TESTIMONY OF EDWIN FRANK RICHTER, M.D.; 2008 Trial Trans. LEXIS 270

Supreme Court of New York, Richmond County

Index No. 12734/03, Index No. 13743/03, Index No. A12734/03

June 12, 2008

Reporter
2008 Trial Trans. LEXIS 270 *

ALEX KLEIN, Plaintiff, - against - CLARISSA N. ALLIANO, ANDREA BEATRIZ REVELORIO and CHASE MANHATTAN AUTOMOTIVE FINANCE CORPORATION, Defendants. ANDREA BEATRIZ REVELORIO, Third-Party Plaintiff, -against- CLARISSA N. ALLIANO and CHASE MANHATTAN AUTOMOTIVE FINANCE CORP., Third-Party Defendants. CHASE MANHATTAN AUTO FINANCE CORP., Third-Party Plaintiff, -against- MARIANNE C. ALLIANO, Third-Party Defendant.

Expert Name: Dr. FRANK RICHTER, III, M.D.

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Counsel

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WILSON, ELSER, MOSKOWITZ, EDELMAN & DICKER, LLP., Attorneys for Defendant Chase Manhattan, White Plains, New York, BY: PHILLIP A. TUMBARELLO, ESQ., of Counsel.

Judges

BEFORE HON. JOSEPH MALTESE, Justice

Proceedings

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[17]oOo

[18]THE COURT: Are we ready to travel?

[19]Get the jury, please.

[20](Jury enters courtroom.)

[21]THE COURT: Mr. O'Toole.

[22]MR. O'TOOLE: If it please the Court,

[23]the plaintiff calls Dr. Edwin Richter to the

[24]stand.

[25]
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[1]D R. E D W I N R I C H T E R called

[2]As a witness, having been first duly sworn,

[3]was examined and testified, as follows:

[4]THE CLERK: Please give your name and

[5]business address.

[6]THE WITNESS: Dr. Edwin Richter,

[7]32 Strawberry Hill Court, Stamford, Connecticut,

[8]06902.

[9]THE COURT: You may inquire.

[10]MR. O'TOOLE: Thanks.

[11]DIRECT EXAMINATION

[12]BY MR. O'TOOLE:

[13]Q Good morning, Doctor.

[14]A Good morning.

[15]Q Please keep your voice up nice and loud so

[16]everybody can hear you.

[17]A I will try.

[18]Q Can you start by sharing with us your

[19]education?

[20]A Yes. I graduated from Harvard University as

[21]an undergraduate in 1983 with a degree in biology with

[22]honors. After that I attended New York University

[23]Medical School, graduating in 1987. After that I

[24]started my internship and residency training in the

[25] **[*3]** field of physical medicine and rehabilitation, also
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[1]known as physiatry. This training was done at NYU

[2]Medical Center. The first year was an internship, what

[3]we call a rotating internship, with rotations in

[4]internal medicine, orthopedics, neurology and

[5]neurosurgery. That was done at Tish Hospital and

[6]Bellevue Hospital.

[7]After that point I did my residency

[8]training in the field of rehabilitation medicine. The

[9]center place of training for that was at the Rusk

[10]Institute of Rehab Medicine. But I also did rotations

[11]at Bellevue, at the Manhattan VA, at the Hospital for

[12]Joint Diseases and Goldwater Hospital. That was a

[13]three-year residency after the internship.

[14]Q Doctor, can you share with us what physiatry

[15]is?

[16]A Yes. It is a specialty of medicine which

[17]deals with the treatment of patients with disabling

[18]conditions. Many of our patients have disorders of

[19]nerves, muscles, bones or joints or the central nervous

[20]system, which would include the brain and spinal cord.

[21]But we also treat patients with a variety of other

[22]medical conditions.

[23]We treat patients who had trauma, **[*4]** people

[24]who have had major fractures, amputations -- for

[25]example, on our in-patient service -- and we follow
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[1]those same types of patients as outpatients, as well as

[2]taking care of out-patients who have other problems

[3]that interfere with their function. Common examples of

[4]those would be neck or back pain or carpal tunnel

[5]syndrome.

[6]We take care of the patient in a variety

[7]of ways. Like other physicians, we take medical

[8]histories, we do physical exams, we review test results

[9]and order other tests. Some of us, myself included,

[10]perform electrodiagnostic testing, which is also known

[11]as EMG. We also may perform various types of

[12]injections in terms of treatment. We prescribe

[13]medicines.

[14]We act commonly as the captain of a team

[15]of rehab professionals. So if a patient needs

[16]treatment with physical therapy, occupational therapy,

[17]speech therapy, vocational therapy, rehab psychology,

[18]among other types of professions, we would tend to act

[19]as the captain of the team for a patient who may have

[20]multiple or complex needs where they need care

[21]coordination or case coordination.

[22]We **[*5]** deal with what we call impairments

[23]and disabilities. An impairment can be the loss of a

[24]body part; more commonly it is the loss or decrease of

[25]function of a body part so that a person can't move the
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[1]same way or lift something the same way. That would be

[2]an example of a reduction of function. A disability is

[3]a loss of an ability to perform an activity that that

[4]person normally would be able to do if they didn't have

[5]that impairment.

[6]So those are a couple of different ways

[7]of describing what a physiatrist does.

[8]Q In addition to being the captain of a rehab

[9]team, do you also serve as a captain for other

[10]specialties?

[11]A Yes. Because a physiatrist focuses a lot on

[12]rehabilitation, on getting people back to their best

[13]possible outcome, we are often a coordinator of care

[14]between various specialists where we will refer to

[15]surgeons, proceduralists, other consultants to help

[16]direct a patient who may have complex needs.

[17]Q As part of your care, long-term care of

[18]disabled persons, have you had experience in terms of

[19]helping them get household needs and accommodations?

[20] **[*6]** A Yes. Yes. When I send a patient home from

[21]the hospital, for example, 95 percent of those patients

[22]need some sort of after care. So sometimes it is going

[23]to out-patient therapy, but in many cases they require

[24]some sort of home therapy and home care because these

[25]are people with impairments and disabilities that limit
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[1]their ability to perform some of their activities of

[2]daily living.

[3]We refer to ADL a lot in my specialty,

[4]which refers to activities of daily living, and then we

[5]break those down into the basic activities of daily

[6]living, such as getting dressed, bathing, grooming,

[7]feeding oneself, and then what we call the instrumental

[8]activities of daily living, which would be things like

[9]cooking, shopping, cleaning the house, balancing a

[10]checkbook or handling personal finance. And various of

[11]my patients have problems with various of those types

[12]of function.

[13]So the physiatrist is the person who is

[14]ultimately responsible, as the discharging physician,

[15]for putting a plan of care together, typically with

[16]input from physical and/or occupational therapy or

[17]social worker or nursing. **[*7]** But then the physiatrist is

[18]the person who ultimately sends the order to a visiting

[19]nurse service or a home therapy service or a care

[20]agency and then in turn receives monthly reports from

[21]those entities and determines what the patient's

[22]continuing needs are, determining in some cases whether

[23]a patient can switch over from home to out-patient

[24]therapy or when someone should stop or start therapy.

[25]Q As part of your routine practice, do you
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[1]place household help or assist patients to get

[2]household help?

[3]A Yes, I do.

[4]Q And are you familiar with the costs attendant

[5]to that household help as a result of doing that on a

[6]routine basis?

[7]A Yes, I am.

[8]Q Sir, you mentioned the Rusk Institute. Can

[9]you share with us the history of the Rusk Institute?

[10]A Yes. The rusk Institute was founded in 1948

[11]by Dr. Howard Rusk. Dr. Rusk had come back from World

[12]War II having treated injured servicemen, and he wanted

[13]to apply the lessons he had learned treating those

[14]patients with taking a more aggressive approach to

[15]getting them back into function than had been the

[16]previous **[*8]** tradition of just letting people convalesce

[17]with bed rest.

[18]And he came to New York University

[19]Medical Center and set up an institute dedicated

[20]specifically to the rehabilitation of patients. It is

[21]now the largest and oldest rehab institute of its kind,

[22]consistently ranked as the number one in the New York

[23]City area.

[24]Q Sir, you trained at Rusk; correct?

[25]A Yes.
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[1]Q And after you trained at Rusk you worked at

[2]Rusk for a number of years; correct?

[3]A Yes, I did.

[4]Q Can you share with us your -- we are done

[5]with the training. Can you share with us your work

[6]experience at Rusk?

[7]A Certainly. I joined the staff of Rusk

[8]immediately upon graduating from the residency. I

[9]started out as an attending physician. That describes

[10]what I did as far as taking care of patients, because I

[11]was no longer a resident practicing under the

[12]supervision of a senior doctor but now able to have my

[13]own practice.

[14]I was also at the beginning of my career

[15]there a clinical instructor. That's an appointment

[16]through the School of Medicine which also put me on the

[17]faculty **[*9]** of NYU Downtown. That meant I was part of the

[18]teaching faculty of NYU.

[19]I also was given over time an increasing

[20]number of administrative responsibilities, so over time

[21]I became the assistant -- sorry, the Associate Clinical

[22]Director of the Rusk Institute. That was an

[23]administrative position where I supervised physicians,

[24]therapists, nurses, had oversight over things like

[25]quality assurance and utilization review, making sure
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[1]that we were taking proper care of patients and

[2]utilizing resources in a proper manner, and served on

[3]numerous committees, both within the Rusk Institute and

[4]within the larger NYU Medical Center.

[5]I also advanced on the academic side, so

[6]I became an Associate Clinical Professor. As part of

[7]my work as an associate professor I was doing research

[8]and teaching. As far as the research goes, I was doing

[9]research in the field of physical medicine and

[10]rehabilitation in several areas, publishing about 50

[11]publications in total, including I believe now seven

[12]textbook chapters.

[13]I have continued to serve as associate

[14]clinical professor and continue to work on the **[*10]** research

[15]staff at Rusk, currently primarily in their chronic

[16]pain laboratory.

[17]I also continue to practice, to take

[18]care of patients. For several years I worked a half

[19]day a week in the clinic at Bellevue, taking care of

[20]in-patients and out-patients, but for the remainder of

[21]my time when I was practicing my office was in the Rusk

[22]Institute, so I would see out-patients there. And I

[23]also had a patient practice on the in-patient unit on

[24]the first floor of Rusk Institute. I took over running

[25]that unit as the unit director and then helped to
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[1]develop a stroke rehab program administratively, so I

[2]then became also the Director of Stroke Rehab at Rusk

[3]Institute.

[4]Q You continue to teach at Rusk to date;

[5]correct?

[6]A Yes, I continue to teach to date. I

[7]occasionally teach medical students, but more

[8]frequently I teach residents, doctors in training. I

[9]also give lectures, such as rounds, to doctors who are

[10]in practice, attending physicians like myself, as well

[11]as to the residents, and I teach in two review courses.

[12]There is an annual review for the state of the art of

[13]rehab medicine **[*11]** at Rusk Institute and there is also a

[14]chronic pain course, and I teach at both of those.

[15]Q Sir, are you also affiliated with Stanford

[16]Hospital?

[17]A Yes, I am.

[18]Q Can you share with us your relationship

[19]Stanford Hospital?

[20]A Yes. I was recruited three years ago to take

[21]over as Director of Rehab Medicine at Stamford Hospital

[22]in Stamford, Connecticut, so I supervise both

[23]in-patient and out-patient rehab there. We have a

[24]17-bed in-patient rehab unit. We also have a large

[25]out-patient rehab facility, and I practice both seeing
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[1]in-patients and out-patients there. I also co-chair

[2]the pain management committee at Stamford Hospital.

[3]Q Sir, in the course of your last I think it is

[4]about 21 years, you have been a doctor; is that

[5]correct?

[6]A I have been a doctor since '87, yes.

[7]Twenty-one years.

[8]Q Have you followed on a long-term basis people

[9]that have been involved in trauma?

[10]A Yes.

[11]Q Have you followed the long-term impact of

[12]trauma upon an arthritic process?

[13]A Yes.

[14]Q Sir, have you testified in court before?

[15]A Yes, I have. **[*12]**

[16]Q Have you testified on behalf of my firm in

[17]the past?

[18]A Yes, I have.

[19]Q Can you share with us how many times you have

[20]testified in court on behalf of Block & O'Toole

[21]clients?

[22]A Four or five times.

[23]Q Have you ever testified directly with me

[24]asking you questions in a courtroom?

[25]A Yes.
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[1]Q Have you ever been retained by the Wilson,

[2]Elser law firm in the past?

[3]A Yes, I have.

[4]Q Now, can you give us an idea of how many

[5]times in total you have testified in a court?

[6]A About 60 times.

[7]Q Of those 60 times, can you tell us how many

[8]times were on behalf of the plaintiff and how many

[9]times on behalf of the defense?

[10]A About half and half.

[11]Q Are you being paid for your time here today?

[12]A Yes.

[13]Q Can you share with us how much you are being

[14]compensated for your time?

[15]A $ 3,500.

[16]Q If you weren't here today, where would you be

[17]and what would you be doing?

[18]A I would be dividing my time between my

[19]office, which is in Tully Health Center in Stamford,

[20]and the hospital unit which we call **[*13]** the van Munching

[21]Rehab Unit of Stamford Hospital.

[22]Q Sir, can you give us an idea of how much of

[23]your time is spent in litigation matters working either

[24]on behalf of the plaintiff or the defense, as opposed

[25]to practicing medicine?
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[1]A Litigation matters, about five percent.

[2]Q So the rest of your time, 95 percent of the

[3]time, is spent practicing medicine?

[4]A Practicing medicine, including some

[5]administrative and academic work, as well as actual

[6]hands-on patient care.

[7]Q As part of your administrative experience and

[8]part of your practicing physician experience, sir, are

[9]you familiar with the going rate for medical costs in

[10]the New York metropolitan area?

[11]A Yes, I am.

[12]Q Can you share with us how that is?

[13]A In a couple of different ways. When I

[14]established my practice at Stamford I engaged a billing

[15]service to do a market analysis where they have access

[16]to statistics about what the range of charges are the

[17]doctors charge for specific types of service. We call

[18]them E&M codes. So I am aware of what the 25th, 50th,

[19]75th percentile are for the different **[*14]** types of common

[20]charges that doctors charge for.

[21]I also in my administrative work at both

[22]hospitals have served on committees where we are

[23]addressing issues of medical costs, so in that regard I

[24]am also familiar with what physician services cost.

[25]Q Are you familiar with the cost of diagnostic
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[1]testing as a result of those administrative and

[2]practice experiences that you have?

[3]A Yes. In addition to the reasons I mentioned

[4]before, when I try to get a patient to have a test,

[5]sometimes a discussion comes up about what it costs, so

[6]that's another reason why I know those things.

[7]Q And, sir, are you familiar also with the cost

[8]of narcotic medications and other prescriptive

[9]medication as a result of both your experience and your

[10]administrative roles?

[11]A Yes.

[12]Q Sir, did there come a time that my firm asked

[13]you to examine then Alison Klein, now Alex Klein?

[14]A Yes.

[15]Q For the purposes of our examination, I will

[16]be referring to the patient as Alex Klein, okay?

[17]A Fine.

[18]Q Sir, when you were first asked by my office

[19]to take a look at Alex **[*15]** Klein, were you provided with

[20]any materials?

[21]A Yes, I was.

[22]Q Can you share with us the materials that you

[23]were provided with?

[24]A Yes. There were a variety of records,

[25]starting with a 5/20/03 ambulance call report, and on
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[1]the same date the emergency room records from Staten

[2]Island Hospital. I started looking at doctor records

[3]starting with Dr. Insalata.

[4]Q Can I stop you for a second? It appears you

[5]are perhaps refreshing your recollection. Do you have

[6]a report in front of you?

[7]A Yes, I do.

[8]Q With the Court's permission, if you don't

[9]remember something off the top of your head, if the

[10]Court says it is okay, you can refresh your

[11]recollection.

[12]THE COURT: You may.

[13]THE WITNESS: Thank you.

[14]MR. O'TOOLE: Thanks, Judge.

[15]A This was addressing impressions of a left

[16]shoulder strain and radiculopathy. Records of

[17]Dr. Perel, a neurologist documenting impressions of

[18]head trauma, post head trauma syndrome, as well as

[19]radiculopathies, cervical, thoracic and lumbar spine.

[20]Rehab records of a Dr. Turkes. And I

[21]will apologize -- I **[*16]** don't know how to pronounce all the

[22]names in these records -- starting with June 5th, 2003

[23]with similar impressions.

[24]I reviewed an MRI report of June 18,

[25]2003 describing a C-4-5 central disc herniation and a
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[1]C-5-6 disc osteophyte complex, compromising the left

[2]C-5-6 neural foramen.

[3]I also looked at the 6/25/03 MRI of the

[4]brain which was normal, an EMG electrodiagnostic test

[5]by Dr. Perel describing left C-5-6 and a L-4-5/S-1

[6]radiculopathy.

[7]July 7, '03 MRI of the lumbar spine

[8]describing the L-5-6 disc. 7/22/03 MRI of left

[9]shoulder showing some cuff impingement. Records of Dr.

[10]Shiau, starting with 8/17/04, recommending a trial of

[11]epidural injections for neck pain.

[12]Pain management records of Dr. Backes, a

[13]consult by a Dr. Bitan describing cervical disc

[14]herniations, and Dr. DiGiacinto's records, the spine

[15]surgeon, starting from April 11, '05, and notably

[16]including from July 26 of 2005 the operative note

[17]describing a C-4-5-6 discectomy and fusion done at

[18]St. Luke's Roosevelt.

[19]Q Doctor, a couple of times you mentioned the

[20]term radiculopathy, and also you said **[*17]** radiculopathies.

[21]Can you share with us what that means.

[22]A Sure. The radiculopathy refers to a problem

[23]with the nerve roots, and what I mean by nerve roots, I

[24]have to describe the central nervous system a little

[25]bit.
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[1]The brain connects to the spinal cord,

[2]and so the brain can send messages down and receive

[3]messages coming back up from the spinal cord. The

[4]spinal cord sends out branches, and we call these

[5]roots. They exit either side of the spine up and down

[6]the length of the spine, and we assign a letter and a

[7]number to describe the different levels of the spine

[8]where these roots are coming out.

[9]These roots come out, form branches

[10]which we call nerves, and those nerves go to pretty

[11]much every part of the body, and they bring

[12]information. That is what we call sensory nerves. So

[13]when we touch something, we feel it. And also there

[14]are other fibers that bring information out to activate

[15]a muscle, and we call those motor nerves.

[16]Now, the nerve root is a fairly short

[17]extension from the spinal cord out to where it starts

[18]to branch and form peripheral nerves, so if there **[*18]** is a

[19]problem where the nerve is exiting the spine, that's

[20]called a radiculopathy. It is basically a nerve root

[21]problem.

[22]Q Sir, during the point of time we were

[23]qualifying you -- for the record, by the way, are you

[24]board certified?

[25]A Yes, I am.
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[1]Q Just checking. All right.

[2]Now, you said that you administer some

[3]test to determine nerve root damage. Is that an EMG

[4]test, sir?

[5]A Yes.

[6]Q As part of your review of Mr. Klein's

[7]records, did you examine the EMG test performed upon

[8]him?

[9]A Yes, I did.

[10]Q Sir you mentioned a term "disc osteophyte

[11]complex." We have heard talk of degeneration in this

[12]courtroom. Can you share with us what degeneration

[13]means?

[14]A Yes. In this context we are talking about

[15]the spine or other parts of the skeleton at full

[16]skeletal development. In teenage years most people

[17]have very smooth contours to their bones. They are the

[18]shape that we see in anatomy textbooks where the

[19]surfaces are very regular. Over time, as we get wear

[20]and tear on the different joints or bones of the spine

[21]or the skeleton, you can **[*19]** get changes that you can see

[22]on x-ray. Or if a surgeon is in there doing an

[23]operation, they can see them directly. These are

[24]changes where surfaces may get rough. You may get what

[25]we call a bone spur, an outcropping of bone that sticks
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[1]out from the normal contour.

[2]Osteophyte is a fancy word for a bone

[3]spur, and people can get those in their neck, in the

[4]cervical spine, because over the years, as their head

[5]moves around on top of their neck, with the wear and

[6]tear of everyday activity, you may start getting some

[7]arthritic type changes there which we call

[8]degenerative.

[9]I am using the word "arthritic," which

[10]is a general term to talk about basically problems with

[11]the joint.. I am not talking about rheumatoid arthritis

[12]or the types of inflammatory deforming arthritis, but I

[13]am talking about the basic everyday wear and tear that

[14]pretty much all of us can expect to experience.

[15]Certainly past the age of 30 is when it often is

[16]evident.

[17]So in that phrase, a disc/osteophyte

[18]complex, an osteophyte would be a bone spur. Disc is

[19]referring to a herniation, a pushing out of the **[*20]** disc

[20]into a space where it is not supposed to be.

[21]Q Now, fair to say that degeneration is natural

[22]and normal?

[23]A Yes, it is.

[24]Q Happens to all of us.

[25]A Yes, it does.
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[1]Q Is it abnormal or strange to find

[2]degeneration present in the spine of a 32-year old

[3]person?

[4]A No, not at all.

[5]Q Is it possible, sir, to have a traumatic

[6]event and an injury traumatically induced that is

[7]superimposed upon a normal degenerative spine?

[8]MR. TUMBARELLO: Objection; outside the

[9]scope of the disclosure provided.

[10]THE COURT: Overruled.

[11]A No, it is not unusual at all. As people

[12]age -- and we typically think of 30, based on studies

[13]of healthy volunteers, as when people have visible

[14]evidence of degenerative changes that we can evaluate

[15]medically. Those people obviously can have accidents,

[16]and if those accidents cause injury, then that injury

[17]or trauma is placed on top of whatever was there before

[18]from the degenerative change.

[19]Q Is it possible to have a disc/osteophyte

[20]complex and have no symptoms at all?

[21]A Yes, it is.

[22]Q Is it **[*21]** possible to have a trauma occur that

[23]activates or makes symptomatic that otherwise quiet

[24]condition?

[25]A Yes.
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[1]Q Sir, you told us what arthritis is. Can you

[2]share with us what the meaning of traumatic arthritis

[3]is?

[4]A Yes. When I talked about arthritis before, I

[5]had mentioned in passing that there are some diseases

[6]like rheumatoid arthritis, or psoriatic arthritis,

[7]which are medical diseases that attack the joints.

[8]There is also the everyday wear and tear of normal life

[9]where you will get some changes over a long period of

[10]time.

[11]If someone has traumatic arthritis, that

[12]is when there is an accident. It subjects an area to

[13]force, and that force accelerates the manifestation of

[14]arthritis so that you start to get arthritic change

[15]because of the trauma rather than just because of the

[16]everyday life that the person had before that trauma.

[17]Q Okay, Doctor. Let's turn to your examination

[18]of Al Klein. Can you share with us when that took

[19]place, sir?

[20]A Yes. That was October 11, 2005.

[21]Q When you met Al Klein, did you take a history

[22]from him?

[23]A **[*22]** Yes.

[24]Q At the time that you conducted that exam,

[25]sir, were you -- we established earlier the patient's
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[1]name was Alison Klein; correct?

[2]A Yes.

[3]Q And can you share with us what a history is,

[4]sir?

[5]A History in this context means talking about

[6]what happened to the patient. If there was an

[7]accident, what about that; if someone had an illness,

[8]to tell me about that; and to ask about what the

[9]symptoms are, what the patient's complaints are, what

[10]sort of treatment they have been having, what made

[11]their problems better or worse. Those would be

[12]examples of historical questions that make up a

[13]history.

[14]Q Is a history important to you as a doctor

[15]evaluating the condition of somebody?

[16]A Yes, it is.

[17]Q Can you share with us why?

[18]A Because, number one, we don't want to

[19]reinvent the wheel. We want to start with the

[20]available information to start moving forward. We want

[21]to know what's likely to happen, and we try to use the

[22]information about the past to help to predict the

[23]future and to guide the care plan in terms of knowing

[24]what to do.

[25] **[*23]** Again, in terms of not reinventing the
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[1]wheel, we don't want to repeat a treatment that failed

[2]previously unless we had a reason why we thought we

[3]could do it differently. So it helps to guide our

[4]decision making.

[5]Q Sir, at the time of your initial exam of Al

[6]Klein, is it fair to say that prior surgeries, other

[7]than the one of July 2005, the discectomy, were denied?

[8]A Yes.

[9]Q And have you since this examination learned

[10]of a surgery involving the mastectomy taking place in

[11]May of 2004?

[12]A Yes, I am.

[13]Q Fair to say that at the time of this

[14]examination the patient wasn't completely forthright

[15]with you about the surgical history?

[16]A Yes.

[17]Q And were you informed at the time of this

[18]examination that the patient was taking

[19]Depo-Testosterone?

[20]A No.

[21]Q Fair to say again there wasn't a full

[22]historical account to you?

[23]A Yes. As far as that goes, yes.

[24]Q Are either of those historical omissions

[25]significant to you in terms of formulating the opinion
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[1]you reached at the time of the October '05 exam?

[2]MR. TUMBARELLO: Objection; **[*24]** beyond the

[3]scope.

[4]THE COURT: Overruled.

[5]A No, they have no bearing on the formulation

[6]of my impressions.

[7]Q Sir, after you took the history of

[8]Mr. Klein -- first off, tell us what the history was.

[9]A Sure. He was right-handed on May 20th, 2003,

[10]he was in a motor vehicle accident. No definite loss

[11]of consciousness that he could recall clearly, but

[12]somewhat I describe as partial anterograde, meaning

[13]after-the-accident amnesia. Some period of time where

[14]he couldn't remember things clearly.

[15]In terms of the treatment, seeing

[16]multiple physicians. As I listed before when I talked

[17]about those medical records, had taken multiple pain

[18]medications and had done courses of physical therapy,

[19]trying to treat things what we call conservatively,

[20]meaning nonsurgically, then on July 2005 having had

[21]that fusion surgery.

[22]And at that point physical therapy was

[23]continuing, medications were alternating between

[24]Vicodin and Percocet. Those are both narcotic or

[25]opioid medicines combined with acetaminophen medicine,
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[1]which is Tylenol, as well as taking some Tylenol

[2]additionally. **[*25]**

[3]He was also wearing something called a

[4]Lidoderm patch. Lidoderm is lidocaine, which is like

[5]the novocain that a dentist gives you for a tooth

[6]extraction, but it's a patch, so you apply it directly

[7]over the area that hurts, and that penetrates through

[8]the skin. We use that a lot to try to decrease the

[9]amount of narcotic medicine that a patient has to take.

[10]So that was a combination of medicines being taken for

[11]pain.

[12]Despite the medicines, pain was

[13]persisting, primarily in the neck and surrounding area,

[14]surrounding area meaning the upper back, shoulder, back

[15]of the head area. There was some tingling which was

[16]radiating down to the fingers in both hands and

[17]radiation of pain.

[18]In terms of other medical history, there

[19]was an allergy to cats. In terms of functional

[20]history, which is part of what we concern ourselves

[21]with in rehab, vocationally he is an attorney who had

[22]tried to go back to court on I believe one occasion

[23]after the surgery but couldn't tolerate it because of

[24]pain.

[25]In terms of those activities of daily
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[1]living, getting assistance from his mother who **[*26]** happene

[2]to be a nurse also but was helping out with household

[3]chores or those instrumental activities of daily

[4]living.

[5]THE COURT: Keep your voice up if you

[6]can, Doctor. These blowers kind of muffle it.

[7]THE WITNESS: Thank you.

[8]Q Doctor, you mentioned that the patient had

[9]informed you about no definite loss of consciousness

[10]but some partial anterogradeamnesia. Could you tell us

[11]what that means?

[12]A Yes. When people are in some sort of

[13]accident where they may hit their head directly, or

[14]sometimes their head is moved back and forth quickly,

[15]which we call acceleration/deceleration, either of

[16]those can cause either a post-concussive syndrome or

[17]even a mild traumatic brain injury. In that situation

[18]they may have a loss of consciousness, they may not,

[19]and often patients aren't clear about it.

[20]If someone was unconscious when the EMS

[21]arrived or the police arrived or someone else arrived

[22]and documented this and the patient may know that from

[23]a secondary source, later on people told him, yes, we

[24]saw you unconscious, if that doesn't happen the patient

[25]may not be sure because **[*27]** they may be dazed or confused
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[1]as opposed to being actually unconscious, and the

[2]patient themself often doesn't know which was which.

[3]In terms of the amnesia, with that

[4]period post trauma people may have a period of time

[5]that they don't recall. Sometimes it is a period after

[6]the accident which we call anterograde, sometimes it is

[7]the period immediately before the accident which we

[8]call posterograde. Sometimes it is a combination of

[9]both. And sometimes it is a complete blank slate.

[10]Other times it is more a question of having basically a

[11]fuzzy memory for a period of time; people remember some

[12]things and not others.

[13]Q This history of questionable loss of

[14]consciousness and an inability to recall events, was

[15]that history borne out by the Staten Island University

[16]ER records that you reviewed?

[17]A Yes, it was.

[18]Q Sir, I want you to assume that there is going

[19]to be testimony that after this accident Al Klein --

[20]the people ran to the scene of the vehicle, the vehicle

[21]was smoking and people were saying the vehicle was

[22]going to blow. Can you make that assumption?

[23]A Sure. **[*28]**

[24]MR. WILSON: Objection, your Honor.

[25]MR. O'TOOLE: It is in evidence already.
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[1]The other trial.

[2]MR. WILSON: Objection.

[3]THE COURT: I am going to sustain.

[4]MR. O'TOOLE: You are going to sustain?

[5]THE COURT: No, I am overruling it. If

[6]it is in evidence already, it is in evidence.

[7]MR. O'TOOLE: It is in evidence in the

[8]first trial. I will rephrase the question.

[9]MR. WILSON: May we approach, your

[10]Honor?

[11]THE COURT: Yes. Inside.

[12]MR. O'TOOLE: I could walk away from

[13]this if you want me to. It is easy. I can get

[14]around this objection.

[15]THE COURT: I am just looking to move

[16]the trial again.

[17]MR. O'TOOLE: I will rephrase the

[18]question.

[19]MR. WILSON: I will withdraw the

[20]objection.

[21]Q Sir, you reviewed the ambulance call report;

[22]correct?

[23]A Yes.

[24]Q And does it indicate whether or not Al Klein

[25]was ambulating at the scene of this accident?
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[1]A Yes, it does say that.

[2]Q Is it fair to say that somebody can be

[3]ambulating after an accident and still be hurt?

[4]A Absolutely.

[5] **[*29]** Q Share with us how, sir.

[6]A Well, if someone is ambulating, I mean that

[7]is a fancy word for saying they are walking, and there

[8]is an old term, "walking wounded." Someone can be

[9]walking around with all different kinds of injuries.

[10]If they are not suffering from a major head injury

[11]that's rendered them unconscious, if they are not

[12]paraplegic or quadriplegic, if they haven't had

[13]fractures of their legs, there are a lot of other types

[14]of injuries people can have where they can walk.

[15]Q Sir, I want you to assume further that in

[16]evidence -- and you reviewed the Staten Island chart;

[17]right?

[18]A Yes.

[19]Q -- that the cervical spine x-rays were

[20]negative for fracture.

[21]A Yes.

[22]Q Were there any significant findings to you at

[23]all in the cervical spine x-ray films taken at the

[24]hospital?

[25]A In terms of the larger scheme of things, no.
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[1]Plain x-ray looks at the bones. It is a very good way

[2]for looking for fracture. It doesn't look at discs or

[3]soft tissue. So it is a good screening tool in the

[4]emergency room for determining if someone might need

[5]spine surgery or **[*30]** needs to be put in a halo or something

[6]like that, but it doesn't have much bearing on the

[7]other findings in this case.

[8]Q What does the straightening of the normal

[9]cervical lordosis mean?

[10]A Straightening of the lordosis most typically

[11]in this scenario is due to spasm. Some people have

[12]abnormal structure of their spine, but if someone has

[13]an injury and their muscles go into spasm, the normal

[14]curve of the neck where we typically have a curvature

[15]like a C can be straightened out by the spasm of the

[16]paraspinal muscles.

[17]Q And then, sir, do you recall whether there

[18]was any indication of straightening of the lordosis in

[19]the cervical spine x-ray?

[20]MR. TUMBARELLO: Objection. There is

[21]nothing in this doctor's report regarding the

[22]lordosis issue.

[23]MR. O'TOOLE: The records are the first

[24]thing that he mentioned, sir, in disclosure.

[25]THE COURT: Overruled. You may answer.
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[1]A The significance of the straightening of the

[2]lordosis in this particular case, since other films

[3]show that Mr. Klein does have basically normal anatomy

[4]of his spine other than some mild wear **[*31]** and tear

[5]degenerative changes, in his case this would pertain to

[6]the spasm of the what we call paraspinal muscles, which

[7]are the long, flat muscles on either side of the spine.

[8]Q Is spasm an indicia of trauma?

[9]A Yes, it is.

[10]Q Tell us why.

[11]A Well, spasm is when a muscle essentially

[12]clenches tightly, and that is a defensive reaction to

[13]pain. When someone is going to get punched in the arm,

[14]they would tighten up the muscles of their arm in

[15]protection. But if someone is in pain, they also

[16]tighten up their muscles in spasm. It is a reflex arc,

[17]so that those muscles are tightening up to try to

[18]protect the structures underneath, and that's how

[19]trauma can induce spasm.

[20]Q Sir, that spasm seen in the cervical spine

[21]x-ray at the hospital, is that something that's

[22]consistent with a notation on the ambulance call report

[23]concerning trauma to the neck?

[24]MR. TUMBARELLO: This is a foundation

[25]objection, your Honor.
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[1]MR. O'TOOLE: It is all in evidence.

[2]THE COURT: If he has reviewed it, he

[3]can comment. Overruled.

[4]A Yes, it is highly consistent with **[*32]** the

[5]documented history of trauma to the neck.

[6]Q Sir, did there come a time after you took the

[7]history from Al Klein that you conducted a physical

[8]examination?

[9]A Yes, I did.

[10]Q Can you share with us what that physical

[11]examination consisted of and what the findings were?

[12]A Yes. It started with inspection. Patient

[13]appeared to be well developed and well nourished. Well

[14]developed means not having any birth defects or

[15]abnormalities like that. Well nourished, meaning not

[16]cachectic.

[17]THE COURT: I want you to define that

[18]for us.

[19]Q Please.

[20]A People vary between thin to heavy, but some

[21]people fall below what you might car normal type of

[22]thin. It would be consistent with some sort of a

[23]disease or mal nourishment. And that was not the case

[24]for Mr. Klein.

[25]I looked at the skin surfaces. There
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[1]was a five-centimeter, which is about two inches,

[2]anterior scar on the front of the neck which was

[3]healing well and was consistent with the history of the

[4]fusion surgery. That is what we would expect to see.

[5]There was tenderness, meaning pain when

[6]I **[*33]** touch on it, over the external occipital protuberans.

[7]The occiput is the bone that makes up the back of the

[8]skull, and there is a prominence here, a part that

[9]sticks out which we call the external occipital

[10]protuberans. And when I pressed over that there was

[11]pain not only where I pressed, but also with radiation,

[12]where radiation means pain traveling from where it is

[13]to include surrounding areas. And he was generally

[14]tender over the occiput, over the surface of the back

[15]of the head.

[16]Then I looked at range of motion,

[17]meaning the degrees through which a body part can move;

[18]in this case, the cervical spine, looking how the neck

[19]could move. Flexing is coming forwards, and he could

[20]only go about 10 degrees (Indicating). Extension is

[21]going backwards, again only about 10 degrees.

[22]Rotating, meaning going like this (Indicating), he

[23]could only go to the left about 40 degrees and to the

[24]right about 50 degrees. And for each of these motions

[25]it was painful.
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[1]Q Doctor, let's turn back for a second. You

[2]talked about the range of motion that you conducted on

[3]the cervical spine.

[4]Did **[*34]** you conduct any other type of

[5]physical examination, palpation or other type of exam?

[6]A Yes.

[7]Q Can you share with us what the findings were

[8]on that exam?

[9]A Yes. When I palpated the cervical spine,

[10]tenderness in the paraspinal muscles and also palpable

[11]spasm. Tender is when I press in and the patient tells

[12]me that it hurts. Spasm is me feeling that tight

[13]knotting up of the muscle. So that's what we see on or

[14]feel and see on inspection and range of motion for the

[15]cervical spine.

[16]Q You told us that spasm is an indicia of

[17]trauma. Can you tell us why the body spasms?

[18]A It's a defense mechanism. When pain is

[19]persisting, the reflex are sends out a message to the

[20]muscles to tighten up to try to be protective. One of

[21]the problems is that when people are in prolonged

[22]spasm, the muscle can get a decrease of blood flow

[23]going both in and out so there is a buildup of some

[24]pain-mediating substances in and around the muscles and

[25]nerves, and therefore you can get a self-perpetuating
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[1]vicious cycle where pain and spasm are actually

[2]reinforcing each other.

[3]Q Is that **[*35]** something that the patient controls,

[4]that self-perpetuation?

[5]A No, it is not.

[6]Q The body is doing it to the patient?

[7]A That's on auto pilot.

[8]Q Now, sir, is spasm considered objective or

[9]subjective?

[10]A Spasm is objective.

[11]Q Why is that, sir?

[12]A Because that's something that I can see or

[13]feel, whereas subjective is something that the patient

[14]tells me they think or feel.

[15]Q Is pain objective or subjective?

[16]A Pain is subjective.

[17]Q Tell us why.

[18]A Pain is the perception of -- the technical

[19]term is noxious stimuli by the body, meaning when we

[20]feel something, that activates pain fibers, little

[21]nerve fibers that are all over our body that wind up

[22]transmitting a message up through the nerves, to the

[23]spinal cord and on up to the brain to the areas that

[24]process sensory information and tell us we have pain.

[25]It is something that is perceived and
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[1]described differently by different people. And we

[2]don't have an x-ray that shows pain. There is no blood

[3]test that shows pain. So because we have to rely on a

[4]person's description, **[*36]** it is a subjective thing.

[5]Q Sir, you talked about both pain in the back

[6]of the head with some radiation, and you talked about

[7]pain and tenderness in the neck. Is there any

[8]significance to those two body parts as they interact

[9]with each other?

[10]A Yes, indeed. Pain in the neck, rather

[11]obviously, can come from injury or trauma to the neck.

[12]There are multiple structures, which

[13]include discs, as well as what we call other soft

[14]tissues like muscles and nerves. So you can have

[15]trauma to the neck, you can injure the little joints

[16]within the spine. So there are various ways that you

[17]can get pain in the neck from an injury to the neck.

[18]As far as getting pain in the back of

[19]the head, that is the one part of the head where the

[20]nerve supply does come through the neck. The supply of

[21]feeling to our face, for example, comes from a

[22]different set of nerves that doesn't flow through the

[23]spine, so those are not affected by injury to the

[24]cervical spine, whereas injury to the cervical spine is

[25]what we call a competent cause of not only neck pain
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[1]but also radiating pain going up to the occiput. **[*37]**

[2]You can also have trauma directly to the

[3]nerves as they travel from the neck up through the back

[4]of the head because those are contiguous structures

[5]flowing from the cervical spine going up to the back of

[6]the head.

[7]Q Is the pain you have described in the back of

[8]the head consistent with a diagnosis of post concussive

[9]syndrome?

[10]A Yes, it is.

[11]Q Can you share with us what that means, sir?

[12]A Well, post concussive means after being

[13]concussed, which is a big word for being hit basically.

[14]We tend to apply it primarily to the head in medical

[15]terminology. So after someone has a blow to the head

[16]they can have a post concussive syndrome.

[17]The symptoms most commonly involve pain,

[18]may also involve dizziness, fatigue, other symptoms,

[19]but the persistent pain with the fatigue, dizziness and

[20]general malaise of not feeling well are the most common

[21]ones.

[22]Q The headache and dizziness, are those

[23]reflected in the records that you reviewed and are now

[24]in evidence?

[25]A Yes.
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[1]Q Sir, you mentioned a range of motion on the

[2]neck. Was the range of motion **[*38]** you measured, was that

[3]normal?

[4]A No, it is well below normal.

[5]Q You said that the flexion and extension was

[6]in degrees. Can you show us what that test involves

[7]and then tell us what the normal is?

[8]A Sure. I can demonstrate it myself.

[9]Right now I am holding my head in what

[10]we call the neutral position, which we note is

[11]zero degrees when we are doing these measurements, and

[12]I can bend my head forward so that my chin, if I wasn't

[13]wearing a tie, would touch my chest (Indicating). So

[14]that's what we call full flexion. Depending upon a

[15]person's anatomy, that might be about 70 degrees. He

[16]could only do 10.

[17]Extension is tilting your head back up,

[18]like you try to look up at a tall building. And many

[19]people can do 40 to 50 degrees. He could only do 10.

[20]In terms of rotation to right and left,

[21]I can turn my head and almost get to my shoulder. Some

[22]people are more flexible than I am, but I can get over

[23]to around 70 degrees. Some people can go farther. And

[24]I can go about the same way this way (Indicating).

[25]He could only go about 40 degrees to the
674

[1]left and **[*39]** 50 degrees to the right. So all of those were

[2]significantly below normal.

[3]Q Is that a significant reduction in the

[4]movement of his neck?

[5]A Yes, it is.

[6]Q Were you surprised to see that in light of

[7]the history of having undergone a cervical fusion from

[8]C-4 to C-6?

[9]A No, I am not surprised. If he was someone

[10]without this history, yes, I would be surprised but,

[11]given the history of the injury and the surgery, not so

[12]surprising.

[13]Q I want you to assume that the defendants have

[14]disclosed an orthopedic knee surgeon who examined

[15]Mr. Klein in 2005, November of 2005 after the fusion

[16]surgery, and I want you to assume that he found a full

[17]range of motion in the cervical spine. Can you assume

[18]that?

[19]A Yes.

[20]Q Is that possible?

[21]A I don't see how that would be possible, given

[22]the effects of a fusion on normal cervical range of

[23]motion.

[24]Q What is that effect of a fusion on cervical

[25]motion?
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[1]A Well, when we do these motions, when we are

[2]rotating or flexing or extending, we have those

[3]different bones of the cervical spine stacked up **[*40]** like

[4]blocks, but they are flexible because they are joints,

[5]so they are able to move back and forth. And each one

[6]contributes to the normal range of motion.

[7]And in this case you have seven

[8]vertebral bodies in the cervical spine, but in this

[9]case you have got two of those motion segments being

[10]fused. So in addition to whatever limitation the

[11]person might have from pain or spasm or tightening of

[12]muscles which might reduce their range of motion even

[13]more, you have got two motion segments out of the seven

[14]knocked out by the fusion itself.

[15]Q Doctor, did your physical exam continue after

[16]range of motion? And I am directing your attention to

[17]the cervical spine, sir.

[18]A Yes, it did.

[19]Q Can you share with us what you did next?

[20]A Well, I looked at things that were related to

[21]the cervical spine. One was to do a neurological

[22]assessment of the arms or upper extremities, as we call

[23]them, because the nerve supply to the arms comes

[24]through the cervical spine, and one of the things I do

[25]is sensory testing. I use a little monofilament, I use
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[1]a tuning fork, I use a little pin, **[*41]** and I do testing in

[2]key areas of both arms. And I found in the territory

[3]supplied by the C-5-C-6 nerves that there was decrease

[4]of sensation. He was not completely numb there, he

[5]could feel, but when we compared those areas to other

[6]parts of his arms or the face, there was a decrease.

[7]That relates to the cervical spine in that this

[8]corresponds to the area where he has pathology on his

[9]scans and where he had surgery.

[10]I also looked at the shoulder girdle and

[11]found some muscle tenderness, which is also consistent

[12]with referred pain coming from the cervical spine.

[13]Q Sir, as part of your preparation for this

[14]examination, you reviewed the EMG performed by

[15]Dr. Perel on 7/20/03; correct?

[16]A Yes.

[17]Q And you perform EMG's in your practice;

[18]correct, sir?

[19]A Yes, I do.

[20]Q And can you share with us how the EMG test is

[21]administered?

[22]A There are two main components. The first one

[23]is called nerve conduction. That's where we put some

[24]little flat electrodes on different body parts, and we

[25]give shocks over where the nerves are running at
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[1]multiple places, and **[*42]** we record how fast the electricity

[2]flows and how big of a change we can measure on the

[3]screen for the impact of that electricity reaching the

[4]nerve.

[5]We also look at something called the

[6]needle EMG or electromyogram. That's where we have a

[7]needle, which is a recording electrode. It is attached

[8]by a wire to a machine, and that machine has a scope on

[9]it, a display, and when we put the needle into the

[10]muscle we watch the response. We look for abnormal

[11]activity on that display when the needle is inserted

[12]and when it is left in there. And we look to see if it

[13]is quiet at rest, which it is supposed to be, and we

[14]look to see what sort of activity there is when the

[15]person moves their muscle.

[16]Q Is that an objective or subjective test, sir?

[17]A That is entirely objective. It does not

[18]require any opinion or statement from the patient at

[19]all.

[20]Q Sir, with the Court's permission, I would

[21]like to approach with Plaintiff's Exhibit Number 14 in

[22]evidence, which is the chart of Dr. Perel.

[23]THE COURT: You may.

[24]Q Sir, I am going to draw your attention first

[25]to the cover page, **[*43]** which reads "EMG nerve conduction
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[1]study," and then I am going to direct your attention to

[2]the data that follows two pages later.

[3]Sir, can you share with us what the

[4]findings of the EMG conducted by Dr. Perel were?

[5]A Yes. He describes an impression of a left

[6]C-5-6 radiculopathy with denervation in the paraspinal

[7]muscles.

[8]And then there are sheets of data. The

[9]first page is the nerve conduction studies which are

[10]normal, which I would expect based on that impression.

[11]And then when I look at the needle EMG report looking

[12]at the paraspinal muscles, I do see there are abnormal

[13]findings more on the left than the right, although he

[14]does actually document some abnormalities on the right

[15]side at C-6-7.

[16]But on the left side at C-5-6 and C-6-7

[17]specifically he is documenting the presence of

[18]spontaneous activity, and there are certain

[19]characteristic spikes of electricity that you don't see

[20]in a normal person but you do see in a muscle where its

[21]nerve supply has been cut off by an injury.

[22]Q Now, is that EMG finding consistent with your

[23]physical exam and consistent with **[*44]** the medical records

[24]you reviewed?

[25]A Yes, it is.
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[1]Q Does it confirm in any way or not confirm a

[2]diagnosis of radiculopathy?

[3]A It does confirm.

[4]Q Sir, I believe you had one further notation

[5]in your report concerning your physical exam. Can you

[6]please share with the jury what that was?

[7]A Yes. We look at mobility as one -- as a

[8]physiatrist, it is an important part of the exam. And

[9]in terms of what we call transfers, meaning getting on

[10]and off a chair, getting on and off the exam table and

[11]general mobility, he was hesitant, moving in a slower,

[12]deliberate manner than a person of 3 0-something years

[13]would typically move. And in particular he did not

[14]rotate his neck spontaneously to any degree at any

[15]time.

[16]So, for example, when I would call him

[17]from the waiting room to come in, he would turn his

[18]entire body to look at me rather than turning his neck

[19]to look at me, and throughout the exam did not turn his

[20]neck from side to side but always looked straight

[21]ahead.

[22]Q Is that significant to you?

[23]A Yes, it is. It is more efficient for a human

[24] **[*45]** being to turn their neck to look at someone over to one

[25]side rather than to turn their entire body. It is not
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[1]natural but it is a strategy that people adapt when

[2]they can't turn their neck or when it hurts too much to

[3]do so.

[4]Q Doctor, when you examined Mr. Klein, did you

[5]ask whether he had had any prior problems with his neck

[6]before the accident of May 20, 2003?

[7]A Yes.

[8]Q And what was the response you got, sir?

[9]A Negative.

[10]MR. O'TOOLE: I would like to approach

[11]the witness with a document in evidence. This is

[12]the chart of Dr. Giannone, Plaintiff's Exhibit 13

[13]in evidence.

[14]Q Sir, I am going to direct your attention to a

[15]note taken on 5/1/03, and the first thing I am going to

[16]ask you is is it fair to say that is 19 days before

[17]this accident?

[18]A Yes.

[19]Q Can you show us, tell us, sir, whether there

[20]is any complaint whatsoever on 5/1/03 of any kind of

[21]neck pain whatsoever before this accident?

[22]A Nothing here.

[23]Q Sir, that absence of any kind -- was there an

[24]examination, physical exam, conducted that day?

[25]A Yes, there was. **[*46]**
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[1]Q Was the patient asked whether anything was

[2]bothering her that day?

[3]A Yes.

[4]Q And the response, there was no complaint

[5]relative to the neck at all; is that correct, sir?

[6]A That is correct.

[7]Q Now, sir, does that absence of any kind of

[8]neck complaint 19 days before this accident, does that

[9]support the history that was given to you by Al Klein?

[10]A Yes, given that the report was that the neck

[11]pain all started after the accident.

[12]Q Sir, after reviewing all the documents and

[13]medical records that you had been furnished with by my

[14]office, after taking a history and conducting a

[15]physical examination, did you come to an impression as

[16]of October 2005 as to Al Klein's condition?

[17]A Yes.

[18]Q Can you share with the jury what that

[19]impression was?

[20]A Sure. It is a multipart impression. First

[21]of all, being status post the motor vehicle accident on

[22]May 20, 2003 with injuries, there was the cervical

[23]radiculopathy. That's the problem with the nerve root

[24]in the neck, cervicogenic headache, meaning a headache

[25]that is coming from the neck, neck pain. **[*47]** There was
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[1]also some post concussive syndrome going on. Those

[2]were the clinical impressions.

[3]And then by way of history, he was again

[4]status post, at that point, cervical epidural steroid

[5]injection, status post cervical discectomy, status post

[6]fusion of C-4 to C-6 and with chronic head and neck

[7]pain at that point in time.

[8]Q Sir, the impression you just gave us -- is

[9]impression basically the same thing as a diagnosis?

[10]A Yes, it is.

[11]Q Sir, can you tell us what your opinion is,

[12]within a reasonable degree of medical certainty, based

[13]on the history provided to you and all the medical

[14]records relative to the 5/21/03 accident?

[15]Was that your diagnosis you just gave us

[16]for Al Klein?

[17]A Yes, it was.

[18]Q Do you have an opinion, within a reasonable

[19]degree of medical certainty, as to the cause of that

[20]diagnosis?

[21]A Yes.

[22]Q What is that opinion, sir?

[23]A That's the motor vehicle accident of May 20,

[24]2003.

[25]Q Sir, do you have an opinion within a
683

[1]reasonable degree of medical certainty as to the level

[2]of permanence of those conditions? **[*48]**

[3]A Yes, I do.

[4]Q Can you share that with us, sir?

[5]A These are permanent.

[6]Q And what does that mean that they are

[7]permanent?

[8]A Well, many people sustain injuries where they

[9]have symptoms that last for a period of time and go

[10]away, either through the natural healing process or

[11]through some treatment by a doctor or therapist.

[12]But we look at the duration of symptoms

[13]and at some point determine that a condition may be

[14]chronic, meaning it is permanent, not going away.

[15]If something is acute -- that means it

[16]happened right after in this case an accident -- it

[17]might go away. If it is subacute, that might mean it

[18]is something that is slow to go away but go away.

[19]Chronic is a synonym in this case for

[20]permanent, meaning that the person has had the pain.

[21]At that point at the time of my exam it was about two

[22]and-a-half years, which more than meets the definition

[23]of chronic pain. And the structural injuries are what

[24]they are. The person is status post the discectomy and

[25]fusion.
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[1]Q Sir, when you say permanent -- I don't mean

[2]to beat a dead horse, **[*49]** but that means for the rest of

[3]his life, correct?

[4]A Correct. For the rest of his life.

[5]Q Sir, the injuries that you have diagnosed

[6]caused by this accident, did they result in significant

[7]limitations for Al Klein?

[8]A Yes, they do.

[9]Q Can you share with us how they result in this

[10]limitation?

[11]A Sure. The injuries, first of all, result in

[12]significant pain. This is pain that has required

[13]multiple treatments, including the use of narcotic

[14]medications to control the pain, which impose

[15]limitations of their own on a person in terms of things

[16]like how sharp they are mentally.

[17]He also has a loss of range of motion.

[18]In his case significant decrease of range of motion,

[19]which will impact negatively on his ability to perform

[20]activities of daily living, certainly would preclude

[21]sports or working out or things like that, would

[22]preclude any type of heavy physical laborer, even light

[23]types of work because of the effects on the neck and

[24]the need to now protect what's left there.

[25]MR. WILSON: Your Honor, the witness
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[1]voice has to -- I can't hear him at all.

[2] **[*50]** THE WITNESS: I am sorry.

[3]THE COURT: Kind of project from the

[4]diaphragm.

[5]THE WITNESS: I will try.

[6]MR. O'TOOLE: Can we encourage the jury,

[7]if you don't hear, put your hands up. I don't

[8]want you to miss anything.

[9]THE COURT: Otherwise, I got to bring in

[10]the karaoke machine. We do have it inside.

[11]Q Doctor, the cervical fusion was in July 2005;

[12]correct?

[13]A Yes.

[14]Q And July 26, 2005. And you examined

[15]Mr. Klein on 10/11/2005; correct?

[16]A Yes.

[17]Q So less than three months after the surgery

[18]was performed; correct?

[19]A That is correct.

[20]Q And you gave an opinion as to what you

[21]prognosed his future medical needs would be at that

[22]time; correct?

[23]A Yes, I did.

[24]Q And did you report -- you put that in a

[25]report; correct?
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[1]A Yes.

[2]Q And did you make those opinions within a

[3]reasonable degree of medical certainty?

[4]A Yes, I did.

[5]Q And did you talk about those medical needs,

[6]specifying the modalities and also attributing a cost

[7]to those modalities?

[8]A Yes.

[9]Q And a frequency to **[*51]** those modalities?

[10]A Yes.

[11]Q And, sir, how were you able to do that only,

[12]you know, two and-a-half months after a fusion surgery?

[13]A Well, first of all, I have to rely on my own

[14]experience treating patients with, among other things,

[15]cervical fusions or other types of fusion, other types

[16]of cervical spine injury and my general experience

[17]treating patients with major disabling conditions.

[18]I also rely on the historical data --

[19]not only what the patient tells me, but all the medical

[20]records -- so that I can track the course of events up

[21]to that point in time. And I also rely on my knowledge

[22]of medical literature, my knowledge of my continuing

[23]medical education that I draw upon in order to make

[24]these projections.

[25]Q Sir, can you share with the jury the opinion
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[1]you reached regarding the prognosis for future medical

[2]services within a reasonable degree of medical

[3]certainty?

[4]A Yes, I can. There are several parts to it.

[5]With need for continued followup, first

[6]of all, with either a neurologist or a physiatrist such

[7]as myself to do ongoing monitoring and management **[*52]** of

[8]him, that would be six visits per year on average at

[9]$ 150 per visit.

[10]Annual followup once a year with a spine

[11]surgeon at, again, $ 150 per year for that office visit.

[12]An MRI to track the condition of the

[13]cervical spine on average every three years. Currently

[14]costs about $ 1,500 per set of scans.

[15]Pain medication, also known as

[16]analgesics. At the time he was taking Vicodin. The

[17]cost would be about $ 80 a month. The Lidoderm patches,

[18]which were costing about $ 167 a month at that time.

[19]Also projected need for future courses

[20]of physical therapy averaging about 36 sessions a year

[21]at $ 100 a session at that time.

[22]He may need at that point additional

[23]fusion surgery due to increased strain on the adjacent

[24]levels, which we also call adjacent level syndrome, and

[25]at that time fusion surgery was costing about 40 to
688

[1]$ 50,000.

[2]Q Sir, can you share with us why it is, in your

[3]opinion, within a reasonable degree of medical

[4]certainty, necessary for Al Klein to have followup on a

[5]regular basis with either a neurologist or a

[6]physiatrist?

[7]A Because that **[*53]** doctor would track the status of

[8]his pain. He is taking serious and what you might call

[9]heavy duty pain medication, requires regular

[10]supervision of a doctor, rightly so. You are not

[11]allowed to prescribe a year's supply of those

[12]medicines; you are supposed to monitor the patient for

[13]their safety. Also to monitor his neurological exam,

[14]his physical examination, to monitor for the

[15]development of any new symptoms. That's what those

[16]visits are for.

[17]Q And these are lifelong needs that you have

[18]described; correct?

[19]A Yes.

[20]Q And, sir, the next question pertains to the

[21]spinal surgeon followup. Why does he need that spinal

[22]surgeon followup?

[23]A To monitor the status of his fusion, to make

[24]sure that that is behaving properly and that he is not

[25]at the stage where he would need additional spine
689

[1]surgery.

[2]Q Why, sir, would he require MRI followup?

[3]A Because MRI is the best way for visualizing

[4]the discs and the nerves in the spinal cord within the

[5]spine. Plain x-ray would not give you the full

[6]picture.

[7]Q How about the future pain meds you have

[8]prognosticated, **[*54]** Vicodin and Lidoderm?

[9]A Yes. And that reflected the medicines he was

[10]taking at that time. We do sometimes have to rotate

[11]between different narcotics because people will get a

[12]certain level of you might call resistance where -- or

[13]the technical term is a tachyphylaxis where the person

[14]is no longer getting the same pain relief from the

[15]narcotic medicine, so we sometimes have to rotate.

[16]But the Vicodin cost would be typical

[17]for other similar medicines, as well, and the Lidoderm,

[18]being the patch that is applied directly, because he

[19]has chronic pain he is going to continue to need

[20]medicine to try to keep a lid on this pain.

[21]Q Are you familiar with the fentanyl patch,

[22]sir?

[23]A Yes, I am.

[24]MR. TUMBARELLO: Objection.

[25]THE COURT: Overruled.
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[1]MR. TUMBARELLO: May we approach, your

[2]Honor?

[3]THE COURT: Inside. How much longer do

[4]you have with the doctor?

[5]MR. O'TOOLE: Maybe 10 minutes. Maybe

[6]less. I can move on from that if you want me to.

[7]I will get there another way. It is not a

[8]problem.

[9]THE COURT: Let's move on.

[10]Q Sir, how about **[*55]** the need for future physical

[11]therapy? Can you tell us the purpose of physical

[12]therapy and the reason Al Klein will need it for the

[13]rest of his life?

[14]A Yes. Physical therapy consists of different

[15]parts. One is what we call modalities, using different

[16]machines and devices that relieve pain; very simple

[17]things, like a hot pack or a cold pack, but also

[18]includes more complex things like electrical

[19]stimulation or a TENS unit or an ultrasound machine.

[20]These are things that are applied to try to improve

[21]blood flow, reduce spasm, decrease pain.

[22]Another part is what we call manual

[23]therapy. Massage would be an example that most people

[24]are familiar with the type of manual therapy.

[25]And then there is exercise therapy;
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[1]specific exercises supervised by a therapist under

[2]doctor's orders to have someone do theraputic exercise

[3]that can help to strengthen them, preserve or increase

[4]range of motion and indirectly may reduce pain.

[5]Q You are aware that since the cervical surgery

[6]of '05 Mr. Klein hasn't tolerated physical therapy very

[7]well. Is that correct?

[8]A That is right.

[9] **[*56]** Q Do you nonetheless recommend it as a future

[10]modality for him?

[11]A I would indeed, at a minimum to treat

[12]exacerbations of his pain with the modalities, as well

[13]as soft tissue work not done directly over the spine

[14]but dealing with things like those paraspinal muscles

[15]and shoulder girdle muscles.

[16]Q Sir, did you reach an opinion and put it in a

[17]report back in 2005, to a reasonable degree of medical

[18]certainty, as to what the household and housekeeping

[19]needs of Al Klein would be as time went on?

[20]A Yes.

[21]Q And can you share with us what that opinion

[22]is within a reasonable degree of medical certainty?

[23]A Yes. By age 50 he would need about 20 hours

[24]a week of household assistance above and beyond what he

[25]could do for himself.
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[1]Q Did you share with us in the report what the

[2]cost of that would be?

[3]A Yes.

[4]Q And what is that cost, sir?

[5]A That would be $ 400 per week.

[6]Q And is that something you are familiar with

[7]in your practice in placing these types of services for

[8]your own patients?

[9]A Yes. It is a very familiar, everyday issue

[10] **[*57]** in my practice.

[11]Q Can you share with us how it is, sir, that

[12]you are prognosing this need some 13 years in the

[13]future? Back then it was 15 years in the future.

[14]A Yes, indeed at that point it was 15 years in

[15]the future. Projecting the need for additional

[16]household help above and beyond what he already was

[17]getting at the time because of the nature of his injury

[18]with the cervical spine fusion and the progression of

[19]arthritic change at adjacent levels.

[20]There is literature that indicates that

[21]at a point of 17 and-a-half months on average after

[22]fusion surgery of this type, with one or two levels

[23]fused, that 75 percent of people, in a research study

[24]which was published in the Journal of Neurosurgery in

[25]January of 2004, had gone on to have significant
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[1]spondylitic change, meaning arthritic change in the

[2]adjacent levels above and below their cervical fusion.

[3]And that's only at a year and-a-half out.

[4]Very conservatively, at 50 years old,

[5]roughly 10 times longer than that, we would expect him

[6]to have significant compromise above and beyond what he

[7]has already. In terms of why **[*58]** that impacts the need for

[8]household help.

[9]We want people with these types of

[10]problems to follow what we call cervical precautions.

[11]We don't want them reaching overhead to manipulate any

[12]sort of objects of even light to moderate weight. We

[13]don't want them lifting objects that are heavy because

[14]those put strain on the neck. We don't want them doing

[15]vigorous pushing or pulling because, again, those

[16]activities all put strain through the neck. And we

[17]don't want them putting their neck into various extreme

[18]postures.

[19]So while we don't normally think about

[20]it, but a lot of household activities involve reaching

[21]to a high shelf or bending down to get something out of

[22]a low drawer. Tasks like changing the linen on a bed,

[23]doing laundry, especially taking wet laundry out of the

[24]washer and transferring it to the dryer, handling heavy

[25]shopping bags, mopping the floor, vacuum, things like
694

[1]that, as well as other types of household tasks, all of

[2]these put some strain on the neck, and he should not be

[3]doing those certainly by that age, if not sooner.

[4]Q Now, sir, have you followed patients **[*59]** with

[5]fusion surgery in the past?

[6]A Yes, I have.

[7]Q And what's the average of someone that in

[8]your experience gets fusion surgery?

[9]A The majority of patients -- and I can speak

[10]not only in my practice but in my review of the

[11]hospital records, of the other doctors' practices, as

[12]well -- the majority of those people are senior

[13]citizens, usually in their 70's or 80's. It's a

[14]minority of people who have these procedures done what

[15]you might call middle age, in a small minority who you

[16]would characterize as young.

[17]Q Is Al Klein, having undergone cervical fusion

[18]surgery in his 30's, at a greater or different risk for

[19]adjacent level problems than somebody who is maybe 70

[20]years of age?

[21]MR. TUMBARELLO: Objection. Outside the

[22]scope of disclosure, your Honor.

[23]THE COURT: Overruled. Generalized.

[24]You may answer.

[25]A He is at significantly greater risk because
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[1]of his life expectancy and his age, life expectancy

[2]meaning the longer you live, if you have a progressive

[3]process, the farther along it can get. And also

[4]younger patients tend to be simply more active **[*60]** than

[5]older patients, so he is at greater risk than an older

[6]patient.

[7]Q Now, sir, at the time that you performed this

[8]examination and rendered this report, were you assuming

[9]that the fusion would be successful from a radiologic

[10]standpoint?

[11]A Yes.

[12]Q And prior to coming here today, have you been

[13]furnished with subsequent records indicating that there

[14]is a pseudarthrosis?

[15]A Yes, I have.

[16]MR. TUMBARELLO: Objection.

[17]THE COURT: Overruled.

[18]Q Sir, the prognosis you just gave to the jury,

[19]that's assuming that there is going to be a good

[20]outcome radiologically at some point from the future;

[21]correct?

[22]A Yes.

[23]Q And, sir, to prepare yourself for being here

[24]today, in addition to reviewing subsequent meds, did

[25]you also examine Al Klein in the last month?
696

[1]A Yes, I did.

[2]MR. TUMBARELLO: Objection.

[3]Q The findings that you found at that time,

[4]sir, were they more or less the same as back in 2005?

[5]THE COURT: Overruled.

[6]MR. TUMBARELLO: May we approach?

[7]MR. WILSON: I join in that objection,

[8]your Honor. **[*61]**

[9]THE COURT: Overruled.

[10]Q When you examined Mr. Klein the last month,

[11]were the physical findings more or less the same as

[12]back in 2005?

[13]A Yes.

[14]Q But his meds were different; correct?

[15]A Yes.

[16]Q Nonetheless, in terms of your future medical

[17]needs prognostication, you are staying with the meds as

[18]back in 2005; correct?

[19]A Yes.

[20]Q He was taking fewer meds back then than

[21]today; correct, sir?

[22]MR. TUMBARELLO: Objection.

[23]THE COURT: Overruled.

[24]A Yes.

[25]Q Are you aware that Dr. DiGiacinto has
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[1]suggested a further revisionary surgery to address the

[2]pseudarthrosis?

[3]A Yes.

[4]Q Now, sir, are you aware that Mr. Klein has

[5]indicated a desire to go forward with that further

[6]surgery?

[7]A Yes.

[8]Q Now, assuming that that surgery is a

[9]radiological success, sir -- that means that it results

[10]in a good fusion you can see on a film -- does that

[11]mean, within a reasonable degree of medical certainty,

[12]that Al Klein won't have continuing pain?

[13]A No. He is at risk for continued pain even

[14]with a very good x-ray **[*62]** or CAT scan or MRI appearance of

[15]the fusion. If he has a successful fusion from the

[16]terms you described where we can see good bone growing

[17]in and motion studies go back to normal as opposed to

[18]abnormal like they have been, the patient can still

[19]have pain.

[20]And this is something that is something

[21]I see in my own practice, and it is something that is

[22]well documented in the literature. The reason being,

[23]as we understand it with our current state of medical

[24]knowledge, is that if you stablize that fusion so that

[25]you no longer have motion there, you still have nerves
698

[1]that may be transmitting a pain message up to the brain

[2]to the part of the brain that perceives pain.

[3]Q Do you have an opinion --

[4]MR. TUMBARELLO: I move to strike the

[5]last answer as being speculative and unapplicable

[6]to this case.

[7]THE COURT: Overruled.

[8]Q Sir, do you have an opinion, within a

[9]reasonable; degree of medical certainty, as to whether

[10]or not, assuming a good radiological fusion, Al Klein

[11]will have pain in his neck for the rest of his life?

[12]MR. TUMBARELLO: Objection.

[13]THE COURT: **[*63]** Overruled.

[14]A Yes.

[15]Q And what is that opinion, sir?

[16]A He will have pain.

[17]Q Sir, there was talk of Depo-Testosterone.

[18]That wasn't revealed to you by Mr. Klein; is that

[19]correct?

[20]A Yes.

[21]Q Sir, have you done any studies or authored

[22]any articles yourself within with the realm of

[23]Depo-Testosterone or similar medications?

[24]A Yes, I have.

[25]Q Are you aware of what their impact is upon
699

[1]the healing of bony fusion?

[2]A Yes.

[3]Q Go ahead, sir.

[4]A Drugs in this family can heal -- can

[5]facilitate, I should say -- they can facilitate the

[6]healing of wounds, including this surgical wounds. So

[7]it can facilitate the healing.

[8]Q When you say "surgical wounds," are you

[9]talking about bony fusion?

[10]A Yes.

[11]MR. TUMBARELLO: Objection again;

[12]outside.

[13]THE COURT: Overruled.

[14]Q This is something you have been an author on

[15]in medical journals; correct, sir?

[16]A Yes, I have.

[17]Q Thank you, sir.

[18]I want you to assume that the defendants

[19]have disclosed a neurologist named Michael Carciente,

[20]Dr. Michael **[*64]** Carciente, and that he is going to testify

[21]that once someone has a fusion at one level, that puts

[22]them at increased risk of requiring fusion at the

[23]adjacent levels.

[24]Would you agree with Dr. Carciente?

[25]A Absolutely.
700

[1]Q Now, sir, could the use of Depo-Testosterone

[2]on a life-long basis reduce the life expectancy of Al

[3]Klein from what it had been when you first met him?

[4]A Well, if it is being done at a dosage that

[5]would be the equal of the typical male level of

[6]testosterone, then that would put someone at a male

[7]life expectancy rather than a female life expectancy.

[8]The male life expectancy in this country is a few years

[9]shorter than the female life expectancy.

[10]MR. O'TOOLE: Thank you.

[11]Pardon me one second, Judge, please.

[12](Short pause.)

[13]MR. O'TOOLE: I have nothing further of

[14]this witness. Thank you, Judge.

[15]THE COURT: Very good. It is almost 20

[16]after 12:00. Let's take 10 minutes, jurors.

[17]Thank you.

[18]MR. O'TOOLE: You know what, Judge, I am

[19]going to have a question or two. I am sorry, sir.

[20]THE COURT: You got it now?

[21] **[*65]** MR. O'TOOLE: Yes, sir. I do.

[22]THE COURT: Do you want to wait, because

[23]we need to take a break? Go ahead.

[24]MR. O'TOOLE: I apologize.

[25]Q Sir, does pseudarthrosis cause pain?
701

[1]A Yes, it can.

[2]Q Why?

[3]A Because you have increased motion, and so

[4]these nerves are getting further traumatized.

[5]MR. O'TOOLE: Sorry. Thank you very

[6]much.

[7]THE COURT: Good. Let's take a break,

[8]jurors.

[9](Jury leaves courtroom.)

[10](Short recess taken.)

[11]oOo

[12](Jury enters courtroom.)

[13]MR. WILSON: May I, your Honor?

[14]THE COURT: Yes. Mr. Wilson.

[15]MR. WILSON: Thank you.

[16]CROSS-EXAMINATION

[17]BY MR. WILSON:

[18]Q Good afternoon, Doctor.

[19]A Good afternoon.

[20]Q My name is Greg Wilson. Have we ever met

[21]before?

[22]A No.

[23]Q Have you ever done any work on my behalf?

[24]A Not that I know of, no.

[25]Q Okay. Doctor, I just want to clarify a few
702

[1]points. How many times in total have you examined

[2]Mr. Klein?

[3]A Two times.

[4]Q Twice; once in 2005 and then again how long

[5]ago?

[6]A June 3rd. **[*66]**

[7]Q Of this year?

[8]A Of this year.

[9]Q And you indicated earlier when Mr. O'Toole

[10]was asking you some questions that a physiatrist is

[11]often the captain of a rehabilitation team. Remember

[12]that?

[13]A Yes.

[14]Q Do you consider yourself the captain of

[15]Mr. Klein's rehabilitation team?

[16]A No.

[17]Q You have not been his treating physician,

[18]have you?

[19]A Correct.

[20]Q Sir, can a person with Mr. Klein's specific

[21]neck injury that you examined in June, can he drive a

[22]car?

[23]A Yes.

[24]Q Can he go to work?

[25]A He could go to work, yes.
703

[1]Q In your report of October 21, 2005, did you

[2]indicate -- I think you testified a little earlier to

[3]the jury that he tried after the surgery but failed to

[4]go to work; correct? Not able to do it.

[5]A Yes. He couldn't function.

[6]Q Okay.

[7]MR. O'TOOLE: Could we just approach for

[8]one second, Judge? It is on an issue I think that

[9]will save a lot time.

[10](Bench conference.)

[11]Q Doctor, I have actually one last question for

[12]you.

[13]You have an EMG with abnormal findings.

[14] **[*67]** Can you have that if you have that osteophyte disc

[15]ridge complex with a herniation?

[16]A If it is pressing on the nerve.

[17]Q So it is possible to get that same abnormal

[18]EMG finding simply from a degenerative disc problem.

[19]A Well --

[20]Q With symptoms.

[21]A You can get an abnormal finding. You

[22]wouldn't get the exact pattern seen here because this

[23]pattern was multiple levels, and the disc ridge complex

[24]is at one level in Mr. Klein.

[25]Q So focusing on that one level, you could get
704

[1]that abnormal reading because of the osteophyte ridge

[2]complex; correct?

[3]A Possibly.

[4]MR. WILSON: I have nothing else. Thank

[5]you.

[6]THE COURT: Mr. Faranda?

[7]MR. FARANDA: Yes, Judge. Briefly.

[8]CROSS-EXAMINATION

[9]BY MR. FARANDA:

[10]Q Good morning. Good afternoon.

[11]A Good afternoon.

[12]Q Dr. Richter, I also have just a few

[13]questions.

[14]You have heard from the testimony that

[15]it is Mr. Klein's intention to have the refusion of the

[16]vertebrae which apparently has failed; correct?

[17]A Yes.

[18]Q And if that refusion is successful, that

[19]there **[*68]** would be a substantial reduction in his pain,

[20]would there not?

[21]A There is likely to be a reduction in pain.

[22]Q Would you call that substantial?

[23]A It might be.

[24]MR. FARANDA: Thank you.

[25]THE COURT: Boy, they are really pushing
705

[1]it, Mr. Tumbarello. Are you going to be as brief?

[2]MR. TUMBARELLO: I will start off with

[3]an apology that I will not be that brief.

[4]CROSS-EXAMINATION

[5]BY MR. TUMBARELLO:

[6]Q Dr. Richter, good to see you again.

[7]A Likewise.

[8]Q Okay. This is the fourth plaintiff's case

[9]that -- fourth plaintiff that I will be talking to you

[10]about. In each case you were retained by the Block &

[11]O'Toole firm?

[12]A Three or four. I am not sure how many.

[13]Q One was a doubleheader, okay?

[14]A Okay.

[15]Q I think the first time we met was on the

[16]Furm's(ph) matter?

[17]A Yes.

[18]Q And in that case Mr. O'Toole and his partner,

[19]Jeff Block, tried that case?

[20]A Yes.

[21]Q All right. And then there was a case

[22]involving a young man named Pimentou(ph)?

[23]A Yes.

[24]Q And a woman named Reyes(ph)?

[25]A Yes. **[*69]**
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[1]Q And that was Mr. Murphy who produced you in

[2]that trial.

[3]A Yes.

[4]Q Okay. Then I think one of my partners on a

[5]case called Nix or Niz, N-I-Z, where Mr. O'Toole called

[6]you as his witness in that case.

[7]MR. O'TOOLE: Objection.

[8]A I don't recall it.

[9]MR. O'TOOLE: It was not a trial. The

[10]witness didn't appear.

[11]THE COURT: Yes.

[12]Q Doctor, in addition to the 60 times that you

[13]have come to court to give live testimony, have you

[14]been deposed in the course of litigation?

[15]A Yes, I have.

[16]Q And on any of those times were you produced

[17]on behalf of the Block & O'Toole firm?

[18]A No.

[19]Q In addition to the times you come to court,

[20]Doctor, I think you testified that you did an

[21]examination of the plaintiff in this case in October of

[22]2005; correct?

[23]A Yes.

[24]Q And in conjunction with that examination, you

[25]wrote the report that you have been referring to
707

[1]throughout today.

[2]A Yes.

[3]Q Did you charge for that examination and

[4]report?

[5]A Yes.

[6]Q Were those fees charged to the Block &

[7] **[*70]** O'Toole law firm?

[8]A Yes.

[9]Q And the examination that you did on the third

[10]of June after we actually started selecting this jury,

[11]did you charge a fee for that work, as well?

[12]A Yes.

[13]Q And were those fees sent to the Block &

[14]O'Toole firm?

[15]A Yes.

[16]Q And the fees for your time in court today,

[17]that will also be sent to the law firm.

[18]A Also.

[19]Q In addition to the times you have testified,

[20]Doctor, have there been other occasions where you have

[21]been retained by the Block & O'Toole firm to do

[22]examinations and write reports such as you did in this

[23]case two and-a-half years ago, almost three years ago?

[24]A Yes.

[25]Q How many times, Doctor, have you been called
708

[1]upon to examine a plaintiff on behalf of the Block &

[2]O'Toole firm and write reports?

[3]A Outside of the cases I have testified on,

[4]maybe about 10 or so.

[5]Q Ten or so? And have you done that kind of

[6]work for other plaintiff law firms?

[7]A Yes, I have.

[8]Q What is your standard and customary --

[9]MR. TUMBARELLO: Withdrawn.

[10]Q What is the fee that you charged **[*71]** the Block &

[11]O'Toole firm for the report and the examination that

[12]you did of the plaintiff in this case in October of

[13]'05?

[14]A $ 1,400.

[15]Q $ 1,400? Is that your standard and customary

[16]fee for an examination and a report?

[17]A No. It is an hourly rate of 350 per hour.

[18]Q So if you charged him $ 1,400, is that

[19]reflective of $ 350 an hour times the number of hours

[20]that you spent?

[21]A Yes, it is.

[22]Q Doctor, will you agree with me that for a

[23]treating physician or an examining physician, which was

[24]your role in this case, it is important for the patient

[25]or the plaintiff, as the case may be, to be honest with
709

[1]that physician?

[2]A Yes.

[3]Q Why is that important, Doctor?

[4]A Because we want to know all of their medical

[5]conditions and what might be wrong with them.

[6]Q Sure. And you would want to know if they

[7]have had certain procedures that have been successful

[8]or unsuccessful or if there have been complications or

[9]not complications?

[10]A Yes.

[11]Q You want to know if they are suffering from

[12]any other diseases or symptoms, etc; correct?

[13] **[*72]** A That is right.

[14]Q Because your goal is to get a comprehensive

[15]view of the entire patient or plaintiff; correct?

[16]A Yes.

[17]Q In this case you did an examination of the

[18]plaintiff; correct?

[19]A Yes.

[20]Q And how long did the physical examination

[21]take?

[22]A The whole visit was probably about an hour.

[23]Q And that would include the time when you

[24]first met with the plaintiff Klein?

[25]A Yes.
710

[1]Q And you took the history from this plaintiff?

[2]A Yes.

[3]Q And then you examined the plaintiff; correct?

[4]A That's right.

[5]Q Now, at the time that you -- and as

[6]Mr. O'Toole said, I will be referring to Mr. Klein as

[7]Mr. Klein.

[8]A Sure.

[9]Q But at the time of your report in October you

[10]referred to it as Miss Klein, Alison; correct?

[11]A Yes.

[12]Q When you did your examination --

[13]MR. TUMBARELLO: Withdrawn.

[14]Q And Mr. Klein at the time of your examination

[15]did not advise you that he was taking testosterone and

[16]had been for quite sometime.

[17]A Yes.

[18]Q And at the time of your examination Mr. Klein

[19]did **[*73]** not advise you that he was post surgery with

[20]respect to a double mastectomy and a nipple areola

[21]chest reconstruction.

[22]A Right.

[23]Q Now, when you examined Mr. Klein at the

[24]behest of the Block & O'Toole firm, did anyone at the

[25]Block & O'Toole firm tell you that Mr. Klein was post
711

[1]mastectomy?

[2]A No.

[3]Q Doctor, would it have been important to you

[4]in making the pain assessment --

[5]MR. TUMBARELLO: Withdrawn.

[6]Q Doctor, would you consider the mastectomy and

[7]chest reconstruction surgery that was done to be

[8]elective in this case?

[9]A Elective? Yes.

[10]Q And cosmetic.

[11]A Well, I don't know if I would characterize it

[12]as cosmetic. It is a complicated issue.

[13]Q It is elective?

[14]A It is elective.

[15]Q Do you know when that surgery was performed?

[16]A The date, no.

[17]Q Would it refresh your recollection if I told

[18]you that the mastectomy surgery was May 18th, 2004?

[19]A Okay.

[20]Q And you would agree with me, I presume, that

[21]May 18th, 2004 is approximately one year after the date

[22]of the accident, May 20th, '03.

[23]A **[*74]** Yes.

[24]Q You would also agree with me that the

[25]mastectomy surgery was a year and-a-quarter prior to
712

[1]the fusion surgery; correct?

[2]A Yes.

[3]Q Now, Doctor, would you agree with me that a

[4]double mastectomy surgery, along with a chest

[5]reconstruction procedure that was done, would be a

[6]competent producing source of pain?

[7]A Of any type of pain?

[8]Q Yes.

[9]A Yes.

[10]Q Doctor, as a physiatrist you deal with pain;

[11]correct?

[12]A Yes, I do.

[13]Q As a physiatrist, have you ever dealt with

[14]the pain that women experience as a result of

[15]mastectomy surgeries?

[16]MR. O'TOOLE: Objection; relevance,

[17]other grounds.

[18]THE COURT: Overruled.

[19]A Yes, I have.

[20]Q Will you share with us, Doctor, what has been

[21]reported to you regarding the pain that your patients

[22]have reported to you having undergone mastectomy

[23]surgery?

[24]A Yes. Some patients report pain in what we

[25]call the pectoral area of the chest or the chest area.
713

[1]Some of them also occasionally get lymphedema, which is

[2]a swelling in the arm.

[3]Q Now, Doctor, when you first **[*75]** saw Mr. Klein,

[4]you reported that he was in some degree of -- some

[5]apparent discomfort.

6 A Yes.

[7]Q And do you know if at the time that Mr. Klein

[8]traveled to San Francisco for the mastectomy and chest

[9]surgery if she was at that time in some degree of

[10]discomfort with respect to her neck?

[11]MR. O'TOOLE: Objection; speculation.

[12]THE COURT: Yes. I mean, did he discuss

[13]that with you at the time?

[14]THE WITNESS: Not specifically, no.

[15]THE COURT: Okay. So it will be

[16]speculative. Move on.

[17]Q In fact, Doctor, when you reviewed the

[18]records that were -- all of the records that you

[19]reviewed in this case, Doctor, were provided to you by

[20]Mr. O'Toole or his law firm?

[21]A Yes.

[22]Q In your review of the records -- and we will

[23]go through them probably in more detail, but just as a

[24]start -- you reviewed records from May 20th, 2003

[25]through July 22, 2003; correct?
714

[1]A And farther on, as well.

[2]Q Well, let's just -- and then from -- let me

[3]ask the question a little bit differently, Doctor.

[4]Did you review any records or did the

[5]O'Toole law **[*76]** firm send you any records for any

[6]treatment, any visits with any doctors, any

[7]hospitalizations, any surgeries, any medications, any

[8]chiropractic care or physical therapy between the

[9]period of July 22, 2003 and August 17th, 2004, a period

[10]of over a year?

[11]A Probably not, from what I am looking at here.

[12]Q Well, if you look at your records --

[13]A Looking at this list, yes.

[14]Q It goes from the 22nd of July of '03 to

[15]August 17th of '04; correct?

[16]A Yes.

[17]Q And now we know that during that period of

[18]time Mr. Klein traveled to San Francisco for the

[19]surgery we just discussed.

[20]A Yes.

[21]Q Do you know if during that period of time

[22]Mr. Klein saw any doctors with respect to any neck

[23]pain?

[24]A I don't know.

[25]Q You don't know. And when you met with
715

[1]Mr. Klein -- now, did you have the medical records from

[2]the Block & O'Toole firm prior to your meeting and

[3]examination of the plaintiff?

[4]A Yes.

[5]Q And you had an opportunity to review the

[6]Block & O'Toole-furnished records before you met with

[7]the plaintiff; right?

[8]A Yes.

[9] **[*77]** Q And, Doctor, when you met with the plaintiff,

[10]did you make any inquiry of the plaintiff regarding how

[11]the plaintiff felt between the period -- in that one

[12]year and one month period when you had no records?

[13]A No.

[14]Q Did you make any inquiry of the plaintiff

[15]whether during that period of time, over a year from

[16]July '03 through August '04, if during that period of

[17]time the plaintiff was taking any pain medicines?

[18]A Not specifically, no.

[19]Q Did you make any inquiry of the plaintiff

[20]whether during that period of time, July '03 through

[21]August '04 for where you have no records, whether the

[22]plaintiff had any physical therapy or chiropractic

[23]care?

[24]A Not specifically, no.

[25]Q Did you make any inquiry whether or not
716

[1]during that period of time the plaintiff had any

[2]radiological studies, any x-rays or CT's or MRI's?

[3]A No.

[4]Q Did you make any inquiry of the plaintiff

[5]whether during that period of time, from two months

[6]after the accident until a year and and three months

[7]after the accident…

[8]I lost it. Sorry about that.

[9]Did you learn that **[*78]** in August of 2003

[10]Mr. Klein returned to the position she had with the law

[11]firm?

[12]A Yes.

[13]Q And that she continued with that position

[14]certainly through the remainder of 2003 through 2004?

[15]A In terms of having the position, yes, it is

[16]my understanding.

[17]Q Yes.

[18]Now, Doctor, you talked about the disc

[19]osteophyte complex in terms of bone growth or bone

[20]spur; correct?

[21]A Yes.

[22]Q And that's another way of talking about this

[23]disc osteophyte complex; correct?

[24]A Right.

[25]Q And you referred to it as degeneration?
717

[1]A Yes.

[2]Q What does desiccation mean with respect to a

[3]cervical disc?

[4]A Drying.

[5]Q Drying?

[6]A Yes.

[7]Q Desiccation and degeneration, are those

[8]similar phenomenas?

[9]A Yes. Desiccation is associated with

[10]degeneration, yes.

[11]Q The desiccation would be the discus material

[12]itself; correct?

[13]A Yes. It means that it is dryer than it

[14]normally would be.

[15]Q And the disc -- I don't know if we still

[16]have -- we still have the model. If it would help you

[17]to talk about it, it will **[*79]** be your choice. We have it,

[18]you can do it.

[19]The disc is between the vertebrae;

[20]correct?

[21]A That's right.

[22]Q And desiccation means the disc between the

[23]vertebrae dries out; correct?

[24]A That's right.

[25]Q And as part of the drying process, loses its
718

[1]elasticity?

[2]A Yes.

[3]Q And it loses some of its ability to serve as

[4]a cushion?

[5]A That's right.

[6]Q And it loses some of its ability with flexion

[7]and movement; correct?

[8]A Yes.

[9]Q And those conditions were all present in

[10]Mr. Klein on the day of the accident; correct?

[11]A As far as we know, yes.

[12]Q Doctor, you reviewed the MRI reports of June

[13]of 2003; correct?

[14]A Yes.

[15]Q And you reviewed the MRI reports of August

[16]'04.

[17]A Yes.

[18]Q And both of those MRI reports showed

[19]desiccation of the disc; correct?

[20]A Yes.

[21]Q Would it be your opinion, Doctor, within a

[22]reasonable degree of medical certainty, that the

[23]desiccation, the drying of this discus material, was

[24]long-standing for some period of time prior to the

[25]accident?
719

[1] **[*80]** A At C-5-6, yes.

[2]Q What about at C-4-5? Did you note that there

[3]was desiccation of the discus material at that level,

[4]as well?

[5]A In some reports it is referenced, in others

[6]not, so there were differences of opinions in terms of

[7]some of the readings.

[8]Q With respect to the MRI report prepared by

[9]the radiologist who first read the films in June of

[10]2003, was there desiccation of the disc material at

[11]that level?

[12]A Yes.

[13]Q Now, desiccation of the disc material is one

[14]indicia of degenerative disc disease; correct?

[15]A Yes.

[16]Q All right? And desiccation is distinct from

[17]the disc osteophyte complex; correct?

[18]A Yes.

[19]Q The disc osteophyte complex, rather than the

[20]loss of moisture in the disc, which is desiccation,

[21]refers to the growth of osteo material or bone

[22]material; correct?

[23]A Yes.

[24]Q And would you agree with me, Doctor, that on

[25]the MRI report of Mr. Klein from June of '03, that with
720

[1]respect to the C-4-5 level, that there was a disc

[2]osteophyte complex reflected?

[3]A I believed that is C-5-6.

[4]Q C-5-6?

[5] **[*81]** A C-5-6, yes.

[6]Q Doctor, you know, you deal with the pain

[7]management of people who have pain complexes, but

[8]having been through medical school, Harvard, etc, you

[9]would agree with me that within this entire complex

[10]everything has a place and everything should be in its

[11]place; correct?

[12]A Yes.

[13]Q And there is not a lot of room in there.

[14]A That's right.

[15]Q So that when you lose fluid from a disc, as

[16]Mr. Klein had prior to this accident, that crunches

[17]things up and reduces the amount of room; correct?

[18]A Well, that can crunch things up in the

[19]vertical direction. It does not -- desiccation alone

[20]does not change the horizontal capacity of the canal.

[21]Q Right. Okay. And the canal itself is narrow

[22]but it is filled with -- the spinal column has its

[23]nerves going through it; right? In the simplest sense.

[24]A Yes.

[25]Q And that when you have the osteophyte disc
721

[1]complex that was diagnosed for Mr. Klein, that involves

[2]the growth of bony material; correct?

[3]A The osteophyte is bony, yes.

[4]Q And bony is hard.

[5]A Yes.

[6]Q And it was noted **[*82]** on that MRI report that

[7]there was a growth of bony material.

[8]A Yes.

[9]Q And since you are already in an area that

[10]doesn't have any room to spare, when you are growing

[11]bony material, that makes it even tighter, doesn't it?

[12]A By virtue of growing into the space, almost

[13]by definition it makes it tighter, but that doesn't

[14]necessarily have significance because many people are

[15]perfectly asymptomatic walking around with these.

[16]Q Sure.

[17]A So it decreases the space almost by

[18]definition, but it doesn't necessarily cause a

[19]significant tightening.

[20]Q Doctor, will you agree with the diagnoses

[21]that we heard from Dr. DiGiacinto yesterday that, based

[22]on his examination of the MRI's, in addition to his

[23]examination of the MRI reports, there was no evidence

[24]of recent trauma at the C-5-6 level?

[25]A In terms of radiologic evidence?
722

[1]MR. O'TOOLE: I have an objection to

[2]form, Judge. If we can just tie that into a time

[3]period.

[4]THE COURT: Why don't you restate it.

[5]Q With respect to the first MRI report,

[6]Doctor -- I mean, you have that report, June 18th, **[*83]** '03.

[7]Is there any evidence on that report of trauma being

[8]sustained in the C-5-6 region?

[9]A No.

[10]Q How about in the C-4-5 region? Do you see

[11]anything on that report?

[12]A Well, in this case we have a C-4-5

[13]herniation, which can be --

[14]Q Does the fact that there is a herniation,

[15]Doctor, the fact that a herniation is noted, does that

[16]indicate to you that that herniation is of recent

[17]vintage, or could it have been of long-standing

[18]vintage?

[19]A It could be either.

[20]Q It could be either. So based on the review

[21]done by the radiologist who wrote that report, there is

[22]nothing in there to indicate that the herniation or the

[23]disc osteophyte complex was caused by the accident of

[24]May 20th, '03.

[25]A Yes.
723

[1]Q You would agree with that.

[2]A Yes.

[3]Q And you have seen nothing in all of the

[4]records you have reviewed or your two physical

[5]examinations of Mr. Klein that would cause you to

[6]contradict the testimony of Dr. DiGiacinto where there

[7]was no causation between the accident of May 20th, '03

[8]and the disc osteophyte complex at the C-5-C-6 level? **[*84]**

[9]MR. O'TOOLE: Objection; asked and

[10]answered.

[11]THE COURT: Overruled. Answer.

[12]A Well, actually, it is a little more

[13]complicated because the osteophyte clearly must have

[14]predated the accident. There is also -- because it is

[15]described as a disc osteophyte complex, it means there

[16]is disc material as well as osteophyte, and I could not

[17]exclude the possibility of this accident aggravating

[18]the degree of herniation of that disc, whereas the

[19]osteophyte is pretty much a clear-cut.

[20]Q Assume if you will then, Doctor, that

[21]Dr. DiGiacinto, the surgeon who operated on Mr. Klein,

[22]could not find any evidence of recent trauma with

[23]respect to the C-5-6 disc area.

[24]MR. O'TOOLE: Objection in that form,

[25]Judge.
724

[1]THE COURT: Overruled.

[2]Do you understand the question?

[3]THE WITNESS: No. Not at this point.

[4]THE COURT: Restate.

[5]Q Assume, Dr. Richter, that yesterday

[6]Dr. DiGiacinto testified that there was nothing, based

[7]on his examination of the plaintiff and all the records

[8]and films, to indicate the presence of any recent

[9]trauma at the C-5-C-6 level. **[*85]**

[10]MR. O'TOOLE: Objection.

[11]THE COURT: Overruled. You may answer.

[12]The jury will recollect what the testimony

[13]actually was.

[14]A Then if that's what he stated, that's what he

[15]stated.

[16]Q And you have nothing that you have seen to

[17]dispute that, do you?

[18]A No.

[19]Q Now, Doctor, assume also that Dr. DiGiacinto

[20]who did the surgery said, based on his subsequent

[21]followup examinations of Mr. Klein's subsequent MRI's,

[22]x-rays, CT scans, everything he has done since that

[23]time, he is of the opinion that with respect to this

[24]dual level fusion that he performed in July of 2005,

[25]that the fusion at the C-4-C-5 level looks like it
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[1]worked as hoped for prior to surgery, but that he

[2]believes that there is likely pseudarthrosis or a lack

[3]of proper fusion at the C-5-6 level.

[4]A Yes.

[5]Q Okay? And you don't disagree with that at

[6]all. You have nothing to dispute that.

[7]A Not at all.

[8]Q Right.

[9]Doctor, would you agree with me then

[10]that if the accident of May 20th, 2003 was not a

[11]causative factor of the issues at C-5-6, and that it is

[12]the C-5-6 level **[*86]** where you have the pseudarthrosis or

[13]the failed fusion, that it would be reasonable to

[14]assume that the accident of that date does not relate

[15]to the pain emanating from the C-5-6 level?

[16]MR. O'TOOLE: Objection to form, Judge.

[17]THE COURT: Overruled.

[18]A No, I would disagree with that. Though the

[19]accident certainly was the precipitating factor for the

[20]patient going to have the surgery and in terms of the

[21]symptoms at the C-5-6 level, in a patient who had been

[22]previously asymptomatic, the accident would be a

[23]competent cause of pain at that level and of the

[24]patient pursuing surgical treatment.

[25]Q Prior to the surgery a number of studies were
726

[1]done; correct? And you have reviewed some of those

[2]studies; correct?

[3]A Yes.

[4]Q And you indicated in response to

[5]Mr. O'Toole's question that, based on your review of

[6]the EMG done July 2nd, 2003 about a month and-a-half

[7]after this accident, that there were radiculopathies

[8]from the C-5-6 level?

[9]A Yes.

[10]Q But you do not note on your report that the

[11]EMG demonstrated any issues with respect to the C-4-5

[12]level?

[13] **[*87]** A That's correct.

[14]Q Further on when you did do your examination

[15]of Mr. Klein in October of 2005, which is two

[16]and-a-half years after the accident and two and-a-half

[17]months after the surgery, based on your examination you

[18]found sensation was present but decreased in the left

[19]C-5-6 distribution.

[20]A Yes.

[21]Q But you didn't note that there was any

[22]decrease in sensation from the C-4-5 level.

[23]A That's right.

[24]Q And what are dermatomes, Doctor?

[25]A Dermatomes are the areas on the skin that
727

[1]correlate to the area where sensation is provided by a

[2]particular nerve root level.

[3]Q Sometimes a person like myself might go into

[4]a doctor's office and you will see the chart that shows

[5]all the nerves?

[6]A Yes.

[7]Q And, you know, makes your head explode if you

[8]don't know what you are looking at. But you know what

[9]you are looking at; right?

[10]A Yes.

[11]Q And that chart -- you have seen that chart or

[12]similar charts, both as part of your education and over

[13]the many, many years you have been in practice;

[14]correct?

[15]A Yes.

[16]Q And based on **[*88]** your practice, you know what

[17]nerves go to what parts of the body; correct?

[18]A Yes.

[19]Q So you know if there is a problem at C-5-6,

[20]you can see, based on dermatomes and other indicia, if

[21]it is a C-5-6 problem; correct?

[22]A Yes.

[23]Q And the same would be for any of the other

[24]cervical, thoracic, lumbar disc areas; right?

[25]A Yes.
728

[1]Q They all -- you know, all of these green

[2]lines that pop out go somewhere and refer to something;

[3]correct (Indicating)?

[4]A Yes.

[5]THE COURT: Mr. Tumbarello, let's pick

[6]up the pace, here.

[7]MR. TUMBARELLO: I am trying, Judge.

[8]Q What is affected, Doctor, by the nerves that

[9]come out of the C-5-6 area; what body parts?

[10]A Actually, the terminology is getting a little

[11]bit confusing because the C-5-6 level when we talk

[12]about spine anatomy is between the C-5 vertebral body

[13]and C-6. When I note decreased sensation in C-5-C-6 on

[14]a sensory exam, I am now talking about the C-5 nerve

[15]root and the C-6-nerve root distribution or dermatome

[16]and the C-6 dermatome.

[17]So in terms of the parts of the body

[18]that are affected **[*89]** by it, we are talking about the

[19]arm -- coming down into the arm and involving this

[20]side. I am indicating the side of the hand closer to

[21]the thumb. This area would be affected by it, sparing

[22]the little finger (Indicating).

[23]Q That would be the C-5-6 dermatome area?

[24]A The C-5 dermatome and the C-6 dermatome.

[25]Q Okay. Now, you said that would be like the
729

[1]index finger and the thumb, this area here

[2](Indicating)?

[3]A Maybe I am not indicating clearly, but

[4]excluding, sparing the little finger.

[5]Q No little finger involvement.

[6]A Part of the ring finger also is spared.

[7]Q Is it possible, Doctor, that someone can have

[8]a problem such as an osteophyte disc complex at the

[9]C-5-C-6 level and not feel neck pain but exhibit

[10]symptoms from that osteophyte disc complex in this area

[11]of the hand that you have indicated that is affected by

[12]the C-5-6 --

[13]MR. O'TOOLE: Objection; calls for

[14]speculation.

[15]THE COURT: Overruled. I will let the

[16]doctor answer that.

[17]A Yes, it is possible to have symptoms in the

[18]hand or arm and not the neck. That's possible.

[19] **[*90]** Q So earlier today when Mr. O'Toole showed you

[20]Dr. Giannone's records from May 1st, 19 days prior to

[21]the accident, that indicated pain and stiffness in the

[22]fingers, I think specifically with reference to the

[23]index finger, could that pain and stiffness which was

[24]reported by Dr. Giannone in both hands bilaterally

[25]having existed for several weeks prior to the May 1st
730

[1]examination, could that pain and stiffness that

[2]Mr. Klein saw Dr. Giannone about have originated from

[3]the C-5-6 disc osteophyte complex?

[4]A Not as described in Dr. Giannone's note, no.

[5]The pattern is not right.

[6]Q Now, Doctor, will you agree with me -- you

[7]talked about loss of consciousness and I think some

[8]form of partial amnesia; correct?

[9]A Yes.

[10]Q And you reviewed the ambulance call report

[11]and the Staten Island University Hospital records?

[12]A Yes.

[13]Q And there was a question mark about that;

[14]correct?

[15]A Right.

[16]Q There may have been loss of consciousness,

[17]there may have not been loss of consciousness; right?

[18]A Yes.

[19]Q And you also reviewed the films that were

[20]taken **[*91]** during the time that the patient was in the

[21]hospital. The accident was 9:45 at night. She left

[22]the next day.

[23]A Right.

[24]Q And those x-rays, Doctor, did they show any

[25]evidence on the x-rays themselves of any injury to this
731

[1]patient's neck?

[2]A No.

[3]Q And after those x-rays were taken and she was

[4]examined by the physicians at Staten Island University

[5]Hospital, the records reflect, you will agree with me,

[6]that the cervical collar which the EMS people had put

[7]on at the scene of the accident was discontinued.

[8]A Yes.

[9]Q Doctor, do you know from any of the records

[10]that you have seen if any physician has ever prescribed

[11]the cervical collar for Mr. Klein? From the records

[12]you have seen.

[13]A I haven't seen a prescription, no.

[14]Q Now, when you talked about the amnesia and

[15]possible loss of consciousness, at some point there was

[16]a brain M:RI done; correct?

[17]A Yes.

[18]Q And you reflect that it was normal in your

[19]report; correct?

[20]A Yes.

[21]Q And you also reviewed the issues about post

[22]concussion syndrome, and that was also found to be

[23] **[*92]** unfounded?

[24]A I don't understand.

[25]MR. TUMBARELLO: I will withdraw that
732

[1]question. I will move on.

[2]Q Now, Doctor, you mentioned the desiccation in

[3]the discs of the cervical spine and the degeneration in

[4]the discs of the cervical spine and the osteophytic

[5]growth in the cervical spine that are reflected on the

[6]June 18th, 2003 MRI and also on the August 25th, 2004

[7]MRI's; correct?

[8]A Actually, as I look at the June 18th, 2003 I

[9]don't see desiccation specifically referenced. What

[10]was the other date?

[11]Q I think your report says that the MRI of

[12]8/25/04 showed similar cervical findings.

[13]A Yes, that's what my report says. Yes.

[14]Q Was desiccation noted anywhere on that

[15]report?

[16]MR. O'TOOLE: Objection. Which report

[17]is he talking about, 6/18 or 8/04?

[18]THE COURT: Clarify, please.

[19]Q Is desiccation noted on the 6/18 report

[20]anywhere?

[21]A No, I don't see desiccation on 6/18.

[22]Q How about on the 8/25/04 report?

[23]A Yes, it is.

[24]Q Is degeneration noted on the 6/18 report?

[25]MR. O'TOOLE: Objection; asked and
733

[1]answered, **[*93]** Judge.

[2]THE COURT: Overruled.

[3]Q Is degeneration noted on the August '04

[4]report?

[5]THE COURT: This has been asked.

[6]A Yes. August, yes.

[7]Q Is osteophyte disc complex noted on the

[8]August '04 --

[9]MR. O'TOOLE: Objection; asked and

[10]answered.

[11]THE COURT: Sustained. Pick up the

[12]pace, please.

[13]Q Doctor you also looked at the MRI of the

[14]lumbar spine; correct?

[15]A Yes.

[16]Q Did that also show evidence of desiccation?

[17]MR. O'TOOLE: Objection; beyond the

[18]scope, Judge. Other grounds.

[19]THE COURT: Sustained as to lumbar.

[20]Q Doctor, would you want to know -- if someone

[21]was suffering from cervical osteophyte disc complex

[22]conditions, would you want to know whether or not that

[23]patient also had osteophyte disc complex in other areas

[24]of the spine?

[25]A Not as far as the neck goes, no.
734

[1]Q Doctor, what was the basis of your finding on

[2]your physical exam when you said "noted to be well

[3]developed, well nourished woman in some apparent

[4]discomfort?"

[5]What was the basis of your findings

[6]there?

[7]A Based on **[*94]** observation.

[8]Q Doctor, of course you saw her two and-a-half

[9]months after the surgery and you noted that there was a

[10]five-centimeter scar?

[11]A Yes.

[12]Q And that was on her neck -- his neck?

[13]A Yes.

[14]Q And you indicated that that was healing well;

[15]correct?

[16]A Sure.

[17]Q At the time of your examination, Doctor, did

[18]you notice or observe any indication that Mr. Klein was

[19]suffering or would be suffering from pseudarthrosis

[20]with respect to the fusion surgery two and-a-half

[21]months previously?

[22]MR. O'TOOLE: Objection. Can we fix

[23]this in time to the first exam or the second exam?

[24]THE COURT: Sustained. Clarify.

[25]Q With respect to your examination two
735

[1]and-a-half months after the disc fusion surgery, did

[2]you observe any signs, any medical indications,

[3]anything in either the records you saw or your physical

[4]examination of this patient to indicate a

[5]pseudarthrosis?

[6]A No.

[7]Q Yet when you saw Mr. Klein last week after

[8]this jury selection had commenced, were your findings

[9]the same?

[10]A Well, there are no physical findings for

[11] **[*95]** pseudarthrosis. It is a diagnosis that has to be made

[12]based on radiologic testing. My review of the records

[13]clearly indicated it.

[14]Q Now, Doctor, you talked to Mr. O'Toole about

[15]paraspinal muscle spasms?

[16]A Yes.

[17]Q Are they reflected in the Staten Island

[18]University Hospital records?

[19]A In terms of being prescribed Flexoril, yes.

[20]Q Flexoril would be a medication that would be

[21]prescribed for --

[22]A Muscle spasm.

[23]Q -- muscle spasm. And that's an oral

[24]medication; correct?

[25]A Yes, it is.
736

[1]Q And so that would affect muscle spasms

[2]anywhere in the body; correct?

[3]A Sure.

[4]Q Was there anything in the records that talked

[5]about paraspinal -- the diagnosis by any of the doctors

[6]at Staten Island University Hospital that diagnosed

[7]paraspinal muscle spasm in this patient's cervical

[8]region?

[9]A I would have to check.

[10]Q That is a yes or no question.

[11](Short pause.)

[12]A I just see a reference to muscle spasm. It

[13]doesn't specify where.

[14]Q Okay, thank you.

[15]Now, Doctor, when you did your

[16]examination in **[*96]** October of 2005, you mentioned that you

[17]examined the patient's skin?

[18]A Yes.

[19]Q And when you did your examination of the

[20]patient's skin, were you, in addition to noting the

[21]five-centimeter cervical scar as a result of the fusion

[22]surgery, did you note the mastectomy scars?

[23]A No.

[24]Q You didn't examine that part of the anatomy?

[25]A That's right.
737

[1]Q Now, when you say you examined the patient's

[2]skin, did you examine the skin area in and about the

[3]face and neck?

[4]A Yes.

[5]Q And did you make an observation whether or

[6]not there was any facial hair growth that would be

[7]indicative of someone on a testosterone regimen?

[8]A I did not make a notation of facial hair

[9]growth which could be either on a testosterone regimen

[10]or for many other medical conditions.

[11]Q But you made no -- do you have a recollection

[12]as you sit here today when you did this examination of

[13]Mr. Klein if there was indicia of facial hair growth?

[14]A I don't recall anything that looked abnormal,

[15]no. Not at all.

[16]Q When you examined Mr. Klein last week, did

[17]you make an observation **[*97]** of facial hair growth?

[18]A Yes, I did.

[19]Q But you don't recall if you made any a couple

[20]of years ago?

[21]MR. O'TOOLE: Objection. Asked and

[22]answered. He just said he didn't.

[23]THE COURT: Overruled. Move on.

[24]Q Now, Doctor, would you agree with me that

[25]some people who have discectomy surgery, the surgery
738

[1]eliminates the symptoms? Correct?

[2]A Yes.

[3]Q Would you agree with me, Doctor, that some

[4]people who have discectomy surgery accompanied by a

[5]fusion, that that procedure eliminates the symptoms?

[6]A For some, yes.

[7]Q Would you agree with me that if Mr. Klein

[8]goes for the surgery that there has been testimony that

[9]he plans to do, that that surgery, if it remedies the

[10]pseudarthrosis at the C-5-6 level and there is no other

[11]pseudarthrosis, that that could alleviate Mr. Klein's

[12]symptoms?

[13]A It may reduce them.

[14]Q Reduce it substantially?

[15]A Possibly.

[16]Q Reduce it to the point where narcotic

[17]medication is not required?

[18]A I don't expect so.

[19]Q Now, Doctor, have you examined patients who

[20]have had fusion surgery -- **[*98]** let me ask you the question

[21]this way, Doctor.

[22]You have examined many patients who are

[23]post fusion surgery; correct?

[24]A Yes, I have.

[25]Q Specifically, cervical fusion; correct?
739

[1]A Yes.

[2]Q Are all of the patients that you have

[3]examined, post cervical fusion surgery, are they all on

[4]narcotic medication?

[5]A Depends upon the timeframe. Early on

[6]virtually all of them. Maybe 99 percent plus take

[7]narcotic medication for a period of time. Later on

[8]most of them get off it.

[9]Q 99 percent get off it?

[10]A No.

[11]Q What percent get off it eventually?

[12]A Oh, well, I would say if you looked at the

[13]whole population of people with cervical fusion, no

[14]more than half get completely off of some type of

[15]narcotic.

[16]Q Now, Doctor, you mentioned Vicodin and

[17]Percocet?

[18]A Yes.

[19]Q What is the difference between those two?

[20]A They are different medications. Vicodin is

[21]hydrocodone, Percocet is oxycodone. They are

[22]considered similar. They are similar narcotic

[23]painkillers.

[24]Q And both in the typical prescription are

[25]combined **[*99]** with Tylenol?
740

[1]A Yes.

[2]Q Hydrocodone, Doctor: Is that a generic drug?

[3]A Hydrocodone can be a generic. Vicodin is the

[4]brand name.

[5]Q Vicodin is the brand name but hydrocodone is

[6]the generic name?

[7]A Yes.

[8]Q Doctor, in your practice, do you prescribe

[9]hydrocodone to your patients?

[10]A Yes.

[11]Q And do you ever prescribe generic brands of

[12]hydrocodone to your patients?

[13]A Yes.

[14]Q And Mr. O'Toole asked you about your

[15]expertise in pricing the cost of brand name Vicodin as

[16]part of your expertise, Doctor. Have you priced the

[17]cost of generic hydrocodone?

[18]A Yes. The prices that I quoted to Mr. O'Toole

[19]when there is a generic equivalent, I was quoting him

[20]the generic cost. When there is no generic equivalent,

[21]I am quoting him the brand name cost.

[22]Q Doctor, you follow what goes on in the

[23]medical field and in the pharmaceutical field; correct?

[24]A Yes.

[25]Q And with respect to a large number of generic
741

[1]drugs, there is advertising that we hear on the radio

[2]and television about Wal-Mart and Safeway offering

[3]generic **[*100]** drugs --

[4]MR. O'TOOLE: Objection.

[5]THE COURT: Sustained. Where are we

[6]going with this?

[7]Q Doctor, have you done any studies to

[8]determine what the least expensive cost would be for a

[9]one-month prescription of generic hydrocodone?

[10]MR. O'TOOLE: Objection.

[11]THE COURT: I am going to let him answer

[12]that.

[13]A I looked at what the average cost would be in

[14]this area based on the data from the New York State

[15]website, as well as the cost cited on the Epocrates

[16]Website for the manufacturer's suggested price.

[17]Q And what is the lowest cost that you were

[18]able to find, based on your research, for someone to go

[19]out and purchase generic hydrocodone?

[20]MR. O'TOOLE: Objection, your Honor.

[21]Beyond the scope. Other grounds.

[22]THE COURT: It is not beyond the scope

[23]but it is a stretch so …

[24]Did you do any research on what's the

[25]lowest versus the highest? Are you doing this
742

[1]range business?

[2]MR. O'TOOLE: Judge, this is a universal

[3]scope.

[4]THE COURT: Don't argue. Don't argue.

[5]Did you do any search as to that?

[6]THE WITNESS: I **[*101]** did look at the range of

[7]prices on the website. Typically the prices don't

[8]vary by more than, say, 10 percent up or down for

[9]these common drugs.

[10]THE COURT: Let's move on, please.

[11]Q You would have the same answers if I asked

[12]about the generic oxycodone, or Percocet.

[13]A That's right.

[14]Q Doctor, you talked about physical therapy;

[15]correct?

[16]A Yes.

[17]Q And I think in your report you mentioned that

[18]Mr. Klein has done courses of physical therapy.

[19]A Yes.

[20]Q Do you know how many physical therapy

[21]sessions Mr. Klein had gone to prior to the accident --

[22]prior to the surgery?

[23]A Not the exact number, no.

[24]Q Would it refresh your recollection if I were

[25]to suggest to you that Mr. Klein's medical records
743

[1]indicate PT session --

[2]MR. O'TOOLE: Objection to reading

[3]documents not in evidence.

[4]THE COURT: Sustained.

[5]Q Doctor, you have made a "P" word. The "P"

[6]word. Not prognosis. You have prognosticated that at

[7]some point in the future Mr. Klein will start to be a

[8]candidate who could be benefited by physical therapy;

[9]correct? **[*102]**

[10]A Yes.

[11]Q With respect to looking into the future,

[12]Doctor, would you agree with me that in making such a

[13]prediction -- that might have been the word I was

[14]looking for -- into what the future will hold, that you

[15]should sometimes look and see what past history has

[16]been?

[17]A That's part of it.

[18]Q Doctor, if you were to be advised or if the

[19]records that come into evidence or may already be in

[20]evidence were to indicate approximately 12 physical

[21]therapy sessions --

[22]MR. O'TOOLE: Objection. Calls for

[23]speculation. If he has an offer of proof or

[24]something in evidence, fine.

[25]THE COURT: Sustained.
744

[1]Q Doctor, did you ask Mr. Klein how many

[2]physical therapy sessions he had actually been to?

[3]A No.

[4]Q Did you ask Mr. O'Toole to provide you with

[5]any medical records reflecting the number of physical

[6]therapy sessions that Mr. Klein had actually been to?

[7]A No.

[8]Q Would you agree with me, Doctor, that there

[9]could well be a relationship with respect to future

[10]physical therapy sessions that this patient may go to

[11]by looking at the number **[*103]** of physical therapy sessions

[12]this patient went to in the past?

[13]A In this particular case not so much because

[14]we now know that he has this problem with the

[15]pseudarthrosis which can help to explain his poor

[16]tolerance of physical therapy after the surgery. So,

[17]therefore, if he has a successful radiologic outcome of

[18]the redo of the fusion, then we would have a reasonable

[19]hope that he will be able to do this therapy.

[20]Q Well, Doctor, have you reviewed the

[21]postsurgical consultation records of Dr. DiGiacinto?

[22]A Yes, I have.

[23]Q And will you agree with me, Doctor, that the

[24]first postsurgical consult was in the middle of April

[25]after the July 26th surgery?
745

[1]A I need to see that. I am sorry.

[2]MR. O'TOOLE: Could I have that question

[3]read back, please.

[4]MR. TUMBARELLO: I will withdraw that

[5]question because I do want to ask another question

[6]before that.

[7]Q Doctor, you know that the surgery was on

[8]July 26th?

[9]A Yes.

[10]Q And you know that Mr. Klein, with the consent

[11]and approval of Dr. DiGiacinto, checked out of the

[12]hospital the next day, the **[*104]** 27th.

[13]A Yes.

[14]Q Assume, Doctor, that the next time Mr. Klein

[15]saw the surgeon, Dr. DiGiacinto, was in the middle of

[16]August of '05, then he saw Dr. DiGiacinto again in

[17]September of '05, and that Dr. DiGiacinto has a note

[18]about looking at some x-rays on or about

[19]October 12th of '05, and then the next visit was in

[20]January of '06.

[21]A Yes.

[22]Q Assume -- you can double-check with the

[23]records you have because I don't want to make a

[24]mistake -- that during none of that period of time

[25]there was a diagnosis of a failed fusion or
746

[1]pseudarthrosis.

[2]A Yes.

[3]Q Do you know if during that period of time --

[4]this is now six months post surgery -- if Mr. Klein

[5]went for any physical therapy?

[6]A I did see reference to actually

[7]Dr. DiGiacinto asking another physician to arrange the

[8]therapy. He made a note that he didn't know therapists

[9]on Staten Island, so he was referring it to someone

[10]else, and I forget who that was.

[11]Q You and I recall that note the same way. He

[12]sent a note to Dr. Giannone saying --

[13]A That is who it was.

[14]Q -- I am in Manhattan **[*105]** and the patient lives in

[15]Staten Island, who do you know that does PT out there.

[16]A Yes. That's right.

[17]Q But do you know if even after Dr. DiGiacinto

[18]sent that note to Dr. Giannone, if Mr. Klein went for

[19]physical therapy at any point on July 26th until

[20]Dr. DiGiacinto's exam in January '06?

[21]A I believe he went for a very small amount and

[22]didn't tolerate it and stopped.

[23]Q Okay. Now, Doctor, you have talked about a

[24]multitude of physical therapy modalities; correct?

[25]A Yes.
747

[1]Q And you would agree with me, Doctor, that as

[2]a physiatrist understanding different physical therapy

[3]modalities is part and parcel of your particular field

[4]of expertise.

[5]A Yes.

[6]Q Okay? And you mentioned a few. One you said

[7]was massage; correct?

[8]A Yes.

[9]Q All right? And that's where the physical

[10]therapist actually puts their hands on the patient and

[11]moves body parts; correct?

[12]A Yes.

[13]Q And also physical therapy exercise also

[14]involves moving of body parts; correct?

[15]A Right.

[16]Q And you would agree with me that sometimes,

[17]depending **[*106]** on how the physical therapist touches the

[18]body, that that could be a competent producing cause of

[19]pain.

[20]A Yes.

[21]Q And you have written a number of physical

[22]therapy -- probably thousands of physical therapy

[23]prescriptions over the years.

[24]A At least, yes.

[25]Q Okay. And when you order physical therapy,
748

[1]you know, you indicate the part of the body that the

[2]physical therapist is supposed to provide the therapy

[3]to; correct?

[4]A Yes.

[5]Q If the therapist has any questions about

[6]that, they always know they can call you; correct?

[7]A That's right.

[8]Q And you can discuss with the therapist the

[9]modality or treatment plan; correct?

[10]A Yes.

[11]Q And if massage causes pain, you can go with

[12]muscle movement and see if that works to achieve the

[13]result of physical therapy; correct?

[14]A Yes.

[15]Q And if muscle movement causes pain, you can

[16]try massage; correct?

[17]A Yes.

[18]Q Now, in addition to those two modalities that

[19]we discussed, you mentioned a TENS unit. What is a

[20]TENS unit?

[21]A TENS unit is an electrical device. It is a

[22] **[*107]** small box with electrodes that the person attaches to a

[23]body part.

[24]Q Right. And it puts electrical currents

[25]through the body; correct?
749

[1]A Yes.

[2]Q The current goes from one pad, electro pad --

[3]A Yes.

[4]Q -- to another. All right? And it's tingly,

[5]and it could be painful, depending on how high they

[6]jack up the power; right?

[7]A Yes.

[8]Q And typically the physical therapist, when

[9]they have you hooked up to these electrodes, they will

[10]say, Do you feel it yet, do you feel it, is it

[11]uncomfortable, is it too painful. Correct?

[12]A That's right.

[13]Q So the amount of pain that is induced by the

[14]TENS therapy is something that could very well be

[15]discussed between the patient and the physical

[16]therapist; correct?

[17]A That's right.

[18]Q And that the physical therapist can throttle

[19]down the power to a level that's comfortable for the

[20]patient; correct?

[21]A Yes.

[22]Q But still provides a form of some effective

[23]therapy; correct?

[24]A Yes.

[25]Q Do you know if at any time after this
750

[1]accident Mr. Klein had TENS electrostimulation **[*108]** therapy?

[2]A NO.

[3]Q Do you know if at any time after the accident

[4]and before the surgery if Mr. Klein had TENS

[5]electrostimulation therapy?

[6]A No.

[7]Q But that's something where the pain could be

[8]adjusted between the therapist?

[9]A Yes.

[10]Q And it could be effective even at those

[11]levels.

[12]A As a treatment?

[13]Q Yes.

[14]A It might be.

[15]Q What is ultrasound in terms of physical

[16]therapy ultrasound, not I am going to have a baby here?

[17]A Yes. Your treatment ultrasound causes water

[18]molecules inside the body to vibrate, and that gives

[19]off heat, so it is a deep heating modality.

[20]Q Does it relieve symptoms of pain?

[21]A Sometimes.

[22]Q What's the design of having someone undergo

[23]ultrasound physical therapy?

[24]A The design is that the therapist holds

[25]something that looks like -- looks kind of like a
751

[1]microphone and applies it over the surface.

[2]Q First they put some cream on you first?

[3]A Some gel.

[4]Q They lather you up with cream and they run it

[5]over there:?

[6]A Yes.

[7]Q And it heats the **[*109]** water molecules inside the

[8]body?

[9]A Inside.

[10]Q To cause relief of pain symptoms; right?

[11]A Yes.

[12]Q And will you agree with me, Doctor, that the

[13]power setting on the ultrasound machine is also

[14]something that could be regulated by the physical

[15]therapist?

[16]A Yes.

[17]Q Because they do attach an electrode in one

[18]place and a -- okay. And that power setting --

[19]MR. TUMBARELLO: I withdraw the

[20]question -- first part of the question. It is

[21]improper.

[22]Q That power setting would affect how much

[23]stimulation or pain the patient felt; correct?

[24]A No, ultrasound is usually not painful.

[25]Q Okay. So ultrasound therapy is not a
752

[1]competent producing cause of pain?

[2]A Shouldn't be.

[3]Q And would it be your opinion, based on your

[4]examination of the records and of Mr. Klein, that

[5]ultrasound may be a form of physical therapy that could

[6]be considered by Mr. Klein?

[7]A Well, pre-fusion it could have been done to

[8]any part of him as to any other patient. Post-fusion

[9]you can't apply it to the cervical paraspinals.

[10]Q But if there are **[*110]** other pains, it could be

[11]helpful?

[12]A Could do it elsewhere, yes.

[13]Q In addition to the TENS unit, the

[14]unultrasound, the massage and the exercise, what other

[15]modalities of physical therapy are you familiar with?

[16]A Well, there are several different types of

[17]heating. There is diathermy, shortwave, infrared,

[18]various heating modalities. There is also --

[19]Q What do the heating modalities accomplish

[20]when used in the form of physical therapy?

[21]A The theory is that they increase local blood

[22]flow and by that process help to facilitate healing.

[23]Q Diathermy: What is that?

[24]A It is another heating treatment. All

[25]variations on heat.
753

[1]Q There is also heat hydrotherapy?

[2]A Yes.

[3]Q That is where you just put a hot pack on

[4]someone.

[5]A Yes. Sure.

[6]Q And that causes healing and relief of

[7]symptoms?

[8]A Yes.

[9]Q And ultrasound is a heating modality that

[10]causes relief of symptoms -- did you say ultrasound?

[11]A I mentioned that before. Ultrasound, yes.

[12]And there is also electrical stimulation.

[13]Q And infrared?

[14] **[*111]** A Infrared is another heating.

[15]Q These modalities, are they painful?

[16]A As a rule, no.

[17]Q Would any of these modalities be helpful for

[18]Mr. Klein?

[19]A They might be.

[20]Q They might be. Do you know if -- two

[21]questions. First, the period of time from the accident

[22]until the surgery, do you know if Mr. Klein had any of

[23]these physical therapy modalities?

[24]A No. Not specifically.

[25]Q Do you know if from the period of time from
754

[1]the surgery to when you first examined Mr. Klein in

[2]October of '05 if he had any of these modalities for

[3]physical therapy?

[4]A No.

[5]Q Do you know if from the period of time from

[6]your examination of Mr. Klein up until today if

[7]Mr. Klein has had any of these modalities of physical

[8]therapy?

[9]A No.

[10]Q Yet you have told Mr. O'Toole that Mr. Klein

[11]may be a candidate for 36 physical therapy session a

[12]year for the rest of his life costing $ 100 a session.

[13]A Yes.

[14]Q Now, those weren't started after the fusion

[15]or after your examination; correct?

[16]A Correct.

[17]Q And would any of those take place between **[*112]** now

[18]and the fusion surgery?

[19]A Well, I don't expect him to get any traction

[20]in terms of relieving his pain so I don't think it

[21]would be helpful.

[22]Q And after the fusion surgery, would there be

[23]a period of time when there wouldn't be any physical

[24]therapy?

[25]A Well, typically right after fusion the
755

[1]therapy consists of teaching someone to get in and out

[2]of bed, on and off a chair, some basic things like

[3]that. Some of the modalities can be done. And then

[4]the idea is to progress someone to more active

[5]exercise.

[6]Q Now, Doctor, in your experience, physical

[7]therapists charge primarily by the modality that they

[8]do; correct?

[9]A Yes.

[10]Q And if there is one modality that works,

[11]which is, let's say, putting hot packs on the back,

[12]okay, and that's the only one they do, would that be a

[13]hundred dollars?

[14]A If someone was only getting a hot pack, you

[15]probably couldn't justify the therapy. But, yes, if

[16]that was the only service they provided, that is what

[17]they would charge.

[18]Q So the cost of the physical therapy would be

[19]directly related to what modality **[*113]** or modalities were

[20]applied.

[21]A Yes.

[22]Q And it could be well under a hundred dollars

[23]per session; correct?

[24]A For some sessions, yes.

[25]Q And your projection of 36 sessions per year
756

[1]would be based on Mr. Klein actually going; correct?

[2]A Yes.

[3]Q If he didn't go, he wouldn't get it.

[4]A That's right.

[5]Q Could you consider looking at the past

[6]history of going to doctors or physical therapists as

[7]an indicia of --

[8]MR. O'TOOLE: Objection. Asked and

[9]answered.

[10]THE COURT: Sustained. Its a quarter to

[11]2:00. Let's wrap it up, please.

[12]MR. TUMBARELLO: Yes.

[13]Q Doctor, do you know if in the period of time,

[14]based on the records you reviewed, if Mr. Klein has had

[15]ongoing regular treatment from a neurologist or a

[16]physiatrist?

[17]A I have seen various records of neurologists

[18]and physiatrists but I can't say that it was ongoing

[19]through the whole period.

[20]Q Doctor, in your testimony to Mr. O'Toole and

[21]in your report you have indicated followup visits with

[22]a neurologist or a physiatrist six times a year.

[23]That's every two months; **[*114]** right?

[24]A Yes.

[25]Q Over the past five years, has Mr. Klein been
757

[1]seeing a physiatrist or a neurologist every two months?

[2]A No.

[3]Q Will you agree with me, Doctor, that looking

[4]at this patient's past history of seeking a

[5]neurologist's care or a physiatrist's care is an

[6]indication of what this patient would do in the future?

[7]A Not necessarily, because he has been seeing

[8]pain management doctors who perform similar functions.

[9]So I certainly would include them in the same category,

[10]someone who could do similar stuff.

[11]Q Now, Doctor, you have seen all of

[12]Dr. DiGiacinto's records, and he has seen Mr. Klein

[13]several times since the surgery; correct?

[14]A Yes.

[15]Q And it is anticipated that future surgery

[16]will take place.

[17]A Yes.

[18]Q And you have estimated the cost of that

[19]future surgery at 40 to $ 50,000?

[20]A Yes.

[21]Q You have indicated that the typical visit

[22]once a year from a spine surgeon would be $ 150;

[23]correct?

[24]A Yes.

[25]Q Now, if the revision to the pseudarthrosis at
758

[1]C-5-6 is effective, why would this patient **[*115]** have to see

[2]the spine surgeon every year for the remainder of his

[3]life?

[4]A Initially it is largely for monitoring to

[5]make sure that it is indeed effective.

[6]Q Yes.

[7]A Following that, it's following for

[8]progression of problems at adjacent levels.

[9]Q Sure. And if there were problems to follow

[10]for, would that be something that the patient would

[11]know about? Would he feel a change in their condition?

[12]A Probably.

[13]Q Wouldn't that be an appropriate time for the

[14]patient to go seek a doctor?

[15]A If that eventually were to happen, that

[16]certainly would be appropriate, sure, for them to go

[17]see the doctor.

[18]Q If the refusion at C-5-6 is successful, as

[19]was the fusion at C-4-5, and it alleviated the pain

[20]symptoms, it really would be up to the patient whether

[21]he wanted to go see a spine surgeon.

[22]A Yes.

[23]Q Especially if on an occasional basis he was

[24]seeing his regular doctor; correct?

[25]A Well, I don't know if his GP would really be
759

[1]able to help him with this issue.

[2]Q Certainly he could -- you know, they could

[3]refer him to --

[4] **[*116]** A Sure.

[5]Q the proper care.

[6]A Sure.

[7]Q And you mentioned an MRI every couple of

[8]years. If the revision is successful and the patient

[9]sees a doctor even annually, it would be the decision

[10]of the doctor to order the MRI at that time; correct?

[11]A Yes.

[12]Q So it wouldn't be automatic to order a

[13]cervical MRI for someone who is not in pain or is

[14]asymptomatic.

[15]A No. It has to be ordered by the doctor.

[16]Q And the reason for a doctor to order it would

[17]be a patient coming into them saying I got a pain in my

[18]neck.

[19]A Yes.

[20]Q And if there is no, you know, change in the

[21]patient's condition, you know, assuming there is a

[22]successful result of the fusion, there would be no

[23]reason to get that MRI.

[24]A If they are having no pain or numbness or any

[25]of those other things, right.
760

[1]Q You would agree with me. Thank you.

[2]A Right.

[3]Q Now, Doctor, you talk about housekeeping and

[4]you say 20 hours a week for $ 400 a week. That's paying

[5]a housekeeper $ 20 an hour; correct?

[6]A Yes.

[7]Q That housekeeper would take care of laundry, **[*117]**

[8]vacuuming, that kind of stuff?

[9]A Yes.

[10]Q You indicate that there is no need for that

[11]at the current time but that 12 or 15 years from now

[12]when Mr. Klein becomes 50 that that may be appropriate;

[13]correct?

[14]A Yes. No need at the time of the report in

[15]part because he was getting some help from a family

[16]member.

[17]Q Sure. And people get into relationships,

[18]whether they are married or, you know, have a partner

[19]of some kind; correct?

[20]A Sometimes.

[21]Q And if you are in a relationship with a

[22]spouse or a partner, some people do some stuff, other

[23]people do the other stuff; correct?

[24]A Yes.

[25]Q I mean, that is like in a normal use; right?
761

[1]MR. O'TOOLE: Objection, your Honor.

[2]Well beyond the scope.

[3]THE COURT: Come on. Let's wrap this

[4]up, please.

[5]MR. TUMBARELLO: I am trying to get

[6]there, Judge.

[7]Q Doctor, assume that before the time of this

[8]trial this plaintiff was in about a seven-year

[9]committed relationship.

[10]A Okay.

[11]Q And assume that it is possible that after the

[12]trial is over that the plaintiff has a --

[13] **[*118]** MR. O'TOOLE: Objection. Calls for

[14]speculation.

[15]MR. TUMBARELLO: So does housekeeping

[16]expenses for 15 years.

[17]MR. O'TOOLE: Oh, you know, Judge, we

[18]have been on the issue.

[19]THE COURT: Sustained. Sustained.

[20]MR. O'TOOLE: That is ridiculous.

[21]Q If someone is in a marital or a partnership

[22]relationship, is it reasonable to assume that one

[23]person, the other person in this relationship, may do

[24]some of these chores you are charging?

[25]MR. O'TOOLE: Objection.
762

[1]THE COURT: I am going to let him

[2]answer.

[3]Q That you are assessing at $ 400 a week?

[4]A Yes, it may happen.

[5]Q Doctor, you talked about life expectancy.

[6]A Yes.

[7]Q And you have indicated that when someone,

[8]when a female is put on testosterone --

[9]A Yes.

[10]Q -- that the female life expectancy, which is

[11]generally longer than a male's, would decrease to that

[12]of a male's. Would that be your opinion?

[13]A Yes.

[14]Q And you know that this patient, this

[15]plaintiff, has had some surgery towards gender

[16]transition.

[17]A Yes.

[18]Q But I am asking you to assume **[*119]** that the only

[19]surgery that's been done relates to the chest area.

[20]A Okay.

[21]Q And that Mr. Klein continues to have the

[22]primary organs of a female.

[23]A Yes.

[24]Q And those primary organs, would you agree

[25]with me, Doctor, that they are subject to cervical
763

[1]cancer?

[2]A Yes.

[3]Q Uterine cancer?

[4]A Yes.

[5]Q All of the other conditions that would affect

[6]a female?

[7]A Yes.

[8]Q And would those conditions be exacerbated,

[9]alleviated or remain the same when you have a female on

[10]a testosterone regimen?

[11]A Actually, it is a mixed picture. I mean,

[12]actually I did exclude to mention that he has had the

[13]mastectomy, so that does alleviate the risk of breast

[14]cancer.

[15]Q Not entirely though; right?

[16]A Not entirely. But in terms of those other

[17]organs, yes, they may still develop cancer. Whether

[18]the risk is the same while on male hormones, that I am

[19]not certain of.

[20]MR. TUMBARELLO: You know what, Doctor?

[21]Thanks for putting up with me again today. May we

[22]meet again under better circumstances.

[23]REDIRECT EXAMINATION

[24]BY MR. O'TOOLE: **[*120]**

[25]Q Did Al Klein's mother cause the need for
764

[1]household services in the future?

[2]A No.

[3]Q Did Al Klein's potential future partner --

[4]MR. WILSON: Objection.

[5]THE COURT: Overruled.

[6]Q cause the need for future household care?

[7]A No.

[8]Q Did Al Klein's family cause the need for

[9]household care?

[10]A No.

[11]MR. TUMBARELLO: Just note my objection

[12]to this as beyond the scope.

[13]THE COURT: Overruled.

[14]Q Have you seen in your lifetime, Doctor, a

[15]correlation between getting -- you know, getting what

[16]you pay for? Have you seen that in your life?

[17]MR. TUMBARELLO: Objection.

[18]THE COURT: Sustained.

[19]Q Doctor, when you are prescribing assistive

[20]devices hypothetically to your patients, do you say, Go

[21]out and get the cheapest possible crappy walker you can

[22]get?

[23]MR. TUMBARELLO: Objection.

[24]THE COURT: Sustained.

[25]MR. TUMBARELLO: Beyond the scope.
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[1]Q Doctor, physical therapy isn't going to cure

[2]Mr. Klein; correct?

[3]A Not at all.

[4]Q The hope is it is going to help him; correct?

[5] **[*121]** A That's right. The hope is it will reduce his

[6]level of pain, make it more manageable.

[7]Q Based on what you have seen in the medical

[8]chart, has Al Klein been in pain for the last five

[9]years?

[10]A Yes.

[11]Q Has he explored a lot of conservative

[12]modalities of treatment to try and alleviate that pain?

[13]A Yes, he has. And that's with a generous use

[14]of the word "conservative," including some of the

[15]invasive procedures he has had with the rhizotomy and

[16]the epidurals.

[17]Q Rhizotomy involves burning the nerve in the

[18]neck; correct?

[19]MR. TUMBARELLO: Objection. Beyond the

[20]scope..

[21]MR. O'TOOLE: It is in evidence. I can

[22]put it in front of him.

[23]THE COURT: It has been mentioned

[24]before. Yes. Let's do it.

[25]Q That involves burning the nerves in the neck;
766

[1]right?

[2]A Yes, it does.

[3]Q That look like the guy is not trying to

[4]address his pain?

[5]MR. TUMBARELLO: Objection.

[6]THE COURT: Sustained. Argumentative.

[7]MR. O'TOOLE: It is.

[8]Q Doctor, is it medically valid to do what

[9]Mr. Tumbairello is trying to do, to separate the **[*122]** C-4-5

[10]and C-5-6 spinal problems --

[11]MR. TUMBARELLO: Objection.

[12]THE COURT: Overruled.

[13]Q -- of Mr. Klein?

[14]A No. Part of the problem, the terminology

[15]gets a little bit confusing. When we are talking about

[16]the spinal levels between the two bones, we talk about

[17]C-4-5 as meaning between four and five, or C-5-6 as

[18]between five and six. When I talk about a sensory

[19]deficit in a C-5-6 distribution, that's shorthand in

[20]medical jargon for sensory changes in the C-5 territory

[21]and sensory changes in the C-6 territory.

[22]So, therefore, the C-4-5 disc in

[23]Mr. Klein's case would be the competent cause for his

[24]C-5 territory sensory loss. The C-6-7 disc osteophyte

[25]complex would be the competent cause for his C-6
767

[1]territory.

[2]In terms of the C-4-5, we attribute it

[3]to the disc herniation. In terms of the C-5-6, we

[4]understand by the basis of what we know of medical

[5]knowledge he had the osteophyte before the accident.

[6]He presumably had some disc there, as well. But he

[7]didn't have symptoms, and he now has symptoms relating

[8]to the accident at that level also.

[9]Q Doctor, **[*123]** fair to say that something like

[10]depicted in Plaintiff's 6 --

[11]MR. TUMBARELLO: Objection. Beyond the

[12]scope.

[13]THE COURT: Objection.

[14]Q Can an accident wake up an asymptomatic

[15]problem, sir?

[16]A Yes.

[17]MR. TUMBARELLO: Objection.

[18]THE COURT: He can answer that.

[19]Q Is there a single person in this room right

[20]now that doesn't have an osteophyte?

[21]MR. TUMBARELLO: Objection.

[22]THE COURT: Overruled.

[23]A I saw some children in the back. They

[24]probably don't.

[25]Q All right. Having an osteophyte, does that
768

[1]make you a bad person?

[2]A Not at all.

[3]MR. TUMBARELLO: Objection.

[4]THE COURT: Sustained.

[5]MR. TUMBARELLO: I ask for an

[6]instruction that that be withdrawn.

[7]THE COURT: Sustained. Come on.

[8]Q Fair to say that Mr. Klein came to this

[9]accident with a spine that was normal for him?

[10]MR. TUMBARELLO: Objection.

[11]THE COURT: Sustained.

[12]Q The osteophyte existed before the accident;

[13]correct?

[14]A Yes.

[15]MR. TUMBARELLO: Asked and answered.

[16]Q Did that place him at a greater risk of being

[17] **[*124]** injured than someone that didn't have an osteophyte?

[18]MR. TUMBARELLO: Objection. Beyond the

[19]scope.

[20]THE COURT: Overruled.

[21]A Yes. It put him at greater risk.

[22]Q But that is a normal finding for a 32-year

[23]old; correct?

[24]A Yes. Sure.

[25]Q Doctor, you gave a cost of 40 to $ 50,000 for
769

[1]this future surgery; correct?

[2]A Yes.

[3]Q Did that include hospital costs?

[4]A That included the immediate surgical costs.

[5]That does not include things like consultants or

[6]followup care.

[7]Q Doctor, what is a baseline?

[8]A In terms of a --

[9]MR. TUMBARELLO: Objection. Beyond the

[10]scope.

[11]THE COURT: Overruled.

[12]A In terms of a person's function.

[13]Q Right.

[14]A A baseline is how that person is functioning,

[15]what their symptoms are, what they can do, how they

[16]move.

[17]Q Can a baseline also pertain to one's clinical

[18]presentation?

[19]A Absolutely.

[20]Q Fair to say that the 5/1/03 office note of

[21]Dr. Giannone provides us with a baseline as to what Al

[22]Klein's neck was before this accident?

[23]A Yes, it does.

[24] **[*125]** Q What does that baseline tell us sir?

[25]A He has got no presenting complaints of neck
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[1]pain, no complaints of decreased range of motion. None

[2]of those are documented there.

[3]Q And the problem with the fingers, the

[4]stiffness and pain in the finger, why doesn't that have

[5]anything to do with the neck, in your opinion?

[6]A Well, in that particular case we are talking

[7]about pain and stiffness. There was a description of

[8]some possible injury a few weeks previously after which

[9]this complaint was going on. And the doctor himself

[10]had a working diagnosis of early osteoarthritis, which

[11]is indeed quite possible.

[12]Q In the fingers; correct?

[13]A In the fingers.

[14]MR. O'TOOLE: Nothing further.

[15]THE COURT: Anything else?

[16]MR. WILSON: No, your Honor.

[17]MR. FARANDA: No, your Honor.

[18]THE COURT: Mr. Tumbarello?

[19]MR. TUMBARELLO: Thank you, your Honor.

[20]THE COURT: Thank you.

[21]All right. You may step down, Doctor.

[22]THE WITNESS: Thank you.

[23](Witness excused.)

[24]THE COURT: Let **[*126]** me see counsel here,

[25]please.

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