Practice Tips: Cross Examination of Defendant's Retained Neuropsychologist in a Traumatic Brain Injury Case, *Shawna Mackeben v. Devin O'Meara*

by Patrick J. Giese

Proving an invisible injury presents many challenges. Proving an invisible injury when your client's primary complaints of memory, attention, and concentration issues all pre-existed the crash, and returned to full-time, gainful employment 53 days after the crash all the while telling doctors, family, and friends she was fine is especially daunting.

On September 8, 2017, Shawna Mackeben was a passenger in a close friend's car that was struck when the defendant blew a red light at the intersection of North Avenue and Halsted Street in Chicago. Unresponsive at the scene, Shawna was taken to Illinois Masonic, where she was admitted to the Intensive Care Unit for one week followed by three weeks of inpatient rehabilitation.

The facts of the crash effectively forced the defendant, a sympathetic woman in her mid-20s, to admit negligence. Leaving a jury only to evaluate damages elevated the importance of the competing retained expert neuropsychological opinions on the extent and duration of Shawna's traumatic brain injury.

So, our task was to demonstrate how a woman who returned to work less than two months after the crash and claimed to be fine *actually* suffered and continued to suffer from a traumatic brain injury. Rather than acknowledge the truth – that 26-year-old Shawna Mackeben was a compliant, dedicated, and hard-working patient whose brain injury prevented her from understanding the scope and breadth of her injury – the defense retained a neuropsychologist to opine that she had a rough couple of months but quickly returned to her baseline cognitive functioning.

Our retained neuropsychologist arrived at her conclusions after meeting the client and conducting her own neuropsychological testing at the facility where she spends the vast majority of her time treating patients with zero connection to litigation. By contrast, defendant's retained neuropsychologist spent the lion's share of his time on academic pursuits and delegated the tedious work of evaluating and interacting with patients to his students.

To exploit that credibility gap, we focused on the defense witness' failure to personally observe Shawna and obtained concessions from his own academic papers emphasizing the importance of clinical interviews and behavioral observation when evaluating brain injured patients.

The final offer before trial was slightly more than Shawna's $216,000 in medical bills. The case was assigned to Judge Daniel Lynch. On February 11, 2020, the jury returned a verdict of $831,679.00.

Cross Examination by Patrick Giese:

Q Doctor, it's nice to see again. My name is Patrick Giese. We met about a month ago at your deposition.
A Hello.
Q After hearing your testimony, it sounds like everyone in this room agrees that not only did Shawna Mackeben suffer a traumatic brain injury as a result of this crash but also that the traumatic brain inujury she suffered was severe; correct?
A Yes.
Q Okay. There is no doubt in your mind nor is there any doubt in any of the testifying treating physicians mind's in this cases that Ms. Mackeben suffered a severe traumatic brain injury as a result of this crash?
A Correct.
Q And there's no doubt that there is objective evidence in this record, including findings on imaging and testimony from the patient's treating physicians, that she suffered a severe traumatic brain injury as a result of this crash?
A Agree.
Q And to be clear, you are not here to tell this jury that Shawna Mackeben was not badly injured. It is your opinion that she is more or less functioning at baseline today; is that fair?
A Read back the question, please.
(Record read as requested.)
A No. My actual opinion is that she appears to be functioning, doing the same things that she did at her preinjury level.
Q And let's be clear for the jury. The opinions that you hold in this case are opinions that you hold despite the fact that before formulating these opinions, you did not personally observe Shawna Mackeben; true?
A Yes.
Q You have never spoken with Shawna Mackeben; true?
A True.
Q We can agree that it is significant as a practitioner that when you

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meet a patient and are performing a neuropsychological evaluation that, as part of that evaluation, you assess the patient's affect?

A Yes.

Q And you talked about Dr. Morris on your direct examination. She's a neuropsychologist that performed a neuropsych evaluation in this case?

A Yes.

Q And she has personally observed Ms. Mackeben?

A Yes.

Q She has spoken with Shawna Mackeben; correct?

A Yes.

Q She has spent a number of hours with Shawna Mackeben where she was personally conducting neuropsychological testing; correct?

A Yes.

Q That's something you have not done?

A Correct.

Q Dr. Morris had the occasion to evaluate Shawna's ability to hold a conversation; true?

A Yes.

Q That's not something you've been able to do; correct?

A Correct.

Q And you understand that the rules permit, if requested, before formulating your opinions as a retained medical witness, that you can, in fact, perform a neuropsychological evaluation?

A Correct.

Q And you did not do that in this case, I think you told us on direct examination, because you trusted that Dr. Morris collected the raw data correctly?

A That is correct.

Q I understand you did not ask through counsel or through the court to conduct such an evaluation; is that true?

A Yes.

Q Can we agree that, as a clinician, it's important to observe patient behavior --

A Yes.

Q -- when performing a neuropsych evaluation?

A Yes.

Q You had no occasion to observe Ms. Mackeben's patient behavior; correct?

A In the context of an evaluation or just period?

Q You've never seen her in your life?

A Never seen her in my life.

Q Very good. Thank you. Is it true that you have previously testified that it is important to closely observe a patient before coming to an opinion on the severity of a patient's brain injury?

A I have said that.

Q Okay. Doctor, I don't think it made it into your CV, but you published a paper in the *Journal of Clinical Neuropsychologists* in December of 2016 called "Discriminating Cognitive Screening and Cognitive Testing From Neuropsychological Assessment: Implications For Professional Practice."

A Yes.

Q Do you more or less remember that?

A I do. I'm little concerned that you didn't find it in my CV though. But go ahead.

Q In any event, this paper was published in December of 2016; correct?
A Yes.
Q Do you agree with the statement that, in a neuropsychological evaluation context, assessment is concerned with the clinician who takes a variety of test schools and considers the data in the context of history, referral information, and observed behavior to understand the person?
A Yes.
Q Okay. Do you agree with this statement?
A I do.
Q Do you agree with this next statement? This assessment process includes not only tests but also critical components like the clinical interview, consideration of demographic and medical histories, and behavorial observations?
A Yes.
Q You did not conduct a clinical interview in this case; is that true?
A That is true.
Q And we discussed how you did not make any behavorial observations; true?
A True.
Q Doctor, do you still have the exhibits that defendant's counsel walked you through on your direct examination in front of you?
A Yes.
Q Why don't we start with Defendant's Exhibit 10.
A Got it.
Q Which is a note from neurosurgery authored by Dr. Boyer. Are you with me?
A I am.
Q Can we agree there's no evaluation here of cognitive deficits such as insight?
A I don't see that noted.
Q Very good. And you're familiar with the term insight and its impact on traumatic brain injuries -- traumatic brain injury patients from your own practice; correct?
A Yes.
Q Insight is when a patient has difficulty understanding the extent, nature, duration of their own brain injury; correct?
A Yes.
Q That's a well-recognized concept in your field?
A Yes.
Q And there are objective ways to measure a patient's ability or a patient's insight, aren't there?
A More subjective than objective, but there are tests that you can give.
Q Very good. Any of those tests listed in Defense Exhibit 10 that would have been performed by the neurosurgeon in November of 2017?
A No.
Q Okay. And then you were asked about the history of present illness in Exhibit 10, and there was some statements attributed to Shawna's mother; is that right?
A Yes.
Q Okay.
A Grandma -- oh, mother, yes.
Q Mother; right? And that's the critical distinction; right? Because at this point in time, Shawna was living full-time with her grandmother;

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correct?
A Yes.
Q And she was receiving 24-hour assistance from her grandmother at that point in time; correct?
A That's my understanding.
Q And so there's no statements in here about Shawna's condition from the person she was living with hours a day and providing her with assistance; is that true?
A Not in this note.
Q All right. And then if we go to the last page of that exhibit. This is the note from the neurosurgeon about her ability to return to work, quote, as tolerated; is that true?
A Yes.
Q Okay. And something that's -- strike that. Dr. Boyer's letter indicating that she could return to work as tolerated. We can agree that's not full clearance; correct?
A No. I don't think we can agree with that at all. I think it means that he's releasing her to go back to work, and if there's a problem, then there's a need to follow up.
Q He's anticipating a problem, which is why he's giving her clearance on a partial basis as opposed to saying she's fully cleared to work?
A I think that's totally speculative. If she -- it says here, if she finds it difficult to return to work, we could get formal neuropsychological testing; however, I think it has little value at this point.
Q All right. Now, you're reading from a different part of the exhibit.
A I apologize.
Q So if we could go to Page 54 of Number 10. This is the last page of the exhibit.
A I'm so sorry.
Q So --
A Okay.
Q The --
A Ask your question again.
Q Sure. The second sentence in this letter is she may return to work as tolerated December 1st, 2017; correct?
A Yes, correct.
Q We can agree that it says as tolerated, not without restriction; correct?
A It doesn't say without restriction.
Q Thank you. You have -- do you have O'Meara Exhibit 12 in front of you?
A Yes.
Q Now, you were asked some questions about this exhibit, which is a note that was drafted by Dr. Whittington in a follow-up visit in November of 2017. Do you remember those questions?
A I do.
Q Okay. In the second to last paragraph, there is a sentence, quote, if she is truly functioning at the level that they are representing to me, I agree that neuropsych is not necessary; is that correct?
A Yes.
Q And you read Dr. Whittington's deposition before you formulated your opinions; correct?
A Yes.
Q Dr. Whittington spoke at length in her deposition about Shawna's inability to perceive her own injuries; correct?
A Yes.
Q And so where we have self reporting as what's documented here about Shawna's functional status, there's also been documented problems with insight while she was under Dr. Whittington's care; correct?
A Yes.
Q And then there's a notation about if she has difficulty with return to work. Do you see that?
A. Yes.
Q Before you gave your discovery deposition in this case on December 23rd of 2019, were you familiar with a person named Crystal Counts?
A No.
Q Before formulating your opinions in this case, did you read the deposition of Crystal Counts?
A No.
Q Before your deposition in this case, before you formulated your opinions in this case, did you know that Crystal Counts was Ms. Mackeben's supervisor at work during the time she suffered this traumatic brain injury?
A No.
Q Is there any witness whose testimony that you've read over the course of this case who has offered testimony on Ms. Mackeben's pre-crash performance at work and compared it to the post-crash performance at work?
A No.
Q If we could turn our attention, now, to O'Meara Exhibit 13. This is documentation of care that Shawna received at Illinois Masonic from Ms. Erica Zalay Barnes; right?
A Yes.
Q Is Ms. Barnes a neuropsychologist?
A No.
Q She's also not a physiatrist; correct?
A Correct.
Q She's not a neurosurgeon?
A Correct.
Q She's not a trauma surgeon?
A No.
Q We can agree you don't have any familiarity with that particular clinician's training with respect to that concept of insight that we've been talking about?
A That particular clinician?
Q Correct.
A That is correct.
Q Okay. Let's turn our attention to O'Meara Exhibit 14. And you were asked some questions in -- actually in Defendant's Exhibit 14 and O'Meara's Exhibit 16 about some care provided by Steve Thiel who is a physician's assistant; correct?
A Yes. Although I don't seem to have. Yes.
Q And I just want to make a few things clear for the jury. Mr. Thiel did not testify in this case; true?
A Not to my knowledge.
Q You have not read a deposition of Mr. Thiel; true?
A True.
Q And in terms of Mr. Thiel's training, I think you called him a practical nursing assistant, but he's a physician's assistant; correct?

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A I misspoke. He's a physician's assistant.
Q And physician's assistant -- and certainly no criticism of physician's assistants generally, but they do not attend medical school; correct?
A Correct.
Q They do one year of classroom training followed by one year of practical, and then they go out and they work very closely under the supervision of a medical doctor; true?
A Yes.
Q Okay. Do we have any idea what training formally Mr. Thiel has with respect to cognitive impairments?
A Specific to him? No, I don't.
Q Have you reviewed his CV?
A No. I haven't.
Q Do we know what rotations, if any, he did during his clinical year during the second and final year of his medical education?
A No.
Q Do we know anywhere else he's worked besides Fifth Avenue Primary Care? I know he's licensed to this profession.
Q What have you reviewed to confirm that?
A In order to practice in the state of Illinois as a physician's assistant, you have to have a license.
Q Understood. Have you seen that license?
A No, I haven't.
Q And you haven't seen his CV?
A No, I haven't.
Q Do you know how much experience he has providing care to patients?
A No.
Q If I could just turn your attention to Page 37 of that O'Meara Exhibit 14.
A Yes, sir.
Q Under psychiatric, I think you told us that Mr. Thiel noted that on January 30th of 2018, Ms. Mackeben's cognition and memory were normal?
A That's what I read.
Q Okay. And if we look at this note, we can agree Mr. Thiel, before coming to that conclusion, hasn't reviewed medical records of Ms. Mackeben's treatment at Illinois Masonic; correct?
A Well, on Page 36, it says history reviewed, no pertinent surgical history.
Q So we don't know one way or the other whether Mr. Thiel reviewed any of the documentation related to Ms. Mackeben's intensive care, week long stay, or her acute inpatient rehabilitation stay; correct?
A Well, based on the statement, will be attending vocational therapy for another two weeks due to her TBI suggests that he knew she had a TBI.
Q Does it -- and I'm asking a different question. I appreciate that.
A Okay.
Q My question is, we can agree, based on this document, Mr. Thiel did not note that he had reviewed records of Ms. Mackeben's intensive care stay or records of her acute inpatient rehabilitation stay at Illinois Masonic; true?
A Yes. I don't see any notation that he did.
Q There's also no indication -- though Mr. Thiel appears to have concluded something about Ms. Mackeben's cognition - - that Mr. Thiel performed any cognitive testing; true?
A I don't see any indication of that.
Q There's no MoCA score --
A Correct.
Q -- listed in this note; correct?
A That's correct.
Q All right. And if I could call your attention back to O'Meara Exhibit 16. It's one, two, three, four pages in, it looks like. It says 3 of 4 on the bottom right.
A Yeah.
Q Okay.
A Sorry. Where do you want me to go?
Q That's fine. Top of the page under psychiatric.
A What -- what page number?
Q It says 3 of 4 on the bottom right

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corner. This is the January 30th, 2018, visit.

A January 30th, 2018. Okay. So that will be at the front.

Q It's I think five pages in. Double-sided, it's the tenth page, it looks like.

A Okay. Yeah.

Q 3 of 4?

A Yes.

Q Going through the review of systems, specifically I would like to orient you to the psychiatric note here.

A Yes.

Q All right. Again, do we know whether Mr. Thiel performed a psychiatric rotation as part of his training?

A I don't know that.

Q We don't know whether he's -- what extent, if any, he has treating patients with psychiatric problems; correct?

A. I just don't have any knowledge about it one way or the other.

Q Sure. And for whatever conclusions Mr. Thiel has drawn where he mentions normal mood and affect, there have been -- there's been no testing performed here; correct?

A Not that I can discern.

Q There's no MoCA score listed here; correct?

A Correct.

Q As far as we know, Mr. Thiel is not trained as a neuropsychologist; correct?

A Correct.

Q Not trained as a neurosurgeon; correct?

A Correct.

Q And, again, there's no evidence here in January of 2018 that Mr. Thiel obtained his history from any other source besides the patient; correct?

A Correct.

Q All right. And if I could call your attention to O'Meara 15, Page 7.

A Go.

Q And you were asked questions about Dr. --

A Sachdeva.

Q Sachdeva's records; correct?

A Yes, sir.

Q You did not review in formulating your opinions here any deposition taken of Dr. Sachdeva; correct?

A Not that I can recall.

Q I can save you some time. That doctor was not deposed in this case.

A Okay. Good.

Q Okay. If you look at the plan. Strike that. You were asked questions about Dr. Sachdeva's notations on Shawna's current condition and her prognosis; correct?

A. Yes.

Q Under plan, does it say, obtain records from Illinois Masonic as part of this doctor's plan for this patient?

A Yes.

Q So we can agree that any conclusions that are documented in -- in O'Meara Exhibit 15 would have been reached without this physician having consulted records from Ms. Mackeben's treatment at Illinois Masonic?

A Yes.

Q All right. If I could direct your attention to O'Meara Exhibit 20.

A Yes.

Q All right. And this is an e-mail exchange between Ms. Mackeben and Ms. Zalay. And you were asked some questions about Ms. Mackeben mentioning that she thought she needed therapy a long time ago, haha, and that's written out in that e-mail; right?

A Yes.

Q All right. If you go down to the e-mail that was sent by Erica Zalay Barnes, the third full paragraph, she writes, brain injuries can take up to one to two years to heal; however, know that sometimes people do not heal 100 percent. Is that true in your clinical experience, that some brain injury patients do not heal 100 percent?

A I think that depends on the severity of the injury. In mild traumatic brain injuries, I wouldn't support that statement, but in more moderate to severe traumatic brain injuries, that certainly can be the case.

Q And so here where everyone agrees that Ms. Mackeben suffered a severe traumatic brain injury, you would agree, based on your clinical experience, having seen patients with brain injuries, there are situations where those patients' brain injuries do not heal 100 percent; true?

A Yes.

Q And patients with a severe brain injury like Shawna Mackeben's would have to learn new ways to do things, as Ms. Zalay Barnes explains in this e-mail; correct?

A Yes.

Q And those same patients with severe traumatic brain injuries like Ms. Mackeben have to compensate for their limitations; correct?

A Yes.

Q And then Ms. Zalay Barnes has an encouraging statement that she has come so far in the last seven months, please recognize that, but also to recognize there is a lot of progress still to be made; correct?

A That's what she said.

Q And this is dated Friday, April 27th, of 2018; correct?

A Yes.

Q All right. Doctor, specifically, in your practice, you do not perform the actual neuropsychological testing. You typically delegate that task to someone else in your office; is that true?

A Yes, sir.

Q You told us on direct examination, you delegate that task to technicians or students; true?

A Yes.

Q And these are folks that are not licensed to practice medicine in the state of Illinois; true?

A They're in training, that is correct.

Q These are folks that have not yet completed their training; correct?

A Correct.

Q And I understand from time to time you may observe testing, but I think we can agree that typically, at least in your office, this task is delegated to someone else; fair?

A The task of test administration is delegated to someone else.

Q Very good.

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A The responsibility for training, how to give the tests, and oversight of scoring and interpretation of the tests is conducted by the qualified professional who is licensed, and that's very typical for neuropsychology.

Q Understood. But in this particular case, you understand that Dr. Morris actually administered the test, scored the data, and came to opinions; right? She was in a room with Shawna Mackeben?

A Yes, she was.

Q All right. And in your practice, the -- the administration of the test, that's delegated to someone like a technician or student who is in the process of completing their training; true?

A Sometimes. True.

Q Well, not just sometimes. It's actually typically the case; correct?

A Read back the original question, please.

Court Reporter: Let me know if this is the right one. All right. And in your practice the -- the administration of the test, that's delegated to someone like a technician or student who is in the process of completing their training; true?

A Okay. Was there a question after that? Because the answer is true.

Court Reporter: Yeah. And then the question after that is, well, not just sometimes. It's actually typically the case --

A Yes.

Q Thank you. Is it true that, for one of your patients, you have never given an opinion under oath as a treating neuropsychologist on a patient's functional status unless you have actually met that patient?

A That's true.

Q All right. Doctor, you're familiar in your field with malingering or symptom magnification. This is a patient exaggerating symptoms to, you know -- for secondary gain; right?

A Yes.

Q For instance, a patient who has a lawsuit pending exaggerating their symptoms to try to increase compensation; right?

A Yes.

Q We can agree that's something that happens. We can also agree that is an ill-advised strategy; correct?

A We agree.

Q Okay. Now, we can also agree that, based on everything that you've reviewed, it is your opinion that Shawna Mackeben is not a malingerer, she's not magnifying her symptoms, there's been no evidence to support that she is seeking secondary gain?

A I agree with that statement.

Q Now, Doctor, we have heard of traumatic brain injuries described as invisible injuries; correct?

A Yes.

Q When I use that term, I mean a broken leg -- someone breaks their leg. They get a cast on it. They're walking around on crutches. Their friends sign the cast. You know that they broke their leg; right?

A Yes.

Q And a brain injury, you might be walking down the street, come across someone with a brain injury, and you would have no idea there was anything wrong with them; is that true?

A That could be, yes.
Q And Dr. Morris's neuropsychological assessment tested for malingering; correct?
A Yes.
Q She tested using the test of memory malingering; correct?
A Among others.
Q And she determined that Shawna was working hard and not exaggerating symptoms; correct?
A Yes, she did.
Q And you agree with that finding?
A Yes, I do.
Q Doctor, if we could go back to your CV, which -- I don't recall what defense exhibit it is.
A 8. It's Number 8.
Q O'Meara Exhibit 8. If we look at Publication Number 41.
A Yes.
Q You conducted a study and published the findings of a study, and the title of that publication was called, "Verbal Learning Differences in Chronic Mild Traumatic Brain Injury Patients;" correct?
A Correct.
Q And, as I understand it, this study examined the long term impact of chronic mild traumatic brain injury and controlled for malingering; correct?
A That's true.
Q And this test that you conducted along with a few of your colleagues, that used the same test of memory malingering that Dr. Morris used in her testing; correct?
A Yes.
Q And, I think you published your findings in the *Journal of the International Neuropsychological Society* in 2010; is that true?
A Yes, sir.
Q And do you agree with the statement that acute mild TBI, it is commonly associated with symptoms, including visual disturbance?
A I just want to make sure I'm understanding your question. You said acute mild TBI?
Q That's right.
A And what do you mean when you say acute? Are you talking about in the first day? Are you talking about in the first week? Or are you talking about in the first month?
Q This was a study that tested patients in various settings --
A Oh, you're referring to my study?
Q Well, here. I'll use acute mild TBI in the same way that you use acute mild TBI in your study, which is folks at various stages and with various histories of mild traumatic brain injury.
A That's not acute. That's chronic. Okay? Acute is within weeks of injury. That's acute. The study that you're citing here, Number 41, was with patients that we recruited that were community dwelling. There was nothing that was acute about their clinical presentation. They weren't freshly injured patients.
Q All right. The publication that was generated as result -- as a result of the study was called "Verbal Learning Differences in Chronic Mild Traumatic Brain Injury;" correct?
A Yes, sir.
Q All right. Can we agree that even mild traumatic brain injury is commonly associated with visual disturbances?
A In the acute stages, yes.

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Q And can we agree that even mild traumatic brain injury is commonly associated with alterations in cognition and behavior?

A In the acute stages, it can be, yes.

Q And we can agree that even mild TBI is associated with impairments in memory?

A In the acute stages, yes.

Q Also impairments in executive functioning?

A For mild traumatic brain injury? That wouldn't be typical in the acute stages, no.

Q Have you and your colleagues published a study that states that acute mild brain injury is commonly associated with symptoms including impairments in executive functioning?

A Acute mild -- I'm just not sure.

Q And, in fact, I can show you the article and refresh your memory.

A You don't need to unless you want to. I just don't remember. It's a ten-year-old study.

Q Fair enough. Can we agree that mild traumatic brain injury is commonly associated with symptoms that include mood alteration?

A In the acute stages, yes.

Q And by the way, we have -- we can agree -- a patient in this case who suffered a severe traumatic brain injury; correct?

A Yes, we can.

Q Can we also agree that traumatic brain injury patients can demonstrate diminished recall years after sustaining even a mild TBI?

A That statement has been made and is controversial, and if you're citing a study that's ten years old, there's been ten years of research since that study was done.

Q Are you suggesting that the study that you published in the *Journal of the International Neuropsychological Society* in 2010 is no longer a fair and accurate representation of the state of the study of mild traumatic brain injury?

A I think that there's been significant advances made based on functional neuroimaging techniques in the last decade on the pathology and the recovery patterns in mild traumatic brain injury, yes.

Q In any event, did your study find that traumatic brain injury patients demonstrated diminished recall even when well-motivated years after sustaining a mild TBI?

A Yes.

Q Did your study also find that non-litigating traumatic brain injury patients, meaning people who do not have a lawsuit pending, can demonstrate diminished recall many years after sustaining even a mild TBI?

A That's what that study showed.

Q And this study also demonstrated that nondepressed traumatic brain injury patients can demonstrate diminished recall many years after sustaining even a mild TBI?

A That's what the study showed.

Q And even gainfully employed individuals demonstrated diminished recall many years after sustaining even a mild TBI?

A That's what the study showed.

Q All right. Doctor, new topic. Diffuse axonal injury. We can agree that Shawna Mackeben suffered a diffuse axonal injury; correct?

A I can cite the radiology notes that state that. Here's what I can say. She had abnormalities on neuroimaging, and those that interpreted that interpreted it as being signs of being diffuse axonal injury.

Q Doctor, we can agree that there's evidence in this record that Shawna suffered a diffuse axonal injury; correct?

A That's a different question, and the answer is yes.

Q. We can agree that diffuse axonal injury is a type of brain injury; correct?

A Yes.

Q And do you agree that given the nature of diffuse axonal injury and it's potential impact on distributed neurobehavioral networks, injury along these pathways could result in widespread cognitive and behavorial dysfunction?

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A Yes.

Q You and your colleagues have completed research that confirms that statement; correct?

A That diffuse axonal injury can cause widespread dysfunction? Yes.

Q All right. Doctor, I would like to now turn our attention specifically to your opinions. I think you told us that you hold the opinion that no treating health care provider felt that a neuropsychological evaluation was necessary and that that indicates that there were no substantial concerns about her cognitive status; is that correct?

A Yes, sir.

Q Doctor, did you review the Masonic records?

A Yes.

Q Did you review Dr. Whittington's testimony?

A Yes.

Q. Didn't Dr. Whittington demonstrate concern about the patient's cognitive status?

A Yes.

Q You read Dr. Whittington's opinion that neuropsych testing would have been appropriate after discharge; true?

A Yes.

Q And you reviewed Dr. Whittington's discharge summary where she documented the need for a neuropsych evaluation; correct?

A If we're looking at the right thing, she said I discussed -- I discussed considering neuropsych evaluation with the patient, and she and her father did not seem to think it would be a benefit.

Q Doctor, can you tell us, did Dr. Whittington document that she discussed considering neuropsych evaluation with the patient?

A Yes, she did.

Q And does that not demonstrate concern about Ms. Mackeben's cognitive status from a physician who followed her care for nearly three weeks?

A I don't know what she was thinking.

Q Okay. We can agree that the document indicates that this physician had a discussion with the patient about the potential for neuropsychological testing; correct?

A Yes.

Q All right. New topic. Doctor, it's my understanding that you did not author a report in this case; correct?

A Yes, sir.

Q Dr. Morris authored a report detailing her findings; correct?

A Yes.

Q That report was written in her own hand; correct?

A I presume.

Q You certainly have no evidence to suggest that she did not draft that herself; correct?

A Correct.

Q Do you have your opinions in front of you?

A I do.

Q Doctor, the opinions that you testified to on direct examination, that document in front of you, did you create that document?

A Yes.

Q Did you type that document --

A No.

Q -- or was it -- it was typed by counsel

or someone from counsel's firm and sent to you for review; correct?
A Let me explain the process.
Q Well --
A Okay. I'll answer your question.
Q You're welcome to explain the process when counsel has an opportunity to question you on --
A Okay. Repeat the question, please.
Q You know what? I'll just withdraw that question.
A Okay.
Q Doctor, we can agree you did not, in fact, author these opinions, you did not type them into a computer, you didn't dictate them to a secretary, you didn't draft that document and then send it to counsel to review; correct?
A Okay. That's you've said two things there. All right? The first part you were saying was that did I author these, and the answer is yes, I authored them. They're my opinions. And the second half of your question is, no, I did not transcribe them. They were transcribed based on my stating what my opinions were.
Q And I just want to make sure it's absolutely clear for the jury. You did not sit at a computer and type these opinions up; correct?
A Correct.
Q You didn't write them out longhand and have them transcribed by someone in your office; correct?
A Correct.
Q You had telephone conversations with counsel, and counsel drafted them up and then sent them to you, correct, by e-mail?
A That's correct.
Q And three minutes later, you sent back an e-mail to counsel saying that you approved these opinions?
A That's right.
Q All right. And to be clear, to approve these opinions, I take it they would have had to accurately reflect your opinions, they would have to accurately list all of the materials that you've reviewed, and they would have to be a -- a correct summary on the first try about what your opinions would be and documented for purposes of this case; true?
A Yes. They're very good at taking dictation.
Q So counsel took dictation from you to formulate these opinions?
A I said these are my opinions, 1, 2, 3, 4, and 5 and 6.
Q Thank you, sir. Let's talk about deficits that Ms. Mackeben suffered after the crash and deficits that she may have had before the crash. Okay?
A Okay.
Q We can agree that before this incident, she was fully functioning, carrying out all activities of daily living, and was successful at work; correct?
A Fully functioning, carrying out all activities of daily living, and at work. Yes. We can agree with that.
Q There's no evidence of vision issues before this incident?
A No.
Q And we can agree that in the days and weeks following the occurrence, Ms. Mackeben could not drive herself; correct?
A Yes.
Q She couldn't grocery shop herself; correct?

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A Yes.
Q She could not take care of her own bills?
A Yes.
Q And I think you told us on direct examination that she utilized automatic withdrawal to take care of her bills; right?
A Yes.
Q And to be clear, that's not receiving a bill, writing a check, sending the bill in. That's setting something up one time and letting it go on a cycle; correct?
A Yes.
Q There's evidence in the record that, after this incident, Ms. Mackeben is prone to outbursts of anger which she didn't have before; correct?
A Yes.
Q You read testimony about Ms. Mackeben throwing a glass at a wedding; correct?
A Yes.
Q There's testimony in this case that you reviewed before formulating your opinions that Ms. Mackeben, after this incident, demonstrated a lack of a filter; correct?
A Yes.
Q And there's also evidence of impulse control from after this crash; correct?
A Yes.
Q The Glasgow Coma score, that's something you're familiar with. I think you told us about it on direct examination.
A I did.
Q And it's your recollection that, at the scene of the occurrence, Ms. Mackeben's Glasgow Coma score was 3?
A That's correct.
Q Is it true that an unconscious person would score a 3 on the Glasgow Coma Scale?
A Yes.
Q Is it also true that a dead person would score a 3 on the Glasgow Coma Scale?
A Yes.

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