A To a significant degree I can state that, yes. To a minimal degree within variations of measurement, no -- I may have gotten that backwards. You can see minimal degrees of improvement which basically are stabilization around the variation of the examination to see a significant functional improvement where a patient can do more than he was before the surgery, essentially never happens in a severe case of cervical stenosis.

Q To you.

A To me.

Q Page 35, line 12, this is from Dr. Burstein's deposition.

"Question: Is it your testimony that the main indications for performing the surgery is to stabilize the patient and prevent further neurological deficits?

"Answer: That was the main objective. And the other objective was that his only possible chance of getting any improvement would be to decompress the cord. That just therapy and keeping him in bed and just watching him certainly would not improve the strength in his arms and legs. The only outside chance he had was by decompressing the spinal cord.

"Question: The longer the compression is

present the more permanent the damage becomes?

"Answer: In general, yes.

"Question: The more severe the compression, the more permanent the damage that results?

"Answer: Yes."

Doctor, do you disagree with Dr. Burstein, the what man who operated on Michael Savino, that when you decompress the spinal cord it's the only chance the patient has for improved neurological status?

A No, I don't disagree with that.

Q Doctor, is that not in conflict to what you just told us?

A No, it's not, sir.

Q Doctor, you were asked some questions about the cause of Michael Savino's death. And in the question, in the hypothetical it includes the fact that an hour before his death IVs and antibiotics were discontinued. Do you recall that hypothetical?

A Yes, I do.

Q Doctor, you were not trying to suggest that by discontinuing the IVs an hour before his death, the family's authorizations for that, that that's what caused Michael's death, are you?

A Not in the least.

Q In fact, doctor, have you at times been in a situation where you've had to discuss with family members that there are things called DNR, do not resuscitate orders?

A Yes, I have.

Q And what that does is that you're called upon to sit down with the family and go over what is a very difficult decision, and that is to say that we doctors can no longer help this patient, and that any further treatment would just prolong his agony and we are recommending that we stop treatment, is that a fair summary?

A I'm going to just be a little bit sticky on the statement. A DNR order specifically means that if a patient's heart stops you don't resuscitate it. DNR does not mean do not treat.

But what you're describing appropriately is futility of further medical treatment. It is different than DNR, but I agree with your overall statement, yes.

Q What we just described may not actually be a do not resuscitate order, but it's something that's regularly done when patients are terminal and modern medicine can't help them any more?

A It's not a DNR order, but I agree fully with that statement, yes.

Q Doctor, you were very precise in formulating various

answers to questions that you were basing it on the date contained in the record. Now, I want to talk with you about that a little bit. When you neurosurgeons make evaluations of patients, they are, in part, dependent upon a complete neurological examination, correct?

A Yes.

Q Now, what you do, either you or a neurologist who appears has done a base line neurological exam on a patient, correct?

A Yes.

Q What you do to track the effect of the patient's condition is that, once you have a base line neurological exam, subsequent exams can tell you as a clinician whether there has been any change, either positive or negative, or stabilization of the patient's neurological status, correct?

A Yes.

Q And that the reason you do that is that you want to actively follow the progress of any pathology that may be impacted on the nervous system, correct?

A That is part of the reason, yes.

Q It's an important reason, isn't it?

A In evaluation of the patient, that's part of the overall picture, yes.

Q Now, are you telling this jury that this patient did

not have any cervical stenosis compressing the spinal cord in April of 1980?

A No, I am not.

Q Doctor, in all probability this patient did, in fact, have some degree of cervical stenosis impacting on his spinal cord in April of 1980, based on the data you have read.

A I suspect that's probably true.

Q I don't think we ever enumerated what it is you reviewed. You reviewed both Franklin admissions?

A Yes.

Q You reviewed the emergency room visit for July 5?

A Yes.

Q Anything else?

A I mentioned some deposition.

Q Some deposition.

A And a Long Island Jewish Hospital record, a VNS, visiting nurses record, and other records. Sorry, I just can't list them all.

Q Doctor, was there a base line neurological exam performed on this patient in April of 1980?

A Not specifically listed in the chart, no.

Q Doctor, the exam in the chart indicates no abnormal reflexes, correct?

A I believe there was a statement to that effect. I

couldn't write it out or point to it without being shown it, yes.

Q You recall seeing it.

A I believe I did, yes.

Q Is that what you referred to, to a reference to an exam in the record?

A I said there was no specific overall neurological exam listed in the record.

Q Doctor, in order for you to be accurate in telling this jury whether the cervical stenosis was a cause, contributing cause to any of his mobility problems, it will be very helpful for you to have a base line neurological exam, number one, correct?

A It will be helpful, yes.

Q And subsequent neurological exams tracking the patient's neurological status from April 27, 1980, to discharge on June 18, that would be helpful, wouldn't it?

A It would be helpful, yes.

Q Doctor, I want you to assume that in the second admission the record very specifically indicates that this patient has had progressive quadriparesis since April of 1980. Correct?

A The chart--

Q Will you assume that?

A I will assume that, yes.

Q Do you recall seeing that?

A Yes, I do.

Q Now, doctor, in order to say that that statement is inaccurate, in order for you to say that that statement is inaccurate, you would need to have a base line neurological exam in April of 1980 and then a subsequent neurological examination that would tell you whether this patient's neurological status was progressively deteriorating over that period of time, isn't that true?

A That would not be the only basis available to make those decisions.

Q Doctor, wouldn't it be best?

A It will be helpful, without question.

Q Doctor, you don't have any specific examinations of this patient's neurological status throughout that entire April, May and June period of time, do you?

A I'd have to take issue with the statement specific. There are definitely examinations specifically by physiotherapists indicating, quote unquote, improving strength, improving active and passive range of motion. That certainly is an important and in this case very important part of the neurological examination.

So without being a specific, here is a neuro

exam, it is a very valuable piece of information which tells me a great deal about what's happening with the patient.

Q So you're basing your opinion on four physical therapists' notes that are in the chart.

A Among other things.

Q Well, we're talking about this neurological thing. That's what you and I were just talking about. And you referred very specifically to four physical therapists' examinations.

A If there were four, yes.

Q I want you to assume there were four.

A Yes.

Q What you're referring, to that describes a description by a doctor?

A Not that I recall.

Q Do you know the training level of the physical therapist who did the exam?

A No.

Q Do you known whether they were measuring the patient's strength from some known base line?

A Their base line, yes.

Q What was their base lane?

A I'm sorry, I've been talking a lot relative to their training as registered physiotherapists. They have a base line

which they establish on their own.

Q When I asked you about base line I meant the patient's condition base line, just like the base line of a neurological exam. Do you know where they start and where they finished?

A No, but I know they document improvement.

Q Okay. And solely on the basis of their improvement you can say that this patient was not being impacted on by a cervical stenosis?

A I did not say he was not being impacted upon by a cervical stenosis.

Q Doctor, let's do the bowel problem at this point. Okay? Number one, do you agree that a problem with the cervical spine can impact on the rectum and lower sigmoid colon?

A Yes.

THE COURT: We'll stand in recess for ten minutes.

Take the jury out, please.

(Recess taken.)

(Jury entered.)

COURT CLERK: Doctor, I remind you that you're still testifying under oath.

THE WITNESS: Thank you.

MR. CARLUCCI: May I proceed, judge?

THE COURT: Yes.

Q Doctor, I think when we broke we were going to get into the bowel problem. Number one, I think you've agreed that the problem with the cervical spine can impact on the rectal and lower sigmoid colon, correct?

A Yes.

Q And, in fact, doctor, it's a relatively well-known complication of stenosis, cervical stenosis, isn't it?

A I can't really respond to that statement without more details.

Q You're familiar that it happens on a somewhat regular basis when patients have a cervical stenosis?

A I'm asking you to tell me what happened.

Q The impact on the sigmoid colon and rectum.

A But what kind of impact?

Q Any kind of impact, number one.

A An impact, yes.

Q One of the impacts is that the rectum does not respond appropriately and the patient begins to have build up of the fecal colon from the rectum into the sigmoid colon?

A At the very end stage, yes.

Q Are you going to tell us, doctor, that the cervical stenosis had no impact on this patient's sigmoid colon and

rectum during the April, May and June hospital admission?

A No, I can't tell you that.

Q Doctor, I want you to assume that Dr. DeLorenzo has said that the cervical spine problem was related to his abdominal process. Do you agree or disagree with that statement?

A Not to the abdominal process which acutely caused the patient to present, not in my opinion.

Q Doctor, let me give a scenario. Hypothetical. Patient with a history of diverticulosis, number one. Number 2, a patient who is 69 years old and has cervical stenosis. Number 3, the patient has a problem that results in a lower sigmoid colon and rectum not evacuating properly and has a build up of fecal matter. Number 5 -- 4?

A 4.

Q Thank you. Number 4, because of the diverticulum and the build up of fecal matter the patient develops diverticulitis. Now Number 5, diverticulitis causes a perforation. Now number 6, the perforation results in an abscess. Now number 7, that abscess results in an obstruction of the small intestine. Do you have the scenario?

A This is a hypothetical?

Q Yes. Do you agree that that is a medical, plausible hypothetical?

A Yes, it is.

MS. HIRSCHHORN: Objection.

THE COURT: Overruled.

Q Doctor, were you aware, number one, and we now know, Mr. Savino had a cervical stenosis, correct?

A Yes.

Q Number 2, when Mr. Savino was admitted to the hospital it was culled a K.U.B., kidneys urinary bladder, films were done?

A Yes.

Q Were you aware those films demonstrated a significant accumulation of fecal matter in the lower portion of the bowel including the sigmoid colon?

A Yes.

Q Doctor, is it plausible that the reason for that build up was the cervical stenosis?

A Among other explanations, yes.

Q Doctor, since there was never any specific evaluation done at that time, you cannot exclude the cervical stenosis as the cause.

MS. HIRSCHHORN: Objection.

THE COURT: Overruled.

A In my opinion, I can.

Q So you don't believe it's possible.

A I did not say it's not possible. I said in this patient I do not feel that's what happened.

Q Doctor, was there any description of the rectal sphincter?

A Not in my reading.

Q Would it be important, in order to decide whether there had been any nervous system involvement compacting the rectum, to have a description of the rectal sphincter?

A It will be a factor, yes.

Q I'm sorry?

A It will be a factor.

Q Doctor, when you're doing a rectal exam on a patient, should you document your findings with regard to any impact on the rectal sphincter of the nervous system?

A (No response.)

Q Withdrawn. Should you describe what you found?

A You should describe any abnormality you fin.

Q Doctor, how many rectal exams were done on this patient?

A I don't know.

Q Were any documented?

A At least Dr. Klein in evaluating his prostate had to do a rectal examination. Beyond that I can't answer. There's also notations the patient was disimpacted manually, and that

requires going in through the rectum. So if that qualifies as an examination, that also --

Q In order to decide whether the cervical stenosis that you agree was present in April was impacting on the rectum, it will be helpful to have a description of the tone of the rectum, correct?

A Yes.

Q That's not there.

A There's no description of abnormal tone seen.

Q There's no description of tone, doctor.

A Correct.

Q Doctor, let's talk about the trabeculations of the bladder. Do you recall that?

A Yes.

Q Doctor, this patient had trabeculations of the bladder, correct?

A It was seen on intravenous pyelogram, yes.

Q That means yes?

A Yes.

Q And what that means is that there was some impact that resulted in the bladder wall thickening because it was using more of its muscle strength to push out the urine, is that a fair summary?

A Yes.

Dr. DiGiacinto - for Deft - Cross

Q Now, doctor, you're not suggesting that in a 69-year-old man that because he may have had some problem with his prostate that resulted in trabeculations that he could not have on top of that an impact on the nervous system that resulted in a neurogenic bladder, are you?

A Based on the information available, I don't see evidence of a neurogenic bladder and I see evidence of an enlarged prostate and a finding on intravenous pyelogram consistent with that enlarged prostate. Based on that, my conclusion is that most of the evidence we have points to the prostate as being the reason for the urinary retention.

I cannot completely rule out any contribution from the cervical spine.

Q Doctor, you understand that part of the claims that the plaintiff is bringing in this lawsuit is that there should have been a neurological evaluation of the patient.

A Yes, I do understand that.

Q And, doctor, isn't it fair to say that the very information that you're talking about that you don't have available to you would be available to you had a neurological evaluation been done and documented in the chart?

A Most likely yes.

Q Doctor, so what you're saying is, based on the fact that it's not written down in the chart, you can't comment to

any reasonable degree of medical certainty as to whether there was any impact on this patient's bladder from the cervical stenosis.

A I can to a degree of medical certainty, not with absolute certainty, comment on that based on the information I have.

Q Doctor, you have to base your opinion on the data that's in the chart. Correct?

A Yes.

Q And a very significant piece of data is completely absent from the chart, and that's a full neurological exam, correct?

A A useful piece of information is absent from the chart, yes.

Q Doctor, if you're trying to decide whether a patient has a neurological impact on the bladder from the cervical stenosis, that's not just an additional token piece of information, that's a very important piece of information for you to make your decisions, isn't it?

A Specifically the neurological examination would give us information that potentially would be relevant to the function of the bladder. It would not define the bladder function any better or any worse, and urological consultation would be required to get that information.

Q But what it will do is give you information about other areas of the patient's body that would then lead you to conclude that there may or may not be a problem with the cervical spine impacting on the bladder, correct?

A Yes, I agree with that.

Q Okay. Doctor, Dr. Zola has described this patient as being quadriparetic on discharge from the hospital on June 19, 1980. Were you aware of that?

A Yes.

Q Doctor, let's assume that this patient was quadriparetic on discharge from the hospital on June of 1980, okay?

A Yes.

Q Now, can we agree, doctor, that, number one, what you're saying is that that picture of the patient being discharged in June of 1980 is consistent with the debilitation from his surgery, is that what you're saying?

A And his medical condition, yes.

Q Okay. Doctor, is it also consistent with the problems of the cervical spine causing quadriparesis?

A Yes.

Q You cannot, based on the data that you have available, exclude the cervical spinal problem as a cause of his quadriparesis, can you?

A No, I cannot.

Q Doctor, one of the ways that you will be able to exclude a problem with the cervical spine as a cause of his quadriparesis was if a neurological examination and evaluation had occurred, correct?

A I don't think it could have excluded it present or absent. I'm not sure if that answers the question.

Q It will be helpful to you in trying to draw a conclusion as to why my client was weak in all four extremities, it will be helpful?

A Yes.

Q If you had a neurological exam and evaluation?

A Yes.

Q And you understand that in part that's the claims that are being made here.

A Yes, I do understand that.

Q Now, doctor, we've heard much testimony about differential diagnosis. We've heard it defined. Doctor, differential diagnosis, the patient has a problem which is observed by the doctor, you create a list of potential causes and then you undergo evaluation to ascertain which of the causes is, in fact, the cause of the patient's quadriparesis?

A Yes.

Q Now, would you agree that a neurological etiology

would have to be part of the differential diagnosis?

A Yes.

Q Would you agree that there was nothing done to rule out a neurological etiology as the cause of the quadriparesis?

A I'm not exactly sure what you mean by nothing was done to rule out. If you mean a neurological examination was not specifically documented in a chart, the chart shows that, it's self-evident.

Q What I'm saying, doctor, is very simply if you have more than one potential cause for a patient's problem, a doctor cannot assume that, well, he's got this, I'll assume its cause number one, and do nothing to find out whether it's cause number two.

MS. HIRSCHHORN: Objection.

THE COURT: Overruled.

Q Can a doctor do that in the process of differential diagnosis?

A I'm sorry, do the first part. In between I lost it.

Q My client was quadriparetic when he left the hospital in June of 1980, correct?

A Yes.

Q Now, two of the causes for that quadriparesis that you've identified, number one, neurological, number two, debilitation, correct?

Dr. DiGiacinto - for Deft - Cross

A Yes.

Q Can a doctor who's practicing in accordance with good and acceptable practice just assume it's a debilitation and not rule out a neurological problem as its cause?

A No.

Q And if a doctor did, in fact, assume it's a debilitation and do nothing to rule out a neurological cause for the quadriparesis, that doctor would be departing from good and acceptable medical practice, wouldn't he?

A It's based on the doctor's opinion as to what he was seeing. If there was clearly a neurological cause in the diagnosis, if that cause would have impacted upon the patient and changed his course of treatment, then I would agree with your statement.

Q Doctor, quite simply I'll ask it again. If there are two things on the list, one neurologic and one non-neurologic, and the doctor assumes it's non-neurologic and does nothing to rule out the neurological cause, would that doctor be departing from good and acceptable medical practice?

A It's too general a question to answer. Because the doctor is looking at the whole patient and the doctor does not have to say oh, there's no other possibility to cause this, but I see weakness and I see an explanation and I'm watching the patient to see if he gets better. If he said there's a

neurological disease and I'm not going to pay any attention to it, and not paying attention to that neurological disease led to a devastating outcome in the patient because he didn't pay attention to it, then I'd have to agree with your statement.

But in general when a patient is being evaluated on a urology service and on a surgery service, the frequency of any kind of concise neuro evaluation on a chart in this type of patient is rare.

So in the standards of care which I've been asked to address in this community, no, that would not constitute a departure in this patient.

Q If Dr. DeLorenzo's testimony was correct and that a decompressive laminectomy would have reversed his quadriparesis and he would have had a much better outcome than the ultimate demise he did, then he would have been able to reverse a tragic outcome, correct?

A In this case, my opinion is no.

Q I asked you--

A Depending -- well, you didn't -- sorry.

Q I asked you if Dr. DeLorenzo was correct.

A In stating what, sir?

Q In stating that a decompressive laminectomy would have improved his outcome.

MS. HIRSCHHORN: Objection.

THE COURT: Sustained.

Q Doctor, this patient had an abscess in his belly, his abdomen, correct?

A The record indicates such, yes.

Q And that abscess was a result of the perforation.

A Yes.

Q Now, as a result of that abscess, he had an infection that was within his entire system, or it's called a sepsis, correct?

A Yes.

Q During the period of time that that perforation occurred and the sepsis developed, my client got very, very ill, didn't he?

A The record indicates that, yes.

Q Now, what the doctors did surgically was go in, remove the abscess, repaired the obstruction, put in a colostomy, correct?

A Correct.

Q They also treated the systemic infection by giving the patient antibiotics into the vein, correct?

A Yes.

Q Now, during the period of time that that infection, that sepsis and abscess were going on, many of Mr. Savino's organs were impacted on by the infection, correct?

A Yes.

Q Now, that impact was what Dr. Zola has characterized as a transient impact, do you agree with that?

A He was getting better, so the answer is yes.

Q Doctor, when this transient impact resolved, when he was no longer in liver failure -- withdrawn, do you think he was ever in liver failure?

A I wouldn't qualify myself as an expert to really be able to comment on that.

Q When the transient impact was reversed and the patient no longer had abnormal liver function tests and no longer had abnormal renal function testings, this patient's clinical condition was improving, correct?

A Yes.

Q And, in fact, doctor, his condition was so improved that by ten days before discharge he no longer needed intravenous medication, correct?

A If the chart so indicates, I won't dispute that.

Q He no longer needed hyperalimentation, correct?

A Again, same stipulation.

Q He was eating, correct?

A Same stipulation. I mean, I don't remember the exact details of those days, I'm sorry.

Q Doctor, you have said that his condition was so bad

on June 18 that he couldn't have a myelogram and he wouldn't be a candidate for surgery. And I'm questioning you about his condition at that time. Are you telling me you don't know that he was eating then?

A You're asking me ten days before discharge as opposed to eight days or seven days, by the time of discharge, yes.

Q Within seven days of discharge are you familiar with his clinical condition?

A Yes, yes.

Q So within seven days of discharge he was eating, wasn't getting IVs, wasn't getting intravenous antibiotics, wasn't receiving hyperalimentation, was alert, oriented and talking with family and health care providers, according to the Nurses Note.

Is that a fair summary of his condition at that time?

A Yes.

Q Now, doctor, you have said that this patient's condition at that time was such that he cannot have undergone a myelogram. Correct? Do you recall saying that?

A Correct.

Q Now, part of your assumption when you made that condition was that he did not have a significant compressive problem with the cervical spine, correct?

A No, sir.

Q No? Even if he had a significant--

THE COURT: No it was not your assumption or no he didn't have a significant compression of the cervical spine?

THE WITNESS: No, it was not my assumption.

Q If he had a significant compression of the cervical spine, would your opinion change when you did the risk/benefit analysis?

A No.

Q So his clinical condition had nothing to do with whether a myelogram would be done or not?

A His clinical condition had a lot to do with whether a myelogram would be done, yes.

Q Doctor, we've just described the patient who was recuperating from surgery and has no impact on any of his organ systems.

A Recuperating is what has to be underlined, sir.

Q Does that mean he had impact on any of his organ systems at that time?

A He was getting better and building up, so it was organ systems and numbers were looking better and better, but he certainly has not completely reversed his catabolic or tear-down state, and was in the process of hopefully building up his

overall condition to improve the tolerance of any procedure at this point in time that we're discussing.

Q Have you ever done an emergency decompressive laminectomy?

A Yes, I have.

Q The reason you do an emergency decompressive laminectomy is because you want to reduce pressure on the spinal cord before it does irreversible damage?

A Definitely.

Q This fact is known and well known, and you were trained at Presbyterian to know, number one, that the longer there's compression on the spinal cord the more damage is being done, correct?

A Yes.

Q There comes a point in time when there's pressure, the damage becomes irreversible, correct?

A Yes.

Q If the pressure is allowed to continue, more and more damage is done until the pressure is relieved, correct?

A More and more damage can be done, and if there's evidence of progression then the answer is yes.

Q And, doctor, one of the reasons that a neurological follow-up of the patient with quadriparesis is done is to track whether there's progression of any compression on the spinal

cord, correct?

A Yes.

Q Doctor, you don't know because there's nothing in the record to tell you whether there was progressive change in this client's neurological status from compression of the cervical spine, do you?

A The information I have which surrounds that answer is that I have evidence in the charts that the patient improved metabolically, and as he was receiving physiotherapy was, quote unquote, getting stronger. I also have the information available after that discharge and upon admission in August that his arms were stronger than they were ever noted to be by anyone and, in fact, one observer thought they were almost normal, and that observer was a trained neurologist.

I have information that makes me thinks that the legs were about the same. I don't have very accurate information to make a good judgment of that.

Q About the same?

A That's the best I can do from the chart.

Q Spasticity in the lower extremities as opposed to no spasticity? That's about the same?

A Yes.

Q Doctor, I want you to assume--

MR. CARLUCCI: On page 18, your Honor, of Dr.

Burnstein's deposition, starting at line 22.

Q "Question: Can weakness due to neurological causes or other types of neurological deficits be quantified to a scale of zero to four?

"Answer: Yes, subjective quantification, not objective. Subjective, right.

"Question: Are you able to quantify the degree of weakness which you characterize in this case as severe?

"Answer: Yes.

"Question: How would you characterize?

"Answer: Minus 3. The Mayo Clinic system, just to educate you, is zero for normality minus four for total paralysis with no movement whatsoever, minus one, minus two, minus three for increasing degrees of weakness. That is why I labilized the severe as a minus three. The moderate is minus two in my physical exam."

To assume that's what Dr. Burstein, the operating neurosurgeon, found in his evaluation, would you agree that there was a change in his condition from June 18 to the August admission?

A Yes.

Q That is progression --

A I'm sorry, I have to take that answer back.

Q Okay.

A The question you asked was a change from June 18 to the August admission, no.

Q Doctor, you've indicated that you believe that there was a cervical stenosis impacting on this patient's cervical spinal cord in April, May and June of 1980, correct?

A Yes.

Q You can't quantify how much of an impact, can you?

A I can to a degree quantify, but not with extreme accuracy.

Q Doctor, how are you able to quantify what degree it impacted on his spinal cord on April 27 as opposed to June 18?

A Based on all the information I have available or based just on that segment of information, sir.

Q Based on all the information you have available?

A In August the patient's arms are moving well so that a trained neurologist on the admission on August 5 states that the arms are almost normal. And he doesn't even think there's a problem in the cervical spine. So the neurology expert feels that the arms are basically okay at that point. Based on that, I feel that the upper portion of the muscular system was functioning as well or better than it ever had.

I have less information to tell me what's going

on with the legs from the day of admission in April to the day of admission in August. My reading of the chart is that it's more or less the same, and that there is some evidence on physiotherapy of improvement of the lower extremities. I cannot be more accurate than that because the information is not available.

Q The patient is spastic in the lower extremities, that indicates that there's a significant impact on the nervous system, doesn't it?

A It indicates that there is cervical cord compression as a possible etiology, yes.

Q Doctor, you're not suggesting the spasticity this patient had in August was unrelated to the cervical stenosis, are you?

A It could be related to thoracic stenosis or something like that, but it probably was, yes.

Q Doctor, doctor --

A I mean, as the etiology I can't say that; as the probable etiology I'm saying yes.

Q The most probable based on all the available data was the cervical stenosis, wasn't it?

A Yes.

Q Now, the cervical stenosis that was causing this patient's spasticity in the lower extremity was not such that

it caused spasticity in June of 1980, was it?

A We don't have a good neurological examination to know that, sir.

Q Exactly. In order for you to offer an opinion you need a good neurological exam to see whether there had been progression of the system?

A With relationship to the spasticity, yes.

Q What about sensation? Was the sensation also impacted on by a problem of the cervical spine?

A Yes, it is.

Q Doctor, you're not going to say that this patient's cervical stenosis had no impact on the sensation during the April admission, are you?

A I can't make a judgment positive or negative in that area.

Q The chart doesn't have sufficient data?

A Correct.

Q Doctor, I want you to assume that we've had testimony that one of the reasons that Michael Savino developed bedsores was he had lack of sensation. Okay? I want you to assume that.

A Yes.

Q Is it fair to say that that lack of sensation was as a result of the cervical spinal stenosis?

Dr. DiGiacinto - for Deft - Cross

A I have no way of knowing that versus peripheral vascular disease which the patient also had.

Q I want you to assume that we had a surgeon on yesterday who said that the peripheral vascular disease was limited to the left lower extremity. I want you to assume that.

A Yes.

Q Can we agree the if there's a sensation problem in the sacrum that that problem would then be unrelated to peripheral vascular disease and more likely caused by the cervical stenosis?

A Yes.

Q Doctor, when for the first time did this patient exhibited diminished sensation during that admission?

A I would have to review I believe the Nurses Notes to see any mention of that. I would be glad to do so if you like.

Q (Handing.)

A Can you help me find my way?

Q I can't force you to something that's not there, sir.

A It will take a while, then. Is this the first admission, part one or two?

Q Yes.

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

Q Doctor, there is no description of sensation in the chart, according to your review, isn't that correct?

A There were mentions of loss of sensation in I believe Nurses Notes.

Q I'm not familiar with what you're referring to.

A (Referring.)

Q Doctor, why don't we move along?

A Yes, sir.

MS. HIRSCHHORN: Your Honor, may we approach?

(An off the record discussion was held.)

Q I'm going to ask the question in a different form.

A Certainly.

Q Other than an entry that indicates that there was lack of sensation in the left hand, was there any description in the record, to your recollection, of any problem with sensation in the sacrum?

A No. Not to my recollection.

Q Doctor, you do know, however, that he did have a sensation problem in the sacrum, from testimony that he developed a bedsore because of in part he couldn't feel that there was a compression, would you agree with that?

A I can't agree with that statement in toto, no. Many patients who have no neurological problem develop bedsores.

Q This patient.

A I can't answer it beyond that without the information available.

Q I want you to assume that we've had testimony that the patient did have difficult my initial sensation in the sacrum. Okay?

A Yes.

Q Number one, number one, is it important in doing an evaluation to detect whether a patient has a problem with sensation?

A It's helpful, yes.

Q Doctor, this patient had a history of arthritis?

A The chart indicates, yes.

Q He was 69 years old?

A Yes.

Q Doctor, is it fair to suspect and anticipate in your evaluation of a patient such as that that he may have a degenerative process in the spine?

A It's always a consideration in anyone in that age group.

Q And since it's always a consideration of anyone in that age group, particularly with arthritis, one should be looking for any potential impact on the spinal cord from degeneration of the spine column, correct?

A In a group of a hundred patients of this age admitted, it's too much of a generalization to fully agree. It's again one of the things that a physician is aware of, yes.

Q So when you do your overall evaluation of a patient such as this you should check for sensation.

A It will be part of your evaluation, yes.

Q Doctor, did Drs. Zola, Zuflacht and Bagdonas document any evaluation of a problem with this patient's sensation?

A Not to my knowledge.

Q Doctor, would you agree that the medical record is something that is important in the normal course of running a hospital?

A Yes.

Q And, in fact, it's something that's important for you doctors to use to communicate to each other, among other things, base line conditions?

A Yes.

Q Doctor, in evaluating this patient, you would want to know when sensation first became a problem, would you not, as a neurosurgeon?

A It will be a piece of information that would definitely be useful.

Q Well, doctor, as you say, in your experience cervical decompressive laminectomies are done to prevent further

progression of a problem, correct?

A Yes, yes.

Q Isn't it important to delineate whether there has been progression of a problem?

A Yes.

Q One of the things that you want to delineate is progression of neurological impact on the motor system, correct?

A Yes.

Q One of the things that you want to delineate is progression of neurological impact on the sensory system, correct?

A Yes.

Q One of the things that is progression or effect from the neurological system is bowel functioning, correct?

A Yes.

Q One of the things you want to know is progression from the neurological aspect of impact on a bladder problem, correct?

A Yes.

Q Doctor, that's why you need to document things in the chart such as when sensation first became a problem, correct?

A It is certainly helpful.

Q Doctor, it's more than helpful, it's necessary, isn't

it?

A It is certainly helpful.

Q Does that mean it's necessary or not?

A Yes.

Q Doctor, an accurate description of a patient's motor strength, is it also important so that you can document and know whether there's been any problem from a cervical stenosis impacting on the motor system, correct?

A Yes.

Q Now, you don't have any documented delineation of what level of motor strength this patient had on discharge in June of 1980, do you?

A I can't agree with not any, unless you're talking about the day or around the days of discharge, then I agree.

Q Doctor, if you look at the last seven days of the Progress Notes, the last seven days of the Progress Notes, and then you took that and you saw the patient one week later and you did an examination of the patient's motor system, could you compare to it what's documented in the last seven days of the Progress Notes and tell whether there had been any change in my client's muscle strength?

A No.

Q Therefore, you as a neurosurgeon could not tell that there was a progressive problem and, therefore, I had better

intervene now to prevent any further progression, correct?

A Based on the scenario you presented, no.

Q Now, let's take a patient who's discharged from the hospital on June 18 with a known problem with mobility, who cannot move by himself, who cannot bear weight at all, who required ambulance transportation, who has, as you've told us, a cervical stenosis. Okay, let's take that patient, send him home, see him again on July 5. Okay? Then you as a neurosurgeon see him on July 8. Okay, are you with me?

A Yes.

Q Now, number one, you see the patient, he's got a problem with mobility on July 8. You would want to look at the record and see whether there's been any progression of system, would you not?

A Among other things, yes.

Q You're not suggesting that that would be a minor thing that you will do, are you?

A It would be minor relative to talking to the patient.

Q Okay. You'd want to know what a trained observer found on his or her examination, would you not?

A As part of the evaluation, yes.

Q Now, based on the data on the July 5 visit, do you have anything that would tell you what the strength of my client's motor system was?

A No, none whatsoever.

Q Doctor, are you saying that it's okay, when a patient leaves the hospital on June 18 with a documented known problem with mobility, to fail to examine the patient for motor strength?

A I think part of the evaluation might include that, yes

Q Might or should?

A It very much depends on the setting in which the patient was being seen. I cannot be totally specific. It certainly would be valuable information, without question.

Q Doctor, we're not talking about a sophisticated exam here, are we?

A I don't believe so, no.

Q What you do is you put some fingers out and say grab my finger and squeeze?

MS. HIRSCHHORN: Objection.

Q Isn't that what you do?

THE COURT: What's your objection?

MS. HIRSCHHORN: I think he's putting words into the doctor's mouth as to what he means.

THE COURT: This is cross-examination. Overruled.

MR. CARLUCCI: Can I have my question read back?

THE COURT: Yes.

(Court Reporter complying.)

A It might be part of an examination, yes.

Q It's one of the things you do, and you do other things to evaluate motor strength, don't you?

A You could, yes.

Q Tell us what a simple evaluation for motor strength would be.

A It would involve allowing the patient to make a motor movement such as bending the arm or lifting the arm against resistance, against an examiner's hand, trying to stop him from doing what he's asked to do.

Q (Indicating.) This is your hand, this is my hand, you tell me to push.

A It may be part of it, yes.

Q You tell me to pull.

A Yes.

Q That's something that can be done very quickly, correct?

A Yes.

Q Doesn't take a whole lot of time for the exam. You do it for the lower extremities also, correct?

A That is correct.

Q Then you make an assessment of the level of resistance.

A Yes.

Q Then you go to your chart when you're examining him, when you examine this patient, go to your chart and you document what you found, right?

A Yes.

Q And the reason you're doing that is because the following day if someone comes in and does the same thing and there's a significant change, the only way they will be able to know that is if you wrote it down.

A Unless the patient could inform you of it.

Q Well, doctor, can patients quantify a progressive deterioration in the motor strength? Is that something you found patients able to do?

A Yes.

Q Isn't that exactly what Mr. Savino did when he went into the hospital in August, didn't he report that I've become progressively weaker since August of 1980?

A I don't believe that Mr. Savino specifically made that statement. I may be incorrect.

Q What Mr. Savino did, doctor, is, in substance, describe a condition that an examining doctor interpreted as a progressive weakening since April of 1980, is that a fair statement?

A There is a statement that reflects that, yes.

Q Patients don't come in and say by the way, doctor, I've had a progressive quadriparesis since April of 1980, do they?

A No.

Q They come into doctors like you and describe what's happened to them over the last several months, then you as a physician interpret that description into a medically identifiable term, correct?

A Yes.

Q That's exactly what happened here, a physician who took the time to take a history and put things together, listening to the patient, described a progressive quadriparesis since April of 1980, correct?

A I believe that statement is in the chart. How he arrived at that statement is what I can't comment on. I wasn't there.

Q Do you have any reason to disagree with it?

A The statement was in the chart, no.

Q Doctor, if as you say the only reason to do a decompressive laminectomy is to correct and stop progression of the disease, and if, as this doctor has written, this patient has had a progressive quadriparesis since April of 1980, isn't it fair to say, then, doctor, that there was a significant period of time where surgical intervention could have been done

to stop the progression of the disease?

A You'll have to define significant period of time to me

Q April to August.

A No.

Q Are you saying that at no time in that period that surgical intervention occurred there would be no improvement in the patient's condition?

A I think it's very unlikely that this patient would have sustained any functional improvement in any period of time.

Q How about prevention of further deterioration?

A Yes.

Q There would have been?

A Yes.

Q Now, you have told us that the patient was in the best metabolic condition on the August admission that he had ever been. Do you recall saying that?

A In the period of time that we're dealing with from April until August, he was better in August than at any point that I have information available on him.

Q Doctor, you have no information about his metabolic status on July 5, do you?

A Only in the sense that he's still recovering from his process. Time has to pass. I don't need a protein reading or

anything else to know that he's still recovering.

Q Protein. Let's talk about protein and healing. His surgical wound healed, correct?

A Yes.

Q The protein problem that's been used in this courtroom for the last week would have impacted on the healing process, wouldn't it?

A Yes.

Q His surgical wound was clean, dry, intact and healing well on discharge from the hospital, wasn't it?

A Yes.

Q His protein problem did not prevent the abdominal wound from healing, did it?

A No.

Q In fact, the protein problem was resolved by the time he was discharged, wasn't it?

A I don't know that, but you can show me the numbers.

Q Doctor, can we say, to a reasonable premise, that if a physician feels that a problem is no longer significant that he or she will not order tests to evaluate it?

A Yes.

Q Was there a protein test taken on June 18?

A Not that I'm aware of.

Q Okay. Doctor, isn't it a fair premise to say the

reason it wasn't taken was because the protein problem had resolved?

A I think if you say was resolving I would agree with you fully; had resolved, I can't answer.

Q The way you'd be able to answer is if there was a lab test done, correct?

A Yes, it will be helpful.

Q You're not going to be critical of her not taking a protein test on discharge, are you?

A No.

Q Doctor, we were talking about the lack of examination on July 5.

MS. HIRSCHHORN: Objection.

THE COURT: What's your objection?

MS. HIRSCHHORN: The way the question is phrased, the lack of examination I think is improper and not suggestive of a meaningful question, and I take exception.

THE COURT: Overruled.

Q Does the July 5 record reflect any examination of muscle strength?

A No, it does not.

Q Does the July 5 record reflect any examination of this patient at all other than looking at the incision, looking