. Mann has shown you your report and has shown
4 you three exhibits which are 5, 6, 7, and you have
5 reviewed the language that differs from those three?

6 A. That is correct.

7 Q. And that language has to do with potentially causation.
8 Isn't that correct?

9 A. That is correct.

10 Q. Causation is -- strike that. Your object was to do
11 testing to try to see how Mr. Casey was at that time in
12 terms of brain function and emotional function. Is
13 that correct?

14 A. That is correct.

15 Q. Whatever brought him to you, whatever caused him to
16 have some deficit, does that have any impact on your
17 findings?

18 A. It only is -- impact is that if it's a possible
19 causality along with other causalities, I'm still
20 really putting out the similarities of the findings to
21 those potential causalities and the nature of those
22 findings, but to me it's mainly a temporal
23 relationship. In terms of this type of air emboli or
24 what we would refer to as hypoxic injury, that's not an
25 area where I'm expertise in, where a brain injury I

1 would be more likely to be firm. So I would only say
2 potentially that, and it -- so it wouldn't -- it would
3 just be my understanding, but I'd have to let those
4 experts figure out if an air emboli did or did not
5 occur.

6 Q. So whether he has some neurological deficit because of
7 a air emboli or he gets hit in the back of the head
8 with a two-by-four, that's not going to change the raw
9 data of the tests that you are administering. Is that
10 correct?

11 A. That is correct. The natural testing is going to tell
12 us how that brain is functioning, how his emotions are
13 functioning at that point and certainly whether or not
14 that represents a change from estimates of his pre-
15 morbid functioning at some time before the incident
16 occurred.

17 Q. So the opinions that you offered in your report and the
18 opinions that you offered in your deposition and at
19 trial, they're not related, they're not based on
20 whatever wording Dr. Fogarty may have had in his office
21 note. They're based on the findings, the raw data that
22 you collected from the testing and your interpretation
23 of that data. Isn't that correct?

24 A. That is correct in terms of my primary role, and
25 ultimately what I'm going to say is that potentially,

1 you know, one of the causals might have been a
2 neurologic deficit due to complication of laser
3 bronchoscopy, but that's all I say. If some
4 complication occurred, I can't be expertise on that
5 because it's just not my area. So ultimately I do
6 recognize that potential to be a causal factor, but, as
7 is in my report, I also gave about four other causal
8 factors.

9 Q. So whether -- so whether or not Dr. Fogarty thought
10 that the air emboli undoubtedly caused his problem or
11 that air emboli could or may not be involved or be the
12 result of some procedure, that really doesn't impact
13 your findings at all?

14 A. It does not on the findings of how this man is
15 functioning cognitively and emotionally. It really
16 doesn't. And in this case, again, I would be less
17 likely to be firm about causality because it enters
18 into an area that I'm not expertise on.

19 Q. And is it also the case that the Social Security
20 Administration doesn't really care about causation of
21 injury, they care about whether or not the person is
22 capable of performing some sort of function or is
23 employable in any way. Is that correct?

24 A. That is correct, but Social Security when they get my
25 evaluation, it goes into answering -- or report -- the

1 question of whether or not this individual can do any
2 employment capacities five days a week, eight days a
3 week -- I mean eight hours a day, five days a week.
4 It's totally about the ability to work. They don't
5 even -- they don't care where the deficits come from.

6 Q. And so, in your experience, any report that Dr. Fogarty
7 may have made regarding causation is not going to
8 impact the Social Security evaluation.

9 A. Yeah, not at all. They really are about can the person
10 work, and they do get my data quite a bit, because it
11 really is relevant to that, but they really don't care
12 about causality at all. It's really can he work or
13 not.

14 Q. And you have reviewed the -- I'll just call it the
15 operative language of these three exhibits that we
16 have. Do you agree with Dr. Boscia that there are
17 minor different -- these differences are minor?

18 A. I do believe they are minor. They change a little bit
19 around the level of certainty. For me they don't
20 represent much difference, because for me it just
21 represents the potential of an event occurring that
22 might be causal. I don't need -- I'm not going to need
23 to make it more certain, because that's not where I'm
24 working at. So for me -- to me all three of them imply
25 the potential for something to have happened, and that

1 something could be air emboli or whatever, but the
2 potential. It wouldn't have changed my thinking about
3 what I'm doing, that -- and the temporal relationship
4 with it. But in terms of exactly what happened, I have
5 no opinion.

6 Q. So if I understand your testimony, if you had had
7 Exhibit 5, 6, or 7 or any combination of them, you may
8 have been curious as to why there was some different
9 language, but it would not have impacted your testing
10 or your ultimate opinion regarding his mental and
11 emotional functioning level at the time that you tested
12 him?

13 A. That's correct. And even more so because I'm still
14 basing that on the evaluation of him over two periods
15 of time where he's not doing well and a lot of things
16 are impacting on him. So that would not have changed,
17 and invariably---

18 Q. Pardon me?

19 A. It would not have changed my testimony about what I
20 did, which is measure this guy's behaviors and where
21 they're at right now. So it wouldn't have changed
22 that.

23 Q. Please answer any questions counsel may have for you.

24 A. Sure.

25 MS. CHEEK:

1 I have no questions. Thank you.

2 MR. MANN:

3 Nothing further.

4 VIDEOGRAPHER:

5 This will conclude the video deposition of Dr.

6 Randolph Waid. We're off the record, 9:56 a.m. on May

7 2, 2017.

8 (There being no further questions, this deposition
9 concluded.)

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1 CERTIFICATE OF REPORTER
2

3 I, ROSALIND POOLE WALTERS, a Notary Public in and for
4 the State of South Carolina, do hereby certify that the
5 foregoing 40 pages represents a true and accurate transcript
6 of the videotape deposition of L. RANDOLPH WAID, PH.D.,
7 which was taken by me on the 2nd day of May, 2017.

8 That the witness was first duly sworn to tell the
9 truth, the whole truth and nothing but the truth of his own
10 knowledge concerning this matter.

11 That I am not related to nor the employee of any of the
12 parties hereto, nor related to or employed by any attorney
13 or counsel employed by the parties hereto, nor interested in
14 the outcome of this action.

15
16
17 _____
18 Rosalind Poole Walters, CVR-M
19 Notary Public for South Carolina
20 Commission Expires: 4/29/26
21
22
23
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Certified Copy

STATE OF SOUTH CAROLINA
COURT OF COMMON PLEAS
COUNTY OF SPARTANBURG

WILLIAM MARK CASEY,

Plaintiff,

vs.

CASE NO: 2006-CP-42-1728

GREGORY J. FELDMAN, M.D., JOSEPH A.
BOSCIA, III, M.D., UPSTATE LUNG and
CRITICAL CARE SPECIALISTS, P.C., and
DEVENDRA SHANTHA, M.D.,

Defendants.

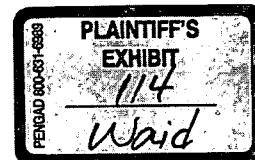
DEPOSITION OF

L. RANDOLPH WAID, Ph.D.

May 15, 2009
10:20 a.m.

Offices of L. Randolph Waid, Ph.D.
1459 Stuart Engals Blvd.
Suite 204-A
Mt. Pleasant, South Carolina

JENNIFER JESSE, Court Reporter



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THOMPSON 002542

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*ALSO MEMBER NORTH CAROLINA BAR

May 7, 2009

L. Randolph Waid, Ph.D.
The Oaks Business Center
1459 Stuart Engals Boulevard
Mount Pleasant, SC 29464

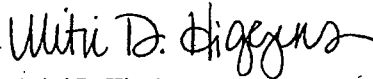
Re: William Mark Casey v. Gregory J. Feldman, MD, Joseph A. Boscia, III,
MD, Upstate Lung and Critical Care Specialists, PC, and Devendra
Shantha, MD
CA No.: 2006-CP- 42-1728
Our File No.: 26-0266

Dear Dr. Waid:

Please find enclosed a Notice of Deposition along with a Subpoena Duces Tecum in
regards to the above matter. We look forward to seeing you on May 15, 2009. If you have any
questions please do not hesitate to call.

I am

Very truly yours,



Mitzi D. Higgins
Paralegal to H. Spencer King
The Ward Law Firm

HSK/mdh

Enclosures

cc: William U. Gunn, Esq. (w/encl.)
✓ Ray E. Thompson, Jr., Esq. (w/encl.)
✓ Noel Turner, III., Esq. (w/encl.)
F. Milton Mann, Jr., Esq. (w/encl.)

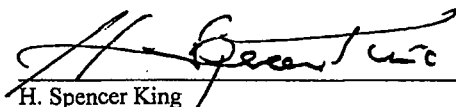
THOMPSON 001372

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF SPARTANBURG	)	FOR THE SEVENTH JUDICIAL CIRCUIT
William Mark Casey,	)	
	)	
Plaintiff,	)	
	)	C.A. No.: 2006-CP-42-1728
v.	)	
	)	
Gregory J. Feldman, MD, Joseph A.	)	
Boscia, III, MD, Upstate Lung and Critical	)	NOTICE OF DEPOSITION OF
Care Specialists, PC, and Devendra	)	L. RANDOLPH WAID, PH.D.
Shantha, MD,	)	
	)	
Defendants.	)	

PLEASE TAKE NOTICE that in accordance with Rules 30 and 32 of the South Carolina Rules of Civil Procedure, testimonies of the following named persons will be taken by deposition upon oral examination before a person authorized to administer oaths by the State of South Carolina at the office of L. Randolph Waid, Ph.D., The Oaks Business Center, 1459 Stuart Engals Boulevard, Suite 204-A, Mount Pleasant, South Carolina 29464 on the date and time listed below with respect to all matters relevant to the subject matter of this section:

<u>Date</u>	<u>Time</u>	<u>Deponent</u>
Friday, May 15, 2009	10:00 a.m.	L. Randolph Waid, Ph.D.

This deposition shall be for the purpose of discovery and for use at trial pursuant to the rules and the depositions shall be oral examinations and shall individually be taken stenographically and transcribed.


H. Spencer King
Attorney for Defendants Gregory J. Feldman, MD,
Joseph A. Boscia, III, MD, and Upstate Lung and
Critical Care Specialists, P.C.
The Ward Law Firm, P.A.
PO Box 3188
Spartanburg, SC 29304-3188

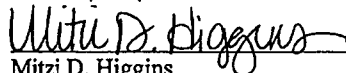
May 7th, 2009

THOMPSON 001373

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF SPARTANBURG	)	FOR THE SEVENTH JUDICIAL CIRCUIT
William Mark Casey,	)	
	)	
Plaintiff,	)	
	)	C.A. No.: 2006-CP-42-1728
v.	)	
	)	
Gregory J. Feldman, MD, Joseph A.	)	
Boscia, III, MD, Upstate Lung and Critical	)	
Care Specialists, PC, and Devendra	)	CERTIFICATE OF SERVICE
Shantha, MD,	)	
	)	
Defendants.	)	

I hereby certify that a copy of the Notice of Deposition of L. Randolph Waid, Ph.D. was served upon him this 7th day of May, 2009 by U.S. Mail, postage paid to the following address:

L. Randolph Waid, Ph.D.
The Oaks Business Center
1459 Stuart Engals Boulevard
Suite 204-A
Mount Pleasant, SC 29464


Mitzi D. Higgins
Paralegal to H. Spencer King

THOMPSON 001374

STATE OF SOUTH CAROLINA
ISSUED BY THE JUDICIAL BRANCH OF THE COMMON PLEAS COURT IN THE COUNTY OF SPARTANBURG

William Mark Casey,
Plaintiff,

v.

Gregory J. Feldman, MD,
Joseph A. Boscia, III, MD, Upstate Lung and
Critical Care Specialists, PC, and
Devendra Shantha, MD,

Defendants.

SUBPOENA DUCES TECUM

C.A. No. 2006-CP-42-1728

TO: L. Randolph Waid, Ph.D., 1459 Stuart Engals Boulevard, Suite 204-A, Mt. Pleasant, SC 29464

☐ YOU ARE COMMANDED to appear in the above named court at the place, date, and time specified below to testify in the above case.

Place of Testimony -	Courtroom:
	Date and Time:

☒ YOU ARE COMMANDED to appear at the place, date, and time specified below to testify at the taking of a deposition in the above case.

Place: 1459 Stuart Engals Boulevard Suite 204-A Mount Pleasant, SC 29464	Date and Time: 10:00 am on May 15, 2009

☒ YOU ARE COMMANDED to produce and permit inspection and copying of the following documents or objects in your possession, custody or control at the place, date and time below:

All medical records from your practice including, but not limited to, doctor's notes, nurse's notes, laboratory studies, pathology reports, pathology specimens, radiology films and/or reports, testing materials, test results or reports in your files from other healthcare providers, as well as any and all other medical records and parts of your medical file concerning treatment of Plaintiff William Mark Casey, SSN [REDACTED], DOB: [REDACTED]/1958 and complete billing records for his care as well as the information listed in ATTACHMENT A.

☐ YOU ARE COMMANDED to permit inspection of the following premises at the date and time specified below.

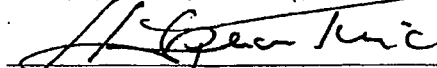
Premises	Date and Time
ANY SUBPOENAED ORGANIZATION NOT A PARTY TO THIS SUIT IS HEREBY DIRECTED PURSUANT TO RULE 30(b)(6), SOUTH CAROLINA RULES OF CIVIL PROCEDURE, TO FILE A DESIGNATION WITH THE COURT SPECIFYING ONE OR MORE OFFICERS, DIRECTORS, OR MANAGING AGENTS, OR OTHER PERSONS WHO CONSENT TO TESTIFY ON ITS BEHALF, AND SHALL SET FORTH, FOR EACH PERSON DESIGNATED, THE MATTERS ON WHICH HE WILL TESTIFY OR PRODUCE DOCUMENTS OR THINGS. THE PERSON SO DESIGNATED SHALL TESTIFY AS TO MATTERS KNOWN OR REASONABLY AVAILABLE TO THE ORGANIZATION.	

ISSUING OFFICER'S NAME, ADDRESS AND PHONE NUMBER
H. Spencer King, Esq.,
The Ward Law Firm, P.A., 233 South Pine Street
PO Box 3188, Spartanburg, SC 29304-3188 (864/582-4365)

I CERTIFY THAT THE SUBPOENA IS ISSUED IN COMPLIANCE WITH RULE 45(c)(1) AND THAT NOTICE AS REQUIRED BY RULE 45(b)(1) HAS BEEN GIVEN TO ALL PARTIES.

ISSUING OFFICER'S SIGNATURE AND TITLE (INDICATE IF ATTORNEY FOR PLAINTIFF OR DEFENDANT)

DATE: May 7, 2009



Attorney for Defendants Gregory J. Feldman, MD, Joseph A. Boscia, MD, and Upstate Lung and Critical Care Specialists, PC

SCCA FORM 254 (7/93)

(See Rule 45, South Carolina Rules of Civil Procedure, Parts (c) & (d) on Reverse)

THOMPSON 001375

ATTACHMENT "A"

1. All records regarding your treatment of Plaintiff William Mark Casey.
2. All reports regarding your treatment of Plaintiff William Mark Casey.
3. All notes, communications, memorandums including e-mails, to and from any third party related to this litigation or the parties to this litigation.
4. Copies of all questions, memoranda and documents furnished to Plaintiff's counsel related to the depositions of other witnesses.
5. All documents of any kind and nature related to this litigation.
6. If any records as described above have been destroyed, please provide documents with the dates of destruction, the name of the person who destroyed them, the basis for the destruction, and the reason for the destruction.

THOMPSON 001376

Certified Copy

STATE OF SOUTH CAROLINA
COURT OF COMMON PLEAS
COUNTY OF SPARTANBURG

WILLIAM MARK CASEY,

Plaintiff,

vs.

CASE NO. 2006-CP-42-1728

GREGORY J. FELDMAN, M.D., JOSEPH A.
BOSCIA, III, M.D., UPSTATE LUNG and
CRITICAL CARE SPECIALISTS, P.C., and
DEVENDRA SHANTHA, M.D.,

Defendants.
~~~~~

**DEPOSITION OF**

**L. RANDOLPH WAID, Ph.D.**

May 15, 2009  
10:20 a.m.

Offices of L. Randolph Waid, Ph.D.  
1459 Stuart Engals Blvd.  
Suite 204-A  
Mt. Pleasant, South Carolina

JENNIFER JESSE, Court Reporter



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**THOMPSON 002542**

STATE OF SOUTH CAROLINA

COURT OF COMMON PLEAS

COUNTY OF SPARTANBURG

WILLIAM MARK CASEY,

Plaintiff,

vs.

CASE NO. 2006-CP-42-1728

GREGORY J. FELDMAN, M.D., JOSEPH A.

BOSCIA, III, M.D., UPSTATE LUNG and

CRITICAL CARE SPECIALISTS, P.C., and

DEVENDRA SHANTHA, M.D.,

Defendants.

DEPOSITION OF: L. RANDOLPH WAID, Ph.D.

DATE: May 15, 2009

TIME: 10:20 a.m.

LOCATION: Offices of  
L. Randolph Waid, Ph.D.  
1459 Stuart Engals Blvd.  
Suite 204-A  
Mt. Pleasant, SC

TAKEN BY: Counsel for the Defendant

REPORTED BY: JENNIFER JESSE, Court Reporter



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THOMPSON 002543

1 APPEARANCES OF COUNSEL:

2 ATTORNEYS FOR THE PLAINTIFF  
3 WILLIAM MARK CASEY:

4 BURTS TURNER RHODES & THOMPSON

5 BY: NOEL TURNER, III  
6 260 North Church Street  
7 Spartanburg, SC 29306  
8 (864) 585-8166

9 mnturner@bellsouth.net

10 and

11 BURTS TURNER RHODES & THOMPSON

12 BY: RAY E. (CHUCK) THOMPSON, JR.

13 260 North Church Street  
14 Spartanburg, SC 29306  
15 (864) 585-8166

16 ret2@bellsouth.net

17 ATTORNEYS FOR THE DEFENDANTS

18 GREGORY J. FELDMAN, M.D., JOSEPH A.  
19 BOSCIA, III, M.D., UPSTATE LUNG and  
20 CRITICAL CARE SPECIALISTS, P.C.:

21 F. MILTON MANN, JR., ESQ.

22 1089 Boiling Springs Road  
23 Spartanburg, SC 29303  
24 (864) 208-0359

25 milton.mann@gmail.com

and

THE WARD LAW FIRM, P.A.

BY: H. SPENCER KING

233 S. Pine Street  
Spartanburg, SC 29302  
(864) 591-2364

sking@wardfirm.com

(appearances continued on next page)



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THOMPSON 002544

1 APPEARANCES OF COUNSEL (CONTINUED):

2 ATTORNEY FOR THE DEFENDANT  
3 DEVENDRA SHANTHA, M.D.:

4 HOLCOMBE BOMAR, P.A.

BY: WILLIAM U. GUNN

100 Dunbar Street, Suite 200

Spartanburg, SC 29306

(864) 594-5301

bgunn@holcombebomar.com

(INDEX AT REAR OF TRANSCRIPT)



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THOMPSON 002545



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STIPULATION

It is stipulated by and among Counsel that this deposition is being taken in accordance with the South Carolina Rules of Civil Procedure, Rule 30; that all objections as to Notice of this deposition are hereby waived; that all objections except as to form are reserved until the time of trial; and that the deponent does not waive reading and signing of this deposition.

\* \* \* \* \*

L. RANDOLPH WAID, Ph.D.,

being first duly sworn, testified as follows:

EXAMINATION

BY MR. MANN:

Q. Dr. Waid, good morning. My name is Milton Mann. I'm an attorney here with Spencer King. We together represent Dr. Feldman, Dr. Boscia, Upstate Lung and Critical Specialists regarding a malpractice case that has been brought upon by Mr. William Mark Casey. And I think you know something about this already, so I won't go into a lot of details.

Mr. Gunn is here on behalf of Dr. Shantha, and Mr. Thompson and Mr. Turner are here on behalf of the plaintiff, Mr. Casey. Are



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THOMPSON 002546

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1 you ready to proceed?

2 A. I am.

3 Q. And you've given depositions before?

4 A. I have.

5 Q. So I don't need to go in a lot of that  
6 kind of silly background stuff?

7 A. You don't.

8 Q. All right. Do you have a copy of your  
9 CV for us today?

10 A. I do in the other room, but sure.

11 Q. And we'll get that and look at it at  
12 some point before we're finished. Can you give me  
13 kind of a condensed version of your professional  
14 training?

15 A. Basically I got a bachelor's degree in  
16 psychology from Temple University. That was  
17 awarded in 1974, a master's degree in psychology  
18 from the University of Richmond. That was awarded  
19 in 1977.

20 I went to the University of North  
21 Texas, trained in the doctoral program of clinical  
22 psychology. I came to the Medical University of  
23 South Carolina for an internship here in '80/'81,  
24 returned to Dallas, completed my studies. And that  
25 was awarded, I believe -- Ph.D. in clinical



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THOMPSON 002547

6

1 psychology -- in 1982.

2 And from there, basically I was working  
3 in Dallas, and I returned to Charleston and joined  
4 the faculty of the Medical University of South  
5 Carolina in 1983.

6 Q. And is that the position you currently  
7 hold?

8 A. I'm still on the faculty at the Medical  
9 University of South Carolina in the Departments of  
10 Neurology and Psychiatry.

11 Q. And do you have a private practice as  
12 well?

13 A. Yes. In 1998, I stepped out of the  
14 University Medical Associates practice plan,  
15 continued my research and established my own  
16 independent private office here in Mt. Pleasant.

17 Q. Okay. And that's what has provided  
18 work, if you will, in this particular case that  
19 we're here about today?

20 A. In this case, I did see him in my  
21 private practice. Yes.

22 Q. What services were you asked to  
23 provide?

24 A. Basically it was services to conduct a  
25 neuropsychological evaluation of Mr. William Mark



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THOMPSON 002548

7

1 Casey secondary to concerns regarding a variety of  
2 operative procedures that had taken place. I  
3 understood that he had also been seen by Joseph  
4 Grace, who had done some initial intellectual  
5 testing. I was basically going to do more  
6 comprehensive assessment of his brain behavior and  
7 emotional functioning.

8 Q. And can you tell me who asked you to do  
9 this?

10 A. This would be coming from counsel, the  
11 office of Ken Anthony and Ray Thompson.

12 Q. All right. And when was that request  
13 made to you?

14 A. That request would have been made  
15 sometime in early August, I believe, is the  
16 first -- this chart's been so photocopied, but in  
17 August I -- and we established him, and within the  
18 month we are able to get the person in and initiate  
19 the evaluation.

20 Q. And the year we would be talking about  
21 would be?

22 A. That would be 2005.

23 Q. Now, I see you referring to something.  
24 Is that your report?

25 A. There is a report here and, again,



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THOMPSON 002549

8

1 obviously some -- my medical records. Yeah.

2 Q. All right. Do you mind if we mark your  
3 actual report as Exhibit No. 1, please?

4 MR. MANN: Defense Exhibit 1.

5 (DFT. EXH. 1, Dr. Waid's report of  
6 neuropsychological evaluation, was marked for  
7 identification.)

8 BY MR. MANN:

9 Q. And Dr. Waid, now that she's marked  
10 this for us, can you tell me what material you've  
11 reviewed to help you assess Mr. Casey?

12 A. Basically at the time of conducting the  
13 initial evaluation, I had extended medical records  
14 from treatment provided upon admission to  
15 Spartanburg Regional Medical Center, as well as  
16 more extended medical records from Spartanburg  
17 Regional Medical Center.

18 Those are primarily for procedures  
19 conducted in July of, I believe -- I have the date  
20 wrong, but I'll get the date better -- July of  
21 2004. I think that's a typo obviously.

22 Treatment records from Upstate Lung and  
23 Critical Care Specialists; treatment records from  
24 Lung and Chest Medical Associates; treatment  
25 records from Jeffrey Smith, M.D., of Piedmont



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THOMPSON 002550

1     Psychiatric Services; treatment records from Joseph  
2     Grace, III, Ph.D.; treatment records from Eugene  
3     Mironer, M-I-R-O-N-E-R, M.D.; educational records  
4     regarding Mr. Casey from Spartanburg County School  
5     District No. 6; and I believe that was the medical  
6     records that I had at the time of conducting the  
7     evaluation.

8             Q.     Okay. And, again, can you kind of, in  
9     layman's terms, describe what a neurological  
10    examination is, what its purpose is, and what you  
11    were trying to determine?

12            A.     A neuropsychological involves  
13    administering a battery of tests to assess  
14    different functional behaviors mediated through  
15    different functional areas of the brain. And in  
16    essence, it's kind of a hierarchical assessment  
17    where you start from the simplest abilities like  
18    can the person see and hear and utilize touch.

19                   And then you have a variety of tests  
20    that get to the functional areas of the brain such  
21    as attention, concentration, executive functioning,  
22    anterior grade memory, the ability to learn and  
23    retain and recall information, language  
24    functioning, visual-spatial skills, motor  
25    functioning, sensory-perceptual functioning, and



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**THOMPSON 002551**

10

1 then obviously an area in which many abilities of  
2 the brain come together in what we call higher  
3 reasoning, problem solving, abstract thinking  
4 skills.

5 So ultimately you give a battery of  
6 tests and delineate and try to identify if all is  
7 working well as what should be based on  
8 understanding of the person's background.

9 Or if you have some deviation from  
10 ideal functioning, that might be suggestive or  
11 consistent with some type of injury. When there's  
12 a more massive injury, it's not so much to diagnose  
13 as to really say where a person's at. When you're  
14 in milder forms of neuropsychological injury,  
15 there's a variety of those which I would consider  
16 this one too, it's to help delineate where a  
17 deficit might be and the potential causal factor of  
18 the deficits.

19 Q. And we listed some information that you  
20 had reviewed in an effort to administer these tests  
21 to Mr. Casey. What was the purpose of reviewing  
22 that information?

23 A. Well obviously, particularly in cases  
24 that involve other types of injuries which are more  
25 typically seen, you try to get the acute



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THOMPSON 002552

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1 information. It's important. If you're looking at  
2 a mechanism for injury, you have to understand the  
3 physics of the injury, the acute neurological  
4 sequelae, the radiographic studies and other  
5 acute -- acute emergent stuff that would be  
6 important in understanding whether or not there is  
7 injury, cortical injury to the -- you know, injury  
8 to the brain.

9 So in any case, you would want to look  
10 at that and understand that and also understand the  
11 course of the treatments that have been -- taken  
12 place and so forth, as well as, obviously to the  
13 extent that you can get them, the records that have  
14 to do with premorbid or preinjury functioning,  
15 educational records, when you're afforded the  
16 opportunity to do that.

17 And so obviously what we're trying to  
18 do is have an understanding of where the human  
19 being was before the hypothesized injury, what was  
20 the nature and what took place at the injury, what  
21 were the acute care. And obviously often we're  
22 measuring them sometime after this, so we want to  
23 certainly know what's happened since the injury.

24 Q. And is this a complete list of the  
25 records that you reviewed in preparation for



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THOMPSON 002553



12

1 administering a battery of tests for Mr. Casey?

2 A. Basically would represent the records  
3 that I reviewed as -- had -- had to do with the  
4 August and September evaluation and subsequent  
5 provision of a report.

6 Q. Okay. Do you also interview the person  
7 that you're going to be treating?

8 A. Yes. We definitely interview the  
9 person that we're going to be evaluating, and  
10 classically that's how we usually start the  
11 evaluation, is kind of interviewing them.

12 My format is generally to review their  
13 understanding of the incident, their own thinking  
14 about it, and then ultimately their complaints as  
15 it relates to now, spontaneously provided. You  
16 want to know where they're at, in terms of care.

17 And then I go through a structured  
18 format that basically allows me to get the data I  
19 think's relevant, such as medical history,  
20 behavioral history, psychiatric history, family  
21 history, and then a current assessment of their  
22 complaints in a structured way to make sure I'm not  
23 missing anything.

24 Obviously sometimes people don't  
25 spontaneously report what you might find in that



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THOMPSON 002554

13

1 structured format. And then you also want to get  
2 some sense of psychoeducational, vocational  
3 background.

4 And so that would all take place  
5 literally as the starting point for how we proceed.

6 Q. As we sit here today, do you have any  
7 recollections of having those conversations or any  
8 of these with Mr. Casey?

9 A. I have -- well, I have notes from that  
10 conversation. I don't want to go as far as to say  
11 I can remember the day and could I pick him out of  
12 a grocery store right now. Some people do take a  
13 picture of their clients for reasons of sometimes  
14 these things don't happen until later on. But I  
15 have -- I do have an awareness of doing it, and I  
16 obviously have notes from the interview process.

17 Q. Okay. And do you have notes beyond  
18 what is in your report?

19 A. I assume there are some notes beyond my  
20 report. Generally I -- my report would certainly  
21 incorporate those areas that I'm talking about and  
22 summarize, at least, what I learned this time  
23 through.

24 Q. How did you find Mr. Casey's  
25 participation in the process?



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THOMPSON 002555

14

1           A.    I found Mr. Casey's participation in  
2   the process to be fine. Obviously we went ahead  
3   and did this over two evaluative dates because I  
4   did believe that there was some symptoms and  
5   fatigue that probably we needed to account for and  
6   not overstretch it into a single day.

7               Sometimes we're not afforded such when  
8   people are referred for IMEs by insurance  
9   companies. I believe eight hours of testing can be  
10  aversive for most human beings.

11              And so we found him to present himself  
12  well. We didn't see a lot of disruptive behavior  
13  as it related to his participation in the  
14  examination or his response to my inquiries. And I  
15  think his affect was mildly depressed, but I didn't  
16  think it highly compromised him.

17              And what I mean there is that  
18  depression and pain certainly can interfere with  
19  people as it relates to day to day. But often in  
20  neuropsychological testing, we can determine how  
21  big a player it is because depression manifests  
22  really in poor effort, I don't know answers and  
23  these kinds of depressive behaviors.

24              Often some people are so depressed that  
25  we don't think it's possible to get a valid



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**THOMPSON 002556**

15

1 assessment or sample of their brain. That wasn't  
2 the case. But I'm certainly not arguing that  
3 depression and anxiety aren't part of the clinical  
4 picture here.

5 And we found his efforts to be good,  
6 and we believed the -- our observations, along with  
7 the test data, was a good fit and a good -- it made  
8 sense, in terms of what kind of problems he was  
9 having.

10 Q. So this testing occurred on two dates,  
11 correct?

12 A. That is correct.

13 Q. Do you know how many hours were spent  
14 on each day?

15 A. Basically the bulk would have been the  
16 first day. That was a fairly extensive interview.  
17 We probably split the testing in half. You're  
18 really looking at about nine or ten hours  
19 because -- we don't charge, but it usually takes  
20 another two or three hours for them to complete  
21 psychological tests, not really my time, but I also  
22 don't let them take it home.

23 Q. Right.

24 A. And so there is some just sitting here  
25 filling out forms kind of stuff. Otherwise, it



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THOMPSON 002557

16

1 does involve engagement with either me or one of my  
2 master's level psychologists that administer a good  
3 variety of the tests.

4 Q. And is that eight to nine hours for  
5 both days?

6 A. Yeah. I would say a culmination of  
7 easily ten hours of effort across two days. I  
8 would tell you the first day was probably five or  
9 six and the second, three or four. I could look  
10 back on the computer and do that, but that would be  
11 it.

12 Q. Okay. So that is between the two days?

13 A. That is between the two days.

14 Q. And did you have any observations of  
15 him being unable to sit?

16 A. No. I think -- we did not have any  
17 observations of him sitting or being excessively  
18 fidgety or not being able to understand  
19 instructions or any real behavioral abnormalities  
20 that would draw into question the reliability of  
21 his -- to meet the demands of testing.

22 Q. And if you would have noticed those  
23 things, you would have noted it within your report?

24 A. We would have noted it, and also we --  
25 or my psychometricians would have noted it, and in



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THOMPSON 002558

17

1 different scenarios we -- I'm brought back in. And  
2 that means anything that pops up as poor effort.  
3 Unlike other places, we tend to confront poor  
4 effort pretty quickly instead of wasting eight to  
5 nine hours of testing.

6 Q. Now, describe to me -- and we'll --  
7 I'll come back to that. So you had your  
8 conversations with Casey, interview with him,  
9 administered a battery of tests. You reviewed the  
10 records that we talked about before. Did you have  
11 any other information that played a role in you  
12 coming up with your report?

13 A. Other than what I've indicated so far,  
14 no. You know, obviously there's been some  
15 elaboration of things since that time through other  
16 evaluations for depositions; but this was, in my  
17 opinion, a report of a neuropsychological  
18 evaluation of this man at this time.

19 Q. Did you have any telephone  
20 conversations with any of his treating physicians?

21 A. I did not have any telephone  
22 conversations. I relied on -- at this juncture, I  
23 relied on the medical records that were available.  
24 There had not been any previous neuropsychological  
25 testing. And Dr. Grace, who did conduct some



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**THOMPSON 002559**

18

1 intellectual testing, had very thorough records and  
2 treatment records, so I was comfortable with  
3 proceeding that way.

4 Q. Now, let me ask you a question: Is it  
5 important for the subject to give you accurate  
6 information about their history?

7 A. Yeah. I think basically you want  
8 credible information. At times other stuff pops  
9 up, to the extent that it may spoil any process,  
10 has to be determined on that new information.  
11 There are times when people don't report things out  
12 of embarrassment. There are times that people --  
13 who don't report things because they just -- it  
14 doesn't come up. But, yeah, I prefer to be given  
15 accurate information, and the more accurate, the  
16 more useful it is.

17 Q. What about did he relate if he was on  
18 any medications when he came for his testing?

19 A. The -- we did review, quite frankly,  
20 not only the medications he was on, but a lot of  
21 things that had been tried, which were also  
22 consistent with the record. I had some interest in  
23 the use of psychostimulant medications by  
24 Dr. Smith; albeit, I have since reviewed his  
25 language regarding that. But I think that's a good



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THOMPSON 002560

19

1 choice with these kind of deficits to assist  
2 people, but he wasn't using that. That had been  
3 discontinued by September 10th. Otherwise, I  
4 understood him to be on Lipitor; Tricor; Mobic;  
5 Hydrocodone; Tramadol -- it's spelled wrong, but  
6 we'll correct it later -- Cymbalta; and Ambien, 10  
7 milligrams.

8 Q. And the drug that you were indicating  
9 that had been discontinued was what?

10 A. Adderall XR, 20 milligrams, twice a  
11 day, generally to assist with attention and focus.

12 Q. Okay. And do you know who told you  
13 that the Adderall had been discontinued?

14 A. It's my understanding that  
15 Mr. [sic] Smith would have told me as of September  
16 10th that the Adderall had been discontinued. That  
17 was my understanding, at least at that point.  
18 Whether or not he returned to it or anything like  
19 that, I wouldn't have known because that was what I  
20 understood as of September 10th.

21 Q. Would you turn to page 3 of your report  
22 for me?

23 A. Uh-huh.

24 Q. And about three or -- oh, well, let's  
25 make this easy. The paragraph right above:



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THOMPSON 002561



1 Medical History --

2 A. Yes, sir.

3 Q. -- can you read that for me? Is that  
4 what you were looking at a second ago?

5 A. It was.

6 Q. All right. And that says that  
7 Mr. Casey reported his current medicines?

8 A. That's what he was reporting that he  
9 was currently using. Yes.

10 Q. Okay. Do you know whether or not he  
11 was on Cymbalta?

12 A. No. I can only know at that point what  
13 they're reporting to me or what I glean from the  
14 interview. At times I get records; but often my  
15 medical records, in most cases, are at least two or  
16 three months, if not more, from when the doctors  
17 might have changed it. So I try to get a report.  
18 I was aware of some of the things that had been  
19 tried and used from the records that were  
20 available. But that's what I understood for him to  
21 be on at that time.

22 Q. Okay. And if there were variations in  
23 these medicines, could that have an impact on the  
24 work that you were trying to do?

25 A. To the extent that a medication,



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THOMPSON 002562

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1 including pain medications, end up compromising the  
2 person, often observable, yes. But, again, the  
3 issue here would be: If I start you on Xanax  
4 today, I'm more likely to think it's going to  
5 interfere than when you've been on it for four  
6 months because you've really basically come to  
7 tolerance and accepted it. So the interference in  
8 cognitive capacity is there.

9 That would be true for hypertensive  
10 medications, pain medications, opiates. You know,  
11 antidepressant, once you're on it, it's not very  
12 interfering from a cognitive capacity. One would  
13 say if it improves your depression, it'd probably  
14 allow your cognitive capacity.

15 So, again, certain medicines have more  
16 possibility of doing that, but you generally can  
17 observe it because sedation is generally the major  
18 problem you're concerned with.

19 Q. And we'll get into this for a little  
20 while. But let me -- let's try to keep my focus --  
21 or our focus, if we will, because I think this kind  
22 of involves the bulk of my questions between the  
23 Cymbalta and the Adderall.

24 Now, you had said starting something  
25 like Cymbalta or being on it for a period of time



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THOMPSON 002563

22

1 you would find it to have less effect?

2 A. Yeah. I think all -- any time you  
3 start a new medication, there's the potential for  
4 it to have a disruptive side effect, even on  
5 cognition.

6 So when I have somebody who's been on  
7 Cymbalta for two or three months or something or  
8 even shorter than that, I'm not sure it's going to  
9 cause a lot of interference cognitively.

10 Q. In your understanding of Cymbalta,  
11 should it be abruptly stopped?

12 A. It matters what dosage you're at. I  
13 generally like to titrate people almost always.  
14 But it's not like Effexor where that's an absolute  
15 no-no. Cymbalta at 60 milligrams probably can be  
16 abruptly stopped without a significant withdrawal  
17 effect.

18 Q. Okay. But now if it was giving a  
19 beneficial effect and then stopped, could that  
20 interfere with your test --

21 A. To the extent --

22 Q. -- processes?

23 A. -- that the depression returned or  
24 the -- with Cymbalta actually, even if there's more  
25 pain, I would say the depression and pain would be



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THOMPSON 002564

23

1 the players, à la, if the Cymbalta was working to  
2 suppress them or give relief.

3 Q. What was your concern about Adderall?

4 A. I was just interested in it as a good  
5 choice. Any time people are having what we call  
6 deficits that might be affecting their attention  
7 and executive functioning, the mechanism there is  
8 twofold.

9 One is in mild head injury, mild  
10 traumatic brain injury. Often it's only that area  
11 that really is causing what people claim as  
12 forgetfulness, but it's a processing deficit. When  
13 you have mechanisms of air emboli or hypoxia, it's  
14 the same thing. The subcortical fibers project to  
15 the attentional executive frontal area, and so it's  
16 a good thing to try and to help with attention and  
17 focus and executive functioning.

18 Many of my mild traumatic brain  
19 injuries go back to school, and they have to use it  
20 because they have an acquired attention problem.

21 Q. And what exactly does that role do?  
22 How does it affect a person?

23 A. It is a psychostimulant. It should  
24 enhance your ability to focus and concentrate, so  
25 it cognitively enhances. It will speed up the



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THOMPSON 002565

24

1 system a little bit. If you have ADD, it  
2 paradoxically will not. But most of us will  
3 feel -- will speed up, more awake. It can give you  
4 a little more energy and fight off fatigue and  
5 lethargy. So it is a medication that can assist  
6 during its clinical course.

7 I will suggest that when you come off  
8 of Adderall and you have a drag effect, you might  
9 feel a little bit worse. So it's a medicine that  
10 has to get in and out because you cannot sleep if  
11 it stayed in there all of the time.

12 Q. Would you expect there to be some  
13 interplay between Cymbalta and Adderall?

14 A. They're comfortably used together. We  
15 have them in chronic pain patients quite a bit. I  
16 wouldn't anticipate any interplay in a negative  
17 sort of way. I mean, I would wonder, you know,  
18 what are you targeting with one versus the other.

19 On the other hand, when we have people  
20 who are -- have a huge draggy effect from the  
21 Adderall or it tends to render them real depressed  
22 when they come off of it, it's not unusual for us  
23 to put them on an antidepressant to control that up  
24 and down draggy feeling from the medicine and then  
25 reintroduce the psychostimulant. So they're used



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THOMPSON 002566

25

1 together.

2 I wouldn't tell you Cymbalta  
3 necessarily would be my choice because I think we  
4 use Cymbalta more often when we think we have a  
5 depressed person who also has pain.

6 Q. And is it your understanding that his  
7 psychiatrist, Jeffrey Smith, was providing him with  
8 these two medications?

9 A. It was my understanding at that time.  
10 Yes.

11 Q. Okay. We'll come back to the actual  
12 testing and stuff --

13 A. Sure.

14 Q. -- but you seemed to indicate that you  
15 received additional information postreport; is that  
16 correct?

17 A. Yes.

18 Q. What have you been asked to review and  
19 consider?

20 A. Well, basically before being asked to  
21 review and consider, I -- my records were requested  
22 to send up to Dr. Jay -- I think his name is Milton  
23 Jay -- and also as a part of that, I got back a  
24 report from Dr. Jay and Dr. Mercer, kind of a  
25 courtesy after they did their medical review. And



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THOMPSON 002567

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1 then more recently, I received numerous depositions  
2 and also a report of an MRI study of the brain. I  
3 believe that's the extent of the new information I  
4 got.

5 Q. Can you give me a list of the  
6 depositions, please?

7 A. Sure. Brian Mercer; Jeffrey Smith;  
8 Milton Jay; Francisco Gonda, G-O-N-D-A; Charles M.  
9 Fogarty, F-O-G-A-R-T-Y; Michael Jantz, J-A-N-T-Z;  
10 Joseph Glover Grace, III. I believe that's it.

11 Q. And now the big question, did you read  
12 all of those?

13 A. Not all of them from word to word. I  
14 concentrated more on relevant issues of the Smith  
15 deposition, the Jay deposition, and the -- I  
16 certainly read some of the other ones but -- and  
17 the Brian Mercer deposition.

18 You know, I'm not an expert on the  
19 procedures and the aspects of malpractice or what  
20 should have happened and not happened. While I've  
21 looked at it, I didn't find myself encoding that as  
22 relevant because I have no opinions about that.

23 So I found those three to be more  
24 relevant as they might relate to my opinions.

25 Q. And that's a good point you're making.



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THOMPSON 002568

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1 What are the limitations of your opinions that  
2 you're prepared to offer today?

3 A. Basically I'm here from a point of view  
4 of conducting a neuropsychological evaluation,  
5 coming to understand some deficits that were  
6 present, the pattern of those deficits and their  
7 consistency with the injuries and/or other  
8 interfering effects, provision of some diagnoses  
9 based on the DSM 4.

10 And essentially those would be my  
11 opinions and their temporal relationship obviously  
12 to the operative procedures and knowing well --  
13 having done many cases of operative procedures or  
14 hypoxic injury or respiratory failure or even toxic  
15 injuries, which would be in this ballpark, the  
16 mechanism being there -- that I am not an expert on  
17 that mechanism, whether it happened and essentially  
18 the medical aspects of that mechanism. I'm not  
19 going to have -- or whether standard of care was  
20 followed. It's just not -- I have no opinions on  
21 those and nor am I an expert on that.

22 Q. Can you tell me before we get a little  
23 bit further into this -- but can you tell me the  
24 difference between a neuropsychologist and a  
25 neurologist?



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THOMPSON 002569



1           A. Well, I can make the difference pretty  
2     easy. I would put it into a trio of practice. I  
3     think the neurosurgeon is essentially a man -- a  
4     physician, medical physician, and if -- when the  
5     patient comes in -- and I'll make the analogy to a  
6     car. The neurosurgeon opens up the hood of the car  
7     and looks at the engine, which would be the brain  
8     or the spine, and essentially sees if there's any  
9     surgical intervention that can be offered that  
10    needs to provide repair.

11           The neurologist often follows up after  
12    the neurosurgeon due to the disruptive neurological  
13    symptoms. He is also a medical doctor. He opens  
14    up the hood of the engine and essentially can  
15    measure it with like EEG or take a scan or pour in  
16    some juices, medication, to try to improve or  
17    affect or get symptomatic relief like from a  
18    headache.

19           The neuropsychologist is a trained  
20    clinical psychologist. Essentially our -- we deal  
21    with their behavior. We get in the driver's seat  
22    next to the driver and essentially see how they are  
23    doing in life, how they are adjusting, particularly  
24    to any deficits that might persist. And, quite  
25    frankly, part of our work -- and I do a lot of



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THOMPSON 002570

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1     this -- is to help people have an awareness for  
2     those deficits to develop more effective  
3     compensatory strategies and to move psychologically  
4     to accepting the injury or the deficits they'll  
5     have to live with.

6             And I point that out because part of  
7     what I'm going to say today too is depression's  
8     often part of injury process, particularly early  
9     on. It is in chronic pain. And people ultimately  
10    sometimes get better with depression further down  
11    the road when they're able to realize this is the  
12    new me and, yeah, these deficits are going to  
13    persist. So my point would be then it should --  
14    helping them adjust and not be depressed.

15            So I would see the neuropsychologist to  
16    be in at what clinical psychology is, the  
17    behavioral level. And we deal with the impairments  
18    and deficits and problems as they relate to the  
19    neuropathology or the adjustment to the  
20    neuropsychological changes.

21            Q.    And to compare that to a psychiatrist?

22            A.    A psychiatrist is medically trained,  
23    involves work in mental illness, as ours does.  
24    Often psychiatrists are much more -- well, many,  
25    many psychiatrists, as the way the practice goes,



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THOMPSON 002571

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1 primarily seem to be involved in providing the  
2 pharmacological intervention.

3 And many, many psychiatrists don't  
4 spend that much time with their people and don't  
5 get involved with the behavioral, cognitive  
6 strategies that change them, which would be more  
7 therapy. I say that because there actually are  
8 some psychiatrists who do therapy, but most don't.

9 Q. Looking back at your report, did it  
10 report -- prior to the June 3rd, '04 incident, did  
11 it report episodes of depression and anxiety?

12 A. Yes. My understanding is that pain,  
13 depression, and anxiety were a part of the  
14 background for this man. And he did not say  
15 lifelong problems. I got more of a sense that a  
16 lot of the depression and pain was associated with  
17 the back pain and many of his medications prior to  
18 that.

19 But obviously he had been seeing  
20 Dr. Smith for a while, and he owned that. So I  
21 certainly had a recent past before this of being  
22 involved in intervention for depression, anxiety,  
23 and pain, even though he didn't formally identify  
24 that. He kind of named the psychiatrist, so I  
25 think he sees that as related to those issues. But



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THOMPSON 002572

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1 he definitely got treatment for those.

2 Q. Now, were you aware that the incident  
3 that's being complained of, this potentially being  
4 a medical malpractice event of June 3rd, 2004,  
5 Mr. Casey had not seen Mr. [sic] Smith until after  
6 that event?

7 A. I think, yeah, he hadn't seen  
8 Mr. Smith until after that and -- but I was -- I  
9 was aware from talking with him some that there was  
10 some depression, anxiety issues. And I thought  
11 they were chronic pain related, is really what I --  
12 the context of what I got. He did own seeing  
13 Dr. Smith now, so that was my knowledge at that  
14 point.

15 Q. Let's talk about what you gleaned from  
16 these depositions that you reviewed. What did you  
17 glean from Dr. Mercer's deposition?

18 A. Dr. Mercer's deposition as well as  
19 Dr. Jay's, basically they acknowledged cognitive  
20 difficulties. They do emphasize the pain and  
21 depression, anxiety background. They essentially  
22 identify their belief that the neuropsychological  
23 testing and other factors do not provide compelling  
24 evidence of a permanent neurological injury or  
25 deficit.



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THOMPSON 002573

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1 Q. Brain injury?

2 A. Yes, that's -- would be fair to say.

3 Yeah.

4 Q. Okay. And you're aware that there's  
5 been a retained neurologist also that has a very  
6 similar opinion as well?

7 A. I believe so, but I'm not sure what  
8 name.

9 Q. Kent Kistler.

10 A. Kent Kistler. No. I wouldn't tell you  
11 I was aware of that.

12 Q. Okay. Did you review Jeffrey Smith's  
13 deposition?

14 A. Yes.

15 Q. And what did you take from that?

16 A. Basically, you know, I don't want to be  
17 critiquing about it, but --

18 Q. Sure.

19 A. -- the bottom line is, I don't know, he  
20 goes back and forth. And I thought he was -- as  
21 much as he thinks my data is equivocal or not  
22 equivocal or whatever he's saying, he misconstrues  
23 cognitive disorder NOS as a diagnosis.

24 Q. Okay.

25 A. He basically seems to be fairly strong



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THOMPSON 002574

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1 on that there isn't a neurologically-mediated  
2 cognitive impairment but kind of unglues that a  
3 little bit later on because he certainly did  
4 acknowledge that these types of events can cause  
5 subcortical injury or a form of hypoxia or a form  
6 of an air emboli. So I saw him going back and  
7 forth on that but seemingly more stronger on that.

8 I disagreed with quite a bit of his  
9 comments as they related to neuropsychological  
10 testing and basically felt that his real knowledge  
11 of Mr. Casey was not particularly good.

12 Q. What about did you look at his  
13 treatment contemporaneous with your testing?

14 A. Basically I was aware of some of that  
15 treatment even when I saw him for the evaluation,  
16 in terms of that. And so I had some sense of  
17 Jeffrey Smith's treatment directed toward  
18 depression, sleep disturbance, anxiety,  
19 restlessness, irritability, low frustration and  
20 tolerance and poor stress tolerance and use of  
21 antidepressants and other medications.

22 Q. Let me ask you to get your copy of his  
23 deposition, and I'd like to direct your attention  
24 to a couple of things, if I may.

25 A. Sure.



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THOMPSON 002575

1 Q. Let me ask you to review pages 22, 23,  
2 24, and 25; and then we will talk about them a  
3 little bit. I don't need you to read all of that  
4 in the record.

5 A. You said through what? 20 what?

6 Q. Let's go through 25.

7 A. Okay.

8 Q. All right. Now, what appeared to be  
9 going on with his medical treatment with Dr. Smith  
10 during this time period, and this is  
11 contemporaneous with the time period of your  
12 testing; is that not correct?

13 A. Well, it's correct by one date at  
14 least, the September, so it does seem like  
15 something was going on in early September. So that  
16 would be August 30th, September 10th, 2005.

17 And there was some issues about  
18 Cymbalta and Adderall and discontinuing the  
19 Adderall and continuing with the Cymbalta, but then  
20 he discontinued the Cymbalta and, by the way, tried  
21 Strattera. But the fact that he didn't respond to  
22 Strattera or got sick on it, is not atypical. And  
23 then he discontinued the Cymbalta because he didn't  
24 think it was working.

25 And reportedly he was more depressed



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THOMPSON 002576

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1 and anxious. And he -- when he returned, he had  
2 not started any Effexor XR. As indicated to him,  
3 he was only taking the Adderall.

4 Q. Okay. And he was -- also discussed  
5 about non -- not being compliant --

6 A. Yeah.

7 Q. -- with his treatment plan?

8 A. Right, and making decisions to stop  
9 something based on his thinking about it, that is  
10 correct.

11 Q. And does this cause you any concern as  
12 it relates to your testing?

13 A. No, not really. Actually if he was on  
14 Adderall, which I don't think he was on Adderall as  
15 of the September 10th date because I asked again,  
16 it would improve his cognitive performance. If he  
17 was more depressed and anxious again, our  
18 observation of that was that we didn't see it as  
19 interfering to the extent of what we saw in the  
20 testing.

21 Don't get me wrong. I think people  
22 should comply with their medicines and ultimately  
23 not make decisions independent because sometimes  
24 that can be dangerous. But, again, behaviorally,  
25 we weren't concerned. We actually asked about the



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THOMPSON 002577



1 Adderall because of its potential to facilitate his  
2 performance.

3 Q. Are you aware of any discussions  
4 regarding Mr. Casey potentially having a drug abuse  
5 problem?

6 A. Yeah. I'm aware of some aspects of  
7 that with opiate pain medicines and a potential for  
8 him to have excessively used those, in terms of  
9 pain, and even the recommendation by Mironer to,  
10 you know, stay away from those because of the  
11 potential for abuse.

12 Q. Did you have Dr. Mironer's deposition  
13 provided to you?

14 A. I thought so.

15 Q. You did not list it, so I --

16 A. It's not in this current pile of stuff.  
17 This is -- the possibility of having set it to the  
18 side, but it was not one I focused on very much.  
19 And I do not see it here. Let me see.

20 MR. THOMPSON: Just for the record, I  
21 don't think --

22 MR. TURNER: And the reason is --

23 MR. THOMPSON: -- received it, I don't  
24 know, maybe Wednesday of this past week, Thursday,  
25 something like that. And I don't think he has



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THOMPSON 002578

1 that.

2 THE WITNESS: Yeah. I wasn't aware of  
3 reading it.

4 MR. TURNER: The reason I don't --

5 MR. THOMPSON: It hadn't been provided  
6 yet.

7 MR. MANN: All right.

8 MR. TURNER: The reason I don't  
9 think -- you know, it was continued --

10 MR. MANN: Yeah.

11 MR. TURNER: -- so we didn't send the  
12 first --

13 MR. MANN: And --

14 MR. TURNER: I'm almost certain he does  
15 not have it.

16 MR. MANN: And I'm not suggesting that  
17 he should or shouldn't, but if he had it, I wanted  
18 to make some references to it.

19 BY MR. MANN:

20 Q. Do you know what Dr. Mironer does for a  
21 living or his area of expertise?

22 A. I think he is a pain management  
23 specialist.

24 Q. He is a board certified pain management  
25 specialist. He's also a board certified



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**THOMPSON 002579**

1     anesthesiologist.

2             A.     Right.

3             Q.     He does not practice anesthesia.

4             A.     Right.

5             Q.     We had his deposition, and he basically  
6     stated that, in his opinion, to a reasonable degree  
7     of medical certainty, Mr. Casey had a substance  
8     abuse problem. Would that cause you concern as it  
9     relates to your testing?

10            A.     It would cause concern. Opiates, I  
11     think, can compromise cognitive impairment if  
12     you're abusively using them. And, again, they --  
13     the impact that it might have is countered even by  
14     the pain. I don't need to tell you pain's a  
15     player. So, you know, if you're getting relief  
16     from pain, you might get improved cognitive  
17     capacity. It's actually from the opiates.

18            If you're looking at excessive usage  
19     where it's sedating you and making you toxic -- but  
20     this was not a toxic man from pain medicines on  
21     that day or if he was on a high dosage or that.

22            So, again, it has to do with the toxic  
23     effect of it. Do I think people who excessively  
24     use it over time and you kind of like get them off  
25     of it can appreciate some cognitive clearing when



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THOMPSON 002580

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1 it's abusive, yes. I wouldn't -- I wouldn't  
2 dispute that. In the testing situation, we'll  
3 often see it because it is impairing in a toxic  
4 sort of way. So, again, it would have to do with  
5 the dosage and tolerance levels and the interchange  
6 with that.

7 In the long run, since we do a lot of  
8 chronic pain, it is our goal to not have people on  
9 opiates long term because most of us believe it  
10 probably doesn't let your brain age very well.

11 Q. In approaching your assessment of  
12 Mr. Casey, were you provided with Dr. Gonda's  
13 records? You didn't list them.

14 A. Doctor who?

15 Q. Gonda.

16 A. No. I don't believe I had Dr. Gonda's  
17 records, if he's -- unless they were talked about  
18 within the records, I'd list it. I generally list  
19 them that way. Sometimes other records will show  
20 up, but I'm not aware that I did get his  
21 deposition, I guess, or look it over.

22 Q. And, again, is this an area that you  
23 deal with, substance abuse?

24 A. Yes. I have about 18 years of research  
25 in research projects in substance abuse, mainly



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THOMPSON 002581

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1 alcohol, but other agents are well-known to us.

2 Q. Okay. And Mr. Casey did not tell you  
3 or indicate that he had a substance abuse problem?

4 A. He did not indicate a substance abuse  
5 problem, as it related to alcohol. I was aware he  
6 used some pain pills, but I -- he didn't call  
7 himself an abuser of pain medication.

8 MR. TURNER: And I just want to voice  
9 an objection to form as to assuming facts that we  
10 would contend are not in evidence that it's  
11 conclusive that he has a substance abuse problem.

12 MR. MANN: And to go back to my  
13 question, no, I said did Mr. Casey convey that to  
14 you. That's a straight up question. Okay.  
15 Dr. Waid answered no.

16 BY MR. MANN:

17 Q. Would you be able -- now let me back  
18 up. If he did have a substance abuse problem, is  
19 that something that would have changed your  
20 approach as to how you administered your testing?

21 A. No. It wouldn't change the approach.  
22 Certainly causal factors come into play, but I'm  
23 not sure it would change even my opinions because I  
24 saw pain -- or referred to it as somatic -- as one  
25 of the causal factors.



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THOMPSON 002582

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1           What I don't do like everybody else  
2       does is I think there are multiple things on board  
3       that are playing a part in the compromises he's  
4       experiencing. So pain slash use of pain  
5       medications would be one of them.

6           Q.    As far as drug abuse goes, are you  
7       familiar with indications of an individual patient  
8       that may be abusing drugs?

9           A.    When you say indications, yeah.

10          Q.    Sure.

11          A.    I think when I talk about the toxic  
12       effect, the clouding of their cognitive capacities,  
13       the excessive sedation, even drug-seeking  
14       behaviors, yes. And so, you know, I would think  
15       fairly, you know, sophisticated in that way because  
16       I do a lot of work in chronic pain here in town, as  
17       well as my substance abuse research history.

18          Q.    Let me ask this: This is Bates stamped  
19       543. It's from Dr. Gonda's records.

20          MR. MANN: Let me ask you to mark that  
21       as Exhibit 2.

22                (DFT. EXH. 2, document Bates stamped  
23       000543, was marked for identification.)

24       BY MR. MANN:

25          Q.    Dr. Waid, let me ask you to look at



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THOMPSON 002583

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1 this, and it is my understanding that that is an  
2 office note from Dr. Gonda's office. Could you  
3 give us a date of that office visit?

4 A. 12/15/2003.

5 Q. So that's before the incident that  
6 brings us together, correct?

7 A. That is correct.

8 Q. I highlighted an area that I'd like to  
9 direct your attention to.

10 A. Sure.

11 Q. Could you review that for me and look  
12 at it?

13 A. Sure.

14 Q. It seems to indicate that he ran out of  
15 his medicines early?

16 A. That is correct.

17 Q. Okay. Would that cause you concern in  
18 a patient?

19 A. Basically when you're treating pain  
20 patients, you want them to sit with the medication.  
21 Lortab, often one of those that does happen that  
22 way because the patient ends up taking a few more  
23 when he has high, intense pain and he runs out.  
24 You generally want to get on top of that behavior.

25 Q. Okay.



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THOMPSON 002584

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1 MR. MANN: Let me ask this to be marked  
2 as Defendant's Exhibit No. 3.

3 (DFT. EXH. 3, document Bates stamped  
4 000541, was marked for identification.)

5 MR. MANN: This is 541, gentlemen, also  
6 again from Dr. Gonda's.

7 BY MR. MANN:

8 Q. Let me ask you to review this for me,  
9 Dr. Waid. And, again, that's a note from  
10 Dr. Waid's [sic], and let me ask you --

11 MR. GUNN: Dr. Gonda or --

12 MR. MANN: Oh, excuse me, Dr. Gonda. I  
13 apologize. Thank you, Mr. Gunn.

14 BY MR. MANN:

15 Q. Can you read at least that whole first  
16 paragraph of the office visit for me?

17 A. Sure. Forty-four-year-old white male  
18 is in for follow up on his --

19 Q. I apologize. You can read it to  
20 yourself.

21 A. Oh, okay.

22 Q. I don't need you to read it into the  
23 record. I'm sorry.

24 All right. And can you give us the  
25 date of that office visit?



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THOMPSON 002585



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1 A. August 27th, 2003.

2 Q. Again, before our incident at issue?

3 A. Yes, sir.

4 Q. What's going on with that office visit,  
5 please?

6 A. That office visit is a man who's  
7 continuing in pain and what I would call as  
8 co-morbid depression. Ultimately he is, again, not  
9 getting full relief on the prescribed medication.  
10 He may be getting some Percocet from friends. And  
11 Dr. Gorda is certainly discussing with him the  
12 potential that adding an antidepressant to the  
13 regimen might be of utility, both with depression  
14 but also potentially with the pain.

15 Q. Okay. So we've got depression in '03?

16 A. Sure.

17 Q. We've got pain, of course, in '03?

18 A. Yes.

19 Q. And those seemed to be affecting his  
20 quality of life?

21 A. Yes.

22 Q. We have buying prescription narcotics  
23 from unapproved sources?

24 A. By report, yes.

25 Q. Okay. Would that also be a concern



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THOMPSON 002586

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1 regarding a drug abuse aspect if you were treating  
2 him, Dr. Waid?

3 A. If I was treating him, I would be doing  
4 the same thing, which is to educate him regarding  
5 the necessity to find a regimen that's going to  
6 work with him. That doesn't mean excessive  
7 opiates.

8 I think in today's world, even in 2003,  
9 we have a bunch of neuropathic pain. One would  
10 wonder why he's not already on those. Cymbalta has  
11 a neuropathic pain component, and that's why it's  
12 used so much in our chronic pain patients.  
13 Neurontin was available then. One would wonder why  
14 there's not already a shift to that. Lyrica, the  
15 newest one on the market. And so ultimately the  
16 strategy in this person should be going toward  
17 those neuropathic pain pills because obviously his  
18 pain is not being managed.

19 And pain -- chronic pain patients do  
20 develop depression. As a matter of fact, about  
21 40, 50 percent of them can even develop a major  
22 depression, particularly during the stages in which  
23 they're being treated and the surgery or the  
24 hopeful pain freeness doesn't get achieved.

25 So he's going through a course of



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THOMPSON 002587

1 events with his pain, as well as some stressors in  
2 his family.

3 Q. Now, you read Dr. Mironer's report?

4 A. Yes, I believe.

5 Q. Okay. And he basically stated he was  
6 not a proper candidate for opiates due to a lack of  
7 the specific diagnosis as to what's causing his  
8 pain?

9 A. Yeah. I'll accept that he said that.

10 Q. Okay. Now, turning, you know,  
11 basically to the issue that we were talking about a  
12 little. But so far we've seen running out of  
13 medications early; is that correct?

14 A. Yes.

15 Q. We've seen obtaining medications from  
16 friends?

17 A. By report, definitely.

18 Q. Would those both be consistent with  
19 someone with a drug abuse problem?

20 A. They are consistent with somebody who's  
21 experiencing pain and basically turning to sources  
22 outside of himself to get pain medicine, which  
23 certainly can be an abusive use of their pain.

24 I said that because ultimately I have  
25 people without chronic pain who are buying



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**THOMPSON 002588**

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1 OxyContin off the streets. That's an opiate  
2 abuser. A chronic pain patient is looking for  
3 relief. And sometimes this type of behavior has to  
4 be ruled in, and you have to get to it. You have  
5 to understand that what you're doing as a  
6 physician's not working.

7 I get referred many of these patients  
8 for psychological therapy treatment techniques to  
9 help them cope with pain. So I don't -- I think  
10 when you used the words substance abuser without a  
11 patient who's come in with chronic pain that I have  
12 some problems characterizing those the same.

13 But clearly excessive use of pain  
14 medications in response to interfering pain needs  
15 to be dealt with early on in the management of a  
16 pain patient. So I would see him right now as  
17 needing that type of intervention, including  
18 neuropathic pain pills, including referral to a  
19 psychologist who's going to see him more often and  
20 get on top of the pain usage.

21 And one of the problems with doctors or  
22 pain specialists is they want to see him once every  
23 month or two months versus you get psychology  
24 involved and you have more of a multi-treatment.  
25 So this behavior is not unusual in chronic pain



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**THOMPSON 002589**

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1 patients, and you've got to get it under control.  
2 But I don't equate it to somebody on the streets  
3 who is just looking to get OxyContin to have fun.

4 Q. But now you would agree with me  
5 obtaining prescription narcotics from any source  
6 but a physician and a pharmacy is an illegal  
7 activity?

8 A. Definitely. I would agree with that.

9 Q. And if an illegal activity -- or excuse  
10 me. It's hard for me to understand how illegal  
11 activity involving drugs is not an abuse of drugs.

12 A. I think it's an abusive usage in  
13 response to treating his pain. I'm just not  
14 equating him to a street user who buys it. I mean,  
15 we make people drop urine who you have on OxyContin  
16 to make sure they are using it and not selling it.  
17 Okay. So there is a whole area there that I'm  
18 very -- I work with Southeastern Spine. We have  
19 many strategies now for doing it, and it's  
20 definitely part of the problem.

21 Q. Let's go back in time --

22 MR. MANN: And we are going to mark  
23 this one 4, please. This is Bates stamped 539,  
24 gentlemen.

25 (DFT. EXH. 4, document Bates stamped



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THOMPSON 002590

1 000539, was marked for identification.)

2 BY MR. MANN:

3 Q. Let me ask you to look at basically the  
4 first sentence or two of that office visit. Can  
5 you give us the date of the office visit first?

6 A. It's August 13th, 2002.

7 Q. And the treating physician?

8 A. It's Dr. Gonda?

9 Q. Correct.

10 A. Yeah.

11 Q. And read us that first sentence or two,  
12 please.

13 A. Mark is in today for followup of the  
14 above problems and also for medicine refill. He's  
15 actually early. He has run out of medication  
16 because his wife was sneaking some of his  
17 medicines.

18 Q. Is that, again, consistent with someone  
19 that is having drug abuse problems?

20 A. Probably some marital problems too but,  
21 yeah. Again, the veracity of his -- of how he's  
22 running out of the medicine, you would want to be a  
23 little cautious. And basically what we do is we  
24 start to say it doesn't matter how it happens.  
25 You've got to stay on top of it, and if you need to



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THOMPSON 002591

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1 lock up your medicine, then do that. And I would  
2 say the same for Adderall and Concerta, which  
3 happens with our college students. Tough. You've  
4 got to stay on top of it. Whether his wife took it  
5 or not, I don't know.

6 Q. Would that be categorized as  
7 potentially drug seeking or drug abuse or both?

8 A. Potentially it could be accurate.  
9 Potentially it could be drug seeking. Ultimately  
10 that's where you've got to get on it and make the  
11 rules clear and get on top of this pattern of  
12 behavior.

13 Q. And the date again was?

14 A. August 13th, 2002.

15 MR. MANN: Let's mark this as 5,  
16 please. Gentlemen, this is 536, please.

17 (DFT. EXH. 5, document Bates stamped  
18 000536, was marked for identification.)

19 BY MR. MANN:

20 Q. And please take a look at that for me.

21 A. Sure.

22 Q. And I think I highlighted an area. And  
23 what's going on with -- first off, give me the  
24 date, if you would, Doctor.

25 A. September 7th, 2001.



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THOMPSON 002592

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1 Q. And we're going back in time. That is  
2 which doctor's office note?

3 A. This, again, is Dr. Gonda's note.

4 Q. What's going on in that visit?

5 A. He's reporting in again. He reported  
6 his Zanaflex helped with sleep. And he reported at  
7 times he has increased the dosage of Ultram, and he  
8 will take three pills, four times a day. Dr. Gonda  
9 warned him that the maximum dosage should be 400  
10 milligrams per day, and that he was taking more  
11 than that.

12 Q. And is that a potential symptom of drug  
13 abuse, taking medication noncompliantly?

14 A. Again, yeah. It's excessive use of the  
15 drug in response to the pain and basically part of  
16 a pattern of trying to manage his pain with  
17 excessive usage of the pain medication.

18 Q. And, Dr. Waid, does that assume that  
19 there is pain?

20 A. That does assume that there is chronic  
21 pain.

22 Q. Okay. And I believe that Dr. Mironer  
23 pointed out that an MRI ruled out any kind of a  
24 mechanical pain that could be identified within the  
25 MRI?



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THOMPSON 002593



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1           A.   That's fine.  If he did, maybe you can  
2   seek his opinion about that.  There are chronic  
3   pain patients who sometimes the structural aspects  
4   are not well-understood.  And other times when  
5   there's more pain than seemingly, the structural  
6   aspect should indicate.  But I'll leave it to them  
7   about that.

8           MR. MANN:  All right.  Let's take a  
9   five-minute break.

10          THE WITNESS:  Sure.

11          (A recess transpired.)

12   BY MR. MANN:

13          Q.   Dr. Waid, let me make sure I'm clear on  
14   one thing.  We've been looking at some of the  
15   records prior to the incident?

16          A.   That is correct.

17          Q.   Okay.  And you've used the term chronic  
18   pain?

19          A.   Well, at that juncture, yes.

20          Q.   Okay.  And the chronic pain that you're  
21   referencing would deal with his back?

22          A.   Basically Dr. Gonda says chronic low  
23   back pain, so I gather that's what he's targeting.

24          Q.   Well, we're not discussing anything, by  
25   any stretch of the imagination, that has to do --



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THOMPSON 002594

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1 during this discussion, we're not discussing  
2 anything that has to do with the procedure  
3 performed in '04 that brings us here?

4 A. Not in my opinion.

5 Q. Okay. Thank you.

6 MR. MANN: Let me ask this to be  
7 marked. We're up to, what, 6, please?

8 THE COURT REPORTER: Yes.

9 MR. MANN: Thank you.

10 (DFT. EXH. 6, document Bates stamped  
11 000535, was marked for identification.)

12 MR. MANN: Thank you, Jennifer, and  
13 this is Bates stamped 535.

14 BY MR. MANN:

15 Q. And Dr. Waid, you can read as much or  
16 as little of this as you like, but I would like to  
17 direct your attention to the date of the office  
18 visit, the doctor, and the area that I've  
19 highlighted in yellow. And could you tell me those  
20 things, please?

21 A. It's October 26, 2000, Dr. Gonda.

22 Q. Okay. And what's going on in the  
23 yellow stuff?

24 A. Basically he still complains of pain  
25 occurring on a daily basis. He did increase the



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THOMPSON 002595

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1 number of Lortab that he took out and ran out  
2 early.

3 Q. So he ran out of meds a little bit  
4 early?

5 A. That is correct.

6 MR. MANN: All right. Let's mark this  
7 one as 7, please.

8 (DFT. EXH. 7, document Bates stamped  
9 000527, was marked for identification.)

10 MR. MANN: Gentlemen, this is 527.  
11 527, gentlemen.

12 BY MR. MANN:

13 Q. Let me ask you again to identify by  
14 date and doctor whose office note and what date  
15 that office visit is.

16 A. September 23rd, 1992.

17 Q. And please tell me what's in that  
18 record -- or please read it first, and then we'll  
19 talk about it, Dr. Waid.

20 A. Okay.

21 Q. Which date and doctor is that note  
22 from?

23 A. September 23rd, 1992, Dr. Gonda.

24 Q. Okay. And what happened in -- what was  
25 Mr. Casey relating to Dr. Gonda during that office



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**THOMPSON 002596**

1 visit date?

2 A. Basically prior to that visit, he was  
3 sitting on his deck talking to his sister, had been  
4 working shifts and tired, little sleep, drank one  
5 beer, a little cold medicine, and apparently had a  
6 fainting episode of some type.

7 And the differential diagnosis was one  
8 of true syncope versus seizure. And he --  
9 Dr. Gonda stated that he could make a case for  
10 syncope based on a multitude of facts including  
11 lack of sleep, drinking one beer, cold medicine and  
12 a pain pill, though, thought that a seizure  
13 disorder needed to be ruled out despite the fact  
14 that he had no incontinence and was not postictal.

15 Q. Can such events have any effect on  
16 cognitive ability?

17 A. Well, I think at the time. But if it  
18 was a seizure and then he had had postictal, then  
19 certainly repetitive seizures can certainly affect  
20 cognitively to the extent that syncope does. Now,  
21 I don't think it does unless you -- when you have  
22 syncope, fall and hit your head.

23 Q. And I'll represent to you I've seen  
24 nowhere in the record that he had other seizures.

25 A. Right. I wasn't aware of him having a



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THOMPSON 002597

1 seizure problem.

2 Q. Would that have been a piece of  
3 information that you would have liked to have known  
4 about?

5 A. I wouldn't -- I asked specifically  
6 about seizures, for sure. I -- other than that,  
7 no. I asked for seizures. I don't know the  
8 relevance of it. I actually think to the relevance  
9 of the pain and use of pain medication to be more  
10 relevant than a syncope episode in 1992 without any  
11 serious after effects.

12 Q. Doctor, in this note, it says that he  
13 took a pain pill that he did not know the name  
14 of --

15 A. Okay.

16 Q. -- correct? That seems to indicate to  
17 me that it wasn't something prescribed to him?

18 A. Potentially.

19 Q. All right. Now, Doctor, let me  
20 backtrack a little bit and ask you a couple of  
21 questions about narcotic use.

22 A. Okay.

23 Q. Does narcotic use have the potential to  
24 diminish Mr. Casey's health?

25 A. It has potential to diminish his



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THOMPSON 002598

1 health. Yes.

2 Q. Now, what about would it have any  
3 effect on his cognitive ability?

4 A. Again, potentially if you get abusive  
5 in your usage of opiates you can impact on your  
6 cognitive ability. On the other hand, if we treat  
7 you and get you off the narcotics and end an  
8 abusive usage, you can have a clearing of your  
9 mental status. So it's, again, certainly an agent  
10 that can compromise your brain functioning,  
11 particularly during toxic usage.

12 Q. Let me see if -- if looking at the  
13 records that I provided you from Dr. Gonda's  
14 records --

15 A. Okay.

16 Q. -- would you agree with me that this  
17 supports that on occasion Mr. Casey has been  
18 noncompliant with his drug use?

19 A. I would say that on occasion he's been  
20 noncompliant with the medications being provided by  
21 Dr. Gonda.

22 Q. Okay. As it relates to drug abuse,  
23 does this tell you any other potential information?

24 A. No. I don't believe it tells me  
25 anything more than the fact that -- actually three



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THOMPSON 002599

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1 or four things. It tells me basically is he wasn't  
2 getting his pain under control; albeit, pain is  
3 subjective. And he, at times, was using more pain  
4 medication than the doctor prescribed. And  
5 ultimately there's also some concern regarding why  
6 there wasn't a shift in the treatment to adjust  
7 that behavior and get better control of the pain  
8 through agents and strategies that were available  
9 at that time.

10 So I think at some point, when we  
11 repetitively have this pattern and how we work  
12 here, we're going to address this primarily by  
13 moving toward use of non-narcotic or nonopioids or  
14 figure out a regimen that works for this man at the  
15 right dosage or consider even mechanical  
16 approaches.

17 So I think there's always a need when a  
18 chronic pain or a pain patient isn't getting the  
19 relief they want. There has to be some alternation  
20 in the strategies, even if it involves making sure  
21 that they understand that you can get a limited  
22 amount and they need to go on other agents that are  
23 not addictive.

24 Q. Thank you. Would you agree with me,  
25 though, that these incidences that we've been



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THOMPSON 002600

1 talking about from Dr. Gonda's records are  
2 consistent with someone that has a substance abuse  
3 problem?

4 A. They are consistent with a patient that  
5 has chronic pain and is excessively using pain  
6 medications not in a complied way; and in that way,  
7 it's abusive.

8 Q. Thank you. And I believe that what  
9 you're telling me is that you're not in a position  
10 to state simply that Mr. Casey is abusing drugs?

11 A. In the context of the parameters, I  
12 told you that's abuse. I just feel that that's a  
13 different form of drug abuse and also can be some  
14 problems with the actual management of the patient.  
15 So I'm putting it on both levels.

16 You have to have good management of the  
17 patient and that incorporates, at times, a  
18 multidisciplined team, rather than having somebody  
19 keep on coming back for refills who is using more  
20 than he's given.

21 So there's interaction between what's  
22 going on in the care, as well as the patient. That  
23 happens more. Now, if you've got somebody without  
24 pain who's just getting off the streets, I think  
25 that's a more classic substance abuser. The fault



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THOMPSON 002601



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1 - can be in the patient, or the fault can be in the  
2 program.

3 Q. And you would agree that none of the  
4 doctors that had been sued in this case had been  
5 providing the medications that we've been  
6 discussing?

7 A. Yeah, I --

8 MR. TURNER: Object to the form of the  
9 question.

10 THE WITNESS: I would agree with that.  
11 Yes.

12 BY MR. MANN:

13 Q. Okay. And, again, the -- let me see if  
14 I can clean this up for Mr. Turner. We have been  
15 discussing instances that were related from  
16 Dr. Gonda's records, correct?

17 A. That is correct.

18 Q. And we were not discussing medications  
19 that were provided by any of the doctors that are  
20 defendants in this case?

21 A. That is my understanding, yes, sir.

22 Q. Thank you. Let me ask this to be  
23 marked as Exhibit 8, please.

24 (DFT. EXH. 8, MRI report, was marked  
25 for identification.)



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THOMPSON 002602

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1 BY MR. MANN:

2 Q. Dr. Waid --

3 MR. MANN: And this -- gentlemen, this  
4 is the MRI report. This is the MRI report that's  
5 been marked as Exhibit 8.

6 BY MR. MANN:

7 Q. Is that the same one you were  
8 discussing earlier?

9 A. Yes.

10 Q. Can you please tell me what this  
11 document purports to be?

12 A. This is a report of an MRI study of the  
13 head without contrast.

14 Q. All right. And who is named in that  
15 MRI report?

16 (The proceedings were interrupted.)

17 MR. KING: Hold on a second.

18 MR. MANN: Are you-all ready?

19 MR. THOMPSON: Yes.

20 MR. MANN: Okay.

21 BY MR. MANN:

22 Q. Who's name is on that report?

23 A. At the top I have Mark Johnson.

24 Q. Oh, okay. And what's the date of  
25 birth?



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THOMPSON 002603

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1           A.    The date of birth is [REDACTED],  
2    1958.

3           Q.    All right.  And do you have an ID or  
4    social security number.

5           A.    ID was [REDACTED].

6           Q.    Okay.  What have you been told about  
7    this report, please?

8           A.    All I had was a copy that I received  
9    the other day.  I had you tell me something in our  
10   crossing when you were down here getting medical  
11   records about an MRI being done that wasn't done  
12   under the name of Mr. Casey.  But I recall you  
13   telling me that, but I do have this MRI and the  
14   disc that went with it.  And this arrived the other  
15   day.

16          Q.    Okay.  And not only is that consistent  
17   with what I told you, this is not Mr. Casey's name,  
18   correct?

19          A.    That -- yes, sir.  That seems to be the  
20   case.

21          Q.    And not his date of birth?

22          A.    It doesn't jive with my date of birth.  
23   I was wondering if I was in error.

24          MR. MANN:  And it is my understanding  
25   we have a stipulation, gentlemen, that this is an



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THOMPSON 002604

1 MRI report on Mr. Casey?

2 MR. TURNER: That's correct.

3 MR. MANN: Okay.

4 BY MR. MANN:

5 Q. Dr. Waid, with the understanding that  
6 we have a stipulation among the parties, that this  
7 actually was an MRI obtained on Mr. Casey?

8 A. That seems to be the case. Yes, sir.

9 Q. Given that it's not in his name I, of  
10 course, have some concerns about that.

11 A. Okay.

12 Q. All right. Have you undergone an MRI  
13 before?

14 A. Not of my brain.

15 Q. Okay. Do you know how the procedure is  
16 conducted?

17 A. No. But I'm sure I'm going to find out  
18 this afternoon.

19 Q. And I hope it comes back equally as  
20 clean --

21 A. As clean as this?

22 Q. -- as positive of a report as this is.

23 A. Okay.

24 Q. All right. But let me ask you then:  
25 Is this a piece of information that you would



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THOMPSON 002605

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1 consider respecting the subjects that you perform  
2 testing on?

3 A. Yes, I would. I'm always willing to  
4 look at neuroradiographic studies of the brain.  
5 Sure.

6 Q. And are you qualified to read that  
7 report and understanding what it's suggesting about  
8 Mr. Casey?

9 A. I'm qualified to understand the report  
10 from the radiologist who provided it indicating  
11 that this MRI seemed -- that he couldn't find any  
12 positive findings. It was negative for any acute  
13 intracranial injury or other findings.

14 Q. Okay. In your interactions with  
15 Mr. Casey, did he display an ability to remember  
16 things?

17 A. Yes, he did.

18 Q. Remember things over periods of time?

19 A. He's not so compromised that he  
20 wouldn't recall personal information and stuff that  
21 he needs to recall.

22 Q. Based upon your observances of him,  
23 would it be consistent in what you perceived to be  
24 his capabilities of him remembering having an MRI?

25 A. I would think he would recall that



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THOMPSON 002606

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1 event more likely than not.

2 Q. And if the event occurred in a town,  
3 say, 90-plus miles away from where he lives, would  
4 that be even more memorable to him?

5 A. I think he would be capable of  
6 remembering the trip and going to get that done.  
7 Yes.

8 Q. Would Mr. Casey have the capability of  
9 providing a name other than his own?

10 A. I think he has the capability of  
11 providing a name other than his own.

12 Q. Okay. So this MRI and the name and  
13 date of birth is consistent with what you feel  
14 Mr. Casey has the ability to remember and  
15 information that he could provide and relate?

16 A. In my opinion, more likely than not, he  
17 would remember this event and be able to provide  
18 it.

19 Q. Okay. Now, if he testified  
20 approximately four to five months later after  
21 having the MRI done that he had never had an MRI  
22 done, would that be problematic for you?

23 MR. TURNER: Object to the form.

24 MR. MANN: We'll play this along, but  
25 objection noted.



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THOMPSON 002607

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1 THE WITNESS: I would believe that he  
2 would remember that event.

3 BY MR. MANN:

4 Q. Okay. So in other words -- and let me  
5 make sure I'm tying this not only to your expertise  
6 but to your understanding of Mr. Casey's condition.  
7 So in five months after having this MRI performed  
8 he gave depositional testimony that he had never  
9 had an MRI performed, you believe he had the  
10 capability of understanding and remembering and  
11 knowing that that is not an accurate answer?

12 A. And it is self-based on my evaluation.  
13 I believe he would have the capability to remember  
14 that fairly unique event.

15 Q. Thank you.

16 MR. TURNER: I don't mean to interrupt  
17 you. The same object to the form on that --

18 MR. MANN: No problem.

19 MR. TURNER: -- as well.

20 BY MR. MANN:

21 Q. All right. Now, Dr. Waid, you know,  
22 again, I just want to come back. And we can pull  
23 out quite a bit more stuff, but I just want to kind  
24 of cut to the chase, if we can, a little bit.

25 A. Sure.



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THOMPSON 002608

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1 Q. All right. I feel personally that  
2 information was withheld by Mr. Casey when he was  
3 seeking your assistance in evaluating him that  
4 should have been provided to you.

5 MR. TURNER: Object to the form.

6 MR. MANN: That's fine.

7 BY MR. MANN:

8 Q. To include information from his  
9 treating physician, information respecting the  
10 drugs that he was taking, information regarding  
11 prior indices of treatment for depression,  
12 agitation, anger and other psychological problems  
13 he experienced prior to the July -- or, excuse me,  
14 the June 4th incident of 2004.

15 MR. TURNER: Object to the form.

16 MR. MANN: That's fine.

17 BY MR. MANN:

18 Q. Do you have a different impression as  
19 to whether or not Mr. Casey was candid with you in  
20 seeking an evaluation from you?

21 A. I believe Mr. Casey was candid, to the  
22 extent of my review with him. I had some  
23 understanding of chronic pain and depression being  
24 on board and that he had been treated for it. I  
25 did not have a report by him of a pattern of,



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THOMPSON 002609



1 perhaps, getting more pain medicine than he would  
2 have utilized. Whether he had thought that was  
3 pertinent or not, I would wonder. But otherwise, I  
4 wasn't not informed of the previous chronic pain,  
5 depression phenomena and treatment for that.

6 In terms of the medication review that  
7 took place initially on August 30th, I believe it  
8 was generally candid. Certainly there was some  
9 ongoing issues about the Adderall. He wasn't able  
10 to list the dosage of Cymbalta. As a matter of  
11 fact, you know, in some regards, whether he was  
12 continuing or not continuing on the Cymbalta, I may  
13 not have been aware of, either by his report or my  
14 own -- my registering of what was happening.  
15 Otherwise, those medications seemed correct.

16 So I don't think he was consciously  
17 trying to hide what medicines he was doing because  
18 there was report of some changing of those  
19 medicines as we saw him over the two days, albeit,  
20 at least the Adderall. And, again, I may not put  
21 the Cymbalta on him whether he reported it or not  
22 reported it. I know I didn't know the dosage, so  
23 there was some misinformation that might have been  
24 on our part. I didn't see him as purposefully  
25 doing that, contriving that.



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THOMPSON 002610

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1 And, again, my issue about this  
2 essentially, other than this kind of data set that  
3 you've provided and, of course, the MRI is not  
4 pertinent to my involvement with him --

5 Q. Right.

6 A. -- you know, I felt he was candid. And  
7 I felt that even the difficulties in his marriage  
8 and some of those have been talked about too. So I  
9 wouldn't put him off as purposively misinforming  
10 me.

11 And, again, I don't know that the pain  
12 and medication thing is acknowledged, even in my  
13 understanding as a potential causal factor for his  
14 cognitive impairments. Again, just because I don't  
15 want to isolate that as the only causal factor, the  
16 depression too. And, again, I knew he had problems  
17 with depression before, again, in the context of  
18 his pain.

19 So I'm not sure I'm terribly  
20 misinformed. It's not as detailed, but I'm not  
21 sure it's changed anything that I -- that -- as it  
22 relates to my neuropsychological evaluation of him.

23 Q. Doctor, what are you aware of his  
24 hospital stay in May and June of 2004 that brings  
25 us here together?



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THOMPSON 002611

1           A.   Well, again, my understanding of that  
2   was a readmission of him in June 3rd of 2004 to  
3   undergo additional procedure by Dr. Feldman and  
4   that -- I depicted for you my understanding of it,  
5   the bronchoscopy and some of the laser and  
6   following the procedure some considerable  
7   difficulties in pneumothorax on the left side and  
8   necessitation for placement of chest tubes,  
9   intubation and mechanical ventilation.

10           Q.   When those events happened, the  
11   pneumothorax, you understand that he was still in  
12   Spartanburg Regional Medical Center?

13           A.   I believe that's correct.   Yes.

14           Q.   Okay.   I will represent that it is.

15           A.   Sure.

16           Q.   Do you know whether or not there was  
17   ever a neurological consult ordered after the event  
18   that gave him the --

19           A.   As best I recall, there was not a  
20   neurological consultation requested in the hospital  
21   setting.

22           Q.   I think it has been consistently  
23   testified that there was not an incident of  
24   hypoxia.

25           A.   The mechanism of emboli, air emboli,



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THOMPSON 002612

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1 and hypoxia for me would be the potential for  
2 those. The experts at some level want to argue  
3 about whether that happened or air emboli. That's  
4 fine. I would just tell you those are the things  
5 that would concern me, and I'm not going to be an  
6 expert at deciding which occurred.

7 Part, again, of saying we had this  
8 incident and here are some deficits that might be  
9 consistent with it, but I can't be an expert on the  
10 mechanism.

11 Q. And I appreciate that. But -- and  
12 you're very much answering my question as to what  
13 I'm asking you about. I think we have a different  
14 interpretation of my question.

15 A. Okay.

16 Q. As a neuropsychologist, would you want  
17 to know whether or not he had an incident of  
18 hypoxia surrounding this event?

19 A. A lack of oxygen to the brain.

20 Q. Correct.

21 A. Basically measured by how?

22 Q. Do what, sir?

23 A. How do you want to measure that? How  
24 are you defining that incident of hypoxia?

25 Q. What I'm telling you is there's a



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THOMPSON 002613

1 complete absence of a report of hypoxia?

2 A. I didn't see that language in there. I  
3 didn't see oxygen saturations taken and a few other  
4 things that might have been useful. That is  
5 correct.

6 Q. Okay. So you would agree that there is  
7 not proof of hypoxia in the records that you've  
8 reviewed?

9 A. In the records I reviewed, I did not  
10 see proof. I saw the mechanisms of -- that we  
11 explained about: pneumothorax, respiratory failure  
12 issues, a need for ventilation and intubation and  
13 chest tubes. Those are clearly the type of  
14 procedures that go down where hypoxia can occur.  
15 But I did not see any proven evidence of oxygen  
16 desaturation, which is sometimes measured or can be  
17 measured.

18 Q. Okay.

19 A. So there's not any. But I would also  
20 say that's often the case --

21 Q. Right.

22 A. -- in these types of cases that end up  
23 with profound impairments when there are no legal  
24 issues. So air emboli, in particular, doesn't  
25 usually result in code for neurology and so forth



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THOMPSON 002614

1 too. So I'm just telling you the mechanisms of  
2 needing ventilation, pneumothorax, respiratory  
3 insufficiency happened, but I did not see anything  
4 more than that.

5 Q. Let me talk about -- you understand  
6 Dr. Jantz has been retained by Mr. Casey's counsel?

7 A. I do understand that, yes.

8 Q. And Dr. Jantz has testified that there  
9 was not a hypoxia event.

10 A. Okay.

11 Q. It's my understanding Dr. Fogarty has  
12 also testified there was not a hypoxia event.

13 A. Okay.

14 Q. All right. Also both have testified  
15 there was not an anoxia event.

16 A. Sure. Well, okay. If there's not  
17 hypoxia, there's not anoxia. Yeah.

18 Q. Okay. And is that information that you  
19 would want to have in consideration as to his  
20 cognitive abilities?

21 A. Well, yes. I mean, in terms of causal  
22 factors and their relation to the surgical  
23 procedure, that's useful information. Again,  
24 that's a mechanism, and I'll let them argue about a  
25 mechanism.



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THOMPSON 002615

1 Q. And, again, maybe you're telling me in  
2 straight up code talk. What I need to ask next:  
3 You're not willing to opine as to what may or may  
4 not have caused a cognitive deficit in Mr. Casey?

5 A. Basically I'm on the opinion that we  
6 have a temporal relationship between this situation  
7 that arose in the emergency room. But I'm not  
8 going to break it down more mechanically than that  
9 because some doctors have talked about the  
10 possibility of coming out of a surgical procedure  
11 with cognitive loss. I have dealt with that, but  
12 my relationship would mainly be temporal. I'm not  
13 an expert on whether that mechanism occurred or  
14 not.

15 Q. Okay. And by temporal, are you saying  
16 in time?

17 A. Yes.

18 Q. Okay. So you're saying that if there  
19 is a -- or excuse me. In your opinion, there is a  
20 cognitive deficit, correct?

21 A. Yes. I believe that he has cognitive  
22 deficits.

23 Q. And you feel that it arises in time  
24 around the incident of '04?

25 A. Yes. That is my belief that there is a



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THOMPSON 002616

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1 temporal relationship to a change in his  
2 functioning, both cognitively. But again, I didn't  
3 see him two months out, eight months out. I saw  
4 him about year -- a little bit over a year out. So  
5 I have no track until that point, so I have to  
6 relate back to those and the differing opinions  
7 they have.

8 Q. Right. And you didn't see him three  
9 months before, four months before either, did you?

10 A. No, I did not.

11 Q. All right. And you didn't see him when  
12 he was being noncompliant in his drug use with  
13 Dr. Gonda, correct?

14 A. Did not know him at that time.

15 Q. Correct. And you didn't see him when  
16 he was suffering from episodes of depression and  
17 anger prior to the June 4 incident?

18 A. That is correct. I did not.

19 Q. Okay. So how are you basing a temporal  
20 analysis when you didn't have -- strike that.  
21 Okay. How are you making a temporal differential  
22 between prior to June of '04 and after June of '04  
23 as this occurred?

24 A. Basically you have an event that takes  
25 place and then ultimately you have the acute



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THOMPSON 002617



1 records that indicate a change in a person and then  
2 you have the subsequent providers and people who  
3 get involved with him who also talk about those  
4 changes, some pro; some con, as they relate to him.

5 So you've seemed to have an acute  
6 event, a change, some recovery process, and a  
7 persistence of new problems. So that's the best  
8 you can do at the juncture of getting involved at  
9 the time that I get involved. So I still see it as  
10 kind of the elephant in the middle of the room. I  
11 know you kind of think of the other things.

12 But, you know, it's similar to a car  
13 accident. When a person's working/functioning,  
14 they might have had some pain. They might have had  
15 some use of pain medication. Ultimately there's a  
16 fairly dramatic change in their functioning at the  
17 time of the incident, and they persist in their  
18 problems.

19 So for me, that's meaningful, and you  
20 get the data as best you can. And ultimately you  
21 do an assessment; and then you see the validity of  
22 it, reliability, and whether or not it can be  
23 consistent with that type of injury. And  
24 neuropsychologists, that's how we do our work.

25 Q. Okay. And I think you indicated that



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THOMPSON 002618

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1 some doctors have differing opinions as to changes  
2 in his capabilities before and after June of '04,  
3 correct?

4 A. By reading some of those. I find some  
5 of those not credible from a point of view of  
6 reading the records.

7 And, for example, Dr. Smith, you know,  
8 ultimately he's trying this guy on lots of stuff  
9 for attention and focus, even though he tries to  
10 offer, in deposition, that he's using Adderall to  
11 boost an antidepressant. That's new -- that's new  
12 to me. It's new to most people. You might use  
13 thyroid medication to boost antidepressant effect,  
14 but I don't think you'd use Adderall or Concerta.  
15 I think you'd use that to help attention, executive  
16 functioning. And I thought that would be a decent  
17 intervention for that cognitive problem.

18 So, again, I think he states that too,  
19 but he's even seemingly more depressed than he used  
20 to be. So I think there's changes going on with  
21 this guy. Some of them can be reactive to where  
22 he's at in his life versus neurological, and  
23 clearly those are more difficult questions.

24 Q. What about Dr. Gonda's opinion as to  
25 his change over time? Did you review that?



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THOMPSON 002619

1           A.    I've reviewed a lot, but you can offer  
2           what it is.

3           Q.    He basically said, other than typical  
4           changes from age, he has not seen a change in  
5           Mr. Casey.

6           MR. TURNER: Object to the form.

7           THE WITNESS: Again, what realms he's  
8           talking about, he'll have to respond to it. Mr. --  
9           the test results do not suggest that we're just  
10          having age-related changes in brain functioning, so  
11          I would have to disagree with him there.  
12          They indicate a very significant pocket of problems  
13          that would be consistent with interfering effects  
14          of a potential injury to the subcortical regions  
15          but also clearly -- in my way of looking at this,  
16          and I'll never bounce off of it, yes, clearly other  
17          factors, depression, pain medication usage, are  
18          potentially part of the causal factors. But it's  
19          not age-related.

20          Q.    Okay.

21          A.    Okay. Because we would see more  
22          deterioration in memory, which is actually okay, et  
23          cetera. So that profile I have in  
24          neuropsychological testing's just not age-related  
25          changes --



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THOMPSON 002620

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1 Q. Okay.

2 A. -- very pronounced deficits in the  
3 frontal lobes.

4 Q. But the testing is not going to show  
5 you when these changes occurred in time, is it?

6 A. There is the issue of trying to rule  
7 out what you can premorbidly. And there is some  
8 issues here of pre-existing school records and  
9 educational records and intelligence testing, and  
10 those got debated interestingly and, in my opinion,  
11 incorrectly by some of the experts involved. But  
12 they're better than not having data.

13 And the previous intellectual testing  
14 was good, and some of the educational performances  
15 were good. So we at least have that data. Whether  
16 it's a static or changeable phenomena, as Dr. Jay  
17 gets into, can be debated, but there is some  
18 records. I say that usually because I have  
19 absolutely nothing sometimes.

20 But I don't know exactly where he's at  
21 on testing as it might be in 2001, 2002, and 2003.  
22 I certainly agree with that.

23 Q. All right. Tell me a little bit about  
24 the testing, if you will.

25 A. Sure.



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THOMPSON 002621

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1 Q. Let's look at your report.

2 A. Okay.

3 Q. Looking at page 5 --

4 A. Yes, sir.

5 Q. -- can you please tell me about the  
6 attention/memory functioning, the first paragraph  
7 there? What test was administered?

8 A. The Stroop test was administered. The  
9 Seashore and Speech-Sounds Rhythm test,  
10 Speech-Sounds Perception and Seashore Rhythm tests  
11 were administered.

12 Q. The first paragraph of page 5?

13 A. Yes, sir.

14 Q. Okay.

15 A. Working memory tests from the Wechsler  
16 Adult Intelligence Scale-3rd Edition and the Paced  
17 Auditory Serial Addition test.

18 Q. Tell me about the Paced Auditory Serial  
19 Addition test.

20 A. The Paced Auditory Serial Addition test  
21 is a test in which you are given numbers on a tape:  
22 1, 9, you have to say 10. Get the 10 out of your  
23 head because the tape will say 4, and then you have  
24 to be able to say 5. It is a test to administer  
25 the attentional regulation and multitasking.



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THOMPSON 002622

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1 Q. How did Mr. Casey perform on that?

2 A. He did well on that particular  
3 attentional test. He did well relative to the  
4 norms. One of the problems with the Paced Auditory  
5 Serial Addition test is that there's incredible  
6 variability because of its sensitivity. And  
7 ultimately, you know, it's hard to know if he would  
8 have been better on that, but he did score well  
9 within the average range on that particular test.

10 Q. Have you -- never mind -- strike that.  
11 Let's look over to page 6, if we can.

12 A. Sure.

13 Q. What's going on in that first paragraph  
14 of your report? What's being tested?

15 A. On page 6 under visual-spatial/visual-  
16 constructional functions?

17 Q. Correct.

18 A. Basically that's a test that gets into  
19 the visual-spatial skills such as visual  
20 inattention, perceptual organizational skills,  
21 making fine discriminations of lines in space, as  
22 well as performance on a visuographic sequencing  
23 test, the Trail Making test A and B.

24 Q. So it does have two components to it?

25 A. It's a variety of visual-spatial



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THOMPSON 002623

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1 processing measures, but also the Trail Making test  
2 does have two components, if that's what you're  
3 focusing in on.

4 Q. Correct, I am. Is there an A and B to  
5 that?

6 A. There is.

7 Q. How did he do on Part A?

8 A. On Part A, he was in the low average  
9 range, a little bit slow in his processing. And in  
10 Part B, he basically was able to effectively shift  
11 in sequence between numbers and letters in a  
12 sequential fashion and perform within the average  
13 range on that.

14 Q. Is there a difference in difficulty  
15 between those two tests?

16 A. There is. The Trail Making test B is a  
17 more demanding test, as it relates to being able to  
18 sequence and shift between numbers and letters.

19 Q. And does that cause you any concern  
20 that he did better on the B than the A?

21 A. Basically, as I indicated to you,  
22 Mr. Casey, in the report -- I'm sorry -- that I  
23 indicated he had some variability in these types of  
24 tasks. Some of them he is able to effectively meet  
25 the demands of the task. And that's what I saw as



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THOMPSON 002624

1 being some variability in his attention and  
2 executive functioning.

3 Q. Let's flip over to page 7 for a second.

4 A. Sure.

5 Q. Let's go down to the third paragraph  
6 from the bottom.

7 A. From the bottom, yes, sir.

8 Q. Yes, sir. And please read that one for  
9 me.

10 A. Mr. Casey's responses?

11 Q. Uh-huh, please.

12 A. Indicated that he did not believe he  
13 had any ongoing descriptions in the realms of  
14 cognitive, emotional, or physical functioning prior  
15 to his involvement in the medical incident.

16 Q. Now, would depression be an emotional  
17 disruption?

18 A. Yes, it would be.

19 Q. Okay. What about anxiety and/or anger  
20 issues?

21 A. Yes, it would be.

22 Q. All right. And you said a number of  
23 times that he told you that he was having those  
24 problems prior to the incident?

25 A. Yes.



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THOMPSON 002625



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1 Q. Where does it say that in your report?

2 A. Basically when we talked about his  
3 depression -- I mean, his chronic pain, he  
4 indicated that he --

5 Q. Can you --

6 A. Right. And I --

7 Q. Can you point to it in the report?

8 A. I didn't have in there -- I didn't have  
9 him as doing psychiatric treatment, and he didn't  
10 report -- he didn't code of being highly disruptive  
11 by that. But -- but in terms of the records and in  
12 terms of understanding him, I knew that he had had  
13 chronic pain and some depression associated with  
14 that chronic pain.

15 Q. And, again, by chronic pain, as you've  
16 used it today, you're referencing his lower back  
17 pain?

18 A. I am.

19 Q. Okay. Let's flip to the back, if we  
20 may, page 8.

21 A. Sure.

22 Q. All right. You've got a section that  
23 looks like -- I don't -- and forgive me if I use  
24 the wrong term. There's axes, and that looks like  
25 your findings. Is that an accurate way of stating



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THOMPSON 002626

1     what that is?

2             A.     That is correct.

3             Q.     Okay. Can we go through these, please?

4             A.     Sure.

5             Q.     All right. Axes [sic] 1, what does

6     that cover and tell -- what does that tell you,

7     please?

8             A.     Axis 1 is the clinical syndromes that

9     the client may be experiencing.

10            Q.     And what did you find in Mr. Casey,

11     please?

12            A.     I said mood disorder with depressed

13     mood.

14            Q.     Okay. Anything else in there?

15            A.     Yeah, secondary to persistent somatic

16     symptoms, or symptomatology --

17            Q.     All right.

18            A.     -- and potential permanent neurological

19     deficit due to complication of laser bronchoscopy.

20            Q.     And would you agree the potential is a

21     far cry from occurred or absolutely or -- in other

22     words, and there's a -- let me back up and start

23     over.

24            A.     Sure.

25            Q.     All right. We both know what a



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THOMPSON 002627

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1 reasonable degree of medical certainty is?

2 A. Yes.

3 Q. And you would agree with me that  
4 potential permanent neurological deficit is a far  
5 cry from the statement of occurred within a  
6 reasonable degree of medical certainty?

7 A. Well, basically when I use that, I am  
8 relying on, at that juncture -- I have two things  
9 to say to that.

10 Q. Sure.

11 A. One is the mechanism at that point it  
12 looked like wasn't as clear, and certainly I would  
13 rely on the experts about the mechanism, if it did  
14 happen or not. So we're talking about the -- what  
15 happened that day, the potential neurological  
16 ramifications of this procedure, and the  
17 difficulties they had.

18 I am using potential, and I -- also my  
19 second joinder was, as I told counsel, it was my  
20 belief that I should re-evaluate this guy again.

21 Q. Okay.

22 A. And I would still say that because I  
23 think we need to clear up some of the interfering  
24 aspects that are contributing to the compromises  
25 I'm experiencing.



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THOMPSON 002628

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1           So when I wrote this, I had the notion  
2     in my head that we need to see this guy again. We  
3     need to clean him up, get him better, get him  
4     better adjusted to the changes that have taken, and  
5     we're about 12, 14 months.

6           And while that would be okay for a  
7     recovery from the neurological process, it's still  
8     real acute with regard to a man having to live with  
9     changes, and I -- and as I indicated there, there  
10    are mood disturbance and sleep disturbance and  
11    things going on. I've told counsel this. I think  
12    he -- it's a man we need to re-evaluate.

13           So I'm still potential -- you know, if  
14    you're asking me now more likely than not, I would  
15    say that, but I really was relying on the idea of  
16    cleaning this case up and getting rid of some of  
17    the competing -- competing potential causal  
18    factors, which, if you ask me, again, I believe  
19    there is a high likelihood; but I wasn't ready to  
20    respond of more likely not or probable not or with  
21    medical certainty.

22           I did this evaluation then, oh, here we  
23    are two or three years later. In reality, I'd like  
24    to see him again, and I think he should get a  
25    re-evaluation.



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THOMPSON 002629

1 Q. Okay.

2 A. And I have said that to counsel. So I  
3 know what you're asking for. I just, in that point  
4 in time, wasn't offering that at that level yet. I  
5 think there's -- more likely than not, there has  
6 been a potential injury, but I do believe that  
7 confounding possibilities existed at a level that  
8 we needed to re-evaluate him.

9 Q. All right. So are you basically saying  
10 that you're changing the language of your report  
11 now?

12 A. I'm saying that's the basis for that  
13 because it wasn't -- being an expert, I often have  
14 to be asked more likely than not or more probable  
15 than not. And I wasn't answering that -- I wasn't  
16 ready to answer that question at that point.

17 Q. Okay.

18 A. And --

19 Q. But you are now?

20 A. You know, I've actually told counsel I  
21 still think it's a good idea to do a  
22 neuropsychological re-evaluation on this guy.

23 Q. Okay.

24 A. That's where I stand as an expert  
25 and -- but, you know, if you asked me do I think



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THOMPSON 002630

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1 more likely than not, yeah, my thinking there would  
2 be there. But I do believe and do respect to you  
3 guys that there are some other factors as I lay  
4 them all out. I think it's unequivocal. I think  
5 it's basically realizing that we've got multiple  
6 etiologies that could be contributing here.

7 Q. Okay.

8 A. And certainly a surgical procedure that  
9 results in mechanical intubation and the  
10 compromises -- I've done many cases like that, and  
11 they do compromise people. How much and what goes  
12 with it is a problem.

13 Also during the adjustment phase when  
14 you don't show a full recovery, people do get  
15 depressed when their brain doesn't work as well and  
16 they aren't the person they were before. And often  
17 that adjustment, depression, and problems takes  
18 longer to clear. This is true in all of my mild  
19 head injuries. They're told they're okay. Their  
20 MRI is fine, but they're making mistakes at work or  
21 maybe they end up losing a job, even though they  
22 don't have real brain damage, and they get  
23 depressed.

24 And we need to clean up the depression,  
25 get them to accept their deficits and then getting



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THOMPSON 002631

1 rid of those factors have a better understanding of  
2 a cleaner catch of the brain.

3 So that's where I'm at as an expert on  
4 this case. I'm not ruling out that I think  
5 definitely an injury could have occurred, but I'm  
6 not ready to say that we shouldn't clean that stuff  
7 up and put it to further evaluation.

8 Q. Okay. And, Doctor, I apologize, but I  
9 just want to make sure that I'm following you. So  
10 if I'm looking at your report, Axes 1 and that word  
11 potential, are you telling me that you're replacing  
12 that word within a reasonable degree of certainty?

13 A. I'm telling you that, more probable  
14 than not, I believe that this man took a hit that  
15 compromised his cognitive capacities at that point  
16 in time. But I'm also telling you I would like to  
17 have ascertained that at a more empirical level by  
18 having re-evaluated him with hopeful improvement in  
19 these other competing, interfering processes,  
20 including depression, sleep disturbance, fatigue  
21 and so forth because a permanent deficit, once you  
22 get rid of those, will persist.

23 Q. Have you requested to do that  
24 follow-up?

25 A. I have indicated that that should be



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THOMPSON 002632

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1 done, and counsel has been so informed that I think  
2 it's a good idea because, otherwise, you're going  
3 to be correct. I'm going to tell you all of those  
4 things, including the surgical procedure that went  
5 astray, could be a causal factor. And quite  
6 frankly, more often than not, they're all  
7 contributing.

8 What I don't have -- what people can't  
9 do, which has been done in this case, is you can't  
10 rule it out either like some people do because  
11 there are biases for an insurance company to say a  
12 brain injury isn't there. I don't think they can  
13 do that empirically, and I think we shouldn't go  
14 beyond empirical stuff.

15 And my point is this was an incident  
16 that changed this man. Yeah, he's gotten depressed  
17 about it. He's compromised. I've heard other  
18 things about effort and malingering. Absolutely  
19 false, a total misuse by Dr. Jay of the TOMM. He  
20 just hadn't read the TOMM manual, and it was good  
21 effort he gave me. The pattern is consistent with  
22 that type of injury.

23 But to -- respect to you, pain and  
24 depression can look like a subcortical injury too.  
25 And I think we clean them up, and it's a simple



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THOMPSON 002633



1 design: Get rid of A, B; and if you still have C,  
2 they're more definitive.

3 Q. Let me ask you about Axes 5.

4 A. Sure.

5 Q. GAF, what does that stand for?

6 A. Global Assessment of Functioning.

7 Q. And what's a 50?

8 A. 50 is serious impairment. But the  
9 problem with this one too is it's a psychiatric  
10 nomenclature. And, you know, in the 40s you've got  
11 to start having some psychotic symptoms, if you  
12 look at the adjectives.

13 50 just means serious impairment in  
14 vocational and social pursuits. It's just a  
15 classification of what this guy can't do. It's not  
16 a causal statement. It's just saying, you know, he  
17 ain't working. He's not as engaged socially. He  
18 has serious impairment there.

19 MR. MANN: Let me take five more  
20 because I think we've done another hour.

21 (A recess transpired.)

22 MR. MANN: Okay. We can go back on if  
23 everybody's ready.

24 Dr. Waid, I think I told you yesterday  
25 I'd need about two, two and a half hours. I think



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THOMPSON 002634

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1 we started at 10:20. I believe it's about 12:15.  
2 I appreciate your help in answering some questions  
3 that I had. I have no further questions, but I  
4 think some of these other gentlemen may have some.

5 THE WITNESS: Okay.

6 MR. MANN: But I thank you for your  
7 time.

8 THE WITNESS: You bet.

9 MR. GUNN: I've got just a small  
10 handful of questions.

11 EXAMINATION

12 BY MR. GUNN:

13 Q. Prior to this case, had you evaluated  
14 any claimants or any patients for either  
15 Mr. Anthony or Mr. Thompson?

16 A. I am not aware of having a case from  
17 their law -- I'm -- I am just not aware if I  
18 haven't already worked with them. There's a  
19 possibility of that the over the last 25 years --

20 Q. Sure.

21 A. -- but obviously they're not a ready  
22 source of referrals to me than there might be.

23 Q. When you saw Mr. Casey on these two  
24 occasions, August 30th and September 10th, 2005,  
25 his personal hygiene was good, was it not?



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THOMPSON 002635

1 A. It was.

2 Q. He was conversant, was he not, sir?

3 A. He was.

4 Q. He didn't ramble or babble or otherwise  
5 speak in a hurried, clipped manner that gave you  
6 any concern?

7 A. No, he did not.

8 Q. All right. He was deliberate and --  
9 well, let me ask you: You indicated that he was  
10 mildly depressed based on your -- was that based on  
11 your evaluations of him?

12 A. Yes. Based on his evaluation, I think  
13 his depression scale depicts more of that, but  
14 that's really more of his life circumstance. In  
15 terms of dealing with effectively one-on-one, I  
16 think he was a little bit dysphoric but not highly  
17 compromised by depression.

18 Q. Okay. Just seemed a little down?

19 A. Yeah.

20 Q. Okay. And by life circumstances, I  
21 assume, in fairness, you're including his divorce,  
22 his financial stressors and other things going on  
23 besides the injury that he gave a history of?

24 A. I am.

25 Q. Have you ever seen, tested, or



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**THOMPSON 002636**

1 evaluated other patients who claimed that -- either  
2 had or claimed they had an air embolus?

3 A. I've done air embolus, and I've also --  
4 but done much more hypoxia, oxygen desaturation, in  
5 that ballpark. But actually there's been several  
6 cases I've seen -- and, again, a lot of these are  
7 not forensic cases where a person comes out of a  
8 surgery absolutely compromised, neurology sends  
9 them over, neurology thinks it's air emboli but  
10 there's no evidence of a procedural problem, but it  
11 happens.

12 And so I've been involved with those  
13 kind of clinical cases, not necessarily any major  
14 suit going on because people just came out  
15 different; and that's the hypothesized problem per  
16 the neurologist. Dr. Bumgartner's, for example,  
17 most recent case I did, surgery, comes out of  
18 surgery really compromised, no pay off, you know,  
19 there's nothing to be gained, and he's just not the  
20 same. And that was just done this year so -- and  
21 Dr. Bumgartner did refer to it as the emboli.

22 Q. Well, in medical literature and in  
23 neuropsychological literature, is there a  
24 phenomenon of patients sometimes undergoing general  
25 anesthesia and having some what they perceive to be



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THOMPSON 002637

1 cognitive deficits, even without an identifiable  
2 event?

3 A. Yes, the -- that, and actually the  
4 research would tell you the more you have a  
5 protracted period like 8- or 12-hour surgical  
6 procedure.

7 There's also research done on  
8 successful heart transplants. Unfortunately they  
9 are long procedures and no incidents, successful,  
10 but they're -- you know, they're under mechanical  
11 respiration and the research on that has shown that  
12 successful heart transplants actually come out with  
13 mild cognitive deficits compared to their relative  
14 cohort group. It's a nice research project -- no  
15 incident.

16 So the subtleties of particularly  
17 protracted ventilation and protracted breathing  
18 definitely can do a little bit of problems.

19 Q. You indicated that you would like to  
20 see and evaluate Mr. Casey again to -- the term you  
21 used was clean up the interfering effects or to  
22 clean up the interfering factors or features in his  
23 life. By those, you're talking about the  
24 depression and anxiety?

25 A. Depression, anxiety, certainly even the



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THOMPSON 002638

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1 somatic of the body pain kind of stuff and even  
2 just being further along in recognizing this is  
3 where you're at, kind of what we call acceptance,  
4 lack of embitterment kind of process, also the  
5 consistency and ruling out the other factors that  
6 might come into play, where you've adopted the sick  
7 role or these other psychological issues.

8 So I do think I made that statement to  
9 counsel and to counsel here mainly because when I  
10 made this opinion here I really thought that's --  
11 was going to -- we needed to do that.

12 Q. When Mr. Casey came down to see you in  
13 Charleston or came to see you, I presume he came --  
14 drove to Charleston and came to Charleston?

15 A. Yes, sir, he did.

16 Q. Did his sister come with him?

17 A. No. I did not have his sister, at  
18 least not involved in the -- I didn't lay eyes on  
19 her. I can't tell you she didn't travel with him.  
20 I also generally like to get a wife to respond to  
21 some forms. I didn't have that situation  
22 obviously. That was -- seemed to be a situation  
23 that he was -- had been somewhat embittered. He  
24 had been divorced for a while. So at this point I  
25 didn't get any collateral input about him that I



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THOMPSON 002639

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1 didn't get from reading Dr. Grace's and other  
2 people's notes. But I didn't have a collateral  
3 interview.

4 Q. Okay.

5 MR. GUNN: I think that's all I've got.  
6 Thank you, sir.

7 THE WITNESS: You bet.

8 EXAMINATION

9 BY MR. TURNER:

10 Q. Dr. Waid, I'm Noel Turner. We met,  
11 just briefly, before. What I'd like to do first --  
12 I think this was mentioned -- but mark as our  
13 Exhibit No. 1 your curriculum vitae. And that  
14 doesn't need to be now --

15 A. I'll get that for you.

16 Q. -- but we'll just do a copy, and that  
17 will clear that exhibit up.

18 In addition to that, I'm going to  
19 quickly move through the questioning we've had on  
20 this alleged drug abuse or drug-seeking conduct.  
21 And I know that that's not the focus, by any means.  
22 I'm going to move quickly to your report after  
23 that.

24 But that -- with the alleged substance  
25 abuse problems, you reviewed some of Dr. Gonda's



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THOMPSON 002640

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1 medical records; and you had received these medical  
2 records or looked at the medical records, at least,  
3 during the deposition, correct?

4 A. Yes, I did.

5 Q. Okay. And in Dr. Gonda's deposition  
6 where he testified under oath -- and tell me if  
7 this -- any of this makes any difference in your --  
8 the results in your report. But you were shown one  
9 where allegedly Mr. Casey got Percocet from some  
10 coworkers to fill in when he was -- when he ran  
11 out?

12 A. Yes. I think he did get some Percocet.  
13 I don't know that is was a coworker, but from  
14 somebody else, yes.

15 Q. Okay. And you're aware -- Dr. Gonda,  
16 he wrote a prescription that's on that same page  
17 for Percocet on August 27th, 2003, b.i.d, so twice  
18 a day, 60 count with a refill on the same date that  
19 he was advised that Mr. Casey had received  
20 Percocet allegedly from a coworker or a friend or  
21 someone?

22 A. That is correct.

23 Q. Okay. And if Dr. Gonda -- I'll tell  
24 you in his deposition -- if this makes any  
25 difference, Dr. Gonda, if he was -- he states if he



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THOMPSON 002641



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1 was concerned about drug-seeking conduct on behalf  
2 of Mr. Casey then he would not have written  
3 Percocet on the same day that he was advised that  
4 he had received it from another source.

5 And would you agree that that's proper  
6 medical care that if a -- if you have any concerns  
7 about drug-seeking conduct and the patient comes in  
8 and says that they had allegedly received Percocet  
9 from a friend or coworker, if you had drug-seeking  
10 concerns, you wouldn't prescribe Percocet that very  
11 same day, would you?

12 MR. KING: Object to form of the  
13 question. Dr. Waid does not and I do not believe  
14 that is prescribed as practicing psychology.

15 MR. TURNER: Okay.

16 BY MR. TURNER:

17 Q. Wouldn't expect a physician to  
18 prescribe Percocet if he was concerned about  
19 drug-seeking conduct?

20 MR. KING: Same objection --

21 MR. TURNER: Okay.

22 MR. KING: -- not qualified as to the  
23 form of the question.

24 THE WITNESS: Do you want me to answer?

25 MR. KING: Yeah.



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THOMPSON 002642

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1 BY MR. TURNER:

2 Q. Yes.

3 A. Basically, since I work with physicians  
4 in several chronic pain management programs,  
5 including Southeastern Spine, I -- as I brought up  
6 earlier too, I would see it as an interaction  
7 between getting his pain under control and making  
8 some programmatic changes in the medication. And  
9 if he provided him more pain medicine, I would  
10 assume that he didn't think it was being misused.  
11 But I would also -- as I indicated earlier to  
12 counsel, I would think that we should get this  
13 program modified so we can manage this man's pain.

14 So I would only tell you if he kept on  
15 prescribing it he thought he was just using it to  
16 get his pain under control.

17 Q. Okay. And, in any of your records or  
18 review or speaking with Mr. Casey, the pain  
19 medications that were written were written by  
20 Dr. Gonda to enable Mr. Casey to continue to work  
21 on his production line job with Michelin and enjoy  
22 activities such as golf?

23 A. It was my understanding that he was  
24 remaining functional with vocational activities and  
25 golf and recreational pursuits, in the context of



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THOMPSON 002643

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1 using the pain medications.

2 Q. And I think Mr. Mann what he was asking  
3 was prescription medications for narcotic pain  
4 medicine that was written prior to the surgical  
5 event of 6/3/2004. Was that your understanding,  
6 Dr. Waid?

7 A. Yes, it was my understanding.

8 Q. Okay. And are you aware that both  
9 Drs. Boscia and Feldman prescribed Percodan,  
10 Oxycodone, OxyContin to Mr. Casey in June 2004 or  
11 after?

12 A. I was aware that he continued on pain  
13 medications. I'm not sure about the specific, but,  
14 yes, I was aware he remained on pain medication.

15 Q. Okay.

16 MR. MANN: Off the record.

17 (PLF. EXH. 1, Dr. Waid's CV, was marked  
18 for identification.)

19 BY MR. TURNER:

20 Q. Dr. Waid, looking at the narcotic use  
21 by Mr. Casey, doesn't it appear that he was taking  
22 the Hydrocodone, primarily referred to as Lortab,  
23 prescribed by his primary care physician Dr. Gonda  
24 for the mechanical back pain?

25 A. That was my understanding that -- why



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THOMPSON 002644

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1 he was taking it. Yes, sir.

2 Q. Okay. And this was for chronic back  
3 pain over a number of years that would be prior to  
4 the surgical procedure of 6/3/2004?

5 A. Yes, sir.

6 Q. Okay. And this prescribed narcotic  
7 use -- and Dr. Gonda -- I'll say Dr. Gonda was his  
8 family physician from 1992 all the way to present  
9 with Mr. Casey. That the prescribed narcotic use  
10 by Dr. Gonda, this would not account for the sudden  
11 and profound change that you noted immediately  
12 postprocedure on 6/3/2004, would it?

13 MR. KING: Objection to the form of the  
14 question, lack of qualification of expertise.

15 THE WITNESS: It appeared to me that an  
16 event occurred when he was hospitalized and that  
17 there was a considerable change in his overall  
18 physical and health and cognitive function, as it  
19 related to complaints after that with regard to  
20 attention, concentration, and memory. And so when  
21 I look at the medical records, those types of  
22 complaints were not present beforehand.

23 BY MR. TURNER:

24 Q. And isn't it true that there are many  
25 people -- a significant small percentage of



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THOMPSON 002645

1 population that take narcotic medication such as  
2 Hydrocodone or even stronger narcotics for long  
3 periods of time and remain functioning at a high  
4 level at their employment, social, or family  
5 activities?

6 A. Yes.

7 Q. And even though they may take  
8 chronic -- or chronically take narcotics over a  
9 long period of time, they function cognitively very  
10 well?

11 A. They do. As a matter of fact, if you  
12 have chronic pain and you use opiates, you're more  
13 likely not to be cognitively impaired versus a  
14 street user who doesn't have pain. There tends to  
15 be a more euphoric and toxic effect with people who  
16 are just taking it to get high. So, two, also pain  
17 is a player. So if you can get rid of pain through  
18 the opiates, you're probably better off cognitively  
19 than without.

20 Q. In your report, Mr. Mann asked you  
21 about the word potentially on that last page.  
22 You're familiar with the sentence that I'm talking  
23 about?

24 A. That is correct.

25 Q. All right.



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**THOMPSON 002646**

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1 MR. MANN: No. I think it was  
2 possibly.

3 MR. TURNER: Okay. Under Axis 1, it's  
4 got: Potential permanent neurological deficit due  
5 to complications --

6 MR. MANN: I'm sorry.

7 MR. TURNER: -- of laser bronchoscopy.

8 MR. MANN: My apology.

9 BY MR. TURNER:

10 Q. We've discussed some other possibly  
11 contributing factors, haven't we, such as  
12 depression and anxiety?

13 A. Yes, sir.

14 Q. Okay. But it's your opinion, within a  
15 reasonable degree of medical certainty, that it's  
16 more likely than not that you believe that  
17 Mr. Casey has a permanent neurological deficit as a  
18 result of the insult from the June 3rd, 2004,  
19 procedure?

20 A. If I'm asked to make the distinction,  
21 that would be my opinion more likely than not when  
22 I'm using that, again, verified by the fact that I  
23 also thought that we would be more empirical in  
24 addressing that question by cleaning this guy up,  
25 giving him some more time for recovery and



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THOMPSON 002647

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1 re-evaluating him to see if there was a persistence  
2 of a narcotic impairment.

3 Clearly on the date I wrote this  
4 report, I wasn't thinking in those types of terms  
5 but believed he has suffered a neurological  
6 deficit. But empirically I believe that we can  
7 clean him up and reassess it that one can be even  
8 more confident about that, but I believe he has had  
9 an insult.

10 Q. All right. Air embolism has been  
11 described as a potential mechanism for that insult,  
12 correct?

13 A. It has been.

14 MR. KING: Objection to the form of the  
15 question, qualification of expertise.

16 BY MR. TURNER:

17 Q. Anesthesia, are you -- you've discussed  
18 long term -- if you're under anesthesia for a long  
19 period of time such as an open heart surgery -- 18  
20 hours I think is what you had used -- that there  
21 may be some residual cognitive dysfunction as a  
22 result of the anesthesia itself?

23 MR. KING: Objection to the form of the  
24 question, qualification of expertise.

25 THE WITNESS: I would respond that the



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THOMPSON 002648

1 literature -- research literature that I'm aware of  
2 and studies that I've looked at because of my work  
3 in that area have done that. That's all I'm  
4 implying, that research studies have indicated  
5 that, and that the risk is greater for protracted  
6 periods of anesthesia.

7 And certainly if you have an incident,  
8 an unfortunate incident where there might be a lack  
9 of respiratory feed and lack of oxygen saturation,  
10 clearly you're getting into a more dangerous area.  
11 But that's based on my understanding of the  
12 research literature. I would agree with counsel.  
13 I'm not an expert on that research other than  
14 reading it and understanding it for people I have  
15 to evaluate postsurgery.

16 BY MR. TURNER:

17 Q. And in patients that you've evaluated  
18 postsurgery, are you aware of literature that  
19 describes in geriatric patients that have undergone  
20 anesthesia in a procedure that even without a  
21 complication from the procedure there are residual  
22 cognitive deficits?

23 MR. KING: Objection to the form of the  
24 question, qualification of expertise.

25 THE WITNESS: Again, based on research



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THOMPSON 002649



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1 that I'm aware of and part of my career clearly, if  
2 you're going to throw age in here, you're adding  
3 another risk factor but -- and you said elderly.  
4 Clearly the indications are significant, but I'm  
5 even just talking about middle-aged people and  
6 ultimately length of time.

7 But anesthesia and cognitive  
8 interference due to surgical procedures or even  
9 being in the hospital is well-documented in the  
10 elderly.

11 BY MR. TURNER:

12 Q. And even in a small percentage of the  
13 population without the additional risk factor of  
14 age, you still will see cognitive deficits as a  
15 result of anesthesia even when there was no  
16 complications as a result of the surgical  
17 procedure?

18 A. In a small percentage --

19 MR. KING: Excuse me.

20 THE WITNESS: I'm sorry.

21 MR. KING: Objection as to the form of  
22 the question, qualification of expertise.

23 THE WITNESS: Again, yes, there can be  
24 a small percentage of people who have cognitive  
25 complaints following protracted anesthesia.



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THOMPSON 002650

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1 BY MR. TURNER:

2 Q. And those cognitive complaints of  
3 cognitive dysfunction would be permanent?

4 MR. KING: Objection to the form of the  
5 question, qualification of expertise.

6 THE WITNESS: In my evaluation of such  
7 patients, the deficits have been permanent, and the  
8 research literature also suggests that those  
9 deficits are permanent.

10 BY MR. TURNER:

11 Q. And you have actually treated patients  
12 that had cerebral air emboli?

13 A. I have. But more often it's been  
14 termed as hypoxia where there's been a lack of  
15 respiratory failure incident more often than an air  
16 emboli. But I definitely have seen air emboli too  
17 where there was no recording of respiratory  
18 failure, that there was just the hypothesized air  
19 emboli because respiratory failure becomes an  
20 event.

21 Q. Okay. And I know you were asked two  
22 pulmonologists have not included, as Mr. Mann  
23 stated, the hypoxia as a theory. However, if I  
24 give you the following hypo, I would like you to  
25 see -- or to give your opinion on it:



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THOMPSON 002651

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1           That Mr. Casey had anesthesia provided  
2           through the rigid bronch to the tip of it during  
3           the procedure; that the emergents occurred  
4           approximately at 1358 military time of the rigid  
5           bronch with the anesthesia; and that he was then  
6           placed on a mask to breath spontaneously  
7           thereafter, sent to the PAC unit and arrived at  
8           1429 -- 1419 in the PAC unit; and that he was on a  
9           mask breathing spontaneously for six minutes before  
10          he was reintubated endotracheally at 1425 p.m.  
11          military time. Do you understand my hypo --

12           A.    I do.

13           Q.    -- in that situation? If Mr. Casey was  
14           not getting enough oxygenation at the cellular  
15           level, in your experience in diagnosing patients  
16           through the neuropsychological testing battery of  
17           tests, hypoxia is a potential concern in that hypo,  
18           is it not?

19           MR. KING: Objection to the form of the  
20           question --

21           MR. GUNN: Object to the form of the  
22           question.

23           MR. KING: -- qualification of  
24           expertise.

25           THE WITNESS: Yes, when you have events



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1 like that, hypoxia is a concern. Obviously for the  
2 neuropsychologist, if there's a persistence of  
3 complaints and a concern about cognitive  
4 impairment, then we're asked to get involved. But  
5 for me it's an event. Again, I will defer to the  
6 experts about the characteristics of the event and  
7 their professional opinions and expertise.

8 But for neuropsychologists, we have an  
9 event, the person's not functioning as well, we are  
10 asked to get involved to assess the brain behavior  
11 functioning and generally assess what the deficits  
12 are and to make an opinion whether it might be  
13 consistent with that type of mechanism.

14 BY MR. TURNER:

15 Q. And as a neuropsychologist, you've  
16 performed -- or administered the WAIS test --

17 A. I do.

18 Q. -- WAIS-III on two different dates; is  
19 that right?

20 A. The WAIS-III was given all on one date.  
21 Obviously he was given the WAIS-III by Dr. Grace  
22 also.

23 Q. Okay. And that was in June of 2005?

24 A. Dr. Grace did do his evaluation in June  
25 of 2005.



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THOMPSON 002653

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1 Q. And you've read Dr. Milton Jay's  
2 deposition, correct?

3 A. I did.

4 Q. And if I'm not mistaken, he is a -- he  
5 has an -- instead of a Ph.D. in neuropsychology, he  
6 has an educational doctorate, correct?

7 A. That is correct.

8 Q. One of the points that I believe he  
9 makes is that your testing and Dr. Grace's testing  
10 are inconsistent and that the data is equivocal.  
11 Do you recall that?

12 A. Yes, I do.

13 Q. Could you elaborate on what your  
14 opinion is on Dr. Milton Jay's critique of your  
15 report of your testing?

16 A. Well, Dr. Jay focuses on how some  
17 subtests of the WAIS-III, a few got better and some  
18 got worse. And when I reviewed that, I was aware  
19 of that.

20 The critique is that it's basically,  
21 one, IQ subtests are not the most sensitive  
22 assessment for brain behavior changes to start off  
23 with. Two, Dr. Jay made a comment that there  
24 should be a practice effect, which is absolutely a  
25 false statement.



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THOMPSON 002654

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1           There's a practice effect always within  
2     three months of any type of injured person,  
3     particularly an injured person of the milder  
4     nature. Picture completion, which got better,  
5     clearly has a practice effect because you have this  
6     series of pictures, you try to find the missing  
7     part. Three months later you've seen that. You're  
8     already ahead of the game. You've got -- and now  
9     you've got to figure out the ones you didn't get.

10           The things that went down, some of them  
11     were processing speed. Processing speed can go  
12     down based on factors that have nothing to do, I  
13     agree, with a neurological injury such as fatigue.

14           And, in essence, to indicate -- the  
15     biggest fallacy in this is basically both him  
16     and -- I think his name is Burger --

17           Q.     Mercer.

18           A.     Mercer, excuse me, basically tried to  
19     argue that after a neurological injury you have an  
20     acute effect and then you should get better, and  
21     they're right. But actually the testing done by  
22     Mr. Casey was done on June of 2005, and my testing  
23     is three months later. And Mr. -- this incident  
24     occurred in May and June of 2004. That argument  
25     makes no sense. He's already plateaued with regard



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THOMPSON 002655

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1 to brain recovery, so that argument makes no sense  
2 as it implies neurological causal factor because  
3 that would apply with like a head injury.

4 If I see you in a -- after a traumatic  
5 brain injury, if you don't die, you will get  
6 better. And if I measure you at two months or  
7 three months out, which is what I recommend to  
8 attorneys, and then I measure you at 13 months out,  
9 you must be better. And if you're not better, it's  
10 not neurological. Now, that's the argument.

11 So to throw that type of argument in  
12 now when he's already a year out from not a  
13 traumatic brain injury a much more subtle injury  
14 that would have a faster recovery period, it loses  
15 its basis. There can be variability on a given day  
16 for a lot of reasons, and the variability, quite  
17 frankly, was not that significant as he made it out  
18 to.

19 Plus the neuropsychological testing is  
20 a much better measure for the brain functioning.  
21 So I just didn't feel like it held any credible or  
22 empirical basis for saying that this is not  
23 neurological for those four arguments I just told  
24 you.

25 My point to you would -- if we did



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THOMPSON 002656

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1 Mr. Casey two weeks after he had this incident and  
2 then a year later he was worse, then I would tell  
3 you that does not make neurological sense. But  
4 he's a year out before he gets the first  
5 measurement, so it just doesn't hold.

6 Q. And it's your opinion that if testing  
7 had been done earlier on, say, immediately after he  
8 was released from the hospital, perhaps, at the  
9 first office visit with Dr. Boscia on June 8th of  
10 2004 that it would -- we would be in a better  
11 position to evaluate?

12 A. Yes, we would. And I do give some  
13 credibility to Dr. Grace who has been involved with  
14 this man over time and, therefore, I think has a  
15 unique way of having more credible data about  
16 the -- where he's at and persistence of some  
17 problems. So he's seen him many times. And the  
18 attention, concentration repetitively shown itself  
19 in those other deficits.

20 But my point is, yeah, there's real no  
21 aspect of measurement of his brain until my  
22 evaluation and a little bit by Dr. Grace having  
23 done an IQ test. And I say a little bit. I mean  
24 that.

25 Q. With a mild injury such as one from



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1 cerebral micro air emboli, in your experience, it's  
2 possible that it would not show up on an MRI scan  
3 because it's such a microscopic level that it's  
4 undetectable by that type of scan --

5 MR. KING: Objection to the form of the  
6 question, qualification of expertise.

7 MR. GUNN: I'll join in that objection.

8 BY MR. TURNER:

9 Q. And I'll rephrase the question.

10 A. Sure.

11 Q. With an MRI, that cerebral micro air  
12 embolism often does not show up on the MRI scan  
13 even though there is damage?

14 MR. KING: Objection to the form of the  
15 question, qualification of expertise.

16 BY MR. TURNER:

17 Q. You may answer, Doctor.

18 A. My understanding of neuroradiographic  
19 studies, MRIs and CAT scan and even positron  
20 emission tomography, the resolution of the MRIs and  
21 CT scans often cannot pick up injury to the brain  
22 that's subtle, mild, involves accidental shearing  
23 and particularly hypoxic or even toxic effects.

24 When it does, we're not arguing about  
25 damage because that means the damage is much more



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THOMPSON 002658

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1 severe and the person often will be compromised  
2 motorically. I was just pointed out by one of the  
3 doctors here, more of a palsy effect. I'm just  
4 telling you that.

5 So that's where it is. That's my  
6 understanding. I certainly agree with counsel. I  
7 don't read them, and I am not an expert.

8 Q. And another issue was the Symptom  
9 Validity test. You administered that to Mr. Casey,  
10 didn't you?

11 A. I did.

12 Q. Okay. And Dr. Milton Jay qualifies 45  
13 on the TOMM test as normal range of effort. Could  
14 you comment on the use of qualification terms such  
15 as normal or abnormal range of effort?

16 A. Yes. Well, I can comment on the  
17 validity assessment in general. Symptom Validity  
18 tests like the test of memory malingering and the  
19 word memory test are designed -- they're generally  
20 procedures that you can get 50 percent correct if  
21 you're guessing. To be a malingerer, you have to  
22 beat 50 percent in the wrong direction. That's  
23 malingering.

24 So on a TOMM, for example, on Trial 2  
25 if you got 18 out of 50 correct, we've got a



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THOMPSON 002659

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1 problem with you; and we think you're consciously  
2 falsifying, meaning you know the right answer and  
3 you're telling us the wrong. 25 out of 50 might be  
4 somebody absolutely not trying or giving us  
5 insufficient effort.

6 The second trial of the TOMM we like  
7 you -- to see your ante up to 45 out of 50 correct.  
8 It's just a cut score. To say 44 is less effort  
9 than 45 is absolutely inaccurate, and what -- if he  
10 read the TOMM manual, when we get a 45 or 40, we  
11 give the retention trial because research clearly  
12 indicates that if these people are insufficient  
13 effort or somehow falsifying, they will always go  
14 down on a retention trial. But it takes 15 minutes  
15 later. It looks like even more of a memory.

16 And so they're trying to fake a memory  
17 problem. They say time's gone by and actually he  
18 got better. There is nothing wrong with his TOMM.  
19 His TOMM indicates adequate effort. It can't be  
20 quantified.

21 Also the word memory test, basically  
22 they cut off scores 82.5. Delayed recall's the  
23 best trial. He goes 90, 85, 85. It can't be  
24 quantified. That's adequate effort, even though I  
25 would suggest, as I did, this guy had some fatigue



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**THOMPSON 002660**

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1 and other issues.

2 The other problem is nobody relies  
3 totally on Symptom Validity tests. If you're going  
4 to come in and falsify and give me poor effort, why  
5 isn't he poor -- doing poorly on memory testing?  
6 He's complaining of forgetfulness. Most lay people  
7 don't understand that, yeah, he is forgetting  
8 because he is not processing. His problem is from  
9 the keyboard to the hard disk. His hard disk is  
10 fine. And we would expect his hard disk to be  
11 injured by this subcortical, potential insult. We  
12 would expect his frontal executive area to be hurt,  
13 and that's where it's a process. And so he scores  
14 poorly invariably on attention, concentration, and  
15 some immediate learning. He shows no evidence of  
16 rapid forgetting.

17 When a client comes in and is  
18 falsifying, giving us poor effort, they tend to do  
19 kind of poorly across the board. They're not  
20 sophisticated enough to understand these tests and  
21 what they're measuring or not measuring.

22 So my point to you is generally when I  
23 have people who are doing poorly on the TOMM, I  
24 have test results that are -- don't make sense  
25 either and are inconsistent with any known



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1 neurological injury. That's not the case. And so  
2 nobody would ever assess validity that way.

3 The problem hanging here is that the  
4 validity scales are fine. Indices embedded within  
5 the battery of neuropsychological tests were fine.  
6 We observed in the good effort. And he does fine  
7 on many, many, many, many things right where he  
8 should. And he has a cluster of deficits in the  
9 frontal executive area that would be consistent  
10 with subcortical injury and/or, as pointed without  
11 by counsel, yes, the pain and fatigue and  
12 depression can be certainly a part of that and can  
13 cause that too.

14 So my point is there's no doubt that  
15 this is a valid assessment with a man giving good  
16 effort in the context of some fatigue and some  
17 dysphoria. But nobody's going to question his  
18 effort.

19 Q. And when you said executive area, are  
20 you referring to executive function?

21 A. Executive function, frontal lobe.

22 Q. All right. And in your experience as a  
23 neuropsychologist, executive function is  
24 associated -- or loss of executive function is  
25 associated with air emboli?



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THOMPSON 002662

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1           A.    They can compromise in subcortical  
2   regions in general.   The reason why we say  
3   subcortical is oxygen emboli tend to be most  
4   affecting where you have more arteries and blood  
5   feed.   The white matter of the brain is much more  
6   fed by arteries and -- and vessels.   And so when  
7   you have insufficient oxygen, even toxic injuries  
8   like carbon monoxide, they -- they injure from down  
9   here more so.   It happens in microscopic ischemia  
10   in late age.   You tend to lose this.   It has a very  
11   different effect on memory testing than you see  
12   when you're hurt from the cortical down or you're  
13   massively injured.

14                So my point is that is very subtle,  
15   very difficult.   No layperson would know how to do  
16   it.   And that's the type of injury we see.   So it  
17   is, again, consistent.   Albeit, again, the other  
18   factors also tend to look like subcortical injury.

19           Q.    And if you had greater damage to the  
20   subcortical region, you would expect more -- an  
21   increased motor and sensory damage than what we're  
22   seeing in Mr. Casey, correct?

23           A.    Yes.   If you have severe injury to  
24   subcortical, you're -- you're going to look -- your  
25   motor function can be compromised.   Parkinson's is



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1 a subcortical. Many people with Parkinson's are  
2 still good cognitively, but they've got pinwheeling  
3 and shuffling and all kinds of problems. That's  
4 where a lot of those sensory motor areas are.

5 Q. And so in Mr. Casey's case, in your  
6 opinion, it doesn't have to be so severe that he  
7 has hemiparalysis or symptoms consistent with  
8 Parkinson's disease for him to have cognitive  
9 deficits that tie back to this surgical procedure  
10 on 6/3/2004?

11 A. That is my opinion, but that's -- and  
12 I -- I would agree with that. And, again, as was  
13 pointed out by Dr. Fogarty, you know, it's  
14 fortunate he doesn't have any gross motor deficit.  
15 If he had had a more significant injury, he would  
16 have more gross motor deficit, if it offended that  
17 area.

18 Q. Okay.

19 MR. TURNER: Give me a moment, Doctor.  
20 We can go off the record.

21 THE WITNESS: Sure.

22 (A recess transpired.)

23 MR. TURNER: If we can go back on the  
24 record. Dr. Waid, thank you for your time. That  
25 is all the questions I have for you today.



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1 MR. MANN: Does anybody want to talk  
2 about reading and signing? Do you want to read?  
3 THE WITNESS: I'll give you my card.  
4 (The deposition was concluded at 1:09  
5 p.m.)  
6  
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CERTIFICATE OF REPORTER

I, Jennifer H. Jesse, Registered Professional Reporter and Notary Public for the State of South Carolina at Large, do hereby certify that the foregoing transcript is a true, accurate, and complete record.

I further certify that I am neither related to nor counsel for any party to the cause pending or interested in the events thereof.

Witness my hand, I have hereunto affixed my official seal this 27th day of May, 2009 at Charleston, Charleston County, South Carolina.

151 *Jennifer Jesse*  
Jennifer H. Jesse

My Commission expires  
December 10, 2017



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CAPTION

The Deposition of L. RANDOLPH WAID, Ph.D., taken  
in the matter, on the date, and at the time and  
place set out on the title page hereof.

It was requested that the deposition be taken  
by the reporter and that same be reduced to  
typewritten form.

It was agreed by and between counsel and the  
parties that the Deponent will read and sign the  
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CERTIFICATE

STATE OF

COUNTY/CITY OF

Before me, this day, personally appeared,  
L. RANDOLPH WAID, Ph.D., who, being duly sworn, states that the  
foregoing transcript of his/her Deposition, taken in the  
matter, on the date, and at the time and place set out  
on the title page hereof, constitutes a true and accurate  
transcript of said deposition.

\_\_\_\_\_  
L. RANDOLPH WAID, Ph.D.

SUBSCRIBED and SWORN to before me this  
\_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_ in the  
jurisdiction aforesaid.

\_\_\_\_\_  
My Commission Expires Notary Public

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Case Caption: WILLIAM MARK CASEY

vs. GREGORY J. FELDMAN, M.D., et al.

Deponent: L. RANDOLPH WAID, Ph.D.

Deposition Date: MAY 15, 2009

To the Reporter:

I have read the entire transcript of my Deposition taken  
in the captioned matter or the same has been read to me.

I request that the following changes be entered upon the  
record for the reasons indicated. I have signed my name to  
the Errata Sheet and the appropriate Certificate and  
authorize you to attach both to the original transcript.

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19 Reason for change: \_\_\_\_\_

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21 SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

22 L. RANDOLPH WAID, Ph.D.

23 \_\_\_\_\_

24 \_\_\_\_\_

25 \_\_\_\_\_



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WORD INDEX  
WALD, L. R. PH.D

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CONDENSED TRANSCRIPT  
WAID, L.R. PH.D

THOMPSON 002715

**Condensed Transcript**

STATE OF SOUTH CAROLINA  
COURT OF COMMON PLEAS  
COUNTY OF SPARTANBURG

WILLIAM MARK CASEY,

Plaintiff,

vs.

CASE NO. 2006-CP-42-1728

GREGORY J. FELDMAN, M.D., JOSEPH A.  
BOSCIA, III, M.D., UPSTATE LUNG and  
CRITICAL CARE SPECIALISTS, P.C., and  
DEVENDRA SHANTHA, M.D.,

Defendants.

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DEPOSITION OF

L. RANDOLPH WAID, Ph.D.

May 15, 2009
10:20 a.m.

Offices of L. Randolph Waid, Ph.D.
1459 Stuart Engals Blvd.
Suite 204-A
Mt. Pleasant, South Carolina

JENNIFER JESSE, Court Reporter



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1 STATE OF SOUTH CAROLINA COURT OF COMMON PLEAS COUNTY OF SPARTANBURG WILLIAM MARK CASSY, Plaintiff, vs. CASE NO. 2006-CP-42-1728 GREGORY J. FELDMAN, M.D., JOSEPH A. BOSCIA, III, M.D., UPSTATE LUNG and CRITICAL CARE SPECIALISTS, P.C., and DEVENDRA SHANTHA, M.D., Defendants. DEPOSITION OF: L. RANDOLPH WAID, Ph.D. DATE: May 15, 2009 TIME: 10:20 a.m. LOCATION: Offices of L. Randolph Waid, Ph.D. 1459 Stuart Engals Blvd. Suite 204-A Mt. Pleasant, SC TAKEN BY: Counsel for the Defendant REPORTED BY: JENNIFER JESSE, Court Reporter	3 1 APPEARANCES OF COUNSEL (CONTINUED): 2 ATTORNEY FOR THE DEFENDANT 3 DEVENDRA SHANTHA, M.D.: 4 5 HOLCOMBE BOMAR, P.A. 6 BY: WILLIAM U. GUNN 7 100 Dunbar Street, Suite 200 8 Spartanburg, SC 29306 9 (864) 594-5301 10 bgunn@holcombebomar.com 11 12 (INDEX AT REAR OF TRANSCRIPT) 13 14 15 16 17 18 19 20 21 22 23 24 25
2 1 APPEARANCES OF COUNSEL: 2 ATTORNEYS FOR THE PLAINTIFF 3 WILLIAM MARK CASEY: 4 5 BURTS TURNER RHODES & THOMPSON 6 BY: NOEL TURNER, III 7 260 North Church Street 8 Spartanburg, SC 29306 9 (864) 585-8166 10 nturner@bellsouth.net 11 and 12 BURTS TURNER RHODES & THOMPSON 13 BY: RAY E. (CHUCK) THOMPSON, JR. 14 260 North Church Street 15 Spartanburg, SC 29306 16 (864) 585-8166 17 rwt2@bellsouth.net 18 19 ATTORNEYS FOR THE DEFENDANTS 20 GREGORY J. FELDMAN, M.D., JOSEPH A. 21 BOSCIA, III, M.D., UPSTATE LUNG and 22 CRITICAL CARE SPECIALISTS, P.C.: 23 24 F. MILTON MANN, JR., ESQ. 25 1069 Boiling Springs Road Spartanburg, SC 29303 (864) 208-0359 milton.mann@gmail.com and THE WARD LAW FIRM, P.A. BY: H. SPENCER KING 233 S. Pine Street Spartanburg, SC 29302 (864) 591-2364 sking@wardfirm.com (appearances continued on next page)	4 1 STIPULATION 2 It is stipulated by and among Counsel 3 that this deposition is being taken in accordance 4 with the South Carolina Rules of Civil Procedure, 5 Rule 30; that all objections as to Notice of this 6 deposition are hereby waived; that all objections 7 except as to form are reserved until the time of 8 trial; and that the deponent does not waive reading 9 and signing of this deposition. 10 * * * * * 11 L. RANDOLPH WAID, Ph.D., 12 being first duly sworn, testified as follows: 13 EXAMINATION 14 BY MR. MANN: 15 Q. Dr. Waid, good morning. My name is 16 Milton Mann. I'm an attorney here with Spencer 17 King. We together represent Dr. Feldman, 18 Dr. Boscia, Upstate Lung and Critical Specialists 19 regarding a malpractice case that has been brought 20 upon by Mr. William Mark Casey. And I think you 21 know something about this already, so I won't go 22 into a lot of details. 23 Mr. Gunn is here on behalf of 24 Dr. Shantha, and Mr. Thompson and Mr. Turner are 25 here on behalf of the plaintiff, Mr. Casey. Are



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5 1 you ready to proceed? 2 A. I am. 3 Q. And you've given depositions before? 4 A. I have. 5 Q. So I don't need to go in a lot of that 6 kind of silly background stuff? 7 A. You don't. 8 Q. All right. Do you have a copy of your 9 CV for us today? 10 A. I do in the other room, but sure. 11 Q. And we'll get that and look at it at 12 some point before we're finished. Can you give me 13 kind of a condensed version of your professional 14 training? 15 A. Basically I got a bachelor's degree in 16 psychology from Temple University. That was 17 awarded in 1974, a master's degree in psychology 18 from the University of Richmond. That was awarded 19 in 1977. 20 I went to the University of North 21 Texas, trained in the doctoral program of clinical 22 psychology. I came to the Medical University of 23 South Carolina for an internship here in '80/'81, 24 returned to Dallas, completed my studies. And that 25 was awarded, I believe -- Ph.D. in clinical	7 1 Casey secondary to concerns regarding a variety of 2 operative procedures that had taken place. I 3 understood that he had also been seen by Joseph 4 Grace, who had done some initial intellectual 5 testing. I was basically going to do more 6 comprehensive assessment of his brain behavior and 7 emotional functioning. 8 Q. And can you tell me who asked you to do 9 this? 10 A. This would be coming from counsel, the 11 office of Ken Anthony and Ray Thompson. 12 Q. All right. And when was that request 13 made to you? 14 A. That request would have been made 15 sometime in early August, I believe, is the 16 first -- this chart's been so photocopied, but in 17 August I -- and we established him, and within the 18 month we are able to get the person in and initiate 19 the evaluation. 20 Q. And the year we would be talking about 21 would be? 22 A. That would be 2005. 23 Q. Now, I see you referring to something. 24 Is that your report? 25 A. There is a report here and, again,
6 1 psychology -- in 1982. 2 And from there, basically I was working 3 in Dallas, and I returned to Charleston and joined 4 the faculty of the Medical University of South 5 Carolina in 1983. 6 Q. And is that the position you currently 7 hold? 8 A. I'm still on the faculty at the Medical 9 University of South Carolina in the Departments of 10 Neurology and Psychiatry. 11 Q. And do you have a private practice as 12 well? 13 A. Yes. In 1998, I stepped out of the 14 University Medical Associates practice plan, 15 continued my research and established my own 16 independent private office here in Mt. Pleasant. 17 Q. Okay. And that's what has provided 18 work, if you will, in this particular case that 19 we're here about today? 20 A. In this case, I did see him in my 21 private practice. Yes. 22 Q. What services were you asked to 23 provide? 24 A. Basically it was services to conduct a 25 neuropsychological evaluation of Mr. William Mark	8 1 obviously some -- my medical records. Yeah. 2 Q. All right. Do you mind if we mark your 3 actual report as Exhibit No. 1, please? 4 MR. MANN: Defense Exhibit 1. 5 (DFT. EXH. 1, Dr. Waid's report of 6 neuropsychological evaluation, was marked for 7 identification.) 8 BY MR. MANN: 9 Q. And Dr. Waid, now that she's marked 10 this for us, can you tell me what material you've 11 reviewed to help you assess Mr. Casey? 12 A. Basically at the time of conducting the 13 initial evaluation, I had extended medical records 14 from treatment provided upon admission to 15 Spartanburg Regional Medical Center, as well as 16 more extended medical records from Spartanburg 17 Regional Medical Center. 18 Those are primarily for procedures 19 conducted in July of, I believe -- I have the date 20 wrong, but I'll get the date better -- July of 21 2004. I think that's a typo obviously. 22 Treatment records from Upstate Lung and 23 Critical Care Specialists; treatment records from 24 Lung and Chest Medical Associates; treatment 25 records from Jeffrey Smith, M.D., of Piedmont



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9 1 Psychiatric Services; treatment records from Joseph 2 Grace, III, Ph.D.; treatment records from Eugene 3 Mironer, M-I-R-O-N-E-R, M.D.; educational records 4 regarding Mr. Casey from Spartanburg County School 5 District No. 6; and I believe that was the medical 6 records that I had at the time of conducting the 7 evaluation. 8 Q. Okay. And, again, can you kind of, in 9 layman's terms, describe what a neurological 10 examination is, what its purpose is, and what you 11 were trying to determine? 12 A. A neuropsychological involves 13 administering a battery of tests to assess 14 different functional behaviors mediated through 15 different functional areas of the brain. And in 16 essence, it's kind of a hierarchical assessment 17 where you start from the simplest abilities like 18 can the person see and hear and utilize touch. 19 And then you have a variety of tests 20 that get to the functional areas of the brain such 21 as attention, concentration, executive functioning, 22 anterior grade memory, the ability to learn and 23 retain and recall information, language 24 functioning, visual-spatial skills, motor 25 functioning, sensory-perceptual functioning, and	11 1 information. It's important. If you're looking at 2 a mechanism for injury, you have to understand the 3 physics of the injury, the acute neurological 4 sequelae, the radiographic studies and other 5 acute -- acute emergent stuff that would be 6 important in understanding whether or not there is 7 injury, cortical injury to the -- you know, injury 8 to the brain. 9 So in any case, you would want to look 10 at that and understand that and also understand the 11 course of the treatments that have been -- taken 12 place and so forth, as well as, obviously to the 13 extent that you can get them, the records that have 14 to do with premorbid or preinjury functioning, 15 educational records, when you're afforded the 16 opportunity to do that. 17 And so obviously what we're trying to 18 do is have an understanding of where the human 19 being was before the hypothesized injury, what was 20 the nature and what took place at the injury, what 21 were the acute care. And obviously often we're 22 measuring them sometime after this, so we want to 23 certainly know what's happened since the injury. 24 Q. And is this a complete list of the 25 records that you reviewed in preparation for
10 1 then obviously an area in which many abilities of 2 the brain come together in what we call higher 3 reasoning, problem solving, abstract thinking 4 skills. 5 So ultimately you give a battery of 6 tests and delineate and try to identify if all is 7 working well as what should be based on 8 understanding of the person's background. 9 Or if you have some deviation from 10 ideal functioning, that might be suggestive or 11 consistent with some type of injury. When there's 12 a more massive injury, it's not so much to diagnose 13 as to really say where a person's at. When you're 14 in milder forms of neuropsychological injury, 15 there's a variety of those which I would consider 16 this one too, it's to help delineate where a 17 deficit might be and the potential causal factor of 18 the deficits. 19 Q. And we listed some information that you 20 had reviewed in an effort to administer these tests 21 to Mr. Casey. What was the purpose of reviewing 22 that information? 23 A. Well obviously, particularly in cases 24 that involve other types of injuries which are more 25 typically seen, you try to get the acute	12 1 administering a battery of tests for Mr. Casey? 2 A. Basically would represent the records 3 that I reviewed as -- had -- had to do with the 4 August and September evaluation and subsequent 5 provision of a report. 6 Q. Okay. Do you also interview the person 7 that you're going to be treating? 8 A. Yes. We definitely interview the 9 person that we're going to be evaluating, and 10 classically that's how we usually start the 11 evaluation, is kind of interviewing them. 12 My format is generally to review their 13 understanding of the incident, their own thinking 14 about it, and then ultimately their complaints as 15 it relates to now, spontaneously provided. You 16 want to know where they're at, in terms of care. 17 And then I go through a structured 18 format that basically allows me to get the date I 19 think's relevant, such as medical history, 20 behavioral history, psychiatric history, family 21 history, and then a current assessment of their 22 complaints in a structured way to make sure I'm not 23 missing anything. 24 Obviously sometimes people don't 25 spontaneously report what you might find in that



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13 1 structured format. And then you also want to get 2 some sense of psychoeducational, vocational 3 background. 4 And so that would all take place 5 literally as the starting point for how we proceed. 6 Q. As we sit here today, do you have any 7 recollections of having those conversations or any 8 of these with Mr. Casey? 9 A. I have -- well, I have notes from that 10 conversation. I don't want to go as far as to say 11 I can remember the day and could I pick him out of 12 a grocery store right now. Some people do take a 13 picture of their clients for reasons of sometimes 14 these things don't happen until later on. But I 15 have -- I do have an awareness of doing it, and I 16 obviously have notes from the interview process. 17 Q. Okay. And do you have notes beyond 18 what is in your report? 19 A. I assume there are some notes beyond my 20 report. Generally I -- my report would certainly 21 incorporate those areas that I'm talking about and 22 summarize, at least, what I learned this time 23 through. 24 Q. How did you find Mr. Casey's 25 participation in the process?	15 1 assessment or sample of their brain. That wasn't 2 the case. But I'm certainly not arguing that 3 depression and anxiety aren't part of the clinical 4 picture here. 5 And we found his efforts to be good, 6 and we believed the -- our observations, along with 7 the test data, was a good fit and a good -- it made 8 sense, in terms of what kind of problems he was 9 having. 10 Q. So this testing occurred on two dates, 11 correct? 12 A. That is correct. 13 Q. Do you know how many hours were spent 14 on each day? 15 A. Basically the bulk would have been the 16 first day. That was a fairly extensive interview. 17 We probably split the testing in half. You're 18 really looking at about nine or ten hours 19 because -- we don't charge, but it usually takes 20 another two or three hours for them to complete 21 psychological tests, not really my time, but I also 22 don't let them take it home. 23 Q. Right. 24 A. And so there is some just sitting here 25 filling out forms kind of stuff. Otherwise, it
14 1 A. I found Mr. Casey's participation in 2 the process to be fine. Obviously we went ahead 3 and did this over two evaluative dates because I 4 did believe that there was some symptoms and 5 fatigue that probably we needed to account for and 6 not overstretch it into a single day. 7 Sometimes we're not afforded such when 8 people are referred for IMEs by insurance 9 companies. I believe eight hours of testing can be 10 aversive for most human beings. 11 And so we found him to present himself 12 well. We didn't see a lot of disruptive behavior 13 as it related to his participation in the 14 examination or his response to my inquiries. And I 15 think his affect was mildly depressed, but I didn't 16 think it highly compromised him. 17 And what I mean there is that 18 depression and pain certainly can interfere with 19 people as it relates to day to day. But often in 20 neuropsychological testing, we can determine how 21 big a player it is because depression manifests 22 really in poor effort, I don't know answers and 23 these kinds of depressive behaviors. 24 Often some people are so depressed that 25 we don't think it's possible to get a valid	16 1 does involve engagement with either me or one of my 2 master's level psychologists that administer a good 3 variety of the tests. 4 Q. And is that eight to nine hours for 5 both days? 6 A. Yeah. I would say a culmination of 7 easily ten hours of effort across two days. I 8 would tell you the first day was probably five or 9 six and the second, three or four. I could look 10 back on the computer and do that, but that would be 11 it. 12 Q. Okay. So that is between the two days? 13 A. That is between the two days. 14 Q. And did you have any observations of 15 him being unable to sit? 16 A. No. I think -- we did not have any 17 observations of him sitting or being excessively 18 fidgety or not being able to understand 19 instructions or any real behavioral abnormalities 20 that would draw into question the reliability of 21 his -- to meet the demands of testing. 22 Q. And if you would have noticed those 23 things, you would have noted it within your report? 24 A. We would have noted it, and also we -- 25 or my psychometricians would have noted it, and in



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17 1 different scenarios we -- I'm brought back in. And 2 that means anything that pops up as poor effort. 3 Unlike other places, we tend to confront poor 4 effort pretty quickly instead of wasting eight to 5 nine hours of testing. 6 Q. Now, describe to me -- and we'll -- 7 I'll come back to that. So you had your 8 conversations with Casey, interview with him, 9 administered a battery of tests. You reviewed the 10 records that we talked about before. Did you have 11 any other information that played a role in you 12 coming up with your report? 13 A. Other than what I've indicated so far, 14 no. You know, obviously there's been some 15 elaboration of things since that time through other 16 evaluations for depositions; but this was, in my 17 opinion, a report of a neuropsychological 18 evaluation of this man at this time. 19 Q. Did you have any telephone 20 conversations with any of his treating physicians? 21 A. I did not have any telephone 22 conversations. I relied on -- at this juncture, I 23 relied on the medical records that were available. 24 There had not been any previous neuropsychological 25 testing. And Dr. Grace, who did conduct some	19 1 choice with these kind of deficits to assist 2 people, but he wasn't using that. That had been 3 discontinued by September 10th. Otherwise, I 4 understood him to be on Lipitor; Tricor; Mobic; 5 Hydrocodone; Tramadol -- it's spelled wrong, but 6 we'll correct it later -- Cymbalta; and Ambien, 10 7 milligrams. 8 Q. And the drug that you were indicating 9 that had been discontinued was what? 10 A. Adderall XR, 20 milligrams, twice a 11 day, generally to assist with attention and focus. 12 Q. Okay. And do you know who told you 13 that the Adderall had been discontinued? 14 A. It's my understanding that 15 Mr. [sic] Smith would have told me as of September 16 10th that the Adderall had been discontinued. That 17 was my understanding, at least at that point. 18 Whether or not he returned to it or anything like 19 that, I wouldn't have known because that was what I 20 understood as of September 10th. 21 Q. Would you turn to page 3 of your report 22 for me? 23 A. Uh-huh. 24 Q. And about three or -- oh, well, let's 25 make this easy. The paragraph right above:
18 1 intellectual testing, had very thorough records and 2 treatment records, so I was comfortable with 3 proceeding that way. 4 Q. Now, let me ask you a question: Is it 5 important for the subject to give you accurate 6 information about their history? 7 A. Yeah. I think basically you want 8 credible information. At times other stuff pops 9 up, to the extent that it may spoil any process, 10 has to be determined on that new information. 11 There are times when people don't report things out 12 of embarrassment. There are times that people -- 13 who don't report things because they just -- it 14 doesn't come up. But, yeah, I prefer to be given 15 accurate information, and the more accurate, the 16 more useful it is. 17 Q. What about did he relate if he was on 18 any medications when he came for his testing? 19 A. The -- we did review, quite frankly, 20 not only the medications he was on, but a lot of 21 things that had been tried, which were also 22 consistent with the record. I had some interest in 23 the use of psychostimulant medications by 24 Dr. Smith; albeit, I have since reviewed his 25 language regarding that. But I think that's a good	20 1 Medical History -- 2 A. Yes, sir. 3 Q. -- can you read that for me? Is that 4 what you were looking at a second ago? 5 A. It was. 6 Q. All right. And that says that 7 Mr. Casey reported his current medicines? 8 A. That's what he was reporting that he 9 was currently using. Yes. 10 Q. Okay. Do you know whether or not he 11 was on Cymbalta? 12 A. No. I can only know at that point what 13 they're reporting to me or what I glean from the 14 interview. At times I get records; but often my 15 medical records, in most cases, are at least two or 16 three months, if not more, from when the doctors 17 might have changed it. So I try to get a report. 18 I was aware of some of the things that had been 19 tried and used from the records that were 20 available. But that's what I understood for him to 21 be on at that time. 22 Q. Okay. And if there were variations in 23 these medicines, could that have an impact on the 24 work that you were trying to do? 25 A. To the extent that a medication,



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21 1 including pain medications, end up compromising the 2 person, often observable, yes. But, again, the 3 issue here would be: If I start you on Xanax 4 today, I'm more likely to think it's going to 5 interfere than when you've been on it for four 6 months because you've really basically come to 7 tolerance and accepted it. So the interference in 8 cognitive capacity is there. 9 That would be true for hypertensive 10 medications, pain medications, opiates. You know, 11 antidepressant, once you're on it, it's not very 12 interfering from a cognitive capacity. One would 13 say if it improves your depression, it'd probably 14 allow your cognitive capacity. 15 So, again, certain medicines have more 16 possibility of doing that, but you generally can 17 observe it because sedation is generally the major 18 problem you're concerned with. 19 Q. And we'll get into this for a little 20 while. But let me -- let's try to keep my focus -- 21 or our focus, if we will, because I think this kind 22 of involves the bulk of my questions between the 23 Cymbalta and the Adderall. 24 Now, you had said starting something 25 like Cymbalta or being on it for a period of time	23 1 the players, à la, if the Cymbalta was working to 2 suppress them or give relief. 3 Q. What was your concern about Adderall? 4 A. I was just interested in it as a good 5 choice. Any time people are having what we call 6 deficits that might be affecting their attention 7 and executive functioning, the mechanism there is 8 twofold. 9 One is in mild head injury, mild 10 traumatic brain injury. Often it's only that area 11 that really is causing what people claim as 12 forgetfulness, but it's a processing deficit. When 13 you have mechanisms of air emboli or hypoxia, it's 14 the same thing. The subcortical fibers project to 15 the attentional executive frontal area, and so it's 16 a good thing to try and to help with attention and 17 focus and executive functioning. 18 Many of my mild traumatic brain 19 injuries go back to school, and they have to use it 20 because they have an acquired attention problem. 21 Q. And what exactly does that role do? 22 How does it affect a person? 23 A. It is a psychostimulant. It should 24 enhance your ability to focus and concentrate, so 25 it cognitively enhances. It will speed up the
22 1 you would find it to have less effect? 2 A. Yeah. I think all -- any time you 3 start a new medication, there's the potential for 4 it to have a disruptive side effect, even on 5 cognition. 6 So when I have somebody who's been on 7 Cymbalta for two or three months or something or 8 even shorter than that, I'm not sure it's going to 9 cause a lot of interference cognitively. 10 Q. In your understanding of Cymbalta, 11 should it be abruptly stopped? 12 A. It matters what dosage you're at. I 13 generally like to titrate people almost always. 14 But it's not like Effexor where that's an absolute 15 no-no. Cymbalta at 60 milligrams probably can be 16 abruptly stopped without a significant withdrawal 17 effect. 18 Q. Okay. But now if it was giving a 19 beneficial effect and then stopped, could that 20 interfere with your test -- 21 A. To the extent -- 22 Q. -- processes? 23 A. -- that the depression returned or 24 the -- with Cymbalta actually, even if there's more 25 pain, I would say the depression and pain would be	24 1 system a little bit. If you have ADD, it 2 paradoxically will not. But most of us will 3 feel -- will speed up, more awake. It can give you 4 a little more energy and fight off fatigue and 5 lethargy. So it is a medication that can assist 6 during its clinical course. 7 I will suggest that when you come off 8 of Adderall and you have a drag effect, you might 9 feel a little bit worse. So it's a medicine that 10 has to get in and out because you cannot sleep if 11 it stayed in there all of the time. 12 Q. Would you expect there to be some 13 interplay between Cymbalta and Adderall? 14 A. They're comfortably used together. We 15 have them in chronic pain patients quite a bit. I 16 wouldn't anticipate any interplay in a negative 17 sort of way. I mean, I would wonder, you know, 18 what are you targeting with one versus the other. 19 On the other hand, when we have people 20 who are -- have a huge draggy effect from the 21 Adderall or it tends to render them real depressed 22 when they come off of it, it's not unusual for us 23 to put them on an antidepressant to control that up 24 and down draggy feeling from the medicine and then 25 reintroduce the psychostimulant. So they're used



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25 1 together. 2 I wouldn't tell you Cymbalta 3 necessarily would be my choice because I think we 4 use Cymbalta more often when we think we have a 5 depressed person who also has pain. 6 Q. And is it your understanding that his 7 psychiatrist, Jeffrey Smith, was providing him with 8 these two medications? 9 A. It was my understanding at that time. 10 Yes. 11 Q. Okay. We'll come back to the actual 12 testing and stuff -- 13 A. Sure. 14 Q. -- but you seemed to indicate that you 15 received additional information postreport; is that 16 correct? 17 A. Yes. 18 Q. What have you been asked to review and 19 consider? 20 A. Well, basically before being asked to 21 review and consider, I -- my records were requested 22 to send up to Dr. Jay -- I think his name is Milton 23 Jay -- and also as a part of that, I got back a 24 report from Dr. Jay and Dr. Mercer, kind of a 25 courtesy after they did their medical review. And	27 1 What are the limitations of your opinions that 2 you're prepared to offer today? 3 A. Basically I'm here from a point of view 4 of conducting a neuropsychological evaluation, 5 coming to understand some deficits that were 6 present, the pattern of those deficits and their 7 consistency with the injuries and/or other 8 interfering effects, provision of some diagnoses 9 based on the DSM 4. 10 And essentially those would be my 11 opinions and their temporal relationship obviously 12 to the operative procedures and knowing well -- 13 having done many cases of operative procedures or 14 hypoxic injury or respiratory failure or even toxic 15 injuries, which would be in this ballpark, the 16 mechanism being there -- that I am not an expert on 17 that mechanism, whether it happened and essentially 18 the medical aspects of that mechanism. I'm not 19 going to have -- or whether standard of care was 20 followed. It's just not -- I have no opinions on 21 those and nor am I an expert on that. 22 Q. Can you tell me before we get a little 23 bit further into this -- but can you tell me the 24 difference between a neuropsychologist and a 25 neurologist?
26 1 then more recently, I received numerous depositions 2 and also a report of an MRI study of the brain. I 3 believe that's the extent of the new information I 4 got. 5 Q. Can you give me a list of the 6 depositions, please? 7 A. Sure. Brian Mercer; Jeffrey Smith; 8 Milton Jay; Francisco Gonda, G-O-N-D-A; Charles M. 9 Fogarty, F-O-G-A-R-T-Y; Michael Jantz, J-A-N-T-Z; 10 Joseph Glover Grace, III. I believe that's it. 11 Q. And now the big question, did you read 12 all of those? 13 A. Not all of them from word to word. I 14 concentrated more on relevant issues of the Smith 15 deposition, the Jay deposition, and the -- I 16 certainly read some of the other ones but -- and 17 the Brian Mercer deposition. 18 You know, I'm not an expert on the 19 procedures and the aspects of malpractice or what 20 should have happened and not happened. While I've 21 looked at it, I didn't find myself encoding that as 22 relevant because I have no opinions about that. 23 So I found those three to be more 24 relevant as they might relate to my opinions. 25 Q. And that's a good point you're making.	28 1 A. Well, I can make the difference pretty 2 easy. I would put it into a trio of practice. I 3 think the neurosurgeon is essentially a man -- a 4 physician, medical physician, and if -- when the 5 patient comes in -- and I'll make the analogy to a 6 car. The neurosurgeon opens up the hood of the car 7 and looks at the engine, which would be the brain 8 or the spine, and essentially sees if there's any 9 surgical intervention that can be offered that 10 needs to provide repair. 11 The neurologist often follows up after 12 the neurosurgeon due to the disruptive neurological 13 symptoms. He is also a medical doctor. He opens 14 up the hood of the engine and essentially can 15 measure it with like EEG or take a scan or pour in 16 some juices, medication, to try to improve or 17 affect or get symptomatic relief like from a 18 headache. 19 The neuropsychologist is a trained 20 clinical psychologist. Essentially our -- we deal 21 with their behavior. We get in the driver's seat 22 next to the driver and essentially see how they are 23 doing in life, how they are adjusting, particularly 24 to any deficits that might persist. And, quite 25 frankly, part of our work -- and I do a lot of



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29 1 this -- is to help people have an awareness for 2 those deficits to develop more effective 3 compensatory strategies and to move psychologically 4 to accepting the injury or the deficits they'll 5 have to live with. 6 And I point that out because part of 7 what I'm going to say today too is depression's 8 often part of injury process, particularly early 9 on. It is in chronic pain. And people ultimately 10 sometimes get better with depression further down 11 the road when they're able to realize this is the 12 new me and, yeah, these deficits are going to 13 persist. So my point would be then it should -- 14 helping them adjust and not be depressed. 15 So I would see the neuropsychologist to 16 be in at what clinical psychology is, the 17 behavioral level. And we deal with the impairments 18 and deficits and problems as they relate to the 19 neuropathology or the adjustment to the 20 neuropsychological changes. 21 Q. And to compare that to a psychiatrist? 22 A. A psychiatrist is medically trained, 23 involves work in mental illness, as ours does. 24 Often psychiatrists are much more -- well, many, 25 many psychiatrists, as the way the practice goes,	31 1 he definitely got treatment for those. 2 Q. Now, were you aware that the incident 3 that's being complained of, this potentially being 4 a medical malpractice event of June 3rd, 2004, 5 Mr. Casey had not seen Mr. [sic] Smith until after 6 that event? 7 A. I think, yeah, he hadn't seen 8 Mr. Smith until after that and -- but I was -- I 9 was aware from talking with him some that there was 10 some depression, anxiety issues. And I thought 11 they were chronic pain related, is really what I -- 12 the context of what I got. He did own seeing 13 Dr. Smith now, so that was my knowledge at that 14 point. 15 Q. Let's talk about what you gleaned from 16 these depositions that you reviewed. What did you 17 glean from Dr. Mercer's deposition? 18 A. Dr. Mercer's deposition as well as 19 Dr. Jay's, basically they acknowledged cognitive 20 difficulties. They do emphasize the pain and 21 depression, anxiety background. They essentially 22 identify their belief that the neuropsychological 23 testing and other factors do not provide compelling 24 evidence of a permanent neurological injury or 25 deficit.
30 1 primarily seem to be involved in providing the 2 pharmacological intervention. 3 And many, many psychiatrists don't 4 spend that much time with their people and don't 5 get involved with the behavioral, cognitive 6 strategies that change them, which would be more 7 therapy. I say that because there actually are 8 some psychiatrists who do therapy, but most don't. 9 Q. Looking back at your report, did it 10 report -- prior to the June 3rd, '04 incident, did 11 it report episodes of depression and anxiety? 12 A. Yes. My understanding is that pain, 13 depression, and anxiety were a part of the 14 background for this man. And he did not say 15 lifelong problems. I got more of a sense that a 16 lot of the depression and pain was associated with 17 the back pain and many of his medications prior to 18 that. 19 But obviously he had been seeing 20 Dr. Smith for a while, and he owned that. So I 21 certainly had a recent past before this of being 22 involved in intervention for depression, anxiety, 23 and pain, even though he didn't formally identify 24 that. He kind of named the psychiatrist, so I 25 think he sees that as related to those issues. But	32 1 Q. Brain injury? 2 A. Yes, that's -- would be fair to say. 3 Yeah. 4 Q. Okay. And you're aware that there's 5 been a retained neurologist also that has a very 6 similar opinion as well? 7 A. I believe so, but I'm not sure what 8 name. 9 Q. Kent Kistler. 10 A. Kent Kistler. No. I wouldn't tell you 11 I was aware of that. 12 Q. Okay. Did you review Jeffrey Smith's 13 deposition? 14 A. Yes. 15 Q. And what did you take from that? 16 A. Basically, you know, I don't want to be 17 critiquing about it, but -- 18 Q. Sure. 19 A. -- the bottom line is, I don't know, he 20 goes back and forth. And I thought he was -- as 21 much as he thinks my data is equivocal or not 22 equivocal or whatever he's saying, he misconstrues 23 cognitive disorder NOS as a diagnosis. 24 Q. Okay. 25 A. He basically seems to be fairly strong



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33 1 on that there isn't a neurologically-mediated 2 cognitive impairment but kind of unglues that a 3 little bit later on because he certainly did 4 acknowledge that these types of events can cause 5 subcortical injury or a form of hypoxia or a form 6 of an air emboli. So I saw him going back and 7 forth on that but seemingly more stronger on that. 8 I disagreed with quite a bit of his 9 comments as they related to neuropsychological 10 testing and basically felt that his real knowledge 11 of Mr. Casey was not particularly good. 12 Q. What about did you look at his 13 treatment contemporaneous with your testing? 14 A. Basically I was aware of some of that 15 treatment even when I saw him for the evaluation, 16 in terms of that. And so I had some sense of 17 Jeffrey Smith's treatment directed toward 18 depression, sleep disturbance, anxiety, 19 restlessness, irritability, low frustration and 20 tolerance and poor stress tolerance and use of 21 antidepressants and other medications. 22 Q. Let me ask you to get your copy of his 23 deposition, and I'd like to direct your attention 24 to a couple of things, if I may. 25 A. Sure.	35 1 and anxious. And he -- when he returned, he had 2 not started any Effexor XR. As indicated to him, 3 he was only taking the Adderall. 4 Q. Okay. And he was -- also discussed 5 about non -- not being compliant -- 6 A. Yeah. 7 Q. -- with his treatment plan? 8 A. Right, and making decisions to stop 9 something based on his thinking about it, that is 10 correct. 11 Q. And does this cause you any concern as 12 it relates to your testing? 13 A. No, not really. Actually if he was on 14 Adderall, which I don't think he was on Adderall as 15 of the September 10th date because I asked again, 16 it would improve his cognitive performance. If he 17 was more depressed and anxious again, our 18 observation of that was that we didn't see it as 19 interfering to the extent of what we saw in the 20 testing. 21 Don't get me wrong. I think people 22 should comply with their medicines and ultimately 23 not make decisions independent because sometimes 24 that can be dangerous. But, again, behaviorally, 25 we weren't concerned. We actually asked about the
34 1 Q. Let me ask you to review pages 22, 23, 2 24, and 25; and then we will talk about them a 3 little bit. I don't need you to read all of that 4 in the record. 5 A. You said through what? 20 what? 6 Q. Let's go through 25. 7 A. Okay. 8 Q. All right. Now, what appeared to be 9 going on with his medical treatment with Dr. Smith 10 during this time period, and this is 11 contemporaneous with the time period of your 12 testing; is that not correct? 13 A. Well, it's correct by one date at 14 least, the September, so it does seem like 15 something was going on in early September. So that 16 would be August 30th, September 10th, 2005. 17 And there was some issues about 18 Cymbalta and Adderall and discontinuing the 19 Adderall and continuing with the Cymbalta, but then 20 he discontinued the Cymbalta and, by the way, tried 21 Strattera. But the fact that he didn't respond to 22 Strattera or got sick on it, is not atypical. And 23 then he discontinued the Cymbalta because he didn't 24 think it was working. 25 And reportedly he was more depressed	36 1 Adderall because of its potential to facilitate his 2 performance. 3 Q. Are you aware of any discussions 4 regarding Mr. Casey potentially having a drug abuse 5 problem? 6 A. Yeah. I'm aware of some aspects of 7 that with opiate pain medicines and a potential for 8 him to have excessively used those, in terms of 9 pain, and even the recommendation by Mironer to, 10 you know, stay away from those because of the 11 potential for abuse. 12 Q. Did you have Dr. Mironer's deposition 13 provided to you? 14 A. I thought so. 15 Q. You did not list it, so I -- 16 A. It's not in this current pile of stuff. 17 This is -- the possibility of having set it to the 18 side, but it was not one I focused on very much. 19 And I do not see it here. Let me see. 20 MR. THOMPSON: Just for the record, I 21 don't think -- 22 MR. TURNER: And the reason is -- 23 MR. THOMPSON: -- received it, I don't 24 know, maybe Wednesday of this past week, Thursday, 25 something like that. And I don't think he has



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37 1 that. 2 THE WITNESS: Yeah. I wasn't aware of 3 reading it. 4 MR. TURNER: The reason I don't -- 5 MR. THOMPSON: It hadn't been provided 6 yet. 7 MR. MANN: All right. 8 MR. TURNER: The reason I don't 9 think -- you know, it was continued -- 10 MR. MANN: Yeah. 11 MR. TURNER: -- so we didn't send the 12 first -- 13 MR. MANN: And -- 14 MR. TURNER: I'm almost certain he does 15 not have it. 16 MR. MANN: And I'm not suggesting that 17 he should or shouldn't, but if he had it, I wanted 18 to make some references to it. 19 BY MR. MANN: 20 Q. Do you know what Dr. Mironer does for a 21 living or his area of expertise? 22 A. I think he is a pain management 23 specialist. 24 Q. He is a board certified pain management 25 specialist. He's also a board certified	39 1 it's abusive, yes. I wouldn't -- I wouldn't 2 dispute that. In the testing situation, we'll 3 often see it because it is impairing in a toxic 4 sort of way. So, again, it would have to do with 5 the dosage and tolerance levels and the interchange 6 with that. 7 In the long run, since we do a lot of 8 chronic pain, it is our goal to not have people on 9 opiates long term because most of us believe it 10 probably doesn't let your brain age very well. 11 Q. In approaching your assessment of 12 Mr. Casey, were you provided with Dr. Gonda's 13 records? You didn't list them. 14 A. Doctor who? 15 Q. Gonda. 16 A. No. I don't believe I had Dr. Gonda's 17 records, if he's -- unless they were talked about 18 within the records, I'd list it. I generally list 19 them that way. Sometimes other records will show 20 up, but I'm not aware that I did get his 21 deposition, I guess, or look it over. 22 Q. And, again, is this an area that you 23 deal with, substance abuse? 24 A. Yes. I have about 18 years of research 25 in research projects in substance abuse, mainly
38 1 anesthesiologist. 2 A. Right. 3 Q. He does not practice anesthesia. 4 A. Right. 5 Q. We had his deposition, and he basically 6 stated that, in his opinion, to a reasonable degree 7 of medical certainty, Mr. Casey had a substance 8 abuse problem. Would that cause you concern as it 9 relates to your testing? 10 A. It would cause concern. Opiates, I 11 think, can compromise cognitive impairment if 12 you're abusively using them. And, again, they -- 13 the impact that it might have is countered even by 14 the pain. I don't need to tell you pain's a 15 player. So, you know, if you're getting relief 16 from pain, you might get improved cognitive 17 capacity. It's actually from the opiates. 18 If you're looking at excessive usage 19 where it's sedating you and making you toxic -- but 20 this was not a toxic man from pain medicines on 21 that day or if he was on a high dosage or that. 22 So, again, it has to do with the toxic 23 effect of it. Do I think people who excessively 24 use it over time and you kind of like get them off 25 of it can appreciate some cognitive clearing when	40 1 alcohol, but other agents are well-known to us. 2 Q. Okay. And Mr. Casey did not tell you 3 or indicate that he had a substance abuse problem? 4 A. He did not indicate a substance abuse 5 problem, as it related to alcohol. I was aware he 6 used some pain pills, but I -- he didn't call 7 himself an abuser of pain medication. 8 MR. TURNER: And I just want to voice 9 an objection to form as to assuming facts that we 10 would contend are not in evidence that it's 11 conclusive that he has a substance abuse problem. 12 MR. MANN: And to go back to my 13 question, no, I said did Mr. Casey convey that to 14 you. That's a straight up question. Okay. 15 Dr. Waid answered no. 16 BY MR. MANN: 17 Q. Would you be able -- now let me back 18 up. If he did have a substance abuse problem, is 19 that something that would have changed your 20 approach as to how you administered your testing? 21 A. No. It wouldn't change the approach. 22 Certainly causal factors come into play, but I'm 23 not sure it would change even my opinions because I 24 saw pain -- or referred to it as somatic -- as one 25 of the causal factors.



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41 1 What I don't do like everybody else 2 does is I think there are multiple things on board 3 that are playing a part in the compromises he's 4 experiencing. So pain slash use of pain 5 medications would be one of them. 6 Q. As far as drug abuse goes, are you 7 familiar with indications of an individual patient 8 that may be abusing drugs? 9 A. When you say indications, yeah. 10 Q. Sure. 11 A. I think when I talk about the toxic 12 effect, the clouding of their cognitive capacities, 13 the excessive sedation, even drug-seeking 14 behaviors, yes. And so, you know, I would think 15 fairly, you know, sophisticated in that way because 16 I do a lot of work in chronic pain here in town, as 17 well as my substance abuse research history. 18 Q. Let me ask this: This is Bates stamped 19 543. It's from Dr. Gonda's records. 20 MR. MANN: Let me ask you to mark that 21 as Exhibit 2. 22 (DFT. EXH. 2, document Bates stamped 23 000543, was marked for identification.) 24 BY MR. MANN: 25 Q. Dr. Waid, let me ask you to look at	43 1 MR. MANN: Let me ask this to be marked 2 as Defendant's Exhibit No. 3. 3 (DFT. EXH. 3, document Bates stamped 4 000541, was marked for identification.) 5 MR. MANN: This is 541, gentlemen, also 6 again from Dr. Gonda's. 7 BY MR. MANN: 8 Q. Let me ask you to review this for me, 9 Dr. Waid. And, again, that's a note from 10 Dr. Waid's [sic], and let me ask you -- 11 MR. GUNN: Dr. Gonda or -- 12 MR. MANN: Oh, excuse me, Dr. Gonda. I 13 apologize. Thank you, Mr. Gunn. 14 BY MR. MANN: 15 Q. Can you read at least that whole first 16 paragraph of the office visit for me? 17 A. Sure. Forty-four-year-old white male 18 is in for follow up on his -- 19 Q. I apologize. You can read it to 20 yourself. 21 A. Oh, okay. 22 Q. I don't need you to read it into the 23 record. I'm sorry. 24 All right. And can you give us the 25 date of that office visit?
42 1 this, and it is my understanding that that is an 2 office note from Dr. Gonda's office. Could you 3 give us a date of that office visit? 4 A. 12/15/2003. 5 Q. So that's before the incident that 6 brings us together, correct? 7 A. That is correct. 8 Q. I highlighted an area that I'd like to 9 direct your attention to. 10 A. Sure. 11 Q. Could you review that for me and look 12 at it? 13 A. Sure. 14 Q. It seems to indicate that he ran out of 15 his medicines early? 16 A. That is correct. 17 Q. Okay. Would that cause you concern in 18 a patient? 19 A. Basically when you're treating pain 20 patients, you want them to sit with the medication. 21 Lortab, often one of those that does happen that 22 way because the patient ends up taking a few more 23 when he has high, intense pain and he runs out. 24 You generally want to get on top of that behavior. 25 Q. Okay.	44 1 A. August 27th, 2003. 2 Q. Again, before our incident at issue? 3 A. Yes, sir. 4 Q. What's going on with that office visit, 5 please? 6 A. That office visit is a man who's 7 continuing in pain and what I would call as 8 co-morbid depression. Ultimately he is, again, not 9 getting full relief on the prescribed medication. 10 He may be getting some Percocet from friends. And 11 Dr. Gonda is certainly discussing with him the 12 potential that adding an antidepressant to the 13 regimen might be of utility, both with depression 14 but also potentially with the pain. 15 Q. Okay. So we've got depression in '03? 16 A. Sure. 17 Q. We've got pain, of course, in '03? 18 A. Yes. 19 Q. And those seemed to be affecting his 20 quality of life? 21 A. Yes. 22 Q. We have buying prescription narcotics 23 from unapproved sources? 24 A. By report, yes. 25 Q. Okay. Would that also be a concern



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45 1 regarding a drug abuse aspect if you were treating 2 him, Dr. Waid? 3 A. If I was treating him, I would be doing 4 the same thing, which is to educate him regarding 5 the necessity to find a regimen that's going to 6 work with him. That doesn't mean excessive 7 opiates. 8 I think in today's world, even in 2003, 9 we have a bunch of neuropathic pain. One would 10 wonder why he's not already on those. Cymbalta has 11 a neuropathic pain component, and that's why it's 12 used so much in our chronic pain patients. 13 Neurontin was available then. One would wonder why 14 there's not already a shift to that. Lyrica, the 15 newest one on the market. And so ultimately the 16 strategy in this person should be going toward 17 those neuropathic pain pills because obviously his 18 pain is not being managed. 19 And pain -- chronic pain patients do 20 develop depression. As a matter of fact, about 21 40, 50 percent of them can even develop a major 22 depression, particularly during the stages in which 23 they're being treated and the surgery or the 24 hopeful pain freeness doesn't get achieved. 25 So he's going through a course of	47 1 OxyContin off the streets. That's an opiate 2 abuser. A chronic pain patient is looking for 3 relief. And sometimes this type of behavior has to 4 be ruled in, and you have to get to it. You have 5 to understand that what you're doing as a 6 physician's not working. 7 I get referred many of these patients 8 for psychological therapy treatment techniques to 9 help them cope with pain. So I don't -- I think 10 when you used the words substance abuser without a 11 patient who's come in with chronic pain that I have 12 some problems characterizing those the same. 13 But clearly excessive use of pain 14 medications in response to interfering pain needs 15 to be dealt with early on in the management of a 16 pain patient. So I would see him right now as 17 needing that type of intervention, including 18 neuropathic pain pills, including referral to a 19 psychologist who's going to see him more often and 20 get on top of the pain usage. 21 And one of the problems with doctors or 22 pain specialists is they want to see him once every 23 month or two months versus you get psychology 24 involved and you have more of a multi-treatment. 25 So this behavior is not unusual in chronic pain
46 1 events with his pain, as well as some stressors in 2 his family. 3 Q. Now, you read Dr. Mironer's report? 4 A. Yes, I believe. 5 Q. Okay. And he basically stated he was 6 not a proper candidate for opiates due to a lack of 7 the specific diagnosis as to what's causing his 8 pain? 9 A. Yeah. I'll accept that he said that. 10 Q. Okay. Now, turning, you know, 11 basically to the issue that we were talking about a 12 little. But so far we've seen running out of 13 medications early; is that correct? 14 A. Yes. 15 Q. We've seen obtaining medications from 16 friends? 17 A. By report, definitely. 18 Q. Would those both be consistent with 19 someone with a drug abuse problem? 20 A. They are consistent with somebody who's 21 experiencing pain and basically turning to sources 22 outside of himself to get pain medicine, which 23 certainly can be an abusive use of their pain. 24 I said that because ultimately I have 25 people without chronic pain who are buying	48 1 patients, and you've got to get it under control. 2 But I don't equate it to somebody on the streets 3 who is just looking to get OxyContin to have fun. 4 Q. But now you would agree with me 5 obtaining prescription narcotics from any source 6 but a physician and a pharmacy is an illegal 7 activity? 8 A. Definitely. I would agree with that. 9 Q. And if an illegal activity -- or excuse 10 me. It's hard for me to understand how illegal 11 activity involving drugs is not an abuse of drugs. 12 A. I think it's an abusive usage in 13 response to treating his pain. I'm just not 14 equating him to a street user who buys it. I mean, 15 we make people drop urine who you have on OxyContin 16 to make sure they are using it and not selling it. 17 Okay. So there is a whole area there that I'm 18 very -- I work with Southeastern Spine. We have 19 many strategies now for doing it, and it's 20 definitely part of the problem. 21 Q. Let's go back in time -- 22 MR. MANN: And we are going to mark 23 this one 4, please. This is Bates stamped 539, 24 gentlemen. 25 (DFT. EXH. 4, document Bates stamped



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49 1 000539, was marked for identification.) 2 BY MR. MANN: 3 Q. Let me ask you to look at basically the 4 first sentence or two of that office visit. Can 5 you give us the date of the office visit first? 6 A. It's August 13th, 2002. 7 Q. And the treating physician? 8 A. It's Dr. Gonda? 9 Q. Correct. 10 A. Yeah. 11 Q. And read us that first sentence or two, 12 please. 13 A. Mark is in today for followup of the 14 above problems and also for medicine refill. He's 15 actually early. He has run out of medication 16 because his wife was sneaking some of his 17 medicines. 18 Q. Is that, again, consistent with someone 19 that is having drug abuse problems? 20 A. Probably some marital problems too but, 21 yeah. Again, the veracity of his -- of how he's 22 running out of the medicine, you would want to be a 23 little cautious. And basically what we do is we 24 start to say it doesn't matter how it happens. 25 You've got to stay on top of it, and if you need to	51 1 Q. And we're going back in time. That is 2 which doctor's office note? 3 A. This, again, is Dr. Gonda's note. 4 Q. What's going on in that visit? 5 A. He's reporting in again. He reported 6 his Zanaflex helped with sleep. And he reported at 7 times he has increased the dosage of Ultram, and he 8 will take three pills, four times a day. Dr. Gonda 9 warned him that the maximum dosage should be 400 10 milligrams per day, and that he was taking more 11 than that. 12 Q. And is that a potential symptom of drug 13 abuse, taking medication noncompliantly? 14 A. Again, yeah. It's excessive use of the 15 drug in response to the pain and basically part of 16 a pattern of trying to manage his pain with 17 excessive usage of the pain medication. 18 Q. And, Dr. Waide, does that assume that 19 there is pain? 20 A. That does assume that there is chronic 21 pain. 22 Q. Okay. And I believe that Dr. Mironer 23 pointed out that an MRI ruled out any kind of a 24 mechanical pain that could be identified within the 25 MRI?
50 1 lock up your medicine, then do that. And I would 2 say the same for Adderall and Concerta, which 3 happens with our college students. Tough. You've 4 got to stay on top of it. Whether his wife took it 5 or not, I don't know. 6 Q. Would that be categorized as 7 potentially drug seeking or drug abuse or both? 8 A. Potentially it could be accurate. 9 Potentially it could be drug seeking. Ultimately 10 that's where you've got to get on it and make the 11 rules clear and get on top of this pattern of 12 behavior. 13 Q. And the date again was? 14 A. August 13th, 2002. 15 MR. MANN: Let's mark this as 5, 16 please. Gentlemen, this is 536, please. 17 (DFT. EXH. 5, document Bates stamped 18 000536, was marked for identification.) 19 BY MR. MANN: 20 Q. And please take a look at that for me. 21 A. Sure. 22 Q. And I think I highlighted an area. And 23 what's going on with -- first off, give me the 24 date, if you would, Doctor. 25 A. September 7th, 2001.	52 1 A. That's fine. If he did, maybe you can 2 seek his opinion about that. There are chronic 3 pain patients who sometimes the structural aspects 4 are not well-understood. And other times when 5 there's more pain than seemingly, the structural 6 aspect should indicate. But I'll leave it to them 7 about that. 8 MR. MANN: All right. Let's take a 9 five-minute break. 10 THE WITNESS: Sure. 11 (A recess transpired.) 12 BY MR. MANN: 13 Q. Dr. Waide, let me make sure I'm clear on 14 one thing. We've been looking at some of the 15 records prior to the incident? 16 A. That is correct. 17 Q. Okay. And you've used the term chronic 18 pain? 19 A. Well, at that juncture, yes. 20 Q. Okay. And the chronic pain that you're 21 referencing would deal with his back? 22 A. Basically Dr. Gonda says chronic low 23 back pain, so I gather that's what he's targeting. 24 Q. Well, we're not discussing anything, by 25 any stretch of the imagination, that has to do --



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53 1 during this discussion, we're not discussing 2 anything that has to do with the procedure 3 performed in '04 that brings us here? 4 A. Not in my opinion. 5 Q. Okay. Thank you. 6 MR. MANN: Let me ask this to be 7 marked. We're up to, what, 6, please? 8 THE COURT REPORTER: Yes. 9 MR. MANN: Thank you. 10 (DFT. EXH. 6, document Bates stamped 11 000535, was marked for identification.) 12 MR. MANN: Thank you, Jennifer, and 13 this is Bates stamped 535. 14 BY MR. MANN: 15 Q. And Dr. Waid, you can read as much or 16 as little of this as you like, but I would like to 17 direct your attention to the date of the office 18 visit, the doctor, and the area that I've 19 highlighted in yellow. And could you tell me those 20 things, please? 21 A. It's October 26, 2000, Dr. Gonda. 22 Q. Okay. And what's going on in the 23 yellow stuff? 24 A. Basically he still complains of pain 25 occurring on a daily basis. He did increase the	55 1 visit date? 2 A. Basically prior to that visit, he was 3 sitting on his deck talking to his sister, had been 4 working shifts and tired, little sleep, drank one 5 beer, a little cold medicine, and apparently had a 6 fainting episode of some type. 7 And the differential diagnosis was one 8 of true syncope versus seizure. And he -- 9 Dr. Gonda stated that he could make a case for 10 syncope based on a multitude of facts including 11 lack of sleep, drinking one beer, cold medicine and 12 a pain pill, though, thought that a seizure 13 disorder needed to be ruled out despite the fact 14 that he had no incontinence and was not postictal. 15 Q. Can such events have any effect on 16 cognitive ability? 17 A. Well, I think at the time. But if it 18 was a seizure and then he had had postictal, then 19 certainly repetitive seizures can certainly affect 20 cognitively to the extent that syncope does. Now, 21 I don't think it does unless you -- when you have 22 syncope, fall and hit your head. 23 Q. And I'll represent to you I've seen 24 nowhere in the record that he had other seizures. 25 A. Right. I wasn't aware of him having a
54 1 number of Lortab that he took out and ran out 2 early. 3 Q. So he ran out of meds a little bit 4 early? 5 A. That is correct. 6 MR. MANN: All right. Let's mark this 7 one as 7, please. 8 (DFT. EXH. 7, document Bates stamped 9 000527, was marked for identification.) 10 MR. MANN: Gentlemen, this is 527. 11 527, gentlemen. 12 BY MR. MANN: 13 Q. Let me ask you again to identify by 14 date and doctor whose office note and what date 15 that office visit is. 16 A. September 23rd, 1992. 17 Q. And please tell me what's in that 18 record -- or please read it first, and then we'll 19 talk about it, Dr. Waid. 20 A. Okay. 21 Q. Which date and doctor is that note 22 from? 23 A. September 23rd, 1992, Dr. Gonda. 24 Q. Okay. And what happened in -- what was 25 Mr. Casey relating to Dr. Gonda during that office	56 1 seizure problem. 2 Q. Would that have been a piece of 3 information that you would have liked to have known 4 about? 5 A. I wouldn't -- I asked specifically 6 about seizures, for sure. I -- other than that, 7 no. I asked for seizures. I don't know the 8 relevance of it. I actually think to the relevance 9 of the pain and use of pain medication to be more 10 relevant than a syncope episode in 1992 without any 11 serious after effects. 12 Q. Doctor, in this note, it says that he 13 took a pain pill that he did not know the name 14 of -- 15 A. Okay. 16 Q. -- correct? That seems to indicate to 17 me that it wasn't something prescribed to him? 18 A. Potentially. 19 Q. All right. Now, Doctor, let me 20 backtrack a little bit and ask you a couple of 21 questions about narcotic use. 22 A. Okay. 23 Q. Does narcotic use have the potential to 24 diminish Mr. Casey's health? 25 A. It has potential to diminish his



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57 1 health. Yes. 2 Q. Now, what about would it have any 3 effect on his cognitive ability? 4 A. Again, potentially if you get abusive 5 in your usage of opiates you can impact on your 6 cognitive ability. On the other hand, if we treat 7 you and get you off the narcotics and end an 8 abusive usage, you can have a clearing of your 9 mental status. So it's, again, certainly an agent 10 that can compromise your brain functioning, 11 particularly during toxic usage. 12 Q. Let me see if -- if looking at the 13 records that I provided you from Dr. Gonda's 14 records -- 15 A. Okay. 16 Q. -- would you agree with me that this 17 supports that on occasion Mr. Casey has been 18 noncompliant with his drug use? 19 A. I would say that on occasion he's been 20 noncompliant with the medications being provided by 21 Dr. Gonda. 22 Q. Okay. As it relates to drug abuse, 23 does this tell you any other potential information? 24 A. No. I don't believe it tells me 25 anything more than the fact that -- actually three	59 1 talking about from Dr. Gonda's records are 2 consistent with someone that has a substance abuse 3 problem? 4 A. They are consistent with a patient that 5 has chronic pain and is excessively using pain 6 medications not in a complied way; and in that way, 7 it's abusive. 8 Q. Thank you. And I believe that what 9 you're telling me is that you're not in a position 10 to state simply that Mr. Casey is abusing drugs? 11 A. In the context of the parameters, I 12 told you that's abuse. I just feel that that's a 13 different form of drug abuse and also can be some 14 problems with the actual management of the patient. 15 So I'm putting it on both levels. 16 You have to have good management of the 17 patient and that incorporates, at times, a 18 multidisciplinary team, rather than having somebody 19 keep on coming back for refills who is using more 20 than he's given. 21 So there's interaction between what's 22 going on in the care, as well as the patient. That 23 happens more. Now, if you've got somebody without 24 pain who's just getting off the streets, I think 25 that's a more classic substance abuser. The fault
58 1 or four things. It tells me basically is he wasn't 2 getting his pain under control; albeit, pain is 3 subjective. And he, at times, was using more pain 4 medication than the doctor prescribed. And 5 ultimately there's also some concern regarding why 6 there wasn't a shift in the treatment to adjust 7 that behavior and get better control of the pain 8 through agents and strategies that were available 9 at that time. 10 So I think at some point, when we 11 repetitively have this pattern and how we work 12 here, we're going to address this primarily by 13 moving toward use of non-narcotic or nonopiates or 14 figure out a regimen that works for this man at the 15 right dosage or consider even mechanical 16 approaches. 17 So I think there's always a need when a 18 chronic pain or a pain patient isn't getting the 19 relief they want. There has to be some alternation 20 in the strategies, even if it involves making sure 21 that they understand that you can get a limited 22 amount and they need to go on other agents that are 23 not addictive. 24 Q. Thank you. Would you agree with me, 25 though, that these incidences that we've been	60 1 can be in the patient, or the fault can be in the 2 program. 3 Q. And you would agree that none of the 4 doctors that had been sued in this case had been 5 providing the medications that we've been 6 discussing? 7 A. Yeah, I -- 8 MR. TURNER: Object to the form of the 9 question. 10 THE WITNESS: I would agree with that. 11 Yes. 12 BY MR. MANN: 13 Q. Okay. And, again, the -- let me see if 14 I can clean this up for Mr. Turner. We have been 15 discussing instances that were related from 16 Dr. Gonda's records, correct? 17 A. That is correct. 18 Q. And we were not discussing medications 19 that were provided by any of the doctors that are 20 defendants in this case? 21 A. That is my understanding, yes, sir. 22 Q. Thank you. Let me ask this to be 23 marked as Exhibit 8, please. 24 (DFT. EXH. 8, MRI report, was marked 25 for identification.)



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61 1 BY MR. MANN: 2 Q. Dr. Waid -- 3 MR. MANN: And this -- gentlemen, this 4 is the MRI report. This is the MRI report that's 5 been marked as Exhibit 8. 6 BY MR. MANN: 7 Q. Is that the same one you were 8 discussing earlier? 9 A. Yes. 10 Q. Can you please tell me what this 11 document purports to be? 12 A. This is a report of an MRI study of the 13 head without contrast. 14 Q. All right. And who is named in that 15 MRI report? 16 (The proceedings were interrupted.) 17 MR. KING: Hold on a second. 18 MR. MANN: Are you-all ready? 19 MR. THOMPSON: Yes. 20 MR. MANN: Okay. 21 BY MR. MANN: 22 Q. Who's name is on that report? 23 A. At the top I have Mark Johnson. 24 Q. Oh, okay. And what's the date of 25 birth?	63 1 MRI report on Mr. Casey? 2 MR. TURNER: That's correct. 3 MR. MANN: Okay. 4 BY MR. MANN: 5 Q. Dr. Waid, with the understanding that 6 we have a stipulation among the parties, that this 7 actually was an MRI obtained on Mr. Casey? 8 A. That seems to be the case. Yes, sir. 9 Q. Given that it's not in his name I, of 10 course, have some concerns about that. 11 A. Okay. 12 Q. All right. Have you undergone an MRI 13 before? 14 A. Not of my brain. 15 Q. Okay. Do you know how the procedure is 16 conducted? 17 A. No. But I'm sure I'm going to find out 18 this afternoon. 19 Q. And I hope it comes back equally as 20 clean -- 21 A. As clean as this? 22 Q. -- as positive of a report as this is. 23 A. Okay. 24 Q. All right. But let me ask you then: 25 Is this a piece of information that you would
62 1 A. The date of birth is [REDACTED], 2 1958. 3 Q. All right. And do you have an ID or 4 social security number. 5 A. ID was [REDACTED] 6 Q. Okay. What have you been told about 7 this report, please? 8 A. All I had was a copy that I received 9 the other day. I had you tell me something in our 10 crossing when you were down here getting medical 11 records about an MRI being done that wasn't done 12 under the name of Mr. Casey. But I recall you 13 telling me that, but I do have this MRI and the 14 disc that went with it. And this arrived the other 15 day. 16 Q. Okay. And not only is that consistent 17 with what I told you, this is not Mr. Casey's name, 18 correct? 19 A. That -- yes, sir. That seems to be the 20 case. 21 Q. And not his date of birth? 22 A. It doesn't jive with my date of birth. 23 I was wondering if I was in error. 24 MR. MANN: And it is my understanding 25 we have a stipulation, gentlemen, that this is an	64 1 consider respecting the subjects that you perform 2 testing on? 3 A. Yes, I would. I'm always willing to 4 look at neuroradiographic studies of the brain. 5 Sure. 6 Q. And are you qualified to read that 7 report and understanding what it's suggesting about 8 Mr. Casey? 9 A. I'm qualified to understand the report 10 from the radiologist who provided it indicating 11 that this MRI seemed -- that he couldn't find any 12 positive findings. It was negative for any acute 13 intracranial injury or other findings. 14 Q. Okay. In your interactions with 15 Mr. Casey, did he display an ability to remember 16 things? 17 A. Yes, he did. 18 Q. Remember things over periods of time? 19 A. He's not so compromised that he 20 wouldn't recall personal information and stuff that 21 he needs to recall. 22 Q. Based upon your observances of him, 23 would it be consistent in what you perceived to be 24 his capabilities of him remembering having an MRI? 25 A. I would think he would recall that



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65 1 event more likely than not. 2 Q. And if the event occurred in a town, 3 say, 90-plus miles away from where he lives, would 4 that be even more memorable to him? 5 A. I think he would be capable of 6 remembering the trip and going to get that done. 7 Yes. 8 Q. Would Mr. Casey have the capability of 9 providing a name other than his own? 10 A. I think he has the capability of 11 providing a name other than his own. 12 Q. Okay. So this MRI and the name and 13 date of birth is consistent with what you feel 14 Mr. Casey has the ability to remember and 15 information that he could provide and relate? 16 A. In my opinion, more likely than not, he 17 would remember this event and be able to provide 18 it. 19 Q. Okay. Now, if he testified 20 approximately four to five months later after 21 having the MRI done that he had never had an MRI 22 done, would that be problematic for you? 23 MR. TURNER: Object to the form. 24 MR. MANN: We'll play this along, but 25 objection noted.	67 1 Q. All right. I feel personally that 2 information was withheld by Mr. Casey when he was 3 seeking your assistance in evaluating him that 4 should have been provided to you. 5 MR. TURNER: Object to the form. 6 MR. MANN: That's fine. 7 BY MR. MANN: 8 Q. To include information from his 9 treating physician, information respecting the 10 drugs that he was taking, information regarding 11 prior indices of treatment for depression, 12 agitation, anger and other psychological problems 13 he experienced prior to the July -- or, excuse me, 14 the June 4th incident of 2004. 15 MR. TURNER: Object to the form. 16 MR. MANN: That's fine. 17 BY MR. MANN: 18 Q. Do you have a different impression as 19 to whether or not Mr. Casey was candid with you in 20 seeking an evaluation from you? 21 A. I believe Mr. Casey was candid, to the 22 extent of my review with him. I had some 23 understanding of chronic pain and depression being 24 on board and that he had been treated for it. I 25 did not have a report by him of a pattern of,
66 1 THE WITNESS: I would believe that he 2 would remember that event. 3 BY MR. MANN: 4 Q. Okay. So in other words -- and let me 5 make sure I'm tying this not only to your expertise 6 but to your understanding of Mr. Casey's condition. 7 So in five months after having this MRI performed 8 he gave depositional testimony that he had never 9 had an MRI performed, you believe he had the 10 capability of understanding and remembering and 11 knowing that that is not an accurate answer? 12 A. And it is self-based on my evaluation. 13 I believe he would have the capability to remember 14 that fairly unique event. 15 Q. Thank you. 16 MR. TURNER: I don't mean to interrupt 17 you. The same object to the form on that -- 18 MR. MANN: No problem. 19 MR. TURNER: -- as well. 20 BY MR. MANN: 21 Q. All right. Now, Dr. Waid, you know, 22 again, I just want to come back. And we can pull 23 out quite a bit more stuff, but I just want to kind 24 of cut to the chase, if we can, a little bit. 25 A. Sure.	68 1 perhaps, getting more pain medicine than he would 2 have utilized. Whether he had thought that was 3 pertinent or not, I would wonder. But otherwise, I 4 wasn't not informed of the previous chronic pain, 5 depression phenomena and treatment for that. 6 In terms of the medication review that 7 took place initially on August 30th, I believe it 8 was generally candid. Certainly there was some 9 ongoing issues about the Adderall. He wasn't able 10 to list the dosage of Cymbalta. As a matter of 11 fact, you know, in some regards, whether he was 12 continuing or not continuing on the Cymbalta, I may 13 not have been aware of, either by his report or my 14 own -- my registering of what was happening. 15 Otherwise, those medications seemed correct. 16 So I don't think he was consciously 17 trying to hide what medicines he was doing because 18 there was report of some changing of those 19 medicines as we saw him over the two days, albeit, 20 at least the Adderall. And, again, I may not put 21 the Cymbalta on him whether he reported it or not 22 reported it. I know I didn't know the dosage, so 23 there was some misinformation that might have been 24 on our part. I didn't see him as purposefully 25 doing that, contriving that.



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69 1 And, again, my issue about this: 2 essentially, other than this kind of data set that 3 you've provided and, of course, the MRI is not 4 pertinent to my involvement with him -- 5 Q. Right. 6 A. -- you know, I felt he was candid. And 7 I felt that even the difficulties in his marriage 8 and some of those have been talked about too. So I 9 wouldn't put him off as purposively misinforming 10 me. 11 And, again, I don't know that the pain 12 and medication thing is acknowledged, even in my 13 understanding as a potential causal factor for his 14 cognitive impairments. Again, just because I don't 15 want to isolate that as the only causal factor, the 16 depression too. And, again, I knew he had problems 17 with depression before, again, in the context of 18 his pain. 19 So I'm not sure I'm terribly 20 misinformed. It's not as detailed, but I'm not 21 sure it's changed anything that I -- that -- as it 22 relates to my neuropsychological evaluation of him. 23 Q. Doctor, what are you aware of his 24 hospital stay in May and June of 2004 that brings 25 us here together?	71 1 and hypoxia for me would be the potential for 2 those. The experts at some level want to argue 3 about whether that happened or air emboli. That's 4 fine. I would just tell you those are the things 5 that would concern me, and I'm not going to be an 6 expert at deciding which occurred. 7 Part, again, of saying we had this 8 incident and here are some deficits that might be 9 consistent with it, but I can't be an expert on the 10 mechanism. 11 Q. And I appreciate that. But -- and 12 you're very much answering my question as to what 13 I'm asking you about. I think we have a different 14 interpretation of my question. 15 A. Okay. 16 Q. As a neuropsychologist, would you want 17 to know whether or not he had an incident of 18 hypoxia surrounding this event? 19 A. A lack of oxygen to the brain. 20 Q. Correct. 21 A. Basically measured by how? 22 Q. Do what, sir? 23 A. How do you want to measure that? How 24 are you defining that incident of hypoxia? 25 Q. What I'm telling you is there's a
70 1 A. Well, again, my understanding of that 2 was a readmission of him in June 3rd of 2004 to 3 undergo additional procedure by Dr. Feldman and 4 that -- I depicted for you my understanding of it, 5 the bronchoscopy and some of the laser and 6 following the procedure some considerable 7 difficulties in pneumothorax on the left side and 8 necessitation for placement of chest tubes, 9 intubation and mechanical ventilation. 10 Q. When those events happened, the 11 pneumothorax, you understand that he was still in 12 Spartanburg Regional Medical Center? 13 A. I believe that's correct. Yes. 14 Q. Okay. I will represent that it is. 15 A. Sure. 16 Q. Do you know whether or not there was 17 ever a neurological consult ordered after the event 18 that gave him the -- 19 A. As best I recall, there was not a 20 neurological consultation requested in the hospital 21 setting. 22 Q. I think it has been consistently 23 testified that there was not an incident of 24 hypoxia. 25 A. The mechanism of emboli, air emboli,	72 1 complete absence of a report of hypoxia? 2 A. I didn't see that language in there. I 3 didn't see oxygen saturations taken and a few other 4 things that might have been useful. That is 5 correct. 6 Q. Okay. So you would agree that there is 7 not proof of hypoxia in the records that you've 8 reviewed? 9 A. In the records I reviewed, I did not 10 see proof. I saw the mechanisms of -- that we 11 explained about: pneumothorax, respiratory failure 12 issues, a need for ventilation and intubation and 13 chest tubes. Those are clearly the type of 14 procedures that go down where hypoxia can occur. 15 But I did not see any proven evidence of oxygen 16 desaturation, which is sometimes measured or can be 17 measured. 18 Q. Okay. 19 A. So there's not any. But I would also 20 say that's often the case -- 21 Q. Right. 22 A. -- in these types of cases that end up 23 with profound impairments when there are no legal 24 issues. So air emboli, in particular, doesn't 25 usually result in code for neurology and so forth



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73 1 too. So I'm just telling you the mechanisms of 2 needing ventilation, pneumothorax, respiratory 3 insufficiency happened, but I did not see anything 4 more than that. 5 Q. Let me talk about -- you understand 6 Dr. Jantz has been retained by Mr. Casey's counsel? 7 A. I do understand that, yes. 8 Q. And Dr. Jantz has testified that there 9 was not a hypoxia event. 10 A. Okay. 11 Q. It's my understanding Dr. Fogarty has 12 also testified there was not a hypoxia event. 13 A. Okay. 14 Q. All right. Also both have testified 15 there was not an anoxia event. 16 A. Sure. Well, okay. If there's not 17 hypoxia, there's not anoxia. Yeah. 18 Q. Okay. And is that information that you 19 would want to have in consideration as to his 20 cognitive abilities? 21 A. Well, yes. I mean, in terms of causal 22 factors and their relation to the surgical 23 procedure, that's useful information. Again, 24 that's a mechanism, and I'll let them argue about a 25 mechanism.	75 1 temporal relationship to a change in his 2 functioning, both cognitively. But again, I didn't 3 see him two months out, eight months out. I saw 4 him about year -- a little bit over a year out. So 5 I have no track until that point, so I have to 6 relate back to those and the differing opinions 7 they have. 8 Q. Right. And you didn't see him three 9 months before, four months before either, did you? 10 A. No, I did not. 11 Q. All right. And you didn't see him when 12 he was being noncompliant in his drug use with 13 Dr. Gonda, correct? 14 A. Did not know him at that time. 15 Q. Correct. And you didn't see him when 16 he was suffering from episodes of depression and 17 anger prior to the June 4 incident? 18 A. That is correct. I did not. 19 Q. Okay. So how are you basing a temporal 20 analysis when you didn't have -- strike that. 21 Okay. How are you making a temporal differential 22 between prior to June of '04 and after June of '04 23 as this occurred? 24 A. Basically you have an event that takes 25 place and then ultimately you have the acute
74 1 Q. And, again, maybe you're telling me in 2 straight up code talk. What I need to ask next: 3 You're not willing to opine as to what may or may 4 not have caused a cognitive deficit in Mr. Casey? 5 A. Basically I'm on the opinion that we 6 have a temporal relationship between this situation 7 that arose in the emergency room. But I'm not 8 going to break it down more mechanically than that 9 because some doctors have talked about the 10 possibility of coming out of a surgical procedure 11 with cognitive loss. I have dealt with that, but 12 my relationship would mainly be temporal. I'm not 13 an expert on whether that mechanism occurred or 14 not. 15 Q. Okay. And by temporal, are you saying 16 in time? 17 A. Yes. 18 Q. Okay. So you're saying that if there 19 is a -- or excuse me. In your opinion, there is a 20 cognitive deficit, correct? 21 A. Yes. I believe that he has cognitive 22 deficits. 23 Q. And you feel that it arises in time 24 around the incident of '04? 25 A. Yes. That is my belief that there is a	76 1 records that indicate a change in a person and then 2 you have the subsequent providers and people who 3 get involved with him who also talk about those 4 changes, some pro; some con, as they relate to him. 5 So you've seemed to have an acute 6 event, a change, some recovery process, and a 7 persistence of new problems. So that's the best 8 you can do at the juncture of getting involved at 9 the time that I get involved. So I still see it as 10 kind of the elephant in the middle of the room. I 11 know you kind of think of the other things. 12 But, you know, it's similar to a car 13 accident. When a person's working/functioning, 14 they might have had some pain. They might have had 15 some use of pain medication. Ultimately there's a 16 fairly dramatic change in their functioning at the 17 time of the incident, and they persist in their 18 problems. 19 So for me, that's meaningful, and you 20 get the data as best you can. And ultimately you 21 do an assessment; and then you see the validity of 22 it, reliability, and whether or not it can be 23 consistent with that type of injury. And 24 neuropsychologists, that's how we do our work. 25 Q. Okay. And I think you indicated that



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77 1 some doctors have differing opinions as to changes 2 in his capabilities before and after June of '04, 3 correct? 4 A. By reading some of those. I find some 5 of those not credible from a point of view of 6 reading the records. 7 And, for example, Dr. Smith, you know, 8 ultimately he's trying this guy on lots of stuff 9 for attention and focus, even though he tries to 10 offer, in deposition, that he's using Adderall to 11 boost an antidepressant. That's new -- that's new 12 to me. It's new to most people. You might use 13 thyroid medication to boost antidepressant effect, 14 but I don't think you'd use Adderall or Concerta. 15 I think you'd use that to help attention, executive 16 functioning. And I thought that would be a decent 17 intervention for that cognitive problem. 18 So, again, I think he states that too, 19 but he's even seemingly more depressed than he used 20 to be. So I think there's changes going on with 21 this guy. Some of them can be reactive to where 22 he's at in his life versus neurological, and 23 clearly those are more difficult questions. 24 Q. What about Dr. Gonda's opinion as to 25 his change over time? Did you review that?	79 1 Q. Okay. 2 A. -- very pronounced deficits in the 3 frontal lobes. 4 Q. But the testing is not going to show 5 you when these changes occurred in time, is it? 6 A. There is the issue of trying to rule 7 out what you can premonitory. And there is some 8 issues here of pre-existing school records and 9 educational records and intelligence testing, and 10 those got debated interestingly and, in my opinion, 11 incorrectly by some of the experts involved. But 12 they're better than not having data. 13 And the previous intellectual testing 14 was good, and some of the educational performances 15 were good. So we at least have that data. Whether 16 it's a static or changeable phenomena, as Dr. Jay 17 gets into, can be debated, but there is some 18 records. I say that usually because I have 19 absolutely nothing sometimes. 20 But I don't know exactly where he's at 21 on testing as it might be in 2001, 2002, and 2003. 22 I certainly agree with that. 23 Q. All right. Tell me a little bit about 24 the testing, if you will. 25 A. Sure.
78 1 A. I've reviewed a lot, but you can offer 2 what it is. 3 Q. He basically said, other than typical 4 changes from age, he has not seen a change in 5 Mr. Casey. 6 MR. TURNER: Object to the form. 7 THE WITNESS: Again, what realms he's 8 talking about, he'll have to respond to it. Mr. -- 9 the test results do not suggest that we're just 10 having age-related changes in brain functioning, so 11 I would have to disagree with him there. 12 They indicate a very significant pocket of problems 13 that would be consistent with interfering effects 14 of a potential injury to the subcortical regions 15 but also clearly -- in my way of looking at this, 16 and I'll never bounce off of it, yes, clearly other 17 factors, depression, pain medication usage, are 18 potentially part of the causal factors. But it's 19 not age-related. 20 Q. Okay. 21 A. Okay. Because we would see more 22 deterioration in memory, which is actually okay, et 23 cetera. So that profile I have in 24 neuropsychological testing's just not age-related 25 changes --	80 1 Q. Let's look at your report. 2 A. Okay. 3 Q. Looking at page 5 -- 4 A. Yes, sir. 5 Q. -- can you please tell me about the 6 attention/memory functioning, the first paragraph 7 there? What test was administered? 8 A. The Stroop test was administered. The 9 Seashore and Speech-Sounds Rhythm test, 10 Speech-Sounds Perception and Seashore Rhythm tests 11 were administered. 12 Q. The first paragraph of page 5? 13 A. Yes, sir. 14 Q. Okay. 15 A. Working memory tests from the Wechsler 16 Adult Intelligence Scale-3rd Edition and the Paced 17 Auditory Serial Addition test. 18 Q. Tell me about the Paced Auditory Serial 19 Addition test. 20 A. The Paced Auditory Serial Addition test 21 is a test in which you are given numbers on a tape: 22 1, 9, you have to say 10. Get the 10 out of your 23 head because the tape will say 4, and then you have 24 to be able to say 5. It is a test to administer 25 the attentional regulation and multitasking.



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81 1 Q. How did Mr. Casey perform on that? 2 A. He did well on that particular 3 attentional test. He did well relative to the 4 norms. One of the problems with the Paced Auditory 5 Serial Addition test is that there's incredible 6 variability because of its sensitivity. And 7 ultimately, you know, it's hard to know if he would 8 have been better on that, but he did score well 9 within the average range on that particular test. 10 Q. Have you -- never mind -- strike that. 11 Let's look over to page 6, if we can. 12 A. Sure. 13 Q. What's going on in that first paragraph 14 of your report? What's being tested? 15 A. On page 6 under visual-spatial/visual- 16 constructional functions? 17 Q. Correct. 18 A. Basically that's a test that gets into 19 the visual-spatial skills such as visual 20 inattention, perceptual organizational skills, 21 making fine discriminations of lines in space, as 22 well as performance on a visuographic sequencing 23 test, the Trail Making test A and B. 24 Q. So it does have two components to it? 25 A. It's a variety of visual-spatial	83 1 being some variability in his attention and 2 executive functioning. 3 Q. Let's flip over to page 7 for a second. 4 A. Sure. 5 Q. Let's go down to the third paragraph 6 from the bottom. 7 A. From the bottom, yes, sir. 8 Q. Yes, sir. And please read that one for 9 me. 10 A. Mr. Casey's responses? 11 Q. Uh-huh, please. 12 A. Indicated that he did not believe he 13 had any ongoing descriptions in the realms of 14 cognitive, emotional, or physical functioning prior 15 to his involvement in the medical incident. 16 Q. Now, would depression be an emotional 17 disruption? 18 A. Yes, it would be. 19 Q. Okay. What about anxiety and/or anger 20 issues? 21 A. Yes, it would be. 22 Q. All right. And you said a number of 23 times that he told you that he was having those 24 problems prior to the incident? 25 A. Yes.
82 1 processing measures, but also the Trail Making test 2 does have two components, if that's what you're 3 focusing in on. 4 Q. Correct, I am. Is there an A and B to 5 that? 6 A. There is. 7 Q. How did he do on Part A? 8 A. On Part A, he was in the low average 9 range, a little bit slow in his processing. And in 10 Part B, he basically was able to effectively shift 11 in sequence between numbers and letters in a 12 sequential fashion and perform within the average 13 range on that. 14 Q. Is there a difference in difficulty 15 between those two tests? 16 A. There is. The Trail Making test B is a 17 more demanding test, as it relates to being able to 18 sequence and shift between numbers and letters. 19 Q. And does that cause you any concern 20 that he did better on the B than the A? 21 A. Basically, as I indicated to you, 22 Mr. Casey, in the report -- I'm sorry -- that I 23 indicated he had some variability in these types of 24 tasks. Some of them he is able to effectively meet 25 the demands of the task. And that's what I saw as	84 1 Q. Where does it say that in your report? 2 A. Basically when we talked about his 3 depression -- I mean, his chronic pain, he 4 indicated that he -- 5 Q. Can you -- 6 A. Right. And I -- 7 Q. Can you point to it in the report? 8 A. I didn't have in there -- I didn't have 9 him as doing psychiatric treatment, and he didn't 10 report -- he didn't code of being highly disruptive 11 by that. But -- but in terms of the records and in 12 terms of understanding him, I knew that he had had 13 chronic pain and some depression associated with 14 that chronic pain. 15 Q. And, again, by chronic pain, as you've 16 used it today, you're referencing his lower back 17 pain? 18 A. I am. 19 Q. Okay. Let's flip to the back, if we 20 may, page 8. 21 A. Sure. 22 Q. All right. You've got a section that 23 looks like -- I don't -- and forgive me if I use 24 the wrong term. There's axes, and that looks like 25 your findings. Is that an accurate way of stating



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85 1 what that is? 2 A. That is correct. 3 Q. Okay. Can we go through these, please? 4 A. Sure. 5 Q. All right. Axes [sic] 1, what does 6 that cover and tell -- what does that tell you, 7 please? 8 A. Axis 1 is the clinical syndromes that 9 the client may be experiencing. 10 Q. And what did you find in Mr. Casey, 11 please? 12 A. I said mood disorder with depressed 13 mood. 14 Q. Okay. Anything else in there? 15 A. Yeah, secondary to persistent somatic 16 symptoms, or symptomatology -- 17 Q. All right. 18 A. -- and potential permanent neurological 19 deficit due to complication of laser bronchoscopy. 20 Q. And would you agree the potential is a 21 far cry from occurred or absolutely or -- in other 22 words, and there's a -- let me back up and start 23 over. 24 A. Sure. 25 Q. All right. We both know what a	87 1 So when I wrote this, I had the notion 2 in my head that we need to see this guy again. We 3 need to clean him up, get him better, get him 4 better adjusted to the changes that have taken, and 5 we're about 12, 14 months. 6 And while that would be okay for a 7 recovery from the neurological process, it's still 8 real acute with regard to a man having to live with 9 changes, and I -- and as I indicated there, there 10 are mood disturbance and sleep disturbance and 11 things going on. I've told counsel this. I think 12 he -- it's a man we need to re-evaluate. 13 So I'm still potential -- you know, if 14 you're asking me now more likely than not, I would 15 say that, but I really was relying on the idea of 16 cleaning this case up and getting rid of some of 17 the competing -- competing potential causal 18 factors, which, if you ask me, again, I believe 19 there is a high likelihood; but I wasn't ready to 20 respond of more likely not or probable not or with 21 medical certainty. 22 I did this evaluation then, oh, here we 23 are two or three years later. In reality, I'd like 24 to see him again, and I think he should get a 25 re-evaluation.
86 1 reasonable degree of medical certainty is? 2 A. Yes. 3 Q. And you would agree with me that 4 potential permanent neurological deficit is a far 5 cry from the statement of occurred within a 6 reasonable degree of medical certainty? 7 A. Well, basically when I use that, I am 8 relying on, at that juncture -- I have two things 9 to say to that. 10 Q. Sure. 11 A. One is the mechanism at that point it 12 looked like wasn't as clear, and certainly I would 13 rely on the experts about the mechanism, if it did 14 happen or not. So we're talking about the -- what 15 happened that day, the potential neurological 16 ramifications of this procedure, and the 17 difficulties they had. 18 I am using potential, and I -- also my 19 second joinder was, as I told counsel, it was my 20 belief that I should re-evaluate this guy again. 21 Q. Okay. 22 A. And I would still say that because I 23 think we need to clear up some of the interfering 24 aspects that are contributing to the compromises 25 I'm experiencing.	88 1 Q. Okay. 2 A. And I have said that to counsel. So I 3 know what you're asking for. I just, in that point 4 in time, wasn't offering that at that level yet. I 5 think there's -- more likely than not, there has 6 been a potential injury, but I do believe that 7 confounding possibilities existed at a level that 8 we needed to re-evaluate him. 9 Q. All right. So are you basically saying 10 that you're changing the language of your report 11 now? 12 A. I'm saying that's the basis for that 13 because it wasn't -- being an expert, I often have 14 to be asked more likely than not or more probable 15 than not. And I wasn't answering that -- I wasn't 16 ready to answer that question at that point. 17 Q. Okay. 18 A. And -- 19 Q. But you are now? 20 A. You know, I've actually told counsel I 21 still think it's a good idea to do a 22 neuropsychological re-evaluation on this guy. 23 Q. Okay. 24 A. That's where I stand as an expert 25 and -- but, you know, if you asked me do I think



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89 1 more likely than not, yeah, my thinking there would 2 be there. But I do believe and do respect to you 3 guys that there are some other factors as I lay 4 them all out. I think it's unequivocal. I think 5 it's basically realizing that we've got multiple 6 etiologies that could be contributing here. 7 Q. Okay. 8 A. And certainly a surgical procedure that 9 results in mechanical intubation and the 10 compromises -- I've done many cases like that, and 11 they do compromise people. How much and what goes 12 with it is a problem. 13 Also during the adjustment phase when 14 you don't show a full recovery, people do get 15 depressed when their brain doesn't work as well and 16 they aren't the person they were before. And often 17 that adjustment, depression, and problems takes 18 longer to clear. This is true in all of my mild 19 head injuries. They're told they're okay. Their 20 MRI is fine, but they're making mistakes at work or 21 maybe they end up losing a job, even though they 22 don't have real brain damage, and they get 23 depressed. 24 And we need to clean up the depression, 25 get them to accept their deficits and then getting	91 1 done, and counsel has been so informed that I think 2 it's a good idea because, otherwise, you're going 3 to be correct. I'm going to tell you all of those 4 things, including the surgical procedure that went 5 astray, could be a causal factor. And quite 6 frankly, more often than not, they're all 7 contributing. 8 What I don't have -- what people can't 9 do, which has been done in this case, is you can't 10 rule it out either like some people do because 11 there are biases for an insurance company to say a 12 brain injury isn't there. I don't think they can 13 do that empirically, and I think we shouldn't go 14 beyond empirical stuff. 15 And my point is this was an incident 16 that changed this man. Yeah, he's gotten depressed 17 about it. He's compromised. I've heard other 18 things about effort and malingering. Absolutely 19 false, a total misuse by Dr. Jay of the TOMM. He 20 just hadn't read the TOMM manual, and it was good 21 effort he gave me. The pattern is consistent with 22 that type of injury. 23 But to -- respect to you, pain and 24 depression can look like a subcortical injury too. 25 And I think we clean them up, and it's a simple
90 1 rid of those factors have a better understanding of 2 a cleaner catch of the brain. 3 So that's where I'm at as an expert on 4 this case. I'm not ruling out that I think 5 definitely an injury could have occurred, but I'm 6 not ready to say that we shouldn't clean that stuff 7 up and put it to further evaluation. 8 Q. Okay. And, Doctor, I apologize, but I 9 just want to make sure that I'm following you. So 10 if I'm looking at your report, Axes 1 and that word 11 potential, are you telling me that you're replacing 12 that word within a reasonable degree of certainty? 13 A. I'm telling you that, more probable 14 than not, I believe that this man took a hit that 15 compromised his cognitive capacities at that point 16 in time. But I'm also telling you I would like to 17 have ascertained that at a more empirical level by 18 having re-evaluated him with hopeful improvement in 19 these other competing, interfering processes, 20 including depression, sleep disturbance, fatigue 21 and so forth because a permanent deficit, once you 22 get rid of those, will persist. 23 Q. Have you requested to do that 24 follow-up? 25 A. I have indicated that that should be	92 1 design: Get rid of A, B; and if you still have C, 2 they're more definitive. 3 Q. Let me ask you about Axes 5. 4 A. Sure. 5 Q. GAF, what does that stand for? 6 A. Global Assessment of Functioning. 7 Q. And what's a 50? 8 A. 50 is serious impairment. But the 9 problem with this one too is it's a psychiatric 10 nomenclature. And, you know, in the 40s you've got 11 to start having some psychotic symptoms, if you 12 look at the adjectives. 13 50 just means serious impairment in 14 vocational and social pursuits. It's just a 15 classification of what this guy can't do. It's not 16 a causal statement. It's just saying, you know, he 17 ain't working. He's not as engaged socially. He 18 has serious impairment there. 19 MR. MANN: Let me take five more 20 because I think we've done another hour. 21 (A recess transpired.) 22 MR. MANN: Okay. We can go back on if 23 everybody's ready. 24 Dr. Waid, I think I told you yesterday 25 I'd need about two, two and a half hours. I think



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93 1 we started at 10:20. I believe it's about 12:15. 2 I appreciate your help in answering some questions 3 that I had. I have no further questions, but I 4 think some of these other gentlemen may have some. 5 THE WITNESS: Okay. 6 MR. MANN: But I thank you for your 7 time. 8 THE WITNESS: You bet. 9 MR. GUNN: I've got just a small 10 handful of questions. 11 EXAMINATION 12 BY MR. GUNN: 13 Q. Prior to this case, had you evaluated 14 any claimants or any patients for either 15 Mr. Anthony or Mr. Thompson? 16 A. I am not aware of having a case from 17 their law -- I'm -- I am just not aware if I 18 haven't already worked with them. There's a 19 possibility of that the over the last 25 years -- 20 Q. Sure. 21 A. -- but obviously they're not a ready 22 source of referrals to me than there might be. 23 Q. When you saw Mr. Casey on these two 24 occasions, August 30th and September 10th, 2005, 25 his personal hygiene was good, was it not?	95 1 evaluated other patients who claimed that -- either 2 had or claimed they had an air embolus? 3 A. I've done air embolus, and I've also -- 4 but done much more hypoxia, oxygen desaturation, in 5 that ballpark. But actually there's been several 6 cases I've seen -- and, again, a lot of these are 7 not forensic cases where a person comes out of a 8 surgery absolutely compromised, neurology sends 9 them over, neurology thinks it's air emboli but 10 there's no evidence of a procedural problem, but it 11 happens. 12 And so I've been involved with those 13 kind of clinical cases, not necessarily any major 14 suit going on because people just came out 15 different; and that's the hypothesized problem per 16 the neurologist. Dr. Bumgartner's, for example, 17 most recent case I did, surgery, comes out of 18 surgery really compromised, no pay off, you know, 19 there's nothing to be gained, and he's just not the 20 same. And that was just done this year so -- and 21 Dr. Bumgartner did refer to it as the emboli. 22 Q. Well, in medical literature and in 23 neuropsychological literature, is there a 24 phenomenon of patients sometimes undergoing general 25 anesthesia and having some what they perceive to be
94 1 A. It was. 2 Q. He was conversant, was he not, sir? 3 A. He was. 4 Q. He didn't ramble or babble or otherwise 5 speak in a hurried, clipped manner that gave you 6 any concern? 7 A. No, he did not. 8 Q. All right. He was deliberate and -- 9 well, let me ask you: You indicated that he was 10 mildly depressed based on your -- was that based on 11 your evaluations of him? 12 A. Yes. Based on his evaluation, I think 13 his depression scale depicts more of that, but 14 that's really more of his life circumstance. In 15 terms of dealing with effectively one-on-one, I 16 think he was a little bit dysphoric but not highly 17 compromised by depression. 18 Q. Okay. Just seemed a little down? 19 A. Yeah. 20 Q. Okay. And by life circumstances, I 21 assume, in fairness, you're including his divorce, 22 his financial stressors and other things going on 23 besides the injury that he gave a history of? 24 A. I am. 25 Q. Have you ever seen, tested, or	96 1 cognitive deficits, even without an identifiable 2 event? 3 A. Yes, the -- that, and actually the 4 research would tell you the more you have a 5 protracted period like 8- or 12-hour surgical 6 procedure. 7 There's also research done on 8 successful heart transplants. Unfortunately they 9 are long procedures and no incidents, successful, 10 but they're -- you know, they're under mechanical 11 respiration and the research on that has shown that 12 successful heart transplants actually come out with 13 mild cognitive deficits compared to their relative 14 cohort group. It's a nice research project -- no 15 incident. 16 So the subtleties of particularly 17 protracted ventilation and protracted breathing 18 definitely can do a little bit of problems. 19 Q. You indicated that you would like to 20 see and evaluate Mr. Casey again to -- the term you 21 used was clean up the interfering effects or to 22 clean up the interfering factors or features in his 23 life. By those, you're talking about the 24 depression and anxiety? 25 A. Depression, anxiety, certainly even the



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97 1 somatic of the body pain kind of stuff and even 2 just being further along in recognizing this is 3 where you're at, kind of what we call acceptance, 4 lack of embitterment kind of process, also the 5 consistency and ruling out the other factors that 6 might come into play, where you've adopted the sick 7 role or these other psychological issues. 8 So I do think I made that statement to 9 counsel and to counsel here mainly because when I 10 made this opinion here I really thought that's -- 11 was going to -- we needed to do that. 12 Q. When Mr. Casey came down to see you in 13 Charleston or came to see you, I presume he came -- 14 drove to Charleston and came to Charleston? 15 A. Yes, sir, he did. 16 Q. Did his sister come with him? 17 A. No. I did not have his sister, at 18 least not involved in the -- I didn't lay eyes on 19 her. I can't tell you she didn't travel with him. 20 I also generally like to get a wife to respond to 21 some forms. I didn't have that situation 22 obviously. That was -- seemed to be a situation 23 that he was -- had been somewhat embittered. He 24 had been divorced for a while. So at this point I 25 didn't get any collateral input about him that I	99 1 medical records; and you had received these medical 2 records or looked at the medical records, at least, 3 during the deposition, correct? 4 A. Yes, I did. 5 Q. Okay. And in Dr. Gonda's deposition 6 where he testified under oath -- and tell me if 7 this -- any of this makes any difference in your -- 8 the results in your report. But you were shown one 9 where allegedly Mr. Casey got Percocet from some 10 coworkers to fill in when he was -- when he ran 11 out? 12 A. Yes. I think he did get some Percocet. 13 I don't know that is was a coworker, but from 14 somebody else, yes. 15 Q. Okay. And you're aware -- Dr. Gonda, 16 he wrote a prescription that's on that same page 17 for Percocet on August 27th, 2003, b.i.d, so twice 18 a day, 60 count with a refill on the same date that 19 he was advised that Mr. Casey had received 20 Percocet allegedly from a coworker or a friend or 21 someone? 22 A. That is correct. 23 Q. Okay. And if Dr. Gonda -- I'll tell 24 you in his deposition -- if this makes any 25 difference, Dr. Gonda, if he was -- he states if he
98 1 didn't get from reading Dr. Grace's and other 2 people's notes. But I didn't have a collateral 3 interview. 4 Q. Okay. 5 MR. GUNN: I think that's all I've got. 6 Thank you, sir. 7 THE WITNESS: You bet. 8 EXAMINATION 9 BY MR. TURNER: 10 Q. Dr. Waid, I'm Noel Turner. We met, 11 just briefly, before. What I'd like to do first -- 12 I think this was mentioned -- but mark as our 13 Exhibit No. 1 your curriculum vitae. And that 14 doesn't need to be now -- 15 A. I'll get that for you. 16 Q. -- but we'll just do a copy, and that 17 will clear that exhibit up. 18 In addition to that, I'm going to 19 quickly move through the questioning we've had on 20 this alleged drug abuse or drug-seeking conduct. 21 And I know that that's not the focus, by any means. 22 I'm going to move quickly to your report after 23 that. 24 But that -- with the alleged substance 25 abuse problems, you reviewed some of Dr. Gonda's	100 1 was concerned about drug-seeking conduct on behalf 2 of Mr. Casey then he would not have written 3 Percocet on the same day that he was advised that 4 he had received it from another source. 5 And would you agree that that's proper 6 medical care that if a -- if you have any concerns 7 about drug-seeking conduct and the patient comes in 8 and says that they had allegedly received Percocet 9 from a friend or coworker, if you had drug-seeking 10 concerns, you wouldn't prescribe Percocet that very 11 same day, would you? 12 MR. KING: Object to form of the 13 question. Dr. Waid does not and I do not believe 14 that is prescribed as practicing psychology. 15 MR. TURNER: Okay. 16 BY MR. TURNER: 17 Q. Wouldn't expect a physician to 18 prescribe Percocet if he was concerned about 19 drug-seeking conduct? 20 MR. KING: Same objection -- 21 MR. TURNER: Okay. 22 MR. KING: -- not qualified as to the 23 form of the question. 24 THE WITNESS: Do you want me to answer? 25 MR. KING: Yeah.



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101 1 BY MR. TURNER: 2 Q. Yes. 3 A. Basically, since I work with physicians 4 in several chronic pain management programs, 5 including Southeastern Spine, I -- as I brought up 6 earlier too, I would see it as an interaction 7 between getting his pain under control and making 8 some programmatic changes in the medication. And 9 if he provided him more pain medicine, I would 10 assume that he didn't think it was being misused. 11 But I would also -- as I indicated earlier to 12 counsel, I would think that we should get this 13 program modified so we can manage this man's pain. 14 So I would only tell you if he kept on 15 prescribing it he thought he was just using it to 16 get his pain under control. 17 Q. Okay. And, in any of your records or 18 review or speaking with Mr. Casey, the pain 19 medications that were written were written by 20 Dr. Gonda to enable Mr. Casey to continue to work 21 on his production line job with Michelin and enjoy 22 activities such as golf? 23 A. It was my understanding that he was 24 remaining functional with vocational activities and 25 golf and recreational pursuits, in the context of	103 1 he was taking it. Yes, sir. 2 Q. Okay. And this was for chronic back 3 pain over a number of years that would be prior to 4 the surgical procedure of 6/3/2004? 5 A. Yes, sir. 6 Q. Okay. And this prescribed narcotic 7 use -- and Dr. Gonda -- I'll say Dr. Gonda was his 8 family physician from 1992 all the way to present 9 with Mr. Casey. That the prescribed narcotic use 10 by Dr. Gonda, this would not account for the sudden 11 and profound change that you noted immediately 12 postprocedure on 6/3/2004, would it? 13 MR. KING: Objection to the form of the 14 question, lack of qualification of expertise. 15 THE WITNESS: It appeared to me that an 16 event occurred when he was hospitalized and that 17 there was a considerable change in his overall 18 physical and health and cognitive function, as it 19 related to complaints after that with regard to 20 attention, concentration, and memory. And so when 21 I look at the medical records, those types of 22 complaints were not present beforehand. 23 BY MR. TURNER: 24 Q. And isn't it true that there are many 25 people -- a significant small percentage of
102 1 using the pain medications. 2 Q. And I think Mr. Mann what he was asking 3 was prescription medications for narcotic pain 4 medicine that was written prior to the surgical 5 event of 6/3/2004. Was that your understanding, 6 Dr. Waid? 7 A. Yes, it was my understanding. 8 Q. Okay. And are you aware that both 9 Drs. Boscia and Feldman prescribed Percodan, 10 Oxycodone, OxyContin to Mr. Casey in June 2004 or 11 after? 12 A. I was aware that he continued on pain 13 medications. I'm not sure about the specific, but, 14 yes, I was aware he remained on pain medication. 15 Q. Okay. 16 MR. MANN: Off the record. 17 (PLF. EXH. 1, Dr. Waid's CV, was marked 18 for identification.) 19 BY MR. TURNER: 20 Q. Dr. Waid, looking at the narcotic use 21 by Mr. Casey, doesn't it appear that he was taking 22 the Hydrocodone, primarily referred to as Lortab, 23 prescribed by his primary care physician Dr. Gonda 24 for the mechanical back pain? 25 A. That was my understanding that -- why	104 1 population that take narcotic medication such as 2 Hydrocodone or even stronger narcotics for long 3 periods of time and remain functioning at a high 4 level at their employment, social, or family 5 activities? 6 A. Yes. 7 Q. And even though they may take 8 chronic -- or chronically take narcotics over a 9 long period of time, they function cognitively very 10 well? 11 A. They do. As a matter of fact, if you 12 have chronic pain and you use opiates, you're more 13 likely not to be cognitively impaired versus a 14 street user who doesn't have pain. There tends to 15 be a more euphoric and toxic effect with people who 16 are just taking it to get high. So, two, also pain 17 is a player. So if you can get rid of pain through 18 the opiates, you're probably better off cognitively 19 than without. 20 Q. In your report, Mr. Mann asked you 21 about the word potentially on that last page. 22 You're familiar with the sentence that I'm talking 23 about? 24 A. That is correct. 25 Q. All right.



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105 1 MR. MANN: No. I think it was 2 possibly. 3 MR. TURNER: Okay. Under Axis 1, it's 4 got: Potential permanent neurological deficit due 5 to complications -- 6 MR. MANN: I'm sorry. 7 MR. TURNER: -- of laser bronchoscopy. 8 MR. MANN: My apology. 9 BY MR. TURNER: 10 Q. We've discussed some other possibly 11 contributing factors, haven't we, such as 12 depression and anxiety? 13 A. Yes, sir. 14 Q. Okay. But it's your opinion, within a 15 reasonable degree of medical certainty, that it's 16 more likely than not that you believe that 17 Mr. Casey has a permanent neurological deficit as a 18 result of the insult from the June 3rd, 2004, 19 procedure? 20 A. If I'm asked to make the distinction, 21 that would be my opinion more likely than not when 22 I'm using that, again, verified by the fact that I 23 also thought that we would be more empirical in 24 addressing that question by cleaning this guy up, 25 giving him some more time for recovery and	107 1 literature -- research literature that I'm aware of 2 and studies that I've looked at because of my work 3 in that area have done that. That's all I'm 4 implying, that research studies have indicated 5 that, and that the risk is greater for protracted 6 periods of anesthesia. 7 And certainly if you have an incident, 8 an unfortunate incident where there might be a lack 9 of respiratory feed and lack of oxygen saturation, 10 clearly you're getting into a more dangerous area. 11 But that's based on my understanding of the 12 research literature. I would agree with counsel. 13 I'm not an expert on that research other than 14 reading it and understanding it for people I have 15 to evaluate postsurgery. 16 BY MR. TURNER: 17 Q. And in patients that you've evaluated 18 postsurgery, are you aware of literature that 19 describes in geriatric patients that have undergone 20 anesthesia in a procedure that even without a 21 complication from the procedure there are residual 22 cognitive deficits? 23 MR. KING: Objection to the form of the 24 question, qualification of expertise. 25 THE WITNESS: Again, based on research
106 1 re-evaluating him to see if there was a persistence 2 of a narcotic impairment. 3 Clearly on the date I wrote this 4 report, I wasn't thinking in those types of terms 5 but believed he has suffered a neurological 6 deficit. But empirically I believe that we can 7 clean him up and reassess it that one can be even 8 more confident about that, but I believe he has had 9 an insult. 10 Q. All right. Air embolism has been 11 described as a potential mechanism for that insult, 12 correct? 13 A. It has been. 14 MR. KING: Objection to the form of the 15 question, qualification of expertise. 16 BY MR. TURNER: 17 Q. Anesthesia, are you -- you've discussed 18 long term -- if you're under anesthesia for a long 19 period of time such as an open heart surgery -- 18 20 hours I think is what you had used -- that there 21 may be some residual cognitive dysfunction as a 22 result of the anesthesia itself? 23 MR. KING: Objection to the form of the 24 question, qualification of expertise. 25 THE WITNESS: I would respond that the	108 1 that I'm aware of and part of my career clearly, if 2 you're going to throw age in here, you're adding 3 another risk factor but -- and you said elderly. 4 Clearly the indications are significant, but I'm 5 even just talking about middle-aged people and 6 ultimately length of time. 7 But anesthesia and cognitive 8 interference due to surgical procedures or even 9 being in the hospital is well-documented in the 10 elderly. 11 BY MR. TURNER: 12 Q. And even in a small percentage of the 13 population without the additional risk factor of 14 age, you still will see cognitive deficits as a 15 result of anesthesia even when there was no 16 complications as a result of the surgical 17 procedure? 18 A. In a small percentage -- 19 MR. KING: Excuse me. 20 THE WITNESS: I'm sorry. 21 MR. KING: Objection as to the form of 22 the question, qualification of expertise. 23 THE WITNESS: Again, yes, there can be 24 a small percentage of people who have cognitive 25 complaints following protracted anesthesia.



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109 1 BY MR. TURNER: 2 Q. And those cognitive complaints of 3 cognitive dysfunction would be permanent? 4 MR. KING: Objection to the form of the 5 question, qualification of expertise. 6 THE WITNESS: In my evaluation of such 7 patients, the deficits have been permanent, and the 8 research literature also suggests that those 9 deficits are permanent. 10 BY MR. TURNER: 11 Q. And you have actually treated patients 12 that had cerebral air emboli? 13 A. I have. But more often it's been 14 termed as hypoxia where there's been a lack of 15 respiratory failure incident more often than an air 16 emboli. But I definitely have seen air emboli too 17 where there was no recording of respiratory 18 failure, that there was just the hypothesized air 19 emboli because respiratory failure becomes an 20 event. 21 Q. Okay. And I know you were asked two 22 pulmonologists have not included, as Mr. Mann 23 stated, the hypoxia as a theory. However, if I 24 give you the following hypo, I would like you to 25 see -- or to give your opinion on it:	111 1 like that, hypoxia is a concern. Obviously for the 2 neuropsychologist, if there's a persistence of 3 complaints and a concern about cognitive 4 impairment, then we're asked to get involved. But 5 for me it's an event. Again, I will defer to the 6 experts about the characteristics of the event and 7 their professional opinions and expertise. 8 But for neuropsychologists, we have an 9 event, the person's not functioning as well, we are 10 asked to get involved to assess the brain behavior 11 functioning and generally assess what the deficits 12 are and to make an opinion whether it might be 13 consistent with that type of mechanism. 14 BY MR. TURNER: 15 Q. And as a neuropsychologist, you've 16 performed -- or administered the WAIS test -- 17 A. I do. 18 Q. -- WAIS-III on two different dates; is 19 that right? 20 A. The WAIS-III was given all on one date. 21 Obviously he was given the WAIS-III by Dr. Grace 22 also. 23 Q. Okay. And that was in June of 2005? 24 A. Dr. Grace did do his evaluation in June 25 of 2005.
110 1 That Mr. Casey had anesthesia provided 2 through the rigid bronch to the tip of it during 3 the procedure; that the emergents occurred 4 approximately at 1358 military time of the rigid 5 bronch with the anesthesia; and that he was then 6 placed on a mask to breath spontaneously 7 thereafter, sent to the PAC unit and arrived at 8 1429 -- 1419 in the PAC unit; and that he was on a 9 mask breathing spontaneously for six minutes before 10 he was reintubated endotracheally at 1425 p.m. 11 military time. Do you understand my hypo -- 12 A. I do. 13 Q. -- in that situation? If Mr. Casey was 14 not getting enough oxygenation at the cellular 15 level, in your experience in diagnosing patients 16 through the neuropsychological testing battery of 17 tests, hypoxia is a potential concern in that hypo, 18 is it not? 19 MR. KING: Objection to the form of the 20 question -- 21 MR. GUNN: Object to the form of the 22 question. 23 MR. KING: -- qualification of 24 expertise. 25 THE WITNESS: Yes, when you have events	112 1 Q. And you've read Dr. Milton Jay's 2 deposition, correct? 3 A. I did. 4 Q. And if I'm not mistaken, he is a -- he 5 has an -- instead of a Ph.D. in neuropsychology, he 6 has an educational doctorate, correct? 7 A. That is correct. 8 Q. One of the points that I believe he 9 makes is that your testing and Dr. Grace's testing 10 are inconsistent and that the data is equivocal. 11 Do you recall that? 12 A. Yes, I do. 13 Q. Could you elaborate on what your 14 opinion is on Dr. Milton Jay's critique of your 15 report of your testing? 16 A. Well, Dr. Jay focuses on how some 17 subtests of the WAIS-III, a few got better and some 18 got worse. And when I reviewed that, I was aware 19 of that. 20 The critique is that it's basically, 21 one, IQ subtests are not the most sensitive 22 assessment for brain behavior changes to start off 23 with. Two, Dr. Jay made a comment that there 24 should be a practice effect, which is absolutely a 25 false statement.



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113 1 There's a practice effect always within 2 three months of any type of injured person, 3 particularly an injured person of the milder 4 nature. Picture completion, which got better, 5 clearly has a practice effect because you have this 6 series of pictures, you try to find the missing 7 part. Three months later you've seen that. You're 8 already ahead of the game. You've got -- and now 9 you've got to figure out the ones you didn't get. 10 The things that went down, some of them 11 were processing speed. Processing speed can go 12 down based on factors that have nothing to do, I 13 agree, with a neurological injury such as fatigue. 14 And, in essence, to indicate -- the 15 biggest fallacy in this is basically both him 16 and -- I think his name is Burger -- 17 Q. Mercer. 18 A. Mercer, excuse me, basically tried to 19 argue that after a neurological injury you have an 20 acute effect and then you should get better, and 21 they're right. But actually the testing done by 22 Mr. Casey was done on June of 2005, and my testing 23 is three months later. And Mr. -- this incident 24 occurred in May and June of 2004. That argument 25 makes no sense. He's already plateaued with regard	115 1 Mr. Casey two weeks after he had this incident and 2 then a year later he was worse, then I would tell 3 you that does not make neurological sense. But 4 he's a year out before he gets the first 5 measurement, so it just doesn't hold. 6 Q. And it's your opinion that if testing 7 had been done earlier on, say, immediately after he 8 was released from the hospital, perhaps, at the 9 first office visit with Dr. Boscia on June 8th of 10 2004 that it would -- we would be in a better 11 position to evaluate? 12 A. Yes, we would. And I do give some 13 credibility to Dr. Grace who has been involved with 14 this man over time and, therefore, I think has a 15 unique way of having more credible data about 16 the -- where he's at and persistence of some 17 problems. So he's seen him many times. And the 18 attention, concentration repetitively shown itself 19 in those other deficits. 20 But my point is, yeah, there's real no 21 aspect of measurement of his brain until my 22 evaluation and a little bit by Dr. Grace having 23 done an IQ test. And I say a little bit. I mean 24 that. 25 Q. With a mild injury such as one from
114 1 to brain recovery, so that argument makes no sense 2 as it implies neurological causal factor because 3 that would apply with like a head injury. 4 If I see you in a -- after a traumatic 5 brain injury, if you don't die, you will get 6 better. And if I measure you at two months or 7 three months out, which is what I recommend to 8 attorneys, and then I measure you at 13 months out, 9 you must be better. And if you're not better, it's 10 not neurological. Now, that's the argument. 11 So to throw that type of argument in 12 now when he's already a year out from not a 13 traumatic brain injury a much more subtle injury 14 that would have a faster recovery period, it loses 15 its basis. There can be variability on a given day 16 for a lot of reasons, and the variability, quite 17 frankly, was not that significant as he made it out 18 to. 19 Plus the neuropsychological testing is 20 a much better measure for the brain functioning. 21 So I just didn't feel like it held any credible or 22 empirical basis for saying that this is not 23 neurological for those four arguments I just told 24 you. 25 My point to you would -- if we did	116 1 cerebral micro air emboli, in your experience, it's 2 possible that it would not show up on an MRI scan 3 because it's such a microscopic level that it's 4 undetectable by that type of scan -- 5 MR. KING: Objection to the form of the 6 question, qualification of expertise. 7 MR. GUNN: I'll join in that objection. 8 BY MR. TURNER: 9 Q. And I'll rephrase the question. 10 A. Sure. 11 Q. With an MRI, that cerebral micro air 12 embolism often does not show up on the MRI scan 13 even though there is damage? 14 MR. KING: Objection to the form of the 15 question, qualification of expertise. 16 BY MR. TURNER: 17 Q. You may answer, Doctor. 18 A. My understanding of neuroradiographic 19 studies, MRIs and CAT scan and even positron 20 emission tomography, the resolution of the MRIs and 21 CT scans often cannot pick up injury to the brain 22 that's subtle, mild, involves accidental shearing 23 and particularly hypoxic or even toxic effects. 24 When it does, we're not arguing about 25 damage because that means the damage is much more



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117 1 severe and the person often will be compromised 2 motorically. I was just pointed out by one of the 3 doctors here, more of a palsy effect. I'm just 4 telling you that. 5 So that's where it is. That's my 6 understanding. I certainly agree with counsel. I 7 don't read them, and I am not an expert. 8 Q. And another issue was the Symptom 9 Validity test. You administered that to Mr. Casey, 10 didn't you? 11 A. I did. 12 Q. Okay. And Dr. Milton Jay qualifies 45 13 on the TOMM test as normal range of effort. Could 14 you comment on the use of qualification terms such 15 as normal or abnormal range of effort? 16 A. Yes. Well, I can comment on the 17 validity assessment in general. Symptom Validity 18 tests like the test of memory malingering and the 19 word memory test are designed -- they're generally 20 procedures that you can get 50 percent correct if 21 you're guessing. To be a malingerer, you have to 22 beat 50 percent in the wrong direction. That's 23 malingering. 24 So on a TOMM, for example, on Trial 2 25 if you got 18 out of 50 correct, we've got a	119 1 and other issues. 2 The other problem is nobody relies 3 totally on Symptom Validity tests. If you're going 4 to come in and falsify and give me poor effort, why 5 isn't he poor -- doing poorly on memory testing? 6 He's complaining of forgetfulness. Most lay people 7 don't understand that, yeah, he is forgetting 8 because he is not processing. His problem is from 9 the keyboard to the hard disk. His hard disk is 10 fine. And we would expect his hard disk to be 11 injured by this subcortical, potential insult. We 12 would expect his frontal executive area to be hurt, 13 and that's where it's a process. And so he scores 14 poorly invariably on attention, concentration, and 15 some immediate learning. He shows no evidence of 16 rapid forgetting. 17 When a client comes in and is 18 falsifying, giving us poor effort, they tend to do 19 kind of poorly across the board. They're not 20 sophisticated enough to understand these tests and 21 what they're measuring or not measuring. 22 So my point to you is generally when I 23 have people who are doing poorly on the TOMM, I 24 have test results that are -- don't make sense 25 either and are inconsistent with any known
118 1 problem with you; and we think you're consciously 2 falsifying, meaning you know the right answer and 3 you're telling us the wrong. 25 out of 50 might be 4 somebody absolutely not trying or giving us 5 insufficient effort. 6 The second trial of the TOMM we like 7 you -- to see your ante up to 45 out of 50 correct. 8 It's just a cut score. To say 44 is less effort 9 than 45 is absolutely inaccurate, and what -- if he 10 read the TOMM manual, when we get a 45 or 40, we 11 give the retention trial because research clearly 12 indicates that if these people are insufficient 13 effort or somehow falsifying, they will always go 14 down on a retention trial. But it takes 15 minutes 15 later. It looks like even more of a memory. 16 And so they're trying to fake a memory 17 problem. They say time's gone by and actually he 18 got better. There is nothing wrong with his TOMM. 19 His TOMM indicates adequate effort. It can't be 20 quantified. 21 Also the word memory test, basically 22 they cut off scores 82.5. Delayed recall's the 23 best trial. He goes 90, 85, 85. It can't be 24 quantified. That's adequate effort, even though I 25 would suggest, as I did, this guy had some fatigue	120 1 neurological injury. That's not the case. And so 2 nobody would ever assess validity that way. 3 The problem hanging here is that the 4 validity scales are fine. Indices embedded within 5 the battery of neuropsychological tests were fine. 6 We observed in the good effort. And he does fine 7 on many, many, many, many things right where he 8 should. And he has a cluster of deficits in the 9 frontal executive area that would be consistent 10 with subcortical injury and/or, as pointed without 11 by counsel, yes, the pain and fatigue and 12 depression can be certainly a part of that and can 13 cause that too. 14 So my point is there's no doubt that 15 this is a valid assessment with a man giving good 16 effort in the context of some fatigue and some 17 dysphoria. But nobody's going to question his 18 effort. 19 Q. And when you said executive area, are 20 you referring to executive function? 21 A. Executive function, frontal lobe. 22 Q. All right. And in your experience as a 23 neuropsychologist, executive function is 24 associated -- or loss of executive function is 25 associated with air emboli?



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121 1 A. They can compromise in subcortical 2 regions in general. The reason why we say 3 subcortical is oxygen emboli tend to be most 4 affecting where you have more arteries and blood 5 feed. The white matter of the brain is much more 6 fed by arteries and -- and vessels. And so when 7 you have insufficient oxygen, even toxic injuries 8 like carbon monoxide, they -- they injure from down 9 here more so. It happens in microscopic ischemia 10 in late age. You tend to lose this. It has a very 11 different effect on memory testing than you see 12 when you're hurt from the cortical down or you're 13 massively injured. 14 So my point is that is very subtle, 15 very difficult. No layperson would know how to do 16 it. And that's the type of injury we see. So it 17 is, again, consistent. Albeit, again, the other 18 factors also tend to look like subcortical injury. 19 Q. And if you had greater damage to the 20 subcortical region, you would expect more -- an 21 increased motor and sensory damage than what we're 22 seeing in Mr. Casey, correct? 23 A. Yes. If you have severe injury to 24 subcortical, you're -- you're going to look -- your 25 motor function can be compromised. Parkinson's is	123 1 MR. MANN: Does anybody want to talk 2 about reading and signing? Do you want to read? 3 THE WITNESS: I'll give you my card. 4 (The deposition was concluded at 1:09 5 p.m.) 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25
122 1 a subcortical. Many people with Parkinson's are 2 still good cognitively, but they've got pinwheeling 3 and shuffling and all kinds of problems. That's 4 where a lot of those sensory motor areas are. 5 Q. And so in Mr. Casey's case, in your 6 opinion, it doesn't have to be so severe that he 7 has hemiparalysis or symptoms consistent with 8 Parkinson's disease for him to have cognitive 9 deficits that tie back to this surgical procedure 10 on 6/3/2004? 11 A. That is my opinion, but that's -- and 12 I -- I would agree with that. And, again, as was 13 pointed out by Dr. Fogarty, you know, it's 14 fortunate he doesn't have any gross motor deficit. 15 If he had had a more significant injury, he would 16 have more gross motor deficit, if it offended that 17 area. 18 Q. Okay. 19 MR. TURNER: Give me a moment, Doctor. 20 We can go off the record. 21 THE WITNESS: Sure. 22 (A recess transpired.) 23 MR. TURNER: If we can go back on the 24 record. Dr. Waid, thank you for your time. That 25 is all the questions I have for you today.	124 1 INDEX 2 Page/Line 3 WITNESS/EXAMINATION 4 BY MR. MANN 4/14 5 BY MR. GUNN 93/12 6 BY MR. TURNER 98/9 7 8 9 10 REQUESTED INFORMATION INDEX 11 (No Information Requested) 12 13 EXHIBITS 14 Page/Line 15 DFT. EXH. 1, Dr. Waid's report of 8/5 16 neuropsychological evaluation 17 DFT. EXH. 2, document Bates stamped 000543 41/22 18 DFT. EXH. 3, document Bates stamped 000541 43/3 19 DFT. EXH. 4, document Bates stamped 000539 48/25 20 DFT. EXH. 5, document Bates stamped 000536 50/17 21 DFT. EXH. 6, document Bates stamped 000535 53/10 22 DFT. EXH. 7, document Bates stamped 000527 54/8 23 DFT. EXH. 8, MRI report 60/24 24 PLF. EXH. 1, Dr. Waid's CV 102/17 25



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125 CERTIFICATE OF REPORTER I, Jennifer H. Jesse, Registered Professional Reporter and Notary Public for the State of South Carolina at Large, do hereby certify that the foregoing transcript is a true, accurate, and complete record. I further certify that I am neither related to nor counsel for any party to the cause pending or interested in the events thereof. Witness my hand, I have hereunto affixed my official seal this 27th day of May, 2009 at Charleston, Charleston County, South Carolina. _____ Jennifer H. Jesse My Commission expires December 10, 2017	127 CERTIFICATE STATE OF _____ COUNTY/CITY OF _____ Before me, this day, personally appeared, L. RANDOLPH WAID, Ph.D., who, being duly sworn, states that the foregoing transcript of his/her Deposition, taken in the matter, on the date, and at the time and place set out on the title page hereof, constitutes a true and accurate transcript of said deposition. _____ L. RANDOLPH WAID, Ph.D. SUBSCRIBED and SWORN to before me this _____ day of _____, 20__ in the jurisdiction aforesaid. _____ My Commission Expires _____ Notary Public "If no changes need to be made on the following two pages, place a check here _____, and return only this signed page."
126 CAPTION The Deposition of L. RANDOLPH WAID, Ph.D., taken in the matter, on the date, and at the time and place set out on the title page hereof. It was requested that the deposition be taken by the reporter and that same be reduced to typewritten form. It was agreed by and between counsel and the parties that the Deponent will read and sign the transcript of said deposition.	128 DEPOSITION ERRATA SHEET RE: SetDepo, LLC File No. 20801 Case Caption: WILLIAM MARK CASEY vs. GREGORY J. FELDMAN, M.D., et al. Deponent: L. RANDOLPH WAID, Ph.D. Deposition Date: MAY 15, 2009 To the Reporter: I have read the entire transcript of my Deposition taken in the captioned matter or the same has been read to me. I request that the following changes be entered upon the record for the reasons indicated. I have signed my name to the Errata Sheet and the appropriate Certificate and authorize you to attach both to the original transcript. Page No. _____ Line No. _____ Change to: _____ Reason for change: _____ Page No. _____ Line No. _____ Change to: _____ Reason for change: _____ Page No. _____ Line No. _____ Change to: _____ Reason for change: _____



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129 1 Deposition of L. RANDOLPH WAID, Ph.D. 2 Page No. _____ Line No. _____ Change to: _____ 3 _____ 4 Reason for change: _____ 5 Page No. _____ Line No. _____ Change to: _____ 6 _____ 7 Reason for change: _____ 8 Page No. _____ Line No. _____ Change to: _____ 9 _____ 10 Reason for change: _____ 11 Page No. _____ Line No. _____ Change to: _____ 12 _____ 13 Reason for change: _____ 14 Page No. _____ Line No. _____ Change to: _____ 15 _____ 16 Reason for change: _____ 17 Page No. _____ Line No. _____ Change to: _____ 18 _____ 19 Reason for change: _____ 20 _____ 21 SIGNATURE: _____ DATE: _____ 22 L. RANDOLPH WAID, Ph.D. 23 _____ 24 _____ 25 _____	Empty space for notes or additional information
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DEFENDANT EXHIBIT 1
WALD, L.R. PH.D

THOMPSON 002793

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REPORT OF NEUROPSYCHOLOGICAL EVALUATION
Confidential-For Professional Use Only

Name: William Mark Casey

Age: 46 (DOB: [REDACTED] 58)

Sex: Male

Handedness: Right

Dates of Evaluation: August 30th and September 10th, 2005

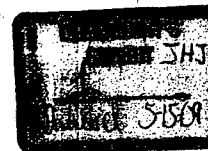
Reason for Referral: William Mark Casey is a 46-year-old Caucasian male referred for neuropsychological evaluation through the offices of Ken Anthony, Esquire, and Ray E. Thompson, Jr., Esquire. The evaluation was conducted to assess Mr. Casey's brain behavior functions and emotional status. Mr. Casey's difficulties stem from medical procedures that were conducted due to recurrent chest pain in May of 2004. An emergent bronchoscopy was conducted following x-rays reportedly revealing a metallic fragment in the chest area. Reportedly, the bronchoscopy did not show a foreign body, but an area of erythema. The following week, Mr. Casey underwent a laser bronchoscopy that resulted in a perforation of the bronchial wall by the laser with resulting pneumomediastinum and respiratory distress necessitating intubation and heavy sedation. Subsequent to this, Mr. Casey has experienced disruptive symptomatology that has rendered him unable to return to employment capacities at the Michelin Company.

Relevant History: Mr. Casey was on time for his scheduled appointments. I reviewed with him the occurrence of chest pain for several weeks in May of 2004 while he was employed at resulting in him reporting it to the company nurse. Subsequently, he was transported to Spartanburg Regional Medical Center and underwent emergent evaluation. Medical records reveal that during the evaluation, Mr. Casey was found to have a left main bronchus containing some foreign body that was metallic in nature. Mr. Casey was seen in consultation by Dr. Feldman who asked Dr. Boscia to do a fiberoptic bronchoscopy. Reportedly, this procedure was undertaken but no piece of metal was found. Mr. Casey was discharged on 5/29/04.

Medical records reveal that Mr. Casey was re-admitted on June 3rd, 2004 and underwent an additional procedure conducted by Gregory Feldman, M.D. This involved bronchoscopy with laser. Acutely following the procedure, he developed considerable pneumomediastinum with reported pneumothorax on the left side. His condition necessitated placement of chest tubes, intubation and mechanical ventilation.

My understanding of Mr. Casey's case was assisted by review of the following medical records:

1. Extended medical records for treatment provided upon admission on 5/28/04 and 6/03/04.
2. Records from Spartanburg Regional Medical Center for procedures conducted in July of 2000.
3. Treatment records from Upstate Lung and Critical Care Specialists.
4. Treatment records from Lung and Chest Medical Associates.
5. Treatment records from Jeffrey Smith, M.D., Piedmont Psychiatric Services.
6. Treatment records from Joseph Grace, III, Ph.D.
7. Treatment records from Y. Eugene Mironer, M.D.
8. Mr. William Mark Casey's educational records from Spartanburg County School District #6.



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Review of records revealed that Mr. Casey experienced disruptive symptoms following the procedure conducted on June 3rd of 2004. Initial follow-up treatment was provided at Upstate Lung and Critical Care Specialists with Mr. Casey complaining of fatigue, sleep disturbance, chest tightness, as well as being agitated and "unable to sit down." There was also report of longstanding chronic back pain. There was conservative intervention including use of Ambien. Difficulties persisted, and there was referral to Carolina Center for Advanced Management of Pain. Mr. Casey underwent evaluation by Eugene Mironer, M.D. He was assessed with mechanical low back pain, depression, and chest wall pain of no muscular origin. There was discussion regarding his treatment options.

Medical records reveal that Mr. Casey sought further evaluation for his difficulties at the Lung and Chest Medical Associates. Evaluation by Wilson P. Smith, Jr., M.D. reviewed the recent surgical procedures, noting that Mr. Casey remained with dyspnea and chest pain with exertion. Dr. Smith assessed Mr. Casey as being very anxious with report from family members noting a change in his ability to tolerate stress. It was noted that Mr. Casey was unable to participate in golf and other recreational activities. Dr. Smith's impression was that pulmonary functioning was normal and chest x-rays failed to show any evidence of sequelae of his bronchial perforation. Dr. Smith expressed concern that Mr. Casey may be experiencing a Posttraumatic Stress Disorder related to his injury and intensive care unit experience. There was recommendation of referral for a psychologist for further evaluation.

Records reveal that Mr. Casey subsequently came under the care of Joseph G. Grace, III, Ph.D. Care appeared to commence on August 4th, 2004. Initial medication intervention was coordinated with Frank Gonda, M.D., Mr. Casey's family physician. Subsequently, there was referral for psychiatric care with Jeffrey Smith, M.D. Treatment has been directed toward Mr. Casey's depression, sleep disturbance, anxiety, restlessness, irritability with low frustration tolerance, and poor stress tolerance. There has been use of antidepressants and other medications. Psychiatric evaluation with Jeffrey Smith, M.D., was conducted in early November. Dr. Smith modified the medication regimen including stopping use of Zoloft and adding Cymbalta 60 mg. Dr. Smith's assessment was one of major depression, single episode, moderate.

In interview, Mr. Casey reported that he has continued under the care of Joseph Grace, III, Ph.D. as well as Jeffrey Smith, M.D. Medical records reveal that Mr. Casey underwent further evaluation at the Lung and Chest Medical Associates in July of 2005. On initial evaluation, he was experiencing dry heaves and nausea as well as chest pain and a squeezing sensation present without exertion. A cardiogram was normal and Dr. Fogarty's impression was chest pain, probably chest wall; nausea and vomiting improved; persistent difficulty concentrating and staying focused; status post laser bronchoscopy complicated by pneumomediastinum and pneumothorax. Dr. Fogarty further stated that Mr. Casey's nausea/vomiting symptoms have appeared to improve since discontinuing Strattera. Dr. Fogarty stated that with regard to Mr. Casey's difficulty concentrating, "air emboli have been reported as a complication of laser bronchoscopy, even without perforation of the endotracheal tree with resulting leakage of air into extrapleural, vascular, and mediastinal spaces. Although, he is fortunate not to have any gross motor deficit, he (Mr. Casey) may well have a permanent neurological deficit in which case the indication for taking medication such as Strattera may be mute."

Mr. Casey also underwent intellectual assessment by Joseph G. Grace, III, Ph.D., in June of 2005. Dr. Grace reviewed Mr. Casey's academic records, stating that Mr. Casey had undergone intelligence testing in the 2nd, 4th, and 6th grades with intellectual quotients in the high average range. Reportedly, academic achievement test scores were generally above the 65th percentile. Dr. Grace conducted intellectual testing with Mr. Casey earning a Full Scale I.Q. of 97, a Verbal I.Q. of 100, and a Performance I.Q. of 91. The test administered was the Wechsler Adult Intelligence Scale-III (WAIS-III). Dr. Grace opined that there was a significant discrepancy between Mr. Casey's early intellectual ability measures and the current I.Q. test results. Dr. Grace stated that the "only reasonable conclusion is that Mr. Casey has experienced a neurological event which has diminished his ability to process information and perform in a number of areas as effectively as he once did."

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In interview, Mr. Casey reported that he continues with fatigue and "lack of motivation." He reported that he lost his job at Michelin approximately one year ago. This has resulted in financial stressors. He reported that he was an active employee at Michelin, performing 12-hour shifts. Mr. Casey also complained of a decreased capacity for attention and memory. As Mr. Casey stated, "I can't remember things." He provided examples of absentmindedness as well as making misjudgments that have resulted in accidents. There was also report of being socially withdrawn and isolated. Mr. Casey reported being avoidant of crowds, offering that he'd rather "stay at home and not be bothered." He acknowledged continuing back pain that pre-existed the medical incidents of May/June, 2004.

A structured symptom review failed to reveal any complaint by Mr. Casey with regard to sensory perceptual functions. Vision is corrected. There was no report of auditory acuity difficulties or tinnitus.

With regard to motor functioning, there was no report of paralysis or lateralized weakness. Mr. Casey reported continuing muscle spasms affecting the lower back. He denied coordination/balance problems. He reported occasional numbness affecting the hands and feet. There was report of paresthesias in the back region.

Mr. Casey reported that back pain is aggravated by physically exerting activities. He continues with episodic chest pain that is aggravated by exertional activities. Mr. Casey was not complaining of headache difficulties. There was report of occasional dizziness, but no report of vertigo, blackout spells, or seizures.

With regard to cognitive processes, Mr. Casey reported a decreased capacity for attention/concentration with an easy distractibility. He reported an inability to think as quickly as before (bradyphrenia). He also stated, "I know I am more forgetful."

With regard to psychological functioning, Mr. Casey acknowledged problems with sadness/depression, stating, "I don't have that much that is making me happy these days." There are episodic difficulties with sleep, though he did state that use of Ambien "definitely helps." He reported experiencing weird dreams, but denied disruptive nightmare activity. There is longstanding anxiety and fearfulness about heights. He reported being impatient and irritable with a lower ability to tolerate stress. Energy level was characterized as diminished. Clinical evaluation failed to reveal paranoid ideation or delusional thinking. Mr. Casey acknowledged considerable worry, particularly with regard to the future. There was no report of hallucinatory processes or evidence of psychotic symptomatology. Appetite was characterized as "variable." Libido was characterized as reduced with a lack of desire.

Mr. Casey reported a significant decline in his pursuit of social and recreational activities. This was particularly relevant to golf which he used to avidly pursue prior to his medical difficulties.

Mr. Casey reported current medications consist of Lipitor, Tricor, Mobic, Hydrocodone 10/500, Tramadol 50 mg 2 tabs q.i.d., Cymbalta, and Ambien 10 mg as needed for sleep. There has also been use of Adderall XR 20 mg b.i.d. to assist with attention/focus. As of 9/10/05, Adderall had been discontinued.

Medical History: Mr. Casey denied previous head or neck injury. There is a history of back pain associated with two bulging discs and arthritis. He has undergone previous hemorrhoidectomy as well as hospitalization for evaluation of chest pain in 2000, undergoing cardiac catheterization.

Mr. Casey denied history of serious infections, allergies, diabetes, or hypertension.

Mr. Casey denied history of psychiatric illness or need for formal treatment. He denied having lifelong problems with his nerves, depression, or mood swings. He is a rare, occasional consumer of alcohol. He denied history of excessive alcohol usage. He does not utilize illicit drugs. There has been no history of formal substance abuse treatment.

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Family History: Noncontributory for psychiatric illness and/or substance abuse problems. Family history is significant for diabetes in a mother and a heart attack in a father.

Psychosocial Review: Mr. Casey is a high school graduate. Reportedly, he was an active athlete while attending Dorman Senior High School in Spartanburg. He denied any repetition of grades or history of learning disabilities or Attention Deficit Disorder. Review of educational records confirmed him to be a high school graduate with a reported intellectual quotient of 113 attained in the 6th grade.

Mr. Casey reported that he was employed at the Michelin Company for over 20 years. His job title was manufacturing professional. He denied ever being in the military service. Mr. Casey attained a formal divorce from his wife after being married for 23 years. The couple were separated for several years before the divorce decree was attained in March of 2005. There are two biological children, a son, age 22, and a daughter, age 19.

Procedures: Wechsler Adult Intelligence Scale-III, Wechsler Memory Scale-III, California Verbal Learning Test-II, Stroop Test, Conner's Continuous Performance Test-II, Judgment of Line Orientation Test, Wisconsin Card Sorting Test, Trail Making Test, Controlled Oral Word Association Test, Paced Auditory Serial Addition Test, Seashore Rhythm Test, Speech Sounds Perception Test, Aphasia Screening Exam, Tactile Performance Test, Sensory Perception Examination, Finger Tapping Test, Grip Strength Test, Pegboard Test, Behavioral Dyscontrol Scale, Test of Memory Malingered, Word Memory Test, Personality Assessment Inventory, Ruff Neuropsychological Inventory.

Examination Results

Neurobehavioral Status: Mr. Casey was on time for his scheduled appointments. He was appropriately attired with good personal hygiene. There was maintenance of appropriate eye contact. There was no evidence of psychomotor retardation or excitement. Mr. Casey was friendly and cooperative in his interactions with the examiner. There was no difficulty understanding instructional sets. He participated well in the evaluative process. He was observed to be somewhat fatigued following a lunch break. A second session was utilized to complete the evaluative process. Affect was mildly depressed, though psychological difficulties did not appear to interfere with his test performance. Specific assessment of effort was undertaken via administration of two symptom validity tests, the Test of Memory Malingered (TOMM) and Word Memory Test. Mr. Casey's performance on both of these tests was within stringent criteria consistent with our observation of providing good effort.

Language Functions: There was no aphasic or agnostic symptomatology. Mr. Casey's conversational speech was prosodic, fluent, of normal rate and tone with occasional slurring. There were no word finding difficulties in conversational speech. Mr. Casey's performance on a letter fluency test (T=45) was in the average range for an individual of his age and educational level. There was no evidence of receptive language dysfunction.

Sensory/Perceptual/Motor Functions: Evaluation failed to reveal any evidence of imperceptions or suppressions affecting tactile or visual modalities during unilateral or bilateral stimulation paradigms. Mr. Casey demonstrated imperceptions and suppressions to left sided auditory stimulation. He performed efficiently on a tactile finger recognition test and made a few unsystematic errors on a Test of Graphesthesia. Mr. Casey had no difficulty recognizing gross tactile forms in each of his extremities.

Mr. Casey reports being right hand dominant. He ambulated without difficulty or need for assistance. He reported some residual low back pain that is aggravated by physically exerting activities. On a test demanding fine motor speed (Finger Tapping Test), he demonstrated bilateral slowness suggestive of moderate impairment. Assessment of grip strength revealed mild deviation from expected performance bilaterally. Mr. Casey's performance on a test demanding fine motor speed and dexterity (Grooved Pegboard Test) revealed deviation from expected performance bilaterally suggestive of mild impairment.

Attention/Memory Functioning: Mr. Casey was errorless in his performance on an extended test of information and orientation. On the Stroop Test, he demonstrated slowed and impaired processing speed for word (T=29) and color (T=35) stimuli. He remained mildly slow, but without added decrement in his performance on a divided attentional task (T=40). Mr. Casey's performance on an attentional task demanding discrimination of rhythmic sounds was below average (T=41) for an individual of his age and educational level. On an attentional task demanding discrimination of speech sounds and matching them to their phonemes (T=36), his performance was suggestive of mild impairment. Mr. Casey's performance on WAIS-III tasks assessing working memory placed him at the 25th percentile. Mr. Casey was also administered the Paced Auditory Serial Addition Test (PASAT), a measure of information processing speed and attentional regulation. Mr. Casey was able to meet the demands of this test. Observation of test performance revealed an average initial trial performance with mild decrements in his performance as the trials became more rapid and demanding. Mr. Casey's total recall score on the PASAT was within the average range (T=57) for an individual of his age and educational level.

Mr. Casey was also administered the Conner's Continuous Performance Test-II to further assess his attentional capacities. Observation of test performance revealed slow responding coupled with lots of errors which is a distinctively problematic pattern that cannot easily be explained by response style. Generally, this pattern is a strong indicator of an attention related deficit. Mr. Casey was generally erratic in his responding, indicative of poor attention capacity. He was also substantially affected by the interstimulus interval. Specifically, responses became slower and a lot more erratic when the interstimulus interval was slowed from one second to two and four seconds. The finding may reflect limitations in his ability to adjust to change in task demands.

Mr. Casey was administered the Wechsler Memory Scale-III (WMS-III) to assess different components of anterograde memory. Mr. Casey was variable in his performance across WMS-III tasks. Mr. Casey's performance on tasks assessing immediate auditory memory placed him at the 34th percentile. Mr. Casey was less efficient in his performance on WMS-III tasks assessing immediate visual memory (10th percentile). He demonstrated an adequate ability to retain auditory (30th percentile) and visual (50th percentile) information after a period of delay. Mr. Casey's performance on WMS-III tasks assessing working memory was in the low average range (21st percentile).

Analysis of separate WMS-III scale performance revealed Mr. Casey to have an average ability to immediately learn and recall orally presented narrative passages. Mr. Casey was below average in his performance on a visual memory task demanding free recall of family pictorial stimuli. He demonstrated a low average ability to retain and recall previously learned narrative passages after a period of delay (percent retention =81). Mr. Casey was deficient in his performance on a visual memory task involving the immediate learning and reproduction of visual designs (2nd percentile). He demonstrated an adequate ability to retain and reconstruct previously learned visual designs after a period of delay (percent retention =77).

Mr. Casey was also administered the California Verbal Learning Test-II (CVLT-II), a repetitive word list learning task. Mr. Casey's total recall score after five administrations of the word list placed him at the 50th percentile compared to age related peers. Observation of test performance revealed significant deficit in his initial trial performance consistent with difficulties with attentional capacities and immediate learning. Yet, Mr. Casey showed a good ability to profit from repetitive administrations, demonstrating a good learning curve. He demonstrated difficulties in his ability to retain and recall word list information in a short and long delay, free and cued recall process. Assessment of learning characteristics revealed heavy reliance on recall from the recency region of the word list. There were no excessive intrusive errors. Mr. Casey was generally efficient in his performance on a recognition task demanding that he discriminate target from non-target words, though he made six false positive errors. Mr. Casey performed efficiently on a long delay, forced choice recognition test consistent with our observation of providing good effort.

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Visual Spatial/Visual Constructional Functions: There was no evidence of visual inattention or neglect processes. Nor was there evidence of constructional difficulties. Mr. Casey's performance on WAIS-III tasks assessing perceptual organizational skills placed him at the 63rd percentile. His performance was improved from that obtained in previous I.Q. testing conducted by Dr. Grace (47th percentile). On a test demanding fine discriminations of lines in space, Mr. Casey's performance was in the low average range (22nd percentile). On a visuographic sequencing test involving the serial processing of numbers, he was slow in the completion of the task (T=42) but without confusional error. When the task became more demanding, involving alternation between numbers and letters in sequential fashion, Mr. Casey's performance was within average limits (T=53).

Higher Reasoning/Problem Solving Abilities: Mr. Casey was able to inhibit and sequence fine motor movements on go-no go types of tasks. Mr. Casey performed efficiently on an executive functioning task involving letter fluency as well as being able to meet the set shifting skills associated with Trail Making Test-Part B.

Mr. Casey was re-administered the Wechsler Adult Intelligence Scale-III (WAIS-III) classifying his intellectual functioning to be in the average range with a Full Scale I.Q. of 96, a Verbal I.Q. of 91, and a Performance I.Q. of 104. Mr. Casey's Full Scale I.Q. places him at the 39th percentile. His performance was generally consistent with that obtained in previous evaluation conducted by Dr. Grace (FS I.Q.=97, V I.Q.=100, P I.Q.=104).

WAIS-III analysis revealed Mr. Casey to perform in the average range on tasks assessing perceptual organizational skills (63rd percentile). Mr. Casey was less efficient in his performance on WAIS-III tasks assessing verbal comprehension skills (32nd percentile). Mr. Casey's performance on tasks assessing working memory (25th percentile) was less efficient than that obtained in previous evaluation by Dr. Grace. Yet, Mr. Casey was more efficient with regard to his performance on processing speed tests (21st percentile) compared to that obtained by Dr. Grace (4th percentile).

Analysis of separate WAIS-III scale performance revealed significant strength on a task demanding attention to visual detail in the tangible environment (91st percentile).

Mr. Casey was administered the Wisconsin Card Sorting Test, which demands the ability to generate and discover the correct solution set as well as to shift the basis of one's responding when the externally imposed demands of the task necessitated this. Observation of test performance revealed Mr. Casey to readily identify the 1st correct hypothesis. Observation of test performance revealed that concentration difficulties interfered considerably with his effective problem solving abilities. Mr. Casey attained only four of the expected six categories but with an acceptable rate of perseverative errors (10%) and six failures to maintain set. The latter finding is consistent with disruption due to attention/concentration difficulties.

Mr. Casey was also administered the Tactual Performance Test (TPT) which demands keen kinesthetic/proprioceptive abilities as well as organizational/planning skills. Mr. Casey's initial dominant hand performance was above average (T=56). Yet, he demonstrated considerable difficulty profiting from this initial learning trial during his 2nd trial, non-dominant hand performance (T=36). Mr. Casey was improved in his 3rd trial, both hands performance (T=43). His incidental memory score (T=33) was suggestive of mild to moderate impairment. Yet, his location score (T=50) was in the average range.

Emotional/Mood State Functioning: Review of medical records revealed considerable concerns regarding Mr. Casey experiencing disruptive psychological difficulties as the result of his involvement in the medical incidents. There has been persistence of fatigue, agitation, and somatic symptomatology as well as concern regarding depression, anxiety, and posttraumatic stress.

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In the current evaluation, Mr. Casey reported continuing difficulties with sadness/depression, sleep disturbance which is assisted by use of Ambien, irritability/impatience, and low energy level. He appears to be quite withdrawn and not engaging in social and recreational pursuits. There are additional environmental stressors including financial stress.

Mr. Casey was administered the Personality Assessment Inventory (PAI) to further assess his psychological functioning. Mr. Casey's response set (validity scales) to the PAI indicated that he presented himself in an honest, straight forward fashion.

The obtained PAI clinical profile reveals an individual who is reporting significant unhappiness, moodiness, and tension. Mr. Casey's self esteem is quite low at this time, and he views himself as ineffectual and powerless to change the direction of his life. The disruptions in his life have left him uncertain about his goals and priorities, and tense and pessimistic about what the future may hold. Mr. Casey reports difficulties in concentrating and making decisions.

Separate scale elevations reveal report of highly disruptive depression. Mr. Casey reports being severely depressed, discouraged, and withdrawn. He appears to be plagued by fears of worthlessness, hopelessness, and personal failure. There is also report of experiencing a discomforting level of anxiety and tension. He is socially isolated at this time and identifies few interpersonal relationships that he describes as being close and warm.

Consistent with ongoing disruptive somatic symptomatology, Mr. Casey reports concern about physical functioning and health matters. He sees his life as being highly compromised by his ongoing numerous and varied physical/health problems.

Mr. Casey reports experiencing recurrent episodes of anxiety associated with a traumatic experience in his life. He identifies the traumatic experience as being the medical incident.

Self concept appears to be quite harsh and negative at this time. Mr. Casey's interpersonal style is best characterized as being withdrawn and isolated at this time. He appears to be very uncomfortable in social situations at this time.

Mr. Casey also reported experiencing periodic and transient thoughts of self harm. He denied any specific suicidal plan. He does endorse being pessimistic and unhappy about his prospects for the future.

Overall, the PAI profile is consistent with an individual who is experiencing disruptive depression and anxiety in the context of ongoing somatic difficulties. There is report of associated neurocognitive difficulties as well as being quite socially withdrawn and isolated.

Mr. Casey also responded to the Ruff Neurobehavioral Inventory. The Ruff allows for an assessment of individuals in the domains of cognitive emotional and physical functioning as well as quality of life pre and post their involvement in a traumatic incident.

Mr. Casey's responses indicated that he did not believe he had any ongoing disruptions in the realms of cognitive, emotional, or physical functioning prior to his involvement in the medical incident.

Mr. Casey reported that post accident, he has experienced significant disruption in cognitive emotional, and physical realms of functioning as well as quality of life. In the cognitive domain, he identified significant disruption with regard to attention/concentration, executive functioning, and learning and memory.

In the emotional domain, Mr. Casey reported significant disruption with regard to anxiety, depression, posttraumatic stress, as well as anger and irritability.

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In the physical realm, he reported significant disruption with regard to somatic symptomatology and pain. Mr. Casey also reported significant disruption of his ability to pursue vocational activities.

Summary/Integration: Mr. Casey is a 46-year-old Caucasian male referred for neuropsychological evaluation. Intellectual evaluation revealed Mr. Casey to be functioning in the average range of abilities. Neurocognitive evaluation revealed slowed mental/information processing speed with variability in Mr. Casey's attentional capacities. Assessment of memory functioning revealed difficulties with immediate learning/memory capacities but no compelling evidence of rapid forgetting (amnestic syndrome). Neuropsychological evaluation revealed Mr. Casey's primary impairments to be deficits in his speed of processing with difficulties sustaining attention/concentration, and reduced immediate learning capacities. There was no compelling evidence for impairment specifically affecting visual spatial skills, receptive or expressive language functions, or higher reasoning capacities. Assessment of sensory perceptual functioning revealed imperceptions and suppressions affecting left sided auditory processes. Motor functioning was characterized by slowness and weakness.

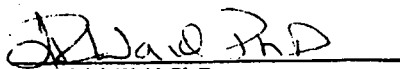
Assessment of emotional functioning revealed continuing difficulties with depression, fatigue/low energy level, anxiety/stress, social withdrawal/isolation, and disruptive pain and somatic symptomatology. Mr. Casey has not efficaciously responded to psychological/psychiatric treatment. This suggests the potential that difficulties/impairments are at least partially attributable to organic injury.

Overall, Mr. Casey's presentation is one of neurocognitive deficits that would be consistent with a subcortical injury. Dr. Fogerty provided rationale for the potential that Mr. Casey may well have a permanent neurological deficit. Pain symptomatology, depression, sleep disturbance, and fatigue could also be contributing to his experience of neurocognitive impairments. Mr. Casey's current neurocognitive and emotional/behavioral deficits are likely due to a multifactorial etiology. What is evident is that Mr. Casey has remained highly compromised with regard to cognitive, emotional, and physical functioning, rendering him unable to return to employment pursuits.

Based on The Diagnostic and Statistical Manual of Mental Disorders-4th Edition-TR (DSM-IV-TR), the following multiaxial assessment is provided:

Axis I	Mood Disorder with depressed mood (293.83) secondary to persistent somatic symptomatology and potential permanent neurological deficit due to complication of laser bronchoscopy. Cognitive Disorder, NOS (294.90) due to the interfering effects of somatic symptomatology, mood disturbance, sleep disturbance/fatigue, and potential permanent neurological deficit due to complications of laser bronchoscopy.
Axis II	No diagnosis (V71.09).
Axis III	Pain/somatic symptomatology; motor weakness; residual back pain; episodic chest pain; status post laser bronchoscopy complicated by pneumomediastinum and pneumothorax.
Axis IV	Marital separation/divorce; disability/unemployment; Workers' Compensation litigation.
Axis V	GAF=50 (Current).

Thank you for allowing me to participate in the evaluative care of Mr. William Mark Casey. If you have any questions regarding the evaluation or report, please do not hesitate to call me.



L. Randolph Waid, Ph.D.
Licensed Clinical Psychologist
Clinical Associate Professor in Psychiatry/Neurology, MUSC

LRW/emf

THOMPSON 002801

PLAINTIFF EXHIBIT 1
WAID, L. R. PH.D

THOMPSON 002802

CURRICULUM VITAE

Lewis Randolph Waid, Ph.D.

WORK ADDRESSES:

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1459 Stuart Engals Boulevard, Suite 204
Mount Pleasant, South Carolina 29464
(843) 881-2778

Medical University of South Carolina
Department of Psychiatry and Behavioral Sciences
67 President Street
P.O. Box 250861
Charleston, SC 29425
(843) 792-2727

DATE AND PLACE OF BIRTH:

1952
San Juan, Puerto Rico
US citizenship

LICENSURE

License #333, South Carolina Board of Examiners in
Psychology (Clinical Psychology)

EDUCATIONAL BACKGROUND

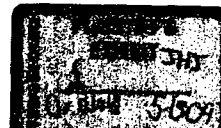
Temple University, Philadelphia, PA, 1974, B.A., Psychology (Magna Cum Laude)

University of Richmond, Richmond, VA, 1977, M.A., General Psychology

VAMC/Medical University of South Carolina, Charleston, SC, 1980-81, Clinical Psychology
Internship

University of North Texas, Denton, Texas, 1982, Ph.D., Clinical Psychology

Rev. Oct-08



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POSITIONS

Current

Clinical Associate Professor, Departments of Psychiatry and Neurology, Medical University of South Carolina, Charleston, SC, 1998 – Present

Independent Practice, Clinical, Forensic, and Neuropsychological Services, Tidewater Executive Center, Mt. Pleasant, SC, 1998 – Present

Adjunct Professor, Department of Psychology, The Citadel, Charleston, SC, 1998 – Present

Neuropsychology Consultant, Strand Regional Specialty Associates, Myrtle Beach, SC, 1998 – 2006

Neuropsychology Consultant, Charleston Pain and Rehabilitation Center, Charleston, SC, 1998 – Present

Past

Associate Professor, Departments of Psychiatry and Behavioral Sciences, and Neurology, Medical University of South Carolina, Charleston, SC, 1993 – 1998

Director, Assessment Center, Institute of Psychiatry, Medical University of South Carolina, Charleston, SC, 1992 – 1998

Director, Post-Doctoral Clinical Neuropsychology Fellowship, Institute of Psychiatry, Medical University of South Carolina, 1992 – 1998

Director, Pre-Doctoral Clinical Psychology Internship (APA Division 40 Neuropsychology Tract) VAMC/MUSC Internship Consortium, Medical University of South Carolina, 1995 – 1998

Assistant Professor, Department of Psychiatry and Behavioral Sciences, Medical University of South Carolina, Charleston, SC, 1983 – 1993

Assistant Professor, Department of Neurology (dual appointment), Medical University of South Carolina, Charleston, SC, 1992 – 1993

Clinical Psychologist/Neuropsychologist, Adult Psychiatry, Institute of Psychiatry, Medical University of South Carolina, Charleston, SC, 1989 – 1992

Clinical Psychologist, Adult Psychiatry, Veterans Administration Medical Center, Charleston, SC, 1983 – 1989

Director, Post-Traumatic Stress Disorder Treatment Team, VA Medical Center, Charleston, SC, 1988 – 1989

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Director, Vietnam Era Veteran Treatment Team, VA Medical Center, Charleston, SC, 1984 – 1987

Director, Psychological Services, Dallas Psychiatric Associates, Dedman Medical Center, Dallas, TX, 1981 – 1983

Independent Practice, Van Buskirk and Associates, Dallas, TX. 1982 – 1983

Clinical Director, Adolescent Security Unit, Commonwealth Psychiatric Clinic, Richmond, VA, 1976 – 1977

Psychiatric Aide, Fairfield Hills State Hospital, Newtown, CT, 1974 – 1975

MAJOR TEACHING ACTIVITIES

Adjunct Professor, Graduate Psychology Program, The Citadel, Charleston, SC, Substance Abuse Counseling, 1998 – 2003

Motivational Interviewing Network of Trainers (MINT), local, regional, and national workshops, 1999 – Present

Clinical supervision of post-doctoral neuropsychology fellows, Institute of Psychiatry, Medical University of South Carolina 1992 – 1998

Clinical supervision of pre-doctoral psychology interns (APA Division 40 Neuropsychology Tract), VAMC/MUSC Internship Consortium, Charleston, SC, 1995 – 1998

Clinical supervision of pre-doctoral psychology interns (Psychological Assessment Rotation), Institute of Psychiatry, Medical University of South Carolina 1992 – 1995

Director, Clinical Psychology Internship Seminar Series, VAMC/MUSC Internship Consortium, Medical University of South Carolina 1992 – 1998

Instructor, College of Dental Medicine, Medical University of South Carolina 1992 – 2000

Clinical supervision of psychology interns, Adult Inpatient Psychiatry Rotation, Institute of Psychiatry, Medical University of South Carolina 1989 – 1992

Clinical supervision of psychology interns, Adult Inpatient/Outpatient psychiatry rotation, Veterans Administration Medical Center, VAMC/MUSC Internship Consortium, Charleston, SC 1983 – 1989

Clinical supervision of neuropsychological assessment practicum for interns, VAMC/MUSC Internship Consortium, Charleston, SC 1986 – 1989.

Preceptor, VAMC/MUSC Clinical Psychology Internship, Charleston, SC, 1983 – 1998

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Lewis Randolph Waid
Curriculum Vitae
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Course Leader, Psychology Internship Seminar Series (Clinical Neuropsychology; Post-Traumatic Stress Disorder; Borderline and Other Personality Disorders; Forensic Psychology)
VAMC/MUSC Internship Consortium, 1983 – 1998

Lecturer, PGY2 Psychiatry Resident Seminars (Clinical Neuropsychology; Stress Related Disorders; Forensic Psychiatry; Adult Attention Deficit Disorder, Medical University of South Carolina 1983 – 1998

Lecturer, Neurology Residents' Neuroscience Seminar Program, (Neuropsychological Assessment), Department of Neurology, Medical University of South Carolina, 1990 – 1998

Behavioral Science seminar Leader, Medical University of South Carolina, Charleston, SC, 1983 – 1995

Interview Workshop Leader, Physical Diagnosis Course, Medical University of South Carolina, Charleston, SC, 1984 – 1998

Lecturer, Veterans Administration Medical Center Inpatient Psychiatry Resident Conference, 1990 – 1992

Psychopathology lecturer, second year medical students, Medical University of South Carolina, Charleston, SC, 1984 – 1987.

Lecturer, Department of Periodontics, College of Dental Medicine, Medical University of South Carolina (Myofascial Pain Dysfunction Syndrome), 1984 – 1990

Instructor, Disturbed Behavior Workshop, Veterans Administration Medical Center, Charleston, SC 1987 – 1989

Teaching/Research Assistant, Department of Psychology, University of North Texas, Denton, TX 1978 – 1980

Teaching Assistant, Department of Psychology, University of Richmond, Richmond, VA 1975 – 1976

AWARDS & HONORS

Best Scientist-Practitioner Award, Clinical Psychology Internship Program, Department of Psychiatry and Behavioral Sciences, Medical University of South Carolina 1992-1993

Outstanding Performance Award, VA Medical Center, Charleston, South Carolina 1985; 1989

Outstanding Teaching Award, Clinical Psychology Internship Program, Department of Psychiatry and Behavioral Sciences, Medical University of South Carolina 1985-86; 1986-87; 1988-89; 1989-90; 1990-91; 1993-94; 1994-95

VA Administrator's Hands and Heart Award, VA Medical Center, Charleston, SC 1986

Passed with Distinction Preliminary Written and Oral Examination for the Ph.D., North Texas State University, Denton, TX 1980

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Lewis Randolph Waid
Curriculum Vitae
Page 5

Outstanding Graduate Student Award, Psychology Department, University of Richmond, Virginia
1976
Graduate Fellowship, University of Richmond, Virginia 1975
Phi Beta Kappa, Temple University, Philadelphia, PA 1974
Athletic Scholarship (Baseball), Temple University, Philadelphia, PA 1970-1974

MEMBERSHIPS IN PROFESSIONAL ORGANIZATIONS

American Psychological Association
Division of Clinical Psychology (12)
Division of Clinical Neuropsychology (40)
American Psychology Law Society (41)
Addictive Behaviors (50)
Southeastern Psychological Association
Research Society on Alcoholism
National Academy of Neuropsychology
International Neuropsychology Society
Coalition of Clinical Practitioners in Neuropsychology
South Carolina Academy of Professional Psychologists
South Carolina Psychological Association
Society for Personality Assessment
South Carolina Head Injury Association
South Carolina Neuropsychology Interest Group (Chair 1994 – 1995)
The Association of Traumatic Stress Specialists
American Academy of Experts in Traumatic Stress
Motivational Interviewing Network of Trainers

COMMITTEESHIPS

Assessment/Treatment of Sexual Offenders Committee, Lowcountry Children's Center,
Charleston, SC, 2000 – 2002
Psychology Education Committee, Department of Psychiatry, Medical University of South
Carolina 1995 – 1998
Outpatient Steering Committee, Department of Psychiatry, Medical University of South Carolina
1997-1998
Lowcountry Children's Center Research Advisory Board, Charleston, SC, 1996 – 1999
Psychiatric Task Force/UMA, Medical University of South Carolina 1995 – 1997
Ambulatory Care System Committee, Institute of Psychiatry, Medical University of South
Carolina 1994 – 1995
Clinical Services Committee, Institute of Psychiatry, Medical University of South Carolina 1994
– 1998
Intern Selection Committee, VAMC/MUSC Consortium, Charleston, SC, 1994 – 1998
Psychology Intern Coordinator, VAMC/MUSC Consortium, Charleston, SC, 1994 – 1998
Geriatric Improvement Team (BICU), Institute of Psychiatry, Medical University of South
Carolina 1992 – 1994

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Executive Committee, 3 North Adult Inpatient Psychiatry Unit, Institute of Psychiatry, Medical University of South Carolina 1989 – 1992
Milieu Management Committee, Institute of Psychiatry, Medical University of South Carolina 1990 – 1992
Co-Founder (Chair), SC Psychological Association Neuropsychology Interest Group 1990 – 1995
Executive Committee, Inpatient Psychiatry Unit, VAMC 1988 – 1989
Disturbed Behavior Task Force Committee, VAMC 1986 – 1989
Psychology Internship Education Committee, VAMC/MUSC 1984 – 1993
Medical District 9 Technical Advisory Group (TAG) on AIDS, Veterans Administration 1987 – 1988
Closed Head Injury Advisory Committee, Department of Physical Medicine and Rehabilitation, MUSC 1986 – 1988
Psychology Internship Seminar Committee, Co-Chair, VAMC/MUSC 1985 – 1988, 1990 – 1993 (Chairman, 1994 – 1998)
Do Not Resuscitate/Death in Dignity Task Force, VAMC 1985 – 1987
Clinical Psychology Training Committee, Department of Psychology, North Texas State University 1979 – 1980

CONSULTANT ACTIVITIES

Drug Abuse Sciences, Naltrel 99-03 study, 2000 – 2001
Departments of Neurology, Neurosurgery, and Physical Medicine and Rehabilitation, Medical University of South Carolina (Clinical Neuropsychology Consultant) 1983 – 1992
Vietnam Veteran Outreach Center (Vet Center), Charleston, SC 1983 – 1987
Advisory Board, SC State Chapter, Head injury Foundation, Orangeburg, SC, 1985 – 1989
Advisory Board Head Injury Program, Southern Pines Hospital, Charleston, SC 1987 – 1989

EDITORIAL ACTIVITY

Reviewer, Vet Center Voice 1986 – 1989
Reviewer, Journal of Traumatic Stress 1997 – 1998

GRANT ACTIVITY

"Gabapentin as an Adjunct to Naltrexone for Alcoholism." NIAAA \$2,355,397, September 2002 – August 2007. Supervising therapist.
"Comparison of CBT and MET plus Naltrexone for Alcoholism." NIAAA (RO1), \$1,218,257, September 1997 – August 2002 (PI: Ray Anton, M.D.) Co-Investigator
"Naltrexone/Acamprosate plus CBT/MET Light for Alcoholism" (COMBINE study). Principal Therapist. NIAAA (U10), \$2,334,861, September 1997 – August 2003

THOMPSON 002808

"Amlodipine Treatment for Cocaine Dependence" NIDA (RO1) \$1,495,259, September 1997 – August 2002. (PI: Robert J. Malcolm, MD) Co-Investigator

"Sertraline and Cognitive Therapy in Depressed Alcoholics." NIAAA (R29), \$503,878, April, 1995 – March, 2001. (PI: Darlene Moak, M.D.) Co-Investigator

"Opiate Antagonist: Alcohol Reactivity and Consumption." NIAAA (P50), \$1,172,633, December 1, 1995 – November 30, 2000. (PI: Ray Anton, M.D.) Co-Investigator

"Naltrexone and Cognitive Behavior Therapy of Alcoholism" NIAAA (RO1), \$1,712,467, 1992 – 1997. (PI: Ray Anton, MD) Co-Investigator

"Neurocognitive and Neuropsychological Manifestations of Eosinophilia Myalgia Syndrome." Showa-Denko America Inc., \$124,674, 1994-1995. Co-Investigator

Charleston Heart Study – "Predictors of Coronary Disease in Blacks," Competitive Renewal: National Heart, Lung, and Blood Institute, Medical University of South Carolina, 1984-1990, \$303,223 annually. (Grant 2-RO1-HL3139-7-04) Assessment of cognitive functioning in elderly black and white cohort. (Competitive renewal 1990-1993). Co-Investigator

Matching alcohol treatments to client heterogeneity. National Institute of Alcohol Abuse and Alcoholism, \$880,000. October 1989 – September 1994. Therapist in Motivational Enhancement Therapy (MET) condition.

"Ritanserlin in the Treatment of Alcohol Dependence: A Double-Blind Placebo-Controlled Phase III Study." (Protocol II RIT-USA-40) Janssen Research Foundation. 1993–1994. Co-Investigator

PUBLICATIONS AND PRESENTATIONS

Journal Articles

Waid, L.R., Kanoy, R.C., Blick, K., and Walker, W. (1978). Relationship of state-trait anxiety and type of practice to reading comprehension of college students. Journal of Psychology, 98, 27–36.

Critelli, J.W. and Waid, L.R. (1980). Physical attractiveness, romantic love, and equity in dating relationships. Journal of Personality Assessment, 44, 624–630.

Rahaim, S., Waid, L.R., Kennelly, K., and Strickland, A. (1980). Differences in the self-monitoring of expressive behavior in depressed and nondepressed individuals. Psychological Reports, 46, 1051–1056.

Kennelly, K., Crawford, D., Waid, L.R., and Rahaim, S. (1980). Partial reinforcement immunizes against helplessness induced short-term memory deficits. Catalog of Selected Documents in Psychology (APA), 10.

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- O'Neil, P.M., Giacinto, J.P., Waid, L.R., Roitzsch, J.C., Miller, W.C., and Kilpatrick, D.G. (1983). Behavioral, psychological, and historical correlates of MacAndrew scale scores among male alcoholics. Journal of Behavioral Assessment, 5, 261-273.
- Mishkin, D.J., Fourrier, J.L., Shelley, L.R., and Waid, L.R. (1986). A common sense approach for treatment of myofascial pain-dysfunction syndrome. Florida Dental Journal, 56. (Also published in The Journal of the Alabama Dental Association, 1986, 70, 34-41).
- Anton, R.F., Waid, L.R., Fossey, M., and AuBuchon, P. (1986). Case report of carbamazepine treatment of organic brain syndrome with psychotic features. Journal of Clinical Psychopharmacology, 6, 232-234.
- Waid, L.R. (1987). Atypical manifestations of post-traumatic stress: Clinicians Beware! PTSD Quarterly Newsletter, 4, 8.
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- Keil, J.E., Sutherland, S.E., Knapp, R.C., Waid, L.R., and Gazes, P.C. (1992). Self-reported sexual functioning in elderly blacks and whites (The Charleston Heart Study Experience). Journal of Aging and Health, 4, 112-125.
- Waid, L.R. and Mintzer, J.E. (1993). Ethnicity, culture and mental health in the elderly. American Association for Geriatric Psychiatry Newsletter, 13(4), 9-13.
- Rhodes, S.K., Shimoda, K.C., Waid, L.R., O'Neil, P.M., Oexmann, M.J., Willi, S.M., and Collop, N.A. (1994). Cognitive deficits in morbidly obese adolescents with sleep apnea. International Journal of Obesity, 18, 13.
- Waid, L.R. (1996). Can we get your attention? Progress Notes - MUSC Institute of Psychiatry, 1, 1-2.
- Mintzer, J.E., Nietert, P., Costa, K., and Waid, L.R. (1996). Cross-cultural perspectives: Agitation in demented patients in the United States. International Psychogeriatrics, 8, 487-490.
- Johnson, D.E., Waid, L.R., and Anton, R.F. (1997). Childhood hyperactivity, gender, and Cloninger's personality dimensions in alcoholics. Addictive Behaviors, 22, 649-653.
- Mintzer, J.E., Colenda, C., Waid, L.R., Lewis, L., Meeks, A., Stuckey, M., Bachman, D.L., Saladin, M., and Sampson, R.R. (1997). Effectiveness of a continuum of care model for agitated dementia patients. Psychiatric Services, 48, 1361-1448.

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- Horner, M.D., Waid, L.R., Johnson, D.E., Latham, P.K., and Anton, R.F. (1999). The relationship of cognitive functioning to amount of recent and lifetime alcohol consumption in outpatient alcoholics. Addictive Behaviors, 24, 449-453.
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Book Chapters

- Waid, L.R., Johnson, D.E., and Anton, R.F. (1997). Attention-Deficit Hyperactivity Disorder and substance abuse. In H.R. Kranzler and B.J. Rounsaville (Eds.), Dual Diagnosis: Substance Abuse and Comorbid Medical and Psychiatric Disorders. Marcel Dekker, Inc., New York, N.Y.
- Waid, L.R., LaRowe, S.D., Anton, R.F., and Johnson, D.E. (2004). Attention-Deficit/Hyperactivity Disorder and Substance Abuse. In H.R. Kranzler and M. Tinsley (Eds.), Dual Diagnosis and Psychiatric Treatment. Marcel Dekker, Inc., New York, N.Y.

Treatment Manuals

Zweban, A., Barrett, D., Waid, L.R., and Anton, R.F. (2000). CPH-101 in heavy alcohol drinkers with impaired control: A 12 + 40-week, placebo-controlled, dose response study ("The Nalmefene Study").

Zweban, A., Barrett, D., Waid, L.R., and Anton, R.F. (2000). Motivating for alcohol reduction and medication management (MARMM): A manual for practitioners treating individuals on medication for alcohol problems.

Published Abstracts

O'Neil, P.M., Waid, L.R., and Giacinto, J.P. (1981). Psychological and behavioral correlates of MacAndrew scale scores among male alcoholics. Alcoholism: Clinical and Experimental Research, 5.

Waid, L.R., Malatesta, V.J., Roitzsch, J., and Giacinto, J.P. (1981). Personality, mood state, and psychological characteristics of young, middle-aged, and elderly alcoholic males. Alcoholism: Clinical and Experimental Research, 5.

Giacinto, J.G., O'Neil, P.M., Waid, L.R., and Roitzsch, J.C. (1981). A comparison of early-onset versus late-onset elderly alcoholic males. Alcoholism: Clinical and Experimental Research, 5.

Holmstrom, V.L., Waid, L.R., and Motsinger, P. (1987). Dementia vs. Pseudodementia: Is this the right question? Neurology, 37, 156.

Waid, L.R., Swavely, S.M., Keil, J.E., Sutherland, S.E., and Gazes, P. (1990). Cognitive functioning and cardiovascular status in elderly blacks and whites. The Clinical Neuropsychologist, 4, 275.

Waid, L.R., Bene, C.B., Bachman, D., and Carson, W.C. (1991). Malformation of the cerebral cortex with heterotopia of the gray matter: A case study. Archives of Clinical Neuropsychology, 6, 233.

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Leverett, J.P., Waid, L.R., Knapp, R.G., Keil, J.E., and Sutherland, S.E. (1992). Correlates of good and poor cognitive performance in elderly adults. Archives of Clinical Neuropsychology, 7, 343-344.

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- Wagner, M., Bachman, D., Cushman, L., Waid, R., and Hummer, J. (1994). Severity of dementia as a risk factor for driving. Archives of Clinical Neuropsychology, 9, 196.
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- Waid, L.R., Knapp, R.G., Williams, M., Keil, J.E., Sutherland, S., and Lackland, D. (1994). Blood pressure and cognitive performance: The Charleston Heart Study. Archives of Clinical Neuropsychology, 9, 197.
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- Waid, L.R., Johnson, D.E., Latham, P.K., Leverett, P., and Anton, R.F. (1994). Neuropsychological performance in alcohol and cocaine abusers. Alcoholism: Clinical and Experimental Research, 18, 524.
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- Rhodes, S.K., Shimoda, K.C., Waid, L.R., O'Neil, P.M., Oexmann, M.J., Willi, S.M., and Collop, N.A. (1994). Cognitive deficits in morbidly obese adolescents with sleep apnea. International Journal of Obesity, 18, 13.
- Hummer, J.T., Fink, C., Waid, L.R., and Wagner, M.T. (1994). WMS-R and MMPI-2 profiles of ADHD-RT versus learning-disabled adults. The Clinical Neuropsychologist, 8, 335.
- Shimoda, K.C., Waid, L.R., Abboud, M.R., Jackson, S.M., Matthews, K., Omfrak, E., Shearer, J., and Laver, S.H. (1994). Neuropsychological functioning in children with sickle cell disease and stroke. The Clinical Neuropsychologist, 8, 332.
- Wellborn, W.R., Hummer, J.T., Waid, L.R., Wagner, M.T., and Barnett, K. (1995). A comparative analysis of psychopathology and memory function in adult patients with mild neurobehavioral syndromes. Archives of Clinical Neuropsychology, 10, 402-403.
- Johnson, D.E., Waid, L.R., Latham, P.K., and Anton, R.F. (1995). The effects of gender and childhood hyperactivity on Cloninger's typologies in outpatient alcoholics. Alcoholism: Clinical and Experimental Research, 19 (Supplement), 56A.
- Horner, M.D., Johnson, D.E., Waid, L.R., Latham, P.K., and Anton, R.F. (1995). The relationship of recent and lifetime alcohol consumption to cognitive functioning in outpatient alcoholics. Alcoholism: Clinical and Experimental Research, 19 (Supplement), 69A.

- Waid, L.R., Johnson, D.E., Latham, P.K., and Anton, R.F. (1995). Neurocognitive and personality characteristics of alcoholics with childhood hyperactivity. Alcoholism: Clinical and Experimental Research, 19 (Supplement), 70A.
- Johnson, D.E., Waid, L.R., and Anton, R.F. (1996). Relationship of rating scales to DSM-IV diagnosis of childhood ADHD in adult alcoholics. Alcoholism: Clinical and Experimental Research, 20 (Supplement), 49A.
- Waid, L.R., Johnson, D.E., Latham, P.K., and Anton, R.F. (1996). Personality and neurocognitive characteristics of alcoholics scoring high and low on the obsessive compulsive drinking scale (OCDS). Alcoholism: Clinical and Experimental Research, 20 (Supplement) 50A.
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- Rhodes, S.K., Waid, L.R., O'Neil, P.M., Collop, N.A., and Willi, S.M. (1997). Neurocognitive functioning and obstructive sleep apnea in morbidly obese adolescents. Archives of Clinical Neuropsychology, 12, 393.
- Johnson, D.E., Waid, L.R., Foer, J., and Anton, R.F. (1997). Alcohol dependence rates in adults with attention deficit/hyperactivity disorder. Alcoholism: Clinical and Experimental Research, 21, 31A.
- Foer, J.F., Waid, L.R., and Gold, P.B. (1997). Litigation and peripheral injury: Neurocognitive effects in mild head injury. The Clinical Neuropsychologist, 11.
- Anton, R.F., Moak, D.H., Waid, L.R., Latham, P.K., Dias, J.K., Roberts, J.S. (1998). Post-treatment outcome of alcoholics treated with CBT with and without naltrexone. American College of Neuropsychopharmacology Meeting Procedures.
- Hayes, J.S., Waid, L.R., Horner, M.D., Johnson, D., Sonne, S., and Brady, K.T. (1998). Neuropsychological functioning in recently abstinent cocaine-dependent individuals. Archives of Clinical Neuropsychology, 13.
- Hayes, J.T., and Waid, L.R. (1998). Chronic neurobehavioral and neurological deficits after decompression sickness: A case study. Archives of Clinical Neuropsychology, 13.
- Waid, L.R., Herron, J.E., Latham, P., Dias, J.K., and Anton, R.F. (1999). Naltrexone, neurocognitive functioning and relapse in recently abstinent alcoholics. Alcoholism: Clinical and Experimental Research, 23, 57A.

Herron, J.E., Waid, L.R., and Anton, R.F. (1999). Craving, neurobehavioral variables, and relapse in outpatient alcoholics. Alcoholism: Clinical and Experimental Research, 23, 57A.

Anton, R.F., Moak, D.H., Latham, P.K., Myrick, D.L., and Waid, L.R. (2003). A double blind comparison of naltrexone combined with CBT or MET in the treatment of alcohol dependence. Alcoholism: Clinical and Experimental Research, 27(5), 191A.

Anton, R.F., Moak, D.H., Latham, P.K., Myrick, D.L., and Waid, L.R. (2004). A double blind comparison of naltrexone combined with CBT or MET in the treatment of alcohol dependence-within study and post-treatment results. Alcoholism: Clinical and Experimental Research, 28(5): suppl. 133A.

Teichner, G., Waid, L.R., and Buddin, W.H. (2005). The Memory and Concentration Test (MACT): Data from a sample demonstrating a range of neurological and psychiatric disorders. Archives of Clinical Neuropsychology, 20, 893.

Conference Presentations

Critelli, J.W. and Waid, L.R. (1979, August). Physical attractiveness, romantic love, and equity in dating relationships. Poster presented at the annual meeting of the American Psychological Association, New York, NY.

Kennelly, K. and Waid, L.R. (1982, March). Partial reinforcement immunizes against working short-term memory deficits. Poster presented at the annual meeting of the Southwestern Psychological Association, Dallas, Texas.

Waid, L.R., Giacinto, J.G., Cimbalic, P., Roitzsch, J.C., and Glick, S. (1983, August). Multi-faceted treatment for myofascial-pain dysfunction: A comparison of treatment components. Poster presented at the annual meeting of the American Psychological Association, Anaheim, California.

Waid, L.R. (1984, May). Neuropsychological evaluation of the elderly patient. Poster presented at Southeastern Regional Medical Education Center sponsored symposium "Geropsychiatry: Evaluation and Treatment of the Aged Patient," Charleston, South Carolina.

Waid, L.R. (1984, August). Japanese prison camp survivors: Psychic scarring. In V. Holmstrom (Chair), Post traumatic stress forty years later: Survivors of Japanese prison camps. Symposium presented at the annual convention of the American Psychological Association, Toronto, Canada.

Holmstrom, V.L., Pritchard, P., and Waid, L.R. (1984, August). Natural history of untreated complex partial epilepsy: Neuropsychological and personality assessment. Poster presented at the annual convention of the American Psychological Association, Toronto, Canada.

Waid, L.R., Anton, R.F., AuBuchon, P., and Fossey, M. (1985, May). A neuropsychological case study of carbamazepine treatment of organic brain syndrome with psychotic features. Poster presented at the Mid-South Conference on Human Neuropsychology, Memphis, Tennessee.

- Waid, L.R., Shaw, D.L., Holmstrom, V.L., and Sexauer, J.D. (1985, August). Objective personality assessment of WW II American POWS: Diagnostic group comparisons. Paper presented at the annual convention of the American Psychological Association, Los Angeles, California.
- Holmstrom, V.L., Waid, L.R., Shaw, D.L., and Sexauer, J.D. (1985, August). Marital adjustment among American World War II POWS. Paper presented at the annual convention of the American Psychological Association, Los Angeles, California.
- Shaw, D.L., Holmstrom, V.L., Waid, L.R., and Sexauer, J.D. (1985, August). Social adjustment among America WW II POWS: Diagnostic group comparisons. Paper presented at the annual convention of the American Psychological Association, Los Angeles, California.
- Sexauer, J.D., Holmstrom, V.L., Shaw, D.L., and Waid, L.R. (1985, August). WW II American POWS: Captivity related stressors and present day symptomatology. Paper presented at the annual convention of the American Psychological Association, Los Angeles, California.
- Waid, L.R., Kahles, J., Hamilton, S., and Lydiard, B. (1986, March). Mentation after medication: The effect of alprazolam on cognitive functioning of panic disordered patients. Paper presented at the annual meeting of the Southeastern Psychological Association, Orlando, Florida.
- Waid, L.R., Cogar, G., and Libet (1986, March). Two case studies of atypical post-traumatic stress: The problem of false negatives. Paper presented at the annual meeting of the Southeastern Psychological Association, Orlando, Florida.
- Libet, J., Waid, L.R., and Cogar G. (1986, March). When social validation is unreliable? Paper presented at the annual meeting of the Southeastern Psychological Association, Orlando, Florida.
- Waid, L.R. and Holmstrom, V.L. (1986, September). Diagnostic and treatment issues of stress disorders among World War II POWS. Paper presented at the 2nd Annual meeting of the Society for Traumatic Stress Studies, Denver, Colorado.
- Waid, L.R., Cogar, G., and Miller, W.C. (1987, February). Vet Center and Medical Center Collaboration. Panel presentation at Region III Veterans Administration Training Conference on "Diagnosis and Management of Post Traumatic Stress Disorder in the VA", Orlando, Florida.
- Holmstrom, V.L., Waid, L.R., and Motsinger, P. (1987, April). Dementia versus pseudodementia: Is this the right question? Poster presented at the 39th Annual meeting of the American Academy of Neurology, New York, New York.
- Waid, L.R. and West, B. (1987, April). Issues in neuropsychology. Paper presented at the Annual meeting of the South Carolina Psychological Association, Myrtle Beach, South Carolina.

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- Waid, L.R. (1987, November). Discovering dissociation in a Vietnam combat veteran: A videotape case presentation. Paper presented at the Fourth International Conference on Multiple Personality/Dissociative States, Chicago, Illinois.
- Waid, L.R. and Schneider, S.K. (1988, March). Perceived versus objective memory functioning in individuals with closed head injury. Poster presented at the annual meeting of the Southeastern Psychological Association, New Orleans, Louisiana.
- Waid, L.R., Roberts, J., and Schneider, S.K. (1988, April). Naltrexone treatment for postconcussional syndrome. Poster presented at conference on Head Injury: An integrated approach to behavioral rehabilitation, Boston, Massachusetts.
- Schneider, S.K., Waid, L.R., and White, D. (1988, April). Secondary mania and its treatment following head injury. Poster presented at conference on Head Injury: An integrated approach to behavioral rehabilitation, Boston, Massachusetts.
- Waid, L.R. (1988, August). Dissociation in combat-related Post-traumatic Stress Disorder. In L.A. Hyer (Chair) Base rates of PTSD and newer measures for its evaluation. Symposium presented at the annual convention of the American Psychological Association, Atlanta, Georgia.
- Waid, L.R., Urbanczyk, S.A., Keil, J.E., Sutherland, S.E., and Gazes, P.C. (1989, March). Cognitive functioning and health status in elderly Blacks and Whites. Poster presented at the annual meeting of the Southeastern Psychological Association, Washington, D.C.
- Waid, L.R., Urbanczyk, S.A., Sutherland, S.E., Keil, J.E., and Gazes, P.C. (1989, June). Cardiovascular status and cognitive functioning: The Charleston Heart Study. Poster presented at the annual meeting of the Society for Epidemiologic Research, Birmingham, Alabama.
- Waid, L.R. and Urbanczyk, S.A. (1989, August). Comparison of high versus low dissociative Vietnam veterans with PTSD. Poster presented at the annual convention of the American Psychological Association, New Orleans, Louisiana.
- Waid, L.R., Swavely, S.M., and West, B. (1990, March). Development of a S.C.P.A. Neuropsychology Interest Group. Paper presented at the annual meeting of the South Carolina Psychological Association, Myrtle Beach, SC.
- Waid, L.R. (1990, March). Emotional and psychological consequences of minor head injury. Paper presented at continuing education workshop: Examining Minor Head Injury: Assessment, Intervention, and Outcome, Charleston, SC.
- Waid, L.R., Swavely, S.M., Keil, J.E., Sutherland, S., and Gazes, P. (1990, June). Cognitive function, cardiovascular status and physical disability in elderly blacks and whites of the Charleston heart study. Poster presented at the annual meeting of the Society for Epidemiologic Research, Snowbird, Utah.

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- Waid, L.R., Swavely, S.M., Keil, J.E., Sutherland, S., and Gazes, P. (1990, August) Cognitive functioning and cardiovascular status in elderly blacks and whites. Poster presented at the annual convention of the American Psychological Association, Boston, Mass.
- Waid, L.R., Bene, C.B., Bachman, D., and Carson, W.C. (1990, November). Malformation of the cerebral cortex with heterotopia of the gray matter: A case study. Poster presented at the annual meeting of the National Academy of Neuropsychology, Reno, Nevada.
- Nicolette, M.K. and Waid, L.R. (1991, March). Anger reduction in closed head injured individuals with group social skills training. Poster presented at the annual meeting of the Southeastern Psychological Association, New Orleans, Louisiana.
- Waid, L.R., Keil, J.E., Sutherland, S.E., Knapp, R.G., and Gazes, P.C. (1991, August). Sexual functioning in elderly blacks and whites: The Charleston Heart Study. Poster presented at the annual convention of the American Psychological Association, San Francisco, California.
- Barton, S.D., Duke, L., and Waid, L.R. (1991, August). Emotional arousal and memory for naturalistic events. Poster presented at the annual convention of the American Psychological Association, San Francisco, California.
- Waid, L.R., Austin, L.S., Kurent, J.E., and Silver, R.M. (1991, November). Neuropsychological impairment in Eosinophilia-Myalgia Syndrome (EMS) associated with Tryptophan use. Poster presented at the annual meeting of the National Academy of Neuropsychology, Dallas, Texas.
- Leverett, J.P., Waid, L.R., Knapp, R.G., Keil, J.E., and Sutherland, S.E. (1991, November). Correlates of good and poor cognitive performance in elderly adults. Poster presented at the annual meeting of the National Academy of Neuropsychology, Dallas, Texas.
- Deroian, P.L. and Waid, L.R. (1991, November). Secondary mania following a cerebrovascular accident. Poster presented at the annual meeting of the National Academy of Neuropsychology, Dallas, Texas.
- Waid, L.R. (1992, February). Memory and aging. Paper presented at conference on Alzheimer's Disease in South Carolina: Progress and Challenge, Charleston, South Carolina.
- Waid, L.R. (1993, May). Assessment and treatment of the borderline patient. Invited presenter at the 10th Annual Psychotherapy Workshop, Department of Psychiatry, Medical College of Georgia, Augusta, Georgia.
- Waid, L.R., Hummer, J.T., Sutherland, S., and Keil, J. (1993, August). Prevalence and correlates of depressive symptoms among elderly blacks and whites. Poster presented at the Annual Convention of the American Psychological Association, Toronto, Canada.
- Beliles, K., Waid, L.R., Wagner, M., Hummer, J., Cofer, J., and Wohlreich, M. (1993, October). Neuropsychiatric status and selection for liver transplantation. Poster presented at the International Liver Transplant Society Annual Meeting, Toronto, Ontario, Canada.

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- Waid, L.R., Knapp, R.G., Williams, M., Keil, J.E., Sutherland, S., and Lackland, D. (1993, October). Blood pressure and cognitive performance: The Charleston Heart Study. Poster presented at the Annual Meeting of the National Academy of Neuropsychology, Phoenix, Arizona.
- Hummer, J.T., Waid, L.R., Rodenbough, J., Sutherland, S.E., Wagner, M.T., and Keil, J.E. (1993, October). Memory performance in depressed versus non-depressed community elderly. Poster presented at the Annual Meeting of the National Academy of Neuropsychology, Phoenix, Arizona.
- Wagner, M.T., Bachman, D., Hummer, J.T., and Waid, L.R. (1993, October). Asymmetric cortical degenerative syndromes: Neurocognitive, neuroradiographic, and natural history case presentation. Poster presented at the Annual Meeting of the National Academy of Neuropsychology, Phoenix, Arizona.
- Wagner, M.T., Bachman, D., Cushman, L., Waid, L.R., and Hummer, J.T. (1993, October). Severity of dementia as a risk factor for driving. Poster presented at the Annual Meeting of the National Academy of Neuropsychology, Phoenix, Arizona.
- Waid, L.R. (1993, November). The Borderline patient: Conceptual and treatment issues. Invited presentation - South Carolina Association of Marriage and Family Therapy Teleconference, Charleston, South Carolina.
- Johnson, D.E., Nayak, M., Hummer, J.T., Waid, L.R., and Wagner, M.T. (1994, March). MMPI-2 profiles of adults with Residual Attention Deficit Disorder. Poster presented at the Annual Meeting of the Southeastern Psychological Association, New Orleans, Louisiana.
- Wagner, M., Munroe, R., Nayak, M., Hummer, J., and Waid, L.R. (1994, March). Neurocognitive, psychological and social factors associated with liver transplantation. Poster presented at the annual meeting of the Southeastern Psychological Association, New Orleans, Louisiana.
- Shimoda, K.C., Abboud, M.R., Waid, L.R., Matthews, K., Onufrak, E., Shearer, J., Jackson, S.M., Cure, J.H., Holden, K., and Laver, J.H. (1994, March). Effects of stroke and moyamoya vessels on intellectual functioning in patients with SCA. Poster presented at the Annual Meeting of the National Sickle Cell Disease Program, New York, New York.
- Nayak, M., Johnson, D.E., Hummer, J.T., Waid, L.R., and Wagner, M.T. (1994, April). Depressive symptomatology in MMPI-2 profiles of ADHD-RT individuals. Poster presented at the Society for Personality Assessment 1994 Midwinter Meeting, Chicago, Illinois.
- Nayak, M., Wagner, M.T., Munroe, R., Hummer, J., and Waid, L.R. (1994, April). Liver transplantation selection: Descriptive neurocognitive and psychiatric findings in pretransplant evaluation. Poster presented at the Transplant Spring Symposium, Medical University of South Carolina, Charleston, South Carolina.

THOMPSON 002819

- Lewis, L.D., Burnside, S.R., Mintzer, J.E., Wellborn, W., and Waid, L.R. (1994, May). Treatment of depression in dementia patients. Poster presented at the Annual Meeting of the American Psychiatric Association, Philadelphia, Pennsylvania.
- Waid, L.R., Johnson, D.E., Latham, P.K., Leverett, P., Anton, R.F., and Brady, K. (1994, June). Neuropsychological performance in alcohol and cocaine abusers. Poster presented at the Annual Scientific Meeting of the Research Society on Alcoholism, Maui, Hawaii.
- Johnson, D.E., Waid, L.R., Latham, P.K., Rittenburg, M.E., and Anton, R.F. (1994, June). Neuropsychological performance in alcoholics with childhood HK/MBD. Poster presented at the Annual Scientific Meeting of the Research Society on Alcoholism, Maui, Hawaii.
- Rittenburg, M.E., Anton, R.F., Waid, L.R., Johnson, D.E., and Latham, P.K. (1994, June). Alcoholism severity in a sample of outpatient adult alcoholics with and without childhood hyperkinesia. Poster presented at the Annual Scientific Meeting of the Research Society on Alcoholism, Maui, Hawaii.
- Waid, L.R. (1994, July). Posttraumatic stress disorder. Invited presenter - Annual Conference of the Southern Association of Workers' Compensation Administrators, Hilton Head, South Carolina.
- Hummer, J.T., Fink, C., Waid, L.R., and Wagner, M.T. (1994, August). WMS-R and MMPI-2 profiles of ADHD-RT versus Learning-Disabled adults. Poster presented at the Annual Convention of the American Psychological Association, Los Angeles, California.
- Shimoda, K.C., Waid, L.R., Abboud, M.R., Jackson, S.M., Matthews, K., Onufra, E., Shearer, J., and Laver, J.H. (1994, August). Neuropsychological functioning in children with sickle cell disease and stroke. Poster presented at the Annual Convention of the American Psychological Association, Los Angeles, California.
- Williams, M.A., Waid, L.R., Sutherland, S.E., Hummer, J.T., and Keil, J.E. (1994, August). Depression among the young old and the old old: The Charleston Heart Study. Poster presented at the Annual Convention of the American Psychological Associations, Los Angeles, California.
- Rhodes, S.K., Shimoda, K.C., Waid, L.R., O'Neil, P.M., Oexmann, M.J., Willi, S.M., and Collop, N.A. (1994, August). Cognitive deficits in morbidly obese adolescents with sleep apnea. Poster presented at the 7th International Congress on Obesity, Toronto, Canada.
- Wellborn, W.R., Hummer, J.T., Waid, L.R., Wagner, M.T., and Barnett, K. (1994, November). A comparative analysis of psychopathology and memory function in adult outpatients with mild neurobehavioral syndromes. Poster presented at the annual meeting of the National Academy of Neuropsychology, Orlando, Florida.

THOMPSON 002820

- Shimoda, K.C., Waid, L.R., Abboud, M.R., Jackson, S.M., Shearer, J., Matthews, K., Onufrak, E., and Laver, J.H. (1995, April). Effects of stroke and moyamoya vessels on sustained attention and impulsivity in children with sickle cell disease. Poster presented at the 5th Florida Conference on Child Health Psychology, Gainesville, Florida.
- Johnson, D.E., Waid, L.R., Latham, P.K., and Anton, R.F. (1995, June). The effects of gender and childhood hyperactivity on Cloninger's typologies in outpatient alcoholics. Poster presented at the annual meeting of the Research Society on Alcoholism, Steamboat Springs, Colorado.
- Horner, M.D., Johnson, D.E., Waid, L.R., Latham, P.K., and Anton, R.F. (1995, June). The relationship of recent and lifetime alcohol consumption to cognitive functioning in outpatient alcoholics. Poster presented at the annual meeting of the Research Society on Alcoholism, Steamboat Springs, Colorado.
- Waid, L.R., Johnson, D.E., Latham, P.K., and Anton, R.F. (1995, June). Neurocognitive and personality characteristics of alcoholics with childhood hyperactivity. Poster presented at the annual meeting of the Research Society on Alcoholism, Steamboat Springs, Colorado.
- Waid, L.R., Johnson, D.E., Saladin, M.E., and Mintzer, J.E. (1995, August). Management of acute agitated behavior in elderly demented patients. Poster presented at the Annual Convention of the American Psychological Association, New York City, New York.
- Waid, L.R. (1995, August). Psychotherapy of alcoholism: Goals and methods. Paper presented at the 35th Annual Southeastern School of Alcohol and Other Drug Studies, Athens, Georgia.
- Johnson, D.E., Waid, L.R., Richman, H., and Anton, R.F. (1996, November). Discriminant analysis of neuropsychological performance in alcoholics with and without childhood hyperactivity. Poster presented at the annual meeting of the National Academy of Neuropsychology, San Francisco, California.
- Johnson, D.E., Waid, L.R., and Anton, R.F. (1996, June). Relationship of rating scales to DSM-IV diagnosis of childhood ADHD in adult alcoholics. Poster presented at the annual meeting of the Research Society on Alcoholism, Washington, D.C.
- Waid, L.R., Johnson, D.E., Latham, P.K., and Anton, R.F. (1996, June). Personality and neurocognitive characteristics of alcoholics scoring high and low on the obsessive compulsive drinking scale (OCDS). Poster presented at the annual meeting of the Research Society on Alcoholism, Washington, D.C.
- Spangenberg, K.B., Henderson, S., Waid, L.R., and Wagner, M.T. (1996, August). Validity of a free and recognition recall condition to assess visual memory in the CERAD battery. Poster presented at the annual meeting of the American Psychological Association, Toronto, Canada.

THOMPSON 002821

- Waid, L.R. (1996, September). Adult ADHD/LD: Conceptual, assessment, and intervention issues. Lecture presented at the 6th annual meeting South Carolina Technical College Counselors' Conference, Charleston, South Carolina.
- Waid, L.R., Johnson, D.E. Richman, H., and Anton, R.F. (1996, October). Comparison of personality and neuropsychological functioning in alcoholics with and without hyperactivity. Poster presented at the annual conference on Psychopathology, Psychopharmacology, Substance Abuse, and Culture, 7 Los Angeles, California.
- Rhodes, S.K., Waid, L.R., O'Neil, P.M., Collop, N.A., and Willi, S.M. (1996, November). Neurocognitive functioning and obstructive sleep apnea in morbidly obese adolescents. Poster presented at the annual meeting of the National Academy of Neuropsychology, New Orleans, Louisiana.
- Waid, L.R. and Leverett, J.P. (1997, April). Neurological models of ADD and neurocognitive correlates of adults with attention deficit disorder. Symposium presented at the annual conference of the South Carolina Psychological Association, Myrtle Beach, South Carolina.
- Johnson, D.E., Waid, L.R., Foer, J., and Anton, R.F. (1997, July). Alcohol dependence rates in adults with attention deficit/hyperactivity disorder. Poster presented at the annual meeting of the Research Society on Alcoholism, San Francisco, California.
- Foer, J.F., Waid, L.R., and Gold, P.B. (1997, August). Litigation and peripheral injury: Neurocognitive effects in mild head injury. Poster presented at the annual meeting of the American Psychological Association, Chicago, Illinois.
- Leverett, J.P., and Waid, L.R. (1998, April). Psychotherapy with traumatic brain injury patients. Symposium presented at the annual meeting of the South Carolina Psychological Association, Myrtle Beach, SC.
- Waid, L.R. (1998, May). Neuropsychological assessment of rheumatological conditions. Lecture presented at the Grand Rounds, Department of Rheumatology, Medical University of South Carolina, Charleston, SC.
- Hayes, J.S., Waid, L.R., Horner, M.D., Johnson, D., Sonne, S., and Brady, K.T. (1998, August). Neuropsychological functioning in recently abstinent cocaine-dependent individuals. Poster presented at the annual meeting of the American Psychological Association, San Francisco, CA.
- Waid, L.R. (1998, August). Differential diagnosis of substance abuse and ADHD. In: Thomas E. Brown (chair) Attention Deficit Disorder and alcohol and drug abuse. Symposium presented at the annual convention of the American Psychological Association, San Francisco, CA.
- Waid, L.R. (1998, September). Minor head injury: Nothing to ignore. Lecture presented at the Mind Your Health Program, Institute of Psychiatry, Medical University of South Carolina, Charleston, SC.

THOMPSON 002822

- Hayes, J.S. and Waid, L.R. (1998, November). Chronic neurobehavioral and neurological deficits after decompression sickness: A case study. Paper presented at the annual meeting of the National Academy of Neuropsychology, Washington, D.C.
- Anton, R.F., Moak, D.H., Waid, L.R., Latham, P.K., Dias, J.K., and Roberts, J.C. (1998, December). Post-treatment outcome of alcoholics treated with CBT with and without naltrexone. Paper presented at the American College of Neuropsychopharmacology meeting, Las Croabas, Puerto Rico.
- Waid, L.R. (1999, April). Conceptual, assessment, and treatment issues for concussion. Lecture presented at the annual conference of the Brain Injury Association of North Carolina, Myrtle Beach, SC.
- Waid, L.R. (1999, April). Meeting South Carolina's current and future need for neuropsychology. In P. Leverett (chair) The Future of the SC Neuropsychology Group. Presented at the annual meeting of the South Carolina Psychological Association, Myrtle Beach, SC.
- Herron, J.E., Waid, L.R., Latham, P., Dias, J.K., and Anton, R. (1999, June). Craving, neurobehavioral variables and relapse in outpatient alcoholics. Poster presented at the annual meeting of the Research Society on Alcoholism, Santa Barbara, CA.
- Waid, L.R., Herron, J.E., Latham, P., Dias, J.K., and Anton, R.F. (1999, June). Naltrexone, neurocognitive functioning and relapse in recently abstinent alcoholics. Poster presented at the annual meeting of the Research Society on Alcoholism, Santa Barbara, CA.
- Waid, L.R. (2001, May). ADHD and math disabilities. Lecture presented to the faculty of Trident Technical College, Charleston, SC.
- Waid, L.R. (2001, November). Brain injury. Lecture presented at the annual convention of the Association of South Carolina Claimant Attorneys for Workers' Compensation, Asheville, NC.
- Waid, L.R. (2001, December). Risk assessment. Lecture presented at the 2001 Judges and Attorneys Substance Abuse and Ethics Seminar, Institute of Psychiatry, Medical University of South Carolina, Charleston, SC.
- Waid, L.R. (2003, August). Mild head injury: When is it physical injury to the brain? Lecture presented at the Annual Convention of the South Carolina Trial Lawyers Association, Hilton Head, SC.
- Waid, L.R. (2004, March). Traumatic and toxic induced brain damage. Lecture presented at the Annual Workers' Compensation Medical Seminar, Greenville, SC.
- Waid, L.R. and Teichner, G. (2004, April). Detection of cognitive and psychiatric malingering. Paper presented at the annual meeting of the South Carolina Psychological Association, Myrtle Beach, SC.

THOMPSON 002823

Waid, L.R. (2004, April). Head injury in workers compensation. Lecture presented at the annual SCSAONH Conference, Myrtle Beach, SC.

Waid, L.R. (2004, December). Assessment of brain injury: Contributions by forensic neuropsychology. Lecture presented at the SCTLA Auto Torts XXVII annual meeting, Atlanta, GA.

Teichner, G. and Waid L.R. (2005, April). Detection of malingering in clinical and forensic assessment. Paper presented at the annual meeting of the South Carolina Psychological Association, Charleston, SC.

Waid, L.R. (2005, May). Use of psychological tests in forensics evaluations. Lecture presented at the Day of Discovery: Forensic Psychiatry Workshop, Medical University of South Carolina, Institute of Psychiatry, Charleston, SC.

Teichner, G., Waid, L.R., and Buddin, W.H. (2005, October). The Memory and Concentration Test (MACT): Data from a sample demonstrating a range of neurological and psychiatric disorders. Poster presented at the annual meeting of the National Academy of Neuropsychology, Tampa Bay, Florida.

Waid, L.R. (2006, March). Clinical neuropsychology: Evaluation, treatment and return to work. Lecture presented to the 27th Annual Workers' Compensation Medical Seminar, Savannah, Georgia.

Waid, L.R., and Teichner, G. (2007, March). A primer in psychological depositions: Tactics for psychologists. Lecture presented at the annual meeting of the South Carolina Psychological Association, Myrtle Beach, SC.

Waid, L.R. (2007, May). Brain injuries: Recognizing and establishing the proof. Lecture presented at the annual meeting of the Association of South Carolina Claimant Attorneys for Workers' Compensation, Columbia, SC.

Waid, L.R. (2007, December). How to deal with a difficult client. Lecture presented at the 9th Annual Paralegal/Legal Assistant Seminar of the Injured Workers' Association, Charleston, SC.

Waid, L.R. (2008, February). Impact of drug addiction on the 21st century workplace. Lecture presented at the 30th Annual Medical Seminar on Workers' Compensation (SCWCEA), Myrtle Beach, SC.

Educational Workshops

Waid, L.R. (1985, June). Counseling techniques for problems of anger and impulse control. Workshop presented at Region III Vet Center Training Conference, sponsored by Southeastern Regional Medical Education Center, Daytona Beach, Florida.

- Waid, L.R. and McDermitt, H.W. (1985, June). Use of cognitive-behavioral therapeutic techniques in the treatment of PTSD. Workshop presented at Region III Vet Center Training Conference, sponsored by Southeastern Regional Medical Education Center, Daytona Beach, Florida.
- Waid, L.R. and Rogers, G. (1985, June). Use of psychological tests in the assessment and treatment of Vietnam veterans. Workshop presented at Region III Vet Center Training Conference, sponsored by Southeastern Regional Medical Education Center, Daytona Beach, Florida.
- Waid, L.R. and Cogar, G. (1986, January). Clinical psychopharmacology and post-traumatic stress disorder (PTSD). Workshop presented at Region III Vet Center Training Conference sponsored by Southeastern Regional Medical Education Center, Orlando, Florida.
- Waid, L.R. (1989, May). The borderline patient: Conceptual, assessment, and treatment issues. Workshop presented at the annual meeting of the South Carolina Psychological Association, Hilton Head, South Carolina.
- Waid, L.R., Swavely, S.M., and West, B. (1991, March). Clinical Neuropsychology. Workshop presented at the annual meeting of the South Carolina Psychological Association, Myrtle Beach, South Carolina.
- Waid, L.R. (1992, October). Neuropsychological assessment of the elderly patient. Workshop presented at Conference on Geriatrics in South Carolina: Two-day Course for Health Professionals, Charleston, South Carolina.
- Waid, L.R. (1996, February). Motivational enhancement therapy. Workshop presented at the 6th Annual Conference - "Advancing Substance Abuse Treatment: Applying Current Research." North Carolina Governor's Institute on Alcohol and Substance Abuse, Greensboro, North Carolina.
- Lassiter, K.S., Leverett, J.P., and Waid, L.R. (1998, March). Assessment of attention deficit disorder and learning disabilities in college age adults: A neuropsychological perspective. Workshop presented at the annual meeting of the Southeastern Psychological Association, Mobile, AL.
- Waid, L.R. (1998, March). Motivational interviewing. Workshop presented to the Institute of Psychiatry, Medical University of South Carolina, Charleston, SC.
- Waid, L.R. (1998, August). ADHD in college students: Assessment, treatment, and conceptual issues. Workshop presented at The Citadel, Charleston, SC.
- Waid, L.R. (1999, April). Motivational interviewing. Three day workshop presented to the Adolescent and Child Psychiatry Department, Medical University of South Carolina, Charleston, SC.
- Waid, L.R. (2000, November). Alzheimer's disease. Workshop presented to the Waccamaw Center for Mental Health, Conway, SC.

THOMPSON 002825

Waid, L.R. (2000, June). Motivational interviewing. Workshop presented to the Walter B. Jones Alcohol and Drug Abuse Treatment Center, Greenville, SC.

Waid, L.R. (2000, December). Motivational interviewing for SA/MH managers. Specialty Institute/North Carolina Council of Community Programs, Pinehurst, NC.

Other Professional Presentations

"Psychological Assessment." Presented at a workshop on Psychosocial Assessment, sponsored by the Lutheran Medical System, Dallas, Texas, 1982.

"Evaluating the substance abuser." Paper presented at the meeting of the Texas Association of Alcoholism and Drug Abuse Counselors, Dallas, Texas, May, 1982.

"Assessment and treatment of the substance abuser." Presented at a workshop on Substance Abuse, sponsored by the Lutheran Medical System, Dallas, Texas, November, 1982.

"Stress disorders among Vietnam veterans." Presented at a workshop on Post-traumatic Stress Disorder, Tideland Community Mental Health Center, Savannah, Georgia, January, 1984.

"Cognitive rehabilitation: Theory and techniques." Presented at the meeting of the South Carolina State Chapter of the Head Injury Foundation, Orangeburg, South Carolina, February, 1984.

"Japanese prison camp survivors: Psychic scarring." Presented at Grand Rounds, Department of Psychiatry and Behavioral Sciences, Medical University of South Carolina, Charleston, South Carolina, March, 1984.

"Stress disorders among Vietnam veterans." Presented at Grand Rounds, Department of Psychiatry and Behavioral Sciences, Medical University of South Carolina, Charleston, South Carolina, June, 1984.

"Cognitive rehabilitation of the head injured patient." Presented for allied health staff, Department of Physical Medicine and Rehabilitation, Roper Hospital, Charleston, South Carolina, August, 1984.

"Psychotherapy issues for veterans with post-traumatic stress disorder." Presented at a workshop on Post-traumatic Stress Disorder and the Vietnam Veteran. Sponsored by the Columbia Community Action Council, Chamber of Commerce, Columbia, South Carolina, November, 1984.

"Neuropsychological assessment of the head injured patient." Presented at the meeting of the South Carolina Association of Rehabilitation Nurses, Charleston, South Carolina, January, 1985.

"Cognitive retraining of the brain injured patient." Presented at the 6th Annual South Carolina Workers' Compensation Medical Seminar, Kiawah Island, South Carolina, March, 1985.

THOMPSON 002826

"Emotional and behavioral problems of the head injured." Presented at the meeting of the Trident Head Injury Support Group, Charleston, South Carolina, April, 1985.

"The head injured victim." Presented at the meeting of the South Carolina Claims Adjustors Association, April, 1986.

"Personality and Psychosocial Consequences of Brain Injury." Presented at a workshop on Traumatic Brain Injury, Healthcare Rehabilitation Center at Southern Pines, Charleston, S.C., June, 1987.

"Diagnostic tests - What they show and what they don't show - Neuropsychology." Presented at the 30th annual convention of the South Carolina Trial Lawyers Association, Hilton Head Island, S.C., August, 1987.

"PTSD and dissociation: A case presentation." Presented at Grand Rounds, Department of Psychiatry and Behavioral Sciences, Medical University of South Carolina, Charleston, S.C., September, 1987.

"PTSD and the Vietnam veteran: Etiology and treatment issues." Invited presentation to the Department of Psychology, University of South Carolina, Columbia, S.C., October, 1988.

"The dissociative defense in PTSD." Invited presentation to the Department of Psychology, University of South Carolina, Columbia, S.C., February, 1989.

"Disaster Related PTSD" workshop. Presented to South Carolina Substance Abuse Commission Counselors, Seabrook Island, S.C., October, 1989.

"Storm over South Carolina: Hugo and Post-Traumatic Stress - ETV Teleconference". Panel participant, Columbia, S.C., March, 1990.

"The Vietnam War." Panel participant, Tim O'Brien's book, The Things They Carried. College of Charleston, March, 2000.

THOMPSON 002827

DEFENDANT EXHIBIT 2
WAID, L.R. PH.D

THOMPSON 002828

Mark Casey

TIME 11:30 AM DATE 11/7/03 PHONE 680-9648
NAME Mark Casey PARENT sister
ADDRESS _____
HISTORY 4/2 LBP - chronic
Lortab not helping.
WORKING DIAGNOSIS Chronic LBP
TREATMENT T to E P - tonight
To office in AM.
REMARKS PHARMACY CALLED 17804 F

4/15/03 Pt. in for discussion re: epidural inj. - states it of help - made pain worse - also RF Ultram - states 7-8 on pain scale - J. Calvert, MD

12/15/03 WILLIAM CASEY

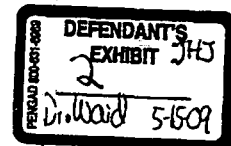
17804

Frank E. Gonda, MD

CHRONIC LOW BACK PAIN
DEPRESSION

- This 45-year old white male with chronic low back pain and depression is in for follow up of the above problems and for medicine refill. Since I saw him last time he went and had one epidural, which did not work. It made his pain worse. He was out of work for several days. He is frustrated that he had to pay for the shot and he was out of work and it did not help. He did have an MRI which showed two bulging disks but no ruptures. He does not want to see a neurosurgeon because he would not be interested in surgery. He believes that the Effexor has helped his depression. He still has all the same family problems but everything is stable.
- O: Patient is in no distress. Blood pressure is 126/94. Pulse is 88. Weight is 177-pounds. Neck is supple. Lungs are clear. Heart is regular. Abdomen is soft and nontender. Back has good range of motion, no tenderness. Straight leg raising is negative. Deep tendon reflexes is 2+.
- A: As above.
- P: Counseled in detail. Suggested we go see another anesthesiologist at Regional Hospital to see if they could help with the shots. He did not want to see the ones at Mary Black Hospital. We will check his insurance. Renew Ultram, 50 mg two p.o. q.i.d. #720 with one refill. Effexor-XR, 75 mg one q.-h.s. #90 with one refill. Bextra, 10 mg one q.-day #90 with one refill. Lortab, 10/500 one b.i.d. #30 with no refills. He ran out early. He still has another refill on his last prescription on the Lortab. I also gave for local purchase Ultram, 50 mg two q.i.d. #100 with no refill. The patient will let me know what he wants to do and we will go from there.

DNR: Frank E. Gonda, MD/ dlq



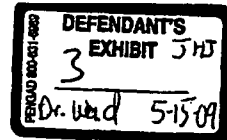
000543

THOMPSON 002829

DEFENDANT EXHIBIT 3
WAID, L.R. PH.D

THOMPSON 002830

William Casey



8/21/03 Samples given Effexor XR 75mg # 204
 Date Drug Name # Dispensed
 Lot Number: 3023834 4/04 Initials: JLC
 Patient was educated regarding proper administration, drug interactions and possible side effects. Patient has been instructed to call our office with any questions or problems.

8/21/03 Samples given Effexor XR 37.5 # 160
 Date Drug Name # Dispensed
 Lot Number: 3033288 12/03 Initials: JLC
 Patient was educated regarding proper administration, drug interactions and possible side effects. Patient has been instructed to call our office with any questions or problems.

90
 45
 135

08/27/03 MARK CASEY 17804 Frank E. Gonda, MD

H: DEPRESSION
 D: CHRONIC LOW BACK PAIN

S: This 44-year-old white male is in for follow up on his depression. He has been on Paxil for two months and cannot tell any improvement whatsoever. He had no side effects from it. He continues to feel down-in-the dumps. He attributes it to all of the family problems that he has had including his two teenage kids who are pretty much failures. He has done everything he could for them. He does not blame himself, but he still feels bad about it. His job is not getting any easier, and he continues with chronic low back pain. He thinks part of his depression is from the back pain, and he wishes to start back on some medicine. He has been buying from friends, Percocet, 10 mg. He says he could easily take two or three a day. He has no trouble working with it. He says it makes life tolerable as far as the pain is concerned.

* Patient is in no distress. Blood pressure is 122/88. Pulse is 72. Weight is 171-pounds. Patient is alert, oriented, and coherent. Speech is not rapid or pressured. There are no feelings of helplessness or hopelessness. There are no suicidal or homicidal thoughts. Sensorium is clear. Recheck of the back is not done today.

A: Depression in a patient with chronic low back pain.

P: Counseled in detail. Trial of Effexor-XR, 37.5 mg one q.-day times one week and then 75 mg one q.-day, samples for four weeks and then a prescription for four weeks. He is also given a prescription for Percocet, 10/325 one p.o. b.i.d., #60 with one refill. Explained to patient that part of pain treatment can also be antidepressants which frequently help reduce the pain. He is willing to continue on an antidepressant. See him back in two months.

DNR: Frank E. Gonda, MD/jmm

DATE 9/23/03	TIME 10:50	CALLER William Casey 217804	PT NAME - CHART # 486	PHONE # 9131	ALL: P.S.C.O. Gonda
AGE 44	WT 171	BY JLC	RE JLC	MEDS Percocet	
Needs no fill Had forgotten this is 9/23/03 pt stated					
9/23/03 Im to RC a class II drug he had 3 more days					
a case and refills. Will use Lorazepam instead. left but pharm. wouldn't					
- pt. has used #120 in one month?? let him get RF					
- Not fill early - pick up Friday 10/1/03 - Redville Rd - per pharm. info					
against the law to put RF on narcotics. like this - had to write new Rx - notified pt - JLC					

✓ JLC notified pt 000541

THOMPSON 002831

DEFENDANT EXHIBIT 4
WAID, L.R. PH.D

THOMPSON 002832

08/13/02

MARK CASEY

10967

Frank E. Gonda, MD

D: CHRONIC LOW BACK PAING: ERECTILE DYSFUNCTIONC: NICOTINE ABUSE

S: Mark is in today for follow up of the above problems and also for medicine refill. He is actually early. He has run out of medication because his wife was sneaking some of his medicines. After 20 years of marriage, they are separating and getting a divorce. She is being treated for depression. Last time he was here, I put him on Neurontin, but he says it did not help after two month's worth of medicine. He still has back pain everyday. It does not keep him from working although it makes work difficult. It does not keep him from playing golf. He is still smoking one-half to one pack of cigarettes per day. He denies bowel or bladder problems. He has no pain in his legs. He still has erection problems, and Viagra works well.

O: Patient is in no distress. Weight is 173-pounds. Blood pressure is 112/78. Pulse is 80. Neck is supple. Lungs are clear. Heart is regular. Abdomen is soft and nontender. Back reveals good range of motion, no tenderness to palpation. Straight leg raising is negative.

A: As above.

P: Counseled in detail. Patient never went for his MRI. He says he cannot afford it, and his insurance will not pay for it at this time. Renew Ultram, 50 mg two p.o. q.i.d., #720 with one refill. Also a one month supply with one refill from local purchase. Zanaflex, 4 mg two p.o. q.h.s., #180 with one refill. Also prescription for local purchase. Renew Viagra, 100 mg one p.o. one hour prior to relations, #10 with five refills. Follow up in six months or p.r.n.

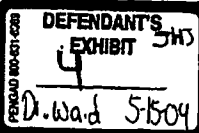
DNR: Frank E. Gonda, MD/ jmm

DATE	TIME	CALLER	PT NAME	CHART#	PHONE#	ALL-PROG
11/21/02	1:43		William Mark Casey			
AGE	SEX	E	BY	MEDS	RE	
58			27			
hurt his back again, would like something stronger. I told him to make an apt						
DISPOSITION						
Carb 5.0 #20/3						
i no 6-8 pm pain						
DRUG STAFF						
576-4399						

1/23/03- pt presents for refill for ultram. pain score of 3-8

01/23/03

MARK CASEY



7804

Frank E. Gonda, MD

D: CHRONIC LOW BACK PAING: ERECTILE DYSFUNCTIONC: NICOTINE ABUSE

S: Mark presents today for follow up of the above problems and for medicine refill. He has no chest pain or shortness of breath. His appetite is good, and he moves his bowels well. Back pain is stable as long as he takes his medicines. He continues to smoke probably less than a half-pack of cigarettes per day. He still has plenty of refills on his Viagra.

000539

THOMPSON 002833

DEFENDANT EXHIBIT 5
WAID, L.R. PH.D

THOMPSON 002834

DATE 3/5/01	TIME 2:00	CALLER Mr. Casey	PT. NAME - CHART #	PHONE # 476-9100	ALL P.S.C.O.	MD Gonda
WT.	T.	BY RAT	MEDS. Rx - Mail Order	RE 10967		
Zanaflex 4mg						
4-6 qd depends on work schedule						
DISPOSITION 36 3/4 180 180 180 6 3 12 340 30 360						
DRUG STORE 3				BY F	TIME 7	A P

09/07/01

MARK CASEY

10967

Frank E. Gonda, MD

D: CHRONIC LOW BACK PAINC: NICOTINE ABUSEG: ERECTILE DYSFUNCTION

S: This 42 year old white male is in for follow up with his above medical problems and for medicine refill. The last time he was here we added Zanaflex and he says that has helped dramatically and he sleeps well all night. He usually takes about three a night. At times he has increased the dosage of the Ultram and he will take three pills four times a day. I have warned him that the maximum dose is 400 mg per day and he is taking more than that. His only complaint today is that he has problems with erections, which he has had four three or four years. He is unable to achieve a complete erection. He still has orgasm and then losses the erection right away. He has been smoking for 25 years. He has no interest in quitting. He does tell me that he tried a Viagra from a friend and it worked extremely well. He would like a prescription.

O: Patient is in no distress. Blood pressure is 130/92. Pulse is 80. Weight is 179-pounds. Neck is supple. Lungs are clear. Heart is regular. Abdomen is soft. GU examination is normal. Testes are descended with no hernias and no atrophy of the testicles. The back reveals good range of motion but lots of discomfort with movement in all directions. There is mild tenderness in the lumbosacral area. Straight leg raising is negative. Deep tendon reflexes is 2+.

A: Chronic low back pain.

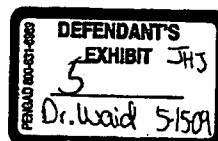
P: Renew Ultram, 50 mg two p.o. q.i.d #720 with one refill. Zanaflex, 4 mg three q.-h.s. #270 with one refill.

A: Erectile dysfunction.

P: Encourage to quit smoking. Check a testosterone level. Add Viagra, 100 mg one p.o. one hour prior to relation #10 with five refills. Follow up six months or p.r.n.

DNR: Frank E. Gonda, MD/ dlq

101- pt notified re. Total + free testosterone level. inf. pt. it shows low test. level. if viagra fails, cert's hormone replacement. — Gonda



000536

THOMPSON 002835

DEFENDANT EXHIBIT 6
WAID, L.R. PH.D

THOMPSON 002836

08/28/00

MARK CASEY

10967

Dr. Frank E. Gonda

WRIST PAIN

- S: This 41-year-old white male is in with wrist pain for the last two months. He thinks it is probably related to the repetitive activity he does at Michelin building tires. He denies numbness, tingling, or burning in his fingers. He says he has pain at the wrist on the ulnar side. Sometimes it feels weak and just wants to give out. He has had no specific injury.
- O: On physical examination, he is in no distress. Blood pressure is 130/80. Pulse is 80. Weight is 182-pounds. The left wrist reveals excellent range of motion. There is no redness or swelling. There is a little tenderness over a rather prominent distal ulna. There is no crepitus. Pulses are 2+. Tinel sign and Phalen sign are negative. Hand grip is normal. Motor and sensory are grossly intact. X-ray of wrist is negative for arthritic changes.
- A: Wrist pain with a normal examination. Possibly related to repetitive activity at work. No sign of carpal tunnel syndrome.
- P: Reassurance. Moist heat. Relafen 500 mg, two p.o. q.-day, #60 with one refill. GI precautions given. He might need to come off of this job for a couple of weeks to let his wrist get better. If he needs to do this, he may have to go through Workman's Comp. *F*
DNR: Dr. Frank E. Gonda/ imm

1/24/00 - Appt. @ SMC for L-spine mri on 11/4/00 @ 9:00 AM, own failed + sent to *CD*
 1/26/00 - Appt. @ Dr. Thirum on 11/4/00 @ 9:30 AM *CD*
 1/26/00 - ~~the~~ mri with request sent to med *CD*

10/26/00

WILLIAM CASEY

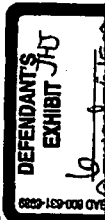
10967

Dr. Frank E. Gonda

CHRONIC LOW BACK PAIN

- S: This 41-year-old white male is in for recheck and medicine refill. He thinks his back pain did improve a little bit with physical therapy. He still has pain everyday whether he is working or playing ball. He did increase the number of Lortab that he took and ran out early. He has not had any in a while. He thinks the Ultram also helps some. He has pain everyday, 24-hours a day in his lower back bilaterally. The pain is non-radiating. He has no bowel or bladder problems. He has no numbness, tingling, or weakness in his legs. X-rays in 1997 of the lumbar spine were negative.
- O: On physical examination, he is in no distress. Blood pressure is 130/80. Pulse is 80. Weight is 178.5-pounds. Back reveals no deformity and has excellent range of motion. There is discomfort with twisting, tilting, and forward bending. There is some tenderness to deep pressure bilaterally in the lower lumbar/upper sacral area. No muscle spasm is noted. Straight leg raising is negative. DTR's are 2+. Motor and sensory are intact.
- A: Chronic low back pain.
- P: Renew Ultram, 50 mg two p.o. q.i.d., #720 with one refill. Lortab-5.0, one q.-four to six hours for moderate pain, #20 with five refills. This is supposed to last six months. Schedule for an MRI of his LS-spine. Schedule him an appointment to the Chronic Pain Clinic. I am hoping that they will find him a candidate for some steroid injections.
DNR: Dr. Frank E. Gonda/ jmm

10/26/00 - Radiology (mri) spoke to Loris @ Olyra, was pre-req'd for MRI *CD*



000535

THOMPSON 002837

DEFENDANT EXHIBIT 7
WAID, L.R. PH.D

THOMPSON 002838

wanted to describe the episode to me since she will not be able to accompany him to his appt. and will not be available at the time that he sees Dr. Gonda. Apparently there is no previous personal hx. of family hx. of seizure disorder. Mr. Casey is otherwise in good health and is very athletic. Told her I will speak with Dr. Gonda about the pt. and hopefully we can begin to arrange his workup before his appt. on Wed. Of course, if any changes in his condition occur prior to the Wed. appt., they should call immediately or have him come to the ER. Carol Casey's phone number is 587-1631. Mark Casey's telephone number is 576-8269. DNR:gc/da

9/23/92

MARK CASEY

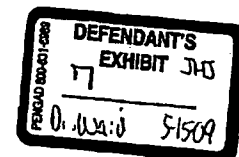
10967

Dr. Gonda

1. Syncope

- S: 33 y/o, white male comes in for the first time. Six days ago he was sitting on his deck talking to his sister. He had been working swing shifts and was very tired. He had had very little sleep. He had drank one beer. Also, he had taken a cold medicine a few days earlier and also a pain pill, which he does not know the name of, for some elbow pain. He was sitting there and he became rather nauseated, felt a little disoriented, and passed out. He does not recall anything else. His sister saw him slump over and thought he was joking. After about a minute he started gurgling and vomiting. He was unconscious for about 2 minutes and then came to. Sister said that his eyes did roll back in his head and his arms appeared stiff, but she did not see any jerking movements. He had no incontinence and did not bite his tongue. As soon as he came to he felt fine, was alert, oriented, no postictal state. He has no previous history of seizure or fainting spells and there is no family history of seizure. Patient has no medical problems, is on no medication. Drinks a couple of beers maybe once or twice a month, and smokes less than one-half pack of cigarettes per day. No distress. Weight is 170 3/4 pounds, B/P is 138/94. Temp is 98.8. HEENT: pupils are equal, round, reactive to light; extraocular movements are intact; discs are sharp; cranial nerves are grossly intact; TM's and throat are clear; neck is supple; thyroid is not enlarged; no carotid bruits; lungs are clear. Heart is regular. Normal S-1, S-2. No murmur or gallop. Abdomen is soft, non-tender, no organomegaly. Extremities reveal full range of motion. DTR's are 2+. Motor and sensory are grossly intact. EKG shows a normal sinus rhythm. No abnormalities. Urinalysis is normal.
- A: Syncope episode. Differential diagnosis includes true syncope or fainting vs. a seizure. One could make a case for syncope based on a multitude of facts including lack of sleep, drinking one beer, cold medicine and a pain pill. I think seizure disorder needs to be ruled out despite that he had no incontinence and was not postictal.
- P: Patient is scheduled for an EEG and a CT scan of the brain at Mary Black next week. Will not start him on medications at this time unless he has a recurrence. Precautions given concerning repeated episodes in dangerous places such as driving. Profile III also drawn today. May need to follow up with a neurology consult for second opinion.

/FG:al



000527

THOMPSON 002839

DEFENDANT EXHIBIT 8
WAID, L.R. PH.D

THOMPSON 002840

McKESSON
Empowering Healthcare

Name: Johnson, Mark
DOB: 18-Oct-1958
ID: 53305541
Study Date: February 04, 2007 12:32

Final Report - MR MRI HEAD W/OUT CONTRAST

INDICATIONS: HEADACHE
COMMENTS:

PROCEDURE: PMR 0010- MRI HEAD W/OUT CONTRAST - Feb 4 2007
Accession #: 7799286

INTERPRETATION: MRI BRAIN WITHOUT CONTRAST

TECHNIQUE: Routine spin echo sequences with FLAIR and diffusion imaging.

FINDINGS: Negative for mass, extra-axial fluid or midline shift. The ventricles and sulci are normal in size. The brain parenchyma is of normal signal intensity without ischemic or demyelinating lesions.

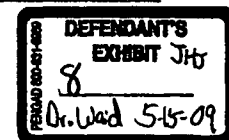
The posterior fossa contents are within normal limits. The cerebellar tonsils terminate above the foramen magnum. The paranasal sinuses are clear.

CONCLUSION: NEGATIVE MRI OF THE BRAIN WITHOUT CONTRAST.

Read by: GREGORY J JOSEPH, MD 001651 on Feb 4 2007 1:57P
Transcribed by: GJJ on Feb 4 2007 1:57P
Signed by: DR. GREGORY J JOSEPH, MD on: Feb 4 2007 1:57P

Signed by: Gregory Joseph

Signed at: 15-Dec-2007



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3/6/2009

THOMPSON 002841

Randy Waid
Dep. Exhibits
copy

THOMPSON 002842

WAID, L. R. PH.D
PLAINTIFF EXHIBIT 1

THOMPSON 002843

CURRICULUM VITAE

Lewis Randolph Waid, Ph.D.

WORK ADDRESSES:

Oaks Business Center
1459 Stuart Engals Boulevard, Suite 204
Mount Pleasant, South Carolina 29464
(843) 881-2778

Medical University of South Carolina
Department of Psychiatry and Behavioral Sciences,
67 President Street
P.O. Box 250861
Charleston, SC 29425
(843) 792-2727

DATE AND PLACE OF BIRTH:

██████████ 1952
San Juan, Puerto Rico
US citizenship

LICENSURE

License #333, South Carolina Board of Examiners in
Psychology (Clinical Psychology)

EDUCATIONAL BACKGROUND

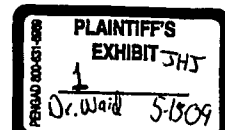
Temple University, Philadelphia, PA, 1974, B.A., Psychology (Magna Cum Laude)

University of Richmond, Richmond, VA, 1977, M.A., General Psychology

VAMC/Medical University of South Carolina, Charleston, SC, 1980-81, Clinical Psychology
Internship

University of North Texas, Denton, Texas, 1982, Ph.D., Clinical Psychology

Rev. Oct-08



THOMPSON 002844

POSITIONS

(Current)

Clinical Associate Professor, Departments of Psychiatry and Neurology, Medical University of South Carolina, Charleston, SC, 1998 – Present

Independent Practice, Clinical, Forensic, and Neuropsychological Services, Tidewater Executive Center, Mt. Pleasant, SC, 1998 – Present

Adjunct Professor, Department of Psychology, The Citadel, Charleston, SC, 1998 – Present

Neuropsychology Consultant, Strand Regional Specialty Associates, Myrtle Beach, SC, 1998 – 2006

Neuropsychology Consultant, Charleston Pain and Rehabilitation Center, Charleston, SC, 1998 – Present

(Past)

Associate Professor, Departments of Psychiatry and Behavioral Sciences, and Neurology, Medical University of South Carolina, Charleston, SC, 1993 – 1998

Director, Assessment Center, Institute of Psychiatry, Medical University of South Carolina, Charleston, SC, 1992 – 1998

Director, Post-Doctoral Clinical Neuropsychology Fellowship, Institute of Psychiatry, Medical University of South Carolina, 1992 – 1998

Director, Pre-Doctoral Clinical Psychology Internship (APA Division 40 Neuropsychology Tract) VAMC/MUSC Internship Consortium, Medical University of South Carolina, 1995 – 1998

Assistant Professor, Department of Psychiatry and Behavioral Sciences, Medical University of South Carolina, Charleston, SC, 1983 – 1993

Assistant Professor, Department of Neurology (dual appointment), Medical University of South Carolina, Charleston, SC, 1992 – 1993

Clinical Psychologist/Neuropsychologist, Adult Psychiatry, Institute of Psychiatry, Medical University of South Carolina, Charleston, SC, 1989 – 1992

Clinical Psychologist, Adult Psychiatry, Veterans Administration Medical Center, Charleston, SC, 1983 – 1989

Director, Post-Traumatic Stress Disorder Treatment Team, VA Medical Center, Charleston, SC, 1988 – 1989

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Lewis Randolph Waid
Curriculum Vitae
Page 3

Director, Vietnam Era Veteran Treatment Team, VA Medical Center, Charleston, SC, 1984 – 1987

Director, Psychological Services, Dallas Psychiatric Associates, Dedman Medical Center, Dallas, TX, 1981 – 1983

Independent Practice, Van Buskirk and Associates, Dallas, TX, 1982 – 1983

Clinical Director, Adolescent Security Unit, Commonwealth Psychiatric Clinic, Richmond, VA, 1976 – 1977

Psychiatric Aide, Fairfield Hills State Hospital, Newtown, CT, 1974 – 1975

MAJOR TEACHING ACTIVITIES

Adjunct Professor, Graduate Psychology Program, The Citadel, Charleston, SC, Substance Abuse Counseling, 1998 – 2003

Motivational Interviewing Network of Trainers (MINT), local, regional, and national workshops, 1999 – Present

Clinical supervision of post-doctoral neuropsychology fellows, Institute of Psychiatry, Medical University of South Carolina 1992 – 1998

Clinical supervision of pre-doctoral psychology interns (APA Division 40 Neuropsychology Tract), VAMC/MUSC Internship Consortium, Charleston, SC, 1995 – 1998

Clinical supervision of pre-doctoral psychology interns (Psychological Assessment Rotation), Institute of Psychiatry, Medical University of South Carolina 1992 – 1995

Director, Clinical Psychology Internship Seminar Series, VAMC/MUSC Internship Consortium, Medical University of South Carolina 1992 – 1998

Instructor, College of Dental Medicine, Medical University of South Carolina 1992 – 2000

Clinical supervision of psychology interns, Adult Inpatient Psychiatry Rotation, Institute of Psychiatry, Medical University of South Carolina 1989 – 1992

Clinical supervision of psychology interns, Adult Inpatient/Outpatient psychiatry rotation, Veterans Administration Medical Center, VAMC/MUSC Internship Consortium, Charleston, SC 1983 – 1989

Clinical supervision of neuropsychological assessment practicum for interns, VAMC/MUSC Internship Consortium, Charleston, SC 1986 – 1989.

Preceptor, VAMC/MUSC Clinical Psychology Internship, Charleston, SC, 1983 – 1998

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Lewis Randolph Waid
Curriculum Vitae
Page 4

Course Leader, Psychology Internship Seminar Series (Clinical Neuropsychology; Post-Traumatic Stress Disorder; Borderline and Other Personality Disorders; Forensic Psychology) VAMC/MUSC Internship Consortium, 1983 – 1998

Lecturer, PGY2 Psychiatry Resident Seminars (Clinical Neuropsychology; Stress Related Disorders; Forensic Psychiatry; Adult Attention Deficit Disorder, Medical University of South Carolina 1983 – 1998

Lecturer, Neurology Residents' Neuroscience Seminar Program, (Neuropsychological Assessment), Department of Neurology, Medical University of South Carolina, 1990 – 1998

Behavioral Science seminar Leader, Medical University of South Carolina, Charleston, SC, 1983 – 1995

Interview Workshop Leader, Physical Diagnosis Course, Medical University of South Carolina, Charleston, SC, 1984 – 1998

Lecturer, Veterans Administration Medical Center Inpatient Psychiatry Resident Conference, 1990 – 1992

Psychopathology lecturer, second year medical students, Medical University of South Carolina, Charleston, SC, 1984 – 1987.

Lecturer, Department of Periodontics, College of Dental Medicine, Medical University of South Carolina (Myofascial Pain Dysfunction Syndrome), 1984 – 1990

Instructor, Disturbed Behavior Workshop, Veterans Administration Medical Center, Charleston, SC 1987 – 1989

Teaching/Research Assistant, Department of Psychology, University of North Texas, Denton, TX 1978 – 1980

Teaching Assistant, Department of Psychology, University of Richmond, Richmond, VA 1975 – 1976

AWARDS & HONORS

Best Scientist-Practitioner Award, Clinical Psychology Internship Program, Department of Psychiatry and Behavioral Sciences, Medical University of South Carolina 1992-1993

Outstanding Performance Award, VA Medical Center, Charleston, South Carolina 1985; 1989

Outstanding Teaching Award, Clinical Psychology Internship Program, Department of Psychiatry and Behavioral Sciences, Medical University of South Carolina 1985-86; 1986-87; 1988-89; 1989-90; 1990-91; 1993-94; 1994-95

VA Administrator's Hands and Heart Award, VA Medical Center, Charleston, SC 1986

Passed with Distinction Preliminary Written and Oral Examination for the Ph.D., North Texas State University, Denton, TX 1980

THOMPSON 002847

Lewis Randolph Waid
Curriculum Vitae
Page 5

Outstanding Graduate Student Award, Psychology Department, University of Richmond, Virginia
1976
Graduate Fellowship, University of Richmond, Virginia 1975
Phi Beta Kappa, Temple University, Philadelphia, PA 1974
Athletic Scholarship (Baseball), Temple University, Philadelphia, PA 1970-1974

MEMBERSHIPS IN PROFESSIONAL ORGANIZATIONS

American Psychological Association
Division of Clinical Psychology (12)
Division of Clinical Neuropsychology (40)
American Psychology Law Society (41)
Addictive Behaviors (50)
Southeastern Psychological Association
Research Society on Alcoholism
National Academy of Neuropsychology
International Neuropsychology Society
Coalition of Clinical Practitioners in Neuropsychology
South Carolina Academy of Professional Psychologists
South Carolina Psychological Association
Society for Personality Assessment
South Carolina Head Injury Association
South Carolina Neuropsychology Interest Group (Chair 1994 – 1995)
The Association of Traumatic Stress Specialists
American Academy of Experts in Traumatic Stress
Motivational Interviewing Network of Trainers

COMMITTEESHIPS

Assessment/Treatment of Sexual Offenders Committee, Lowcountry Children's Center,
Charleston, SC, 2000 – 2002
Psychology Education Committee, Department of Psychiatry, Medical University of South
Carolina 1995 – 1998
Outpatient Steering Committee, Department of Psychiatry, Medical University of South Carolina
1997-1998
Lowcountry Children's Center Research Advisory Board, Charleston, SC, 1996 – 1999
Psychiatric Task Force/UMA, Medical University of South Carolina 1995 – 1997
Ambulatory Care System Committee, Institute of Psychiatry, Medical University of South
Carolina 1994 – 1995
Clinical Services Committee, Institute of Psychiatry, Medical University of South Carolina 1994
– 1998
Intern Selection Committee, VAMC/MUSC Consortium, Charleston, SC, 1994 – 1998
Psychology Intern Coordinator, VAMC/MUSC Consortium, Charleston, SC, 1994 – 1998
Geriatric Improvement Team (BICU), Institute of Psychiatry, Medical University of South
Carolina 1992 – 1994

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Executive Committee, 3 North Adult Inpatient Psychiatry Unit, Institute of Psychiatry, Medical University of South Carolina 1989 – 1992
Milieu Management Committee, Institute of Psychiatry, Medical University of South Carolina 1990 – 1992
Co-Founder (Chair), SC Psychological Association Neuropsychology Interest Group 1990 – 1995
Executive Committee, Inpatient Psychiatry Unit, VAMC 1988 – 1989
Disturbed Behavior Task Force Committee, VAMC 1986 – 1989
Psychology Internship Education Committee, VAMC/MUSC 1984 – 1993
Medical District 9 Technical Advisory Group (TAG) on AIDS, Veterans Administration 1987 – 1988
Closed Head Injury Advisory Committee, Department of Physical Medicine and Rehabilitation, MUSC 1986 – 1988
Psychology Internship Seminar Committee, Co-Chair, VAMC/MUSC 1985 – 1988, 1990 – 1993 (Chairman, 1994 – 1998)
Do Not Resuscitate/Death in Dignity Task Force, VAMC 1985 – 1987
Clinical Psychology Training Committee, Department of Psychology, North Texas State University 1979 – 1980

CONSULTANT ACTIVITIES

Drug Abuse Sciences, Naltrel 99-03 study, 2000 – 2001
Departments of Neurology, Neurosurgery, and Physical Medicine and Rehabilitation, Medical University of South Carolina (Clinical Neuropsychology Consultant) 1983 – 1992
Vietnam Veteran Outreach Center (Vet Center), Charleston, SC 1983 – 1987
Advisory Board, SC State Chapter, Head injury Foundation, Orangeburg, SC, 1985 – 1989
Advisory Board Head Injury Program, Southern Pines Hospital, Charleston, SC 1987 – 1989

EDITORIAL ACTIVITY

Reviewer, Vet Center Voice 1986 – 1989
Reviewer, Journal of Traumatic Stress 1997 – 1998

GRANT ACTIVITY

“Gabapentin as an Adjunct to Naltrexone for Alcoholism.” NIAAA \$2,355,397, September 2002 – August 2007. Supervising therapist.
“Comparison of CBT and MET plus Naltrexone for Alcoholism.” NIAAA (RO1), \$1,218,257, September 1997 – August 2002 (PI: Ray Anton, M.D.) Co-Investigator
“Naltrexone/Acamprosate plus CBT/MET Light for Alcoholism” (COMBINE study). Principal Therapist. NIAAA (U10), \$2,334,861, September 1997 – August 2003

THOMPSON 002849

- "Amlodipine Treatment for Cocaine Dependence" NIDA (ROI) \$1,495,259, September 1997 – August 2002. (PI: Robert J. Malcolm, MD) Co-Investigator
- "Sertraline and Cognitive Therapy in Depressed Alcoholics." NIAAA (R29), \$503,878, April, 1995 – March, 2001. (PI: Darlene Moak, M.D.) Co-Investigator
- "Opiate Antagonist: Alcohol Reactivity and Consumption." NIAAA (P50), \$1,172,633, December 1, 1995 – November 30, 2000. (PI: Ray Anton, M.D.) Co-Investigator
- "Naltrexone and Cognitive Behavior Therapy of Alcoholism" NIAAA (RO1), \$1,712,467, 1992 – 1997. (PI: Ray Anton, MD) Co-Investigator
- "Neurocognitive and Neuropsychological Manifestations of Eosinophilia Myalgia Syndrome." Showa-Denko America Inc., \$124,674, 1994-1995. Co-Investigator
- Charleston Heart Study – "Predictors of Coronary Disease in Blacks," Competitive Renewal: National Heart, Lung, and Blood Institute, Medical University of South Carolina, 1984-1990, \$303,223 annually. (Grant 2-RO1-HL3139-7-04) Assessment of cognitive functioning in elderly black and white cohort. (Competitive renewal 1990-1993). Co-Investigator
- Matching alcohol treatments to client heterogeneity. National Institute of Alcohol Abuse and Alcoholism, \$880,000. October 1989 – September 1994. Therapist in Motivational Enhancement Therapy (MET) condition.
- "Ritanserin in the Treatment of Alcohol Dependence: A Double-Blind Placebo-Controlled Phase III Study." (Protocol II RIT-USA-40) Janssen Research Foundation. 1993-1994. Co-Investigator

PUBLICATIONS AND PRESENTATIONS

Journal Articles

- Waid, L.R., Kanoy, R.C., Blick, K., and Walker, W. (1978). Relationship of state-trait anxiety and type of practice to reading comprehension of college students. Journal of Psychology, 98, 27-36.
- Critelli, J.W. and Waid, L.R. (1980). Physical attractiveness, romantic love, and equity in dating relationships. Journal of Personality Assessment, 44, 624-630.
- Rahaim, S., Waid, L.R., Kennelly, K., and Strickland, A. (1980). Differences in the self-monitoring of expressive behavior in depressed and nondepressed individuals. Psychological Reports, 46, 1051-1056.
- Kennelly, K., Crawford, D., Waid, L.R., and Rahaim, S. (1980). Partial reinforcement immunizes against helplessness induced short-term memory deficits. Catalog of Selected Documents in Psychology (APA), 10.

THOMPSON 002850

- Cimbalic, P., Thompson, R., and Waid, L.R. (1981). Black and white students' preferences for help sources. Journal of Student Personnel.
- O'Neil, P.M., Giacinto, J.P., Waid, L.R., Roitzsch, J.C., Miller, W.C., and Kilpatrick, D.G. (1983). Behavioral, psychological, and historical correlates of MacAndrew scale scores among male alcoholics. Journal of Behavioral Assessment, 5, 261-273.
- Mishkin, D.J., Fourrier, J.L., Shelley, L.R., and Waid, L.R. (1986). A common sense approach for treatment of myofascial pain-dysfunction syndrome. Florida Dental Journal, 56, (Also published in The Journal of the Alabama Dental Association, 1986, 70, 34-41).
- Anton, R.F., Waid, L.R., Fossey, M., and AuBuchon, P. (1986). Case report of carbamazepine treatment of organic brain syndrome with psychotic features. Journal of Clinical Psychopharmacology, 6, 232-234.
- Waid, L.R. (1987). Atypical manifestations of post-traumatic stress: Clinicians Beware! PTSD Quarterly Newsletter, 4, 8.
- Stevens J., Keil, J.E., Waid, L.R., and Gazes, P.C. (1990). Accuracy of current, 4 year and 28 year self-reported body weight in an elderly population. American Journal of Epidemiology, 132, 1156-1163.
- Keil, J.E., Sutherland, S.E., Knapp, R.C., Waid, L.R., and Gazes, P.C. (1992). Self-reported sexual functioning in elderly blacks and whites (The Charleston Heart Study Experience). Journal of Aging and Health, 4, 112-125.
- Waid, L.R. and Mintzer, J.E. (1993). Ethnicity, culture and mental health in the elderly. American Association for Geriatric Psychiatry Newsletter, 13(4), 9-13.
- Rhodes, S.K., Shimoda, K.C., Waid, L.R., O'Neil, P.M., Oexmann, M.J., Willi, S.M., and Collop, N.A. (1994). Cognitive deficits in morbidly obese adolescents with sleep apnea. International Journal of Obesity, 18, 13.
- Waid, L.R. (1996). Can we get your attention? Progress Notes - MUSC Institute of Psychiatry, 1, 1-2.
- Mintzer, J.E., Nietert, P., Costa, K., and Waid, L.R. (1996). Cross-cultural perspectives: Agitation in demented patients in the United States. International Psychogeriatrics, 8, 487-490.
- Johnson, D.E., Waid, L.R., and Anton, R.F. (1997). Childhood hyperactivity, gender, and Cloninger's personality dimensions in alcoholics. Addictive Behaviors, 22, 649-653.
- Mintzer, J.E., Colenda, C., Waid, L.R., Lewis, L., Meeks, A., Stuckey, M., Bachman, D.L., Saladin, M., and Sampson, R.R. (1997). Effectiveness of a continuum of care model for agitated dementia patients. Psychiatric Services, 48, 1361-1448.

THOMPSON 002851

- Horner, M.D., Waid, L.R., Johnson, D.E., Latham, P.K., and Anton, R.F. (1999). The relationship of cognitive functioning to amount of recent and lifetime alcohol consumption in outpatient alcoholics. Addictive Behaviors, 24, 449-453.
- Epstein, S.A., Kay, E., Clauw, Heaton, R., Klein, D., Krupp, L., Kuck, J., Leslie, V., Masur, D., Wagner, M., Waid, L.R., and Bisook, S. (1999). Psychiatric disorders in patients with fibromyalgia: A multicenter investigation. Psychosomatics.
- Clure, C., Brady, K.T., Saladin, M.D., Johnson, D., Waid, L.R., and Rittenbury, M. (1999). Attention-Deficient Hyperactivity Disorder and substance use: Symptom pattern and drug choice. American Journal of Drug and Alcohol Abuse, 25, 441-448.
- Anton, R.F., Moak, D.H., Waid, L.R., Latham, P.K., Malcolm, R.J., and Dias, J.K. (1999). Naltrexone and cognitive behavioral therapy for the treatment of outpatient alcoholics: Results of a placebo-controlled trial. American Journal of Psychiatry, 156:11, 1758-1764.
- Anton, R.F., Moak, D.H., Latham P.K., Waid, L.R., Malcolm, R.J., Dias, J.K., Roberts, J.S. (2001). Post-treatment results of combining naltrexone with cognitive-behavior therapy for the treatment of alcoholism. Journal of Clinical Psychopharmacology, 21, 72-77.
- Johnson, D.E., Epstein, J.N., Waid, L.R., Latham, P.K., Voronin, K.E., and Anton, R.F. (2001). Neuropsychological performance deficits in adults with Attention-Deficit Hyperactivity Disorder. Archives of Clinical Neuropsychology, 16, 587-604.
- Moak, D.H., Anton, R.F., Latham, P.K., Voronin, K.E., and Waid, L.R. (2003) Sertraline and cognitive behavioral therapy for depressed alcoholics: Results of a placebo-controlled trial. Journal of Clinical Psychopharmacology, 23, 553-562.
- Anton, R.F., Moak, D.H., Latham, P., Waid, L.R., Myrick, N., Voronin, K., Thevos, A., Wang, W., and Woolson, R. (2005) Naltrexone combined with either cognitive behavioral or motivational enhancement therapy for alcohol dependence. Journal of Clinical Psychopharmacology, 25 (4): 349-357. Reprinted in International Drug Therapy Newsletter, 40 (10): 75-85 (2005).

Book Chapters

- Waid, L.R., Johnson, D.E., and Anton, R.F. (1997). Attention-Deficit Hyperactivity Disorder and substance abuse. In H.R. Kranzler and B.J. Rounsaville (Eds.), Dual Diagnosis: Substance Abuse and Comorbid Medical and Psychiatric Disorders. Marcel Dekker, Inc., New York, N.Y.
- Waid, L.R., LaRowe, S.D., Anton, R.F., and Johnson, D.E. (2004). Attention-Deficit/Hyperactivity Disorder and Substance Abuse. In H.R. Kranzler and M. Tinsley (Eds.), Dual Diagnosis and Psychiatric Treatment. Marcel Dekker, Inc., New York, N.Y.

Treatment Manuals

Zweban, A., Barrett, D., Waid, L.R., and Anton, R.F. (2000). CPH-101 in heavy alcohol drinkers with impaired control: A 12 + 40-week, placebo-controlled, dose response study ("The Nalmefene Study").

Zweban, A., Barrett, D., Waid, L.R., and Anton, R.F. (2000). Motivating for alcohol reduction and medication management (MARMM): A manual for practitioners treating individuals on medication for alcohol problems.

Published Abstracts

O'Neil, P.M., Waid, L.R., and Giacinto, J.P. (1981). Psychological and behavioral correlates of MacAndrew scale scores among male alcoholics. Alcoholism: Clinical and Experimental Research, 5.

Waid, L.R., Malatesta, V.J., Roitzsch, J., and Giacinto, J.P. (1981). Personality, mood state, and psychological characteristics of young, middle-aged, and elderly alcoholic males. Alcoholism: Clinical and Experimental Research, 5.

Giacinto, J.G., O'Neil, P.M., Waid, L.R., and Roitzsch, J.C. (1981). A comparison of early-onset versus late-onset elderly alcoholic males. Alcoholism: Clinical and Experimental Research, 5.

Holmstrom, V.L., Waid, L.R., and Motsinger, P. (1987). Dementia vs. Pseudodementia: Is this the right question? Neurology, 37, 156.

Waid, L.R., Swavely, S.M., Keil, J.E., Sutherland, S.E., and Gazes, P. (1990). Cognitive functioning and cardiovascular status in elderly blacks and whites. The Clinical Neuropsychologist, 4, 275.

Waid, L.R., Bene, C.B., Bachman, D., and Carson, W.C. (1991). Malformation of the cerebral cortex with heterotopia of the gray matter: A case study. Archives of Clinical Neuropsychology, 6, 233.

Waid, L.R., Austin, L.S., Kurent, J.E., and Silver, R.M. (1992). Neuropsychological impairment in Eosinophilia-Myalgia Syndrome (EMS) associated with L-Tryptophan use. Archives of Clinical Neuropsychology, 7, 368.

Leverett, J.P., Waid, L.R., Knapp, R.G., Keil, J.E., and Sutherland, S.E. (1992). Correlates of good and poor cognitive performance in elderly adults. Archives of Clinical Neuropsychology, 7, 343-344.

Hummer, J.T., Waid, L.R., Rodenbough, J., Sutherland, S., Wagner, M., and Keil, J. (1994). Memory performance in depressed versus non-depressed community elderly. Archives of Clinical Neuropsychology, 9, 142.

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- Wagner, M., Bachman, D., Cushman, L., Waid, R., and Hummer, J. (1994). Severity of dementia as a risk factor for driving. Archives of Clinical Neuropsychology, 9, 196.
- Wagner, M., Bachman, D., Hummer, J., and Waid, R. (1994). Asymmetric cortical degenerative syndromes: Neurocognitive, neuroradiographic, and natural history case presentation. Archives of Clinical Neuropsychology, 9, 196.
- Waid, L.R., Knapp, R.G., Williams, M., Keil, J.E., Sutherland, S., and Lackland, D. (1994). Blood pressure and cognitive performance: The Charleston Heart Study. Archives of Clinical Neuropsychology, 9, 197.
- Rittenbury, M.E., Anton, R.F., Waid, L.R., Johnson, D.E., and Latham, P.K. (1994). Alcoholism severity in a sample of outpatient adult alcoholics with and without childhood hyperkinesia. Alcoholism: Clinical and Experimental Research, 18, 496.
- Waid, L.R., Johnson, D.E., Latham, P.K., Leverett, P., and Anton, R.F. (1994). Neuropsychological performance in alcohol and cocaine abusers. Alcoholism: Clinical and Experimental Research, 18, 524.
- Johnson, D.E., Waid, L.R., Latham, P.K., Rittenbury, M.E., and Anton, R.F. (1994). Neuropsychological performance in alcoholics with childhood HK/MBD. Alcoholism: Clinical and Experimental Research, 18, 525.
- Rhodes, S.K., Shimoda, K.C., Waid, L.R., O'Neil, P.M., Oexmann, M.J., Willi, S.M., and Collop, N.A. (1994). Cognitive deficits in morbidly obese adolescents with sleep apnea. International Journal of Obesity, 18, 13.
- Hummer, J.T., Fink, C., Waid, L.R., and Wagner, M.T. (1994). WMS-R and MMPI-2 profiles of ADHD-RT versus learning-disabled adults. The Clinical Neuropsychologist, 8, 335.
- Shimoda, K.C., Waid, L.R., Abboud, M.R., Jackson, S.M., Matthews, K., Onnfrak, E., Shearer, J., and Laver, S.H. (1994). Neuropsychological functioning in children with sickle cell disease and stroke. The Clinical Neuropsychologist, 8, 332.
- Wellborn, W.R., Hummer, J.T., Waid, L.R., Wagner, M.T., and Barnett, K. (1995). A comparative analysis of psychopathology and memory function in adult patients with mild neurobehavioral syndromes. Archives of Clinical Neuropsychology, 10, 402-403.
- Johnson, D.E., Waid, L.R., Latham, P.K., and Anton, R.F. (1995). The effects of gender and childhood hyperactivity on Cloninger's typologies in outpatient alcoholics. Alcoholism: Clinical and Experimental Research, 19 (Supplement), 56A.
- Horner, M.D., Johnson, D.E., Waid, L.R., Latham, P.K., and Anton, R.F. (1995). The relationship of recent and lifetime alcohol consumption to cognitive functioning in outpatient alcoholics. Alcoholism: Clinical and Experimental Research, 19 (Supplement), 69A.

- Waid, L.R., Johnson, D.E., Latham, P.K., and Anton, R.F. (1995). Neurocognitive and personality characteristics of alcoholics with childhood hyperactivity. Alcoholism: Clinical and Experimental Research, 19 (Supplement), 70A.
- Johnson, D.E., Waid, L.R., and Anton, R.F. (1996). Relationship of rating scales to DSM-IV diagnosis of childhood ADHD in adult alcoholics. Alcoholism: Clinical and Experimental Research, 20 (Supplement), 49A.
- Waid, L.R., Johnson, D.E., Latham, P.K., and Anton, R.F. (1996). Personality and neurocognitive characteristics of alcoholics scoring high and low on the obsessive compulsive drinking scale (OCDS). Alcoholism: Clinical and Experimental Research, 20 (Supplement) 50A.
- Johnson, D.E., Waid, L.R., Richman, H., and Anton, R.F. (1996). Discriminant analysis of neuropsychological performance in alcoholics with and without childhood hyperactivity. Archives of Clinical Neuropsychology, 11, 404.
- Waid, L.R., Johnson, D.E., Richman, H., and Anton, R.F. (1997). Comparison of personality and neuropsychological functioning in alcoholics with and without hyperactivity. Journal of Psychopathology and Behavioral Assessment.
- Rhodes, S.K., Waid, L.R., O'Neil, P.M., Collop, N.A., and Willi, S.M. (1997). Neurocognitive functioning and obstructive sleep apnea in morbidly obese adolescents. Archives of Clinical Neuropsychology, 12, 393.
- Johnson, D.E., Waid, L.R., Foer, J., and Anton, R.F. (1997). Alcohol dependence rates in adults with attention deficit/hyperactivity disorder. Alcoholism: Clinical and Experimental Research, 21, 31A.
- Foer, J.F., Waid, L.R., and Gold, P.B. (1997). Litigation and peripheral injury: Neurocognitive effects in mild head injury. The Clinical Neuropsychologist, 11.
- Anton, R.F., Moak, D.H., Waid, L.R., Latham, P.K., Dias, J.K., Roberts, J.S. (1998). Post-treatment outcome of alcoholics treated with CBT with and without naltrexone. American College of Neuropsychopharmacology Meeting Procedures.
- Hayes, J.S., Waid, L.R., Horner, M.D., Johnson, D., Sonne, S., and Brady, K.T. (1998). Neuropsychological functioning in recently abstinent cocaine-dependent individuals. Archives of Clinical Neuropsychology, 13.
- Hayes, J.T., and Waid, L.R. (1998). Chronic neurobehavioral and neurological deficits after decompression sickness: A case study. Archives of Clinical Neuropsychology, 13.
- Waid, L.R., Herron, J.E., Latham, P., Dias, J.K., and Anton, R.F. (1999). Naltrexone, neurocognitive functioning and relapse in recently abstinent alcoholics. Alcoholism: Clinical and Experimental Research, 23, 57A.

- Herron, J.E., Waid, L.R., and Anton, R.F. (1999). Craving, neurobehavioral variables, and relapse in outpatient alcoholics. Alcoholism: Clinical and Experimental Research, 23, 57A.
- Anton, R.F., Moak, D.H., Latham, P.K., Myrick, D.L., and Waid, L.R. (2003). A double blind comparison of naltrexone combined with CBT or MET in the treatment of alcohol dependence Alcoholism: Clinical and Experimental Research, 27(5), 191A.
- Anton, R.F., Moak, D.H., Latham, P.K., Myrick, D.L., and Waid, L.R. (2004). A double blind comparison of naltrexone combined with CBT or MET in the treatment of alcohol dependence-within study and post-treatment results. Alcoholism: Clinical and Experimental Research, 28(5): suppl. 133A.
- Teichner, G., Waid, L.R., and Buddin, W.H. (2005). The Memory and Concentration Test (MACT): Data from a sample demonstrating a range of neurological and psychiatric disorders. Archives of Clinical Neuropsychology, 20, 893.

Conference Presentations

- Critelli, J.W. and Waid, L.R. (1979, August). Physical attractiveness, romantic love, and equity in dating relationships. Poster presented at the annual meeting of the American Psychological Association, New York, NY.
- Kennelly, K. and Waid, L.R. (1982, March). Partial reinforcement immunizes against working short-term memory deficits. Poster presented at the annual meeting of the Southwestern Psychological Association, Dallas, Texas.
- Waid, L.R., Giacinto, J.G., Cimbalic, P., Roitzsch, J.C., and Glick, S. (1983, August). Multi-faceted treatment for myofascial-pain dysfunction: A comparison of treatment components. Poster presented at the annual meeting of the American Psychological Association, Anaheim, California.
- Waid, L.R. (1984, May). Neuropsychological evaluation of the elderly patient. Poster presented at Southeastern Regional Medical Education Center sponsored symposium "Geropsychiatry: Evaluation and Treatment of the Aged Patient," Charleston, South Carolina.
- Waid, L.R. (1984, August). Japanese prison camp survivors: Psychic scarring. In V. Holmstrom (Chair), Post traumatic stress forty years later: Survivors of Japanese prison camps. Symposium presented at the annual convention of the American Psychological Association, Toronto, Canada.
- Holmstrom, V.L., Pritchard, P., and Waid, L.R. (1984, August). Natural history of untreated complex partial epilepsy: Neuropsychological and personality assessment. Poster presented at the annual convention of the American Psychological Association, Toronto, Canada.
- Waid, L.R., Anton, R.F., AuBuchon, P., and Fossey, M. (1985, May). A neuropsychological case study of carbamazepine treatment of organic brain syndrome with psychotic features. Poster presented at the Mid-South Conference on Human Neuropsychology, Memphis, Tennessee.

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- Waid, L.R., Shaw, D.L., Holmstrom, V.L., and Sexauer, J.D. (1985, August). Objective personality assessment of WW II American POWS: Diagnostic group comparisons. Paper presented at the annual convention of the American Psychological Association, Los Angeles, California.
- Holmstrom, V.L., Waid, L.R., Shaw, D.L., and Sexauer, J.D. (1985, August). Marital adjustment among American World War II POWS. Paper presented at the annual convention of the American Psychological Association, Los Angeles, California.
- Shaw, D.L., Holmstrom, V.L., Waid, L.R., and Sexauer, J.D. (1985, August). Social adjustment among America WW II POWS: Diagnostic group comparisons. Paper presented at the annual convention of the American Psychological Association, Los Angeles, California.
- Sexauer, J.D., Holmstrom, V.L., Shaw, D.L., and Waid, L.R. (1985, August). WW II American POWS: Captivity related stressors and present day symptomatology. Paper presented at the annual convention of the American Psychological Association, Los Angeles, California.
- Waid, L.R., Kahles, J., Hamilton, S., and Lydiard, B. (1986, March). Mentation after medication: The effect of alprazolam on cognitive functioning of panic disordered patients. Paper presented at the annual meeting of the Southeastern Psychological Association, Orlando, Florida.
- Waid, L.R., Cogar, G., and Libet (1986, March). Two case studies of atypical post-traumatic stress: The problem of false negatives. Paper presented at the annual meeting of the Southeastern Psychological Association, Orlando, Florida.
- Libet, J., Waid, L.R., and Cogar G. (1986, March). When social validation is unreliable? Paper presented at the annual meeting of the Southeastern Psychological Association, Orlando, Florida.
- Waid, L.R. and Holmstrom, V.L. (1986, September). Diagnostic and treatment issues of stress disorders among World War II POWS. Paper presented at the 2nd Annual meeting of the Society for Traumatic Stress Studies, Denver, Colorado.
- Waid, L.R., Cogar, G., and Miller, W.C. (1987, February). Vet Center and Medical Center Collaboration. Panel presentation at Region III Veterans Administration Training Conference on "Diagnosis and Management of Post Traumatic Stress Disorder in the VA", Orlando, Florida.
- Holmstrom, V.L., Waid, L.R., and Motsinger, P. (1987, April). Dementia versus pseudodementia: Is this the right question? Poster presented at the 39th Annual meeting of the American Academy of Neurology, New York, New York.
- Waid, L.R. and West, B. (1987, April). Issues in neuropsychology. Paper presented at the Annual meeting of the South Carolina Psychological Association, Myrtle Beach, South Carolina.

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- Waid, L.R. (1987, November). Discovering dissociation in a Vietnam combat veteran: A videotape case presentation. Paper presented at the Fourth International Conference on Multiple Personality/Dissociative States, Chicago, Illinois.
- Waid, L.R. and Schneider, S.K. (1988, March). Perceived versus objective memory functioning in individuals with closed head injury. Poster presented at the annual meeting of the Southeastern Psychological Association, New Orleans, Louisiana.
- Waid, L.R., Roberts, J., and Schneider, S.K. (1988, April). Naltrexone treatment for postconcussional syndrome. Poster presented at conference on Head Injury: An integrated approach to behavioral rehabilitation, Boston, Massachusetts.
- Schneider, S.K., Waid, L.R., and White, D. (1988, April). Secondary mania and its treatment following head injury. Poster presented at conference on Head Injury: An integrated approach to behavioral rehabilitation, Boston, Massachusetts.
- Waid, L.R. (1988, August). Dissociation in combat-related Post-traumatic Stress Disorder. In L.A. Hyer (Chair) Base rates of PTSD and newer measures for its evaluation. Symposium presented at the annual convention of the American Psychological Association, Atlanta, Georgia.
- Waid, L.R., Urbanczyk, S.A., Keil, J.E., Sutherland, S.E., and Gazes, P.C. (1989, March). Cognitive functioning and health status in elderly Blacks and Whites. Poster presented at the annual meeting of the Southeastern Psychological Association, Washington, D.C.
- Waid, L.R., Urbanczyk, S.A., Sutherland, S.E., Keil, J.E., and Gazes, P.C. (1989, June). Cardiovascular status and cognitive functioning: The Charleston Heart Study. Poster presented at the annual meeting of the Society for Epidemiologic Research, Birmingham, Alabama.
- Waid, L.R. and Urbanczyk, S.A. (1989, August). Comparison of high versus low dissociative Vietnam veterans with PTSD. Poster presented at the annual convention of the American Psychological Association, New Orleans, Louisiana.
- Waid, L.R., Swavely, S.M., and West, B. (1990, March). Development of a S.C.P.A. Neuropsychology Interest Group. Paper presented at the annual meeting of the South Carolina Psychological Association, Myrtle Beach, SC.
- Waid, L.R. (1990, March). Emotional and psychological consequences of minor head injury. Paper presented at continuing education workshop: Examining Minor Head Injury: Assessment, Intervention, and Outcome, Charleston, SC.
- Waid, L.R., Swavely, S.M., Keil, J.E., Sutherland, S., and Gazes, P. (1990, June). Cognitive function, cardiovascular status and physical disability in elderly blacks and whites of the Charleston heart study. Poster presented at the annual meeting of the Society for Epidemiologic Research, Snowbird, Utah.

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- Waid, L.R., Swavely, S.M., Keil, J.E., Sutherland, S., and Gazes, P. (1990, August) Cognitive functioning and cardiovascular status in elderly blacks and whites. Poster presented at the annual convention of the American Psychological Association, Boston, Mass.
- Waid, L.R., Bene, C.B., Bachman, D., and Carson, W.C. (1990, November). Malformation of the cerebral cortex with heterotopia of the gray matter: A case study. Poster presented at the annual meeting of the National Academy of Neuropsychology, Reno, Nevada.
- Nicolette, M.K. and Waid, L.R. (1991, March). Anger reduction in closed head injured individuals with group social skills training. Poster presented at the annual meeting of the Southeastern Psychological Association, New Orleans, Louisiana.
- Waid, L.R., Keil, J.E., Sutherland, S.E., Knapp, R.G., and Gazes, P.C. (1991, August). Sexual functioning in elderly blacks and whites: The Charleston Heart Study. Poster presented at the annual convention of the American Psychological Association, San Francisco, California.
- Barton, S.D., Duke, L., and Waid, L.R. (1991, August). Emotional arousal and memory for naturalistic events. Poster presented at the annual convention of the American Psychological Association, San Francisco, California.
- Waid, L.R., Austin, L.S., Kurent, J.E., and Silver, R.M. (1991, November). Neuropsychological impairment in Eosinophilia-Myalgia Syndrome (EMS) associated with Tryptophan use. Poster presented at the annual meeting of the National Academy of Neuropsychology, Dallas, Texas.
- Leverett, J.P., Waid, L.R., Knapp, R.G., Keil, J.E., and Sutherland, S.E. (1991, November). Correlates of good and poor cognitive performance in elderly adults. Poster presented at the annual meeting of the National Academy of Neuropsychology, Dallas, Texas.
- Deroian, P.L. and Waid, L.R. (1991, November). Secondary mania following a cerebrovascular accident. Poster presented at the annual meeting of the National Academy of Neuropsychology, Dallas, Texas.
- Waid, L.R. (1992, February). Memory and aging. Paper presented at conference on Alzheimer's Disease in South Carolina: Progress and Challenge, Charleston, South Carolina.
- Waid, L.R. (1993, May). Assessment and treatment of the borderline patient. Invited presenter at the 10th Annual Psychotherapy Workshop, Department of Psychiatry, Medical College of Georgia, Augusta, Georgia.
- Waid, L.R., Hummer, J.T., Sutherland, S., and Keil, J. (1993, August). Prevalence and correlates of depressive symptoms among elderly blacks and whites. Poster presented at the Annual Convention of the American Psychological Association, Toronto, Canada.
- Beliles, K., Waid, L.R., Wagner, M., Hummer, J., Cofer, J., and Wohlreich, M. (1993, October). Neuropsychiatric status and selection for liver transplantation. Poster presented at the International Liver Transplant Society Annual Meeting, Toronto, Ontario, Canada.

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- Waid, L.R., Knapp, R.G., Williams, M., Keil, J.E., Sutherland, S., and Lackland, D. (1993, October). Blood pressure and cognitive performance: The Charleston Heart Study. Poster presented at the Annual Meeting of the National Academy of Neuropsychology, Phoenix, Arizona.
- Hummer, J.T., Waid, L.R., Rodenbough, J., Sutherland, S.E., Wagner, M.T., and Keil, J.E. (1993, October). Memory performance in depressed versus non-depressed community elderly. Poster presented at the Annual Meeting of the National Academy of Neuropsychology, Phoenix, Arizona.
- Wagner, M.T., Bachman, D., Hummer, J.T., and Waid, L.R. (1993, October). Asymmetric cortical degenerative syndromes: Neurocognitive, neuroradiographic, and natural history case presentation. Poster presented at the Annual Meeting of the National Academy of Neuropsychology, Phoenix, Arizona.
- Wagner, M.T., Bachman, D., Cushman, L., Waid, L.R., and Hummer, J.T. (1993, October). Severity of dementia as a risk factor for driving. Poster presented at the Annual Meeting of the National Academy of Neuropsychology, Phoenix, Arizona.
- Waid, L.R. (1993, November). The Borderline patient: Conceptual and treatment issues. Invited presentation - South Carolina Association of Marriage and Family Therapy Teleconference, Charleston, South Carolina.
- Johnson, D.E., Nayak, M., Hummer, J.T., Waid, L.R., and Wagner, M.T. (1994, March). MMPI-2 profiles of adults with Residual Attention Deficit Disorder. Poster presented at the Annual Meeting of the Southeastern Psychological Association, New Orleans, Louisiana.
- Wagner, M., Munroe, R., Nayak, M., Hummer, J., and Waid, L.R. (1994, March). Neurocognitive, psychological and social factors associated with liver transplantation. Poster presented at the annual meeting of the Southeastern Psychological Association, New Orleans, Louisiana.
- Shimoda, K.C., Abboud, M.R., Waid, L.R., Matthews, K., Onufrak, E., Shearer, J., Jackson, S.M., Cure, J.H., Holden, K., and Laver, J.H. (1994, March). Effects of stroke and moyamoya vessels on intellectual functioning in patients with SCA. Poster presented at the Annual Meeting of the National Sickle Cell Disease Program, New York, New York.
- Nayak, M., Johnson, D.E., Hummer, J.T., Waid, L.R., and Wagner, M.T. (1994, April). Depressive symptomatology in MMPI-2 profiles of ADHD-RT individuals. Poster presented at the Society for Personality Assessment 1994 Midwinter Meeting, Chicago, Illinois.
- Nayak, M., Wagner, M.T., Munroe, R., Hummer, J., and Waid, L.R. (1994, April). Liver transplantation selection: Descriptive neurocognitive and psychiatric findings in pretransplant evaluation. Poster presented at the Transplant Spring Symposium, Medical University of South Carolina, Charleston, South Carolina.

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- Lewis, L.D., Burnside, S.R., Mintzer, J.E., Wellborn, W., and Waid, L.R. (1994, May). Treatment of depression in dementia patients. Poster presented at the Annual Meeting of the American Psychiatric Association, Philadelphia, Pennsylvania.
- Waid, L.R., Johnson, D.E., Latham, P.K., Leverett, P., Anton, R.F., and Brady, K. (1994, June). Neuropsychological performance in alcohol and cocaine abusers. Poster presented at the Annual Scientific Meeting of the Research Society on Alcoholism, Maui, Hawaii.
- Johnson, D.E., Waid, L.R., Latham, P.K., Rittenburg, M.E., and Anton, R.F. (1994, June). Neuropsychological performance in alcoholics with childhood HK/MBD. Poster presented at the Annual Scientific Meeting of the Research Society on Alcoholism, Maui, Hawaii.
- Rittenburg, M.E., Anton, R.F., Waid, L.R., Johnson, D.E., and Latham, P.K. (1994, June). Alcoholism severity in a sample of outpatient adult alcoholics with and without childhood hyperkinesia. Poster presented at the Annual Scientific Meeting of the Research Society on Alcoholism, Maui, Hawaii.
- Waid, L.R. (1994, July). Posttraumatic stress disorder. Invited presenter - Annual Conference of the Southern Association of Workers' Compensation Administrators, Hilton Head, South Carolina.
- Hummer, J.T., Fink, C., Waid, L.R., and Wagner, M.T. (1994, August). WMS-R and MMPI-2 profiles of ADHD-RT versus Learning-Disabled adults. Poster presented at the Annual Convention of the American Psychological Association, Los Angeles, California.
- Shimoda, K.C., Waid, L.R., Abboud, M.R., Jackson, S.M., Matthews, K., Onufrak, E. Shearer, J., and Laver, J.H. (1994, August). Neuropsychological functioning in children with sickle cell disease and stroke. Poster presented at the Annual Convention of the American Psychological Association, Los Angeles, California.
- Williams, M.A., Waid, L.R., Sutherland, S.E., Hummer, J.T., and Keil, J.E. (1994, August). Depression among the young old and the old old: The Charleston Heart Study. Poster presented at the Annual Convention of the American Psychological Associations, Los Angeles, California.
- Rhodes, S.K., Shimoda, K.C., Waid, L.R., O'Neil, P.M., Oexmann, M.J., Willi, S.M., and Collop, N.A. (1994, August). Cognitive deficits in morbidly obese adolescents with sleep apnea. Poster presented at the 7th International Congress on Obesity, Toronto, Canada.
- Wellborn, W.R., Hummer, J.T., Waid, L.R., Wagner, M.T., and Barnett, K. (1994, November). A comparative analysis of psychopathology and memory function in adult outpatients with mild neurobehavioral syndromes. Poster presented at the annual meeting of the National Academy of Neuropsychology, Orlando, Florida.

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- Shimoda, K.C., Waid, L.R., Abboud, M.R., Jackson, S.M., Shearer, J., Matthews, K., Onufrak, E., and Laver, J.H. (1995, April). Effects of stroke and moyamoya vessels on sustained attention and impulsivity in children with sickle cell disease. Poster presented at the 5th Florida Conference on Child Health Psychology, Gainesville, Florida.
- Johnson, D.E., Waid, L.R., Latham, P.K., and Anton, R.F. (1995, June). The effects of gender and childhood hyperactivity on Cloninger's typologies in outpatient alcoholics. Poster presented at the annual meeting of the Research Society on Alcoholism, Steamboat Springs, Colorado.
- Horner, M.D., Johnson, D.E., Waid, L.R., Latham, P.K., and Anton, R.F. (1995, June). The relationship of recent and lifetime alcohol consumption to cognitive functioning in outpatient alcoholics. Poster presented at the annual meeting of the Research Society on Alcoholism, Steamboat Springs, Colorado.
- Waid, L.R., Johnson, D.E., Latham, P.K., and Anton, R.F. (1995, June). Neurocognitive and personality characteristics of alcoholics with childhood hyperactivity. Poster presented at the annual meeting of the Research Society on Alcoholism, Steamboat Springs, Colorado.
- Waid, L.R., Johnson, D.E., Saladin, M.E., and Mintzer, J.E. (1995, August). Management of acute agitated behavior in elderly demented patients. Poster presented at the Annual Convention of the American Psychological Association, New York City, New York.
- Waid, L.R. (1995, August). Psychotherapy of alcoholism: Goals and methods. Paper presented at the 35th Annual Southeastern School of Alcohol and Other Drug Studies, Athens, Georgia.
- Johnson, D.E., Waid, L.R., Richman, H., and Anton, R.F. (1996, November). Discriminant analysis of neuropsychological performance in alcoholics with and without childhood hyperactivity. Poster presented at the annual meeting of the National Academy of Neuropsychology, San Francisco, California.
- Johnson, D.E., Waid, L.R., and Anton, R.F. (1996, June). Relationship of rating scales to DSM-IV diagnosis of childhood ADHD in adult alcoholics. Poster presented at the annual meeting of the Research Society on Alcoholism, Washington, D.C.
- Waid, L.R., Johnson, D.E., Latham, P.K., and Anton, R.F. (1996, June). Personality and neurocognitive characteristics of alcoholics scoring high and low on the obsessive compulsive drinking scale (OCDS). Poster presented at the annual meeting of the Research Society on Alcoholism, Washington, D.C.
- Spangenberg, K.B., Henderson, S., Waid, L.R., and Wagner, M.T. (1996, August). Validity of a free and recognition recall condition to assess visual memory in the CERAD battery. Poster presented at the annual meeting of the American Psychological Association, Toronto, Canada.

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- Waid, L.R. (1996, September). Adult ADHD/LD: Conceptual, assessment, and intervention issues. Lecture presented at the 6th annual meeting South Carolina Technical College Counselors' Conference, Charleston, South Carolina.
- Waid, L.R., Johnson, D.E. Richman, H., and Anton, R.F. (1996, October). Comparison of personality and neuropsychological functioning in alcoholics with and without hyperactivity. Poster presented at the annual conference on Psychopathology, Psychopharmacology, Substance Abuse, and Culture, 7 Los Angeles, California.
- Rhodes, S.K., Waid, L.R., O'Neil, P.M., Collop, N.A., and Willi, S.M. (1996, November). Neurocognitive functioning and obstructive sleep apnea in morbidly obese adolescents. Poster presented at the annual meeting of the National Academy of Neuropsychology, New Orleans, Louisiana.
- Waid, L.R. and Leverett, J.P. (1997, April). Neurological models of ADD and neurocognitive correlates of adults with attention deficit disorder. Symposium presented at the annual conference of the South Carolina Psychological Association, Myrtle Beach, South Carolina.
- Johnson, D.E., Waid, L.R., Foer, J., and Anton, R.F. (1997, July). Alcohol dependence rates in adults with attention deficit/hyperactivity disorder. Poster presented at the annual meeting of the Research Society on Alcoholism, San Francisco, California.
- Foer, J.F., Waid, L.R., and Gold, P.B. (1997, August). Litigation and peripheral injury: Neurocognitive effects in mild head injury. Poster presented at the annual meeting of the American Psychological Association, Chicago, Illinois.
- Leverett, J.P., and Waid, L.R. (1998, April). Psychotherapy with traumatic brain injury patients. Symposium presented at the annual meeting of the South Carolina Psychological Association, Myrtle Beach, SC.
- Waid, L.R. (1998, May). Neuropsychological assessment of rheumatological conditions. Lecture presented at the Grand Rounds, Department of Rheumatology, Medical University of South Carolina, Charleston, SC.
- Hayes, J.S., Waid, L.R., Horner, M.D., Johnson, D., Sonne, S., and Brady, K.T. (1998, August). Neuropsychological functioning in recently abstinent cocaine-dependent individuals. Poster presented at the annual meeting of the American Psychological Association, San Francisco, CA.
- Waid, L.R. (1998, August). Differential diagnosis of substance abuse and ADHD. In: Thomas E. Brown (chair) Attention Deficit Disorder and alcohol and drug abuse. Symposium presented at the annual convention of the American Psychological Association, San Francisco, CA.
- Waid, L.R. (1998, September). Minor head injury: Nothing to ignore. Lecture presented at the Mind Your Health Program, Institute of Psychiatry, Medical University of South Carolina, Charleston, SC.

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- Hayes, J.S. and Waid, L.R. (1998, November). Chronic neurobehavioral and neurological deficits after decompression sickness: A case study. Paper presented at the annual meeting of the National Academy of Neuropsychology, Washington, D.C.
- Anton, R.F., Moak, D.H., Waid, L.R., Latham, P.K., Dias, J.K., and Roberts, J.C. (1998, December). Post-treatment outcome of alcoholics treated with CBT with and without naltrexone. Paper presented at the American College of Neuropharmacology meeting, Las Croabas, Puerto Rico.
- Waid, L.R. (1999, April). Conceptual, assessment, and treatment issues for concussion. Lecture presented at the annual conference of the Brain Injury Association of North Carolina, Myrtle Beach, SC.
- Waid, L.R. (1999, April). Meeting South Carolina's current and future need for neuropsychology. In P. Leverett (chair) The Future of the SC Neuropsychology Group. Presented at the annual meeting of the South Carolina Psychological Association, Myrtle Beach, SC.
- Herron, J.E., Waid, L.R., Latham, P., Dias, J.K., and Anton, R. (1999, June). Craving, neurobehavioral variables and relapse in outpatient alcoholics. Poster presented at the annual meeting of the Research Society on Alcoholism, Santa Barbara, CA.
- Waid, L.R., Herron, J.E., Latham, P., Dias, J.K., and Anton, R.F. (1999, June). Naltrexone, neurocognitive functioning and relapse in recently abstinent alcoholics. Poster presented at the annual meeting of the Research Society on Alcoholism, Santa Barbara, CA.
- Waid, L.R. (2001, May). ADHD and math disabilities. Lecture presented to the faculty of Trident Technical College, Charleston, SC.
- Waid, L.R. (2001, November). Brain injury. Lecture presented at the annual convention of the Association of South Carolina Claimant Attorneys for Workers' Compensation, Asheville, NC.
- Waid, L.R. (2001, December). Risk assessment. Lecture presented at the 2001 Judges and Attorneys Substance Abuse and Ethics Seminar, Institute of Psychiatry, Medical University of South Carolina, Charleston, SC.
- X Waid, L.R. (2003, August). Mild head injury: When is it physical injury to the brain? Lecture presented at the Annual Convention of the South Carolina Trial Lawyers Association, Hilton Head, SC.
- Waid, L.R. (2004, March). Traumatic and toxic induced brain damage. Lecture presented at the Annual Workers' Compensation Medical Seminar, Greenville, SC.
- Waid, L.R. and Teichner, G. (2004, April). Detection of cognitive and psychiatric malingering. Paper presented at the annual meeting of the South Carolina Psychological Association, Myrtle Beach, SC.

Waid, L.R. (2004, April). Head injury in workers compensation. Lecture presented at the annual SCSAONH Conference, Myrtle Beach, SC.

Waid, L.R. (2004, December). Assessment of brain injury: Contributions by forensic neuropsychology. Lecture presented at the SCTL Auto Torts XXVII annual meeting, Atlanta, GA.

Teichner, G. and Waid L.R. (2005, April). Detection of malingering in clinical and forensic assessment. Paper presented at the annual meeting of the South Carolina Psychological Association, Charleston, SC.

Waid, L.R. (2005, May). Use of psychological tests in forensics evaluations. Lecture presented at the Day of Discovery: Forensic Psychiatry Workshop, Medical University of South Carolina, Institute of Psychiatry, Charleston, SC.

Teichner, G., Waid, L.R., and Buddin, W.H. (2005, October). The Memory and Concentration Test (MACT): Data from a sample demonstrating a range of neurological and psychiatric disorders. Poster presented at the annual meeting of the National Academy of Neuropsychology, Tampa Bay, Florida.

Waid, L.R. (2006, March). Clinical neuropsychology: Evaluation, treatment and return to work. Lecture presented to the 27th Annual Workers' Compensation Medical Seminar, Savannah, Georgia.

Waid, L.R., and Teichner, G. (2007, March). A primer in psychological depositions: Tactics for psychologists. Lecture presented at the annual meeting of the South Carolina Psychological Association, Myrtle Beach, SC.

Waid, L.R. (2007, May). Brain injuries: Recognizing and establishing the proof. Lecture presented at the annual meeting of the Association of South Carolina Claimant Attorneys for Workers' Compensation, Columbia, SC.

Waid, L.R. (2007, December). How to deal with a difficult client. Lecture presented at the 9th Annual Paralegal/Legal Assistant Seminar of the Injured Workers' Association, Charleston, SC.

Waid, L.R. (2008, February). Impact of drug addiction on the 21st century workplace. Lecture presented at the 30th Annual Medical Seminar on Workers' Compensation (SCWCEA), Myrtle Beach, SC.

Educational Workshops

Waid, L.R. (1985, June). Counseling techniques for problems of anger and impulse control. Workshop presented at Region III Vet Center Training Conference, sponsored by Southeastern Regional Medical Education Center, Daytona Beach, Florida.

Waid, L.R. and McDermitt, H.W. (1985, June). Use of cognitive-behavioral therapeutic techniques in the treatment of PTSD. Workshop presented at Region III Vet Center Training Conference, sponsored by Southeastern Regional Medical Education Center, Daytona Beach, Florida.

Waid, L.R. and Rogers, G. (1985, June). Use of psychological tests in the assessment and treatment of Vietnam veterans. Workshop presented at Region III Vet Center Training Conference, sponsored by Southeastern Regional Medical Education Center, Daytona Beach, Florida.

Waid, L.R. and Cogar, G. (1986, January). Clinical psychopharmacology and post-traumatic stress disorder (PTSD). Workshop presented at Region III Vet Center Training Conference sponsored by Southeastern Regional Medical Education Center, Orlando, Florida.

Waid, L.R. (1989, May). The borderline patient: Conceptual, assessment, and treatment issues. Workshop presented at the annual meeting of the South Carolina Psychological Association, Hilton Head, South Carolina.

Waid, L.R., Swavely, S.M., and West, B. (1991, March). Clinical Neuropsychology. Workshop presented at the annual meeting of the South Carolina Psychological Association, Myrtle Beach, South Carolina

Waid, L.R. (1992, October). Neuropsychological assessment of the elderly patient. Workshop presented at Conference on Geriatrics in South Carolina: Two-day Course for Health Professionals, Charleston, South Carolina.

Waid, L.R. (1996, February). Motivational enhancement therapy. Workshop presented at the 6th Annual Conference - "Advancing Substance Abuse Treatment: Applying Current Research." North Carolina Governor's Institute on Alcohol and Substance Abuse, Greensboro, North Carolina.

Lassiter, K.S., Leverett, J.P., and Waid, L.R. (1998, March). Assessment of attention deficit disorder and learning disabilities in college age adults: A neuropsychological perspective. Workshop presented at the annual meeting of the Southeastern Psychological Association, Mobile, AL.

Waid, L.R. (1998, March). Motivational interviewing. Workshop presented to the Institute of Psychiatry, Medical University of South Carolina, Charleston, SC.

Waid, L.R. (1998, August). ADHD in college students: Assessment, treatment, and conceptual issues. Workshop presented at The Citadel, Charleston, SC.

Waid, L.R. (1999, April). Motivational interviewing. Three day workshop presented to the Adolescent and Child Psychiatry Department, Medical University of South Carolina, Charleston, SC.

Waid, L.R. (2000, November). Alzheimer's disease. Workshop presented to the Waccamaw Center for Mental Health, Conway, SC.

Waid, L.R. (2000, June). Motivational interviewing. Workshop presented to the Walter B. Jones Alcohol and Drug Abuse Treatment Center, Greenville, SC.

Waid, L.R. (2000, December). Motivational interviewing for SA/MH managers. Specialty Institute/North Carolina Council of Community Programs, Pinehurst, NC.

Other Professional Presentations

"Psychological Assessment." Presented at a workshop on Psychosocial Assessment, sponsored by the Lutheran Medical System, Dallas, Texas, 1982.

"Evaluating the substance abuser." Paper presented at the meeting of the Texas Association of Alcoholism and Drug Abuse Counselors, Dallas, Texas, May, 1982.

"Assessment and treatment of the substance abuser." Presented at a workshop on Substance Abuse, sponsored by the Lutheran Medical System, Dallas, Texas, November, 1982.

"Stress disorders among Vietnam veterans." Presented at a workshop on Post-traumatic Stress Disorder, Tideland's Community Mental Health Center, Savannah, Georgia, January, 1984.

"Cognitive rehabilitation: Theory and techniques." Presented at the meeting of the South Carolina State Chapter of the Head Injury Foundation, Orangeburg, South Carolina, February, 1984.

"Japanese prison camp survivors: Psychic scarring." Presented at Grand Rounds, Department of Psychiatry and Behavioral Sciences, Medical University of South Carolina, Charleston, South Carolina, March, 1984.

"Stress disorders among Vietnam veterans." Presented at Grand Rounds, Department of Psychiatry and Behavioral Sciences, Medical University of South Carolina, Charleston, South Carolina, June, 1984.

"Cognitive rehabilitation of the head injured patient." Presented for allied health staff, Department of Physical Medicine and Rehabilitation, Roper Hospital, Charleston, South Carolina, August, 1984.

"Psychotherapy issues for veterans with post-traumatic stress disorder." Presented at a workshop on Post-traumatic Stress Disorder and the Vietnam Veteran. Sponsored by the Columbia Community Action Council, Chamber of Commerce, Columbia, South Carolina, November, 1984.

"Neuropsychological assessment of the head injured patient." Presented at the meeting of the South Carolina Association of Rehabilitation Nurses, Charleston, South Carolina, January, 1985.

"Cognitive retraining of the brain injured patient." Presented at the 6th Annual South Carolina Workers' Compensation Medical Seminar, Kiawah Island, South Carolina, March, 1985.

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"Emotional and behavioral problems of the head injured." Presented at the meeting of the Trident Head Injury Support Group, Charleston, South Carolina, April, 1985.

"The head injured victim." Presented at the meeting of the South Carolina Claims Adjustors Association, April, 1986.

"Personality and Psychosocial Consequences of Brain Injury." Presented at a workshop on Traumatic Brain Injury, Healthcare Rehabilitation Center at Southern Pines, Charleston, S.C., June, 1987.

"Diagnostic tests - What they show and what they don't show - Neuropsychology." Presented at the 30th annual convention of the South Carolina Trial Lawyers Association, Hilton Head Island, S.C., August, 1987.

"PTSD and dissociation: A case presentation." Presented at Grand Rounds, Department of Psychiatry and Behavioral Sciences, Medical University of South Carolina, Charleston, S.C., September, 1987.

"PTSD and the Vietnam veteran: Etiology and treatment issues." Invited presentation to the Department of Psychology, University of South Carolina, Columbia, S.C., October, 1988.

"The dissociative defense in PTSD." Invited presentation to the Department of Psychology, University of South Carolina, Columbia, S.C., February, 1989.

"Disaster Related PTSD" workshop. Presented to South Carolina Substance Abuse Commission Counselors, Seabrook Island, S.C., October, 1989.

"Storm over South Carolina: Hugo and Post-Traumatic Stress - ETV Teleconference". Panel participant, Columbia, S.C., March, 1990.

"The Vietnam War." Panel participant, Tim O'Brien's book, The Things They Carried. College of Charleston, March, 2000.

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WALD, L.R. PH.D
DEFENDANT EXHIBIT 1

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REPORT OF NEUROPSYCHOLOGICAL EVALUATION
Confidential-For Professional Use Only

Name: William Mark Casey

Age: 46 (DOB: [REDACTED] '58)

Sex: Male

Handedness: Right

Dates of Evaluation: August 30th and September 10th, 2005

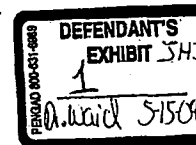
Reason for Referral: William Mark Casey is a 46-year-old Caucasian male referred for neuropsychological evaluation through the offices of Ken Anthony, Esquire, and Ray E. Thompson, Jr., Esquire. The evaluation was conducted to assess Mr. Casey's brain behavior functions and emotional status. Mr. Casey's difficulties stem from medical procedures that were conducted due to recurrent chest pain in May of 2004. An emergent bronchoscopy was conducted following x-rays reportedly revealing a metallic fragment in the chest area. Reportedly, the bronchoscopy did not show a foreign body, but an area of erythema. The following week, Mr. Casey underwent a laser bronchoscopy that resulted in a perforation of the bronchial wall by the laser with resulting pneumomediastinum and respiratory distress necessitating intubation and heavy sedation. Subsequent to this, Mr. Casey has experienced disruptive symptomatology that has rendered him unable to return to employment capacities at the Michelin Company.

Relevant History: Mr. Casey was on time for his scheduled appointments. I reviewed with him the occurrence of chest pain for several weeks in May of 2004 while he was employed at resulting in him reporting it to the company nurse. Subsequently, he was transported to Spartanburg Regional Medical Center and underwent emergent evaluation. Medical records reveal that during the evaluation, Mr. Casey was found to have a left main bronchus containing some foreign body that was metallic in nature. Mr. Casey was seen in consultation by Dr. Feldman who asked Dr. Boscia to do a fiberoptic bronchoscopy. Reportedly, this procedure was undertaken but no piece of metal was found. Mr. Casey was discharged on 5/29/04.

Medical records reveal that Mr. Casey was re-admitted on June 3rd, 2004 and underwent an additional procedure conducted by Gregory Feldman, M.D. This involved bronchoscopy with laser. Acutely following the procedure, he developed considerable pneumomediastinum with reported pneumothorax on the left side. His condition necessitated placement of chest tubes, intubation and mechanical ventilation.

My understanding of Mr. Casey's case was assisted by review of the following medical records:

1. Extended medical records for treatment provided upon admission on 5/28/04 and 6/03/04.
2. Records from Spartanburg Regional Medical Center for procedures conducted in July of 2000.
3. Treatment records from Upstate Lung and Critical Care Specialists.
4. Treatment records from Lung and Chest Medical Associates.
5. Treatment records from Jeffrey Smith, M.D., Piedmont Psychiatric Services.
6. Treatment records from Joseph Grace, III, Ph.D.
7. Treatment records from Y. Eugene Mironer, M.D.
8. Mr. William Mark Casey's educational records from Spartanburg County School District #6.



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Review of records revealed that Mr. Casey experienced disruptive symptoms following the procedure conducted on June 3rd of 2004. Initial follow-up treatment was provided at Upstate Lung and Critical Care Specialists with Mr. Casey complaining of fatigue, sleep disturbance, chest tightness, as well as being agitated and "unable to sit down." There was also report of longstanding chronic back pain. There was conservative intervention including use of Ambien. Difficulties persisted, and there was referral to Carolina Center for Advanced Management of Pain. Mr. Casey underwent evaluation by Eugene Mironer, M.D. He was assessed with mechanical low back pain, depression, and chest wall pain of no muscular origin. There was discussion regarding his treatment options.

Medical records reveal that Mr. Casey sought further evaluation for his difficulties at the Lung and Chest Medical Associates. Evaluation by Wilson P. Smith, Jr., M.D. reviewed the recent surgical procedures, noting that Mr. Casey remained with dyspnea and chest pain with exertion. Dr. Smith assessed Mr. Casey as being very anxious with report from family members noting a change in his ability to tolerate stress. It was noted that Mr. Casey was unable to participate in golf and other recreational activities. Dr. Smith's impression was that pulmonary functioning was normal and chest x-rays failed to show any evidence of sequelae of his bronchial perforation. Dr. Smith expressed concern that Mr. Casey may be experiencing a Posttraumatic Stress Disorder related to his injury and intensive care unit experience. There was recommendation of referral for a psychologist for further evaluation.

Records reveal that Mr. Casey subsequently came under the care of Joseph G. Grace, III, Ph.D. Care appeared to commence on August 4th, 2004. Initial medication intervention was coordinated with Frank Gonda, M.D., Mr. Casey's family physician. Subsequently, there was referral for psychiatric care with Jeffrey Smith, M.D. Treatment has been directed toward Mr. Casey's depression, sleep disturbance, anxiety, restlessness, irritability with low frustration tolerance, and poor stress tolerance. There has been use of antidepressants and other medications. Psychiatric evaluation with Jeffrey Smith, M.D., was conducted in early November. Dr. Smith modified the medication regimen including stopping use of Zoloft and adding Cymbalta 60 mg. Dr. Smith's assessment was one of major depression, single episode, moderate.

In interview, Mr. Casey reported that he has continued under the care of Joseph Grace, III, Ph.D. as well as Jeffrey Smith, M.D. Medical records reveal that Mr. Casey underwent further evaluation at the Lung and Chest Medical Associates in July of 2005. On initial evaluation, he was experiencing dry heaves and nausea as well as chest pain and a squeezing sensation present without exertion. A cardiogram was normal and Dr. Fogarty's impression was chest pain, probably chest wall; nausea and vomiting improved; persistent difficulty concentrating and staying focused; status post laser bronchoscopy complicated by pneumomediastinum and pneumothorax. Dr. Fogarty further stated that Mr. Casey's nausea/vomiting symptoms have appeared to improve since discontinuing Strattera. Dr. Fogarty stated that with regard to Mr. Casey's difficulty concentrating, "air emboli have been reported as a complication of laser bronchoscopy, even without perforation of the endotracheal tube with resulting leakage of air into extrapleural, vascular, and mediastinal spaces. Although, he is fortunate not to have any gross motor deficit, he (Mr. Casey) may well have a permanent neurological deficit in which case the indication for taking medication such as Strattera may be mute."

Mr. Casey also underwent intellectual assessment by Joseph G. Grace, III, Ph.D., in June of 2005. Dr. Grace reviewed Mr. Casey's academic records, stating that Mr. Casey had undergone intelligence testing in the 2nd, 4th, and 6th grades with intellectual quotients in the high average range. Reportedly, academic achievement test scores were generally above the 65th percentile. Dr. Grace conducted intellectual testing with Mr. Casey earning a Full Scale I.Q. of 97, a Verbal I.Q. of 100, and a Performance I.Q. of 91. The test administered was the Wechsler Adult Intelligence Scale-III (WAIS-III). Dr. Grace opined that there was a significant discrepancy between Mr. Casey's early intellectual ability measures and the current I.Q. test results. Dr. Grace stated that the "only reasonable conclusion is that Mr. Casey has experienced a neurological event which has diminished his ability to process information and perform in a number of areas as effectively as he once did."

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In interview, Mr. Casey reported that he continues with fatigue and "lack of motivation." He reported that he lost his job at Michelin approximately one year ago. This has resulted in financial stressors. He reported that he was an active employee at Michelin, performing 12-hour shifts. Mr. Casey also complained of a decreased capacity for attention and memory. As Mr. Casey stated, "I can't remember things." He provided examples of absentmindedness as well as making misjudgments that have resulted in accidents. There was also report of being socially withdrawn and isolated. Mr. Casey reported being avoidant of crowds, offering that he'd rather "stay at home and not be bothered." He acknowledged continuing back pain that pre-existed the medical incidents of May/June, 2004.

A structured symptom review failed to reveal any complaint by Mr. Casey with regard to sensory perceptual functions. Vision is corrected. There was no report of auditory acuity difficulties or tinnitus.

With regard to motor functioning, there was no report of paralysis or lateralized weakness. Mr. Casey reported continuing muscle spasms affecting the lower back. He denied coordination/balance problems. He reported occasional numbness affecting the hands and feet. There was report of paresthesias in the back region.

Mr. Casey reported that back pain is aggravated by physically exerting activities. He continues with episodic chest pain that is aggravated by exertional activities. Mr. Casey was not complaining of headache difficulties. There was report of occasional dizziness, but no report of vertigo, blackout spells, or seizures.

With regard to cognitive processes, Mr. Casey reported a decreased capacity for attention/concentration with an easy distractibility. He reported an inability to think as quickly as before (bradyphrenia). He also stated, "I know I am more forgetful."

With regard to psychological functioning, Mr. Casey acknowledged problems with sadness/depression, stating, "I don't have that much that is making me happy these days." There are episodic difficulties with sleep, though he did state that use of Ambien "definitely helps." He reported experiencing weird dreams, but denied disruptive nightmare activity. There is longstanding anxiety and fearfulness about heights. He reported being impatient and irritable with a lower ability to tolerate stress. Energy level was characterized as diminished. Clinical evaluation failed to reveal paranoid ideation or delusional thinking. Mr. Casey acknowledged considerable worry, particularly with regard to the future. There was no report of hallucinatory processes or evidence of psychotic symptomatology. Appetite was characterized as "variable." Libido was characterized as reduced with a lack of desire.

Mr. Casey reported a significant decline in his pursuit of social and recreational activities. This was particularly relevant to golf which he used to avidly pursue prior to his medical difficulties.

Mr. Casey reported current medications consist of Lipitor, Tricor, Mobic, Hydrocodone 10/500, Tramador 50 mg 2 tabs q.i.d., Cymbalta, and Ambien 10 mg as needed for sleep. There has also been use of Adderall XR 20 mg b.i.d. to assist with attention/focus. As of 9/10/05, Adderall had been discontinued.

Medical History: Mr. Casey denied previous head or neck injury. There is a history of back pain associated with two bulging discs and arthritis. He has undergone previous hemorrhoidectomy as well as hospitalization for evaluation of chest pain in 2000, undergoing cardiac catheterization.

Mr. Casey denied history of serious infections, allergies, diabetes, or hypertension.

Mr. Casey denied history of psychiatric illness or need for formal treatment. He denied having lifelong problems with his nerves, depression, or mood swings. He is a rare, occasional consumer of alcohol. He denied history of excessive alcohol usage. He does not utilize illicit drugs. There has been no history of formal substance abuse treatment.

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Family History: Noncontributory for psychiatric illness and/or substance abuse problems. Family history is significant for diabetes in a mother and a heart attack in a father.

Psychosocial Review: Mr. Casey is a high school graduate. Reportedly, he was an active athlete while attending Dorman Senior High School in Spartanburg. He denied any repetition of grades or history of learning disabilities or Attention Deficit Disorder. Review of educational records confirmed him to be a high school graduate with a reported intellectual quotient of 113 attained in the 6th grade.

Mr. Casey reported that he was employed at the Michelin Company for over 20 years. His job title was manufacturing professional. He denied ever being in the military service. Mr. Casey attained a formal divorce from his wife after being married for 23 years. The couple were separated for several years before the divorce decree was attained in March of 2005. There are two biological children, a son, age 22, and a daughter, age 19.

Procedures: Wechsler Adult Intelligence Scale-III, Wechsler Memory Scale-III, California Verbal Learning Test-II, Stroop Test, Conner's Continuous Performance Test-II, Judgment of Line Orientation Test, Wisconsin Card Sorting Test, Trail Making Test, Controlled Oral Word Association Test, Paced Auditory Serial Addition Test, Seashore Rhythm Test, Speech Sounds Perception Test, Aphasia Screening Exam, Tactual Performance Test, Sensory Perceptual Examination, Finger Tapping Test, Grip Strength Test, Grooved Pegboard Test, Behavioral Dyscontrol Scale, Test of Memory Malingering, Word Memory Test, Personality Assessment Inventory, Ruff Neurobehavioral Inventory.

Examination Results

Neurobehavioral Status: Mr. Casey was on time for his scheduled appointments. He was appropriately attired with good personal hygiene. There was maintenance of appropriate eye contact. There was no evidence of psychomotor retardation or excitement. Mr. Casey was friendly and cooperative in his interactions with the examiner. There was no difficulty understanding instructional sets. He participated well in the evaluative process. He was observed to be somewhat fatigued following a lunch break. A second session was utilized to complete the evaluative process. Affect was mildly depressed, though psychological difficulties did not appear to interfere with his test performance. Specific assessment of effort was undertaken via administration of two symptom validity tests, the Test of Memory Malingering (TOMM) and Word Memory Test. Mr. Casey's performance on both of these tests was within stringent criteria consistent with our observation of providing good effort.

Language Functions: There was no aphasic or agnostic symptomatology. Mr. Casey's conversational speech was prosodic, fluent, of normal rate and tone with occasional slurring. There were no word finding difficulties in conversational speech. Mr. Casey's performance on a letter fluency test (T=45) was in the average range for an individual of his age and educational level. There was no evidence of receptive language dysfunction.

Sensory Perceptual/Motor Functions: Evaluation failed to reveal any evidence of imperceptions or suppressions affecting tactile or visual modalities during unilateral or bilateral stimulation paradigms. Mr. Casey demonstrated imperceptions and suppressions to left sided auditory stimulation. He performed efficiently on a tactile finger recognition test and made a few unsystematic errors on a Test of Graphesthesia. Mr. Casey had no difficulty recognizing gross tactile forms in each of his extremities.

Mr. Casey reports being right hand dominant. He ambulated without difficulty or need for assistance. He reported some residual low back pain that is aggravated by physically exerting activities. On a test demanding fine motor speed (Finger Tapping Test), he demonstrated bilateral slowness suggestive of moderate impairment. Assessment of grip strength revealed mild deviation from expected performance bilaterally. Mr. Casey's performance on a test demanding fine motor speed and dexterity (Grooved Pegboard Test) revealed deviation from expected performance bilaterally suggestive of mild impairment.

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Attention/Memory Functioning: Mr. Casey was errorless in his performance on an extended test of information and orientation. On the Stroop Test, he demonstrated slowed and impaired processing speed for word (T=29) and color (T=35) stimuli. He remained mildly slow, but without added decrement in his performance on a divided attentional task (T=40). Mr. Casey's performance on an attentional task demanding discrimination of rhythmic sounds was below average (T=41) for an individual of his age and educational level. On an attentional task demanding discrimination of speech sounds and matching them to their phonemes (T=36), his performance was suggestive of mild impairment. Mr. Casey's performance on WAIS-III tasks assessing working memory placed him at the 25th percentile. Mr. Casey was also administered the Paced Auditory Serial Addition Test (PASAT), a measure of information processing speed and attentional regulation. Mr. Casey was able to meet the demands of this test. Observation of test performance revealed an average initial trial performance with mild decrements in his performance as the trials became more rapid and demanding. Mr. Casey's total recall score on the PASAT was within the average range (T=57) for an individual of his age and educational level.

Mr. Casey was also administered the Conner's Continuous Performance Test-II to further assess his attentional capacities. Observation of test performance revealed slow responding coupled with lots of errors which is a distinctively problematic pattern that cannot easily be explained by response style. Generally, this pattern is a strong indicator of an attention related deficit. Mr. Casey was generally erratic in his responding, indicative of poor attention capacity. He was also substantially affected by the interstimulus interval. Specifically, responses became slower and a lot more erratic when the interstimulus interval was slowed from one second to two and four seconds. The finding may reflect limitations in his ability to adjust to change in task demands.

Mr. Casey was administered the Wechsler Memory Scale-III (WMS-III) to assess different components of anterograde memory. Mr. Casey was variable in his performance across WMS-III tasks. Mr. Casey's performance on tasks assessing immediate auditory memory placed him at the 34th percentile. Mr. Casey was less efficient in his performance on WMS-III tasks assessing immediate visual memory (10th percentile). He demonstrated an adequate ability to retain auditory (30th percentile) and visual (50th percentile) information after a period of delay. Mr. Casey's performance on WMS-III tasks assessing working memory was in the low average range (21st percentile).

Analysis of separate WMS-III scale performance revealed Mr. Casey to have an average ability to immediately learn and recall orally presented narrative passages. Mr. Casey was below average in his performance on a visual memory task demanding free recall of family pictorial stimuli. He demonstrated a low average ability to retain and recall previously learned narrative passages after a period of delay (percent retention =81). Mr. Casey was deficient in his performance on a visual memory task involving the immediate learning and reproduction of visual designs (2nd percentile). He demonstrated an adequate ability to retain and reconstruct previously learned visual designs after a period of delay (percent retention =77).

Mr. Casey was also administered the California Verbal Learning Test-II (CVLT-II), a repetitive word list learning task. Mr. Casey's total recall score after five administrations of the word list placed him at the 50th percentile compared to age related peers. Observation of test performance revealed significant deficit in his initial trial performance consistent with difficulties with attentional capacities and immediate learning. Yet, Mr. Casey showed a good ability to profit from repetitive administrations, demonstrating a good learning curve. He demonstrated difficulties in his ability to retain and recall word list information in a short and long delay, free and cued recall process. Assessment of learning characteristics revealed heavy reliance on recall from the recency region of the word list. There were no excessive intrusive errors. Mr. Casey was generally efficient in his performance on a recognition task demanding that he discriminate target from non-target words, though he made six false positive errors. Mr. Casey performed efficiently on a long delay, forced choice recognition test consistent with our observation of providing good effort.

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Visual Spatial/Visual Constructional Functions: There was no evidence of visual inattention or neglect processes. Nor was there evidence of constructional difficulties. Mr. Casey's performance on WAIS-III tasks assessing perceptual organizational skills placed him at the 63rd percentile. His performance was improved from that obtained in previous I.Q. testing conducted by Dr. Grace (47th percentile). On a test demanding fine discriminations of lines in space, Mr. Casey's performance was in the low average range (22nd percentile). On a visuographic sequencing test involving the serial processing of numbers, he was slow in the completion of the task (T=42) but without confusional error. When the task became more demanding, involving alternation between numbers and letters in sequential fashion, Mr. Casey's performance was within average limits (T=53).

Higher Reasoning/Problem Solving Abilities: Mr. Casey was able to inhibit and sequence fine motor movements on go-no go types of tasks. Mr. Casey performed efficiently on an executive functioning task involving letter fluency as well as being able to meet the set shifting skills associated with Trail Making Test-Part B.

Mr. Casey was re-administered the Wechsler Adult Intelligence Scale-III (WAIS-III) classifying his intellectual functioning to be in the average range with a Full Scale I.Q. of 96, a Verbal I.Q. of 91, and a Performance I.Q. of 104. Mr. Casey's Full Scale I.Q. places him at the 39th percentile. His performance was generally consistent with that obtained in previous evaluation conducted by Dr. Grace (FS I.Q.=97, V I.Q.=100, P I.Q.=104).

WAIS-III analysis revealed Mr. Casey to perform in the average range on tasks assessing perceptual organizational skills (63rd percentile). Mr. Casey was less efficient in his performance on WAIS-III tasks assessing verbal comprehension skills (32nd percentile). Mr. Casey's performance on tasks assessing working memory (25th percentile) was less efficient than that obtained in previous evaluation by Dr. Grace. Yet, Mr. Casey was more efficient with regard to his performance on processing speed tests (21st percentile) compared to that obtained by Dr. Grace (4th percentile).

Analysis of separate WAIS-III scale performance revealed significant strength on a task demanding attention to visual detail in the tangible environment (91st percentile).

Mr. Casey was administered the Wisconsin Card Sorting Test, which demands the ability to generate and discover the correct solution set as well as to shift the basis of one's responding when the externally imposed demands of the task necessitated this. Observation of test performance revealed Mr. Casey to readily identify the 1st correct hypothesis. Observation of test performance revealed that concentration difficulties interfered considerably with his effective problem solving abilities. Mr. Casey attained only four of the expected six categories but with an acceptable rate of perseverative errors (10%) and six failures to maintain set. The latter finding is consistent with disruption due to attention/concentration difficulties.

Mr. Casey was also administered the Tactual Performance Test (TPT) which demands keen kinesthetic/proprioceptive abilities as well as organizational/planning skills. Mr. Casey's initial dominant hand performance was above average (T=56). Yet, he demonstrated considerable difficulty profiting from this initial learning trial during his 2nd trial, non-dominant hand performance (T=36). Mr. Casey was improved in his 3rd trial, both hands performance (T=43). His incidental memory score (T=33) was suggestive of mild to moderate impairment. Yet, his location score (T=50) was in the average range.

Emotional/Mood State Functioning: Review of medical records revealed considerable concerns regarding Mr. Casey experiencing disruptive psychological difficulties as the result of his involvement in the medical incidents. There has been persistence of fatigue, agitation, and somatic symptomatology as well as concern regarding depression, anxiety, and posttraumatic stress.

THOMPSON 002875

In the current evaluation, Mr. Casey reported continuing difficulties with sadness/depression, sleep disturbance which is assisted by use of Ambien, irritability/impatience, and low energy level. He appears to be quite withdrawn and not engaging in social and recreational pursuits. There are additional environmental stressors including financial stress.

Mr. Casey was administered the Personality Assessment Inventory (PAI) to further assess his psychological functioning. Mr. Casey's response set (validity scales) to the PAI indicated that he presented himself in an honest, straight forward fashion.

The obtained PAI clinical profile reveals an individual who is reporting significant unhappiness, moodiness, and tension. Mr. Casey's self esteem is quite low at this time, and he views himself as ineffectual and powerless to change the direction of his life. The disruptions in his life have left him uncertain about his goals and priorities, and tense and pessimistic about what the future may hold. Mr. Casey reports difficulties in concentrating and making decisions.

Separate scale elevations reveal report of highly disruptive depression. Mr. Casey reports being severely depressed, discouraged, and withdrawn. He appears to be plagued by fears of worthlessness, hopelessness, and personal failure. There is also report of experiencing a discomfoting level of anxiety and tension. He is socially isolated at this time and identifies few interpersonal relationships that he describes as being close and warm.

Consistent with ongoing disruptive somatic symptomatology, Mr. Casey reports concern about physical functioning and health matters. He sees his life as being highly compromised by his ongoing numerous and varied physical/health problems.

Mr. Casey reports experiencing recurrent episodes of anxiety associated with a traumatic experience in his life. He identifies the traumatic experience as being the medical incident.

Self concept appears to be quite harsh and negative at this time. Mr. Casey's interpersonal style is best characterized as being withdrawn and isolated at this time. He appears to be very uncomfortable in social situations at this time.

Mr. Casey also reported experiencing periodic and transient thoughts of self harm. He denied any specific suicidal plan. He does endorse being pessimistic and unhappy about his prospects for the future.

Overall, the PAI profile is consistent with an individual who is experiencing disruptive depression and anxiety in the context of ongoing somatic difficulties. There is report of associated neurocognitive difficulties as well as being quite socially withdrawn and isolated.

Mr. Casey also responded to the Ruff Neurobehavioral Inventory. The Ruff allows for an assessment of individuals in the domains of cognitive emotional and physical functioning as well as quality of life pre and post their involvement in a traumatic incident.

Mr. Casey's responses indicated that he did not believe he had any ongoing disruptions in the realms of cognitive, emotional, or physical functioning prior to his involvement in the medical incident.

Mr. Casey reported that post accident, he has experienced significant disruption in cognitive emotional, and physical realms of functioning as well as quality of life. In the cognitive domain, he identified significant disruption with regard to attention/concentration, executive functioning, and learning and memory.

In the emotional domain, Mr. Casey reported significant disruption with regard to anxiety, depression, posttraumatic stress, as well as anger and irritability.

THOMPSON 002876

In the physical realm, he reported significant disruption with regard to somatic symptomatology and pain. Mr. Casey also reported significant disruption of his ability to pursue vocational activities.

Summary/Integration: Mr. Casey is a 46-year-old Caucasian male referred for neuropsychological evaluation. Intellectual evaluation revealed Mr. Casey to be functioning in the average range of abilities. Neurocognitive evaluation revealed slowed mental/information processing speed with variability in Mr. Casey's attentional capacities. Assessment of memory functioning revealed difficulties with immediate learning/memory capacities but no compelling evidence of rapid forgetting (amnestic syndrome). Neuropsychological evaluation revealed Mr. Casey's primary impairments to be deficits in his speed of processing with difficulties sustaining attention/concentration, and reduced immediate learning capacities. There was no compelling evidence for impairment specifically affecting visual spatial skills, receptive or expressive language functions, or higher reasoning capacities. Assessment of sensory perceptual functioning revealed imperceptions and suppressions affecting left sided auditory processes. Motor functioning was characterized by slowness and weakness.

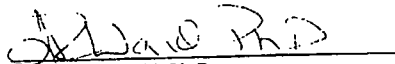
Assessment of emotional functioning revealed continuing difficulties with depression, fatigue/low energy level, anxiety/stress, social withdrawal/isolation, and disruptive pain and somatic symptomatology. Mr. Casey has not efficaciously responded to psychological/psychiatric treatment. This suggests the potential that difficulties/impairments are at least partially attributable to organic injury.

Overall, Mr. Casey's presentation is one of neurocognitive deficits that would be consistent with a subcortical injury. Dr. Fogerty provided rationale for the potential that Mr. Casey may well have a permanent neurological deficit. Pain symptomatology, depression, sleep disturbance, and fatigue could also be contributing to his experience of neurocognitive impairments. Mr. Casey's current neurocognitive and emotional/behavioral deficits are likely due to a multifactorial etiology. What is evident is that Mr. Casey has remained highly compromised with regard to cognitive, emotional, and physical functioning, rendering him unable to return to employment pursuits.

Based on The Diagnostic and Statistical Manual of Mental Disorders-4th Edition-TR (DSM-IV-TR), the following multiaxial assessment is provided:

Axis I	Mood Disorder with depressed mood (293.83) secondary to persistent somatic symptomatology and potential permanent neurological deficit due to complication of laser bronchoscopy.
	Cognitive Disorder, NOS (294.90) due to the interfering effects of somatic symptomatology, mood disturbance, sleep disturbance/fatigue, and potential permanent neurological deficit due to complications of laser bronchoscopy.
Axis II	No diagnosis (V71.09).
Axis III	Pain/somatic symptomatology; motor weakness; residual back pain; episodic chest pain; status post laser bronchoscopy complicated by pneumomediastinum and pneumothorax.
Axis IV	Marital separation/divorce; disability/unemployment; Workers' Compensation litigation.
Axis V	GAF=50 (Current).

Thank you for allowing me to participate in the evaluative care of Mr. William Mark Casey. If you have any questions regarding the evaluation or report, please do not hesitate to call me.



L. Randolph Waid, Ph.D.
Licensed Clinical Psychologist
Clinical Associate Professor in Psychiatry/Neurology, MUSC

LRW/emf

THOMPSON 002877

WAID, L.R. PH.D.
DEFENDANT EXHIBIT 2

THOMPSON 002878

Mark Casey

TIME 11:30 P.M. DATE 11/7/03 PHONE 680-9648
NAME Mark Casey PARENT sister
ADDRESS _____
HISTORY 4/2 LBP - chronic
contact not helping. CHARGE IF ANY: \$ _____
WORKING DIAGNOSIS Chronic LBP
TREATMENT T to EP - tonight
T to office - 11/7/03 A.M.
REMARKS (PHARMACY CALLED) 17804 F

4/15/03 Pt. in for discussion re: epidural inj. - states it of
help - made pain worse - also RF Ultram - states 7-8 on pain
scale - G. Calvert, CPN

12/15/03 WILLIAM CASEY

17804

Frank E. Gonda, MD

D: CHRONIC LOW BACK PAIN
: DEPRESSION

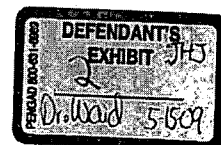
This 45-year old white male with chronic low back pain and depression is in for follow up of the above problems and for medicine refill. Since I saw him last time he went and had one epidural, which did not work. It made his pain worse. He was out of work for several days. He is frustrated that he had to pay for the shot and he was out of work and it did not help. He did have an MRI which showed two bulging disks but no ruptures. He does not want to see a neurosurgeon because he would not be interested in surgery. He believes that the Effexor has helped his depression. He still has all the same family problems but everything is stable.

O: Patient is in no distress. Blood pressure is 126/94. Pulse is 88. Weight is 177-pounds. Neck is supple. Lungs are clear. Heart is regular. Abdomen is soft and nontender. Back has good range of motion, no tenderness. Straight leg raising is negative. Deep tendon reflexes is 2+.

A: As above.

P: Counseled in detail. Suggested we go see another anesthesiologist at Regional Hospital to see if they could help with the shots. He did not want to see the ones at Mary Black Hospital. We will check his insurance. Renew Ultram, 50 mg two p.o. q.i.d. #720 with one refill. Effexor-XR, 75 mg one q.-h.s. #90 with one refill. Bextra, 10 mg one q.-day #90 with one refill. Lortab, 10/500 one b.i.d. #30 with no refills. He ran out early. He still has another refill on his last prescription on the Lortab. I also gave for local purchase Ultram, 50 mg two q.i.d. #100 with no refill. The patient will let me know what he wants to do and we will go from there.

DNR: Frank E. Gonda, MD/ dlq



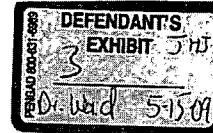
000543

THOMPSON 002879

WALD, L.R. PH.D
DEFENDANT EXHIBIT 3

THOMPSON 002880

William Casey



9/27/03 Date Samples given Effexor XR 75mg # 2bx
 Lot Number: 3023834 4/04 Initials: JRC
 Patient was educated regarding proper administration, drug interactions and possible side effects. Patient has been instructed to call our office with any questions or problems.

8/27/03 Date Samples given Effexor XR 37.5/75 # 1bx
 Lot Number: 3033288 12/03 Initials: JRC
 Patient was educated regarding proper administration, drug interactions and possible side effects. Patient has been instructed to call our office with any questions or problems.

90
45
135

- 08/27/03 MARK CASEY 17804 Frank E. Gonda, MD

H: DEPRESSION
D: CHRONIC LOW BACK PAIN

S: This 44-year-old white male is in for follow up on his depression. He has been on Paxil for two months and cannot tell any improvement whatsoever. He had no side effects from it. He continues to feel down-in-the dumps. He attributes it to all of the family problems that he has had including his two teenage kids who are pretty much failures. He has done everything he could for them. He does not blame himself, but he still feels bad about it. His job is not getting any easier, and he continues with chronic low back pain. He thinks part of his depression is from the back pain, and he wishes to start back on some medicine. He has been buying from friends, Percocet, 10 mg. He says he could easily take two or three a day. He has no trouble working with it. He says it makes life tolerable as far as the pain is concerned.

* Patient is in no distress. Blood pressure is 122/88. Pulse is 72. Weight is 171-pounds. Patient is alert, oriented, and coherent. Speech is not rapid or pressured. There are no feelings of helplessness or hopelessness. There are no suicidal or homicidal thoughts. Sensorium is clear. Recheck of the back is not done today.

A: Depression in a patient with chronic low back pain.

P: Counseled in detail. Trial of Effexor-XR, 37.5 mg one q.-day times one week and then 75 mg one q.-day, samples for four weeks and then a prescription for four weeks. He is also given a prescription for Percocet, 10/325 one p.o. b.i.d., #60 with one refill. Explained to patient that part of pain treatment can also be antidepressants which frequently help reduce the pain. He is willing to continue on an antidepressant. See him back in two months.

DNR: Frank E. Gonda, MD/jmm

DATE 9/23/03	TIME 10:50	CALLER William Casey	PT NAME - CHART # 217804	PHONE # 486-9131	ALL P.S.C.O. Gonda
AGE / WT 48	BY JRC	MEDS: Doripenem Percocet			
Needs no fill Had forgotten this is 9/23/03 pt stated 9/23/03 Im to RC a class II drug he had 3 more days a case and refills. Will use Lorazepam instead. left but pharm. wouldn't - pt has used #120 in one month. let him get RF - Not fill early. Pick up Friday. Redville Rd. - per pharm. info against the law to put RF on nars. like this - had to write new Rx - notified pt - JRC Double 10/500 r. no bid #60/b. 214 r. with. 7					

JRC notified pt 000541

THOMPSON 002881

WAID, L.R., PH.D.
DEFENDANT EXHIBIT 4

THOMPSON 002882

08/13/02

MARK CASEY

10967

Frank E. Gonda, MD

D: CHRONIC LOW BACK PAIN
 G: ERECTILE DYSFUNCTION
 C: NICOTINE ABUSE

S: Mark is in today for follow up of the above problems and also for medicine refill. He is actually early. He has run out of medication because his wife was sneaking some of his medicines. After 20 years of marriage, they are separating and getting a divorce. She is being treated for depression. Last time he was here, I put him on Neurontin, but he says it did not help after two month's worth of medicine. He still has back pain everyday. It does not keep him from working although it makes work difficult. It does not keep him from playing golf. He is still smoking one-half to one pack of cigarettes per day. He denies bowel or bladder problems. He has no pain in his legs. He still has erection problems, and Viagra works well.

O: Patient is in no distress. Weight is 173-pounds. Blood pressure is 112/78. Pulse is 80. Neck is supple. Lungs are clear. Heart is regular. Abdomen is soft and nontender. Back reveals good range of motion, no tenderness to palpation. Straight leg raising is negative.

A: As above.

P: Counseled in detail. Patient never went for his MRI. He says he cannot afford it, and his insurance will not pay for it at this time. Renew Ultram, 50 mg two p.o. q.i.d., #720 with one refill. Also a one month supply with one refill from local purchase. Zanaflex, 4 mg two p.o. q.h.s., #180 with one refill. Also prescription for local purchase. Renew Viagra, 100 mg one p.o. one hour prior to relations, #10 with five refills. Follow up in six months or p.r.n.

DNR: Frank E. Gonda, MD/ jmm

TR	TIME A	CALLER	PT NAME	CHART #	PHONE	ALL PREC BY
11/21/02	10:30		William Mark Casey	576-4399		Gonda
DATE	TIME	BY	MEDS	RE		
11/21/02	10:30	L7	sent his back	as per med		
like smoking changes. I told him to make an apt						
DISPOSITION						
Lortab 50 #20/φ						
T 10 5-8 pm pain						
DRUG STAFF						
CUB Residual Rd						
576-4399						

1/23/03- Pt presents for refill for ultram. pain score 0 - Dttanunm

01/23/03

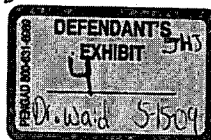
MARK CASEY

17804

Frank E. Gonda, MD

D: CHRONIC LOW BACK PAIN
 G: ERECTILE DYSFUNCTION
 C: NICOTINE ABUSE

S: Mark presents today for follow up of the above problems and for medicine refill. He has no chest pain or shortness of breath. His appetite is good, and he moves his bowels well. Back pain is stable as long as he takes his medicines. He continues to smoke probably less than a half-pack of cigarettes per day. He still has plenty of refills on his Vioara.



THOMPSON 002883

WAID, L.R. PH.D.
DEFENDANT EXHIBIT 5

THOMPSON 002884

DATE 25/01/01	TIME 2:00 P	CALLER M. Casey	PT. NAME - CHART #	PHONE # 476-9400	ALL P.S.C.O.	MD Gonda
WT.	T.	BY RGT	MEDS: Rx - Mail Order	RE 10967		
Zanaflex 4mg						
4-6 qd depends on work schedule						
DISPOSITION 263/180 180 6 12 30						
540				DRUG STORE 3	BY F	TIME A P

09/07/01

MARK CASEY

10967

Frank E. Gonda, MD

D: CHRONIC LOW BACK PAINC: NICOTINE ABUSEG: ERECTILE DYSFUNCTION

S: This 42 year old white male is in for follow up with his above medical problems and for medicine refill. The last time he was here we added Zanaflex and he says that has helped dramatically and he sleeps well all night. He usually takes about three a night. At times he has increased the dosage of the Ultram and he will take three pills four times a day. I have warned him that the maximum dose is 400 mg per day and he is taking more than that. His only complaint today is that he has problems with erections, which he has had four three or four years. He is unable to achieve a complete erection. He still has orgasm and then losses the erection right away. He has been smoking for 25 years. He has no interest in quitting. He does tell me that he tried a Viagra from a friend and it worked extremely well. He would like a prescription.

O: Patient is in no distress. Blood pressure is 130/92. Pulse is 80. Weight is 179-pounds. Neck is supple. Lungs are clear. Heart is regular. Abdomen is soft. GU examination is normal. Testes are descended with no hernias and no atrophy of the testicles. The back reveals good range of motion but lots of discomfort with movement in all directions. There is mild tenderness in the lumbosacral area. Straight leg raising is negative. Deep tendon reflexes is 2+.

A: Chronic low back pain.

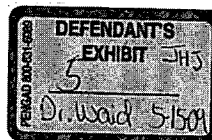
P: Renew Ultram, 50 mg two p.o. q.i.d #720 with one refill. Zanaflex, 4 mg three q.-h.s. #270 with one refill.

A: Erectile dysfunction.

P: Encourage to quit smoking. Check a testosterone level. Add Viagra, 100 mg one p.o. one hour prior to relation #10 with five refills. Follow up six months or p.r.n.

DNR: Frank E. Gonda, MD/ dlq

101- pt notified re. Total + free testosterone level. Inf. pt. it shows low 1 test. level. of Viagra fails, cants hormone replacement. for Met.



000536

THOMPSON 002885

WALD, L.R., PH.D.
DEFENDANT EXHIBIT 6

THOMPSON 002886

08/28/00

MARK CASEY

10967

Dr. Frank E. Gonda

WRIST PAIN

- S: This 41-year-old white male is in with wrist pain for the last two months. He thinks it is probably related to the repetitive activity he does at Michelin building tires. He denies numbness, tingling, or burning in his fingers. He says he has pain at the wrist on the ulnar side. Sometimes it feels weak and just wants to give out. He has had no specific injury.
- O: On physical examination, he is in no distress. Blood pressure is 130/80. Pulse is 80. Weight is 182-pounds. The left wrist reveals excellent range of motion. There is no redness or swelling. There is a little tenderness over a rather prominent distal ulna. There is no crepitus. Pulses are 2+. Tinel sign and Phalen sign are negative. Hand grip is normal. Motor and sensory are grossly intact. X-ray of wrist is negative for arthritic changes.
- A: Wrist pain with a normal examination. Possibly related to repetitive activity at work. No sign of carpal tunnel syndrome.
- P: Reassurance. Moist heat. Relafen 500 mg, two p.o. q.-day, #60 with one refill. GI precautions given. He might need to come off of this job for a couple of weeks to let his wrist get better. If he needs to do this, he may have to go through Workman's Comp. *F*
- DNR: Dr. Frank E. Gonda/ jmm

12/4/00 - appt. @ GMC for L-spine met on 11/4/00 @ 9:00 AM, pain failed + sent to pt - (2)
1/6/00 - appt. @ Dr. Thirumala on 11/4/00 @ 9:30 AM - (2)
5/1/00 - MRI with request sent to med lab - (2)

10/26/00

WILLIAM CASEY

10967

Dr. Frank E. Gonda

CHRONIC LOW BACK PAIN

- S: This 41-year-old white male is in for recheck and medicine refill. He thinks his back pain did improve a little bit with physical therapy. He still has pain everyday whether he is working or playing ball. He did increase the number of Lortab that he took and ran out early. He has not had any in a while. He thinks the Ultram also helps some. He has pain everyday, 24-hours a day in his lower back bilaterally. The pain is non-radiating. He has no bowel or bladder problems. He has no numbness, tingling, or weakness in his legs. X-rays in 1997 of the lumbar spine were negative.
- O: On physical examination, he is in no distress. Blood pressure is 130/80. Pulse is 80. Weight is 178.5-pounds. Back reveals no deformity and has excellent range of motion. There is discomfort with twisting, tilting, and forward bending. There is some tenderness to deep pressure bilaterally in the lower lumbar/upper sacral area. No muscle spasm is noted. Straight leg raising is negative. DTR's are 2+. Motor and sensory are intact.
- A: Chronic low back pain.
- P: Renew Ultram, 50 mg two p.o. q.i.d., #720 with one refill. Lortab-5.0, one q.-four to six hours for moderate pain, #20 with five refills. This is supposed to last six months. Schedule for an MRI of his LS-spine. Schedule him an appointment to the Chronic Pain Clinic. I am hoping that they will find him a candidate for some steroid injections.
- DNR: Dr. Frank E. Gonda/ jmm

10/27/00 - Natalindrogen (MRI) spoke to Lexis @ Alpha, not pre-req required for MRI - (2)



000535

THOMPSON 002887

WAID, L.R., PH.D
DEFENDANT EXHIBIT 7

THOMPSON 002888

wanted to describe the episode to me since she will not be able to accompany him to his appt. and will not be available at the time that he sees Dr. Gonda. Apparently there is no previous personal hx. of family hx. of seizure disorder. Mr. Casey is otherwise in good health and is very athletic. Told her I will speak with Dr. Gonda about the pt. and hopefully we can begin to arrange his workup before his appt. on Wed. Of course, if any changes in his condition occur prior to the Wed. appt., they should call immediately or have him come to the ER. Carol Casey's phone number is 587-1631. Mark Casey's telephone number is 576-8269. DNR:gc/da

9/23/92

MARK CASEY

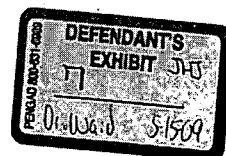
10967

Dr. Gonda

1. Syncope

- S: 33 y/o, white male comes in for the first time. Six days ago he was sitting on his deck talking to his sister. He had been working swing shifts and was very tired. He had had very little sleep. He had drank one beer. Also, he had taken a cold medicine a few days earlier and also a pain pill, which he does not know the name of, for some elbow pain. He was sitting there and he became rather nauseated, felt a little disoriented, and passed out. He does not recall anything else. His sister saw him slump over and thought he was joking. After about a minute he started gurgling and vomiting. He was unconscious for about 2 minutes and then came to. Sister said that his eyes did roll back in his heads and his arms appeared stiff, but she did not see any jerking movements. He had no incontinence and did not bite his tongue. As soon as he came to he felt fine, was alert, oriented, no postictal state. He has no previous history of seizure or fainting spells and there is no family history of seizure. Patient has no medical problems, is on no medication. Drinks a couple of beers maybe once or twice a month, and smokes less than one-half pack of cigarettes per day. No distress. Weight is 170 3/4 pounds. B/P is 138/94. Temp is 98.8. HEENT: pupils are equal, round, reactive to light; extraocular movements are intact; discs are sharp; cranial nerves are grossly intact; TM's and throat are clear; neck is supple; thyroid is not enlarged; no carotid bruits; lungs are clear. Heart is regular. Normal S-1, S-2. No murmur or gallop. Abdomen is soft, non-tender, no organomegaly. Extremities reveal full range of motion. DTR's are 2+. Motor and sensory are grossly intact. EKG shows a normal sinus rhythm. No abnormalities. Urinalysis is normal.
- A: Syncope episode. Differential diagnosis includes true syncope or fainting vs. a seizure. One could make a case for syncope based on a multitude of facts including lack of sleep, drinking one beer, cold medicine and a pain pill. I think seizure disorder needs to be ruled out despite that he had no incontinence and was not postictal.
- P: Patient is scheduled for an EEG and a CT scan of the brain at Mary Black next week. Will not start him on medications at this time unless he has a recurrence. Precautions given concerning repeated episodes in dangerous places such as driving. Profile III also drawn today. May need to follow up with a neurology consult for second opinion.

/FG:al



000527

THOMPSON 002889

WAID, L.R. PH.D.
DEFENDANT EXHIBIT 8

THOMPSON 002890

McKESSON
Empowering Healthcare

Name: Johnson, Mark
DOB: 18-Oct-1958
ID: 53305541
Study Date: February 04, 2007 12:32

Final Report - MR MRI HEAD W/OUT CONTRAST

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INDICATIONS: HEADACHE
COMMENTS:

PROCEDURE: PMR 0010- MRI HEAD W/OUT CONTRAST - Feb 4 2007
Accession #: 7799286

INTERPRETATION: MRI BRAIN WITHOUT CONTRAST

TECHNIQUE: Routine spin echo sequences with FLAIR and diffusion imaging.

FINDINGS: Negative for mass, extra-axial fluid or midline shift. The ventricles and sulci are normal in size. The brain parenchyma is of normal signal intensity without ischemic or demyelinating lesions.

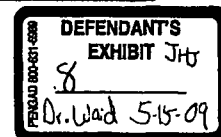
The posterior fossa contents are within normal limits. The cerebellar tonsils terminate above the foramen magnum. The paranasal sinuses are clear.

CONCLUSION: NEGATIVE MRI OF THE BRAIN WITHOUT CONTRAST.

Read by: GREGORY J JOSEPH, MD 001651 on Feb 4 2007 1:57P
Transcribed by: GJJ on Feb 4 2007 1:57P
Signed by: DR. GREGORY J JOSEPH, MD on: Feb 4 2007 1:57P

Signed by: Gregory Joseph

Signed at: 15-Dec-2007



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3/6/2009

THOMPSON 002891