SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NASSAU : TRIAL TERM PART 12

BESSIE SAVINO, as Executrix of the Goods, Chattels and Credits of MICHAEL SAVINO, Deceased, and BESSIE SAVINO, Individually,

Plaintiffs,

-against- Index No. 27262/82

FRANKLIN GENERAL HOSPITAL, S. PAUL ZOLA, M.D., JEROME J. ZUFLACHT, M.D., ALBIN ALGIRD BAGDONAS, M.D., Individually, and ZUFLACHT, M.D., ZOLA, M.D., & BADGONAS, M.D., P.C.,

Defendants.

Mineola, New York
May 6, 1994

B E F O R E:

HONORABLE HARRY H. KUTNER
Justice of the Supreme Court
and a Jury

A P P E A R A N C E S:

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BY: MADELEINE HIRSCHHORN, ESQ.

MARIA C. GARDNER, CSR, RPR
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Official Court Reporters

(Jury entered.)

THE COURT: Good morning.

Ready to proceed, Miss Hirschhorn?

MS. HIRSCHHORN: Yes.

THE COURT: Call your witness.

MS. HIRSCHHORN: Dr. George DiGiacinto.

D R. G E O R G E V. D I G I A C I N T O, called by the Defendant herein, 53 East 67th Street, New York, N.Y. 10021, being duly sworn, was examined and testified as follows.

DIRECT EXAMINATION

BY MS. HIRSCHHORN:

Q Good morning, doctor.

A Good morning.

Q Doctor, can you tell the court and jury about your education and medical background, please?

A Yes. I attended Columbia College in New York City and graduated in 1966. In 1966 to 1970 I attended the Harvard Medical School. From 1970 to 1972 I did two years of surgical residency at the Roosevelt Hospital in New York City. After being in the United States Navy from 1972 to '74, one year of which was spent as a neurology officer, I began my training in neurological surgery. I trained from 1974 to 1978 at Columbia Presbyterian Medical Center in New York, New York, and

completed my formal education.

Q Thereafter, what did you do professionally?

A In 1978 I went into the private practice of neurosurgery, and also became an instructor in neurosurgery at Columbia Presbyterian Medical Centre. I've been in practice and an instructor since that time.

Q Doctor, do you have any present hospital affiliations?

A Yes, I do.

Q What hospitals are you affiliated with?

A I am an attending neurosurgeon at the St. Luke's Roosevelt Hospital Medical Center, Beth Israel North Medical Center, and Harlem Hospital Medical Center, all in New York City.

Q Do you hold any positions with any of these hospitals?

A Yes, I do. I am an instructor in neurosurgery at Harlem Hospital Medical Center through Columbia University, and I am the active director of the division of neurosurgery at St. Luke's Roosevelt Hospital Center in New York.

Q Doctor, are you board certified in the field of neurologic surgery?

A Yes, I am.

MS. HIRSCHHORN: Your Honor, at this time I

would ask that this witness be declared an expert in the field of neurosurgery.

MR. CARLUCCI: No objection, sir.

MS. NOBLE: No objection.

THE COURT: Proceed.

Q Doctor, can you tell the court and jury the difference between the specialties of neurology and neurosurgery, please.

A The specialty of neurology is involved primarily with the diagnosis of diseases of the nervous system. Am I speaking loud enough? I can't tell from here, I'm sorry. That diagnose will include the evaluation of the patient and ordering of certain tests.

The specialty of neurosurgery will include that area of diagnosis and go beyond that to include the area of surgical decision-making and treatment of diseases of the nervous system, which are amenable or which will benefit from surgery.

Q Prior to becoming specialized in neurosurgery, what was the extent of your training in general surgery?

A I did two full years of training in general surgery as a house officer at the Roosevelt Hospital in New York City.

Q Doctor, when were you asked to review this file?

A I believe I was contacted by your office in December

of 1993.

Q And since that time, have you and I had occasion to meet prior to you coming to court today?

A Yes, we have.

Q Doctor, are you being paid for the time you spend reviewing the records and the time you are spending testifying in court today?

A Yes, I am.

Q What would your fee for the services be?

A My fee for the services of review will be on an hourly basis, and it was a fairly big chart, I believe it's eight or ten hours of review to this point. And my fee for testimony today will be $2,000.

Q What will your hourly fee be, doctor?

A $250 an hour, I'm sorry.

Q Doctor, from your review of the admissions of Michael Savino to Franklin General Hospital, I would like you to assume, from the record which is in evidence and from testimony elicited during the course of this trial, that Michael Savino, on April 27th of 1980, came to Franklin General Hospital by ambulance; that he had been in urinary retention for a period of 48 hours, and was asked by his family doctor, Dr. Fahnrich, to see Dr. Klein at Franklin General Hospital; he came there by ambulance, and he was seen by Dr. Klein, an attending in

urology, and a catheter was inserted. The patient gave a history of a CVA, or a stroke, ten or twelve years before, and a history of diffuse arthritis.

In the days from April 27 to April 28, the first two days of the patient's admission, and prior to the time that he was seen in consultation by Dr. Zola, there is a record from the History Physical and Nurses Notes that were obtained during that period of time that this patient was unable to stand, had diffuse arthritis in all four extremities, had difficulty using the left hand and making a fist; and during the course of his care at Franklin General Hospital, he was treated by Dr. Klein and underwent an intravenous pyelogram which showed trabeculation of the bladder. On examination, he had an enlarged prostate.

And while under Dr. Klein's care and treatment in the first two days of his admission, Dr. Klein determined that he had an abdominal distension, and on April 29, two days after Mr. Savino came to Franklin General Hospital, he called Dr. Zola to see the patient in surgical consultation. Dr. Zola examined the patient and treated the patient conservatively initially with a Levin tube and then a Cantor tube.

Sir, it was then determined, after a series of tests were ordered, that surgery was required. However, when Dr. Zola called in internists to assess the patient's

condition, internists other than his family doctor who had seen him, it was determined that this patient had cardiac problems and, therefore, surgery was delayed.

In the interim, patient was found to have liver and kidney problems as determined by laboratory tests that were ordered to assess various kidney and liver functions. He was also found to be protein depleted with very low albumins, and was treated with a course of hyperalimentation. The patient subsequently went on and was cleared for surgery, and Dr. Zola operated, found an abscess, peritonitis, and created a colostomy.

Patient had problems recovering from anesthesia, and had been assessed as a poor anesthesia risk, a grade 4, prior to the time he was operated on, with a notation of B.U.N., blood urea nitrogen level with three arrows going up in the air.

Ventilation assistance was required for breathing, but the patient was weaned off the ventilator, and during the course of his admission was gradually weaned off hyperalimentation and was able to resume taking some oral feed.

He also received bedside physical therapy, and there are records in the hospital chart by the physical therapist indicating that the patient was showing improvement, and both active and passive range of motion exercises were

performed.

When this patient, who had all of these presenting problems and problems that occurred during the course of his admission, was discharged on June 19, he was weak, he was debilitated, and he was unable to stand.

Based on this picture of this patient, from the time of his admission to the time of his discharge, do you have an opinion, with a reasonable degree of medical certainty, as to whether the symptoms the patient exhibited on discharge were consistent with his past history and present condition?

A Yes, I do have an opinion.

Q Doctor, can you tell us what your opinion is.

A My opinion is that the symptoms which the patient exhibited upon discharge and through his hospital course were related primarily to the two processes which had been identified and were being actively treated. More specifically, the urinary obstruction secondary to an enlarged prostate, as further demonstrated by physical exam and trabeculation, or muscular overgrowth of the bladder, and his acute abdominal problem which was related to an intra-abdominal abscess causing a small bowel obstruction.

These two processes, and most specifically the major process being the acute abdominal infection and obstruction, led to a patient who was becoming progressively

more and more weakened and debilitated due to protein loss, due to what we call a catabolic state, or the body literally is living off itself rather than being able to obtain nutrition from the outside.

All of these factors add to a picture of a generally very debilitated patient. And that's what we're seeing through the course of the hospitalization and up to the time of discharge.

Q Was the ileus caused by spinal cord compression?

A The abdominal distension, which was found to be an ileus, was caused by the intra-abdominal infection causing a mass which blocked the flow of fluid through the tube, or hose which we call the small bowel. So it was related to an infection in the abdomen.

Q Doctor, if a neurologist had been called in by any of the doctors who treated Mr. Savino during his first admission, and the neurologist called in a neurosurgeon, or any of the treating doctors went directly and called in a neurosurgeon during this first admission in April, was Mr. Savino a candidate for a myelogram at any time during the first admission after Dr. Zola saw this patient in surgical consultation?

A In my opinion he was not.

Q Why?

A By the time Dr. Zola saw the patient in consultation, he had an on-going process which very clearly was related to an intra-abdominal abscess. This became progressively clearer and clearer. This patient, therefore, had an on-going infection and a progressively downhill course in terms of his ability to tolerate any type of testing.

Furthermore, he was found, from a cardiac point of view, to be a very bad risk for any sort of procedure. Very specifically, with relationship to the myelogram, there are two things that make him -- or three things that make him not a candidate. Number one, it is an absolute contraindication to perform a myelogram and stick a needle from the outside through blood vessels and soft tissue into the spinal fluid space, which is a very, very isolated space, the presence of infection of the type that Mr. Savino was suffering from afforded an absolute contraindication.

Secondly, the physical performance of a myelogram, which required that a patient be positioned with his stomach down and tilted on a tilt table so his feet are much higher than his head, would have been impossible in this patient both because of his abdominal distension and because of his general cardiac condition.

So I feel that it would have been impossible to perform a myelogram, and it would have been absolutely

inappropriate to try to perform a myelogram given the medical history that we have available on this patient.

Q Doctor, during the course of this first admission, if, indeed, despite the contraindications for it, a myelogram had been performed and there was an indication of a need for surgery to correct the patient's spinal cord compression problem, do you have an opinion, with a reasonable degree of medical certainty, as to whether Michael Savino was a candidate for a cervical laminectomy during the course of his admission from April 27 to June 19 of 1980?

A I do have an opinion.

Q Will you please tell us what your opinion is in that regard.

A My opinion is that at no time during that hospitalization was this patient a candidate for cervical surgery. He was too debilitated, as even with the assumption that the tests could have been done, he would not have medically or surgically tolerated such a procedure. Moreover, there was no evidence that I have available that there was any reason at that time to perform a cervical laminectomy on this patient.

So either in the hypothetical and in the reality of this patient, there was medical contraindications of performing either a myelogram or surgery, and there was no

reason to perform the surgery.

Q Was this patient receiving physical therapy during the course of his admission?

A The hospital record indicates that when it was possible he was, yes.

Q Was this appropriate for Michael Savino under the conditions with which he presented and his past medical history?

A Yes, it was.

Q If there had been a diagnosis of cervical stenosis or narrowing of the spinal cord during the patient's first admission, would that diagnosis at that time, the first admission, have changed the management of this patient while he was at the hospital from April to June?

A No, it would not.

Q Why is that, doctor?

A Again, he was admitted with one acute process, which was urinary obstruction due to prostate enlargement, and he then was found to probably have on admission and to further develop during admission a major abdominal catastrophe, an intra-abdominal infection which was causing an ileus or failure of the bowel to move properly, and an actual blockage of the bowel. Both of those conditions absolutely took precedence and had to be treated.

Moreover, the lack of any documentation of progression of anything that might be attributed to cervical spinal cord compression and, indeed, the documentation of improvement in strength, which I feel was mostly due to an improvement in his overall condition, that factor in addition to the major contraindications I've already discussed failed to ever make him a candidate for surgery, and failed, therefore, to change any management during that first hospital admission.

Q After the patient is discharged on June 19, 1990, he sees Dr. Zola in the emergency room at Franklin General Hospital on July 5, 1980. And during that time, Dr. Zola debrides decubiti that the patient had and checks his colostomy site. There is no complaint by the patient or his family of any other changes in symptoms and, indeed, in a note in a home health care nursing record for a period running from July 2 to July 4, the only notation of patient complaints as relayed by the family is of some temperature and diarrhea.

Do you have an opinion, with a reasonable degree of medical certainty, as to whether Michael Savino would have been a candidate for a myelogram in the interim from June 19 to July 5, 1980, when Dr. Zola saw this patient in the emergency room at Franklin General Hospital?

A Yes, I do have an opinion.

Q What is your opinion, doctor?

A That he would not have been a candidate.

Q Why is that?

A He was recently discharged from the hospital. While his acute problems had been treated, he was certainly in a recovery phase. He was eating better at home, he was gradually building up his strength, his protein reserve, what I described this catabolic body breakdown state was being reversed and he was progressively building up.

Moreover, there's nothing that I've been aware of in evidence that shows that there's been any loss of further function. And given those two factors, there's no indication at that point in time to proceed further with his evaluation or treatment.

Q Prior to your coming here today, there was testimony by Dr. Robert DeLorenzo, a neurologist, who practices in Virginia, and Dr. DeLorenzo testified that if during the first admission Michael Savino had undergone myelography he would have been a candidate for cervical laminectomy, and that had cervical laminectomy been performed during the first admission and preferably early on in April and May, that bowel and bladder problems that Michael Savino suffered from during this admission would have been reversed.

Do you agree with this opinion that was rendered by Dr. DeLorenzo?

A No, I do not.

Q Why don't you agree?

A I'll try to break it down and be as responsive as I can to the question.

I've stated my opinion as to why the patient was not a candidate for studies. I stated my opinion as to what explained the bowel and bladder problems. Those two factors certainly weigh heavy in my statement that I do not agree with Dr. DeLorenzo.

Moreover, I feel that if we make the assumption that any of the bowel and bladder problems were related to cervical spinal cord compression, ignoring the prostate enlargement, ignore the intra-abdominal abscess, et cetera, et cetera, if we make the assumption that they were related to the spinal cord compression, then with a high degree of medical certainty these findings would not have been reversible by a cervical laminectomy.

A cervical laminectomy is realistically presented to the patient as a way of stabilizing his current condition. By that I mean the hope is that further progression and loss of function would stop. The likelihood of any existing condition reversing is essentially nil. And, therefore, given the assumptions that I've made in this answer, performing a cervical laminectomy, if it were possible, if it

were indicated, would not have resulted in a reversal of bowel and bladder symptoms if they were related to the cervical spinal cord compression.

Q Do you perform cervical laminectomies during the course of your practice?

A Yes, I do.

Q Do neurologists performs cervical laminectomies?

A No, they do not.

Q If the patient underwent myelography and cervical laminectomy despite what you have said about the contraindications for such a procedure, even if there were signs and symptoms indicative of cervical stenosis, would a cervical laminectomy performed in the interim between June 19, 1980, and July 7, 1980, have resulted in any reversal of the symptoms which the patient had?

A In my opinion it would not have.

Q We've been talking about cervical stenosis throughout the course of this trial. Can you as a neurosurgeon define cervical stenosis for us?

A I'll certainly try. The cervical spine is our neck. I think everyone recognizes where that is. The spinal canal is the space between the bones of the neck which form a tunnel, and we can think of that tunnel very much as a pipe. The spinal cord, when it has adequate space to run through that

pipe, functions as it normally does. As arthritis develops, as ligaments in the neck get thicker, as disks tends to bulge out, as the structures surrounding this pipe or the spinal cord undergo degeneration as a process we all are undergoing, the space where the spinal cord runs becomes narrower.

I often describe to it patients as rust beginning to fill up the pipe so that the space of the pipe gradually becomes smaller and smaller until it begins to impinge upon or compress or limit the space for the spinal cord.

This process of progressive narrowing because of joints getting bigger and bone forming because of disks degenerating and bunching, and because of ligaments getting thicker with wear and tear, is the process of cervical spondylosis or cervical spinal cord narrowing.

Q How was this condition diagnosed back in 1980?

A In 1980, the only tests that was available and the only test that was used was through a myelogram.

Q You previously described that for us, doctor. What were the treatments available for cervical stenosis diagnosed in 1980?

A The most commonly used treatment was physical therapy. The second more commonly used treatment, I guess, and way down, would be an operation called a cervical laminectomy,

which would be designed to relieve the pressure against the spinal cord.

Q What were the risks and benefits of a cervical laminectomy in 1980?

A The benefits of the cervical laminectomy are to relieve the pressure against the spinal cord with the hope that relieving that pressure will stabilize the condition, meaning that it will avoid further progression and loss of any neurological function which may be related to that condition.

The risks are infection, hemorrhage as a result of the surgery and, very specifically, increased loss of function in the spinal cord, which, in effect, would speed up the process of neurological loss. That's really the major risk of the procedure.

Q Is this what occurred when Michael Savino underwent a cervical laminectomy in September of 1980?

A The records would indicate that that was the case.

Q Michael Savino lost the use of his hands. Is that consistent with the risks inherent in the performance of a cervical laminectomy?

A Yes, it is.

Q In August, early August 1980, the patient and the patient's family on behalf of the family contacted Dr. Albin Bagdonas, who is Dr. Zola's partner.

Dr. DiGiacinto - for Deft - Direct

(Indicating.) That's Dr. Zola sitting there, and this is Dr. Bagdonas. You've never met these doctors before, have you?

A No, I have not.

Q And it's now August 1, and the patient tells Dr. Bagdonas, the patient's family, that the patient is not getting any better and is having problems. And at that time, Dr. Bagdonas sees the patient, and by testimony indicates that there's been a sufficient amount of time for the patient to be showing improvement from his resolution of his acute problems for which he was treated during the first admission, and requests that the patient be admitted to Franklin General Hospital for a neurologic evaluation.

Dr. Bagdonas admits the patient to the hospital and calls in a board certified neurologist, Dr. Burton Diamond. Drs. Zuflacht, Zola and Bagdonas continue to see the patient to monitor his progress from the problems for which they treated him during the course of his first admission, but Dr. Burton Diamond now comes in and sees the patient in neurologic consultation on August 5. His partner, Dr. Kramer, also sees the patient. And there is a note in the record on August 11 indicating some concern about doing a myelogram, lack of patient cooperation, and the question of positioning of the patient.

On August 13, Dr. Stephen Burstein comes to see the patient. Dr. Stephen Burstein is a board certified neurosurgeon. He evaluates the patient and indicates that the patient needs myelography to further evaluate a problem, for further evaluation of a problem. When Dr. Diamond sees the patient initially on August 5, Dr. Diamond indicates that the patient may have a spinal lesion, that the patient has mild proximal weakness in his arms, and indicates that there's sensation to the nipple level, and writes down as his impression that there is a lesion in the thoracic spine.

Thereafter, when Dr. Burstein sees the patient on August 13, he writes a consultation report indicating the need for myelography, but that the patient has declined myelogram and prefers to stay with physical therapy or conservative treatment for his neurologic symptoms.

The patient has a change of heart, and on or about August 22 indicates that he would like a myelography. Dr. Burstein has signed off the case on August 13 because the patient has indicated he doesn't want any of the diagnostic procedures that a neurosurgeon would render such as myelogram.

On August 22 the patient has a change of heart, and on August 26 Dr. Burstein sees the patient, makes arrangements for a myelogram. The myelogram is then performed on August 28, and there is a report indicating that the patient

had some problems during the course of the myelogram procedure, there were difficulties positioning the patient, and that it was difficult to recover the pantopaque, being the dye used, and that residuals of the pantopaque were left in this patient. The myelogram does show narrowing in the cervical area.

Do you have an opinion, with a reasonable degree of medical certainty, as to whether this patient was a candidate for myelography during the second admission from August 1 into October?

A I do have an opinion.

Q What is your opinion, doctor?

A Given the information available, it is hard for me to be sure that this patient was ever a candidate for myelography or further treatment. His clinical condition never was one which made him, I think, to any degree a reasonable candidate for surgery. The myelography, which as I have indicated was, number one, medically contraindicated and, number two, almost physically impossible to perform on the first admission, was proven on the second admission to be almost physically impossible to perform and, indeed, had to be performed in a manner which was totally incorrect because the patient never could lie on his stomach and allow proper studies to be done.

I really feel that doing a myelogram on this

patient was a very risky and difficult procedure, as was proven out. And again, based on the records I have, I'm not sure that he would have been considered a candidate for myelography at any point.

Q Doctor, what is the significance of Dr. Diamond's comment on his neurologic report that when he saw the patient in the beginning of August the patient had mild proximal weakness of the arms?

A The significance of that finding by the neurologist is that at that point in time, based on the records that I have reviewed, this was the best strength that the patient ever showed in his upper extremities.

It was Dr. Diamond's opinion that the findings in the upper extremities were so relatively normal that he wasn't even convinced that there was an abnormality as high up in the cervical spinal cord. I should explain that the findings that Dr. Diamond noted most convincingly were so-called sensory level, well below the level of the cervical spine, and weakness in the lower extremities which, by description, is similar to what it had been and perhaps even better than it had been on the first admission.

His level, if you will, the point in the nervous system where he felt the lesion was most likely located was in the level of the thoracic spine, the chest portion of the

spinal cord, below the level of the cervical spine. Again, the significance is that his findings indicated not terribly major weakness in the upper extremities, better strength than the chart indicates we had seen at any time to that time.

Q If, indeed, this patient had ever been a candidate for myelography and for laminectomy, would this period of time when he had mild proximal weakness be the optimum period for treatment?

A I think the answer is yes, but more because this was the time he was in his best metabolic condition from when we first come to know him in April, I believe it was, until this time.

Really, the major problems with the myelography was performing the study, and he was really perhaps at this point, or perhaps not, but at any point that we see him he is perhaps better on his admission the second time to Franklin General Hospital for the study.

Q In the interim, between this visit by Dr. Diamond on August 5 where he notes mild proximal weakness of the arms, sensation above the nipple level, Dr. Burstein sees him on August 13 and writes a consultation report, and notes that now there is evidence of severe quadriparesis involving both upper and lower extremities.

Doctor, do you have an opinion as to what

happened to this patient in the intervening time?

A Based on the record available, I do have an opinion.

Q What is that?

A The records indicate that the patient was showing more weakness in his upper extremities. Comparing one examiner to another is always difficult, but Dr. Diamond didn't even place the abnormality in the neck and Dr. Burstein felt very strongly that there was such significant weakness in the neck that it clearly must be there. This means that in that intervening week or eight days, I forget exactly.

Q August 8 to August 13.

A He was showing loss of strength in the upper extremities. This is not in a situation where anything else was going on, he was not in this catabolic breakdown state, he was not otherwise weakened as far as the record indicated, so that he was losing function in his upper extremities at this time.

Q Doctor, given the patient's clinical condition from the time he came into the hospital in April of 1980 up to August 13, 1980, where he is showing progressive neurologic deficits from the time he was evaluated by Dr. Diamond on August 5, would myelography still have been contraindicated?

A I think again based on the information I have available, myelography may always have been contraindicated in

this patient because of his condition. But playing a little bit of a balancing act, you're balancing a very difficult study and, to a certain degree, risky study which may not have much to offer if it shows the need for surgery against progression of a neurological deficit, progressive weakness.

On balance, he is more of a candidate at that time than any point in his clinical course that I'm aware of.

Q Doctor, during the course of a neurosurgeon treating a patient, where a patient is showing progressive neurologic defects as was seen between August 5 when Dr. Diamond saw this patient and August 13 when Dr. Burstein saw this patient, would it be in accord with good and accepted practice for a neurosurgeon to counsel a patient showing these problems against undergoing myelography and cervical laminectomy?

A I have to answer that by saying it may be appropriate. Again, depending on the overall condition and depending on what the neurosurgeon felt he had to offer the patient if he were to undergo a cervical laminectomy. The prognosis for stabilization and improvement versus the risk of the surgery.

We always have, and when I talk to a patient I always have what I call a risk/benefit balance. And when the risk is prohibitive for the patient not surviving surgery, for heart reasons or lung reasons, or when the risk is prohibitive

because of the very big chance of making the patient worse, that's a major factor versus the benefit of stopping further progression. And I have to underline that, because in this type of patient a neurosurgeon doesn't expect that he will reverse what's already lost, he merely wants to stop it.

So the benefit side versus the risk side in this type of patient is a very close balance. It's certainly not weighted very heavily on the benefit side, if at all, and it may be weighted more heavily on the risk side. That's why I can't say that this patient definitely was or definitely was not a candidate for myelography at the date stated.

Q If this patient were counseled on a risk/benefit analysis, what would the benefits be in relation to the risks for Michael Savino based on his past medical history and problems as documented from the time of his admission on August 5 up to August 13?

A I hope I've touched on some of those answers, but I'll try to restate simply. The potential benefit for such a study which would only be done if surgery were contemplated, would be to stop the progression of loss of neurological function. It would be to stop the weakness in the arms and the legs where it was. It would not be to reverse the lesion and the loss which already existed. So the benefit is to stop where we are.

The risk would be, number one, to put a patient through a myelogram, which is an uncomfortable but also relatively dangerous procedure in someone who's still pretty weak and who can't even lie on his stomach, and the risk of surgery in a patient of this type is, number one, death during anesthesia, number two, a mild to moderate to marked progression of his loss of neurological function just as an outcome of the surgery itself.

Q According to the record, prior to the time that Michael Savino underwent a cervical laminectomy did he have the use of his hands?

A Yes. I'm sorry. At that time, yes.

Q Following the cervical laminectomy Michael Savino lost the use of his hands. There is a notation in the recovery room record that the patient cannot move his hands, in the recovery room following the cervical laminectomy. There has been testimony by family members that following the cervical laminectomy Michael Savino lost the use of his hands.

Michael Savino was hospitalized during the course of his life at other hospitals, and in the histories that were offered by the patient or the patient's family, there is also documentation that Michael Savino had the use of his hands up until the time of the cervical laminectomy, but lost the use of his hands in the immediate postoperative period

while still in the recovery room and never regained the use of his hands.

Do you have an opinion as to the cause of the loss of the use of the hands following the cervical laminectomy?

A Yes, I do.

Q What is your opinion as to that cause of the loss of the hand function?

A That it was the result of a poor outcome from a cervical laminectomy.

Q Was this one of the known risks of cervical laminectomies?

A Yes, it is.

Q Doctor, based on your review of both admissions, was Michael Savino's condition any worse at the time of the second admission than when he was discharged from Franklin General Hospital in June of 1980?

A Based on my review of the records, his condition was not worse on the second admission than it was at the time of his discharge from the first admission.

Q In your opinion, was Michael Savino ever a candidate for cervical laminectomy?

A I think I've discussed that a good deal in my testimony. It had to be a close call as to whether he was or

was not a candidate. And I think, without having actually been treating the patient, at best I can say it was a close call as to whether he would ever have been at this time fit for such a procedure and whether he would have predictably tolerated such a procedure.

Q If, in fact, he ever were a candidate for cervical laminectomy, when would that situation have existed in terms of the course of his hospitalization at Franklin General Hospital from April to June then from August to October?

A Based on the records I've reviewed, it appears that his best neurological condition and his best metabolic condition, his best body condition, existed at or around the time he was admitted to the hospital in August of 1980. So that's the point if there was an opportunity to do a study, he would perhaps have been the best candidate at that time.

Q After Michael Savino leaves Franklin General Hospital in October of 1980, he goes to Brunswick Hospital for a period of rehabilitation, then returns home in December of 1980, and from December of 1980 to May of 1983 Mr. Savino has several admissions to Long Island Jewish Hospital. And ultimately in May of 1983, when he's admitted for sepsis, there is a determination to discontinue the antibiotics and discontinue the intravenous, and Michael Savino dies within an hour thereafter in May of 1983.

Dr. DiGiacinto - for Deft - Direct

Doctor, based on your review of the record, do you have an opinion as to the cause of Michael Savino's death?

A Yes, I do.

Q What was the cause of his death?

A The sepsis at the time of his last admission to the hospital.

Q Doctor, was the absence of an evaluation by a neurologist or a neurosurgeon during the course of Michael Savino's first admission to Franklin General Hospital from April to June of 1990, and the absence of any neurologic evaluation or neurosurgical consultation by a neurologist or neurosurgeon, the proximate cause of Michael Savino's death?

A No, it was not.

Q What is the basis for your opinion that that was not the cause of Michael Savino's death?

A Without going over all of my testimony again, he was not a candidate for a study or a cervical laminectomy at any time during his first admission and, at best, was barely a candidate at the time of his second admission.

His neurological status at the time of surgery was such that the sequelae would have followed anyhow the cervical laminectomy exacerbated or made worse his condition.

But I don't think that this patient, unfortunately, ever would have benefited to the point that it

would have reversed his ultimate outcome at any point in time.

Q During the course of Michael Savino's admission during his first admission, he was receiving physical therapy. And during the interval period, between his first admission and his readmission to Franklin General Hospital in August of 1980, arrangements were made for Michael Savino to receive physical therapy at home.

Do you have an opinion, with a reasonable degree of medical certainty, as to whether this was appropriate treatment for Michael Savino?

A Yes, I do have an opinion.

Q What is that, doctor?

A My opinion is that this was appropriate therapy for Michael Savino given the condition that was presented in his hospital record.

MS. HIRSCHHORN: Thank you, I have no further questions.

MR. CARLUCCI: May I inquire?

THE COURT: You may.

MR. CARLUCCI: Your Honor, to save some time, you may be needing this later on, I'll just hand it up to you. (Handing.)

CROSS-EXAMINATION

BY MR. CARLUCCI:

Dr. DiGiacinto - for Deft - Cross

Q Doctor, would you pronounce your name for me so I can say it right?

A Certainly. Dee-ja-sin-toe.

Q Have we met?

A I don't believe so.

Q You were at Neurological Institute?

A Yes.

Q What years?

A 1974 to 1978 as a resident, then as an attending from 1978 until 1981 or '82.

Q Dr. Schlessinger was director of neurosurgery at that time?

A Yes, he was.

Q We have a few things we need to cover, doctor. Let's get some of the housekeeping stuff out of the way, then we'll get into the medicine.

Number one, you said you were contacted December of 1993 by Mrs. Hirschhorn?

A I believe by someone in her office.

Q Do you know who?

A I do not.

Q Do you know how they came to get your name?

A No, I don't.

Q Have you testified for them before?

A For them, no.

Q Have you testified for other people before?

A Yes, I have.

Q On how many occasions have you testified?

A Four or five, on that order or magnitude.

Q For what law firms?

A Bower & Gardner, Schneider and Kleinck and --

Q Weitz.

A Somebody. Heidell, Pittoni, Murphy & Bach. You're pushing me beyond that. I can't remember. I think there was a second Bower & Gardner case I testified on.

Q Can you say you've testified more for the defense than you have for the plaintiff?

A Yes.

Q You said you told us that in your opinion, to a reasonable degree of medical certainty, that there was no difference in Mr. Savino's neurological status between the first and second admission.

A I don't think that's exactly accurate. I think I testified that he was perhaps somewhat better in terms of his overall function on his second admission.

Q In terms of his overall metabolic status?

A And his strength.

Q You thought that his neurological status was actually

better?

A From what we have documented in the chart, he appears to have shown at least as good if not better strength in his upper extremities at the time of his admission in August than any other point that the chart reveals.

Q Doctor, I think I was relatively specific. I said overall neurological status. Are you saying that his overall neurological status was better at the time of admission on the second hospitalization than on discharge from the first?

A Well, I'll answer the question the same way, simply yes.

Q Simply yes. What's clonus?

A Clonus is a situation in which the legs or arms or any part of the body jerks, either as a result of a reflex being tested or spontaneously.

Q Is that a normal finding?

A It can be, yes.

Q I want you to assume we've heard testimony that type of finding would indicate problems with the cervical spine. Do you agree with that?

A It can, yes.

Q What are the significance of spasms in the lower extremities?

A Again I'll answer the question essentially the same

was as for clonus.

Q I want you to assume this patient had no documented evidence of spasm in the lower extremities or clonus on discharge in June, yet on admission in August he had both positive findings of clonus and spasticity.

Would you agree that is a significant change in his neurological status?

A In and of itself no.

Q Doctor, it's a change. It's a change?

A Based on the records that I have reviewed, it does not represent a significant change, no.

Q Doctor, you have said you've read the record. Have you read any of the depositions?

A Yes, I have.

Q Did you read the operating neurosurgeon's deposition?

A I would have to guess. I believe, I believe that I did, yes.

Q Doctor, do you recall that Dr. Burstein said that this patient, this patient was unable to move --

MS. HIRSCHHORN: Objection.

THE COURT: Sustained.

Q Do you recall reading the following testimony at page 36 of Dr. Burstein's deposition at line 19?

MR. CARLUCCI: Ready, your Honor?

THE COURT: Go ahead.

Q "Question: Sir, did you obtain any history at the time of the patient complaining of inability to move any of his extremities?

"Answer: He hardly had an ability to move them before surgery, and there was no change whatsoever after surgery at any time."

Do you recall reading that?

A Honestly, I can't recall. But I presume that that's an accurate representation.

Q Doctor, would it be fair to say that, if the operating neurosurgeon made that representation under oath, that the reality is the surgery that he performed had nothing to do with this patient's ability to move his extremities?

A (No response.)

Q Can you answer that? I'll rephrase it for you if you can't.

A I can't take it as a totally isolated statement because of my awareness of the record, which indicated that he was moving and everyone felt that he was moving his upper extremities better before the surgery than after. So as a totally isolated state I would agree with it, but as a statement relative to this case I think there was some degree of change in the upper extremities after the surgery.

Dr. DiGiacinto - for Deft - Cross

Q If Dr. Burnstein's statement was an accurate assessment of what he saw, that there was no change in the extremities, then would you agree that the surgery had nothing to do with any problem he had in the upper extremities?

A Given that supposition, yes.

Q Would you also agree, doctor, that often times in the immediate post-operative period after doing decompressive laminectomy that there's some decrease in neurological function in the immediate postoperative period?

A There very frequently is, yes.

Q Would you agree, then, if in the recovery room there was a notation about his upper extremities, that may well have been accounted for in this medicine postoperative problem?

A Yes, I agree with that.

Q Doctor, you have said that neurologists essentially identify problems, and then at times send patients to people like you for treatment, correct?

A Yes.

Q And then what happens at let's say Presbyterian where you were trained, let's talk a little bit about the interaction of neurologists and neurosurgeons.

A Yes.

MS. HIRSCHHORN: Objection.

THE COURT: What's the objection?

MS. HIRSCHHORN: My objection is that what goes on at a single isolated institution is not relevant. We're talking about a standard.

THE COURT: Objection is sustained.

Q Doctor, are you familiar with the community's standards for the interaction between neurologists and neurosurgeons?

A Yes.

Q Now, what happens in the community is a neurologist patient may develop a problem such as a cervical stenosis such that the neurologist may feel that there needs to be surgical intervention, that happens, correct?

A Yes.

Q And then what then happens is that the patient is sent to someone like you, and you make a decision as to whether you're going to do any operative intervention.

A Loosely speaking, that's right.

Q Then once you do this operative intervention, if you choose to do so, once the patient recovers from the surgical intervention the patient then is followed by the neurologist, correct?

A Not necessarily, no.

Q At times?

A Yes.

Q Many times?

A Again, at the exclusion of being followed also by the neurosurgeon, I have to say no.

Q I'm not talking about limited exclusion, I was saying the patient is then followed postoperative by the neurologist.

A If medically indicated yes; if not, in no.

Q Would you say that a neurologist, a trained neurologist would be able to recognize if there had been an improvement in the patient's neurological status post-operatively?

A Yes.

Q Therefore, doctor, when Dr. DeLorenzo told us that in his experience and in his opinion patients with cervical stenosis who undergo decompressive laminectomy improve, he has a basis for saying that, isn't that correct?

A I have no way of commenting on that because I don't know what his practice includes, sir.

Q Doctor, were you told anything about Dr. DeLorenzo's background?

A No.

Q Were you told that he was director of neurology at the Medical College of Virginia?

A I believe I was aware of that.

Q Were you told he was a graduate of Yale?

Dr. DiGiacinto - for Deft - Cross

A I don't recall, I'm sorry.

Q Were you told that he has both an M.D. and PhD in neuropharmacology as well as a master of public health?

A I don't believe I was aware of that.

Q Doctor, were you trying to suggest, saying that a neurosurgeon operates and a neurologist doesn't, that a neurologist's opinion about the effects of the surgical procedure should not be listed, sir?

A No.

Q You would agree that a neurologist is fully capable of commenting on a neurology patient's response to a surgical intervention?

A Yes.

Q Doctor, would you also agree that Dr. Burstein, as an operating neurosurgeon, can and does make observations about the effects of neurosurgical interventions?

A Yes.

Q Doctor, I want you to assume the following testimony.

MR. CARLUCCI: Page 35, your Honor.

Q Before I read this, are you saying under oath that every time you've done a cervical decompressive laminectomy for cervical stenosis that not a single one of your patients' neurological symptoms improved? Are you saying that?