STATE OF NEW YORK COUNTY OF ERIE

SUPREME COURT PART 21

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CHARLENE VanDUSEN and MICHAEL VanDUSEN

Plaintiffs Index No. 10754/01

vs. Trial Testimony of Dr. Capicotto

DELBERT McMASTER and JANET McMASTER and DELBERT E. McMASTER AGENCY, INC.

Defendants

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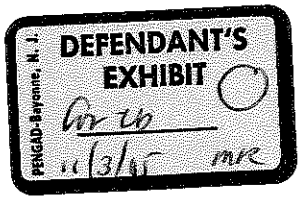
25 Delaware Avenue
Buffalo, New York
January 26, 2005

BEFORE: HONORABLE JOHN M. CURRAN

Justice

APPEARANCES: SHAWN W. CAREY, ESQ.
Appearing for the Plaintiff

JAMES P. BURGIO, ESQ.
Appearing for the Defendant



Sally S. Frizzell, CSR
Official Court Reporter

THE COURT: Mr. Carey, Mr. Burgio, good morning. Are you all set, Mr. Carey?

MR. CAREY: Yes, we are.

THE COURT: Bring the jury out, please.

(9:39 a.m. - Jury present.)

THE CLERK: Good morning, jurors. Please answer as I call your names.

(Jury roll called.)

THE CLERK: All jurors and counsel are present, Your Honor.

THE COURT: Thank you. Good morning. Thank you all very much for being here on time, despite the weather.

(Discussion off the record.)

THE COURT: Mr. Carey, your next witness, sir?

MR. CAREY: Thank you, Your Honor. The plaintiffs call Dr. William Capicotto.

THE DEPUTY: Place your left hand on the Bible, rise your right hand, listen to the words of Madam Clerk.

W I L L I A M C A P I C O T T O, having first been duly sworn, testified as follows:

THE CLERK: Please be seated. Please state

your full name and business address for the record, spelling your name.

THE WITNESS: William Capicotto, C-a-p-i-c-o-t-t-o. And my office address is 135 Linwood Avenue, Buffalo, New York, 14209.

THE CLERK: Thank you.

THE COURT: All set, Mr. Carey.

DIRECT EXAMINATION

BY MR. CAREY:

Q. Thank you, Your Honor. Good morning, Doctor.

A. Good morning.

Q. Could you please tell the jury, what is your occupation?

A. I am an orthopedic spine surgeon.

Q. And how long have you been an orthopedic spine surgeon?

A. I started practice in 1986, so 18 years.

Q. And what type of an education did you obtain to become an orthopedic surgeon?

A. Well, I graduated from high school at Niagara Wheatfield, in Sanborn, New York. And I graduated from college, University of Buffalo, in 1976. I have to think back. Then completed four years of medical school at the University of Buffalo Medical School. I completed that in

1980. And then the next six years were spent in a combination of an internship, followed by a residency, and then a spinal fellowship. I completed that in June of -- June 30th of 1986. And then I went into practice on July 1st of 1986.

Q. And when you say the spinal fellowship, what was that and where did you do that?

A. I -- also in Buffalo, New York, through the University of Buffalo, School of Medicine.

Q. Okay. And what did that entail?

A. Well, that was a specific year that was completely devoted to the treatment of people that have some sort of injury or disorder or a disease in -- of their spine. Prior to that I -- during our residency in orthopedics, that's the bones and joints, I did have quite a bit of spine training in there. But this specific year was after I had graduated from my residency, and it was a year just devoted to treatment of spinal problems.

Q. Are you affiliated with any hospitals locally?

A. I am a staff member at the Buffalo General Hospital, which is part of the Kaleida Health System. I'm also -- I also have staff privileges in the Catholic Health System.

Q. And obviously, Doctor, you're licensed to practice

medicine in New York State?

A. Yes.

Q. And what does it mean to be board certified?

A. Board certification means that there is a panel or a board of doctors that are responsible for administering examinations and certifying an applicant's credentials. So once your doctor completes all of his or her training, the gold standard in our society, in the United States, is to sit for your board examinations. And in orthopedics, at the time, that was a series -- a two day series of written examinations, eight hours a day, followed, I believe two years after that, by a two-day series of oral or verbal examinations which each applicant, such as myself, would go into a room where there would be a panel of doctors, and you -- you would be given certain cases to discuss with them. So one might be -- in one room might be just the hand surgeons, and the other room of doctors was the spine surgeons, and another room was the joint replacement surgeons, and you'd have to go -- and that was like a two-day oral -- oral examination. So I fortunately passed those.

Q. And are you board certified as an orthopedic spine surgeon, Doctor?

A. Yes.

Q. And how long have you been board certified?

A. Since 1988.

Q. And do you also teach orthopedic spine surgery at any local medical schools?

A. I am affiliated with the University of Buffalo. Our fellowship program -- we don't have a formal fellowship program anymore. We -- a few years ago we disbanded that. But I am responsible for the training of medical students, residents, and other health personnel like surgical technicians that come in, they have to learn how to do -- help us during surgery, and students of that nature.

Q. All right. And, Doctor, is it fair to say that since becoming board certified, that you have devoted your professional life to the actual treatment and care of spine patients?

A. Yes.

Q. And are you familiar with the term trauma, Doctor?

A. Yes.

Q. And in -- in the context of a spine surgeon, orthopedic spine surgeon, what does trauma mean, or why is it important?

A. Well, trauma would be the application of -- there is different types of trauma. But we usually think of trauma as an acute single event that has usually a

sufficient force that would injure a structure. That's how most -- that's how -- when I -- originally my first thought of trauma would be an uncontrolled force that would cause an injury.

Q. And as a treating orthopedic surgeon, do you have, or have you treated patients suffering from traumatic spinal injuries?

A. Well, that's what I do on a daily basis.

Q. And as a treating orthopedic surgeon, through the many years, do you ever determine when a patient comes in, do you ever take a history to try and determine what the cause of that person's condition is?

A. Yes.

Q. All right. Is that what you do routinely?

A. That's the standard. As a patient presents to my office, they usually have what we call a chief complaint. That's usually pain, or pain and weakness, something of that nature. And usually it starts in their spine, whether it's different parts of their spine, it may or may not go into one of their extremities such as their arms or their legs. And the issue is, how did that happen. Very -- it's kind of -- kind of sounds simple, but, you know, who, what, where, when and why. How did this happen? What brought you here? So we ask the patient for their chief complaint, and

then we need to get a reasonable history. It doesn't have to be the most detailed, and sometimes it can't be. But we try to get a reasonable history of what happened to that particular individual, that they're suffering pain, pain and weakness, that they ended up being to come into my practice.

Q. And is the way -- the trauma, and is the way the trauma occurred relevant to your assessing what type of injury they may have?

A. It -- it does have a degree of relevance. Sometimes it could be -- it could be -- the importance of it can vary. If -- if a patient comes into my office and they have a herniated disc, the thing that I really need to know is that they have a herniated disc. But the routine thing in medicine is, how did it happen?

Q. Let me ask you that, Doctor. What is a herniated disc?

A. Well, first of all, a disc, it's called the intervertebral disc, is the structure between two vertebrae that's kind of spongy, and it's a very strong structure that helps us to move.

Q. And, Doctor, do you have anything with you that would help demonstrate for the jury what a disc is, and what you're describing?

A. I did bring a model -- I brought two models with

me, to help. And I do have one that shows a herniated disc.

MR. CAREY: Your Honor, if I may approach to have it marked?

THE COURT: Sure, go right ahead.

(Plaintiff's 26, model of spine, marked for identification.)

MR. CAREY: Would it be possible for the doctor to stand before the jury to demonstrate?

THE COURT: That's fine.

BY MR. CAREY:

Q. Doctor, if you could, using what's been marked as Exhibit 26, for demonstrative purposes, could you explain to the jury what you're describing as a herniated disc?

A. This is a -- this is a plastic model of the lumbar spine. And it's as if -- as if it's standing like I'm standing, facing you. This is how it would look from the front. This is how it would look facing Mr. Carey. And then if I turned from the back, these are the back -- when you look, when somebody bends over, especially if they're real skinny, these are the bumps in the back, this is the spine. And then this would be looking towards the front of the courtroom. And it's -- the spine itself is made up of vertebrae, which are these blocks of bone that we see. And the lumbar spine we call L, for lumbar, lumbar 1, lumbar 2,

3, 4, 5. And then we have the sacrum. The sacrum we usually just call S1, it's a number of bones that are usually healed together that they call the sacrum. And in between the vertebrae -- in order for us to bend and to bend from side to side, or twist, we have these intervening structures that are called the intervertebral discs, or discs. And they help to help the spine move. If we didn't have any discs, we'd be like a -- like a candy cane, and we wouldn't be able to bend or twist. So the discs are structures that are very flexible, they're very, very strong. And, actually, the outer covering is a very, very thick ligament that goes around and around a number of times. And if you went into -- if you went to the medical school and went to the laboratory and looked at the disc under the microscope, you'd actually see that the disc grows right into the bone, I mean, it's really grown in there, so it's firmly attached to the bone.

In its normal state, the disc is the circumference of the disc, is at the same edge of the vertebrae. And then we'll look straight down the center of the spine, and this is the canal, or the spinal cord, and the spinal nerve roots.

Now, if a disc suffers a sufficient trauma, the outer covering of the disc, which is this big ligament that goes

around and around, can tear. And the center of the disc has a very mucusy, jelly substance in it that can squirt out. And if it squirts out and pinches a nerve root, that can cause severe pain, it can cause severe pain in the back, or the leg, or the back and the leg.

So this model has a herniated disc between the third and fourth lumbar vertebrae on the right side.

So if this -- if this were my spine, and I had a disc herniation like this at L3-4, I'd probably have terrible, terrible pain on my back on the right side, and it would go down the buttock and the right side of my thigh.

MR. BURGIO: I'm sorry --

THE COURT: Let's break it up, Mr. Carey, a little bit, with a question. Go ahead.

MR. BURGIO: I'm sorry, because I'm not looking at you, Doctor, was the herniation on the right side?

THE WITNESS: Yes, this is the herniation, right side.

MR. BURGIO: And then the pain, did you say, would be down the right side?

THE WITNESS: In this -- in this specific model, the herniation --

MR. BURGIO: In that model, right?

THE WITNESS: The herniation of this v give pain down the front of the leg, on the right side.

MR. BURGIO: And, yes, Your Honor, I would ask for a question every once in a while.

THE COURT: Go ahead, Mr. Carey.

BY MR. CAREY:

Q. And, Doctor, with regards to the, I think you talked about the nerve endings which run through the spine, and that the disc, if it's herniated, will impinge on those and cause pain?

A. Correct.

Q. Can the -- the herniated disc, or the material itself leaking out, can that also cause pain or irritation to those nerve roots?

A. Yes.

Q. So in addition to the actual pressure of a herniation, the material itself just leaking out will cause irritation and pain in the nerve roots?

A. Right. Right. There is a few different components. In --

Q. Doctor, if you could face the jury?

A. Sorry. There is a few different components. There is first for the disc to herniate the ligament, what

we call the annulus has to tear, and it is a big ligament, so if the -- just the annulus tearing c[ut] really severe back pain, and maybe a little bit of [leg] pain with it, you know, that goes into the -- into the buttocks and legs.

When the center of the disc pours out of the tear, then that's what we call a herniation, the inside has pushed out of the compartment into someplace that it's really not supposed to be. It's the same as if you hear somebody has a hernia, like somebody will get an inguinal hernia. And the hernia means that the bowel has pushed through the abdominal wall and is sticking out and there is a bulge there. And if you've ever seen somebody with a hernia, they've have a bulge there. And they might have to push it back in, and then it pops back out. And in general surgery, you would fix the hernia, you would close it, or put some mesh over it to keep the bowel from coming out. We can't do that in the spine.

Q. Why not?

A. Let's put it this way. Well, once that ligament rips, we do not have the technical ability, at this point in time, to push the mucusy disc, center, back in and sew it closed.

Q. So is it fair to say then, Doctor, is a herniated

disc a permanent injury?

A. Yes.

MR. BURGIO: Your Honor, we're -- we have to at some point get to this particular patient.

THE COURT: We will. Mr. Carey, a little more background is fine. Make sure it ultimately hooks up to where we're going to be on this particular case.

MR. CAREY: It absolutely will, Your Honor.

THE COURT: Great, go ahead.

BY MR. CAREY:

Q. Dr. Capicotto, with regards to -- and this model, that's a herniation on the right side, correct?

A. It's a herniation on the right side between the 3rd and 4th vertebrae.

Q. And a herniation on the right side will -- will or can elicit pain on the right side, down the right leg, correct?

A. It can -- well, it can do both sides. But in a classic sense, in a classic sense, like if you're going to medical school and you learn about herniated discs, what they'll tell you is if you have a disc on the right side, you'll always have pain in the right leg. They don't tell you, you can have pain in the left leg, also. But in a

classic sense, this should give pain, a herniation such as this, between the 3rd and 4th vertebrae should give pain in the back, through the buttocks, and down the front of the thigh.

Q. And what about pain in the -- or I'm sorry, a herniation at L4-5?

A. A herniation at L4-5 is more typical. That will give quite a bit of back pain. That characteristic of the L4-5 disc, it causes a real lot of back pain, a real lot of spinal pain, and it will cause pain that goes into the buttocks and down the legs, in the back of the legs, and it usually will go through the buttocks, down the back of the legs, and into the calves.

Q. And, Doctor, I believe you mentioned that in medical school, the classic disc causes pain down the leg that the herniation is on the side of?

A. Right.

Q. But that you also have seen in your practice --

MR. BURGIO: Your Honor, I'm going to object to the leading.

THE COURT: Try to stay away from the leading, Mr. Carey. Ask direct questions.

BY MR. CAREY:

Q. Doctor, you mentioned what they don't tell you in

medical school you is you get pain on the other side, too?

A. That is correct, yes.

Q. And has that been your experience as a treating spine surgeon for 18 years?

A. Yes. Most patients will have what we call bilateral, meaning both, pain on both sides. If they have a herniated disc, they will have pain on both sides. And most of those patients will usually have pain, it will be worse on one side or the other. But if you talk to them or if you have them sit down and fill out a, like we do, a pain diagram, in my practice, just to get an idea of where the patient's symptoms are, and the patient will draw, well, it hurts me there, hurts me there, hurts me there, and it kind of gives me -- when I look at it in the office the first time I meet the patient, I can just look at the picture they drew and I kind of have an idea of what's -- what's going on -- what kind of an injury they have, or where it should -- where that injury should be coming from in their spine.

Q. And, Doctor, you could have a seat again, if you'd like. And so all the jurors can -- Doctor, in terms of diagnosing a herniated disc, what are the ways that you use to diagnose a herniated disc?

A. Well, there is -- there is three -- there is three

major components when a patient comes to the office. First is their history, where they're telling their pain is in their body, or even if they draw that picture, that pain diagram.

The next is an examination. And on the examination, you should be able to hone in a little bit better on where their pain is coming from. That's why we do a physical examination.

And then the third part would be various tests that we use to either confirm our diagnosis of where the problem is, or to kind of refute that -- our diagnosis. So we have tests such as X-rays or CAT scan or an MRI or other tests that we have to have, a dye injected in the patient's spine such as a test called myelograms or discograms. Each and every test has a different purpose. It's different technology. And each -- when you go in order of the tests, each test would help to validate or I guess refute the doctor's diagnosis.

Q. All right.

A. So I have a diagnosis, so we start with test one, test two, test three, until we have a concluding diagnosis.

Q. Well, Doctor, with regards to, in your experience, or your opinion, with a reasonable degree of medical certainty, what is the -- going from most definitive, or I

should say going from least definitive to most definitive, in terms of those diagnostic tests, is the X-ray the best test, is the CAT scan, or what is the best test?

A. The simplest and most routine test would be just a simple X-ray of the spine. That shows the bones, it doesn't really show the discs. But it may have some signs in the X-ray that can kind of point you to where it's going. The next step would probably be a CAT scan, which CAT scan means, is C-A-T, computer axial tomography, which is a real fancy X-ray, actually. And you go into a scanner, you lay there and they take a bunch of pictures and they put them together with a computer program, and they can show -- they can show the picture of the spine in different directions, to help us see if there is anything wrong.

The next -- and those are call non-invasive, because the patient just lays there, so they're not -- we're not putting anything in their body, or sticking a needle in.

The next step would be an MRI, which stands for magnetic resonance imaging. That's a test where the patient lays in the tube. It's actually a large electro magnet. And through some very sophisticated technology, it causes the electrons in our body to spin. And they can -- these magnets will pick up the little electrical signals, and they can make a picture. And it -- it works very well for soft

tissues such as discs or spinal cord tumors.

And then after we go to the MRI, the next step would be more of what we call invasive --

Q. Doctor, let me ask you first, are all MRI's equal or created equal or --

A. No, there is -- there is a different between MRI's. There is different -- usually they measure the power of the magnets in tesla units. And so that could have -- the standard has been a 1.5 tesla unit, was pretty much the standard of care in the United States, is to give the best clarity or the best resolution. But there is other machines that are .35, .5 tesla, 1 tesla, 1.0, and then 1.5. So there are different strengths. And all things being equal, you would consider that the unit that is like a 1.5 would have a more clear picture than a unit that was a .35.

Q. All right. And in terms of, are there different things that can affect the validity of an MRI, from the standpoint of movement of the patient?

A. There is a lot of things that can affect the quality of an MRI. First and foremost is -- well, there is -- there is issues regarding the patient, the patient's size, the tinier they are, usually the easier they are to image. The other issue is the temperature in the room. If the patient is chilly and they're shivering, or if they

cannot lay -- if they're in a lot of pain and they can't lay still, it can degrade the image.

Sometimes patients have to hold their breath, and they can't hold their breath for an extended period of time. So it will -- it can degrade the image or lower the image quality.

On the -- on the other side of the -- you know, you have the patients -- there is issues regarding the patients. And then there is issues regarding the operation of the machine. If your technician doing the test behind the wall is very patient, and takes appropriate -- a long enough time, they can get a higher quality image rather than if they kind of try to zip through it. So there are differences. There is many -- there can be many reasons that you can look at two patients the same size, say 150 pounds, go to the same scanner, and one image may be crystal clear and the other image might be quite degraded. And it could be patient movement, patient temperature causing the shiver, and it could also be issues regarding the actual operation of the machine.

Q. And, Doctor, with regards to --

THE COURT: Mr. Carey, pardon me one second. Our alternate juror, if you want to move over one, feel free to move. I notice you moving around a

little bit.

A JUROR: No, that's okay.

THE COURT: If you're fine, you're fine. Sorry, Mr. Carey. I want to make sure everybody can see. Go ahead.

MR. CAREY: Dr. Capicotto, can -- now, the MRI is also done lying prone, correct?

THE WITNESS: Yes.

MR. CAREY: And are their occasions when --

MR. BURGIO: Object to the leading, Your Honor.

THE COURT: You haven't gotten there yet, but that's where we're going. Sustained. Stay away from the leading.

BY MR. CAREY:

Q. Can a -- can a herniated disc be larger or cause more problems with someone standing and thus be more visible if someone was standing or imaging if they were standing, as opposed to lying prone?

A. Yes.

Q. So do you have an opinion with a reasonable degree of medical certainty that an MRI of a patient in a prone position, a herniation could --

MR. BURGIO: Your Honor --

MR. CAREY: -- would be more difficult to detect than if they were able to be photographed standing up?

THE COURT: Do you have an objection?

MR. BURGIO: Objection to the leading.

THE COURT: That's sustained. I'm not sure the application it has to this case, Mr. Carey, so I'm not sure of the relevance. It seems to be calling for speculation. And on this particular subject I see no need for the expertise. Go ahead, at this point.

BY MR. CAREY:

Q. Doctor, I believe you also mentioned -- we moved from X-rays to CAT scans to MRI's. Was there another diagnostic test which is more reliable?

A. The -- there is -- after -- the MRI's are probably the last -- they're the most sophisticated of the non-invasive tests. After that, you get to invasive tests in which needles are placed into the spinal canal or into the discs themselves. And then different types of medicines, or they're actually dyes are injected into the patients, either their spinal canal or to their disc.

If the needle is placed into the spinal canal and dye is injected into the spinal canal, the dye comes down along the

nerve roots and gives a picture, and that's called a myelogram. And that's usually just one needle into the spinal canal, inject the dye, and they take a bunch of X-rays with it, and then a CAT scan.

After that, there is a test called a discogram. And a discogram is a -- I explain it to my patients as it is a stress test for the disc. And needles are placed in the bottom three or four discs, into the very center of the discs where the kind of jelly, mucusy area of the disc is. And then dye is squirted into that disc under pressure. And by increasing the pressure of the disc, that causes stress to the disc, the same as if I jumped up and down, my disc would be stressed, when I compress them. Well, this way, a patient would be laying face down on an X-ray table, and the doctor would put needles into their disc and actually stress the disc, so if the disc is healthy, it's real, real hard, and you can't inject -- can hardly inject any fluid into it, and the patient may not feel anything. Or they may feel a sense of pressure. If the disc is what we call pathologic, meaning ill, injured, usually what happens is severe pain will be caused by stressing that disc. By increasing the pressure, as I said, it's a stress test for the disc. It will cause that patient pain. And the pain that it will cause the patient is usually their, what we call their

typical pain. Now, it may be a little more severe in character, but they -- they will know that that is their pain. And it -- it is reproducible, you can squeeze in some fluid, and they'll tell you, that's their pain, if that's the disc that's causing their troubles. And you can go back and inject it again, and it will tell you the same thing. So, those are invasive tests. What we do is, while the dye is being injected, the doctor will take a few X-rays, so we can sometimes see if the dye is squirting out, out of the disc. And then after the X-rays -- after the X-rays are done and they take the needles out, they'll send the patient for a CAT scan, to help us, to see where that dye is. And that increases the accuracy of the test.

gold standard

Q. All right.

A. So the discogram is probably -- or is the gold standard, in that it usually gives -- not only does it give you a picture like an MRI does, but it tells you something about the -- whether or not that specific disc is healthy, meaning it's hard, you can't inject -- it's like trying to inject fluid into a Super Bowl -- a super ball. It won't go. Or if it tells you if it's not, if it's an injured disc, and it's a little softer, and it causes the patient their pain.

Q. All right. And, Doctor, these are -- and I take

gold standard - discogram

it you're a spinal surgeon, so at some point in the course of your treatment of your patients, you perform surgeries?

A. Yes.

Q. Okay. And we've talked about measures of diagnosing a herniated disc, pre-surgically, correct?

A. Correct.

Q. Is there a one hundred percent foolproof way of determining whether someone has a herniated disc in their spine, as opposed to not -- I'm not talking about pre-surgical, I'm talking about after surgery?

A. Oh, I mean, you can see the disc, in the operating room, you can see -- it's -- it's always very enlightening, very interesting, operating on somebody. And, you know, you -- as you go in, you go down into their spinal canal and you move the nerve roots out of the way, and you see the disc herniation. And sometimes it looks just like the pictures on the MRI on the disc, or times it looks bigger, or you can sometimes see a tear. But, you know, the -- obviously, the best way -- the best way to see a disc herniation is to go to the operating room, you can see it right there, so.

Q. And, Doctor, is surgery a common way to treat a herniated disc injury?

A. Yes.

Q. In your experience?

A. Yes.

Q. And, Doctor, have you ever treated a patient named Charlene VanDusen?

A. Yes.

Q. And do you see Mrs. VanDusen here in the courtroom?

A. Yes, she's in the pink sweater.

Q. When was the first time you treated Charlene VanDusen?

A. Do you want me -- can I look at my chart?

Q. Actually, why don't we have that marked, Doctor. What is that you're referring to?

A. This is my office record on Charlene VanDusen.

Q. All right. Would this assist you in explaining to the jury your care and treatment of Charlene VanDusen?

A. Yes.

MR. CAREY: Okay, could I have this marked?

MR. BURGIO: Your Honor, before it's marked, can we establish, is that the complete record?

THE COURT: Is that the complete record, Doctor?

THE WITNESS: Yes, sir.

THE COURT: Great. Have it marked.

THE WITNESS: It's the complete medical record.

THE COURT: Complete medical record, but -- one second, Doctor, hang on.

THE WITNESS: It's a complete medical record that I would use in the treatment of Mrs. VanDusen, in the treatment and care, diagnosis, treatment and care. It has -- it doesn't have any issues regarding financial -- you know, when he says complete record, it does not have any financial information like a bill that went out for surgery or anything like that. I don't have that. I have the medical record.

THE COURT: I'm sorry, is this the complete office record pertaining to her care and treatment?

THE WITNESS: Yes, this is what I rely on, my daily treatment of Mrs. VanDusen.

THE COURT: This is exhibit 27?

MR. CAREY: Yes.

(Plaintiff's Exhibit 27, office chart, marked for identification.)

BY MR. CAREY:

Q. Doctor, if you could, please, in referring to your

chart, could you tell the jury, when was the first time you saw Mrs. VanDusen?

A. I believe it was November 18th. I'm just looking here. Yeah, November 18th, 2002.

Q. And did you prepare a report documenting your course of treatment on that day?

A. Yes, sir.

Q. Do you have that report before you?

A. Yes.

Q. And what is the date of that report?

A. November 21st, 2002.

Q. All right. And does that assist you in explaining to the jury your treatment of Mrs. VanDusen on that November 18th, 2002?

A. Yes.

Q. Did you take a history that day?

A. I did.

Q. What was the history that you took from Mrs. VanDusen?

A. That she was working as a marketing director for Windshield, Incorporated. And she was making a call to a business. And as she was leaving, she stepped -- she was walking through the doorway, the heel of her shoe stuck in the threshold, causing her to trip and twist and fall

directly on her buttocks. I have my handwritten notes also, while at work the heel of her shoe caught between the threshold of the door, twisted, and fell to the ground. She told me that she had fallen backwards on her buttocks.

Q. You have both a report and your handwritten notes?

A. Yes.

Q. And obviously, Doctor, when you're talking about the report, you don't type this up yourself, right?

A. No, sir.

Q. But you do take handwritten notes in the time you're taking the history?

A. Myself, I also have a nurse practitioner who assists me in history taking, and usually between the two of us, we get a fairly good history.

Q. All right. And in this case, you took that history of Mrs. VanDusen as to how she was injured?

MR. BURGIO: Your Honor, this is asked and answered. We can't ask all the questions twice.

THE COURT: We've been over the history. Go ahead.

BY MR. CAREY:

Q. Well, was the history of the accident as she gave it to you, was that relevant to you in terms of diagnosing any injury to Mrs. VanDusen?

A. Yes. Well, she -- yes.

Q. Why?

A. Well, she had fallen on her buttocks. Her complaint was that she had pain in her low back that went to both legs, but was worse on the right side than left.

Q. And, Doctor, I believe you said in your notes you've got that she twisted and fell, landing on her buttocks?

A. Correct.

Q. Is that relevant, just in terms of the twisting and falling on her buttocks, is that relevant to you, as the spine surgeon, in assessing what type of injury Mrs. VanDusen may have suffered?

A. Yes.

Q. Why?

A. Well, there is -- we call it -- there is different mechanisms of injury that can cause the, as I talked about, the outer ligament of the disc is called the annulus, the very thick ligament. For a disc to be injured, the ligament, or the annulus, has to tear. There has to be a relationship in it. And then the inside of the disc may or may not spit out and herniate, or rupture outside that tear. Twisting -- a -- a force that causes twisting, and then what we call, in orthopedics we call axial compression, twisting

and squishing down is probably one of the easiest ways that a disc will tear, compared to just pushing down, you -- you would need less force pushing straight down if you twist and push down at the same time, compared to just pushing straight down. So that -- that force that we talk about is axial compression, plus a rotation or twisting is a very simple and common way that a disc -- the covering of the disc, the ligament, the annulus, will tear. And then once the ligament is torn, the inside of the disc will generally find its way out that tear.

Q. All right. All right. And so do you have an opinion with a medical -- reasonable degree of medical certainty as to whether or not the -- the accident as described to you by Mrs. VanDusen was a competent producing cause of a potential disc injury?

A. That -- yes, that is a competent producing cause of an injury to the disc.

Q. All right. What else, did you take any -- any other further history of Mrs. VanDusen with regards to her medical treatment or her pain level?

A. Yes. She -- it was interesting, she had -- she was injured on March 20th of 2001. I saw her approximately 18, 20 months later, in November of 2002. So she had a period of time for this problem to heal. Probably the most

important component of healing a disc injury percent of people that suffer a herniated dis lumbar spine are better within three months. means either they're pain free or their pain much better that they're pretty much back to normal activities. So once a patient or a person who has a disc herniation is out three months after injury and they're still suffering, the likelihood that they're going to get better without surgery is quite low. Once they hit a year, it's -- after the injury, and they're not better, the likelihood that they're going to improve without an operation is extremely low, you're talking probably 1 or 2 percent. So the most important treatment is actually time. And most people should get better within three months.

She also went to physical therapy. She modified her lifestyle. That's another important factor. She had -- she had been seen by Dr. Bansal, who is an anesthesiologist who has a practice in pain management. She had gone for epidural injections, which is a form of treatment in which a needle is placed in the spinal canal and a Novocain type of medication and cortisone is placed around the disc and over the nerve roots. And that also had not worked. So she had -- she had had more than an adequate or a reasonable course of treatment.

Q. Did you determine from Mrs. VanDusen whether she treated with any other doctors for her back injury?

A. Well, she had seen Dr. Bansal. Dr. Scanlon was her private physician, and he I think was kind of directing her care, even though he's not a spine doctor, he was helping her along. She had also seen -- she saw -- she saw Dr. Huckell, Cameron, who had done a test on her. And she had at one point seen Dr. Lewis, I believe, who's a neurosurgeon also, does spine surgery.

Q. And do you know Dr. Huckell?

A. Yes.

Q. And do you know Dr. Lewis?

A. Yes.

Q. And did you do -- did she bring along any diagnostic tests on that first day?

A. She did bring some pictures of a discogram. Dr. Huckell had attempted to perform a discogram on Charlene VanDusen, and she brought along those pictures. In addition, she brought along two different MRI examinations of her lumbar spine.

Q. All right. And did you review those MRI's?

A. Yes.

Q. All right. And did they -- did they appear relevant to you in any way, as you reviewed them?

A. Well, there were some -- there were some changes in the MRI's that were suspicious of troubles at L4-5 and at L5-S1, which were the bottom two disc levels.

Q. And specifically what changes did you see on these MRI's?

A. There was an MRI from Northtowns Imaging which was performed April 25th, 2001, which was about a month after the injury. And that showed that there was some -- was some stenosis or mild compression at L4-5, along with a possible protrusion or annular tear at L5-S1. There is also an MRI that was performed on June 25th of 2002, about 15 months after the injury that showed what I said was similar changes as the original MRI, however, there was -- I thought there was motion artifact meaning that Mrs. VanDusen had moved in the scanner. And there was some degradation of the quality of the images. And she noted that she had -- she had a bit of claustrophobia, which makes it difficult for patients to lay in the scanner.

Q. And did you take any further medical history from her?

A. Well, in regards to her -- in regards to her spine, she had -- I had asked her, she did not have any troubles with her low back that she recalled, in her life.

Q. And as an orthopedic spine surgeon, is that most

relevant history that you're looking for is with regards to her back problems?

A. Well, we're kind of looking for major -- I mean, adults having a backache is the second highest cause for people in the United States, or people in North America, missing work. The number one cause for people in our society to miss work is a cold. The number two reason for people in our society to miss work is low back pain. So, having -- having a backache, in and of itself, you can't put too much weight in it. But we're looking at like something really -- something really severe that, meaning did they have another herniated disc, or did they have a fracture of their spine, usually something with a little more meat on it than a person that had a backache and had an X-ray or something of that nature.

Q. All right. And, Doctor, did you -- did you have any history from Mrs. VanDusen that she had ever missed any time from work, prior to March 20th of 2001, for any back pain?

she hadn't worked

A. I don't believe she had.

Q. And did you take any history in November of 2002 as to whether or not she had been out of work since March 20th of 2001, because of the back injury?

A. Correct, that -- you are correct, it was her last

day that she -- the day she was injured was March 20th of 2001, and that was the last day she worked.

MR. BURGIO: Your Honor, may we approach?

(Discussion at the bench off the record.)

MR. CAREY: Doctor, did she also indicate to you any surgical history not related to any back problem?

MR. BURGIO: Your Honor, I thought we just talked about this.

THE COURT: No, overruled. We're going to move beyond this pretty soon. Go ahead.

THE WITNESS: She had -- I know she had some female type surgery I believe in the past, I'm just looking to see if I can find it here.

BY MR. CAREY:

Q. And she told you about that?

A. Yes.

Q. Is that documented in your record?

A. I just want to find it. I'm pretty certain it is.

Q. And just for the sake of moving this along, the second paragraph on page 2 of your initial report?

MR. BURGIO: Your Honor, he said he believed that she told him that.

THE WITNESS: Yeah, I do have it in my

handwriting. My typewritten is hard to find it, but in the area of my handwritten notes, she had had gynecologic surgery in the past.

BY MR. CAREY:

Q. Okay. And, Doctor, did you also take a physical exam of Mrs. VanDusen that day?

A. Yes.

Q. And what did you -- what did you find from that physical exam?

A. Well, in regards -- in regards to her spine?

Q. Yes.

A. Her -- when she stood, she had normal balance, meaning she wasn't tilted to the right or left. There was severe tenderness directly over her spine, when I actually pushed on the spine itself, on those little bumps in the middle of the back, right over the spine, when you pushed on those bottom three vertebrae, at L3-L4, L4-L5 and S1, she was quite tender there. Actually, it says severe tenderness. She got in and out of a chair with difficulty. When she was sitting, she tended to sit on the left buttocks. Her gait was normal, reciprocal, as we say. She could only bend forward 30 degrees before pain would stop her from bending further. She could only bend backwards about 10 degrees.

She was able to walk on her heels and toes, however she had a difficult time performing that. In addition to pain or tenderness right on the spine, the right side of her muscles in the low back were tender, as was the sciatic notch, right over -- in her buttock. Below her spine there is an area where the sciatic nerve comes out, and she was very tender in that area.

Q. All right. And, Doctor, is that consistent with a disc injury, in your experience?

A. It -- it's -- yes, yes.

Q. And, Doctor, did you make an opinion on that date, November 18th, 2002, as to what Mrs. VanDusen may be suffering from?

A. Well, I thought that she had a disc herniation at L5-S1, with what we call radiculopathy, which means pain going into the legs. I wasn't completely certain. And I do mention later on in my letter that there was either a disc herniation or an annular tear at L5-S1 or at L4-5. So I thought she had some form of injury at one or both of those levels.

Q. Did you make -- did you -- did you make a request for authorization for any other diagnostic test?

A. Yes, I asked for an updated MRI on a 1.5 tesla machine.

Q. And, by the way, have there been other MRI's that were not on the 1.5 tesla machine?

A. I believe that the first -- the first two MRI's that Northtowns machine I believe is a .35 and the Physicians machine I believe is a 1.0 tesla machine. So neither of them are the 1.5 --

Q. All right.

A. -- variety.

Q. And what does it mean, to have L4-5 stenotic --

A. Well, as -- it was a bit narrow in that area, stenosis means that the canal -- the diameter of the canal was a little narrower compared to immediately above it and below it.

Q. What can cause narrowing of the canal?

A. Well, you can have it from a disc herniation, can cause it. or degeneration

Q. And, Doctor, did -- on that date, did you make a determination as to what the cause of Mrs. VanDusen's problems was?

A. Well, my -- my diagnosis was that she had some form of injury to one of the bottom, either the bottom disc, or the bottom two -- either the L4-5 disc, or L5-S1, or both of those had either been torn and/or herniated, that was causing her severe pain.

Q. And on that date, on November 18th, 2002, did you record in your report whether or not the fall of March 20th of 2001 was the cause of that injury?

A. I -- I did.

Q. What did you report?

A. Well, I'll read from my letter. Once again, this lady denies any trouble with her back prior to the injury of 3/20/01. Causality is therefore one hundred percent related to the injury of 3/20/01 at Windshield, Incorporated.

I note that she has not worked since that time, and remains totally disabled for the next --

Q. All right. And with regards to -- did you make a determination as to when you -- when you would see her again?

A. I was going to see her in approximately six weeks.

Q. And, by the way, during this -- did you -- did you then see her six weeks later?

A. Yes, I saw her on January 7th of 2003.

Q. And what did you do that day?

A. I examined her, I noted in my letter that she was miserable with pain in her back and legs. I examined her. She was tender over her spine. She had a little -- a loss of lumbar flexion, and I basically requested for some more testing, because we hadn't received authorization for

further testing.

Q. All right. And did you -- did you have an opinion at that time as to whether she was still disabled from returning to work?

A. Yes, I noted that she was totally disabled.

Q. All right. And when was the next time you saw Mrs. VanDusen?

A. February -- February 10th of 2003.

Q. All right. And between your treatment of Mrs. VanDusen on January 17th in 2003, and your examination of her on February 10th of 2003, had Mrs. VanDusen undergone any tests?

A. Yes.

Q. What tests had she undergone?

A. She underwent a discogram of her lumbar spine.

Q. All right. And had you reviewed that discogram?

A. I did see that, yeah, yes.

Q. And is that something that you commonly rely on, and I believe you've testified that's something you commonly rely on in your practice to determine, I think you called it, the gold standard, for determine whether somebody has a disc herniation?

A. Yes.

Q. And do you know if there is a -- a film or --

there is some report of that discogram?

A. I do have the report by Dr. Iqbal, yes.

Q. Who is Dr. Iqbal?

A. Dr. Iqbal is one of the radiologists at the Buffalo General Hospital, and he performs -- actually, he performs, I would say, the great majority of the invasive tests for spine, for the spine surgeons. He does myelograms and discograms for us.

Q. And is a discogram something that you commonly rely on Dr. Iqbal to perform on your patients?

A. Yes.

Q. All right. And was it your understanding Mrs. VanDusen had had a prior discogram attempted by someone else?

A. She had one by Dr. Huckell. I had seen the X-ray portion of the discogram. I don't believe that a CAT scan was done afterwards. It wasn't attempted -- it wasn't a complete discogram. He didn't -- he wasn't able to get the -- all the discs done.

Q. All right. And, Doctor, as an orthopedic surgeon, do you -- do you generally do your own discogram, or do you have Dr. Iqbal do it?

A. No, I -- I -- I have Dr. Iqbal do my discograms.

Q. Why?

A. Well, there is -- there is two major reasons. The major reason is he probably does a thousand a year.

Q. Is it fair to say, Doctor, he's better at them than you are?

A. Yes, quite facile at -- at performing discograms. He has a team. They're dedicated to -- a specific dedication to doing those specific tests. And -- and performing a discogram has -- it's like any other job, in that there is certain nuances in a job, to get it done. And, it's one of those things that if you're doing it all the time, you tend to be more facile, or better at it.

THE COURT: Doctor, pardon me for one second. We've got that point. Let's move on to the treatment of Mrs. VanDusen. Excuse me for interrupting.

Q. I'd like to have marked in evidence -- let me ask you, the discogram report, is that something that you -- that you commonly rely on in the treatment of your patients?

A. Yes.

Q. Is that something that you referred to and relied on, in the course of your treatment of Mrs. VanDusen?

A. Yes.

Q. All right. And is that the report that you did rely on?

A. Yes.

MR. CAREY: All right. May I have this marked? Is this also part of it?

(Plaintiff's Exhibit 28, discogram report, marked for identification.)

MR. CAREY: Your Honor, I'd seek to move Plaintiff's 28 into evidence.

MR. BURGIO: No objection.

THE COURT: Mark it.

(Plaintiff's Exhibit 28 marked into evidence.)

BY MR. CAREY:

Q. Referring to Plaintiff's 28 in evidence, Doctor, would you please tell the jury what that discogram -- well, first of all, what date was that discogram done?

A. January 29th of 2003.

Q. All right. What did that discogram reveal, to you, as the treating orthopedic surgeon?

A. It revealed that the disc at L4-5 had a herniation. It -- when Dr. Iqbal -- Dr. Iqbal injected the bottom three discs. The specific disc at L4-5, which was in between -- that was the middle disc, reproduced Mrs. VanDusen's severe back pain. The disc above it and the disc below it caused no pain on injection. So she had a

herniated disc at L4-5.

Q. And -- and, Doctor, by the way, with regards to the discs above and below it, were there any signs of degenerative changes in those discs?

A. No.

Q. And is that consistent with the other MRI's you reviewed with regards to showing no degenerative changes in Mrs. VanDusen's discs?

A. Yes.

Q. And is that significant to you in determining the cause of the herniation which you did find in Mrs. VanDusen's disc?

A. Yeah. The way that Dr. Iqbal performs a test is that the patient is not aware of which discs are being injected. And the important factor here is that only one disc caused pain, and caused the pain that she was familiar with, or her typical pain. That is the disc that Dr. Iqbal found to be herniated. So as he's injecting the discs, she doesn't know which one is L4-5 or which one is L5-S1 or L3-4, he's injecting the disc, and she says, that is the one that's hurting me. And that happens to be L4-5. And the test did show that that disc was herniated, so it was not a normal looking disc. It did -- it was the only one of the three that had a herniation. There is no degeneration. It

was a traumatically injured disc.

Q. And, Doctor, when you say injecting fluid, is there -- is there a certain amount of fluid that is involved in determining whether or not a disc is injured as well?

A. Usually a normal disc will take anywhere from, say 1 or maybe 2 cc's of fluid. Once it starts taking more than 2 cc's, it's usually abnormal. Mrs. VanDusen's disc at L4-5 took 3 and a half cc's of fluid and caused severe pain. So that's -- that's more -- it's more fluid than normal. It's not twice as much, but almost twice as much as normal.

Q. Is that also indicative of a disc herniation?

A. Well, I think there is three things there that are important. Number one, number one, that specific disc reproduced her specific pain. That's the most important part right there.

The other part is that, that when -- when -- the dye is injected, so you can see the dye on the X-ray and CAT scan, it shows there is a herniated disc. That confirms, she's saying it hurts, that's pain, the disc is herniated on the picture, and it took 3 and a half cc's of fluid, which is a fair amount of fluid. It's not one or 2 .cc's, it's another -- even if 2 cc's is the upper normal of a normal disc, she's taking 3 and a half. So, there -- and it's just the one disc, it's not like all three discs, it's just one.

Q. All right. And, Doctor, and I apologize on one question earlier you -- we had talked about degenerative conditions as opposed to a -- let me ask you, what are the differences between degenerative disc pain and traumatic disc pain or traumatic disc herniation?

A. Well, a degenerative disc usually shows a lot of collapse. The MRI in particular will show that it's lost its water content. When the disc is injected on a discogram, the dye will not be nice -- on a discogram, when you look at the X-ray, it looks like a little cotton ball in the center of the disc. And that's what a normal disc looks like. And a degenerated disc, it kind of just flows out, like pouring a pancake, pancake batter, the dye just flows out, throughout the disc.

Mrs. VanDusen's disc at L3-4 and at L5-S1, the one above and below were normal. They had little cotton balls, like little bunny tail. The one in the middle that the dye poured out to the left side, and there was a herniation there. And that was confirmed on the pictures, the X-ray pictures with the discogram, and then on the CAT scan afterwards.

MR. BURGIO: Your Honor, this has been discussed, again.

THE COURT: Move on, Mr. Carey.

BY MR. CAREY:

Q. Doctor, is that relevant in determining whether or not Mrs. VanDusen's injury was traumatically caused, as opposed to just simple degenerative change?

A. That's a traumatic injury. That was not a degenerative -- it was not a degenerative process, it was a traumatic injury, it was an acute, one time event.

Q. And if there had been degenerative changes, would you have expected to see them at the discs above and below as well?

A. Yes, you would have seen more widespread changes. And the actual picture would have, like I said, kind of just -- the dye would have seeped everywhere, and not just out the left side.

Q. Okay. And, Doctor, after you reviewed this discogram, and I believe it was -- did you make some determine -- well, strike that. Let's go back. Did you see Mrs. VanDusen after you reviewed the discogram?

A. Actually, I -- yes, I did. I reviewed the -- let me just get it. My -- the letter that we were just discussing was actually a letter that I had sent out for notification, because she had a discogram and then I had spoken to her over the weekend. She had the discogram on a Friday, and was having some -- having some difficulty over

the weekend, and I wanted to document what was going on. That was on February 10th. I did see her on February -- on February 14th of 2003. And we reviewed the discogram together.

Q. All right. And on that date, February 14th of 2003, did you make any recommendations to Mrs. VanDusen as to what course of treatment you would recommend?

A. Well, I advised her that she was going to need surgery to correct that problem.

Q. And did you discuss with her different types of surgery, or one particular surgery, or do you recall?

A. Well, I thought that she was more suited to have the disc removed and having a spinal fusion. And there are different ways to approach it. She wanted to approach it with a -- with a more minimal kind of approach, a smaller incision type of surgery, and just to take the herniation out to see how she would fare. And then she was hoping that that would remedy her problem.

Q. All right. And did you go on to perform a surgery on Mrs. VanDusen?

A. Yes.

Q. And what surgery did you perform?

A. I did a discectomy, a small surgery that we had discussed, and performed that on March 14th -- a month

later, March 14th of 2003.

Q. And, Doctor, did you --

THE COURT: What was the date, Doctor? I'm sorry. Pardon me, Mr. Carey, what was the date?

THE WITNESS: March 14th, 2003.

THE COURT: Sorry. Go ahead.

BY MR. CAREY:

Q. And, Doctor, do you have an operative report regarding that surgery?

A. Yes.

Q. Okay. And would it be possible to tear that out of your file? I'd like to have that.

(Plaintiff's 29, operative record, marked for identification.)

Q. And, Doctor, is plaintiff's Exhibit 29 an operative report which you prepared with regards to the surgery you performed on Mrs. VanDusen on March 14th, 2003?

A. Yes, sir.

MR. CAREY: Your Honor, I'd like to move it into evidence.

THE COURT: Any objection?

MR. BURGIO: No.

THE COURT: Mark it.

(Plaintiff's Exhibit 29 marked into

evidence.)

BY MR. CAREY:

Q. Doctor, would referring to the operative report assist you in your explaining to the jury what you found in Mrs. VanDusen's back on March 14th, 2003?

A. Yes.

Q. Did you -- first off, on March 14th, 2003, where was this surgery performed?

A. Buffalo General Hospital.

Q. And where had the discogram been performed?

A. Also at the Buffalo General Hospital.

Q. Okay. Had that been performed -- and that had been performed by Dr. Iqbal, correct?

MR. BURGIO: Your Honor, we can't go back over this.

THE COURT: It seems to be repetitive, Mr. Carey. Let's keep moving forward.

BY MR. CAREY:

Q. Okay. Did you have a preoperative diagnosis for Mrs. VanDusen at the time you went in for this surgery on March 14th?

A. Right. The diagnosis was L4-5 herniated disc with radiculopathy.

Q. And that was a diagnosis -- did you have a

postoperative diagnosis?

A. It was the same, L4-5 herniated disc with radiculopathy.

Q. And why did you have the same postoperative diagnosis and preoperative diagnosis?

A. Well, the intra-- as they say in medicine, the intraoperative findings, what I saw in surgery was she had a disc herniation, the same as Dr. Iqbal diagnosed on the discogram. So the diagnosis going in was the same as the diagnosis leaving the operating room. And what was found was a herniated disc at L4-5.

Q. All right. And could you describe the surgery that you performed -- performed on Mrs. VanDusen on March 14th, 2003, for the jury?

A. The surgery was performed under general anesthetic, which means that the anesthesiologist would, in addition to intravenous medicine, would put a tube -- put a tube into Mrs. VanDusen's -- down her mouth and into her throat and into her lungs and then gave her general anesthetic to keep her asleep, almost into a -- into a coma, so to speak, so that she could not hear. The anesthesiologist will give the medicine to paralyse them so they can't move on the table, and also give them medicine that gives them amnesia. So in the past we would hear

horror stories of people saying, well, I heard something going on during surgery. The medicines now stop that. So, she's -- the doctor -- the anesthesiologist was breathing for her, giving her fluids, and giving her medicine to keep her comatose, paralyzed, and give her amnesia.

Q. And what did you do?

A. All right. She was face down on the table, on an operating table, that's called a Jackson table. That's a table that we use to operate on patient's spines, face down, protected, her arms out at her sides. And then we would give her a little bit of antibiotics intravenously to reduce the risk of her getting an infection, and paint her back with antiseptic, and then drape the spine and made a small incision over her lower back -- I'd have to see the scar, I don't remember how long the scar was, but it's usually not that long, and inch or maybe two inches, right at L4-5. And go down through the skin, and then down onto the spine, on the left side of the spine, take the muscles away from the spine, and then make a little hole in the back of the spine between L4 and L5, and that's called a laminotomy.

Q. And, Doctor, when you say in your report the spine was stripped on the left side, what does that mean?

A. That means that the muscles were peeled off.

Q. And I'm sorry, proceed as to what --

A. And then we make a little hole in the bone between L4 and 5, that's a laminotomy, and then you can see the nerve root. As it will say in my report, the L5 root was identified and gently retracted immediately, which means I saw the root and I moved it over, out of the way. And when I moved that out of the way, the disc herniation is immediately underneath that. And there was, I noted, the L4-5 disc was identified, in a small to moderate -- in a small to moderate size, left-sided disc herniation was noted. A discectomy was performed, which means removing that herniated part of that disc.

Q. And how do you remove it?

A. We actually get a tiny scalpel, make a little hole in the annulus, in the outer covering of the disc, the ligament, and take small instruments and reach inside the disc and then pull out any free disc fragments that are there. There may be pieces of the annulus, the ligament, and the center, the jelly part, which is called the nucleus, and we pull that out.

Q. And what is the goal of that surgery, Doctor?

A. The disc is herniated, and pushing against a nerve root. It's causing a degree of -- it's causing pain, a combination of spine pain, and pain in her legs. The herniation was on the left side. And so then I open that

area on the left side and remove the pressure so the disc would not be pushing against the nerve root on the left side.

Q. And that surgery was completed. Do you know if Mrs. VanDusen spent any time in the hospital?

A. She was in the hospital for a few days. I don't have the actual hospital -- let me just see here.

THE COURT: A few days is your testimony, Doctor?

THE WITNESS: Yes.

THE COURT: That's fine. Go ahead, Mr. Carey.

BY MR. CAREY:

Q. And, Doctor, with regards to the patients that you treat for surgery, and specifically with Mrs. VanDusen, did you anticipate that Mrs. VanDusen would experience post surgical pain?

A. Yes.

Q. What type of pain do they experience post surgical?

A. Fairly severe pain.

Q. And why?

A. Well, the incision actually, in a lady Mrs. VanDusen's size, the -- from the skin down to where the

disc is removed is probably about four inches deep. So it's -- say the incision is two inches long, and four inches deep. That kind of invasion into a person's body is typically quite painful, wherever it is, whether it's in there taking out their gallbladder or appendix.

MR. BURGIO: Your Honor, taking out the gallbladder is not the subject here.

THE COURT: Let's get to the next subject, Mr. Carey, if we can, please.

MR. CAREY: In your treatment of Mrs. VanDusen, is it your understanding that she did have substantial post surgical pain?

MR. BURGIO: Your Honor, asked and answered.

THE COURT: No, is that your understanding, sir?

THE WITNESS: Yes, sir.

THE COURT: Next question.

BY MR. CAREY:

Q. When did you next see Mrs. VanDusen after the surgery?

A. April 10th, about one month after surgery.

Q. All right. And what was your -- what did you find with Mrs. VanDusen at that time?

A. She was recovering. She was sore. The incision

had healed. She wasn't wearing her brace. It tended to bother her. And I note that she had relatively reasonable pain relief.

Q. Okay. Did she -- did she describe to you that -- that her pain had improved from the surgery?

A. She -- she had moderate pain relief. She did not have wonderful pain relief.

Q. Did you anticipate that she would have wonderful pain relief?

A. No.

Q. Why?

A. Well, I --

MR. BURGIO: Your Honor, this is speculation, isn't it?

MR. CAREY: He's the treating --

THE COURT: No, go ahead, Doctor.

THE WITNESS: She had a lot of spinal pain, plus she had pain in both her legs. Actually her right leg pain was a bit worse than the left leg pain. And the problem with that type of patient, and in particular at L4-5, L4-5 is a disc that's noted to cause a lot of spinal pain. And with the pain being in both her legs, to stabilize that -- that level, holding it together and fusing it,

even though it's a larger operation, I -- I thought that that's the operation that she needed. It was a larger -- quite a bit larger operation than a lumbar discectomy.

Her request for removing the disc, doing the discectomy, was not out of line. Many -- some doctors would say, well, let's try discectomy first, and if it doesn't work we'll do a fusion. I'm more of the opinion saying, look, you need a fusion. She wanted to try just more minimum surgery, which many people will do; they'll say, we'll give it a shot. But, I -- my -- in my experience, she was going to need to have a spinal fusion, so I did not expect her to have superb pain relief.

BY MR. CAREY:

Q. And did you make any recommendations on April 24th, 2003, as to limitations that she had, in terms of activities?

A. She could straight leg raise 80 degrees bilaterally. That -- that was basically it.

Q. And did you -- did you make any recommendations as to types of activities she should not perform?

A. I asked her to wear her brace. She also should

not be performing any type of vigorous activities such as pushing, pulling, lifting, bending, leaning, or carrying.

Q. And did you make any determination on that date as to whether or not Mrs. VanDusen continued to be disabled from work?

A. I had placed her on total temporary disability for three months after a discectomy.

Q. And is that standard?

A. In my practice it is, yes.

Q. And when was the next time you saw Mrs. VanDusen?

A. July 29th of 2003.

Q. All right. And did you take a physical -- physical exam that day?

A. Yes.

Q. All right. And did you also determine -- make a -- have an opinion that day with regards to Mrs. VanDusen's condition?

A. Well, she had -- I note, I kind of misspoke in my letter. I said, this lady continues to suffer from an L4-5 disc herniation. Technically she did, but she was postoperative, I should have said she recovered from surgery.

I asked her to perform some stretching exercises, and that was -- that was pretty much it.

Q. All right. And did you also prescribe any Valium for her that day?

A. Yes.

Q. Why?

A. She had quite a bit of spasm in her back. She had rated her pain that day at 10 out of 10. We have a standard pain scale that's used in medicine, and she was suffering quite severe pain in her back and legs, with a lot of muscle spasms, so I placed her on Valium to try to --

Q. And what is the significance of muscle spasm?

A. It is in reaction to her -- her spine is unstable at L4-5. And the pain will cause the muscle to go in spasm. And it's very difficult for patients to live with, so I placed her on Valium to reduce that.

Q. All right. And when was the next time you saw Mrs. VanDusen?

A. August 6th, 2003.

Q. And what was your -- what did you find at that time?

A. Well, I think it was pretty much the same as the July visit. Her spine was tender, L4-L5 and S1. She had difficult time getting in and out of a chair. It took a few -- it took a few seconds for her to stand up. She could only bend forward 20 degrees.

MR. BURGIO: Again, Your Honor, I think this was all covered with Mrs. VanDusen.

MR. CAREY: This is postoperative.

THE COURT: Mr. Carey, how much more do you have, sir?

MR. CAREY: Not much more, we're going to go to the other surgery, and then we're done.

THE COURT: Let's go to it.

BY MR. CAREY:

Q. Doctor, have you continued to treat Mrs. VanDusen since August of 2003?

A. Yes.

Q. And how -- approximately how many times have you seen her?

A. Three, three times since that visit we talked.

Q. Okay. And has her condition improved?

A. No.

Q. All right. Has her condition worsened?

A. Yes.

Q. Is there -- has a determination been made as to what her future course of treatment is with you?

A. Well, she needs to have her spine fused, at least at L4-5.

Q. And is it your opinion, within a reasonable degree

of medical certainty, that Mrs. VanDusen will need that lumbar fusion in the immediate future?

A. Yes.

Q. And is it your understanding that that fusion is to be performed in the immediate future?

A. There has been some issues. We -- actually we were going to perform it, but there's been some issues, some family issues with the health of one of her children, so --

Q. Okay.

A. That's -- it's going to be performed, but not at this specific point in time.

Q. Okay. And in terms of when it will be performed, do you have an understanding as to when it will be performed?

A. Well, her -- her one child has some health issues.

MR. BURGIO: Your Honor, it's a simple question.

THE WITNESS: I don't have a date.

THE COURT: It's going to happen soon.

THE WITNESS: I don't have a specific date.

THE COURT: It's going to happen soon is his testimony. Let's go ahead, Mr. Carey.

BY MR. CAREY:

Q. And, Doctor, what is the surgery that you're going

to perform?

A. She's going to have to have her spine fused at least between L4-L5, and actually down to the sacrum.

Q. And do you have anything that would help you explain to the jury what the procedure is that you're going to need to do on Mrs. VanDusen's back?

A. Yes, I do.

Q. What do you have?

A. I brought a model that I use in my office to show patients these operations.

Q. All right. May I please have that marked?

MR. CAREY: And, Doctor, if you will, if you will step in front of the jury to explain, please -- why don't we have this marked.

(Plaintiff's Exhibit 30, model, marked for identification.)

Q. Doctor, using Exhibit 30, could you please explain to the jury what surgery it is that you're referring to, which -- that you'll be performing on Mrs. VanDusen?

A. This is a model of the lumbar spine, as we showed before. And what we're seeing here are the bottom vertebrae, this would be L4-L5, and the sacrum, are held in place with titanium screws and rods. In addition we would take some bone from the bone bank, and also some bone marrow

from her pelvis, and then pack this around -- around the spine. And also remove the discs at L4-5 and L5-S1 and put struts of bone between the vertebra so that this entire area from L4 to the sacrum would be one massive bone.

Q. Okay. And, Doctor, are there any risks with regards to this surgery?

A. Well, they're long surgeries. They take, some are about three hours to perform. We have to give patients antibiotics to reduce the risk of infection. They're done under general anesthetic. So there is general risks of death and paralysis and heart attacks and strokes, things of that -- potential complications of that nature that we have to discuss with patients before surgery.

Q. All right. And, by the way, with regards to the bone that you put in to replace the disc, how many levels is that, that you're talking about?

A. Well, she's going to need to have her spine fused from L4 to the sacrum, just because the entire area is painful.

Q. And where would you get that bone from?

A. Well, some of the bone will be taken from her.

Q. Where, from her?

A. Well, usually from the back of the lamina. We used to take bone from the pelvis, and we still do at times

if patients want us to, but more and more we're using bone from the bone bank, and we'll put a needle into the pelvic bone and put in bone marrow, and mix that with bone from the bone bank. It's usually less -- that technique is less painful for the patient, compared to taking the -- compared to taking a lot of bone from the pelvis.

Q. All right. And, Doctor, post surgically is there going to be significant pain for Mrs. VanDusen?

A. Yes.

Q. And will there be any scarring from this?

A. Well, the whole area is -- will be scarred. It's an incision that's probably going to be about six inches long, and then it goes down, down to the spine. So that whole area of soft tissue will be one large scar.

Q. All right. And from where -- can you demonstrate on your own back what area -- where that scar is going to be?

A. Well, probably in the low back, right from the top -- a little bit above the crease in the buttock, up about six inches from there.

Q. All right. Thank you, Doctor. You can have a seat. Doctor, what is -- what is the goal of this fusion surgery?

A. The goal is to give moderate pain relief.

Q. Will this surgery eliminate all of Mrs. VanDusen's pain?

A. No.

MR. BURGIO: Your Honor, that's speculation.

THE COURT: No, overruled.

THE WITNESS: No. I -- I explain to my patients that these operations are what we call palliative, they're not curative. They're not going to make her normal or bring her back to her pre-injury state. They should fairly reliably give her 50 percent to maybe 60 percent pain relief, unlikely to give her more pain relief than that.

BY MR. CAREY:

Q. All right. And, Doctor, are you talking about on a permanent basis?

A. Yes.

Q. All right. Will this -- in your opinion, will this improve Mrs. VanDusen's ability to engage in life activities?

A. Yes.

Q. All of them?

A. No. I -- once again, she's -- her pain scale has been between 8 and 10 out of 10 for quite a while. And if

her -- the -- the philosophy is, if we can improve her pain by 50 percent, she'll be able to be a bit more active. I think that she'll still lead quite a sedentary lifestyle. That's -- it's the nature of the -- it's the nature of this problem that she has, and it's also a limitation of the surgery, that -- the very surgeries that we have to remedy this are limited in their abilities. So if we can reduce her pain 50 percent and make her more comfortable and allow her to live a more comfortable sedentary lifestyle, that's what I would expect.

Q. And, Doctor, you mentioned earlier before that if the discs were not in the spine, your spine would be like a candy cane?

A. Stiff like a candy cane, correct, yes.

Q. Is that -- is that what Mrs. VanDusen's spine is going to be like from L4 down to S1?

A. Yes, she's going to lose two motion segments in her spine. She has five motion segments in the lumbar spine, she's going to lose two of them.

Q. Does that have any effect on her susceptibility to future injury, on different parts of her spine?

A. Well, it puts more stress on the --

MR. BURGIO: Your Honor, this is speculative.

THE COURT: No, we'll hear it. Go ahead.

Make it brief, Doctor.

THE WITNESS: It puts more stress on the area right above the L3-4 disc, so that's more susceptible to injury. And on a long-term injury, it actually puts a lot of stress through the sacroiliac joints. So down the road she'll probably get some arthritis in her sacroiliac joints because that's the joint above and the joint below. That's what we usually tell our patients.

BY MR. CAREY:

Q. And is that your opinion, within a reasonable degree of medical certainty?

A. Oh, yes, it is, yeah.

Q. And, Doctor, do you have an opinion with regards to whether or not Mrs. VanDusen will be able to return to employment, or work, after this fusion surgery?

A. That's very doubtful. I don't think she's going to be able to return to work.

Q. Why?

A. Well, once again, the nature of her problem, and the nature of the surgery would not allow her to return to a vigorous lifestyle. It will allow her to return to a more sedentary lifestyle. For a patient such as this to return

to the work place, first of all, I don't believe that she'll be able to work on a full-time basis. She might be able to work, say, two, three, four hours, three or four days a week, provided the environment that she's working in allows her to change positions, not have to push, pull, lift, carry, that kind of -- those -- those kind of tasks. So it's -- those type of -- on an ideal setting, you can -- you can formulate a job. But in the real world, there aren't many jobs like that. So --

MR. BURGIO: Your Honor --

THE COURT: That's enough. Let's go. What else do you have. I got to give the jury a break here.

BY MR. CAREY:

Q. And, Doctor, first off, with regards to her ability to engage in -- strike that. Will it affect her ability to sit for periods of time?

A. Yes.

Q. Affect her ability to stand for periods of time?

A. Yes, sir.

Q. Walk?

A. Yes.

Q. Drive?

A. Yes.

Q. And, Doctor, and I know I'm backtracking briefly, what is the cost of the surgery that you're talking about, the fusion surgery?

A. Approximately $15,000.

Q. And that's for the surgeon?

A. Correct, that's the surgeon fee.

Q. That's not counting the hospitalization?

A. Correct.

Q. And in doing these surgeries, do you have an opinion, with a reasonable degree of medical certainty, as to what the cost of the hospitalization will be?

A. Yes, I can give you a range, pretty close.

Q. And what is that?

A. Somewhere between 60 and $70,000.

Q. In addition to the $15,000?

A. Yes, sir.

Q. All right. And what about with regards to the discectomy to date?

A. Cost -- the fee, schedule-wise?

Q. Yes?

A. About $3,200, $3,300, somewhere in there.

Q. For the discectomy?

A. I believe so, yes.

Q. All right. And what about the hospitalization?

A. Probably in the order of $15,000.

Q. All right. And, Doctor, will Mrs. VanDusen continue to need pain medication into the future?

A. Yes.

Q. And do you see that ever stopping?

A. No.

Q. And is that unusual in patients that you perform these surgeries on?

A. No, it's typical. Patients that have these types of operations will have to take narcotics, muscle relaxants, perhaps once or twice a day, or three or four times a week, that's fairly routine, even after what we consider successful surgery.

Q. All right. Doctor, last two questions, is -- is it your opinion, or all of the opinions you've set forth today, are these opinions you make with a reasonable degree of medical certainty?

A. Yes, sir.

Q. And in your opinion, are all of the injuries and the conditions that Mrs. VanDusen suffers from, are these all permanent?

A. Yes, sir.

Q. All right. And that's your opinion with a reasonable degree of medical certainty?

A. Yes, sir.

Q. And, Doctor, do you have an opinion, within a reasonable degree of medical certainty, what the cause of the injury and all the treatment and the future problems that Mrs. VanDusen will have, is?

A. Well, I believe the cause, as I've noted in my letters, was of her -- of her problems was the fall she suffered on March 20th of 2001.

Q. Thank you, Doctor. Oh, and, Doctor, briefly, are you being paid to appear today, for your time.

A. I'm being paid for my -- for my day away from the office, yes.

Q. And if you weren't here testifying, what would you be doing?

A. I'd be in the office, and also in the operating room.

Q. All right. And when you -- have you testified in courtroom before?

A. Oh, yes, yeah.

MR. BURGIO: Relevance, Your Honor.

THE COURT: That's sustained. I think we're good.

MR. CAREY: All right.

THE COURT: Thank you, Mr. Carey.

Members of the jury, thank you very much for hanging in there.

Doctor, you can step down, sir.

Go ahead. You can stretch your legs. Let's take a 15 minute recess, so you get a good stretch. You've really worked hard this morning. We appreciate it. And we'll see you back here in the courtroom at 11:30. Thank you.

(11:14 a.m. - Recess - 11:32 a.m.)

(Defendant's Exhibit U, Dr. Scanlon's records, marked for identification.)

(Defendant's Exhibit V, pharmacy sheet, marked for identification.)

THE CLERK: All jurors and counsel are present, Your Honor.

THE COURT: Great. Everybody have a seat. Mr. Burgio, we're all set for you, sir.

CROSS EXAMINATION

BY MR. BURGIO:

Q. Dr. Capicotto, you'll agree with me that taking a history from the patient is a very important part of your treatment and diagnosis, and I think you said that to the jury earlier this morning, is that correct?

A. I don't know if I said very important, but it

is -- it's standard, what we do, and it's important.

Q. It's one of the elements, right?

A. It's one of the elements of treating a patient, correct.

Q. And you certainly expect that the patient, in this case, Charlene VanDusen, is truthful with you, when she tells you her history, is that correct?

A. Yes.

Q. Okay. In other words, you don't go out and verify whether she fell on March 20th of 2001?

A. No.

Q. And you don't know if she fell on her buttocks on if she fell on her knees, do you?

A. Correct.

Q. And you don't know for a personal fact, personal knowledge as to whether or not she tripped on a carpet or got her heel caught in a threshold, you don't know that for a fact, you're believing her, true?

A. Yes, sir.

Q. And, again, the opinion that you gave this jury that the treatment that you gave her relative to surgery and her -- your meetings with her, and ordering the discogram, and ordering an MRI, that treatment was based on the history she gave you? And the reason that you saw it as causally

related to an accident is based on her history, is that true?

A. Yes, sir.

Q. So you'll agree with me, if her history is inaccurate, then your opinion relative to causal relationship may not be accurate?

A. Can you --

Q. If she gave you a false history, then your opinion on causal relationship may be inaccurate?

A. I'm not certain what you mean by a false history. Patients don't always -- they may not remember every single thing. They have their history, her recollection. I -- my problem is the word false.

Q. True or false, if she gave you a false history, if she never fell, your opinion on causal relationship would be inaccurate, true?

A. You're correct there, yes.

Q. Okay. If she actually had been in a car accident on March 20th of 2001, that would have been an inaccurate history, and actually your theory on causal relationship would be inaccurate because it's based on her history, that's true, isn't it?

A. It's possible.

Q. Now, Doctor, did she give you -- certainly there

are more causes to a herniated disc than a fall, true?

A. Yes, a fall is one way it can be injured, yes.

Q. And there are hundreds of ways to herniate a disc, are there not?

A. I don't know if there is hundreds, but there is multiple ways a disc can be injured.

Q. And you've treated people that have had herniated discs that weren't traumatic, haven't you?

A. I think that disc herniations are traumatic injuries.

Q. And is it your opinion that this disc herniation occurred on March 20th of 2001, by her history, that it occurred on that specific day?

A. Yes, yes, sir.

Q. Okay. And no day thereafter?

A. You're correct.

Q. Okay. But, let's go back to the other causes of a herniated disc, okay. People in motor vehicle accidents, may they suffer herniated discs in the lumbar spine?

A. It can happen, you're correct.

Q. And people in work related occupations that have to lift and bend, certainly, they can sustain herniated discs, is that true?

A. Yes, sir.

Q. And people who are rear ended in a motor vehicle accident by a vehicle going 45 miles an hour, they can suffer a herniated disc at that particular time, is that true?

A. That's possible also.

Q. Okay. And you've treated those kinds of herniated traumatic discs, haven't you?

A. Yes, sir.

Q. And people that are bending, are lifting, how about playing racket ball, can that cause a herniated disc, you twist wrong?

A. I assume it can happen, yes.

Q. And how about sneezing, even a sneeze can cause a herniated disc, can't it, Doctor, it's possible?

A. I guess under the right circumstances, it can happen.

Q. Did, in -- giving you her history, did Mrs. VanDusen tell you that she had been involved in a car accident in October of 1998?

A. I don't believe so.

Q. Okay. You can look at your notes. And, of course, you told this jury that you don't expect everyone to tell you about a prior back history, about every little backache, but certainly you expect them to tell you that

they've been in a car accident, don't you?

A. Not necessarily.

Q. Okay. And, Doctor, do you expect them to tell you they were in a car accident when they were treated by two neurosurgeons, had an MRI and an X-ray, and were treated by a family physician for over eight months for that car accident, wouldn't you expect that that would be a part of the history, isn't that what you're looking for?

A. Well, I don't -- it all depends on -- it would depend on --

Q. Doctor, yes or no, is that a part of what you're looking for?

A. It could be.

Q. Okay. Was it given to you here, that she was in a car accident in October of 1998?

A. No, it was not.

Q. Did you review Dr. Lewis's records from the year 1999?

A. No.

Q. Do you know that Dr. Lewis ordered a discogram, the same kind of discogram that you ordered, for her in 1999, did you know that?

A. No.

Q. If somebody orders a discogram -- how much does an

MRI cost?

A. Probably about $1,000 -- close to $1,000.

Q. And a discogram, how much is that going to cost?

A. Close to $2,000.

Q. Okay. So a doctor is not going to order those tests because somebody's having a little backache, are they?

A. I would not assume so.

Q. No, okay. All right. But she didn't tell you that those tests were ordered for her in 1999, did she?

A. You're correct.

Q. And it would have been nice to have an MRI from 1999 to compare to the MRI that you ordered in January of 2003, wouldn't it?

A. It would have been interesting.

Q. Yes, okay. Because then you could compare them, right?

A. Correct.

Q. Okay. And you could see if there are any changes, true?

A. Yes.

Q. Okay. Because a car accident can cause a herniated disc?

A. It's possible, correct.

Q. It's possible, sure. Did she tell you that she

was treated not only by Dr. Lewis, by Dr. Moreland and Sisters Hospital in an emergency situation in February of 1999, did she give you that history?

A. No.

Q. No?

A. No.

Q. Now, you didn't see her in November of 2002, true?

A. Yes, sir.

Q. Did she tell you she had been in a car accident in November of 2001, where a lady rear-ended her at 45 miles per hour?

A. No.

Q. Did she give you a history falling while dancing in the year 2000, just before this accident?

A. No.

Q. Did she give you a history of being on a tanning table and injuring her low back sometime in the year 2000?

MR. CAREY: Objection, misstatement of the facts on that.

THE COURT: Rephrase it.

BY MR. BURGIO:

Q. Did she give you a history of having complaints of back pain because of some kind of twisting or turning incident that happened on a tanning table?

A. No, I'm not aware of that.

Q. Okay. Now, Doctor, before you came up with your opinion about causal relationship, in this particular case, as you related it to the March 20th, 2001 alleged accident, you knew that she had been treated by other physicians, is that true?

A. Yes.

Q. Did you, before you came to that opinion, did you review the records of Dr. Scanlon?

A. No.

Q. Did you review the records before you came to that opinion, of Dr. Huckell?

A. No.

Q. Did you review the records of Dr. Bansal?

A. I don't believe so.

Q. Now, you know Dr. Bansal to be a pain management specialist, do you not?

A. Yes.

Q. She works at Buffalo General Hospital?

A. Correct.

Q. You know her to be a competent pain management specialist?

A. Yes.

Q. Okay. You know Dr. Huckell to be a competent

surgeon?

A. Yes.

Q. Did you review the records from Millard Fillmore Hospital on the day of the accident, when she went to the hospital, on the day you say she herniated a disc?

A. No, I did not.

Q. Are you aware that they didn't even order an X-ray for her low back on the day that she allegedly injured her low back?

A. I'm not aware of that.

Q. But that's generally what happens when we make an opinion about whether an injury concerns -- occurs on a specific date, we review the diagnostic tests from that date, that's important, isn't it?

A. It can be.

Q. Sure. Certainly relevant, isn't it?

A. It's possible. I can't say that it's definitely relative, but -- relevant, rather.

Q. And, Doctor, there was an MRI within four weeks of this particular accident that was negative for a herniated disc, was it not?

A. You're correct, that was the one -- the original one I believe was at Northtowns Imaging in April of 2001.

Q. And that report says, there is no evidence, within

four weeks of the accident, no evidence for significant focal soft disc herniation or significant canal stenosis, is that what it says? Doctor, can I --

A. I have it here.

Q. All right.

A. 4/25/01, by Dr. Tabone.

Q. Yes, no evidence for significant focal soft disc herniation or significant canal stenosis?

A. Correct.

Q. Now, Doctor, were you aware that in 1999, Dr. Lewis, who you know as a neurosurgeon -- and a neurosurgeon does maybe not exactly the same kind of surgery that you do, but certainly is addressing the same kind of issues, medical issues that you address, is that a fair statement?

A. Dr. Lewis and I perform a number of similar surgeries, yes.

Q. Are you aware that he sent her for an X-ray at the Mercy Hospital in 1999?

A. No, I'm not aware of that.

Q. Now, you told me that a narrowing of a disc space is evidence of an injury, is it not, even on X-ray?

A. I'm not certain I said that.

Q. It's evidence of stenotic change, what does that mean, that's a pathology, isn't it, or not?

A. I'm not sure exactly what you're referring to. But I think we talked about degeneration, and the disc shrinking, and the discs's interspace being narrower. I think that's what we were talking about before.

Q. All right. Are you aware of an X-ray that showed very minimal degenerative change in 1999 at L4-L5, are you aware of that?

A. I'm not aware of that.

Q. And that's a finding, is it not, Doctor, of a degenerative change, in the lumbar spine?

A. I'd have to see the X-ray. But I'm not -- wouldn't be arguing the report. That's the doctor's opinion.

Q. That's that doctor's opinion?

A. Right.

Q. You haven't seen the X-ray, or the report, because it wasn't told to you that she had treatment in 1999?

A. You're correct.

Q. Now, Doctor, looking -- you continued to take a history, on page 2 of your November 21st, 2000 -- well, let's look at page 1, we'll go page 1, and page 2.

A history. You said -- of course, you're concerned that she's exhausted her conservative treatment, are you not, before you invade her with

surgery, is that a fair statement?

A. I don't know if exhausted is the appropriate word. I think that she had an adequate trial of time and on non-operative care.

Q. That's why you ask her about it. You want to see -- you want to find out -- what her treatment has been relative to her low back, right?

A. Yes, sir.

Q. And she said that she undertook physical therapy?

A. Correct.

Q. Did she seem to understand what that word meant, physical therapy? Did she give you that word, or did you give it that word?

A. Well, she -- she -- in my handwritten notes, she tried therapy, but it did not give her relief.

Q. Okay.

A. So I did not put how many sessions she went or how many days, weeks or month, but it was not effective in helping her.

Q. Okay. And if she told you that, and Dr. Bansal's records of October 18th, 2001, which have been marked into evidence -- he's messed up the order. Do you have the -- well, they've been marked into evidence, there is no question about that. If her October 18th, 2001 report says

that she returned -- that's a year before you saw her, right, had not started physical therapy as suggested to her. I again counseled her that she needs to start physical therapy in conjunction with these injections. If she told you she had undertaken physical therapy, she wasn't being very truthful or reliable with you, was she, as it relates to physical therapy?

A. Well, I -- I don't know as it relates to the letter that you're showing me. My understanding is that she did have some therapy.

Q. Okay.

A. I don't know exactly to what extent she had it.

Q. But what I just read from Dr. Bansal's records which indicated that she had not started physical therapy?

A. At that specific point in time, you're correct.

Q. And, Doctor, you'll agree that certainly if -- certainly she could have started after with Dr. Bansal, except that on page 2 of that report, you'll read with me that, I tried to call Dr. Scanlon's office, but he was not available. Therefore, I told the patient that I would call in a five day supply for the Lorcet, and asked her to return back to her pharmacist. I never got a call from her pharmacist, that the patient was not due for her script until October 24th of 2001, and they could not fill it.

Patient was quite upset that she could not get an earlier refill on her medications. At this time she wanted to find another physician and wanted her records sent to her home.

So, Doctor, you'll agree with me that this appears this is the last time she saw Dr. Bansal, would you not?

A. It appears that way, yes.

Q. And you'll agree with me that according to Dr. Bansal, in her records, which are in evidence, your patient, Charlene VanDusen, according to Dr. Bansal, on my initial consultation, which records in this court have shown to be August of the year 2001, I had done a detailed history and physical in which she neglected to tell me about her narcotic medication intake, Demerol, and also that Dr. Scanlon was giving her that. That's what that says, is that correct?

A. Yes.

Q. So apparently she was a little less than truthful with Dr. Bansal relative to her history, you would agree?

A. Well, I don't know what went on between Mrs. VanDusen and Dr. Bansal. I can read the letter as you can. But I wasn't there. And I think the letter should stand for itself. I can't -- I can't make any inferences from that.

Q. But when a patient comes to you, and you continue to ask for the history, one of the parts of the history to ask them is, under what medications are you today, what medications do you take on a daily basis, is that true?

A. We ask her what medicines they're taking, you're correct.

Q. And it's true, because you wouldn't want to give them a medication for pain or anything else that might be contrary to the medications they're taking, that's one of the reasons, isn't it?

A. You're correct, yes.

Q. And the other reason is, some of these pain medications are actually narcotics, are they not?

A. Yes.

Q. And they're actually addictive, are they not?

A. Yes.

Q. So, Doctor, turning to page 2 of your report, about the second paragraph, she told you, and you took the history, she takes a total of four Lortab, 10 milligram tablets per day. She states that she could take more, however, tries to limit herself to only four tablets per day so that she does not become dependent on these medicines. Is that what she told you?

A. Yes.

Q. Did she tell you, Doctor, that Dr. Scanlon was prescribing to her, for her, the month before she met you, a drug called meperidine? How do you say that?

A. Meperidine. It's Demerol.

Q. Can we call it Demerol?

A. Yeah, that's easier.

Q. And that she was being prescribed 210 tablets per month, a hundred milligrams. Did she tell you that?

A. No.

Q. So, Doctor, she wasn't being very accurate or truthful with you about her drug use on the date of this accident, was she?

A. Correct.

Q. Doctor, I'm going to show you what has been marked as Exhibit F. Not only did she not tell you about the Demerol, let's look at Rite Aid pharmacy records for the months preceding your November treatment.

MR. CAREY: May we have these marked?

MR. BURGIO: It is marked.

THE COURT: What is it marked?

MR. BURGIO: It's F. And I'm offering it into evidence, Your Honor.

MR. CAREY: May I see it? I object as to the relevance. It goes back to a different time

period for medications not in any way related to this action. So I would object to them going into evidence.

THE COURT: Is there a certification attached to it? Is it a business record?

MR. BURGIO: Yes, Your Honor, by a paralegal from the Rite Aid Corporation.

MR. CAREY: Still an objection as to relevance, Your Honor.

THE COURT: Are you objecting on the foundational problem with respect to the business records, or no.

MR. CAREY: Not with regards to what -- it is what it is, but I have an issue with regards to -- it says --

THE COURT: Your objection is solely on relevance, correct?

MR. CAREY: Not entirely because it's -- we don't know if these are all Miss VanDusen, or if they're family members, dispensed to her. I mean, that's all. I mean, she's got five children.

MR. BURGIO: Your Honor.

THE COURT: I get the point.

MR. BURGIO: Your Honor, I'll redact any at a

later date. But I don't see --

THE COURT: I'm going to admit it. Mark it as received. The objection based on relevance is overruled. That is a history report that goes back to '98, which I don't think is too far out of relevancy. And we can always redact it later if the lawyers can agree, okay.

MR. CAREY: Yes.

THE COURT: Go ahead and mark it.

(Defendant's Exhibit F marked into evidence.)

BY MR. BURGIO:

Q. So, Doctor, pharmacies are required, are they not, probably by some law to keep records of prescriptions that they fill in connection with various patients?

A. Yes.

Q. And this is in evidence, and it relates to Charlene VanDusen, same address, who was your patient?

A. Yes.

Q. And it goes back to 1998. First question, Doctor, is a drug called Tussionex, does that have hydrocodone in it?

A. It does have a narcotic base and it is a cough medicine, cough suppressant.

Q. And hydrocodone, what is that, the nature of that

drug?

A. Well, hydrocodone is also a narcotic.

Q. Okay. And do we have a history here, from, first of all, a Dr. Egnatchik, do you know him to be a spine surgeon, do you, sir?

A. Yes.

Q. And did Dr. Egnatchik, a spine surgeon, on March 5th of 1999, did he prescribe hydrocodone for Charlene VanDusen?

A. Yes.

Q. And did that then appear on several occasions during the months of April, 1999, now it's Dr. Moreland, he's also a spine surgeon, is he not?

A. Correct.

Q. And June, 1999, July, 1999, Dr. Lewis a spine surgeon?

A. Yes.

Q. All right. And this is a narcotic pain medication, is it not, Doctor?

A. You're correct.

Q. And it would be, certainly, a more serious kind of medication that you would prescribe to a patient, not one that was just suffering from the everyday backache that you talked about before?

A. Correct.

Q. And, Doctor, now do we get to a point where we continue in October and November of 1999 where Dr. Lewis is still prescribing hydrocodone for the plaintiff, Charlene VanDusen?

A. Yes.

Q. And that would, of course -- he's the neurosurgeon, the low back surgeon, just like you're a spine surgeon, is that true?

A. Yes, sir.

Q. And now do we get to that point where the record says that word that I have a hard time pronouncing, meperidine, which is Demerol, correct?

A. Yes.

Q. So when we use the word Demerol, it's the same thing as meperidine.

Now, you know Dr. Scanlon to be the family physician, you knew that from the history of Charlene VanDusen, is that true?

A. Yes.

Q. And back in July of 2001, he's ordering 180 Demerols per month, is that what this record shows?

A. Yes.

Q. And back in August of 2001, and we're leading up

now, are we not, to your treatment, he orders another 180 of Demerol?

A. Yes.

Q. September 11th, 2001, another 180 of Demerol?

A. Correct.

Q. September 24th, 2001, Dr. Bansal ordered hydrocodone?

A. Yes.

Q. And, of course, that was her concern, right, that she was going to order the hydrocodone, and the patient was on the Demerol, that's not indicated -- that's contraindicated, is it not?

A. I don't know if it's contraindicated. It's an additional narcotic.

Q. Okay. And, Doctor, just to complete this line, you saw her in November, she got 210 Demerols, 100 milligrams on October 31st and November 26th, another 210 refill of the prescription from Dr. Scanlon?

A. Yes.

Q. All that Demerol was not disclosed to you during your history, is that true?

A. Correct.

Q. And, Doctor, let me show you Exhibit V for identification, which I'm sure you'll recognize. Take a

moment and see if you can recognize what that is, and where it came from?

A. Well, this looks like a page from the PDR which is the Physicians' Desk Reference, on meperidine, which is Demerol.

Q. And would you read the warning? Is that an accurate warning that would be in a book that you keep on your desk and refer to at times as it relates to medications?

A. Well, I don't keep it on my desk. It's in the office. Every now and then a couple of times a year I might look at it.

Q. Okay. Let me ask it this way. Is it a book that you consider to be a valid resource for you to evaluate medications and the use of medications by your patients?

A. It's okay. Valid resource, it's not like -- there are -- it is an easy, it's a -- it's a relatively easy way, and it's relatively quick.

Q. You use it?

A. Yeah. It's okay, you know, if I need to find something out quick. It's useful in that -- in that -- in that manner.

Q. All right. Is this a valid warning for the drug Demerol?

A. I think -- I think so, yes.

Q. Okay. And, Doctor, so, therefore, you'll agree with this warning, that Demerol can produce drug dependency of a morphine type, you agree with that?

A. That's correct.

Q. And, Doctor, has a potential for being abused, is that correct?

A. That's correct.

Q. Because there is a psycho dependence and physical dependence on the drug, because of its properties, being a morphine type?

A. Correct.

Q. And the tolerance may develop upon repeated administration of the drug, do you agree with that?

A. Yes.

Q. And that it should be prescribed and administered with the same degree of caution that's appropriate to the use of morphine?

A. Yes.

MR. CAREY: Jim, can I see that, please?

Q. Now, Doctor, let's look first at your November 18th, 2002 record, and let's get to the part, I believe it's page 1 where you review the lumbar discography performed by Dr. Huckell?

A. Yes.

Q. You'll agree that Dr. Huckell undertook a lumbar discography on August 16th, 2002, at the Sisters Hospital, is that true?

A. Yes.

Q. And you'll agree with me that at that time was tested the L4-5 disc?

A. Correct.

Q. And that's the same disc that you told this jury that was herniated on the left side when you did your discography that you ordered in January of 2003, same disc?

A. That's the same disc, correct.

Q. Same woman?

A. Correct.

Q. You looked at the films yourself, did you not?

A. Yes.

Q. Doctor, your findings were that she had a normal L4-L5 disc, isn't that true?

A. Well, no, what I said is they are morphologically normal. That didn't mean it's normal. And I didn't have the report.

Q. Okay. Doctor, have you ever seen the report?

A. No, I have not.

Q. All right. Let's look at Dr. Huckell's records,

here pursuant to a subpoena?

MR. CAREY: These ones are already in evidence.

MR. BURGIO: These are more records in them, for whatever reason.

(Defendant's Exhibit W, Dr. Huckell's records, marked for identification.)

MR. BURGIO: Your Honor, there is a certification on the front page.

BY MR. BURGIO:

Q. So, Doctor, you never saw, before you came to your conclusion that this herniated disc was caused by a fall in March of 2001, you never saw Dr. Huckell's report?

A. I don't believe so.

Q. But, Doctor, you did see the films?

A. Correct.

Q. And what is the word that you use, morphologically? I don't know that word.

A. Morphologically normal. The inside of the disc, the center portion of the disc looked okay, looked normal.

Q. It looked normal. It didn't look like there was any pathology that you would operate on, is that true, at that particular time, on that particular disc?

A. That, I don't know. That, I can't -- I don't have

that test in front of me, so I can't -- I can't say. It was an incomplete examination.

Q. As it related to L5-S1?

A. I'd have to go back and see the actual MRI.

Q. All right. Well, let's look at the report. They tested L2, L3. That's one of those lumbar discs, is that true?

A. Correct.

Q. And she reported typical reproduction of pain, but there was no disc tear or disc degeneration noted, true?

A. Can I -- just want to read this here okay. All right.

Q. All right. So they're not getting into that hard disc, that super ball that you talked about, but she's complaining about pain, is she not?

A. He says that she reported typical reproduction of pain.

Q. Okay.

A. With a half millimeter at L2-3.

Q. All right. When we get down to L4-5, it says, does it not, there was no annular disc tear. This is a report of Dr. Huckell?

A. That's what he's saying, that's right.

Q. That's a different finding on October --

MR. CAREY: I'm going to object. He's reading what's not in evidence.

THE COURT: He says it's not in evidence. I don't think it is, either. That objection is sustained.

MR. BURGIO: I offer it in evidence.

THE COURT: Any objection?

MR. CAREY: No.

THE COURT: Let's mark it.

(Defendant's Exhibit W marked into evidence.)

BY MR. BURGIO:

Q. And this finding of October 16th, 2002, is different than the finding you had in January of 2003, is it not?

A. You're correct.

Q. As it relates to that disc?

A. Yes.

Q. And, Doctor, moving on in this -- this packet, they did do that CAT scan that you said that they do in connection with the discographies, and does it not say that at L4-5, it was negative for central spinal stenosis or specific focal disc herniation, does it not say that?

A. Yes, you're correct.

Q. And that's a different finding than you had in

January of 2003?

A. Correct.

Q. And it's a different finding that you had when you did the surgery a few months later, when you actually were there in the operating room?

A. Yes.

Q. Okay. Now, Doctor, when you came down to your first visit, November 21st, 2002, when you came down to your opinion as to what the injury is, looking at opinion, you said that she was suffering from a disc herniation at L5-S1?

A. Correct, that's the first sentence of the opinion.

MR. CAREY: Your Honor, it was asked and answered on direct.

THE COURT: No, keep going.

BY MR. BURGIO:

Q. And you were wrong, correct, there was no disc herniation at L5-S1?

A. Correct.

Q. And you were concerned because that discogram of October hadn't checked out the L5-S1 disc and you wanted another one for that reason, is that true?

A. Yes.

Q. That was your thinking?

A. Correct.

Q. And then when you did the discogram in January of 2003, there was no injury at L5-S1, was there?

A. Correct.

Q. So your initial opinion about where this injury was, was wrong?

A. No. If you read further down into the opinion, I do note that I was concerned about L4-5 and/or L5-S1.

Q. But as it related to a disc herniation at L5-S1 it was inaccurate and it was wrong, there was no disc herniation at L5-S1?

A. You're correct about that.

Q. Now, look at January 17th of 2003. Middle of that first narrative paragraph which starts with, this lady?

A. Yes.

Q. Down near the end does it say, she is quite frustrated and wants to go ahead with surgery?

A. Correct.

Q. Even before you found out any pathology on this lady, in other words, even before you had identified that she had a herniated disc, she wanted to have surgery, is that what you say here?

A. That's what I -- well, I'll leave the sentence as it stands. I don't remember our exact discussion on January 7th of 2003.

Q. Well, sir, is it -- is it true that you said, I have explained to her at this point, and I assume you mean on January 7th of 2003, we do not have definitive evidence of cervical pathology, of course you meant lumbar pathology, is that true?

A. Correct.

Q. And unfortunately the tests are going to need to be performed again?

A. Correct.

Q. So she -- true?

A. Yes, correct.

Q. So now we have it in the context of what I'm talking about. She wanted surgery before you found any pathology?

A. Correct.

Q. And that's what you told her?

A. Correct.

Q. Because that would be foolish?

A. Correct.

Q. So, what do you do, you send her for an MRI, and you send her to Physicians Imaging Center of Western New York. Well, Doctor, is that in your records? 1/24/03.

A. Yes.

Q. Yes?

A. Yes, I have that.

Q. And, Doctor, you sent her to this place that has this high resonance that you talked to this injury about?

A. Yes.

Q. And as of January 24th, 2003, is Dr. Rand, a radiologist, competent?

A. Yes.

Q. And is his impression that he sent to you, because you're the physician on the report, is that true?

A. Yes.

Q. Was it, impression, negative MRI evaluation of the lumbar spine?

A. Yes.

Q. Now, if Dr. Rand had seen either a disc herniation at L4-5 or L5-S1 like you originally thought, it would have been, if that was his impression that that is what he saw, he would have put it on his report, is that right?

A. Yes.

Q. He did not?

A. You're correct.

Q. Now, Doctor, we proceed to January 29th, 2003. And there has been a discogram. And then you have determined that there is a disc herniation on the left side at L4-5, true?

A. Correct.

Q. Did you know that you got to fill out a sheet when you go to the Buffalo General Hospital to have a discogram?

A. Yes.

Q. And do you know that they ask you to describe your -- there is a nurse's notes that would write down what the patient tells them, what their complaints are?

A. Yes.

Q. And would it surprise you that she didn't say anything about any left leg complaints, that her complaints were lower back pain radiating down the right leg, have you ever seen that, Doctor?

A. I don't believe I've seen that document.

(Defendant's Exhibit X, hospital record, marked for identification.)

Q. Doctor, you may not have seen this particular sheet, but you've seen sheets like this, and you know that your radiologist does this at the hospital?

A. Yes.

Q. Okay. And when it says nurse's notes, it's part of a hospital record?

A. Correct.

Q. Okay. Are you seeing it now?

A. Yes.

Q. And would you agree with me that there is no complaints relative to left-sided radicular pain, pain going down the left side, it just refers to right?

A. You're correct.

Q. And, Doctor, did you know that Dr. Scanlon made reports during the course of his treatment, during the year 2001, did you know that?

A. I haven't seen any reports.

Q. All right. And, Doctor, would it surprise you then -- I'll show you V. Those are the types of reports that you've seen in connection with the care and treatment?

MR. CAREY: Your Honor, may I see the documents?

THE COURT: Show them to Mr. Carey.

MR. CAREY: These are not -- they're not medical records. I would object to them.

THE COURT: I'm sorry?

MR. CAREY: My objection is they're not medical records and they're not in evidence.

THE COURT: You're not going to read from them?

MR. BURGIO: I'm not reading from them.

THE COURT: If you don't read from them -- they're not in evidence, don't read from them.

BY MR. BURGIO:

Q. Doctor, would it surprise you that on the dates that Dr. Scanlon saw the patient in June of 2002, July of 2002, and up until the date that you -- she came under your care and treatment, that the plaintiff was making complaints of pain to her right leg only?

A. I think that's consistent with what had been said before.

Q. All right. So you have no information that's different than that, from Dr. Scanlon's office, or any records, as it relates to what was told to Dr. Scanlon, you have no information?

A. No, I don't.

Q. And then, Doctor, quickly, you actually recommended a different surgery, but the surgery you undertook was what you called a -- I'm sorry, disc removal?

A. A discectomy.

Q. Discectomy?

A. Yeah.

Q. And certainly, Doctor, when you do that, you expect -- when she came to you, her pain level was 10 out of 10, correct?

A. Yes.

Q. And certainly, Doctor the, goal for that is for

whatever percentage, if you take the disc out, it shouldn't be causing pain, as much pain, as it had been before, once she heals, isn't that the goal of it?

A. Not in -- in this -- in this particular situation, my belief that she was a candidate to remove the disc and do a spinal fusion, and I think if we go back to my records, my concern was that she would not get pain relief from the discectomy.

Q. I understand. But you undertook that surgery anyways, charged her $3,300, and she still needs a fusion, true? Withdraw the question. Doctor, the goal of the surgery, by taking a disc out, was to reduce her pain, true?

A. If I -- in her particular situation, I did not believe that a discectomy would give her pain relief. And I went through that process with her. And I -- and I documented that in my letters.

Q. And she still wanted that surgery, though, right?

A. She --

Q. She preferred that?

A. She wanted to have a smaller surgery, in hopes that that would relieve her pain.

Q. And even though you didn't believe that, she went through that surgery, and you performed that surgery?

A. Right. I did that -- as I said before, I did not

believe that her request was out of bounds or unusual. There are many people that, in fact even doctors will -- the spine surgeons will say, well, let's do the first step and do the discectomy, and if that doesn't work then we'll do the fusion.

My approach is different than that. I thought she was more of a candidate for a discectomy with a fusion. She preferred the discectomy. There was no issue regarding it not being medically correct to try a discectomy first. So we did the discectomy first. But as my recommendation proved, that didn't work.

Q. All right. That's what I meant. The point of it is that you removed what you removed, which was the pathology, and she still was complaining of pain at a 10 out of 10 level, within three months of your surgery?

A. Yes.

Q. Okay. Now, Doctor, certainly, between October of 2002, when she had the discography and the -- or disc -- what do you call it, discogram or discography?

A. Same.

Q. Okay. Discogram, that Huckell performed, and the one that you had, Doctor, at Buffalo General perform in January of 2003, certainly, because you weren't with Mrs. VanDusen on every day, it's possible that she could

have sustained a turning or twisting injury in that period of time, possible?

A. I guess anything is possible.

Q. Okay. It's possible that she could have gone bowling or something, any even athletic activity, and she could have sustained this left sided herniated disc between that -- those two periods of time?

A. I think anything is possible.

Q. Okay. Now, Doctor, quickly, about the goal of the second surgery, and that would be to get her doing as many activities as possible, is that true?

A. Well, it's to reduce her pain, which would thereby hopefully help her to increase her activities.

Q. Right. And -- and you've done operations on people who are injured at work that have lumbar disc fusions and they go back to work, some of them, don't they?

A. Yes.

Q. And isn't that your goal, to get them back to work, I mean, you're a doctor, you're trying to heal them, isn't it?

A. My goal is to try and reduce their pain. Whether or not they can go back to the same type of work is a completely different issue.

Q. One of your goals is to return them to society so

that they can contribute to society in any way?

A. That would be hopeful, yes.

Q. Okay. And that might be, even if it's answering phones, or your husband has a construction business, if you're at home, and you have an office at home, that you could answer the phones, you could take a few notes, and you'd be in the same environment that you are, that's one of your goals, right?

A. Correct.

Q. Okay. And you even said that certainly you're very hopeful that she can go back to a job where she at least works half a day, three days a week, that's one of your goals, isn't it?

A. Correct.

Q. Just a second, Your Honor. I think I'm finished. Doctor, just for the record, how much do you charge for your appearance here?

A. For the day, it's probably going to be about $8,000, maybe $9,000 for the day.

MR. BURGIO: Thank you for your time.

THE COURT: Redirect?

MR. CAREY: Yes.

REDIRECT EXAMINATION

BY MR. CAREY:

Q. Doctor, in the course of your treatment of Mrs. VanDusen, and -- has there been -- first off, do you know who a Dr. Wayne Fricke?

A. Yes.

Q. Who is he?

MR. BURGIO: Your Honor, may we approach?

THE COURT: Sure.

(Discussion at the bench off the record.)

THE COURT: The objection is sustained.

Let's go to another area, Mr. Carey.

BY MR. CAREY:

Q. Doctor, Mr. Burgio asked you about an MRI which was performed at the request of Dr. Lewis back in '99, after a car accident?

A. Yes.

Q. I'd like to show you what's already in evidence marked as C in evidence, it's a copy of an MRI report from that MRI back in February of '99. And, Doctor, does that indicate that the history here -- what does it indicate that Dr. Lewis is trying to do with his MRI?

A. Rule out disc herniation.

Q. All right. Does it make a finding?

A. No -- negative, meaning no disc herniations. He says no evidence of disc herniation or bulges.

Q. Does it say anything further about the discs?

A. Disc remain -- discs remained their normal high intensity on T2 images.

Q. And does it say anything further?

A. No fractures, no spondylolisthesis.

Q. Now, Doctor, would that indicate to you whether or not Mrs. VanDusen sustained any injury to her lumbar spine in that automobile accident of October of '98?

A. It does not appear she did.

Q. And with reference to a -- that was -- before we leave Dr. Lewis's records, let's show you what's also in evidence, this is a -- that X-ray of March of '99. Does that indicate anything on there, to you, as to a significant degenerative condition in Mrs. VanDusen's L4-5?

A. No. Dr. Fosket, F-o-s-k-e-t, is the radiologist. She notes very minimal degenerative change at L4-5.

Q. Is that the type of change which would cause the problems which you've been treating Mrs. VanDusen for?

A. No.

Q. Okay. And, Doctor, Mr. Burgio asked you, were you aware that she had treated with Dr. Lewis before, for this automobile accident? And it's fair to say that, I think you testified you didn't -- you weren't aware of that?

A. Correct.

Q. Would you expect that Dr. Lewis would be aware that he had treated her previously?

A. I guess if he had his old records, he might be aware that he treated her.

Q. Again, from what is in evidence, which is all Dr. Lewis's records --

MR. BURGIO: Your Honor, I'll object to --

THE COURT: What's the basis of the objection?

MR. BURGIO: I don't know that he's going to be able to operate and discuss with --

MR. CAREY: They're in evidence, Your Honor.

MR. BURGIO: All right.

THE COURT: Overruled. Go ahead.

BY MR. CAREY:

Q. This is a report of Dr. Lewis from November 7th of 2002, Doctor. Is that correct?

A. Yes.

Q. This is from -- C in evidence. And in this, this is the same Dr. Lewis that treated her for the automobile accident. Dr. Lewis takes a history, and he puts down, she has no significant medical history, isn't that correct, Doctor?

A. That's what it says. That's what he has there.

Q. That's what Dr. Lewis has, that she has no significant medical history?

A. Right.

Q. Is that -- would you agree with that, that based on your evaluation of everything before March 20th of 2001, there is no significant medical history there in Mrs. VanDusen's back?

A. I didn't think there was.

Q. And neither did Dr. Lewis, when he treated her in November of 2002, correct?

A. That's his statement, yes.

Q. And does it indicate that at that time he had also reviewed Dr. Huckell's discogram?

A. Yes.

Q. All right. And what is his request, upon seeing Mrs. VanDusen in November of 2002?

MR. BURGIO: Your Honor, this is outside of my cross.

THE COURT: We'll let it go for a little bit. We're going to wind up soon. Overruled.

THE WITNESS: He asked for permission, or authorization for a repeat discogram and the CAT scan after the discogram.

BY MR. CAREY:

Q. And that's exactly what you requested, too, correct?

A. Yes.

Q. So Dr. Lewis was in agreement with you, that that's what was -- that's what he was seeking as of November of 2002, after Dr. Huckell's discogram, and before yours?

A. Yes.

Q. All right. And, by the way, what does Dr. Lewis say about Mrs. VanDusen's pain syndrome?

A. Her pain syndrome is most consistent with lumbar instability, and she may ultimately require a lumbar interbody fusion.

Q. And is that the surgery that you were just describing?

A. Yes.

Q. Okay. And that's what you recommend as well?

A. Yes.

Q. And, Doctor, with regards to Dr. Huckell's records, and I'm reading from J in evidence -- and you're -- you've seen the reports from Dr. Huckell before?

A. Yes.

Q. Okay. And this is a report from July 18th of 2002. Could you read what -- and this is a letter to Dr. Scanlon -- what it reads with regards to her MRI?

A. Her MRI at Northtowns and Physicians MRI somewhat contradict one another. In my opinion her worst pathology is present at L4-5. And this is probably the source of her pain.

Q. Okay. And is that the same opinion that you have?

A. Correct.

Q. Okay. And, Doctor, in -- can Demerol cause a herniated disc?

A. No.

Q. And can physical therapy cure a herniated disc?

A. No.

Q. So in your opinion, if Mrs. VanDusen had undergone significant physical therapy, would that have repaired her herniated disc?

A. I don't believe so. As I said, the most important aspect of her treatment was the time frame, the amount of time. Whether or not she was put at total bed rest or sent to physical therapy, if it was going to heal, it was going to heal.

Q. And can physical therapy actually make a condition worse?

A. Yes.

Q. And did -- did Mrs. VanDusen ever mention to you that she had been using Demerol since she was a young adult

woman, for endometriosis?

A. Yes.

Q. And is it fair to say, Doctor, that endometriosis and her treatment of that is irrelevant with regards to your treatment of her back condition?

A. Yes.

MR. BURGIO: Your Honor, relevance.

THE COURT: Overruled.

BY MR. CAREY:

Q. Oh, and with regards to Dr. Rand's MRI that was performed just before your discogram, can you pull that out, doctor?

A. I have that.

Q. Does it say anything about any problems in taking an accurate MRI on that date?

A. Well, he notes that there was motion artifact, so the quality of the scan was not up -- up to his -- up to snuff. It wasn't up to standards.

Q. Okay. Does he say anything about whether or not the exam could be done due to spasms?

A. Yes. The patient could not complete the examination due to spasms.

Q. And that is what you had observed in your treatment of Mrs. VanDusen, muscle spasms?

A. Well, that's the reason I had placed her on the Valium, yes.

Q. And spasms are indications of pain, physical indications of pain?

A. Indication of pain, and as Dr. Lewis says, instability.

Q. And, by the way, was the CAT scan of the lumbar spine, after the -- in conjunction with the discogram, was that interpreted in consultation with Dr. Rand?

A. Yes, it was.

Q. So Dr. Rand, who had done the MRI, was consulted with regards to the follow-up CAT scan and discogram?

A. Yeah. And Dr. Iqbal at times will review cases with Dr. Rand, and he noted that he had reviewed it with Dr. Rand.

Q. From the standpoint of working -- or, I'm sorry, from the standpoint of the right leg versus left leg, which I believe Mr. Burgio asked you about, does it change your opinion in any way that Mrs. VanDusen was experiencing pain on the right side, oftentimes on the right leg?

A. No. Actually the pain diagram she filled out the first day she came in to see me, she showed on her pain diagram, she demonstrates that there was pain in both her legs. It just happens that her right leg pain was

predominant. She had severe pain in her back, and pain in both legs, worse on the right than left.

The issue is that Dr. Lewis said it first, is that she had a degree of instability, therefore, the pain can be worse on the opposite side of the herniation.

Q. Is this uncommon in the patients that you treat who have suffered an L4-5 disc herniation?

A. No, that's not uncommon.

Q. And, Doctor, just to clarify, do you have an opinion with a reasonable degree of medical certainty whether or not Mrs. VanDusen will be able to return to work again, in the future?

MR. BURGIO: Your Honor, I'll object.

THE COURT: Sustained. That's been covered.

MR. CAREY: Doctor, is there anything -- is there anything that you've heard here today on cross examination that's -- based on the other records of doctor -- or mentioned by Mr. Burgio, does it change your opinion in any way as to the cause or the nature of the injuries that Mrs. VanDusen has sustained?

MR. BURGIO: Object to the form of the question.

THE COURT: Sustained.

MR. CAREY: Do you have Scanlon's records?

THE COURT: Mr. Carey, we need to wind this up, or we have to bring the doctor back after lunch.

MR. CAREY: Two seconds.

Mr. Burgio, do you have Dr. Scanlon's records?

MR. BURGIO: There were two sets of records subpoenaed to the courtroom.

MR. CAREY: I know. But you were just referencing the ones that were marked.

MR. BURGIO: Why don't you just ask him a question.

MR. CAREY: Well, I'd like to refer to the records, as you did.

BY MR. BURGIO:

Q. Dr. Capicotto, if Mrs. VanDusen presented to Dr. Scanlon three days after this March 20th, fall of 2001, with dramatically increased low back pain running down both legs, would that be indicative that she had suffered a traumatic injury on March 20th, 2001, as she told you?

A. Yes.

Q. All right. And if Dr. Scanlon for the first time after that traumatic injury referred this --

MR. BURGIO: Your Honor, I've got to object.

THE COURT: Sustained. Any more questions, or do we have to bring him back after lunch? Any more questions, Mr. Carey?

MR. CAREY: No more questions, Doctor.

MR. BURGIO: 30 seconds.

RECROSS EXAMINATION

BY MR. BURGIO:

Q. Demerol is an addictive morphine, is it not?

A. Addictive narcotic.

Q. And you expected her to tell you about that when she came to see you, did you not?

A. Yes.

Q. Because there is something in your business that's called drug seeking behavior, is there not?

A. Yes.

Q. Okay. And if one of the records here confirms in October, November, of 2001, that was a diagnosis that's in evidence, drug seeking behavior?

MR. CAREY: Objection.

THE COURT: Sustained. 30 seconds are up.

MR. BURGIO: That's one of your concerns?

MR. CAREY: Objection.

THE COURT: Sustained.

BY MR. BURGIO:

Q. Doctor, no matter what happened at that MRI, Dr. Rand is the person that you sent Charlene VanDusen to?

A. Yes, sir.

Q. You trust his opinion?

A. I do.

Q. All right. And he said, he put his license -- his mark as a licensed physician saying that it was a negative MRI, evaluation of the lumbar spine on that date, that's what he did, right?

A. Well, if you read the report above, he mentions the artifact. But he does say essentially negative, I believe, negative MRI. But he mentions the artifact, the motion artifact.

Q. Right. But he doesn't say anything about, I can't give you an opinion, Doctor, because of that motion artifact. He gave you an opinion from a doctor, right? It was normal.

A. Well, he says negative MRI. I think he says negative because he cannot state whether there is a herniation or not because --

Q. Well, Your Honor --

THE COURT: That's sustained. That's enough. Are you all set, Mr. Burgio?

MR. BURGIO: Yes.

THE COURT: All right. Doctor, you're all set. You may step down.

(Conclusion of Dr. Capicotto's testimony.)