SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF SUFFOLK : PART 28

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MELINDA PALMESE and MARK PALMESE,

Plaintiffs,

- against -

BROOKHAVEN MEMORIAL HOSPITAL, DR. LEON FINKELSTEIN, DR. HENRY MORETA, DR. MARK GUDESBLATT, DR. JEFFREY EPSTEIN, DR. R. JAMES SEYMOUR and JRJC BODY SALON, INC., d/b/a THE BODY SHOPPE,

Index Number 16832/91

Defendants.

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February 24, 1997
Riverhead, New York

B E F O R E:

HON. ALAN D. OSHRIN,
Supreme Court Justice,
and a Jury

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

HARLEY & BROWNE, ESQS.
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BY: ROBERT G. HARLEY, ESQ.
For the Plaintiffs

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For Defendant Brookhaven Memorial Hospital

TESTIMONY OF DR. GEORGE V. DiGIACINTO

(Appearances continued on following page)

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KRAL, CLERKIN, REDMOND, RYAN, PERRY & GIRVAN, ESQS.
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WILLIAM K. COYLE
Supreme Court Reporter

COURT CLERK: Trial continued.

Do Counsel waive the Jury roll call?

MR. HARLEY: Yes.

MR. SNYDER: Yes.

MR. ROTH: Yes.

MR. GIRVAN: Yes.

THE COURT: Members of the Jury, the plaintiffs have rested.

You recall you heard one witness for the defendant taken out of order. With that testimony before you, we now reach the point where the defendants may present any testimony they feel they wish to.

Mr. Snyder.

MR. SNYDER: Yes. Thank you, your Honor. I call Dr. DiGiacinto.

(Whereupon Dr. DiGiacinto took the witness stand.)

COURT CLERK: Would you raise your right hand, Doctor?

D R. G E O R G E V. D i G I A C I N T O,
being first duly sworn, was called as an expert witness by the Defendant and testified as follows:

COURT CLERK: Please state your name and address for the record.

THE WITNESS: George Vincent DiGiacinto, 425 West 59th Street, New York, New York 10019.

COURT CLERK: Thank you, sir.

THE COURT: You may inquire.

MR. SNYDER: Thank you, your Honor.

DIRECT EXAMINATION

BY MR. SNYDER:

Q Dr. DiGiacinto, please try to keep your voice up so we all can hear you.

A Yes, sir.

Q Doctor, are you a physician and surgeon duly licensed to practice medicine in the State of New York?

A Yes, I am.

Q And when were you so licensed, sir?

A I was licensed in 1974.

Q And Dr. DiGiacinto, beginning with your college education and proceeding through medical school, and any subsequent postgraduate training that you had, would you please advise the Court and Jury of your background and training in medicine?

A Yes, I attended Columbia College in New York City, graduating in 1966.

From 1966 to 1970 I attended the Harvard Medical School in Boston, and graduated with an M.D. Degree in that year.

From 1970 to '72 I was a Surgical House Officer at the Roosevelt Hospital in New York City.

Between 1972 and '74 I was a Medical Officer in the United States Navy.

Starting in 1974 and finishing in July of 1978, I did a Neurosurgical Residency training program at Columbia Presbyterian Hospital in New York City.

Since 1978 I have been in the practice of Neurosurgery.

Q And Doctor, are you currently affiliated with any hospitals?

A Yes, I am.

Q And what hospitals are those, sir?

A I am the Director of Neurosurgery at St. Luke's Roosevelt Hospital in New York City, and I'm the Attending Neurosurgeon at Harlem Hospital in New York City, and at Beth Israel Hospital in New York City as well.

Q And Doctor, are you Board Certified in any areas of medicine?

A Yes, I am.

Q In what area?

A In Neurosurgery.

Q And when were you so Board Certified?

A In 1981.

Q And Dr. DiGiacinto, do you devote your practice of medicine to any particular area?

A Neurosurgery exclusively.

Q And Doctor, have you contributed any articles to learned Peer Review journals or contributed to textbooks in the field of Neurosurgery?

A Yes, I have.

Q And approximately how many, sir?

A Approximately twenty articles.

Q And Doctor, do you also hold any

academic appointments in the field of medicine?

A I'm an Instructor in Neurosurgery at Columbia Presbyterian Medical Center.

Q And Doctor, is that the Neurological Institute?

A Neurological Institute, yes.

Q What's the Neurological Institute?

A The Neurological Institute is a, I don't know if I'd call it a non-entity, it's the part of the Columbia Presbyterian Medical Center that deals exclusively with neurology and neurosurgery. It was, and still is, a building. A one time, when I was training, all neurosurgery and neurology was done within that building. Now the operating rooms have moved into the main hospital, but it still exists as a building itself.

Q Doctor, you indicated that you are an Instructor in Neurosurgery at Columbia Presbyterian?

A Yes, correct.

Q And do you actually teach neurosurgery?

A Yes.

Q To whom do you teach neurosurgery?

A Residents who are in training in both neurological surgery as well as general surgery at

Columbia Presbyterian, at St. Luke's Roosevelt, and at Harlem.

Q Dr. DiGiacinto, at the request of my office, did you review certain materials pertaining to the care and treatment of a patient by the name of Melinda Palmese?

A Yes, I have.

Q And do you remember when my office first contacted you, approximately?

A Late in 1992.

Q And Doctor, do you recall what materials you reviewed at the request of my office?

A At that time I reviewed a copy of the hospital record relative to the admission in February of 1989, as well as subsequent treatment at Mount Sinai Hospital, and treatments that followed upon that admission, several Mather Hospital records, in addition I reviewed transcripts of examinations before trial, I think that's the right term, of the plaintiff and of, I believe, all of the defendants in the trial.

Q Doctor, those, you received the materials from time to time from my office as they became available?

A Yes.

In addition I reviewed X-rays which were sent by the office, and I've also seen trial transcripts from this trial itself.

Q What trial transcripts have you seen from this trial?

A Testimony of Dr. Seymour, Dr. Finkelstein, and Dr. Miller.

Q Yes.

A I believe those were the ones that I have seen so far.

Q And Dr. Miller's testimony you just read over the weekend?

A Yes.

Q And Dr. DiGiacinto, with regard to those X-rays that you mentioned, did they include various imaging studies from Brookhaven Memorial Hospital?

A Yes.

Q Did they include MRI's?

A Yes.

Q CAT scans?

A Yes.

Q Post-myelogram CAT scans?

A Yes.

Q A myelogram itself?

A Yes.

Q By the way, did you review any films from other areas?

A I reviewed films that dated back, as far back I think as 1987 or '88, prior to this admission to the hospital. I don't remember exactly where they came from.

Q Dr. DiGiacinto, are you being reimbursed for your time here in court?

A Yes.

Q And at what rate?

A I will be paid $2,500 for today's testimony.

Q And Doctor, are you also being reimbursed, or have you been reimbursed for the time you spent reviewing the various materials that were sent to you and the times that you discussed the matter with me personally or with other attorneys from my office?

A Yes.

Q And at what rate is that, sir?

A Two hundred fifty dollars an hour.

Q Doctor, have you testified in the past?

A Yes, I have.

Q And have you testified for my office?

A Not to my recollection.

Q Doctor, have you reviewed other files from my office?

A Yes.

Q Do you know how many?

A I think two or three, I'm really not a hundred percent sure.

Q Sir, have you reviewed files on behalf of other defendants in medical malpractice cases?

A Yes, I have.

Q And have you reviewed files on behalf of plaintiffs in medical malpractice cases?

A Yes, I have.

Q And Doctor, what would you say the breakdown is in terms of the amounts you reviewed for defendants or plaintiffs, if you can give a percentage?

A I think about two-thirds for defendants, and one-third for plaintiffs, that's a very rough guess.

Q Thank you, sir.

Dr. DiGiacinto, I'd like to show you --

MR. SNYDER: Can the doctor please have the Brookhaven Memorial Hospital record.

COURT OFFICER: (Handing Plaintiffs' 1 to the witness.)

THE WITNESS: Thank you.

Q Doctor, that's the original of the Brookhaven Memorial Hospital record, it's been marked in evidence.

You've seen copies of that?

A Yes, sir.

Q All right. And when you were referring to the hospital record of 1989, that's the hospital record you were referring to, is that right?

A Yes.

Q And Doctor, this patient was admitted to the hospital after having complained of a sudden onset of pain in her back and lower extremities?

A That is correct.

Q Doctor, ultimately the patient was seen by neurologists -- and by the way, what's the difference between neurology and neurosurgery, if you would?

A Neurology is the specialty that's devoted to the diagnosis of diseases involving the nervous system, brain, spinal cord, nerves as they go out, and the muscles as well.

The main difference is that the neurosurgeons are not quite as involved in the diagnosis of some of the entities as involved in others, but the main difference is that neurosurgeons actually perform surgery and anything that's, that can be corrected by surgery. A neurologist does not perform surgery of any kind.

Q Doctor, let me ask you something. If a neurosurgeon is called in to consult on a case, is the determination to perform an operation one made by the neurosurgeon?

A Yes.

Q Can someone else tell a neurosurgeon that he has to perform surgery?

A It can certainly be suggested, but the neurosurgeon is the one with the expertise to know whether or not there was an indication, to know whether it's practical to do that surgery, and really is the one that makes the decision, he can't be compelled by someone else to do surgery.

Q And Doctor, you told us you reviewed various imaging studies that were taken of this patient?

A That is correct.

Q Doctor, based upon your review of the hospital records, did the physicians who were treating Mrs. Palmese at Brookhaven Memorial Hospital, undertake an exhaustive workup to try and determine whether or not there was any --

MR. HARLEY: Objection.

MR. SNYDER: I'll withdraw the term, if he doesn't like that.

Q Did the doctors at Brookhaven Hospital undertake a workup to determine whether or not there was a pathology that might have been responsible for the patient's symptoms and complaints?

A Yes, they did.

Q And Doctor, from a neurosurgical standpoint, are the various imaging studies important?

A Yes.

Q Tell us why.

A Which ones?

I'm sorry, I didn't --

Q The imaging studies we're talking about now, MRI's, for instance, of the spinal column, CAT scans of the spinal column, myelograms, tests of those nature.

A I didn't understand the question. I apologize.

Q Are those kinds of studies important, from a neurosurgical standpoint?

A Yes.

Q Why?

A The goal of a diagnostic workup is to determine if there's anything that's correctable affecting the patient's nervous system. In this particular case the spinal cord or the nerve roots coming from the spinal cord, the imaging studies, which are, some are X-ray studies, an MRI scan is technically not an X-ray study, enables us to get a very accurate view of the spinal cord and of the nerves coming from the spinal cord to determine if there's any identifiable pathology; very specifically in reference to this case, whether there's any compression of anything in either the spinal cord or the nerves coming from the spinal cord. That's why they are the major diagnostic

tools which would be utilized in this case.

Q Doctor, do these diagnostic tools enable a neurosurgeon, for instance, -- withdrawn.

Doctor, do you read these kind of films, do you read MRI's?

A I look at them. I don't render an official report, but I do look at them, yes.

Q You're capable of reading them?

A Yes.

Q When you say you don't render an official report, who does that, who renders an official report?

A A neuroradiologist would render an official report.

Q Is that the way it is at your hospital?

A Yes.

Q That's the way it is at most hospitals, right?

A I believe so, yes.

Q In fact the radiologist would always render a report with regards to some radiology studies, it may not be a neuroradiologist in certain hospitals, certain small hospitals?

A That is correct.

Q Doctor, I want you to assume that at Brookhaven Memorial Hospital these films are all interpreted by a neuroradiologist.

That would be appropriate, Doctor, right?

A Yes.

Q Now Doctor, did this patient present a difficult diagnostic problem?

A Yes.

Q Okay, tell us why, please?

A The patient presented with sudden onset of pain and a numbness and involved a neurological deficit including weakness and numbness which varied a great deal, as well as dysfunction in urinary and bowel symptoms.

Throughout the hospital admission multiple tests were done to determine if there was any evidence of compression of the spinal cord or the nerves coming from the spinal cord anywhere in the so-called neuro axis, meaning from the neck all the way down to the end of the spine. Throughout the performance of these studies there is no evidence of any compression ever identified anywhere. Therefore, the clear diagnosis of the

cause of the patient's neurological deficit just never became known.

MR. SNYDER: Your Honor, with the Court's permission I would like to look at some of the films with the doctor.

THE COURT: Doctor, you can step down.

THE WITNESS: Thank you.

(Whereupon Dr. DiGiacinto approached the shadow box.)

THE COURT: Doctor, when you testify, remember you are talking to the Jury and the Reporter, so if you stand closer to the rail and face both the Jury and the Reporter, it will help.

THE WITNESS: Yes.

Q Doctor, first of all even before we start looking at the films, why are studies such as these that were performed at Brookhaven Memorial Hospital, done, why are they undertaken?

A Again, the goal of the studies and the goal of the doctors taking care of the patient is to try to determine, number one, what's the cause of

the patient's problem, and number two, if there is anything surgically that should be done to correct it.

Therefore the goal of the studies in this particular case is to look for something pressing against the nerves or the spinal cord.

Q Now Doctor, you used the term neuro axis.

What specifically are you referring to?

A Well if you run your finger from the top of the brain all the way down your spine to the end of the spinal column, that's what we call, roughly, is the neuro axis.

Q And Doctor, what are the neural structures within the spinal cord, what are the neural structures that we're dealing with from the top of the spinal cord all the way down to the bottom?

A You mean within the spinal canal?

Q Yes.

A The brain obviously is in the skull, which ends in the portion of the brain stem called the medulla oblongata. The spinal cord starts at the base of the skull and runs through the cervical

thoracic vertebra and ends approximately at the T-12 level. At the end of the spinal cord --

MR. SNYDER: Referring to Exhibit, Defendants' Exhibit G, I'm sorry, the model of the spine.

A Yes, we start at the base of the skull, and the yellow, you can see in there is meant to represent the lining of the nervous system with the dura.

So if we run the finger from the base of the skull down to approximately T-12, this is the area in which the spinal cord runs.

The very end of the spinal cord, it's called the conus medullaris, coming out from the spinal cord, and to a lesser extent from the conus, are the nerve roots which will be going down to the lower extremities, and that, I think, you probably heard called the caudaequina or horse's tail. They are just nerve roots which are floating within the spinal fluid.

So the spinal cord starts at the base of the skull and ends approximately T-12 in the conus medullaris, and from thereon we are just dealing with nerve roots floating in spinal fluid.

Q When you say nerve roots are floating in spinal fluid, can you explain that, what does that mean?

A I think it's, it explains itself, they are literally just in there. If I move around, my nerve roots are just sort of flopping around in there, they're floating in the spinal cord.

Q Is there something that keeps the spinal fluid from leaking out?

A The dura or the lining membrane of the nervous system is covering the brain, it's covering the spinal cord, and it invests or covers the nerve roots until they go out about, oh, three-quarters of an inch away from the central dura itself. That's a water-tight seal which contains the spinal fluid.

Q Doctor, with regard to this membrane, the dura, we've heard the term thecal sac. What's a thecal sac?

A That's the dura.

Q Same thing, the terms can be used interchangeably?

A Essentially, yes.

Q Thank you, Doctor.

Doctor, this patient made certain

complaints while she was at Brookhaven Memorial Hospital, is that correct?

A Yes.

Q And these are called clinical complaints?

A Yes.

Q What is a clinical complaint, or what is a clinical assessment of a patient?

A A clinical complaint is something that a patient tells you about, that I have a pain in my ear, I can't see out of my eye, my foot is weak, those are clinical complaints.

The clinical assessment of a patient involves listening to the patient's clinical complaints and then doing a clinical examination, asking the patient how he or she feels a pin, or touch, and asking the patient to lift their arm up or their leg up and resist, pushing, that's how you get a clinical examination on a patient.

So the clinical assessment of the patient will include both clinical listening to the clinical complaints, and doing an examination.

Q Doctor, can the clinical assessment of a patient lead a physician to look in certain areas

to see what might be causing the findings that are elicited?

A Yes.

Q Okay, Doctor, what would a physician do in a situation such as presented by Melinda Palmese to try and look for the cause of her problems?

A The combination of her complaints would lead one to doing exactly what was done, which was imaging studies, myelograms, spinal CT's, CT scans, MRI scans, all of which would make an effort to look at the nervous system, along with the neuro axis, specifically the cervical thoracic and lumbar spine.

Q Doctor, why are those neuro imaging studies important to the practice of neurosurgery?

A Neurosurgery requires a diagnosis to make a decision about surgery.

One has to find the cause of something. In this case one would be looking for compression of something to decide that neurosurgery was indicated to treat that compression.

Therefore the neuro imaging studies would be the guide that will say: Yes, there is

something pressing on the spinal cord, pressing on the nerve roots, or there is not something. And that would really be the thing that determined whether neurosurgery was indicated or not.

Q In other words, the findings on the studies would be the determining factor?

A Yes.

Q For a neurosurgical determination regarding a particular patient?

A Yes.

Q All right. Now Doctor, by the way, a number of studies were done, a number of studies were done referable to this patient, they started with CT scans, there was an MRI of the lumbar spine, and there was a myelogram, then there was a post CT myelogram, and then there were MRI's again of the thoracic spine, and the cervical spine and the bone scan, is that right?

A Yes, sir.

Q Doctor, in your opinion, with a reasonable degree of medical certainty, did the physicians who were ordering these studies and were attending to this patient, order the appropriate studies for Mrs. Palmese?

A Yes, in my opinion they did.

Q Doctor, were there any other studies, imaging studies that could have been done to determine what was her problem?

A No.

Q Doctor, in 1989 MRI CAT scans, these were state of the art, is that right?

A Yes.

Q I understand that there are newer machines now, and some hospitals may have --

A The imaging studies have improved over the years, but the MRI scan is currently the state of the art study, which is not to say that myelograms and CT's after myelograms are not still utilized.

Q And Doctor, I would like you to look at, if you would, we're looking at Defendant's Exhibit H in evidence, for the record.

THE COURT: Okay.

Q Now Doctor, what are we looking at here?

A We're looking at a lateral X-ray of the lumbar spine in the sacrum. This is the sacrum. We can call this S1-L5, L4, L3, L2, and L1, and we're

seeing the lowest thoracic vertebrae, T-12.

We're also seeing the ribs as they are aiming down here.

Q Does this film, Doctor, show any pathology?

A The one abnormality, which I'm sure has been pointed out to you before, is this tiny little bone spur pushing back between L1 and L2 off the L1 vertebral body.

Q Now Doctor, what kind of a film is this, is this a plane film?

A This is what we call, we would call a plane X-ray of the lumbar spine.

Q All right. And Doctor, at this time I would like to look at what is Defendants' Exhibit C in evidence.

Doctor, would you tell us what this is?

A This is upside down?

Q The sticker was upside --

A No, I'm sorry, it wasn't upside down, it's my mistake.

This is a view that is showing us T-10, T-11, T-12, L1, L2 and L3.

So this is, I would call a plane

lateral X-ray of the thoracal lumbar region, and as I mentioned T-10, 11, 12, L1, L2, L3.

Q This has been identified as a scout film that was taken prior to the myelogram being performed.

Doctor, what is a scout film?

A One of the things that you want to do, before taking a myelogram, is get your machine set correctly so you know you get a good picture of the bone. So the scout film makes sure you have that technique properly done before any dye is put in.

Q Does this show any pathology?

A This shows the same L1, little chip of bone there.

Q Okay. Doctor, I am going to put up this film. (Handing)

What is this, Doctor?

A This is a --

Q I'm sorry, let me identify it for the record.

MR. SNYDER: This is Defendants' Exhibit E-2 in evidence.

Q Okay, what is this?

A This is a lateral lumbar spine film

after radiopaque material, we commonly call it dye, has been put into the spinal fluid space, and it's very specifically we're again seeing the sacrum, L5 through L1, and seeing the dye column going up.

Q Doctor, this is a film that Dr. Miller referred to when he testified, and he attached great significance to this film.

Do you remember reading in his transcript?

A Yes, I do.

Q He attached significance to this film because he said here there's a nice broad dye column, and then you get up to the area of L1-L2, the column narrows.

What is it that we're looking at here?

A What we're looking at is myelogram dye put into the spinal fluid space, we're seeing again that same bone spicule there, we're seeing filling of the dye only to a certain level.

The dye is basically layered out right here, and you can see a fluid level there, and there's just a little dye getting up here.

So enough dye has been put in here to fill the fluid space up to here, but it hasn't

filled the space above there.

Q Why is that, Doctor?

A It's just the volume of dye that's been put in, it hasn't been increased enough or positioned well enough to show the filling.

We can see dye here, but this is a so-called water soluble dye, and if it's not very concentrated it's very thin and harder to see.

We can see, if we look carefully, that the dye fills all the way back to the spinal column, which is about here. It's just that it's layered here, because it's much thicker from here down.

So we're seeing a sufficient amount of dye to fill right up to this L1-L2 level, but not to fill above that level.

Q Doctor, I'm making reference now to Defendants' Exhibit E-1, which is also part of the myelogram.

So what do we see here?

A We're seeing that this dye now has been rolled up a little higher, literally the patient is being rolled, again the problem is that we're filling with enough dye to give us a very thin line here. If you look very carefully, you can see

the dye in a much fainter degree filling up to the back of the spinal column. But this is again showing the dye on the front of the spinal column in this position. (Indicating) Because this is how the patient is positioned, and not filling the back of the spinal column.

We're again seeing it running past the L1-L2 level, with the canal being incompletely filled except way down here in the lower lumbar region. (Indicating)

Q Doctor, where is the conus medullaris?

A The conus medullaris is right about here. (Indicating)

Q Can you actually see it?

A There's not enough dye on this film to see it, no.

Q What about the caudaequina, Doctor, where is that?

A The caudaequina runs all the way from approximately L1 on down, so all of the space in here has the roots of the caudaequina, some of which you can just barely make out coming down here very, very faintly.

Q Do you see any compression of the

caudaequina on this film, Doctor?

A No, sir, there is none.

Q What is compression of the caudaequina, what does that mean?

A It means that the space that the spinal column usually allows for the nerve roots to pass through, has been compromised so that there's no space for anything except the nerve roots, and indeed the nerve roots themselves are being clamped down upon.

There's normally probably about 60 or 70 percent empty space in the spinal canal, especially from about T-12 on down, and the nerve roots of the caudaequina, as I say, are floating or bathed in the spinal fluid.

When there's compression, all of that space is taken up by something causing the compression and that narrowing, so that there's no extra space, would be what was necessary to say there was compression of the caudaequina.

Q Doctor, were other studies performed as well?

A Yes.

Q And do other studies give different

kinds of information than are given by the myelogram?

A They give similar kinds of information in different ways; if that's a good way to answer the question?

They are again looking for structures within the spinal canal, specifically the spinal cord, conus and caudaequina, they are looking for anything that's intruding or pushing into the spinal canal taking up space in there.

Q Do you see anything on this myelogram that's intruding into the spinal canal?

A No.

Q Do you see anything that's taking up space?

A Well there is minimal bulging at L1-L2 of one or two millimeters, and nothing beyond that. There's nothing that's causing compression.

Q There is a difference between a compression and a bulge?

A Yes.

Q What is the difference?

THE COURT: Do you want all the lights on now?

MR. SNYDER: One second, please.

You can leave it like that.

Q Doctor, do these films all reveal the same pathology, in other words, specifically at the L1-L2 interspace?

A Yes, they do.

Q And that pathology, I want you to assume, has been identified as a small evulsion fracture of the L1 endplate, okay?

A Yes.

Q Doctor, based upon your review of the Brookhaven Memorial Hospital records, the fact that this evulsion fracture was present, was that, was that made known to these physicians, at least through the radiology report?

A It was noted that there was an evulsion, what was causing an evulsion fracture at the endplate of L1, yes.

Q And I want you to assume that the doctors who were treating this patient have testified here in court that they were aware of that finding.

A Yes, sir.

Q Based upon the radiographic studies

that were performed?

A Yes.

Q Doctor, there was a bone scan that was performed relative to this fracture. You saw that when you reviewed the Brookhaven Memorial Hospital records, is that correct?

A Yes.

Q Now the bone scan was interpreted as being negative.

We've heard testimony that that means that that was evidence that this was an old fracture.

What does that mean, an old fracture?

A The negative bone scan means the fracture, if it was a fracture, has healed, there is no active process of healing going on.

Old might be three or four or five or six or eight, twelve, or sixteen or twenty-four or thirty-two months.

Q Doctor, you've seen other films relating to earlier studies that were performed of this patient, correct?

A Yes, I have.

Q Okay, Doctor, I want to show you

Defendants' Exhibit I in evidence. This is a positive print. And it's, and this is Defendants' Exhibit I in evidence, Melinda Palmese, November 11, 1987.

Is that the same fracture on this film?

A Yes.

Q Where is it?

A Somebody happened to put a circle on that. (Indicating)

Q That was Dr. Tenner.

A Yes, it's right there.

Q Doctor, is that the very same fracture that was seen on all these other films that we just looked at?

A Yes.

Q Doctor, has that fracture moved in any way?

A No.

Q Doctor, does that indicate that that fracture existed at least back, as far back as November 11, 1987?

A Yes, it does.

Q Doctor, Dr. Miller testified that he wasn't sure, he didn't know what the mechanism of

injury was to Mrs. Palmese.

All right, in your opinion, Doctor, -- but he did know that this fracture was somehow involved, that it was causing compression.

First off, Doctor, do you have an opinion, with a reasonable degree of medical certainty, as to whether this fracture, that was seen back in November of 1987, was seen again in February and March of 1989, was in any way responsible for the symptoms that Mrs. Palmese was complaining of?

A I do have an opinion.

Q What's your opinion, sir?

A That with absolute certainty, it was not responsible for the symptoms that the patient was complaining of.

Q How do you know that?

A The fracture was present in 1987, we know it's not an acute fracture, we know it had nothing to do with the event that led to the hospital admission, but more importantly we know that from the myelogram, from the post-myelogram CT, from the MRI scans, that it was not causing any significant degree of compromise of the space in the

spinal canal. It measures one or two millimeters. The canal is very capacious or large there, and there's an extra ton of space, so that it's physically impossible, and we've demonstrated that with absolute certainty on the imaging studies that this was causing any compression of any part of the neural system.

Q Doctor, I want you to further assume that Dr. Miller testified that not only was this piece of bone compressing the caudaequina, but she also had a mixed caudaequina-conus medullaris compromise.

All right, I want you to assume that that's what he said.

First of all, Doctor, on this patient where is this fracture located in reference to the spinal structures that we're talking about?

A It is off the so-called inferior endplate of the L1 vertebral body.

Q Okay, and what is the significance of that with reference to the conus medullaris?

A On other imaging studies, which we have available, indicated that the conus stops approximately an inch and a half higher than that

level.

Q Doctor, assuming that this fracture were causing some kind of compression, do you agree with Dr. Miller that it was compressing the conus medullaris?

A It's not causing any compression, but if it were ten times bigger and extending all the way across the spinal canal, it could only compress the caudaequina.

We've demonstrated radiographically that the conus has ended at least an inch or inch and a half above this fracture. So if it suddenly grew right across and mashed everything there, it could only catch the caudaequina and not the conus medullaris.

Q Can you show us where those structures would be?

A On this exhibit --

THE COURT: Exhibit G?

THE WITNESS: Yes.

Q The model of the spine.

A Counting from the bottom of the sacrum, L5, L4, L3, L2, L1, we're talking about that evulsion fracture, or that piece of bone at L1-L2,

we're talking about the conus ending approximately T-12-L1, so that's somewhere between an inch and inch and a half. At L1-L2, again, in, by the imaging studies, the only thing in there, and the only thing, if that thing suddenly grew and went all the way across, it would be the so-called caudaequina or the nerve roots coming from the spinal cord.

Q Now Doctor, we know, correct, Doctor, we know that this fracture at the L1 endplate was not at the level of the conus medullaris, it was below it?

A Correct.

Q In your view, in your opinion with a reasonable degree of medical certainty, it could not in any way have caused any compression or any injury to the conus medullaris?

A That is correct.

Q In fact, Doctor, I would like you to refer to the MRI study that was performed on this patient on March 27, 1989.

And what does it say with reference to the conus of Mrs. Palmese?

A This is a magnetic resonance imaging of

the thoracic spine dated 3-27-89 for Melinda Palmese: No evidence of spinal canal stenosis, normal appearance and position of the conus.

Q Okay, Doctor, does this agree with your finding that this could not possibly be impinging upon the conus in any way, shape and form?

A Yes, it does.

Q Now Doctor, in fact, Doctor, if a physician came into court and said that that somehow damaged the conus medullaris, with this fracture, would that be anatomically impossible?

A Yes, it would be anatomically impossible.

Q Doctor, I would like to refer to the MRI, talking about Defendants' Exhibit F in evidence.

THE COURT: You want the lights out?

MR. SNYDER: Yes, your Honor.

Q Now Doctor, I want you to assume that Dr. Miller testified last week that these imaging studies don't allow one to see the conus, the caudaequina, or other structures, that they are just making an inference as to what is there.

Do you agree with that?

A No, I don't.

Q Doctor, what do these imaging studies show?

What's an MRI show?

A This is an MRI scan of the spine showing the, again, very much like the plane film we looked at, the sacrum, L5, L4, L3, L2, L1, and T-12. It enables us to see the structure of the bones, the structure of the discs, the configuration or shape of the spinal canal where the conus is seen to end right at about the T-12-L1 level.

I'm demonstrating it here, it's very clearly shown on this study.

We are seeing down here the nerve roots on the caudaequina starting off the L1 body and extending down. So it does show those structures, which I have just mentioned, very clearly.

Q So that, Doctor, so we're clear, the MRI study that we're looking at here, it doesn't infer anything, does it, it actually shows the structures, you can actually see them on these studies?

A Yes, sir.

Q So if Dr. Miller said that you can't see those things on these studies, do you have an opinion, with a reasonable degree of medical certainty, as to whether that is correct?

A I do have an opinion.

Q And your opinion is, sir?

A I disagree, it's not correct.

Q In fact does this MRI, does it show the L1-L2 area?

A Yes, it does.

Q Show the Jury where that is, please.

A (Indicating) L5, L4, L3, L2, L1, this is the L1 vertebral body there, the L2 vertebral body, this is the, what's been called evulsion fracture at the base of L1.

So this is the area we've been focusing in on all along.

Q Now Doctor, what is this, what is the white area behind that?

A The white area actually represents the spinal fluid space.

Q And what is in the spinal fluid space?

A Up here where we can't see is the spinal cord. Here, ending about T-12, is the conus

medullaris, down here is spinal fluid, plus the nerve roots of the caudaequina.

Q And Doctor, is there any compression of the caudaequina?

A None whatsoever.

Q What is the significance of there being no compression of the caudaequina?

A There's nothing to fix.

Q Doctor, I want you to assume, with a reasonable degree of medical certainty, that Dr. Miller, a neurologist, not a neurosurgeon, testified at Page 43 of his trial testimony, with reference to questioning by Mr. Harley:

"Question: Okay, and Doctor, do you have an opinion, with a reasonable degree of medical certainty, as to what the treatment for that is?

"Answer: I think the treatment should have been removal of whatever was pressing on the nerves or the conus at that level."

Do you agree with that, Doctor?

A I agree, except that there wasn't anything pressing on the conus or the nerves at that level.

Q So if Dr. Miller said removal of

whatever that was pressing on the nerves of the conus, first of all we know, from anatomy, this could not have been pressing on the conus?

A Correct.

Q We also know, again from these films, that it's not compressing on the caudaequina?

A Correct.

Q Doctor, Dr. Miller then went on to testify at the very same page:

"Question: And is that by surgery, Doctor?

"Answer: Yes.

"Question: And Doctor, was the failure to do so a departure from accepted standards of care?

"Answer: Yes."

Doctor, do you have an opinion, with a reasonable degree of medical certainty, as to whether neurological surgical intervention was warranted for this patient while she was at Brookhaven Memorial Hospital in February and March of 1989?

A Yes, I do have an opinion.

Q And what is your opinion?

A That there was no indication that neurological surgery of any kind was indicated for this patient while she was at Brookhaven Hospital.

Q And Doctor, do you have an opinion, with a reasonable degree of medical certainty, whether it was appropriate for Dr. Seymour to indicate to this patient that there was nothing to operate upon?

A I do have an opinion.

Q And what's your opinion?

A That it was appropriate for Dr. Seymour to say there was nothing to operate upon.

Q And Doctor, I want you to -- oh, by the way, Doctor, what is exploratory surgery?

A You go looking for something when you're not sure if there's anything there, you can't see what's there, or what's not there, so you go look around, I guess.

Q I want you to assume that Dr. Miller testified that in his opinion, with a reasonable degree of medical certainty, exploratory neurological surgery was indicated for this patient.

Do you agree with that, sir?

A No, I do not.

Q Tell us why not.

A We don't have to do exploratory surgery, because we have very sophisticated and very neurological imaging studies, the ones that we are talking about and looking at, which demonstrate that there is nothing to operate on, there is no compression of the caudaequina at this level, there's no indication that exploratory surgery would be necessary because there's nothing to explore.

It's been well demonstrated on the films that there is no compression of any neural structure.

Q Doctor, in situations like this, do you do exploratory neurological surgery?

A No.

Q Why not?

A The imaging studies, thank goodness, have taught us that we don't have to look, we know what's there already, and we know what's not there. If it's not there, there is no compression of anything, so exploratory surgery would be totally contraindicated, it would not be appropriate.

Q Doctor, you told us that that piece of bone was approximately one to two millimeters long?

A That's how Dr. Tenner measured it, it impinges into the thecal sac about one or two millimeters.

Q Okay. Doctor, in your opinion, with a reasonable degree of medical certainty, had imaging studies such as MRI's or CAT scans been done in November of 1987, when this film was obtained, would the findings be the same then as they were in 1989?

A They would be identical, in my opinion.

Q Doctor, if in fact this piece of bone was responsible for the patient's complaints and symptoms in 1989, and I want you to assume that this piece of bone existed as far back as November 11, 1987, would you expect her to have symptoms from this piece of bone from the time the fracture occurred?

A Yes.

Q Okay. Dr. DiGiacinto, Dr. Miller testified that the bone didn't move since the time of these films in November of '87. Do you agree with that?

A Yes.

Q Yet he said that the bone was responsible for the patient's complaints and her

symptoms.

You disagreed with that, I take it?

A I do disagree with that, yes.

Q He said, Doctor, that while the bone didn't move, the spinal cord must have, and that's what caused the problem.

Do you agree with that or disagree with that?

A I disagree with it.

Q Tell us why.

A That piece of bone is not causing any impingement upon anything, number one.

Number two, the spinal cord and the spinal nerve roots, as I mentioned, are floating in spinal fluid, they're moving all the time, there is no spinal cord there, so no spinal cord can be injured, there is tons of extra space, so there's no compression of caudaequina. So I really don't understand the statement that the spinal cord must have moved and that's related to the injury; it doesn't mean anything.

Q Doctor, you know surgery was ultimately performed on this patient by Dr. Hollis?

A Yes, I do.

Q And Doctor, I'm referring to the Mount Sinai Hospital record, which is in evidence.

MR. SNYDER: Your Honor, I apologize, I don't know the number.

THE COURT: No problem.

COURT OFFICER: Plaintiffs' Exhibit 5.

MR. SNYDER: Thank you.

Q Plaintiffs' Exhibit 5, Dr. Hollis writes in his operative report that the fractured inferior piece of L1 vertebral body, that's the thing we're talking about right here? (Indicating)

A Yes.

Q And the adjoining piece of disc -- do you see the adjoining piece of disc there?

A The outer margin of the disc, the outer margin of the disc called the anulus fibrosus was attached right there.

Q So he says it should be noted that the fractured inferior piece of L1 vertebral body, and adjoining piece of disc, were causing significant impingement on the thecal sac at this level.

Do you agree that this was causing significant impingement on the thecal sac?

A No, I don't.

Q Doctor, with regard to being able to visualize what it is we're talking about, Dr. Miller testified that in his opinion the surgeon, who was actually seeing it, or looking into the area, his eyeballs are in a better position to make a determination as to what's there and what isn't there than these neuro imaging studies.

Do you agree with that or disagree with that?

A I disagree with that.

Q Now Doctor, you are a neurological surgeon?

A Yes.

Q You perform this kind of surgery, if decompression is called for, you perform spinal decompression?

A Yes, I do.

Q Are you able to see, Doctor, impingement on neural structures when you perform an operation such as Dr. Hollis performed?

A Specifically you're able to see whether or not anything is pressing into the thecal sac of the dura.

You're not seeing any neurological structures unless you have actually opened the dura.

The second issue was that you are seeing at a very skewed angle and very often we try, either with direct vision or magnified or even with microscope, to estimate degrees of impingement or compression. It's very difficult, with any degree of certainty, to measure under those circumstances because, you know, the tip of this pen (indicating) would look like a log, a firewood log, and you have a very difficult time knowing what you are looking at, so that the estimation of compression of neural structures is impossible unless you open the dura, the estimation of the degree of compression of dura or thecal sac is, at best, a guesstimate.

Q All right. Now Doctor, Dr. Hollis wrote in his handwritten operative note on, it looks like July 26, 1989, that he has a section called findings.

Do you see where I am referring to?

A Yes.

Q Can you read that, please, what's there with findings?

A Findings: Fracture, the word I can't

read -- well healed noted in the body of L1.

Q First of all, he finds a healed fracture, right, this is nothing acute?

A Yes.

Q Now Doctor, what does he say after that, read the next sentence.

A Thecal sac depressed inward approximately four millimeters by fractured off bone fragment, and I think that says disc.

Q Okay. Now first of all, was he able to measure whether something is four millimeters?

A You can't do this in this type of operative procedure, you can't get a ruler in there to measure.

Q Is there any way to measure it during the operative procedure?

A Other than going to the X-rays and measuring off them, no.

Q He didn't take any X-rays?

A I don't know.

Q Doctor, I want you to assume no X-rays were taken.

All right. He also writes in this note, he has a little mark, it looks like a squiggle

or sideways L.

What does that mean, in medical parlance?

A Approximately.

Q What does that indicate to you, that this was a guess on his part, as to how big this fragment was?

MR. HARLEY: Objection to form.

THE COURT: Sustained.

Q What does that indicate to you?

A It indicates that he's estimating, he's not claiming that it's an accurate measurement.

Q Doctor, Dr. Tenner actually looked at the MRI's, looked at the CAT scan and he measured, and he said it was one to two millimeters.

In your opinion, with a reasonable degree of medical certainty, which is the more accurate way of making the determination?

A With reasonable degree of medical certainty, the MRI scan is the more accurate way.

Q Okay. Doctor, I want you to further assume that -- take a look at Defendants' Exhibit B-5 in evidence.

Doctor, what are we looking at?

A This is a post-myelogram CT scan, it's taking the spine and actually cutting off, it's just like a knife goes through there, then you are looking at what you see. So that here we're right at L1-L2, we're cutting through the disc itself, and then looking right at it.

This is the left side and this is the right side. So it's as if you have, if you are cutting it off and then looking up at the image. In addition, this is a CT scan that's been done after myelogram dye has been put into the patient and so that we're allowed to see the vertebral body, the surrounding tissues.

This is the aorta up here, this is the so-called lamina and the area of interest is this white circle with dark dots in it. This is the, this margin here is the dura or the edge of the thecal sac. The white is the myelogram dye, which actually is telling us where there is cerebral spinal fluid or spinal fluid, and the dark dots, dark dots are actually the nerve roots of the caudaequina.

So we're seeing here that we're dealing with the caudaequina, we're actually seeing, you can

count the individual nerve roots that we're seeing, and we're also seeing that the nerve roots are taking up perhaps a third, at best, of the total space of the thecal sac or the space where there's spinal fluid. The white indicates that there's probably two-thirds extra space there. It tells us conclusively that there's no evidence of any compression whatsoever in the region of the canal.

We also see on the next view, this little piece of bone that we're talking about, that can truly be measured to be in perhaps one, and maximum two millimeters, we can see very accurately how far it's compressing against the thecal sac and we can still see all of this extra space, full of spinal fluid.

This tells us conclusively that there is absolutely no possibility of any pressure on the nerve roots at that level.

Q Doctor, if there was some impingement on the thecal sac --

A Yes?

Q What side is the impingement on?

A More on the left side than the right side.

Q And Doctor, --

MR. SNYDER: Your Honor, I'm finished with the films.

THE COURT: Do you want the witness to return to the stand?

MR. SNYDER: Yes.

(Whereupon Dr. DiGiacinto resumed the witness stand.)

MR. SNYDER: I don't need to use these anymore, your Honor.

THE COURT: Just leave them over there.

MR. SNYDER: I'll leave them on the table. I don't want them to fall.

Q Doctor, you know -- by the way, what is a T-8 sensory level?

A A T-8 sensory level is a measurement of where sensation changes in the trunk of the body.

The T-8 level defines the level in the spinal cord, where the nerve is coming off, where sensation is normal, then converts to abnormal. So if one were working their way down the chest at approximately, oh, close to here (indicating), this is around where T-8 is, you would notice a change in

alteration below that level.

Q Doctor, did you see anywhere that this patient had a T-8 sensory level?

A There was mention in one of the subsequent records that there was a T-8 sensory level, yes.

Q Doctor, what is the significance of a T-8 sensory level, in this patient?

A It means that the level of dysfunction, change in function of the neuro axis of the spinal cord, has to be at the T-8 level or higher, it cannot be lower than that to cause the T-8 level.

So that, for example, if we're talking about L1-L2, it's impossible to create a T-8 or T-9 or T-10 or T-11 sensory level.

Q Doctor, if you could, with this, would you show the Jury T-8?

A Again, I have to count, L5, 4, 3, 2, 1, T-12, 11, 10, 9, 8, so this is the T-8 level (indicating), and relative to L1-L2. (Indicating)

Q Now Doctor, I want you to assume that Dr. Ahn, who was a physiatrist at the Rusk Institute, testified here in court that in his opinion the T-8 sensory level was something that

developed subsequent and as a result of the surgical procedures performed on the patient at Mount Sinai Hospital; okay?

A Yes.

Q Do you agree that the T-8 sensory level resulted from something, from the surgical procedures performed at Mount Sinai Hospital?

A No, I don't agree.

Q Tell us why.

A Well again, with the model, the surgery was performed at the L1-L2 level. The incision that was made in front came down here, the incision in the back was directly over L1-L2.

T-8 is way up here, it's not a little bit, but very much outside the surgical field. There's no indication in the operative report, there is no indication, and knowing the technique that's used, it's not possible that surgery at L1-L2 could cause a T-8 sensory level.

Q Doctor, one point. The patient was found, while she was at Brookhaven Memorial Hospital, while she was at Mount Sinai Hospital, prior to surgery, to have either normal deep tendon reflexes or occasional hyperreflexia of the deep

tendon reflexes of the lower extremities.

What is the significance of that, Doctor, in your opinion?

A Obviously the normal reflexes would tell us that there was not any pathology demonstrated by their normalcy.

Hyperreflexia or increased reflexia, you tap and the leg jumps, and we all know what that looks like, I think, it is indicative not of an injury off a nerve root, not of an injury of the caudaequina, but an injury well above that level and specifically an injury in the region of the spinal cord or abnormality in the region of the spinal cord.

Q When you talk about the spinal cord, what do you mean?

A Well the part of the, of the nervous system above T-12, in this case, not the nerve roots of the caudaequina, not the level of the conus medullaris, but above that level from really from T-11 or T-12 on up.

Q Now Doctor, we heard the terminology of upper motor neuron, lower motor neuron, what does that mean?

A Lower motor neuron is the nerve root that has left the spinal cord. It may occur in the lumbar region. There are nerve roots coming off the spinal cord and the cervical and thoracic region that are also so-called lower motor neurons, they're out of the spinal cord.

An upper motor neuron lesion are lesions of the spinal cord itself causing different neurological findings than you get with lower motor neuron lesions.

Q Doctor, were these patient's findings consistent with upper or lower motor damage?

A The findings of hyperreflexia point to upper motor neuron lesion.

Q And Doctor, you told us that in your opinion, with a reasonable degree of medical certainty, this L1 fracture was not responsible for the patient's problems?

A That is correct.

Q Doctor, also it's your opinion that neurosurgery was not indicated for the patient while she was at Brookhaven Memorial Hospital, is that correct?

A That is correct.

Q Doctor, do you have an opinion, with a reasonable degree of medical certainty, as to what caused the patient's problems?

A With certainty, it's very difficult to know what caused her problems. We can anatomically look to where the lesion most likely is, and through the various findings that have been accumulated, from the time of admission at Brookhaven, through the records that I had available, my best positioning of an abnormality would be in the spinal cord, somewhere between T-8, T-9, T-10.

Q Doctor, what kind of process would cause her problems in that area?

A The types of abnormalities that you can see could be compression, but we know that's not there, because we have imaged that whole area very, very thoroughly.

It could be a vascular insult such as a stroke to the cord, it could be an inflammatory process when there's an entity called transverse myelitis, which is a non-specific term of inflammation, multiple sclerosis is one of the forms of transverse myelitis, but most of them are of unknown origin or etiology.

That's a distinct possibility, given the constellation and evolution of the symptoms that the patient showed.

Q Doctor, are either one of those conditions surgically treatable?

A No, they're not.

Q Doctor, was there any surgical intervention that could have been offered to Melinda Palmese while she was at Brookhaven Memorial Hospital, that could have altered or changed her symptomatology or her outcome?

A No, there was not.

MR. SNYDER: Thank you, sir, I have nothing further.

THE COURT: Mr. Girvan?

MR. GIRVAN: Thank you.

CROSS EXAMINATION

BY MR. GIRVAN:

Q Good afternoon, Doctor.

A Good afternoon.

Q I introduced myself to you, Doctor, this morning?

A Yes.

Q Upon your arrival here in the

courtroom?

A Yes.

Q That's the first time you and I had ever met?

A To my recollection, yes.

Q Doctor, you know I represent Drs. Moreta, Gudesblatt and Epstein?

A Yes, sir.

Q And you were not asked to comment on their care one way or the other by Mr. Snyder, or when you reviewed the case, correct?

A I --

Q Were you asked to comment on their level of care?

A I was asked to review the entire level of care of the patient, yes.

Q Now do you have an opinion, within a reasonable degree of neurosurgical and medical certainty, as to whether or not Drs. Moreta and Gudesblatt comported with good and accepted neurological care in deferring a neurosurgical decision to two neurosurgeons?

A I do have an opinion.

Q What is that opinion?

A That they showed appropriate wisdom, they made the right decision in deferring to the neurosurgeons, yes.

Q And Doctor, based on the testimony that you've just very recently given, in terms of your hypothesis of the possibilities that could explain Mrs. Palmese's condition, is there any medical treatment that is affordable, which can in any way change the outcome of those conditions?

A No.

Q Now, Doctor, there has been testimony by Dr. Miller, who is a neurologist at Maimonides Hospital, to the effect that, in his opinion, given the clinical picture of Mrs. Palmese, in combination with the imaging studies and other tests performed upon her, that Drs. Moreta and Gudesblatt either individually or together, should have sought a third neurosurgical opinion. And the testimony, in effect, indicates that if that, if that neurosurgeon did not want to operate then, that the process for consulting should have continued neurosurgically until a neurosurgeon agreed to surgery.

Can you comment on whether you agree or disagree with that proposition?

A I totally disagree with that proposition.

Q And why is that?

A In this case, number one, the neurologist, as well as the neurosurgeons, might realize that there is no indication for surgery.

Secondly, it seeking an opinion from one neurosurgeon and then a second neurosurgeon, both of which put together the imaging studies with the clinical picture, with all opinions being in the same direction, there certainly was not indication to go on and get a third or fourth or fifth opinion.

Q Doctor, if Mrs. Palmese was given a prescription to go to you, back on March 31, 1989, and you were given the chart, and you did an exam on her, and you read the films that were available, would you have told Mrs. Palmese she needed surgery?

A No, I would not.

Q Would you have thought the need to consult with any of your colleagues, to get a fourth opinion as to whether or not Mrs. Palmese should have had surgery?

A No, I wouldn't have felt that necessary.

Q Now Doctor, there's been testimony by the same Dr. Miller along the lines that in his opinion, again judging the clinical picture, and judging the imaging studies, there was a surgical lesion, something needed to be decompressed, that's his opinion.

You read those answers?

A Yes, I have.

Q And let me just assume, for argument's sake, Doctor, in a hypothetical situation, that there is a patient that has compression involving a nerve root in the caudaequina. Make that assumption.

If that patient were to have a compression involving the nerve root, and a physician was to undertake a clinical examination and test the deep tendon reflexes of the knee and the ankle, would you expect there to be an absence or reduced reflexes?

A The finding of nerve root compression in this region should lead to a decrease in the knee jerk reflex or ankle jerk reflex if it were altered.

Q And is that a clinical way of measuring whether or not there exists compression?

A Yes, it is.

Q And in this hypothetical, Doctor, I specifically use the caudaequina because, you know, do you not, that if you're at the caudaequina or below, you know you're dealing with lower motor neuron pathology?

A Yes.

Q And you know, do you not, Doctor, that if you are dealing with lower motor neuron pathology with compression, you would have areflexia or hyperreflexia as opposed to an upper neuron lesion involving the conus or above, is that a fair statement?

A Yes.

Q And is the conus not the end or terminal point of the spinal cord, by which you make the demarcation between that which is upper and that which is lower, anatomically?

A Yes.

Q The brain would be encompassed by upper motor neuron disease?

A Yes.

Q So that if, and again if I asked you to make a hypothetical, let us assume a patient comes

into you, and you demonstrate compression on the conus, would you have a clinical way in which to measure that?

A Again, you would have your examination clinically to try to measure an abnormality pointing to the conus, if I understand your question properly?

Q As between a clinical assessment, in terms of testing muscle strength testing, and reflexes, and the diagnostic modalities that were available to these doctors in this case, do you put more weight and reliance on the diagnostic studies, or the clinical assessment?

A To conclude what?

Q To conclude whether or not there's compression?

A You put more weight on the diagnostic studies, because they can actually show you whether there's compression or not.

An abnormality on neurological examination may tell you that something is not working properly but that, per se, doesn't tell you that there's compression causing that loss of function or that relieving that compression could

reverse that function.

The clinical examination will help you decide if the level is L4 or T-8, but it doesn't tell you whether there's compression or not, it tells us where the problem is, if that answers the question?

Q Would it be fair to state that one of the primary purposes of a clinical assessment is to help to guide you to investigate the level of possible involvement?

A Yes.

Q And therefore the diagnostic modalities becomes the end game or end result of what it is you were put on suspicion of, in terms of making a surgical or non-surgical decision?

A The diagnostic studies are designed to help you look at the level of loss of function. So that the examination might tell you that the patient has an absolute T-8 level motor loss of function, sensory loss of function, but if you do a myelogram and a CT scan or an MRI scan and there's no compression of anything, if everything is floating free, even though you have reached a pretty good conclusion about where the problem is, what you have

concluded definitively from the X-ray and MRI studies is that there is no compression and nothing you can do surgically to change that process even if it's there.

Q Okay. And just in a pure hypothetical case, can you have a displacement of a nerve root and not have a compression, is there a distinction between displacement and compression?

A Yes.

Q And what is that distinction?

A As mentioned in the lower lumbar spine, and we saw it very well on the X-ray studies, there is 60 percent extra space, you can move enough, halfway across that extra space, and it's still not compressed, it's displaced away from its absolutely normal position, but it's not compressed because there's all that spinal fluid around it.

MR. GIRVAN: I have no further questions.

THE COURT: Mr. Harley, if we start now --

MR. GIRVAN: One more question.

CROSS EXAMINATION

BY MR. GIRVAN: (Continuing)

Q Do you have an opinion as to whether Dr. Epstein's decision to not operate on this patient, was in conformance with accepted standards of neurosurgical care?

A I do have an opinion.

Q What is that opinion?

A That it was in conformance with neurosurgical standards of care.

Q Thank you.

MR. GIRVAN: No further questions.

THE COURT: If we start now, is there some possibility that we'll finish before lunch, or would you prefer to take lunch at this time?

MR. HARLEY: I think there's a reasonable possibility --

THE COURT: Folks, it's up to you. He's the witness for today. We can either stop now and come back after lunch, or we can go for a while and see how hungry everybody gets.

JUROR ONE: We'll hang.

THE COURT: Go ahead.

JUROR ONE: Yes.

CROSS EXAMINATION

BY MR. HARLEY:

Q Doctor, when you reviewed this case for Mr. Snyder's office, did you, as you went through these voluminous records, did you take notes?

A No, sir.

Q You didn't take any notes?

A No, sir.

Q As you went through all of these records then, in order to pull your thoughts together, this was back when, 1991?

A '92.

Q 1992.

Did you, did you prepare a report for Mr. Snyder's office?

A No, sir.

Q You mean all of this information that we're sitting here with all these notes and things, you've kept all of that in your head?

A No, sir.

Q No?

A No.

Q You didn't write anything?

A No, I just pulled out pertinent sheets, which you can get down to very, a few.

Q Having been in court before, Doctor, you know that if you had a writing or you prepared anything, for instance, as Dr. Miller had, that I, as the other lawyer, would get a chance to look at it?

A I understand that's true, yes.

Q And by not having any kind of thing in writing, there is nothing for me to look at, right?

A I guess that's true.

Q Doctor, you have talked about the times that you have reviewed cases.

Have you testified in court other than today?

A Yes, I have, sir.

Q On how many occasions?

A Approximately 23 or 24 times over the last ten years.

Q Okay. And Doctor, at least here in New York State, have you testified outside of New York State?

A I have not testified outside of New York State, I testified on out of state cases, but

in New York State.

Q And Doctor, at least in New York, in terms of how often you find you have done it, defending doctors who are sued, as opposed to being for patients, what would you say the split was?

A In terms of --

Q How, what would be the percentage of times you actually testified defending doctors who have been sued?

THE COURT: As opposed to what?

MR. HARLEY: As opposed to patients.

A I would say approximately three-quarters of the time are for doctors who are being sued.

Q And Doctor, in talking about these imaging studies, although we hear that radiologists and neuroradiologists do these things, as a matter of profession, a doctor like you, a neurosurgeon, also reads these films as part of your profession, is that correct?

A That is correct.

Q And while a radiologist, when a radiologist reviews a film, he or she will dictate a

report, you won't necessarily do that, but you will read it and you will depend on your own judgment along with advice from others but with your own judgment as to what these films showed?

A That's true for the most part, yes.

Q Okay, and neurologists -- and Doctor, this is not unique for you as a neurosurgeon, that's part of what neurosurgeons do, is that correct?

A That is correct.

Q And Doctor, is it also the case that that's what neurologists do, for the most part?

A I have a little harder time answering that with certainty. I know some neurologists though don't know an MRI scan from a Picasso, so the answer is that more often neurosurgeons look at them.

I can agree in a little broader generalization that's true for neurologists as well.

Q Okay. But in general, even other doctors, doctors who have been trained in medicine and trained in various specialities, if they wanted to know what was on one of these imaging studies, they would have to have someone like you to talk to or show to and talk to?

A Or a neuroradiologist.

Q Or a neuroradiologist.

Because when you showed us these films, and you show us little things on them, they look straightforward to us, in fact it takes a tremendous amount of training and study to know what's on there, is that correct?

A Yes, sir.

Q As a matter of fact even today, I mean even when you looked at it, and you have to look at it carefully, because even today there was a film that went up there and it was upside down, and for a minute you looked at whether it was upside down and said: Oh yes, and after you looked at it more carefully, you said: Yes, it was upside down, and you turned it right side up?

A Yes, sir.

Q And as far as people like us were concerned, we wouldn't know upside down from inside out or backwards, is that correct?

A Correct.

Q We have to depend on what you tell us?

A "We" meaning the Jury, today?

Q We people, we who don't read these

things, we, lawyers, jurors, other doctors even, have to totally depend on what you tell us is on those things?

A What other doctors who are capable of looking at the study tells you, yes.

Q And Doctor, if we have one doctor who says one thing that's on these films, and another doctor who says another thing, we really have to decide which one of us is, which one of them is telling the truth, isn't that right?

A I guess so, yes.

Q Now Doctor, for instance, you told us that this one finding on the myelogram means that there wasn't quite enough fluid up there, enough radiopaque fluid, that's why it looks like it's a narrowing, is that correct?

A On that film, yes.

Q Ah, now Doctor, that was very, most specifically the area that was being looked at at this time, the area where you say there just wasn't enough radiopaque fluid, is that correct?

A That is correct.

Q And if the radiologist at the time had reached that conclusion, she could have had another

study done, or done something to try and be sure that the fluid gets there?

A But she did, she did a CT scan.

Q And you're telling us what the CT scan says?

A We looked at it, yes, sir.

Q Doctor, now these neurologists and neurosurgeons at Brookhaven, presumably they also would read these studies, and it would be your opinion that they would reach the same conclusion that you have reached?

A I can't conclude that. I don't know what conclusion they reached.

Q Well Doctor, you are telling us what the standards of care require, and you are telling us that this is what, that this is what, that's what these films show, is that correct?

A Yes, sir.

Q So wouldn't you expect that if Dr. Epstein and Dr. Gudesblatt and Dr. Moreta, a trained neurosurgeon, and two trained neurologists, would look at those films, they would see the same thing you would see, wouldn't you, wouldn't you expect that, Doctor?

A Oh yes, I would; I didn't understand your question, so I'm sorry.

Q Okay. And Doctor, you told us that you reviewed the Brookhaven records, is that correct?

A Yes, sir.

Q Did you see the notes that these doctors, Dr. Gudesblatt, Dr. Moreta and Dr. Epstein wrote after they had viewed these studies, these imaging studies?

A I read the chart, so I'm sure I did, sir.

Q And did you note, Doctor, and would you expect, Doctor, that after Dr. Moreta and Dr. Gudesblatt and Dr. Epstein, after they had reviewed these films, if they saw the same thing that you saw, they would know that this patient couldn't have compression on any part of her spinal column?

MR. SNYDER: Excuse me. I don't mean to interrupt. But I left my copy of the hospital record on Mr. Harley's desk. I can't find it.

MR. HARLEY: Here. (Handing)

MR. SNYDER: Thank you.

THE COURT: Do you want to repeat

the question, or do you want the Reporter to read it back?

MR. HARLEY: I'll repeat it.

Q Wouldn't you expect, Doctor, that these two trained neurologists, and this trained neurosurgeon, after viewing these films, would see the same thing you saw and would know that there could not be compression on the spinal column?

A Yes, sir.

Q And therefore the patient could not have caudaequina syndrome?

A No, sir.

Q Well Doctor, does not caudaequina syndrome imply some kind of compression on the spinal column?

A Cauda -- excuse me, caudaequina syndrome is a constellation of clinical complaints and findings.

Compression would tell you why the patient had caudaequina syndrome. You can have a caudaequina syndrome and have no compression whatsoever.

Q Well Doctor, did you consider this patient had caudaequina syndrome?

A No.

Q Okay, and that's based upon what, Doctor?

A Summation of all of the medical information I have from '87 through 1990, '91, whenever it ended, I'm not sure.

Q Well Doctor, you know that after viewing these X-rays these doctors were, had concluded that the likely cause of this patient's complaint -- withdrawn.

Doctor, so what you are saying is these doctors, if they saw the same thing that you saw on the X-ray, would know that the patient's complaint could not be secondary to any cord compression?

A That is my opinion, yes.

Q And Doctor, would you agree that they should know -- let me just, I am going to ask you in a minute -- that they should know --

MR. GIRVAN: Would you note for the record --

THE COURT: Wait one second. When he's ready, he'll identify the exhibit.

Q -- that he should know, viewing those

films, that it could not be secondary to this fracture at L1-L2?

A That's my opinion.

Q They would absolutely know that, is that correct, if they saw the same things that you saw, and based on the opinions you have given this Jury?

A That is my opinion.

Q Well I want you to note Dr. Epstein's note.

A Exhibit?

THE COURT: What exhibit number?

MR. HARLEY: It's Exhibit 1.

THE COURT: Go ahead.

Q It's the note of 3-21 in the progress notes.

THE COURT: 3-21. That is the big blowup.

Doctor, you have the actual chart.

MR. HARLEY: I'm waiting until you find it, Doctor.

THE WITNESS: I have it here.

Q Do you see where he writes X-ray

reviewed?

I want you to assume that he's told us that these are the imaging studies you have just had in front of the Jury. He writes: Agree with caudaequina syndrome, probably secondary to fracture at L1 endplate.

Do you see that, Doctor?

A Yes, I do, sir.

Q So would it seem that Dr. Epstein, reviewing all these films, that you say clearly show that there is no compression, after that he still is saying: Probably this caudaequina syndrome is as a result of the fracture at the L1 endplate, is that not what his words say, Doctor?

A Yes, it is, sir.

Q Okay. So there's at least one doctor who would at least at that stage disagree with your reading of those X-rays, Doctor?

A I don't know if I can go quite that far, sir. I don't know how he interpreted the X-rays. "Probably" isn't too strong. I don't know if I can actually say yes or no to that question, sir.

Q That's all right, Doctor. Thank you.

A What's stated there is stated, yes.

Q And Doctor, Dr. Moreta talks about a caudaequina syndrome, that's the note immediately above it, versus atypical myofascial pain syndrome, is that correct?

A Atypical myofascial pain syndrome.

Q Could myofascial pain, Doctor, syndrome, result in urinary incontinence?

A I would not think so.

Q Doctor, would not a complete workup, a complete neurological workup of a patient who has complaints of changes in urinary and bowel function, connected with severe back pain and a suspected caudaequina syndrome, would not a complete workup include ruling out neurogenic bladder?

A It would include it in terms of trying to localize the level of diagnosis, it would not include it in terms of trying to make a decision as to whether surgery was indicated or not.

(2)

[redacted] Doctor, did anyone, that you can see, during this hospitalization, any of these doctors, do a perianal pinprick test?

A Not to my recollection.

Q Is that part of the workup, Doctor, to

determine whether or not there is in fact urinary incontinence?

A It would be part of the information you would want, yes sir.

Q And Doctor, is there a test called a cystometrogram?

A Yes, sir.

Q And Doctor, is that a test that would give you information as to the neural functioning of the patient's bladder?

A Yes, it is.

Q And would that test give you information that you would want to know?

A Not in terms of deciding about surgery or not, no sir.

Q But in terms -- let's leave the surgery -- in terms of working up this patient to finding out what's wrong with her, would the information, information given by a cystometrogram, be important to you?

A It would be another piece of information, yes.

Q So when Mr. Snyder, at the outset, asked you if these doctors had done an exhaustive

neurological workup, and then changed his question to say did they do a workup, in fact they did not do an exhaustive neurological workup, did they, Doctor?

A They did an exhaustive neurological workup to find out if there was anything that could be fixed, and there was not anything that could be fixed.

Q Now Doctor, that Mount Sinai handwritten operative note that you were asked to read, I would like you to go back to that page, please.

THE COURT: Exhibit 5. We'll give you the record, Doctor.

THE WITNESS: Thank you.

Do you have a guess where it is, sir?

Q It's in the early pages of the progress, it's dated 7-26.

A Yes, sir, I have it.

Q Now Doctor, I don't remember, but one of the questioners asked you to read the first two full lines, and most of the third line of the findings.

Doctor, I would like you to read the

end of the third line of the findings, then the fourth line of the findings. I want you to read where the line that begins: L1-L2.

MR. HARLEY: Your Honor, may I approach the witness and point it out?

THE COURT: Sure.

MR. HARLEY: Thank you.

THE WITNESS: I'm sorry, am I looking at the right note?

MR. HARLEY: Yes, begin right there. (Indicating)

A I'm reading a note, I'm not sure who it's written by.

Q Well I want you to assume that at least based on the questions that were -- that was a note that was earlier identified as a note by Dr. Hollis, and you read the first part of the note.

I'm now asking you to read the last part of it.

A I'll read: L1/2 disc removed. Once vertebra decompressed, sac rebounded up.

Q Sac rebounded up?

A Right.

Q Now what sac do you suppose that means?

A The thecal sac.

Q And Doctor, when doctors use the word rebounded, do they mean the same thing that us laypeople would mean when they use the word rebounded?

A I don't know what you laypeople mean.

Q Okay, Doctor. Then what do you, as a doctor, think when a doctor writes: Sac rebounded up, what do you think he means?

A I think he means it went from here to here (indicating) which is two millimeters moving backwards.

Q Well what he wrote was: Once the vertebra was decompressed -- by the say, Doctor, that word, decompressed, we've heard that before.

Doctor, what does decompressed mean?

A Relieve compression.

Q Once -- so what it says is once the compression was relieved, the sac rebounded up, that's what it says, right, Doctor?

A Ah, that's what it says, yes sir.

Q And Doctor, Dr. Hollis, although you seem to be somewhat dismissive of what one can see, Dr. Hollis in fact was visualizing with his eyes

this operative site, is that correct?

MR. SNYDER: Can I object to the form of the question, it's argumentative.

THE COURT: Excuse me.

Do you want to ask him whether he could see it rebound, is that --

MR. HARLEY: No.

THE COURT: Okay, rephrase the question.

MR. HARLEY: I was asking another different question.

THE COURT: Rephrase it.

Q When Dr. Hollis is in the operative site, he is looking at it, is that correct, whether through instruments or through his eyes, he's looking at it, is that correct?

A Yes, sir.

Q Okay. Now Doctor, you gave us your, sort of a capsule summary of what you saw when Mr. Snyder sent you the records back in 19 -- whenever he gave them to you, and you said that what you saw here was this patient had, based on the records you had, this patient had sudden onset of this, of this

syndrome, is that correct?

A That's the history given, yes sir.

Q And Doctor, you were given lots and lots of records, you saw nothing to, nothing to suggest that that history was in some way inaccurate?

A Correct.

Q And did you see, Doctor, that what she complained of was severe pain and she was being treated at Brookhaven for severe pain?

A Yes, sir.

Q And you saw in the records various notations, Doctor, of urinary and bowel problems, is that correct?

A Yes, sir.

Q Okay. And those things all go together with a, they're part of the constellation of things that go along with a caudaequina syndrome, is that correct, is that not correct, Doctor?

A They can be part of a caudaequina syndrome, yes, although I don't believe the total constellation points to a caudaequina syndrome, if that's what you are asking me?

A I am going to read what Dr. Moreta said

in this courtroom, and I'm going to ask you if you agree with it.

I asked him, and this is on Page 29 of the trial testimony:

"Question: What are the symptoms, what are the group of symptoms one looks, one expects to find in some or all of caudaequina syndrome?

"Answer: You can have pain in the lower extremities, radicular pain going down the legs, you can have weakness, you can have numbness in the lower extremities, you can have problems with bowel and bladder."

Do you agree with that, Doctor?

A Yes, I do, sir.

Q Doctor, is what you are telling us that because the patient had normal reflexes -- withdrawn.

Are you saying that because of the normal reflexes, the patient couldn't have a, some compression at L1 or L2, or that it would be unusual, which is it?

A On clinical grounds, if one were using the reflexes to make the diagnosis of a caudaequina syndrome, the finding that would strengthen that

diagnosis would be decreased reflexes.

Q Okay. Doctor, try to answer my question now.

Are you saying that you never -- withdrawn.

Are you saying that because of the normal reflexes, you shouldn't consider caudaequina syndrome at all, or are you saying that normal reflexes can be part of the caudaequina syndrome, but not usually; can you pick one of those two?

A The latter.

Q Okay. So what you are saying is it is unusual, but it doesn't rule it out?

A That is correct.

Q Okay. As a matter of fact these doctors, Dr. Moreta, Dr. Gudesblatt, Dr. Epstein, knew that her reflexes were normal, and they were still considering caudaequina syndrome, is that correct?

A Yes.

Q And that's proper for them to do so?

A Yes, sir.

Q And if a doctor were to come into this courtroom and tell this Jury that if you have normal

cord, normal reflexes, that it absolutely rules out caudaequina syndrome, you would disagree with that doctor?

A It would be very unusual.

Q Doctor, would you disagree with that doctor if the doctor said normal reflexes rule out caudaequina syndrome, would you disagree with that doctor?

A If I could answer by saying minimally, because it would be incredibly unusual, then I would say I would disagree with it.

Q We have now gone from unlikely to unusual to incredibly unusual, because as you sit there, you don't know which one of the doctors may have testified to that in this courtroom, and you don't want to perhaps be disagreeing with --

MR. SNYDER: Objection.

THE COURT: Do you want to try the question -- do you want to try the question again?

MR. HARLEY: Thank you, your Honor.

Q Doctor, as a diagnostician, you are not only looking for the usual, but the unusual?

A Yes, sir.

Q Even Dr. Moreta, in one of his notes here, says: Well if it's a cord, if it's a myofascial syndrome, it's an atypical one, right?

A Yes, sir.

Q And atypical one is a way of saying unusual, right?

A Yes, sir.

Q And it is certainly right to think of the usual and unusual when you have a problem in front of you that you haven't solved?

A Yes, sir.

Q Okay. Doctor, is it common for radiologists, when they do reports, to advise clinical correlation?

A It is common, yes.

Q And Doctor, and I think the Jury has heard this endlessly, but essentially what that means is look at the study, but correlate those studies with what symptoms and signs your patient is showing, is that correct?

A Yes, sir.

Q Now Doctor, you observed that the patient had sudden onset of severe pain?

A Yes, sir.

Q Correct?

A Yes, sir.

Q And that pain, from everything we can see in the Brookhaven chart, stayed essentially the same throughout her five weeks at Brookhaven, is that correct?

A I believe it went up and down a little bit, but essentially the same, yes.

Q And Doctor, nothing they did, including the application of serious painkillers, seemed to have much of an affect on that, sometimes it had affect, sometimes not, but basically by the end of it, the pain was essentially the same as it was at the beginning?

A I can agree with that, yes.

Q And we see at Brookhaven that the doctors reported change in her bowel and bladder function, is that correct?

A Yes.

Q And we see at the end, or did you see at the end, when she was discharged after -- withdrawn.

Did you see that during a good part of

the time she was at Brookhaven, there was a Foley catheter in place?

A Yes, sir.

Q And would you agree that while the Foley catheter is in place, without doing other kinds of tests and studies, it's not possible to tell whether or not she has normal urination?

A That is correct.

Q And you will agree that they didn't do those tests that could have been done?

A That's true.

Q And Doctor, will you agree that when the Foley was removed, she began showing signs of urinary incontinence right in the hospital record?

A Yes, sir.

Q And Doctor, I want you to assume then that she continued these complaints until her admission at Mount Sinai, will you assume that, Doctor?

A Yes, I will.

Q And accept that in the interim, a cystometrogram test had been done, which concluded that she, that her bladder was in fact incompetent.

A Okay.

Q And have you seen those records?

A I believe I have seen the cystometrogram, I'm aware of it.

Q Okay. And then Doctor, Dr. Hollis did the operation that we've heard described here today which, among other things, included what he described as a decompression, which resulted in the thecal sac rebounding.

You will agree that that's what the record says?

A Yes, sir.

Q And Doctor, have you been told that although after the surgery Melinda Palmese's bowel and bladder function, and some of her inability to walk, remained, her pain went away?

A I do understand that, yes.

Q Do you accept that, that that's the case, Doctor?

A If she says so, yes sir.

Q And Doctor, it is, is it still you position that whatever was wrong with her, was not where Dr. Hollis operated, but was farther up her spine?

A It is my opinion that the pathology at

L1-L2 had nothing to do with the neurological deficit.

I've tried to localize the level where my opinion states it's most likely to be the origin of the problem.

Q So Doctor, is it that two things happened to her, right before admission, that caused these problems?

A Which two things?

Q I don't know. Something at the L1 and something at a higher level?

A Well, no, nothing happened at L1.

Q I see.

A We don't know what happened at the higher level.

Q Doctor, Melinda has been under a fair amount of medical care since then, is that correct?

A Yes, sir.

Q And you've reviewed all those records?

A I don't know if I reviewed all of them, I haven't seen anything in the last several years since maybe '93, I think.

Q But of all the doctors who have seen her, all the doctors that did tests and studies,

including the doctors at Mount Sinai that operated, you, who spent, oh, who comes in and testified in defense of doctors on many occasions, have come up with a diagnosis, is that correct, you have come up with the cause of this woman's problems?

A No, sir.

Q I thought you just testified to us earlier that her problem had something to do with the upper spine?

A Given all of the information I had, if I had to localize the level of the problem, I would put it in the spinal cord; I've not come up with the diagnosis.

Q Doctor, you said there was absolutely no need for a third opinion here?

A In my opinion, no.

Q Were you told that Dr. Seymour, the neurosurgeon, advised, he says, advised Mark Palmese, while Melinda was in Brookhaven, that she should go to another institution, that she should go to a tertiary care institution to have them figure out what's wrong with her?

A I am aware of that, and I don't disagree with that.

Q So you don't have a problem with the idea of if the neurologists were not satisfied with what the neurosurgeons were telling them, that it's appropriate to get another opinion?

A My interpretation of that --

Q Doctor, can you answer my question?

A I don't --

Q If you can't answer it yes or no --

A I can't, I don't agree with your statement.

Q Nothing further. Thank you.

THE COURT: Mr. Snyder.

MR. SNYDER: I have nothing further, your Honor.

THE COURT: Mr. Girvan?

MR. GIRVAN: Yes, thank you.

RECROSS EXAMINATION

BY MR. GIRVAN:

Q Just a few questions.

THE COURT: Did you say two?

MR. GIRVAN: A few.

THE COURT: I'm sometimes hard of hearing.

MR. GIRVAN: I said "one" last

time, and I asked two. A few will come to seven.

Q Good afternoon, again, Doctor.

Doctor, you explained before that in your opinion these aren't, the constellation of that which you read about, and reviewed, both the chart and the X-rays, did not point to a caudaequina syndrome?

A That is correct.

Q Will you explain your opinion, and what the basis of that opinion is?

A There are several findings that bring it into question. Number one, under the finding of normal reflexes, again, as has been pointed out, doesn't rule out caudaequina, but there were at least two notations with hyper or increased reflexes, which point specifically to the spinal cord.

There was the finding of initial complaint of some numbness in the left leg and with marked weakness in the right. That's a spinal, not a caudaequina problem.

There is question about what type of loss of function the patient had in terms of the

bladder. The patient at one point was able to void 300 cc's at one time. That's much more commonly a problem -- excuse me, a finding consistent with spinal cord. It's very difficult, based on the information available, to determine exactly what level the dysfunction in the nervous system is, and I did not try to come up with a diagnosis, I tried to give my best opinion.

My main, best opinion is that there's nothing pressing on anything, and that we have to put as much information together as we can to try to reach a level of loss of function, and that's what I was attempting to do in discussing this.

Q Now Doctor, are there various types of diagnostic considerations that fall under the ambit of caudaequina syndrome?

THE COURT: Are you objecting?

MR. HARLEY: Yes.

MR. GIRVAN: Withdrawn.

Q Are there different etiologies or medical causes for a caudaequina syndrome?

A Yes, sir.

Q And Doctor, can there be a surgical etiology, for lack of a better term, there is

something there that needs to be surgically addressed that can explain a caudaequina syndrome?

A Yes, the compression of the caudaequina, which would be visible on the imaging studies, would be the surgical cause.

Q And Doctor, are there other nonsurgical causes that lead to a caudaequina syndrome?

A Yes, sir.

Q Are there several other causes?

A Probably, yes.

Q Now Doctor, Mr. Harley and Dr. Miller, in a question and answer earlier in this trial, made some moment about the fact that the neurologists and neurosurgeons in this case did not conduct a perianal pinprick examination and/or did not consider cystometric evaluation of Mrs. Palmese's bowel function, and Dr. Miller, in essence, has testified that the failure to do so was a departure.

My question to you, Doctor, let's assume that both of those tests were performed at Brookhaven Hospital, if a cystometrogram could have been done there, would that have added in any respect to the decision whether to operate or not operate?

A It would have had no impact whatsoever.

Q Why not?

A Again, the cystometrics and the testing for perianal sensation might be another piece of information that helped you localize the level of loss of function, but they would not change the fact that all of the imaging studies, without question, showed no evidence of compression of anything, and therefore nothing that surgery could correct, whether the cystometrogram was normal, whether it showed this, whether it showed that, whether there was or wasn't perianal sensation, it would not have changed the simple fact that nothing had pressure on it.

Q And Doctor, to reduce it, hopefully, in plain speech, that type of test would allow you to determine whether there's a lack of sensation in the perianal area, is that correct?

A Yes, sir.

Q And you already know that we have documented lack of sensation well above that area, extending almost as high as the T-8 and T-9 level, correct, in this patient?

A Yes.

Q And Doctor, Mr. Harley has, throughout the course of this trial, demonstrated on blowup documents some of the notes that were documented by my client, and particularly a note of Dr. Epstein of March 21, where he talks, among other things, about patient may need decompression.

In that same note, however, he mentions that in the morning his plan is to discuss with a neuroradiologist.

Does that conform to good and accepted neurological care, to want to discuss with a colleague, and in particular, with a neuroradiologist, to get an opinion about neurodiagnostic imaging studies?

A Yes, sir.

Q And does that same note mention that Dr. Epstein's thinking at that time, he's thinking out loud in that note, includes the possibility of a chip contusion or a contusion of the spine?

A I guess so, yes.

Q Should Dr. Epstein have operated either on March 21, or March 22, either before or after he discussed this case with the neuroradiologist?

A No, sir.

MR. GIRVAN: I have no further questions.

THE COURT: Mr. Harley?

MR. HARLEY: Nothing further.

THE COURT: Doctor, you are excused.

THE WITNESS: Thank you.

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